A COMPARATIVE ASSESSMENT OF ACCESS TO HEALTHCARE BETWEEN

HOMELESS BISEXUAL AND GAY YOUNG ADULT MEN IN NEW YORK CITY

by

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ABSTRACT OF THE DISSERTATION

A Comparative Assessment of Access to Healthcare Between Homeless Bisexual And

Gay Young Adult Men In New York City

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Background: In recent years, attention to homeless lesbian, gay, bisexual, transgender

and questioning (LGBTQ) youth has grown. Studies show that they are

disproportionately homeless when compared to non-LGBTQ youth. As a result of

homelessness, they face unprecedented health disparities. However, few studies have

examined access to and utilization of healthcare by the LGBTQ youth, particularly

among subgroups like homeless bisexual and gay youth.

Purpose: The purpose of the study was to conduct a comparative assessment of access to

healthcare and to compare access between homeless bisexual and homeless gay young

adult men in New York City.

Methods: The purposive sample of 30 subjects aged 18 and older was asked to answer a

brief survey questionnaire and undergo semi-structured interviews. Subjects were

recruited from a drop-in homeless youth center in New York City. Content analysis

methods and Andersen's Behavioral Model of Health Services (of vulnerable population)

theory were employed to critically analyze and investigate access to healthcare in this community within external contextual, individual (predisposing, enabling, and need), and health behavioral characteristics. Verbal informed consent was obtained.

Findings: Of the 30 participants, 56.6 % (17) were bisexual and 43.3% (13) gay. Homeless bisexual young adult men had more physical and mental health problems than homeless young adult gay men. Additionally, bisexual young adult men were disproportionately affected by barriers to healthcare than gay men. Bisexuals used hospital emergency departments more frequently than gays alongside using fewer LGBTQ-specific healthcare services than gays. The underlying structural barriers to healthcare between the two groups included the fragmentation of healthcare (including access to medication), interruptions in government benefits, lack of access to transportation, geographic concentration of healthcare services, limitation in LGBTQ-homeless shelters, and misperception of preventive healthcare. Facilitators of healthcare included comprehensive medical care, provision of incentives (like food, transportation fare, gift cards, and clothing), rapport with healthcare providers, and social support.

Conclusion: Homeless bisexual young adult men were found to use hospital ERs significantly more than homeless young adult gay men. Conversely, the research showed that more gay men accessed LGBTQ-specific healthcare services than bisexual men. Moreover, bisexual men described more physical and mental/behavioral health disease burdens than their counterparts. More largescale research is needed to examine the

behavioral characteristics between the two groups, especially to investigate why they

access healthcare services differently.

Dedication

To my mother, who was a homeless preadolescent child over fifty years ago in a

developing country.

To the urban homeless bisexual and gay young adult men in New York City who opened

their hearts to share the agony of living homeless and your experiences with the

healthcare system. I was there, too. I understand your struggles with sexual identity

issues, your desire for acceptance, and the longing for a humble abode that is supportive,

empathetic, and understanding of your needs.

Acknowledgments

To my beloved husband who has supported me unconditionally, John Joseph Loughran. We share this achievement together. Your unyielding love and grounded spirit helped me to shoot for the stars even in challenging and dubious times.

To my amazing twin girls, Rosanna June and Marguerite Sorrell, who taught me that the unimaginable can be accomplished with hard work and perseverance and who brightened our lives with hope and prosperity every day.

To my parents, James David Gunness and Dulcie Cusmie Gunness, who sacrificed their lives in honor of their kids to create more educational opportunities and a better future. To my beloved grandmother, Rosanna Gunness, who taught me patience, kindness and compassion. To the professors, mentors, and friends who have ushered me along the way by inspiring and motivating me to excel beyond measure.

Definitions

1. Access to healthcare: entry to the appropriate healthcare services at the right time in a way that contributes to better health outcomes and decreases disease burden among individuals and communities.

2. Bisexual: An individual who is sexually and romantically attracted to men and women.

3. Cisgender: An individual whose gender matches their sex assigned at birth.

4. Gay: An individual who identifies as a man and who is predominantly sexually and romantically attracted to other men.

5. Gender expression and gender role conformity further describe the extent to which a person does or does not adhere to expected gender norms and roles.

6. Gender Identity refers to a person's internal sense of being male, female, or something else. Since this is an internal feeling, a person's gender identity may not necessarily visible to others.

7. Homelessness: "(A) an individual who lacks a fixed, regular, and adequate nighttime residence . . . and (B) includes (i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement; (ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping

accommodation for human beings …; (iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and (iv) migratory children who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii)." (US Department of Education, 2002)

8. Lesbian: An individual who identifies as a woman and who is predominantly sexually and romantically attracted to other women.

9. Queer: An individual who does not identify as lesbian, gay, bisexual, or transgender but feels more comfortable identifying as "queer," which is commonly thought of as a term that is fluid and inclusive of diverse sexual orientations and/or gender identities.

10. Questioning: An individual who is unsure about his/her sexual orientation and/or gender identity and prefers to identify as "questioning" rather than adhering to a label that does not designate how he/she feels.

11. Sex: Designation of male/female based on biological characteristics.

12. Sexual Orientation: A label used to designate an individual's desire for intimate, emotional and/or sexual relationships with people of the same gender/sex, another gender/sex, or multiple genders/sexes.

13. Sexuality: A person's exploration of sexual acts, sexual orientation, sexual pleasure, and desire.

14. Survival Sex: Sex work engaged in by a person because of their extreme need. It describes the practice of people who are homeless or otherwise disadvantaged in society, trading sex for food, a place to sleep, other basic needs, or for drugs.

15. Transgender: An individual who identifies as the opposite sex from the sexual genitalia that he/she was born with.

16. Vulnerable population: "The degree to which a population, individual, or organization is unable to anticipate, cope with, resist, and recover from the impacts of disasters". WHO's example of such groups are children, pregnant women, elderly people, malnourished people, and people who are ill or immunocompromised (WHO, 2016). However, issues of poverty and its ramifications like homelessness, poor housing, and destitution (which reflect conditions of homeless LGBTQ young adults in NYC) are also major influencers of vulnerability (WHO, 2016).

17. Young adults (youth): Adolescents or young adult between 13 and 24 years of age (CDC, 2015).

Acronyms

ADD: Attention Deficit Disorder

ADHD: Attention Deficit Hyperactivity Disorder

AIDS: Acquired Immunodeficiency Syndrome

AHA: Affordable Healthcare Act

APA: American Pediatric Association

BG: Bisexual and Gay

BM: Behavioral Model

BMVP: Behavioral Model of Vulnerable Populations

CA: Content Analysis

CCA: Conventional Content Analysis

CDC: Centers for Disease Control and Prevention

CHN: Community Healthcare Network

DCA: Direct Content Analysis

DHHS: Department of Health and Human Services

DYCD: Department of Youth and Community Development

GT: Grounded Theory

HIV: Human Immunodeficiency Virus

HPV: Human Papilloma Virus

HRSA: Health Resources and Services Administration

IRB: Institutional Review Board

LGBTQ: Lesbian, Gay, Bisexual, Transgender and Questioning

MSM: Men who have sex with men

MVC: Mobile Van Clinics

NAC: New Alternatives Center

NYC: New York City

PREP: Pre-Exposure Prophylaxis

STIs: Sexually Transmitted Diseases

TB: Tuberculosis

US: United States

WHO: World Health Organization

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Chapter 1

Introduction

The purpose of this chapter is to justify the need for inquiry into the lived experience of homeless urban bisexual and gay (BG) men's access to and utilization of healthcare. The chapter posits the problem statement (the need to study this population), the problem's significance (the magnitude of the problem), the purpose of the study, the goals and objectives, and the research questions.

Problem Statement

In 2011, the Institute of Medicine (IOM) recognized that the Lesbian, Gay, Bisexual, Transgender and Queer/Questioning (LGBTQ) community is understudied with regards to health disparities (IOM, 2011). The IOM also acknowledged that studies have been fragmented or uneven across the LGBTQ spectrum. One of the reasons is that research conducted in the community is done predominantly with gay men and lesbian women, and less with bisexual men and transgenders (IOM, 2011). Additionally, research involving bisexual young adult men often integrate them into the same category as gay men or along with the general LGBTQ population. Nonetheless, bisexual and gay young adult men face unprecedented high rates of disease burden and health disparities compared to other groups in the United States (US) (Bandurraga, 2011; Bao, Whitbeck, L. B., Chen, X., Hoyt, D. R., Tyler, K. A., and Johnson, 2004; Boehmer, Bowen, and Bauer, 2007; Boehmer, Miao, Linkletter, and Clark, 2012; Cochran, Stewart, Ginzler and Cauce, 2002; Conron, K.J.; Centers for Disease Control and Prevention, 2010, HIV and AIDS among gay and bisexual men; Daley and MacDonnell, 2011; Durso and Gates, 2012; Gangamma, Slesnick, Toviessi, and Serovich, 2008; Garofalo, Deleon, Osmer,

Doll, and Harper, 2006; Haas et al., 2011; Hershberger and D'Augelli, 1995; Kitts, 2010; Marshall et al., 2008; McBride, 2012; Unger, Kipke, Simon, Montgomery, and Johnson, 1997; Whitbeck, et. al. 2014; Whitbeck and Hoyt, 1999). For example, Black bisexual and gay young adult men have greater rates of Human Immunodeficiency Virus (HIV) infection compared to any other population groups in the US (CDC, 2014). Young bisexual and gay adult men are also affected by disease conditions other than HIV. Sexually Transmitted Infections (STIs), suicide, psychiatric disorders, substance abuse, and victimization are at alarming rates, thereby crippling the health of the community (Cochran et al., 2002; Gangamma et al., 2008; Herek and Garnets, 2007; International Organization for Migration (IOM), 2011; McLaughlin, 2010; Remafedi, 1998; Roberts, 2010; Struble, 2010; Van Leeuwen et al., 2006; Walls, Hancock, and Wisneski, 2009; Whitbeck, 2004). Conchran (2002) found that, in general, bisexual and gay men have higher rates of depression, panic attacks, and psychological distress than their counterparts, heterosexual men. Moreover, bisexual and gay men also tend to have lower social support than heterosexual men (Dobinson, 2010). Given that studies show bisexual and gay men are at an increased risk for certain diseases, more research is needed to examine their access to and utilization of healthcare (including preventive healthcare) and compare the differences between the two groups. This is of critical importance particularly among one of the most vulnerable populations—homeless urban bisexual and gay young adult men.

Even though bisexual men represent the largest group in the LGBTQ spectrum, very limited studies specifically focus on their access to healthcare (Gates, 2011). Some studies conducted on bisexual men and their access to healthcare reveal more health

information on lesbian and bisexual women than bisexual men (Boehmer, 2012; Buchmueller, 2010; Heck, Sell, and Gorin, 2006; Wheldon, 2013). Very few studies focused on the health and behavior of bisexual men, and hardly any on homeless bisexual young adult men.

One study which examined homeless bisexual and gay men aged between 18 and 44 discovered that 26% reported poor health, 50% were found to be Hepatitis B positive, 31% were Hepatitis C positive, and 15% HIV-positive (Salem et al., 2015). However, there was no comparison between the two groups. With respect to access to healthcare, almost 50% reported ER visits (Salem et al., 2015). In another study that specifically examined bisexual men, sexually active bisexual men were found to be at an increased risk for anal cancer due to higher rates of Human Papilloma Virus (HPV) (Dobinson, 2010). Furthermore, bisexual men have reported unpleasant experiences with medical providers, particularly around stigma and judgment on their sexual identity, ignoring their sexual status and/or asking explicit questions about their lifestyle without focusing on non-sexual issues that are medically relevant (Dobinson, 2010).

In general, research on bisexual men have demonstrated that a significant proportion live in poverty (Ross et al, 2016). This is particularly disturbing given that there is a strong association between poor health outcomes and poverty (Braveman, 2010). More specifically, poor mental health, symptoms of depression, and, specifically, posttraumatic stress disorder is prevalent among bisexual individuals (Ross et al., 2016). In Conron's study (2010), bisexual men reported more barriers to healthcare than heterosexuals (Conron, 2010). Bisexual men also reported health disparities such as depression/sadness, suicidal ideation, and cardiovascular disease risk (Conron, 2010).

Adding to the list of health disparities, intimate partner violence among bisexual adults is three times greater than heterosexual adults (New Mexico Department of Health, 2010). Bisexual adults (23%) are also more likely to have increased rates of binge drinking than heterosexuals (14%) respectively (New Mexico Department of Health, 2010). In addition, they are two times greater to be depressed than heterosexual adults, 37% versus 17% respectively (New Mexico Department of Health, 2010). Dobinson (2010) revealed that bisexual men and women reported greater levels of suicide attempts, self-harm, and suicidal ideations than heterosexuals and even higher than gay men and lesbians.

With regard to homelessness, no study was identified that specifically focused on bisexual young adult men. Instead, they were lumped in with the LGBTQ population. In general, rates of homelessness among LGBTQ young adults are disproportionately higher compared to their heterosexual counterparts. Two of the main reasons for homelessness in this population are 1) rejection/neglect from their families because of their sexual orientation or gender identity and 2) they have grown out of the foster care system (Corliss et al., 2011; Durso and Gates, 2012). The average duration of homelessness for LGBTQ young adults in general is approximately two and a half years (Freeman and Hamilton, 2013). As a consequence of family rejection and conflict, many LGBTQ young adults flee their homes before becoming gainfully employed or educated, and thus, end up undereducated and underemployed/unemployed. Lack of education and/or employment may restrict their ability to develop the social capital necessary for stability and upward mobility. Many LGBTQ youth (of color) may have also come from already impoverished communities that lack LGBTQ resources and social support (National Gay

and Lesbian Taskforce, 2007; Kosciw, G., Greytak, A., Palmer, A., & Boesen, J., 2014; Movement Advancement Project, 2012). Regrettably, once they become homeless, they are at greater risk of engaging in drug use and risky sexual behaviors, thereby putting them at an increased risk for diseases discussed earlier (Corliss et al., 2011; Cochran et al., 2002).

Although the unprecedented Affordable Healthcare Act (AHA) has increased healthcare insurance coverage to approximately 6.1 million young adults (between the ages of 19 and 25), homeless LGBTQ young adults continue to "slip through the cracks" in the healthcare system. Youth of color are disproportionately overrepresented in failing to access healthcare services among LGBTQ homeless youths (Choi, 2015). Furthermore, access to healthcare also varies within subgroups of the LGBTQ community. For instance, several studies revealed that lesbian and bisexual women are less inclined to have a routine place for healthcare (Boehmer, 2012; Buchmueller, 2010; Heck et al., 2006; Wheldon, 2013). Lesbian and bisexual women who are homeless tend to have higher risk for substance use and abuse (Corliss, et al, 2011). Also, transgenders are less likely to have health insurance than LGB or heterosexuals (Diaz, 2001; Herbst et al., 2008; Kenagy, 2005; National Gay and Lesbian Taskforce, 2009; Whitbeck, 2004). Nonetheless, no study was identified to determine the impact AHA has on homeless bisexual and gay young adult men in New York City (NYC) and whether it has enabled them to gain entry into the healthcare system.

Even though HIV and Sexually Transmitted Infection (STI) screening have been incorporated into primary healthcare settings (serving underserved populations in NYC) and the American Pediatric Association recommends annual check-ups for youths (APA,

2016), little is known about how homeless urban bisexual and gay young adult men perceive their need for healthcare, by what means they access healthcare, the degree to which they use healthcare services, and how they fare in comparison to each other. Therefore, **the purpose of the study is to conduct a comparative assessment of access to healthcare (with an emphasis on preventive care) between homeless bisexual young adult men and homeless gay young adult men in NYC and compare the experiences of the two groups.** Understanding the lived experiences of homeless bisexual and gay men's entry and utilization of healthcare is paramount in preventing morbidity and mortality in the community. These findings will highlight differences and similarities (if any) with access to and utilization of healthcare in the homeless bisexual young adult men and homeless gay young adult men community in NYC and inform the urban public health community to tailor healthcare services more specifically to meet their needs.

Defining "Young Adult", "Homelessness", "Bisexuality" "Gay" and "Male"

While researching this subject, a major challenge encountered was the varying definitions of young adult, homelessness, and bisexual and gay men used in studies. For the purpose of this study, the terms "youth" and "young adults" are used interchangeably, since young adults fall within the youth definition of between 13 and 24 years of age as used in many studies (Bandurraga, 2011; CDC, 2010; CDC, 2015; D'Augelli, 2002; Durso and Gates, 2012; Gangamma et al., 2008; Garofalo, 2002; Ginsburg et al., 2002; Grossman, 2006; Hoffman, 2009; Kruks, 2010; Pilgrim and Blum, 2012; Quintana, 2010; Safe School Coalition, 2011; Tyler, 2012; Young and Rice, 2011). This study defines young adults to be between the ages of 18 and 35.

With respect to homelessness, this study uses the US Department of Education's definition of homeless as "(A) an individual who lacks a fixed, regular, and adequate nighttime residence . . . and (B) includes (i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement; (ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings …; (iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and (iv) migratory children who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii)." (US Department of Education, 2002).

Most studies use a standard question such as "what is your sexual orientation?" that has response options such as "gay, lesbian, bisexual, transgender, or questioning/queer" to measure the sexual orientation of the study subjects. However, this study employs a more involved measure using attraction and behavior to accurately measure the sexual status of subjects. Therefore, bisexuality is defined by male participants who are 1) mostly attracted to females (including male-to-female transgenders), 2) equally attracted to females (including male-to-female transgenders) and males, and 3) mostly attracted to males. Gay is defined by male participants who are

only attracted to males. Male is defined by subjects who were biologically born male and identify to the male gender.

Problem Significance

The perplexity of this research study requires me to focus on the following three major areas: homelessness, young adulthood, and sexual orientation (specifically bisexual and gay men when available) as it relates to access to healthcare and healthcare utilization. As discussed earlier, bisexual and gay young adult men face an overwhelming degree of health disparities that are not found among their heterosexual counterparts. Rates of homelessness among LGBTQ youths are disproportionately high, considering that LGBTQ persons in general make up only about 3–5% of the general population in the US (Human Rights Campaign, 2012). It is estimated that the number of homeless and runaway youth in the US range from 575,000 to 1.6 million per year (DHHS, 2013). However, recent studies have shown that 20–40% of them identify as LGBTQ (Choi, Wilson, Shelton, and Gates, 2015; Durso and Gates, 2012; Kipke, Weiss, and Wong, 2007; Lankenau, Clatts, Welle, Goldsamt, and Gwadz, 2005; Quintana, Rosenthal, and Krehely, 2010; Ray, 2006; Van Leeuwen et al., 2006). And, given that bisexual men represent the larger of the LGBTQ spectrum, they may also be overrepresented among homeless LGBTQ young adults as well.

In NYC alone, a 2008 census study revealed that among 3,800 homeless young adults, 40% identified as LGBTQ (Empire State Coalition of Youth and Family Services, 2011). In the same study, youth of color (primarily Blacks and Latinos) represented an overwhelming 85% of the homeless LGBTQ population (Empire State Coalition of

Youth and Family Services, 2011). This alarming rate of homelessness among LGBTQ

youth make them much more susceptible to HIV, STIs, and other diseases than their

counterparts—heterosexual homeless youth. For instance, in 2014, youths between the

ages of 13 and 24 accounted for an estimated 22% of all new HIV diagnoses in the US

(CDC, 2014), many of whom were bisexual and gay men. Moreover, almost half (over

19 million) of STI infections in the US each year occur in youths (Tyler, K., Whitbeck,

L., Chen, X., and Johnson, K., 2007). Homeless LGBTQ youths, particularly Black

abused youths, experience high rates of STIs (CDC, 2010). A recent study showed that

easily preventable diseases like syphilis, gonorrhea, and chlamydia escalated among men

who have sex with men (Gay, Lesbian, Straight Education Network, 2013). In another

study, self-reported viral STIs were significantly higher among bisexual women (a range

from 15 to 17.2%) than among lesbians (a range from 2.3 to 6.7%) (Fang et al., 2010).

Involvement in survival sex/sex work (sex in return for money, food, and/or a place to

stay) can put homeless bisexual and gay young men at heightened risk for HIV infection

and other STIs, especially when they are known to engage in more risky sexual behaviors

(MacKellar DA, Valleroy LA, Hoffmann JP et al, 2000; Tevendale HD, Lightfoot M,

Slocum SL, 2009).

Mental and behavioral health conditions are also overrepresented among

homeless LGBTQ young adults. One study found that gay homeless male youths are

more likely to experience depressive episodes (Whitebeck, 2004). In the Van Leeuwen

study (2006), 62% of homeless LGB youths attempted suicide, compared to 29% of non-

LGB homeless youths. Homelessness, isolation from families and friends, and lack of

social support may increase LGBTQ youths' risk of misusing/abusing drugs and having

multiple sex partners.

For reasons discussed above, improving access to healthcare is critical in

preventing and mitigating health disparities unique to urban homeless bisexual and gay

young adult men. However, there are other factors (like social and environment issues)

that inhibit them from accessing health and medical care. Sexual and gender stigma are

significant deterrents to accessing health and medical care (Daley and MacDonnell,

2011). LGBTQ patients frequently chose not to disclose their sexual identity due to a

perceived fear of "lack of absolute confidentiality, family conflicts, rejection, social

isolation and other consequence of invisibility" (Rondahl, Innala, and Carlsson, 2006, p.

374). Furthermore, a greater association exists between the perceived stigma due to

one's homeless status and sexual orientation among homeless youth in NYC and Canada

(Kidd, 2007). This is the reason LGBTQ youth prefer private confidential health services

(Hoffman, 2009).

With regard to LGBTQ persons using a regular source of healthcare, research

findings have demonstrated inconsistency among LGBTQ groups (Boehmer, 2012;

Buchmueller, 2010; Heck et al., 2006; Wheldon, 2013). For instance, several studies

reveal that lesbian and bisexual women are less inclined to have a regular source for

healthcare (Boehmer, 2012; Buchmueller, 2010; Heck et al., 2006; Wheldon, 2013).

They are also less likely to have insurance coverage (Boehmer, 2012; Buchmueller, 2010;

Conron, 2010; Diamant, 2000; Heck et al., 2006). With regard to LGB youths

specifically, being uninsured predicted major obstacles with accessing healthcare

(Chance, 2013). In spite of the various research reviewed, no studies have been

identified that examine urban homeless bisexual and gay young adult men's experiences with access to and utilization of healthcare (with an emphasis on preventive care) in NYC, nor have studies compared the two groups.

In summary, some of the most important healthcare challenges for LGBTQ youths in general, regardless of their housing status, are the following: (1) disclosure of sexual orientation or gender identity when receiving medical care; (2) lack of competent, experienced healthcare providers trained regarding the specific health-care needs of LGBTQ youth; (3) structural barriers that inhibit access to health insurance and thus limit the visiting and medical decision-making rights for LGBTQ people and their significant others; and (4) lack of culturally appropriate prevention services (Mayer et al., 2008). Given the social, structural, and environmental complexities homeless bisexual and gay youth face and the fact that they represent a large number of LGBTQ homeless youth population, understanding where they fare with access to healthcare is critical in mitigating and preventing diseases affecting them. It is unknown whether they face similar challenges as discussed above and/or to what degree they face them.

Study Purpose

Homeless bisexual and gay young adult men encompass all races and ethnicities, religions, and family dynamics. Research suggests that when they are homeless, they face unprecedented health disparities (along with their LTQ peers) associated with social stigma, discrimination, racism, and denial of their civil and human rights (Whitehead et al., 2016; Mattocks et al., 2014; Institute of Medicine, 2011; Badgett and Goldberg, 2009; Kidd, 2007, Van Leeuwen et al., 2006). The LGBTQ companion document to

Healthy People 2020 stresses that more research is needed to properly capture, understand, and address the multidisciplinary factors that contribute to health disparities within the LGBTQ community (Healthy People, 2020).

The purpose of the study is to conduct a comparative assessment of access to healthcare (with an emphasis on preventive care) among homeless bisexual young adult men and homeless gay young adult men in NYC and compare the experiences of the two groups. The results of the study ought to provide a better understanding of barriers affecting access to healthcare, identify factors that influence healthcare access and, subsequently, contribute to the growing body of literature on access to healthcare, particularly among homeless bisexual and gay young adult men in urban areas. It also offers suggestions about how to improve access to healthcare among homeless bisexual and gay young adult men and help to prevent the spread of disease and/or mitigate disease progression. The research also supports, in part, the US Department of Health and Human Services recommended actions to improve the health and well-being of LGBTQ communities (DHHS, 2012).

Research Questions and Objectives

The objectives and questions that guide this study are derived from discussions with program directors at homeless LGBTQ youth shelters and drop-in centers, a critical review of the literature, and from my personal experiences volunteering at a homeless LGBTQ youth drop-in center in NYC. The research questions address the gaps in the literature that may explain homeless bisexual young adult men's general experience with access to healthcare (with an emphasis on preventive care) compared to homeless gay

young adult men. I have used a brief questionnaire followed by semi-structured in-person interviews to explore how bisexual and gay young adult men in NYC access and/or use healthcare, and whether sexual orientation affects individual experiences.

Primary Research Objectives

Healthcare need.

1.   To evaluate the self-perceived health of homeless bisexual and gay young adults in NYC and assess their need for healthcare (with an emphasis on preventive care)

2.   To compare the self-perceived health of homeless bisexual young adult men in NYC and assess their need for healthcare (with an emphasis on preventive care) with that of homeless gay young adult men in NYC

Healthcare access/availability.

3.   To determine the self-perceived facilitators of access to healthcare (with an emphasis on preventive care) as experienced by homeless bisexual young adult men in NYC and compare their experiences to the experiences of homeless gay young adult men in NYC

4.   To determine the self-perceived barriers of access to healthcare (with an emphasis on preventive care) as experienced by homeless bisexual young adult men in NYC and compare their experiences to the experiences of homeless gay young adult men in NYC

Healthcare utilization.

5.	To determine the type, location, and frequency of healthcare utilization (with an emphasis on preventive care) among homeless bisexual young adult men in NYC and compare this to the utilization patterns of homeless gay young adult men in NYC

Breakdown of Research Questions

1. What are the self-perceived needs for healthcare among homeless bisexual young adult men in NYC compared to homeless gay young adult men in NYC?

2. What are the facilitators of healthcare access (with an emphasis on preventive care) between homeless bisexual young adult men in NYC and homeless gay young adult men in NYC?

3. What are the barriers to healthcare access (with an emphasis on preventive care) between homeless bisexual young adult men in NYC and homeless gay young adult men in NYC?

4. Where, when, and how frequently do homeless bisexual young adult men in NYC access healthcare and how is that compared to the utilization patterns of homeless gay young adult men in NYC?

Chapter 2

This chapter critically analyses the literature in the following topics, as they are components of access to healthcare among homeless bisexual and gay young adult men: 1) overall critique of study methodologies on homeless LGBTQ young adults, 2) access to healthcare and utilization of healthcare, 3) health disparities, and 4) socioeconomic insecurities.

Literature Review

Homelessness—evident in cases of unstable housing, street living, runaways, and couch surfing—poses great health risks to homeless LGBTQ young adults, including bisexual and gay young adult men (McBride, 2012; Van Leeuwen, et al., 2006). However, data collection on the sexual orientation and gender identity of LGBTQ young adults is not commonly collected in states and local public health agencies, thereby making it difficult to generalize the bio-pyscho-social-medical needs of the community. Furthermore, sexual orientation and gender identity are just two characteristics of an individual's identity. Many other factors influence their health. Some of these are sexual attraction and behavior, race/ethnicity, and socioeconomic status. The intersection of these characteristics helps to shape an individual's health, access to care, and experience with the healthcare system. Nonetheless, some cities and geographic regions seem to "pull" homeless LGBTQ young adults, thereby creating more of an urban epidemic in the US. The attempt to examine access to healthcare among homeless bisexual and gay young adult men in NYC and make a comparison between gay and bisexual men involves a complex multi-level multidimensional approach concerning at least three major arenas

which are in themselves complicated—homelessness, sexual attraction/behavior, and young adult age (youth).

Literature on the homeless population of the US is extensive. Likewise, literature on access to healthcare among LGBTQ has received growing attention in light of the unprecedented AHA initiative (Ranji, Beamesderfer, Kates and Salganicoff, 2014). With regard to the bisexual and gay men community, research efforts and many interventions, predominantly focused on HIV infection, treatment and prevention, as well as health disparities are in abundance (Coulter, Kenst and Bowen, 2014; Walls and Bells, 2011). However, locating research studies on the actual access to healthcare among homeless bisexual and gay young adult men continues to be a challenge, particularly when examining preventive healthcare access and comparing access to healthcare between homeless bisexual young adult men and homeless gay young adult men in NYC. Due to the limited number of studies on this topic, this literature review has been expanded to include broader subject areas such as LGBTQ, homelessness, Blacks and other minority groups, and youth in general, as they relate to access to and utilization of healthcare.

Critique of Study Methodologies on Homeless LGBTQ Young Adults

In general, scientific literature on access to healthcare among homeless bisexual young adult men is limited. Literature findings usually lump them under the LGBTQ umbrella and are varied, inconsistent, and often outdated, providing yet another reason for the importance of conducting this research study. Furthermore, most studies have been based on subsets of the homeless LGBTQ youth community—individuals with

specific health issues (HIV and mental health), HIV prevention and education, those with gender identity issues (like transgender sex workers), and those who are living in a geographic region or specific healthcare center or program (Mayer et al, 2008; Choi, 2015). In addition, many studies on homeless LGBTQ focused mainly on secondary and tertiary public health prevention (after disease occurred) instead of examining their access to primary preventive healthcare access. With reference to sexual orientation, many studies designed to examine LGBTQ individuals defined them only based on sexual behaviors, overlooking sexual identity and attraction. In essence, current studies fail to address homeless gay and bisexual young adult men's access to preventive healthcare and healthcare use or compare the differences between the two groups.

Most studies examining access to healthcare are qualitative in nature in part due to the lack of research in the field. Some studies even lack a theoretical framework or are weak on their design and methodological approach. For example, a study done to determine the correlation of engaging in survival sex among homeless youth and young adults failed to include a theoretical framework (Whitehead, 2015; Bell, 2010). For those studies that are quantitative in nature, statistical analysis is either sparse or not statistically significant, sample size was poor, methods were not clearly defined, and/or survey instruments lacked reliability and validity, making it difficult to generalize. For instance, a study done to examine challenges faced by homeless sexual minorities had only 83 participants in its sample size; therefore, it couldn't establish statistical significance.

Lastly, measurements and definitions of sexual orientation and homelessness vary according to the different nations, states, and local communities, making it challenging to

ascertain commonalities among each subgroup (Coker, Austin, Schuster, 2010). The

definition of homelessness also varies in empirical studies (Coker et al., 2010).

Nonetheless, the reviewed studies contributed to the growing body of literature in some

aspect of homeless LGBTQ young adults and their access to healthcare.

Access to Healthcare and Utilization of Healthcare

Access to healthcare is paramount in preventing and mitigating health disparities

unique to homeless bisexual and gay young adults. However, healthcare services may be

too heterocentric and gender-normative, as medical providers may not be familiar with

those health disparities affecting homeless gay and bisexual young adult men. DCA

Some of the highlighted issues associated with lack of access to healthcare among

LGBTQ youths are (a) fear of disclosing sexual orientation or gender identity when

receiving medical care; (b) lack of competent, professionally trained and experienced

healthcare providers who understand the healthcare needs of LGBTQ youth; (c) structural

barriers that inhibit access to health insurance and limit visiting and medical decision

making rights for LGBTQ people and their significant others; and (d) a lack of culturally

appropriate prevention services (Mayer et al., 2008).

Access to healthcare or lack thereof is not exclusively determined on the

individual level. External factors such as environment and community factors also

influence access to healthcare. For instance, one of the biggest challenges to the

provision of quality healthcare to LGBTQ youths is funding, community support, and

collaboration among providers (Choi, 2015). On an institutional level, most health

assessments conducted at healthcare institutions do not include any identification of

sexual orientation, and thus fail to recognize LGBTQ youth, which serves as a deterrent to them from disclosing their sexual status. Furthermore, a recent study reported that one-third of US medical schools do not devote topics on gender identity, coming out, and disparities in access to health among LGBTQ individuals (Obedin-Maliver et al., 2011). The schools that did only dedicated about five hours or less in their curriculum, making it difficult to discuss the multi-dimensional issues LGBTQ patients are subjected to.

Healthcare providers' stigmatization of LGBTQ persons is another significant deterrent to accessing healthcare and medical care (Whitehead and Stephenson, 2016; Mattocks et al., 2015; Daley and MacDonnell, 2011). Research has found that the majority of LGBTQ patients do not disclose their sexual identity due to the fear of breach in confidentiality, family conflicts, rejection, and social isolation (Institute of Medicine, 2011; Rondahl et al., 2006). Subsequently, they experience a heightened risk of suicide, substance use, and unaddressed domestic violence. LGBTQ youths prefer private confidential health services with their providers (Ginsburg et al., 1995; Ginsburg et al., 2002; Hoffman, 2009).

The use of regular or routine healthcare like annual check-ups, immunizations, drug provision, disease monitoring, and health education are other areas of access to healthcare that are understudied, particularly among homeless bisexual young adult men, hence the purpose of my study. However, there have been inconsistent findings with regard to the use of a regular (or specific) healthcare site among non-homeless bisexual and heterosexual men (Conron, 2010; Wheldon, 2013). Furthermore, studies have shown discrepancies when assessing differences in healthcare use among LGBTQ subgroups (Boehmer, 2012; Buchmueller, 2010; Heck et al., 2006; Wheldon, 2013). For instance,

several studies revealed that lesbian and bisexual women are less likely to have a routine place for healthcare (Boehmer, 2012; Buchmueller, 2010; Heck et al., 2006; Wheldon, 2013). They are also less likely to have insurance coverage (Boehmer, 2012; Buchmueller, 2010; Conron, 2010; Diamant et al., 2000; Heck et al., 2006). However, among heterosexual and LGBTQ groups, transgender individuals are much less likely to have health insurance than the rest (Health People, 2020; Kaiser Family Foundation, 2016).

LGBTQ persons also reported lack of trust in their providers and often experience discrimination in the healthcare community (Eliason, 2001; Mattocks et al., 2015; Scherzer, 2000). According to Newman (2014), discrimination and ill-prepared healthcare centers hamper LGBTQ youths' access to healthcare. In a study conducted in NYC, only 44% of medical providers reported having adequate skills to work with LGBTQ youths (Kitts, 2010). Medical providers who have poor viewpoints on LGBTQ youths may hinder their access to quality healthcare. Klamen (1999) indicated that 28% of medical providers consider homosexuality to be immoral and 29% perceived it to be an obstacle towards the foundation of family. In a more recent study, family physicians, who are typically the providers for youth, generally are not trained to provide adequate healthcare to LGBTQ youth (IOM, 2009). Additionally, LGBTQ patients have reported that some healthcare providers are unfriendly towards them because of their sexual orientation (Garnero, 2010). Rindahl (2006) reported that nurses normally assume their patients are heterosexual. Aiding to the stigma, one study showed that many nurses view gay men as sexual perverts and child molesters (Christensen, 2005). Lastly, the primary

healthcare needs of LGBTQ youths have been overshadowed by HIV, AIDS, and STI

issues (Neville and Henrickson, 2006).

Barriers to healthcare access may be more challenging for certain subsets of the

LGBTQ community. Healthcare service access and acquisition are often difficult for

transgender and gender expansive young adults (Shelton, 2015). This is because they

often encounter stigma and discrimination and face complex social and systemic

obstacles. For instance, providers who serve transgender youth reported that transgender

youth experience the greatest challenges with access to healthcare (Travers et al., 2010).

In Grossman's study (2006), transgender youths revealed the following four health-

related issues: unsafe environments, restricted access to healthcare centers and services,

insufficient mental health services, and an absence of care and support by relatives and

their communities. In another study examining at-risk male-to-female transgender youth

of color, 41% reported challenges finding medical services (Garofalo, 2005). However,

these studies may underestimate stigma and discrimination experienced by transgenders

given that a recent study indicated that 90% of transgenders believed that medical staff

are not adequately trained and educated to provide the care they need (Lambda Legal,

2010). As a matter of fact, 52% expressed concern about refusal of medical care when

they need it (Lambda Legal, 2010).

Regarding bisexual and gay young adults in NYC, Black bisexual and gay young

adult men (who represent a large proportion of homeless LGBTQ youth in NYC)

continue to be underrepresented in accessing healthcare. For instance, Community

Healthcare Network (CHN), a not-for-profit healthcare agency serving underserved New

Yorkers, revealed that more Hispanics are on HIV Pre-Exposure Prophylaxis (PrEP) than

Blacks. It is unknown why Black LGBTQ young adults are not accessing this innovative

intervention when they account for more HIV infections than Hispanics (CDC, 2015).

Moreover, a recent study discovered that youth of color may not have a thorough

understanding of PrEP and its benefits on HIV prevention and may jeopardize its

potential impact as an effective HIV prevention intervention (Perez-Figeuroa, 2015).

Health Disparities

Homelessness for LGBTQ youth complicates access to healthcare, treatment, and

recovery. Exposure to elements in the environment, violence, and/or unsafe conditions

can cause injuries and chronic disease conditions make it challenging to manage their

health and well-being (Coker et al., 2010; O'Connell, 2005); wounds, lesions and cuts,

for instance, can worsen or become infected. As a consequence of homelessness,

research shows that LGBTQ youths consistently face numerous public health risk factors

with staggering rates of poor health outcomes (Gangamma et al., 2008; Tyler et al.,

2007). Several studies reveal that homelessness puts LGBTQ youth at higher risk for

HIV infection, smoking, alcohol and substance use/abuse, suicide, sexual abuse,

victimization, and violence/harassment (Gangamma et al., 2008). Given the high rates of

the health disparities affecting homeless LGBTQ young adults, I will discuss the

following major health issues found in the literature: a. communicable diseases (physical

health), b. behavioral health, and c. mental health.

Communicable diseases. HIV/AIDS has significantly affected LGBTQ youth of

color. According to the CDC, in 2010, youths aged between 13 and 24 accounted for

26% of new infections (CDC, 2015). Overall, youth, in general, represent only 17% of

the US population; however, in 2010, young gay and bisexual men and other men who have sex with men accounted for 72% of new infections among youths (CDC, 2015). This group showed a 4% increase of estimated new infections from 22% in 2008 to 26% in 2010. Black youths accounted for 57% new youth infections (7,000 total—5,600 males and 1,400 females) in that year. Hispanic youths accounted for 20% of new infections (2,100 males and 290 females), and white youths were at 20% as well (2,100 males and 280 females). Ironically, over 60% of the youths were unaware of their HIV infection, which suggests a gap in access to healthcare (CDC, 2012).

STIs also dramatically affect homeless LGBTQ young adults (Tyler, 2007). In the US, homeless youths, LGBTQ youths, Black youths and abused youths experience high rates of STIs (Tyler et al., 2007; CDC, 2009). Furthermore, almost half of the over 19 million STIs each year occur in youths in the US (Weinstock, Berman and Cates, 2000). In one study, 21% of homeless youth reported an STI (Tyler et al., 2007) and recent data shows that the infection rates of syphilis, gonorrhea, and chlamydia among men who have sex with men are rising (CDC, 2015). In another study, self-reported viral STIs showed higher rates among bisexual women (15 to 17.2%) than among lesbians (2.3 to 6.7%) (Tao, 2008). Lack of healthcare coverage directly affects homeless LGBTQ youths' ability to obtain professional assistance to prevent STIs, avoid transmitting infections, and/or receive treatment. In fact, 39% of youths aged under 25 in the US reported lacking health coverage (Commonwealth Fund, 2012). However, little is known about healthcare coverage among homeless bisexual and gay youths in particular, whether they even have coverage, where they go for healthcare, how often they go for healthcare, and what barriers they face in attempting to access healthcare.

Behavioral health. Health behaviors such as smoking, alcohol consumption, and substance use and abuse have a dramatic impact on the homeless LGBTQ young adult community. Homeless LGBTQ young adults may use substances to deal with the psychological stressors of homelessness (Rosaio, Schrimshaw, and Hunter, 2011). In a national longitudinal study, runaways were 7 to 12 times more likely to have a history of substance use than non-runaway youths (Whitbeck and Hoyt, 1999). Another study (Gleghorn, 1997) that examined the relationships between drug use patterns and HIV risk behaviors revealed that homeless youth using either heroin, methamphetamine, or cocaine were exposed to greater sexual risks than non-users. Youths who consumed primary stimulants and combined heroin/stimulants have the greatest risk of contracting HIV (Gleghorn, 1997). These studies, however, did not account for homeless LGBTQ youths who face astronomical health disparities (such as smoking, alcohol, and substance use) than their heterosexual homeless youth counterparts (Cray, Miller and Durso, 2013).

National and state studies have demonstrated higher rates of substance abuse among LGBTQ youths in general compared with non-LGBTQ youths. However, Van Leeuwen et al. (2006) stated that a significant proportion of LBG youth had tried substances like cocaine, crack, ecstasy, and mushrooms during their lifetime. The study also revealed that even though both homeless LGB and non-LGB youths had tried drugs and alcohol by age 12, substance use was more prevalent in LGB (42%) than in non-LGB (27%) youth. For homeless LGBTQ youth, they were more likely to engage in amphetamine and injection drug use than non-LGBTQ homeless youth (Noell and Ochs, 2001). Moreover, Marshall et al. (2008) found that LGB youths (not including TQ) were at three times the risk for substance abuse when compared to non-LGB youths. Female

LGB youths were at five times the risk for substance use when compared to their

counterparts—heterosexual females—and also when compared to male and female

youths who identified as bisexual (Marshall et al., 2008). Studies have found that youth

who self-identify as bisexual men, or who report having both male and female sex

partners, were found to be consistently at greater risk for substance use compared to their

lesbian/gay counterparts (Brener, 2002). In fact, Brener (2002) and Russell (2002)

discovered that bisexual youths were more likely to report binge drinking, illicit drug use,

and marijuana use.

Binge drinking and alcohol consumption are widespread among homeless

LGBTQ youths. According to several studies, alcohol use is known to be a major cause

of morbidity and mortality among adolescents in general (Hingson et al., 2005; O'Malley

et al., 1998; Sindelar et al., 2004; Weinberg et al., 1998). Among LGBTQ youths, it is

considered a top public health concern (Gay and Lesbian Medical Association and

LGBTQ Health Experts, 2001). In fact, several studies have established that LGBTQ

youths report more alcohol use than their heterosexual counterparts (Bontempo and

D'Augelli, 2002; Caldwell et al., 1998; DuRant et al., 1998). To complicate the issue

further, gender characteristics and health behaviors based on sexual orientation may play

a critical role in alcohol use and abuse. Eisenberg (2003) and Russell (2002) suggest that

sexual minority females (like lesbians and bisexual women) report higher proportions of

alcohol use in comparison to sexual minority males, which is not the case among their

same-gender heterosexual counterparts.

Smoking is also an ill health behavior commonly found among LGBTQ youths

and more prevalent among bisexuals. However, studies on smoking among homeless

bisexual and gay young adult men have been scarce. Smoking in the scientific literature mainly targeted LGBTQ in general and not necessarily homeless LGBTQ. Burkhalter et al. (2009) found that the prevalence of smoking is significantly higher among lesbian and bisexual women at 70% to 350% compared to gay and bisexual men at 27% to 71%, respectively. Conversely, among sexual minorities, those who identified as bisexual men seem to have the highest rate of smoking (ALA, 2010). In another study, Garofalo (2002) found that LGB students were more likely to smoke cigarettes than heterosexual youth. Similarly, in a national longitudinal study, bisexual boys and girls or those reporting same-sex attractions, relationships, and/or partners were more likely to smoke compared to youths who reported opposite-sex attractions (Easton, 2008; Russell, 2003; Udry and Chantala, 2002). Tobacco use was also found to be 2.5 times higher in bisexual adolescents than in their heterosexual peers (Austin et al., 2004).

A different type of behavioral health issue that is unique to homeless LGBTQ population is survival sex or sex work. Survival sex is defined as a youth's involvement in the exchange of sex for money or other critical resources (e.g., food, shelter, or drugs). Homeless bisexual and gay youth may not perceive themselves as engaging in prostitution but instead doing "whatever is necessary" for survival. In a 2001 study, Reback et al. showed that over 65% of transgender youths reported a history of sex work, and 50% performed sex work as their primary source of income. Survival sex puts homeless LGBTQ youths at heightened risk for HIV infection and other STIs, especially when they may engage in more risky sexual behaviors (MacKellar DA, Valleroy LA, Hoffmann JP, et al, 2000; Tevendale HD, Lightfoot M, Slocum SL, 2009). Bisexual and gay men, in particular, are disproportionately overrepresented in youth sex work

(Whitbeck, 2015; Coleman, 1989). For instance, Whitbeck (2015) found that 44% of

homeless gay youth reported engaging in sex work just to meet their basic needs.

Moreover, Black youths (including LGB) who received testing for HIV were much more

likely to participate in survival sex than their counterparts who were not tested for HIV

(Walls and Bell, 2011).

Mental health. Rates of mental health problems (such as depression, anxiety,

posttraumatic stress disorder, psychopathology and suicide) among LGBTQ youths are

disproportionately high (Cochran et al., 2002; Hatzenbuehler, 2016; Whitbeck et al.,

2004). In general, many LGBTQ youths are victims of verbal, physical and sexual abuse

(National Coalition for the Homeless, 2009). Several studies have found victimization

(like violence, bullying, and verbal harassment) to be a risk factor for suicide attempts

and suicidal ideation (Bagley and Tremblay, 2000; Bontempo and D'Augelli, 2002;

Huebner, Rebchook, and Kegeles, 2004; Rivers, 2001; Russell and Joyner, 2001).

Additionally, societal stress associated with being LGBTQ (such as stigmatization and

discrimination) is assumed to increase risk behaviors linked to substance use,

psychological distress, and sexual risk behaviors (Friedman and Downey, 2002; Meyer,

2003; Rosario et al., 2001, 2002). Whitbeck et al. (2015) found that 58% of homeless

LGBTQ youths in Midwestern urban areas have been sexually victimized. The study

also revealed that LGB youths are at greater risk for sexual abuse by caretakers than their

heterosexual counterparts. Hatzenbuehler (2016) found that suicide attempts are much

greater among LGB youth, particularly among those in non-supportive environments.

Sexual abuse may even occur before LGBTQ youths become homeless. One study found

that LGBTQ youth reported twice the rate of sexual abuse than non-LGBTQ youth before

the age of 12 than heterosexual youth (Rew, Whittaker, Tayler-Seehafer, and Smith, 2005). In another study, LGBTQ persons reported over seven times of sexual violence when compared to their counterparts—heterosexual youths (Cochran et al., 2002).

In a recent study, the Massachusetts Youth Risk Behavior Survey, conducted among high school students found that LGB students were four times more likely to have attempted suicide than non-LGB students (Massachusetts Department of Education, 2006). Similarly, Eisenberg and Resnick (2006) revealed that a staggering 73% lesbian and bisexual adolescent girls and about 47% gay and bisexual boys had suicidal ideations compared to 53% and 35% of non-gay/bisexual girls and boys, respectively. One study found that initial suicide attempts occur before disclosing sexual orientation (D'Augelli et al., 2001). With respect to the general adult LGBTQ population, Conchran (2003) showed that bisexual and gay men in general have a higher rate of depression, panic attacks, and psychological distress than their heterosexual counterparts. Lesbian and bisexual women tend to have a higher rate of generalized anxiety disorder than heterosexual women (Conchran, 2003).

Socioeconomic Insecurity

Socioeconomic insecurities may be a major deterrent to healthcare access. In 2011, the Institute of Medicine reported that over 40% adolescents in the US are living in either low-income poverty or near poverty. More specifically, adolescents who are Black or Hispanic are twice as likely to live in poverty (IOM, 2011). As a result, they are less likely to have protective social support networks and financial resources and subsequently experience more stress than adolescents who are not poor. Nevertheless,

there have been limited studies demonstrating the association of socioeconomic status

with homeless bisexual and gay young adult men in NYC and/or studies comparing the

two groups. For this review, those factors that comprise socioeconomic insecurities are

defined as a. low educational attainment, b. unemployment/underemployment, and c.

discrimination.

Low educational attainment. According to the Center for American Progress

(2010), LGBTQ communities of color have lower educational attainment than their white

LGBTQ peers. This is due in part to a hostile school environment experienced by

LGBTQ of color, which negatively impacts their educational experience. In a Gay,

Lesbian, Straight Education Network study (2013), over 46% of LGBTQ youth of color

experienced physical violence in school because of their sexual orientation. Furthermore,

the study found that 80% of LGBTQ students of color were verbally harassed in the year

they were surveyed, and one-third of African American LGBTQ students experienced

physical violence in school because of their sexual orientation (KOSCIW, G.,

GREYTAK, A., PALMER, A., & BOESEN, J., 2014, 2013). In another study, Coker et

al. (2010) revealed consistently high rates of harassment or bullying at school for

LGBTQ youths, compared to their non-LGBTQ counterparts.

There are limited studies on the educational status of homeless LGBTQ youths.

Instead, studies examined educational attainment in the general LGBTQ youth

population. However, one study found that over 60% of homeless LGBTQ youths of

high school age in Detroit had dropped out of school due to bullying or discrimination

(National Gay and Lesbian Taskforce, 2007). In another study, more than half of

homeless LGBTQ youth reported experiencing discrimination from peers during school

(Milburn, Ayala, Rice, Batterham, and Rotherham-Borus, 2006). More general studies involving the larger LGBTQ youth population showed that fear, harassment, and violence often deter LGBTQ youths of color from attending school (KOSCIW, G., GREYTAK, A., PALMER, A., & BOESEN, J., 2014, 2013; National Gay and Lesbian Taskforce, 2007; Movement Advancement Project [MAP], 2012). Furthermore, some studies have found that LGBTQ youth of color, like African Americans, Latinos, Native Americans, and Asian Pacific Islanders, reported absenteeism attributed to their fear of being bullied or harassed (KOSCIW, G., GREYTAK, A., PALMER, A., & BOESEN, J., 2014, 2013; MOVEMENT ADVANCEMENT PROJECT, 2012)). Conversely, transgender youth were found to experience increased rates of abuse and harassment. Seventy-four percent of transgender youths experience sexual harassment due to their sexual identity and expression (KOSCIW, G., GREYTAK, A., PALMER, A., & BOESEN, J., 2014, 2013) resulting in about 30% dropping out of school to avoid harassment. Missed school days contribute to a substantial achievement gap. The lack of safe schools for LGBTQ youth may restrict their chances of securing employment or earning wages that can provide coverage for health insurance and pay for transportation to and from medical appointments.

Employment. Very limited studies have examined employment among homeless LGBTQ youth. Available studies mainly focus on LGBTQ employment overall. In general, unemployment rates for LGBTQ workers of color exceeded non-LGBTQ unemployment rates, particularly among Latinos (14% versus 11%), African Americans (15% versus 12%), and Asian and Pacific Islanders (11% versus 8%) (Penn, 2013). Within the LGBTQ community, transgender unemployment was even higher than other

LGBTQ, accounting for 28% among Blacks, 18% for Latinos and 18% for multiracial individuals (National Gay and Lesbian Task Force and the National Center for Transgender Equality, 2011).

Other factors that perpetuate unemployment within LGBTQ included the use of background checks and its subsequent disqualification of candidates. Background checks are more likely to hinder homeless minority LGBTQ youths' job searches, particularly if they have a criminal history or a record of delinquent behavior. According to a 2012 Lambda Legal survey, a staggering 79% of LGBTQ minority youths said that they'd had interactions with security or law enforcement during middle school or high school, compared with 63% of white LGBTQ youth.

Discrimination based on sexual orientation and gender identity is a significant factor affecting LGBTQ youth's ability to obtain and maintain employment (MOVEMENT ADVANCEMENT PROJECT, 2012)). A MAP survey (2012) revealed that 75%–82% of Asian/Pacific Islander LGBTQ workers experienced discrimination at their place of employment based on their sexual orientation. Another study found that an estimated 50% of Black LGBTQ experience similar discrimination (Penn 2013). One of the gaps in policy is that federal and state regulations do not specifically include legal protections for sexual orientation. Therefore, LGBTQ youth experiencing discrimination cannot make a claim, which puts them at a disadvantage in the workforce. Lack of employment puts homeless LGBTQ young adults in a precarious position, making it extremely difficult to secure housing and meet other competing needs, much less access to healthcare.

In summary, the articles reviewed here offered many valuable insights regarding the many limitations of prior studies examining various factors impacting homeless LGBTQ young adults' access to healthcare. Moreover, these findings also reiterate that the homeless LGBTQ young adult population remains understudied and there is a need for closer examination of their access to healthcare in the US. It is clear that LGBTQ youth experience greater ill health outcomes resulting in disproportionately negative health outcomes than their heterosexual counterparts even though studies have shown that LGBTQ youth value quality and adequate provider healthcare services like other youth (Ginsburg et al., 2002; Hoffman et al., 2009). Furthermore, the many health disparities these youth face intersect with the aforementioned socioeconomic issues, cultural factors, and medical practices of the healthcare system, creating a ripple effect that compounds the crisis even further. All these factors suggest a need to better understand access to healthcare among some of the most vulnerable population— homeless bisexual and gay young adult men.

Throughout the literature review, a number of consistent factors that may inhibit access to healthcare among homeless bisexual and gay young adults were identified. However, it is important to note that the continuing physiological, psychological, and sexual development of young adults may change their attraction, sexual orientation identity, and gender identity over time, which may require healthcare systems to adapt to these changes. As young adults, sexual orientation may not just involve sexual activity but also attraction and identity. It may also be more fluid for some young adults who are not decided on their sexual orientation, attraction, or simply to engage in sex. For instance, some LGBTQ young adults may initially identify as bisexual to avoid stigma

and to be more accepted in their community. As a result, there may be a delay in sexual disclosure to providers due to fear and stigma. Similarly, homeless LGBTQ young adults who are struggling with gender identity may also experience gender fluctuation, gender expansion, or gender non-conformity (Stroumsa, 2014). Transgender young adults have a distinctive set of medical, physical, and mental health needs. For instance, they may need hormonal therapy, sex re-assignment surgery, and/or psychological counseling to address their transgender needs (Stroumsa, 2014). These needs may perpetuate an unwanted reliance on the medical community, which may heighten the risk of exposure, stigmatization, discrimination thus, resulting in poor health outcomes. Lastly, changing values and social norms, social acceptance and more equality in the LGBTQ community may shape how sexual orientation and gender identity is expressed (Saewyc, 2011).

Ill health among young homeless LGBTQ adults has non-clinical implications as well. If left untreated, it can affect their ability to work and/or pursue an education. Lack of research on the homeless LGBTQ young adult population is part of what allows them to fall through the cracks in the public health system. More work is needed to closely examine the impact of the diverse range of sexual behaviors, sexual and gender identities, and fluidity that characterizes homeless LGBTQ young adults. It is also important to examine homeless status, socioeconomic status, and social support dynamics beyond "what meets the eye." In each of these arenas, varying and complex factors exist. Understanding the full range of experiences that homeless bisexual and gay young adults face with access to healthcare will allow public health authorities to tailor interventions specific to this community, attract more useful research and hopefully, improve health outcomes among homeless bisexual and gay young adult men in the community.

Chapter 3

Theoretical Framework

Although this study utilizes content analysis to understand the participants' access

to and utilization of the healthcare system, themes and categories identified in the

analysis are matched with the appropriate domains of the Behavioral Model of Health

Services Use (BM). In this way, I can identify where the strengths and weaknesses exist

with access to healthcare and where resources are to be allocated. Therefore, this chapter

discusses the following relevant points: 1. a definition of access to healthcare, 2. the

origin of the BM and its five-phase transformation, 3. Gelberg and Andersen's BM for

vulnerable population (BMVP), and 4. application of BMVP to previous studies.

Definition of Access to Healthcare

Access to healthcare is rarely one-dimensional; it is often a complex web of

multilevel factors and multidimensional forces that determines an individual's ability to

access and use healthcare when needed or recommended. For the purpose of this study, it

is important to understand what "access" means. According to the Institute of Medicine's

Committee on Monitoring Access to Personal Health Care Services, "Access to health

services means the timely use of personal health services to achieve the best health

outcomes" (IOM, 1993). The IOM's definition of access uses measurements of

healthcare services and outcome variables to predict whether access was achieved. Some

of these measurements include the following: 1. determining the presence or absence of

healthcare resources that promote access such as health insurance or having a routine

source of care, 2. assessments by patients on how feasible it is for them to gain entry into

healthcare, and 3. whether or not patients have successfully received the healthcare

needed. On the other hand, Andersen (1995) and Andersen and Davidson's (2001)

definition of access is "the actual use of personal health services, including those factors

that either facilitate or inhibit the use of health care services". Considering these

aforementioned definitions, access not only means entry to healthcare services but rather

entry to the appropriate healthcare services at the right time in a way that contributes to

better health outcomes and decreases disease burden among individuals and

communities.

Unfortunately, equality and equity on access to healthcare in the US continue to

be a major challenge for public health practitioners and the medical community,

particularly among vulnerable populations. Vulnerable populations are often at greater

risk for diseases and have higher rates of morbidity and mortality (Andersen et al., 2000;

Shi and Stevens, 2005). According to the World Health Organization (2002), what

determines a vulnerable group "is the degree to which a population, individual or

organization is unable to anticipate, cope with, resist and recover from the impacts of

disasters". WHO's example of such groups are children, pregnant women, elderly

people, malnourished people, and people who are ill or immunocompromised (WHO,

2016). However, issues of poverty and its ramifications like homelessness, poor housing,

and destitution (which reflect conditions of homeless bisexual and gay young adult men

in NYC) are also major influencers of vulnerability (WHO, 2016).

In recent years, extensive research, funding, and nationwide initiatives have been

dedicated to mitigating health disparities among vulnerable populations, particularly with

the AHA. Yet, access to healthcare continues to be a problem for people of color (Kaiser

Family Foundation, 2016). For instance, Blacks, Hispanics, and American Indians are

less likely to establish a regular source of healthcare than their White counterparts (Kaiser Family Foundation, 2016). Moreover, LGBT individuals are more likely to experience challenges in obtaining healthcare than heterosexuals (Kaiser Family Foundation, 2016).

Utilization of healthcare services occurs where the actual medical and mental health needs of the patient are fulfilled by the healthcare system. However, prior research has demonstrated that access to and utilization of healthcare varies based on sexual orientation, race, social/cultural factors, and other demographic characteristics. For instance, LGBTQ-related sexual/gender stigma is a significant deterrent in accessing health and medical care (Daley and MacDonnell, 2011). With respect to the actual use of healthcare services, findings about whether bisexual and heterosexual men have a regular place they go to for routine healthcare are inconsistent (Conron, 2010; Wheldon, 2013). Conversely, lesbian and bisexual women are less inclined to have a regular site for healthcare services (Boehmer, 2012; Buchmueller, 2010; Heck et al., 2006; Wheldon, 2013). They are also less likely to have insurance coverage (Buchmueller, 2010; Conron, 2010; Diamant et al., 2000; Heck et al., 2006). Additionally, the Hammond Study (2010) revealed that Black men who have greater mistrust towards medical professionals were less likely to receive routine medical examinations.

The Origin of the BM and Its Five Phases

To date, one of the most widely used models to study access to and utilization of healthcare is the BM. BM was developed in 1968 by sociologist Andersen to examine an individual's use of healthcare services, particularly physician care (Andersen, 1968,

1973, 1995, 2001 and 2008). The original model describes the use of healthcare services through the following three different domains: "predisposing", "enabling" and "need". These domains were developed to understand, predict, and examine the manner in which an individual accesses and utilizes healthcare. Since the inception of the BM, this model has been revised through five distinct major phases.

Phase one of the BM included the original model, which hypothesized that an individual's use of healthcare was based on his predisposition towards health (such as demographics, social structure, and health beliefs), the enabling factors he experienced (such as family and community resources) that either inhibited or promoted his use of healthcare, and his perceived need or clinically evaluated need for healthcare services (Andersen, 1968; Andersen and Andersen, 1967). Phase two of the BM was published in 1978 (Aday and Adnersen, 1978; Andersen, 2008). It grouped the three domains under the description "population characteristics" and incorporated both the healthcare system and client satisfaction into the model. The healthcare system component of the model allowed the researcher to examine policies, resources, and organization. Client satisfaction was employed as an outcome measure of healthcare services which assessed convenience, availability of care, and quality of care.

Phase three of the BM involved the addition of a linear model consisting of the following three overarching principles: primary determinants, health behaviors, and health outcomes. Primary determinants included population characteristics such as the healthcare system and the external environment. Health behaviors focused on personal health behaviors and the individual's actual use of healthcare to demonstrate that health behaviors affect health outcomes. Health outcomes were extended to include an

individual's perceived health status, evaluated health status and their satisfaction with

healthcare services (Andersen, 1995). The fourth phase of the BM is quite unique in that

it added a fourth principle—environment—as well as incorporated feedback loops to

demonstrate the interconnectedness between environment, individual characteristics,

individual health behaviors, and health outcomes (Andersen, 2008). Basically, the

revised framework sought to show the relationship between health outcomes and health

beliefs and/or need. Using this revised model allows the researcher to asses direct and

indirect effects when an individual's behavior or characteristics change. For instance, if a

homeless LGBTQ young adult experiences an increase in "need" due to an STI infection,

the model predicts that there will be an increase in healthcare service use as well. The

fifth iteration of the model formally added contextual determinants of healthcare

utilization and separated this domain from individual characteristics in order to inform

the researcher of non-individual factors affecting health outcomes (Andersen, 2008).

Contextual factors included healthcare organization/systems, public health measures in

the community and provider-related characteristics. Additionally, the actual healthcare

experience of patient and provider was implemented under the health behavior principle

to examine the behavior of healthcare providers during care (such as provider

communication and patient and provider interaction). Figure 1 shows the BM in all its

phases—1–5.

Contextual Characteristics   Individual Characteristics   Health Behaviors   Health Outcomes

Predisposing>>>>>>Enabling>>>>>>Need		
Demographic	Health Policy	Environmental
Social	Financing	Pop Health
		Indices
Beliefs	Organization	

Predisposing>>>>>>Enabling>>>>>>Need		
Demographic	Financing	Perceived
Social	Organization	Evaluated
Beliefs		
Genetics		

Personal Health
Practices
Process of Medical Care
Use of Personal Health
Services

Perceived Health
Evaluated Health
Customer Satisfaction
Quality of Life

Phase 1 _____ Phase 2 _____ Phase 3 _____ Phase 4 _____ Phase 5 _____

Figure 1. Phases of BM

Gelberg and Andersen's BM for Vulnerable Populations

To examine the multidimensional factors that affect access to healthcare among homeless bisexual and gay young adult men in NYC, the preferred BM that is used in this study is the Gelberg and Andersen BM for Vulnerable Populations (BMVP) (Gelberg et al., 2000). BMVP stems from the original BM framework but also considers specific characteristics that are unique to vulnerable populations. In 2000, Gelberg et al. described vulnerable populations as homeless persons, minorities, undocumented immigrants, mentally ill individuals, chronically ill individuals, children, and adolescents, some of which captures important characteristics of the lives of homeless bisexual and gay young adult men living in NYC. BMVP is primarily divided into two main domains—"traditional" and "vulnerable"—within the following four principles of the model: contextual characteristics, individual characteristics, health behaviors, and health outcomes. The *traditional* domain basically remains the same as the BM using the individual characteristic noted under the phase five model. The *vulnerable* domain, however, focuses closely on social structure and enabling issues under the phase five model. In Table 1, I clarify the differences between the two domains, as they are interlaced within the four principles of the BM and later illustrate how each domain affects access to healthcare.

Table 1

Traditional versus vulnerable domains

TRADITIONAL DOMAIN			
Contextual Characteristics	Individual Characteristics	Health Behavior	Health Outcome

	Predisposing Factors	Enabling Factors	Need Factors		
General Factors Government policy and funding Healthcare system Social, economic and political conditions	**Demographics** Age Gender Race Sexual orientation Gender identity	**Personal Resources** Insurance Income Perceived barriers to care Regular source of care Residence Social support Stigma/ Discrimination	**Perceived Health** Symptoms Diagnoses General state	**Personal Health Practices** Diet Exercise Self-Care Drugs and Tobacco use Adherence to care	**Health Status** Perceived health Evaluated health
	Health Beliefs Attitudes toward services Knowledge about disease Values concerning health/illness	**Community Resources** Health services resources Region	**Evaluated Health** Symptoms Diagnoses Routine healthcare Recommen- ded healthcare		**Satisfaction with Care** General satisfaction Technical quality Interpersonal aspects Coordination Communicatio n Financial aspects Time spent with provider Administrative Hassle Comprehensiv eness Convenience Continuity of care
	Social Structure Education Employment Ethnicity Family size Occupation Religion Social networks				
VULNERABLE DOMAIN					
Contextual Characteristic s	**Individual Characteristics**			**Health Behavior**	**Health Outcome**

	Predisposing Factors	Enabling Factors	Need Factors		
Policy Context of LGBTQ rights Context of LGBTQ young adults Context of LGBTQ young adult homelessness Context of educational program Context of employment programs for young adults Context of reception Context of US/States Justice system Healthcare utilization before homelessness	**Social Structure** Migration movement (internal/ external) Underground network	**Personal Resources** Competing needs Hunger Public benefits Self-help skills Ability to navigate systems Case manager Transportation Telephone Information Sources	**Perceived Health** Acute health issues Comorbid conditions Depression/ suicide Addiction	**Personal Health Practices** Food sources Hygiene Unsafe Sexual Behavior Survival Sex Substance Use /	
	Young Adult Abuse and neglect history Youth homelessness Youth living conditions Foster care or group home living Family Rejection				
	Other Vulnerable Delinquent behavior/prison history Mobility Psychological resources				

	Residential resources History of homelessness Couch surfing Victimization				

Individual characteristics: Predisposing factors. The BMVP'S traditional

domain predisposing factors are described as an individual who is more or less likely to

use healthcare services based on her or his demographics (such as age, race, and gender),

position within the social structure (such as relationships, cultural norms, and values),

and beliefs about healthcare services. However, as laid out in the vulnerable domain of

predisposing factors, an individual is more or less likely to use healthcare services based

on different characteristics linked to her or his social structure, such as sexual orientation,

gender identity, living conditions, and severity of homelessness. In Figure 2, I depict a

model illustrating the differences between the two domains and their differing

relationship to healthcare access.

(Please note: The changes in oval shapes have no significant meaning. The different

color of this principle from subsequent principles reflects the different BMVP principles

applied to the study.)

Traditional Predisposing Domain of the BMVP   **Health Outcome**

Age

Sex

Race/Ethc

Improved Health Outcomes

Vs

Decreased Health Outcomes

Vulnerable Predisposing Domain of the BMVP

Sexuality/ Gender

Homeless- ness
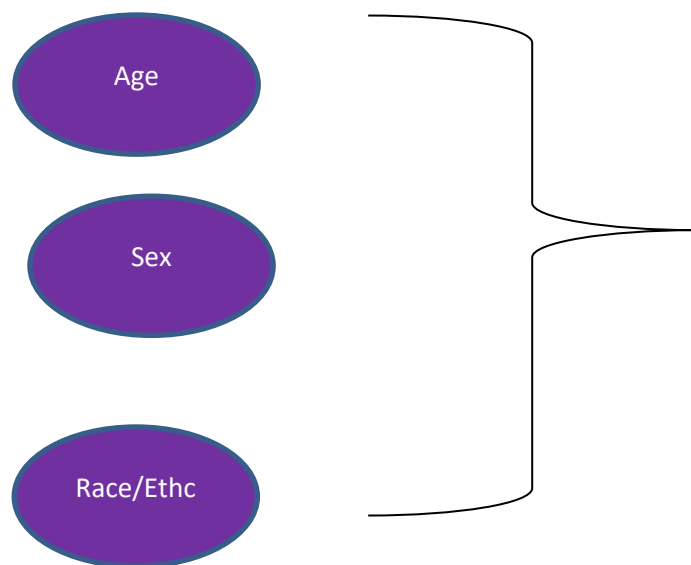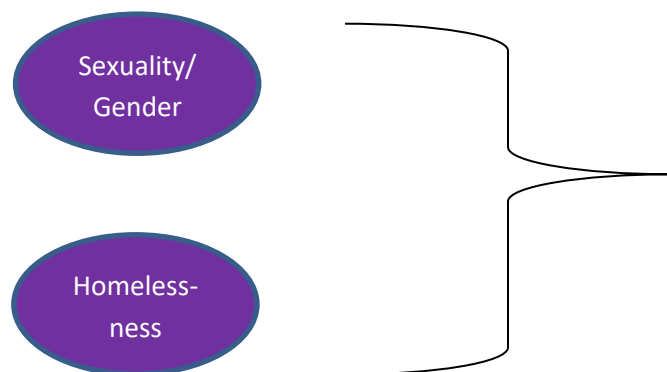
Figure 2. A comparison of the traditional and vulnerable predisposing domains of the

BMVP

Individual characteristics: Enabling factors.

The term "enabling" under the Gelberg-Andersen's BMVP model is not used as it is typically defined—to allow or empower. Instead, it governs two opposing components—either to allow or to restrict. Under the traditional enabling domain of the BMVP, enabling factors are characteristics that either enable access or restrict access to healthcare. These factors involve an individual's connection with the resources within their family (such as income, social support, insurance status) and community (the availability of services and quality of services). However, under the vulnerable enabling domain of the BMVP, there are much more nuances in comparison to the traditional enabling factors (See Table 1). For instance, family resources may be compromised by competing needs such as meeting basic human needs (food, shelter, and clothing), access to benefits and government subsidies, ability to navigate the system, means of transportation, case management, and availability and use of educational/informational resources. At the community level, under the label of "community resources", vulnerable communities often face issues of safety and crime. Moreover, the availability of social service resources in the community may be limited or scarce. In Figure 3, I depict a model illustrating the differences between the two domains and their differing relationship to healthcare access.

(Please note: The changes in oval shapes have no significant meaning. The different color of this principle from subsequent principles reflects the different BMVP principles applied to the study.)

Traditional Enabling Domain of the BMVP   **Health Outcome**

Income

Social
Support

Insurance

Vulnerable Enabling Domain of the BMVP

Improved Health
Outcomes

Vs

Decreased Health
Outcomes

Govt.
Benefits

Transport-
ation

Safety

Availability of
resources
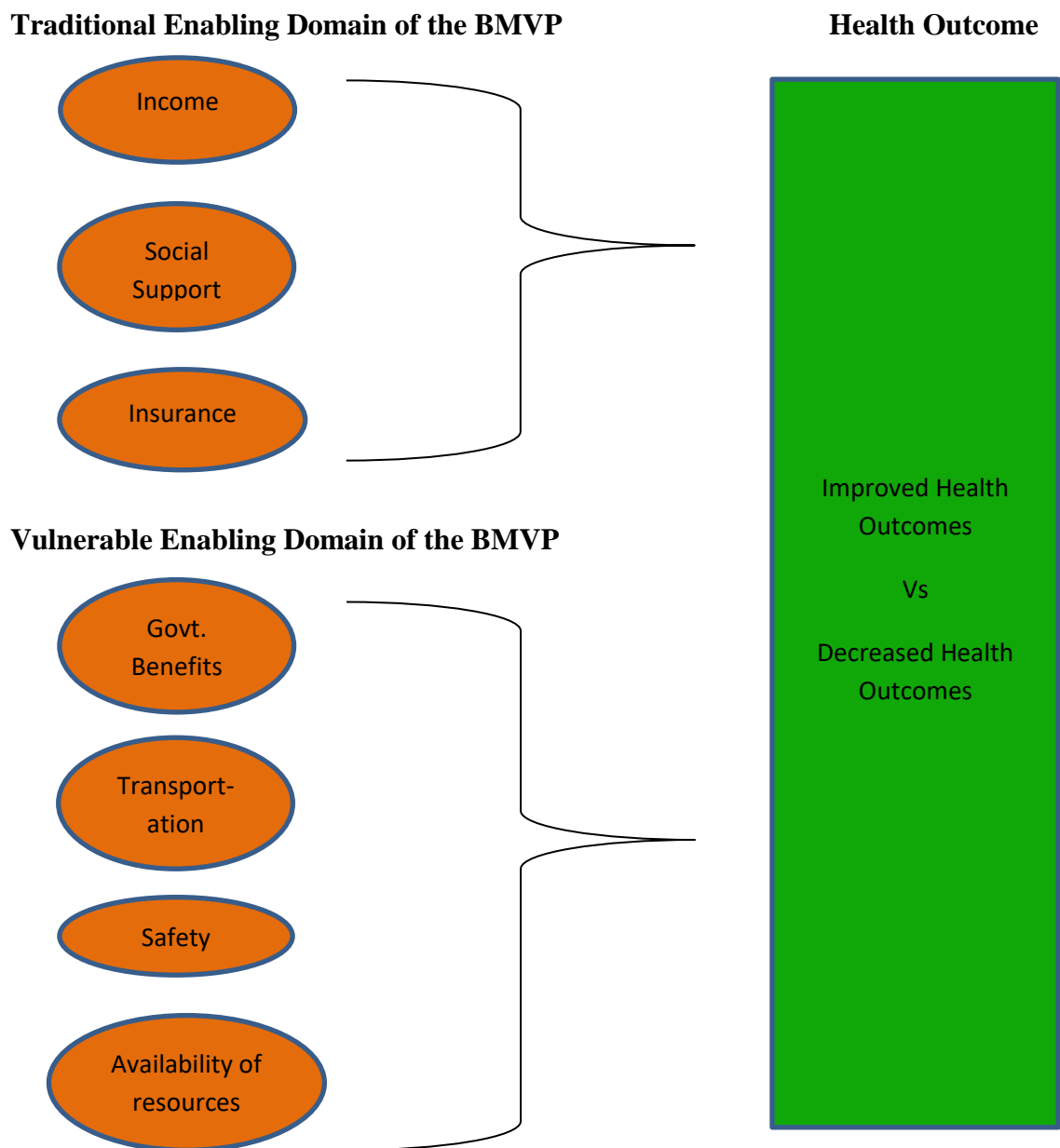
Figure 3. A comparison of the traditional and vulnerable enabling domains of the BMVP

Individual characteristic: Need factors.

Under this domain, the term "need" refers to both the individual's self-perceived need as well as the individual's need as perceived by his or her healthcare provider. For instance, the traditional domain need factors include an individual's perception of his or her need for healthcare services (whether the individual thinks a medical problem exists or their general state of wellness) and/or evaluated need (professional medical assessment of the individual's health status and need for healthcare services including routine annual check-ups). In contrast, vulnerable domain need factors focus on conditions more likely to impact vulnerable populations such as ones affected by HIV/AIDS, STIs, mental health issues, and substance use issues. In Figure 4, I depict a model illustrating the differences between the two domains and their differing relationships to healthcare access.

(Please note: The changes in oval shapes have no significant meaning. The different color of this principle from subsequent principles reflects the different BMVP principles applied to the study.)

{See Figure 4 in next page}

Traditional Need Domain of the BMVP   **Health Outcome**

Patient's Perceived Need

Provider's Perceived Need

Vulnerable Need Domain of the BMVP

Patient'sPerceived Need (foot care, suicide, substance use, sexual assault, unsafe sex),

Provider-perceived need (anal pap smears, STI screening, counseling)

Improved Health Outcomes

Vs

Decreased Health Outcomes
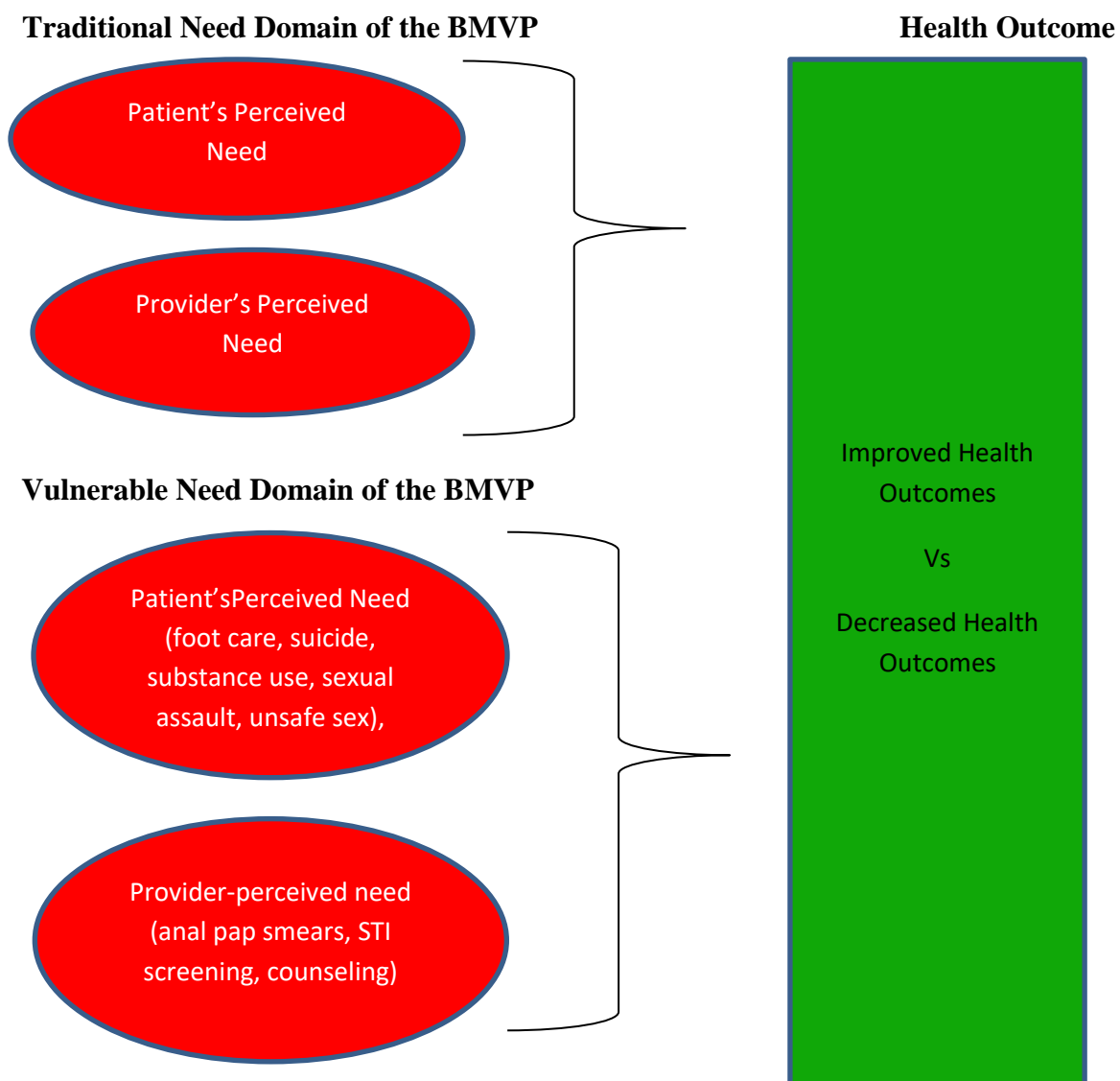
Figure 4. A comparison of the traditional and vulnerable need domains of the BMVP

Health behavior.

In the traditional health behavior domain, critical factors include health behaviors such as diet, smoking, exercise, and adherence/use of healthcare. However, under the vulnerable health behavior domain, the most critical factors refer to whether or not individuals have access to healthcare as well as the lack of resources in their community. It encompasses behaviors that make an individual more susceptible to diseases as a consequence of being vulnerable (such as unsafe sex and survival sex). In Figure 5, I depict a model illustrating the differences between the two domains and their differing relationships to healthcare access.

(Please note: The changes in oval shapes have no significant meaning. The different color of this principle from subsequent principles reflects the different BMVP principles applied to the study.)

Traditional Health Behavior Domain of the BMVP   **Health Outcome**

Diet

Smoking

Exercise

Improved Health Outcomes

Vs

Decreased Health Outcomes

Vulnerable Health Behavior Domain of the BMVP

Survival Sex

Delinquent Activity Sex
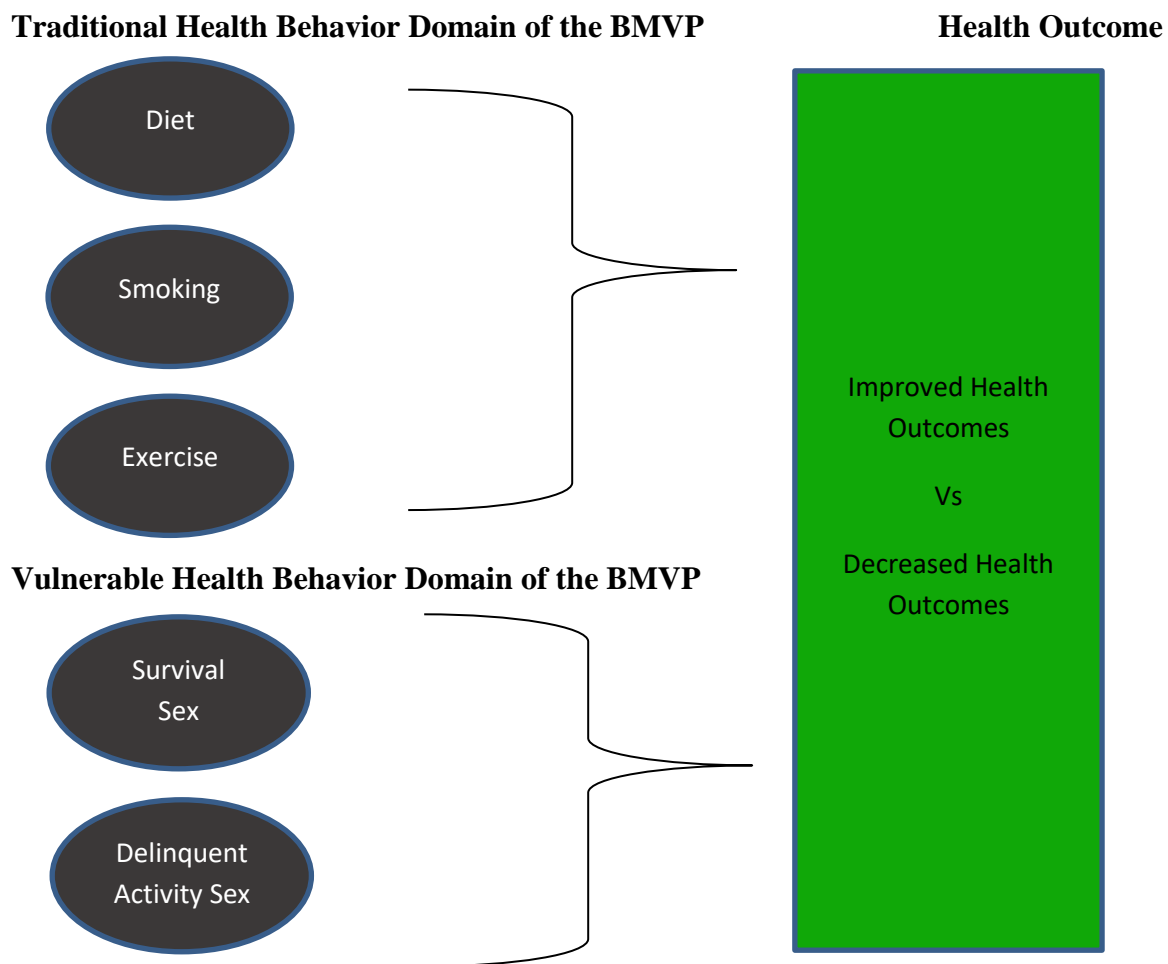
Figure 5. A comparison of the traditional and vulnerable health behavior domains of the

BMVP

Contextual characteristics.

Contextual characteristics are measured based on macro level forces that influences an individual's experiences with the availability of healthcare services and resources (Andersen, 2008). This includes external factors like organizational, communal, environmental, and geographic factors. Contextual characteristics are also broken down into two domains—predisposing and enabling factors. Figure 6 illustrates that the traditional predisposing contextual characteristics are factors beyond the individual characteristics such as age of community and community demographic characteristics (age, sexual orientation, etc.) (Andersen, 2008). Examples of the vulnerable predisposing contextual characteristics include LGBTQ youth homelessness and their establishment as a community. Figure 7 illustrates the traditional enabling contextual characteristics in the environment or community for actual access and utilization of healthcare. This includes community resources like the number of healthcare agencies in a specific geographic region or number of providers (Andersen, 2008). The vulnerable enabling contextual characteristics includes healthcare centers and social service programs that are specifically geared towards the homeless LGBTQ youth community. I aim to unearth some of the broader overarching factors affecting healthcare by applying the contextual characteristic domain in this study. The results of the study in this domain will help identify the resources or lack thereof that exists in the homeless bisexual and gay community in NYC.

(Please note: The changes in oval shapes have no significant meaning. The different color of this principle from subsequent principles reflects the different BMVP principles applied to the study.)

Traditional Contextual Predisposing Domain of the BMVP   **Health Outcome**

Vulnerable Contextual Predisposing Domain of the BMVP
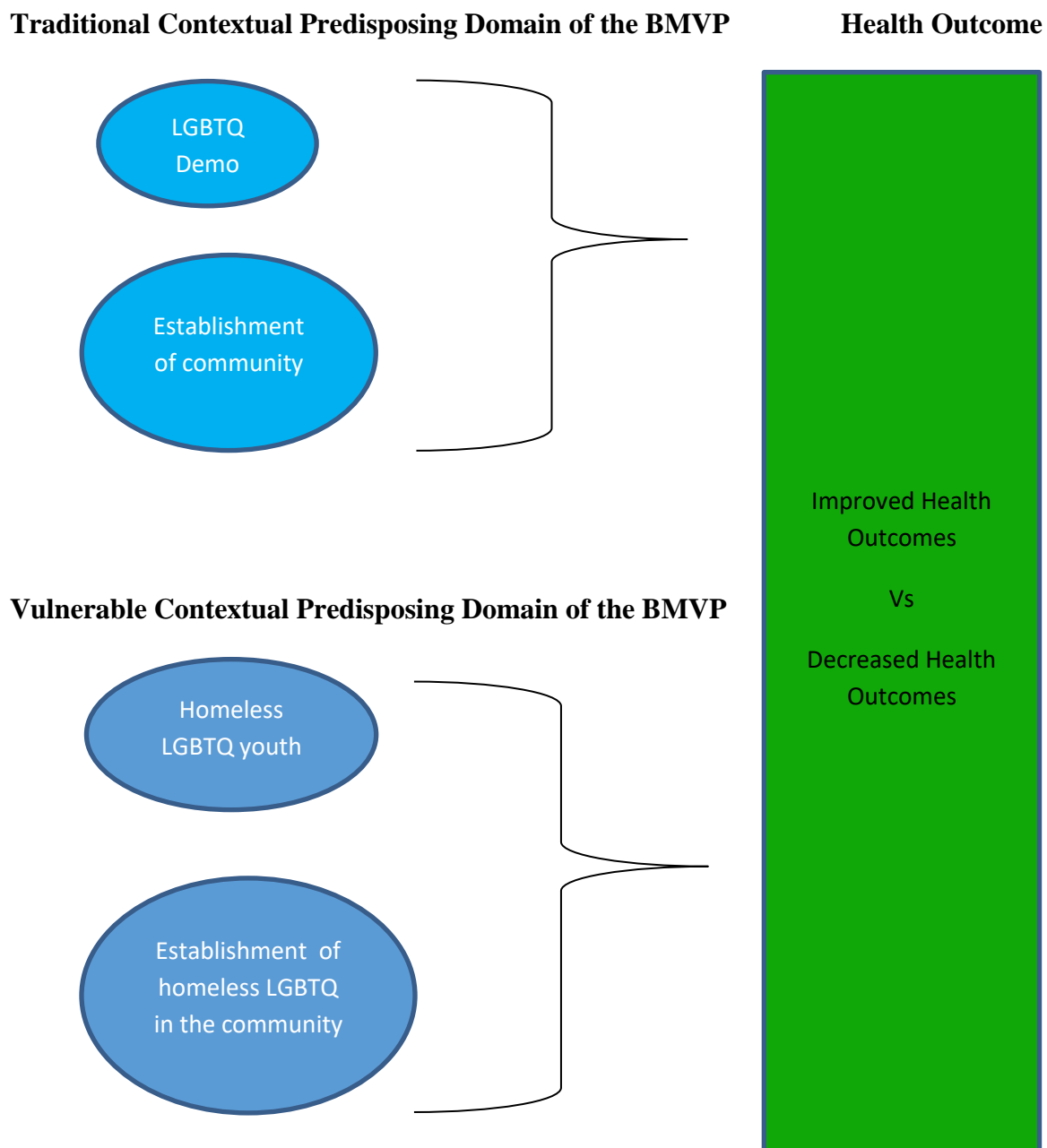
Figure 6. A comparison of the traditional and vulnerable contextual predisposing

domains of the BMVP

Traditional Contextual Enabling Domain of the BMVP   **Health Outcome**

Health Centers

Social Services

Improved Health Outcomes

Vs

Decreased Health Outcomes

Vulnerable Contextual Enabling Domain of the BMVP

Homeless LGBTQ men health centers

Homeless LGBTQ men social services
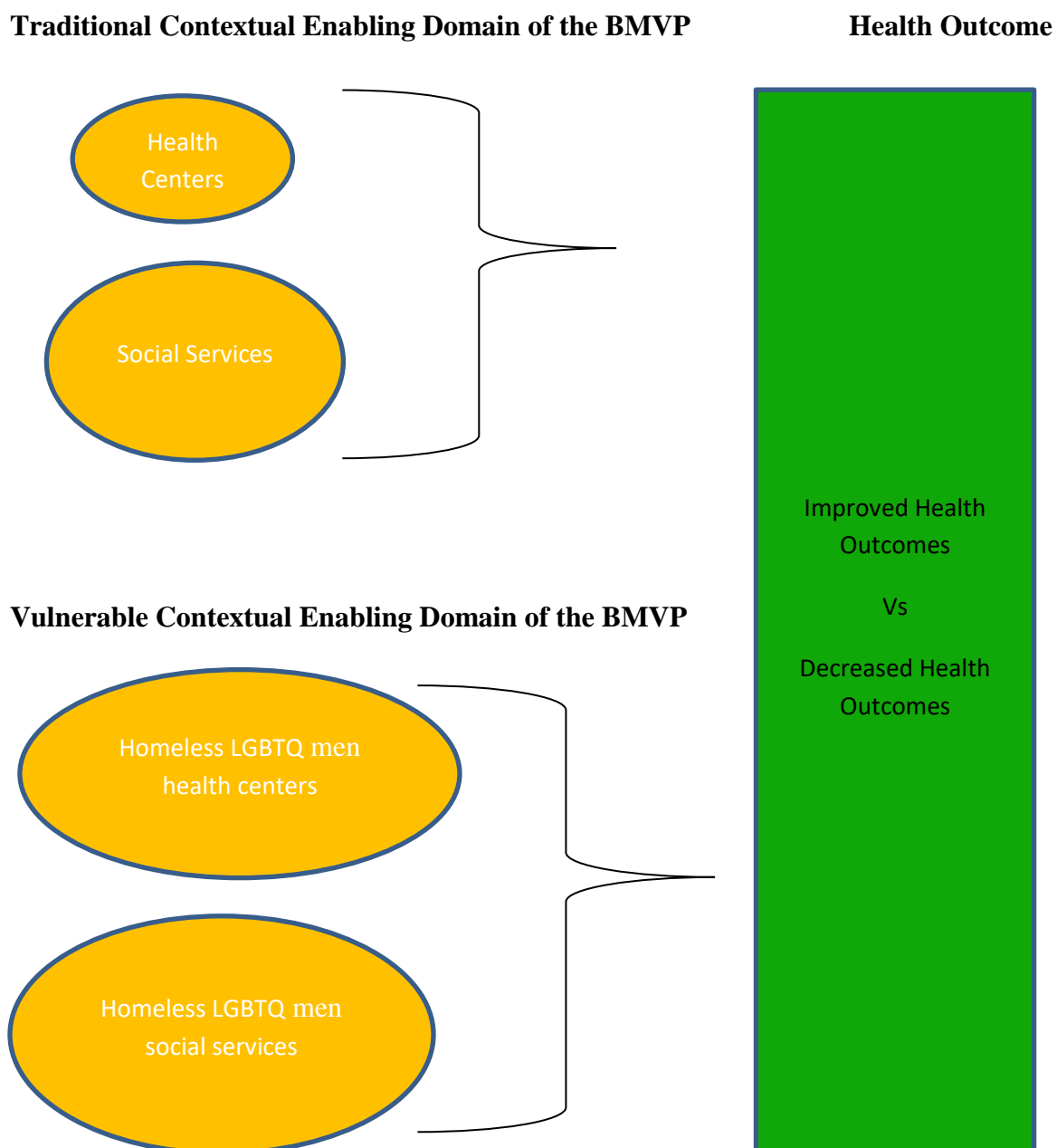
Figure 7. A comparison of the traditional and vulnerable contextual predisposing

domains of the BMVP

Complete BMVP (model as it relates to homeless LGBTQ youth).

When I applied some of the known factors affecting access to healthcare among homeless LGBTQ youth in their respective BVMP domains, they seem to fall into place seamlessly. However, it is still unclear whether homeless bisexual and gay young adult men in NYC have the same experience, how they fare with preventive care, and whether a difference between the two groups exists. Figure 8 depicts the complete BMVP module that is in the study. (Please note: The changes in the size of the shapes have no significant meaning. The different color reflects the different BMVP principles applied to the study.)

{See Figure 8 in next page}
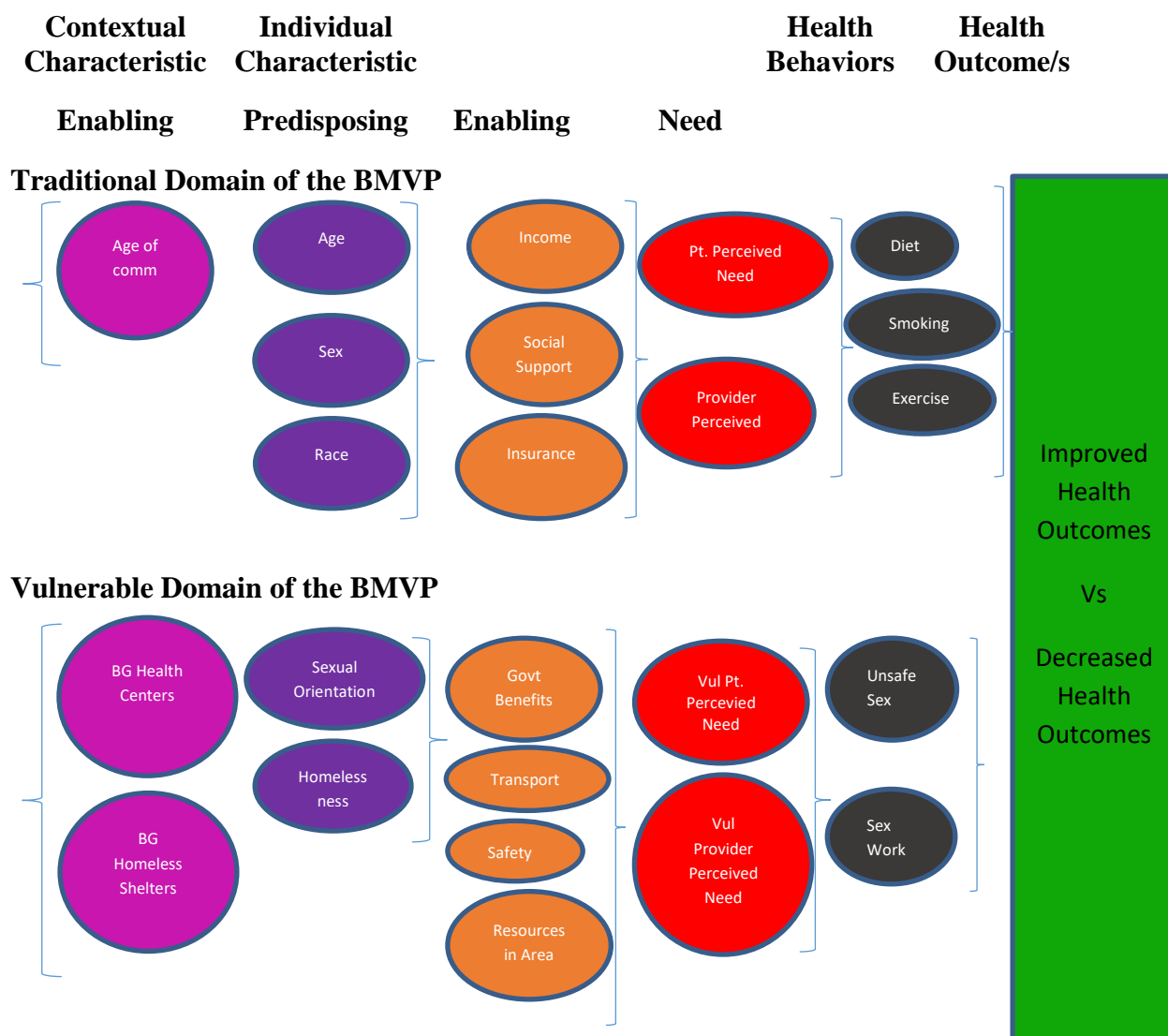
Figure 8. Abbreviated BMVP assessing access to healthcare among homeless LGBTQ

Application of BMVP in Previous Studies

Some studies use the BMVP to examine access to healthcare and utilization among homeless individuals (Gibson, 2014; Riley et al., 2011; Stein, 2016; Teruya et al., 2010). Stein et al. (2016) used the model to examine the impact of Hepatitis B and C infection and healthcare utilization among homeless individuals in Los Angeles. The study found that *predisposing* variables predicted healthcare utilization among homeless individuals as they did for the general population. However, minority status did not necessarily predict negative healthcare utilization outcomes. Blacks were found to have greater access to a regular source of care and fewer hospitalizations in the past 12 months than other races. Additionally, hepatitis infection was linked most strongly to *predisposing* factors associated with hepatitis risk in all populations such as intravenous drug use, alcohol use, and risky sexual behaviors. With respect to vulnerable-specific *predisposing* variables, the study found that participants with a history of childhood abuse experienced more obstacles to healthcare use. Childhood abuse was also strongly associated with the duration of homelessness, drug/alcohol use, risky sexual behavior, and mental illness.

In another study, Teruya et al. (2010) examined health and healthcare disparities among 1331 homeless African American, Latina, and White women in Los Angeles. Researchers used the BMVP to determine if predisposing factors (like race and ethnicity and other factors) inhibited or facilitated healthcare access and whether they were associated with women's *need* for medical care. The study revealed that Black and Latina homeless women were more likely to report that their needs were met than White, non-Latina women. Also, women suffering from conditions like substance abuse, violence, or

depression had more unmet medical care. In terms of enabling factors, a greater proportionate of Black women reported receiving public assistance, whereas White women relied more on family and friends for resources. The study concluded that the varying predisposing and enabling factors among the racial/ethnic subgroups can have important healthcare ramifications for the purpose of outreach to homeless women.

Riley et al. (2011) conducted a longitudinal study to examine the impact of health insurance coverage on healthcare utilization and HIV antiretroviral therapy among 330 unstably housed HIV-positive individuals. Researchers wanted to control for predisposing factors like homelessness, unmet sustenance needs, and substance use. They concluded that the continuity of insurance was positively associated with increased healthcare utilization among stably housed HIV-positive individuals, but the benefits of healthcare coverage could be overshadowed by other unmet competing needs in the case of unstably housed HIV-positive individuals. The study suggests that further examination of healthcare policies geared towards reducing roadblocks regarding routine health insurance coverage among vulnerable populations is necessary. For instance, competing and unmet needs should be met before routine preventive care and regular health insurance are promoted.

In an unconventional empirical study, Gibson et al. (2014) examined accessibility and utilization patterns among vulnerable populations using a mobile van clinic (MVC). An MVC offers a non-traditional healthcare service that enables access to healthcare regardless of social barriers, geographic restrictions, stigma, transportation issues, costs, and ability to pay. In spite of fixed mental health and substance dependent treatment services in the area, individuals preferred to utilize the MVC. To explain this pattern of

healthcare utilization, Gibson et al. employed five components of Penchansky's and Thomas' BM—*accessibility, affordability, acceptability, availability*, and *accommodation*—and need factors (1981). Their version of BM had similar domains to the BMVP model that are used in this study. Their study revealed that enabling factors like geographic distance did not impact frequency of use. However, there was a striking difference when considering the location of residence and race/ethnicity. Participants living less than 5 miles and more than 50 miles of the MVC were predominantly minorities and undocumented immigrants. Conversely, participants who lived between 5 and 50 miles were White and US citizens. A similar finding was also identified among participants who were struggling with housing and health insurance. Those who were traveling greater than 50 miles were more likely to be homeless. Lastly, an important distinction made in Gibson's study is that the ACA has no appropriations for the specific MVC used in the study, despite that fact that they serve vulnerable communities that would otherwise be missed. Even though there are federally qualified healthcare centers in close vicinity to the MVC, individuals who are socially and medically marginalized did not access them. Instead, they seemed to have preferred the MVC.

The empirical evidence constantly suggests that varying predisposing, enabling, and need factors inhibit access to care as depicted in the BMVP, particularly among marginalized groups and subgroups seeking to establish regular or routine healthcare. Because most homeless bisexual and gay young adult men in NYC are people of color (primarily Blacks and Latinos) with varying gender identities, they may be predisposed to experience reduced access to healthcare. For instance, several studies revealed the strong relationship between race and/or sexual identity and health disparities/disease burden

(Boehmer, 2012; Buchmueller, 2010; CDC, 2014; Choi, 2015; Diaz et al., 2001; Heck et al., 2006; Herbst et al., 2008; Kenagy, 2005; National Gay and Lesbian Taskforce, 2009; Wheldon, 2013; Whitbeck, 2004). In this study, I explore the relationships among individual characteristics (predisposing, enabling, and need), health behaviors, and contextual characteristics (enabling factors) as they may impact patients' access to healthcare and health outcome. Interviews were begun by asking for demographic information via questionnaire (such as age, race/ethnicity, gender identity, sexual orientation, education, and employment), and additional information on health status, homelessness, and healthcare utilization were also collected (See Appendix 3). Data gathered from the study is coded, organized into themes, and categorized into the most appropriate BMVP stages for further evaluation and analysis.

Chapter 4

Methodology

Study Purpose

Access to healthcare may vary for homeless bisexual and gay young adult men in NYC. For this study, there were two foci regarding access to healthcare—a) accessing healthcare as needed and/or only when ill or symptomatic and b) accessing preventive healthcare on a routine or regular basis for annual checkups. Establishing a routine source of healthcare (such as annual check-ups, STI/HIV screening, vaccinations, and healthy living) helps to identify disease conditions early and mitigate morbidity and mortality (Altena, Brilleslijper-Kater, and Wolf, 2010; Bandurraga, 2011; Boehmer, Miao, Linkletter, and Clark, 2012). Since it is unknown when and whether homeless bisexual and gay young adult men access healthcare, **the purpose of the study is to assess their access to healthcare (with an emphasis on preventive care) among homeless bisexual young adult men and homeless gay young adult men in NYC and compare the experiences of the two groups.** Given that self-perceived need and access to healthcare (with an emphasis on preventive healthcare) is not well researched among homeless bisexual and gay young adult men in NYC, the most appropriate research methodology for the study is Content Analysis (CA).

Content Analysis

A greater understanding of access to healthcare among homeless bisexual and gay young adult men in US cities is needed for the following four main reasons: 1. to offer a basis for future reduction of health disparities among homeless bisexual and gay young adult men, 2. to improve the quality and accessibility of routine and preventive

healthcare, 3. to establish a basis of conceptual awareness for substantive theory development, particularly theory on access to healthcare and preventive care, and 4. to apprise the healthcare and public health communities of factors affecting access to healthcare in the homeless bisexual and gay young adult male community. One scholarly goal of this study is to provide a theoretical understanding of this phenomenon that will lead to further research and public health practice. In doing so, CA served as the central methodological guide to this qualitative study. It helped to frame the BMVP model to demonstrate what factors influence or restrict access to healthcare among homeless bisexual and gay young adult men in NYC in each of its domains.

CA is a research technique that gained recognition in the mid-20th century (Hsieh and Shannon, 2005). More recently, CA is commonly used by sociologist and health researchers for the objective, systematic, and quantitative analysis in the context of communication (Nandy and Sarvela, 1997; Neuendorf, 2001). CA is defined as "a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns" (Hsieh and Shannon, 2005, p.1278). It involves the quantification and analysis of meaning and relationships of words and concepts. CA goes further than word numeration and mining objective content from texts. It examines the obvious as well as underlying meanings, themes, and patterns that may surface in the text/s under study. This allows the researcher to gain a better understanding of the social reality experienced by the study's subjects and then draw a subjective opinion. The use of CA often generates an array of explanations, typologies, and themes that exemplify the phenomenon under study.

There are three types of CA methodologies—conventional content analysis (CCA), direct content analysis (DCA), and summative content analysis (SCA). For the purpose of this study, CCA is used as the primary methodology to identify key themes and concepts. CCA is often used to explain a phenomenon, particularly when the population is understudied or when there is limited theory on a population (Hsieh and Shannon, 2005). In this type of analysis, researchers follow the typical path of inductive analysis, allowing names, codes, categories and themes to evolve. Data collection begins with an iterative review process of the actual data collected to gain an in depth understanding of the topic under study as well as the subject under study. Codes are often derived from the actual text content. Once codes are initiated, it is then arranged into categories to form a meaningful cluster. Categories are important to organize and place codes that are related to each other. If categories are too large, subcategories can be formed. However, once codes and categories are established, they will individually be defined. An advantage of using the CCA methodology is that the researcher can harvest critical data directly from the study's subjects without prescribed theoretical underpinnings. However, the following are the two main limitations to using CCA: 1. CCA can easily be mistaken for Grounded Theory or phenomenology, which are both other forms of qualitative methodology and 2. Lack of developing a complete understanding of the context which may limit the researcher's ability to recognize key concepts, etc.

Another form of methodology that is utilized in this study is DCA. DCA is employed when existing theories or research on a phenomenon is limited (Hsieh and Shannon, 2005). Its goal is to build on existing theoretical framework and/or hone in

more on the research questions. Although there have been many studies and theories on

access to healthcare, there is a considerable gap in research on homeless bisexual and gay

young adult men's access to healthcare in NYC. Since the results of this study were

matched to an already developed theoretical model—BMVP—DCA served as a

supplement to the CCA once themes and categories were derived.

Primary Research Objectives

Primary research objectives of the study were classified in the following three

major factors associated with access to healthcare: health need, healthcare access and

availability, and healthcare utilization. Healthcare need is the perceived health needs of

the participant. Therefore, the research objective for healthcare need is to evaluate the

self-perceived health of homeless bisexual young men in NYC and assess their need for

healthcare (with an emphasis on preventive care) compared to that of homeless gay

young adult men in NYC. Healthcare access and availability speaks to entry into the

healthcare system and the availability of healthcare resources. This factor has two

objectives—1. to determine the self-perceived facilitators of access to healthcare (with an

emphasis on preventive care) as experienced by homeless bisexual young adult men in

NYC and compare their experiences to the experiences of homeless gay young adult men

in NYC and 2. to determine the self-perceived barriers of access to healthcare (with an

emphasis on preventive care) as experienced by homeless bisexual young adult men in

NYC and compare their experiences to the experiences of homeless gay young adult men

in NYC. Healthcare utilization is the actual routine use of healthcare services and

resources available to participants. Therefore, the objective is to determine the type,

location, and frequency of healthcare utilization (with an emphasis on preventive care)

among homeless bisexual young adult men in NYC and compare this to the utilization

patterns of homeless gay young adult men in NYC.

Breakdown of Research Questions

1. What are the self-perceived needs for healthcare among homeless bisexual young
   adult men in NYC compared to homeless gay young adult men in NYC?

2. What are the facilitators of healthcare access (with an emphasis on preventive
   care) between homeless bisexual young adult men in NYC and homeless gay
   young adult men in NYC?

3. What are the barriers to healthcare access (with an emphasis on preventive care)
   between homeless bisexual young adult men in NYC and homeless gay young
   adult men in NYC?

4. Where, when, and *how frequently* do homeless bisexual young adult men in NYC
   access healthcare and how is that compared to the utilization patterns of homeless
   gay young adult men in NYC?

Study Design

Up to 30 participants (17 homeless bisexual young adult men and 13 homeless

gay young adult men) were recruited and interviewed in this study until saturation was

reached. Participants who met the inclusion criteria were informed in detail about the

purpose of the research in layman's terms and were advised of the risks and benefits of

the study as mandated by Rutgers Institutional Review Board (IRB). A consent form was

administered by the interviewer prior to obtain verbal consent from participants (see

Appendix 2). Verbal consent only was the recommended by IRB based on the

vulnerability of the population, therefore a signed consent was not necessary. However, participants were given detailed information of the study, study procedures, and potential risks. In the event that the participant was not comfortable with the study or was experiencing any physical or mental health issue, the interviewer ended the interview immediately and provided a referral for appropriate medical/mental healthcare as needed. Before the interview discussion began, participants were asked to complete a brief demographic questionnaire with additional questions concerning access to healthcare, homelessness, and health status (see Appendix 3).

At the end of the interview, each participant was given a list of LGBTQ-sensitive, affordable healthcare providers in NYC (see Appendix 4). In the event that a participant withdrew from the study, basic demographic information was used to compare them to those who participated. Those who refuse to participate were also given the referral list. Throughout the study, I maintained a journal log documenting my experiences and detailing a step-by-step description of the process that took place. Throughout the study, no outstanding issues interrupted the survey questionnaire or interviews.

Once all the interviews were completed, they were transcribed verbatim. During transcription, the transcriptionist removed the participant's names and any identifying information from the transcript to protect participants' confidentiality. Pseudonyms were used to replace the participant's name as well as the agencies they accessed. Traditional CA was used to identify trends, themes, and concepts associated with urban homeless bisexual and gay young adult men and their access to and utilization of healthcare services in NYC. Included in the transcript were notes and/or comments (if any) that were pertinent to the participants' emotional reaction and experiences with access to

healthcare. Transcripts were imported into the NVivo computer software program. Ongoing analysis was conducted via NVivo to code the data and link themes with domains within the BMVP.

Researcher's Role

As an immigrant sexual minority youth of color raised in a single-parent household in working-class NYC, access to quality healthcare was extremely challenging to access. Most of the healthcare services available in my community failed to meet my medical and mental health needs as a young gay immigrant youth. I fell through the cracks in the system in many respects. Issues of sexuality were never discussed with medical providers in the community. Referrals to affordable healthcare and social services were far reaching, leaving me feeling hopeless. HIV and STI screenings were never available in my community, perpetuating to heighten the stigma and fear to be gay. It was hard being a gay youth, being an immigrant of color, and being in a low socioeconomic status.

When I was finally able to afford health insurance, most of the conventional healthcare services available (for middle-class New Yorkers) also failed to meet my needs. They offered services that didn't match my social/cultural Indo-Caribbean background. In the medical charts, they labelled me as African American and often prescribed treatment plans which reflected that population. Dietary recommendations usually neglected to include the type of food from my culture (like roti bread, curry cuisines, and vegan breakfast). Provider rapport was limited because providers failed to assess my sexual and mental health needs; they rarely performed thorough physical

examinations or considered primary preventive interventions for diseases I was at high risk for (like frequent screening of STIs/HIV, smoking cessation, binge drinking, and/or vaccinations like Hepatitis A and B and meningitis). Dentists never mentioned anything about the increased risk for HIV post dental procedures. Overall, medical professionals provided healthcare that they believed to be best for me based on their assumptions without fully understanding my need as a young sexual minority of color with very limited resources and limited understanding of the US healthcare system. Therefore, my wish, drive, and passion was to establish quality healthcare that meets the need of my unique demographic and sociocultural profile.

Gaining acceptance on my sexual identity from friends and family in my community was another challenge to contend with, forcing me to couch surf for over ten years. I moved 13 times in 12 years looking for a comfortable place to call home. At that time, I never considered myself homeless until this study when it became crystalized that I fell into the definition of homelessness, hence the enormous lift to strive for upwardly mobility. It wasn't until I became educated in public health that I learned the complex multidisciplinary factors that influenced my access to healthcare. Following my undergraduate degree, my entire career has been focused on eradicating health disparities in hard-to-reach underserved populations (such as HIV-positive patients, substance dependent clients, immigrants, refugees, and lately, homeless bisexual and gay young adult men).

My experience in public health is broad and diverse. I view public health practice from a perspective that emphasizes partnership collaboration, training and education, research, and medical/behavioral health. Serving the US ports of entry as the Acting

Officer-In-Charge at the New York Quarantine Station has demonstrated my executive leadership skills to spearhead the first unprecedented Ebola Entry Public Health Screening Program in the US. The successful management of the program has proven my adeptness to migrant/travelers of Ebola Affected Countries accessing US healthcare system. Furthermore, my evaluation of hospitals' preparedness to all hazardous emergencies allowed for strategic partnership building with healthcare institutions ensuring that they adhere to federal and state standards in developing quality and effective screening and treatment of highly infectious patients. Managing the operations of a HIV/AIDS treatment adherence research project involved coordinating efforts with providers, patients, and stakeholders that enhanced the center's capacity to provide resources for optimal treatment adherence services. Lastly, educating and counseling HIV-positive patients at a long-term residential alternative to incarceration drug treatment program opened my eyes to the ramifications of poverty and its dramatic impact on the health and wellness of communities.

As a seasoned public health practitioner, the devastating impact of health, poverty, and homelessness remains fresh in my eyes and in my heart. Although my personal struggles were a thing of the past, I am keenly interested in the health of the underserved. Health disparities in the homeless LGBTQ youth community in NYC continues at an alarming rate. Even worse is that this disparity is marginalized within a sub population in the LGBTQ community, primarily with Black and Latin LGBTQ youth, a seemingly already socioeconomically marginalized and disenfranchised population group. Yet, it is unclear about their access to healthcare, utilization of healthcare, and health-seeking behavior. Having spent almost two decades working,

studying, and serving marginalized populations and witnessing the blatant political, socioeconomic, and social disregard towards homeless bisexual youths, I felt compelled to dedicate my research project to better understand their experiences with access to healthcare.

I have been volunteering since September 2013 at the New Alternatives Drop-In Center. Some of my responsibilities include soliciting donations, assisting with providing meals, administering supplies and clothing, and observing client and group dynamics at the Center. As a result, I have established a relationship with the homeless LGBTQ youths at the Center. They see my role as altruistic, striving to help meet their basic needs, therefore, they are forthcoming and open about their experiences with their utilization of healthcare. Additionally, I have accessed many LGBTQ healthcare services myself and have almost 20 years of experience in public health, many of which involves access to healthcare, healthcare utilization, etc. As the Principal Investigator, I developed and implemented the research instrument, recruited participants, conducted participant observation, conducted the interviews, collected and analyzed data, and produced research findings.

Individual Semi-Structured Interviews

CCA was used to unearth previously unnoticed or overlooked issues, as the study explores homeless bisexual and gay young adult men's experiences with the healthcare system in NYC. Therefore, the study applied individual face-to-face semi-structured interviews of homeless bisexual gay young adult men in NYC. Interviews were conducted by me, Harlem J. Gunness. Useing a semi-structured interview guide (see

Appendix 1) enabled participants to describe their experiences following a series of questions and prompts which allowed for new insights and themes to emerge.

Semi-structured interviews were conducted at the New Alternatives Center (NAC) in a private office separate from other clients. Interviews were conducted from May 2017 through July 2017. Interviews lasted half an hour on average. Each participant was given a $20 gift card after completing the interview as well as a two-fare NYC MetroCard of $5.50. Interviews began with a brief demographic survey questionnaire, a history of participant experience with homelessness, and current experiences within the NYC healthcare system. As the interview progressed, the researcher solicited the participant's feedback on the barriers or facilitators of the healthcare system and whether the participant had an annual check-up in the past 12 months. Questions were also geared towards the domains of the BMVP. Interviews were conducted in English and were audio recorded. All written documents, audio recorded materials, and laptop (with protected password) used in this study were locked in a private office at Rutgers Newark University Campus and were only accessible to me, the researcher, and Dr. Chase, the dissertation committee chair.

Recruitment and Sample

The recruitment strategy used in this study was purposive sampling. Purposive sampling is a purposeful selection of participants based on characteristics that pertain to the topic under study (Schatzman and Strauss, 1973). It is commonly used in CCA research (Sandelowski, 1995). Participant recruitment began in May 2017 after receiving approval from the Rutgers Institutional Review Board (IRB) and continued throughout

the study until saturation was achieved. An announcement of the study (Appendix 5) and invitation to participate was made available during office operations during the week and on Sundays during dinner. I posted the study flyer on the agency's bulletin board and distributed the flyers to clients. Those who were interested in the study were referred to e for enrollment. They were given a pre-screening form (Appendix 8) to complete to determine their eligibility. Once eligibility was determined, I proceeded with consent procedures.

Recruitment Site

Participants were recruited from the NAC located at St Johns Church, 83 Christopher St, New York, NY 10014. The NAC is open on Tuesdays (from 1:30pm to 7pm), Wednesdays (6:30pm to 7:30pm), Thursdays (1:30pm to 6:30pm), and Sundays (from 2pm to 8pm). I have been a volunteer at the NAC since September 2013. As a result, I have an existing relationship with Ms. Kate Barnhart, the NAC Program Director, as well as the clients of the NAC. Ms. Barnhart has a keen interest in this study in that she sees a need to understand homeless LGBTQ young adults' experiences with the NYC healthcare system. She was very supportive and offered private and confidential space within the facility to accommodate client interviews. A letter of support from Ms. Barnhart was submitted to Rutgers IRB.

The NAC provides case management and educational services primarily to English-speaking homeless LGBTQ youth. There are approximately 650 clients registered at the NAC, with an estimated 250 clients who are active participants. The average number of homeless LGBTQ youths at the Center receiving services on any

given week is about 75 persons. As a drop-in center, the NAC serves any homeless

LGBTQ young adult; this is different from homeless shelters that provide services to a

very small number of homeless LGBTQ youth. The NAC's unique program design and

case management provide continuity of care and support to homeless LGBTQ young

adults unlike many other programs. The NAC provides Sunday dinners, which is a

highly recognized service and is known in the homeless LGBTQ youth community; these

are home-cooked hot meals prepared by volunteers to serve over 50–70 young adults.

The NAC works with many young adults who slip through the cracks in the social

services, shelters, and healthcare systems. Based on my observations, the NAC's clients

exhibit gender identities and sexual expressions that cross the entire LGBTQ spectrum.

One common subgroup of the NAC is transsexual young adults, many who have

experienced severe discrimination from other homeless programs, law enforcement, and

the general public. The NAC's clients represent homeless LGBTQ youths in NYC in the

following ways: 1) by race—11% White, 45% Black, 20% Latino, 14% Mixed Race, 1%

Asian, 1% Native American, and 8% other/unknown; 2) by gender—58% male, 25%

female, 8% male-to-female transgender, 2% female-to-male transgender, and 7% gender

not specified.

Community Profile

The NAC is located in the West Village where many homeless LGBTQ young

adults gather, socialize, and/or sleep. The West Village is historically known for the

Stonewall Riots, the first documented revolt against the government's LGBTQ

discrimination (in this case, the NYC police department) and for its role in fighting for

the equal rights of LGBTQ individuals in the US (History, 2013). Stone Wall is now a historic landmark, just a block away from the NAC. The West Village provided the impetus for LGBTQ civil rights and advocacy groups in subsequent years. The East and West Villages are also known for their integral role in providing social services and resources for the LGBTQ community. Within these two communities, LGBTQ-specific social and healthcare services, HIV testing sites/support groups, gay-friendly churches, gay bars, and pornographic retail stores can all be found. They are also home to some of the most prestigious universities in the world—New York University and Cooper Union School, schools that are accepting and tolerant of the LGBTQ community. The geographic location of the NAC and the many LGBTQ resources surrounding it are easily accessible by public transportation (bus and subway). With LGBTQ agency liaisons, networks and partnerships within 'arm's reach' and the well-known Christopher Street piers (where many homeless LGBTQ youths congregate), the NAC offers a safe haven for them.

Inclusion and Exclusion Criteria

The *inclusion criteria* in the study were as follows: 1. the individual identifies as lesbian, gay, bisexual, and/or transgender, 2. the individual is 18 years of age and older, 3. the individual is homeless as defined by having no parental or guardian supervision or neglect lasting a day or more, 4. the individual is currently living in NYC, and 5. the individual is English-speaking. Homeless LGBTQ young adults who are not living in NYC, have cognitive impairment, language and/or hearing impairments, have severe mental disabilities, psychiatric disorders, and/or are institutionalized were excluded from the study.

Pilot Study

A brief pilot study was conducted to test the semi-structured interview questions and brief demographic questionnaire. The purpose of the pilot was to introduce the topic of access to healthcare to participants, determine their interest, and inquire whether there may be unacknowledged factors barring them from participating in the study. Semi-structured interviews were conducted with at least two participants. Participants were recruited from the NAC based on a referral from the program director. The researcher used the semi-structured interview guide (in Appendix 1) to conduct the pilot interview and assessed whether the participants understood the questions and whether the questions were soliciting responses relevant to the study. At the end of the pilot study, the semi-structured interview guide was modified based on the client's feedback. The demographic questionnaire was tested on a group of 10 homeless bisexual and gay young adult men at the NAC to ensure that the program's clients understood the survey questions and answers. Modifications were made based on the participants' feedback. Recruitment occurred in the same fashion as described above for recruitment to the actual study.

Semi-Structured Interview: Data Analysis

The process of content analysis began with the onset of the interviews and throughout the data collection process. Beginning this early in the process gave me flexibility to maneuver back and forth between concept generation and data collection. This method of flexibility allowed me to steer subsequent data collection in a direction

closer to data substance that answered the research questions. The following steps described in detail occurred during data analysis.

Preparing the data. CCA requires repetitious processing of data collection and CA. I initiated informal analysis and reflection from the start of the study by journaling the interview process (like participants' behaviors, environmental conditions, my thought process, any biases that may occur and/or any other factors that may influence the study or participants' responses). A good example of this is that I reviewed participants' answers to survey questions with them to ensure that they chose the responses they actually wanted. If there were any responses that needed further clarification, I asked for the same, which was documented in my journal. During the interview, I often referred back to the survey and my journal to document changes and/or clarify any discrepancies. To prepare the data, semi-structured interviews were transcribed verbatim. During transcription, the transcriptionist removed the participant's names and any other identifying information (like the names of agencies, hospitals, and shelters they accessed) from the transcript to protect the participants' confidentiality. Pseudonyms were used instead.

Unit of analysis. During this process, formal analysis like coding, identifying trends, themes and concepts began. Initially, transcripts were imported into the NVivo Version 11, a qualitative analysis computer software program used to store, refine, and enrich the coding process. Each transcript was reviewed several times to achieve a thorough understanding of the content. The unit of text essentially means labelling phrases, expressions, and/or words used by participant to themes. Using this method allowed for data to be dissected into various fragments and analyzed line by line (words,

sentences and paragraphs). Once themes were developed, they were carefully scrutinized and compared for similarities and differences. Consistent evaluation and comparison of themes were used to facilitate the range of variation and expound characteristics (Strauss and Corbin, 1998). This enabled me to generate categories relating to the phenomena of accessing and utilizing healthcare, which helped build a foundation for coding and classification development.

Categorization and coding scheme. Categories and coding scheme were developed mainly from the raw data especially after themes were established. Given that this study did not have a theory per se, categories were derived inductively from the data. The purpose of this method was to further develop categories and connect these categories to subcategories. It transformed the data from a descriptive form to a more conceptual form. It was also used to classify the relationship and link between and within categories and subcategories. Following the development of categories, a coding scheme was established under the umbrella of the following three main research objectives: 1. perceived health need; 2. access or entry into the healthcare system; and 3. actual utilization of healthcare services (See Appendix 7). Coding did not necessarily follow a sequential order; it was an integrative back and forth process as one phase of coding guided me to another.

Pre-testing the coding scheme. Pre-testing the coding scheme in qualitative research is essential in data analysis. To achieve consistency in coding, I discussed samples of coded data with Dr. Chase and doctoral peers (in our weekly dissertation support group) for feedback. I compared the feedback from them with the coding

scheme, which showed high levels of consistency. Following the pre-testing, the entire completed data set was tested for validity and reliability.

Drawing conclusion. Final conclusions were drawn based on a reiterative review process of the codes and categories developed. As the researcher, I examined the properties and dimensions for its relationship to each other and unearthed trends and patterns.

Presentation of results. Results were presented under each theme and reinforced by secondary data and quotes from interviews. Results were also presented under each research question to demonstrate whether the questions were answered. Lastly, study results were classified and matched with its appropriate domain under the BMVP model.

Figuring and language. Two other factors that were applied during the coding process are figuring and language. The sketching of figures was incorporated as an analytic tool to maximize the analytical process. It allowed me to elicit more abstract thinking of the data and make room for more depth and understanding of the data. Figuring also enabled me to examine the associations between categories and its theoretical relation to each other (Strauss and Corbin, 1998).

The other factor, language, is an effective analytical instrument, particularly when working with a marginalized community that may have symbolic verbal expressions, terms, and dialect that may not be understood in mainstream society. Particular consideration was given to the symbolic connotations, expressions, and metaphors that the participants used to describe their experience with access to healthcare. Symbolic terminologies (if any) used by homeless LGBTQ young adults created theoretical and

analytical inquiries that were used to understand and compare the social and cultural context of their experience with access to healthcare.

Validity and Trustworthiness

As it stands, reliability and validity measures used in traditional quantitative studies are usually not applicable to qualitative research (Morrow, 2005). Given the fact that qualitative studies are primarily inductive and exploratory in nature, these studies require a different set of rules by which to be judged. Morrow (2005) suggested that quality and trustworthiness are instruments used to evaluate qualitative studies. She defined trustworthiness as credibility and quality as the state of being good (Morrow, 2005). A trustworthy study is also one that represents the viewpoint of research participants (Lietz and Zayas, 2010; Moustakas,1994). On the other hand, Morrow (2005) recommended that co-researchers review the transcripts as a valid measure of the study. This method of validation will establish correctness of the phenomenon by itself. For the qualitative component of this study, I followed Moustakas' recommendations by having Dr. Chase (my doctoral committee chair and experienced ethnographer) randomly review sections of the analysis process (theme, category and code development, and findings). Additionally, I documented my own biases during the interview process and throughout the data process to ensure it did not skew the data. Lastly, a rich and dynamic presentation of the study results alongside findings with suitable citations enriched its transferability.

Credibility

Credibility in qualitative research is equivalent to internal validity whereby its primary purpose is to establish accurate representation of study results as experienced by

the participants. To achieve credibility, the results underwent triangulation as well as prolonged engagement. My prolonged engagement was established by working as a volunteer at the NAC for over four years, donating essential items, and supporting community events. Participating in these activities at the NAC allowed me to gain trust in the homeless LGBTQ young adult community. It also enabled me to recruit study subjects using purposive sampling.

Another means to establish validity is through triangulation. Given that qualitative and quantitative data were collected during the interview, data triangulation was applied to confirm results, cross-validate results, and/or corroborate findings. To achieve triangulation, I compared the survey results with that of the qualitative interview results and field notes from my journal entries. Another method of triangulation was the consistent vetting of information, coding, and category development from transcripts.

Transferability

Transferability is also known as external validity in qualitative research, which involves the relevance of study's findings in other scientific contexts. The participants provided rich and in-depth account of their experiences with access to healthcare. Furthermore, the sample size was not determined by quantitative power calculations but by the saturation of data and the quality of data provided. As the sole researcher in this study, I provided a wealth of information as well as description of study methods to inform the reader as to the depth of transferability of study findings to other forums. Based on the information provided in the result chapters, the reader can also assess an adequate level of transferability.

Dependability

Dependability was not necessary to prove because credibility was already established. This study was able to maintain consistency in replication of the study through prolonged engagement and triangulation of methods.

Confirmability

Confirmability is the ability to establish a neutral unbiased account of study methods and study results. This study achieved confirmability through various quality measures such as 1. audio recording and transcription, 2. raw data extraction, thematic development, categorization, synthesis, analysis and interpretation, 3. trustworthiness and methodological compatibility, 4. validity and reliability of data, and 5. reflexivity.

Another measure of confirmability is recognizing the researcher's bias throughout the study (Merriam, 1988). Throughout the study, I maintained a journal documenting my thoughts, impressions, and/or interpretations of discussions, events, and circumstances. Furthermore, data synthesis and analysis underwent a thorough repetitious process, which was subsequently audited by social research scholars and professionals who are subject matter experts in the field.

Reflexivity

Reflexivity is the researcher's ability to reflect on his/her understanding of self and how it may influence the research process (Aamodt, 1991; Davies, 1999). In this research, there was discourse between me and the subjects; maintaining keen awareness of my historical, sociocultural, economic, and political positions were critical in not clouding my judgement and interfering with the study results (Anderson, 1989). As a result, I employed the following reflexive questions to maintain consistency in the research process: 1. How did my cultural experiences as a homeless gay immigrant youth

in NYC shape my understanding of today's homeless bisexual and gay young adult men in NYC? 2. What was the political situation of NYC, NY State, and the US when I was a homeless youth 20 years ago compared to today? 3. Are there any differences in the migration patterns of today's homeless bisexual and gay young adult men in NYC and their access to healthcare compared to when I was a youth? 4. What are the social capital and cultural capital variations experienced by today's homeless young adult men in NYC compared to when I was a youth? 5. What were the social determinants of access to healthcare among homeless young adult men compared to when I was a youth? 6. What were the strategies I employed to gain access to healthcare compared to today's homeless bisexual and gay young adult men in NYC? 7. Are the experiences of access to healthcare individual or collective? By referring to these questions during the research process, I identified any unforeseen biases that may influence the study and maintained neutrality.

Theoretical Sensitivity

Another aspect of the analytical process using the CCA methodology is theoretical sensitivity. Theoretical sensitivity is the capacity to distinguish essential components of the data and bring significance to them. During this process, the researcher uses his/her judgment based on his/her experience in the field, during the literature review, as well as his/her involvement in data mining and analysis (Strauss and Corbin, 1998). Becoming sensitive to the theoretical concepts is crucial in identifying indicators (properties) of the said concepts within the data (Strauss and Corbin, 1998). In an effort to gain acute theoretical sensitivity, I used my experience working with the

community, compared findings to that in the literature review, and shared it with professionals in the field for feedback.

CCA's Application in the BMVP

It is worth noting how CCA was applied to the theoretical framework of the BMVP. Once core categories and subcategories were identified, I matched them to the most appropriate domains in the BMVP. This included themes and concepts relating to contextual characteristics, individual characteristics (predisposing, enabling and need factors) as well as health outcomes. Matching the concepts to the BMVP will enable public health agencies to clearly identify where the individual, structural, and systematic strengths and weaknesses are in accessing healthcare for homeless bisexual and gay young adult men in NYC. Results of the analysis were used to compare access to and utilization of healthcare between homeless bisexual young adult men and homeless gay young adult men.

Brief Questionnaire: Data Analysis

The brief questionnaire was developed using valid and reliable questions from previous government population-based surveys and peer-reviewed scientific journals. Most of the questions were derived from research studies on LGBTQ individuals, homeless persons, young adults, and/or other vulnerable populations. Question 1 is derived from the CDC's 2015 SF-12 Health Survey. Question 2 is derived from the 2009 Williams Institute's "Best Practices for Asking Questions about Sexual Orientation on Surveys". Question 3 is derived from the 2014 National Health Interview Survey (CDC, 2014). Question 4 is derived from the CDC's 2015 SF-12 Health Survey. Question 5 is

derived from the 2012 Coalition for the Homeless. Question 6 is derived from the 2014

NHIS Questionnaire (CDC, 2014). Question 7 is derived from the 2012 Coalition for the

Homeless. Question 8 is derived from the Behavioral Risk Factor Surveillance System

Questionnaire (CDC, 2011). Question 9 is derived from the 2001 Survey on Disparities

in Quality of Health Care (Commonwealth Fund, 2001). Question 10 is derived from the

2014 NHIS Questionnaire (CDC, 2014). Question 11 is derived from the CDC's 2015

SF-12 Health Survey (CDC, 2012). Question 12 is derived from the CDC's 2015 SF-12

Health Survey (CDC, 2015). Based on the pilot study, some questions were modified to

fit the target population and validated by professionals serving the community.

Questions with yes/no response variables were given a dichotomous value—

yes=1, no=2. Questions involving a choice of one or more response variables were

initially calculated as a dichotomous variable. For instance, response variables from

Question 9 were dichotomized into the following values: 1=don't go anywhere for

healthcare and 2=go somewhere for healthcare. However, subcategories for each

response variable was subsequently formed to create a dichotomous variable—yes=1,

no=2. For instance, Question 9's response variable d (hospital ER) was dichotomized

into yes=1 (meaning yes, subject usually goes for healthcare at hospital ER) and no=2

(meaning no, subject does not go for healthcare at hospital ER). Question 10 also

underwent a similar re-categorizing for analysis. On the other hand, Question 6's

response variables—a (employed for wages) and b (self-employed)—were collapsed into

one variable and dichotomized into a yes=1 and no=2 variable. All other response

variables for that question were subcategorized and dichotomized into yes=1 and no=2.

Question 5 on education was collapsed into three response categories. The first three

responses—"Never attended school or only attended kindergarten," "Grades 1 through 8 (Elementary)," and "Grades 9 through 11 (Some high school)"—were collapsed into the less than a high school diploma category. High school diploma remained the same; however, participants who reported "College 1 year to 3 years (Some college or technical school)" and "College 4 years or more (College graduate)" were collapsed into one or more years of college.

In particular, Question 2 on sexual orientation was also collapsed into two subcategories—bisexual and gay. For instance, the following responses, "Mostly attracted to females", "Equally attracted to females and males", and "Mostly attracted to males" were collapsed into the bisexual subcategory. Subsequently, bisexual was dichotomized into yes=1 (meaning yes, subject has sexual attraction/interaction with males, females and/or transgenders) and no=2 (meaning no, subject has no sexual attraction to both with males and females/transgenders). Response "Only attracted to males" was dichotomized into yes=1 (meaning yes, has sexual attraction with males) and no=2 (meaning no, subject has no sexual attraction to males).

The data extracted from the completed surveys included all questions asked during the interview in the following four areas: 1. health status; 2. healthcare access and utilization; 3. homelessness, and; 4. demographics. A brief descriptive analysis was conducted on the demographic characteristics, health status, mental health status, duration of homelessness among homeless bisexual young adult men in NYC and homeless gay young adult men in NYC. Results of the analysis were compared to the answers during the interview.

Table 2 shows an outline of the timeline for the study.

Table 2

Study timeline

Dissertation Activity	Projected Date of Completion
Proposal Defense	November 17, 2016
IRB Submission	November 21, 2016
Waiting for IRB Approval	April 15, 2017
Implementation of Study	May 15–July 15, 2017
Data Analysis	August 16–November 30, 2017
Prepare Study Results/Writing	December 1, 2017–February 11, 2018
Dissertation Defense	May 8, 2018

Human Subject Protection

The study was approved by the Institutional Review Board (IRB) of Rutgers University, School of Biomedical and Health Science, which ensured that the human subject protections were in place. As the study data included sensitive information about access to healthcare, medical/psychological history, the experiences of homeless bisexual and gay young adult men, and geographic identifiers of where participants reside and where the sample population was selected, portions of the data used for this study was and will not be publicly available. The principal investigator completed the human subjects' protection training before the study began.

Risks and Benefits

The anticipated risks to participate in the study were minimal. However, I had prepared a plan in advance in the event the discussion of access to healthcare provoked some sensitive issues or heightened emotions. In this case, I would cease the discussion and refer the participant to mental health services. There was no such incident during the survey and interview discussion. Each participant was given a $20 gift card and a two-way fare MetroCard (a credit card-looking device that is used in the NYC public transportation system) worth $5.50 after the interview was completed. This study aims to benefit urban homeless bisexual and gay young adult men by enlightening the public health community about the nuances of the selected group's access to and utilization of the healthcare system in NYC and highlight the barriers/facilitators they encounter. The study may also bring awareness to the participant or a deeper understanding about their access to healthcare. Nonetheless, the participants were informed of the possible risks and benefits of the study. This information was also documented in the informed consent and reviewed with the participant before the study began.

Privacy and Confidentiality

To protect the privacy and confidentiality of each participant, no personal identifiers was collected or included in the study. In the event confidential information was revealed during the interview, it was deleted and not included in the results or analysis. Furthermore, study materials were kept in a secured locked file cabinet at Dr. Chase's Office located at Rutgers School of Nursing, Ackerson Hall, Room 202A, 180

University Avenue, Newark, NJ 07102-1897. Electronic data was secured in a password

protected computer and stored in the same location.

Dissemination, Notifications, and Reporting of Results

Participants were not notified of their individual survey results as these were not

calculated individually. Study results indicated descriptive data and how their

participation in the study has helped to identify facilitators and barriers to accessing

healthcare. Study results were shared with subjects individually. However, there will be

a PowerPoint presentation for all clients are the Center on a Sunday night after dinner.

Aggregate results will be shared with the faculty and peers at Rutgers University via a

PowerPoint presentation. It will also be shared with the scientific community via

publication in peer-reviewed journals and at professional conferences.

Chapter 5

Demographic Findings

In this chapter, I discuss my findings on the survey questionnaire. The purpose of the survey questionnaire was to capture the demographic profile of the participants in the study as well as to briefly assess their health status, mental health status, and duration of homelessness. I administered a brief, in-person questionnaire to the 30 participants during the period of June 2017–August 2017. Subsequently, individual semi-structured interviews were conducted with the same cohort of participants. Once participants completed the survey, I reviewed each survey response with the participant for accuracy. Next, I entered all survey data into Statistical Package for the Social Sciences (SPSS) version 20 statistical software for analysis. Descriptive analysis was used to summarize participants' demographic information and other responses to the survey questions.

Even though my sample size was significantly small to make predictions, the data still served an important purpose: it illuminated the lived experiences of homeless young adult bisexual and gay living in NYC. Thus, I report this data despite the small numbers in each category in order to convey a full and accurate portrait of my sample as shown in Table 3. I report descriptive data providing a general overview of my results using the following categories: 1. demographics, 2. healthcare need, 3. healthcare access and availability, and 4. healthcare utilization.

Demographics

Among the 30 participants in the study, the average age was 25.6 years (ranging from 19 to 33). Bisexual men constituted 57% (n=17) of the sample and homeless gay young adult men made up 43% (n=13). Blacks were overwhelmingly represented in the

sample, making up 70% (n=21) of all participants. Whites represented 20% (n=6) of the sample, and other races constituted 10% (n=3). All participants under the "Other race" variable reported to have African (Black) ancestry with one or more other races. Seventy percent (n=21) of all participants were non-Hispanic and 30% (n=9) reported having Hispanic origin.

Socioeconomic Characteristics

43% (n=13) of participants had a high school diploma or GED, 30% (n=9) had at least one year of college education, and 28% (n=8) did not have a high school diploma. With respect to employment, 50% (n=15) of the participants were unemployed, 30% (n=9) were employed or self-employed, and 13% (n=4) were unable to work for reasons unknown. Participants who reported "Other" under employment represented 7% (n=2) of the sample; these two participants identified themselves as a student and a sex worker. One-third, 33% (n=10), of participants reported income from other sources such as public assistance, food stamps, and/or sex work. Thirty percent (n=9) reported income from social security disability and/or social security income. Only 23% (n=7) reported receiving income from regular employment and 6% (n=2) reported receiving income from unemployment insurance (note that the number of those who reported receiving income from employment (n=7) was lower from those who reported being employed (n=9) because two participants reported being employed but did not receive an income from their work due to unpaid internships). Six percent (n=2) reported having no source of income.

The average duration of homelessness reported by survey participants was 44 months (3.66 years; ranging from 1 to 127 months). A large number of participants, 73%

(n=22), reported living in homeless shelters. Only 13% (n=4) were unsheltered while another 13% (n=4) reported other forms of housing.

Healthcare Need

Eighty percent (n=24) of participants reported no physical problems. Only 13% (n=4) reported experiencing physical problems affecting their work, school, or other regular daily activities. Seven percent (n=2) of participants did not know of or did not recall having any issues with their physical health. However, this was not the case for mental health. Forty percent (n=12) of survey participants reported mental health problems that interfered with their work, school, or other regular daily activities.

Healthcare Access and Availability

A significant proportion of participants, 66% (n=19), reported having received routine healthcare within the last 12 months. Thirty-three percent (n=10) reported not receiving any routine healthcare within the last 12 months. Only 3% (n=1) was uncertain about whether or not he had received routine healthcare within the last 12 months. It should be noted that the survey included no items seeking to identify or measure facilitators to healthcare. This issue was addressed during qualitative interviews and is discussed in detail in Chapters 6 through 8.

Healthcare Utilization

Most participants, 87% (n=26), reported having a regular place to go for routine healthcare. With respect to healthcare barriers, 73% (n=22) reported having at least one barrier for not receiving healthcare. Clinics were the most widely used healthcare

facilities by 40% (n=12) of participants, followed by ER visits at 27% (n=8), doctor's

office visits at 17% (n=5), and MVCs at 7% (n=2).

Table 3

Demographics frequencies

Characteristics	N	%	M	SD	Min	Max	
Age (Years)	30	100%	25.60	3.11	19	33	
Sexual Orientation	30	100%					
Bisexual	17	56.6%					
Gay	13	43.4%					
Race	30	100%					
Black	21	70.0%					
White	6	20.0%					
Other	3	10.0%					
Ethnicity	30	100%					
Hispanic	9	30%					
Non-Hispanic	21	70%					
Education	30	100%					
< High School,	8	27.7%					
High School Diploma	13	43.3%					
>1 year college	9	30.0%					
Employment	30	100%					
Employed	9	30%					
Unemployed	15	50%					
Unable to work	4	13.4%					
Other (Student, sex worker)	2	6.6%					
Income	30	100%					
Employed	7	23.3%					
Unemployment income	2	6.66%					
SSI/SSD	9	30%					
Other (sex work)	10	33.3%					
None	2	6.66%					

Received routine healthcare within 12 months	30	100%					
No	10	33.3%					
Yes	19	66.3%					
Unknown	1	3.3%					
Routine place for healthcare	30	100%					
No	4	13.3%					
Yes	26	86.7%					
Type of healthcare utilized							
Health Clinic							
No	18	60%					
Yes	12	40%					
ER							
No	22	73%					
Yes	8	27%					
Mobile Clinic							
No	28	93%					
Yes	2	7%					
Doctor's Office							
No	25	83%					
Yes	5	17%					
Reason for not receiving healthcare	30	100%					
No	8	26.7%					
Yes	22	73.3%					
Physical problem/s	30	100%					
No	24	80%					
Yes	4	13.3%					
Unknown	2	6.7%					
Mental health problem/s	30	100%					
No	18	60%					
Yes	12	40%					
Duration of homelessness	30	100%	44.57	36.95	1	127	
Living situation	30	100%					

Unsheltered	4	13.3%					
Sheltered	22	73.4%					
Other	4	13.3%					

Demographic Differences Between Bisexual and Gay Participants

Table 4 highlights the demographic differences found in the results of the study between bisexual and gay participants. Overall, homeless bisexual men were overrepresented in this sample compared to gay men, constituting 56.6 % (n=17) of the sample. The mean ages for both groups were similar; bisexual men was 26 years and gay men was 25 years. Representation of Black bisexual men were slightly less than Black gay men—64.7% (n=11) and 76.9% (n=10) respectively. On the other hand, the number of White bisexual participants was slightly higher than that of White gay men (23.5%; n=4: 15.3%; n=2 respectively). "Other" race represented 11.8% (n=2) of all bisexual men and 7.7% (n=1) of all gay participants. However, all of the three individuals reporting their race as "Other" all identified as mixed race, with at least one Black parent. Non-Hispanic bisexual men were significantly overrepresented in this sample at 82% (n=14), compared to non-Hispanic gay men at 54% (n=7).

With respect to the socioeconomic status of participants, bisexual men with one or more years of college were greater 35% (n=6) in the sample than gay men 23% (n=3). The proportion of bisexual men with a high school diploma was similar to that of gay men, 41 % (n=7) and 46% (n=6) respectively. The proportion of bisexual men with less than a high school diploma was 24% (n=4) slightly less than that of gay men at 31% (n=4). The rate of employment among bisexual men was greater at 35% (n=6) than that of gay participants at 23% (n=3). Conversely, a larger proportion of gay participants

were unemployed when compared with bisexual men, 62% (n=8) and 41% (n=7)

respectively. Among participants who were unable to work, only bisexual men were

represented at 24% (n=4). Twenty-four percent (n=4) of bisexual men and 23% (n=3) of

gay men reported earning an income (please note that income from employment differed

from employment rates because two participants reported being employed but not

receiving any wages). Only bisexual men (12%, n=2) in this sample reported receiving

unemployment income. Slightly more gay men (31%, n=4) reported receiving social

security/disability income than bisexual men (29%, n=5). With regard to "Other" forms

of income, bisexual men (29%, n=5) were less than gay men (38%, n=5). "No form" of

income was found to be similar between the two groups, 6% (n=1) with bisexual men and

7% (n=1) with gay men.

Regarding the different types of living situations (housing/shelter types reported),

the rate of unsheltered homelessness was greater among bisexual men (18%, n=3) than

among gay men (8%, n=1). Similarly, "Other" living situations were more common

among bisexual participants (18%, n=3) than among gay men (8%, n=1). As for those

who reported living in some form of shelter, rates were the same for the two groups.

Seventy one percent (n=12) of bisexual men reported having no physical

problems related with their work, school, or other regular daily activities, which was less

than gay men (92%, n=12). Only 24% (n=4) of bisexual men reported having any

physical health problems related with work, school, or other regular daily activities.

Slightly less bisexual men (35%, n=6) reported mental health problems related with

work, school, or other regular daily activities (such as feeling depressed or anxious)

compared to gay men (46%, n=6). On the contrary, more bisexual men (65%, n=11)

reported having no mental health problems with work, school, or other regular daily activities compared to only 54% (n=7) of their gay counterparts.

Thirty-five percent (n=6) of bisexual men reported having no routine healthcare within the past 12 months while this was true of 31% (n=4) of their gay counterparts. On the other hand, 59% (n=10) of bisexual men reported having received routine healthcare compared to 69% (n=9) of gay men. Only one participant, a bisexual man, answered that he was unsure whether he had routine healthcare.

Eighty-two percent (n=14) of bisexual men reported having a regular place for healthcare compared to 92% (n=12) of gay men. Even though a large proportion of bisexual and gay men reported having access to healthcare, a great percentage in both groups showed to also have barriers to healthcare. More bisexual men experienced barriers to healthcare access and utilization than gay men, 76% (n=13) and 69% (n=9) respectively. Alternatively, for those who reported having no barriers to healthcare access and utilization, bisexual men represented slightly less (24%, n=4) than gay men (31%, n=4), respectively.

Regarding the type of healthcare facility used, only 29% (n=5) bisexual men reported visiting health clinics but a larger proportion of gay men (54%, n=7) gained access. Conversely, 29% (n=5) of bisexual men reported using hospital ERs versus 23% (n=3) of gay men. Accessing doctor's offices were similar in both groups—18% (n=3) of bisexual men and 15% (n=2) of gay men. Only one participant in each group accessed MVCs. In the survey questionnaire, both bisexual men and gay men reported that they did not utilize more than one healthcare agency for healthcare.

Table 4

SPSS descriptive data analysis

Characteristics of Homeless Bisexual and Gay Young Adult Men in New York City*†

Characteristics	Sexuality type		Total
	Bisexual	Gay	
	Count (%)	Count (%)	Count (%)
Total *N:* 30	17 (56.6)	13 (43.3)	30 (100.0)
	Mean (SD)	Mean (SD)	
Age in years	25.92 (-)	25.23 (-)	
	Count (%)	Count (%)	
Race (N=30)			
Black	11 (64.7)	10 (76.9)	
White	4 (23.5)	2 (15.3)	
Other	2 (11.7)	1 (7.6)	
Ethnicity (N=30)			
Hispanic	3 (17.6)	6 (46.1)	
Non-Hispanic	14 (82.3)	7 (53.8)	
Education (**N = 30)**			

< HS,	*4 (23.5)*	*4 (30.7)*	
HS Diploma	*7 (41.1)*	*6 (46.1)*	
>1 year college	*6 (35.3)*	*3 (23.0)*	

Employment status *(N = 30)*

Employed	*6 (35.3)*	*3 (23.0)*	
Unemployed	*7 (41.1)*	*8 (61.5)*	
Unable to work	*4 (23.5)*	*- (-)*	
Other (Student, sex worker)	*- (-)*	*2 (15.3)*	

Income source *(N = 30)*

Employed	*4 (23.5)*	*3 (23.0)*	
Unemployment income	*2 (11.7)*	*- (-)*	
SSI/SSD	*5 (29.4)*	*4 (30.7)*	
Other (sex work)	*5 (29.4)*	*5 (38.4)*	
None	*1 (5.8)*	*1 (7.6)*	

Received routine healthcare within 12 months *(N =30)*

No	*6 (35.3)*	*4 (30.7)*	
Yes	*10 (58.8)*	*9 (69.2)*	
Unknown	*1 (5.8)*	*- (-)*	

Routine place for healthcare *(N = 30)*

No	*3 (17.6)*	*1 (7.6)*	
Yes	*14 (82.3)*	*12 (92.3)*	

Type of health utilized (N= 30)

Health Clinic

No	12 (70.5)	6 (46.1)
Yes	5 (29.4)	7 (58.3)

ER

No	12 (70.5)	10 (76.9)
Yes	5 (29.4)	3(23.0)

Mobile Clinic

No	16 94.1)	12 (92.3)
Yes	1 (5.8)	1(7.6)

Doctor's Office

No	14 (82.3)	11 (84.6)
Yes	3 (17.6)	2(15.3)

Reason for not receiving healthcare (N =30)

No	*4 (23.5)*	*4 (30.7)*	
Yes	*13 (76.4)*	*9 (69.2)*	

Physical problem/s (N = 30)

No	*12 (70.5)*	*12(92.3)*	
Yes	*4 (23.5)*	*- (-)*	

Unknown	*1 (5.8)*	*1 (7.6)*	
Mental health problem/s (*N=30*)			
No	*11 (64.7)*	*7 (53.8)*	
Yes	*6 (35.2)*	*6 (46.1)*	
Living situation (*N=30*)			
Unsheltered	*3 (17.6)*	*1 (7.6)*	
Sheltered	*11 (64.7)*	*11 (84.6)*	
Other	*3 (17.6)*	*1 (7.6)*	

N = 30 unless specified because of missing values

Chapter 6

Qualitative Results

Core Elements

This chapter recaps the three main foci of the study—healthcare need, healthcare access/availability, and healthcare utilization and the corresponding study objectives, along with the research questions associated with them. However, in order to capture a comprehensive picture of homeless bisexual and gay young adult men in NYC, it is important to first discuss my findings on the three core demographic factors that define the population: homelessness, sexual orientation, and young adulthood. In the latter part of the chapter, I offer a description of the daily life of a homeless bisexual young man constructed from my semi-structured interviews.

Main Foci of the Study

This study focused on three main foci surrounding access to healthcare: healthcare need, healthcare access and availability, and healthcare utilization. I define **healthcare need** as the medical and mental/behavioral health status of young bisexual and gay men. I define **healthcare access** as their ability to access healthcare (including preventive care) when it is needed or required according to the recommendations of the US Department of Health and Human Services, Office of Adolescent Health (HHS, 2018). Even though these recommendations were designed for adolescents, they are also appropriate for young adults since many homeless bisexual and gay young adult men fall into the defined age of adolescents at the onset of their homelessness. Recommended clinical services include immunizations to protect them from vaccine-preventable diseases like hepatitis A and B, HPV, pneumonia and meningitis; routine screening tests,

and laboratory work in order to detect and/or treat diseases early, avoid disease progression in illness (such as hypertension, TB, depression, drug and alcohol consumption, HIV and STIs), and mental/behavioral health services. **Healthcare availability** focuses on the availability of appropriate healthcare services in geographic areas in close proximity to them, the healthcare center's capacity to treat bisexual and gay men according to the standards described above, and ability to be certified to provide necessary services. **Healthcare utilization** refers to the types and frequency of healthcare utilization. Within each of these foci are the following four research questions of the study:

Healthcare Need Research Question:

- What are the self-perceived needs for healthcare among young homeless bisexual men in NYC compared to young homeless gay men in NYC?

Healthcare Access and Availability Research Questions

- What are the facilitators of healthcare access (with an emphasis on preventive care) for young homeless bisexual men in NYC and young homeless gay men in NYC?

- What are the barriers to healthcare access (with an emphasis on preventive care) for homeless bisexual young adult men in NYC and homeless gay young adult men in NYC?

Healthcare Utilization Research Question

- Where, when, and how frequently do homeless bisexual young adult men in NYC access healthcare and how does that compare with the utilization patterns of homeless gay young adult men in NYC?

Core Demographic Factors

I conducted semi-structured interviews with each participant following the administration of the survey questionnaire. Accordingly, it is imperative to highlight the three core demographic factors when studying homeless bisexual and gay young adult men in NYC and demonstrate their interconnectedness with the three themes of the study (as shown in Figure 10). The three core demographic factors are dealt with in the following sections.

Young adulthood (youth)

The physiological and psychological development of bisexual and gay young adult men means that they have different healthcare needs than those of other age groups. Access to preventive healthcare is critical for assessing their medical needs. As demonstrated in Figure 10, it is evident that their access to preventive healthcare is restricted, making them more susceptible to easily preventable diseases. If they do not get the routine healthcare as recommended, the health and mental health of the community will continue to decline, adding to the already disproportionate rate of morbidity and mortality in the community.

The intricacies of negotiating sexual orientation and the three distinct but overlapping facets of sexual identity, sexual attraction, and sexual behavior. Sexual identity is an individual's choosing of a specific sexual identity in the sexual orientation spectrum or lack of identification to any sexual identity. For instance, some men may sexually identify as straight but have sex with men, women and/or both, putting them at risk to diseases that may otherwise not be recognized. Sexual attraction refers to an individual's sensual and erotic desire for another person. Some men may identify as gay,

straight, or bisexual and have attraction to transgender women, but if a medical provider is not fully informed or educated on how to discuss it, it may lead to confusion, depression or worse, suicide. Sexual behavior is the act of engaging in sexual activities like fellatio or intercourse with another person. For instance, some bisexual men will only have sex with male-to-female transgenders or some straight men will never have sex with another man unless there is a woman in the room. Some of these activities may put them at high risk for HIV/STI. These various facets of sexuality have major health implications, especially to young impoverished homeless men of color. Sexuality as a whole carries with it medical and mental health needs which require access to and utilization of healthcare (including sexual health assessments with medical providers).

Navigating the fragmented shelter system (homelessness) both in terms of sheltered living situations (temporary emergency housing or couch surfing) and unsheltered living situations (living in the streets, parks or subway cars) while trying to maintain personal safety under very challenging circumstances and extremely scarce resources can restrict access to and utilization of healthcare often resulting in alarming rates of morbidity and mortality.

As I present my findings of the interconnectedness, these three core elements when combined are what represent the healthcare challenges for homeless bisexual and gay young adult men and for the healthcare system in NYC.
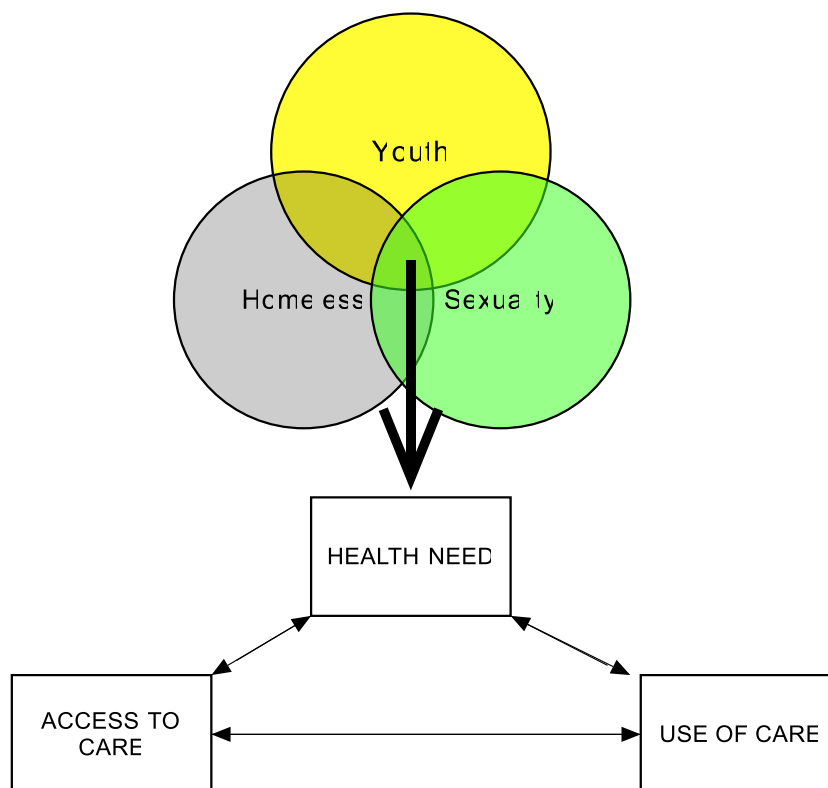
Figure 9. Interconnectedness of study themes with core demographic factors

The Intricacies of Sexuality

In this study, homeless bisexual men made up the majority of the sample, 17 (56.7%), while homeless gay men made up 13 (43.3%). For gay participants, sexual attraction and sexual behaviors seemed to be one-dimensional; they described sex as men having sex with men. However, bisexual participants painted a much more nuanced picture; they reported attraction to and sexual experiences with cisgender women (women identifying as the sex they are biologically assigned at birth), transsexual persons (both male-to-female and female-to-male persons), and men.

During one particular interview, a respondent who was mostly attracted to men offered a detailed description of the multidimensional complexity and fluidity of bisexual identity, attraction, and sexuality as described in the quote below:

I've at least had sex with one transgender woman. I am somewhat on a talking basis with another transgender woman, but these were both pre-op transsexual people. So they were born biologically male and they are transitioning to being biologically female. The older one, who is in her 40s, I don't know if she's ever going to have the full surgery to get rid of the penis she was born with, I think she's reconciled with it one way or another. The lady I am talking to now has an option that she may opt for the full sex reassignment surgery.

Now I've been attracted to cisgender women and when I came out, I came out as a bisexual. In all honestly, seeing I, you know ... My sexuality has evolved, I guess you would say I'm a pansexual, but usually when I ask people, because few people are academically on the same train, you know, enlightened about the nature of the fluidity of gender and the sexual orientation. I say I am gay because one, I am somewhat gender variant than the, I would say, quote-unquote average straight man, and two, most folks I mess with, for the most part, though I have a desire for vagina-having people and I would mess with a female-to-male transitioning person and I have been attracted to them. I figured because most folks ain't gonna have that long ... don't want to have that long conversation trying to explain the difference between gender and sexual orientation, I tell them I'm gay because it helps them to find that I'm not a straight man or what they have in

their mind as a straight man. Like I said, more actually to the reality of my sexual orientation, I'm pansexual.

Most of my sex partners have been people with penises, because yeah ... Cisgender gay men, one trans woman, those have been the partners. I've had emotional attachments, might have did something physical with cisgender women. I know of several trans men I have flirted with and the fact that they were pre-op and had a vagina did not at all turn me away from being attracted or wanting a relationship. [29, Black, Bisexual, Male]

This quote speaks volumes regarding the breadth and depth and complexity of sexuality among bisexual men. It highlights the flexibility and fluidity of their sexual identity, attraction, and experiences. It is evident in this quote that sexuality for bisexual men is not fixed or one dimensional. In this instance, it encompasses all genders (cisgenders, male-to-female transgenders, and female-to male transgenders). Moreover, it covers variation in transgenderism and transgender transition such as pre-operation, peri-operation, and post-operation stages. Pre-operation transgenders are individuals who identify to the opposite sex but have not had any clinical physiological changes. Peri-operation transgenders are individuals who are in the process of physiologically transforming to the opposite gender than the one they were assigned to at birth. Post-operation transgenders are individuals who have physiologically transformed to the opposite sex. Bear in mind that transgender transition also varies by personal preferences and there are no set standards for anyone.

An underlying issue that was presented in the quote was the frustration of disclosing sexual status or sexual identity. The participant clearly said that people may not understand the dynamics of his sexuality, therefore, he used "gay" as a default sexual identity status. He also noted that his sexuality and gender identity has evolved overtime. At first, he identified as bisexual, subsequently he disclosed to others as gay and, now, he considers himself pansexual.

In closing, it's important that medical and mental health providers be informed of these various sexual identities and the need they give rise to for specialized routine preventive care. Routine preventive care allows medical providers to recognize the different processes of their transformation and implement appropriate medical interventions/treatment when needed. Failure to do so may make the participant more susceptible to diseases that can easily be prevented.

Sexual Health Assessments

Forty-seven percent (14) of participants described the absence of any in-depth discussion of sexual, identity, attraction, and/or sexual behavior with their healthcare providers—an issue which was not mentioned as a problem during the administration of the survey questionnaire. Of this group, 71% (10) were bisexual and 29% (4) were gay. Bisexual men in particular reported very limited discussions of these important factors or sometimes even having no discussions at all with their healthcare providers on sexual identity, attraction, and/or sexual related behavior. Most within this group of bisexual participants reported that their providers did not attempt to ask them about their sexual behaviors. When I tried to explore the issue further, one subject reported:

No. That's not what they were concerned with. 'What are you here for today? I have your physical,' that kind of stuff. When they have a STI testing it's just a screening and not talking to me about anything. [21, Black, Bisexual]

This participant felt that medical providers are not interested in his sexuality. This simple neglect by medical providers may have profound implications, particularly for bisexual young men. It may deter them from accessing healthcare, thus putting them at increased risk for disease like STIs, HIV, and other communicable diseases. His comments also highlighted that discussing sexual health is not a routine practice during some physicals (preventive care), which emphasizes the need for further sexual health training of medical providers. Even during STI testing, a pivotal opportunity to initiate sexual health discussion, there was no involved assessment of sexual health identity, attraction, and behaviors.

In contrast to the above participant, other bisexual participants reported that sexual identity was part of their healthcare providers' intake form but that there was no discussion related to the nuances of sexual attraction and behavior beyond that. According to participants, discussion of sexual identity, attraction, and behavior also varied by the type of healthcare sought (such as urgent care, ER care, care from a private doctor, HIV/STI screening, type of provider (nurse, physician, or social worker), the purpose of the visit (routine care, injury or STI/HIV screening), and the state of mind or willingness of the participant. This broad and varying type of sexual health assessments have its own implications on the health of homeless bisexual young adult men. Capturing sexual identity is invaluable for surveillance and data collection, but understanding the patient's sexual identity, attraction, and behavior is essential for

providing preventive services, particularly when rates of communicable diseases and mental health conditions are disproportionately higher in the community. As noted earlier, bisexuals' attraction, identity, and behavior may evolve or change overtime; therefore tracking, documenting, and exploring it are critical for effective intervention and health promotion.

The type of healthcare sought and the medical/mental health status of the participant are other opportunities for sexual health discussion between the provider and patient. Obviously, in critical situations when participants were medical/mentally compromised, sexual health discussion was not achievable. However, in other circumstances, there seemed to be plenty of missed opportunities for medical and mental health evaluation by medical staff to conduct comprehensive sexual health assessment. For instance, some bisexuals reported that a nurse or medical assistant usually conducts the intake at hospital ER or healthcare agency while primary care providers may engage in more detailed discussions about sexuality. However, bisexuals' visits to primary care providers were infrequent and inconsistent. Additionally, bisexual participants regularly changed healthcare agencies due to relocation caused by homelessness and interruptions with benefits and/or change in provider. Furthermore, they noted that discussion about sexuality rarely occurs during ER visits, which is one of the main healthcare access points for them. Lastly, some bisexuals reported that they were often "not in the mood" to discuss sexual health issues at the time of their visits. Lack of inclination to discuss sexuality may suggests a number of things for this participant. For instance, the participant may not be in the mood to discuss sexuality because of their fear of stigma, discrimination, or rejection. He may be too mentally or emotionally unstable to discuss

sexual issues because of the already overwhelming issues surrounding homelessness. Quite often homelessness aggravates psychological and physiological issues that would usually be controlled. Nonetheless, healthcare providers' lack of interest in discussing and exploring sexual identity, attraction, and sexual activity emerged as an initial barrier of access to healthcare, which may be adding to high rates of disease burden in the community.

Fragmentation of Access to Shelter Services

It is important to note that the type and duration of homelessness experienced by participants varied. Homeless shelters' services varied dramatically depending on the type of services they provide. Length of stay was impacted by several factors such as capacity of the shelter, patient's medical and mental health diagnosis, and/or eligibility for government services. The mean of homelessness reported was 45 months (the full range reported by participants was from 1 to 127 months), suggesting many participants' substantial reliance on homeless shelters. Most participants had been homeless for more than a year, and periods of less than 12 months spent living without stable residence were unusual. Both bisexual and gay homeless men experienced significant fragmentation when attempting to secure shelter throughout their experience with homelessness, and thus, moved around a lot to different sites.

This study was unable to capture the length of stay at homeless shelters or the reasons for leaving specific shelters; however, based on the participants' comments, the overall length of stay ranged from one month to 127 months. For instance, participants who qualify for public assistance were eligible for transitional housing or public housing, which are more long term. Additionally, participants with dual diagnosis (like mental

health, HIV, and/or substance addiction) qualified for temporary housing. Homeless

shelters also offered healthcare services to bisexual and gay men, so it was sometimes

unclear whether participants were actually living in the shelters they named or just using

drop-in health-related services. Nonetheless, Table 5 lists the non-sheltered places where

participants stayed. These places include living in abandoned buildings, living in the

streets, living in the train/subway cars, and "couch surfing" with friends and families. A

total of 10 (33%) participants reported living in non-sheltered places. Bisexual men

made up the larger of the two groups, accounting for seven (41%) among all bisexuals,

whereas three (23%) gay men did the same. The most common non-sheltered place to

live was NYC subway cars. Overall, six participants (20%) reported living in subway

cars—four (24%) bisexual men and two gay men (15%).

Table 5

Reported use of non-housing shelter

Non-housing shelter	Bisexual men	Gay men	All men
	(N = 17) N (%)	(N = 13) N (%)	(N = 30) N (%)
Abandoned buildings	-	1 (8%)	1 (3%)
Living in the streets	1 (6%)	-	1 (3%)

Living in train/subway [cars	4 (24%)	2 (15%)	6 (20%)
Couch surfing	2 (12%)	-	2 (7%)
Total	7 (41%)	3 (23%)	10 (33%)

The reported use of homeless shelter housing, however, shows a dramatic disparity between LGBTQ-specific shelters and non-LGBTQ shelters. As shown in Table 6, the use of LGBTQ-specific homeless shelter was reported only nine times, highlighting the limitation of homeless shelter for bisexual and gay youth. Of this group, four were bisexual men and five were gay men. Conversely, significantly more bisexual and gay men indicated that they stayed in non-LGBTQ-specific homeless shelters. Nevertheless, it is important to note that many participants usually used more than one homeless shelter since becoming homeless due to the restrictions imposed by homeless shelters in NYC.

Participants reported to have accessed a total of 14 homeless shelters in NYC. Of this group, only two catered to the specific needs of homeless LGBTQ youth. The top four types of homeless shelters accessed were men's homeless shelter (10), LGBTQ Homeless shelter-Alex (5), Single Room Occupancies (5), and LGBTQ Homeless shelter-Susan (4) [Note that agency names were changed to protect their identity].

Table 6

Reported use of homeless shelters

Type of Shelter	All men	Bisexual men	Gay men

LGBTQ-Specific shelter	9	4	5
Non-LGBTQ Specific Shelter	26	13	13
Total	35	17	18

*Study participants may have accessed more than one shelter throughout the duration of their homelessness.

Homeless LGBTQ shelters are very limited in NYC; therefore, housing is extremely difficult to secure, given the number of homeless LGBTQ youth in the city. Furthermore, homeless men's shelters in NYC are reported to be unsafe, forcing participants to leave and live out in the streets. For these reasons, participants frequently move around to different shelters throughout the five boroughs of NYC. Two participants described their experiences moving from shelter to shelter in the following way:

> So I went to [Homeless Shelter Alex] and I'm a client there and I went to street works and after that I was a client there. I'm still a client at both places, and then after that a couple of weeks later I found out about [Homeless Shelter Susan]. So after that I stayed there for a while. That's how I found this place, Wards Island, and that's where I'm currently staying and I have appointments all week. [21, Black, Bisexual, Male]

> [I was with Homeless Transitional Shelter], and they had me living all over the place, because they had their major house on Vice Avenue, and then they moved that house out to East New York on Elton Avenue somewhere, then back. And

then, in the same neighborhood on Intervale [a street in the South Bronx], then back, and then they moved everybody back all the way out to Well, no, not all the way out. On Longfellow, which was six or seven blocks, but still more or less the same neighborhood. Now, I reside in Harlem where I've been since July. [29, Black, Bisexual, Male]

Not only did participants move around among shelters, shelters moved around as well. The first quote highlights the complexity of LGBTQ-specific homeless shelters in NYC. There are only two known homeless shelters that specifically provide services to homeless LGBTQ youth. LGBTQ-specific homeless shelters also provide referrals and other supportive services; therefore, a participant may continue to be a client to one or more programs. The fact that they are connected to more than one program strongly suggests their desperate need for services, their willingness to access services, gaps in services, and the lack of comprehensive services in the community.

The second quote emphasizes two different issues—the actual relocation of the shelter and residential drug treatment program. Due to the relocation of the program, the participant had to move around with it to adhere to the drug treatment program. Nonetheless, it is unknown whether the participant completed the drug treatment program, but he remains homeless.

Description of Homeless Services (Shelters versus Programs) in NYC

This study focused primarily on access to and utilization of healthcare; therefore, it wasn't able to fully capture the nuance of the use of homeless shelters in the city. There were two main types of homeless services used by participants—homeless shelters

and homeless programs. In the following sections, I provide a breakdown of the different

type of homeless services discussed by the participants:

Homeless shelters. Men's homeless shelter usually provides the following

services: hot nutritious meals during the day; emergency shelter and a safe place from the

streets; longer-term housing in residential recovery programs; medical services such as

preventive care, medical evaluations, management of chronic conditions and specialty

care; hot showers and free clothing. However not all programs provide all these services;

it varies depending on the program, staffing, and funding.

LGBTQ-specific homeless shelter. LGBTQ-specific homeless shelter usually

provides an array of the following services: drop-in services provide food, medical care,

mental health services, education and employment training and referrals; outreach

services to provide supportive services, and educational programming to homeless,

runaways, street-based individuals, and at-risk LGBTQ youth, mainly aged between 16

and 24; emergency housing programs provide shelter for 1 to 6 months with the hope that

LGBTQ youth transition into independent housing (their own apartment); transitional

living provides more long-term housing shelter for up to two years, however, youth must

maintain employment, education, and preparation for independent living; healthcare

services such as prevention, outreach, and treatment for HIV/AIDS/STIs, and medical

referrals (physicals, PPDs, vaccinations are only provided to clients who enter the

emergency and transitional housing programs); supportive housing provides housing for

individuals with mental health conditions, substance abuse issues (past or present),

individuals living with HIV/AIDS, and young adults aging out of foster care. These

types of housing include shared apartment style buildings, scattered site supported

housing, community residences, and other forms of congregate housing.

There are other types of housing as well like dual-diagnosis residential programs

and drug treatment programs. Dual-diagnosis residential programs provide temporary

emergency housing services for single men who are dually diagnosed with mental illness

and substance abuse. They offer meals, case management, housing assistance, creative

arts therapy, job training, education resources, and medical and psychiatric services.

Their programs are mainly designed to enable homeless men to secure long-term

permanent housing and become self-sufficient. Drug treatment programs provides

inpatient and outpatient substance abuse treatment services for homeless men with

substance use conditions and advanced chemical addiction.

Personal Safety

An underlying barrier found with regard to access to healthcare that was not

revealed in the survey questionnaire was safety. Safety in the homeless shelters was a

poignant issue for some study participants. Some of them reported shelters and single-

room occupancies to be drug-infested, crime-ridden, and poorly managed:

Even being in the shelter, you have fights to use the bathroom, we have to fight to

use the shower, everything is a battle. Then you have to deal with people with

drug addictions and mental illness and people coming out of prisons and jails, all

these different personalities and people in different situations—it can be

overwhelming. [25, Bisexual, White, Male]

This participant, like others, reported that homeless shelters in NYC are unsafe for

bisexual and gay men to the extent which they expressed concern for their health and

safety. The quote also suggests that shelters were lacking policies and procedures to protect the clients they serve, particularly when "everything is a battle". Having to face these structural challenges at homeless shelters were a major deterrent in using homeless shelters in NYC. Feelings of fear and frustration compromised participants' mental health, exacerbating their health needs. In fact, one gay respondent was worried about his safety after receiving threats from a resident neighbor in one of the shelters he lived in because of his sexual identity. Subsequently, he avoided the shelter and decided to live on the streets. He shared his experience in the following quote:

> There were a lot of threats on my life and who I was and it was better for me to be homeless than to deal with that every day. The staff was acting like they didn't care, either. I felt bothersome to them. [23, Black, Gay, Male]

This respondent was threatened because of his sexual orientation. These assaults were not just verbal but also emotional and had a deeper impact on him, which prompted a serious concern for his safety. Like many bisexual and gay youth, he tried to ignore (or tolerate) harassment, threats, assaults, and violence, but the fear and the emotional damage wears on them, especially if it was frequent, as it was for him. Constant fear of going to their residence can be debilitating to the extent that it can cripple their mood, lifestyle, and plans, leaving bisexual and gay men feeling unmotivated, helpless, and hopeless. Even the staff at the facility showed no remorse for the participant. Their non-verbal response showed no interest in helping him, which speaks to their poor professionalism and insensitivity. The fact that the participant felt like he was a bother to them indicates that he had already internalized feelings of guilt for being victimized, which is devastating for any victim of harassment or assault. All these factors led the

participant to leave the facility, forcing him back into the streets. Fear and victimization among gay and bisexual men are all too common, making it especially important for them to have access to safe shelters in the city. Furthermore, his comments strongly suggest that the staff neglected to assist him, which emphasizes the need for educating the staff in these facilities about the needs of the clientele they serve, including bisexual and gay men.

Transplant Homelessness

In my review of the literature, I did not see a discussion of the migration of bisexual and gay men to NYC from other places in the US, a term I call transplant homelessness. Eight out of the 30 homeless participants migrated to NYC as a consequence of homelessness or sexual freedom. Some of them left their homes to come to NYC for sexual freedom, and a few of them were already homeless before they arrived to NYC. Participants migrated from places like Indiana, Florida, Pennsylvania, California, New Jersey, Massachusetts, Tennessee, Long Island-New York, and Rockland County-New York. Of the eight participants, five were gay men and three were bisexual men. Many of them reported coming to NYC for more resources, including healthcare as quoted in the following four responses:

> Yes. I came here because there was no healthcare in Massachusetts. There were
> no services for LGBT people and there was only one place for youth and you
> have to get on a waiting list for youth got only ten beds and you would have to be
> working. It was either that or you go to the men's shelter which was crazy -- 1000
> men staying in one building.

I would have to say a good experience was when I first came to New York. I was really surprised that there is someone at the shelter that was able to sign me up for health care. I would never see that in Massachusetts. You have to wait a really long time. I was really surprised that that was available, that someone was available to set me up moments after stepping off the bus in New York. [24, White, Gay, Male]

Well, I've been shocked at how better the health care system was, say from my native Indiana, because even when I was a young man and I had Medicaid through, I guess, the CHIP program and I aged out of that, I went a few years where I had no health insurance at all. Now when I first came here and I was in seminary, the program I fell out of, I was shocked I could get Medicaid, of course at the time I had Medicaid as well as the insurance I was having through the denomination, because they offer all the folks who are there in the seminary their insurance. [29, Black, Bisexual, Male]

I'm actually from Rockland County. I was born and raised there. I lived there for 21 years. I was finding myself at that time, being in the LGBT community and I've met people in NYC who tell me about a lot of resources that they had for people in the community. I left home to come to New York City, I wanted to see how it would be living here so I left my mother's home and came here and I went to Sylvia's Place. [30, Black, Gay, Male]

Transplant bisexual and gay men appeared to come from communities where LGBTQ social and healthcare services were scarce. They perceived NYC to have more

and better healthcare services than their place of origin. In fact, one of them migrated to NYC specifically for healthcare services and LGBTQ resources. Nonetheless, there were several mixed reviews in terms of the point at which they acquired government benefits (that enabled access to healthcare). For instance, one respondent reported that he enrolled in government benefits briefly after arriving in NYC, yet another one reported that he went for a few years without health insurance because he was unaware of his eligibility for government benefits. Despite the challenges they faced, overall, participants were pleased with the healthcare services offered in NYC compared to the services they received at their place of origin.

Among all the transplants, only two were able to thoroughly articulate navigating the healthcare system in NYC during the interviews. They seemed to have a better understanding of the healthcare system mainly because of their prior experience navigating the healthcare system due to pre-existing conditions. One participant was a well-educated Black homeless bisexual young adult man with borderline autism and the other participant a White HIV-positive homeless gay young adult man. Other reasons transplant bisexuals and gays moved to NYC were to escape the stigma associated with their sexual orientation and preferences and unavailability of specialty medical care and mental health services in their community of origin.

Young Adulthood

The average age of participants in the study was 25 years. They were homeless on an average of 3.6 years more than the average duration of homelessness (2.5 years), as shown in previous LGBTQ youth studies (Empire State Coalition of Youth and Family Services, 2011). The fact that participants in this study had a longer duration of

homelessness suggests that they may have been homeless when they were younger, which may have qualified them for youth services, as defined by the NYC Department of Youth and Community Development (DYCD) Runaway and Homeless Youth guidelines for entry into the youth shelter system. According to NYC DYCD Runaway and Homeless Youth, the age definition for youth is 16–21 years, but during the development of this research study, the agency expanded the maximum age for homeless youth services to 25 years. The fact that the NYC DYCD was unable to secure adequate housing for participants when they were younger resulted in prolonged homeless, pushing them further into poverty and marginalization, and widening the gap of healthcare access between them.

During the interviews, there were no discussion of age as an issue for healthcare access and utilization except for a couple of times when it came up as age-related discrimination at a healthcare facility and at a place of employment. For instance, a homeless bisexual young adult man who became HIV-positive aged 19 felt that medical providers did not take the time to explain his diagnosis and treatment options because he was too young to understand. This was a major deterrent for him in seeking further healthcare services.

Age was also an issue with respect to education and employment. In this study, many bisexual and gay men remained homeless from youth into young adulthood. Unfortunately, they were unable to pursue their education (like university, trade, or vocational training), which made them less competitive to secure well-paying jobs that would help get them out of poverty and out of homelessness. Now that they are young adults, securing employment while managing their health and mental health conditions

becomes cumbersome, particularly when access to healthcare seems so fragmented. Below is an example of the day in the life of a bisexual young adult man, highlighting his experience with healthcare in NYC.

Descriptive Example of a Homeless Bisexual (or Gay) Young Adult Man in NYC

Rayquan (alias given to protect participant's identity) is a 24-year-old African American male from Crown Heights, Brooklyn, NY. He is mostly attracted to women but also has sex with transgender women. Rayquan became homeless three years ago after his parents found out about his transgender girlfriend. His father could not come to terms with his sexuality because of his strong religious beliefs.

Rayquan completed his high school diploma two years ago but hasn't been able to secure steady employment. He often gets part-time work but never earns enough wages to pay for rent. Nonetheless, he recently got a part-time job at McDonalds. Sometimes, his work hours conflicts with the opening and closing hours at the homeless shelter where he stays. When he has to work late, he is unable to get to the shelter on time before the door closes. When this happens, he sleeps in subway cars resulting in inadequate sleep. Without adequate sleep, it becomes hard for him to focus and work the next day.

Rayquan was diagnosed with schizophrenia during his late adolescent years. He saw a psychiatrist while living at his parents' home. However, since he became homeless, he stopped taking his medication because of problems with his government benefits (Medicaid). Even though he is eligible for Medicaid, when he gets it, he never receives the notification for recertification, because he moves around from shelter to

shelter. Medicaid requires an address for notifications, but he never gets the notification on time despite leaving an address with the NAC.

Rayquan learned about MVCs because it was located near the pier where he and his LGBTQ homeless friends hang out. His girlfriend at the time (a male-to-female transgender) was getting an HIV test and referred him to the clinic. The van was associated with an LGBTQ-health center, but they stopped taking patients without Medicaid due to limitations in their clinic size and provider capacity. Rayquan is unmotivated to recertify his benefits because it takes too long to get them; moreover, once he gets them, they expire before he can establish care with a provider he knows and trust. Getting psychiatric medication is another problem. It is hard for him to adhere to medication while being homeless. He often forgets to take it, loses it during the course of the day, and/or suffers from side effects. Furthermore, to get his medication, he has to travel far to a pharmacy that is not at the same location where he normally gets his healthcare.

Rayquan usually travels on foot around the city; however, lately, he has been getting blisters from walking. When he's experiencing pain, he tries to get a free transportation fare (MetroCard) at a clinic, but that often involves taking a test or engaging in a program. If that does not work, he would ask for a free swipe from subway commuters, but he feels humiliated soliciting a free ride. Furthermore, it takes an average of an hour to actually get a free swipe. At times, when he is in a lot of pain, he would be forced to jump the turnstiles to get into the subway, putting himself at risk of getting a ticket or getting arrested (if he doesn't have his identification with him).

On two occasions, when Rayquan became extremely hungry and exhausted, he succumbed to his foot pain and fainted on the street. He was admitted in the hospital. Though he was at the hospital for an acute condition, he did not mind staying in the hospital because it is a place to get some rest, eat, and recuperate. The medical staff at the hospital were sometimes nice, depending on the shift and day. Some staff were rude and disrespectful, chastising him for staying in the hospital because he is homeless. They perceived him as fit and strong and employable, but they think he's trying to "ride" the system. During his stay at the hospital, no one really talked about his sexuality. They just treated him for acute conditions and discharged him once he was stable.

In summary, Rayquan seems to be in a cyclical pattern of poverty, health inequality, health inequity, fragmented healthcare, and unstable housing. Systematic macro and micro structural factors have impeded his ability to secure healthcare, housing, employment, and education. These barriers are often overlapping, each having a ripple effect on the other, widening his gap to adequate routine preventive "well" care and heightening his risks for easily preventable illness.

Summary

In this chapter, I discussed the three core demographic factors (homelessness, sexuality and young adulthood) that represents the population under study and touched upon their interconnectedness to the three main foci of the study—healthcare need, healthcare access/availability, and healthcare utilization. To review the salient points of this chapter, sexuality plays a critical role in the healthcare needs of bisexual and gay men. More specifically, the term bisexuality is wide-ranging, varying, and fluctuating. It

cannot be fixed or limited to one dimension for bisexual participants in the study. Therefore, bisexual men present unique healthcare needs that are different from gay men and require different healthcare resources from conventional healthcare systems or even from LGBTQ healthcare clinics. A major gap highlighted by the bisexual participants is the lack of sexual health assessment in the healthcare systems they accessed.

The other core demographic factor—homelessness—was found to be consistent with sexuality in that it is wide-ranging, varying, and fluctuating, thereby making it impossible for participants to find stable housing. First, LGBTQ homeless shelters were very limited, compelling participants to access shelters that do not cater to their needs, risking their personal safety and thus, forcing them into the streets or "ping-ponging" to different homeless shelters. Second, the fragmentation of homeless services offered no other alternative to the participants but to access more than one agency for different needs. Third, a cohort of bisexual and gay participants were "transplants", which added another dimension to homelessness and need for healthcare services in the mix of already scarce resources.

Lastly, young adulthood is a point at which major discovery and transformation occur in youth's lives. It is a time to explore their identities beyond sexuality, such as the pursuit of education, weighing employment opportunities, and planning their future. Instead, participants suffer with the anguish of homelessness and health issues (associated with their sexuality) which may stunt their development, leaving them helpless and hopeless. The next chapter explores, in a detailed manner, the actual healthcare needs of the participants considering these fundamental demographic characteristics (sexuality, homelessness, and youth).

Chapter 7

Qualitative Results

Healthcare Needs

This chapter discusses the healthcare needs of the participants and the barriers they face while accessing and utilizing healthcare in NYC. To begin, I cover the prevalence of physical health needs shared by the participants, followed by their mental/behavioral health needs. Additionally, I discuss their underlying competing needs which the participants described during our interviews as issues that inhibited their access and utilization of healthcare services. In total, 30 participants participated in semi-structured individual interviews for this study. As homeless bisexual and gay young adult men in NYC, they defined their healthcare needs in terms of physical and mental/behavioral health problems. Their accounts also included different types of medical procedures, prevention services, and medical incidents or injuries.

The well-documented literature review shows that homeless LGBTQ youth face significant health disparities (Bandurraga, 2011; Boehmer et al., 2012; Burkhalter et al., 2009; CDC, 2010; Cochran et al., 2012; Conron, Scout, and Austin, 2008; Daley and MacDonnell, 2011; Durso and Gates, 2012; Easton et al., 2008; Gangamma et al., 2008; Haas et al., 2011; Herbst et al., 2008; Kitts, 2010; Kruks, 2010; Marshall et al., 2008; Marshall et al., 2009; McBride, 2012; Pilgrim and Blum, 2012; Roberts et al., 2010; Russell et al., 2011; Ryan et al., 2009; Solorio et al., 2008; Terry et al., 2010; Whitbeck, 2015). Specifically, rates of new HIV infection are greater among bisexual and gay young adult Black men (CDC, 2015). Additionally, suicide attempts and depression are common among LGBTQ youth (Cochran et al., 2002; Hatzenbuehler, 2016; Whitbeck et

al., 2004). However, each subgroup within the LGBTQ spectrum experiences problems and illness that are unique to that subgroup. Furthermore, the manner in which each subgroup accesses and utilizes healthcare may also have unique features. In this study, I aimed to explore healthcare access and utilization of healthcare among bisexual and gay men, which first required an understanding of their healthcare needs. I framed this chapter around the following research question:

- *What are the self-perceived healthcare needs of homeless bisexual young adult men in NYC compared to homeless gay young adult men in NYC?*

The participants' healthcare needs were found to be very complex, with overlapping themes that generated many categories and codes. To describe this convoluted web of physical and mental/behavioral health needs, I developed a conceptual model as shown in Figure 10 that explains the intersection of healthcare needs, homelessness, and utilization of healthcare services in NYC. I further describe each major point of access to healthcare later in the chapter. The Venn Figure in Figure 10 below shows the overlap of physical health (1), mental health (2), and behavioral health (3). Many homeless bisexual and gay youth fall into the center where all three circles overlap, meaning that they have physical and mental/behavioral health needs. These men address their physical healthcare needs mainly through brief preventive care, primarily involving HIV and STI testing, which I characterized as convenient and habitual (4). Stigma, however impacts HIV/STI testing. Only very few study participants reported utilizing routine preventive care (9) such as those who were HIV-positive, on HIV pre-exposure prophylaxis (PreP) and recently incarcerated. However, for HIV-positive participants, healthcare access was often interrupted due to the constraints of the

homeless shelter system such as their operating hours. Ironically, HIV-negative participants (who had other chronic diseases) typically did not manage their health conditions as often as HIV-positive participants.

Of the three categories of healthcare needs, mental health (2) seems to be the least addressed, with mental health services the least accessed despite the overwhelming prevalence of mental health conditions among participants. Behavioral health conditions like substance use and incarceration also had mental health implications, thereby compounding the issue further. Behavioral health (3) was usually accessed through a substance use treatment program and/or similar programs while incarcerated. Participants also had access to routine healthcare while in these programs. However, as a consequence of incarceration, bisexual and gay men usually experienced severe mental health conditions. Bisexual and gay men who were involved with the justice system (usually due to their involvement in illicit activities) did receive brief healthcare check-ups, but that was usually after discharge from prison or jail. Healthcare access and utilization are not consistent.

Lack of stable and adequate housing (6) had a major effect on participants' healthcare needs. Participants reported a range of competing needs (7), such as education, employment, food, and clothing, which impeded their ability to meet their health needs. They also reported specialty health needs beyond that of preventive primary healthcare such as dental care, ophthalmology, and nutrition health needs.
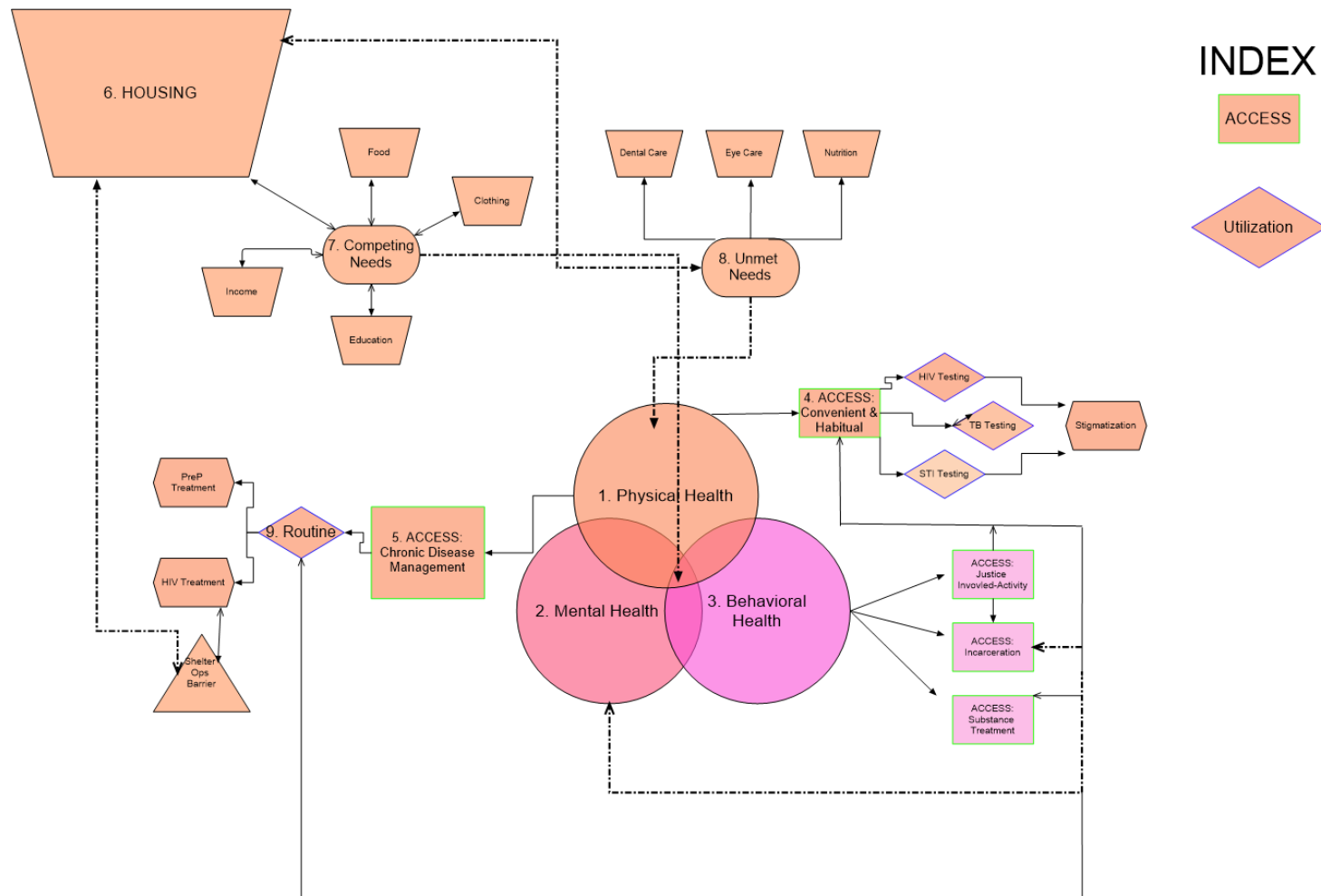
Figure 10. Healthcare access and utilization points for participants with healthcare needs

Physical Health Problems

I highlight my findings based on the actual physical health needs disclosed by the participants during the interviews and the relevant themes, codes, and categories that surfaced during data analysis. Participants reported a significant burden of physical health problems during interviews in a way that was strikingly different than that which they reported in the survey questionnaire. In the questionnaire, only four bisexual men reported physical problems, whereas no gay men reported physical issues. In contrast, during interviews, participants reported physical health problems 97 times, with many study participants reporting more than one condition. Notably, bisexual men reported a total of 59 (61%) physical problems, whereas gay men reported a total of 38 (39%) physical problems as shown in Table 7.

As shown in Table 7, 16 (94%) bisexual men had more than one physical health issue and 12 (92%) gay men had more than one physical issue. The average number of physical health issues among all participants was three, and the median was also three. The range spanned from 0 to 6 and the standard deviation was 1.5, which means that most of the participants probably had between 1.5 to 4.5 physical health problems—a much greater number than participants reported in the survey.

To assess the data further, the dataset was divided between the two groups— bisexual and gay men—as shown in Tables 8 and 9. Bisexual men (3.5) had a slightly larger average number of physical health problems when compared to gay men (2.9). The median is also slightly higher for bisexual men than for gay men, at 4 and 3 respectively. However, the standard deviation remained the same at 1.49.

During my interviews, I employed the following semi-structured interview question: "Describe your health status", thereby prompting the participants to discuss their respective health concerns. As the discussion continued, I probed them to unearth those factors in the healthcare system that probably contributed to poor health outcomes as well as improved health outcomes. This allowed participants to open-up and reveal a wealth of data about their health conditions, health status, the manner in which they seek healthcare, the type of healthcare they received and their frequency of healthcare access and utilization. Table 10 has a list of 28 physical health issues discussed by study participants in the order of most common to least common (Please note that this list reflects the raw data as it was presented and that some issues like vaccinations (flu shot and pneumonia shot) were perceived as a health problem to participants since they wanted it as a preventive measure).

In participants' accounts of their healthcare utilization, several prominent themes emerged. The most common feature of men's use of healthcare was that they primarily accessed healthcare through brief preventative care encounters. Furthermore, a minority of men accessed routine care for the management of chronic diseases.

Brief Preventive Healthcare Encounters

In participants' accounts of healthcare access, the most common theme was the use of very brief preventive services for a narrow range of health issues. Men reported accessing the following three primary preventative services: HIV testing, STI screening, and TB testing. Other health issues, such as diseases or conditions requiring treatment and/or chronic disease management, seemed challenging for them to manage (which is

addressed later in the chapter). Although these brief encounters provided a window of opportunity to access more healthcare services, primary preventive healthcare was hardly attainable among study participants.

HIV services were the most significant healthcare services discussed, which includes two types of services—HIV testing and HIV treatment. Within each of these categories, underlying themes surfaced. The following two themes emerged regarding HIV testing: that it was convenient and routine and that bisexual men experienced stigmatization. However, for HIV-positive participants, access to HIV treatment and utilization of healthcare was characterized as consistency, which is discussed in a later section addressing chronic disease management.

HIV testing perceived to be convenient and routine. During interview discussions, participants revealed that HIV testing seemed to be very convenient, so much so that they had developed the habit of routine testing. Many HIV prevention programs emphasize routine HIV testing, and the finding that participants in this study were routinely being tested for shows that HIV prevention programs are reaching at least some high-risk communities. Moreover, the fact that bisexual and gay men in this study were getting tested also suggests that the community appears to be aware of the importance of HIV testing, which is a great step in preventing HIV infection.

HIV testing was reported to be available at mobile healthcare clinics (usually associated with LGBTQ-specific community healthcare centers or LGBTQ-specific homeless agencies), hospital ERs, and other social service agencies. MVCs belonging to these healthcare centers were situated in places where homeless bisexual and gay men are

known to be located. HIV testing sites also offered MetroCards, which was another

convenience for participants as it became affordable for study participants to get to and

from testing sites. As a reminder, a MetroCard is an NYC transportation card (similar to

a bank card) to which one can add monetary value to access the NYC transportation

system. The current fare for a subway or local bus ride is $2.75, but one must first

purchase a card which costs $1. A majority of study participants (25) discussed receiving

HIV testing and prevention services at some point while homeless. Of this number,

testing was similar between both groups—14 (82%) were bisexual men and 11 (85%)

were gay men.   As discussed in the previous chapter, many study participants reported

receiving multiple or routine HIV testing at healthcare agencies. Most study participants

reported learning of HIV testing through a peer. A few others reported that they became

familiar with testing sites through a friend working at the sites or through an agency.

Bisexual men explained that HIV testing sites were available to them through the

agencies they accessed and/or the places at which they convened. They perceived HIV

testing as quick, convenient, accessible, and providing needed resources (like

MetroCards). Most bisexual men received HIV testing via a mobile van or LGBTQ

healthcare center. A few stated that they received an HIV test during other medical

testing or procedures. Very few bisexual men received HIV testing at hospital ERs.

Like bisexual men, most gay participants discussed accessing HIV testing

primarily through mobile HIV testing sites located in the places they normally socialize

such as Christopher Street in Greenwich Village, a place known to welcome LGBTQ

community members. Some participants reported getting screened frequently—every

three or four months. Other gay participants tapped into LGBTQ-specific clinics or

centers that were co-located at a homeless shelter. A few stated that they get tested

following "at risk" activities. 'At risk' activities were described as engaging in sex with

another person. However, the degree of risk involved and the specific activities they

engaged in are unknown. This study was not designed to assess sexual risk categories.

Although many bisexual and gay men have not had an annual routine preventive

check-up, they reported HIV testing to be very convenient and easily accessible

compared to more involved medical care encounters as described below:

> I either go on Christopher Street to the [Healthcare agency Zed truck] or
>
> the [Healthcare agency Barry] truck. The clinic trucks or the [Healthcare
>
> agency Carrie], like whatever's out and on the street. On Christopher
>
> Street, these vans will come out and do HIV testing or whatever. Swabs
>
> and stuff like that and I make sure to get tested. [23, Black, Gay, Male]

> [I] feel like there's a big emphasis on screening, it's mostly about that. So
>
> it's easy for you to find access to screening. You can get like an HIV test
>
> anywhere now. I think for more serious problems, it's a little bit harder.
>
> [23, Black, Gay, Male]

These participants offer general examples of how this cohort of men received HIV

testing. Given that homeless bisexual and young adult men were not residentially fixed

to a specific neighborhood, and that they habitually live transient lifestyles, NYC's

healthcare system has systematically targeted them at a number of the geographic areas

or venues they access. Mobile medical vans were located in areas like Christopher Street

Pier in Greenwich Village, NYC where study participant normally congregate (or hang

out). Medical mobile vans were also co-located near other homeless agencies and

programs that participants use, hence why they often get tested in more than one

healthcare agency. However, it is important to highlight their willingness to get tested

whenever it is available. Getting tested at these various locations was shown to be very

effective in that participants were getting screened for disease conditions they were at

high risk for. This was also usually their initial entry into the healthcare system, but this

clearly is not adequate on its own and contributes to the emergency of health disparities

in the community. Based on participants' responses, it seemed that HIV/STI testing sites

only scratches the surface of deeper systematic issues of this population that require

much greater access to NYC's healthcare system.

One participant did call attention to the overwhelming emphasis on HIV testing

and the significant challenge of finding healthcare for more involved medical conditions.

Paradoxically, the emphasis on HIV/STI testing (at least among funding agencies)

seemed to be hurting efforts to provide more comprehensive healthcare services targeting

homeless bisexual and gay young men. Those quotes speak volumes about the lack of

healthcare services beyond that of brief preventive care encounters and the need for more

comprehensive services for homeless bisexual and gay men. They also speak to the

fragmentation of healthcare services, which is discussed in detail in the following

chapter. Finally, participants' quotes also suggest a lack of coordinated efforts among

healthcare agencies serving this population.

Non-HIV STI screening. STIs were the second most commonly screened disease

condition reported by participants. Nineteen (63%) study participants discussed STI

screening. There were no outstanding differences between bisexual and gay men

accessing STI screenings—11 (65%) were bisexual men, and 8 (62%) were gay men. Very few participants disclosed having an STI (other than HIV) or receiving treatment for one. Participants received STI screening at LGBTQ-specific health centers or medical mobile vans that were situated in neighborhoods where bisexual and gay men convene, similar to HIV testing sites. In fact, many of the HIV testing sites also offered screening for other STIs.

TB shelter screening. Tuberculosis screening was the third most commonly screened disease condition reported by study participants. Six participants reported having received TB screening. Of this group, 5 (71%) were bisexual men and 1 (13%) was a gay man, suggesting that more bisexual men than gay men accessed homeless men's shelters in NYC. However, there was a distinct difference in TB screening than HIV/STI testing. TB screening was primarily offered by homeless shelters at a point of entry into the shelter system. It was part of the shelter intake process, which seems mandatory, and serves as an important public health intervention to prevent TB outbreak. Nonetheless, a physical exam was not mentioned as part of the process as described below:

> When you do your intake [to the homeless shelter] and everything, they
> assign you a bed, and they give you a series of appointments as far as
> getting the psych evaluation, get the PPD, and from there you're
> supposed to make it to the appointment to get it taken care of. Part of
> what makes people not comply, aside from their own issues, is that often
> you spend the whole day sitting there waiting to be seen. [31, White,
> Bisexual, Male]

This participant was given a battery of evaluations during the shelter intake process, although it seemed that some screenings (TB tests and psychiatric evaluations) had more precedence over others (physical exams and vaccinations). Moreover, long wait times at healthcare agencies were reported to be a critical barrier. The above participant appeared to experience this barrier more than once. He also hinted that homeless individuals have other problems, which suggests additional barriers to healthcare services aside from having to be screened to get into homeless shelters and long wait times at healthcare agencies.

Stigmatization. While participants were pleased that some healthcare agencies target bisexual and gay men where they congregate, a few felt that stand-alone HIV/STI testing sites (like mobile medical vans) were associated with stigma. In previous studies, stigma has been shown to be a major deterrent in accessing healthcare, particularly because of the medical staff's ill treatment of LGBTQ patients and their lack of awareness of their own biases towards them. As much as there have been significant advancements in tailoring community health to the LGBTQ community, this bisexual participant expressed fear of being stigmatized by their peers, the public, as well as medical providers.

> The HOTT van is a little more obvious because it's a van on the street
> and people make their own assumptions and make comments. You're
> walking into the van [and people think,] "Oh you're going to get a STD
> screening. 'You're dirty' or 'You're broke'. I feel a little more isolated in
> there. I think the stigma is coming from some of my peers and some of
> the public. Like what the HOTT van is associated with. A lot of

healthcare providers who are associated with LGBT seem to have a sort

of negative stigma when it comes to STD and HIV testing in my

experience because you'll go and people will make comments. And make

statements that are very much not true. And because of that visibility

within the specific spaces, to be assumed that this is, you know, how you

are, where you are, and how the public views you. [24, Black, Bisexual,

Male]

The study participant expressed fear of accessing the MVC due to potential

stigmatization by his peers and the public (passer-by). The Health Outreach to Teens

(HOTT) belongs to an LGBTQ-specific healthcare center that is known for targeting

homeless youth. From my experience working in the community, medical mobile vans

display advertisements on the van's exterior advertising the sponsoring LGBTQ

healthcare center or homeless shelter it is affiliated with. The participant's fear of stigma

seemed to go beyond that associated with HIV/STI testing. His comments suggest the

fear of being stigmatized for being homeless, poor, and a sexual minority. He was also

discouraged from using LGBTQ healthcare centers because of offensive and fallacious

comments made by medical mobile clinic staff towards homeless youth. Stigma from the

general public was also associated with the type of vehicle used for screening. This

participant believed that when the public sees the details of the vehicle's purpose on the

vans, they make assumptions about his health and socioeconomic status. And the very

fact that the healthcare center was located in commonly known areas where homeless

LGBTQ youth convene suggests (to him) potential stigma relating to that as well.

Moreover, this young man's comments reveal his insecurities and his vulnerability about

being impoverished, homeless, and bisexual, as well as his need for LGBTQ-focused healthcare facilities. These feelings of vulnerability have left him feeling very isolated, acommon phenomenon among bisexual men.

Chronic Disease Management

Two conflicting themes surfaced regarding chronic disease management, with some participants reporting receiving consistent care for chronic diseases and others reporting fragmented and irregular healthcare access. Consistency in healthcare was reported by HIV-positive study participants. However, HIV-negative study participants (who represented most of the study sample) reported irregular bouts of medical management of chronic diseases, expressing a desire to stabilize their care.

Consistent care for HIV-positive men. A unique subgroup that appeared to have consistent routine access to healthcare and established preventive care were those receiving HIV treatment, including HIV PreP. Four participants (13%) identified as HIV-positive (two were bisexual, and two were gay). However, their experience with access to healthcare was very different from that of other participants. Two HIV-positive study participants reported the following, respectively:

> You get treated a lot different being positive that you do being negative.
> It's a lot - I don't even know how to say it. Depending on where you go it
> could be in a good way because most clinics that I go to treat you… like
> you were their child. That's the best experience I've ever had instead of
> going to [Hospital Butterfly] where they treat you like you're an outsider.

To them, your status matters. You get a lot more respect and a lot more understanding than you do at any other place. [27, White, Gay, Male]

I feel like actually, they're not just regular doctors or nurses, they're actually people that take their job seriously. They care about their patients. They're in it not because of a check. They actually want to make sure that people are better and they actually care and if they think that there's an issue, they keep you [for observation], they don't send you home… I'm constantly having these episodes where my leg is swollen with abscesses. When I went there, they also educate you. They help me understand a lot about my body. I'm in so much pain but I know that if I go to [Hospital Moth], I'll feel better. [29, Black, Bisexual, Male]

Here, it is evident that the quality of care at HIV treatment centers is perceived as superior to that of non-HIV care and the care available at hospital ERs. Participants appreciated the quality care offered by the medical staff at HIV clinics, including their bedside manner, patient education, and advocacy. HIV staff seemed to be dedicated to serving the HIV community; they seemed to exhibit a positive bedside manner. Participants reported that these staff members were empathetic, compassionate, respectful, and understanding of their health and needs. Additionally, HIV healthcare agencies appeared to provide resources and dedicate time to educate participants regarding their health and their bodies, as noted by this young man above.

HIV-positive study participants seem to be very knowledgeable about the healthcare system in NYC and well connected with it, more specifically, LGBTQ-

friendly healthcare agencies and LGBTQ-specific social services that were not usually available to non-HIV persons (such as housing placement, day programs, free food, nutrition classes, art classes, music classes, support groups, healthcare services, dental services, and incentives). These programs were reported to be very effective in getting them engaged in healthcare. HIV-positive study participants also seemed to have a much better understanding of accessing other social services like Medicaid, housing shelters, and insurance services, which also served as strong facilitators for access, utilization, and maintenance of healthcare. Study participants reported that HIV programs offered more comprehensive services, attempting to address some social determinants of health. Generally, they seem to get routine preventive care and access to holistic services more often than non-HIV study participants in this sample, which appears to be a reversal of stigma. Usually, HIV-positive status means greater stigmatization and greater burdens, but in terms of healthcare access and diversity of services, it appears to confer a big advantage. Stigma is now more associated with poverty and homelessness.

Fragmented Healthcare

Fragmentation of healthcare was reported by most study participants, particularly those who were HIV-negative. Fragmentation is discussed in depth in the following chapter. Nonetheless, in contrast to the experiences reported above by HIV-positive study participants, one HIV-positive bisexual respondent was found to be struggling with access to and utilization of healthcare. He described his frustration with fragmented care (having to access ERs and different health centers because of multiple acute health-related concerns) until he was driven to establish care at one place. To do so, he

researched HIV care sites (via the internet) that were in proximity to the shelter where he was staying.

> Interviewer: So you're getting yourself acquainted with [Healthcare agency Zed]. How did you find out about [Healthcare agency Zed]?
>
> Interviewee: I wasn't getting better going to the emergency room, and I wanted to go someplace where I actually felt stable, and I don't have to spread myself so thin, just going to different places and not knowing exactly what's wrong with me. So I just went online and researched something that was close to [Homeless shelter Alex] and [Healthcare agency Zed] popped up. [29, Black, Bisexual, Male]

This participant offers a general example of a homeless bisexual man's use of healthcare. Reported use of hospital ERs for primary healthcare was a common phenomenon among bisexual study participants. As many of them reported, hospital ERs usually just stabilize their condition instead of offering or linking them to routine preventive "wellness" healthcare. Moreover, the strategy of accessing hospital ERs was adequate for acute emergencies but appeared to be mentally and physically exhausting and taxing, particularly when using it for primary care and/or when diagnosis was undetermined. This study participant's desire to "stabilize" his care echoes that of many other study participants. It voices the need to establish routine preventive "wellness" healthcare among homeless bisexual young adult men and the urgency to develop a relationship with a primary healthcare provider.

Pre-exposure Prophylaxis (PreP)

Another subgroup identified during the analysis that experienced fragmented healthcare was bisexual and gay men accessing PreP. Thirteen percent (4) of the sample size disclosed that they were on PreP or considering starting it (one bisexual and three gay men). They were offered PreP mainly at LGBTQ-specific health centers. According to their reports, PreP treatment consisted of a medication regimen that was difficult to follow being homeless. It requires consistent follow-ups and evaluation with primary care providers. However, only one respondent in this subgroup had established a primary care provider. The rest were unable to do so because they utilized different healthcare centers for brief preventive care and not for routine preventive "wellness" healthcare.

Shelter Hours of Operation as a Barrier to Care

There were no significant differences between HIV-positive bisexual and gay men accessing healthcare. However, homeless shelters' operating hours were a major deterrent in accessing healthcare among both groups. According to their reports, NYC homeless shelters are strictly for sleeping. Shelters only accept homeless persons during certain hours at nights and evict them early in the morning. According to study participants, this gravely affected their health and their access to healthcare.

> So depending on what shelter you're in, trying to keep an appointment
> has been the most difficult because they kick you out at like six in the
> morning so then when it's time for you to go to your appointment, my
> experience has been where I'll leave the shelter early, or I'll get on the
> train and I'll fall asleep or pass out. So I'll miss the appointment or it'll be

some kind of obstacle, like the shelter won't give you carfare to go. [29, Black, Bisexual, Male]

It's kind of hard to keep appointments when you're tired all the time and moving from place to place. Like most of the time you're so focused on where you are at or where you're going to be going next that anything else is secondary. So I think something that would be helpful is if doctors offices or doctors themselves would check in at shelters or drop-in spaces where people spend a lot of their time or they can go there for resources.

Just when you're homeless, you're exposed to a lot. Like if you're living in a shelter, if one person catches a cold in that shelter the whole shelter gets it. If you're waking up at 6 o'clock in the morning you have to be out until 10:30 or 11 and it's slowly draining you; it's a lot of stress. Being homeless is actually a lot more expensive than people think it is. You always have to have money to go somewhere, to be on the train, have money for food. It's actually really expensive and when you have a place, you can just sit. You can just sit in - even if you just want to make a pot of spaghetti, you have food for the whole day. It takes a lot of the anxiety away from just living. Anxiety is really bad for your health, especially when you're HIV-positive. [24, Mixed Race, Bisexual, Male]

Here, it is apparent that homeless shelter hours have an enormous impact on the health of HIV-positive study participants. Shelters open entry very late at night and then

discharge clients very early in the morning. These hours of operation take a toll on participants' health, particularly when it occurs every day, triggering a host of physical and mental health issues like lack of sleep, fatigue, anxiety, and stress. Hours of operations were also associated with missing medical appointments, which were critical problems for HIV-positive participants. Medical appointments were necessary for follow-up care and medication refills that cannot go unfilled. Missed refills can result in lack of adherence to medication, which causes drug resistance, a serious detriment to the health of HIV-positive patients. One participant suggested having medical providers stationed at homeless shelters, which suggests a need for more (and consistent) healthcare at NYC shelters. Lastly, lack of stable housing interrupted study participants' ability to sleep, rest, and adequately recuperate. It also affected their mental health and their ability to secure food.

Mental and Behavioral Health Needs

There was a significant proportion of participants (29, 97%) who reported mental/behavioral needs in the study sample; only one participant disclosed no mental/behavioral health concerns. This result diverges from the survey questionnaire results, which indicated that only 12 (40%) study participants had mental/behavioral health issues. As a reminder, studies have shown that homelessness has serious mental health implications like depression, risk of suicide, and anxiety. Homelessness also impacts the behavioral health of homeless bisexual and gay young adult men through behaviors such as substance use, smoking, poor diet, and justice-involved activities. Justice-involved activities (a term used to describe illegal activities/behavior) usually occur as a result of survival strategies, such as when participants steal food in the face of

hunger, jump subway turnstiles to sleep in the subway, or attend medical appointments. However, the issue is not the activity per se but the consequences they face once they are involved in the justice system. LGBTQ youth, in particular, face a disproportionate degree of assaults and violence in the justice system (Beck, 2012). I discuss mental health and behavioral health separately and describe their interconnectedness with homelessness and access to healthcare and healthcare utilization. Table 11 shows 15 mental health and behavioral conditions discussed by study participants in the order of most common to least common.

Bisexual men's account of mental/behavioral conditions were greater compared to gay men—55 and 32 respectively. Twelve (71%) bisexual men reported more than one mental/behavioral health condition versus 7 (54%) of gay men. Furthermore, bisexual men were shown to have a greater mental health disease burden in the following conditions compared to gay men—substance use (6:1), bipolar disorder (6:3), ADHD (5:1), and schizophrenia (5:1).

Overall, the mean for all participants with mental/behavioral problems was 6. However, the mean for bisexual men was double that of gay men—4 and 2, respectively, which clearly indicates that mental health conditions were more common in bisexual men that gay men. The median was also higher for bisexual men than gay men—4 and 2, respectively. There was a greater discrepancy with the mode: 6 for bisexual men and 1 for gay men. The overall standard deviation was 4.0, but bisexuals had a slightly greater rate (3) than gay men (2). When broken down into separate behavioral and mental health groupings, bisexual men reported more mental health issues than gay men—38 and 22

respectively. Similarly, bisexual men's account of behavioral health problems were more than gay men—17 and 10 respectively.

Behavioral Health

Nineteen (63%) participants experienced one or more behavioral health issues. In particular, I have chosen to describe the following three behavioral health categories that emerged during the analysis: justice-involved activities, substance use, and incarceration. Unfortunately, based on my experience with this community and studies on LGBTQ youth in general, other common behavioral health conditions such as smoking and poor diet were either not discussed in detail or not discussed at all, so they will not be explored here.

Justice-involved activity. Justice-involved activity was pervasive among the participants. About half of the participants in the sample reported justice-involved activities. However, there were variations in the type and frequency of activities described. About a third of the participants were involved in minor activities like jumping the turnstiles in the subway (when all other access to transportation options failed). Nevertheless, several participants received a summons for jumping the turnstiles. It was reported that lack of proper government-issued identification at the time (a common problem among homeless LGBTQ young adults who are rejected from home) of the summons resulted in their arrest. One respondent reported that there were multiple warrants out for his arrest regarding his failure to show up in court for turnstile summons. For more severe justice-involved activities like verbal altercations, fights, and assaults, they occurred equally between bisexual and gay men; however, this study was not able to

capture the health implications of these activities. Nevertheless, the literature suggests that crime-involved activities have serious ramifications for the health and well-being of bisexual and gay men. The fact that they must jump the subway turnstile to attend their medical appointments reflects a systematic gap in access to healthcare.

Substance use. Seven study participants reported a history of substance use. Of this group, four were bisexual and three were gay. Their drug of choice was primarily alcohol. However, one reported marijuana use and another chose not to disclose which drug he used. This study was not able to determine the amount of substance used per participant. Nonetheless, the use of alcohol was severe enough to result in justice-involved activities such as violence, physical altercation, or even incarceration as evidenced in the following quote:

> My last year in high school, I was almost going to 12th grade, at that age
> I feel like I didn't need the medication anymore. That I could do it on my
> own. It kind of messed me up. I didn't graduate, I wound up going to a
> GED program that I never completed. I ended up being homeless and
> incarcerated and all this other stuff. My main thing is now trying to get
> back on my medication as soon as possible. I'm 26 years old. I just want
> a better life. I don't want to be doing this homeless transient thing
> anymore. I want to get my housing arrangement set up first. I'm not
> really a big fan of the shelter system. So I've been having a little bit of a
> problem with alcohol lately. I never really drank a lot but it's starting to
> get to a point where I don't want to keep drinking. The last time I drank
> was two weeks ago and I'm trying not to start that habit back up. Before I

was incarcerated, I was drinking like crazy. The outpatient [program]

that I'm going to is helping me to stop drinking. [26, White, Bisexual,

Male]

Per this participant's account, he grapples with a history of alcohol abuse. However, it appears that after stopping his psychiatric medication, his alcohol addiction escalated. Consequently, this affected other areas of his life such as education and housing. He was unable to complete his high school education and secure housing. Moreover, his substance use led him in and out of the justice system.

Participants (like this bisexual participant) reported accessing inpatient and outpatient drug treatment programs to manage their addiction. These programs serve as an entry into the healthcare system because they provide counseling services and support groups. The fact that this participant felt that he needed his psychiatric medication suggests that he was contemplating on improving his access to healthcare. His desire to use an outpatient substance treatment program will provide an opportunity to help him recover and improve his health. Lastly, the participant's distaste for homeless shelters suggest that there might not be adequate services in the shelter for a bisexual man.

History of incarceration.

Six study participants disclosed a history of recent incarceration. Of this group, three were bisexual men and three were gay men. Some participants were recently discharged from jail (within the last year), while other participants were incarcerated a year or more ago. The duration of incarceration varied from a range of one month to two years. During their incarceration, participants reported that the justice system provided

them with routine healthcare, but it often ended soon after their release as indicated in the following quote:

> As opposed to the upstate prison where you might never see a doctor. You're guaranteed to see a doctor when you're at Rikers Island [NYC jail] so the healthcare there's not bad at all.

> Interviewer: So in the past year you haven't had any physical, what about vaccinations? Flu shots? HIV testing?
>
> Interviewee: Yes at Fortune Society… It's a program I go to, it helps keep men out of prison.
>
> Interviewer: Do you have a history of or have you been in prison or jail?
>
> Interviewee: Once, yes. For a couple of months. [26, Black, Gay, Male]

Here, it seems that only certain aspects of the justice system provide adequate healthcare. Once participants are discharged from the justice system, it is a challenge to re-establish healthcare. One participant was referred to an agency that serves individuals who are discharged from the military. This participant saw a counselor at the agency which enabled him initial access to healthcare, but it seemed as though securing housing was his priority rather than accessing healthcare services, which is a common phenomenon among study participants. The need for housing seems to supersede healthcare and most other needs, making it challenging for participants to access healthcare and more specifically, routine preventive "wellness" healthcare.

Mental Health

As per Table 11, mental health conditions were reported 60 times by study participants, indicating that most have one or more mental health problem. Many of these mental health problems were diagnosed before participants became homeless. The inability to manage mental health problems seems to trigger a host of problems for bisexual and gay men, such as mental instability and a reduced ability to negotiate with others regarding sexual orientation issues, particularly at a time when they are exploring their sexual orientation. Below, I discuss the two most common mental health conditions (depression and feeling stressed/overwhelmed) described by study participants that seemed to be associated with or exacerbated by homelessness.

Depression. The first common mental health issue was depression. Twelve (40%) participants reported a history of, or treatment for, depression. Within this group, nine (53%) bisexual men reported depression as a problem versus three (23%) gay men. Both groups seemed to have co-morbid mental health conditions like depression, schizophrenia, and asthma. Very few participants specifically mentioned access to mental health services or treatment of mental health conditions. It was clear that depression overlapped with feeling stressed and overwhelmed as indicated in the quote below:

> I have ADHD, bipolar disorder, and depression. And I've been collecting SSI [Social Security Income] ever since I was a little kid. My uncle helped me get the process started for my SSI in 2010, and I was accepted again in 2012. I was getting a little bit of money from that, but after all the money my uncle gave me to help me out here and there, I thought it was only right to give them back the money: not all of it but a little bit so

I have some for myself. I was giving my uncle 80% [of SSI benefits] and

keeping 20%, and then I confronted him about it, and he told me he spent

it all because he thought I wasn't responsible enough. Then I was

incarcerated for two years and now I'm just trying to get back on [SSI]

now. I got denied twice for SSI again because I didn't have enough

medical proof because I'm not taking my medication right now and I

have to get blood work done. I'll be seeing a psychiatrist on Thursday

again so hopefully I'll get back on my medication. [26, White, Bisexual,

Male]

Interviewer: Did you miss the appointment because of the stress of being

homeless or did you miss the appointment because there weren't

available when you are available? What are the reasons you think you

missed it?

I think those to have to do with it but it's like a chain of events.

Sometimes there are other things that happened over the course of days

that led to me missing the appointment, that made me tired or make me

not want to go or make me not wake up. It's usually just a chain of events

that led to not going to the appointment. That usually has something to

do directly with homelessness in some way shape or form. [21, Mixed

race, Gay, Male]

Here, it is evident that homelessness has gravely affected the mental health of the

participants through chains of events, which have had a ripple effect on their mental

health and general well-being. One participant described the agony of having to manage

his condition without medication and the severe consequences it has had on his life.

Consequences included his undecisive sexual orientation, his inability to manage his

benefits on his own, the misuse/abuse of government benefits by a family member, denial

of benefits by the government, substance use (disclosed elsewhere in the interview but

important to share here), and a history of incarceration. Although he had a mental health

diagnosis prior to homelessness, the cascade of events occurring after he became

homeless inhibited his access to healthcare so severely that he misplaced his medical

records to prove his mental illness. The fact that he had to go to a homeless program to

get a referral to see a psychiatrist and get blood test done demonstrates his desperate need

for access to healthcare. As the other study participant described, when "other things get

in the way" while homeless, it takes a toll on the mental health of bisexual and gay men.

They become exhausted, unmotivated, and depressed to the extent that they have no

desire or energy to pursue healthcare or attend medical appointments.

Feeling stressed and overwhelmed. Stress and overwhelming feelings were

reported by the participants due mostly to the multiple challenges of homelessness, and

less frequently, due to inhibited access to healthcare. Factors that caused stress were

work, work training, multi-tasking (going to work and school), expiration of Medicaid

government benefits, lack of financial support, and lack of sleep. A few participants

reported that medical conditions and problems with health insurance also caused some

stress. Thirteen (40%) participants reported feeling stress or overwhelmed. Within this

group, seven (54%) gay men and six (35%) bisexual men reported feeling stressed and

overwhelmed.

Like, you have basically totally free healthcare, but you have to do what

they say when they say to do it. It was more stress than it was worth, I

never really needed it. And the things I needed it for, it barely covered it.

I ended up paying lots of money for skin cream [for eczema], or if I had

ADHD and had to take medication to control it, it was still so very

expensive. A couple of hundred dollars for medications and pills. I had

to take days off of work to go to these meetings [medical appointments

and benefits meetings], I have to do all these things. [25, Black,

Bisexual, Male]

This participant seemed overwhelmed by having to access healthcare. Even

though healthcare services were available at no cost, the type of services available were

limited. Furthermore, the policies and procedures of the healthcare institutions accessed

exceeded his ability to comply. Despite these challenges, he was forced to adhere to

institutional standards, which proved to be a deterrent on his ability to access and utilize

healthcare.

Two other components of access to healthcare addressed here were coverage for

medication and employment. It seemed as though this participant did not have adequate

insurance coverage for the medication he needed to treat his condition, which created an

additional barrier to healthcare. The cost of his medication was too high, making it

challenging for him to manage a chronic condition.

Taking leave from work was another barrier to healthcare. For many participants,

securing employment is difficult. Quite frequently, the jobs they are able to get are part-

time and unsteady. Having to take leave from work for medical appointments cuts into

their salaries, making it harder to earn ample wages. Additionally, employers may be reluctant give a leave from work, particularly if employees are working temporarily or recently started the job. Navigating the healthcare system and bureaucracy is cumbersome for a population that is already underserved with very limited resources. This burden adds another dimension of stress to the mental health conditions they already face.

Competing Needs

Apart from challenges emerging from physical and mental/behavioral health conditions, participants disclosed other competing needs including the need for income, food, education, housing, employment, and clothing. Participants felt that money would give them access to healthcare and transportation and help pay for medication, co-payments, and transportation to and from healthcare agencies. Food was associated with homeless programs, nutrition, and socializing. Participants shared that the only meals of nutritional value they received were through homeless programs. At these programs, they were able to socialize with their peers leading to better access to healthcare, because peers share information about healthcare services and other valuable resources available in NYC.

Employment among study participants was temporary, sporadic, and inconsistent. During the interviews, they disclosed how difficult it was to work or keep a job and keep medical appointments as well. Many study participants who gained employment lost their health insurance due to the fact that their insurance was tied to government benefits, which they received when under the poverty level. As for education, very few participants expressed an interest in pursuing an education. Those who did, disclosed

how challenging it was to be homeless and/or working while in school. Lastly, securing clothing was an issue among a few participants, and they typically went to various homeless programs to get adequate clothing to wear.

Unmet Medical Needs

Three unmet medical needs beyond those of routine primary preventive "wellness" care were identified—dental care, nutritional care, and ophthalmological care. Sixteen (53%) study participants in the sample size reported having issues with dental care while homeless. Of this group, bisexual men represented 47% (8) and gay men 62% (8). Tooth decay was the most common dental problem. Other dental issues included getting dentures, crowns, root canals, braces, abscesses, and the need for tooth removal. Only one respondent discussed preventive dental care such as routine teeth cleaning. He was able to access dental care through one of the LGBTQ health centers that provided comprehensive healthcare services. Even though study participants were referred to a dental clinic for routine dental care, many accessed hospital ERs instead. It was unclear why study participants didn't access routine dental care, but it may be the same reasons they didn't access routine preventive "wellness" healthcare.

Six (20%) participants disclosed nutrition as a health issue. Of this group, five (83%) were bisexual men and one (17%) was gay. Dieting was the most common nutrition issue discussed. Participants were interested in special diets, vegetarian diets, weight loss diets, and nutritional classes. Other concerns reported included weight gain from the adverse effects of psychiatric medication, nutrition to combat medical issues (like diabetes), and fear of weight loss, specifically among HIV-positive participants.

Ophthalmological (eye) care was discussed by four (13%) participants. Of this group, three (75%) were bisexual men and one (25%) was gay. Eye examinations and getting a prescription for spectacles were among their most common concerns.

Summary

In this chapter, I discussed the physical and mental/behavioral health conditions affecting homeless bisexual and gay young men in NYC. There was a dramatic difference with study participants' responses from the survey questionnaire compared to the interviews. The interview discussions unearthed a plethora of health information regarding participants' healthcare needs. The study results showed that, on average, bisexual men had more physical and mental/behavioral health problems than gay men.

HIV prevention services (like HIV testing) were the most common healthcare need discussed among study participants mainly because it was readily available at places they accessed. However, these services were only brief encounters with the healthcare system in NYC, often leaving study participants with limited or no routine preventive "wellness" care. Though HIV testing services were available to the participants, stigma was associated with medical mobile vans providing these services. The only participants who received routine preventive "wellness" care were those who were HIV-positive. However, homeless shelters' operating hours interrupted their access to and utilization of routine healthcare.

Mental/behavioral health added a different dimension to healthcare need. More bisexual men were shown to have more than one mental health condition than gay men. However, unlike the recurrent brief encounters with preventive healthcare services, access to mental health services was hardly discussed. Study participants struggled

immensely with managing mental health problems, most of which they had before homelessness. Nonetheless, the hardship of homelessness intensified the feelings of stress and overwhelmment with study participants.

With respect to behavioral health, both bisexual and gay men reported issues of justice-involved activities, substance use, and a history of incarceration which further complicated their access to and utilization of healthcare. Jumping the subway turnstile seems like a common behavior with study participants putting them at risk for arrests, summons, and encounters with the justice system.

Study participants were also found to have other unmet specialty medical needs, such as dental care, nutritional care, and ophthalmological care, demanding the need for more comprehensive healthcare services beyond that of the traditional HIV/STI testing and basic preventive care. The next chapter discusses the nuance of navigating the healthcare system in NYC and highlights the barriers and facilitators of healthcare found among the participants.

Chapter 8

Qualitative Results

Access and Utilization

In this chapter, I discuss the participants' responses regarding access to healthcare and healthcare utilization. As a reminder, I define access to healthcare as entry into the appropriate healthcare services at the right time in a way that contributes to better health outcomes and decreases disease burden among individuals and communities (Andersen and Davidson, 2001; IOM, 2001). Here, utilization of healthcare refers to access to primary care and preventive "wellness" care, including annual physicals and check-ups. As previously noted, participants' audiotaped responses were first transcribed and then coded for analysis utilizing NVivo, a qualitative data analysis software package. Iterative reviews of transcripts were conducted to develop coding categories and identify themes related to healthcare access and utilization.

In specific, this chapter addresses the following three research questions: 1) What facilitates access to healthcare (with an emphasis on preventive care) among homeless bisexual young adult men in NYC and homeless gay young adult men in NYC? 2) What are the barriers to healthcare (with an emphasis on preventive care) among homeless bisexual young adult men in NYC and homeless gay young adult men in NYC? 3) Where, when, and *how frequently* do homeless bisexual young adult men in NYC access healthcare and how does this compare to the utilization patterns of homeless gay young adult men in NYC?

Two major themes surfaced during the analysis—fragmentation of access to healthcare and cyclical navigation of the healthcare system, which, at times, overlapp

each other. For instance, when participants accessed healthcare, they faced a series of obstacles, which made it difficult to establish routine preventive healthcare. Access to and utilization of healthcare was usually interrupted due to the cancellation and/or recertification of government benefits, change of healthcare provider, shelter relocation, negative experience at healthcare center, lack of required medical documentation, delay in the bureaucratic process of healthcare benefits, and the type of healthcare being accessed. Instead, participants primarily accessed HIV/STI testing sites even if they were not "at risk" for HIV.

Due to this type of fragmentation of healthcare, participants repeatedly re-enter the healthcare system, often at different facilities or at places that only provided acute healthcare, such as hospital ERs. Therefore, for this analysis, I am not following the sequential order of objectives as I did in Chapter 7. Instead, I have developed categories and subcategories that are critical to describing the lived experiences of homeless bisexual and gay young adult men in NYC. Within the two themes of fragmentation and cyclical navigation, I address the three research questions in the following reverse order: utilization of healthcare, preceded by barriers to healthcare access and utilization, and facilitators of access to and utilization of healthcare.

Given the complexity of healthcare access and utilization as experienced by study participants, I developed the conceptual model (see Figure 11) to illustrate my findings while highlighting the salient points. The model is divided into three parts, reflecting three phases of access to healthcare and utilization of healthcare—Phase 1: initial access to care, Phase 2: barriers and facilitators to care, and Phase3: maintenance of care.

In Phase 1, study participants described the initial entry to healthcare as occurring primarily through their peers—other homeless bisexual and gay men. Often, their access to healthcare was primarily intermittent and brief, through HIV/STI testing sites or hospital ER visits, the latter of which is discussed at length later in this chapter. This was described as a cyclical back and forth occurrence—repeated brief entries into the healthcare system via HIV/STI screening. Other means of entry into the healthcare system occurred through homeless programs (like shelters and substance abuse treatment programs), justice-system programs (like jail or prison), and/or when participants self-referred themselves to ERs because of an illness. These alternative entry points were also found to connect some participants (albeit very few) to different areas of healthcare in Phase 3 such as primary care, specialty care, and/or routine healthcare.

Phase 2 lays out the barriers and facilitators to healthcare. This phase is crucial, as it determines whether participants will establish routine preventive healthcare. Barriers included breaks in communication (provider's disinterest in discussing sexual health or referrals to benefits), issues with government benefits (such as inability to recertify), lack of transportation (such as inability to purchase MetroCards), and participants' misunderstanding of routine preventive healthcare care. In the Barriers box, the arrow points back towards Phase 1, illustrating the way in which participants return to the cycle of brief, repeated re-entry into healthcare if these barriers are not addressed. On the other hand, some study participants experienced healthcare facilitators, including social support (peer-based), compassionate healthcare providers, provision of incentives (such as MetroCards and food), and comprehensive, accessible healthcare options (primary care, psychiatry, dermatology, and dental) offered together at one location.

Under Phase2, the Facilitator box points forward to Phase 3 (Maintenance of Care),

highlighting the pathways that enabled participants to gain access to regular utilization of

healthcare. Quite often, study participants moved temporarily from Phase 2 to Phase 3

when their government benefits were activated, but this didn't last for long due to

recertification problems.

Phase 3 describes the point at which participants established healthcare

maintenance with a regular provider. Very few participants reached this phase due to the

expiration of benefits, the challenges of the homeless shelter system, and transportation

issues. Together, these barriers led to the fragmentation of healthcare and the cyclical

navigation process, as study participants were continuously shuffled between Phase 1 and

Phase 2. In the next part of this chapter, I describe the three phases of healthcare access

and utilization as experienced by study participants in detail.

{See Figure 11 in the next page}
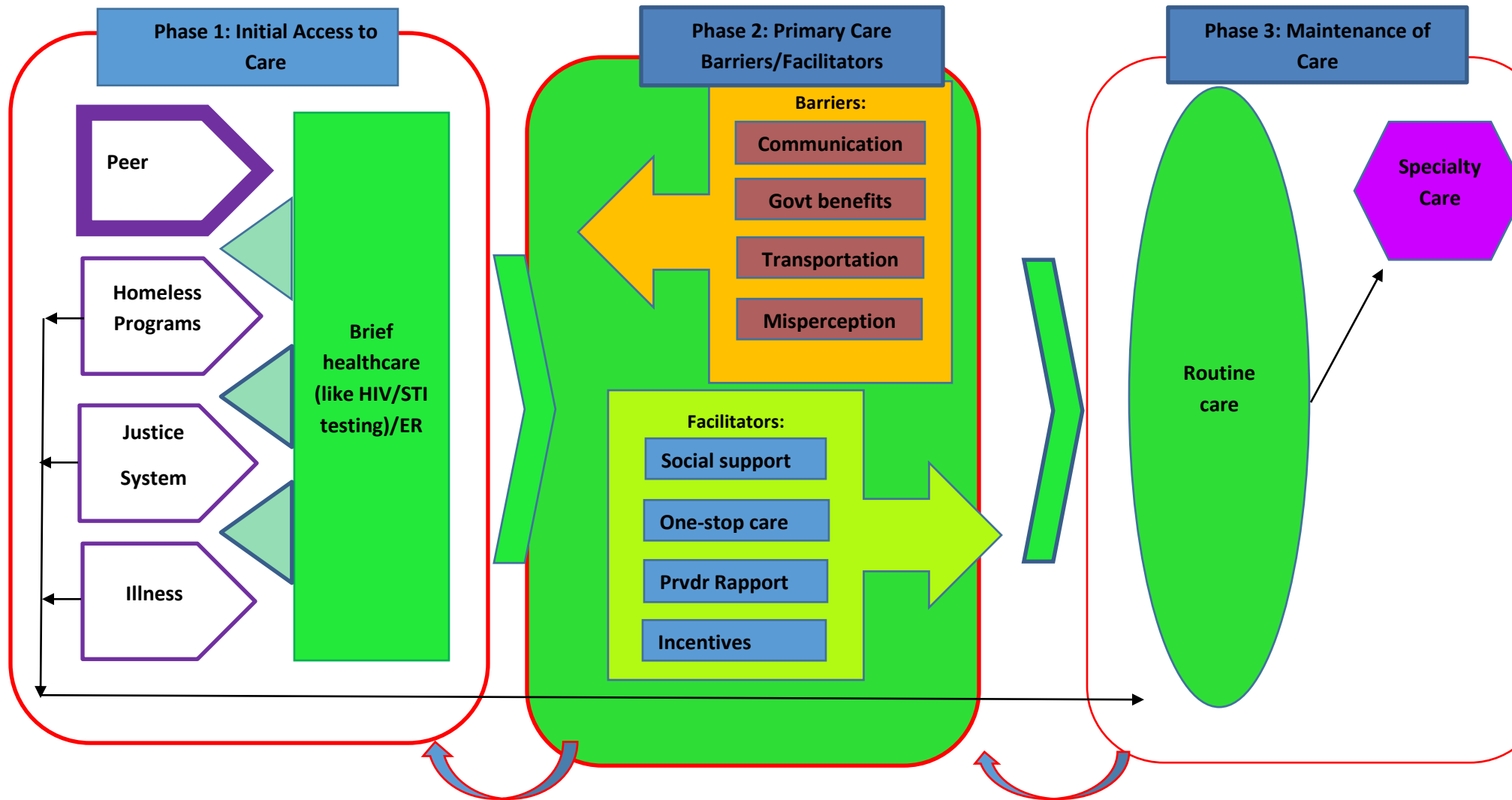
Figure 11. Phases of healthcare access and utilization

Fragmentation of Care ("Ping-Ponging")

There were striking differences between the interview results and the survey questionnaire results concerning access to and utilization of healthcare. For the purpose of this study, a healthcare agency is defined as any institution, agency, or program that provides medical care (including STI/HIV testing) and/or mental health services. These include hospitals, healthcare clinics, community health centers, STI/HIV testing centers, MVCs, and private doctor's offices. Participants' descriptions of access to and utilization of healthcare agencies were broad, varying, and extremely convoluted. This was very different from their responses to the survey questionnaire, in which an overwhelming number of participants reported having a routine place for healthcare. Furthermore, 66% reported that they received routine preventive healthcare within the last 12 months. However, both the absence of access to healthcare and fragmentation of healthcare was profoundly common among all participants. For instance, some participants routinely accessed more than one healthcare agency, some accessed healthcare only when in dire need, some used it intermittently, and a few participants never accessed it at all. According to the IOM and Andersen's (1993; 2001) definition of access to healthcare, homeless bisexual and gay young men rarely accessed healthcare at all.

Many participants reported dropping in and out of healthcare, and they frequently accessed healthcare only through MVCs and/or STI/HIV testing sites. This contradicted their responses to the survey questionnaire, in which all participants reported that they did not go to more than one place for healthcare services, and only two reported using MVCs (which usually provided HIV testing and STI screening). Some participants accessed one healthcare center for primary care and then another facility for other types of healthcare

services. Very few participants used only a single healthcare site for the entire period in which they had been homeless. If they did use only one site, it was mainly for HIV testing. One participant referred to accessing healthcare agencies as "ping-ponging" between clinics, health centers, and hospitals depending on his medical and mental health needs. This "ping-ponging" ultimately appeared to widen the gap in access to and utilization of preventive healthcare. The fact that participants answered yes to having routine healthcare in the survey questionnaire may reflect a misunderstanding that brief HIV/STI testing is routine healthcare or the research question did not properly address the question as intended.

Utilization of NYC Healthcare Services

In sum, participants reported having accessed a total of 38 different NYC healthcare agencies on at least a 100 different occasions during the period in which they had been homeless, with many participants accessing more than one agency. In Figure 12, I note the location of some of the hospitals, health centers, and homeless shelters used by the participants. The majority of these homeless services were located in Manhattan. This concentration of resources made it very difficult to use healthcare services because a large number of participants lived in other boroughs. Participants who lived outside of Manhattan required transportation to and from these healthcare facilities, adding another layer of complexity to their healthcare utilization experience.

Table 12 lists healthcare agencies used by the participants. As stated earlier, their interview responses differed dramatically from their survey questionnaire responses. In the questionnaire, an equal number of bisexual and gay participants (n=11) reported

accessing healthcare agencies (not including hospitals), whereas in the interview

discussion, participants accessed healthcare agencies a total of 58 times, with some

participants accessing more than one agency since the onset of homelessness. Even

though bisexual men made up a larger proportion of the study sample size, their reported

use of healthcare agencies was only 20 times compared to gay participants—38 times.

Similarly, this underrepresentation of healthcare utilization was also shown in the mean

results of the two groups, whereby bisexual men had a mean of 1.33 versus gay men who

had a mean of 1.5. Conversely, Table 13 shows the opposite results whereby bisexual

men used hospital ERs 29 times versus gay men who used it 11 times. Additionally,

discrepancies were found in the mean between the groups—bisexual men at 1.8 and gay

men 0.69. While the results show that bisexual men were accessing healthcare, the type

of healthcare they were accessing was alarming. The frequent use of hospital ERs

strongly suggests that they are not using healthcare agencies, more specifically healthcare

agencies that are designed for LGBTQ-specific individuals.
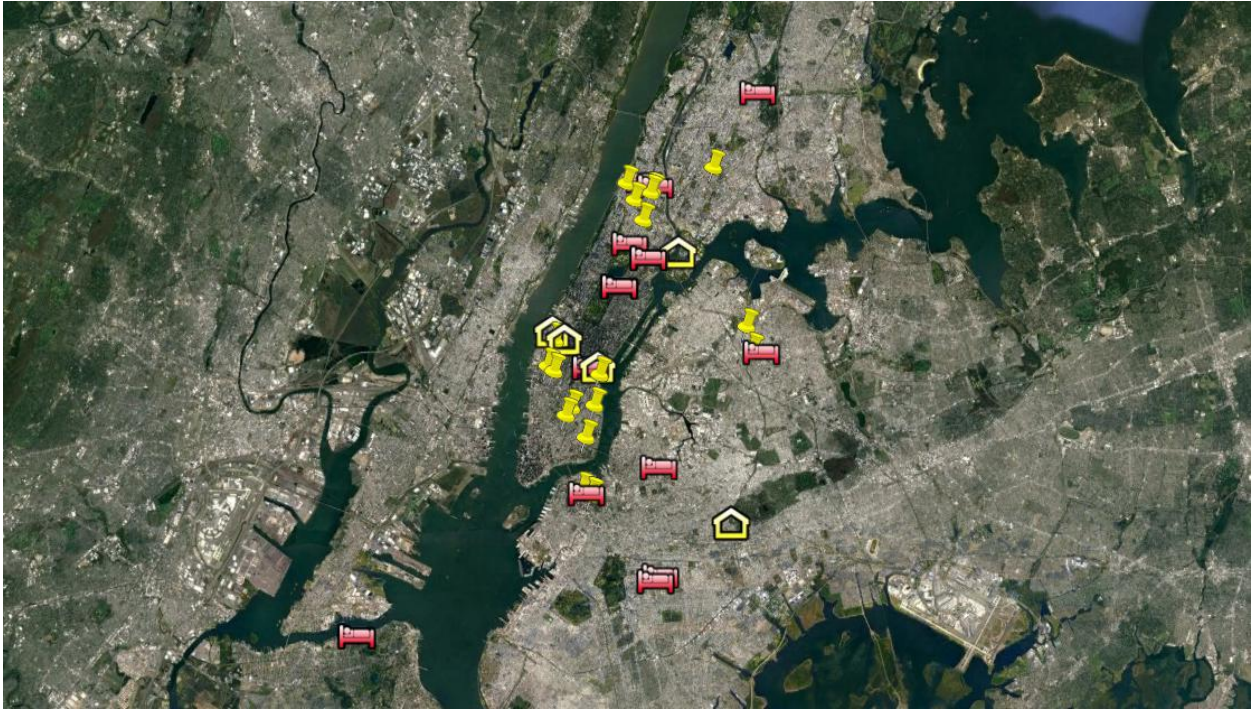
Figure 12. Geographic location of homeless shelters (⌂), healthcare centers (📍), and

hospitals (🛏) (Google Maps, 2017)

[Note: Not all agencies are listed on the map, as some have multiple sites throughout the

city, but these are the most commonly used.]

Below, I provide brief descriptive "snapshots" of the four agencies most

commonly utilized by study participants. These snapshots will provide a sense of where,

when, and how frequently participants accessed healthcare. The four healthcare facilities

are healthcare agency-Zed (accessed by 10 participants), healthcare agency-Linden

(accessed by 8 participants), hospital-Butterfly (accessed by 7 participants), and hospital-

Moth (accessed by 7 participants). Seventy-three percent (n=22) of the participants

accessed these facilities 32 times, with some participants accessing multiple agencies

during the length of their homelessness. Of this amount, 65% (n=11) were bisexual men

and 85% (n=11) were gay men. Bisexual participants accessed these four healthcare

facilities 18 times compared to 14 times by gay participants. Importantly, each of these

facilities offer a different suite of healthcare services; for instance, Zed is a full-fledged,

community-based healthcare agency and housing provider that targets LGBTQ

individuals and members of marginalized communities. Zed was accessed by a slightly

greater number of gay participants—6 (35%) versus 4 (31%) bisexual participants—even

though bisexual participants represent the larger subsample. Linden was one of the first

official LGBTQ-specific community healthcare agencies in NYC to provide primary care

services for the community. Twenty-four percent (n=4) of bisexual and 31% (n=4) of

gay men accessed this center even though bisexual participants represent the larger

subsample.

A total of 14 participants accessed Butterfly and Moth hospital ERs. Bisexual

men were overrepresented at 10 (59%) when compared to 4 (31%) gay men. Bisexual

participants accessed hospital-Butterfly ER for the following reasons: it was familiar to

them, it was known to provide homeless shelter services, they grew up in the

communities they used hospitals, and/or it provided housing services for veterans. Gay

participants reported accessing hospital-Butterfly ER because it provided homeless

shelter services as well as proof of homeless status for government benefits. Bisexual

participants chose to access hospital-Moth ER because they wanted professional medical

providers, their medical provider was associated with the hospital, and/or it was the

closest facility to their location at the time they needed care. Gay participants accessed it

due to its proximity to where they were located when they needed emergency care.

Although hospital-Moth has several sites scattered throughout the city, participants most

frequently accessed the Chelsea and Midtown West locations, which are in close

proximity to neighborhoods historically known to offer services and resources for the LGBTQ community. The total number of hospitals accessed among study participants were 16. Fifty-nine percent (n=10) of bisexual men reported using ERs 29 times compared to 62% (n=8) of gay men who used them 11 times. Even though the proportion of bisexual and gay men using ER is similar, the frequency of ER usage was greater among bisexual men than gay men.

There was another trend in access to and utilization of healthcare; some homeless shelters and homeless drop-in centers provided healthcare services to participants, either via a collocated medical clinic or a mobile medical van in proximity to the shelter/center. For this study, these healthcare agencies were divided into two groups—*LGBTQ-centric shelters/centers* and *non-LGBTQ shelters/centers*. In these groups combined, bisexual participants reported accessing these centers 17 times compared to gay men who reported 23 times (even though bisexuals represented the larger sample group). Of those, 27 participants reported accessing specifically *LGBTQ-centric healthcare agencies*, of which bisexual men reported 14 times and gay men reported 13 times. Regarding access to *non-LGBTQ shelters/centers*, bisexual men reported 7 times while gay men reported 6.

Eight (27%) participants did not recall the name of the healthcare center they accessed. Bisexual men and gay men were equally represented in this subgroup. Some had a vague remembrance of the center, and all articulated that they had accessed a health center and not a hospital. Eleven (36%) study participants reported having had access to healthcare before becoming homeless, as evidenced in the following quote:

Interviewer: Since you became homeless, what has been your experience with access to healthcare?

Interviewee: I was getting SSI since I was seven for bipolar disorder. [25, White, Bisexual, Male]

The participant quoted above was diagnosed with a chronic mental health condition at a very young age. Many participants had received mental health diagnoses prior to becoming homeless, but this study was unable to determine whether their homelessness was caused by an inability to manage mental health problems or whether their mental health problems were exacerbated by homelessness.

This participant was also receiving government benefits, which served as a gateway to healthcare. Some government benefits (like Medicaid) enabled access to healthcare because it provides free or low-cost health insurance to those who qualify. This is discussed in length later in this chapter. However, the fact that the participant above had government benefits since the age of seven suggests that he may have had access to healthcare throughout young adulthood. But as with many other participants, several factors influenced his access to healthcare, including the interruption of government benefits, which dramatically affected the management of his mental health symptoms.

Of the 11 participants who reported having had access to healthcare before becoming homeless, eight (47%) were bisexual men and three (23%) were gay men. Bisexual men reported gaining access to healthcare before becoming homeless mainly due to having had health insurance, getting referrals to affordable healthcare, accessing

healthcare services in another state, the type of medical issue (like TB), incarceration, non-homeless sheltered living, and familiarity with a healthcare institution. Gay men reported having had access to healthcare before homelessness due to being on a parent's health insurance, Medicaid eligibility due to a pre-existing condition (like schizophrenia), and/or non-homeless sheltered living. Once homeless, healthcare, specifically routine preventive healthcare, became fragmented and inconsistent for most participants.

Barriers to healthcare access and utilization

Fragmentation of healthcare in and of itself was a barrier to routine preventive healthcare. This barred the establishment and follow-up of proper healthcare as defined by IOM and Andersen's standards (Andersen and Davidson, 2001; IOM, 1993). Fragmentation of healthcare led to behavioral shifts not only in individuals seeking healthcare but also in the healthcare system itself. Most of the services utilized were rapid and simple screenings that involved brief encounters with a healthcare provider, not necessarily a physician. Likewise, the majority of services targeting homeless bisexual and gay men were HIV/STI testing. Undoubtedly, fragmentation curbed the habit of routine preventive healthcare, making it very challenging for bisexual and gay men to establish healthcare routines and build trust with providers.

Issues with access and adherence to medication was a subcomponent of healthcare that was problematic for study participants. In this study, participants reported the fragmentation of access to and utilization of medication that was similar to their experience with the healthcare system in general. About half the participants encountered barriers when attempting to obtain medication and medication refills. Barriers included long

distance in proximity to a healthcare agency, difficulty accessing transportation to and from the healthcare facility, no recertification or notification of government benefits, medication copays, and lack of health insurance coverage. Of these, a primary reason for breaks in access to medication was pharmacy location; pharmacies offering free or low-cost medication were generally not located in the areas in which most participants were staying, as described by this participant:

> Through the prescription that Bellevue gave me, I didn't have to pay money because my Medicaid took care of it. But I had to leave Manhattan and take the train all the way to another borough just to get that prescription. [27, Black, Gay, Male]

This study participant reported having government benefits, and as a result, he was entitled to free medication. However, he had to travel to another borough to get his medication. Quite often, participants such as this one, could not afford to pay for transportation to and from medical destinations, meaning that even those who had free health coverage via Medicaid still faced economic obstacles to healthcare services.

Lack of healthcare coverage or lack of insurance further complicated medication access for participants. Even though most men qualified for free or "affordable" medication, the process of acquiring insurance was extremely involved, as is the process of maintaining health insurance (which is discussed later). Additionally, some health insurance plans imposed restrictions that made it challenging to afford medication, as noted by this participant:

> I had insurance for a while, but once I started working they took it away. Once I started working it became hard to keep the appointments that they asked me to

keep so I could keep my health care. And rescheduling was equally as difficult.

Like, you have basically totally free healthcare but you have to do what they say

when they say to do it. It was more stress than it was worth. I never really needed

it. And the things I needed it for, it barely covered it. I ended up paying lots of

money for skin cream, or if I had ADHD and had to take medication to control it,

it was still so very expensive. A couple of hundred dollars for medications and

pills. I had to take days off of work to go to these meetings. I have to do all these

things. [25, Black, Bisexual, Male]

As the participant mentioned in the above quote, government benefits, although

free, came with many restrictions. Once the participant started working, he was unable to

maintain medical appointments (like physicals and mental health follow-up) that was

required for benefit eligibility. As a result, he lost his benefits. For him and many

homeless youths, trying to successfully juggle work, homelessness, and the medical

system presents a variety of social and structural complications that leave them frustrated,

unmotivated, and uninspired to use the healthcare system.

One participant went as far as using the services of an attorney to dispute

insurance eligibility in order to receive medication. A few other participants reported

having to access hospital ERs for medication refills. And even though some participants

did have access to a pharmacy, they could not necessarily afford the co-payment for their

medication. Thus, the participants richly described how a great range of barriers led them

to poor medication adherence, resulting in poor health outcomes.

Basically the medications, when it comes to getting medications. So depending on

what shelter you're in, trying to keep an appointment has been the most difficult

because they kick you out at like six in the morning so then when it's time for you

to go to your appointment, my experience has been where I'll leave the shelter early

or I'll get on the train and I'll fall asleep or pass out. So I'll miss the appointment or

it'll be some kind of obstacle, like the shelter won't give you carfare to go. [29,

Black, Bisexual, Male]

This participant reported a complex, overlapping array of barriers to medication

adherence such as limited shelter hours, exhaustion, missed appointments, and a lack of

transportation. As a rule, limiting factors like these appeared to have an overlapping

effect on each other, making it much harder for the participant to get the healthcare he

needed. Although homeless shelters were available to house the participant, its hours of

operation conflicted with the participant's medical needs. These hours did not allow for

proper rest and recuperation, and instead forced him out on the streets exhausted and

unequipped to confront the other myriad challenges involved in seeking out healthcare. It

is possible that physical exhaustion was the primary culprit behind his missed medical

appointments, but a lack of support and his limited options for transportation certainly

impeded, if not prohibited, his ability to attend his medical appointments.

Communication barrier. A major barrier to gaining access to healthcare was the

lack of clear communication between agencies and participants. Many participants

complained about not having a fixed mailing address where they could receive important

notices regarding benefits. Health insurance, Medicaid, and public assistance routinely

need to be renewed or updated; however, when such renewal notices were sent to the

participants, they did not receive them in time to respond accordingly, hence the

continuous interruption in healthcare services and benefits. Although some participants

have used the NAC as their mailing address, they were not routinely accessing services there and, as a result, missed important letters and deadlines for renewal. In an attempt to stay informed about their benefits and other important resources, a third of all participants (10) in the sample confirmed that they accessed the Internet periodically to check emails for notifications. Two-thirds of these 10 participants were bisexual men, while one third was gay.

Another communication flaw was the inability or unwillingness of medical providers to discuss sexual health and the sexual health needs of bisexual men in particular. Many bisexual participants shared that their providers only discussed sexual identity and not necessarily sexual attraction or sexual behaviors. Lack of discussion about the nature, frequency, and duration of their sexual activities was a major barrier to meeting the healthcare needs of bisexual men because their medical providers could not grasp or advise in accordance with their patients' sexual health needs.

In general, a major concern reported by the participants was the poor customer service they experienced in healthcare settings, particularly when they were medically or mentally compromised. They complained that some medical staff exhibited poor professional etiquette, such as rudeness or insensitivity, and that these staff members sometimes ignored symptoms, acted presumptuously (such as assuming that participants came to the ER to sleep instead of to address a real medical concern), engaged in verbal altercations with them, were judgmental, vindictive, moody, unfriendly, or dismissive, had bad attitudes and/or displayed a lack of empathy, offered no follow-up communication, lacked compassion, understanding, training, and experience, and

discriminated against them. One participant who experienced blatant discrimination while in a psychiatric unit described the following experience:

> Interviewee: I would ask them questions like, "Oh. 'Cause I didn't know being homo was a sin," I said. They was like, "Yeah, it's a sin." I was like, "Oh, I didn't know that." But damn, that's crazy.

> Interviewer: At the psych ward, they told you it's a sin?

> Interviewee: One of them. One of the nurses, but she's very religious. I guess that's her opinion and stuff, like… [24, Black, Bisexual, Male]

Abuse can be verbal, physical, emotional, and written. The participant above experienced verbal discrimination based on his sexual orientation while already mentally compromised and in a psychiatric hospital. Participant responses indicate that staff and/or clinician discrimination was a significant problem for them, thereby proving to be a serious deterrent for homeless LGBTQ youth seeking healthcare. The experience described above suggests that hospital staff were not fully trained regarding cultural sensitivity and competency. Putting this aside for a moment, healthcare professionals are expected to separate their personal biases and beliefs from the care they provide so they can properly treat all patients. This study showed that participants' experiences of discrimination varied not only across different agencies but also among different levels of staff. The threat of discrimination widened the gap in healthcare access, making it difficult for bisexual and gay men to get quality care at a time when they needed it most.

Misperception of preventive healthcare. Participants consistently exhibited what appeared to be misperceptions about healthcare itself during interviews, especially regarding routine preventive healthcare. Most participants understood themselves to have access to healthcare even though they had only brief, fragmented episodes of healthcare such as HIV testing, STI screening, or ER visits. I got the impression that they were not educated or informed about the type of healthcare recommended for homeless bisexual and gay young adult men like routine check-ups, physicals, vaccinations, anal pap-smears, etc. In fact, only a few participants articulated the notion that they had had a routine preventive annual check-up such as a physical and vaccinations any time in the recent past. Some examples of participants' misunderstanding of routine preventive care can be seen in the following interview excerpts:

Interviewer: And what did they do?

Interviewee: I had my temperature taken, they gave me an STD test and blood pressure. It was simple.

Interviewer: Okay. In the past 12 months, you've had a physical?

Interviewee: Yes. They had given me ... When I had the dental abscess, and I went to the Lennox Hospital, they had given me the big tetanus shot and, I think, two prescriptions.

Interviewer: Was there a difference with access to healthcare in California versus New York?

Interviewee: Not really. They have the same thing going on, especially within the community. They have the same outreach and they try to make sure people are tested and things like that. [28, White, Bisexual, Male]

This study participant perceived routine preventive healthcare consisting of basic tests like checking the temperature and blood pressure and STD testing. Even though these medical procedures are only fragments of a routine preventive healthcare visit, it was not an annual checkup. Regretfully, it was this participant's closest experience to an annual physical. His perception of healthcare—devoid of primary healthcare or annual physicals/check-ups—was prevalent among most participants, as was his use of hospital ERs to address acute illness and primary care needs. Moreover, he disclosed that a similar type of situation exists outside of NYC as well—in this case, California.

Participants' misunderstanding of healthcare was even more complicated than their limited understanding of access to healthcare. Some were not able to identify the insurance they used, the medical terms for their conditions, or the medications they had been prescribed. Even though the majority of participants had one or more medical issues requiring routine healthcare and routine follow-ups, their beliefs and behaviors regarding access to healthcare stood in stark opposition to their need for ongoing health and mental health services.

Cyclical navigation of the healthcare system. Cyclical navigation of the healthcare system involved the brief routine and habitual HIV/STI testing. Beyond that, many participants complained about "ping-ponging" between healthcare services, making it very difficult for them to establish routine healthcare. In fact, only a very few participants had established healthcare at one specific site for the duration of their

homelessness. Those who were successful in establishing a source of routine healthcare

usually did so through a familiar hospital ER as opposed to a source of primary or

preventive care. Participants described navigating the healthcare system as bothersome,

time-consuming, bureaucratic, and laborious. Some major underlying factors that made it

difficult for participants to navigate the healthcare system were government benefits,

healthcare insurance, medical records, mail correspondence, and customer service. These

barriers perpetuated participants' cyclical back and forth navigation of the healthcare

system in NYC.

Government benefits. Government benefits like Medicaid, Supplemental

Nutrition Assistance Program (SNAP Food Stamps), and public assistance serve as

critical resources facilitating access to healthcare for the participants. For instance,

during the interviews, 67% of participants disclosed that they either had had Medicaid in

the past, were currently on Medicaid, or had applied for it. Most participants gained

access to government benefits through homeless shelters or programs like the NAC,

which assisted them in gathering the required documents necessary for completing their

applications. However, participants also noted that navigating the bureaucracy to obtain

government benefits was stressful and very time consuming, as detailed below:

> I just had Medicaid and SNAP benefits (food stamps). So it was kind of hard, it's
>
> really hard being homeless with healthcare because I would never really get any
>
> notices for recertification, they would cut off my Medicaid and my medications
>
> that I can't stop taking. The mail situation made it really difficult, not getting my
>
> mail, and sometimes I wanted to make an appointment, but I couldn't even see a
>
> doctor or anything like that. I had to go through the process of recertification. I've

done the process so many times in the last eight years it's not even funny. I've lost count. [30, Black, Gay, Male]

Getting back on Medicaid. Sometimes, especially when you go to the Medicaid office, they require you to have originals and everything. And I've been struggling to get my originals for the longest. Not only that but sometimes they tell you what you have is not acceptable so depending on where you go, but they'll tell you, "Oh, this benefit card has no picture. We can't take it." [24, Black, Bisexual, Male]

Actually, when I first got here, I tried to apply for food stamps and health care all together and I had a big plan to get it all sorted but they sent me the letter in the office, which was like down the street, but by the time I got the letter, it was after the date of the appointment. So I just never tried to get it after that because I felt so disorganized. [23, Black, Gay, Male]

It is annoying because usually you don't know you have to renew it until it's off. Because they're supposed to send you mail but the way that they work it seems like, let's say it's supposed to get shut off in a week and a half to recertify. Unless they put it on your card.

It's not on there. If you call for food stamps, rental assistance, cash assistance, public assistance it'll tell you when it expires. But Medicaid doesn't because it's totally separate.

What they'll do is with the benefit card, when you call and let's say tomorrow I have an appointment to recertify? Though so you have one reminder and then you hit a button and then I'll tell you that you have a recertification tomorrow. But they don't

include Medicaid. And I have no idea why to be honest with you to the best of my

knowledge I think it's because the organizations themselves [sort] out separately.

[24, Black, Bisexual, Male]

While the participants quoted above encountered many roadblocks in attempting

to access and utilize healthcare, they identified the recertification of government benefits

and the requirements of benefits as the central barriers they experienced. The need to

recertify frequently in order to receive government benefits kick started an ugly chain of

events—termination of benefits, which inhibited their ability to make medical

appointments and the subsequent inability to refill medications and stopping adherence to

life-saving medications in its tracks. According to the participants, there were also

inconsistencies folded into the requirements necessary to access government benefits.

For instance, a benefit identification card without a picture was acceptable at some

government agency sites but not at others. Another issue was the inconvenience of

learning that one's Medicaid card had expired. Although participants can call some

government agencies (like SNAPS) for information about expiration dates, Medicaid

doesn't offer such a service, making it much harder to find out about upcoming

recertifications while homeless.

Other examples that posed problems in obtaining government benefits include the

following: in order to successfully qualify for government benefits, agencies require

participants to provide original documents (like government-issued identification and

medical records); some government agencies require proof of homelessness as an

additional requirement for benefits, but at the same time, participants struggled to secure

a residence where they could receive the government correspondence which is necessary

to manage recertification and benefits. Some participants used the address of the NAC, other homeless programs, or the homes of relatives or friends to get around this and receive mail. Still, they were not able to visit these places frequently enough to retrieve their mail on a regular basis, thus missing the deadlines for benefits recertification or for keeping crucial appointments.

Lack of medical record documentation itself was another significant barrier to accessing and utilizing healthcare. Certain government agencies require medical documentation to determine eligibility; for instance, Social Security Disability requires medical records to decide on medical disability entitlements. However, some participants had difficulty obtaining their medical records, especially given the extent of these records and the number of different healthcare agencies that housed them. It was a huge burden and very time consuming for participants to gather all of their medical records together while homeless. One participant suggested that a healthcare navigator who could facilitate the collection of medical records would be a great idea, because the process is so convoluted, bureaucratic, and lengthy. Participants reported that even if they had a copy of their medical records, it was easily misplaced or lost due to their homelessness.

As previously noted, many participants qualified for healthcare insurance—mainly Medicaid—as part of their government benefits. Participants utilized seven different types of health insurance (such as MetroPlus and Fidelis); however, as with other government benefits, coverage was limited and plagued with barriers. It certainly didn't cover all their medical needs. Some health insurances required co-pays, which was very difficult for homeless young men to provide. And unfortunately, health

insurance was discontinued immediately after participants gained employment, providing them with any income, which again interrupted their treatment.

The proximity of healthcare services. The great geographic distance between bisexual and gay participants' dwellings and the locations of potential healthcare centers/clinics was also part of what led to dramatically fragmented healthcare for homeless bisexual and gay young adult men. Half of the participants (15) reported that they were staying in a borough different from that of the healthcare facilities they accessed. Of this number, 47% (8) were bisexual men and 54% (7) were gay men. Some bisexual men reported sleeping on the subway the night before their appointments in order to get to these medical appointments in another borough. Other participants accessed healthcare facilities in more than one borough, some with a primary provider in one and specialty provider in another. One participant had to travel from southeastern Queens to hospital-Knox in Manhattan (a 21-mile distance involving taking multiple buses and subways with an estimate 2-hour travel time) for routine healthcare but then went to Brooklyn for an electrocardiogram test as noted in the quote below:

Interviewer: But, I'm talking about where did you see a doctor when you were in Rosedale [town located in Southeastern, Queens, NY]? At the Holiday Inn?

Interviewee: I went all the way to Lennox.

Interviewer: So, you would normally go to Lennox?

Interviewee: Yeah. If I have any concern, they said to come back there.

Interviewer: So, you would go to Lennox for your healthcare needs.

Interviewee: Mm-hmm (affirmative).

Interviewer: Okay. So, you're saying that you had a routine check-up done. Where was the routine checkup?

Interviewee: Oh, the last time I had that, that was in a part of Brooklyn, when they had this thing: "Medicaid, get paid". Because I was going to the welfare center in Queens, and the guy took me to a place in Brooklyn. And they said everything was fine, and they did the thing on me. I think it's called the EKG. [27, Black, Gay, Male]

In the above quote, the participant describes several roadblocks to healthcare access and utilization that were intensified by distance, widely disparate agency locations, specialty medical services, lack of transportation, government benefits, acute health needs, and routine preventive healthcare. Accordingly, the healthcare services the participant needed were scattered through three boroughs in NYC—Queens, Manhattan, and Brooklyn. The great geographic distances between the place he stayed, each healthcare facility, and the location of his social service agencies presented challenges. Additionally, specialty care was not co-located with any other healthcare facility he accessed, adding additional long distances to this process. The participant appeared to have used a hospital ER for acute care as well as primary care, even though it was the furthest distance from where he resides. Lastly, the transportation required to access all of these agencies was in itself a barrier to healthcare access and utilization because of the inability to pay for transportation.

Another participant (gay) was on PreP to help prevent HIV infection, which he got from healthcare agency Zed. This meant that despite living in the Bronx, he continued to go to Manhattan to get his medication. A different gay participant said that his Medicaid insurance was not active and that he had to go out of borough to get medication for an acute illness. Many participants also reported moving around to different homeless shelters for a myriad of reasons, which made it challenging to establish healthcare at one single site.

Transportation accessibility.

Another major barrier to healthcare access was transportation accessibility. As indicated above, many participants were located at far distances from their healthcare sites. Their main source of transport to and from healthcare facilities were NYC subways and buses. However, access to these forms of transportation was reported to be very problematic. Sixty-three percent of participants (19) discussed not being able to afford MetroCards to access healthcare and attend other appointments that will maintain healthcare. Of this number, 71% (12) were bisexual men and 54% (7) were gay men. The participants described four methods of gaining access to NYC transportation services.

Free swipe. Half of the participants reported asking other subway and bus passengers for free swipes. Of this number, 47% (8) were bisexual men and 54% (7) were gay men. They learned over time that this is not illegal once the fare has been purchased. However, they reported having to ask several passengers and wait a long time before actually getting access to the bus or subway they needed. Participants who chose

this method also encountered harsh verbal assaults from some passengers, often making them feel humiliated, guilty, and embarrassed.

MetroCard incentives. Many participants discussed receiving MetroCards when they accessed certain healthcare and social service programs. Thirty percent (9) of participants mentioned receiving MetroCards from programs they utilized. Of this number, 29% (5) were bisexual men and 31% (4) were gay men. However, obtaining MetroCards had its own challenges, as some agencies required proof of the participant's participation and effort, as described by one man below:

> You only get MetroCards if you go to groups or something. Or if you speak to your caseworker and bring evidence that you have a doctor's appointment or some type of appointment. Then the caseworker feels like it's worth their money then I'll give it to you. [29, Black, Bisexual, Male]

As noted above, the distribution of MetroCards was restricted by agency policies, the whims of agency staff, and proof of participation. Healthcare agency policies required participants to attend a group or participate in an activity to receive MetroCards. Another means of getting a MetroCard was proof of a medical appointment. However, proof of appointment can easily be misplaced or lost due to homelessness. Lastly, the issuance of MetroCards was subject to the discretion of the agency staff.

Some participants pointed out that they first had to find a way to get to their appointments (which, as reported earlier, was very burdensome) in order to get a reimbursement. Participants appeared to place a lot of value on MetroCards, as some reported collecting and saving them and only using them when in dire need. One

participant reported not going to any medical appointments because of not having a

MetroCard. Conversely, another participant reported that he had too many appointments,

and his current collection of MetroCards were not enough. Another participant felt that

he had no other alternative but to use emergency medical services for transportation due

to the lack of a MetroCard.

Jumping turnstiles.

Many participants disclosed that they have illegally accessed the transportation

system to get to medical appointments by jumping over turnstiles without paying a fare.

However, this appeared to be a last resort when they couldn't afford a MetroCard and/or

were not given a free swipe. To avoid repeatedly jumping the turnstiles, some

participants shared that they had slept on the subway the night before a medical

appointment to get to it on time. Nevertheless, jumping the turnstiles sometimes led to

arrests and other encounters with law enforcement as evidenced below:

> I would ask somebody for a swipe or I would hop a train. I was mostly getting
>
> locked up in my early 20s because of turnstile jumping. The four times that I was
>
> supposed to show up at court, I never did so I had warrants. [28, Mixed race,
>
> Bisexual, Male]

This participant experienced several setbacks with access to healthcare as a

consequence of homelessness, lack of transportation fare, subsequent need to engage in

solicitation, and ultimately, his justice-involved activities. These series of events seemed

to have a rippling effect on his life, widening the gap between himself and healthcare

access. Because he was unable to afford transportation fare, he was forced to solicit for

it. When a free train swipe did not become available, he was forced to hop the turnstile in an attempt to attend his medical appointments, thus subjecting him to justice-involved activities. This chain of events was so frequent such that it resulted in warrants issued for participants' arrests. In this participant's case, not having a residence at which to receive mail correspondence meant that he failed to appear in court, resulting in several open warrants, which put him at high risk for incarceration.

   Self-purchase MetroCards. Thirteen percent of the participants (4) discussed self-purchasing their MetroCards when they had the money to do so, though many participants reported a lack of income and unemployment while homeless, which is discussed in the following chapter. Further, participants reported using their government benefits (however limited it may be) to purchase MetroCards, but this cut into their ability to purchase other critical requirements such as food. A few mentioned that they would sometimes ask a family member to purchase a MetroCard. However, purchasing a MetroCard was the least mentioned option that bisexual men and gay young adult men used to access the transportation system in NYC because quite frankly, they couldn't afford it.

Facilitators of Access to Healthcare

   This chapter has addressed the major barriers encountered by study participants attempting to access healthcare and how bisexual and gay men compared in their experience of these factors. However, interviews also revealed a few factors that facilitated access to healthcare among bisexual men and gay young adult men in NYC. Some of the main factors discussed during the interviews included the provision of social

support (22 cases involving peers and 11 involving parents), provision of incentives (7 cases), provider rapport, and provision of comprehensive healthcare services (6 cases).

Social support. Provision of social support that facilitated access to healthcare was important and commonly reported, particularly in connection to initial healthcare access. There were two major types of support offered—peer support and family support. Of this group, 71% (12) were bisexual men, and 77% (10) were gay. In cases of peer support, participants revealed that a peer, usually another homeless LGBTQ young adult, was often the first to refer them to a healthcare agency as evidenced in the quote below:

Well, one of my friend said, "There's a drop-in center in Harlem, you should go there. All you gotta do is tell them you're homeless, and you're bisexual, and they'll accept you." So I went. It was 2012, at the end of 2012, around Christmas, I went. [24, Black, Bisexual, Male]

The statement above is a typical example of how participants enter the healthcare system in NYC. There seemed to be an underground network built on trust among bisexual and gay young adult men in the community. However, when participants entered the healthcare system, they struggled to establish care. Furthermore, healthcare agencies that catered to the needs of homeless bisexual and gay young adult men were very limited and mainly concentrated in one area—Manhattan.

On some occasions, participants' peers accompanied them to a healthcare center or hospital ER. Peers normally referred participants to an agency if they were satisfied with its services. Some participants escorted their friends to a new healthcare agency and subsequently began using it. There were no outstanding differences in peer support

between bisexual and gay young adult men except one—for some gay men, the peer who referred them worked at the healthcare center. Family support (such as support from a mother, aunt, sister, or brother) accounted for the support experiences of 37% of participants (11). Within this group, 41% (7) were bisexual men and 31% (4) were gay men. One distinction between the experiences of bisexual men and gay men is that gay men usually received a great deal of support from their mothers and were in continuous communication with them. These individuals (albeit very few) also seem to have better management of their health and better access to healthcare.

Provider rapport. Sixty-three percent of participants (19) reported that feeling comfortable with healthcare providers—building a strong rapport—was essential in creating good access to healthcare. Of this group, 59% (10) were bisexual men and 69% (9) were gay men. Participants preferred medical providers who were encouraging, open, honest, patient, flexible, sympathetic, and who seemed to be seeking out their patients' best interests. They preferred providers who were good listeners and who exhibited good bedside manners. They wanted providers who were attentive to their needs, good at carefully explaining medical procedures and medication, and periodically following up on them (checking-up on their medical status). Forty percent of participants (12) also shared that establishing an ongoing relationship with their providers and accessing them continuously helped to make them feel comfortable as noted in the following quote:

> I feel like actually they're not just regular doctors or nurses, they're actually people that take their job seriously. They care about their patients. They're in it not because of a check. They actually want to make sure that people are better and they actually care and if they think that there's an issue, they keep you, they don't send you home.

They keep you for observation. I'm constantly having these episodes where my leg is swollen with abscesses. When I went there they also educate you. They help me understand a lot about my body. I'm in so much pain but I know that if I go to Mount Sinai, I'll feel better. [29, Black, Bisexual, Male]

This participant perceived his healthcare providers to be different from "regular" providers, suggesting that his previous providers were not compassionate, possibly uncaring, and seemingly untrained to manage the health of homeless bisexual young adult men. Providers who exhibited a sincere interest in treating bisexual and gay men appeared more appealing to study participants, motivating them to access healthcare. Reassurance and trust were two other factors that were associated with compassionate care. Participants who trusted their providers, like this participant, were reassured that they would get the appropriate healthcare at the time they needed it. The fact that this participant felt comforted by his providers made it appealing to continue care with them or with the healthcare institution. Nonetheless, this standard of healthcare seemed to be rare in this community, adding to the challenge for bisexual and gay men to establish routine preventive healthcare in NYC.

Providing incentives. As discussed earlier, the majority of study participants shared that they valued healthcare agencies that offered incentives such as MetroCards and gift cards. Incentives served as a great resource to get participants to get them into healthcare as well as to get them engaged in programs that would benefit their lives. One participant particularly appreciated a housing program that offered healthcare services and a host of incentives.

They offer a lot of incentive programs. So if you go to your appointments, they give

you a $15 gift card. For each appointment, procedure, prep test, they'll send you a

gift card. [24, Mixed race, Bisexual, Male]

As described here, incentives facilitated access to healthcare. Additionally,

provision of incentives for different types of appointments, program services, and

activities facilitated the continuity of care. Providing incentives for a population like this

one, which is already terribly underserved, impoverished, and marginalized, seemed to be

an effective way to get them into healthcare.

Comprehensive healthcare services. Even though only a few participants

articulated the observation that comprehensive healthcare (including medical care, dental

care, psychiatric care, dermatological care, access to a pharmacy, HIV/STI testing, and

holistic care) facilitated access to healthcare, participants who were satisfied with their

healthcare services used multiple services grouped together under one healthcare agency

umbrella. This addressed one of the most important reasons that participants experienced

fragmented healthcare; them often accessing needed healthcare services at different

agencies and at various locations makes it difficult to get to care and share medical

information. These two participants offered clear examples of the advantages of

comprehensive care for many homeless bisexual and gay study participants:

Ultimately when I got re-certified, I firmly committed back into care, I was a

Brightpoint, well it was Health PSI before they changed their name to Brightpoint.

And I have been consistent with them for the last two, if not, going on three years.

I see my psych nurse practitioner in relation to my mental health there. I see the

primary care physician for all the other physical things. I get my meds from the

Boom Pharmacy, which is related to the clinic they have in the Boom Health building. [29, Black, Bisexual, Male]

Interviewer: Okay. So you said you go to the, to your doctor, once a month, and what factors you think that makes it a good healthcare system that contribute to your good health?

Interviewee: Everything you need is there. You don't gotta go far.

Interviewer: Everything you need is there. Like, one stop shopping.

Interviewee: Mm-hmm.

Interviewer: That makes it a good healthcare system for you?

Interviewee: And their service is good. They're reliable." [24, Black, Bisexual, Male]

As these men describe, the "one-stop shopping" approach to healthcare served as an entry into the healthcare system and preserved the continuity of care. Additionally, access to government benefits and/or recertification of benefits facilitated access to healthcare. Again, lack of recertification was one of the chief obstacles to healthcare access and utilization. Apparently, comprehensive healthcare (or one-stop shopping) alleviated the need to travel to different healthcare sites, particularly when transportation was also a major barrier to healthcare. During the interviews, it became clear that establishing "one-stop shopping" in one facility reduced the burdens of homeless gay and bisexual men. In this matter, there were no outstanding differences between bisexual and gay men in the study.

Chapter 9

Theoretical Application

BMVP

This chapter discusses the ways in which my study's findings intersect with the BMVP (Andersen and Davidson, 2001), as previously introduced in Chapter 3 as part of the theoretical framework for this dissertation. This version of the Behavioral Model was designed to apply to vulnerable groups like homeless bisexual and gay young adult men in NYC (Andersen and Davidson, 2001). As described in the previous chapter, the lived experiences of the homeless bisexual and gay young adult men in this study appear to fit seamlessly into the BMVP when they attempt to access healthcare. In order to confirm this, I revisited my initial codes, categories, and themes and matched them to each of the following BMVP domains as shown in Figure 13—contextual characteristics (or factors external to study participants), individual characteristics (individual factors that predispose study participants to certain outcomes, enable or help to block healthcare access, and shape study participants' needs), health behaviors (such as diet, substance use, illicit/justice-involved activities, and sex work), and health outcomes. In each section below, I review how the core BMVP domains fit with my study findings. In doing so, I summarize the results of this research project. It is important to note that I begin with the list of model domains nestled under the Individual Characteristics label and review the domain of Contextual Characteristics last, even though it appears first in the model.

{See Figure 13 in the next page}

Figure 13. BMVP model of study sample
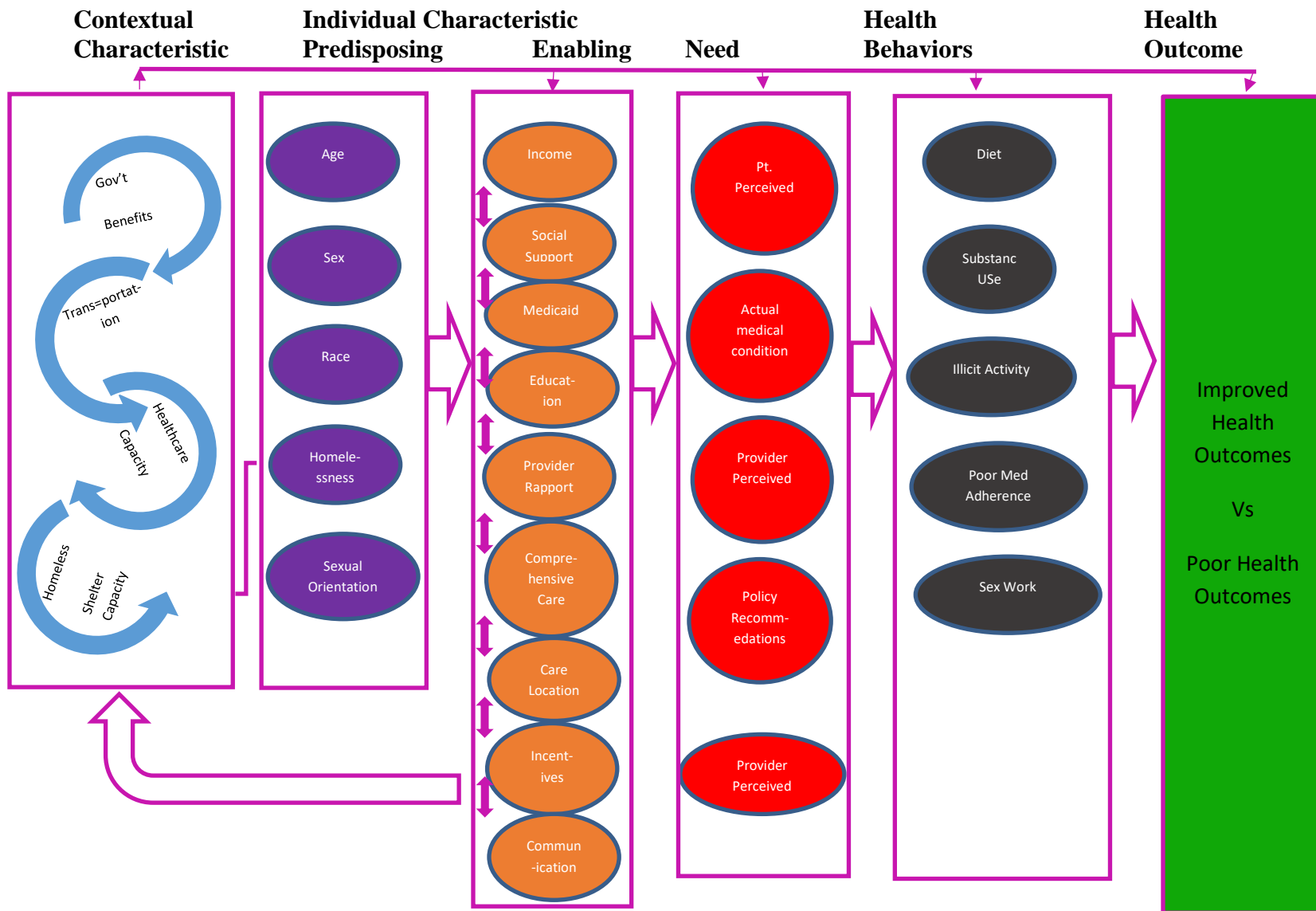
Individual Characteristics

      Predisposing factors.

      In this study, the demographic characteristics of the study sample fit well into the predisposing domain of the BMVP model. By design, study participants were young and as bisexual and gay men—all were sexual minorities. Blacks were overrepresented in the sample, and all study participants were homeless.

      Enabling factors**.**

      Over half of the participants were undereducated, having a high school diploma or less. Further, over 50% were unemployed or unable to work. Moreover, many participants reported an income from a source other than employment. Both of these characteristics appeared to make it more difficult for participants to access healthcare. There was one factor, however, that assisted in linking them to healthcare—a network of peer (and occasionally, family) support. Many participants reported that it was a peer in their social support system that initially introduced them to the healthcare system in NYC.

      On a personal level, however, family resources and support were limited among both bisexual and gay men (although some gay men appeared to maintain more supportive ties with their mothers). Participants often shared that one of the main reasons they became homeless was due to family conflict centered around their sexual identity. Other participants became homeless due to the death of a parent.

      As discussed earlier, bisexual and gay men's connections with community resources were often very fragmented. Their access to healthcare was frequently interrupted by underlying barriers such as lack of transportation, difficulty recertifying

their government benefits, and inability to secure stable housing. Most participants did not have a regular source of routine preventive healthcare. Instead, they periodically accessed basic HIV testing and STI screening sites and considered these to be equivalent to a regular source of care, although these sites rarely met their overall medical and mental needs. The healthcare services they accessed were limited to geographic areas far from the homeless shelters where participants lived, and they struggled immensely to navigate the system and secure some semblance of proper healthcare.

Access to healthcare was very frequently disrupted due to interruptions in government benefits. Even though most (if not all) participants were entitled to government benefits, there were frequent delays in getting these benefits, and even worse, participants often failed to maintain their benefits once they were issued. This failure was mainly due to poor notification regarding upcoming recertification requirements, which created a cyclical effect of reapplying for benefits, further inhibiting participants' access to healthcare. Further, transportation to and from healthcare facilities was a major impediment to healthcare access. Participants were unable to afford transportation fares and often had to find some means to get to their healthcare sites first in order to receive reimbursements or incentives like prepaid MetroCards. Most study participants also experienced unstable living conditions. They complained of compromised safety when staying in homeless shelters, which were reportedly filled with crime, drugs, and violence.

Need factors.

Although the great majority of bisexual and gay men reported no medical or mental health issues on their survey questionnaires, interviews revealed that most (if not all) had one or more significant medical or mental health conditions. Some of these were

so severe that they required routine follow-up care and periodic evaluations. For instance, many participants disclosed their mental health diagnoses during interviews but also explained that they had stopped taking their medications or were not adhering to a prescribed medication regimen as a consequence of homelessness (clearly poor medication adherence and other factors discussed here overlap with the Health Behaviors domain of the BMVP, which is explored in the next section). Additionally, many of the ER visits that they reported involved medical conditions that could have been prevented. For example, poor dental health was pervasive throughout the group, and at times, triggered emergency surgeries, abscesses, and infections. Other medical factors discussed related to this domain were asthma, hypertension, TB, HIV, and STIs. However, HIV testing and STI screening were the most common types of preventive care reported by participants in this study.

Some of the mental health/behavioral health findings of this study concerned the prevalence of delinquent activity, recent histories of incarceration, and substance use among study participants. Again, these factors overlap with the Health Behaviors domain of the BMVP, as discussed in the next section. Additionally, some participants were involved in violence or connected with someone who was involved in violence. Lastly, depression, feelings of stress and overwhelmment, and diagnoses of bipolar disorder and such commonly disclosed mental health conditions that bisexual men and gay men in this study reported.

Health Behavior

Health behaviors were dramatically impacted by homelessness. Bisexual and gay men reported many challenges and barriers to maintaining adequate self-care and eating a healthy diet. Some utilized strategies such as survival sex and turnstile jumping or other illegal activities. During interviews, participants shared the profound impact of constant exposure to adverse weather and environmental factors that compromised their physical and mental health. As a consequence of homelessness, participants reported that they were frequently sleep deprived, fatigued, and exhausted. Undependable, unhealthy sources of food created serious challenges to maintaining dietary health. Some participants disclosed that they were concerned about being overweight and expressed an interest in nutritional care.

As indicated earlier, delinquent activities were a byproduct of homelessness for many participants mainly to gain access to transportation. However, some participants disclosed more severe delinquent behaviors like violence and theft. Violence was reported mainly in association with homeless shelters. Violence was also exacerbated when participants were not able to adhere to prescribed psychiatric medications or when substance use was involved. A minority of participants disclosed a recent history of incarceration but refused to discuss the details. Additionally, a few participants disclosed that they engaged in survival sex but did not discuss risky sexual behaviors in detail. While study participants had some agency in what they chose to do, it's important to note that many of these poor health behaviors were overwhelmingly impacted by systematic and structural barriers in the healthcare, social service, and government benefit systems and were not necessarily under the control of the participants themselves. This is highlighted under the section dealing with contextual characteristics.

Contextual Characteristics

Macro-level factors that emerged during the interviews created major systematic barriers to healthcare access for bisexual and gay men in the study. These have been noted earlier and include the activation and recertification of government benefits, extremely limited housing shelter options, distant, limited and geographically concentrated healthcare resources, and expensive, time-consuming transportation options. The activation of government benefits was often delayed, thereby deferring access to and utilization of healthcare. Once benefits were activated, it became extremely difficult to maintain continuous activation due to the lack of communication during the recertification process. Government agencies require homeless bisexual and gay young adults to provide a mailing address in order to notify them when their benefits are about to expire. Securing a reliable mailing address was problematic for the transient bisexual men and gay men in this study, as they frequently moved around to different homeless shelters and other dwelling places.

Another systematic barrier young homeless bisexual and gay men encountered was the limited and concentrated pool of safe and reliable healthcare agencies that were made available to them in NYC. Participants primarily accessed basic HIV testing and STD screening sites and rarely accessed a source of routine preventive care for check-ups, physicals, and/or vaccinations. Furthermore, the limited number of healthcare agencies serving LGBTQ individuals was geographically concentrated in the borough of Manhattan, while many homeless shelters were scattered throughout the outer boroughs like Brooklyn, the Bronx, and Queens, further widening the gap in healthcare access. Participants were often torn and overwhelmed because they had to go to different sites in

different locales for different kinds of healthcare. Depending on the hospital ERs, most created a major barrier due to the lack of referrals and follow-ups available via this healthcare source. Even though many bisexual men and gay men accessed ERs (and at times, the same ER routinely), there was no city-wide system in place to identify them as homeless persons and connect them to services and resources within the city. Instead, participants were treated and discharged without any kind of follow-up.

There were a limited number of LGBTQ-specific housing shelters and resources available for bisexual and gay men. Only two LGBTQ-specific homeless shelters were reported by the participants. Quite often these shelters were filled to capacity, forcing bisexual and gay men to relocate to alternate housing outlets such as men's shelters, the subway, parks, and abandoned buildings, making it hard to secure stable housing. Paradoxically, the limited operating hours of men's shelter impeded participants' access to healthcare. Essentially, shelters were used exclusively for sleeping. As a result, participants were forced out into the streets early in the morning, while sleepy, exhausted and tired, making it challenging for them to adhere to medical appointments.

Lastly, transportation was highlighted as a chief barrier to healthcare access and utilization. Participants simply could not afford the transportation fare to go to their medical appointments, visit government agencies, and access other programs serving the population. Most of them had to solicit fares from other customers. Others jumped the turnstile at the risk of an arrest, a significant risk for homeless bisexual and gay young adult men who often did not have proper identification documents with them.

Chapter 10

Discussion

Despite seemingly remarkable progress in the LGBTQ community in recent years, subsets of the community, such as homeless bisexual and gay young adult men, continue to face unprecedented health disparities. Yet little is known about their access to and utilization of healthcare services.

Previous research found that bisexual and gay men aged 20–24 (primarily Blacks and Latinos) account for 81% (7,868) of new HIV diagnoses among youth (CDC, 2014). However, this research identifies a gap in the current research, namely that studies focused predominantly on HIV infection, treatment, and prevention rather than on healthcare access and the availability of primary preventive services (Coulter et al., 2014; Walls and Bells, 2011). Other studies also found that bisexual men experience more health disparities (such as depression and suicide attempts) and barriers to healthcare, but these studies had no comparison with homeless bisexual and gay young adult men (Conron, 2010; Dobinson, 2010). Further, findings regarding access to and utilization of healthcare services are inconsistent across multiple empirical studies of LGBTQ individuals.

In light of this gap in existing research, this study was designed to investigate and record any findings which fell inside this research gap. Therefore, the stated purpose of this study was to conduct a comparative analysis of access to healthcare between homeless bisexual and gay men in NYC. This purpose was achieved. However, surprisingly, the findings also revealed possible future applications beyond the purely academic, such as the potential impact and modification of healthcare education for

providers, possible adjustments in healthcare outreach strategies in communities, and finally, opportunities for healthcare policy changes.

The Research Method

The central goal of this study was to conduct a comparative assessment of access to healthcare among homeless bisexual and gay young adult men in NYC. The CCA methodology and the BMVP model proved effective at eliciting responses and revealing some previous unknowns. First, the CCA methodology applied to the study was useful in explaining patterns of access to healthcare, particularly within this vulnerable, understudied population. Second, the BMVP model was shown to be very applicable to the bisexual and gay homeless men who made up the study sample. The model facilitated the careful examination of the multidimensional social determinants that shaped access to healthcare in this population. In the next section, I state a few general findings and explore the study findings in relationship to each of the research questions.

General Population Characteristics as Compared to the Literature

In a finding that is consistent with existing literature, the homeless bisexual and gay young adult men recruited for this study were predominantly youth of color, and most were Black (Page, 2017). Additionally, bisexual men made up a larger proportion of the study participants than gay men; this parallels their representation in the LGBTQ community (Gates, 2011). Lastly, a large majority of participants were unemployed or underemployed. This calls to mind Penn's (2013) study, which elucidated that the unemployment rates for LGBTQ workers of color (particularly Blacks, Latinos, and Asians) exceeded those of non-LGBTQ workers.

However, there are several surprising contrasts within the group studied as compared with current literature on homeless LGBTQ youth. First, bisexual and gay adults in this study were found to be older than the reported average age of 25. According to the Center for American Progress (2010), the average age for homeless gay and lesbian youth in NYC is 14; however, bisexuals were not included in this report.

Second, bisexual and gay men in this study reported a longer duration of homelessness, meaning that they became homeless at a younger age—often late adolescence. The average duration of homelessness for the bisexual and gay youth in this study was over 3.6 years, which is longer than what is noted in at least one existing study that reported an average of 2.5 years (Freeman and Hamilton, 2013).

Finally, I found that 73% of participants had earned a high school diploma (or beyond), which appeared to contradict a previous study that showed over 60% of homeless youth of high school age to have dropped out of high school before earning their degree (National Gay and Lesbian Taskforce, 2007). This was perhaps one of the most surprising findings uncovered by the study and one which opens the door to an examination of the relationship between education and utilization of healthcare services.

Research questions.

Four research questions were crafted and presented.

Research question 1: Assessing healthcare needs.

The first research question posed for this study asked, "What are the self-perceived needs for healthcare among homeless young bisexual men in NYC compared to those of homeless young gay men in NYC?" The methodology used to elicit responses was both an interview and a survey.

Surprisingly, one of the most unexpected outcomes of the gathering of research was the fact that the responses on the questionnaire differed significantly from the responses in the interview. The surveys revealed responses contradictory to other research studies and their findings. One such example is that on the survey instrument, 80% of study participants reported that they had no medical issue that interfered with their work, school, or other regular activities, a finding which conflicts with other research studies (Choi et al., 2015; Gangamma et al., 2008; Tyler et al., 2007). Similarly, on the survey, 60% of the participants reported no mental/behavioral health problems that affected their ability to work, go to school, or perform regular daily activities, which was once again a departure from the literature (Conron, 2010; Hatzenbuehler, 2016; Ross et al., 2016; Van Leeuwen, 2006; Whitebeck, 2004). For example, Cochran (2003) found that bisexual and gay men have higher rates of depression, panic attacks, and psychological distress than their heterosexual male counterparts. Thus, this study finding was unexpected.

Second, during the subsequent face-to-face interview section, participants reported a considerable number of medical and mental/behavioral health issues and concerns in complete contrast to the information they provided on the surveys. This was true for both bisexual and gay subsamples. Bisexual men reported significantly more physical health needs than gay men—65% (59) and 35% (32) respectively. However, when these were broken down into individual concerns, most centered on accessing HIV/STI preventive and screening measures, paralleling existing studies (Ober, Martino, Ewing and Tucker, 2012; Wray et al., 2018). Neither bisexual nor gay men in this study reported concerns about routine preventive "wellness" healthcare (such as annual check-

ups, vaccinations, and physicals). The number of bisexual men who reported seeking out

HIV testing were similar to that of gay men—14 (82%) and 11 (85%) respectively. For

STI screening, 63% (19) of the participants were screened, but bisexual men represented

the majority at 58% (11) and gay men were 42% (8). Both groups reported that they

received HIV testing and STI screening via medical mobile vans or LGBTQ healthcare

centers. Nonetheless, bisexual men expressed concerns about stigmatization when

accessing these sites, which aligns with other studies (Dobinson, 2010; Kidd, 2007).

Third, another set of ubiquitously reported healthcare needs among both groups

centered on mental and behavioral health. Bisexual men also reported a greater number

of mental and behavioral health problems compared to gay men—55 and 32 respectively.

About half of the participants reported delinquent activities, of which 47% (8) were

bisexuals and 46% (6) were gay. Consistent with other studies, 40% of participants (12)

reported a history of or treatment for depression (Cochran et al., 2002; Hatzenbuehler,

2016; Whitbeck et al., 2004). Within this group, bisexual men were overrepresented,

accounting for 53% (9) of participants with a history of depression versus 23% (3) of gay

men. Both groups appeared to grapple with comorbid mental health conditions.

Nevertheless, very few participants spoke openly about the details of accessing mental

health services and/or treatment. Forty percent of participants (13) reported feeling

stressed or overwhelmed. Within this group, there were almost equal numbers of gay and

bisexual men—7 (41%) and 6 (46%) respectively.

Unmet medical needs.

In addition, during the interview discussions, three areas of unmet medical needs

surfaced repeatedly—dental care, nutritional care, and ophthalmological care. Prevalent

dental care issues have also been reported among homeless individuals in another study (King and Gibson, 2003). Over 50% of study participants described experiencing dental care problems while homeless. Of this group, bisexual men represented 47% (8) and gay men represented 62% (8). Tooth decay, an easily preventable condition, was the most commonly reported dental problem. Ophthalmological care was also reported as an unmet need, a finding also reported by Noel et al. (2015) in a study that demonstrated that visual impairment is prevalent among homeless adults.

Research question 2: Access to and availability of healthcare.

The second research question posed by this study asked, "What are the facilitators of healthcare access (with an emphasis on preventive care) among both young homeless bisexual men in NYC and young homeless gay men in NYC?" Again, the findings of this study vary from the findings of other studies found in the literature. In this study, 66% of the participants (19) in the survey reported having received routine healthcare within the past 12 months, which differs from the findings of other studies (Boehmer, 2012; Buchmueller, 2010; Heck et al., 2006; Wheldon, 2013). The participants reported four main factors that were perceived to be facilitators of access to healthcare—1. social support, 2. provision of incentives, 3. comfort/rapport with healthcare providers, and 4. availability of comprehensive healthcare services. The significance of these became evident as the study progressed as each of these contributed not only to the new research, which was different from previous studies and opened up new areas of future study, but even more significantly, each of these revealed possible areas of broad educational and policy changes, which could be implemented.

Social support.

Peer support was a pivotal factor that facilitated initial access to healthcare services among both groups. Seventy-three percent of participants (22) accessed healthcare through the support of a peer—12 (71%) bisexual men and 10 (77%) gay men. According to Hwang et al. (2009), higher levels of perceived social support was related to better physical and mental health status among homeless adults. It is unknown whether the peer support reported in this study was associated with improved health outcomes as the design did not permit the collection of such data. However, study participants did report peer support to be the main factor that enabled them to connect to healthcare services during the interview process.

Provision of incentives.

Provision of incentives (such as transportation fare, food, gift vouchers and clothing) was another important facilitator of access to healthcare. For example, all participants were offered free Sunday dinners at the NAC, a homeless program providing meals and case management to LGBTQ youth in NYC. And during every visit, clients are required to update the NAC regarding their housing status and government benefit status. Case management is provided to them based on their status, facilitating their access to healthcare and other services. As discussed earlier, the provision of no-cost transportation fare was reported by 63% (19) of the participants to facilitate improved access to and utilization of healthcare services and other programs benefitting homeless bisexual and gay individuals. Free transportation appeared to be so important that it seems likely that if it were readily accessible, there might be much more utilization of healthcare services and resources. This finding was consistent with another study that

showed that material incentives may have positive short-term effects on clinic attendance, particularly for marginal populations like the homeless (Lutge, 2015). However, that study focused only on TB treatment outcomes and not on routine preventive "wellness" healthcare.

Comfort/rapport with healthcare providers.

Consistent with the findings of other studies, comfort and rapport with one's healthcare provider was reported to be essential in accessing healthcare (Choi, 2015; Garnero, 2010; Ginsburg et al., 1995; Ginsburg et al., 2002; Grossman, 2006; Hoffman et al., 2009; Lambda Legal, 2010; Newman, 2014). Sixty-three percent of participants (19) reported that feeling comfortable with their providers was an essential part of creating access to healthcare. Participants also preferred medical providers who were encouraging, open, honest, patient, flexible, sympathetic, and who sought their best interests. They preferred good listeners and those with good bedside manners who were more attentive to their needs and explained medical procedures and medication requirements in detail. They wanted healthcare providers who periodically checked in with them to monitor their progress.

Availability of comprehensive healthcare services.

Comprehensive healthcare services that were grouped together under one umbrella agency were reported to be a good facilitator of access to healthcare for the participants. Participants who were satisfied with their healthcare often received multiple services at one healthcare agency. This reduced the burden of having to travel to different places for healthcare (when transportation itself is such a challenge) and the difficulty of having to share medical records between healthcare agencies. The

importance of comprehensive healthcare services grouped together under one roof or agency (such as co-located mental health services, dental care, and social services) for homeless individuals corroborates the recommendations of the National Healthcare for the Homeless Council (2009) and the Health Resources and Services Administration (2017).

Research question 3: Barriers to healthcare access.

The third question posed by this study asked "What are the barriers to healthcare access (with an emphasis on preventive care) among young homeless bisexual men in NYC and young homeless gay men in NYC?" Participants reported several barriers to healthcare, some of which were consistent with those reported in an article published by the HRSA (2017) about homeless youth—1. fragmentation of healthcare (such as inconsistent access to medication), 2. interruptions in government benefits, 3. lack of access to transportation, 4. geographic concentration of healthcare services, 5. limited LGBTQ-friendly homeless shelters, and 6. misperceptions about preventive healthcare.

Fragmentation of healthcare

Fragmentation of healthcare (including interrupted and blocked access to medication) was pervasive among participants. Access to and utilization of healthcare (aside from HIV/STI testing and screening) was reported to be inconsistent and varying. Participants expressed frustration about going in and out of the healthcare system. In general, they appeared to define "healthcare" as HIV/STI testing; their conception of healthcare did not appear to include routine, preventive "wellness" healthcare. Moreover, they often "ping-ponged" (bounced around) from healthcare agency to healthcare agency,

often tapping into them for brief services since their homelessness. Hospital ERs were commonly utilized for acute yet preventable conditions and diseases, a finding also reported in other studies (Hwang et al., 2005; Kushel, 2002). Very few participants had an established routine of preventive healthcare with a usual and consistent provider. Frequent interruptions in government benefits were some of the most cited reasons for inconsistent and fragmentation of care.

Interruptions in government benefits.

Government benefits such as Medicaid, the Supplemental Nutrition Assistance Program, (SNAP food stamps), and public assistance were critical resources for accessing healthcare. However, periodic recertification requirements often interrupted their distribution. Quite often, participants were not informed of the need to renew their benefits due to missed or delayed notifications when benefits expired. Notification was usually mailed to a temporary address (such as a relative's home or a shelter), which participants visited infrequently. Owing to this, recertification notices were often missed. Complex enrollment rules and requirements and extended wait times for benefit activation were also identified as issues.

Limited LGBTQ-specific healthcare services.

Participants reported that LGBTQ-specific healthcare services, which also facilitated healthcare access, were concentrated in one limited geographic area— Manhattan. However, half of all the participants (15) reported that they were currently staying in another borough far from the location of the healthcare facilities they accessed. Eight (47%) bisexual men and 7 (54%) gay men made up this group. Participants reported that LGBTQ services were not available to them in most of the other boroughs.

To gain access to these services, they were required to confront another healthcare

barrier—transportation access.

Lack of access to transportation.

Access to transportation was another major barrier that prevented the participants

from accessing healthcare. Participants usually used subways and buses to get to

healthcare services, homeless shelters, and other homeless services. However, due to

their inability to afford transportation fares, their access to healthcare was limited. Sixty-

three percent of participants (19) reported that they were unable to afford the

transportation fares required to access healthcare services and attend medical

appointments. Of this, 71% (12) was bisexual and 54% (7) was gay. As a result of this

problem, participants frequently missed appointments and experienced delays in care.

Lack of transportation also affected participant access to medication, medication refills,

and/or had impacted medication adherence. These results were consistent with the

findings of another study showing that patients with lower incomes had higher rates of

transportation barriers to healthcare access than those with higher incomes (Sayed, 2013).

Misperceptions about healthcare.

One important and unexpected finding centered on what might be called the

"misperception" of routine preventive "wellness" care. In this study, participants did not

perceive routine preventive "wellness" care to be the core of healthcare access. For them,

healthcare appeared to be synonymous with HIV tests, STI screening, and ER visits.

Even though these services are understood by healthcare professionals to constitute small

components of any individual's healthcare regimen, for this group, it appeared to be the

center of their care. This meant that the bisexual and gay men in this study lived with a

significant number of unmet medical needs. It also meant that the definition of access to

healthcare used in this study did not appear to coincide with the definition of healthcare

used by the participants themselves. In fact, only a few men described any kind of

routine preventive annual check-up such as a physical or a check-up. Participants who

described experiencing routine preventive care fell into 3 groups—HIV-positive

individuals, those with a history of incarceration, and/or those who had needed a physical

to access government benefits or enter a shelter system.

Research question 4: Healthcare utilization.

The fourth question posed by this study focused on the differences between young

homeless bisexual men and young homeless gay men and was "Where, when, and *how*

frequently do young homeless bisexual men in NYC access healthcare and does that

compare to the utilization patterns of young homeless gay men in NYC?" Eighty-seven

percent of the participants (26) reported having a routine place at which they received

healthcare, a finding very different from most other studies (Chance, 2013; Heck et al.,

2006; Wheldon, 2013; Buchmueller, 2010; Boehmer, 2012). However, one study showed

that sexual and ethnic minority men were more likely to have a usual place for care as

compared to white heterosexual men, but this study did not include homeless bisexual

and gay men (Trinh, 2017). Although initial access to healthcare agencies was

commonly reported by most participants (during the interviews), utilization of healthcare

was ultimately described as fragmented and inconsistent, which is comparable with the

findings of other studies (Boehmer, 2012; Buchmueller, 2010; Chance, 2013; Heck et al.,

2006; Wheldon, 2013). In this study, gay men appeared to utilize more healthcare

agencies than bisexual men as shown in Table 14. Using the interview data, gay men

reported utilizing non-hospital healthcare agencies 38 times (65% of occurrences), while bisexual men reported accessing them 20 times (35% of occurrences). Among the two groups, the number of bisexual men were less in proportion than gay men—14 (82%) and 12 (92%), respectively. Moreover, the frequency of non-hospital healthcare agency use was significantly less among bisexual men even though they made up the larger part of the sample size. Conversely, bisexual men reported utilizing hospital ERs much more often than gay men. Bisexual men used ER 29 times (73% of occurrences) while gay men did so 11 times (27% of occurrences). Among those who reported ER use, 10 were bisexual men representing 59% and 8 were gay men representing 62%. Even though the proportion of bisexual and gay men using ERs is similar, the frequency of ER usage was greater among bisexual men than gay men.

Results of the study interviews also showed a concentration of LGBTQ healthcare agencies in one geographic area which is consistent with another study (Martos, 2017). According to Martos et al. (2017), LGBT community health centers are centralized in urban areas. In this study, that concentration was Manhattan. Half of participants (15) in the study reported that they are staying in another borough away from the location of the healthcare facilities they accessed. Of this number, 47% (8) were bisexual men and 54% (7) were gay men. Some participants reported accessing healthcare facilities in more than one borough, some with their primary provider in one borough and specialty provider in another. Martos et al. (2017) also noted that the most common health services provided were wellness programs, HIV/STI services, and counseling services. Even though similar services were provided to participants that were partially accessed, most

participants accessed primarily HIV/STI services. Very few participants reported using

wellness programs.

Study Limitations

There were several study limitations that should be considered. I would first like

to consider the survey findings. First, the sample was too small to show significant

results, so these findings cannot be assumed to be representative of all young homeless

bisexual and gay men in NYC. Second, there is also a possible sample bias associated

with this study. The bisexual and gay participants were recruited at one drop-in center in

NYC that is known to provide services to the homeless LGBTQ youths who fall through

cracks in the social service system. Young homeless bisexual and gay men who do not

use this program were not included in this study sample. Third, recall bias may also be an

issue. Participants may not recall all the events that led them to access or utilize

healthcare services, so their accounts may not be fully accurate. Participants may have

also chosen to tell the researcher what they think they were expected to say rather than

what occurred. Fourth, volunteer bias may also be a factor, because those who

volunteered may not have the same characteristics as those who did not. Fifth, due to

these reasons, the study was unable to achieve generalizability. With respect to interview

data, the goal of this study was to conduct a comparative analysis of access to healthcare

for young homeless bisexual and gay men through inductive exploration, without

necessarily seeking generalizability. However, as a researcher, I made the following

attempts to mitigate the effects of any potential biases influencing the integrity of the

study: validity and trustworthiness, credibility, conformability, theoretical sensitivity, and

reflexivity as described in Chapter 3. Nonetheless, as with most qualitative studies,

removing biases is completely impossible. Finally, the 30 participants interviewed could

not represent the full range of bisexual and gay men's experiences with the NYC

healthcare system. Therefore, the study cannot be considered generalizable to all young

homeless bisexual and gay men in NYC.

Directions for Future Study

Directions for future study include not only expanding the sample and

demographic but also looking at the implications for education and policy. Bisexual

participants described the dynamics surrounding sexual identification, sexual attraction,

and sexual behavior in complex and nuanced ways. Some participants chose not to

identify to any predetermined categories of sexuality but rather chose to remain open and

fluid in terms of their identity, attraction, and behavior. This suggests that more research

is needed in order to understand the impact of these three components of sexuality on

access to healthcare and also perhaps the development of new research instruments to

measure fluidity of sexuality. It would also be useful to examine gay and bisexual men's

dates of entry and exit into homeless shelters and compare them with patterns of access to

and utilization of healthcare in order to determine whether the shelter system enables

healthcare access and utilization. Studies should also assess whether pre-existing

mental/behavioral health conditions in homeless bisexual and gay young adult men lead

to homelessness and affect access to healthcare. Given that HIV-positive homeless

bisexual and gay men in this study showed better establishment and utilization of routine

preventive "wellness" care, future research should compare their experiences with those

of HIV-negative homeless bisexual and gay men.

More refined survey questions should be developed to capture more details on barriers and facilitators of access to and utilization of healthcare. Transportation barriers should be studied more closely in order to develop solutions for poor homeless individuals. Lastly, future research should seek to explore whether perceived social support is related to better physical and mental health status in the population.

Recommendations

Despite the limitations of the study, it did unearth several compelling areas for additional research, which could have a significant impact on major areas of healthcare to this demographic: the education of healthcare providers, education and information targeted towards homeless bisexual and gay young adult men (on primary preventive healthcare), strengthen collaboration with homeless agencies as well as hospitals, better maintenance of government benefits, and most importantly these findings could have an important effect on healthcare policy, not just at the local level, but also at the state level and possibility even at the national level.

The education of healthcare providers.

When it comes to the education of healthcare providers, this research suggests that training and education in three major areas—youth-related health needs, homeless-related health needs, and LGBTQ-related health needs—should be offered to all medical staff in hospital ERs and those serving underserved communities throughout the city. Furthermore, there should be specialized competency training in these three areas for medical providers who wish to serve this unique community. In this way, medical staff will be more culturally sensitive to the needs of homeless bisexual and gay young adults,

which will create an environment that is understanding and supportive of their medical

and mental/behavioral needs.

Education and information targeted towards homeless bisexual and gay men.

Education should also be directed to homeless bisexual and gay young adult men.

Given that this study found a "misperception" of what constitutes routine healthcare—

and very little awareness of routine preventive care—among both bisexual and gay men,

it would be advantageous for the public health community, healthcare agencies, hospitals,

and programs targeting homeless LGBTQ youth to offer education about routine

preventive care and provide means for access and maintenance of healthcare.

Strengthen collaboration.

Study interviews indicated disconnection from the healthcare system that became

evident when bisexual and gay men accessed hospital ERs. There was no mention of

referrals to or coordination with homeless services, except at one hospital that specializes

in homeless services. Therefore, I recommend that NYC hospitals modify their policies

to assess patients for homelessness during ER intakes. Hospitals should also connect

patients who are identified as homeless with internal and external homeless services and

should coordinate with the homeless services serving LGBTQ youth in NYC.

Additionally, there have been a number of discussions on homeless agencies and

programs collaborating to provide homeless services for bisexual and gay men; however,

very little discussion has occurred on collaboration between healthcare agencies and

service providers. More collaboration needs to occur between healthcare agencies

serving this community that could provide a coordinated community-line approach.

Additionally, the exchange of medical records and information between and among

agencies is necessary to fully understand the medical and mental/behavioral needs of young homeless bisexual and gay men.

Better maintenance of government benefits.

Participants' inability to renew and/or maintain government benefits (like Medicaid, food stamps, and public assistance) was found to be a significant barrier to healthcare. This places a substantial burden on their lives, in addition to government agencies and healthcare programs. Access to and utilization of healthcare is frequently interrupted when benefits are not renewed or maintained, leading to the fragmentation in healthcare and/or the individual being lost to follow-up. Moreover, government agencies lack the ability to maintain contact with homeless bisexual and gay young adult men when benefits are due for renewal. Similarly, homeless programs do not have the capacity to track participants' benefit renewal due dates, locate participants when benefits are due, and/or facilitate renewal. Therefore, it is recommended that government agencies and homeless programs develop or improve systems for homeless bisexual and gay young adult men to "stay on top" of their benefits for timely renewal and proper maintenance. This will allow participants to have open access to healthcare, which will help reduce the fragmentation they experience.

Healthcare policy.

Finally, when it comes to healthcare policy at the legislative level, there may be significant fiscal implications when bisexual young adult men opt for using their local ER for routine physician and mental healthcare services. There should be more focus in the manner in which healthcare programs are targeting homeless bisexual young adult men, particularly those with mental health problems. Bisexuals represent the largest in the

LGBTQ spectrum as well as in this study, but they continue to fall through the cracks in the system.

This study's research findings provided suggestions and recommendations for the public health community as well as for the hospital ER community, specifying that new policies are needed to reduce the barriers to healthcare and lessen the alarming rates of disease burden in the young homeless bisexual community in NYC. Findings from this study also shed light on the multidimensional social determinants of access to healthcare experienced by young homeless bisexual and gay men. Understanding the factors that restrict, delay, and/or mitigate access to healthcare is critical for LGBTQ-focused healthcare practitioners and youth homeless program leadership who aim to end homelessness and health disparities in the homeless bisexual and gay community. Finally, Andersen's BMVP proved advantageous for examining the access to and utilization behaviors of this vulnerable group of homeless bisexual and gay young adult men in NYC. The BMVP was useful in providing a framework for organizing a considerable number of variables affecting the access to and utilization of healthcare in a meaningful way.

In conclusion, the study, which started out with a small cohort of participants in a very defined demographic region, led to potentially innovative and ground-breaking changes in the entire healthcare system relating to this underrepresented group.

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Appendix 1

Semi-Structured Interview Guide

Aim	Question	Probe
1. To explore homeless bisexual and gay men young adults experience on access to healthcare in NYC	Please describe what your healthcare experience has been like? Healthcare in general?	How did you get into healthcare? What were some of the things that made this a good or bad experience?
	What has it been like for you to access healthcare recently?	How is this different from when you were not homeless?
		How is this compare to your non-LGBTQ peers?
	Please describe any problems you have faced when getting healthcare. Did you end up gaining access to healthcare? What happened?	How did you deal with these issues? What do you do for money? Does it affect your ability to get healthcare?
	Please describe what helped you to get access to healthcare.	Did homeless agencies help you? What about friends and social support? Who helped you and how?
	Tell me more about a time you wanted healthcare but didn't receive it.	
	Tell me about your recent experience with preventive "wellness" care.	How is this different from when you were not homeless?
	What has been your experience accessing general healthcare versus accessing to preventive care?	Is there a difference?
2. To determine the type, location, and frequency of healthcare utilization by homeless bisexual	Tell me about the type of healthcare you receive? Why do you go there?	Where do you go for healthcare, how far is it from you stay, how often do you go, what type of care do you receive?

and gay men young adults		
3. To assess the general self-assessed health of homeless bisexual and gay men young adults	Describe your health status.	What factors in the healthcare system you think contribute to good health or bad health?
4. Conclusion	Is there anything else you would like to tell me about your experience with access to healthcare?	

Appendix 2

Informed Consent Form

TITLE OF STUDY: Comparative Assessment of Access to Healthcare between Homeless Gay Young Men and Homeless Bisexual Young Men in New York City

Principal Investigator:
Harlem J. Gunness, MPH, PhD Candidate

This consent form is part of an informed consent process for a research study and it will provide
information that will help you to decide whether you wish to volunteer for this research study. It will help you to understand what the study is about and what will happen in the course of the Study.

If you have questions at any time during the research study, you should feel free to ask them and should expect to be given answers that you completely understand.

After all of your questions have been answered, if you still wish to take part in the study, you will be asked to give verbal consent to participate.

You are not giving up any of your legal rights by verbally consenting and volunteering for this research study.

Who is conducting this research study?
Harlem J. Gunness is the Principal Investigator of this research study. A Principal Investigator has the overall responsibility for the conduct of the study. However, there are often other individuals who are part of the research team.

Harlem J. Gunness may be reached at 917-434-4201 or email gunneshj@shp.rutgers.edu.
The Principal Investigator or another member of the study team will also read the consent form to you. You will be given a copy of the consent form to keep.

SPONSOR OF THE STUDY: This study is funded by Rutgers-Newark, School of Nursing, Urban Systems Program.

Why is this study being done?
The purpose of this study is to conduct a qualitative assessment of access to healthcare (with an emphasis on preventive care) among homeless young gay men and homeless young bisexual men in New York City and compare the experiences of the two groups.

Why have you been asked to take part in this study?
We are asking you take part in this study based on your experience with access to healthcare or lack thereof in the New York City area. Your experience also provides

insight on homeless gay and bisexual young adult men's experiences with access to healthcare.

Who may take part in this study? And who may not?
The inclusion criteria in the study are as follows:
1. Male
2. Individual identifies as gay or bisexual,
3. Individual is 18 years and older,
4. Individual self-reports homelessness as defined by living without family support and living in shelters, on the streets, in cars or vacant buildings, or "couch surfing" or living in other unstable circumstances for one day or more,
5. Individual is currently living in NYC, and
6. Individual is English-speaking.

Exclusion Criteria includes:
1. Homeless GB young adults who are not living in NYC,
2. Homeless young adults who do not identify as GB,
3. Middle-age and older GB adults, and/or
4. Individuals who are not homeless.

How long will the study take and how many subjects will participate?
You will be one of approximately 30 participants. If you decide to volunteer, we will ask you to participate in an individual interview that will take about 60 minutes.

What will you be asked to do if you take part in this research study?
During the interview, we will ask you to share your experience with access to healthcare among homeless gay and bisexual young adult men. You will be asked to fill out a survey that will take you about 5 min to do, and then there will be an individual interview that will take about 60 min. The interview will be audio-taped. Once the interviews are transcribed, the audiotapes will be destroyed.

What are the risks and/or discomforts you might experience if you take part in this study?
You may experience a variety of emotions from thinking about and discussing your experience as a homeless young man accessing healthcare in NYC. If you are emotionally or physically upset by the questions, the principal investigator will stop the interview and call the social worker at NAC for immediate attention. The principal investigator will remain with you until the social worker arrives. The social worker will conduct a thorough assessment with you and provide clinical intervention as needed.

Are there any benefits for you if you choose to take part in this research study?
Each participant in the study will receive a list of affordable LGBTQ providers in NYC. The information you give us will help us to understand more about being a homeless gay and/or bisexual young adult man. However, it is possible that you might receive no direct personal benefit from taking part in this study.

What are your alternatives if you don't want to take part in this study?

Your alternative is not to take part in this study.

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Will there be any cost to you to take part in this study?
There are no costs to you to take part in this study.

Will you be paid to take part in this study?
You will be given a $20 in gift card and a $5.50 Metrocard for taking part in the study.

How will information about you be kept private or confidential?
All efforts will be made to keep your participation in the study confidential, but total confidentiality cannot be guaranteed. We will keep all your answers private, as required by law. The study records will be kept in a locked file cabinet and will be password-protected on the computer. Access will be allowed only to the researchers involved in the study.

What will happen if you do not wish to take part in the study or if you later decide not to
stay in the study?
Participation in this study is voluntary. You may choose not to participate or you may change
your mind at any time.

If you do not wish to enter the study or decide to stop participating, your relationship with the study staff or New Alternatives Center (NAC) will not change, and you may do so without penalty and without loss of benefits to which you are otherwise entitled.

Who can you call if you have any questions?
If you have any questions about taking part in this study or if you feel you may have suffered a
research related injury, you can call the Principal Investigator:
Harlem J. Gunness, MPH, PhD Candidate
CDC NYQS
Terminal 4, Rm. 219.016,
Jamaica,
NY 11430
Email: gunneshj@shp.rutgers.edu
If you have any questions about your rights as a research subject, you can call:
Rutgers Health Sciences, IRB Director- Newark
973-972-3608
Or
Human Subject Protection Program - Newark
973-972-1149

What are your rights if you decide to take part in this research study?

You have the right to ask questions about any part of the study at any time. You should not agree to participate in this study unless you have had a chance to ask questions and have been given answers to all of your questions.

RUTGERS, THE STATE UNIVERSITY OF NEW JERSEY IRB
AUDIO/VIDEOTAPE ADDENDUM TO CONSENT FORM

You have already agreed to participate in a research study conducted by Harlem J. Gunness. We are asking for your permission to allow us to audiotape the interview as part of that research study. You do not have to agree to be recorded in order to participate in the main part of the study.

The recording will be used for transcribing the interview. The recording will include the interview conversation. Your name or any other identifying information will not be recorded.
The recording(s) will be stored in a locked file cabinet with no link to your identity and will be
destroyed once the interviews are transcribed.

The investigator will not use the recording(s) for any other reason than those stated in the consent form without your written permission.

Appendix 3

Survey Questionnaire

Demographic Characteristics

1. *Age:*

   What is your age? _ _ years old

2. *Sexual Orientation:* People are different in their sexual attraction to other people. Which best describes your feelings? Please circle one answer. Are you:
   a) Only attracted to females
   b) Mostly attracted to females
   c) Equally attracted to females and males
   d) Mostly attracted to males
   e) Only attracted to males
   f) Don't Know/Not sure

3. *Race:* Which of the following would you say is your race? Please circle one answer:
   a) Alaskan/Native American
   b) Asian
   c) Pacific Islander
   d) Black/African Decent
   e) White
   f) Don't know / Not sure
   g) Other? Please specify_____

4. Ethnicity: Ethnicity refers to the self-reported cultural identity as Hispanic or Non-Hispanic in ancestry.
   Are you Hispanic, Latino/a, or Spanish origin? Please circle one answer:
   a) Yes
   b) No
   c) Don't know / Not sure

5. Education: What is the highest grade or year of school you completed? Please circle one answer:
   a) Never attended school or only attended kindergarten
   b) Grades 1 through 8 (Elementary)
   c) Grades 9 through 11 (Some high school)
   d) Grade 12 or GED (High school graduate)
   e) College 1 year to 3 years (Some college or technical school)

    f) College 4 years or more (College graduate)

    g) Don't know / Not sure

6.   Employment Status: Are you currently? Please circle one or more answer.
    a) Employed for wages
    b) Self-employed
    c) Out of work for one year or more
    d) Out of work for less than one year
    e) A student
    f) Unable to work
    g) Don't know / Not sure
    h) Other, specify_____

7.   What sources of income do you have? (check all that apply; note that food stamps do
not count as income). Please circle one answer.
    a) Employment income
    b) Unemployment Income
    c) Supplemental Security Income (SSI)
    d) Social Security Disability Income (SSDI)
    e) Other, specify_____

Healthcare access

8.   In the past 12 months, have you had a routine check-up by a doctor or a health professional? By routine, we mean a place where you go for yearly physical or check-up (like physical examination, <u>regular</u> screenings, vaccinations or health living). Please circle one answer.
    a) Yes
    b) No
    c) Don't know/Not sure

9.   What kind of place do you **usually** go to for healthcare? Please circle one or more answer.
    a) Don't get preventive care anywhere
    b) Clinic or health center
    c) Doctor's office
    d) Hospital emergency room
    e) Hospital outpatient department
    f) Mobile (van) clinic
    g) Urgent care center
    h) Some other place
    i) Don't go to only one place
    j) Don't know/Not Sure
    k) Other, please specify_____

10. In the past 12 months, what prevented you from getting healthcare? Please circle one or more answer:
    a) Don't know where to go for healthcare
    b) Usual source of healthcare in this area is no longer available
    c) Can't find a provider who understands your needs
    d) Likes to go to different places for different health needs
    e) Don't trust the doctors
    f) Cost of healthcare care too high
    g) Fear of stigma or discrimination by medical staff
    h) Don't have healthcare insurance
    i) Healthcare agency don't accept your health insurance
    j) Don't have the proper paperwork (like social security card, birth certificate, green card) for healthcare benefits
    k) Lack of transportation
    l) Recently moved
    m) Lack of support from friends, peers and family
    n) I don't have any problems accessing healthcare
    o) Don't know/Not sure
    p) Other reason, please specify_____

Measures of Health Status

11. During the past 4 weeks, have you had problems with your work, school or other regular daily activities as a result of your physical health? Please circle one answer.
    a. Yes
    b. No
    e. Don't know/Not Sure

12. During the past 4 weeks, have you had problems with your work, school or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? Please circle one answer.
    a. Yes
    b. No
    e. Don't know/Not Sure

Appendix 4

List of LGBTQ-sensitive Affordable Healthcare Providers in NYC

Name of Healthcare Agency	Address	Contact Information
Callen-Lorde Community Healthcare Center-Manhattan	356 West 18th St, New York, NY 10011	Phone: (212) 271-7200
Callen-Lorde Community Healthcare Center-Bronx	3144 3rd Ave, Bronx, NY 10451	Phone: (718) 215-1800
Community Healthcare Network-Downtown	150 Essex Street New York, NY 10002	Phone: (212) 477-1120
Community Healthcare Network-Downtown-Bronx	975 Westchester Avenue Bronx, NY 10459	Phone: (718) 320-4466
Community Healthcare Network-Downtown-Brooklyn	94-98 Manhattan Avenue, #98 Brooklyn, NY 11206	Phone: (718) 388-0390

Community Healthcare Network-Downtown-Queens	90-04 161st Street, 5th floor Jamaica NY 11432	Phone: (718) 523-2123
APICHA	400 Broadway, New York, NY	Phone: (866) 274-2429
Mount Sinai Adolescent Center	312-320 East 94th Street New York, NY 10128	Phone: (800) 637-4624
Metropolitan Hospital Comprehensive LGBT Health Center	1901 First Avenue at 97th Street, 4th Floor.	Phone: 212-423-7292 Email metlgbt@nychhc.org.
Brooklyn Hospital PATH Center	121 DeKalb Avenue, Brooklyn, NY 11201	Phone: (718) 260-6559

Seeking Bisexual and Gay Young Men For a Research Study

Description of Project:
Bisexual men (meaning men who have sex with men and women or transgenders) and gay men (men who have sex with men) are wanted for a study to understand your experience with access to healthcare and the use of healthcare.
You are invited to take part in an interview that will take about one hour. Your participation is strictly voluntary and confidential. Your name or other identifying information will not be used during the interview.

To Participate You Must:
1. Be male
1. Identify as gay or bisexual,
2. 18 years and older,
3. Self-report as homeless as defined by living without family support and living in shelters, on the streets, in cars or vacant buildings, or "couch surfing" or living in other unstable circumstances for one day or more,
4. Currently living in NYC, and
5. English-speaking.

Participants will receive $20 gift card and $5.50 Metrocard.
To learn more, contact the principal investigator of the study, Harlem Gunness at gunneshj@rutgers.edu or call: 917-434-4201

This research is conducted under the direction of Dr. Sabrina Chase, School of Nursing-Urban Systems Department, and has be reviewed and approved by the Rutgers-Newark University Institutional Review Board

Appendix 6

Script of the Recruitment Announcement

Hello Everyone,

My name is Harlem Gunness. I am a doctoral student at Rutgers University. My purpose for being here today is to inform you of a study I am conducting to better understand access to healthcare among homeless gay and bisexual young adult men. The study will be a brief survey questionnaire consisting of 15 questions and an interview discussing your experience with healthcare since you became homeless. This is a voluntary study. Whether or not you participate in the study, it will not affect the services you receive at the Center. Your name or any identifying information will not be used in the study. The answers you give will be kept confidential. The information you share in the study may help to improve access to healthcare for lesbian, gay, bisexual, transgender and queer/questioning youths like yourself.

To participate in the study, you must:

1.   Be male

1.   Identify as gay or bisexual,

2.   18 years and older,

3.   Self-report as homeless as defined by living without family support and living in shelters, on the streets, in cars or vacant buildings, or "couch surfing" or living in other unstable circumstances for one day or more,

4.   Currently living in NYC, and

5.   English-speaking.

If you agree to participate, you will receive a $20 gift card and $5.50 MetroCard. I am at the Center tonight so if you are interest or have questions, please come and see me in the office. You can also reach me at gunneshj@rutgers.edu or call: 917-434-4201. Again, this study is voluntary and will not affect the services you receive at the Center. Thank you and have a good night!

Appendix 7

Qualitative Interview Codebook

Study Objective	Theme	Category	Code	Definition	Anchor samples
A. Medical health needs	Convenient and habitual			Healthcare services offered in places that this in close proximity to bisexual and gay men. It also includes incentives (like MetroCards) to get to and from clinic. Habitual is the repetitive behavior of accessing healthcare services	
		HIV testing	HIVtst	Participants who reported HIV testing	"Normally I am at Greenwich Village and I might see Healthcare agency ZA0 or Community health vans and they'll do all the testing and I'll go in. Sometimes they have incentives for

					a MetroCard if you get tested and I'll do that. That's an update for me on my status."
	Consistency			Participants who have established consistency in routine care	
		HIV Treatment	HIVtx	Participants on HIV treatment	"You get treated a lot different being positive that you do being negative. It's a lot - I don't even know how to say it. Depending on where you go it could be in a good way because most clinics that I go to treat you - like Healthcare agency ZA0 when I went for my first time - they treated you like you were their child. That's the best experience I've ever had instead of going to Harlem Hospital where they treat you like you're an outsider. To them your status matters. You get a lot more respect and a lot more understanding than

					you do at any other place."
		Pre-exposure prophylaxis	PreP	Participants on PreP treatment or considering treatment	"No, I found a clinic in Harlem and the only reason I'm going there is because they gave me prep pills and I needed to switch my PCP today or else I would get charged for the pills. The clinic is with Healthcare agency ZA0 but I'm not sure of the name."
		Sexually transmitted infections	STI	Participants who had STI screening	"It's always good to know if they've had previous STIs or STDs. Like for instance me, I developed syphilis about 2 1/2 years ago. I got my three shots for it. So most of the time I do say "listen, I had syphilis but it's dormant so you're not gonna catch nothing unless - you won't get anything unless it flares up."
		Tuberculosis	TB	Participants who had TB screening	"When you do your intake and everything, they

					assign you a bed and they give you a series of appointments as far as getting the psych evaluation, get the PPD, and from there you're supposed to make it to the appointment to get it taken care of. Part of what makes people not comply, aside from their own issues, is that often times you spend the whole day sitting there waiting to be seen."
		Unforese en medical needs	UMNs	Unforeseen medical needs that surfaced during interviews (such as dental care, nutritional care and ophthalmologica l care	"With my HIV status I wanted something where I can actually when I leave Ward's Island instead of riding the train and sleeping all day. Maybe looking into nutrition programs, I could volunteer and do things for my community and they try to give back. And also better my health at the same time. They have a day program that starts at 8 AM and they feed you two times

					a day, they teach you about nutrition, and then there is also the clinic upstairs and dental."
B. Mental/ Behavio r health need					
	Delinque nt Activity			Participants who have exhibited delinquent behaviors that were against the law (like jumping turnstiles and violence)	
		Jumping turnstiles	Jmptrnls	Participants who jumped turnstiles without paying transportation	"I would ask somebody for a swipe or I would hop a train. I was mostly getting locked up in my early 20s because of turnstile jumping. The four times that I was supposed to show up at court, I never dead so I had warrants."
		Violence	Vlnc	Participants who experienced	"Even being in the shelter, you have

				violence during homelessness	fights to use the bathroom, we have to fight to use the shower, everything is a battle. Then you have to deal with people with drug addictions and mental illness and people coming out of prisons and jails, all these different personalities and people in different situations - it can be overwhelming. I mostly just meditate and sit in quiet places when it's really bad."
	Depression			Participants who reported history of or treatment for depression	"I'm not trying to pay too much attention to that because my depression really will cripple me if I think about it too much."
	Stress/overwhelmed			Participants who reported or showed evidence of stress or becoming overwhelmed	"It was, I wouldn't say that it wasn't stressful because it was for me. You have to restart everything so I would say it was hard but I tried to persevere."

	Competing needs			Participants who expressed competing needs (such as income [money], food, education, housing, employment and clothing.) that takes precedent over accessing healthcare	"From going to different outreach, as far as going for food or for clothing, and you go to different places and they have different healthcare outreach there."
	Fundamental elements of the study				
		Sexual Identity	Sxlty	Identity, attraction, and sexuality; gay= men having sex with men; bisexual: cisgender women, transsexual persons (male-to-female and female-to-male), and men	"When I say I'm mostly attracted to females it's because it mostly I've been in relationships with -- most recently I was in a ten month relationship with a female-identifying person. Once we broke up I had sex in the mail but usually I'm in male identifying relationships."
		Homelessness	Hmlss	Type and duration of places bisexual men and gay men live without	"Hope Wisdom and Serenity Transitional Living and they had me living all over the

				a residence; sheltered versus unsheltered	place, because they had their major house on Vice Avenue and then they moved that house out to East New York on Elton Avenue somewhere, then back. And then, in the same neighborhood on Intervale, then back, and then they moved everybody back all the way out to ... Well, no, not all the way out. On Longfellow, which was six or seven blocks, but still more or less the same neighborhood. Now, I reside in Harlem where I've been since July."
		Transplant homelessness	Thmlss	Bisexual men and gay men who have migrated to NYC from places in the US other than NYC	"I'm actually from Rockland County. I was born and raised there. I lived there for 21 years. I was finding myself at that time, being in the LGBT community and I've met people in NYC who tell me about a lot of resources that they had for people

					in the community. I left home to come to New York City, I wanted to see how it would be living here so I left my mother's home and came here and I went to Sylvia's Place."
D. Access to healthc are and healthc are utilizati on					
	Fragment ation of access to healthcar e and utilizatio n of healthcar e			Incomplete, break or interruptions of access to and utilization of healthcare; dropping in and out of healthcare	
		Healthcar e services accessed	Hlthaccss	Healthcare agencies that bisexual men and gay men that actually accessed and utilized in NYC	
		Medicati on access	Mdaccss		"Through the prescription that Bellevue gave me. I didn't have to pay

					money, because my Medicaid took care of it. But, I had to leave Manhattan and take the train all the way to another borough just to get that prescription."
		Experience with healthcare before homelessness	Hlthaccss B4hmlnss		Interviewer: Since you became homeless, what has been your experience with access to healthcare? Interviewee: I was getting SSI since I was seven for bipolar disorder."
		Break in communication	BrkinComm	Limited, lack or absence of communication between healthcare providers, government agencies and homeless bisexual men and gay men	"Interviewee: I would ask them questions like, "Oh." 'Cause I didn't know being homo was a sin. I said. They was like, "Yeah, it's a sin." I was like, "Oh, I didn't know that." But damn, that's crazy. Interviewer: At the psych ward, they told you it's a sin? Interviewee: One of them. One of the nurses, but she's very religious. I

					guess that's her opinion and stuff like"
		Misperce ption of Preventiv e Healthcar e	MispPrev Hlth	Bisexual men and gay men poor perception or misunderstandin g of preventive healthcare in NYC	"Interviewer: And what did they do? Interviewee: I had my temperature taken, they gave me an STD test and blood pressure. It was simple. " "Interviewer: Okay. In the past 12 months, you've had a physical? Interviewee: Yes. They had given me ... When I had the dental abscess, and I went to the Lennox Hospital, they had given me the big tetanus shot and, I think, two prescriptions."
	Cyclical navigatio n of the healthcar e system			The repeated cycle of making one's way through the healthcare	
		Governm ent benefits	Gvtbene	Government entitlements for homeless young adults (like	"I just had Medicaid and snap benefits (food stamps). So it was

| | | | | Medicaid, Supplemental Nutrition Assistance Program, [SNAP Food Stamps], and public assistance) | kind of hard, it's really hard being homeless with healthcare because I would never really get any notices for recertification, they would cut off my Medicaid and my medications that I can't stop taking. The mail situation made it really difficult, not getting my mail, and sometimes I wanted to make an appointment but I couldn't even see a doctor or anything like that. I had to go through the process of recertification. I've done the process so many times in the last eight years it's not even funny. I've lost count." |
| | | Proximity of healthcare services | PrmtyHlthSvs | Geographic distance between bisexual men and gay men dwelling location and the actual location of healthcare centers/clinics | "Before I went to Boom Health I was going all the way out to Far Rockaway, Queens which was like two hours. I was still living in Manhattan but I would go to Far Rockaway for |

					healthcare. But after that I switched to Boom Health which made it more convenient for me."
		Transportation accessibility	Transaccss	Main mode of transport to and from healthcare facilities (like NYC subways and buses)	"You only get MetroCards if you go to groups or something. Or if you speak to your caseworker and bring evidence that you have a doctor's appointment or some type of appointment. Then the caseworker feels like it's worth their money then I'll give it to you."
	Facilitators of access of healthcare			Factors that help bring bisexual men and gay men in to healthcare and/or keep them in care	
		Social support	Sclsppt	Support from either a peer (another homeless LGBTQ young adult) or a parent	"Well, one of my friend said, "There's a drop-in center in Harlem, you should go there. All you gotta do is tell them you're homeless, and you're bisexual, and they'll accept you." So I went. It

					was 2012, at the end of 2012, around Christmas, I went."
		Comfortability of medical providers	CfmtMed	Medical providers state of being comfortable with bisexual men and gay men	"I feel like actually they're not just regular doctors or nurses, they're actually people that take their job seriously. They care about their patients. They're in it not because of a check. They actually want to make sure that people are better and they actually care and if they think that there's an issue, they keep you, they don't send you home. They keep you for observation. I'm constantly having these episodes where my leg is swollen with abscesses. When I went there they also educate you. They help me understand a lot about my body. I'm in so much pain but I know that if I go to Mount Sinai, I'll feel better."

		Providing incentives	Pvdints	Provision of no-cost items (like MetroCards, gift cards, food and clothing) that incites or has a tendency to incite access to or utilization of healthcare services	"They offer a lot of incentive programs. So if you go to your appointments they give you a $15 gift card. For each appointment, procedure, prep test, they'll send you a gift card."
		Comprehensive healthcare services	Complhthsvcs	Provision of a broad array of healthcare services beyond primary care such as dental care, psychiatry, ophthalmology, podiatry and nutrition	"Ultimately when I got re-certified, I firmly committed back into care, I was a Brightpoint, well it was Health PSI before they changed their name to Brightpoint. And I have been consistent with them for the last two, if not, going on three years. I see my psych nurse practitioner in relation to my mental health there. I see the primary care physician for all the other physical things. I get my meds from the Boom Pharmacy, which is related to the clinic they have in the

					Boom Health building."
NA	Fundame ntal elements of the study				
		Intricacy of Sexuality	Sxlty	Identity, attraction, and sexuality; gay= men having sex with men; bisexual: men having sex with cisgender women, transsexual persons (male-to-female and female-to-male), and men	"When I say I'm mostly attracted to females it's because it mostly I've been in relationships with -- most recently I was in a ten month relationship with a female-identifying person. Once we broke up I had sex in the mail but usually I'm in male identifying relationships."
		Sexual Health Assessme nt	SxHlthAs st	Discussion on sexual health assessment at healthcare agencies or provider's discussion on sexual health with participants	"No. That's not what they were concerned with. What are you here for today I have your physical that kind of stuff. When they have a STI testing it's just a screening and not talking to me about anything."

| | | Fragmentation in shelter | FrgShltr | Type and duration of places bisexual men and gay men live without a residence; sheltered versus unsheltered | "Hope Wisdom and Serenity Transitional Living and they had me living all over the place, because they had their major house on Vice Avenue and then they moved that house out to East New York on Elton Avenue somewhere, then back. And then, in the same neighborhood on Intervale, then back, and then they moved everybody back all the way out to ... Well, no, not all the way out. On Longfellow, which was six or seven blocks, but still more or less the same neighborhood. Now, I reside in Harlem where I've been since July." |
| | | Personal Safety | PrsnlSfty | Participant's concerned for their safety | "Even being in the shelter, you have fights to use the bathroom, we have to fight to use the shower, everything is a battle. Then you have to deal |

					with people with drug addictions and mental illness and people coming out of prisons and jails, all these different personalities and people in different situations - it can be overwhelming."
		Transplant homelessness	Thmlss	Bisexual men and gay men who have migrated to NYC from places in the US other than NYC	"I'm actually from Rockland County. I was born and raised there. I lived there for 21 years. I was finding myself at that time, being in the LGBT community and I've met people in NYC who tell me about a lot of resources that they had for people in the community. I left home to come to New York City, I wanted to see how it would be living here so I left my mother's home and came here and I went to Sylvia's Place."
A. Medical	Convenie			Healthcare services offered in places that are	

| health needs | nt and habitual | | | in close proximity to bisexual and gay men. It also includes incentives (like MetroCards) to get to and from clinic.

Habitual is the repetitive behavior of accessing healthcare services | |
|---|---|---|---|---|---|
| | | HIV testing | HIVtst | Participants who reported HIV testing | "Normally I am at Greenwich Village and I might see Healthcare agency ZA0 or Community health vans and they'll do all the testing and I'll go in. Sometimes they have incentives for a MetroCard if you get tested and I'll do that. That's an update for me on my status." |
| | | Stigmatiz ation | Stgmztn | Participants who expressed stigma as a barrier of access to healthcare | "The hot van is a little more obvious because it's a van on the street and people who make their own |

					assumptions and make comments. You're walking into the van like "oh you're going to get a STD screening", "you're dirty" or "you're broke" -- I feel a little more isolated in there. I think the stigma is coming from some of my peers and some of the public. Like what the hot van is associated with. A lot of healthcare providers who are associated with LGBT seem to have a sort of negative stigma when it comes to STD and HIV testing in my experience because you'll go and people will make comments. And make statements that are very much not true. And because of that visibility within the specific spaces, to be assumed that this is, you know, how you are, where you are, and how

					the public views you."
	Consistency			Participants who have established consistency in routine care	
		HIV Treatment	HIVtx	Participants on HIV treatment	"You get treated a lot different being positive that you do being negative. It's a lot - I don't even know how to say it. Depending on where you go it could be in a good way because most clinics that I go to treat you - like Healthcare agency ZA0 when I went for my first time - they treated you like you were their child. That's the best experience I've ever had instead of going to Harlem Hospital where they treat you like you're an outsider. To them your status matters. You get a lot more respect and a lot more understanding than you do at any other place."

		Shelter operation al barrier	ShltrOptn lBrrr	Operational barriers to HIV treatment	"Basically the medications, when it comes to getting medications. So depending on what shelter you're in, trying to keep an appointment has been the most difficult because they kick you out at like six in the morning so then when it's time for you to go to your appointment, my experience has been where I'll leave the shelter early or I'll get on the train and I'll fall asleep or pass out. So I'll miss the appointment or it'll be some kind of obstacle, like the shelter won't give you car fare to go."
		Pre- exposure prophyla xis	PreP	Participants on PreP treatment or considering treatment	"No, I found a clinic in Harlem and the only reason I'm going there is because they gave me prep pills and I needed to switch my PCP today or else I would get charged for the pills. The clinic is with Healthcare

					agency ZA0 but I'm not sure of the name."
		Sexually transmitted infections	STI screening	Participants who had STI screening	"It's always good to know if they've had previous STIs or STDs. Like for instance me, I developed syphilis about 2 1/2 years ago. I got my three shots for it. So most of the time I do say "listen, I had syphilis but it's dormant so you're not gonna catch nothing unless - you won't get anything unless it flares up."
		Tuberculosis	TB	Participants who had TB screening	"When you do your intake and everything, they assign you a bed and they give you a series of appointments as far as getting the psych evaluation, get the PPD, and from there you're supposed to make it to the appointment to get it taken care of. Part of what makes people not comply, aside from their own issues, is

					that often times you spend the whole day sitting there waiting to be seen."
		Unmet medical needs	UMNs	Unmet medical needs that surfaced during interviews (such as dental care, nutritional care and ophthalmological care	"With my HIV status I wanted something where I can actually when I leave Ward's Island instead of riding the train and sleeping all day. Maybe looking into nutrition programs, I could volunteer and do things for my community and they try to give back. And also better my health at the same time. They have a day program that starts at 8 AM and they feed you two times a day, they teach you about nutrition, and then there is also the clinic upstairs and dental."
B. Mental/ Behavior health need					

	Delinque nt Activity			Participants who have exhibited delinquent behaviors that were against the law (like jumping turnstiles and violence)	
		Jumping turnstiles	Jmptrnls	Participants who jumped NYC subway turnstiles without paying transportation	"I would ask somebody for a swipe or I would hop a train. I was mostly getting locked up in my early 20s because of turnstile jumping. The four times that I was supposed to show up at court, I never dead so I had warrants."
		Violence	Vlnc	Participants who experienced violence during homelessness or were victimized while homeless	"Even being in the shelter, you have fights to use the bathroom, we have to fight to use the shower, everything is a battle. Then you have to deal with people with drug addictions and mental illness and people coming out of prisons and jails, all these different personalities and people in different

					situations - it can be overwhelming. I mostly just meditate and sit in quiet places when it's really bad."
	Depression			Participants who reported history of or treatment for depression	"I'm not trying to pay too much attention to that because my depression really will cripple me if I think about it too much."
	Stress/overwhelmed			Participants who reported or showed evidence of stress or becoming overwhelmed	"It was, I wouldn't say that it wasn't stressful because it was for me. You have to restart everything so I would say it was hard but I tried to persevere."
	Competing needs			Participants who expressed competing needs (such as income [money], food, education, housing, employment and clothing.) that takes precedent over accessing healthcare	"From going to different outreach, as far as going for food or for clothing, and you go to different places and they have different healthcare outreach there."

D. Access to healthcare and healthcare utilization					
	Fragmentation of access to healthcare and utilization of healthcare			Incomplete, break or interruptions on access to and utilization of healthcare; not getting the proper care needed or required	
		Healthcare services accessed	Hlthaccss	Healthcare agencies that bisexual men and gay men that actually accessed and utilized in NYC	
		Medication access	Mdaccss	Bisexual men and gay men need for access to medication	"Through the prescription that Bellevue gave me. I didn't have to pay money, because my Medicaid took care of it. But, I had to leave Manhattan and take the train all the way to another borough

					just to get that prescription."
		Healthcare before homelessness	HlthaccssB4hmlnss	Bisexual men and gay men who have had access to healthcare before homelessness	Interviewer: Since you became homeless, what has been your experience with access to healthcare? Interviewee: I was getting SSI since I was seven for bipolar disorder."
		Break in communica-tion	BrkinComm	Limited, lack or absence of communication between healthcare providers and/or government agencies and homeless bisexual men and gay men	"Interviewee: I would ask them questions like, "Oh." 'Cause I didn't know being homo was a sin. I said. They was like, "Yeah, it's a sin." I was like, "Oh, I didn't know that." But damn, that's crazy. Interviewer: At the psych ward, they told you it's a sin? Interviewee: One of them. One of the nurses, but she's very religious. I

					guess that's her opinion and stuff like"
		Misperce ption of Preventiv e Healthcar e	MispPrev Hlth	Bisexual men and gay men poor perception or misunderstandin g of preventive healthcare in NYC	"Interviewer: And what did they do? Interviewee: I had my temperature taken, they gave me an STD test and blood pressure. It was simple. " "Interviewer: Okay. In the past 12 months, you've had a physical? Interviewee: Yes. They had given me ... When I had the dental abscess, and I went to the Lennox Hospital, they had given me the big tetanus shot and, I think, two prescriptions."
	Cyclical navigatio n of the healthcar e system			The repeated cycle of making one's way through the healthcare	
		Governm ent benefits	Gvtbene	Government entitlements for homeless young adults (like	"I just had Medicaid and snap benefits (food stamps). So it was

| | | | | Medicaid, Supplemental Nutrition Assistance Program, [SNAP Food Stamps], and public assistance) | kind of hard, it's really hard being homeless with healthcare because I would never really get any notices for recertification, they would cut off my Medicaid and my medications that I can't stop taking. The mail situation made it really difficult, not getting my mail, and sometimes I wanted to make an appointment but I couldn't even see a doctor or anything like that. I had to go through the process of recertification. I've done the process so many times in the last eight years it's not even funny. I've lost count." |
| | | Proximity of healthcare services | PrmtyHlthSvs | Geographic distance between bisexual men and gay men dwelling location and the actual location of healthcare centers/clinics | "Before I went to Boom Health I was going all the way out to Far Rockaway, Queens which was like two hours. I was still living in Manhattan but I would go to Far Rockaway for |

					healthcare. But after that I switched to Boom Health which made it more convenient for me."
		Transport ation accessibil ity	Transacc ss	Main mode of transport to and from healthcare facilities (like NYC subways and buses); transportation fare or free access into the transportation system	"You only get MetroCards if you go to groups or something. Or if you speak to your caseworker and bring evidence that you have a doctor's appointment or some type of appointment. Then the caseworker feels like it's worth their money then I'll give it to you."
	Facilitato rs of access to healthcar e			Factors that help bring bisexual men and gay men in to healthcare and/or keep them in care	
		Social support	Sclsppt	Support from either a peer (another homeless LGBTQ young adult) or a parent	"Well, one of my friend said, "There's a drop-in center in Harlem, you should go there. All you gotta do is tell them you're homeless, and you're bisexual, and they'll accept you." So I went. It

					was 2012, at the end of 2012, around Christmas, I went."
		Comfortability of medical providers	CfmtMed	Medical providers state of being comfortable with homeless bisexual and gay young adult men	"I feel like actually they're not just regular doctors or nurses, they're actually people that take their job seriously. They care about their patients. They're in it not because of a check. They actually want to make sure that people are better and they actually care and if they think that there's an issue, they keep you, they don't send you home. They keep you for observation. I'm constantly having these episodes where my leg is swollen with abscesses. When I went there they also educate you. They help me understand a lot about my body. I'm in so much pain but I know that if I go to Mount Sinai, I'll feel better."

| | | Providing incentives | Pvdints | Provision of no-cost items (like MetroCards, gift cards, food and clothing) that incites or has a tendency to incite access to or utilization of healthcare services | "They offer a lot of incentive programs. So if you go to your appointments they give you a $15 gift card. For each appointment, procedure, prep test, they'll send you a gift card." |
| | | Comprehensive healthcare services | Comphlthsvcs | Provision of a broad array of healthcare services beyond primary care such as dental care, psychiatry, ophthalmology, podiatry and nutrition | "Ultimately when I got re-certified, I firmly committed back into care, I was a Brightpoint, well it was Health PSI before they changed their name to Brightpoint. And I have been consistent with them for the last two, if not, going on three years. I see my psych nurse practitioner in relation to my mental health there. I see the primary care physician for all the other physical things. I get my meds from the Boom Pharmacy, which is related to the clinic they have in the |

					Boom Health building."

Appendix 8

Study Screening Tool

1. *Age:* What is your age? _ _ years old

2. *Gender:* What gender do you identify to? Please choose one answer:
    a. Male
    b. Female
    c. Transgender female (biological male who identifies as female)
    d. Transgender male (biological female who identifies as male)
    e. Queer
    f. Questioning/Not sure

3. *Sexual Orientation:* People are different in their sexual attraction to other people. Which best describes your feelings? Please choose one answer. Are you:
    a. Only attracted to females
    b. Mostly attracted to females
    c. Equally attracted to females and males
    d. Mostly attracted to males
    e. Only attracted to males
    f. Don't Know/Not sure

4. Do you speak, read, and understand English? Please choose one answer.
    a. Yes
    b. No

5. What is your current housing situation like? Please choose one answer.
    a. Unsheltered (living on the street)
    b. Staying at shelter (like Ward's Island and Brooklyn Women)
    c. Staying with a friend or family member
    d. Other, please specify_____

6. How long have you been homeless?

    a. _ _ (years) _ _(months)

Table 7.

Physical health problems

Participant Number	Sexual Orientation Status	Number of Physical Health Problems Reported N (%)
1	Bisexual	6 (35%)
4	Bisexual	2 (12%)
5	Bisexual	6 (35%)
6	Bisexual	4 (24%)
9	Bisexual	4 (24%)
10	Bisexual	3 (18%)
11	Bisexual	4 (24%)
13	Bisexual	2 (12%)
14	Bisexual	2 (12%)
16	Bisexual	4 (24%)
17	Bisexual	2 (12%)
18	Bisexual	4 (24%)
21	Bisexual	4 (24%)
22	Bisexual	6 (35%)
26	Bisexual	3 (18%)
27	Bisexual	2 (12%)
28	Bisexual	1 (6%)
2	Gay	2 (15%)
3	Gay	2 (15%)
7	Gay	3 (23%)
8	Gay	2 (15%)
12	Gay	2 (15%)
15	Gay	2 (15%)
19	Gay	4 (31%)
20	Gay	5 (38%)
23	Gay	3 (23%)
24	Gay	4 (31%)
25	Gay	6 (46%)
29	Gay	-
30	Gay	3 (23%)
Mean		**3.233333333**
Median		**3**

Mode		**1**
Std Dev.		**1.520599297**
Range		**0-6**
Total	**30**	**97**
Bisexual	**17**	**59**
Gay	**13**	**38**

Table 8

Physical health-bisexual men

Participant Number	Sexual Orientation Status	Number of Physical Health Problems Reported N (%)
1	Bisexual	6 (35%)
4	Bisexual	2 (12%)
5	Bisexual	6 (35%)
6	Bisexual	4 (24%)
9	Bisexual	4 (24%)
10	Bisexual	3 (18%)
11	Bisexual	4 (24%)
13	Bisexual	2 (12%)
14	Bisexual	2 (12%)
16	Bisexual	4 (24%)
17	Bisexual	2 (12%)
18	Bisexual	4 (24%)
21	Bisexual	4 (24%)
22	Bisexual	6 (35%)
26	Bisexual	3 (18%)
27	Bisexual	2 (12%)
28	Bisexual	1 (6%)
Total	**17**	**59**
Mean		**3.470588235**

Table 9

Physical health-gay men

Participant Number	Sexual Orientation Status	Number of Physical Health Problems Reported N (%)
2	Gay	2 (15%)
3	Gay	2 (15%)
7	Gay	3 (23%)
8	Gay	2 (15%)
12	Gay	2 (15%)
15	Gay	2 (15%)
19	Gay	4 (31%)
20	Gay	5 (38%)
23	Gay	3 (23%)
24	Gay	4 (31%)
25	Gay	6 (46%)
29	Gay	-
30	Gay	3 (23%)
Total	**13**	**38**
Mean		**2.923076923**

Median		4		Median		3
Mode		4		Mode		2
Std Dev.		1.499711622		Std Dev.		1.491593802
Range		0-6		Range		0-6

Table 10

List of physical health issues reported by participants during interviews

	Physical Health Problems	Bisexual men (N = 17)	Gay men (N = 13)	All men (N = 30)
		N (%)	N (%)	N (%)
1.	HIV prevention	14 (83%)	11 (85%)	25 (83%)
2.	STI (non-HIV	11 (65)	12 (93%)	23 (77%)
3.	TB	6 (35%)	1 (8%)	7 (23%)
4.	HIV treatment	2 (12%)	2 (15%)	4 (13%)
5.	Hypertension	2 (12%)	2 (15%)	4 (13%)
6.	Asthma	2 (12%)	2 (15%)	4 (13%)
7.	Fatigue	3 (18%)	2 (15%)	5 (13%)
8.	Abscess	2 (12%)	1 (8%)	3 (10%)
9.	Eczema	2 (12%)	-	2 (7%)
10.	Injury	2 (12%)	-	2 (7%)
11.	Seizures	2 (12%)	-	2 (7%)
12.	Allergies	1 (6%)	1 (8%)	2 (7%)
13.	Blisters	1 (6%)	-	1 (3%)
14.	Syphilis	-	1 (8%)	1 (3%)
15.	HPV	1 (6%)	-	1 (3%)
16.	Diabetes	1 (6%)	-	1 (3%)
17.	Heart disease	-	1 (8%)	1 (3%)
18.	Sleep deprivation	1 (6%)	-	1 (3%)
19.	Stomach virus	-	1 (8%)	1 (3%)

20.	Sinus infection	1 (6%)	-	1 (3%)
21.	Kidney disease	-	1 (8%)	1 (3%)
22.	Vaccination	1 (6%)	-	1 (3%)
23.	Flu shot	1 (6%)	-	1 (3%)
24.	Scoliosis	1 (6%)	-	1 (3%)
25.	Autism	1 (6%)	-	1 (3%)
26.	Shingles	1 (6%)	-	1 (3%)
Total		**59 (61%)**	**38 (39%)**	**97 (100%)**

Table 11

Mental/behavioral health conditions of the participants

Participant Number	Behavioral Health Conditions	Bisexual men (N = 17) N (%)	Gay men (N = 13) N (%)	All men (N = 30) N (%)
1.	Justice-Involved Activity	8 (47%)	6 (46%)	14 (46%)
2.	Substance use/misuse	6 (35%)	1 (8%)	7 (23%)
3.	Incarceration	3 (18%)	3 (23%)	6 (20%)
	Mental Health Conditions			
4.	Depression	8 (47%)	4 (31%)	12 (40%)
5.	Stressed/overwhelmed	6 (35%)	6 (46%)	12 (40%)
6.	Bipolar	6 (35%)	3 (23%)	9 (30%)
7.	Attention Deficit Hyperactivity Disorder (ADHD)	5 (29%)	1 (8%)	6 (20%)
8.	Schizophrenia	5 (29%)	1 (8%)	6 (20%)
9.	Anxiety	1 (6%)	3 (23%)	4 (13%)
10.	Unknown diagnosis	3 (18%)	1 (8%)	4 (13%)
11.	Multiple Personality Disorder	2 (12%)	1 (8%)	3 (10%)
12.	Post-Traumatic Stress Disorder (PTSD)	-	2 (15%)	2 (7%)
13.	Attention Deficit Disorder (ADD)	1 (6%)	-	1 (3%)
14.	Suicide	1 (6%)	-	1(3%)

Total	**55**	**32**	**87**
Mean	**3.928571429**	**2.285714**	**6.214286**
Median	**4**	**1.5**	**6**
Mode	**6**	**1**	**6**
Std Dev.	2.603960876	1.905952	4.038716
Range	0-8	0-6	1-14

Table 12

Healthcare agencies accessed

Healthcare Agency	Bisexual men (N = 17) N (%)	Gay men (N = 13) N (%)	All men (N = 30) N (%)
Health agency Zed	4 (24%)	6 (46%)	10 (33%)
Health agency Linden	4 (24%)	4 (31%)	8 (27%)
Unknown Health Center	4 (24%)	4 (31%)	8 (27%)
Health and Housing agency Sterlin	2 (12%)	2 (15%)	4 (13%)
Health agency Barry	1 (6%)	3 (23%)	4 (13%)
Health agency Big	2 (12%)	2 (15%)	4 (13%)
Health and Housing agency Drew	2 (12%)	1 (8%)	3 (10%)
Health agency Carrie	1 (6%)	2 (15%)	3 (10%)
Health agency Deed	-	2 (15%)	2 (7%)

Health agency PS	1 (6%)	1 (8%)	2 (7%)
Health agency Comey	-	2 (15%)	2 (7%)
ZA28 Health agency	1 (6%)	-	1 (3%)
ZA4 Health agency	-	1 (8%)	1 (3%)
ZA17 Health agency	1 (6%)	-	1 (3%)
ZA15 Health agency	1 (6%)	-	1 (3%)
ZA33 Health agency	1 (6%)	-	1 (3%)
ZA25 Health agency	1 (6%)	-	1 (3%)
ZA31 Health agency	-	1 (8%)	1 (3%)
Private doc	1 (6%)	-	1 (3%)
ZA13 Health agency	-	1 (8%)	1 (3%)
ZA16 Health and housing agency	1 (6%)	-	1 (3%)
Total	28	32	100
Mean	1.333333	1.52381	2.85714
Median	1	1	2
Mode	1	0	1

Std Dev.	1.433325	1.59221	2.62381
Range	0, 4	0, 6	1, 10

[Note that code names were given to agencies to protect their identity]

Table 13

Hospital facilities accessed

	Bisexual men	Gay men	All men
Hospitals	(N = 17) N (%)	(N = 13) N (%)	(N = 30) N (%)
Hospital Butterfly	5 (29%)	2 (15%)	7 (23%)
Mount Sinai Hospital	5 (29%)	2 (15%)	7 (23%)
Healthcare agency Zed	5 (29%)	1 (8%)	6 (20%)
Betsy North Hospital	2 (12%)	2 (15%)	4 (13%)
Knox Hospital	1 (6%)	1 (8%)	2 (7%)
Rosey Hospital	2 (12%)	-	2 (7%)
New York University Medical Center	2 (12%)	-	2 (7%)
Hospital Moses	-	2 (15%)	2 (7%)
Hospital Downey	1 (6%)	-	1 (3%)

Hospital Kingdom	1 (6%)	-	1 (3%)
Hospital Instate	1 (6%)	-	1 (3%)
Hospital Emily	1 (6%)	-	1 (3%)
Hospital Meteo	1 (6%)	-	1 (3%)
Hospital Brooklyn	1 (6%)	-	1 (3%)
Hospital Wolly	1 (6%)	-	1 (3%)
Hospital Richard	-	1 (8%)	1 (3%)
Total	29	11	40
Mean	1.8125	0.6875	2.5
Median	1	0	1.5
Mode	1	0	1
Std Dev.	1.6286018	0.84548	2.15058
Range			

[Note that code named were given to hospitals to protect their identity]

Table 14

Utilization of hospital versus non-hospital facilities

Agency	Number of times accessed	Number of times bisexual men accessed (%)	Number of times gay men accessed (%)
Hospital	40	29 (73%)	11 (27%)
Non-hospital	60	28 (47%)	32 (53%)
Total	100	57 (57%)	43 (43%)