



HEALTHY FLORIDA - ST PETE

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# PROJECT REPORT

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## HEALTHY FLORIDA - ST. PETE PROJECT REPORT

The high-level impact of social determinants on the health of South St. Petersburg have been previously well documented. A clearer understanding of the specific barriers to care were needed to adequately address the disparities that persist in communities of color. When we ask people directly about their experiences with the health care system, we can learn if the community is meeting the health care needs of its residents. This is a process that occurs at the international and national levels with large scale formal surveys undertaken by governments and large foundations<sup>1</sup>. This project brought this methodology to the local community of south St. Pete. The survey was designed using questions similar to large scale the International Health Policy Survey from the Commonwealth fund to gain a clearer understanding of the specific barriers to health care and to the social determinants that contribute to persistent health disparities in the vulnerable communities of color in south St. Pete. The Social Barriers project of the Fight Like Health, St. Pete initiative took a grassroots approach aimed to identify and quantify the specific local barriers to health and health care access for the most vulnerable neighborhoods of south St. Pete.

### METHODS

To achieve the aim, the project team developed and distributed a survey about health status and health services access to south St. Pete residents. The survey was designed to gain a clearer understanding of the specific barriers to health care and to the social determinants that contribute to persistent health disparities in the vulnerable communities of color in south St. Pete. It consisted of 18 closed-ended questions inquiring about health status, recent access of health care services, and barriers to that access. In accordance with epidemiological survey recommendations, this survey opened with a request for respondents to rate their overall health on an ordinal scale of 1 to 5 (poor to excellent) as self-rated health is predictive of mortality, morbidity, and health service usage at the community level<sup>2</sup>. Physical, mental and oral health were addressed in the survey. To understand how social determinants and community environments contribute to health status and health care access, questions about housing, food, safety, and transportation were included. Demographic characteristics including gender, education, income, race and ethnicity were elicited from respondents.

The survey was distributed in-person at more than 20 community events in south St. Pete, as well as via an online campaign aimed at residents in our target ZIP codes in south St. Pete. Most of the events focused on health literacy and health services access and included health fairs and community presentations. Survey respondents were also recruited at food pantry distribution centers, large family-oriented events, college campuses, and churches. This survey targeted working age adults, 18 to 64 years, with some respondents indicating they were retired, mostly due to disability, rather than being at retirement age.

To triangulate the data from the survey and enhance the understanding of factors that enhance or impede the south St. Pete residents' access to health care we held two focus group sessions. The first focus group was comprised of community members for an emic perspective of health and health care of the south St. Pete community and to see if the opinions and perceptions added to the data collected in the survey

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<sup>1</sup> Osborn, R., Squires, D., Doty, M.M., Sarnak, D.O., & Schneider, E.C. (2016). In new survey of eleven countries, US adults still struggle with access to and affordability of health care. *Health Affairs* 35(12): 2327-2336. doi: 10.1377/hlthaff.2016.1088

<sup>2</sup> Zajacova, A. & Beam Dowd, J. (2011). Reliability of self-rated health in US adults. *American Journal of Epidemiology*, 174(8): 977-983. doi: 10.1093/aje/kwr204

responses. Leaders of the agencies and organizations that provide services to the community were the participants of the second group as a check to see if the service community perceived the same needs and solutions as were elicited from the community by the survey and through the first focus group.

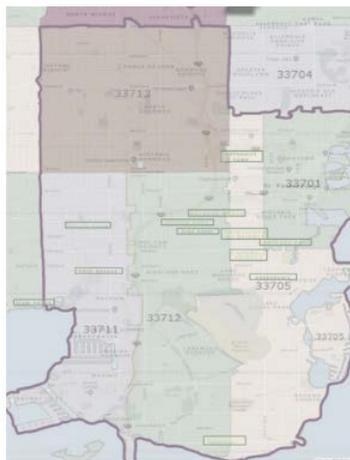
## SURVEY COMMUNITY AND RESPONDENT CHARACTERISTICS

There were 281 responses to the survey; ten respondents did not answer the questions about their neighborhood of residence. Of those that did report, 79.3% ( $n = 215$ ) reported neighborhoods or ZIP codes from the primary target areas of Palmetto Park, Child's Park, Jordan Park, Methodist Town, Melrose Mercy, Pine Acres, Cromwell Heights, Thirteenth Street Heights, Twinbrooks, Clam Bayou, Harbordale, Bartlett Park, and the Greater Pinellas Point neighborhoods. The remaining 56 respondents reported residents in ZIP codes from other areas of Pinellas County and nearby parts of Florida.

The US Census bureau estimates total population in the five ZIP codes<sup>3</sup> at 118,033 (MOE  $\pm$  1,137) and the population for adults between 18 and 64 years at 77,503 (MOE  $\pm$  1,412). The demographic characteristics of the respondents differed substantially from the distribution reflected in the American Community Survey (ACS) 5-year estimates from 2016. There are two major contributing factors that likely explain these differences. Firstly, using the ZIP codes to pinpoint the community demographics is an inexact process; the ZIP codes that include the targeted highly vulnerable areas expand beyond the boundaries of the target neighborhoods, see Figure 1 for the broad area reflected by the ZIP codes and the highlighted neighborhoods of interest. Secondly, the specific outreach methods used in this survey were aimed at learning the experiences of community members most affected with difficulties in accessing health care services, this segment of the population may not exactly mirror the total population. Figures 2 and 3 depict the discrepancies in the distributions of population characteristics.

Because the income levels of the respondents were significantly lower than that reported in the same general area by the ACS and the proportion of the respondents who are minority races was larger, we believe the survey was successful at reaching respondents who represent the most vulnerable neighborhoods in south St. Petersburg.

Figure 1: Survey Target by ZIP code and Neighborhoods



<sup>3</sup> ZIP Codes for estimated target area of interest: 33701, 33705, 33711, 33712, and 33713

Figure 2: Population racial reports by ACS 2016 and Survey Report

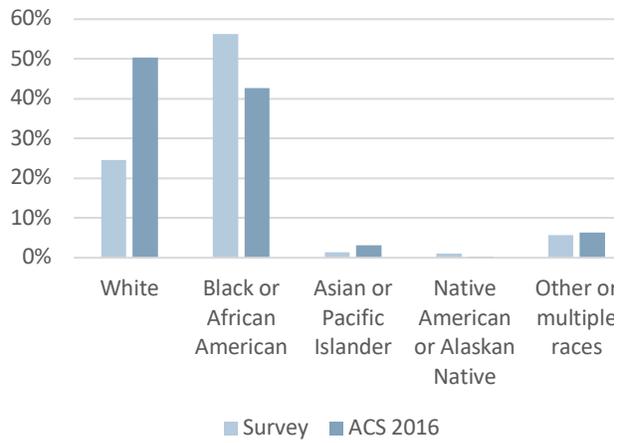
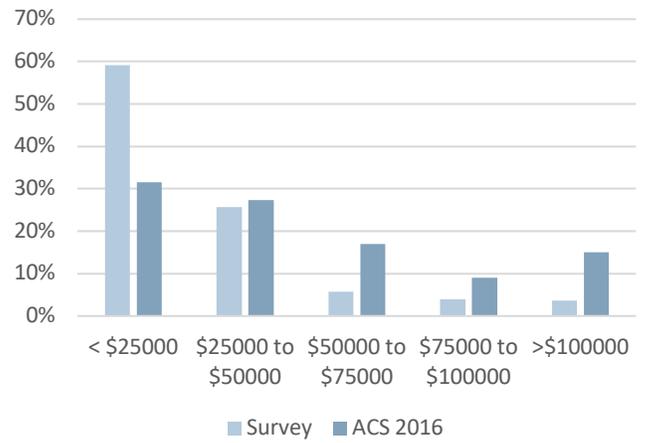


Figure 3: Household income reports by ACS 2016 and Survey Report



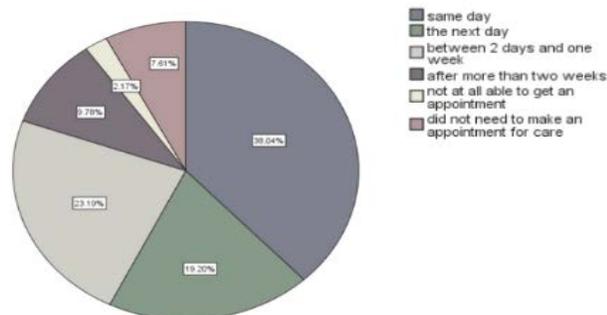
## RECEIVING HEALTH CARE SERVICES

About three-fourths of respondents ( $n = 206$ , 74.4%) reported having received a routine physical checkup within the past 12 months. Twelve percent reported longer than two years since their most recent physical exam, while four respondents (1.4%) had never received a routine physical examination.

More than four out of ten respondents reported delays to care when they were ill or injured. The delays ranged from two days to longer than two weeks, with a few respondents who reported no availability of care at all (figure 4). More than half (54%) of respondents reported receiving some health care by visiting a hospital emergency department (ED) within the last 12 months. The number of visits per person ranged from one ( $n = 22$ ) to ten (one respondent) with the majority ( $n = 97$ ) reporting more than one visit, but not recalling the exact number. Nearly half of the respondents reported that their visits to the EDs were for conditions that could have been managed in a clinic or office had services been available.

Figure 4: Access to acute care

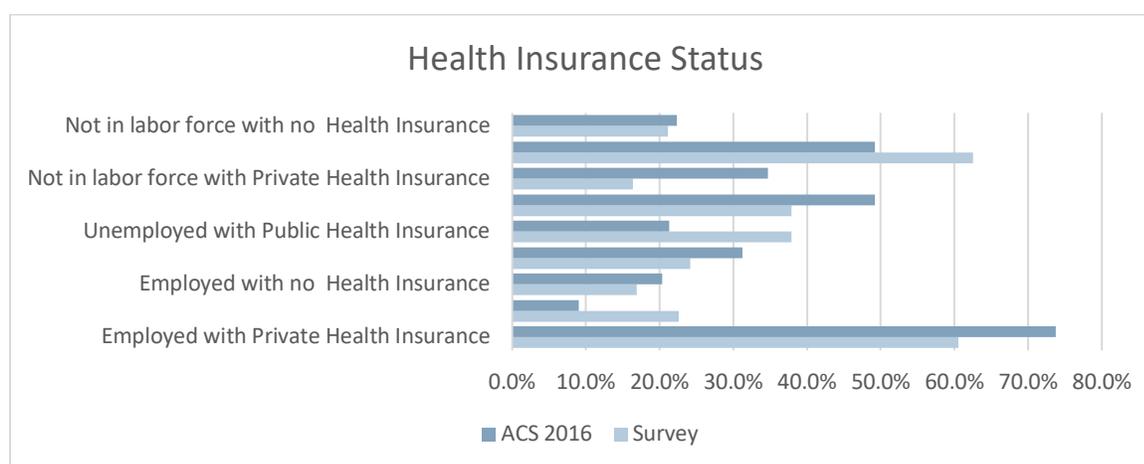
Last time you were sick or needed medical attention, how quickly could you get an appointment to see a doctor or nurse? (Do not consider any visits to a hospital emergency room)



## HEALTH INSURANCE COVERAGE

Most of the respondents reported having health insurance ( $n = 220$ , 81.5%), leaving 18.5% without health care coverage. This is lower than the most recent report of Florida's statewide uninsured rate for adults ages 18 to 64 years of 20.1%<sup>4</sup>. When comparing survey respondents' health insurance coverage by employment status to the most recent US census data for the communities of interest, the respondents have greater levels of coverage through public insurance programs<sup>5</sup> than the community at large<sup>6</sup>. See figure 5. The survey did not specifically ask if respondents use the Pinellas County Health Plan (Blue Card) because it is not truly an insurance arrangement, but four respondents volunteered that they participated with the plan.

Figure 5: Respondents health coverage status compared with overall community coverage



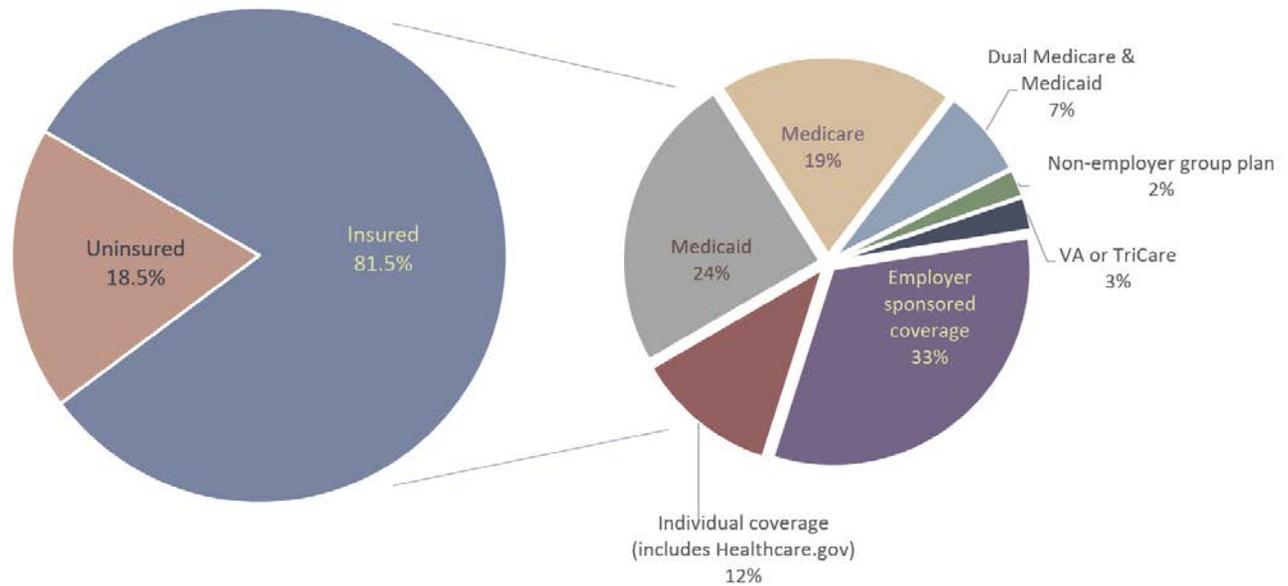
The distribution of types of health insurance coverage reported by the survey respondents indicates a greater reliance on public programs, specifically reliance on Florida Medicaid services, than the overall adult community at large. See figure 6.

<sup>4</sup> National Center for Health Statistics. Health insurance coverage: Early release of estimates from the National Health Insurance Survey, 2018. Released May 2018 available on-line: <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201805.pdf>

<sup>5</sup> Public insurance includes Medicare, Medicaid, dual eligible Medicare & Medicaid, VA coverage, and Tri-Care

<sup>6</sup> As reported by the U.S. Census Bureau American Community Survey 5-year estimates from 2016 for ZIP Codes 33701, 33705, 33711, 33712, and 33713

Figure 6: Health insurance coverage



This higher reliance on Medicaid and evidence of disability through dual Medicare and Medicaid may reflect a more vulnerable sample of respondents than the population that lives in the full community as analyzed by ZIP code through the ACS.

As expected, employment status had significant correlation to the health insurance status for the survey sample. The respondents not in the labor force were much more likely to have some type of public coverage (Medicare, Medicaid or both) than those who were in the labor force (employed and seeking employment), see table 1. Because adult eligibility in Florida for public coverage is based on age and disability, the survey sample likely contained a greater proportion of people with disabilities than does the population of the communities.

Table 1: Insurance status by employment category

	Employed full or part time n = 103	Not employed, seeking work n = 18	Not employed, not seeking work n = 101
Employer sponsored coverage	60 (58.3%)	4 (22.8%)	8 (7.9%)
Individual coverage	13 (12.6%)	2 (11.1%)	11 (10.9%)
Medicaid	18 (17.5%)	7 (38.9%)	29 (28.7%)
Medicare	8 (7.8%)	1 (5.6%)	34 (33.7%)
Dual Medicare & Medicaid	1 (1.0%)	1 (5.6%)	13 (13.9%)
Non-employer group	2 (1.9%)	1 (5.6%)	2 (2.0%)
VA or Tri-care	1 (1.0%)	2 (11.1%)	3 (3.0%)

$\chi^2 (df = 12) = 83.20, p < .001$

## BARRIER TO HEALTH CARE ACCESS

Many respondents reported some types of barriers to receiving health services. While most respondents had received some routine preventive services during the past year, about one-half ( $n = 140$ , 49.8%) had missed some type of needed health service for a variety of reasons. The reasons in descending order of frequency were cost ( $n = 70$ , 24.9%), having unreliable transportation ( $n = 33$ , 11.7%), not considering health care service a priority ( $n = 28$ , 10.0%), inability to find a provider who accepted insurance ( $n = 20$ , 7.1%), the service not being available during non-working hours ( $n = 12$ , 4.3%), and anxiety, fear or mistrust of health providers ( $n = 11$ , 3.9%). These do not add to 100% because some participants selected more than one reason.

The hours of service affected more than one-fourth of respondents ( $n = 73$  26%) who reported that their work or school schedules impeded their access. Conversely, a similar number ( $n = 75$ , 28.4%) reported the availability of health services outside of traditional work hours. Lack of transportation impeded access to health care appointments for 17% ( $n = 50$ ) respondents. The actual time of transit to places of care was significantly correlated to reporting lack of transportation as a barrier. Respondents who required travel longer than 30 minutes by their self-reported usual method of transportation to community health centers and clinics were more likely to report lack of transportation as a barrier than those with shorter transit times ( $\chi^2 (df = 4) = 28.81, p < .001$ ).

## RELATIONSHIP OF INSURANCE STATUS ON HEALTH ACCESS

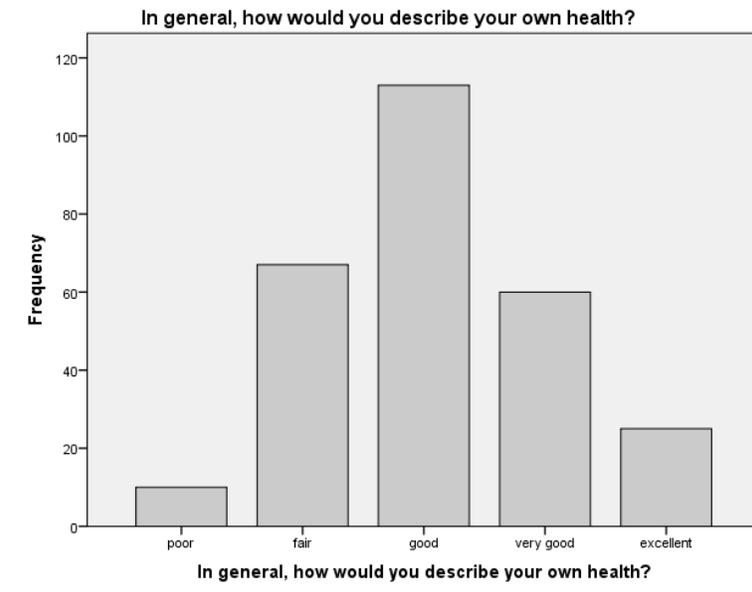
To determine if health insurance affected the reported use and barrier to use of health services we ran cross tabulations and checked for significant variations in the rates that respondents reported specific barriers. Significantly fewer respondents without coverage reported using routine preventive services than those with coverage,  $\chi^2 (df = 4) = 12.29, p = .02$ .

The barriers that respondents reported were related to their status as insured versus non-insured. As expected, the cost as a barrier to care when respondents were experiencing medical needs was significantly correlated to being uninsured,  $\chi^2 (df = 1) = 14.44, p < .001$ . Similarly, more respondents who were uninsured were affected by cost inhibiting their ability to receive treatments or diagnostic services,  $\chi^2 (df = 1) = 16.07, p < .001$ , or for obtaining prescription medications,  $\chi^2 (df = 1) = 27.59, p < .001$ . Having insurance did not have significant influence on the frequency that respondents reported using the ED for services,  $\chi^2 (df = 2) = 4.16, p = .13$ , or the likelihood that the condition precipitating the ED could have been managed at a clinic,  $\chi^2 (df = 1) = 3.12, p = .21$ . Likewise, being uninsured did not influence if respondents identified that the availability of clinic-based care during non-working hours obstructed their ability to access health care,  $\chi^2 (df = 1) = 0.35, p = .55$ .

## HEALTH OF RESPONDENTS

The respondents were asked to self-rate their overall health on a 5-point scale; 72% of respondents considered their health to be good, very good, or excellent (figure 7).

Figure 7: Perception of personal health



## INFLUENCE OF SOCIAL DETERMINANTS ON HEALTH OF RESPONDENTS

The term, “*social determinants of health*,” refers to the milieu where and how people live their lives. These determinants include social, economic, and physical environments. One purpose of this survey was to explore how social factors influence the self-perceived health of the residents of south St. Pete. Area statistics of health insurance, household income, race, and employment status have been presented in this report. Other social determinants investigated included highest education levels attained, household income, food and housing insecurity, and crime exposure. A small proportion (13%) of respondents had not completed high school and nearly half (47%) had attended post-secondary school, see figure 8. Insecurity for housing and food and concerns for crime in their neighborhood were widespread for the respondents. More than half of respondents expressed insecurity for food (54%) and housing (56%) and being concerned about crime (54%), see figure 9.

Figure 8: Education level of respondents

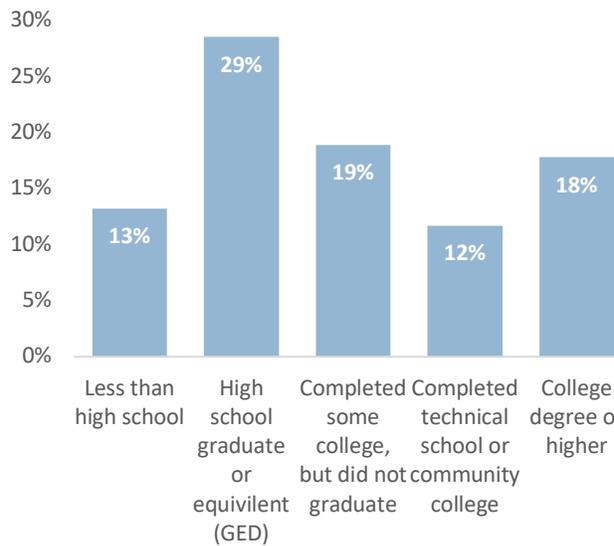
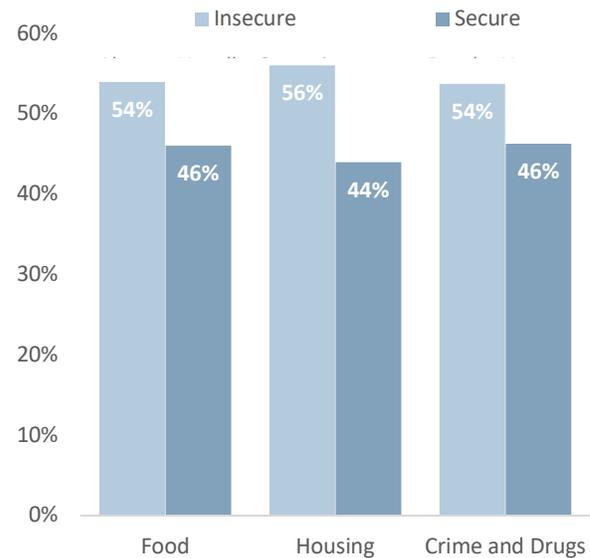


Figure 9 Food, Housing & Safety Security



There was significant variation in how the respondents rated their health by their insurance coverage type, by their employment status, by income levels and by food security. There were not significant differences in self-perception of health by race, gender, ethnicity, housing security or concern for crime. See table 2.

A multiple regression model was used to assess which of the social determinants that influenced the respondents' self-perceived health status contributed the greatest influence on the variance reported. Because the bivariate analyses showed education level, household income, employment status, health insurance, and food security had influence on health status, the model included these factors to determine which contributed the greatest explanatory value for the way respondents reported their self-perceived health status. Preliminary analyses ensured no violations of assumptions for linear regression. The model explains 89.1% of the total variance of respondents' rating of health status,  $F(df = 5, 216) = 354.67$ ,  $p < .001$ . When controlling for the influence of each of the factors, employment status did not significantly predict the rating of health. The remaining four determinants exerted influence on perception of health in a significant way. Food security provided the greatest explanatory value for health status (Beta = .336  $p < .001$ ), followed by insurance status (Beta = .268  $p < .001$ ), highest education achieved (Beta = .198,  $p < .001$ ), and household income level (Beta = .154,  $p = .002$ ).

Table 2: Influence of social determinants on health (next page)

\*post hoc comparisons, mean differences significant at  $p \leq .05$

In general, how would you describe your own health on a scale of 1 (poor) to 5 (excellent)		
	<i>m(SD)</i>	ANOVA results
How often are you stressed about enough money to buy nutritious meals ( <i>N</i> = 238)		
Always ( <i>n</i> = 44)	2.80 (1.11)*	<i>F</i> ( <i>df</i> = 4, 233) = 3.71, <i>p</i> = .006
Usually ( <i>n</i> = 30)	2.97 (0.72)	
Sometimes ( <i>n</i> = 54)	3.11 (0.90)	
Rarely ( <i>n</i> = 45)	3.24 (0.88)	
Never ( <i>n</i> = 65)	3.45 (0.92)*	
Health Insurance Status ( <i>N</i> = 275)		
Private Insurance ( <i>n</i> = 101)	3.30 (.91)*	<i>F</i> ( <i>df</i> = 2,272) = 3.99, <i>p</i> = .020
Public Insurance ( <i>n</i> = 117)	2.93 (1.02)*	
Uninsured ( <i>n</i> = 57)	3.02 (0.99)	
Highest Education Attained ( <i>N</i> = 248)		
Less than high school graduate ( <i>n</i> = 36)	2.89 (0.95)	<i>F</i> ( <i>df</i> = 2, 243) = 3.11, <i>p</i> = .016
High school graduate or GED ( <i>n</i> = 76)	3.08 (1.07)	
Some college, no degree ( <i>n</i> = 53)	3.15 (0.79)	
Completed technical school or community college ( <i>n</i> = 33)	2.79 (0.93)*	
College degree or higher ( <i>n</i> = 50)	3.46 (0.97)*	
Household Income Level ( <i>N</i> = 240)		
Less than \$25,000 ( <i>n</i> = 142)	2.94 (0.97)*	<i>F</i> ( <i>df</i> = 2, 235) = 3.42, <i>p</i> = .010
\$25,000 to \$49,999 ( <i>n</i> = 62)	3.29 (0.91)	
\$50,000 to \$69,999 ( <i>n</i> = 16)	3.31 (0.87)	
\$70,000 to \$99,999 ( <i>n</i> = 10)	3.40 (0.97)	
\$100,000 or more ( <i>n</i> = 10)	3.80 (0.92)*	
Employment Status ( <i>N</i> = 275)		
Employed (full or part time) ( <i>n</i> = 122)	3.36 (0.90)*	<i>F</i> ( <i>df</i> = 2,272) = 9.84, <i>p</i> < .001
Not employed, seeking work ( <i>n</i> = 29)	3.03 (0.98)	
Not employed, not seeking work ( <i>n</i> = 124)	2.82 (0.98)*	

## MENTAL HEALTH STATUS

To assess for mental health in the community we used standard language from the International Health Policy Survey; the question asked survey takers if they had experienced emotional distress that they found difficult to cope with by themselves in the past two years. A large proportion of respondents ( $n = 118$ , 42%) answered the in the affirmative; they had experienced such emotional distress. Further, when asked if they were able to get professional help for their distress, 35 respondents (12.0%) reported they were not able receive help due to unavailability or unaffordability of services. Being insured did not have significant relationship to either the report of emotional distress or ability to receive care for the distress. Respondents that reported emotional distress rated their overall health significantly lower ( $m = 2.92$ ,  $sd = 1.02$ ) than respondents without emotional distress ( $m = 3.26$ ,  $sd = 0.93$ ),  $t(253) = -2.74$ ,  $p = .007$ .

## ORAL HEALTH STATUS

To assess for oral health issues among survey respondents, they were asked if they had experienced problems with their mouth or teeth in the past two years that made them believe they should visit a dentist. More than half of respondents ( $n = 144$ , 51.2%) reported having such dental or oral health problems in the past two years. Almost half of those respondents ( $n = 70$ , 48.6%) reported inability to receive dental services. Respondents with private health insurance were less likely than those with either public coverage or no insurance to experience dental problems,  $\chi^2(df = 2) = 8.85$ ,  $p = .012$ . Uninsured respondents were much more likely to report problems obtaining dental services than those with either public or private insurance,  $\chi^2(df = 4) = 28.96$ ,  $p < .001$ .

## DISCUSSION OF SURVEY FINDINGS

### USE OF HEALTH CARE SERVICES

Most of the survey respondents were insured and had received preventive care in the past 12 months. Those who were not insured, predictably had lower utilization of preventive health services. Nearly half of respondents reported significant delays or omissions of care for acute needs when they were ill or injured. More than half of respondents received at least some of their non-emergency care through hospital emergency rooms (ERs) during the past year; this ER use was prevalent regardless of the insured status of the respondents.

### BARRIERS TO HEALTH CARE

The most reported barriers to health care access for the sample were from the financial outlay associated with receiving services and from lack of transportation to a care clinic. From the survey, out-of-pocket costs created a greater barrier to receiving services for uninsured respondents than for insured respondents but having to incur costs to pay for health services prevented substantial health care delivery for both insured and uninsured respondents. In addition to cost, lack of transportation obstructed access to care, especially for those respondents who live more than 30 minutes to the nearest clinic. Additional barriers to care that respondents reported in descending order of frequency were respondents who placed a low priority of the necessity of health care, inability to locate in-network care providers, care services not

being available during convenient hours, and fear or mistrust of the health providers or the health care system.

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## MENTAL AND DENTAL HEALTH

The survey exposed that respondents perceive there is inadequate access to mental health services and to dental care for the community members. The prevalence of significant emotional distress illuminated the high risk of mental health concerns for the community. The cost-sharing required or even the unavailability of mental health services highlights the inadequacy of mental health resources available in south St. Pete.

More than half of respondents reported significant dental concerns during the past 24 months, with half of them not having any access to dentists to address their problems. Cost barriers for services extended to obtaining dental care in addition to medical care. Health insurance does not include dental care, and dental coverage frequently requires high out-of-pocket payments for restorative or corrective services like extractions, fillings and crowns.

The mental and dental health results underscore the need of south St. Pete community leaders to focus efforts on all aspects of health in addition to traditional physical health care.

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## SOCIAL DETERMINANTS OF HEALTH

The community members who responded to the survey rated their overall health status significantly lower ( $m = 3.08$ ) than the most recently reported national self-health ratings 2016<sup>7</sup> ( $m = 3.20$ ) ( $t(6439) = 1.97$   $p = .049$ ). The social determinant factors that explained most of the variability in the south St. Pete self-health rating are those that have been reported in other literature. People who have unstable food supply were most likely to rate their health lower; more than eight in ten respondents to this survey expressed some level of food insecurity. To improve the overall health of this community, in addition to addressing the traditional health aspects of access and coverage, programming to manage availability of low-cost high nutritional value food would alleviate the food insecurity and improve overall health.

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<sup>7</sup> Centers for Disease Control and Prevention (CDC). National Center for Health Statistics (NCHS). National Health and Nutrition Examination Survey Data. Hyattsville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, [2015-16] [<https://www.cdc.gov/Nchs/Nhanes/Search/DataPage.aspx?Component=Questionnaire&CycleBeginYear=2015>].

## FOCUS GROUP REPORT

### RECRUITMENT OF FOCUS GROUP PARTICIPANTS

The community member focus group consisted of six participants who either took the survey or received a flyer about the survey at community events. The organizational leader focus group consisted of seven leaders of influential organizations in the community. Most of the organizations represented were new to the Fight Like Health St. Pete partnership. We also had a local funder, and a Healthy Florida – St. Pete project steering committee member join.

### FOCUS GROUP THEMATIC ANALYSIS

Each of the focus groups were audio recorded and transcribed for analysis. The transcription was checked by a focus group facilitator for authenticity of capturing the tone and language of the session. Prior to thematic analysis, the analyst read the transcripts and listened to each recording multiple times to establish potential themes and codes for the analysis. Using QDA Miner, five overall themes emerged from the data with three to ten individual codes within each of the themes, see figure 10. As the primary purpose of this project was to establish the social determinants that enrich or impair residents' access to care, the majority of coding was aimed at extracting these concepts.

Figure 10. Themes from Focus Groups

#### BARRIERS TO HEALTH CARE ACCESS SERVICES

- Being uninsured
- Cost
- Lack of health care literacy
- Lack of respect from providers
- Lack of transparency
- Lack of trust in service
- Language/ culture incongruency
- Time
- Insufficient transportation
- Poor quality of care

#### ENABLERS TO HEALTH SERVICE ACCESS

- Alternate access - Emergency Room
- Being insured
- Individual assistance - Health Navigators
- Quality/ coordination of service
- Self-Advocacy
- Services available

#### COMPONENT OF HEALTH

- Chronic illness
- Holistic health
- Mental health
- Self care

#### HEALTH INSURANCE

- Difficulty of using coverage
- Ease of using health insurance
- Difficulty of obtaining coverage
- Ease of obtaining coverage

#### SEEKING CARE

- Preventative care
- Ease of using health insurance
- Missing work/school

## BARRIERS TO HEALTH CARE ACCESS

Within the theme of barriers to access of health care, between the two focus groups, ten sub-themes emerged; five of them overlapped between the community members and the service providers. Both groups agreed that lack of respect from care providers, lack of transparency of service design, and lack of health care literacy presented primary access problems. Both groups mentioned that competing demands on time (in the context of wait times in clinics or doctors' offices) present inconvenience to consumers, but it did not rise to the level of a barrier to access.

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### LACK OF HEALTH LITERACY

The service providers in the focus group referred to lack of health literacy 16 times as either a problem for the community that blocks access to health care or in reference to their existing or potential programs to improve the health literacy of the community.

"I know that we see a lot of education needs still. Healthcare literacy is still a big struggle. Obviously, we want to connect people to the options of care that are available for them, but there is still a big gap in healthcare literacy and it's all demographics and whether people have had insurance or not. People don't really understand what it is, whether it's "where is my doctor and who do I go to," or questions that are okay to ask the doctor."

"We have the booklets, but we also have links on our website to the ... materials, which I do have to say were some of the ones that were put together ... a few years ago. They have updated them, but they are a wonderful resource, and if people want, we have physical booklets in a few languages. ...they are a great resource for people. It has a glossary of terms in the back, and for that alone I think it's practically worth its weight in gold".

There were references from the community members in the focus group that concurred with the assessment concerning needing education about health care. The community members expressed that the complexity of the system was part of a lack of transparency and that a key barrier to the education is the time required to invest in it.

"I knew I needed to get the insurance, but the big hindrance for me was like time and education, I felt like I didn't have the time to do the research and figure it out."

"But I don't know who to go to. I don't know what to say, it's just like a lot of stuff. I just wish that when you actually have health insurance, they actually really work with you and help you. I try to reach out to them and ask questions and stuff, but all they ever say is 'go online.' "

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### LACK OF TRANSPARENCY IN HEALTH CARE

Lack of transparency in health care means the inequity of knowledge between health care providers and payers and consumers of health care. The inequity encompasses knowledge (or lack of knowledge) regarding the necessity health care services, how to access the services, and the awareness about hidden costs to the consumers of obtaining services. What the community members perceive as a lack of transparency could also indicate a lack of health literacy. In some areas, education could make particular things clearer for health consumers. The lack of transparency from the organizational leaders' focus

group members' perspective centered on the state Medicaid insurance providers and inability of enrollees to navigate the complex system:

"We talked to people at the health agencies at the state and they say it's automatic that women know. They don't know. So how do you access care if you don't even know you have the coverage."

The community members had more concerns with lack of transparency in pricing from providers and from insurance companies:

"And they never know how much it's going to cost and so I have to do the research, find the place, find the doctor, then figure out what the cost."

"I can't even find people who can answer a simple question like "what is the price?" or they give you to somebody else and the next person doesn't know"

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## LANGUAGE OR CULTURAL INCONGRUENCY

Community members only mentioned language and cultural incongruence one time, while the organizational leaders perceive it as a major barrier, mentioning it eight times. The leaders were concerned about barriers from providers who lack understanding of the living conditions or cultural context of their patients. The issues of cultural incongruence were closely related to a lack of trust in the health care system.

"It's been African Americans and poor individuals who have not had the best history in this country with medical care. There's been research done recently called Medical Apartheid ...and there was the Tuskegee experiment ... So that if you are living generation to generation and your grandfather tells you about this experiment and then you see him not going to the doctor, you're not going to go to the doctor."

"...they did some research, and doctors really believe that African Americans have a higher tolerance for pain, and so they would hold off on medications or certain things like that."

The organizational leaders' focus group even pulled in their personal experiences to describe the influence of culture on complicating access to care while relating the complexity back to health literacy issues:

"I had a personal experience the other day of selecting a doctor, and it's like male, female, person of color, person trained outside the country, and it's really stressful. And think about how much we are aware of. And I can ask some questions to kind of try and get the culturally appropriate doctor who might understand my background."

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## LACK OF TRUST IN HEALTH CARE PROVIDERS AND HEALTH CARE SYSTEM

Closely related to the cultural incongruence and the lack of transparency was the community focus group members' lack of trust in the health care providers and the health care system at large. They spoke of receiving care in the past that had been unhelpful and of considering the motives of health care system to be money-driven rather than for the good of the community.

"I think that M.D. stands for "more drugs." You know drug you up, drug you up, drug you up. They just keep you coming back, it's a cyclical thing."

"It's a money-driven situation, medicine is a money driven organization. The more they can diagnose you (and sometimes misdiagnose you), the more you come back to see"

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## LACK OF RESPECT FROM HEALTH CARE PROVIDERS

The cultural incongruity influenced the community members' perceptions of disrespect. The community members expressed their concerns about lack of respect from providers by mentioning inequity in care and attitudes of doctors:

"And then why are some doctors so arrogant"

"If they treated everyone the same...And not every person is treated the same. If I went in the hospital and I look like who I am, maybe I have a choice, but if another person, you know number 45 goes into the hospital, he is treated very differently. He gets a different kind of care. I'm not saying he shouldn't get the best care, I'm just saying we all should be treated the same."

The organizational leaders were in agreement with the community members about disrespect being a contributor to lack of health care use:

"But even getting an appointment and then feeling intimidated, a lot of times ... they get lectured when they end up in the emergency room or somewhere else about "why aren't you doing this, why aren't you doing that," like they're being noncompliant on purpose. And I think that's intimidating, cause they're just going to tell me not to breathe in my house. So, those are some of the things I've seen."

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## BEING UNINSURED AND THE COSTS OF HEALTH CARE

Despite all community members in the group all seeming to have health insurance they expressed believing that being uninsured is a barrier to receiving care. Even with being insured, cost was a primary obstacle to receiving all the health care they needed. Juggling multiple specialists and the out-of-pocket copayments for visits was an issue for several participants. Another expressed that even with health insurance, mental health services remain out of reach because of cost. Dental care costs remained high for the participants with health coverage. Notably, no member of the organizational leader focus group explicitly brought out either being uninsured or cost of care as a barrier to access to services. Perhaps, these barriers are so obvious, there was not a reason to bring them up in the discussion.

"... I had some issues with my teeth and I had to pay \$2,000 out of pocket to get 2 wisdom teeth out, and I was on Medicaid."

"And even now having healthcare through my employer, they cover like 80% of the cost. But I had a skin issue and I saw a dermatologist and had to pay \$70 - \$100 to just be looked at. I don't got money for that, I mean, I could be spending that on groceries."

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## ENABLERS TO HEALTH CARE ACCESS

None of the six sub-themes (being insured, alternate access in emergency room, self-advocacy, quality and coordinated care, service availability, and individualized assistance through health navigators) that emerged from the broad theme of enablers health care access were explicitly shared between the service provider and community members focus groups.

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## BEING INSURED

While the organizational leaders' group did not explicitly discuss the effects of health insurance on access to care, the aura of the conversation implied that coverage is a primary enabler to care. The community members were explicit that having health insurance is critical for to having access to health care:

"If you have coverage, that's makes it easier because you all you have to do is make an appointment and go."

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## ACCESS THROUGH THE EMERGENCY ROOM

The members of the community focus group offered ways individuals could help themselves get access to services. One avenue of access they point out that is always available is through emergency rooms of hospitals, even without health insurance:

"...if you don't have medical you don't have any choices, you don't have any choice. .... They have to see you....go to the emergency room, they have to see you. But if you walk into a doctor's office they're going to say 'I need to see ID and your insurance card.'"

"...people are pretty much using the emergency room as their primary care? They don't have any choice, there's no choice. Of course, even myself ...., I had to do that to help my mom out."

For the members of the community focus group, even with health insurance, sometimes navigating the health care system is more transparent and less complex when entering it through the emergency room door:

"The only way you're going to get a referral with a name is if you go to the emergency room and when they discharge you they tell you where you can go, and that's in their network through the hospital to send you out to certain doctors."

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## SELF-ADVOCACY

The members of the community focus group expressed self-reliance and the importance of self-advocacy when using health care services. The theme indicates that members expect significant responsibility from individuals to manage health needs and to attain services. The leaders' group did not mention self-advocacy, self-reliance, or autonomy as providing empowerment to health care access.

"Even though we wish we could have health care that more accessible to us, we do have to do the work. You know why, because when it comes down to your health anyway, you don't want to be referred to just anybody. Sometimes you have to take that extra time to look for yourself."

"....I am my own advocate, this is my body, my temple so I don't take any chances."

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## QUALITY AND COORDINATED CARE

The members of the community discussed the value of seamless communication and high quality (good) care as making their continued access of services easier to manage. The focus group of organizational leaders mentioned that high quality is important to improving the health care system, but the mention was not related to accessing care. The community members said

"...it's the network. The minute they open the computer up, they can see the other doctors that you've already been to. So, if you have to come back next month, they automatically know what the other doctors are doing. And they keep up with what's going on. ... So, they know when you're due for another appointment."

"I just changed my primary [doctor], and she' already onboard, telling me just put in a user ID and password, so that's good, you don't need a lot of paper at home."

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## AVAILABILITY OF SERVICES

The organizational leaders focus group considered service availability through network adequacy to be a prime enabler of access to service. From the data shared among the members of this focus groups, the networks for the Medicaid Managed Care Plans in Pinellas County were perceived to be relatively strong. The organizational leader focus group did not discuss network adequacy for private plans.

"...our overall networks are a lot stronger than a lot of the other places, specialties included, strictly because of our population density."

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## INDIVIDUALIZED ASSISTANCE THROUGH HEALTH NAVIGATORS

Harkening to the discussion and concern that health care illiteracy is a major contributor to lack of access to services, the organizational leader focus group spent a majority of their focus group time discussing ways to overcoming the barrier of low health care literacy. They determined that deploying cadres of "navigators" in the communities could shift the current levels of lack of access to effective access to care in the local community.

"I think we need someone in the community to help disseminate the information and get the right information around."

"I guess we need more navigators, not just to sit in the office, but for them to go to the community where it's needed."

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## COMPONENTS OF HEALTH

The community members were asked to describe what *health* means to them and throughout the discussion, the analysis considered the conversation that went back to this point to illuminate how the members perceive and value *health* as a means of illuminating factors that can enhance utilization of services that can improve health.

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## CHRONIC CONDITIONS

The community members focus group participants discussed how growing problems of chronic conditions (high blood pressure and diabetes) are lowering the health of the community. They pointed out specific cases of these problems that are occurring in young Black women who are relatives, friends and themselves. Concomitant with discussion of chronic problems were mentions of chronic condition management to help people live with the conditions.

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## HEALTH IS HOLISTIC

The group was cohesive on expressing they consider *health* to be all-encompassing and holistic involving multiple aspects of life:

“I think what health means to me is mental, emotional, spiritual, a whole list of approaches.”

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## MENTAL HEALTH

The notion of mental health came up repeatedly as a component of health in the community members focus group and was closely related to concerns with lack of mental health care access and awareness. From the community members:

“I think that mental health, particularly in the black community is always something that is overlooked as a part of health.”

“I wish it didn't cost so much for you to have your mental health assessed.”

The members of the organizational leaders focus group concurred with scarcity of mental health care access. In relation to mental health care, there was agreement between the focus groups; the community members considered anxieties and issues with coping with stressors as an indicator for needing mental health care. The organizational leaders' group discussed diagnosable severe mental illnesses as being the current key trigger that allows access to mental health services, but were concerned that people need access to mental health services prior to having major incident that may trigger a diagnosis:

...depression, bipolar, all those kinds of things, unless you are full-blown schizophrenic, which emerges in a whole different way, there are a lot of people suffering that can't even get a diagnosis to begin before it gets so bad that they end up on the streets or hurting them self or somebody else, or just disrupting their whole family situation. ... I think [the problem] could be brought under some control if people had better access [to mental health care] sooner rather than later.”

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## SELF-CARE

Similar to the divergence between the organizational leaders and the community members on the concept of self-advocacy as an enabler of access, self-care as a component of health was only addressed by the community member focus group. The group stressed that to manage one's own *health* is a responsibility of each individual. This came out with specific mantras:

“You've got to take care of yourself”

“this is my body, my temple ...”

The specific ways of self-caretaking were expressed by chronic disease management (diabetes) and through diet. Fried foods and fast foods came up frequently as a cultural norm and as things to be avoided. The consensus of the groups was well-articulated by one member who said:

“I incorporate it all into my life [self-care], if I don't do that, then I'm not being true to myself. then I can't blame anybody but me if I don't do what I need to do to take care of my whole person.”

## HEALTH INSURANCE

Albeit the organizational leaders focus group did not explicitly mention being uninsured as an access barrier, the prevailing undertone from both focus groups was the notion that having health insurance improves access to health care. With this concept as a basic assumption, the community focus group was probed to learn their experiences with obtaining and using health insurance. Initially this theme was divided into two sub-themes, obtaining coverage and using coverage. But, because of disparate reports about the experiences, the concept needed to be recoded into four sub-themes, difficulty of obtaining coverage, ease of obtaining coverage, difficulty using coverage, and ease of using coverage. It was evident that the circumstances and the situations for each individual who seeks and uses care greatly impacts the ease or difficulty she or he experiences when obtaining or using health insurance.

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### EASE OF OBTAINING COVERAGE

The ease of obtaining coverage was the least mentioned aspect of health insurance. One member described an experience with someone coming to her home and talking to her about the policy she purchased. It was not clear if the person was a navigator, community advocate or an insurance agent, but the community member was satisfied with the process. Another member described many ways she encountered outreach efforts for health insurance enrollment:

“Some people come to your job. ... They tell you to go to the marketplace, Healthcare.gov. And then you have people sometimes downtown and other areas who are out there to get you set up to see if you can get some type of healthcare assistance through these marketplaces and these small businesses that have their way of getting you connected to the right person who can get those health insurance benefits.”

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### DIFFICULTY OBTAINING COVERAGE

The difficulties the focus groups encountered when seeking health care coverage related to costs of coverage and to the confusion that surrounds getting coverage through Medicaid and disability services.

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#### RELATED TO COST:

“I didn't have health insurance because even with Obamacare and the marketplace it was still high. ...you didn't qualify to get Obamacare, they wanted you to pay like \$300 a month and I don't what bracket you go on or know how they do it with their numbers, but it's like we ain't living like that. I don't know what they're tallying up, but I show different.”

“once I actually took the time to do all of that [learn how to seek coverage], the next hindrance was the cost.”

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#### RELATED TO CONFUSION:

In contrast to simplicity expressed regarding employer or Healthcare.gov based coverage, the community members expressed confusion regarding access to public coverage through Medicaid and disability benefits. The time involved to complete paperwork or online forms, even with assistance seems to be a dissuader to making applications:

"...when I was on Medicaid, it was like really confusing to try to figure out how to do the application. So, I just straight up called them and said "will you do this application on the phone with me right now?" And it took maybe like an hour, no like 30 or 45 minutes, but I guess it was nice that they are there to answer your questions and do it with you, but it's super confusing from my perspective to try and do it on your own."

The idea of confusion surrounding Medicaid coverage was echoed by the organizational leaders focus group, this was even to the point of speculation that the confusion could have purposeful intent to block coverage.

"Some part of me thinks that is purposeful, that women don't know that they have that access."

At least one community member agreed that there appears to be intent of delaying or denying access to public coverage:

"she's having a hard time trying to get insurance too. They told me she had to apply for disability through county. But I think they're trying to discourage you, see it's like they don't want you."

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## EASE OF USING COVERAGE

The community members with private health insurance coverage expressed some ease of using their coverage by describing a few recent ways they had recently obtained services covered by their plans and how they navigate the system to find service providers.

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## DIFFICULTY USING COVERAGE

Resonant with the obtaining coverage difficulties, the using coverage difficulties related to access barriers of confusion and of cost, even when the community members had health insurance. These obstacles were expressed by members with private health insurance and with Medicaid coverage.

"Like my deductible now is \$6,500. ... When I saw my primary [doctor] he wanted me to go to the hospital last month. But before they would pay anything, \$6,500 has to be paid for me to them be covered."

"So I just straight up don't have a network of the doctors because my health insurance won't help me actually get in the network"

Even more complicated was the junction between private coverage and the Medicaid program known as "Share-of-Cost" that provides benefits for low-income people with chronic health problems to protect them from catastrophic medical bills. One focus group member who is enrolled in the "Share-of-Cost" program reports that to meet her monthly requirement she resorts to frequent emergency room visits:

"I have a share-of-cost that is \$28.70 every month. So I have to go to the hospital to meet that share-of-cost for me to get Medicaid every month, which sometimes I still end up with a bill. Even though I have health insurance through my job, it still doesn't cover [100 percent of] it."

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## SEEKING CARE

Theme of seeking care was only elicited from members of the community focus group. This makes sense as the process was designed to obtain personal experiences about care seeking behaviors and to determine

if we could relate the behaviors to specific barriers or enablers of overall health care access. This theme was subdivided into missing time at work, seeking preventive care services, and seeking services when ill or injured.

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## MISSING WORK

The members of the community group did not report specific barriers to access related to having to miss time at work, though several were adamantly specific that they do not take time off for illness. The discussion about number of days off approached a contest between the members for the fewest days taken for illness:

“I have not taken off any work at all in the last I don't know how many years.”

In spite of the lack of sick-time taken off of work, there was consensus among the group that employers were offering paid sick time in some form. The remarks made by the group indicate hidden incentives in the structure of “sick time” that encourage employees not to take the benefit:

“I should take advantage of those days because it feels like 10 days I could have had off over the past 2 years that I never even used.”

“We do have sick days, but you can accumulate them and then when you leave they will buy them back...”.

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## PREVENTIVE CARE

No one in the community member focus group reported skipping preventive care services. There was agreement among those who spoke that illness prevention through routine checkups was important.

“I go once a year for just routine checkups to make sure I'm okay.”

“I go get blood work and all of that every 6 months because of my age.”

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## SICK CARE

Financial outlay was an issue that was closely related to every mention of seeking care when ill or injured. It was apparent that using this service type is strongly tied to the cost of care. Needing to pay out-of-pocket triggered the community members to seek cheaper services or to avoid services altogether. One member reported seeking advice from family or friends for less expensive over-the-counter or herbal remedies before seeking any contact with a doctor, indicating that cost was the driving motivation for her actions. Another group member reported using novel technology provided by her insurance carrier for cost-containment with satisfaction:

“I have this thing called TeleDoc, so now you can call, and they can call you back and it's like \$20. Instead of going to the doctor's office where you pay \$50 or \$65. ... that's another way to save money. ... now they have doctors you can call instead of always going to the emergency room or going in to see a primary doctor and have that big copay, and \$20, I think it beats \$65.”

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## AGGREGATION OF FINDINGS FROM BOTH FOCUS GROUPS

The data obtained from the focus groups confirmed that community members are interested in health and health care access. The community members demonstrated strong self-reliance on their attitudes and abilities to navigate or to circumnavigate the health care system to meet their individual health care needs. When discussing complexity of services and need for education, they limited their solutions to self-help for finding their own resources.

The organizational leaders exhibited significant interest in low health care literacy within the community and of their current and potential efforts and programs to improve the literacy ways of assisting people with low literacy to access to coverage and to access to care. The organizational leaders' group recognized that their efforts are funded by cyclical grants and they expressed concern about program sustainability and about possible duplication of efforts by multiple organizations.

The organizational leaders focused their solutions to lack of health care access on the need for health care literacy in the form of community assisters (navigators). They specified the navigators could be members of the local community to enhance cultural congruence. The roles defined would be in health care literacy education and providing assistance to individuals navigating complex service delivery systems. Based on the high levels of personal self-sufficiency expressed by the focus group members and the omission of any mentions of using existing community-based programs (other than phone contacts with the Medicaid enrollment specialists), it is unclear from this small sample how the community would respond to such interventions. Before any program planning in this area commences, more data will be needed to determine if this type of navigator outreach would provide high return on investment. This assessment is consistent with the remarks from leaders' groups about current outreach programs through multitude of health fairs the leaders mentions attendance is often mostly from the service providers and the community uptake is minimal.

The community members were very clear that frequency of obtaining services was inextricably related their out-of-pocket costs. This perception was substantiated by the consistent reporting of the community members that the took advantage of the preventive care benefits from their health insurance, that largely are associated with no out-of-pocket costs. Any comprehensive program initiative aimed at increasing the use of appropriate health service utilization should address management of out-of-pocket costs for non-preventive health care services.

## TRIANGULATING THE FINDINGS FROM SURVEY AND THE FOCUS GROUPS

The members of the community focus group confirmed and explained some of the findings of the survey. Our community focus group members were insured as were more than 81 percent of the survey respondents.

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### RECEIVING HEALTH CARE SERVICE

Like most of the survey respondents, the community focus group participants also used preventive services routinely and they clarified that they consider preventive care to be an important factor in the maintenance of one's health. The barrier of cost for health care services for uninsured survey respondents spanned the continuum of preventive and curative care. For insured respondents and for the focus group participants who were insured, financial barriers were largely limited to curative services. This differentiation may indicate adequate knowledge within the community about the need for preventive services (health literacy), but the actual barrier to obtaining the preventive care is the cost of the service.

Our survey respondents, insured and uninsured, used hospital emergency rooms (ERs) as a frequent avenue to care. The community member focus group agreed this is a recurrent phenomenon and they further explained that it occurs because the ERs are required by law to provide care to anyone who goes there without requiring payment at the time of service. This obligation on the part of the ER, removed the immediate cost barrier to services when someone is ill or injured. Even if the service could be obtained in a less expensive clinic, the clinics require out-of-pocket payment immediately versus an ER who does not collect money at the time of service. This distinction made the ER a more accessible option.

Additionally, when a patient is discharged from the ER, the ER provides referrals for ongoing follow-up care. The focus group felt obtaining referrals to specialists was difficult through a doctor's office or clinic. The complexity described by the focus group in finding care while covered by insurance was also reported by survey respondents in their reporting of inability to find a network provider.

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## BARRIERS TO HEALTH CARE

Much like the survey respondents, the focus group members reported that costs were the primary obstacle to accessing health care. They explained that even with insurance, co-payments and insurance deductibles require high out-of-pocket outlays that present significant barriers to health care. Unlike the survey respondents, lack of transportation did not arise in the focus group discussion as a barrier to health care. The focus group members may have had selection bias relating to transportation, as transportation was needed to attend the focus group. Hence the focus group members may not be representative of the community in regard to transportation limitations.

The community members in the focus group described some encounters with health care professionals that they perceived as disrespectful. One focus group participant emphasized historical lack of trust among minority communities. The distrust related to memories of blatant discrimination like the notorious Tuskegee syphilis study and to the more contemporary perception of the health care industry being a money driven endeavor. These comments likely reflect the experiences and views of the few survey respondents who reported fear, anxiety and mistrust as barriers to health care.

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## MENTAL AND DENTAL HEALTH CARE

The inadequacy of mental health services came out clearly from the survey respondents and from both focus groups (service organization leaders and community members). The focus groups bemoaned a dearth of mental health services and the pervasive stigma associated with mental illnesses. They also decried the lack of attention to identifying individuals whose mental health is at risk.

The focus groups explained how even when having health insurance, obtaining dental care could be cost-prohibitive, clarifying the same finding that came out of the survey. In the face of needing dental services, half of the survey respondents reported being unable to obtain them. This pointed to the substantial agreement between the survey respondents and the community focus group that dental care was financially difficult to obtain and that there may not be an adequate supply of dentists in the area.

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## HEALTH CARE LITERACY

The majority of survey respondents and the community member focus group participants sought and obtained preventive health services. This behavior indicates the presence of health literacy about the importance of prevention. The low prioritization of health care by that resulted in ten percent of survey

respondents skipping health services may reflect a lack of health care literacy for the minority of respondents that the organizational service leaders identified as a priority community need.

The community members focus group did not explicitly describe a lack of literacy about health care that prompted them to skip service, but they did highlight the complexity of navigating insurance provider networks as a source of significant frustration. The organizational leaders' focus group considered low health care literacy and poor understanding about accessing and using public and private health insurance as a major barrier to care. The perception of health care consumers that the health care and health insurance systems are complicated may indicate a need for health care literacy, or it may reveal a need to simplify the system. It is not unreasonable to understand that high frustration could lead to individuals skipping care, though from the data collected in this project, it remains unclear if poor health care literacy is a major barrier to accessing health care.

## RECOMMENDATIONS

Based on the findings of this project, this project makes several recommendations that would improve the health and health care access for the vulnerable communities of south St. Pete. The primary barrier to obtaining health care services in this vulnerable community is the out-of-pocket cost of care. For people without health insurance, this takes the form of impeding preventive services along with curative services. Ensuring Federal Qualified Health Centers are funded with adequate staff and hours will help address the issues for the uninsured population. The issue of out-of-pocket cost impediments for people with health insurance, but with co-payments or deductibles that are insurmountable for people with low income (as were most of the respondents) will require more creativity. One creative innovation is a community-based health incentive program that is modeled on employer-based wellness incentive programs. Such a program could offer participants dollar-based voucher rewards for healthy behaviors like attending screening events, smoking cessation, and exercise. The vouchers would be redeemable as co-payment or co-insurance at participating health service provider clinics.

Another area that may provide some improved access is ensuring that services are reachable to all parts of the community with 30 minutes or less via public transit services. The solution may be addressed through stakeholders working with the Pinellas Suncoast Transit Authority to verify routes serving the communities of need have direct lines to local health care clinics. Further, publicizing the routes to the community and to the health care providers may be necessary. A system of tokens for health care-related rides on transit could also be explored.

Trust building between the communities of color and the health care providers should come through outreach directly between the care-providing community and the health care consumer community. To reach this goal, as the organizational leaders' focus group suggested, some outreach and training to help the health care providers who serve the south St. Pete community understand the cultural and social context of their patients and clients could alleviate some of the perceptions of disrespect and mistrust discovered from this project. Cultural leaders of the local communities may be the most appropriate ambassadors to lead this type of project. Additionally, ensuring that health-care provider training that takes place in the metropolitan area from the local universities (University of South Florida) includes

clinics in the vulnerable communities of need can help prepare future generations of providers to deliver care with cultural humility and congruence.

Based on the discordance of perceptions between community members and service organization leaders regarding needs about health care literacy, prior to new program planning in this area, more data should be gathered and analyzed to ascertain if this type of navigator outreach would provide high return on investment. However, it was clear from the data that navigating the enrollment processes for public insurance coverage and the provider networks for public and private insurance is complicated and difficult. In addition, consumer assistance programs, funders should consider sponsoring feedback systems to state policymakers that can inform them about appropriate ways to simplify the enrollment processes and network navigation for public insurance coverage (Medicaid). Streamlining these systems would improve the access to coverage and usage and may reduce state and provider costs.

There is a lack of dental care accessibility and mental health providers servicing the community of need. Targeted programming to address these needs may include coordination with mental health provider-training institutions in the immediate metropolitan area to establish regular outreach clinics located in the south St. Pete communities. Working the Florida Oral Health Coalition may offer some novel remedies for the lack of dental providers in the communities.

The correlation between food insecurity and self-perception of poor health raises concern about affordable access to high nutritional food for the most vulnerable members of the south St. Pete communities. We could not determine the direction of this relationship. The question is: Does the lack of reliable access to healthy food lead to poorer health, or is the difficulty in accessing high nutritional food caused by disabilities of poor health? The results confirmed that the residents of south St. Pete have low self-perceived health in comparison with the rest of the country. Hence, regardless of the causality link, any additional programming that enhances the access of highly nutritional food to people in poorer health has great potential to improving the health status of this community.

It cannot be overstated that, based on the report of the survey respondents and community members' focus group, financial factors dominate all other barriers to health care access. There are certainly some community members who could benefit from education about health, health care, and navigating the complex health insurance networks. But, when adequate levels of health literacy are present, cost continues to obstruct access to care. A comprehensive plan to address barriers to access must include solutions to the high out-of-pocket expenditure problem.



For online resources for this  
project visit:

[www.healthyfla.org/stpete](http://www.healthyfla.org/stpete)



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