



Health Care for the Homeless
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Bibliography #23

**Health Care Issues for
Persons Who Are Homeless**

February 2004

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2004

Wehler, C, Weinreb, LF, Huntington, N, Scott, R, Hosmer, D, Fletcher, K, Goldberg, R, Gundersen, C. **Risk and protective factors for adult and child hunger among low-income housed and homeless female-headed families.** Am J Public Health 94(1):109-115, 2004.

OBJECTIVES: We sought to identify factors associated with adult or child hunger. **METHODS:** Low-income housed and homeless mothers were interviewed about socioeconomic, psychosocial, health, and food sufficiency information. Multinomial logistic regression produced models predicting adult or child hunger. **RESULTS:** Predictors of adult hunger included mothers' childhood sexual molestation and current parenting difficulties, or "hassles." Risk factors for child hunger included mothers' childhood sexual molestation, housing subsidies, brief local residence, having more or older children, and substandard housing. **CONCLUSIONS:** This study found that the odds of hunger, although affected by resource constraints in low-income female-headed families, were also worsened by mothers' poor physical and mental health. Eliminating hunger thus may require broader interventions than food programs.

2003

Cohen, DA, Mason, K, Bedimo, A, Scribner, R, Basolo, V, Farley, T. **Neighborhood physical conditions and health.** American Journal of Public Health 93(3): 467-471, 2003.

This article explores the relationship between boarded-up housing and rates of gonorrhea and premature mortality, and is based on an ecological study done, of 107 US cities. Controlling race, poverty, education, population change, and health insurance coverage, the authors developed several models predicting rates of gonorrhea and premature death before age 65 from all causes and from specific causes. The article states that boarded up housing remained a predictor of gonorrhea rates, all causes premature mortality and premature mortality due to the malignant neoplasms, diabetes, homicide and suicide after control for socioeconomic factors, The authors assert that boarded-up housing may be related to mortality risk because of its potential adverse impact on social relationships and opportunities to engage in healthful behaviors. Neighborhood physical conditions deserve further consideration as a potential global factor influencing health and well-being (authors).

Drury L. **Community care for people who are homeless and mentally ill.** J Health Care Poor Underserved. 14(2):194-207, 2003.

This qualitative longitudinal study documents the experiences of 60 people who are homeless and mentally ill from their state mental hospital discharge through their first two years in community housing. The study explores the personal, cultural, and environmental contexts of life for adults who are homeless and mentally ill and examines the interaction between an individual's needs and community resources. The research identifies forces that perpetuate homelessness and traces the struggles that people who are homeless and mentally ill encounter during the transition from the streets to stable housing. The findings describe a culturally based pattern of mutual avoidance between homeless mentally ill clients and caregivers, which limits delivery of services to the population. Recommendations include development of alternative systems of care delivery, expansion of educational experiences with underserved populations, and increased funding for service or research with people who are homeless and mentally ill.

Fitzpatrick, K, La Gory, M, Ritchey, F. **Factors associated with health-compromising behavior among the homeless.** *Journal of Health Care for the Poor and Underserved* 14(1): 70-86, 2003.

This exploratory study examined a set of sociodemographic, risk, and protective factors associated with health-compromising behavior among the homeless. One hundred and sixty-one homeless adults living in a midsize, southern metropolitan area were surveyed. Information was collected using structured in-depth interviews that assessed residential and event histories, life circumstances, mental and physical health symptoms, and health-related risk behaviors (drug and alcohol use, risky sexual practices, sleeping outdoors, aggressive behavior, and weapon possession). Descriptive results showed differences in health-compromising behavior for ascribed characteristics such as age, race, and gender. Younger people, nonwhites, and men took more risks. Multivariate results indicated that while sociodemographic risk factors were important predictors of health-compromising behavior for people who are homeless, other variables, including childhood memories, victimization, and local nativism, were also significant. The implications of these findings are explored in the larger context of a social policy framework (authors).

Fountain, J, Howes, S, Mardsen, J, Taylor, C, Strang, J. **Drug and alcohol use and the link with homelessness: Results from a survey of homeless people in London.** *Addiction Research and Theory* 11(4): 245-256, 2003.

A community survey using a structured questionnaire was used between January and October 2000 with 389 homeless people currently or recently sleeping on the streets in London. Data were collected on basic demographics, their histories of homelessness, substance use (alcohol and drugs), dependence on the main substance used in the last month, utilization of homeless services, and income and expenditure. In the month prior to interview, 324 of the sample had used a substance, 139 were dependent on heroin, and 97 were dependent on alcohol. Sixty-three-percent reported that their alcohol or drug use was one reason they became homeless, but the majority had used at least one additional drug since then. Overall, alcohol and drug use, injecting, daily use and dependency increased the longer the respondents had been homeless. This study suggests that a clear link exists between substance use and homelessness. Efforts to address homelessness must simultaneously address the substance use of this population (authors).

Grazier, K, Hegedus, A, Carli, A, Neal, D, Reynolds, K. **Integration of behavioral and physical health care for a Medicaid population through a public-public population.** *Psychiatric Services* 54(11): 1508-1512, 2003.

This article documents a unique organizational, legal, and financial partnership between a state, a university, a Medicaid managed health care plan, and a county to provide integrated mental health, substance abuse, and primary and specialty health care services to Medicaid, low-income, and indigent consumers in Washtenaw county, Michigan. According to the authors, major regulatory, financial, and clinical changes were required within and among the various partners in the Washtenaw County Integrated Health Care Project. A new entity, the Washtenaw Community Health Organization, was created to implement the project. By sharing resources as well as financial risks, the state, the county, and the university have been able to provide ongoing integrated care to a vulnerable population of patients. Although resource intensive in conceptualization and implementation, the project can be viewed as a model for other states that face growing needy populations and decreasing Medicaid budgets.

Han B, Wells BL, Taylor AM. **Use of the Health Care for the Homeless Program services and other health care services by homeless adults.** J Health Care Poor Underserved 14(1):87-99, 2003.

This study examined factors associated with the use of the Health Care for the Homeless Program and other health care services by homeless adults. A total of 941 homeless adults were identified in 52 soup kitchens in U.S. communities. Descriptive statistics and logistic regression models were applied. Among homeless adults, having dental problems was the most robust factor associated with their use of Health Care for the Homeless Program services. Among homeless adults who did not visit Health Care for the Homeless Program services during last six months, the number of emergency room visits was the most powerful factor associated with their use of other health care services. The results of the study can help health care providers better serve homeless adults to meet their health needs.

Johnson LJ, McCool AC. **Dietary intake and nutritional status of older adult homeless women: A pilot study.** J Nutr Elder 23(1):1-21, 2003.

A pilot study was conducted to identify eating patterns, food sources, and nutritional problems among a limited population of older homeless women located in a large urban area. Most of these women's food came from shelter meals, and their food intake was inadequate for most nutrients. The availability of fruits, vegetables, dairy products, and whole grains was very limited. Foods high in saturated fats and simple carbohydrates provided most of their caloric intake. Although some women were obese, most were found to have low BMI and mid-arm muscle mass area measurements indicating low body fat stores and potential muscle wasting.

Lewis, J, Andersen, R, Gelberg, L. Health care for homeless women: **Unmet needs and barriers to care.** Journal of General Internal Medicine 18(11): 921-928, 2003.

This study determines how much perceived unmet need for medical care there is among homeless women, what homeless women perceive to be barriers to health care, and how barriers and other factors are associated with unmet needs. Based on a cross-sectional study of homeless women by the authors, utilizing structured interviews, the authors evaluate the perceived unmet need for medical care in the past 60 days, the relationship between unmet need and demographic variables, place of stay, source of health care, insurance, and perceived barriers to care. Of the 974 women, 37 percent reported unmet need for medical care. Controlling for other factors, the odds of unmet need were lower among those with a regular source of care, while having health insurance was not significantly associated. The odds of unmet need were higher among those who experienced the barriers: not knowing where to go, long office waiting times and being too sick to seek care. The authors conclude that there is significant unmet need for medical care among homeless women. Homeless women must be educated regarding sources of care, and clinics serving the homeless must decrease waiting times (authors).

Minnesota Primary Care Association. **Health care and the homeless.** Health Care and the Homeless 3(7): July, 2003.

This is a monthly fact sheet sent out by the Minnesota Primary Care Association. This resource is a great example of how PCAs and PCOs can share important information with health centers, community partners, and state lawmakers in a compact, easy-to-read format. This issue also has interesting information about

national and state-level developments in primary health care and welfare trends. Available From: Minnesota Primary Care Association, 1113 E. Franklin Avenue, Suite 211, Minneapolis, MN 55404, (612) 253-4715, tony.wijesinha@mnpca.org, <http://www.mnpca.nonprofitoffice.com>

Nadkarni, M, Philbrick, J. **Free clinics and the uninsured: The increasing demands of chronic illness.** Journal of Health Care for the Poor and Underserved 14(2): 165-175, 2003.

This article discusses the safety net needed for the uninsured, such as community health centers, public hospitals, and academic health centers. Despite the fact that there are three hundred forty five free clinics in the United States, there is very little information published about them. This article provides detailed descriptions of demographic and clinical characteristics of free clinic patients. The authors assert that this information is vital for clinic management as well as broader public policy concerns, and describe the experience from the first five years of operation of the Charlottesville Free Clinic in Charlottesville, Virginia (authors).

National Health Care for the Homeless Council. **Mainstreaming health care for homeless people.** Nashville, TN: National Health Care for the Homeless Council, 2003.

Mass homelessness signifies the failure of numerous systems, and the eradication of homelessness will require significant adjustments to many mainstream public programs, particularly in the areas of health care, housing and income support. This paper very briefly examines the interaction of the health care system with homelessness, and describes an effective approach to mainstreaming in health care that can help to prevent and end homelessness (authors). Available From: National Health Care for the Homeless Council, P.O. Box 60427, Nashville TN 37206-0427, (615) 226-2292, council@nhchc.org, www.nhchc.org.

Penson RT, Fergus LA, Haston RJ, Clark JR, Demotses A, O'Connell JJ, Chabner BA, Lynch TJ Jr. **The Kenneth B. Schwartz Center at Massachusetts General Hospital hematology-oncology department: Hope for the homeless.** Oncologist 8(5):488-95, 2003.

Shortly before his death in 1995, Kenneth B. Schwartz, a cancer patient at Massachusetts General Hospital (MGH), founded the Kenneth B. Schwartz Center at MGH. The Schwartz Center is a nonprofit organization dedicated to supporting and advancing compassionate health care delivery, which provides hope to the patient and support to caregivers and encourages the healing process. The Center sponsors the Schwartz Center Rounds, a monthly multidisciplinary forum during which caregivers discuss a specific cancer patient, reflect on the important psychological issues faced by patients, their families, and their caregivers, and gain insight and support from their fellow staff members. A homeless man with head and neck cancer presents to the emergency room: a sad and familiar story. But this story is redeemed by his 35-year friendship with a priest, a man whose unconditional love and support became critical to the patient's care and treatment. The patient had lived for 30 years in homeless shelters, had problems with alcohol abuse, and was notoriously noncompliant with medical caregivers. He could not speak due to his disease, was illiterate with limited intellectual capacity, and had neither a job nor a family. Despite huge and apparently insurmountable problems for the patient, the oncology team was able to carve out a package of care, successfully communicate, and mobilize a support network to allow successful completion of chemoradiation therapy. The team developed a strong commitment to his care and an affectionate bond, which very positively affected all of those involved. We discuss issues of access to cancer care, and the special problems presented by homeless patients.

Rew, L. **Relationships of sexual abuse, connectedness, and loneliness to perceived well-being in homeless youth.** *Journal of Specialized Pediatric Nursing* 7(2): 51-63, 2003.

In this article, the authors attempt to describe the respondents' perceptions of connectedness, loneliness, and well-being; and to explore relationships among these variables. Survey data from 96 participants, focus group interviews with 32 participants, and 10 individual interviews were analyzed. Sixty percent of the sample reported sexual abuse, which was significantly related to loneliness and inversely related to connectedness and perceived well-being. Subjects felt lonely and disconnected. They perceived their well-being in terms of current health status. High rates of sexual abuse, lack of connectedness, and loneliness may help to explain poor perceived well-being in homeless youth (author).

Shoenberger JM, Houpt JC, Swadron SP. **Occult trauma in high-risk populations.** *Emerg Med Clin North Am* 21(4):1145-63, 2003.

Several groups of patients are at increased risk for traumatic injury that is "occult," or not apparent on initial presentation. Perhaps the most notorious are those who abuse alcohol, but other groups include the elderly, coagulopathic, those with neurological disease, and the mentally ill. Moreover, traumatic injury can coexist with (or be masked by) medical pathology, resulting in the disposition of injured patients to nonsurgical services where surveillance for traumatic injury diminishes. Because delays or failures in diagnosis might result in unnecessary pain, morbidity, and mortality, it is important for the emergency physician to identify occult presentations of trauma before disposition. This review highlights commonly missed traumatic injuries in adult patients.

Stratigos AJ, Katsambas AD. **Medical and cutaneous disorders associated with homelessness.** *Skinmed* 2(3):168-72, 2003.

Homelessness is a rising problem with socioeconomic roots that affects millions of people around the world. Homeless people suffer from a wide range of health problems and, consequently, have high rates of morbidity and mortality. Various infectious and noninfectious skin conditions have been described among the homeless, with trauma, superficial fungal infections, and foot problems being the most prevalent. Poor hygiene conditions, exposure to harmful environmental agents, and impaired access to health care may further exacerbate these skin diseases and lead to serious and occasionally life-threatening situations. As an integral part of the medical care for the homeless, dermatologic care is essential in diagnosing and managing their skin diseases, in preventing more serious complications and in improving the overall health status of the homeless population.

2002

Beauchamp T, Jennings B, Kinney E, Levine R. **Pharmaceutical research involving the homeless.** *J Med Philos* 27(5): 547-564, Oct. 2002.

Discussions of research involving vulnerable populations have left the homeless comparatively ignored. Participation by these subjects in drug studies has the potential to be upsetting, inconvenient, or unpleasant. Participation occasionally produces injury, health emergencies, and chronic health problems. Nonetheless, no

ethical justification exists for the categorical exclusion of homeless persons from research. The appropriate framework for informed consent for these subjects of pharmaceutical research is not a single event of oral or written consent, but a multi-staged arrangement of disclosure, dialogue, and permission-giving. Payments and other rewards in biomedical research raise issues of whether it is ethical to offer inducements to the homeless in exchange for participation in drug studies. Such inducements can influence desperate persons who are seriously lacking in resources. The key is to strike a balance between a rate of payment high enough that it does not exploit subjects by underpayment and low enough that it does not create an irresistible inducement. This proposal does not underestimate the risks of research, which are often overestimated and need to be appraised in light of the relevant empirical literature.

Central City Association of Los Angeles. **Downtown's human tragedy: It's not acceptable anymore: A public health and safety plan.**

This report describes homelessness in Downtown Los Angeles and proposes a 14-point plan to address issues of public health and safety. It addresses the public health, safety and economic crises, and pinpoints target populations effected. The report's recommendations focus on service resistant addicted, mentally ill, panhandlers, parolees, drug dealers and other criminals (authors).

Chau, S, Chin, M, Chang, J, Luecha, A, Cheng, E, Schlesinger, J, Veena, R, Huang, D, Maxwell, AE, Usatine, R, Bastani, R, Gelberg, L. **Cancer risk behaviors and screening rates among homeless adults in Los Angeles County.** Cancer Epidemiology, Biomarkers & Prevention 11 (5): 431-438, 2002.

This article examines the many barriers to health care and preventive services facing people who are homeless, despite the fact that they have an increased prevalence of most risk factors for cancer. A group of adults who are homeless, at nine different locations within Los Angeles County were surveyed during the summers of 1998 and 1999. The majority of this population had not been to cancer screening exams, however, their risk factors make them more likely to develop cancer. The authors assert that given the lower cancer screening rates compounded by higher cancer risk factors, populations of homeless adults need increased access to cancer screening, and education on the availability of free services. Also, the authors suggest that facilities for people who are homeless and their staff should reinforce the purposes of cancer screening, provide more screening services, and implement institutional efforts to reduce high-risk behaviors (authors).

Cheung RC, Hanson AK, Maganti K, Keefe EB, Matsui SM. **Viral hepatitis and other infectious diseases in a homeless population.** J Clin Gastroenterol 34(4): 475-480, Apr 2002.

This study consists of a retrospective analysis of the history and laboratory data collected from all homeless veterans admitted to a Veterans Administration (VA) domiciliary from May 1995 to March 2000. Of the homeless veterans admitted to a VA domiciliary program, 597 of 829 were screened for markers of all four infectious diseases. The overall prevalence of anti-hepatitis C virus (HCV) antibody, and positive result for purified protein derivative (PPD), anti-HIV antibody, and hepatitis B surface antigen (HbsAg) were 41.7%, 20.6%, 1.84% and 1.17%, respectively. At least one of the four markers was positive in 52.6% and more than one in 12%. Co-infection with HCV occurred commonly in veterans who were positive for anti-HIV (72.7%) and HBsAg (57.1%). Four self-reported major risk factors (intravenous drug use, alcohol abuse, previous imprisonment, and prior stay in a shelter) were evaluated. Multivariate analysis indicates that intravenous

drug use and anti-HBs reactivity are independent risk factors for HCV infection, HCV infection for anti-hepatitis B surface antibody reactivity, and older age for PPD positivity. Chronic hepatitis C and co-infections are common among the homeless population. Patients infected with HIV and hepatitis B virus frequently are co-infected with HCV. Infections frequently are associated with certain identifiable risk factors.

Connor, SE, Cook, RL, Herbert, MI, Neal, SM, Williams, JT. **Smoking cessation in a homeless population: There is a will, but is there a way?** *Journal of General Internal Medicine* 17 (5): 369-372, 2002.

In this article, the authors seek to determine the prevalence of smoking, interest in smoking, cessation, and preferences for smoking cessation treatment among a diverse sample of 236 adults who are homeless. The authors also determine how readiness to quit smoking might vary according to living situation, demographic factors, and current participation in a substance abuse treatment program. The findings suggest an urgent need to develop and implement smoking cessation programs for people who are homeless (authors).

Ensign J, Panke A. **Barriers and bridges to care: Voices of homeless female adolescent youth in Seattle, Washington, USA.** *J Adv Nurs* 37(2): 166-172, Jan 2002.

The purpose of this study was to conduct an assessment of reproductive health-seeking behaviors, sources of advice, and access to care issues among a sample of clinic-based homeless adolescent women. Adolescent women are among the most vulnerable and medically underserved subgroups within the homeless population in the United States. Homeless youth are rarely invited to participate in research aimed at improving their access to appropriate health care. Also, the culture in which they live and the personal experience of being homeless are often not addressed. The research was descriptive, using focus groups and individual interviews with a purposeful sample of 20 female youth, aged 14-23 years. The women said that they seek health advice from other women, including their mothers even while they are homeless. They reported first trying self-care interventions, and going to clinics when self-care actions no longer worked. They stated that the main barriers to health care were lack of insurance, confusion over consent, transportation problems, lack of respect (from providers) for their own self-knowledge, and judgementalism from providers. Using the concept of cultural competency, the results provide insights into how to improve communication and health care services for these women. Health care providers need to recognize and appreciate the lifestyle, beliefs, and adaptive attitudes of homeless youth, rather than labeling them as 'deviant'. All personnel who interact with and on behalf of homeless youth must be adequately trained in general knowledge regarding the health of homeless youth as well as in an understanding of the role that culture plays in their health-seeking behaviors.

Gray, E. **HCH UDS Pilot Project 2001-2002: A technical assistance publication.** Nashville, TN: National Health Care for the Homeless Council, 2002.

This technical assistance publication proposes the collection of additional data by HCH projects as part of their annual UDS reports to enable more realistic assessments of HCH project productivity, staff accountability and client needs; and to provide more accurate measures of national HCH Program effectiveness. The document includes data collection tools for HCH projects to use for this purpose that were developed and field-tested by the Region IX HCH Advisory Committee's HCH UDS Work Group in 2001-2002. The proposed tools include new measures to assess different levels of care in five categories of service that are considered intrinsic to the HCH model of care: case management, mental health, substance abuse, health education, medical, nursing and outreach (authors). Available From: National Health Care for the Homeless Council, P.O Box 60427, Nashville, TN 37206, (615) 226-2292, www.nhchc.org.

Hwang SW. **Is homelessness hazardous to your health? Obstacles to the demonstration of a causal relationship.** *Can J Pub Health* 93(6): 407-410, Nov-Dec 2002.

Homeless people suffer from high levels of morbidity and mortality, but there is surprisingly little empiric evidence that homelessness has a direct adverse effect on health. This study examined the relationship between shelter use and risk of death using longitudinal data in a cohort of 8,769 homeless men in Toronto, Ontario. Shelter use was modelled as a time-dependent covariate in a Cox regression analysis. In a model adjusted for age and previous pattern of homelessness, the risk of death during months in which homeless shelters were used was significantly increased. Among men, periods of homeless shelter use are associated with higher mortality. There are three reasons why this finding does not necessarily mean that homelessness itself increases the risk of death. First, the hazard of death associated with shelter use compared to non-shelter use may be significantly different from that associated with homelessness compared to non-homelessness. Second, the association between shelter use and risk of death may be confounded by other variables such as alcohol and drug use. Finally, because the mechanism and time-course of the putative effect of homelessness on health is uncertain, appropriate modelling of the time-dependent covariate is difficult to ensure. Further research into the possible adverse effects of homelessness on health is needed and would have important implications for public policy.

O'Toole, TP, Gibbon, JL, Seltzer, D, Hanusa, BH, Fine, MJ. **Urban homelessness and poverty during economic prosperity and welfare reform: Changes in self-reported comorbidities, insurance, and sources for usual care, 1995 - 1997.** *Journal of Urban Health* 79 (2): 200-210, 2002.

In this article, the authors report findings from two cross-sectional, community-based surveys of homeless and urban poor adults in Pittsburgh, PA. The authors assess changes in demographic composition, source for usual care, self-reported comorbidities, and issues of subsistence between samples of adults who were homeless in 1995 and 1997. The changes noted are discussed in the context of the relative economic prosperity in the region at the time and its effect on homelessness, as well as the structural supports for health care to urban poor during the shift to Medicaid managed-care coverage and eligibility restrictions (authors).

Post, PA. **Hard to reach: Rural homelessness and health care.** Nashville, TN: National Health Care for the Homeless Council, 2002.

This report examines obstacles to health care encountered by people who experience homelessness in small communities and remote rural areas of the United States. Information presented here was obtained from the research literature and from 32 service providers and others who are knowledgeable about rural poverty and homelessness in 17 states. The document summarizes what is known about the causes of rural homelessness, and how unstably housed people living in rural areas differ from their urban counterparts. In addition, it describes health problems often experienced by rural homeless clients, highlights strategies that homeless service providers are using to meet the challenges these clients present, and lists their recommendations for policy and practice to improve service access and reduce the incidence of rural homelessness. Sources cited in this report and additional resources about rural homelessness in particular states are included in the bibliography (authors).

Rew L. **Characteristics and health care needs of homeless adolescents.** Nurs Clin North Am 37(3): 423-431, Sept 2002.

There is a significant and growing number of adolescents who separate early from their families and become homeless. These youths are heterogeneous in terms of gender, race, ethnicity, and socioeconomic status, but the majority come from families that have been disruptive or dysfunctional in some way. Homeless adolescents are vulnerable to a variety of physical and psychologic problems related not only to their family histories but to the stressful environments in which they try to survive. Although numerous federal, state, and local programs have been developed to meet their needs for shelter, health care, and education, much remains to be done to ensure their healthy development and to prepare them for responsible life in the larger society.

Rosenbawm, S, Zuvekas, A. **Healthcare use by homeless persons: Implications for public policy.** Health Services Research 34(6): 1303-1305, 2000.

The authors present findings from a study that examines the use of healthcare by homeless persons. Despite a limited sample size, the complexities of tracking homeless study participants, and the short follow-up time involved, the study presents compelling findings regarding the willingness of homeless persons to seek out and use appropriate healthcare, despite of what can only be thought of as overwhelming tasks of daily living. The finding suggests that policies that promote healthcare access among the homeless through broader funding will in fact reach a population that values healthcare and uses it appropriately (authors).

Smith HM, Reporter R, Rood MP, Linscott AJ, Mascola LM, Hogrefe W, Purcell RH. **Prevalence study of antibody to ratborne pathogens and other agents among patients using a free clinic in downtown Los Angeles.** J Infect Dis 186(11): 1673-1676, Dec 2002.

Norway rats (*Rattus norvegicus*) are hosts for various microbes. Homeless people who have contact with rats may be at risk of infection by them. The Los Angeles County Department of Health Services initiated a seroepidemiologic study among patients who used a free clinic in downtown Los Angeles; 200 serum specimens obtained for other routine assays were tested for antibodies to ratborne pathogens and other agents. The seroprevalence of antibody to hepatitis E virus in this population was 13.6%; to *Bartonella elizabethae*, 12.5%; to *B. quintana*, 9.5%; to *B. henselae*, 3.5%; to Seoul virus, 0.5%; and to *Rickettsia typhi*, 0.0%. This study found that patients and locally trapped rats had antibodies to some of the same agents.

Szerlip MI, Szerlip HM. **Identification of cardiovascular risk factors in homeless adults.** Am J Med Sci 324(5): 243-246, Nov 2002.

BACKGROUND: Cardiovascular disease is an important health problem among homeless adults; however, the common cardiac risk factors present in this population are unknown. This study was undertaken to identify the reversible cardiovascular risks present in the homeless. **METHODS:** A retrospective chart review was performed randomly on 100 patients who were seen at a homeless clinic in New Orleans, Louisiana. These patients were compared with 200 matched nonhomeless patients who attended an inner-city primary care clinic. Each chart from the 2 groups was reviewed for the presence of hypertension, diabetes mellitus type 2, cigarette smoking, and hypercholesterolemia. Statistical comparisons were made between the homeless and the control subjects. **RESULTS:** Hypertension was present in 65% of the homeless but only 52% of the nonhomeless [$P < 0.05$; odds ratio 1.78 (CI, 1.09 to 2.9)]. Smoking was far more common in the homeless than the nonhomeless, 75 versus 57%, respectively [$P < 0.005$; odds ratio 2.22 (CI, 1.27 to 3.88)].

There was no difference in the prevalence of diabetes or total cholesterol. Compared with national data hypertension, smoking and diabetes seem to be represented excessively in the homeless population. CONCLUSIONS: Smoking and hypertension are significantly more prevalent in the homeless population than in a matched cohort. Educational and preventive programs are needed to reduce the prevalence of cardiovascular disease and reduce the overutilization of expensive healthcare resources.

Zerger, S. **Learning about homelessness and health in your community: A data resource guide.** Nashville, TN: National Health Care for the Homeless Council, 2002.

This publication contains helpful resources for service providers, researchers and advocates seeking data about homelessness and health. The data resource guide will be particularly useful to those who are preparing funding applications for the federal Health Care for the Homeless or other Consolidated Health Center programs. Data resources cited in this document are available free-of-charge via the Internet. Information available from these resources includes national, state and local statistics on poverty, employment patterns, housing, health status indicators, and health risk factors that may have an impact on the homeless population. Listings of health, housing and homeless services and resources that are available at state and local levels are also included (authors). Available From: National Health Care for the Homeless Council, P.O Box 60427, Nashville, TN 37206, (615) 226-2292, www.nhchc.org.

2001

Boyce WF. **Disadvantaged persons' participation in health promotion projects: Some structural dimensions.** Soc Sci Med, 52(10):1551-64, May 2001.

A structural perspective was used in studying community participation of disadvantaged groups (poor women, street youth, and disabled persons) in health promotion projects. Five community projects in the Canadian Health Promotion Contribution Program were examined in a comparative case study utilizing in-depth interviews, documents, and secondary sources. Analysis revealed relatively low numbers and restricted range of participants, difficulties in recruiting and maintaining participants, declining rates of active participation over time, and limited target group influence and power. This paper reports on the relationship between various dimensions of structure (social-cultural, organizational, political-legal-economic) and the community participation process. Participation was influenced by structural factors such as bureaucratic rules and regulators, perceived minority group rights and relations, agency reputations and responsibilities, available resources, and organizational roles. Control of projects by target group members, rather than by service agencies, was an important overall organizational structural factor which allowed community members to achieve influence in projects. The study concludes that a conceptual model based on structural factors is useful in explaining how key factors from federal and local levels can restrict or facilitate community participation.

D'Amore J; Hung O; Cjaomg W; Goldfrank L. **The epidemiology of the homeless population and its impact on an urban emergency department.** *Academic Emergency Medicine*, 8(11):1051-5, November 2001.

This study characterizes the homeless adult population of an urban emergency department (ED) and study the medical, psychiatric, and social factors that contribute to homelessness. Methods included a prospective, case-control study of all homeless adults patients presenting to an urban, tertiary care ED and a random set of non-homeless controls over an eight-week period during summer 1999. Research assistants administered a 50-item questionnaire and were trained in assessing dentition and triceps skin-fold thickness. Inclusion criteria: all homeless adults who consented to participate. Homelessness was defined as being any person not residing at a private address, group home, or drug treatment program. Randomly selected controls were concurrently enrolled with a 3:1 homeless: control rate. Exclusion criteria: critically ill, injured, or incapacitated patients, or patients < 21 years of age. Two hundred fifty-two homeless subjects and 88 controls were enrolled. Data are presented for homeless vs control patients: mean age = 42 vs 48; male gender 95% vs 54%; history of TB 49% vs 15%; history of HIV infection 35% vs 13%; history of penetrating trauma 62% vs 16%; history of depression 70% vs 15%; history of schizophrenia 27% vs 7%; history of alcoholism 81% vs 15%; significant tooth loss (>3) 43% vs 18%; percentage of body fat 16.5% vs 19.7%; mean number of ED visits/year 6.0 vs 1.6. In the study population, homelessness was associated with a history of significantly higher rates of infectious disease, ethanol and substance use, psychiatric illness, social isolation, and rates of ED use.

Elliott BA, Beattie MK, Kaitfors SE. **Health needs of people living below poverty level.** *Fam Med* 33(5): 361-366, May 2001.

BACKGROUND AND OBJECTIVES: Low-income populations, especially persons without health insurance, suffer disproportionately with a variety of chronic ailments, postpone getting medical care, and have shorter life spans. This study was conducted to better understand the health care needs and behaviors of people living in poverty. **METHODS:** Participants for the study were recruited through agencies serving low-income and homeless people, neighborhood businesses, churches, and subsidized housing units. All participants were adults who had incomes below 200% of the federal poverty level. Subjects completed face-to-face interviews to answer questions about demographics and their concerns about health care. Quantitative and qualitative analyses were performed. **RESULTS:** A total of 750 people were interviewed, with 729 providing usable data. Thirty-seven percent of subjects reported spending at least part of the previous year without health insurance. Fifty-six percent of these individuals were persons who were employed but whose employers did not provide health insurance. Reported health concerns were access to care (reported by 21% of subjects), costs of care (13%), and ability to purchase medications (15%). Forty-five percent of subjects reported receiving mental health services; these subjects were concerned about their ability to continue receiving care and to afford medications. **CONCLUSIONS:** The portion of the low-income population that is uninsured for part or all of a year is greater than in published reports. The health behaviors of this group are easily understood when coverage (if any), level of income, age, and health care needs are considered.

Hatton DC, Kleffel D, Bennett S, Gaffrey EA. **Homeless women and children's access to health care: A paradox.** *J Community Health Nurs*, 18(1):25-34, Spring 2001.

Homeless women and children who reside in shelters experience many health-related problems. The aim of the qualitative study reported here was to (a) explore how shelter staffs manage health problems among their residents and assist them in accessing health services, and (b) identify clinical strategies for community health nurses working with this population. Findings demonstrate a paradox whereby homeless shelter staffs try to

gain access to care for their residents through a system that is designed to keep them out. In addition, findings indicate a need for increased community health nursing services in homeless shelters. Strategies for resolving this paradox include providing assessment, policy development, and assurance of health care for homeless women and children.

Kushel MB; Vittinghoff E; Haas JS. **Factors associated with the health care utilization of homeless persons.** *Jl of the American Medical Association*, 285(2):200-6, Jan 10, 2001.

Homeless persons face numerous barriers to receiving health care and have high rates of illness and disability. Factors associated with health care utilization by homeless persons have not been explored from a national perspective. This studies objective is to describe factors associated with use of and perceived barriers to receipt of health care among homeless persons. Secondary data analysis of the National Survey of Homeless Assistance Providers and Clients was utilized; a total of 2974 currently homeless persons were interviewed through homeless assistance programs throughout the United States in October and November 1996. The main outcome measures included self-reported use of ambulatory care services, emergency departments, and inpatient hospital services, emergency departments, and inpatient hospital services; inability to receive necessary care; and inability to comply with prescription medication in the prior year. Overall, 62.8% of subjects had one or more ambulatory care visits during the preceding year, 32.2% visited an emergency department, and 23.3% had been hospitalized. However, 24.6% reported having been unable to receive necessary medical care. Of the 1201 respondents who reported having been prescribed medication, 32.1% reported being unable to comply. After adjustment for age, sex, race/ethnicity, medical illness, mental health problems, substance abuse, and other covariates, having health insurance was associated with greater use of ambulatory care, inpatient hospitalization, and lower reporting of barriers to needed care and prescription medication compliance. Insurance was not associated with a greater use of ambulatory care and fewer reported barriers. Provision of insurance may improve the substantial morbidity experienced by homeless persons and decrease their reliance on acute hospital-based care.

Leginski, W. **Health issues in homelessness.** Berkeley, CA: Institute of Government Studies, University of California at Berkeley, 2001.

This monograph reviews the most significant facets of urban homelessness and calls on us to offer policy solutions. The author discusses the issue of health status and health services among homeless persons, and how the complex interaction between federal, state and local social policies affects the lives of people who are vulnerable. According to the author, there are many generalizations offered about homelessness in the United States, and particularly the urban homeless, the prevalence and severity of health problems among people who are homeless ranks high (author). Available From: Institute of Government Studies, University of California at Berkeley, 102 Moses Hall, Berkeley, CA 94720-2370, (510) 642-6723, www.igs.berkeley.edu/events/homeless/papers/.

McCabe S; Macnee CL; Anderson MK. **Homeless patients' experience of satisfaction with care.** *Archives of Psychiatric Nursing*, 15(2):78-85, Apr 2001.

This article explores satisfaction with health care and the interrelationship among experiences of being homeless, participants' health perceptions, and experiences of satisfaction with health care. It was conducted using participants selected from five sites in one southeastern state. Participant interviews were conducted at a nurse-managed primary health care clinic for homeless, at a nighttime soup-kitchen, and at three private, not-

for-profit, homeless shelters in two different towns. It was part of a larger study designed to develop and validate a reliable measure of client satisfaction with primary health care among homeless people. Face-to-face interviews with 17 homeless person were conducted, with the semistructured interview constituting the primary data source. Common themes were identified and the interrelationship of theme clusters was explored. Analysis yielded five distinct themes that represent the experiences of satisfaction with health care. These themes were mediated and directly informed by five themes of homelessness and three themes of health identified in the shared experiences of the participants. It suggests that satisfaction with health care for homeless persons differs from currently identified dimensions of satisfaction with care, and that some aspects of homelessness are seen by participants as positive and health-promoting.

Power R, Hunter G. **Developing a strategy for community-based health promotion targeting homeless populations.** Health Educ Res 16(5): 593-602, Oct 2001.

There is a need for targeted health promotion aimed at homeless populations. A survey of 100 Big Issue newspaper vendors was conducted, along with in-depth interviews and focus groups, in order to identify health promotion needs. Drug and alcohol problems, the effects of cold weather, nutritional deficiencies, and poor personal hygiene were reported as the main health concerns. However, health was not always an immediate priority for the homeless, with daily concerns predominating, such as shelter and getting money for food. A range of information needs were highlighted and a number of key health promotion topics identified. Social network and social activity data were collected from 14 Big Issue vendors to assess their penetration of groups of homeless people. Both generic and targeted health promotion activities are recommended, and the role of health advocacy and peer education should be further explored.

Raoult D, Foucault C, Brouqui P. **Infections in the homeless.** Lancet Infect Dis 1(2): 77-84, Sep 2001.

Homeless people in developed countries have specific problems predisposing them to infectious diseases. Respiratory infections and outbreaks of tuberculosis and other aerosol transmitted infections have been reported. Homeless intravenous drug users are at an increased risk of contracting HIV, and hepatitis B and C infections. Skin problems are the main reason the homeless seek medical attention, and these commonly include scabies, pediculosis, tinea infections, and impetigo. Many foot disorders are more prevalent in the homeless including ulcers, cellulitis, erysipelas, and gas gangrene. The louse transmitted bacteria *Bartonella quintana* has recently been found to cause clinical conditions in the homeless such as urban trench fever, bacillary angiomatosis, endocarditis, and chronic afebrile bacteraemia. Treatment of homeless people is complicated by financial constraints, self-neglect, and lack of adherence. Patients with serious and contagious illnesses should be hospitalised. Physicians should be aware of these specific issues to enhance care.

Rosenheck R; Morrisey J; Lam J; Calloway M; Stolar M; Johnson M; Randolph F; Blasinsky M; Goldman H. **Service delivery and community: Social capital, service systems integration, and outcomes among homeless persons with severe mental illness.** Health Serv Res, 36(4):691-710, August 2001.

OBJECTIVES: This study evaluated the influence of features of community social environment and service system integration on service use, housing, and clinical outcomes among homeless people with serious mental illness. **STUDY SETTING:** A one-year observational outcome study was conducted of homeless people with serious mental illness at 18 sites. **DATA SOURCES:** Measures of community social environment (e.g., social capital) were based on local surveys and voting records. Housing affordability was assessed with housing survey data. Service system integration was assessed through interviews with key informants at each site to

document interorganizational transactions. Standardized clinical measures were used to assess clinical and housing outcomes in face-to-face interviews. **PRINCIPAL FINDINGS:** Social capital was associated with greater service systems integration, which was associated in turn with greater access to assistance from a public housing agency and to a greater probability of exiting from homelessness at 12 months. Housing affordability also predicted exit from homelessness. Neither environmental factors nor systems integration predicted outcomes for psychiatric problems, substance abuse, employment, physical health, or income support. **CONCLUSION:** Community social capital and service system integration are related through a series of direct and indirect pathways with better housing outcomes but not with superior clinical outcomes for homeless people with mental illness. Implications for designing improved service systems are discussed.

Shi L; Politzer RM; Regan J; Lewis-Idema D; Falik M. **The impact of managed care on the mix of vulnerable populations served by community health centers.** *Jl of Ambulatory Care Management*, 24(1):51-66, Jan 2001.

This article examined the impact of managed care involvement on vulnerable populations served by community health centers (CHCs), while controlling for center rural-urban location and size, and found that centers involved in managed care have served a significantly smaller proportion of uninsured patients but a higher proportion of Medicaid users than those not involved in managed care. The results suggest that the increase in Medicaid managed care patients may lead to a reduced capacity to care for the uninsured, thus hampering CHCs from expanding access to health care for the medically indigent.

Steele RW; O'Keefe MA. **A program description of health care interventions for homeless teenagers.** *Clin Pediatr (Phila)*, 40(5):259-63, May 2001.

This prospective review was designed to determine the effectiveness of a broad spectrum health intervention program for homeless and runaway youth. Diagnosis, treatment and counseling for drug use, sexually transmitted diseases (STDs) and other health issues were provided all new admissions to a residential care facility during a two-month enrollment. Education was continued during a one month follow-up period based on the program entitled Bright Futures, previously developed and published by the National Center for Education in Maternal and Child Health. Sixty percent of the 106 study residents had STDs on admission while only 7% developed new STDs after completing therapy and undergoing counseling. Drug dependence was reduced from 41% to 3%, and 42% achieved full-time or part-time employment. Fifty-nine percent completed hepatitis B immunization with the three-dose series. This experience suggests that an organized program of interventions in a residential care facility for homeless teenagers can significantly reduce drug dependence and STDs.

Trevena LJ; Nutbeam D; Simpson JM. **Asking the right questions of disadvantaged and homeless communities: The role of housing, patterns of illness and reporting behaviors in the measurement of health status.** *Aust N Z J Public Health*, 25(4):298-304, Aug 2001.

OBJECTIVE: To assess the self-reported health status and its relationship to demographic variables among patrons of a charity-run meals service at The Exodus Foundation, in urban Sydney, Australia. **METHOD:** Random sample cross-sectional study of 100 face-to-face interviews (79% recruitment rate). Subject reported health status was measured by subjective rating scale, open-ended and checklist questions about presence of type of acute and chronic disease. **RESULTS:** Compared to housed but poor counterparts within the Exodus sample, homeless people were significantly more likely to report fair to poor health status and had more serious patterns of illness (diseases of the digestive system, depression, common cold, bronchitis, refractive

errors, drug/alcohol dependence, diabetes mellitus Type II). Exodus patrons reported fewer acute and chronic illnesses with open-ended questions than with a checklist. **CONCLUSION:** In this population, there was a strong relationship between poor health and homelessness. When patterns of illness and injury were measured within this group, they showed more serious illness than in the general population. Such patterns may not be identified by methods often used in traditional population health surveys.

2000

DiMarco MA. **Faculty practice at a homeless shelter for women and children.** *Holist Nurs Pract* 14(2): 29-37, Jan 2000.

Homelessness in America has significantly increased in recent years. Exact numbers of homeless persons in the United States are difficult to assess, though estimates of homeless persons range from 250,000 to 3 million. The homeless population has shifted to include women and children, including two parent families. Providing health care for the homeless is one of the most important and challenging health issues today. There are many barriers to providing adequate health care. The purpose of this article is to describe the complexity of the role and the experiences of a pediatric nurse practitioner at a clinic in a homeless shelter that houses approximately 30 women and children.

Gelberg L; Andersen RM; Leake BD. **The behavioral model for vulnerable populations: Application to medical care use and outcomes for homeless people.** *Health Serv Res*, 34(6):1273-302, February 2000. Comment in: *Health Serv Res*, 34(6):1303-5, February 2000.

OBJECTIVES: (1) To present the Behavioral Model for Vulnerable Populations, a major revision of a leading model of access to care that is particularly applicable to vulnerable populations; and (2) to test the model in a prospective study designed to define and determine predictors of the course of health services utilization and physical health outcomes within one vulnerable population: homeless adults. We paid particular attention to the effects of mental health, substance use, residential history, competing needs, and victimization. **METHODS:** A community-based probability sample of 363 homeless individuals was interviewed and examined for four study conditions (high blood pressure, functional vision impairment, skin/leg/foot problems, and tuberculosis skin test positivity). Persons with at least one study condition were followed longitudinally for up to eight months. **PRINCIPAL FINDINGS:** Homeless adults had high rates of functional vision impairment (37 percent), skin/leg/foot problems (36 percent), and TB skin test positivity (31 percent), but a rate of high blood pressure similar to that of the general population (14 percent). Utilization was high for high blood pressure (81 percent) and TB skin test positivity (78 percent), but lower for vision impairment (33 percent) and skin/leg/foot problems (44 percent). Health status for high blood pressure, vision impairment, and skin/leg/foot problems improved over time. In general, more severe homeless status, mental health problems, and substance abuse did not deter homeless individuals from obtaining care. Better health outcomes were predicted by a variety of variables, most notably having a community clinic or private physician as a regular source of care. Generally, use of currently available services did not affect health outcomes. **CONCLUSIONS:** Homeless persons are willing to obtain care if they believe it is important. Our findings suggest that case identification and referral for physical health care can be successfully accomplished among homeless persons and can occur concurrently with successful efforts to help them find permanent housing, alleviate their mental illness, and abstain from substance abuse.

Rosenbaum S, Zuvekas A. **Healthcare use by homeless persons: Implications for public policy.** Health Serv Res, 34(6):1303-5, February 2000. Comment on: Health Serv Res, 34(6):1273-302, February 2000.

Stuart HL; Arboleda-Florez J. **Homeless shelter users in the postdeinstitutionalization era.** Can J Psychiatry, 45(1):55-62, February 2000.

OBJECTIVE: To describe the psychiatric symptomatology and mental health service needs of homeless shelter users in Calgary, Alberta. Data were collected as part of a broad-based community action initiative designed to reduce the problem of homelessness. **METHODS:** A semistructured interview was conducted with a representative sample of 250 emergency shelter users. Mental health problems were measured through self-reports of 9 psychiatric symptoms known to be related to illnesses prevalent among homeless populations (depression, anxiety, and psychoses). The CAGE alcohol screen was also used. **RESULTS:** Three-quarters of the sample expressed some symptomatology. About one-third were estimated to have a significant mental health problem. The lifetime prevalence of alcohol abuse was 33.6%. Higher levels of psychiatric symptomatology related to a wide range of hardships, personal and public health risks, addictive behaviors, victimization, economic and interpersonal life events, dissatisfaction and stress. Those with significant symptomatology frequently needed mental health care services but often did not know where to access them. **CONCLUSIONS:** Prevalence of mental health and substance abuse problems within homeless populations is significant and associated with considerable hardship as well as personal and public health risks.

1999

Barrow SM; Herman DB; Cordova P; Struening EL. **Mortality among homeless shelter residents in New York City.** American Journal of Public Health, 89(4):529-34, Apr 1999.

This study examined the rates and predictors of mortality among sheltered homeless men and women in New York City. Identifying data on a representative sample of shelter residents surveyed in 1987 were matched against national mortality records for 1987 through 1994. Standardized mortality ratios were computed to compare death rates among homeless people with those of the general US and New York City populations. Logistic regression analysis was used to examine predictors of mortality within the homeless sample. Age-adjusted death rates of homeless men and women were four times those of the general US population and 2 to 3 times those of the general population of New York City. Among homeless men, prior use of injectable drugs, incarceration, and chronic homelessness itself compounds the high risk of death associated with disease/disability and intravenous drug use. Interventions must address not only the health conditions of the homeless but also the societal conditions that perpetuate homelessness.

Blewett DR; Barnett GO; Chueh HC. **Experience with an electronic health record for a homeless population.** Proc AMIA Symp, 481-5, 1999.

A computerized electronic medical record (EMR) system using client-server architecture was designed and implemented by the Laboratory of Computer Science for use by the Boston Health Care for the Homeless Program (BHCHP) to meet the unique medical record needs of the homeless. For the past three years, this EMR has been used to assist providers in the delivery of health care to the homeless population of Boston. As the BHCHP has grown and technology improved, it is important to review what features of the EMR work, and to investigate what improvements can be made for the better delivery of care to the homeless.

Bureau of Primary Health Care. **Starting a student-run homeless clinic. A guidebook for health professions students on the process of establishing a clinic.** Reston, VA: The American Medical Student Association/Foundation, 1999.

The purpose of this manual is to provide a "how-to" framework for the development of a student run clinic. The manual details, with examples, the phases for clinic development. The clinics that are referenced fall along a spectrum of student involvement, from entirely student-run to student participation in existing clinics. Because the structure of a clinic is based on community needs, volunteer support, and financial backing, this guide explains how various clinics approach the stages of clinic development. AVAILABLE FROM: The American Medical Student Association/Foundation, 1902 Association Drive, Reston, VA 20191. Phone: (703) 620-6600 ext. 217. Fax: (703) 620-5873.

Douglass RL; Torres RE; Surfus P; Krinke B; Dale L. **Health care needs and services utilization among sheltered and unsheltered Michigan homeless.** J Health Care Poor Underserved, 10(1):5-18, February 1999.

Duchon LM; Weitzman BC; Shinn M. **The relationship of residential instability to medical care utilization among poor mothers in New York City.** Med Care, 37(12):1282-93, December 1999.

OBJECTIVES: This study examines the relationship between residential instability, including mobility and previous homelessness, and the use of medical care among previously sheltered and never-sheltered mothers in New York City. The study represents one of the first efforts to follow up on families after they are no longer homeless. **METHODS:** Mothers from 543 welfare families in NYC were interviewed, once in 1988 (Time 1) and again beginning in 1992 (Time 2). The sample included 251 families who first entered shelters after their 1988 interview, and 292 families who spent no time in shelters before or after that point. Mothers were asked about the source and volume of medical care used in the year before follow-up. **RESULTS:** Analyses showed that previously sheltered mothers had a greater reliance on emergency departments (EDs) and weaker ties to private physicians or health maintenance organizations (HMOs) than did mothers who never used shelters. Mobility before the Time 1 interview was associated with greater reliance on EDs and absence of a usual source of care. More recent mobility was not associated with a usual source of care. Current residential stability reduced the likelihood of using an emergency department or having no regular source of care. None of the measures of residential instability were related to the volume of outpatient care used by mothers. **CONCLUSIONS:** A history of residential instability, particularly previous shelter use, strongly predicts where poor mothers currently seek health care. The study provides evidence that upon leaving shelters, mothers are not being well integrated into primary care services.

Ericsson NS; Corey PD. **Health problems and service utilization in the homeless.** Journal of Health Care for the Poor and Underserved 10(4): 443-452, 1999.

This article examines the health problems and utilization patterns of homeless individuals (n=292) seeking medical services in a small southern community. Results showed that the medical problems for which the homeless sought treatment were often (72%) a recurring problem for which treatment had previously been received. The most prevalent medical problem was upper respiratory infection (47%), likely exacerbated by the high rate of cigarette smoking among the sample (73%). More than half (51%) had used other medical

services in the past month. Despite high rates of utilization, the homeless may be underutilizing appropriate preventive medical services, waiting until the medical problem becomes serious before seeking treatment, and overutilizing emergency rooms for non-emergency care. Community-based services sensitive to the needs of the homeless are likely to cost communities less money while providing better services to the homeless.

Health Care for the Homeless Branch. **Principles of practice - a clinical resource guide for Health Care for the Homeless programs. (PAL 99-12).** HCH/DPSP/BPHC/HRSA/DHHS, March 1, 1999.

This Program Assistance Letter (PAL) describes clinical issues specific to the Health Care for the Homeless Program, section 330(h) of the Public Health Service Act. It is intended to provide a greater understanding to current and prospective grantees of the clinical components of delivering services to homeless persons. This guidance should be used as a companion document to the BPHC Policy Information Notice (PIN) 98-23, Health Center Program Expectations. Topics include program goals and challenges, definitions, program services and delivery of services. AVAILABLE FROM: BPHC ACCESS at <http://www.bphc.hrsa.gov>.

Koegel P; Sullivan G; Brunam A; Morton SC; Wenzel S. **Utilization of mental health and substance abuse services among homeless adults in Los Angeles.** Medical Care 37(3): 306-317, 1999.

This article examines utilization and predictors of mental health and substance abuse treatment among a community-based probability sample of homeless adults. The data analyzed were collected through interviews with 1,563 homeless individuals. Two-thirds of these homeless adults met criteria for chronic substance dependence, whereas 22% met criteria for chronic mental illness, with substantial overlap between those two disorders: 77% of those with chronic mental illness were also chronic substance abusers. Only one-fifth of each of those two groups reported receiving treatment within the last 60 days. Mental health service utilization was predicted largely by factors related to need (e.g., diagnosis, acknowledgment of mental health problem), whereas substance abuse service utilization was predicted by myriad additional factors.

O'Toole TP; Gibbon JL; Hanusa BH; Fine MJ. **Preferences for sites of care among urban homeless and housed poor adults.** J Gen Intern Med, 14(10):599-605, October 1999.

OBJECTIVE: To describe sources of health care used by homeless and housed poor adults. **DESIGN:** In a cross-sectional survey, face-to-face interviews were conducted to assess source of usual care, preferred site of care for specific problems, perceived need for health insurance at different sites of care, and satisfaction with care received. Factors associated with selecting non-ambulatory-care sites for usual care were identified. **SETTING:** Twenty-four community-based sites (e.g., soup kitchens, drop-in centers, emergency shelters) frequented by the homeless and housed poor in Allegheny County, Pa. **PARTICIPANTS:** Of the 388 survey respondents, 85.6% were male, 78.1% African American, 76.9% 30 - 49 years of age, 59.3% were homeless less than 1 year, and 70.6% had health insurance. **RESULTS:** Overall, 350 (90.2%) of the respondents were able to identify a source of usual medical care. Of those, 51.3% identified traditional ambulatory care sites (e.g., hospital-based clinics, community and VA clinics, private physicians offices); 28.9% chose emergency departments; 8.0%, clinics based in shelters or drop-in centers; and 2.1%, other sites. **CONCLUSIONS:** Having no health insurance or need for care in the past 6 months increased the use of a non-ambulatory-care site as a place for usual care. Programs designed to decrease emergency department use may need to be directed at those not currently accessing any care.

O'Toole TP; Gibbon JL; Hanusa BH; Fine MJ. **Utilization of health care services among subgroups of urban homeless and housed poor.** *Journal of Health Politics* 24(1): 91-114, 1999.

This article describes health services utilization by homeless and housed poor adults stratified by six-month primary sheltering arrangements. A cross-sectional survey of 373 homeless adults was conducted. Interviews at twenty-four community based sites in Allegheny County, PA, assessed demographic and clinical characteristics, reasons for homelessness, functional status and social support networks, and health services utilization during the previous six months. Subjects were classified as unsheltered, emergency-sheltered, bridge-housed, doubled-up, and housed-poor. Overall, 62.7% reported health service use in the past six months, with significantly more use among emergency-sheltered and bridge-housed housed subjects than unsheltered subjects. The authors conclude that health services use is substantial and associated with sheltering arrangement, comorbid illness, race, health insurance, and social support.

Sachs-Ericsson N; Wise E; Debrody CP; Paniucki HB. **Health problems and service utilization in the homeless.** *J Health Care Poor Underserved*, 10(4):443-52, November 1999.

This study examined the health problems and utilization patterns of homeless individuals (n=292) seeking medical services in a small, southern community. Results showed that medical problems for which the homeless sought treatment were often (72.6%) a reoccurring problem for which treatment had previously been received. The most prevalent medical problem was upper respiratory infection (47%), likely exacerbated by a high rate (73%) of cigarette smoking among the sample. More than half (51.4 %) of the participants had used other medical services in the past month. Despite high rates of use, the homeless may be underutilizing appropriate preventive medical services, waiting until medical problems become serious before seeking treatment, and overusing emergency rooms for nonemergency care. Community-based services sensitive to the needs of the homeless are likely to cost communities less money while providing better services.

Strehlow AJ; Amos-Jones T. **The homeless as a vulnerable population.** *Nurs Clin North Am*, 34(2):261-74, June 1999.

Understanding the nature of homelessness and the relationship between resource availability, relative risks, and health status is critical for nurses to diagnose and treat health-related problems in this vulnerable population. This article discusses the homeless as a vulnerable population by using the health-related problems of vulnerable population's model as a theoretical framework. Specific primary, secondary, and tertiary nursing interventions useful for providing care are discussed and a case study is provided to exemplify these relationships.

Wilk J. **Health care for the homeless: A model for nursing education.** *Int Nurs Rev*, 46(6):171-5, Nov.-Dec. 1999.

1998

Buckner JC. **Displaced children: meeting the health, mental health, and educational needs of immigrant, migrant, and homeless youth.** *Adolescent Medicine: State of the Art Reviews* 9(2): 323-334, 1998.

This chapter explores the common needs of displaced children in the United States, focusing on three subgroups - children of immigrants, children from families of migrant farmworkers, and youth who are homeless, either with their families or on their own. Although these groups are not fully inclusive of all who experience residential instability and displacement (e.g., victims of natural disasters), together they illustrate the nature of the problem. Many of the challenges and needs of displaced children are common across age groups, but there are also differences between younger children and adolescents.

Bureau of Primary Health Care. **Health care access for homeless children.** Bethesda, MD: Bureau of Primary Health Care, February 1998.

This fact sheet provides information surrounding: (1) the health care needs of homeless children, (2) homeless children's access to health care; and (3) what works to get and keep homeless children in health care, including expanding community-based health care and eliminating barriers to care. AVAILABLE FROM: Office of Communications, HRSA, 5600 Fishers Ln., Room 14-45 Rockville, MD 20857, (301) 443-3376.

Bureau of Primary Health Care. **Health Care for the Homeless process and outcome measures: A chronicle of twenty pilot studies.** Bethesda, MD: Health Care for the Homeless Branch, April 27, 1998.

This paper is an overview of an initiative, funded by the Bureau of Primary Health Care, which involved the participation of 20 Health Care for the Homeless grantees in studies on multiple topics related to the provision of health care services to homeless people. The first part of the document contains information regarding the history of this initiative and general observations made throughout the course of the initiative. Following that is a compilation of individual summaries that are edited versions of the 20 participants' final project reports. AVAILABLE FROM: Health Care for the Homeless Branch, DPSP/BPHC/HRSA, 4350 East-West Highway, 9th Fl., Bethesda, MD 20814. Phone: (301) 594-4474.

Dansec ER; Holden EW. **Are there different types of homeless families? A typology of homeless families based on cluster analysis.** *Family Relations* 47(2): 159-165, 1998.

This article presents an analysis to identify different types of homeless families through an empirical method and to examine variations in children's outcomes among these types of homeless families. Cluster analysis was conducted using data from 180 families and 348 children participating in a comprehensive health care program for children in homeless families. Three empirically derived groups of homeless families were identified and differentiated by previous history of homelessness, parenting stress, and major life stressors. One group displayed higher rates of parenting stressors and major life concerns. Children in this group consistently exhibited greater behavior problems and showed a trend suggesting poorer cognitive, academic, and adaptive behavior outcomes than children in the other groups. The authors discuss the result within the context of developing better models to examine the effects of homelessness and poverty on children.

Duchon LM. **Families and their health care after homelessness: Opportunities for improving access.** New York, NY: Garland Publishing, Inc., 1998.

This book focuses on the health and health care use of families after they have left the shelter system. The first three chapters provide a review of relevant literature. An examination of the research is contained in the following three chapters. This research was based on self-reported data collected during a follow-up study of 543 poor New York City mothers. The chapters concerning the research compares ever- and never-sheltered families on various characteristics and factors, and presents findings that indicate that the ever-homeless families are more likely to use emergency departments and clinics, even if the families are no longer homeless. The final chapter offers a discussion of recent development in health and welfare policies and offers recommendations to improve health care provision to homeless families. AVAILABLE FROM: Garland Publishing, c/o Taylor & Francis, Inc., 47 Runway Rd., Levittown, PA 19057, (800) 821-8312.

Ensign J; Gittelsohn J. **Health and access to care: Perspectives of homeless youth in Baltimore City, USA.** Social Science and Medicine 47(12): 2087-2099, 1998.

In this article, a combination of qualitative techniques from participatory rural appraisal and rapid assessment procedures was used to investigate the perceptions of health needs of shelter-based youth in Baltimore. The most common youth-identified health problems included STDs, HIV/AIDS, pregnancy, depression, drug use and injuries. The youth also spoke of environmental safety threats of violence and victimization by adults, as well as racism and sexism in their lives. Youth reported that trusted adult figures such as grandmothers are important sources of health advice. Many homeless youth will less that ideal family situations remain in contact with and continue to seek advice from parents and other family members. The authors state health interventions with urban street youth need to acknowledge the primacy of the social context for these youth, as well as the reality of violence as a daily health threat.

Earnest MP; Grimm SM; Malmgren MA; Martin BA; Meehan M; Potter MB; Steele AW; Zocholl JR. **Quality improvement in an integrated urban healthcare system: A necessary journey.** Clin Perform Qual Health Care, 6(4):193-200, Oct.-Dec. 1998.

Public hospitals and clinics in the United States provide health care for the needs of large numbers of people who are medically indigent, homeless, chronically mentally ill, and suffer medical and social disorders associated with poverty. These "safety-net" healthcare providers traditionally struggle with barriers to providing high-quality, patient-sensitive care, including decaying physical facilities, burdensome bureaucracies, underfunded capital equipment and construction programs, and complex, politically driven budgets and governance. However, these same institutions now must compete for their own Medicaid and Medicare clientele because the private sector is marketing to those patients. They also must continue to provide increasing services to growing numbers of uninsured patients. To accomplish this, these institutions must reinvent themselves as patient-focused, high-quality, cost-effective healthcare providers. The Denver Health system is the public safety-net provider for the city and county of Denver. This large public institution has instituted a multifaceted performance-improvement program. The program includes training employees for patient-focused service, implementing continuous quality-improvement practices, instituting clinical pathways, revising the preexisting ambulatory quality-management program, reengineering key aspects of ambulatory clinic services, and redesigning the hospital-based patient-care services. Major successes have been achieved in some initiatives, but not in all. Many key "lessons learned" may guide others.

Herman D; Susser E (eds.). **Homelessness in America: A collection of articles from the American Journal of Public Health**. Washington, DC: American Public Health Association, Reprint Series #3, 1998.

The papers in this volume illustrate thinking about the problem of homelessness from a public health perspective. They seek to understand and describe the multiple levels of causation of homelessness, across multiple macro-level factors as well as over time within the life course of the individual. The volume is organized into three sections: (1) the problem of homelessness: description, scope and causation; (2) individual-level risk factors for homelessness; and (3) health conditions among homeless people. AVAILABLE FROM: American Public Health Association, 1015 Fifteenth St. NW, Washington, DC 20005.

Reichenbach EM; McNamee MJ; Seibel LV. **The community health nursing implications of the self-reported health status of a local homeless population**. Public Health Nurs, 15(6):398-405, December 1998.

This study explored the personal characteristics and the health and health-related concerns reported by members of the local homeless population in order to design population-specific health programming. The study also examined whether there were significant differences between homeless who are shelter residents and those who are not. An exploratory descriptive design was used to analyze retrospective data collected by a local County Health Department in interviews of 132 homeless adults. The demographic characteristics found reflect many common patterns: marked over-representation of males, mean age in the mid-thirties, education levels comparable to similar socio-economic groups, high unemployment rates, and low health insurance rates. One third of the sample reported self-assessed health statuses of fair or poor. The most frequently identified physical health issue was joint problems, followed by cardiovascular disease. Depression was mentioned most frequently as a self-identified mental health problem. Loneliness was the number one fear identified. This study identifies health concerns that local homeless people themselves find important and provides direction for development of sound population-specific health programming.

Rosenheck R; Kizer KW. **Hospitalizations and the homeless**. N Engl J Med, 339(16):1166; discussion 1167, October 15, 1998.

Rosenheck R; Seibyl CL. **Homelessness: Health service use and related costs**. Med Care, 36(8):1256-64, August 1998. Comment in: Med Care, 36(8):1121-2, August 1998.

OBJECTIVES: This study examines health service use and costs for homeless and domiciled veterans hospitalized in psychiatric and substance abuse units at Department of Veterans Affairs (VA) medical centers, nationwide. **METHODS:** A national survey of residential status at the time of admission was conducted on all VA inpatients hospitalized in acute mental health care units on September 30, 1995. Survey data were merged with computerized workload data bases to assess service use and cost during the 6 months before and after the date of discharge from the index hospitalization. **RESULTS:** Of 9,108 veterans with complete survey data, 1,797 had been literally homeless at the time of admission, and 1,380 were doubled up temporarily, for a total homelessness rate of 35%. Combining patients from general psychiatry and substance abuse programs, the average annual cost of care for homeless veterans, after adjusting for other factors, was \$27,206; \$3,196 higher than the cost of care for domiciled veterans. Approximately 26% of annual inpatient VA mental health expenditures are spent on the care of homeless persons. **CONCLUSIONS:** Homelessness adds substantially to

the cost of health care services for persons with mental illness in VA, and most likely, in other "safety net" systems that serve the poor. These high costs, along with the prospect of declining public funding for health and social welfare programs, and an anticipated increase in the numbers of homeless mentally ill persons, portend a difficult time ahead for both homeless patients and the organizations that care for them.

Salit SA; Kuhn EM; Hartz AJ; Vu JM; Mosso AL. **Hospitalization costs associated with homelessness in New York City.** N Engl J Med, 338(24):1734-40, June 11, 1998. Comment in: N Engl J Med, 338(24):1761-3, June 11, 1998.

BACKGROUND: Homelessness is believed to be a cause of health problems and high medical costs, but data supporting this association have been difficult to obtain. We compared lengths of stay and reasons for hospital admission among homeless and other low-income persons in New York City to estimate the hospitalization costs associated with homelessness. **METHODS:** We obtained hospital-discharge data on 18,864 admissions of homeless adults to New York City's public general hospitals (excluding admissions for childbirth) and 383,986 nonmaternity admissions of other low-income adults to all general hospitals in New York City during 1992 and 1993. The differences in length of stay were adjusted for diagnosis-related group, principal diagnosis, selected coexisting illnesses, and demographic characteristics. **RESULTS:** Of the admissions of homeless people, 51.5% were for treatment of substance abuse or mental illness, as compared with 22.8% for the other low-income patients, and another 19.7% of the admissions of homeless people were for trauma, respiratory disorders, skin disorders, and infectious diseases (excluding AIDS), many of which are potentially preventable medical conditions. For the homeless, 80.6% of the admissions involved either a principal or a secondary diagnosis of substance abuse or mental illness -- roughly twice the rates for the other patients. The homeless patients stayed 4.1 days, or 36%, longer per admission on average than the other patients, even after adjustments were made for differences in the rates of substance abuse and mental illness and other clinical and demographic characteristics. The costs of the additional days per discharge averaged \$4,094 for psychiatric patients, \$3,370 for patients with AIDS, and \$2,414 for all types of patients. **CONCLUSIONS:** Homelessness is associated with substantial excess costs per hospital stay in New York City. Decisions to fund housing and supportive services for the homeless should take into account the potential of these services to reduce the high costs of hospitalization in this population.

Vostanis P; Grattan E; Cumella S. **Mental health problems of homeless children and families: Longitudinal study.** British Medical Journal 316(7135): 899-902, 1998.

This article examines the mental health needs of homeless children and families before and after rehousing using a longitudinal study. A cross sectional, longitudinal study of 58 rehoused families with 103 children and 21 comparison families with 54 children of low socioeconomic status in stable housing was conducted in Birmingham, England. Results indicated that mental health problems remained significantly higher in rehoused mothers and their children than in the comparison group. Homeless mothers continued to have significantly less social support at follow up. Mothers with a history of abuse and poor social integration were more likely to have children with persistent mental health problems. The authors conclude that local strategies for rapid rehousing into permanent accommodation, effective social support and health care for parents and children, and protection from violence and intimidation should be developed and implemented.

Wojtusik L; White MC. **Health status, needs, and health care barriers among the homeless.** Journal of Health Care for the Poor and Underserved 9(2): 140-152, 1998.

Perceived health status, health conditions, and access and barriers to care are important predictors of mortality and the use of services among the homeless. This article assesses these issues by structured interview of 128 homeless adults from San Francisco. Forty-nine percent of these adults rated their health as poor or fair. Men were four times as likely as women to report their health status as excellent or good. Persons of color were more likely to report unmet needs for shelter, regular meals, employment, and job skills and training. The authors state that these findings add information on those homeless people not often included in research and indicate that these marginalized individuals may be in the poorest health.

Wunsch D. **Can managed care work for homeless people? Guidance for state Medicaid programs.** Nashville, TN: National HCH Council, 1998.

As managed care becomes the preferred mechanism for organizing and delivering health care, homeless people are increasingly included among enrollees in state Medicaid managed care programs. As a special needs population, their participation is challenging. This document presents nineteen quality and access issues specific to the special needs of homeless people in a managed care environment. AVAILABLE FROM: National HCH Council, PO Box 68019, Nashville, TN 37206-8019. Phone: (615) 226-2292. Fax: (615) 226-1656. E-mail: hch@nashville.net

1997

Breakey WR. **It's time for the public health community to declare war on homelessness.** American Journal of Public Health 87(2):153-155, 1997.

The author emphasizes that homelessness should be recognized as a major public health concern, that should be responded to with the same urgency as when there is an epidemic of an infectious disease affecting a few hundred people. This editorial recognizes and explains why predictors and causes of homelessness are so complex. Public health officials are urged to use their positions to vigorously address issues surrounding homelessness.

Breakey WR. **Homelessness should be treated as a major health issue.** The Scientist, 11(22): 8-9, November 10, 1997.

The author looks at homelessness as a major health issue, citing the relationship between homelessness and disease and the vulnerability of homeless children who are among the fastest growing segment of the homeless population. Health concerns, as they relate to homelessness, need to be brought into the public health arena to a far greater extent with an emphasis on preventive strategies. Scientists have a responsibility to become effective advocates for public policy issues.

Camacho S; Gorsuch S; Lin A; Shakoor N; Sipe E.. **A look at health care for the homeless and a proposal for enabling services at ACCESS, Inc.** Ohio: Northeastern Ohio Universities College of Medicine, 1997.

This paper gives a brief overview of homelessness, followed by a more focused look at illness and health care, specifically Ohio House Bill #167 which requires some Medicaid recipients to enroll in a Health Maintenance Organization (HMO) by choice or face assignment. The authors report on the frustrating impact of this Act through an investigation of staff and clients of ACCESS, Inc., a homeless shelter for single women and women with children in Akron, Ohio. By knowing the barriers and problems homeless persons face when choosing an HMO and primary care physician (PCP), guidelines can then be set to ease this transition. It is hoped that this groundbreaking work will help all homeless individuals who are faced with the confusion of gaining access into the health care system.

Cousineau MR. **Health status of and access to health services by residents of urban encampments in Los Angeles.** Journal Health Care for the Poor and Underserved 8(1):70-83, 1997.

This paper reports findings from a survey of 134 homeless people living in 42 urban encampments in central Los Angeles. These data, of concern to public health officials, include the physical conditions in the camps, the health status of residents, their use of drugs and alcohol, and their access to and use of health care services such as substance abuse treatment. Many encampment residents report poor health status, over 30% report chronic illnesses, and 40% report a substance abuse problem. Although outreach efforts have had success in bringing HIV and tuberculosis screening services to encampments, residents report significant barriers to using primary health care and drug and alcohol treatment services. Public hospitals and clinics remain the major source of primary medical care for the homeless people living in encampments. Outreach and case management continue to be critical components of improved access to health care for homeless people.

Flynn L. **The health practices of homeless women: a Causal model.** Nursing Research 46(2): 72-77, 1997.

This article describes a study in which a theoretical model was developed and tested to explain the effects of learned helplessness, self-esteem, and depression on the health practices of homeless women. The author collected data from a sample of 122 homeless women recruited from six shelters in New Jersey and Washington, D.C. Results indicated support for the theoretical model by showing that learned helplessness had a direct negative effect on self-esteem and a direct positive effect on depression. In addition, the findings support psychological variables such as learned helplessness and diminished self-esteem as having a negative effect on health practices.

Gallagher TC; Andersen RM; Kogel P; Gelberg L. **Determinants of regular source of care among homeless adults in Los Angeles.** Medical Care, 35(8): 814-830, 1997.

The authors conducted a multiple logistic regression to predict regular source of care among the homeless, using an adaptation of the Behavioral Model of health services utilization as an analytic framework. Results indicated that 57% of the sample reported having a regular source of care. Some factors found to be barriers to having a regular source of care among this population included homelessness-related characteristics such as competing needs, long-term homelessness, and social isolation. The authors conclude that in the context of resources, the distribution of a regular source of care among the homeless appears to be highly inequitable, and that some of the characteristics identifying those with a regular source of care suggest, among other things, a lack of fit between the needs of the homeless and the organization of health services.

Gelberg L. **Homelessness and health.** Journal of the American Board of Family Practice 10(1): 67-71, 1997.

The author addresses the crisis of homelessness in America as it relates to the increased risk for illness among homeless persons. Discussion includes issues of mental health, substance abuse, contagious diseases, obstetric care, dental care and convalescent facilities. Homeless patients who receive care from model programs, such as the Health Care for the Homeless Program, utilize services as least as much as low-income domiciled patients, and the author suggests that increased vigor must be applied to health services research, in the areas of access, cost, organization, and quality, to improved the quality of health care for the homeless population.

Gelberg L; Gallagher TC; Andersen RM; Koegel P. **Competing priorities as a barrier to medical care among homeless adults in Los Angeles.** American Journal of Public Health, 87(2):217-220, 1997.

The authors describe a study where the role of competing priorities as a barrier to the utilization of physical health services was assessed in a subset (n=363) of a probability sample of homeless adults in Los Angeles. Unadjusted odds of four measures of health services utilization were calculated for those with frequent difficulty in meeting their subsistence needs. These odds were then adjusted for a range of characteristics assumed to affect the utilization of health services among the homeless. Before and after adjustment, those with frequent subsistence difficulty were less likely to have regular source of care and more likely to have gone without needed medical care. Subsistence difficulty had no impact on the likelihood of having been hospitalized. Results remained the same after adjustment. The authors conclude frequent subsistence difficulty appears to be an important nonfinancial barrier to the utilization of health services perceived among homeless adults.

Gillis LM; Singer J. **Breaking through the barriers: Healthcare for the homeless.** Journal of Nursing Administration 27(6): 30-34, 1997.

This article provides an overview of the homeless population and outlines four barriers to health care for persons who are homeless: financial, bureaucratic, programmatic, and personal. The authors also highlight the major health care needs of this population. A community-based service delivery system developed by one agency in responding to the needs of homeless persons is discussed as a model of care.

Hatton DC. **Managing health problems among homeless women with children in a transitional shelter.** Image J Nurs Sch, 29(1):33-7, Spring 1997.

PURPOSE: To describe health problems among homeless women with children living in a transitional shelter, analyze how they managed various ailments and when and how they sought care. **DESIGN:** Qualitative using grounded theory and dimensional analysis. **SAMPLE:** During 1992 and 1993, data were gathered from a convenience sample of 13 Latina, 11 white, and 6 African American women (n=30) who lived in a transitional shelter in California. **METHODS:** In-depth, semi-structured interviews. **FINDINGS:** Despite many supportive services, respondents had difficulty managing health problems. Typically, a woman reported she managed a health problem by overcoming it alone. **CONCLUSIONS:** The pattern of overcoming it alone existed years before transitional shelter life, and, in many instances, persisted during shelter years. **CLINICAL IMPLICATIONS:** Clinical nursing interventions that address shame, fear, lack of information, and eligibility for services could improve health outcomes among women and children living in transitional shelters.

HomeBase/The Center for Common Concerns. **Meeting the health care needs of California's homeless population** . San Francisco, CA: HomeBase/The Center for Common Concerns, 1997.

This report explores the health care needs of homeless people and provides a guide to expanding California's health care options for the future. It is intended to bring about discussion and change to the health care system for homeless people. Barriers to health care for homeless people are identified, as are the medical needs of this population and possible steps to overcoming the barriers. A framework of the existing system of health services for homeless people in California is presented, along with information on current and future trends affecting these services. AVAILABLE FROM: HomeBase/The Center for Common Concerns, 870 Market Street, Suite 1228, San Francisco, CA 94102.

Hwang SW; Orav EJ; O'Connell JJ; Lebow JM; Brennan TA. **Causes of death in homeless adults in Boston.** Ann Intern Med, 126(8):625-8, April 15, 1997.

BACKGROUND: Homeless persons have high mortality rates. OBJECTIVE: To ascertain causes of death in a group of homeless persons. DESIGN: Cohort study. PATIENTS: 17,292 adults seen by the Boston Health Care for the Homeless Program from 1988 to 1993. MEASUREMENTS: Cause-specific mortality rates adjusted for race and rate ratios that compare mortality rates in homeless persons with those in the general population of Boston. RESULTS: Homicide was the leading cause of death among men who were 18 to 24 years of age (mortality rate, 242.7 per 100000 person-years; rate ratio, 4.1). The acquired immunodeficiency syndrome was the major cause of death in men (mortality rate, 336.5 per 100000 person-years; rate ratio, 2.0) and women (mortality rate, 116.0 per 100000 person-years; rate ratio, 5.0) who were 25 to 44 years of age. Heart disease and cancer were the leading causes of death in persons who were 45 to 64 years of age. CONCLUSIONS: The most common causes of death among homeless adults who have contact with clinicians vary by age group. Efforts to reduce the rate of death among homeless persons should focus on these causes.

Macnee CL; Forrest LJ. **Factors associated with return visits to a homeless clinic.** Journal of Health Care for the Poor and Underserved 8(4): 437-445, 1997.

This article examines the characteristics of homeless clients and their return visits to a nurse-managed primary health care clinic in northeast Tennessee using a retrospective chart review of 1,467 records from clients seen between 1991 and 1994. Client characteristics examined included age, education, race, gender, sheltered status, report of chronic disease, and report of family living in the area. Only 47% of clients made return visits to the clinic. Those with reported chronic disease, males, whites, and those living on the street were more likely to have returned to the clinic. The authors conclude the results suggest the need for program planning and evaluation for this population, which particularly considers women, nonwhites, and those without chronic disease as target groups for treatment.

Marmot M; Ryff C; Bumpass L; Shipley M; Marks N. **Social inequalities in health: Next questions and converging evidence.** Social Science and Medicine 44(6):901-910, 1997.

Mortality studies show that social inequalities in health include, but not limited to, worse health among the poor. There is a social gradient: mortality rises with decreasing socio-economic status. Three large sample studies, one British and two American, brought together for their complementarity in samples, measures, and

design, all show similar social gradients for adult men and women in physical and mental morbidity and in psychological well-being. These gradients are observed both with educational and occupational status and are not explained by parents' social status or lack of an intact family during childhood. They are also not accounted for by intelligence measured in school. This suggests that indirect selection cannot account for inequalities in health. Possible mediators that link social position to physical and mental health include smoking and features of the psycho-social environment at work and outside.

McMurray-Avila, M. **Organizing health services for homeless people: A practical guide.** Nashville, TN, National HCH Council, 1997.

The purpose of this guidebook is: (1) to provide an easy reference for communities or groups interested in starting health care project to serve people who are homeless, by outlining some basic but necessary steps in the process; (2) to assist current Health Care for the Homeless (HCH) projects that want to improve or expand their services, by offering ideas, resources and contacts; and (3) to describe the rationale for the continuing existence of the HCH program. The book may be read in its entirety or used selectively. Divided into six parts, the book addresses the following topics: (1) overview of homelessness; (2) evolution of the HCH Program; (3) developing a framework; (4) service delivery strategies; (5) organizational tools; (6) maintaining the gains and increasing the impact. AVAILABLE FROM: National HCH Council, PO Box 68019, Nashville, TN 37206-8019. Phone: (615) 226-2292. Fax: (615) 226-1656. COST: \$17.50

National Clearinghouse for Primary Care Information. **BPHC-Funded Primary Care Centers.** McLean, VA: National Clearinghouse for Primary Care Information, 1997.

This eleventh edition of the Directory provides information on six Federal grant programs administered by the Bureau of Primary Health Care (BPHC), U.S. Department of Health and Human Services. These grant programs provide support for primary health services to medically underserved, disadvantaged, high-risk and hard-to-reach populations in the U.S. and its territories. Two of these grant programs include the Health Care for the Homeless Program and the Integrated Primary Care and Substance Abuse Treatment Program. The Directory is divided into three sections: (1) reference indexes provide information on specific grantee organizations; (2) a listing of grantee organizations and the contact and funding information for each; and (3) appendices of grantee support organizations. AVAILABLE FROM: National Clearinghouse for Primary Care Information, 8201 Greensboro Drive, Suite 600, McLean, VA 22102, (703) 821-8955.

National Health Care for the Homeless Council. **Mending the rift: Successes from the first decade of Health Care for the Homeless** Nashville, TN.: National HCH Council, 1997.

This booklet, marking the 10th anniversary of the Stewart B. McKinney Homeless Assistance Act, celebrates the success of Health Care for the Homeless by relating stories collected from projects around the country. The stories reveal the persistence, the creativity and the caring of HCH providers, and the resilient but fragile humanity of homeless persons.

Ober K; Carlson L; Anderson P. **Cardiovascular risk factors in homeless adults.** J Cardiovasc Nurs, 11(4):50-9, July 1997.

Homelessness is a growing problem in the U. S., with population numbers ranging from 300,000 to several million. This article reviews five studies that focused on identification and assessment of cardiovascular risk factors in the homeless population. A case study presents the successful outcome of a homeless male with several risk factors. Assessment and intervention by a nurse practitioner led to his re-entry into the domiciled population. Implications for clinical practice and recommendations

O'Connell J. **Death on the streets.** Harvard Medical Alumni Bulletin, Winter 1997.

The author chronicles some of his experiences inside the clinics and shelters that are part of Boston's Health Care for the Homeless program. The prevalence rate of death among people who have been patients in the Boston Health Care for the Homeless Program is examined and discussed. The author explains that the causes are complex: exposure to extremes of weather and temperature; the spread of communicable diseases, such as tuberculosis and pneumonia, in crowded shelters with inadequate ventilation; neglected chronic illnesses; horrifying violence; the high frequency of co-morbid medical and psychiatric illnesses; substance abuse; and inadequate nutrition. Several stories of patients who display these complexities are described.

O'Connell JJ; Lozier JN; Gingles K. **Increased demand and decreased capacity: Challenges to the McKinney Act's Health Care for the Homeless program.** Nashville, TN: The National Health Care for the Homeless Council, 1997.

This report analyzes Health Care for the Homeless (HCH) program proposals that allowed existing grantees to apply for a 3% increase in grant funding to expand their activities. The report provides a snapshot of homelessness in America in the summer 1997 as seen by experienced, front-line providers of care. This report catalogs grantees proposals and attempts to identify major obstacles and challenges facing HCH grantees.

Plumb JD. **Homelessness: Care, prevention, and public policy.** Ann Intern Med 126(12):973-5, 1997.

Homeless men, women, and children make up a growing population that is vulnerable to preventable disease, progressive morbidity, and premature death. Homelessness and poverty are inextricably linked, and subgroups of persons who live in poverty have a particularly high risk for becoming homeless. Providing effective primary care for homeless persons is a formidable task because of many internal and external barriers to care. Targeted care strategies and new approaches to primary care are required to lower these barriers. Effective disease prevention in the homeless requires effective programs and policies to prevent homelessness. It is imperative that health professionals, the societies to which they belong, and academic health systems reaffirm their social responsibility, commit to changing public policies that perpetuate homelessness, and assist in the development and provision of primary health care services for persons who are homeless or on the brink of homelessness.

White MC; Tulsy JP; Dawson C; Zolopa AR; Moss AR. **Association between time homeless and perceived health status among the homeless in San Francisco.** J Community Health, 22(4):271-82, 1997.

The purpose of this study was to describe the perceived health of the homeless, and to measure the effect of time homeless on perceived health status, after controlling for sociodemographic characteristics and health conditions. The design was cross-sectional; the population was a representative sample of homeless in San Francisco, interviewed on health issues. Analysis of predictors of poor or fair health status was by logistic regression. In this sample of 2780 persons, 37.4% reported that their health status was poor or fair as compared to good or excellent. Reporting poor or fair health status was significantly associated with time homeless, after controlling for sociodemographic variables and health problems including results from screening for HIV and TB. Comparisons with data from the National Health Interview Survey (NHIS) showed poorer health status among the homeless persons in this study. Standardized morbidity ratios were highest for asthma; there was twice the number of homeless persons reporting asthma, in younger as well as older adults, as would be expected using NHIS rates. There was also an excess of arthritis, high blood pressure and diabetes in those age 18-44 as compared to adults in the Health Interview Survey. The time spent homeless remains associated with self-reported health status, after known contributors to poor health are controlled. Persons who have been homeless for longer periods of time may be the persons to whom health care interventions should be aimed.

1996

Committee on Community Health Services. **Health needs of homeless children and families.** Pediatrics 98(4): 789-791, 1996.

This article attempts to substantiate the existence of homelessness in virtually every community, illustrate the pervasive health and psychosocial problems facing the growing population of children who are homeless, and encourage practitioners to include homeless children in their health care delivery practices, social services, and advocacy efforts. The recommendations will guide practitioners in taking actions to diminish the severe negative impact that living in temporary shelters has on the health and well-being of developing children. In this statement the American Academy of Pediatrics reaffirms its stance that homeless children need permanent dwellings in order to thrive.

El-Kabir D; Ramsden S. **Primary health care of the single homeless.** In Bhugra D (ed.), *Homelessness and Mental Health*. New York, NY: Cambridge University Press, 170-183, 1996.

This chapter examines the health care of the 'single' homeless with a number of needs and in a number of housing situations. The authors begin by defining what they identify as 'single' homeless and present a profile of their demographics, and physical and psychiatric morbidity. The chapter presents various aspects of treatment and provides examples of types of health care provision for this population. The authors also examine why some programs fail to reach their desired scope or sustain themselves. The chapter concludes with a recommendation for further integration of services.

Foti SK. **A clinic that heals the homeless.** Hospitals & Health Networks, p.84: March 20, 1996.

The author describes the Health Care Center for the Homeless in Winter Park, Fl. Patients ailments range from cancer to rashes and foot sores. Much of the financing comes from the Robert Wood Johnson Foundation, local hospitals and private benefactors. Doctors, nurses, and dentists donate their time and a mobile medical van provides outreach.

Gelberg L; Doblin BH; Leake BD. **Ambulatory health services provided to low-income and homeless adult patients in a major community health center.** J Gen Intern Med 11:156-62, March 1996.

OBJECTIVE. The homeless are more likely than other poor and vulnerable populations to manifest serious health problems. Early research focused on needs assessments of this population; current work has shifted to examine issues of access, use of health services, and barriers to care. However, current research has not examined whether model clinics designed for the homeless have created parity with their low-income domiciled peers in terms of provision of ambulatory services. Such data are increasingly in demand as managed care looms just over the political horizon as a means of providing services to low-income patients. **SETTING.** A major community ambulatory health center in West Los Angeles. **PATIENTS.** Homeless (n=210) and low-income domiciled (n=250) patients. **DESIGN.** A medical record review of care provided over a one-year period to homeless and low-income domiciled adult patients in a major community ambulatory health center in West Los Angeles was conducted. Data were collected on length of visits, laboratory tests, procedures, and services, immunizations, specialty clinic referrals, medications, and travel vouchers. **RESULTS.** On average, homeless patients were provided with as many outside laboratory tests per patient as low-income domiciled patients (1.1 vs. 1.3). Further, they returned for more visits (3.4 vs. 2.9), were more likely to have had longer visits (88% vs. 61%), and were provided with more laboratory tests (2.3 vs. 1.7), procedures and services (3.1 vs. 1.1), referrals (1.3 vs. 0.7), medications (4.4 vs. 3.3), and travel vouchers (0.6 vs. 0.2). Many of the procedures and services received by the homeless were for nonmedical assistance. Preventive health services such as tuberculosis skin tests, sexually transmitted disease (STD) screening, and Pap tests were provided to both homeless and domiciled patients at low rates. **CONCLUSIONS.** Findings from this study on the provision of care in a major West Los Angeles community health center indicate that homeless patients receiving care from a model program designed to address their special needs will return for follow-up visits and will utilize services at least as much as low-income domiciled patients.

Health Resources and Services Administration, Bureau of Primary Health Care. **Models that work: Compendium of innovative primary health care programs for underserved and vulnerable populations.** Bethesda, MD: Bureau of Primary Health Care, 1996.

This compendium is intended to serve as a resource for ideas, lessons learned, unique approaches, and contacts to help improve the health care delivery system for underserved and vulnerable populations. The programs profiled represent creative community-driven solutions to significant health challenges, developed by building partnerships and identifying resources in the community. The "Models That Work" Campaign has five components: (1) identifying models; (2) sharing information; (3) promoting replication; (4) building partnerships; and (5) improving outcomes. **AVAILABLE FROM:** NCPCI, 2070 Chain Bridge Road, Suite 450, Vienna, VA 22182. Phone: (800) 400-BPHC. Fax: (703) 821-2098.

Kleinman LC; Freeman H; Perlman J; Gelberg L. **Homing in on the homeless: Assessing the physical health of homeless adults in Los Angeles County using an original method to obtain physical examination data in a survey.** Health Serv Res 31:533-49, December 1996.

OBJECTIVE: Public policy that decreases the funding for social services may combine with the ascendancy of corporate managed care to increase the health care deficit. Assessing the health impact of these policy changes on various populations is a fundamental challenge for health services research. Disadvantaged populations, such as the homeless, are likely to be affected disproportionately. Research quality data on the physical health of such populations are difficult and expensive to obtain. In particular, physical examination data have not been available and self-reports are insufficient. Our objective: to develop and utilize a structured physical exam system enabling lay survey researchers to report reliably physical findings related to six tracer conditions in a disadvantaged population. **STUDY SETTING:** A field survey of homeless adults in Los Angeles County, Ca. Respondents were 363 homeless adults representing a subsample of a probability sample of the county's homeless adult population. **STUDY DESIGN:** We integrated existing measures with expert clinical opinion and original means of data collection into a structured physical exam enabling lay interviewers to identify the prevalence of vision problems, significant skin disorders, peripheral vascular disease of the lower extremities, selected podiatric disorders, hypertension, and tuberculosis in a sample of homeless adults. **PRINCIPAL MEASURES:** We describe lay interviewer performance in terms of mastery of the necessary material based on written and practical exams and in terms of the number of respondents successfully followed. We base our description of the instrument on the time necessary to complete it, and on the proportion of each component successfully completed during the field survey, as well as on interrater reliability. We report the prevalence of the various clinical conditions according to self-report and according to the structured limited physical exam, as well as the marginal proportion of respondents who were identified by the physical exam and not by self-report. **PRINCIPAL FINDINGS:** Interviewers performed the exam successfully under field conditions. Respondent acceptance of the instrument was high. Interrater agreement was 100% regarding the need for referral on the basis of blood pressure and vision. Kappa statistics for skin, foot, and edema findings were .67, .71, and .81, respectively. Adjusted for sampling weights, 60% of this population required referral for at least one of the specified conditions. For those portions of the survey for which both self-report and physical exam data were available, lay interviewers made significant percentages of referrals on the basis of physical findings alone. **CONCLUSIONS:** High blood pressure, poor vision, peripheral vascular diseases of the feet and legs, and significant skin conditions are prevalent among the homeless in Los Angeles County. Without physical exam data, estimates of the prevalence of these conditions will be incorrect. Researchers can use laypersons to collect reliable and valid physical exam data on disadvantaged populations. This represents a new tool for assessing and monitoring the health of these populations.

Lough M; Schank M. **Health and social support among older women in congregate housing.** Public Health Nursing 13(6): 434-441, 1996.

This study of community-dwelling elderly found that perceptions of positive health status and adequate social support do not decline with age, even among the old. The relationship between health status and social support reflects the reciprocal nature of person and environment found in the ecologic model.

Office of Inspector General, Dept. of Health and Human Services. **Access to community health centers by homeless persons.** Office of Inspector General, Department of Health and Human Services, 1996.

This study determined the extent that federally-funded community health centers serve homeless people and how services can be improved. Seventy-two urban homeless shelters were randomly selected. Findings show that two thirds of the community health centers provide outreach services for homeless people. Outreach includes sending staff to homeless shelters, and/or contacting homeless shelters to provide information on services available. AVAILABLE FROM: Kansas City Regional Office, (816) 426-3697.

1995

Collins A. **The Hahnemann Homeless Clinics Project: Taking health care to the streets and shelters.** Journal of the American Medical Association 273(5): 433, 1995.

This article describes the Homeless Clinics Project (HCP) of the Hahnemann University School of Medicine. First organized by medical students in Philadelphia in 1989, the HCP has grown into one of the largest free clinics in the nation run by medical students. Three basic tenets guide all administrative decisions: (1) to provide direct health care to homeless persons in need and to help them gain access to the health care system with patient education and direct assistance; (2) to provide a primary care experience for first- and second-year medical students and allied health students; and (3) to sensitize future health care providers to the needs and social problems of individuals not likely to be served adequately in conventional medical settings.

Cousineau MR; Wittenberg E; Pollatsek J. **A study of the Health Care for the Homeless Program. Final Report & Executive Summary.** Rockville, MD: U.S. Department of Health and Human Services, Health Resources and Services Administration, 1995.

This report was designed to combine qualitative and quantitative approaches to assess structure, process and outcome indicators of access, quality, satisfaction with care, health status, and costs. Chapter I attempts to capture the distinctive characteristics of the Health Care for the Homeless (HCH) program that makes it unique among health care delivery systems. Chapter II describes the study's research design and questions. A literature review is presented in Chapter III. In Chapter IV through IX, the study's findings are presented in the context of the research questions. The final chapter provides conclusions and recommendations. ALSO: Executive Summary, 33 pages. AVAILABLE FROM: National Clearinghouse for Primary Care Information, 2070 Chain Bridge Road, Suite 450, Vienna, VA 22182, (800) 400-2742.

Jezewski MA. **Staying connected: The core of facilitating health care for homeless persons.** Public Health Nursing 12(3): 203-210, 1995.

A grounded theory study explored the ways nurses and others in nurse-managed shelter clinics facilitate health care for homeless persons. Analysis of in-depth interview and participant observation data yielded a core category, "staying connected," that represents the essence of what the staff do to facilitate care for homeless persons. The three most important aspects of "staying connected" are the links that nurses establish with the homeless patient, networks with other providers, and facilitation of the homeless person's

connections with the health care system. The article describes of "staying connected" demonstrate the barriers to facilitating health care and breakdowns that occur while trying to facilitate care. Barriers include lack of health insurance, insensitivity of health care providers, stigmatization, cultural barriers, and communication breakdowns. Nurses can have a powerful influence, both macro- and micro-socially, in facilitation of care for these people.

National Health Care for the Homeless Council. **A bitter pill: Welfare reform and the health of homeless people.** Nashville, TN: National Health Care for the Homeless Council, July, 1995.

The authors discuss the functions of welfare and of welfare "reform." The public welfare programs which impact upon the health of homeless persons are described, and the changes in these programs that would result from likely Congressional action are analyzed. The authors also provide suggestions for effective advocacy at the federal and state levels, which will assume increasing importance in the future given the likelihood of block grants and the trend toward giving more authority to the states. AVAILABLE FROM: National Health Care for the Homeless Council, P.O. Box 68019, Nashville, TN 37206-8019, (615) 226-2292.

Padgett DK; Struening EL; Andrews H; Pittman J. **Predictors of emergency room use by homeless adults in New York City: The influence of predisposing, enabling and need factors.** Social Science and Medicine 41(4):547-556, 1995.

This study examined predictors of emergency room use among homeless adults by employing data from a 1987 shelter survey of 1260 homeless adults in the New York City shelter system. Findings indicate that health symptoms and injuries were strong predictors of emergency room use for men and women, but other significant predictors differed markedly by gender. A high prevalence of victimization and injuries underlies emergency room use among homeless men and women. Based on the findings, the authors suggest expanding health and victim services as well as developing preventive measures.

Shiner M. **Adding insult to injury: Homelessness and health service use.** Sociology of Health & Illness 17(4):525-549, 1995.

This article describes a qualitative study that considers why homeless people make little use of the primary health care services provided by the National Health Service. Current approaches to this question have tended to develop in a sociological vacuum, unaffected by relevant developments in medical sociology and broader social theory. An approach informed by Alfred Schutz's phenomenology has been used in this article to develop a more theoretical account of homeless people's use of health services than has hitherto been offered. Running throughout this article is the claim that, amongst "rough sleepers," there is a distinct culture that makes use of mainstream health services unlikely. Sleeping rough, it is argued transforms the way mainstream health services are seen and renders inappropriate the rules of thumb that govern health and illness behavior in wider society.

Wagner JD; Menke EM; Ciccone JK. **What is known about the health of rural homeless families?** Public Health Nursing 12(6):400-408, 1995.

The authors explain that families represent the fastest-growing subgroup of the homeless population. Most of the research has focused on urban homeless families and not on rural homeless families. This article describes

a study in which the characteristics and health of rural homeless families in Ohio was examined. The majority of mothers perceived themselves and their children as having no physical health problems. Results show that 52% of the children under six years of age had Denver Developmental Screening Test (DDST) scores that indicated they might have developmental lags and 15 of the children over four years of age had scores that indicated they might have behavioral problems. The reported use of illegal drugs, alcohol, and cigarettes was high for this group of mothers. Strategies are included that nurses can use in working with rural homeless families.

1994

Burg MA. **Health problems of sheltered homeless women and their dependent children.** *Health and Social Work* 19(2):125-131, 1994.

This article introduces an analytic framework that classifies the types of health problems that emerge among homeless women and their dependent children residing in the shelter system. The framework covers three categories of health problems: illnesses coincident with homelessness; those exacerbated by limited health care access; and those associated with the psychosocial burdens of homelessness. The author also discusses the failures of the current structure of health care reimbursement and the deficiencies of service delivery to homeless families. The author contends that the analytic framework conceptualizes the interrelationship between health and poverty and can be used as an instrument for informed social work intervention, advocacy, training, and research activities.

Harris SN; Mowbray CT; Solarz A. **Physical health, mental health, and substance abuse problems of shelter users.** *Health and Social Work* 19(1):37-45, 1994.

This article summarizes the findings concerning physical health, mental health, and substance abuse problems among users of four of Detroit's largest homeless shelters. Shelter users with mental illness or substance abuse problems were compared to those without mental illness or substance use disorders. Alcohol abusers were significantly more likely to have low blood pressure, symptoms of liver disease, and a tuberculosis treatment history. No health differences were found for those with or without a history of psychiatric hospitalization. Contrary to expectations, few gender differences were found. The authors contend that, aside from the obvious need for low-income housing, comprehensive and integrated treatment approaches from health care, mental health, and substance abuse agencies are needed to help homeless individuals.

Piliavin I; Westerfelt A; Wong YI; Afflerback A. **Health status and health-care utilization among the homeless.** *Social Services Review* 68(2):237-253, 1994.

This article examines the degree to which correlates of health status among samples in prior studies can be generalized to other study samples of homeless individuals. It also examines health care use among homeless individuals in order to determine whether health services are used by all homeless people who report less than good health and, if not, the characteristics of those who fail to obtain these services. Findings indicate that those homeless individuals most likely to report less than good health include: women; older people; individuals who are divorced, separated or widowed; those experiencing symptoms of severe alcoholism; individuals with prior psychiatric hospitalizations; and those experiencing longer spells of homelessness.

Usatine RP; Gelberg L; Smith MH; Lesser J. **Health care for the homeless: A family medicine perspective.** American Family Physician 49(1): 139-146, 1994.

Many factors contribute to the health problems of homeless persons, including exposure to adverse weather, trauma and crime, overcrowding in shelters, unusual sleeping accommodations, poor hygiene and nutritional status, alcoholism, drug abuse, and psychiatric illness. In this article, the authors consider the factors that decrease a person's ability to resist illness or the complications of disease and the main health consequences of these factors. The authors state that family physicians are uniquely suited to providing kind, compassionate, complete, and effective care to these persons and their families.

Winkleby MA; Boyce T. **Health-related risk factors of homeless families and single adults.** Journal of Community Health 19(1):7-23, 1994.

This article examines how homeless adults living with children differ in sociodemographic characteristics, adverse childhood experiences and addictive and psychiatric disorders from homeless adults not living with children. Data were analyzed from two surveys of family and single adult shelters in Santa Clara County, Calif. Findings indicate that adults with children, particularly women, were significantly younger, less educated, less likely to have experienced full-time employment, and more likely to have been supported by public assistance before becoming homeless than adults without children. Adults with children were also significantly less likely to enter homelessness with histories of excessive alcohol consumption. Women with children were less likely to have histories of psychiatric hospitalizations than adults without children. Homeless women with children are most likely to benefit from case management and educational/occupational interventions.

1993

Cousineau MR. **Health care and homelessness: The policy context.** San Jose, CA: National Health Care for the Homeless Council, 1993.

Over 200 providers of health services for homeless people gathered in San Jose, California in the spring of 1993 for a symposium on homelessness and health care. The symposium immediately followed the Fourth National Health Care for the Homeless Conference and allowed front line providers an opportunity to explore key policy issues affecting their work. This report summarizes the proceedings of the symposium. The discussions and presentations reviewed in this report occurred during an opening plenary session which focused on National health care reform, and during focus group sessions that explored a variety of health care-related topics. AVAILABLE FROM: National Health Care for the Homeless Council, P.O. Box 68019, Nashville, TN 37206-8019, (615) 386-0302. COST: \$5.00.

Davis LA; Winkleby MA. **Sociodemographic and health-related factors among African-American, Caucasian and Hispanic homeless men: A comparative study.** Journal of Social Distress and the Homeless 2(2):83-101, 1993.

The authors stratified data from a 1989-1990 cross-sectional survey of homeless adults in Santa Clara County, Calif., by ethnicity to examine if adverse childhood events and adult medical disorders preceding homelessness differed in African-American, Caucasian, foreign-born Hispanic and native-born Hispanic men.

Foreign-born Hispanics were the most likely to have low levels of education and job skills. Native-born Hispanics were most likely among the three ethnic groups to suffer from alcohol abuse. The lower prevalence of adverse childhood events, addictive disorders and psychiatric hospitalizations among homeless African-Americans suggests that factors such as childhood poverty may play a disproportionate role in homelessness among this ethnic minority group.

Ineichen B. **Homes and health: How housing and health interact.** New York, NY: Chapman and Hall, 1993.

This book examines the relationship between where people live and their health. The author reviews how housing in British cities has influenced the health of its citizens throughout the past 150 years. The author also discusses in detail current issues concerning housing and health, and describes attempts at housing particular groups in England whose health is at risk. The author contends that understanding the relationship between housing and health is essential for those involved in the design and management of housing, or its public health aspects. AVAILABLE FROM: International Thompson Publishing, One Penn Plaza, 41st Floor, New York, NY 10119, (800) 842-3636. COST: \$38.95.

Institute on Health Care for the Poor and Underserved. **Factbook on health care for the poor and underserved.** Nashville, TN: Meharry Medical College, 1993.

This factbook is a compilation of materials originally published in *The Journal of Health Care for the Poor and Underserved*, covering 99 articles and spanning four years. It provides new comparisons and fresh insights, salient quotations - opinions, declarations, and musings - from authors and conference participants, and capsule summaries of research findings.

Savarese M; Weber CM. **Case management for persons who are homeless.** J Case Manag 2:3-8, Spring 1993.

Comprehensive, client-centered continuous care with a multidisciplinary team using the case management model has proven to be essential in providing health care services to the homeless. Despite their heterogeneity, homeless persons share the common experiences of being poor, isolated, and in crisis. The process of case management is inherently therapeutic for its recipients and providers. It has the potential to be a source of human support for those who have none. Case management models can be effective systems for providing health care to these persons while addressing their special needs and characteristics.

Susser E; Moore R; Link B. **Risk factors for homelessness.** American Journal of Epidemiology 115(2):546-556, 1993.

This article reviews findings concerning risk factors for homelessness among adults over the past decade. Risk factors the authors identify include demographic characteristics, health disorders, and childhood experiences. The data used are drawn from studies published in professional journals since 1980. The authors also propose a conceptual framework and study design to investigate the causal pathways linking these risk factors to homelessness. The authors assert that study design should take into account the role that broad societal processes play in causing homelessness.

Winkleby MA; Fleshin D. **Physical, addictive, and psychiatric disorders among homeless veterans and nonveterans.** Public Health Reports 108(1)30-36, 1993.

This study examines the proportion of veterans among homeless adults in three shelters in Santa Clara County, Calif., and whether adverse childhood events, histories of mental, physical and addictive disorders differ among nonveterans, combat-exposed veterans and noncombat-exposed veterans. Findings indicate that 42% of those surveyed were veterans and that both groups of veterans were significantly more likely to report excessive alcohol consumption prior to becoming homeless. In addition, the length of time between military discharge and initial loss of shelter was more than a decade for 76% of the combat-exposed veterans. The authors contend that further research is needed to determine whether or not military service increases the risk of homelessness.

Undated

Bureau of Primary Health Care. **The Children's Health Insurance Program and homeless children: Considerations for the states (draft).** Bethesda, MD: Health Care for the Homeless Program, DSP, BPHC, HRSA, DHHS.

This discussion paper looks at the Children's Health Insurance Program (CHIP) which offers opportunities for States to extend health insurance coverage to homeless children, and to improve homeless children's access to health care services. States may use up to 10% of their CHIP funds to expand existing community-based health delivery systems and develop outreach activities to link the most difficult-to-reach children with needed care. This way, states can reduce barriers to care and enhance those existing systems of care that are most appropriate for homeless children. AVAILABLE FROM: Health Care for the Homeless Program. Phone: (301) 594-4430.

Clark M; Rafferty M. **The sickness that won't heal -- health care for the nation's homeless.** Health Policy Advisory Center Bulletin 16(4):20-28, undated.

The article summarizes health data on homeless persons and the high incidence of mental and physical health problems. The authors discuss this population's extensive use of public hospital emergency rooms for health care and the difficulties in developing comprehensive, coordinated systems of care. A number of successful programs such as the Henry Street Settlement House and the St. Frances' Residence in New York City are discussed.

McIntosh, B, Richardson, K. **Comprehensive pharmacy services booklet series.** Tysons Corner, VA: Association of Clinicians for the Underserved, undated.

This series of 9 of booklets, from the American Pharmacists Association, discusses topics relevant to providing health care to people experiencing homelessness. Volume 1 discusses affordable access, efficient pharmacy management and improving patient outcomes through pharmaceutical care. Volume 2 explains the Public Health Service Section 340B Drug Pricing program. Volume 3 examines in-house and contract pharmacy alternatives, physician dispensing alternatives, and the no-pharmacy alternative. Volume 4 focuses on pharmaceutical assistance programs. Volume 5 describes pharmacy management in the Community Health Center. Volume 6 discusses clinical pharmacy services, such as collaborative drug therapy, disease

management clinics, drug formulary management and drug utilization evaluations. Volume 7 examines the role of a pharmacist on the primary care team, as well as in an intervention. Volume 8 looks at the guidelines and functions of contracted pharmacy services. Volume 9 focuses on how pharmacists can follow federal guidelines when conducting health outcomes evaluations (authors). Available From: HRSA Pharmaceutical Services and Support Center, American Pharmacists Association, 2215 Constitution Avenue NW, Washington, DC 20037, <http://pssc.aphanet.org>. (COST: \$36.00).