The Homeless Child Health Care Inventory: Assessing the Efficacy of Linkages to Primary Care

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Abstract. *Each year, the New York City homeless family shelter system provides transitional housing for nearly 20,000 homeless children. While the health care needs of these children are substantial, there is currently no system-wide mechanism for ensuring that they have access to appropriate medical care. This report analyzes information from the Homeless Child Health Care Inventory, a survey conducted by Montefiore Medical Center's Division of Community Pediatrics, to examine the adequacy of health care resources available to the homeless children in New York City. Results showed that available health care resources varied considerably throughout the shelter system and that nearly 50% of homeless children in New York City did not have access to appropriate medical care.*

Homelessness, which first gained national attention in the mid-1980s, continues to be a growing problem. It is estimated that more than 2 million of America's poor become homeless for some period of time in the course of a single year.[1] Current research suggests that homeless families with children represent the fastest-growing segment of the homeless population.[2] Concerns about the health status of homeless children in New York City and the lack of available information regarding existing health care services led to the development of the Homeless Child Health Care Inventory (HCHI). Information from the HCHI reflects the adequacy of health care resources available to the nearly 20,000 children who spend some time in the New York City homeless shelter system each year.

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The health problems associated with homelessness are considerable and, in the case of homeless children, may threaten their future development and function. Children in homeless families suffer from acute and chronic medical problems beyond those experienced by housed children of similar economic status.[3] Homeless children experience higher rates of delayed immunizations, upper respiratory infections, gastrointestinal disorders, and ear infections.[2,3] In addition, nutritional deficiencies and developmental delays are diagnosed with increasing frequency.[4,5]

Transience, poverty, and other social problems complicate homeless families' ability to access appropriate health care for their children. Frequently, homeless families are placed in shelters far from their original neighborhoods, in unfamiliar areas that lack adequate health and supportive services. Immunizations and health maintenance examinations can rarely compete for attention against more immediate and compelling needs as families struggle to cope with the instability and day-to-day stress of being homeless. Often chronic conditions such as anemia, asthma, and recurrent otitis media go untreated or undertreated.[6] Although improvements have been made in the general quality of shelter conditions for homeless families in New York City, little attention has been paid to ensuring adequate access to primary health care for homeless children.

Background—Homelessness in New York City

Nowhere has the impact of homelessness been so evident as in the nation's major urban centers. In New York City, the problem has reached crisis proportions. During the past 5 years, 239,425 people, or 3.3% of the city's population, spent some time in emergency shelters. In 1992 alone, 86,000 different individuals passed through the city's shelter system.[1] In keeping with the national trend, homeless families with children comprise an ever-increasing proportion of the homeless population in New York City. While the number of homeless single adults decreased between 1988 and 1992, the incidence of family homelessness in-

creased by 32%.[1] Each year more than 11,000 families with nearly 20,000 children seek assistance from the city's emergency housing system and remain in the system, on average, for 7 months.[7] Minority children are overrepresented within this population, with 1 in 12 African-American children having spent time in a city shelter at some point over the past 5 years.[1]

In response to the steady demand for shelter, the city of New York has developed an expansive emergency housing system for homeless families. What began as a crisis-driven system with thousands of families living in squalid, often dangerous congregate shelters and large "welfare" hotels, has been transformed in recent years. Congregate shelters and welfare hotels have largely been replaced by dozens of program-intensive, apartment-style transitional housing facilities.

Between 1988 and 1992, more than 60 of these so-called "Tier II" shelters were developed, supplying an additional 2,800 units of transitional housing for homeless families in New York City. Beyond providing homeless families with a "roof over their heads," these program-intensive shelters offer an array of supportive and/or rehabilitative services. While a handful of these Tier II shelters are operated directly by the Department of Homeless Services (DHS), the city agency responsible for homeless services, the majority (90%) are managed by private not-for-profit groups. In either case, families are referred to Tier II shelters by DHS, and funding is provided through the city's homeless families program budget.

Despite the extensive Tier II development that has taken place over the past few years, the number of families seeking shelter in New York City has surpassed the supply of available Tier II units. As of October 1992, there were approximately 5,500 homeless families with 9,500 children living in the city's emergency housing system, of which 70% lived in Tier II units.[7] The balance of the city's homeless families are housed in privately owned commercial hotels, most of which are located in isolated areas of the outer boroughs, and in transitional housing facilities operated under the direction of the city's housing agency.

Even though the homeless family shelter system has changed from one consisting primarily of welfare hotels and congregate shelters to one dominated by program-intensive transitional (Tier II) shelters, there has been no mechanism for ensuring that the health needs of homeless children are adequately addressed. Virtually all homeless families in New York City are eligible for Medicaid, but given the barriers to care associated with poverty and homelessness and the dearth of primary care resources available in the majority of areas where homeless facilities are located, such coverage in no way ensures access to appropriate health care.

While a number of on- and off-site health care providers serve the various shelters and hotels throughout the city, health care resources reflect only whatever arrangements the operator of each facility has been able to establish. Health care programs operate independently of each other and are responsible for identifying their own funding sources. Each program determines which homeless facilities it will serve and what services it will provide. Before completion of the HCHI, there was no current, centralized information about the health care resources available to homeless children.

Methods

Background information was obtained on all of the nearly 90 facilities utilized by the city to provide emergency shelter for families which, at the time of the HCHI (July 1992), housed nearly 9,200 homeless children.[7] This information included the location of each facility and the number and age of homeless children housed in each. The field research team also looked at the average length of time families remained in the shelter system and the regulations governing health care access for homeless families.

Questionnaires were developed to provide information used to assess the efficacy of health care resources available to the homeless children living in each facility. Generally, the survey questions concerned the available health care resources (both on- and off-site) and the mechanism for advising families of available health

services. Data were gathered via on-site interviews with shelter/hotel personnel and homeless families. In addition, interviews with identified off-site health care providers were conducted to determine if they perceived there to be an effective referral/linkage system. Interviewers would respond affirmatively to the question of linkage if the following conditions were met: (1) shelter staff identified an appropriate, accessible medical facility; (2) the medical facility was known to the families; and (3) the relationship was confirmed by staff of the medical facility.

Questionnaires were completed by second- and third-year medical students, who visited each homeless facility included in the survey and conducted face-to-face interviews with shelter/hotel staff, on-site health care providers, and homeless families. Information concerning off-site health care providers was obtained through telephone interviews.

Definitions

Following are the relevant definitions for the purposes of data analysis:

Homeless child: An individual less than 21 years of age living in the New York City homeless family shelter system.

Homeless family: Households residing in the New York City homeless family shelter system.

Homeless facility: A shelter or hotel utilized by the city of New York to house homeless families.

Capacity: The maximum number of families that a particular homeless shelter or hotel can house on a given night.

Size: Refers to the capacity of a homeless facility.

On-site nursing: Refers to nursing services that are available to homeless children on-site at various homeless facilities in New York City.

On-site services: Refers to medical services available to homeless children on-site at various homeless facilities in New York City that include physician and/or midlevel practitioner presence.

Medical presence: Refers to the presence of on-site nursing and/or on-site medical services at homeless facilities in New York City.

Primary care linkage: Refers to homeless facilities that have an effective linkage with an off-site medical provider capable of meeting the health care needs of families while they are homeless.

Tier II: An apartment-style transitional shelter for homeless families operated under the jurisdiction of New York City's Department of Homeless Services that is required to offer a range of social and supportive services.

Family Center: A transitional housing facility operated under the supervision of the New York City Department of Housing Preservation and Development that is not required to offer social and supportive services.

Hotel: A private, commercial hotel that houses homeless families referred by the city and is not required to provide social and supportive services.

Results

The HCHI was conducted between July and October of 1992. The 79 shelters and welfare hotels included in the inventory housed approximately 94% of the homeless families in New York City at that time. These facilities provide shelter and services to approximately 4,691 families, which have 8,634 children, each night. As shown in Figure 1, the majority (53%) of homeless children at the time of the HCHI were under 5 years of age; a significant proportion (25%) were younger than 2.

Variation in On-Site Health Resources

On-site health resources available at homeless facilities throughout the city varied significantly in terms of who provided the services, how the services were funded, and how frequently the services were offered. As defined above, on-site health resources were divided into two general categories: (1) on-site nursing services and (2) on-site medical services, which include some physi-

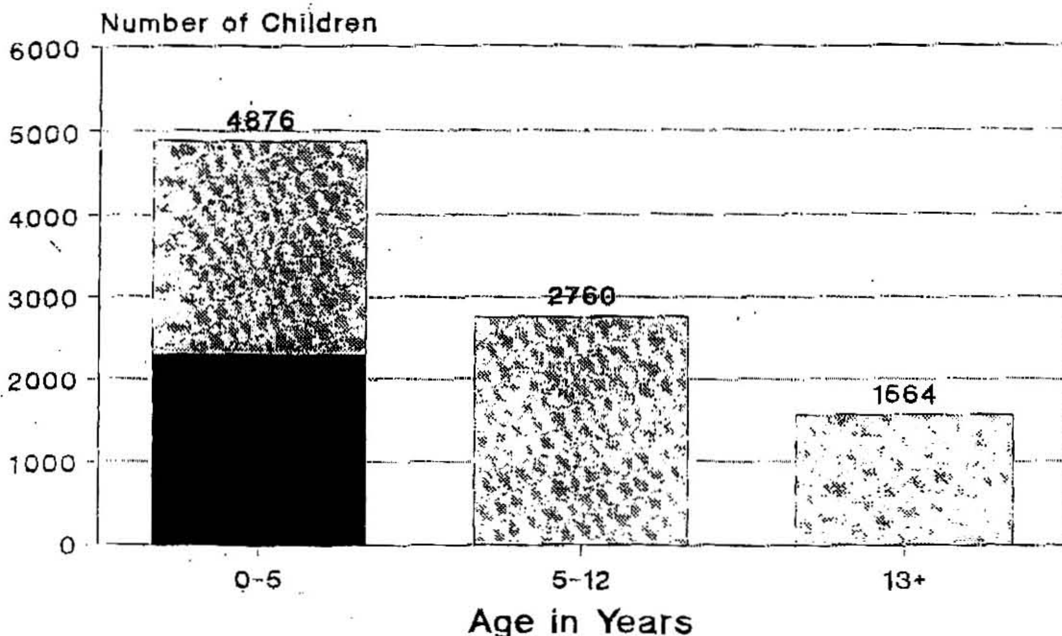

FIG. 1. Age distribution of homeless children in New York City. The data are taken from census information provided by the New York City Department of Homeless Services, showing the number and age of children residing in the New York City Shelter System on June 6, 1992. ■, children less than 2 years of age.

cian and/or midlevel practitioner presence. The survey revealed that more than 20 independent health care programs provided on-site health resources at 45 (57%) of the facilities surveyed. As shown in Figure 2, the on-site health resources varied significantly, in direct relation to capacity. Nearly all children (97.2%) living in facilities with the capacity to house more than 80 families had access to some type of on-site health resources, while children in smaller facilities generally lacked such access. Only 10.1% of children living in facilities with a capacity of fewer than 26 families had access to any type of one-site health resources.

Lack of Effective Linkages for Primary Care

Despite the fact that shelter staff at virtually all of the facilities included in the survey identified medical facilities with which they had established relationships, the data showed that more than half of these linkages were ineffective. In many instances, there may have been a relationship "on paper," i.e., there was a written agreement stating that a medical facility would accept referrals

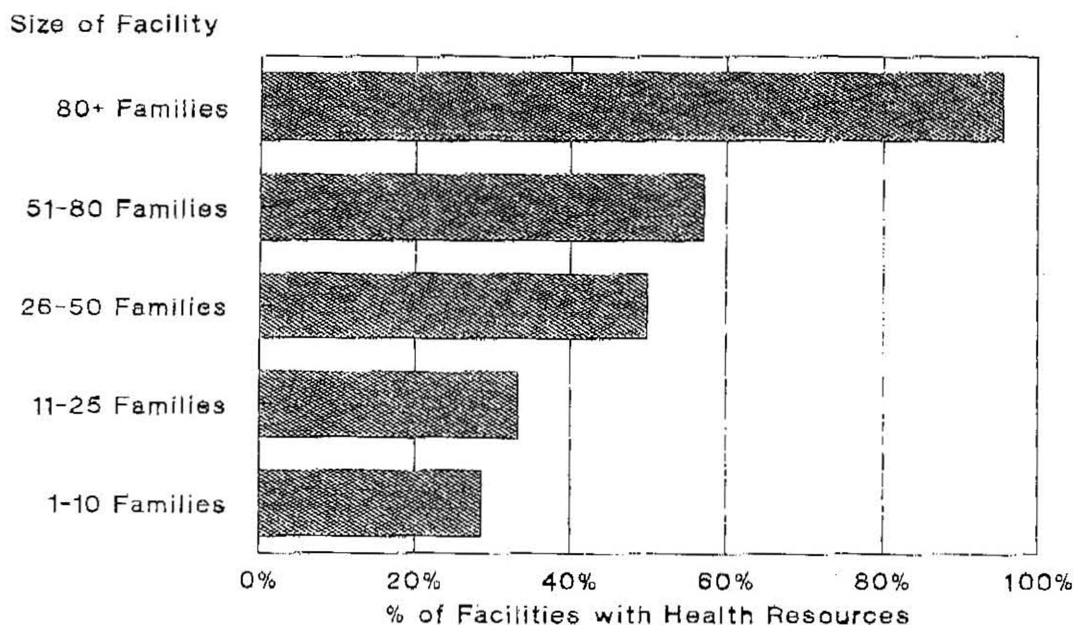

FIG. 2. Relationship between size of facility and availability of on-site health resources. On-site health resources include regularly scheduled part-time or full-time on-site nursing and/or on-site medical services, which include physician and/or midlevel practitioner presence. Facility size refers to the number of families that a facility provides shelter to on a given night.

from a particular shelter or hotel, but the linkage was never firmly established. It is noteworthy that 44 of the 79 facilities (56%) included in the HCHI did not have an effective linkage with a medical facility where parents could access health care for their children while they were homeless. These facilities house approximately 2,174 families with 4,214 children at a given point in time, or 49% of all homeless children residing at facilities included in the HCHI.

Children Living in Facilities With No On-Site Medical Presence Were Less Likely to Have Access to Comprehensive Medical Care

The majority of facilities that had functional linkages with off-site medical providers also had some type of on-site medical presence. The likelihood that facilities without an on-site medical presence effectively fostered access to health care was extremely low. Only 7 of the 34 facilities (21%) with no on-site medical services were found to have a functional linkage with a health care

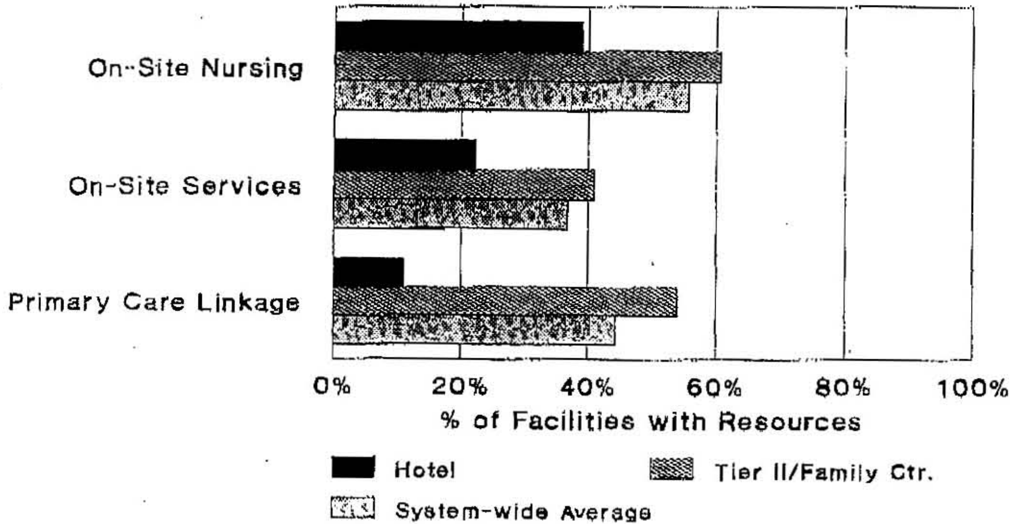

FIG. 3. Health resources available at homeless facilities. Health resources include on-site health resources (see Fig. 2) and health services available through established relationships (linkages) with off-site medical providers. Linkage is defined as an effective system for referring homeless families to off-site medical providers capable of providing comprehensive pediatric primary care to children while they are homeless.

provider capable of meeting families' pediatric health care needs while they are homeless, compared with 28 of the 45 facilities (62%) that had an on-site medical presence. As stated above, 56% of all facilities (with or without an on-site medical presence) had functional linkages with an off-site medical provider.

Children Living in Welfare Hotels Were Least Likely to Have Access to Appropriate Medical Care

Welfare hotels, which housed 1,788 of the 9,200 homeless children residing in the shelter system at the time of the HCHI, were least likely to offer on-site medical care or to have a functional linkage with an off-site medical provider. Figure 3 shows how welfare hotels compared to other facilities and to the shelter system overall in terms of availability of on-site medical care and functional linkages with local medical providers. Little more than a third (38.9%) of the hotels offered on-site nursing compared to 60.6% of Tier II shelters and Family Centers and 55.7% of the system overall. On-site services were available in 22.2% of hotels compared to 40.9% of Tier II shelters and Family Centers and

36.7% of the system overall. Linkages with off-site medical providers were effective at only 11% of hotels compared to 54% of Tier II shelters and Family Centers and 36.7% of the homeless shelter system overall.

Discussion

The New York City shelter system provides transitional housing for more than 20,000 homeless children each year. Many of the health problems disproportionately represented among homeless children, such as developmental delays, nutritional deficiencies, and chronic conditions that have gone untreated, have significant potential for interfering with normal development, learning readiness, and general functionality.[4,5] The presence of children in the shelter system provides a unique intervention opportunity to diagnose and address these problems.

Unfortunately, as the homeless family shelter system has evolved from one that warehoused families in congregate shelters and welfare hotels to one that provides most families with apartment-style transitional housing accompanied by an array of required social and supportive services, there has been no concomitant development of standards with regard to health care services. Although nearly a quarter of a billion dollars is spent in New York City each year to provide shelter and services to homeless families, few resources have been devoted to monitoring the health care needs of homeless children or ensuring that these needs are adequately addressed. For the most part, health care programs serving homeless children and families operate more or less independently and are responsible for identifying their own funding sources. Each determines which facilities they will serve and what services they will provide. As a result, health services vary considerably throughout the system and many homeless children lack access to appropriate medical care. Without an overall plan for ensuring that the health needs of homeless children are adequately addressed, the availability of health services will remain uneven at best.

A number of innovative approaches have been developed in New York City over the past several years to meet the health care needs of homeless children and their families. These include offering on-site medical clinics at shelters and hotels, bringing primary care services to homeless facilities via mobile medical units, offering nursing services to provide health assessments and referrals, and making special arrangements with nearby community-based health care resources. One such approach has been undertaken by the New York Children's Health Project (NYCHP) of Montefiore Medical Center. The NYCHP provides pediatric primary care services to more than 4,000 homeless children each year, using mobile medical units that visit homeless facilities throughout New York City. (The NYCHP is described in detail in the following article.)

Conclusion

Realistically, a single health services model cannot be applied throughout the New York City homeless shelter system, since the location, size, and type of facilities housing homeless families vary significantly. On the other hand, an organized approach could be developed to ensure that 1) all children have access to basic medical care while they are living within the homeless shelter system, 2) health resources are rationally distributed throughout the system, 3) existing health care linkages between homeless facilities and medical providers are functioning effectively, and 4) as families leave the shelter system for permanent housing, they are linked up with appropriate medical providers in their new neighborhoods.

Understandably, the first priority of government policy-makers in addressing family homelessness has been to place roofs over the heads of those in crisis. Still, as the system for serving homeless families in New York City has undergone a transformation intended to better meet the needs of those families and to improve their ability to remain housed once they leave the shelter system, health care remains an afterthought. Since homeless children com-

prise one of the highest health-risk groups in this nation, failure to exploit the intervention opportunity that the shelter system presents is an important void. Addressing that void should be an urgent priority.

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