

HEALING HANDS



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Health Care for Homeless Children: A Clinician's Perspective

Dr. Peter Sherman, a pediatrician and Medical Director for the New York Children's Health Project, sees many patients from New York City homeless shelters. We asked Dr. Sherman to share his thoughts about treating homeless children, the fastest growing segment of the homeless population in the United States. Approximately 40% of homeless people are families with children. (Shinn and Weitzman, 1996; US Conference of Mayors, 1997)

According to a number of research studies and my own experience, homeless children suffer disproportionately from acute illnesses. Living in close quarters at shelters heightens their risk of chicken pox, gastroenteritis, respiratory and ear infections, and a variety of dermatological conditions. Often their mothers run to emergency rooms for treatment because there is no access to a regular source of nonemergent care.

FACTS ABOUT HOMELESS FAMILIES:

- 80% of homeless children under 18 live with a parent in a shelter.
- 77% of homeless families have three children or fewer.
- 58% of homeless families are African American; 22% white; 15% Latino.
- 48% of children in shelter are under the age of five.
- The typical homeless family is a single mother, 30 years old, with two or three children averaging five years of age.

— Homes for the Homeless/
Institute for Children and Poverty.

In fact, acute illnesses are often just the tip of the iceberg. Homeless children also suffer from chronic illnesses that can lead to long-term functional disorders. Multiple ear infections result in hearing loss that may delay speech and language development, and eventually affect school performance.

Sleep loss and exhaustion, common side-effects of asthma, also reduce a child's capacity to learn and a mother's ability to cope with the inordinate stress of being homeless.

In addition, many homeless children have developmental delays secondary to poor prenatal care, premature birth and/or weak parenting skills. Children in shelters also have behavioral problems borne of parenting issues or the trauma of having witnessed domestic violence. Depressed or stressed-out mothers can't give adequate attention to their children, and may be unaware of the importance of early childhood education. Nevertheless, most mothers are loving and caring, and hungry for knowledge and support that will help their children.



Photo by Pat Van Doren, *It's About the Children*
<http://nch.ari.net/vandoren>

HCH clinicians see seizure disorders in homeless children who have never been to a neurologist; heart murmurs, genetic abnormalities and dental problems, never before noticed or documented. *The rate of referral to pediatric specialists is seven times higher for the children we see from homeless shelters than for children in the average general pediatric practice.* In general, these children have not had access to quality medical care with complete histories and physical examinations that would routinely pick up such conditions.

Despite similarities in the health status of poor children who are housed and those who are homeless, there are marked differences. (Weinreb et al, 1998; Rubin et al, 1997; AAP, 1996) Homeless children have

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a higher incidence of asthma and ear infections, elevated lead levels and dental problems. There are more speech delays in homeless toddlers, and poorer academic performance in school-age homeless children.

Insurance: necessary but not sufficient. Three common barriers to health care for homeless children are gaps in health coverage, difficulty accessing care, and variable quality of care. Most homeless children are eligible for Medicaid or SCHIP. Because health insurance is a strong predictor of access to primary and preventive care, every effort should be made to assist children in obtaining entitlements.

But even children who are insured don't always get the care they need. Finding doctors who will accept Medicaid patients with special needs may be difficult. Moreover, the Medicaid managed care system fosters confusion for many of our clients who live in one part of the city and are assigned providers in another, but can't get there.

Lack of appropriate medications for asthma or other chronic conditions is a red flag that should alert clinicians to the absence of quality care. Wherever possible, clinicians who treat homeless children should be affiliated with academic tertiary care centers with the capacity to serve high-risk populations.

Outreach for continuity of care. Homeless kids have so many problems, and their transience makes comprehensive medical care,

referrals and tracking difficult. At the New York Children's Health Project, we actively track patients through a referral management initiative funded by SmithKline Beecham pharmaceuticals. Outreach workers make appointments at Montefiore Medical Center, provide transportation and track outpatient visits. A worker at Montefiore faxes back copies of progress notes to our clinicians, and multidisciplinary meetings are held to discuss current cases. A child born with a heart murmur who misses a cardiology appointment can be immediately identified and rescheduled. Support from the Children's Health Fund, a foundation created by Dr. Irwin Redlener, is central to our ability to have comprehensive programs such as this.

My advice to HCH clinicians is to think locally. Depend on personal contacts to make your system work; develop strong rapport with shelter staff, and meet with key personnel at referral agencies you utilize. The better connected you are, the more effective you can be. Physicians are not taught how to do that in medical school.

Strategies to avoid burnout. To maintain perspective, HCH clinicians need to do more than just see patients. Network; make professional connections; take a step back from clinical care to write a paper. Try to accentuate the positive. You can't solve everyone's problems, but you can make a large difference in some peoples' lives. Of course, being a pediatrician helps. There's a lot that is positive about working with kids! ■

The Power of Networking

Carilyn White, RN, works part-time at Family House, an emergency family shelter in Toledo, Ohio, that serves about 80 children a month. On the day of our interview, 35 children and 20 adults are residing at the shelter. Some are domestic violence victims. "There are always more children than adults," she observes. ("Sit down, pumpkin, and I'll be right with you.")

When homeless children first come to Family House, they are seen by a social worker, a preschool liaison and Carilyn. Her job is to help them get to other health care providers. First, she does a health assessment. If there is evidence of contagious disease, the child is referred to a physician within 24 hours. If not, White refers to various agencies in the city for appropriate medical, vision or dental care. She also makes referrals, as needed, for WIC. She is

careful to let clients choose their preferred providers. The most common health problems she encounters are lice, ringworm, eczema, asthma, inadequate nutrition and developmental delays.

Most of Carilyn's clients are on Medicaid, but she also sees uninsured children. Many of these children are from Michigan or other cities in Ohio. Others have moms who have been in prison. White helps such families reapply for Medicaid or transfer to an HMO in the Toledo area. She gives them the 1-800 Ohio Medicaid number to call, but first gets them to a provider.

Family House subcontracts with Cordelia Martin Health Center, a federally funded HCH project. But if a child hasn't been seen there in the past, there can be delays. When that happens, Carilyn reaches out to

other providers in the community and builds close working relationships with them.

Thanks to her networking skills, she "can always find someone to see a sick child."

White attends health fairs and community events likely to attract children, and keeps a list of agencies and businesses with resources for families with children. As a result, free diabetic supplies, bandages, toothbrushes, underwear, pencils and crayons – almost anything her clients need – are just a phone call away. "Without my community connections, I couldn't do this job as well," she says. ■

LIFE IN A SHELTER

Crowded bedrooms,
lots of strangers,
too many rules,
loud, crying babies,
people everywhere.

But,
it was better than our car.

Justin, age 14

Breaking the Cycle of Family Homelessness Through Intensive Case Management

As clinicians know, children aren't merely small adults. Accordingly, homeless children have health and social service needs that are distinct from, yet intimately related to those of their parents. To address these interconnected needs, the Outreach and Primary Health Services for Homeless Children Program was established in 1992 as part of the federal HCH Program. The Homeless Children's Program provides targeted funding through the Bureau of Primary Health Care for outreach, health care and referral services to homeless children, children at risk of homelessness and their families. The Bureau currently disburses approximately \$2.3 million annually among ten community-based projects nationwide: in Birmingham, AL; Oakland and San Mateo, CA; Denver, CO; Baltimore, MD; St. Paul, MN; Albuquerque, NM; Portland, OR; Houston and San Antonio, TX. These projects serve diverse populations with a variety of innovative service models. All endeavor to provide a "medical home" for their clients by creating linkages among providers of health care, mental health services, social services and educational programs. Grantees work in coalition with other community programs serving homeless and at-risk children and their families, within the public, private and voluntary sectors. Project users totaled 10,667 in 1997: 7,467 children and 3,200 adults.

For more information about the Homeless Children's Program, contact Program Coordinator, Linda Overstreet, at (301)594-4430 or consult the HCP web site: <http://www.bphc.hrsa.dhhs.gov/hch/hcp/hcp1.htm>.

Northern California's Center for the Vulnerable Child (CVC), one of these federal grantees, serves over 500 children in Alameda County each year who are homeless or at risk of homelessness. Affiliated with Children's Hospital Oakland, CVC functions as a comprehensive "medical home" for these children, offering on-site primary, specialty and emergency health care including mental health services, developmental services, family/social service assessments and referrals. No clients are turned away because of insurance status or inability to pay; most clients are Medicaid eligible. Because the staff:client ratio remains small despite a growing population of potential clients, CVC has a waiting list.

The focal point of CVC services is intensive case management. Because the average client is four years old, there is also strong emphasis on child development. "Our child-focused, family-focused model is our strength," declares Senior Research Analyst and Homeless Health Care Director, Cheryl Zlotnick, DrPH, RN. "Since homeless families are less transient than single adults, tracking them – hence case management – is a bit easier."

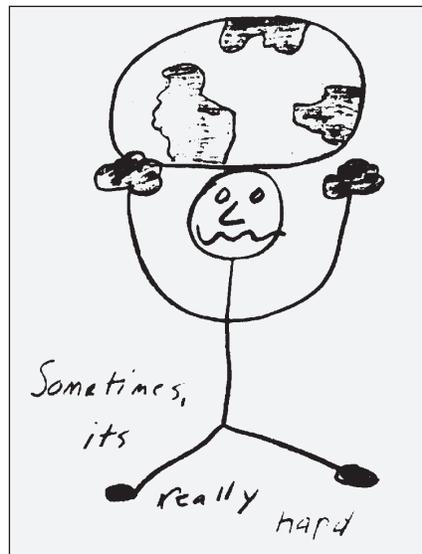
Another distinguishing characteristic is the project's strong foster care component, described in a recently published article.¹ "We see a cycle: a lot of homeless children find their way into foster care because of a parent's substance use problem," observes Zlotnick. "Our systems of care – substance use treatment and recovery, homeless and foster care programs – are becoming intertwined." Case workers deal with three, overlapping categories of clients: homeless families, typically a mother and one or

more children; children in foster care; and reunified families, usually a mother newly rejoined with a child formerly in foster care. Case managers engage clients, offer therapy, model parenting, give referrals and get assessments for developmental delays, IEPs and admission to Head Start. "We're also big on toys," adds Zlotnick.

To prevent repetition of the homeless cycle, case workers provide emotional and logistical support for reunified families through home visiting – as many as three home visits per week until the family is stabilized. The typical client is a mom recovering from a substance abuse problem, already struggling to manage her own life, but suddenly expected to manage her child again as well.

The HCH grant partially supports three case managers and a child care worker – about 35% of total staff funding. CVC relies on foundations and other federal grants to support three additional case managers, two psychologists and an infant development specialist. The Center has also received BPHC funding to develop a case management assessment tool for different service types and goals within a multi-disciplinary model.

HCH clinicians who deal mostly with adults may fail to notice parenting issues, notes Cheryl. "If you forget that a homeless mother is a parent, you're missing something very important. Her child may not be getting emotional and social needs met, which has serious ramifications for the child's psychological development, socialization and education. When working with a family unit, we look at each individual separately, then at the whole family together, before developing a case management strategy." ■



Sometimes,
its
really hard

Brandon, age 9

¹ Zlotnick C, Kronstadt D and Klee L. "Foster Care Children and Family Homelessness," *AJPH* Sept 1998: 88(9), 1368 -1374.

STEP Up for Homeless Children

The National Health Care for the Homeless Council has launched a one-year Shelter TennCare Enrollment Project (STEP) to improve the health status of homeless children in Tennessee by increasing their access to health coverage and primary care. Most homeless children are eligible for health coverage under TennCare, Tennessee's Medicaid Managed Care program. Although 97% of all Tennessee children are estimated to be insured, approximately 46,000 low-income, hard-to-reach children—including many who are homeless—remain uninsured and without needed care.

Using Emergency Shelter Grant funds through the state Department of Human Services, the Council has hired social worker Tony Halton to train emergency shelter staff across the state to facilitate TennCare enrollment and track newly enrolled children through a first primary care visit. The project seeks to develop successful outreach strategies that can be replicated statewide and shared with advocates in other states where Medicaid Managed Care or State Child Health Insurance Programs are being implemented. ■

CARDBOARD BOXES

"Homeless people live in cardboard boxes, don't they?"
That's what some kid said to me today.
Then he laughed.
I wanted to hit him
But I didn't... I laughed too.
Then,
I went back to the shelter and ~~died~~ cried.

Jamie, age 13

Poetry and drawing are from *Poems, Pictures, and Other Great Stuff: a collection of poetry and artwork by homeless children and youth* – used with permission from the Salem-Keizer Public Schools, Salem, Oregon.

RESOURCES:

American Academy of Pediatrics (AAP): "Health Needs of Homeless Children & Families" (RE9637), *Pediatrics* Oct 1996; 98(4), 351-353; <http://www.aap.org>.

The Better Homes Fund: Ellen L. Bassuk *et al.* "Homeless Families and Children: A Longitudinal Study," <http://www.hmcnet.harvard.edu/psych/redbook/66.htm>. See also: Weinreb L, Goldberg R, Bassuk E and Perloff J. "Determinants of Health and Service Use Patterns in Homeless and Low-Income Housed Children," *Pediatrics* Sept 1998; 102(3 Pt 1), 554-562.

Homes for the Homeless/ Institute for Children and Poverty: *Ten Cities: A Snapshot of Family Homelessness Across America, 1997-98* (ISBN # 0-96417844-4-3); 212/529-5252; <http://www.HomesfortheHomeless.com>.

National Coalition for the Homeless: Shinn M and Weitzman B. "Homeless Families Are Different" in *Homelessness in America, 1996*; 202/737-6444; <http://nch.ari.net/facts.html>.

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