The Role of Medicaid in Improving Access to Care for Homeless People

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PURPOSE

This report examines the ability of homeless people to get the health care they need. In particular, it asks whether having health insurance increases access to care for homeless people, as it does for the housed population.

Within the general rubric of health care we include treatment for physical health, mental health, and substance abuse problems. We look at two types of health insurance, Medicaid and "other" health insurance, which, for the homeless population, is largely Medicare or veterans health benefits. We also examine other factors that affect receipt of care, including use of homeless assistance services, homeless history, physical and mental health and substance abuse conditions, receipt of public cash benefits, geographic location, and demographic characteristics.

APPROACH

We used data from the National Survey of Homeless Assistance Providers and Clients (NSHAPC), which is the only nationally representative sample to interview homeless people conducted during the 1990s. It was conducted in 76 metropolitan statistical areas (MSAs) and groups of rural counties throughout the United States. Of these, 28 were the largest MSAs in the country, 24 were MSAs randomly selected to represent all remaining MSAs, and 24 were randomly selected groups of rural counties representing non-MSA areas. In addition to being the only available source of national data with which to pursue our inquiries, NSHAPC gives us the advantages of a large sample (2,938 homeless adults) and information about the many factors that may affect receipt of health care.

We conducted separate analyses for single homeless adults and for adults and children in homeless families. We analyzed single adults as a group; in addition, we further differentiated between those who receive Supplemental Security Income (SSI) and those who do not. We made this distinction because SSI carries with it automatic eligibility for Medicaid, so its beneficiaries would almost certainly have health insurance. In addition, a major criterion for SSI eligibility is a high level of disability, which is likely to affect need for health care. For parents and children in homeless families, we likewise made distinctions based on cash benefit receipt. However, for the families we use Aid to Families with Dependent Children or General Assistance (AFDC-GA) as the benefit by which we create subgroups for analysis. As with SSI, AFDC-GA carries with it automatic eligibility for Medicaid or other publicly provided health insurance.

POTENTIAL CONTRIBUTION

Relatively little research has examined the relationship of insurance to health care receipt among homeless people, although the patterns of increased access and utilization for those with health insurance are well documented in the housed population, both low-income and not. Most of the few studies that do exist focusing on homeless people are limited as to sample (either just single men, or just families) and location, and often by the types of care they include in their analyses.

Other limitations of previous research include failures to differentiate between (1) families and singles when both are available in the data being analyzed, (2) types of health insurance, (3) and beneficiaries and non-beneficiaries of certain important types of public cash benefits. Our analyses address all of these issues.

ANSWERS TO THE MAJOR RESEARCH QUESTIONS

DOES HAVING INSURANCE HELP HOMELESS PEOPLE GET ACCESS TO CARE?

The most general answers to this question are "Yes" for physical health care, "somewhat" for mental health care, and "a little" for substance abuse treatment. Having health insurance increased the odds for having seen a doctor or a nurse, getting ambulatory care, being hospitalized, and being able to see a doctor when one is needed.

DOES IT MATTER WHAT TYPE OF INSURANCE IT IS?

Yes. Increased use of health care of most varieties, including behavioral health care (mental health or substance abuse treatment), was more strongly associated with having non-Medicaid health insurance than with having Medicaid. Medicare (as a consequence of receiving Social Security or SSDI benefits) and veterans benefits were the two most common other types of insurance, although a few people reported having private health insurance.

DOES IT MATTER WHAT TYPE OF CARE IT IS?

Yes. Emergency room care was least likely to be affected by having insurance (only children showed any effects, and only for non-Medicaid insurance). Seeing a doctor or a nurse for any reason, receiving ambulatory care, and being hospitalized were responsive to having insurance, as was mental health treatment for singles. Access to substance abuse treatment was mostly not affected.

DOES IT MATTER WHETHER THE HOMELESS PERSON IS A PARENT IN A HOMELESS FAMILY, A CHILD IN A HOMELESS FAMILY, OR A SINGLE HOMELESS ADULT?

Yes, quite a bit. Medicaid did little for parents in homeless families, where its only observable effect was to increase the odds of being able to see a doctor when one was needed. Other health insurance did better for these parents if they had it, increasing the odds of receiving ambulatory care and decreasing the odds of hospitalization (which were not affected by the amount of ambulatory care received).

Children fared a little better than their parents, but only if they were *not* in families receiving AFDC-GA. Medicaid increased the odds that these children would receive both ambulatory care and hospitalization, while having non-Medicaid health insurance increased the odds of

hospitalization and emergency room use. This was the only example in the study where insurance of any variety affected emergency room use. One would have hoped the effect would be negative—that is, having insurance would reduce the need to use emergency rooms—but such is not the case.

Having Medicaid increased the odds that single people not receiving SSI would get any care and ambulatory care, while having other insurance increased the odds that all groups of single homeless adults had received any care, been hospitalized, and been able to see a doctor when necessary. Having other insurance made it more likely that singles without SSI would get mental health care and that all singles would get inpatient substance abuse treatment, while having Medicaid actually *decreased* the odds that singles with SSI would get any mental health treatment.

HOW DO CHRONIC PHYSICAL HEALTH PROBLEMS AND PAST-YEAR PROBLEMS WITH ALCOHOL, DRUGS, AND MENTAL HEALTH AFFECT USE OF CARE?

Not surprisingly, having more physical health conditions was an important predictor of receipt of care, but only for singles. Further, it was important mostly for medical care as opposed to behavioral health care.

Alcohol, drug, and mental health (ADM) statuses were among the strongest predictors for all types of medical care and some behavioral health care among parents in homeless families and singles. Their parents' ADM status also made a substantial difference for children with respect to emergency room use and hospitalization. For parents, having had only mental health problems was associated with every type of medical care, especially among parents without AFDC-GA, and having both mental health and substance abuse problems was associated with receipt of care for both among all homeless families. A parent's ADM problems also affected the likelihood of their children receiving care, especially in emergency rooms and hospitals overnight.

For singles, having both mental health and substance abuse problems significantly increased the odds that they received care for those problems in the last year. Most of this effect came from single homeless people who did *not* have SSI.

HOW DOES BEING CONNECTED IN ONE OR MORE WAYS TO THE HOMELESS ASSISTANCE SYSTEM AFFECT USE OF CARE?

It helps. Being a resident of a transitional housing program increases the chances of having Medicaid, and sleeping out (not using residential programs) decreases those odds. Having Medicaid, as we have seen, increases certain types of health care use. Emergency shelter or transitional housing use by parents and especially children in homeless families was associated with greater use of medical health care, compared to people in families who did not use these facilities. Both emergency shelter and transitional housing use had the same effect on receipt of behavioral health care for singles, increasing it for most categories of care, but only for those without SSI. In contrast, having slept in places not meant for habitation during the last week was

negatively associated with receipt of care for everyone—parents, children, and single homeless adults.

The analysis also included a variable indicating that the respondent (parent or single adult) received help within the past 30 days with a variety of issues and problems, including housing, signing up for benefits, and employment. Our hope was that this variable would act as a barometer of the respondent's having a case manager, since we were interested in examining the possibility that having a case manager might be responsible for helping one get to care and also get health insurance. This variable was associated with higher odds that single homeless adults would get any mental health treatment and in particular outpatient treatment, and that children in homeless families without AFDC-GA would see a doctor for any reason, get ambulatory care, and be able to get health care when it was needed. However, it actually *decreased* the odds that parents in homeless families would get outpatient substance abuse treatment.

These results do not conclusively support the hypothesis that better system connections lead to greater access to care, because we do not have the data that would allow us to sort out causal ordering. Complex patterns could be operating that we cannot examine. For instance, requirements of certain programs might increase the odds that people would have received care within the past year, as when a program requires prior participation in substance abuse treatment, or sends a resident for treatment to help with a relapse. Or it could be that anyone getting to the stage of receiving help with housing options has been stable and without significant problems for long enough that use of health care would be lower than for people coming to the program more recently.

HOW DOES BEING CONNECTED TO MAJOR PUBLIC BENEFIT PROGRAMS AFFECT USE OF CARE?

There are two answers to this question. First, receipt of benefits is strongly associated with having insurance. Receipt of means-tested public benefits very strongly predicts having Medicaid, while receipt of non-means-tested public benefits (Social Security, SSDI, veterans cash benefits) very strongly predicts having non-Medicaid health insurance. Thus to the extent that having insurance gets one better access to care, being connected to the programs that create insurance eligibility increases access.

However, it is also true that having or not having the cash benefit, whether AFDC-GA for families or SSI for singles, is extremely interactive with most of the variables we examined to see their effects on receipt of care. We assessed the effects of having AFDC-GA (for families) or SSI (for singles) as part of our models for all families and all singles, before splitting them into subgroups. These models were able to control for the effects of other variables with which benefits receipt is interactive, including receipt of health insurance.

The results show that having SSI makes a difference, over and above the effects of health insurance, for receipt of many types of health care for singles,. However, having AFDC-GA does not make much difference for parents or children in homeless families.

Singles with SSI were less likely than those without SSI to report seeing a doctor or nurse for any reason or getting ambulatory care, but they were more likely to say they could see a doctor

when needed. They were also more likely to report every type of mental health treatment, but substance abuse treatment was not affected.

Getting AFDC-GA did not affect any health care variable for parents in homeless families, with the exception of outpatient substance abuse treatment for which it increased the odds of receipt. For children in homeless families, AFDC-GA receipt increased the odds of being able to see a doctor when one was needed, but did not affect any other type of health care (behavioral health care was not measured for children).

Perhaps the most striking result throughout the many analyses presented is that effects that are significant in the general population (e.g., all parents, all children, all singles) were rarely significant in both subpopulations defined by cash benefit receipt or non-receipt.

CONCLUSION

At a broad level of generalization, we can say that having health insurance helps homeless people to access health care, but we found many exceptions. We also observed that factors other than insurance are at least as important in determining whether or not homeless people get health care. Access to care differed considerably for different subpopulations and for particular types of care; these factors may be more important for the homeless than the housed population, as their access to care is more likely to be affected by their connection to various parts of the homeless assistance network. We conclude that to fully understand the role of health insurance for homeless people's access to care, we need to take a closer look at how homeless people access health and behavioral health care. Further, we need to examine the routes to care for those who receive cash benefits and have insurance and those who do not.

It is important to try to understand what other factors may intervene in receipt of care for homeless people, paralleling and expanding the type of analysis recently presented for the housed poor population (Davidoff, Kenney, Dubay, and Yemane, 2001; Dubay and Kenney, 2001). Since we see so few effects of insurance for parents and children in homeless families, especially for the types of care (ambulatory) that we would prefer to see used, one is tempted to conclude that something about the programs they participate in either provides health care or assures that most residents get what they need, thus masking the effects of having insurance or cash benefits. An examination of program effects and access routes would best be done in the field, at least to start, talking to homeless program staff and their clients, rather than through a survey that is limited in the array of questions it can ask on any particular topic. Once an adequate grasp of possibilities is in hand, surveys could discover how generalizable they are, and how they interact with the specific varieties of care that are available to homeless people in different communities.

CHAPTER 1

INTRODUCTION

The Kaiser Commission on Medicaid and the Uninsured commissioned this report to learn more about the role that Medicaid plays in the ability of homeless people to get health care. This report examines the ability of homeless people to get the health care they need, and the factors that affect their receipt of care. Within the general rubric of health care we include treatment for physical health, mental health, and substance abuse problems.

Among the general population, research has long documented the relationship between having health insurance and receiving health care. Most recently, Fragale and Haley (2001) have documented this relationship for the housed low-income adult population, while Currie and Gruber (1996), Dubay and Kenney (2001), Kaestner (1999), and Newacheck et al. (1998) do the same for housed low-income children. Research on the effects of health insurance on access to care for homeless people is considerably sparser, but what little exists shows positive effects for adults (Glied et al., 1998, Kushel, Vittinghoff, and Haas, 2001, Padgett and Streuning, 1991, Padgett, Streuning, and Andrews, 1990) and children (Miller and Lin, 1988, Weinreb et al., 1998). While there is ample evidence at the national level of insurance effects for the housed low-income population, all studies of homeless populations have been at the local level except for Kushel, Vittinghoff, and Haas (2001), who used the National Survey of Homeless Assistance Providers and Clients (NSHAPC) as their source of data.

One can approach the basic research question of this project in (at least) two ways. First, one can seek to establish a relationship between having insurance and getting care, holding constant as many other potentially relevant factors as possible. This is the approach followed by Kushel, Vittinghoff, and Haas (2001). These researchers used the National Survey of Homeless Assistance Providers and Clients (NSHAPC), the only available national database with individual-level client information, to look at all homeless adults (that is, they did not differentiate by their family status). They also did not differentiate by type of insurance, grouping Medicaid, veterans health care, private insurance, and other insurance together in one dummy variable). They found that having health insurance significantly increased the likelihood of using ambulatory care, being hospitalized, being able to get medical care when needed, and being able to comply with medications regimes. However, having health insurance did not affect the likelihood of using emergency rooms. These results were obtained while holding constant many factors that might themselves be expected to affect need for and use of health care, including age, gender, race/ethnicity, veteran status, housing status, locale, number of comorbid chronic physical health conditions, and past-year alcohol, drug, and mental health problems.

The results obtained by Kushel, Vittinghoff, and Haas (2001) are important, showing as they do that insurance aids homeless people to get health care at least as much as it helps housed people. However, the analytic approach masks rather than reveals potentially significant interaction effects among the variables Kushel, Vittinghoff, and Haas held constant or did not include. These interactions may alter the association of having health insurance and getting health care. Equally important, they may explain how the association was created, and thus be relevant for

policies seeking to increase health care access. In this report we explore the different routes to health care access that may depend on one's family status, connection to case managers or other aspects of program and service systems, and eligibility for cash benefits that entail eligibility for Medicaid. As part of this exploration we conduct separate analyses for homeless families and single individuals. Within families we look separately at insurance and access for parents and children. Among single individuals we look separately at the linkage between insurance and health care access for those with SSI and those without SSI. While almost 9 in 10 single homeless people with SSI have Medicaid, twice as many single homeless adults have Medicaid without having SSI. It is quite likely that their route into health care as well as their needs and patterns of service use differ. In all analyses, we treat having Medicaid, the primary health insurance for the homeless population, and having any other type of health insurance as two separate dummy variables, to see whether type of insurance makes a difference.

METHODS

The NSHAPC Survey

Our analyses are based on data from NSHAPC, a survey conducted by the U.S. Bureau of the Census in 1996 at the behest of the federal Interagency Council on the Homeless. The NSHAPC methodology has been described in detail elsewhere (Burt et al., 1999, Chapter 2 and Appendixes A – D). Briefly, the survey was nationally representative of people using homeless assistance programs in fall 1996. It was conducted in 76 primary sampling units (PSUs). The first 28 were the 28 largest metropolitan statistical areas (MSAs) in the United States. The next 24 were MSAs randomly selected from 12 strata defined by geographical region and MSA size. The final 24 were randomly selected groups of counties outside of MSAs (i.e., rural areas), defined by the catchment areas of community action agencies (which completely cover the non-MSA parts of the United States). All homeless assistance programs in these MSAs falling into one of 16 types were catalogued and assessed for size. A sample of programs was selected from this list proportional to program size, and to assure representation of each PSU and of all types of programs within the PSU. Clients were recruited for interviewing at selected programs, using a fixed skip interval after a random start. Five to eight clients completed interviews during each of about 700 program visits, with a response rate of 96 percent. Clients were paid $10.00 once they completed the interview. The final analytic sample included 4,133 respondents, of whom 2,938 were currently homeless, 677 were formerly homeless, and 518 were other service users who reported never having been homeless. In this report we focus on parents and children in currently homeless families (N = 465), and currently homeless single people (N = 2,473).

Descriptive and Independent Variables

Gender was recorded by observation. Respondents reported both their *age* in years and their date of birth, which was used to calculate age if age was not reported. They reported their *race and Hispanic origin* on two standard Census Bureau questions (race and Hispanic origin were asked separately). We combined responses to create the categories of non-Hispanic white, non-Hispanic black, Hispanic, American Indian/Native American, Asian/Pacific Islander, and other.

For the present analysis we collapsed the last four categories into "other" because sample sizes did not make it feasible to use all categories. *Location* was determined by the site from which the respondent was recruited for NSHAPC. *Veteran status* was determined by a question asking whether the respondent had ever been on active-duty military service in the U.S. Armed Forces, Reserves, or National Guard.

Family Status. Respondents were classified as head of a homeless family if they reported that one or more of their own minor children were homeless with them. Otherwise respondents were classified as single, even if they had children residing elsewhere. Respondents were asked the number and ages of minor children who were homeless with them. *Number of children* was coded as 1, 2, or 3 or more children homeless with the respondent; *Age of youngest child* was classified as under 2, 2 to 5, and 6 or older.

Defining Alcohol, Drug, and Mental Health (ADM) Status. Individuals are classified as having an ADM problem if they have had at least one alcohol use, drug use, or mental health problem during the past year. Presence of each problem is defined completely on the basis of self-report, without verification by any official records.

Clients are classified as having a ***past year alcohol use problem*** if *any* of the following conditions were met: (1) they scored 0.17 or higher on a modified Addiction Severity Index[1] (ASI) measure, (2) they reported drinking to get drunk three or more times a week within the past year, (3) they reported being treated for alcohol abuse within the past year, or (4) they reported ever having been treated for alcohol abuse *and* drinking three or more times a week within the past year.

Clients are classified as having a ***past year drug use problem*** if *any* of the following conditions were met: (1) they scored 0.10 or higher on a modified ASI measure, (2) they reported being treated for drug abuse within the past year, (3) they reported using drugs intravenously (shooting up), or (4) they reported using any of a variety of specific drugs three or more times a week within the past year.

Clients are classified as having a ***past year mental health problem*** if *any* of the following conditions were met: (1) they scored 0.25 or higher on a modified Addiction Severity Index (ASI) measure, (2) they reported receiving treatment or counseling or being hospitalized for emotional or mental problems within the past year, (3) they reported on the ASI taking prescribed medications for psychological or emotional problems within the past year, (4) they reported that a mental health condition was the single most important thing keeping them from getting out of homelessness, or (5) they reported receiving treatment or counseling or being

[1] The Addiction Severity Index is an instrument developed by the National Institute on Drug Abuse (Fureman, Parikh, Bragg, and McLellan, 1990). It contains subscales to measure a client=s level of problems with alcohol, with drugs, and with mental or emotional problems. Cutoff levels used in this report are slight modifications of the means reported in Zanis, McLellan, Cnaan, and Randall (1994).

hospitalized for emotional or mental problems at some point in their lives *and* having one or more of the ASI's seven emotional or psychological conditions within the past year.[2]

System Involvement. Respondents were asked for all sources of cash income, and also whether they were receiving a variety of public benefits at the time of the interview. Responses indicating receipt of AFDC, GA, Supplemental Security Income (SSI), food stamps, or a housing subsidy form the basis of variables indicating receipt of specific benefits or combinations of benefits. All variables are based on self-report, without verification from program records. A series of questions asked whether the respondent had received help getting a variety of things within the past 30 days. For the variable "received case manager (CM) help in the past month," we selected items most indicative of serious involvement with a case manager or other persistent staff position, including: assistance with getting financial or other public benefits, help finding a job, assistance with finding affordable housing, and assistance with rent, mortgage, or utilities for securing permanent housing. The variable was scored 1 if the respondent reported any of these types of assistance, and 0 if none were reported.

Health Insurance. Respondents were asked whether they had health insurance and, if they had children with them, whether their children had health insurance. If the answer was yes, they were asked what kind, with the options being Medicaid, VA medical care, private insurance, and "other." "Other" responses were examined and recoded into one of the primary categories if it was clear where they belonged. Respondents could identify more than one type of insurance, and some did. For this report we created dummy variables for Medicaid, any other insurance, and no insurance.

Length of Current Homeless Spell. Respondents' answers, which might be given in years, months, weeks, or days, were converted to consistent 30-day months or portions of months.

Where Slept in Last Seven Days Plus Day of Interview. Respondents were asked in detail where they had slept or rested during the seven days preceding their interview, and also where they were staying "today." Responses for "today" were checked against the type of program from which they were recruited (their sampling frame). Responses plus frame information was used to create variables indicating whether they had slept or rested in emergency shelters during the eight days in question, in homeless assistance programs offering transitional housing, and/or in places not meant for human habitation. Respondents could have slept in one, two, or all three of these venues during the time period, and often did. Thus each location is treated as its own dummy variable.

Current Health Conditions. A number of health conditions were included in the NSHAPC questionnaire. These were selected because other research indicated their frequency of occurrence among homeless populations. Thus conditions such as skin disease, infection, sores, and ulcers, and lice and scabies were included and some other conditions were not. *Acute infectious conditions* on the questionnaire included chest infection, cold, cough, bronchitis (URI), pneumonia, tuberculosis, and sexually transmitted diseases other than AIDS. *Acute*

[2] The eighth ASI item, "taking prescribed medications for psychological or emotional problems," is a criterion in its own right for classifying a client as having a mental health problem.

noninfectious conditions included the skin conditions and infestations just mentioned. *Chronic conditions* included diabetes, anemia, high blood pressure, heart disease or stroke, problems with one's liver, arthritis/rheumatism/joint problems, cancer, problems walking/lost limb/other handicap, and AIDS. In this report *acute infectious conditions* are represented by a dummy variable indicating the presence of *any* such condition. *Acute noninfectious conditions* are also represented by a dummy variable signifying presence or absence. *Chronic conditions* are represented by an ordinal variable with the values of none, one, two, and three or more conditions.

Dependent Variables

Physical Health Care. The respondent reported the last time she or he was treated or examined by a doctor or nurse for health problems, including routine checkups. If the respondent had children with her/him, the question was repeated with respect to the children. If a health care visit was reported within the past 12 months, the variable "received physical health care" was coded 1; otherwise it was coded 0.

Physical Health Care Setting. Respondents were asked where they (their children) received care, both during the most recent visit and for any care received within the past 12 months. Every setting in which they received care was recorded. *Ambulatory care* settings included a hospital outpatient clinic; a Veteran Affairs (VA) outpatient clinic; a community health clinic; a Health Care for the Homeless clinic; a doctor or nurse in a shelter, soup kitchen, or other program; a private doctor's office, or a migrant health care facility. *Inpatient* settings included a VA hospital as an inpatient or any other hospital as an inpatient. The *emergency room* setting was coded if the respondent said the care was received at a hospital emergency room.

Unmet Need. Responses to the question "Have you needed to see a doctor/nurse in the last year but were not able?" were coded as a dummy variable for which a yes response coded 1 and a no response was coded 0. A similarly worded question asked about unmet need for the respondent's children, and was likewise coded as 1 if the children had needed a doctor/nurse but been unable to see one, and as 0 if this had not happened within the last year. Respondents with no children were not asked the question, and are not included in the analyses of children's access to health care.

Mental Health Care. The respondent reported whether he or she had "ever received *outpatient treatment or counseling* for emotional or mental problems." If the answer was yes, the most recent treatment episode was recorded. A dummy variable was created for which an episode within the past 12 months was coded 1and anything else was coded 0. For *inpatient treatment* the question read "have you ever been HOSPITALIZED for emotional or mental problems?" and was followed by questions about frequency and recency if the answer was yes. A dummy variable was created for which a hospitalization within the past 12 months was coded 1 and anything else was coded 0. A summary variable for *any mental health treatment* was created to reflect outpatient *and/or* inpatient treatment within the past year. Anyone who had not been classified as having a mental health problem was coded as "missing" for these three dummy variables. No questions were asked about children's receipt of mental health care.

Substance Abuse Treatment. The respondent reported whether he or she had "ever received *OUTPATIENT treatment* for problems with alcohol (drugs)." If the answer was yes, the most recent treatment episode was recorded. A dummy variable was created for which an outpatient episode within the past 12 months was coded 1and anything else was coded 0. For *inpatient treatment* the question read "have you ever received INPATIENT treatment (including detox) for problems with alcohol (drugs)?" and was followed by questions about frequency and recency if the answer was yes. A dummy variable was created for which inpatient treatment within the past 12 months was coded 1 and anything else was coded 0. A summary variable for *any substance abuse treatment* was created to reflect outpatient *and/or* inpatient treatment within the past year. Anyone who had not been classified as having an alcohol or drug problem was coded as "missing" for these three dummy variables. No questions were asked about children's receipt of care related to drug or alcohol use.

OVERVIEW OF REST OF REPORT

The next three chapters of this report present results related to access to and use of treatment for physical and mental health and substance use problems. They follow a general pattern. They first describe the subsample of interest on personal and other factors that may affect access to and receipt of care, both as a whole and in subgroups reflecting benefit receipt (AFDC or GA for families, and SSI for singles). They then present descriptive information about receipt of physical health care and mental health and substance abuse treatment. They conclude with regression analyses examining factors affecting receipt of care. Chapter 2 focuses on the responding parent in homeless families. Bivariate and regression results are reported separately for households that did and did not receive AFDC or GA (62 percent received one or the other, among whom 93 percent reported receiving Medicaid). Chapter 3 focuses on children homeless with their parents, also splitting the sample by the parent's AFDC/GA status. Chapter 4 reports findings for single homeless adults. Bivariate and regression results are reported separately for people who did and did not report receiving SSI (11 percent did get SSI). Nine out of ten of these individuals also reported receiving Medicaid. The report ends with a chapter summarizing results and discussing their implications. It will describe the clear associations that have emerged, the factors that seem to be important in assuring access to health care, and what might be done to improve access.

CHAPTER 2
ADULTS IN HOMELESS FAMILIES

INTRODUCTION

This chapter examines whether having health insurance affects the probability that adults in homeless families will receive health care. It focuses on receipt of care among the 465 homeless families that were part of the NSHAPC sample during the 12 months before the family was interviewed in the fall of 1996. During this time Aid to Families with Dependent Children (AFDC) was the federal-state program offering cash assistance to needy families, and 52 percent of the homeless families in NSHAPC reported receiving AFDC. Another 10 percent of homeless families reported receiving General Assistance (GA). AFDC families were categorically eligible for Medicaid, and beneficiaries of cash assistance from most state or local GA programs were also eligible for either Medicaid itself or another public health insurance program. One would have thought that all of these families would report having health insurance, but in fact 5.9 percent did not. At the same time, some parents in homeless families that were not receiving either AFDC or GA reported having Medicaid (21.7 percent) and other health insurance (12.3 percent), but many more were uninsured (67.0 percent).[3]

We begin by looking at demographic and other characteristics of the parent respondent for a homeless family, including any differences that might be associated with the family's receipt of AFDC or GA. NSHAPC did not collect information on the other parent, even if that other parent was also homeless with the family. We continue with an overview of the types of health care the parent reported during the past 12 months, again examining differences between parents in families reporting AFDC or GA receipt and those that did not.

CHARACTERISTICS OF ADULTS IN HOMELESS FAMILIES

Families headed by a woman without a spouse or partner comprise the large majority of homeless families. In NSHAPC, mothers were the respondents for 6 out of 7 homeless families, and only 18 percent of them reported the presence of a spouse or partner as part of their homeless family. Conversely, three-quarters of fathers responding for a homeless family reported being with a spouse or partner (Burt, Aron, and Lee, 2001, table 3.1). A man was the respondent for 15.8 percent of the homeless families in NSHAPC. Homeless families without AFDC or GA were more likely to be headed by a man than families receiving these benefits (Table 2-1),[4] but two-parent or male-headed families were in the minority even for those without AFDC-GA.

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[3] People could check more than one type of insurance, so these percentages add up to more than 100 percent.

[4] All differences mentioned in the text are significant at $p < .05$ or better. If a difference is described as marginal, its significance level is less than .10 but greater than .05. Differences that do not reach this level of significance are not

Homeless families receiving AFDC or GA were significantly less likely to be white non-Hispanics than those without cash assistance. They were more likely to have been interviewed in a central city, and less likely to be headed by a veteran. They were also less likely to have just become homeless within the past month.

There were significant differences in the extent to which the parent in the two groups of families reported experiencing alcohol, drug, or mental health (ADM) problems in the year before being interviewed. Parents in homeless families not receiving AFDC or GA were more likely than those receiving cash benefits to report only having mental health problems. Conversely, a parent with drug problems (with or without co-occurring alcohol problems) and a parent with both mental health and some substance use problem was more common in families receiving AFDC or GA. Parents not reporting any ADM problems in the past year were equally common in both types of families.

In addition to the cash benefits that the AFDC-GA families received, more of them also received other benefits than was true for families without the cash assistance. Food stamps was the most commonly received other benefit, but Medicaid and a housing subsidy were other possible benefits mentioned by homeless families. There was no difference in the likelihood of a family receiving help from a case manager or other helping professional to get into or remain in housing.

Finally, there was a very large difference in Medicaid receipt between families with and without AFDC-GA. Virtually all families with AFDC-GA had Medicaid (92.9 percent), compared to only 21.7 percent among non-AFDC-GA families. Neither type of family was very likely to receive other health insurance, so non-AFDC-GA families were significantly less likely than AFDC-GA families to have any health insurance.

ACCESS TO AND USE OF CARE

At a purely descriptive level one can already begin to see differences in access to care between AFDC-GA and non-AFDC-GA families, even without controlling for many other factors. However, the differences are in the unexpected direction that parents in families *without* AFDC-GA were *more* likely to receive care in ambulatory and hospital settings than were those in families receiving AFDC-GA (Table 2-2).

Families with and without AFDC-GA were equally likely to report having been "treated or examined by a doctor or nurse for health problems, including routine checkups" at least once in the past year.[5] However, families without AFDC-GA reported receiving care in more settings.

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discussed. Many differences in tables may appear great, but small samples sizes reduce them to the level of non-significance.

[5] Although this question was asked as the first in the NSHAPC section on physical health care, and refers to "health reasons" and "routine checkups," it seems likely in light of the influence of ADM statuses on results that people answered it affirmatively if they saw a doctor or nurse for any reason, including in a mental health or substance abuse care setting. Thus it should be considered the most general indicator of use of care.

Parents in the two family subgroups were equally likely to have been hospitalized (about 1 in 4 in each group). But parents in non-AFDC-GA households were significantly more likely to have received ambulatory care and marginally more likely to have received care in an emergency room than parents in AFDC-GA families. Despite these patterns, parents in families without AFDC-GA were more likely than AFDC families to say that they had been unable to see a doctor or nurse in the past year when they needed one.

Receipt of mental health treatment was assessed only for people who revealed a mental health problem within the 12 months before being interviewed. The same was true for substance abuse treatment and having a substance abuse problem. The difference in mental health treatment receipt between families with and without AFDC-GA appears substantial but is not statistically significant due to the small size of the subsamples with mental health problems. Differences for substance abuse treatment are marginally significant, with parents in AFDC-GA families being more likely than parents in non-AFDC-GA families to receive such treatment overall, and more likely to receive it in an outpatient setting.

RESULTS OF REGRESSION ANALYSES: INSURANCE, USE, AND ACCESS

INSURANCE RECEIPT

Medicaid Receipt

The strongest predictors of Medicaid receipt for adults in homeless families are receipt of AFDC or GA (odds ratio of 18.15) and receipt of other public benefits (odds ratio of 8.72). Indeed, other than being employed, which has a significant negative effect on Medicaid receipt, these are the only significant predictors of which families will have Medicaid and which will not.

Receipt of Other Health Insurance

While receipt of AFDC-GA is positively associated with Medicaid receipt, it has a negative effect on receipt of other types of health insurance coverage. As receipt of other benefits such as SSI, SSDI, or Social Security benefits has no effect on non-Medicaid coverage, we conclude that homeless families' receipt of non-Medicaid coverage has little to do with their receipt of other public benefits. In fact, our model does not account for much of the variation in which families get non-Medicaid coverage and which do not (22.8 percent of the variance, compared to 54.9 percent for predicting Medicaid receipt). The only other significant predictor of non-Medicaid coverage is having both substance abuse and mental health problems, which increases the likelihood of non-Medicaid coverage relative to parents in homeless families who have no ADM problems.

RESULTS FROM THE NSHAPC SECTION ON PHYSICAL HEALTH CARE

In the remaining logistical regression analyses, Medicaid and other health insurance are treated as separate dummy variables, each compared to the omitted category of not having any health insurance. As will be seen, they have quite different effects for the adults in homeless families. Combining them into an insurance/no insurance variable just obscured those differences and masked the effects of having some type of health insurance other than Medicaid.

Contact with a Doctor or Nurse for Health Reasons

Surprisingly, for homeless families, having health insurance did *not* predict having seen a doctor or nurse in the last year.[6] Nor did receipt of AFDC-GA make a difference (Table 2-3). In contrast, sleeping in places not meant for habitation has a strong negative effect. The only other factor affecting receipt of care is having mental health plus substance abuse problems (compared to not having any ADM problems), which increases the likelihood of receiving care. Sleeping out significantly affects the likelihood of receiving care in both family subgroups (those that did and did not receive AFDC-GA), as well as for all families. Being male is a factor increasing likelihood of care only for families receiving AFDC-GA.

Ambulatory Care

Having health insurance is the strongest predictor of receiving health care in an ambulatory setting during the last 12 months, having health insurance is the strongest (Table 2-4). However, it is not Medicaid that has this effect, but insurance other than Medicaid. Parents with non-Medicaid health insurance are more than six times as likely as parents without any health insurance to have received ambulatory care. This is the only factor that significantly affects ambulatory care use for both family subgroups, those with and those without AFDC-GA.

The only other factor increasing the probability of receiving ambulatory care is being male. Two factors decreased the probability of receiving ambulatory care—being in a central city or suburban area as opposed to a rural area, and having been homeless for more than five years. Having AFDC-GA does not affect receipt of ambulatory care at all.

The influence of having non-Medicaid health insurance remains the strongest predictor for both subgroups of homeless families. But there the similarities end. Use of emergency shelter or transitional housing programs increases the likelihood that parents in homeless families *with* AFDC-GA will get ambulatory care, as does contact with a case manager, while an exceptionally lengthy homeless spell reduces that likelihood. None of these variables have any effect on parents in families *without* AFDC-GA. But they, unlike the AFDC-GA families, are affected by

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[6] For the family analyses, two variables were modified. The age variable was modified by leaving out the 50 and older category, and the ADM status variable was modified by leaving out alcohol only. Very few families were in each of these categories, and those families were identical on many of the variables of interest. Under these circumstances the models automatically dropped the variables and with them the relevant respondents.

their geographic location (rural more), their age (25-49 more than 18-24) and ADM status (having a mental health problem only, compared to no ADM problems).

The pattern observed for ambulatory care, of the two family subgroups being responsible for the statistical significance of distinct sets of variables in the merged analysis, will become a theme as we continue to describe our results for families. In addition, models of the subgroups separately often provide more predictive power (as measured by the pseudo-R^2) than models treating all families as a single group.

Emergency Room Care

Neither insurance nor receipt of AFDC-GA has any effect on the likelihood of receiving emergency room care, overall or for either family subgroup (Table 2-5). For parents in all homeless families, the factors significantly increasing the likelihood of emergency room use are having one or more chronic physical health problems and having a mental health problem, either by itself or coupled with substance abuse.

Once again the predictors of care differ for families with and without AFDC-GA. For those without these benefits, the only significant predictor (positive) of emergency room use is having a mental health problem uncomplicated by a substance use problem. For families with AFDC-GA, being in a central city or suburban area, being male, and having both mental health and substance abuse problems increase the odds of having used an emergency room, while having received help from a case worker decreases the odds.

Hospitalization

Having non-Medicaid health insurance *decreases* the odds of hospitalization for parents in homeless families (Table 2-6). Examination of the results for the two family subgroups indicates that families receiving AFDC-GA are responsible for this effect. AFDC-GA receipt continues to be insignificant. Being in a transitional housing program increases the probability that an adult in a homeless family will have been hospitalized during the previous year, and is the only predictor that affects both family subgroups significantly and similarly.

Factors affecting all homeless families for which the contribution comes from the AFDC-GA families include age (the younger the more hospitalization) and having mental health plus substance abuse problems. Factors affecting all homeless families for which the contribution comes from the non-AFDC-GA families include having drug problems without mental health problems, and having only mental health problems. The final anomaly in Table 2-6 is the opposite effects that having a very long homeless spell has in the two family subgroups. Those *without* AFDC-GA are less likely to have been hospitalized if their homeless spell lasted five years or more, while similar families *with* AFDC-GA are more likely to be hospitalized. The result is that spell length was not significantly related to hospitalization in the analysis that included all families.

Inability to Obtain Care When Needed

One factor significantly predicts an inability to get care when needed for parents in all homeless families and for both family subgroups (Table 2-7)--having only a mental health problem. Having Medicaid reduces lack of access (that is, it increases ability to get care when needed), but only for families without AFDC-GA. Having AFDC-GA has no effect. Having been homeless for less than one month also predicts better access for families without AFDC-GA, but does nothing for families with cash benefits. Having one or more chronic conditions and having slept in places not meant for habitation during the last week have the opposite effect, reducing access for those without AFDC-GA but not for those with cash benefits.

Summary

The effects of having health insurance for parents in homeless families is not as straightforward as one might have expected. Health insurance has no effects on whether a parent in a homeless family had seen a doctor or nurse in the past year, or on use of emergency rooms. Of the five access/care variables examined so far, having Medicaid affected only one—these parents' ability to see a doctor when they needed one. The effect was good (an increased likelihood of being able to get needed care), but comes only from families without AFDC-GA. Having other health insurance affected only two of the five access/care variables—receipt of ambulatory care and hospitalization. Ambulatory care was more likely with other health insurance for both family subgroups. However, hospitalization was actually *less* likely for homeless families who had both AFDC-GA and other health insurance. One possibility might have been that these families' greater use of ambulatory care related to having other health insurance reduced their need for hospitalization, but further analyses indicate that receiving more ambulatory care does not affect the probability of hospitalization.

The only reasonably consistent predictors of more care were ADM statuses. In particular, having only mental health problems increased the likelihood of receiving ambulatory and emergency room care and hospitalization, but also made it harder to get needed care. The effects on being less able to get needed care were present for both family subgroups, while the results for ambulatory care, emergency room use, and hospitalization were driven by the non-AFDC-GA subgroup. In contrast, having mental health plus substance abuse problems increased ambulatory care, emergency room use, and hospitalizations. The latter two occurred only for families that had AFDC-GA, while ambulatory care effects occurred only for families without AFDC-GA.

The influence of ADM statuses on the results for all of these variables suggest two possibilities, both of which may be true. First, people with one or more ADM problems may use more care. Second, during the NSHAPC interview people were not responding to these questions only about the care they received for physical health problems, even though the questions were included in a section on physical health and they followed questions about physical health conditions.

TREATMENT FOR MENTAL HEALTH PROBLEMS

The analyses for receipt of mental health care were conducted only for people who reported a mental health problem within the last year. As this criterion resulted in a major reduction in sample size, it was not possible to run models separately for families with and without AFDC-GA. In addition, so few adults in homeless families reported inpatient mental health treatment that we could not conduct meaningful analysis with this dependent variable. Therefore Table 2-8 reports only factors affecting outpatient mental health care, and only for the entire subsample of parents in homeless families who had mental health problems.

There are no significant effects of having health insurance on receipt of outpatient mental health treatment for parents in homeless families, nor does receipt of AFDC-GA make any difference. Being in an urban or suburban environment makes outpatient mental health treatment more likely, as does having both mental health and substance abuse problems (as opposed to having only mental health problems).

TREATMENT FOR SUBSTANCE USE PROBLEMS

The analyses for receipt of substance abuse treatment were conducted only for people who reported a substance use problem within the last year. As this criterion resulted in a major reduction in sample size, it was not possible to run models separately for families with and without AFDC-GA. Therefore the three substance abuse treatment variables (all, inpatient, and outpatient) are shown only for all families with substance abuse problems taken together. Roughly equal proportions of families have received outpatient (13.4 percent) and inpatient (9.5 percent) treatment, so the influence of these two variables on the treatment summary measure (any type of substance abuse treatment) is relatively evenly distributed.

With AFDC-GA in the analysis, neither type of health insurance affects the likelihood that parents in homeless families will have experienced treatment for substance abuse in the last year, but having AFDC-GA increases the odds of receiving outpatient treatment (Table 2-9). [7]

No variable predicts both outpatient and inpatient substance abuse treatment. Being homeless for more than five years increases the odds of inpatient treatment, and is the only variable to do so. Many variables affect the odds of receiving outpatient substance abuse treatment including being older (age 25 to 49),[8] having mental health in addition to substance abuse problems, and having AFDC-GA, which increase the odds, and being African-American, receiving help getting

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[7] Without AFDC-GA in the model, both insurance variables increase the likelihood of inpatient treatment for substance abuse among parents in homeless families. For outpatient substance abuse treatment, without AFDC-GA in the model Medicaid does not make a difference, and having other insurance actually decreases the odds of receiving such treatment.

[8] Note that no coefficients or odds ratios are given in Table 2-9 for sleeping in places not meant for habitation. Only two of the respondents in this analysis (those with substance use problems in the last year) *had not* slept out during the week before being interviewed, and neither of them reported inpatient or outpatient substance abuse treatment. Thus a "no" perfectly predicted failure (no treatment), and these two respondents were dropped from these analyses only.

housing benefits, using emergency shelter, and having one or more chronic conditions, which decrease the odds.

IMPLICATIONS

As already noted, having health insurance is not consistently related to receipt of care for parents in homeless families. Further, inclusion or exclusion of AFDC-GA receipt from our analyses did not make any difference for homeless parents' receipt of basic medical care or mental health care. However, in models that included AFDC-GA receipt, effects of Medicaid and other health insurance on substance abuse treatment were reduced to insignificance.

Findings are mixed both as to which subgroup of homeless families is affected (AFDC-GA or non-AFDC-GA), whether, given insurance, its influence on receipt is positive or negative, and whether Medicaid and other insurance have similar effects. One might expect that the effects of Medicaid would not be apparent among families receiving AFDC-GA because virtually all of them have it. But effects of Medicaid are no more apparent in the models using all homeless families, where having and not having Medicaid is much more evenly distributed (62 percent have Medicaid and 38 percent do not, with 32.5 percent having no health insurance at all), or among families without AFDC-GA.

This confusion of effects has been masked in previously reported findings because parents in homeless families have not been analyzed separately from single homeless adults. As will be seen in Chapter 4, the results for the latter are much closer to what we might expect from previously published accounts.

Table 2-1
Characteristics of Parents in Homeless Families, All and by AFDC-GA Status
(weighted percentages)

	Client Group		
	All Currently Homeless Families (N = 462)	Currently Homeless Families Receiving AFDC or GA (N=266)	Currently Homeless Families Not Receiving AFDC or GA (N=195)
Percent of All Currently Homeless Families	100.0	56.6	43.4
Male	15.8	6.0*	28.8*
Age			
24 and younger	25.0	26.2	23.7
25-49	73.3	73.8	72.7
50 and older	1.6	0.1	3.6
Race			
Black non-Hispanic	42.9	49.5+	33.9+
White non-Hispanic	38.0	27.3*	52.5*
Other	19.1	23.2	13.7
Location			
Central cities	68.8	77.0*	57.6*
Suburbs/urban fringe (balance MSA)	21.0	17.0	26.6
Rural (non-MSA)	10.2	6.1	15.8
Veteran	5.3	0.9*	11.2*
Length of Current Homeless Spell			
Less than 1 month	12.3	4.8*	22.3*
1-60 months	80.2	85.3	73.1
More than 60 months (5 years)	7.6	9.8	4.6
Past Year ADM Status			
No ADM problems reported	40.4	37.8	43.9
Only alcohol problems	5.0	2.6	8.2
Drug problems, ± alcohol problems, but no mental health problems	12.2	18.3*	4.4*
Only mental health problems	21.8	13.8*	32.4*
Mental health plus AOD problems	20.7	27.5*	11.2*
System Involvement of Household			
Gets AFDC/GA now	56.6	100.0	0.0
Gets other benefits now	76.5	94.8*	52.3*
Received CM help in past month	38.7	38.6	38.2
Health Insurance Status			
Medicaid	62.0	92.9*	21.7*
Other health insurance	9.2	7.0	12.3
No health insurance	32.5	5.9	67.0
Past 7 Days, Slept in:			
Emergency Shelter	33.9	31.9	36.5
Transitional Housing Program	43.0	42.9	42.9
Places not meant for habitation	6.3	7.9	4.4
Number of Co-Occurring Chronic Illnesses			
0	54.3	51.2	58.6
1	26.3	27.2	24.8
2	14.7	17.2	11.8
3 or more	4.6	4.5	4.9

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. Note: Percentages do not sum to 100% due to rounding, or because respondents could give more than one response.
Cells marked with an asterisk (*) are significantly different from each other at $p < .05$; those marked with a plus sign (+) are marginally different from each other at $p < .10$).

Table 2-2
Access of Parents in Homeless Families to Care for Physical, Mental Health and Substance Abuse Problems, All and by AFDC-GA Status
(weighted percentages)

Within the Past 12 Months:	Client Group: All Currently Homeless Families (N = 462)	Currently Homeless Families Receiving AFDC or GA (N=266)	Currently Homeless Families Not Receiving AFDC or GA (N=192)
Treated by a Doctor or Nurse for Health Reasons	79.8	81.7	77.3
Setting of Care:[1]			
An ambulatory care setting	58.0	49.5*	69.0*
A hospital as an inpatient	24.5	25.1	23.9
An emergency room	37.1	30.5+	45.7+
Number of Times Received Medical Treatment, Not Counting Repeat Visits for the Same Condition			
Never	21.4	19.1	24.4
Once	12.4	9.0	16.8
2 or 3 times	34.8	39.2	29.2
4 to 10 times	19.2	18.7	19.9
11 or more times	12.1	14.0	9.7
Needed to See a Doctor or Nurse but Was not Able to	26.6	19.6*	35.9*
Received Mental Health Treatment of Any Type[2]	19.4	23.7	13.9
Setting of Mental Health Treatment:[12]			
Outpatient setting	19.2	23.5	13.7
Inpatient setting	2.2	1.9	2.7
Received Substance Abuse Treatment of Any Type[3]	17.6	25.8+	7.1+
Setting of Substance Abuse Treatment:[13]			
Outpatient setting	13.4	20.5+	4.4+
Inpatient setting	9.5	14.4	3.0

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. Note: Percentages do not sum to 100% due to rounding, or because respondents could give more than one response.
Cells marked with an asterisk (*) are significantly different from each other at $p < .05$; those marked with a plus sign (+) are marginally different from each other at $p < .10$).

[1]Respondents may have received care in more than one setting during the past 12 months.

[2]Percentages calculated using only people reporting a mental health problem in the past year. Ns = 188, all families; 110, families with AFDC-GA; 76, families without AFDC-GA.

[3]Percentages calculated using only people reporting an alcohol or drug problem in the past year. Ns = 144, all families; 97, families with AFDC-GA; 45, families without AFDC-GA.

Table 2-3
Predictors of Treatment by a Doctor or Nurse for Health Reasons for Parents in Homeless Families, All and by AFDC-GA Status
(weighted percentages)

Predictor Variables	All Currently Homeless Families (N = 437)		Currently Homeless Families Receiving AFDC or GA (N=238)		Currently Homeless Families Not Receiving AFDC or GA (N=171)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Race						
Other		1.00		1.00		1.00
White	-0.292	0.75	-0.059	0.94	0.145	1.16
Black	1.077	2.94	1.481	4.40	1.540	4.66
Location						
Rural		1.00		1.00		1.00
Urban or suburban	-1.023	0.36	-1.187	0.30	-1.478	0.23
Sex						
Female		1.00		1.00		1.00
Male	0.711	2.04	3.848 **	46.89	-0.444	0.64
Age[1]						
24 and younger		1.00		1.00		1.00
25-49	-0.535	0.59	-1.130	0.32	0.355	1.43
ADM Status[2]						
No ADM problems reported		1.00		1.00		1.00
Drug problems, ± alcohol problems, but	-0.413	0.66	-0.969	0.38	.	.
Only mental health problems	1.200	3.32	1.625	5.08	1.230	3.42
Mental health plus AOD problems	1.102 *	3.01	1.154	3.17	1.427	4.17
Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	0.432	1.54	0.660	1.93	0.439	1.55
Length of Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	0.635	1.89	-0.996	0.37	1.191	3.29
More than 60 months (5 years)	-1.166	0.31	-0.239	0.79	-0.744	0.48
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	-0.044	0.96	-0.697	0.50	0.531	1.70
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	0.698	2.01	0.251	1.28	1.106	3.02
Slept Out						
No		1.00		1.00		1.00
Yes	-2.593 **	0.07	-3.431 **	0.03	-2.466 *	0.08
One or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	-0.274	0.76	0.290	1.34	-0.672	0.51
Has Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	0.254	1.29	0.501	1.65	0.075	1.08
Other insurance	1.128	3.09	.	.	0.814	2.26
AFDC-GA						
No		1.00				
Yes	0.678	1.97				
Adjusted Pseudo-R^2	0.219		0.367		0.171	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01. Note: Variables missing parameter estimates or odds ratios were excluded from the model.

[1] Clients aged fifty and over were dropped from the model. [2] Clients with only alcohol problems were dropped from the model.

Table 2-4
Predictors of Ambulatory Care for Parents in Homeless Families,
All and by AFDC-GA Status
(weighted percentages)

Predictor Variables	All Currently Homeless Families (N = 437)		Currently Homeless Families Receiving AFDC or GA (N=254)		Currently Homeless Families Not Receiving AFDC or GA (N=183)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Race						
Other		1.00		1.00		1.00
White	-0.039	0.96	-0.535	0.59	0.821	2.27
Black	0.380	1.46	-0.145	0.87	1.099	3.00
Location						
Rural		1.00		1.00		1.00
Urban or suburban	-1.481 *	0.23	-0.013	0.99	-2.908 **	0.05
Sex						
Female		1.00		1.00		1.00
Male	1.073 *	2.92	1.298	3.66	1.319	3.74
Age[1]						
24 and younger		1.00		1.00		1.00
25-49	0.169	1.18	-0.495	0.61	1.466 *	4.33
ADM Status[2]						
No ADM problems reported		1.00		1.00		1.00
Drug problems, ± alcohol problems, but	-0.517	0.60	-0.219	0.80	-0.319	0.73
Only mental health problems	0.870	2.39	0.901	2.46	1.382 **	3.98
Mental health plus AOD problems	-0.012	0.99	-0.609	0.54	1.244	3.47
Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	0.654	1.92	1.095 *	2.99	0.729	2.07
Length of Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	-0.238	0.79	-0.002	1.00	0.742	2.10
More than 60 months (5 years)	-2.602 **	0.07	-3.698 **	0.02	-0.939	0.39
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	0.973	2.65	1.860 *	6.42	0.441	1.55
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	0.875	2.40	1.706 *	5.51	0.957	2.60
Slept Out						
No		1.00		1.00		1.00
Yes	-0.509	0.60	-0.418	0.66	-1.204	0.30
One or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	-0.092	0.91	0.064	1.07	-0.228	0.80
Has Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	0.082	1.09	-0.848	0.43	0.486	1.63
Other insurance	1.896 **	6.66	3.117 **	22.57	1.631 *	5.11
AFDC-GA						
No		1.00				
Yes	-0.401	0.67				
Adjusted Pseudo-R^2	0.206		0.292		0.275	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01. Note: Variables missing parameter estimates or odds ratios were excluded from the model.

[1] Clients aged fifty and over were dropped from the model. [2] Clients with only alcohol problems were dropped from the model.

Table 2-5
Predictors of Emergency Room Care for Parents in Homeless Families,
All and by AFDC-GA Status
(weighted percentages)

Predictor Variables	All Currently Homeless Families (N = 437)		Currently Homeless Families Receiving AFDC or GA (N=254)		Currently Homeless Families Not Receiving AFDC or GA (N=183)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Race						
Other		1.00		1.00		1.00
White	0.570	1.77	1.089	2.97	0.350	1.42
Black	0.510	1.67	0.045	1.05	0.996	2.71
Location						
Rural		1.00		1.00		1.00
Urban or suburban	0.484	1.62	2.344 **	10.43	-0.541	0.58
Sex						
Female		1.00		1.00		1.00
Male	-0.101	0.90	3.936 *	51.20	-0.725	0.48
Age[1]						
24 and younger		1.00		1.00		1.00
25-49	-0.421	0.66	-0.163	0.85	-0.996	0.37
ADM Status[2]						
No ADM problems reported		1.00		1.00		1.00
Drug problems, ± alcohol problems, but	0.869	2.38	1.176	3.24	1.281	3.60
Only mental health problems	1.367 **	3.92	1.014	2.76	1.473 *	4.36
Mental health plus AOD problems	1.156 *	3.18	1.842 **	6.31	-0.425	0.65
Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	-0.735 *	0.48	-1.034 *	0.36	-0.556	0.57
Length of Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	0.347	1.42	0.617	1.85	0.620	1.86
More than 60 months (5 years)	-0.786	0.46	0.145	1.16	-0.318	0.73
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	0.407	1.50	0.551	1.74	-0.155	0.86
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	0.751	2.12	0.086	1.09	0.602	1.83
Slept Out						
No		1.00		1.00		1.00
Yes	-1.234	0.29	-2.295	0.10	-0.096	0.91
One or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	0.959 **	2.61	0.738	2.09	1.292	3.64
Has Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	-0.275	0.76	-0.694	0.50	-0.180	0.84
Other insurance	-0.416	0.66	-0.748	0.47	0.030	1.03
AFDC-GA						
No		1.00				
Yes	-0.161	0.85				
Adjusted Pseudo-R^2	0.137		0.222		0.213	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01. Note: Variables missing parameter estimates or odds ratios were excluded from the model.

[1] Clients aged fifty and over were dropped from the model. [2] Clients with only alcohol problems were dropped from the model.

Table 2-6
Predictors of Hospitalization for Parents in Homeless Families,
All and by AFDC-GA Status
(weighted percentages)

Predictor Variables	All Currently Homeless Families (N = 437)		Currently Homeless Families Receiving AFDC or GA (N=238)		Currently Homeless Families Not Receiving AFDC or GA (N=183)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Race						
Other		1.00		1.00		1.00
White	0.245	1.28	1.096	2.99	-0.829	0.44
Black	-0.512	0.60	-0.018	0.98	-1.674	0.19
Location						
Rural		1.00		1.00		1.00
Urban or suburban	-0.893	0.41	0.541	1.72	-2.412 *	0.09
Sex						
Female		1.00		1.00		1.00
Male	1.794	6.01	.	.	1.545	4.69
Age[1]						
24 and younger		1.00		1.00		1.00
25-49	-0.967 *	0.38	-1.484 **	0.23	-0.951	0.39
ADM Status[2]						
No ADM problems reported		1.00		1.00		1.00
Drug problems, + alcohol problems, but	1.591 *	4.91	1.091	2.98	2.909 *	18.33
Only mental health problems	1.008 *	2.74	0.205	1.23	1.665 *	5.28
Mental health plus AOD problems	1.266 *	3.55	1.722 *	5.60	0.284	1.33
Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	0.299	1.35	0.166	1.18	0.900	2.46
Length of Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	0.067	1.07	-0.181	0.83	1.143	3.14
More than 60 months (5 years)	0.994	2.70	2.061 *	7.85	-2.483	0.08
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	1.020	2.77	1.900 *	6.69	0.562	1.75
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	1.600 *	4.95	2.055 *	7.81	1.660 *	5.26
Slept Out						
No		1.00		1.00		1.00
Yes	-0.729	0.48	0.546	1.73	-1.080	0.34
One or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	0.370	1.45	-0.112	0.89	0.888	2.43
Has Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	-0.288	0.75	-0.076	0.93	-0.411	0.66
Other insurance	-1.394 *	0.25	-2.834 *	0.06	-0.474	0.62
AFDC-GA						
No		1.00				
Yes	-0.091	0.91				
Adjusted Pseudo-R^2	0.174		0.246		0.279	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01. Note: Variables missing parameter estimates or odds ratios were excluded from the model.

[1] Clients aged fifty and over were dropped from the model. [2] Clients with only alcohol problems were dropped from the model.

Table 2-7
Predictors of Whether Parents in Homeless Families Were Unable to See a Doctor when Needed, All and by AFDC-GA Status
(weighted percentages)

Predictor Variables	All Currently Homeless Families (N = 437)		Currently Homeless Families Receiving AFDC or GA (N=254)		Currently Homeless Families Not Receiving AFDC or GA (N=183)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Race						
Other		1.00		1.00		1.00
White	0.550	1.73	1.423	4.15	0.964	2.62
Black	0.016	1.02	0.067	1.07	0.468	1.60
Location						
Rural		1.00		1.00		1.00
Urban or suburban	-0.214	0.81	0.687	1.99	-0.944	0.39
Sex						
Female		1.00		1.00		1.00
Male	0.018	1.02	2.835	17.03	-0.679	0.51
Age[1]						
24 and younger		1.00		1.00		1.00
25-49	0.219	1.25	0.005	1.01	0.593	1.81
ADM Status[2]						
No ADM problems reported		1.00		1.00		1.00
Drug problems, ± alcohol problems, but	0.148	1.16	0.280	1.32	-2.677 *	0.07
Only mental health problems	1.560 **	4.76	1.746 *	5.73	1.365 *	3.91
Mental health plus AOD problems	0.237	1.27	0.356	1.43	0.646	1.91
Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	-0.356	0.70	-0.460	0.63	0.042	1.04
Length of Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	-1.809 *	0.16	-0.209	0.81	-2.569 **	0.08
More than 60 months (5 years)	-0.384	0.68	-0.048	0.95	0.989	2.69
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	-0.256	0.77	-0.866	0.42	0.398	1.49
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	-0.015	0.98	-0.832	0.44	0.525	1.69
Slept Out						
No		1.00		1.00		1.00
Yes	2.785 *	16.20	3.014	20.37	2.772 *	15.99
One or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	0.887 *	2.43	-0.034	0.97	1.957 **	7.08
Has Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	-1.462 **	0.23	-1.417	0.24	-2.234 **	0.11
Other insurance	0.217	1.24	-0.124	0.88	0.897	2.45
AFDC-GA						
No		1.00				
Yes	-0.081	0.92				
Adjusted Pseudo-R^2	0.310		0.282		0.411	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01. Note: Variables missing parameter estimates or odds ratios were excluded from the model.

[1] Clients aged fifty and over were dropped from the model. [2] Clients with only alcohol problems were dropped from the model.

Table 2-8

Predictors of Mental Health Treatment for Parents in Homeless Families with Mental Health Problems
(weighted percentages)

Predictor Variables	Any MH Treatment (N = 187)		MH Inpatient Treatment (N = 188)		MH Outpatient Treatment (N = 180)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Race						
Other		1.00		1.00		1.00
White	0.372	1.45	-0.228	0.80	0.539	1.71
Black	-0.951	0.39	0.503	1.65	-0.890	0.41
Location						
Rural		1.00		1.00		1.00
Urban or suburban	2.281 **	9.79	0.680	1.97	2.372 **	10.72
Sex						
Female		1.00		1.00		1.00
Male	0.168	1.18	-1.955	0.14	0.320 **	1.38
Age[1]						
24 and younger		1.00		1.00		1.00
25-49	1.386	4.00	0.923	2.52	1.334	3.80
ADM Status						
all other ADM statuses		1.00				
MH plus alcohol and/or drugs	1.126 *	3.08	0.285	1.33	1.141 *	3.13
Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	0.885	2.42	1.259	3.52	0.987	2.68
Length of Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	1.309	3.70	1.930	6.89	1.372	3.94
More than 60 months (5 years)	0.879	2.41			0.980	2.66
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	-0.817	0.44	-0.755	0.47	-0.989	0.37
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	0.931	2.54	0.276	1.32	0.966	2.63
Slept Out						
No		1.00		1.00		1.00
Yes	-0.293	0.75	-0.842	0.43	-0.391	0.68
One or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	-0.731	0.48	0.538	1.71	-0.803	0.45
Has Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	0.313	1.37	2.031	7.63	0.545	1.72
Other insurance	-1.561	0.21	0.901	2.46	-1.873	0.15
AFDC-GA						
No		1.00				
Yes	0.273	1.31				
Adjusted Pseudo-R^2	0.335		0.217		0.357	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01. Note: Variables missing parameter estimates or odds ratios were excluded from the model.

[1] Clients aged fifty and over were dropped from the model.

Table 2-9

Predictors of Alcohol or Drug Treatment for Parents in Homeless Families with Alcohol or Drug Problems
(weighted percentages)

Predictor Variables	Any AOD Treatment (N = 124)		AOD Inpatient Treatment (N = 124)		AOD Outpatient Treatment (N = 124)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Race						
Other		1.00		1.00		1.00
White	-0.679	0.51	-1.277	0.28	-0.406	0.67
Black	-1.108	0.33	-1.516	0.22	-2.591 *	0.07
Location						
Rural		1.00		1.00		1.00
Urban or suburban	-1.266	0.28	-0.646	0.52	-0.457	0.63
Sex						
Female		1.00		1.00		1.00
Male	3.577 *	35.78	-1.608	0.20	2.477	11.91
Age[1]						
24 and younger		1.00		.		1.00
25-49	4.639 **	103.43	.	.	4.270 **	71.55
ADM Status						
all other ADM statuses		1.00		1.00		
MH plus alcohol and/or drugs	2.614 *	13.65	-0.424	0.65	3.155 **	23.46
Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	-2.088 *	0.12	-0.079	0.92	-2.115 *	0.12
Length of Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	2.710	15.03	.	.	3.819	45.54
More than 60 months (5 years)	4.672 **	106.93	3.740 **	42.09	0.369	1.45
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	-2.368 *	0.09	1.856	6.40	-4.751 **	0.01
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	-0.300	0.74	1.666	5.29	-1.657	0.19
Slept Out						
No		.		.		.
Yes	.	.	.	.	.	.
One or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	-2.090 *	0.12	-0.793	0.45	-2.291 *	0.10
Has Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	-1.772	0.17	1.832	6.25	-2.807	0.06
Other insurance	-0.165	0.85	0.834	2.30	-1.877	0.15
AFDC-GA						
No		1.00		1.00		1.00
Yes	2.962	19.33	2.134	8.45	3.883 *	48.59
Adjusted Pseudo-R^2	0.540		0.363		0.592	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01. Note: Variables missing parameter estimates or odds ratios were excluded from the model.

[1] Clients aged fifty and over were dropped from the model.

CHAPTER 3
CHILDREN IN HOMELESS FAMILIES

INTRODUCTION

This chapter examines whether the health insurance status of children living with homeless adults affects the probability that they will receive health care. The focus of this chapter is again on the 465 homeless families that were part of the NSHAPC sample. Having examined the effect of health insurance for the family head in Chapter 2, we now turn to the effect of health insurance for children under eighteen years old who are living with homeless adults. All findings are based on the adult's responses about their children's health insurance and health care.

Though the federal SCHIP program, with its expanded insurance coverage for children was not authorized until 1997, it is still likely that all children in homeless families would have been eligible for Medicaid in 1996. Considering this, it is somewhat surprising that in 20.4 percent of homeless families, the children were reported to be without any health insurance (Table 3-1). This is smaller than the percentage of their parents without health insurance (32.5 percent), but it indicates that a sizable share of children did not access health insurance for which they were probably eligible.

A closer look at Table 3-1 reveals that, similar to adults in homeless families, almost all of the children who were reported to be without health insurance were in families that did not receive AFDC or GA. Only 58 percent of children in families without AFDC or GA have health insurance. Although this level of coverage is considerably better than their parents, among whom only 33 percent have insurance), it is still far short of the full coverage that might be expected from their income eligibility. In contrast, 96 percent of children in AFDC-GA families have health insurance. Thus despite the presumptive eligibility of all children in homeless families for public health insurance, the extent to which they actually had insurance is still strongly associated with the family's receipt of other public benefits. Nevertheless, it is interesting that even 4 percent of children in families receiving AFDC or GA did not have health insurance, considering that all children in families receiving these benefits would have been eligible for public programs.

This chapter first describes the number and ages of children under 18 years old and identified as living with a homeless adult in the survey, including any differences that might be associated with the family's receipt of AFDC or GA.[9] We continue with an overview of the types of health

[9] NSHAPC did not collect much descriptive information about children in homeless families. Other than their sex, age, living arrangement, and health care use, all other predictor variables in the children's analyses are really their homeless parent's characteristics. For a more complete look at demographic characteristics of adults in homeless families, see Table 2-1.

care that the children of homeless adults were reported to have, again examining differences between children in families that received AFDC or GA and those that did not.

CHARACTERISTICS OF CHILDREN IN HOMELESS FAMILIES

The NSHAPC asked respondents to describe every child under the age of 18 who was living with the client at the time of the survey. From Table 3-1 we see that about a third of homeless adults with children had at least three children living with them, while 28 percent had two children and almost 40 percent had just one child. Families not receiving AFDC-GA appeared to be slightly larger than families receiving AFDC-GA, but the differences are not significant.

The age of the youngest child living in homeless families did not differ between those receiving and not receiving AFDC. Just over a quarter of all homeless families include a child younger than two. The rest are about evenly split between the youngest child being a preschooler (ages 3 through 5) or of school age (6 and older).

ACCESS TO AND USE OF CARE

In general, children of homeless adults have better access to health care and are more likely to visit a doctor than their parents, no matter the family's benefit status (Table 3-2). Most (87 percent) children in homeless families were reported to have received health care from a doctor or nurse in the year prior to the interview, and only 10 percent could not receive care when they needed it.

Still, significant differences exist in the level of access to and use of health care between children in families receiving AFDC-GA and those in families not receiving AFDC-GA. Children in families receiving AFDC-GA are significantly less likely to have been unable to see a doctor when they needed to (3 versus 19 percent). However, children in families *not* receiving AFDC-GA are significantly more likely than those in families receiving AFDC-GA to receive care in an ambulatory care setting (75 versus 59 percent).

RESULTS OF REGRESSION ANALYSES: INSURANCE, USE, AND ACCESS

WHO GETS HEALTH INSURANCE?

Medicaid Receipt

The same variables predict children's receipt of Medicaid as predicted their parents' coverage, as might be expected. Children in families that receive AFDC-GA or other public benefits are the most likely to be covered by Medicaid. Children of veterans and children in a family in which the youngest child is under two are also more likely to be covered by Medicaid.

Receipt of Other Health Insurance

Receiving AFDC-GA decreases the likelihood that children will be covered by non-Medicaid sources of health insurance, just as was found for parents in homeless families. However, our model predicting children's non-Medicaid coverage suggests that other types of public benefits do have a positive effect on coverage, in contrast to our findings for adults in homeless families. Being the child in a household receiving Social Security or SSDI increases the likelihood that the child will be covered through non-Medicaid sources, mostly Medicare.

Other than public benefits, the only factor that has a significant effect on children's receipt of non-Medicaid health insurance coverage is the length of their homeless parent's spell of homelessness. If the parent has been homeless for more than five years, the child is less likely to receive non-Medicaid health insurance.

RESULTS FROM THE NSHAPC SECTION ON PHYSICAL HEALTH CARE

The descriptive statistics presented above only begin to describe the differences in access to health care and treatment that exist between children in families with and without AFDC-GA. In this section we present results from regression models that control for a range of variables in an effort to determine the effect of Medicaid and other types of health insurance on all types of treatment. We again treat Medicaid and other health insurance as separate dummy variables, each compared to the omitted category of not having any health insurance (see Chapter 2).

Contact with a Doctor or Nurse for Health Reasons

Table 3-3 shows predictors of any contact with a doctor or a nurse in the past year among all children in homeless families, and among those with and without AFDC-GA. Neither type of health insurance has a significant effect on receipt of care; thus having health insurance does not seem to predict our broadest measure of health care utilization for children in homeless families. The factors that do predict health care treatment vary depending on whether we are looking at families with or without AFDC-GA. Only sleeping out in the past week affects receipt of care among AFDC-GA children (negatively). Among families not receiving AFDC-GA, the children of both white and African American families were less likely than families of all other races to have visited a doctor or nurse. The same was true for children in urban or suburban areas (compared to rural areas), and children in families with two children (compared to three or more children). Children in families not receiving AFDC-GA that were headed by a male, had received help getting benefits or finding housing in the past month, had spent time in an emergency or transitional shelter, or whose youngest child was less than six years old were significantly more likely to have visited a doctor or nurse in the past year.

Ambulatory Care

Medicaid has contradictory effects on children's use of ambulatory care in the year prior to the NSHAPC interview. Having Medicaid makes children in families receiving AFDC-GA significantly *less* likely to receive ambulatory care, while Medicaid receipt has a significant positive effect for children in families not receiving AFDC-GA. As so few children in AFDC-GA families are *not* covered by Medicaid, some third factor may explain both lack of health care coverage and lack of care, making the association between Medicaid and care receipt non-causal. AFDC-GA receipt itself does not affect receipt of ambulatory care.

Other than Medicaid, the same factors do not make a difference in receipt of ambulatory care for children in families with and without AFDC-GA. For children in families receiving AFDC-GA, having a male homeless parent decreases the likelihood that the child will receive ambulatory care, while being age 25-49 (compared to 24 and younger) and being interviewed or spending time in an emergency or transitional shelter all increase the likelihood of the child receiving ambulatory care.

For children in families not receiving AFDC-GA we find positive effects for children in families headed by a male and those that have received help getting benefits in the past month. Negative effects were found for families with two children (compared to three or more children) or if the parent slept outside in the week prior to being interviewed.

Emergency Room Care

In contrast to the effects for ambulatory care, those of health insurance on children in homeless families' use of emergency room care are consistent across the subgroups of families with and without AFDC-GA. Having health insurance other than Medicaid has a significant positive effect on emergency room use, while having Medicaid does not make a difference. This is the only effect of health insurance on emergency room use we found for any population.

The direction of other variables' effects on emergency care was similar between children in families with and without AFDC-GA, though the power of these effects differed between the two subgroups of families. Among all families, children of adults with drug and/or alcohol problems only or mental health problems only were more likely to receive care from an emergency room. We found the same effects for families with and without AFDC-GA, though the effect of drug or alcohol problems alone was not significant for families not receiving AFDC-GA. In families receiving these benefits, children of adults with mental health *and* substance abuse problems were *less* likely to receive emergency room treatment.

For families with AFDC-GA, children of white and African American parents were more likely to receive emergency care, as were those in families staying in emergency or transitional shelters. In families not receiving AFDC-GA, children of male-headed families were more likely to receive emergency room care, while children in families with less than three children were less likely to receive this type of care.

Hospitalization

The results displayed in Table 3-6 show that, similar to emergency room care, other non-Medicaid types of health insurance have a larger effect on hospital care than Medicaid. Except for children in families receiving AFDC-GA, receipt of non-Medicaid health insurance increases the likelihood that the child will receive hospital care.

The only consistent significant effect for families with and without AFDC-GA was the effect of having a homeless parent with mental health problems only (compared to adults with no ADM problems), which is positively associated with the child receiving hospital care. Children of parents with only substance use problems were also more likely to be hospitalized, though the effect was significant only for children in families receiving AFDC-GA.

We again find that for children in families receiving AFDC-GA, spending time in an emergency or transitional shelter has a positive effect on hospital care. Children of white and African Americans families receiving AFDC-GA were more likely to receive hospital care (compared to other races), as were those in families with a child less than two years old (relative to families with a youngest child older than five).

In families not receiving AFDC-GA, children of homeless families headed by a male were more likely than in those headed by a female to be hospitalized. Those in families with less than three children were less likely than those in families with at least three children to receive hospital care in the last year. This may be just a matter of the odds of at least one child in large families needing hospitalization over any given period of time.

Inability to Obtain Care When Needed

Though a child's receipt of Medicaid does not seem to affect receipt of specific types of health care, the results shown in Table 3-7 suggest that having Medicaid does make it less likely that a child will be unable to access health care when needed. Having Medicaid makes it more likely that children will be able to get care when needed, according to their homeless parents. This effect occurs for both subgroups of families, though it is significant only for all families combined.

Ability to obtain care when needed is also the only health care indicator that shows an effect of AFDC-GA receipt, holding constant health insurance coverage. Children in AFDC-GA families are more likely to be able to get needed care.

The only factor showing the same effect in both subgroups of children is having a parent with more than one chronic medical condition. Children in such families have a harder time getting care when needed, whether or not the families receive AFDC or GA.

For children in families receiving AFDC-GA, those in African American families were significantly more likely to report that the child was able to access care (compared to all other nonwhite races), while those whose parents had received help with housing options had more

trouble accessing needed care than those whose families had not received this type of assistance. Children in families not receiving AFDC-GA where the parent has one or more chronic physical conditions, only mental health problems, or both mental health and substance abuse problems were less likely to be able to obtain care (compared to adults with no ADM problems), while those in families from urban/suburban areas (compared to rural areas) were more likely to be able to access care.

SUMMARY

What is clear from the above analysis is that children are more likely than their parents to have Medicaid, but not other types of health insurance. One in three homeless parents have no health insurance, but only one in five children in these families lacks coverage. Less clear for children in homeless families are the effects of having health insurance on service use.

The effects of having Medicaid and other types of health insurance for children depend largely on the type of care and whether or not the child's family receives AFDC or General Assistance.[10] Both Medicaid and other health insurance increased the chances that a child would be hospitalized in the past year; children in non-AFDC-GA families were the source of this effect. Having Medicaid increased the likelihood that children in non-AFDC-GA families would receive ambulatory care, but actually *decreased* those odds for children in families with AFDC-GA. Neither Medicaid nor other types of health insurance increased the odds of our most general variable—having seen a doctor or nurse in the past year for any reason.. Similarly, Medicaid did not alter the odds of receiving care in an emergency room. Contrary to expectations, having other types of health insurance *did* increase homeless children's chances of receiving emergency room care, across all subgroups.

Taking these findings together, it seems appropriate to conclude that health insurance may make it more likely that children in some homeless families will receive some types of health care, but the effects are spotty. Other than health insurance there are few reliable predictors of service use, though the location where the client had spent time in the past week or was interviewed does seem to have an effect on access to care. Specifically, the children of clients interviewed or spending time in emergency or transitional shelters were generally more likely to access several types of health care, while children of clients who indicated that they had slept outside in the past week were often found to be less likely to access care. These findings were not found to be significant for all types of care, but their overall consistency does support the argument that homeless families with more of an attachment to the system, as indicated in where the client spends time or sleeps, could also extend to an attachment to service use and health care.

[10] No Medicaid or other health insurance effects on children's use of care were influenced by including or excluding AFDC-GA receipt in the models.

Table 3-1
Characteristics of Children and Their Homeless Families, All and by AFDC-GA Status
(weighted percentages)

	Client Group		
	All Currently Homeless Families (N = 462)	Currently Homeless Families Receiving AFDC or GA (N=266)	Currently Homeless Families Not Receiving AFDC or GA (N=195)
Percent of All Currently Homeless Families	100.0	56.6	43.4
Child's Health Insurance Status			
Medicaid	73.0	93.1*	47.0*
Other health insurance	6.3	2.7	10.9
No health insurance	20.4	3.9*	41.9*
Number of Children in Homeless Household			
1	39.5	43.7	34.4
2	27.8	26.4	30.1
3 or more	32.7	30.0	35.5
Age of Youngest Child in Homeless Household			
Less than 2	26.1	26.9	25.0
2 through 5	35.5	37.8	33.2
6 or older	38.4	35.3	41.8

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. Note: Percentages do not sum to 100% due to rounding, or because respondents could give more than one response.
Cells marked with an asterisk (*) are significantly different from each other at $p < .05$.

Table 3-2

Children in Homeless Families' Access to Care, All and by AFDC-GA Status

(weighted percentages)

Within the Past 12 Months:	Client Group		
	Children in All Currently Homeless Families (N = 462)	Children in Currently Homeless Families Receiving AFDC or GA (N=266)	Children in Currently Homeless Families Not Receiving AFDC or GA (N=192)
Child(ren) Received Care of Any Type from a Doctor or Nurse	86.7	89.6	82.6
Setting of Care:[1]			
An ambulatory care setting	65.9	58.5*	75.2*
A hospital as an inpatient	45.5	45.7	45.7
An emergency room	38.3	35.5	42.5
Child(ren) Needed to See a Doctor or Nurse but Was Not Able to	10.0	2.9*	19.4*

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. Note: Percentages do not sum to 100% due to rounding, or because respondents could give more than one response.
Cells marked with an asterisk (*) are significantly different from each other at $p < .05$.
[1]Respondents' children may have received care in more than one setting during the past 12 months.

Table 3-3
Predictors of Any Physical Health Care for Children in Homeless Families, All and by AFDC-GA Status
(weighted percentages)

Predictor Variables	Children in All Currently Homeless Families (N =437)		Children in Currently Homeless Families Receiving AFDC or GA (N=266)		Children in Currently Homeless Families Not Receiving AFDC or GA (N=192)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Parent's Race						
Other		1.00		1.00		1.00
White	-1.693	0.18	-0.354	0.70	-4.932 **	0.01
Black	-1.296	0.27	0.952	2.59	-5.611 **	0.00
Location						
Rural		1.00		1.00		1.00
Urban or suburban	-0.992	0.37	0.204	1.23	-5.981 **	0.00
Parent's Sex						
Female		1.00		1.00		1.00
Male	1.623 **	5.07	-1.217	0.30	3.119 **	22.63
Paent's Age[1]						
24 and younger		1.00		1.00		1.00
25-49	0.792	2.21	-0.902	0.41	4.982 **	145.74
Parent's ADM Status[2]						
No ADM problems reported		1.00		1.00		1.00
Drug problems, + alcohol problems, but	0.798	2.22	-0.307	0.74		
Only mental health problems	1.465 *	4.33	1.599	4.95	2.273	9.71
Mental health plus AOD problems	2.029	7.60	2.318	10.16	0.449	1.57
Parent Received Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	0.818	2.27	-0.505	0.60	5.129 *	168.89
Length of Parent's Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	-0.856	0.43	-2.357	0.09	1.599	4.95
More than 60 months (5 years)	1.316	3.73	.	.	-2.879	0.06
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	2.212 **	9.14	1.623	5.07	5.655 **	285.81
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	0.849	2.34	0.996	2.71	3.790 *	44.27
Slept Out						
No		1.00		1.00		1.00
Yes	-3.450 **	0.03	-3.881 **	0.02	-6.029 **	0.00
Parent Has One or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	-1.299 *	0.27	-1.833	0.16	-3.424	0.03
# of Children with Client						
1 child	-0.371	0.69	-1.163	0.31	3.022	20.53
2 children	-0.871	0.42	1.256	3.51	-2.219 *	0.11
3 or more children		1.00		1.00		1.00
Age of Youngest Child with Client						
Less than 2 years old	1.708	5.52	-0.617	0.54	5.219 **	184.84
Two to 5 years old	0.867	2.38	0.048	1.05	3.077 *	21.69
Older than 5		1.00		1.00		1.00
Child's Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	0.547	1.73	2.224	9.25	-0.616	0.54
Other insurance	2.218	9.19	1.130	3.10	.	.
AFDC-GA						
No		1.00				
Yes	0.598	1.82				
Adjusted Pseudo-R2	0.489		0.507		0.770	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01.
[1] Children of clients aged 50 and older dropped from the model. [2] Children of clients with only alcohol problems were dropped from the model.

Table 3-4
Predictors of Ambulatory Care for Children in Homeless Families, All and by AFDC-GA Status
(weighted percentages)

Predictor Variables	Children in All Currently Homeless Families (N = 437)		Children in Currently Homeless Families Receiving AFDC or GA (N=266)		Children in Currently Homeless Families Not Receiving AFDC or GA (N=192)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Parent's Race						
Other		1.00		1.00		1.00
White	0.978	2.66	1.268	3.55	-0.103	0.90
Black	-0.535	0.59	-1.132	0.32	-0.556	0.57
Location						
Rural		1.00		1.00		1.00
Urban or suburban	-0.552	0.58	0.260	1.30	-1.502	0.22
Parent's Sex						
Female		1.00		1.00		1.00
Male	0.524	1.69	-3.541 *	0.03	2.092 **	8.10
Paent's Age[1]						
24 and younger		1.00		1.00		1.00
25-49	1.187 *	3.28	1.368 *	3.93	1.450	4.26
Parent's ADM Status[2]						
No ADM problems reported		1.00		1.00		1.00
Drug problems, + alcohol problems, but	-0.279	0.76	-0.431	0.65	0.261	1.30
Only mental health problems	0.159	1.17	-0.699	0.50	0.951	2.59
Mental health plus AOD problems	0.238	1.27	0.161	1.18	-1.445	0.24
Parent Received Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	0.665	1.94	0.512	1.67	2.144 **	8.53
Length of Parent's Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	-0.180	0.84	0.689	1.99	0.972	2.64
More than 60 months (5 years)	-0.912	0.40	-2.277	0.10	-0.512	0.60
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	1.890 **	6.62	2.296 **	9.93	0.394	1.48
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	0.637	1.89	1.582 *	4.86	-1.293	0.27
Slept Out						
No		1.00		1.00		1.00
Yes	-2.539 **	0.08	-1.635	0.19	-3.253 *	0.04
Parent Has One or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	0.259	1.30	0.940	2.56	-0.991	0.37
# of Children with Client						
1 child	-0.081	0.92	0.102	1.11	-0.252	0.78
2 children	-0.239	0.79	1.201	3.32	-2.093 **	0.12
3 or more children		1.00		1.00		1.00
Age of Youngest Child with Client						
Less than 2 years old	0.328	1.39	0.282	1.33	0.789	2.20
Two to 5 years old	-0.015	0.98	0.086	1.09	0.794	2.21
Older than 5		1.00		1.00		1.00
Child's Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	0.537	1.71	-2.441 **	0.09	1.984 *	7.27
Other insurance	1.672	5.32	-2.117	0.12	1.304	3.68
AFDC-GA						
No		1.00				
Yes	-0.425	0.65				
Adjusted Pseudo-R2	0.262		0.415		0.456	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01.
[1] Children of clients aged 50 and older dropped from the model. [2] Children of clients with only alcohol problems were dropped from the model.

Table 3-5
Predictors of Emergency Room Care for Children in Homeless Families, All and by AFDC-GA Status
(weighted percentages)

Predictor Variables	Children in All Currently Homeless Families (N = 437)		Children in Currently Homeless Families Receiving AFDC or GA (N=266)		Children in Currently Homeless Families Not Receiving AFDC or GA (N=192)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Parent's Race						
Other		1.00		1.00		1.00
White	1.258 **	3.52	2.436 **	11.43	0.208	1.23
Black	0.588	1.80	1.335 *	3.80	0.127	1.13
Location						
Rural		1.00		1.00		1.00
Urban or suburban	0.210	1.23	0.226	1.25	0.377	1.46
Parent's Sex						
Female		1.00		1.00		1.00
Male	1.379 *	3.97	1.599	4.95	1.606 *	4.98
Paent's Age[1]						
24 and younger		1.00		1.00		1.00
25-49	-0.388	0.68	-0.637	0.53	-0.705	0.49
Parent's ADM Status[2]						
No ADM problems reported		1.00		1.00		1.00
Drug problems, + alcohol problems, but	1.551 *	4.71	1.620 *	5.05	2.095	8.12
Only mental health problems	1.852 **	6.37	1.784 *	5.95	1.258 *	3.52
Mental health plus AOD problems	-0.779	0.46	-1.182 *	0.31	-1.015	0.36
Parent Received Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	0.544	1.72	0.806	2.24	-0.149	0.86
Length of Parent's Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	0.574	1.78	0.939	2.56	0.378	1.46
More than 60 months (5 years)	1.802 *	6.06	2.209	9.11	1.528	4.61
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	1.260 **	3.52	1.691 **	5.42	0.480	1.62
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	0.862	2.37	1.233 *	3.43	-0.024	0.98
Slept Out						
No		1.00		1.00		1.00
Yes	-1.881 *	0.15	-1.604	0.20	0.228	1.26
Parent Has One or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	-0.019	0.98	-0.231	0.79	0.480	1.62
# of Children with Client						
1 child	-0.965 *	0.38	0.172	1.19	-2.757 **	0.06
2 children	-1.311 **	0.27	-0.178	0.84	-2.918 **	0.05
3 or more children		1.00		1.00		1.00
Age of Youngest Child with Client						
Less than 2 years old	0.442	1.56	0.721	2.06	-0.031	0.97
Two to 5 years old	0.137	1.15	0.648	1.91	0.079	1.08
Older than 5		1.00		1.00		1.00
Child's Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	-0.094	0.91	0.285	1.33	0.535	1.71
Other insurance	1.573 *	4.82	2.667 *	14.39	1.636 *	5.13
AFDC-GA						
No		1.00				
Yes	0.191	1.21				
Adjusted Pseudo-R2	0.271		0.343		0.362	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01.
[1] Children of clients aged 50 and older dropped from the model. [2] Children of clients with only alcohol problems were dropped from the model.

Table 3-6
Predictors of Hospitalization for Children in Homeless Families,
All and by AFDC-GA Status
(weighted percentages)

Predictor Variables	Children in All Currently Homeless Families (N = 437)		Children in Currently Homeless Families Receiving AFDC or GA (N=266)		Children in Currently Homeless Families Not Receiving AFDC or GA (N=192)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Parent's Race						
Other		1.00		1.00		1.00
White	1.829 **	6.23	3.484 **	32.58	-0.003	1.00
Black	0.773	2.17	1.301 *	3.67	0.306	1.36
Location						
Rural		1.00		1.00		1.00
Urban or suburban	0.753	2.12	1.158	3.19	0.177	1.19
Parent's Sex						
Female		1.00		1.00		1.00
Male	1.746 **	5.73	2.349	10.48	1.990 *	7.31
Paent's Age[1]						
24 and younger		1.00		1.00		1.00
25-49	-0.258	0.77	-0.527	0.59	-0.584	0.56
Parent's ADM Status[2]						
No ADM problems reported		1.00		1.00		1.00
Drug problems, + alcohol problems, but	1.477 *	4.38	1.660 *	5.26	2.240	9.39
Only mental health problems	2.066 **	7.89	2.213 *	9.15	1.544 *	4.69
Mental health plus AOD problems	-0.094	0.91	-0.468	0.63	-0.668	0.51
Parent Received Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	-0.004	1.00	-0.204	0.82	0.083	1.09
Length of Parent's Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	0.280	1.32	0.658	1.93	0.388	1.47
More than 60 months (5 years)	1.118	3.06	1.698	5.47	1.362	3.90
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	1.520 **	4.57	2.327 **	10.25	0.375	1.45
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	1.600 **	4.95	2.228 **	9.28	0.248	1.28
Slept Out						
No		1.00		1.00		1.00
Yes	-2.071 *	0.13	-2.007	0.13	0.093	1.10
Parent Has One or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	0.472	1.60	0.417	1.52	0.618	1.86
# of Children with Client						
1 child	-0.618	0.54	0.597	1.82	-2.595 **	0.07
2 children	-1.409 **	0.24	-0.739	0.48	-2.759 **	0.06
3 or more children		1.00		1.00		1.00
Age of Youngest Child with Client						
Less than 2 years old	0.909	2.48	1.549 *	4.71	0.147	1.16
Two to 5 years old	0.310	1.36	0.797	2.22	0.401	1.49
Older than 5		1.00		1.00		1.00
Child's Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	-0.071	0.93	-0.474	0.62	0.594	1.81
Other insurance	1.491 *	4.44	1.855	6.39	1.242 *	3.46
AFDC-GA						
No		1.00				
Yes	0.477	1.61				
Adjusted Pseudo-R2	0.281		0.399		0.373	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01.
[1] Children of clients aged 50 and older dropped from the model. [2] Children of clients with only alcohol problems were dropped from the model.

Note: Variables missing parameter estimates or odds ratios were excluded from the model.

Table 3-7
Predictors of Whether Children in Homeless Families were Unable to See a Doctor when Needed, All and by AFDC-GA Status
(weighted percentages)

Predictor Variables	Children in All Currently Homeless Families (N = 437)		Children in Currently Homeless Families Receiving AFDC or GA (N=266)		Children in Currently Homeless Families Not Receiving AFDC or GA (N=192)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Parent's Race						
Other		1.00		1.00		1.00
White	0.087	1.09	-2.068	0.13	0.396	1.49
Black	-0.181	0.83	-4.583 **	0.01	1.005	2.73
Location						
Rural		1.00		1.00		1.00
Urban or suburban	-0.987	0.37	5.249	190.41	-2.112 *	0.12
Parent's Sex						
Female		1.00		1.00		1.00
Male	1.060	2.89	2.975	19.60	0.653	1.92
Paent's Age[1]						
24 and younger		1.00		1.00		1.00
25-49	0.131	1.14	0.020	1.02	0.177	1.19
Parent's ADM Status[2]						
No ADM problems reported		1.00		1.00		1.00
Drug problems, + alcohol problems, but	-1.089	0.34	1.962	7.12	.	.
Only mental health problems	1.550 *	4.71	2.042	7.71	2.055 *	7.81
Mental health plus AOD problems	0.848	2.33	0.075	1.08	2.392 *	10.94
Parent Received Help Getting Benefits, etc.						
No						
Yes	-0.610	0.54	3.146 **	23.25	-1.897 *	0.15
Length of Parent's Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	-1.715	0.18	2.602	13.49	-1.312	0.27
More than 60 months (5 years)	-0.774	0.46	.	.	0.036	1.04
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	-0.047	0.95	-3.201	0.04	0.467	1.60
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	0.254	1.29	1.479	4.39	0.308	1.36
Slept Out						
No		1.00		1.00		1.00
Yes	-0.174	0.84	1.413	4.11	-1.854	0.16
Parent Has One or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	0.675	1.96	2.532 *	12.57	1.320 *	3.74
# of Children with Client						
1 child	-0.781	0.46	1.131	3.10	-1.490	0.23
2 children	-0.319	0.73	0.560	1.75	-0.045	0.96
3 or more children		1.00		1.00		1.00
Age of Youngest Child with Client						
Less than 2 years old	0.409	1.51	-2.486	0.08	0.895	2.45
Two to 5 years old	0.545	1.72	0.695	2.00	0.802	2.23
Older than 5		1.00		1.00		1.00
Child's Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	-1.033	0.36	-4.447	0.01	-1.214	0.30
Other insurance	-0.231	0.79	.	.	0.303	1.35
AFDC-GA						
No		1.00				
Yes	-1.539 **	0.21				
Adjusted Pseudo-R2	0.353		0.411		0.386	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01.
[1] Children of clients aged 50 and older dropped from the model. [2] Children of clients with only alcohol problems were dropped from the model.

Note: Variables missing parameter estimates or odds ratios were excluded from the model.

CHAPTER 4
SINGLE HOMELESS ADULTS

INTRODUCTION

This chapter examines whether having health insurance affects the probability that single homeless adults will receive health care. Among the 2,472 single homeless adults who were part of the NSHAPC sample, it focuses on receipt of care during the 12 months before the respondent was interviewed in the fall of 1996. This was the period just before the rules changed for Supplemental Security Income (SSI) in January 1997, so it was still possible for a person to qualify for and remain on SSI with a primary diagnosis of substance abuse. In most states, receipt of SSI automatically qualifies the beneficiary for Medicaid, so SSI is important for the access it gives to health insurance as well as for the cash assistance it provides. SSI receipt interacts with many of the outcomes of interest in this report—so much so that many effects are swamped. We therefore present analyses separately for those with and without SSI, as well as for the entire singles subsample.

We begin by looking at demographic and other characteristics of single homeless adults, including any differences that might be associated with receipt of SSI. We continue with an overview of the types of health care reported during the past 12 months, again examining differences between singles receiving and not receiving SSI.

CHARACTERISTICS OF SINGLE HOMELESS ADULTS

In keeping with the common view of single homeless people, the single adults in the NSHAPC sample were much more likely to be male than female. About three-quarters were male, regardless of whether or not they received SSI (Table 4-1).[11]

Single homeless people with and without SSI did not differ in their racial background, but they did differ by age. Those with SSI were more likely to be 50 or older and those without SSI were more likely to be under 50 years of age. The large majority of both groups were found in central cities (at least 7 in 10), with approximately another 1 in 5 found in suburban and urban fringe areas. Nor did they differ in their proportion of veterans (about 1 in 4 for each group). Those with SSI were almost twice as likely as single adults without SSI to have been homeless more than 60 months (37.0 versus 21.6 percent).

There were significant differences in the extent to which single homeless people with and without SSI reported ADM problems in the year before their NSHAPC interview. This finding

[11] All differences mentioned in the text are significant at $p < .05$ or better. Differences that do not reach this level of significance are not discussed.

is not unexpected, since having a severe and persistent disability is a major eligibility criterion for SSI. Single adults with and without SSI did not differ in their proportion with no past-year ADM problems (about 1 in 4 in each group), or in the proportion with a combination of mental health and substance abuse problems (31-32 percent). However, those with SSI were more than twice as likely as those without to report having *only* mental health problems, and those without SSI were more likely to report substance use problems, whether only with alcohol or with drugs with or without alcohol. Single homeless adults with SSI were also twice as likely as those without it to have three or more co-occurring chronic physical illnesses, which might also have helped them to qualify for SSI benefits.

There was a very large difference in Medicaid receipt between single adults with and without SSI. Most people with SSI had Medicaid (86.6 percent), compared to only 18.7 percent among those without SSI. Nevertheless, about two-thirds of single adults with Medicaid did *not* receive SSI, basically because so few singles actually received SSI—a notoriously difficult program to get into. The two groups reported equal rates of having other health insurance, but clearly those without SSI were far more likely to have no health insurance of any kind.

In addition to the cash benefits that the SSI group received, more of them also received other means-tested benefits than was true for those without SSI. Food stamps was the most commonly received other benefit. In addition, respondents with SSI were more likely than those without it to have received help from a case manager or other helping professional to access public benefits or get into or remain in housing. Involvement in the more intensive components of the homeless assistance system may account for this greater access to help. Those with SSI were more likely than those without it to have used a transitional housing program in the past week, and less likely to have used emergency shelter or to have slept in places not meant for habitation. Thus those with SSI appear more connected to programs and services, which may also affect their access to medical care.

ACCESS TO AND USE OF CARE

Unlike the results for homeless families, in which differences in access to care were unexpectedly in favor of households *without* cash benefits and with less health insurance coverage, the results for single homeless adults are in line with expectations. The analyses we have done for this report are the first, to our knowledge, that distinguish results for singles and families. Glied et al. (1998) used data only on single homeless men, and so had no opportunity to examine the situation for families. Kushel, Vittinghoff, and Haas (2001), although using the same NSHAPC data that we are using, not only did not conduct separate analyses for singles and families, but did not use a family status variable as a control in their regression analyses. Our data make plain that the results reported in the Kushel, Vittinghoff, and Haas analyses are driven by the situation of single homeless people, who dominate the homeless population in terms of numbers in a point-in-time survey such as NSHAPC, and mask the quite different situation for homeless families.

There were no differences between single homeless adults with and without SSI in their probability of being treated by a doctor or nurse for health reasons,[12] nor in their use of ambulatory care settings and emergency rooms. However, singles with SSI were more likely than those without it to have been hospitalized during the year preceding the NSHAPC interview. For the most part the two groups do not differ with respect to the frequency with which they received medical care during the last year, except that those receiving SSI were more likely to report receiving care for 11 or more separate episodes of illness. Single homeless adults without SSI reported more unmet need than those with SSI, in the form of needing to see a doctor or nurse but not being able to do so.

Receipt of mental health treatment was assessed only for people who revealed a mental health problem within the 12 months before being interviewed. The same was true for substance abuse treatment and having a substance abuse problem. No differences were observed between singles with and without SSI in the rate of receiving substance abuse treatment, either overall or specifically for outpatient and inpatient treatment. However, significantly more of the SSI group received mental health treatment, both overall and in inpatient and outpatient settings. The finding for mental health treatment is not surprising, since the SSI group was more likely to report mental health problems. But the similarity in rates of substance abuse treatment between the two groups *is* surprising, given that those without SSI were more likely to report substance abuse problems than those with SSI.

RESULTS OF REGRESSION ANALYSES: INSURANCE, USE, AND ACCESS

PREDICTING INSURANCE RECEIPT

Medicaid Receipt

The answer to the question of which single homeless adults receive Medicaid and which do not is that those with other benefits, particularly SSI, are the most likely to have Medicaid. Controlling for a range of demographic and other variables, SSI receipt is the best predictor of whether a single homeless adult will receive Medicaid, with an odds ratio of 45.11. Those that do receive SSI are much more likely to receive Medicaid, as are those that receive other types of public cash benefits (odds ratio of 4.86).

Other factors linked to Medicaid receipt also relate to the types of services the client accesses. For instance, those spending time in a transitional shelter are more likely to receive Medicaid,

[12] Although this question was asked as the first in the NSHAPC section on physical health care, and refers to "health reasons" and "routine checkups," it seems likely in light of the influence of ADM statuses on results that people answered it affirmatively if they saw a doctor or nurse for any reason, including in relation to a mental health or substance abuse problem. Thus it should be considered the most general indicator of use of care.

while those who slept outside in the week prior to being interviewed were significantly less likely to have this form of health coverage.

Being homeless for less than a month and being a veteran decrease the likelihood that the client will receive Medicaid, whereas having every combination of ADM problem except mental health only increases the likelihood of receiving Medicaid.

Receipt of Other Health Insurance

Public benefits also relate to receipt of other non-Medicaid health insurance, though the types of benefits that make a difference are different than those that affect Medicaid receipt. In particular, the non-means-tested benefits of Social Security and Social Security Disability Insurance (SSDI) both increase the likelihood of receiving other health coverage, which mostly is Medicare. SSI does not affect receipt of non-Medicaid health insurance.

In addition to Social Security benefits, analyses indicate other avenues to coverage. Being a veteran can lead to VA coverage; being employed can lead to employer coverage. Both of these variables have a significant positive effect on receipt of non-Medicaid health insurance.

Other demographic variables that have an effect are being white or African-American, which both have positive effects on non-Medicaid coverage compared to people of other races, including Hispanics.

RESULTS FROM THE NSHAPC SECTION ON PHYSICAL HEALTH CARE

To assess the effects of having insurance on receipt of health care using logistical regression analyses, Medicaid and other health insurance are treated as separate dummy variables, comparing each to the omitted category of not having any health insurance. Although results for single homeless adults are more consistent than those for adults in homeless families, some anomalies remain. Combining the two types of insurance into an insurance/no insurance variable just obscured those differences and masked the effects of having some type of health insurance other than Medicaid, so we retained both types of insurance in our models.

Contact with a Doctor or Nurse for Health Reasons

Having Medicaid made it more likely that single homeless adults received treatment from a doctor or nurse in the 12 months preceding the interview (Table 4-3). Having other health insurance had the same effect. In addition, SSI produced its own significant effect, which was negative—those *with* SSI were *less* likely to have seen a doctor or nurse in the past year. Each health insurance variable was significant for singles without SSI, but only other health insurance increased the likelihood of care for those with SSI.

Only one other variable, having three or more chronic physical conditions, affected (positively) the likelihood of care for both singles subgroups, and therefore also for all singles. Singles with SSI were more likely to receive care if they were in an urban or suburban setting as opposed to a rural one, and less likely to receive care if they had had assistance getting housing benefits. Neither of these variables affected the probability of receiving care for singles without SSI, and thus were not significant in the model for all singles. Being male and having mental health plus substance abuse problems increased the probability of care for those without SSI, which was decreased if one had slept in places not meant for habitation during the last week. The latter two variables were also significant when all homeless single adults were analyzed together in the same model.

Ambulatory Care

Having Medicaid and having other health insurance increased the likelihood that single homeless adults would receive care in ambulatory settings, but the effect stemmed entirely from singles without SSI (Table 4-4). For this group, having other health insurance also increased the odds of getting ambulatory care. Having SSI affected receipt of ambulatory care *negatively*. Having three or more chronic physical conditions increased the probability of receiving ambulatory treatment for those without SSI, while having slept out in the past week decreased it for both subgroups of singles.

Being male and having received help with housing options predicted greater receipt of ambulatory care for singles without SSI, but not for those who had it. Being male also significantly affected receipt of ambulatory care for all singles.

Emergency Room Care

Having health insurance of either type did not make a difference for emergency room use in either subgroup of single homeless adults (Table 4-5). This is the same finding reported by Kushel, Vittinghoff, and Haas (2001). Nor did receipt of SSI affect emergency room use. The only factor affecting emergency room use for singles with SSI was being white (compared to "other race"), which did not affect emergency room use for the whole singles sample.

For those without SSI, the strongest effects were due to ADM status, and especially to the presence of a mental health problem, with or without an accompanying substance abuse problem. Having three or more chronic physical conditions increased the likelihood of an emergency room episode, as did being male. All of these effects are reflected in the model for all homeless singles.

Hospitalization

Having non-Medicaid health insurance increased the likelihood of hospitalization during the past year for both subgroups of single homeless adults (Table 4-6), and thus for all homeless singles.

SSI receipt did not affect the likelihood of hospitalization. Hospitalization was affected by the same ADM statuses that affected emergency room use, and again, mostly for singles without SSI. However, having a mental health plus a substance abuse problem also increased the likelihood that singles *with* SSI would be hospitalized. Having three or more chronic conditions increased the chances of hospitalization for both subgroups of singles, and having help with housing options increased those chances for singles without SSI.

Inability to Obtain Care When Needed

Having non-Medicaid health insurance decreased the odds that homeless singles in both subgroup were not able to get care when they needed it. That is, having other insurance increased access. Medicaid did not have the same effect. Having SSI also increased access, even with the two insurance variables in the model.

Having three or more chronic physical conditions and mental health plus substance abuse problems reduced odds of being able to get medical care when it was needed. Having mental health problems only, or substance abuse problems without mental health complications, reduced the odds of getting needed care for one or the other of the two subgroups, while having only alcohol problems increased those chances for the singles sample as a whole. Being male and sleeping out reduced the odds of getting needed care for singles with SSI. Being in an urban or suburban location made it more likely that those without SSI *would* get care when they needed it.

Summary

Unlike the situation for families, having health insurance helps single homeless adults get care. The effects of Medicaid are most visible in the subgroup without SSI, probably because (1) so few of those who have SSI did not have Medicaid and (2) those with SSI are so few compared to those without it. Having Medicaid increases the likelihood of having seen a doctor or nurse during the last year, and of receiving care in ambulatory settings. Having other health insurance has all the same effects plus increasing the probability of being hospitalized and reducing the likelihood that one would need care and not be able to get it.

Having three or more chronic physical conditions increases the likelihood of receiving care in all settings except an emergency room. In addition, it increases the probability that people will have had treatment needs but not been able to get care. This same pattern exists for most of the ADM statuses—being more likely to get care (in particular, hospital care), but also being more likely to need it and not be able to get it. Thus it would appear that the more health-related conditions homeless people have, the more likely they are to need care. They manage to get this care often, but not as often as they need it.

TREATMENT FOR MENTAL HEALTH PROBLEMS

The effects of having health insurance on treatment for mental health problems vary depending on whether the client is receiving SSI, which is itself a significant predictor of more mental health treatment for all singles. For single homeless adults who are not receiving SSI, having non-Medicaid health insurance increases the likelihood of receiving all types of mental health treatment—inpatient treatment, outpatient treatment, and any treatment (Tables 4-8 through 4-10). Looking at the group of single homeless adults who are receiving SSI, our regression results show that having Medicaid or other types of insurance decreases the likelihood of receiving any type of mental health treatment, and that having Medicaid decreases the likelihood of receiving outpatient treatment. Considering the fact that single homeless adults with SSI are significantly more likely than their counterparts without SSI to have received mental health treatment in any setting, these findings suggest that having health insurance is much more important in obtaining mental health care for individuals not receiving SSI than it is for individuals receiving these benefits.

Among other predictors of mental health care in Table 4-8, only use of transitional shelters has a positive effect for singles with and without SSI, but is not significant for all single homeless adults. Effects that are significant for singles without SSI—using an emergency shelter and receiving help with housing options (positive), and being homeless less than one month (negative)—do not affect all singles. Looking only at single homeless adults receiving SSI, having substance abuse problems along with mental health problems increases the likelihood of receiving any mental health treatment, compared to those with only mental health problems, while being African American and living in an urban or suburban environment reduces the likelihood.

These are essentially the same predictors that emerge for receipt of outpatient mental health treatment (Table 4-9), which is clearly what drives the results on the variable combining types of mental health care. The only differences are that being in transitional housing is now significant for all singles, and having both mental health and substance abuse problems does not decrease the likelihood of individuals on SSI receiving outpatient treatment, as it does with any mental health treatment, and being male does increase the likelihood of those not on SSI receiving outpatient treatment, whereas gender has no effect on any mental health treatment.

There are essentially no significant predictors of inpatient mental health treatment for singles receiving SSI, although *having* SSI itself is a significant predictor of for all homeless singles. For singles without SSI, being 50 and older is associated with less inpatient care, and having a substance abuse problem accompanying one's mental health problem increases the likelihood of inpatient mental health care, compared to those who only have a mental health problem.

TREATMENT FOR SUBSTANCE USE PROBLEMS

Findings relating to receipt of substance abuse treatment are driven largely by patterns of service use relating to the group of clients who do not have SSI. Only clients with past year substance abuse problems are included in these analyses.

Having Medicaid does not affect single homeless adults' receipt of either inpatient or outpatient substance abuse treatment (Tables 4-11, 4-12, and 4-13). In contrast, having non-Medicaid insurance increases the likelihood that clients not receiving SSI will receive any substance abuse treatment (Table 4-11) and that all homeless singles will receive inpatient treatment (Table 4-13).

Otherwise, spending time in a transitional shelter increases the likelihood that single homeless clients not receiving SSI will receive all types of substance abuse treatment, and also increases the likelihood that single adults *with* SSI will receive outpatient treatment. Again looking only at individuals not receiving SSI, we find that being white and age 25-49 have positive effects on inpatient treatment and any treatment, while sleeping in places not meant for habitation has negative effects for outpatient and any treatment.

As for individuals receiving SSI, we find no significant effects except for the model predicting outpatient treatment for substance abuse problems. Here we find that clients with dual diagnoses, those living in urban/suburban areas and in transitional housing programs, and those age 25-49 are more likely to receive inpatient treatment, and males are less likely to do so.

IMPLICATIONS

Not surprisingly, the situation with single homeless adults who do not have SSI drives the results for all singles, as they make up a very large majority of this group. Having Medicaid increased the access of single homeless people to seeing a doctor or nurse for any reason and to ambulatory care, but did not have broad effects across the spectrum of physical and behavioral health care. This was especially true when compared to the effects of having other types of health insurance. Regardless of subgroup, those with non-Medicaid insurance were more likely to see a doctor or nurse, be hospitalized, and have their needs for care met. Non-Medicaid insurance also increased the odds that singles without SSI would get ambulatory care, inpatient and outpatient mental health care, and any substance abuse treatment.

Including SSI receipt in the models for all singles, as we have for all analyses in this chapter, does not make any difference for the effects of Medicaid receipt on any physical health care variable or any substance abuse treatment indicator. It does, however, reduce to insignificance the positive effects of Medicaid receipt on mental health care that emerge in models that do not include SSI as a variable. The effects of SSI and Medicaid on seeing a doctor or nurse, or on ambulatory care, are opposite (SSI effects are negative, while Medicaid effects are positive), so both are statistically significant in models containing both predictors. The effects of SSI and Medicaid on mental health care are both positive, and therefore likely to be confounded, with one losing its significance when both are included.

Having various ADM problems increases the likelihood of care, mostly around hospitalization, but also increases the inability to get medical care when it is needed. These effects occur mostly, but not exclusively, among singles without SSI. Having three or more chronic physical conditions increases the likelihood of all types of physical health care, as well as outpatient substance abuse treatment for singles with SSI.

Some indicators of connection (or disconnection) to the homeless assistance system suggest that greater involvement increases access. Sleeping in places not meant for habitation reduces the likelihood of seeing a doctor or nurse for any reason, of ambulatory care, and of both inpatient and outpatient mental health and substance abuse treatment. Staying in transitional housing (programs more service-intense than emergency shelters) increases the likelihood of receiving all types of substance abuse and mental health care (but not physical health care), and being in touch with case managers or other staff who help with housing options increases hospitalization and both types of mental health treatment.

Table 4-1
Characteristics of Single Adult Homeless Households, All and by SSI Status
(weighted percentages)

	Client Group		
	All Currently Homeless Singles (N = 2,443)	Currently Homeless Singles Receiving SSI (N=274)	Currently Homeless Singles Not Receiving SSI (N=2168)
Percent of All Currently Homeless Single Adults	100.0	11.0	89.0
Male	77.3	71.6	77.8
Age			
24 and younger	10.3	2.5*	11.6*
25-49	73.5	62.3*	74.4*
50 and older	16.1	35.2*	14.1*
Race			
Black non-Hispanic	39.6	33.0	40.9
White non-Hispanic	41.4	47.0	39.8
Other	19.1	20.0	19.3
Location			
Central cities	71.0	74.5	70.0
Suburbs/urban fringe (balance MSA)	20.5	22.9	20.5
Rural (non-MSA)	8.5	2.6*	9.5*
Veteran	25.7	22.0	25.3
Length of Current Homeless Spell			
Less than 1 month	3.8	0.6	4.0
1-60 months	73.4	62.5*	74.3*
More than 60 months (5 years)	22.8	37.0*	21.6*
Past Year ADM Status			
No ADM problems reported	23.3	25.2	22.8
Only alcohol problems	12.8	7.2*	13.9*
Drug problems, + alcohol problems, but no mental health problems	18.0	6.7*	19.8*
Only mental health problems	13.7	28.9*	12.2*
Mental health plus AOD problems	32.1	32.1	31.4
System Involvement of Household			
Gets SSI now	11.0	100.0	0.0
Gets other benefits now	41.2	58.5*	39.8*
Received CM help in past month	22.5	35.0*	21.3*
Health Insurance Status			
Medicaid	25.9	86.6*	18.7*
Other health insurance	19.9	21.0	18.8
No health insurance	58.5	10.2*	65.5*
Past 7 Days, Slept in:			
Emergency Shelter	37.2	25.7*	39.3*
Transitional Housing Program	29.9	49.3*	28.0*
Places not meant for habitation	32.0	20.1*	33.9*
Number of Co-Occurring Chronic Illnesses			
0	53.9	46.8*	54.0*
1	25.2	23.2	26.0
2	10.4	10.8	10.5
3 or more	10.5	19.2*	9.5*

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. Note: Percentages do not sum to 100% due to rounding, or because respondents could give more than one response.
Cells marked with an asterisk (*) are significantly different from each other at $p < .05$.

Table 4-2

Single Adult Homeless Households' Access to Care for Physical, Mental Health, and Substance Abuse Problems, All and by SSI Status

(weighted percentages)

Within the Past 12 Months:	Client Group		
	All Currently Homeless Singles (N = 2,471)	Currently Homeless Singles Receiving SSI (N=274)	Currently Homeless Singles Not Receiving SSI (N=2168)
Treated by a Doctor or Nurse for Health Reasons	72.3	78.5	71.3
Setting of Care:[1]			
An ambulatory care setting	50.5	56.2	50.6
A hospital as an inpatient	23.3	32.4*	21.3*
An emergency room	31.1	33.6	31.5
Number of Times Received Medical Treatment, Not Counting Repeat Visits for the Same Condition			
Never	31.3	24.7	32.4
Once	21.0	17.9	20.2
2 or 3 times	21.2	19.7	21.8
4 to 10 times	18.5	22.6	18.3
11 or more times	8.0	15.1*	7.3*
Needed to See a Doctor or Nurse but Was Not Able to	23.6	12.0*	25.3*
Received Mental Health Treatment of Any Type[2]	21.1	43.2*	18.7*
Setting of Mental Health Treatment:[12]			
Outpatient setting	18.5	39.9*	16.2*
Inpatient setting	8.5	17.9*	7.5*
Received Substance Abuse Treatment of Any Type[3]	22.2	20.9	21.5
Setting of Substance Abuse Treatment:[13]			
Outpatient setting	16.3	18.2	16.5
Inpatient setting	14.5	16.6	13.2

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. Note: Percentages do not sum to 100% due to rounding, or because respondents could give more than one response.
Cells marked with an asterisk (*) are significantly different from each other at $p < .05$.
[1]Respondents may have received care in more than one setting during the past 12 months.
[2]Percentages calculated using only people reporting a mental health problem in the past year. Ns = 1096, all singles; 167, singles with SSI; 910, singles without SSI.
[3]Percentages calculated using only people reporting an alcohol or drug problem in the past year. Ns = 1582, all singles; 147, singles with SSI; 1417, singles without SSI.

Table 4-3
Predictors of Treatment by a Doctor or Nurse for Health Reasons for Homeless Singles, All and by SSI Status
(weighted percentages)

Predictor Variables	All Currently Homeless Singles (N = 2438)		Currently Homeless Singles Receiving SSI (N=270)		Currently Homeless Singles Not Receiving SSI (N=2164)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Race						
Other		1.00		1.00		1.00
White	-0.040	0.96	-0.008	0.99	-0.019	0.98
Black	-0.027	0.97	0.351	1.42	-0.087	0.92
Location						
Rural		1.00		1.00		1.00
Urban or suburban	-0.413	0.66	2.417 *	11.21	-0.485	0.62
Sex						
Female		1.00		1.00		1.00
Male	0.543	1.72	0.126	1.13	0.729 *	2.07
Age						
24 and younger		1.00		1.00		1.00
25-49	0.089	1.09	0.208	1.23	0.199	1.22
50 and over	0.290	1.34	0.248	1.28	0.381	1.46
ADM Status						
No ADM problems reported		1.00		1.00		1.00
Alcohol problems only	-0.044	0.96	0.084	1.09	-0.153	0.86
Drug problems, ± alcohol problems, but no	0.375	1.46	1.544	4.68	0.337	1.40
Only mental health problems	0.573	1.77	0.684	1.98	0.528	1.70
Mental health plus AOD problems	0.818 **	2.27	1.327	3.77	0.738 *	2.09
Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	-0.081	0.92	-1.434 *	0.24	0.145	1.16
Length of Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	-0.877	0.42	.	.	-0.881	0.41
More than 60 months (5 years)	0.128	1.14	0.622	1.86	0.080	1.08
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	-0.015	0.99	0.200	1.22	-0.058	0.94
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	-0.100	0.91	-0.629	0.53	0.049	1.05
Slept Out						
No		1.00		1.00		1.00
Yes	-0.874 **	0.42	-0.432	0.65	-0.901 **	0.41
Three or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	1.460 **	4.31	3.637 **	37.97	1.128 **	3.09
Has Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	1.280 **	3.60	0.482	1.62	1.499 **	4.48
Other insurance	1.072 **	2.92	2.529 **	12.54	0.928 **	2.53
SSI NOW						
No		1.00				
Yes	-0.937 *	0.39				
Adjusted Pseudo-R^2	0.143		0.259		0.155	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01. Note: Variables missing parameter estimates or odds ratios were excluded from the model.

Table 4-4
Predictors of Ambulatory Care for Homeless Singles,
All and by SSI Status
(weighted percentages)

Predictor Variables	All Currently Homeless Singles (N = 2444)		Currently Homeless Singles Receiving SSI (N=275)		Currently Homeless Singles Not Receiving SSI (N=2169)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Race						
Other		1.00		1.00		1.00
White	0.195	1.21	0.546	1.73	0.226	1.25
Black	0.054	1.06	0.865	2.38	0.010	1.01
Location						
Rural		1.00		1.00		1.00
Urban or suburban	0.204	1.23	0.530	1.70	0.191	1.21
Sex						
Female		1.00		1.00		1.00
Male	0.536 *	1.71	0.610	1.84	0.618 *	1.86
Age						
24 and younger		1.00		1.00		1.00
25-49	0.032	1.03	0.362	1.44	0.033	1.03
50 and over	0.170	1.18	0.002	1.00	0.365	1.44
ADM Status						
No ADM problems reported		1.00		1.00		1.00
Alcohol problems only	-0.078	0.92	0.060	1.06	-0.130	0.88
Drug problems, ± alcohol problems, but no	0.032	1.03	1.366	3.92	-0.054	0.95
Only mental health problems	-0.150	0.86	0.453	1.57	-0.397	0.67
Mental health plus AOD problems	0.238	1.27	0.994	2.70	0.090	1.09
Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	0.422	1.53	-0.430	0.65	0.555 *	1.74
Length of Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	-0.357	0.70	-0.542	0.58	-0.315	0.73
More than 60 months (5 years)	0.081	1.08	0.932	2.54	-0.069	0.93
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	0.341	1.41	0.721	2.06	0.305	1.36
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	0.358	1.43	-0.123	0.88	0.439	1.55
Slept Out						
No		1.00		1.00		1.00
Yes	-0.724 **	0.48	-1.678 *	0.19	-0.638 **	0.53
Three or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	1.491 **	4.44	1.174	3.24	1.511 **	4.53
Has Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	0.887 **	2.43	-0.635	0.53	1.062 **	2.89
Other insurance	0.661 **	1.94	0.873	2.39	0.653 *	1.92
SSI NOW						
No		1.00				
Yes	-0.815 *	0.44				
Adjusted Pseudo-R^2	0.140		0.169		0.155	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01.

Table 4-5
Predictors of Emergency Room Care for Homeless Singles, All and by SSI Status
(weighted percentages)

Predictor Variables	All Currently Homeless Singles (N = 2444)		Currently Homeless Singles Receiving SSI (N=275)		Currently Homeless Singles Not Receiving SSI (N=2169)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Race						
Other		1.00		1.00		1.00
White	0.287	1.33	1.394 *	4.03	0.078	1.08
Black	-0.152	0.86	1.074	2.93	-0.312	0.73
Location						
Rural		1.00		1.00		1.00
Urban or suburban	0.027	1.03	1.595	4.93	0.053	1.05
Sex						
Female		1.00		1.00		1.00
Male	0.626 **	1.87	0.419	1.52	0.681 **	1.98
Age						
24 and younger		1.00		1.00		1.00
25-49	0.080	1.08	-0.247	0.78	0.148	1.16
50 and over	-0.326	0.72	0.079	1.08	-0.378	0.69
ADM Status						
No ADM problems reported		1.00		1.00		1.00
Alcohol problems only	0.634	1.89	-0.947	0.39	0.762	2.14
Drug problems, + alcohol problems, but no	0.535	1.71	0.424	1.53	0.648	1.91
Only mental health problems	1.474 **	4.36	0.279	1.32	1.874 **	6.52
Mental health plus AOD problems	1.049 **	2.85	1.131	3.10	1.115 **	3.05
Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	0.377	1.46	0.283	1.33	0.414	1.51
Length of Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	0.194	1.21	1.058	2.88	0.163	1.18
More than 60 months (5 years)	0.020	1.02	-0.034	0.97	0.088	1.09
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	0.146	1.16	-0.543	0.58	0.244	1.28
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	-0.094	0.91	-0.677	0.51	0.053	1.05
Slept Out						
No		1.00		1.00		1.00
Yes	-0.208	0.81	-0.015	0.99	-0.250	0.78
Three or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	0.713 *	2.04	0.566	1.76	0.821 *	2.27
Has Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	0.152	1.16	-0.202	0.82	0.043	1.04
Other insurance	0.329	1.39	0.783	2.19	0.209	1.23
SSI NOW						
No		1.00				
Yes	-0.279	0.76				
Adjusted Pseudo-R^2	0.094		0.133		0.111	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01.

Table 4-6
Predictors of Hospitalization for Homeless Singles,
All and by SSI Status
(weighted percentages)

Predictor Variables	All Currently Homeless Singles (N = 2444)		Currently Homeless Singles Receiving SSI (N=275)		Currently Homeless Singles Not Receiving SSI (N=2169)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Race						
Other		1.00		1.00		1.00
White	-0.010	0.99	0.639	1.89	-0.066	0.94
Black	-0.380	0.68	0.508	1.66	-0.473	0.62
Location						
Rural		1.00		1.00		1.00
Urban or suburban	-0.385	0.68	3.776 **	43.63	-0.412	0.66
Sex						
Female		1.00		1.00		1.00
Male	-0.454	0.64	0.093	1.10	-0.558	0.57
Age						
24 and younger		1.00		1.00		1.00
25-49	0.093	1.10	-0.495	0.61	0.086	1.09
50 and over	0.135	1.14	-0.445	0.64	0.227	1.25
ADM Status						
No ADM problems reported		1.00		1.00		1.00
Alcohol problems only	1.260 **	3.52	-1.098	0.33	1.406 **	4.08
Drug problems, ± alcohol problems, but no	0.689	1.99	0.952	2.59	0.790 *	2.20
Only mental health problems	0.772	2.16	0.263	1.30	0.944 *	2.57
Mental health plus AOD problems	1.664 **	5.28	2.090 **	8.08	1.721 **	5.59
Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	0.524 *	1.69	-0.185	0.83	0.603 *	1.83
Length of Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	-0.084	0.92	1.607	4.99	-0.128	0.88
More than 60 months (5 years)	-0.081	0.92	0.599	1.82	-0.158	0.85
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	0.178	1.19	-0.144	0.87	0.163	1.18
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	0.268	1.31	0.855	2.35	0.184	1.20
Slept Out						
No		1.00		1.00		1.00
Yes	-0.062	0.94	-0.387	0.68	-0.037	0.96
Three or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	0.901 **	2.46	1.572 **	4.82	0.863 *	2.37
Has Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	0.115	1.12	-0.867	0.42	0.182	1.20
Other insurance	1.290 **	3.63	1.702 **	5.48	1.289 **	3.63
SSI NOW						
No		1.00				
Yes	0.438	1.55				
Adjusted Pseudo-R^2	0.150		0.246		0.151	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01.

Table 4-7
Predictors of Whether Homeless Singles Could Not See a Doctor When Needed, All and by SSI Status
(weighted percentages)

Predictor Variables	All Currently Homeless Singles (N = 2444)		Currently Homeless Singles Receiving SSI (N=310)		Currently Homeless Singles Not Receiving SSI (N=2130)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Race						
Other		1.00		1.00		1.00
White	0.190	1.21	0.669	1.95	0.128	1.14
Black	-0.506	0.60	-0.427	0.65	-0.544	0.58
Location						
Rural		1.00		1.00		1.00
Urban or suburban	-0.956 *	0.38	-1.928	0.15	-1.251 **	0.29
Sex						
Female		1.00		1.00		1.00
Male	0.564 *	1.76	1.271 *	3.56	0.412	1.51
Age						
24 and younger		1.00		1.00		1.00
25-49	-0.226	0.80	-0.064	0.94	-0.297	0.74
50 and over	-0.525	0.59	0.185	1.20	-0.816	0.44
ADM Status						
No ADM problems reported		1.00		1.00		1.00
Alcohol problems only	1.054 *	2.87	1.889	6.61	0.830	2.29
Drug problems, ± alcohol problems, but no	0.232	1.26	3.518 **	33.72	-0.289	0.75
Only mental health problems	0.940 *	2.56	0.050	1.05	0.888 *	2.43
Mental health plus AOD problems	1.263 **	3.54	2.771 **	15.98	1.075 **	2.93
Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	0.148	1.16	-0.427	0.65	0.192	1.21
Length of Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	-0.282	0.75	.	.	-0.340	0.71
More than 60 months (5 years)	0.010	1.01	-0.339	0.71	0.079	1.08
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	0.021	1.02	-0.195	0.82	0.024	1.02
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	-0.522	0.59	0.280	1.32	-0.557	0.57
Slept Out						
No		1.00		1.00		1.00
Yes	0.213	1.24	1.661 *	5.26	0.080	1.08
Three or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	1.033 **	2.81	1.497 *	4.47	0.807 *	2.24
Has Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	-0.207	0.81	-0.353	0.70	-0.565	0.57
Other insurance	-1.414 **	0.24	-1.931 *	0.14	-1.375 **	0.25
SSI NOW						
No		1.00				
Yes	-0.932 *	0.39				
Adjusted Pseudo-R^2	0.143		0.300		0.150	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01. Note: Variables missing parameter estimates or odds ratios were excluded from the model.

Table 4-8

Predictors of Any Type of Mental Health Treatment for Homeless Singles with Mental Health Problems
(weighted percentages)

Predictor Variables	All Currently Homeless Singles (N = 1084)		Currently Homeless Singles Receiving SSI (N=172)		Currently Homeless Singles Not Receiving SSI (N=910)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Race						
Other		1.00		1.00		1.00
White	0.881	2.41	-1.390	0.25	0.765	2.15
Black	0.549	1.73	-2.382 **	0.09	-0.209	0.81
Location						
Rural		1.00		1.00		1.00
Urban or suburban	-1.141	0.32	2.943 *	18.98	-0.501	0.61
Sex						
Female		1.00		1.00		1.00
Male	-0.039	0.96	0.990	2.69	0.675	1.96
Age						
24 and younger		1.00		1.00		1.00
25-49	0.105	1.11	-0.658	0.52	-0.305	0.74
50 and older	-1.304 *	0.27	0.430	1.54	-0.832	0.44
ADM Status						
all other ADM statuses		1.00		1.00		1.00
MH plus alcohol and/or drugs	0.802 *	2.23	1.374 *	3.95	0.162	1.18
Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	0.265	1.30	0.368	1.45	0.917 **	2.50
Length of Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	-0.790	0.45			-2.293 **	0.10
More than 60 months (5 years)	0.388	1.47	0.017	1.02	0.613	1.85
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	0.224	1.25	-0.845	0.43	1.004 **	2.73
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	0.500	1.65	1.893 **	6.64	1.533 **	4.63
Slept Out						
No		1.00		1.00		1.00
Yes	-0.468	0.63	-0.279	0.76	-0.586	0.56
Three or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	-0.373	0.69	-0.121	0.89	-0.388	0.68
Has Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	-0.006	0.99	-1.853 *	0.16	0.525	1.69
Other insurance	0.635	1.89	-1.164 *	0.31	1.141 **	3.13
SSI NOW						
No		1.00				
Yes	1.033 *	2.81				
Adjusted Pseudo-R^2	0.114		0.326		0.290	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01. Note: Variables missing parameter estimates or odds ratios were excluded from the model.

Table 4-9
Predictors of Outpatient Mental Health Treatment for Homeless Singles with Mental Health Problems, All and by SSI Status
(weighted percentages)

Predictor Variables	All Currently Homeless Singles (N = 1084)		Currently Homeless Singles Receiving SSI (N=172)		Currently Homeless Singles Not Receiving SSI (N=910)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Race						
Other		1.00		1.00		1.00
White	0.277	1.32	-0.903	0.41	0.537	1.71
Black	-0.751	0.47	-2.196 *	0.11	-0.354	0.70
Location						
Rural		1.00		1.00		1.00
Urban or suburban	0.523	1.69	2.535 *	12.61	0.496	1.64
Sex						
Female		1.00		1.00		1.00
Male	0.830 **	2.29	0.949	2.58	0.768 *	2.16
Age						
24 and younger		1.00		1.00		1.00
25-49	-0.537	0.58	-1.377	0.25	-0.464	0.63
50 and older	-0.521	0.59	0.075	1.08	-0.625	0.54
ADM Status						
all other ADM statuses		1.00		1.00		1.00
MH plus alcohol and/or drugs	0.052	1.05	1.141	3.13	-0.197	0.82
Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	1.301 **	3.67	1.101	3.01	1.252 **	3.50
Length of Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	-2.099 *	0.12	.	.	-2.335 *	0.10
More than 60 months (5 years)	0.574	1.77	0.179	1.20	0.450	1.57
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	0.542	1.72	-1.230	0.29	1.046 **	2.85
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	1.587 **	4.89	1.566 *	4.79	2.066 **	7.89
Slept Out						
No		1.00		1.00		1.00
Yes	-0.780 *	0.46	-0.253	0.78	-0.497	0.61
Three or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	-0.348	0.71	-0.563	0.57	-0.203	0.82
Has Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	0.192	1.21	-2.089 *	0.12	0.431	1.54
Other insurance	0.585 *	1.79	-0.663	0.52	0.760 *	2.14
SSI NOW						
No		1.00				
Yes	1.110 **	3.03				
Adjusted Pseudo-R^2	0.316		0.369		0.334	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01. Note: Variables missing parameter estimates or odds ratios were excluded from the model.

Table 4-10
Predictors of Inpatient Mental Health Treatment for Homeless Singles with Mental Health Problems, All and by SSI Status
(weighted percentages)

Predictor Variables	All Currently Homeless Singles (N = 1084)		Currently Homeless Singles Receiving SSI (N=167)		Currently Homeless Singles Not Receiving SSI (N=910)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Race						
Other		1.00		1.00		1.00
White	0.481	1.62	1.101	3.01	0.730	2.08
Black	-0.502	0.61	1.548	4.70	0.165	1.18
Location						
Rural		1.00		.		1.00
Urban or suburban	-0.414	0.66	.	.	-1.216	0.30
Sex						
Female		1.00		1.00		1.00
Male	0.706 *	2.03	0.040	1.04	-0.025	0.98
Age						
24 and younger		1.00		1.00		1.00
25-49	-0.363	0.70	-0.030	0.97	0.104	1.11
50 and older	-0.716	0.49	-0.592	0.55	-1.740 **	0.18
ADM Status						
all other ADM statuses		1.00		1.00		1.00
MH plus alcohol and/or drugs	0.306	1.36	1.283	3.61	0.847 *	2.33
Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	0.994 **	2.70	0.450	1.57	0.178	1.19
Length of Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	-2.070 **	0.13	2.655	14.22	-0.979	0.38
More than 60 months (5 years)	0.701 *	2.02	0.237	1.27	0.384	1.47
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	0.712 *	2.04	-0.420	0.66	0.267	1.31
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	1.326 **	3.76	1.302	3.68	0.262	1.30
Slept Out						
No		1.00		1.00		1.00
Yes	-0.812 *	0.44	-0.204	0.82	-0.529	0.59
Three or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	-0.422	0.66	-0.877	0.42	-0.079	0.92
Has Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	0.249	1.28	-0.031	0.97	0.012	1.01
Other insurance	0.811 *	2.25	0.226	1.25	0.786 *	2.19
SSI NOW						
No		1.00				
Yes	1.115 **	3.05				
Adjusted Pseudo-R^2	0.273		0.015		0.120	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01. Note: Variables missing parameter estimates or odds ratios were excluded from the model.

Table 4-11

Predictors of any AOD Treatment for Homeless Singles with AOD Problems, All and by SSI Status

(weighted percentages)

Predictor Variables	All Currently Homeless Singles (N = 1565)		Currently Homeless Singles Receiving SSI (N=147)		Currently Homeless Singles Not Receiving SSI (N=1417)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Race						
Other		1.00		1.00		1.00
White	0.710	2.03	-0.635	0.53	0.917 *	2.50
Black	0.211	1.23	-0.755	0.47	0.456	1.58
Location						
Rural		1.00		1.00		1.00
Urban or suburban	0.077	1.08	1.742	5.71	-0.605	0.55
Sex						
Female		1.00		1.00		1.00
Male	0.284	1.33	-1.539	0.21	0.262	1.30
Age						
24 and younger		1.00		1.00		1.00
25-49	1.809 **	6.10	1.352	3.87	1.215 *	3.37
50 and older	0.981	2.67	0.940	2.56	0.700	2.01
ADM Status						
all other ADM statuses		1.00		1.00		1.00
MH plus alcohol and/or drugs	0.640 **	1.90	0.666	1.95	0.519 *	1.68
Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	0.114	1.12	-0.665	0.51	-0.259	0.77
Length of Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	-1.687	0.18			-0.782	0.46
More than 60 months (5 years)	-0.171	0.84	0.151	1.16	-0.565	0.57
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	0.420	1.52	1.434	4.20	0.239	1.27
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	1.488 **	4.43	1.361	3.90	1.410 **	4.10
Slept Out						
No		1.00		1.00		1.00
Yes	-0.418	0.66	-1.308	0.27	-0.815 *	0.44
Three or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	-0.091	0.91	0.471	1.60	-0.029	0.97
Has Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	0.256	1.29	0.091	1.10	0.549	1.73
Other insurance	0.502	1.65	1.189	3.28	0.594 *	1.81
SSI NOW						
No		1.00				
Yes	0.443	1.56				
Adjusted Pseudo-R^2	0.182		0.024		0.184	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01. Note: Variables missing parameter estimates or odds ratios were excluded from the model.

Table 4-12
Predictors of AOD Outpatient Treatment for Homeless Singles with AOD Problems, All and by SSI Status
(weighted percentages)

Predictor Variables	All Currently Homeless Singles (N = 1565)		Currently Homeless Singles Receiving SSI (N=147)		Currently Homeless Singles Not Receiving SSI (N=1417)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Race						
Other		1.00		1.00		1.00
White	0.433	1.54	-0.851	0.43	0.604	1.83
Black	0.143	1.15	-1.383	0.25	0.276	1.32
Location						
Rural		1.00		1.00		1.00
Urban or suburban	-0.247	0.78	3.303 **	27.19	-0.403	0.67
Sex						
Female		1.00		1.00		1.00
Male	0.239	1.27	-2.831 *	0.06	0.434	1.54
Age						
24 and younger		1.00		1.00		1.00
25-49	1.011	2.75	3.053 *	21.18	1.011	2.75
50 and older	0.683	1.98	2.320	10.17	0.819	2.27
ADM Status						
all other ADM statuses		1.00		1.00		1.00
MH plus alcohol and/or drugs	0.784 **	2.19	1.579 *	4.85	0.730 **	2.08
Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	-0.207	0.81	-0.506	0.60	-0.298	0.74
Length of Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	-0.768	0.46			-0.810	0.44
More than 60 months (5 years)	-0.411	0.66	0.354	1.42	-0.482	0.62
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	0.578	1.78	1.396	4.04	0.462	1.59
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	1.084 **	2.96	1.927 *	6.87	1.118 **	3.06
Slept Out						
No		1.00		1.00		1.00
Yes	-0.908 **	0.40	-1.441	0.24	-0.869 *	0.42
Three or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	0.329	1.39	0.864	2.37	0.145	1.16
Has Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	0.174	1.19	0.007	1.01	0.257	1.29
Other insurance	0.502	1.65	1.198	3.31	0.427	1.53
SSI NOW						
No		1.00				
Yes	0.332	1.39				
Adjusted Pseudo-R^2	0.152		0.349		0.147	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = $p < .05$; ** = $p < .01$. Note: Variables missing parameter estimates or odds ratios were excluded from the model.

Table 4-13
Predictors of AOD Inpatient Treatment for Homeless Singles with AOD Problems, All and by SSI Status
(weighted percentages)

Predictor Variables	All Currently Homeless Singles (N = 1565)		Currently Homeless Singles Receiving SSI (N=147)		Currently Homeless Singles Not Receiving SSI (N=1417)	
	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio	Parameter Estimate	Odds Ratio
Race						
Other		1.00		1.00		1.00
White	0.697	2.01	-0.822	0.44	0.984 *	2.67
Black	0.295	1.34	-1.719	0.18	0.515	1.67
Location						
Rural		1.00		1.00		1.00
Urban or suburban	-0.423	0.65	1.114	3.05	-0.168	0.85
Sex						
Female		1.00		1.00		1.00
Male	0.127	1.14	-1.688	0.18	0.449	1.57
Age						
24 and younger		1.00		1.00		1.00
25-49	1.164 *	3.20	0.954	2.60	1.975 **	7.21
50 and older	0.610	1.84	0.309	1.36	1.124	7.21
ADM Status						
all other ADM statuses		1.00		1.00		1.00
MH plus alcohol and/or drugs	0.531 *	1.70	0.428	1.53	0.675 **	1.96
Help Getting Benefits, etc.						
No		1.00		1.00		1.00
Yes	-0.217	0.80	-0.604	0.55	0.129	1.14
Length of Current Homeless Spell						
1-60 months		1.00		1.00		1.00
Less than 1 month	-0.731	0.48	.	.	-1.803	0.16
More than 60 months (5 years)	-0.490	0.61	0.088	1.09	-0.194	0.82
Emergency Shelter Use						
No		1.00		1.00		1.00
Yes	0.367	1.44	1.269	3.56	0.276	1.32
Transitional Housing Program Use						
No		1.00		1.00		1.00
Yes	1.331 **	3.79	1.262	3.53	1.630 **	5.10
Slept Out						
No		1.00		1.00		1.00
Yes	-0.849 **	0.43	-0.874	0.42	-0.375	0.69
Three or More Chronic Conditions						
No		1.00		1.00		1.00
Yes	0.169	1.18	0.889	2.43	-0.515	0.60
Has Health Insurance						
No insurance		1.00		1.00		1.00
Medicaid	0.439	1.55	0.517	1.68	0.375	1.46
Other insurance	0.661 *	1.94	0.501	1.65	0.459	1.58
SSI NOW						
No		1.00				
Yes	0.104	1.11				
Adjusted Pseudo-R^2	0.177		0.190		0.199	

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01. Note: Variables missing parameter estimates or odds ratios were excluded from the model.

CHAPTER 5: CONCLUSION

We set out in this project to examine the relationship between having health insurance and obtaining medical and behavioral health care among homeless people. Relatively little research has examined this relationship, although the patterns of increased access and utilization for those with health insurance are well documented in the housed population, both low-income and not. Most of the few studies that do exist focusing on homeless people are limited as to sample (either just single men, or just families) and location, and also often by the types of care they include in their analyses.

The only source of national data on homeless people is the National Survey of Homeless Assistance Providers and Clients, conducted in 1996 by the U.S. Bureau of the Census for the Interagency Council on the Homeless. While the health care data in NSHAPC are not extensive, and the relationship between the timing of health care receipt and the timing of homelessness is ambiguous, NSHAPC still offers the best opportunity to see whether having health insurance makes the same difference for homeless people as it does for the low-income housed population. One study (Kushel, Vittinghoff, and Haas, 2001) using NSHAPC has already reported positive effects of having health insurance on homeless adults' receipt of ambulatory care, hospitalization, ability to see a doctor or nurse when necessary, and ability to comply with medications regimens. This study did not, however, differentiate among or control for types of homeless people (parents in homeless families and single homeless adults), nor did it differentiate between types of health insurance (Medicaid and other types). Since homeless families and single homeless adults differ on many factors, including their access to cash assistance and Medicaid, we felt it was important to conduct separate analyses for the two groups. And, as we were specifically requested to examine the role of Medicaid, we felt the latter distinction was important to make. As should be clear by now, these distinctions are quire important, and failure to make them masks many interactions of population, insurance type, and ability to get health care.

In this last chapter we try to summarize our findings related to six broad issues, which are depicted in three summary tables that look at predictive variables across all types of health and behavioral health care. The issues are:

1. Does having insurance help homeless people get access to care?

2. Does it matter what type of insurance it is?

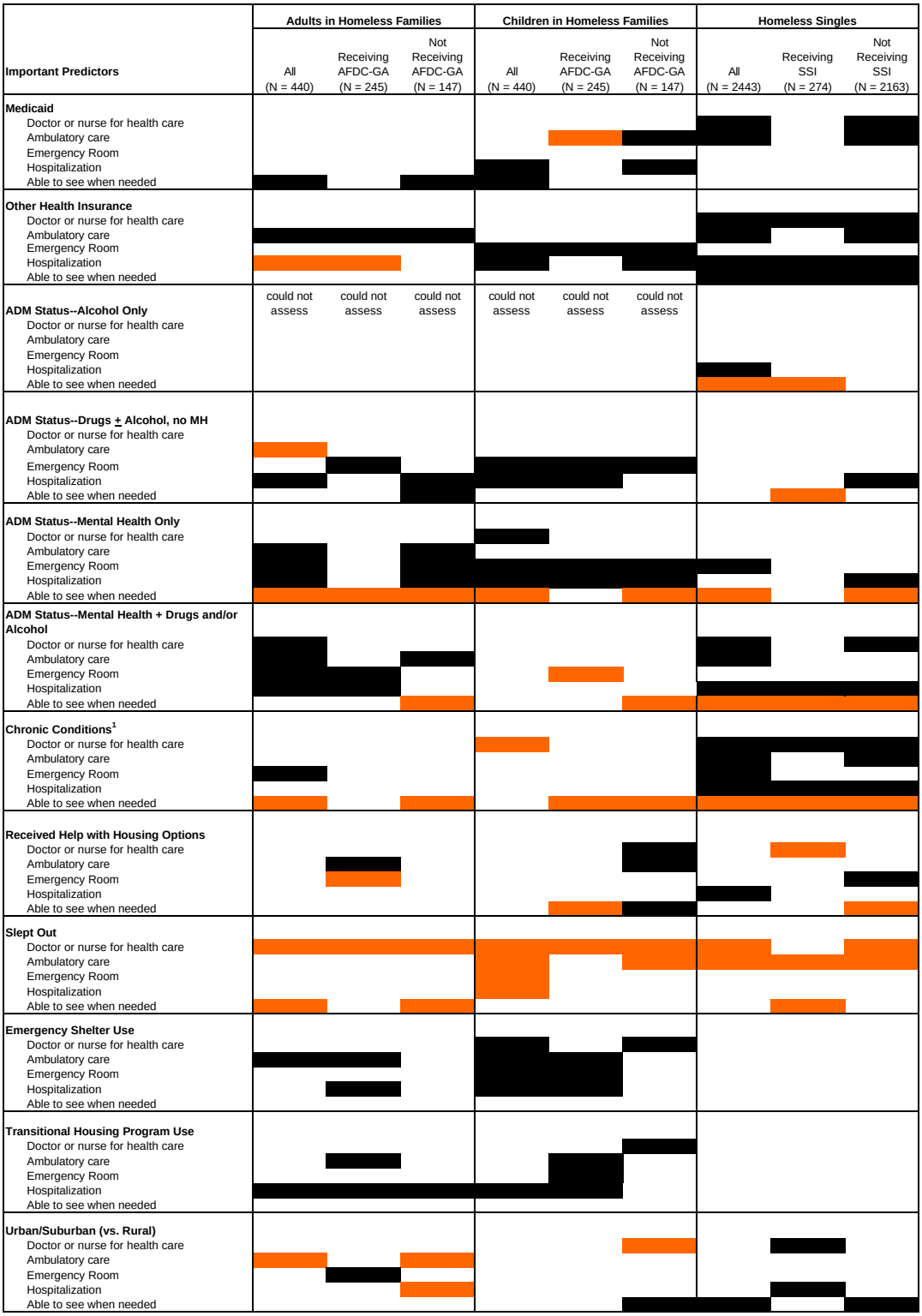
3. Does it matter what type of care it is?

4. Does it matter whether the homeless person is a parent in a homeless family, a child in a homeless family, or a single homeless adults?

5. How do past-year problems with alcohol, drugs, and mental health affect use of care?

Table 5-1

Summary of Important Predictors for Medical Care
(weighted percentages)



Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01. Note: Due to small subsample sizes, the variable "ADM Status-Alcohol Only" had to be dropped for all family analyses. Relevant cells are identified as "could not assess."

[1]Variable for families is "1 or more" = 1; variable for singles is "3 or more" = 1.

Table 5-2

Summary of Important Predictors for Mental Health and Substance Abuse Treatment
(weighted percentages)

Important Predictors	Homeless Families1	Homeless Singles		
	All Adults (N = 440)	All (N = 2443)	Receiving SSI (N = 274)	Not Receiving SSI (N = 2163)
Medicaid				
Any mental health	Inap. Could not assess			
Inpatient				
Outpatient				
Any substance abuse				
Inpatient				
Outpatient				
Other Health Insurance				
Any mental health	Inap. Could not assess			
Inpatient				
Outpatient				
Any substance abuse				
Inpatient				
Outpatient				
ADM Status--Mental Health + Drugs and/or Alcohol[2]				
Any mental health	Inap. Could not assess			
Inpatient				
Outpatient				
Any substance abuse				
Inpatient				
Outpatient				
Chronic Conditions[3]				
Any mental health	Inap. Could not assess			
Inpatient				
Outpatient				
Any substance abuse				
Inpatient				
Outpatient				
Received Help with Housing Options				
Any mental health	Inap. Could not assess			
Inpatient				
Outpatient				
Any substance abuse				
Inpatient				
Outpatient				
Slept Out				
Any mental health	Could not assess			
Inpatient				
Outpatient				
Any substance abuse				
Inpatient				
Outpatient				
Emergency Shelter Use				
Any mental health	Inap. Could not assess			
Inpatient				
Outpatient				
Any substance abuse				
Inpatient				
Outpatient				
Transitional Housing Program Use				
Any mental health	Inap. Could not assess			
Inpatient				
Outpatient				
Any substance abuse				
Inpatient				
Outpatient				
Urban/Suburban (vs. Rural)				
Any mental health	Inap.			
Inpatient	Could not assess		Could not assess	
Outpatient				
Any substance abuse				
Inpatient				
Outpatient				

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01. N.A. - Not Applicable. Note: Due to small subsample sizes, the variable "ADM Status-Alcohol Only" had to be dropped for all family analyses. Relevant cells are identified as "could not assess."

[1]Due to small sample sizes, the analyses of mental health and substance abuse treatment for the family subgroups of "AFDC-GA" and "no AFDC-GA" had to be dropped altogether. [2]Compared to "ADM status=mental health only" for mental health treatment variables, and to "ADM status = alcohol only, or drugs + alcohol but no mental health" for substance abuse treatment variables. [3]Variable for families is "1 or more" = 1; variable for singles is "3 or more" = 1.

6. How does being connected in one or more ways to either the homeless assistance system or the larger public benefits system affect use of care?

Tables 5-1 and 5-2 summarize the effects of the most important predictor variables on medical care and mental health and substance abuse treatment. The tables take a little interpreting, so we will walk the reader through the first row of Table 5-1, which summarizes the effect of having Medicaid on medical care. Within the overall row, the five medical care dependent variables (seeing a doctor or nurse for any reason, ambulatory care, emergency room use, hospitalization, and being able to see a doctor when one is needed) appear below the predictor (Medicaid). The columns in the table represent the different samples and subsamples we examined in this project. The first three columns are for adults in homeless families—first for all homeless families, then for those receiving AFDC-GA, and then for those who do not. The next three columns are for children in homeless families, with the same subgroups as for their parents. The last three columns are for single homeless adults, first for all of them, and then for those receiving and not receiving SSI.

The cells indicate whether we found any association or effect of the predictor (Medicaid in this case) on a dependent variable. The darker bars indicate a significant positive effect, lighter bars indicate a significant negative effect, and no shading indicates no relationship. Basically, the more shaded cells there are in the intersection of a row and column, the more dependent variables were affected significantly by that predictor.

DOES HAVING INSURANCE HELP HOMELESS PEOPLE GET ACCESS TO CARE?

The first row in Table 5-1 and Table 5-2 shows the effects of having Medicaid; the second row in each table shows the effects of having other health insurance (both are being compared to not having any insurance as the omitted variable). The rather remarkable thing about the Medicaid rows is how few cells are shaded—that is, how few of the health care utilization variables were affected by having Medicaid. Having other types of health insurance had more consistently positive effects.

DOES IT MATTER WHAT TYPE OF INSURANCE IT IS?

Yes. Increased use of health care of most varieties, including behavioral health care, was more strongly associated with having non-Medicaid health insurance than with having Medicaid. Medicare (as a consequence of receiving Social Security or SSDI benefits) and VA health care were the two most common other types of insurance, although a few people reported having private health insurance.

DOES IT MATTER WHAT TYPE OF CARE IT IS?

Yes. Emergency room care was least likely to be affected by having insurance (only children showed any effects, and only for non-Medicaid insurance). Seeing a doctor or nurse or any reason, receiving ambulatory care, and being hospitalized were also responsive to having insurance, as was mental health treatment for singles. Access to substance abuse treatment was mostly not affected.

DOES IT MATTER WHETHER THE HOMELESS PERSON IS A PARENT IN A HOMELESS FAMILY, A CHILD IN A HOMELESS FAMILY, OR A SINGLE HOMELESS ADULT?

Yes, quite a bit. Medicaid did little for parents in homeless families, where its only observable effects were to increase the odds of being able to see a doctor when one was needed. Other health insurance did better for these parents if they had it, increasing the odds of ambulatory care and decreasing the odds of hospitalization (which were not affected by the amount of ambulatory care received).

Children fared a little better than their parents, but only if they were *not* in families receiving AFDC-GA. Medicaid increased the odds that these children would receive both ambulatory care and hospitalization, while having non-Medicaid health insurance increased the odds of hospitalization and emergency room use. This was the only example in the study where insurance of any variety affected emergency room use. One would have hoped the effect would be negative—that is, having insurance would reduce the need to use emergency rooms—but such is not the case.

Having Medicaid increased the odds that single people not receiving SSI would get any care and ambulatory care, while having other insurance increased the odds that all groups of single homeless adults had received any care, been hospitalized, and been able to see a doctor when necessary. Having other insurance made it more likely that singles without SSI would get mental health care and that all singles would get inpatient substance abuse treatment., while having Medicaid actually *decreased* the odds that singles with SSI would get any mental health treatment.

HOW DO CHRONIC PHYSICAL HEALTH PROBLEMS AND PAST-YEAR PROBLEMS WITH ALCOHOL, DRUGS, AND MENTAL HEALTH AFFECT USE OF CARE?

Not surprisingly, having more physical health conditions was an important predictor of receipt of care, but only for singles, and mostly for medical care as opposed to behavioral health care.

ADM statuses were among the strongest predictors for all types of medical care and some behavioral health care among parents in homeless families, and for singles, and also made a substantial difference for children with respect to emergency room use and hospitalization. For parents, having had only mental health problems was associated with every type of medical care, especially among parents without AFDC-GA, and having both mental health and substance abuse problems was associated with receipt of care for both among all homeless families. A parent's ADM problems also affected the likelihood of their children receiving care, especially in emergency rooms and overnight hospital stays. For singles, having both mental health and substance abuse problems significantly increased the odds that they would have received care for those problems in the last year, with most of the effect coming from singles *without* SSI.

HOW DOES BEING CONNECTED IN ONE OR MORE WAYS TO THE HOMELESS ASSISTANCE SYSTEM AFFECT USE OF CARE?

It helps. Being a resident of a transitional housing program increases the chances of having Medicaid, and sleeping out (not using residential programs) decreases those odds. Having

Medicaid, as we have seen, increases certain types of health care use. Emergency shelter or transitional housing use by parents and especially children in homeless families is associated with greater use of medical health care, compared to those who do not use these facilities. Transitional housing use, and to a lesser extent emergency shelter use, have the same effects on receipt of behavioral health care for singles, increasing it for most categories of care, but only for those without SSI. In contrast, having slept in places not meant for habitation during the last week is negatively associated with receipt of care, for parents, children, and single homeless adults.

We also included a variable indicating that the respondent (parent or single) received help within the past 30 days with a variety of issues and problems, including housing, signing up for benefits, and employment. Our hope was that this variable would act as a sort of index of the respondent's having a case manager, since we were interested in examining the possibility that having a case manager might be responsible for helping one get to care and also get health insurance. This variable was associated with higher odds that single homeless adults would get any mental health treatment and in particular outpatient treatment, and that children in homeless families without AFDC-GA would see a doctor for any reason, get ambulatory care, and be able to get health care when it was needed. However, it actually *decreased* the odds that parents in homeless families would get outpatient substance abuse treatment.

These results do not conclusively support the hypothesis that better system connections lead to greater access to care, because we do not have the data that would allow us to sort out causal ordering. There could be complex patterns at work that we cannot examine. For instance, requirements of certain programs might increase the odds that people would have received care within the past year, as when a program requires prior participation in substance abuse treatment, or sends a resident for treatment to help with a relapse. Or it could be that anyone getting to the stage of receiving help with housing options has been stable and without significant problems for long enough that use of health care would be lower than for people coming to the program more recently.

HOW DOES BEING CONNECTED TO MAJOR PUBLIC BENEFIT PROGRAMS AFFECT USE OF CARE?

There are two answers to this question. First, receipt of benefits is strongly associated with having insurance. Receipt of means-tested public benefits of several varieties very strongly predicts having Medicaid, while receipt of non-means-tested public benefits (Social Security, SSDI, veterans cash benefits) very strongly predicts having non-Medicaid health insurance. Thus to the extent that having insurance gets one better access to care, being connected to the programs that create insurance eligibility increases access.

However, it is also true that having or not having the cash benefit, whether AFDC-GA for families or SSI for singles, is extremely interactive with most of the variables we examined to index access to care. We assessed the effects of having AFDC-GA (for families) or SSI (for singles) as part of our models for all families and all singles, before splitting them into subgroups. These models were able to control for the effects of other variables with which benefits receipt is highly interactive, including receipt of health insurance. The results (Table 5-3) show that having SSI makes a difference for many health care variables for singles, but that

Table 5-3

Summary of Effects of SSI or AFDC-GA Receipt

(weighted percentages)

Important Predictors	Homeless Families		Homeless Singles
	All (N = 440)		All (N = 2443)
	Adults	Children	
Gets SSI			
Doctor or nurse for health care	Inap.	Inap.	
Ambulatory care	Inap.	Inap.	
Emergency Room	Inap.	Inap.	
Hospitalization	Inap.	Inap.	
Able to see when needed	Inap.	Inap.	
Any mental health	Inap.	Inap.	
Inpatient	Inap.	Inap.	
Outpatient	Inap.	Inap.	
Any substance abuse	Inap.	Inap.	
Inpatient	Inap.	Inap.	
Outpatient	Inap.	Inap.	
Gets AFDC or GA			Inap.
Doctor or nurse for health care			Inap.
Ambulatory care			Inap.
Emergency Room			Inap.
Hospitalization			Inap.
Able to see when needed			Inap.
Any mental health	Inap.	Inap.	Inap.
Inpatient	Could not assess	Inap.	Inap.
Outpatient		Inap.	Inap.
Any substance abuse		Inap.	Inap.
Inpatient		Inap.	Inap.
Outpatient		Inap.	Inap.

Source: Urban Institute analysis of weighted 1996 NSHAPC client data. * = p < .05; ** = p < .01. SSI receipt was used as a predictor only for single homeless adults; AFDC-GA receipt was used as a predictor only for adults and children in homeless families.

having AFDC-GA does not make much difference for parents or children in homeless families. Singles with SSI were less likely than those without SSI to report seeing a doctor or nurse for any reason or getting ambulatory care, but they were more likely to say they could see a doctor when needed. They were also more likely to report every type of mental health treatment, but substance abuse treatment was not affected. Getting AFDC-GA did not affect any health care variable for parents in homeless families, with the exception of outpatient substance abuse treatment for which it increased the odds of receipt. For children in homeless families, AFDC-GA receipt increased the odds of being able to see a doctor when one was needed, but did not affect any other type of health care (behavior al health care was not measured for children).

Perhaps the most striking result throughout the many analyses presented is that effects that are significant in the general population (e.g., families, or children, or singles) are rarely significant in both subpopulations defined by cash benefit receipt or non-receipt. One might have expected not to see effects of insurance coverage in the subpopulations with cash benefits, since the vast majority also has insurance coverage through Medicaid. But the effects should have shown up if they existed when we looked at the "all" categories that combined the subgroups. And they do not.

CONCLUSION

At a broad level of generalization, we can say that having health insurance helps homeless people to access health care, but we found many exceptions. We also observed that factors other than insurance are at least as important in determining whether or not homeless people get health care. Access to care differed considerably for different subpopulations and for particular types of care; these factors may be more important for the homeless than the housed population, as their access to care is more likely to be affected by their connection to various parts of the homeless assistance network. We conclude that to fully understand the role of health insurance for homeless people's access to care, we need to take a closer look at how homeless people access health and behavioral health care. Further, we need to examine the routes to care for those who do receive cash benefits and have insurance and those who do not.

It is important to try to understand what other factors may intervene in receipt of care, as has been discovered in the housed poor population (Davidoff, Kenney, Dubay, and Yemane, 2001; Dubay and Kenney, 2001). Since we see so few effects of insurance for parents and children in homeless families, especially for the types of care (ambulatory) that we would prefer to see used, one is tempted to conclude that something about the programs they participate in either provides health care or assures that most residents get what they need, thus masking the effects of having insurance. An examination of program effects and access routes would best be done in the field, at least to start, talking to homeless program staff and their clients, rather than through a survey that is limited in the array of questions it can ask on any particular topic. Once an adequate grasp of possibilities is in hand, surveys could discover how generalizable they are, and how they interact with the specific varieties of care that are available to homeless people in different communities.

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