Health Care of Homeless Families

A Growing Challenge for Family Medicine

Linda F. Weinreb, MD, and Ellen L. Bassuk, MD
Worcester, Massachusetts

The number of homeless families in the United States is growing at an alarming rate. Homeless families are at an increased risk for numerous medical conditions and have complex health and psychosocial needs. In response to the growing crisis, policymakers have generally focused on families' immediate needs rather than developing a comprehensive long-term response. Health programs have been challenged to develop effective methods of providing outreach and comprehensive, continuous, coordinated services. Family medicine is uniquely qualified to meet the health care needs of homeless families and can play an important role in providing clinical service, designing medical education, developing research, and defining a national advocacy agenda. **J Fam Pract 1990; 31:74-80.**

Nationwide, the numbers of homeless persons are increasing. Although historically the stereotypical homeless person was an unattached middle-aged man suffering from alcohol abuse, the composition of the homeless population has changed. It now includes adult individuals, families, and runaway youth. In fact, families with children make up one third of the overall population and are the most rapidly growing subgroup.

The experience of homelessness adversely affects the health and well-being of families. Homelessness increases the risk of developing certain medical conditions, magnifies the severity of various common illnesses, and almost always makes treatment more difficult.[1] Furthermore, homeless children are being raised in substandard conditions in emergency shelters and welfare hotels with their basic emotional, social, educational, and physical needs largely unmet.

Family medicine is uniquely qualified to meet the health needs of homeless families. Family physicians have a long history of caring for underserved populations, understanding the relationship between family health and its social and environmental context, and providing continuous, coordinated services to families with complex health needs.

This paper reviews the extent and causes of family homelessness, the health care needs of these families, and the challenges presented to providers. It concludes by discussing policy and programmatic responses as well as the important role that family medicine can play in providing clinical service and medical education, developing research, and defining a national advocacy agenda.

EXTENT OF THE FAMILY HOMELESSNESS PROBLEM

An estimated 2.5 to 3 million persons are homeless each year. More than one third consist of families with children. In some cities, such as Portland, Ore, New York City, Trenton, and Norfolk, families make up more than one half of the overall homeless population.[2-4] According to a recent Government Accounting Office report, 68,000 to 100,000 children in families are homeless on any given night.[1,5] An additional 186,000 children and youths are precariously housed in shared living arrangements.[5]

CHARACTERISTICS OF HOMELESS FAMILIES

A majority of the nation's homeless families are headed by a mother with two or three children, most of whom are

Submitted, revised, April 12, 1990.

From the Department of Family and Community Medicine, University of Massachusetts, Worcester, the Department of Psychiatry, Harvard Medical School, Boston, and The Better Homes Foundation, Newton, Massachusetts. Requests for reprints should be addressed to Linda Weinreb, MD, Department of Family and Community Medicine, University of Massachusetts Medical Center, 55 Lake Ave North, Worcester, MA 01655.

5 years old or younger.[1,6] In large eastern cities, nearly 90% of homeless families are headed by women[6–8]; in the West and Southwest, the percentage is approximately 70%.[9,10]

Although there is considerable variation, most homeless mothers are in their late 20's, are single or divorced, and have had some high school education.[1,6] Homeless families living in large cities are commonly from minority groups,[6,8] whereas those living in nonurban areas are primarily white. A majority of homeless mothers have not worked regularly and have received public income assistance (Aid to Families With Dependent Children [AFDC]) for more than 2 years.[6]

WHY ARE FAMILIES HOMELESS?

Although the systemic causes of homelessness would require a discussion beyond the scope of this article, experts generally agree that the following factors have contributed to the increasing numbers of homeless families: (1) scarcity of decent, affordable low-income housing; (2) inadequate income maintenance and social welfare benefits; (3) increase in families headed by women; and (4) inadequate social services and supports.

This country is experiencing a severe low-income housing crisis. Minimal federal support for constructing new housing as well as the loss of existing units through condominium conversion and gentrification have contributed to the extreme housing shortage.[11] Each year, up to 2.5 million people are displaced from their homes as a result of rent increases, changes in income that prohibit paying rent, and condominium conversion.[11]

Inadequate public income assistance further compounds the crisis in affordable housing. Although the majority of homeless families receive AFDC, these benefits have failed to keep pace with inflation and fall well below the federally established poverty level in most states.[12] For example, in Massachusetts, AFDC benefits combined with food stamps are 15% below the poverty level. In Boston, where the median rent for a one-bedroom apartment is $500 and for a two-bedroom apartment is $660, many families are at high risk of becoming homeless.[13] Thus, housing costs are consuming increasing percentages of household income. Recent Massachusetts data indicate that many families are spending up to 60% of their income on rent,[13] far more than the 30% that is generally considered reasonable. Of course, little money is left for other necessities.

The increasing numbers of homeless families also reflect the dramatic growth of families headed by women in the past 15 years; higher divorce rates and growing numbers of mothers who have never married account for this trend.[12] Families headed by women are far more likely to be poor than two-parent families. In 1986, for instance, approximately one half of female-headed families were poor compared with only 8% of two-parent families.[12] Thus, families headed by women are more likely to be precariously housed and are therefore more vulnerable to losing their homes.

While it is clear that a scarcity of housing, inadequate income, and changes in family composition contribute to homelessness, these factors do not explain why only some poor families turn to emergency shelters for refuge. Data indicate that the relative absence of support networks differentiate poor families who are doubled up in overcrowded apartments from those who must rely on emergency facilities.

Anthropologists have described how extensive kin and nonkin domestic networks help poor women survive in the community.[14,15] In contrast to poor, housed mothers, however, homeless mothers frequently have fragmented supports and fewer close relationships with women.[16] When asked to name three persons on whom they could count during times of stress, one fourth of a sample of sheltered mothers in Massachusetts were unable to name anyone. Although one fifth of the mothers named only one individual, many mentioned a professional or recent shelter contact. Over one fourth described their minor child as a major support.[6] Given these findings, it is not surprising that poor families without family or friends are more vulnerable in this housing market and more likely to require emergency shelter.[16]

Although the experience of doubling up stresses and exhausts even the most committed family members and friends, other factors may also contribute to the fragmented supports reported by homeless mothers. When compared with poor housed mothers, homeless mothers are more commonly victims of family violence. In the Massachusetts study, 40% of homeless mothers reported having been abused as children. Over 40% also described a history of battering by a boyfriend or spouse.[16] Although available information about violence among homeless mothers remains limited, it may be that a background of family violence explains, in part, the difficulties that some homeless mothers have in establishing and sustaining relationships as adults.

HEALTH NEEDS OF HOMELESS FAMILIES

Most studies describing the health needs of homeless families have significant methodologic shortcomings. Nevertheless, there is a growing body of data showing that homeless families have difficulty accessing medical care, fail to receive essential preventive services, and are

at high risk of developing numerous acute and chronic illnesses.

Although homeless adult family members have fewer health problems than homeless unattached individuals, they are sicker than a general population of adults. Based on data from the Robert Wood Johnson–Pew-supported Health Care for the Homeless programs in 16 cities, Wright and Weber[17] reported that "homeless adult family members are . . . much more ill on virtually all indicators than the general ambulatory population" they used as a comparison. This conclusion may underestimate the severity of the problem, since illness prevalence rates for the housed comparison group were reported by the National Ambulatory Medical Survey, which consists of a sample of patients who come to physicians' offices.

The most common acute health problems manifested by homeless adult family members include upper respiratory tract infections, trauma, and skin problems. The most prevalent chronic illnesses were genitourinary tract problems, gastrointestinal tract illnesses, and hypertension. With the exception of some limited information about pregnancy outcome and prenatal care services,[18] no systematic data describe the preventive health needs of homeless adult family members.

Homeless pregnant women, estimated at 16% to 20% of all homeless mothers, are at high risk for poor nutrition, receiving inadequate or no prenatal care, and having babies of low birthweight.[18] Moreover, compared with the infant mortality rate of 16.6 per 1000 live births reported for women living in New York City low-income housing projects, the mortality rate for infants born to mothers in New York City welfare hotels in 1984 was 24.9.[18]

Surprisingly, there are no systematic data describing the prevalence of substance abuse among homeless mothers. Anecdotal reports, however, especially from service providers in cities nationwide, suggest that increasing numbers of homeless mothers are abusing "crack" and alcohol.[3,19] In addition to causing an increase in pregnancy-related complications, the effects on newborns may be devastating. For example, fetal alcohol syndrome has become the leading cause of mental retardation in this country.[20]

Homeless children have serious unmet medical needs too. When compared with a general population of children, those who are homeless are at risk for delayed preventive care, poor nutrition, higher frequency of acute and chronic illness, developmental lags, emotional and behavioral problems, and learning difficulties.

Based on data from the Health Care for the Homeless programs, Wright and Weber[17] reported that homeless children suffer from chronic illness at twice the rate of a general ambulatory population. Chronic physical conditions among children include anemia, heart disease, peripheral vascular disease, and neurologic disorders. The most common acute illnesses are upper respiratory tract infections, minor skin problems, and otitis media.

Other studies also indicate that homeless children have more illness than a general population of children. Alperstein et al[21] conducted a retrospective chart review of 265 homeless preschool children living in New York City welfare hotels and compared them with housed preschool children of similar socioeconomic status who were attending the same pediatric clinic. Homeless children had higher rates of child abuse and medical problems and more frequent hospital admissions.[21] In Seattle, children in shelters had more health problems compared with a general population.[10]

In addition to acute and chronic medical problems, homeless children are at high risk for poor nutrition. Homeless families are not only extremely poor, but they have limited access to transportation and child care; thus, routine shopping often becomes a burden. In addition, many families living in welfare hotels lack refrigerators and cooking facilities. Limited access to large supermarkets, as well as the high cost of healthful foods, prevents the selection and preparation of a nutritionally sound diet.

In a study comparing children living in New York City welfare hotels with domiciled children of similar socioeconomic status, Acker et al[22] found that homeless children were at greater risk for iron deficiency. Miller and Lin[10] reported that 35% of homeless children were overweight, perhaps resulting from difficulties in preparing nutritious meals. Additional studies are needed to evaluate growth and nutritional variables prospectively, particularly for children who remain homeless for extended periods.

Not surprisingly, homeless children often do not receive preventive medical services, such as routine immunizations.[10,21,22] Almost one half of homeless children in the Acker et al[22] study had delayed immunizations—a significantly higher percentage than a comparison group of poor housed children.

With respect to developmental lags, emotional difficulties, and learning problems, Bassuk and Rosenberg,[16] using the Denver Developmental Screening Test, reported that 54% of homeless preschoolers had at least one developmental delay compared with 16% of housed preschoolers; 33% of homeless children manifested two or more delays.[23] Because the Denver test is a gross screening measure, the percentage may be even greater.[24]

In the Massachusetts study, many homeless school-aged children manifested severe anxiety, depression, and school problems.[6,25] More than one half required further psychiatric evaluation. School problems included repeating a grade (43%), participating in special classes (25%), and failing or performing below-average work (43%).[25] These findings are not surprising given that many homeless children attend school erratically, if at all.

POLICY RESPONSE TO FAMILY HOMELESSNESS

Rather than responding to the multidimensional causes of family homelessness, policymakers have understandably, although shortsightedly, focused on the immediate need for food, clothing, and shelter. In response to the crisis in numbers, an emergency sheltering system has mushroomed nationwide. Emergency facilities range from small neighborhood-based shelters to large barracks-type shelters to welfare hotels and motels. Many locales have no specialized programs for homeless families, while others provide only substandard temporary housing in shelters and hotels. Many facilities are unsafe and overcrowded, lack privacy, and fail to provide cooking facilities or cribs. Because many shelters have restricted lengths of stay, families frequently are forced to move from shelter to hotel.

Emergency shelters were originally established to respond to what was viewed as a short-term situational crisis. With the worsening housing crisis and declining value of public assistance payments, however, homelessness for many families has become recurrent or even chronic. In addition to housing and economic needs, many families have complex social service and health problems as well. As a result, emergency shelters have in reality become human service organizations that now provide a range of onsite support services as well as linkages to existing community programs. Similarly, transitional facilities, which are a form of supportive housing established to help multiproblem families return to community life, have instead been increasingly used to provide more functional families with housing.[26]

While increasing the supply of decent affordable housing is essential to developing an effective long-term solution to homelessness, it is not sufficient. Policymakers must also assume some responsibility for the well-being of these families. In addition to housing and adequate income maintenance, programs should be developed that address medical, psychological, and substance abuse problems, family violence, inadequate supports, and specialized needs of the children. A long-term response should be focused on developing service-enriched housing, that is, permanent housing linked with a wide range of human services as well as health care.

HEALTH CARE RESPONSE

The health problems of homeless families cannot be addressed separately from the context in which they occur.

> The most basic health problem of homeless people is the lack of a home; to condemn someone to homelessness is to visit him or her with a host of other evils. Ignoring the causes of homelessness leads to treating only symptoms and turns medical problems into costly but necessary stop-gap measures. Attempts to address the health problems of homeless persons separately from their systemic causes is largely palliative.[27]

Although many of the health care needs of homeless families will not be eliminated until the systemic causes of homelessness are addressed, medical programs that provide comprehensive care can improve the health status of homeless mothers and children.

Homeless families present numerous challenges to health care providers. Because the health needs of homeless mothers and children are inextricably related to the social, economic, physical, and psychological exigencies of being homeless, families without shelter are limited in their ability to follow prescribed recommendations. In addition, providing essential preventive medical care, especially during infancy, childhood, and pregnancy, becomes a great challenge when caring for families who have multiple problems, are severely stressed, and tend to use health services only during crises.

To ensure effective care, health care providers must help families surmount the numerous obstacles that interfere with their ability to access services. These barriers include financial difficulties, bureaucratic complexities, fragmented services, limited child care and transportation, and prior negative or frustrating experiences with the health care system.

Nationwide financial barriers, especially the lack of health insurance, limit access to health services for poor individuals and families.[28,29] Moreover, it is estimated that one third of the 37 million uninsured Americans are children.[1,30–32] A recent study of homeless children indicated that more than one third had no health insurance and more than one half did not have a regular health care provider.[10]

The Medicaid program, begun in 1966, has improved access to health care for many poor families. Restrictive eligibility criteria and declining physician participation, however, have reduced its potential benefits. Because states determine Medicaid eligibility (ie, families must qualify for AFDC to receive Medicaid), qualifying income criteria vary widely. For example, in 1988, a family of three living in California qualified for Medicaid at or below a monthly income of $633 (78% of federal poverty level), whereas the same-sized family in Alabama was eligible at a monthly income at or below $118 (15% of federal poverty level).[33]

Receiving high-quality medical care, though more difficult for families without health insurance, can be problematic even for those with Medicaid. Because Medicaid reimbursement levels for physician services are low, physician participation in the Medicaid program has declined.[1,34] Thus, many poor adults and children with Med-

icaid coverage have effectively been organized out of the traditional fee-for-service medical system. Furthermore, a shrinking pool of resources and health care providers serving low-income communities has also contributed to the health care access problems of poor families.[1] Unfortunately, many homeless families must therefore rely on emergency departments, outpatient departments of large public hospitals, and neighborhood health care centers for their medical care. In many of these settings, families receive care from multiple providers, decreasing the likelihood of receiving comprehensive and continuous care.

In addition to financial barriers, common bureaucratic problems that interfere with ongoing services include complicated registration procedures, long waits, restricted clinic hours, and inflexible scheduling. Completing registration materials may be difficult for a mother who has no child care and at the same time must supervise all her children. It is not unusual for a family to wait weeks or even months for a routine visit that will include essential preventive care.

In addition to limited child care services and transportation, some homeless families have had prior frustrating experiences with the traditional health care system. For example, it is not uncommon for a mother to be considered neglectful or even immoral for missing an appointment for an immunization. In other instances, health care providers may not have had the time or motivation to address critical psychosocial issues. Many times, successful interventions require aggressive outreach, coordinating multiple caretakers, and intensive long-term follow-up—all of which take extra time in a physician's already busy schedule.

CHARACTERISTICS OF HEALTH CARE PROGRAMS FOR HOMELESS FAMILIES

Throughout the United States, various health care programs target the medical needs of homeless families. The most effective generally share certain common features, including outreach, use of multidisciplinary teams, a family-oriented focus, and provision of ongoing medical care that is integrated with existing community services.

The Health Care for the Homeless program that began in 1985 in 19 cities has been the largest national effort to develop a community-based health care system for homeless persons. Numerous other programs have recently emerged. Most recognize the need to offer aggressive outreach and to deliver services at sites where homeless families congregate.

Outreach increases the likelihood of engaging hard-to-reach clients and thus ensures screening, management of acute illnesses, linkage of families with local health and social services, and follow-up. Outreach activities include the development of shelter-based clinics and roving multidisciplinary teams of medical and support personnel. Mobile medical vans that regularly visit shelters and welfare hotels are being increasingly used; vans now operate in New York City, Boston, Birmingham, and Oakland. Despite the potential fragmentation of care and the difficulties in performing a full range of health services, outreach is critical to the success of any health care program for homeless families.

To provide effective medical care to homeless families, strong linkages must be established between outreach services and local neighborhood health centers or hospital clinics. In some cities the same staff perform community outreach and clinical work at the health center. For example, the Venice Family Clinic, affiliated with the UCLA Medical Center, has provided free primary medical services for West Los Angeles low-income and homeless families for over 15 years. Its staff provides outreach and works onsite at seven local facilities. In other programs, clinic workers communicate regularly with outreach staff based in the shelters. The Family Health and Social Service Center, for instance, is a neighborhood health center located in Worcester, Massachusetts, that serves homeless families and is also a training site for the University of Massachusetts Family Practice Residency Program. It has developed strong ties with the local McKinney-funded Homeless Outreach and Advocacy Program. Frequent communication among staff ensures coordinated, continuous care.

Neighborhood health centers, such as the Worcester program, were initially developed to respond to the health care needs of poor families, but are now providing services to increasing numbers of homeless families. In many cities community-based health centers have become the focal point of medical programs for homeless families. Family physicians are often the sole physicians serving homeless families. In contrast, in some locales care is provided at multiple sites by various specialists.

ROLE OF FAMILY MEDICINE

With growing shortages of physicians choosing a primary care specialty and even fewer choosing inner-city practice,[35,36] family physicians are increasingly being called upon to provide medical care to poor and homeless families. This situation, along with the increasing numbers of homeless families with complex health needs, poses a unique challenge to family physicians. Family physicians have a long tradition of caring for underserved populations. In addition, the skills and values that are central to the daily practice of family medicine are essential in caring for homeless families.

As a specialty, family medicine is particularly suited to provide context-sensitive care to this population. Family physicians understand that a family's health and illness is rooted not only in each individual member's development and physiology, but also in the broader social context. Aspects of the environment, family constellation, economic resources, and social supports bear directly upon the physical and emotional well-being of family members and must be reflected in any treatment plan.

In addition to recognizing the necessity of broadly defining health and comprehensively appraising families, family physicians also understand the critical importance of ongoing care. Homeless families experience numerous stresses, have multiple health and psychosocial needs, and maintain few, if any, stable relationships. Family physicians are experts at accepting responsibility for managing health needs over time and understanding the challenges inherent in this commitment. Most important, they are skilled at forming ongoing, supportive relationships with families that are aimed at improving health, building competence, and fostering adherence to medical recommendations. Likewise, family medicine, recognizing the understandable fragmentation of services within a highly technological health care system, includes among its primary responsibilities the coordination of health services, social services, and supports.

For the reasons described above, family medicine is also uniquely suited to develop training curricula for primary care professionals. Departments of family medicine must also assure that medical students and residents work with underserved populations; clinical and community rotations with poor populations should be a mandatory part of the curriculum offered by departments of family medicine. These rotations expose students and residents to faculty role models, familiarize them with the challenges of caring for groups with complex needs and restricted access to care, and, it is hoped, encourage some individuals to practice in underserved areas.

Though there continues to be a scarcity of methodologically rigorous clinical research about homeless families, the majority of work in this area has been conducted by pediatricians and psychiatrists. Recently, however, family medicine researchers have begun to join their colleagues. For example, Miller and Lin of the University of Washington Department of Family Medicine have described the health needs of homeless children.[10] Researchers from the University of Massachusetts Department of Family and Community Medicine are in the process of completing a preliminary study evaluating the health and psychosocial needs as well as the functioning of homeless families in the Worcester area.

Family medicine can contribute significantly to research efforts that attempt to describe the health care needs of homeless families and their service utilization patterns. Understanding how families and children cope with the stresses of homelessness lends itself well to research methods that are familiar to those in family medicine. Evaluations that are family-oriented, that are focused on strengths rather than deficits, and that emphasize adaptation, coping strategies, and resiliency can offer important information that can be translated into effective interventions. Studies evaluating a family practice model of service delivery for homeless families, especially when compared with more fragmented methods of medical care, may demonstrate multiple advantages of this specialty's practice.

Finally, family physicians, both individually and as a group, must join with their colleagues in pediatrics, psychiatry, and public health to advocate on behalf of poor and homeless families. On a local level, family physicians can work with social welfare agencies, schools, and health facilities to provide education and training and promote improved service delivery. On a national level, family physicians, as a group, should actively work together to address the systemic issues that contribute to homelessness and promote ill health. Through a channel such as the American Academy of Family Physicians, family physicians can strongly advocate to improve health and support services and welfare benefits and to increase the supply of housing. Without broad-based long-term efforts to reduce the prevalence of homelessness, efforts at improving service delivery, however, will remain only palliative.

Family medicine's long tradition of working with underserved patients, its clinical expertise in providing ongoing primary care that is comprehensive and family-based, and its knowledge of family assessment and functioning place it in a unique position to assume a leadership role in working with homeless families. Through direct service, medical education, clinical research, and advocacy, family medicine can help many families and contribute significantly to eradicating homelessness.

References

1. Institute of Medicine: Homelessness, Health, and Human Needs. Washington, DC, National Academy Press, 1988
2. US Conference of Mayors. A Status Report on Homeless Families in America's Cities: A 29-City Survey. Washington DC, US Conference of Mayors, May 1987
3. Alperstein, G, Arnstein, E: Homeless children: A challenge for pediatricians. Pediatr Clin North Am 1988; 35:1412–1425
4. Health needs of homeless children. Report of the American Academy of Pediatrics Committee on Community Health Services. Pediatrics 1988; 82:938–940
5. Children and Youths: Report to Congressional Committees, US General Accounting Office. Washington, DC, Government Printing Office, 1989
6. Bassuk EL, Rubin L, Lauriat A: Characteristics of sheltered homeless families. Am J Public Health 1986; 76:1097–1101

7. Dumpson JR: A Shelter Is Not a Home: Report of the Manhattan Borough President's Task Force on Housing for Homeless Families. New York, Manhattan Borough President's Task Force, March 1987
8. Molnar J: Home Is Where the Heart Is: The Crisis of Homeless Children and Families in New York City. New York, Bank Street College of Education, March 1988
9. McChesney KY: New findings on homeless families. Family Professional 1986; 1(2)
10. Miller D, Lin E: Children in sheltered homeless families: Reported health status and use of health services. Pediatrics 1988; 81: 668–673
11. Hartman C: The housing part of the homeless problem. In Bassuk EL (ed): The Mental Health Needs of Homeless Persons. New Directions for Mental Health Services. San Francisco, Jossey-Bass, 1986, vol 30
12. Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means. US Congress, House of Representatives. Committee on Ways and Means. 100th Congress, 2nd session. Washington DC, Government Printing Office, March 24, 1988
13. Gallagher E: No Place Like Home: A Report on the Tragedy of Homeless Children and Their Families in Massachusetts. Boston, Massachusetts Committee for Children and Youth, 1986
14. Stack CB: All Our Kin: Strategies for Survival in a Black Community. New York, Harper & Row, 1974
15. Susser I, Street N: Poverty and Politics in an Urban Neighborhood. New York, Oxford University Press, 1982
16. Bassuk EL, Rosenberg L: Why does family homelessness occur? A case control study. Am J Public Health 1988, 78: 783–788
17. Wright JD, Weber E: Homelessness and Health. New York, McGraw-Hill, 1987
18. Chavkin W, Kristal A, Seabron C, et al: The reproductive experience of women living in hotels for the homeless in New York City. NY State J Med 1987; 87:10–13
19. Twins of the Streets: Homelessness and Addiction. New York Times, May 22, 1989, p 1, col 3
20. Warren K, Bast R: Alcohol-related birth defects: An update. Public Health Rep 1988; 103:638–642
21. Alperstein G, Rappaport C, Flanigan J: Health problems of homeless children in New York City. Am J Public Health 1987; 78:1232–1233
22. Acker PJ, Fierman A, Dreyer B: An assessment of parameters of health care and nutrition in homeless children. Am J Dis Child 1987; 141:388
23. Bassuk EL, Rosenberg L: Psychosocial characteristics of homeless and housed children. Pediatrics, 1990; 85:257–261
24. Meisels SJ: Can developmental screening tests identify children who are developmentally at risk? Pediatrics 1989; 83:578–585
25. Bassuk EL, Rubin L: Homeless children: A neglected population. Am J Orthopsychiatry 1987; 57:279–286
26. Bassuk EL: Redefining transitional housing for homeless families. Yale Law Policy Rev 1988; 6:309–330
27. Vladeck B, Bassuk E: The shame of homelessness in America. Los Angeles Times, Oct 16, 1988, p 2, col 1
28. Freeman H, Blendon R, Aiken L, et al: Americans report on their access to health care. Health Affairs, Spring 1987:6–18
29. Newacheck P, Halfon N: Access to ambulatory care services for economically disadvantaged children. Pediatrics 1986; 78:813–819
30. Reinhardt U: Health insurance for the nation's poor. Health Affairs, Spring 1987:101–112
31. Rosenbaum S, Johnson K: Providing health care for low income children: Reconciling child health goals with child health financing realities. Millbank Q 1986; 64:442–478
32. Wise P, Zeisel S: Poverty and child health. Pediatr Clin North Am 1988; 35:1169–1186
33. Medicaid Source Book: Background Data and Analysis. US Congress, House of Representatives. Committee on Energy and Commerce. Report by the Congressional Research Service. 100th Congress, 2nd session. Washington DC, Government Printing Office, November 1988
34. Perloff J, Kletke P, Neckerman K: Physicians' decisions to limit Medicaid participation: Determinants and policy implications. J Health Polit Policy Law 1987; 12:221–235
35. Gessert C, Blossom J, Sommers P, et al: Family physicians for underserved areas: The role of residency training. West J Med 1989; 150: 226–230
36. Muller C: Review of twenty years of research on medical care utilization. Health Serv Res 1986; 21:129–144