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Access to Healthcare: An Analysis of Helena, Montana's Homeless Population

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**Access to Healthcare:
An Analysis of Helena, Montana's Homeless Population**

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This thesis for honors recognition has been approved for the

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Abstract

Access to Healthcare: An Analysis of Helena Montana's Homeless Population

Homelessness is a serious problem in the United States, and access to and uses of healthcare are key topics of public discourse and political platforms. The scientific literature indicates that homeless individuals have less access to healthcare than those who are not homeless. There have not been studies performed on the access to and use of healthcare by the homeless population in Helena; therefore this study examines the relationship between homelessness and healthcare in the Helena area. It was predicted that the individuals who lack resources, such as insurance and financial assets, will have less access to healthcare than individuals who do have these resources, following the theory of fundamental causes by Phelan and Link (2010). It was also predicted that individuals who are homeless will tend to seek medical care at the emergency room most often because of easy access. Thirty-five homeless individuals in the Helena community were surveyed about their access to and use of healthcare. Descriptive and inferential statistical analyses were performed. Descriptive data indicated that the majority of the homeless respondents most often use the emergency room for their medical care. Sex, race, age, and homeless status had a significant effect on location of medical care within the last year. Sex, age, duration, and homeless status had a significant effect on the location of where homeless individuals most often sought medical attention throughout life. A common trend found was that homeless status had a significant effect on where an individual seeks medical attention. Homeless individuals in the Helena area have less access to healthcare and are less likely to seek medical attention from a physician rather than the emergency room. The access to and use of healthcare occurred less frequently for the homeless individuals than those who are not homeless.

INTRODUCTION

Homelessness is a serious problem in the United States today. According to Baggett et al. 2.3 to 3.5 million Americans experience homelessness each year (2010). There are many factors that can cause an individual to become homeless; these may include poverty, lack of affordable housing, and the lack of comprehensive health insurance. The housing and economic crises that homeless individuals experience and the healthcare crisis are closely linked, with homeless individuals unable to seek medical attention because of financial burdens. Lack of health insurance can cause homeless individuals to have to pay out of their pockets for medical needs which tend to be very expensive, so many homeless individuals are unable to pay for medical care. Not being able to pay for medical care can cause homeless individuals to stop seeking medical attention or become even more in debt. As stated by Eitzen et al. nearly 47 million individuals are uninsured in the United States today (2011). More than half of the 2.3 to 3.5 million individuals who are experiencing homelessness are not insured (Brown et al. 2010). Knowing this information, what is the access to and use of healthcare by those who are homeless? It is very important that these issues are examined. Homelessness is a growing problem in the United States (National 2009). Therefore it is important that there is more information on homeless access to healthcare. Healthcare access and use are also key topics in the United States for both public discourse and as platforms for political candidates, especially with the newly implemented Affordable Care Act.

Many non-profit organizations have recently been talking about and working towards bettering the human rights of the citizens; healthcare is classified as a human right according to the Human Rights Resource Center that has published the Universal

Declaration of Human Rights. Article 25:1 of the Universal Declaration of Human Rights states (2014):

Everyone has the right to a standard living adequate for the health and well-being of himself and of his family, including food, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. (9)

This indicates that healthcare must be provided as a public good for everyone. All healthcare, including hospitals, clinics, medicines, and doctors' services must be accessible to, available to, accepting of, and of good quality for everyone when and where it is needed (NESRI 2009).

Within the scientific literature there are a few studies on this particular topic. However, most of the research conducted has been on a national scale. For example, Baggett et al. looked at the United States as a whole (Baggett et al. 2010:1326). Nevertheless, the national relationships may be different from those in Helena, MT. With Helena being a close-knit community, it would be beneficial to perform this study in Helena and bring homeless healthcare access and use to the attention of the Helena community. It will also be beneficial to addressing any problems related to equal access to healthcare.

This study will look at access to and use of healthcare by the homeless in the Helena community using Phelan and Link's theory of fundamental causes (Phelan and Link 2010). "The idea that resources of money, knowledge, power, prestige, and beneficial social connections are critical to maintaining a health advantage" is the central

concept to this theory (Phelan and Link 2010:S31). The literature used to formulate the research question--what is the relationship between the access to and use of healthcare and homelessness--will be outlined in the literature review. It is expected that individuals who lack resources, such as insurance and financial assets, will have less access to healthcare than individuals who do have these resources. These individuals will also suffer more ill health than those who have access to resources such as money, knowledge, power, prestige, and beneficial social connections. It is also expected that individuals who are homeless will tend to seek medical care at the emergency room most often because of easy access. The more permanent an individual's homeless status is, the less access to and use of healthcare they will have. The steps that will be taken to perform this research project will be outlined in the methodology section of this paper.

LITERATURE REVIEW

Zlotnick and Zerger argue that an individual's health is impacted by the individual's housing situation: "The realities of homelessness contribute to poor health, and poor health may lead to and sustain homelessness when individuals are unable to afford or obtain access to preventive care" (2008:18). Individuals who live on the street or in shelters have poorer health than individuals who are in the housed population due to lack of adequate and reliable nutrition and poor hygiene (Zlotnick and Zerger 2008). These individuals are more likely exposed to violence, they are more exposed to contagious diseases, and they lack a safe place to rest (2008). Zlotnick and Zerger state that many homeless adults have difficulty gaining access to healthcare services which results in these individuals receiving little or fragmented healthcare (2008).

How does one define homelessness? Lee et al. state that there are three major types of homelessness that have been defined (2010:503). Transitional, or temporary, describes individuals who are in transition between stable housing situations. Episodic homelessness entails cycling in and out of homelessness over short periods of time. The last type of homelessness is chronic homelessness, which is a more permanent condition (2010:503).

Baggett et al. (2010) performed a study similar to the one that was performed here, in Helena. Baggett et al. surveyed homeless individuals at a national level instead of a community level. They found that there are high rates of unmet healthcare needs experienced by homeless individuals. The unmet needs were related to being uninsured and having competing priorities (2010). Homeless individuals tend to prioritize items, such as healthcare, food, shelter, work, etc., in an order in which the most important is living through the night. Baggett et al, found that homeless individuals prioritized healthcare after other items such as food, shelter, and work. Being uninsured was the main reason these individuals have less access to healthcare; however the barrier of competing priorities also plays an important role when it comes to seeking medical attention (Baggett et al. 2010). It is important to do a study in the Helena community on a large social problem like homeless access to healthcare and see how the situation for the homeless in Helena compares to the national findings.

Brown et al. found that older homeless adults had significantly better access to healthcare than younger adults (2010). The older homeless individuals were more likely to have a regular place to receive healthcare, have a regular healthcare provider, and to have health insurance. Public health insurance was reported most by the individuals who

had health insurance. The older homeless individuals who reported they had health insurance said that they had a regular place for care and a regular provider, and they were also less likely to report being unable to receive care that was needed (Brown 2010:1065). They conducted a multivariate analysis of inability to obtain needed healthcare with age, gender, race, and health insurance. The only significant association was between lack of insurance and the inability to obtain needed healthcare. This indicates that age was in fact not significantly associated as previously thought by Brown et al, because of the adjustments made when running a multivariate analysis. Brown et al. also found that there were no significant differences between the older and younger homeless individuals when examining the rates of having an emergency room visit within the past year or having had an inpatient hospitalization in the past year (2010). Another multivariate test was run for the relationship between rate of having an emergency room visit and/or hospitalization by age, gender, race, and health insurance. The final conclusion made by Brown et al (2010) for the variable age, was that age was not significantly associated with the inability to obtain needed healthcare. Once again there was not a significant association with either having had an emergency room visit or a hospital admission during the prior year. These findings show that insurance status independently predicts better healthcare access. By having health insurance, the individual will have better access to ambulatory care and fewer barriers to obtaining medical care. The findings also show that age is not independently associated with better healthcare access. Age affects the insurance status of an individual, where the older homeless individuals are more likely to have health insurance, which results in better access to healthcare.

Kirby found that individuals benefit from living among individuals who have similar economic circumstances because they will face similar barriers when it comes to seeking medical attention (2008). These individuals will also benefit from the experience and knowledge of those around them. Kirby states that this collective knowledge from those around them that is embedded in poor communities may compensate for the otherwise negative influence of community-level poverty (2008). Community-level poverty is described in terms of limited access to physical resources, unlike individual-level poverty where the individual has the inability to meet the basic necessities of life, regardless of their availability. Kirby also emphasizes that barriers to obtaining healthcare do not exist only at the individual level, but also at the community level (2008).

Therefore, if an individual lives in a community that is poorer than other communities, there will be more barriers when obtaining healthcare due to the lack of resources in that community. Barriers are prevalent when examining both individual and community level poverty.

Homeless individuals experience poor access to healthcare as a result of their socioeconomic status (Baggett et al. 2010, Phelan et al. 2010, Lee et al. 2010). Individuals who are of a lower socioeconomic status are less likely to be able to afford healthcare services or even to obtain health insurance. These are the two main barriers that individuals of the lower class must overcome in order to obtain equal healthcare services. Overcoming these barriers is nearly impossible for these individuals to do. Zlotnick and Zerger concluded that homeless individuals were less likely to receive regular exams because of barriers and competing priorities (2008). This conclusion is consistent with those of Baggett et al (2010) who state that the work most often performed by homeless

individuals is day labor, where they are barely paid enough to live or eat, let alone seek medical attention (2010). Day labor jobs tend to be higher-risk jobs which can result in strain on the individuals' body. These jobs most often do not include health insurance benefits, therefore lowering the chance of these individuals being able to seek medical attention (Baggett et al. 2010). These jobs can also act as a competing priority for the homeless when seeking medical attention because they are unable to take the time off to go to an appointment.

Nickasch and Marnocha (2009) looked at the healthcare experiences of the homeless from the homeless individuals' perspective. There were five main conclusions that were made from this study. These included: (a) the great majority of homeless people have an external locus of control, where individuals believe that their fate is determined by chance or outside forces that are beyond their own personal control; (b) most homeless individuals lack the necessary resources to meet their physical needs of shelter, air, water, and food; (c) most homeless individuals lack the financial resources to seek adequate healthcare; (d) access to resources is limited because of poor transportation, telephones, and mail; and (e) all those who took part in the research felt that healthcare providers lack compassion for the homeless (2008:39). These individuals prioritized their needs from high to low, with healthcare being on the low end of the spectrum. Since many of the homeless individuals were unable to meet many physical needs, such as a shelter, clothing, and healthy food, there was a great burden placed on their health. Many individuals were also unable to obtain healthcare because they were unable to afford it; they expressed that difficulties were encountered trying to obtain health insurance, coupled with the financial burden of paying for the health insurance if they did obtain it.

Another issue that was found by Nikasch and Marnocha was the lack of available resources. Individuals encountered difficulties trying to set up appointments or services because many homeless individuals lack a permanent address or telephone number. The lack of these two items makes it difficult to schedule a doctor's appointment. Another resource that was less attainable by the homeless was transportation to the doctor's appointment. The last issue expressed in this study was the lack of compassion that the physicians had for the homeless individuals (Nikasch and Marnocha 2009). The lack of compassion that a physician had for the homeless individuals was expressed during interviews. Many of the homeless felt judged by their appearance and that they were not treated adequately because they were homeless (2009).

The conclusions of Nikasch and Marnocha (2009) are consistent with the conclusions of others. Homeless individuals tend to prioritize healthcare behind many other important things; this finding is consistent with the idea of overcoming barriers that each of the other studies discussed. The lack of health insurance also played a part in all of these findings; since the individuals were less likely to have health insurance they were less able to access medical care. If the individuals had health insurance, they were able to obtain better healthcare than the individuals who were unable to obtain health insurance. The lack of available resources is also consistent between all of the studies; lack of available resources creates another barrier that the homeless individuals must overcome. The concept of barriers is consistent throughout all of the studies.

Research is consistent in finding that individuals who are of lower socioeconomic status will have less access to healthcare. Those individuals who have health insurance have better healthcare access than those who do not have health insurance. Health

insurance was independently associated with better access to ambulatory care, a personal healthcare consultation, treatment, or intervention using advanced medical technology or procedures delivered on an outpatient basis, for those individuals who had fewer barriers to overcome in order to obtain medical care (Brown et. al 2010).

Looking at all of these studies as a whole, this research expects to find similar results in the homeless community of Helena. Individuals who classify themselves as homeless will have less access to healthcare because they cannot afford medical attention; they will be unable to seek medical attention from a primary care physician. Individuals who are less likely to obtain health insurance will have less access to healthcare. Insurance is a necessity for individuals to have consistent and quality healthcare: “The unmet needs of the homeless individuals are most consistently related to being uninsured” (Baggett et al. 2010:1331). It is also predicted that many of the individuals who are homeless will seek medical attention at an emergency department instead of maintaining a primary physician.

METHODOLOGY

Study Location

The research was performed with individuals at God's Love, the local homeless shelter in Helena, Montana. God's Love is available for men and women eighteen years and older. It provides twenty-four/seven emergency shelter for homeless individuals in the Helena area, provides three meals per day, and offers counseling. The dorm-style accommodations are fit for approximately thirty-five men and there are two rooms that can house eight women. Families are also welcome to use God's Love as an emergency

shelter.

Study Design

The data for this research were collected by providing a voluntary questionnaire to homeless individuals at God's Love. The data obtained from the questionnaire were used to determine access to healthcare by the homeless population in Helena. These data will not be representative of all homeless individuals in the United States, but they may represent the Helena homeless. This research will help the community of Helena understand the issue with access to healthcare by the homeless.

The data obtained through the questionnaire were quantitative. The questionnaire consisted of twenty-two questions that provided critical information. The questions included, but were not limited to “How would you classify your status (transitional/temporary, episodic, or chronic) when it comes to being homeless?”, “What has led to your condition?”, “Where do you most often seek medical attention?” (Emergency Department, Walk-in Clinic, Primary Care Physician, or Urgent Care), “If you don't seek medical attention, what are the reasons behind it? (For example: no insurance, or competing priorities)” and “What is your age?” A full copy of the questionnaire is located in Appendix A. Individuals who participated in the questionnaire were individuals who were currently taking residence at God's Love or those individuals who eat meals at God's Love. The use of a questionnaire was appropriate to determine the status of an individual seeking help and where they went to receive medical attention. Placing a questionnaire at God's Love instead of conducting interviews was more convenient for the homeless individuals, because they did not have to have a set time to meet for the interview and they were able to answer the questionnaire at their

convenience.

Since the research worked with human subjects, I needed to become human subjects certified from the NIH and also be approved by the Institutional Review Board at Carroll College in order to continue with the research. Once approval was granted, I was able to begin the research with the homeless population in Helena, Montana. Initially, I asked two individuals at God's Love to participate in the survey as pre-testers. Once the pre-tests were analyzed and it was determined that the instrument would be sufficient to examine the access to healthcare by the homeless population in Helena, Montana, research proceeded.

The questionnaire was placed at God's Love for four weeks (mid-October to mid-November) where the residents were able to complete it when convenient for them. Individuals who took part in the questionnaire were informed that it was voluntary and anonymous, that they were able to skip any questions they did not feel comfortable answering, and that they could stop taking the questionnaire at any point.

During the four week period, the questionnaires were collected the Thursday of each week and the data were coded and entered into the Statistical Package for the Social Sciences (SPSS). The open-ended questions were entered into an Excel spreadsheet, where they were coded for themes. Once the data were entered into the SPSS software and Excel, the hard copies of the questionnaires were shredded.

Statistical Analyses

Quantitative data were a better way to portray this information instead of qualitative. Quantitative data gave an overall understanding of the situation the homeless in Helena have when it comes to healthcare access. It has also allowed me to test the

relationship between causal factors and access. The data obtained from the questionnaire were statistically analyzed using contingency analyses and chi-square tests. The data collected were counted and coded into specific variables for each of the questions asked on the questionnaire. The analyses were conducted through the use of SPSS.

Many of questions on the questionnaire required single answers, however, some individuals did not indicate just one answer and instead marked multiple answers; however, since I obtained just above the minimum amount of questionnaires needed to run a statistical analysis (35 respondents), I was unable to throw out the questionnaires in which there were multiple answers to these particular questions. Two models were run to analyze the data, with the first having replicated the individuals' answers to the questionnaire as a "new" respondent and changed only the answer to the question where they had chosen multiple answers. This resulted in fifty-nine respondents instead of the initial thirty-five. By replicating the individuals' data, I was able to keep all of the data obtained through the surveys. This model I will call "Model 1." The second model marked the answers to those particular questions as a "missing" value if the respondent supplied multiple answers. This model was a more realistic approach to analyzing this data; it did not indicate that there were more respondents than there actually were to the questionnaire and it did not indicate that there was more diversity among those respondents than what was actually present. This model I will call "Model 2."

First, a two-way contingency analysis was conducted to determine if there was a relationship between the key dependent variable (location of healthcare access and use) and the various independent variables: sex, age, race, education, homeless status (transitional, episodic, or chronic), the individuals health when given the questionnaire,

employment, how long they have been homeless (days, months, or years), if they have insurance, and the barriers that have kept them from seeking medical attention. A chi-square test was used to analyze if the relationships were significant or not, alpha levels of 0.05 and 0.1 were used. An alpha of 0.1 was used to reduce the risk of type II error where I would fail to detect an effect that is present. For those variables that were significantly associated with location, I performed subsequent analyses which tested for associations between the independent variables, for example, a two-way contingency analysis between sex and age. Again, alpha levels of 0.05 and 0.1 were used to determine if the association was significant or not.

For those independent variables that were significantly associated, I performed a three-way contingency analysis testing for interactions between the independent variables in their effect on the dependent variables. This was used to determine if the variables were independent or dependent upon each other when examining the relationship with where a homeless individual has sought medical attention (within the past year or throughout their life).

These three steps were replicated for two different definitions of location: one being where the homeless individual has sought medical attention most often during their lifetime and the second being where the homeless individual has sought medical attention most often within the last year. They were also replicated for the two different models: replicated data and missing data.

RESULTS

Descriptive Data

Thirty-five individuals who were seeking shelter at God's Love were identified through random voluntary sampling. All individuals of God's Love were encouraged to participate in the questionnaire, and during the four-week run of the questionnaire thirty-five individuals responded. As stated above, some of the thirty-five respondents were duplicated for one of the statistical models (Model 1) resulting in fifty-nine total responses used for analysis of model one. The thirty-five respondents who initially responded to the questionnaire were used to run Model 2. The initial descriptive data (age, sex, race, education and employment) obtained from the thirty-five questionnaires are located in Table 1. The homeless individuals were asked how long they had been homeless (duration) and how they would classify their homeless status; these results are found within Table 2. Other descriptive data that were obtained from the questionnaires were the reasoning for not seeking medical attention, how the individual's health was the day they completed the questionnaire, and if they had insurance or not (Table 3).

With the exception of one individual who did not answer the question, all of the participants have sought medical attention at some point. When asked where they have most often sought medical attention throughout their life, 12 indicated they go to the emergency room, seven use walk-in-clinics, five go to primary physicians, one indicated they use the urgent care, and nine indicated "other" (Figure 1). Of the individuals who indicated "other", two stated they used the V.A., one indicated they use Indian Health, three indicated they used Healthcare for the Homeless, and three indicated that they did not seek medical care anywhere (Figure 2). One participant did not indicate where they most often seek medical attention. When asked if they have sought medical attention within the past year, twenty-six of the participants responded yes, eight responded no and one

did not answer the question. Of the twenty-six participants who stated yes that they have sought medical attention within the past year, five indicated they used the emergency room, nine used walk-in-clinics, seven went to a primary physician, two sought attention at the urgent care, and one indicated “other” (Figure 1). All three of the participants who responded “other” indicated they used the V.A.

When asked if there have been any medical services in the Helena area that they have found useful, seventeen out of the thirty-five participants responded (Figure 3). Four indicated they have found Healthcare for the Homeless to be useful, one indicated Indian Health Services, one indicated urgent care, one indicated mental-health, three indicated the Cooperative Health¹ has been useful to them, two indicated that the V.A. has been useful, two indicated the emergency room has been useful, and one stated that a Dermatologist has been useful. Two participants stated that they have not needed medical services yet.

Model One—Replication

Location Used Throughout Life—Two-Way Contingency Analysis

Using a pairwise test to look at the relationships between the location where a homeless individual has sought medical attention ever and the multiple independent variables, there was a significant relationship between four of the interactions. Location and sex ($P=0.056$), location and age ($P=0.011$), location and homeless status ($P=0.020$), and location and duration ($P=0.038$). All of the relationships ran for this test can be found in Table 4. Therefore, the location of choice was not independent of sex, age, homeless status, and duration.

¹ Cooperative Health is a non-governmental, nonprofit organization that partners with the community to provide patient-centered, quality healthcare regardless of ability to pay.

Sex. In the examination of where the homeless individuals have sought medical attention ever based on their sex, of the eighteen female participants, six indicated they sought medical attention at the emergency room, six stated they did at a physician, three indicated they sought medical attention at walk-in-clinics, and two indicated they had sought medical attention at another type of medical center. Males followed a similar suit. Of the forty male respondents, nine indicated they sought medical attention at the emergency room, ten at walk-in-clinics, four at a physician, three at the urgent care, and fourteen stated they had sought medical attention at another type of medical center.

Age. When examining where the homeless individuals have sought medical attention ever based on their age, it was found that of the four individuals who were in the age range of 18-21, three indicated they sought medical attention at a physician while only one stated that they sought medical attention at the emergency room. In the age range of 22-29 year old respondents, one stated they sought medical attention at walk-in-clinics, two stated they did at the urgent care, and three stated that they have sought medical attention at another type of medical center. For the twelve respondents who are among the 30-39 year olds, five stated that they have sought medical attention at walk-in-clinics, three stated they have used the emergency room, three have sought medical attention at a physician, and one stated they have used the urgent care. Respondents who were among the age range of 40-49 sought medical attention at the emergency room most often (six respondents), one indicated that they had sought medical attention at a walk-in clinic, two went to a physician, and one stated they sought medical attention at another type of medical center. Fifty to fifty-nine year old homeless individuals most often sought medical attention at another type of medical center (six respondents), five indicated they

use walk-in clinics, three sought medical attention at the emergency room, one individual stated they had sought medical attention at the physician, and one indicated using the urgent care for their medical needs. The 60-69 year old individuals had a similar trend as the 50-59 year olds. Six of the 60-69 year old homeless individuals indicated they had sought medical attention at another type of medical center, two indicated they sought medical attention at the emergency room, and there was one respondent for each of the other locations (walk-in-clinics, physician, and urgent care).

Homeless Status. In the examination of where the homeless individuals have sought medical attention ever based on their homeless status, it was found that of the individuals who classified themselves as being transitional or temporarily homeless, ten indicated they use the emergency room for their medical needs, ten also stated they had sought medical attention most often at a physician, nine stated that walk-in-clinics was where they had sought medical attention, two used the urgent care, and seven indicated they had used another type of medical center for their healthcare needs. There were only four individuals who classified themselves as episodic; these four individuals were equally split between using urgent care and using another type of medical center for their healthcare needs. Eleven individuals classified their homelessness as chronic. Four of these individuals sought medical care at the emergency room, one indicated that they had sought medical attention at a walk-in most often, one stated that the urgent care was where they sought medical attention, and five indicated that they had sought medical attention at some other type of medical center.

Duration of Homelessness. The last variable that had a significant association with the location at which an individual sought medical attention most often throughout

their lives was the duration of the individual's current state of homelessness. Thirteen individuals stated that they had been homeless for days upon the completion of the questionnaire. Of these thirteen individuals, four stated they used walk-in-clinics most often, three indicated using a physician, three also indicated using the urgent care as their primary location for seeking medical attention, one stated they used the emergency room, and two indicated they used some other type of medical center for their healthcare needs. Twenty-one individuals stated they had been homeless for months upon the completion of the questionnaire. Of these twenty-one individuals, seven stated they most often sought medical attention at a physician, six indicated they used the emergency room, three had used walk-in-clinics, and five indicated they had used some other type of medical center. There were also twenty-one individuals who stated they had been homeless for years upon the completion of the questionnaire, seven of these individuals stated they had used the emergency room most often, four stated they used walk-in-clinics, two used the urgent care, and eight indicated they had sought medical attention at another medical facility. No respondents stated that they had seen a physician for their medical needs.

The subsequent two-way contingency analysis, between the causal variables, indicated that homeless status and age were significant with each other ($P=0.016$), how long an individual had been homeless for (duration) and age were significant with each other ($P=0.028$), and homeless status and duration were significant with each other ($P=0.002$) (Table 5). Most of the p-values obtained from these analyses were less than 0.05 and many were also less than 0.01.

Location Within Past Year—Two-Way Contingency Analysis

It was found that there were also four significant relationships when analyzing

where an individual has sought medical attention within the last year and the multiple causal variables. They varied slightly from the relationships found when examining where a homeless individual ever seeks medical attention. The significant relationships were with sex ($P=0.082$), race ($P=0.006$), age ($P=0.005$), and homeless status ($P=0.004$). All relationships that were tested to find these significant values are located within Table 6.

Sex. In the examination of where the homeless individuals have sought medical attention within the past year based upon their sex, it was found that of the seventeen female homeless participants, six stated they had sought medical attention at a physician, five had used the emergency room, four used the urgent care, and two had used walk-in clinics as their primary source of medical care. The male respondents (twenty-six) were more likely to seek medical attention at either the emergency room or the urgent care. Ten of the male participants stated they had used walk-in-clinics, seven stated they most often used the emergency room, while there were three respondents for each of the remaining choices (physician, urgent care, and other types of medical centers). Comparing these results to the ones found for the two-way contingency analysis for location-life, they are similar in that females were more likely to use the emergency room or a physician for their primary healthcare needs. Men on the other hand had a small difference between the results. Men stated that throughout their lives they have used another type of medical center for their healthcare needs; however, walk-ins and emergency rooms were the next most common places to seek medical attention.

Race. In the examination of where the homeless individuals have sought medical attention within the past year based on their race, it was found that of the ten respondents

who indicated they were either American Indian or Alaskan Native, four most often used the emergency room within the last year, three had used walk-in-clinics, and three had gone to a physician for their medical needs. Thirty-one of the respondents classified themselves as Caucasian. Of these thirty-one individuals, ten indicated that they had used walk-in-clinics most often within the past year, eight had used the emergency room, six used a primary physician, five had used urgent care, and two indicated they use another type of medical center for their medical needs within the past year. One respondent who indicated that their race was Asian; they had used another type of medical center for their healthcare needs within the past year. Both of the individuals who marked “other” for their race used the urgent care most often within the past year for their healthcare needs. These results are unable to be compared to results that were found for where an individual has sought medical attention throughout their life most often. This is because there was no significant relationship between the variables race and location when examining the location of healthcare use throughout an individual’s life.

Age. When examining where the homeless individuals have sought medical attention within the past year based on their age, it was found that of the four individuals who were in the age range of 18-21, three indicated they sought medical attention at the urgent care while only one stated that they sought medical attention at the emergency room. In the age range of 22-29 year old respondents, two stated they had sought medical attention at the urgent care. For the eleven respondents who are among the 30-39 year olds, two stated that they have sought medical attention at walk-in-clinics; four stated they have used the emergency room, four have sought medical attention at a physician, and one stated they have used the urgent care. Respondents who were among the age

range of 40-49 sought medical attention at the emergency room most often (three respondents), two indicated that they had sought medical attention at a walk-in clinic, and two went to a physician. Fifty to fifty-nine year old homeless individuals most often sought medical attention at walk-in-clinics (eight respondents), one indicated they use urgent care, two sought medical attention at the emergency room, two individuals stated they had sought medical attention at the physician, and one indicated using other types of medical centers for their healthcare needs. Of the six respondents who were among the 60-69 age range, two indicated they used the emergency room, two at another type of medical center, one sought medical attention at a physician, and one at walk-in clinics. When comparing these results to those found using the variable location throughout their life, the results are different but not drastically. There were only slight deviations between the amounts of respondents for each of the location categories within the age ranges. Most of the age ranges were consistent with where the homeless individuals sought medical care even with these slight deviations in respondent numbers.

Homeless Status. For the last variable that had a significant association with the location at which a homeless individual sought medical attention most often within the past year was the individuals' homeless status. Thirty-one individuals stated that their current homeless status was transitional or temporary, of these thirty-one individuals, nine stated that they had sought medical attention at the emergency room, nine indicated that they go to a physician for their medical needs, eight had used walk-in clinics, and five had gone to an urgent care when in need of medical attention within the past year. There were only three respondents who classified their status as episodic, two of them had used urgent care and one had used another type of medical center. Individuals who

classified their homeless status as chronic (six respondents) had used either the emergency room (three) or walk-in-clinics (two) for their healthcare needs. The results are consistent with those found when running the two-way contingency analysis for the location of medical care a homeless individual has sought throughout their life.

Individuals who classified their homeless status as transitional/temporary were more likely to seek medical care at either an emergency room or a physician, episodic homeless individuals sought medical care at either urgent cares or another medical center, the chronic homeless individuals had sought medical care at either an emergency room or a walk-in clinic.

The subsequent two-way analysis, between the causal variables, performed on the variables associated with the location of medical care sought by a homeless individual within the past year was different than those for the location of medical sought by a homeless individual throughout their life. The analysis indicated that homeless status and age were significant with each other ($P=0.016$), and homeless status and race were significant with each other ($P=0.045$) (Table 7).

Location Ever—Three-Way Contingency Analysis

It was found after running a three-way contingency analysis between location and status, controlling for age, there was a significance for the 22-29 and 40-49 age groups ($P=0.050$, and 0.038 respectively). Individuals who were among the age groups of 50-59 and 60-69 were not significant ($P= 0.695$, and 0.484 respectively). Ages 18-21 and ages 30-39 were disregarded due to a lack of respondents in these categories.

In a three-way contingency analysis between location and duration, controlling for age, there was a statistical significance for the age range of 18-21 ($P=0.046$) and the age

range of 22-29 ($P=0.050$). Individuals who were among the rest of the age ranges were not significant.

The last three-way contingency was between location and, status controlling for duration. There was no statistical significance for any of the categories of duration.

Location Within Past Year—Three-Way Contingency Analysis

It was found after running a three-way contingency analysis between location and status, controlling for age, there was no significance. Ages 18-49 were disregarded due to an increased number of zeros present in the data for those age ranges. The 50-59 and the 60-69 age groups were found to be not significant ($P=0.624$, and 0.125 respectively).

The three-way contingency analysis between location, status, and race was significant for Caucasians ($P<0.001$) but not for American Indian or Alaskan Natives ($P=0.135$). The data for individuals who stated they were of another race was disregarded due to the lack of data.

Model Two—Missing

Two-Way Contingency—Location Throughout-Life

There was only one significant relationship detected after analyzing the various variables, between location and insurance status ($P=0.049$) (Table 8). These results were different from the results found in the first model in that there was no significant relationship between location and insurance status within the first model. This model also did not result in the four significant results found within the first model: location and sex, location and age, location and homeless status, and location and duration of homelessness.

Since there was only one significant relationship between the location of medical

care a homeless individual has used most throughout their life, there was no need to run a subsequent two-way contingency analysis (or three-way contingency analysis).

Two-Way Contingency—Location Within Past Year

It was found that there were two significant relationships when analyzing where an individual has sought medical attention within the last year and the multiple independent variables. Location and status ($P=0.076$) and location and insurance status ($P=0.026$) had significant relationships (Table 9). These results were different from the results found in the first model in that there was no significant relationship between location and insurance status within the first model. The significant relationships of location and sex, location and race, and location and age that were found within the first model were not found within the second model. The only similar result found between these two models was the significant relationship between location and homeless status.

A subsequent two-way analysis, between the causal variables, resulted in no significant relationships. Since there were no significant relationships between these causal variables, there was no need to run a three-way contingency analysis.

DISCUSSION OF RESULTS

Access to and use of healthcare by the homeless is something that has been studied at the national level, but there has not been a study on this particular topic in Helena, Montana. The scientific literature states that the access to and use of healthcare by the homeless depends on the barriers the individual encounters, availability of resources, and insurance status. The study performed by Brown et al. (2010) also examined the effect of age, gender, and race on the access and use of healthcare. The

results of this study indicated that none of these had a significant effect on the access and use of healthcare. In the present study, I found that both age and sex were significant along with the individual's homeless status and how long they have been homeless when examining where they sought medical attention ever. I also found that both age and sex were significant along with the individual's homeless status when examining where they sought medical attention within the past year. Both of these were found using the first model, replication. The second model, missing, indicated that the insurance status was significant when examining where a homeless individual sought medical attention most often throughout their life. I also found that the status of homelessness and if they had insurance was significant when examining where the homelessness individuals sought medical attention within the past year.

Descriptive Data

The descriptive data obtained during this study indicate that the majority of homeless individuals sought medical attention at the emergency room whether throughout their life or within the past year. Because the emergency room is where homeless individuals have most often sought medical attention throughout their life and within the past year, the prediction that the emergency room will be the main location of medical care by the homeless is supported.

How long an individual has been homeless was associated with where they sought medical attention both within the past year and ever. As the amount of time an individual has been homeless increased, there was a decrease in likelihood of the individual seeking medical attention at a physician, while the rate of emergency room visits increased. It is logical that as the amount of time an individual is homeless increases, the likelihood of

them obtaining and maintaining insurance goes down. Brown et al. concluded that individuals who had health insurance were more likely to have better access to healthcare in which they would have a primary physician (2010), indicating that those individuals who do not have health insurance will have less access to healthcare and will unlikely have a primary physician, resulting in the individual seeking medical attention at an emergency room. My study indicated that insurance did not have a significant effect on where a homeless individual sought medical attention ever or within the past year for model 1 and there was a significant effect when examining model 2.

Previous research has concluded that barriers had a significant effect on the access to and use of healthcare by a homeless individual. Within the questionnaire there was a question that specifically asked why an individual would not seek medical attention with answers that varied from no insurance to not being sick (Question 11; Appendix A). When examining the data before running contingency analyses, it appeared that barriers had an effect on the access to and use of healthcare by the homeless individuals in Helena as well; however, after running analyses, barriers did not have a statistical significance on where the homeless seek medical attention. This result was not consistent with the results found within the literature. Barriers did not have an effect on the location where a homeless individual sought medical attention within the past year or ever. This could be because Helena, unlike other cities is smaller, everything is within walking distance, and there are medical centers located near God's Love.

Model One—Replication

Two-way Contingency Analyses

Two-way contingency analyses indicated that sex, race, age, and homeless status

had a significant effect on location of medical care within the last year. Two-way contingency analyses for the location of where the homeless individuals sought medical attention most often throughout-life indicated that sex, age, duration, and homeless status had a significant effect. A common trend was that homeless status had a significant effect on where an individual seeks medical attention. This trend gives us the ability to predict where a homeless individual will seek medical care based on what their homeless status is currently. Individuals who classified their status as transitional or temporary used the emergency room, walk-in clinics, and physicians most often. The use of physicians may be a result of the individual only recently becoming homeless and still having an established physician that they can go to.

The two-way contingency analysis that was run between location and homeless status can help predict where an individual will seek medical attention is only true for individuals who classified their homeless status as either temporary or chronic. There was not enough data to fully determine if this would also be true for individuals who are episodic.

Healthcare for the Homeless, a clinic that is located next to God's Love, is another option for medical care in Helena for the homeless population; however it was intentionally not included as an option when asking where the individual had sought medical attention ever or within the past year because I wanted to know how many of the respondents would add it as an "other" option. I chose not to include the option of the Healthcare for the Homeless because I did not want to bias my results by placing an option that looked inviting to the respondent due to the name of the medical center. The choice to not include Healthcare for the Homeless on the questionnaire may have skewed

my data; by not having it on the questionnaire, the respondent may have not known that they could place it in the “other” option.

Three-way Contingency Analyses

In conducting the three-way contingency analysis, data from groups that did not have enough respondents were removed from the analysis. Contingency analysis relies on having non-zero categories. Running a contingency analysis with too many zeros does not accurately describe the relationship and could increase a rate of type II errors. In order to reduce the chance of type II errors, I restricted the statistical analyses to those variable combinations that did not contain zero results.

Location Ever—Three-Way Contingency Analysis

It was found that age and status were dependent upon each other when it came to the location of medical care among individuals who were in the age ranges of 22-29 and 40-49. This allows us to predict where a homeless individual will seek medical care based on their age and their homeless status. However, there was only significance for the age ranges of 20-29 and 40-49 year olds, which indicates that a prediction of where a homeless individual will seek medical care based on these two variables, will only be true for those falling into the 22-29 and 40-49 years old age ranges.

Age and duration of homelessness are dependent upon each other when it came to the location of medical care by individuals who were within the age groups of 18-21 and 22-29. Predictions can be made about where a homeless individual will seek medical care based on their age and how long they have been homeless. These predictions can only be held true for those homeless individuals who fall into the 18-21 and 22-29 years old age ranges. These results are not consistent with the results found by Brown et al. (2010),

where their results were that age was not statistically significant with the location of medical care. Brown et al (2010) obtained their data from a national survey while my data was obtained locally with only 35 respondents. This large difference may be what resulted in the difference of conclusions.

Homeless status and duration of homelessness seemed to be independent of each other when it came to where a homeless individual sought medical care. The lack of interaction between these two variables implies that they act separately on the decision of location of medical care.

Location Within Past Year—Three-way Contingency Analysis

Status and age were independent of each other when examining the location at which a homeless individual had sought medical attention within the past year. These results are not similar to the ones found when examining the same relationship except for changing the location to be where a homeless individual had ever sought medical attention before. With the variables of status and age being independent upon each other when examining the location at which a homeless individual had sought medical attention with the past year indicates that it is not possible to predict where an individual would seek medical attention based on their age and homeless status together.

Status and race were dependent upon each other when examining the location at which a homeless individual had sought medical attention within the past year. However, this is only true for Caucasian individuals. This allows us to predict where a homeless individual will seek medical attention within a year of being homeless and/or within the present year of homelessness, but only if they are Caucasian. These predictions will not apply to homeless individuals of other races.

Model Two—Missing*Two-Way Contingency Analyses*

Two-way contingency analyses indicated homeless status and insurance status had a significant effect on location of medical care within the last year. Two-way contingency analyses for the location of where the homeless individuals sought medical attention most often throughout their lives, indicated that only insurance had a significant effect. A common trend was that after performing the two-way contingency analyses, health insurance status had a significant effect on where an individual seeks medical attention. This trend gives us the ability to predict where a homeless individual will seek medical care based on their insurance status. Individuals who stated they had health insurance most often sought medical attention at primary physicians.

Homeless status had the most influence on where an individual sought medical attention both throughout their lives and within the past year. Insurance status was another variable that had a significant effect on where a homeless individual sought medical attention. This relationship was only found within the second model, where the individuals who provided more than one answer to two questions were marked as missing data. The individuals who had health insurance were more likely to have an established primary physician where they sought their medical care. Since many homeless individuals do not have insurance, this may be the reason that the majority of them do not have good access to or use of healthcare in Helena.

The results obtained from this study show that individuals who are homeless have less access to and use of healthcare. By examining individuals' health insurance status and their homeless status, one can predict where that individual will seek medical

attention. Predicting where an individual will seek medical attention could potentially be beneficial to healthcare workers and policy makers. Healthcare workers, specifically those who focus on improving the quality of medical care and making sure that everyone gets equal access to healthcare, would benefit from these results. They would be able to determine which medical centers would most likely have homeless individuals seeking help and improve the quality of healthcare by providing new equipment and funding. By providing new equipment and funding, these medical centers would better serve the health of the homeless.

This study is important for individuals who are part of the healthcare field or anyone interested in the access to healthcare by the homeless. The data obtained from this study provides healthcare professionals and advocates with the information necessary for improving the access to and use of healthcare by the homeless. The significant variables, found within this study, can help predict where someone will seek medical attention. Knowing these variables provides us with a place to start examining and improving the healthcare system. This study provides us with more information that can be used to bring equality to healthcare access and quality.

CONCLUSIONS

The access to and use of healthcare by the homeless is an important issue to examine because homelessness is continuing to become a bigger problem in the United States. The results from this study are not representative of all homeless individuals, but they give us insight into Helena's homeless population's use of healthcare.

This study provides the community of Helena with information about the access

to and use of healthcare by the homeless. The information presented in this study is useful to many individuals within the community. Healthcare workers can benefit from it by understanding where homeless individuals will seek medical attention based on their insurance and homeless status. Individuals of the Helena community may benefit from the results found within this study, because it will give them an idea of the inequality of healthcare there is between the homeless and those who are not homeless.

There is need for further research to completely understand the access to and use of healthcare among the homeless in Helena. With the newly implemented Affordable Care Act and the possible expansion of Medicaid in Montana, there is a need for further research on this particular subject. In future studies that examine this subject, there may be evidence that indicates that insurance does independently predict better healthcare as supported by the research of Brown et al (2010).

Future studies on this particular topic in Helena should be widened by adding the women's homeless shelter, the YWCA, to get a larger female population. A larger population would allow us to examine the difference between men and women with a greater confidence because the populations would possibly be closer in range with each other. It could also be further expanded by examining the access to and use of healthcare by the middle and upper classes and comparing these results with those found by this study to determine if the homeless individuals do in fact have less access than those who are of higher socioeconomic class. Another interesting aspect to examine within this study would be to investigate Healthcare for the Homeless clinic to examine how many individuals they see in a day, if there are many repeats, and the cost of healthcare at the clinic. This would determine if the homeless individuals do use the Healthcare for the

Homeless clinic for their healthcare needs more than what was presented in my study.

With homelessness being a serious problem in the United States and the use and access to healthcare being key topics in both society and used for political platforms, this study has given us an insight into the access to and use of healthcare by those individuals who are homeless in the Helena area. Healthcare is a human right and therefore all individuals should have equal access to quality medical care. Nevertheless, the homeless in Helena have been denied this human right by the lack of quality healthcare they have access to. It is important to continue studying this topic in order to increase the quality of, access to, and use of healthcare for homeless individuals. The data presented in this study can be used to work towards improving the access to and use of healthcare by the homeless individuals, which could result in a decrease in the homeless population in the Helena area by increasing the homeless population's health status.

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APPENDIX A. Questionnaire

Homeless Survey

If you are currently homeless and are at least 18 years old, you are invited to participate in this survey because you have a unique perspective on healthcare for the homeless. The answers to this survey will be used in a Sociology senior research project on the Access to Healthcare by the Homeless Community in Helena, Montana. The results of the research project will be used in a Senior Thesis paper at Carroll College, which will be available to the public upon completion. This survey should take between five and ten minutes of your time. Your answers will be completely anonymous and your participation is entirely voluntary. You may choose to skip certain questions if you'd like, and you may stop taking the questionnaire at any time. If you have filled out this survey already, please do not fill out again. Thank you.

Thank you for taking the time to complete this survey.

1. What is your sex? *Please check one*
 - Male
 - Female

2. What is your age? *Please check one*
 - 18-21
 - 22-29
 - 30-39
 - 40-49
 - 50-59
 - 60-69
 - 70+

3. What is your race? *Please check one*
 - American Indian or Alaskan Native
 - Asian
 - Black or African-American
 - Native Hawaiian or Other Pacific Islander
 - White
 - Other: _____ *(please specify)*

4. What is the highest level of education you have completed? *Please check one*
 - 6th grade education
 - 8th grade education
 - High school graduate
 - Associates Degree
 - Bachelor's Degree
 - Master's Degree

5. What is your employment status? *Please check one*
- Unemployed
 - Retired
 - Full-time
 - Part-time
 - Other _____(please specify)
6. How would you define your homeless status? *Please check one*
- Transitional or temporary (you are in transition between stable housing situations)
 - Episodic (you cycle in and out of homelessness over short periods of time)
 - Chronic (more permanent)
7. How long have you *currently* been homeless?
- _____Years
_____Months
_____Days
8. What has led to you being homeless? *Please check all that apply*
- Loss of job
 - Mental health
 - Domestic violence
 - Physical Health
 - Divorce
 - Other: _____(please specify)
9. Do you seek medical care?
- Yes
 - No
10. Where do you most often seek medical care? *Please check one*
- ER
 - Walk-in-Clinic
 - Physician
 - Urgent care
 - Other: _____(please specify)
11. If you don't seek medical attention, what are the reasons behind it? *Please check all that apply*
- No insurance
 - Can't pay
 - Transportation restraints

- Forget
- Other: _____ (please specify)

12. Do you have health insurance? *Please check one*

- Yes
- No

13. **If you answered no to question number 12**, why don't you have health insurance? *Please check all that apply*

- Cannot afford it
- Don't know how to get it
- Couldn't get insurance in the past because of an already existing medical problem
- Other: _____ (please specify)

14. **If you answered yes to question number 12**, what type of health insurance do you have?

- Private insurance
- Medicaid
- Medicare
- Employee insurance
- VA insurance
- Tribal healthcare coverage

15. Which of the following forms of other insurance do you have? *Mark all that apply*

- Dental
- Eye
- Prescription
- Other _____ (please specify)
- None

16. How would you rate your overall health today?

- Poor
- Fair
- Good
- Excellent

17. Have you received medical care within the past year?

- Yes
- No

18. **If you answered yes to question number 17**, where did you seek medical care? *Please check all that apply*

- Primary Physician

- Walk-in-Clinic
- ER
- Urgent Care
- Other _____(please specify)

19. Have you ever been treated differently at a medical center because you are homeless?

- Yes
- No

20. **If you answered yes to question number 19**, please share your experience in the space below.

21. What types of medical services have you found useful in the Helena community and why?

22. Is there anything else you would like to share about your experience with access to healthcare in the Helena, Montana area? If so, please respond in the spaces provided below.

APPENDIX B. Tables and Figures

Table 1: Descriptive data for age, sex, race, education, and employment; number of respondents and percentage of total respondents.

Variable	Total Number	Percentage (%)
<i>Age</i>		
18-21	2	5.7
22-29	3	8.6
30-39	7	20.0
40-49	6	17.1
50-59	10	28.6
60-69	7	20.0
<i>Sex</i>		
Female	9	26.5
Male	25	73.5
<i>Race</i>		
American Indian/Alaskan Native	7	20.0
Asian	1	2.9
White	25	71.4
“Other”	2	5.7
<i>Education</i>		
6 th grade	1	2.9
8 th grade	7	20.6
High School Diploma	21	61.8
Associate Degree	3	8.8
Master’s Degree	2	5.9
<i>Employment</i>		
Unemployed	16	48.5
Retired	3	9.1
Full-Time	5	15.2
Part-Time	3	9.1
“Other”	6	18.2

Table 2: Descriptive data for homeless status and duration of homelessness.

Variable	Total Number	Percentage (%)
<i>Homeless Status</i>		
Transitional/Temporary	21	70.0
Episodic	3	10.0
Chronic	6	20.0
<i>Duration of Homelessness</i>		
Days	6	18.8
Months	14	43.8
Years	12	37.5

Table 3: Descriptive data for barriers to not seeking medical care, health of the individual today, and insurance status.

Variable	Total Number	Percentage (%)
<i>Barriers</i>		
No Insurance	16	66.7
Unable to pay	3	12.5
Unable to find transportation	1	4.2
Not Sick	4	16.7
<i>Health</i>		
Poor	11	34.4
Fair	13	40.6
Good	7	21.9
Excellent	1	3.1
<i>Insurance</i>		
Yes	10	30.3
No	23	69.7

Table 4: Two-way contingency analysis for where a homeless individual has sought medical attention most often throughout their life (Model 1).

Relationship	P-value
Location X sex	0.056*
Location X race	0.134
Location X age	0.011**
Location X education	0.613
Location X homeless status	0.020**
Location X health today	0.489
Location X employment	0.292
Location X duration	0.038**
Location X insurance	0.294
Location X barriers	0.827

*p < 0.1 **p < 0.05

Table 5: Subsequent two-way contingency analysis for where a homeless individual has sought medical attention most often throughout their life (Model 1).

Relationship	P-value
Age X homeless status	0.016
Age X duration of homelessness	0.028
Status X duration of homelessness	0.002

p < 0.05

Table 6: Two-way contingency analysis for where a homeless individual has sought medical attention most often within the past year (Model 1).

Relationship	P-value
Location X sex	0.082*
Location X race	0.006**
Location X age	0.005**
Location X education	0.168
Location X homeless status	0.004**
Location X health today	0.339
Location X employment	0.158
Location X duration	0.230
Location X insurance	0.313
Location X barriers	0.842

*p < 0.1

**p < 0.05

Table 7: Subsequent two-way contingency analysis for where a homeless individual has sought medical attention most often within the past year (Model 1).

Relationship	P-value
Race X age	< 0.001**
Race X homeless status	0.045*
Race X sex	0.287
Age X homeless status	0.016*
Age X sex	0.136
Sex X homeless status	0.329

*p < 0.05 **p < 0.001

Table 8: Two-way contingency analysis for where a homeless individual has sought medical attention most often throughout their life (Model 2).

Relationship	P-value
Location X age	0.656
Location X barriers	0.244
Location X duration of homelessness	0.243
Location X education	0.655
Location X employment	0.784
Location X health today	0.476
Location X homeless status	0.187
Location X insurance	0.049*
Location X race	0.455
Location X sex	0.316

*p < 0.05

Table 9: Two-way contingency analysis for where a homeless individual has sought medical attention most often within the past year (Model 2).

Relationship	P-value
Location X age	0.716
Location X barriers	0.287
Location X duration of homelessness	0.359
Location X education	0.316

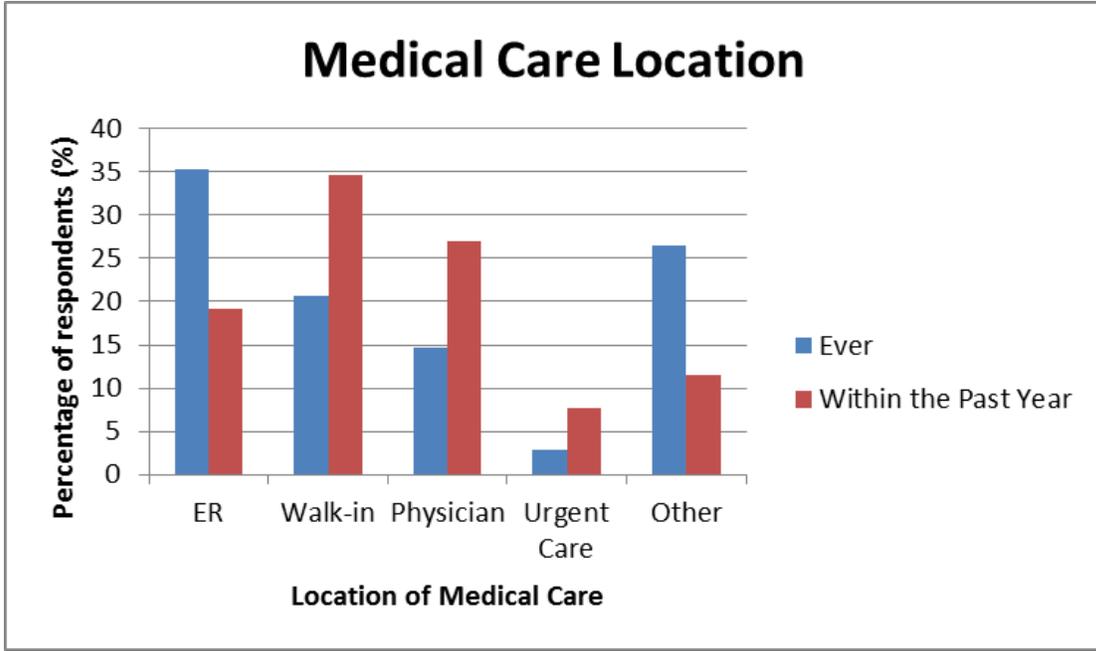


Figure 1: Indicates where homeless individuals have sought medical care within the past year or throughout their life “ever”. Within the past year as well as over a lifetime, the emergency room and walk-in clinics were used most. See figure 2 for details on the “Other” category.

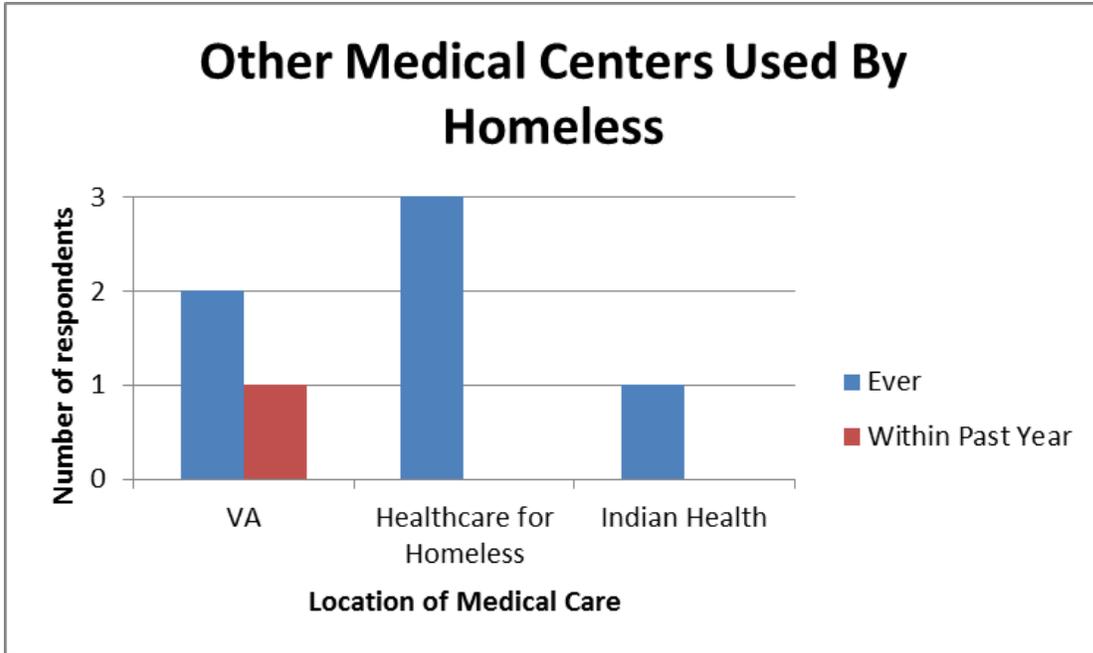


Figure 2: Indicates where the homeless individuals who responded “Other” in Figure 1 have sought medical attention within the past year as well as over a lifetime.

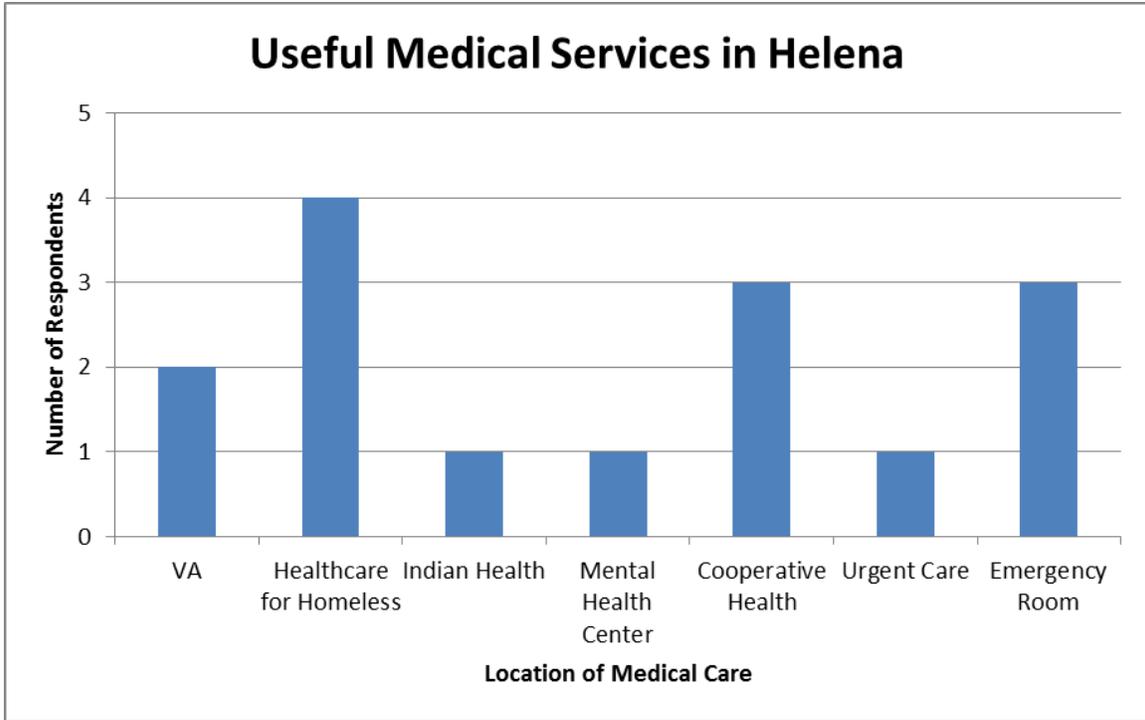


Figure 3: Indicates what other medical services that the homeless have found useful in Helena. This graph indicates that many homeless individuals have found the emergency room useful for their healthcare needs. The individuals in the Helena area also use the Healthcare for the Homeless for their healthcare needs.

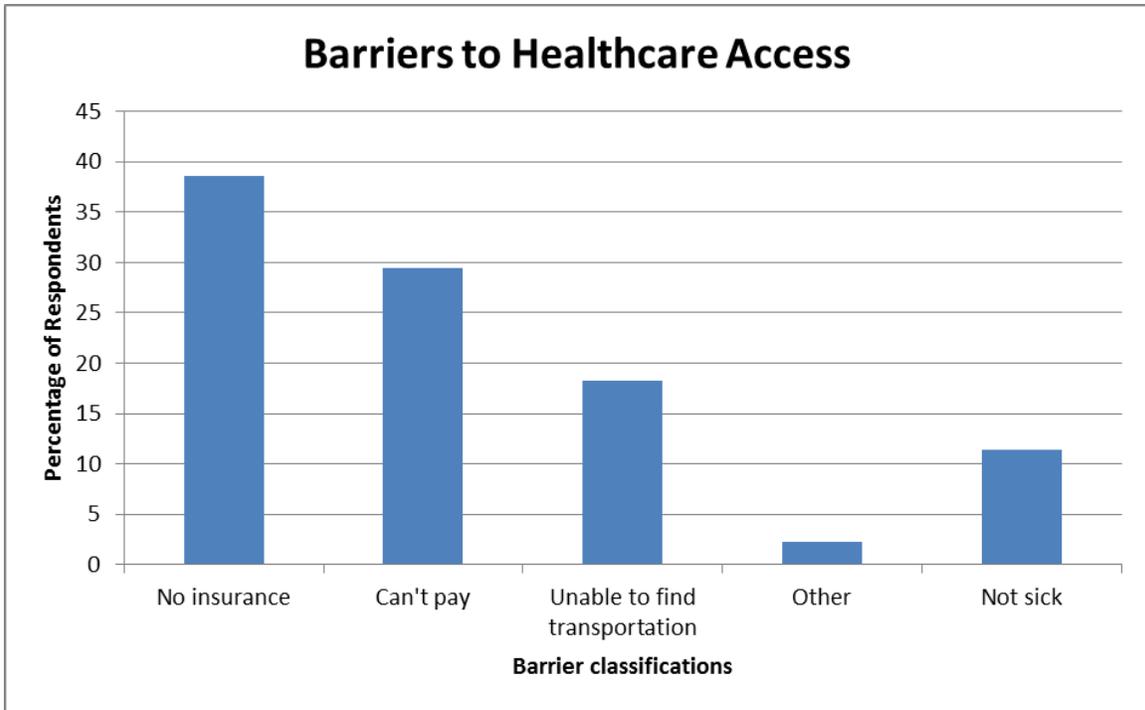


Figure 4: Shows the barriers to healthcare access that a homeless individual encounters. No insurance was the largest barrier for the homeless respondents on their healthcare access.