

HEALING HANDS



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Aging on the Streets

Across America, the number of older adults seen in clinics and shelters is increasing. In 2006, 184 HCH grantees reported over 155,000 men and women aged 50 and older (22% of all clients), up from 98,000 in 2002 (18% of all clients served by 152 grantees).^{1,2} While some of these individuals have long histories of homelessness, a significant proportion are newly homeless. Harsh economic realities have increased the tension between fixed incomes and today's high costs of housing, food, transportation, and health care. In many cases, homelessness is precipitated by job loss, eviction, or the death of a spouse or other supportive family member before the survivor is eligible for Social Security or Medicare benefits. This issue features HCH providers' perspectives on mitigating the risks of homelessness faced by older adults.

Whether it's San Francisco, Chicago, New York, Dallas, San Diego, rural Tennessee, Boston, Los Angeles, or West Valley City, Utah, the homeless population is graying along with the rest of the baby boom generation. Adults over age 49 comprised 13% of the U.S. population in 2005 and are expected to account for 22% by 2045. As this contingent expands, America can expect to see even more elders who are poor and homeless unless factors that predict homelessness change.^{3,4} Today, 10% of all adults over 50 years have incomes below the Federal poverty level.⁵ Although this is a dramatic improvement over 1966 when 29% of seniors aged 65 and older were living in poverty,⁶ homelessness among older adults is again on the rise due to rent inflation outstripping their economic capacity and limited access to subsidized housing.⁷

This demographic shift is of particular concern because homelessness exacerbates chronic diseases that become more common with aging and causes premature mortality. Indeed, middle-aged people who live on the streets often have health problems characteristic of housed individuals who are 10 to 20 years older.⁸⁻¹¹ **Margot Kushel, MD**, associate professor of medicine in residence at the University of California, San Francisco, cites research using a national cohort of 43,868 hospitalized veterans, which found that "homeless inpatients were younger than their housed counterparts in every major diagnostic category. While this was true for substance abuse and mental health related admissions . . . , the most dramatic age difference was seen in the medical-surgical admissions."⁸

Although homeless people face chronic disease at younger ages (50s and 60s), many are unable to access the health and social services they need because they are not eligible for Social Security and Medicare benefits. Because financial barriers are often the proximate cause of homelessness for older adults, many could end their homelessness with rental assistance or access to affordable housing. Those with disabling conditions could achieve stability through access to permanent supportive housing.^{7,12}

Given their higher health risks and limited access to services that could mitigate these risks, it is not surprising that mortality rates are as much as 3 to 4 times higher for homeless people than for the general population.^{8,13} While the average life expectancy in the U.S. is approaching 80 years, local studies indicate that homeless people live only to ages 42–52 years.^{13,14}

WHO ARE HOMELESS SENIORS? There are two primary explanations for the growing numbers of older homeless adults in the United States: aging of already homeless people and loss of housing in old age.

Chronically Homeless Older Adults Survivors of long-term and multiple episodes of homelessness have been aging over the past 15 years and their numbers are increasing. Despite daunting health risks, some find shelters intolerable; others do not have friends or family willing and able to take them in, or they may refuse to become a burden to others. Many simply do not have affordable options for stable housing.⁷ A number of these individuals have serious mental illness or substance dependence that may have contributed to their loss of housing. Personal risk factors accumulated over a lifetime and "enculturation to street or shelter" as well as systemic and programmatic factors may prolong homelessness into old age.⁷

Hahn and associates examined trends in age, housing, health status, health service utilization, and drug use in San Francisco over a 14-year period.¹⁵ Their work, based on interviews with 8,968 individuals at shelters and meal programs, shows a 9 year increase in the median age (37–46) of homeless people interviewed, 1990–2003; in the most recent sample, 1/3 of interviewees were older than 50 years. The rate of aging in this homeless cohort exceeded that of the general population, consistent with homeless population trends in Los Angeles, New York City, St. Louis, Pittsburgh, and Toronto.¹⁵ Although substance use and mental health problems were the major medical issues reported, the increased aging of this cohort suggests that chronic health conditions are likely to

become more prominent. Giribaldi and co-workers provided evidence of this trend, reporting that 85% of homeless clients over age 50 had at least one chronic medical condition.^{9,15}

In other research, O'Connell and colleagues followed a group of 30 individuals (8 women and 22 men) who were 60 and older in Boston. Between 2000–2004, the clinicians found that there were 9 (30%) deaths, 6 (20%) people placed in nursing homes, and (despite aggressive effort) only 5 (17%) were housed, while 7 (23%) remained on the streets. The authors concluded that “elderly rough sleepers have high morbidity and mortality and pose significant challenges to programs seeking to provide housing and supportive health care services for this vulnerable sub-group of [the] elderly homeless.”¹⁶

Newly Homeless in Old Age The second group is comprised of newly homeless older adults who are victims of structural economic constraints. Fixed incomes juxtaposed with exorbitant inflation of housing and health care costs produce untenable alternatives—when a combined pension and Social Security payment no longer covers the rent, let alone food and medicine; when a landlord decides to remodel a rental property into condos and evicts tenants; when a partner dies leaving a spouse without benefits, too young for social services, and with no other family support; when an individual with a health care catastrophe depletes all savings and resources; or when a person is released from prison without resources to affordable housing.¹⁷⁻¹⁹

Betsy Baldwin has been a case manager and patient liaison at Southwest Community Health Center in Bridgeport, Connecticut, for 19 years. Baldwin says, “It takes at least \$19/hour (approximately \$39,000/year) to live in Connecticut today. Many of the folks I see are first-time homeless older adults who can no longer meet expenses. Many worked all their lives and their retirement income includes a pension and Social Security that ranges from \$300 to \$800 total. It costs \$700 for an efficiency apartment in this community. Often my clients have nobody to help them, and many of them can't read, although they try not to let you know that.”

Once homeless, deteriorating health only exacerbates these problems. **Bechara Choucair, MD**, medical director of Heartland Health Outreach in Chicago, says, “my experience is that older homeless adults have more chronic health needs: high blood pressure, cardiac conditions, cancer, diabetes, vision and dental needs. Those with HIV and mental health problems who have been on medication for a number of years are often facing the side-effects of those meds too. Access to care becomes a bigger issue because they need specialized as well as primary care.”

“Ongoing research at Loyola University is confirming what we see at Heartland,” Choucair continues. “Key findings show that in Chicago a majority of older adults became homeless for the first time in middle age (median age 47); the number of homeless folks ages 50 to 64 increased 20% between 2001 and 2006, and while 40% have the background and willingness to work, 60% are limited in employment because of chronic illness.” The Loyola research emphasizes older adults' vulnerability to homelessness, he says:

- By the time they reach 50, older adults are less resilient and not as able to bounce back from life's challenges.
- Older adults are living in a vastly changed society with little relevance to that of their youth.

- Older adults have reached a different stage in their life and require different support mechanisms.
- Stereotyping based on age and homelessness presents “a double whammy.”
- Many fall through the cracks in seeking social services because they are not old enough for benefits.

In New York City, the proportion of homeless people who are elderly has increased in less than 10 years from 2.0% (1998) to 2.6% (2006) and can be expected to continue to increase as baby boomers age.¹⁹ One explanation for this precipitous increase is the dramatic inflation of rental housing costs, which places even full-time workers at risk of homelessness. The fair market rent for a one-bedroom apartment is over \$1003 per month.⁷

The medical literature generally defines older adulthood as comprising three groups: the young-old (65 to 74 years), the middle-old (75 to 84 years), and the old-old (85 years to death). As previously noted, clinicians find that the continual stress of life on the streets adds 10 to 20 years to their homeless clients' physiological age. In 1990, Gelberg and colleagues observed that a 50 year old who is homeless exhibits health conditions more often seen in individuals in their the mid- to late-60s, and other research continues to support these findings.^{5,9,20} Some research has even delineated older adults as 41 years and older and found that 72% of these respondents reported having chronic disease.²¹

“Although they are chronologically younger, the health and functional problems of middle-aged homeless adults resemble those of geriatric individuals in the general population.” – Lillian Gelberg, MD²⁰

Kellogg and Rabiner characterize their aging clients at St. Vincent's Hospital and HCH program in Manhattan as:¹⁹

- Survivors
- Many relatively robust but subject to premature death
- Impoverished
- Socially disaffiliated
- Ranging in age from under 64 (94%) to 65 and older (6%)



“The interesting thing about my patients,” says **Mark Rabiner, MD**, a hospitalist at St. Vincent's, “is that they are ordinary folks trying to get along in a tough world. Judy worked for 37 years as a beautician and when she lost her husband; the \$6,000 burial costs wiped out all her savings. Ron worked in Jamaica as a sailor, then in Florida in the citrus fields, and finally ended up working the door at the Pussy Cat Lounge in New York City.”



“Christine was a home health aid for 20 years but when her arthritis got so bad she couldn’t work, she became homeless. She’s at a senior center now. And Pedro delivered dry cleaning for minimum wage into his mid-60s and then ran out of money. This should be a reminder that we are all just one step away from homelessness,” Rabiner points out.

Other clinicians relate similar patient histories. **Dana Gamble, LCSW**, manager of Children’s Medical Services for the Santa Barbara County Public Health Department and former Santa Barbara Health Care for the Homeless administrator, describes a 62-year-old blues singer who was living on the streets in a wheel chair. “He was blind with advanced diabetes and an amputated leg, even though he had Medicaid, he trusted few. He’d been placed and kicked out of skilled nursing facilities. Finally we were able to reunite him with a sister in Baltimore. He sang all the way to the airport. A month later, he died surrounded by family at a skilled nursing center.”

Margot Kushel says that the clients she sees during hospital ward rotations are becoming homeless later (50s or 60s) or staying homeless longer. And while many seem older, they are not yet eligible for Social Security. “Back in November, a 75-year-old man was sent to the hospital by the shelter,” she recalls. “His partner had died and he had no other family. He had walking problems, dementia, and failure to thrive. The case managers were able to place him in a board and care facility because he had SSI, so now he is secure. But such cases seem like the canary in the coal mine—how many other vulnerable folks are out there?”

In Denver, **Ed Farrell, MD**, medical director of the Colorado Coalition for the Homeless Stout Street Clinic, says that “while our 2005 UDS data show less than 3% of the clinic’s clients were older adults in their 50s and 60s (2.0% men, 0.8% women), the elderly often have multiple medical diagnoses, frequently take numerous medications with greater likelihood for adverse interactions or effects, are more likely to have cognitive impairment, and are more vulnerable because they are on the streets or in the shelters. On the plus side, anyone who is over 60 and without income is eligible for a state-funded old age pension in Colorado.”

“The issue of vulnerability includes so many things,” adds Farrell: “the elements, assault, other people taking their meds, having to forage for food and shelter, walking blocks and blocks to access services, reduced physical mobility. I’ll never forget being out in one of our heavy snow storms several years ago, when I came upon an elderly gentleman trying to cross a mountain of snow on the walkway. He was 3- and 4-pointing his way (using his hands, knees, and feet for support) over the icy mound of snow. He knew where to go for shelter but it was 8 blocks away. I was so disheartened for him.”

“We’ve had a great increase in homeless people and lots of folks who were marginally housed before Hurricane Katrina now have no place to go, but we’ve not seen any spikes among the older homeless,” says **Willie Mae Martin, MSW**, director of the New Orleans HCH program. “It’s possible that many of the older adults were evacuated. Rents in New Orleans have skyrocketed, and people who have come looking for work—laborers or those with entry level skills—just can’t afford to live here. Homeless folks are also sicker now than before the storm, so our outreach workers make sure the older ones are the first placed in housing so they won’t linger on the streets.”

ECONOMIC IMPLICATIONS Elderly homeless people have multiple, interrelated, high-risk health factors that may be associated with high-cost care. These factors include chronic medical illnesses, functional limitations, mental illness, substance dependence, trauma, malnutrition, exposure to the elements, and victimization.^{9,19-21} Understanding the impact of homelessness over the life span is important to provide the best housing and service approaches for specific age groups, including older adults, so that their health conditions and the costs and efficacy of treatment can be fully appreciated.¹²

The nature and variety of chronic illnesses experienced by older homeless adults add to the burden of both geriatric care and homelessness. The St. Vincent’s HCH program sees patients with hypertension, diabetes, arthritis, dementia, obesity, osteoporosis, decubitus ulcers, as well as cardiac, pulmonary, vascular, gastrointestinal, neurologic, urologic, psychiatric, and chronic renal conditions.¹⁹ The medical geriatric care challenges for the older adult homeless person include:

- Decline in activities of daily living (ADL) related to frailty
- Chronic disease burdens
- Cognitive impairments
- Sensory impairments
- Diet adherence
- Drug treatment adherence
- Access to primary health care
- Competition for sustenance needs

Meeting dietary needs of homeless patients with diabetes can be especially challenging because shelters and homeless meal programs typically do not have budgets to accommodate special diets. In addition, poverty, limited access to entitlements, lack of family or a supportive network, environmental hazards, vulnerability to victimization, stigmatization, and transient life style present social barriers to appropriate geriatric care.^{19,22}

STANDARDS OF CARE Establishing a client’s health care needs relies on a geriatric assessment to establish a baseline for care that includes:^{19,23,24}

- Medical status based on history, physical, and laboratory tests
- Medication review
- Functional status that measures mobility, continence, mentation, and self-sufficiency for ADLs and IADLs
- Cognitive and psychological health using both dementia and affect screens
- Health literacy
- Determination of social networks and support
- Access to and source of primary health care services

Health care maintenance for older homeless adults should include: flu shots, Pneumovax and tetanus vaccine, assessment of functional status, history and physical, dental care, assessment of diet, Mini Mental State Examination (MMSE), review of medications, assessment of substance dependence (drugs, alcohol, cigarettes), tuberculin skin test (PPD), and selected lab studies.¹⁹ Early identification of geriatric syndromes—falls, dementia, incontinence, sensory loss, failure to thrive—may enable easier care management and improved client quality of life.

Ed Farrell in Colorado cautions that clinicians also need to be watchful for depression in older adults because it often presents atypically. Research indicates that symptoms of apathy, low motivation, low energy, sleep disturbances, and loss of appetite more commonly indicate depression in older adults than do self-reproach, hopelessness, and recurring thoughts of death.^{25,26} The Geriatric Depression Scale: Short Form (GDS:SF) is focused on the patient's mood and helps the clinician quickly decide whether further assessment is needed (a free online video demonstrating the use of this tool is part of Best Practices in Nursing Care to Older Adults, from the Hartford Institute for Geriatric Nursing at New York University's College of Nursing, <http://links.lww.com/A101>).²⁶

Ongoing attention to health literacy—including clients' ability to read and level of understanding—is important as well. Baker and colleagues found that inadequate health literacy predicted all-cause mortality and cardiovascular death among elderly individuals living on their own in the community because they had low knowledge base, were unable to manage their disease, and did not seek preventative services.²⁴

Clinicians must also be aware of cognitive loss in their clients and determine whether it is normal or pathological, its natural history and etiology (depression or delirium secondary to drugs), assess for decisional competence, and set realistic goals of treatment.¹⁹

In addition, establishing the causes of urinary incontinence in elderly individuals is important. Reversible or episodic incontinence may be caused by delirium, restricted mobility, infection, impaction of stool, polyuria, or pharmaceuticals. Chronic incontinence is especially difficult for homeless people to manage; treatment depends on its cause (urge, stress, overflow, functional). Prompt diagnosis will promote better care management and client quality of life.

FINDING WORKABLE SOLUTIONS Nationwide the mantra is “housing first.” Many clinicians agree with Mark Rabiner's view that “placement is the key for homeless people. Everyone on the St. Vincent's team helps with housing because it will get the majority over the hump. We prep our clients for housing interviews so they'll know what to expect, and we pick up the phone to find out why. We are our client's advocate and we also make sure they are connected with available aftercare services.”

Bechara Choucair acknowledges the importance of the Heartland Alliance Housing program but says “finding housing is still a challenge. It is very important to have clients work with benefit and entitlements counselors,” he adds. Moreover, “care centers need to create partnerships with specialists for their older clients and find help with the cost of prescription drugs through patient assistance programs. In addition, counselors need training to better meet the needs of older adults, particularly those with Alzheimer's and substance use problems.”

Keys to Success in Elder Care¹⁹

- Establish good client rapport
- Outreach
- Multidisciplinary team
- One-stop shopping (multiple services on-site)
- Close hospital affiliation and link to hospitalist
- Referral network
- Geriatric assessment
- Continuity of care
- Skill at managing chronic disease
- Case management for placement and follow up
- Aftercare
- Safe and ADA-accessible environment (to prevent falls)
- Mental health evaluation
- Pharmacologic support
- Drug administration support (LPN)
- Stay in touch with colleagues in other programs to find out what's working for them and share your successes

Others caution that housing for formerly homeless elders will need to offer new and creative service options and carefully address the “delicate issues of competency and guardianship.”^{14,16} O'Connell and co-authors describe the ethical dilemmas posed by fiercely independent elderly clients who challenge their caregivers' every attempt to make life more comfortable, particularly in the face of deteriorating chronic or terminal illness.⁴ Understanding “the characteristics and needs of homeless people who are unable or unwilling to enter available housing or residential programs as well as motivation and readiness to change” is important to the discussion of “housing first” versus “treatment first” approaches to engaging disabled homeless people.¹²

Longitudinal research about rehousing older people in permanent accommodations lists significant mitigating factors that enable older adults to remain housed: history of stable accommodation, revived contact with relatives, becoming part the center's activities, and accepting regular help from support workers. Because unsettledness is associated with prolonged previous homelessness and client fears about living independently, rehousing older adults is really difficult and additional research detailing good outcomes is needed.²⁷

In addition, a community's response to and education about homeless individuals contribute to successful solutions. Recently neighbors of a planned supportive housing apartment designed for senior homeless residents in a suburb of Salt Lake City have become alarmed about the possible threat of formerly homeless residents to their children. **Allan Ainsworth**, executive director of the Fourth Street Clinic in downtown Salt Lake, responds to the community with facts and empathy: “Salt Lake's adopted supportive housing approach is one of the most enlightened in the country, and the housing authority's strong management track record speaks for itself—other centers within the community have been well accepted. Numerous studies show that criminal behavior drops off markedly as people reach their 50s. We really owe it to ourselves and our community to provide the best safe, secure, and supportive housing possible to homeless people who survive into their 50s and beyond, because they have experienced amazing hardships and deserve some security as they age.”

Santa Barbara is a small city of 90,000 with incredibly high living costs, even for California. Dana Gamble relates that “under the direction of the city’s police chief, city departments have come together to plan programs and work in a team approach called the Restorative Policing Program (RPP). Case managers, police officers, and shelter providers all work together to achieve the best care and placement of older adults who are homeless.”

Gamble adds, “Engaging clients sometimes proves extremely difficult. Working as a team, however, the RPP is able to place clients in transitional living facilities, group homes, or permanent housing. Because the program is a voluntary effort between departments, it does not appear on any budget but brings together the expertise of each for the greater good of those in need.”

In Los Angeles, a significant report published in March 2008 by Shelter Partnership, Inc., focuses on the needs of elderly homeless people. The document includes an excellent review of the literature, discusses barriers to housing and services, relates interviews with a diverse group of older homeless adults, and describes new initiatives in the LA community. In planning for new housing developments the committee took note of advice in the literature that promotes flexible shelter rules, the need for clients to interact frequently with care providers, and initiatives to ensure peer engagement.⁵

The Shelter Partnership began work 18 months ago when there were no permanent housing facilities for homeless older adults in the county. Today, one facility is open and three more are planned:⁵

- *Sequoia Lodge*, opened by the Union Rescue Mission (URM) at the Hope Gardens Family Center, is a transitional living facility reserved for homeless women 55 years of age and older. There are 22 units and most tenants have SSI income or General Relief (GR). Rents are set at 30% of Area Median Income (approximately \$360) and include meals, although clients on GR are charged less. On-site services include case management, activities for residents, and weekly visits from the LA County Department of Mental Health with backup care available from the Hope Gardens mental health director. The center has a collaborative agreement with the Northeast Valley Health Corp. HCH clinic and Olive View for off-site health care. A URM van is available to provide transportation.
- *New Carver Apartments* will provide 97 efficiency apartments for low income older adults and men and women with physical disabilities in

the South Park community of downtown LA. Ground was broken by the Skid Row Housing Trust in February 2008. When finished, the five story building will also include administrative offices, social services offices, a lobby, and a community room located on the third floor.

- *Bonnie Brae Village Apartments* is a proposed four-story apartment building with 92-units in the Westlake neighborhood just west of downtown LA, scheduled for completion in December 2009—45 units will be permanent supportive housing for homeless seniors with mental illness or chronic substance abuse whose incomes are below 30% AMI, and 47 units for other low-income seniors. The Housing Authority of the City of Los Angeles will subsidize rents with Section 8 Vouchers under the Project-Based Assistance Program.
- *Willis Avenue* is currently being designed by A Community of Friends with 42 one-bedroom units for senior tenants aged 55 and up who have very low incomes, are mentally ill, and are currently homeless or at-risk of becoming homeless. A manager’s unit will be on site and services will be provided and accessed by Heritage Clinic, an experienced mental health service provider.

Although there are often bumps in the road on the journey to successful placement for homeless people, Mark Rabiner suggests trying creative problem-solving techniques. For example:

- In New York City, clients often need to interview for housing options and clinicians work with them so that they can present “their best selves.” Get your clients cleaned up, showered and shaven with clean, combed hair. Help them access services like Dress for Success.
- If your client is medically frail and qualifies for home health care services, help demonstrate that he or she will have medical support if accepted into a housing program.
- When your client is a chronic spender or bad with money in general, connect him or her with a representative payee so that bills and rent are certain to be paid. Or if your client has a credit history, gather letters of reference to demonstrate his or her current responsibility with money.
- If your client has a psychiatric diagnosis but doesn’t want to take meds, get as much info from the psychiatrist as possible and then see if he or she can function without psychotropic medications (i.e., whether the client’s symptoms influence his or her ability to pay rent, maintain a household, or act appropriately within the community). Also find out why the client doesn’t want to take medications (side effects?) and determine if there are other solutions.

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