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Meeting the Housing and Care Needs of Older Homeless Adults: A Permanent Supportive Housing Program Targeting Homeless Elders

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Abstract

The homeless population is aging faster than the general population in the United States. As this vulnerable population continues to age, addressing complex care and housing needs will become increasingly important. This article reviews the often-overlooked issue of homelessness among older adults, including their poor health status and unique care needs, the factors that contribute to homelessness in this population, and the costs of homelessness to the U.S. health care system. Permanent supportive housing programs are presented as a potential solution to elder homelessness, and Hearth, an outreach and permanent supportive housing model in Boston, is described. Finally, specific policy changes are presented that could promote access to housing among the growing older homeless population.

Keywords

Homeless persons; aged; housing

Introduction

Homelessness is common in the United States, affecting an estimated 1.5 million Americans each year (U.S. Department of Housing and Urban Development [HUD], 2012). Definitions of homelessness vary, but in the U.S. homelessness is most commonly defined by Congress's 1987 McKinney-Vento Homeless Assistance Act (42 U.S.C. 11431 et seq.). The McKinney-Vento Act defines homeless individuals or families as lacking "a fixed, regular, and adequate nighttime residence," including persons residing in emergency shelters or places not meant for human habitation. Congress expanded the definition of homelessness in 2009 to include individuals at imminent risk of homelessness (42 U.S.C. 11302 et seq.).

While it is widely known that the general population is aging, few are aware that the homeless population is aging at an even faster rate. Over the past two decades, the median age of single homeless adults in the U.S. increased from 37 years in 1990 (Hahn, Kushel, Bangsberg, Riley, & Moss, 2006) to nearly 50 years in 2010 (U.S. Interagency Council on Homelessness [USICH], 2010; Culhane, Metraux, Byrne, Steno, & Bainbridge, 2013); one-

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third of homeless adults were aged 50 and older in 2003 (Hahn et al., 2006), a proportion that is likely even higher today. This aging trend is thought to be due to a cohort effect: individuals born in the second half of the baby boom generation, between 1954 and 1964, have a higher risk of homelessness compared to other age cohorts (Culhane et al., 2013).

While the causes of this increased risk of homelessness are still being investigated, several social and economic factors may have contributed. These include economic recessions in the late 1970s and early 1980s as this cohort entered the labor market. These recessions led to depressed wages for unskilled workers and rising rates of youth unemployment, even as costs of housing rentals were rising. The crack cocaine epidemic of the 1980s may also have increased the risk of homelessness, through the associated risks of addiction, strict sentencing laws, and resulting involvement in the criminal justice system. Finally, social welfare expenditures dropped during the 1980s and 1990s, at the same time as demand for services among socioeconomically disadvantaged baby boomers increased (Culhane et al., 2013).

Because of the negative physical health, mental health, and economic outcomes associated with homelessness, the lack of stable, permanent housing must be addressed among all age groups. As the homeless population continues to age, however, addressing the care and housing needs of vulnerable older homeless persons will become increasingly pressing. This article reviews the often-overlooked issue of homelessness among older adults, including their poor health status and unique care needs, the factors that contribute to homelessness in this population, and the costs of homelessness to the U.S. health care system. Permanent supportive housing programs are presented as a potential solution to elder homelessness, and Hearth, an outreach and permanent supportive housing model in Boston developed specifically for older homeless adults, is described. Finally, specific policy changes are presented that could promote access to housing among the growing older homeless population.

Aging among Homeless Adults

Homeless adults of all ages have poor health status compared to the general population, including high rates of physical and mental health problems and premature mortality (Burt et al., 1999; Hwang, Orav, O'Connell, Lebow, & Brennan, 1997; Hwang, 2000). However, homeless adults in their 50s have unique health care needs, both compared to their younger counterparts and to the general adult population.

Compared to younger homeless adults, older homeless adults have higher rates of chronic illnesses and geriatric conditions, including high blood pressure, arthritis (Garibaldi, Conde-Martel, & O'Toole, 2005), and functional disability (Gelberg, Linn, & Mayer-Oakes, 1990). Both older and younger homeless adults experience premature mortality, but older adults are more likely to die from chronic conditions including cardiovascular disease and cancer, while younger adults typically die from infectious disease and substance use (Baggett et al., 2013).

Older homeless adults also have unique care needs compared to the general population. In the general population, individuals aged 50–64 are considered middle-aged, and have lower rates of chronic conditions compared to seniors aged 65 and older (Pleis, Ward, & Lucas, 2010). In contrast, homeless adults aged 50 and older have rates of chronic conditions similar to or higher than community-dwelling adults 15–20 years older, including so-called "geriatric conditions" that are often thought to be limited to the elderly (Gelberg et al., 1990; Brown, Kiely, Bharel, & Mitchell, 2012). Geriatric conditions include memory loss, falls, difficulty performing activities of daily living (ADLs), and urinary incontinence. Because

homeless adults experience early onset of these conditions, many experts consider them to be “elderly” at age 50, 15 years earlier than the general population (Gelberg et al., 1990).

Even for seniors who have housing, managing geriatric conditions is challenging. An individual who falls frequently may need to use a walker or work with physical therapy to improve lower extremity strength; a person with difficulty bathing may need caregiver support and modifications to their home environment. These challenges are only compounded for older homeless adults, who must cope with these conditions in the chaotic and often dangerous setting of homeless shelters and the street. Homeless people are unable to modify their physical environment to match their physical limitations, and adaptive equipment such as walkers and glasses may be stolen or lost. Features of the shelter environment, such as bunk beds and shared bathing facilities, may increase the risk of falls and injury. Moreover, many shelters require clients to vacate during the day, placing already vulnerable older adults at increased risk of injuries and victimization as they walk long distances to obtain food and shelter (Kushel, 2012).

Factors Contributing to Homelessness among Older Adults

Although relatively little is known about how older adults become homeless, there appear to be two main pathways. Some older adults have experienced many years of personal challenges, including mental illness, substance use problems, and imprisonment. These individuals tend to become homeless as younger adults and remain chronically homeless over many years. A second group of older adults have led relatively conventional but financially vulnerable lives and encounter a crisis late in life that leads to homelessness. Crises may include loss of housing (due to sale by a landlord or eviction), death of a partner or family member, or disabling illness (Shinn et al., 2007). Older adults who become homeless late in life are at increased risk for remaining homeless long-term (Caton et al., 2005).

While the causes of homelessness are complex, they are often grouped into three broad categories: predisposing personal vulnerabilities (e.g., poverty and social isolation), structural factors (e.g., the lack of affordable housing), and the absence of a safety net (e.g., lack of health or social insurance) (Burt, Aron, Lee, & Valente, 2001). Nearly all older adults at risk for homelessness live in poverty (Shinn et al., 2007), and financial problems are the most common cause of homelessness reported by older adults. Other common triggers for homelessness among older adults include difficulty paying rent or a mortgage, and loss of housing due to sale by a landlord, foreclosure, or other factors (Crane et al., 2005).

Older adults with social vulnerabilities are also at increased risk of homelessness. Social isolation increases the risk of homelessness, as does lacking children, relatives or friends willing to provide housing (Shinn et al., 2007). Loss or breakdown of a relationship may lead to homelessness, including the death of a partner or relative, a divorce, or a dispute with a landlord, cotenant, or neighbor (Crane et al., 2005).

Regardless of the path to or precipitants of homelessness, older adults face significant challenges in regaining housing. Unlike younger adults, re-entry into the work force is unlikely. Moreover, due to the high burden of comorbidity and disability among older homeless adults, they are almost certain to require more rather than fewer services over time. Therefore, effective programs for homeless elders must adopt a service framework that recognizes the progression towards greater dependence as part of the natural course of aging.

The Costs of Chronic Homelessness

Over the past decade, clinicians, researchers, and policy makers have increasingly recognized both the human and societal costs of chronic homelessness, which is often considered the most severe form of homelessness. A person is considered chronically homeless if they have a disabling condition and have been continuously homeless for more than a year or have had at least 4 episodes of homelessness over 3 years (USICH, 2010). Not only do chronically homeless persons have poor health status, poor quality of life, and premature mortality (Burt, 2003), their care is extremely costly to the U.S. health care system.

Homeless individuals are hospitalized at rates 4 times higher than U.S. norms (Kushel, Vittinghoff, & Haas, 2001), and also have longer hospital stays; one study found an average additional cost of $2400 per hospitalization for homeless compared to low-income housed individuals (Salit, Kuhn, Hartz, Vu, & Mosso, 1998). Similarly, homeless individuals use the emergency department (ED) at rates 3 times higher than the general population (Kushel, Perr, Bangsberg, Clark, & Moss, 2002), have longer ED stays, and are more likely to arrive at the ED by ambulance compared to patients who are not homeless (Pearson, Bruggman, & Haukoos, 2007).

While few studies have focused on use of health services among older versus younger homeless adults, rates of ED visits among older persons appear to be similarly high (Kushel et al., 2001, 2002), while hospitalization rates and ambulance use may be even higher (Brown & Steinman, in press). Rates of institutionalization among older homeless adults have not been reported, but are also likely to be high given the elevated rates of geriatric conditions in this population.

Addressing Chronic Homelessness: Permanent Supportive Housing

Over the past decade, permanent supportive housing programs have emerged as an important resource to address chronic homelessness. Permanent supportive housing is defined by the U.S. Department of Housing and Urban Development (HUD) as permanent, subsidized housing with on-site or closely linked supportive services for chronically homeless persons (U.S. HUD, 2008). These programs directly address the underlying causes of homelessness to allow chronically homeless individuals to obtain and retain stable housing: subsidies make housing affordable for persons with low incomes, while a comprehensive array of optional supportive services address underlying personal vulnerabilities that increase the risk of homelessness. Supportive services may include medical, psychiatric, personal care, case management, vocational, and substance use counseling services.

To be eligible for federal funds from HUD, permanent supportive programs must demonstrate that the residents they serve are homeless and disabled as defined by the McKinney Act. The McKinney Act includes standard definitions of disability such as those in the Social Security Act, but also includes disabilities related to housing status, including “physical, mental, or emotional impairment which substantially impairs a persons ability to live independently, and could be improved by more suitable housing (e.g., a substance use disorder)” (U.S. HUD, 2008).

Benefits of Permanent Supportive Housing Programs

Permanent supportive housing programs have demonstrated improved health outcomes and decreased health care costs among chronically homeless persons with a range of disabilities including active substance use, severe mental illness, and HIV/AIDS (Fitzpatrick-Lewis et

al., 2011). These successes have led to increasing support for these programs by federal agencies, and to proposals to fund supportive services with Medicaid. As the homeless population continues to age, however, these programs must adapt to address the needs of their younger residents as well as the unique health problems and high disability rates of older homeless adults.

Permanent Supportive Housing vs. Affordable Assisted Living

Although there is no single definition of affordable assisted living, in general terms it is an assisted living facility with monthly fees that are affordable to low- or moderate-income individuals. Permanent supportive housing and affordable assisted living programs both provide housing coupled with supportive services for persons with disabilities, but the programs differ in several key aspects. Assisted living facilities are regulated and certified at the state level, and often provide more intensive medical and personal care services than do permanent supportive housing programs, including 24-hour staffing and at least 8 hours of daily nursing care. Typically, a permanent supportive housing resident who needs skilled nursing care or more intensive support of ADLs and IADLs may move to an assisted living facility to receive higher-level care.

Funding mechanisms also differ. As discussed above, permanent supportive housing programs that meet federal guidelines are eligible for HUD funding, while assisted living facilities are generally not federally funded. However, an increasing number of states provide assisted living “Medicaid waivers,” which use Medicaid funds to pay for eligible patients to live in assisted living facilities rather than more costly long-term care facilities. The growth of Medicaid waivers for assisted living may make these facilities affordable to an increasing number of older adults.

The Hearth Model: Outreach and Permanent Supportive Housing for Older Homeless Adults

Founded in 1991, Hearth is a Boston-based non-profit dedicated to preventing and ending elder homelessness through a two-pronged strategy of outreach and housing. The Hearth Outreach Program identifies elders who are currently homeless or at risk of homelessness and helps them to obtain and remain in permanent housing, while Hearth permanent supportive housing provides safe, affordable housing and optional on-site supportive services. As described below, both elements of the Hearth model address the unique needs of homeless adults aged 50 and older.

Hearth Outreach Program

The Hearth Outreach Program seeks to identify and house individuals aged 50 years or older who are currently homeless or at risk of becoming homeless. To achieve this goal, the Program employs a team of 6 case managers supervised by a licensed social worker. Each case manager works closely with up to 25 clients to help them obtain and retain long-term housing.

To identify older adults who are currently homeless, case managers visit 10 Boston homeless shelters weekly. At shelters, they get referrals from shelter staff and meet with shelter clients to answer questions about how to obtain permanent housing. Through frequent visits to the shelter, case managers build close relationships with shelter staff and clients and act as an important resource for assistance and advice in obtaining housing.

After identifying and enrolling clients in the Outreach Program, case managers help clients to navigate the challenging and lengthy subsidized housing application process. Case

managers fill out paperwork, accompany clients to interviews, follow-up with agencies, and ensure that the housing unit applied for is safe and affordable. Because the wait for a subsidized housing unit may exceed a year, case managers provide ongoing emotional support to clients. They may also help clients to obtain health care, sort out legal and financial issues, address substance use, or apply for Social Security or veterans' benefits.

Once a permanent apartment is identified, case managers accompany their clients to sign the lease, furnish and move into the unit, set up utilities, plan for healthy meals, access local transportation, and get acclimated to the neighborhood. After these initial steps are in place, case managers work with clients to identify additional services the client would like to receive. Case managers continue to check in regularly to ensure that the rent is paid, that clients are connected to the community, and that they continue to receive treatment for physical and mental disabilities, substance use, or other problems they have identified. In addition to one-on-one interaction with staff members, Outreach offers newly housed clients the option of mutual aid via a psycho-educational support group called Back on Our Feet. The group provides new residents with information and support from group facilitators (Outreach staff) and peers who have been housed for a longer period of time.

In addition to case managers who work with elders who are currently homeless, Hearth employs an "at-risk" case manager who works specifically with older adults at risk of homelessness. The at-risk case manager receives referrals from day shelters, medical providers, elder services, and visiting nurse association agencies, among other sources. Referred clients face a variety of threats to their housing, including eviction, foreclosure, or financial crisis; others are "doubled-up" with friends or relatives in housing that cannot accommodate them long-term. After at-risk elders are identified and enrolled in the program, the case manager helps the client to stabilize their housing by accessing services including tenant counseling, landlord mediation, money management, and eviction prevention. For clients who cannot remain in their housing, case managers help them to identify new housing.

Hearth Outreach now serves over 250 homeless elders annually, and is expanding its services to help 350 clients, including 50 elders at risk of homelessness. Since 1995, the Outreach team has placed over 1000 clients in permanent housing. Over 96% of elders placed in housing maintain housing for one year or longer, surpassing HUD's benchmark housing retention rate of 71% at 6 months. Funding for the Outreach program comes from a combination of McKinney-Vento Homeless Assistance Act funds, Emergency Solutions Grant funds, and philanthropy.

Hearth Permanent Supportive Housing Program

Hearth currently operates 196 units of permanent supportive housing in 8 residences across greater Boston, including a newly constructed 59-unit building. Each residence is supported by an interdisciplinary team that manages and coordinates the care needed to allow residents to remain in their own apartments, including site directors, licensed social workers, registered nurses, resident assistants, and personal care homemakers. Hearth also provides group meals and activities to residents to nurture a sense of community in each residence.

The Hearth model of care addresses both the care needs that are unique to older homeless adults and the factors that contribute to homelessness in the older population. To address high rates of chronic illnesses and geriatric conditions, Hearth staff members facilitate access to medical care by helping residents to make medical appointments and by arranging transportation. To accommodate high rates of disability and mobility impairment, all residences are equal opportunity and fully wheelchair accessible. Optional supportive services are designed to address personal vulnerabilities that commonly precipitate

homelessness among older homeless adults. Group activities and shared living spaces are available to address social isolation; frequent check-ins with social workers and client-centered individual action plans address behavioral issues and mental illness; and on-site substance awareness groups and counseling address substance use problems (Hearth, 2009).

Because no single public agency or funding source focuses on the older homeless populations' special need for housing linked with supportive services, Hearth relies on several funding sources. These include Section 8 project-based housing subsidies and Medicaid and Department of Mental Health funding of eligible services, among other local and state funding sources.

Case Studies: Hearth Residents

Three case studies of Hearth clients illustrate how the Hearth permanent supportive housing model serves the complex medical and social needs of its residents. These cases highlight the role that outreach, subsidized housing, and supportive services play in helping older homeless adults secure and maintain permanent, stable housing.

Case 1: Ms. S—Ms. S is a 65-year-old woman who has lived in Hearth housing for the past 10 years. She has multiple medical and psychiatric comorbidities, including paranoid schizophrenia, diabetes, and severe mobility impairment caused by a degenerative hip condition. Before moving into Hearth housing, Ms. S was staying in a local homeless shelter. She first became homeless after her husband died, and she could no longer afford to pay rent in their shared apartment. She took a room in a multi-family house, but was evicted after falling behind on her rent. Staff members at the homeless shelter where Ms. S was staying referred her to a Hearth Outreach case manager, who worked with Ms. S over a period of a year to help her obtain Hearth housing.

Due to her religious beliefs, Ms. S had refused medical care for many years before moving to Hearth, including treatment for her degenerative hip condition. At Hearth, staff members including the patient's nurse and social worker gradually built rapport and trust both with Ms. S and with members of her religious community. After several years in Hearth housing, Ms. S consented to medical care and was seen by an orthopedic surgeon. Unfortunately, her hip joints had degenerated to the point where they were deemed inoperable. Today, Ms. S uses a walker and struggles greatly with personal care because she has lost so much mobility.

Ms. S considers Hearth staff and other residents to be part of her family, and hopes to continue living at Hearth. However, she currently requires a skilled nursing facility level of care, which is beyond the level of services provided by Hearth supportive housing programs. Staff members are struggling with their desire to honor Ms. S's wish to age in place, versus the reality that she needs more care than staff is able to provide. Both personal care homemaking and nursing staff have gone above and beyond their job descriptions to allow Ms. S to remain in her apartment as long as possible by providing a combination of support services, personal care, home care, and service coordination.

Case 2: Ms. E—Ms. E is a 63-year-old woman with schizoaffective disorder, high blood pressure, emphysema, diabetes, urinary incontinence, and tobacco dependence who has lived in Hearth housing for 8 years. Before moving to Hearth, Ms. E stayed in local shelters or rented a room in the YMCA. She had lost connections with family over a period of years before becoming homeless, and was very socially isolated before coming to Hearth. Like Ms. S, Ms. E was referred to the Hearth Outreach team by shelter staff members, and obtained Hearth housing after working closely with her case manager over a period of 9 months.

At Hearth, Ms. E has experienced gradual functional and cognitive decline, with decreasing ability to perform self-care and increasing paranoia and irritability. Although she now requires more assistance with ADLs and IADLs, she has become increasingly resistant to receiving care, especially related to her significant urinary incontinence.

Hearth staff members have developed several strategies to provide care to Ms. E, including checking in frequently with her and her treatment team and developing a client-centered action plan to motivate her to improve her hygiene, choose her days for bathing, and cooperate with staff. Staff members also encourage Ms. E to cut down on her smoking, and she receives additional smoking-cessation support from an on-site substance awareness group.

Case 3: Mr. R—Mr. R is a 71-year-old man with schizophrenia, dementia, traumatic brain injury from an attempted suicide, diabetes, coronary heart disease, and alcohol abuse. He has lived in Hearth housing for over 10 years. He previously lived in a group home, but was at risk for losing his housing due to escalating care needs. Staff members at his group home contacted the Hearth Outreach team, and a case manager was able to place Mr. R in Hearth housing.

Due to severe cognitive impairment, poor concentration, and impaired judgment, Mr. R requires assistance and supervision from Hearth staff to remain safely housed and to complete ADLs and IADLs. Mr. R has periods of sobriety, followed by relapses and episodes of binge-drinking. On-site social work and nursing staff work with Mr. R to provide support around relapse prevention, including brief interventions and treatment referrals. Mr. R also continues to smoke in his apartment, although this is a lease violation. Hearth staff members provide daily reminders about safe smoking, with a focus on harm reduction.

These three cases emphasize the key elements of Hearth's success, including a continuum of service-enriched subsidized rental units to meet specific physical and mental health needs; a multidisciplinary services team to meet physical and mental health needs including assessment, treatment planning, crisis management, medication management, and care coordination; wellness promotion and meal assistance to promote health; financial management, personal care, and homemaking services to help residents address daily needs; and group activities to prevent isolation and promote social engagement (Hearth, 2009).

Promoting Affordable Living for Older Adults who are Homeless

Because permanent supportive housing programs help chronically homeless individuals to maintain housing while decreasing use of acute care services and associated costs (Fitzpatrick-Lewis et al., 2011), the federal government has recognized these programs as a priority intervention to address chronic homelessness (United States Interagency Council on Homelessness, 2010). An increasing number of communities across the country now offer permanent supportive housing programs for chronically homeless adults. Hearth serves as a potential model to be replicated, and the lessons learned from Hearth's more than 20 years of work with homeless elders may be adapted to help existing permanent supportive housing models become more aging-informed.

National awareness of the problem of and solutions for elder homelessness is gradually increasing through the efforts of Hearth and several partner organizations. Together with the non-profit Corporation for Supportive Housing and Shelter Partnership, Inc., Hearth has formed the National Leadership Initiative to End Elder Homelessness. This group is working to achieve national recognition of the impending crisis of elder homelessness and of the

importance of providing permanent supportive housing to elders who are homeless or at risk of homelessness.

The Initiative proposes several concrete policy responses to help prevent and end elder homelessness by addressing the lack of affordable housing units in the U.S. Key recommendations include 1) amending the Low-Income Tax Credit Program to provide a 15% credit increase for permanent supportive housing; 2) increasing funding for publicly assisted housing in need of renovation to create new permanent supportive housing through the Section 8 program, Public Housing capital account, and other funding sources; and 3) improving the HUD Section 202 program through several measures, including encouraging communities to make these housing units more available to older adults who are homeless or at risk of homeless (National Leadership Initiative to End Elder Homelessness, 2011).

Because of the recent sequestration order, however, several HUD housing grants will be cut, resulting in an estimated 100,000 homeless and formerly homeless individuals being removed from their current housing and shelter programs (U.S. HUD, 2013). Ongoing advocacy and leadership are necessary to promote policy initiatives and prevent the reduction of existing resources.

Conclusion

Permanent supportive housing programs have proven effective in decreasing the number of chronically homeless Americans and the costs associated with high rates of acute medical care. The Hearth model offers a way to extend these programs to address the complex needs of older homeless adults and improve their health and quality of life, while working to decrease high rates of costly acute care use and institutionalization in this population.

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