

Health Care for the Homeless: An Aging Demographic 2006 to 2010

Introduction

Homelessness in America is a growing problem. The department of Housing and Urban Development's (HUD) Annual Homeless Assessment Report to Congress (AHAR) estimates that more than 1.59 million people spent at least one night in an emergency shelter or transitional housing program in 2010. Of this group, an estimated 2.8% of this population or 44,520 individuals were over the age of 62 (Department of Housing and Urban Development, 2011). The Homelessness Research Institute predicts the number of elderly homeless individuals is expected to increase by about 33% between 2010 and 2020 and more than double by 2050 (Sermons & Henry, 2010). Programs like the Health Care for the Homeless serve to both medically care for this growing population as well as collect data about their specific demographics and health care needs.

The Health Care for the Homeless (HCH) program is a grant program authorized in section 330(h) of the Public Health Service Act that funds community based organizations that provide primary health care, mental health, addiction and social services to homeless patients living in America. The HCH program was first established through the McKinney Homeless Assistance Act of 1987. In 2002, the program was combined with the Community Health Centers, Migrant Health Centers and Primary Care in Public Housing within the Consolidated Health Care program (National Health Care for the Homeless Council, 2011).

The HCH program currently funds 208 grantees in all 50 states, the District of Columbia, and Puerto Rico. In 2010, HCH projects served 805,064 patients, 90.3% of which were living at or below the federal poverty level. Of the over 800,000 people, 64.9% had no public or private health insurance (Health Resources and Services Administration, 2011).

Primary health services provided must include, "Basic health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology; diagnostic laboratory and radiologic services; preventative health services; emergency medical services; and pharmaceutical services as may be appropriate for particular centers" (National Health Care for the Homeless Council, 2011). Additionally, substance abuse treatment mental health referrals, and other specialty service referrals are to be provided. Patients also receive case management services and other necessary services including outreach, transportation, and education about the availability and proper use of health services (National Health Care for the Homeless Council, 2011).

The Uniform Data System (UDS) is a reporting requirement for grantees like the HCH that tracks information including patient demographics, health care services provided, staffing, clinical indicators, utilization rates, costs, and revenues at the grantee, state, and national levels (Health Resources and Services Administration, 2010). In the Public Health Service Act amended in 2010, homeless patients are defined as, "...an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing," (Public Health Service Act §330, 42 USCS §254b, 2010). Additionally, the definition has expanded to include individuals who are "doubled up" and are required to live with friends and/or extended family members to maintain a housing situation. Individuals who are to be released from a prison or hospital may be considered homeless if they do not have a stable housing situation to which they can return (HRSA/Bureau of Primary Health Care, 2011).

Through the use of data collected by the UDS from HCH clinics nation-wide, we examined demographic and health care trends unique to the rapidly growing elderly female population. We also reviewed current literature with the goal of identifying possible pathways to homelessness among this

population as well as specific health care needs that are important to identify in this population that is predicted to continue to drastically increase.

Methods

We obtained Health Care for the Homeless data collected by the Agency for Health Care Research and Quality (AHRQ) on medical care services delivered each year in HCH clinics in all fifty states, the District of Columbia, and Puerto Rico. Data were recorded at the clinics in the form of de-identified surveys completed by clinic personnel and submitted to the Uniform Data System (UDS). The data used are reported on the UDS website in the form of a summarized report grouped into both state and national pools. We compared UDS data between 2006 to 2010 (<http://bphc.hrsa.gov/healthcenterdatastatistics/nationaldata/index.html>) and examined frequencies of key demographic variables and diagnostic and preventative health variables. Additionally, we compared changes in reported patient demographics across the four years graphically and statistically using nonparametric Chi square tests.

Results

The majority of HCH patients in 2010 were Caucasian (43.9%) males (56.3%) between the ages of 20-64 years old (81.6%) (Table 1). Overall, there was a greater than 100,000 user increase in HCH clinic services between 2006 to 2010. During this time, there was also an increase in the proportion of female patients visiting the HCH clinics (Table 1). In 2006, 42.6% of clinic service users were female, compared to 43.7% in 2010. When examined by age group, the greatest increase in female patients occurred in the greater than or equal to 65 year old range. While the male population in this group has only modestly increased from 10,173 male patients to 11,920, the female population appears to have markedly grown. In 2006, 7550 elderly female patients comprising 42.6% of this subset of the population visited HCH centers. In 2010, this number increased by almost a third of the original population to 10,026 patients comprising 45.7% of this subset of the population. However, despite this trend in increase of women in the HCH patient population, there were no statistically significant changes in the male to female ratio between 2006 and 2010 in any age groups (Table 2).

The housing status of HCH patients appears to be in flux. There are fewer HCH patients living in homeless shelters and on the street and more who are reporting housing of one form or another. In 2010, 4.3% fewer patients lived in homeless shelters and 0.7% fewer lived on the street compared with 2006. These percentages are decreasing, while those for other forms of housing increased. Comparing the 2006 data with that of 2010, there were 1.6% more patients lived in transitional living facilities and 5.8% more patients were doubled up in motels/hotels/apartments/other housing (Table 1). Again, however there were no statistically significant changes in housing status groupings when comparing 2006 and 2010 aggregate data.

Additionally, data suggest a change in insurance status amongst HCH patients. In 2006, 70.1% of patients were uninsured. This percentage dropped to 64.9% in 2010, greater than a 5% change. Within the same time frame, more patients presented with Medicaid (+3.7%), Medicare (+0.3%), other public insurance (+0.9%), and private insurance (+0.4%) (Table 1). There were no statistically significant changes in insurance status groupings when comparing 2006 and 2010 aggregate data.

Table 1, Demographics

	2006		2010		CHANGE	
	PATIENTS	% TOTAL	PATIENTS	% TOTAL	PATIENTS	% TOTAL
Total Patients	701,623	100.0%	805,064	100.0%	103,441	114.7%
Age						
<20 years old	118,411	16.9%	125,959	15.6%	7,548	-1.2%
20-64 years old	565,489	80.6%	657,159	81.6%	91,670	1.0%
≥65 years old	17,723	2.5%	21,946	2.7%	4,223	0.2%
Gender						
Total Male	402,780	57.4%	453,326	56.3%	50,546	-1.1%
Race						
Caucasian	232,299	33.1%	353,131	43.9%	120,832	10.8%
African American	244,585	34.9%	265,696	33.0%	21,111	-1.9%
Hispanic or Latino	148,291	21.1%	178,232	22.1%	29,941	1.0%
Asian/Pacific Islander/American Indian/Alaska Native	24,040	3.4%	32,973	4.1%	8,933	0.7%
Unreported/ Refused to Report	52,408	7.5%	129,802	16.1%	77,394	8.7%
>1 Race	--		23,462	2.9%	--	--
Housing Status						
Shelter	278,405	39.7%	284,488	35.3%	6,083	-4.3%
Transitional	82,663	11.8%	107,927	13.4%	25,264	1.6%
Doubling Up	112,518	16.0%	176,018	21.9%	63,500	5.8%
Street	70,704	10.1%	75,310	9.4%	4,606	-0.7%
Other	67,274	9.6%	79,818	9.9%	12,544	0.3%
Unknown	56,051	8.0%	47,041	5.8%	-9,010	-2.1%
Income as Percent Poverty Level Known						
≤100%	534,116	76.1%	632,625	78.6%	98,509	2.5%
101-150%	36,444	5.2%	38,991	4.8%	2,547	-0.4%
151-200%	8,994	1.3%	15,816	2.0%	6,822	0.7%
>200%	9,689	1.4%	12,965	1.6%	3,276	0.2%
Unknown	112,380	16.0%	104,667	13.0%	-7,713	-3.0%
Insurance, % Total Population						
Uninsured	492,026	70.1%	522,165	64.9%	30,139	-5.3%
Medicaid	153,041	21.8%	205,246	25.5%	52,205	3.7%
Medicare	23,880	3.4%	29,607	3.7%	5,727	0.3%
Other Public Insurance	15,416	2.2%	24,748	3.1%	9,332	0.9%
Private Insurance	17,260	2.5%	23,298	2.9%	6,038	0.4%

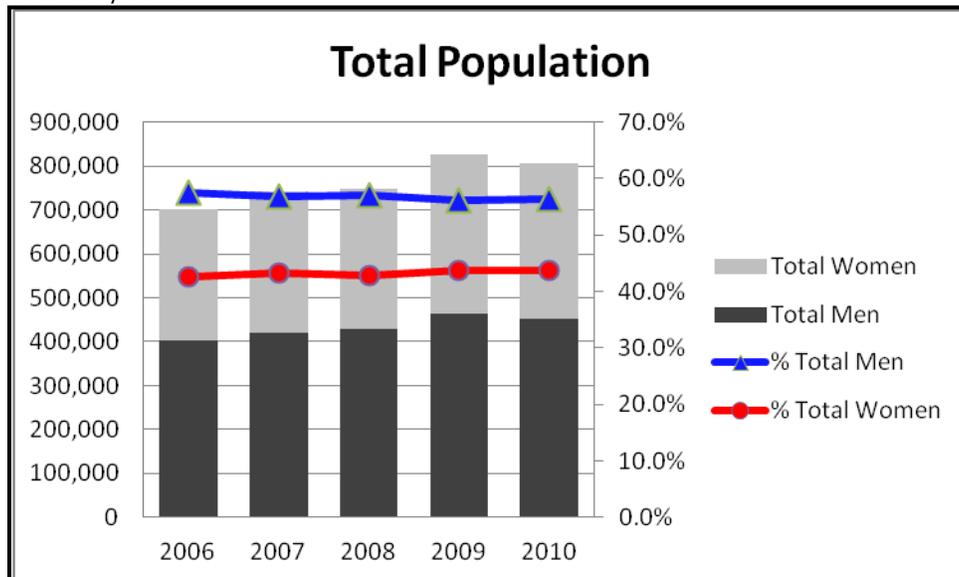
Source: (Health Resources and Services Administration, 2011) and (Health Resources and Services Administration, 2007)

Table 2, Age and Gender

AGE AND GENDER	2006		2010		CHANGE	
	PATIENTS	% GROUP	PATIENTS	% GROUP	PATIENTS	% GROUP
<20 years old	118,411	--	125,959	--	+7,548	--
Male	56,660	47.9%	59,287	47.1%	+2,627	-0.3%
Female	61,751	52.1%	66,672	52.9%	+4,921	0.3%
20-64 years old	565,489	--	657,159	--	+91,670	--
Male	335,947	59.4%	382,119	58.1%	+46,172	-1.3%
Female	229,542	40.6%	275,040	41.9%	+45,498	1.3%
≥65 years old	17,723	--	21,946	--	+4,223	--
Male	10,173	57.4%	11,920	54.3%	1,747	-3.1%
Female	7,550	42.6%	10,026	45.7%	2,476	3.1%
65-69	9,117	51.4%	11,614	52.9%	+2,497	1.5%
Male	5,566	61.1%	6,873	59.2%	+1,307	-1.9%
Female	3,611	39.6%	4,741	40.8%	+1,130	1.2%
70-74	4,200	23.7%	5,142	23.4%	942	-0.27%
Male	2,416	57.5%	2,750	53.5%	334	-4.0%
Female	1,784	42.5%	2,392	46.5%	608	4.0%
75-79	2,401	13.6%	2,725	12.4%	+324	-1.1%
Male	1,338	55.7%	1,291	47.4%	-47	-8.4%
Female	1,063	44.3%	1,434	52.6%	+371	8.4%
80-84	1,079	6.1%	1,441	6.6%	+362	0.5%
Male	498	46.2%	601	41.7%	+103	-4.4%
Female	581	53.8%	840	58.3%	+259	4.4%
≥85	866	4.9%	1,024	4.7%	158	-0.2%
Male	355	41.0%	405	39.6%	+50	-1.4%
Female	511	59.0%	619	60.4%	+108	1.4%

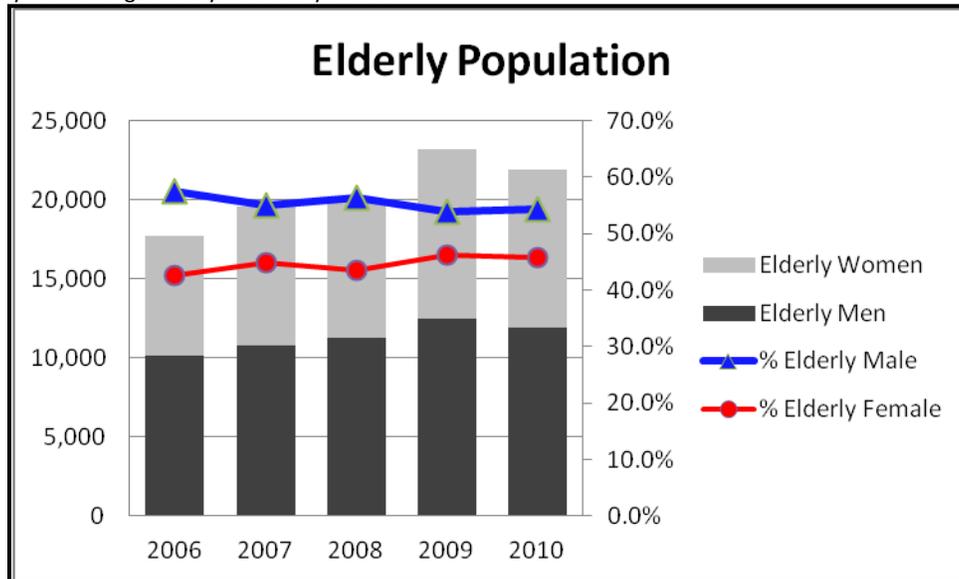
Source: (Health Resources and Services Administration, 2011) and (Health Resources and Services Administration, 2007)

Figure 1, Total Patients by Gender



Source: (Health Resources and Services Administration, 2011), (Health Resources and Services Administration, 2010), (Health Resources and Services Administration, 2009), (Health Resources and Services Administration, 2008), and (Health Resources and Services Administration, 2007)

Figure 2, Elderly Patients aged ≥65 years old by Gender



Source: (Health Resources and Services Administration, 2011), (Health Resources and Services Administration, 2010), (Health Resources and Services Administration, 2009), (Health Resources and Services Administration, 2008), and (Health Resources and Services Administration, 2007)

Data also revealed increasing numbers of mammograms and pap tests being performed (Table 4) as well as a rise in the number of primary diagnoses of cardiovascular related disease, depression and mood disorders, and anxiety including PTSD (Table 3).

Table 3, Select Primary Diagnoses

	2006		2010		CHANGE	
	PATIENTS	% TOTAL	PATIENTS	% TOTAL	PATIENTS	% TOTAL
Cardiovascular Related Disease						
Diabetes Mellitus	34,637	4.9%	51,256	6.4%	16,619	1.4%
Heart Disease	8,087	1.2%	9,933	1.2%	1,846	0.1%
Hypertension	62,495	8.9%	92,790	11.5%	30,295	2.6%
Overweight/Obese	--	--	11,574	1.4%	--	--
Substance Abuse/Mental Health Disease						
Alcohol Abuse	21,483	3.1%	21,555	2.7%	72	-0.4%
Other Substance abuse (excluding tobacco)	23,572	3.4%	26,884	3.3%	3,312	-0.1%
Tobacco	--	--	11,695	1.5%	--	--
Depression/Mood Disorders	34,520	4.9%	63,833	7.9%	29,313	3.0%
Anxiety including PTSD	11,393	1.6%	25,069	3.1%	13,676	1.5%

Source: (Health Resources and Services Administration, 2011) and (Health Resources and Services Administration, 2007)

Table 4, Women's Health Screening

	2006		2010		CHANGE	
	PATIENTS	% GROUP	PATIENTS	% GROUP	PATIENTS	% GROUP
Screening Exams						
Mammogram*	5,300	10.3%	9,294	12.2%	3,994	1.9%
Pap Test**	28,602	12.8%	38,622	14.5%	10,020	1.7%
Abnormal Findings						
Abnormal Breast Findings***	632	11.9%	1,120	12.1%	488	0.1%
Abnormal Cervical Findings***	1,876	6.6%	3,348	8.7%	1,472	2.1%

Source: (Health Resources and Services Administration, 2011) and (Health Resources and Services Administration, 2007)

*The USPSTF recommended ages for mammograms are 50-74 years old. %Group for "Mammogram" was calculated using total female patients aged 50-74, which were 51,493 and 76,090 respectively. **For low risk patients, the USPSTF recommends pap smears for women aged 21-65. %Group for "Pap Test" was calculated using total female patients aged 21-64, which were 222,849 and 266,520 respectively. ***%Group was calculated based on number of patients receiving screening exam.

Discussion

Over the past four years, the number of homeless individuals treated at Health Care for the Homeless clinics has increased by more than 100,000 patients (Table 1). This increase can be partially explained by an increase in HCH grantees. Yet, the most substantial growth in the patient population occurred in years when there were minimal grantee changes. The largest grantee number increase occurred between 2006 and 2007, when grantee numbers rose from 184 to 202 (Health Resources and Services Administration, 2007; Health Resources and Services Administration, 2008). This rise was associated with an increase of 40,965 patients. Yet, from 2007 to 2010, the number of grantees only changed by 6, whereas the population served climbed by 60,476 (Health Resources and Services Administration, 2008; Health Resources and Services Administration, 2009; Health Resources and Services Administration, 2010; Health Resources and Services Administration, 2011). These trends suggest that the increase in patients may also reflect an increase in the overall population of homeless in America. Additional sources have documented an increase in the number of homeless in America. In 2006, the Annual Homelessness Assessment Report to Congress (AHAR) reports that about 1.15 million total persons used emergency shelter and/or transitional housing during the six-month period studied (Khadduri, Culhane, Buron, Cortes, Holin, & Poulin, 2008). This figure rose to 1.59 million in 2010 (Department of Housing and Urban Development, 2011).

The increase in patient population might also indicate that growing numbers of poor and unstably housed individuals are beginning to use HCH sites for their primary health care, possibly due to inadequate access to other forms of health care. In 2010, there were more patients who lived under 100% of the poverty level than in 2006. Trends within the data suggest that fewer "homeless" patients are living on the street or in shelters and more are living in transitional housing or doubled up (Table 1). Additionally, data show that fewer patients are uninsured and more are now insured with Medicaid, Medicare, other public insurance, or private insurance (Table 1). These changes may reflect a shift in the homeless population that could be explained by the recent economic conditions possibly forcing more individuals to seek cheaper health resources. Another possible explanation is that many homeless patients are continuing to use these services as their primary source of health care as they transition into more stable situations. In the past, lack of insurance has been independently associated with unmet needs for medical or surgical care, prescription medications, mental health care, and eyeglasses (Baggett et al., 2010). As Health Care Reform continues and laws like the Patient Protection and Affordable Care Act (PPACA) signed into law in March 2010 go into effect, the housing and insurance status of many HCH patients may continue to shift away from the previous, stereotypical uninsured "homeless" individual.

In addition to a growing homeless population, our data suggest that the elderly homeless population may also be rising. In 2006, HCH patients aged 65 and older comprised 2.5% of the total

patients served compared with an increase to 2.7% in 2010 (Table 1). This value is comparable to that observed in the 2010 AHAR data, which found an estimated 2.8% of the homeless population were over the age of 62 (Department of Housing and Urban Development, 2011). A recent paper published by the National Alliance to End Homelessness made waves in 2010 when they projected that the elderly homeless population is expected to increase by 33 percent between 2010 and 2020, and more than double between 2010 and 2050 (Sermons & Henry, 2010).

There is good reason to assume that the elderly homeless population will continue to increase. On average, our nation is aging. According to the 2010 U.S. Census, more people in the United States were aged 65 and older than in any previous census (Werner, 2011). As the baby boomer population continues to age, the number of elderly adults in the U.S. will continue to grow. Fixed incomes and rising health care costs have always left the elderly population vulnerable to experiencing poverty. However, surveys have shown that the recent economic crisis is further impacting this susceptible population. In 2009, Experience Works published a paper looking at more than 2,000 older job seekers across 30 states and Puerto Rico. This study found that for many older workers, a combination of circumstances led them to seek employment. Among job seekers aged 55-60, these reasons included loss of previous employment (20%), death of a loved one (16%), medical bills due to personal illness or that of spouse (15%) and homelessness (11%). About 68% of respondents reported that their retirement income was not enough to live on and 46% stated that they needed to work to keep their homes/apartments (Experience Works, 2009).

In a 2009 article published in USA Today, author Stephanie Armour further explores how the mortgage crisis has affected senior homeowners. Citing two reports conducted by the AARP, she states that more than 600,000 seniors are delinquent or in foreclosure and that 25.5 million seniors aged 50 and older have a mortgage. Armour argues that the elderly population lacks the money or job opportunities to catch up on mortgage payments once they fall behind. Many seniors have developed financial problems due to staggering medical bills, aiding adult children, victimization by predatory lenders, and reverse mortgages with adjustable rates that they could not afford. She further explains that many seniors had relied on their home equity as a retirement nest egg that disappeared with plummeting home values (Armour, 2009). The 2010 Retirement Confidence Survey conducted by Employee Benefit Research Institute shows that about 54% of RCS workers aged 55 and older reported the total value of their household's savings and investments, excluding the value of their primary home and defined benefit plans, is less than \$25,000. Almost 27% reported having less than \$1,000 in assets (Helman et al., 2010). As the recession continues to impact the economy, the elderly population will continue to be at increased risk for experiencing poverty and homelessness due to lack of financial resources and mounting financial strain.

The rising number of elderly homeless raises a number of health care issues that need to be addressed. Homelessness alone is associated with an increased risk of morbidity for acute infections like tuberculosis as well as for chronic diseases such as diabetes, obesity, hypertension, peripheral vascular disease and chronic liver and kidney disease (Koon et al, 2010). Now consider a 2001 study that found elderly homeless individuals were more likely to spend a longer duration of time on the street than younger homeless individuals, presumably due to a lack of social resources that prohibit their ability to find transitional housing or to double-up (Hecht and Coyle, 2001). This longer duration in unstable housing further subjects an already frail elderly population to poor living conditions and worsening health problems. The elderly homeless also tend to spend longer amounts of time seeking employment than their younger counterparts (Experience Works, 2009). Homeless individuals who do manage to become employed typically find work that is intermittent in nature, has unpredictable hours, or for which absence may lead to termination or replacement. A 2010 study found that employment in the setting of poverty was associated with unmet health care needs because work was prioritized over health care (Baggett et al, 2010). Additionally, the elderly homeless population is often exposed to a lack

of food due to the need to prioritize the purchase of food with that of paying for medication, rent, and other health care needs (Experience Works, 2009). One fourth of homeless adults in the 2003 Health Care for the Homeless User Survey were food insufficient and about 68% had gone without food for at least one day in the past month (Baggett et al, 2011).

In addition to these economic and social factors, elderly homeless individuals are more likely to have functional impairment, frailty, depression, visual impairment, and urinary incontinence compared to population-based cohorts (Brown et al, 2011). This is a growing population at risk for multiple acute and chronic diseases. Overall, the HCH data suggest that clinics are improving their screenings for chronic diseases like diabetes mellitus (2006, 4.9%; 2010, 6.4%) and hypertension (2006, 8.9%; 2010, 11.5%) as more patients are being screened and diagnosed (Table 3). However, these percentages are significantly lower than the national averages which indicate that, depending on type of insurance, 82.0-90.6% of diabetes patients receive annual HgA1C screens (NCQA, 2011). Approximately 33.5% of Americans have high blood pressure, yet only 11.5% of HCH patients were diagnosed in 2010 (NCQA, 2011). In 2007, it was estimated that diabetes contributed about \$116 billion to medical care costs and hypertension contributed \$43.5 billion (NCQA, 2011). Uncontrolled hypertension and diabetes significantly impact quality of and length of life. On average, men and women with hypertension die 5.1 and 4.9 years earlier, respectively, than their normotensive counterparts (NCQA, 2011). While it appears that screening and diagnosis for these chronic and costly conditions are increasing, there is still room for improvement.

Within this growing elderly homeless population, we observed growth amongst elderly female patients (Table 2, Figure 2). In 2006, elderly female patients comprised 42.6% of the patients aged 65 and older who visited HCH centers. In 2010, this number increased by almost a third of the original population and represented about 45.7% of this population subset. Traditionally, homeless populations have been predominantly male. While none of the changes in the male to female ratios between 2006 and 2010 were statistically significant, the gender gap appears to be decreasing across all age groups, with a more marked decrease in the elderly female population (Figure 1, 2). What is particularly interesting about this elderly female data is the contrast with the 2010 census data regarding the male to female ratio among the elderly population. According to the census, though there have been more elderly females than males across the last three censuses, elderly males showed more rapid growth as mortality differentials have begun to narrow. These data showed that there are increasing numbers of elderly males per females (Werner, 2011). A possible explanation for the increase in elderly females seen in the HCH data may be explained by the Pew Research Study which showed that, though initially experiencing higher rates of lay-offs and unemployment rates than women, men of all ages have been faring better in the job market from 2009 to 2011. The study revealed that the unemployment rate for men has fallen from 10.6% in June 2009 to 9.5% in May 2011 whereas the unemployment rate for women has increased from 8.3% to 8.5%, respectively. Within the sectors of education and health services, a significant source of jobs for women during the recession, men are now being hired at a faster rate than women, possibly decreasing a significant job source for females (Kochhar, 2011).

According to the Health Care for the Homeless (HCH) program, the elderly female homeless population may be growing at a faster rate than the elderly male population, making the need for specifically targeted health initiatives for this population increasingly more crucial. Specific health care issues include, but are not limited to, screening for breast cancer, cervical cancer, and mental health illness. The HCH data shows some improvement in mammography (2006, 10.3%; 2010, 12.2%) and pap tests (2006, 12.8%; 2010, 14.5%) performed between 2006 and 2010 (Table 4). Like the screening for chronic illness, these statistics also fall short of the 2010 national averages of mammography screens (51.3-70.8%) and cervical cancer screening (67.2-77.0%)(NCQA, 2011). Annually, treatment of cervical cancer in the US costs \$300-400 million and treatment of breast cancer costs \$7 billion (NCQA, 2011). Due to their homeless status, this population may be at an increased risk for physical and sexual abuse,

therefore increasing the necessity for screening (Koon et al, 2010). Of those who were screened, 12.1% had abnormal breast findings and 8.7% were found to have abnormal cervical findings (Table 4). Access to and cost of health care may not be the only deterring factors to the acceptance of pap smear screens. A 2009 study showed that 38% of homeless women in need of pap smear screening declined a free pap test (Bharel et al, 2009). Among medically underserved women, more than half of women in a 2005 study were not followed up in accordance with the established guidelines (Benard et al, 2005). A major reason not to follow up care included significant life stressors such as homelessness (Coker et al, 2006).

Additionally, homeless elderly females are in need for mental health screening. There is a high prevalence of psychiatric disorders and cognitive impairment in the elderly homeless population. Among the elderly, a greater proportion of women than men have severe mental illness (Stergiopoulos and Herrmann, 2003). While elderly individuals report loss of job and insufficient access to affordable housing as primary causes of homelessness, elderly women are about three times more likely than men to report eviction as the cause of homelessness (Hecht and Coyle, 2001). This suggests that older women's pathways to homelessness may be more crisis driven than men's. Additionally, elderly homeless individuals may have greater difficulty coping with problems once having experienced the trauma of homelessness. Elderly female homeless patients are already more likely to report histories of mental health problems and may have an increasingly more difficult time handling the stress associated with homelessness than their male counterparts (Hecht and Coyle, 2001). Mental illness and stress can further impact and/or lead to more acute and chronic health care issues like those previously discussed of hypertension, frailty, and worsening cognitive impairment and ability to care for one's self. The HCH data reveal moderate improvements in screening for depression/mood disorders (2006, 4.9%; 2010, 7.9%) and anxiety including PTSD (2006, 1.6%; 2010, 3.1%). These values are significantly lower than the national statistic that 50.7-67.4% of patients are newly diagnosed with depression and stay on their medications for 12 weeks (NCQA, 2011). Improved mental health screening efforts are needed, especially in this at-risk population.

Conclusion

The elderly homeless comprise a small, but growing sub-set of the national homeless population. This group is particularly susceptible to economic vulnerability and unmet health care needs (National Coalition for the Homeless, 2006). While studies have traditionally referred to the "elderly" homeless as a population greater than 62-65 years of age, the "elderly" population may actually be substantially larger than these age-defined calculations. Homeless individuals are subject to increased morbidity and mortality, pre-maturely aging homeless individuals to health status on par with the typical 62+ year old person. Homeless individuals aged 55 and older could potentially be considered part of this "elderly" population based solely on health status (National Coalition for the Homeless, 2006).

In order to address specific health care issues related with homelessness, a thorough history and physical is needed. Additionally, compliance with treatments may be best achieved with patient education, a written and well-explained action plan, and a simplified medication regimen (Koon et al, 2010). As discussed previously, employment in the setting of poverty is also associated with unmet health care needs because work is prioritized over health care (Baggett et al, 2010). To better serve this population, health care practices need to have more flexible hours that are compatible with work schedules. New laws like the PPACA should also help to alleviate some of the unmet needs. To combat issues like food insufficiency, also associated with a lack of health care service utilization, efforts to provide primary care for homeless persons need to be matched by public health and policy initiatives to provide for basic subsistence needs among very poor (Baggett et al, 2011).

Elderly females are at an increased risk for common diseases and co-morbidities that affect individuals in their age group, including inability to perform activities of daily living, falls, impaired

cognitive and executive function, frailty, and depression. Additionally, homelessness itself increases their risk of developing many acute illnesses and chronic conditions. This population is particularly susceptible to mental health problems which may be further exacerbated by a lack of coping skills and resources to recover from their homeless situation. The prevalence of mental health problems and significant life stressors associated with homelessness may create a further self-imposed barrier to care for the previously mentioned health issues and those that are gender-specific. As this population continues to grow, targeted evaluation and social as well as health care related management of this particularly vulnerable subset of the elderly population are crucial.

Health Care for the Homeless clinics provide an invaluable service to homeless individuals across America. Trends for screening and services provided are improving, even with the increasing number of patients visiting these clinics. However, the screening and treatment services still do not come close to matching national statistics among non-homeless individuals. New health care reforms like the Patient Protection and Affordable Care Act (PPACA) may help to alleviate the burdens to these clinics by making affordable health care available to all Americans and by providing \$11 billion to Health Centers over the course of 2011 through 2015, allowing HCH programs to expand services available and locations (National Health Care for the Homeless Council, 2011).

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