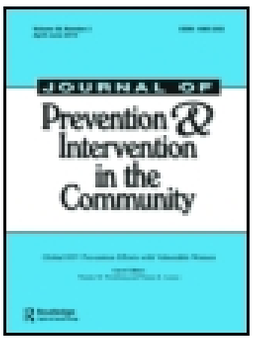

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Creating structural community cohesion: Addressing racial equity in older adult homelessness

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ABSTRACT

Older adults and racial minorities are overrepresented in homeless populations. Shelter and housing options for homeless older adults who have complex health and social needs are necessary, but not readily available. Older homeless adults that require, but do not receive, health-sensitive, age-sensitive, and racial equity housing, remain vulnerable to poor outcomes and premature mortality. Accordingly, this study examines the development of a coalition to better address older adult homelessness within a racial equity framework. A community coalition was established to better address older adult homelessness within the lens of age-sensitivity and racial equity, due to a disconnect between healthcare and senior housing placement programs, creating unaddressed multifaceted health issues/complications. The community coalition development is described, including the coalition process, activities, and outcomes. Local rehoused older adults are also interviewed and described to better understand their central life circumstances.

KEYWORDS

Aging; homelessness; racial equity

Introduction

Homelessness is a compound economic, psychosocial, and health issue requiring multidimensional solutions, that can be further complicated by aging populations (Purkey & MacKenzie, 2019). Approximately one-half of homeless individuals in the United States are over 50 years of age (Brown, Thomas, et al., 2013). Contributing factors, such as human capital, social capital, and life events, rather than disability or economic capital, seem to lead older adults into homelessness (Hatchett, 2004). Older adults that are experiencing homelessness, are more likely to be male and better educated

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than some housed adults, but have had shorter job tenures, fewer social ties, and faced with multiple cascading risks, such as job and housing loss (Shinn et al., 2007). While homeless services can be equal across varying populations, outcomes may not be equitable for the most at-risk age and racial groups experiencing homelessness.

Individuals that experience homelessness biologically age faster than the general population in the United States, partly due to multilevel internal and external associated stressors (Brown, Thomas, et al., 2013). As a consequence, health conditions found more often among older adults (e.g. falls, cognitive impairment, frailty, major depression, sensory impairment, and urinary incontinence) are relatively common, among older homeless populations (Brown, Kiely, et al., 2013). However, the current homeless structural systems do not adequately address the complex health needs of older adults that are experiencing homelessness, creating serious challenges for suitable rehousing (Brown, Thomas, et al., 2013). For example, individuals experiencing homelessness often struggle to manage their chronic health conditions, due in part to the absence of affordable, contemporary, age-friendly, and disability-access housing, with the necessary nutritional, physical, and health services (Sorrell, 2016). Older adults that have experienced homelessness also have low engagement in advance care planning, in part due to limited clinical and legal attention provided, despite the high morbidity and mortality levels (Sudore et al., 2018). Furthermore, experiencing homelessness in older age can also expose individuals to added harm, through exposure to elder victimization (Tong, Kaplan, Guzman, Ponath, & Kushel, 2019).

In addition to health and age-sensitive housing options, racially equitable solutions to homelessness are needed to address disproportional overrepresentation (Reid et al., 2019) and vulnerabilities that have come with discrimination and hardships (Wrighting et al., 2019). Black race is disproportionally overly represented among homelessness (Montgomery, Dichter, Thomasson, Fu, & Roberts, 2015). Lifetime prevalence of homelessness among members of the baby boomer population in the Health and Retirement Study (HRS) indicates that 6.2% of respondents had a period of homelessness at some point in their lives, with higher rates for non-Hispanic blacks (16.8%) and Hispanics of any race (8.1%) than for non-Hispanic whites (4.8%). The black-white gap, remained significant in HRS even after adjustment for socio-ecological factors, such as education, veteran status, and geographic region (Fusaro, Levy, & Shaefer, 2018). Moreover, minority racial subgroups of the U.S. homeless population have increased health risks and poorer service outcomes (Jones, 2016), highlighting inequities within the homelessness service system. Creating racially equitable solutions to homelessness, aims to have equitable treatment across race, through identifying and then addressing the disadvantages of vulnerable racial groups (Government Alliance on Race and Equity, 2017).

Shelter/housing options for homeless older adults who have complex health and social needs, such as older racial minority adults, are insufficiently available (Campbell et al., 2019). Because healthcare services among individuals that are experiencing homelessness, do not regularly meet the standards of universally accessible and patient-centered care, they disproportionally affect those most at-risk, such as racial minorities and older adults (Brown, Kiely, Bharel, & Mitchell, 2012). Thus, when individuals that are homeless are provided with housing that is insufficient to individual needs, housing by itself does not necessarily equate to a sense of safety, health, and wellness (Canham, Custodio, Mauboules, Good, & Bosma, 2020; Ogden, 2014; Petrusak, Perry, & Hassevoort, 2017; Smith et al., 2019). The East End of Richmond, VA has been designated as one of Richmond's highest areas of poverty with racial inequities and health disparities at the forefront of challenges facing this community (Zimmerman et al., 2016) The average life expectancy (67 years) of residents in the East End is the second lowest in the city. This is a 16-year difference compared to the area of Richmond with the highest life expectancy, representing residents living only 5–10 miles away. In the East End, there is an increasingly older, majority ethnic minority, adults experiencing homelessness. Furthermore, homelessness among racial minority elders has increased, as homelessness for other age groups has not (Homeward, 2018). Accordingly, we aimed to establish a coalition to better address older adult homelessness within a racial equity framework, generally defined 50+ years as the "older" segment of the homeless population, in the East End of Richmond, VA.

Through our coalition, we aim to better address older adults' homelessness within the lens of health/age sensitivity and racial equity (Nelson, Brooks, & Government Alliance on Race and Equity, 2016). In Richmond, Virginia, one solution structured to address homelessness is the public senior housing system (Reid et al., 2019). However, there is a disconnect between healthcare, senior housing, and housing placement programs, with unaddressed multifaceted health issues/complications. A solution is needed to address the difficulties older adults have in transitioning out of homelessness, and how the current system of rapid rehousing is not suited for complex health and housing needs of older adults. To address complex housing, health, and racial-economic complexities experienced by older adults in Richmond's East End, professionals across the care sector were brought together to work collaboratively. The group was tasked with addressing homelessness management, direct wellness services, and advocating for improvements in access to care. In this study, we aim to describe the coalition that was developed to address older adult homelessness within a local low-income racially diverse context and describe the process,

activities, and the outcomes of community coalition building, examining partner cohesion and rehoused older adults.

Methods

This coalition development project focused on addressing health outcomes as central consequences of inequality, among low-income minority older adults experiencing homelessness. This housing-health coalition effort was led by a steering committee of three organizations involved in securing the initial project funding, while independently already managing older adult housing-related cases. The steering committee included: (1) Homeward, a planning and coordinating organization for homeless services in the greater Richmond region; (2) Richmond City: Virginia Department of Health, the nursing health division; and (3) Virginia Commonwealth University (VCU) Richmond Health and Wellness Program (RHWP), a wellness care coordination service offered in five Richmond public housing buildings (Parsons, Slattum, & Bleich, 2019). This partnership across academic, public/private health, and housing agencies was solidified through local grant-funding, to build a multisector coalition, aimed at creating a comprehensive housing service that addresses the health needs of at-risk racially diverse low-income older adults experiencing housing insecurity. The steering committee aimed to improve housing opportunities, living conditions, overall health, and access to community resources, by coordinating services more cohesively across community agencies, for housing-risked older adults: defined as homeless, rehoused, and at-risk for homelessness. The steering committee did not aim to merge the programmatic pieces, instead, they intended to learn from each other's experience and expertise in order to leverage care for the local racially diverse older adults and create a service and research pipeline within existing homelessness and housing systems.

Specific coalition building, high-priority needs, were established by the steering committee to address efficiency and effectiveness in the complexity of homelessness, health equity, and healthcare services for housing-risked racially diverse older adults. Five specific aims were planned to address priority housing/health community equity needs. (1) Provide community-based education and wellness screening sessions within local older adult low-income apartment communities, through an establishment of a Community Coalition, to assess older adult needs and build trust with the community. (2) Hire a Senior Transition Coach, housed at the local health department, to assist with older adults, designated to transition to new housing over the next year (rehoused). This newly hired coach was also tasked with providing feedback to the Community Coalition about, but not limited to, identified service gaps across agencies to better develop local

strategies. This newly hired coach was also responsible for surveying the older adult clients that were served. (3) Develop and implement a homeless diversion strategy to provide rapid rehousing for identified older adults. (4) Evaluate the developed Community Coalition. (5) Evaluate the psychosocial health needs of served rehoused older adults.

Coalition activities

Key community aging-services leaders that worked in housing or healthcare, as well as local community members, were invited, by the steering committee, to attend monthly Housing Community Coalition meetings. Community housed at-risk older adults, were also invited to serve on the coalition as community liaisons. The community liaisons were compensated for their time/effort. Coalition meetings occurred within local community center settings. Eventually, coalition members themselves invited other key leaders they considered necessary for the housing/health coalition.

Once the coalition was developed, specific programmatic coalition activities were planned for monthly Community Coalition meetings, to create a shared understanding of the needs of at-risk, racially diverse, older adults within housing and health. The discussion domains were as follows: (a) establish a planning coalition for older adults by capitalizing on existing partnerships and strengthening community leadership to ensure culturally appropriate, relevant, and effective services. (b) Learn how race, gender, and age were related to equity, health outcomes, and housing stability, and assess the structures and mechanisms within service care models for unintended consequences, bias, and discrimination using the Racial Equity Toolkit (Nelson et al., 2016). (c) Develop a research-to-action pipeline by training the coalition members in survey instrumentation and implementation of findings identified by the community. (d) Learn from community members about barriers to health, benefits of social supports, and pathways into and out of homelessness. (e) Improve service providers' knowledge of the heterogeneity of aging and how to integrate the lifespan model of human development into service delivery for older adults.

Surveys were administered to the coalition members using Google forms at baseline and then at 12-month follow-up. The survey assessed core knowledge, connectivity, and acquired feedback from participating local organizations. Appropriate IRB approvals were obtained. Study findings focus on the evaluation of the cohesion and knowledge of the coalition.

Targeted community survey

Surveys were also administered at two separate time points, to consenting rehoused older adults interacting with the hired Senior Transition Coach.

The survey was developed as part of programmatic coalition activities for learning, from community members, about barriers to health, benefits of social supports, and pathways into and out of homelessness. All clients served by the hired coach were surveyed. The survey assessed psychosocial and health needs at baseline and 6 months later. The Senior Transition Coach collected all the data for the rehoused older adults as part of Virginia Department of Health services. As part of an agreement with the health department, data were de-identified and presented for evaluation. Study findings focus on the psychosocial and health needs of rehoused older adults. Proper IRB approvals were obtained for the survey component.

Results

Coalition programmatic activities

Coalition knowledge

Chi-square analyses comparing Time-1 and Time-2 levels were conducted (Table 1). Overall, there was no change in percentage agreement with key coalition initiatives, with approximately 40% awareness/knowledge of older adult health equity and housing challenges/opportunities; 61% awareness/knowledge of how race, gender, and age related to health equity, health outcomes, and housing stability; and 29% awareness/knowledge of the heterogeneity of aging. There was a significant increase in the awareness/knowledge of the Racial Equity Toolkit, a community equity instrument introduced in the coalition, from 4% to 39% ($p = .0133$). Coalition members were also asked whether a similar coalition existed, at both time points, 4% indicated the existence of a similar coalition.

Chi-square analyses comparing Time-1 and Time-2 levels were also conducted examining actionable items (Table 1). Overall, there was no change in key coalition actionable initiatives, with approximately 10% feeling comfortable using the Racial Equity Toolkit; 49% being part of a research-to-action pipeline; 51% speaking to community members about pathways in/out of homelessness; and 41% integrating lifespan model into older adult service delivery. There was a statistical trend showing an increase in assessing the structures and mechanisms for unintended consequences, bias, and discrimination from 15 to 30% ($p = .2259$).

Coalition connectedness

Chi-square analyses comparing Time-1 and Time-2 levels were conducted to assess coalition member contacts with represented organizations (Table 2). General trajectories indicated an increase in coalition connectedness. There was a significant increase in contact with Health Quality Innovators, a

Table 1. Coalition programmatic activities: knowledge effects.

	Total $n = 49$ (%)	Time 1 $n = 26$ (%)	Time 2 $n = 23$ (%)	p Value
Do you know of a similar existing Coalition or group in the East End community that addresses older adult homelessness? (%Yes)	4	4	4	.9294
Knowledge: Key initiatives				
How informed are you about how aging influences health equity among people experiencing no housing, low-income housing, mixed-income housing, or private housing? (% Extremely)	43	39	48	.7560
How aware are you of ways in which race, gender, and age relate to health equity, health outcomes, and housing stability? (% Extremely)	61	62	61	.5554
How aware are you about the heterogeneity of aging? (% Extremely)	29	30	26	.6361
How informed are you about the Racial Equity Toolkit? (% Extremely)	20	4	39	.0133
Knowledge: Action impact				
How comfortable are you with using the Racial Equity Toolkit? (% Extremely)	10	8	13	.5381
Are you a part of a research-to-action pipeline, including training in survey instrumentation and implementation of community findings? (%Yes)	49	46	52	.6740
How often have you assessed the structures and mechanisms within your service care models for unintended consequences, bias, and discrimination. (% Regularly/Weekly)	22	15	30	.2259
How often have you spoken to a community member about barriers to health, benefits of social supports, and pathways into and out of homelessness? (% Regularly/Weekly)	51	50	52	.6013
How often do you integrate the lifespan model of human development into your service delivery for older adults? (% Regularly/Weekly)	41	42	39	.3758

Note. At Time 1, 16 people did not respond. At Time 2, 55 people did not respond.

Medicare Quality Improvement service provider, from 19% contact at baseline to 78% at Time 2. There were trends toward increases in RHWP contacts, the low-income wellness clinic (88–100%, $p = .0927$), and Lucy Corr: a continuing care community program (35–61%, $p = .0661$). Furthermore, during the two time periods, there was an increase in represented membership.

Table 2. Representing and responding coalition partners: coalition connectedness.

	Some contact (%) Total $n = 49$ (%)	Some contact (%) Time 1 $n = 26$ (%)	Some contact (%) Time 2 $n = 23$ (%)	p Value
Richmond Health and Wellness Program: low-income residential wellness and care coordination clinic	94	88	100	.0927
Richmond Memorial: grantor and local health foundation	67	65	70	.7555
Homeward: homeless services	69	62	78	.2050
Beacon LLC: housing agency, locally serving low-income adults.	40	33	48	.3115
East End Library: local library	57	58	56	.9001
Richmond Health District: local health department	92	85	100	.0497
VA Center on Aging: academic research/service center	67	65	70	.7555
Greater Richmond Age Wave: local older adult advocacy organization	63	58	70	.3896
Senior Connections: local Area Agency on Aging	94	92	96	.6260
Home Again: emergency housing placement	63	58	70	.3896
St. Joseph's Villa: nonprofit support organization	45	46	43	.8509
Richmond Opportunities: local public housing support	35	27	43	.2244
Bon Secours: health system and medical care provider	63	58	70	.3896
Health Quality Innovators: Medicare Quality Improvement analytics	47	19	78	<.0001
Lucy Corr: continuing care community	47	35	61	.0661
Feedmore: in-need food/meal distribution service	82	77	87	.3654
Humana: health system and medical care provider	83	–	83	–

Note. Some contact defined as responses given as occasional or regular/weekly contact, vs. no or rare contact. At Time 1, $n = 16$ people did not respond. At Time 2, $n = 55$ people did not respond.

Coalition feedback

The majority (91%) of the coalition members indicated having a positive experience with the coalition and 96% planned to continue participating in the coalition. Eighty-seven percent of respondents agreed that the coalition strengthens community leadership to combat homelessness. Eighty-three percent agreed that the coalition is needed to combat local homelessness (Table 3).

Targeted community survey

As part of the proposed coalition activities, a Senior Transition Coach was hired to support rehoused older adults, and collect psychosocial and physical data to identify the health needs of rehoused at-risk older adults. Data were collected from $n = 28$ residents at Time 1 (December 2018) and

Table 3. Coalition feedback.

	$n = 23$ (%)
How would you describe your experience with the Richmond Memorial East end Aging Coalition (RMEeAC)? (% Positive-Extremely Positive)	91
Richmond Memorial East end Aging Coalition (RMEeAC) is an East End Coalition that strengthens community leadership to combat older adult homelessness. (%Agree)	87
An East End Coalition is needed to strengthen community leadership to combat older adult homelessness? (%Agree)	83
Do you plan to continue to be a part of the Richmond Memorial East end Aging Coalition (RMEeAC)?) (% Yes)	96
Characteristics	
How long have you been a part of the Richmond Memorial East end Aging Coalition (RMEeAC)?) (for the 12-month duration)	43

$n = 21$ residents at Time 2 (May 2018). Due to the de-identification process, it is unknown what percentage was measured at both time points. The demographic characteristics of the 49 total participants sampled, was not significantly different across time. Total sample age ranged from 57 to 101 years, with an average of 70.61 years, 75% ($n = 37$) were female and 83% ($n = 47$) were African American. Twenty-two percent ($n = 11$) of the sample had graduated from high school. The sample averaged 32.48 years living in the East End of Richmond. Participants reported on average earning $300/week (range: $0–1,020).

Rehoused older adult participants on average reported that in the past 30 days they experience on average, 9.5 unhealthy physical days/month ($SD = 12.01$, range = 0–31), 5.7 unhealthy mental health days/month ($SD = 9.88$, range = 0–31), with 4.35 days/month where health interfered with daily living ($SD = 8.13$, range = 0–31). Fifty-percent of the sample reported past-month smoking, 50% report past month alcohol use, with 10% at alcohol abusive rates. Most of the sample reported managing high blood pressure (88%), arthritis (72%), about half reporting managing depression (58%), anxiety (50%), high cholesterol (50%), stress (48%), heart problems (44%), and diabetes (35%). Social factors indicated that most of the sample were not actively volunteering (81%); they reported less than three or more identified supports (50%); and experienced lack of companionship (40%), being left out (37%), and isolation (33%).

Discussion

In this study, we aimed to describe a community coalition-building process, planned coalition activities, and explore the outcomes of the coalition on partner cohesion and the housing-risked older adults we aimed to serve. Study findings focused on the evaluation of the knowledge, cohesion, and feedback from the coalition members, and the psychosocial and health needs of rehoused older adults. Findings indicated that the coalition forum created increases in knowledge and action around key objectives and

connections between the represented organizations. The older adults that we served reported managing many health and psychosocial needs. The findings indicate a need to continue building such coalitions, as a mechanism to address equitable homelessness services, for some of the most vulnerable segments of the older adult populations.

This study demonstrated the feasibility of creating a community housing-health coalition, to address racial inequalities in older adult homelessness, through building partnerships from existing community leadership, to ensure the use of culturally relevant, appropriate, and established local strategies. Study findings indicated that the coalition increased community cohesion, was perceived positively, and was considered needed by the coalition members. As planned, the study coalition was perceived by members, to successfully fill a gap in the community. Key leaders in the community that worked with aging, housing, healthcare, and local community members were invited, and successfully participated in the study coalition. Coalition meetings successfully occurred within local community center settings to carry out specific activities and to create a shared understanding of the needs of at-risk older adults within housing and health domains. As planned, through education and training, the coalition focused on training members on race, gender, and age equity effects on health and housing stability outcomes; and better understand the structures and mechanisms within service care models for unintended consequences, bias, and discrimination using the Racial Equity Toolkit (Nelson et al., 2016). As part of the coalition, dialogue was created about a research-to-action pipeline, by training the coalition members in survey instrumentation and implementation of findings. Members also learned, from each other, about experienced barriers to health, benefits of social supports, and pathways into and out of homelessness during meetings. Altogether these activities helped members individually and collectively improve knowledge about the heterogeneity of aging and how to integrate the lifespan model of human development into service delivery for vulnerable older adults.

Study survey findings indicated that there is room for enhanced community awareness and knowledge on the aging influences on health equity and housing; how race, gender, and age related to health equity, health outcomes, and housing stability; the heterogeneity of aging; and use of equity tools such as the Racial Equity Toolkit. Findings also indicated a need to increase research-to-action pipeline participation, community discussions about pathways in/out of homelessness, integrating lifespan model into older adult service delivery, and assessment of the local structures and mechanisms for unintended consequences from bias and discrimination. Furthermore, we found that rehoused racially diverse older adults are still at risk of health complications. Interviewed rehoused older adult participants disproportionally represented

older racial minority females. Interviewed rehoused older adults reported experiencing significant physical and mental health disability, symptoms management, and had behavioral/social health risks needing intervention.

In conclusion, this coalition development project focused on addressing housing and health as root causes of inequality, among low-income older adults, led by a steering committee of three organizations across academic, public/private health, and housing agencies. Five specific aims were planned to address priority housing/health community equity needs. All aims were accomplished during the first year. The last two aims: evaluate the community coalition and the psychosocial health needs of rehoused older adults were the focus of the current study. Findings indicating increasing community cohesion and highlighted serious physical, psychosocial, and behavioral health needs of rehoused community older adults. Service and research work continue to be needed, to support older adults experiencing housing insecurity.

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