

# Predictors of Nursing Home Admission Among a Cohort of Homeless Older Adults Entering Emergency Shelter

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**Objective:** This study examined the extent and timing of nursing home admissions among older adults who had their first visit at an emergency shelter or re-entered after an extended absence. We assessed the relationships between demographic characteristics, health and behavioral health conditions, and health services utilization measures and the risk of nursing home admission.

**Methods:** We linked administrative data from the emergency shelter system in Boston, MA to claims data from the Massachusetts Medicaid program. Using the linked data, we identified a cohort of 432 adults aged 55 and above who entered the shelter for the first time (or re-entered after an extended absence) between 2012 and 2015. We estimated Kaplan-Meier survival curves and hazard functions to describe the extent and timing of nursing home admissions in this population following the date of their initial shelter entry and Cox proportional hazards regression models to identify predictors of the risk of nursing home admission.

**Results:** Roughly 12% of the study cohort had a nursing home admission within 4 years of their initial shelter entry and risk of shelter admission was highest in the first few months following shelter entry. Older age, diagnoses indicating alcohol use disorder, greater overall disease burden, and a prior history of nursing home admission were all associated with a higher risk of nursing home admission following shelter entry.

**Conclusions:** Amidst ongoing growth in the number of older homeless adults, our study findings have important implications for efforts to meet the housing and health needs of this population.

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The project on which this study was based was funded by a grant from the Blue Cross Blue Shield of Massachusetts Foundation. Created in 2001, the mission of the Blue Cross Blue Shield of Massachusetts Foundation is to expand access to health Massachusetts through grantmaking and policy initiatives. J.S.R.'s work on this study supported by award 2T32CA057711-26 from the National Cancer Institute of the National Institutes of Health. Research described in this publication was supported by award 2T32CA057711-26 from the National Cancer Institute of the National Institutes of Health. The funding organization had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; or decision to submit the manuscript for publication. The content of this article is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

The authors declare no conflict of interest.

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ISSN: 0025-7079/21/5904-S212

**Key Words:** older homeless adults, nursing homes, nursing home admission, homeless persons

(*Med Care* 2021;59: S212–S219)

## INTRODUCTION AND AIMS

Studies document an increase in older homeless adults in the United States, driven by a distinct age cohort effect in the single homeless adult population.<sup>1,2</sup> In 2017, roughly one third of the population of sheltered homeless individuals, those not experiencing homelessness as part of a family with children, were older than 50 years, as compared with less than a quarter in 2007.<sup>3</sup> The number of homeless adults 50 and older is projected to continue to grow over the next decade.<sup>4</sup> Older homeless adults experience geriatric conditions like mobility and cognitive impairment and difficulty in performing activities of daily living much earlier in life than their housed counterparts.<sup>5,6</sup> Absent alternatives to independent housing arrangements, older homeless adults may need to rely increasingly on nursing home care. Such care, with an average annual cost of \$92,376,<sup>7</sup> is more expensive than community-based permanent supportive housing (PSH) for this population,<sup>8</sup> which costs roughly \$20,000 annually.<sup>9</sup> Further, research suggests that many nursing home providers may be ill-equipped to effectively address behavioral health conditions<sup>10</sup> that are found at higher rates among persons experiencing homelessness.<sup>11</sup> By contrast, availability of services for behavioral health issues is typically a core component of PSH.<sup>9</sup>

Despite the nexus of homelessness and nursing home use among older homeless adults, there is a dearth of research on this topic. The sole previous study on this link examined military Veterans, and found that Veterans who were homeless had more complex medical needs, tended to have longer stays, and entered nursing homes at younger ages (62.5 y) than their stably housed counterparts (75.3 y).<sup>12</sup> However, no prior study has examined use of nursing homes in a cohort of homeless adults. Thus, it remains unclear how often older homeless adults access nursing home care, when they are at highest risk of entering a nursing home, and what factors are associated with their risk of entering a nursing home.

We examine the extent, timing, and predictors of nursing home use among one segment of the older adult homeless population—those entering emergency shelter for the first time or re-entering after an extended absence. This group is important for 2 reasons. First, evidence shows that nearly half of homeless adults age 50 and above became homeless for the

first time after age 50.<sup>13</sup> Second, the initial entry point into the homeless assistance system may be a critical time to target interventions geared toward facilitating access to nursing home care for those who truly require it, or to alternative forms of housing and supports if nursing home admission is avoidable. Avoiding nursing home admissions when possible may be an especially important goal in light of the ongoing global pandemic, where nursing home residents have had an increased risk of coronavirus disease 2019 (COVID-19) infection and mortality.<sup>14</sup>

Thus, this study addresses the following 2 aims: (1) to assess the extent to which older homeless adults who are entering shelter for the first time or re-entering after an extended absence experience a nursing home admission following initial entry into emergency shelter; and (2) to identify demographic characteristics, health and behavioral health conditions, and health services utilization measures associated with the risk of nursing home admission following initial entry into emergency shelter among older homeless adults.

## METHODS

### Data and Sample

We used administrative data from 2 sources: Homelessness Management Information Systems (HMIS) data from the City of Boston and claims data from MassHealth, Massachusetts' Medicaid program. HMIS data are client-level data that allow tracking of entries and exits from the single

adult shelter system in Boston over time. From these data, we identified a cohort of 4804 individuals who spent at least 1 night in emergency shelter between 2009 and 2015, were aged 55 and older at the time of their shelter stay, and who had valid Social Security numbers to link their information to MassHealth claims.

HMIS records were linked with MassHealth claims data using deterministic matching<sup>15</sup> based on Social Security number. A total of 4333 (90.2%) of individuals in the sample had a matching MassHealth record, and 4000 (83.3%) had at least 1 claim between January 1, 2009 to December 31, 2015. MassHealth data contained all fee-for-service and managed care encounter claims data for this period for all 4000 of these individuals. Thus, our linked data include a complete history of shelter utilization and MassHealth claims, enabling us to examine the timing of all shelter entries and exits relative to the timing of all claims.

We further restrict our sample to approximate a first-entry cohort of older shelter users. by focusing on the 434 individuals who entered shelter between 2012 and 2015 and had no prior record of emergency shelter utilization from 2009 to 2011 (Fig. 1 illustrates our sample selection). Although our data do not permit us to definitively identify first-time shelter users, our sample selection criteria create a study cohort comprised of individuals who either are truly new shelter entrants or who are re-entering shelter after an absence of at least 3 years. We also conduct a parallel set of

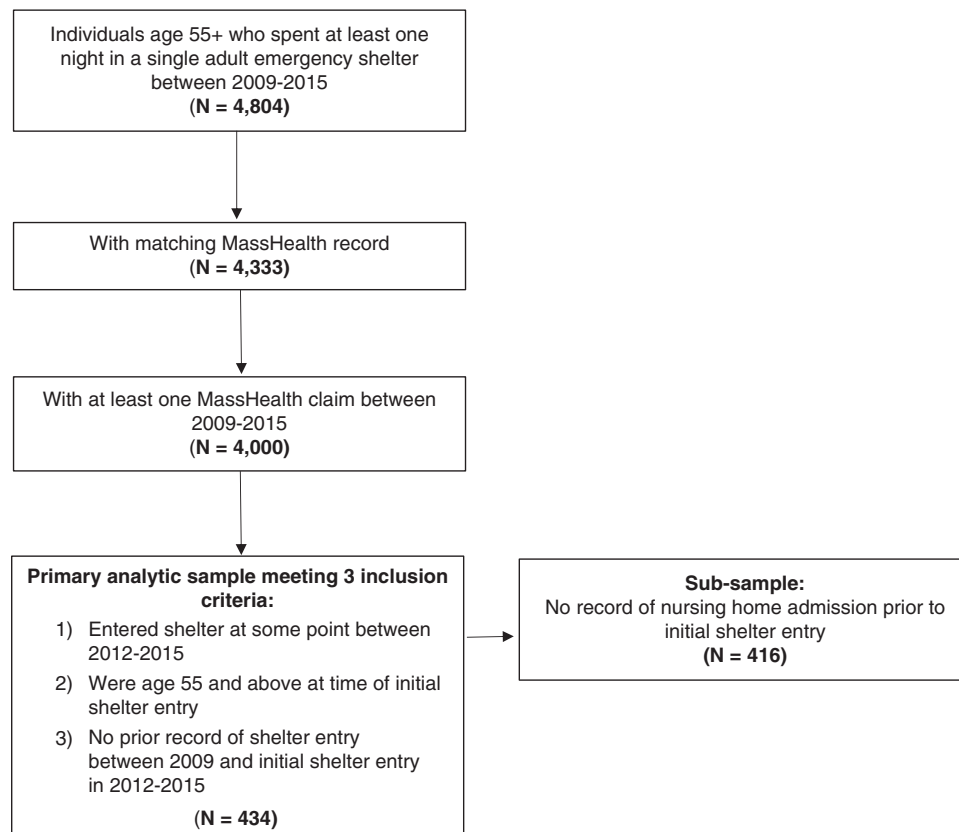


FIGURE 1. Flow diagram of analytic sample selection.

analyses after further restricting our sample to only include the 416 individuals who also had no record of a nursing home stay before their initial shelter entry.

## Dependent Variable

The dependent variable is the number of days from initial shelter entry in the HMIS data to date of first nursing home admission in the claims data. Respondents were identified as having entered a nursing home if they had an entry in the claims data where the provider-type was coded as “nursing facility.” Those with no record of admission to a nursing home following their initial shelter entry date were censored on December 31, 2015, the last date MassHealth claims data were available. The maximum follow-up time was 1459 days, or ~4 years.

## Independent Variables

Available demographic information in the HMIS data include age at initial shelter entry, sex, race, and Veteran status. We used the International Classification of Diseases, Ninth Revision (ICD-9) codes from the MassHealth claims data to identify whether, in the 1-year period before their initial shelter entry date, individuals in the cohort had diagnoses of an array of behavioral and physical health conditions. The conditions we identified were adapted from a prior study<sup>16</sup> that examined the disease burden among homeless adults in Boston using MassHealth claims data. The behavioral health diagnoses included psychosis, schizophrenia, major depression, and other mood disorders. We also identified individuals with diagnoses indicating alcohol and drug use disorders as well as with the following set of physical health conditions: hepatitis C, human immunodeficiency virus, asthma or chronic obstructive pulmonary disease, liver disease, hypertension, congestive heart failure, other heart disease, and diabetes. Finally, given evidence that cognitive impairment is a strong predictor of nursing home admissions in the general population,<sup>17</sup> we used ICD-9 codes adapted from prior research<sup>18</sup> to create a measure of any cognitive impairment, which included dementia and mild cognitive impairment.

We also used MassHealth claims for the 1-year period before initial shelter entry to assign all individuals in this study cohort with a medical comorbidity score using the algorithm developed by Gagne et al,<sup>19</sup> which was developed specifically for older adults. This score was calculated by using ICD-9 codes to identify 20 different medical conditions, each of which was weighted based on its estimated association with mortality. This composite measure of morbidity provides complementary information to that offered by examining the set of discrete physical and behavioral health conditions.

Finally, we used claim-type and provider-type codes in the claims data to construct measures of the total number of days or visits in the 1-year period before initial shelter entry for: inpatient behavioral health, inpatient medical, outpatient behavioral health, outpatient medical and nursing homes.

## Analysis

We used survival analysis to address our aims. Specifically, we estimated hazard functions to descriptively assess how the risk of nursing home admission varied over time

following initial shelter entry and used the Kaplan-Meier method to estimate incidence of nursing home entry over time.<sup>20</sup> We then used Cox proportional hazard regression models to examine predictors of nursing home admission following initial shelter entry. We estimated 4 models to better understand the relationship between our measures of behavioral and physical health conditions and risk of nursing home entry. The first model included each discrete behavioral and physical health condition and cognitive impairment as separate predictors; the second included composite measures identifying whether individuals had any of the mental health conditions we considered, any diagnoses indicating alcohol or drug use disorder, a cooccurring mental health and drug or alcohol use disorder, and any of the physical health conditions we considered. The third included only the cognitive impairment indicator, and the fourth model included the Gagne comorbidity score as a single measure of disease burden. All 4 models controlled all demographic characteristics and health services utilization measures. Analyses were conducted using the R environment for statistical computing<sup>21</sup>; using the *muhaz* package<sup>22</sup> for hazard function estimation and the *survival* package<sup>23</sup> to estimate Kaplan-Meier curves and Cox regression models.

## RESULTS

Table 1 presents descriptive statistics for the primary analytic sample as well as for the subgroups who did and did not have a prior record of nursing home use. The primary analytic sample was predominantly male and had an average age at the time of their index shelter entry of about 61 years. A slight majority of the sample was White, and 36% were Black; contemporaneous data suggest that the 41% of the population of all sheltered individuals in Boston were White and 35% were Black.<sup>24</sup> Differences in the race distribution of our sample could be due to missing race information for 12% of our cohort or because the racial composition of older shelter differs from that of the overall sheltered population.

Roughly 1 in 10 members were identified as having a diagnoses indicating an alcohol or drug use disorder, 1 in 4 had any mental illness and nearly 40% had at least 1 of the physical health conditions we considered in the year before their initial shelter entry. The average Gagne comorbidity score among cohort members was 0.74; as a point of comparison, the mean comorbidity score in the sample Gagne et al<sup>19</sup> used to develop their scoring algorithm, which had a mean age of 79.7 years, was 1.76. In the year before their initial shelter entry, members of the study cohort had, on average, about 3.1 inpatient behavioral or physical health hospitalization days, spent about 2.6 days in nursing homes, and had, on average, 32 outpatient visits. Finally, 12.2% of the primary analytic sample had a record indicating entry into a nursing home following their initial emergency shelter stay.

Figure 2 plots the hazard function of risk of nursing home admission over time following initial shelter entry. Figure 3 plots the complement of the Kaplan-Meier survival function, thus representing the cumulative incidence of nursing home admission among study cohort members over time. For both the full analytic sample and among the

**TABLE 1.** Sample Characteristics

Variable	Primary Analytic Sample (N = 434), n (%) / Mean (SD)	Individuals With No Prior History of Nursing Home Stay (N = 416), n (%) / Mean (SD)	Individuals With Prior History of Nursing Home Stay (N = 18)	P
Sex				0.362
Male	316 (72.8)	305 (73.3)	11 (61.1)	
Female	115 (26.5)	108 (26.0)	7 (38.9)	
Other	3 (0.7)	3 (0.7)	0 (0.0)	
Age at shelter entry	60.7 (5.4)	60.7 (5.3)	62.8 (7.7)	<0.001
Race/ethnicity				0.837
White	226 (52.1)	215 (51.7)	11 (61.1)	
Black	156 (35.9)	151 (36.3)	5 (27.8)	
Other/unknown	52 (12.0)	50 (12.0)	2 (11.1)	
Veteran status				0.095
Yes	59 (13.6)	54 (13.0)	5 (27.8)	
No	321 (74.0)	311 (74.8)	10 (55.6)	
Unknown/missing	54 (12.4)	51 (12.3)	3 (16.7)	
Diagnoses in 12 mo before index shelter entry				
Alcohol use disorder	31 (7.1)	28 (6.7)	2 (11.1)	0.310
Drug use disorder	17 (3.9)	17 (4.1)	0 (0.0)	1.00
Psychoses	85 (19.6)	75 (18.0)	10 (55.6)	<0.001
Major depression	51 (11.8)	44 (10.6)	7 (38.9)	0.002
Schizophrenia	41 (9.5)	35 (8.4)	6 (33.3)	0.004
Mood disorder	100 (23.0)	89 (21.4)	11 (61.1)	<0.001
Hepatitis C	26 (6.0)	23 (5.5)	3 (16.7)	0.085
HIV	12 (2.8)	10 (2.4)	2 (11.1)	0.084
Asthma/COPD	43 (9.9)	37 (8.9)	6 (33.3)	0.005
Liver disease	23 (5.3)	20 (4.8)	3 (16.7)	0.063
Hypertension	104 (24.0)	97 (23.3)	7 (38.9)	0.157
Congestive heart failure	10 (2.3)	7 (1.7)	3 (16.7)	0.006
Other heart disease	29 (6.7)	21 (5.0)	8 (44.4)	<0.001
Diabetes	59 (13.6)	54 (12.2)	6 (33.3)	0.024
Cognitive impairment	7 (1.6)	3 (0.7)	4 (22.2)	<0.001
Any alcohol or drug use disorder	43 (9.9)	40 (9.6)	3 (16.7)	0.407
Any mental illness	112 (25.8)	101 (24.3)	11 (61.1)	0.001
Cooccurring alcohol/drug use disorder and mental illness	27 (6.2)	24 (5.8)	3 (16.7)	0.094
Any health condition	169 (38.9)	155 (37.2)	14 (77.8)	<0.001
Gagne comorbidity index score	0.74 (1.6)	0.63 (1.4)	3.2 (3.3)	0.004
Service use in 12 mo before index shelter entry				
Inpatient behavioral health (d)	1.3 (6.2)	1.2 (5.6)	3.4 (14.4)	0.534
Inpatient medical (d)	1.8 (9.0)	1.4 (7.2)	10.9 (26.9)	0.151
Nursing home (d)	2.6 (19.6)	—	61.9 (76.5)	—
Outpatient behavioral health, visits	6.0 (26.9)	6.1 (27.3)	5.8 (11.0)	0.924
Outpatient medical, visits	25.6 (42.5)	22.3 (36.3)	100.6 (87.4)	0.001
Nursing home entry following index shelter entry	53 (12.2)	45 (10.8)	8 (44.4)	<0.001

P-value represents results of comparison between individuals with no prior history of nursing home stay and individuals with prior history of nursing home stay. COPD indicates chronic obstructive pulmonary disease; HIV, human immunodeficiency virus.

subgroup with no prior history of nursing home admission, the estimated hazard function increases slightly in the immediate period following shelter entry and then decreases over time. This pattern indicates that risk of nursing home admission is highest in the period directly following initial shelter entry and then declines and remains substantially lower over the remainder of the follow-up period. The Kaplan-Meier estimates mirror this pattern, indicating that, in the full analytic sample, the cumulative incidence of nursing home admission was 3.0% at 6 months, 5.8% at 12 months, 7.0% at 18 months, and 8.6% at 24 months. Notably, among the 12.2% of individuals in the cohort who entered a nursing home during the 4-year follow-up period, nearly half (5.8%) did so within the first year of their initial shelter entry. This

same pattern held true in the subgroup of individuals with no prior history of nursing home admission.

Table 2 presents the results of the Cox regression models for the full analytic sample. Older age at initial shelter entry had a significant positive association with risk of nursing home admission in models 1, 2, and 3 and a marginally significant association in model 4. None of the other demographic predictors were significantly associated with risk of nursing home admission in any of the models. In model 1, alcohol use disorder was associated with a more than 5-fold increase in the risk of nursing home admission [hazard ratio (HR) = 5.19, *P* <0.001], but none of the other discrete behavioral or physical health conditions were associated with nursing home admission. A similar pattern

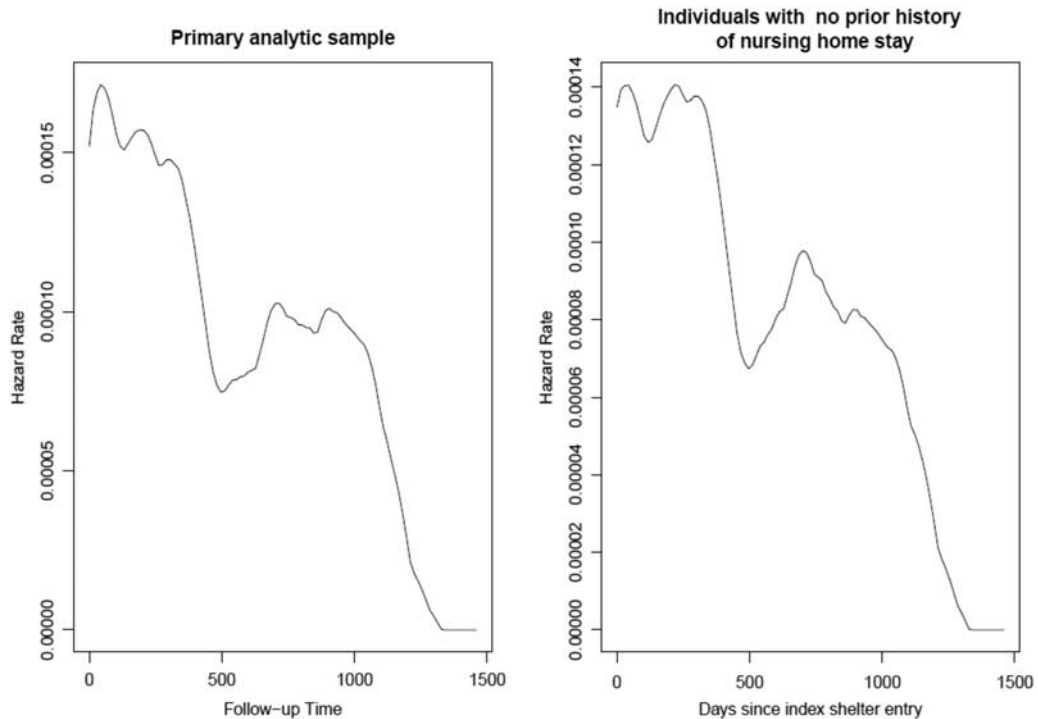


FIGURE 2. Estimated hazard rate of nursing home admission following initial shelter entry.

emerged from model 2, where diagnosis of alcohol or drug use disorder was associated with an increased risk of nursing home admission (HR = 3.31,  $P = 0.043$ ), whereas any mental illness, cooccurring mental illness and drug or alcohol use disorder and any physical health condition were not associated with risk of nursing home admission. In model 3, cognitive impairment had a strong, yet marginally significant positive association with nursing home admission (HR = 3.55,  $P = 0.08$ ). In model 4, the Gagne comorbidity score was positively associated with risk of nursing home admission (HR = 1.26,  $P = 0.002$ ). With a HR

of 1.26, an increase of 1 SD in the Gagne comorbidity score observed in the primary analytic sample (1.6) would translate into roughly 2-fold increase in the hazard of nursing home admission ( $1.26 \times 1.6 = 2.02$ ). Apart from the number of nursing home days in the year before individuals' initial date of shelter entry, none of the behavioral or physical health service utilization measures had a significant association with the risk of nursing home admission following shelter entry in any of the models. Model results (not shown) for the subgroup with no prior nursing home history were substantively similar.

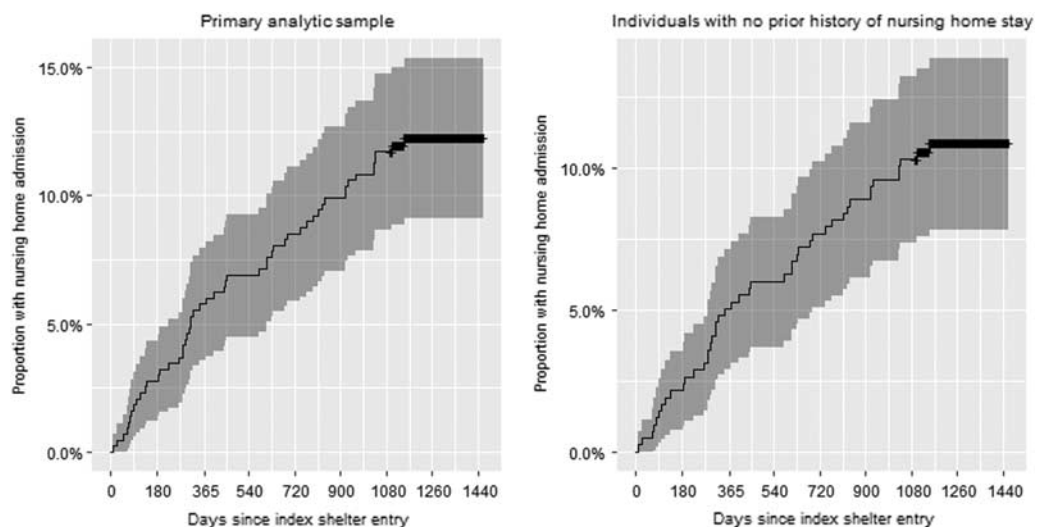


FIGURE 3. Kaplan-Meier estimates of probability of nursing home admission following initial shelter entry.

**TABLE 2.** Results of Cox Proportional Hazard Regression Models Predicting Risk of Nursing Home Admission Following Initial Shelter Entry

Variable	Model 1		Model 2		Model 3		Model 4	
	Hazard Ratio	P	Hazard Ratio	P	Hazard Ratio	P	Hazard Ratio	P
Sex								
Female	Reference		Reference		Reference		Reference	
Male	0.89	0.75	0.99	0.98	1.03	0.92	1.01	0.98
Other	0.00	0.99	0.00	1.00	0.00	1.00	0.00	1.00
Age at index shelter entry	1.08	0.002	1.06	0.01	1.06	0.02	1.05	0.055
Race								
Black	Reference		Reference		Reference		Reference	
White	1.34	0.39	1.44	0.26	1.39	0.30	1.59	0.15
Other/missing	0.84	0.76	0.65	0.44	0.78	0.64	0.73	0.59
Veteran status								
No	Reference		Reference		Reference		Reference	
Yes	0.78	0.63	0.79	0.61	0.46	0.12	0.85	0.71
Unknown/missing	1.02	0.97	0.55	0.24	0.94	0.89	0.39	0.08
Diagnoses in 12 mo before index shelter entry								
Alcohol use disorder	5.19	<0.001						
Drug use disorder	0.49	0.56						
Psychoses	3.83	0.22						
Major depression	0.99	0.99						
Schizophrenia	1.26	0.68						
Mood disorder	0.32	0.32						
Hepatitis C	1.73	0.32						
HIV	0.00	1.00						
Asthma/COPD	1.39	0.49						
Liver disease	1.46	0.53						
Hypertension	1.52	0.27						
Congestive heart failure	0.34	0.29						
Other heart disease	0.62	0.42						
Diabetes	1.46	0.36						
Cognitive impairment	3.84	0.21			3.55	0.08		
Any mental health diagnoses			1.39	0.43				
Any drug/alcohol use disorder diagnoses			3.31	0.043				
Cooccurring mental health and drug/alcohol use disorder diagnoses			0.59	0.48				
Any health diagnoses			1.75	0.11				
Gagne comorbidity index score							1.26	0.002
Service use in 12 mo before index shelter entry								
Inpatient behavioral health (d)	1.00	0.98	1.01	0.73	1.02	0.27	1.02	0.35
Inpatient medical (d)	1.00	0.81	1.01	0.45	1.01	0.30	1.01	0.48
Nursing home (d)	1.01	0.02	1.01	0.004	1.01	<0.001	1.01	0.006
Outpatient behavioral health, visits	1.00	0.57	1.00	0.51	1.00	0.78	1.00	0.69
Outpatient medical, visits	1.00	0.70	1.00	0.90	1.00	0.48	1.00	0.85

COPD indicates chronic obstructive pulmonary disease; HIV, human immunodeficiency virus.

### DISCUSSION

To our knowledge, this is the first study to examine nursing home admissions among older homeless adults. This evidence adds to our understanding of the health and residential outcomes of older homeless adults, a population that is poised to grow substantially over the coming decade. Three key findings emerge from our study.

First, we found that 12.2% of adults age 55 and above entering emergency shelter for the first time or re-entering after an extended absence have a record of a nursing home admission within 4 years of the date of their initial shelter entry and nearly half of these individuals entered a nursing home within a year of entering shelter. There are no comparable data on nursing home admissions for the general population, but Census data show that 3.1% of the overall US

population aged 65 and above were residing in a nursing home in 2010.<sup>25</sup> Thus, the incidence of nursing home admission among older homeless adult likely far greater than that for housed older adults nationwide.

Second, we found that risk of nursing home admission was highest in the immediate period following initial shelter entry and was substantially lower thereafter. This trend could be reflective of a dominant pattern wherein a serious health problem requiring nursing home placement precedes a housing crisis. Alternatively, it is possible that individuals develop a new health problem or experience rapid worsening of an existing health problem soon after entering shelter. We could not identify whether and which of these situations were salient explanations of the pattern we observed, and this topic merits closer investigation.

Third, our findings suggest that factors driving nursing home admission among older adults entering shelter differ in key respects from those observed in the general population. Much like prior research in the general population,<sup>17,26,27</sup> we found older age, prior nursing home use and higher morbidity (as measured by the Gagne comorbidity score) to be positively associated with risk of nursing home admission following shelter entry. Alternatively, whereas prior studies show cognitive impairment to be a particularly important predictor of nursing home admission,<sup>17,26,27</sup> we did not find strong evidence of this relationship in our study. However, because relatively few members of our study cohort had a cognitive impairment this null finding may have been influenced by insufficient statistical power.

Similarly, contrary to some prior studies showing that conditions like diabetes, hypertension, and depression are associated with nursing home admission in the general population,<sup>26</sup> diagnoses indicating alcohol use disorder was the only discrete health or behavioral health condition that we found to be associated with nursing home admission. Alcohol use disorder is a known risk factor for poorer health and mortality<sup>28</sup>; it is thus possible that our measure of alcohol use disorder is a proxy for other conditions (eg, functional impairment, falls) that increase risk of nursing home admission. Similarly, while prior inpatient hospitalization is a risk factor for nursing home admission in the general population,<sup>17</sup> we did not find inpatient stays or any of the health service utilization predictors we considered to be associated with nursing home admission.

The incongruence between our study and prior studies conducted in the general population may stem from several factors. First, with respect to lack of association between certain health conditions and nursing home admission, it is possible that those with serious mental illness, substance use disorders, or other health needs who do need nursing home care are not able to ultimately access it. This lack of access could result from systemic barriers to health care encountered by people who are homeless, such as stigma and discrimination, or the inability or unwillingness of nursing homes to accept and meet the needs of individuals who are actively using illicit substances. Nursing home admissions among older homeless adults could be driven more by social factors such as lack of social/familial support, unemployment, and limited income. We could not measure these factors in the present study, but they are associated with homelessness<sup>29</sup> and nursing home admission in the general population.<sup>17</sup> Race is another social factor associated with nursing home admission in the general population,<sup>17</sup> but was as not a significant predictor in our study. This finding could be influenced by missing race information in our data. Alternatively, unobserved racial differences in the likelihood of exiting shelter for stable housing, may have obscured the relationship of race and nursing home admission in our study.

Our findings have several implications for policy and programmatic efforts to address the housing and health care needs among older homeless adults. Our estimate of the incidence of nursing home admissions in our cohort provides important baseline information. As noted by Kushel,<sup>8</sup> some proportion of nursing home admissions among older

homeless adults may be preventable through the provision of PSH, which is effective in reducing homelessness<sup>30</sup> and can, in some cases, generate cost savings.<sup>31</sup> Thus, preventing nursing home admissions where possible is both a humane and cost-effective policy. Our incidence estimates provide important context for informing the necessary scope of efforts to prevent nursing home admissions.

The divergence of our findings from prior research about predictors of nursing home admission in the general population suggest a need for specialized procedures for assessing the need for nursing home care for older adults using emergency shelter. These procedures should ensure that those with needs requiring nursing home care are identified and able to quickly access such care. Navigation services for those identified as needing nursing home care can be a valuable strategy. Conversely, these procedures could focus on preventing nursing home admission for those who may be able to live independently by facilitating linkages to housing resources. A range of housing options should be considered including PSH or mainstream low-income housing programs for older adults. Given the limited capacity of these programs, alternative housing options should also be considered, such as older homeless adults serving as live-in caregivers for housed family members.<sup>32</sup>

Our study has limitations. We relied on data from a single jurisdiction and it is unclear whether our findings are more broadly generalizable. We also did not have access to measures of activities of daily living, falls, familial support, or other factors that are salient predictors of nursing home admission among older adults.<sup>17</sup> Future research should examine these predictors. Our cohort was comprised entirely of homeless individuals who accessed emergency shelter. Thus, we could not examine nursing home use among other segments of the homeless population, most notably those who experience unsheltered homelessness. Last, while we documented extent of nursing home admissions, our findings do not address what share of admissions might be preventable via the provision of alternative forms of housing assistance and health care supports. This is a pertinent policy question that should be addressed in future research.

Despite these limitations, our study findings are important in the context of the ongoing aging of the homeless population. Older homeless adults entering the homeless shelter system for the first time or after a long time away from an emergency shelter access nursing home care at high rates. All efforts should be made to assist these elders in getting the health care and social services they need to both improve their overall care and health but also to contain health care costs.

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