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Understanding Health Needs and Perspectives of Middle Age and Older Women Experiencing Homelessness

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Abstract

Middle age and older homeless women have unique health and social delivery needs; yet, limited data exists about such needs. The purpose of this qualitative study was to understand perspectives among prefrail and frail homeless women (N=20; ages 43-62) that included a quantitative description of sample characteristics using frequencies, percents and means; and a qualitative analysis of focus group data utilizing content analysis. The average age was 53.4; the majority of the sample was African American (70%). In total, 60% reported living in a shelter for the last 30 days, while 20% were unsheltered. The majority of the sample reported walking independently (80%) and not using an assistive device (65%). Over one third (35%) fell in the last 30 days and 70% fell in the last year. Content analysis revealed several themes that included (1) healthcare needs and challenges experienced; (2) perspectives on sexual decision making; (3) employment difficulties; (4) existing support systems; and (5) development of future program planning. Future research development and implications are discussed.

Keywords

Prefrail; frail; homeless; women; health needs; women's health; older; aging

Introduction

In the United States, homelessness among women is rapidly increasing (Cederbaum, Wenzel, Gilbert, & Chereji, 2013). In Los Angeles County, there were 57,737 homeless adults in Los Angeles County and 23.1% were women (Los Angeles Homeless Services Authority (LAHSA), 2014). Population demographics indicate that the homeless adult population is aging (Hahn, Kushel, Bangsberg, Riley, & Moss, 2006). While older homeless women are largely invisible (Kisor & Kendal-Wilson, 2002), in one service agency report,

about 50% were over 51 years of age which necessitates age-related services (Downtown Women's Action Coalition (DWAC, 2013).

Causes of homelessness among women include domestic violence, lack of affordable housing, lack of employment, substance use/drug addiction, and job loss (Colorado Coalition for the Homeless, 2010; DWAC, 2013). Further, other contributory factors include mental health problems, family disputes, abuse or neglect by family members (Kisor & Kendal-Wilson, 2002). According to DWAC (2013), causes of women's homelessness include sexism, racism, and ageism. Older adults in shelters find it more challenging to adapt as compared to their younger counterparts as they experience difficulties negotiating social service systems, and waiting for long periods of time for help, and experiencing chaos in the shelter system (Davis-Berman, 2011). Available research among older, homeless women exists (Davis-Berman, 2011; Washington, 2005; Washington & Moxley, 2008); however, research is limited and does not specifically address middle age and older homeless pre-frail and frail women.

Geriatric Syndromes among Homeless Populations

As individuals age, factors related to geriatric syndromes become more prevalent issues for both healthcare providers and homeless service agency providers, and have been the topic of recent research among the homeless. Frailty, a geriatric syndrome, can be defined as an accumulation of deficits (Rockwood & Mitnitski, 2007) in physical, psychological and social domains (Gobbens, van Assen, Luijkx, & Schols, 2012). Among homeless adults, 16.4 percent of the population met the criteria for being frail using the Fried five-item frailty instrument (Brown, Kiely, Bharel, & Mitchell, 2012). Significant predictors of frailty among homeless adults (N=150; 40-73 years of age) included age, gender, health care utilization, nutrition and resilience (Salem, Nyamathi, Brecht, et al., 2013). It is presumed that those who are older and frail would utilize more healthcare services. In a study which focused on use of acute services, 22% of those who were frail had greater or equal to four emergency department visits during a one year period (Brown, Kiely, Bharel, Grande, & Mitchell, 2013).

Healthcare needs among homeless women are an important area to explore. In one study among older homeless African American women, the majority reported their health to be fair or poor; further, most frequently cited health conditions included hypertension, arthritis, respiratory illness and emotional/mental illness (Washington, 2005). In a cross sectional study among homeless women, those who did not know where to go, experienced long office wait times or were too sick to seek care had a higher odds of unmet health care need (Lewis, Andersen, Gelberg, 2003). In another study among sheltered homeless women, barriers to health care included lack of money (63.5%), transportation (32.1%) and uncertainty regarding where to go (16.8%); interestingly, physical activity and nutrition were also areas of need (Wilson, 2005). In particular, physical activity and nutrition were other areas of need (Wilson, 2005). In addition, for women, substance abuse and mental illness were contributing factors of homelessness (Washington & Moxley, 2008). In one homeless service agency report, 26.8% of homeless women who took part in the survey

were in recovery for substance use and among this group, 62.2% had used drugs or alcohol in the past year (DWAC, 2013).

There are limited studies that have focused on health needs and perspectives among prefrail and frail homeless middle age and older homeless women - a population which is not well understood. Thus, the purpose of this study is to understand perspectives about acute and chronic health needs and challenges, preventive measures, and barriers and facilitators to healthcare, as well as proposed solutions for intervention among prefrail and frail homeless women.

Methods

Design

A qualitative study was conducted among prefrail and/or frail homeless women (N=20) between May to June 2013 in order to gain greater depth and perspective related this population. The study was approved by the University of California, Los Angeles Human Subjects Protection Committee.

Participants and Setting

This study was conducted in a large, urban drop-in day center in Central City East, Los Angeles. A total of 20 homeless women participated in the four focus groups, with four to seven participants in each group. Due to the fact that this was a drop-in day center which serves 200 women per day, the experiences that were shared among participants were not specific to the site or any services which were provided at that particular site. Eligibility criteria included women who were: a) 40 years of age; b) homeless; and c) prefrail or frail as determined by two structured instruments; d) free of evidence of acute, psychotic hallucinations, and e) English-speaking. As homeless women may be prefrail and frail at younger ages, an older woman was defined as 40 and above based on prior research (Salem, Nyamathi, Brecht, et al., 2013). Further, in this study, an individual was defined as homeless if they lacked a fixed, regular, and adequate nighttime residence; they had a primary nighttime residence which was a supervised publicly or privately operated shelter designed to provide temporary living accommodations (United States Department of Housing and Urban Development, 1995).

Procedure

Prior to the start of the study, the principal investigator (PI) and the community-based partner liaison worked closely to set up the recruitment phase of the study, location for the screening, and focus groups. Informational sessions were held weekly by the PI at the facilities and the PI met with interested persons in a private area and fully described the study, the time required for participation, and the potential study risks. All potential participants were informed that they had the freedom to withdraw from the study at any time. After providing information about the study, among those interested in continuing, the PI obtained oral consent for screening by asking the following: (1) year born; (2) homeless yes or no; and (3) where they slept. Two screening instruments assessed frailty: (1) the Tilburg Frailty Instrument (TFI) and (2) the SHARE-FI; the screening took approximately

20 minutes to administer. The participants were asked to squeeze a grip dynamometer two times on the left hand and two times on the right hand as part of the SHARE-FI measure. Those designated as frail on the TFI and prefrail or frail on the SHARE-FI were invited to be part of the study.

Shortly thereafter, for all those eligible, the PI and participant arranged a meeting time within a private area of the facility for the focus groups and a short survey to be conducted. After an oral waiver of screening consent, focus groups and survey administration were conducted. In total, four focus groups were conducted by the PI with prefrail and frail homeless women and each lasted about one hour. Each focus group was mixed between prefrail and frail homeless women (4-7 participants in each) and was guided by the semi structured interview guide (SSIG). The SSIG was devised and focused on health needs, barriers and facilitators to obtaining health and social services, along with areas perceived as important by homeless women. Further, a paper-and-pencil questionnaire was utilized with women in order to describe the study sample. In addition, the focus groups were audiotaped and participants selected a pseudonym based on their preference; a random number was subsequently assigned to each participant. Focus group compensation was a \$20US gift card to a neighboring vendor.

Data Analysis

For quantitative data, frequencies, percents and means were used to describe the sample characteristics of age, birthplace, race/ethnicity, highest level of education, marital status, children, monthly income, religious affiliation, living arrangements, frailty, mobility, use of assistive devices, and falls.

For qualitative data, after the four audio files were transcribed by an independent transcriptionist, content analysis was conducted (Hsieh & Shannon, 2005; Saldana, 2013) with transcripts initially coded line by line. Categories and subcategories were then developed, and linkages between subcategories and categories were identified. Likewise, similarities and differences were explored and subthemes redeveloped. During this analytic process, diagrams were illustrated which presented linkages between the categories and subcategories, serving as an explanatory framework. The PI and another senior researcher with expertise in content analysis and vulnerable populations met and reviewed the codes, categories, subcategories, themes and diagrams, exploring the data and discussing the findings. The PI also reviewed the findings with the partner and stakeholder at the community-based site who has expertise with the population.

Trustworthiness of the data was established by using credibility, transferability, dependability and confirmability (Shenton, 2004). In this study, credibility was established by understanding the culture of the organization and the fact that each individual had the opportunity not to participate; further, frequent debriefing occurred between the collaborators (Shenton, 2004). Next, transferability was ensured by describing data collection methods, length of data collection sessions, and period of time for data collection sessions (Shenton, 2004). Dependability was addressed by describing the research design and implementation and the detail of the data gathering (Shenton, 2004). Confirmability will

be addressed by recognizing limitations to the methods of the study and the potential effects of these limitations (Shenton, 2004).

Measures

Sociodemographic factors assessed age, birthplace, race and ethnicity, highest level of education, marital status, children, monthly income, religious affiliation, living arrangements, and factors which contributed to homelessness. **Mobility** was assessed by asking participants if they could walk independently. Responses included “yes or no.” **Use of Assistive Devices** was assessed by asking participants which ones device they might use. Responses included using a “walker, cane, wheelchair, prosthesis, crutches, other or none.” **Falls** were assessed by asking participants if they fell in the last 30 days and in the last year. Responses included “yes or no.” **Frailty** was assessed using TFI (Gobbens, van Assen, Luijkx, Wijnen-Sponselee, & Schols, 2010) and SHARE-FI (Romero-Ortuno, Walsh, Lawlor, & Kenny, 2010). The TFI is a 15-item self – report instrument which focuses on physical, psychological and social domains (Gobbens et al., 2010). An individual who scores 5/15 was considered frail (Gobbens et al., 2010). The second instrument included the SHARE-FI, which is a five-item self-report instrument which focuses on (1) exhaustion, (2) loss of appetite, (3) weakness, (4) walking difficulties, and (5) low physical activity. For women, the SHARE-FI differentiates non-frail (< 0.32), prefrail (< 2.13), and frail (< 6) into the following respective categories; grip strength is accounted for in one part of the screening tool (Romero-Ortuno et al., 2010).

Results

Demographic characteristics of the sample are presented in Table 1. The average age was 53.4 (N=20; ages 43-62; SD: 5.2); the majority of the sample was African American (70%), followed by Caucasian/White (15%), and equal with mixed race/ethnicity (15%). In terms of life partners, 55% were never married, 30% were divorced, and 15% were separated. In this sample, 35% reported being homeless for between 1-3 years, followed by an equal distribution of participants being homeless less than one year and 4-6 years. In total, 60% reported living in a shelter for the last 30 days, while 20% were unsheltered. The majority of the sample reported walking independently (80%) and not using an assistive device (65%). Over one third (35%) fell in the last 30 days and 70% fell in the last year.

Middle age and older homeless women shared perspectives related to health and healthcare needs, along with challenges experienced which included length of time getting to the right person; knowledge of access, paperwork and provider access; being fearful of having certain tests done or medical procedures; past experience with providers; needs when taking medication and challenges eating nutritious foods.

One woman shared, “my health has completely deteriorated with my breathing, with my posture, with the concrete not giving; it's putting wear on my hips.” *Participant 16*

Further, women shared that due to older age, they should be given priority. Another woman shared following:

“As you age, everything deteriorates, you know faster. And the more you out here, the more your, your body is adapting to this, you know your surroundings and everything, and you just get caught up into it till you know you so old and somebody looks at you and says, I wonder what happened to her along the way.”

Participant 20

Homeless women described several areas of need which included vision, dental care and managing pain. Two women were concerned that they had not received information about Hepatitis C virus. Further, having comprehensive and holistic care which included diagnostics and specialist providers were noted. Women shared the need for memory testing, colonoscopies, HIV and cancer screening. Other women voiced the desire to have access to more medical clinics and healthcare providers.

Homeless women also described the need for pain relief to maintain sobriety. One woman shared, “If they don't give you appropriate pain relief, you're going to find something. And, and, it's very frustrating when you really, really want to stay clean and you're miserable. I didn't get clean to be miserable.” *Participant 17*

Another woman described that discussions regarding mammograms were available, but, other aspects of prevention were more limited. She shared, “...they do talk about breasts now and mammograms and stuff like that but they don't say anything about...preventative measures, pregnancy, to prevent pregnancies, STDs. They don't, no one talks about that you know.” *Participant 8*

Another woman shared the need for practitioners to take certain types of insurance. In particular, she shared, “And I also think that we need more doctors that will take Medi-Cal because switching over doesn't always give us the same comprehensive as regular Medi-Cal.” *Participant 12*

The need for more comprehensive mental health coverage was also verbalized, “Mental health isn't covered, really. They don't have like psychiatry available... it's not like concurrent with your medical treatment. And a lot of times that's another referral that's far away or whatever. You know, umm, it would be nice if it was a little bit more comprehensive in terms of treatment.” *Participant 17*

Homeless women described several areas of challenges meeting healthcare needs which included length of time getting to the right person, knowledge of paperwork and provider access, personal fears of testing, experiences with providers, challenges taking medicine and challenges eating right.

Homeless women described **length of time getting to the right person** as, “hurry up and wait.” Further, they described wait times and getting to the right person; in particular, one woman said, “Getting to the people that you need to see right away is key and it seems that you have to go through a big rigmarole to get to them.” *Participant 13*

One homeless woman explained the challenges of being referred. She recommended,

“It would be nice if they would get rid of referrals so people can have access to walk and ask a doctor if they will be their primary physician. The less referred, the [easier the] access because... the referral may never come.” *Participant 12*

During the focus groups, homeless women shared **knowledge of access, paperwork and provider access**. Two women shared this concern.

One woman shared, “the number one thing that some of the...people.... in general down here just don't know where to go for, for help because they might need different types of healthcare.” *Participant 20*

Other homeless women shared that they felt that they do not get proper medical attention and that they lacked paperwork to have access to health insurance resources. One woman said, “I believe you need a birth certificate, ID. I don't have all that.” *Participant 19*

Homeless women also shared that they were **fearful of having certain tests done or medical procedures**. For instance, one shared, “And on my mom's side of the family gets diabetes. My sister got it and I am so scared to go to the doctor to have it done. But, we do need people that come out here.” *Participant 10*

Another woman shared fear related to surgery and leaning on prayer. She shared, “I'm scared to do my surgery. I'm scared to do what I have to do. I keep putting it off but it's not -- it's making it worse for me. And I agree now with the doctor and I'm running scared and don't know which way to go, but at the same time that's where prayer comes in.” *Participant 11*

During the focus groups, several of the homeless women shared **past experiences with providers**. One woman described healthcare providers attitude towards her when they found out she was homeless. She recounted that individuals questioned, “You're in the shelter. What happened? Instead of her asking about my medical, how did I feel, she wanted to know how did I get homeless.” *Participant 10*

While another one shared that she perceived that the healthcare provider had an attitude and wouldn't be of assistance to her.

Homeless women shared **needs when taking medication**. One woman shared, “But I know with me you know, I'm on all kinds of medication and some of it, the medication I have to run to the restroom. So it was hard for me, I couldn't even take my medicine right.” *Participant 14*

While another woman shared concerns about taking her medication, she described, “Certain medications that you have to take and you know it's going to make you drowsy, so you want to be in a place where you can lay down and go to sleep.” *Participant 20*

Another woman shared, “... when we sleep, our medicine be taken. Some people take and steal your medicine out of your bag and your purse.” *Participant 10*

Across several of the focus groups, homeless women described challenges eating nutritious foods. Homeless women noted that there were not a lot of choices when it comes to food. As one woman stated, "...when we're out on the street, it's so hard to eat right and to keep up; and our health just goes." *Participant 16*

Another participant shared her perspective about weight gain. She said,

"... since I've been homeless, my health has been kind of down because I'm not walking as far as I can or used to because I've gained so much weight. And ... I know I'm eating too much because of the stress. I just can't move around like I used to. And carrying them bags and suitcases around and stuff every morning and not getting enough rest." *Participant 10*

Others shared limitations related to certain food options, "And you know you got to take what they're offering you; you know what I'm saying. But some things are real detrimental to my health, what I eat so I have to be very careful." *Participant 8*

While another woman shared, "There's not a lot of choices when it comes to things like that, fresh or anything. And when you're diabetic you can't have a lot of carbs." *Participant 9*

Another theme included perspectives on sexual decision-making. Some women shared they were not interested in having sex, or that it was not a priority in their lives. Others shared that they are set in their ways and it would be difficult to change behaviors which had been learned.

One woman shared, "If you reach 40, you're not wrapping up and you're not protecting yourself, then I think you're not going to listen to nobody [provide] a refresher course." *Participant 8*

While another woman felt that various ages were interested in different things. One woman said,

"It's mostly younger, 30, in the 30s and younger that are really interested in this stuff because they're also interested in drugs and everything else. So ...if you reach ...40, 50 years old, and you don't know by now, you ain't going to do it." *Participant 9*

However, other women shared that their partners **did not wear condoms and challenges negotiating safer sex**. One woman said, "He's not wearing condoms. He said because he's healthy. I say what about me? You don't know me. You know what I mean?" Other women described that enforcing the use of condoms may present relationship challenges. *Participant 15*

One woman shared: "A lot of times when I'm with my partner, he is asking me for sex and he don't want to wear a condom and I can't make him wear a condom. So I'm afraid to lose him and so I would have to say that we don't use a condom." *Participant 7*

Homeless women described a desire to obtain employment, but, challenges seeking employment. The majority of women shared that they wanted to go back to work. One

woman said, “I don't do drugs. I'm not an alcoholic. My health is still good right now but I just can't seem to get that job so I can get out of here.” *Participant 20*

Challenges with employment were varied; some women noted that physical challenges limited them taking on specific jobs. For one woman, she shared physical and age-related difficulties when trying to seek a new job.

She said, “...I have so much pain on a daily basis and difficulty with balance and walking and everything. And now I have numbness in my left hand too. So it's you know, it's harder when you're a little bit older trying to find a job too and break into something new, you know.” *Participant 17*

Another participant shared her perspective, “When you get older, you get sicker. You get less energy. I could do double shifts and [it did] not bother me. Now I can't even work at all. It's -- but you get tired.” *Participant 9*

While another woman shared that she felt inexperienced and said, “I'm an inexperienced person trying to break into a field and that's really difficult because I don't have the experience you know. I have 30 years' experience on one thing, but, it's no longer appropriate physically.” *Participant 17*

Homeless women also described the difficulties of job searching when residing in a shelter.

“I want to get a job and I want to get on my feet again, but it's like even if I went looking for jobs and I got back late at the shelter or past 6:00, they go, we have no room.”

She continued to share, “No matter how much you try, sleeping on the street and you don't have a shelter, you don't have a bed, it's hard to just even keep a job...” *Participant 16*

Homeless women described existing support systems which included support of other homeless women and leaning on a higher power. The participant's discussed areas of strength which included educating each other, having strength within and calling on a higher power.

Women described that information was passed by word - of - mouth and described one another as blood sisters. One woman shared, “We're most helpful to each other because we're in the same boat.” While several of the women agreed; she continued, “We are each other's support group....I guess though we bicker and may want to scratch each other's eyes out, but at the end of the day we tell you.” *Participant 8*

Interestingly, during one of the focus groups, one of the participants stated that, “When we hear something, we have to share it with each other.” *Participant 18*

Not all women felt that women helped one another. Several shared that sometimes information is not passed to another; however, women shared that they felt grateful that they met people who were helpful. Women also shared **leaning on a higher power**. One shared, “And to be homeless in a place like this, atmosphere where everything is going on around

you, you have to, you have to maintain a strongness within yourself and God if you believe, or whoever or whatever your religion is....” *Participant 20*

Spirituality and maintaining strength within self was important. While another woman noted that, “I roll by myself and just pray to God that, I just ask God to watch over and protect me. That's all I can do.” *Participant 9*

In terms of opportunities for future program planning, homeless women described the type of staff to be involved and specific topical content for each of the modules. Some of the proposed solutions which homeless women shared included the need for involvement of women on the study who had previously experienced homelessness.

One participant noted, “So I think they need to be on the study, people that's been homeless, be a part of the staff, too.” *Participant 8*

During one of the focus group sessions, women demonstrated sharing resources, and in effect titled the program, *Women Helping Women*. The program would consist of targeted care and provide referrals for a place to stay, where to buy certain foods and providing women resources based on diet, where to get condoms, and emergency showers. Woman shared that the program should also be located in all shelters where women reside.

Focus group participants also noted the need for specific content areas which included basic health and wellness, hygiene classes, general self-care, self-esteem building classes, physical activity classes (e.g. yoga, weight lifting, etcetera) and refresher courses related to sexually transmitted diseases (STDs), having a greater understanding of the basics of STDs, cardiovascular disease and information for vision and dental care.

Homeless women also presented several areas of need as it related to sexual and women's health. Women recognized the need for a sexual health refresher course. In particular, one woman revealed the importance of knowing more information about basic STDs and preventive measures. Another woman felt that film and educational videos about the impact of drug use on the body should be made available, along with how to prepare meals on a budget. One woman shared wanting to know how to physically protect herself from attack. She shared,

“You got to have some kind of defense on how to protect yourself. If you go into the store and somebody attacks you, the basics because some women don't know how to defend themselves at all.” *Participant 9*

In terms of information, homeless women described wanting to have pamphlets and booklets related to health information such as screening for HIV, TB and where to go. Further, they made mention of developing a short, simple, color-coded, resource handbook with limited text.

Discussion

The aim of this qualitative study was to understand health needs, preventive measures, barriers and facilitators to obtaining health and social services, and proposed solutions

perceived as important by women experiencing homelessness. Several themes emerged which included (1) healthcare needs and challenges experienced; (2) perspectives on sexual decision making; (3) employment difficulties; (4) existing support systems; and (5) development of future program planning.

In this sample, middle age and older homeless women described healthcare provider accessibility and shared several areas of need which included vision, dental care, managing pain, and having comprehensive, holistic care which included diagnostics and specialist providers. Researchers working with younger populations have found similarities in terms of the need for healthcare; in particular, among younger homeless populations, structural barriers have been noted and include limited clinic sites, hours, and long wait times (Hudson et al., 2010); further, among homeless women with a history of incarceration areas of need included dental care (Salem, Nyamathi, Idemundia, Slaughter, & Ames, 2013). One service center report noted that 42.3 percent of homeless women reported their health as fair or poor and 66.2% reported their dental care as fair or poor (DWAC, 2013). However, improvements have been made as it relates to health insurance enrollment and the total number of women who reported their health to be fair or poor has decreased (DWAC, 2013). Homeless women also described challenges taking medication, which contributes to difficulty self-managing chronic conditions.

Another important point is fear related to testing. In general, homeless women may be shuffling priorities on a daily basis and the need to meet basic necessities takes precedence over healthcare. Further, having knowledge of a family history of a health condition may elicit a greater amount of fear which leads to reluctance with testing. In one study among homeless women 18 to 83 years of age, a large proportion of women declined pap screening, even if it was available suspecting that previous trauma in the population may play a role as a barrier (Bharel, Casey, & Wittenberg, 2009). For providers, it is important to acknowledge historical trauma, family history of illness and associated fears in order to develop culturally sensitive programs to improve secondary prevention.

Some women in our sample of primarily middle age and older African American women disclosed that they would benefit from having a refresher course focused on STDs; however, other women did not feel that those who were set in their ways would change behavior or that sex may not be a priority in comparison to other needs. A growing trend has been the increase of HIV prevalence affecting older adults (Joint United Nations Programme on HIV/AIDS (UNAIDS), 2013). In fact, middle age and older African American women are one of the fastest growing groups at risk for HIV infection (Cornelius, Moneyham, & LeGrand, 2008; Stampley, Mallory, & Gabrielson, 2005). According to DWAC (2013), throughout the lifespan, a little less than one third (31.5%) of women who were living on the street felt the need to perform sexual favors for food, protection, cash or other needs. Although engaging in sexual favors in this needs survey was not assessed, sexual decision-making may be influenced by other means (DWAC, 2013). For providers, it is important to note these varied responses and experiences of homeless women; thus, different perceptions of risk and decision-making may be influenced by multiple factors.

In addition, the availability of food options and challenges eating healthy were noted by some of the participants. Among middle age and older women, challenges may include having a chronic condition and having to manage diet as structural determinants affect accessibility to food. Future research should focus on culturally sensitive nutrition classes which are tailored and delivered in individual and group sessions which include accessibility and resources for healthier options. In this sample, women also shared their interest in seeking employment and the challenges which they perceive. Further, in this study, homeless women shared support systems which included other women along with leaning on a higher power. Interestingly, other researchers who have studied experiences among women in shelters have found that women took on the role of helper or nurturer to others which included working in the shelter taking care of others, ministering in the shelter, or serving as a mother figure to the younger women (Davis-Berman, 2011).

Further, middle age and older homeless women discussed areas of future program planning and areas of intervention which included having those who had experienced homelessness to be involved in the program. Previous research has utilized peer coaches (Nyamathi, Flaskerud, Leake, Dixon, & Lu, 2001) and lay village women in India (Nyamathi, Ekstrand, et al., 2013; Nyamathi, Hanson, et al., 2012; Nyamathi, Salem, et al., 2012; Nyamathi, Sinha, et al., 2013) to conduct various health promotion programs. Future research should focus upon utilizing a peer-led model with formerly homeless women who would take part in the intervention core components. For academicians interested in utilizing peer – led or peer leadership models, it is important to note that service agencies may have utilized these models in the past and/or are currently adopting these models. It is important to consider that when utilizing these models, development of the roles, responsibilities and maintaining boundaries is important for the peers and participants.

Interestingly, in this sample, we were also able to quantitatively explore mobility, use of assistive devices and falls. Based upon self-report, we found that 35% have fallen in the last 30 days and 70% of the sample had a fall in the past year. In terms of utilization of assistive devices, we found that 65% do not use an assistive device. However, we did not have knowledge of the location or circumstances of the fall. In another study with homeless adults, 53.4% had at least one fall in the prior year (Brown et al., 2013). Given the high percentage of falls in this cohort; these findings are important to explore in the future as knowledge related to falls, fear of falling and fall prevention is limited among this population and necessitates areas of intervention.

Public Health Nursing Practice Implications

These study findings provide a foundation for future work with this population and community. For public health nurses (PHN), understanding that specific types of healthcare, such as vision and dental care, along with managing pain are critical areas of need, along with HIV testing, understanding what influences sexual decision making and negotiating safe sex with partners is also an area of need. In terms of interpersonal interaction with the provider, it is important for the PHN and other providers to be cognizant that the population waits for long periods of time to locate a provider. Helping facilitate adequate resources and referrals are critical. Further, if a screening test is needed, PHNs and other providers should

address fear related to testing, take additional time to answer questions and follow up with clients.

In addition, for providers, taking into account current life experiences when working with clients and how that influences decision making regarding health care is important. Likewise, for many women, obtaining adequate nutrition is a challenge, thus, it is imperative that providers work with women to develop healthy budget alternatives and to make appropriate decisions based on food which is available in the community. Furthermore, in terms of managing chronic health conditions for many women experiencing homelessness, helping them to manage one or more chronic health conditions while homeless is an important consideration which includes storing medications, obtaining adequate nutrition, having access to care and stable housing. A promising area for PHNs is to work with community -based sites to develop chronic disease self-management programs.

It is important to note that these findings are limited to women aged 43 to 62 in the Skid Row expanse of Los Angeles. These women also met the inclusion for being prefrail or frail based upon the SHARE-FI and frail based on the TFI instrument. While it was interesting to assess prefrail and frail homeless women in this sample, we were not able to identify differences between the women in this sample or younger homeless women as portrayed in the literature. Further, based on these findings, it is also plausible that women may have had isolated experiences or a lack of awareness related to how specific systems work in the area. Despite these limitations, we believe that this understudied subpopulation of the larger homeless population has presented valuable information for academicians and service providers which encompass health needs, delivery of information, location of delivery and opportunities for intervention. It's imperative to develop a multidisciplinary partnership with social work, medicine, gerontology, and nursing which will facilitate and establish targeted delivery and care.

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Table 1
Sociodemographic characteristics (N=20)

Characteristics	Mean	SD
Age	53.45	5.2
	N	%
< 50	4	20
50	16	80
Children		
Yes	14	70
No	6	30
Birthplace		
United States	18	90
Outside United States	2	10
Race/Ethnicity		
African American	14	70
Caucasian/White	3	15
Mixed/Other	3	15
Marital Status		
Never married or unmarried	11	55
Divorced	6	30
Separated	3	15
Highest Level of Education		
11 th grade	3	15
12 th grade/GED	5	25
College freshman or some college	9	45
College completion	1	5
Certificate	1	5
Not applicable	1	5
Lifetime Years Homeless		
Less than 1 year	4	20
1-3 years	7	35
4-6 years	4	20
7-9 years	3	15
10-13 years	1	5
17-19 years	1	5
Living Arrangements (Last 30 days)		
Shelter	12	60
Unsheltered	4	20
Own/Rent/Apartment or House	2	10
Someone else's apartment, room or house	1	5
Other	1	5

Table 2
Mobility, Use of Assistive Devices, and Falls (N=20)

Characteristic	N	%
Walking Independently		
Yes	16	80
No	4	20
Utilization of Assistive Devices		
None	13	65
Cane	5	25
Wheelchair	1	5
Other	1	5
Falls in the Last 30 Days		
Yes	7	35
No	13	65
Falls in the Past Year		
Yes	14	70
No	6	30