



City of Philadelphia Homeless Death Review Report 2011-2015

December 2017



MEDICAL EXAMINER'S OFFICE



DEPARTMENT OF PUBLIC HEALTH

Thomas Farley, MD, MPH – Health Commissioner

Sam Gulino, MD – Chief Medical Examiner

Report Prepared by:

Roy Hoffman, MD, MPH – Medical Director, Fatality Review Program

David Bissell, MPH – Program Coordinator, Fatality Review Program

With Assistance From:

HDR Advisory Team Members: Roberta Cancellier, Dennis Culhane, David Holloman, Marvin Levine, Marcella Maguire, Priya Mammen, Michelle Mangan, Silvana Mazzella, and Stephanie Puccia

This report is dedicated to all those who have experienced homelessness in Philadelphia, including the late James Womer, Jr. – who later became a tireless advocate for the homeless.

PHILADELPHIA HOMELESS DEATH REVIEW TEAM (2011-2015)

ADULT PROBATION AND PAROLE

Josette Springer*, Anthony Fattizzi, Jillian Eidson

AIDS ACTIVITIES COORDINATING OFFICE

Jamie Hamilton*, Debra Thomson, Evelyn Torres

CORIZON PRISON HEALTH SERVICES

Veda Hodge*, Melinda Valenti*

HAHNEMANN UNIVERSITY HOSPITAL

Stephanie Puccia

HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA

Heather Sheaffer*, Deborah Lowenstein

INDEPENDENCE FOUNDATION

Eunice King*

KEYSTONE MERCY HEALTH PLAN

Eric Berman*, Carolyn Macy

MERCY PHILADELPHIA HOSPITAL

Susan Cusack*, Kay Stephens

MHM SERVICES

Maryjane Rule*, Dawn Lenny

PHILADELPHIA DEPARTMENT OF BEHAVIORAL HEALTH AND INTELLECTUAL disABILITY SERVICES

Matthew Hurford*, Bridgette Tobler*,
Samuel Cutler*, Gail Harrison*, Marvin Levine*,
Natalie Meadows*, Suet Lim*, Marcella Maguire*,
Stacy Small, Michele Wexler, Ricardo Tull,
Timothy Sheahan

PHILADELPHIA DEPARTMENT OF HUMAN SERVICES

Robert Spencer*, Andrew Jarzyniecki

PHILADELPHIA OFFICE OF HOMELESS SERVICES

James Burks*, Leti Egea-Hinton*, Tara Gaudin, Michele Mangan
Peggy Brannan, David Holloman, Roberta Cancellier

PHILADELPHIA POLICE DEPARTMENT

John Gorman*, David Jardine

PHILADELPHIA PRISONS

Terrell Bagby*, Adrienne Lyde, Jennifer Albandoz

PREVENTION POINT PHILADELPHIA

Yaya Liem*, Jose Benitez*, Silvana Mazzella, Kate Perch

PROJECT HOME

Beth Lewis*, Alyssa Bowers*, Carol Thomas,
Laura Weinbaum

PUBLIC HEALTH MANAGEMENT CORPORATION

Sandy Orlin*, Deborah McMillan*, Beth Browning

SUNDAY BREAKFAST RESCUE MISSION

Richard McMillen

THOMAS JEFFERSON UNIVERSITY HOSPITAL

Bon Ku, Priya Mammen

UNIVERSITY OF PENNSYLVANIA

Dennis Culhane

UNIVERSITY OF THE SCIENCES IN PHILADELPHIA

Stephen Metraux

VETERANS AFFAIRS MEDICAL CENTER

Stephen Bennett*, Andrew Brenza*, Bob Lechtenberg*, Dara Katz

*denotes past members

TABLE OF CONTENTS

EXECUTIVE SUMMARY	1
GENERAL BACKGROUND SECTION ONE	3
HISTORY OF THE PHILADELPHIA HOMELESS DEATH REVIEW TEAM	3
METHODOLOGY OF THE PHILADELPHIA HOMELESS DEATH REVIEW TEAM	3
OVERALL DATA AND DEMOGRAPHICS OF THE HOMELESS DECEDENTS REVIEWED	5
Figure 1.1: <i>Decedents by Year of Death</i>	5
Figure 1.2: <i>Decedents by Manner of Death</i>	5
Figure 1.3: <i>Decedents by Primary Cause of Death</i>	6
Figure 1.4: <i>Decedents by Primary Cause/Contributing Conditions of Death</i>	6
Figure 1.5: <i>Decedents by Age Group</i>	7
Figure 1.6: <i>Decedents by Race/Ethnicity</i>	7
Figure 1.7: <i>Decedents by Last “Home Address”</i>	8
HOMELESSNESS SECTION TWO	9
BACKGROUND	9
Figure 2.1: <i>Philadelphia Point-In-Time Homeless Count: Sheltered and Unsheltered</i>	10
Figure 2.2: <i>Philadelphia Supportive Housing Capacity, by Type</i>	11
DATA	12
Figure 2.3: <i>Decedent’s Housing Status at Time of Death</i>	12
Figure 2.4: <i>Decedent’s Last Time in Shelter Prior to Death</i>	12
Figure 2.5: <i>Decedent’s History of Housing and Outreach</i>	13
Figure 2.6: <i>Shelter Usage History for Drug-Related Deaths vs. Non-Drug-Related Deaths</i>	14
Figure 2.7: <i>Chronic Homelessness of Decedents</i>	14
RECOMMENDATIONS	15
BEHAVIORAL HEALTH SECTION THREE	17
BACKGROUND	17
DATA	18
Figure 3.1: <i>Decedents by Mental Health Diagnoses</i>	18
Figure 3.2: <i>Decedents with Known Mental Illness by Time Since Last CRC Visit</i>	18
Figure 3.3: <i>Decedents with Known Mental Illness by Time Since Last Involuntary Hospitalization</i>	18
Figure 3.4: <i>Decedents by Substance Use/Abuse</i>	19
Figure 3.5: <i>Decedent’s Toxicology Findings at Time of Death</i>	19
Figure 3.6: <i>Decedents with Substance Use Disorder by Time Since Last D&A Treatment</i>	20
Figure 3.7: <i>Decedents with Substance Use Disorder with History of Inpatient Treatment or ICM</i>	20
Figure 3.8: <i>Decedents with Drug- or Alcohol-Related Deaths by System/Service Contact</i>	21
Figure 3.9: <i>Mean Age of Death for Drug- and Non-Drug-Related Deaths</i>	21
Figure 3.10: <i>Race/Ethnicity for Drug-Related Deaths</i>	22
Figure 3.11: <i>Race/Ethnicity for Non-Drug-Related Deaths</i>	22
Figure 3.12: <i>Decedent History by Behavioral Health Conditions</i>	22
RECOMMENDATIONS	23

PHYSICAL HEALTH SECTION FOUR	25
BACKGROUND	25
DATA	26
Figure 4.1: Decedents by Known Medical Conditions	26
Figure 4.2: Decedents with Known History of HIV	26
Figure 4.3: Decedents by Time Since Last ED Visit	27
Figure 4.4: “Hidden Homeless” by Time Since Last ED Visit	27
Figure 4.5: Decedent’s Insurance Status at Time of Death	28
RECOMMENDATIONS	28
 ADDITIONAL DATA SECTION FIVE	 30
WEATHER-RELATED DEATHS	30
Figure 5.1: Homeless Deaths by Season	30
VETERANS	31
Figure 5.2: Decedents by Veteran Status	31
CRIMINAL JUSTICE INVOLVEMENT	32
Figure 5.3: Decedents with Known Incarceration History, by Time Since Release	32
RECOMMENDATIONS	33

EXECUTIVE SUMMARY

Homelessness is a longstanding problem that has not changed significantly in Philadelphia over the last decade. From 2011 through 2015, the total number of identified homeless persons in Philadelphia, both sheltered and unsheltered, has hovered around 6,000. While Philadelphia's overall supportive housing capacity has gradually increased by almost 7% over this time period, the number of homeless persons identified as unsheltered has increased from about 500 to 670.

Many medical and behavioral health conditions are overrepresented among homeless people. In addition, people experiencing homelessness are more vulnerable to morbidity and mortality than those who have a home. All of this leads to a significantly decreased life expectancy for people experiencing homelessness as compared to the overall population. The Philadelphia Homeless Death Review Team (HDRT) was started in 2009 with the goal of reducing the number of preventable homeless deaths and improving the health and well-being of people experiencing homelessness. In order to accomplish this goal, the team identifies shortfalls and gaps in our systems and community resources through the review of each homeless death, and it makes data-driven recommendations in order to address these identified shortfalls.

The HDRT identified 269 persons who died between 2011 and 2015 and were homeless in Philadelphia at the time of death. Of the 269 persons reviewed, 85 percent were male, 14 percent were veterans, and 19 percent were considered chronically homeless. 43 percent of the decedents were non-Hispanic White, 43 percent were non-Hispanic Black, and 12 percent were Hispanic.

As a result of data collected and analyzed during the review of 2011-2015 deaths, the HDRT found:

- The average age of death for a homeless decedent was 49 years
- Less than two percent of decedents died of hypothermia (an average of one decedent per year)
- 60 percent of decedents were "street homeless" at the time of death
- 25 percent of decedents were unknown to Philadelphia's homeless or outreach service systems
- 87 percent of decedents had a known history of a substance use disorder
- 51 percent of decedents had drugs and/or alcohol as a primary or contributory cause of death
- 68 percent of decedents had a known history of mental illness, with 61 percent of the overall decedents having co-occurring diagnoses
- 58 percent of decedents had no health insurance coverage at the time of death

The following actions and accomplishments within the City of Philadelphia have been influenced either directly or partially by the members, the discussions, and the findings of the HDRT meetings:

- Increased the number of treatment beds specifically designated for people experiencing homelessness
- Continued the expansion of Housing First inventory
- Opened Philadelphia's first medical respite program
- Helped provide evidence for continued funding of the city's Winter Initiative
- Implemented the Healthy Baby Initiative in city-run shelters
- Increased focus and outreach to newly identified homeless hot spots
- Increased the knowledge and interest in individuals experiencing homelessness who are hard to find (e.g., living in abandoned homes)

Based on the data and discussions that came from the reviews, the Philadelphia HDRT recommends the following actions be taken:

HOMELESSNESS

- Continue to implement Housing First approaches, policies, and practices in Philadelphia
- Create more opportunities to assist individuals at-risk for homelessness
- Expand housing with services to individuals experiencing homelessness
- Philadelphia's public and private shelters should devise ways to communicate on a regular basis as well as support standardization and collaboration among themselves
- Explore more ways to make street outreach more efficient by developing a "hotspot" designation protocol

BEHAVIORAL HEALTH

- The Department of Behavioral Health and Intellectual disAbility Services should examine whether there is sufficient capacity and access to low-demand, behavioral health-supportive safe haven slots or progressive demand residences in Philadelphia and, if necessary, increase the capacity
- Support citywide efforts surrounding the prevention and treatment of substance use disorders
- Strengthen the coordination and communication between hospitals and Community Behavioral Health for individuals with behavioral health conditions, particularly for involuntary commitments of individuals with a history of homelessness
- Improve the quality and standards for boarding homes, rooming homes, and recovery houses
- Create more capacity and expertise to work with individuals with co-occurring diagnoses

PHYSICAL HEALTH

- Create a more coordinated process for hospital and emergency department (ED) discharges of people identifying themselves as homeless, ideally utilizing the Critical Time Intervention approach
- The Office of Homeless Services should coordinate with hospital, ED, and jail staff by providing them with updated shelter information and maintaining ongoing communication about discharge needs
- Hospitals should staff EDs with homeless interventionists or peer recovery coaches
- Create a mechanism (such as Accountable Care Organizations) for stronger coordination between emergency departments and Managed Care Organizations around high utilizers
- Create a Philadelphia Emergency Department Leadership Group that would promote collaboration and efforts on standardization among EDs across the city
- Help homeless individuals enroll in and maintain enrollment in Medicaid
- Health insurance plans and hospitals should partner with city officials to expand the number of medical respite beds in Philadelphia

ADDITIONAL

- The Office of Homeless Services to maintain the system of Code Blue emergencies and the availability of winter beds, which prevent deaths due to hypothermia
- Strengthen the discharge policies and procedures of those leaving jails, especially for those with a history of a substance use disorder
- Homeless advocates should encourage more cities and counties to track the number of homeless deaths

This 2011-2015 Homeless Death Review Report presents the mortality data and identified systemic shortfalls in order to further the efforts of those working to prevent future homeless deaths, improve the health and well-being of homeless individuals, and move toward an end to homelessness in Philadelphia.

SECTION 1: GENERAL BACKGROUND

HISTORY OF THE PHILADELPHIA HOMELESS DEATH REVIEW TEAM

In February 2008, a wheelchair-bound man experiencing homelessness attempted to cross a highway median in Philadelphia after being turned away from an overnight drop-in center that was full. A drunk driver struck and killed not only this homeless man, but also a Good Samaritan who had pulled over and was attempting to help him. Through that tragedy, the community galvanized support for an increase in shelter and housing for individuals experiencing homelessness, and the idea was born that the City of Philadelphia would create a homeless death review process.

OHS is the city department charged with providing the leadership, coordination, planning and mobilization of resources to make homelessness rare, brief, and non-recurring in Philadelphia, and it coordinates the activities of the Philadelphia Continuum of Care. DBHIDS provides the funding and coordination of homeless street outreach, the city's safe havens, homeless-specific treatment programs, and service funding for people with behavioral health conditions who are experiencing homelessness.

Starting in January 2009, the Philadelphia Medical Examiner's Office (MEO), in conjunction with Philadelphia's Office of Homeless Services (OHS) and Department of Behavioral Health and Intellectual Disability Services (DBHIDS), started to lay the groundwork for planning the Philadelphia Homeless Death Review Team (HDRT). The first review meeting took place on June 15, 2009, and the HDRT has been meeting quarterly ever since.

There are several metropolitan areas (such as New York City, Denver, and Sacramento) that regularly compile data on homeless deaths. More recently, there have been quite a number of jurisdictions that have put out reports or published numbers about their homeless deaths (such as New Orleans, Austin, Nashville, Hawaii, and Columbia, SC). As far as the authors of this report are aware, Santa Barbara is the only other jurisdiction besides Philadelphia that currently conducts an ongoing, multidisciplinary team review of homeless deaths.

METHODOLOGY OF THE PHILADELPHIA HOMELESS DEATH REVIEW TEAM

In order for a decedent to be eligible for review by the HDRT, the person must have been homeless at the time of death, and the incident leading to death must have occurred within Philadelphia.

Homelessness, as defined by the US Department of Housing and Urban Development (HUD), includes living in publicly or privately operated shelters (such as an emergency shelter, transitional shelter, safe haven, or seasonal winter bed) as well as living on the streets or outdoors, in a car, in a subway station, an abandoned house, or a building not meant for human habitation.

For purposes of the HDRT, homelessness also includes anyone with a recent history of homelessness who was in a temporary accommodation, such as staying a few weeks with a friend or family, spending a few nights at an acquaintance's residence, or otherwise sleeping on couches and not having one's own, fixed nighttime residence. However, those living in permanent supportive housing, a boarding home, nursing home, jail, or a recovery house at the time of death were not considered homeless and thus not included in this report.

Possible homeless deaths are first identified through the MEO investigators or by community partners. After the HDRT is made aware of a possible homeless death, OHS and DBHIDS are notified. OHS and DBHIDS staff members check the databases in their respective departments to look for prior contact with the individual and to establish whether records corroborate homelessness. Absence of a history of service use in the homeless, outreach, or behavioral health systems, however, does not preclude a homelessness designation. Other sources of information to help determine the decedent's homelessness status include the next of kin or other close family and friends, MEO investigators, and individual HDRT members and their colleagues who may have known the decedent.

The Homeless Death Review process has two main components: monthly conference calls and quarterly in-person reviews. Conference call members are from the public and private sectors, including OHS, DBHIDS, Project HOME (homeless street outreach), Philadelphia Veterans Administration Medical Center, AIDS Activities Coordinating Office, Prevention Point Philadelphia (a nonprofit organization that provides harm reduction services), and Public Health Management Corporation (the Health Care for the Homeless grantee). The multiple purposes of the conference call include but are not limited to: verifying the housing status of a decedent who was possibly homeless, helping the MEO investigators locate next of kin when one has not already been identified, and starting the process of gathering information for the quarterly review.

At the quarterly in-person reviews, representatives of approximately 20 city and non-city agencies meet face-to-face to review the human service and health encounter history of about 15 individuals. The Medical Director of the Fatality Review Program presents each case, including the cause of death, circumstances surrounding the death, and a summary of encounters with the different agencies represented on the team. At the end of each full-case presentation, the HDRT members discuss gaps and missed opportunities among our systems and community resources, noting trends across cases and focusing on the unique qualities of the individual case reviewed. The data and discussions derived from these meetings are the basis of this report.

OVERALL DATA AND DEMOGRAPHICS OF THE HOMELESS DECEDENTS REVIEWED

The MEO, which is a division of the Philadelphia Department of Public Health, has been actively tracking homeless deaths since January 1, 2009. As with any health metric, it is not possible to know if a problem is getting better or worse unless it is being measured, ideally with active rather than passive surveillance. Prior to the start of our surveillance, there were wide estimates as to the number of homeless people dying in Philadelphia each year as well as causes of these deaths.

The HDRT was initially surprised to learn that the number of deaths identified was much lower than estimates had been prior to the start of the review process. However, the number of homeless deaths identified in Philadelphia has gradually increased since 2009 from an average of 45 per year in 2009-2010, to an average of about 50 per year in 2011-2013, to an average of about 60 per year in 2014-2016.

Part of the initial increase in the total number of deaths reviewed was likely due to better surveillance methods in identifying people who were homeless at the time of death. Later increases in the number of deaths reviewed were partly due to Philadelphia's ongoing opioid crisis, as described later in this report.

Fig 1.1 Decedents by Year of Death (N=269)

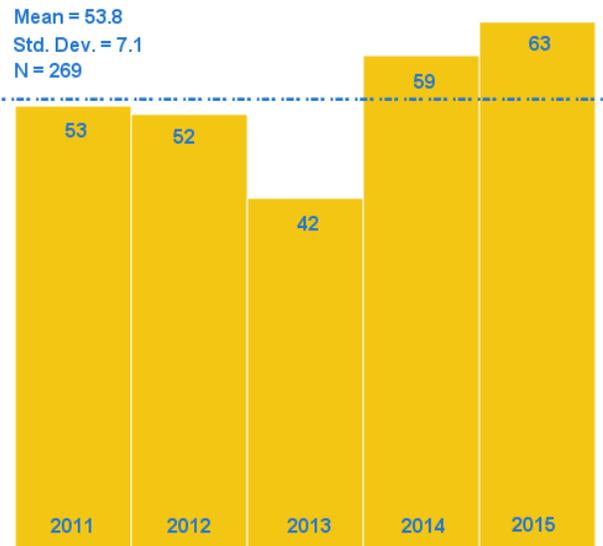
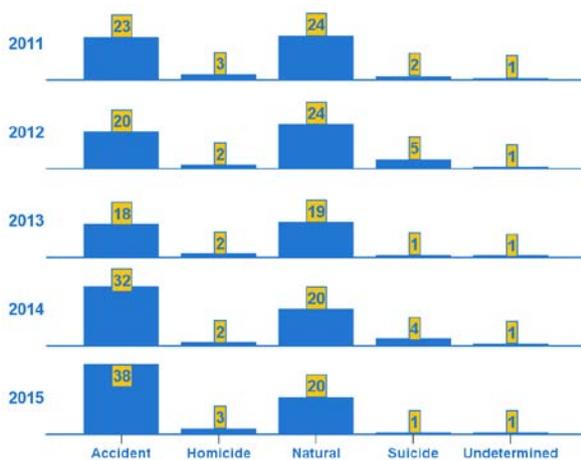


Fig 1.2 Decedents by Manner of Death (N=269)

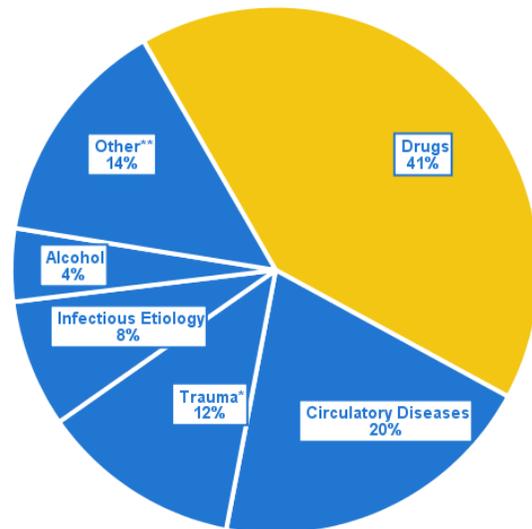


Almost half of all homeless deaths (49%) were due to unintentional (accidental) causes and 40% were due to natural (medical) causes. Homicides occurred at an average of 2.4 deaths per year and accounted for 4% of all homeless deaths reviewed. Suicides occurred at an average of 2.6 deaths per year and accounted for 5% of the total.

Based on the annual Point-in-Time counts, there are approximately 6000 homeless people in Philadelphia on any given night. That gives a suicide death rate of approximately 46.7/100,000 homeless people, which was over double the highest age-group-related suicide rate for U.S. adults (ages 45 to 54) at approximately 20/100,000 in 2009.¹

¹ <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6128a8.htm>

Fig 1.3 Decedents by Primary Cause of Death (N=269)



Increases in the overall number of Philadelphia homeless deaths over the last few years are partly due to the ever-increasing problem of opioids as a cause of unintentional fatal drug intoxications, a crisis that has plagued not only Philadelphia but the nation as a whole.

- * includes blunt trauma, gunshot wound, stab wound
- ** includes cancer, suffocation, hypothermia, drowning, fire, and others

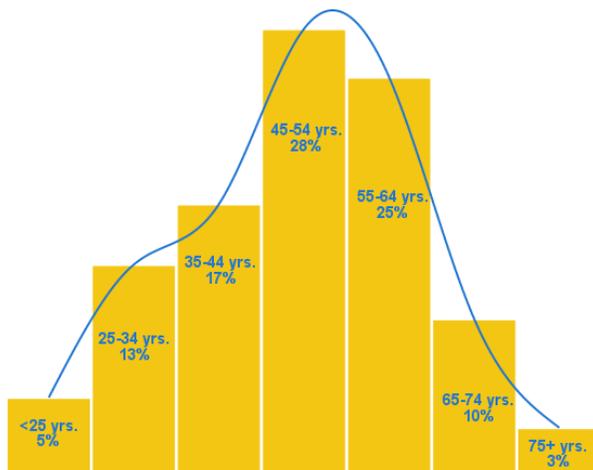
Deaths due to unintentional drug overdose are currently the most common cause of death among the Philadelphia homeless, having doubled in number from 2011 to 2015. Deaths due to drugs increased from 34% of all homeless deaths in 2011 to 56% of all homeless deaths in 2015. Cardiovascular disease was the next most common cause of death, accounting for the primary cause of death in 20% of all decedents.

Fig 1.4 Decedents by Primary Cause/Contributing Conditions of Death (N=269)

	Primary Cause						Contributing Condition					
	2011	2012	2013	2014	2015	Total	2011	2012	2013	2014	2015	Total
Drugs	18	18	13	27	35	111	0	1	1	1	1	4
Cardiovascular Disease*	8	9	13	10	14	54	6	3	5	4	2	20
Trauma (blunt, gunshot, stab)	6	8	6	9	4	33	0	0	0	0	0	0
Diseases of Infectious Etiology (incl. HIV)	6	3	3	2	3	17	0	0	0	0	0	1
Fire, Drowning, or Suffocation	3	3	3	3	2	14	0	0	0	0	0	0
Alcohol	1	5	2	1	3	12	0	5	3	1	2	11
Cancer	3	3	0	2	1	9	0	0	0	0	0	0
Hypothermia	1	0	1	1	1	4	1	0	0	0	0	1
Diabetes	1	0	0	1	0	2	4	1	2	3	5	15
Respiratory System Disease*	1	1	0	0	0	2	1	2	1	1	2	7
Other	3	2	1	3	0	9	1	1	1	1	4	8
Total	53	52	52	59	63	269	**					

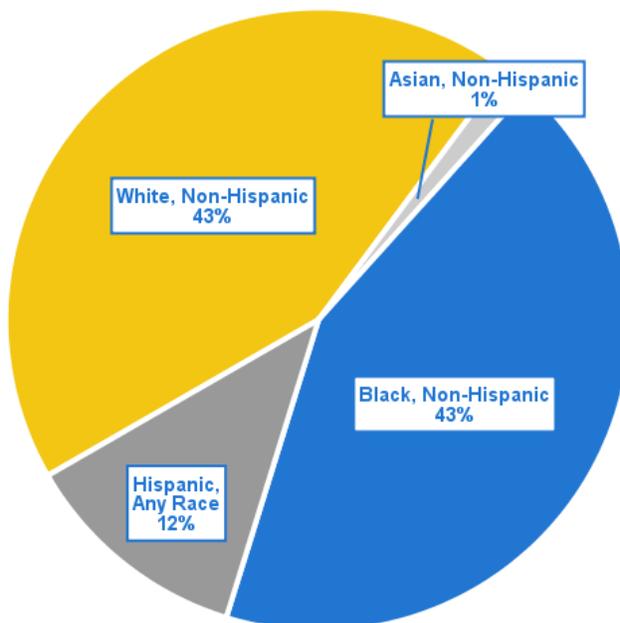
- * not including diseases of an infectious etiology (e.g. pneumonia, endocarditis)
- ** contributing conditions could be none or multiple conditions

Fig. 1.5 Decedents by Age Group (N=269)



Homeless people in Philadelphia, on average, die at a much younger age than those who are housed. The average age of death of a homeless Philadelphian from 2011-2015 was 49 years, which represents three decades of life lost prematurely as compared to the average age of death for the typical American (79 years).

Fig. 1.6 Decedents by Race/Ethnicity (N=269)

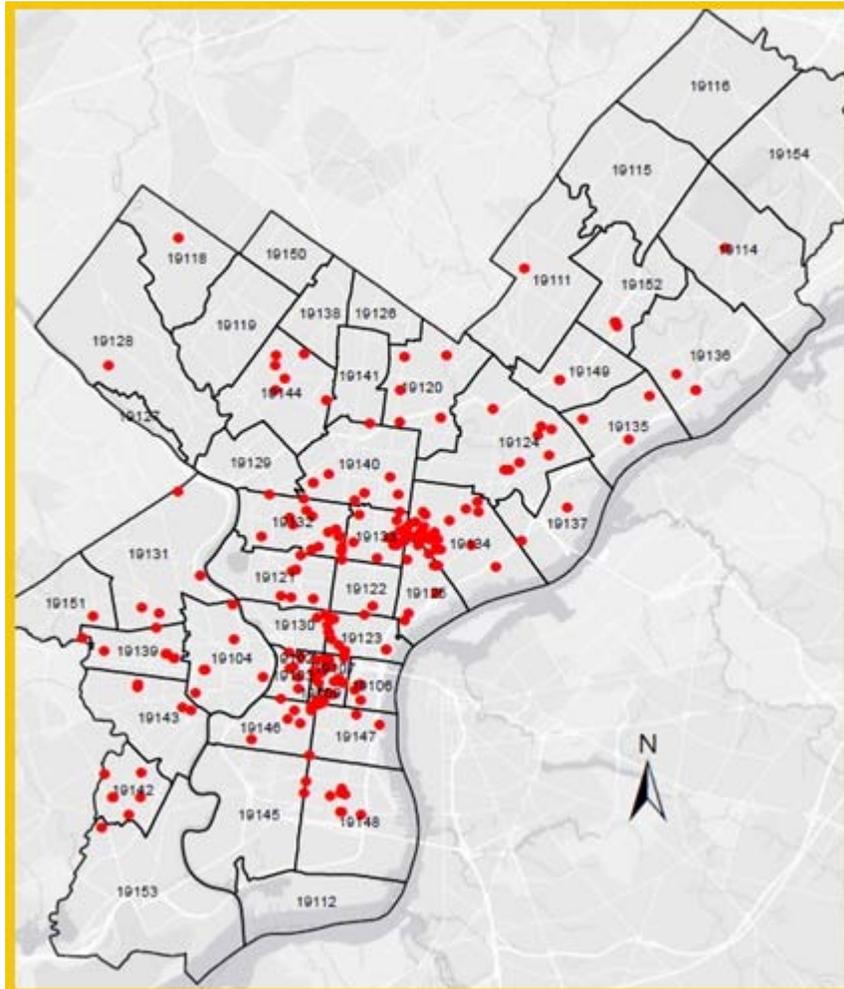


Race and ethnicity for Philadelphia's homeless decedents were similar to that of the general population in Philadelphia, but quite dissimilar from that of the overall homeless population in Philadelphia as measured during the 2015 Point-in-Time count. Homeless decedents were 43% non-Hispanic Black and 43% non-Hispanic White, while Philadelphia's overall homeless population was 83% non-Hispanic Black and 14% non-Hispanic White². The sex of the homeless decedents was predominantly male (85%), which was significantly greater than the Philadelphia homeless population of 59% male. Of note, three of the homeless decedents were transgender (two were trans-women, one was a trans-man). The two trans-women died as a result of homicidal violence.

² https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_CoC_PA-500-2015_PA_2015.pdf

Red dots in Figure 1.7 depict decedents' last known address (or, if street homeless, where they were found at the incident leading to death). The map shows that homeless deaths were generally scattered throughout Philadelphia, although there were areas of clustering in Center City and the Kensington neighborhood.

Fig. 1.7 Decedents by Last Known Address (N=269)



The HDRT's work in identifying homeless decedents and mapping them has been beneficial to Philadelphia's street outreach efforts. Small hotspots of homelessness have been uncovered over the years, and the growing concentration of drug-related deaths in the Kensington neighborhood, a region considered by many to be the epicenter of Philadelphia's drug trade, has provided the data-driven argument to push for more outreach, shelter, and services in this neighborhood.

SECTION 2: HOMELESSNESS

BACKGROUND

The causes of homelessness are many. Although circumstances and experiences can vary, one of the primary reasons individuals and families experience homelessness is because they cannot find housing they can afford. Inadequate supports for individuals dealing with mental health and substance use challenges are also major contributors to homelessness.

Philadelphia has a 26% poverty rate,³ one of the highest in the nation. There is a disparity between housing costs and income by way of minimum wage, public support, and earned benefits. Additionally, the amount of housing assistance available in Philadelphia simply cannot keep up with the demand.

The United States Interagency Council on Homelessness created *Opening Doors*,⁴ a federal strategic plan to prevent and end homelessness that hones in on four sub-populations: families, youth, veterans, and chronically homeless individuals.

Services for people experiencing homelessness are coordinated within communities by local planning bodies called Continuums of Care (CoC). The Office of Homeless Services (OHS) supports the Philadelphia CoC Board, which is the local planning body for the region.

In Philadelphia, a comprehensive system of care exists for individuals and families experiencing homelessness. Contributing to this continuum of services are the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) and health care systems. Collectively, physical and behavioral health services are available. However, gaps in services and capacity still exist.

FAMILIES

typically experience homelessness in the aftermath of an unforeseen financial emergency: medical bills, a car accident, death in the family, or loss of steady employment.

YOUTH

under the age of 25 often experience homelessness due to family conflict: neglect, abuse, or getting kicked out due to sexuality or poverty.

VETERANS

experience homelessness due to combat-related disabilities (physical disability, mental distress, post-traumatic distress) or difficulty readjusting to civilian life.

CHRONIC

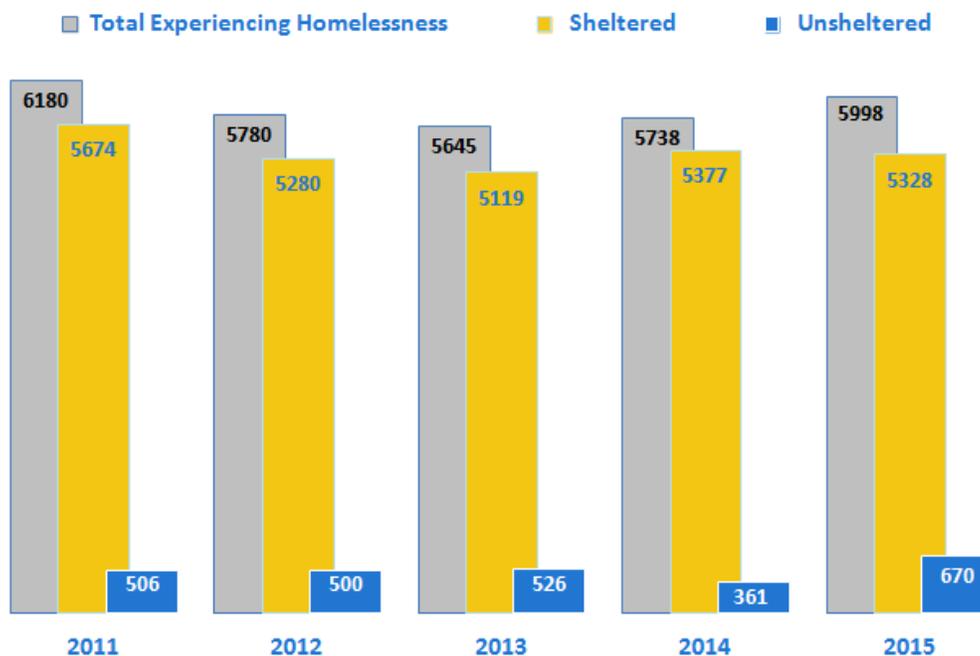
homelessness is long-term or repeated bouts of homelessness experienced by people who typically struggle with chronic behavioral health or physical health conditions.

³ http://www.pewtrusts.org/~media/assets/2016/03/philadelphia_the_state_of_the_city_2016.pdf

⁴ <https://www.usich.gov/opening-doors>

Once a year in late January, CoCs nationwide conduct a count according to standards of the U.S. Department of Housing and Urban Development (HUD). This Point-in-Time (PIT) Count is an unduplicated one-night count of both sheltered and unsheltered homeless people.

Fig. 2.1 Philadelphia Point-in-Time Homeless Count: Sheltered and Unsheltered



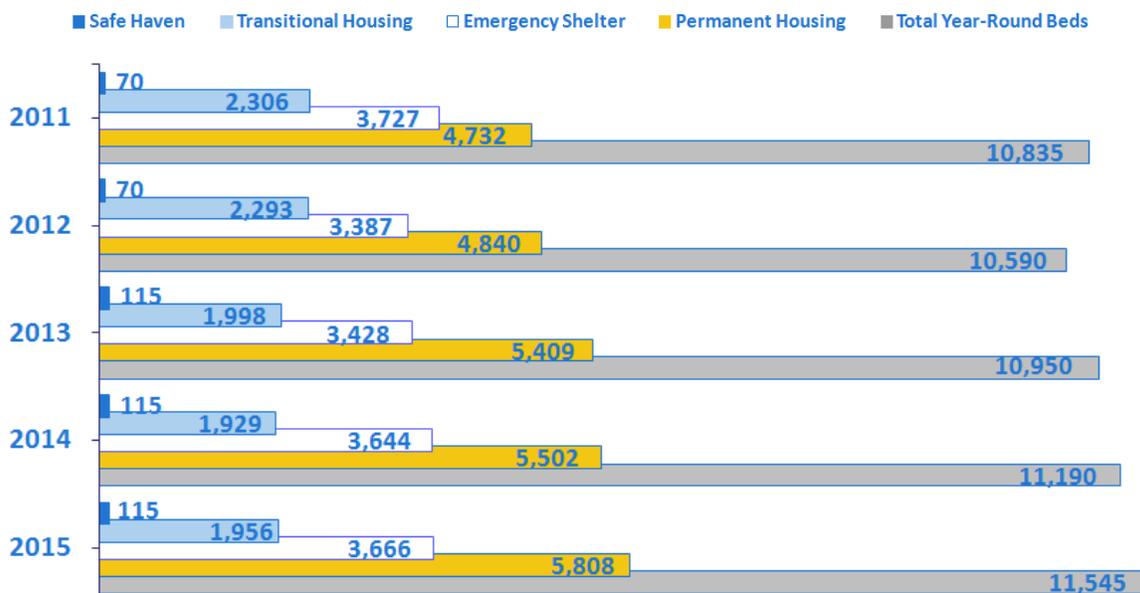
As a point of reference, the PIT Count nationwide in January 2015 identified 564,708 people experiencing homelessness.⁵ 69% were in a sheltered location, while 31% were in unsheltered locations. On a single night in Philadelphia in January 2015, the PIT Count identified 5,998 people as experiencing homelessness.⁶ 5328 people (89%) were in a sheltered location for the night such as in an emergency shelter, transitional housing program, or safe haven.

However, there were also 670 people (11%) counted that night who were unsheltered – which means residing in a public or private place not fit for or designed as a sleeping accommodation for people. Unsheltered locations include the streets, vehicles, and parks. Of the 670 people without shelter, 55 of them were young adults between the ages of 18 and 24.

⁵ <https://www.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf>

⁶ https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_CoC_PA-500-2015_PA_2015.pdf

Fig. 2.2 Philadelphia Supportive Housing Capacity, by Type*



*figures do not include seasonal/winter beds

The Philadelphia CoC had 3,666 emergency housing beds, 1,956 transitional housing beds, and 115 safe haven beds in 2015.⁷ An additional 378 beds in emergency housing were available during the winter season. Despite the consistent prioritization of new funding toward the creation of permanent supportive housing opportunities, the demand for supportive housing continues to outpace the supply.

⁷ There were actually a total of 244 safe haven beds in Philadelphia in 2015, but for purposes of classification by HUD standards, 129 of them were officially categorized as emergency housing beds

DATA

The purpose of the HDRT is to review the history of people who were homeless at the time of death. While official definitions of homelessness provide a sound framework, there are those who die in circumstances that defy easy categorization. This poses a challenge for the HDRT to determine if a possibly homeless person should be included for review or not. Homelessness can be defined as living on the street, staying in temporary accommodations, or being housed in publicly or privately operated shelters.

For purposes of this report, street homeless or “living on the street” can include sleeping on the sidewalks or in an abandoned lot, but also living in a tent, living in one’s car, sleeping in a subway station, spending the night at an overnight café or winter bed, or living in an abandoned home. It also includes anyone deemed homeless by the review team but whose last known place of sleeping was unknown. Forty percent of the homeless deaths reviewed occurred when the decedent was officially sheltered, either staying in temporary accommodation or housed in an emergency shelter, in a safe haven, or in transitional housing.

For people experiencing homelessness, connection to services provides an opportunity to reconnect with housing in the community. Despite the presence of street outreach 24 hours a day, 365 days a year in Philadelphia, a community-wide hotline to report an individual experiencing homelessness, and a large network of emergency shelters and low-demand entry level settings (safe havens and overnight cafes), nearly one-third of decedents reviewed were not known to the shelter system.

Fig. 2.3 Decedent’s Housing Status at Time of Death (N=269)

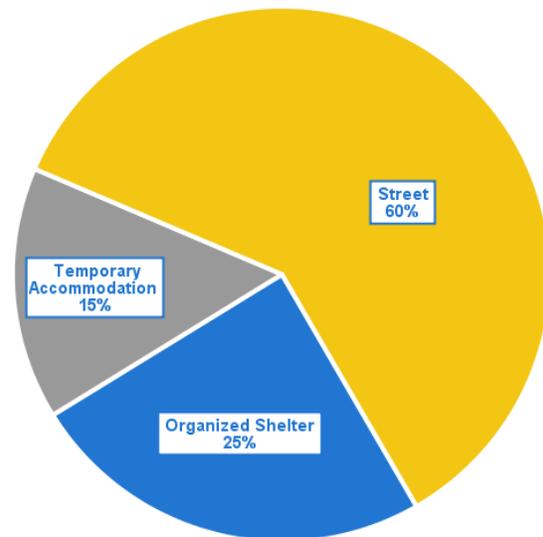


Fig. 2.4 Decedent’s Last Time in Shelter Prior to Death (N=269)

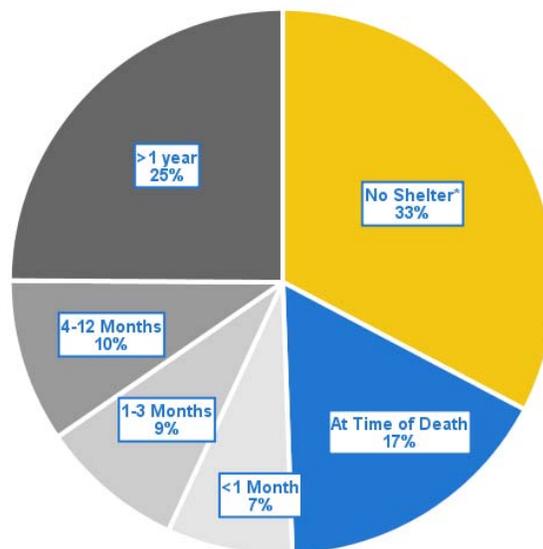
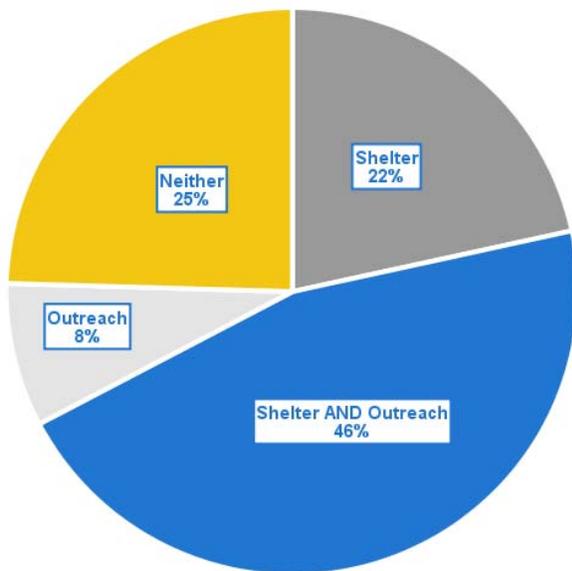


Fig. 2.5 Decedent's History of Housing* and Outreach (N=269)



* emergency, transitional, safe haven and/or permanent supportive housing history

Three-quarters of the identified homeless deaths had a documented history of outreach contact or shelter usage in Philadelphia at some point in their lives. Yet there is a group of individuals who remain hidden. In Philadelphia, most of these individuals live outside Center City, and many of them live in abandoned houses or “abandominiums,” a problem that is not unique to Philadelphia but perhaps more prevalent among the most populous American cities.

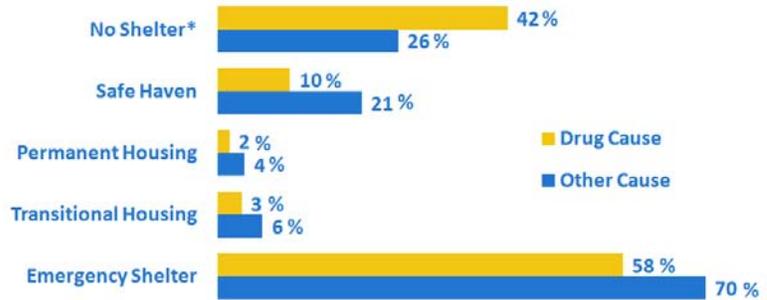
The Philadelphia HDRT has brought to light people experiencing homelessness who were largely unknown to the homeless system in a magnitude previously unseen to many service providers, outreach workers, and academicians. The HDRT found that a number of homeless individuals lived outside the limited scope of outreach services, and that they didn't seek shelter let alone other social services offered to those in need. In fact, a study of Philadelphia's “hidden homeless” deaths from 2009 to 2011 showed many differences in characteristics of these hidden homeless as compared to the homeless population that utilizes shelters, such as race, prevalence of mental illness, and prevalence of substance use disorders.⁸

As a result of the work of the HDRT, more attention has been given to identifying and enumerating homeless people in Philadelphia who were previously not known to city agencies or through the PIT Count, offering services in new areas of the city where outreach workers now canvass, and looking into how better to meet their needs.

⁸ Metraux, S., Manjielievskaia, J., Treglia, D., et. al. “Posthumously Assessing a Homeless Population: Services Use and Characteristics.” *Psychiatric Services* 67.12 (2016): 1334-1339. *Psychiatry Online Web*. 2 Mar. 2017.

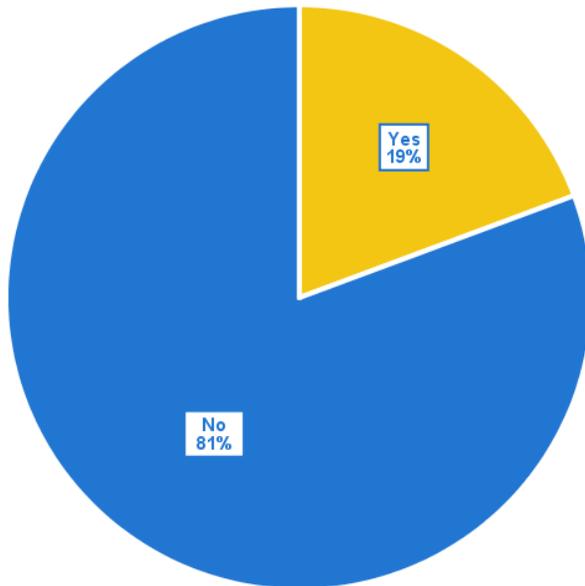
The characteristics of those who died as a direct or indirect result of drugs (other than alcohol) are quite different from the characteristics of those who died from non-drug-related causes. As can be seen in Figure 2.6, a larger percentage of those who died from drugs had no history of shelter usage as compared to those who died from other causes (42% vs. 26%). One of the hypotheses to explain this difference is that many of the decedents who were active in their drug addiction tended to live in abandoned houses.

Fig. 2.6 Shelter Usage History for Drug-Related Deaths (n=115) vs. Non-Drug-Related Deaths (n=154)



*includes abandoned houses, street, or unknown housing

Fig. 2.7 Chronic Homelessness* of Decedents (N=269)



*Determination is limited by contact with the subset of agencies that provide information at the review meetings

According to HUD, a chronically homeless individual is someone with a disability who has either experienced continuous homelessness for a year or longer, or who has experienced 12 months or more of homelessness over at least four episodes in the last three years. Nearly one-fifth (19%) of the decedents reviewed were defined as chronically homeless, as compared to 26% of Philadelphia’s homeless population and 15% of the U.S. homeless population.^{9, 10}

⁹ https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_CoC_PA-500-2015_PA_2015.pdf

¹⁰ <https://www.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf>

RECOMMENDATIONS

1. Continue to implement Housing First approaches, policies, and practices in Philadelphia

Housing First, which was pioneered by Pathways to Housing in New York in 1992, is a proven model whereby permanent housing is offered to homeless people with few to no barriers, contingencies, or preconditions. Initially implemented in Philadelphia through DBHIDS, Housing First focused on providing individualized, community-based services exclusively to chronically homeless people with mental health and substance use disorder diagnoses, but it has since expanded its reach to more individuals over the years. The Housing First approach views safe and stable housing as fundamental to human flourishing, and so it prioritizes connecting people to permanent housing. Additional supportive services are offered and encouraged, but they are voluntary and *not* a requirement for maintaining housing. Although Housing First has proven to be very effective, there are multiple pathways for homeless individuals with behavioral health challenges (such as Journey of Hope, safe havens, etc.), because no single solution fits everyone.

Some of the ways to achieve this goal could be:

- a. OHS to provide more training and resources for staff in emergency and transitional housing programs so that programs and staff are more Housing First focused and supportive of the individuals they serve
- b. OHS to create and implement an assessment tool for permanent supportive housing eligibility that prioritizes those with long histories of homelessness, severe service needs, and multiple system involvement
- c. Continue discussions to explore the creation of a safe haven for the Kensington neighborhood

2. Create more opportunities to assist individuals at-risk for homelessness and expand housing with services to individuals experiencing homelessness.

The current need in Philadelphia for permanent supportive housing, a type of housing that serves people who are experiencing homelessness and are identified as needing long-term community-based services, is greater than the units available. Additionally, prevention services are needed to support those at risk of homelessness. Preventing homelessness is always in the best interest of individuals and families, and is economically more efficient for the service providers and agencies serving these clients.

Some of the ways to achieve this goal could be:

- a. Create a Medicaid supportive housing benefit in Pennsylvania for Medicaid beneficiaries who are chronically homeless and have chronic behavioral health or physical health conditions, particularly those who need support around substance use and recovery
- b. DBHIDS and OHS to pilot shallow rent subsidies (e.g. \$500/month) to people experiencing chronic homelessness and others, such as those over a certain age or those who receive Social Security Income (SSI)
- c. Continue discussions at the Housing Cabinet to allocate a larger percentage of newly developed housing units to people experiencing homelessness
- d. DBHIDS to continue to help nonprofit organizations to serve as a representative payee program in Philadelphia, by specifically helping individuals with money management to maintain rent payments and housing
- e. In partnership with all interested and invested entities, DBHIDS to continue to provide aggressive and expedited SSI enrollment for anyone over age 55 meeting the program requirements

3. Philadelphia’s public and private shelters should devise ways to communicate on a regular basis as well as support standardization and collaboration among themselves

Philadelphia-specific trainings could create a customizable and cost-efficient way to provide quality instruction among shelters and could include strategies for being engaging, empathetic, and trauma-informed. Improved skills among shelter workers could encourage more people experiencing homelessness to utilize shelters. Uniform record-keeping and access to information across the shelter system could facilitate communication and collaboration among shelters and help the HDRT better understand the shortfalls and strengths of our systems and resources. In addition, the benefit of behavioral case management within shelters can be better utilized across the shelter system.

Some of the ways to achieve this goal could be:

- a. OHS to create a forum for all Philadelphia shelter directors and managers to meet and communicate on a regular basis
- b. OHS or other third party to convene an annual summit of all Philadelphia shelters
- c. Create and provide system-wide training sessions for all Philadelphia shelters
- d. Strengthen relationship with behavioral health case management in various shelters for better utilization and coordination of supports

4. Explore ways to make street outreach more efficient by developing a “hotspot” designation protocol

Street outreach team members develop rapport with people experiencing homelessness, and they are present 24 hours a day, 365 days a year. A community-wide hotline allows Philadelphians to call at any time they see an individual outdoors who appears to be homeless and in need of assistance, and a central dispatcher deploys an outreach team to the location. In the past two years, DBHIDS created two additional outreach teams through One Day at a Time (ODAAAT) and Prevention Point Philadelphia. However, outreach teams need access to additional services and resources to which clients can be connected.

Some of the ways to achieve this goal could be:

- a. DBHIDS to remain attentive to the demands on homeless outreach and continue to assess the volume of outreach traffic and need for additional capacity
- b. DBHIDS to continue to create special trainings for outreach workers that are especially geared toward youth, transgender individuals, and those with an opioid use disorder
- c. DBHIDS to explore the value and funding ability of adding “housing navigators” to outreach teams - a position whose sole purpose is to connect individuals to appropriate housing and treatment resources where available
- d. DBHIDS to develop a protocol clearly defining the parameters constituting an official “hotspot” designation and manage the ongoing list of designations

SECTION 3: BEHAVIORAL HEALTH

BACKGROUND

Behavioral health disorders (mental illness and substance use disorders) are quite prevalent in adult populations. Recent estimates show that nearly 1 in 5 U.S. adults experience mental illness in a given year.¹¹ Roughly one in twelve Americans aged 12 or older has had a substance use disorder in the past year.^{12,13}

The Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) is a \$1.5 Billion single-payer public system that oversees a broad continuum of behavioral health services including but not limited to prevention, early intervention, outreach and engagement, inpatient, outpatient, residential, and community support services for children, adults, and families. From 2005 to 2015, DBHIDS led Philadelphia through a decade of transformation to become a recovery-oriented system of care. With a solid foundation of community engagement around recovery and resilience, it was a natural progression for DBHIDS to adopt a population health approach. Taking a much broader view, DBHIDS seeks to improve the health status of all Philadelphians, not just those who experience stigma as a result of an intellectual disAbility or a behavioral health challenge.

Individuals in Philadelphia with behavioral health issues are overrepresented among homeless persons. For the street population, 80-90% of the people seen by outreach had behavioral health challenges, a much higher percentage than the overall prevalence in Philadelphia adults.¹⁴

According to The Corporation for Supportive Housing, the United States needs 1.2 million more supportive housing units to address the housing needs of homeless persons, particularly for those with behavioral health challenges.¹⁵

¹¹ Hughes, A., Williams, M. R., Lipari, R. N., Bose, J., Copello, E. A. P., & Kroutil, L. A. (2016, September). *Prescription drug use and misuse in the United States: Results from the 2015 National Survey on Drug Use and Health*. NSDUH Data Review. Retrieved from <http://www.samhsa.gov/data/>

¹² Center for Behavioral Health Statistics and Quality. (2015). Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from <http://www.samhsa.gov/data/>

¹³ Mental Health By the Numbers. (n.d.). Retrieved February 10, 2017, from <http://www.nami.org/Learn-More/Mental-Health-By-the-Numbers#sthash.nkkFkY3p.dpuf>

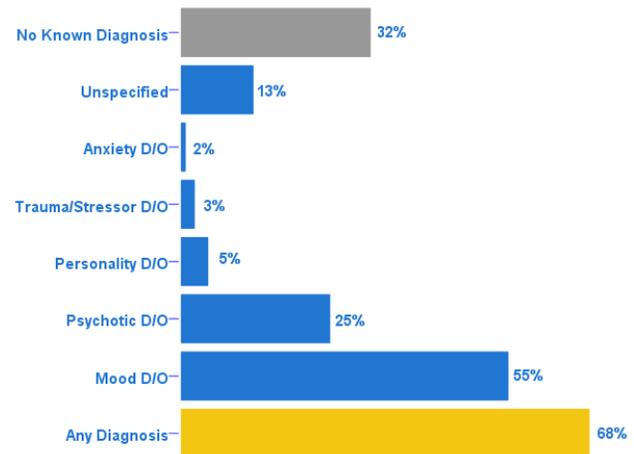
¹⁴ Unpublished DBHIDS outreach activity report

¹⁵ <http://www.csh.org/data>

DATA

Over two-thirds (68%) of the homeless decedents were diagnosed with a mental health disorder at some point in their lives. Over half (55%) had been diagnosed with a mood disorder, such as bipolar disorder or depression, and one-quarter had been diagnosed with a psychotic disorder, such as schizophrenia. For 13% of the decedents, the type of mental health disorder was unspecified, which typically meant the next of kin did not know the exact name of the mental illness with which the decedent had been diagnosed.

Fig. 3.1 Decedents by Mental Health Diagnoses (N=269)*



*Decedents may have more than one mental health diagnosis.

One hundred eighty-three (68%) of the homeless decedents had a known history of mental illness. Over half (56%) of these decedents with mental illness had had a Crisis Response Center (CRC) visit in Philadelphia at some point, with 14% of them having had such a visit within the three months preceding death. Looking specifically at involuntary hospitalizations (known as a “302” in Pennsylvania), Figure 3.3 shows that 14% of the decedents with a history of mental illness had one 302 within the year preceding their deaths.

Fig. 3.2 Decedents with Known Mental Illness (n=183), by Time Since Last Crisis Response Center (CRC) Visit

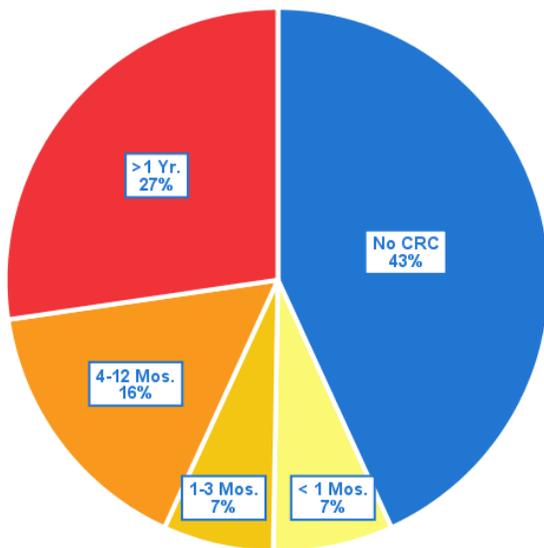


Fig. 3.3 Decedents with Known Mental Illness (n=183), by Time Since Last Involuntary Hospitalization (302)

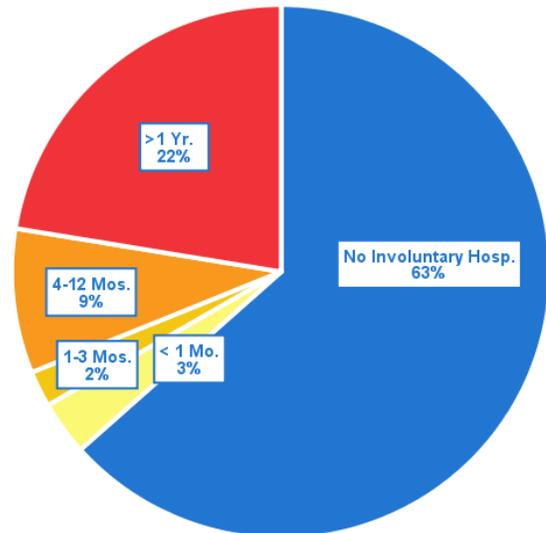
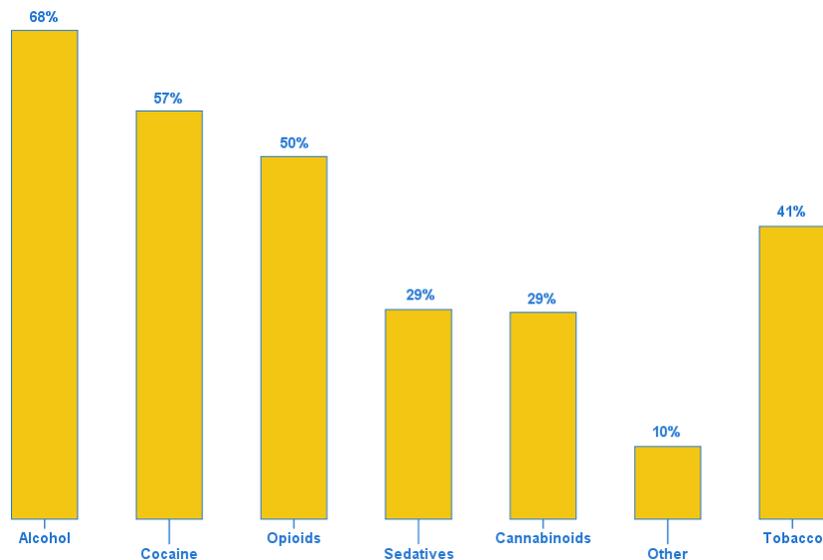


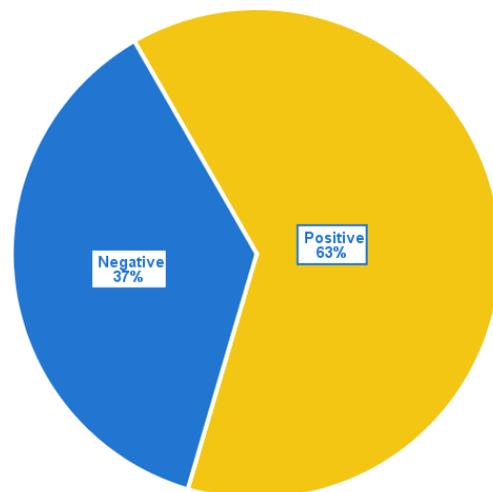
Fig. 3.4 Decedents by Substance Use/Abuse* (N=269)



* Decedents may have abused more than one substance.

Two hundred thirty-five (87%) of the homeless decedents had a known history of a substance use disorder. Alcohol was the most commonly abused substance (68% of all decedents), with cocaine and opioids close behind (57% and 50% respectively). The “Other” category includes abuse of PCP (6%), amphetamines (3%), and hallucinogens (1%).

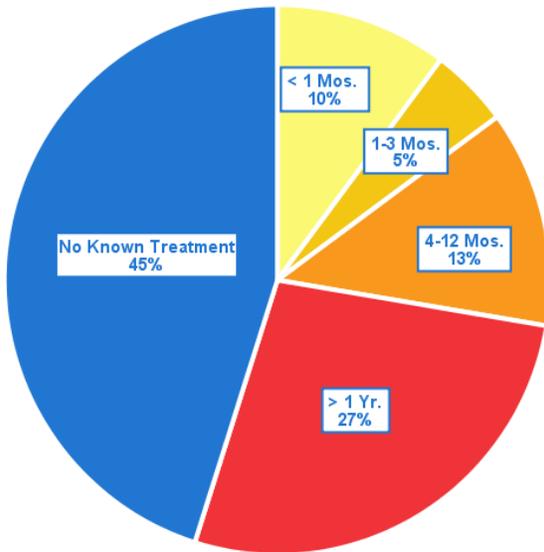
Fig. 3.5 Decedent’s Toxicology Findings at Time of Death (n=229)*



*Analyses were not performed on 40 decedents; toxicology testing did not include cannabinoids (marijuana)

As mentioned previously, just over half of the decedents had drugs or alcohol as a primary or contributing cause of death. Of the 229 decedents who underwent toxicology testing, nearly two-thirds (63%) had alcohol or an illicit substance in their body at the time of death.

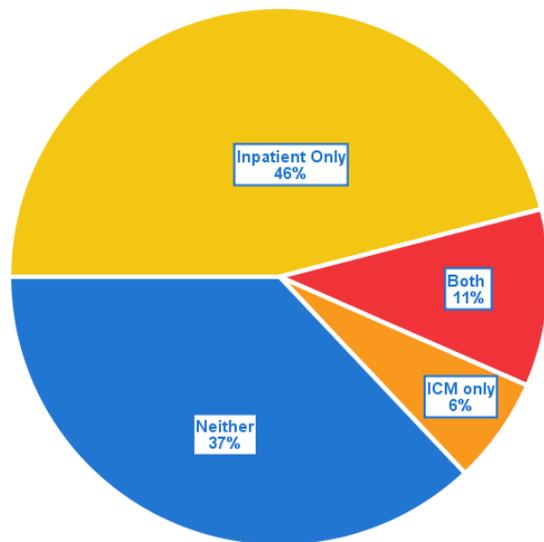
Fig. 3.6 Decedents with Substance Use Disorder (n=235), by Time Since Last Drug & Alcohol (D&A) Treatment



Despite the large percentage of decedents with a documented history of a substance use disorder, only about 55% of those decedents were known to have ever undergone drug and alcohol treatment in Philadelphia. Fifteen percent of the decedents with substance use disorders had received drug and alcohol (D&A) treatment within three months of their death.

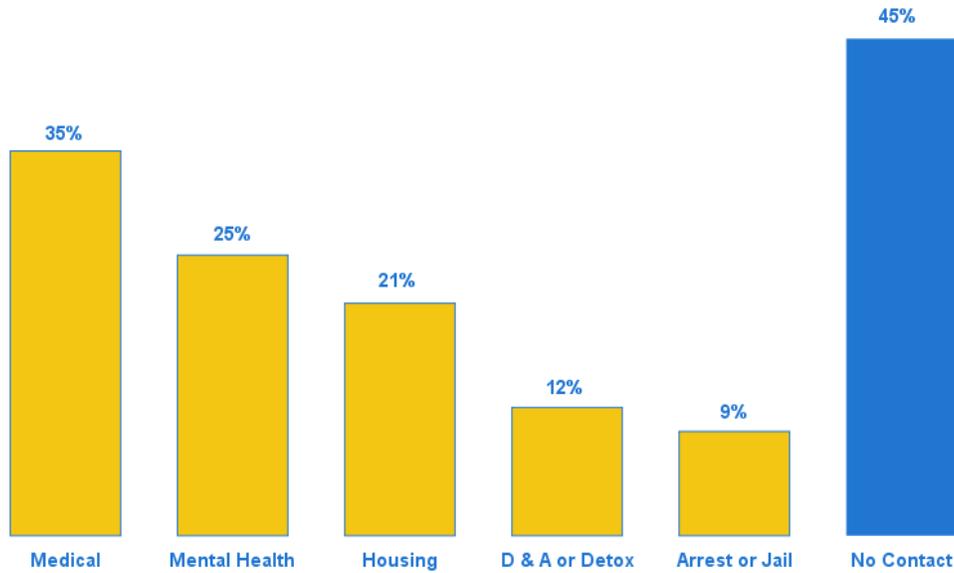
*Drug and/or alcohol inpatient or outpatient treatment only.

Fig. 3.7 Decedents with Substance Use Disorder (n=235), with History of Inpatient Treatment or ICM



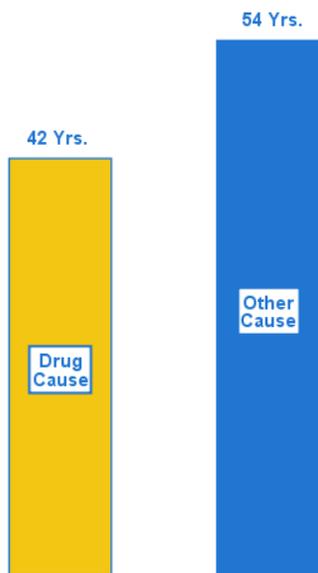
Over half (57%) of the decedents with a history of a substance use disorder had undergone an inpatient D&A treatment (which includes “detox”), and 17% had had Behavioral Health Special Initiative (BHSI) intensive case management (ICM) at one time.

Fig 3.8 Decedents with Drug- or Alcohol-Related Deaths (n=138), by System/Service Contact within Three Months of Death



As mentioned previously, a difference in the characteristics of homeless decedents who died from unintentional drug overdose was noted. Ten of the decedents who died from an unintentional drug overdose had recently been released from jail and hadn't yet secured permanent housing.

Fig 3.9 Mean Age of Death for Drug-Related Deaths (n=115) and for Non-Drug-Related Deaths (n=154)



In addition, the homeless decedents who died from unintentional drug overdose (115 or 43% of the total) tended to be younger (age of death = 42 vs. 54), were more likely to be white (54% vs. 36%), and were more likely to be Hispanic (17% vs. 8%) than the homeless decedents who died from other causes.

Fig 3.10 Race/Ethnicity for Drug-Related Deaths (n=115)

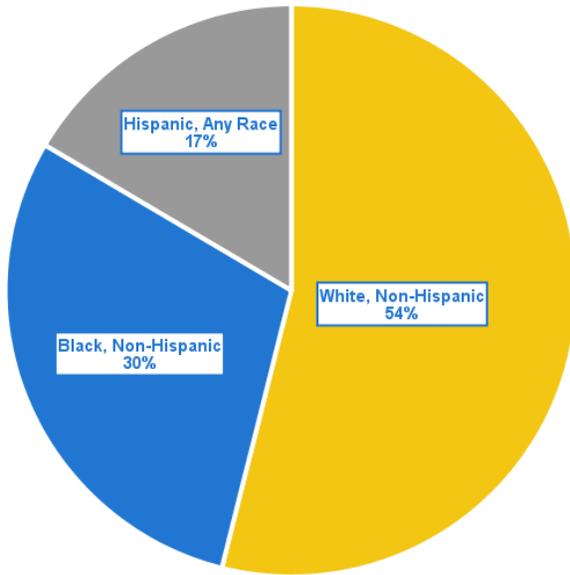
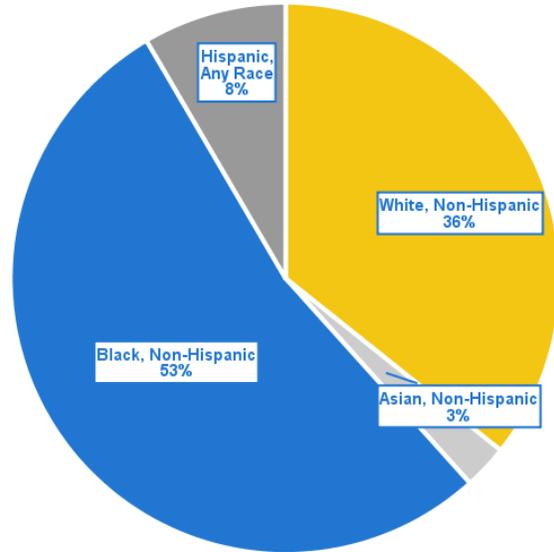
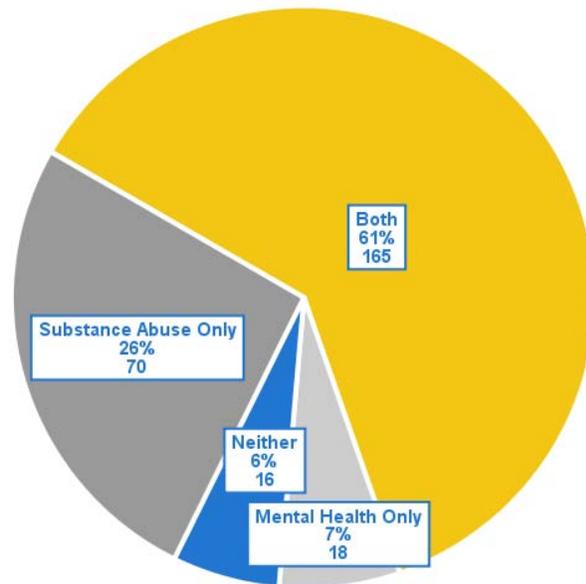


Fig 3.11 Race/Ethnicity for Non-Drug-Related Deaths (n=154)



Behavioral health diagnoses are prevalent among homeless people in general and overrepresented among the homeless decedents reviewed. As mentioned previously, 87% had a history of a substance use disorder and 68% had a history of mental illness. Nearly two-thirds (61%) of the homeless decedents reviewed were dually-diagnosed, having both a substance use disorder and a mental illness. Providing the proper behavioral health care for dually-diagnosed individuals is particularly challenging. When adding in the element of homelessness and the lack of sufficient community resources to treat those with co-occurring disorders, this presents an even greater obstacle to the health and well-being of the homeless population in Philadelphia.

Fig 3.12 Decedent History by Behavioral Health Conditions (N=269)



RECOMMENDATIONS

1. The Department of Behavioral Health and Intellectual disAbility Services should examine whether there is sufficient capacity and access to low demand, behavioral health-supportive safe haven slots or progressive demand residences in Philadelphia and, if necessary, increase the capacity

There already aren't enough beds in Philadelphia to provide housing for all the homeless people who need it. Homeless people with unmanaged behavioral health challenges are going to cost the city money, whether through increased emergency department visits, inpatient hospitalizations to treat their mental health conditions, spending time in an emergency shelter bed, or encounters with law enforcement. Providing a stable safe haven or progressive demand residence placement that includes behavioral health support, such as peer support, is a strategy that is better for the homeless individual and could also save Philadelphia money in the long run.

2. Support citywide efforts surrounding the prevention and treatment of substance use disorders.

Substance use disorders are common in Philadelphia, and people who are addicted to drugs are at increased risk for homelessness. The increase in opioid use over the past several years has contributed to a marked increase in drug-related deaths. Preventing people from developing substance use disorders and providing adequate treatment to those already addicted can help decrease the number of drug-related deaths and the number of people experiencing homelessness, as well as potentially save costs to multiple city agencies. The Mayor's Task Force to Combat the Opioid Epidemic in Philadelphia issued eighteen aggressive recommendations detailing the necessary work to be completed, with two recommendations specifically noting housing and homelessness. In alignment with these recommendations, DBHIDS expanded the capacity of Medication-Assisted Treatment throughout the city, continues to provide Narcan administration training and distribute Narcan to various entities and community members across the city, and expanded the BHSI Intensive Case Management by adding a specialized team for this population.

In addition to the Mayor's Task Force recommendations, some ways to achieve this goal could be:

- a. DBHIDS to create and sustain an Overdose Fatality Review Team
- b. Conduct a needs assessment on the barriers to treatment for inpatient D&A care

3. Strengthen the coordination and communication between hospitals and Community Behavioral Health (CBH) for individuals with behavioral health conditions, particularly for involuntary commitments of individuals with a history of homelessness.

As the data from the report have shown, many of the homeless decedents had a history of behavioral health conditions, with many of them having had involuntary commitments and emergency psychiatric evaluations. Many of these homeless decedents have complicated histories, but some of them have case managers. An important opportunity to best meet a homeless person's behavioral health needs would be to coordinate with these case

managers at the time of engagement with emergency departments or inpatient services.

Some of the ways to hopefully achieve this goal could be:

- a. CBH to find ways to encourage hospitals to call them back with the disposition of a patient after CBH authorizes payment for services
- b. Hospitals need better and timelier access to on-call case management
- c. CBH Quality Review Team should do special audits of select cases of homeless deaths, individuals with co-occurring diagnoses, and those with severe mental illness
- d. CBH should add a new alert code to the alert system in its clinical information system database that would notify CBH care managers about a client's increased suicide risk

4. Improve the quality and standards for boarding homes, rooming homes, and recovery houses

Many of the people experiencing homelessness in Philadelphia have passed through boarding homes and recovery houses at one time or another. There are currently no agreed-upon standards for independent operators of such homes. These places of residence are an opportunity to reach out to a segment of our society that is often on the cusp of experiencing homelessness. By creating and improving standards as well as offering more points of engagement, we might be able to decrease the number of people who move on to being homeless.

Some of the ways to hopefully achieve this goal could be:

- a. Licenses and Inspections (L&I) should partner with boarding home operators to create quality standards for recovery houses, including creating an eviction process
- b. DBHIDS to continue to expand the capacity of DBHIDS-funded Recovery Houses, all of which are required to accept individual on psychiatric medications and Medication-Assisted Treatment

5. Other recommendations:

- a. Create more capacity and expertise to work with individuals with co-occurring diagnoses
- b. Ensure that people with severe mental illness who are released from Mental Health Court after a 302 evaluation are provided the proper resources and engagement
- c. DBHIDS to partner with the Office of Homeless Services (OHS) to establish suicide prevention and assessment training protocols in all Philadelphia shelters and help ensure more Mental Health First Aid training occurs at these sites
- d. For years, DBHIDS has been challenged with nursing home placement for individuals with behavioral health challenges. The state, local Area Agency on Aging, OHS, and others should partner with DBHIDS to help interface with nursing homes and long term care facilities so that individuals with chronic homelessness and behavioral health challenges can be placed
- e. DBHIDS to explore the Critical Time Intervention model for outreach as an alternative for those homeless people who are not eligible for Assertive Community Treatment (ACT) teams

SECTION 4: PHYSICAL HEALTH

BACKGROUND

The medical care for those experiencing homelessness is especially complex in the acute care setting. Homeless people are at high risk for many medical issues, including environmental exposures, the sequelae of infectious diseases, and chronic medical conditions such as diabetes and congestive heart failure, yet their medical care is significantly limited by the lack of housing security, food security, and general safety.

Many homeless patients who require ongoing outpatient treatment and follow up have difficulty accessing the services they need. As a result, homeless patients may return frequently to the emergency department (ED) or require hospital admission for failed outpatient therapy. The existence of comorbid mental illness and substance use disorders further impedes health management and can be an obstacle to reliable medical care.

Another barrier to ED treatment of homeless patients is that a large percentage of them present outside of usual business hours.¹⁶ Limited access to ancillary services during these periods of utilization may not allow for proper engagement with hospital-based social services, city-based services, and intensive coordination of care where appropriate.

The multiple barriers facing homeless patients often prove to be daunting and overwhelming for ED staff members, many of whom do not have a full understanding of how to communicate and coordinate with the city's homeless and behavioral health services systems. As a result, many of these time-constrained ED workers end up feeling helpless and frustrated, and they see their role as nothing more than a temporary band-aid to much larger problems. The ED serves as a safety net for individuals, but it is not intended to serve as the primary or exclusive point of care for those with extensive social service needs beyond emergency medical treatment.

¹⁶ Ku, B., Scott, K., Kertesz, S., and Pitts, S. "Factors Associated with Use of Urban Emergency Departments by the U.S. Homeless Population." *Public Health Reports*. 2010 May-Jun; 125 (3): 398-405.

DATA

Cardiovascular diseases such as hypertension and cardiac disease are common chronic medical conditions in the U.S. These two conditions alone were found in 41% and 23%, respectively, of the homeless decedents. Hepatitis B and Hepatitis C were also common among the homeless decedents, with one-third of the decedents known to be infected with at least one of these viruses.

Fig. 4.1 Decedents by Known Medical Conditions (n=269)

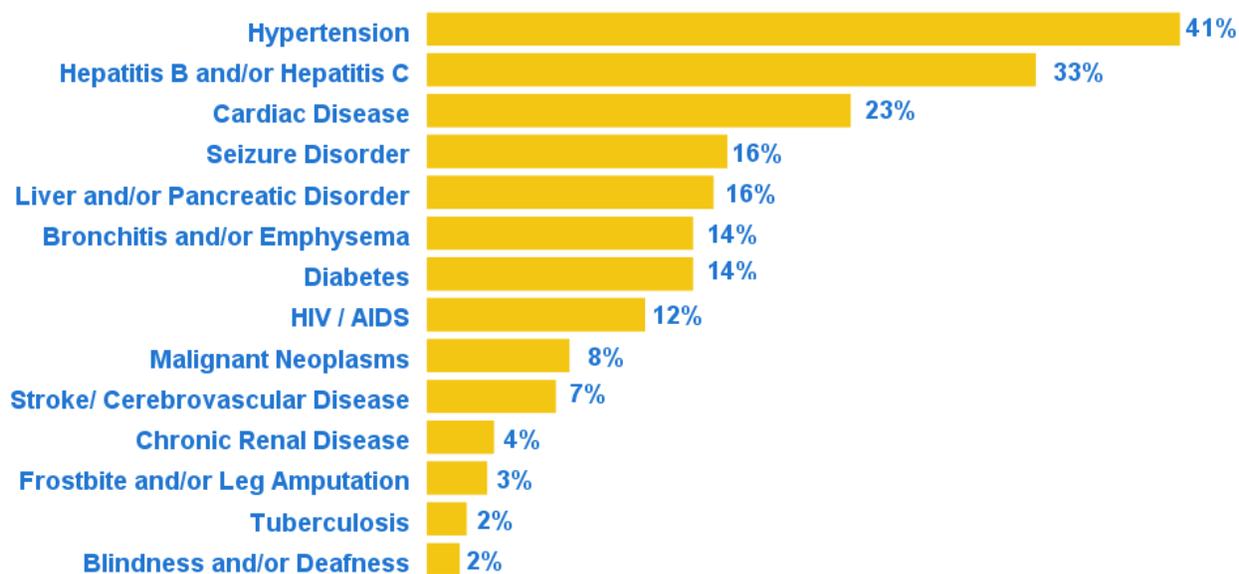
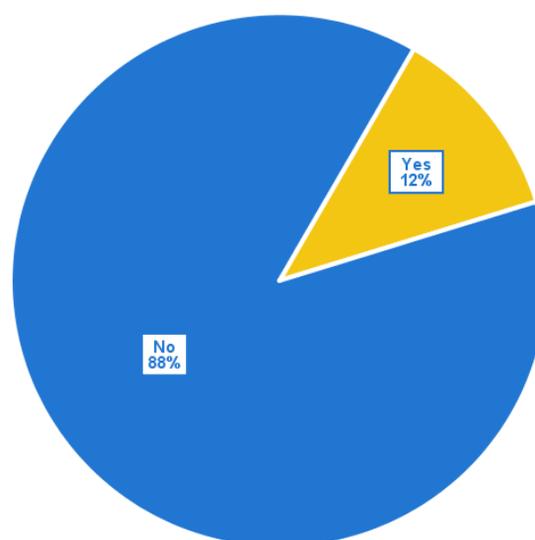
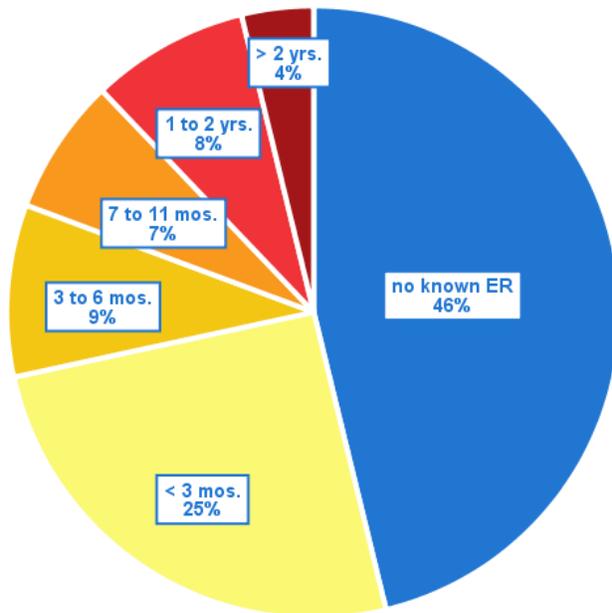


Fig. 4.2 Decedents with Known History of HIV (n=269)



Thirty-one (12%) of the homeless decedents were known to be HIV positive, while six decedents (2% of the total) died as a direct or indirect result of their HIV infection. The relatively large percentage of homeless decedents having infectious diseases such as Hepatitis C and HIV is not surprising, as many of these decedents also had a history of a substance use disorder and these viruses are easily spread through injection drug use.

Fig. 4.3 Decedents by Time Since Last ED Visit (N=264)*



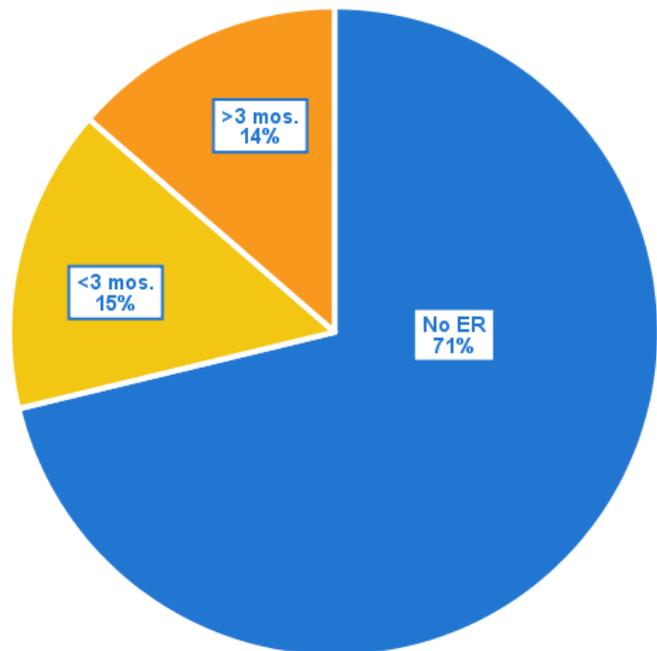
*5 decedents were not included due to unknown service dates

Nearly half of the homeless decedents reviewed had no known history of treatment in a Philadelphia ED. However, this number may be an overestimation, as the HDRT had the input of just three of Philadelphia’s five major hospital systems up until 2016. In addition, at least 5% of the homeless decedents had only been living in Philadelphia for a relatively short period of time prior to their death. Finally, many of the homeless decedents had numerous aliases, which made looking up their ED visit history all the more difficult.

However, the numbers also show what a frequent point of contact an ED is for Philadelphia’s homeless population, as one-quarter of the homeless decedents visited an ED within three months of death. The ED serves as an important point of potential engagement for interventions.

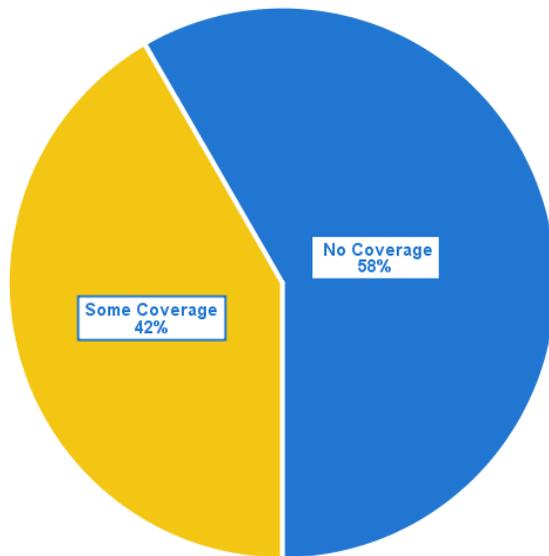
When looking more closely at the “hidden homeless” (those unknown to the city shelters and street outreach), we see a different picture of ED usage as compared to the general population of homeless decedents. The hidden homeless not only tend to eschew shelters, but they also tend to avoid other systems, including both medical systems and social services. Nearly three-quarters (71%) of the hidden homeless had no known ED contact, meaning that policy planners will need to utilize different strategies in order to engage them.

Fig. 4.4 “Hidden Homeless”* by Time Since Last ED Visit (N=66)



* defined here as those unknown to shelters AND outreach systems

Fig. 4.5 Decedent's Insurance Status at Time of Death
(N=269)



Over half of the homeless decedents (58%) did not have any health care coverage (such as Medicaid, Medicare, or Veterans health care coverage) at the time of their death. With all the medical and behavioral health conditions that homeless people tend to have, the lack of health care coverage can lead to unmet healthcare needs, overburdening of EDs, and increased morbidity and mortality. Most of the homeless decedents would have qualified for some form of health care coverage had they completed an application, which highlights the additional burdens many of them face in order to sign up and maintain health insurance.

RECOMMENDATIONS

As Philadelphia's homeless population ages and their needs become greater, the strain that will be felt by emergency departments and hospitals will increase.

1. Create a more coordinated process for hospital and emergency department (ED) discharges of people identifying themselves as homeless

The ED is a relatively frequent point of contact for homeless persons in Philadelphia that can serve as an opportunity for intervention, especially as a critical time for housing intervention. However, staff members in Philadelphia EDs often don't have direct or easy access to the most updated homeless resources as well as patients' case workers or intensive case managers.

Some of the ways to achieve this goal could be:

- a. Employ the Critical Time Intervention (CTI) model with hospital discharges, particularly with involuntary commitment and ED discharges. The CTI model, which was pioneered in New York in the mid-1980s, is an evidence-based practice that is designed to prevent recurrent homelessness, particularly for people with severe mental illness
- b. The Office of Homeless Services (OHS) should coordinate with hospital, CRC, ED, and jail staff, providing them with up-to-date shelter information, training them on how to talk about and help people access shelters, and creating a constant conversation about needs and challenges, especially as regards the discharge process for homeless individuals
- c. Hospitals should staff EDs with homeless interventionists or peer recovery coaches – workers who could focus on homelessness and overdose reversals but could also fulfill other roles in the ED such as offering rapid HIV testing, HIV counseling, and other services
- d. Create a mechanism (such as Accountable Care Organizations) for stronger coordination between EDs and Managed Care Organizations around “high utilizers”

2. Create a Philadelphia Emergency Department (ED) Leadership Group that would promote collaboration and efforts on standardization among EDs across the city

In a city of 1.5 million people but just a small handful of major hospital systems, the opportunity for citywide standardization is ripe. Despite the concern of competition, models of collaboration already exist in Philadelphia health care: the Obstetrics & Gynecology department chairs have been meeting since 2007 and the Philadelphia Labor & Delivery Leadership Group was created in 2015. An ED leadership group in Philadelphia, comprised of physicians, nurses, and social workers from the different EDs in conjunction with EMS workers, could collaborate by sharing best practices among each other, engaging in joint educational activities, and possibly working on joint research opportunities. If large enough, the leadership group might have subgroups or committees, such a group that dealt specifically with homelessness issues, or one that dealt with HIV testing, an important subject that is often the focus of discussion with the city's FIMR-HIV team.

3. Help homeless individuals enroll in and maintain enrollment in Medicaid

As described earlier in this report, the homeless decedents had many chronic medical and behavioral health conditions. While most of the decedents qualified for Medicaid, the majority of them had no health insurance at the time of death. As a result, most of the medical care the decedents received was provided in an emergency department. If more of the homeless decedents had active medical insurance, they would have had more opportunities to receive the medical care they needed at the time they needed it and perhaps that would have resulted in less morbidity and mortality.

Some of the way to achieve this goal could be:

- a. Reduce the barriers for obtaining Medicaid posed to individuals without a fixed home
- b. Increase the time between Medicaid renewals from annually to every two years, as it was previously

4. Health insurance plans and hospitals should partner with city officials to expand the number of medical respite beds in Philadelphia

Medical respite care provides an opportunity to safely transition patients with unstable housing from a hospital to a safe environment to recuperate from an acute illness. As of 2016, there were 78 medical respite programs in the United States.¹⁷

A shelter-based model allows organizations to utilize existing facilities for medical respite. This model provides a low-cost, rapid path for implementing a service that fills the gap between hospital and shelter. In 2014, Public Health Management Corporation in conjunction with DePaul House opened up Philadelphia's first and only medical respite program for homeless individuals. With four beds as of February 2017, it is a wonderful start for Philadelphia respite care capacity, but it is currently only accessible to ambulatory males and is not nearly enough to meet the medical respite needs of the city.

¹⁷ https://www.nhchc.org/wp-content/uploads/2011/10/2016-MEDICAL-RESPITE-PROGRAM-DIRECTORY_FINAL2.pdf

SECTION 5: ADDITIONAL DATA

WEATHER-RELATED DEATHS

There has always been a concern of weather, especially extreme temperatures, causing homeless deaths. Many in Philadelphia have been surprised to find that fewer homeless people freeze to death on the streets than was previously thought. And hyperthermia (overheating) has never been implicated in the cause of death for a homeless decedent in Philadelphia since the HDRT started reviewing deaths in 2009.

Part of the reason for the lower-than-expected number of winter-related deaths among homeless people is the city's Winter Initiative. From December through March, the City of Philadelphia increases the number of emergency housing beds available, thus decreasing the number of people without shelter.

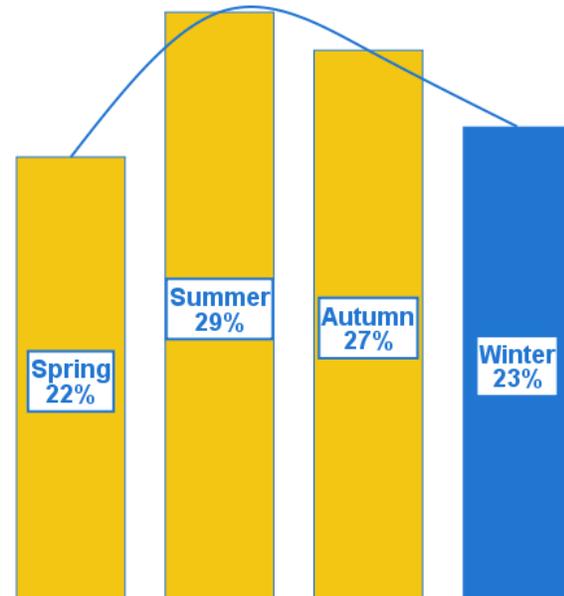
During the 2016-2017 Winter Initiative, 404 emergency shelter beds were made available.

Another part of Philadelphia's Winter Initiative is activating a "Code Blue" emergency whenever the National Weather Bureau predicts wind chill temperatures of 20 degrees Fahrenheit (or 32 degrees Fahrenheit with precipitation) or lower. The Code Blue activities include:

- an increase in homelessness outreach coverage, including extended hours;
- access to vacant emergency shelter beds funded by the Office of Homeless Services (OHS);
- prohibition of evictions and termination from emergency housing ; and
- implementation of court-ordered transportation to shelter by the police.

Thus, despite winters typical of other Northeastern U.S. cities with extremes of temperatures, very few homeless deaths in Philadelphia were weather-related. There were only five cases of hypothermia (low body temperature) as a primary or contributing cause of death during the five-year span covered in this report.

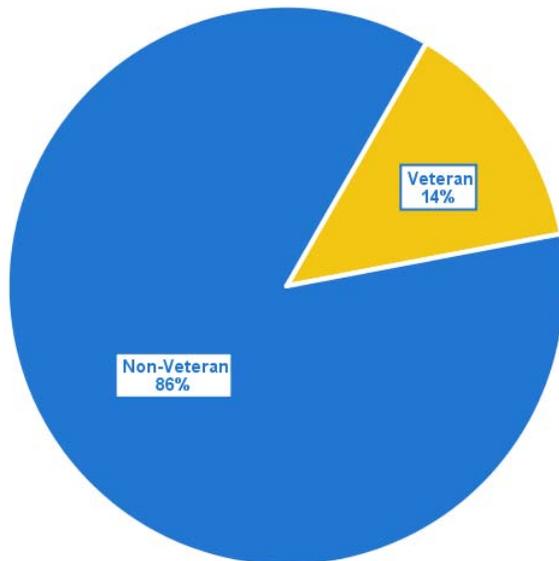
Fig. 5.1 Homeless Deaths by Season* (N=269)



*start: Spring 3/20; Summer 6/21; Autumn 9/22; Winter 12/21

VETERANS

Fig. 5.2 Decedents by Veteran Status* (N=269)



*Veteran status is based on Veterans Administration criteria, and does not include all men and women who served in the U.S. armed forces

A local collaborative known as “Philly Vets Home 2015” celebrated an effective end to homelessness among veterans in December 2015 and reports more than 1800 veterans housed since 2011. Four communities were approved and recognized by the White House, Veterans Administration (VA), HUD, and USICH (the US Interagency Council on Homelessness) for having effectively ended veteran homelessness in their communities: New Orleans, Houston, Las Vegas, and Philadelphia. An effective end to homelessness means that communities have (1) a process and system to identify veterans at risk for homelessness, and (2) the resources and coordination to rapidly and effectively provide assistance and housing. Comparing the 2010 and 2015 Point-in-Time counts, Philadelphia saw a 77% reduction in the number of unsheltered veterans.

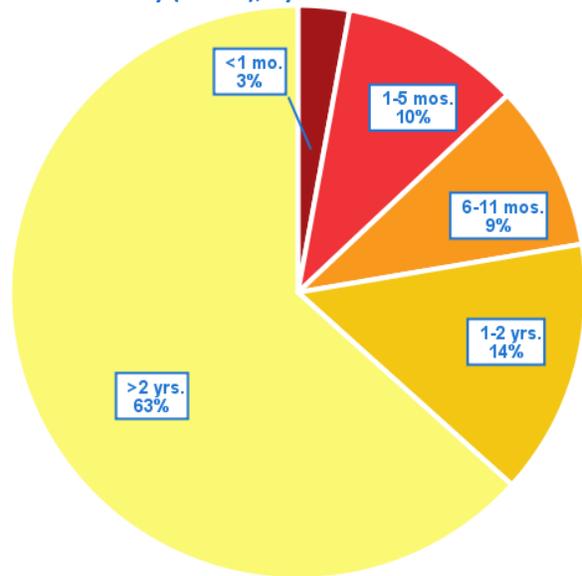
Using a by-name list to identify, engage, and ultimately house veterans has been a central component of the team’s success. The collaboration with the VA has increased accuracy in identifying veterans and connecting them with housing and other services for which they are eligible.

When looking specifically at the 269 homeless people who died in Philadelphia over the five-year period of this report, we have seen a gradual decrease in the percentage of those who were veterans. Overall, there were 37 individuals (14% of all deaths) who were reported to have been veterans, but this number has dropped from over 15% in 2011-2012 to 12% in 2013-2015.

CRIMINAL JUSTICE INVOLVEMENT

A narrow majority of the homeless decedents we reviewed (52%) had been incarcerated. Most of the crimes committed were drug-related or non-violent. A small but significant number of the decedents (10) had been discharged from a prison or jail less than six months before their death. For those with a substance use disorder, an additional potential threat is the loss of tolerance to their drugs of abuse during incarceration, so that a dose that previously got them high could now cause a fatal overdose. A particularly dangerous situation appears to have resulted when a person with a history of a substance use disorder was let out of jail but not connected to drug treatment services. The team reviewed several cases of decedents who died of an accidental drug overdose days to weeks after release.

Fig. 5.3 Decedents with Known Incarceration History (n=139), by Time Since Release



RECOMMENDATIONS

1. OHS to maintain the system of Code Blue emergencies and the availability of winter beds, which prevent deaths due to hypothermia.

Public health interventions are often victims of their own success. By solving problems, the public forgets that the problem ever existed and may challenge the rationale to continue to fund efforts to prevent the recurrence of the problem. Philadelphia's Winter Initiative has been amazingly successful, as demonstrated by the fact that an average of one homeless person per year has died from hypothermia in a city of over 1.5 million people with over 6000 homeless people at any one time.

2. Strengthen the discharge policies and procedures of those leaving jails, especially for those with a history of a substance use disorder

Every person leaving prison or jail is in need of good discharge planning with re-entry options. The HDRT has learned that a discharge is a particularly vulnerable time for the person who doesn't have a home or household to which they can return, especially if that person has a history of a substance use disorder.

Consistent with the recommendations by the Mayor's Task Force to Combat the Opioid Epidemic, some of the ways to achieve this goal could be:

- a. Provide Narcan and Narcan administration training to inmates with a history of opioid abuse when they are leaving jail
- b. DBHIDS to improve coordination between prisons and Forensic Services provided by DBHIDS, including but not limited to Forensic Intensive Recovery (FIR), evaluation and assessment resources, housing, jobs, and reconnection to communities
- c. Courts to create more programs to divert and help sex workers (instead of sending repeat offenders to jail, connect them with therapeutic and re-entry services)

3. Homeless advocates should encourage more cities and counties to track the number of homeless deaths

If cities and counties do not know how many homeless people are dying in their jurisdictions, they will never know if the problem is getting better or worse over time, nor will they be able to track the success of any interventions. For some cities and counties, tracking homeless deaths could be the first steps toward taking a more systematic approach to dealing with the local issues that contribute to homeless deaths, including but not necessarily limited to starting their own homeless death review teams.