CITY OF PHILADELPHIA HOMELESS DEATH REVIEW

April 2012

2009-2010 Report

A report on the homeless individuals who died in 2009-2010 and were reviewed by the Philadelphia Homeless Death Review Team

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EXECUTIVE SUMMARY

Philadelphia's Homeless Death Review Team (HDRT) identified 90 persons who met homeless criteria at the time of death from the beginning of 2009 to the end of 2010. The average age of death was 53 years. Of the 90 persons reviewed, 83 percent were male; 63 percent were African American; and 39 percent were considered chronically homeless. Twenty-three percent of the decedents were unknown to city homeless service systems, including emergency shelter and street outreach services, while nine percent had some street outreach contact but no history with shelter. Despite winters with severe temperatures and record snowfalls in both 2009 and 2010, surprisingly few homeless deaths were weather-related: only five cases of hypothermia as a primary cause of death during the two-year span are covered in this report. As a result of data collected and analyzed during the review of 2009-2010 deaths, the HDRT found that:

- 74 percent of decedents had at least one known chronic (physical) medical condition at time of death.
- 52 percent of decedents had documentation of psychiatric illnesses.
- 63 percent of decedents had a history of substance use/abuse, with 44 percent of decedents having drug or alcohol intoxication as a primary or contributing cause of death.
- Yet 61 percent of decedents had no health care coverage at the time of death.

In Philadelphia, there is a comprehensive system of care for physical, mental, and behavioral health available for people experiencing homelessness. Ninety-four percent of the homeless decedents encountered one or more homelessness-related service systems during their lifetime, with more than one-half interacting with three or more. Just over one-third came into contact with at least one system in the last 30 days of their lives. Based on our data, we conclude that:

- Gaps in health care and/or coverage may contribute to inadequate access to appropriate care.
- For individuals with multiple physical and behavioral health conditions, lack of coordination among systems may contribute to unmet needs and housing instability.
- The scarcity of housing subsidies and restrictions on and reductions in service funding limit the number of people who can be assisted.

In part as a result of HDRT findings, the City of Philadelphia has already taken the following actions in support of its goal to end homelessness:

- The City and stakeholders have developed a process to prioritize chronic, vulnerable individuals for engagement, treatment, and housing.
- The City has increased the number of long-term residential drug treatment slots for chronically homeless men and women to overcome addiction.
- The City has expanded the City's Housing First inventory for seriously mentally ill homeless individuals and individuals dually diagnosed with mental illness and addiction; and developed options for those addicted to alcohol with no immediately observable mental illness.

The HDRT recommends the following actions be taken as part of Philadelphia's goal to end homelessness:

- Continue to seek resources to increase permanent supportive housing and appropriate services.
- Continue to identify and explore best practices to address addiction and those with dual diagnoses.
- Formalize partnerships and data sharing between the homeless service system, managed care organizations, and hospitals to improve coordination and discharge planning processes.
- Consider a medical respite program for Philadelphia that is connected to long-term housing.

This 2009-2010 Homeless Death Review Report presents the mortality data below to further the efforts of those working to end homelessness.

BACKGROUND | SECTION ONE

History of the Homeless Death Review

In January 2009, the City of Philadelphia established a Homeless Death Review process in response to the death of Jeffrey Williams, a wheelchair bound man experiencing homelessness who died in search of a place to sleep. Jeffrey was attempting to cross a highway median after being turned away from an overnight drop-in center that was full. A Good Samaritan pulled over and attempted to help Jeffrey. Both were struck by a car and killed.

After Jeffrey's death in 2008, staff at the City of Philadelphia's Office of Supportive Housing (OSH) and Department of Behavioral Health (DBH) proposed that the Medical Examiner's Office (MEO)[1] establish a Homeless Death Review process in order to review and assess every homeless decedent. The quarterly Homeless Death Review began in January 2009, becoming the first of its kind in the country.

The Philadelphia Homeless Death Review Team (HDRT) includes representatives from universities, hospitals, and managed care organizations, as well as homeless service providers and representatives from other publicly funded services. The review process is designed to identify changes to policy, protocol, or programs that may prevent future deaths and guide our strategy to end homelessness in Philadelphia.

Methodology

Eligible cases for the HDRT are persons who died within Philadelphia and were homeless at the time of death. Determination of a decedent's homeless status is probably the most difficult task of the HDRT. The Philadelphia HDRT has benefited from homeless death review criteria used in other places, including Los Angeles County, New York City, San Francisco, and King County, Washington. But, the Philadelphia HDRT is primarily guided by aspects of the federal definition of homelessness[2], excerpted below:

The McKinney-Vento Homeless Assistance Act
As amended by S. 896 The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009

SEC. 103. [42 USC 11302]. GENERAL DEFINITION OF HOMELESS INDIVIDUAL.

(a) IN GENERAL.—For purposes of this Act, the term "homeless", "homeless individual", and "homeless person" means—

(1) an individual or family who lacks a fixed, regular, and adequate nighttime residence;

(2) an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

(3) an individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing);

(4) an individual who resided in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided;

[1] The Philadelphia MEO ensures that the HDRT is able to retrieve accurate mortality data for its review. The MEO runs several fatality reviews for the Philadelphia Department of Public Health (PDPH). Previous fatality review reports, as well as other PDPH reports, are available at http://www.phila.gov/health/Commissioner/Reports.html

[2] *McKinney-Vento Homeless Assistance Act as amended by S. 896 The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009*, US Department of Housing and Urban Development (HUD), general definition of homeless individual as at http://www.hudhre.info/documents/HomelessAssistanceActAmendedbyHEARTH.pdf

"Possibly homeless" decedents are identified mainly through a query protocol of the MEO database, but approximately 10 percent of homeless decedents are not known to the Philadelphia MEO. Additional possibly homeless decedents are brought to the HDRT's attention by community partners such as local hospitals, members of the HDRT, and emergency shelter workers. In 2009 and 2010, the HDRT reviewed a total of 90 decedents. Final determination of the decedent's housing/homelessness status was gathered from the following sources:

- Decedent's next of kin (whenever possible)
- Area hospitals: address of record and/or familiarity of decedent with hospital personnel
- The Office of Supportive Housing's shelter database
- Records from non-city emergency or transitional shelters
- Records in the Philadelphia Homeless Outreach Database
- MEO investigators
- Individual HDRT members with personal knowledge of a decedent's housing status

The Philadelphia HDRT has developed a checklist as to which cases qualify as being possibly homeless (Appendix III). After a decedent is identified as possibly homeless, a conference call is convened to conduct a preliminary discussion of the case as well as make a more definitive determination on the decedent's homeless status.

Eventually, a decedent identified as being homeless will be discussed at an in-person review meeting, typically held four to seven months after the date of death. In addition to reviewing persons who were homeless at the time of death, the HDRT reviews a very limited number of decedents (approximately 2-4 per year) who had a lengthy history of homelessness but were not homeless at the time of their death. The reviews of these formerly homeless persons provide a rich discussion about potential gaps in systems and community resources histories. However, no data from the formerly homeless are collected or analyzed in this Homeless Death Review Report.

The number of identified homeless deaths has increased gradually since the inception of the review, from 43 in 2009 to more than 50 in 2011. Since homeless deaths were not formally measured by the City of Philadelphia before, it is not possible to know if the increase is due to an increased rate of homeless death, a routine fluctuation in the relatively small number of cases, an improved efficiency in identifying eligible cases, or some combination thereof.

MORTALITY DEMOGRAPHICS | SECTION TWO

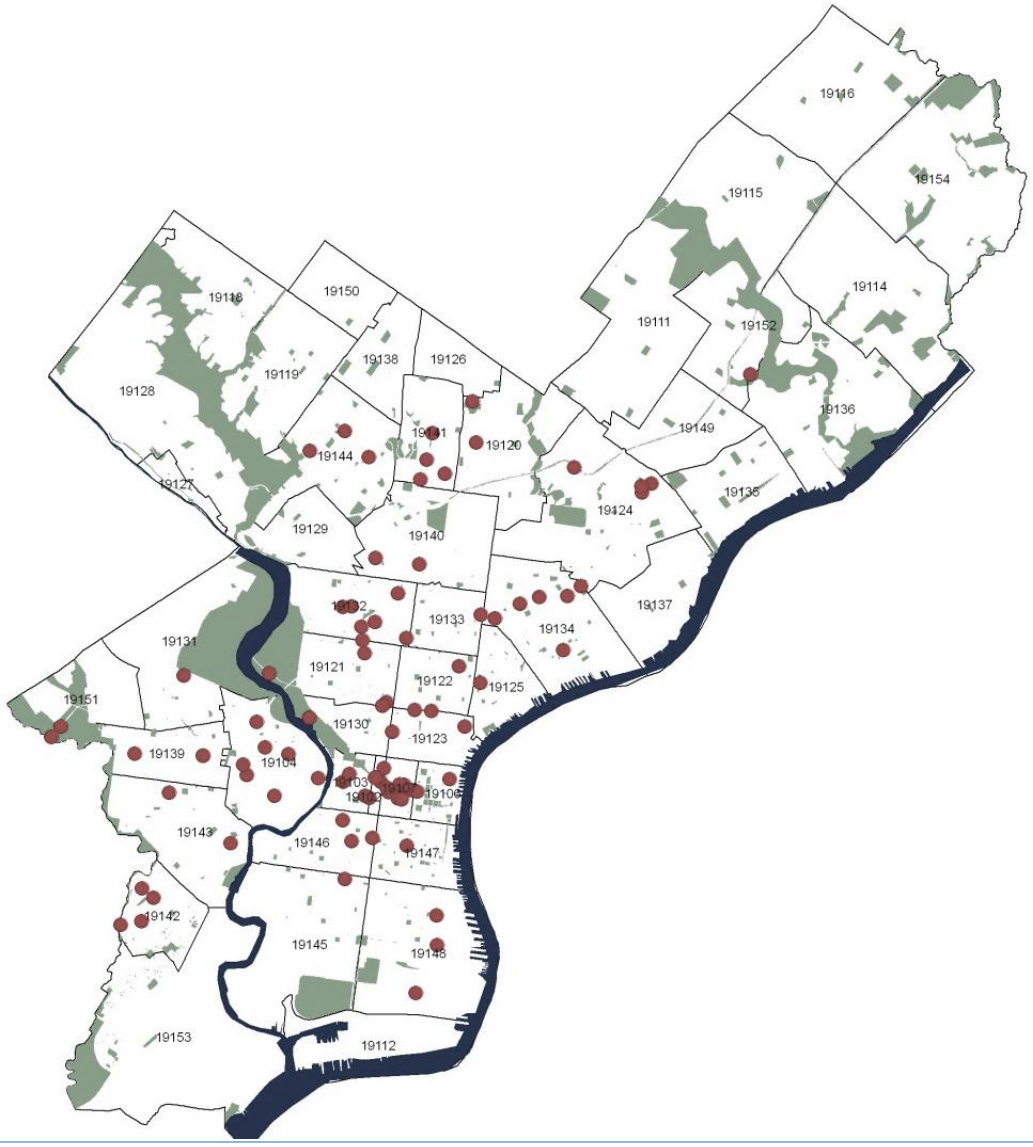
The HDRT identified 90 individuals who died in Philadelphia from 2009 to 2010 and were homeless at time of death. In its investigation of deaths, the MEO collects data regarding location of death, age, gender, and race. While the number of eligible cases is too few to generalize findings to the larger population of people experiencing homelessness in Philadelphia, HDRT observed important tendencies worthy of continued review.

Location of Death

While many homeless services are offered in the Center City region, and Center City is the focus of most street outreach efforts, homeless deaths occurred at sites scattered throughout the City of Philadelphia.

Red dots in Figure 1.1 depict where decedents were living or were found at the incident leading to death, showing that homeless deaths were scattered throughout Philadelphia, with a small concentration near Center City.

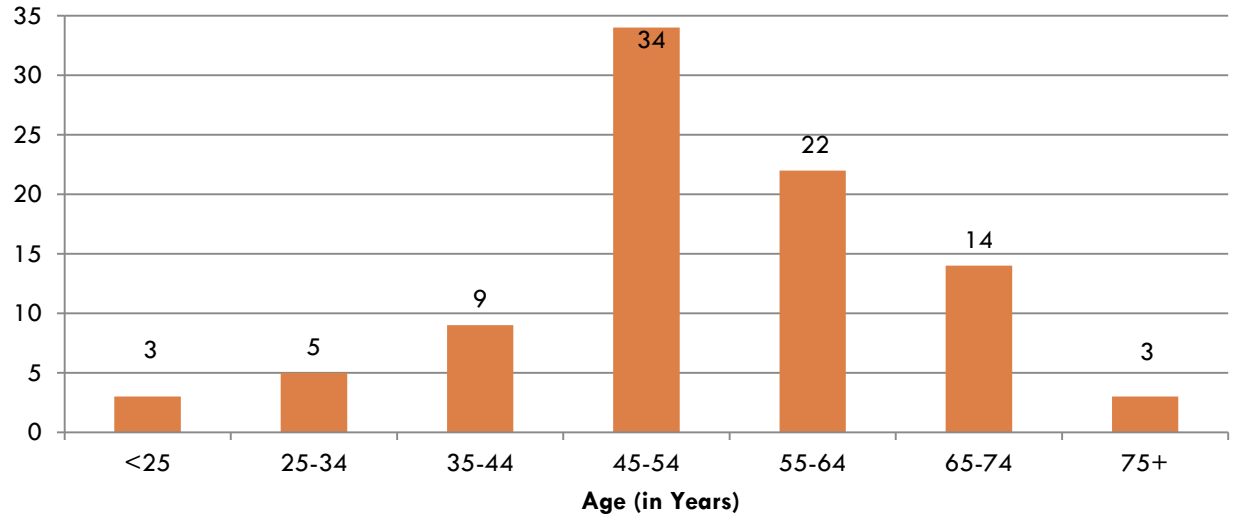
Figure 1.1 Map Of Homeless Death Incidence Location (N=87)*
(does not include three decedents where location of death was unknown)



Age of Decedents

The average age of death among homeless decedents was 53 years. Thirty-four percent of reviewed individuals died between the ages of 45 and 54.

Figure 1.2 Age Of Homeless Decedents



Other cities demonstrated similar findings of premature death among people experiencing homelessness and that homeless people are 3-4 times more likely to die young than the general population.[3] A 2007 study of homeless deaths in Los Angeles County revealed an average age of 48 years.[4] In Seattle, the average age of death was 47.[5] This compares to life expectancy of the general population, which for the United States is 78.5 years.[6]

Gender of Decedents

A majority of Philadelphia homeless decedents in 2009 and 2010 were male (83 percent). This finding is proportionate with the findings of street outreach services, whose contacts in 2010 were 78 percent with males. In 2010 Outreach had contact with approximately 5,319 unique individuals, of whom 78 percent were male and 24 percent were female. Compared to shelter data, however, the ratio of male decedents is higher. Of 7,928 single individuals in shelter in 2011, men comprised 69%; in 2010. In the U.S., of the total sheltered population between October 2009 and September 2010, 62 percent were male and 38 percent were female.7

[3] O'Connell, J. (2005). Premature mortality in homeless populations: A review of the literature. Nashville: National Health Care for the Homeless Council, Inc.
[4] Dying Without Dignity: Homeless Deaths in Los Angeles County, 2000-2007 http://www.nationalhomeless.org/publications/dyingwithoutdignity/dyingwithoutdignity.pdf
[5] King County 2003 Homeless Death Review. Seattle: Health Care for the Homeless Network
[6] Centers for Disease Control and Prevention, Life Expectancy, http://www.cdc.gov/nchs/fastats/lifexpec.htm
[7] SAMHSA (2011). Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States. Retrieved from: http://homeless.samhsa.gov/ResourceFiles/hrc_factsheet.pdf

Race/Ethnicity of Decedents

Heads of household using homeless shelter in Philadelphia are 79 percent African-American, 14 percent White, and one percent Asian.8 Of Homeless Outreach contacts documented in 2010, 78 percent were with African American individuals, 20 percent with white individuals and two percent with people of Asian descent. According to the homeless decedents reviewed, 63 percent were Black/Non-Hispanic, 28 percent were White/Non-Hispanic, four percent were Asian/Non-Hispanic and three percent were Hispanic (of any race). Based on these figures, it appears that White and Asian homeless persons in Philadelphia were disproportionately represented amongst the 2009-2010 decedents as compared to users of homeless shelters and individuals with outreach contacts.

Figure 1.3 Race/Ethnicity Of Philadelphia Shelter Stayers, Outreach Contacts & Decedents

	Shelter Stayers	2010 Homeless Outreach Contacts	2009-2010 Decedents (n=90)
Black, Non-Hispanic	79%	78%	63%
White, Non-Hispanic	14%	20%	28%
Asian, Non-Hispanic	1%	2%	4%
Hispanic (of any race)	N/A	<1%	3%
Refused/no data	6%	N/A	N/A

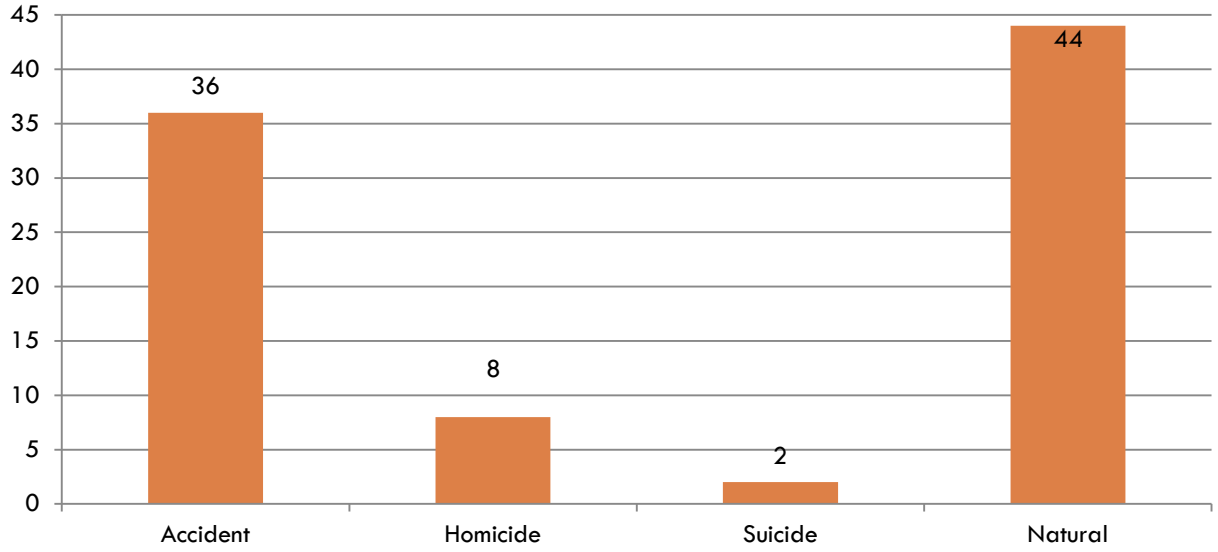
[8] City of Philadelphia, Office of Supportive Housing, Homeless Management Information System (2009)

MANNER AND CAUSES OF DEATH | SECTION THREE

Manner of Death

Similar to the overall general population, the most frequent manner of death for the homeless decedents was natural. [Manner of death can be classified as either homicide, suicide, accidental, natural or undetermined. A natural manner of death is reserved for natural processes, such as infectious diseases, cardiovascular conditions, and cancers.] However, the percentage of cases of accidental death (40 percent of total) as well as homicides (9 percent of total) was disproportionately larger for homeless decedents than for Philadelphia residents as a whole.

Figure 2.1 Manner Of Death For Homeless Decedents, 2009-10 (n=90)



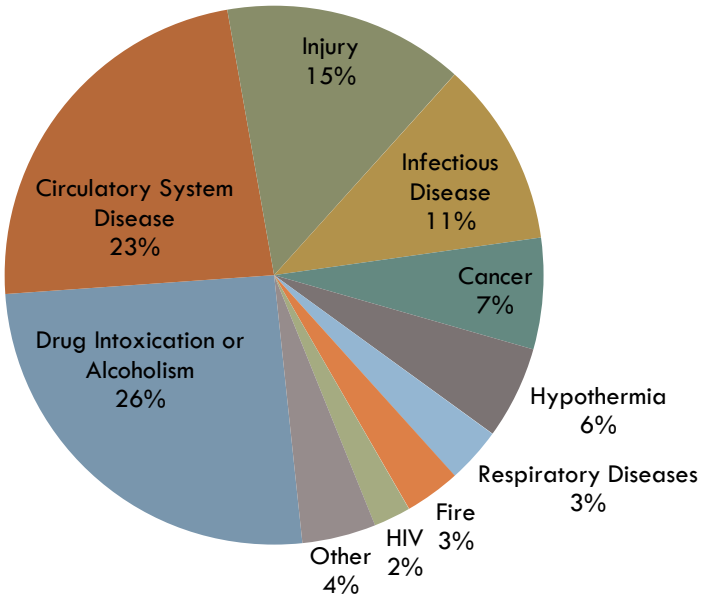
Cause of Death

The leading causes of death in the cohort reviewed were drug intoxication or alcoholism (N=23, or 25 percent) and diseases of the circulatory system (N=21, or 23 percent), with injuries, such as blunt force, stabbings, or gunshot wounds coming in as third most common (N=13, or 14 percent). Figure 2.2 summarizes the primary cause of death as well as conditions that significantly contributed to the death of the individual reviewed. A year-by-year breakdown of causes of death during 2009 and 2010 can be found in the Homeless Death Review Summary in the Appendix.

Figure 2.2 Primary Cause of Death and Significant Conditions Contributing to Death, 2009-10 (n=90)

Categories	Primary Cause	Contributing Condition
	Total	Total
Drug Intoxication or Alcoholism	23	17
Circulatory System Diseases*	21	9
Injury (e.g. blunt force, gunshot wound)	13	1
Diseases of an Infectious Etiology	10	1
Cancer	6	1
Hypothermia	5	6
Respiratory System Diseases*	3	7
Fire	3	0
HIV**	2	2
Diabetes	0	5
Hyperthermia	0	0
Other	4	2
TOTAL	**90**	***

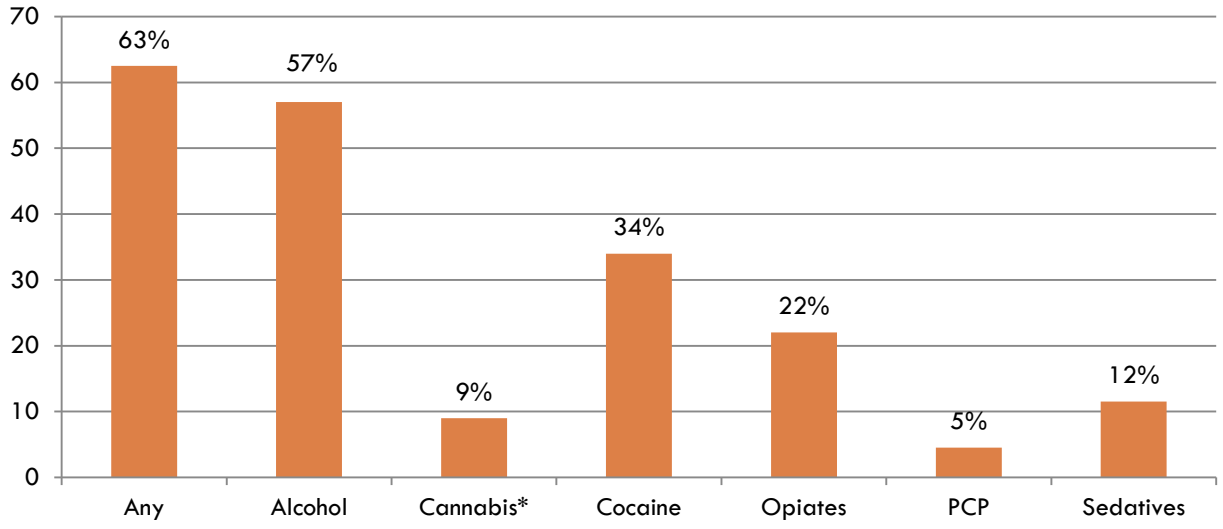
**not including diseases of an infectious etiology (e.g. pneumonia, endocarditis)*
***category selected when HIV caused or contributed to cause of death*
****contributing conditions could be none or multiple conditions*



Substance Abuse

In 2009 and 2010, substance abuse was the most common cause of death among the homeless decedents, playing a role in just under half (44 percent) of all homeless deaths. In 25 percent of the cases reviewed, drug and/or alcohol intoxication was the primary cause of death, and it played a contributing factor in an additional 19 percent of deaths.

Figure 2.3 Percentage of Decedents with Known History of Substance Use, 2009-10 (n=90)



** indicates nine percent for cases in 2010 only (not collected for 2009 deaths)*

Figure 2.3 depicts the substances that were known to be used by the homeless decedents. A known history was determined by the documentation of treatment for substance abuse in medical records, reports by family, or agencies familiar with the decedent, and results found through toxicology screening completed by the medical examiner on autopsy. The HDRT found that 63 percent of Philadelphia's homeless decedents in 2009 and 2010 had a known history of substance use (of any kind). The most commonly abused substance was alcohol, which was used/abused by over half (57 percent) of the decedents.

Circulatory System Diseases

Circulatory system diseases include such ailments as heart disease, high blood pressure, and stroke. Common causes of diseases related to the circulatory system are poor diet, lack of exercise, cigarette smoking, and genetics. In the U.S., diseases of the heart are the leading cause of death. Approximately 12 percent of all adults who are not institutionalized were diagnosed with heart disease in 2010, just one of several circulatory system diseases.[9]

Circulatory system diseases were the second leading cause of death for the homeless decedents, with one-third (33 percent) of them having it as either the primary cause of death or a significant condition contributing to death.

[9]Centers for Disease Control (2010). Heart Disease. Retrieved from: http://www.cdc.gov/nchs/fastats/heart.htm

Injury-Related Deaths

Fifteen percent of decedents died from or experienced death related to injury, the third leading cause among Philadelphia homeless deaths reviewed. Injury deaths include a wide range of incidents, such as blunt force injury sustained from a motor vehicle crash to gunshot wounds sustained from a firearm. Suicide deaths are also included in the injury deaths category, and could be the result of a blunt force injury sustained from a fall.

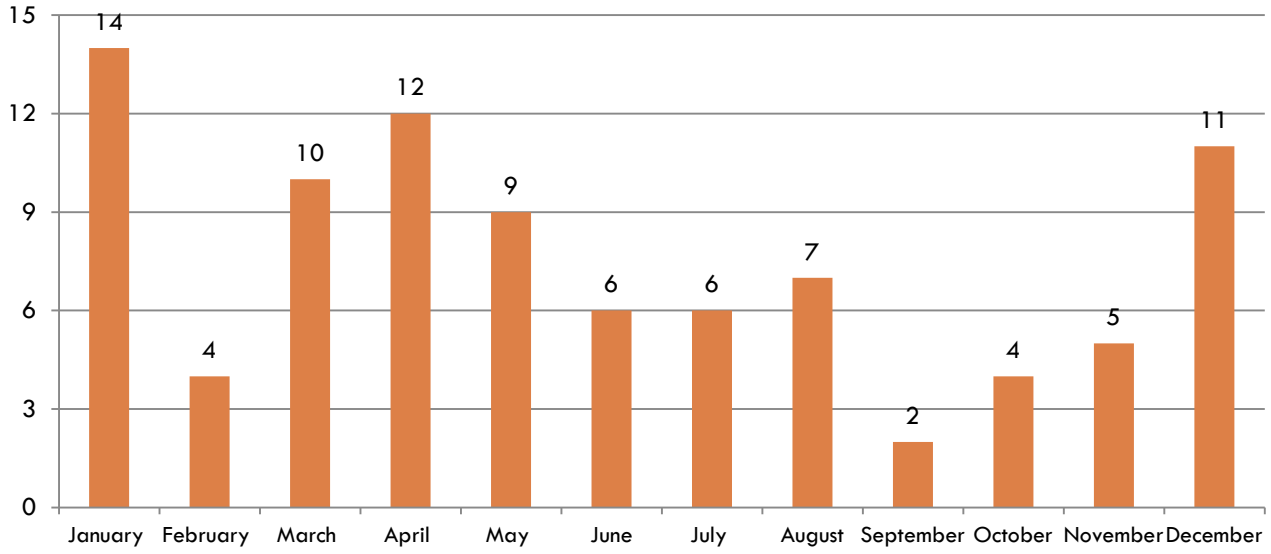
Weather-Related Deaths

There was not one single hyperthermia death (i.e. a death caused by extreme heat) of a homeless person in either 2009 or 2010 – despite a minor heat wave in 2010 that killed a number of Philadelphia citizens.

Contrary to initial expectations, hypothermia was not a major cause of death among homeless persons. In fact, of total hypothermia deaths (where hypothermia either caused or contributed to death) in Philadelphia from 2009 to 2010, only a minority of the cases (11 of 40, or 28 percent) was of homeless individuals.

Also perhaps unexpectedly, homeless deaths do not follow a clear pattern of increase during cold months, as shown below in Figure 2.4. While January had the highest number of homeless deaths at 14, the second highest month was April, with a total of 12 deaths. The start of spring is a time of hope and relief at the end of winter for homeless persons, but it also seems to increase vulnerability.

Figure 2.4 Number of Decedents by Month of Death, 2009-10 (n=90)



→ Since 1987 Philadelphia has followed an aggressive cold weather fatality prevention strategy, known as Code Blue, designed to reduce the number of freezing deaths to zero. When actual temperatures/wind chill is predicted to drop below 20, additional shelter beds are made available, and expanded street outreach personnel utilize all means necessary to bring people at risk of exposure indoors, including court-ordered transportation to shelter and involuntary psychiatric commitment.

Last Service Received before Death

One focus of the HDRT is to review decedents' interactions with systems, particularly publicly-funded systems under the purview of the City, in order to identify potential interventions that may have prevented individuals from dying while experiencing homelessness or future opportunities for strengthened collaboration or program/policy changes that may contribute to preventing future homeless deaths. With that focus in mind, the HDRT examined services received 30 days prior to death and, in particular, the last system each decedent encountered.

Figure 3.1 highlights that 33 of the 90 persons (36 percent) who died while experiencing homelessness had some system interaction that HDRT was aware of within 30 days prior to their death. This includes all deaths occurring while a person was residing in shelter or safe haven settings, as well as outdoors. Shelter was the last contact for one-third of those who had a system interaction 30 days prior to their death; and homeless services (shelter and street outreach) accounted for 54 percent of encounters.

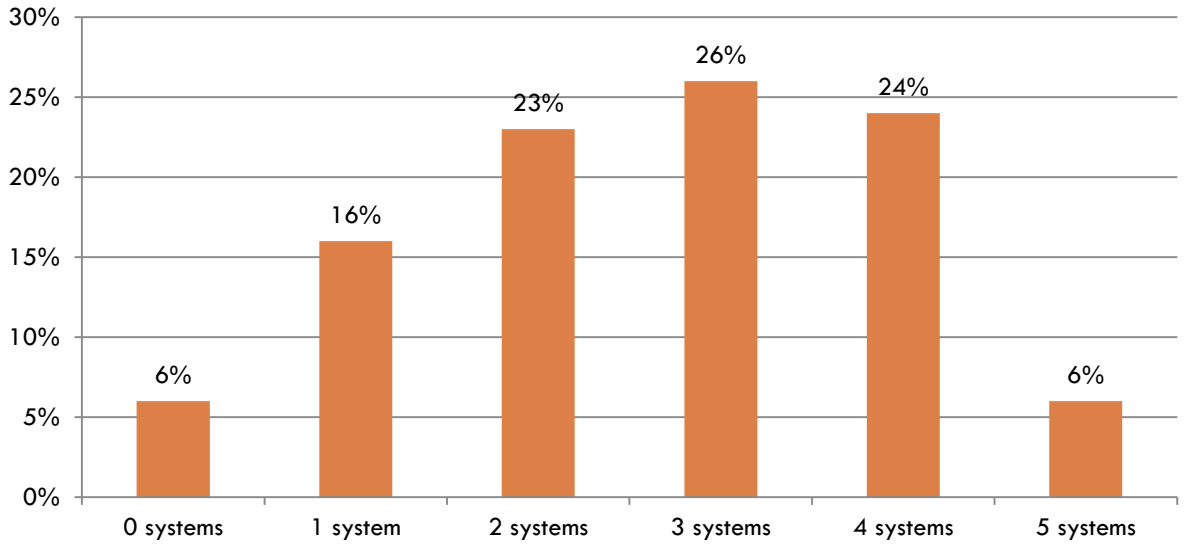
Figure 3.1 Last System Touched for Decedents with Service Interaction <30 Days Prior to Death, 2009-10 (n=33)

System	Number	Percent
Emergency Shelter	11	33%
Physical Health*	9	27%
Street Outreach	7	21%
Behavioral Health Care	5	15%
Police (person arrested)	1	3%

** Includes emergency room (4), hospital (2) VA medical (2), and Health Care for the Homeless encounters (1)*

Figure 3.2 shows that 94 percent of decedents (N=85) had a known history of involvement in one or more systems, with more than one-half known to three or more. Systems examined for history include: homeless (shelter and/or outreach), hospital, drug and alcohol, mental health, criminal justice, child welfare (as a parent), and VA medical.

Figure 3.2 Percentage of Decedents with Known History of System Involvement, 2009-10 (n=90)



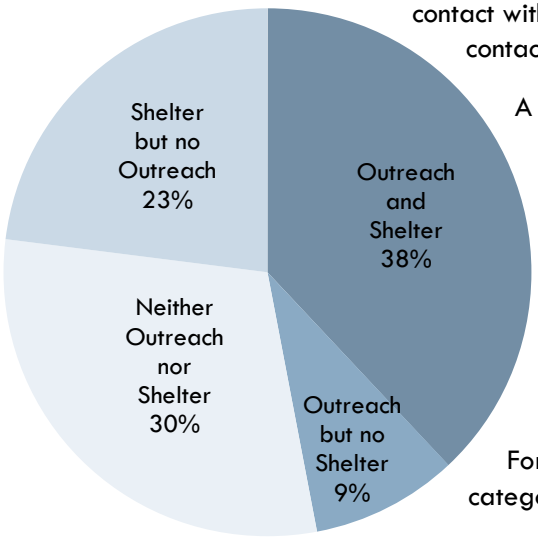
Access to Outreach and Shelter Services

In Philadelphia, services for people experiencing homelessness funded by the City of Philadelphia are a complex network of housing, outreach, and physical and mental health care. Homeless Outreach and shelter are often the first contact a person experiencing homelessness has with this network.

As depicted in Figure 3.3, 77 percent of homeless decedents (69 individuals) were known to Outreach and/or the shelter system, leaving 23 percent (21 individuals) without any history of Outreach or shelter use. Outreach and shelter are often entry portals into treatment and housing opportunities and can lead to reconnection for those who had been disconnected from supports.

→In 1989, Philadelphia pioneered centralized intake for shelter services, now a nationally recognized best practice.

Figure 3.3 Percentage of Decedents with Outreach and Shelter Use History, 2009-10 (n=90)



Thirty-eight percent of the homeless decedents had a history of both shelter and contact with Homeless Outreach, 23 percent had shelter history with no Outreach contacts, and nine percent had Outreach contact but no shelter history.

A majority of individuals reviewed were categorized as sheltered homeless (63 percent) at the time of death, meaning the individual stayed in emergency housing, including shelters and drop-in centers, or stayed with a friend/relative as a short term or temporary housing alternative.

Twenty-eight percent of decedents (25 individuals) were unsheltered at time of death, meaning they were sleeping on the streets, in parks, under bridges, in homeless encampments, or other structures not meant for human habitation.

For the remaining nine percent of homeless decedents, their last known category of homelessness was not known.

Veterans Experiencing Homelessness

In the U.S., veterans comprise approximately one-third of the homeless population, with the average profile a single male with mental illness and substance addiction who also comes from an economically disadvantaged community.[10] Sixteen percent of homeless decedents reviewed by the HDRT were veterans.

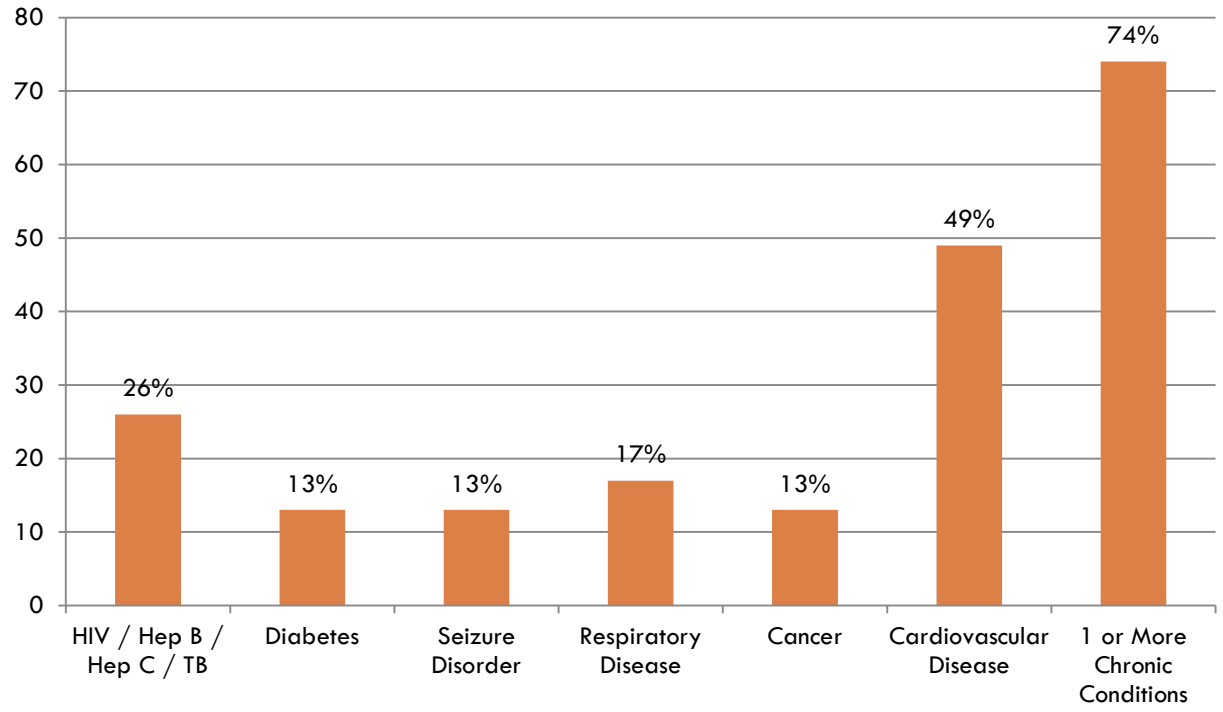
→As part of President Obama's Federal Strategic Plan to Prevent and End Homelessness by 2015, the VA and HUD have worked together to create new supportive housing vouchers, known as HUD VASH vouchers. A VA Housing First initiative in Philadelphia made possible by VASH vouchers, which provide housing for veterans who are unable to find success in traditional rehabilitation programs, is currently underway.

Physical Illness and Access to Care

Seventy-four percent of the homeless decedents had at least one known chronic (physical) medical condition at the time of death. These data were collected through medical records, agency data collection systems, and familial report as well as upon autopsy at the Medical Examiner's Office.

Because Philadelphia does not have a county hospital, non-profit and other academically-based institutions are common sources of care for people experiencing homelessness.

Figure 3.4 Percentage of Decedents with Known Chronic Medical Conditions at Time of Death, 2010 only (n=47)



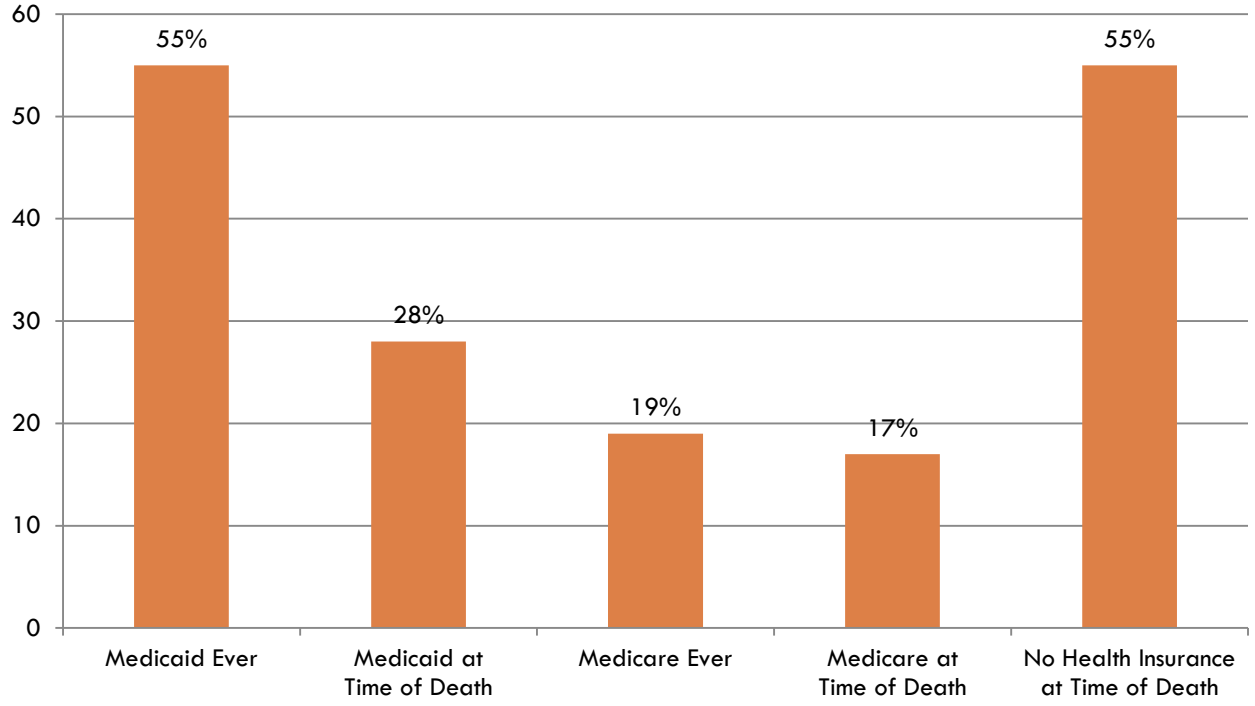
[10] National Coalition for the Homeless (2012). Homeless Veterans http://www.nationalhomeless.org/

Healthcare Coverage of Homeless Decedents in Philadelphia

- Fifty-five percent of homeless decedents had no health benefits at the time of death, though a majority had a serious medical condition, indicating that lack of insurance is a barrier to care which may result in untimely death.
- The discovery that 17 percent of homeless decedents had Medicare coverage at the time of death and 19 percent had ever received Medicare may be further evidence that death for individuals experiencing long periods of homelessness occurs before the Medicare-eligible age of 65 years old and older.
- Just four percent of decedents had health care coverage through the Veterans Administration, though 16 percent were eligible veterans.
- Throughout the life-course, 55 percent of the decedents were covered by Medicaid and 28 percent had Medicaid at the time of death.

In Philadelphia, 45 percent of decedents were covered by Medicaid or Medicare at the time of death, as shown in Figure 3.5 below. The remaining 55 percent of homeless decedents had no documentation of health care coverage when they died – as compared to 16 percent of the general population in the U.S. who is uninsured.[11]

Figure 3.5 Percentage of Decedents with Public Health Insurance, 2009-10 (n=90)

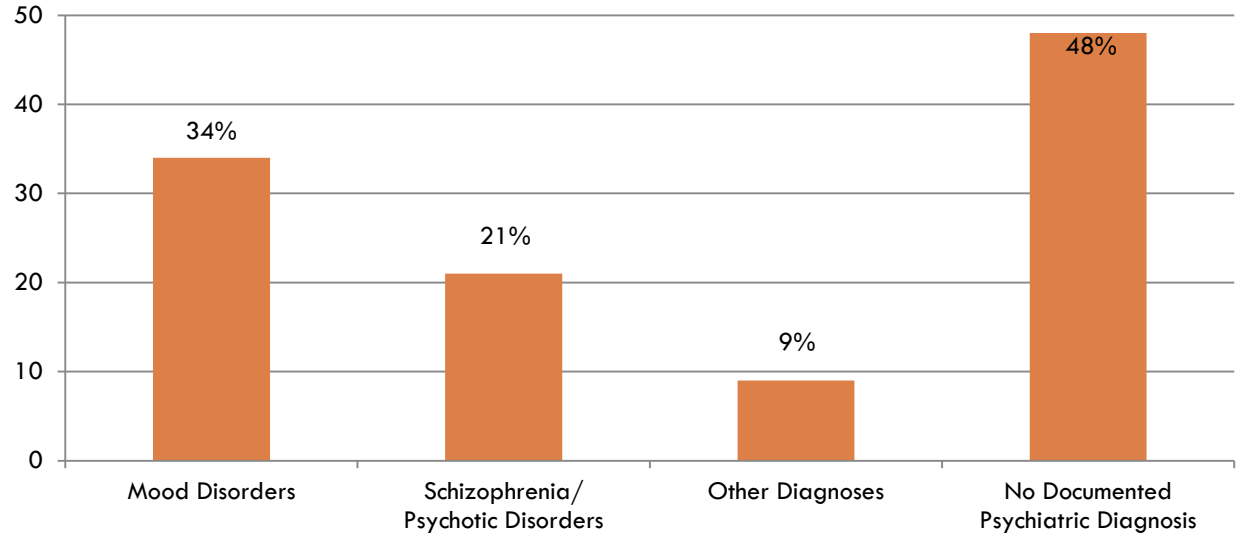


[11] DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60-239, *Income, Poverty, and Health Insurance Coverage in the United States: 2010*, U.S. Government Printing Office, Washington, DC,2011.http://www.census.gov/prod/2011pubs/p60-239.pdf

Psychiatric Conditions Among Homeless Decedents

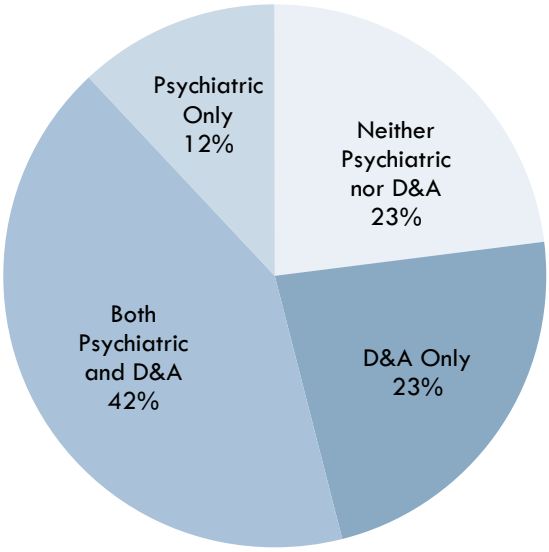
Among reviewed cases, 21 percent received a diagnosis of schizophrenia or other psychotic disorder during the lifecourse. Thirty-four percent were diagnosed with a mood disorder, such as major depression or bipolar disorder. Approximately nine percent experienced other psychiatric conditions, which includes personality disorders and others. Decedents with multiple diagnoses are represented below in all applicable categories. Just under half had no known psychiatric history.

Figure 3.6 Percentage of Decedents with Psychiatric Diagnoses, 2009-10 (n=90)



Individuals dually diagnosed with addiction and mental illness pose unique housing and service challenges. Three-quarters of the decedents reviewed had a history of mental illness and/or addiction, with 42 percent having suffered from both disorders. Twenty-three percent had no record of either. (Figure 3.7)

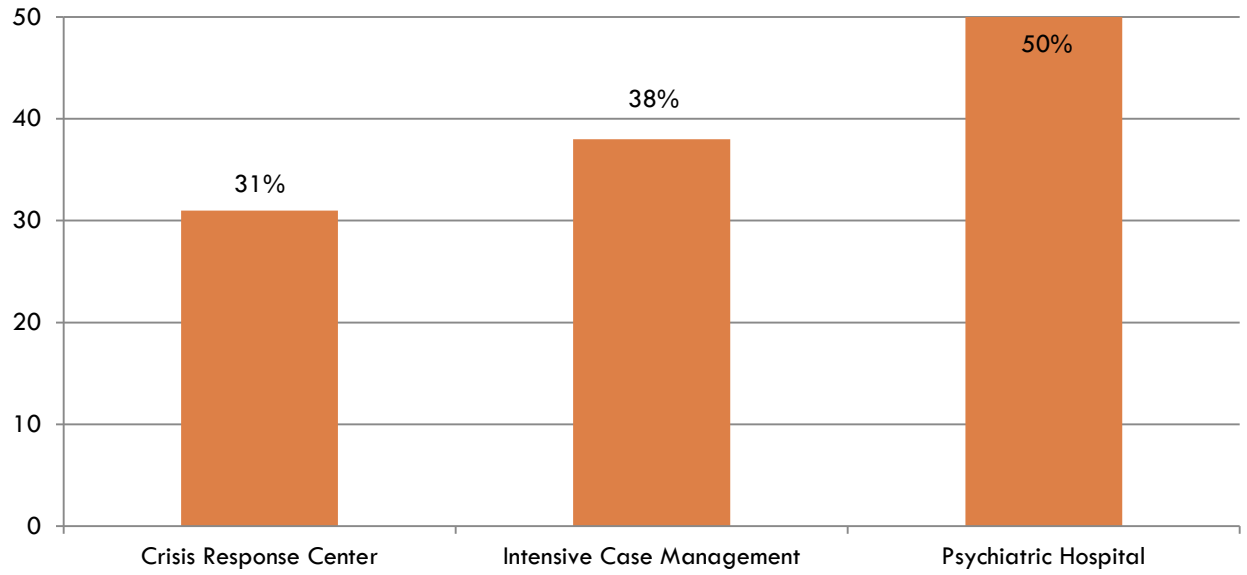
Figure 3.7 Percentage of Decedents with Psychiatric Condition and/or Drug & Alcohol Addiction, 2009-10 (n=90)



Decedent Use of Mental Health Services

The mental health service used most commonly by the homeless decedents was psychiatric hospitalization (50 percent). The average cost of an inpatient psychiatric hospitalization is $750 per diem. Involuntary psychiatric commitments to treatment were documented for 22 percent of reviewed cases. Thirty-eight percent of homeless decedents had a history of receiving mental health case management services and 31 percent had used psychiatric crisis response centers.

Figure 3.8 Percentage of Decedent Use of Public Psychiatric Services, 2009-10 (n=90)



Decedent Use of Addiction Treatment and Recovery Services

While 63 percent of homeless decedents had service evidence of substance abuse challenges and 44 percent had an addiction related primary or secondary cause of death, only 38 percent had history of addiction treatment.

Intellectual disAbility Among Homeless Decedents

Two percent (2 percent) of homeless decedents had documented intellectual disabilities. Anecdotal data from the HDRT indicates that many more had cognitive challenges that made accessing and maintaining support for recovery a challenge. However, there are limited public services to assist persons whose cognitive challenges resulted from life events experienced in adolescence or adulthood such as traumatic brain injury or the consequences of long-term substance abuse.

In Philadelphia, there is a comprehensive system of care for physical, mental and behavioral health available for people experiencing homelessness. Ninety-four percent encountered one or more systems during their lifetime, with more than one-half interacting with three or more. Just over one-third came into contact with a system 30 days prior to their death. Based on our findings, we conclude that:

1. Gaps in health care and/or coverage remain and contribute to inadequate access to appropriate care.
2. For individuals with multiple physical and behavioral health conditions, lack of coordination among systems may contribute to unmet needs and housing instability.
3. The scarcity of housing subsidies and restrictions and reductions in service funding limit the number of people who can be assisted.

Healthcare Coverage and Access to Care

In Philadelphia, 45 percent of the homeless decedents had Medicaid or Medicare coverage at the time of death. The remaining 55 percent had no documentation of any health care coverage when they died, as compared with 16 percent of the general population in the U.S. who are uninsured.[12]

The Philadelphia Department of Public Health operates eight district health centers that provide health care services to any resident, regardless of health insurance status, documentation status, or ability to pay for services. There are another 27 Federally Qualified Health Centers within the City of Philadelphia, including Mary Howard Health Center (a Health Care for the Homeless Health Center), which provides preventive health care, family planning, assistance with benefits, and other services. Additionally, Project HOME operates its own health clinic in North Philadelphia specifically for people experiencing homelessness.

Persons experiencing homelessness must focus each day on meeting basic, immediate needs such as food and shelter. Life without a home is often chaotic, and accessing health care when financial resources are few is typically only pursued when the need is urgent. As such, chronically homeless individuals often rely on emergency rooms for their health care. While use of emergency room for urgent care by people experiencing homelessness is appropriate, up to 75 percent of emergency room use by chronically homeless individuals is undertaken for treatment of preventable conditions that could be addressed in a primary care setting.[13]

Among the general population, emergency room use goes up when barriers to accessing primary care go up.[14] Barriers to accessing preventive services by homeless persons can be so numerous as to be completely prohibitive. Barriers may include logistical challenges such as lack of identification, lack of access to transportation, and the inability to make appointments (due to lack of having a phone). Barriers may also include a lack of trust that the homeless person will be treated fairly by medical professionals, despite their complex needs. Meanwhile, ER's are always open and staff must address the health concerns of every person who walks through the door.

Case managers, Homeless Outreach teams, and other professionals in Philadelphia provide free public transportation tokens to people experiencing homelessness for appointments. Additionally, for homeless persons

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[12] DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60-239, *Income, Poverty, and Health Insurance Coverage in the United States: 2010*, U.S. Government Printing Office, Washington, DC,2011. http://www.census.gov/prod/2011pubs/p60-239.pdf
[13] CDC, 2011; Levinson, 2004
[14] Rust, et al, 2008

who have ICM services, case managers are often able to transport them to appointments and to act as liaisons between them and the medical professionals providing their care.

Because of the Pennsylvania General Assistance (GA) Program, there is a fairly broad health care safety net in Pennsylvania (as of March 2012) due to eligibility requirements for Medicaid prioritizing those in need. For the FY2013 state budget, however, the elimination of GA is proposed, and many of those who have health insurance today can expect to lose their coverage. The implementation of the Affordable Care Act (ACA) will become critical, as coverage can be expected to be regained again in January 2014.

Review of homeless decedents' Medicaid coverage indicated that those with Social Security Insurance (SSI) or Social Security Disability Insurance (SSDI) had fairly consistent coverage, while those with GA were inconsistently covered. As the requirements of public welfare agencies change and the recipient must be notified of changes, the lack of a consistent address and phone number for people experiencing homelessness can mean they are the last to know they no longer have health insurance.

Access to Behavioral Health and Recovery Supports in Philadelphia

Community Behavioral Health (CBH) manages behavioral health services for Philadelphia residents on Medicaid and has a network of over 300 providers that offer a wide array of services. Uninsured and underinsured Philadelphians have access to fourteen Community Mental Health Centers, which often provide non-emergency psychiatric treatment for little or no charge. Additionally, Philadelphia has four Crisis Response Centers, which provide public psychiatric emergency services in the community and are the point of entry for all persons who are involuntarily psychiatrically committed. There are also numerous hospitals providing outpatient and inpatient emergent and non-emergency care.

Addiction treatment in Philadelphia is only accessed voluntarily. For those individuals who wish to receive treatment for addiction, a comprehensive network of drug and alcohol treatment centers, inpatient and outpatient, exists. For homeless individuals with Medicare or Medicaid, some treatment may be covered. Additionally, the Behavioral Health Special Initiative (BHSI) provides drug and alcohol treatment coverage for priority populations, including chronically homeless individuals, who are uninsured and underinsured.

Among reviewed cases, 63 percent had some evidence of suffering from a substance use disorder, meaning individuals accessed treatment or died because of drug or alcohol related problems. Thirty-eight percent of decedents received drug and alcohol detoxification and rehabilitation services. The rate of substance use is much higher than the general population, where 8.9 percent of the population has used illegal drugs and 6.7 percent report heavy drinking. [15]

National data indicates that only one in four persons who need addiction treatment receive it in their lifetime, so Philadelphia's rate of one in three people, for a severely disenfranchised population accessing treatment, well exceeds the national average.[16]

As a result of the findings of the HDRT, DBHIDS has expanded its programs to assist persons experiencing homelessness as they enter recovery from addiction. From having just two programs with 34 program slots to now having five programs and 121 program slots, the Journey of Hope network offers an addiction recovery option specially tailored to the needs of homeless persons challenged by substance use disorders. In 2010, 51 percent of program participants graduated from the program, with most subsequently entering supportive

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[15] US Department of Health and Human Services (2010), Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings http://www.samhsa.gov/data/NSDUH/2k10Results/Web/HTML/2k10Results.htm

[16] White,W.L., (2008), Recovery Management and Recovery Oriented Systems of Care. Addiction Technology Transfer Monographs, http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=390&rcID=9

housing, where they can continue their recovery journey. This exceeds the national average in 2008, in which only 46 percent of persons admitted to long term residential treatment completed their program.[17]

DBHIDS has also partnered with the Office of Supportive Housing (OSH) to expand the Pathways CHIP (Chronic Homeless Inebriate Program). Offering a Housing First model of permanent supportive housing options for persons suffering from alcoholism, this model allows persons with no evidence of serious mental illness to have access to Housing First programming as well. While only 30 slots are available through this program due to limits on addiction treatment funding (which is not a Medicaid entitlement service), the service system is learning a great deal about how to serve individuals with diseases of addiction.

The Future of Health Care for People Experiencing Homelessness in Philadelphia

In May 2011, Philadelphia completed its first citywide street count, in partnership with the national 100,000 Homes Initiative. More than 250 volunteers spanned out across the city to interview individuals who were found on the street between four am and six am. Five hundred twenty six (526) interviews were completed and results allowed the City to target individuals with the most complex medical issues for a new supportive housing initiative. Consistent with deaths reviewed through the Homeless Death Review, the results indicated that while the most concentrated area of street homelessness is in Center City, a significant number of persons are outside that area, with a significant population of people experiencing homelessness in the Kensington area.

The HDRT found homeless decedents who used preventive care at a clinic like Mary Howard Health Center very often also used emergency room services for non-acute medical needs and psychiatric care within the same week, or even the same day.

Horizon House, a comprehensive community care system for individuals with disabilities, provides co-located mental and physical health care. A review of costs and benefits of co-location may point to a greater role for co-location in reducing expensive, inappropriate emergency and inpatient use[18]. Other initiatives, such as the national 100,000 Homes campaign, examine the impact to health of supportive housing. To date, the findings suggests that without housing, preventive health care measures are just a stop gap.

Most Americans go home to rest when their healthcare provider tells them they have pneumonia or an exacerbation of a pre-existing medical condition. Shelters, drop-in centers and safe havens are seldom equipped to support the medical needs of their residents. It is not atypical for patients who are discharged to the street to become sick again and, worse yet, to experience a life-threatening emergency that might end in hospitalization or even death.

Philadelphia continues to explore a Medical Respite model, which is shelter or supportive housing with medical supports for those being discharged from acute hospitals. A medical respite would provide hospitals a discharge plan for people experiencing homelessness who no longer need inpatient treatment but for whom homelessness compromises their wellness. Medical respite may be an important additional service, but without long-term housing options, a person leaving medical respite is still homeless and still vulnerable.

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[17] http://www.samhsa.gov/data/DASIS/TEDS2k8DWeb/TEDS2k8Dindex.htm

[18] Pirraglia, P.A., Kilbourne, A.M., Zongshan, L., Friedmann,P.D., & O'Toole, T.P. (2011). Colocated general medical care and preventable hospital admissions for veterans with serious mental illness. *Psychiatric Services*, 62:5, 554-557.

Moving Forward and Questions for Future Research

Many homeless persons suffer from significant addiction disorders, and the treatment system must continue to evolve to address these needs. As part of the DBHIDS recovery transformation processes, new resources are being directed to services that engage those who are still active in their addiction and not formally ready to enter treatment. Still, these persons are willing to maintain limited relationships with the outreach and treatment professionals and will know how to get help when they are ready for it. Other programs are being developed that take a 'harm reduction' approach and can offer supportive housing options. But those programs remain severely limited in capacity due to funding restrictions. The HDRT found that there were individuals who made multiple attempts at recovery, but ultimately were not successful at achieving sobriety and housing stability. Adequate funding for treatment and housing, as well as a commitment by outreach workers and recovery personnel to offer help again and again, must be in place.

The questions raised by this work will be developed further in future reports. And the best questions lead to actions that the HDRT hopes to take in the future, including:

- Research on current national best practices to address these issues and developing similar programming at the local level.
- Where best practices do not exist, developing both services and research projects to develop new best practices to prevent homeless deaths.
- Exploring whether local data and existing research can help us predict those most vulnerable to death.
- Gathering more information regarding costs and implications of homeless deaths.
- Improving coordination between the multiple social service systems to reduce fragmentation. For example, formalizing relationships and protocols between the homeless service system and local hospitals to try to prevent hospital discharges to the streets or shelter that are without resources to care for these individuals.
- Increasing partnerships between the homeless service system, health care providers, and Managed Care Organizations (MCOs).
- Continuing research on medical respite models and how to fund and sustain them.
- Continuing to target scarce supportive housing resources to the most vulnerable.
- Research that examines the impact of insurance coverage on number, type and manner of deaths.

Philadelphia Responds to Homeless Death Review

The Homeless Death Review process requires inter-agency collaboration and coordination. A series of incidents, which may have gone noticed but unaddressed prior to formal death review, have resulted in an immediate response. Decisive action that immediately addresses the vulnerabilities of homeless individuals is critical to ending homeless death.

Just a few of these actions are highlighted in this report:

Issue: 44 percent of homeless decedents died either directly or indirectly from drug or alcohol intoxication

Response→ Philadelphia developed 121 slots for Journey of Hope programs, specialized addiction treatment for the chronically homeless AND specialized slots for Housing First for those with only a Drug & Alcohol diagnosis. Addiction treatment leads directly to supportive housing to help enhance recovery.

Issue: Many homeless decedents used local emergency departments for drug and alcohol-related issues or for care that is not medically acute.

Response→ The City and leadership at local hospitals as well as insurance companies have begun working in collaboration to address use of emergency department services and identify post-discharge options.

Issue: Some homeless decedents were found to have well over 500 encounters with shelters, hospitals and other public systems. **Still, these individuals remained homeless at a high cost to the public.**

Response→ In a new initiative called 100K Homes Philly, the City joined the 100,000 Homes national campaign to identify and house the most vulnerable homeless individuals in Philadelphia. In addition, the City's Office of Health and Opportunity, which oversees the Philadelphia County's human services systems (including child welfare, behavioral health, health, homelessness) has initiated a transformation of the supportive housing system. The result will be a single portal for all permanent supportive housing opportunities—to identify target populations and ensure streamlined access to housing and services. The private sector has joined the City to ensure a subset of this initiative targets chronically homeless individuals.

APPENDICES

I. Philadelphia Homeless Death Review Summary, 2009-2010

2009-2010 Philadelphia Homeless Death Summary

Number of Homeless Decedents by Month of Death

	2009	2010	2009-10	
	N	N	N	%
January	11	3	14	16
February	2	2	4	4
March	4	6	10	11
April	5	7	12	13
May	4	5	9	10
June	4	2	6	7
July	4	2	6	7
August	4	3	7	8
September	0	2	2	2
October	1	3	4	4
November	2	3	5	6
December	2	9	11	12
Total	43	47	90	100

Number of Homeless Decedents by Manner of Death

	2009	2010	2009-10	
	N	N	N	%
Accident	15	21	36	40
Homicide	5	3	8	9
Suicide	2	0	2	2
Natural	21	23	44	49
Undetermined	0	0	0	0
Total	43	47	90	100

Number of Homeless Decedents by Race/Ethnicity

	2009	2010	2009-10	
	N	N	N	%
White, Non-Hispanic	12	14	26	29
Black, Non-Hispanic	27	30	56	62
Asian, Non-Hispanic	3	1	4	4
Hispanic (of any Race)	1	2	3	3
Other	0	0	0	0
Unknown/Missing	0	0	1	1
Total	43	47	90	100

Number of Homeless Decedents by Gender

	2009	2010	2009-10	
	N	N	N	%
Female	8	7	15	17
Male	35	40	75	83
Total	43	47	90	100

Number of Homeless Decedents by Age

	2009	2010	2009-10	
	N	N	N	%
<20	0	1	1	1
20-24	2	0	2	2
25-29	1	3	4	4
30-34	0	1	1	1
35-39	2	1	3	3
40-44	3	3	6	7
45-49	6	9	15	17
50-54	11	8	19	21
55-59	4	9	13	14
60-64	6	3	9	10
65-69	5	5	10	11
70-74	2	2	4	4
75-79	1	1	2	2
80+	0	1	1	1
Unknown	0	0	0	0
Total	43	47	90	100

Number of Homeless Decedents by Primary Cause of Death and "Significant Conditions Contributing to Death"

	Primary Cause	Contr. Cond.
	Total ('09+'10)	Total ('09+'10)
Drug Intoxication or Alcoholism	23 (9+14)	17 (10+7)
Circulatory System Diseases*	21 (11+10)	9 (6+3)
Injury (e.g. blunt force, gunshot wound)	13 (9+4)	1 (1+0)
Diseases of an Infectious Etiology	10 (9+1)	1 (0+1)
Cancer	6 (1+5)	1 (0+1)
Hypothermia	5 (1+4)	6 (4+2)
Respiratory System Diseases*	3 (2+1)	7 (4+3)
Fire	3 (0+3)	0
HIV**	2 (0+2)	2 (2+0)
Diabetes	0	5 (4+1)
Hyperthermia	0	0
Other	4 (1+3)	2 (0+2)
Total	90 (43+47)	***

**not including diseases of an infectious etiology (e.g. pneumonia, endocarditis)*
*** category selected when HIV caused or contributed to death*
****contributing conditions could be none or multiple conditions*

Number of Homeless Dececedents by Veteran Status

	2009	2010	2009-10	
	N	N	N	%
Veteran	6	8	14	16
Non-Veteran	37	39	76	84
Total	43	47	90	100

Number of Homeless Dececedents by Known HIV Status

	2009	2010	2009-10	
	N	N	N	%
HIV Positive	7	4	11	12
HIV Negative	36	43	79	88
Total	43	47	90	100

II. Homeless Death Review Toolkit

To our knowledge, formal Homeless Death Reviews have been conducted in major metropolitan areas including New York City, Los Angeles County, New York City, San Francisco, and Seattle. Philadelphia researched these processes, as well as the City's existing Fatality Review processes, in development of the Homeless Death Review Team (HDRT).

In support of its goal to recognize shortfalls in the homeless services system, the HDRT follows a strategic process for death review, which is designed to reveal system gaps, acknowledge what worked for the individual and to assess what role the system can play in preventing future deaths. To do this, the Philadelphia HDRT assesses eligible cases to determine the role of homeless services in the life of the individual reviewed. Eligible cases for review are those in which 1) a person died in Philadelphia, 2) was homeless at the time of death and, 3) was a Philadelphia resident at the time of death.

When a person is found dead in Philadelphia and is suspected to be homeless, the Homeless Death Review coordinator notifies the Office of Supportive Housing and the Department of Behavioral Health. Staff members check data systems in their respective departments to determine the history of the individual and establish whether records substantiate homelessness. Absence of a history of service use in the homeless, outreach or behavioral health systems, however, does not preclude a homelessness consideration. Because determination of homelessness can be difficult, with sometimes contradictory information from various sources, the HDRT developed a checklist to help establish the rationale for considering each individual to be homeless. That checklist is included in this Appendix.

The Homeless Death Review process has two main components: ad-hoc conference calls and quarterly in-person reviews. Conference call members are from the public and private sectors, including OSH (shelter, transitional and permanent housing), DBHIDS (mental health and substance abuse), Project HOME (street outreach), Philadelphia VA (veterans), AIDS Activities Coordinating Office (HIV), and Public Health Management Corporation (the Health Care for the Homeless grantee). The multiple purposes of the conference call include verifying the housing status of a 'possibly homeless' decedent, helping the Medical Examiner's Office locate next of kin when such has not already been identified, starting the process of gathering information for the quarterly homeless death review, and addressing any immediate system implication that a death may uncover.

At the quarterly in-person reviews, representatives of up to 20-agencies meet face-to-face to review human services and health encounter history of 12-14 cases, guided by pre-meeting analysis of agency data and documentation of use using the Data Collection Tool (included in this Appendix). The Medical Director of the Fatality Review Program presents each case, including the cause of death and information gleaned by the MEO investigators. HDRT members, then present encounters with the agencies they represent. At the end of each full-case presentation, the HDRT discusses gaps and missed opportunities, noting trends across cases as well as focusing on the unique qualities of the individual case reviewed. These meetings occur every three months (on average) and are the cornerstone of the Philadelphia Homeless Death Review process. The data and discussions derived from these meetings are the basis of this report.

III. Philadelphia Homeless Death Review Checklist

Decedent's Name: _____ Date of Death: _____
Place of Death:_____ Category of Place: _____

Means of Possible Case Identification

- ☐ CME "Possible Homeless Decedent" query
- ☐ MEO Investigator
- ☐ HDR Conference Call member (specify person or agency:_____)
- ☐ Hospital Social Worker (specify hospital:_____)
- ☐ Media/newspaper
- ☐ Other person/agency (specify:_____)

Category of Homelessness

Check off all that apply (and specify details far below):

Clearly Homeless

- ☐ Registered as staying in emergency or transitional housing program at time of death
(this includes special programs clearly marked for homeless persons – such as PNH Transition program)
- ☐ *Evidence* of living in abandoned house/other sheltered structure (not meant for human habitation) at time of death

Not Homeless

- ☐ Living in private accommodation (as owner or renter) at time of death
- ☐ Registered as living in permanent housing program (DBH, OSH or other) at time of death
- ☐ Living in boarding home at time of death
- ☐ Living in nursing home at time of death
- ☐ Family member/friend stated dec'd living with them at time of death (and meets our criteria for being housed)
- ☐ Other

Seemingly Homeless (2 points each) *three or more total points qualifies for conference call review:*

- ☐ *Appeared to be* living on street/other unsheltered area at time of death
- ☐ *Appeared to be* living in abandoned house/other structure (not meant for human habitation) at time of death
- ☐ Close family member/friend/partner stated dec'd was homeless
- ☐ Public health professional (e.g. hospital SW, outreach worker) who knew dec'd well stated he/she was homeless
- ☐ Recent contact (within past three months) with emergency housing/HMIS
- ☐ Residing in motel for less than 30 days at time of death (with no known permanent address)
- ☐ *Temporarily* sleeping at friend/acquaintance at time of death (with no known permanent address)
- ☐ MEO Investigators have *strong* suspicion dec'd was homeless (no Accurint address, no NOK to corroborate)
- ☐ Other

Possibly Homeless (1 point each)

- ☐ Not-too-distant contact (more than three months but less than three years) with emergency housing/HMIS
- ☐ Distant family member/friend believed dec'd was homeless
- ☐ Hospital records stated dec'd was homeless
- ☐ Other agency (e.g. police) believed dec'd was homeless
- ☐ MEO Investigators have *some* suspicion dec'd was homeless (no ID found on dec'd, manner of dress)
- ☐ Other

Additional details for any of the above checked boxes

1.
2.
3.
4.
5.

IV. Philadelphia Homeless Death Review - Data Collection Tool 1.3

A. Demographics

HDR Case#
1. MEO Case#
2. Name:
3. Gender: □ M □ F □ Unknown
4. Hispanic? □ Y □ N □ Unknown
5. Race: □ White □ Black □ Asian □ Native American □ Other:_____ □ Unknown
6. DOB (mm/dd/yy): ____/____/____
7. Age at Death:_____ (estimated, if no DOB)
8. SS#:_____
9. Marital Status: □ Single/Never Married □ Married □ Divorced □ Widowed □ Unknown
10. Known Children? □ Y □ N □ Unknown
11. Veteran? □ Y □ N □ Unknown
12. Highest Completed Educational Level: □ Unknown □ None □ K -8th Grade □ 9th-11th Grade □ HS Graduate/GED □ Some College □ College Graduate or more
13. Occupation: _____
14. Fluency in English? □ Y □ N □ Unknown

B. Death Information

15. Date of Death (mm/dd/yy): ____/____/____
16. Time of Death: _____:_____ □AM □PM
17. Weather-related Death? □ Y □ N
    Code Blue in Effect? □ Y □ N
    Code Red in Effect? □ Y □ N
18. Category of Place (of Death):_____ *(see descriptions in Q#26)*
19. Address of Death:_____ Zip Code:_____
20. Did Injury or Incident Lead to Death? □ Y □ N
    Date of Incident (mm/dd/yy): ____/____/____
    Time of Incident: _____:_____ □AM □PM
    Category of Place (of Incident):_____ *(see descriptions in Q#26)*
    Address of Incident:_____ Zip Code:_____
21. Who Initially Found the Decedent Injured or Dead? □ N/A □ Unknown
    □ Passerby/Random Stranger □ Family/Partner □ Friend/Neighbor/Acquaintance
    □ Outreach Worker □ Police □ Other:_____
22. Cause of Death:

Injury
- □ Motorized Vehicle Crash
- □ Firearm
- □ Weapon other than Firearm
- □ Hypothermia
- □ Hyperthermia
- □ Fall or Crush
- □ Fire, Smoke, Burn, or Electrocution
- □ Drowning
- □ Suffocation or Strangulation
- □ Poisoning by Psychoactive Substance
- □ Poisoning by Other Substance
- □ Other:_____

Medical
- □ Cardiovascular Disease
- □ Cerebrovascular Disease
- □ Cirrhosis / Chronic Liver Disease
- □ Chronic Obstructive Pulmonary Disease
- □ Renal Disease
- □ Malignant Neoplasm
- □ Alzheimer's
- □ Diabetes
- □ Influenza and Pneumonia
- □ HIV/AIDS
- □ Viral Hepatitis
- □ Tuberculosis
- □ Other Infectious Etiology:_____
- □ Other Non-Infectious Etiology:_____

23. Conditions Contributing to Death
24. Manner of Death: □ Natural □ Accident □ Homicide □ Suicide □ Undetermined □ Pending
25. Was Toxicology Screen Performed at Autopsy? □ Y □ N Results:

C. Homelessness Information

26. Last Known Category of Homelessness (just prior to date of incident/death):

Sheltered

□ Emergency Shelter (City or Non-City Shelter)
□ Transitional Housing
□ Residential Program (DBH)
□ Overnight Cafe
□ Safe Haven
□ Temporarily Staying in Family Member's Room/Home
□ Temporarily Staying in Friend's/Acquaintance's Room/Home
□ Abandoned Building/Home/Structure (with Roof) _____
□ Subway Station
□ Car/Van/Other Vehicle
□ Detox Center/Substance Abuse Treatment Facility
□ CRC/Other Psychiatric Hospital or Facility
□ Hospital (Non-Psychiatric)
□ Jail/Prison/Juvenile Detention Facility
□ Other:_____

Unsheltered

□ Sidewalk/Side of Street
□ Expressway
□ Park Area
□ Vacant Lot
□ Building Entrance
□ Structure without Roof
□ Construction Site
□ Makeshift Shelter/Tent
□ Other:_____

27. Was Decedent Considered Chronically Homeless*? □Y □N
(*based on federal definition of chronic homelessness)

D. Homeless Services Utilization History

28. Date of First Known Contact (with any agency) as Homeless Person (mm/dd/yy): ____/____/____

29. Emergency Shelter Housing History? □Y □N — Total # of Days in Shelter:_____
Type of Housing: □City-Funded □Sunday Breakfast □ Other:_____
First Known Entry/Exit Date (mm/dd/yy): ____/____/____
Last Known Entry/Exit Date (mm/dd/yy): ____/____/____

30. City and HUD-Funded Transitional Housing History? □Y □N — Total # of Days in Housing:____
First Known Entry/Exit Date (mm/dd/yy): ____/____/____
Last Known Entry/Exit Date (mm/dd/yy): ____/____/____

31. City and HUD-Funded Permanent Housing History? □Y □N — Type of Program:_____
First Known Entry/Exit Date (mm/dd/yy): ____/____/____
Last Known Entry/Exit Date (mm/dd/yy): ____/____/____
Total # of Admissions:____ — Total # of Days in Program:____

32. Intensive Case Management History? □Y □N — Total # of Cases:_____
First Known Date (mm/dd/yy): ____/____/____
Last Known Date (mm/dd/yy): ____/____/____

33. Street Outreach (OCC) History? □Y □N — Total # of Contacts:_____
First Known Date (mm/dd/yy): ____/____/____
Last Known Date (mm/dd/yy): ____/____/____

33a. Total # Times Street Outreach Services Provided

Food	Medical Service	Clothing
Drug or Alcohol Service	Transportation	Other Mental Health Service
Employment/Vocational	Self-Care, Hygiene	Legal/Court Issues
Self-Preservation	Benefits Eligibility	Police Assistance
Engagement	Other:_____	

33b. Total # Times Street Outreach Placements Provided

BHS Shelter/Safe Haven	Non-Psych ER/Hosp	Other Social Service Agency
Detox Program	Overnight Café	CRC (Involuntary)
Boarding Home	CRC (Voluntary)	OHS Shelter
PDR (AAS-Gatekept)	Private Shelter	Family/Friend

E. Medical History (not including Behavioral Health)

34. Known History of any of the Following Medical Conditions?

Infectious Diseases

HIV/AIDS
Tuberculosis
Pneumonia or Influenza
Endocarditis
Hepatitis B
Hepatitis C

Cardiovascular Conditions

Hypertension
Cardiac Disease
Stroke and Other Cerebrovascular Disease
Chronic Venous Insufficiency
Chronic Renal Disease
End-Stage Renal Disease

Gastrointestinal Conditions

Cirrhosis or other Chronic Liver Disease
Peptic Ulcer Disease
Pancreatitis

Neurological Conditions (other than Behavioral Health-related)

Seizure Disorder
Neurodegenerative Disorders (Dementia, Alzheimer's, Others)

Other Conditions

Diabetes
COPD (Chronic Bronchitis/Emphysema)
Obesity
Anemia (Sickle Cell or Other)
Malignant Neoplasms
If yes, specify:____
Glaucoma or Blindness
Use of Hearing Aid or Deafness
History of Amputation
History of Frostbite, Hypothermia, or Immersion Foot

F. Medical Services Utilization History

35. Known History of Health Care for the Homeless Visits? □ Y □ N Total # of Visits:_____
First Known Date (mm/dd/yy): ____/____/____
Last Known Date (mm/dd/yy): ____/____/____

36. Known History of Emergency Room Visits in 3 Years Prior to Death? □ Y □ N
Source for ER information below (name of Hospital or Insurance Provider):_____
Last Known ER Visit (mm/dd/yy): ____/____/____
Total # of ER Visits in 1 Month Prior to Death: ____
Total # of ER Visits in 3 Months Prior to Death: ____
Total # of ER Visits in 1 Year Prior to Death: ____
Total # of ER Visits in 3 Years Prior to Death: ____

37. Known History of (*Non-Psychiatric*) Hospitalizations in 5 Years Prior to Death? □ Y □ N
Source for information below (name of Hospital or Insurance Provider):_____
First Admission Date within Previous 5 Years (mm/dd/yy): ____/____/____
Last Discharge Date within Previous 5 Years (mm/dd/yy): ____/____/____
Total # of Non-Psychiatric Hospitalizations in 3 Months Prior to Death:____
Total # of Non-Psychiatric Hospitalizations in 1 Year Prior to Death: ____
Total # of Non-Psychiatric Hospitalizations in 5 Years Prior to Death: ____

38. Known History of VA Medical Center Hospitalizations? □ Y □ N
First Admission Date (mm/dd/yy): ____/____/____
Last Discharge Date (mm/dd/yy): ____/____/____
Total # of Admissions:_____

39. Health Insurance/Benefit Status

	Ever?	at Time of Death? (if no, explain if known why)
Medicaid?	□ Y □ N	□ Y □ N:_____
Medicare?	□ Y □ N	□ Y □ N:_____
Veterans?	□ Y □ N	□ Y □ N:_____
SSI?	□ Y □ N	□ Y □ N:_____
SSDI?	□ Y □ N	□ Y □ N:_____

G. Behavioral Health History

40. Known History of any of the Following Conditions?

Mental Health Conditions

Schizophrenia or other Psychoses	□ Y □ N	Mental Retardation	□ Y □ N
Depression or other Mood Disorders	□ Y □ N	Personality Disorders	□ Y □ N
Other Psychiatric Conditions	□ Y □ N		

Addictions

Tobacco Use	□ Y □ N		
Alcohol Abuse/Dependency	□ Y □ N		
Drug Abuse/Dependency			
Cocaine	□ Y □ N	Opiates	□ Y □ N
Benzodiazepines/Sedatives	□ Y □ N	Amphetamines	□ Y □ N
PCP	□ Y □ N	Cannabis	□ Y □ N
Hallucinogens	□ Y □ N	Inhalants	□ Y □ N
Other:_____	□ Y □ N		

H. Behavioral Health Services Utilization History

41. Known History of CRC Visits? □ Y □ N Total # of Visits:_____
First Admission Date (mm/dd/yy): ____/____/____
Last Discharge Date (mm/dd/yy): ____/____/____

42. Known History of Mobile Emergency Visits? □ Y □ N
Total # of Visits:_____
First Known Usage Date (mm/dd/yy): ____/____/____
Last Known Usage Date (mm/dd/yy): ____/____/____

43a. Known History of Psychiatric Hospitalizations? □ Y □ N Total # of Admissions:_____
First Admission Date within Previous 5 Years (mm/dd/yy): ____/____/____
Last Discharge Date within Previous 5 Years (mm/dd/yy): ____/____/____

43b. Was Decedent Ever Involuntarily Committed to a Psychiatric Institution (302'ed)? □ Y □ N
Last Known Date (mm/dd/yy): ____/____/____

44. DBH Residential Housing History? □Y □N Type of Program:_____
First Known Entry/Exit Date (mm/dd/yy): ____/____/____
Last Known Entry/Exit Date (mm/dd/yy): ____/____/____
Total # of Admissions:____ Total # of Days in Program:____

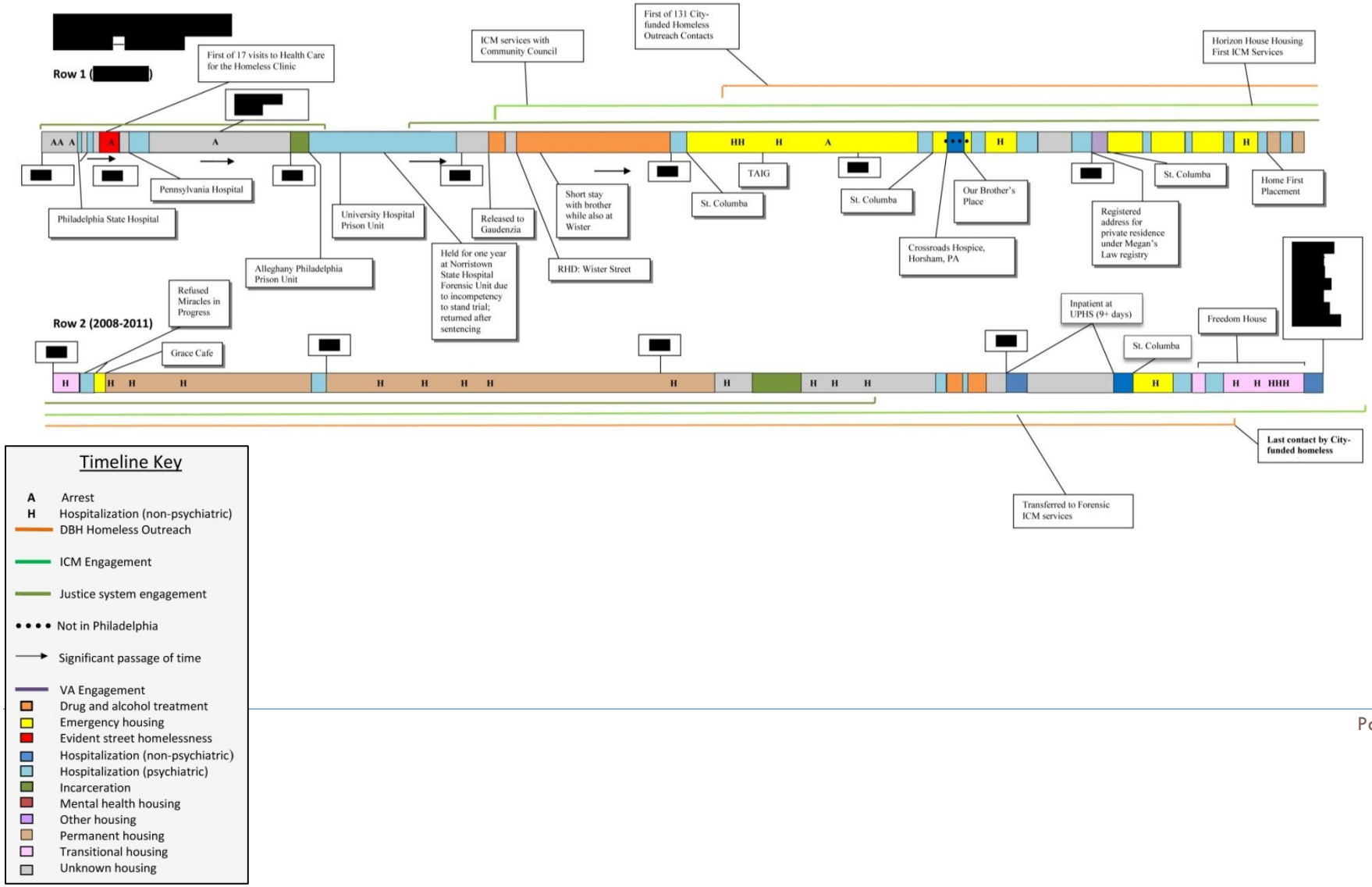
45. Known History of Drug and Alcohol Detox or Treatment? □ Y □ N
Total # of Stays:_____
First Admission Date (mm/dd/yy): ____/____/____
Last Discharge Date (mm/dd/yy): ____/____/____

I. Criminal Justice History

46. PPN:_____ PA ID:_____ FBI ID:_____
47. Known to Philadelphia Police and/or Courts as Minor? □ Y □ N
48. Known to Philadelphia Police and/or Courts as Adult? □ Y □ N
49. Known History of being Arrested? □ Y □ N Total Number of Known Arrests:_____
Date of Last Arrest (mm/dd/yy): ____/____/____
50. Known History of Incarceration? □ Y □ N Total Number of Known Incarcerations:_____
Date of Last Incarceration (mm/dd/yy): ____/____/____
51. Known History with Community Court? □ Y □ N
52. Known History of Prostitution? □ Y □ N
53. Known History of Drug Dealing? □ Y □ N
54. Known History of Drug Possession? □ Y □ N

J. DHS History

55. Any Contact with DHS as a Minor? □ Y □ N History with CYD? □ Y □ N
History of being put into Placement? □ Y □ N History with JJS? □ Y □ N
56. Any Contact with DHS as a Parent/Caregiver? □ Y □ N
History of own Child/Dependent put into Placement? □ Y □ N

V. Philadelphia Homeless Death Review Timeline Sample

The Philadelphia HDRT uses timelines to visually represent interactions between a homeless decedent and public systems. The timeline below visually depicts the use of one homeless decedent in Philadelphia who had significant contact with multiple systems. The Team finds it a useful tool for visually demonstrating where systems overlap and how they could be better coordinated.