



City of Philadelphia  
**Homeless Death Review  
2009**

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

October 2010

## Acknowledgments

This report acknowledges Donald F. Schwarz, MD, MPH and Sam P. Gulino, MD, who were willing to embark on and support a formal death review process for men and women who were homeless - despite budget reductions, staff shortages, and program cuts ... because it's the right thing to do.

## Dedication

This report is dedicated to Jeffrey Williams, a man experiencing homelessness who died after being hit by a car while crossing the Vine Street Expressway (Interstate 676) on February 18, 2008; and Joseph Kelly, Sr., a 55-year-old man and a Good Samaritan, who died that same day. When he saw a wheelchair-bound Mr. Williams trying to cross the highway median, Mr. Kelly pulled over and got out of his truck in the middle of the night and at great personal risk – and was ultimately struck down and killed alongside Mr. Williams.

On the night of his death, Mr. Williams had gone to the door of one of the city's "overnight cafes" and asked for a place to stay. It was full. Mr. Williams told workers he would go to another café a few blocks away, but he never arrived.

Mr. Williams' death affected the homeless service and advocacy community deeply.

The Philadelphia Homeless Death Review was knit together out of this tragic event to focus on the lives of homeless men and women before their death; to search for clues to how they might have lived; and to identify changes in policy, protocol or programs that might prevent future deaths.

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## Executive Summary

In 2009, the City of Philadelphia established a Homeless Death Review process, and this report summarizes that process as well as the data collected from that first year.

The purpose of a fatality review team is not to uncover the cause of death, but rather to conduct a comprehensive review in order to gain a better understanding of the circumstances surrounding the death. With the aid of quality data gathering and support from leadership of the systems involved, findings from the Philadelphia Homeless Death Review (PHDR) – and the actions taken as a result of those findings – may help prevent future homeless deaths as well as improve the health and safety of the men and women who are currently homeless in Philadelphia.

Forty-three homeless Philadelphians were identified to have died in calendar year 2009. Nearly a quarter of these homeless persons were men between the ages of 50 and 54, and 60% were African-American. The most common cause of death was circulatory system diseases, but when looking at the combination of primary cause of death and contributing conditions, drug intoxication or alcoholism was the most common factor for these homeless decedents. A full two thirds (2/3) of the decedents were chronically homeless, which by the U.S. Department of Housing & Urban Development (HUD) definition means they have a disabling condition and have been homeless continuously for one year, or four times in the past three years.

At the very least, the PHDR process has created a system that now provides us with consistent information about the number of homeless people who are dying in Philadelphia in a given year. Without a baseline number, we would never be able to determine if there are trends, or if we are having a “good” year or a “bad” year. The PHDR process has continued to refine and improve upon the tracking of deaths of homeless persons in Philadelphia - to the point where we feel we capture approximately 90-95% or more of the eligible cases.

While the PHDR is too young to make firm conclusions about a typology, and the cohort of decedents too small to compare to the general population, a multi-system review did tell us the following about the homeless men and women we reviewed:

- For most, homelessness did not occur in isolation, as all but 5% were known to at least one of seven local systems (those seven systems, as presented on p.17 of this report, include shelters, hospitals, mental health, drug and alcohol, criminal justice, criminal welfare, and veterans administration). In addition: 72% of the decedents were known to either street outreach teams or the emergency shelter system, and 35% were known to both. Fifty-nine percent (59%) were known to three or more systems. For the most part, the decedents were touched by many organizations charged to help. This suggests that help is available, and that maximizing interventions and increasing cross-systems coordination could potentially make a difference.

- Transience, and the inability to accept help or remain connected to services, are byproducts of addiction. In 44% of the deaths reviewed, drug intoxication or alcoholism was either a primary cause of death or a contributing condition. In 65% of the decedents, there was a history of some substance use or dependency. Of those with a substance use or abuse history, nearly all had used alcohol, and 2/3 had undergone drug and alcohol treatment. The PHDR team saw again and again the fragility of recovery and the complications added by severe mental illness, known in 51% of the men and women who died. We could begin to see an emerging “typology:” that of an aging alcoholic.

With regard to the death review process itself, we learned that defining homelessness is not a black or white issue, but many shades of gray. We used the HUD definition as a guide, and we discussed as a group the individual cases that fell outside a neat definition.

The observations of the PHDR team have already led to numerous actionable items and actions taken, including changing the admission processes of mental health crisis center and drug treatment intake; communicating “missing persons” status more broadly; and the initiation of a process by Thomas Jefferson University Hospital’s Department of Emergency Medicine to coordinate efforts for chronically homeless men and women who are frequent users of the emergency room. Over the past two years, 89 addiction treatment slots for chronically homeless men and women have been created, and the City is currently planning further expansion of housing resources targeted to men and women whose primary challenge is addiction.

## History of the Philadelphia Homeless Death Review

The City of Philadelphia's first regular fatality review, a child death review process, was started by the Philadelphia Department of Public Health (PDPH) in June 1993. New fatality review processes have been added over the years, which have expanded the reach of the PDPH fatality review unit to include vulnerable groups other than just children.

In 2008, a wheelchair-bound man experiencing homelessness was struck by a car and killed while crossing an urban interstate highway in Philadelphia. Out of this occurrence, a series of conversations began between individuals at the City of Philadelphia's Office of Supportive Housing and the Department of Behavioral Health. By late 2008, discussions moved forward with the Medical Examiner's Office (MEO) about establishing a process to review, assess, and potentially prevent future deaths of homeless persons in Philadelphia.

Dates and names of current MEO fatality review teams:

- Child Death Review (Homicide and Non-Homicide Teams): 1993 to present
- Fetal & Infant Mortality Review (FIMR): 2003 to 2005, and then 2008 to present
- Homeless Death Review: January 2009 to present
- FIMR/HIV Prevention: started in September 2010  
*(a joint project of the MEO and the AIDS Activities Coordinating Office (AACO) that is not a fatality review but rather a perinatal HIV transmission review, based on the FIMR methodology of death review)*
- Maternal Mortality Review (MMR): started in October 2010

### Philadelphia Homeless Death Review Process

Started in January 2009, the Philadelphia Homeless Death Review process has two components: a conference call and a full review. Eligible cases for review are persons who died within Philadelphia and were both homeless and a Philadelphia resident at the time of their death.

Upon learning of the death of a possibly homeless person, the MEO 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. However, absence in the homeless or behavioral health systems does not preclude the person from being considered homeless. Ad hoc weekly conference calls are convened by the MEO, typically within seven days of the date of death.

Ten members from the primary agencies working with homeless individuals share preliminary information from their data systems or from direct experience. The first task of the conference call members is to help determine whether or not a decedent was indeed homeless at the time of death and thus eligible for a full review. In addition, the group looks for any potential immediate issues that need to be addressed – including whether the MEO investigators need help identifying the decedent or tracking down the next of kin. Conference call members are from both the public and private sectors, and they include the Office of Supportive Housing (shelter), Department of Behavioral Health (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).

Full reviews happen three to four times a year, where typically 12-14 cases are discussed. There are twenty members on the review team from a variety of city and non-city agencies – including input from many of the local hospitals that treat the majority of homeless persons in the city. (See membership listing, Appendix b) Prior to the full review, all members are asked to review their data systems and complete the relevant portions of a Data Collection Tool (included at Appendix c) for each of the homeless decedents. At the full review, the Medical Examiner presents the case, including the cause of death and information gleaned by the MEO investigators. Team members around the table then add to the discussion by highlighting the decedent's interaction with their particular system. Throughout the process, any team member may ask questions and make observations about the specifics of the reviewed cases. The ultimate goal of the group is to point out any identified systematic shortfalls or gaps in community resources, and to make recommendations so that the systems in place can better address the health and well-being of the homeless community – and hopefully prevent future, avoidable homeless deaths.

Comments are recorded by MEO staff, and recommendations are tracked and discussed with the leadership of the Office of Supportive Housing and Department of Behavioral Health for possible implementation. Information is then entered into a database developed by the MEO, which is the basis for the data provided in this report.

## Overview of Philadelphia's Programs to Address Homelessness

The City of Philadelphia invests more than \$125 million annually to address homelessness through a full continuum of services. Components of Philadelphia's Continuum of Care include:

- Cross-departmental winter initiative intervention, known as “Code Blue,” to protect homeless men and women from cold weather exposure
- Similar citywide initiative in instances of severe heat, called “Code Red”
- Philadelphia Police Department Homeless Detail
- Robust Health Care for the Homeless efforts
- Street Outreach
- Quarterly Homeless Street Count
- Safe Havens
- Drug Treatment specifically for chronically homeless individuals
- Overnight Café
- SOAR (SSI/SSDI Outreach, Access and Recovery) a national model to connect homeless individuals with SSI benefits
- Emergency Shelter, which includes a variety of social service supports
- Transitional Housing
- Permanent and Permanent Supportive Housing, including inventory with behavioral health supports and more than 300 Housing First units

In 2008, Mayor Michael Nutter made a substantial commitment to address homelessness by focusing on expanding housing and treatment opportunities for homeless men, women, and families. The housing opportunities are all accompanied by behavioral health and other supportive services to help individuals and families maintain housing, and are designed to move individuals and families to permanent housing and free up new “entry-level” slots. Specifically, the expansion included:

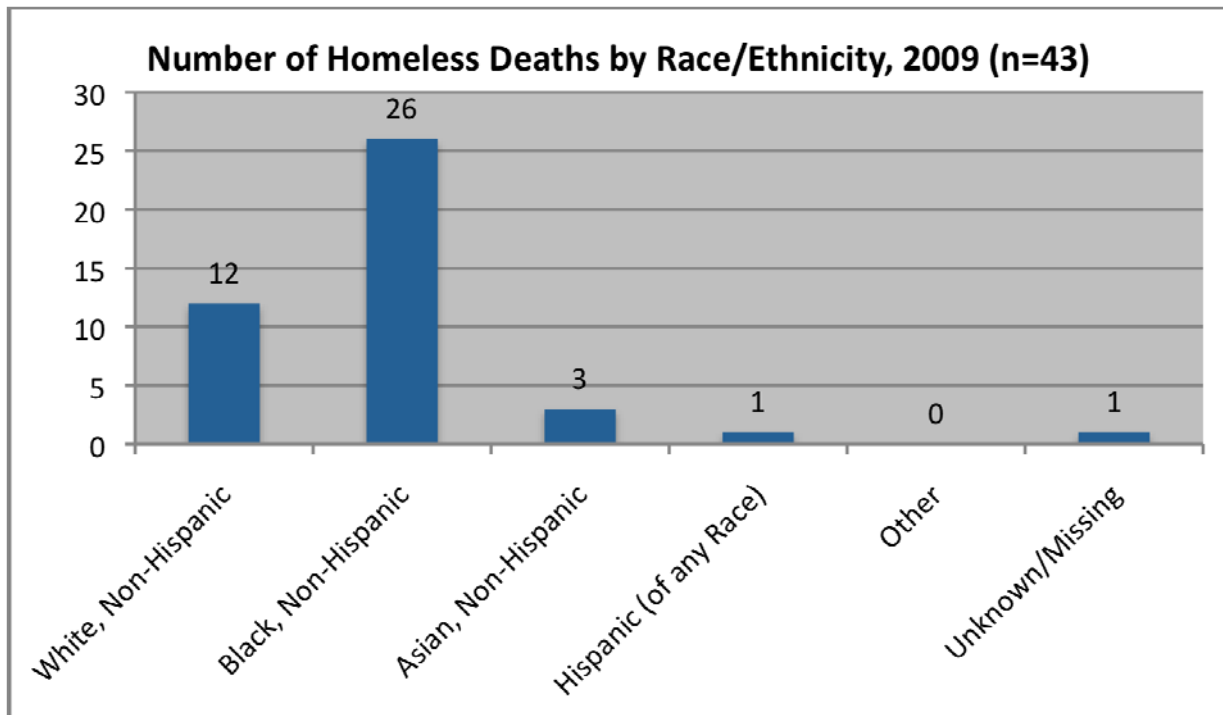
- 300 permanent, subsidized housing opportunities through the Philadelphia Housing Authority (PHA) annually for families who have been living in transitional housing;
- 200 permanent, subsidized PHA housing vouchers annually for single individuals who have been living in transitional housing or behavioral health supported housing;
- 125 permanent, subsidized “Housing First” opportunities for chronically homeless individuals. Housing First provides immediate access to both permanent housing and services and has been shown to be cost effective compared to the costs associated with living on the street and cycling through emergency housing, hospitals and the criminal justice system.
- 75 safe haven and drug treatment beds for chronically homeless individuals with severe mental illness or acute drug or alcohol addictions. Safe Havens provide low-demand housing and support services for individuals on the street to help engage them into treatment and/or longer-term housing.



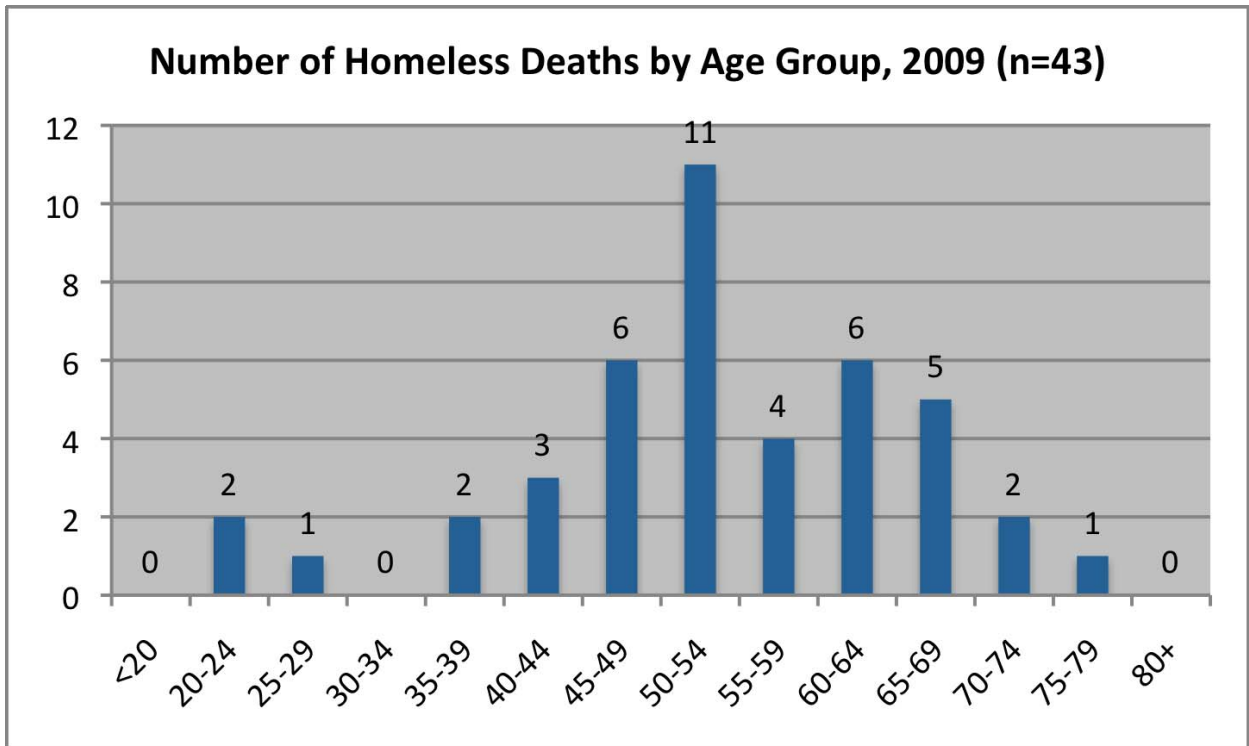
## Demographics of the Homeless Decedents in 2009

Forty-three (43) individuals who died in Philadelphia in 2009 were identified by the Medical Examiner's Office as homeless. While some of these 43 persons had had children earlier in their lives, none of them were homeless as part of a family with children at the time of their death. The basic demographics of this population showed that:

- 1) **The overwhelming majority of those who died, 81%, were male.** This is consistent with the gender distribution among the overall single adult homeless population, which is predominantly male.
- 2) **The majority of those who died, 60%, were African American, and 28% were White.** Only one (2%) of the decedents was identified as Hispanic and 3 (7%) were identified as Asian. Homeless deaths in 2009 were disproportionately White, as compared to Philadelphia's homeless shelter population, which self-identifies as 79% African American, 14% White; and 6% Hispanic. (Philadelphia Homeless Management Information System: US Conference of Mayors Hunger and Homelessness Report, 2009).



3) **Two-thirds of the homeless decedents were aged 50 years or older, and virtually all (93%) who died were younger than age 70.** Eleven of the decedents (26%) were between the ages of 50-54 years when they died, which represents both the median and modal age category. Noteworthy here is that only 3 persons died who were younger than 39 years of age, and that all but one of the Philadelphia homeless persons who died in 2009 were under the age of 73 years. While one cannot determine life expectancy from this table, the relatively early ages of death are consistent with research indicating that the life expectancy for homeless persons is considerably lower than that of the general population.



## Causes of Death

The table below details the primary and contributing causes of death for each of the 43 homeless men and women who died in 2009. For each individual represented, there is always one primary cause and either none, one, or multiple contributing conditions involved in their death

**Number of Homeless Decedents in 2009  
by Primary Cause of Death and "Significant Conditions Contributing to Death" (n=43)**

	Primary Cause	Contributing Conditions***
Cancer	1	0
Circulatory System Disease*	11	5
Diabetes	0	4
Diseases of an Infectious Etiology	10	1
Drug Intoxication or Alcoholism	9	10
Fire	0	0
HIV**	0	2
Hyperthermia	0	0
Hypothermia	0	4
Injury (e.g. blunt force, gunshot wound)	9	1
Respiratory System Disease*	2	3
Other	1	1
Total	43	***

\* *not including diseases of an infectious etiology (e.g. pneumonia, endocarditis)*

\*\* *even if a decedent had HIV, it may not necessarily have caused death or contributed to it*

\*\*\**contributing conditions could be none or multiple conditions*

Key findings from this table include:

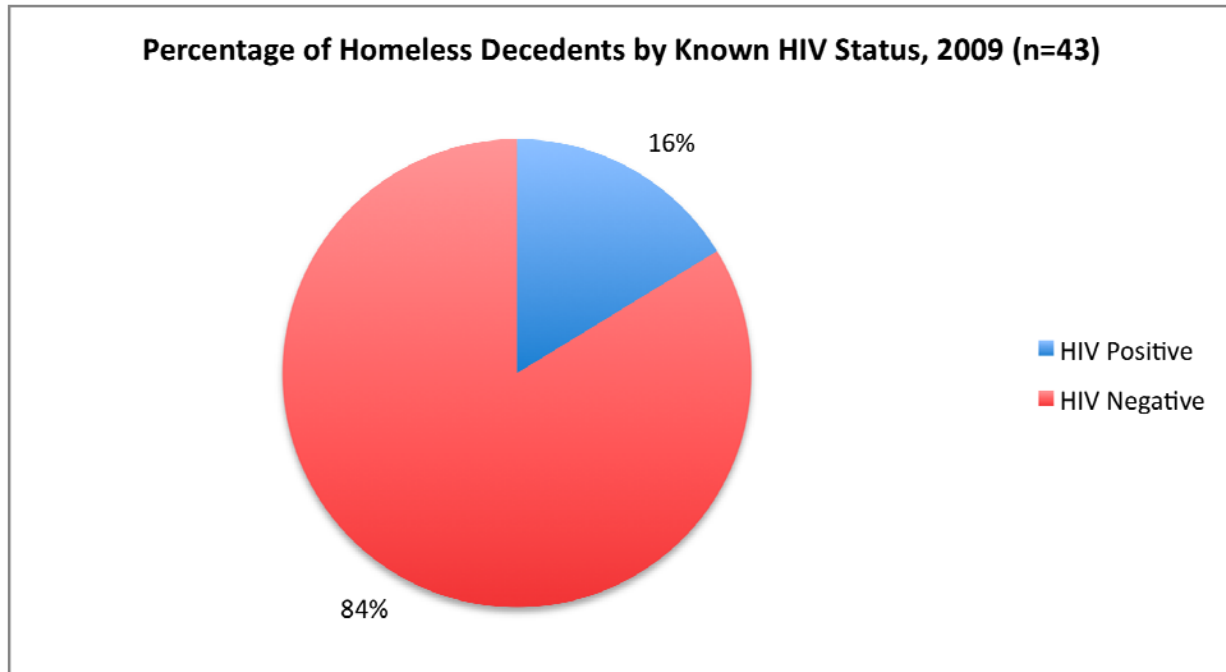
**Eleven homeless decedents (26%) had circulatory system diseases listed as the primary cause of death in 2009.** Circulatory system disease, including coronary artery disease, hypertension, atherosclerosis and various other diseases, is also the leading cause of death among the general population.

**When primary and contributing causes of death are combined, drug intoxication or alcoholism is involved in 19 of the homeless deaths (44%).** This underscores the associations between substance abuse and the single adult homeless population.

**Hypothermia was not a primary cause of any homeless deaths, but it was a contributing factor in four (9%) of the deaths in 2009.** Contrary to what is commonly believed, few homeless people died directly or indirectly due to exposure to cold (i.e., “froze to death”).

**Injury was a common cause of death, accounting or contributing to 10 (23%) of the total homeless deaths in 2009.** Half of these deaths by injury were homicides, two were suicides, and the remaining were accidents. This may be one area to focus on in efforts to reduce deaths among the homeless population.

No homeless person died as a direct consequence of HIV/AIDS in 2009, although this was a contributing factor in two of the deaths (5%). **However, seven (16%) homeless persons in 2009 were known to be HIV positive at the time of their death (shown in figure below).**



## Homeless History and Location of Death

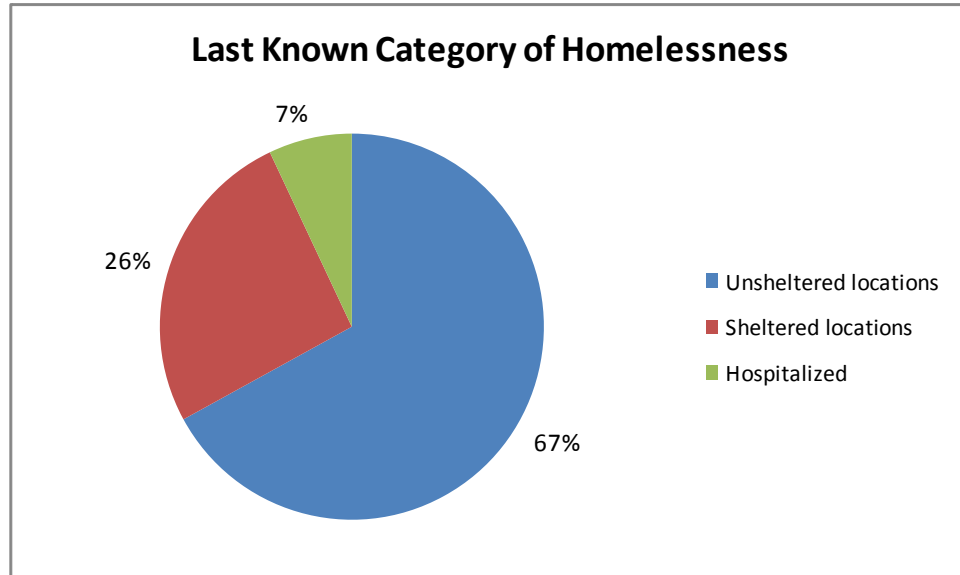
Homelessness involves a variety of makeshift and temporary living situations. These living situations can be parsed into three categories:

- sheltered living arrangements (shelter, safe haven, transitional housing, etc.) made available by homeless service providers;
- unsheltered living arrangements (outdoor camps, abandoned housing, automobiles, etc.) that involve staying in places not meant for human habitation; and
- temporary residence in institutions (hospitals, jails, etc.) such that upon discharge, an individual has no living arrangements in the community.

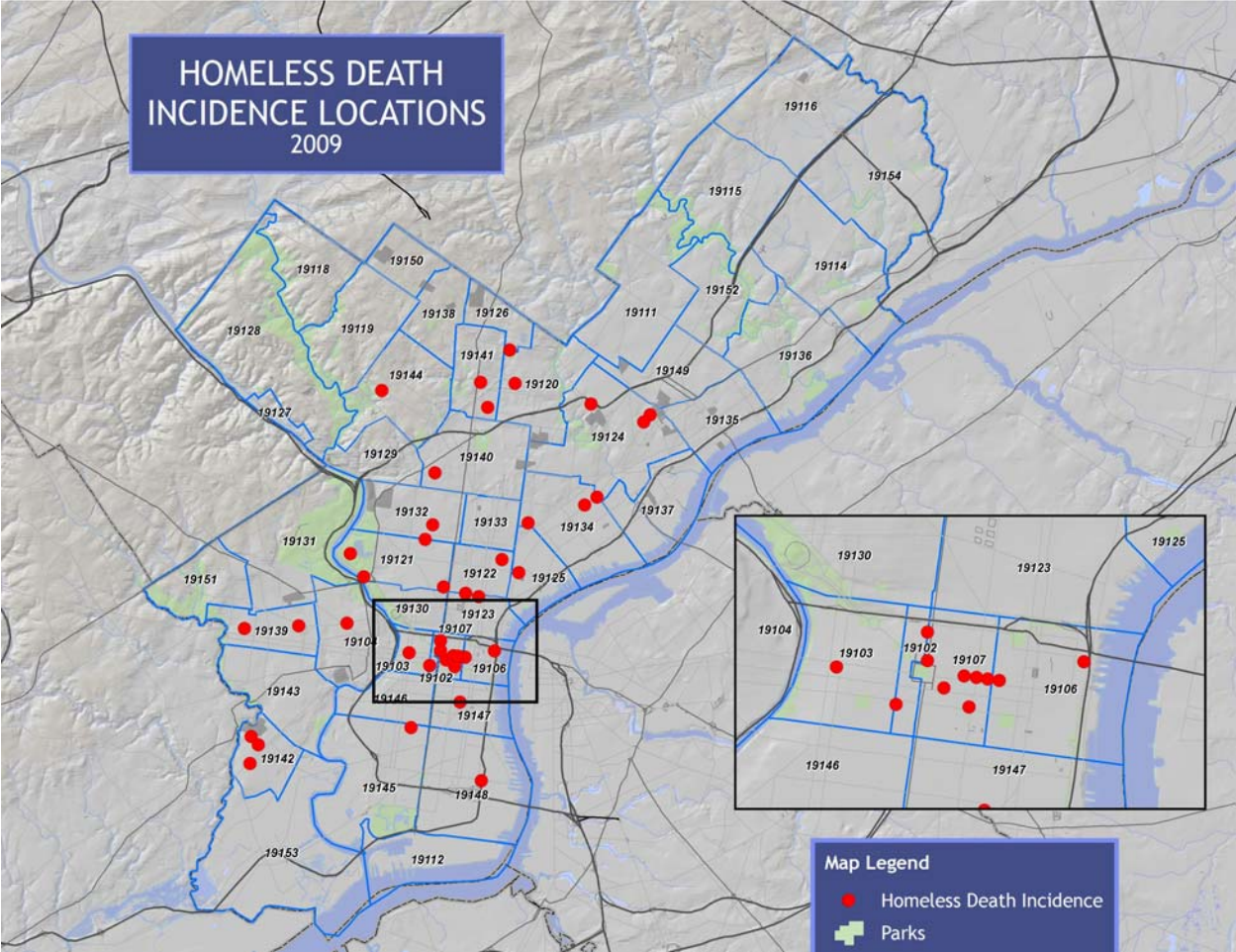
According to our data analysis of the Homeless Death Review, we learned the following about the Philadelphia homeless decedents in 2009:

**Two-thirds of the decedents (29 persons) were staying in unsheltered locations at the time of their deaths.** Specific living situations for this group were unclear, as the majority was listed as last living on sidewalks. This section of the data collection tool will be revised in order to gather more specific information for the future.

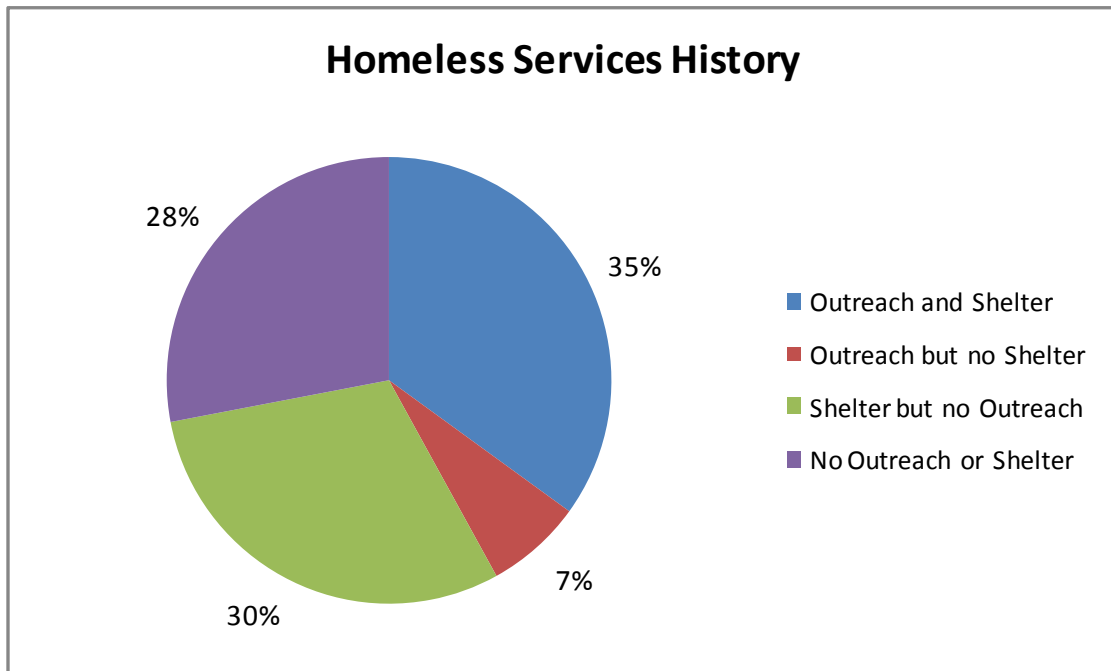
**Another 25% of the decedents (11 persons) were last staying in shelter locations.** Such locations included emergency shelters (8 persons), residential programs (1 person) and safe havens (2 persons).



**Three persons (7%) were last staying in institutional settings.** This included one each in a detoxification program, a psychiatric hospital, and a non-psychiatric hospital. As there is no regular reporting system to the Medical Examiner's Office for deaths that occur in hospitals and in jails, and since institutional staff may not be aware of the housing situations of those who are hospitalized and incarcerated, it is likely that this category was under-identified and thus underreported.



**Twenty-eight persons (65% or almost two-thirds) of homeless adults had records showing that they received some type of homeless service.** Another 7% had no shelter history but were engaged by outreach services. However, a significant minority (28%) of the homeless decedents who were reviewed had absolutely no history of shelter use or outreach contact. This latter group likely constitutes the most difficult group to engage in services – services that might help prevent death while homeless.

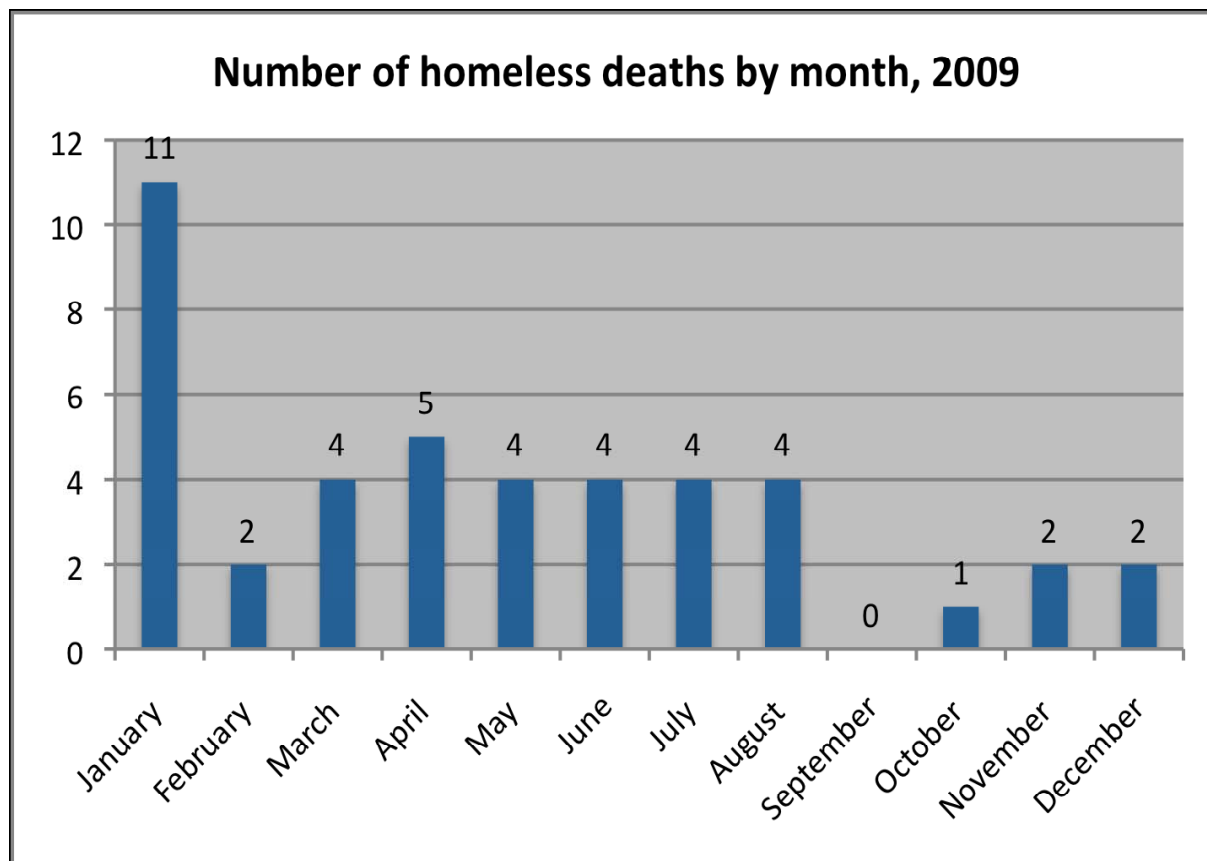


Of those who stayed in City-funded emergency housing (shelter), the chart below depicts the lengths of stay for each of the 43 decedents, shown in 60-day intervals. Fifteen (15) decedents did not stay in shelter; 5 stayed a year or more.

Total Days in Shelter	0	1-30	31-90	91-150	151-210	211-270	271-330	331-365	365+	Total
Total Individuals	15	10	5	3	1	2	2	0	5	43

## Time of Year of Deaths

**Although eleven homeless people (26% of total) died in January, the overall distribution of deaths is split evenly between warmer months (April – September) and colder months (October – March).** Aside from January, which appears somewhat anomalous, no other month saw more than five homeless deaths and September did not experience a single death. Below is a depiction of the number of homeless deaths in each month of 2009.



Because there were so many more deaths in January 2009 than in any other month, the Homeless Death Review team examined this data more closely.

First, the group carefully reviewed again the details of each death in order to ensure consistency with the somewhat evolving “definition of homelessness.” However, the team could not find any cases that needed to be reclassified as “not homeless.”

Second, the group reviewed weather patterns in January 2009 and subsequent months by reviewing the City’s “Code Blue” records, an inclement weather protocol implemented by the City and designed to protect homeless men and women living on the streets (see box on next page). A “Code Blue” is called when “real feel” temperatures are 20 degrees or below or precipitation with temperatures below 32 degrees is predicted.



It was theorized that perhaps the spike in deaths was due to the more severe weather patterns experienced during January 2009. However, further investigation and comparison to 2010 winter months could not explain a direct relationship between the frequency of Code Blue nights and the number of homeless person deaths. (See chart below)

**Comparison of 2009 and 2010 Code Blue Nights  
and Number of Homeless Deaths in the Months of January and February**

	2009 Code Blue Nights	2009 # of Deaths	2010 Code Blue Nights	2010 # of Deaths
January	24	11	18	3
February	15	2	20	2

While we might have anticipated more deaths in the colder months (December – March), cold weather by itself does not appear to account for the spike in January 2009 homeless deaths, nor does it appear to be increasing the overall number of Philadelphia homeless deaths. For the time being, the January 2009 spike still remains unexplained.

On the other hand, it is possible that the Code Blue efforts, which were first started by the City of Philadelphia in January 2005, are indeed preventing additional cold weather exposure deaths for homeless men and women. Continued data surveillance from future years of the Philadelphia Homeless Death Review will hopefully assist in making a determination.

### Code Blue further explained

The extraordinary measures taken during Code Blue activation to sustain the lives of chronically homeless men and women living outdoors in Philadelphia include the following actions:

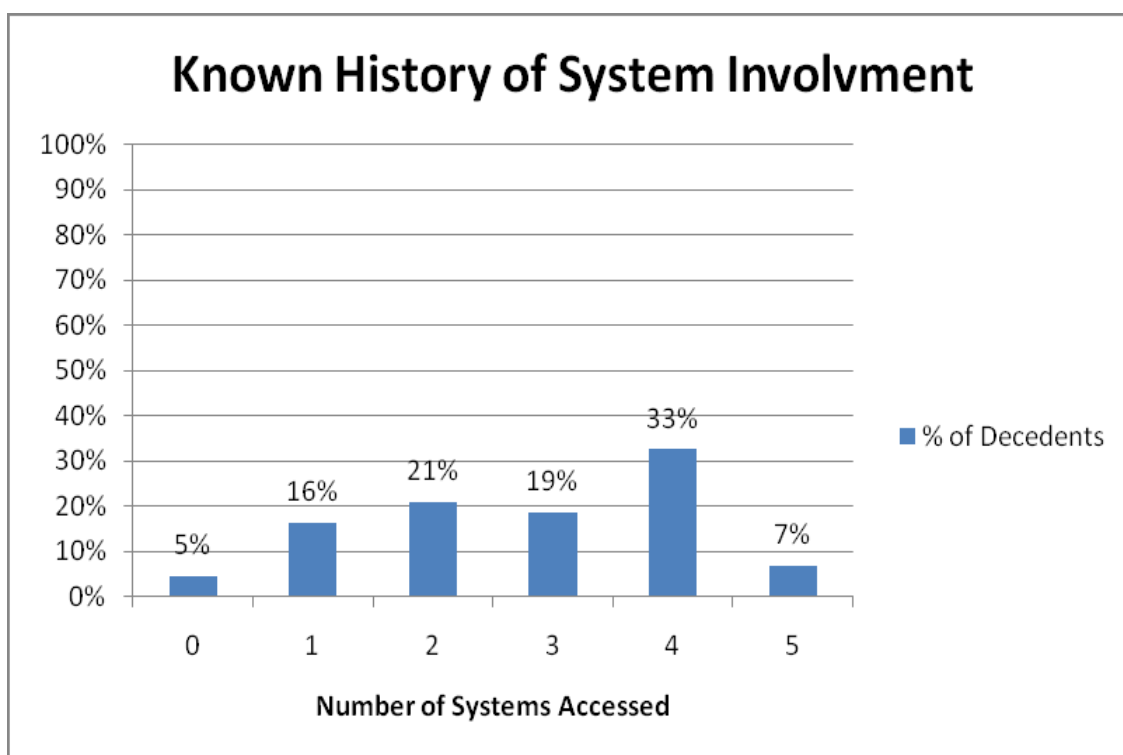
1. Street outreach teams have extended hours, which increases the number of staff available to assist persons who remain on the street.
2. Additional space can be made available at emergency shelters and other locations.
3. Men and women who have been discharged or previously prohibited from utilizing shelters (due to violations of rules and regulations) will be provided a bed.
4. Outreach teams and the Philadelphia Police Department can implement the COTS (Court Ordered Transportation to Shelter) procedure by alerting an on-call City Solicitor and Court of Common Pleas Judge to obtain permission to transport individuals to shelter to ensure their safety.
5. Outreach teams are able to involuntarily commit a person who has severe mental illness and will not come into shelter. Called a “Code Blue 302”, this process ensures at least a psychiatric evaluation and typically a 3-day hospital stay in a psychiatric unit. The person is assertively care managed, with attempts to ensure an appropriate discharge plan to supportive housing.
6. Participating shelters allow clients to remain indoors throughout the day.

## Multiple Systems Involvement

To determine the number of systems “known” to each homeless decedent, we looked at histories according to the following seven systems:

1. Shelters
2. Hospital (includes emergency room visits and hospitalizations)\*
3. Mental Health
4. Drug & Alcohol
5. Criminal Justice
6. Child Welfare
7. Veterans Administration

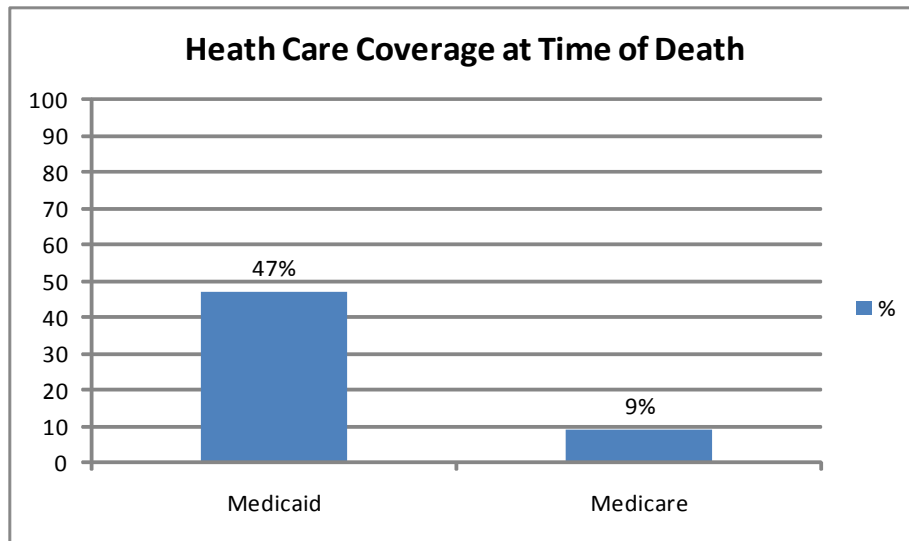
**Ninety-five percent (95%) of the homeless decedents were known to at least one system, and fifty-nine percent of those who died were known to three or more systems.**



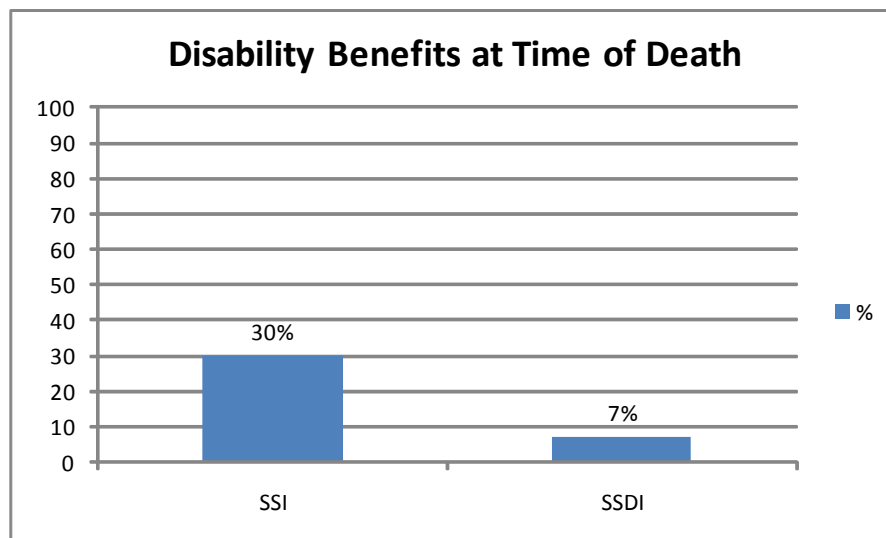
\* Information on the subsequent pages details systems involvement in mental health, substance abuse, criminal justice, child welfare, and veterans. Hospital and emergency room information is not included as information collected was too limited for more detailed analysis or conclusions.

## Public Health Care Coverage and Disability Benefits at Time of Death

**Medicaid covered 47% of the homeless decedents, and another 9% had Medicare benefits.** Of the remaining 44% decedents, an additional few individuals would have been eligible for health services due to their veteran status, and it is possible that a small number may have been covered by private health insurance. Regardless, a significant minority (up to as many as 44% of the decedents) lacked health care coverage at the time of their death.



**Thirty percent of the homeless decedents were receiving disability benefits through the Supplemental Security Income (SSI) program. Additionally, 7% received Social Security Disability Insurance (SSDI) benefits.**

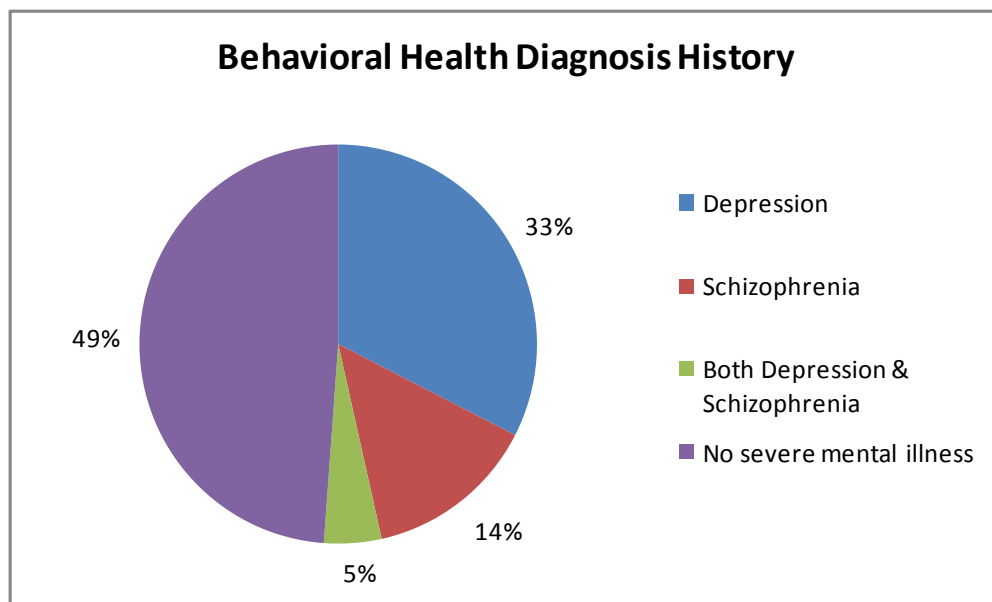


In addition: 13 of the 20 persons who were eligible for Medicaid coverage presumably had this health coverage linked with their SSI benefits. For those who were receiving disability benefits, 88% of them had health care coverage through Medicaid and/or Medicaid at the time of death, whereas for those who were not receiving disability benefits, only 33% of them had their health care coverage through Medicaid and/or Medicare at the time of death.

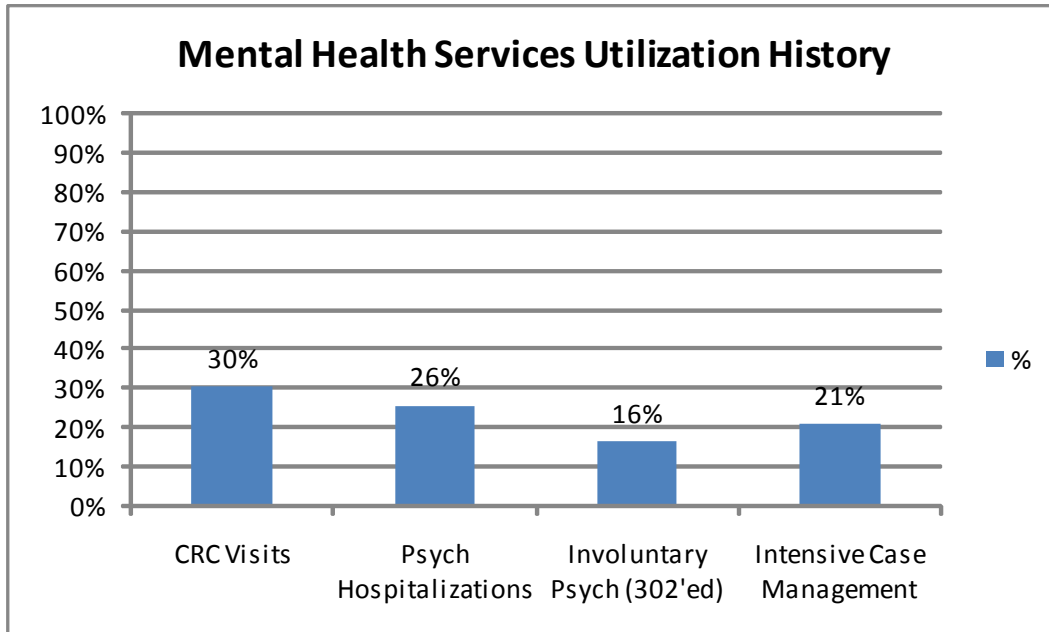
## Behavioral Health History

The findings related to behavioral health (mental illness and substance abuse) come from the records of the City of Philadelphia's Department of Behavioral Health and Mental Retardation (DBH/MR). The findings, based on services accessed through the DBH/MR system, give some indication of the prevalence of psychiatric and substance abuse disorders among the homeless decedents prior to their death. DBH/MR data systems indicate whether someone has accessed publicly funded behavioral health services in the recent past. Both mental illness and substance abuse were highly prevalent in this deceased population, and substance abuse was cited as a primary or contributing cause for many of the homeless deaths.

**24 persons (51%) of the homeless decedents were identified as having been diagnosed with a severe mental illness (either schizophrenia and/or a mood disorder) during their lifetimes.** 33% of the homeless decedents had a history of depression or mood disorders, 14% had a history of schizophrenia, and 5% had a history of both. Mental illness is clearly a major issue in relation to homelessness and homeless deaths.



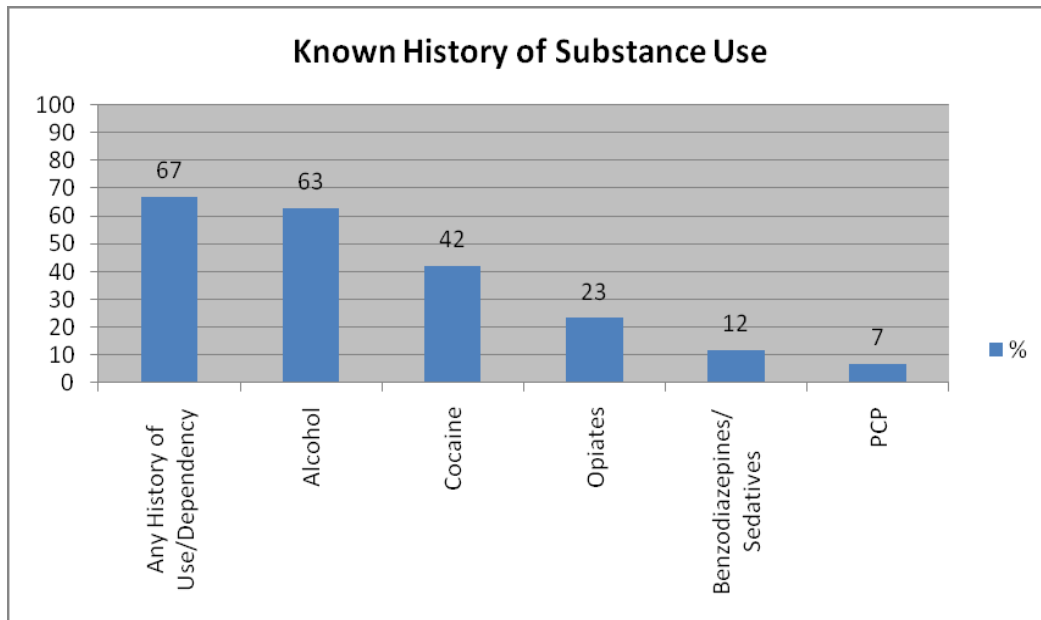
Mental health services utilization history among the homeless decedents was quite high. Close to one third (30%) had received services at a crisis response center (CRC), at least 26% had had a publicly funded psychiatric hospitalization, and 21% had received intensive case management services.



Among the 24 homeless decedents who had been diagnosed with a serious mental illness, the utilization percentages are much higher: **41% of them received services at a crisis response center (CRC), 45% had records of publicly funded psychological hospitalizations, 32% had received Intensive Case Management, and 27% had an involuntary admission into psychological treatment.**

**67% of the homeless decedents had a history of any substance use or dependency, and 63% of the decedents had a specific history of alcohol abuse.** This means that nearly every homeless decedent identified as having abused substances had an alcohol abuse or dependency problem. 16% of the decedents (seven individuals) had a history of sole alcohol abuse with no other known drug use.

Additionally, 42% of the decedents had a history of cocaine use or abuse, 23% had a history of opiate use or abuse, 12% had used benzodiazepines, and 7% had used PCP.

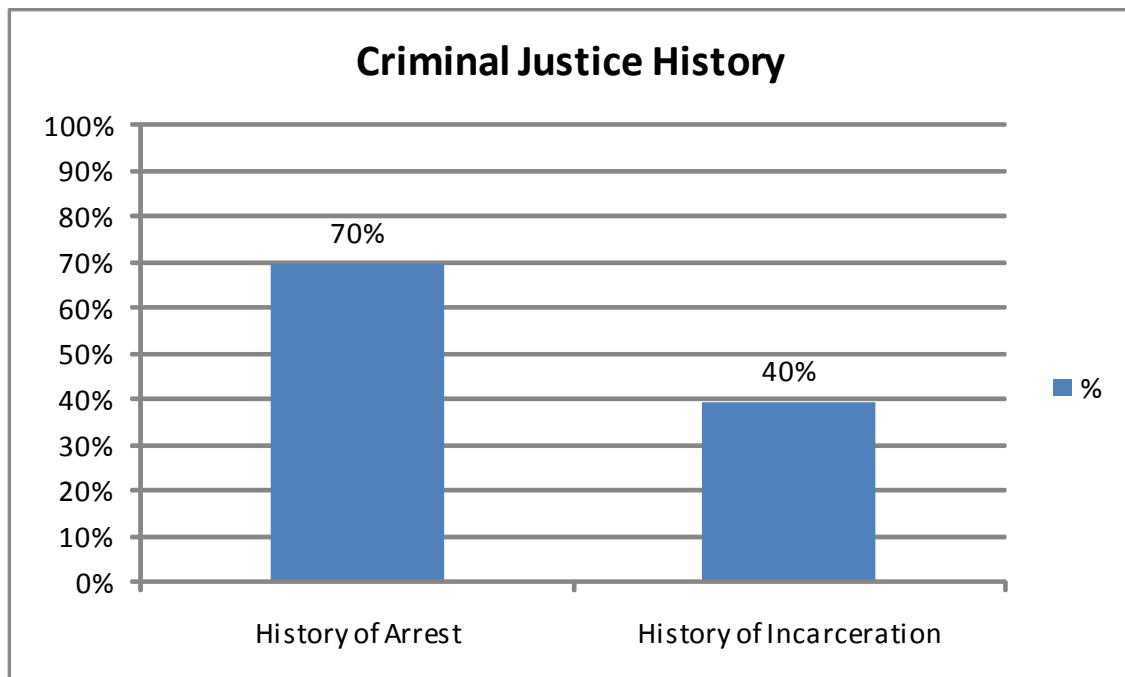


Looking at the 24 persons who had been diagnosed with a severe mental illness, 77% of them had a history of substance abuse (larger than the 67% prevalence for the general homeless decedent population).

**Of those with a history of substance abuse, 62% had a record of having had some type of publicly funded drug and alcohol treatment.**

## Criminal Justice History

**70% of the homeless decedents had previously been arrested, and 40% had a history of incarceration.** The PHDR team did not collect specific data about the accused crimes which lead to these arrests, the frequency of convictions, or the length or frequency of incarcerations. However, the variance between arrests and incarceration suggests individuals may have been arrested for minor infractions that did not merit incarceration. Interactions between these homeless decedents and the criminal justice system were obviously frequent, but more specific data will be need to be collected at future reviews in order to better attempt to understand this relationship.

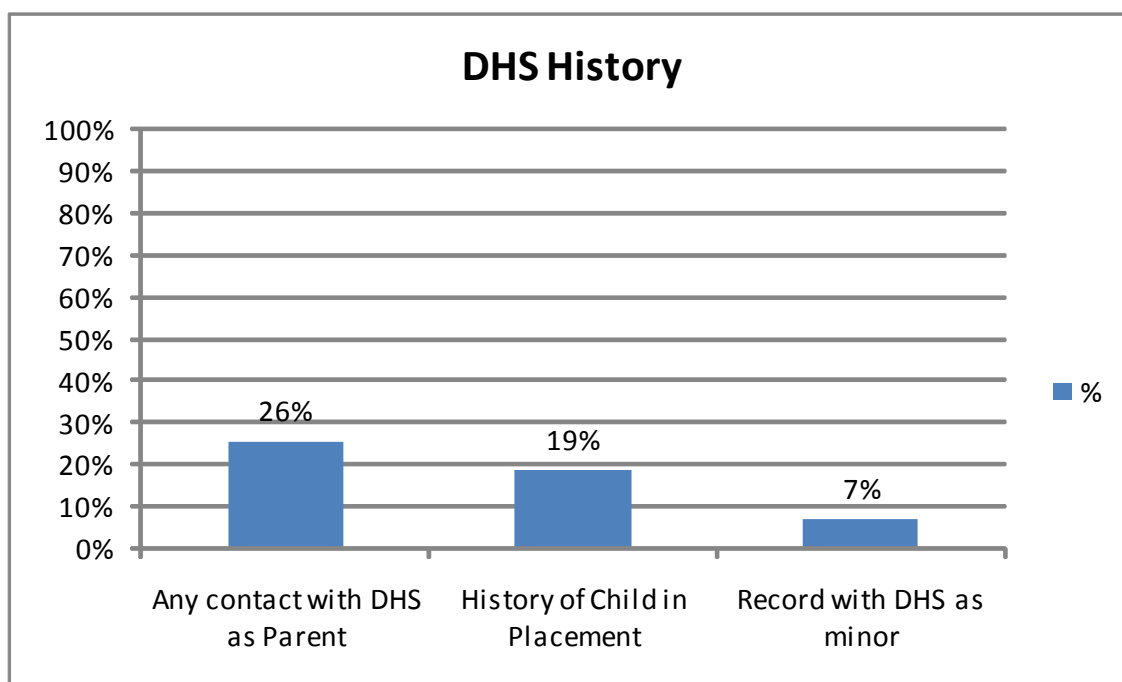


## Child Welfare History

**26% of the homeless decedents had had contact with the City of Philadelphia’s Department of Human Services (DHS) as a parent or caregiver, and 19% had had a child in placement. In addition, 7% of the homeless decedents had a record with DHS as a minor.** In a manner similar to criminal justice involvement, more data would be helpful to better understand the relationship between the homeless decedents and the child welfare system.

Unfortunately, DHS’s electronic record-keeping is relatively recent, and older files are usually difficult to access. As a result, it might not ever be possible to properly analyze homeless decedents’ distant DHS contacts – especially their records with DHS as a minor.

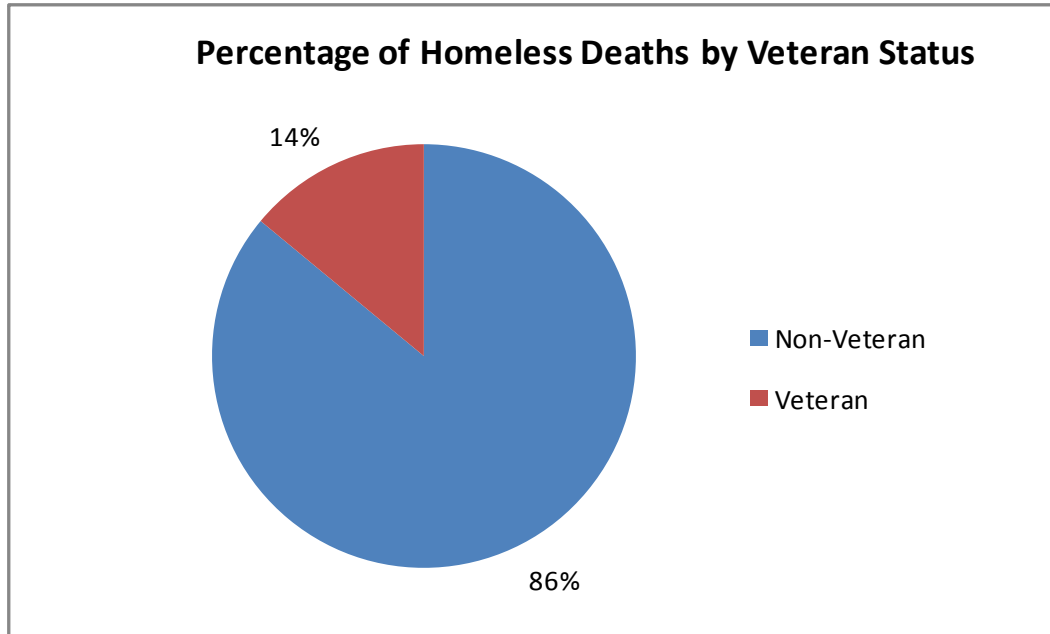
When looking only at the **18 homeless decedents who were known to be parents, we learned that fully one half (50%) of them had contact with DHS as a parent.**





## Veteran Status and Services

**Six persons among the 43 decedents (14%) were identified as veterans according to Veteran Administration records.**



Nationwide, estimates of the veteran population among men and women living on the streets are as high as 25%, so the number of homeless decedents known to be veterans was lower than originally anticipated.

In addition, five of these six veterans had had histories of hospitalizations in the VA health system (though not necessarily at the time of death).

## Actions That Have Already Resulted from the Philadelphia Homeless Death Review

1. The death of an individual who was taken to a Crisis Center by a street outreach team member, but who left when the street outreach worker left, resulted in a change in protocol so that street outreach workers will remain with consumers to encourage them to be served by the Crisis Center.
2. After the high-profile death of a severely mentally ill woman reported as missing by her Case Manager (and who was later found to have spent a couple nights in the City's low-demand overnight cafes), the behavioral health system's missing persons notification process was expanded to include more of the emergency housing system. Regular data matches were also run between persons utilizing overnight café services and persons receiving mental health case management services. If a person using a café had a case manager, that case manager was notified and requested to assist with other more appropriate placements.
3. Through the Philadelphia Homeless Death Review, the City and its partners have established an information sharing process that has allowed us to identify a next of kin in 98% of the homeless deaths. The MEO has established relationships with area hospital social workers and discharge planners so that we receive information about homeless individuals who die in a hospital but are not MEO cases.
4. After the death of an individual who requested drug treatment several days before death, the behavioral health system tightened its protocol to further ensure that assessment centers for addiction treatment were aware of the priority for serving homeless individuals and to be certain that every homeless person who requested treatment would be served.
5. The frequency of deaths in which alcohol or substance abuse is a contributing factor has confirmed the City's commitment to expand drug treatment slots for chronically homeless men and women; and affirmed efforts currently under development, which will establish new Housing First slots in collaboration with Emergency Departments; and create new a housing program specifically for men with chronic alcohol addiction.

## Next Steps and Questions for Further Exploration

As we continue the work of the Homeless Death Review through 2010 and beyond, the following will continue to be areas of focus and further research, discussion, and/or exploration:

### Homeless Definition

Although the City of Philadelphia has benefited from reviewing definitions used by other locations that report on homeless deaths (including Los Angeles County, New York City, San Francisco, and King County, Washington), we ultimately adopted the federal definition of “homelessness,” shown below from the United States Code, Title 42, Chapter 119, Subchapter 1:

The term "homeless" or "homeless individual or homeless person" includes-

- an individual who lacks a fixed, regular, and adequate nighttime residence; and
- an individual who has a primary nighttime residence that is -
  - a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); or
  - an institution that provides a temporary residence for individuals intended to be institutionalized; or
  - a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

Group discussion has occurred around people who were offered a place to stay and refused, as well as around what constitutes “fixed, regular, and adequate” housing. In addition, people suffering from mental illness have proven challenging to classify as homeless, especially when a family member seeks to provide a residence but the individual refuses.

Finally, we are limited by record-keeping and data sources, especially when an individual does not have a street outreach or shelter history, and there is no indication in the behavioral health databases of homelessness. We are limited because individuals may use multiple names, dates of birth, and/or social security numbers, and not every local hospital and managed care organizations participate in the review and/or information sharing processes. Until now, we have relied on verbal reports from family or hospital personnel as collected by Medical Examiner investigators. We are considering standard questions for investigators that will help us collect more specific information when homeless status is identified, such as “where did s/he sleep?”

One lesson we have learned through the PHDR process is the importance of active surveillance with a multidisciplinary team when attempting to track homeless deaths. We have learned that it is near impossible to accurately determine homelessness status solely based on death certificate information, or even with the additional help of Medical Examiner investigative information.

## Program and System Improvements

General areas that require further planning, generated at the face-to-face meetings and reviewed with the heads of the Department of Behavioral Health and the Office of Supportive Housing, include:

1. Increased service/system coordination
2. Discharge planning from prisons, hospitals, etc.
3. Location of homeless deaths.

We noted several deaths in an area with known heroin users, and we did some preliminary GIS mapping. Knowing the lethality of these locations could lead to additional resources (e.g. street outreach teams focused on recovery) being deployed to these locations. We have also initiated discussions about coordinating efforts to ensure that after a homeless decedent has been identified as living in an abandoned building, that unit gets boarded up, and street outreach attempts to engage any individuals still living in the location.

## Need for Additional Data and Analysis

As noted throughout the course of this report, there are several areas in which more data, kept over a longer period of time, is needed to help determine the extent and impact of experiences and system interaction on the lives and deaths of homeless men and women. Some of these may include:

- Impact of weather
- Criminal Justice history
- Child welfare system history
- Medical history (through hospitals and managed care organization partners)
- Last known system to “touch” a person prior to death
- Relationship between health care benefits and income supports and time elapsed before death

We collected a great deal of data about the 43 homeless men and women who died, and we are exploring further ways to better organize and analyze future data in order to continue to identify possible changes from interventions. We will benefit from further analysis of the multiple systems data, and for individuals with complex service histories, we hope to develop a new format of case presentations at the full reviews: to describe decedents’ service interactions chronologically rather than system-by-system. This type of snapshot will help us get a more comprehensive picture of services utilized by the homeless men and women of Philadelphia.

One of the most immediate benefits of the Homeless Death Review is that the information sharing among partners has resulted in a more rapid identification of the deceased individual and “next of kin” in cases where the Medical Examiner’s investigators had little information. Identification of the homeless decedent and/or his or her next of kin occurred in every case in 2009 – with the exception of one, an African American male who has not yet been identified despite tremendous efforts and an article in the local city newspaper. As every individual is a son, daughter, sister, brother, we hope to have a breakthrough on this gentleman’s identity.

## Possible Research Questions

With regard to research, we are curious about the role of social networks in prevention of homelessness and death. Preliminary conversations with a local researcher may result in some data collection in this regard. We will continue to review data for emerging “typologies” based on multiple systems involvement, and we are particularly interested in which systems were involved immediately prior to death.

We are interested in understanding if there is a relationship between maintaining Medicaid benefits and earlier death, and we will continue to collaborate with emergency departments to coordinate around heavy users of services with long histories of homelessness.

Other possible future research questions to address include: determining where the older homeless persons are dying (as we were able to identify very few decedents aged 65 or older who were homeless at the time of death), how many homeless decedents are indeed HIV positive (and not simply known to have HIV while alive), and what are the demographics of deaths of formerly homeless persons (who were not homeless at the time of their death).

## Expanding the Team/Sharing the Information

We believe the systematic and collaborative review of the lives and experiences of homeless men and women prior to their death can influence policy and program decisions in a beneficial manner. We seek to:

1. Expand the number of people at the table, both full participating team members and others who simply provide information about the deceased (e.g. other hospitals and emergency departments, Medicaid managed care organizations)
2. Use the PHDR team as a springboard for conversations with professionals across the City to discuss common issues or new interventions (e.g. discussing the feasibility of creating a medical respite program in Philadelphia)
3. Further improve our ability to track and identify homeless person deaths – so that we might one day be able to say with confidence that we are reporting on 99% of homeless decedents.
4. Collaborate with local researchers on targeted research projects using data from the PHDR
5. Share our successes and lessons learned with other cities, so that Philadelphia’s approach can serve as model for places interested in establishing their own homeless death review process. For cities interested in learning about their homeless decedents, we highly recommend the development of a review process that employs active surveillance and a multidisciplinary team to track homeless deaths. If an in-person review team is not possible, we recommend a conference call team at the minimum – because determining whether or not a decedent was truly homeless at the time of death is not such an easy question to answer.
6. Share Philadelphia’s work with the greater public health community: we plan to submit an abstract for poster presentation at the 2011 American Public Health Association Annual Meeting.

## 2009 Philadelphia Homeless Death Summary

**Number of Homeless Decedents by Month of Death**

	2009	
	N	%
January	11	26
February	2	5
March	4	9
April	5	12
May	4	9
June	4	9
July	4	9
August	4	9
September	0	0
October	1	2
November	2	5
December	2	5
Total	43	100

**Number of Homeless Decedents by Gender**

	2009	
	N	%
Female	8	19
Male	35	81
Total	43	100

**Number of Homeless Decedents by Veteran Status**

	2009	
	N	%
Veteran	6	14
Non-Veteran	37	86
Total	43	100

**Number of Homeless Decedents by Age**

	2009	
	N	%
<20	0	0
20-24	2	5
25-29	1	2
30-34	0	0
35-39	2	5
40-44	3	7
45-49	6	14
50-54	11	26
55-59	4	9
60-64	6	14
65-69	5	12
70-74	2	5
75-79	1	2
80+	0	0
Unknown	0	0
Total	43	100

**Number of Homeless Decedents by Known HIV Status**

	2009	
	N	%
HIV Positive	7	16
HIV Negative	36	84
Total	43	100

**Number of Homeless Decedents by Manner of Death**

	2009	
	N	%
Accident	15	35
Homicide	5	12
Suicide	2	5
Natural	21	49
Undetermined	0	0
Total	43	100

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

	Primary Cause	Contributing Conditions
Hypothermia	0	4
Hyperthermia	0	0
Drug Intoxication or Alcoholism	9	10
Circulatory System Disease*	11	5
Respiratory System Disease*	2	3
Diabetes	0	4
Diseases of an Infectious Etiology	10	1
HIV**	0	2
Injury (e.g. blunt force, gunshot wound)	9	1
Fire	0	0
Cancer	1	0
Other	1	1
Total	43	***

**Number of Homeless Decedents by Race/Ethnicity**

	2009	
	N	%
White, Non-Hispanic	12	28
Black, Non-Hispanic	26	60
Asian, Non-Hispanic	3	7
Hispanic (of any Race)	1	2
Other	0	0
Unknown/Missing	1	2
Total	43	100

\*not including diseases of an infectious etiology (e.g. pneumonia, endocarditis)

\*\* even if decedent had HIV, it may not necessarily have caused death or contributed to it

\*\*\*contributing conditions could be none or multiple conditions

# Philadelphia Homeless Death Review Team (2010)

## Team Members

Jose A. Benitez, MSW Executive Director, Prevention Point Philadelphia	<i>Alternate:</i> Yaya Liem Syringe Exchange Program Coordinator, PPP
Amy Bennett Quality Review Representative, Community Behavioral Health	<i>Alternate:</i> Gail Edelson, MD, MSPH Medical Director, Community Behavioral Health
*Stephen Bennett, LCSW Social Worker Supervisor/Community Based Program Coordinator, Philadelphia VA Medical Center	
Eric J. Berman, DO, MS Chief Medical Officer, Keystone Mercy Health Plan	<i>Alternate:</i> Maria Pajil Battle Senior VP, Public Affairs & Marketing, KMHP
Patricia Blow Director, Adult Probation/Parole Department, Philadelphia Courts	<i>Alternate:</i> Josette Springer Supervisor, Adult Probation/Parole Department
*Roberta Cancellier, MSW Deputy Director, Policy & Planning, Office of Supportive Housing	<i>Alternate:</i> *Michele Mangan, MSW Senior Project Manager and Analyst, OSH
Dennis P. Culhane, PhD Prof, School of Social Policy and Practice, University of Pennsylvania	<i>Alternate:</i> Stephen Metraux, PhD Assistant Professor, University of the Sciences in Philadelphia
Susan Cusack, MSN, MBA Vice President of Operations, Mercy Philadelphia Hospital	<i>Alternate:</i> Kay Stephens, RN, CDE Director, Community & Ambulatory Services, Mercy Philadelphia
Samuel J. Cutler Drug and Alcohol Abuse Program Mgr, Office of Addiction Services	<i>Alternate:</i> *David Holloman Coordinator, Homeless Outreach Services, CBH
*Leti Egea-Hinton Deputy Director, Operations, Office of Supportive Housing	<i>Alternate:</i> *Peggy Brannan Administrator, Single Intake & Case Mgmt, OSH
*Sam Gulino, MD Chief Medical Examiner, Medical Examiner's Office, Philadelphia Department of Public Health	
Insp. David Jardine Field Operations - Investigations Coordinator, Police Department	<i>Alternate:</i> Sgt. John Gorman Police Department
Eunice King, PhD, RN Senior Program Officer, Director of Research and Evaluation, Independence Foundation	
Bon Ku, MD, MPP Assistant Professor of Emergency Medicine, Thomas Jefferson University	<i>Alternate:</i> Robert McNamara, MD, FAAEM Chairman, Dept of Emergency Med, Temple School of Medicine
*Beth Lewis, DSW, LCSW Program Director, Outreach Coordination Center, Project H.O.M.E.	<i>Alternate:</i> *Laura Weinbaum Director of Policy, Project H.O.M.E.
*Marcella Maguire, PhD Director, Homeless Services, Department of Behavioral Health	<i>Alternate:</i> *David Holloman Coordinator, Homeless Outreach Services, CBH
Richard J. McMillen Executive Director, Sunday Breakfast Rescue Mission	
Thomas J. Mudrick Senior Advisor, Performance Management & Accountability, DHS	<i>Alternate:</i> Abdulhakiym Muhammad Program Analyst, PM&A, Department of Human Services
*Sandy Orlin, MSN, CRNP Clinical Director, PHMC/Health Care for the Homeless	<i>Alternate:</i> *Beth Browning Infection Control Coordinator, PHMC/HCH
Stephanie Puccia, MSW Asst Director, Dept of Case Management, Hahnemann University Hospital	<i>Alternate:</i> Tracy Griffith, LCSW Social Work Team Leader, Hospital of the U. of Pennsylvania
*Evelyn Torres, MBA Manager of Client Services, AIDS Activities Coordinating Office	

## Team Staff

Team Facilitator: Roy Hoffman, MD, MPH Medical Director, Fatality Review Program	Team Coordinator: Ugo Chizea-Abuah, MSPH Program Coordinator, Fatality Review Program
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\* signifies a member or alternate member for the Homeless Death Conference Call team





# Philadelphia Homeless Death Review

## Data Collection Tool 1.0

### 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. Was Person Found Dead or Injured?  Y  N  
Found by Whom?  Police  Passerby  Outreach Worker  Family/Friend  
 Neighbor  Other: \_\_\_\_\_
22. Cause of Death:
- | <i>Injury</i>  | <i>Medical</i>   |
|--|--|
| <input type="checkbox"/> Motorized Vehicle Crash               | <input type="checkbox"/> Cardiovascular Disease                |
| <input type="checkbox"/> Firearm                               | <input type="checkbox"/> Cerebrovascular Disease               |
| <input type="checkbox"/> Weapon other than Firearm             | <input type="checkbox"/> Cirrhosis / Chronic Liver Disease     |
| <input type="checkbox"/> Hypothermia                           | <input type="checkbox"/> Chronic Obstructive Pulmonary Disease |
| <input type="checkbox"/> Hyperthermia                          | <input type="checkbox"/> Renal Disease                         |
| <input type="checkbox"/> Fall or Crush                         | <input type="checkbox"/> Malignant Neoplasm                    |
| <input type="checkbox"/> Fire, Smoke, Burn, or Electrocutation | <input type="checkbox"/> Alzheimer's                           |
| <input type="checkbox"/> Drowning                              | <input type="checkbox"/> Diabetes                              |
| <input type="checkbox"/> Suffocation or Strangulation          | <input type="checkbox"/> Influenza and Pneumonia               |
| <input type="checkbox"/> Poisoning by Psychoactive Substance   | <input type="checkbox"/> HIV/AIDS                              |
| <input type="checkbox"/> Poisoning by Other Substance          | <input type="checkbox"/> Viral Hepatitis                       |
| <input type="checkbox"/> Other: _____                          | <input type="checkbox"/> Tuberculosis                          |
|  | <input type="checkbox"/> Other Infectious Etiology: _____      |
|  | <input type="checkbox"/> Other Non-Infectious Etiology: _____  |
23. Conditions Contributing to Death: \_\_\_\_\_  
\_\_\_\_\_
24. Manner of Death:  Natural  Accident  Homicide  Suicide  Undetermined
25. Was Toxicology Screen Performed at Autopsy?  Y  N  
Results: \_\_\_\_\_

# Philadelphia Homeless Death Review

## Data Collection Tool 1.0

### 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
- Other: \_\_\_\_\_

Note: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

27. Was Decedent Considered Chronically Homeless\*? Y N

(\*based on federal definition of chronic homelessness)

# Philadelphia Homeless Death Review

## Data Collection Tool 1.0

### D. Homeless Services Utilization History

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

29. City-Funded Emergency Shelter Housing History? Y N

First Known Entry/Exit Date (mm/yy): \_\_\_\_/\_\_\_\_

Last Known Entry/Exit Date (mm/yy): \_\_\_\_/\_\_\_\_

Total # of Days in Shelter: \_\_\_\_\_

30. City and HUD-Funded Transitional Housing History? Y N

First Known Entry/Exit Date (mm/yy): \_\_\_\_/\_\_\_\_

Last Known Entry/Exit Date (mm/yy): \_\_\_\_/\_\_\_\_

Total # of Days in Housing: \_\_\_\_\_

31. City and HUD-Funded Residential Program History? Y N

First Known Entry/Exit Date (mm/yy): \_\_\_\_/\_\_\_\_

Last Known Entry/Exit Date (mm/yy): \_\_\_\_/\_\_\_\_

Type of Program: \_\_\_\_\_ Total # of Days in Program: \_\_\_\_\_

32. Intensive Case Management History? Y N

First Known Date (mm/yy): \_\_\_\_/\_\_\_\_

Last Known Date (mm/yy): \_\_\_\_/\_\_\_\_ Total # of Cases: \_\_\_\_\_

33. Street Outreach (OCC) History? Y N

First Known Date (mm/yy): \_\_\_\_/\_\_\_\_

Last Known Date (mm/yy): \_\_\_\_/\_\_\_\_ Total # of Contacts: \_\_\_\_\_

33a. Street Outreach Services Provided? (if yes, provide total # times service was provided)

Food  N  Y: \_\_\_\_\_ Medical Service  N  Y: \_\_\_\_\_

Clothing  N  Y: \_\_\_\_\_ D&A Service  N  Y: \_\_\_\_\_

Transportation  N  Y: \_\_\_\_\_ MH Service  N  Y: \_\_\_\_\_

Employment/Vocational  N  Y: \_\_\_\_\_ Self-Care, Hygiene  N  Y: \_\_\_\_\_

Legal/Court Issues  N  Y: \_\_\_\_\_ Self-Preservation  N  Y: \_\_\_\_\_

Benefits Eligibility  N  Y: \_\_\_\_\_ Police Assistance  N  Y: \_\_\_\_\_

Engagement  N  Y: \_\_\_\_\_ Other: \_\_\_\_\_  N  Y: \_\_\_\_\_

33b. Street Outreach Placements Provided? (if yes, provide total # times placement was provided)

BHS Shelter/Safe Haven  N  Y: \_\_\_\_\_ Non-Psych ER/Hosp  N  Y: \_\_\_\_\_

Other Social Service Agency  N  Y: \_\_\_\_\_ Detox Program  N  Y: \_\_\_\_\_

Overnight Café  N  Y: \_\_\_\_\_ CRC (Involuntary)  N  Y: \_\_\_\_\_

Boarding Home  N  Y: \_\_\_\_\_ CRC (Voluntary)  N  Y: \_\_\_\_\_

OHS Shelter  N  Y: \_\_\_\_\_ PDR (AAS-Gatekept)  N  Y: \_\_\_\_\_

Private Shelter  N  Y: \_\_\_\_\_ Family/Friend  N  Y: \_\_\_\_\_

# Philadelphia Homeless Death Review

## Data Collection Tool 1.0

### E. Medical History (not including Behavioral Health)

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

##### *Infectious Diseases*

- |                        |   |
|------------------------|---|
| HIV/AIDS               | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Tuberculosis           | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Pneumonia or Influenza | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Endocarditis           | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Hepatitis B            | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Hepatitis C            | <input type="checkbox"/> Y <input type="checkbox"/> N |

##### *Cardiovascular Conditions*

- |  |   |
|--|---|
| Hypertension                             | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cardiac Disease                          | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Stroke and Other Cerebrovascular Disease | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Chronic Venous Insufficiency             | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Chronic Renal Disease                    | <input type="checkbox"/> Y <input type="checkbox"/> N |
| End-Stage Renal Disease                  | <input type="checkbox"/> Y <input type="checkbox"/> N |

##### *Neurological Conditions (other than Behavioral Health-related)*

- |   |   |
|---|---|
| Seizure Disorder  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Neurodegenerative Disorders (Dementia, Alzheimer's, Others) | <input type="checkbox"/> Y <input type="checkbox"/> N |

##### *Gastrointestinal Conditions*

- |  |   |
|--|---|
| Cirrhosis or other Chronic Liver Disease | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Peptic Ulcer Disease                     | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Pancreatitis                             | <input type="checkbox"/> Y <input type="checkbox"/> N |

##### *Other Conditions*

- |  |   |
|--|---|
| Diabetes   | <input type="checkbox"/> Y <input type="checkbox"/> N |
| COPD (Chronic Bronchitis/Emphysema)                  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Obesity  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Anemia (Sickle Cell or Other)                        | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Malignant Neoplasms                                  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Glaucoma or Blindness                                | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Use of Hearing Aid or Deafness                       | <input type="checkbox"/> Y <input type="checkbox"/> N |
| History of Amputation                                | <input type="checkbox"/> Y <input type="checkbox"/> N |
| History of Frostbite, Hypothermia, or Immersion Foot | <input type="checkbox"/> Y <input type="checkbox"/> N |

If yes, specify: \_\_\_\_\_

# Philadelphia Homeless Death Review

## Data Collection Tool 1.0

### F. Medical Services Utilization History

35. Known History of Health Care for the Homeless Visits?  Y  N

First Known Date (mm/yy): \_\_\_\_/\_\_\_\_

Last Known Date (mm/yy): \_\_\_\_/\_\_\_\_

Total # of Visits: \_\_\_\_\_

36. Known History of Emergency Room Visits in 3 Years Prior to Death?  Y  N

Last Known ER Visit (mm/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

Last Known Admission Date (mm/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 Known Admission Date (mm/yy): \_\_\_\_/\_\_\_\_

Last Known Admission Date (mm/yy): \_\_\_\_/\_\_\_\_

Total # of Admissions: \_\_\_\_\_

39. Health Insurance/Benefit Status at Time of Death (if no, explain if known why)

Medicaid?  Y  N: \_\_\_\_\_

Medicare?  Y  N: \_\_\_\_\_

Veterans?  Y  N: \_\_\_\_\_

SSI?  Y  N: \_\_\_\_\_

SSDI?  Y  N: \_\_\_\_\_

# Philadelphia Homeless Death Review

## Data Collection Tool 1.0

### G. Behavioral Health History

#### 40. Known History of any of the Following Conditions?

##### *Mental Health Conditions*

Schizophrenia or other Psychoses  Y  N

Depression or other Mood Disorders  Y  N

Personality Disorders  Y  N

Other Psychiatric Conditions  Y  N

Mental Retardation  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

First Known Admission Date (mm/yy): \_\_\_\_/\_\_\_\_

Last Known Admission Date (mm/yy): \_\_\_\_/\_\_\_\_

Total # of Visits: \_\_\_\_\_

#### 42. Known History of Drug and Alcohol Detox Treatment? Y N

If yes, what for: \_\_\_\_\_

First Known Admission Date (mm/yy): \_\_\_\_/\_\_\_\_

Last Known Admission Date (mm/yy): \_\_\_\_/\_\_\_\_

Total # of Stays: \_\_\_\_\_

#### 43. Known History of Psychiatric Hospitalizations in 5 Years Prior to Death? Y N

First Known Admission Date (mm/yy): \_\_\_\_/\_\_\_\_

Last Known Admission Date (mm/yy): \_\_\_\_/\_\_\_\_

Total # of Admissions: \_\_\_\_\_

#### 44. Was Decedent Ever Involuntarily Committed to a Psychiatric Institution (302'ed)? Y N

Last Known Date (mm/yy): \_\_\_\_/\_\_\_\_

# Philadelphia Homeless Death Review

## Data Collection Tool 1.0

### I. Criminal Justice History

45. PPN: \_\_\_\_\_ PA ID: \_\_\_\_\_ FBI  
ID: \_\_\_\_\_

46. Known to Philadelphia Police and/or Courts as Minor?  Y  N

47. Known to Philadelphia Police and/or Courts as Adult?  Y  N

48. Known History of being Arrested?  Y  N

Total Number of Known Arrests: \_\_\_\_\_

Date of Last Arrest (mm/yy): \_\_\_\_/\_\_\_\_

49. Known History of Incarceration?  Y  N

Total Number of Known Incarcerations: \_\_\_\_\_

Date of Last Incarceration (mm/yy): \_\_\_\_/\_\_\_\_

50. Known History with Community Court?  Y  N

51. Known History of Prostitution?  Y  N

52. Known History of Drug Dealing?  Y  N

### J. DHS History

53. Any Contact with DHS as a Minor?  Y  N

History with JJS?  Y  N

History with CYD?  Y  N

History of being put into Placement?  Y  N

54. Any Contact with DHS as a Parent/Caregiver?  Y  N

History of own Child/Dependent put into Placement?  Y  N