Sacramento County 2016 Homeless Deaths Report

January 1, 2002 – December 31, 2015

78 deaths in 2015

705 deaths from 2002 – 2015

of people experiencing homelessness in our community

or 1 person every 7 days for the past 14 years

Dia de Los Muertos - "Day of the Dead" - Altar, Loaves & Fishes, 2013

December 19, 2016

SACRAMENTO REGIONAL COALITION TO END HOMELESSNESS

Dedication

In memory of all the people experiencing homelessness who have died in our community

The names and ages of the 78 Coroner reported homeless deaths from January 1, 2015 – December 31, 2015, are listed in alphabetical order by last name in Appendix II of this report.

We hope that this publication not only provides a proper and dignified memorial to their death, many in an untimely manner, but provides a catalyst for change fueling the political and community will to find solutions to end homelessness in our community and prevent the tragic deaths of Sacramentans who have fallen on hard times.

We release this report on December 19, 2015 in conjunction with the 3rd Annual Interfaith Homeless Memorial Service

National Homeless Memorial Day – on or around December 21 annually - sponsored by the National Coalition for the Homeless, National Health Care for the Homeless Council and the National Consumer Advisory Board.

December 21 is the longest and darkest night of the year. December 22 begins the march towards a new year, spring and hope that we can take action to end the senseless and untimely deaths of people experiencing homelessness.

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Photo Credit: *The cover photo of the "Day of the Dead" Altar, Loaves & Fishes, 2013 was taken by Paula Lomazzi, Executive Director, Sacramento Homeless Organizing Committee [SHOC]*

SACRAMENTO REGIONAL COALITION TO END HOMELESSNESS

Sacramento Regional Coalition To End Homelessness

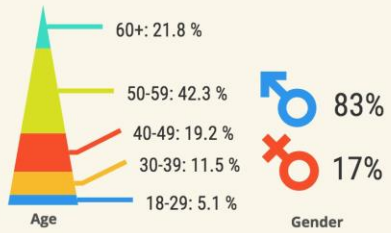
2016 County Homeless Deaths Report

January 1, 2002 – December 31, 2015

Key Findings: 78 Deaths in 2015

705 Deaths (2002-2015)

1 person every 7 days for the past 14 years



Blunt Force Head Trauma

Increased from 65% of violent deaths in 2002 – 2013

To 71.4% in 2015 and deaths from wounds increased to 29% in 2015 from 21% in 2002

Transportation Accidents

Homeless men overwhelmingly make up deaths by transportation accidents [82%]

Roughly in the same percentages as overall deaths (86%)

Violent Deaths

Compared to 2002 – 2014 violent deaths increased from 23% to 26% in 2015.

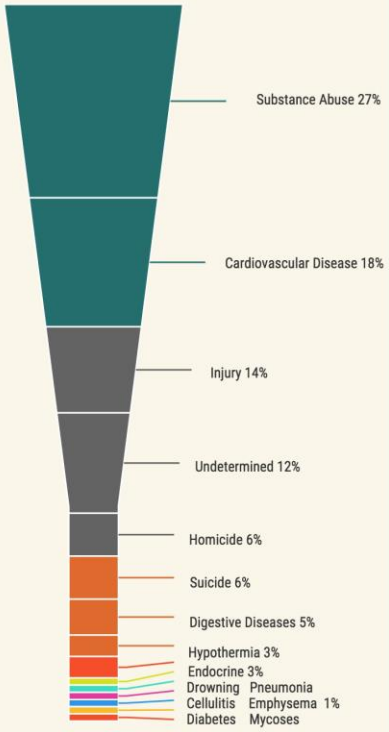
These include gunshot wounds, stabbings, hangings, and blunt force head injuries

Ethnic Comparisons

41% of homeless deaths were people of color - African Americans (AA) comprised 63% of the people of color deaths

Vastly over-represented compared to 10% AA in Sacramento County's general population

Underlying Causes of Death



Mortality Rates 4x Homicide Rates 31x Suicide Rates 16x the General Population

I. Executive Summary

Goal: To support the communities understanding of the tragedy that befalls Sacramentans facing homelessness and implement recommendations to prevent the untimely deaths of people experiencing homelessness in our county.

Note: Please see Appendix I for discussion of the methodology of this report.

Below is a summary of the significant findings of this study as well as recommendations:

RESULTS:

- **Number of Coroner reported homeless deaths:** There were 78 Coroner reported deaths of homeless people January 2015–December 2015. The total from 2002 - 2015 is ***705 deaths***, *or roughly one death per week, every week for a 14 year period.*
- **Demographics:**
  - ✓ *Gender:* 83% where male and 17% female
  - ✓ *Age:* 61% were between 40 – 59. In 2015 the average age for women was 47.4 and 49.9 for men
  - ✓ *Number of lost years due to untimely deaths:* Using 75 years of age as the life expectancy national average, overall, the lives of the homeless people was cut short on average by 34% [25 years years];
  - ✓ *Race/ethnicity:* The majority of homeless deaths were Caucasian (59%), with homeless people of color [African American; Asian and Hispanics] comprising 41% of the homeless deaths – with African Americans comprising 26% of the total;
  - ✓ *Race/ethnicity & Gender:* The percentage of homeless women of color who die is 1.55 times greater than male homeless people of color;
  - ✓ *Race/ethnicity & Age:* 2.5 times as many Caucasian homeless men live to 50-59 as Black homeless men [63.6% compared to 24.2%];
- **Manner and Cause[s] of death:**
  - ✓ *Manner of death:* 49% were accidents, while only 27% died of natural causes; 6% suicides and 6% homicides;
  - ✓ *Underlying Cause[s] of death:* alcohol and drug induced deaths was the leading cause of death [27%], followed by violent deaths [26%] – blunt force head injuries, gun shots, stabbings or hangings;
  - ✓ *Top 5 Causes of Death:* Alcohol/drug [27%]; Cardiovascular disease [18%]; Injury [14%] Homicide & Suicide [6% each];
  - ✓ *Violent deaths:* 71.4% of violent deaths were blunt force head injuries, followed by gunshot wounds [14.2%]; stabbings [9.5%] and hangings [4.7%];
  - ✓ *Accidental deaths:* 38 or 49% of total homeless deaths were accidental deaths. Substance poisoning led accidental deaths with 55% followed by transportation accidents [29%];
  - ✓ *Natural deaths:* Cardiovascular disease accounted 21 deaths or 52% of the natural deaths, while diseases of the digestive system accounted for 14% of the natural deaths;
  - ✓ *Manner of deaths by gender, age and ethnicity:* homeless men were 7 times more likely to die by accident than homeless women [42% compared to 6%]; homeless people between the ages of 40 – 49 had the highest percentage of deaths by accident [60%]; 61% of all Caucasian deaths were by accident compared to 50% for Black homeless deaths;
  - ✓ *Homicides:* 80% [4 out of 5] of homicides were people of color;
- **Comparison of Mortality rates of Homeless to General Population:**
  - ✓ *Mortality rate:* mortality rate per 100,000 for the homeless population is 4 times higher than the general population and almost two [1.7] times higher than the 2007 – 2009 mortality rate;
  - ✓ *Homicide rate:* homicide rate per 100,000 for the homeless population is 31 times higher than the homicide rate for the general population;
  - ✓ *Suicide rate:* suicide rate per 100,000 for the homeless population is 16 times higher than the suicide rate for the general population;
  - ✓ *Alcohol & Drug related death rate:* alcohol and drug related death rate per 100,000 for the homeless population is 52 times higher than the alcohol and drug related death rate for the general population.

Sacramento County 2016 Homeless Deaths Report:
Policy Recommendations supported by findings of report

Overall Recommendation: County Coroner establish a Homeless Deaths Review Committee, similar to review panels for children & youth and victims of domestic violence. Follow the best practice of Philadelphia who implemented a Homeless Deaths Review Panel in 2009.

	Policy	Findings
	Expand the sources of funding for the Sacramento City & County Affordable Housing Trust fund to create more affordable & accessible housing	705 homeless deaths over 14 years: 1 death every 7 days
	Support for housing first approach, but were housing is lacking – increase the capacity of crisis response system to serve more homeless people through a no barrier Triage Center; year round emergency shelter; 1st Steps Communities & rapid rehousing	75% of the homeless deaths were in Spring; Summer & Fall – evenly distributed across seasons 48.9% died within 1 day – 6 months of leaving a homeless program
	Fund a Weekend Drop in Center to provide a safe location for homeless people	Almost 50% [48.5%] of the deaths were on either Friday, Saturday or Sunday 27% died of blunt force injury; gun shots; stabbings or hangings
	Increase funding for alcohol & other drugs and mental health treatment programs - Increase effective linkage to Medi-Cal existing services. Refund VOA's free treatment on demand program	28% died of alcohol/substance abuse induced deaths – the leading underlying cause of death
	Expand funding for Respite Care facilities	Homeless people are routinely discharged to the streets by local hospitals & jail – many need a respite care facility to recover from surgeries etc
	Increase funding for nurse street outreach program to assist homeless individuals into comprehensive ongoing care.	38% of the homeless decedents never visited a primary care medical home
	Continue outreach, enrollment and navigation services for homeless people enrolled in Medi-Cal or other healthcare coverage	14% died of cardiovascular disease; 5% of infection; 4% internal disease and 1% of diabetes – many deaths preventable with access to preventative health care
	Ensure full enrollment of homeless people on CalFresh & full implementation of Restaurant Meals Program	Almost 50% [48.6%] of homeless people died of poor health conditions [high blood pressure etc.] which are related to poor nutrition
	Free or subsidized transportation for homeless people	Lack of transportation is a major barrier to access health care as well as substance abuse & mental health treatment programs

II. FINDINGS

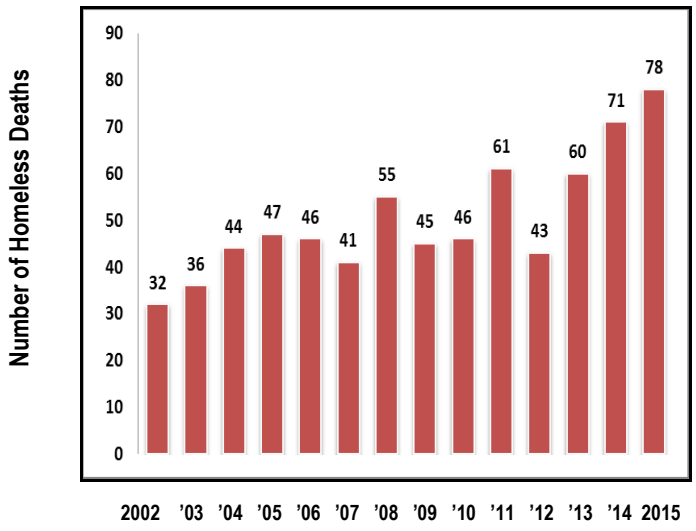
Number of Coroner reported deaths:
1 death every 7 days for 14 years

There were 78 Coroner reported deaths of homeless people from January 1, 2015 – December 31, 2015 for a total of ***705 deaths from 2002 - 2015.*** See Table 1 below for the number of deaths by year and Figure 1 for a year by year graph.

Table 1: Number of Homeless Deaths by Year: 2002 – 2015

YEAR	FREQUENCY	PERCENT
2002	32	4.5%
2003	36	5.1%
2004	44	6.2%
2005	47	6.6%
2006	46	6.5%
2007	41	5.8%
2008	55	7.8%
2009	45	6.4%
2010	46	6.5%
2011	61	8.6%
2012	43	6.1%
2013	60	8.5%
2014	71	10.1%
2015	78	11.1%
Total	705	100%

Figure 1: Homeless Deaths by year: 2002-2015



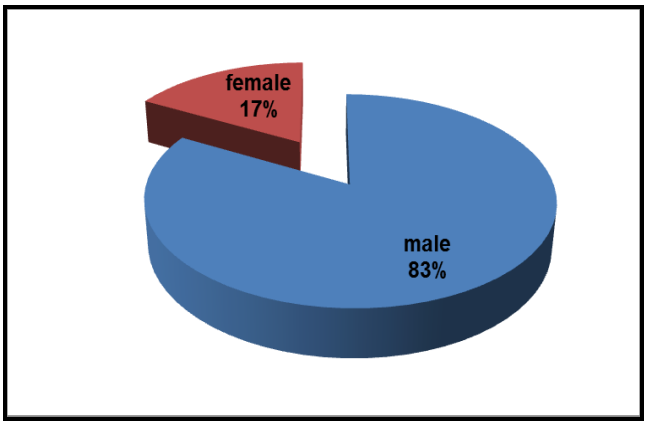
From 2002 – 2012 the average number of homeless deaths was 45. From 2013 – 2015 the average number of homeless deaths was 69 – *a 1.5 times increase in the last three years and a 1.7 times for 2015*.

DEMOGRAPHICS

Gender

Overwhelmingly the percentage of homeless deaths were male, 65 homeless men or 83%, while there were 13 homeless female deaths, or 17% [Figure 2]

Figure 2: Gender of homeless deaths



From 2002 – 2014 the average percentage of homeless male deaths was 83.5% and average percentage of females was 13.5% - so the 2015 findings are very consistent with the 13 year average.

Age

Figure 3 shows the age range of the homeless deaths by age category. 61% of the decedents were between the ages of 40 – 59.

Figure 3: Homeless Deaths by Age Category: 2015

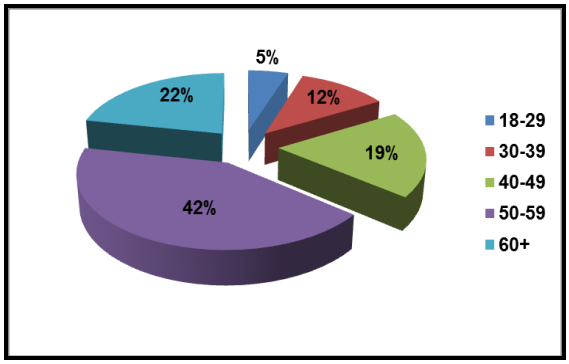


Table 2 indicates the average age of homeless deaths by gender. In 2015 the average age of homeless women was 47.7 years, while for homeless men it was 49.9 years old.

Table 2: Homeless Deaths Average Age by Gender: 2015

AGE					
Gender	Min	Max	Average	N	%
Female	35	77	47.4	13	17%
Male	21	69	49.9	65	83%

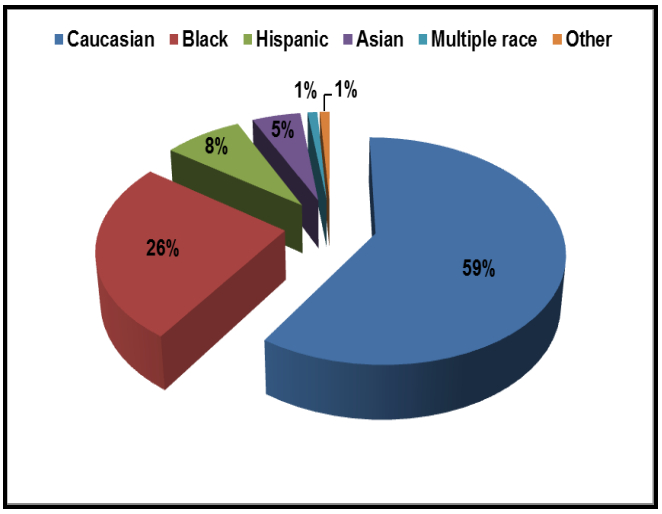
From 2002 – 2014 the average age at death for homeless women was 48 and for homeless men was 50. The 2015 average age for homeless women and men decreased slightly to 47.4 and 49.9 respectively.

Using 75 years of age as the life expectancy national average, overall, the lives of the homeless people were cut short on average by 34% or about 30 years.

Ethnicity

Figure 4 shows the ethnic distribution of homeless deaths. While 59% were Caucasian, 41% were people of color, disproportionately Black.

Figure 4: Distribution of Homeless Deaths by Race/Ethnicity: 2015



From 2002 – 2014 Caucasians represented 69% of the homeless deaths – this declined significantly in 2015 to 59% with a corresponding increase in Black homeless deaths – increasing from 17% from 2002 – 2014 to 26% in 2015 – a 1.5 times increase

Race/Ethnicity & Gender

Table 3 [next page] shows the homeless deaths by ethnicity and gender. It is important to note that the percentage of homeless female people of color is 1.55 times greater than male homeless people of color.

Table 3: Homeless Deaths by Race/Ethnicity & Gender: 2015

Ethnicity	Caucasian		Black		Hispanic		Asian		Total	
Gender	N	%	N	%	N	%	N	%	N	%
Female	5	45%	4	36%	1	9%	1	9%	11	15%
Male	42	65%	15	23%	5	8%	3	5%	65	85%
Total	47	62%	19	25%	6	8%	4	5%	76	100%

From 2002 – 2014 Caucasian homeless women and men represented 66% and 70% of the homeless deaths respectively. This declined significantly in 2015 to 45.4% and 64.6% respectively – or a 1.6 times increase in homeless female people of color and a 1.2 times increase in homeless male people of color – in both cases Black deaths accounted for the increase.

Race/Ethnicity & Age

Over 2.5 times as many Caucasian homeless men live to the ages of 50-59 as Black homeless men [63.6% compared to 24.2% respectively.] [Table 4 below].

Table 4: Race/Ethnicity and Age: 2015

Ethnicity	Caucasian		Black		Hispanic		Asian		Total	
Age	N	%	N	%	N	%	N	%	N	%
18-29	3	75%	1	25%	-	-	-	-	4	5%
30-39	5	55%	3	33%	1	11%	-	-	9	12%
40-49	8	53%	1	7%	3	20%	3	20%	15	19%
50-59	21	64%	8	24 %	3	9%	1	3%	33	42%
60+	10	59%	6	41%	1	6%	-	-	17	21%
Total	47	60%	19	24%	8	10%	4	5%	78	100%

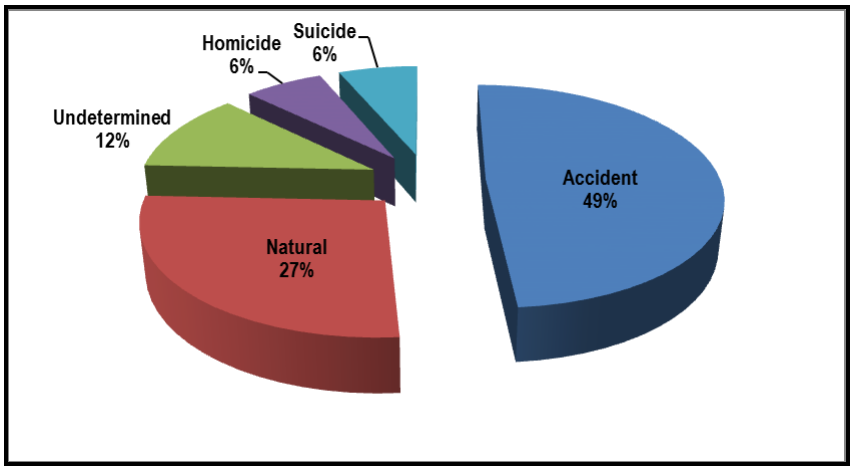
MANNER & CAUSE OF DEATH

Manner of Death

The manner of death is the cause of death indicated on the death certificate, which includes the following five categories: *Natural, Accident, Suicide, Homicide, and unknown.*

As Figure 5 shows, only about 30% [29%] of the homeless deaths are natural, with 12% undetermined, leaving almost 60% of the deaths to Accidents [49%], Suicides and Homicides [6% each].

Figure 5: Manner of Death: 2015

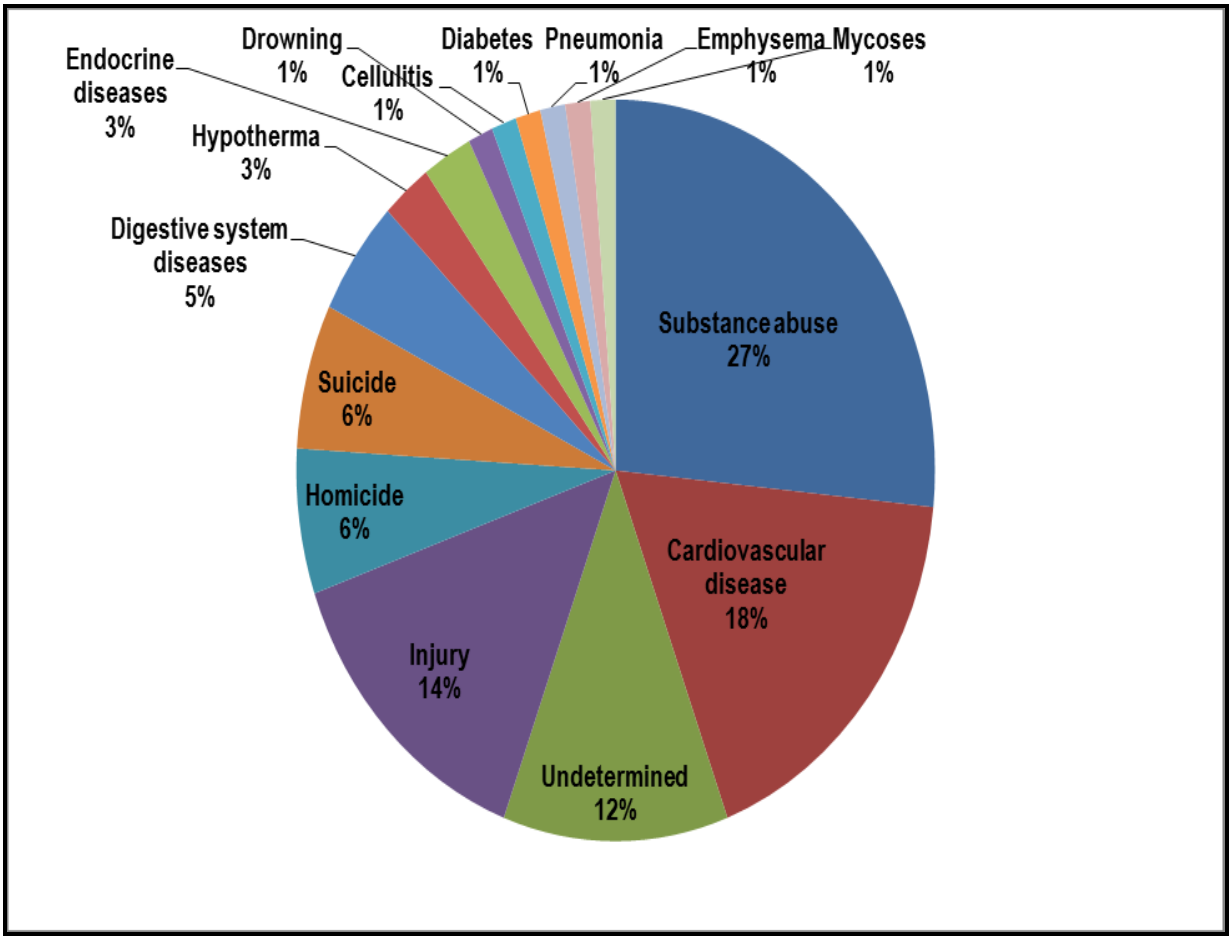


Comparing 2002 - 2014 to 2015 manner of deaths – the most significant change was the increase in accidental deaths – increasing from 40% to 49%

Underlying Cause of Death

Figure 6 details the underlying causes of death of homeless people in 2015. Substance abuse [27%], Cardiovascular disease [18%], Injury [14%], suicides and homicides [6% each] account for 71% of the underlying causes of death of homeless people.

Figure 6: Underlying Causes of Death of Homeless People: 2015



26% of the homeless deaths were violent deaths: 14% injuries - blunt force head injuries; gun shots; stabbings and hangings [some were suicide]; 6% homicides and 6% suicides

Additionally, 27% of the homeless deaths were from substance abuse.

Important Points:

- **Compared to 2002 – 2014 violent deaths increased from 23% to 26% in 2015. These include blunt force head injuries, gunshot wounds, stabbings or hangings;**
- **Homicide and suicide deaths increased from 5% each in 2002 – 2014 to 6% in 2015;**
- **Natural deaths decreased slightly from 29% in 2002 – 2014 to 27% in 2015;**
- **Alcohol and drug related deaths remained about the same [28% from 2002 – 2014 and 27% in 2015];**
- **Hypothermia/hyperthermia underlying cause of death remained at 3%;**
- **Despite the large number of homeless people living near the American River, only 2% drowned in 2002 – 2014 and only 1% in 2015**

Top 5 Causes of Death

Table 5 [below] identifies the five leading underlying causes of the death of homeless people in 2015.

Table 5: Top Five Causes of Death: 2015

Underlying Cause[s] of death	Percentage of homeless deaths
Alcohol/drug induced	27%
Cardiovascular disease	18%
Injury	14%
Homicide	6%
Suicide	6%

The top 3 causes of death were the same in 2015 compared to 2002 – 2014: Alcohol and drugs decreased from 35% to 27% in 2015; injuries decreased from 24% to 17% in 2015 and Cardiovascular disease remained about the same [17% in 2002 – 2013 and 18% in 2015. In 2015 homicide and suicide [6% each] replaced hypothermia and wounds as the fourth and fifth causes of homeless deaths [4% each in 2002 – 2014]

Violent Causes of Death

Table 6 below identifies that 26% of the deaths of homeless people are violent, with blunt force head injuries accounting for 71.4% of the violent deaths.

Table 6: Types of Violent Deaths: 2015

	Count	% violent causes	% total homeless deaths [N=78]
Blunt	15	71.4%	19.2%
Gunshot	3	14.2%	3.8%
Stabbing	2	9.5%	2.6%
Hangings [suicide]	1	4.7%	1.2%
Total Violent Causes	21	100%	26.9%

Blunt force head injuries increased from 65% of violent deaths in 2002 – 2013 to 71.4% in 2015 and deaths from wounds increased to 29% in 2015 from 21% in 2002

Accidental Deaths

Table 7 identifies the 38 accidental deaths by type of accident with exposure to drugs and other biological substances accounting for 55% of all accidental deaths and transportation accidents accounting for 29% of all accidental deaths.

Table 7: Types of Accidental Deaths: 2015

Cause of death	TOTAL	
	N	%
Transportation Accidents	11	29%
Railway	1	3%
Pedestrian Hit by car	7	18%
Bicyclist Hit by Car	1	3%
Car collision	2	5%
Substance poisoning	21	55%
Meth	12	32%
Opioid	1	3%
Cocaine	1	3%
Mixed	3	8%
Unspecified drug	4	11%
All other accidents	5	16%
Drowning	1	3%
Hypothermia	2	5%
Cellulitis	1	3%
Aortic aneurysm	1	3%
TOTAL	38	100%

Types of Accidental Homeless Deaths by Gender; Age & Ethnicity: 2015

Table 8 identifies the types of accidental deaths by gender, age and ethnicity in 2015.

Table 8: Types of Accidental Homeless Deaths by Gender; Age & Ethnicity: 2015

Demographics	Transportation accidents		Accidental poisoning by & exposure to drugs & other biological substances		All Other Accidents		TOTAL	
Gender	N	%	N	%	N	%	N	%
Male	9	82%	19	91%	5	83%	33	87%
Female	2	18%	2	9%	1	17%	5	13%
Age								
18 - 29	2	18%	2	9%	-		4	11%
30 - 39	-		4	19%	-		4	11%
40 - 49	4	36%	4	19%	1	17%	9	24%
50 - 59	3	27%	10	48%	1	17%	14	37%
60+	2	18%	1	5%	4	66%	7	18%
Ethnicity								
Caucasian	5	45%	14	67%	3	50%	22	58%
Black	2	18%	6	28%	2	34%	10	26%
Hispanic	3	27%	-		-		3	8%
Asian	1	9%	-		1	17%	2	5%
Other/missing	-		1	5%	-		1	3%
TOTAL	11		21		6		38	100%

Important points:

- Transportation accidents: Homeless men overwhelmingly make up deaths by transportation accidents [82%] – roughly in the same percentages as overall deaths [86%]
- Drugs deaths:
  - ✓ Age: only 2 deaths by drugs were ages 18 – 29 while 30 – 49 year olds accounted for 38% of accidental drug deaths and almost half [48%] of drug deaths were 50 – 59 years old
  - ✓ Ethnicity: Caucasians accounted for 67% of the accidental drug deaths

Natural Deaths

Cardiovascular disease account for 52% of the 21 natural deaths of homeless people, followed by diseases of the digestive system [14%] [Table 9 below]. These conditions are treatable through engagement in treatment with a primary care team.

Table 9: Natural Causes of Homeless Deaths: 2015

Cause of Death	Total	
	N	%
Diseases of the Circulatory System	***11***	***57%***
Essential Hypertension	1	5%
Hypertensive Heart disease	2	10%
Atherosclerotic Cardiovascular disease	8	38%
Cardiomyopathy	1	5%
Diseases of the Digestive System	***3***	***14%***
Alcoholic liver disease	2	14%
Chronic hepatitis	1	5%
Endocrine, nutritional and metabolic diseases	***2***	***10%***
Diabetes Mellitus	1	5%
Obesity	1	5%
All other natural causes	***4***	***19%***
Bacterial pneumonia	1	5%
Renal failure	1	5%
Emphysema	1	5%
Mycoses	1	5%
TOTAL	21	100%

Manner of Death by Gender; Age & Ethnicity

Table 10 identifies the manner of homeless deaths by gender; age and ethnicity.

Table10: Manner of Homeless Deaths by Gender; Age & Ethnicity: 2015

Demographics	Accident		Homicide		Suicide		Natural		Other		TOTAL	
Gender												
Male	33	42%	3	4%	4	5%	18	23%	7	9%	65	83%
Female	5	6%	2	3%	1	1%	3	4%	2	3%	13	17%
Age Groups												
18 - 29	4	5%	-		-		-		-		4	5%
30 - 39	4	5%	2	3%	2	3%	1	1%	-		9	12%
40 - 49	9	12%	2	3%	1	1%	2	3%	1	1%	15	19%
50 - 59	14	18%	1	1%	1	1%	9	12%	8	10%	33	42%
60+	7	9%	-		5	6%	5	6%	-		17	22%
Ethnicity												
Caucasian	22	28%	1	1%	4	5%	12	15%	7	9%	46	59%
Black	10	12.8%	2	3%	-		8	10%	-		20	21%
Hispanic	3	4%	1	1%	-		1	1%	1	1%	6	8%
Asian	2	3%	1	1%	1	1%	-		-		4	5%
Multiple	1	1%	-		-		-		-		1	1%
Other/missing	-		-		-		-		1	1%	1	1%

Important points:

- **Gender:** men account for 8 times as many deaths by accident compared to women [42% compared to 6%]. However, within each gender category, accidents account for 50% of homeless male deaths and 38% of homeless female deaths.
- **Age:** 61% of those between 18 – 39 years old died accidental deaths; while 60% of those between 40 – 59 years old died accidental deaths.
- **Ethnicity:** 50% of Black homeless deaths were accidental deaths; while people of color accounted for 80% [4 out of 5 homicides] of the homicides

Mortality Rates

Estimated mortality rates for the homeless population in 2015 [Table 11] are about **4 times higher** than for the general population in Sacramento County, and 1.7 times higher than 2007-2009 average [1,777] [Table 12].

Table 11: Mortality Rates per 100,000: General Population vs. Homeless Population in Sacramento County: 2015

Population	Mortality rate per 100,000
General population	706
Homeless population	2,933

Table 12: Mortality Rates per 100,000: General Population vs. Homeless Population in Sacramento County: 2007, 2008, 2009

Population	Mortality Rate per 100,000 population		
	2007	2008	2009
General Population	678	688	680
Homeless Population	1,672	2,054	1,607

Homicide Rates

The estimated homicide rate per 100,000 for homeless people is **31 times higher** than the homicide rate for Sacramento's general population. [Table 13]

Table 13: Homicide Rates per 100,000: General Population vs. Homeless Population in Sacramento County: 2015

Population	Mortality rate per 100,000
General population	6
Homeless population	188

Suicide Rates

The estimated suicide rate per 100,000 for the homeless population is almost **16 times higher [15.9]** than the suicide rate for Sacramento's general population. [Table 14]

Table 14: Suicide Rates per 100,000: General Population vs. Homeless Population in Sacramento County: 2015

Population	Mortality rate per 100,000
General population	11.8
Homeless population	188

Alcohol & Drug Related Deaths Rates

The estimated rate per 100,000 of homeless alcohol and drug related deaths is **52 times higher** than the alcohol and drug related deaths for Sacramento's general population. [Table 15]

Table 15: Alcohol & Drug Related Rates per 100,000: General Population vs. Homeless Population in Sacramento County: 2015

Population	Mortality rate per 100,000
General population	16.6
Homeless population	865

III. Policy Recommendations

The Sacramento Regional Coalition to End Homelessness [SRCEH] Board of Directors is making the following policy recommendations, based on our analysis of the data in this report. **The policy recommendations are in priority order:**

I. Affordable Housing & Emergency Shelter:

A. Affordable Housing: Expand the sources of funding for City/County Affordable Housing Trust Fund to create affordable housing: increase the sources of funding to significantly expand the Sacramento City/County Affordable Housing Trust Fund to significantly increase the supply of affordable housing, especially for those at or below 30%- 50% Area Median Income [AMI] .

As Sacramento Steps Forward [SSF] points out in their *2013 Sacramento Countywide Homeless County Report, "housing programs are competing for scarcer funding at the federal, state, regional and local levels. Current cuts to the Housing Choice Voucher Program and administrative resources for public housing authorities due to Sequestration will mean significantly reduced resources in this region, and may lead to even greater increases in homelessness.* Add to the *"…negative impacts on affordable housing with the abolishment of redevelopment agencies throughout California on February 1, 2012, and a 'slow-down' in the pipeline to develop permanent supportive housing, a critical strategy for reducing chronic homelessness."*

Since the SSF report, the continued gentrification of downtown and midtown has seen a dramatic escalation in rents making Sacramento one of the hottest rental markets in the nation combined with a less than 3% rental vacancy rate.

Thus, our community faces tremendous challenges in ending and preventing homelessness, including lowering the number of deaths of people experiencing homelessness, with few resources to create affordable and accessible housing.

Our recommendation is to increase the resources to create affordable housing locally is to significantly expand the sources of funding for the Sacramento City/County Affordable Housing Trust Fund to the scale of the housing crisis – ideally to $100 million annually

Currently, the Trust Fund is funded by only one source, a commercial linkage fee, a fee to builders of commercial buildings based on the square feet of the project. Given the recession, very little commercial building was taking place and the Trust Fund shrank to less than $1 million in 2013, and as of December, 2015, the City/County Affordable Housing Trust Fund was a combined $4.9 million - $2.7 for the City and $2.2 million for the County. The City Council and County Board of Supervisors needs to consider a range of additional sources of funding for the Trust Fund to replace the tens of millions of redevelopment funds that were lost annually.

B. Emergency Shelter:

1. We support the "housing first approach." However, with a lack of affordable housing units, we recommend increasing the capacity of the crisis response system to serve more homeless people through a variety of means including year round shelter. Finally, again given the lack of affordable housing, we support First Steps Communities, as well as SSF's "Triage Center" and other safety options including supporting the Safe Ground concept for safe places for tents.

While we advocate for increased funding for housing and the housing first approach, we have the immediate need to increase emergency shelter and safety options for the roughly 36%, or about 1,000 homeless people is outside, often alone, and as our report underscores, exposed to a high level of violence.

Given this, we recommend increasing the capacity of the crisis response system to serve more homeless people through a variety of means including year round shelter; a no barrier Triage Center and support the creation of First Steps Communities

2. ***Weekend Drop In Center:***

A critical finding in the *Homeless Deaths Report: 2002 – 2014* was that homeless people tend to pass away at a higher frequency on the weekends, specifically Friday, Saturday and Sunday. Specifically, almost 50% [48.5%] of homeless people died on Friday, Saturday and Sunday, presumably when homeless programs are closed.

We recommend a weekend Drop-In Center where homeless people can be safe, have access to a bathroom, shower, food, storage facility for food and medicine, barbeque pit for cooking.

I. Health Care:

A. Increased funding for alcohol, other drugs and mental health treatment services and programs:

Given the findings of this report, that 27% had deaths with alcohol/substance abuse induced deaths as an underlying cause of their death, we need to significantly increase the availability access and linkage to alcohol and drug treatment services and programs as strategy to help reduce preventable deaths of homeless people.

The County should refund VOA's Substance Abuse Outreach & Treatment Program which provided free outpatient drug treatment services and treatment on demand.

We also recommend the County provide a list of all the clinics/providers who prescribe Naloxone since some clinics have implemented AB 635 which provides for family members, direct service programs etc. to obtain a prescription for Naloxone [emergency drug overdose treatment].

The County should also include clinics that provide prescriptions for other medication assisted treatments which includes Campral, Suboxone, and Vivitrol.

A. Expand funding for a Respite Care facility:

Currently, Sacramento County, three of the largest hospital organizations and Salvation Army support the Interim Care Program (ICP) operated by Well Space Community Clinic Inc. This community collaborative was developed after the media exposed the need when many homeless patients were being discharged from hospitals with extended health care needs but nowhere to properly rehabilitate.

Since 2004, hospital case managers coordinate the discharge of potentially homeless individuals to ICP. Individuals being discharged from the hospital must be able to conduct Activities of Daily Living with little assistance. Salvation Army secures at least 18 beds for ICP clients and Well Space's medical and social worker staff monitors these individuals and assist them with medical and psychosocial needs during their recuperation at the Salvation Army Shelter.

Since this is not a medical facility and the Well Space staff are not on site 24/7 and limited days and hour throughout the week; therefore, the Interim Care Program is not a Respite facility and clients have limited health care service.

We recommend expanding funding for a Medical Respite model, which is shelter or supportive housing with medical supports for those being discharged from 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.

B. Prioritize nursing services to ensure health screening and navigation at the Year Round Shelter and Winter shelter sites as well as street outreach.

Outreach services can be defined many ways when discussing outreach for our County's homeless population. They are defined as navigators, paraprofessionals and mental health worker, medical teams etc. All of these are important and productive in their own way. Outreach has taken different forms within our community. We have patient navigators, mental health outreach; faith based outreach, veteran outreach and licensed nurse outreach.

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For the period of this report, the Sacramento County DHHS Health Care for the Homeless Program utilized two licensed nurses [note: which increased to 3 RN's in 2014] to go to shelters, parks, downtown hotels and other homeless service areas. RNs provide health screening, and triage, and then assist the person to obtain the needed healthcare service. The RNs advocate for patient's immediate health care needs with local health professionals for urgent and acute problems. . The registered nurse's ability to expedite care helps to promotes positive health outcomes and prevents potential hospitalizations and costly emergency room [ER] visits.

Across the nation, we have homeless shelters and advocates helping the homeless improve their current circumstance. The federal grants that support health care for the homeless grantees requires that the funded health center provide is comprehensive primary care with enabling services to assist homeless individuals to participate in health improvement activities, such as transportation assistance and case management. These centers may also use their grant budgets for outreach and linkage activities.

In addition to County RNs, FQHCs such as Wellspace and Elica also have deployed RNs for outreach and linkage of homeless individuals to a primary care center.

Almost all adults who are homeless have Medi-Cal Managed Care. This service structure is not easy to navigate. The County developed a Medi-Cal Managed Care "Care Coordination Work Group" in 2016 and began work on care coordination materials to assist with vulnerable populations such as the homeless who suffer from health disparities. Since adults who are homeless have multiple chronic conditions and often co-occurring behavioral health conditions, these individuals tend to use high cost services. Health Plans are committed to make greater efforts to coordinate care for this population.

D. Outreach, enrollment, navigation and follow-up to access health care:

Generally the enrollment of homeless people onto the Affordable Care Act, usually Medi-Cal, has been successful.

Enrollment does not mean Access: However, despite the number of homeless people enrolled, this has not translated into increased access to health care for multiple reasons:

- ✓ Pressing priorities for food and shelter and safety override needs for healthcare;
- ✓ Disorganization due to untreated mental health conditions or substance use disorders;
- ✓ Distrust of "helpers" that may include navigators and doctors;
- ✓ Difficulty in figuring out who their provider is;
- ✓ Lack of transportation creates significant access barriers;
- ✓ Primary care appointment availability in some clinics;
- ✓ Confusion regarding service navigation

Access to health care is a critical strategy in addressing some of the underlying causes of death of homeless people, as well as addressing the myriad of health care issues that are exacerbated by being homeless.

Access does not mean health improvement. Even when an individual experiencing homelessness participates in health care with a primary care team, the challenges persist. Many have little control over their diet, their stress level, their ability to rest, sleep soundly or properly store their medications. Ongoing support and advocacy for safe housing is needed even after primary care linkage is made.

Navigators to Case Managers: At this point there are almost 100 navigators in the homeless delivery system. With the severe lack of housing, the issue has become "navigation to where?" Currently SSF's navigator team, "Common Cents" has performed more than 4,000 unduplicated vulnerability assessments, but only able to place about 5% of their case load into housing.

SRCEH supports Mayor Steinberg's draft proposal of re-tooling the current navigator teams and turning them into case management navigators, so that the system does not lose homeless people after the first encounter, but rather stays with their homeless caseload until they find housing. SRCEH supports the Los Angeles County homeless provider motto: *"Whatever it takes as long as it takes."*

We recommend increased funding resources to support additional licensed nurse outreach services, with a priority of out-stationing nurses at the Winter Shelter sites as well as street outreach.

E. Nutrition: Ensure full enrollment on CalFresh and implementation of the Restaurant Meals Program and all Certified Farmers Markets accept the EBT card so that homeless people as well as other low income people have access to fresh fruit and vegetables.

While not directly related to the manner and cause of death, many of the poor health conditions of homeless people, such a poor dental care, high blood pressure, cardiovascular issues, and diabetes are directly attributable to poor nutrition.

The recommendations below are supported by the 2010 report by the Sacramento Hunger Coalition, *Hunger and Homelessness in Sacramento: 2010 Hunger & Food Insecurity Report.* The report is a survey of 112 homeless people at the 2010 Homeless Connect event. Several key findings include:

- 53.2% currently do not receive Food Stamps [now called *Cal Fresh*] and 65.0% of respondents receiving food stamps report they only lasted between 2-3 weeks per month;
- Nearly 60.0% have no access to food storage facilities; while between 56.0% - 84.0% have no access to any kind of cooking facilities;
- Access to free food is limited, with even the most common source, "sidewalk giveaways," only being utilized by 49.9% of respondents;
- Over one third identify lack of storage and cooking facilities and transportation as barriers to accessing nutritious food while over 25.0% state healthy food is not accessible to them. Additionally, over 20.0% stated they cannot use their EBT cards at local Farmers Markets;
- Greater availability of Farmer's Markets, Community Gardens and BBQ areas in parks topped the list of programs respondents would like to see expanded in the Sacramento region, with 75.0% - 85.0% indicating interest in these.

- ✓ ***We recommend that Sacramento County continue to be aggressive in their enrollment of eligible homeless people [note: if a person receives SSI they are not eligible for CalFresh] on to CalFresh, still often referred to as Food Stamps.***
- ✓ ***Additionally we recommend the County fully implement the Restaurant Meals Program [RMP].***

The RMP is a program for homeless people, seniors and people with disabilities to be able to use their EBT [electronic benefits transfer card] at participating restaurants. Currently, there are only 42 participating restaurants in Sacramento County, compared to over 1,200 in Los Angeles County, the latter due to aggressive outreach by LA County. Sacramento County should automatically enroll homeless people into the RMP instead of the current practice of applying. This is an unnecessary barrier that could easily be removed by enrolling homeless people onto the program automatically.

III. Transportation:

Subsidize transportation options for homeless people:

Lack of transportation is a significant barrier for many homeless people seeking health care, shelter, housing, employment and other benefits.

We recommend that Sacramento County provides free or subsidized transportation options for homeless people including bus and light rail passes.

IV. Homeless Deaths Review Committee:

We recommend the County Coroner's Office convene a Homeless Deaths Review Committee, similar to death review panels for children and youth and victims of domestic violence, comprised of identified system partners with the goal to continuously assess, monitor and recommend improvements to community services and supports for people experiencing homelessness.

Best practices: Philadelphia and San Francisco:

Philadelphia: 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.

San Francisco: San Francisco as of May 2015 was considering establishing a Homeless Deaths Review panel similar to Philadelphia. One aim would be for medical examiner's staff to provide information to homeless outreach workers so they can "immediately" respond to the location where the person died and see if people who knew the subject need help. In cases where the person died of a drug overdose, for example, if the people around them were also using drugs, "maybe they're ready to reconsider their use," and/or …" creates an opening that could be well used by the outreach team to talk with people about their options and provide support."

APPENDIX I:

METHODOLOGY

Coroner's Office:
This report is based on the report of deaths of people experiencing homelessness, January 1, 2015 – December 31, 2015 as reported by the Sacramento County Coroner's office.

The data in the Coroner's report included: Name; Date of death; Age; Ethnicity; Causes[s] of death [A,B,C,D]; and Manner of death.

Death Investigation is pursuant to the California Government Code Section 27491 for all deaths meeting the jurisdictional requirements (of CaGov Code Sec 27491) occurring within Sacramento County. Death investigation included the following: Death Scene Investigation (when possible); Forensic Examination of remains (autopsy, external examination and or medical record review); Forensic Toxicology analysis when warranted/possible; Decedent Identification Confirmation; Follow-up investigation/Interviews with all relevant investigative parties/stakeholders (law enforcement, EMS, hospitals, reporting party, service providers, families, friends, coworkers, etc.); Decedent Record review (medical records, criminal records, work history records, military records, local/state/federal personal information database records all inclusive)

As part of the overall investigation the Coroner's office determines the decedent's address. The components included in this determination include the reporting party's information, death scene investigation, interviews of friends and family and witnesses, evidence found at autopsy that may confirm a homeless lifestyle and record checks.

This report is not a report of every homeless persons death in 2015, however we feel confident that the report captures most of the deaths of people experiencing homelessness and gives us a large enough database to be able to identify issues and comparisons to SRCEH findings in our previous two homeless deaths reports and make recommendations for the future on how to lower the number of preventable deaths of homeless people.

Methodology for data analysis:
The database was provided by Sacramento County Coroner's Office.

Data analysis was performed by Amandeep Mann, Masters in Public Health [MPH], Biostatistics and Intern to Sacramento County Epidemiology Department, with supervision by Jamie White [MPH] Epidemiology Program Manager and Dr. Olivia Kasirye, Public Health Officer, Sacramento County Department of Health & Human Service. The draft report was reviewed by this department as well as the Primary Health Services Division, Department of Health & Human Services.

Report and recommendations:
The report was written by Bob Erlenbusch, Executive Director, and Cara Dwyer, Director of Homeless Speakers Bureau, Sacramento Regional Coalition to End Homelessness [SRCEH] based on the data analysis provided by the Department of Health and Human Services, Public Health Division Sacramento County.

Infographic provided by Kai Erlenbusch.

Recommendations were made by the SRCEH Board of Directors.

APPENDIX II:

NAMES OF HOMELESS PEOPLE WHO PASSED AWAY: JANUARY 1, 2015 – DECEMBER 31, 2015

Decedent Name	*Age*
Alexander, Jim	57 Years
Allen, Rodney	46 Years
Anderson, Paul	56 Years
Antonelli, Joshua	31 Years
Arnold, Roger	60 Years
Becher, Artyom	29 Years
Bennett, Brian	45 Years
Benoit, Teddie	50 Years
Bernaix, Anna	54 Years
Bishop, Russina	44 Years
Boyle, William	62 Years
Boylston, Samuel	64 Years
Brazovan, Joseph	26 Years
Browne, Robert	32 Years
Burrows, Carol	61 Years
Colwell, William	47 Years
Coons, Daniel	53 Years
Corey, Earl	55 Years
Cortez, Luis	34 Years
Cropp, Louis	51 Years
Danley, Joseph	32 Years
Favors, Gyakunta	38 Years
Fechner, Sandy	61 Years
Feld, Daniel	69 Years
Folosom, Robert	61 Years
Frith, Aaron	47 Years
Gagliano, Neal	30 Years
Garofolo, Barry	48 Years
Hargain, Murray	54 Years
Hershenow, Thomas	57 Years
Hinkson, Kenneth	55 Years
Irizarry, Debbie	55 Years
Johnson, Jerome	65 Years
Johnson Nathaniel	57 Years
Jordan, Christopher	48 Years
Kessenich, John	56 Years
Key, Steven	50 Years
Knifton, Danielle	35 Years
Kozlowski, Waclaw	59 Years
Lacey, Quincy	36 Years
Lewis, Mildred	56 Years
Li, Vay	42 Years
Lucchesi, Geneive	77 Years
Marton, Michael	62 Years
Mcentee, Robert	52 Years
Mckinney, Mark	54 Years
Miner, Bobby	52 Years
Mitchell, Sonny	41 Years
Momk, Jerry	42 Years
Montoya , Gilbert	64 Years
Munson, Daniel	57 Years
Nelson, Micki	53 Years
Nieves, Armando	49 Years
Otanil, John	51 Years
Patel , Smruti	44 Years
Patti, Thomas	55 Years
Peterson, Charles	60 Years
Plater, Ronald	24 Years
Pohl, John	42 Years
Pope, Nathaniel	58 Years
Pratt, Elliott	54 Years
Pruitt, Melvin	64 Years
Ramirez, Thomas	49 Years
Reid, Linda	65 Years
Roberts, Beverly	58 Years
Roby, Tawni	52 Years
Rogers, Sandra	73 Years
Russell, Edward	50 Years
Sandoval, Lawrence	59 Years
Schneider, David	33 Years
See, Douglas	21 Years
Shepard, Gordan	61 Years
Sutton, Kevin	57 Years
Villegas, Victor	46 Years
Walker, Gary	56 Years
Westfall, William	59 Years
Williams, Ronald	50 Years
Wright, Thomas	60 Years

CONTACT INFORMATION

Bob Erlenbusch
Executive Director
Sacramento Regional Coalition to End Homelessness [SRCEH]
1331 Garden Highway, Suite 100
Sacramento, CA 95833
Office: 916-993-7708
Cell: 916-889-4367
bob@srceh.org

Cara Dwyer
Director, Homeless Speakers Bureau
SRCEH
1331 Garden Highway, Suite 100
Sacramento, CA 95833
Cell: 504-812-3096
cara@srceh.org

www.srceh.org