OF SANTA	AGEN Clerk of the I 105 E. Anapa Santa Ba	F SUPERVISORS IDA LETTER Board of Supervisors amu Street, Suite 407 rbara, CA 93101 5) 568-2240	Agenda Number:	
			Department Name:	Public Health
			Department No.:	041
			For Agenda Of:	May 17, 2016
			Placement:	Departmental
			Estimated Time:	45 min
			Continued Item:	No
			If Yes, date from:	
			Vote Required:	Majority
то:	Board of Supervisors			
FROM:	Department	Takashi Wada, MD, MPH Director and Health Officer		
	Director(s)	Public Health Department		
	Contact Info:	Dana Gamble, LCSW, Assistant Deputy Director, Public Health		
		Department		
SUBJECT:	Homeless Death Review Team Report			

County Counsel Concurrence

As to form: Yes

Other Concurrence: N/A As to form: N/A

Recommended Actions:

That the Board of Supervisors:

- a) Receive a written report and an oral presentation from the Homeless Death Review Team on deaths of homeless persons in Santa Barbara County for the period January 1, 2014 through December 31, 2014.
- b) Determine that these activities are exempt from California Environmental Quality Act review per CEQA Guideline Section 15061(b) (3), since it can be seen with certainty that there is no possibility that the activities may have a significant effect on the environment.

Auditor-Controller Concurrence

As to form: N/A

Summary Text:

This item is on the agenda to provide the Board with a presentational update on Homeless Deaths in Santa Barbara County. The Homeless Death Review Team (HDRT) was created by County staff in 2008 to review homeless deaths and their causes, explore means to avert similar deaths and, where available, compile statistical data to identify trends. A report on the deaths of homeless persons has been provided to the Board of Supervisors on a regular basis since data began to be collected and analyzed in 2009. The current report includes data from the 2014 calendar year and provides comparative data from 2009 through 2014.

Background: Responding to citizens' and community advocates' concerns about deaths among homeless people in Santa Barbara County, it was determined that a better understanding was needed of the extent and circumstances of these deaths. To that end, the HDRT was formed to review and analyze these deaths in order to develop strategies to better assist this population.

Homeless Death Review Team Report Agenda Date: May 17, 2016 Page 2 of 3

The HDRT has conducted systematic reviews of the deaths of homeless persons who died beginning on January 1, 2009. Reports have been organized on a calendar year basis to promote comparisons across years. The definition of homelessness for the purposes of these analyses is the definition from the Federal Bureau of Primary Health Care. Data from multiple sources, including County departments (Public Health Department, Department of Behavioral Wellness, and the Department of Social Services), was combined with data from community-based organizations (homeless shelters and hospitals) to obtain a more complete picture for each individual. The reviews were focused on answering the following questions:

- What are the characteristics and trends in the deaths of homeless individuals in Santa Barbara County?
- What are the recommendations to improve care and reduce preventable premature deaths within the homeless population?

The systematic analysis of deaths of homeless persons revealed opportunities to improve continuity of care and coordination. The County departments identified the following recommendations:

- Coordination of services between agencies and as much as possible in one location; i.e., patient centered medical home model for medical and behavioral health and social service needs.
- Additional resources for drug and alcohol treatment programs including detox treatment and long term residential treatment.
- Improved outreach and programs for people suffering with mental illness and co-occurring substance use disorders including housing/beds across a continuum of care from emergency shelter to psychiatric inpatient care.
- Urgent need for medical respite services to care for homeless patients discharged from the hospitals that have skilled nursing needs. The shelters are inappropriately used as skilled nursing facilities because of lack of alternatives and these patients have poor outcomes and high rates of re-hospitalization.
- Lack of stable housing is the biggest barrier to improving health for people with illness. People experiencing homelessness have no safe place to rest and recover, their medications are often lost or stolen, they can't get to medical appointments and they have no stable working phone for communication. This leads to ambulance rides to the emergency rooms where care is costly and can be excessive as well as frustrating for the hospital medical staff who witness this downward cycle. The burden is not only felt by medical providers, but by the departments of social services, mental health, the sheriff's department and the community as a whole. The 2014 homeless death report shows the outcomes are tragic.

The HDRT included 32 cases of deaths of homeless persons in the study between January 1, 2014 and December 31, 2014. This number of homeless deaths has increased from prior years. 81% of the deaths were male, 19% were female. Looking at race, the vast majority (75%) were Caucasian. Overall, 22% were of Latino/Hispanic ethnicity. The average age at time of death was 53 years old. A comprehensive view of the findings from 2014 in concert with data from the previous calendar years is included in the report.

The HDRT begins its annual analysis soon after the end of the calendar year to be reviewed. Determination of the cause of death, confirmation of the decedents' homeless status as per the HRSA definition, and verification of service contacts (medical visits, hospitalizations, shelter stays, interactions with law enforcement, etc.) takes many months. The HDRT then compiles relevant data from the Homeless Death Review Team Report Agenda Date: May 17, 2016 Page 3 of 3

various sources in order for the author to write the actual report. This review process takes up to 18 months from start to finish.

Performance Measure:

N/A

Fiscal and Facilities Impacts:

Budgeted: N/A

Fiscal Analysis:

There are no fiscal or facilities impacts to accepting this report and reviewing the recommendations.

Key_Contract_Risks:

N/A

Staffing Impacts:

Legal Positions:	FTEs:
0	0

Special Instructions:

Please send an electronic copy of the Minute Order to the PHD Contracts Unit at: PHDCU@sbcphd.org.

Attachments:

- A. Homeless Death Review Team Report
- B. Homeless Death Review Team Report Presentation

Authored by:

Dana Gamble, Assistant Deputy Director