COLORADO COALITION FOR THE Homeless Creating Lasting Solutions

We Will Remember 2013:
HOMELESS DEATH REVIEW

One hundred and twenty-four men, women and youth died in Denver in 2013, each death the result of the experience of homelessness. This report, compiled by the Colorado Coalition for the Homeless, details these deaths. All of the individuals identified here struggled against considerable odds for survival, but time on the streets contributed significantly to their passing.

Although there is no official tracking of homeless deaths in Colorado, the Colorado Coalition for the Homeless conducts an unofficial count through a coordinated process involving the Denver Coroner's office and more than 25 homeless service organizations in the seven-county Denver metropolitan area. This includes: medical clinicians; health care professionals; case managers; outreach and social workers; hospice, shelter, and emergency service personnel; housing managers; chaplains; volunteers; and, others who provide direct assistance for those that are homeless. Not all deaths are reported to the Coroner's office, so the broader involvement of homeless service providers is essential.

We Will Remember 2013 details the trends in deaths among the homeless population by capturing information about gender, age, seasonal distribution, type and cause of death, and health insurance status at the time of death. Each year, this information helps our community better understand the challenges faced by individuals experiencing homelessness, in order to acknowledge those we have lost and work to prevent such tragedies in the future.

Produced in conjunction with the

HOMELESS PERSONS'
MEMORIAL VIGIL

DECEMBER 18, 2013

REMEMBERING THOSE WHO LIVED
AND DIED ON THE STREETS IN 2013

A HEALTH PROBLEM CAN LEAD TO A DOWNWARD SPIRAL

As a consequence of homelessness, health care is frequently interrupted and uncoordinated. Mobility barriers, lack of health insurance, fragmented health services, and a mainstream health care system that often is not prepared to deal with the complex psychosocial problems presented by homeless patients partially explain discontinuity of care. Transience makes comprehensive medical care, referrals, and follow-up difficult to achieve effectively. Without homes, people are exposed to the elements, dehydration, infectious diseases, violence, unsanitary conditions, malnutrition, trauma, and addictive substances.[1]

PRIMARY CAUSE OF DEATH

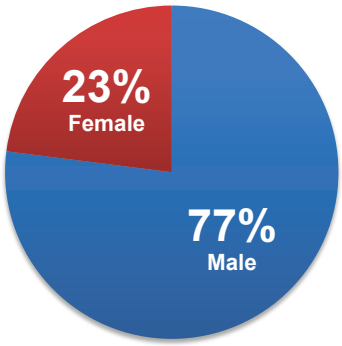
1. Chronic Drug and Alcohol Abuse
2. Heart Disease
3. Blunt Force Injury
4. Pneumonia
5. Hyper/hypothermia

The leading cause of death was attributed to complications from chronic drug and alcohol abuse. The second leading cause of death was heart disease. The third, fourth, and fifth leading causes of death were blunt force injuries, pneumonia, and hyper/hypothermia. Thirty-four of the deaths reported are classified as unknown or pending.

People experiencing homelessness experience three to six times the rates of serious illnesses and injuries compared to those who are housed. Historically, the vast majority of homeless people lack health insurance, primarily because they do not qualify for public insurance and cannot afford private insurance. For those who do become insured, co-payments and the cost of prescription medications often inhibit homeless families and individuals from seeking needed medical and mental health care, thereby neglecting health concerns until they become emergencies.[2]

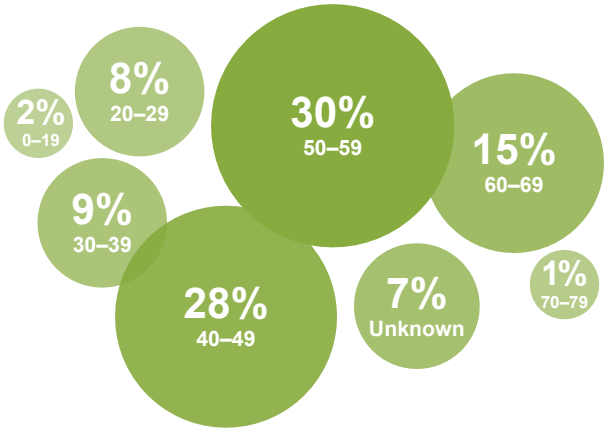
As a result of these factors, individuals experiencing frequent homelessness are three to four times more likely to die prematurely than the general population. The average life expectancy in the homeless population is estimated between 42 and 52 years, compared to 78 years in the housed population.[3]

GENDER



Ninety-five of the 124 deaths were male, 29 were female.

AGE



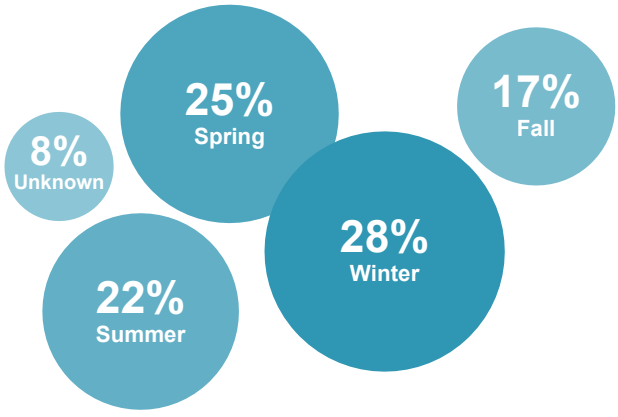
Deaths among this group ranged from 16 to 74 years with an average of 49 years of age; the highest percentage of deaths were among individuals aged 50 to 59 years.

HOUSING IS HEALTH CARE

Residential instability increases risk for serious health problems, exacerbates existing illness, complicates treatment, and often exposes persons to further traumatization. Lack of stable housing presents serious barriers to improving the health of people with acute or chronic illnesses. Meeting immediate needs for food, shelter, and safety leaves little time for medical appointments. Discomforts associated with illness and treatment side effects are compounded by lack of privacy, risk of abuse, theft of medications, and no safe place to rest and recover.

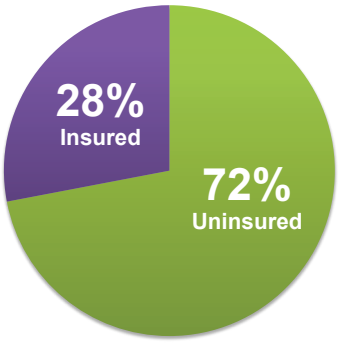
In extreme situations, many turn to emergency rooms although they are costly and inappropriate for ongoing care. Untreated addictions, as well as physical and mental illnesses present serious barriers to employment and permanent housing, perpetuating an ever-worsening cycle of poor physical health, hospitalization, incarceration, poverty, and homelessness. These are tragic outcomes for those experiencing homelessness; burdensome on health care, social service, and corrections systems; and, costly to taxpayers.

SEASONAL DISTRIBUTION OF DEATHS



The most deaths occurred in Winter (December 21–March 19) with 33, followed by Spring (March 20–June 20) with 31. Summer (June 21–September 21) had 27 deaths while Fall (September 22–December 20) had the least with 21. Actual dates were unknown for 10 people.

MEDICAID STATUS



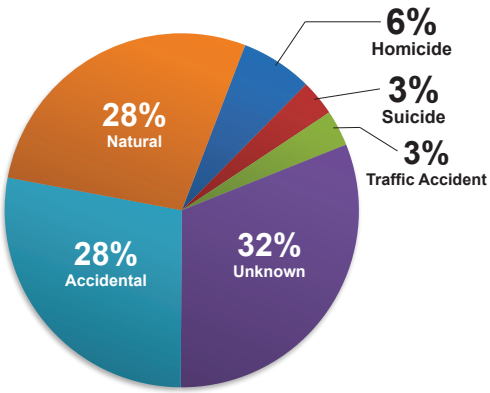
Thirty-five people (28%) were enrolled in Medicaid at the time of their death. The remaining 89 people (72%) had no documentation of health coverage when they died, as compared to 15.1 percent of the general population in Colorado who are uninsured.[4]

CONSISTENT HEALTH COVERAGE IS VITAL

Without housing and health care, simple cuts become infected, routine colds develop into pneumonia, and manageable chronic diseases such as asthma, hypertension, diabetes, and HIV become disabling, life-threatening, and costly conditions. Historically, adults without dependent children or a disability have been ineligible for Medicaid, the government's health insurance program for low-income families and individuals. However, as a result of the Affordable Care Act, in Colorado, nearly all U.S. citizens and legal residents under the age of 65 with incomes up to 133 percent of the federal poverty level (less than $16,000 for an individual) will qualify for Medicaid beginning in January 2014.

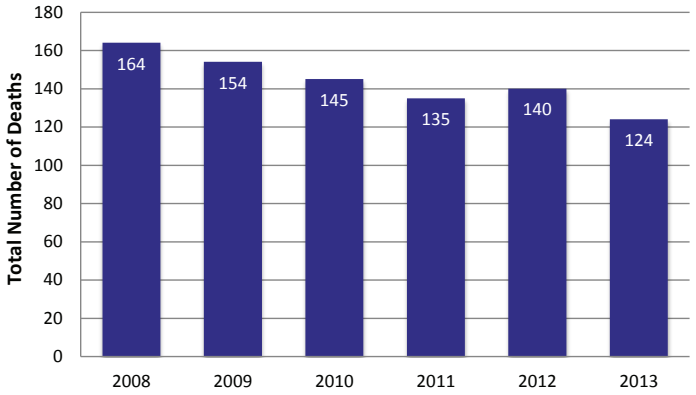
Medicaid provides the consistent health coverage needed to prevent and treat the health issues of individuals experiencing homelessness and remains the primary health insurance option open to those living in poverty.[5]

MANNER OF DEATH



Of the 124 deaths among the homeless population, there were eight homicides, four suicides, four traffic accidents, 34 deaths categorized as accidental, 34 natural, and 40 unknown.

TOTAL NUMBER OF DEATHS



For the period of December 19, 2012 through December 18, 2013, 124 people who were homeless died in the Denver community.

BRINGING INTEGRATED HEALTH CARE TO HOMELESS FAMILIES AND INDIVIDUALS

Traditionally, primary care, mental health care, and addictions treatment have been provided by different agencies scattered throughout the community. Accessing health care through multiple avenues can be frustrating, even to those with stable housing and reliable transportation. People who are homeless—particularly those with trauma history, mental illnesses, and co-occurring substance use disorders—have substantially greater difficulty navigating these complex service systems. Building trust in a mix of unknown care providers who may not treat them with dignity and respect often impedes action. Thus, skilled screening, assessment, evaluation, and treatment of physical and mental health conditions, in one location, from one care plan, are crucial in settings serving homeless patients.

The Coalition's integrated health care model responds to the specialized needs of homeless adults and children, delivering patient-centered physical care (medical, dental, vision, pharmacy, and chronic disease self-management) with behavioral health care (mental health care and substance treatment services) and supportive housing in one location—at the new Stout Street Health Center.

The Stout Street Health Center is replacing the existing Stout Street Clinic, an aging structure that currently lacks space to effectively meet the complex health care needs of an expanding homeless community. Located at 22nd and Stout Streets in Downtown Denver, this new property will join a fully integrated health care center serving homeless and at-risk families and individuals with 78 units of affordable, supportive housing at the Renaissance Stout Street Lofts. It will be complete in Spring 2014. The Stout Street Health Center will offer lasting solutions to homelessness through greater access to integrated health care, housing and the vital support services needed to ensure an improved quality of life for each of the families and individuals served.

REFERENCES

[1] **National Healthcare for the Homeless Council**. (2011). The Nexus of Health Reform, Housing & Homelessness: Recommendations for the Obama Administration from the National Healthcare for the Homeless Council. Available at http://www.nationalhomeless.org/factsheets/PPR/2010/9%20-%20Universal%20Health%20Care%206-10-10.pdf.

[2] **National Coalition for the Homeless**. (2010). NCH Public Policy Recommendations Universal Health Care. Available at http://www.nationalhomeless.org/factsheets/PPR/2010/9%20-%20Universal%20Health%20Care%206-10-10.pdf

[3] **National Coalition for the Homeless**. (2009). Health Care and Homelessness. Available at http://www.nationalhomeless.org/factsheets/health.html.

[4] **Colorado Health Institute**. (2012, September). Counting Colorado's Uninsured: The Latest Estimates. http://www.coloradohealthinstitute.org/uploads/downloads/counting_uninsured_ACS.pdf

[5] **National Health Care for the Homeless Council**: http://www.nhchc.org/wp-content/uploads/2013/02/NHCHC-Medicaid-Expansion-Position-Paper.pdf

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