Poverty and Homelessness Board

All Member Meeting
June 21, 2018
12:00 p.m. – 1:30 p.m.

Carmichael Room, Serbu Youth Campus
2727 Martin Luther King Junior Blvd

AGENDA

Time	Topic
11:45 a.m.	Arrival and Lunch
12:00 p.m.	Welcome and Agenda Review
12:05	Consent Agenda: ▪ Minutes from April 19, 2018 All Member Meeting ▪ Shelter Feasibility Study Timeline ▪ Revised PHB Meeting Schedule and Filming PHB Meetings ▪ Announce combined PHB Executive Committee and Human Services Commission meeting for Monday, July 16 11:30 – 12:00....PHB Pre Meeting 12:00 – 12:15....*Break* 12:15 – 1:30.....Combined PHB/HSC Meeting
12:10	Committee Updates - *LEAGUE- Kris McAlister* - *Youth Homelessness Solutions Workgroup- Susan Lopez* - *Employment Workgroup – Noreen Dunnells* - *Shelter and Supportive Housing Development- Pat Farr* - *HealthCare Committee- (see memo in board packet)*
12:15	Welcome new PHB Member Lacey Henry, Homeless Youth Representative
12:20	Public Shelter Feasibility Study Update - Alex Dreher, Human Services Division
12:30	Revised PHB Meeting Schedule and Filming PHB Meetings - Alex Dreher, Human Services Division
12:40	PHB Communications Plan - Pat Walsh, Chair, Poverty and Homelessness Board
1:00	Domicile Unknown Deaths- Kris McAlister
1:20	Wrap up Summarize board decisions, assignments, and next steps
1:25	Call for Agenda Items for the next All Member meeting in September Public Comment *(individuals who plan to offer comment must sign in with name and contact prior to beginning of the meeting)*
1:30	Adjourn

The Poverty and Homeless Board (PHB) is an action oriented group of elected officials, community stakeholders, and individuals who represent low-income and homeless people's concerns. The purpose of the PHB is to create innovative partnerships and programs that use best practices to reduce poverty and homelessness in Lane County. The PHB will work to generate resources, community and legislative support for housing and services to achieve its goals.

PHB Alternating Schedule

mtg dates	com	work group	time	conference room/ site
01/18/18	PHB	*Executive Committee*	12:00-1:30	Conf Rm #530, Charnelton Bldg
02/15/18	**PHB**	**All Member**	**12:00-1:30**	Carmichael Room, Serbu Campus, 2727 Martin Luther King Jr. Blvd
03/15/18	PHB	*Executive Committee*	12:00-1:30	Conf Rm #530, Charnelton Bldg
04/19/18	**PHB**	**All Member**	**12:00-1:30**	Carmichael Room, Serbu Campus, 2727 Martin Luther King Jr. Blvd
05/17/18	PHB	*Executive Committee*	12:00-1:30	Conf Rm #530, Charnelton Bldg
06/21/18	**PHB**	**All Member**	**12:00-1:30**	Carmichael Room, Serbu Campus, 2727 Martin Luther King Jr. Blvd
7/16/2018 ~~7/19/2018~~	PHB	*Exec Com joins HSC meeting on Monday*	11:30-1:30	Conf Rm #530, Charnelton Bldg
~~08/16/18~~	~~**PHB**~~	~~**Cancelled for August**~~	—	—
9/20/2018	**PHB**	**All Member**	**12:00-1:30**	Carmichael Room, Serbu Campus, 2727 Martin Luther King Jr. Blvd
10/18/2018	PHB	*Executive Committee*	12:00-1:30	Sloat Room, Atrium Building 99 W 10th Ave
11/15/2018	**PHB**	**All Member**	**12:00-1:30**	Bascom-Tykeson Eugene Public Library 100 W 10th Ave
~~12/20/2018~~	~~**PHB**~~	~~**cancelled for December**~~	—	—

2019

01/17/19	PHB	*Executive Committee*	12:00-1:30	Sloat Room, Atrium Building 99 W 10th Ave
02/21/19	PHB	All Member	**12:00-1:30**	Bascom-Tykeson Eugene Public Library 100 W 10th Ave
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MEMO

TO: POVERTY AND HOMELESSNESS BOARD

FROM: DR. RICK KINCADE

SUBJECT: PHB HEALTH WORKGROUP

DATE: JUNE 21, 2018

The purpose of this memo is to update the PHB on the PHB Health Workgroup's progress. Please see the accompanying matrix for additional information.

Background

The PHB Health Workgroup has met three times since its inception. During that time, the group has identified service gaps and needs that impact the health and well-being of individuals who experience homelessness or are at risk of homelessness.

The group identified three priority initiatives to explore further:

1. Increase Safe Areas
2. Improve Care Coordination and Discharge Planning
3. Increase Direct Care in Sheltered Environments

Increase Safe Areas

The PHB Health Workgroup defines safe areas as sanctioned or unsanctioned areas where unhoused persons can rest, receive assistance, or simply be, without persecution, discrimination, or citation for their presence. Oversight may be present, but is not a qualifying condition. Police following local law, based on complaints may be participants or neighbors being the primary enforcement. The Egan Warming Centers are examples of safe areas.

Improve Care Coordination and Discharge Planning

This initiative is specific to people who are in a healthcare type setting. Members of the PHB Health Workgroup identified a lack of coordination and discharge planning as a major gap in our community which leads to discontinuity of care and negatively impacts any health gains an individual may experience while in care. Improving coordination and discharge planning efforts amongst health care, behavioral health, social services, and housing can greatly improve the health outcomes of this vulnerable population. This initiative is aligned with PHB Strategic Plan Goal 2.4A: Support collaboration among community health care organizations that serve people who are homeless and supportive housing community members.

Increase Direct Care in Sheltered Environments

The focus of this initiative is to deliver care where people are. Sheltered environments are an example of those places. These are areas assisted by nonprofit or government program oversight, serving homeless and indigent populations. Program area rules may preclude access for some individuals. Eugene Mission and Conestoga Huts are examples of sheltered environments. This initiative is aligned with PHB Strategic Plan Goal 1.2D: Create 16 infirmary beds of emergency shelter to provide immediate medical triage, assessment, and care.

Next Steps

The PHB Health Workgroup reconvenes on Wednesday, July 25th to draft a work plan and will continue revising it through the summer and incorporate feedback from LEAGUE. We will propose a work plan to the full PHB for final approval in the fall.

Poverty and Homelessness Board: Health Workgroup Brainstorming Initiatives

Population Focus	Location of Care	Possible Initiatives	Current Partners	Resource Needs
Vulnerable; Currently homeless	Street Shelters Outreach care Emergency Department Ambulatory Clinic Hospital Community Court Library City Hall Other public spaces	Increase Mobile Care Teams	Occupy Medical White Bird CAHOOTS & other services ShelterCare Street Outreach Looking Glass Laurel Hill South Lane Mental Health Eugene-Springfield Fire and EMS HIV Alliance Pharmacies PeaceHealth Transitions Willamette Family Peer Support Workers Law Enforcement	Vehicles Training/Workforce Supplies Tracking systems Expanded social services Examples: Legal, flexible funds, enrollment assistance Low level respite Med storage & distribution Mobile med cart SSI/SSDI Outreach, Access and Recovery (SOAR)
		Increase Direct Care in Sheltered Environments	Eugene Mission New Roads Looking Glass Warming Centers Dining Room Catholic Community Services Lindholm Center (Eugene Service Station) Catholic Workers (Brother Charlie) Car Camps & Conestogas "Safe Spots" Community Supportive Shelters & Nightengale Carry it Forward Center for Family Development	Providers Mobile record/Tracking system Technology (telemed) Increase safe spots Use mobile services Space for clinics Peer support/Navigators Mental Health and SUD counseling SSI/SSDI Outreach, Access and Recovery (SOAR)
		Increase "Safe" Areas	Same partners from initiative above City of Eugene City of Springfield Parks Department	Sanctioned areas Funding Political support New Partners Services at sanctioned and unsanctioned areas
Medically vulnerable; Housed in health care type setting	Medical Respite Behavioral Health Respite MLK type facility Skilled Nursing Facility State Hospital SUD treatment facility Jail Youth Services Hotel Rooms	Improve Care Coordination & Discharge Planning	ShelterCare PeaceHealth Respite Skilled nursing facilies Looking Glass Mental Health Hospital System Drug Court Willamette Family (Buckley) Hospice/Palliative Care McKenzie Willamette Rural Providers	Increase stable supportive housing Technology information systems Peer support/Navigators/Community Health Workers Training Readily available resource mapping Transportation Additional partners SSI/SSDI Outreach, Access and Recovery (SOAR)
		Increase respite beds (Medical & Behavioral Health) & capacity	ShelterCare Laurel Hill Center Motels paid by hospital Catholic Workers	Low Level Respite: Mobile services, food, meds, laundry, nursing, transport Medium Level Respite: Motel vouchers, home health, iutpatient services, food, laundry High Level Respite: Additional funding and partners
Vulnerable, medically stable; Currently in housing	Ambulatory Care Supportive Housing Foster Care Independent Housing MLK Type Facility Transitional Housing	Improve Welness Care (Preventative & chronic care)	All Primary Care Providers Pharmacies Behavioral Health Centers Willamette Family Laurel Hill Community Centers & Meal Sites	Increase access & availability of healthy foods/ Nutrition & Diet Stable Supportive Housing Immunizations Discount Prescriptions Peer Support/Navigators/Community Health Workers SSI/SSDI Outreach, Access and Recovery (SOAR)

PUBLIC SHELTER FEASIBILITY STUDY 2018

Lane County Human Services | LANE COUNTY OREGON | Eugene | TAC TECHNICAL ASSISTANCE COLLABORATIVE

JUNE: SYSTEM MAP

Map of current homeless service system to identify strengths, gaps, and needs.

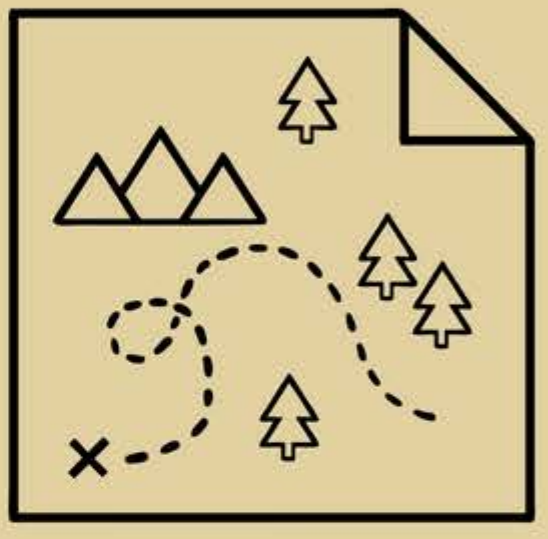
JULY: SYSTEM ANALYSIS REPORT

SEPTEMBER: SHELTER RECOMMENDATION REPORT

DECEMBER: FINAL SHELTER FEASIBILITY AND SYSTEMS ANALYSIS REPORT

APRIL/MAY: GAPS ANALYSIS, DATA COLLECTION, STAKEHOLDER INTERVIEWS

TAC will hear from stakeholders that represent service providers, gov't, non-profits, people experiencing homelessness, advocates, and more.



AUGUST: IMPACT PROJECTIONS

Cost/benefit analysis based on different intervention scenarios.

OCTOBER/NOVEMBER: REVISIONS PROCESS

Present preliminary report to stakeholders and the community for feedback and revision.

FOR UPDATES GO TO: LANECOUNTY.ORG/SHELTERSTUDY

Domicile UNKNOWN

Review of deaths among people experiencing homelessness in Multnomah County in 2016

Multnomah County

This report is dedicated to Israel Bayer, executive director of Street Roots.

Israel's compassion, inspiration and persistence in working to end homelessness led to this unprecedented collaboration with Multnomah County and this annual review.

The 2016 Domicile Unknown report should remove all doubt that homelessness is the challenge of our time. Eighty of our neighbors died on our Multnomah County streets in 2016, dying 30 years before their time and in situations that were largely preventable. After the severe cold weather in early 2017 led to at least six deaths from cold exposure, we know that the 2017 numbers could be even worse.

These deaths reveal some hard truths: The housing crisis is now claiming lives in every geographic quadrant of our county. Secondly, a growing number of the suspicious deaths the Medical Examiner's Office investigates every year are among people experiencing homelessness. Finally, these neighbors are literally dying right in front of us, with 32 people passing in a public space.

This is unacceptable. This is not normal. The housing crisis is not an accident, an act of nature or "how it's always been." Homelessness is the result of sustained policy and practices that, since the Reagan Administration, have shifted wealth to the rich by reducing federal investment in housing for people in need.

In Multnomah County we have said, "Enough." The year 2016 was a turning point for our community. For the first time, we officially joined our investments with the city of Portland and created a Joint Office of Homeless Services. Both governments made hard choices to find tens of millions of dollars in new funding for housing services.

We immediately began work to double the number of shelter beds with new permanent year-round shelters. Specifically, we established safe, welcoming space for women experiencing domestic violence, couples and families. We also opened new seasonal and severe weather shelters. We increased the number of people who moved back into permanent housing and helped record numbers of people from ever becoming homeless in the first place. These investments in housing stability, shelters and the support that helps people stay housed save lives and save money long-term.

The latest Point in Time Count shows the progress we've made, but also the important work that still remains. Though we counted more people sleeping in shelter than outside for the first time, overall more neighbors said they were homeless and more neighbors said they were homeless, for longer periods of time. That's why we can't stand still as the crisis around us grows. We have to continue working together and investing in the solutions we know are making a difference.

We started Domicile Unknown in 2011 when Israel first asked the County a simple question – how many people die on our streets each year? The information, he thought, could better help us respond to the housing crisis. The work has helped us see that we also need to look for long-term revenue options that could more fully fund affordable housing, We need support in the Oregon Legislature for housing stability. And we need to continue to look for ways to reduce the harm of injection drug use.

And, while this report continues to inform, more than anything, it also compels us to act. Beyond any statistic, it is the reminder that someone's beloved child, sister, brother, or parent died a premature and preventable death.

Deborah Kafoury

Israel Bayer

Introduction

The Multnomah County Health Department's annual review of homeless deaths finds that 80 people who were experiencing homelessness died on local streets in 2016. Since Multnomah County first began tracking deaths in 2011, at least 359 people have died.

The Department undertakes this report to determine the number, characteristics and causes of homeless deaths in Multnomah County. "Domicile Unknown" is intended to help the public, elected officials and social service providers identify how resources and policies can be directed to save lives.

What the report captures

The Oregon State Medical Examiner and Multnomah County Medical Examiner's Office are responsible for investigating all suspicious or unattended deaths, including accidental or violent deaths or overdoses.

The Health Department works with the Multnomah County Medical Examiner's Office to review cases in which people were likely homeless. The methodology has remained the same since the first report in 2011. It does not capture all deaths among people who were homeless, such as those who died in a hospital of natural causes. As a result, it is almost certainly an undercount.

Key Findings

- The people who died while experiencing homelessness in 2016 were similar in number, race, gender and cause of death to those who died in 2015.
- Of the 359 deaths identified since the first Domicile Unknown report, 88 people died in 2015, 56 in 2014, 32 in 2013, 56 in 2012 and 47 in 2011.
- Most of the people who died in 2016 were men, who ranged in age from 20 to 78.
- Seventeen women died in 2016, the same as the previous year. Their ages ranged from 25 to 62.
- Racial and ethnic numbers were also similar to 2015. Most of those who died were white, with nine of the deaths occurring among African American/Blacks.
- As in 2015, alcohol or drug toxicity either caused or contributed to half the 80 deaths in 2016.

Methods

Data Source

The Oregon State Medical Examiner maintains a database of all deaths investigated under its jurisdiction. In December 2010, the data field **domicile unknown** was added to the database for Multnomah County so that deaths of individuals who may have been homeless at the time of their death could be easily extracted. Death investigators make multiple attempts to identify a place of residence for decedents through scene investigation and interviews with relatives and social contacts.

According to ORS 146.090 the Medical Examiner investigates and certifies the cause and manner of all human deaths that are:

(a) Apparently homicidal, suicidal or occurring under suspicious or unknown circumstances;

(b) Resulting from the unlawful use of controlled substances or the use or abuse of chemicals or toxic agents;

(c) Occurring while incarcerated in any jail, correction facility or in police custody;

(d) Apparently accidental or following an injury;

(e) By disease, injury or toxic agent during or arising from employment;

(f) While not under the care of a physician during the period immediately previous to death;

(g) Related to disease which might constitute a threat to the public health; or

(h) In which a human body apparently has been disposed of in an offensive manner.

For the period January 1, 2016 through December 31, 2016, we extracted from the database the date of death, sex, race, age, cause, and manner for death for records in which the individual's address was noted to be "domicile unknown" or "transient."

Data Analysis

Case information for all investigated deaths in Multnomah County during 2016 was extracted from the Medical Examiner database. Ninety-one cases were coded "domicile unknown." Two reviewers independently assessed death narrative reports, supplemental information, and address information for each case to determine which investigations supported the classification of homeless using the Housing and Urban Development or Health and Human Services definitions.[1] Discrepancies in classification were resolved by concurrent assessment or by using a third reviewer. Ultimately, eighty (88%) of 91 individuals initially coded as domicile unknown were classified as experiencing homelessness in Multnomah County at the time of their death. Of the 11 cases not included in this analysis, six (55%) included information that indicated that the individual was likely not homeless; three (27%) died in a Multnomah County hospital, but records indicated that they were transient in another county; and two (18%) were infant or fetal deaths in mothers who likely were transient in another county. This analysis is limited to the 80 individuals experiencing homelessness in Multnomah County at the time of death.

To protect the privacy of decedents, demographic data were suppressed if cell counts were below three. Low counts for manner of death were not suppressed because this information is publically available from the Oregon Health Authority.

1 https://www.nhchc.org/faq/official-definition-homelessness/

To create the map (Figure 1), the variable location of death was used, unless the location was a hospital, in which case the location leading to the death was used. Data were geocoded (i.e., assigned geographic coordinates) to the street level when possible; however, some locations were geocoded only to an approximate location (e.g., highway onramp). Decedents found on or in bodies of water were excluded, for a total of 75 deaths reflected on the map. The kernel density function was used to calculate the density of deaths by their point location. The kernel density tool fits a smoothly curved surface over each point; more points are reflected as "warmer" colors on the map (shades of red), while less points are reflected by "cooler" colors (shades of blue). In this manner, individual death locations are obscured for confidentiality, but the overall pattern of death is displayed. Mapping was performed in ArcMap 10.3.1.

Because of the limitations of using Medical Examiner data for this report (e.g. calculating denominators is not possible because deaths could include non-Multnomah County residents), we compiled only the frequencies of each variable and did not attempt to analyze differences in this group of homeless decedents to any other group, or to estimate specific rates. Frequencies were compiled using SAS 9.3. For the season of death, the year was divided into October-March and April-September.

Results

Age, Sex, Race

Seventy-nine percent of individuals who died were male with an average age of 51 years at death. The 17 females who died had an average age of 43 years. Although race was not established in all cases, the majority of decedents were classified as White (64, 82%), followed by Black/African American (9, 12%). Other racial categories accounted for fewer than three deaths each. Racial information was missing for two of the deaths.

Table 1

Demographics of Homeless Medical Examiner Cases, Multnomah County, 2016

Sex	Number (%)	Mean Age (range) (N=80)
Male	63 (79%)	51 (20-78)
Female	17 (21%)	43 (25-62)
TOTAL		49 (20-78)

Race*	Number (%)(N=78)
White	64 (82%)
African-American/Black	9 (12%)
Other	5 (6%)

**Note: Values may not add up to total due to missing data and low counts.*

Season

Because people experiencing homelessness are often exposed to environments without shelter, we looked at the frequency of deaths during cooler (October-March) and warmer (April-September) periods of the year. In 2016, around half the deaths (38, 48%) occurred between April and September, while 42 (52%) occurred during the colder months of October-March. However, the one death attributed to hypothermia occurred in September.

Table 2

Season of Death among Homeless Medical Examiner Cases, Multnomah County, 2016

Season	Number (%)
April - September	38 (48%)
October - March	42 (52%)

Cause and Manner of Death

The Medical Examiner database includes information on the cause and manner of death. The manner of death is classified as natural, accident, suicide, homicide, or undetermined. Natural deaths are usually medical conditions, while the most common causes of accidental deaths are trauma and intoxication.

Table 3 shows the distribution of deaths by manner. Among the 33 accidental deaths, 20 (61%) were related to drug or alcohol consumption, while the most of the remaining individuals died from trauma (subtotals not shown). For the 32 natural deaths, nearly half (15, 47%) were from alcohol-related liver disease or atherosclerotic heart disease; other causes included cerebral edema, hemorrhage, sepsis, chronic obstructive pulmonary disease, and unspecified natural disease. Twelve deaths in total were attributed to suicide and homicide, while 3 had an undetermined manner. Causes of death for these undetermined manner included drowning and overdose.

Table 3

Manner of Death among Homeless Medical Examiner Cases, Multnomah County, 2016

Manner of Death	Number (%)
Accident	33 (41%)
Natural	32 (40%)
Suicide	9 (11%)
Homicide	3 (4%)
Undetermined	3 (4%)
TOTAL	80 (100%)

Toxicology

In half of the 80 deaths in 2016, drug or alcohol toxicity either caused or contributed to death. Some deaths were associated with more than one substance, and opioids (heroin or prescription) were noted in 19 (48%) individuals for whom drug or alcohol toxicity caused or contributed to death, or nearly one-quarter of all homeless deaths.

Table 4

Deaths Involving Substances as Primary or Contributing Causes of Death among Homeless Medical Examiner Cases, Multnomah County, 2016

Substance	Number (%) (N=80)
No substance	40 (50%)
Any substance*	40 (50%)
Any opioid (heroin, prescription, or unspecified opioids)	19 (48%)
Any alcohol	19 (48%)
Any heroin	16 (40%)
Any methamphetamine	12 (30%)
Any prescription opioid	4(10%)
Any cocaine	3 (8%)

**Note: Deaths involving more than one substance fall under more than one category. All these categories should have the same justification – alcohol is not a subset of opioid.*

Location

Over one-third of homeless deaths occurred in outdoor public spaces followed by hospitals (Table 5). Outdoor public spaces included deaths where the decedent was struck by a vehicle or train (9, 28%).

Table 5

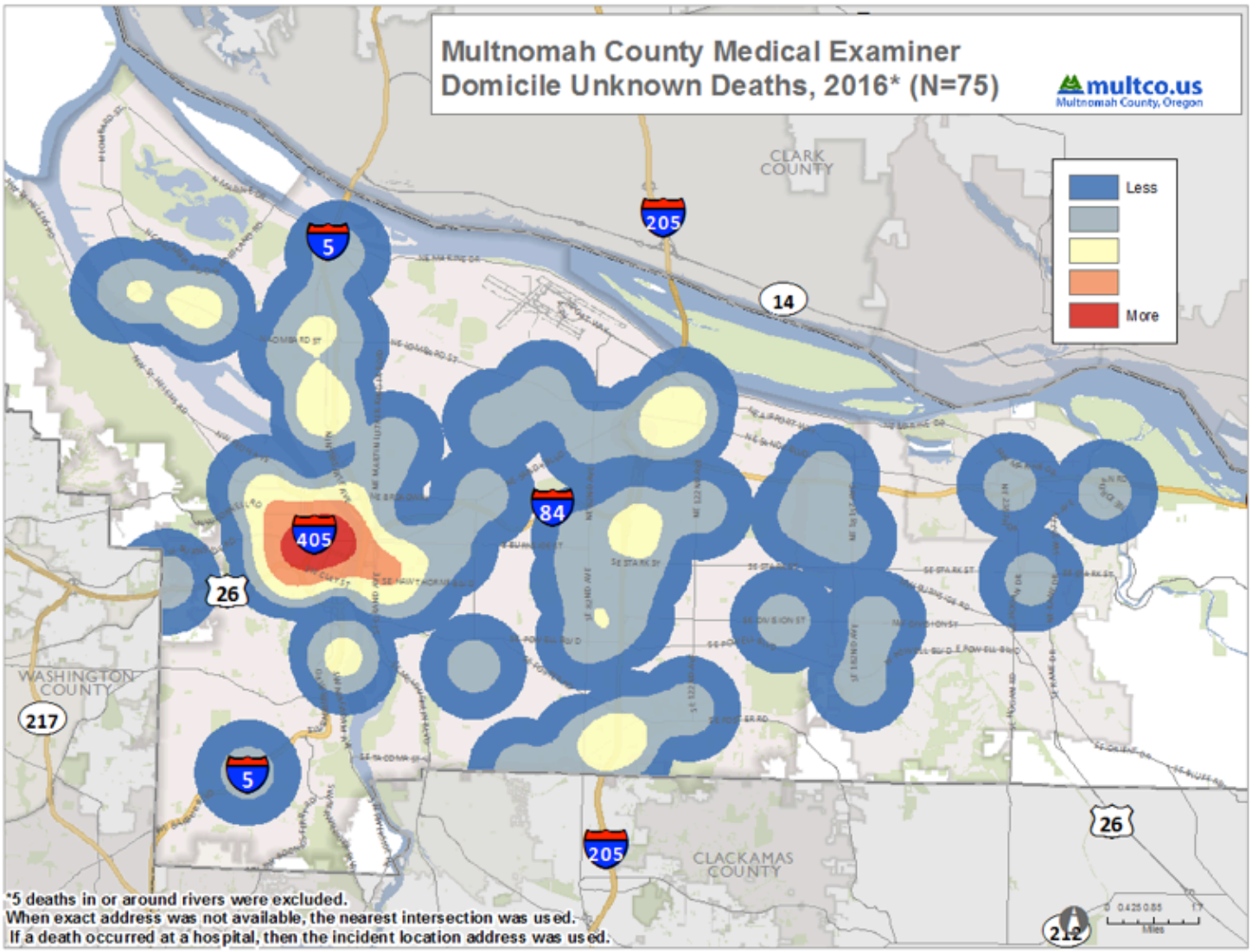
Location of Death among Homeless Medical Examiner Cases, Multnomah County 2016

Location	Number (%)
Outdoor public	32 (40%)
Hospital	12 (15%)
Hotel/Motel/Shelter	11 (14%)
Car, RV, camper*	9 (11%)
River	5 (6%)
Home/apartment	5 (6%)
Outdoor private	3 (4%)
Other non-residential	3 (4%)
TOTAL	80 (100%)

** Found dead in/around vehicle versus struck by vehicle*

Figure 1 shows the location of homeless deaths by location of deceased. For individuals who died in hospitals, the location is where the event leading to death occurred. Deaths in or around rivers are excluded from the map. Deaths are fairly geographically distributed across the county, with a larger concentration in the downtown area.

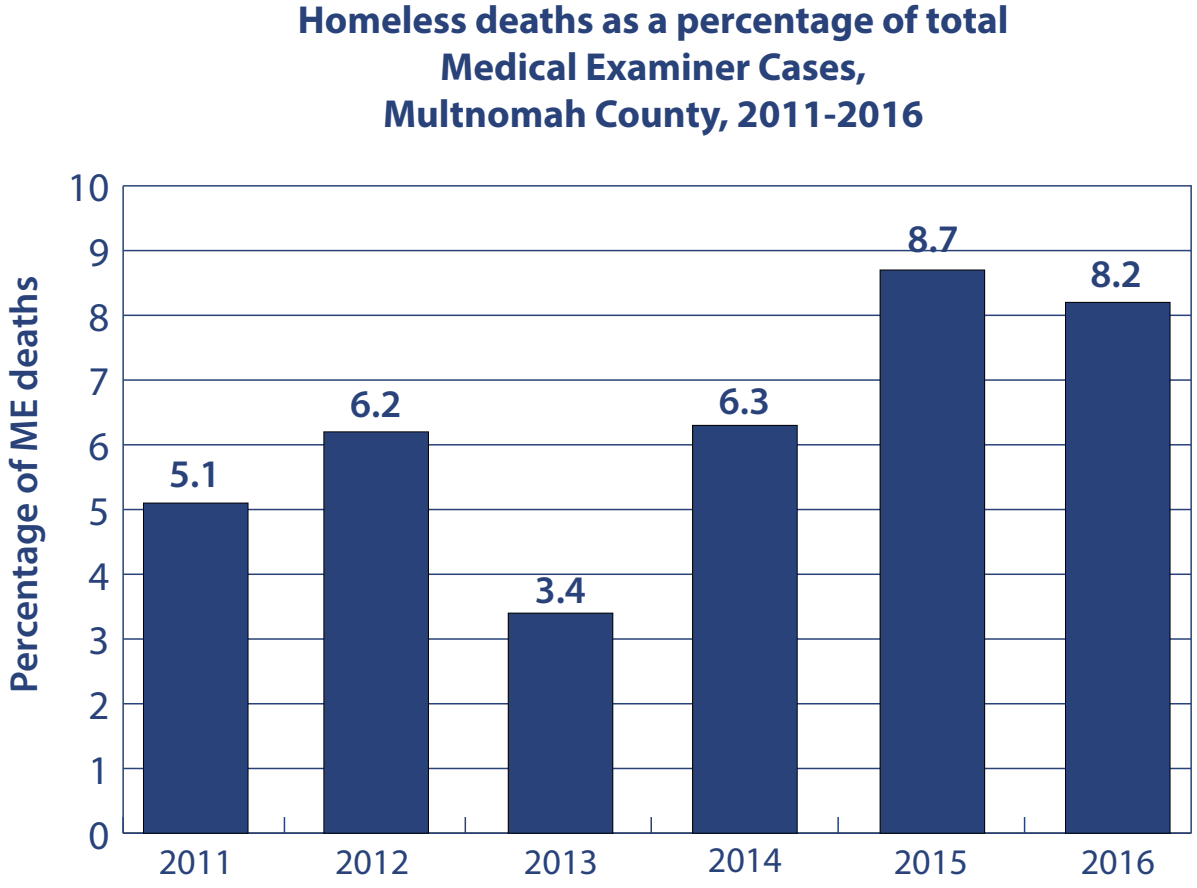
Figure 1. Multnomah County ME Domicile Unknown Cases by Location of Death, 2016



Comparison to previous years

Since 2011, medical examiner deaths occurring in homeless individuals have been increasing, although the data show some variability. 2013 had the lowest count during the previous 6 years (32 deaths), and 2015 had the highest (88 deaths). The overall proportion of ME-investigated cases who are in homeless individuals has also varied over time, ranging from 3.4% in 2013 to 8.2% in 2016 (Figure 2).

Figure 2. Percent of Multnomah County ME deaths who are Domicile Unknown, 2011-2016



Acknowledgments

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