

An Interdisciplinary Mortality Review Committee to Improve Quality of Services Provided to Homeless New Yorkers

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BACKGROUND

Governed by a unique right to shelter mandate, New York City (NYC) provides temporary emergency shelter to every man, woman, and child who is eligible for services, every night. NYC Department Homeless Services (DHS) provides shelter to about 59,000 homeless people in NYC on a given night and serves unsheltered homeless through outreach and low-threshold programs. Deaths among the homeless population increased by 30% from FY 2016 to FY 2017. This highlights the need to review homeless deaths to identify strategies for averting preventable deaths and improving quality of services provided.

Aims:

1. To improve quality of services provided to homeless individuals served by DHS.
2. To identify and design best practices that can reduce preventable deaths among homeless individuals served by DHS.

METHODS

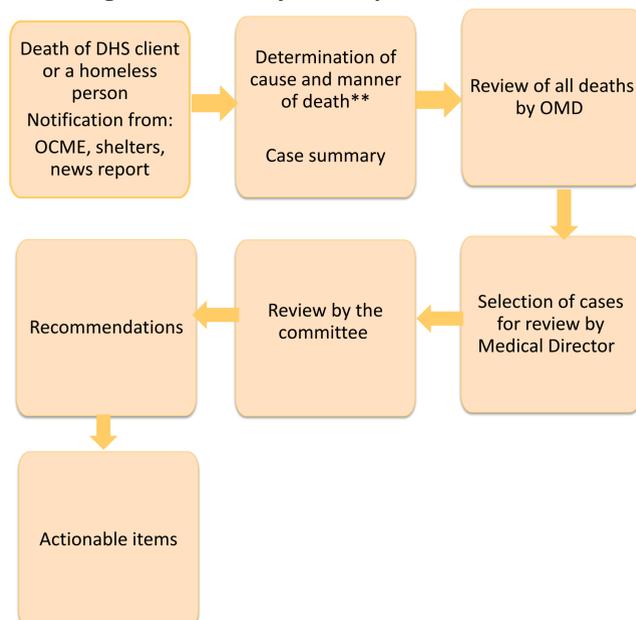
Composition of mortality review committee:

We formed a committee comprised of DHS Executive Office, Deputy and Associate Commissioners from shelter and street Programs, Office of the Medical Director (OMD), and NYC Office of Chief Medical Examiner (OCME) in November 2017. Figure 1 highlights the review process.

Data Sources:

- OCME: Autopsy, toxicology and scene investigation
- NYC DHS: Medical and behavioral health information, case summary
- NYC DOHMH*: Cause of death as reported on death certificates
- News reports

Figure 1: Mortality review process, NYC DHS



*NYC DOHMH: NYC Department of Health & Mental Hygiene
 ** Provided by OCME and NYC DOHMH

METHODS

Selection criteria of cases:

OMD periodically reviews all deaths of DHS clients and other homeless persons and selects and summarizes the cases for the committee to review (Table 1).

Table 1: Selection and inclusion criteria for case review

INCLUSION CRITERIA	EXCLUSION CRITERIA
1. Premature natural death (< 65 years) which is <ul style="list-style-type: none"> • Unexpected • Unexplained • Under unusual circumstances - time of the day, location • No history of medical or mental health condition • Unusual cause of death reported- for example epilepsy 	1. Natural cause of death: <ul style="list-style-type: none"> • Cancer • CVD/stroke • Kidney failure • Liver Cirrhosis
2. Overdose death, suicide, homicide, violence related	2. Death of a person ≥ 65 years
3. Children <18 years who are not known to be medically fragile or terminally ill	3. Motor vehicle or other transport related accident
4. High profile cases	
5. Deaths which were potentially preventable based on known circumstances. For example, if a client was not given naloxone for an observed overdose	
6. Cases requested by review team members	

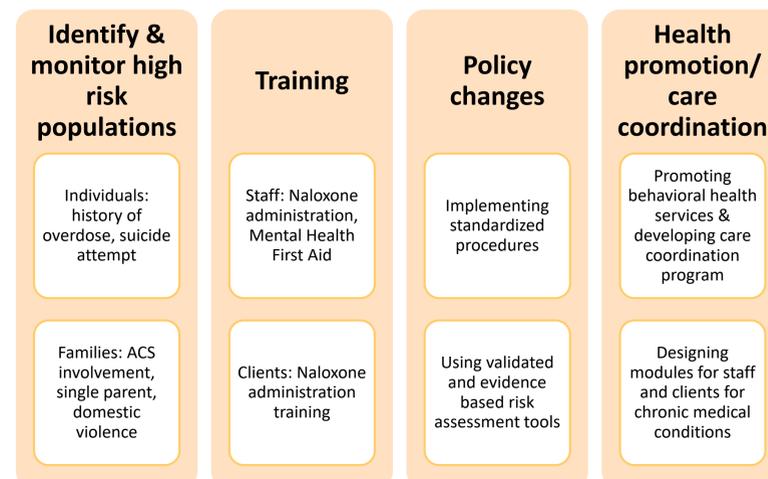
RESULTS

In 2017, 294 homeless individuals died in NYC, of those 59 (Table 2) met the inclusion criteria. We selected 38 cases for review. We identified various opportunities for improvement (Figure 2).

Table 2: Cases meeting inclusion criteria for review (N=59)

Cases met review criteria	n
Overdose related	33
Premature natural death (heart disease, seizures, diabetes, ketoacidosis)	13
Suicide	8
Infant	2
Toddler	1
Child birth related	1
Homicide	1

Figure 2: Recommendations of mortality review committee



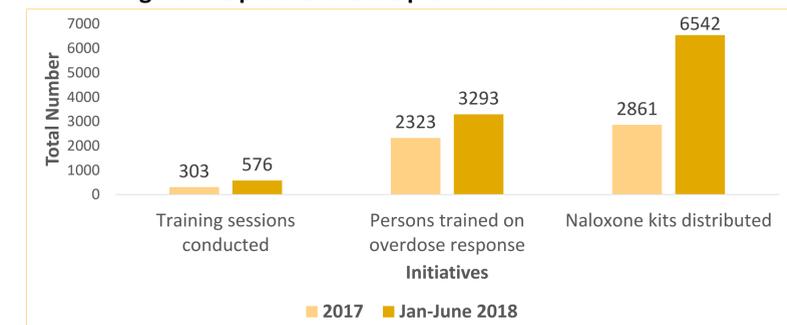
ACTIONS IMPLEMENTED

We implemented several interventions (Figure 3) to improve the medical and behavioral health services for our sheltered and street population.

Figure 3: Initiative to improve health of DHS population

New screening questions for substance use	Trainings conducted	New initiatives	Health promotion
<ul style="list-style-type: none"> • Have you overdosed in your: <ul style="list-style-type: none"> • Lifetime • Past 12 months • Past 30 days 	<ul style="list-style-type: none"> • Naloxone Administration (Figure 4) • Mental Health First Aid 	<ul style="list-style-type: none"> • Implemented substance use and overdose response policy • Established a workgroup to improve screening and assessment tools 	<ul style="list-style-type: none"> • Designing modules for chronic medical conditions • Disseminating information on behavioral health services including suicide prevention

Figure 4: Opioid overdose prevention initiative



NEXT STEPS

Continue to complete quarterly mortality reviews and discuss findings with senior leadership to improve quality of medical and behavioral health services provided to the sheltered and street population in NYC.

CONCLUSION

The ongoing review of preventable deaths provides an opportunity to identify and target program level areas for quality improvement to better serve the needs of homeless New Yorkers.

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Selected References

1. NYC Department of Homeless Services Stats and Reports. <https://www1.nyc.gov/site/dhs/about/stats-and-reports.page>
2. Twelfth Annual Report on Homeless Deaths (July 1, 2016 – June 30, 2017). New York City Department of Health and Mental Hygiene Bureau of Vital Statistics and New York City Department of Homeless Services

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