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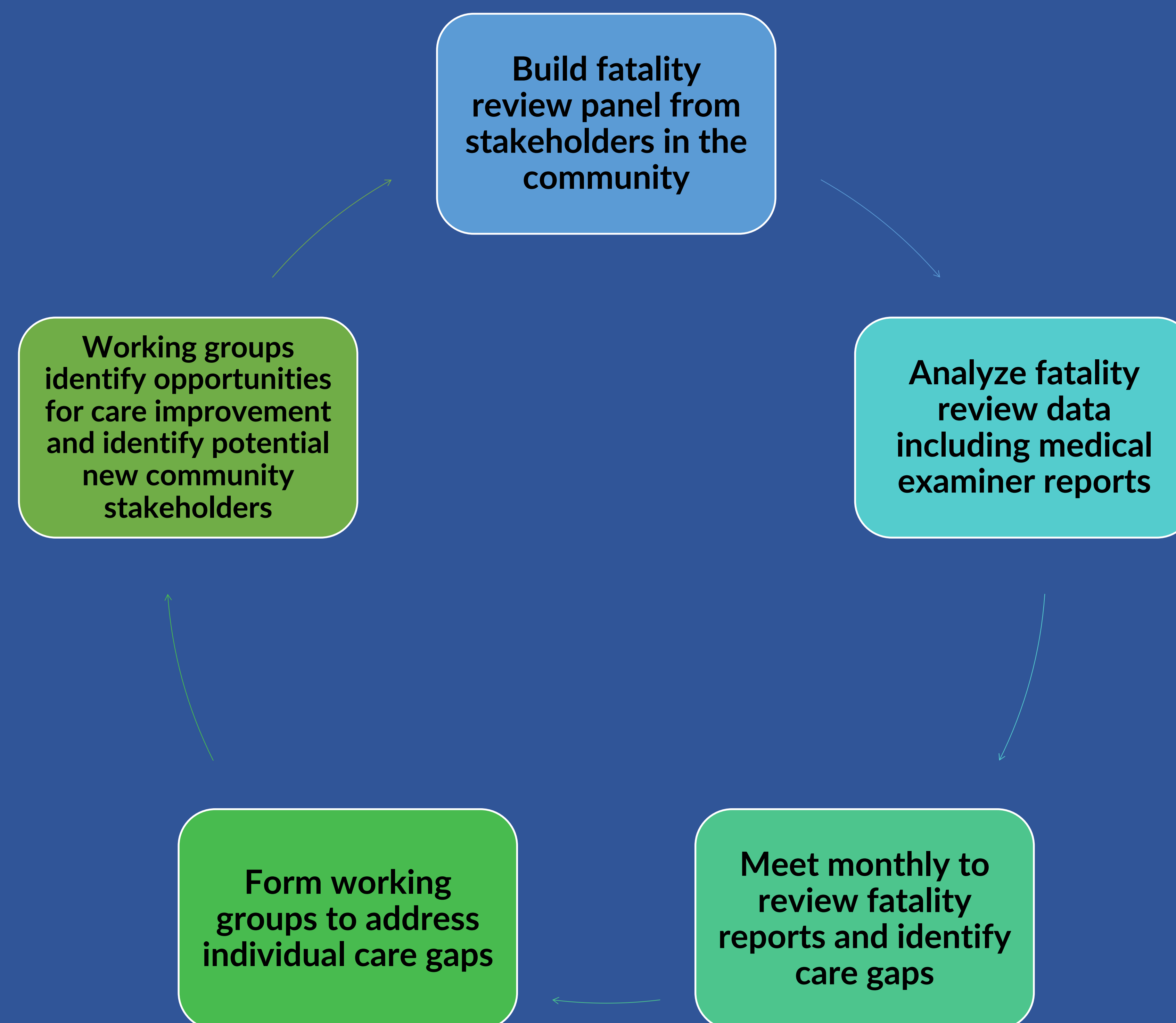
## BACKGROUND

- Persons experiencing homelessness (PEH) have higher rates of morbidity and mortality when compared to the general population. Often, multiple organizations will provide care for PEH, but this can lead to a fragmented system with silos of information that are not shared equally amongst stakeholders. Our approach is to create a multi-organization case fatality review board to determine, categorize, and geographically map leading causes of death and formulate multi-partnership solutions to address these causes.

## METHODS

- Our fatality review board is composed of a wide variety of stakeholders in our community who contribute to providing care for PEH. The board is composed of representatives from local Emergency Medical Service (EMS) agencies, the VA, local hospitals (including the safety-net hospital which serves a majority of the PEH population), local housing and shelter organizations, and a county mental health authority that provides outreach services.
- Approximately once per month members met to review individual fatality reports. These cases were compiled into a database using all available information from stakeholders. Confidentiality and data sharing agreements were established in order to protect identifying information. The data was supplemented with information from the Medical Examiner's database, including toxicology and autopsies if available, for approximately half of the fatalities. The data were analyzed and geographically mapped to identify priority areas of interest based on the recent years' fatalities.
- After an initial report was created, a separate meeting once a month occurred to discuss big picture interventions based on the data.

## Building a Multi-Organization Infrastructure to Address Fatality in Urban Population



## RESULTS

We identified three main areas of focus for future interventions:

- Medication compliance and management.
  - Hospital Discharge Process.
  - Connection to Substance use Treatment.
- Working groups were formed to specifically address these topics based on data from the fatality review board.

## DISCUSSION

- Insights:** Originally the board reviewed fatalities on a solely case-by-case basis, but integration of multiple organizations allowed for a bigger picture approach that allowed for systems-level interventions. Information was no longer fragmented and siloed, allowing for each organization to quickly share information and identify solutions. In some cases, PEH were identified during review who had very limited interactions with any of the representative organizations, leading to identification of potential gaps in our services for PEH.
- Future work:** Evaluating the results of specific interventions created by the working groups. Current initiatives include surveying PEH for barriers to medication compliance, improving hospital discharge processes and handoffs to recuperative care, and determining gaps in connecting to substance use treatment.

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