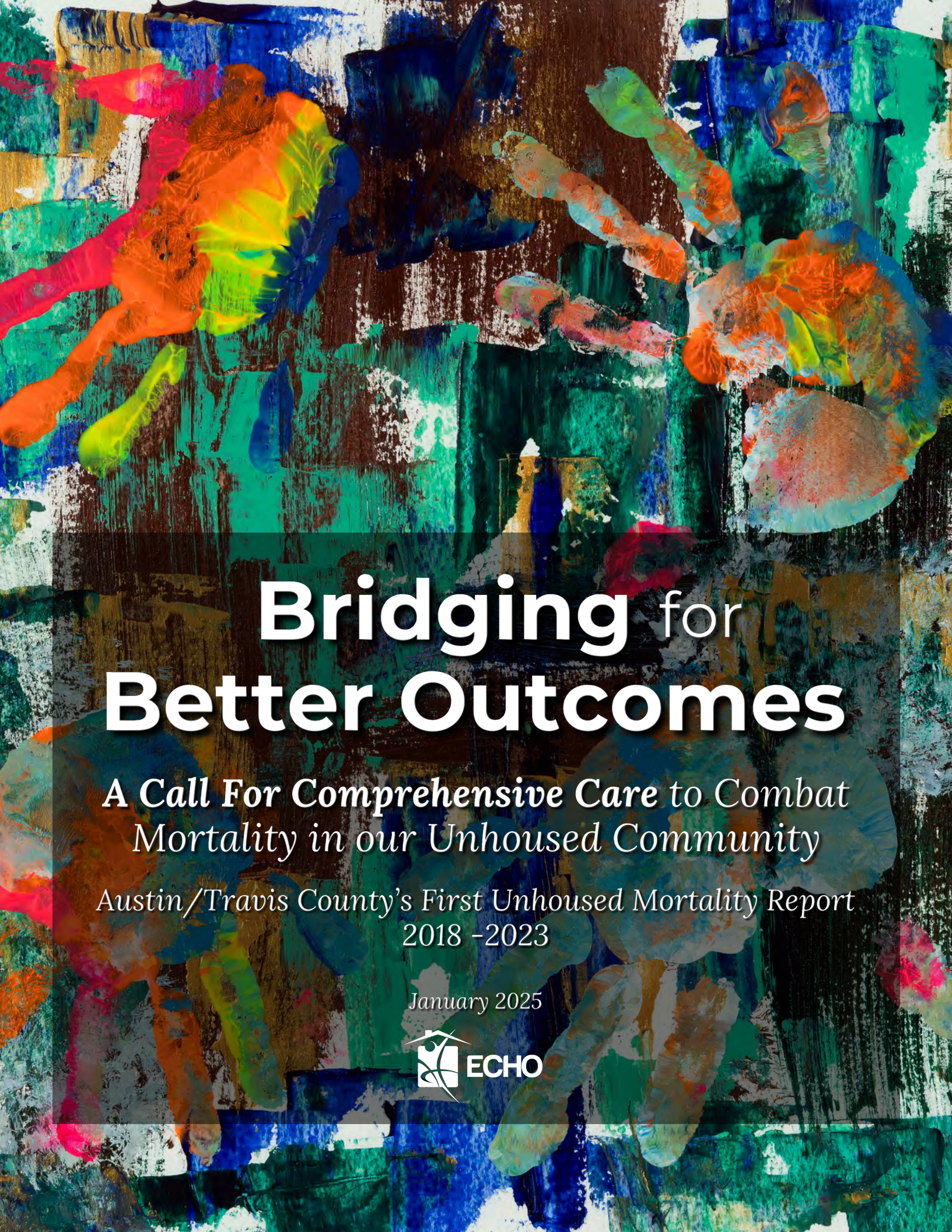


Bridging for Better Outcomes

A Call For Comprehensive Care to Combat Mortality in our Unhoused Community

Austin/Travis County's First Unhoused Mortality Report 2018 -2023

January 2025

ECHO

About the Cover Image

The cover image is a work by local artist Tom Jett. Tom painted this work at Art from the Streets, a nonprofit studio in Austin dedicated to providing people with lived experience of homelessness space and materials to create art. Learn about the organization and support the artists at ***artfromthestreets.org****.*

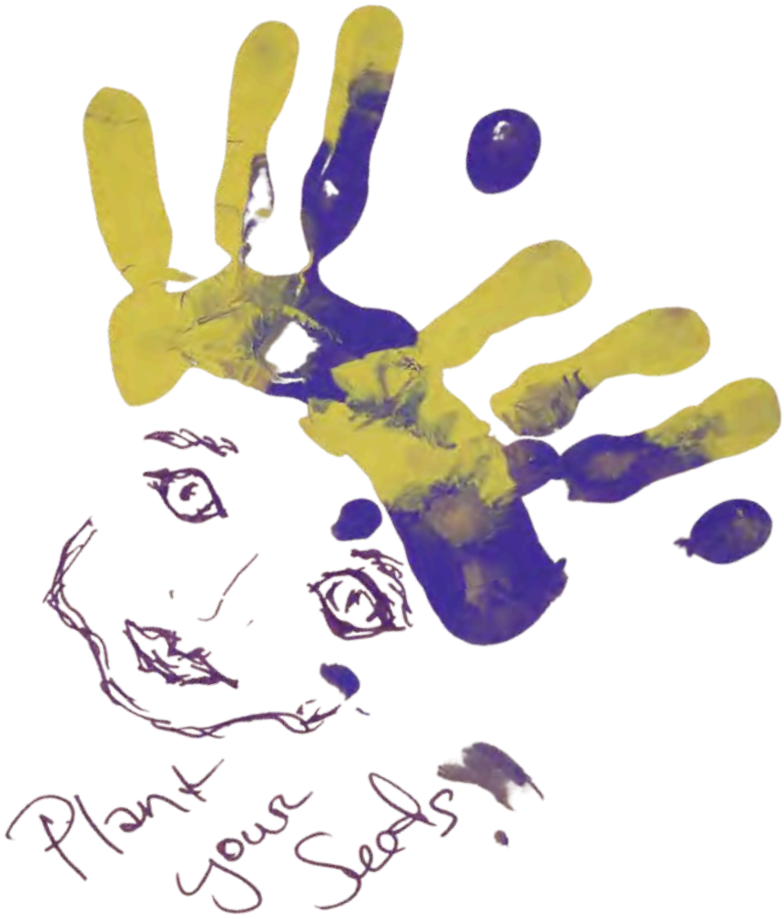
About the Authors

Danica Fraher, LMSW, MPH, is the Healthcare Systems Manager at the Ending Community Homelessness Coalition (ECHO), where she bridges housing and healthcare systems to support unhoused populations in Austin/Travis County. She leads initiatives like the Permanent Supportive Housing Health Care Collaborative and the At Home Initiative, focusing on integration through strategic planning and stakeholder collaboration.

Danica envisioned, led, and authored Austin's first comprehensive report on unhoused mortality, conducting data analysis and amplifying community voices to highlight preventable early deaths. Her work strengthens healthcare partnerships, advances innovative programming, and drives solutions that improve outcomes across systems.

Sarina Attri, BS is currently a Master of Public Health Student in Epidemiology at the Rollins School of Public Health at Emory University. Sarina worked as an intern for ECHO in the summer of 2024, where she helped clean, analyze, and visualize data for this report. She is passionate about harnessing the power of data to help inform prevention efforts for people experiencing homelessness. Sarina also worked on homeless mortality at the University of Houston College of Medicine, where she developed Harris County's 2022 Homeless Mortality Report.

Prior to her work on homeless mortality, Sarina conducted research on adolescent e-cigarette use and traffic safety at the UTHealth School of Public Health and worked on health communication through internships at the Centers for Disease Control and Prevention (CDC) and Texas Department of State Health Services.



The Ending Community Homelessness Coalition (ECHO) is the backbone of our community's Homelessness Response System. As the lead agency for the Austin/Travis County Continuum of Care, we lead and align a coalition responsible for planning and implementing community-wide strategies to end homelessness. We work alongside people with firsthand experience of homelessness and nonprofit, government, and philanthropic partners to build a future in which everyone in our community has housing of their choice that provides a foundation for optimal health, success, and stability. Learn more: austinecho.org

Connect with Us

Dedication

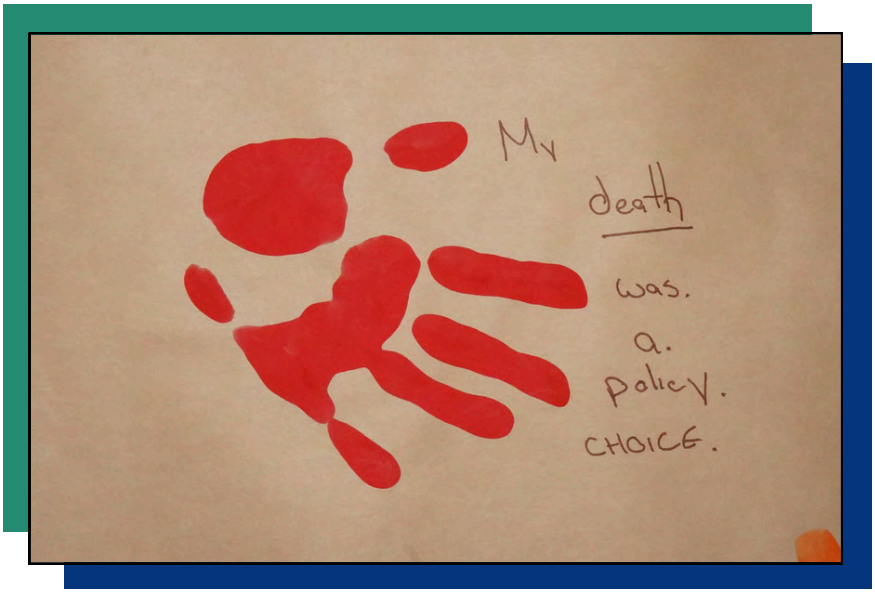
This report is dedicated to the memory of those we have lost to the streets. Your lives, stories, and experiences guide our work, and we remember you.

Table of Contents

A Message to Readers

Before moving forward, a few key notes:

- *Behind each number in this report,* ***there is a person.***
- *To make progress in promoting positive system change as a community, we first must accept our part in its failures.* ***There is much room for growth in these findings, and that is not to point blame as it is to center on collective opportunity.*** *The solutions to these problems leave no room for ego.*
- *Throughout listening sessions with service providers and persons experiencing homelessness, we shared stories of those we have lost;* ***these stories will be interwoven into this report to continually bring us back as a community to the collective why behind this report: No person should die on the streets. This is a policy choice that we as a community can overcome.***



Throughout this report, you will see painted handprints. These come from our listening sessions with service providers and persons experiencing homelessness. Each handprint represents someone our community has lost to the the streets. To learn more, check out our Data Cleaning & Analysis section.

Introduction

People who've experienced homelessness are dying far too young and far too often. This crisis goes beyond humanitarian concerns or political debates: It is a matter of life and death.

To put this in stark terms: a 40-year-old person experiencing homelessness has the same risk of dying as a 60-year-old person with housing. Communities that have studied mortality find unhoused people die as much as 30 years earlier than the general population.

Despite these alarming facts, we face a major problem: no one knows exactly how many people experiencing homelessness die each year in America. There is no national system to count these deaths, and no standard way to track them. This leaves each city and county to figure it out on their own.

A 2018 study found at least 5,807 deaths among people experiencing homelessness – but this only counted 2% of U.S. counties. The real number is much higher.

Here in Travis County, we're taking action. This report takes a critical first step in understanding the scope of deaths in our community, though the work to understand the full extent of this crisis is ongoing. For the first time anywhere in the nation, we're bringing together a more complete picture: medical examiner records, hospital data, the homeless services database (HMIS), and – crucially – the experiences of service providers and people who have lived through homelessness themselves. This comprehensive approach is especially novel in Texas, where we lack the advantages of a unified public health system or expanded Medicaid coverage that would make this data easier to collect. But we believe this work is too important to wait.

Until now, when we've looked at how to improve our homeless response system, we've only considered information from people who survived. But we must also learn from those who didn't survive. Their stories

can show us where our system needs to change, and how we can prevent future deaths.

We're not alone in this effort. Cities across America are starting to use death data to make more informed decisions about homeless services. In Phoenix, after a record-breaking 425 heat-related deaths in 2022, officials used this information to launch cooling centers, build shade structures, and bring water directly to people living outside. In Orange County, California, they've formed a special committee where medical examiners, homeless service providers, hospitals, and public health experts share information about each death to spot patterns and prevent similar tragedies. Other communities are following suit, recognizing that understanding the causes of these deaths is the first step to preventing them. This growing movement shows that data about deaths can lead to real, life-saving changes in how we help people experiencing homelessness.

This report is more than just numbers and stories – it's a roadmap for change. *By bringing mortality data into our planning, we can build a system that responds better to our community's needs and gaps. This approach honors those we've lost while working to prevent future deaths.* ***When we combine data-driven decisions with strong partnerships across our community, we can create solutions that protect and uplift our neighbors before it's too late.***

Key Findings

Deaths among Austin/Travis County's homeless population are rising.

- *Between 2018 to 2023, the number of known deaths occurring in the unhoused community total* ***1,010 people. Deaths have risen sharply****, from 7 per month in 2018 to 22 per month in 2023.*

- *The average age of death for people who die on the streets is 48; it's 55 for people who die in hospitals. The* ***overall average age of death is 50****. People experiencing homelessness in Travis County die* ***20 years younger*** *than people with houses.*

- ***Overdose, transportation accidents (cars and trains), and cardiovascular disease top the list of causes.*** *Chronic homelessness is linked to multiple health complications, including sepsis and respiratory and digestive system diseases.*

Unhoused Hispanic people die younger (48) on average than other groups (Black, 52, White, 50).

- *White people experiencing homelessness have the largest difference in life expectancy when compared to their housed counterparts, dying* ***23 years younger.*** *Black people die* ***13-15 years younger****, and Hispanic people die* ***14 years younger*** *than their housed peers.*

While men make up the majority of deaths in our community (82.5%), women die younger.

- *Women experiencing homelessness in our community die around age 49; those who die on the streets (medical examiner) pass even earlier - at just 46 years old.*

Key Findings

Overdose is a growing crisis for people who live outside.

- *Overdoses have surged,* ***increasing by 333% from 2018 to 2023,*** *rising from 21 deaths in 2018 to 91 in 2023.* ***Methamphetamine is the primary driver,*** *implicated in at least 223 of 304 known overdoses during this period.*

- ***Fentanyl plays a significant role,*** *often in combination with methamphetamine:* ***119 overdose deaths involved fentanyl, with 109 cases involving both fentanyl and meth.*** *Only 10 deaths were attributed to fentanyl alone, suggesting unintentional exposure due to contamination in the drug supply.*

- ***One-third of overdoses involve only a single drug****. This suggests the need for targeted harm reduction strategies for meth, like addressing risks related to potency, contamination (e.g., fentanyl), and safe use practices.*

- *The lack of harm reduction tools, like fentanyl testing strips (illegal in Texas), exacerbates this crisis.*

> "I can't tell a story about just one person - someone I knew personally or was familiar with, their likes and dislikes. That wouldn't be fair or reality. The truth is I was connected to someone who died on the streets within the very first week of becoming homeless. I inherited her tent, nevermind the tear in the door and the birth certificate of a young woman I've never met in the pocket on the wall.
>
> - Person with Lived Experience

Key Findings

Nearly half of people who died on the streets (47%, 331 individuals) had no record of ever interacting with the Homelessness Response System (HRS)**.** *(medical examiner data)*

- *Over half (53%) of individuals who died had never completed a Coordinated Assessment.*
- *Of people who have taken a CA, only 11% (115 individuals) had taken one in the six months prior to their death.*

People who died used shelters more often than the overall unhoused population.

- *Nearly two-thirds (62.7%) of people who died had used shelter services at some point, compared to 47.7% of the general unhoused population.*
- ***Just 6% (64) of people who died between 2018 and 2023 were able to access a shelter bed in the six months prior to their deaths.***
- *Of people who died in hospitals, the number is even less: only 28 people were in shelter for at least one night. The low degree of access suggests significant barriers, possibly related to shelter requirements like the ability to perform Activities of Daily Living, or ADLs.*

Coordinated entry, street outreach, day shelter, and emergency shelter were the top four largest HRS service types utilized in the year prior to death. **These are primary areas to target for intervention.**

Key Findings

Investing in housing addresses the root causes of homelessness and curbs the staggering costs of preventable healthcare use.

- *The cost to care for 364 people in the year prior to their deaths totaled* ***$11.1 million in emergency medical services, ER visits, and inpatient care.*** *This could have funded 81% of Permanent Supportive Housing (PSH) services and rent for the same population.*

- ***People who died had a median of nine additional diagnoses*** *beyond their primary cause of death. Only 35 people (10%) who passed away in the hospital had no prior healthcare encounters.*

- *The top 10 causes of death account for* ***more than three-quarters of all deaths among unhoused people.*** *This highlights extreme vulnerability to a narrow set of preventable or manageable conditions, driven by systemic inequities and limited access to care.*

Housing is protective to health and longevity.

- *The median age of death for those who accessed permanent housing was 61.5 years, compared to 52 years for those who remained unhoused. This demonstrates the urgent need to expand permanent housing to improve life expectancy. Of note, this could also indicate that people who are entering housing are not as medically complex as those who are unhoused.*

Individuals who died in the hospital (364) had over 4,000 medical encounters in the year prior to their death. EMS-911 and ER visits were most frequent.

Recommendations at a Glance

1 The Need for Housing and Shelter

(Click/tap to jump to this section)

- ***Prioritize Permanent Housing:*** *Stable housing is the cornerstone of improving life expectancy and overall well-being.* ***Expand non-traditional housing choices*** *like recovery housing, long-term care, nursing homes, re-entry homes, shared housing, and hospice care.*

- ***Make Low-Barrier Shelter Transparent and Accessible:*** *Shelters can serve as life-saving interim solutions. Knowing when and where shelter beds are available is critical for people in need.* ***Develop population-specific shelters tailored*** *to the unique needs of vulnerable populations.*

2 Health Care Access Saves Lives

- ***Health systems should invest in housing****: This is a strategic and* ***cost-effective approach to improving health outcomes and reducing avoidable healthcare costs.***

- ***Center Lived Experience in Healthcare and HRS Innovation.***

- ***Support housing retention through integrated, person-centered health care****. This saves lives and ensures that "Housing First" doesn't devolve into "Housing Only."*

- ***Create a Bridge to Housing*** *with medical respite and low-barrier substance use treatment centers.* ***Open the door to recovery*** *by expanding support for substance use respite and treatment.*

- ***Build a Robust Discharge Planning Process.*** *Being discharged from a hospital to the streets is a death sentence for many.*

- ***Expand and integrate street outreach*** *with health care teams.*

- ***Expand SOAR Programs*** *for Life-Saving Benefits Access.*

Recommendations at a Glance

3 Community and Belonging as the Foundation of Care

- ***Community is a social determinant of health:*** *we must create opportunities for connection.*
- *Uplift* ***peer-led support groups****, facilitate* ***peer-led housing transitions****, expand* ***peer-led outreach teams****, and create* ***pathways to leadership for peers.***
- ***Integrate family reunification services****, when appropriate, as a part of a continuum of opportunities for connection.*

4 Uplifting Basic Needs through Proactive Engagement

- ***Utilize Coordinated Entry (CE) as a life-saving referral hub. Integrate medical triage*** *into CE; housing as a lifeline: we must* ***create pathways to housing for medically complex individuals. Streamline access to the APAT*** *and Coordinated Assessors.*
- *Expand HRS Services that are* ***working with people at risk of early death.*** *Create safe, accessible,* ***indoor community hubs.***

5 Innovating through Harm Reduction

- ***Expand harm reduction tools, education, and research.***
- ***Create Safe Spaces:*** *A calm, indoor space with minimal external stimuli and access to basic resources isn't just a compassionate solution — it's a practical one. Examples from around the world demonstrate the effectiveness of these sites, which we will explore further.*
- ***Addressing the Gap in Behavioral Health Care:*** *Without safe spaces, our community will need to dramatically increase the availability of psychiatric beds to address the behavioral health crises often linked to substance use.*

Recommendations at a Glance

6 Broader Systems Change to Fuel Progress

- ***Launch a Mortality Action Alliance:*** *Form a cross-sector advisory group to address these findings and implement recommendations from this report.*

- ***Unifying Data to Transform Care and Save Lives:*** *Data sharing is essential to transforming care coordination and creating direct pathways to housing and treatment.*

- ***Prevent Traffic Deaths with Targeted Intervention and Collaboration with the City and TXDOT.***

- ***Advocacy for Policy Change in Harm Reduction:*** *Advocating for legal access to harm reduction tools, such as substance testing strips and safe use sites, can prevent accidental overdoses and reduce the burden on emergency services.*

- ***Advocacy for Policy Change by expanding Medicaid in Texas:*** *Not only would we be ensuring more people can get the care they need, we could access federal funding to underwrite programs that sustainably integrate housing and healthcare for individuals with complex needs.*

What Can We Do Right Now?

Actionable Next Steps

For **All Stakeholders**

Scale permanent housing with the momentum required to support our community. We must also **diversify HRS housing opportunities** to serve the needs of all persons experiencing homelessness.

For **All Stakeholders**

Open the door to recovery by **expanding support for substance use respite and low-barrier treatment** in our community.

For **Homelessness Response System/ Continuum of Care Leaders**

Prioritize folks with complex needs by **developing a prioritization system that creates a pathway to housing** for people at risk of early death.

For **Health Systems Leaders**

Develop a **medical triage team** integrated with Coordinated Entry **that can facilitate placement into respite, long term care, substance treatment, and hospice opportunities** within our community.

For **Local Government**

Make **low-barrier shelter transparent and accessible with real-time shelter bed availability, a clear process for access, and appropriate staffing and services** to meet the needs of anyone seeking shelter.

Overview of Methods

This report integrates the analysis of housing, healthcare, and mortality data with narrative storytelling through listening sessions with service providers and persons experiencing homelessness. Data sources for this project include:

- ***The Homelessness Management Information System (HMIS),*** *which provides data on an individual's homelessness status, chronicity, demographics, and homelessness response system utilization.*

- ***Hospital data from the local health information exchange (Connxus),*** *for only those who are in HMIS and have a Release of Information (ROI).*

- *Unhoused death data from the* ***Travis County Medical Examiner's (ME) Office.***

- ***CDCWonder data,*** *which provides death statistics from the overall Travis County population.*

- ***Listening session (1) with our unhoused community*** *(in person and virtual survey offered). The session was recorded and sticky notes and butcher paper were utilized for polling purposes. Google Forms was used for the optional virtual survey (if not willing or able to attend in person).*

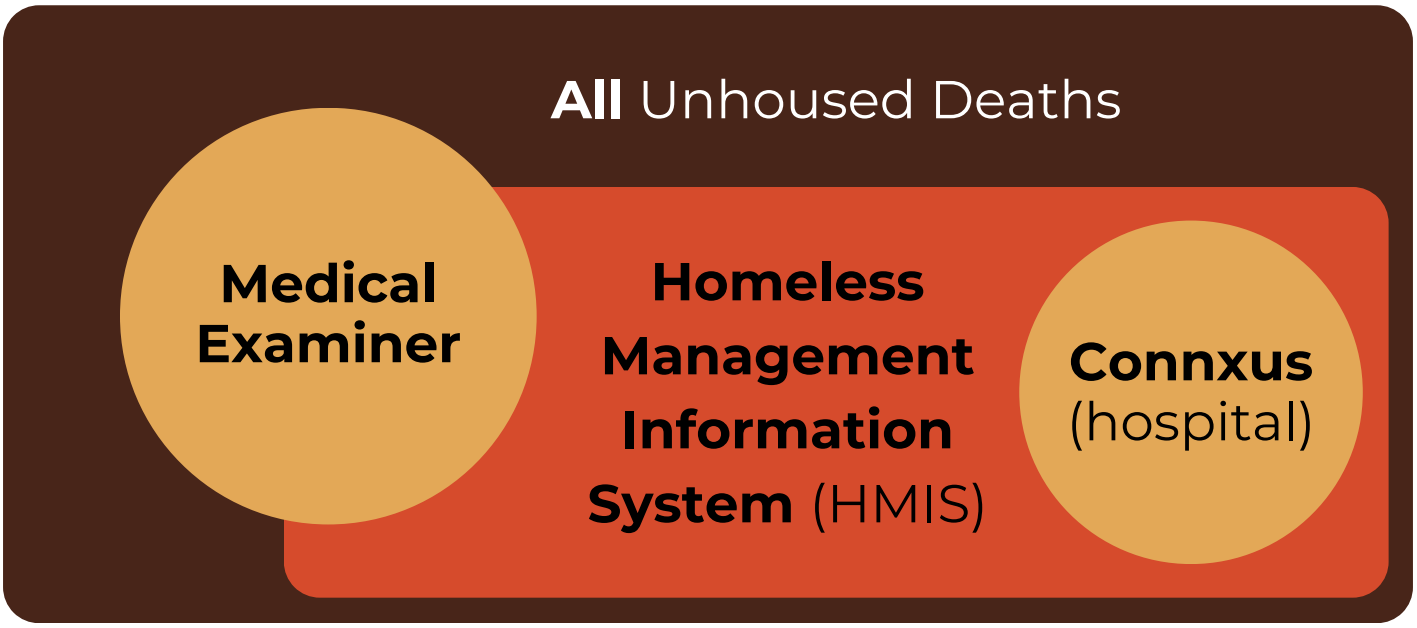
- ***Feedback Survey from the Austin Homeless Advisory Council (AHAC)*** *at the beginning of this project, following a presentation that introduced the project scope and concept.*

- ***Listening sessions (2) with service providers*** *(in person and a virtual survey offered). The sessions were recorded and Slido was utilized for polling purposes. Google Forms was used for the optional virtual survey (if not willing or able to attend in person).*

Overview of Methods

While all methods of this report are important, the most critical component is this: ***the findings of this report are an undercount.*** *As illustrated in this graph, the report contains only hospital deaths for persons also in HMIS. ECHO received hospital data for all individuals who were in the HMIS system and had a release of information (ROI). This means that ECHO does not have any data for individuals who died while experiencing homelessness but were not in HMIS and/or did not sign off on a ROI.*

The Medical Examiner, while having a methodology superior to many places across the country, does rely on the report of family, friends, or service providers for cases that are not clearly evident – and this might cause a degree of underreporting of deaths of individuals who may be experiencing homelessness but be in an institution (treatment center, nursing home) or might have found temporary refuge in a motel. Any deaths that are a part of an active investigation are also not included.



For an in depth look at our methods, please see the Appendix: Data Cleaning and Analysis Section.

Seeds

In memory of Country

By Linda Jackson

Spring is here! Time for new things, new days, new plants, fresh flowers. Time for the world to turn green again. Time to plant seeds.

Time to care for them and watch them grow. We are taught as children that we reap what we sow, but sometimes the planters don't actually witness the harvest. That's a story that I'd like to tell.

You see, I was asked to plant some seeds for a friend of mine. He asked that I plant as many as I can. I hope that as you read this story, something beautiful will start to grow.

Most people know him as Country. That's not his name. He's an old cowboy. I mean the rodeo kind. He used to ride bulls. There's some who don't believe him but I know it's true. In his younger days he toured with some of my cousins. It's a hard life that takes a sturdy demeanor.

Anyway, during the snowpocalypse of 2021, I stopped by to check on him. I wanted to make sure there was nothing he needed. I tried to get him to go to a hotel for the storm, but that wasn't going to happen. In typical cowboy style, he declined, insisting that he had everything he needed plus a lantern for heat. He lives in a tent under HWY 183.

He doesn't ask for much and I've never seen him on the corner holding a sign, but when I started to leave he stopped me and handed me an envelope. It was one of those yellow bubble ones made for breakables. He said that it was given to him earlier that day by a little boy. The boy had talked his dad into stopping under the bridge so he could give the envelope to Country. He told Country that he had been saving for a long time. He wanted to do something to help people in need.

I watched an old cowboy cry. He said he didn't know how much was in there. He never opened it, but he said it felt like about $1.80. I'm not real sure why. I imagine it has to do with the cost of a beer. He said that he wanted me to take it and to plant a seed, and if it was possible, plant as many as I could. I have to tell you, he wasn't the only one that cried. It's a beautiful thing, compassion. When the heart of a little boy can bring tears to a stubborn old cowboy. Or when someone who lives on the fringe of survival reaches out to others in need. When they share a Christ-like love to those doing the outreach.

I don't know how many times I've told that story. I don't know how many lives it's touched. I will tell you that it's still sowing seeds of Hope into the lives of those in need. And although my friend no longer walks this Earth, the seed he planted is not ready for harvest.

To be quite honest, I still don't know how much is in the envelope, but I know the amount doesn't matter. It's the gift that matters. The gift of a seed and the hope it brings as it grows.

“I am going to say her name was Amber. She was the most intelligent, smart, funny, troubled. She's someone in another lifetime that I would have been really good friends with. And we spent, for various reasons, time together... I just hope she knew that she was loved. You know, we didn't do everything perfectly. The system didn't do everything perfectly, but she had people who knew her. She had people who loved her. And people who know that she's gone and miss her. And I'm one of them.

- *Service Provider*

Who is Dying on our Streets?

> *"Too many people to list, with too many stories! That's the story itself."*
>
> – *Person with Lived Experience*

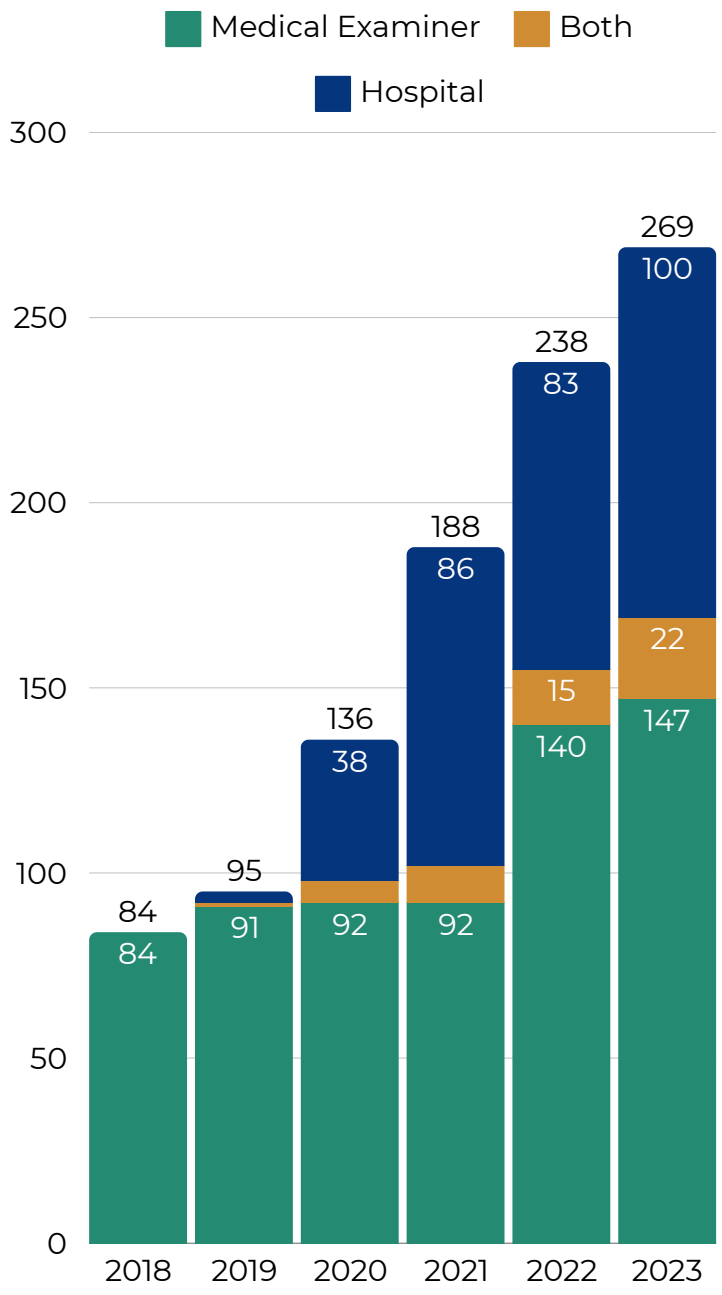
Between 2018 and 2023, the number of known deaths occurring in the unhoused community total 1,010 people.

We learned about these deaths in two ways: 646 people died on the streets and were reported to the medical examiner, while 310 died in hospitals. Some people (54) appear in both records, which happens when someone is brought to the hospital from the streets but dies within 24 hours.

The numbers also reveal a grim trend: Between 2018 and 2023, an average of 14 people experiencing homelessness passed away each month in Austin.

But this rate has been steadily rising, starting at an average of 7 deaths per month in 2018 and increasing to 22 per month in 2023.

***Deceased Unhoused Persons** by Data Source*
2018-2023



Who is Dying on our Streets?

Data Source	Average Age of Death	Median Age of Death
Medical Examiner	48	49
Hospital	55	58
Both (ME + Hospital)	50	52
General Population (CDC Wonder)	70	73

> I had a young gentleman around my age, so about 36 at the time, and he had congestive a-fib, heart issues... and it was just tough to see that. What really hit home was that he was my age....And what also stung was all of the hospital visits. He didn't have any family in the area so I made the time... but it was extra heavy.
>
> - Service Provider

Unhoused people in Travis County die 20 years younger than people with homes.

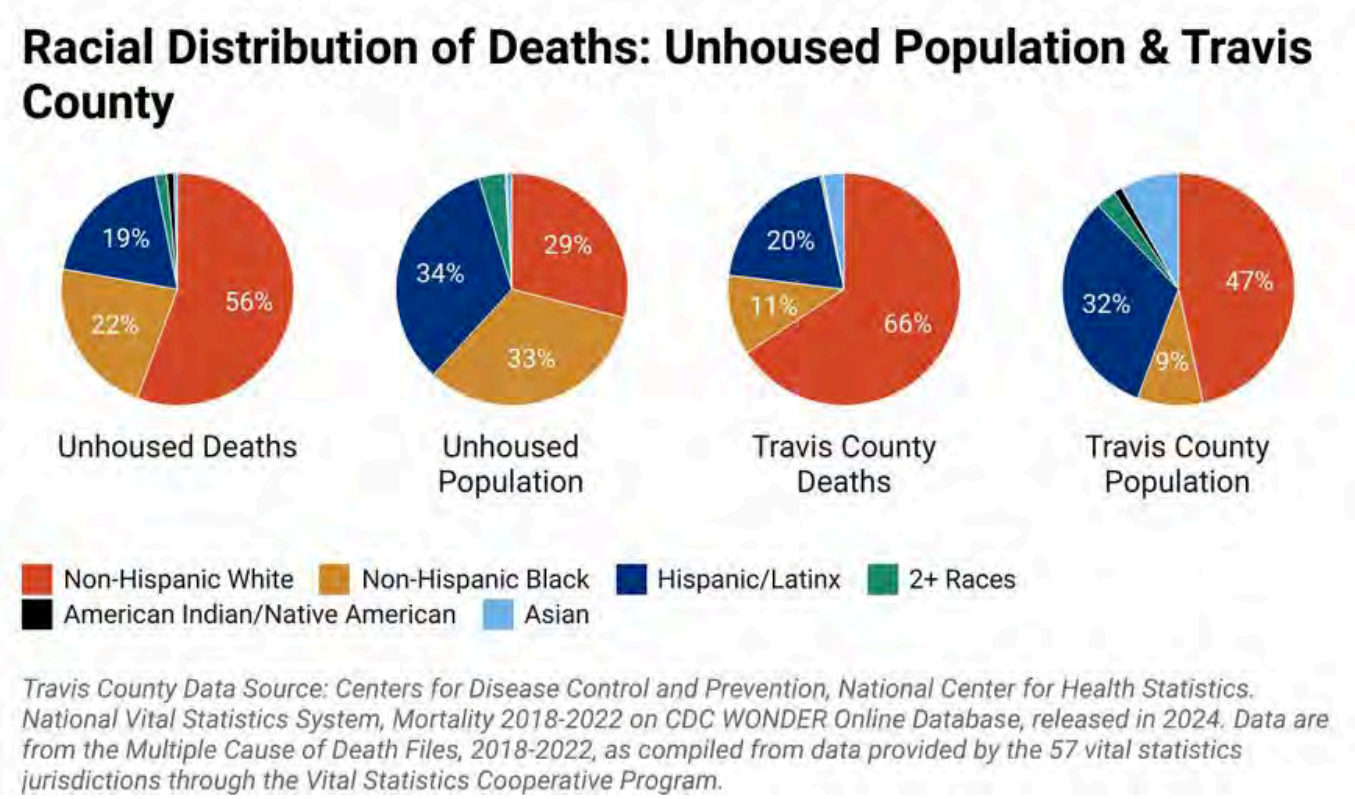
People who die on the streets have an average age of death below 50 (48). People who die in the hospital live slightly longer, with an average age of death at 55. All together, the average age of death for our unhoused community is 50 years old. These trends appear to be constant over time (See Supplemental).

While men make up the majority of unhoused deaths (82.5%, or 833 people), data suggests that the 176 women who died experiencing homelessness were extremely high risk.

Women experiencing homelessness in our community die around age 49 (overall: hospital and medical examiner included); those who die on the streets pass even earlier - at just 46 years old.

Who is Dying on our Streets?

A Demographic Profile
Race & Ethnicity



Travis County Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2022 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

The race and ethnicity of people who have passed tell an important story. While non-Hispanic white people make up a smaller proportion of our unhoused population (27.8%), they make up the largest proportion of unhoused deaths (55.6%).

This is also reflected in the overall Travis County population; while white people make up 47.9% of the population, this group accounts for 66.6% of all deaths.

While deaths of people who are Black are not over-represented in homelessness death data, when looking at deaths in our overall community they are disproportionate (11.3% of deaths, 9.4% of the total Travis county population).

Black unhoused people make up 31.5% of our unhoused community and account for 22.1% of all deaths. Hispanic community members who experience homelessness die the youngest, at around 48 years old on

A Demographic Profile

average, while Black unhoused folks live the longest (52). These trends match patterns seen in national data. One theory, dubbed racial mortality inversion, suggests that structural vulnerabilities that exist for Black individuals make this group more vulnerable to homelessness following various disruptions in life, such as domestic violence, incarceration, or job loss. In contrast, the relative social and economic privileges afforded to most white Americans means this group must exhaust various forms of social stability before experiencing homelessness - and are more often entering homelessness due to cases of medical or behavioral health crises.

Differences in life expectancy are starkly contrasted with housed Travis County residents:

- *White people experiencing homelessness die 23 years younger than their housed neighbors*
- *Black people experiencing homelessness die 13-15 years younger*
- *Hispanic people experiencing homelessness die 14 years younger*

> "I had a best friend who I camped with and did pretty much everything with/went everywhere with. She was safe and encouraging, as well as just a good energy to be around. Being a homeless African American gay male was a uniquely dangerous and difficult demographic to be a part of but my friend would take up for me, advocate for me, and sometimes fight for me. She was found overdosed and it was like the life I had on the streets became unsafe again."
>
> - Person with Lived Experience

A Demographic Profile

Of the 1,010 people* who died experiencing homelessness from 2018 to 2023:

At least 85 people who died on the street were veterans.

At least 182 people had previously experienced domestic violence.

At least 41 people were actively fleeing domestic violence.

*Most people (58%) who die on our streets are chronically homeless.***

*Special Populations: As these data are from HMIS, those who were not in the database are not represented in these numbers. Total unknown count for veterans: 333. Total unknown count for domestic violence: 360. Total unknown count for actively fleeing: 836. Total unknown count for chronic: 333.
**This is statistically significant when compared to rates of death in non-chronic groups. Significance testing: chi square test (p value < .0001).*

Very few people* who died on our streets were receiving benefits.

20% (201 people) had Medicaid

12% (120 people) had Medicare

17% (176 people) got Supplemental Security Income (SSI)

10% (101 people) got Social Security Disability Income (SSDI)

6% (58 people) got benefits from an employer

3% (34 people) had Social Security (retirement)

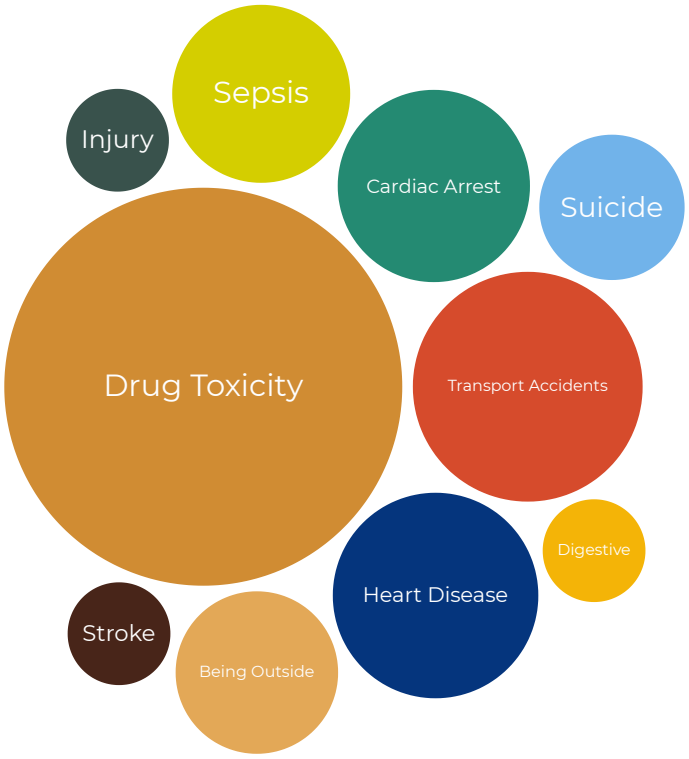
Benefits Access: This data is from HMIS, and are limited to those who touched the HRS. These data are also self report.

> "I lost a friend. [His name was] Chucky, he used to sleep in that park. He'd go and drive to Footlocker just to get the striped shirt, and then he'd go and volunteer with people playing basketball to be their ref with a whistle and everything. Everyone loved Chucky. And then one morning they found him... Someone had stolen his sleeping bag and he passed away. Frozen to death.

- *Person with Lived Experience*

How are people dying?

Leading Causes of Death in our Community



Overdose, transport accidents involving cars and trains, and cardiovascular disease are the leading causes of death in our unhoused community.

This aligns with national trends; a recent review of mortality reports across the nation found drug toxicity to be the leading cause of accidental death for people experiencing homelessness. In 73% of reports studied, cardiovascular disease was the leading natural cause of death.

The top 10 causes of death account for more than three-quarters of all deaths among unhoused people.

This is striking when compared to the general Travis County population, where the top 10 causes of death account for about 15% of total deaths. The disproportionately high percentage of deaths from the top 10 causes among people experiencing homelessness highlights extreme vulnerability to a narrow set of preventable or manageable conditions, driven by systemic inequities and limited access to care. In contrast, the general population's deaths are more evenly distributed, reflecting broader access to healthcare and the mitigating effects of social stability.

How are people dying?

Comparison of Leading Causes of Death

Rank	Unhoused	Percentage of Total Deaths	General Population	Percentage of Total Deaths
1	Drug toxicity	30%	Heart disease	4%
2	Transport accidents	10%	Cancer	4%
3	Cardiovascular disease	8%	Accidents	2%
4	Cardiac arrest	7%	Cerebrovascular disease	1%
5	Sepsis	6%	Alzheimer disease	1%
6	Environmental Causes	5%	COVID-19	1%
7	Intentional self-harm	4%	Intentional self-harm	1%
8	Diseases of the digestive system	2%	Chronic lower respiratory diseases	1%
9	Injury to the body	2%	Chronic liver disease and cirrhosis	0%
10	Cerebrovascular disease	2%	Diabetes	0%

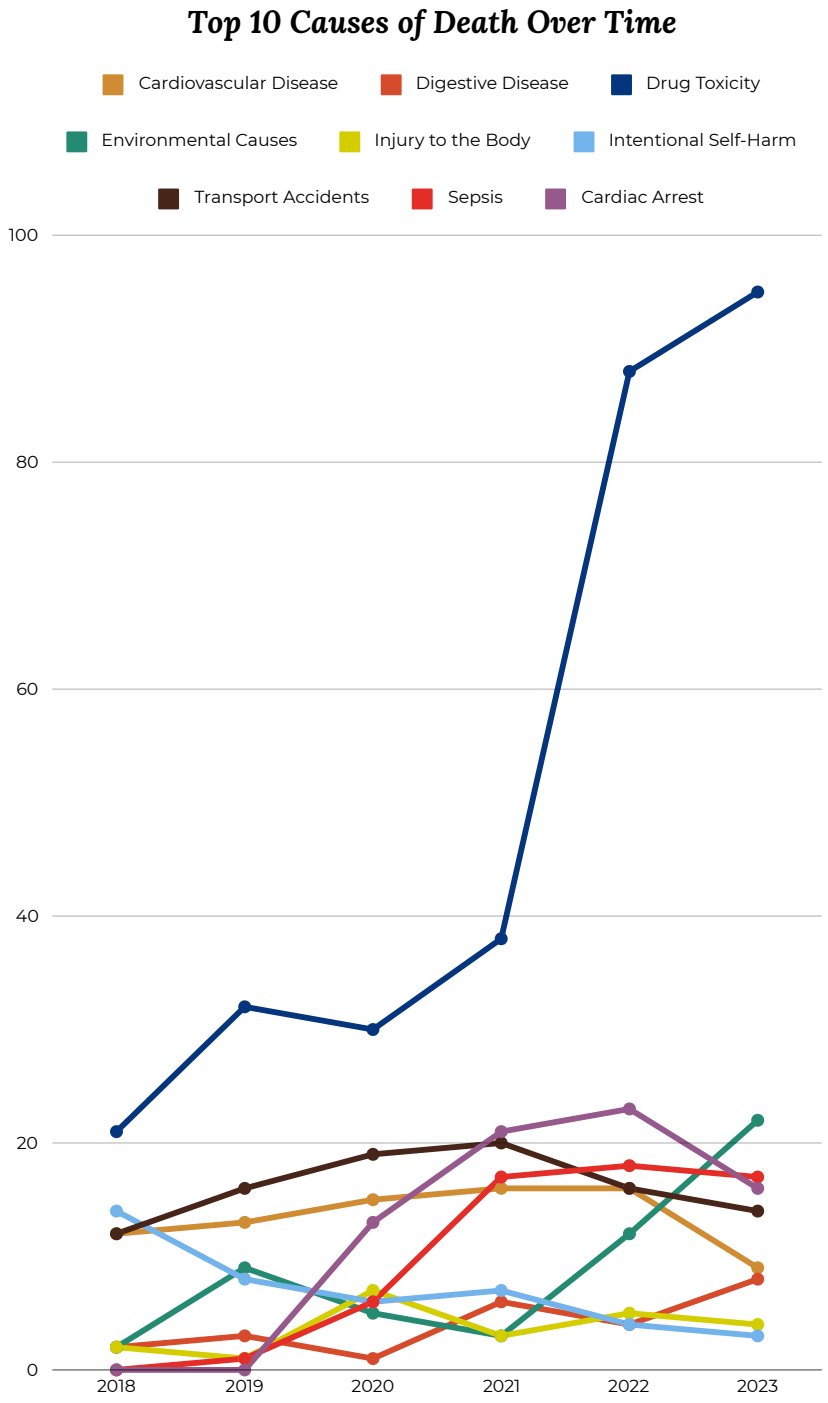
How are people dying?

Overdose deaths have risen dramatically, increasing by 150% since 2021.

This is largely due to increases in methamphetamine and fentanyl overdoses, which will be explored in more detail in the next section.

The data suggests that the prolonged stress associated with homelessness, along with complex health conditions, may increase the risk of a sudden cardiac event even in people without a history of heart problems.

At first glance, cardiac arrests among people experiencing homelessness might seem directly tied to cardiovascular disease. Surprisingly, though, this isn't often the case—only 12 out of 73 people had a history of heart disease. Instead, the medical records show a wide range of other health issues. The most common were blood tests, nicotine dependence, acidosis (a dangerous buildup of acid in the body), respiratory failure, viral infections, and bradycardia (a very slow heart rate)—none of which are directly tied to heart disease.

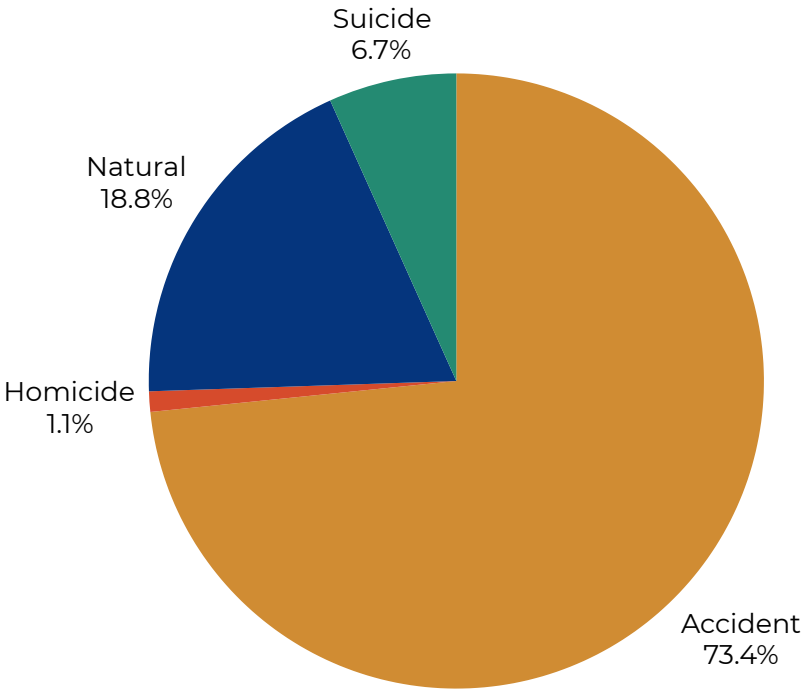


How are people dying?

Most deaths reported by the medical examiner were ruled accidental (about 73.4%, or 480 cases).

Many of these deaths stem from overdoses and transportation-related accidents. Far fewer deaths, about 18.8% or 123 cases, were considered natural, meaning they resulted from health conditions like chronic disease. Notably, over six years, there were only seven homicides reported, making up just 1.1% of the total medical examiner deaths. This is mirrored in mortality data across the nation.

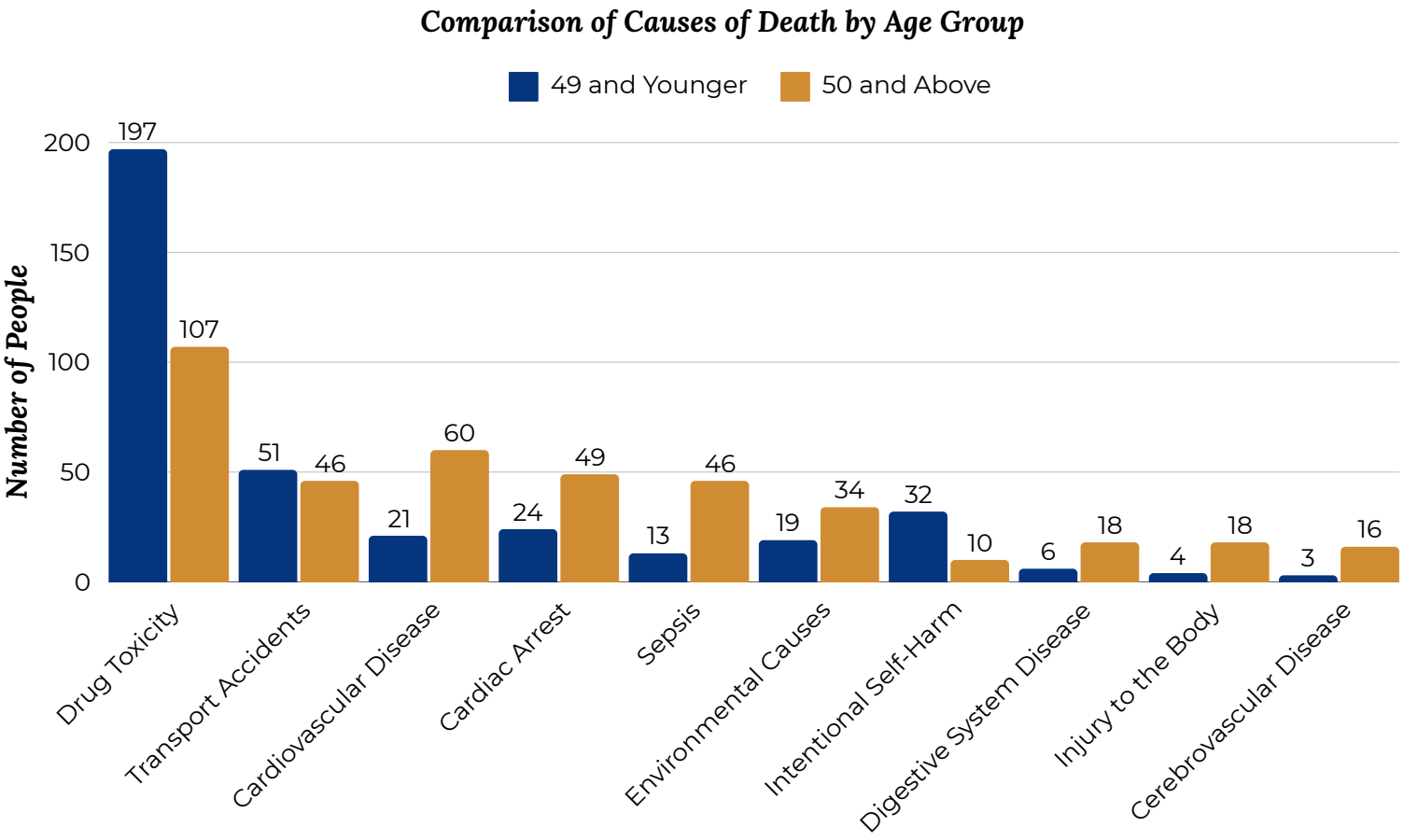
Manner of Deaths Provided by Medical Examiner



> The main cause of early death that we're seeing among ones that we have lost on the street, is being othered. Because if you weren't othered, then people would be caring for you, and you would have a community, none of [these] things would be happening.
>
> - Service Provider

How are people dying?

Leading Causes of Death
Comparison Across Age



Among younger adults (defined as those under 50) the leading causes of death are overdose, transportation accidents, and suicide.

For this group, the risk factors align with the challenges they face daily, with accidental deaths often stemming from struggles with substance use or from dangerous interactions with traffic and other hazards on the streets.

For people 50 and older, deaths are more often linked to health conditions that develop over time.

Cardiovascular disease and infections like sepsis, along with other chronic illnesses, are the leading causes. Deaths from environmental factors—such as extreme temperatures—also increase in this group, likely due to the physical toll of prolonged exposure without stable shelter, which can weaken the body over time.

How are people dying?

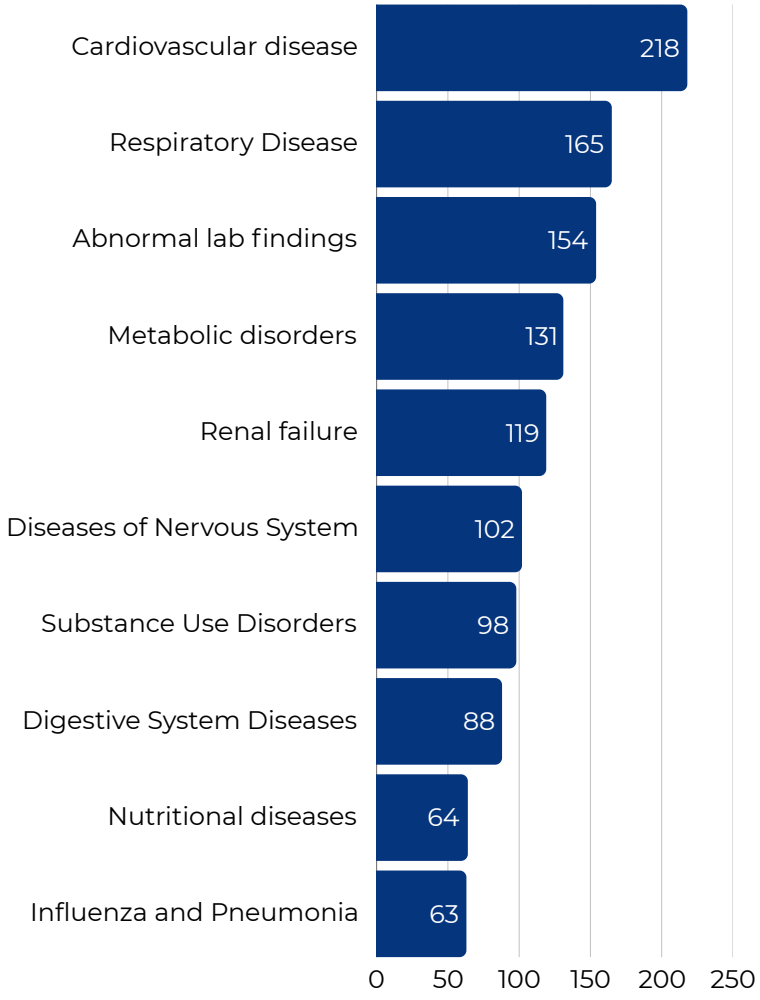
For people experiencing chronic homelessness, the dangers are all too real and are often linked to multiple health challenges.

People who've lived on the streets for extended periods have higher rates of death from drug toxicity, transportation accidents, heart disease, and other serious health complications, like sepsis and diseases affecting the respiratory and digestive systems.

Compounding health complications create an overwhelming burden, especially for those without access to regular medical care.

It's clear from the data that people living outside face a high degree of medical complexity. Hospital records show that individuals who passed away had a ***median of nine additional diagnoses, not including the main cause of death****. When looking at data from the Medical Examiner, this number fell to four—not because these folks had fewer health issues, but because the secondary conditions noted were limited to a maximum number of manual write-ins (four being the max).* ***The most common additional health issues for people who passed include cardiovascular disease, respiratory diseases, abnormal lab findings, metabolic disorders, and kidney failure.***

Top 10 Comorbidities in Our Community

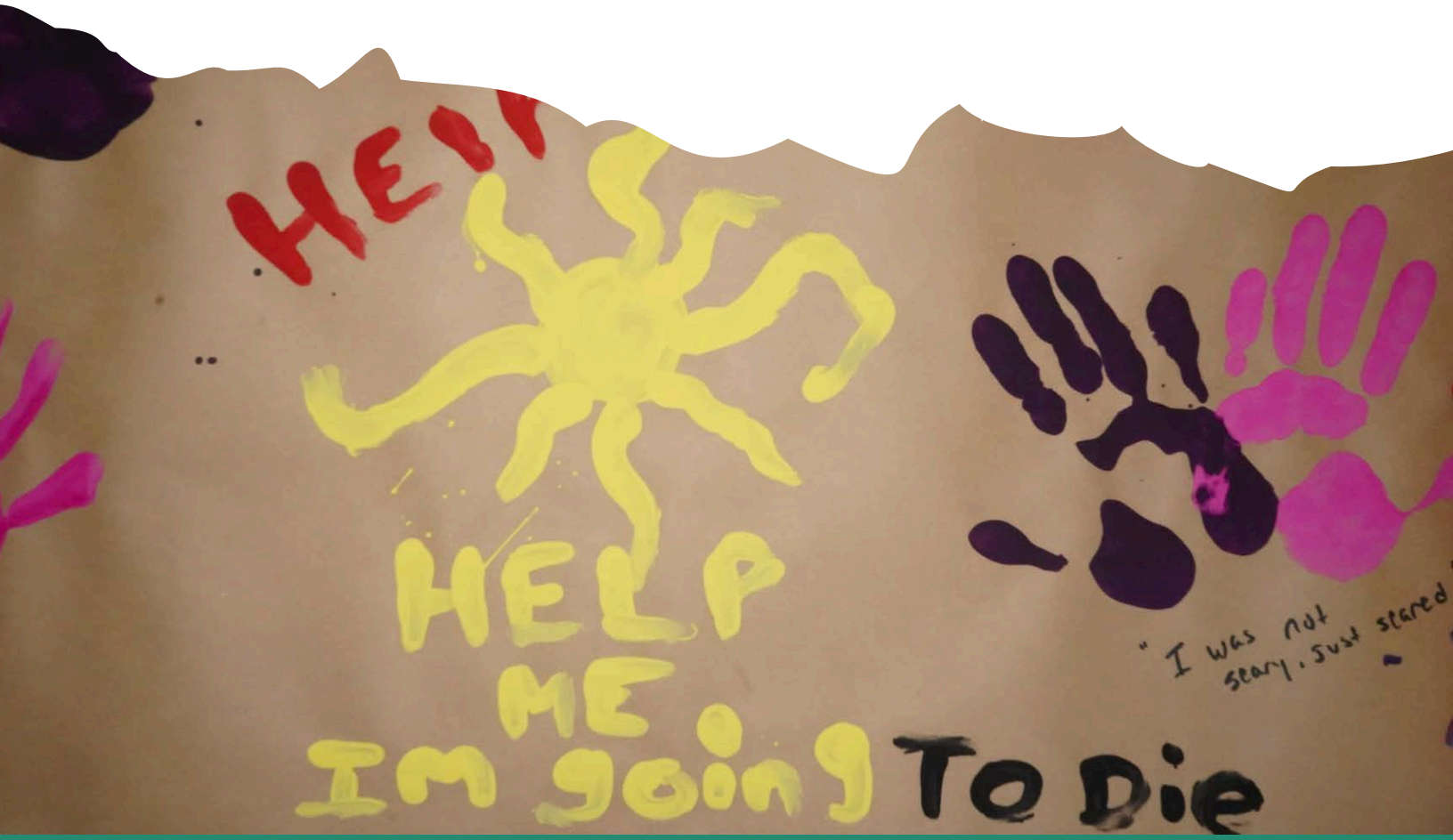


How are people dying?

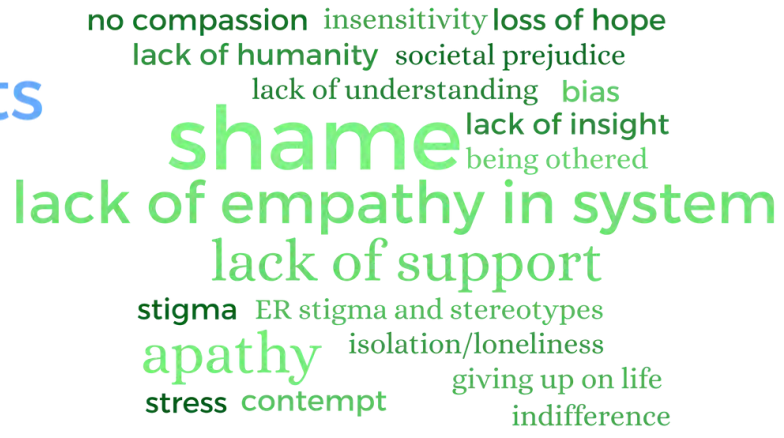
The weather in Texas can be deadly for people living outside.

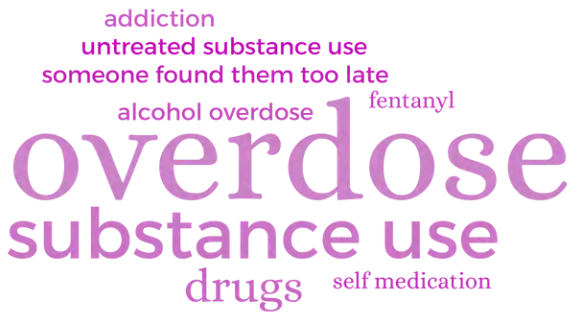
There are 36 known deaths from environmental exposure (heat [20] and cold [16]), and these deaths peak during our hottest (July) and our coldest months (February), highlighting the urgent need for both cooling and warming centers with 24/7 access. ***Of note, 17 of the 20 people who have died from excessive heat died in 2023.***

> "Two years ago, my husband got out of prison. He was home for 23 hours and had heatstroke in our tent.... he died of dehydration and heatstroke in our tent."
>
> - Person with Lived Experience



"What are the main causes of early mortality that you are seeing when serving your clients?"

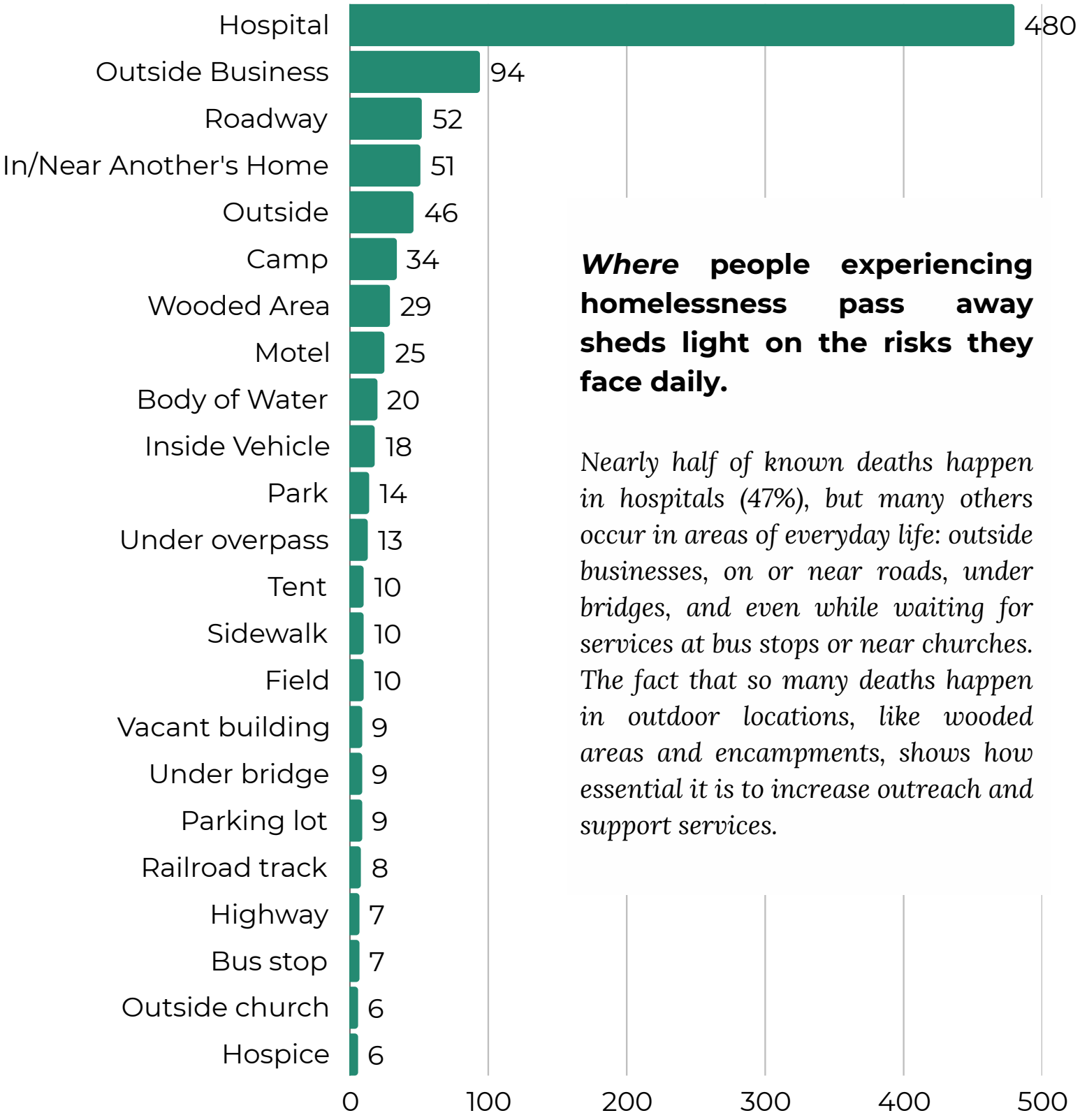




Responses from the listening session on causes of early mortality: *Top responses included overdose, exposure to the elements, suicide, and unmanaged chronic illness. For persons experiencing homelessness, this question was slightly adapted: What are the main causes of early death that you are seeing among those you have lost to the streets? These responses dramatically align with data found throughout this report.*

Where are people dying?

Location of Death for Unhoused Community



Where people experiencing homelessness pass away sheds light on the risks they face daily.

Nearly half of known deaths happen in hospitals (47%), but many others occur in areas of everyday life: outside businesses, on or near roads, under bridges, and even while waiting for services at bus stops or near churches. The fact that so many deaths happen in outdoor locations, like wooded areas and encampments, shows how essential it is to increase outreach and support services.

> I lost a friend two weeks ago from yesterday, and he was smoking pot. You could go buy pot in this park in my neighborhood... And it was fentanyl. He died of an OD of fentanyl... Fifth death in the park related to fentanyl... You don't realize you're just playing Russian roulette.

- *Person with Lived Experience*

Overdose in Our Community

Drug usage by people experiencing homelessness has long been misunderstood by those who have not had to experience a night on the streets. When a person does not have the luxury of a roof and locked door, drugs can often be a ***source of comfort, connection, safety, relief - a small escape in an otherwise harsh reality.***

We ask readers to leave judgment at the door.

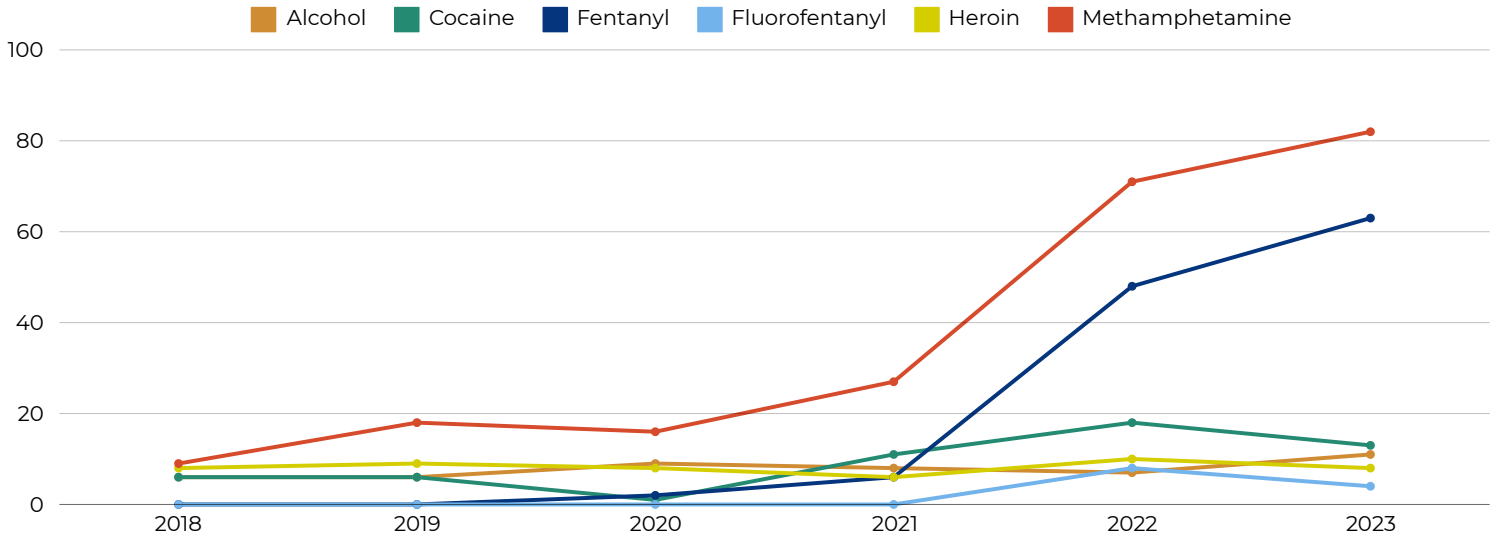
Note: *While there were 304 known deaths to overdose in our unhoused community, this deeper dive on overdose only contains 289 persons. Fifteen cases couldn't be included because the data source didn't list a specific drug with the overdose.*

Across the nation, Overdose deaths have increased by 400% since 2001, making it a leading cause of injury death.

Austin's unhoused community has mirrored this national trend, with overdose deaths rising by an astounding 333% from 2018 to 2023.

From 2021 to 2022 alone, overdose deaths more than doubled (113%). Methamphetamine (meth) and fentanyl-related overdoses drive these increases, with meth involved in the vast majority of overdose cases (at least 223 out of 304 known overdoses between 2018 and 2023).

Number of Deaths Involving Each Drug Over Time, 2018-2023

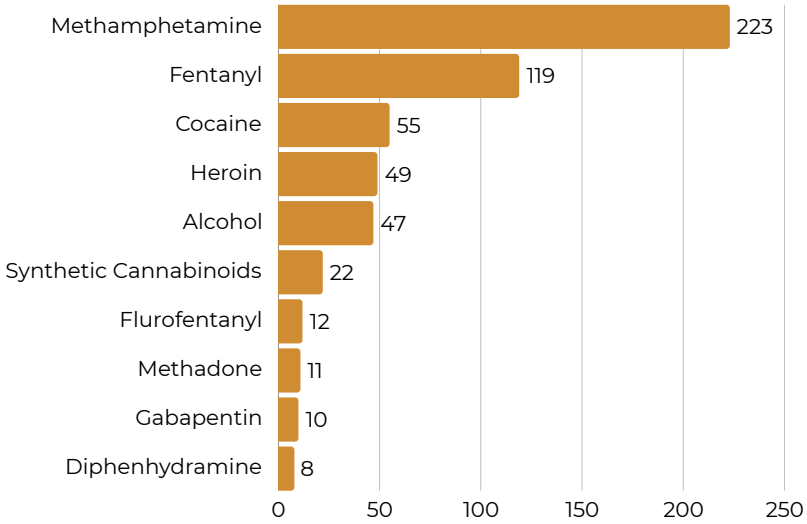


Overdose in Our Community

Fentanyl is also a significant factor, but it's often combined with meth.

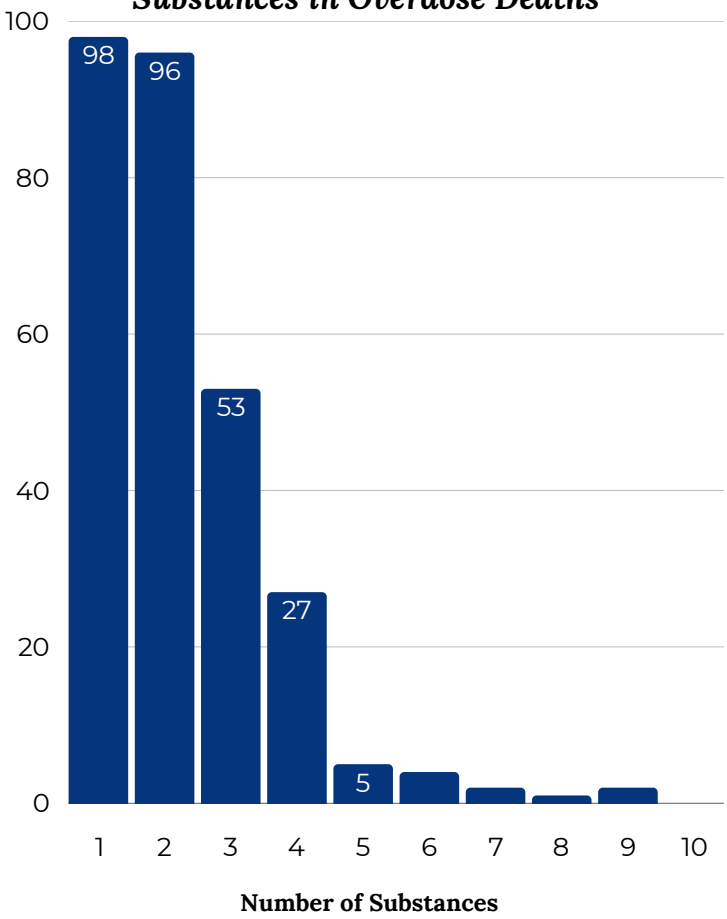
In 119 cases involving fentanyl, nearly all (109) were paired with meth. Only 10 deaths were due to fentanyl alone, suggesting that people might not realize fentanyl is present in their drug supply, as fentanyl testing strips are still illegal in Texas.

Frequency of Substances in Overdoses



Note: *This represents the number of times a drug was found present in toxicology screen. If a person took cocaine and alcohol, they would be represented in both numbers here.*

Distribution of the Number of Substances in Overdose Deaths



One third of overdoses only contained one drug.

Of people with polysubstance usage, the majority of usage (52%) contained 2-3 drugs.

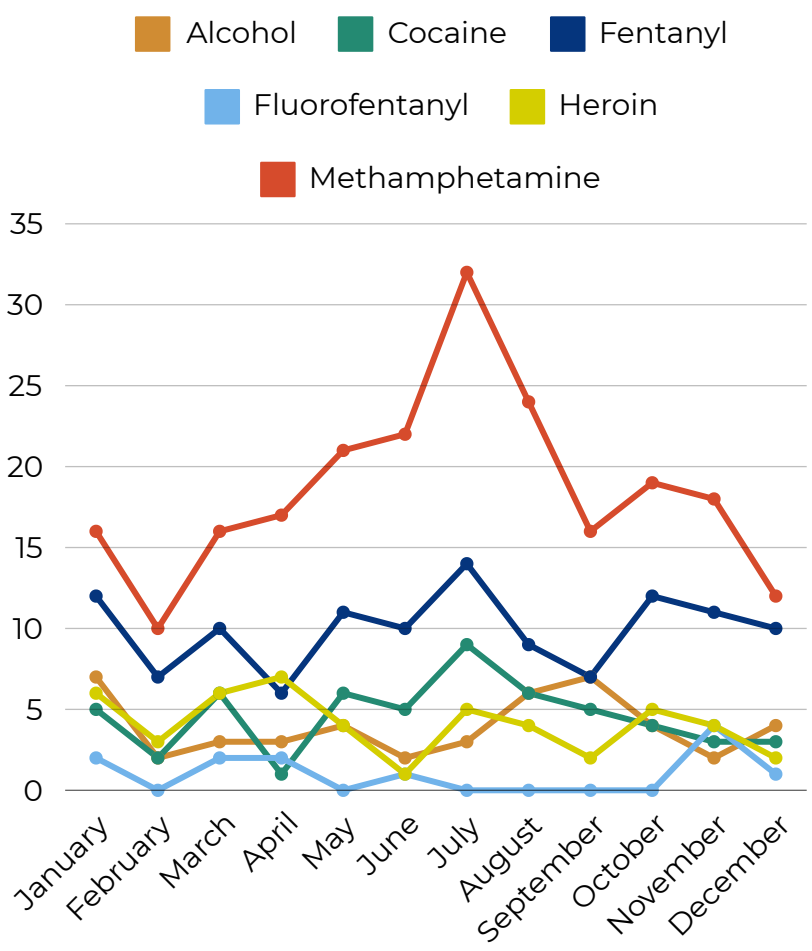
The fact that one-third of overdoses involve only a single drug suggests the need for targeted harm reduction strategies focused on methamphetamine (top drug associated with overdose). This may include addressing risks related to potency, contamination (e.g., fentanyl), and safe use practices.

Overdose in Our Community

Deaths involving meth usage are persistently higher than other drug types, and there is a sharp spike in the summer, especially in July.

Factors like malnutrition, dehydration, and stimulant use increase the risk of a deadly cardiac event in the heat.

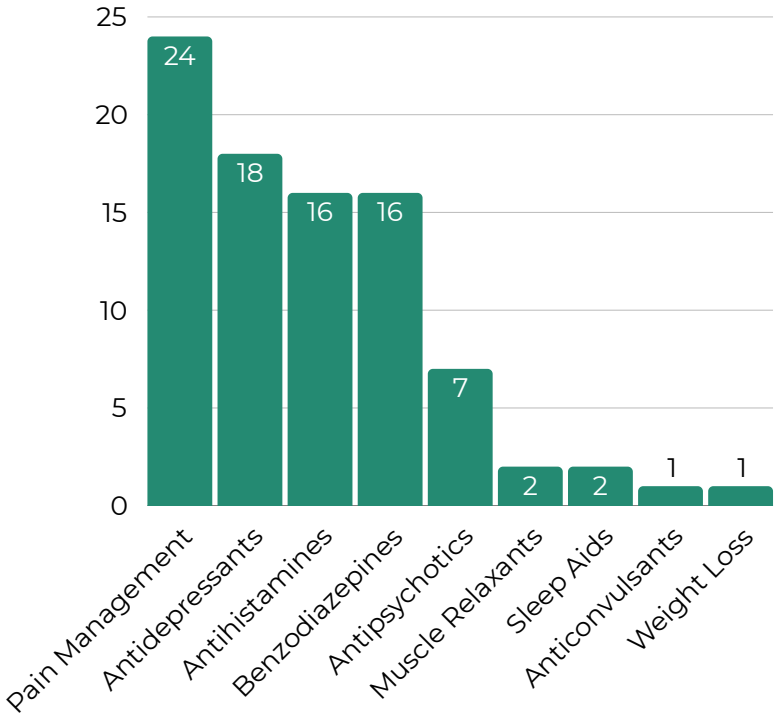
Number of Deaths Involving Each Drug, by Month



> The transition from being homeless to getting housing can also be traumatic. Going from a community, if you had a support system within your camp or whatever the case may be and then being isolated can really take its toll on people... They use alone now, whereas there used to be a lot of folks around that would check in on them, that had the same batch or whatnot, and now they're using alone. And we've lost people that way.
>
> - Service Provider

Overdose in Our Community

Number of Times Prescription Type was Involved in an Overdose*



**Drug groupings are as follows: Antidepressants included are: Fluoxetine, Trazodone, mirtazapine, citalopram, Sertraline. Benzodiazepines included are Alprazolam, Clonazepam, Lorazepam, diazepam, Chlordiazepoxide. Mood Stabilizers/Anticonvulsants are Lamotrigine and Levetiracetam. Antipsychotics are Olanzapine and Quetiapine. Pain Management drugs include Gabapentin, morphine, Codeine, Tramadol, hydrocodone, buprenorphine. Muscle Relaxants include cyclobenzaprine. Antihistamines include Hydroxyzine, Diphenhydramine, promethazine. Sleep Aids include Zolpidem, doxylamine, Weight Loss medications include phentermine.*

Forty-nine people who died of an overdose were taking a prescription medication.

This suggests people using drugs might be self-medicating to manage other issues such as chronic pain or behavioral health, and might have recently interacted with the healthcare system to obtain the prescription.

When breaking this down by prescription classification, pain management medications were most common this includes: Gabapentin, morphine, Codeine, Tramadol, hydrocodone, buprenorphine) followed by antidepressant usage (Fluoxetine, Trazodone, mirtazapine, citalopram, Sertraline).

> So much of the work that we do is siloed, including in death. People just disappeared... Did they pass away? Were they successful? You don't know. A lot of our work is successful because it's a patchwork of relationships and it's a patchwork of workarounds. That's a large part of how we do, it's what is the gap that I can squeeze in... [It's] astonishing that the death of a whole community of people is literally because they fell through very large gaps, and even their death is a gap. Even their absence is a gap.

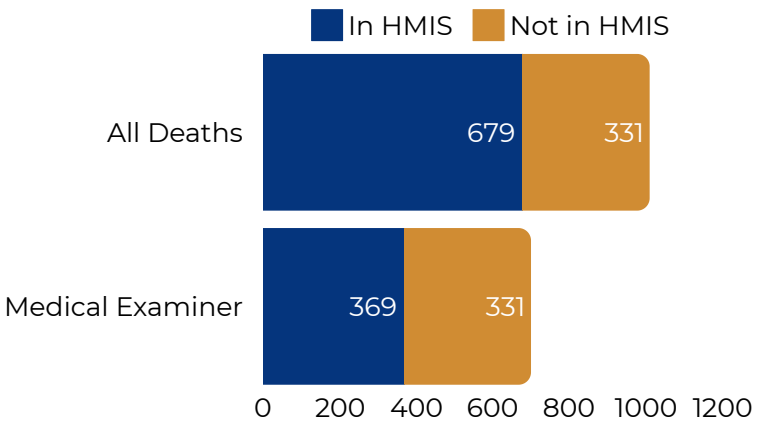
- *Service Provider*

HRS Service Interactions

Nearly half (47%, 331 individuals) of those who died on the streets (Medical Examiner) had no record of ever interacting with the homelessness response system.

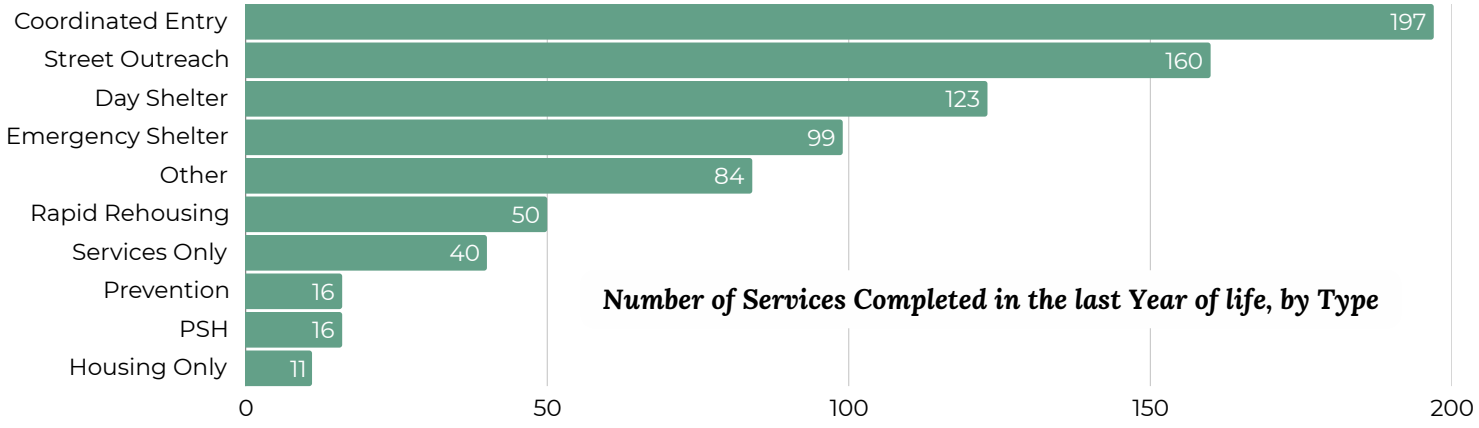
Of the 1,010 people who died from 2018 to 2023, nearly 70% (679 individuals) were recorded in HMIS. As all hospital data provided pertains only to individuals in HMIS—potentially skewing these findings—the Medical Examiner data above offer a more comprehensive perspective. This staggering figure underscores a critical gap in outreach and engagement efforts, highlighting the urgent need to expand access to coordinated entry and services for people experiencing homelessness.

Persons in HMIS at Time of Death



Coordinated entry, street outreach, day shelter, and emergency shelter were the top four largest HRS service types utilized in the year prior to death.

This trend remains constant even when looking at services six months prior to death. These would be ideal points for intervention for people who are at highest risk of early mortality.



Number of Services Completed in the last Year of life, by Type

HRS Service Interactions

Engagement with the HRS drops nearly 20% in the year prior to death, highlighting the need for proactive and early intervention.

Among the 679 people who had engaged with services, 415 (61%) folks engaged with the HRS services one year prior to death. This dropped to 285 (42%) at six months prior to death. This illustrates the fatigue and despair of continually trying to engage with a slow system while in crisis, and highlights the need for proactive and early intervention.

People who die experiencing homelessness sought shelter more often than the general unhoused population.

From 2018 to 2023, 62.7% of people who died had used shelter services at some point, compared to only 47.7% of the population as a whole. Similarly, day shelter use was higher among the deceased (49%) compared to 30% of the general unhoused population.

Conversely, just 6% (64) of people who died between 2018 and 2023 were able to access a shelter bed in the six months prior to their deaths.

Of people who died in hospitals, the number is even less: only 28 people were in shelter for at least one night. The low degree of access suggests significant barriers, possibly related to shelter requirements like the ability to perform Activities of Daily Living (ADLs). These requirements may unintentionally exclude those with severe physical or mental health challenges and who are at high risk of early mortality. This speaks to the tremendous need for low-barrier access to shelter in our community.

> "Someone I knew died on the curb outside [a shelter] waiting to get in..."
>
> - Person with Lived Experience

HRS Service Interactions

People who died while in a permanent housing program in our Continuum of Care (CoC) live 9.5 years longer than people who remain unhoused.

The median age of death was 52 years for people experiencing homelessness, compared to 61.5 years for individuals who were housed at the time of their passing. This finding suggests that stable housing could contribute to a longer life, further uplifting the need for permanent supportive housing for our community. However, it may also indicate that people with more severe health challenges face greater barriers to securing housing, underscoring the need for tailored support to reach our most medically vulnerable community members.

	Average Age of Death	Median Age of Death
Housed (Prior Experience of Homelessness)	58	61.5
Unhoused at Time of Death	50	52

The data suggest that for some individuals, the journey from homelessness to housing was not a lasting solution, with a few people returning to the streets and later passing away.

Among people who died, we found that several had engaged with housing programs meant to reduce the risk of early mortality in the year prior to their death: 50 individuals had been in rapid rehousing, 16 in Permanent Supportive Housing, and 11 were in housing without additional support services within the year before their death. ***These findings underscore the importance of not only securing housing but also ensuring that the right supports are in place to help people maintain stability and well-being over the long term.***

HRS Service Interactions

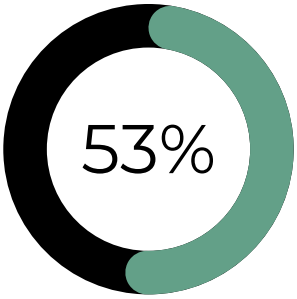
More than half of those who died (53%, or 537 individuals) had never completed any form of Coordinated Assessment by the time of their death.

Coordinated Assessment is a critical tool for accessing housing and support services and our community's first response when identifying an individual as experiencing homelessness. These findings highlight a substantial portion of the unhoused population who are not engaging with the Homeless Response System and are dying on the streets. Among those who do engage, many are not being reassessed regularly. This underscores the urgent need for expanded Coordinated Assessment efforts, proactive outreach, and consistent follow-up to connect people at the greatest risk with life-saving support and services.

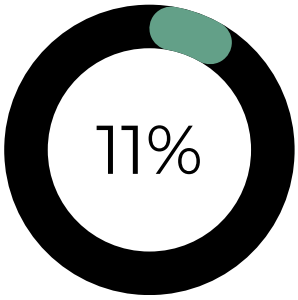
Only 11% (115 individuals) had taken a Coordinated Assessment in the six months prior to their death.

Best practice recommendations are to complete a Coordinated Assessment every six months, as situations can change and this might impact your score. The average scores from these last assessments were 9.8 on the APAT and 11 on the VI-SPADT (prior assessment).

Percentage of People who Died who have ever taken a Coordinated Assessment



Percentage of People who took a CA six months prior to death



HRS Service Interactions

When examining APAT scores, the data reveal a sobering truth. Our community does not prioritize housing for those at higher risk of mortality.

The APAT was designed to prioritize people least likely to self-resolve their own homelessness. It does not identify people at the greatest risk of harm or mortality.

While the APAT is functioning as designed, these numbers reveal a critical gap. The data suggest that the tool alone may not be enough to capture people at high risk of early death. This points to a need for deeper assessment criteria, shared community action, and ongoing adaptation to ensure that people at high risk of death receive the care and support they need before it's too late.

Group	Average & Median APAT Score	APAT Health Scores (avg out of 8)
Deceased	10	4.4
Overall Unhoused Population	9	3.5

The APAT score is Important, and also not the full picture. These are all critical components of the PSH referral process:

1. ***Chronic Homelessness***
2. *Highest APAT* ***Score***
3. *Meet Criteria for one of more* ***Subpopulations*** *(Veteran, Youth, Older Adult, Domestic Violence, etc) (tiebreaker)*
4. *Highest* ***Length of Time*** *Homeless (tiebreaker)*
5. ***Earlier APAT Date*** *(tiebreaker)*

Critical Context*: Prioritization only happens because* ***there is not enough affordable housing for everyone.***

> I remember asking older clinicians, how do you go back in the next day after you lose someone that was completely avoidable, in my opinion, and tell this next person that what you can do for them is enough?
>
> You move forward because you have to because there's still other people that need your help as well.

- *Service Provider*

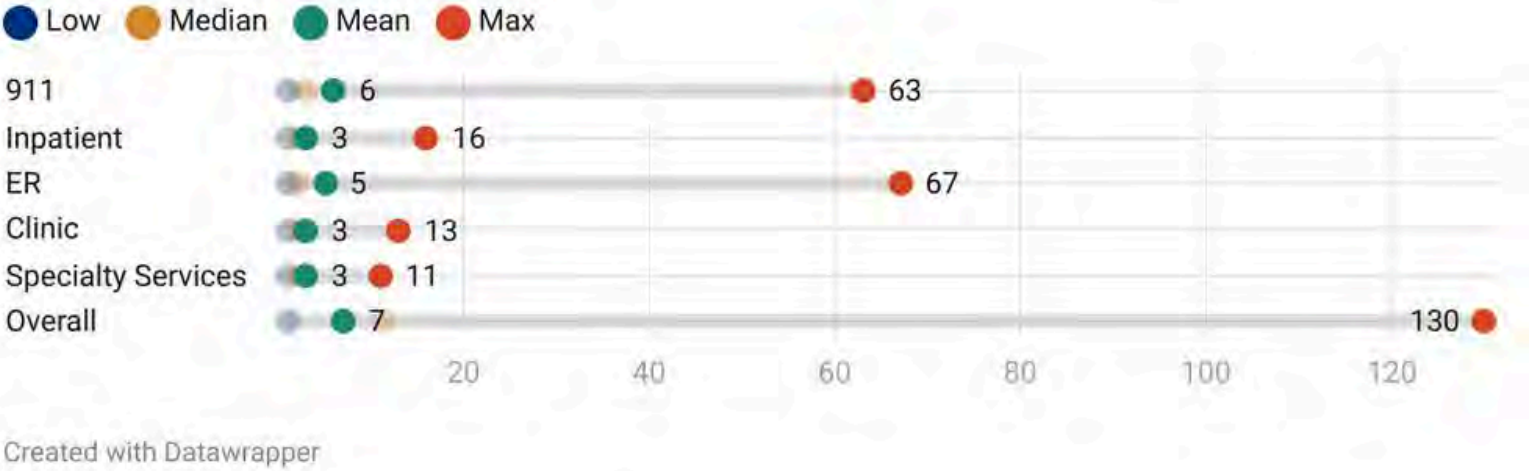
Health Systems Interactions

In their final year of life, the 364 known people who died experiencing homelessness in a hospital had 4,109 medical encounters.

Our unhoused community relied heavily on emergency services in their final year of life, with some individuals calling 911 as many as 63 times and visiting the ER up to 67 times. While the average person had seven healthcare encounters, others reached a staggering 130 interactions across various services, highlighting an overburdened system and a critical need for proactive, preventive care solutions.

An important consideration: *These data are an underestimate to the total burden of early unhoused mortality to emergency care services, as not all who died experiencing homelessness that engaged with health systems have signed a release of information with HMIS.*

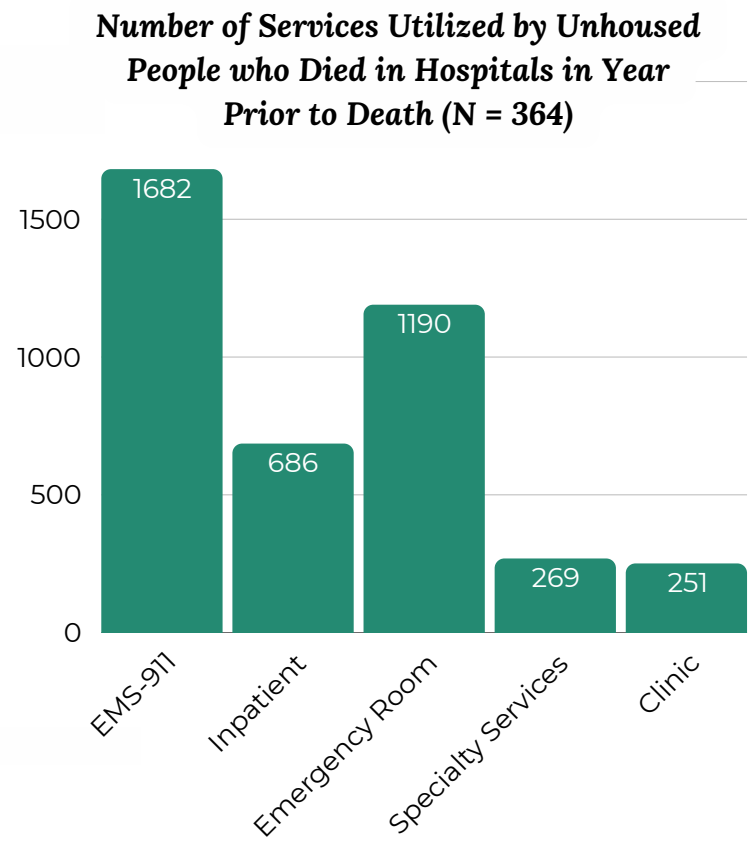
Health Utilization of Services Per Person, Last Year Prior to Death



Health Systems Interactions

Emergency medical services (EMS) were the most frequently used healthcare resource among Austin's unhoused community, with nearly three-quarters (74.2%) having at least one EMS encounter.

Emergency room visits were similarly prevalent, with 69.2% making at least one visit, while 53.8% received inpatient services.



> *I think for me some of the most difficult parts of working with vulnerable populations in healthcare is the desperation... The patients that come in the most frequently are literally dying. It is a different sense of urgency that doesn't leave you. Because if you don't get this person off the streets, they are going to die.*
>
> - Service Provider

Health Systems Interactions

The length of inpatient stays in the year before death varied widely, with each visit averaging seven days, and a typical stay of four days.

This amounts to an average of over $21,000 per stay, highlighting the immense financial burden of hospitalizations for individuals experiencing homelessness. Investing in preventive care and housing solutions could significantly reduce these high costs and improve outcomes.

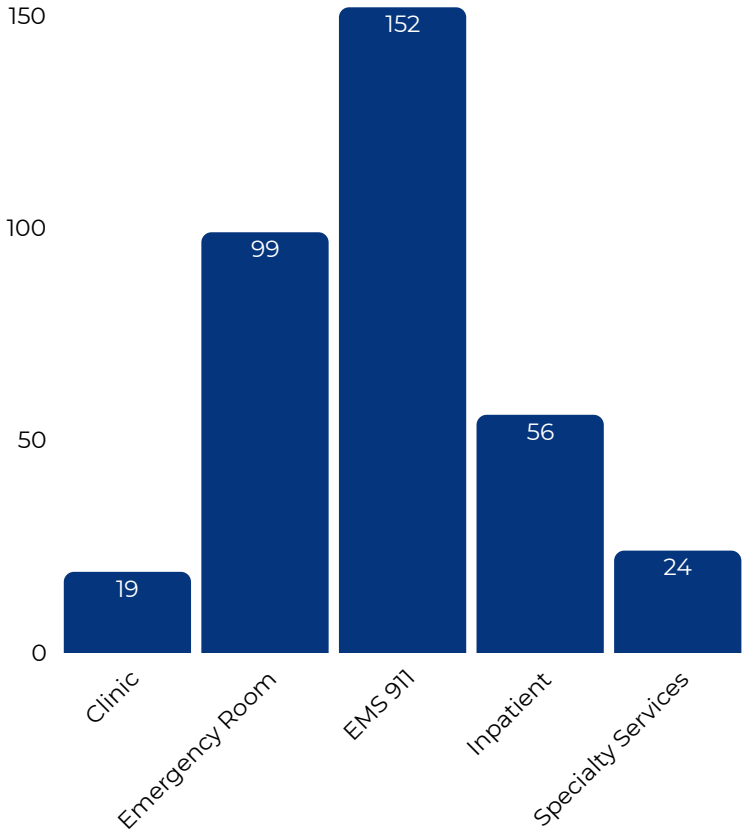
Nearly a quarter of people who died in the hospital had another health encounter in the month prior to their death, suggesting that most individuals had significant medical needs and were actively seeking help.

On average, people had around 11 visits, with a typical (median) of 7 visits, indicating frequent touchpoints with the healthcare system. Only 35 people had no health encounters at all in the year prior to death.

Among individuals who passed away in the hospital, 59% (212) met chronic homelessness status based on their last HRS encounter.

This suggests that individuals with frequent engagement to hospital systems are also predominantly those prioritized in the HRS due to HUD Chronicity requirements.

Second to Last Health Encounter Prior to Death (Key Areas for Intervention)



Health Systems Interactions

Summary of Health Services Costs for Persons who Died in Hospitals (364), Year Prior to Death

	EMS 911	Emergency Room	Inpatient
Number of Times Used in Year Prior to Death	1682	1190	269
Average Cost Per Service*	$ 1034.68	$ 2961.11	$ 21,941.20
Total Average Cost to Hospitals	$ 1,740,331	$ 3,523,720	$ 5,901,913
Range (By Person)	1-63 transports	1-67 visits	1-16 visits

In the year prior to their deaths, the 364 *known* individuals experiencing homelessness who died in local hospitals incurred over $11.1 million in EMS, emergency room, and inpatient care costs. This represents 81% of the funding required to provide PSH for an entire year.

Investing in PSH not only addresses homelessness but also offers a clear fiscal strategy to reduce costly, preventable healthcare utilization while improving lives.

Health Services Cost in year prior to death*	Cost to House and Provide all PSH Services** for year
$ 11,165,966	$ 13,763,067

*Inpatient cost is $3,060 per day, average inpatient visit was 7.17 days. Sources: Cost data provided by Central Health. Hospital Adjusted Expenses per inpatient day from Kaiser Family Foundation (2022). AHA Annual Survey for ER Costs, 2020-2021, EMS Costs: Central Health Data.

**Permanent Supportive Housing (PSH) services are based on ECHO's system modeling. Services are estimated at $19,000/person and rent is estimated at $1,800/person. This highlights the potential for significant cost savings and improved outcomes through housing-first interventions.

The Pirate of Sixth Street

A Song by Ben Jones and Cody Andrews

Oh, the Pirate of Sixth Street,
with a hat three points high,
Gathered treasure the landlubbers
lost in the night
Always barefoot he wandered,
Into the unknown
Beneath the lights of the city
The streets were his home

Cos he knew 'You are Loved'
was much more than a sign
As he painted the world
that he saw in his mind
The skulls and the anchors
where his heart longed to be
Born out on the Gulf Coast,
away on the sea.

The voyage to find
a new home on dry land
With a crew who won't let him
Run aground in the sand
He now had a galleon
to sail on upstream
Feeding his own
Neapolitan dream

There were storms, there were shipwrecks
Isolation took hold
When he said Fuck the world
Cos it gave him fools gold
A pain in the ass to some,
right til the end
But to me, all I know
is that he was my friend

His ship left port too early,
Three sheets to the wind
No more skulls, No more crossbones
One last toothy grin
Through tears and with love,
He was finally free,
Commanding the cosmic waves
Eternally.

Oh, the Pirate of Sixth Street,
Exists on the breeze
He's part of the fabric
In you and in me
Sometimes I still hear
a faint, slurred mumbled sound
Just the Pirate reminding me
He's still around

"By having the information, providers have a better, in-depth understanding and awareness, which will improve overall interactions and experiences if paired with the right resource and support."

- *Person with Lived Experience*

Recommendations

What immediate resources would be helpful to provide clients to minimize the risk of early mortality?*

Word cloud of themes taken from listening sessions with service providers and persons experiencing homelessness on immediate needs to reduce early mortality in our community.

**For persons experiencing homelessness, this question was adapted to: What services did your friend or loved one really appreciate, or want more of?*

Recommendations

These recommendations emerged from shared spaces and brave conversations among individuals with lived expertise of homelessness, persons who use drugs, healthcare professionals, emergency personnel, and homelessness response system providers. The five major themes identified during listening sessions with service providers and persons experiencing homelessness will frame these recommendations.

1. ***The Need for Housing and Shelter:*** *Safe, stable housing is the foundation for health and dignity and critical to preventing early death.*

2. ***Health Care Access Saves Lives****: Equitable and timely healthcare can address urgent needs and reduce preventable deaths.*

3. ***Community and Belonging as the Foundation of Care:*** *Connection and support are vital for resilience and improving well-being.*

4. ***Uplifting Basic Needs:*** *Meeting needs through outreach and proactive engagement.*

5. ***Broader Systems Change to Fuel Progress****: Transformative action is required to create sustainable solutions and reduce early mortality across the community.*

In addition to these themes, the findings of this report highlight the urgent need for ***Harm Reduction: Meeting the Crisis with Compassion and Innovation.***

Recommendations

Prioritize Permanent Housing: Stable housing is the cornerstone of improving life expectancy and overall well-being for people most at risk.

The data is clear: permanent housing creates a foundation for better health outcomes. Our City and County are leading the way with ambitious investments in Permanent Supportive Housing (PSH), adding over 1,200 units by the end of 2027, with the first properties already accepting tenants. These much-needed expansions represent essential progress, but continued investment is crucial to meet the growing demand in our community.

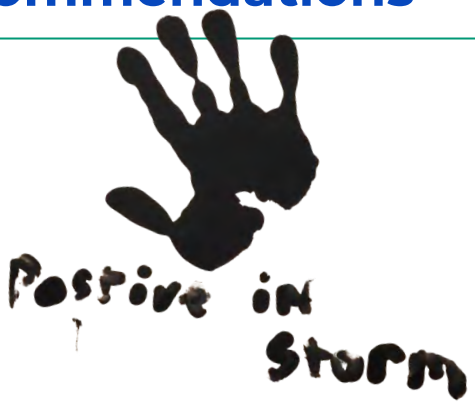
Diversify Housing Options: The Homelessness Response System must go beyond traditional housing solutions.

Options like recovery housing, long-term care facilities, nursing homes, re-entry homes, shared housing, and hospice care are vital for bridging gaps in support for high-risk populations (See Permanent Housing Continuum, Supplemental, Figure 3). While Permanent Supportive Housing is the highest level of care currently funded by our system, it still operates as independent living. Many individuals require higher levels of care, and addressing these needs will require creative solutions and braided funding streams to provide not only housing first, but housing choice.

Make Shelter Occupancy Transparent: Knowing when, where, and how to access available shelter beds is critical.

Currently, no streamlined system exists to provide real-time shelter occupancy information, though this is available in other communities. Many HMIS vendors offer this, and ECHO is in the process of finding a new vendor to meet our community's needs. Thus, this is not so much a technological limitation as much as it is a challenge rooted in a mindset of the status quo. The need for shelter transparency is paramount, and would be a transformative step forward.

Recommendations



Make Low-Barrier Shelter Accessible: Shelters can serve as life-saving interim solutions for individuals with high levels of need.

Accessing shelter is undoubtedly affected by limited capacity; our community has only 1,552 shelter beds, with much more capacity needed.

In addition, many shelters face challenges accommodating individuals with significant needs, such as people who cannot complete Activities of Daily Living (ADLs) like dressing or managing incontinence. Addressing these barriers is essential to ensuring everyone has access to safe shelter. Shelters must incorporate the services needed (such as nursing care) to reimagine and adapt shelter resources to meet the needs of those at risk of early death.

> "There was this woman I was working with.... She had a colostomy bag and she was really excited because, a couple of weeks down the road, she was going in to have it removed.
> Then, unfortunately, she became septic. And, sometimes it's really hard to get people in the camp connected to the right services right away, as fast as they need them. And I was just... I got to go and sit with her all the way to the end... She was the first person I lost in that place.

- Service Provider & Person with Lived Experience

Recommendations

Develop Population-Specific Spaces & Services: Listening sessions revealed a strong call for shelters tailored to the unique needs of specific populations.

Dedicated spaces for older adults, people undergoing dialysis, and abstinence or non-abstinence-focused groups were repeatedly mentioned. Additional considerations include couples, individuals with pets, families, LGBTQ+ folks, and women. Recent progress has been made on this front by dedicating the 8th Street shelter to women and LGBTQ+ individuals, but more tailored spaces and services are needed. While designing for each group is undoubtedly complex, targeted solutions can significantly enhance safety and inclusivity for individuals who often feel excluded from standard shelter settings. Thoughtful investment in population-specific shelters creates a sense of belonging and safety for diverse groups, ultimately improving outcomes for all.

Health systems should invest in housing-first solutions as a strategic approach to improving health outcomes and reducing preventable emergency health utilization.

The data show that the $11.1 million spent on emergency medical services, ER visits, and inpatient care for 364 individuals (a known underestimate, see Overview of Methods) in the year prior to their deaths could have fully funded 81% of PSH services for a year - nearly the full cost. This highlights a critical opportunity: Providing housing is not only more humane but also a smarter investment to address the root causes driving avoidable healthcare costs.

Recommendations

Expand and Integrate Street Outreach with Health Care teams.

HRS outreach teams, street medicine teams, and EMS are all working hard to serve people experiencing homelessness, but their efforts often operate in silos, or at best, one to one relationships. Our community has a HRS street outreach team coordination meeting, but presently there is no opportunity for all of these entities to coordinate care together, leading to fragmented care. To reduce preventable deaths and maximize impact, it is essential to bring these teams together. We propose creating regular coordination meetings between HRS outreach teams, healthcare outreach teams, and EMS to align efforts, share information, and collaboratively address service gaps.

> "They all wanted to be treated with care and kindness but also humanity and respect."
>
> - *Person with Lived Experience*

Centering Lived Experience in Healthcare and HRS Innovation.

Hire individuals with lived experience of homelessness to bring essential perspectives and build trust within healthcare teams. Peer navigators, for instance, can bridge the gap between patients and providers, ensuring follow-through on care plans.

Additionally, elevating people with lived expertise into HRS governance and decision-making roles ensures programs meet real-world needs while fostering lasting solutions. For those interested in contributing, the Systems Improvement Committee is formalizing peer support best practices and welcomes participation. Join virtual meetings at austinecho.org/leadershipcouncil.

Recommendations

Support Housing Retention Through Integrated, Person-Centered Health Care: This saves lives and ensures that "Housing First" doesn't devolve into "Housing Only."

Healthcare and housing must go hand in hand. An example of this is the Permanent Supportive Housing (PSH) Health Care Collaborative—a groundbreaking initiative in our community. This collaboration, led by Central Health, CommUnity Care, Integral Care, and ECHO, and supported by philanthropic donors like Indeed and Oracle, is a first of its kind for a non-Medicaid expansion state. Its innovative, person-centered, and "Anywhere Care" model brings intensive healthcare directly to people exiting chronic homelessness, meeting them where they are.

To sustain its impact beyond 2026 and expand to meet the needs of all PSH residents in our community, a long-term funding solution is urgently needed. *Without it, this transformative program risks losing momentum, leaving many without access to the care that is critical for maintaining housing and health.*

Create a Bridge to Housing with Medical Respite and Low-Barrier Substance Use Treatment Centers.

These options are critical missing links in our community's HRS. For individuals with severe health conditions, medical respite provides a safe, stable environment for recovery after hospital discharge. However, these services are not yet fully integrated into the HRS pipeline, leaving significant gaps in continuity of care and putting people in danger of discharging to the streets. (See example respite pathway, Supplemental, Figure 5). Additionally, for people who seek a pathway to drug treatment, there must be an intentional and responsive way to connect people with a route to recovery. To address this, we must prioritize bringing medical respite care, substance use treatment centers, the Sobering Center, the Outreach Screening Assessment Referral (OSAR) line, and recovery housing into the HRS framework. This integration

Recommendations

would allow individuals to seamlessly transition from hospitals, medical respite, treatment programs, and ultimately to permanent housing. Ensuring these connections is essential for people who require the full spectrum of care needs.

Opening the Door to Recovery: Expanding Support for Substance Use Respite and Treatment.

Austin's Sobering Center is a lifeline for people needing a safe space to get sober and connect with substance use treatment—but its capacity is stretched far too thin. With 20 beds, it plays a critical role in supporting those at a vulnerable crossroads. However, the demand for treatment and recovery support continues to grow. For those seeking recovery, the wait for a treatment bed can stretch painfully long—days, even weeks—leaving a vulnerable gap in care at a time when support is most critical.

There's a solution within reach. The Sobering Center has a newly renovated second floor, perfectly suited to house 11 substance use disorder (SUD) respite beds and 3 detox beds. But to make this vision a reality, a $1 million investment is needed to operationalize and staff these additional resources.

This expansion would transform the Sobering Center into a bridge to recovery, offering individuals the stability they need while waiting for long-term treatment options to become available. It's an opportunity for Austin to strengthen its commitment to saving lives, supporting recovery, and addressing the substance use crisis head-on.

Recommendations

Build a Robust Discharge Planning Process: Being discharged from a hospital to the streets is a death sentence for many.

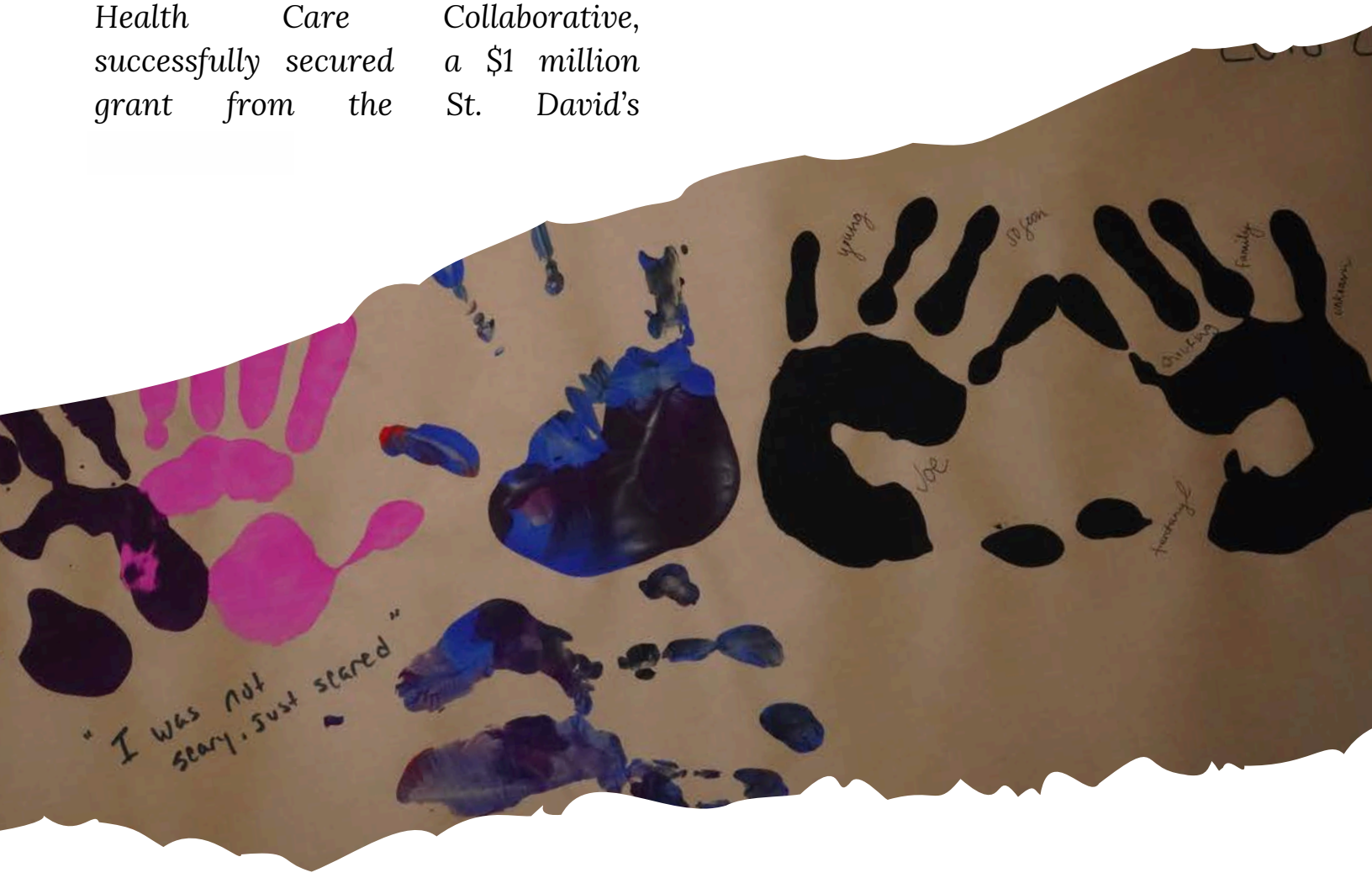
Hospitals must develop discharge protocols that prioritize connecting patients to housing or shelter navigation resources. No one should leave a hospital with a chemo bag and no place to go. Medical systems must include medical respite or housing referrals as a default part of the discharge process to prevent unnecessary suffering and death. Experiencing homelessness exacerbates illness—robust discharge planning can change that narrative.

> I had a client who came to my office in our walk-in services, and he was desperate for a solution because he had just started chemo. He had a port, and they gave him his chemo bag and they gave him a hazmat bag in case he spilled his chemo. And this was last summer, which I remember how hot that was. He asked, why did they give me this hazmat cleanup stuff? It's hard for me to do my chemo on the street. It's really hot. And this is how it went... Here you go. Good luck.
>
> - Service Provider

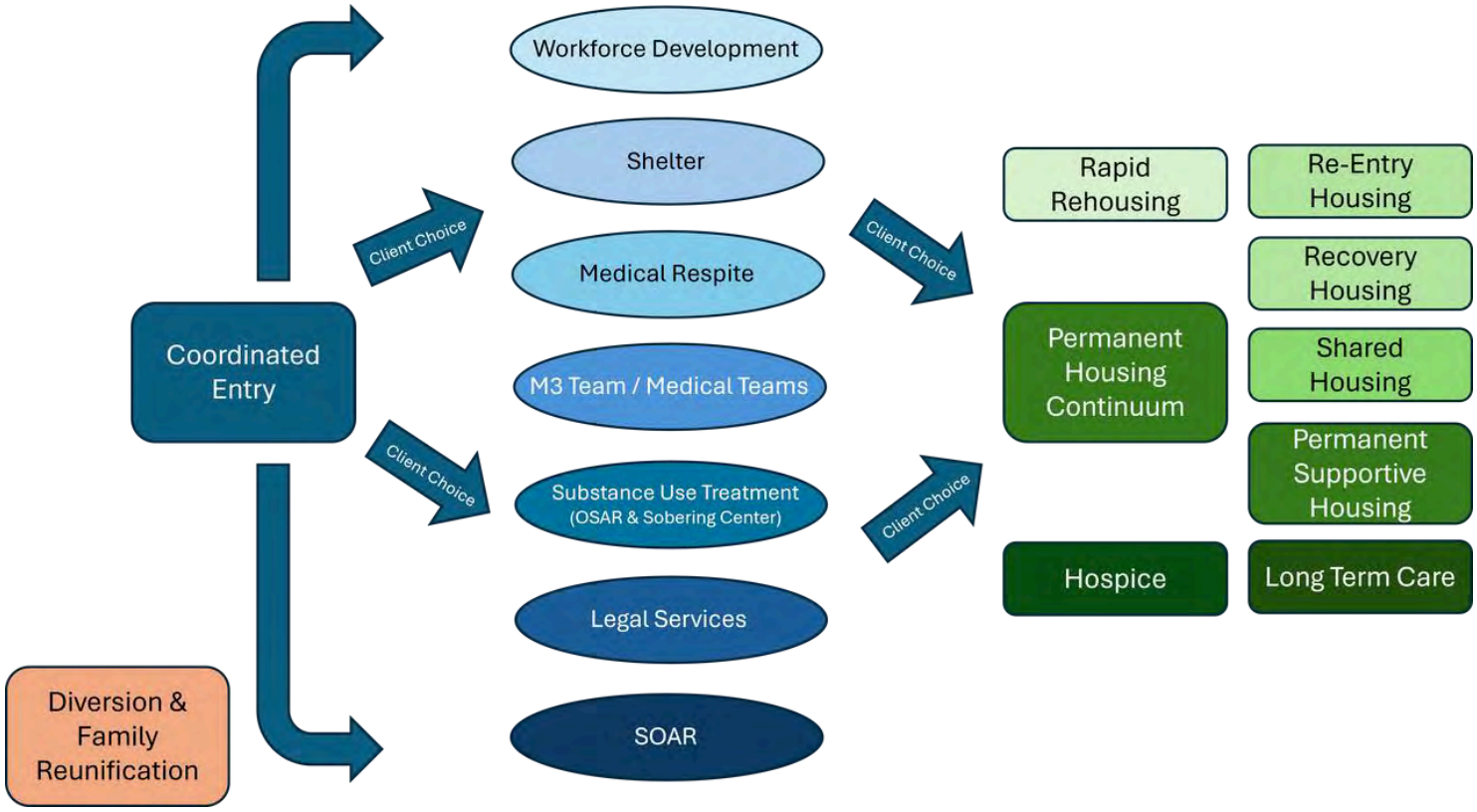
Recommendations

Expand SOAR Programs for Life-Saving Benefits Access.

Expanding SOAR (Supplemental Security Income/Social Security Disability Insurance Outreach, Access, and Recovery) programs will unlock life-saving resources for individuals with critical medical and behavioral health needs. In a significant step forward, ECHO, on behalf of the PSH Health Care Collaborative, successfully secured a $1 million grant from the St. David's Foundation to enhance SOAR access across our community. These funds will make it easier for individuals to connect with a SOAR Benefits Specialist before a housing referral, ensuring that more people can access the benefits and services they need to stabilize their lives. This investment allows us to scale our efforts and help even more individuals find the support they deserve.



Recommendations



Example flow of Coordinated Entry as a services referral hub while waiting for a referral to permanent housing (See: Permanent Housing Continuum, Supplemental, Figure 3). These services are not exhaustive, and are not intended to exclude other valuable services that may be a need to our community.

Utilize Coordinated Entry as a Life-Saving Referral Hub.

Transform Coordinated Entry (CE, also known as Coordinated Assessment (CA)) into a proactive linkage system that connects individuals to critical services in addition to housing referral, acting as a centralized connector for healthcare and other supportive services. By prioritizing CE as a key referral hub, we can create life-saving pathways for individuals in crisis, ensuring that no one is left without access to the care and resources they need.

Integrate medical triage into Coordinated Entry.

The current Austin Prioritization Assessment Tool (APAT, the CE tool) does not evaluate vulnerability to death, and many assessors do not have the medical expertise needed to identify high-risk conditions. There have also been concerns raised that

Recommendations

incorporating too many medical questions could belabor assessors or be administered incorrectly.

To address this gap, we propose a dedicated medical assessment team embedded within the Coordinated Entry process. This team, staffed by health professionals, would evaluate flagged individuals for care needs, including medical respite, long-term care, or skilled nursing facilities. They could also assist with crucial paperwork, such as SOAR applications, and connect individuals to substance treatment programs. (See Example Medical Triage Flow, Supplemental Figure 4). Such a team would be a groundbreaking addition to the HRS, offering long-sought after solutions for people who are too medically complex for street medicine teams alone to fully support.

Housing is a Lifeline. We must create pathways to housing for medically complex individuals.

The data highlights a critical gap: People most at risk of early death are not being prioritized for housing. This is not surprising, as the APAT was not designed to prioritize based on mortality or the level of care needed. To be clear, we do not advocate for returning to tools like the VI-SPDAT, which prioritized based on presumed links to mortality but carried significant racial biases favoring white individuals. Instead, we must continue to uphold the intention of APAT—to prioritize based on racial and gender equity and to champion client choice as part of an anti-racist approach. However, we must also recognize that our community needs a pathway to housing for individuals with complex medical needs. Innovative practices from Michigan's Department of Health and Human Services offer valuable lessons for our community. Their have developed a medical modifier alongside prioritization scores, ensuring individuals with complex medical needs aren't overlooked. Importantly, their approach also includes safeguards to prevent deprioritization of people of color who may not access emergency health services, providing a more equitable and holistic perspective on needs.

Recommendations

Incorporating levels of care into our Coordinated Assessment (CA) process could similarly address gaps for individuals with chronic or progressive medical conditions, such as advanced diabetes, mobility limitations, or dialysis needs. These individuals face significant barriers to maintaining housing without intensive support, and matching them to appropriate care models—medical respite, Permanent Supportive Housing, long-term care, or hospice—could prevent avoidable suffering, housing loss, and repeated cycles of homelessness.

Aligning this effort with a proposed medical triage team (see page 65) would ensure that housing placements are tailored to both whole-person health considerations and housing needs. Integrating medical considerations into housing prioritization reflects care, equity, and adaptability, creating pathways for those most at risk while saving lives and fostering stability in our system.

Streamline access to APAT and Coordinated Assessors.

Simplify and expand the prioritization assessment training process by integrating it into multiple access points across the HRS and health systems, to include hospitals, hospital transition teams, medical respite, EMS, and clinics that expand beyond the Healthcare for the Homeless specific providers.

By making these assessments more accessible, we can ensure individuals with high needs are identified and connected to services quickly and efficiently, enhancing the system's ability to respond to people most at risk.

Recommendations

> "If there was a place where you could just walk in and start work, that would be amazing, because a lot of people out here do want to work. It's just hard to go through the application process when you're out here, so if there was a place where you could just go in and start, I know there's day labor, but even that has problems. So more of that, more easy access jobs."
>
> - Person with Lived Experience

Expand HRS Services that are Working with People at Risk of Early Death.

Focus outreach and support efforts on the areas where individuals in crisis are most frequently engaged: when taking a ***Coordinated Assessment, street outreach, day shelters, and emergency shelters.***

Additionally, expanding the presence of HMIS and CA assessors in critical healthcare settings, including hospitals, medical respite centers, and transition teams would be transformative. Strengthen collaboration with all street medicine teams and EMS to ensure that individuals in acute crisis are connected to housing and health resources as quickly and seamlessly as possible. This targeted approach will help address gaps in care and improve outcomes for people most in need.

Create safe, accessible, indoor community hubs.

Day shelters in our community are a cornerstone of support for individuals facing early mortality, however our day shelters are often also housed outside and do not have a large indoor space to provide shelter from extreme weather. Addressing this gap by creating more indoor options will build on the success of day shelter programs and ensure individuals have safe, weather-protected spaces to access the support they need.

Recommendations

Indoor community centers could provide a safe refuge from the elements while serving as one-stop shops for essential services. These hubs should offer individuals a secure place to be during the day, protecting them from extreme weather conditions while connecting them to vital resources like healthcare, housing support, safe spaces, workforce opportunities, and social services.

More than just resource centers, these spaces should foster a sense of belonging and stability, offering a foundation for individuals to rebuild their lives. Austin has already set the foundation for this with the development of Neighborhood Centers, which could be expanded to meet the full potential of an indoor community hub.

> *[What immediate resource could save a life?]*
>
> AIR CONDITIONING.
> AIR CONDITIONING.
> AIR CONDITIONING.

- Person with Lived Experience

Prepare for Climate-Related Risks with Expanded Shelter and a Coordinated Response.

Seventeen of the 20 documented heat-related deaths in our community happened in 2023. Climate-related deaths are an alarming and growing trend that cannot be addressed by limited shelter access or shelters that close during critical hours. To prevent these tragedies, Austin must expand access to cooling and warming centers, learning from innovations happening in cities such as Phoenix.

By establishing a dedicated Heat Response Office in Austin could coordinate similar life-saving initiatives while tailoring them to our city's unique needs. This office could oversee expanded cooling and warming shelters, distribute resources like water and emergency supplies, and facilitate targeted outreach during extreme weather. By investing in these innovative and accessible solutions, Austin has the opportunity to lead in climate resilience while protecting the most vulnerable in our community.

Recommendations

Basics through Outreach & Engagement
Climate Response

Phoenix's Heat Response Office is a leading example of how cities can proactively address extreme weather risks.

Phoenix has created a model that saves lives and brings the community together to combat climate impacts.

62 facilities serve as and provide:

- *Cooling centers*
- *Hydration stations*
- *Free transportation services*
- *Innovative programs like "We're Cool," a phone-based wellness check system during high heat*

Community & Belonging
Peer Leadership

Community is a social determinant of health.

We must create opportunities for connection by establishing community hubs where individuals can access services while fostering relationships with peers and providers. These spaces could offer social activities, wellness programs, and peer-led workshops.

Uplift Peer-Led Support Groups.

Develop peer-led groups focused on shared challenges like substance use recovery, mental health management, or transitioning into housing.

Recommendations

Facilitate Peer-Led Housing Transitions.

Isolation is a huge problem that many people face when getting housing. Pair individuals entering housing with peer mentors who have successfully navigated similar transitions, offering guidance and reducing feelings of isolation. Similarly, implementing a buddy system where people who lived together on the streets can be housed in the same apartment complex to provide a continued linkage to community and support.

Expand Peer-Led Outreach Teams.

Include individuals with lived experience of homelessness in outreach efforts. Peer support specialists bring invaluable insights and can establish trust with hard-to-reach individuals, helping to bridge the gap to services and housing.

Create Pathways to Leadership for Peers.

Ensure that individuals with lived expertise are not limited to peer support roles. Develop clear pathways for professional growth, including training, mentorship, and access to leadership opportunities within the homeless response system. Their unique perspective is critical to shaping programs and systems that truly meet the needs of the community.

> "It's amazing that even in the worst situations, the connections, the networking, the growth, and just the humanization that comes with this line of work helps really put perspective on how short life is and how significant one voice, one opinion, one action can be.
>
> - Person with Lived Experience

Recommendations

Community & Belonging
Family Reunification

Integrate Family Reunification Services, when appropriate, as a part of a continuum of opportunities for connection.

Help individuals reconnect with family or supportive loved ones, fostering natural support networks that can help people stabilize and thrive.

Harm Reduction Innovation
Tools & Education

Expand Harm Reduction Tools and Education.

Distribute Harm Reduction Supplies and Education: *Provide naloxone, and overdose prevention kits across shelters, outreach teams, and housing programs. This handout is available as a resource for safer use practices for stimulants in particular. To learn more about harm reduction best practices and plug into resources, check out our HRS Best Practices in Harm Reduction Guide.*

Education on Prescription Interactions: *More research is urgently needed to understand how prescribed medications interact with methamphetamine and other substances. Just as prescription bottles warn against combining certain medications with alcohol, it could be life-saving to identify which prescriptions, when paired with stimulants, create potentially deadly combinations. This knowledge would allow for targeted education, equipping individuals with the information they need to make safer choices and reduce risks associated with drug interactions.*

Innovate for Stimulant Use Disorder: *Advocate for research and funding to address the lack of FDA-approved medications for stimulant use disorder while exploring alternative therapies and pilot programs to bridge this critical gap. Evidence-based interventions like* ***Contingency Management****, which uses small rewards to encourage abstinence, and the* ***Community Reinforcement***

Recommendations

Approach, *which replaces substance use with healthier alternatives like employment and social connections, have proven effective. These methods can be tailored to supportive housing communities, fostering recovery in a stable environment and saving lives by addressing treatment gaps.*

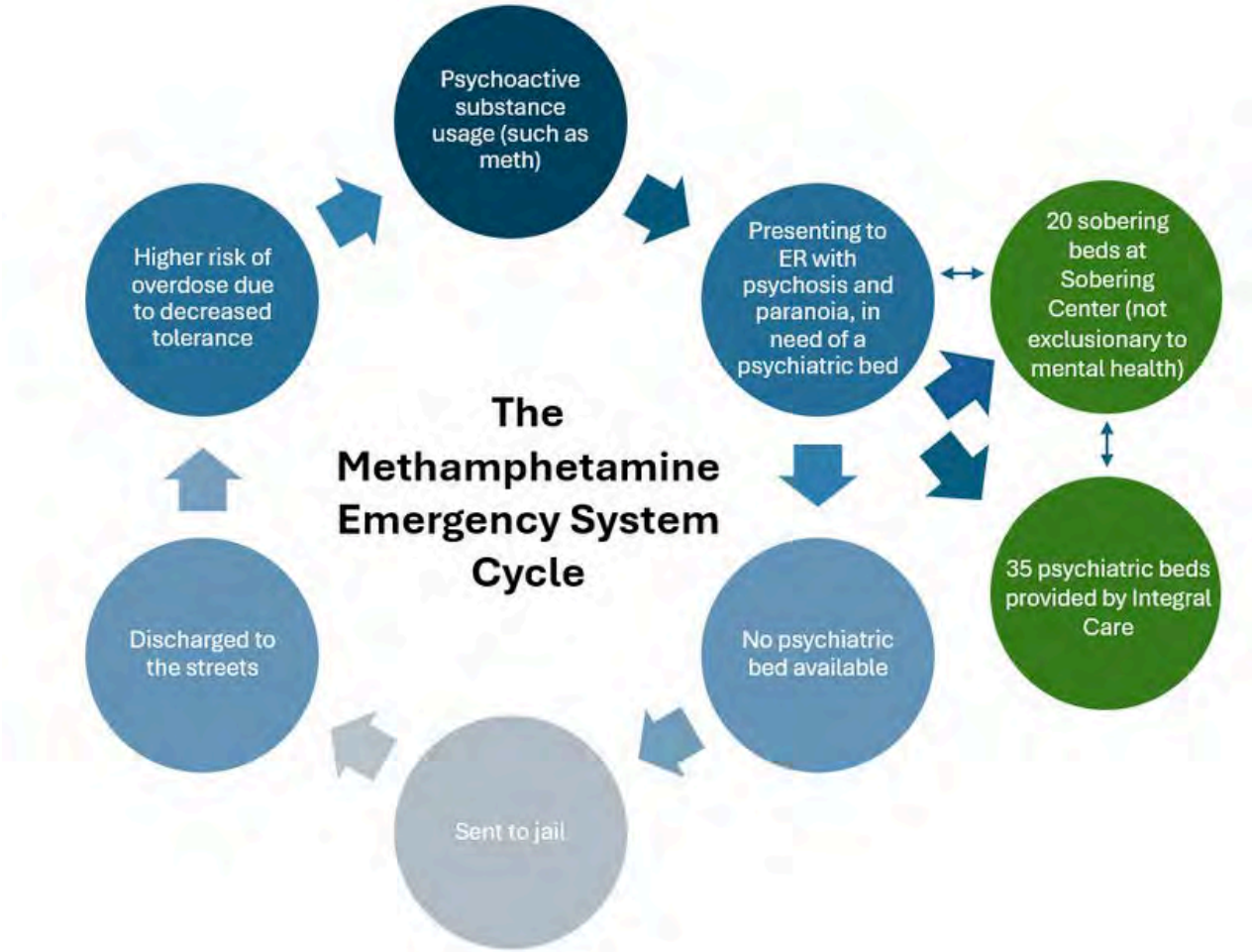
Creating Safe Spaces: Reducing Harm with Care and Innovation.

Meth-related overdoses spike in July, driven by the deadly combination of excessive heat, dehydration, and malnutrition and amplified by stimulant use, which puts a person's heart into dangerous overdrive. ***A calm, indoor space with minimal external stimuli and access to basic resources isn't just a compassionate solution—it's a practical one.*** *Such spaces have the potential to save hundreds of lives, offering immediate relief while reducing the risks associated with stimulant use during extreme weather.*

Examples from around the world demonstrate the effectiveness of these sites. Vancouver's Insite, the first legal supervised consumption site in North America, has significantly reduced overdose deaths while connecting individuals to healthcare and addiction treatment.

Similarly, Australia's Medically Supervised Injecting Centre has been operating successfully since 2001, improving public health outcomes in its community. Adopting such evidence-based models in our community, tailored to our local needs and values, could not only save lives but also reduce healthcare costs and improve community well-being.

Recommendations



A Critical Choice for Our Community: Addressing the Gap in Behavioral Health Care.

Without safe spaces (see page 72), our community will need to dramatically increase the availability of psychiatric beds to address the behavioral health crises often linked to meth use. As of 2023, Austin's hospitals have a total of 210 psychiatric beds, with 80 additional beds projected for 2024. However, there are no State or County requirements to have a set number of these beds designated for those that are uninsured. Because of this, the Sobering Center and Integral Care provide the bulk of emergency care management for those who are uninsured and are in need of a higher level of care. ***At present, this leaves our community with 55 beds (35 psychiatric), with all but four designated for voluntary status, leaving a significant gap in care for people who cannot voluntarily seek help.***

Recommendations

Harm Reduction Innovation
The Need for Behavioral Health Care

Without critical resources to increase psychiatric beds, taxpayer-funded jails will remain the default holding space for mental health and substance use crises—settings where individuals cannot heal or break the cycle.

The recent creation of a 25-bed Therapeutic Diversion Center is a step forward, offering crisis respite to divert individuals from jail. However, these beds provide a lower level of care. ***Our community would greatly benefit from a dedicated behavioral health center that provides whole-person, low-barrier psychiatric and substance use treatment services in tandem****. By expanding behavioral health care and harm reduction strategies, our community can move toward a more compassionate system that fosters recovery, stability, and dignity for people in need.*

Broader Systems Change
Unity Across Data & Teams

Unifying Data to Transform Care and Save Lives.

Data sharing is essential to transforming care coordination and creating direct pathways to housing and treatment. Collaborating with jails, hospitals, EMS, and other health systems partners to share real-time information allows for better identification of frequent emergency system users and targeted interventions to address their needs.

An emerging example is Watershed, a data integration platform gaining momentum among local health system partners. By integrating HMIS data into platforms like Watershed, we can prioritize resources, ensure seamless care across agencies, and develop programs that link individuals to housing and treatment directly from jails or emergency settings. Breaking down silos not only reduces costly cycles of instability but also strengthens the entire system, saving lives, lowering public costs, and creating a more effective safety net for our community.

Recommendations

> *There's a segment of the homeless community that nobody really talks about that dies or gets killed. Those are the ones with the backpacks that are crossing the street. The hit-and-runs that keep going.*

- Person with Lived Experience

Launch a Mortality Action Alliance.

Form a cross-sector advisory group to address the findings and implement recommendations from this report. Bringing together health system partners, city and county government, HRS providers, and individuals with lived experience of homelessness, this group will prioritize actionable strategies to reduce preventable deaths. By aligning efforts, securing funding, and driving systemic change, the group can lead meaningful improvements in health outcomes and accountability across our community.

Prevent Traffic Deaths with Targeted Intervention.

Work with the City and TXDOT to analyze fatal traffic collisions involving individuals experiencing homelessness. Leverage this data to enhance pedestrian safety plans and inform infrastructure, programming, and policy improvements to prevent future fatalities.

Invest in Harm Reduction to Save Lives.

Harm reduction saves lives. Advocating for legal access to harm reduction tools, such as substance testing strips and safe use sites, can prevent accidental overdoses and reduce the burden on emergency services. Communities that adopt harm reduction policies consistently report significant reductions in preventable deaths, demonstrating the urgent need for these measures in our region. Local leadership is already paving the way. Austin's 2024-2025 budget includes funds for emergency

Recommendations

shelter ($2.86M), permanent supportive housing ($2.6M), crisis response teams ($1.45M), and harm reduction programs ($203K). Travis County has renewed their opioid overdose crisis declaration and are funding expanded harm reduction efforts, further demonstrating the urgent need to prioritize these measures. By fully embracing harm reduction policies, we can save lives, disrupt the cycle of crisis, and build a safer, healthier future for everyone.

Expand Medicaid to Fund Supportive Housing.

Medicaid expansion is a transformative policy that funds supportive housing programs across the country. To date, Texas is one of just 10 states not to expand Medicaid, leaving 726,000 Texans in the "coverage gap" - unable to qualify for health care plans through either Medicaid or the Affordable Care Act. In addition, in states where Medicaid is expanded, it has been leveraged to cover services like case management, behavioral health care, and housing-related supports for individuals experiencing homelessness.

By expanding Medicaid in Texas, not only would we be ensuring more people can get the care they need, we could access federal funding to underwrite programs that integrate housing and healthcare, creating sustainable solutions for individuals with complex needs. This policy change would strengthen the safety net and enhance our ability to address homelessness and mortality comprehensively. Find contact information for your state representatives and senators here.

> All it takes is the effort to say, 'Hey, I need you.' If you care about me and what I care about, I need you as my neighbor to show up. I need you to be there.

- *Person with Lived Experience*

Appendix

Behind the Curtain: Data Cleaning and Analysis

Hospital Data

Connxus, the local health information exchange, provided health utilization data from 2019 - 2023 for those ECHO has a Release of Information for and who also signed for medical releases of information. This means that every person in this report that died in the hospital is in HMIS. It is likely that many persons experiencing homelessness who die in the hospital may not have engaged with the Homelessness Response System, and if so, these folks are not captured in our data due to this limitation. Additionally, death data provided was the primary complaint at the last visit, not the official cause of death, as these data were not available.

Homeless Management Information System (HMIS) Data

HMIS data were linked to both hospital and ME data for this analysis. This data provides insights to HRS service utilization, coordinated entry, special populations, benefits status, and homelessness chronicity, among other areas. When available, we used HMIS data for race and gender, as these data are self-report. When not available, we used medical examiner data (which is more prone to error as this is only based on observation/ identifying documents available and not self-report).

Medical Examiner Data

Unhoused death data were provided by Travis County's Medical Examiner office using a public information request. Starting in 2018, the ME department has a box for persons experiencing homelessness, and ECHO was provided data on all who were checked 'Yes' for experiencing homelessness at the time of death. To be classified as homeless by the ME office, a person must be clearly experiencing homelessness at the time of death - such as a death in an encampment - or confirmed by friends or family that the Office connects in the wake of the individual's death. Active cases were not included in this report.

Ensuring Homelessness Status in Hospital Death Data

We cross referenced death data captured in HMIS (a neutral exit from permanent housing in our Continuum of Care) with hospital data to ensure there was no overlap in the data. If there were any overlap, then a person who was recently housed could appear in the hospital dataset and be counted as an unhoused death incorrectly. However, no overlap appeared in the data sent from the hospital and HMIS data of housed deaths. Resultantly, people who died in the hospital were not housed by any Continuum of Care housing providers.

CDC Wonder Data

Population comparison data were pulled from CDC Wonder to examine differences with Travis County level data to compare trends in causes of death among those experiencing homelessness.

Behind the Curtain: Data Cleaning and Analysis

ECHO_unique_ID	MCD - ICD Sub-Chapter	MCD - ICD Sub-Chapter Code	Broader Categorization
1	Intestinal infectious diseases	A00-A09	Infection and parsasitic diseases (excluding sepsis)
2	Tuberculosis	A16-A19	Infection and parsasitic diseases (excluding sepsis)
3	Certain zoonotic bacterial diseases	A20-A28	Infection and parsasitic diseases (excluding sepsis)
4	Other bacterial diseases	A30-A49	Infection and parsasitic diseases (excluding sepsis)
4.5	**Sepsis**	**A40-41**	**Sepsis**
5	Infections with a predominantly sexual mode of transmission	A50-A64	Infection and parsasitic diseases (excluding sepsis)
6	Other spirochaetal diseases	A65-A69	Infection and parsasitic diseases (excluding sepsis)
7	Other diseases caused by chlamydiae	A70-A74	Infection and parsasitic diseases (excluding sepsis)
8	Rickettsioses	A75-A79	Infection and parsasitic diseases (excluding sepsis)
9	Viral infections of the central nervous system	A80-A89	Infection and parsasitic diseases (excluding sepsis)
10	Arthropod-borne viral fevers and viral haemorrhagic fevers	A90-A99	Infection and parsasitic diseases (excluding sepsis)
11	Viral infections characterized by skin and mucous membrane lesions	B00-B09	Infection and parsasitic diseases (excluding sepsis)
12	Viral hepatitis	B15-B19	Infection and parsasitic diseases (excluding sepsis)
13	Human immunodeficiency virus [HIV] disease	B20-B24	Infection and parsasitic diseases (excluding sepsis)
14	Other viral diseases	B25-B34	Infection and parsasitic diseases (excluding sepsis)
15	Mycoses	B35-B49	Infection and parsasitic diseases (excluding sepsis)
16	Protozoal diseases	B50-B64	Infection and parsasitic diseases (excluding sepsis)
17	Helminthiases	B65-B83	Infection and parsasitic diseases (excluding sepsis)
18	Pediculosis, acariasis and other infestations	B85-B89	Infection and parsasitic diseases (excluding sepsis)
19	Sequelae of infectious and parasitic diseases	B90-B94	Infection and parsasitic diseases (excluding sepsis)
19.5	Bacterial, viral, amd other infectious agents	B95-B98	Infection and parsasitic diseases (excluding sepsis)
20	Other infectious diseases	B99-B99	Infection and parsasitic diseases (excluding sepsis)
21	Malignant neoplasms	C00-C97	Cancer
22	In situ neoplasms	D00-D09	Non-cancerous neoplasms
23	Benign neoplasms	D10-D36	Non-cancerous neoplasms
24	Neoplasms of uncertain or unknown behaviour	D37-D48	Non-cancerous neoplasms
25	Nutritional anaemias	D50-D53	Anaemias
26	Haemolytic anaemias	D55-D59	Anaemias
27	Aplastic and other anaemias	D60-D64	Anaemias

Development of ECHO Codes for Cause of Death Analysis: Above, see the ECHO ID paired with ICD-10 Subchapter Coding. This allowed for the Medical Examiner data to be paired with hospital data, which only used ICD-10 scoring.

Cause of Death Data Standardization Across Sources: ECHO Unique IDs

Causes of death provided by the Medical Examiner were written out descriptively (i.e. "blunt force trauma" or "atherosclerotic and hypertensive cardiovascular disease"), and contributing factors and injury descriptions were added on as needed basis for every individual. To combine these with hospital death data (ICD-10 Codes only), we developed 'ECHO Codes' based off the subchapters of the ICD-10 codes (a global method for coding disease and causes of death).

For each case, 2-3 ECHO staff independently looked up the descriptions provided by the ME and put them into a digital 2019 ICD-10 reference tool. Using this tool, ECHO staff independently coded primary causes of death by using an 'ECHO Code' that narrowed cause of death down to an ICD-10 subchapter. Comorbidities noted by the ME were same way. After independent review, ECHO staff met and gained consensus on each ECHO code for each individual.

The developed 'ECHO Codes', based off the subchapters of the ICD codes, were used to marry the hospital death data (ICD-10 codes) with ME data (previously descriptions, now ECHO Codes) for analysis. The sub-chapters were then modified as needed to better fit project needs; highly relevant categories were further specified and highly specific/less relevant categories were combined. This resulted in cause of death coding that loosely corresponds with the ICD-10 sub-chapters. For individuals in both the hospital and ME data, the cause of death was taken from the medical examiner's data since this is the official cause of death.

Behind the Curtain: Data Cleaning and Analysis

Data Cleaning

In cases of drug toxicity, the medical examiner listed all drugs in the individual's system at the time of death. These were manually coded by ECHO staff. Addresses provided by the ME office were standardized (Ex: 1234 Example St.) for analysis. The ME office did provide a variable, "Death Place Type" that denoted different places of death; these data were manually cleaned for analysis (Ex: 'Parking lot (outside)' revised to 'Parking Lot'). In all cases, the more specific descriptor was used in the analysis.

To clean the hospital data, we first excluded any individuals who are alive based on a dichotomous (Y/N) universal variable. The resulting data set included all health encounters from 2019-2023 for persons who died unhoused. To determine when and how each person died, we identified the last health encounter for each person. The date of the last encounter was used as a proxy for the death date (unless the person was in the Medical Examiner (ME) dataset, as the ME provides an official cause of death and the hospital data does not). The resulting data set often had many separate encounters/rows for the last encounter date, with many different diagnosis codes. To identify the diagnosis that was likely the cause of death, we used the priority 1 label and/or F (i.e., final diagnosis). The rest of the rows for each person's last encounter were counted as comorbidities.

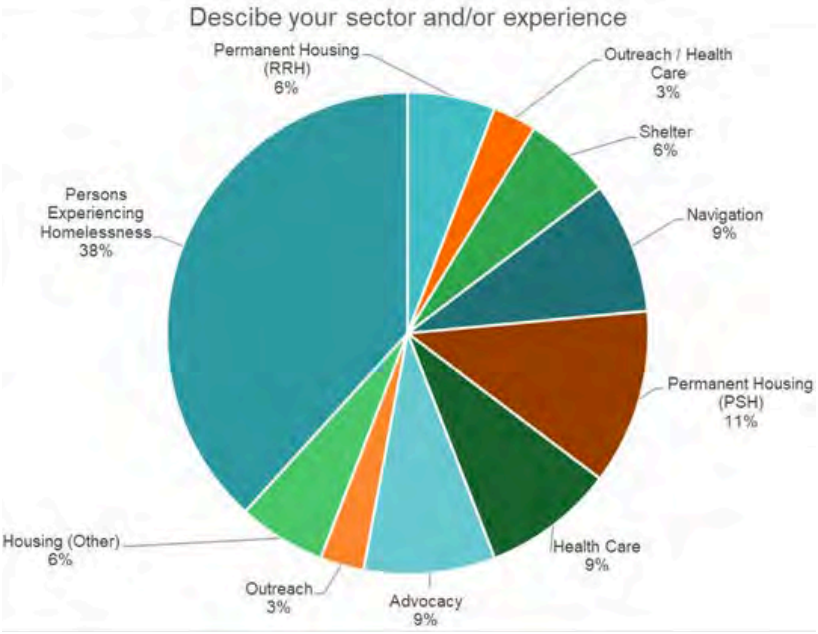
Listening Sessions

Listening sessions were critical for this project, and allowed us to connect with our community's experience with death on the streets and to learn about what our system can do better to eliminate early death.

Recruitment & Participation

Recruitment for listening sessions with service providers utilized CTOSH, a local email listserv for homelessness service providers. To engage with members of our community experiencing homelessness, ECHO worked with The Other Ones Foundation (TOOF). TOOF staff spoke with their clients, managed the interest list, and even provided space for the listening session to be on site to make it easier for folks to attend.

While originally ECHO planned to only do one listening session with service providers, there was so much interest that we decided to separate it into two sessions (Total persons: 21). As shown in this graph, a wide variety of service providers attended the provider listening session. Organizations that were present included: Family Eldercare, City of Austin EMS, The Other Ones Foundation, Texas Department of Family and Protective Services, Caritas of Austin, CommUnity Care, Capital Area Public Defender Service, Austin Mutual Aid, Sunrise Homeless Navigation Center, Integral Care, Housing Authority of Travis County, Austin Police Department, and the Austin Area Urban League.



Behind the Curtain: Listening Sessions

Centering on our Collective Why

Because grief and loss are hard to express in words, at the beginning of every session we began with art: to center on the collective why that compelled each person to take part in these sessions. Here is a brief excerpt on how this concept was shared out:

"We are going to do an activity that really centers on why we are all here today, having hard conversations about death and loss.
I'd like you to think about the folks that you've lost to the streets. The folks that came to mind when you saw the invite for this listening session, and who compelled you to take the time to be here today.

I'd like you to pick a color of paint you think they'd like best, and place your hand in the paint - I'd recommend using your non-dominant hand for this part. Next to the handprint, write something about them - it could be an inside joke, something they loved. Anything that reminds you of them. Do this for as many people as you would like to."

These handprints helped folks to feel comfortable enough to share stories of people we've lost with each other. You will see these handprints, along with quotes pulled from these sessions, throughout this report.

Five questions were explored in these sessions following the art activity (see Supplemental, Table 1). Of note, as some service providers also had lived expertise, the designation of questions is more based on the session type than necessarily people that were in the room.

Polling data was collected via Slido or sticky notes, depending on the session type, and were compiled to extract main themes. The stories, feedback, and artistry that came from these sessions are at the foundation of this work, and are blended into this final report to ensure our findings reflect the experiences of people most affected.

A feedback survey from the Austin Homeless Advisory Council, provided following a presentation of this project's scope at the beginning of this project, was also explored for major themes and incorporated into the final recommendations of this report.

Limitations

While this is the most comprehensive report on unhoused mortality that has ever been produced for Travis County, there are a number of limitations to this report that are notable.

- *First and foremost, this report contains only the hospital deaths for persons also in HMIS. ECHO received hospital data for all individuals who were in the HMIS system and had a release of information. This means that ECHO does not have any data for individuals who died while experiencing homelessness but were not in HMIS and/or did not sign off on a ROI.* ***Because of this, the findings of this report are an undercount****.*

- *Additionally, hospital data was not available for 2018 and extremely limited in 2019 (N= 3), reflecting changes in the way that the data might have been previously categorized that make it unavailable for this report.*

- *Because hospital data did not provide the official cause of death data, ECHO staff used a proxy: primary diagnosis code for the last health encounter visit. As this is not official cause of death data, this is a limitation of the report. Additionally, as the experience of homelessness is traumatic and multi-faceted, causes of death for folks experiencing homelessness may be difficult to accurately determine across all data types.*

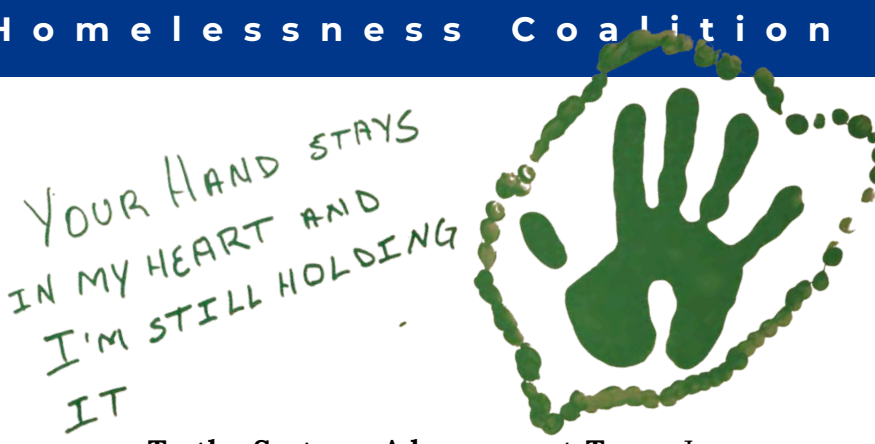
- *For folks experiencing homelessness, the original aim was to do individual interviews instead of a listening session to promote a sense of safety and privacy for folks who would like to participate. Due to reductions in staffing capacity, this was shifted to one listening session. If done again, we feel it would be better to have an even more intimate letting (five people at maximum) to promote discussion.*

- *While we did attempt to look at transgender and sexual orientation to assess for increased risk to these communities, unfortunately the data for these variables is very new in HMIS. There were not enough data available to draw sound conclusions. Additionally, Medical Examiner data and hospital data only provided data on sex (male/female).*

- *The Medical Examiner's jurisdiction involves cases that are unexpected, sudden, violent, or unattended deaths, deaths that occur within 24 hours of admission to a hospital, or deaths in custody. However, while the ME may be called out to various areas, whether they report on the death largely depends.*
  - *In cases of "zero concern", these are not reported. Some examples of this include: Extensive medical history, natural causes with an overseeing physician, if a person is in 24/7 nursing care, or if that person is over 70.*
  - *While the Medical Examiner's use of a checkbox for tracking homelessness-related deaths exceeds national standards, the classification is not foolproof. Deaths of individuals in institutions like medical respite, treatment facilities, nursing homes, or jails may go unclassified unless staff, friends, or family report their homelessness status.*

- ***This report does not include legal systems data, limiting our understanding of how incarceration, arrests, and legal barriers impact homelessness and mortality.*** *Future iterations will aim to address these gaps by promoting data sharing and emphasizing the role of data quality in improving outcomes.*

Acknowledgements



- **To those living on the streets**, thank you for sharing your courage and trust. Your stories are the heart of this work. Special thanks to Amy Orvis, BL, Deontre Gardner, G-Bob, Jess Nairns Chain, Jessica Saner, John Thierry, Leonard Ramirez, Regina Schnee, and Shannon Sorgman. Special thanks to Linda Jackson for sharing her poem, Seeds, which inspires this report.

- **To service providers who joined our listening session**, thank you for your honesty and dedication. Special thanks to Allie Roberts, Amber Price, Atma Meek, Chris Craft, LMSW, Don Leonard, Elizabeth Endyke, Kaleigh Phelan, Kristin Josephson, FNP-C, Linda Jackson, Melvin Tealer, Pablo Montes, Ruben Pizarro, Ryan Jannak, Sara Weier, Toby Wayne Nunley, Vaughn, and Victoria Perez. Ben Jones and Cody Andrews, thank you for honoring The Pirate of Sixth Street through song.

- **To the Travis County Medical Examiner's Office, Central Health, and the connxus health information exchange,** thank you for your invaluable partnership. Your data contributions have been instrumental for the development of this report and helping to build a deeper understanding of unhoused mortality in our community.

- **To artist Tom Jett and Art from the Streets**, your cover art brings depth and humanity to this report, capturing the spirit of those we remember. Thank you for lending your vision and for honoring this work in a way that words alone could never capture.

- **To the Systems Advancement Team**, Jason Phillips, Kyle Walker, and LaShandraia Dwyer, your guidance and collaboration were invaluable.

- **To the Communications Team,** and especially Chris Davis, thank you for your help in crafting this visually compelling and accessible report.

- To the **Austin Homelessness Advisory Council**, your expertise and recommendations shaped the report's direction.

- **To The Other Ones Foundation**, thank you for hosting a listening session and amplifying lived experience.

- **To Dr. Ben King, Ashley Meehan, MPH, and the national Unhoused Mortality Workgroup**, thank you for your expert guidance in reporting on unhoused mortality.

- **To my ECHO colleagues**, your teamwork made this possible. Special thanks to Akram Al-Turk, Lyric Wardlow, Meagan Biscamp, Sara Fuetter, Tania Hughes, Matthew Mollica, Kate Moore, Chris Murray, Joseph Montano, Carrie Van Balen, and Linda Wolfe.

And to all who supported this effort with feedback, involvement, and care: thank you for holding this work in your hands and hearts.

This report was enhanced by AI-assisted research and drafting tools, which supported data analysis, language refinement, and formatting to ensure clarity and accessibility.

Supplemental

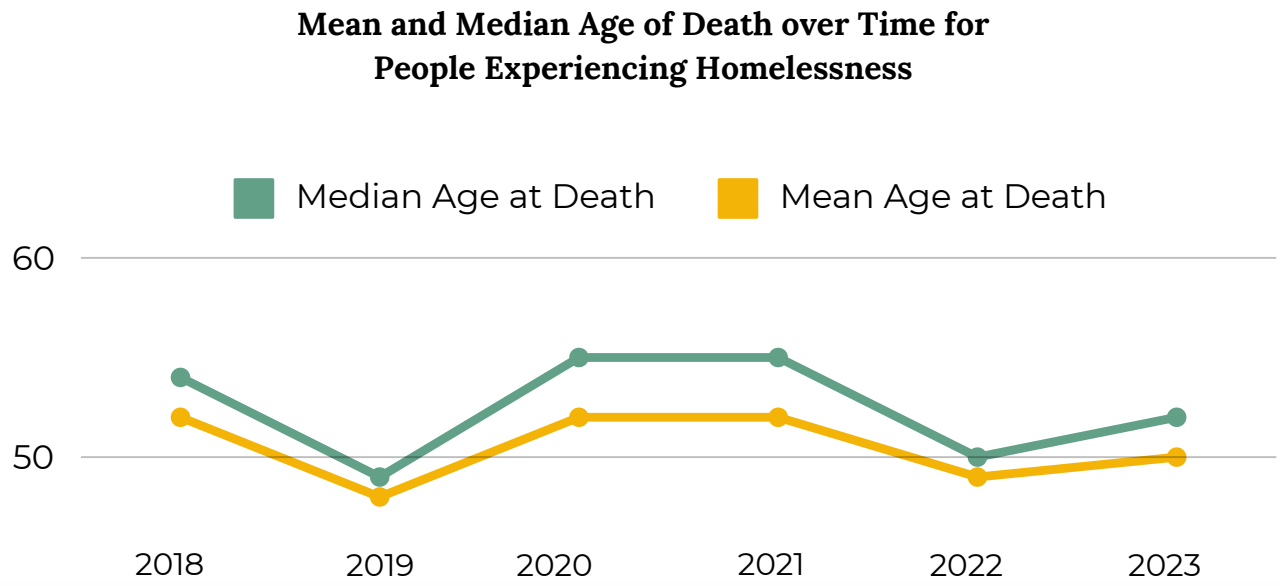


Figure 1. Mean and median age of death over time for persons experiencing homelessness, 2018-2023

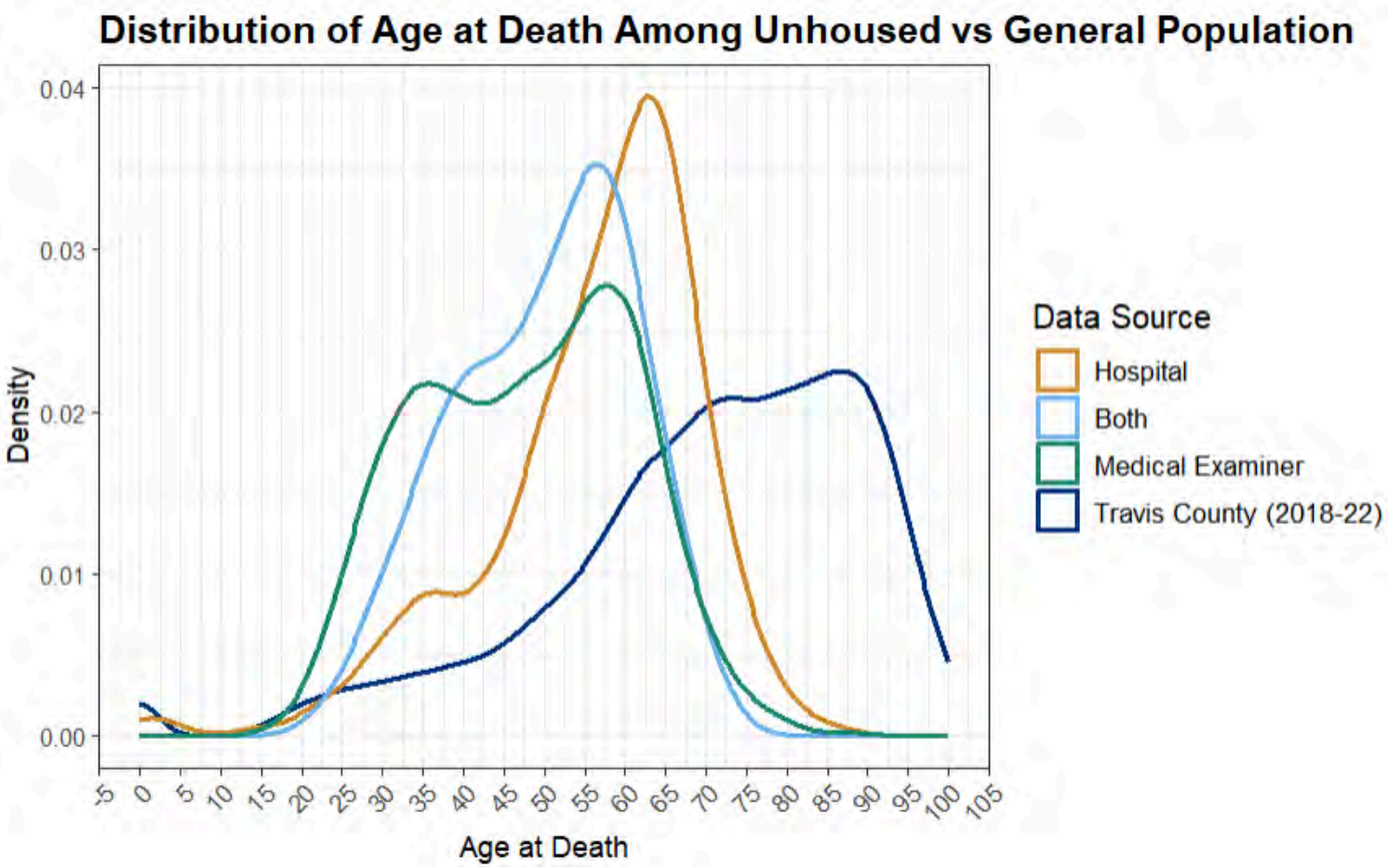


Figure 2. Visualization of the age of death for unhoused persons who died in a hospital, streets (medical examiner) or both (arrived at hospital but died within 24 hours of arrival), compared with Travis County ages of death..

Supplemental

Listening Session Questions		
Question One:	Service Providers	What has your experience been with death and loss when serving your clients? Give me one word.
	Persons with Lived Expertise	What has been your experience with death and loss been like on the streets? Give me one word.
Question Two:	Service Providers	What are the main causes of early mortality that you are seeing when serving your clients?
	Persons with Lived Expertise	What are the main causes of early death that you are seeing among those you have lost to the streets?
Question Three:	Service Providers	What immediate resource would be helpful to provide clients to minimize risk of early mortality?
	Persons with Lived Expertise	What services did your friend or loved one really appreciate, or want more of?
Question Four:	Service Providers	This work is hard. What supports around loss are you wanting or needing as a service provider?
	Persons with Lived Expertise	What are some supports or resources that would have been helpful for your loved one, that they didn't have access to?
Question Five:	Service Providers	What long-term structural changes would you like to see come out of this report to better serve your clients facing early mortality?
	Persons with Lived Expertise	Is there anything else you would like to share?

Table 1. Breakdown of questions asked during service provider and lived expertise listening sessions.

Supplemental

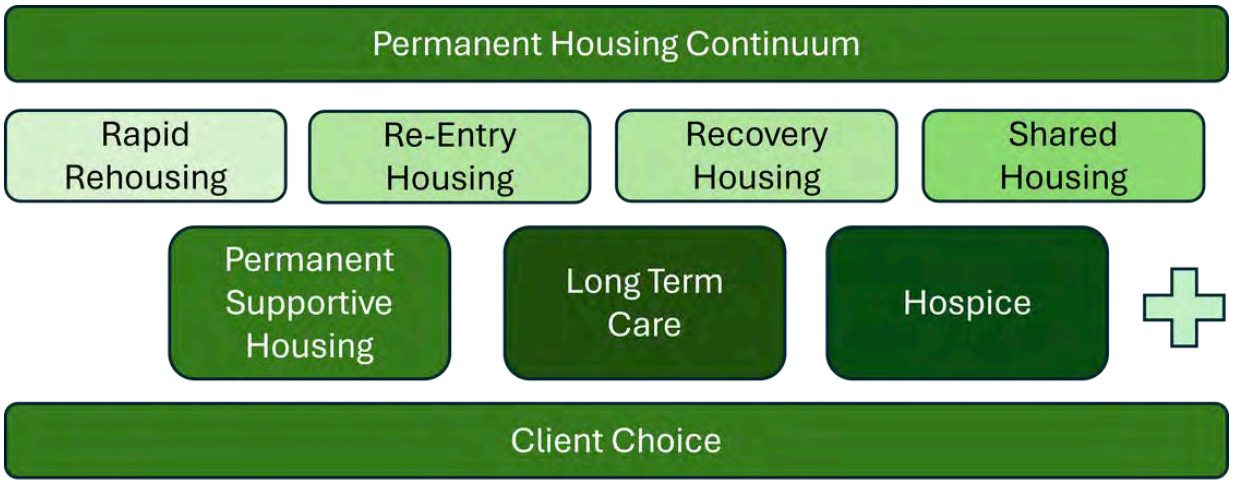


Figure 3. Example flow of Permanent Housing Continuum. *This is not an exhaustive list of housing opportunities.*

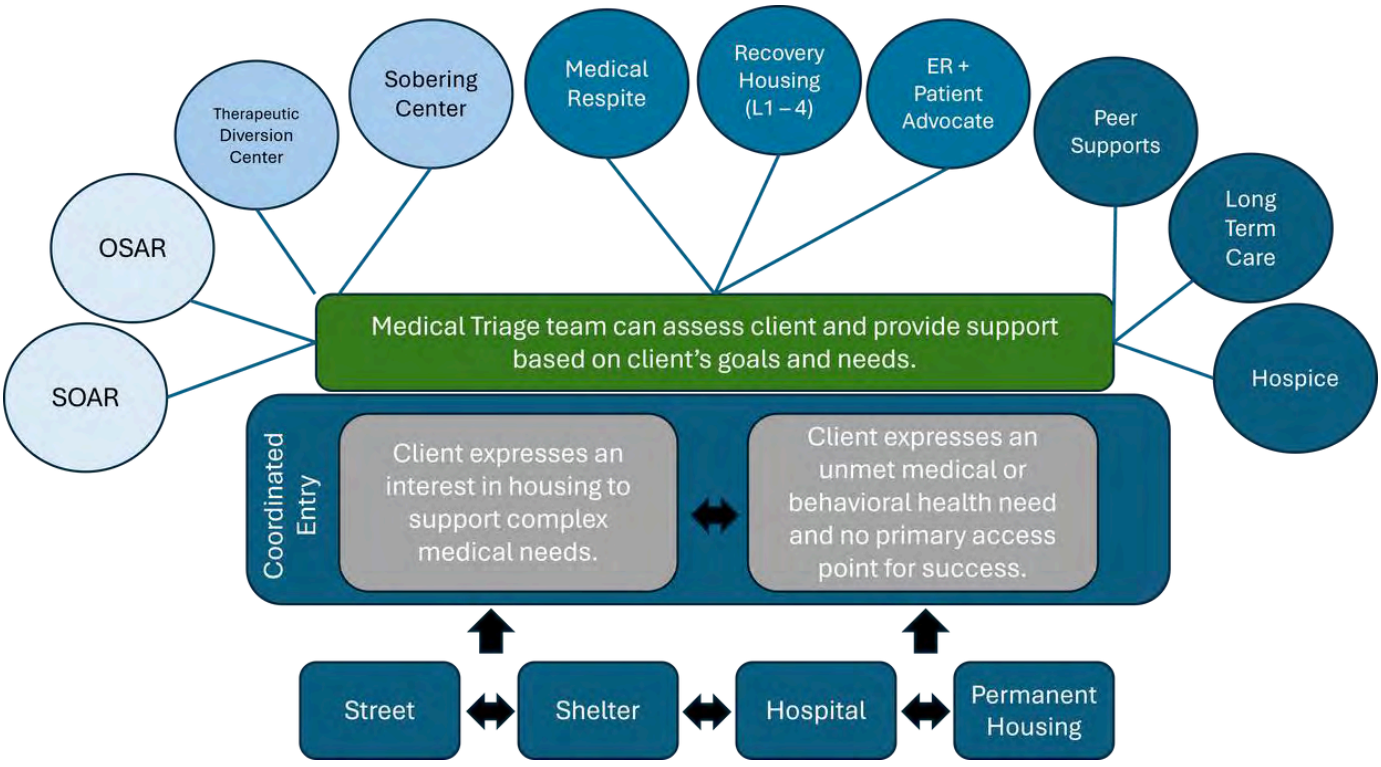


Figure 4. Example flow of the impact a Medical Triage team could have in connecting a person experiencing homelessness with harm reduction resources.

Supplemental

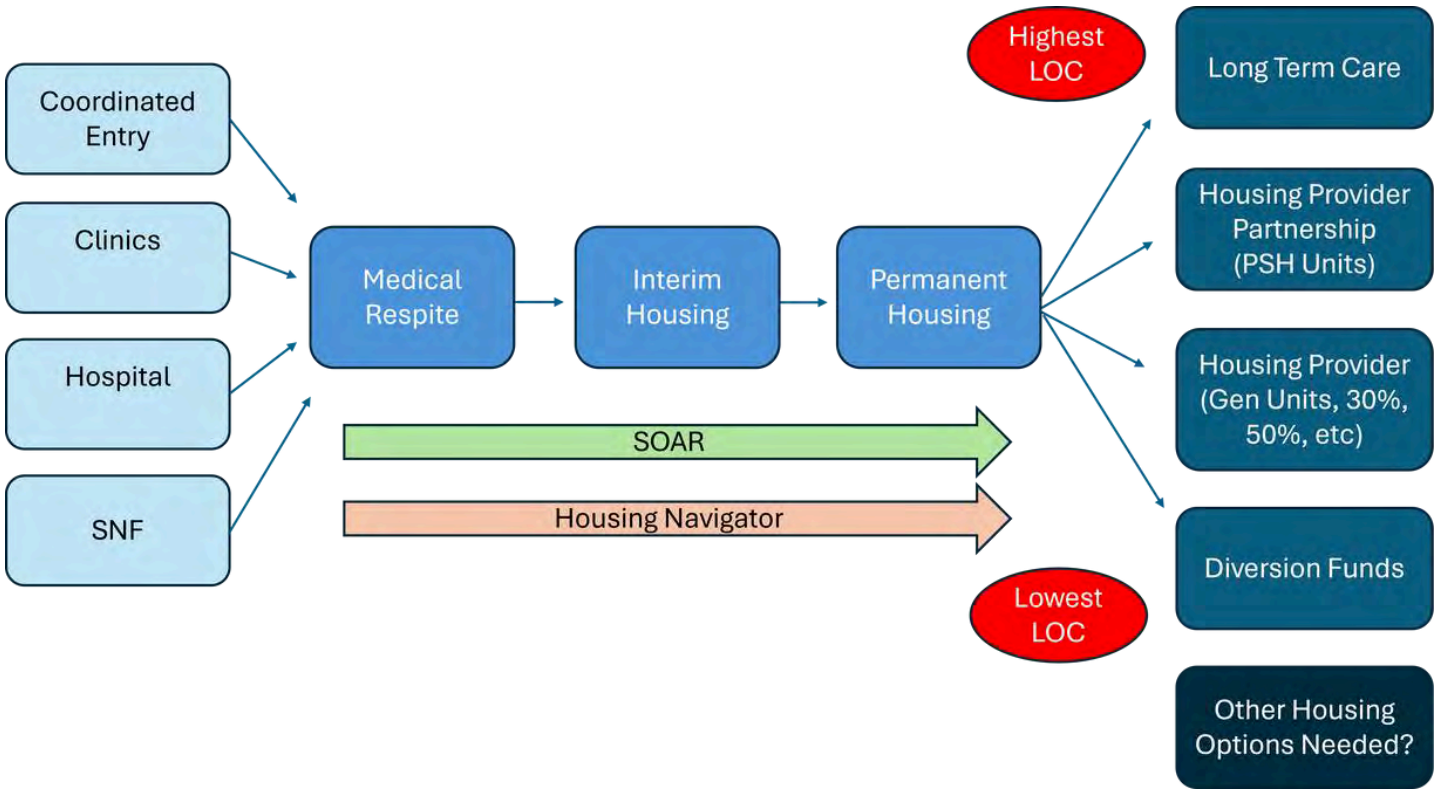
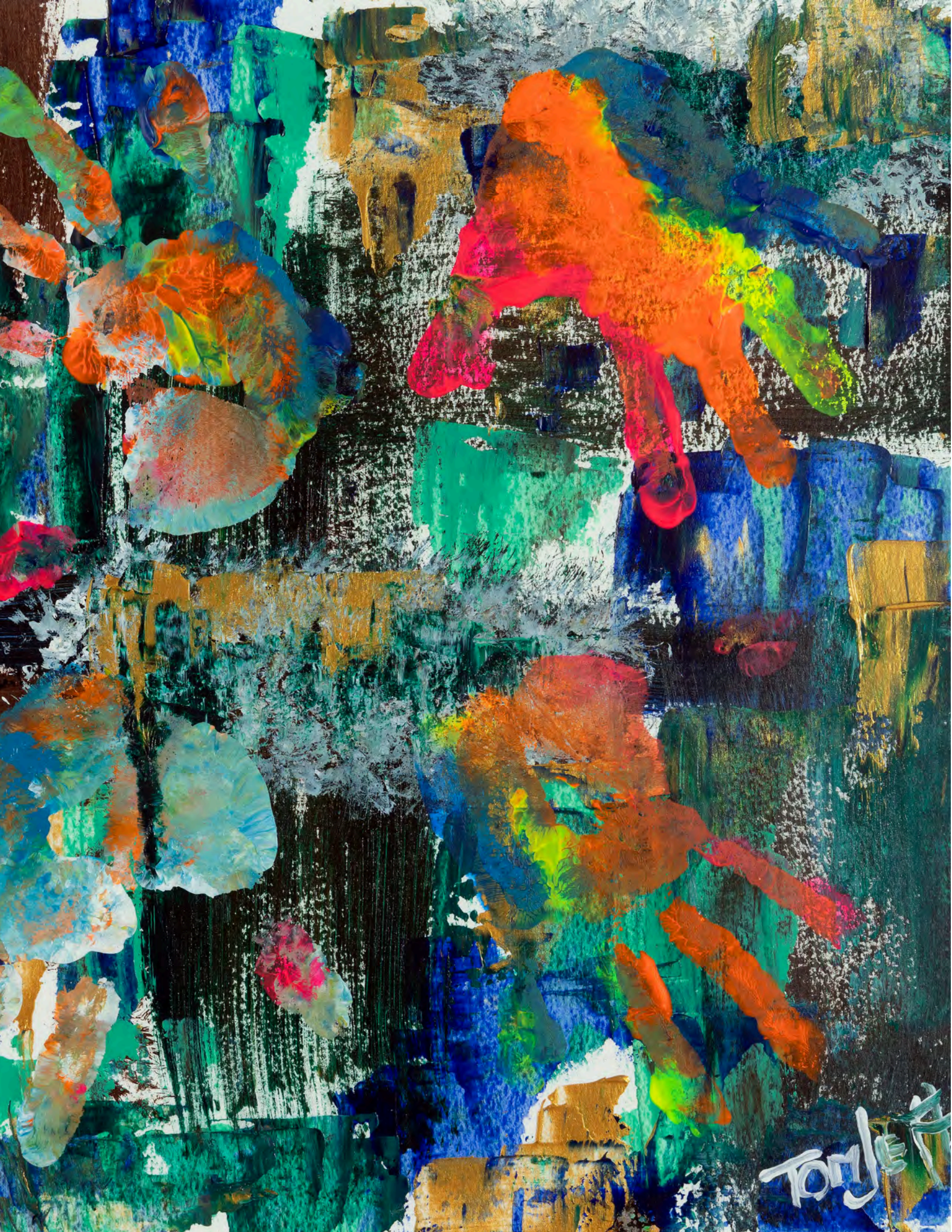


Figure 5. Example flow of developing a pipeline to housing for medically complex individuals from medical respite. *In this example, we create a Coordinated Entry referral to respite and develop a subpopulation prioritization for medical respite clients through a partnership with housing partners to establish CoC housing referrals. This is one of numerous possibilities for our community.*


Tony