

Illinois Department of Public Health

Illinois Homelessness Mortality and Morbidity Report 2017 - 2023

Executive Summary

NATURE IS NOT ADEQUATE SHELTER



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3 Executive Summary

3.1 Context

Between 2017 and 2023, approximately 10,000 people in Illinois experienced “literal homelessness,” which is tallied during an annual Point-in-Time count on a night in January. “Literal homelessness” is a term defined by the U.S. Department of Housing and Urban Development (HUD) to generally include people living in shelters, on the street, or in another place not meant for human habitation, such as a car or abandoned building. In addition, it is estimated that 108,850 to 233,712 people per year were living with others (family or friends) in unstable arrangements, commonly referred to as “doubled-up” (based on U.S. Census Bureau data for Illinois).

Research demonstrates that people experiencing homelessness are at an increased risk and severity of many acute and chronic health conditions. Many chronic age-related conditions affect people experiencing homelessness 10 to 20 years earlier than the general population, often resulting in premature death. Therefore, homelessness is a significant public health concern. Access to safe, affordable, and stable housing is a core social determinant of health. Public health has an important role to play in partnering to change the conditions that limit access to housing and supporting health-promoting systems for people experiencing homelessness. To get a better understanding of health needs, IDPH partnered with researchers at the University of Illinois Chicago School of Public Health to conduct a detailed analysis of the mortality and morbidity of people experiencing homelessness in Illinois. The statewide Office to Prevent and End Homelessness provided guidance and leadership to the project. Death certificates and hospital data, covering the years 2017 through 2023, were utilized in this report to describe the mortality and morbidity of people experiencing homelessness in Illinois.

3.2 Updates in This Report

To make the report more accessible for advocates and service providers, the report has been restructured by key health themes (demographic characteristics, geography, time-related events, health conditions and causes of death, and hospital-specific outcomes) rather than by data sources and methodology (death records and hospital discharge data). This decision was made because last year’s report clearly showed that the demographic characteristics and health concerns of people experiencing homelessness were mirrored in both the death records and hospital data. The prior report demonstrated that the average age at the time of death was almost 20 years younger among people experiencing homelessness. The findings from the hospital data indicate that the health issues contributing to the death of people experiencing homelessness are pervasive years prior to death. If effective early interventions can be initiated, then this disparity can be reduced.

While much of the findings cover the issues addressed in last year’s report, this report includes new elements developed with input from the community, including:

- all deaths and hospital visits of PEH during the year 2023;
- a more detailed description of children, teens, and youth experiencing homelessness;
- a more detailed description of hospital visits involving severe mental illness;
- risk of drug-related overdose and drug treatment provided;
- a more detailed analysis of non-fatal and fatal cold-related injuries;
- deaths occurring on public transportation;
- an evaluation of changes in contributing causes of death to attempt to explain trend in deaths observed over the past seven years.

3.3 Key Findings of People Experiencing Homelessness in Illinois, 2017-2023

3.3.1 DEMOGRAPHICS OF PEOPLE EXPERIENCING HOMELESSNESS

- A total of 2,996 deaths involving people experiencing homelessness (PEH) were identified in the Illinois statewide vital records. The average age at the time of death was almost 20 years younger than the general Illinois population (55.5 vs 74.2 years old).
- In addition to the nearly 3,000 deaths, a total of 1,824,004 hospital visits involving 75,145 people experiencing homelessness were identified in the Illinois statewide hospital records for 2017-2023, with 12.0% (219,234) of the visits coded with Z59 (the ICD-10 code for homelessness). While 75,145 people had homelessness coded during at least one hospital visit in this seven-year period, hospital staff did not code their housing status as homeless during the vast majority of their hospital visits.
- PEH seeking hospital-based medical care and those who died were predominantly middle-aged (mean age 45 years during hospital visits and 56 at time of death), male, non-Hispanic White, and non-Hispanic Black.

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- 313 PEH decedents were identified as veterans on their death records. Additionally, 30 decedents had been employed in public sector jobs, of which seven were former police officers, two were paramedics, and one was a correctional officer.
 - Consistent with prior research, PEH decedents in Illinois have signs of greater social isolation relative to the general population.

3.3.2 GEOGRAPHIC AND TEMPORAL PATTERNS

- The majority of deaths and hospital visits occurred within urban counties (94.8% and 86.6% respectively), with PEH living in greater Chicagoland (IDPH Westchester Region that includes Suburban Cook and the city of Chicago) having the highest representation. However, PEH deaths and hospital visits have been identified in every region of Illinois.
- Hospitals in rural counties had 171,541 hospital visits involving PEH. The characteristics and medical needs of PEH decedents and those seeking hospital care varied across IDPH and CoC regions. This illustrates the need to tailor interventions to the local level.
- Compared to the general Illinois population, PEH disproportionately died in outdoor or in other informal settings, such as abandoned buildings (19.6% vs. 0.6%), with 89 deaths occurring on public transportation, most of which occurred on trains or in train stations. There was a marked increase in the number of public transportation deaths in 2022 and 2023.
- The trend in deaths of PEH increased significantly from 2017 to January of 2022 but began to significantly decline since May 2022 ($p < 0.001$), though overall PEH mortality is still above baseline levels from prior to the COVID pandemic. In addition, there was a surge in PEH deaths at the end of 2023, starting in November. It is unclear if the surge in deaths has persisted into 2024.

3.3.3 HEALTH ISSUES AND RELATED OUTCOMES

- Coinciding with the younger age of death, a lower proportion of PEH died from chronic health conditions associated with the aging process, such as diseases of the circulatory, respiratory, and nervous systems, or cancer. However, compared to the general population, PEH disproportionately died from drug-related overdoses (39.3% vs 4.9%), traumatic injuries (11.3% vs 5.6%), and excessive cold (3.7% vs 0.1%).
- The most common comorbidities noted for PEH hospital patients included hypertension, chronic pulmonary disease, substance use disorders, psychoses, and depression.
- There was almost three times the proportion of PEH murdered compared to the general population (3.1% vs 1.1%). Compared to all PEH deaths, PEH who were murdered were disproportionately 44 years or younger and non-Hispanic Black. There were 29,483 hospital visits to treat PEH for injuries caused by assaults.
- There were 56 suicides and 19,651 suicide attempts involving PEH over seven years. The proportion of deaths attributed to suicide is marginally higher than what was identified in the general population.
- Approximately 15-20% of visits, depending on type and coding, were injuries. The vast majority were classified as accidental injuries. In both death records and hospital visits, PEH disproportionately suffered unintentional injuries, such as falls and from transportation-related incidents in which PEH were primarily injured as pedestrian roadway users.
- 112 PEH had cold exposure identified as a contributing cause of death with an additional 6,930 cold injuries treated in the hospital setting. The findings demonstrate that a proportion of cold injuries occur at temperatures when many municipalities do not have expanded emergency shelter services for extreme cold weather (typically below 32°F).

3.3.4 HEALTHCARE UTILIZATION AND RELATED OUTCOMES

- There was a median of 14 hospital visits per person over these years. The pattern of utilization is characterized by long periods with few hospital visits, followed by brief intensive periods of high hospital utilization. During the years a person had at least one visit coded for homelessness, they had an average of 6.8 ED visits and 2.4 admissions. By comparison, during the years the same person had no visits coded for homelessness, they had an average of 1.6 ED visits and 0.4 admissions.
- People experiencing homelessness who were high utilizers of medical care in the hospital setting were disproportionately diagnosed with an array of serious cardiovascular, respiratory, neurologic, and renal disorders, as well as psychiatric and substance use conditions. Chronic conditions are exacerbated during periods of homelessness because of inadequate access to medical

care necessary to manage these chronic conditions.

- The majority of PEH were discharged to home or self-care. For PEH, this may be a discharge to a shelter or the streets, which may result in difficulty accessing continued care or treatment, as amenities available to adequately control chronic health conditions may not be available in these settings.

3.4 Recommendations

This report would not be possible without the use of data. Even with this data, we acknowledge that homelessness in Illinois is still undercounted due to disconnected data sources that fail to capture the full experience of individuals navigating multiple systems. This gap prevents us from fully understanding who is experiencing homelessness, why this occurs, and what resources are required to make homelessness rare, brief, and non-recurring.

Data is essential to understanding the complexities of homelessness and helps us get closer to identifying the true number of people who are experiencing it. Adopting a multi-agency, multi-sector approach to expand and integrate data sources supports the building of a comprehensive system that prioritizes improved data, while minimizing the need to increase data collection, which can be burdensome to the individuals included and the systems that support it.

Addressing homelessness through a public health lens requires strengthening data infrastructure and removing systematic barriers to care to advance health equity. By doing this, we can develop policies that prevent premature mortality, reduce negative health outcomes, and create pathways to housing stability. The recommendations below are essential steps. Accurate, up-to-date data shared in real time forms the foundation for well-informed and effective policy solutions.

- Work to enhance the identification and documentation of individuals experiencing homelessness within healthcare settings.
- Integrate broader data sources to enrich understanding of homelessness demographics and service utilization.
- Evaluate the feasibility of establishing a mortality review board for individuals experiencing homelessness.
- Conduct a statewide warming center access assessment.
- Explore opportunities to gather housing status at death.
- Develop and implement a provider engagement strategy.

3.5 Conclusions

The demographics of PEH decedents were similar to PEH patients treated in the hospital setting. This indicates that a similar group of PEH was identified in both the vital records and the hospital data. For those individuals identified as experiencing homelessness, data were unavailable regarding the duration or frequency of unstable housing. A proportion of the people included in this analysis likely experienced homelessness only for part of the seven years. However, research shows that there are persistent adverse health effects associated with episodic or short-term homelessness (Oppenheimer 2016). More importantly, early access to general health and psychiatric services, as well as housing programs, has been shown to be associated with reduced morbidity and mortality in people experiencing homelessness. Improved surveillance data of mortality and health care utilization patterns of PEH can inform policies that address unstable housing or homelessness, reemployment and healthy work, and the health care needs of PEH.

Building on existing research, this report documents severe health inequities between people experiencing homelessness in Illinois and other residents. This population experiences a high burden of mortality and morbidity, specifically related to life expectancy, the burden of chronic disease, accidental and violent injury victimization, substance use, and cold-related mortality. Through research into morbidity and mortality data, the goal was to shine a light on opportunities to improve systems of care for people experiencing homelessness in the state. It is important to understand that homelessness is not inevitable, but rather is driven by structural forces, such as housing costs and gaps in safety net programs. This report can aid in identifying avenues to improve the health of people experiencing homelessness, which should seek both to strengthen systems of care for PEH and to change the conditions that drive housing instability and homelessness. People experiencing homelessness are human beings first, and the numbers reported here reflect lived experience. Advocates and practitioners have long understood that homelessness is a public health issue, and housing is a health-promoting intervention.

3.6 How to Use this Report

The Illinois Homelessness Mortality and Morbidity Report is intended to be used by local health departments, Continuums of Care, housing service providers, medical professionals, community health organizations, legislators, and academic institutions to guide policymaking, planning, evaluation, data collection, research, and service delivery. The focus of the report is intentionally broad because people experiencing homelessness have diverse health and housing needs. While all of the content is important, we understand that individual stakeholders' needs and interests are often specific. This year, we have structured the report by key themes to make it easier for readers to navigate to key issues that are relevant to them.



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