

ASK & CODE:

Documenting Homelessness Throughout the Health Care System

October 25, 2016

WHY THIS ISSUE?

- People who are homeless have **greater health care needs** & use health care services at higher rates
- Housing status is an **important factor in clinical decision-making**
- **Social determinants of health**—like lack of housing—are increasingly a focus in health reform changes
- **Value-based reimbursements** are beginning to include patient risk factors, population health status, and outcome measures
- **Greater insurance coverage** through Medicaid expansion
- **Data and coding** are required for billing, as well as important to payers, public health goals & policy initiatives

SPEAKERS TODAY

- **Tracy Olsten**, CPC, CPC-I, CPMA, Senior Coding Specialist, Colorado Coalition for the Homeless, Denver, CO
- **Brett Feldman**, MSPAS, PA-C, Director, Street Medicine, Lehigh Valley Health Network, Allentown, PA
- **Jenny Ismert**, Vice President Health Policy, UnitedHealthcare Community & State
- *Moderator:* **Barbara DiPietro**, PhD, Senior Director of Policy, National HCH Council

ICD-10-CM Z Series:

Factors influencing health status & contact with health services

Z55-Z65 Series: Persons with potential health hazards related to socioeconomic & psychosocial circumstances

Z59 Series: Problems related to housing & economic circumstances

Z59.0 = Homeless

ASKING & CODING

- **Common questions:**
 - How to ask the question? What counts as “homeless”?
 - How to make time amid many screenings and questions?
 - Where to insert the answer in the EHR?
 - What to say to the patient/client in response?
 - What if the patient doesn’t want to say due to stigma?
 - Will coding for housing status benefit—or complicate—billing?
- **Strategies:**
 - Add housing status fields to the HER (not open text!)
 - Assess utility of homeless data
 - Implement formal procedures for asking & coding
 - Train staff

RATIONALE

- Targeted interventions using coding data that improve health, lower costs, and improve outcomes
 - **Supportive housing**
 - **Medical respite care**
 - **Frequent user initiatives**
 - **Health Homes**
- **New Resource:** [Policy brief on “Ask and Code”](#)

Colorado Coalition for the Homeless



Serving the homeless community in the Denver Metro area



Who Are We?

“We create lasting solutions to homelessness by addressing not only emergency needs, but also by dealing with the underlying issues facing our clients and communities.”

—John Parvensky, President



The Colorado Coalition for the Homeless has been helping the homeless for more than 30 years. We consider the definition of homelessness to be anyone who lacks a fixed, regular or adequate residence.



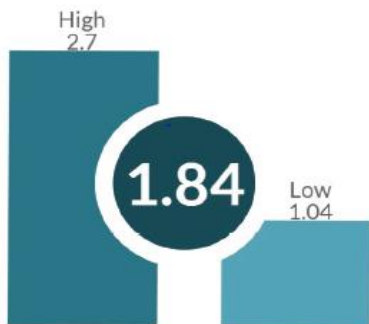
A Little History

Homeless = VERY sick people

- Let's face it, people living on the street without sanitary conditions and stable housing have a harder time taking care of chronic medical conditions, are susceptible to various pneumonia's, TB and other medical conditions a housed person may not encounter.
- These individuals may not seek medical care on a consistent basis because they are transient



HOW DO YOU SHOW THE COMPLEXITY OF SUCH INDIVIDUALS?



Documents services provided

On average, Colorado CHC claims only contain 1.84 lines per claim, likely under reporting what is actually done during an encounter.

How this impacts Colorado's CHCs:

- KPI payments in the ACC are reliant on claims accurately reflecting procedures done.
- Colorado Access and its network of providers, including CHCs, are under pressure to improve poor performance on well-child visits.
- Payers don't have access to more complete data that may be embedded in EHRs - if its not captured through claims, it didn't happen.



Demonstrates medical necessity

61% of CHC Medicaid claims YTD only contain one line per claim.

How this impacts Colorado's CHCs:

- HCPF data shows CHC patients are less complex/sick than those of private payers due to incomplete diagnosis and CPT coding.
- Creating an actuarially sound new payment system in Medicaid requires sound claims data.
- CHPA's ability to negotiate performance based contracts with private insurers depends on CHC performance on patient care measured by claims.



What Are We Doing?

- Mobile Clinic for medical services on the go
- Shelter Examinations
- TB Clinics
- Integrated Services
 - Medical
 - Behavioral Health
 - SUD Services
 - Vision Services
 - Dental Services
 - Pharmacy
 - Physical Therapy
 - Respiratory Therapy



How Are We Reporting This?

- Diagnosis Codes to identify clients that are at a high risk based on their residence status
 - Z59.0 Homelessness
 - Z59.1 Lack of Housing

RULES AROUND THE CODE

1. Can never be used as a primary code.
2. All medical conditions need to be listed first
3. Homeless status needs to be documented in the medical record



Who Does It Benefit?

- CMS- Centers for Medicare/Medicaid Services
- State of Colorado Medicaid
- Coalition for the Homeless
 - Reporting mechanism
- The Patient
- Quality Measures



Mending the Holes in Your Safety Net

Screening for Homelessness in the Emergency Department

Brett J. Feldman, MSPAS, PA-C

Director LVHN Street Medicine

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610-402-CARE LVHN.org

Why the Holes?

- **Difficulty with.....**
 - **Defining Homelessness**
 - **Identifying the Homeless**
 - ED Implementation of Screening
 - Developing Efficacious Response

Defining Homelessness

- Department of Health and Human Services (HHS)
 - individual who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle
 - “doubled up,” a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members.
 - released from a prison or a hospital may be considered homeless if they do not have a stable housing situation to which they can return.

(HRSA/Bureau of Primary Health Care, Program Assistance Letter 99-12, Health Care for the Homeless Principles of Practice)

Defining Homelessness

- U.S. Department of Housing and Urban Development (HUD)
 - lacks a fixed, regular, and adequate nighttime residence, which includes a primary nighttime residence (**shelter**, **street**)
 - Individual or family is being **evicted within 14 days** from their primary nighttime residence
 - Has **moved two or more times in the 60 days** immediately prior to applying for assistance
 - also includes other markers of chronic housing instability
- (https://www.hudexchange.info/resources/documents/HEARTH_HomelessDefinition_FinalRule.pdf)

Defining Homelessness

- U.S. Department of Housing and Urban Development (HUD)
 - Does NOT include:
 - Living with relatives or friends
 - Being discharged from an institution which is required to provide or arrange housing upon release

Veterans Administration Screening

- **2 or more moves** due to economic reasons during the past **60 days**
- Living in the **home of another** due to economic reasons
- Has been notified in writing that right to **occupy** current housing or living situation will be **terminated** within 21 days
- Lives in a **hotel/motel**
- Is exiting an **institution without a stable housing plan**

(www.va.gov)

LVHN ED Screening Tool

In the last 60 days have you:

1. Been concerned about losing your housing?
2. Changed residences more than twice?
3. Lived with a friend or family member you do not normally reside with due to financial hardship?
4. Faced eviction or have been evicted from your current living situation?
5. Slept outside, in an abandoned building, your car, in an emergency shelter or a motel due to financial hardship?

What is the Denominator?

Identifying ALL the homeless

Studies Identifying the Homeless

- Kushel, M.B., Perry, S., Bangsberg, D., Clark, R., Moss, A.R. **Emergency department use among the homeless and marginally housed: results from a community-based study.** *Am J Public Health*. 2002;92:778–784.
 - Individuals in **homeless shelters**, Day-time free meal programs (**soup kitchens**), and low rent apartments
 - ED usage was **self reported**
- Ku, B.S., Scott, K.C., Kertesz, S.G., Pitts, S.R. **Factors associated with use of urban emergency departments by the U.S. homeless population.** *Public Health Rep*. 2010;125:398–405.
 - Used National Hospital Ambulatory Care Surveys (NHAMCS-ED)
 - “Patient Residence” item contained a check box for “homeless”
 - Of surveys, only 0.6% qualified
 - Other available check boxes were “Other Institution,” and “Other Residence”

Studies Identifying the Homeless

- Sadowski, L.S., Kee, R.A., VanderWeele, T.J., Buchanan, D. **Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: a randomized trial.** *J Am Med Assoc.* 2009;301:1771–1778.
 - Included **only inpatients**
 - Homeless defined as those “**without stable housing** (housing for which a person has adequate resources and for which there are no time limits) during the 30 days prior to hospitalization”
- Bon S. Ku, Fields, J.M., Santana, A., Wasserman, D., Borman, L., and Scott, K.C. **The urban homeless: Super utilizers of the Emergency Department.** *Pop Health Management*, 2014.
 - Homeless **self- identified**, **local shelter address**, or **ED staff identified** known pt
 - Only 15% of homeless self-identified

Prospective validation of a predictive model that identifies homeless people at risk of re-presentation to the emergency department.

[Australas Emerg Nurs J.](#) 2012 Feb;15(1):2-13. doi: 10.1016/j.aenj.2011.12.004. Epub 2012 Jan 31.

- Homelessness defined as:
 - Living on the streets
 - In crisis accommodation
 - Boarding houses
 - Unstable housing

Study Findings Related to Screening

- 2,888 individuals screened
 - 7% total patients were identified as homeless
 - 10% of all ED visits
 - 43% re-presented to ED within 28 days
 - Who Identified the Homeless?
 - Clerical staff 18%
 - ALERT 8.1%
 - Researchers 73.9%

*ALERT: Admission, Liaison, Early Referral Team provides care coordination to people with complex care needs, such as homeless individuals.

Implementing a Screening Tool for Homelessness at LVHN: A Pilot Project

- GOALS:
 - Estimate prevalence in the ED
 - Projection of Utilization Patterns
 - Projection of Cost
 - Ultimately justify/ inform needed resources

Prevalence by Site

SITE	At Risk %	Homeless %	Total %
17th	4%	14%	18%
CC	3%	5%	8%
MHC	3%	6%	9%

N=4,499 total pts meeting inclusion criteria

Collateral Benefits

- ED providers have changed treatment plan based on housing status
- Overall greater awareness of social determinants of health
- Presence of researchers caused awareness, facilitating Street Medicine Consults
- **Avg. consult decrease from Hospital Day #5 to Day #0!!**

Street Medicine Action Plan

- Widespread screening in urban location and in community clinics
- Homeless Hotline
- Nurse Triage of consults and care coordination
- Increased Street Medicine resources including staff to meet volume

Unanswered Questions

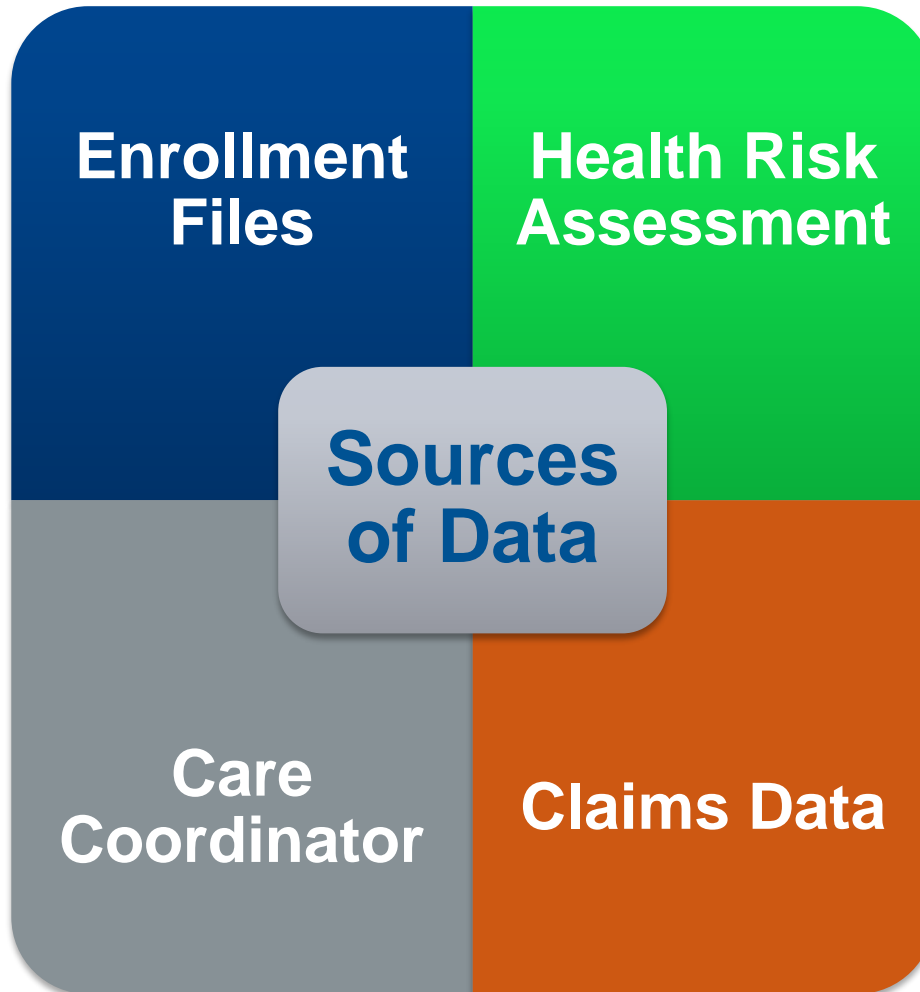
- Who “owns” definition of homelessness?
- How do we study this population to include in homeless research?
- How does this “new” homeless population access/ utilize healthcare?
- What aspects of street medicine still apply?



ICD-10 Coding for Social Determinants of Health – Why It Matters

Jenny Ismert, Vice President, Health Policy

Unlocking Power of Data



ICD 10 SDOH

- Allows for refinement in engagement strategy and services
- Provides a more complete picture of individual's needs and circumstances
- Deepens understanding of network and system strengths and weaknesses
- Facilitates future investments if efficacy can be demonstrated

Why Data Matters to Providers

Patient Benefits

- Better linkages to services
- Fosters addressing root cause of issues
- Decreased assessment fatigue

Practice Benefits

- More complete picture of individuals being served
- Provides proof points
- Demonstrates complexity of patient population panels
- Supports opportunities for unique partnerships or payment models

System Benefits

- Demonstrating ROI fosters Medicaid program design that supports improved outcomes
- Uncovers needs, gaps and best practices

Opportunities

Understand how significantly ICD-10 codes are being underutilized

Training to increase awareness of ICD-10 and value

Develop pilots and collaborations informed by data

Support providers in the “now that I know, now what” situation

Questions?

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QUESTIONS?

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