Discharge Planning for Homeless Patients
Mid-Year Updates

May 29, 2019

Welcome

Jaime Welcher
Education Program Manager
California Hospital Association
Guidebook: Discharge Planning for Homeless Patients

CHA’s latest guidebook includes valuable checklists and sample forms, and:
• Describes the required elements of a homeless patient discharge planning policy
• Details how to implement the plan throughout the facility
• Covers what to expect regarding enforcement

Go to www.calhospital.org/free-resources for a copy.

Faculty

Peggy Broussard Wheeler serves as vice president of CHA’s Rural Health & Governance. She is responsible for developing, advocating and executing public policies, legislation and regulations on behalf of small and rural hospitals at the state and national levels. In addition, she serves as the issue manager for language access, governance, prison and homeless issues.
Trini Juarez RN, MBA, BSN, Associate Chief Nursing Officer at Salinas Valley Memorial Hospital (SVMH). Trini has 40 years’ experience as a Registered Nurse and over 30 years of leadership roles in all service lines within an acute care hospital including the most recent addition to Integrated Care Management Services at SVMH.

Troy Scott RN, MBA, BSN is the Care Coordination Specialist for Salinas Valley Memorial Hospital. In this role, he works with leadership on developing the strategic direction for hospital case management, as well as maximizing organizational improvement, efficiencies and the equity and value of health care delivery. Troy has extensive experience in quality improvement in both acute and post-acute care. He is in the final year of a graduate program in Quality and Patient Safety at Johns Hopkins University.
Introduction

- Growing problem of homeless patients
- Media reports
  - Limited ability to set the record straight due to medical privacy laws
- Legislation – where we started and where we ended

Which Hospitals Must Comply?

- General acute care hospitals
  - Includes critical access hospitals
- Acute psychiatric hospitals
- Special hospitals (maternal/dental)
- Not hospitals operated by the state of California
**Effective Dates**

- Most provisions: January 1, 2019
- Requirement for written plan to coordinate with community partners: July 1, 2019
- Homeless patient log: July 1, 2019

**Elements of the Written Policy**

- Purpose of policy: “to help prepare homeless patient for return to community by connecting him or her with available community resources, treatment, shelter, and other supportive services”
- Provide information about discharge to patient in a culturally competent manner (this is already required by law, may wish to say it again in homeless part of policy to satisfy surveyors)
Elements of the Written Policy (cont.)

- An individual discharge plan must be prepared for each homeless patient
- “Discharge planning will be guided by the best interests of the homeless patient, his or her physical and mental condition, and his or her preferences for placement”
- How to identify a post-discharge destination for each patient
- Maintain homeless log (by July 1, 2019)

Elements of the Written Policy (cont.)

- Services that must be offered to the homeless patients prior to discharge:
  - Physical exam/determination of stability for discharge (already required by EMTALA)
  - Referral for follow-up care (medical, behavioral)
  - If follow-up behavioral health care is required, contact health plan or primary care provider or other provider (including entry into coordinated entry system) if applicable
  - Meal
  - Weather-appropriate clothing
Elements of the Written Policy (cont.)

- Services that must be offered to homeless patients prior to discharge (continued)
  - Discharge medications
  - Infectious disease screening
  - Vaccinations
  - Transportation (30 miles/minutes)
  - Screen/enroll in affordable coverage, if any

*Note: Patient can decline offered services; see CHA sample documentation form in guidebook.*

Identifying Post-Discharge Destination

Identify a destination:

- **Social services agency, nonprofit social services provider, or governmental services provider** that has agreed to accept the patient
  - Must document name of person who agreed to accept the patient
  - Must send written/electronic info about post-discharge health and behavioral health needs
Identifying Post-Discharge Destination (cont.)

- **Homeless patient’s “residence”** – is “the location identified to the hospital by the patient as his or her principal dwelling place”
- **An alternative destination** as indicated by the homeless patient

Document well! Be prepared for “decline to state.”

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Coordinating Services/Referrals with Community Partners

- By July 1, 2019, hospitals must implement a written plan for coordinating services and referrals for homeless patients with available:
  - County behavioral health agency
  - Health care and social services agencies in the region
  - Other health care providers
  - Nonprofit social services providers
Coordination Plan

- Must include a list of local homeless shelters
  - Hours of operation
  - Admission procedures/requirements
  - Population served
  - General scope of medical and behavioral health services available
  - Contact information for intake coordinator
- Referral procedures
- Training protocols for discharge planning staff

Log of Patients Experiencing Homelessness

Effective July 1, 2019
- Maintain a log of homeless patients discharged; and
- The destinations to which they were released after discharge:
  - Shelter that has agreed, in advance, to accept the patient
  - Homeless patient’s “residence”
  - Alternate destination indicated by the patient
Documentation of Compliance

Effective July 1, 2019

- Maintain evidence of completion of the homeless patient discharge protocol
  - In the log; or
  - In the patient’s medical record

Identifying Patients Experiencing Homelessness: OSHPD Data

- Must use ZIP code “ZZZZZ” for homeless patients
  - For inpatient discharges, this has been required since at least 2015
  - For emergency, ASC, outpatient: required starting with 2019 data
- Don’t confuse this with unknown ZIP code (XXXXX) or foreign (YYYYY)
ICD-10-CM Coding for Social Determinants of Health

- ICD-10-CM codes Z55-Z65 allow hospitals to capture social determinants of health (SDOHs)
- Effective 2/18/18, any clinician involved in the care of the patient can document SDOHs, including case manager, discharge planner, social worker (previously, only MD)
- Useful for population health management

ICD-10-CM Coding for Social Determinants of Health (cont.)

- Z59: Problems related to housing and economic circumstances, including:
  - Homelessness
  - Discord with neighbors/lodgers/landlord
  - Lack of food/safe drinking water
  - Extreme poverty
  - Low income
  - Other
- Not limited to homelessness
ICD-10-CM Coding for Social Determinants of Health (cont.)

Other codes for problems related to:
- Education/literacy
- Employment/unemployment
- Occupational exposures to risk factors
- Social environment
- Upbringing
- Primary support group/family
- Other psychosocial
- Criminal justice involved (victim/perpetrator)
- Exposure to disaster, war
SVMHS Hospital District

Monterey County
- Demographics
  - 426,000 residents
  - 55% Latino
  - $60,000 median household income

Sallinas
- Demographics
  - 220,000 residents in Hospital District
  - 75% Latino
  - $50,000 median household income

Our Vision
The vision of Salinas Valley Memorial Healthcare System is to be a center of excellence where an inspired team delivers compassionate and culturally sensitive care, outstanding quality, and an exceptional patient experience.

Our Mission
The mission of Salinas Valley Memorial Healthcare System is to provide quality healthcare for our patients and to improve the health and well-being of our community.
Monterey County Homeless

HOMELESS IN MONTEREY COUNTY


Monterey County Homeless

Total Homeless Population: 2,837

26% Sheltered
74% Unsheltered

Salinas Homeless Encampment

Low Income Housing
SVMH Homeless Visits to the Emergency Department 2018

2018 ER Arrival by Time

SVMH Homeless Visits 2018

Homeless Visits 2018

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CHA provided the following recommendations:
Task 1: Establish a Task Force
Task 2: Inform the Task Force
Task 3: Identify the Homeless Patients
Task 4: Determine Meal Plan
Task 5: Weather-appropriate clothing
Task 6: Provide for Discharge Medications
Task 7: Infectious Disease Screening or Referral
Task 8: Vaccination Plan
Task 9: Transportation-30 minutes/30 miles
Task 10: Screening for Affordable Health Coverage

Program Development

2018
- Formed a multidisciplinary team to interpret SB 1152 with Key Stakeholders/Department Leads
- Key stakeholders identified best practices and department processes to ensure compliance with SB 1152 regulations and to ensure needs of this population are being met
- Project Management Plan developed with action steps and milestones
July 1st 2019

Written Log

- Each hospital shall maintain a log of homeless patients discharged and the destinations to which they were released after discharge

- The hospital shall maintain evidence of completion of the homeless patient discharge protocol in the log or in the patient’s medical record
Starting July 1, 2019, each hospital is required to maintain a log of homeless patients discharged and the destinations to which they were released.

**Program Development/Opportunities**

**July 1st 2019**

A hospital shall develop a written plan for coordinating services and referrals for homeless patients including:

- A list of local homeless shelters, including their hours of operation, admission procedures and requirements, client population served, and general scope of medical and behavioral health services available.

- The hospital’s procedures for homeless patient discharge referrals to shelter, medical care, and behavioral health care.
Program Development/Opportunities

Outreach to Homeless Agencies/Program

• Whole Person Care
• Dorothy’s Place
• Hospital Council meetings with regional Vice President Jo Coffaro
• The Coalition of Homeless Service Providers
• Medical Respite Center
• Salinas CAT Team

SVMH Homeless Visits 2018

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*Forecast
Speaker Contact Information

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Questions?

Online questions:  
Type your question in the Q & A box, press enter

Phone questions:  
To ask a question, press *1
Explaining County Mental Health and Substance Use Disorder Services and Funding
June 13, 2019
1:30-3:30 p.m.

CHA’s webinar, *Explaining County Mental Health and Substance Use Disorder Services and Funding*, will describe the variety of funding counties use so that hospitals can collaborate to improve the delivery system for individuals with behavioral health conditions (mental illness or substance use disorders).

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Behavioral Health Care Symposium
December 9-10, Riverside (Livestreaming Available)

Discharge Planning for Homeless Patients Summit
December 11, Riverside (Livestreaming Available)
Thank you for participating in today’s webinar. An online evaluation will be sent to you shortly.

For education questions, contact Jaime Welcher at (916) 552-7527 or jwelcher@calhospital.org.