



SEPTEMBER 2015

Improving Care for Medicaid Beneficiaries Experiencing Homelessness: Handout #4 - for health plans and health care providers

HOW TO SCREEN MEDICAID BENEFICIARIES TO IDENTIFY THOSE WHO ARE EXPERIENCING OR AT RISK OF HOMELESSNESS

Some experts on the connections between housing and health have suggested that housing or homeless status is a “vital sign” and should be integrated into health risk assessments and other routine screening when vulnerable patients (including extremely low income children and people with disabilities) come in contact with health care providers.

A few relatively simple questions about where people are living now, and where they have been living in the past two months, or how often they have moved within the last 6 months, could help to identify Medicaid beneficiaries and health plan members who are currently homeless, as well as those at high risk of becoming homeless. People who have moved two or more times in the past 6 months are at risk of homelessness if they have incomes below the poverty level and limited social support networks (family or friends) who can provide assistance.

Nationwide, VA Medical Centers have begun to implement a routine screening for all veterans who receive outpatient care at VA medical facilities throughout the country. **The VA’s screening questions are on the last page of this document.** The VA’s screening tool could be adapted by health plans, hospitals, and other health care providers, and used to help identify persons who are homeless or imminently at risk of becoming homeless. For more information see:

<http://www.endveteranhomelessness.org/content/universal-screening-homelessness-and-risk-among-veterans-monitoring-housing-stability-and>

1. Using address information to identify Medicaid beneficiaries or health plan members who are homeless

Often state Medicaid data systems do not contain information about beneficiaries’ homelessness, and health plans often do not receive data from the state that identifies members as homeless. Some states may be using information provided at the time of enrollment to identify beneficiaries who are (or have been) homeless.

Mailing address information can be used to identify people who are likely to have been homeless at the time they enrolled in Medicaid. People who are experiencing homelessness often use the mailing address of a clinic, homeless shelter, drop-in center, county welfare department, mental health

ABOUT STATE HEALTH AND VALUE STRATEGIES

State Health and Value Strategies, a program funded by the Robert Wood Johnson Foundation, provides technical assistance to support state efforts to enhance the value of health care by improving population health and reforming the delivery of health care services. The program is directed by Heather Howard at the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit statenetwork.org.

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service provider, or treatment program. A state or a health plan may be able to compile a list of these addresses and use them to identify people who are likely to be homeless or experiencing housing instability.

In addition, hospitals, clinics, and other health care providers often use a zip code such as 99999, XXXXX, or ZZZZZ in the address for patients who are identified as homeless at the time they receive care. When address information is included in encounter data, health plans or Medicaid agencies may be able to search for encounters with one of these zip codes, to identify some of their members who are homeless.

2. Screening to identify the most vulnerable homeless members, and those most likely to have avoidable use of high-cost services

Among people who experience homelessness, some are more highly vulnerable than others, and a small group of individuals use health care and other public services in ways that are extraordinarily costly. These are the people for whom more effective interventions, including services and supports that connect people to housing are most likely to have a very big impact on health outcomes and service utilization/costs.

- **High levels of vulnerability** are often assessed with a standardized triage tool such as the Vulnerability Index & Service Prioritization Tool (VI-SPDAT), which has been used in many communities nationwide. There are two tools—the Individual VI-SPDAT and the Family VI-SPDAT, which can be administered by social workers, outreach workers, or trained volunteers.

These tools are being used in communities to match homeless people to the most appropriate assistance to meet their needs, and to prioritize the most vulnerable people for available housing resources. For more information see:

<http://www.orgcode.com/product/vi-spdatt/>

- **Frequent users** of high cost hospital inpatient and emergency room services, and other public services are often identified based on a history of service utilization or a predictive algorithm that uses available data to predict the likelihood of future service utilization and avoidable costs. Some health plans use proprietary algorithms to identify these members. Here is a link to a tool some hospitals are using to identify and link these homeless patients to programs that offer services linked to housing opportunities:

<http://economicrt.org/publication/crisis-indicator/>

The U.S. Department of Housing and Urban Development (HUD) has provided guidance to encourage recipients of federal funding for permanent supportive housing for homeless persons to give first priority to persons with the most severe service needs, instead of using a “first-come, first-served” approach to providing housing assistance.¹ These standardized assessment tools are one way to identify homeless persons with severe service needs, who may be given priority for housing, consistent with the HUD guidance. The identification of homeless persons with severe services may also be based upon criteria used by a state Medicaid department to identify high-need, high-cost beneficiaries.

Endnotes

¹ See <http://portal.hud.gov/hudportal/documents/huddoc?id=14-12cpdn.pdf>

This HUD guidance specifies that severe service needs should be identified and verified through data-driven methods such as an administrative data match or through the use of a standardized assessment tool. The determination must not be based on a specific diagnosis or disability type, but only on the severity of needs of the individual.

VA Homelessness Screening Clinical Reminder

Screen not performed:

- Already receiving homelessness services or assistance *
- Long-term resident of Nursing Home/Long-Term Care Facility
- Declines screening at this time
- Veteran/Caregiver unable to answer

1. In the past 2 months, have you been living in stable housing that you own, rent, or stay in as part of a household?

- Yes, living in stable housing → Proceed to question 2
- No, not living in stable housing → Proceed to question 3 **POSITIVE FOR HOUSING INSTABILITY**

2. Are you worried or concerned that in the next 2 months you may NOT have stable housing that you own, rent, or stay in as part of a household?

- Yes, worried about housing in the near future → Proceed to question 3 **POSITIVE FOR RISK**
- No, not worried about housing in the near future → Reminder completed **NEGATIVE**

3. Where have you lived for MOST of the past 2 months?

- Apartment/House/Room – no government subsidy
- Apartment/House/Room – with government subsidy
- With Friend/Family
- Motel/Hotel
- Hospital, Rehabilitation Center, Drug Treatment Center
- Homeless Shelter
- Anywhere outside (e.g., street, vehicle, abandoned building)
- Other * _____

4. Would you like to be referred to talk more about your housing situation?

- Patient agrees to referral
- Patient declines referral at this time – given information for future reference

What's the best way to reach you?

How to reach: _____

* When adapting the VA screening tool for use by a health plan or health care provider, this should be modified so that if a member/patient is already receiving homelessness services, screening would be completed and information about the current assistance / service provider(s) would be noted.