Social determinants of health: Homelessness

Coding homelessness

The ICD-10-CM official guidelines for coding and reporting state, "For social determinants of health (SDOH), such as information found in categories Z55-Z65, persons with potential health hazards related to socioeconomic and psychosocial circumstances, code assignment may be based on medical record documentation from clinicians involved in the care of the patient who are not the patient's provider since this information represents social information, rather than medical diagnoses."

Patient self-reported documentation may also be used to assign codes for social determinants of health, as long as the patient self-reported information is signed off by and incorporated into the health record by either a clinician or provider.

SDOH diagnosis codes are one of the few tools that are shared collectively to measure and evaluate SDOH on a national scale. Providers should submit corresponding Z codes for potential hazards identified that may impact the health status of the member. SDOH codes are represented in ICD-10-CM code categories Z55-Z65, *persons with potential health hazards related to socioeconomic and psychosocial circumstances*.

Codes in category Z59, *problems related to housing and economic circumstances*, include the following:

- Z59.0 Homelessness
- Z59.1 Inadequate housing
- Z59.2 Discord with neighbors, lodgers and landlord
- Z59.3 Problems related to living in residential institution
- Z59.4 Lack of adequate food and safe drinking water
- Z59.5 Extreme poverty
- Z59.6 Low income
- Z59.7 Insufficient social insurance and welfare support
- Z59.8 Other problems related to housing and economic circumstances
- Z59.9 Problem related to housing and economic circumstances, unspecific

Consistent use of the ICD-10-CM code Z59.0 increases opportunities to compare data across systems and raise providers' attention to a high-risk acuity factor as patients move within and across systems.

Asking about homelessness

People without homes may not identify themselves as **homeless** due to stigma, pride, safety concerns, shame, or the thought that a temporary living arrangement is **home**. When asked for an address, people without homes of their own often provide one that belongs to a friend or relative, a shelter, or a previous residence. Places where people stay might change daily as individuals and families move between shelters and/or temporary stays with friends or family.

It is also possible that bad experiences seeking healthcare in the past will prevent someone from self-disclosing homelessness for fear of being treated poorly. There is no common methodology for asking about housing status in healthcare settings, and different organizations have adopted various practices to determine

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homelessness. These usually involve a short series of questions or multiple-choice questions about the patient's current living situation.

Question	Response options	Result indicator	ICD-10 codes
What is your living situation today?	I have a steady place to live.	N/A	N/A
	I have a place today, but I am worried about losing it in the future.	Housing	Z59.8 Other problems related to housing and economic circumstances Z59.1 Inadequate housing
	I do not have a steady place to live. (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park.)	Housing	Z59.0 Homelessness Z59.8 Other problems related to housing and economic circumstances Z59.1 Inadequate housing
	Patient chooses not to answer	N/A	N/A
Think about the place you live. Do you have problems with any of the following? Choose all that apply.	Pests such as bugs, ants, or mice	Housing	Z59.1 Inadequate housing
	Lack of heat	Housing	Z59.1 Inadequate housing
	Oven or stove not working	Housing	Z59.1 Inadequate housing
	Smoke detectors missing or not working	Housing	Z59.1 Inadequate housing
	Water leaks	Housing	Z59.1 Inadequate housing

Screening tools

Screening can be performed by RN, social worker, therapist, or a patient (patients may be more likely to disclose sensitive information when self-administered). It can be done online, via patient web portal, telephone, at check-in, or during office visit.

Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE):

- Set of national core measures
- Aligns with national initiatives prioritizing SDOH (Healthy People 2020)
- Emphasizes measures that are actionable

The PRAPARE tool is intended to be used across the general health center program, but the questions may be tailored to local needs and patient populations. It contains two questions related to housing status and housing stability.

Accountable Health Communities Screening Tool:

- CMS developed
- 10-item screening tool to identify patient needs in five domains (food security, housing, transportation, utility, and safety)
- Designed to be short, accessible, consistent, and inclusive

Health Leads:

- 10-item screening tool
- Updated language to foster meaningful/effective dialogue between providers/patients around essential needs
- Fully translated questionnaire template to remove barriers for Spanish-speaking patients

Challenges to asking

There are a few challenges to consider regarding asking about housing status:

- An additional screening tool may be difficult to incorporate in order to capture a growing number of other social concerns (e.g., intimate partner violence, behavioral health screenings, and veteran status) while still ensuring prompt access to care.
- Staff asking these questions may not have all adequate resources to help if patients ask for assistance with their housing in response to the issue being raised.
- Providers with many complex patients may prioritize their limited time in securing authorizations for services and other documentation rather than focus on coding.

Strategies to consider implementing

In determining whether and how to inquire about housing status — and enter code Z59.0 when appropriate — organizations should consider the following strategies:

- **Add fields to health records:** Add an option in the electronic health record (EHR) address area that is formatted in a searchable way (not an open text field), ensuring that this field has been integrated with the practice management system.
- **Assess utility of homeless data:** Assess the need for and potential use of information about homelessness, for reasons that could include assessing community need, individual patient care, and population-based health initiatives.
- **Implement formal procedure for asking and coding:** Determine where screening for housing status is best incorporated into the process without hindering access to care and ensure some action follows from a positive screen (e.g., flagging the condition for medical providers, or triggering referrals to case managers or social workers).
- **Train staff:** Stigma around homelessness exists even among highly trained medical professionals, who may need to be reminded to treat homelessness as a barrier to the recovery and future good health of their patients.

Telehealth can fill SDOH critical gaps:

- Episodic care for low-acuity health conditions
- Medication adjustment therapy
- Follow-up on laboratory results
- Chronic care management
- Decreased no-show rates
- Remote access to specialists in rural areas
- Counseling services when there is a transportation barrier

- Virtual outreach with housing assistance or eligibility assistance
- Health education

Conclusion

Asking about housing status and using the Z59.0 code to document homelessness in a patient's medical record is a way to identify individuals who need targeted healthcare and housing interventions, and to inform emerging payment methodologies. Implementing strategies to screen for homelessness in a variety of service settings can have both short- and long-term benefits to achieving higher quality care, improved health outcomes, and lower total costs. Standardizing coding can ensure more consistent data that is better able to inform policy and payment changes. Developing relationships with the local homeless services system may also enable better care transitions, improved health outcomes, and reduced readmission rates.

Resources:

- Health Leads, *Social Needs Screening Toolkit* (2018).
- Office of Disease Prevention and Health Promotion, HealthyPeople.gov, Social Determinants of Health.
- WI Department of Health Services: **https://www.dhs.wisconsin.gov/hw2020/index.htm**
- ICD-10-CM. Optum, 2021.