HCH UDS PILOT PROJECT 2001– 2002

A Technical Assistance Publication

prepared by

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Region IX Health Care for the Homeless
Advisory Committee

Acknowledgements

The proposed data collection process and tools described in this document were developed by the Region IX HCH Advisory Committee and field tested by pilot project participants listed on page 3. This technical assistance publication was prepared in consultation with the advisory committee by Pilot Project Committee Chair Eleanor Gray, RN, who directs the Cooperative Health Care for the Homeless Network, Northeast Valley Health Corporation, based in Los Angeles, California.

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The National Health Care for the Homeless Council is a membership organization comprised of health care professionals and agencies that serve homeless people in communities across America. The National Council works to improve the delivery of care to homeless people, and to reduce the necessity for dedicated health care for the homeless programs by addressing the root causes of homelessness.

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EXECUTIVE SUMMARY

The HCH Uniform Data System (UDS) Pilot Project was initiated in 2000 by a group of Health Care for the Homeless (HCH) project representatives in Public Health Service Region IX. This initiative was motivated by a desire to increase the capacity of the Bureau of Primary Health Care's current UDS to reflect the complexity and intensity of HCH services delivered to homeless individuals.

This technical assistance publication describes the rationale for the collection of additional data by HCH projects for inclusion in their annual UDS reports, and proposes data collection tools for this purpose that were developed and pilot tested by the HCH UDS Work Group in 2001–2002.

The document reports benefits to HCH projects that use these tools, and identifies the technical and financial resources that are required to adapt HCH information systems and data collection processes to include these additional data elements.

The goals of this initiative are to enable more realistic assessments of HCH project productivity, staff accountability, and client needs, and to provide more accurate measures of national HCH program effectiveness.

The proposed data collection tools, appended to this report, include new measures to assess different levels of care in five categories of service that are considered intrinsic to the HCH model of care: case management, mental health, substance abuse, health education, medical, nursing and outreach services.

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I. BACKGROUND AND RATIONALE

A. Introduction

The Uniform Data System (UDS) is the Bureau of Primary Health Care's (BPHC) integrated annual reporting system. It is designed to provide information to report program accomplishments and ensure compliance with legislative mandates. Over the past few years, revisions in the UDS have been made to streamline the data collection process and make it more efficient. Many Health Care for the Homeless (HCH) projects feel that important homeless program and service delivery data are not being gathered. The current UDS is simply not designed to reflect the complexity or intensity of services that HCH projects provide. The multiple and complex problems and numerous obstacles to overcoming them that people experiencing homelessness face warrant an approach to health care that goes beyond that usually provided in conventional clinic settings. The current UDS does not reflect the depth and breadth of services or the level of care that homeless individuals receive as clients of HCH providers.

In April 2000, during the National Health Care for the Homeless Conference, representatives of HCH projects in Public Health Service Region IX (Arizona, California, Hawaii, and Nevada) discussed their concerns with representatives from the Bureau of Primary Health Care. It was agreed that a special BPHC-supported task force would review, discuss and identify a process to document the services that Health Care for the Homeless programs deliver and develop a tool or process to measure their service outcomes. The goal of this effort was not to reduce data reporting requirements for HCH projects, but to specify additional information that would more accurately reflect the comprehensive services that Health Care for the Homeless projects alone provide.

The first "HCH UDS Workgroup" meeting was held in Los Angeles, October 18 –19, 2000. Participants in that meeting developed guidelines for the development of these supplemental data collection tools, which members of the HCH UDS Pilot Project produced and tested in 2001-2002.

B. Benefits of Collecting Data with HCH UDS Add-On Tables

Several programs that participated in the pilot project have continued to use the data collection tools developed by the HCH UDS Work Group within their organizations. Data collected with these tools allow HCH providers to analyze the severity level of issues faced by their clients. They also allow managers to see where staff time is spent and to define more specifically what types of work their staff is doing. With this knowledge, managers can assure that resources are available to support these services.

Some project directors state that the use of these tools has made their productivity expectations more realistic, demonstrating clearly what they had suspected all along — that more or less time is necessary for patient encounters requiring different levels of service.

Many programs that have outstationed staff continually struggle with staff accountability. The use of these tools enables staff to be more accountable for their time, and allows managers to assist staff in using their time wisely, assuring that limited resources are used for maximum benefits.

The current UDS report allows reporting of only the following enabling services: Case Management FTE and encounters, Outreach FTE, and Health Education FTE and encounters. A significant amount of time is spent performing these activities, but the level at which they are performed is not reflected in the UDS report. Many managers believe that they have historically undercounted or underreported their program's activities in the UDS report.

Overall, programs that participated in the pilot project were very pleased with having found a method of data collection that clearly defines the activities of a Health Care for the Homeless project. Managers found this information extremely helpful in preparing their budgets and staffing patterns for the following year. One HCH project states, "we love [these data collection tools] and will never go back to the 'old way' of counting our program activities!" Another program reported a 28% increase in encounters after implementing the new service documentation tools.

C. Impact on HCH Project Information Systems

HCH projects understand the importance of collecting data, both to improve the quality of their services (and the care their clients receive) and to demonstrate to others the unique nature, complexity, and importance of the services they provide to our nation's most disenfranchised populations. The commitment of HCH projects to data collection is clearly exemplified by the process summarized in this report. The reality, however, is that even minor modifications in data collection will require substantial resources, which most HCH projects do not currently have.

A small sample of HCH projects from Region IX identified the following types of resources they would need to successfully implement any addition to their current data collection processes:

Technical assistance – to modify existing data collection systems, ranging from paper-and-pencil forms to sophisticated electronic records. It should be noted that tracking data is often more complicated in HCH projects, which provide services in multiple and nontraditional settings (e.g. mobile clinics serving persons on the street or under a bridge).

Financial support – to enable HCH projects to implement additional data collection proposals. Some projects will require funds to pay a computer consultant to make the necessary changes to their management information system; others would benefit from funds for portable (laptop) computers to enable them to collect data more efficiently and effectively in the field. Any additional data collection requirements will also necessitate funding for increased staff time.

D. Work Group Objectives

The Work Group focused on *additional* data that HCH projects could collect, *not* on fundamental changes to the current UDS.

The Work Group's primary objectives were to:
- Discuss key questions we need to answer about our programs;
- Identify what data need to be collected (that are not currently being collected) to address those key questions; and
- Identify how those missing data might best be collected.

E. Summary of Current UDS Limitations for Homeless Health Care

Fundamental problems with the current UDS impel the need for these additional data:

- **Incomplete count of HCH service recipients:** Currently, no encounter data are available on homeless individuals served by HCH projects that are part of Community Health Centers (CHCs). As of October 2000, 69 of 135 HCH grantees were sponsored by CHCs; thus UDS data did not reflect the volume or type of services provided to homeless individuals by over half (51%) of HCH projects. (New programs that received funding since October 2000 were not included in this calculation.) Further, there are no data from which to determine whether and/or how required HCH services are being provided in CHC-sponsored projects. Therefore, data collected in the UDS provide only a partial picture of HCH projects, preventing comprehensive evaluation of the national Health Care for the Homeless Program. Although this problem is not addressed by the proposed add-on tables, the group felt that this issue warrants further discussion, to ensure that whatever data are collected for the UDS report reflect the services provided by all HCH projects.

- **Limited measures of HCH encounters, services, and client needs:** Homeless individuals have multiple and complex needs; they require different and more intensive services than do housed clients. The current UDS does not capture these qualitative differences in HCH services.

  ***Client encounters*:** Data collected by HCH projects serving only homeless individuals are compared with aggregate data collected by CHCs serving both housed and homeless individuals. Under the current UDS, stand-alone HCH projects repeatedly report a lower average number of encounters than do CHCs with affiliated HCH projects, but do not have the opportunity to report the greater amount of time required per encounter to provide appropriate and adequate health services to homeless clients.

  ***Services provided*:** Health care providers working in HCH projects frequently play a variety of roles to meet the needs of their clients, particularly those serving homeless individuals who distrust the healthcare system and are unwilling to accept services from a variety of providers or make multiple visits to the clinic. Under the current UDS, each provider is linked to only one type of encounter, which does not accurately reflect the way in which services are delivered in HCH projects. For example, many types of HCH providers participate in outreach and case management.

***Client needs*:** HCH providers know that many of their homeless clients have multiple health problems and want the data they report to demonstrate the complexity of their client's health needs, which the current UDS cannot capture because it asks only for "presenting problems." (As one participant put it, "*As a provider, I know the person's number one problem is heroin addiction, but he's presenting with an abscess*.") Nor can health information be captured on billing charts if the information cannot be assigned ICD codes. (For example, a caseworker without medical credentials is unable to make diagnoses and cannot record "alcoholism" even if s/he knows the client is an alcoholic.) It is not possible to capture comprehensive health information about homeless patients in the current UDS. (It should be noted that the proposed add-on tables do *not* include data on additional diagnoses or other client characteristics, which warrant further discussion.)

As noted earlier, the focus of this Work Group was not on changing data currently collected by the UDS, but on additional data that could be collected to enable HCH projects to describe more accurately what they do and the needs of the clients they serve.

F. Proposed Data Collection Categories and Current UDS Limitations:

We have identified seven major service categories that are especially vital to improve the health and quality of life of individuals experiencing homelessness:

- Case Management
- Mental Health
- Substance Abuse
- Health Education
- Medical
- Nursing
- Outreach

Each of these major categories is represented in the health care data currently collected in the Uniform Data System. However, additional information is necessary to enable the continued improvement of services provided by HCH projects and to document more accurately the uniqueness and complexity of these services.

Case Management Services

Current data fields: In the current UDS, case management is listed as one of several "enabling services" that may be provided by some centers, and data fields are available to indicate one of three possible delivery methods for these services (Table 2: Services Offered and Delivery Method). In addition, FTEs and the number of encounters made by case managers may be indicated (Table 5: Staffing and Utilization).

Current UDS Limitations: Case management is certainly an "enabling service" used for homeless individuals, and it is useful to track the number of encounters provided by case managers in the course of treating them. However, given the importance of case management services in the delivery of care to homeless indi-

viduals and therefore to the mission of the HCH program generally, and given the complexity of issues homeless individuals bring with them to case managers, we propose that data be collected in more detail to more accurately reflect the depth and breadth of case management in the homeless health care setting. (See levels of service, detailed in the Case Management Tools, pp. 20–23.)

Mental Health Services

Current data fields: The current UDS includes Mental Health Treatment/ Counseling; Developmental Screening; 24-Hour Crisis Intervention/Counseling; and Other Mental Health Services in the list of services that centers may deliver, as well as three service delivery methods (Table 2: Services Offered and Delivery Method). In addition, Mental Health Specialist Services (FTEs, Encounters, and Users) are included in Table 5: Staffing and Utilization.

Current UDS Limitations: This level of information does not reflect the central importance of mental health services for health care to homeless individuals or the importance of gathering detailed data on the process of delivering this kind of care.

Substance Abuse Services

Current data fields: In the current UDS, Substance Abuse Treatment/Counseling and Other Substance Abuse Services are included in the list of services centers might deliver, with three categories of service delivery method (Table 2: Services Offered and Delivery Method). Moreover, Substance Abuse Specialist Services (FTEs, Encounters, and Users) are included in Table 5: Staffing and Utilization.

Current UDS Limitations: Again, these data fields simply do not reflect the level or intensity of care which HCH projects must provide to help homeless clients with substance use disorders achieve positive outcomes.

Health Education Services

Current data fields: Health Education is included in the list of "enabling services" centers might deliver, and three service delivery alternatives are provided in Table 2: Services Offered and Delivery Method. Education Specialists (FTEs, Encounters, and Users) are included in Table 5: Staffing and Utilization.

Current UDS Limitations: These data fields are not sufficient to capture the variety of health education services that HCH projects provide. For example, distinguishing individual from group health education would be valuable for HCH projects, which often rely on a wide range of educational approaches— such as explaining to clients why they should take a TB test, teaching them how to manage their diabetes with limited dietary choice, and how to avoid sexually transmitted diseases.

Medical Services

Current data fields: The current UDS includes data fields for the following medical services: General Primary Medical Care, Diagnostic Tests/Screenings, Emergency Medical Services, Urgent Medical Care, Family Planning, Following Hospitalized Patients, Obstetrical and Gynecological Care, Directly Observed TB Care and Other Specialty Care, plus three categories of service delivery method (Table 2: Services Offered and Delivery Method). Number of FTEs and number of encounters made by various Physician and Mid-level providers are also included (Table 5: Staffing and Utilization).

Current UDS Limitations: It is unrealistic to expect a health care provider working in a HCH setting to see the same number of patients as a provider working in a Community Health Center (CHC) setting within a comparable period of time. The multiplicity and complexity of health-related issues typically experienced by individuals who are homeless require providers to spend more time per patient encounter than is typically required in caring for individuals who are housed. Thus acuity and complexity of health conditions plus social factors complicating care must be taken into consideration in monitoring patient encounters and measuring provider productivity, particularly within a HCH setting. We propose more detailed data collection to reflect more accurately the depth and breadth of primary medical care provided in a homeless health care setting. This would also allow for a more complete description of the use of provider time and enable a more accurate assessment of provider productivity.

Nursing Services

Current data fields: The definition of an encounter used in the current UDS is a face-to-face contact between a user and a provider who exercises independent judgment in the provision of services to that individual.

Current UDS Limitations: This definition of 'encounter' excludes nursing services, which are an important and complex component of services delivered within a homeless health care setting. We propose that data be collected in more detail to reflect more accurately the depth and breadth of these services. Encounters recorded should reflect the distinct type of service that is being provided. Many of the functions that must be performed by licensed personnel or "under the direction of licensed personnel" should be counted among patient encounters.

Outreach Services

Outreach services provide critical access to services and safety for many homeless people, particularly those who live on the streets. These services are aimed at the dissolution of systemic and psychological barriers to care.[1] By necessity, outreach services are as diverse as the needs of individuals. They include engagement, information and referral, direct medical care, mental health or substance abuse services, formal referrals for specialty care not available in an HCH setting, treat-

[1] Marsha McMurray-Avila. *Organizing Health Services for Homeless People,* 2nd Edition. Nashville: National Health Care for the Homeless Council, Inc., 2001, p. 166.

ment plan development, social service assistance, case management, counseling, support groups, life skills training, health education, crisis intervention, disease screening, patient advocacy, and provision of food and clothing.

Outreach workers also provide follow-up on HCH clients, assess ongoing needs of people who are homeless, keep HCH staff informed of health issues on the streets including trends in drug-use or violence, serve as HCH representatives to other agencies, and keep other HCH staff in touch with the realities of their clients' living situations. The importance of outreach services to the overall effectiveness of health care provided to homeless individuals cannot be overstated.

Current data fields: Outreach is listed as one of the "enabling services" that centers might deliver in the current UDS, and three categories of service delivery method are provided in Table 2: Services Offered and Delivery Method. In addition, Outreach Workers (FTEs only, not encounters and users) are included in Table 5: Staffing and Utilization.

Current UDS Limitations: The extent to which outreach services are critical to the effectiveness of care provided to homeless individuals is simply not reflected in the current UDS. Exclusion of information on the quantity of outreach services provided (numbers of encounters and users) is very frustrating for HCH staff, who consider outreach to be an essential component of HCH services. Outreach services are not sufficiently captured by enumerating encounters and users, however; we propose including indicators of the complexity and duration of those encounters, on at least a rudimentary level.

G. Process Overview

In proposing additional data to include in UDS reporting, HCH projects were committed to balancing the need to convey more complete information about service delivery with the reality of limited resources that could be devoted to data collection. The diversity of service delivery environments within and among HCH projects, the complexity of data collection processes within these settings, and numerous, often conflicting views regarding which data are needed and how best to collect them presented additional challenges to HCH UDS Pilot Project participants. Given these factors, arriving at common data elements and a data collection process that works for all projects was, and will continue to be, a daunting task.

For these reasons, we proposed an exploratory, interactive process involving only a few HCH projects initially, in which lessons learned were identified after each step of an incremental process and applied to subsequent steps, so that improvements could be made continuously. This approach enabled us to learn important lessons from the field and generate specific recommendations about the following:

- Common data elements that enable HCH projects to assess and improve service provision to homeless clients;
- Common data elements that adequately reflect the complexity of services provided by HCH projects, regardless of sponsorship arrangement, enabling a more accurate description of the national HCH program;
- Definitions for common data elements that are meaningful, readily understood, and can be collected consistently by a variety of staff;
- HCH resources required to collect the proposed additional data; and
- Innovative techniques to address financial and procedural encountered in more comprehensive data collection.

***Initial Review*:** The add-on tables presented in this report were created and reviewed by a small group of motivated HCH representatives from Region IX. As noted in this report, numerous unresolved issues remained at the end of phase one which required further discussion and clarification before phase two of the pilot could commence. Efforts were made to obtain input from other HCH professionals in Region IX; those interested in participating were given opportunities to comment either in person or by e-mail.

***Field testing*:** The exploratory, interactive nature of the process described above did not require broad consensus initially – only HCH projects that volunteered to pilot one or more of the add-on tables agreed on consistent definitions and methods for data collection during this exploratory stage. We proposed that a handful of Region IX HCH projects, diverse in size and service models (e.g., including all sponsorship arrangements), be selected to collect data for a short time, using one or more of the proposed add-on tables. *Ideally, at least two HCH projects would volunteer to collect data specified in each of the proposed add-on tables*.

Defining data: HCH projects that volunteered to participate in this pilot project committed to meet by telephone or in person to define the "levels" described in the add-on tables clearly, so that all staff collecting these data would be consistent in their documentation.

***Trial Data Collection Period*:** Each HCH project that volunteered to participate in the pilot project determined the dates within which data would be collected.

***Follow-up Interviews*:** After the pre-determined data collection period, an in-depth interview was conducted with each HCH project participating in the data collection pilot to glean lessons learned on the issues described above, and to identify potential improvements for a subsequent data collection period.

H. General Discussion Points

The UDS issues specified above evoked the following points for further discussion:

- It would be beneficial to include HCH projects of all sponsorship types in piloting this data collection process.
- What constitutes an encounter for each of the add-on tables needs to be clearly defined.
- For each of the tables, it will need to be determined whether levels of service should be based on the amount of time spent to provide a particular service or on all services provided, regardless of the amount of time it took to provide them.
- The proposed add-on tables are primarily categorized by type of service, rather than by type of provider. More discussion is required to determine whether this is the most feasible and appropriate method of categorization.

II. HCH ADD-ON TABLES

A. Data Collection Categories & Definitions

For each service category, a breakdown into "levels" was discussed. Add-on **Levels of Service tables** were proposed to enable HCH projects to capture the type and amount of data they need on a given category of services, to improve the specified services, and to describe their practices more accurately.

CASE MANAGEMENT SERVICES

CASE MANAGEMENT		
	USERS	**ENCOUNTERS**
Level 1: Assessment (15 min.)		
Level 2: Planning/Referrals and Follow-up/Phone Calls/Intervention (15-30 min.) (Note: includes maintenance)		
Level 3: Assisted/Supported Referral and Counseling (30+ min.)		

Definitions

LEVEL 1: Assessment
Can be done by any provider (e.g**.** nurse, outreach worker, case manager, social worker, medical provider) who has contact with a client. The objective is to ensure that the client receives an assessment of health and social service needs, information about available health and social services, and a follow-up plan of care. Duties include conducting an initial assessment of the client's needs for food, shelter, income, health care, education, and transportation; identifying an emergency contact; prioritizing the need for immediate care, services and/or treatment; developing a plan to address identified needs, including care available at the service site or by referral; identifying the client's ability to participate in implementing the care plan; assisting the client to meet the care plan goals; promoting and facilitating communication among providers serving the client; monitoring and evaluating services received by reviewing progress toward attainment of care plan goals; acting as a liaison between the client and other agencies; and documenting all contact and issues in the client record.

LEVEL 2: Planning/Referrals/Follow-up/Intervention
Level two case management includes level one services plus those listed in level two. Can be provided by any person who has regular contact with the client, including a case manager, outreach worker, medical provider, social worker, or nurse. The objective is to ensure that the client receives services that are not available in the primary care site at an outside referral site. Duties include establishing with other agencies communication and arrangements for secondary referrals and transportation; assessing the client's ability and willingness to participate in the plan of care; documentation of the referral and transportation plan; and tracking and evaluating the appropriateness of the referral.

LEVEL 3: Assisted/Supported Referral and Counseling
Can be delivered by a person who has training as a case manager, medical provider, social worker, or nurse. The objective is to ensure that high-risk clients who require special assistance to negotiate complex, highly structured systems successfully negotiate the transition from the primary care site to another service/support system by accompanying the client. Duties include encouraging client participation in the development of the care plan, advocating on behalf of the client within the outside referral system, and establishing a plan for follow-up, continuing contact, and re-evaluation.

Discussion Points:

- The data being collected on Case Management at these different levels of service are strictly time-oriented. Initially, the time "codes" the case manager used were: <5 minutes, 5-30 minutes, 30-60 minutes, 1-2 hours, and >2 hours. After reviewing these data, however, it was determined that the following increments would be more useful: <15 minutes, 16-30 minutes, 31-60 minutes, 61-90 minutes, 91-120 minutes, 2-3 hours, 3-4 hours, 4-5 hours, 5-8 hours, >8 hours. Time increments over 2 hours were later collapsed into a single "2 hours or more" category.

- After extensive discussion about whether to focus on clearly defining time limits or levels of service to characterize service provision, the group arrived at the following recommendation: that time periods be redefined as 0-15 minutes = Level One, 15-30 minutes = Level Two, and 30-45 or greater = Level Three. Times should be defined to mirror the RVU system. These time frames should be factored into the identified levels on the Case Management table.

- Ideally, actual time spent in patient encounters would provide better data, but would place a heavier burden on persons completing the data collection forms. In the most recent discussion with this subgroup, it was decided that using median points of the categories to calculate an average amount of time spent per service level would be a useful indicator of intensity.

- Using time categories to track intensity of service remains a topic for discussion, but it should be noted that the case manager and administrative staff at the pilot site are finding these data very useful for planning purposes.

- It will be necessary to determine a given program's needs for case management data. A clear definition (amount of time vs. services provided) of each level of service is necessary prior to initiating data collection.

MENTAL HEALTH SERVICES

MENTAL HEALTH			
		Users	**Encounters**
Level 1	Identified a need and/or referral for mental health services		
Level 2	Mental health assessment		
Level 3	Mental health treatment		
	Individual, Couple, Family		
	Group		
	Medication Management		

Definitions:

LEVEL 1: Identified a need and/or referral for Mental Health Services
Level 1 is the identification of the need and/or referral for mental health services by non-mental health personnel.

LEVEL 2: Mental Health Assessment
Level 2 is the actual mental health assessment and clinical diagnosis provided by a mental health provider.

LEVEL 3: Mental Health Treatment
Level 2 is mental health treatment including medication management and/or therapeutic intervention via therapy (individual and group). The patient's intervention must be documented in the medical record for the individual or group session.

Discussion Points:

- These data will not enable us to quantify participation in HCH residential programs.
- This table does not enable the collection of data on counseling encounters that MSW Social Workers have with clients who are not mentally ill, or other social work services of that nature.

SUBSTANCE ABUSE SERVICES

SUBSTANCE ABUSE			
		Users	**Encounters**
Level 1	Identified a need and/or referral for substance abuse services		
Level 2A	Substance abuse assessment		
Level 2B	Substance abuse assessment/Dually diagnosed		
Level 3	Substance abuse treatment		
	Individual		
	Group		
	Medication Management		

Definitions:

LEVEL 1: Identified a need and/or referral for substance abuse services.
Level 1 is the identification of a need and/or referral for substance abuse services by non-substance abuse personnel.

LEVEL 2: SUBSTANCE abuse assessment
Level 2 is the actual substance abuse assessment and clinical diagnosis by a substance abuse provider. (See note, below)

LEVEL 2B*:* Substance abuse assessment/dually diagnosed individuals
Level 2B is the assessment of those individuals that are both substance abusers and have a mental health diagnosis.

LEVEL 3: SUBSTANCE abuse treatment
Level 3 is substance abuse treatment including therapeutic intervention via therapy (individual and group).

Note: A substance abuse provider is identified as an individual with special knowledge, training, and/or certification in substance abuse treatment or therapy.

Discussion Points:

- This subgroup struggled with how to determine the best way to track dual-diagnoses encounters. As noted in the substance abuse table, 2B Substance abuse assessment/Dually diagnosed has been added so these data can be reported.
- These data will not enable us to quantify participation in HCH residential programs.

HEALTH EDUCATION SERVICES

HEALTH EDUCATION		
	USERS	**ENCOUNTERS**
Level 1: Informal/client-initiated – prevention health efforts, individual and group opportunities which may last up to 15 minutes		
a) Individual		
b) Group		
Level 2: Formal or structured/harm reduction, risk reduction and/or safe sex education (delete-health maintenance)		
a) Individual		
b) Group		
Level 3: Chronic disease management		
a) Individual		
b) Group		

Definitions:

Preventive medicine counseling and risk factor reduction interventions should include such issues as family problems, diet and exercise, substance abuse, sexual behaviors, injury prevention and oral hygiene.

A. Individual: Preventive medicine counseling and/or risk factor reduction interventions provided to an individual. Any individual trained in the specific area or subject in which health education is performed can provide these interventions.
LEVEL 1: Intervention lasting 15 minutes.
LEVEL 2: Intervention lasting 30 minutes.
LEVEL 3: Intervention lasting 1 hour.

B. Group: Preventive medicine counseling and risk factor reduction interventions provided to individuals in a group setting. Any individual trained in the specific area or subject in which health education is performed can perform this.
LEVEL 1: Intervention lasting 30 minutes.
LEVEL 2: Intervention lasting 60 minutes.

Remaining Questions/Issues:

- Definitions and examples of appropriate encounters for each level would clarify what each encompasses.

MEDICAL SERVICES

MEDICAL		
	USERS	**ENCOUNTERS**
Level 1: Minimal Service		
Level 2: Problem-Focused Hx/Ex **(99201 or 99211)**		
Level 3: Expanded Problem Hx/Ex **(99202 or 99212)**		
Level 4: Detailed Hx and Exam **(99203 or 99213)**		
Level 5: Comp Hx and Exam **(99201 or 99214)**		

Definitions

The purpose of the document is to provide guidelines for choosing levels of care performed by a medical provider. The UDS group will use the guidelines established by the American Medical Association as presented in the 2001 ICD-9 codebook. Although the ICD-9 codebook recognizes different codes for new and established patients, for the purpose of these definitions we will consider new and established patients together, determining levels of care based on the complexity of their medical conditions.

LEVEL 1: Minimal service Office or other outpatient visit for the evaluation and management of a patient that may be performed by a professional as defined by their scope of practice (RN, midlevel or physician).

LEVEL 2: Problem focused history and exam Office or other outpatient visits for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- A problem focused history
- A problem focused examination
- Straightforward medical decision making

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. If a case manager provides this service, a case management encounter may be counted.

Usually, the presenting problem(s) are self-limited or minor. Medical Providers typically spend 10 minutes face-to-face with the patient and/or family.

A medical provider must perform this visit.

LEVEL 3: Expanded problem history/exam Office or other outpatient visits for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- An expanded problem focused history
- An expanded problem focused examination
- Medical decision making of low complexity

Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's

needs. If a case manager provides this service, a case management encounter may be counted.

Usually, the presenting problem(s) are of low to moderate severity. Medical Providers typically spend 15 minutes face-to-face with the patient and/or family.

LEVEL 4: Detailed problem history and exam Office or other outpatient visits for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- A detailed history
- A detailed examination
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. If a case manager provides this service, a case management encounter may be counted.

Usually, the presenting problem(s) are of moderate to high severity. Medical Providers typically spend 25 minutes face-to-face with the patient and/or family.

LEVEL 5: Comprehensive history and exam Office or other outpatient visits for the evaluation and management of a patient, which requires at least 2 of these 3 key components.

- A comprehensive history
- A comprehensive examination
- Medical decision making of high complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. If a case manager provides this service, a case management encounter may be counted.

Usually, the presenting problem(s) are of moderate to high severity. Medical Providers typically spend 40 minutes face-to-face with the patient and/or family.

Discussion Points:

- Using time categories to track intensity of service remains a topic for discussion; at this time no productivity standards are established for Health Care for the Homeless providers. As homeless provider productivity may be (and sometimes is) compared to that of the mainstream systems, we hope this better defines the variation in productivity.

- This table does not reflect medical diagnosis and treatment of clients.

- Discussion is still needed regarding utilizing different levels of care to assess productivity and physician/mid-level provider time.

NURSING SERVICES

NURSING		
	USERS	**ENCOUNTERS**
Level 1: Triage/Medical Screening		
Level 2: Implement Treatment (wound care, referral, etc.)		
Level 3: Medical Follow-up		

Definitions

Nursing levels of care are defined below, in an effort to delineate degrees of complexity in patient encounters by HCH staff. The current CPT code billing system only recognizes one level of nursing care, which is billable under the V015.89 code. An RN as defined in their scope of work MUST perform these visits. (These visits do not include lab testing, PPD screening or any activity that is directly related to a medical provider encounter.)

LEVEL 1: Triage / medical screening Office or other outpatient visit where the presenting complaint is minimal. Typically, 5 minutes are spent on assessment or performance of services.

LEVEL 2: Problem focused Office or other outpatient visits for the assessment and management of a patient. Requires 2 of the 3 key components listed below:

- A problem-focused history
- A problem-focused nursing assessment/medical screening
- A straightforward nursing assessment/plan

Counseling and coordination of care with providers or agencies are provided, consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) is/are of low to moderate severity. Nurses typically spend 15 minutes face-to-face with the patient and/or family.

LEVEL 3: Detailed Office or other outpatient visit for the assessment and management of a patient which requires at least 2 of these 3 key components:

- A detailed history
- A detailed nursing assessment/medical screening
- A nursing assessment/plan of moderate complexity

Counseling and/or coordination of care with providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Nurses typically spend 25 minutes face-to-face with the patient and/or family.

Discussion Points:

- Services that are performed to carry out a medical provider's orders cannot be listed as separate encounters (e.g., lab testing, PPD/tuberculosis screening or any activity that is directly to the medical provider encounter).

- This table needs to track the unique nature of nursing in the HCH setting.

OUTREACH SERVICES

OUTREACH				
	USERS		**ENCOUNTERS**	
Level 1: Approach				
Level 2: Engagement				
Level 3: Referral				

Definitions

Note: Outreach services may be performed by any individual trained to perform outreach services as defined by their HCH project.

LEVEL 1: Approach

Brief initial contacts to establish a visible presence; provide general information on services and ask client(s) if they currently need assistance. *These encounters may not provide a sufficient amount of unique client information that can be used to generate a client record.*

LEVEL 2: Engagement

Establish individualized rapport; listen to client's story/problems and offer support/encouragement; begin to identify basic client need(s). These encounters will usually allow clinician to obtain basic client information, such as name ("street" name/alias), gender, possibly DOB and ethnicity; however, it is unlikely that all client data needed for the UDS (e.g., income level or family size) will be provided. Therefore, these encounters should also be reported in a UDS "add-on" table.

LEVEL 3: Information and Referral

Obtain information about a client's specific need(s); provide information about available services; make and help to facilitate referral. These encounters will usually allow for obtaining of basic client information, e.g. name ("street" name/alias), gender, DOB and ethnicity; however, the client may or may not be willing to provide all client data needed for the UDS, e.g. income level, family size. Therefore, these encounters should also be reported in a UDS "add-on" table.

Discussion Points:

- The subgroup identified several creative methods for collecting outreach and case management data in addition to tracking these levels of encounters on forms. See the "Outreach & Case Management Services – Suggested Data Elements" document for examples of these.

- Discussion took place regarding the documentation of level-one users; programs must be clear that they are collecting, and therefore reporting, unique client information.

In reference to the actual BPHC UDS Manual, Table 5, line 26: The workgroup felt strongly that the columns for encounters and users should be opened up. This is a major area of effort within the homeless program setting and should be reflected/reported as such. (Table 5 is attached.)

Overall, programs that participated in the pilot project were very pleased in having found a method of data collection that clearly defines the activities of a Health Care for the Homeless program. This information was invaluable for these programs in preparing their budgets and staffing patterns for the following year.

B. Data Collection Tools

The following proposed data collection tools are appended to this document:

- HCH Case Management Tools
- HCH Mental Health Tools
- HCH Nursing Tools
- HCH Outreach Tool

HCH CASE MANAGEMENT ENCOUNTER LOG

Patient Last Name – First Initial

	DATE	Initial Encounter / Needs Assessment	Planning / Referral / Follow-Up / Intervention	Assisted or Supported Referral / Counseling	(Time spent w / pt) Comments	In Person	Phone / Other
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							

Time Codes: A = < 15 min. B = 16 to 30 min. C = 31 to 60 min. D = > 1 hour

FAMILY HEALTH CENTERS OF SAN DIEGO

HEALTH CARE FOR THE HOMELESS ENCOUNTER FORM

CLIENT INFORMATION
DATE _____/_____/_____
CLIENT NAME _____, _____
Last name, *First name*
SSN _____-_____-_____ DATE OF BIRTH _____/_____/_____
Substance Abuse History Y N U Mental Health Issues Y N U

Procedure code	*Please X all that apply*	Description
Case Management		
CMA		Level 1: Assess-ment
CMP		Level 2: Planning/Referrals/Follow-up/Intervention
CMR		Level 3: Assisted Supported Referral and Counseling
Outreach		
OUTA		Level 1: Approach
OUTE		Level 2: Engagement
OUTR		Level 3: Referral
Mental Health		
MHAR		Level 1: Assessment and referral for MH services
MHPA		Level 2: Mental Health provider assessment
		Level 3: Mental Health Treatment
MHTI		A) Individual
MHTG		B) Group
Substance Abuse		
SAAR		Level 1: Assessment and referral for SA services
SAPA		Level 2: Substance Abuse provider assessment
SADD		- Dual Diagnosis Assessment
		Level 3: Substance Abuse Treatment
SATI		A) Individual
SATG		B) Group
Health Education		
		Level 1: Informal/client-initiated – prevention
HEII		A) Individual
HEIG		B) Group
		Level 2: Formal or structured/health maintenance
HEFI		A) Individual
HEFG		B) Group
		Level 3: Chronic Disease Management
HECDI		A) Individual
HECDG		B) Group
Case Manager:		Site:

Referrals: *(Please X all that apply)*							
	FOOD		EMPLOYMENT		SOCIAL SERVICES		MEDICAL
	CLOTHING		HOTEL VOUCHERS		MEDI-CAL/DSS		DENTAL
	SHELTER		REHAB. PROGRAM		CMS		VISION
	DAY CENTER		DETOX		TRANSPORTATION		ER

OTHER:	NOTES/DETAIL:

HCH CASE MANAGEMENT

Provider **MCHP**
Medicare
Grant

LAST NAME: _____
FIRST NAME: _____
DOB: _____
SOC. SEC.#: _____

Limited English: Y N
Employed: Y N
Ethnicity: W B H NA A O
Marital Status: Single Married
Separated Widowed Divorced

Circle One: Male Female

Date Homeless:_____
Substance Abuse History: Y N
Mental Health Issues: Y N
Behavioral Health Date:_____
Treatment Plan Date:_____
Review Date:_____

Site:_____ **DOS:**_____

	Housing Status			**Case Management**			**Referred To**	
1	Shelter		W205	Triage Screening (¼ hour)		AHC	AHCCCS	
2	Transitional		W215	Home Based Counseling		DEN	Dental	
3	Doubling Up		W203	Case Management 1/4		ADV	Advocates for the	
4	Unknown		W221	Psychosocial Rehab		SHE	Shelter	
5	Street		RW00	RW Intake		VLO	VO	
6	Other		RW00	RW CM 1/4		DES	DES – Food Stamps	
7	Migrant		X045	Assessment		SOC	Social Services	
8	Seasonal		X016	Discharge Screening		SAT	Substance Abuse	
	Income/Poverty			**Depression**		TRN	Transitional Housing	
IP001	< 100%		X100	Intake CM (¼ hour)		PER	Permanent Housing	
IP002	100% ($650 per month)		X100	Referred to Psych		MDL	Medical	
IP003	101-150% ($850 per		X100	Declined referral to Psych		PSY	Psychiatric	
IP004	151-200% ($1300 per			**Levels-Case Management**				
IP005	Over 200		X195	Level 1 - Assessment			**Referral From**	
IP006	Unknown		X195	Level 2 – Intervention/Referral		X1869	Dept of Corrections	
	Dental		X195	Level 3 – Assisted/Counseling		X1870	CASS	
X1853	No Need			**Levels-Outreach**		X1871	Safe Haven	
X1854	Already in Program		X195	Level 1 - Approached		X1872	Home Base	
X1855	Sent for Initial Screen-		X195	Level 2 - Engagement		X1873	HCH Medical Staff	
X1930	Assessed for Dental		X195	Level 3 - Referral		X1874	Other Medical	
				Levels-Substance Abuse		X1875	Overflow	
	Transportation		X195	Level 1 – Id need or refer		X1876	Churches	
X1896	Bus Ticket		X195	Level 2 - Assessment		X1877	Treatment Centers	
X1897	Staff		X195	Level 3 – Treatment-Individual		X1878	Law Enforcement	
X1898	Van Voucher		X195	Level 4 – Treatment- Group				
				Nursing				
	Translation		X4	Health Education			**Immunizations**	
X1894	Medical		X6	Nursing Assessment		90718	Adult Td	
X1895	Social Services		X180	Nursing Procedure **(V015.89)**		90720	DTP and HIB	
			X045	Provides Medication		90701	DTP	
	SMI			**Supplies/Medications**		90632	Hepatitis A	
X1856	Yes		0330	Gauze		90744	Hep B Ped/Adolescent	
X1857	No		0354	Band-Aids		90746	Hepatitis B	
			0348	Antibiotic Ointment		90645	Hib Vaccine	
	Substance Abuse		0349	Antifungal Powder/Ointment		90658	Influenza (Adult)	
X0476	SAS Offered		0238	Hydrocortisone Cream		90705	Measles	
X0477	SAS Refused		0232	Antacid Tabs		90702	Pediatric DT	
X1892	Sober Days		0205	Cough Medicine		86580	Skin Test, TB	
X1893	Relapse Days		0207	Cough Drops		90396	Varicella	
X0452	Counseling		0461	Tylenol		90732	Pneumococcal, Adult	
X1938	Naltrexone discussed		0193	A & D Ointment				
X1939	Naltrexone Started		0356	Hygiene / Blankets / Water				
X1940	Naltrexone Ended		0226	Lice Shampoo			Updated 10/30/02	

HEALTH CARE FOR THE HOMELESS
SOCIAL SERVICE PROGRESS NOTE

I agree to the health care provider placing the Flu Shot, releasing the Flu Shot results to other health care providers for continuity of care.

Signature of parent/guardian or adult vaccine recipient Date:

In person _____ Phone_____ Collateral contact_____

15 mins. _____ 30 mins. _____ 45 mins. _____ 60 mins. _____ ( ) mins. _____

Data _____

Assessment _____

Plan _____

Ibuprofen 200mg:

Are you allergic to aspirin or any other drug that is used for fever, pain, or inflammation? YES____ NO _____

Have you ever had an ulcer or any bleeding in your stomach? YES_____ NO _____

Do you have a history of any kidney disease? YES_____ NO _____

Pseudoephedrine HCL 30mg:

Do you have high blood pressure? YES _____ NO_____

Is it under control? YES_____ NO _____

Do you have heart trouble? YES _____ NO_____

Do you have thyroid disease? YES_____ NO_____

Are you on any psychiatric medications? YES_____ NO_____

Social Services:

Responsible Staff _____

MCDPHS HCH CLINIC FORM

- ☐ **MCHP** _____
- ☐ Medicare _____
- ☐ Grant
- ☐ Other

Limited English: Y
Employed: Y N
Marital Status: Single
Separated Widowed Di-

Circle One: Male

Date Homeless
Substance Abuse History: Y N
Mental Health Issues: Y N

DOS:_____

	Housing			**Immun / Inj/**			**Pharmancy Continued**	
001	Shelter		9065	Influenza (Adult)		0214	Maricol	
002	Transitional		9070	Measles		0227	Multivitamins	
003	Doubling Up		9070	MMR		0293	Pen VK 500 mg	
004	Unknown		9070	Pediatric DT		0231	Prenatal Vitamins	
005	Street		9073	Pneumococcal, Adult		0205	Robitussin DM	
006	Other		9071	Polio (IPV)(Adult		0481	Tegretol 200 mg	
007	Migrant		8658	Skin Test, TB		0233	Tinactin CR .15 gr	
008	Seasonal		1105	Callus Debridement, (2 to 4)			**Laboratory**	
	Income/Poverty Level		5367	Catheterization, bladder		82962	Accu-Check	
IP001	< 100%		6921	Cerumen Removal		87490	Chlamydia	
IP002	100% ($650 per month)		9300	EKG Tracking		86703	HIV	
IP003	101-150% ($850 per month)		1175	Excision of Nail		87081	G.C. Culture	
IP004	151-200% ($1300 per month)		1006	I & D Abs/Cyst		82270	Hemocult	
IP005	Over 200		2055	Injection, Trigger Point		85018	Hemoglobin	
IP006	Unknown		9078	INJ. IM Antibio		87220	KOH Smear	
	New Patient		9078	Injection, Ther		88164	Pap Smear	
99201	Minimal Service		9078	IV Ther Infus – 1st. Hr		81025	Preg Test Urine	
99202	Prob. Focused Hx?Ex		9476	Pulse OX		86592	R.P.R.	
99203	Exp. Problem Hx/Ex		1799	Suture Removal		87070	Throat (B-Strep)	
99204	Detailed Hx & Exam		1200	Suture, smpl 2.5 – 7.5 cm		87088	Urine Culture	
99205	Comp Hx & Exam		9466	SVN – Initial		81003	Urine Dipstick	
	Established Patient		9466	SVN – Subsequest		81015	Urine Micrscp Exame	
99211	Minimal Service		1104	Wound Debridement		36406	Venipunct/3yrs under	
99212	Prob. Focused Hx/Ex		9047	Immunization Admin. 1st.		36415	Venipunct / Adult	
99213	Exp. Problem Hx/Ex		9047	Immuniz Admin. Ea Add'l		87210	Wet mount	
99214	Detailed Hx & Exam					87273	Herpes Culture	
99215	Comp Hx & Exam			**Nursing Procedures**			**Referral**	
			X180	Nursing Procedures		DEN	Dental	
			NP00	POS PPD Reading		EMR	Emergency Room	
	Goal Statistics		NP01	PPD Reading		SAC	Substance Abuse Counseling	
GS001	Hepatitis B Screening					SOC	Social Services	
GS002	First Hep B Injection			**Pharmacy**		VIS	Vista Colina	
GS003	Second Hep B Injection		0221	Acetaminophen Tabs		TB	TB Clinic	
GS004	Hep B Series Comp.		0456	Albuterol Inhaler		ANO	Another Chance	
GS005	Hepatitis C Screening		0455	Atrovent Inhaler				
			0009	Augmentin 500 mg				
	Imm / Inj / Skin Test		0512	Augmentin 875 mg				
90718	Adult Td		0324	Bactrim DS				
90701	DTP		0270	Beclovent Inhaler			**Pharmacy / Supplies Write In**	
90720	DTP and HIB		0457	Cimetidine 400 mg				
90632	Hepatitis A		0367	Cortisporin Otic				
90744	Hep B (Ped/Adolescent)		0256	Dilantin 100 mg				
90746	Hepatitis B		0257	Ibuprofen 600 mg				
90645	Hib Vaccine		0273	Ibuprofen 800 mg				
90703	Tetanus Toxoid		0011	Keflex 500 mg				

789.00	Abdominal Pain	389.9	Hearing Loss	924.9	Contusion	477.9	Allergic Rhinitis
285.9	Anemia Unspec	382.9	Otitis Media	276.5	Dehydration	491.0	Bronchitis, Chronic
413.9	Angina	475	Peritonsillar Absesses	829.0	Fracture	786.09	Dyspnea
493.90	Asthma	524.60	TMJ	919.4	Insect Bite	519.8	Otr Resp System Dis
466.0	Bronchitis, Acute	369.9	Visual Disturbance	E960.0	S/P Assult	486	Pneumonia
682.9	Cellulitis/Abscess		**Gastrointestinal**	848.9	Sprain (Unspec)	461.9	Sinusitis, Acute
786.50	Chest Pain	571.2	Alcoholic Liver Dis-	692.71	Sunburn	473.9	Sinusitis, Chronic
786.52	Chest Wall Pain	574.20	Cholelithiasis	991.9	Effect Hypother Unsp	780.57	Sleep Apnea
428.0	CHF	575.0	Cholecstitis – Acute	992.5	Heat Exhaustion	011.9	TB, Pulmonary
079.98	Chlamydia	787.91	Diarrhea	992.6	Heat Fatigue		**Skin / Tissue**
564.0	Constipation	530.10	Esophagitis	992.7	Heat Edema	706.1	Acne
780.39	Convulsive Disorder	558.9	Gastroenteritis		**Nysc./Skel/Connect/Tiss**	702.0	Actinic Keratosis
496	COPD	530.81	GERD	720.0	Ankylosing Spondylitis	917.2	Blister, Foot
436	CVA	455.6	Hemorrhoids	726.73	Calcaneal Spur	917.3	Blister, Foot Infected
310.1	Dementia	070.1	Hepatitis A	723.1	Cervicalgia	692.9	Contct Dermatitis
110.9	Dermatophytosis-Unsp	070.30	Hepatitis B	729.5	Limb Pain	700	Corn & Callouses
250.00	Diabetes NIDDM	070.51	Hepatitis C	710.0	S L E	691.0	Diaper Dermatitis
250.01	Diabetes IDDM	553.9	Hernia – Unspecified	729.2	Neuralgia/Neuritis	684	Impetigo
536.8	Dyspepsia	569.89	Intestinal Disorder	714.0	Rheumatoid Arthritis	692.9	Eczema
782.3	Edema	278.00	Obesity	724.3	Scatica	704.8	Folliculitis
780.79	Fatigue	577.1	Pancreatitis	727.00	Synovitis/Tenosynovitis	709.4	Foreign Body in Skin
535.5	Gastritis w/o hemor-	533.90	Peptic Ulcer Disease	729.2	Neuralgia/Neuritis	680.9	Furuncle
V70.0	Gen Medical Exam	569.3	Rectal Bleeding	714.0	Rheumatoid Arthritis	703.0	Ingrown Nail
784.0	Headache		**Gynecology**		**Neoplasms**	782.1	Nonspec Skin Erup-
401.9	Hypertension	795.0	Abnormal Pap Smear	174.9	Breast (Female)	698.9	Sebaceous Cyst
242.90	Hypothyroidism	626	Amenorrhea	202.80	Lymphoma	696.1	Psoriasis
414.9	Ischemic Heart Disease	611.72	Brease Mass	173.9	Skin	706.2	Sebaceous Cyst
719.40	Joint Pain	V25.41	Contraceptive, Oral		**Neurology**	706.3	Seborrhea
724.2	Low Back Pain	V25.09	Contraceptive, Other	331.0	Alzheimer's Disease	690.1	Seborrheic Dermatitis
460	Nasopharyngitis	626.8	DUB	354.0	Carpel Tunnel Synd	454.1	Stasis Dermatitis
099.4	Non GC Urethritis	625.3	Dysmenorrhea	294.8	Organic Brain Synd	707.0	Ulcer, Debubitis
715.00	Osteroarthritis/DJD	V16.3	Fam Hx Breast Cancer	346.90	Migraine Headache	707.1	Ulcer, Diabetic (leg)
462	Pharyngitis, Acute	V72.3	Gyn Exam/Pap	782782.0	Paresthesias	707.8	Ulcer, Other
780.2	Syncope	V76.12	Mammogram	332.0	Parkinson's Disease	708.9	Uriticaria / Hives
110.3	Tinea Cruris	256.3	Ovarian Def. (HRT)	780.4	Vertigo		**Miscellaneous**
110.4	Tinea Pedis	V24.2	Post Partum Exam		**Psychiatry**	793.1	Abn. Chest X-Ray
305.1	Tobacco Use	V22.2	Pregnancy	303.90	Alcoholism	796.4	Abn. Lab Test
465.9	URI	X1850	First Trimester	300.00	Anxiety Disorder	794.8	Abn Liver FX Test
599.0	UTI	X1851	Second Trimester	296.7	Bipolar	995.2	Adverse Reaction/Med
879.8	Wound,	X1852	Third Trimester	**311**	**Depression**	521.0	Dental Caries
	Circulatory	218.9	Uterine Fibroids	**X1001**	**Referred to CM**	525.9	Dental Disorder, Unsp
427.9	Arrhythmia	625.9	Uterine Ligament Pain	**X1002**	**TESTED-not referred**	780.4	Dizziness/Giddiness
427.31	Atrial Fibrillation	616.10	Vaginitis, Unspecified	304.390	Drug Addiction	780.6	Fever/Unknown Orgin
785.2	Heart Murmur		**Infectious Dis-**	977.9	Drug Overdose	785.6	Lymph Node Enlrgmnt
272.4	Hyperlipidemia	V01.6	Exposure to STD	V40.9	Drug Seeking Behavior	V68.1	Medication Refill *
443.9	Peripheral Vas Disease	054.10	Genital Herpes	308.0	Emotional Disturbance	581.3	Minimal Change Syn
451.9	Phlebitis	098.0	Gonorrhea	V61.9	Family Problems	785.1	Palpitations
746.9	Valvular Heart Disease	054.9	Herpes Simplex	293.9	Organic Mental Disrdr	V65.2	Person Feigning Ill-
454.9	Varicose Veins	053.9	Herpes Zoster	301.9	Personality Disorder	780.50	Sleep Disturbance
	Endocrine	042	HIV	298.9	Psychosis	783.1	Weight Gain
279.4	Autoimmune Disease	V08	HIV Asymptomatic	295.90	Schizophrenia	783.2	Weight Loss, Abnor-
274.9	Gout	132.9	Pediculosis		**Renal**	V65.5	Worried Well
242.90	Hyperthyroidism	614.9	Pelvic Inflam Disease	585	Chronic Renal Failure	V01.1	Tuberculosis
	EYE/ENT	795.5	Positive PPD	788.1	Dysuria	V04.8	Immun. Influenza
112.0	Candidiasis, Mouth	133.0	Scabies	599.7	Hematuria	V05.3	Immun / Viral Hepa-
366.10	Cataract	097.9	Syphilis	788.30	Incontinence (Urinary)	V05.9	Immun (One)
372.00	Conjunctivitis, Acute	079.99	Viral Infection	601.9	Prostatitis	V06.9	Unspec Combined Vac
380.4	Cerumen, Impacted	078.19	Viral Warts	791.0	Proteinuria		**DX Code Write In**
918.1	Corneal Abrasion		**Injuries**	590.80	Pyelonephritis		
362.01	Diabetic Retinopathy	919.0	Abrasion	592.9	Urinary Calculus		
388.9	Ear Disorder – Unspec	949.0	Burns				
365.9	Glaucoma	854.00	Closed Head Injury				
							Updated 5/29/02

MCDPHS PSYCHIATRIC FORM

☐ **Provider's Name**
☐

☐ **MCHP** _____
☐ Medicare_____
☐ Grant _____
☐ Other_____

Limited English: Y N
Employed: Y N
Marital Status: Single Married
Separated Widowed Divorced
Circle One: Male Female

Date Homeless:_____
Substance Abuse History: Y N
Mental Health Issues: Y N

DOS: _____

	Housing Status			**Pharmacy**			**Diagnosis Codes**	
001	Shelter		053	Amitriptyline 25 mg		296.90	Mood D/O NOS	
002	Transitional		053	Amitriptyline 50 mg		298.9	Psychotic D/O NOS	
003	Doubling Up		024	Benadryl		311	Depressive D/O	
004	Unknown		053	Buspar 5 mg		300.00	Anxiety D/O NOS	
005	Street		053	Buspar 10 mg		301.9	Personality D/O NOS	
006	Other		053	Celexa 20 mg				
007	Migrant		053	Cogentin 1 mg		303.90	Alcohol Dependence	
008	Seasonal		053	Cogentin 2 mg		305.00	Alcohol Abuse	
	Income / Poverty Level		054	Depakote 250 mg		304.40	Amphetamine Dependence	
IP001	< 100%		054	Depakote 500 mg		305.70	Amphetamine Abuse	
IP002	100% ($650 per month)		054	Haloperidol 2 mg		304.00	Opioid Dependence	
IP003	101-150% ($850 per month)		054	Haloperidol 5 mg		304.20	Cocaine Dependence	
IP004	151-200% ($1300 per month)		056	Haloperidol 10 mg		305.60	Cocaine Abuse	
IP005	Over 200		054	Lithium Carbonate 300 mg		304.80	Polysubstance Dependence	
IP006	Unknown		054	Luvox 100 mg		305.90	Substance Abuse	
	Provider Charge		054	Naltrexone 50 mg		292.84	Drug Induced Mood D/O	
90801	Diagnosis Interview		054	Nortriptyline 25 mg		292.12	Drug Induced Psychotic D/O	
90804	INDIV Psychotherapy (20-30		054	Nortriptyline 50 mg		291.8	Alcohol Induced Mood D/O	
90805	INDIV Therapy (20-30 min)		033	Paxil 20 mg		312.31	Pathological gambling	
90806	INDIV Therapy (40-50 min)		052	Prozac 20 mg		295.90	Schizophrenia	
90807	INDIV Therapy (40-50 min)		055	Risperidone 1 mg		295.70	Schizoaffective D/O	
90885	PSY Eval of Records		055	Risperidone 2 mg				
99371	Phone Consult / Psychiatric		055	Seroquel 25 mg		296.40	Bipolar I, Manic	
90862	Medication (Monitoring)		055	Seroquel 100 mg		296.6	Bipolar I, Mixed	
90889	Report Preparation		055	Seroquel 200 mg		296.5	Bipolar I, Depressed	
90887	Coord of Care (30 min)		055	Serzone 100 mg		296.89	Bipolar II D/O	
W2020	Emerg Crisis (15 min)		055	Serzone 150 mg		301.13	Cyclothymic D/O	
W2030	Prep Treatment Plan		055	Trazadone 50 mg				
RW001	Ryan White Intake		055	Trazadone 100 mg		296.20	Major Depression, Single	
RW002	Ryan White CM ¼ hr		056	Wellbutrin SR 100 mg		296.30	Major Depression, Recurrent	
	Levels- Psychiatric		056	Wellbutrin SR 150 mg		296.33	MDD, recurrent w/o psychosis	
X1945	Level 1 – Id need or Refer		052	Zoloft 50 mg		296.34	MDD, recurrent w/psychosis	
X1946	Level 2 - Assessment		056	Zoloft 100 mg		300.4	Dysthymia	
X1947	Level 3 – Treatment - Individual		052	Zyprexa 5 mg		296.34	MDD, recurrent w/psychosis	
X1948	Level 3–Mental Health–Med Mgmt		053	Zyprexa 7.5 mg				
X1949	Level 3– Sub Abuse–Med Mgmt		052	Zyprexa 10 mg		300.01	Panic D/O	
	Naltrexone			**Laboratory**		300.02	GAD	
X1941	Initial Visit					309.81	PTSD	
X1942	30 Day Visit					300.3	OCD	
X1943	60 Day Visit							
X1944	Extended Naltrexone					302.9	Paraphilia NOS	
						312.30	Impulse Control D/O NOS	
						309.0	Adjustment D/O, Depressed	
						309.24	Adjustment D/O, Anxiety	
						293.9	Organic Mental D/O	
	Updated 8/28/02							

YTD report

HCH NURSE ENCOUNTER REPORT

From 01-01-2002 to 09-30-2002

Totals					
Contact Method	**A**	**B**	**C**	**D**	**Method Totals**
Initial Encounter/ Basic Needs Assessment & Care/ Information Exchange	421	11	3	7	442
Medical Assessment/ Referral/ Treatment	297	134	2	0	433
Follow-up/ Assisted or Supported Referral/ Counseling	9	4	0	0	13
Time Code Totals	**727**	**149**	**5**	**7**	**888**

Referral Totals				
Referral Method	**CL**	**H**	**CM**	**Method Total**
	133	**2**	**1**	**136**

Time Codes:	**A** = <15 min.	**B** = 16 to 30 min.	**C** = 31 to 60 min.	**D** = > 1 hour
Referral Codes:	**CL** = HCH Clinic	**H =** Hospital	**CM** = Case Manager	

One month report

HCH NURSE ENCOUNTER REPORT

From 09-01-2002 to 09-30-2002

Totals					
Contact Method	**A**	**B**	**C**	**D**	**Method Totals**
Initial Encounter/ Basic Needs Assessment & Care/ Information Exchange	94	1	0	1	96
Medical Assessment/ Referral/ Treatment	11	0	0	0	11
Follow-up/ Assisted or Supported Referral/ Counseling	0	0	0	0	0
Time Code Totals	**105**	**1**	**0**	**1**	**107**

Referral Totals				
Referral Method	**CL**	**H**	**CM**	**Method Total**
	13	**0**	**1**	**14**

Time Codes:	**A** = <15 min.	**B** = 16 to 30 min.	**C** = 31 to 60 min.	**D** = > 1 hour
Referral Codes:	**CL** = HCH Clinic	**H =** Hospital	**CM** = Case Manager	

YTD report

HCH CASE MANAGEMENT REPORT

From 01-01-2002 to 09-30-2002

	Totals				
Contact Method	**A**	**B**	**C**	**D**	**Method Totals**
Initial Encounter/ Needs Assessment	49	102	38	2	191
Planning/Referral/ Follow-up/Intervention	233	168	87	16	504
Assisted or Supported/ Referral/Counseling	0	3	41	102	146
Time Code Totals	**282**	**273**	**166**	**120**	**841**

Time Codes:	**A** = <15 min. **B** = 16 to 30 min. **C** = 31 to 60 min. **D** = > 1 hour

One month report

HCH CASE MANAGEMENT REPORT

From 09-01-2002 to 09-30-2002

	Totals				
Contact Method	**A**	**B**	**C**	**D**	**Method Totals**
Initial Encounter/ Needs Assessment	2	9	8	0	19
Planning/Referral/ Follow-up/Intervention	14	11	15	0	40
Assisted or Supported/ Referral/Counseling	0	1	2	11	14
Time Code Totals	**16**	**21**	**25**	**11**	**73**

Time Codes:	**A** = <15 min. **B** = 16 to 30 min. **C** = 31 to 60 min. **D** = > 1 hour

HCH OUTREACH NURSE ENCOUNTER LOG

Patient Last Name – First Initial

Patient Last Name & First Initial

	DATE	Initial Encounter / Basic Needs Assessment & Care / Information Exchange	Medical Assessment / Referral / Treatment	Follow-Up / Assisted / Supported Referral / Counseling	Referral Codes / Time Codes Comments
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

Time Codes: **A= 1 - 15 min.** **B= 15 to 30 min.** **C= 31 to 60 min.** **D= > 1 hour**

Referral Codes: **CL = HCH Clinic** **H = Hospital** **CM = Case Manager**