

Better Together:

Data Integration Best Practices for Health Centers & Homeless Services



HMIS + Communities: Working Together Across Systems to End Homelessness



Webinar Instructions

- Webinar will last about 60 minutes
- Access to recorded version
- Participants in 'listen only' mode
- Submit content related questions in Q&A box on right side of screen
- For technical issues, request assistance through the Chat box



Questions?

- Please submit your content related questions via the Q&A box
- Send to Host, Presenter and Panelists

▼ Q&A

×

All (0)

Select a question and then type your answer here.
There's a 256-character limit.

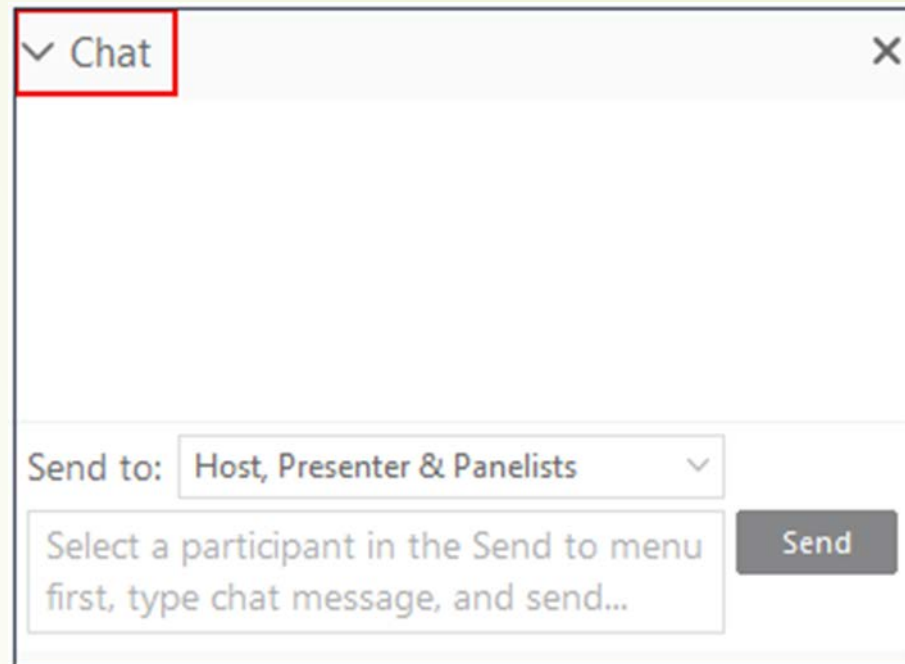
Send

Send Privately...



Technical Issues?

- Please submit any technical issues related questions via the Chat box
- Send the message directly to the Host
- Host will work directly with you to resolve those issues





Learning Objectives

Those attending today's webinar will...

- Become familiar with how SDOH data is being collected, leveraged, and shared in FQHCs and housing agencies
- Consider strategies for improving data use at the intersection of health and housing
- Deepen understanding of data use as a crucial tool for improving care coordination for those experiencing homelessness and housing instability



National Training & Technical Assistance Partners



Joseph Kenkel
Research Assistant
NHCHC



Ian Costello
Program Manager
CSH





Purpose and Background

- Healthcare and homeless service organizations struggle to collect and interpret data
- Data is a prerequisite to decision making; it's a "strategic asset" and sometimes as valuable as money in the bank
- Data sharing and integration is more widespread and accepted and can be done in a client-centered, secure manner
- Important now more than ever



Core Questions

- What data do health centers collect?
- How are data used within health centers and among health centers?
- How do health centers engage with CoCs?
- How and where are data shared between sectors?
- How do we scale that with observed practices and successes?



Project Method

- Project from CSH and NHCHC with support from HRSA
- Numerous focus groups with providers from healthcare and homeless providers at all levels of an organization
- Months-long targeted survey to additional stakeholders
- Extensive literature review and topic research



Data Collection

- To much to collect, at too many point, by too many people
- Leads patients and participants to repeat themselves and their stories for services
- Tools can get in the way of establishing a provider-client relationship



Data Collection – Solutions

- Inventory and cross-walk questions from different tools
- Consolidate questions where possible into one form that can be responded to at one time
- Develop a framework and policy for data collection that lays out in detail the data collection and recording process of the organization, specifying collection tools and roles for staff



Social Determinants of Health (SDOH) in Brief

- Social, Economic, Environmental Factors
 - Predictors of individual health outcomes
 - Contributors of broader health inequities
- SDOH screening and intervention as prevention for chronic conditions
 - Street-based medicine
 - PSH
 - Food insecurity



*“Everything we
do with medical
care is
sabotaged by
the lack of
housing.”*



SDOH Screening Efficacy

- Improvement in advocacy vs. screening and intervention
- Limited provider screening efficacy
 - Low competency in screening (Beaune et al., 2014)
 - Low staff confidence in screening tools (Schwartz et al., 2020)





SDOH Screening Practices

- What is the Health Center's role in screening for non-health factors?
- Spectrum of screening approaches:



Intake questions
(e.g. "Where are
you staying right
now?")

Agency-specific
questionnaires
& screening
protocol

State, regional,
or locally
mandated
screening tools

Integrated
EHR
Screening
Tools



Standardized SDOH Screening Tools

- **PRAPARE** - Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE Core Measures	
Race	Education
Ethnicity	Employment
Migrant and/or Seasonal Farm Work	Insurance
Veteran Status	Income
Language	Material Security
Housing Status	Transportation
Housing Stability	Social Integration and Support
Address/Neighborhood	Stress



Standardized SDOH Screening Tools

- **PRAPARE** - Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Race	Education
Ethnicity	Employment
Migrant and/or Seasonal Farm Work	Insurance
Veteran Status	Income
Language	Material Security
Housing Status	Transportation
Housing Stability	Social Integration and Support
Address/Neighborhood	Stress

SDOH tools emphasize **Actionable Variables**

- Expanded access to care
- Warm handoff
- Internal/External referrals
- Automatically triggered case management resources



Standardized SDOH Screening Tools

- ICD-10 “Z-Codes”
 - “Factors influencing health status and contact with health services”
- Z55 – Z65
 - “Persons with potential health hazards related to socioeconomics and psychosocial circumstances”
- Tracking SDOH over time and supporting care coordination

Common Z-Codes

- Z56.0, Unemployment
- Z59.0, Homelessness
- Z59.5, Extreme poverty
- Z60.5, Target of perceived adverse discrimination and persecution



Challenges to SDOH Screening

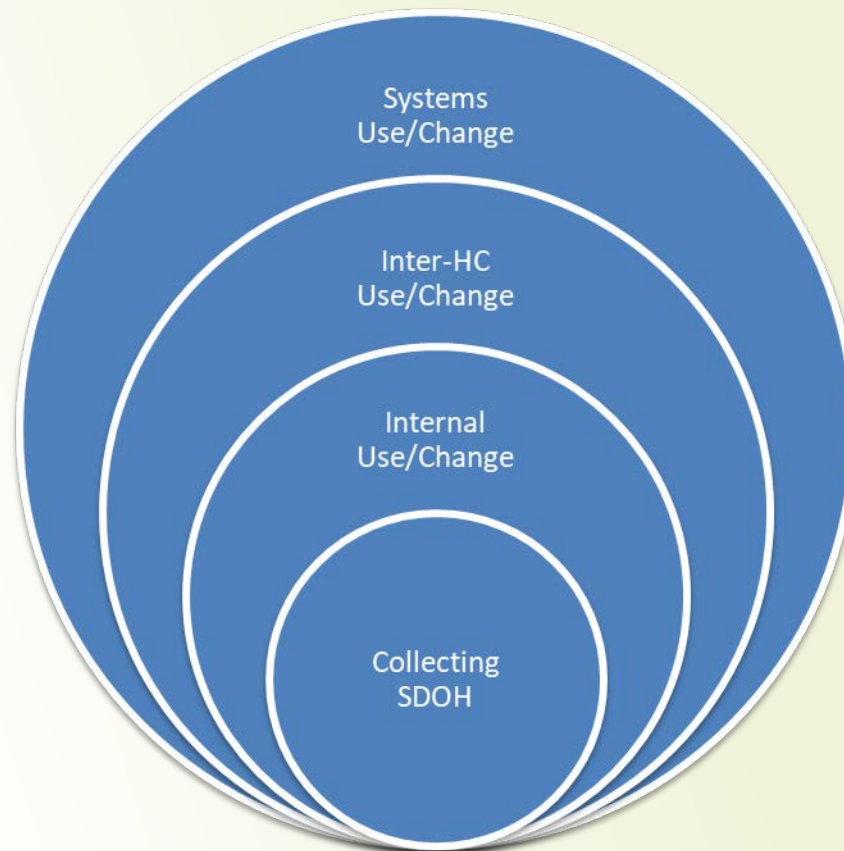
- Time burden on staff and patient
- Trauma-informed screening
- Staff buy-in
 - Attitudes toward data collection
 - Effects on rapport
 - Ethics of data collection
- EHR expenses

"Once staff see why documentation is important—in its ability to prove the need for housing and show a greater need—it changes the whole conversation. From an advocacy standpoint, it is essential to see the need."

"SDoH screening is cumbersome—if screening only took 2 minutes rather than 15, we'd be more interested."



Leveraging SDoH





Leveraging SDoH – Internal

- Internal care coordination
- EHR use at POC
- Integration of agency teams
 - Inner-agency referrals
 - Case conferencing
- Quicker linkage to appropriate care





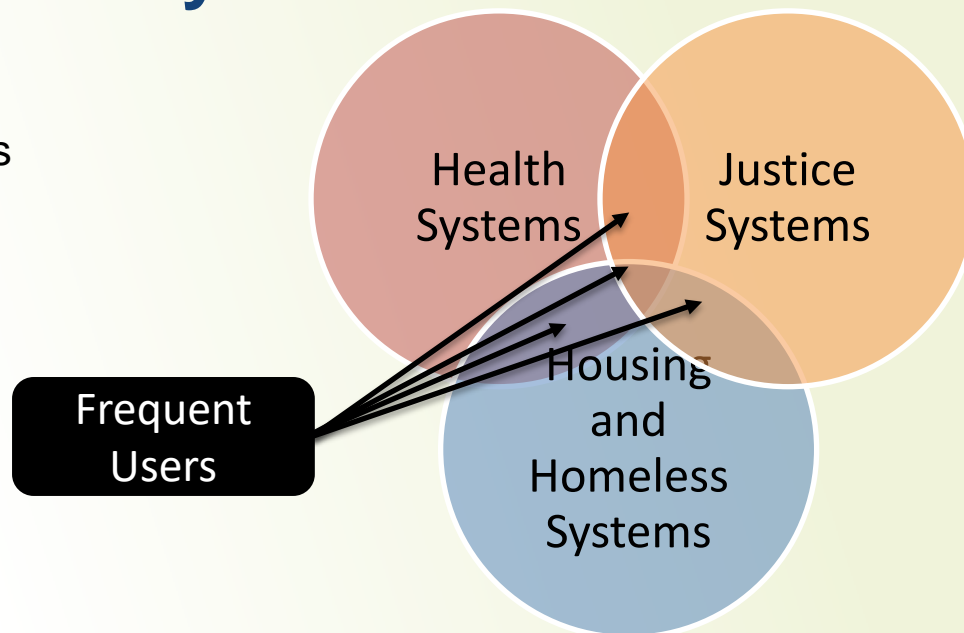
Leveraging SDoH – External

- Electronic Health Records vs. Health Information Exchanges (HIE)
- HIE as trauma-informed tool
- Accessing HIEs
 - HIT vendors
 - HCCNs
 - Established partnerships
 - Homelessness-health coalitions



Leveraging SDOH – Systems Level

- Systematic referral networks
- Condition prevalence
- Resource prioritization
- FUSE-type approach





The data gap

- Differing data definitions
- Limited evidence for screening tools
- Data collection on health in supportive housing setting, housing in health settings
- More research using RCT or QE
- Limited academic-service provider partnerships
- Need for better “big data” applications
- Need for research on societal barriers and acceptance of persons with lived experience of homelessness as neighbors, YIMBY
- Disaggregated data across demographics



Closing the gap

- Quality data and clear policies and procedures
- Comprehensive review and published data sets
- Leveraging those Z-codes for health centers
- Changing institutional culture on data and becoming data driven
- Monitoring progress internally, asking questions, and making improvements



CoCs and Community Assessments

- Our report is aimed at a health center/health-focused audience
- Creates foundational knowledge of key terms and processes of CoC
- Meant to encourage health centers to engage with CoCs
 - Data sharing and integration
 - System contributor/investor
 - Advisor/collaborator
- What we've said to them / what they know
- Common goals



CoCs and Community Assessments

Where to begin?

- Thoughtful, secure data sharing among partners is encouraged
- Many communities across the country already have meaningful and successful cross-sector data sharing initiatives – *they don't all look alike!*
- Reach out back, even as data folks in our roles
- Health centers often want to collaborate on data
- Be patient; be flexible



CoCs and Community Assessments

- Health center participation in CES and conducting assessments
- Health center participation in HMIS
- Data sharing, even at aggregate level and system performance conversations across sectors
- Where do health center patients who may experience homelessness fit in CES prioritization?
- Have you thought about FUSE (Frequent Users Systems Engagement)?
- Facilitate networking to/from local providers for referrals, or justice-involved systems



Communication and Performance Management

- Health Centers have reporting obligations too
- Uniform Data System (UDS), annual aggregate reporting
- Enormous amount of data, difficult to format and analyze
- Heavy reliance on paper forms, data entry to EHR is often secondary
- Start small, build to last; make obvious connections
- Review data with FQHC partners
- One-time matches, where possible
- Define measures of system health and monitor them



Privacy Concerns and Data Sharing Infrastructure

- Ethical concerns in collecting data

"We need to make sure that we have appropriate controls in place—being mindful of what we need to know to serve the person vs. curiosity that won't propel care forward. Confidentiality and data collection is a justice issue. People in poverty are often overexposed in data. We know everything down to their blood type is. People don't know that much about me or you."



Privacy Concerns and Data Sharing Infrastructure

- HIPAA privacy rule
- Better safe than to risk legal issues
- Intersectional privacy concerns
 - Different paradigms of confidentiality
 - Different rules for information delivery
- MOUs and Data Contracts





Privacy Concerns and Data Sharing Infrastructure

Recommendations:

- Audit your organization's policies and ensure there are standardized procedures for informing patients of their privacy rights.
- Make sure you and those at your organization know the HIPAA guidelines on data sharing.
- Don't be discouraged from data partnerships, despite the red tape.
- Make privacy and patient information a point of conversation in your non-health partnerships.
- Identify key organizational contacts to discuss strategies for effective, safe data sharing relationships.



Okay, but what can I do to get started?

- Inventory and cross walk questions, if you have multiple assessments and cut down on the total number of questions asked
- Reach out to health centers in your area, if you have not already – this takes many forms!
- What is the community vision for data sharing and integration?
 - How do health centers fit into that vision?
 - What data do they hold that would be useful to you?
- Review your HMIS documentation and privacy policy to remove structural barriers to sharing



About NHSDC

- The National Human Services Data Consortium (NHSDC) is an organization focused on developing effective leadership for the best use of information technology to manage human services. NHSDC provides information, assistance, peer to peer education and lifelong learning to its conference participants, website members and other interested parties in the articulation, planning, implementation and continuous operation of technology initiatives to collect, aggregate, analyze and present information regarding the provision of human services.
- NHSDC holds two conferences every year that convene human services administrators primarily working in the homeless services data space together to learn best practices and share knowledge. The past 3 events have been put on with HUD as a co-sponsor. Learn more on at www.nhsdc.org and sign up for emails from NHSDC!
- **After this virtual conference is over, NHSDC will be sending out a survey to learn about your experience. Please help us by signing up for emails and participating in the survey!**



THANK YOU! – Questions?



NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL