

## **HUD Exchange - Better Together: Health and HMIS Data, Best Practices and Examples from the Field, 5/4/20**

Ian Costello: Good afternoon, everyone. We're going to get started here in just a few moments. I just want to make sure that you can hear me. So Joey, if you want to gesture that you can -- OK. Great. All right. Great. That's the first challenge always.

I want to welcome you all to our NHSDC session, "Better Together." We're going to talk about the data expiration, best practices for health centers and homeless services. We're really pleased to bring you this session and we'd like to thank NHSDC for allowing us to continue to present, as well as our partners and facilitators in all of logistical health that we've received to bring this session to you. So thank you for attending.

So just a few housekeeping rules, as always on these webinars. So first of all, the webinar is going to be about an hour long. We've tried to reserve as much time as we could for questions and answers at the end in case there are any. Participants are in listen-only mode, which means that you're all muted so we don't get pesty background noises. And I'll do my best to mute myself and unmute myself.

You can submit questions as we go or you can wait until the end, however you like. And you can use the question-and-answer box, which should be appearing on the right-hand of your screen. And same thing for technical issues, if you have any. If maybe you've lost audio or video or what have you, you can bring that up in the chat box and we'll try and address that for you.

So this is what the question-and-answer box looks like. So go ahead and submit your questions at any time and we'll address them at the end. And then technical issues, if you have them, this is what the chat box looks like. You can send to the host, presenter, and panelist, whichever one that you want, for your technical issue and we'll try and address it as quickly as we can.

So without further ado.

Joseph Kenkel: Hey, everyone. I'm going to start with our learning objectives today. We hope that you all will walk away from the webinar today having become more familiar with how social determinants of health -- or SDOH -- data is being collected, leveraged, and shared in federally-qualified health centers -- or FQHCs -- and housing agencies.

We hope you will consider strategies for improving data use at the intersection of health and housing. And also deepen understanding of data use as a crucial tool for improving care coordination for those experiencing homelessness and housing instability.

So who's presenting today? My name's Joseph Kenkel. I'm a research assistant with the National Health Care for the Homeless Council, or I'll refer to it as the Council for short. We're a national member organization providing training and technical assistance to health centers, primary care associations, and Health Center Controlled Networks who serve individuals experiencing homelessness, and families experiencing homelessness.

We're a national training and technical assistance partner, along with our colleagues at CSH who, under the guidance of HRSA provide training and technical assistance support to federally-qualifying health centers or community health centers that provide services to medically underserved communities, such as those experiencing homelessness.

And also --

Ian Costello: Yeah.

Joseph Kenkel: -- my colleague Ian. Yeah.

Ian Costello: And I'm Ian Costello and I am a project manager and data analyst with CSH, the Corporation for Supportive Housing. And I've been working closely with Joe and the Council on this project for the better part of a year now. And CSH is -- we do technical assistance, we do lending. My role as -- it's really great. I get to work with a lot of data and a lot of communities and spreadsheets and help people connect data and technology to decision making. So yeah.

Oh, some other housekeeping things I just remembered from my notes. This recording will be available online for you. And also the slides will be also be made available as well.

And far as the echo goes, I'll try and make sure that I mute it when I'm not talking. So hopefully it's me and I can address that. And if not, I'll switch out my Bluetooth, because sometimes that's the problem too.

So just the purpose and background of the report and this presentation, we know that health care and homeless services really struggle to collect data. It's sort of surprising when we did our initial review and focus groups and surveys with folks that there was so many similarities between the kinds of data and the issues that data and its collection create in the housing and also a health care context. And so we really want to bring that to the forefront with our report as well as this presentation.

And we also want to bring understanding around what data should or could be to an organization, that data is a strategic asset. And what I mean by that is that it's as valuable as your money in the bank, your fiscal assets like buildings or equipment. It's really a valuable piece of equipment that you can use within your own organization, that you can use to improve programs and improve decision making.

We also learned that data sharing is more widespread than people might think, and that there are communities and organizations that are doing data integration, doing data sharing, across the country with great success. And things -- data integration and sharing concepts and programs and operations with different -- have different levels of sophistication and accomplish different things. And so we wanted to bring those examples out as well.

And I think during our current -- during the current crisis that we're experiencing right now, I think it's important more than ever to highlight these kind of things for the benefit of everyone.

So some of the core questions we asked for this project. What do health centers collect? What tools are they using? What are they using that data for? How does that relate or not relate to the CoC context, the homeless services context? How and where are these data being shared across sectors or across health centers?

And then probably the most importantly is how do we package those strategies, package those practices that we've observed, into a concise report, a concise presentation, so that they can be scaled and brought to other sectors, other providers, and have the CoCs also work at it?

So our approach. We had -- the initial impetus of this presentation was actually a report that was -- is supported by HRSA. And we started back in probably September. We brought together a couple focus groups that consisted of providers, both health care and homeless providers, everyone from clinicians to data administrators, people with -- (inaudible) -- experience, outreach workers. Really, we tried to get as much experience and perspective as we could to understand some of these questions and begin to parse them out.

This also led to a months-long targeted survey that was put online that had additional stakeholders that we reached out to, that we wanted to make sure that we had geographic distribution, capacity distribution, to make sure that we really did do a 360 review.

And the last thing obviously we did was an extensive lit review as well as topic research on data sharing and best practices and good programming.

So the data collection piece. The most important thing I think that we need to recognize is that there's a lot of data that's being collected. Perhaps too much data that's being collected at too many points by too many people. And this extends to surveys that are being collected.

One of the focus groups that we had, I -- this moment sort of sticks in my mind, where we had all these different folks from different health centers across the country and we asked them, what kinds of data do you collect? And they were very quick to construct a list and we couldn't jot down the examples that they were throwing out fast enough.

So they talked about the obvious ones, the VI-SPDATs with the vulnerability assessments that are conducted on the homeless side for those health centers that are participating in that. But they also said that they have Medicaid required reports and agency required reports. And so that stuck out to me as one of the observations. Like, oh, yeah, this resonates me coming from the CoC world, coming from the HMIS world, as something that is an issue, that's pervasive and ubiquitous across I think data science in general.

And the fallout from that -- the result of having too many tools, of having too much information that you need to collect -- particularly if it's not done all at once, if it has to be sort of drawn out from someone's experience within a health center, within a homeless services -- that it really gets in the way. It disrupts the relationship between a provider and a participant or client or patient.

Saying, you know, I'd love to serve you -- or at least the impression is, I'd love to serve you; I'd love to provide you services. But first you need to walk through your entire life story and ask you deeply personal questions.

And so there's I think a place for technology and for data, and a lot of providers that we've communicated with have started along this journey and are pretty far along as well in trying to address some of these things through data, through technology.

Let me switch slides here.

And some of the solutions that we were able to encapsulate -- and we'll go into a bit of detail later on -- worked from simple understanding to more complicated and complex solutions. The first one that can I think be done right away is taking a stock of what are the different -- and maybe you've done this already. But what are the collection tools that are being used within your organization?

And that could extend to the (HUD TDEs ?), the VI-SPDAT, other assessments or other questions that are being asked, and trying to crosswalk those against each other and saying, OK, this question in the HUD TDE is very similar to this question in the VI-SPDAT, so is there a way that we can solve both of these -- resolve both of these questions at the same time with the same response?

And that really just begins with an inventory of your questions and saying, OK, these questions are similar. And maybe we can connect them at this point in time and then you can understand the scope of the problem and begin to think about where in our processes of data collection can we reconcile that response to these different tools. That's one I way I think to limit the traumatization, the re-traumatization, of those that we serve, because they only have to respond once to a question.

And obviously -- so that sort of solution can extend then from the personal-interpersonal-organizational to the inter-organizational and system, by saying, all right, if we can settle these questions, how do we share that response them outside of our organization with other organizations that maybe we refer our patients to or refer a participant to. And that's where we get into the more complex, the more complicated of developing policies and procedures, developing data use agreements and sharing those sort of things with partners.

Open HMIS, being able to see within -- no matter the partner, no matter the provider, being able to see certain responses I think is a real critical step to addressing some of this data collection re-traumatization. And so that can be taken steps further about how do you connect referrals or how you use some of the data from health centers that may not naturally go into HMIS for prioritization, for example, or for referral networks.

Joseph Kenkel: So thank you, Ian. So a few slides back Ian sort of mentioned the core questions we were looking at in our survey that we sent out to our health center partners. And the first question was really looking at what kind of data are health centers collecting that's helpful in our search for a more comprehensive system and looking at housing partnerships, et cetera?

And so a lot of you on the call today might be well acquainted with the social determinants of health -- SDOH. But we wanted to make sure we did a little bit of level setting so you can understand what data is being collected at the health center level.

So just briefly, SDOH can briefly be summed up as the social, economic, and environmental factors at the centers of health. They're among the largest predictors of individual health outcomes, as well as contributors to broader health and equities in our health care system as a whole.

Study after study over the past decade or more continue to compile -- even in this year, 2020 -- really show that SDOH screening and intervention is key when looking at prevention for chronic conditions. And with the widespread adoption of realizing the importance of SDOH, also we've seen really encouraging approaches take center stage as a means of intervention and prevention for chronic physical and mental health conditions, such as street-based medicine. So making health care most accessible to individuals regardless of housing status, street homeless status, et cetera.

Permanent supportive housing you're all familiar with, but really looking at housing as a key segue into health and a comprehensive view of the health around the individual. And finally, approaches that really emphasize socioeconomic context of an individual. So screening and addressing something like food insecurity as a means of preventing or treating a physical or mental health condition.

So as we sort of transition into our responses on our survey we have this quote on the screen we thought was a great way of segueing and also is just a really good way of summing up one of the key social determinants of health, which is housing. And this is coming from the medical side of things, a care provider saying, "Everything that we do with medical care is sabotaged by a lack of housing."

So despite the obvious improvements over the last years, and they continue to change, we've seen a lot of successes. But screening for social determinants of health on the health side of things remains a challenge. Recent studies that -- even coming out this year -- show that the efficacy of screening is low, posing a concern for community health centers and hospitals who interact with social determinants of health on a day-to-day basis.

Health centers within the HRSA health center program, as we mentioned, those were the key population in our project that we're presenting today. HRSA health centers are uniquely positioned to set the tone and standard for social determinants of health screening. Data use, data partnerships, systems level integration, because they do serve 1 in 12 people in the United States, regardless of housing status, regardless of income.

And so this project in part aimed to look at how these health centers in particular are collecting and leveraging that data to make sure that -- we're making sure that no one is left behind.

So what is and what should be a health center's role in screening for non-health factors, such as housing? We know that social determinants of health significantly health outcomes and that screening can determine interventions and diversion efforts. But we also know that social determinants of health are the data points that guide health care teams towards health and housing linkages.

So for those of you out there -- housing providers out there -- know that this is what's taking place in the health center setting to gather housing status and determine treatment options. The health center setting you know is also -- serves as an entry-level point -- as a service entry point, excuse me. So it's crucial to have this insight into how health centers are gathering non-health data, such as housing status.

So what we learned from our assessment is that really a range of resources are currently being used in the health center setting for assessing these needs and translating social determinants of health data into tailored services. But while these vary across health centers, almost everybody that we surveyed had at least a basic protocol for screening for SDOH, which is great.

But at a minimum, health centers are embedding questions, even if it's just a single question into intake paperwork, such as where are you staying right now? What is your housing status? That information is being collected and either kept on record or input into EHR for access to members of the care team.

Some agency-specific questionnaires -- they're not as common -- are being used to gather that data and make it available to folks in the interagency care team. Some -- Ian mentioned this a little bit before -- but state, regional, or locally-mandated screening tools, such as Medicaid, required screening tools are being utilized. But by and large, the most exciting and the most streamlined approach that we've seen in our assessment are specific standardized screening tools that are being integrated into EHR. So I'll dive into that a little bit now.

So standardized social determinants of health screening tools. Similar to the VI-SPDAT or other methods of determining vulnerability that you've come across, there are standardized tools as well for determining risk factors in regards to health -- in regards to social determinants of health influencing outcomes.

So a common example of this that we've seen a lot in our health center participants is the PRAPARE tool. PRAPARE stands for Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences. And this is a tool that's been created by NACHC, or the National Association for Community Health Centers.

And it's a standardized assessment, just like the VI-SPDAT, that is tailored specifically to help health care providers better understand patient social determinants of health.

So as with the VI-SPDAT, as with other measures like this, you want to focus on variables or focus on risk factors that are actionable that you can use to inform care or treatment decisions that lead to expanded access of care, warm handoffs internally or externally to referrals. So from

the medical side of things that would look like leading towards a referral to a housing agency or leading a referral to case management.

And so the example that we've highlighted here are the housing status and housing stability, which is included as one of the key factors within the PRAPARE tool core measures.

So the most streamlined -- (inaudible) -- that we've seen, like I said, is using this tool within -- as a module within the HER to automatically trigger case management resources, to really expedite the process of building a care team and building continuity of care as quickly as possible.

So within our conversations we also came across other standardized social determinants of health screening tools that were more on the diagnostic side of things. So for those of you that aren't familiar with ICD-10 codes, ICD-10 are the codes utilized by -- excuse me, that were lifted by the World Health Organization that include 14,000-plus codes for representing symptoms, medical conditions. They include both primary and secondary diagnostic codes.

So the Z codes are a specific subset of those ICD-10 that are secondary but are used to track social determinants of health or used to track social situation. So the ICD-10-Z codes specifically refer to "factors influencing health service and contact with health services." And even within those, from Z55 to Z65 are for "persons with potential health hazards related to socioeconomic and psychosocial circumstances."

So these are codes that are specifically included within medical records from the clinician side of things to track something like housing status, which is a really great tool to -- as with the -- what I said before with the PRAPARE, to really guide where partnership is -- where partnership with external agencies is going to benefit the patient at hand.

So common Z codes include, on the right there, unemployment, homelessness, poverty, and discrimination and persecution. All of these, as I said, could be included within the medical record and tracked at a really fundamental level there.

So continuing our conversations with our health center participants, we wanted to zero in on what challenges and what barriers are being faced at getting and tracking social determinants of health data at the patient level. And really what we found are challenges that we know to be ubiquitous when it comes to data collection in general, things that you all will be really familiar with.

Folks in homeless services, housing providers, and other systems of care dealing with gathering data, as Ian was saying, can really be a burden -- a time burden -- on both staff and the patient. Many patients, especially those with complex medical cases or who are experiencing homelessness, receive services from several different providers, from several different sectors at a single time. And this can all get really confusing and really overwhelming. (It can accumulate ?) to exhaust the patient and staff that have been tasked with administering this sorts of measures.

Furthermore, the trauma-informed piece -- I know Ian mentioned briefly as well, but self-reports social determinants of health screening measures, such as the PRAPARE, can be difficult for patients experiencing homelessness and other traumatic situations. And where is the balance between trying to find and gather accurate and valid data that's also in a trauma-informed way? And making sure that the relationship between health care team and the patient is being emphasized and realized.

Staff buy-in is something that we came across pretty much across the board on all of our health and our recipient health center partners' responses. Attitudes towards data collection. You know, we have some quotes from our survey from some clinicians that don't see social determinants of health data or housing data being important to the presenting condition at hand. And therefore, viewing data or viewing these sorts of measures as something that's a bureaucratic -- just another thing to do and to check off the list.

Health centers are also, to the last point here, the expense of EHR system that are useful for integrating these sorts of measures. We know that health centers are limited in the amount of resources that they have. To first provide essential services, let alone to sort of have this scaffolding beneath of advanced technology.

So this is something that we saw in our survey as well, of just across the board it looks different at every health center, as it does at every housing provider or every homelessness services agency. The technology is just different. There's no standard and this poses a challenge for adopting these sorts of screening tools at a national level.

So I'll take this opportunity to shift modes from the collection piece -- collecting social determinants of health data -- towards what it looks like to leverage that data internally in a health center level, as well as the inter-health center or inter-health piece. So sharing data between health centers and hospitals, et cetera. And then we'll look larger at the system's use, so the system's integration level.

So firstly internal. How are health centers using data and leveraging data internally? So the ideal is that social determinants of health screening tools will strengthen care coordination and service provision. Often the first step for clinicians is to access with data from an EHR underlying database for case review and care. And we find that this is happening. Specific EHR data, including housing, income, and food insecurity can be retrieved in real-time to make treatment decisions. And at the point of care can be access for informing decisions.

Next, integration of agency teams. Using this data to form inter-agency referrals. So not necessarily with external agencies. A lot of health centers that we work with at the Council and that we have as participants in this survey have a lot of diversity in the types of care that they provide. And so they can use this internal social determinants of health data to guide where a patient might go internally. And that does look like case conferencing as well as just integrating a care team and using this data to guide every step of the way.

But look towards externally, between health centers or health hospital systems, EHRs often don't quite do the trick. They're intended to be immediate and transactional at the point-of-care level,

which is critical for inter-agency data use. But another thing for external sorts of partnerships. Becomes expectedly more complex when you get to that level.

So health centers are, by -- increasingly -- it's not by any means ubiquitous at this point, but more and more we're seeing health centers participating in health information exchanges, using the sharing to -- much like on an internal level you can use an EHR to gather data pretty instantaneously. Looking externally and using the HIE to gather information and participate and partner on a different level, on a whole different level with that information.

So similarly, HIEs can be leveraged as a trauma-informed tool by having access to maybe past experiences that you might not -- without the HIE information, you might not know the patient history. And so you can leverage that information to approach in a more trauma-informed way.

So we know that health centers are accessing these HIEs through health information technology vendors, through their health center control networks. HCCNs are a HRSA designation for funding, so within this you find a lot of health centers able to have access to expanded resources such as an HIE. Other sorts of established partnerships, like homeless and health coalitions, formed nonprofits, like we've seen in Hawaii, that offer a lot of access to less traditional sorts of partnership sharing like information sharing.

So it's -- HIEs are an exciting sort of thing that we hope to discuss more and we hope to explore more and learn more about.

Ian Costello: Thanks, Joey. So I just wanted to take it from the -- hopefully you can still hear me. I switched my earbud. OK. Great. Hopefully it's less echo.

So I want to go from the internal-external to the systems level. And I'm not sure if you can see the Q&A, but one of our colleagues here raises a really important point. And I actually wanted to raise a few things that I mentioned beforehand.

And from Jennifer -- so there's a distinction I think that needs to be called out between what social needs are, what SDOH is. And I really do encourage you to look at the two resources that Jennifer posted in the Q&A. They're from a really great -- if you haven't signed up, they have a fabulous newsletter. And so I know everyone's always looking for the next listserv, so -- but I really do recommend Health Shares (ph). It's a really fabulous resource. You can learn a lot from even just their free content.

And the two resources that she linked in there talks about social needs versus social determinants and that. It's individual versus community or societal. And so I'm not an expert in all of these things. I'm not a provider, never been a case worker or worked with patients or participants at that level. But I've worked with people who have done that.

And I think related to those questions, related to those observations and insights, I think at the system level is where you can really be thinking about these things as far as how can it -- at the same time, how can the data that we're collecting at an individual level address this person's

experience of homelessness, address this person's diabetes, address this person's chronic illness, as a result perhaps of their environment?

Maybe the -- the example that's provided is that maybe somebody has mold. And so they come into a health center that is addressing someone's health challenge as a result of them having mold. Maybe they have some sort of respiratory thing. And maybe they're able to address that person's mold. But it doesn't address necessarily their neighbor's mold or the next building's over's mold. And so how can the data that you're collecting on this one person related to their environment and how their environment is affecting their health, help others, help the community, help the system?

And one of the ways that it could do that, that you could begin to connect data to these sort of policy interventions, is by collecting it. And so -- yeah. I'll make sure that maybe there's a resource slide that I can draw from to plug all these things in at the end, so that when I post the -- I'm sorry. I'm addressing the chat here. Once the webinar goes up, the slides get posted, I can maybe create a resource slide so that it has all the different things that we're talking about so it can all be captured.

But one of the ways that I think you could connect some of the data that you collect from participants to these interventions is understanding the prevalence. So you can see across sectors, so across the homeless community -- (inaudible) -- understand who is crossing over? And is that important? And to what extent do people cross over? And then we get into these -- (inaudible) -- user systems engagement type programs -- FUSE programs -- that can then connect them in housing and other resources.

So the analysis of the prevalence of certain conditions can lead you to think, OK, what does that mean as far as social determinants of health? What are the kind of policies that are in place in our community or not in place in our community that may be causing these conditions that we're beginning to see?

So one of the things is you have to understand to what extent is there an issue in my community? Is there an issue with diabetes or HIV/AIDS transmission or respiratory -- (inaudible)? I live in Los Angeles. In L.A. we have a large problem with pollution, particularly by one freeway called the 710. And the 710 carries a lot of the nation's goods. We have the biggest port -- one of the biggest ports, if not the biggest port, in the United States down in Long Beach and Los Angeles. And so all the trucks that come through the 710 carry all the goods that then go to the rest of the country.

As a result of that, the communities that live along this freeway have much higher rates of respiratory issues, of perhaps even cancer. Issues have become a real big deal here and that your zip code is probably one of the biggest social determinants of health that we experience locally.

And so the collection of that information from folks that come into health centers, that may experience homelessness, some other systems that you have. I mean, this is not inclusive; there's just three of the big ones.

But that's really the value when you're trying to connect someone's individual needs. And yes, offering them services and offering them a solution. And at the same time, keeping that person's -- (inaudible) -- and aggregating it to say at the system -- (inaudible) -- experiencing -- (inaudible) -- we need to either put into place or change that may be impacting those things. So it's really getting at the root cause analysis of these social determinants.

So I hope I was able to do justice to your insight. I think it's a really, really good point and is very, very critical.

OK. I don't want to get too far ahead of myself. So how do -- what do you do? There's a really great report that came from the National Academies of Science. They put together a committee that evaluated the data -- well, among other things -- the data gap that we experience that connect housing, particularly from supportive housing, to health outcomes. So to what extent does someone being in housing, particularly PSH, impact someone's health outcomes.

And it seems sort of like a no-brainer. Like, of course, if you're in housing you're probably going to experience less negative health consequences. That's true. I mean, there's really no question that PSH particularly is an evidence-based practice that ends someone's homelessness. But when it gets down to how does it impact someone with diabetes, how does it impact someone's asthma or someone's heart condition, it's sort of -- probably, but we don't know to a specific degree what that means, how it does it.

It certainly lowers risk of emergency service use. And the Academy, the committee that reviewed all these different reports also came out saying -- also has a quantifiable significant impact -- that is, PSH has a quantifiable significant impact -- on people living with HIV/AIDS and their ability to control their condition. And that I think is connected with access to medicine, access to refrigeration, access to supportive services that are able to say, hey, are you med compliant? How did it go? What do you need? How do we help?

So along with all of that they said -- (inaudible) -- to a scientific degree, we can't really say how it affects housing -- how that affects health outcomes. And they also gave us the path forward to say, this is what we noticed as gaps. And so we sort of took that as a way to frame then some of the solutions that we wanted to consider. And I think that these are in some ways truisms, that these exist and everybody know them because they were my experience working with HMIS, in working in a CoC environment. And they're certainly I think the health centers' experience as well.

And that's -- different data definitions among tools, someone has a different definition of homelessness and it's a real big one that we see. And that there's limited partnerships across the community within academia and also service providers. I think there's some great examples that are going on across the country. In Los Angeles we have the Homeless Policy Research Institute, HPRI. Definitely recommend you check them out if you haven't already. The California Policy Lab, among others that really connect into the provider community, the provider experience, and try to leverage their academic backgrounds as a way to help improve programs and make people's lives better.

And then also just aggregated data across demographics. I think that we get really hung up on privacy and so -- and rightly so; that's a very important point that we should keep in mind. But a lot of the time we focus on the aggregate and we don't look at demographics, particularly race, ethnicity, gender.

And so this raises very, very large equity issues when we're looking at data, looking at -- (inaudible) -- performance, looking at how to improve performance. Those demographics are also critical. We need to really remember it and get into the practice of understanding how do we use data to address policy? And understanding that all policy is racial policy. And understanding before I make decisions how it may impact communities of color, women, and make sure that they're not increasing equity or advancing inequity -- or make it so that we're not advancing inequities, that we're really using our policy -- (inaudible) -- so bring those barriers down.

To do that, we need the data. And you need to make sure that you're looking at demographic data and keeping that in mind as you do analysis.

So I may have gotten ahead of myself a little bit. But the quality data begins with policies and procedures. I know it's really bland and dull but it's so, so important because it really does help the organization help people on the ground and help those that you serve understand what you're collecting and why. How does my response, whether I say A or B, really affect policy, really affect program and program improvement, affect my life?

So having all these things down -- and what I mean by that is having the collection procedure, having the policy of why we collect these things, what we do with our data, in very clear terms that can be communicated easily to someone that you're serving to get that data and make sure that that message is consistent across the organization. Consistent across CoC, consistent across HMIS, so that you can build these into the procedures that come with your community. Can be one of the most important steps to getting to a more complicated, advanced solution, like data integration, like sharing even.

Because all of these things are predicated on good policies and procedures. So the data use agreements that you need to sign, everything that needs to happen, it's so much easier if you have good, comprehensive, concise policies and procedures. Everything else really is kind of gravy.

Coming from that, you have connecting to health centers and other organizations that may serve the same populations that you do. And creating a culture in your organization, in your community, that is data-driven. There's some great resources that exist. I'll make sure to put a link on the slide that I create before the presentation is posted.

There's another HRSA provider called HITEQ and they have fabulous resources, fabulous webinars, on how to become more data-driven. They're geared more toward health centers, but I mean, many of the concepts that they explain, that they bring forward, are geared toward just data folks. So a lot of the things that they were talking about resonated with me as someone with an HMIS and CoC background.

Going to try and speed through some of this so we can address the questions that are popping up. Why we're telling you all this is we went to health centers and we talked about the kinds of data that the health centers are -- the kind of data that CoCs are collecting, why it's important from a health center perspective to engage with CoCs on a more in-depth level than maybe people have. We talked with health center partners at the focus groups and in surveys and we asked them very directly, what is your relationship with your CoC? And we got as many responses as stars in the sky.

But there are many health centers that do already contribute at a pretty deep level within CoCs and that's I think a good model. And so we're telling you all this because we want you to be educated and understand what a health center goes through and thinks about so that you can reach out to them as well and begin that relationship. And it doesn't -- again, it doesn't have to start with data integration and data use agreements and all that stuff; it can really start quite small. So the main takeaway here is that you have a lot of common goals that you can advance together.

So again, where do you want to begin? One of the things is that -- to recognize one, that data sharing and data integration is being encouraged. So HUD encourages data sharing. HRSA encourages data sharing. Obviously this happens under the aegis of HIPAA and where it's covered, where it's necessary, and other privacy obligations that you have in your community through HMIS agreements and policy and procedures. But at the same -- so that's one thing that you need to recognize.

The other thing is that, like I said, data sharing and all the stuff doesn't look alike. And that you really need to make it work for your community and start small. Because maybe it's a coffee, maybe it's just chatting with someone in a health center environment, that hopefully we're giving you some of the language, some of the tools, some of the things that health centers think about to start a meaningful dialogue and go down the path of data integration.

Beginning to think about how does the data that health centers collect, prioritization criteria, for example, affects my (binding ?) list. How can I get a more complete picture of those that are experiencing homelessness in my community? And I think it's really critical that you include health center data in that, as well as justice-involved data.

And I know it's cliché and annoying to hear, but also just to be patient and flexible because these things obviously don't happen overnight. None of the communities that we engaged with that had very meaningful data sharing processes, didn't happen quickly. And I think anyone who's done it will tell you that you have to be patient. And it's annoying to hear, but it's so necessary to remember.

So again, these are some of the things that we thought about as far as what are the kinds of strategies that you could employ with health centers to advance some of these data sharing questions? One is maybe -- like Joey was saying, health centers are an entry point to CES, to folks that are experiencing homelessness that never maybe engaged with homeless services in the past. So them collecting on housing status, on homeless status, may be an important data point for your organization. So starting there might be a good way to just begin.

All the way up to a FUSE program and having a data sharing protocol because the health centers and the homeless population to understand who is going back and forth between those two sectors, to what extent, and how do we prioritize them toward housing?

So from a communication/performance management standpoint, health centers have reporting obligations too, just like we all do. Instead of HMIS, they collect in a system called the Uniform Data System. And it's a federal system that collects aggregate reporting. So it's not record-by-record, it's not very -- or it's not detailed -- I mean, it's very detailed, but it's not client-specific detail.

And it's an enormous amount of data. I mean, if you've ever worked with UDS data, it is really cumbersome. I had a good deal of difficulty working with it. And it's getting better, I have to say. They have data standards, just like HMIS does. And they improve it year over year, just like HMIS does. And so you can be secure in the fact that health centers do collect information to maybe work your way up from CES, from HMIS participation, to doing a one-time match.

So saying maybe it's not a complete FUSE full-blown program where we have all these sophisticated policies and data sharing protocols. Maybe it's just one time extract of the health center information and the HMIS information to determine who are we seeing that's the same and what is their experience, as far as service experience, and how can we -- through policy, through system performance, understand how to maybe stop those cycles of re-incarceration, of re-entry into health systems and use of emergency services and re-experiences of homelessness.

So these are small building blocks that hopefully work your way up to more sophisticated data sharing practices.

Joseph Kenkel: Great. Thanks, Ian. In the interest of time, I won't spend too much time on these couple of slides, just so that we can address some questions that we've gotten. Thank you all for your participation in the comment box, by the way.

But we just wanted to briefly touch on the privacy piece of things, which from all angles can be a little bit of a challenge and something that deters partnership often times, and in what we've seen in our survey as well.

But in terms of ethical concerns of collecting data, this quote here came from our survey and we wanted to make sure that we just gave you a chance to read it. Because we thought it was a great way of kind of summing up how a lot of providers on -- (inaudible) -- side of things are viewing this issue. So we need to make sure that we have appropriate controls in place, being mindful of what we need to know to serve the person, versus 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 what their blood type is. People don't know or have access to that much about me or you.

So like I said just briefly, the HIPAA privacy rule -- and Ian kind of mentioned this before too, is under HIPAA there are several avenues of establishing partnerships. HIPAA does not prevent health centers and other covered entities to use and disclose some PHI without written authorization for care coordination and continuity of care. Poverty disclosures are specific -- subject to specific rules regarding each agency's relationship.

And Ian, did you actually -- do you want to kind of comment on the covered entity piece?

Ian Costello: Yeah. So --

Joseph Kenkel: Just quickly.

Ian Costello: Yeah, sure. So covered entities is -- it's a very specific definition. I am not a HIPAA expert. And so I think -- and what I do know is that HIPAA is often used as a barrier. That many organizations are maybe risk averse. And that's totally their prerogative to safeguard data, safeguard patient rights. But there's more to it than that. So there are covered entities that have to abide by HIPAA. I would encourage you to look at particularly HUD resources.

Fran Ledger, who may you've participated in some of her webinars, there at NHSDC, she did a great session with NAEH -- National Alliance to End Homelessness. She did a great webinar on some of this data stuff. And I'll be sure to find the link and post it in the resources here. Where she talked -- where the question came up around, OK, well, we're an HMIS entity. How does HIPAA affect or not affect us? And she encouraged everyone to look at their privacy plans, to consult counsel where it's possible. But it's not as big a barrier I think as some may build it out to be.

So there are certain things that HIPAA require of you as a covered entity. And there may be homeless organizations that are not necessarily covered entities. So it's better to be safe than sorry, so talk to counsel. Get as much data -- get as much resources and information as you can on it, and have a very clear understanding of what are the do's and don'ts, what are my obligations as a provider to share information before you really start down that path. It'll save you a lot of headache later on.

Joseph Kenkel: Thank you. And yes, I think we can get to questions. That'd be great.

Ian Costello: Great. So I'll try and start from the top as much as I can. Let's see. So, "What about CoCs that utilize the full SPDAT as opposed to the VI? Is there any impact on the screening component?" I can't recall exactly what this was in relation to. If you could maybe post a little more detail in the chat, I can maybe explain.

But while we're waiting for that, "We are serving all the Z code populations that were referenced, but we're not a health organization. Do we need training on social determinants of health?" In many ways I think that we sort of come with an understanding of what social determinants of health are. They're not -- they're pretty obvious, right? So they're things like environment, like experiences of homelessness, family history, incarceration. All these things are fairly obvious things that we could infer would impact health.

I don't know if you need necessarily specific training on SDOH to collect information on the people that you're serving already. I think we call out Z codes as something that you can know that health centers are able -- there are many health centers that do collect Z codes; there are many that don't. And it's an emerging trend that providers do -- that health centers do start to collect Z codes and ICD-10 codes. And that comes with an environment -- that comes with a changing of the culture.

So where providers, particularly in the health environment -- and I found this surprising when we did our focus group, but it makes sense I think, is that if you're a provider -- and maybe you experience this in your own work if you're a clinician or a social worker or work with participants in your program. And that's, if I can't solve your problem today, then why am I documenting it?

So as a nurse or a physician or someone doing intake that may collect on certain information, a lot of folks say, well, so what if I say in your record that you're experiencing homelessness? What does it matter? And it matters because then we can understand prevalence. Maybe then that Z code can connect into a referral network that can help.

But from a clinician standpoint, what we got from the focus group is that it's very one-on-one and interpersonal and transactional between them and the patient. And that anything that they record in their record is up to them to resolve. And that's a mindset I think that needs to be changed on the health side, because only through knowing what people are going through, what people are experiencing, both for themselves to receive appropriate services and also as a system to address some of those systemic and inter-organizational issues.

Joe, anything else to add on that? I'm sorry. I don't mean to --

Joseph Kenkel: No, no. That was great. Thank you.

Ian Costello: OK. Let's see. "Before we set up a new data collection software, do you have recommendations for us? We'll be proposing a wellness navigation center for our county. We're unfamiliar with (sales ?) tools nationwide -- (inaudible)."

I would suggest I think, if you haven't already, engage with the CoC, engage with you HMIS administrator. There may be opportunities to have direct links. All these different software -- it's really hard to say because all the different software solutions that exist are different and have different capabilities and different needs.

If you haven't already, I would connect with your HMIS administrator to see what's possible. What do you want out of it? So starting small. So understanding, where are my referrals coming and going? Is it possible to establish a direct link between these softwares? What do our providers -- so who's going to be participating in this software? What do they think about it? What do they need from it? So those are very general recommendations. But I think first and foremost is to open some dialogue, if you haven't already, with your HMIS administrator in your community.

And to do that, if you don't already know who those folks are, you can start with the CoC and you can go to the HUD website to figure out who the CoC leads are. And generally speaking, they have contacts as well that you can get a hold of folks.

"FQHCs do not collect info into UDS. We extract EHR data and submit." That's true. I'm sorry. That's a very important distinction. UDS isn't the software that people use; it's the -- what do you call it -- repository I guess is maybe a better term. Where extracts from individual health centers are formatted in such a way, similar to the annual performance reports that get uploaded into Sage. They're formatted in such a way that it just uploads into the repository and there you go. So hopefully that -- yeah, that's a very important distinction. Thank you.

Let's see. I think we can handle a few more questions. "Are there any CoCs contributing HMIS data to regional or state HIEs?" (Pause.) I don't know about that way. I'm not sure about if it's HMIS to HIEs. But certainly HIEs to HMIS. So that is happening. Health centers individually also contribute to HMIS. That's a really good question. I don't want to say for sure. I have an inclination that maybe one or two, off the top of my head, but I don't want to misspeak.

Let's see. Oh, "Is the report published? Can you share the link?" Yes, the report -- so yes, we could share the link. No, it is not published but it's on its way.

And I think we have time to do one more. Let's see. "We currently track homelessness on a chronic problem list in our EHR. Is there a better suggestion for this?" About tracking homelessness? I'm not sure. Maybe the Z codes are right for you. That would probably be my quick recommendation. I'm not sure, I'm sorry, without more specifics.

Joey, I don't know if you have any thoughts before we close.

Joseph Kenkel: No, no. Yeah, I would agree. I think looking into the Z code solution would be great. But we can also make our contact information available to follow up with any questions that we weren't able to answer as well. I know I'd be happy to kind of tap into some of the counsel resources to make sure everybody has their questions answered as well.

Ian Costello: Yeah. Great. So just -- so we will post our contact information on the webinar. I'll update the slides with the resources that we discussed and we'll make our contact information available in case you have questions or want to connect with us. We really thank you for your participation and all of your great insights and thoughts. It's been quite a journey to complete this project and do this presentation.

So I hope everyone is able to stay safe and be well.

Joseph Kenkel: Thanks, everyone.

(END)