# HUD Policy Brief:
## Understanding the Impact And Potential for Health Centers

## Data Matching

### Introduction

Health centers are increasingly addressing the social determinants of health for their patient population through partnerships and linkages to local housing and service resources. In this continuous effort to improve health outcomes for patients, there are many resources that exist through partner federal, state, and mainstream infrastructures that should be part of a health center's "toolbox" to aid in linking patients to local housing. Matching data from the homeless crisis response system to claims data from health centers is one way to identify and engage individuals in both systems who are experiencing homelessness and medically vulnerable. Health centers can be key partners in linking eligible individuals who are experiencing homelessness to sustainable affordable housing and providing integrated care.

### Data Matching Basics

Across the country, communities see similar patterns playing out – there is a subset of particularly vulnerable individuals experiencing homelessness (usually single adults) who cycle in and out of hospital emergency rooms, get picked up by police and enter jails, and interact with many other public services. These 'frequent users' experience poor outcomes and unmet needs, and the health care system incurs high costs related to avoidable crisis care utilization. Evidence in study after study has shown that housing – particularly supportive housing – can reduce utilization and costs associated with emergency crisis care for single adults with chronic disabilities, and improve health and other outcomes. Despite the proven benefits of supportive housing, communities typically have far more people that need this intervention than they can serve with existing resources. High utilization of crisis services is a factor they may choose to help prioritize individuals for available units. In order to examine the impact that high service utilization is having on hospitals or the local health care system, and to "make the case" for increased investment in housing, communities are performing data matches between homeless management information systems (HMIS) and health system data (hospitals, health centers, managed care, and Medicaid agencies, to name a few) to look at the intersection between homelessness and high levels of health care utilization.

> CSH FUSE is a proven model identifying frequent users of jails, shelters, hospitals and/or other crisis public services and then improving their lives through supportive housing. For more information, see csh.org/fuse

> HUD issued a notice in January 2017 that included matched administrative data as an option for CoCs to use in the prioritization process for housing. Find it here.

***Goals***

The most common goals for sharing data related to homelessness and health care services are:

- To identify highly vulnerable persons who are experiencing homelessness and quickly **connect them to housing**.
- To **understand the complexities** of the target population, both medically and socially, to help address policy concerns such as rising health care costs, and shape integrated housing and services interventions to meet the needs.
- To **identify the costliest and most vulnerable subset** of high utilizers to prioritize them for supportive housing. If a Continuum of Care[1] (CoC) has identified this population as a priority

[1] The local body responsible for coordinating resources and programs for persons experiencing homelessness in their community.

for housing through their coordinated entry system[2] (CES), then data from a match can help to prioritize individuals.

- To **increase coordination** between health and homeless/housing systems in order to improve outcomes for shared patients/clients.
- To **make the business case** for creating and/or targeting supportive housing for the costliest and most vulnerable subset of individuals experiencing homelessness. Baseline data can help illustrate the potential return on investment (ROI) that can be generated by funding supportive housing for the costliest and most vulnerable high utilizers.[3]

***How it Works***

Sharing data across health care, homeless, criminal justice or other systems can range from simple, one-time matching to fully integrating data at the city, county, or state level. In the homeless field, some states have state-wide HMIS databases; more typical is that each Continuum of Care (CoC) has its own database. Many states are using or developing state data warehouses to be able to view data on those who are receiving Medicaid, child welfare, TANF and SNAP benefits in their state and who might also be homeless.

Here is an example of a data sharing process:

- Identify a high utilizer population, looking at frequency of use across multiple systems;
- Match data from those systems to identify individual high utilizers or a priority population;
- Work across systems to locate identified individuals. This could include specialized outreach teams or flagging charts;
- Locate, engage and connect these individuals to housing and services;
- Evaluate and track outcomes – impact and cost effectiveness; and
- Replicate and scale the model.

The State of Connecticut (CT) began matching data from HMIS and Medicaid in 2012 to target high users of Medicaid services who are also homeless. Since then, CT continues to match data on a regular basis. The cohort of those who received supportive housing has shown significant decreases in average number of emergency department visits (13 in the year before housing to 5 in the first year of housing) and overnight hospitalizations (8.5 in the year before housing to 2.7 after).

## Health Center Connections

Having an understanding of data matching and how it can help identify and improve outcomes for highly vulnerable patients provides another tool in the Social Determinants of Health toolbox for health centers. Some specific steps that health centers can take include:

- Define your purpose for data sharing. Do you want to find out the homeless status of your patients? Or do you want to connect patients experiencing homelessness to housing more quickly?
- Find out what may be already happening in your community. Your local CoC may be interested.[4] Make a pitch to the CoC to explore a data matching partnership. For example, your community may be interested in using matched data to inform your local housing coordinated entry prioritization process. You may be interested in connecting your patients who are homeless to housing resources. Participating in data matching can help ensure that your most vulnerable patients experiencing homelessness have their utilization information captured in the CES, for use in decisions about prioritization for housing. Getting your patients

[2] HUD requires every CoC to operate a coordinated entry system for persons at-risk of or experiencing homelessness. This system coordinates screening, assessment, and referrals to resources in a given geographic area, using a comprehensive and standardized assessment tool.
[3] CSH Social Innovation Fund Projects use data matching to identify high utilizers of health and/or criminal justice systems and provide them with supportive housing. Information on these projects can be found here.
[4] You can find your local CoC here.

housing will lead to better care coordination as well as increased chances for better health outcomes.

- Identify a team internally to participate. Your Health Information Exchanges (HIE) staff will be important to identify the data, how to get it, and how to share it. Health Centers will need legal counsel to advise on privacy and Health Insurance Portability and Accountability Act of 1996 (HIPAA) and to draft data use agreements; staff from your social work and even front desk staff -anyone who has contact with patients who are homeless on a regular basis will have an interest in this issue and can help identify patients who may be frequent utilizers and homeless.
- Develop a plan and the legal documents to allow the sharing of the data, and define how the data will be used.

The core leadership team should include individuals who:

- Are committed to providing the staffing capacity and support to drive the data match effort forward
- Have decision making authority and ability to influence the process
- Have direct access to data sets regarding the proposed target population
- Have direct access to the proposed target population

***Challenges and How to Overcome Them***

Frequent challenges experienced by communities beginning data sharing work include:

- **Data systems do not talk to each other**. CoCs use the HMIS database to document basic demographic information as well as homeless status and system utilization. HIEs, electronic health records, and managed care databases are completely separate from HMIS.

  There are a couple of ways to share data when the systems do not talk to each other. One way is to execute data sharing agreements between the health care system and HMIS and send encrypted files or datasets to one of the entities (data usually flows from HMIS to the health center) or to an outside entity (like a university) to do an analysis. The other way is to allow one data system to "reach into" another data system to pull the information. For example, in NYC, the coordinated entry system can pull directly from the Human Resources Administration database (which has state public benefits information) and the Medicaid warehouse to get information that is relevant to an individual's vulnerability assessment for prioritizing them for permanent housing. Either way requires data use or business associate agreements and secure file transfer protocols.

- **Verification of homelessness in health records may be lacking**. Many health centers, as well as hospitals and Managed Care Organizations (MCOs), do not document the homeless status of patients. This lack of information can be a challenge to identifying homeless patients for referrals to the homeless system. In addition, definitions of 'homeless' are often different depending on the system. For instance, the education system uses a different definition of homeless than the CoC homeless system. And persons who are doubled up are not homeless under the HUD definition.

  Health centers and other partners can work together to ensure that even when definitions do not align, enough information about homeless status is collected to make a determination based on any of the common definitions.

- **HIPAA and Protected Health Information (PHI) concerns.** Privacy concerns continue to be a barrier to cross-system data sharing. In many cases, creating a Business Associates Agreement between partners can help to set up parameters and protocols for data sharing that protects participant privacy under HIPAA. CoCs are required to post a Privacy Notice that outlines what the CoC will do with the data in HMIS.

  Determining what information can and should be shared with other providers is something that both health centers and CoCs should consider from the start when setting up arrangements

with each other. Sharing the least amount of personal health information possible is the best practice.

- **Consents and ROI concerns.** Most CoCs have consent forms that allow them to share data with partners who have signed a Memorandum of Understanding with the CoC. Your health center patients sign releases of information that allow you to share certain identifiable information for the purposes of treatment, including care coordination.

  Before sharing data, review your ROI forms and the CoC consent forms to ensure that you have current patient's and client's permission to share data.

- **Time**. Data sharing takes time, even when all partners agree on the goals and are willing to work together. Leadership and sustained commitment from all partners is crucial.

Health centers should identify staff resources and potential monetary resources to support this work, understanding that it is valuable and can lead to significantly improved outcomes for patients.

## Resources

- CSH's FUSE center, available at csh.org/fuse, has a wealth of resources and information about FUSE, including a tutorial for health centers looking to partner in a FUSE initiative.
- USICH's Data-Driven Strategies for Client Identification, Enrollment, and Cross-Systems Care Coordination, available here discusses data matching, FUSE, and other strategies that can help housing, healthcare, and social service providers identify shared clients and link them to the services they need.
- USICH's Project 25: Saving Money While Saving Lives, available here, highlights one community's challenges and successes with matching data to connect homeless, frequent users of public resources to housing and services.
- In Enhancing Coordinated Entry through Partnerships with Mainstream Resources and Programs, available here, USICH explains why and how to include mainstream resources in communities' coordinated entry process.

## ABOUT CSH

CSH has been the national leader in supportive housing for over 25 years. We have worked in 48 states to help create stable, permanent homes for individuals and families. This housing has transformed the lives of over 200,000 people who once lived in abject poverty, on our streets or in institutions. A nonprofit Community Development Financial Institution (CDFI), CSH has earned a reputation as a highly effective, financially stable organization with strong partnerships across government, community organizations, foundations, and financial institutions. Our loans and grants totaling over $750 MM have been instrumental in developing supportive housing in every corner of the country. Through our resources and knowledge, CSH is advancing innovative solutions that use housing as a platform for services to improve lives, maximize public resources, build healthy communities and break the cycle of intergenerational poverty. Visit us at csh.org to learn more.

*This resource is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $450,000 with 0 percent financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government. For more information, please visit HRSA.gov.*