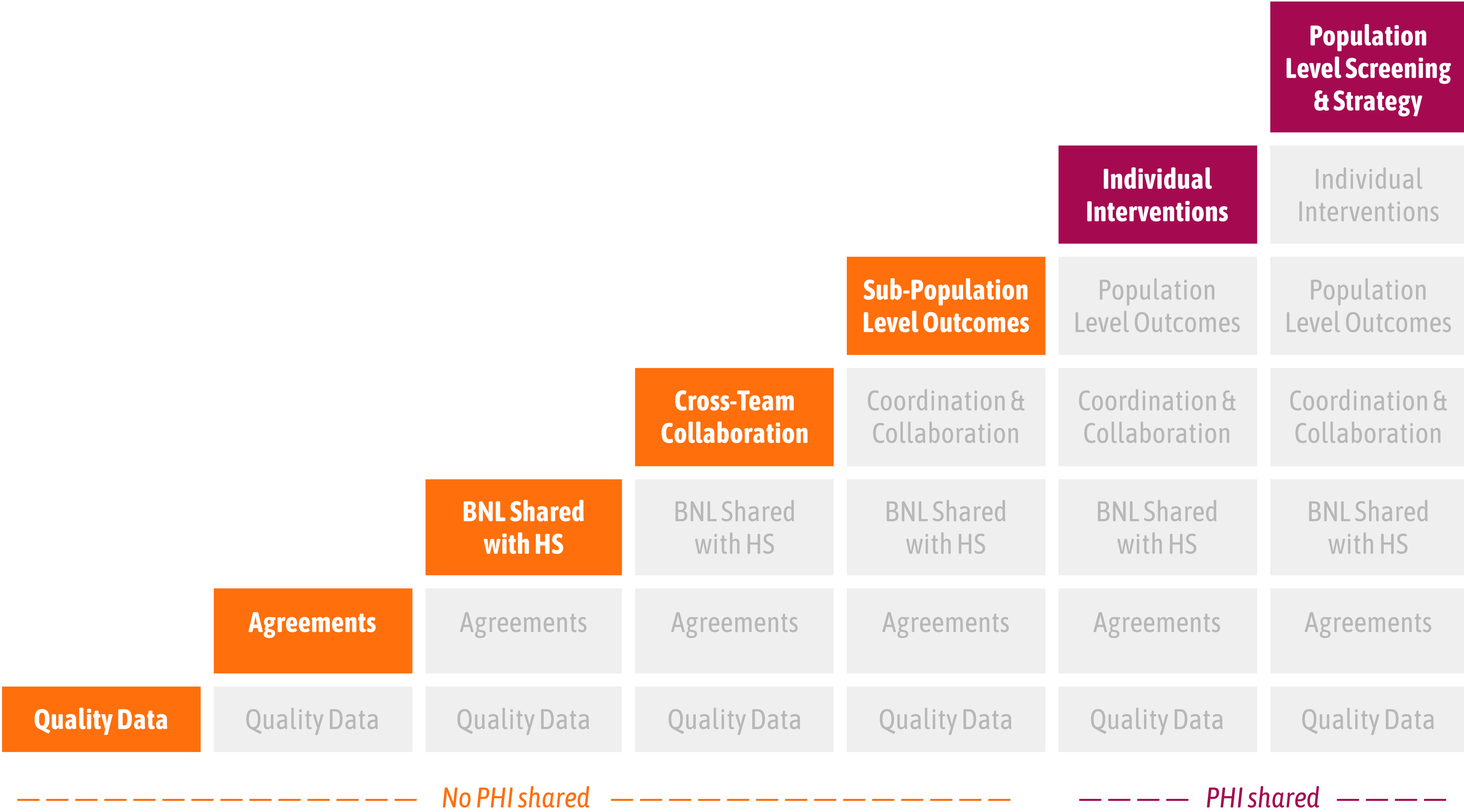
Healthcare System and Homeless Response **System Data Sharing Toolkit**

Purpose

This tool is designed to help facilitate data sharing between Hospital Systems (HS) and the Homeless Response Systems (HRS) in a broader effort to drive reductions in those experiencing chronic homelessness.

The phases are intended to outline an incremental approach to bridging services through data sharing; however, this process is not necessarily linear and the work toward each milestone can occur simultaneously.

Ultimately, this tool is intended to outline an approach to bi-directional data sharing among community support sectors that will modernize collaboration and create a more coordinated effort in ending homelessness in a community.



Quality Data

GOALS

- **Homeless Response System:** To achieve quality data for All Singles including data on chronic homelessness
- **Hospital Systems:** To learn more about the HRS and the initiative in reducing Chronic Homelessness.
- **HRS and Hospital Systems:** Establish an MOU agreement that outlines project goals and objectives.

DETAILS OF ACTIVITIES

- HRS works toward achieving perfect scores on the Chronic and All Singles BNL Scorecard
- HS and HRS work together and build partnerships and set initial project agreements. HS learning and understanding the impacts of chronic homelessness in terms of hospital utilization

DATA SHARING AGREEMENTS

- MOU (Memorandum of Understanding)

SAMPLE DATA ELEMENTS

No data was shared at this point.

RESOURCES FOR QUALITY DATA

- Scorecard
- BNL Guidelines
- Other BfZ resources

Agreements

GOALS

- HRS compliance team and HS compliance team are connected and working together.
- To establish the necessary agreements that are required to share data to meet the project goals.

DETAILS OF ACTIVITIES

The compliance teams from both the Hospital and Homeless Response systems work together to create and finalize the necessary agreements.

DATA SHARING AGREEMENTS

- BAA (Business Associate Agreement)
- MOU

SAMPLE DATA ELEMENTS

Having agreements in place does not mean PHI/PII is being shared. No data is shared at this point.

RESOURCES FOR AGREEMENTS

- BAA (sample)
- DUA (sample)
- ROI (sample)
- Universal ROI from VA
- HIPAA Regulations on Sharing of PHI

By-Name List Data Shared with Hospital Systems

GOALS

- Homeless Response Systems add partner Hospital Systems to their Release of Information.
- Establish a data sharing process for the By-Name List data of Chronically Homeless individuals from the Homeless Response System to the Hospital System.
- This is an effort to identify the Chronic Homeless individuals from the BNL that are high utilizers of the hospital system.

DETAILS OF ACTIVITIES

- Homeless Response Systems add the partner Hospital Systems to their ROI.
- HRS confirms that consent is in place from each chronically homeless individual to be able to share their names/information with the hospital system.

DATA SHARING AGREEMENTS

- BAA
- MOU
- Individual release of information/consent is obtained from each individual from the **Homeless Response System**

SAMPLE DATA ELEMENTS

The Hospital System is not sharing any data at this point.
Homeless Response System shares the Chronically Homeless By-Name List with the Hospital System.
Data elements include:

- First Name
- Last Name
- Date of Birth
- SSN (If necessary)

RESOURCES FOR BY-NAME LIST DATA SHARING

- BNL Guidelines & Resources

Cross-Team Collaboration

GOALS

- HS and HRS discuss **trends/patterns** in the shared data and coordinate on population-level outcomes.
- HS is coordinating care internally and sharing relevant patterns without PHI attached.
- HRS reacts to the trends and patterns identified by the HS. Preparing for system-level outcomes.

DETAILS OF ACTIVITIES

- The hospital system provides **de-identified** aggregate data to HRS.
- HRS and HS coordinate around overlap, gaps, and trends in shared data.
- HRS and HS develop a process for respite/shelter beds availability for discharge from HS.

DATA SHARING AGREEMENTS

- BAA
- MOU
- Individual consent within the Homeless Response System

SAMPLE DATA ELEMENTS

No Protected Health Information is shared

De-identified Aggregate Data Sharing examples;

- Average length of stay
- # of the length of stays (days) - add up all days that this pop was in the hospital, in ER, etc.
- The number of Emergency Department utilization
- Total # of ED visits
- Total # of minutes in the ED

RESOURCES FOR CROSS-TEAM COLLABORATION

- Providing Read Only Access to HMIS
  - HMIS Participation Agreement Template
    - Requires adjustments to specify Read Only
- Providing Write & Read Access to HMIS
  - HMIS Participation Agreement Template

Sub-Population Level Outcomes

GOALS

- HRS and HS co-develop a plan of action to use the aggregate data that is shared from the HS, either through dedicated Case Manager or other system.
- HRS uses aggregated data from the HS as a metric to measure a reduction in chronic homelessness based on the BNL that is shared monthly. HS follows similar process with high-utilizers within their system.

DETAILS OF ACTIVITIES

- Population-level data sharing (aggregate) from HS provides an avenue for HRS to measure a reduction in chronic homelessness.
- High-level trends are shared to inform process and practice change within HRS and HS.

DATA SHARING AGREEMENTS

- BAA
- MOU
- Individual consent within the Homeless Response System

SAMPLE DATA ELEMENTS

No Protected Health Information is shared

De-identified Aggregate Data Sharing examples;

- Average length of stay
- # of the length of stays (days) - add up all days that this pop was in the hospital, in ER, etc.
- The number of Emergency Department utilization
- Total # of ED visits
- Total # of minutes in the ED

RESOURCES FOR POPULATION LEVEL OUTCOMES

Individual Interventions

GOALS

Create a bi-directional data sharing process to improve coordination of care on both HRS and HS sides with the shared end goal of decreasing chronic homelessness and population-level outcomes.

DETAILS OF ACTIVITIES

Individual Interventions:
- Case Conferencing across systems
- Care Coordination
- Hospital Housing Status Assessment
- Respite Care

Reporting Metrics:
Data Sharing examples;
- Length of Stays (In days) for each identified individual
- Total # of ED visits for each identified individual
- Total # of minutes in the ED for each identified individual

DATA SHARING AGREEMENTS

- DUA - Data Use Agreement will be in place but does NOT mean that identified information will be shared - ROI and applicable consents still needed
- BAA
- MOU
- **HRS obtains release of information/consent from each individual from the Hospital System**
- Individual consent within the Homeless Response System

SAMPLE DATA ELEMENTS

Potential Data Elements to be shared:
List of examples

RESOURCES FOR INDIVIDUAL INTERVENTIONS

- HIEs as a tool for Homelessness & Healthcare Collaboration (Desk Research)

Population Level Screening & Strategy

GOALS

Hospital Systems and Homeless Response Systems co-develop a strategy to collect and use housing status data points to get a housing intervention in place.

DETAILS OF ACTIVITIES

- HS creates a process to collect and store housing status in their database/EHR system.
- HS identifies existing data fields in the EHR system to collect and store housing status (or builds new fields if necessary).
- HS create a process to identify and record the housing status of all patients in an accurate and uniform way, including consistent, shared definitions of homelessness sub-populations.

DATA SHARING AGREEMENTS

- **All Business and Data Sharing Agreements are in place.**
- **All consents and ROIs are in place**

SAMPLE DATA ELEMENTS

- Any specific data elements needed for specific providers for case conferencing reasons.
- Answers to screening questions are able to be shared across systems. Name, location of the site, screening questions

RESOURCES FOR INDIVIDUAL INTERVENTIONS

- Social Determinants of Health Screenings in Healthcare Settings (Desk Research)
- VA SOP Outline on Housing Screenings (From Shawn Liu)
- VA Guideline Doc on Housing Screenings

DATA ELEMENTS FOR REFERENCE

- First Name, Last Name
- Date of Birth
- Last known permanent address
- Social Security Number (is this needed to be able to identify someone)
- Unique identifier for the individual in the electronic health record (Integration of HMIS number, hospital id number)
- Medicaid id number
- Medicare id number
- Diagnosis (ICD-10 codes)
- Medication(s)
- Treatment Plan
- Emergency contact
- Care team
  - Housing Navigator
  - Primary Care Physician
  - Medical Specialists
  - Behavioral Health Specialists
  - Community agencies

Data Sharing Toolkit FAQ

Below is a list of questions shared with legal and compliance team members of our Scale AIM Call. The responses outlined in purple are from members of the Common Spirit Team.

If data is shared from another organization (outside of your health system), is it restricted by the same PHI and HIPAA restraints as internal data?

Ex. A local homelessness leader shares a spreadsheet with names, DOB and SSN of individuals experiencing homelessness and asks if your team has served these patients.

"We can receive information from an external entity by we cannot provide any information back regarding patient level data (ex. we could not inform the partner if an individual on their list was seen in the hospital). We could provide aggregate (ex. 50% of the the individuals on the list were seen as long as the list is larger enough and the percent doesn't allow individuals to be identified)."

Context

The limitations of sharing PHI include outside patient-level data shared with the hospital system. In order to confirm any patient-level data (even if it's the HRS sharing their BNL), both parties must have legal documentation that allows the sharing of PHI for care coordination.

If the aforementioned data set is less than the hospital system's identifiable threshold, there would be additional limitations in what hospital staff could share. Typically, an identifiable threshold is placed to prevent sharing any data point that could be used to reverse identify the patient in question.

Ex. If the HRS shares a list with three names on it, there are reasonable logical methods that could be used to glean which patient is which. The identifiable threshold is put in place to prevent this.

What documents and approvals are typically required for a team member from the healthcare system to be allowed to share aggregate level trends and data?

Ex. As part of a care coordination/case conferencing conversation, a representative from the healthcare system was asked to create a report on aggregate level statistics for a patient population such as average length of stay, ED utilization, total # ED visits, etc.

"We can provide de-identified data at the aggregate level as long as the population is great enough."

Context

The limitations of sharing PHI include outside patient-level data shared with the hospital system. In order to confirm any patient-level data (even if it's the HRS sharing their BNL), both parties must have legal documentation that allows the sharing of PHI for care coordination.

If the aforementioned data set is less than the hospital system's identifiable threshold, there would be additional limitations in what hospital staff could share. Typically, an identifiable threshold is placed to prevent sharing any data point that could be used to reverse identify the patient in question.

Ex. If the HRS shares a list with three names on it, there are reasonable logical methods that could be used to glean which patient is which. The identifiable threshold is put in place to prevent this.

What type of DUA would be required for bi-directional data sharing (under the umbrella of care coordination) between a healthcare system and homeless response system?

Ex. Once a month, representatives from the homeless response system and healthcare system meet and walkthrough a list of individuals experiencing homelessness as identified by the homelessness system AND then a list of individuals experiencing homelessness as identified by the healthcare system. Conversations include the sharing of individual data and trends to help identify housing and care options for that individual.

"In order for bi-directional data to be exchanged, we would need a bi-directional Release of Authorization where both organizations are identified and individual documents that data can be shared between both entities."

Context

Although the procedure and requirements differ by hospital system, general guidance indicates that a bi-directional Release of Authorization (similar to that which is used for external referrals) would create the structure for data sharing between HRS and HS. However, this does not account for the structural complexities of sharing data from HMIS or any EHR. Further steps are required.