

Data Sharing Landscape Assessment in Hawaii



An assessment of data sharing efforts
and opportunities in Hawaii



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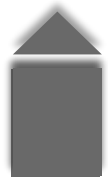
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Introduction & Background

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01



Project Purpose & Objectives



This project seeks to identify opportunities for data sharing to support housing opportunities for frequent users across multiple systems, such as homelessness, justice, and healthcare. Work on the project was conducted between July and September 2019.

The framework and approach is based largely on the ongoing work in over 30 communities across the country implementing CSH's signature Frequent Users Systems Engagement (FUSE) initiative. FUSE is an evidence-based, data-driven model, which identifies community-determined frequent users across systems, connecting them to housing and wrap-around services that meet their needs.

In Hawaii, in response to the state's homeless crisis, stakeholders are interested in launching a local FUSE initiative. The first step is to thoroughly understand the data landscape from multiple angles.

- *What kinds of data are stored and how?*
- *What data is used to help connect people to housing?*
- *Is data shared with other organizations or sectors already?*
- *If so, how can these efforts be leveraged and improved in the future?*

This assessment, combined with observations and insights from key stakeholders about what has and has not worked well, currently and in previous efforts, will provide a national perspective on best and promising practices related to data sharing and supportive housing.

This perspective will drive one of our primary goals, to tailor recommendations to local needs, particularly recognizing Hawaii's distinctive geography, history, and cultural relevance.



Objectives:

1. *Conduct Data Sharing Landscape Assessment*
2. *Produce a set of recommendations to advance supportive housing, particularly focusing on the FUSE model*



REPORT METHODOLOGY

Initial Research & Document Review

July 2019

- Search and review of policies, reports, meeting minutes, funding applications
- Scan of governmental organizations and non-profit service providers
- Research of healthcare and Medicaid Managed Care Organizations (MCOs) and other programs available to members experiencing homelessness or with experience across multiple systems

Phone Conversations

July 2019

Structured meetings with stakeholders from a wide range of organizations, both governmental and private. Questions centered around organizational role and mission in system, work with data and data sharing, challenges and opportunities to improve.



In-person, Deep-dive Meetings

August 2019

Based on initial phone conversations and additional research, in-person meetings were conducted in Honolulu with a select amount of stakeholders* who are responsible for data, policy, or programs implementation at a systems level.

*Because of a then-pending and unreleased RFP for Medicaid services, CSH was unable to speak with the Hawaii State Med-QUEST Division or other DHS stakeholders.

Follow-up & Recommendation Review

August/September 2019

- During in-person meetings, additional insight was gathered which required research or follow-up conversations.
- The final draft set of recommendations were shown to a small group of stakeholders to review and provide feedback



POLICY BACKGROUND



The focus of this work and the recommendations made are to support the vision of connecting frequent users of multiple systems to supportive housing. While certainly there are improvements to IT, programs and process on an operations level, at the system and policy level much hinges on the implementation of the Medicaid waiver (commonly known as the 1115) obtained by the State of Hawaii. The waiver includes Medicaid reimbursement for tenancy supports which are implemented in this case by the Hawaii Department of Human Services, Med-QUEST Division, which administers Medicaid.

In September 2019, Med-QUEST released the Request for Proposals (RFP) for MCOs, which among other things, requires MCOs to contract with service providers for housing to more comprehensively support members in housing and coordinate services and integrate communication between members' plans, healthcare providers, and housing providers.

This project presents a critical and timely opportunity for both housing and healthcare systems to plan accordingly and implement the strategies and processes that support data quality, sharing, and integration. Not only is it directly responsive to the goals of this RFP and the waiver requirements, it is best practice to reduce emergency service usage and costs. Most importantly, these strategies facilitate the connection of supportive housing to the most vulnerable and frequent service users, who are often overlooked because the full extent of their service history across systems is not visible to any one system.

Awards will be announced January 2020, with new services provided to members by July 1, 2020.



Summary of Findings by Stakeholder

- + *Continuums of Care (CoC)*
- + *Service Providers*
- + *The Queen's Medical Center – Queen's Care Coalition*
- + *United Healthcare – myConnections*
- + *State Organizations & Agencies*

02



Continuums of Care (CoCs) – Homeless Services System

In Hawaii, there are two CoCs, one representing Honolulu City and Oahu, and the other representing the “balance of state” (BoS), meaning the neighboring islands.

Each CoC has a lead organization: in Honolulu, the lead is Partners in Care (PIC) and in the BoS CoC the lead is Bridging the Gap (BTG). CoCs have broad latitude to determine programming, funding, policies, priorities, and data organization and sharing.

Both CoCs share an instance of the federally mandated data management system for homeless services, HMIS. Each CoC has selected HMIS administrators who interface with each other and the software vendor, Caseworthy. HMIS administrators set up programs, conduct user training, maintain the system and data privacy, and are often first-line technical assistance for community service providers and users.

The data that HMIS collects is guided by HUD data standards, but communities are allowed to collect data on custom points as long as all HUD elements are included. These custom elements allow for addressing local and specific challenges or policy priorities for the communities. HMIS data should be viewed and cultivated as a strategic resource for the communities and the state. Few data sources can match the comprehensive level of detail on programs, services, and persons experiencing homelessness and is a critical tool in planning, policy, and addressing gaps.

Conversations across stakeholders indicated that there was low confidence in the HMIS system and data. HMIS data needs to be a central piece of every systems-level discussion and decision in a community to plan in real time the services and housing for the people experiencing homelessness then and in the future.

Without confidence in HMIS, service providers will input minimal or poor quality data making it unusable. Planning and surveying need will not be data-driven, preventing the community from thoroughly understanding the realities of homelessness and responding.



Continuums of Care (CoCs) – Homeless Services System



Responsibilities of the CoC Challenges in the Hawaii CoCs

HUD Annual Reporting: CoCs must submit a count of all persons experiencing homelessness (PIT count), an inventory of all housing resources (HIC), and a report on system performance measures (SPMs) for federally funded programs.

The PIT counts in both CoCs showed an overall decrease in homelessness. On Oahu, unsheltered homelessness rose 12% and exceeds sheltered homelessness for the first time. Shelter availability, reluctance to access shelter, and data quality with the sheltered count which is conducted through bed reporting in HMIS may be factors.

HMIS Administration: Oversees the database used for all homeless services data. CoCs select and work with a vendor and may designate an HMIS admin separate from the CoC organization for day-to-day operations.

Joint management of HMIS between the CoCs has been challenging. Differences in approach, policy, objectives, and interpretations have paralyzed HMIS development. Service providers and non-traditional partners have expressed apprehension using HMIS, which is integral to understanding homelessness in a community. As of September 2019, the PIC CoC had decided to separate out the Oahu portion of the database to have more direct control over its functionality.

CoC Program Administration: Federal competitive funding stream which requires evaluation of programs, reallocation and budget decisions, and systems planning.

Though recently increasing, funding for HMIS and staff for data administration is low for CoCs of their size. HUD provides limited opportunities throughout the year to obtain more HMIS funding, but these are competitive (i.e., not guaranteed) and often funding for direct programs is prioritized over data infrastructure.

CES Implementation and Prioritization: Coordinated Entry arranges community resources to assess and connect the most vulnerable to needed and scarce resources, like PSH. CoCs establish policies and procedures for assessment, matching, and prioritizing.

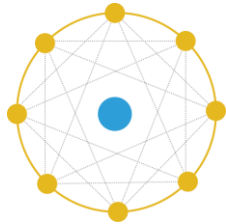
Lack of trust in and use of the HMIS leads to a lack of data quality. The tools used for CES prioritization, like the by-name list, use HMIS data, but are managed outside HMIS. This makes it hard to keep information up-to-date and of quality when attempting to locate and house people. This is a community decision which eases the administration of CES, but does not resolve the underlying data quality issues in HMIS on which CES tools like the by-name list are based.



Service Providers



The consequence of the system-level and CoC-level challenges are felt in real terms by providers in the community and impact their ability to deliver services.



HMIS Administration

HMIS is a major sticking point in the community for direct service and housing providers, as well as other supportive service providers. One provider had great interest in participating in HMIS, but had no idea where to start to sign the necessary agreements, train staff, obtain credentials, and start inputting information. Providers required to use HMIS described the current system as one of the major challenges that they encounter.



Data Collection & Services Coordination

Street outreach efforts in Honolulu particularly are not coordinated in fanning out over the entire geography. Many teams saturate areas like Downtown or Kaka'ako and overlook other areas with need. Data collection for outreach in most communities is difficult, the HMIS issues in Hawaii compound this challenge by not collecting data in real-time. Instead, they rely on paper forms and notes which could get lost, not entered, or ignored. Tablets were provided to outreach teams at one point by a different HMIS vendor. Use of the tablets was spotty, and even given quality data, the systems did not sync with community HMIS.



Gap in Permanent Housing Resources

Without exception, service providers cited a lack of permanent housing, particularly supportive and affordable housing as a critical challenge. Much of the progress to lower the homeless count number has been done *despite* the affordability and supportive housing gap. With Federal resources being scarce and competitive, they are not enough to make up the core of Hawaii's need for supportive housing. That need is then compounded by both lack of any housing and limited land resources.



The Queen's Healthcare System – Queen's Care Coalition



The Queen's Medical Center (Queen's) is one of the busiest emergency rooms in the state. It was estimated that the ER sees 60% to 70% of patients experiencing homelessness, the balance being seen by ERs at Hawaii Pacific Health or Kaiser Permanente. The Queen's Care Coalition is a program led by the emergency room medical director and a team of social workers to navigate high-utilizing patients to housing.

In the last year, Queen's partnered with the local CoC to gain access to HMIS and provide vulnerability screens on patients experiencing homelessness in the system. This gives the CoC a better picture of a patient's vulnerability, which in turn leads to the community prioritizing those who are medically fragile for housing. These patients may otherwise not be found or prioritized by the homeless system.

The strong partnership with the CoC has led to a one-time match between the highest-priority people on the community's by-name list, and the top 50 utilizers of Queen's services who were experiencing homelessness. The by-name list orders all known persons experiencing homelessness in a community by vulnerability as determined by the community. The higher on the list one is, the more likely to be prioritized for housing and supportive housing.

The results of the CoC/Queen's match were stark: the 1st priority patient for Queen's appeared as 84th on the CoC by-name list. This type of mismatch is not uncommon in communities that link healthcare to homelessness information. The next step in communities has been to establish ongoing matches and monitor and adjust prioritization criteria or set up other housing for frequent users through a FUSE approach.



Mission Statement

To fulfill the intent of Queen Emma and King Kamehameha IV to provide in perpetuity quality health care services to improve the well-being of Native Hawaiians and all of the people of Hawaii.



United Healthcare Hawaii operates the myConnections program, which works with hospitals and health centers to navigate and refer any Medicaid participants from any of the Medicaid MCOs to community resources that range from transportation and food to housing and ongoing health and preventative care. The program collects survey information about members' needs and found that the second highest need is housing (the first being food resources). Based on these surveys, myConnections recruits partners to refer members and follow-up.

While the referrals seems to be working well for those who get connect and meet the need, the main challenge is ensuring that a connection was made between the member and the resource. Returned data from providers, if any, comes in the form of phone calls, emails, and maybe batch Excel sheets, which are hard to compile and track.

The data from the program demonstrates a system challenge in coordinating data and resources, particularly for referrals to the homeless service system. The refusal rate to emergency shelter is not surprising. Emergency shelters vary in quality, service offerings, and rules, and the refusal rate speaks to a need in the community to continue to standardize shelter services and monitor those standards.

Creating a bridge between HMIS and myConnections, if done properly, may assist in locating patients. Multi-systems data could be referenced to see where patients have most recently been seen or used services. They could hopefully then be contacted and engaged in supportive services with providers.

myConnections Statistics:

(Oct 2018 – July 2019)

- 27,500 screenings
- 1,132 report at least one need
- ~350 report living situation as a need
- 41% of people with living situation need report being housing unstable
- 507 referrals made to housing resources or homeless services

<i>Referral Result</i>	<i>Emergency Shelter (327 referrals)</i>	<i>Homeless Outreach (85 referrals)</i>
Need Met	6%	6%
In Progress	8%	8%
Ineligible	8%	12%
Need Met, Other	8%	25%
Refused	52%	18%
Unable to Contact Patient	18%	31%

Statewide Organizations & Agencies

One of the core social determinants of health is housing, and specifically supportive housing for some who experience homelessness, are frequent users of emergency medical services, and/or cycle in and out of jail. The significant overlap of the homeless, health, and justice populations and the effort to identify, locate, and prioritize their housing is an interdisciplinary challenge that requires coordinated and sustained government leadership.

As in most jurisdictions, the government response to these three systems is split among agencies and offices across all levels of government. The Hawaii Department of Human Services has in its purview the **Homeless Programs Office (HPO)**, which coordinates the state-wide response to homelessness and is the HUD collaborative applicant for BTG. The HPO funds many agencies serving populations experiencing homelessness, though the proportion of funding has diminished over time as the City of Honolulu has picked up a greater share.

Department of Human Services, through the **Med-QUEST Division**, manages the Hawaii Medicaid program and most of the other public benefits programs (TANF, SNAP, GA). Med-QUEST will continue to administer the recently renewed 1115 waiver, which includes the new community integration services which are targeted to support populations experiencing homelessness.

The **Hawaii Interagency Council on Homelessness (“Interagency Council”)** was set up to coordinate the statewide and local response to homelessness which is inclusive of healthcare and housing governmental and non-governmental agencies and organizations. In particular, the Interagency Council could be able to influence data sharing policy in Hawaii, including potentially merging the two CoC’s HMIS data into one warehouse across the state (see Section 4). Membership appears to currently be limited across government and not-for-profit agencies but could be expanded to include membership of MCOs in the state.



Short-Term Recommendations

- + *Recommendations Summary*
- + *HMIS Best Practice*
- + *Data Sharing & Data Matches*
- + *Establishing a Funders' Collaborative*
- + *Improving PIC HMIS Implementation*
- + *Collaborate and Execute a Multi-MCO Data Match with PIC*

03



RECOMMENDATIONS SUMMARY, pt. 1

<i>Recommendation</i>	<i>Details</i>	<i>Potential Timeline</i>
1. Implementing and monitoring HMIS best practices	<p>The top priority should be to resolve the governance challenges of the shared HMIS software. Additionally, building back system trust with service providers by showing the value of their data, and collaboratively focusing on data quality as a community, using standard HUD reports as rally points.</p>	<p>Some steps could be implemented immediately, others can be implemented within a year. Trainings and meetings on HUD System Performance Measures could take longer to integrate into the administration and governance structure of the CoCs.</p>
2. Develop data sharing and data matching protocols and processes	<p>As an intermediate step toward full data integration, data systems and HMIS in particular should develop formal processes, agreements, and standards for non-traditional, non-law enforcement partners (e.g., School districts, MCOs, hospitals, libraries) to read/write into databases.</p>	<p>Planning could start immediately. Depending on time to draft and work through legal and CoC governance structures, it could take up to a year to develop and launch.</p>
3. Establishing a Funders' Collaborative	<p>A “funders’ collaborative” which brings public, private, and philanthropic funders together to better align resources across homeless services. Using public and restrictive dollars for long-term durable housing solutions and using private unrestricted dollars to fund innovation or fill gaps in program budgets that are not allowable expenses for public funding. During CSH’s stakeholder interview process, this concept was raised as a way to fund PIC’s efforts to improve HMIS data, but we see this as a broader, and much more far-reaching effort for Hawaii.</p>	<p>Planning the collaborative could start immediately and the Governor’s Office expressed a desire to lead it; alternatively, it could be led by AUW, which is similar to the model in other communities. After launch, a collaborative could start making impacts inside of a year if properly staffed and attended. Tapping into the hospitality and tourism sector for support is an additional option that has lent political support to efforts in other jurisdictions.</p>

RECOMMENDATIONS SUMMARY, pt. 2



<i>Recommendation</i>	<i>Details</i>	<i>Potential Timeline</i>
4. Improving PIC HMIS Implementation	<p>During the time CSH was conducting this landscape assessment, the HMIS database shared by the CoCs was split off. As of mid-September 2019, AUW and PIC are now managing their own HMIS implementations. Critical to this improvement will be the following items: management of CES and the by-name list within the database, security protocols with sharing the by-name list, more effective capture of healthcare/MCO provider, and improvement of outreach services</p>	<p>The work on this has already begun, and ideally would be completed long before the new MCO contracts are set to begin. In the interim, MCO partners can begin meeting with PIC to discuss their needs, the type of data they want to collect and know about members, and what would be critical to helping programs like myConnections improve services and outcomes.</p>
5. Plan and Execute a Multi-MCO Data Match with PIC	<p>PIC reported having executed a data match against one MCO's systems. For a cost, the HMIS data was sent to that MCO and the overlap examined. This model – particularly with an improved database – is something that could happen with other MCOs and even be set up as something regularly occurring.</p>	<p>Once the MCO contracts are announced and providers known, the timing would be right to sit down with AUW and PIC to begin outlining these data matches.</p>



Long-Term Recommendations

- + *Recommendations Summary*
- + *Queen's Care Coalition Model & Replication*
- + *State Interagency Council on Homelessness*
- + *State-Wide Data Warehouse*

04



RECOMMENDATIONS SUMMARY, pt.1



<i>Recommendation</i>	<i>Details</i>	<i>Potential Timeline</i>
<p>1. Queen’s Care Coalition Model Replication and Expansion</p>	<p>Replicating this model where hospitals are tracking frequent users, particularly of their patients experiencing homelessness means hospital staff regularly access and input HMIS data, physicians provide policy and community leadership, and hospital management and CoC leadership support these efforts, all make this project a potential national model. There is potential as well for this model to expand to other-than hospitals: for example, an MCO could adapt it for members that are high cost consumers of emergency health services</p>	<p>Finding the right community and champions for this project and convincing stakeholders of value and assuaging concerns may be the biggest hurdle. Under even the most optimal conditions it still may take a year or longer to get to launch.</p>
<p>2. Strengthening the State Interagency Council on Homelessness</p>	<p>The Interagency Council must become the backbone where statewide challenges and solutions are discussed and agreed on. Membership could be expanded to include MCO representation, particularly in light of the 1115 opportunities. Additionally, the Council must obtain clarity on its authority in state structures and secure participation from the senior and principal members by focusing on the system-wide and statewide agenda.</p>	<p>Much of the work to strengthen the Council is underway. Though the continuous development of a statewide agenda is still a year or more from completion, as it must be adjusted and monitored for changes and improvements.</p>



RECOMMENDATIONS SUMMARY, pt. 2



<i>Recommendation</i>	<i>Details</i>	<i>Potential Timeline</i>
3. Statewide Data Warehouse	<p>Hawaii Department of Health’s Data Warehouse project provides either a foundation or model for other systems to participate. At a minimum, homeless data (including outreach) and Medicaid data should be joined to coordinate care, verify referrals and outcomes, and house the most vulnerable in as close to real time as possible. Other systems can and should be included, such as justice and behavioral health. Due to the Med-Quest RFP, CSH could not interview relevant parties involved in planning the warehouse.</p>	<p>The system setup and planning could be a year or more. Then, each system that would need to participate to make the system effective could take time to clear both technical and legal hurdles before fully participating.</p>



About

- + *About CSH*
- + *Acknowledgements*
- + *Questions & Feedback*

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ABOUT CSH



CSH is a national non-profit that works across four lines of business, including training and education, lending, consulting and assistance, and policy reform.

*Building on nearly 30 years of success developing multi and cross-sector partnerships, CSH engages broader systems to fully invest in solutions that drive equity, help people thrive, and harness data to generate concrete and sustainable results. By aligning affordable housing with services and other sectors, CSH helps communities move away from crisis, optimize their public resources, and ensure a better future for everyone. More information at **[csh.org](https://www.csh.org)**.*



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Aloha United Way

Hawaii Department of Human Services

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Partners In Care

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The Institute for Human Services

The Queen's Medical Center

United Healthcare - myConnections

Waikiki Health



QUESTIONS & FEEDBACK



Questions, concerns, and feedback about this project can be directed to Kim Keaton (kim.keaton@csh.org), Director, Data and Analytics or Ian Costello (ian.costello@csh.org), Program Manager, Data and Analytics at CSH.

