

Cross Systems Data to Support Outcomes Focused Financing:

Critical data elements to use in planning

Background and Purpose

In the past five years, CSH has led the charge in the use of Pay for Success as an innovative tool to scale supportive housing to address a range of community needs. CSH has worked in more than twenty jurisdictions to advance this model to date. Much of this work was made possible through two grants (in 2014 and 2016) from the Corporation for National and Community Service (CNCS). These awards have afforded the opportunity to work with diverse communities across the country in planning and, in some cases, implementing these initiatives using a supportive housing intervention. As the field has progressed, the focus has shifted to one of “outcomes-focused” financing, because the range of innovative financing mechanisms has broadened. The term “outcomes-focused financing,” for the purposes of this publication, includes such financing models as Pay for Success, social impact bonds, outcomes-based contracting, and flexible pools of funding tied to outcomes and performance.

CSH has always underscored the importance of data in planning supportive housing initiatives for people using multiple systems. The CSH FUSE,¹ model of supportive housing has been implemented in more than 40 communities across the country. FUSE begins with cross system data matching between the homeless and other systems (justice, health) to determine

the target population for a supportive housing intervention. Most of the outcomes-focused supportive housing projects in operation today have a similar frame – a focus on the most frequent users across multiple systems to target with housing and services for the financed intervention. However, it is often the case that communities are beginning at square-one when it comes to looking at their data across systems. Too frequently, the data are siloed with little or no track record of sharing, and it takes a lot of time and capacity to learn about other systems, what they track, and what might be useful to share for planning a supportive housing intervention.

CSH has produced this publication to make the feasibility stage of planning a little easier. Part of “getting to yes” for data sharing is to know what to ask for – this publication is a tool to help begin those conversations and includes common data elements across a range of public systems that are key to the outcomes-focused project lifecycle. The information presented here will help translate across systems what data may be captured and useful for the purposes of planning an outcomes-focused supportive housing intervention. The Appendix of this report offers some real world examples from four sites that have executed data matches during the planning phase of their supportive housing projects.

¹ For more on FUSE, visit www.csh.org/fuse

Data and Feasibility Phase

The feasibility phase is a key stage of planning an outcomes-focused supportive housing project, where the viability of such a project in a particular local area is assessed.² Analyzing cross-systems data that indicates justice, homeless and health care

systems utilization, for example, is critical to the feasibility phase because it 1) helps the community's stakeholders define the target population; and 2) offers the information necessary to define and understand the current experiences of individuals who could benefit from supportive housing. Typically, communities focus on utilization and cost across several systems to get a clearer understanding of how the target population intersects across several systems and develop a community view of how systems are being used. The resulting picture is often poor coordination and outcomes resulting in continued homelessness, rearrests and incarcerations, and repeated health system crisis utilization. These data, when calculated and captured in the aggregate, can help planners make the value case for potential funders and investors.

It is worth noting that many initiatives do not make it past the feasibility phase precisely because the data were not available to help make any kind of a value case for the project. If data is available, it helps moves the project along. Matched cross systems data is used to make research-based estimates on what potential cost avoidance or "savings" might be for the target population once housed, which then helps to cost out the total investment for the initiative. Eventually, these data on utilization for the eligible cohort will be used to create the benchmarks that trigger payment to contractors and/or investors.

Finally, setting up data extraction and matching protocols early on in the feasibility process sets a community up for future data matching. Communities should, as much as possible, set up processes that are repeatable, even going so far as investing in a data warehouse, cloud server space, or other type of infrastructure to support regular cross system data matching and integration. These efforts will pay off when the program is up and running for the purposes of implementation monitoring, real time tracking, and evaluation.

Major Data Systems to Consider

This section provides an overview of data elements key to understanding utilization across the main systems of interest: homeless, jail, healthcare, behavioral health and child welfare systems. For all systems, "identifying data" is necessary to capture in order to improve match rates across data sets. That includes at a minimum first/middle/last names, date of birth, Social Security number, race/ethnicity, and gender. These fields are not listed in each section but are critical to the overall matching effort. The fields listed here are not meant to be exhaustive lists from each system, but rather as conversation starters with partnering stakeholders as data matching efforts are being explored.

Homeless/HMIS

Justice

Health

Behavioral Health

Child Welfare

² For an example of a feasibility report in Austin, see here: <https://www.csh.org/wp->

Homeless/HMIS

What is it? Any outcomes-focused supportive housing project will have a focus on people experiencing homelessness. The regional Homeless Management Information System (HMIS) is where services across a homeless Continuum of Care (CoC) – emergency shelter use, housing placements, outreach contacts, and more – are recorded. Typically, an HMIS covers the same geography as the CoC, which does not necessarily match with other political boundaries, such as cities or counties. In some locations a state will administer a statewide database (CA, GA, CT, RI, MI and UT). Smaller communities are often captured in a “Balance of State” CoC HMIS, which maintains data across areas of a state usually outside cities/large metro areas.³ The key agencies to contact for obtaining HMIS data will be a CoC lead agency as well as an HMIS lead agency, which manages the HMIS for the CoC, for a given region. Information on these for every CoC across the country can be found on the U.S. Department of Housing and Urban Development’s (HUD) web site.⁴ It should be noted that the unique structure of CoCs means that people from different agencies are entering in data into the same HMIS on the same clients across a region. This brings up need for consistent training to ensure quality, and not every CoC is well-resourced in this regard. It is therefore important to discuss the quality of the data when engaging in discussion about data elements to share from HMIS.

Privacy Considerations: HMIS data does not fall under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, though it does have to adhere to certain privacy standards.⁵ A CoC’s HMIS privacy notice (signed by all clients), privacy plan, and policies and procedures are all key to data sharing and are available on the CoC’s web site.⁶ A typical data sharing exercise with HMIS would include support and participation from both the HMIS lead agency and the CoC, a review of the privacy notice to see if it covers data sharing, and potentially a CoC board vote on the effort. Finally, the ability to share HMIS data and match with other administrative records for data on utilization across systems is something that has been pointed out as a potential factor for prioritizing people for supportive housing in a January 2017 HUD notice.⁷ Since then, the ability and willingness of CoCs to engage in data sharing exercises has increased and there are several examples of communities including HMIS in data sharing efforts to draw from.

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³ <https://www.csh.org/wp-content/uploads/2018/07/25-List-of-U.-S.-BoS-CoCs.pdf>

⁴ <https://www.hudexchange.info/grantees/contacts/>

⁵ Full information on data privacy in HMIS is available here: <https://www.hudexchange.info/resource/5758/coordinated-entry-management-and-data-guide/>

⁶ An example is provided here for the Iowa Balance of State CoC: <https://www.icalliances.org/iowa-forms>

⁷ <https://files.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf>

Table 1: HMIS Data Elements to Consider⁸

Field Name	Description
Client UID	Masked unique identifier to distinguish clients individually
Household ID	Masked unique identifier to associate clients into a single household or family (of interest if your project is intending to serve families or to see if that individual was in services as a family at one point)
Relationship to the Head of Household	Indicator to distinguish who is the head of household and who are the members of the household
Enrollment ID or Application ID	Masked unique identifier associated with a project or program enrollment
Organization identifiers	For each client, which organization was the service provider. Only useful if you are interested in looking at which partners are seeing clients, for example to help determine an effective outreach strategy
Project type	This is important for looking back in the pre-housing period for homeless system use
Disabling condition/disability elements	These fields note if client has a physical disability, chronic health condition, mental health problem, developmental disability and/or substance use issue
Project start date/exit date	These indicate when a program enrollment began and ended (or just when a client exited)
Prior living situation	The types of living situations clients are entering homeless services from; includes broadly homeless situations, institutions (e.g. jail), temporary and permanent housing, and other (e.g. unknown)
Date homelessness started	This field is meant to capture the approximate date homelessness started for an individual
Destination	The types of living situations clients are exiting homeless services to; includes broadly homeless situations, institutions (e.g. jail), temporary and permanent housing, and other (e.g. deceased, unknown)
Housing move-in date	If a client has exited to permanent housing, rapid rehousing, or permanent supportive housing, this field captures that date. It could be useful for knowing what types of interventions a client has utilized
Health Insurance	This is critical if health care partners are involved, for example MCOs, and want to know what plans homeless members have
Bed night date	Within a shelter enrollment that has a start and end date, this field helps clarify the exact amount of nights within that enrollment a person was at a shelter
Date of engagement	This field is populated by outreach providers, some shelters (those that enter in night by night stays), and some service providers, and is useful particular for looking at outreach contacts, which helps build out a potential target population by including street homeless individuals who may not seek other services through the CoC (though should be noted that it is difficult to monitor for quality, especially given the street-based data entry session)

⁸ For more information and a full list of data elements and standards, please visit HUD's HMIS web page: <https://www.hudexchange.info/programs/hmis/hmis-data-and-technical-standards/>

Justice Data

What is it? The primary source of data for outcomes-focused supportive housing initiatives is data on bookings and incarcerations at local county jails. Jails do a fair amount more than incarcerate people before and/or after adjudication – they also release individuals to the community; hold probation, parole, and bail-bond violators; detain juveniles awaiting transfer to juvenile facilities; and hold persons living with mental illness pending transfer to other facilities.⁹ Jail from data systems can range greatly in terms of age, flexibility and quality, but some key components of the data are captured in all jail data systems and are useful for seeing if or how individuals experiencing homelessness are also spending time in local jails.

Other justice data that is less frequently accessed in outcomes-focused supportive housing initiatives but may also be useful include juvenile detention data with fields mirroring an adult jail in addition to more services such as education; court data; probation data; and medical records for services rendered to inmates while incarcerated, including medications. With respect to court data, information about specialty court dockets like homeless, mental health, drug and veteran courts, would typically prove most useful. While some communities have integration across the various justice data set types, many do not.

Privacy Considerations: The majority of states and local jurisdictions consider adult criminal history data to be public (Nevada is an exception), though they do adhere to some general privacy policies.¹⁰ Most efforts find it relatively easy to “get to yes” to receive jail data for an outcomes-focused supportive housing planning effort; however, most jails aren’t very well resourced in IT and typically they will want to export the data to whomever is integrating the data across multiple sources.

Table 2: Jail Data Elements to Consider

Field Name	Description
Inmate or Person ID or Number	Person level unique identifier
Booking ID or Number	Each booking has an ID. Many people will have more than one booking.
Street address	Address field of individual. May be useful for determining homelessness if a shelter address is used or “homeless” or other type of proxy is written in this field.
Jail entry date	Date individual was booked and entered into jail. Many counties calculate a separate booking cost vs. a daily cost of keeping someone incarcerated. A way to calculate the cost is booking cost + (total days incarcerated*daily cost).
Jail exit date	Date individual was released. See above for calculation notes.
Mental health	Some jails include a flag for mental health issues in an inmate. If including, it is important to have a conversation about what goes into the flag, and how it is used. This information can be at the person level or at a unit level, for example if a jail has a wing or area dedicated to specific populations.
Homeless	Some jails include a flag and potentially other data on homelessness. It won’t be as complete as what is generated through a match but could be useful in the analysis.
Medical records: Medications	This is not frequently available because it’s usually kept in a separate database from the jail records, but is worth asking about. Medications costs are key drivers determining “how expensive” an inmate is and if available can provide a more detailed calculation of costs per person

⁹ <https://www.bjs.gov/index.cfm?ty=tp&tid=1>

¹⁰ https://it.ojp.gov/documents/ncisp/privacy_guideline.pdf

Health Data

What is it? Health utilization data can come from many different sources from across the health care industry's stakeholders, wherever patients are seen and then all throughout the billing and payment process as the data flows from hospitals to managed care to state Medicaid systems (for example). For the purposes of site-specific outcomes-focused supportive housing endeavors, the most typical source of data comes from local hospitals that provide the emergency medical care and subsequent inpatient care that ends up being so costly for patients without a fixed home. Hospitals have electronic health record (EHR) systems that differ from one another, but generally all contain the types of data in Table 3 below. The data maintained by other, more downstream health system partners – managed care, Medicaid – will generally mirror the types of data seen at hospitals in terms of utilization because those are the services they are ultimately paying on.

When planning outcomes-focused supportive housing initiatives, an obvious cost center for the types of clients served are the costs generated by crisis use of hospitals. However, there is not one way to calculate the costs incurred by hospitals – this is an incredibly complex area that is beyond the scope of this publication. For the purposes here, it is useful to engage in a discussion with health care stakeholders about what costs or revenues are meaningful for them. A couple of simpler methods are to use the amount reimbursed by insurers for services, or to use the amount charged by the hospitals for those services. The table below includes some general definitions of costs, charges or prices, and reimbursements for discussion purposes.

Privacy Considerations: Hospital partners will always have concerns related to privacy and will cite HIPAA as restricting them from sharing what's known as PII (personally identifiable information) or PHI (protected health information). However, many health partners are beginning to view sharing of this information as allowable under the care coordination provision¹¹ because the effort to get a person into housing to improve health outcomes is a form of care coordination. The type of sharing agreement used is a Business Associates Agreement. Finally, a hospital may still be reticent to share any PHI or PII at the individual level during the planning phase of an outcomes based supportive housing initiative; in cases like these a work-around may be to send already matched files from HMIS and jails systems to the health/hospital partner for matching, which then can be reported back to the group in a de-identified or aggregate fashion.

When planning outcomes-focused supportive housing initiatives, an obvious cost center for the types of clients served are the costs generated by crisis use of hospitals

¹¹ https://www.hhs.gov/sites/default/files/exchange_health_care_ops.pdf

Table 3: Health Data Elements to Consider

Field Name	Description
Person ID, Patient or Member Number	Person level unique identifier
Hospital admit date	Date person was admitted to hospital
Hospital discharge date	Date person was discharged from hospital
Department or source	This is one or multiple fields that denote where a patient received services – inpatient, outpatient, emergency room, clinic, ICU, psychiatric inpatient, and so on
Length of stay	Date difference between the admit and discharge dates
Hospital readmission	Using admit and discharge dates to track if patients are readmitted to hospital after discharge. Hospitals generally track readmission within 30 days of discharge as a key performance indicator
ICD 10 CM code diagnosis	ICD or “z codes” are alphanumeric codes used by health professionals internationally to record diagnosis or health determinations on a number of conditions, including homelessness (Z59.0) and other Social Determinants of Health. You may just want to look at the “principal diagnosis” to capture the condition why someone was chiefly entered into the hospital. It should be noted, however, that for the purposes of planning for an outcomes-focused supportive housing initiative diagnostic codes are not mission critical
Emergency Transport Date	Date in Emergency Services data systems where person was transported to hospital by ambulance
Health insurance status	Field indicating whether the person is insured or uninsured
Health insurance type	If person is insured, what is the source of the insurance (e.g., Medicaid, VA, private)
Cost of care¹²	This is a complex field and means something different to different stakeholders. For providers: the expense incurred to deliver health care services to patients. To payers: the amount they pay to providers for services rendered. To patients: the amount they pay out-of-pocket for health care services
Charge or price	The amount asked by a provider for a health care good or service, which appears on a medical bill.
Reimbursement	A payment made by a third party to a provider for services. This may be an amount for every service delivered (fee-for-service), for each day in the hospital (per diem), for each episode of hospitalization (e.g., diagnosis-related groups, or DRGs), or for each patient considered to be under their care (capitation).

¹² This field and the below two fields are taken from <https://journalofethics.ama-assn.org/article/challenge-understanding-health-care-costs-and-charges/2015-11>

Behavioral Health Data

What is it? Behavioral health is a term that captures both substance use and mental health treatment. Sometimes these are merged into one database and other times they are not. The way in which behavioral health systems are organized – and thus how the data are kept – differ from state to state and county to county. States also differ on what services are covered and the mechanisms for how health plans and state Medicaid systems pay for such services. The data on people receiving these services will not be comprehensive – not all treatment providers are required to report into regional or state administrative data systems.¹³ However, in communities that were able to perform a match between homeless, jail and behavioral health systems they found significant overlap with behavioral health for frequent users of systems experiencing homelessness.

Privacy Considerations: While mental health treatment data generally follows HIPAA regulations as described in the health data section above, substance use treatment data is covered under a more stringent privacy regulation called 42 C.F.R. Part 2.¹⁴ Most substance use remains illegal across our country and therefore the stigma associated with substance use disorders has historically required a higher level of privacy of data because a data breach could result in arrest. The issues are currently under debate¹⁵, complex and beyond the scope of this publication. For the purposes of planning outcomes focused supportive housing initiatives, many initiatives follow a similar process mentioned above: already matched data sets are sent to the entity maintaining the treatment data, which then reports substance use and mental health treatment utilization back to the group in an aggregate report.

Table 4: Behavioral Health Data Elements to Consider

Field Name	Description
Person ID or Patient Number	Person level unique identifier
Treatment admit date	Date person was admitted to treatment
Treatment discharge date	Date person was discharged from treatment
Type of treatment	In-patient, out-patient, detoxification, hospital setting
Number of prior treatment episodes	Number of times person has participated in treatment services prior to current episode
Health insurance status	Field indicating whether the person is insured or uninsured
Health insurance type	If person is insured, what is the source of the insurance (e.g., Medicaid, VA, private)
Mental health status	If person has a diagnosed SMI
Substance use status	If person has been diagnosed with a substance use disorder
Substances used	If the person has been diagnosed, what substance are currently being used
Co-occurring disorders	If person has dual or multiple diagnoses of SMI/SUD

¹³ <https://www.samhsa.gov/data/data-we-collect/mental-health-client-level-data>

¹⁴ <https://lac.org/addiction-confidentiality-42-cfr-part-2-important/#8>

¹⁵ <https://www.modernhealthcare.com/government/lawmakers-hoping-overhaul-privacy-rules-substance-use-disorders>

Child Welfare Data

What is it? Similar to the structure for homeless services data, the federal Children’s Bureau requires states to collect data uniformly on child welfare cases, including demographic information on the child’s race, age, gender, and date of entry into care. Called “Statewide Automated Child Welfare Information Systems (SACWIS),” these systems include case-related information, such as the reason identified for removing the child and placing him or her into foster care, service goals, funding source, number of placements, and availability for adoption. States may include other data elements to meet their needs, including elements that help caseworkers manage their caseloads within the structure of the state child welfare system.¹⁶

Privacy Considerations: Confidentiality is important in child welfare to ensure the protection of children, and is governed by myriad federal acts and further state regulations.¹⁷ Yet, there is a strong case to be made for sharing child welfare data because homelessness in particular, along with mental health and substance use, are frequently contributing factors to child welfare system involvement. The Administration for Children and Families has produced a child welfare data sharing [toolkit](#) that outlines the types of information that could be shared and provides sample agreements.

Table 5: Child Welfare Data Elements to Consider¹⁸

Field Name	Description
Person ID Household ID	Person level unique identifier
Assessment Composite Scores	Systems which conduct risk assessments, families’ assessments, safety assessments may compile composite scores summarizing a determination. While individual question responses may also be important, the composite scores can serve as a factor to determine priority populations.
Household Income	Level of income for entire family
Household Income Sources	Sources of income for entire family (e.g., benefits, TANF, SSI, earned income)
Housing Status	Where a family or child currently resides
Foster Care Determination/Redetermination	Child eligibility screening for foster care
History of child welfare system involvement	Household or child episodes with child welfare and foster care systems
Placement history of child	Record of child’s involvement in foster care, adoption, independent living, and homeless systems

¹⁶ <http://www.ncsl.org/research/human-services/child-welfare-information-systems.aspx>

¹⁷ https://www.acf.hhs.gov/sites/default/files/assets/acf_confidentiality_toolkit_final_08_12_2014.pdf

¹⁸ For broader elements, see page 5 of this SACWIS requirements document in Delaware: https://kids.delaware.gov/rfp/f2/4.2.6_SACWISRequirements.pdf

Getting Started on Data Matching

CSH has worked with communities across the country on data matching involving homeless and other systems' data, and has created a simple, 10-step check list to getting started on data sharing conversations. From beginning to end, embarking on a data sharing agreement and resulting match can take months or even years. The checklist in Table 6 below can help you organize the tasks before you get started. These steps can be done in order, although many may be occurring at the same time.

The beginning of a data matching journey can feel like a convoluted and difficult process with many barriers to success – technical, legal, leadership and beyond. However, communities across the country are demonstrating that it can be done while ensuring the safety and privacy of clients. Because people experiencing homelessness are frequently shared clients and patients across systems, any effort to plan and implement an outcomes focused supportive housing initiative should be accompanied by a data matching exercise.

Table 6: 10 Step Process to Get Started

10 STEP PROCESS DATA MATCH CHECKLIST

1	Review your CoC's privacy documents and ROI. If too restrictive, you will not be able to conduct matching using identifiable data but may be able to explore other approaches that don't involve using identified data, such as hashing approaches.
2	Engage leadership of cross sector partner(s) at hospital, state Medicaid, or managed care organizations, jail leadership, and other systems; meet regularly to continue discussing and refining the purpose of the matching project. Draft a document stating the purpose that all parties can agree on.
3	Learn about data matching processes already happening locally, as there may be agreements in place to leverage or note as precedent.
4	Figure out exactly who needs to be a party to an agreement, and what type of agreement is necessary for the match (BAA, DUA, MOU).
5	Determine the party that will do the actual data matching – will it be the health partner or HMIS agency, or a third party, like a county agency or a university partner.
6	Request legal review of the data sharing purpose document by your agency legal counsel.
7	Determine the data sharing process through meetings between stakeholder system data leads and CoC data leads determine the process for the data sharing – what fields will be needed to do the match, what fields will be needed for the analysis related to the agreed upon purpose, and how data extracts will be obtained and transferred.
8	Present on the data sharing exercise to the HMIS committee in your community – check your privacy policies to see who needs to approve the matching project before the HMIS lead agency can move forward.
9	Draft the data sharing agreement or MOU. Note that this will likely go through several edits between each partner's lawyers and the CoC counsel, so starting with a draft – even an imperfect one – will kick start the process.
10	Sign the agreement and begin the sharing process. Stick to the purpose and the specific processes outlined in the agreement when discussing and sharing information about the matching.

About CSH

CSH is a national nonprofit organization and Community Development Financial Institution that transforms how communities use housing solutions to improve the lives of the most vulnerable people.

CSH offers capital, expertise, information and innovation that allow our partners to use supportive housing to achieve stability, strength and success for the people in most need. CSH blends 25 years of experience and dedication with a practical and entrepreneurial spirit, making us the source for housing solutions. CSH is an industry leader with national influence and deep connections in a growing number of local communities. We are headquartered in New York City with staff stationed in more than 20 locations around the country. For more information about CSH's work related to Pay for Success, please see www.csh.org/impact



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Appendix A: Cross-Site Comparison of Pay for Success Data Sharing Efforts

	Denver Social Impact Bond	Anchorage, Alaska Pay for Success	Oklahoma PFS	Austin PFS
<i>Initiative overview</i>	<p>Five-year project, launched in 2016, targeting 250 frequent users of emergency services in Denver. Uses supportive housing intervention. Housing is leveraged from federal & state resources – LIHTC for two new developments (160 units); and scattered site vouchers through HUD CoC & state housing authority. Services are funded through a combination of PFS investment & Medicaid.</p>	<p>In transaction structuring phase of Pay for Success (PFS) and a recipient of the HUD-DOJ Pay for Success Permanent Supportive Housing award. Known as “Anchorage Home for Good”, the project aims to serve 150 frequent utilizers of the justice and health systems. The project is currently in the pilot phase funded by local philanthropic partners with the goal of housing an initial 40 participants by the summer of 2020</p>	<p>In transaction structuring phase of PFS, focused on a scaling supportive housing intervention for at least 50 young adults experiencing homelessness in Oklahoma City and Tulsa with the state posited as the outcome payer based on housing stability outcomes. The target population is youth with a history of involvement with both the juvenile justice and child welfare systems.</p>	<p>At the very end of PFS transaction structuring, the AT Home PFS project is planning for implementation in 2020. Currently the project is in the PFS pilot phase serving 24 participants through local philanthropic support. When scaled up via PFS financing the project will serve 200+ frequent utilizers of the justice and health systems in supportive housing. AT Home PFS is also a recipient of the HUD-DOJ Pay for Success Permanent Supportive Housing award.</p>

Data systems shared

<ul style="list-style-type: none"> • Denver police – arrest & jail records • Denver sheriff – arrest & jail record • HMIS 	<ul style="list-style-type: none"> • Municipality of Anchorage (Muni) arrests and encounter data • Muni crisis response/transport data • HMIS 	<ul style="list-style-type: none"> • State level data: Child Welfare, Department of Human Services (ODHS), Juvenile Justice, Office of Juvenile Affairs (OJA), Department of Corrections (ODOC), and Mental Health services, Department of Mental Health and Substance Abuse Services (ODMHSAS) 	<ul style="list-style-type: none"> • HMIS, Travis County justice system (including arrest and jail day data) • Health utilization data from the Austin/Travis County Integrated Care Collaborative (ICC)
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Type of data sharing agreement used

<ul style="list-style-type: none"> • Urban Institute and Colorado Coalition for the Homeless • Urban Institute and Mental Health Center of Denver • Urban Institute and Denver Sheriff's Office (within the Urban Institute Contract with the City of Denver) • Urban Institute and the Crime Prevention Control Commission • Urban institute and Denver Health • Urban Institute and HMIS 	<ul style="list-style-type: none"> • Separate DUAs between the Muni and the following: University of Alaska Anchorage (UAA- data repository/list aggregator), Social Finance, and supportive housing providers (to share participant names for outreach/engagement) 	<ul style="list-style-type: none"> • A data sharing MOU across state departments and the Urban Institute 	<ul style="list-style-type: none"> • DUA between lead/HMIS provider (ECHO) between both ICC and Travis County in the initial feasibility stage. Later in the transaction structuring phase, an additional DUA was executed between the project Evaluator (Abt) and ECHO.
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<i>Entity that performed/s the matching</i>	City of Denver – Crime Prevention Control Commission	University of Alaska Anchorage (UAA- data repository/list aggregator),	The Urban Institute	Austin/Travis County Integrated Care Collaborative (ICC)
<i>One thing that could have been done differently had we known...</i>	Included more health data sharing from the beginning.	Ensuring the hospitals were ^} * æ ^å early in the data sharing process and understood c@ãÁ[^È	HMIS data integrated into the data match to determine how (and if) the target population is interacting with the homelessness system. If we had known the barriers would be so significant to enter into a DUA with the HMIS administrators we would have begun working with them to problem-solve sooner	More initial engagement with the County on Justice data and how it will be used; consider integrating City of Austin Police department data to know more about the target population’s interactions with the justice system.
<i>This was successful because...</i>	Urban Institute took the lead in creating the data sharing agreements and recommending the processes based on their significant experience	Because of the close partnership and leadership from the Muni, the PFS project was able to access data and match re: interactions with the Anchorage Police Department and Muni Crisis response. Also, the UAA serving as the data aggregator and list manager added critical capacity to the data matching effort.	The data was all state-level for the initial match which made sharing easier. There was an existing DUA in place across state departments, so Urban was able to be added fairly easily. Also, department-level leadership was critical in getting signatures for the updated DUA with Urban in a timely manner.	The ICC has exceptional capacity to aggregate and match data as the existing data warehouse across health providers in Austin/Travis County. ICC was able to quickly match data and share back with ECHO – both individual level data and aggregated.