Improved Health and Housing Outcomes Through Information Sharing

CHH | Collaborative for Health and Home

A summary report on understanding the impact of information sharing between nonprofit organizations and the health sector on client health and well being.

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How does better information sharing between health and social supports improve health and housing outcomes for those experiencing chronic homelessness?

Social Determinants of Health (SDoH)

Individual health is largely determined by the conditions in which people live and work; these conditions are called social determinants of health (SDoH)[1]. SDoH are estimated to account for "60-80 percent of health outcomes" [2] (See Figure 1.1 and Box 1.1 for a full list). Considering SDoH when changing a broad system is necessary to create equity for those accessing the system of care. Equitable systems provide unique, client-specific access to services as is necessary and best for each individual; it is a low barrier system.

Social-Health Information Exchange (S-HIE)

Equitable systems function when all players within this system are provided the tools to respond to a patient/client's needs by working within a system where referrals and follow through are all connected[3]. Such an integrated system requires social-health information exchanges (S-HIE). In S-HIE's, open information sharing practices work to provide equitable health care access to the most vulnerable by equipping professionals with the ability to access the information necessary to quickly move clients through the system.

Why CHH?

The opportunity to move forward on S-HIE fits with CHH's overall vision and strategy to "realign or reallocate resources and enhance collaboration for programs and services so that people experiencing chronic homelessness with complex health concerns will receive the health services they need at the right time and place, and by the right provider on their journey home"[4]. Additionally, S-HIE directly supports CRSTF's recommendation 5 to "ensure open communication and access to information amongst organizations and agencies serving homeless Calgarians"[5]. Ensuring open communication throughout multiple systems (e.g. homeless serving, health, police, justice, etc.) would keep CHH on track to support aligned vision through "shared measurement practices" which would be an asset to mobilize future funding[6]. Creating a platform for continuous communication mutually reinforces a collective culture of collaboration between providers[7].

[1] Mikkonen, J., & Raphael, D. (2010). *Social Determinants of Health: The Canadian Facts*, York University School of Health Policy and Management, Toronto.
[2] Booske BC, Athens JK, Kindig DA, Park H, Remington PL. Different perspectives for assigning weights to determinants of health. Madison, WI: University of Wisconsin Population Health Institute; 2010.
[3] Colorado Health (2018). *Social Health Information Exchange: Connecting Health Care with Services that Address the Social Determinants of Health*.
[4] Collaborative for Health and Home (2019). *Line of Sight, Collaborative for Health and Home*.
[5] Calgary Recovery Services Task Force. (2016). *Calgary Recovery Services Task Force: Final Report and Recommendations.* Calgary, AB.
[6] Turner, S., Merchant, K., Kania, J., & Martin, E. (2012). Understanding the value of backbone organizations in collective impact: Part 2. *Stanford Social Innovation Review*.
[7] Ibid

What Would CSDC Accomplish?

The collaborative services delivery cluster (CSDC) project will establish consistency in information sharing practices across the HSSC and community health agencies by enhancing information sharing practices. Using the Homeless Management Information Sharing (HMIS) system as a platform, users will be able to create and use unique client profiles to share "base-level" information: name, age, race, gender; and some elements of "mid-level": agency affiliation[8] (Appendix A – Benefits to Stakeholders). Additionally, staff will be educated on the legalities around information sharing so that they can be confident when sharing information with other service providers.

Benefits to Clients

Research done out of the Bissell Centre in Edmonton[9] found that clients want to have control over their data, who can see it and how it's being used, but still find tremendous value in sharing their data for the benefit of themselves and others. Additionally, clients relayed that they would prefer broad consent over tiered consent.

[8] Ardelli, B., Mikhail, S. (2019). CHH Open Communications Working Group 2018-2019 Summary Report

[9] Breakey, S., & DiPinto, G. (2018). *The Perspective of Social Service Participants on Consent, Privacy of Information and Data Governance*. *The Perspective of Social Service Participants on Consent, Privacy of Information and Data Governance*. Bissell Centre. Retrieved from https://bissellcentre.org/wp-content/uploads/2018/09/2018.09-Participant-Perspectives-Data-Use-FINAL.pdf

Figure 1.1 A Model of the Determinants of Health

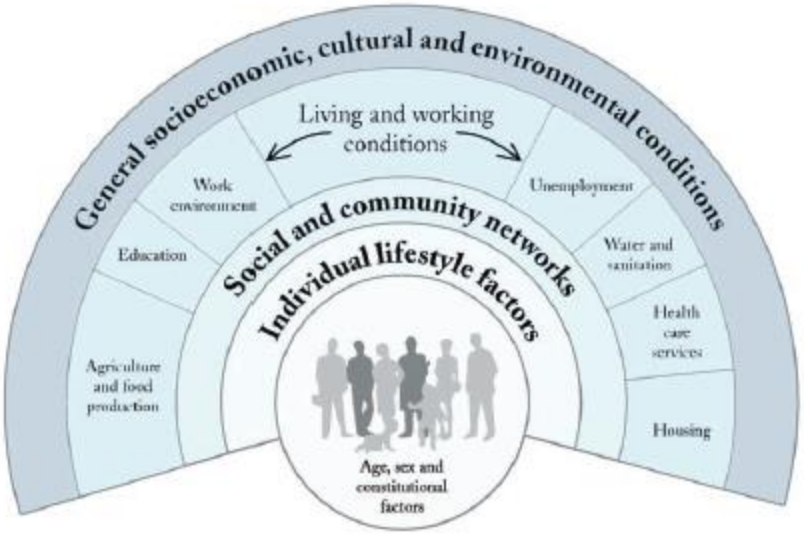


Figure shows one influential model of the determinants of health that illustrates how various health-influencing factors are embedded within broader aspects of society.

Source: Dahlgren, G. and Whitehead, M. (1991). Policies and Strategies to Promote Social Equity in Health. Stockholm: Institute for Futures Studies.

Box 1.1 Social Determinants of Health

Among the variety of models of the social determinants of health that exist, the one developed at a York University Conference held in Toronto in 2002 has proven especially useful for understanding why some Canadians are healthier than others. The 14 social determinants of health in this model are:

Aboriginal status
disability
early life
education
employment and working conditions
food insecurity
health services
gender
housing
income and income distribution
race
social exclusion
social safety net
unemployment and job security

Each of these social determinants of health has been shown to have strong effects upon the health of Canadians. Their effects are actually much stronger than the ones associated with behaviours such as diet, physical activity, and even tobacco and excessive alcohol use.

Source: Raphael, D. (2009). Social Determinants of Health: Canadian Perspectives, 2nd edition. Toronto: Canadian Scholars' Press.

Case Studies

Scenario	Current System	Immediate CHH Impact	Benefit to Client
Client is chronically homeless and struggling with addiction to alcohol. Due to addiction, client struggles to maintain housing in community. Client has gone to door agency to apply for housing again.	Client would be referred to CAA. Client history would be discussed at CAA table if people present at that particular meeting happened to know the client's history. A plan of action would be made based on the knowledge available at this meeting.	Referring staff could look up client history prior to CAA meeting and advocate for a specific case for support based on research done with staff who have worked with the client. This work would be done prior to CAA meeting.	Client would not be required to recall any previous work they have done. They will be asked and may relay the information if they wish but will not be delayed if they struggle to remember who they have worked with before or what work has already been done. Application towards housing will continue where it was previously left off.
Client has been referred to housing program but has refused to meet new worker and is transient.	New worker leaves messages at various shelters for client, calls referring agency to try to find out when the client is there and hopes that the client call back.	Agency can see if and when client checks into a particular shelter and any workers the client regularly speaks to. ROI not necessary to obtain information from workers in other organizations.	Client is not delayed in obtaining housing due to notification. Client can connect with the organization they are most familiar with and work with them to do a supported, warm transfer.
Client has been connected to a shelter worker and is in need of ID and other health benefits	Worker begins the process of applying for ID and benefits. Time spent on incomplete applications has been wasted (for both worker and client).	Worker can see if any other professionals have begun the same process and either start where the previous worker left off or do a warm transfer to previous worker.	Client does not have to repeat any work they have already done and will obtain their ID faster. Alternatively, client may choose to return to original worker and complete the application.
Client is in need of housing and is unsure if they have had an NSQ done.	Worker does another NSQ; causing a duplication of NSQ's.	Worker can see if an NSQ has been done and will respond to client accordingly.	Client is not required to recall whether or not they have completed an NSQ and can continue the application with the worker they are present with.

Appendix A - Benefits to Stakeholders

Role of Case Managers: Refer clients to community resources and supports; help client learn living skills; support client in their housing.

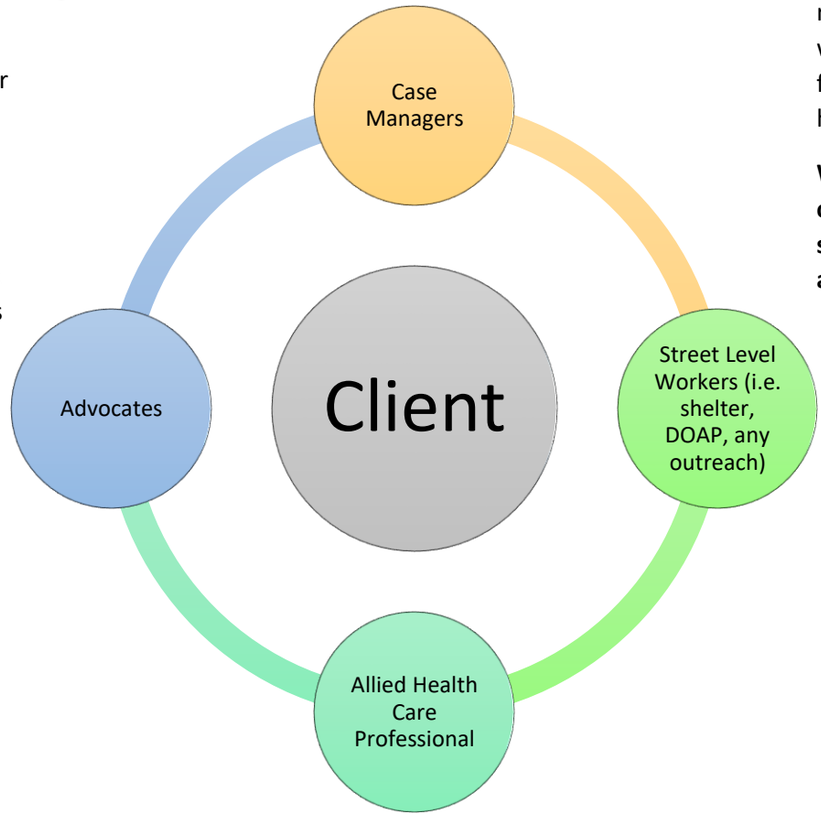
What impact would an open communication system have on your work as case worker? Case workers would be able to see:

- Identify which other agencies the client has sought resources from
- Identify which agencies client might regularly frequent
- Identify what resources client has obtained in the past
- Information necessary for obtaining future resources (i.e. FASD diagnosis)

Role of Advocate: Apply for income and medical supports.

What impact would an open communication system have on your work as an advocate? Advocates would be able to see:

- If another agency had completed applications for AISH
- If another agency had completed applications for Housing
- Who has helped clients obtain ID in the past
- Contact clients where they typically stay and leave messages
- Better collaborate with other organizations providing support for the same client



Role of Street Level: Forms relationships with clients when they are not ready for change (exit homelessness).

What impact would an open communication system have on your work as street level?

- Coordinated medical ban across shelters
- Contact clients where they typically stay and leave messages
- Find out which organizations have already worked with the client
- No fear of information sharing

Role of Allied Health Care Professional (AHCP): Most often nurses, but can be nurse practitioners, or occupational therapists. Goal is to connect clients to social supports and resources such as housing and health benefits.

What impact would an open communication system have on your work as an employment coach? AHCPs would be able to see:

- Contact clients where they typically stay and leave messages
- Better collaborate with other organizations providing support for the same client
- Find out which other professionals' clients are connected to (client frequently don't remember who else they are working with)
- Learn of other professionals who have started working with clients on health benefits or other services (e.g. ID)
- Able to see and respond to gaps in service
- Learn whether or not an NSQ has been done
- Clarify roles of other professionals
- Better plan applications for housing based on increased understanding of client needs and existing connections