TECHNICAL ASSISTANCE PLAN FOR PATH PROGRAM PARTICIPATION IN HOMELESS MANAGEMENT INFORMATION SYSTEMS (HMIS)

2013–2016

Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Homeless Programs Branch

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The Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services (HHS) is one of nineteen federal agencies partnered with the U.S. Interagency Council on Homelessness (USICH). After a discussion among all USICH federal partners, SAMHSA’s Projects for Assistance in Transition from Homelessness (PATH) Program and the U.S. Department of Veterans Affairs’ (VA) Supportive Services for Veteran Families (SSVF) agreed to collect data for its programs in a local Homeless Management Information System (HMIS). HMIS is a locally administered, electronic data collection system that stores longitudinal client-level information about persons who access the homeless service system. Aggregating data at the national level will allow federal agencies to track progress on meeting the goals in the federal strategic plan to end homelessness, Opening Doors.

This Technical Assistance Plan describes the background, rationale, objectives, and action steps involved for the Projects for Assistance in Transition from Homelessness (PATH) program data to be collected in a local HMIS nationwide by 2016. The plan gives SAMHSA staff and State PATH Contacts the information needed to understand the benefits and challenges of transitioning data collection to HMIS. For PATH providers, the benefits and advantages of HMIS are clear:

- Clients will be referred to housing and services more quickly and effectively
- Clients will have records in HMIS that can “move” with them from program to program as they receive a variety of services.
- PATH provider staff can accurately perform intakes and assessments using demographic information data elements.
- PATH provider staff can track client progress against expected client outcomes.
- PATH provider agency managers and State PATH Contacts can use HMIS data to monitor and improve PATH program performance.
- Communities can incorporate PATH client population data into their local strategic planning and improve service responses to PATH client needs.

SAMHSA will support PATH providers during the transition to HMIS data collection, details of which are incorporated in the PATH HMIS Transition Plan Overview, located in Appendix A and Appendix E. SAMHSA will provide training opportunities on HMIS and data collection using the Transition PATH Annual Report, which is a new reporting format for 2013.

The goals and objectives of this technical assistance plan for PATH data collection in HMIS are illustrated on the next page.

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1 HMIS records are not electronic medical records; HMIS records are stored in a locally controlled system and are accessed by users in participating agencies in the Continuum of Care (CoC), a group organized locally to work on access to housing and services for persons experiencing homelessness or at risk of homelessness. Access to these records is decided by the CoC’s policies on data sharing and by agreements among and between participating agencies.
SAMHSA TECHNICAL ASSISTANCE PLAN FOR COLLECTING PATH DATA IN HMIS

GOAL 1
Establish a reliable framework for tracking client outcomes and program performance

OBJECTIVES
SAMHSA revises PATH Annual Report form and aligns PATH report with HMIS data standards
SAMHSA develops a reliable PATH reporting data platform
SAMHSA evaluates implementation of PATH provider participation in HMIS plan and makes ongoing improvements to process

GOAL 2
Transition PATH provider annual report data collection to local Homeless Management Information Systems (HMIS)

OBJECTIVES
SAMHSA develops plan and timeline for PATH provider participation in HMIS
SAMHSA Homeless and Housing Resource Network (HHRN) staff and HUD contractor provide technical assistance and training to PATH providers
SAMHSA employs a phased implementation process for the Technical Assistance Plan for PATH participation in HMIS

GOAL 3
Use PATH data to improve services and outcomes for PATH participants

OBJECTIVES
SAMHSA compiles PATH Annual Report data
PATH providers make program improvements under the leadership of SAMHSA and State PATH Contacts
II. OVERVIEW

FEDERAL EFFORTS TO ADDRESS HOMELESSNESS

The Stewart B. McKinney Homeless Assistance Act of 1987 was the first major federal response to the problem of homelessness in the United States. This legislation authorized emergency relief programs for shelter, food, mobile health care, and transitional housing, recognizing that homelessness was a national problem requiring a national response. It was renamed the McKinney-Vento Act in 2000.

In 2001, Congress directed the U.S. Department of Housing and Urban Development (HUD) to develop a strategy for collecting data and provide an analysis on the extent and nature of homelessness, as well as the effectiveness of the McKinney-Vento programs. This directive stressed the importance of developing unduplicated counts of persons experiencing homelessness at the local level.

HUD’s response to this directive was the beginning of what would become the Homeless Management Information System (HMIS); the HMIS Data and Technical Standards (HMIS Standards) were introduced in 2004. The HMIS Standards provided all Continuum of Care (CoC) programs, which incorporate the primary homeless housing and services grants funded under the McKinney-Vento Act, with a foundation for ensuring consistency of the data collected across communities nationwide.

The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act brought about significant changes to the U.S. Interagency Council on Homelessness (USICH) and HUD’s CoC programs serving people who are experiencing homelessness. In addition, HEARTH included several new community-wide outcomes against which CoCs will measure their community’s progress in reducing homelessness.

The HEARTH Act further defines the mission of the USICH:

“To coordinate the Federal response to homelessness and to create a national partnership at every level of government and with the private sector to reduce and end homelessness in the nation while maximizing the effectiveness of the Federal government in contributing to the end of homelessness.”

SAMHSA has been an active participant on the USICH since its inception and works with federal partners individually on a variety of issues—one of these is HMIS. As HHS Secretary Kathleen Sebelius notes, “Homelessness cannot be solved by a single agency or organization, by a single level of government, or by a single sector … preventing and ending homelessness will take real coordination, collaboration, and a constant exchange of ideas.”

Signed into law in 2009, the HEARTH Act reauthorized and amended the McKinney-Vento Act. It addresses two specific findings:

- A lack of affordable housing and limited scale of housing assistance programs are the primary causes of homelessness.
- Homelessness affects all types of communities in the U.S., including rural, urban, and suburban areas.
In 2010, USICH released *Opening Doors,* the nation’s first comprehensive strategic plan to prevent and end homelessness. It is a roadmap for joint action by the Council’s member agencies. It is the federal government’s ten-year plan to end homelessness by 2020. The plan is updated annually. Priority is given to several special populations, including persons experiencing chronic homelessness, and veterans, families, youth and children experiencing homelessness.

As part of the U.S. Department of Health and Human Services, SAMHSA is working with its USICH partners to implement *Opening Doors.* A key part of this work is aligning efforts to gather and share data with other federal agencies on the nature and extent of homelessness. Improved data collection for programs that serve people who are at risk of or who are experiencing homelessness is important for tracking progress on ending homelessness. Many of the USICH federal agencies are moving toward data collection in HMIS over the next few years.

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2 *Opening Doors* and annual updates are located at usich.gov.
SAMHSA’S HISTORY
The Substance Abuse and Mental Health Services Administration (SAMHSA) was established in 1992 as part of a reorganization of federal mental health services. SAMHSA’s mission is to target substance use and mental health services to the people most in need and to translate research in these areas more effectively and rapidly into the general health care system. To accomplish its work, SAMHSA administers a combination of competitive, formula, and block grant programs and data collection activities.

In particular, SAMHSA provides leadership and devotes its resources toward helping the nation act on the knowledge that:

• Behavioral Health is essential for health;
• Prevention works;
• Treatment is effective; and
• People recover from mental health and substance use disorders.

SAMHSA pursues its mission “to reduce the impact of substance abuse and mental illness on America’s communities” at a time of significant change. The Patient Protection and Affordable Care Act (the Affordable Care Act) and the Mental Health Parity and Addictions Equity Act are ushering in sweeping changes in health care service delivery, payment methods, and data collection. The evidence base for behavioral health prevention, treatment, and recovery support services continues to demonstrate positive outcomes for people with, and at risk for, mental health and substance use disorders. At the same time, state and federal budgets are shrinking, which necessitates setting strategic priorities.

THE PATH PROGRAM
Created as part of the Stewart B. McKinney Homeless Assistance Amendments Act of 1990, Projects for Assistance in Transition from Homelessness (PATH) is a formula grant program that provides funds to the fifty states, the District of Columbia, Puerto Rico, and the four U.S. territories (Northern Mariana Islands, Guam, American Samoa, and the U.S. Virgin Islands). It is the only federal formula grant program authorized to address the needs of people with serious mental illnesses, including those with co-occurring substance use disorders, who experience homelessness or are at risk of becoming homeless.

The PATH program is administered by SAMHSA’s Center for Mental Health Services. More than 500 local organizations in the fifty states, the District of Columbia, Puerto Rico, and the four U.S. territories receive PATH funds to provide community-based outreach, mental health services, substance use disorder treatment,
case management, and other support services, as well as a limited set of housing services. In some states PATH funds, combined with state and local matching funds, are the only resources specifically designated to serve individuals with serious mental illnesses who are experiencing homelessness or at risk of homelessness.

The latest available data (fiscal year 2012) reveal that PATH is reaching this vulnerable group. Among clients for whom a diagnosis was reported, 31 percent had schizophrenia and other psychotic disorders, and 50 percent had affective disorders, such as depression. More than two-thirds (69 percent) of PATH clients were living outdoors or in short- or long-term shelters. The vast majority of providers used PATH funds to provide community mental health services (91 percent), outreach (92 percent), and case management (87 percent) to this underserved group.

One of the main goals of the PATH program is to link clients to resources that are available in their community. These resources may include mainstream benefits, housing assistance programs, employment, and other supportive services. In assisting clients with accessing needed resources, PATH staff strives to transition people out of homelessness to a stable and safe place that supports recovery.

One way of linking clients to community resources is through the HMIS, where users of the system can find information on services that are available, make referrals to service providers across the community, and follow up to determine if services have been accessed. Moreover, in many communities coordinated intake and assessment systems allow clients to complete a single application on a common form as the standard entry point for many different services.

In July 2013, HUD instructed its Continuum of Care entities and its housing providers to give priority to persons experiencing chronic homelessness. Many persons in this population are those experiencing serious mental illness and other disabilities. HUD’s prioritizing those experiencing chronic homelessness for placement in housing means that PATH-eligible clients may be prioritized for housing. For PATH clients to take advantage of this resource, it is important for PATH providers to utilize the local HMIS to include their clients in the coordinated assessment system which may

PATH Program Objectives

- Increase the number of persons experiencing homelessness who are contacted
- Increase the percentage of enrolled persons experiencing homelessness who receive community mental health services
- Increase the percentage of persons experiencing homelessness and serious mental illness who become enrolled in PATH services
- Provide training for PATH providers on SSI/SSDI Outreach, Access, and Recovery (SOAR) to ensure eligible clients experiencing homelessness are receiving benefits
prioritize the most vulnerable people for housing.

**NATIONAL PATH DATA COLLECTION**

Each year SAMHSA sets targets for its programs’ performance, in line with the Government Performance and Results Act (GPRA) of 1993, as updated in 2010. GPRA requires federal agencies to set goals, measure results, and report progress. In carrying out the intent of GPRA, each federal agency monitors progress toward meeting its annual GPRA measures.

The PATH GPRA measures for fiscal year 2013 are as follows:

- Increase the percentage of enrolled persons experiencing homelessness who receive community mental health services to at least 50 percent;
- Increase the number of persons experiencing homelessness who are contacted to at least 182,000;
- Increase the percentage of contacted persons experiencing homelessness and serious mental illness who become enrolled in services to at least 55 percent; and
- Increase the number of PATH providers trained in SSI/SSDI Outreach, Access, and Recovery (SOAR) to at least 5,420.

SAMHSA staff works closely with State PATH Contacts to ensure consistency in data collection and reporting to improve performance measurement. In 2005, the PATH Administrative Workgroup developed national definitions for “outreach,” “enrollment,” and “imminent risk,” and defined the documentation necessary for “serious mental illness” and enrollment. The definitions were disseminated to State PATH Contacts and PATH providers and incorporated into the PATH Annual Report Provider Guide. In the past several years SAMHSA has also encouraged tracking outcomes for PATH clients. These are related to access to housing, income, and primary medical care.

In addition to annual reporting to Congress on PATH program outcomes, SAMHSA uses PATH Annual Report data to improve and streamline the program. For example, states may be

In her **SNAPS Weekly Focus** of July 12, 2013, Ann Oliva, the Director of HUD’s Office of Special Needs Assistance Programs (SNAPS), directed HUD’s permanent supportive housing (PSH) grantees to give priority to persons experiencing chronic homelessness. She stated, “PSH is designed to provide housing and services for people who are disabled—in other words, it should be used to house those that, without this type of assistance, would continue to live on the streets. Unfortunately this limited and intensive resource is not always being prioritized for the population that has been on the streets the longest… HUD is asking PSH providers to prioritize chronically homeless persons and persons that are the most vulnerable in all PSH units as they become available, both for individuals and families.”
encouraged to adjust a program’s activity to increase outreach to unsheltered persons who are experiencing homelessness or increase the percentage of persons contacted who become enrolled in PATH programs. In West Virginia, for example, PATH providers will be encouraged to increase outreach efforts in order to reach more of those who are identified as unsheltered during the annual point in time count. After reviewing PATH report data, SAMHSA can make program improvements to advance annual GPRA goals and targets.
III. HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS)

A Homeless Management Information System (HMIS) is a locally administered, electronic data collection system that stores longitudinal, person-level information about individuals who are experiencing homelessness or who are at risk of homelessness and access services.

The U.S. Department of Housing and Urban Development (HUD) responded to a congressional directive to gather data on the nature and extent of homelessness by convening grassroots communities, technology experts, and service providers informing the development of the HMIS Data and Technical Standards (HMIS Standards).

The HMIS Standards provide a secure structure for collecting and reporting information on people who are at risk of or are experiencing homelessness. These standards are updated periodically to reflect advances in security and privacy and meet the needs of new programs using HMIS.

Since 2001, HMIS has become an integral part of systems that serve people who are experiencing homelessness, providing data at the community level on the nature and extent of homelessness. This information, in turn, has helped inform local planning, raised awareness of the issue of homelessness, and improved local service delivery. At the national level, HUD reports annually to Congress on the nature and extent of homelessness in the Annual Homeless Assessment Report (AHAR), which contains data submitted from HMIS by communities across the country. This report informs the U.S. Interagency Council on Homelessness (USICH) and its member agencies on progress towards meeting goals of Opening Doors, the federal plan to end homelessness.

Participation in HMIS has grown to include additional federal partners, such as the U.S. Departments of Health and Human Services (HHS) and Veterans Affairs (VA). As part of the most recent revision of the HMIS Standards, SAMHSA and the VA provided recommendations to HUD in order to accommodate their program reporting needs.

HMIS DATA AND TECHNICAL STANDARDS

The HMIS Standards help ensure consistency of data collection efforts across programs. These standards address data elements as well as privacy and security measures. The first data standards were published by HUD in 2004 and updated in 2010 and 2013. The 2013 draft data standards incorporate the data elements needed for the PATH Annual Report and for some VA programs. There are a number of software vendors that provide HMIS software that meet HUD specifications. The Continuum of Care (CoC) in a community selects the HMIS vendor. Vendors of HMIS software must conform to HMIS Standards in order for communities to collect and report data consistently across the nation.

The HMIS Standards require all programs participating in HMIS to collect a set of Universal Data Elements (UDEs). UDEs contain basic demographic and identifying information on individuals served by programs. This information is important, as it establishes a record identification for an individual based on a combination of unique identifiers, such as parts of a name, birth date, and Social Security number. This information helps avoid duplication of clients in the HMIS, thus creating an accurate count of the number of persons served.
Additionally, Program Specific Data Elements (PSDEs) are data elements that include information specific to programs. The PSDEs required for collection will differ depending on the program type. PATH PSDEs include data elements unique to street outreach programs and reflect information related to client outcomes and PATH goals, such as tracking the number of referrals assisted by a provider and referral outcomes. PATH providers will be offered training and resources to support data collection efforts, including guidance on new terminology and data collection processes.

### HMIS Privacy and Confidentiality

The HMIS Standards outline requirements for privacy and security, with the ultimate goal of protecting all client information. This includes requirements for maintaining client privacy in the collection and management of HMIS data. *The standards have been developed specifically to protect a client’s personal information from unauthorized disclosure.* More information about privacy and security is located in Appendix D of this Technical Assistance Plan.

Programs participating in HMIS should have agreed-upon policies and operating procedures that outline how clients are informed of privacy policies, including policies about use and disclosure of their information. Sensitive information—such as mental health status, HIV/AIDS status, or other information regarding a disability—often is not shared among HMIS users.

As part of SAMHSA’s Technical Assistance Plan for HMIS Implementation, PATH providers will receive guidance and participate in an orientation about client confidentiality, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 CFR Part 2, the primary federal privacy and confidentiality requirements for certain service and health providers. PATH providers will also be encouraged to speak to their HMIS Lead Agency (see below) to learn more about the specifics of their local system, including the policies and procedures that ensure client confidentiality and system security.

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<thead>
<tr>
<th>Universal Data Elements</th>
<th>PATH Program Specific Data Elements</th>
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<tbody>
<tr>
<td>• Name</td>
<td>• Birth Date</td>
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<td>• Social Security Number</td>
<td>• Gender</td>
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<td>• Race</td>
<td>• Ethnicity</td>
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<tr>
<td>• Veteran Status</td>
<td>• Residence Prior to Program Entry</td>
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<tr>
<td>• Disabling Condition</td>
<td>• Zip Code of Last Permanent Address</td>
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<tr>
<td>• Program Entry Date</td>
<td>• Housing Status</td>
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<td>• Program Exit Date</td>
<td>• Date of Contact</td>
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<td>• Date of Contact</td>
<td>• Date of Enrollment</td>
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<td>• Referrals Assisted</td>
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HMIS Governance

HMIS is governed by local Continuums of Care (CoCs). The CoC is the community's lead for strategic planning on homelessness, including its participation in HMIS. Each community selects an agency that acts as the CoC Lead Agency; these agencies are listed on the OneCPD website: www.onecpd.info.

The CoC is responsible for appointing an HMIS Lead Agency, contracting with a software vendor, and ensuring adherence to data quality and standards. The CoC enters into an agreement with the HMIS Lead Agency; the HMIS Lead Agency, in turn, enters into agreements with each service provider agency that has staff entering data into HMIS. These agreements define the roles and responsibilities of the HMIS Lead Agency, the provider agencies, and the CoC. The CoC is responsible for setting the overall policies for the HMIS, while the HMIS Lead Agency is responsible for managing the HMIS, including developing and following operating procedures consistent with policies that have been set by the CoC. Individual agencies may further define policies and procedures consistent with those of their CoC and HMIS Lead Agency.

HMIS Lead Agencies will designate an HMIS System Administrator who handles the day-to-day management and operation of the HMIS. This will include orienting staff members who are new to entering data in HMIS (end users), training end users, engaging in “help desk” functions, and assisting agencies to learn how to generate accurate reports. Many PATH providers are already engaged in their local HMIS and are confidently using HMIS to generate their PATH Annual Report. Others are actively involved with their CoC and are prepared to begin collecting data in HMIS.

Often, communities collaborate with several different agencies within their HMIS. Many HMIS software packages offer more functionality than simple reporting capability; it is advantageous for a variety of agencies to participate in HMIS governance for this reason. This participation can become important when decisions are made to utilize the system for community-wide improvements, improve or upgrade the system, invest in additional system functionality, or replace dysfunctional systems. It is advisable for PATH provider agencies to be familiar with the policies and procedures, management, and governance of their local HMIS and to build a productive relationship with the HMIS System Administrator.

A CoC represents a specific geographic area. For some communities this may be a city or county; for others, the CoC may cover a state or an area called “Balance of State.” Usually, a Balance of State is the total area in the state not covered by urban areas with their own CoCs.
IV. PATH PARTICIPATION IN HMIS

The PATH program is a critical part of a community's system of care for individuals who experience homelessness or are at risk of homelessness, often providing people who are unsheltered a first step into a larger system of services and supports. Participation in HMIS provides a platform for coordinating care and improving access to mainstream programs and housing resources. Given that one of the goals of the PATH program is linking clients to resources in the community, effective PATH provider participation in the community's HMIS will allow for more effective and streamlined referrals and easier tracking of clients' current needs.

The PATH program joins a range of programs that are currently participating or preparing for participation in HMIS. These include programs in the U.S. Department of Housing and Urban Development (HUD) (Continuum of Care [CoC], Emergency Solutions Grant [ESG], and Housing Opportunities for Persons with HIV/AIDS); the U.S. Department of Veterans Affairs (Supportive Services, Grant and Per Diem, HUD-Veterans Affairs Supportive Housing); and the U.S. Department of Health and Human Services (Runaway and Homeless Youth).

In November 2006, SAMHSA and HUD began investigating the potential to align data collection, reporting, and performance measurement practices for HUD and the PATH program. A workgroup composed of staff from HUD and SAMHSA, State PATH Contacts, and HUD and PATH technical assistance contractors held regular meetings. The workgroup recommended new street outreach data elements to support the effort to integrate PATH data into HMIS.

In December 2009, SAMHSA invited State PATH Contacts and members of the PATH Consumer Provider Network to Washington, D.C., to identify implementation strategies for PATH data reporting in HMIS. Following this meeting, HUD and SAMHSA announced on December 21, 2009, that the agencies had agreed to align reporting requirements by establishing common collection methods and performance outcomes. As a result, all PATH programs will collect and report data into a local HMIS. In 2009, SAMHSA also notified its PATH grantees of this requirement (see http://PATHprogram.samhsa.gov/Resource/PATH-and-Homelessness-Management-Information-Systems-HMIS-47572.aspx). The 2010 revised HMIS Data and Technical Standards (HMIS Standards) contained this workgroup's street outreach data elements. The PATH Annual Report included voluntary outcome measures beginning in 2009.

SAMHSA requires states not already using HMIS to transition PATH providers to collecting data in HMIS, with the aim of 100 percent participation by October 2016. PATH providers will benefit from a range of resources to help with this transition, as noted in later sections of this Technical Assistance Plan.

SAMHSA recognizes that it can be difficult to quantify all the services provided under the PATH program. Outreach to persons experiencing homelessness or at risk of homelessness and have a serious mental illness involves building relationships and establishing trust with individuals—this work takes time and patience. A client's readiness to accept help often results from this level of effort. The HMIS design is intended to gather some of this information in order to document the PATH provider staff's persistence to support this vulnerable population.
BENEFITS OF PATH PARTICIPATION IN HMIS

Participation in HMIS has numerous benefits, which are experienced at many levels—from state and federal agencies, to the staff managing and providing services to people who are homeless, and, ultimately, to the clients who receive these services. A number of these benefits are described in the pages that follow.

BENEFITS FOR COMMUNITIES

Communities use HMIS to coordinate case management, streamline referrals, and coordinate assessment of clients to prioritize serving those most vulnerable. In communities where HMIS software is web-based, intakes, needs and vulnerability assessments, and eligibility screenings for all clients are increasingly completed within the HMIS. These practices are effective in reducing duplicative intakes, assessments, and reports by numerous agencies, thus increasing productivity, reducing service costs, and targeting housing and services to those most in need. HMIS also helps enhance service providers’ understanding of the immediate needs of clients across the community.

BENEFITS FOR COMMUNITIES

- Helps demonstrate the extent and scope of homelessness in the community
- Helps provide an unduplicated count of individuals experiencing homelessness
- Helps identify service and housing gaps within the community so that resources can be targeted to meet these gaps more effectively and efficiently, thus reducing the incidence of homelessness
- Provides quality data to support policy and program decisions
BENEFITS FOR CLIENTS

Clients indicate that the decreased need to retell their stories confers dignity and respect on the process of having to access services while in crisis. For example, when clients can access services with a single intake, it minimizes the need to secure transportation and childcare to submit applications at multiple locations. In some communities, service providers have agreed on standardized intake, assessment, and eligibility screening, allowing them to have a common application form for a variety of services and to prioritize services and housing to those most vulnerable. This approach allows for more appropriate and effective referrals to be made and decreases the chance that clients feel that they are being given the runaround. While HMIS will reduce time for intakes, PATH outreach workers will still conduct a separate mental health assessment when needed.

HMIS Benefits,
Julie Eberbach,
Iowa Institute

From HMIS 101–Benefits of HMIS

“I knew of a personal example in a community in Iowa, where a young woman entered a shelter and had a really severe medical condition. Because she had a shared record with a Health Care for the Homeless provider through HMIS, they were able to deliver her medicines within 30-45 minutes. That’s a real social benefit that goes way beyond the fact that when she came in and did her intake and assessment, they had the data that helped build her record that contributes to the larger pool of data that informs social policy.”

BENEFITS FOR CLIENTS

- Helps reduce the number of times a person must engage in an intake and assessment
- Helps streamline the referral process because agencies are interconnected and client information is shared among partner agencies with confidentiality
- Enhances coordinated case management, within an agency and across agencies, to better serve clients
- Improves the eligibility determination process for mainstream benefits
Benefits for Program and PATH Provider Staff

There are numerous benefits of HMIS participation for program staff. Staff can be more organized, save time, and prepare outcome reports with ease. Intakes and needs assessments can be thorough—often they can be completed in HMIS and can assist providers in making appropriate and efficient referrals.

In addition, program and agency managers can use their HMIS to prepare reports for federal funders and report progress and outcomes to state and local funders, private foundations, and individual donors. Aggregated client data are sometimes shared with the public to increase awareness about homelessness and advocate for change.

As communities move toward implementing a HUD-required coordinated assessment system, PATH programs are more likely to join in both the planning and implementation of the system when they are part of a local HMIS and are participating in their CoC. This participation will provide greater access to community-wide resources, save staff time and effort, and provide greater access to housing and services for PATH clients, who are among the most vulnerable in their communities.

Benefits for Program and PATH Staff

- Helps to improve tracking of program and service outcomes for clients
- Helps to inform PATH program reports
- Helps to coordinate services internally among agency programs and externally with other providers
- Helps to analyze performance of the program
- Helps to increase the efficiency of doing intakes and assessments
- Helps to decrease duplicative intakes and assessments
- Helps to screen for eligibility for community programs and streamline referrals
- Helps to prioritize those most vulnerable for housing and services to assure quicker access
- Helps to track and monitor referrals and track client access to services
- Helps staff to complete activity reports accurately and in a timely manner
COORDINATING PATH HMIS PARTICIPATION

SAMHSA has planned an orderly transition of PATH data collection from current systems into HMIS. This Technical Assistance Plan includes Appendix A and Appendix E, which detail the steps and training opportunities that will occur at specific intervals during the transition period between 2013 and 2016.

Each State PATH Contact (SPC) will coordinate activity for the state’s PATH providers to collect data in HMIS. States and territories have been invited to join one of four Learning Communities for phased implementation during this transition. Groups will be formed based on readiness to transition PATH data collection to HMIS and their shared challenges and barriers to making this transition. In each group State PATH Contacts will be invited to participate in the Learning Community and to share challenges and successes with peers in their group. State PATH Contacts will guide their state’s PATH providers through various action steps throughout the transition period. These action steps and phases are clearly outlined in the PATH HMIS Toolkit located in Appendix H.

Each State PATH Contact and PATH provider will be linked to additional resources during the transition. There will be online training webinars, self-paced learning modules, and online question and answer sessions to address common challenges and barriers, as well as share successes. Roles and responsibilities for the HMIS Transition include:

- **STATE PATH CONTACTS**: Coordinate transition to HMIS among PATH providers in their state, including planning, monitoring, and troubleshooting the transition to HMIS.
- **PATH PROVIDERS**: Identify and contact their local CoC and HMIS Lead Agencies for scheduling and participating in HMIS orientation, licensing, and training.
- **LOCAL HMIS LEAD AGENCY**: Work with HMIS vendor to generate an accurate PATH report and train PATH providers in HMIS data entry and PATH report generation.
- **LOCAL CoC LEAD**: Orient PATH providers on HMIS policies and procedures (e.g., privacy and confidentiality procedures), assist PATH providers with access to local HMIS, and help PATH providers take part in local CoC strategic planning.
- **SAMHSA**: Support transition to data collection in HMIS through training, technical assistance, and provision of resource materials for State PATH Contacts and PATH providers.

**WHAT IS A LEARNING COMMUNITY?**

A “Learning Community” is an opportunity to foster collaborative learning among colleagues within a particular work environment or field. Members can share each other’s resources and skills to enhance their learning experience.
V. PATH DATA COLLECTION

CONSIDERATIONS FOR A SUCCESSFUL HMIS TRANSITION

There are a number of details that need careful attention in a PATH provider’s plan to collect PATH data in the local Homeless Management Information System (HMIS). Some of these details may seem challenging at times, but inherent in each is an opportunity to find advantageous solutions.

IMPORTANT CONCEPTS SPECIFIC TO DATA COLLECTION AND REPORTING

• **Data Accuracy:** Consistently collecting accurate data can save time and effort for providers and can result in more reliable data. HMIS systems typically have the ability to provide data accuracy checks, which may be absent from other data collection tools. These features are embedded within the software, so the technology offers a practical, easier, and more reliable way to check data for accuracy.

• **Data Reliability:** Reliability of the data refers to the ability to draw accurate conclusions about the data based on what is reported. As an example, in the past a provider may have provided “estimated” counts. Estimation reduces the reliability of the data and may limit the ability of the provider to use the information effectively. In using HMIS, a record will be opened for each PATH client as soon as personal identifying information is available, typically name, date of birth, and some portion of the social security number. An HMIS system can de-duplicate client records that have been opened for the same person by different providers in the community. Therefore, more reliable data on actual counts, based on de-duplicated client records, will give each PATH provider and State PATH Contact (SPC) a more accurate count of the program’s scope, activities, and outcomes.

• **Data Consistency:** Data consistency is important as it allows SAMHSA and SPCs to look at PATH data across providers and states/territories, compare data, and develop targets based on these comparisons. This big picture helps providers, SPCs, and SAMHSA to identify trends and needs within the PATH program. Participation in HMIS will greatly improve consistency in PATH data reporting and can assist in addressing PATH reporting processes that have been inconsistent in the past. To further increase data consistency, the PATH Data Advisory Group will work to clarify and standardize definitions for PATH data elements and will be open to input from all states/territories throughout this process.

IMPORTANT MATTERS FOR PATH PROVIDERS COLLECTING DATA IN HMIS

• **Client Privacy and Confidentiality:** Providers need to assure their clients that information being collected is confidential and secure. Obtaining client consent to enter data into HMIS may take time. PATH providers should work with the HMIS Lead Agency to ensure that confidential information, such as a disability determination, is protected properly. The HMIS Lead Agency can provide information and guidance on privacy and confidentiality policies. The U.S. Department of Housing and Urban Development (HUD) standards require robust privacy and confidentiality standards—these are contained in the HMIS Technical Standards, which are updated periodically. The HMIS Lead Agency can provide up-to-date information on the current standards in place. Information for PATH providers and their agency managers on both HIPAA and 42 CFR Part 2 are contained in Appendix D.
• **Double Data Entry (entering data into a “Legacy” system and HMIS):** In many cases, the PATH program is part of an agency that reports data through an information system that has been operating for some time and is required by other funders. In such cases, provider staff may face entering data into two separate systems, which could be time-consuming and burdensome. Fortunately, opening a client case record in HMIS only occurs once and some clients may already have open records in HMIS. Data entered for instances of PATH services—outreach contact, services given, or referrals made—can be entered into HMIS relatively quickly. Typically, case notes are not entered into HMIS unless there is a reason to share information specific to a referral being made, in which case client consent would be needed for sharing any protected personal information. Providers may choose to keep all case notes in their agency’s legacy system. In some agencies there are technological solutions for uploading data into another system—these are more complex solutions that require close coordination between agency management and information technology staff of the provider agency and the HMIS Lead Agency. SPCs and PATH providers will find the PATH HMIS Toolkit helpful in identifying ways to resolve problems with double data entry or legacy systems. The Toolkit is located in Appendix H.

• **Connecting to the Local HMIS:** Because most states do not have a statewide HMIS, connecting to the local Continuum of Care (CoC) and its HMIS will be the responsibility of the PATH provider. CoCs are likely to welcome PATH participation in HMIS. This topic will be discussed at the PATH HMIS Learning Community meetings.

• **Time Required Learning a New System:** An initial commitment of time and energy will be required of PATH providers who are not already participating in a local HMIS. It is expected that providers will ultimately save time as HMIS typically improves the provider’s ability to deliver services more effectively. To offset the time it takes learning a new system, PATH providers are expected to experience the following benefits:
  » Time savings in data collection
  » Time savings in reporting due to the increased functionality of the new PATH reporting platform, the PATH Data Exchange (PDX)
    » Beginning with the 2014 PATH Annual Report, PDX is expected to accept data uploads directly from an HMIS
  » Accuracy and consistency of data for all clients
  » Increased capacity to identify appropriate resources for clients
  » Increased capacity to track client referrals
  » Increased capacity to monitor program outcomes
TRANSITION PLAN FOR STATES AND PROVIDERS TO COLLECT DATA THROUGH HMIS

A transition period for collecting PATH data in HMIS began on November 1, 2012, when the former PATH Annual Report form expired. The PATH Data Advisory Group developed a new report, which SAMHSA submitted to the U.S. Office of Management and Budget (OMB). It was approved by OMB and was made available to PATH providers following training and technical assistance in June 2013. The new PATH report form is expected to remain in effect for up to three reporting periods and is known as the Transition PATH Annual Report form.

On April 2, 2013, HUD released the 2013 Draft HMIS Data Standards for public comment.

When the new HMIS Standards are final, SAMHSA will work closely with HUD to ensure that the PATH Annual Report is 100 percent aligned with the new data standards. This will require submission of a new PATH Annual Report form to OMB. Until a new form is submitted and approved, PATH providers will use the Transition PATH Annual Report form to submit annual report data.

Once data elements in the new HMIS Standards and the new PATH Annual Report are fully aligned, all PATH providers will be expected to use HMIS to collect their PATH data for annual reporting. This will occur by 2016.

During this transition, SAMHSA will work with a group of three to five states to understand how PATH data collection in HMIS is progressing by:

• Identifying obstacles and successful strategies for collecting PATH data in HMIS; and
• Learning about the best approaches to support and train all PATH providers and State PATH Contacts to make this transition successful.

In addition, SAMHSA is developing new technology for data collection. Currently, PATH providers enter their Annual Report data using a platform that is technologically outdated. A new reporting platform will:

• Allow providers to report data more easily, with few technical difficulties; and
• Reduce data entry errors.

To guide this interim period, SAMHSA developed a transition plan overview, located in Appendix A of this Technical Assistance Plan. Training and technical assistance will continue to be provided to State PATH Contacts and PATH providers on the Transition PATH Annual Report form and, at a later date, on PATH data collection in HMIS. Those PATH providers most ready to collect PATH data in HMIS will do so. SAMHSA expects a successful, but somewhat lengthy transition period, lasting through 2015. This Technical Assistance Plan incorporates the transition plan and outlines what will occur during this time.

The appendices that follow provide information and resources to assist SPCs and PATH providers during this transition. Additional resources may become available from the ongoing technical assistance events that will be held during this transition. SAMHSA will notify the PATH community when additional resources are available.

SAMHSA looks forward to working with the PATH community during this exciting transition and welcomes thoughts and suggestions.
## VI. APPENDICES

### APPENDIX A: PATH HMIS TRANSITION PLAN OVERVIEW 2013 – 2016

### TIMELINE FOR STATE PATH CONTACTS AND PATH PROVIDERS

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Task</th>
<th>Milestone/Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/13 – 9/13</td>
<td>Identify and assess HMIS readiness for PATH provider participation</td>
<td>GPOs receive grantee responses to HMIS readiness questions, analyze responses</td>
</tr>
<tr>
<td>10/13 – 11/13</td>
<td>Communicate Transition Plan and timeline to State PATH Contacts and</td>
<td>Communications sent out by SAMHSA—Transition Plan disseminated</td>
</tr>
<tr>
<td></td>
<td>PATH providers</td>
<td></td>
</tr>
<tr>
<td>6/13</td>
<td>Provide training on Transition PATH Annual Report form and timeline</td>
<td>Training(s) completed for State PATH Contacts and PATH providers</td>
</tr>
<tr>
<td></td>
<td>for new data collection period and provide transition report format</td>
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<tr>
<td></td>
<td>to PATH providers, along with the Provider Guide and FAQ for training</td>
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<tr>
<td></td>
<td>s and ongoing use</td>
<td></td>
</tr>
<tr>
<td>11/13</td>
<td>State PATH Contacts and PATH providers are divided into implementation</td>
<td>States and territories assigned to PATH-HMIS Learning Communities; continuous feedback loop established</td>
</tr>
<tr>
<td></td>
<td>groups according to readiness for HMIS participation. Groups will</td>
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<tr>
<td></td>
<td>receive orientation and training for HMIS and linkage to their local</td>
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<td></td>
<td>HMIS Administrators—these will be PATH-HMIS Learning Communities,</td>
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<td></td>
<td>four facilitated online groups to help identify successful practices,</td>
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<tr>
<td></td>
<td>challenges, and obstacles related to entering PATH client data into</td>
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<td></td>
<td>HMIS.</td>
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<tr>
<td>11/13 – 11/16</td>
<td>All Learning Communities meet, receive training, resources,</td>
<td>Ongoing online meetings held</td>
</tr>
<tr>
<td></td>
<td>materials, and technical assistance on collecting PATH data in HMIS,</td>
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<tr>
<td></td>
<td>as appropriate to HMIS readiness—addressing challenges and successes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and sharing information among members of Learning Communities</td>
<td></td>
</tr>
<tr>
<td>Date Range</td>
<td>Description</td>
<td>Outcome</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>9/13 and</td>
<td>Provide technical assistance and consultation to states, identifying any training needs and supporting providers to improve data quality</td>
<td>TA and consultation given, challenges and barriers addressed and resolved with State PATH Contacts</td>
</tr>
<tr>
<td>ongoing</td>
<td></td>
<td>and PATH providers</td>
</tr>
<tr>
<td>11/13 and</td>
<td>Receive feedback throughout the transition period from State PATH Contacts in the Data Advisory Group and make adjustments to training, resources, and materials as necessary</td>
<td>Feedback received from SPC Data Advisory Group throughout the transition period—feedback noted,</td>
</tr>
<tr>
<td>ongoing</td>
<td></td>
<td>incorporated into training materials for Learning Communities</td>
</tr>
<tr>
<td>8/13 – 2/14</td>
<td>Contractor builds new data reporting platform (PATH Data Exchange—PDX) to specifications of the Transition PATH Annual Report form and anticipated future changes (e.g., other changes for the next version of the PATH Annual Report form—a new report based on final HMIS Data Standards.)</td>
<td>Reporting platform (PDX) completed with transition period data elements</td>
</tr>
<tr>
<td>5/14 – 12/14</td>
<td>New PATH Annual Report format to be developed containing data elements consistent with published and revised HMIS Data and Technical Standards (estimated to be available for use on July 1, 2014), depending on when new data standards are finalized and OMB and public clearance is final</td>
<td>New PATH Annual Report form developed with revised HUD data standards</td>
</tr>
<tr>
<td>Est. 7/15</td>
<td>Adopt new PATH Annual Report form, which has been publicly reviewed, revised, and published in final form</td>
<td>New PATH Annual Report form published in final form after public comment period</td>
</tr>
<tr>
<td>7/15 – 6/16</td>
<td>First full year of PATH providers collecting data in HMIS and data submitted to PDX</td>
<td>Data tables from HMIS collection submitted by providers and entered into PDX</td>
</tr>
</tbody>
</table>
APPENDIX B: RESOURCES FOR PATH PROVIDERS AND STATE PATH CONTACTS

HOMELESSNESS RESOURCE CENTER (HRC) WEBSITE
The Substance Abuse and Mental Health Services Administration's website dedicated to disseminating knowledge and best practices to prevent and end homelessness:
http://homeless.samhsa.gov

PATH WEBSITE
http://pathprogram.samhsa.gov

UNITED STATES INTERAGENCY COUNCIL ON HOMELESSNESS WEBSITE
http://www.usich.gov/

ONECPD WEBSITE
The Department of Housing and Urban Development's resource site for HUD-funded programs, including CoC and HMIS information:
http://www.onecpd.info

INTRODUCTORY GUIDE TO COC PROGRAMS
A high-level introduction to the Continuum of Care (CoC) Program:
https://www.onecpd.info/resource/2036/introductory-guide-to-the-coc-program

CONTINUUM OF CARE CONTACTS
Find CoC contacts in your geographic area:

HMIS PROPOSED RULE
New HMIS requirements under the HEARTH Act:
https://www.onecpd.info/resource/1967/hearth-proposed-rule-for-hmis-requirements/
HMIS DATA STANDARDS 2010
https://www.onecpd.info/resource/1220/final-hmis-data-standards

HEARTH ACT

HMIS DRAFT DATA STANDARDS 2013
Appendix C: Using HMIS for PATH Data Collection Flow Chart

1. PATH staff enters client level data into local HMIS.

2. PATH provider generates PATH Annual Report from de-identified, de-duplicated, and aggregated HMIS data.

3. PATH provider inputs de-identified, de-duplicated, and aggregated Annual Report data into the PATH Data Exchange (PDX).

4. PDX collects and stores all validated PATH report data generated from local HMIS systems nationwide.

5. State PATH Contact reviews and validates PATH provider data in PDX.

6. SAMHSA contractor staff contacts State PATH Contacts to correct data entry errors where needed.

7. SAMHSA reviews data.

8. SAMHSA uses finalized data to generate PATH data tables.

9. SAMHSA publishes national PATH outcomes.
APPENDIX D: PRIVACY AND CONFIDENTIALITY IN HMIS

OVERVIEW

The Projects for Assistance in Transition from Homelessness (PATH) program joins nine federally funded programs that currently are participating or preparing for participation in a local Homeless Management Information System (HMIS). These include the Continuum of Care (CoC), Emergency Solutions Grant, and Housing Opportunities for Persons with HIV/AIDS programs in the U.S. Department of Housing and Urban Development (HUD); the Supportive Services for Veteran Families, Veterans Homelessness Prevention Demonstration Program, Domiciliary Care for Homeless Veterans, Grant and Per Diem, and the HUD-Veterans Affairs Supportive Housing Program in the U.S. Department of Veterans Affairs (VA); and the Runaway and Homeless Youth Program in the U.S. Department of Health and Human Services (HHS).

HHS, within which the Substance Abuse and Mental Health Services Administration (SAMHSA) operates, is one of the 19 federal agencies in the U.S. Interagency Council on Homelessness that has agreed to collect data through HMIS to meet the goals of Opening Doors, the federal plan to end homelessness. HMIS is a locally administered, electronic data collection system that stores longitudinal, person-level information about persons who access the homelessness service system. The information is collected to benefit the client and ensure the following:

- An accurate intake and assessment is completed to define the clients' needs for housing and services.
- Eligibility is determined for certain shelter, housing, and services programs that meet clients' needs.
- Progress of clients' access to services and housing is tracked.

In addition, aggregating data at the national level allows federal agencies to track their progress toward meeting the federal goal of ending homelessness and to be held accountable for program expenditures.

HMIS DATA AND TECHNICAL STANDARDS

HMIS is regulated by HUD’s HMIS Data and Technical Standards to protect all personal information that can be used to identify a specific individual. This includes information that can be manipulated and/or linked with other available information that could identify a specific individual.

HUD published requirements for HMIS in 2004, with subsequent updates released in 2010, 2011, and March 2013. The 2013 Notice revises the 2010 HMIS Data Standards and contains the data elements agreed upon by HUD, HHS, and VA. The PATH program and its Data Advisory Group fully participated in these revision activities.
In 2011, HUD issued HMIS regulations that provided guidance on privacy and confidentiality, and security standards. These regulations identified the governing bodies responsible for policies and procedures, management, and oversight. In the HMIS Requirements Proposed Rule, 76 Federal Register 237 (December 9, 2011), HUD noted the following:

“HMIS policies and procedures must meet HUD standards … and must meet applicable state or local governmental requirements (related to data quality and security),” and

“In particular, (HMIS) governing policies must allow any covered health organization that is also a covered entity under the Health Insurance Portability and Accountability Act (HIPAA) to make disclosures of protected health information in a manner that fully complies with HIPAA privacy and security rules.”

HMIS cannot supersede any requirements of Title 42, Public Health, in the Code of Federal Regulations (CFR) or HIPAA. Policies governing the operation of a local HMIS must ensure that the privacy and confidentiality of clients is maintained through high data standards and must follow local, state, and federal client confidentiality laws.

Data reported by providers to the local CoC, state and federal funders, and the public cannot identify any single individual. To ensure the confidentiality of this Protected Personal Information (PPI), data are de-duplicated, de-identified, and aggregated in HMIS. This allows for information, under appropriate circumstances, to be shared with any outside entity that has interacted with the client in some manner. For example, a CoC may distribute information annually on the total number of persons served, the percentage of individuals who were living in households with (and without) children, as well as those who are veterans, have a disability, and/or are experiencing chronic homelessness. These data are usually considered in the CoC’s strategic planning and help ensure that resources are used effectively.

HUD issued guidance on baseline and additional privacy standards in its 2008 training, HMIS 101. These privacy standards outline the minimum baseline PPI requirements:

- PPI may be collected only when appropriate to the purpose for which the information is obtained or when required by law.
- PPI may be collected only by lawful and fair means and where appropriate, with the knowledge or consent of the individual.
- A sign must be posted at each intake desk or comparable location that explains the general reasons for collecting this information.

Case Study: Maryland PATH Provider Agency

A PATH provider agency in Maryland collects all demographic information in HMIS (e.g., name, gender, race, social security number) and shares this information with other provider agencies in the local CoC. While most clients experiencing homelessness receive services from numerous agencies, the HMIS software is able to create an individual record of identification. This helps avoid duplication of clients in the system and allows for an accurate count of the number of persons in the community experiencing homelessness.

For this provider agency, Personal Protected Information (PPI) is shared only with the client’s written and oral consent. Access to all PPI is normally “locked,” and only the agencies entering the data have access to it in HMIS. Information about disabling conditions is always locked.

If clients wish to share information about their disabling condition in order to determine eligibility for housing or services, oral and written consent is necessary.
• A copy of the privacy notice must be given to the client.
• Use and disclosure of the PPI can be made only with the consent of the individual or when required by law.

CoC entities are responsible for establishing privacy and security standards for their HMIS. However, these standards must adhere to HUD’s HMIS Data and Technical Standards. The CoC oversees the HMIS Lead Agency, which contracts with an HMIS vendor and, in turn, this HMIS vendor must adhere to all security standards. HMIS Lead Agencies are responsible for:

• Developing a security plan for HMIS that is approved by the CoC;
• Hiring and overseeing an HMIS security officer to ensure compliance with security standards;
• Obtaining criminal background checks on security officers;
• Ensuring all HMIS users receive security training;
• Implementing a policy for responding to security incidents;
• Preparing protocols for disaster recovery; and
• Reviewing security procedures at least annually.

Providers that serve people who are experiencing homelessness or who are at risk of homelessness must ensure privacy and confidentiality. Their responsibilities include the following:

• Establishing, at minimum, the baseline privacy and security requirements outlined by HUD’s HMIS Data and Technical Standards;
• Complying with the conditions under HIPAA or 42 CFR and establishing appropriate procedures for obtaining consent;
• Posting privacy policies at each intake desk;
• Determining the level of personal information to be shared in HMIS (e.g., for referrals where eligibility must be established);
• Taking responsibility and ensuring end users abide by confidentiality and privacy procedures (e.g., not sharing passwords, closing computer screens when leaving desktop); and
• Training staff on privacy and data sharing.

Providers are aware of the need to keep individual information private. This includes not only information about mental illness or substance use disorders, but also HIV/AIDS, domestic violence history, income, housing status, legal status, and other such personal information.

For clients, there are other PPI safeguards. In the 2013 Notice, the categories “client refused” and “client does not know” are offered as answers to many standard intake and assessment questions housed in HMIS. Therefore, if a client does not trust the privacy and security standards of the provider agency, it is possible that he/she may choose these answers instead of providing personal information.

In order for a provider to document eligibility for a program, a client must provide personal information and the provider must obtain the client’s consent
in order for the information to be entered into HMIS. Typically, this would be information to qualify for permanent supportive housing, such as a history of mental illness and/or a substance use disorder, which are conditions most often documented by a service provider covered by HIPAA and 42 CFR.

Once the data are entered into HMIS, the provider agency, with consent of the client, may share information that is appropriate and benefits the client. In addition, client information is used to:

- Track client progress against goals and help clients access services and achieve stability; and
- Report program or project progress to funders and the CoC, using de-identified, de-duplicated, aggregated data.

Similar to services funded by other federal agencies, the PATH program and its providers benefit from participation in HMIS in the following ways:

- Connects PATH providers to a larger network of local resources
- Connects PATH providers to local planning efforts to end homelessness
- Raises the profile of PATH programs nationally

NOTES ON THIS SECTION:
PATH HMIS PRIVACY AND CONFIDENTIALITY SNAPSHOT
ENTITIES COVERED UNDER HIPAA, 42 CFR AND HMIS

**HIPAA**
Any provider of medical or other health services, or medical supplies, who transmits any health information in electronic form in connection with a transaction for which the Department of Health and Human Services (HHS) has adopted a standard

**42 CFR**
Programs providing alcohol and/or drug prevention or treatment services

**HMIS DATA AND TECHNICAL STANDARDS**
Any person entering data into and/or accessing a local HMIS
## HOW KEY PRIVACY AND CONFIDENTIALITY ISSUES ARE ADDRESSED IN HMIS

<table>
<thead>
<tr>
<th>Confidentiality/Privacy Key Issues</th>
<th>HMIS Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client consent to <strong>collect</strong> Personal Protected Information (PPI)</td>
<td>HMIS Standards do not require informed/explicit consent for <strong>collection</strong> of PPI. PATH providers can require informed consent in the form of written consent as per 42 CFR requirements/HIPAA.</td>
</tr>
<tr>
<td>Client consent for <strong>disclosure</strong> of information to other parties</td>
<td>A provider participating in HMIS may use or disclose PPI from HMIS under the following circumstances and only with client consent.</td>
</tr>
<tr>
<td></td>
<td>• Provide or coordinate services to an individual</td>
</tr>
<tr>
<td></td>
<td>• Initiate functions related to payment or reimbursement for services</td>
</tr>
<tr>
<td></td>
<td>• Carry out administrative functions, including but not limited to legal, audit, personnel, oversight, and management functions</td>
</tr>
<tr>
<td></td>
<td>• Create de-identified PPI</td>
</tr>
<tr>
<td></td>
<td>• Abide by uses and disclosures required by law, including to avert a serious threat to health or safety, situations involving victims of abuse, neglect, or domestic violence; and for academic research purposes</td>
</tr>
<tr>
<td></td>
<td>• Disclosure for law enforcement purposes</td>
</tr>
<tr>
<td></td>
<td>Under 42 CFR, PATH providers may obtain multi-party consent to share information in an HMIS for the purposes stated above.</td>
</tr>
<tr>
<td>Withdrawal of consent for disclosure of PPI</td>
<td>As per 42 CFR Part 2, a client may ask to see his/her HMIS record and withdraw consent at any time.</td>
</tr>
<tr>
<td>Sharing information electronically</td>
<td>Under HMIS Data Standards, providers may choose to limit the uses and disclosures of PPI; for providers that are required to comply with HIPAA and 42 CFR, information sharing must be limited to comply with these requirements or any other state or local requirements more stringent than federal requirements.</td>
</tr>
<tr>
<td></td>
<td>The level of access to client records/PPI is determined by the provider and outlined in participation agreements with the HMIS Lead Agency.</td>
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<tr>
<td></td>
<td>Providers may opt to share only aggregate, de-identified client information.</td>
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</tbody>
</table>
### Using data in HMIS to generate reports

All data from HMIS used in reporting progress to funders or others is only entered into the applicable reporting platform as aggregated and de-identified information (PPI is not visible). Currently this includes reports sent to the Department of Housing and Urban Development (HUD) in the Annual Homeless Assessment Report on the nature and extent of homelessness. Some PATH providers already utilize HMIS and generate their PATH report data from their HMIS database. Communities and other funders may also have additional reporting requirements; however, these requirements cannot include the unnecessary disclosure of PPI. Local, state, and federal privacy laws supersede HMIS Data Standards if these are more stringent.

<table>
<thead>
<tr>
<th>HIPAA Security Standards</th>
<th>HMIS Security Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify a security official.</td>
<td>Security Officer—HMIS Lead Agency and each PATH provider assigns staff for this role</td>
</tr>
<tr>
<td>Implement physical safeguards for all workstations that access electronic Protected Health Information (PHI) to restrict access to authorized users.</td>
<td>Physical Safeguards—physical measures to protect HMIS data as outlined in HMIS Technical Standards. Generally, HMIS standards follow those of HIPAA.</td>
</tr>
<tr>
<td>Implement technical policies and procedures for electronic information systems that maintain electronic PHI.</td>
<td>Security Plan—implementation of administrative, physical, and technical safeguards to protect PPI and PHI</td>
</tr>
<tr>
<td>Implement policies and procedures to ensure that all members of its workforce have appropriate access to electronic-protected health information.</td>
<td>Technical Safeguards—protect and control access to electronic HMIS information and outline policies and procedures for its use</td>
</tr>
<tr>
<td>Establish policies and procedures for responding to an emergency or other occurrence (e.g., fire, vandalism, system failure, natural disaster).</td>
<td>Disaster recovery plan must be in place.</td>
</tr>
<tr>
<td>Implement policies and procedures to address security incidents.</td>
<td>Protocols for reporting security incidents must be in place.</td>
</tr>
<tr>
<td>Implement policies and procedures for authorizing access to electronic protected health information that are consistent with the applicable requirements of HIPAA security standards.</td>
<td>Workforce Security—criminal background checks for all users in HMIS</td>
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</tr>
<tr>
<td>Implement a security awareness and training program for all members of its workforce (including management).</td>
<td>Security awareness training held for all HMIS users</td>
</tr>
<tr>
<td>Perform a periodic technical and nontechnical evaluation.</td>
<td>Annual security review required for all agencies using HMIS</td>
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APPENDIX E: TRAINING AND TECHNICAL ASSISTANCE (TA) OPPORTUNITIES

LEARNING COMMUNITIES

States and territories will be grouped into Learning Communities in order to provide a forum where State PATH Contacts (SPCs) can work with one another to share successful strategies and challenges that they are facing related to the HMIS transition. Sharing information about processes and implementation ideas that SPCs and Continuum of Care entities in their state have found to be successful will be instrumental in making the Learning Communities worthwhile experiences for all participants.

Learning Communities will be formed based on:

- The nature and complexity of challenges that the state/territory must address to allow for a successful transition to collecting data in HMIS;
- The readiness of the state or territory’s PATH providers to collect data in HMIS, if they are not already using HMIS.

TRAINING FOR ALL LEARNING COMMUNITIES

SAMHSA will host virtual trainings for SPCs monthly during federal fiscal year 2014 in order to address challenges and issues that are common across Learning Communities. These trainings will provide opportunities for all SPCs to gather information about common concerns and learn from experts in identified topic areas.

One of the first of these trainings will be a basic “course” about HMIS and will afford both SPCs and their provider agencies an opportunity to learn the concepts, terminology, and benefits of HMIS. This training will be in the format of a webinar and will be archived on the PATH website. From time to time, HUD staff may participate in trainings to provide information related to updates in the HMIS Data and Technical Standards and to answer questions from the PATH community.

PATH SUPPORT TEAM ASSISTANCE

Each Learning Community will be assigned a SAMHSA Government Project Officer and a PATH Support Team member from SAMHSA's Homeless and Housing Resource Network (HHRN). PATH Support Team members will facilitate Learning Community calls and ensure that SPCs in each Learning Community are receiving the support that they need. SPCs will receive the contact information for their PATH Support Team member and will be able to reach out to this person with any questions that arise throughout the transition process.

PATH FREQUENTLY ASKED QUESTION DOCUMENT

SAMHSA has developed a Question and Answer document in order to respond to common questions and concerns related to the Transition PATH Annual Report form and the HMIS transition. Click here to download this document. This document will be periodically updated to address new questions and concerns as they arise.
PATH WEBSITE HMIS TOPIC PAGE

The [HMIS topic page](http://path.org) on the [PATH website](http://path.org) will be updated periodically with information and resources relevant to the HMIS transition. SPCs will be notified when new resources are available. SPCs and PATH providers who are seeking additional information related to HMIS are encouraged to review all available resources.

INDIVIDUAL TA REQUESTS

States/territories are encouraged to submit TA requests if their TA needs are unique to their state and are not met by the TA opportunities listed above. SPCs can download the TA request form by logging into the [PATH website](http://path.org), navigating to the [State PATH Contact Resource Center](http://path.org), and selecting “PATH Resources.” SPCs who are logged into the PATH website can also download this request form by clicking [here](http://path.org). When completing this form, SPCs outline their unique TA needs and explain why these needs cannot be met through the Learning Communities and other TA resources.
APPENDIX F: FREQUENTLY ASKED QUESTIONS

1. What training and training resources will be available related to the HMIS transition?
   - State PATH Contacts will participate in Learning Communities that emphasize peer learning and networking.
   - Additional resources will be provided during the Learning Community meetings. State PATH Contacts may also want to share additional resources among Learning Community members.
   - Some State PATH Contacts may wish to set up Learning Communities within their state to assist PATH providers with this transition.
   - The PATH HMIS Toolkit (Appendix H) provides resources that State PATH Contacts can use to assist in facilitating a learning community within their state.
   - All PATH providers will be invited to virtual trainings on key issues related to the HMIS transition.
   - PATH providers should contact their State PATH Contact regarding state-specific training opportunities.

2. What initial steps can State PATH Contacts take immediately to begin preparing for the HMIS transition?
   - State PATH Contacts can begin by creating a list of the Continuum of Cares (CoCs) in which their PATH providers work and identifying the local HMIS used by each CoC. State PATH Contacts may also want to contact the HMIS System Administrator for each CoC to begin an initial conversation.
   - State PATH Contacts can also create a list of challenges and barriers that the state or specific PATH providers face related to the HMIS transition (e.g., the PATH Provider is also a Community Mental Health Center and must collect data in an electronic health record). State PATH Contacts can bring this list to their Learning Community meetings for discussion.

3. For providers that are currently using HMIS for PATH data collection, do the current HMIS Data Standards include all the elements of the new PATH data requirements?
   - The current HMIS Data Standards, from 2010, do not include all of the new PATH data elements. The new data elements in the 2013 standards are expected to be incorporated into HMIS software by each vendor.
   - HUD and SAMHSA provided HMIS vendors with instructions for programming the new (transition) PATH Annual Report form into each vendor's HMIS software.
   - For any PATH data elements that cannot be collected by HMIS, providers need to track this information separately until HUD's new HMIS Data Standards are programmed into each HMIS. An Excel spreadsheet template will be made available for this purpose.
4. Will HMIS be set up to enter all these new data elements?
   - The 2013 draft HMIS data standards include these new data elements. HMIS vendors have received program specifications to collect all new elements.

5. Will HMIS vendors be required to develop the new PATH Annual Report form as per the new specifications and be able to generate the 2013 PATH Annual Report form?
   - HMIS vendors will be required to incorporate the new HMIS data standards, which include the PATH Annual Report data elements, when the HMIS Data Standards are final.
   - HMIS vendors have been given programming instructions for generating the new (transition) PATH Annual Report form.
   - HMIS software nationwide will be able to generate the new (transition) PATH Annual Report form. The timing of when this will happen has not yet been determined, but will occur after HUD's HMIS Data Standards are final.
   - If providers are in a position of not having entered all the new data elements into their HMIS, SAMHSA does not expect them to be able to generate the entire PATH Annual Report form for 2013 if they have not collected the new data elements.

6. Will there be a specific PATH report that should be used to extract PATH data from HMIS for the Annual Report?
   - When the 2013 HUD HMIS Data Standards are finalized and programmed by HMIS vendors into local systems, each provider should be able to report the specific data needed to complete the new (transition) PATH Annual Report form from HMIS.

7. The new data standards have not been finalized yet. What will SAMHSA do with the PATH Annual Report form if HUD decides to change the data standards from what they originally proposed?
   - SAMHSA views this PATH Annual Report form as a transition report form and will make revisions to the form in the future so that it will fully align with HUD's final HMIS Data Standards.
   - This transition report will be used during the next two to three years.
8. Should PATH providers continue to migrate to HMIS even though the new HUD HMIS data standards have not yet been released?
   • PATH providers should continue the process of transitioning to using their local HMIS for data collection, even though the final 2013 HUD HMIS Data Standards have not been published yet.
   • Data elements that cannot yet be entered into HMIS can be collected through separate means. An Excel spreadsheet template will be made available for this purpose.

9. What if a provider is not inputting data into HMIS right now?
   • If providers are currently not using HMIS, they should continue to use the same data collection methods that they have been using.
   • Providers should incorporate the new PATH data elements into this data collection method in order to report on the new data elements in the 2014 PATH Annual Report form.
   • SAMHSA expects all PATH providers to input data into HMIS by 2016.
   • For the transition period, an Excel spreadsheet was provided to SPCs for PATH providers who may choose to use this method to track new data elements outside of their current management information system.

10. Will SAMHSA recommend which vendor it believes has the user-friendliest HMIS system containing the new 2013 PATH Annual Report form?
    • PATH providers should work with their Continuum of Care and HMIS Lead Agency to enter their data into the particular HMIS system already in use in their area.
    • SAMHSA encourages PATH providers to work with their existing local HMIS.
    • The benefit of using the local HMIS is to increase service linkages for PATH clients.

11. What are the privacy and confidentiality requirements related to inputting and storing PATH data in HMIS?
    • A provider entering data into HMIS, or into any comparable system, must comply with all requirements of federal, state, and local laws or regulations that protect personal health information. This includes HIPAA and 42 CFR Part 2, both of which require protection of health information. More information of privacy and confidentiality issues is contained in Appendix D.
      » Federal: HIPAA, 42 CFR Part 2, and HUD HMIS Technical Standards
      » State: applicable state requirements, laws, regulations
» Local: applicable local requirements, including those of the local HMIS
» Agency: applicable agency requirements, policies, and procedures

• Current HMIS Technical Standards require that systems be HIPAA-compliant.
  » HUD is issuing updated Technical Standards for comment later this year that may specifically address 42 CFR Part 2.
• The requirement under 42 CFR to protect the content and nature of any substance use treatment pertains to programs that provide substance use diagnosis, treatment, or referrals for treatment. This requirement is not addressed in the current HMIS Technical Standards.
  » To be a “program” that falls under 42 CFR Part 2, a provider organization or entity must be federally assisted and provide alcohol or drug abuse diagnosis, treatment, or referral for treatment (42 CFR § 2.11).

  » Information protected by 42 CFR Part 2 is any information disclosed by a Part 2 program that identifies an individual directly or indirectly as having a current or past drug or alcohol problem, or as a participant in a Part 2 program.

  » Providers who are not currently using HMIS should contact their Continuum of Care (CoC) and/or their HMIS Lead Agency to review the policies and procedures governing privacy and confidentiality. It may also be helpful for providers to discuss questions about privacy and security with other providers in their Continuum who enter data for Shelter Plus Care residents.

  » Providers should look at the MOUs or other agreements that they may have with their HMIS administrator and/or CoCs to ensure language about privacy and confidentiality are included. HMIS Technical Standards will soon be updated by HUD to address privacy and confidentiality concerns, and State PATH Contacts will be notified when this guidance is available.

  » Any additional questions about HMIS privacy and confidentiality standards can be submitted through HUD's Ask A Question (AAQ) portal located here: https://www.onecpd.info/ask-a-question/. Please label any questions as being HMIS-related. HUD will be able to review these questions and provide a response.

12. We have many clients to whom we outreach and provide information but who would never agree to sign an HMIS release allowing us to enter them as a statistic in the system. Will this cause problems?
  • If the client does not want any data entered into HMIS for any reason, providers should enter “Refused” where that response is an option.
  • It may be possible for providers to enter minimal identifying information (see answer to question #13) in order to count those clients as outreach contacts.
  • Once a client is enrolled into a PATH program, it may be possible to allay the client’s concerns about HMIS. The privacy and confidentiality policies and procedures of the Continuum of Care and its HMIS should be explained to the client in enough detail for the client to make an informed choice about this matter.
13. In terms of HMIS entry, how will providers be able to enter clients served in outreach if there is not enough data available on those clients? How does HMIS count outreached/contacted numbers in such cases?

- Until a relationship is developed with a client that allows a PATH worker to enter all the data elements that identify that client so the client record can be de-duplicated in HMIS, it may be possible to enter information about the client in less traditional ways (e.g., male living in vacant house on 621 5th Street).
- Some Continuum of Cares (CoCs) have been collecting minimal identifying data elements for many years when doing their annual point in time count of persons experiencing homelessness and have developed guidelines to help providers and outreach workers.
- The HMIS Administrator may be able to suggest ways that the local CoC has decided to collect only minimal identifying data on clients.
- When additional identifying information about the client is available, the client record can be updated to include more accurate information, given that the client gives consent for this information to be entered.
- PATH providers should speak with their HMIS Administrator and/or their CoC about data collection for outreach contacts where identifying information is not readily available.

14. How will in-reach be entered into HMIS?

- At this time, SAMHSA considers in-reach as a form of outreach and will be entered as outreach. SAMHSA is considering ways to broaden street outreach whenever possible and encourages providers to do more street outreach with PATH funds.

15. Does HMIS, or will HMIS, be able to efficiently track referrals made?

- HMIS vendors will incorporate the 2013 HMIS Data Standards Final Notice, which includes all PATH Annual Report data elements, including referrals made.
- Providers will track referrals in order to generate the data needed for the new (transition) PATH Annual Report form.

16. The proposed HMIS Data Standards are adding the terms “Client doesn’t know” and “Client refused”—will PATH also utilize these terms in the Demographics section (DS #12)? Does “Don’t Know” in PATH mean “Client Doesn’t Know,” as it does for HUD projects, or does it mean the data entry staff person doesn’t know?

- These terms refer to the client not knowing the information or refusing to give the information, not the data entry staff person.
- Currently, these terms are not in use for PATH, but they are choices for other projects in HMIS.
- If providers are already using HMIS, they may use the terms “Client doesn’t know” and “Client refused” until their HMIS vendor programs the systems to contain the entries “Don’t know” and “Refused” into the system.
17. Many of the PATH providers work in an agency already utilizing an electronic record system. It will take several hours to make the changes within the system to account for these new data elements. Many of the pure outreach folks never reach the clinical record. Has SAMHSA developed a working database that we can easily track this information in a standardized manner?

• PATH providers are asked to begin collecting their data in the local HMIS, not to change their existing electronic record system.
• The benefit of collecting PATH data in HMIS is that clients will have electronic access, through HMIS, to the services and housing placements that are available in the local community.
• Referrals for services and housing can be made easily and efficiently within HMIS.
• HMIS is the standardized manner that SAMHSA is asking PATH providers to use.

18. How long will vendors have to program the new HMIS Data Standards?

• HUD will allow vendors adequate time after the 2013 HMIS Data Standards Final Notice is published in final form to complete programming into their HMIS software.

NOTES ON THIS SECTION:
APPENDIX G: FAQ GLOSSARY

Annual Reporting Period: The time frame when the PATH Annual Report online system is open for providers to enter and submit data. This time frame has not yet been determined for the 2013 report but early November is the anticipated date.

Data Collection Period: PATH providers report data on the PATH Annual Report form based on a one-year cycle determined by their state. This period typically aligns with the state’s fiscal year.

PDX (PATH Data Exchange): This is the new PATH Annual Report online system where providers will enter data into the online annual report form and submit reports for validation.


Reporting Deadline: The date by which all PATH providers must submit their data into the PATH Annual Report online system. This date has not yet been determined for the 2013 report.

Appendix H: PATH HMIS Toolkit

The PATH HMIS Toolkit

The transition of SAMHSA’s Projects for Assistance in Transition from Homelessness (PATH) program to using Homeless Management Information Systems (HMIS) may seem complex and challenging. Consequently, State PATH Contacts (SPCs) may want assistance to begin this transition process, and the PATH HMIS Toolkit is intended to provide practical, step-by-step guidance to SPCs as they navigate the transition to HMIS.

The documents within the toolkit lay out a comprehensive framework and detailed process for transitioning PATH providers to HMIS; however, the toolkit is not prescriptive. Each SPC is encouraged to customize the process and tools to the specific needs and situations of his/her state or territory. SAMHSA will equip SPCs in this transition to HMIS through Learning Communities that emphasize peer learning and networking. Some SPCs may choose to implement a Learning Community with their own providers and stakeholders and find the toolkit materials especially helpful to facilitate progress with state/territory-based Learning Community members.

The PATH HMIS Toolkit consists of the following components:

1. PATH HMIS Transition Roadmap

The roadmap is a visual representation of a step-by-step process for SPCs to follow in leading the transition of PATH programs to HMIS. Of note, normally a state/territory’s PATH providers are in the same phase at the same time, although this may not always be the case.

The roadmap is the governing document for the toolkit. Each page illustrates one of six phases that naturally leads to the next phase towards completing the PATH HMIS transition. The phases are outlined below:

- Phase 1: Pre-planning
- Phase 2: Stakeholder identification
- Phase 3: Barrier identification
- Phase 4: Creating an action plan to address barriers
- Phase 5: Implementing the action plan
- Phase 6: Troubleshooting and refining solutions
2. Needs Assessment and Information Gathering Tools

These tools are online questionnaires that SPCs may choose to distribute to their state or territory's PATH providers and HMIS Lead Agencies. The tools are designed to be useful for states/territories and providers at all levels of HMIS implementation. The information obtained will help SPCs to obtain an assessment of current HMIS implementation and identify barriers, strengths, and weaknesses. Accurate identification of these barriers, strengths, and weaknesses is the key to a successful transition that includes effective use of HMIS by PATH programs.

When surveys are completed, SPCs can request the results by emailing path@samhsa.hhs.gov.

A preview link that can be used to test or view the survey without submitting data, as well as an active link for data collection, are provided for the following tools:

» PATH Provider Needs Assessment
» HMIS Lead Information Gathering Tool

In addition, a sample data analysis is provided to illustrate the information SPCs will be able to glean from these assessments and tools.

For SPCs to distribute to PATH Providers: PATH Provider Needs Assessment

PREVIEW ONLY
Does not collect data:
https://www.surveymonkey.com/s.aspx?PREVIEW_MODE=DO_NOT_USE_THIS_LINK_FOR_COLLECTION&sm=ExabnB%2bkyKhJGl5ZlhajNfCTubDlVRcFvfon%2flIPo7E%3d

ACTIVE DATA COLLECTION LINK
Use this link for data collection:
https://www.surveymonkey.com/s/PATHproviderneedsassmtHMIS

For SPCs to distribute to HMIS Leads/Administrators: HMIS Lead Information Gathering Tool

PREVIEW ONLY
Does not collect data:
https://www.surveymonkey.com/s.aspx?PREVIEW_MODE=DO_NOT_USE_THIS_LINK_FOR_COLLECTION&sm=QFQp0m3RFVnsCc3WNsaDjk5OkasJOVl9YIN3Ttbqnc%3d

ACTIVE DATA COLLECTION LINK
Use this link for data collection:
https://www.surveymonkey.com/s/HMISinfoqathering

PATH HMIS TOOLKIT: SAMPLE DATA REPORTS

The following sample data reports are provided as examples to illustrate the information State PATH Contacts can expect to receive if they utilize the information gathering tools provided in this toolkit with their PATH providers and HMIS Lead Agencies.
SAMPLE DATA REPORT:  
Information Provided by HMIS Lead Agencies for PATH HMIS Transition

Are any PATH providers currently participating in your HMIS?

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses (%)</th>
<th>Responses (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>33%</td>
<td>4</td>
</tr>
<tr>
<td>No</td>
<td>67%</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>12</td>
</tr>
</tbody>
</table>

Of those HMIS Leads who do not have PATH providers participating in HMIS:

Has the CoC developed plans to integrate all PATH providers into the HMIS in the coming years?

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses (%)</th>
<th>Responses (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, we have plans in place and are already implementing the plans</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>Yes, we are in the planning process</td>
<td>25%</td>
<td>1</td>
</tr>
<tr>
<td>We have started thinking about the changes, but haven’t developed plans yet.</td>
<td>50%</td>
<td>2</td>
</tr>
<tr>
<td>No, we have not yet started preparations for this change.</td>
<td>25%</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>
As a local HMIS/CoC Lead, what information do you need to make the transition of PATH programs to HMIS smooth and effective? (Multiple answers possible.)
Of those HMIS Leads who have some or all PATH providers participating in HMIS:

For which purposes do PATH programs currently utilize the HMIS? (Multiple answers possible.)

![Graph showing purposes of HMIS utilization]

- Referring clients to other programs
- Residential services – bed coverage
- Data Collection
- Identifying services clients received at other organizations
- Tracking client outcomes
- Other (Unsure)
Generally speaking, how would you describe the data quality of PATH programs in the HMIS?

75% (six respondents) indicated that the data quality of existing PATH HMIS users is average compared to other users. 12.5% (one respondent) indicated that the data quality of existing PATH HMIS users is above average, and 12.5% (one respondent) indicated that data quality of existing PATH HMIS users is below average.

Questions asked of all HMIS Leads:
What options are available for sharing client data among different agencies in the HMIS? (I.e., Do all agencies participating in the HMIS have access to all client data? Is some client data only selectively shared? Are any agencies prohibited from sharing client data? Are prohibitions on sharing of client data decided at the agency level, CoC level, local or State government level?)

75% (six respondents) have some version of a partially open system with ability to share certain client/program data and limit access to more sensitive items. 25% (two respondents) have a system which is currently “closed” or in which PATH data is invisible to other users.

What type of client consent is required for sharing client data between agencies? (Multiple answers possible.)

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses (%)</th>
<th>Responses (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client consent is given verbally or in writing at the time of enrollment to allow sharing between all relevant organizations for service coordination.</td>
<td>50%</td>
<td>4</td>
</tr>
<tr>
<td>The client must sign a separate and specific release of information.</td>
<td>37%</td>
<td>3</td>
</tr>
<tr>
<td>Sharing of client information is never permitted.</td>
<td>13%</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>8</td>
</tr>
</tbody>
</table>
Is data integrated into the HMIS from other databases or systems?

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses (%)</th>
<th>Responses (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>25%</td>
<td>2</td>
</tr>
<tr>
<td>No</td>
<td>75%</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>8</td>
</tr>
</tbody>
</table>

Which funding sources currently support the HMIS? (Multiple answers possible.)
Are agencies charged fees for licenses to use the HMIS?

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses (%)</th>
<th>Responses (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, for all users</td>
<td>13%</td>
<td>1</td>
</tr>
<tr>
<td>Yes, for some users</td>
<td>37%</td>
<td>3</td>
</tr>
<tr>
<td>No</td>
<td>50%</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>8</td>
</tr>
</tbody>
</table>

Are agencies charged fees to have reports generated?

13% (one respondent) charges fees for generating reports at this time.

Are agencies charged fees to customize the HMIS for new programs?

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses (%)</th>
<th>Responses (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, for all users</td>
<td>13%</td>
<td>1</td>
</tr>
<tr>
<td>Yes, for some users</td>
<td>13%</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>74%</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>8</td>
</tr>
</tbody>
</table>
Is funding available through existing sources to cover costs of vendor fees, user licenses, system administration, and/or training costs for new HMIS users from PATH programs in your area?

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses (%)</th>
<th>Responses (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current funding is sufficient for incorporation of PATH users (but may be re-evaluated later).</td>
<td>37%</td>
<td>3</td>
</tr>
<tr>
<td>All costs associated with PATH users joining the HMIS will need to be covered by additional outside funds.</td>
<td>25%</td>
<td>2</td>
</tr>
<tr>
<td>Unsure</td>
<td>37%</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>8</td>
</tr>
</tbody>
</table>

What are your main concerns related to the transition of PATH providers into HMIS? (Multiple answers possible.)

- Inability to cover costs
- Insufficient HMIS staff resources
- Incorporating new program modules/PATH data elements into HMIS
- Decrease in data quality until new PATH users are trained
- N/A, all PATH providers using HMIS
- Other
SAMPLE DATA REPORT:  
Results of PATH Provider Needs Assessment

Does your organization currently use HMIS to collect any of the data elements for its PATH program?

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses (%)</th>
<th>Responses (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>47%</td>
<td>7</td>
</tr>
<tr>
<td>No</td>
<td>53%</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>15</td>
</tr>
</tbody>
</table>

Of PATH providers currently using HMIS:
Does your organization use any other mechanisms to collect data on its PATH program? (Multiple answers possible.)
On a scale of 1 – 5, how comfortable does your organization feel using the HMIS system?

The average score was 3.22—on average, PATH users feel moderately comfortable with HMIS.

Who is paying for the HMIS licenses and/or user fees for your program? (Multiple answers possible.)

Have you received local HMIS training from the HMIS Lead Agency?

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses (%)</th>
<th>Responses (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, we have been fully trained</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>Yes, but we need additional training</td>
<td>71%</td>
<td>5</td>
</tr>
<tr>
<td>No</td>
<td>29%</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>7</td>
</tr>
</tbody>
</table>
For which of the following purposes does your organization use HMIS? (Multiple answers possible.)

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses (%)</th>
<th>Responses (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collect client data</td>
<td>100%</td>
<td>7</td>
</tr>
<tr>
<td>Referrals to other organizations</td>
<td>29%</td>
<td>2</td>
</tr>
<tr>
<td>Determine how clients are engaging with other service providers</td>
<td>57%</td>
<td>4</td>
</tr>
<tr>
<td>Generate PATH Annual Report</td>
<td>14%</td>
<td>1</td>
</tr>
<tr>
<td>Create reports about PATH clients</td>
<td>14%</td>
<td>1</td>
</tr>
<tr>
<td>Create reports that identify missing data</td>
<td>29%</td>
<td>2</td>
</tr>
<tr>
<td>Create reports that show trends about PATH client population</td>
<td>14%</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>7</td>
</tr>
</tbody>
</table>
Of PATH providers not using HMIS:

How does your organization currently collect data on the PATH program?

What are the main reasons your organization has not adopted use of HMIS? (Multiple answers possible.)
On a scale of 1 – 5 how ready do you think your organization is to transition to using a local HMIS system?

The average score was 2.1—on average, PATH providers do not yet feel ready to transition to HMIS.

What kind of training or resources will help your organization feel ready to transition to HMIS? (Multiple answers possible.)

Questions asked of all PATH providers:

Who records/enters client data for your organization? (Multiple answers possible.)
<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses (%)</th>
<th>Responses (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case managers</td>
<td>13%</td>
<td>2</td>
</tr>
<tr>
<td>Outreach staff</td>
<td>80%</td>
<td>12</td>
</tr>
<tr>
<td>Other direct service staff</td>
<td>7%</td>
<td>1</td>
</tr>
<tr>
<td>Data or administrative staff</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>Other (PATH supervisor)</td>
<td>7%</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

What are your organization’s challenges in collecting data? (Multiple answers possible.)

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses (%)</th>
<th>Responses (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited staff time</td>
<td>60%</td>
<td>9</td>
</tr>
<tr>
<td>Limited resources to hire data entry staff</td>
<td>47%</td>
<td>7</td>
</tr>
<tr>
<td>Integrating data collection into service delivery is difficult</td>
<td>27%</td>
<td>4</td>
</tr>
<tr>
<td>Clients decline to provide information</td>
<td>20%</td>
<td>3</td>
</tr>
<tr>
<td>Other (outdated technology, duplicate data entry)</td>
<td>33%</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>
What are your organization’s challenges in using the data you collect? (Multiple answers possible.)

![Bar chart showing challenges in using data]

How does your organization share information with other programs your PATH clients access? (Multiple answers possible.)

![Bar chart showing methods of information sharing]
How do you refer your PATH clients to other programs or services? (Multiple answers possible.)

![Graph showing methods of referring clients]

What are your challenges in tracking client outcomes, coordinating referrals, and linking your clients to services at other agencies? (Multiple answers possible.)

![Graph showing challenges in tracking outcomes]

Draft—November 8, 2013
3. Templates for Roadmap Phases 1 – 4

Editable/writable templates are provided for the first four phases of the roadmap to assist SPCs in understanding the needs of providers and stakeholders, identifying barriers, and developing solution-oriented action plans. The templates are provided as Excel spreadsheets and can be downloaded by clicking on the files in the Attachments sidebar on the left side of this document. The first tab of each Excel document provides instructions and examples for using the template. The second tab provides the template where users can enter information. The templates included in the toolkit are:

» Provider Assessment Table (Phase 1)
» Stakeholder Assessment Table (Phase 2)
» Barrier Identification Table (Phase 3)
» Action Plan Template (Phase 4)

State PATH Contacts will learn the use of the PATH HMIS Toolkit within their Learning Communities and can rely on feedback from other states/territories on effective use of these tools in moving through the phases of the PATH HMIS transition.

HOW TO USE THE TOOLKIT

To use the toolkit, start at Phase 1 of the roadmap and follow each step indicated. The roadmap uses words and symbols to indicate the points at which additional components of the toolkit are deployed. The intended use of the toolkit is to follow the phases sequentially. By following the phases and steps as described, State PATH Contacts and their providers will make progress in transitioning to HMIS usage. However, as noted above, the toolkit is meant to be a guide, and SPCs and/or PATH providers can modify steps or phases. Ultimately, SPCs and providers are encouraged to use the toolkit and its components in the manner that is most useful for meeting their needs.

3 If you do not see the Attachments sidebar, please click on the paper clip icon to the left of this document to make the sidebar appear.
**PATH HMIS TRANSITION**

**PHASE 1: PRE-PLANNING**

1. **Conduct needs assessments with all PATH providers in your jurisdiction,**

2. **Review needs assessment results and group PATH providers by HMIS implementation status:**
   - 1) Using HMIS;
   - 2) Working on transition to HMIS;
   - or
   - 3) Not using HMIS, nor working toward HMIS transition.

3. **List barriers, strengths, and weaknesses for each provider (see Provider Assessment Template).**

---

**Legend**

- Keep going.
- Slow down.
- Stop!
  - Take time to work through the barriers.
- Download Excel document.
- Link to Active Survey Monkey.
Brainstorm stakeholders by name.

Group stakeholders by relationship status, including:
1) Those with whom you already work well;
2) Those with whom you have some difficulty; or
3) Those who you don’t know or don’t know well (see Stakeholder Identification Template).

Those with whom you work well:
Contact them to enlist their support for HMIS transition.

Those with whom you have had some difficulty:
1) Identify those that are critical to the mission.
2) Add these relationships to a list of challenges/barriers to be addressed.

Those you don’t know well:
Reach out and begin building relationships.
PATH HMIS TRANSITION

PHASE 3: BARRIER IDENTIFICATION

- Analyze needs assessment results and other data.
- Group all of the barriers, strengths, and weaknesses into themes.
- List the main barriers (see Barrier Identification Template).
- Identify weaknesses that need to be addressed now. Table weaknesses that can be addressed later.
- Find resources to close knowledge gaps and address key weaknesses.
- What else do you need to know to understand the barriers and develop solutions?
- Which strengths can be leveraged to overcome each barrier?

LEGEND

Keep going.
Slow down.
Stop! Take time to work through the barriers.
Download Excel document.
Link to Active Survey Monkey.

[Click to go back to Table of Contents]
PATH HMIS TRANSITION

PHASE 4: CREATING AN ACTION PLAN TO ADDRESS BARRIERS

- Review the list of barriers and prioritize them.
- Starting with the top priority barrier, brainstorm possible solutions to this challenge.
- Identify who will help you solve each barrier (e.g., an ally, or multiple allies).
- Initiate conversation about barrier with allies.
- Consult others for ideas if you don’t know. (e.g., Learning Community, other states, providers, CoCs, HMIS administrators).
- Identify new barriers.
- Receive input.
- Propose solution to other stakeholder(s).

- Add new barriers to the list and return to the beginning of Phase 4.

For each barrier, create an individual action plan including tasks, responsible parties, and timelines (see Action Plan Template).

[Click to go back to Table of Contents]
PATH HMIS TRANSITION

PHASE 5: IMPLEMENTING THE ACTION PLAN

1. Review your action plan for each barrier.
2. Communicate with stakeholders to ensure clarity and buy-in on task(s), responsible parties, and timelines.
3. Follow up with each responsible party on progress regularly.
4. Success!

Next steps:
- Identify new barriers.
- Troubleshoot and refine solutions (Phase 6).

Legend:
- Keep going.
- Slow down.
- Stop! Take time to work through the barriers.
- Download Excel document.
- Link to Active Survey Monkey.
**PATH HMIS TRANSITION**

**PHASE 6: TROUBLESHOOTING AND REFINING SOLUTIONS**

Follow up with each responsible party regularly to assess progress on your action plan for each barrier.

Identify areas in which solutions are not working as planned.

Initiate conversation with stakeholder(s).

Receive input.

Identify new barriers.

Add to list of barriers and prioritize; Repeat Phases 3 – 6.

Refine action plan. Revise tasks, as well as review responsible parties and timeline.

Repeat Phase 5.

Success!