Implementation of the Wake Continuum of Care
Homeless Management Information System (HMIS)

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Chapel Hill

2006
According to Dr. Carol Caton, professor of Sociomedical Sciences at Columbia University’s Mailman School of Public Health, “Homelessness is a social problem of enormous public health significance.” Dr. Caton states, “As research on homelessness moves into its third decade, what we know about it and the causes of its widespread prevalence among different groups of America’s most impoverished is overshadowed by our inability to prevent it.” The National Alliance to End Homelessness webpage states that “approximately 3.5 million individuals experience homelessness each year.” Martha Burt, researcher at The Urban Institute, estimates that “440,000 to 840,000 people are homeless at any one given time” in the US and that “one in ten poor people experience at least one night of homelessness in the course of a year.” From a “Point in Time” count of North Carolina’s homeless in January 2005, the NC Department of Health and Human Services reports, “More than 11,000 people were homeless and more than 2,300 of them were children.” During a Wake County “Point in Time” survey, “1,235 homeless persons were counted in December 2003.” In January 2005, the point in time count in Wake County showed 1,106 homeless persons.

In order to address the increasing problem of homelessness in the US, Congress passed the McKinney-Vento Homeless Assistance Act, which was signed into law on July 22, 1987. This legislation created the Interagency Council on Homelessness and designated the Department of Housing and Urban Development (HUD) as the agency to administer grant funding in support of
homeless service providers. In the mid-1990’s, HUD announced a new paradigm for distributing its homeless assistance funding called the ‘continuum of care.’. The concept behind the community-based continuum of care model is “a homeless service delivery system that included prevention, emergency shelter, transitional housing, support services and permanent housing.” In response to HUD’s requirement for the establishment of a group of local caregivers to prioritize their community’s needs and activities around homelessness, Wake Continuum of Care (CoC) Collaborative was formed in 1996 and has grown to approximately 30 public and private agencies providing homeless services. The Wake CoC continues to function as the coordinating organization for homeless services in the county.

As the mission of the Wake CoC shifted from “managing homelessness to ending and preventing homelessness,” The National Alliance to End Homelessness urged strategic planning at the local level. Wake CoC partnered with the City of Raleigh, Wake County Human Services and Triangle United Way to develop and implement a strategic plan entitled, “Ending Homelessness: The 10-Year Action Plan.” The finalized Plan was presented to the Wake County Board of Commissioners and the Raleigh City Council in February 2005. The multifaceted Plan includes input from persons who were homeless as well as from interested members of the community at large.

To further efforts in preventing and ending homelessness at the national level, Congress directed HUD in the Conference Report on the FY 2001 HUD Appropriations Act to report to the Appropriations Committee on its strategies for
collecting data on homelessness. The initial report entitled, “HUD’s Strategy for Homeless Data Collection, Reporting and Analysis” states that the conferees, “agree that local jurisdictions should be collecting an array of data on homelessness in order to prevent duplicate counting of homeless persons, and to analyze their patterns of use of assistance, including how they enter and exit the homeless assistance system and the effectiveness of the systems.”

To strengthen the resolve of local CoC agencies to develop and utilize a Homeless Management Information System (HMIS), HUD stated through Federal Register comments that “all recipients of HUD McKinney-Vento Act program funds are expected to participate in an HMIS.” In addition, “the annual CoC application requires information about a CoC’s progress in developing and implementing its HMIS” with required “Annual Progress Reports to be derived from HMIS data.” The ultimate goal of the HMIS data is for “performance measurement of both the McKinney-Vento grantees and CoC more generally.” In order to obtain an unduplicated count of homeless persons at the local CoC level, HUD “requires homeless clients be asked for personal identifying information, including name, date of birth, and Social Security number, when seeking housing or services.” At the time the information is requested, the agency must explain “how the information will be used, how it will be protected, and the advantages of providing accurate information.” In the July 28, 2004 Federal Register, HUD iterates the benefits of an HMIS as “providing significant opportunities to improve access to, and delivery of, services for people experiencing homelessness. An HMIS can accurately describe the scope of homelessness and
the effectiveness of efforts to ameliorate it. An HMIS can strengthen community planning and resource allocation.” Furthermore, the HMIS is promoted in the Federal Register Notice as a tool for “front-line service staff to provide more effective client services through improved referrals, intra-agency case management and service coordination” and “as an operational tool to share assessments of client needs, to link clients to needed services from multiple providers, to link the provision of services across providers and to determine the current location of clients within the service system.”

From the public health perspective, the health and well-being of the homeless population is compromised by “accident, injury, exposure to the extremes of heat and cold and a range of communicable diseases facilitated by crowding.” Given the breadth of HUD's vision for the HMIS, there are many potential uses of the HMIS for public health tracking and service delivery purposes, e.g. tracking persons exposed to communicable diseases to administer treatment or to notify the individual of exposure; referring for medical care; and documenting prescribed medications and health histories in the event that emergency treatment is required. The Tulsa, Oklahoma CoC reported that the use of the HMIS to notify potentially exposed homeless persons of a TB case in a local shelter improved the time required to contact all parties from 90 days [based on an exposure in the previous year] to 2 days. The Michigan Coalition Against Homelessness webpage lists multiple participating agencies including public health departments and schools. In addition, their HMIS includes information regarding client diagnoses, history and childhood immunizations.
Wake County Human Services assumed the lead in the development, implementation and ongoing management of the Wake Continuum of Care’s Homeless Management Information System (HMIS) in the summer of 2003. According to Jack Rogers, Director of Economic Self-Sufficiency, Human Services staff presented the HMIS funding request for $184,000 to the Wake E-Government Steering committee on July 28, 2003. The committee approved $111,000 to hire a project manager and to contract for a software program to be tailored to the needs of the Wake CoC. Subsequently, Phil Conen, of Phil Conen Solutions, Inc., was named project manager and Softscape, Inc. was awarded the software development contract.16

At the May 19, 2004 meeting with Wake County representatives and Anne Lezak from ADL Consulting, the firm contracted to write the 10-Year Plan, Mr. Conen explained the county’s perspective on the function of the HMIS, i.e., “to track outcomes, programs and services for effectiveness and to serve as a cornerstone for service coordination to prevent intentional or unintentional service duplication.”17 During May 2004, Mr. Conen led meetings with Wake CoC partners to discuss the technical aspects and potential of the HMIS as well as to provide a demonstration of a similar system developed by Softscape, Inc. These meetings allowed for Wake CoC member input into the system’s design as well as an opportunity to address any concerns. During the May 13, 2004 meeting, Mr. Conen explained the client intake process and the minimum data set that the agencies would be asked to collect to establish a client record, i.e. first name, last name, social security number and gender. Mr. Conen explained that after a client
record is established, the HMIS may be used as a tool for case management service plan development, client referrals to other agencies or for waiting list management. Other features were explained such as routine emergency bed management for the homeless shelters and “White Flag” status notification among agencies in situations of outdoor temperature extremes and other foul weather. In addition, the group discussed the “firewalls” in the system that would address client confidentiality concerns as well as the type of information that would “never be shared” such as HIV/AIDS status, medical history, and alcohol, substance abuse and psychiatric histories. In October 2004, the HMIS system was released for use by the Wake CoC agencies after participation in user training sessions coordinated by the project manager. According to “A Quick Reference Guide to Using PHIL (Presenting Homeless Information Logically),” [a local moniker for the Wake CoC’s HMIS], the system includes multiple screens allowing for the collection of a variety of client information including the HUD-mandated elements of General Intake with basic demographics; Client Consent; Income and Benefits, Education and Vocation, and Detailed Demographics assessments. The HMIS also allows for the collection of non-mandatory, agency-specified information such as Relationships/Households; Alias History; TB Tests; Program Enrollments and Exits; Services; Service Plans; Other Agency-Based Assessments; Notifications/Alerts; Address History; Incidents; Case Notes; Contact History; Documents Presented; and Ancillary Services. Agency-based functionality includes tabs for case management, bed management, referral, “White Flag” notification, and routine and ad hoc reporting.
In April 2005, six months into HMIS implementation, the Wake CoC discussed the establishment of participation levels in the organization, which were tied to HMIS availability to the individual agency. This discussion occurred as a result of Wake County expressing an interest in the Wake CoC assuming the administration of the HMIS and the costs associated with HMIS. In June 2005, the membership levels were approved as follows:

"WCoC Membership Policy: (Adopted 6/14/05 with no sunset)

- Visitors
  - Attends 1-2 full CoC meetings over the course of 1 operating year that begins the month after the SuperNOFA [HUD grant] application is submitted.
- Participating Member (agency or individual)
  - Attends at least 40% of the full CoC meetings over the course of 1 operating year that begins the month after the SuperNOFA [HUD grant] application is submitted.
  - Attends WCoC orientation, unless grandfathered in.
  - Must request to be a Participating Member
  - In return for 40% participation, a Participating Member has access to HMIS
  - HMIS access may require attendance at HMIS provider meetings and a fee for access.
- HUD Member (agency)
  - Required to attend 100% of full CoC meetings over the course of 1 operating year that begins the month after the SuperNOFA [HUD grant] application is submitted.
  - Required to use HMIS
  - In return for 100% participation and use of HMIS, a HUD member may submit a project for the annual SuperNOFA.22

Kay Ferguson, Wake County Human Services administrator and Wake County representative on the 10-Year Action Plan Oversight Team, indicated that the levels of Wake CoC participation were established in part to determine an
appropriate fee structure associated with HMIS participation. Although not implemented to date, Ms. Ferguson stated that the fees could vary greatly among the three levels from none for “Visitors” to a moderate amount for “Participating” members to a significant amount for “HUD” members. The fee structure would take into consideration an agency’s access to HUD grant funding through the Wake CoC that could be used to offset the costs of HMIS management. The discussion of the membership levels and potential fees may have had an impact on the progression of the HMIS implementation within Wake CoC agencies.\(^{23}\)

After the first year of HMIS availability, a survey was designed and administered to determine the extent of HMIS implementation by the Wake CoC agencies, the current phase of implementation, the anticipated future use of the HMIS, any technical and non-technical problems experienced by agency staff and suggestions for improvement of future versions of the software. The 11-question survey tool was designed to be completed by agency staff in 10 minutes or less. The survey tool and accompanying consent form were reviewed and approved by the Investigational Review Board at the UNC School of Public Health (See Attachments I and II). The survey was administered to Wake CoC members at their monthly meeting on November 8, 2005 and through subsequent contacts with agency representatives over the following week. Of the current listing of 41 Wake CoC agencies, the survey was completed by representatives of 20 agencies, mainly the larger, service-oriented organizations and those with emergency overnight bed availability (See Attachment III). Prior to the survey administration, Phil Conen, HMIS project manager, identified 14 Wake CoC agencies thought to
be using the HMIS including the South Wilmington Street Center (Homeless Shelter), Passage Home, Raleigh Rescue Mission, Salvation Army, and others; and 16 Wake CoC agencies not using the HMIS that consisted primarily of small, faith-based organizations without a primary focus on service delivery to persons who are homeless. Mr. Conen identified 8 agencies where the HMIS is considered to be not applicable to their activities including the Raleigh Police Department, City of Raleigh, The Literacy Council of Wake County, Smart Start, and others. One agency, Interact, was exempted from HMIS participation by HUD due to the vulnerable population (victims of domestic violence) served and the potential consequences of a breach in confidentiality. There were two agencies that were no longer in existence or without current contact information.  

<table>
<thead>
<tr>
<th>Chart 1: Wake CoC Agencies' Presumed Use of HMIS</th>
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<tr>
<td><strong># of Agencies</strong></td>
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<td>Using HMIS</td>
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<tr>
<td>Not Using HMIS</td>
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<td>Unknown</td>
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All of the Wake CoC agencies were contacted in person or by telephone and email to solicit a response to the survey. The survey was completed by all 14 of the agencies thought to be using the HMIS, three of 16 agencies thought not to
be using the HMIS, two of the 8 agencies in which the HMIS was not applicable and the one agency exempt from HMIS participation, a total of 20 agencies. The survey results indicated a variation from the presumed status of participation. Two of the agencies thought to be using the system were not doing so according to the survey results. One of the agencies thought not to be using the HMIS was using it for information purposes only. The agency staff indicated that they were not entering data into the system. Based on the survey results, the actual number of HMIS user agencies was 13, with 17 agencies not using the system at the time of survey administration.

![Chart 2: Wake CoC Agencies' Actual Use of HMIS (n=41)](chart2.png)

Regarding membership levels, the 20 agencies surveyed included 1 "Visitor" member, 12 "Participating" members and 7 "HUD" members. Chart 3 indicates HMIS use by membership level. As expected, all CoC members receiving HUD funding use the HMIS with an equal split of users and non-users.
among the Participating group. There were no Visitor level members participating in the HMIS at the time of survey administration.

Chart 3: Wake CoC Agencies' Use of the HMIS by Membership Level (n=20)

The second survey question inquired as to the frequency of HMIS usage within the agency, i.e. daily, weekly, monthly, annually or not applicable. Chart 4 illustrates the agencies' responses (n=20).
For the agencies using the HMIS, the frequency of use may be an indicator of the extent of HMIS implementation in the agency, the size of the population served, the type of services rendered and/or the degree of commitment to the HMIS process.

Chart 5 indicates variation in the frequency of HMIS use by each Wake CoC membership group. It is interesting to note that the HUD agencies’ use of the system is similar to the Participating agencies, which may more accurately reflect the various agencies’ business needs rather than their membership status or HMIS mandate. For example, the agencies that operate shelters with nightly check-in activities would be more inclined to use the system daily; where agencies that provide case management services would have a tendency to use the system on a more sporadic basis.
The next 4 survey questions, numbers 3 through 6, inquired as to how the agencies were using the HMIS currently as well as how they anticipated using the HMIS in 6 months, in 1 year, and in 5 years. The possible answers for each of the four questions included:

1) Client Intake;

2) Case Management Services (notes and service plans);

3) Program and Service Tracking – including referrals;

4) Generation of Reports, and/or

5) Bed Management features.

Of the 13 agencies reportedly using the HMIS, 11 of them indicated they currently were performing Client Intake with the system. The remaining 2 agencies indicated that they were using the system for Case Management Services (notes and service plans), with 1 of the 2 agencies also using the system for Program and Service Tracking purposes. Six of the remaining 11 agencies
indicated they were using the Case Management Services functionality as well as the 2 above for a total of 8 agencies. Eight agencies in addition to the 1 agency mentioned above stated they were using the Program and Service Tracking for a total of 9 agencies currently using this functionality. Only 5 of the 13 agencies reported a current use of Report Generations, the least used functionality, with 8 of the agencies indicating the use of the Bed Management features. The Bed Management functionality allows for agencies to track the use of facility beds and is the basis for locating emergency shelter beds among HMIS participating agencies on any given night. Chart 6 illustrates the reported use of the HMIS for all time periods requested in the survey.

![Chart 6: Wake CoC Agencies' Anticipated Use of HMIS Functionality](image-url)
Although the anticipated use of all functionality increases over time, the Generation of Reports has the most potential for a significant increase within the next year.

In addition, the variation in the number of functional elements used by agencies may indicate investment in the HMIS as well as the degree of agency skill in using the system. Chart 7 includes information regarding the number of surveyed agencies using none of the system functionality, 1 functional element, 2 functional elements, etc. In analyzing survey questions 3 through 6, it is noted that there is a steady progression in the projected use of the HMIS functional elements. Seven of the agencies currently using at least one functional element anticipate an increase in the number of system elements to be used within the next 6 months. Three of the remaining 13 agencies currently use all five HMIS functional elements.
It is interesting to note that the current non-users of the HMIS are optimistic about the system’s future usefulness within their organizations. All but one agency reported an anticipated use of at least one category within a 6-month period and all agencies surveyed reported some level of anticipated use within a 5-year period. Chart 8 shows the anticipated use of the HMIS by the current non-user group surveyed.

The use of HMIS functional elements also varies by Wake CoC membership level. The HUD membership group (n=7) uses a range of 1 (n=1) to 5 (n=2) functional elements currently and anticipates using either 4 (n=2) or 5 (n=5) functional elements within 6 months. The Participating membership group uses a range of 1 to 5 function elements with a projected range of use to remain the same, even after a period of 5 years. The number of Participating members
using 5 functional elements will increase, however, from 1 currently to 3 within the next 6 months and is projected to remain the same over time.

Question 7 of the survey tool addressed the phases of HMIS implementation within the Wake CoC agencies. The phases of implementation defined by HUD in the September 2002 “HMIS Implementation Guide” were used as a model to define the survey response options as follows:

Phase 1 = Data Collection mode (focusing on data entry and staff training only)
Phase 2 = Program/service tracking and case management mode (focusing on using the system to enhance service delivery)
Phase 3 = Referral mode (using the system to make referrals to other Continuum of Care Agencies)
Phase 4 = Administrative mode (focusing on administrative tasks and reporting, ex. Bed availability lists and HUD reporting). 25

According to the survey results, the Wake CoC agencies that have implemented the HMIS have done so at various phases as illustrated in Chart 9.
Seven of the agencies currently using the system reported multiple phases of implementation, with the most common combinations of phases 1, 2 and/or 4. Phase 3, referral mode, was the least reported phase. According to email correspondence with Phil Conen, project manager, the Wake CoC agencies participating in the HMIS had been discouraged from using the referral properties of the HMIS due to system inadequacies at the time the survey was administered. The system problems were to be addressed during an enhancement phase scheduled for November 2005.26

Chart 10 indicates the phases of HMIS participation by Wake CoC membership level. Of the 13 HMIS user agencies, the HUD group functions at a higher level than the Participating members with all 7 HUD agencies collecting data; 5 agencies performing systematic tracking and case management; and 3 agencies using the system for bed management and reporting purposes.
The next two survey questions addressed the agencies' collection of client health information (e.g. past or current medical history, medication use, communicable disease, alcohol/substance abuse) and whether the information was shared with other HMIS participating agencies. Five of the 11 agencies indicated they collected client health information with only 2 of those agencies sharing information with another agency. The sharing of information was limited to TB testing and only with client consent. One agency currently not collecting client health information indicated that they “could see using …the system for TB tests given within the past 12 months”. Another agency indicated their desire “to use [the HMIS] for TB tracking in the future.”

When asked about problems experienced with the HMIS, five user agencies indicated that they had experienced technical problems as did one of the non-user agencies. The type of problems included reports not functioning; system “crashes”; Internet Explorer and printing issues; and problems associated with the
HUD required intake questions. Nine of the 11 HMIS participating agencies reported non-technical problems experienced with the HMIS as did one of the non-user agencies. The list of non-technical complaints was longer than the technical and consisted of the following:

- “errors in system case notes cannot be voided and you must add another note explaining the error”;
- “not having enough time to use the system”;
- “data quality problems since the data must be current and the staff doesn’t know how to use the system”;
- “hard to revise some business practices to fit the new system”;
- “some communication issues with vendors and getting other agencies to participate”;
- “user manuals 1 and 2 unhelpful with version 3 much better”;
- “time consuming to review data going from one screen to another and not a lot of portability”;
- “issues regarding being able to view former clients’ alcohol and drug assessment information from other agencies”;
- “not user friendly to a layperson and staff needs to be shown how to use the system”;
- “having to make more than one attempt to get into the HMIS”;
and
- “hard to train staff”.
The fact that a currently non-HMIS participating agency experienced difficulties with the system may have led to enough staff dissatisfaction to result in the discontinuation of use.

As the final survey question, the survey respondents were asked for any suggestions for improving future versions of the HMIS (after implementation of the November 2005 enhancements). Eight of the current HMIS participating agencies and one non-user agency made suggestions as follows:

- "increase the speed of operations and a "back" or "previous" button that makes returning to the previous screen easier";
- "being able to look up a client and add them to the case list without having to look them up again";
- "being able to refresh where you are in the system and not having to pull a client up again";
- "continue to work on user friendliness";
- "transfer management to Wake CoC";
- "data located in more integral areas – do not like to look through multiple evaluations to find where required data is stored";
- "making a check off format for services so they don’t have to be individually input";
- "waiting to pass judgment on the system after seeing how the enhancements are going to work";
- "expand progress notes and the variety of options for note taking";
-“interface with current systems such as Wake Co. Mental Health to address needs of psychiatric patients”;
-“be able to print all screens”;
-“allow agencies to choose required questions (ESG, Supernova [sic], etc.)”; and
-“funding for all agencies interested in implementing [the HMIS]”.

The major study limitation to note is the potential for a bias in the results due to the 49% response rate to the questionnaire as well as the type of agencies that responded. The Wake CoC agencies completing the survey were the larger organizations with a primary mission of serving the homeless population. These agencies actively participate in Wake CoC general and subcommittee meetings and activities and are classified primarily as HUD or Participating members. These larger organizations appear to be more vested in the HMIS process, which may be due to the requirement of system participation and system generated reporting in order to qualify for grant funding. HUD grant funding, e.g., a total of $2,690,832 in FY04 and $2,309,650 in FY05, constitutes a considerable resource for Wake County government as well as for the local non-profit agencies serving persons who are homeless. The responses missing from the survey results are primarily from small, faith-based organizations with fewer resources and the infrastructure needed to impact homeless services on a large scale. These agencies are generally classified as Visitors. Several of the agencies listed on the Wake CoC roster were unknown to the HMIS project manager, who indicated in email correspondence that “no contact [was] ever made” with him regarding the
Having survey results from these less actively involved organizations would provide a clearer idea of the feasibility of implementing the HMIS within all agencies involved at any level with the homeless population. In order to achieve the HUD goal of unduplicated counts of the homeless population, it would appear essential to have all involved agencies participate regardless of the population served and the degree of service delivery.

The general conclusions from this study of the implementation of the HMIS with Wake CoC agencies are that there have been some successes to date along with some opportunities for improvement within the system itself and with implementation in target agencies. Almost 32% of the listed Wake CoC organizations have implemented the system to some degree and all 20 of the surveyed organizations have shown interest in expanding the use of the HMIS as early as within 6 months and at the latest within a 5-year period. Seven of the 13 agencies reportedly using the HMIS are doing so in a complete and integrated manner by utilizing the system’s current functional capacity for data collection, client management and, to some degree, reporting. In addition, these 7 agencies appear poised and ready to incorporate the referral component when available.

In order to increase the number of participating agencies and the degree of HMIS utilization, the system will need to be revised to improve some technical aspects such as maneuverability among screens and printing and reporting functionality. However, the majority of the agencies’ concerns appear to be related to non-technical aspects of system integration such as revising business
practices to incorporate the HMIS, staff confidence in working with the system, and the ability to tailor the software to meet agency needs.

Although the HMIS project manager is in the process of addressing many of the technical concerns with a system enhancement that was to be implemented in November 2005, the non-technical issues may be more of a challenge for current as well as future participants. It may be useful for the Wake CoC to establish a priority list for future HMIS participation among the member agencies as well as to verify the CoC membership status of identified agencies. It may also be helpful for the Wake CoC to enter into a formal agreement with member agencies that outlines HMIS access and membership fees for the desired level of participation in the organization. Tying fees to membership rather than to HMIS participation, i.e., a user fee may remove perceived barriers to the HMIS and increase system use.

For the agencies on the priority list for future implementation and/or HMIS expansion, it may be necessary for the Wake CoC HMIS subcommittee to establish a technical and non-technical needs assessment to determine the readiness of each agency’s computer equipment, but more importantly, the readiness of its staff. Although a potentially time-consuming venture, the energy put forth at the beginning of the process may lead to a higher level of ongoing participation and staff satisfaction. The goal of staff training and intervention would be to de-mystify the HMIS in order to ease staff anxiety and address any reluctance to use the system. This training would serve to increase confidence in the HMIS as a useful tool for the agency as well as confidence in the users’
abilities to navigate within the system. The ultimate goal would be to increase efficiency within the system and to improve overall satisfaction. To increase the participation of eligible agencies, additional outreach such as onsite visits may be required to market the HMIS and to accomplish the needs assessment.

From the public health perspective, the HMIS has the potential to be a powerful tool for documenting the presence of communicable and chronic diseases, and for service tracking and case management of a variety of physical and mental health problems. It appears from the survey results that the public health-related capacity of the system has been only minimally explored to date since the agencies using the system in this manner are doing so to track TB testing only. The Wake CoC agencies might consider soliciting the involvement of the Wake County Human Services Public Health administrators to gain insight into the potential uses of the system for health-related purposes and to assist with HIPAA (Health Insurance Portability and Accountability Act of 1996) and other confidentiality barriers to information sharing. The system is unlikely to be used to its fullest public health capacity until such perceived barriers and actual confidentiality issues are addressed.
References:


8. and 9. Wake Continuum of Care Orientation Manual, Wake Continuum of Care, revised January 23, 2004, pgs. 2 and 3; copy provided by Wake County Human Services staff, October 2005.


16. Telephone Interview with Jack H. Rogers, III, Director of Economic Self-Sufficiency, Wake County Human Services, 12/28/2005

17. Author’s Notes from the May 19, 2004 Meeting with Wake County Officials and Anne Lezak, ADL Consulting, the firm contracted to write the City of Raleigh, Wake Continuum of Care, Wake County Human Services and Triangle United Way’s “Ending Homelessness: The 10-Year Action Plan”.

18. Author’s Notes from the May 13, 2004 Meeting with Wake County Officials and Wake Continuum of Care Agencies to discuss the proposed HMIS.


21. Telephone interview with Kay Ferguson, Wake County Human Services, 01/19/06.

22. Email correspondence from Tabitha Bivens, NC State University, serving as Wake CoC Secretary, 01/19/06.

24, 26, and 28. Email correspondence regarding the HMIS use by Wake CoC agencies from Phil Conen on November 2, 2005.

27. Email correspondence regarding HUD grant funding from Kay Ferguson, Wake County Human Services, 01/11/06.
Homeless Management Information System (HMIS) Utilization Survey  
Wake Continuum of Care Agencies  
Fall 2005

The following survey consists of 11 questions and is designed to be completed in 10 minutes or less.

Date Survey Taken: ________________________________________________

Question 1:  
Are you currently using the HMIS in your agency?  Yes or No  (Circle one)  

1. a. If yes, on what date (month/year) was the HMIS operational in your agency?  
   ________________________________________________ (month/year)

1. b. If no, do you have a firm date established to start using the HMIS?  
   Yes ___________ (Indicate Month/Year) or No  (Circle one)

Question 2:  
How frequently does your agency staff use the HMIS? (Choose one of the following):  
On a daily basis, a weekly basis, a monthly basis, an annual basis or N/A  
   ________________________________________________ (Answer to Question 2)

Question 3:  
How is your agency using the HMIS currently? (Mark all that apply with an X or write N/A if not applicable to your agency):  
   ___________  Client Intake? 
   ___________  Case Management services (notes and service plans)? 
   ___________  Program and Service Tracking – including referrals? 
   ___________  Generation of reports? 
   ___________  Bed Management features?
Attachment I

Question 4:
How do you anticipate your agency will be using the HMIS in 6 months? (Mark all that apply with an X or write N/A if not applicable to your agency):

___________ Client Intake?

___________ Case Management services (notes and service plans)?

___________ Program and Service Tracking – including referrals?

___________ Generation of reports?

___________ Bed Management features?

Question 5:
How do you anticipate your agency will be using the HMIS in 1 year? (Mark all that apply with an X or write N/A if not applicable to your agency):

___________ Client Intake?

___________ Case Management services (notes and service plans)?

___________ Program and Service Tracking – including referrals?

___________ Generation of reports?

___________ Bed Management features?

Question 6:
How do you anticipate your agency will be using the HMIS in 5 years? (Mark all that apply with an X or write N/A if not applicable to your agency):

___________ Client Intake?

___________ Case Management services (notes and service plans)?

___________ Program and Service Tracking – including referrals?

___________ Generation of reports?

___________ Bed Management features?
Question 7:
In what phase(s) of HMIS implementation would you say your agency is functioning currently? (Check all that apply):

_____ Phase 1 = Data collection mode (focusing on data entry and staff training only)
_____ Phase 2 = Program/service tracking and case management mode (focusing on using the system to enhance service delivery)
_____ Phase 3 = Referral mode (using the system to make referrals to other Continuum of Care Agencies)
_____ Phase 4 = Administrative mode (focusing on administrative tasks and reporting, e.g. Bed availability lists and HUD reporting)

Question 8:
Are you collecting and storing client health information on the HMIS (e.g. past or current medical history, medication use, communicable disease, alcohol/substance abuse)?

Yes or No (Circle one)

8. a. If yes, are you sharing client health information with other Continuum of Care agencies through the HMIS? Yes or No (Circle one)

Question 9:
Have you experienced any technical problems with the HMIS? Yes or No (Circle one)

If yes, please explain:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Question 10:
Have you experienced any other problems (not technical) with the HMIS?

Yes or No (Circle one)

If yes, please explain:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Question 11:
What suggestions, if any, do you have for improving future versions of the HMIS (after implementation of the fall 2005 enhancements)?

Your assistance in completing this survey is greatly appreciated. Please mail the completed survey in the attached self-addressed envelope or to the following address by November 18, 2005:

Anne B. Rogers, RN, BSN
8801 Stage Ford Road
Raleigh, N.C. 27615
Contact Numbers: 919-848-1349 or 919-647-8181
What are some general things you should know about research studies?
You are being asked to take part in a research study. Your participation in the study is voluntary. You may refuse to participate, or you may withdraw your consent to be in the study, for any reason, without penalty.

Research studies are designed to obtain new knowledge. This new information may help people in the future. You may not receive any direct benefit from being in the research study. There also may be risks to being in research studies.

Details about this study are discussed below. It is important that you understand this information so that you can make an informed choice about participating in this research study. You will be given a copy of this consent form. You should ask the researchers named above any questions you have about this study at any time.

What is the purpose of this study?
We want to understand to what degree each of the Wake Continuum of Care agencies have implemented the Homeless Management Information System over the past year. We also want to receive feedback from agency staff regarding any suggestions you may have to improve the system or any problems you may be experiencing with system implementation. The information obtained from the survey will be used to fulfill part of the course requirements for a Masters in Public Health from the University of North Carolina at Chapel Hill.

How many people will take part in this study?
If you decide to participate in this study, you will be one of approximately 39 people in this research study. The study survey will be given to all Wake Continuum of Care agencies for their input.
How long will your part in this study last?
The survey will take about 10 minutes to complete. You can choose to stop the survey at any time or choose not to answer any of the survey questions. You may choose not to answer any of the survey questions. You may choose not to send the survey back to me.

What will happen if you take part in the study
You will fill out the survey, and if you choose, forward the survey with your responses to me by mail. I have attached 2 self-addressed, stamped envelopes for your convenience. One for you to use to mail the survey and one for you to use to mail the signed consent form.

What are the possible benefits from being in this study?
You or your agency may not receive any direct benefits from being in this study. Wake County Human Services may gain valuable information regarding the implementation of the Homeless Management Information system and any problems the Wake Continuum of Care agencies may be experiencing or suggestions for system improvements. There may be a benefit should system improvements occur as a result of your participation in the study.

What are the possible risks from being in this study?
There is a minimal risk of harm to study participants. The minimal risk includes the potential for a breach in confidentiality of your name or your agency’s name. A breach of confidentiality could result in embarrassment to you or your agency, especially if you indicate the agency has failed to implement the HMIS system or if you provide negative information regarding the HMIS. This could result in a loss of job or denial of a promotional opportunity if your answers to survey questions cast a negative light on your agency. Your risk will be minimized by the use of the study identification number on the survey and the consent form and by providing two self-addressed, stamped envelopes for you to mail the survey and the consent form separately.

How will your privacy be protected?
I am asking that you provide your name and contact information on this consent form in order to be certain that I can contact you regarding any responses that I cannot read. I am asking you to provide the name of your agency on this consent form to determine how many agencies responded. I am including an identification number on this consent form that matches the identification number on the survey and am requesting that you mail the forms to me separately. Neither your name nor your agency’s name will be used in the presentation of this research to others, so no one other than me will know what you said. I will store paper copies of your responses in a locked cabinet in my office and will remove all identifying information once the survey data is entered into the computer. The computer file will be password protected. Please do not hesitate to contact me if you have questions regarding how your privacy and the confidentiality of the survey information will be protected.

Will you receive anything for being in this study?
I cannot compensate you for your time, but your information is very important to us.

Will it cost you anything to be in this study?
There are no costs for being in the study.
Attachment II

**What if you have questions about this study?**
You have the right to ask, and have answered, any questions you may have about this research. If you have questions, or concerns, you should contact me at 919-647-8181 (office) or 919-848-1349 (home). You can also contact me or my advisor at the phone numbers and email addresses listed at the beginning of this form.

**What if you have questions about your rights as a research participant?**
All research on human volunteers is reviewed by a committee that works to protect your rights and welfare. If you have questions or concerns about your rights as a research subject you may contact, anonymously if you wish, the Public Health Institutional Review Board at 919-966-9347 or by email at ph_irb@unc.edu.

**Participant’s Agreement:**
I have read the information provided above. I have asked all the questions I have at this time. I voluntarily agree to participate in this research study.

Signature of Research Participant ____________________________ Date ____________

Printed Name of Research Participant ____________________________

Signature of Person Obtaining Consent (if in person) ____________________________ Date ____________

Printed Name of Person Obtaining Consent (if in person) ____________________________

Please provide the following contact information:

Wake Continuum of Care Agency Name: ____________________________

Agency Address: __________________________________________________________

Title of Research Participant (Person completing the survey): ____________________________

Phone number of Research Participant: ____________________________

Email address of Research Participant: ____________________________

Thank you for helping me with this study.
<table>
<thead>
<tr>
<th>A</th>
<th>CoC Mbrship Level</th>
<th>C</th>
<th>Using yes=1 no=2</th>
<th>Yes, date 1 tech l=yes</th>
<th>Comments</th>
<th>Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>22 HUD</td>
<td>1</td>
<td>Jan-05</td>
<td>1</td>
<td>case note was accidentally saved to the wrong client; with paper files note can be voided but in HIMS notes cannot be removed; you must add another note explaining the previous note</td>
<td>increase speed of operations; a &quot;back&quot; or &quot;previous&quot; button that makes returning to a previous screen easier</td>
</tr>
<tr>
<td>3</td>
<td>17 Participating</td>
<td>1</td>
<td>unknown</td>
<td>1</td>
<td>not having enough time to use system; data quality problems since the data must be current and the staff doesn’t know how to use the system</td>
<td>being able to look up a client and add them to the case list without having to look them up again; being able to refresh where you are in the system and not having to pull a client up</td>
</tr>
<tr>
<td>4</td>
<td>11 Participating</td>
<td>1</td>
<td>unknown</td>
<td>2</td>
<td>Hard to revise some business practices to fit the new system - problem overcome; some communication issues with vendors; getting other agencies to participate</td>
<td>continue to work on user friendliness</td>
</tr>
<tr>
<td>5</td>
<td>14 HUD</td>
<td>1</td>
<td>Dec-04</td>
<td>1</td>
<td>Reports don’t work well; user manuals 1 and 2 unhelpful; version 3 much better</td>
<td>transfer management to Wake CoC</td>
</tr>
<tr>
<td>6</td>
<td>8 HUD</td>
<td>1</td>
<td>Nov-04</td>
<td>1</td>
<td>Time consuming to review data going from one screen to another; not a lot of portability</td>
<td>Data located in more integral areas; do not like to look through multiple tabs to find where required data is being stored</td>
</tr>
<tr>
<td>7</td>
<td>6 HUD</td>
<td>1</td>
<td>Jan-05</td>
<td>1</td>
<td>Issues regarding being able to view alcohol and drug assessment information from other agencies or former clients</td>
<td>making a check off format for services so they don’t have to be individually input</td>
</tr>
<tr>
<td>8</td>
<td>3 HUD</td>
<td>1</td>
<td>Dec-04</td>
<td>2</td>
<td>Hard to train staff and change time Print all screens. Allow agencies to choose required questions (ESG, Supanova, etc.)</td>
<td>expand progress notes and the variety of options for note taking</td>
</tr>
<tr>
<td>9</td>
<td>18 Participating</td>
<td>1</td>
<td>unknown</td>
<td>1</td>
<td>Thought that we were cleared for getting reports but found we were not. That has been corrected; it would have been helpful to have known earlier.</td>
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<tr>
<td>10</td>
<td>23 Participating</td>
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<td>May-05</td>
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<tr>
<td>11</td>
<td>25 Participating</td>
<td>1</td>
<td>Sep-05</td>
<td>1</td>
<td>Difficulty in getting into HIMS; Have to make more than one attempt</td>
<td>waiting to pass judgement on the system after seeing how the enhancements are going to work</td>
</tr>
<tr>
<td>12</td>
<td>7 HUD</td>
<td>1</td>
<td>Jul-05</td>
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<td>Thought that we were cleared for getting reports but found we were not. That has been corrected; it would have been helpful to have known earlier.</td>
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<tr>
<td>13</td>
<td>4 Participating</td>
<td>1</td>
<td>Jan-05</td>
<td>1</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>9 HUD</td>
<td>1</td>
<td>Dec-04</td>
<td>1</td>
<td>None</td>
<td></td>
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<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>None</td>
<td></td>
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<tr>
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<td>26 Participating</td>
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<td>n/a</td>
<td>Funding for all agencies interested in implementing this program</td>
<td>None</td>
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<td>n/a</td>
<td>n/a</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>5 Participating</td>
<td>2</td>
<td>n/a</td>
<td>n/a</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>19</td>
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<td>n/a</td>
<td>n/a</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Visitor</td>
<td>2</td>
<td>1</td>
<td></td>
<td>Hard to train staff and change time management;</td>
<td>just keep making it more user friendly</td>
</tr>
<tr>
<td>21</td>
<td>2 Participating</td>
<td>2</td>
<td>n/a</td>
<td>n/a</td>
<td>Print all screens. Allow agencies to choose required questions (ESG, Supanova, etc.)</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>12 Participating</td>
<td>2</td>
<td>n/a</td>
<td></td>
<td>Funding for all agencies interested in implementing this program</td>
<td></td>
</tr>
</tbody>
</table>