HMIS March Office Hours-HS17-005

00:03 Mary Schwartz: Not seeing a bunch of people coming on anymore, so let's get going. Thanks for joining the call today. This is kind of an extra or supplemental call. We had our normal scheduled call last week. This one is going to be just specifically about COVID-19 responses and some guidance that we've come up with for you all there. So plenty of time to ask questions. We have a few presenters and let's get started. So everybody's on mute and you're going to stay on mute for the whole call, just your... The folks you see on the screen are going to be chatting today. We will answer questions as they come in. Please use the Q&A feature, that's what we're here for and we expect to get to all your questions, hopefully. So, make sure to reference a slide number if you can when you're asking a question because sometimes we don't get to them until further down the line and context is good for giving the right answer.

01:12 MS: It could be, as usual, that there's a question that you're asking that we're not able to answer immediately on this call and we'll ask you to put it in AAQ if that's the case. And you would do that by going to the HUD Exchange and submitting a question under the HMIS topic. And then, of course, if you can, give us some context. If you are asking about something on this call, try and reference slide numbers, something like that, so that we have a little more information when we go to answer the AAQ later.

01:46 MS: So, I'm going to introduce everyone who's on the phone with me today. I'm Mary Schwartz from Abt Associate. We've got Fran Ledger here from the HUD SNAPS Office. We've got Brian Roccapriore from Cloudburst, Abby Burgess' staff for those of you that missed her like we did, helping us from ICA on the Q&A portal. Brian and Abby will be helping us get your questions answered. Meredith from Partnership Center is here, both as our fellow TA provider and the community presenter today, so that's exciting. And then we are joined by Susan Walker, a colleague of ours and yours, in the Louisiana Balance of State and her colleague, Weston is on the phone, as well. And I want to give a shout out to Melissa and Lee, of course, who are on the back end helping us with this Adobe Connector and the technical side of the shop. So, let's get rolling.

02:46 MS: The agenda that we're going to go through, Data Sharing and Privacy Guidance, that relates to COVID-19. We're going to ask that Meredith's going to take us through the general project of the Data Collection Guidance and kick-off this new, main presentation section and Susan will also give us a community perspective on COVID-19 response and then we'll have plenty of time for Q&A. So, Ms. Ledger...

03:15 Fran Ledger: Hello, everybody.

03:16 MS: Take it away.

03:17 FL: Thank you for joining us today. I appreciate you being here. I know folks are stretched thin right now. This is a very important topic for us. HUD has received a ton of calls, emails, AAQs regarding data sharing and HMIS set-up to respond to COVID-19. A lot of privacy questions and so we have put up some guidance and we hope that this call will help. It will be recorded and available and I think that the primary thing that we're trying to do at HUD is relieve as much tension and pressure off of communities, as possible. So check the page, you'll see a link to it soon, from HUD on the HUD Exchange, giving information out about what HUD is doing around COVID response. But know that in everything that we're trying to do, our goal is not to increase any kind of requirements or pressure on you guys as you work in your communities and are also trying to

balance things in your personal life.

04:35 FL: So, I'm going to start off talking a little bit about data sharing and then I'll pass it back to Mary. One of the things that's really key here is that everything that you're going to hear today around data sharing, it falls in line with the 2004 HMIS Data and Technical Standards, so there's nothing new. This is really important. There're no waivers required for what you're going to be doing when you apply things to COVID-19 response. You'll be able to look right straight to the 2004 Data Standards Sharing.

05:13 FL: Now, what we're providing for you today is some things that are very specific scenarios related to COVID-19 that may be coming up that's helpful. Also, we released the Coordinated Entry Data and Management Guide. We updated information that helped clarify some things around consent because there was a lot of confusion around consent and part of that confusion was definitely on HUD's side, our responsibility. We had not been clear in the past, but we were trying to make things more clear. So hopefully, you're going to hear that from us today as Mary steps through the process of how you would respond regarding to COVID.

05:54 FL: But what you see here on your screen is a process for looking through the data standards and your privacy notice and figuring out, "Do you need to... What do you need to do around consent and what are permissible things for using disclosures?" And this is available in the Coordinated Entry Data and Management Guide so you can go in there and get more detail, but this is capturing it in one slide. And this is very compact, it's hard to see. You'll be able to go into that guide and look at it more closely. But we wanted to see there's kind of a process that you can step through and look at this.

06:36 FL: The other thing that's a really critical message that I want to give today and this is going to apply both to the data collection and data sharing, which is striking a balance because we want to make sure as you think about what you want to do around data sharing and what you want to do around data collection really keeps in mind the stressors that are going on in your community. It is very difficult when you're trying to respond to an emergency situation or disaster, especially as life-threatening as this, to apply a lot of data collection requirements in implementing new things and putting them into place, so really being thoughtful about the choices that you're making and balancing it with the things that are needed in the moment to be responsive.

07:28 FL: You can think about strategies, about how you structure things, and how you sequence things and really try to scale things back as much as possible so you're doing those things that are most essential and you're really taking into consideration those things that are needed on the front line. You're going to hear today from two different approaches. There are several in the documents that we released just recently; I think a couple of days ago. There's actually three different community scenarios put in there that you can take a look at. So, I definitely want to thank our presenters today for giving us two examples that are happening in communities that you can look at; they're different and I think useful to take a look at. With that, I'll turn it over to Mary.

08:14 MS: Okay. Thanks, Fran. And so again, going back to what Fran said, this is guidance so we're going to go into what the current HMIS Data Standards and Privacy Standards from 2004 say about what you can share, what data you can share, PII, PPI you can share under the existing guidelines in circumstances like this infectious disease emergency, such as COVID-19, so we just want to make it really clear we're not changing anything that's currently in existence. We're not

offering waivers for this situation in this unprecedented place we're at right now. This is all allowable under existing privacy guidance. So, what you can find when you get into the standards is that there are two primary provisions in the standards to support the disclosures that we've been asked about through the AAQ and that HUD has been emailed about. We're also going to get a document out soon that accompanies this information in this PowerPoint and I'll go through a couple of different scenarios.

09:30 MS: Basically, the two provisions that exist right now in the data standards are that disclosures can occur if they're required by law, so that's kind of the first test that you would do. The second is that disclosures can occur to avert a serious threat to health or safety, and there are two tests there, so... And I'm going to walk you through on the next slide how you can walk through those tests yourself. But first, you'd say, "Is this a required disclosure, yes or no, by law?" If no, then you would say, "Is this disclosure: A, is it necessary to prevent or lessen the threat; and B, is it being made to a person who can reasonably be assumed to be able to prevent or lessen the threat? So, is the disclosure necessary, A? And am I making this disclosure to a person who has the ability to lessen that threat?" So, that's the tests or questions you would ask yourself as you think about whether PII can be disclosed under current privacy standards.

10:52 MS: So, this is that same walking through and I'm going to go through this fast. Again, we're going to make these slides available so you can look at it in more detail later and we expect to have a document that accompanies this since they tend to be a little more thorough. But for example, in the first column. If the covered homeless organization, that's you, the HMIS users and participating agencies in the community, are disclosing a client's personal identifying information to a public health authority, first you'd say, "Is that disclosure allowed and is it a law that I'm being asked to follow to disclose?" If yes, then disclose that data.

11:31 FL: If no, then ask yourself, "Is that disclosure necessary to prevent or lessen a serious and imminent threat and will that disclosure be made to a person who can reasonably prevent or lessen the threat?" So, in this guidance and in the forthcoming document, we're helping you by answering those questions for you in some cases, so "public health authority" does qualify as a recipient who... Disclosure to a public health authority would be necessary to prevent or lessen a serious and imminent threat and a public health authority is reasonably able to prevent or lessen that threat. And we go on to a healthcare provider. You actually have to use good faith and we can't make a judgement for you on the healthcare provider situation, it's kind of a case-by-case basis for you, but once you decide that the disclosure is necessary in good faith, then we can generally assume that a healthcare provider is able to... Reasonably able to help prevent or lessen that threat. Again, all of this starts with that first question, which is, "Is this disclosure required by law?" and if yes, you don't have to go through the other steps.

12:56 MS: We're going to give you these slides, let you think about it, what the situations are locally that you're more likely dealing with is in this process of referring folks using HMIS or in your system who've been maybe diagnosed with COVID and making referrals to third-party quarantine or isolation facilities or other emergency shelter staff and working through those processes. So, disclosing PII about clients can be allowable if the disclosure is required by law or if the disclosure is necessary to prevent or can be made to a person who is able to prevent or lessen the threat.

13:41 MS: So, you would be walking through those tests with each person or entity that you are

releasing client PII, or disclosing client PII, to so... Remember that the authority to disclose is not unlimited so back to those three examples on that chart. For example, if your public health agency is not asking you for PPI and is simply asking you for account of people, right? Who have been tested or exposed or diagnosed with COVID-19, you don't need to give them PPI. The request needs to be there, so your authority to disclose is not unlimited. If it's efficient to give adequate notice to a healthcare provider without disclosing PPI of one or more participants, then you don't disclose PPI. So you still got to apply some common sense, need to know, is this something that's necessary, is disclosing PPI?

14:50 MS: One good example is in the process of providing referrals. You would not send a list of all infected participants to every shelter in your community with PPI in it. Even though you're disclosing information that might be useful, it's not required to release a list of all people, for example. You would just disclose the PPI of the single person who's being referred at the time. So these are just a few quick examples of where your authority exists under the existing guidance and making sure you check that with your authority being not unlimited for all these circumstances, too. Fran, anything to add there before we move past these slides?

15:43 FL: Sorry. No, I think that's perfect, that was great.

15:45 MS: Okay, great. So, we want to make sure you understand, right? Your privacy notices should be in line with the HUD standards. It should say all of the uses and disclosures that are allowable with and without client consent. If you need to make changes though the process of this response locally, you find your privacy notices aren't as up to date as they should be. Make changes as needed and changes can be retroactive in most cases and you can have privacy notices that are more restrictive, but not less restrictive, than the HUD standards. So, make sure you're understanding how your privacy notices locally do and don't connect up with what you're minimally required to do. And your ability to change a privacy notice is not unlimited, either, so you do just need to stick within the HMIS Privacy and Security Standards, as they're stated in the 2004 guidance, and you cannot get less restrictive than those.

16:57 MS: And we have any information that we're going to be publishing updating the data sharing and privacy guidance, releasing the document that's forthcoming. All of that's going to happen on this COVID-19 information page that you can find on that HUD exchange, and then beyond HMIS-specific stuff with COVID-19, certainly there's lots of resources there, as you develop your communities' responses. So we're going to move on to Meredith and Susan in our community example and I will turn my attention towards questions.

17:38 Meredith Alspaugh: Thank you, can you hear me okay?

17:41 MS: Yes.

17:42 MA: Okay. I think I'm experiencing some issues with the interface just so you all know. I'm not seeing anything on my screen so I'm going to wing it through here. I think I can click through but we'll see. So hi, everyone. This is Meredith Alspaugh from The Partnership Center. I'm kind of wearing two hats today, like Fran mentioned. I'm going to talk a little bit sort of broadly and generally about HMIS project set-up and data collection in the context of COVID-19, but then give an example of what we have set up locally for the shelters and street outreach and health departments to use.

18:26 MA: So, just starting off generally, broad-stroke, big picture, if you all saw the resources that HUD put out on the HUD exchange over the weekend, some of this information is available in there, too. But I really wanted to highlight these questions to consider and really even say, again, I know Fran has already said it once, but HUD's not requiring additional data collection for COVID-19. So the things we're talking about the processes we're talking about the set-ups we're talking about are intended to be helpful to you and your communities and serve as a way to share information that is necessary to prevent the further spread of the virus, and to protect the workers and the clients that you're all working so hard to serve. So it's important that these shelter workers and the outreach workers have certain parts, bits of information in order to effectively do the job that they're trying to do.

19:30 MA: So, just thinking through, generally speaking, what data is necessary locally to inform the community planning and response? Excuse me. Do you have any processes currently in place that could be used as a starting point? So lots of communities use HMIS for alerts and tracking hepatitis or tuberculosis outbreaks, different things like that, and so this is an opportunity to build on what you're already doing if you're currently doing something like that. What additional data could be helpful to your community? Again, there's nothing that is required, but what additional data could be helpful to manage this information about people experiencing homelessness, so that they and their service providers are remaining safe? As Mary has already talked through, considering the privacy and security policies around the governance of HMIS and data sharing, is really critical. And then also thinking through, is the HMIS robust enough to be used for this type of process? Is it large enough? Is your coverage complete enough for alerts and for tracking? And if it's not, how can it be used by individual projects to help? You don't want to say, "Well, we don't have 100% coverage, so not going to do it." I think it's important to look at what you can do with your system and be effective with sharing this information.

21:06 MA: So moving quickly through, we were contacted by shelters that were expressing concern about some of their clients who were getting tested for COVID-19, but no one knew what the status was. No one knew should they be getting monitored, should they be quarantining, should they be in another location? What do we do if that client never shows back up at our shelter? How do we share any information with our partner agencies that may be coming into contact with this person who may test positive for the COVID-19 virus. So, locally, internally, and with the health departments, both the city and the county health departments, looked at existing frameworks like I mentioned. We have a TV notification process built into our HMIS, into our software, and how can we expand on that existing process, those existing policies and procedures for doing those kinds of notifications? And again, expanding on it, how can we make this project something that is beneficial not only to the service providers at the shelters in the street level, but for the city and the county health departments also?

22:30 MA: At the request of the city and the county health commissioners, we created a standalone project in our system that is accessible by street outreach workers, as well as shelter providers to record information about clients who are referred for testing. And then it's also accessible for the city and the county health staff to be able to record the results information and quarantining information that they have.

23:02 MA: So a couple points on access, and again, this is kind of, this is sort of highlighting some of the points Mary's already said, but this is a need-to-know kind of basis. And we're not opening

this project up to the entire system. It's not for everyone in town to have access to. It's really limited and restricted to authorized workers at the street outreach projects and the shelter projects. We're asking all executive directors to authorize those users in an attempt to make sure that they understand the fact that this is different and that this is data sharing because of a public health crisis and a public health emergency, and that there's, it's not business as usual. We are trying to maintain a level of confidentiality while also trying to get the relevant information to folks. And then obviously data cannot be shared with anyone outside of the authorized users of the system.

24:01 MA: When you log into the project, users are seeing a dashboard kind of like what you're seeing on your screen here. And we're telling users... Well, actually I'll get to that in a second. Let me just walk through the dashboard. So you can see a public ID, sort of a client ID, contact information for the client, the location of the shelter or outreach project that entered the client into this project. Their quarantine status, whether or not they are self-quarantining somewhere or if the shelter has space to put them somewhere safe. We also have a quarantine facility here in our area, and some folks that can't safely self-isolate in a shelter or on the street are being placed in the city facility. So we've got some dates in there, some information about results and then the client messaging. And we'll talk a little bit more about client messaging here in a second.

24:58 MA: So just quickly going through workflow for street and shelter workers. We do also provide within the program, the pre-screening questions that our city and health departments have given us so that they can make sure that the clients they're referring for testing, understand the questions that they're going to be asked when they call for screening. So they're pretty basic, like triaging simple. Do you have a fever? Are you taking any medicine? Shortness of breath, those kinds of different symptoms that they might be experiencing. As always we, our street outreach workers and our case managers in the shelter are fantastic, but they're not necessarily health professionals, so we are also really encouraging them to follow the advice of the health professionals. When in doubt, send those folks along for the medical staff to be able to screen them.

25:28 MA: If they do refer that client on for testing, then that client has an intake into the system. And I know that's a little small to see there, but the information that is recorded about clients in this project is very minimal. It's just basic demographic information and then there's information for the tracking form. So like I showed you on the dashboard a minute ago, it's the client phone number, the location, the date they were sent for a test, and where they were sent for a test. And from the shelter worker perspective, that is all of the information that they're going to be collecting.

26:32 MA: In this particular project, the health departments are going to be collecting the rest of the data. So once the client has an intake, and they are enrolled in this project, the health departments are entering, they're coming into the system to look at the client data, they're checking regularly to see which of the clients experiencing homelessness are in the project, they are updating test results, they are updating quarantine locations. If a client is negative, they are having that client sent back to the shelter that originally referred them if they were in a quarantine location. And then they also have the ability to record some additional medical information if they are staying in the quarantine location. So just looking at that screen again, you can see here those checkboxes down here, are the information that the health department staff are recording.

27:27 MA: And so that's nurses, that's epidemiologists, that's a variety of different people from the health departments who have been identified as the ones that would have this information that are recording information here. As I mentioned, there are a few other health-department-only fields for

the folks that are staying at the quarantine center. They are providing some behavioral health services to folks that are staying at the center, so those workers have the ability to track some contact notes, taking the temperature and different vitals of the patients that are staying at the center, are also being recorded here. Any medical interventions that they're recording are also going in here, and then they also can record COVID-19 messaging. Gosh, I'm sorry, that's so small on your screen. This is the last thing I want to touch on here. In our system, we have three types of messages that can be for a client, or about a client.

28:29 MA: And the messages that are for a client, a client can access anywhere in the system. They can... If they have their own scan card system, it's very software-specific, but they can read their own messages to them. The agencies that are participating in this COVID-19 tracking project, also have the ability to message each other, both within the same organization or with a partner organization. So if there's a situation where maybe a client left before they got their test results, or they had some sort of crisis and left the shelter. If one shelter wants to let another shelter know what's maybe something that's happened there, or some information about that particular client that is relevant for multiple shelters, they can share that information within the constructs of Justice Partnership. And then the health department can create what we call COVID-19 related message, and that's going to blast out to the whole system. And the health department messages are sort of higher priority, I suppose. So you would know that there's definitely a reason for that person to contact health staff, to contact the health department.

29:51 MA: Very likely their results have come in, or there's something very significant that they need to get in touch with the health department for. So those little green, red, and blue icons appear next to a client record anywhere in the system that they may show up, so that they know they have those messages waiting and they can review that information that's very likely or very pertinent to their current situation. So that was the real fast [chuckle] version of the way that we've implemented from our project here locally. One more thing I do want to add to that, if you are doing this in your own communities, and maybe Susan or Weston would chime in on this, too. I think it's important to be flexible with this ever-evolving process, this ever-evolving crisis. Different guidance came to us on a daily basis from the city versus the county. So being flexible and being proactive to the extent that you can, are really going to be helpful in getting something meaningful up and running. I think trying to set a standard and stick to it might be challenging, because everything is changing so quickly here. Okay, so with that, I'm going to stop talking about our situation, and I'm going to turn it over to Susan Walker and Weston Schild from Louisiana Balance of State.

31:15 Susan Walker: Hello. Thank you. Can you hear me?

31:18 MA: Yeah, yup.

31:20 SW: Okay, great. I'm Susan Walker, HMIS, System Administrator for Louisiana Balance of State, and I'm here with Capital Area Alliance for the Homeless Executive Director Weston Schild. I started working in HMIS in Rhode Island in 2015, while working on a graduate public health degree. And I've also done research, analysis, community organizing, and I was an enumerator in the 2018 test census. I just left Rhode Island in December and started working in Baton Rouge in January. I'm happy to report that I still like my job, even though it's been a little stressful. And I still have a lot to learn about my new job, a lot to learn about Louisiana, and we're all learning about COVID-19 and how to collect data on it together. So Weston, do you want to introduce yourself and tell us about the one-stop?

32:11 Weston Shield: Hi, Weston Shield here. Executive Director for Capital Area Alliance for the Homeless. We run a one-stop drop-in center in Baton Rouge, Louisiana, and we also manage HMIS for Louisiana Balance of State.

32:29 SW: Oh, what's going on in this picture, Weston?

32:30 WS: Sorry, what was that?

32:30 SW: I have got the picture up of your, of the set up with a laptop.

32:30 WS: Oh yes, yeah, this is us adapting, as I'm sure everyone is to COVID, and we're doing remote intakes in our courtyard where clients can talk to a case manager inside without having to come in the building and receive some case management.

33:00 SW: Awesome, so the Louisiana Balance of State is comprised of 22 parishes shown in green on this map created by Clay. I refer to this almost daily. Thanks Clay, at the LA BOSCOC. And the bulk of our projects are in Baton Rouge serving the urban population but there are HMIS participating and non-participating projects throughout the rural areas. The system administrators for Monroe and North Lake COC Christine Demetrius are also CAH staff, so our three COCs generally work together, operate in tandem, and the other Louisiana system administrators have a wealth of HMIS expertise and experience with emergency data collection and they're a great team to work with. All right, you have anything else for this slide, Weston?

33:51 WS: No, I'm good.

33:54 SW: So on Sunday night citing the rapid COVID-19 growth, the governor warned that Louisiana could be the next Italy. And providers have been organizing quickly to prepare for COVID-19's impact on our system and our clients, and it's been remarkable to observe the process and participate in it. So here's a timeline, I started thinking about what data to collect when we started talking about this all the time, about two weeks ago, and even though if I didn't provide HMIS guidance on the March 10th webinar, this is ultimately where I grounded the data collection approach. I searched for reporting guidance on diseases, I participated in online discussions, followed epi Twitter, wrote up a short set of adjustable questions. On Saturday the 14th, Gordon Levine Balance of State COC manager and appointer for the cause asked me if I could have something for Monday and I was like, "Alright, I already got started." And so, on Saturday, Weston put the programs into the HMIS, put the questions into the HMIS and on Sunday, Clay and Andrea from the COC and Weston and I continued to fine tune questions, plans to roll out guidance.

35:11 SW: On Monday, Andy, our Louisiana statewide system administrator shared the questions with everyone in his team. Louisiana Services Network Data Consortium on Monday and Weston implemented it for North Lake and Monroe. So, by... On Friday, we had three isolation sites planned, that was some statewide planning. I had nothing to do with that. And LSNDC convened to discuss creating new projects for isolation facilities out at state parks and how we're going to manage clients in those locations. So, and as of today, new users are trained for data collection at the isolation facilities and I believe all the... I know all the Louisiana system administrators have access to our uniform set of data questions, and I'm not sure how much usage they're getting around the state, but they're definitely being used in the balance of state.

36:10 SW: So, since the very data elements to have to collect is always the challenge and I want to echo Meredith's part... That we need to think about what we're doing and revise because we're in uncharted territory. Absolutely, but I want some clarity around works and contexts. So I looked at standardized case report forms from CDC and WHO and realized they were just not ideal, because you need training to fill this out. And this is a lot of data and this is not the kind of data we need to collect in our setting and each of those have standards, you know this... We're not qualified to fill out that form, and test result data would be great to report on but there's a number of barriers to obtaining test result data. It seems like the example Meredith gave. So a lot of the processes have more and I just sort of assumed there weren't going to be processes.

37:14 SW: And I also want to mention too that just in general data on people who have passed away, doesn't pipeline into HMIS very easily. And someone might ask you about that outcome with HMIS clients, and it's just good to know that that data is hard to get, and you might not have it. So HUD provided specific guidance on responding to your clients showing symptoms. So I leaned in with that. This is an excerpt from the Louisiana adaptation of the Atlanta triage tool, thanks to Andrea for putting the cue to enter data into HMIS, but I also want to stress we want more than screener data. I would like to see data for everybody, screeners can sometimes narrow the number of people that you collect data on if you're only collecting screening data. So this is an important piece of public health, but I'm thinking beyond it.

38:18 SW: I'm seeing missing data and that's... Moving on and then this blue box here is from the CDC's guidance for responding to COVID-19 around people with homelessness, experiencing homelessness. So the blue box are the questions that I really think are essential. And this box is basically what appears in the guidance that HUD put out minus the green section on the bottom and minus the considerations over here, and just I combine the three symptoms into one data element in kind of the same way that we take a few criteria for literal homeless or used homelessness or chronic homelessness, and we just make one criteria, one standard out of a few things. So you have one way to look at the data, which is really important when you're trying to figure things out. Sometimes having to look at multiple columns just makes it really hard to know what's going on. So and symptomatic of COVID-19 is a yes/no variable, as well as a when variable.

39:32 SW: So, we definitely use the date. And as for these helper questions, we're still sorting them out and figuring out and finding out where this isn't fully thought out. I wanted to go into more depth with that, but I'm happy to answer email. So, we might need an outcomes question, and then I also want to add emergency isolation site team requested a question to distinguish people who have a home to return to from those who do not. And if its current living situation as a committee, they wanted something easier to use, so I just turned around the coordinated entry issue hoping that the existing statuses are your responses enough to change in demand, but it seems like in an emergency process, we don't need a long process. We need a quick data element to help just making decisions. So, we have this accurate discharge is there a safe place to return to. Question.

40:33 SW: So, I consider the question on the top row of this table to be a grey area. "How many people got COVID-19?" Because it depends on your defining homelessness and how you're also getting your COVID-19 information. So, I saw a potential for errors of exclusion and omission and I'm trying to at least consider the whole population. And the two COVID-19 questions that I think are essential are across as much as the greatest proportion of these whole populations as we can get to answer some really important public health and advocacy questions. And it really... The table

basically summarizes a year of studying public health; it's all about the denominator. And we have this denominator data, at least for most of these groups.

41:32 SW: So, I set up a fake data table, made a fake chart to show people the power of reporting on two simple variables across all of your clients. In my imaginary TSH project, COVID-19 impacts about 50% of the clients for over two weeks, but they all recover on the last day of the month. And, I think that's a more meaningful statement than saying "Nine clients had COVID-19". So, that's why you want to report over time. So, it would really be nice to read, to collect data uniformly across all of these settings but, the end users in my COC don't even know me, I'm new at my job. And this is going to take more community organizer work, calling, circling back, meeting people where they're at via video conference, and demonstrating how working together moves everyone farther.

42:28 SW: Having advocates are going to need strong and valid numbers. I know data collection is hard, but if we can deliver sandwiches, I think it's possible to update client records. As a census enumerator, I walked door to door everyday asking strangers for sensitive information and I had nothing to offer them. So it's possible; it's going to be time consuming, but we can get good data. And, I personally feel responsible for that. So, if all of the data is not available, I'm going to try really hard to understand what's missing and why. It's going to be difficult to know if the data is correct and up to date. Before COVID-19, my data quality goal throughout the state was to have annual assessments on time, and now I'm asking for ongoing daily monitoring in real-time. Let's try this all together and see how it works and share ideas.

43:27 SW: And then just about data sharing, we've voted this information in on the balance of state yesterday, and I think actually what happened is, we already had this in the LSNDC data sharing agreement, and it sort of got circled from... Our privacy notice is up to date now and we can implement emergency data sharing practices. So, thank you for my local colleagues, for all of the support and the warm welcome I've received in Louisiana. Thanks for inviting us to present and thank you all for listening. And I look forward to questions.

44:07 MS: Thanks Susan, thanks Weston, thanks Meredith for the community presentations, all three of you. So, we're going to go into Q&A mode which is mostly just awkward silence as we answer questions. [chuckle] But before we do that, I wanted to make sure that you got this information. So the latest hot topic on the HMIS AAQ, regarding COVID-19 & HMIS, is what to do with inventory changes. Now, you guys know we have, in the data manual, the HMIS data manual, which is a link at the end of the slide deck resource link, it gives you instructions for documenting reductions in inventory and increases in inventory, you can also add new projects, if you wanted to track beds that were added specifically for COVID-19 responses, you can change the PVD-Es of the existing beds if that makes sense and is feasible. Basically, resource this effort appropriately. Do what makes sense for you locally. There is no have-to, except in terms of reporting on those kind of known reporting dates for HIC and APRs and LSA. So, keep track in... Of whatever changes you're deciding to do locally, if you do at all, in your inventory just as you're running reports down the road you may find you need to detail in the notes sections of any of the reports that you run, what's going on at this time regarding any data quality issues you may see down the road. But the instructions are there.

46:12 MS: If it makes sense for you and it's feasible to resource that effort, you have the ability to reduce inventory, increase inventory, add projects, change PDDE's on existing projects, to

accurately represent what's going on right now for you. But, that minor fluctuation in day-to-day bed changes is not necessary, it's not expected. And knowing your reporting date for inventory information, to head, is good to keep in mind too. Am I... I've got bad audio, huh?

46:58 S?: It's a little choppy. Do you want me to jump into some questions here, Mary?

47:06 MS: Yes, why don't you do that? And if you think there's anything worth repeating in that inventory section, that maybe didn't come across very clear, yes. I'm going to stop talking, yes.

47:15 S?: Okay, well, so there's a couple of questions, mostly around the inventory side of what type of project would a COVID-19 quarantine facility be?

47:28 MS: There is no definition of that in the data standard. I mean, stuff that goes into HMIS... I don't know, Meredith do you want to jump in if my audio isn't good, but generally you need to track homeless, dedicated homeless beds. If a quarantine facility isn't dedicated for homeless, you might not need to track it at HMIS. If you want to, you might put it in as an other. I don't know, there's nothing defined.

48:02 MA: Yeah, I think it's going to be a locally determined decision based on how you're using a COVID project, and if it's a services-only project, if it's treating at a medical facility or respite center as opposed to an emergency shelter. Yeah, it's going to be something that is really evaluated on a community level.

48:23 S?: Alright, I'll keep going. We have an emergency shelter that closed their night-by-night shelters and are now offering hotel stays for clients. This is called more of an entry/exit recording type, which would not fit a current project type. Do you have any advice how to handle these or should the client just get an emergency shelter stay for each night they're in the hotel?

48:57 MS: I think this again is a feasibility question for you. You can modify that PDDE method to both... Well, could you? I'm trying to think about client data. So yeah, I think if you're going to keep it the method the same, that might end up being a bigger data collection burden, in which case you might want to stop... If all beds are being converted over to a completely different method and then switching from night-by-night to emergency, and that's going to happen for the foreseeable future, I recognize part of the trouble here is that we don't know how long this is going to be, so should you take the effort now? , I think if you were not to have those beds, the whole project beds change method, and you want to record that in HMIS starting now for the foreseeable future, that you would probably want to do a stop on one project and create a new project going forward. I don't think you'd want to mix methods for emergency shelter tracking within a single project. Meredith, check me on that. A, am I coming through audio wise okay, and B, did that make sense?

50:27 MA: Yeah, I think that makes sense.

50:32 S?: Alright, and what about exit destinations for those that leave a project to a quarantine facility?

50:41 MS: So I think, again, it's not so easy necessarily as a one size fits all answer here, but I suggest the hospital or other residential non-psychiatric medical facility, if it's being used in that sort of capacity, because that is what it is.

51:06 MA: I agree.

51:06 MS: They would maintain their homeless status also for the 90 days, if they were in that center for that long. Similar to a medical facility.

51:20 S?: We had a same question about prior residents, but I assume that same general answer would apply.

51:30 MS: Right.

51:34 S?: Okay, we are foreseeing major utilization swings if one shelter has a large infection rate and people need to be moved to quarantine. This will likely leave some inventory empty for cleaning before using again. And I think that was kind of addressed in, we're sort of expecting some irregularities in this time frame, so just do the best you can with what you've got. Update your inventory if it's going to be a while, but you don't need to do it every single day.

52:08 S?: So, if you're locally using a bed management software tool, or something that is like a hotel bed reservation type system that requires you to be more day-to-day with your inventory, you should have a way to take bed offline and then put them back online and all that stuff, but that's not at all in the data standards. So, that's going to have to be stuff that you figure out locally how to work out. And that's partly why we say minor day-to-day fluctuations, like that kind of thing where a bed is offline for a couple of days and then comes back online later. That's not really trackable or it's infeasible, under the existing standards. But, certainly we recognize that that might be important for you if your using HMIS in a bed management way.

[pause]

53:16 MS: Yeah, we've totally got to that silent portion of the conversation, where we're just reading your questions as they come in and trying to address it. So any of you step in, if you have something. Any of our folks on the phone, if you have anything to bring up.

53:32 FL: But I do want to... This is, I just want to say that HUD is keeping in mind that the data... Because when you are doing this kind of work, this situation is going to impact your data. And so we know, moving forward, that that will be something that we have to keep in mind when we're making decisions based on the data. So it will impact how we look at the system performance measures. It will impact how we look at the HIC PIT, the LSA. So just in all the other ways that we try to approach how we look at data, we will keep this in mind, too. So, yeah, HUD tries to be fair and mindful of what communities are facing when we are looking at these things. There’re some things that, by statute or by regulation, that we don't have flexibility around. But when we do have flexibility, if we try to be. So, hopefully, that's helpful for folks when you're grappling some of these difficult questions around your system.

55:07 MS: I learned... Well, because it's what I do. I'm going to go ahead and share with you the joke I came up with. Actually, my co-workers Willow and Piper helped today. Why did the butter knife put on a bow tie? Because he wanted to look sharp.

[laughter]

55:32 MS: As we're all looking so sharp in our homes these days, I'm sure none of you are wearing sweatpants right now. And we hope that this... We just hope for the best for everybody and hope for the best for you and all the hard work you're doing. And we know that you're working harder than any of us right now to try and address this situation on the ground. So, please, keep the questions coming. If we didn't get to a specific answer for you today on the call, submit an HMI to AAQ. If we need to, we'll get this posted, obviously, out as soon as possible, and share the slides as soon as we can. I have a lot of emails over on the side and it looks like a few folks are letting us know on the call, that there were quite a few folks that weren't able to get in. That tends to be the case right now. Since so many people are working from home, systems like these are swamped. And I've experienced it over and over again on calls, so if we can do more than we're doing, definitely let us know.

56:41 MS: We plan to just hold our next regularly scheduled call on April 15th, same time. Same bat time, same bat channel. Join us. We will likely have COVID-19 as a topic in some way, shape or form, as well as whatever else is going on for all of us at that time. We will continue to answer your questions as we can and will let you know via the Hub and the HUD Exchange what additional resources are coming out. If you don't already know about it, get in the loop on the Friday office hours that are being held regarding the more general information about COVID-19 coming out from HUD. So if you need to link into that, it's being offered through the HUD Exchange. And you can find more information, maybe from your CoC lead, if you don't know about it already. So again, we'll talk to you April 15th. Thank you to all our presenters today. Susan, Weston, thanks for joining. Abby, nice to see you again. And for my friends that are regularly here, thanks so much. We'll talk to you all soon. Be well. Be safe. Don't touch. Talk to you soon.

[laughter]

57:47 MS: Take care everyone.