HMIS User Guide

HMIS – Homeless Management Information System

This guide includes step by step details on how to enter, exit and record information for clients in all programs.

Kings Tulare Homeless Alliance

5/16/2016

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HMIS User Guide

HMIS – Homeless Management Information System

A Homeless Management Information System (HMIS) is a locally administered data system that stores client-level information about clients who are homeless or at risk of becoming homeless in our Continuum of Care (CoC). An HMIS has the capacity to integrate and unduplicate data across programs within a CoC. Aggregate data is used to understand the size, characteristics and needs of the community at the local, state and national level. The HMIS also enables agencies to improve case management by collecting information about client needs, goals and service outcomes.

HMIS Data Quality

In order to draw reasonable conclusions about the extent of homelessness and the impact of homeless services, data should be accurate, consistent and recorded in a timely manner. Complete and accurate data for the month must be entered into the HMIS by the fifth working day of the following month.

All computers accessing the HMIS must be private and secure and be password protected. Virus and firewall protection must be updated regularly.

The Privacy Policy must be displayed at all intake areas and must be able to provide a copy to clients upon request. All clients are required to complete the Client Consent form before entered into ClientTrack. This form must be kept on file.

For more information regarding Data Quality please refer to the Kings/Tulare HMIS Data Quality Plan

Logging In

ClientTrack is a web based system which requires to use either Internet Explorer 7.0 or higher or Firefox 3.0 or higher. The system url is as follows:

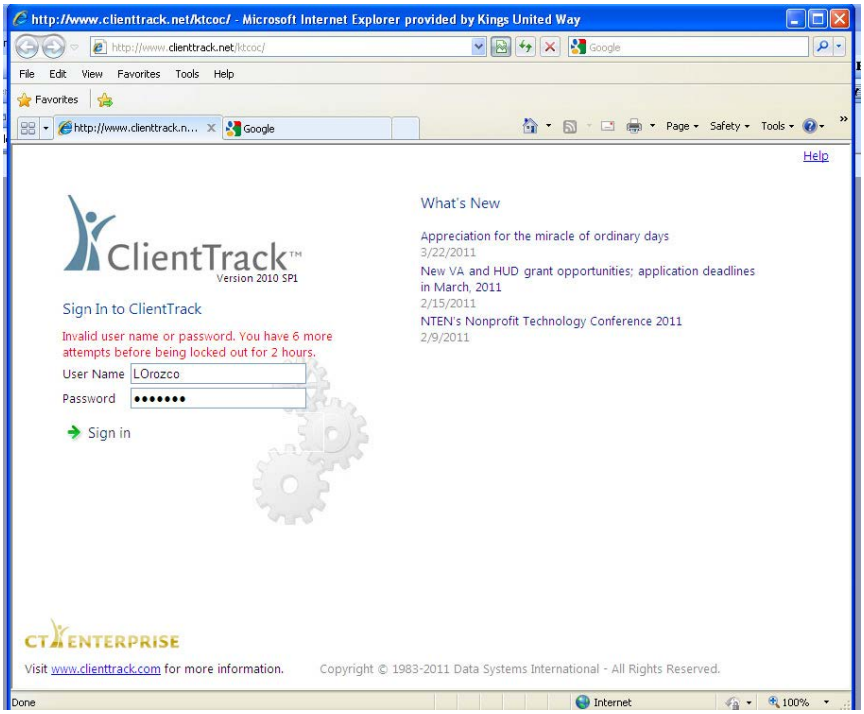
https://www.clienttrack.net/ktcoc

Use this space to jot down you username and password… just remember to keep this secure

Username: _____

Password: _____

Enter your assigned username and password and click Sign In. You will be asked to change your password as soon as you are logged in. You will have the option to set up a security question in order to re-set your password in case you can't remember it in the future.
You can also contact support at yvetteo@kingsunitedway.org to have it re-set by an administrator.
You may need to turn off your pop-up blockers for this site. If you see a message indicating that the application window did not open, click on the "click here to launch it" link to open ClientTrack.

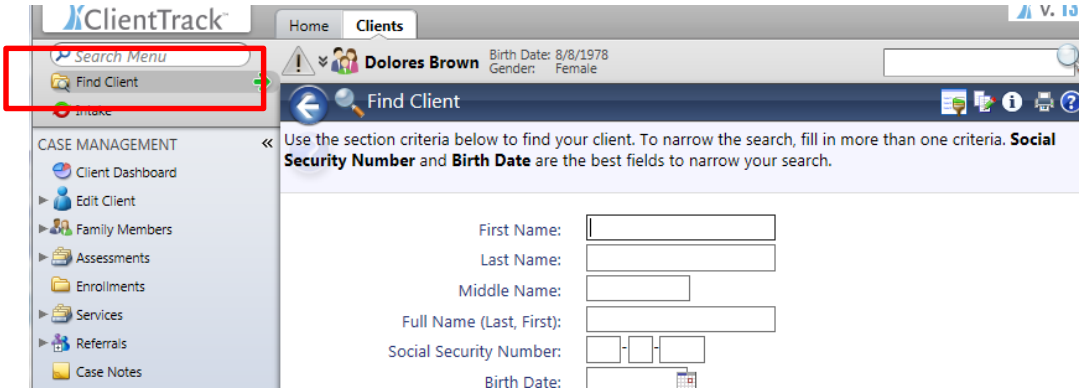


Searching for an Existing Client

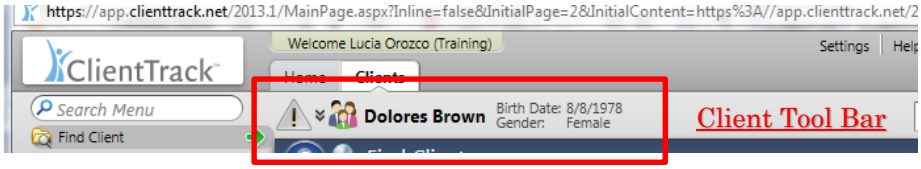
On the Clients Tab, click on the Find Client menu item to find an existing client in the database.

Enter your search criteria and click on Search at the bottom right corner. Partial information is permitted.

All records for that search criteria will display. Click on the record.



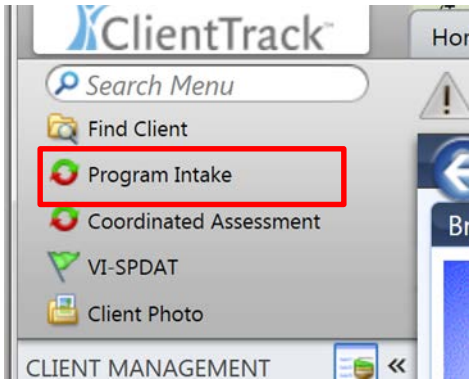
Once the client is selected the client dashboard will be displayed which includes client's demographics, enrollments, services and picture (if available). The information displayed on the top tool bar is the selected client, all information entered from this point forward while on the clients tab will be associated with the client selected.



Intake Workflow

The Intake workflow has been designed to capture the essential data to satisfy all program requirements for every grant and funding type. Please refer to appendix A for workgroups available for your program type.

On the Clients Tab click on Program Intake. The workflow begins by asking the user whether they would like to add a new client, use the current client, or search for another existing client.



It is important not to duplicate a client in the system. Please email client ID's of duplicates to YvetteO@kingsunitedway.org for merging

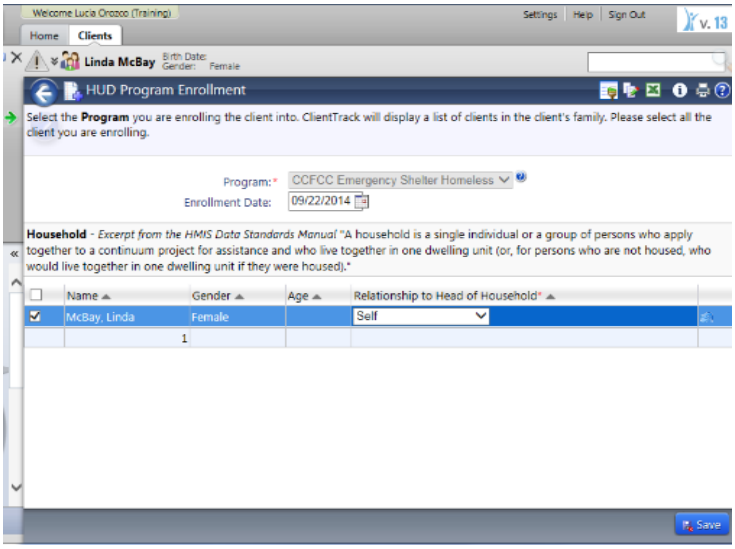
Step 1: Searching Existing Clients. Begin by entering the first and last name of the new client along with their social security number and date of birth if available. The database will automatically check the system for duplicate clients.

Step 2: If no existing clients were found, step 2 prompts you to complete a client intake.

Step 3: Enter all available demographics specific to the client.

Step 4: Every client must be associated with a family account. Click on the magnifying glass to add a new family account. When the new window opens click on Add New Family at the top right corner. Click Save.

Step 5: Enroll the client by selecting the program and recording the entry date. To add case members check off the box next to each family member that is entering the program with the Head of Household.



Grant is no longer required when enrolling a client

Step 6: Complete all individual assessments. The Intake workflow cycles through each case member to collect assessment data. The system uses conditional logic to determine which assessment to include based on certain responses or age of the member.

Here you will find a complete list of all available assessments. Workflows use conditional logic to show or hide assessments required for each program type.

- Universal Data
- Barriers
- Domestic Violence
- Income
- Veteran Assessment
- AMI Assessment

Coordinated Assessment Workflow

The Coordinated Homeless Assessment workflow should be used to collect information on individuals (and families) presenting themselves for services as indicated in the Every Door Open, Coordinated Entry Strategy. Housing providers within the region should use the same assessment tool, policies on eligibility verification, and data collection forms.

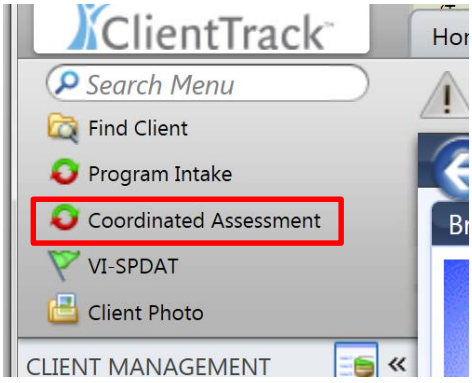
The Goals of this workflow include:

- Match the right resources with the right individuals most appropriately
- Prevent unnecessary burden on individuals and families
- Prioritize and target resources
- Increase community-wide coordination and collaboration
- Meet HUD's requirements for CoCs (Homeless Emergency Assistance and Rapid Transition to Housing: Emergency Solutions Grants Program and Consolidated Plan Conforming Amendments - 24 CFR Parts 91and 576)

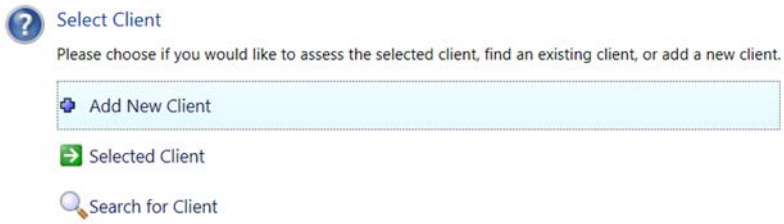
The Coordinated Assessment includes the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT). The VI-SPDAT is a pre-screening tool used to assess the health and social needs of homeless persons to determine whether a client has high, moderate, or low acuity. The tool is used to prioritize who to serve next and why in a transparent manner.

This guide will help you complete the Coordinated Homeless Assessment workflow in ClientTrack and walk you through, step by step, to record and determine each client's level of acuity.

Step 1: The Coordinated Homeless Assessment is found in the Clients tab favorite's area. Click on the *Coordinated Assessment* workflow to start the assessment.



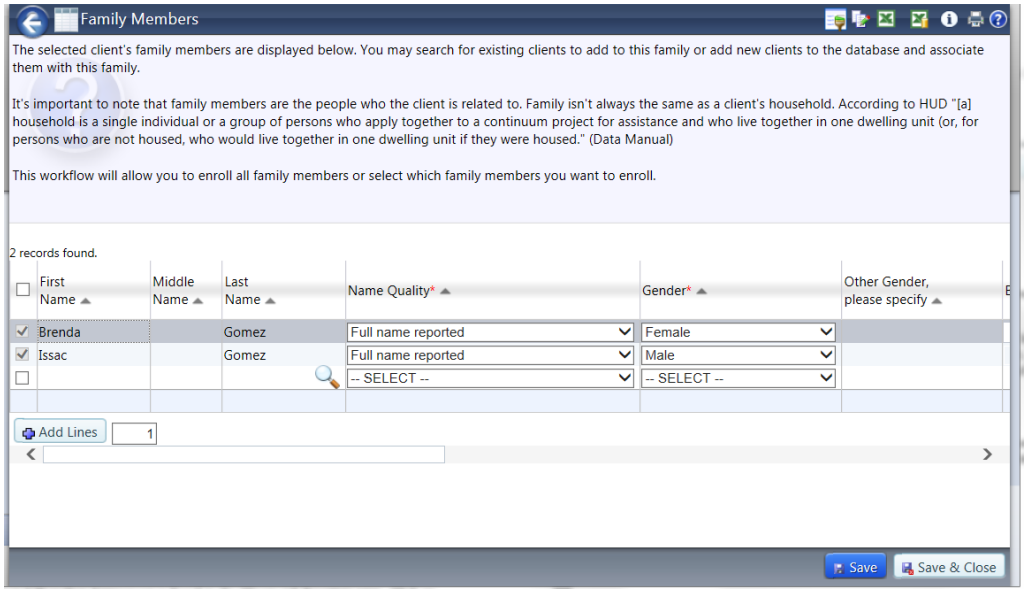
Step 2: Select Add New Client to enter information for a new client or click on Selected Client to continue with the client identified in the tool bar.



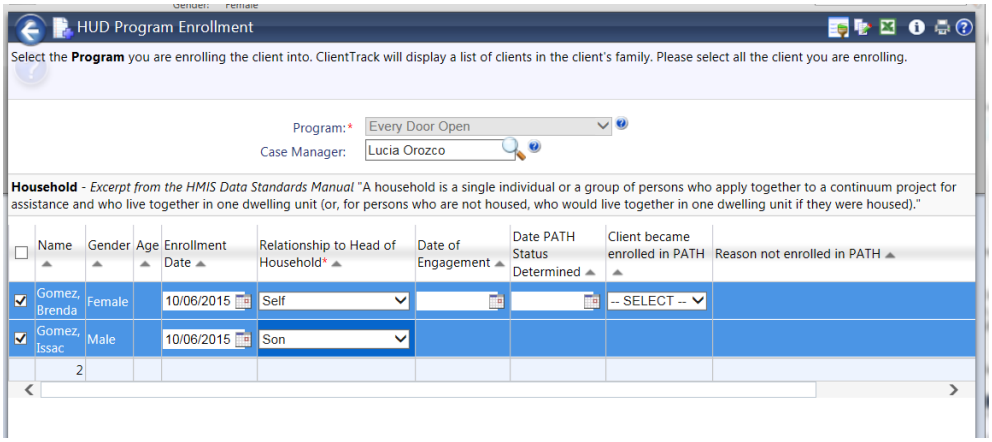
The workflow begins by searching existing clients. Enter the required information and select Search.

If no existing clients were found, continue to complete a Client Intake. If the search identified a duplicate and it is determined to be the same client, select the client and verify the information by confirming the accuracy and completeness of the data. When completed select Finished.

Step 3: Add family members if applicable, otherwise select Save and Close.

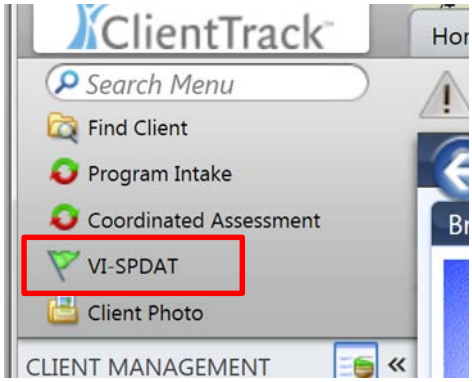


Step 4: Create the enrollment by selecting Every Door Open in the Program drop down field. Record the enrollment entry date for every family member. Confirm the relationship to head of household and click Save.

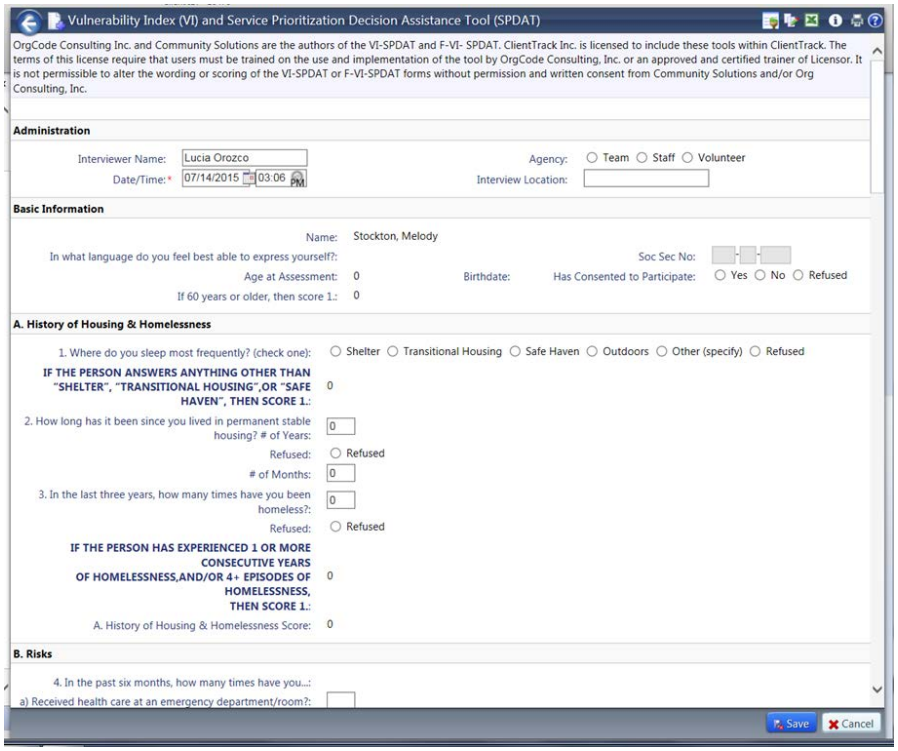


Step 5: After recording the enrollment, the workflow will proceed to the Universal Data Assessment for each family member. Complete the assessment and click Save. The workflow is now completed.

Step 6: The next step is to complete the VI-SPDAT. The assessment can be found in the favorite's area, at the top left corner of your screen.

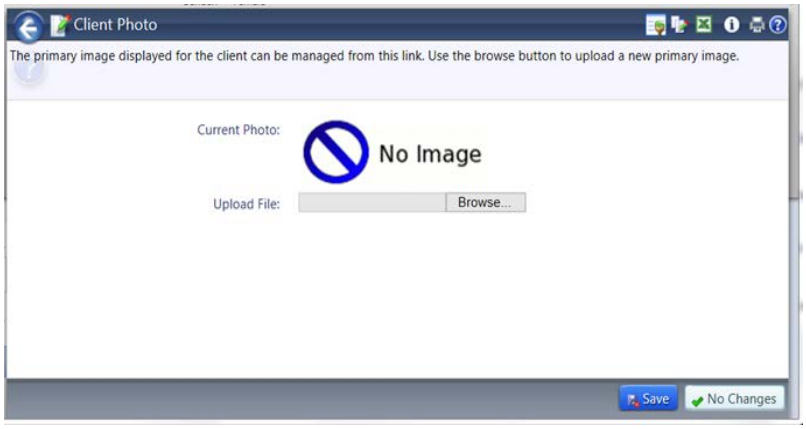


Step 7: Select the appropriate assessment depending on their family type Single Adult or Family. Record the information as completed on the form. When finished, click Save.



Step 8: Upload a Photo

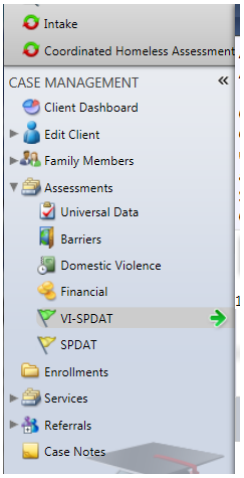
Continue by uploading a client photo, if the client has consented to taking a picture. Select Client Photo from the top favorite's area. To upload a photo, click Browse. A new window will open which gives you access to all computer files.



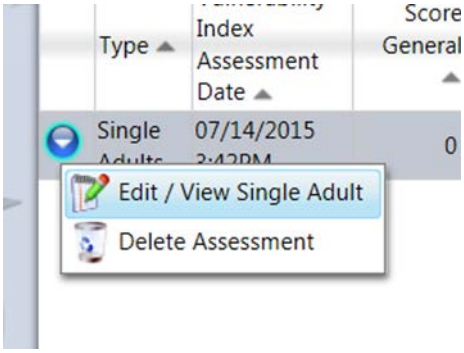
Select the appropriate client photo file and click Open. Select Save. If there is another adult in the household, click Find Client, search and select the family member and complete step 8 to upload the photo for that adult member.

To Edit a VI-SPDAT Assessment:

Expand Assessments in the left Navigation panel and scroll down to the green flag that reads VI-SPDAT.



Click on the action gear next to the assessment you need to edit and click on Edit/View Single Adult or Edit/View Family.



Make the appropriate changes and click Save at the bottom right corner.

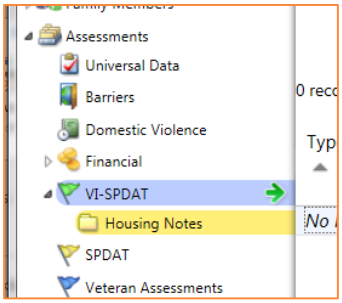
To change the status of the VI-SPDAT, edit the assessment and change the Status field, click Save. VI-SPDAT assessment options are as follows:

1. Open – defaults and remains open until client is referred or housed.
2. Closed – assessment is changed to closed when the client no longer needs housing.
3. Referred – When Housing Navigator has referred client to appropriate housing program.

To add a Housing Note:

Housing Notes are available and can be accessed by all users.

To add a housing note related to the housing priority list, click on Housing Notes located under VI-SPDAT. Type in a title and case note and click Save at the bottom of the screen.

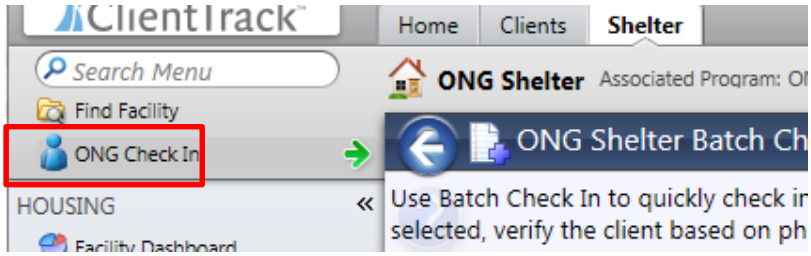


Note: Client case notes directly relating to case management should not be recorded using Housing Notes as they are visible to all HMIS users. To enter restricted case notes, see page 24, CASE NOTES.

Shelter Check In

The shelter check in functionality is specifically designed for emergency shelter programs that track clients night by night. The night by night method track's "bed nights" for shelters which allow clients to enter and exit in an irregular basis and do not require a continuous stay.

Step 1: On the Shelter tab, click on the ONG Check In found in the favorites area of the navigation panel.

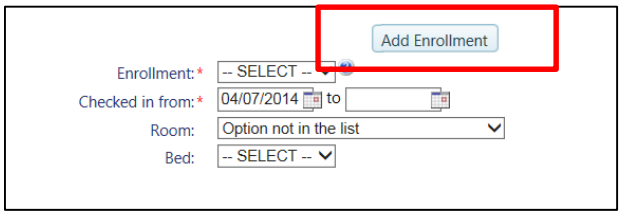


Step 2: Type in the Client ID or Client's first and last name and click on the magnifying glass. (partial names are permitted)

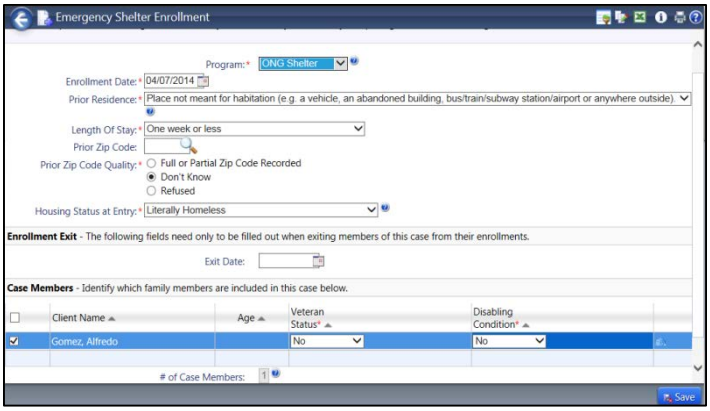
Step 3: Select the enrollment at the bottom of the page; confirm the check in from date, enter the checkout date, select the Room and Bed (optional) and click Save at the bottom right corner.

If you find the client in step 1 above, but have no option under Enrollments, follow these next steps:

Click on **Add Enrollment**.



Record enrollment and Universal Data by selecting ONG Shelter for the Program field and complete the additional information. Click **Save** at the bottom right corner.



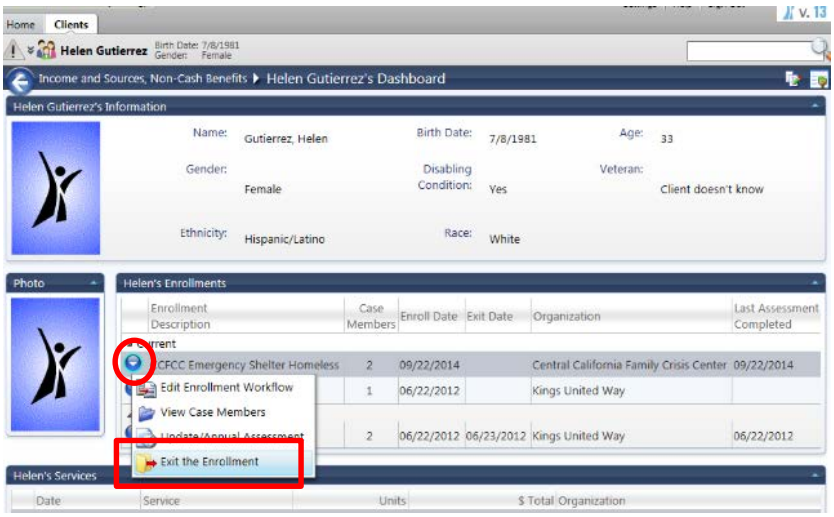
Finish checking in the client by following step 3 of the Shelter Check In above.

Exiting a Client

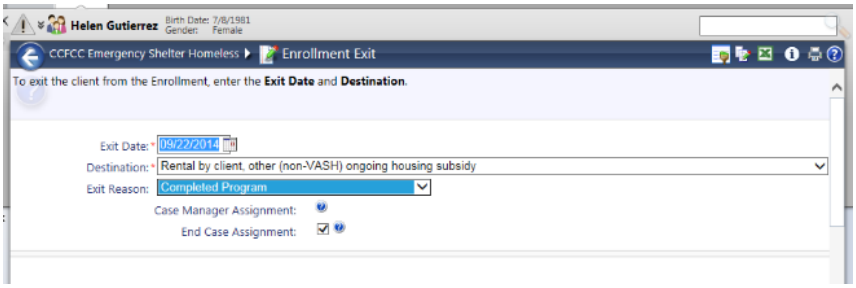
The exit workflow collects program-specific data that is required upon exit of the program. The difference between the entry and exit assessment demonstrates quantifiable changes that can help identify whether working with the client had a substantial effect on their situation. Regardless of the date the information was collected, the exit data must accurately reflect the client's response or circumstance as of the date of program exit. The exit assessment date must also correspond with the program exit date.

Step 1: On the Clients tab click on Find Client, search for the applicable client and click on the record.

Step 2: On the client's dashboard, click on the action gear next to the program the client is exiting. From the drop down, click on Exit the Enrollment.



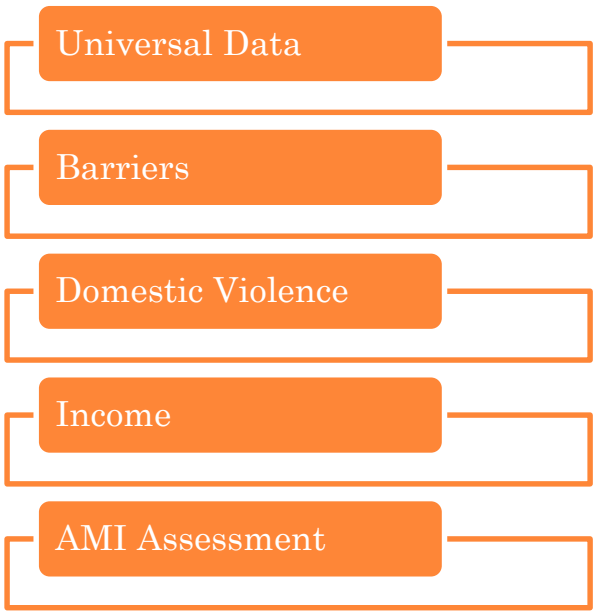
Step 3: Complete the exit information. Check off the End Case Assignment box to deactivate the associated case manager assignment.



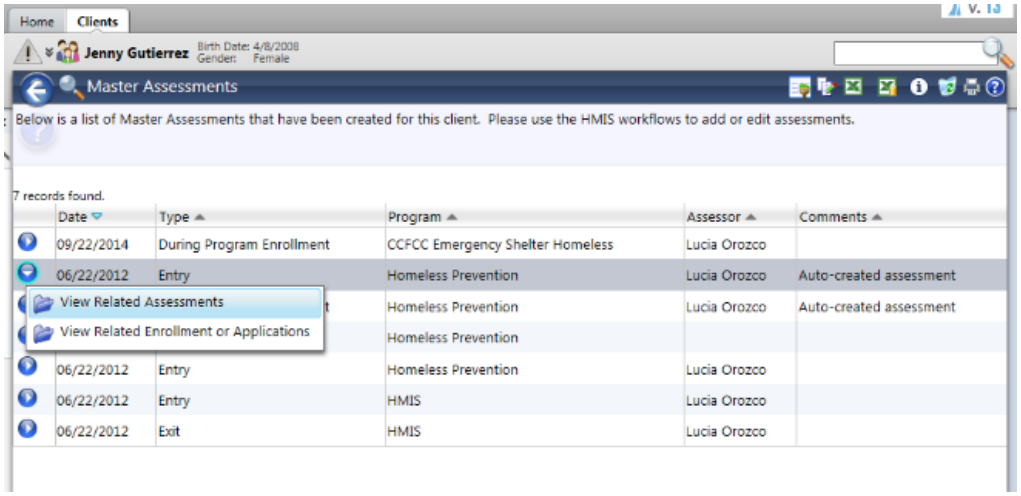
Step 4: If applicable, record any services the client received during the enrollment period.

Step 5: Complete the exit assessments based on the client's status at time of exit. The workflow cycles through each case member to collect assessment data. The system uses conditional logic to determine which assessment to include based on certain responses or age of the member.

Exit Assessments available. Workflows use conditional logic to show or hide assessments required for each program type.



To view individual assessments for each Master assessment, click on Assessments on the left navigation panel. Next to the appropriate assessment, click on the action gear and select View Related Assessments. You can also view related enrollments for each Master Assessment.

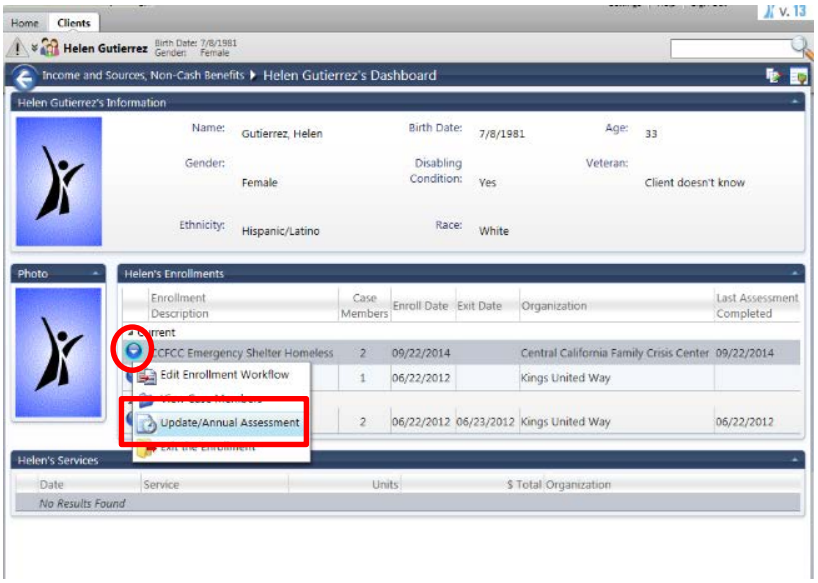


Annual Assessment

The annual assessment is to be recorded no more than 30 days before or after the anniversary of the client's *entry date,* regardless of the date of the most recent 'update' or 'annual assessment', if any. Information must be accurate as of the *Information Date.*

Step 1: On the Clients tab click on Find Client, search for the applicable client and click on the record.

Step 2: On the client's dashboard, click on the action gear next to the appropriate program. From the drop down, click on Update/Annual Assessment.



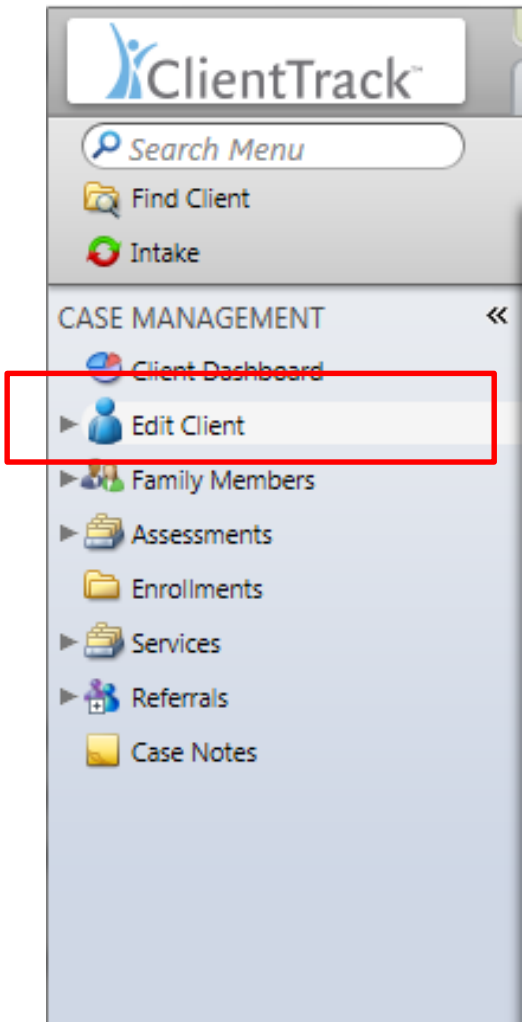
Step 3: Complete the assessments according to information at time of program anniversary.

> Annual Assessments need to be completed for each family member. Updates are required for persons aging into adulthood.

Edit a Client

Search for a client by clicking on Find Client. Once you have selected the client, click on Edit Client in the Case Management menu. You can also view, edit or delete (if user level permits) assessments and enrollments. These options are in the Case Management Menu.

Once appropriate changes are made, simply select Save at the bottom right corner of the form.



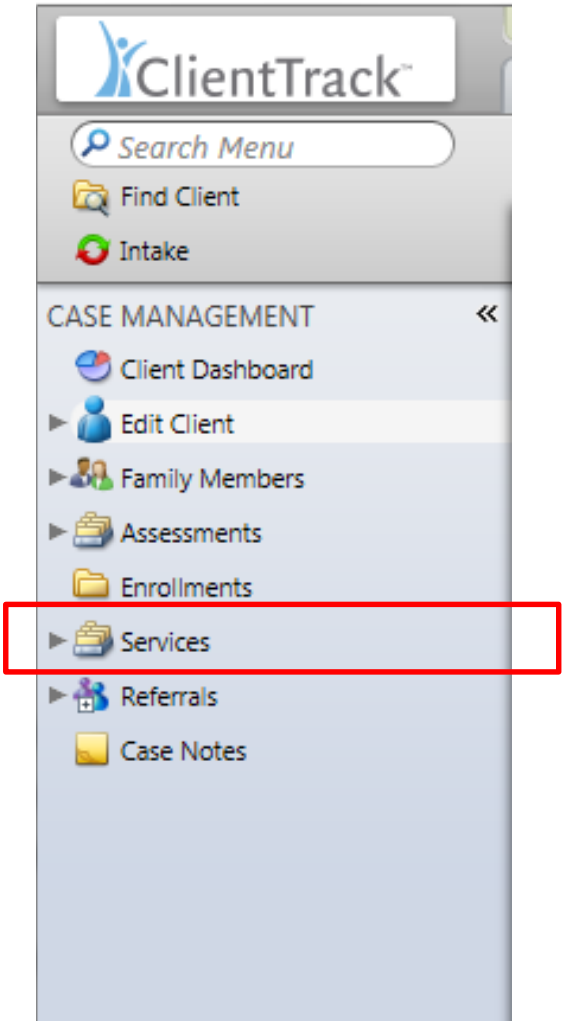
Add a client photo:

Click on Client Photo under Edit Client and upload the image.

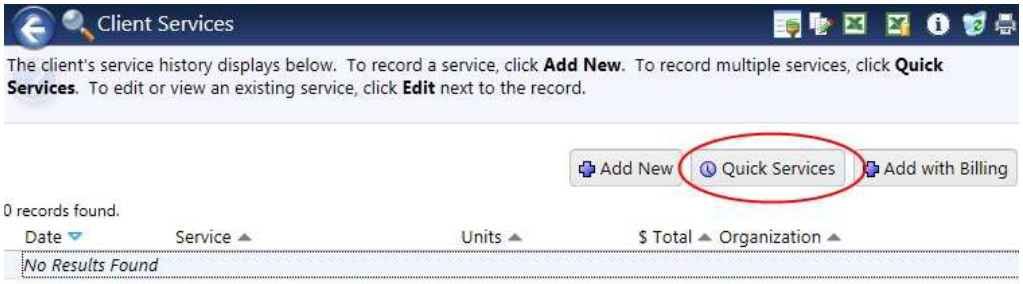
What a great way to track your clients…

Recording Services

To record services, on the Clients tab, click on Services. On this page click on Add New to record one service at a time. Click on Quick Services to record multiple services at one time.



Step 1. On the Client Services page, click Quick Service.



Step 2. On the Quick Services page, select the appropriate Screen filter and Grant from the dropdown menus.

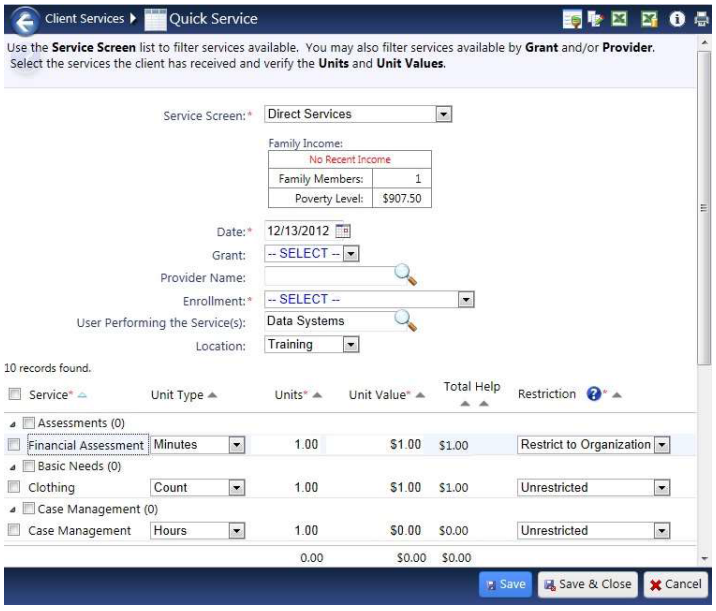
Step 3. Record each Service provided to the client by checking the checkbox next to the particular Service.

Step 4. Type the number of service Units provided to the client, the unit cost, and $/Unit. Depending on your organization's setup, the unit cost may appear automatically.

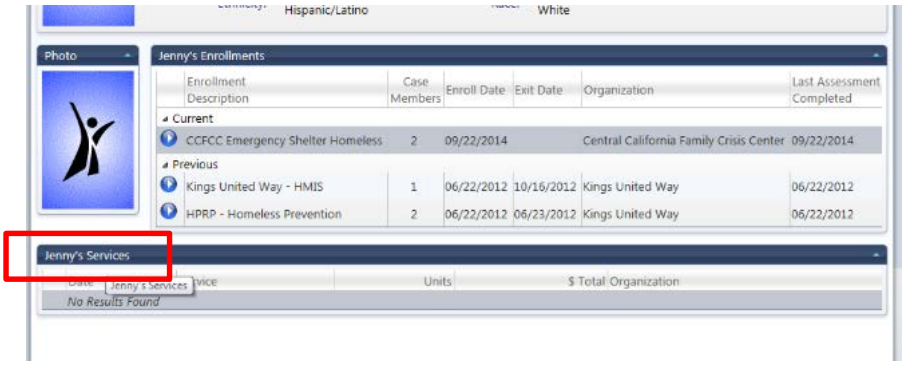
Step 5. When finished recording services corresponding to the parameters entered at the top of the page, click Save Selections.

Step 6. To record Services provided under a different set of parameters, repeat steps 2-5.

Step 7. When finished recording Services, click Save & Close.



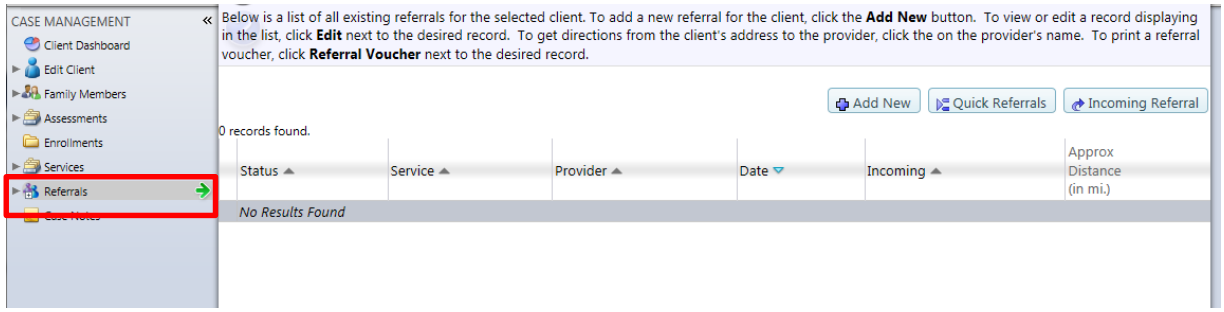
Services can be viewed, edited or deleted on the client's dashboard. Click on the title Services from the dashboard to go to Client's Services.



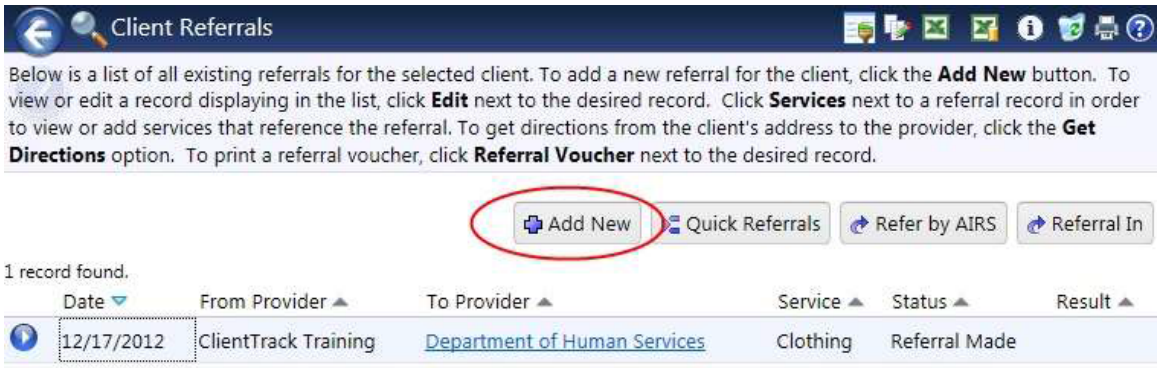
Click on the edit icon to edit a record. Click on the delete icon to delete a record.

Recording Referrals

To access referrals, on the Clients Tab in the Case Management section, click Referrals.



Step 1. On the Client Referrals page, click Add New.



Step 2. On the Client Referrals page, enter a Referral Date.

Step 3. Select the Status of the referral.

Step 4. Select a Referral Service from the dropdown menu.

Step 5. Click on the Refer to Provider search icon to look for providers that provide the service you have selected. (only providers that provide that service will be displayed for selection)

Step 6. If desired, type Comments.

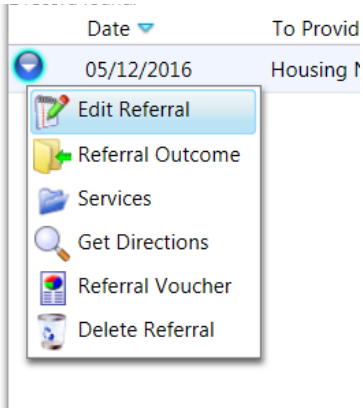
Step 7. If the client has authorized that his/her information can be released to the selected provider, check Email Authorized. This will cause a window to open upon form completion that allows you to craft an email to send to this provider with information regarding the referral.

Step 8. Click Save.

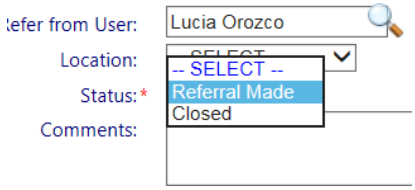
To Edit a Referral

Once a client has been referred to your agency, you will need to update the status of the referral.

Step 1. To do this, click on the Edit Icon next to the referral record you need to update.

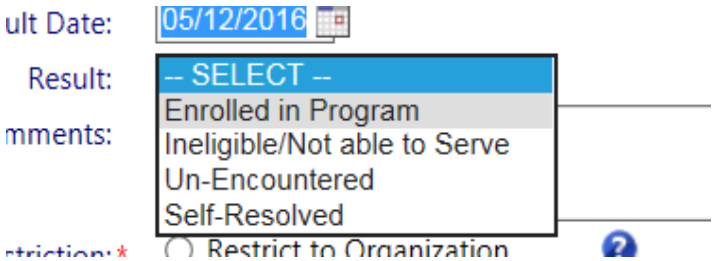


Step 2. Referral status consists of two components. First is the referral status. This consists of the current position of the referral. Options are as follows:



- *Referral Made* – Referral has been initiated, made to provider. Default option.
- *Closed – Referral has closed and requires an outcome.*

Second, the referral warrants an outcome. Referral outcome choices are as follows:

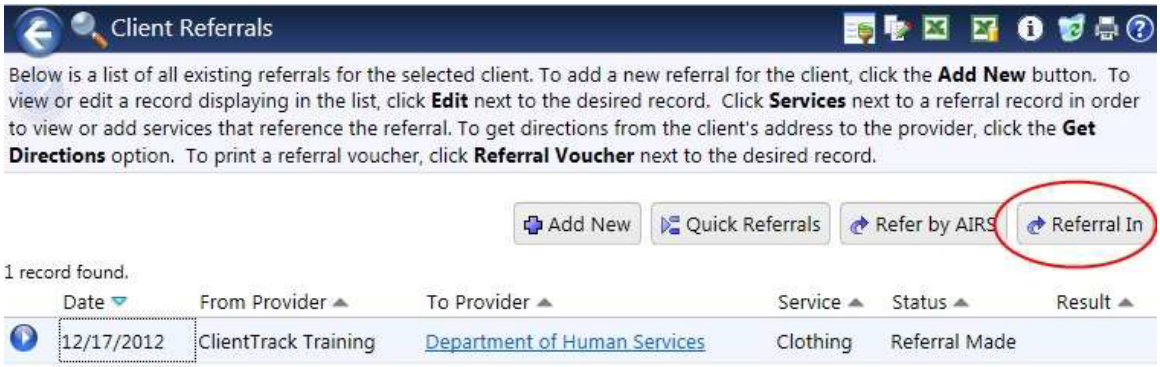


- *Enrolled in Program* – The client referred has been deemed eligible and has enrolled into the referred program.
- *Ineligible/Not Able to Serve* – The client referred has been deemed ineligible to participate in the program or was not able to serve due to other reasons.
- *Un-Encountered* – Provider has documented search efforts per Every Door Open manual and has been unable to locate the client.
- Self-Resolved – Client has found permanent housing on their own and no longer need assistance.

Step 3. Once the referral has been updated accordingly, Click Save.

To record a referral into your organization:

Step 1. On the Client Referrals page, click Referral In.

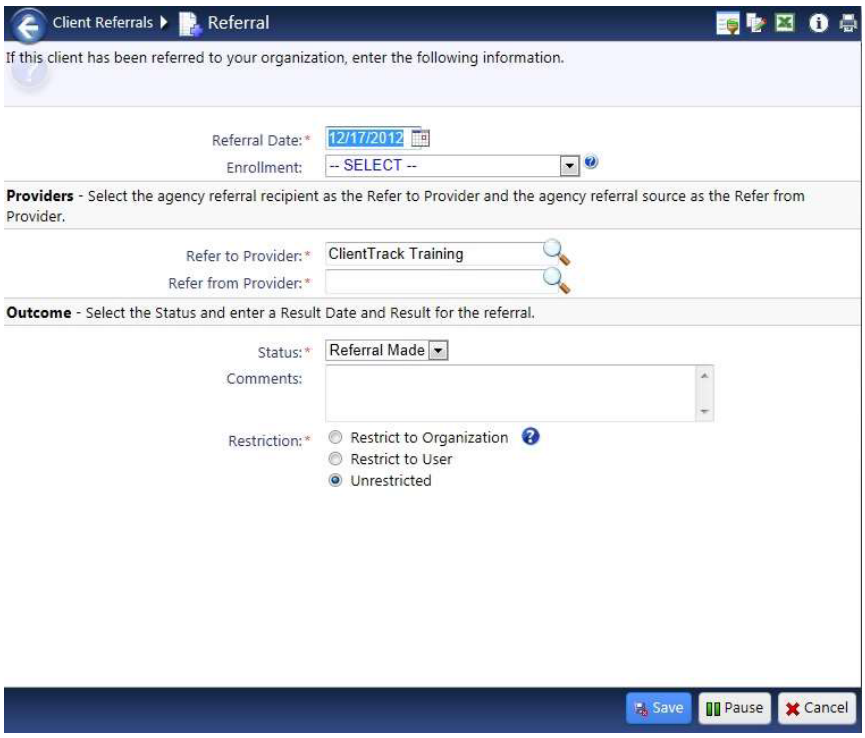


Step 2. Since the client has been referred to your organization from another provider, Verify that your organization's name is in the Refer to Provider field on the Referral page.

Step 3. Type the provider's name that referred the client to your organization in the Refer from Provider field.

Step 4. Complete the additional information concerning the referral.

Step 5. Click Save.



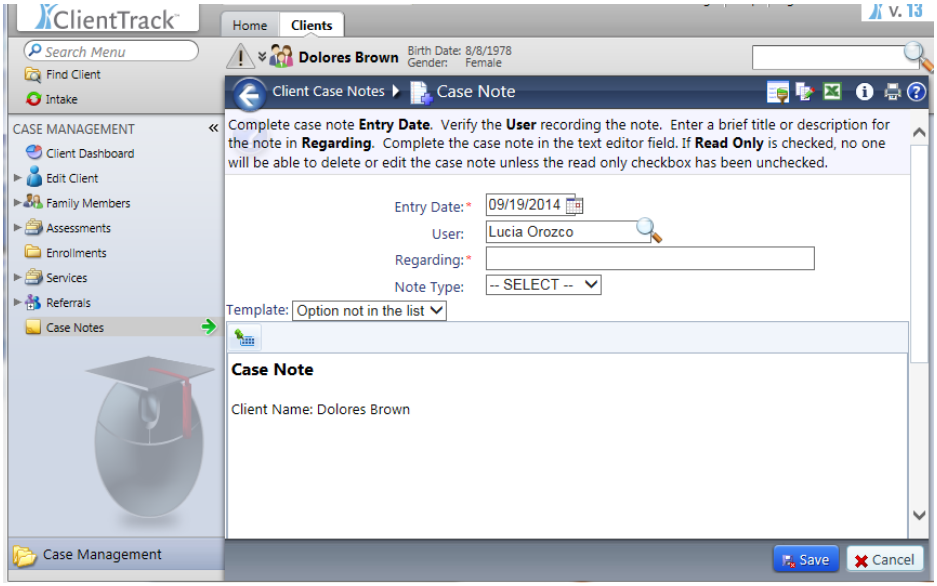
Case Notes

The case note tool is a way to document client visits, interactions and services. Case notes are secure and are not shared with any other organization.

Step 1. To access case notes, select Case Notes from your navigation panel.

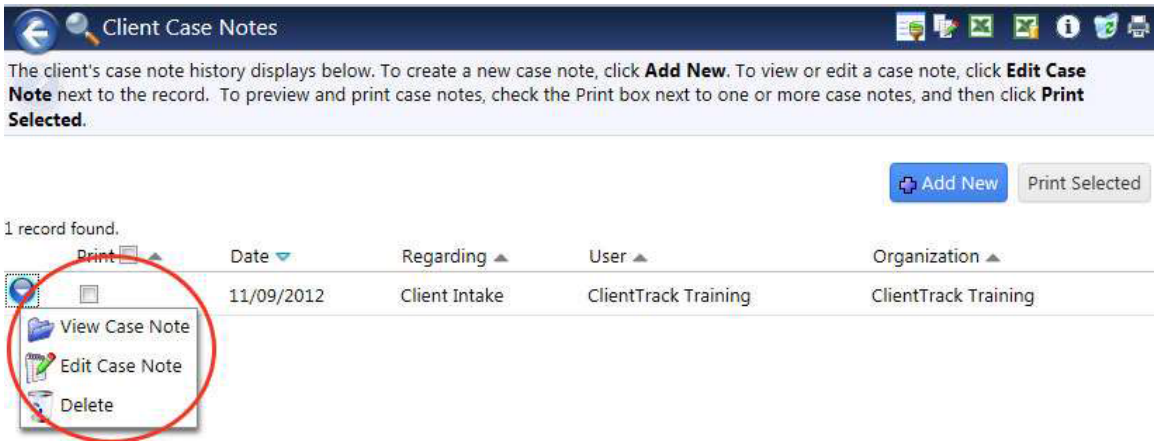
Step 2. Click on Add New at the top right corner.

Step 3. Complete the case note and save.



Select Read only at the bottom of the screen if you only want to allow members of your organization to have read only access.

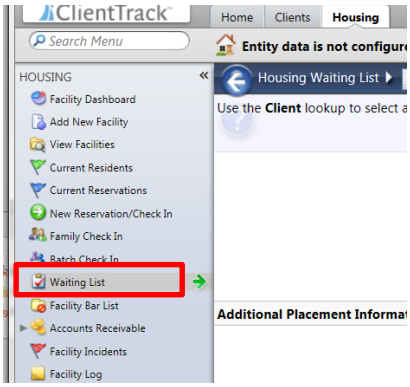
Once a case note has been entered, it is displayed on the Client Case Notes page where you can edit, or delete it.



Wait List

The Client Wait list is a record of the referrals or facilities for which the client has been put on a waiting list. After clients are added to a waiting list, the provider assigned to the referral is able to access the list from the Wait List.

Step 1. On the Home Tab select Waiting List.

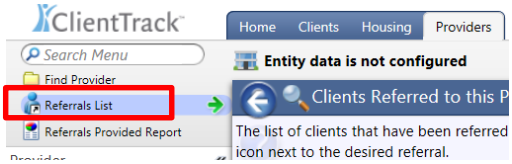


Step 2. Click on Add New.

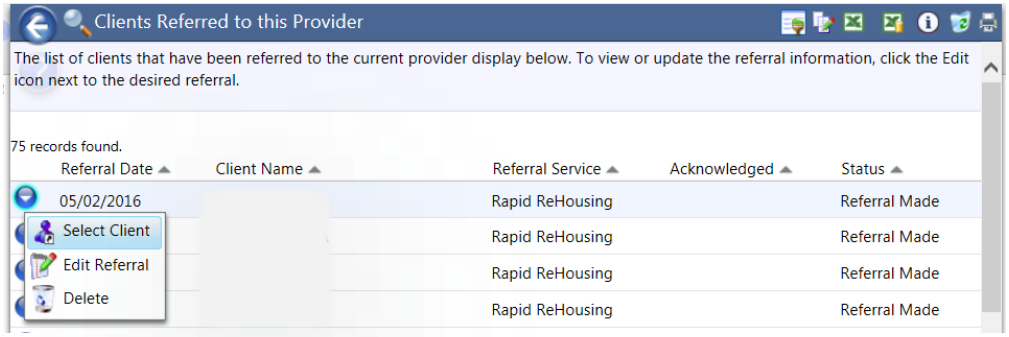
Step 3. Complete the Housing Waiting List and click Save.

Referral List

The Provider Referral list is a list of referrals that have been sent to your organization. To access the list of referrals sent to your organization, go to the Providers Tab. Click on Referral List.



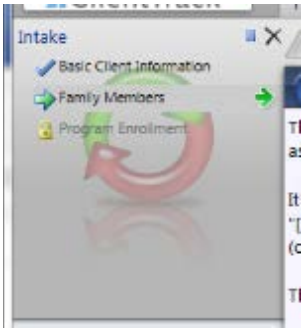
A list of all referrals made to your organization by other providers will be listed here. You can edit the referral or select the client from this list by clicking on the action gear next to that record.



Ease of Use Features

During a workflow, the workflow name along with a group of status icons and navigation buttons appear in the upper left navigation panel.

The icon indicates a workflow.



Workflow Navigation Buttons:

-Delete Workflow

-Stop Workflow

-Pause Workflow

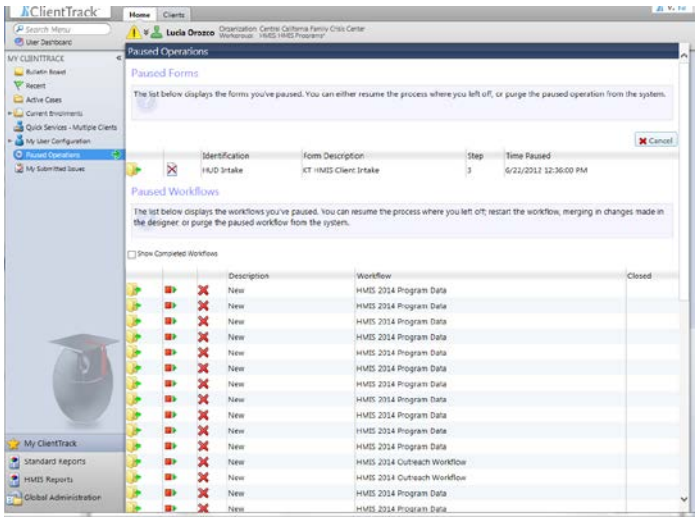
Workflow Status Icons:

- Workflow Step Completed

-Current Workflow Step

-Workflow Step Locked

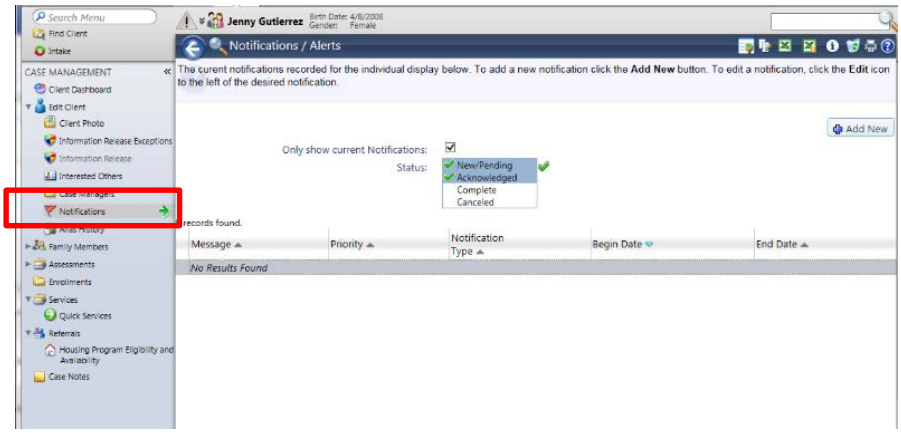
As the user proceeds through the workflow, the status icon will change to indicate the progress. To pause a Workflow and return at a later time, click the Pause button. To cancel the Workflow and discard unsaved data, click the delete button. Data is saved as each form step is completed. To access paused workflows, go to the Home tab and click on My ClientTrack, select Paused Operations. Click on the Resume the Workflow icon to resume a workflow.



Any user can resume a workflow whether they started the workflow or not

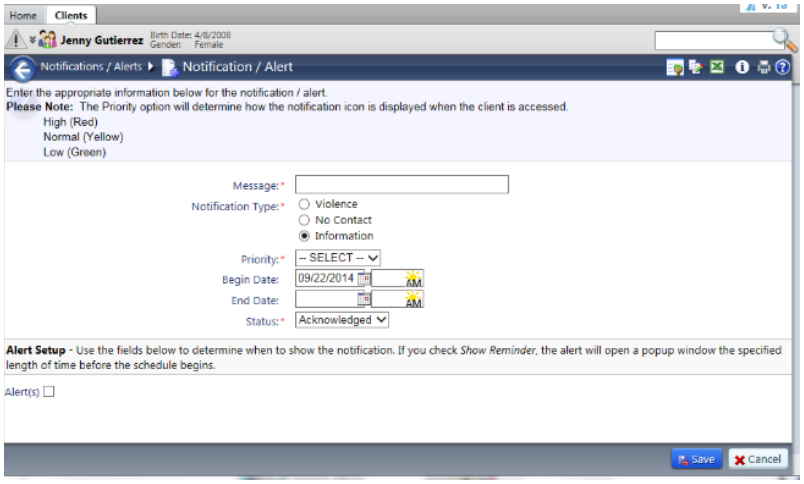
Notifications allow users to enter alerts regarding a specific client. These alerts will appear immediately once you select a particular client.

Step 1. To create a notification go to the Clients tab and click on Notifications under Edit Client.



Step 2. Click on Add New at the top right corner.

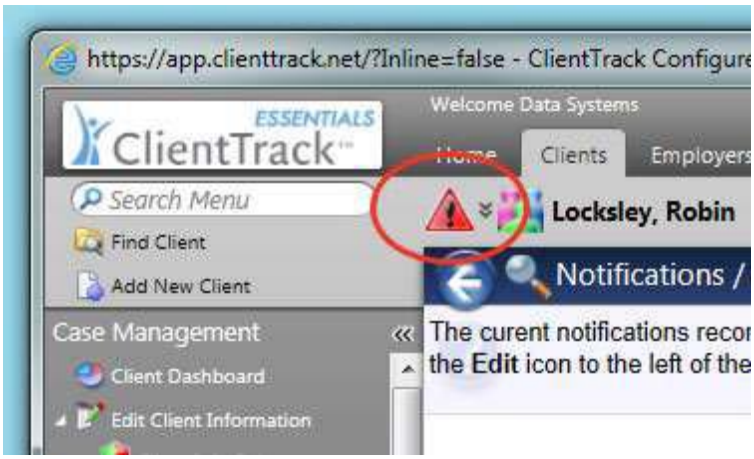
Step 3. Complete the notification/alert information. The Urgency Option selection determines the Notification icon that will appear when the client is selected. Check the Alert box if you would like an alert message the next time you select the client record.



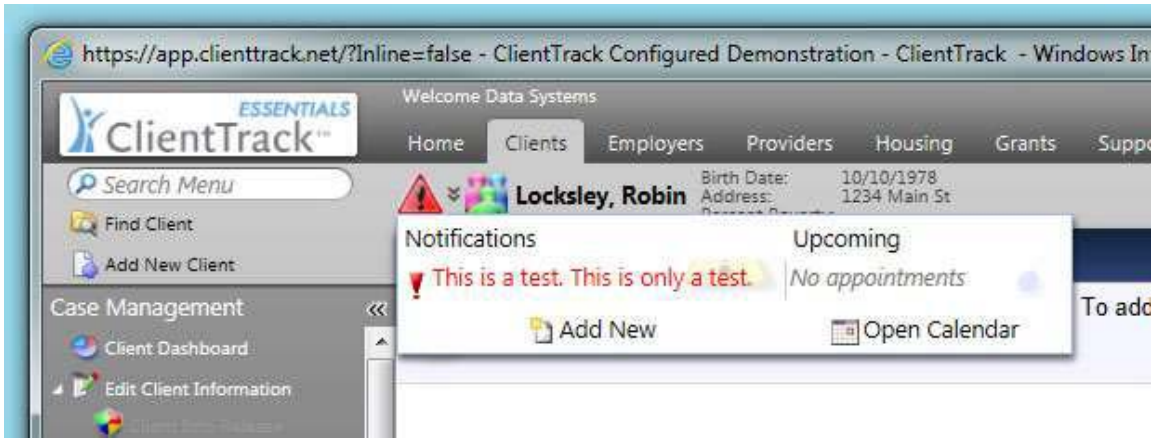
Step 4. Click Save.

Notifications can be edited or deleted by clicking back onto the Notification section found under Edit Client. You can search by New/Pending or Completed notifications.

After you have entered in a notification, depending on the urgency, a red, yellow or green exclamation mark will show up next to the client's name. If there is more than one notification, the color representing the most urgent notification will be displayed.



Clicking on the exclamation mark will display a brief summary of the alerts.
The Notification popup page opens to display the notification information. You can modify the data, Snooze the alert, Dismiss the alert, or change the time in minutes that the popup window will be displayed.



Appendix A

HMIS Workgroup	Project Types
HMIS: Emergency Shelter Programs	Emergency Shelters
HMIS: HMIS Programs	Transitional Housing, Permanent Supportive Housing, Homeless Prevention, Rapid Rehousing, Services Only, HUD VASH
Non-HUD: Emergency Shelter Programs	Non-HUD Funded Emergency Shelters
HMIS: Street Outreach	Street Outreach, Services Only

Appendix B

Acronym List

AHAR	Annual Homeless Assessment Report
APR	Annual Performance Report
CoC	Continuum of Care
HMIS	Homeless Management Information Systems
HPRP	Homeless Prevention and Rapid Re-Housing Program
PATH	Partnership for Advancing Technology in Housing
PIT	Point In Time
SHP	Supportive Housing Program
SPDAT	Service Prioritization Decision Assistance Tool
SSO	Supportive Services Only
SSVF	Supportive Services for Veteran Families
VA	U.S. Department of Veterans Affairs
VI-SPDAT	Vulnerability Index – Service Prioritization Decision Assistance Tool