ASU CIC - Reducing Homelessness Challenge

Frequently Asked Questions (FAQs)

1. Does the solution need to integrate with other platforms?

Yes. This would include HMIS/Wellsky, campus data system/intake, Athena, Salesforce and others. The first priority though will be solving HMIS integration, either through an API hopefully (Jessie following up) or other alternatives (i.e., daily early morning flat file download CRN is already getting the data from which is dropped into our system/database and then available on the platform; the issue is how to avoid double entry for information that needs to go into HMIS without an API—ghost key strokes of the providers and have it go in HMIS that way, etc.). Given HMIS does not update data throughout the day, I'd prefer getting a download early morning each day however we do it, add to data fields throughout the day as data is being inputted, and then at the end of the day feedback what is required to HMIS that was inputted throughout the day. That allows the users to have real time information.

I assume this (integration) would not necessarily always have to be constant downloads of data, but could be streaming/connectivity on an as needed basis for giving/receiving data to minimize the amount of data we're holding. That may vary by vendor/system we're dealing with. I don't know if this could be templated in some way to optimize and make it easier for us and whoever we're dealing with.

2. Does it meet HIPPA compliance? I believe for the database to provide the information service providers need to optimize services and for the most effective dataset for analysis and trending we will need some HIPPA protected data in it. Eventually. So, while we should certainly not start with having to deal with HIPPA data in initial features, it should be on the roadmap as a to do at some point. Ultimately, it would be ideal to have HIE's dropping in data as well as the health care related service providers. There will then certainly need to be access/permission/fire walls in place to protect the data appropriately and allow analysis without having to know names, etc. This would also need to meet the terms of any data sharing arrangements we enter into as part of having more health care providers supplying data and participating in the platform.

3. Is it Athena compatible? See #1.

4. Will it integrate with Salesforce? See #1.

5.   Does it need to incorporate/feed HMIS data and agency case management data? Give and take data with/from HMIS. See #1.

6. Will it tie to client's HMIS number and allow for bar code scanning to add data? Yes and yes. HMIS number has to be a part of how we ID the person, but we could change I guess to another "ID" if we think there's a better approach and then attach to the ID the HMIS number. On bar code scanning, although we could/should as part of the project (not the prototype I wouldn't think) determine if the digital ID aspect of the project (which I assume for our purposes id effectively being piloted in the Baltimore project and we'd just tie into best practices/options from what they learn). If there is

anything we should be doing to pave the way for this in AZ in advance of a viable technology solution, we should have that on the roadmap as well.

7. Does information entered in-system get sent to HMIS? See #1.

8. Does this system communicate with HMIS in real time? See #1.

9. Will it draw information from HMIS? See #`1.

10. Will there be interoperability with Human Service Campus data systems? See #1.

11. Can I enroll in AHCCCS via MAP? I think ideally we would identify the key programs we think homeless people can/should be in and build out the ability to enroll in those programs via MAP. I would also go one step further, and it's in the press release and visual, and build functionality that shows if they are currently participating in available programs as well as what programs they should be in that we're not showing them in.

12. Data integration (data from different places with different meanings)? Yes.

13.   What will be required to update/support/maintain any platform technology that is developed? Yes. CRN is currently discussing their interest in doing so. I suspect any commitment they make may require a financial commitment or guarantee for them to be willing to expend time/resources beyond TJ at this early stage. For them, they don't know if we can get this off the ground and beyond the campus. While we can talk to Amy and her campus IT team to confirm, I don't think her team today does this kind of thing but I could be wrong.

14.   What analytics reporting will be available? Trending, predictive analytics (talked specifically with Cole about some of what he is already doing at the Brian Garcia Center with predictive analytics). Determining what type of standard reporting we'd like available and creating the reporting would be a piece of this project. More advanced or custom analytics should also be doable, at worst initially through data exports for the more sophisticated analytics and over time through the platform. Data exporting will need to accommodate potential HIPPA data and having data attached to a person but still anonymous to the person/group doing the analysis. Typically, I think this is done through other identifiers unknown to the users.

15.   What will be the ongoing costs to support? Unknown until we ultimately decide the scope/scale of the solution.

16.   Does it need to have permissions setup? Security, firewalls. Yes.

17.   Will it require duplicate data entry? If it does, we should stop now.

18. Will it be able to capture voice or digital signatures? I think yes, at least digital signatures, particularly if we want to integrate digital ID at some point. Again, more down the line on the roadmap.

19. Will it be able to save attachments scanned or digital documents? We should build in this functionality. When? See the roadmap.

20. How will success be measured? I see two key measurement points: prototype roll out, and after. For the prototype roll out we should be measuring things like provider "delight" with the prototype functionality, learning from the prototype to guide future development (so "bad" stuff isn't bad, it's about learning and adjusting), service provider learning and understanding of the agile development process and our learning how best to deliver it and interact with the providers. This sets the stage for the agile development process that will follow in the build out of the features, etc. that are not done in the prototype. In that stage, I would still include adjustments for learning on agile development process. In addition, it would include the desired functionality being delivered within the timeframes set, service provider use of the functionality and ultimately enhance outcomes for people experiencing homelessness (fewer people becoming homeless, once homeless, homeless for less time and fewer coming back to homelessness once housed).

21. How will data sharing and privacy compliance be addressed? Data sharing agreements as necessary. It would be nice to develop an acceptable prototype agreement that is largely unchanged from participant to participant. I could help with this. System structured for access/permissions as appropriate, and for anonymous data for analysis/trending.

22. Will clients be able to access? Yes. But much later stage. I would view this as a web portal displaying certain key information including programs they're in, programs they are eligible for but not in, where to go for services based on where they are at, appointments with providers using the platform or supplying data including appointment data, places they have received services/assistance from, etc. A dashboard.

23. Do agencies have different access levels? They will and access level will depend upon their privacy/security needs.

24. Where is the MAP database housed and who will own? For now, HSC. Long term financially viable model would probably shift it to CRN as the owner since it fits what they are doing today. We'll have to determine when/if that is possible or ultimately have to support it from our campus efforts or fees from users. Some fee based use would be only fair for support/maintenance but once we have a better feel for the platform benefits, needs and costs we can sort that out.

25. Who will manage technical issues, data quality, and digital signatures? See #13.

26. Does the patient sign-up equate a release? Patient sign up could include a release if it doesn't already. Ideally, we'd coordinate with all of the providers on the campus to include in their standard release something that is broad enough to cover what we're envisioning with the platform.

27. Could you pull reports? See #14

28. Do staff have different permission levels? I would expect that to be the case. Different organizations and then staff within organizations will have different permission levels, at least for access to data for review, analytics, etc. and perhaps for some dashboard features depending upon the feature.

29. Who manages the portal? See #13

30. Who do we report issues to? See #13

31. Can clients schedule appointments? This could certainly be a feature. It would require I assume either service provider calendars are loaded onto the platform for clients to access or appointments in the platform could download to service provider calendars on their systems. I would see this coming in at the same time as the client portal, a later phase item on the roadmap in my view.

32. Will it work with mobile phones? Develop the platform so it's compatible.

33. How can different systems connect? API's, interfaces. API's, interfaces.

34. What information is the most beneficial for the client? May depend upon the client and their specific needs. That will vary. That's also why a platform that brings together all of the information so it can be delivered to the service provider in relevant, digestible chunks is so valuable. Use the technology to solve the complex and make service provider execution simple with a focus on the face to face client interaction.

35. What training will be required and who will lead? Ideally, the system is set up so it's so intuitive that very little training is required. "One click" approach everyone strives for. Otherwise, I suspect for the prototype rollout CIC will train on roll out, we'll set up a train the trainer program for future use/roll out and use that model to manage costs into the future. Part of the buy in for the system will be to periodically help train new users, and asking each organization to have at least two trained users at any one time.

36. How often will MAP information be updated? See #13. Once it's "done" (which may be never), we'll need to look at a development and release protocol to ensure the platform is periodically updated for bugs and new technology, and can continue to perform the envisioned functions and newly visioned features as we continue to learn and grow the platform.

37.   Which information in MAP will require updating and who will update? You will have updates in the ordinary course by providers through data entry. For example, a demographic changes and is inputted for the person. Otherwise, I assume it will vary depending upon the data. For data of that type in the MAP database that changes, we'll need to build a protocol/process for automated updating based on how we are receiving it assuming it's not just providers updating in the normal course of business. But if updated by one it will then be updated for all users.

38. How many areas can house kiosks for ease of use? Don't know.

39. Do we have other partners we can partner with to house kiosks or have assistors? Yes, after testing at the campus we can test it at locations identified at that time.

40. Can I find housing options in MAP? That is the intent.

41. Can I see any mental health providers the client is enrolled with? That is the intent.

42. Can I access data entered by all programs on the platform? Yes, depending upon type of data and permission levels.

43. How quickly can the system adjust and improve its tools? As we work toward the end of the major feature development, the roadmap should have a to do around determining how/who will do updates/releases.

44. Can the tool conform to HUD and HIPAA regulation on release of information? Yes, we should be able to do this. Others have.

45. Will alerts have text or email options? Yes, that should be doable and is desirable. User could have the option of requesting either or both methods of notification, among any others.

46. Will it interface with Outlook for appointments? Yes, that would be great although if some service providers don't use outlook for appointments we'd have to consider solving for both outlook and servicer provider specific appointment calendars.

47. Does it include enrollments with medical/MH providers? Ideally.

48. When does it pull shelter information? That would depend upon when the information is available and updated. It will vary.

49. Where does it pull shelter information? Ideally through API's/interfaces with other systems with that information.

50. Will we consider long term scalability in our design decisions as we build the foundation for the solution or expect to address it at a later date? Prefer, part of developing the roadmap.

51. Ability for non-campus providers (AHCCCS, Healthcurrent, shelters, etc.) to share data either through a database or live stream to enhance the power of the solution (i.e., be able to see where they have been outside the campus—other providers, shelters, healthcare, etc.). yes.

52. MAP should allow us to engage more meaningfully and more frequently face-to-face with people experiencing homelessness. If done well, it should free up providers to focus on connecting with these people and identify other potential insights to help them (and potentially add to the platform—features, data, functions).