OPHI – Choice Neighborhoods HUD Team Training On Case Management

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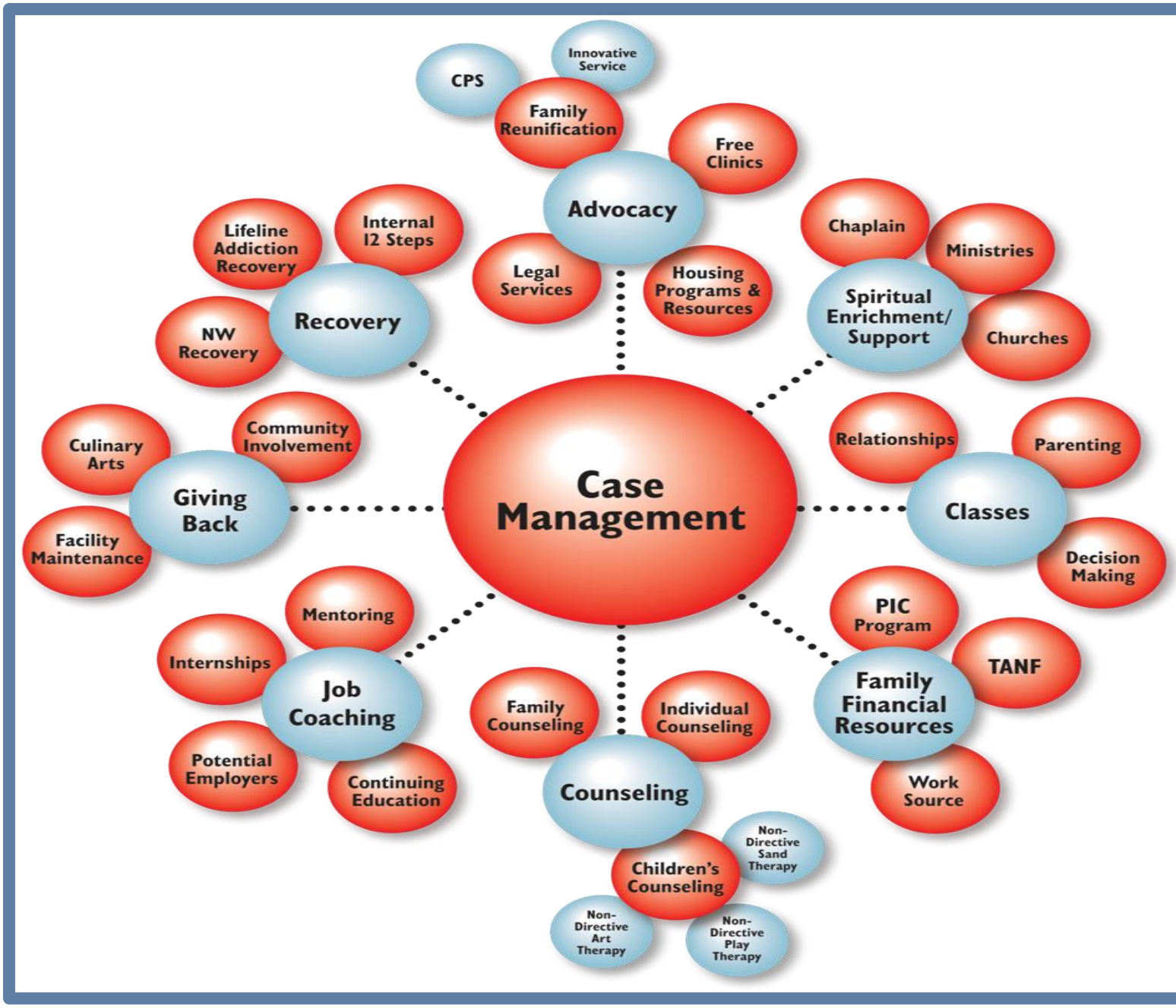
by Pamela A. Lawrence, MSW

Case Management: a definition

National Association of Social Workers defines Case Management as…

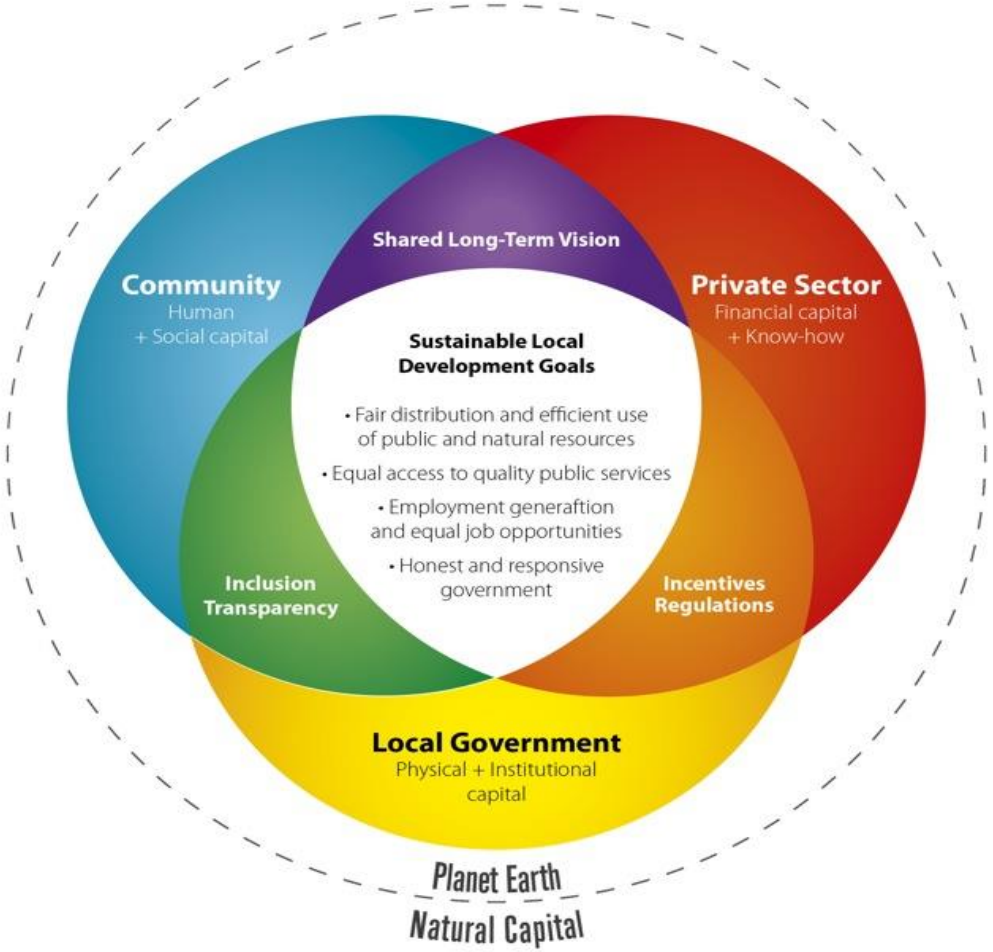
"A process to plan, seek, advocate for, and monitor services from different social services or health care organizations and staff on behalf of a client. The process enables social workers (other helping professionals) in an organization, or in different organizations, to coordinate their efforts to serve a given client through professional teamwork, thus expanding the range of needed services offered. Case management limits problems arising from fragmentation of services, staff turnover, and inadequate coordination among providers. Case management can occur within a single, large organization or within a community program that coordinates services among settings." (Barker, 2003).


Case Management
Advocacy
CPS
Innovative Service
Family Reunification
Free Clinics
Legal Services
Housing Programs & Resources
Recovery
Lifeline Addiction Recovery
Internal 12 Steps
NW Recovery
Spiritual Enrichment/ Support
Chaplain
Ministries
Churches
Giving Back
Culinary Arts
Community Involvement
Facility Maintenance
Classes
Relationships
Parenting
Decision Making
Job Coaching
Mentoring
Internships
Potential Employers
Continuing Education
Counseling
Family Counseling
Individual Counseling
Children's Counseling
Non-Directive Sand Therapy
Non-Directive Art Therapy
Non-Directive Play Therapy
Family Financial Resources
PIC Program
TANF
Work Source

Service Coordination: a definition

Service Coordination is a **systems-centered approach** to coordinating multiple services across agencies within a community, based on the needs of the target resident population, in order to increase accessibility, utilization, and quality of services and to reduce fragmentation in service delivery systems. Service coordination often requires the negotiation of enhanced services to address unique needs and gaps in available services. Partnership- and network-building with community-based supportive and social service agencies are critical components of service coordination.

Coordination of Systems



CN NOFA Specific Language

Service Coordination and Case Management

Should be available to all original residents of the target public and/or assisted housing site(s) as well as to all residents who occupy the revitalized public and/or assisted housing. Your service coordination strategy should leverage and improve access to existing high-quality case management and service coordination services for HUD-assisted as well as other low-income residents in the neighborhood and support Hard to House residents (as defined in this notice), as well as households with children ages 0-5, school-aged children, transition age youth (as defined in this notice), and elderly or disabled members. Case management (as defined in this notice) should be provided to individuals and families that are Hard to House or otherwise high need throughout the grant period. These households will require sustained and intensive supportive services to successfully relocate to the revitalized housing or maintain stability in other housing of their choice, as well as to improve self-sufficiency.

Choice Neighborhoods Required Activities

- Activities ensuring the **long-term viability** of the neighborhood on an economic, educational, and environmental basis;

- Activities that **promote economic self-sufficiency** of residents of the revitalized housing and of the surrounding neighborhood;

- Partnering with local educators, and engaging in local community planning, to help **increase access to programs** that combine a continuum of effective community services, strong family supports, and comprehensive education reforms to improve the academic and developmental outcomes for resident children and youth;

- **Appropriate service coordination**, supportive services, mobility counseling and housing search assistance for residents displaced as a result of revitalization of severely distressed projects

CN Related Eligible Activities:

- **People Implementation Entity.** An entity with proven experience in supportive service design and implementation which has primary responsibility for facilitating the achievement of the supportive services strategy. This strategy should be **minimally comprised of case management and service coordination** related to health, economic development, education and early childhood education, service providers in order to help residents be stably housed, improve outcomes for children, enhance adults' capacity for self-sufficiency and economic security, and services for elderly and persons with disabilities to maintain independence;

- **Partnering** with employers and for-profit and nonprofit organizations to create jobs and job training opportunities, with a focus on job opportunities accessible by mass transit;

- Relocation assistance, including tenant-based rental assistance renewable under section 8 of the United States Housing Act of 1937, and **supportive services for families that are displaced**, including mobility and relocation counseling over multiple years, reasonable moving costs, and security deposits

- **Leveraging other resources**, including additional housing resources, retail, supportive services,
  jobs, and other economic development uses on or near the project that will benefit future residents of the site

CNS Data Dictionary

Choice Neighborhoods Data Dictionary currently defines as Case Management as:

Metric	Definition	Description	Frequency	Data Sources	Recording, Collection and Aggregation Responsibilities	Scope/Unit of Measurement
Current Total Original Assisted Residents in Case Management	Number of Original Assisted Residents in Case Management	Number of Current Total Original Assisted Residents who are receiving case management supportive services.	Quarterly	Grantee	Grantee	Persons

Number of current total original assisted residents who are receiving case management supportive services.

Case Management is an **individual or family-centered approach** to assisting people with accessing the services they want and need. It includes screening/assessment/risk management, individualized service planning based on resident needs and choices, provision of options and information, linkage/referral to formal and informal services and supports, service coordination at the client-level, crisis intervention, follow-up, advocacy, monitoring/evaluation of resident progress as well as timeliness and effectiveness of service delivery, and maintenance of records.

Case Management recipients include: # persons who have established an Individual Development Plan or # of Family Members (Family Development Plan) actually participating and benefitting from an orchestrated family-centered intervention strategy e.g., family strategy to assist children with special needs, academic challenges resulting in strengthening parenting skills, communication skills, advocacy skills, academic assistance, testing, etc.

Active Case management is broadly defined but most require a schedule of face to face interactions (Quarterly at a minimum) and an Annual Reassessment to determine status of achievement – In short, a quarterly and Annual status checks is realistic and will support our reporting. Any individual who has been assessed by case management will be included as in active case management. The combination of not in case management and in case management must never exceed total assisted residents.

Why Is Case Management Important?

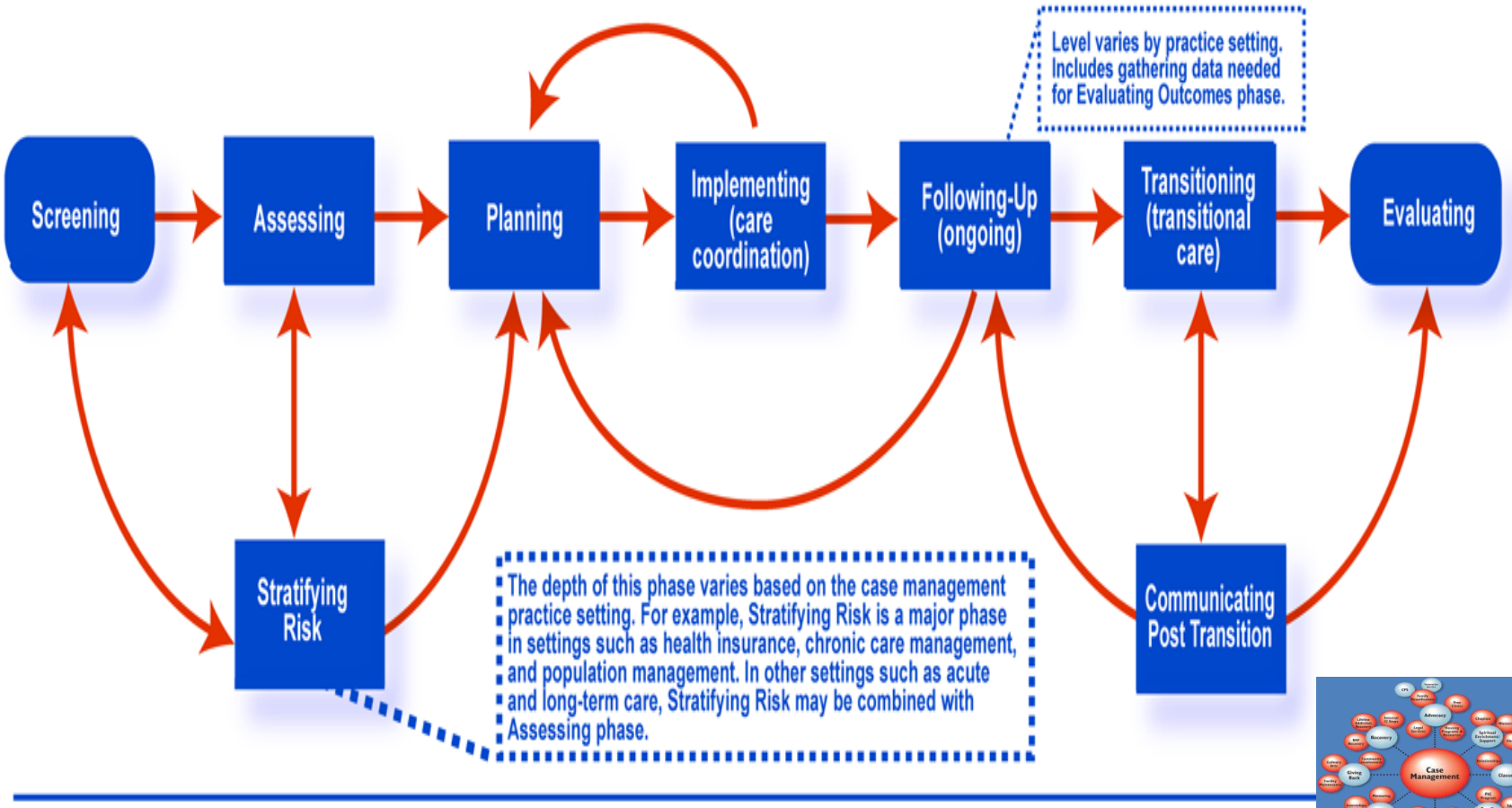
The main objective of case management is **continuity of care**.

This is seen to have two facets.

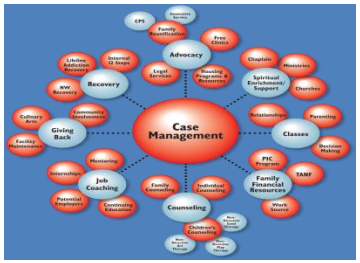
1. Services are comprehensive and coordinated; and,
2. Services can continue over time as well as being provided as the client's needs change.

This is particularly crucial when the client group is seen to have a significant and 'lifelong' disability and/or are considered "hard to house".

CASE MANAGEMENT PROCESS
High Level



Case Management- Levels of Care



Common Business Practices:

Weekly Contact

Bi-Weekly Contact

Monthly Contact

Quarterly/As Needed

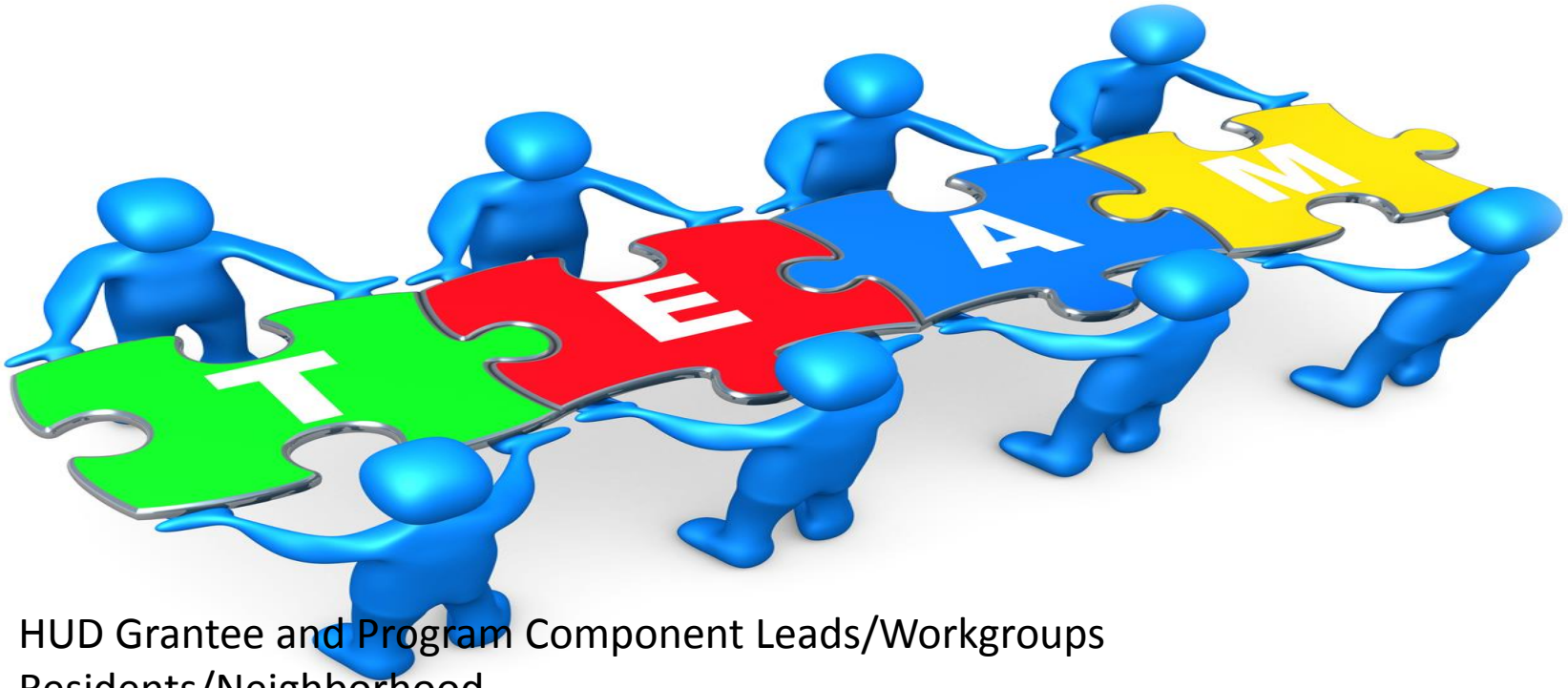
How to Evaluate an Effective Client-Level Case Management Model

- Case manager makes contact with the identified and engaged clients, he or she conducts a face-to-face comprehensive assessment with each client of that client's strengths and limitations and of the social, financial, and institutional resources available to the client. The social work case manager focuses particularly on how these resources relate to the principal concerns identified during the assessment. On the basis of this assessment, the social worker develops an individualized service plan with the client that identifies priorities, desired outcomes, and the strategies and resources to be used in attaining the outcomes. The responsibilities of the case manager, the client, and others should be clarified throughout development of the plan. The direct contact between case manager and client is essential to effectively accomplish the assessment and service plan development.
- Additional case management tasks related to client intervention include implementing the service plan aimed at mobilizing the formal and informal resources and the services needed to maximize the client's physical, social, and emotional well-being, and coordinating and monitoring service delivery. The case manager also advocates on behalf of the plan for needed client resources and services; periodically reassesses client status, the effectiveness of interventions, and the attainment of outcomes with revision of the service plan as indicated; and terminates the case.
- At all stages of client intervention, it is crucial that the case manager be granted sufficient authority to access, allocate, monitor, and evaluate service and fiscal resources. Such authority is a prerequisite of effective case management practice. Optimal control over and management of scarce resources may be more readily achieved in delivery systems structured with a single point of entry and integrated funding. Case managers will be more effective in delivery systems that are designed to reduce fragmentation.

LIFE WORKS SELF-SUFFICIENCY CASE MANAGEMENT MODEL

Assumptions	Activities	Immediate Outcomes	Intermediate Outcomes	Final Project Goals
1. Some low-income individuals are not appropriate for SS project at the time they present for services. When severely developmentally disabled, mentally handicapped, or compromised by substance abuse they are referred to appropriate services. 2. All individuals and families have strengths and resources that can be applied to meeting their needs 3. Customers participate in developing self-sufficiency plans and completing individualized sets of activities that contribute to their self-sufficiency. 4. Customer needs vary widely; not all customers need all services. Customers may need stabilization services, supportive services, training or education services, and/or job placement services. 5. Not all customers have the same goals, skills, and interests. Not all progress at same rate, nor are ready for services at the same time.	Case Management Activities: • Orientation • Assessment • Plan Development • Referral with advocacy or brokering and referral follow-up • Service Coordination • Reassessment • Attrition follow-up • Advising – includes informal life skills and problem solving • Training • Facilitating support groups • Home Visits Stabilization Services: • Family Crisis Intervention • Food • Clothing • Shelter and Utilities • Emergency medical or mental health • Emergency detoxification Supportive/Transition Services: • Transportation • Child care • Health care including mental and dental • Health Services, nutrition training	❖ Referrals are made to community services in accordance with case plans. ❖ Customer has basic life skills (home management, money management, parenting, etc.) ❖ Customer abilities in problem solving, conflict management, self-reliance, and resilience are increased. ❖ Customers experience fewer crises that impede participation and can manage these.	❖ Completion of an education, employment-training program. ❖ Employment at a predetermined minimum hourly rate with employee benefits or self-employed ❖ Reduced use of social welfare programs and reduced dependence on system-provided personal and family interventions.	Family Self Sufficiency

Case Management Takes Teamwork!



- HUD Grantee and Program Component Leads/Workgroups
- Residents/Neighborhood
- Provider Partners
- HUD Team (Field, Region, HQ)
- Federal Partners
- And so forth…..