Knoxville's Plan to Address Homelessness: Case Management Standards of Care

Knoxville's Plan to Address Homelessness: Case Management Standards of Care
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City of Knoxville, Tennessee
Madeline Rogero, Mayor

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Introduction

History:

In 2013, Mayor Madeline Rogero convened The Mayor's Roundtable on Homelessness. As a result *Knoxville's Plan to Address Homelessness (Plan)* was drafted. Once the *Plan* was approved by the Knoxville's City Council in April of 2014, the Knoxville-Knox County Homeless Coalition was charged to develop community-wide standards of care and accountability regarding homeless outreach services, case management, and housing placement. With this charge, the Coalition targeted a number of community agencies and agency representatives to inform and direct this effort. What follows, then, is the work of that steering committee, which has been vetted by members of the Coalition.

Intended Use:

Before acknowledging the hard work of all that were involved with this process, it is important to write about the significance of adopting community-wide standards of care and accountability in working for and with the homeless. Above all, standards of care provide guidance to homeless service providers and clear expectations of how to best respond in a practice setting. They provide a clear outline, based on evidence-based principles and practice, and define an appropriate quality of care when working with the homeless.

From a community perspective, standards of care are a statement of identity: this is who we are and how we, as a community, have decided to work with and for the homeless. Transversely, it allows the community to identify malpractice - practices that hinder or act in opposition to the community's efforts.

Knoxville's Plan to Address Homelessness sends a clear message to the community that homelessness in Knoxville is not acceptable. Any community-wide effort with this sentiment as its starting point requires a universal language and consistent effort. The standards that follow are intended to inform this unification.

Acknowledgements:

As mentioned previously, many agencies allowed their staff to devote time and attention toward the creation of these standards. Thanks, then, is given to Catholic Charities, Cherokee Health Systems, Knoxville-Knox County Community Action Committee, Family Promise of Knoxville, Helen Ross McNabb, Knoxville Homeless Information Management System, Knox County Public Defender's Community Law Office, and Volunteer Ministry Center. Specific acknowledgment is extended to the representatives of these agencies who served as members of the steering committee and helped create the following pages: Marigail Mullin, Bill Fields, Matt Tillery,

Misty Goodwin, Anne Umbach-Stokes, Michael Waltke, Lisa Higginbotham, Bruce Spangler and Gabe Cline.

Review:

As discussed at the Mayor's Roundtable meeting on September 21, 2015, this document will be reviewed annually by the full Roundtable. It is expected that, as agencies implement these standards, situations will arise that may lead to its revision, additional standards may need to be added, or some may become obsolete and no longer necessary. This document, then, will be reviewed on the third quarter meeting of the Mayor's Roundtable on Homelessness.

Respectfully,

R. Chris Smith, LCSW

President

Knoxville-Knox County Homeless Coalition

"The mission of the Knoxville-Knox County Homeless Coalition is to foster collaborative community partnerships in a focused effort that seeks permanent solutions to prevent, reduce and end homelessness."-
Adopted January 27, 2009

Section 1: Definition of Terms

- *Case Management* is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, advocacy, and follow-up for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes (*Case Management Society of America, 2010).*

  Case Management includes referral and related activities (such as scheduling appointments for the individual/family) to help an them obtain needed services, including activities that link them with appropriate medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan (*Centers for Medicare and Medicaid Services 2008).*

- *Outreach services* engage individuals and families experiencing homelessness usually not served or underserved by existing community service providers. These services become the first step or entrée to securing assistance for immediate health, safety, and security needs with permanent housing and integration into the

community as desired outcomes. Outreach services include but are not limited to, street outreach efforts, drop-in centers, and day-time emergency shelters.

- *Housing Placement Standards* refer specifically to those tasks that involve getting individuals and families into, then ensuring that they remain in, appropriate housing.

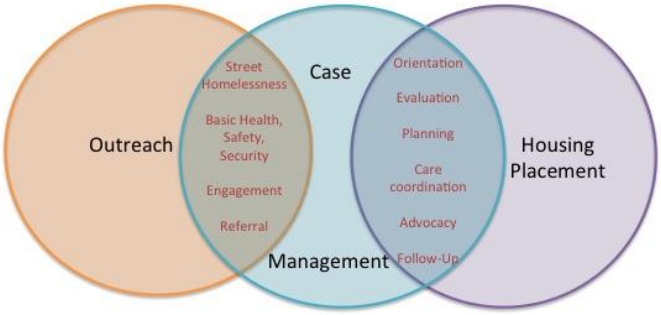

Figure 1.1 Case Management Spectrum

Section 2: Critical Service Elements

The order in which a homeless individual/family receives specific case management services will vary depending on needs and goals, program requirements, and available resources. This section provides an introduction to critical elements that are characteristic of effective case management in all practice settings and situations. Subsequent sections elaborate on these elements.

Assessment of Daily Functioning and/or Needs

- Homeless service providers typically assess individuals/families in life domains (See page 12): Utilizing a standardized assessment tool (e.g. Self-Sufficiency Outcomes Matrix, Vulnerability Index-Service Prioritization and Decision Assistance Tool, Daily Living Activities Functional Assessment-20) can also assist the case manager in working with the individual/family to determine needs, set goals, and document progress.

- Each individual/family has unique needs and circumstances surrounding their experience. The initial assessment should identify life-threatening situations, as well as the physical, psychosocial and social needs of the individual/family being served. The initial assessment should also identify

the strengths and capacities of individual/family, including the ability to make decisions.

- Homeless service providers assist individuals to develop and identify support systems that will continue to have significant, essential, and meaningful impacts on daily functioning.

Crisis Response

- Homeless service providers perform an assessment to determine that proper services are delivered and coordinated for an individual/family in a crisis situation. A crisis situation is defined as one that compromises the functioning of the individual or family. The goal is to ensure the necessary care is available during and following the crisis episode.

- Homeless service providers should be aware of the mandatory reporting laws in their State and adhere to all reporting requirements (State of Tennessee, 2004).

- Homeless service providers should be knowledgeable of the crisis continuum in their area and be effective in accessing crisis services through 911, Crisis Stabilization Unit, Mobile Crisis Unit, or an emergency room.

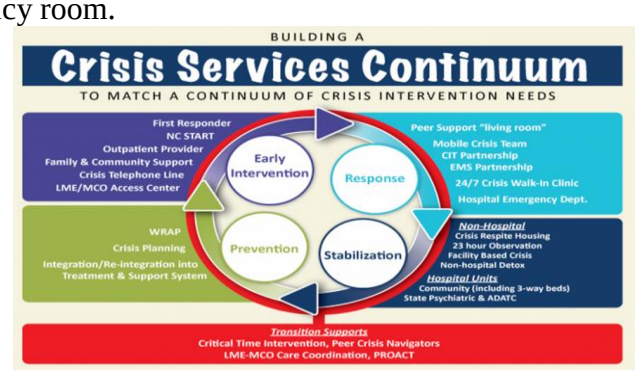

Figure 2.1 Crisis Continuum

Coordination, Collaboration, and Facilitation

- When working in a multi-agency/multi-disciplinary team, effort must be made to identify one "lead" case manager who can ensure effective and efficient coordination of care. Moving homeless individuals/families into housing often demands the coordination of a variety of services – services that may be provided by multiple agencies and homeless service workers. If ample attention and effort is not made to continue to communicate during coordination/collaboration, there is risk for duplication of services or confusion about roles and tasks. More importantly, poor communication and/or role definition may result in a negative outcome, which may include damage to the individual/family seeking housing.

- As the designated tool for Coordinated Assessment, the assessment of person(s) experiencing homelessness is to be documented in the Knoxville Homeless Management Information System (KnoxHMIS) (i.e. intake, case

notes, services, referrals, and community prioritization). Secondary or more mainstream service providers (e.g. local hospitals, schools, community behavioral healthcare, housing authority, re-entry programs, and career centers) whose primary work is not focused on the homeless, but who interface regularly with those who are homeless or at risk of homelessness, must find practical means to interface with KnoxHMIS. Each community has been tasked by the Department of Housing and Urban Development to form Coordinated Assessment (§ 24 CFR 578.3, 2012). Our community has adopted a virtual "No Wrong" approach (Department of Housing and Urban Development, Coordinated Assessment, 2013) . In order to meet this requirement, *Knoxville's Plan to Address Homelessness* designates KnoxHMIS as the primary data collection tool to facilitate coordination of care across the continuum of service providers.

Figure 2.2 TN-502 No Wrong Door

Linkage, Referral, and Advocacy

- Homeless service providers identify needed services for which the individual/family is eligible and assists them with meeting the referral-to-service prerequisites (i.e. birth certificates, social security card, identification, etc.)

- Subsequently, homeless service providers assist with linking the individual/family to the appropriate service, meaning that they must ensure that the individual/family requiring the service are receiving the care needed from the other agency/provider.

- Providers advocate for individuals/families when they are unable to do so for themselves and assist individuals with tasks that are identified on their case plan.

- Services could include behavioral health, physical health, housing, financial assistance, food, governmental services, etc.

Crisis Intervention

- The goal in a crisis situation is to ensure the necessary care is available during and following the crisis episode.

- Homeless service providers assess then intervene to ensure that proper services are coordinated and delivered for an individual/family in a crisis situation.

Dignity and Worth of Individual/Family

- All service referrals, coordination, and planning are done in collaboration with the individual/family being served in an effort that respects the individual/family's self-determination.

- Empowering individuals/families can result in a higher degree of motivation. Focusing on their strengths, needs, abilities, and preferences drives personal goal attainment and service planning.

- Homeless service providers honor the dignity and worth of the individual/family. Case managers should respond respectfully and effectively to individuals of all cultures, languages, races, ethnic backgrounds, religions, etc., in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each.

Case Planning

- Planning is a collaborative process with the case manager, individual/family being served and their support system.

- Homeless service providers, in collaboration of the individual/family being served, are tasked with designing a plan that is focused on the individual/family being served.

- Case plans must have specific goals and measurable objectives that are directed toward self-sufficiency. Any services provided should be driven by the goals identified on the care plan.

- Case plans should be reviewed with the individual/family regularly.

- Case plans should be developed according to the individual/family's strengths, needs, abilities, and preferences.

Continuity of Care

- Transitions between services and/or service providers require clear communication between parties to ensure that care is maintained during and after the transition.

- It is the responsibility of the case manager to confirm that rationale for the service is understood and that the transition is agreed upon by the individual/family being served.

(This Section has been adapted from: Case Management Society of America, 2010)

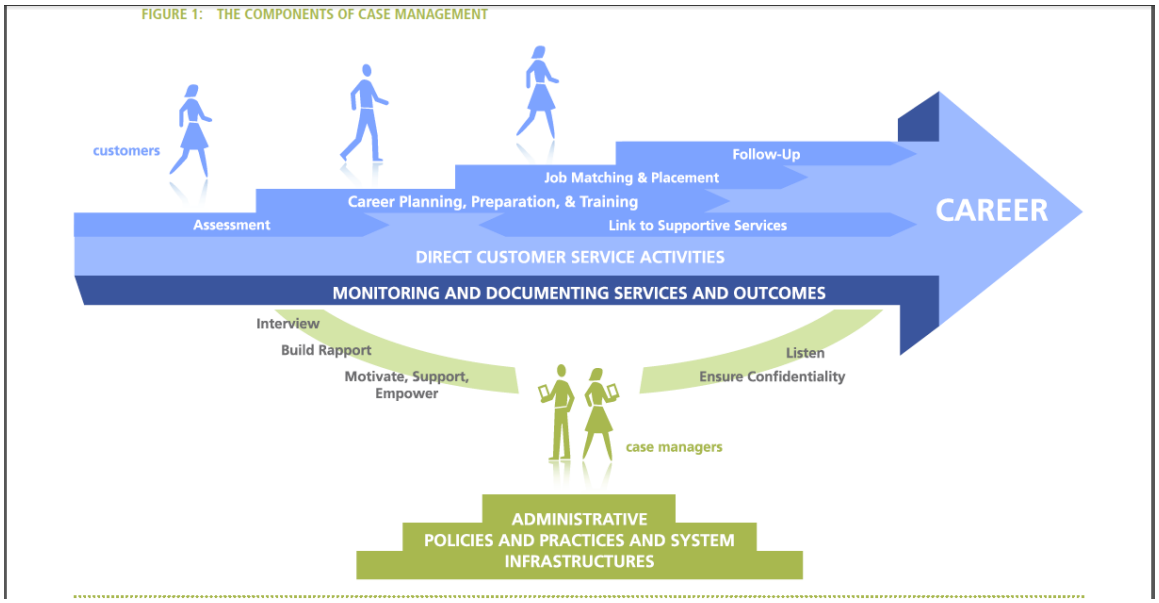

Figure 2.4 Components of Critical Service Elements

Section 3: Screening and Access to Services

The purpose of screening is to determine an individual's or family's needs, eligibility, and goodness of fit. Clearly defining screening processes and eligibility provides transparency for the individual/family seeking services to understand how to access services to meet their needs and expedite their goals. In regards to screening/access to services, case management/outreach programs should implement systems to reduce barriers and minimize the times between initial contact, screening, and admission/referral.

Specifically, case management/outreach programs should implement policies and written procedures that define:

- The screening process
- Eligibility criteria
- Exclusionary criteria
- Process for program re-entry after being previously discharged

When screening is conducted, it:

- Is clearly documented

- Identifies a review of the individual's eligibility
- Documents alternative resources provided if the individual is ineligible for the program
- Gives priority to urgent needs and emergency situations

Section 4: Orientation

Program orientation allows individuals to understand the breadth of services offered, inform the individuals of agency policy and procedures, define roles of parties involved in the case plan, and outline expectations.

Each individual/family who enters the program receives an orientation that:

- Occurs during the initial visit
- Is provided in a way that meets the individual's/family's comprehension level (i.e.: addresses literacy level, overcomes language barriers, etc.).
- Is documented

Each orientation includes the following:

- Rights of the individual/family being served
- Expectations of the individual being served and of the agency serving the individual
- Clear identification of those who are to provide agency services
- Confidentiality policies and standards of conduct from agency
- Discharge criteria and process for program re-entry
- Grievance procedures
- Inform individual/family of appropriate crisis services and after-hours emergency services
- Familiarization with premises, as applicable

Section 5: Assessment

The purposes of an assessment are to (1) assess an individual's/family's safety, immediate needs, level of functioning, extent of homelessness, mental and physical health, legal history, substance abuse concerns, income/ benefits needs, strengths and capacity for decision making, specific wants or wishes of the individual/family, and (2) coordinate care of services provided to the individual to expedite their stability.

Individuals/families engaged in the case management program participate in an assessment that is:

- Comprehensive
- Strengths-Based
- Person-Centered
- Culturally Responsive

The assessment process:

- Is conducted by qualified personnel, as deemed by the agency's accrediting body(ies)
- Attempts to discern immediate and life threatening situations
- Focuses on the individual's needs (i.e. identifying both immediate and long term needs)
- Identifies the individual's/family's goals and expectations
- Identifies all service providers with whom the individual/family is engaged
- Identifies service providers with whom the individual/family is eligible and appropriate for referral
- Coordinates with service providers with whom the individual/family is currently engaged as appropriate and with informed consent
- Occurs within appropriate timeframes; generally within one week of initial contact or admittance to the program.

The assessment process gathers the following information (at a minimum):

- Presenting problems/needs from the individual's/family's perspective
- Urgent needs including risk to self or others
- Individual's/family's reported strengths, needs, abilities, and preferences
- Current and previous service providers
- Universal and program-specific data in the Knox Homeless Management Information System as outlined in the HUD Data Standards.
- A review of life domains should be recorded in the case plan. The following items should be included as a life domain, as appropriate to the individual's or family's psychosocial needs:

- *Shelter/Housing*, including preferences, eligibility for various housing sites, housing affordability level (i.e. not more than 30% of individual's income)
- *Basic Needs*, including food/nutrition and the need for household furnishings, eating utensils, hygiene products, and basic cleaning supplies
- *Income,* including sources, amounts, assessment of adequate income to meet housing needs, credit/debt assessment and budgeting needs
- *Employment,* including eligibility, work history, current employment, and preferences
- *Education,* including identification of literacy concerns, education history and need for additional education/vocational training
- *Independent Living Skills*, such as hygiene and activities of daily living, including an assessment of need for assistance with daily tasks
- *Social Support*, including assessment of family support systems and community involvement
- *Parenting*, including an assessment of need and preferences regarding parenting classes, childcare, and education
- *Safety*, including crisis intervention planning, assessment of abuse/neglect, and housing environmental review
- *Physical Health History*, including healthcare coverage and any needed housing accommodations for physical disability
- *Mental Health History,* including determination of disability, services received, and need for further treatment
- *Legal History*, including outstanding events, compliance, and need for legal assistance
- *Substance Abuse History*, including need for treatment
- *Transportation,* including access and barriers
- *Communication Preferences*, including English proficiency and/or need for assistive technology such as language lines and/or alerting devices for individuals with hearing, voice, speech, or language disorders

Section 6: Case Planning/Evaluation

Each assessment results in the development of a case plan that is the basis for delivery of services. Services should be flexible, responding to the unique needs of individuals while respecting cultural and ethnic backgrounds of the recipient. All services should be informed by safety guidelines for both recipients and staff members.

The documented case plan is:

- Developed with the individual's/family's active participation
- Based on the information obtained during assessment
- Based on the strengths, needs, abilities, and preferences of the individual/family
- Focused on the integration of the individual/family into their community and natural support systems
- Agreed upon by the individual/family being served and service provider(s).

The case plan contains the following elements:

- Goals that are expressed in a way that is understandable and/or meaningful to the individual/family being served
- Goals that are actualized into specific, measurable objectives
- Objectives that are achievable and maintainable (especially when looking at obtaining housing)
- Objectives that are time-limited
- Services and supports to be provided, and by whom
- Frequency of interventions or services to be provided

The case plan is reviewed routinely as appropriate to the program type (e.g. Emergency Shelter, Transitional Housing, Permanent Supportive Housing, Homeless Prevention, Rapid-Rehousing, Supportive Services Only, or Street Outreach) with the individual/family being served and updates documented as appropriate.

Section 7: Care Coordination

Care coordination is the practice of organizing and sharing information amongst multiple agencies or providers who may be serving the same individual/family. The goal of care coordination is to achieve unduplicated, comprehensive, effective care with an individual/family as work is done toward housing placement and stability.

- Case managers assist with referral/linkage to those community supports indicated in the case plan.

- Case managers assist in the coordination of the individual's/family's behavioral health and physical health care services.
- Case managers advocate as needed on the individual's/family's behalf to reduce barriers to needed services.
- Case Managers request releases of information for all other providers engaged in serving the individual/family and coordinates services as needed.
- Case Managers document:
    - The individual's/family's ongoing progress toward goals
    - Barriers to goal attainment
    - Plan to address barriers
    - Significant events or change in the life of the individual/family
    - All referrals, linkage, and advocacy

Section 8: Housing Placement

- Housing should sufficiently match the individual/family's level of functioning.
- Housing options should be appropriate to address the specific needs of the individual/family.
- Case managers responsible for housing placement should link individuals with options that are consistent with the individual's/family's housing plan/preferences and subject to current availability and eligibility criteria established by the provider.
- Once an individual/family is housed, providers should ensure households are adequately furnished with a bed, a chair, cookware, eating utensils, hygiene products, basic cleaning supplies and towels. If other items are needed and can be collected for the individual/family, those items, too, should be gathered.
- Housing should be safe, clean and meet Housing Quality Standards established by the Federal Department of Housing and Urban Development (US Housing and Urban Development, 2001).
- Housing should be well maintained, meeting all applicable building and safety codes (Department of Housing and Urban Development, ESG Minimum Habitability Standards, 24 CFR 576.403). The placement should have the capacity and strive to make repairs in a timely manner.
- Housing should meet energy efficiency standards.
- Case managers assisting individuals/families in locating and securing affordable market housing should ensure that such housing meets comparable market rent guidelines (Tennessee Housing Development Agency, 2015) and rent is

reasonable (Department of Housing and Urban Development: HOME Rent Limits, 2015) in comparison to participant's income (Department of Housing and Urban Development, HOME Income Limits 2015). Average monthly cost of utilities should also be considered before housing placement is made to ensure affordability.

Section 9: Transition and/or Discharge

Transition/Discharge care is defined as a set of actions designed to ensure the coordination and continuity of care as individuals transfer between different locations or different levels of care. It includes logistical arrangements, education of the individual/family, and coordination among the professionals involved in the transition. Transitional care, which encompasses both the sending and the receiving aspects of the transfer, is essential for persons with complex needs. Special attention should be made to prevent feelings of abandonment by the individual/family during the transition/discharge process.

Transition planning is initiated at intake, involves the individual/family being served, and includes:

- Identifying criteria that indicate that the individual/family served is ready to successfully discharge from the program (i.e. what goals will be met)
- Identifying factors that indicate that the individual/family served needs a higher or different level of care
- Identifying needed support systems or services to assist the individual/family in maintaining their progress

When the individual/family served is successfully discharged from the program, the following should be provided:

- Needed support systems and methods to access
- Names and contact information for all service providers and natural supports
- Dates/times of any scheduled appointments
- Process to contact terminating service provider with questions or request for program re-entry.

Case managers should make attempts at follow-up with individuals/families following transition/discharge to ensure a seamless transition of services. This follow-up should only be conducted with the prior permission of the individual/family being served.

Agencies providing *outreach* services should define follow-up timelines that help individuals or families track short-term and long-term progress toward goals that were identified during the assessment.

Individuals/families shall be offered case management services to ensure that they maintain residential, financial and personal stability after housing placement. Individuals/families provided assistance in locating and securing affordable housing should be provided case management for a minimum of ninety days following the date of the housing placement.

Case manager provide landlords/property managers with agency contact information and inform them if/when terminating services with individual or family.

The individual/family should have a case plan that addresses sustainability (and support services put in place as needed) in the areas of: income, health care, mental health care, substance abuse, housekeeping/life skills.

(This Section has been adapted from: Commission on Accreditation of Rehabilitation Services, *2014)*

Section 10: Case Loads

The type and mix that case managers carry varies from agency to agency. It is important to remember that caseloads do not always accurately reflect workload, as some cases invariably are more complex and require more care than others.

- It is generally recommended that case managers work with 25 individuals; however, the actual caseload may need to be lower for individuals/families that present acute needs in service or to account for those individuals who cannot be located by the case manager. There are also instances that may cause an increase in case loads such as when individuals/families are stabilized and only require periodic and/or long-term follow-up.

- Caseloads should be continually reviewed to ensure case managers have the needed time to balance service provision and systemic, community barriers.

- Caseloads are determined by the complexity of needs of the individual/family. If a case manager works primarily with individuals/families that have needs that extend beyond housing (i.e. mental health concerns, substance abuse concerns, etc.), the caseload should be decreased to allow management tasks.

- Caseloads should be reflective of the other professional obligations of the case manager. If the case manager performs other functions within an agency, such as direct service delivery of administrative tasks, caseloads should be decreased to allow those functions to be done competently.

Section 11: Staffing

Case Managers will work with individuals/families in a professional service environment, employing all the skills and practices necessary to ensure that resources are obtained and coordinated to meet their needs.

- Case Managers should maintain competence and qualifications in their area of service that meets the agency's accrediting body(ies). It is recommended that the case manager have, at a minimum, a degree in social work, or another health and human services field that promotes the physical, psychological, and/or vocational well-being of the persons served.
- Case managers should be open, good listeners who are nonjudgmental.
- Case managers should be competent communicators and be able to speak to the various needs of the individual/family to community providers.
- Case managers should be able to treat individuals/families with respect and dignity, with an awareness of cultural competency.
- Case managers must be knowledgeable of a variety of available services, the service landscape of their community, and ways to access those services.
- Case managers should receive regular training that includes, but is not limited to: care for the caregiver, use of standards and ethical conduct, avoiding burnout, available community resources and how to access them, diversity, and other practices to enhance professional development. In addition, it is recommended that case managers should be trained in First Aid, CPR, and crisis de-escalation (e.g. *Handle With Care* or *Crisis Prevention Intervention*) as appropriate to their job duties and work environment.
- Agencies need to provide clear job descriptions and expectations for their case managers, as well as conduct annual performance measures and evaluations.

References

Case Management Society of America (2010). Standards of Practice for Case Management. Retrieved May 12, 2015, from http://www.cmsa.org/portals/0/pdf/memberonly/standardsofpractice.pdf

Centers for Medicare and Medicaid Services (2008). Retrieved May 12, 2015 from http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/DataCompendium/16_2008DataCompendium.html

City of Knoxville Office on Homelessness (2014). Knoxville's Plan to Address Homelessness. Retrieved May12, 2015, from http://www.cityofknoxville.org/development/homelessnessplandraft2014.pdf

Commission on Accreditation of Rehabilitation Services (2013). Behavioral Health Standards Manual. Retrieved May 12, 2015, from http://www.access2counseling.com/assets/2013-bh-sm.pdf

Department of Housing and Urban Development (2013). Coordinated Assessment – Models and Principles Under the CoC Program Interim Rule. Retrieved May 16, 2015, from https://www.youtube.com/watch?v=9j9faz1cHQQ&feature=youtu.be

Department of Housing and Urban Development (2014). HUD HMIS Data Standards Manual. Retrieved May 16, 2015, from https://www.hudexchange.info/resources/documents/HMIS-Data-Standards-Manual.pdf

Department of Housing and Urban Development (2012). Homeless Emergency Assistance and Rapid Transition to Housing: Emergency Solutions Grants Program and Consolidated Plan Conforming Amendments, § 24 CFR 576.400 . Retrieved May 12, 2015, from https://www.hudexchange.info/resources/documents/HEARTH_ESGInterimRule&ConPlanConformingAmendments.pdf

Department of Housing and Urban Development (2012). HUD Exchange:

Emergency Solutions Grants Minimum Habitability Standards for Emergency Shelters and Permanent Housing, 24 CFR 576.403. Retrieved May 16, 2015, from https://www.hudexchange.info/resource/3766/esg-minimum-habitability-standards-for-emergency-shelters-and-permanent-housing/

Department of Housing and Urban Development (2015). HUD Exchange: HOME Rent Limits. Retrieved May16, 2015, from https://www.hudexchange.info/manage-a-program/home-rent-limits/

Department of Housing and Urban Development (2015). HUD Exchange: HOME Income Limits. Retrieved May16, 2015, from https://www.hudexchange.info/manage-a-program/home-rent-limits/

Department of Housing and Urban Development (2001). Voucher program Guidebook: Housing Choice, Chapter 10. Retrieved May 15, 2015, from http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/hcv/forms/guidebook

State of Tennessee (2004). Programs and Services for Abused Persons: Part 1 Adult Protection, TCA Chapter 6. Retrieved May 16, 2015, from http://www.state.tn.us/humanserv/adfam/aps-act.pdf

Tennessee Housing development Agency (2015). HUD Fair Market Numbers: Knoxville, TN. Retrieved May 16, 2015, from https://www.socialserve.com/landlord/HelpfulLinks.html?city_id=49385&ch=TN