

Housing Case Management

Funded by the Division of Housing and Neighborhood Development (DHND), in collaboration with the Mayor's Office of Health Policy and AIDS Funding (OHP)

Implementation: January 1, 2005 – December 31, 2005

Availability of HOPWA Funding

The Division of Housing and Neighborhood Development (DHND) announces the availability of funds for the implementation of a pilot case management program called Housing Case Management.

Application for Funding and Agency Requirements

The standard DHND NOFA application, process, and forms will apply.

Application Deadline

November 15, 2004 by 4:00 PM.

Budget

The standard DHND NOFA budget forms apply. Budgets for this program must include and are limited to the following:

- Two (2) full-time case managers
- One (1) part-time case manager supervisor
- Fringe benefits
- Training for case managers and inpatient facility support staff
- Local mileage for case managers
- Computers (if need can be documented for the implementation of Factors)
- One (1) part-time Data personnel (if need can be documented for the implementation of Factors)
- Maximum administrative cost of seven percent (7%)

HOUSING Case Management Description

Housing Case Management (HCM) is a HOPWA-funded centralized model of case management that utilizes a case manager to ensure that eligible HIV-infected persons and families in inpatient settings gain and maintain access to medical care. Inpatient settings are defined as transitional or long-term housing facilities where clients receive medical and housing referral assistance, and supportive services such as substance abuse and mental health counseling. HCM consists of a range of client-centered services that link clients with primary medical care, psychosocial and

other support services. The goal is to ensure timely, coordinated access to medically-appropriate levels of health and support services, continuity of care, ongoing assessment of the client's and other family members' needs and personal support systems. Inpatient case-management services prevent unnecessary hospitalization and expedite discharge from inpatient facilities as medically appropriate.

Key activities include initial assessment of the client's needs and personal support systems; development of a comprehensive, individualized service plan; coordination of services required to implement the plan; client monitoring to assess the ongoing effectiveness of the plan; and periodic reevaluation and revision of the plan as necessary, which may include client-specific advocacy and/or review of service utilization.

Legal Authority

HIV/AIDS Bureau (HAB) Policy 99-02 establishes guidelines for allowable housing-related expenditures under the Ryan White CARE Act. This policy emphasizes coordination of services and funding between CARE Act and HOPWA-funded agencies. According to HAB, forty-four percent (44%) of housing providers that receive CARE Act funds also receive grants from the HUD Housing Opportunities for People With AIDS (HOPWA) program. The HOPWA program is a flexible block grant that can be used for a wide range of housing and housing-related services for people living with HIV/AIDS including all services allowed under the CARE Act.

Intent and Purpose of Housing Case Management

The policy of the Division of Housing and Neighborhood Development (DHND) is to target its funding toward housing initiatives and to direct all support services toward Ryan White CARE Act-funded programs. In order to ensure that inpatient clients get the needed medical care and maintain that care, DHND and the Mayor's Office of Health Policy and AIDS Funding (OHP) combined resources to develop Housing Case Management for implementation in FY 2005.

The overall purpose of HCM is to develop and implement a service delivery strategy that will fill the gaps in care between inpatient facilities and the Ryan White continuum of care. HCM is also

intended to ensure that the Title I continuum of care maintains the capacity to meet the needs of inpatient clients.

Goals of Housing Case Management

- To coordinate medical access and support services between inpatient facilities receiving HOPWA and/or Ryan White CARE Act funds and the Ryan White continuum of care.
- To develop long-term housing strategies for clients in inpatient care (see *Long-Term Housing Strategies for Clients* in the following section).
- To provide ongoing training to case managers and housing support staff regarding available community resources, coordination of services, assessment of needs, and case planning and monitoring.
- To increase the capacity of the Ryan White Title I case management system.

Long-term Housing Strategies for Clients¹

Most case managers and housing services providers conduct intake interviews and needs assessments at the time of program entry for persons receiving housing services. Many also develop in-depth individualized service plans with a client to outline the goals and objectives for that client's participation in the program. This is particularly true in emergency and transitional housing programs, which are intended to address a range of client issues in addition to the housing need.

Under the HAB housing policy, providers must ensure that proper documentation of the need for housing is obtained from qualified professionals, and that the certification is kept with the client's file, as described above. The case manager or housing provider also must develop a housing strategy to identify long-term housing options for the client that will be paid for by sources other than CARE Act or HOPWA funds. This may be a separate plan, or a part of a broader individualized service plan.

¹ Housing is Healthcare: A Guide to Implementing the HIV/AIDS Bureau (HAB) Ryan White CARE Act Housing Policy. U.S Department of Health and Human Services, Health Resources and Services Administration (HRSA), HIV/AIDS Bureau. 2001.

The emphasis of the housing strategy is on identifying and obtaining other funding resources to assist the client long-term, if necessary. The strategy is not intended to require that the client move to a new location. Some clients currently live in housing for which another subsidy may be found, minimizing displacement. In other cases, continued assistance may require a move to an assisted facility. In many cases, the objective of the housing strategy will be to transition the client off housing assistance altogether.

Good housing strategies assess the client's ability to live independently, to pay rent, and to live with or without specific types of supportive services. Assessments should take into consideration a client's:

- Current and potential income;
- Credit and rental histories;
- Health;
- Mobility;
- Household size;
- Familial or community support; and
- Any other factors which may qualify or disqualify him/her from certain types of housing assistance in the community.

Housing strategies will also need to consider the availability of long term housing subsidies in determining realistic time frames and options. In a community with a ten-year wait for Section 8 housing, waiting for a certificate to become available is not a realistic transition plan. Case managers and housing providers will have to work with clients specifically around planning to live without a subsidy if no other resources can be expected to become available within a reasonable period of time.

In developing the long-term housing strategy, a provider must identify sources other than the CARE Act or HOPWA to fund the long-term assistance required by the client. To do this, providers should make use of the information identified in the coordinated planning process described below to identify the most appropriate and likely alternative sources, if any, for each client.

As with the certification of need for housing services, long-term housing strategies will need to be updated and revised periodically, in keeping with the client's progress. Reassessment of the client's status and modification of the long-term housing strategy to respond to the client's current situation should occur as appropriate on an ongoing basis, but in all cases at least every six months.

➤ ***Case Management Standards of Care***

The New Orleans EMA provides case management services to clients in accordance with the standards that are developed and approved by the Service Delivery Committee of the New Orleans Regional AIDS Planning Council, approved by the Executive Committee, and then adopted by the whole council. These standards are developed by the Service Delivery Committee by incorporating guidelines from the Ryan White CARE Act and the Medicaid Case Management Services Provider Manual issued by the Louisiana Medicaid Program, Department of Health and Hospitals. In addition, the Service Delivery Committee consists of service delivery professionals who provide input on how best to design and implement services that will best meet the needs of clients and fill in the gaps in care.

Overview of Case Management Model

Over the last three years, the New Orleans EMA has placed emphasis on defining case management services, the structure of case management, and the role of case managers. This focus on case management has served as an analysis of the systems framework of case management. In this analysis, the New Orleans EMA has attempted to better understand and address issues surrounding “funds or payer of last resort”, “increased access to care”, “reduced disparity”, and “comprehensive, coordinated care”. Focus on these issues has been intended to ultimately ensure that each client achieves positive outcomes such as adherence to appointments and medications, and decreases in negative outcomes such as the number of emergency room visits, psychiatric crisis, incidents of violence or arrest, substance abuse, etc. In studying case management in the New Orleans EMA, the grantee has also begun to place greater focus on the various types of case management and their effectiveness, the role of the case manager in each type, and the practicality of each model within this EMA.

The implementation of Factors ©, which is a comprehensive client-level data system has also caused the EMA to look at centralization versus decentralization or fragmentation of case management services. This is important in order to ensure that the EMA can track clients through the system of care. This becomes particularly crucial when considering the clients who do not receive primary medical services from Title I primary medical physicians, but instead, from private doctors who may not have interaction with the Title I continuum of care and therefore would be less likely to notify the EMA that the client is in care. This lack of coordination becomes more evident if the client is not involved in “active case management” in which a case manager attempts to identify all care providers during the assessment and service delivery processes.

Entry into Case Management

Clients may currently enter case management through any of a number of routes: outreach; early intervention services (EIS), including HIV/AIDS counseling and testing; other prevention initiatives; emergency rooms; doctors, nurses, and other health care practitioners; social workers and other human service professionals; family members; self-referral; and other community entities. Referrals into case management will either consist of clients who have not received services from Title I previously or clients who previously received services then dropped out of the service delivery system, but who have re-emerged in need of services. Entry into case management will be facilitated by the intake specialist, who may also work in the capacity of case manager, in accordance with policies and procedures established by the service delivery committee of the Planning Council. When clients are referred to case management agencies, the intake specialist will complete a “Referral to Case Management” form or receive a completed form from the referring entity. Under this centralized case management framework, case management is the gateway to All Title I services, even primary medical care. This means that a client is not a Title I client and therefore not reimbursable for any Title I funds until they have been referred to Title I case management for access into the continuum of care.

Case Management Services

- Intake and Eligibility Determination (CEV)
- Assessments
 - Initial
 - Comprehensive
- Reassessments
 - Quarterly
 - Annual
- Comprehensive Plan of Care
- Building and Implementing Supports
- Monitoring Support Strategies
- Transition/Closure of Case

Implementation

➤ **Centralized Agency**

HOUSING case management (HCM) will be implemented by a single agency that will implement the HCM program. The centralized agency will contract with DHND to receive HOPWA funding for the implementation of HCM.

➤ **Monitoring**

Through Memorandum of Understanding with DHND, OHP will monitor the HCM program. Monitoring will consist of quality assurance of client care. DHND will continue to perform all fiscal and contract-related monitoring and audits.

➤ **Data Management**

The centralized case management provider must implement the Factors client level data system currently being implemented by Ryan White Title I.