Recording: https://youtu.be/olu1vw3A3D0

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CoC Training: Case Management 101

Natalie Siva &
Shelby Ferguson, H3

Contra Costa
Health, Housing & Homeless
Services Division (H3)

December 11, 2023

Housekeeping

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1. Respect the trainer(s)
2. Respect attendees
3. Make and take space
4. Share the mic
5. Acknowledge power and privilege

About

Continuum of Care Trainings: Monthly trainings for homeless service providers covering various topics such as Housing First, Trauma-Informed Care, and Mainstream Benefits

Hosted by H3 the **2nd Monday** of every month from **10am-Noon**

Required for direct service staff (case managers, care coordinators, etc.) and program managers and open to all

Required Trainings

Some trainings such as **Housing First** are required by our funder, the US Department of Housing and Urban Development **(HUD)** to ensure all programs and staff in our CoC operate under the same principles and practices

Other trainings are relevant trainings H3 and/or providers has identified as important such as **Housing Focused Case Management**

Monitoring

- Attendance is monitored by H3 staff and discussed during monthly/quarterly provider check-ins with CE Manager and/or CoC Administrator

- **Providers/programs lacking attendance at trainings can be subject to Corrective Action Plans**

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Agenda

- Introductions
- Test your Knowledge
- 4 goals of case management
- Best Practices
- Case Example – Break outs!
- Recognition and Survey

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Introduce yourself in the chat

Name, Agency, Role & favorite holiday dish

Test your knowledge

Shelby Ferguson

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Barriers

What gets in the way of doing your case management work?

a) Trying to manage your participant's behavioral health needs
b) Lack of training or support
c) Getting too emotionally involved
d) All of the Above

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Caseloads

How many people are currently on your caseload?

a) 1-10
b) 10-20
c) 20- 30
d) 30 +

Meetings

How long are your case management meetings with your participants (on average)?

a) 10 minutes or less
b) 30 minutes
c) 1 hour
d) More than an hour

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4 Goals of Case Management

Natalie Siva

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4 Goals of Case Management

1. Document Readiness
2. Increasing Income & Connecting to Benefits
3. Connecting to Services
4. Connecting to Permanent Housing*

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Housing Stability Plan

Shelby Ferguson

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Housing Stability Plan – Instructions

Step 1: Search and click on your participant's name in the search bar, which will take you to their profile page
Step 2: Once in the participant's profile, click on the 'Assessments' tab at the top

Don D Fake -test

PROFILE CONTACT LOCATION PROGRAMS SERVICES NOTES ASSESSMENTS FILES HISTORY REFERRALS

Step 3: Once in the 'assessments' tab, you'll see an assessment titled 'Stability Plan' – click start

ASSESSMENTS

Stability Plan START

Step 4: Once you've answered all the questions, click save at the bottom on the plan and you're done!

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Goal 1: Document Readiness

Natalie Siva

Test Your Knowledge!

Which housing documents do you know how to assist a participant in attaining? Click all that apply.

1) ID (identification card)
2) SSC (Social Security card)
3) BC (Birth certificate)
4) Income verification
5) Disability certification

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How to get your participants document ready

ID – use fee waiver form

Social Security Card – apply for a new SSC at your local SS office

Income Verification –

SSI: Make an account online (faster) : https://www.ssa.gov/manage-benefits/get-benefit-letter

CalWORKS, GA, Medi-Cal, CalFresh- make an account online (faster): Apply for Services | EHSD

Birth Certificates – California – Vital Records (fastest) : Obtaining Certified Copies Online (ca.gov)

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Disability Certification

DISABILITY CERTIFICATION

(Please complete all sections including signatures)

1. Name of Client: ____

The above named individual is a client of the ______________________________ program. As required by the US Department of Housing and Urban Development (HUD), we must verify the following self-reported disabilities before entering this information into the Homeless Management Information System: Mental health issues, chronic health conditions, physical/medical conditions, developmental disabilities.

A disability as defined by HUD is as follows:

(1) a disability as defined in Section 223 of the Social Security Act;
(2) a physical, mental, or emotional impairment which is (a) expected to be of long, continued and indefinite duration, (b) substantially impedes an individual's ability to live independently, and (c) of such a nature that such ability could be improved by more suitable housing conditions.
(3) a developmental disability as defined in Section 102 of the Developmental Disabilities Assistance and Bill of Rights Act;
(4) the disease of acquired immunodeficiency syndrome or any conditions arising from the etiological agency for acquired immunodeficiency syndrome; OR
(5) a diagnosable substance abuse disorder.

Other Definitions:

- *Mental Health Problem* – a mental health condition that is expected to be of long-continued and indefinite duration and may substantially impedes a client's ability to live independently. A mental health problem may include serious depression, serious anxiety, hallucinations, violent behavior or thoughts of suicide.
- *Chronic Health Condition* - a diagnosed condition that is more than three months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance. Examples of chronic health conditions include, but are not limited to, heart disease (including coronary heart disease, angina, heart attack and any other kind of heart condition or disease); severe asthma; diabetes; arthritis-related conditions (including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia); adult onset cognitive impairments (including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive related conditions); severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysema.
- *Physical/Medical* -a physical impairment which is (a) expected to be of long, continued and indefinite duration, (b) substantially impedes an individual's ability to live independently, and (c) of such a nature that such ability could be improved by more suitable housing conditions.
- *Developmental* - a severe, chronic disability that is attributed to a mental or physical impairment (or combination of physical and mental impairments) that occurs before 22 years of age and limits the capacity for independent living and economic self-sufficiency.

2. Please indicate the type of disability that is being verified (you may check more than one) and sign below to certify that the individual meets HUD's definition of said disability. Certification must be signed by a qualified licensed professional.

☐ Mental Health Problem: ____________ ☐ Chronic Health Condition: ____________

☐ Physical/Medical: ________________ ☐ Developmental

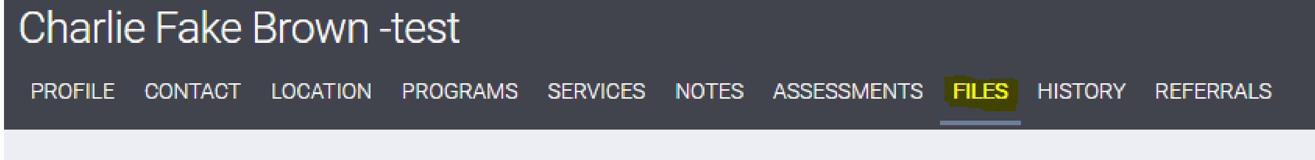
____________________ ____________ ____________________
Print Name *Date* *License No and License Type*

____________________ ______________________________
Signature *Contact Info (phone or email)*

Uploading Documents to HMIS

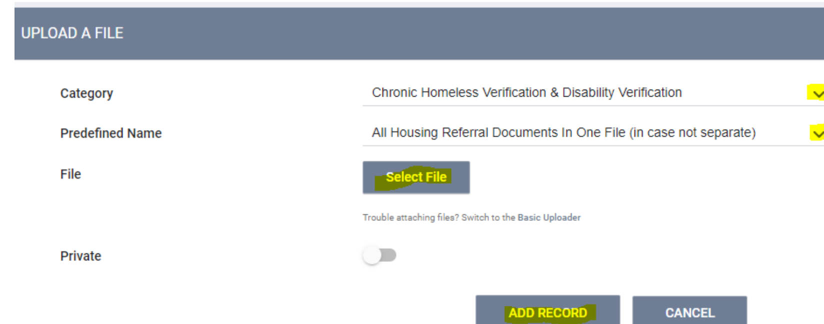
Step 1: Search and click on your participant's name in the search bar, which will take you to their profile page

Step 2: From their profile page, click on the global **'Files'** tab up at the top



Step 3: Once under files, click **'Add File'**

Step 4: Edit the category and name of the file you're uploading and click **'select file'** to upload a file you already have saved on your computer and click **'Add Record'**



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Goal 2: Increasing Income & Connecting to Benefits

Natalie Siva

Steps to Increasing Income

Increasing Income

- Budgeting
- Decreasing Expenses
- Forecasting Potential Income
- Connecting to benefits or employment

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Your job is to help your participants maximize their available income to pay for housing

By helping the participant increase income

and/or

By helping the participant decrease expenses

Budgeting

To know how much rent a person could currently pay, the first step is a budget assessment:

- **Current income**: sources and amounts
- **Current debts**: amounts and monthly payments
- **How much is currently available for housing?**
  - If that is not enough for housing, the gap is what you and the participant must seek to close.

Remember: Without a deep, permanent subsidy, many participants will pay more than 50% of their income for housing.

see budgeting template

Increasing Income through Employment

Questions to Ask:

- What kinds of jobs are they interested in and what do they pay?
- What is their projected income? Will that pay the rent?
- If they are on disability, how many hours can they work?
- Are there health risks associated with this person working?
- Do they need child-care to go to work?
- What about transportation to get to work?

- **Resources**:
  - **Contra Costa Workforce Development:** Bounce Back Contra Costa | Workforce Development Board of Contra Costa County (wdbccc.com)
  - **Rubicon:** Rubicon Programs

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Connect your participants to benefits:

- CalFresh, CalWORKS, General Assistance and Medi-CAL: BenefitsCal. Together, we benefit.
- WIC: Apply for WIC Today :: Public Health :: Contra Costa Health (cchealth.org)
- SSDI: Apply Online for Disability Benefits (ssa.gov)
- SSI: Apply for Supplemental Security Income (SSI) | SSA
- Medi-Care and Medi-Cal: CCHP Medi-cal :: Health Plan :: Contra Costa Health (cchealth.org)
- VA Benefits: Home - VA/DoD eBenefits

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Combining Benefits and Earned Income

COMBINING BENEFITS WITH EARNED INCOME MIGHT BE NECESSARY

KNOWING HOW/IF THESE CAN BE COMBINED IS IMPORTANT

Decreasing Expenses

- Food Pantries
- Clothing closets/consignment shops
- Nonprofit/religious furniture donations
- Daycare vouchers
- Bus passes
- Reducing Storage Units

Forecasting Potential Income

How do you forecast income?

- Forecasting future revenue involves looking at a household's previous income to determine a realistic future income.

- For example, if a person was earning $15-20 an hour at their previous job, would it be realistic to for them to find housing based on hopes they will find a job earning 2-3 times that? Of course this is possible, but may not be realistic right now.

Test your Knowledge!

How can you help your participants prepare for housing?

a) Budgeting
b) Increasing Income
c) Decreasing Expenses
d) Forecasting Potential Income
e) All of the Above

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Goal 3: Connecting to Services

Natalie Siva

Connecting Participants to Services

Services

- Behavioral Health Services:
  - Alcohol and Other Drugs **(AOD)**
  - Mental Health
  - Enhanced Care Management **(ECM)**
  - CalAIM
- Healthcare for the Homeless **(HCH)**
- VA healthcare
- Legal Services
- Transportation
- In Home Supportive Services **(IHSS)**

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Contra Costa Health Plan - Finding a Mental Health Provider

Mental Health Access: 1-888-678-7277

- Ask your primary care provider
- Search for a CCHP mental health provider on our website. You can search for CCHP mental providers using our online provider search tool or by downloading the list on our Publications / Member Materials webpage. All CCHP members can access mental health providers from either the Regional Medical Center (RMC) or Community Provider Network (CPN).
- **Call CCHP's Mental Health Line for help finding a mental health provider.** Call 1-877-661-6230 (Option 4) (TTY 711 for hearing or speech impaired)

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Connecting to Services – Alcohol and Other Drugs (AOD)

Visit Online: Alcohol & Other Drugs Services :: Behavioral Health :: Contra Costa Health (cchealth.org)

Or Call

Behavioral Health Access Line

800-846-1652 (Call Toll Free)

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Connecting to Services – Physical Health

- **County Clinics:**
  - Clinic locations: Medi-Cal :: Contra Costa Health Services :: Contra Costa Health (cchealth.org)
  - Making an Appt: How to Make an Appointment :: Contra Costa Health Services :: Contra Costa Health (cchealth.org)

- **Health Care for the Homeless (HCH):**
  - For Schedule and Services Offered: Health Care for the Homeless :: Public Health :: Contra Costa Health (cchealth.org)

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What barriers do you experience when connecting your participants to benefits and services?

Raise your hand or answer in the chat!

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Goal 4: Connecting to Permanent Housing

*Including shared housing!

Test your Knowledge!

What is the most common barrier you see to getting your participants housed?

a) Not being open to shared housing
b) Eviction
c) Poor credit history
d) No rental history
e) Criminal history
f) Low income
g) All of the above

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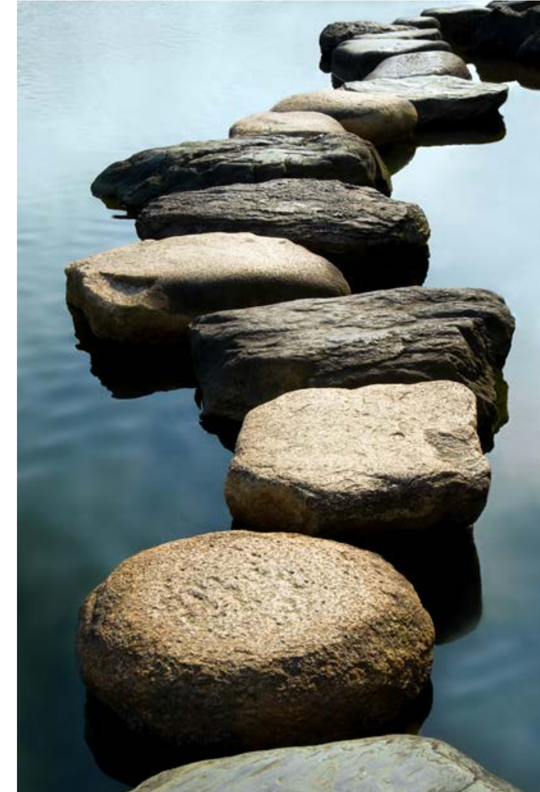
Types of Permanent Housing

- **Rapid Rehousing*** (RRH) – placements through Coordinated Entry
  - Shared Housing
  - Staying with Friends or Family (permanent)
- **Permanent Supportive Housing** (PSH) – placements through Coordinated Entry
- Affordable Housing
- **Vouchers** - placements often through Coordinated Entry



A Note on Coordinated Entry Prioritization

- Currently using the VI-SPDAT as the Coordinated Entry Housing Needs Assessment
- Prioritize by VI-SPDAT score and length of time homeless

Step 1: Conduct a VI-SPDAT (housing needs assessment) with your participant
Step 2: Add the participant to the Community Queue in HMIS

After you've completed and saved the VI-SPDAT, you'll be taken to this screen. Click 'Refer Directly to Community Queue(s)' and your participant will be added to the Community Queue.

VI-SPDAT-V2 Score Summary

GENERAL	0
HISTORY OF HOUSING & HOMELESSNESS	0
SOCIALIZATION & DAILY FUNCTION	4
VI-SPDAT-V2 PRE-SCREEN TOTAL	**7**

Housing Queue

REFER DIRECTLY TO COMMUNITY QUEUE(S)

Test your Knowledge

Which is NOT one of the 4 goals of case management?

a) Addressing client interpersonal issues
b) Increasing income and benefits
c) Connecting to services
d) Document readiness

Best Practices

Shelby Ferguson

Models

Motivational Interviewing

Trauma Informed Care

Housing First

Harm Reduction

Critical Time Intervention

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Case Study – Break Out Groups!

Please identify one note taker and one person to report out

Case Study

You are working with a single adult who has been at the shelter for over a year. They are on a fixed income, not able to increase and they have a disability. Their name comes up for Rapid Rehousing and they said they are not interested in shared housing. This same person also came up for a shared permanent supportive housing unit where they would have their own room in a shared apartment, and they have declined both options.

Questions:

1) **Where do you go from here?**
2) **How do you have a conversation with this person about their housing options?**
3) **How do you educate the person on the reality of the current rental market and shared housing?**

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Group Report Out

One person reports out from each group

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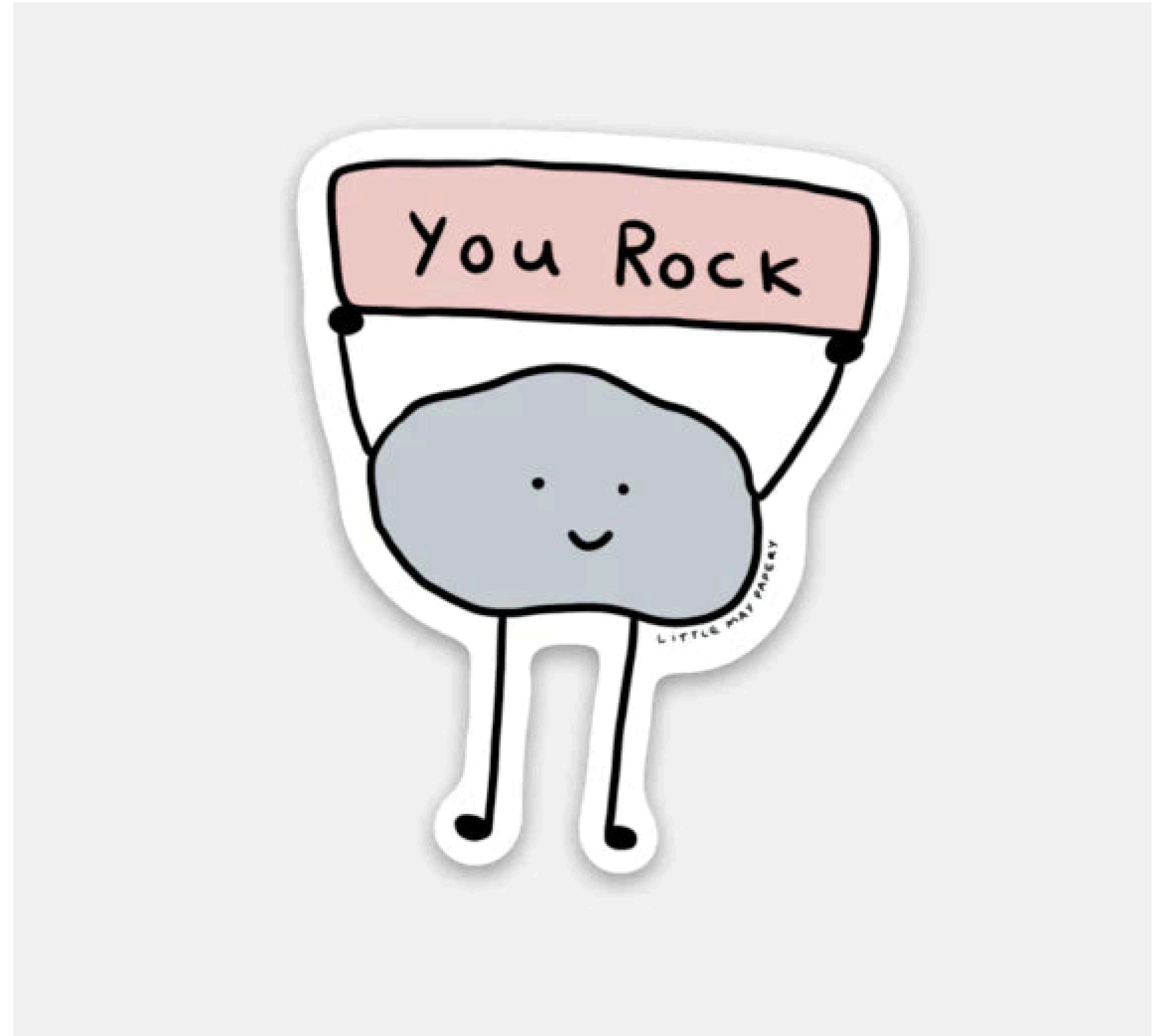
Recognition

Recognize a case manager for their outstanding work!



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Survey

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Questions

Natalie Siva : Natalie.Siva@cchealth.org

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Thank You!

Next Training:
Monday, January 8th , 2024
10:00am – 12:00pm