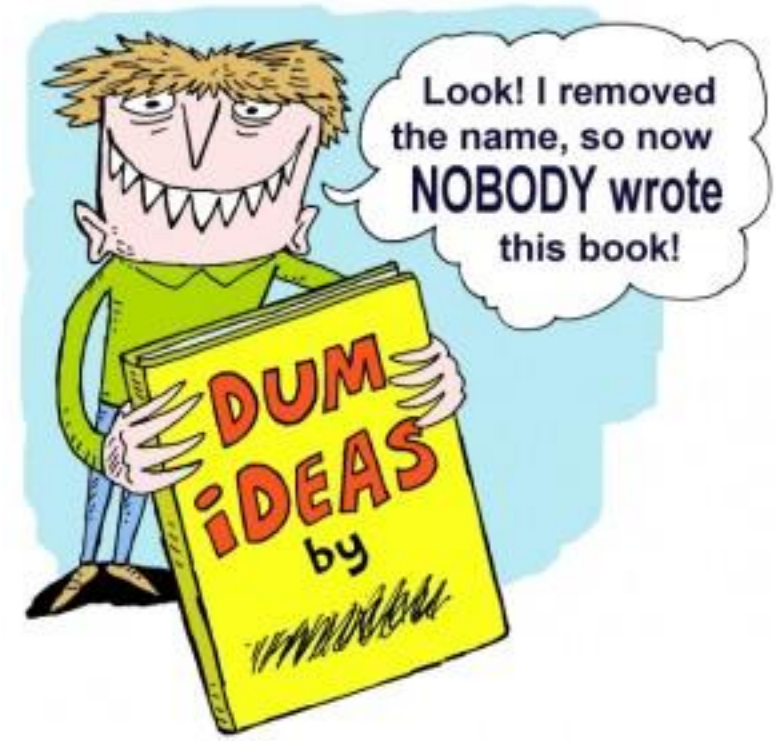

Urban Strategies, Inc.

Case Management Handbook

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PREFACE

Purpose of this Handbook

The intent of this handbook is to structure the delivery of case management programs designed by Urban Strategies. It is best used as a reference guide, in conjunction with technical information and guides that govern the use of the *Efforts To Outcomes (LEARN)* database that will be the repository of the majority of program related data. This handbook will describe:

1. Workflow and tasks
2. How to maintain good quality paper and electronic records
3. Key aspects of quality assurance, performance management and regulatory compliance
4. Fiscal responsibilities of direct service staff
5. Supervisory responsibilities
6. The role of site-based staff versus central office staff in ensuring data quality

Urban Strategies loves data! Being data-driven means keeping it real.

However, Urban Strategies does not believe in collecting data. Urban Strategies believes in obtaining information that is necessary to provide high quality services.

Resident participants provide most of the information needed for case management. This handbook illustrates how to respectfully and legally obtain information.

Formal authorization is required if personal information is requested from, or shared with other parties. All personal information is obtained exclusively for providing services that benefit resident participants.

The success of Urban Strategies programs hinges on excellent customer service.

Resident participants are more willing to share when case managers demonstrate empathy, skill and trust.

Collecting data is necessary but not sufficient to help resident participants achieve their goals.

Often, not much information, not even informed consent, is needed to provide tangible and meaningful support.

DISCLAIMER

The handbook guides the activities of site-based case management staff unless otherwise specified by a member of Urban Strategies Executive Team. Staff is required to participate in training and seek supervisor's help when clarity is needed.

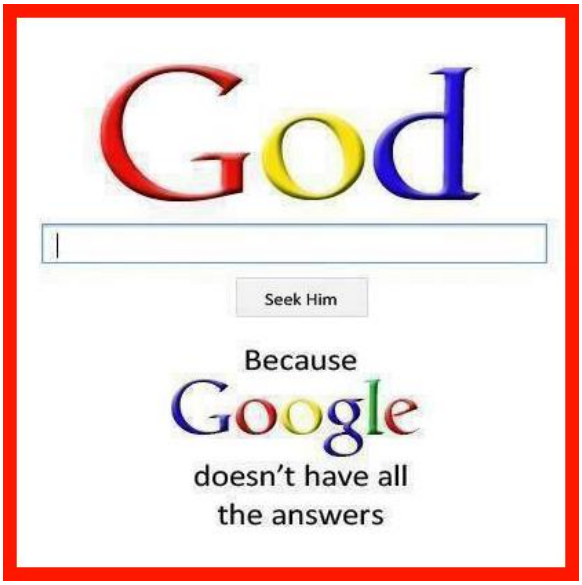
However, this handbook does not replace or negate the need for:

1. Assigned job duties/responsibilities
2. Supervision and staff training
3. Leadership in identifying and solving problems
4. Quality control audits and program evaluation
5. Personnel evaluation

This handbook does not contain answers to all potential questions, nor will it address all issues that may arise for a particular individual, family or community.

Site supervisors and Project Managers are expected to understand, follow and train others to follow the programmatic and fiscal compliance requirements, including reporting and invoicing requirements, for grants that fund programs.

Direct service staff is expected to exercise good judgment in interpreting the meaning and intent of the statements in this handbook. Staff must consult supervisors or project managers for additional guidance whenever necessary.



Mission of Direct Service Staff
To develop trusting, goal-oriented and time-sensitive working relationships and offer excellent customer service to help original resident participants of revitalizing communities to remain stably housed, and benefit from the reinvestment in their neighborhood.

Helping People Adapt to their Changing World
The Urban Strategies case management model was designed specifically to help original resident participants of low-income neighborhoods respond to the vision and timeline of comprehensive neighborhood revitalization.

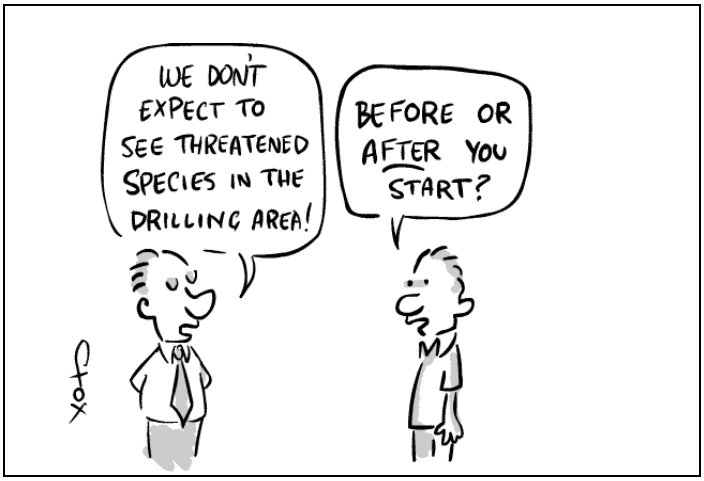
Two Way Partnership
Families will exercise informed choice, access resources and achieve their desired goals by participating in human service programs.

Case Managers will support self-determination, motivate action and mitigate systemic barriers that individuals encounter as they pursue their goals.

Guiding Principles

Case Management is both an art form and prescribed approach in working with people to create change.

1. **First do no harm.**
   - To ignore vulnerable residents is to do harm.
   - Residents need timely and accurate information as well as supportive services in order to cope with stress.



2. **All individuals are capable of change once they decide that change is worth it.**
    - When change is necessary, nobody likes to be told that they must "do or die" or that they "sold out".
    - People don't resist change if change is good. What people resist is loss. Sometimes some loss is worth the pain it causes.

3. **Dual-Generational Approach**
    - Giving parents and children the opportunity to succeed together
    - Children thrive when their parents can set a good example and be involved in their lives
    - Program design is intentional, not co-location
    - Plan and support for both personal goals of each adult and goals related to adult's responsibility towards dependent(s)

4. **Self-sufficiency is a myth.**
    - All residents have strengths that they draw on when they are stressed.
    - All individuals can take control of their assets, and use them to access resources.

5. **No one does it alone. We don't either.**

   - Transforming people and place involves collective action.
   - Partners and resident participants respect us when we say what we can do, and do what we said we would do.
   - Partners and resident participants deserve credit and recognition for their work.

Recommended Approach to Case Management

Motivational Interviewing[1]

Motivational Interviewing is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change. This approach focuses on the identification, examination, and resolution of ambivalence about changing behavior.

The Principles of Motivational Interviewing[2]

1. **Collaboration vs. Confrontation**
   - Create a partnership, not one based on an "expert" role vs. "resident participant" role
   - Keep the process focused on mutual understanding – not just being right

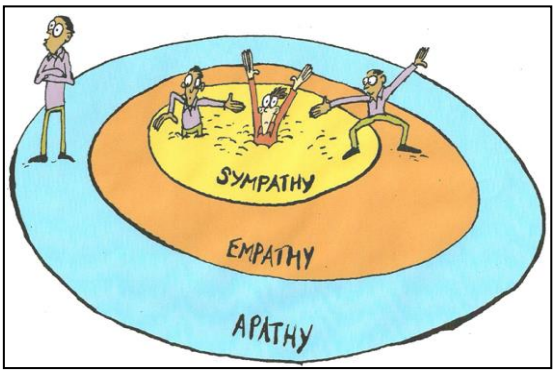
2. **Evocation – Drawing out, rather than imposing ideas**
   - Motivation and commitment to change are most powerful and durable when it comes from the person
   - Drawing out a resident participant's own thoughts and ideas, rather than imposing your own ideas and opinions

[1] Center for Evidence-based Practices at Case Western Reserve University http://www.centerforebp.case.edu/practices/mi

[2] Rollnick, S., and Miller, W.R. What is motivational interviewing? Behavioral and Cognitive Psychotherapy. 1995; 23:325-334

3. **Autonomy vs. Authority**
    - True power for change rests within the resident participant – it is up to them to follow through making changes happen
    - This is a more empowering approach and gives them responsibility for their own actions and choices

4. **Express Empathy**
    - Empathy involves seeing the world through the resident participant's eyes, thinking about things as the resident participant thinks about them, feeling things as the resident participant feels them
    - This provides the basis for resident participants to be heard and understood, and in turn, resident participants are more likely to honestly share their experiences in depth



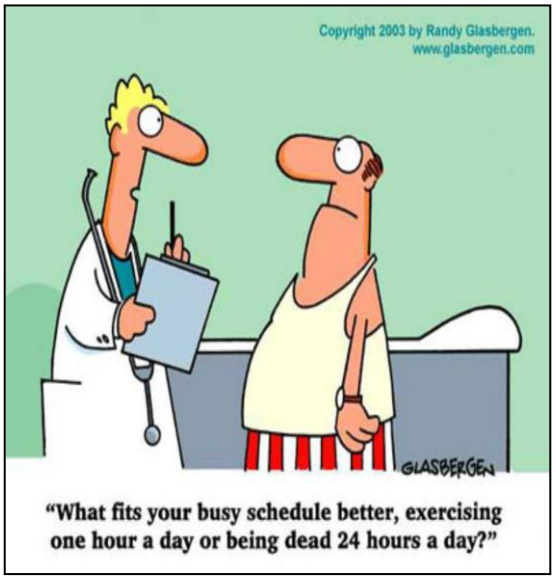
5. **Support Self-Efficacy**
    - A resident participant's belief that change is possible (self-efficacy) is needed to instill hope about making those difficult changes
    - Resident participants may have previously tried and been unable to achieve or maintain the desired change, creating doubt about their ability to succeed
    - As the facilitator – support self-efficacy by focusing on previous successes and highlighting skills and strengths that the resident participant already has

6. **Roll with Resistance**
    - Avoid eliciting resistance by not confronting the resident participant and when resistance occurs, work to de-escalate and avoid a negative interaction

- Actions and statements that demonstrate resistance remain unchallenged especially early on in the relationship – this will disrupt any power struggles that may derail the process of change
- If the resident participant is given the power to define the "problem" and their own solutions, there is little for them to resist

7. Develop Discrepancy

- Motivation for change occurs when people perceive a mismatch between "where they are and where they want to be"
    - Help resident participants examine the discrepancies between their current circumstances/behavior and their values and future goals
- Be careful not to use strategies to develop discrepancy at the expense of the other principles – gradually help resident participants become aware of how current behaviors may lead them away from, rather than toward, their important goals

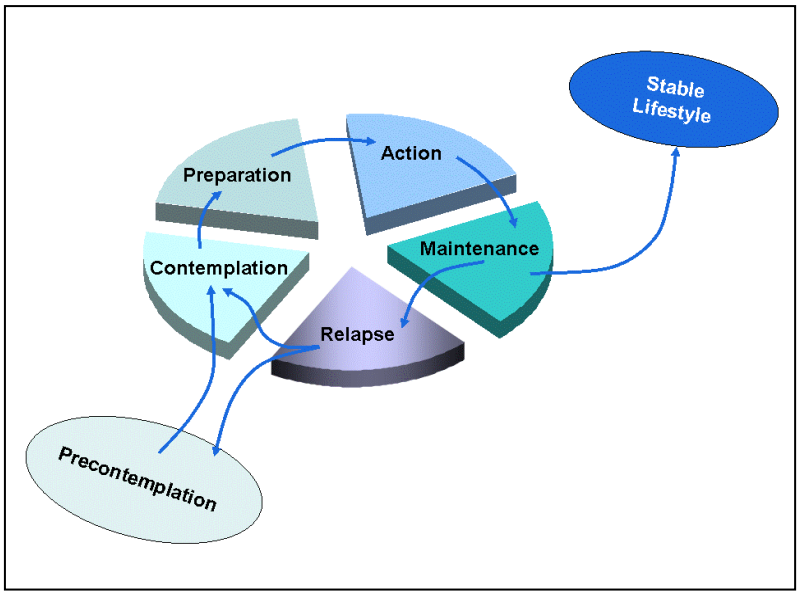


Stages of Change

Stages of Change[3]

1. **Pre-contemplation**
2. **Contemplation**
3. **Preparation**
4. **Action**
5. **Maintenance**
6. **Relapse**

Understanding a resident participant's readiness for change is vital in supporting that resident participant's journey towards making and sustaining change.



Using Stages of Change to help move the resident participant through the change process

Stage of Change	Characteristics of the Resident Participant	Techniques to consider as the Case Manager
Pre-contemplation Case Manager's goal in this stage is to move from "No" to "I'll think about it"	• Not currently considering change: • "Ignorance is bliss" • They may be "in denial" about their situation and not consider a specific issue to be of serious concern. • They may have tried unsuccessfully to change so many times that they have given up.	• Validate resident participant's experience and lack of readiness • Clarify: decision is theirs • In a simple, direct statement – give your opinion of the benefit for change • Encourage re-evaluation of current behavior • Encourage self-exploration, not action • Encourage them to reframe their current position on change to "the potential beginning of change, rather than a decision not to change"

[3] Bray, J., Kowalchuk, A., and Waters, V. Brief Intervention: Stages of Change and Motivational Interviewing. InSight SBIRT Residency Training Program. https://www.bcm.edu/education/programs/sbirt/index.cfm?pmid=25042

Stage of Change	Characteristics of the Resident Participant	Techniques to consider as the Case Manager
Contemplation Case Manager's goal in this stage is for the resident participant to have a clear understanding of what change means	• Ambivalent about change: "Sitting on the fence" • During this stage, the person weighs benefits versus costs of barriers (time, expense, bother, fear. • Not considering change within the next month	• Validate lack of readiness & their experiences • Clarify: decision is theirs • Encourage evaluation of pros and cons of behavior change, and clarify perceptions • Encourage further self –exploration • Leave the door open to moving forward
Preparation Case Manager's goal is for the resident participant to have a plan about how to make the change a reality	• Some experience with change and are trying to change: "Testing the waters" • The person is prepared to experiment with small changes. • Planning to act within 1 month	• Praise the decision • Prioritize behavior change opportunities • Identify and assist in problem solving re: obstacles • Verify that Resident participant has underlying skills for behavior change • Help Resident participant identify social support • Encourage small initial steps
Action Case Manager's goal in this stage is to celebrate the action taken and prepare resident participant for possible set-backs	• The person takes definitive action to change behavior. • Practicing new behavior for 3-6 months	• Focus on restructuring cues and social support • Bolster self-efficacy for dealing with obstacles • Combat feelings of loss and reiterate long-term benefits
Maintenance Case Manager's goal in this stage is to build long-term supports for resident participant	• Continued commitment to sustaining new behavior • The person strives to maintain the new behavior over the long term. • Post-6 months	• Plan for follow-up support • Reinforce internal rewards • Discuss coping with relapse

Stage of Change	Characteristics of the Resident Participant	Techniques to consider as the Case Manager
Relapse Case Manager's goal in this stage is to maintain relationship and not shame the resident participant	• Resumption of old behaviors: "Fall from grace"	• Evaluate trigger for relapse • Reassess motivation and barriers and plan stronger coping strategies

In general, for people to progress they need:

- A growing awareness that the advantages (the "pros") of changing outweigh the disadvantages (the "cons") — this is also known as "decisional balance"
- Confidence that they can make and maintain changes in situations that tempt them to return to old, potentially unhealthy behavior—this is also known as "self-efficacy"
- Strategies that can help them make and maintain change

Strategies for making and maintaining behavior change

1. Consciousness-Raising—increasing awareness via information, education, and personal feedback about the healthy behavior.
2. Dramatic Relief—feeling fear, anxiety, or worry because of the unhealthy behavior, or feeling inspiration and hope when they hear about how people are able to change to healthy behaviors
3. Self-Reevaluation—realizing that the healthy behavior is an important part of who they are and want to be
4. Environmental Reevaluation—realizing how their unhealthy behavior affects others and how they could have more positive effects by changing
5. Social Liberation—realizing that society is more supportive of the healthy behavior
6. Self-Liberation—believing in one's ability to change and making commitments and recommitments to act on that belief
7. Helping Relationships—finding people who are supportive of their change
8. Counter-Conditioning—substituting unhealthy ways of acting and thinking for healthy ways
9. Reinforcement Management—increasing the rewards that come from positive behavior and reducing those that come from negative behavior
10. Stimulus Control—using reminders and cues that encourage healthy behavior as substitutes for those that encourage the unhealthy behavior.

Stages of the Relationship:
Relationships with your resident participants go through several stages, and the beginning is often the hardest. One framework to think about it is:

1. The Current State of Affairs
2. The Preferred State of Affairs
3. Strategies for Action

It may take a number of visits to move through each of these stages. It is also possible to move back and forth among the stages throughout your work with a resident participant. In the first stage, "The Current State of Affairs," resident participants tell you their stories. Often, case managers feel they have so much to get done with their resident participants that they can't wait and listen to the resident participants tell their stories. However, waiting and listening are incredibly important tools for building trust and rapport. From hearing their stories, you begin to understand:

- What the issues are as they see them
- How much insight and maturity they possess
- Who their main sources of support are, if any
- Other information that will help you develop a good working relationship

In the second stage, "The Preferred State of Affairs," you assist resident participants in identifying their goals and developing hope that some of their problems can be solved.

In the third stage, "Strategies for Action," you discuss with your resident participants what they are willing to do to meet their goals and then help them choose strategies.

Interviewing Skills:
Case Managers frequently conduct interviews to obtain and provide information needed to carry out the case management process. Preparation is needed anytime you will be conducting an assessment, or interviewing a resident participant to gather necessary personal information. Preparation will help insure that the goals of the interview are met, that the flow of the interview is organized and purposeful, and that the length of the assessment is no longer than necessary. It can also help build the case manager's level of confidence.

Consider the following when preparing for an assessment with a resident participant:

- Know the purpose of the assessment and what needs to be accomplished
- Gather any relevant forms that need to be signed. Most forms should have been signed during your initial meeting.
- Make an appointment for the assessment, if possible. This demonstrates respect and helps insure that the individuals involved will have sufficient time set aside to fully participate in the assessment.

Consider the following environmental factors:

- The room arrangement is important in supporting the resident participant's comfort level. Studies have shown that people are more willing to share personal information if the room is arranged so that the case manager is not sitting behind a desk. Talking with a person from behind a desk implies a position of authority, which impedes trust between the resident participant and case manager.
- If you are meeting the resident participant in his or her own home, sit near the resident participant and at an angle and level that will allow direct eye contact.
- Minimize noise and distractions as much as possible. Silence your cell phone, and consider holding calls to your office phone until after the assessment. If meeting in the resident participant's home, ask for permission to cut down the volume or turn off televisions or radios.
- People tend to feel more comfortable and in control when they are in a familiar environment. The purpose of your meeting with a resident participant will help determine the best setting.

Consider the following at the time of the assessment interview:

- An assessment should be done in a private space where the resident participant can talk without being seen or overheard.
- State the purpose of the assessment and approximately how long it should take to complete
- Let the resident participant know that you will be taking notes, and explain how the information being collected will be used.
- Use a conversational style. Allow the resident participant to share and be attentive to information you are collecting on the assessment.
- Start the assessment with questions that are less personal and save more personal questions for later in the interview when the resident participant may feel more comfortable and have a higher level of trust.
- Avoid leading questions. Leading questions project the case manager's values and may cause the resident participant to say what they think the case manager wants to hear or what may be the "correct" answer. Be mindful that "why" questions tend to put people on the defensive and should be used with caution.
- Avoid filling in all moments of silence with questions or comments. Silence can actually allow a person to reflect on what was said and identify additional information that needs to be shared. When there is silence, pause a few seconds before asking another question.
- Give resident participants an opportunity to ask their own questions or to clarify anything that was discussed.
- Thank the resident participant for their time and participation. Make sure they know how to reach you if there are changes, they have questions, or want to provide additional information at a later time.

Active Listening

Active listening involves interaction between the case manager and the resident participant. The case manager must try to understand what the resident participant is saying and communicate back those feelings and thoughts so the resident participant knows he or she is being understood. Another term for this type of interaction is "accurate listening." When a case manager is engaged in accurate listening, s/he understands what the resident participant is saying and what her/his thoughts, feelings, and motivations are. The case manager also pays attention to nonverbal cues, such as lack of eye contact or fidgeting. The resident participant, in turn, senses that the case manager is paying attention and is trying to understand. Because case managers have so many resident participants, they often feel rushed. However, it is worth taking the extra time to listen and truly understand the specific circumstances of each resident participant. Prompting the resident participant to elaborate enables you to understand the situation more fully and encourages her/him to discover and evaluate possibilities for change.

Body Language

Before you begin talking or listening, it is important to consider the nonverbal cues that you give and receive. Your body language tells your resident participant when you are paying attention, even though you may not be saying anything with words. The resident participant feels great when they know they have your complete attention.

Techniques for active listening include encouraging, asking open-ended questions, asking closed-ended questions, moving from the general to the specific, paraphrasing, and summarizing.

- **Encouraging**

  Purpose: This is how you convey interest and tell your resident participant to continue talking.

  To Do This: Give small verbal or nonverbal prompts.

  Examples: "Uh-huh" "Go on"

- **Open-Ended Questions**

  Purpose: Open-ended questions are questions that cannot be answered with "yes" or "no" – they require elaboration. These questions encourage the resident participant to talk about experiences and invite specifics. They are typically very general and help you get a broad sense of what's going on.

  To Do This: Ask questions that get the resident participant to tell a small story when they answer.

  Examples: "Tell me more." "What are your thoughts about . . . ?"

- **Closed-Ended Questions**

  Purpose: Closed-ended questions are questions that can be answered with "yes" or "no" or have a specific answer. These questions are typically used to obtain factual information.

To Do This: Ask a specific question that has only one possible answer or can be answered with "yes" or "no."
Examples: "What time did all this happen?" "Did you go to school today?"

- **Moving from the General to the Specific**

  Purpose: Getting more details from the resident participant helps her/him recognize patterns and see where there is room for change. You may have a general sense of the resident participant's situation, but to truly understand what's going on, you need details. It's not enough to know that the resident participant fights with her boyfriend, for example. You need to know more to help her figure out what to do. The specifics enable you to understand her experience and make relevant comments in response.
  To Do This: Ask follow-up questions to solicit more information about the particular situation.
  Example: "When does the fighting occur? What happens right before? Are there any warning signs? How do you feel before, during, and after the fight? Does anyone else know? What have you tried?"

- **Paraphrasing**

  Purpose: Paraphrasing is restating what the resident participant has said to show that you understand. This gives the resident participant a chance to hear what you are thinking and to correct or clarify what you've said. Paraphrasing is not repeating what the resident participant has said word for word, which can appear condescending.
  To Do This: Put what the resident participant says into your own words.
  Example: Resident participant: "I don't think I can go to school. How can I leave my baby with a stranger all day?" Response: "You're not sure you can leave your baby to go to school."

- **Summarizing**

  Purpose: Summarizing affirms what the resident participant has said and shows that you've understood the whole message. Use this technique when the resident participant finishes sharing something to help them see the full picture.
  To Do This: Think about all the things the resident participant has said and how they link together. State the overall message, including the relevant parts.
  *Example: "*So, all in all, you think that getting your GED is the next thing you want to do.

Strategies for Drawing Out Change Talk[4]	
Ask Evocative Questions	Ask an open question, the answer to which is likely to be change talk
Explore Decisional Balance	Ask for the pros and cons of both changing and staying the same
Good Things/Not-so-good Things	Ask about the positives and negatives of the target behavior
Ask for Elaboration/Examples	When a change talk theme emerges – ask details like "In what ways?" "Tell me more?" "What does that look like?" "When was the last time that happened?"
Look Back	Ask about a time before the target behavior emerged. How were things better, different?
Look Forward	Ask what may happen if things continue as they are (status quo). Try the miracle question: If you were 100% successful in making the changes you want, what would be different? How would you like your life to be five years from now?
Query Extremes	What are the worst things that might happen if you don't make this change? What are the best things that might happen if you do make this change?
Use Change Rulers	"On a scale from 1 to 10, how important is it to you to change [a specific behavior] where 1 is not at all important, and a 10 is extremely important?" Follow up with "and why are you at a _____ and not ____ [a lower number than stated]?" "What might happen that could move you from ____ to [a higher number]?" Alternatively, you could also ask, "How confident are you that you could make the change if you decided to do it?"
Explore Goals and Values	Ask what the person's guiding values are. What do they want in life? Ask how the continuation of target behavior fits in with the person's goals or values. Does it help realize an important goal or value, interfere with it, or is it irrelevant?
Come alongside	Explicitly side with the negative (status quo) side of ambivalence. "Perhaps ____ is so important to you that you won't give it up, no matter what the cost?"

[4] Miller, W.R., and Rollnick, S. Motivational Interviewing: Preparing People to Change Addictive Behavior. New York: Guilford Press, 1991.

Brokering Referrals:

Facilitating a resident participant's receipt of service is a fundamental task of case management. Cooperative relationships with both formal and informal resources within the community need to be established. In the end, service linkages are vital to a resident participant achieving his or her goals. The case manager's role is to get individuals and organizations to work jointly with a resident participant to meet their needs. The best service linkages are just as invested in seeing the resident participant succeed, thus creating the win-win scenario needed for a long term partnership.

Advocacy:

Linking resident participants to resources often involves a mix of advocacy and mediation. It is essential that case managers be knowledgeable about referral sources and supportive groups and individuals with whom services may be coordinated.

Some tips for being a strong advocate include:

- Have knowledge of admission and acceptance criteria for various programs, services, and resources
- Be aware of relevant laws, rules, and regulations that may influence eligibility or entitlement to services
- Demonstrate program solving and negotiation skills to gain support
- Use productive strategies for persuading gatekeepers and resource holders to provide assistance

Teaching self-advocacy skills is part of the process of empowerment. Whenever possible, case managers should afford resident participants the opportunity to speak for themselves and to convey first-hand information about their personal successes and struggles. People who learn to advocate on their own behalf help overcome stereotypes that may devalue those who are disadvantaged. People receiving case management should not be excluded from making decisions about things that affect their lives and should see self-advocacy as essential to their well-being.

Cultural Competence:

"Culture is defined as an integrated pattern of human behavior which includes thought, communication, language, beliefs, values, practices, customs, courtesies, rituals, manners of interaction, roles, relationships, and expected behaviors of a racial, ethnic, religious or social group; the ability to transmit the above to succeeding generations."[5]

The person's cultural identification is a powerful factor that must be considered in all aspects of interaction and intervention. Understanding the people we serve requires that the

[5] Developed by the National Center for Cultural Competence, 2002.

case manager be knowledgeable of their culture. Mistakes are often made in assuming that all members of a particular group are the same.

Culturally competent practice requires the case manager to be aware of their own cultural/ethnic background and how this may affect the person's interaction with them. Cultural differences must be recognized, understood, accepted and incorporated in all aspects of the case management process. Besides the challenge of meeting the needs of people from culturally diverse backgrounds, be careful not to generalize attributes to them because of their background. An effective case manager is keenly aware of their resident participant's ethnicity, race, gender and age, while maintaining sensitivity to the fact that the resident participant is also a unique individual.

Relocation & Re-Occupancy Support

Urban Strategies provides case management on a housing platform, therefore special attention will be paid to the impact of housing redevelopment on households we serve. This proactive case management intervention is defined as Mobility Support, which is assistance provided to Eligible Families in close collaboration with the entity responsible for relocation. Mobility Support is provided in a consistent manner with the formally adopted Relocation Plan, in order to help Eligible Families understand what to expect during the relocation process, assess the housing options provided by the relocation entity and make informed choices about where they would like to relocate, and coordinate effective strategies to address any known barriers that will hinder a smooth transition for families who choose to return to the revitalized housing.

As part of Mobility Support services, case managers will:

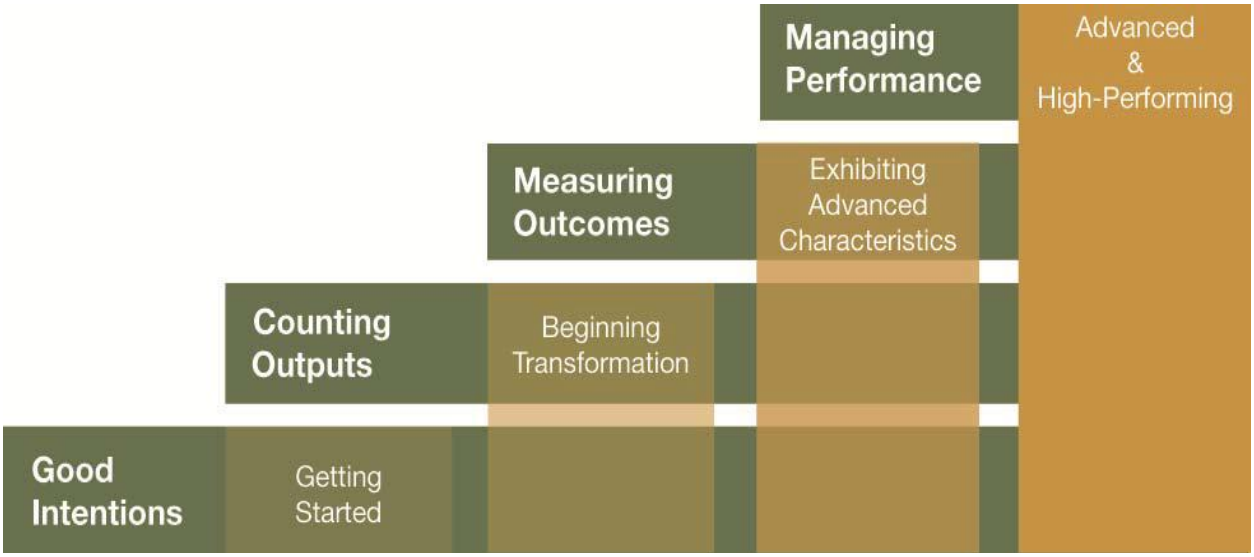
- Help resident participants in evaluating the available housing options, and the relative benefits of each of the available options for various household members based on location, rent, access to healthcare, transportation and other essential services, school options and access to school, and other considerations important to each household;
- Help resident participants understand how to complete their responsibilities in the relocation process, including by stressing the importance of responding to relocation staff, timely completion of applications for housing and relocation benefits, collection and presentation of required documentation (e.g., picture ID, Social Security Cards, birth certificates);
- Provide information on available transportation options for resident participants during the search for housing;
- Help households understand whom they should contact to obtain the information and services that they need to complete the relocation process.
- Provide Case Management services for Eligible Families throughout their participation in Case Management to:
    - Cure issues with late or delinquent rent, utilities and other bills;
    - Address criminal backgrounds, and expunge criminal records where possible;
    - Address and prevent lease violations, and remain stably housed wherever they live;
    - Proactively prepare to move into CNI replacement housing if they so choose.

- Advocate for and provide special attention to the needs of elderly, disabled and other vulnerable residents as they go through the relocation process, and providing or coordinating with the relocation entity to secure any additional supportive services that they might need;
- Provide special attention to the needs of non-English speaking individuals and others who might need additional assistance in understanding the relocation process fully.

CHAPTER 3: Learning for Effective Action to Revitalize Neighborhoods (LEARN)

LEARN is the only database of its kind that is designed to longitudinally track and analyze the impact of human capital programs that are implemented in conjunction with neighborhood revitalization and housing redevelopment efforts. LEARN was built using Social Solutions' Efforts to Outcomes (ETO®) software. LEARN features the use of Urban Strategies' proprietary Family Risk Index (FRI) to determine and mitigate the risk of eviction, unemployment, incarceration, homelessness, household instability, physical or mental illness, and disconnection from school, job or caring adult (for children/youth). This database will connect adult and youth outcomes and results can be reported for families and for individuals. Outcomes are tracked using TouchPoints. This data collection allows us to analyze and visualize outcomes and change over time for specific participants, groups, programs or agency wide.

"The system will help us to understand neighborhood conditions, and account for assets and needs related to human development – including access to economic opportunities and essential services such as schools, health clinics, banking, fresh food and transportation. LEARN will also help us fully understand the impact of interventions."



Learn is a Performance Management system that does more than count outputs and measure outcomes. The information gathered in LEARN will be used to build a culture of learning and change, guide decisions and operations, and ultimately improve outcomes for our resident participants.

As we think about how we measure the impact case management has on our resident participants, let's share a simple language:

- **Results:** conditions of well-being we want
  Example – A safe community
- **Indicators:** how we measure the conditions
  Example – Crime rate

- **Baselines:** where the measures say we are
- **Turning the Curve:** what success is beyond the baseline
- **Strategies:** what methods work to improve the conditions
  Example – Installation of new street lights to make residents feel safer
- **Performance Measures:** what we use to judge if our efforts are working
  Example – Average police department response time

"Results" and "Outcomes" are the same thing

- **Outcomes are measurable changes** in your program participants' attitudes, emotions, knowledge, skills, behavior or social condition.
- **Outcomes are goals** that you work intentionally to achieve and hold yourselves accountable.
- **Outcomes** must be:
  - Relatively enduring changes
  - Relevant to customers
  - Different from Outputs (e.g. lives touched)

Results-Based Accountability

The following are the conditions of wellbeing that we want for our resident participants and their household members:

1. Live in safe and stable housing that is affordable and well maintained.
2. Work for a fair wage or be self-employed.
3. Be engaged in the healthy academic and personal development of dependents.
4. Be successful in education and workforce preparation.
5. Focus on and work towards healthy lifestyles.
6. Access opportunities to move into housing and neighborhood of choice.

Indicators

The following are the ways in which we will measure these conditions:

1. **Live in safe and stable housing that is affordable and well maintained.**
   - Averted or reduced risk of eviction
   - Completed corrective actions to prevent or mitigate lease violation
   - Caught up with late or insufficient rental payments
   - Passed housekeeping or maintenance inspections
2. **Work for a fair wage or be self-employed**
   - Resident participant signed up for earned income disregard (EID)
   - Placed into part-time employment
   - Placed into full-time employment
   - Maintained employment 6 months or more
   - Secured job with increased wages

3. **Children and youth are prepared for college and career**
    - Child is on track to enter kindergarten ready for academic success
    - Dependent is on track to graduate from high school with a diploma
    - Child entered kindergarten ready for academic success
    - Dependent graduated from high school with a diploma
4. **Be successful in education and workforce preparation.**
    - Resident participant actively participating in high school diploma or GED program
    - Resident participant is enrolled in post-secondary education program
    - Resident participant obtained a professional license
    - Resident participant completed a certificate program (other than GED)
    - Resident participant obtained a college degree
    - Resident participant obtained a high school diploma
    - Resident participant obtained "other credential"
5. **Focus on and work towards healthy lifestyles.**
    - Resident participant applied for health insurance for self
    - Resident participant secured health insurance for self
    - Elderly resident participant enrolled in senior lunch program or meals on wheels
    - Elderly resident participant in need receives in-home healthcare services
    - Elderly resident participant in need receives appropriate supportive services
    - Elderly resident participant secured mobility assistance or assistive device(s)
    - Pregnant women accessed prenatal care
    - Pregnant woman accessed adequate nutritional resources
    - Resident participant reports regularly utilizing the community's fitness amenities
    - Resident participant regularly participates in health, fitness, and nutrition programs
    - Resident participant reports regularly consuming fresh food and produce
    - Resident participant received annual physical within the past 12 months
    - Resident participant accessed annual dental care within the past 12 months
    - Resident participant accessed vision care
    - Resident participant accessed resources/services to help with hearing
    - Resident participant in need accessed appropriate medical care (including preventive and palliative care)
    - Resident participant in need participates in mental health services
    - Resident participant in need participates in substance abuse or relapse prevention services
    - Resident participant with history of substance use reports being clean for 30 days
6. **Access opportunities to move into housing and neighborhood of choice.**
    - Resident participant created savings for down payment
    - Resident participant's family moved into housing of choice
    - Resident participant purchased a home
    - Resident participant's credit score increased
    - Resident participant applied for EITC within the past 12 months
    - Resident participant applied for childcare tax credit within the past 12 months
    - Resident participant applied for other tax credits within the past 12 months

Building a Case Load:

If you build it, they will come -- right?
It worked for Kevin Costner in the movie "Field of Dreams," but in the real world of creating healthier communities, the definitive answer is "Maybe."
Intentional outreach strategies must be employed in order to reach resident participants and have them voluntarily choose to participate in case management services. We recommend using a variety of strategies from door-knocking, to community meetings, to large scale neighborhood events. People are attracted to different interactions. Some will come to a neighborhood event, hear about the service being provided, and choose to self-enroll. Others will attend a community meeting because they want more information on the services being provided, and this provides a safe space to ask questions without the pressure of a one-on-one conversation. Lastly, there will be resident participants who will need to be sought out. These resident participants will benefit from a visit from a case manager to explain the services and answer any questions the resident participant may have about participating. As you make positive connections with resident participants, word-of-mouth will become another powerful outreach tool.

"Why should I enroll?"

The best answers to this question can be found in the experiences of past and current resident participants. The following quotes were given by resident participants receiving case management services through Urban Strategies:

"Case management is like having a counselor, they get me and it helps to have someone to talk to"

"My case manager keeps me focused on my goals, they check up on me so I feel more pressured to do what I say I will do"

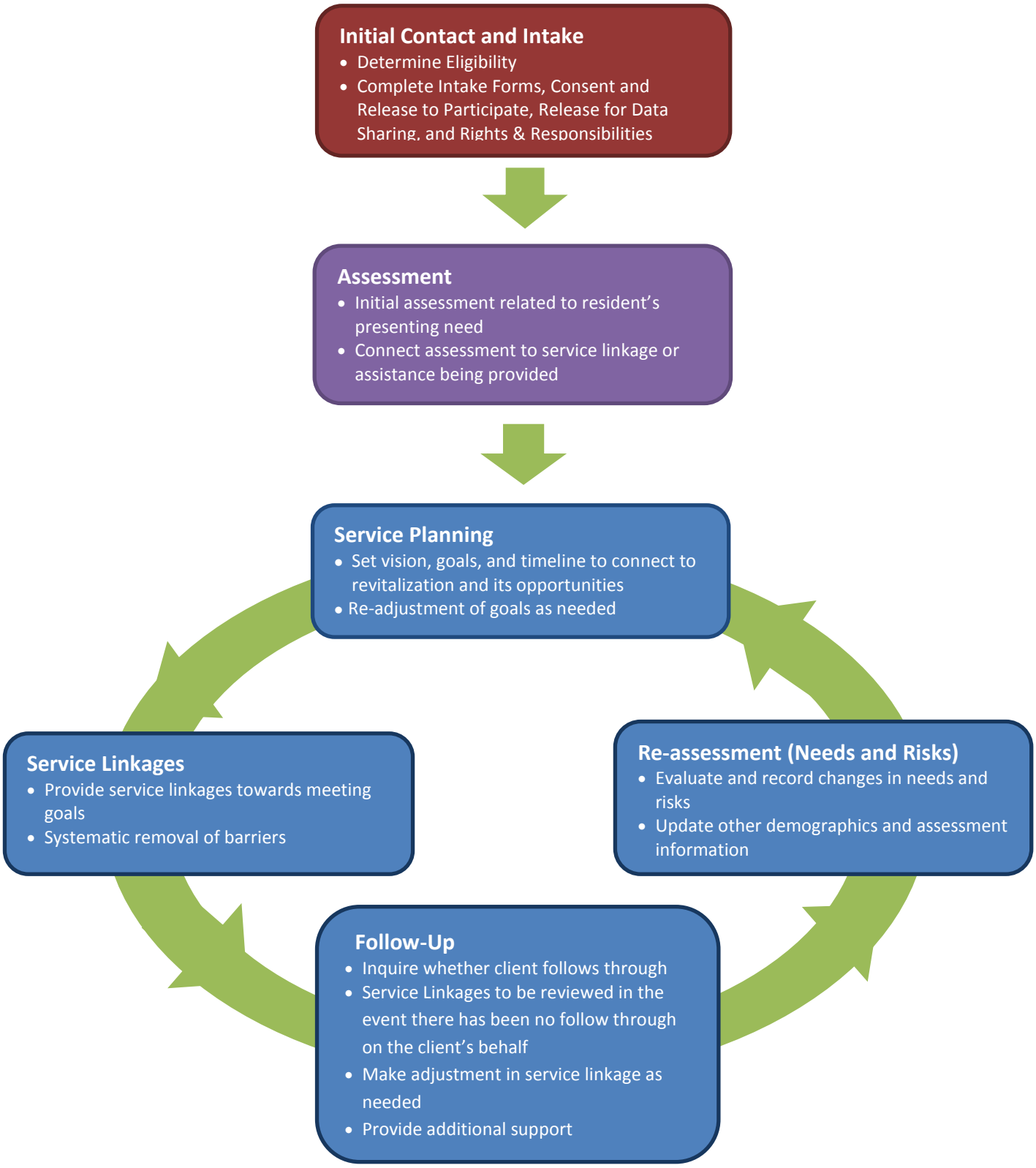
"My case manager knows a lot about resources and helps me get connected to the resources that really help"

"My case manager has helped with legal services and things that sometimes I don't fully understand"

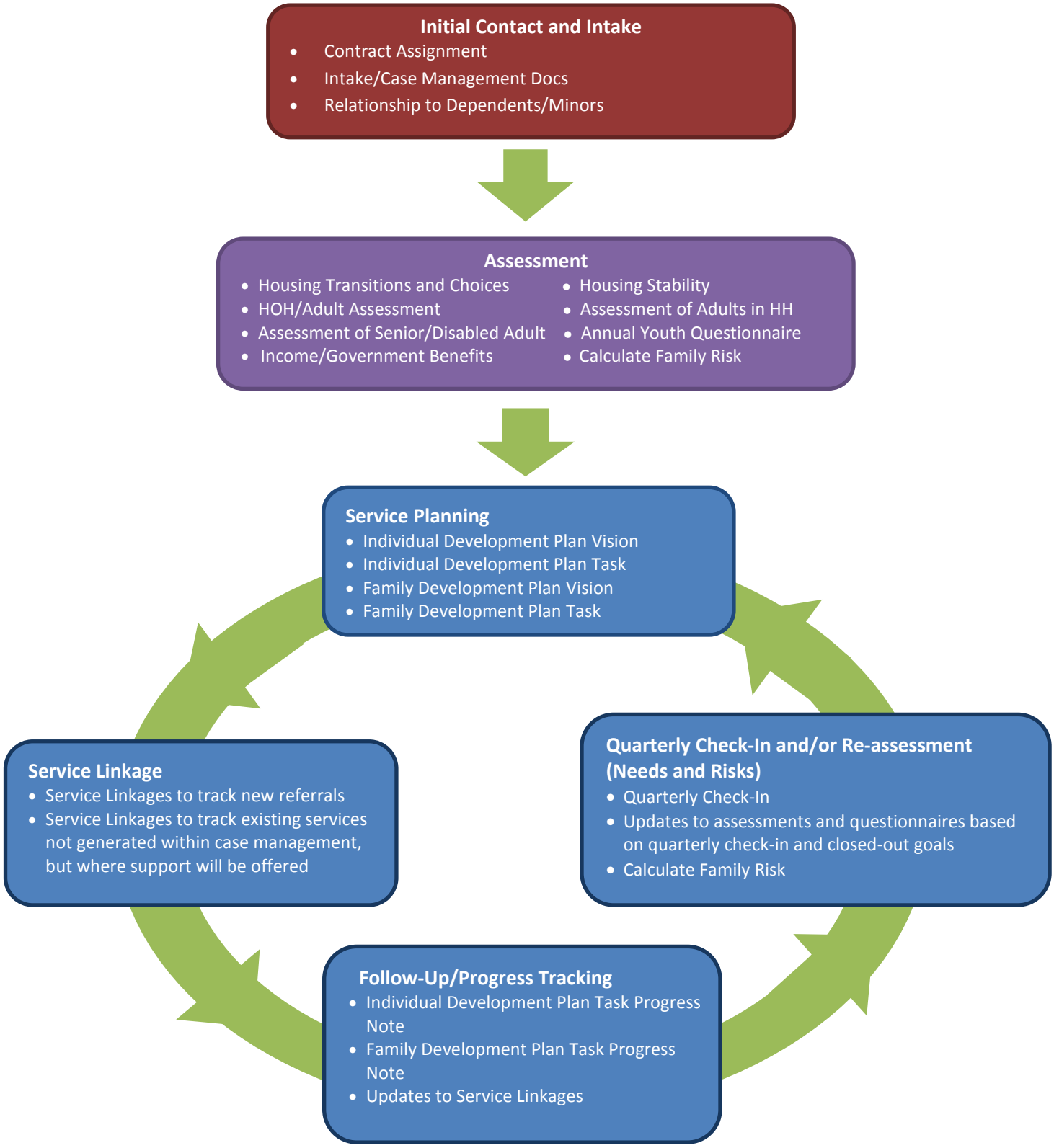
"My case manager helps me see the steps I need to take to accomplish my goals, and supports me in taking those steps"

"Case management helps me stay accountable to myself and the goals I have set. It's nice to know I have someone on my side who will advocate for me and listen to me"

Case Management Work Flow Diagram



LEARN TouchPoint Flow Chart



Act on the Mission:
Lay the foundation for a trusting, goal-oriented, time-sensitive working relationship.

Preparing for first meeting with a resident participant:
Establishing a good impression during your first meeting is critical. With proper thought and preparation, you can set a positive tone for the rest of your relationship. Both you and your resident participant will have assumptions and opinions about each other. You may have been given information about your resident participant and formed an opinion before meeting her/him. Try to keep an open mind. In the same way, the resident participant may have ideas about who you are and what you can and can't do for her/him. So the slate must be cleared, and you must separate yourself from your assumptions. It's crucial that you use this first meeting to create a warm tone and set appropriate expectations.

Take a moment to think about what kind of impression you want to make. Think of when you started in your job. Who were the people that made strong first impressions? Who were the people that did not? Who were the people that were caring, available, and nonjudgmental? How did they communicate that?

Case Manager Focus:
Begin building rapport with the resident participant. It is often quoted that "People don't care how much you know until they know how much you care." The development of a healthy relationship with resident participants and referral sources is strongly influenced by the case manager's projection of attitudes of respect, empathy and cultural sensitivity toward others.

Resident Participant Involvement:
During this initial meeting, the resident participant is the expert on his or her own life. The resident participant's role is to inform you of his or her reality. The resident participant is ultimately responsible for the level in which he or she participates in case management services.

Case Management Tasks:

1. **Build Trust:**
   Clearly communicate the terms of engagement with the program, including:
   - Rights and Responsibilities as a participant
   - Code of Conduct
   - Consent to Participate
   - Privacy & Confidentiality

2. **Orient to Goals:**
   Provide accurate information about program benefits and resources available.

3. **Consider Time Available:**
   Communicate the timeframe during which services and resources can be accessed.

4. **Clearly Communicate Next Steps:**
   - When will the next appointment or contact take place?
   - What will the case manager be responsible for between now and the next meeting?
   - What will the resident participant be responsible for between now and the next meeting?

Administrative Tasks:

1. Confirm and document program eligibility*
2. Document resident participant's Consent to Participate
3. Collect demographic and baseline information for the household

*Note:
Eligibility rules vary based on city, site, program and funder. Consult supervisor for specifics.

TouchPoints in LEARN to complete at Intake:

***Contract Assignment**

- All participants need to be assigned to the CNI Contract initially, and as further funding is secured the appropriate participants should be assigned to the respective funding source.

1a. Intake/Case Management Documents

- Upload the following forms – Consent to Participate, Release of Information, Intake Form

1c. Relationship to Dependents/Minors in Household

Purpose:

1. Begin assessing risk factors
2. Gain understanding of resident participant's reality – needs, challenges, strengths, and priorities

Act on the Mission:
Do something meaningful and beneficial to the resident participant right away. Give the resident participant a reason to come back.

Case Management Tasks:

1. **Build Trust:**
   - Take the resident participant's word upon honor.
   - Meet the resident participant's presenting need first.
2. **Orient to Goals:**
   - Agree on a priority issue to work on in the near future. Explain how case management can help.
3. **Consider Time Available:**
   - Offer an appointment time, and resist the temptation of creating a "drop-in" culture. While attending to resident participant's needs as they arise is important, unless it is an emergency, a scheduled appointment time will allow you to balance your case load more efficiently.

4. Establish Resident participant's Baseline:

Assessments to consider include:

- Housing Transitions and Choices
- Housing Stability
- Adult Assessment/Head of Household
- Assessment of Adults in Household
- Senior & Disabled Adult Assessment
- Annual Youth Questionnaire
- Household Income & Government Benefits

Completing all of these assessments with a resident participant at one time will be very overwhelming, so consider which assessments will provide you with the baseline data you need to begin establishing an Individual Development Plan and/or Family Development Plan. As you continue building a relationship with each resident participant, there will be opportunities to gather additional data that makes sense according to the goals your resident participant wants to accomplish within his or her plan. Do not complete an assessment for the sake of completing an assessment. Have a clear purpose in mind for the data you are collecting from your resident participant.

Next Steps:

1. Address the individual's goals and presenting needs in the context of family risks and resilience
2. Identify real or potential risks (if any):
    a. To family: of eviction, homelessness, household instability
    b. To individuals: of unemployment, incarceration, physical or mental illness
    c. To children and youth: of disconnection from school, job or caring adult
3. Identify priority issues to be addressed through case management

TouchPoints in LEARN to complete during Assessment:

2b. Housing Stability

- Only the ADULT members of the household must be listed, including the Head of Household. Thus, remove children and/or school-age youth by clicking on the red X next to each applicable name.

2a. Housing Transitions and Choices

- Update this assessment whenever there is a change in address for this household
- Ensure that all family members are listed and "All" is selected above the list of participants in the upper left corner.

3a. Head of Household/Adult Assessment

- This TP will be taken for any adult who enrolls in case management.
- If the enrolled adult is the Head of Household or Lead Adult Participant, the TP will feed the risk score calculation for the household.
- This TP will also be taken when an out-of-school Transition-Age-Youth enrolls in case management.

3b. Assessment of Adults in Household

- Select one adult or out-of-school youth (age 16+) at a time by clicking their name and enter the answers for each. Remove all children and in-school youth by clicking on the red X. Do not enter any answers with "ALL" selected.

3c. Assessment of Senior/Disabled Adult

- This is a supplemental assessment for Seniors or Disabled Adults. This does not replace other assessments. This risk score is standalone and does not factor into the Family Risk Score.

3d. Annual Youth Questionnaire

- This questionnaire should be updated in the spring during a discussion with the family around summer programming for youth, and to address any desire to change schools before the next school year.
- "Pre-School Youth" is defined as a child who is 0-5
- "In-School Youth" is defined as a child/youth who is 5-19 and enrolled in K-12
- "None of the Above" is defined for all other household members AND those aged 16-24 who are not enrolled in school
- This TP feeds into the calculation of the household risk score, and must be following by the Calculate Family Risk Score TP.

1b. Household Income & Government Benefits

- Complete this TP if there is a financial need or goal that you are addressing through Case Management.

3e. Calculate Family Risk

- Complete this TP when the Head of Household/Adult Assessment, Housing Stablity, and Annual Youth Questionnaire are complete.
- Record this TouchPoint against the current LAP to calculate family risk.
- If you are establishing a new LAP and need to transfer historical records:
    - First, make sure you are recording this as a multiple participant TouchPoint
        - Go to **Record Touchpoint** on **Navigation Bar** and select **Calculate Family Risk**
        - Search and select **BOTH** the former LAP and the New Lead Participant
        - Both names of the outgoing and incoming Lead Adults should be listed on left of Touchpoint
    - Second, answer Yes to "Are you transferring historical family risks to a New Lead Adult"
    - Third, select the outgoing Lead Adult and identify the risk score for the Annual Youth Questionnaire;
    - Fourth, select the new Lead Adult and manually enter the Annual Youth Questionnaire risk score below. (The adult assessment and housing stability scores will be populated)
    - Fifth, determine if any of the automatic high-risk statuses under each assessment category have a value of YES. If yes, enter YES for "Automatic High Risk for Family?" in the available box.
- If not establishing a new LAP and transferring historical family risk records, select No to the question "Are you transferring historical family risks to a New Lead Adult?"
    - All calculations will be made automatically
    - Determine if any of the automatic high-risk statuses under each assessment category have a value of YES. If yes, enter YES for "Automatic High Risk for Family?" in the available box.
- In the case of the LAP changing, this TP allows for the case manager to indicate who the most recent LAP is. The inactive LAP should then be dismissed from the program.
- This TP quantifies the baseline and change in condition for a family over time. This TP will be used for macro-level research on systemic issues and promising best practices. This TP offers data for the purposes of making population comparisons across sites.
- The Risk Score will be used as a measurement tool but not as the driver of frequency of contact. Frequency of Contact based on risk score will only apply to Families/Individuals who are not consistently engaged in case management. Our protocol is that the FDP/IDP drives how the CM interacts with the client/family. It is the Task and Service Linkage Follow up that drives the frequency of contact for engaged families/clients

An overview of the Assessment TouchPoints can be found in **APPENDIX FORM A**

Workflow Step 3A: Service Planning

(Adults – Personal Goals and Caregiving Responsibilities)

Purpose:

1. Determine individual development vision
2. Identify individual's personal aspirations and goals
3. Identify individual's responsibilities towards family members:
   a. Dependent children and youth if individual is a parent or caregiving adult
   b. All other household members if individual is Head of Household

Act on the Mission:
Encourage the resident participant to say what they want to work on, and make progress at their own pace.

1. **Build Trust:**
   - Take the resident participant's worries seriously.
   - Agree to work on what the resident participant wants, even if that does not appear to be the most pressing issue.

2. **Assist with Visioning:**
   - Create an opportunity for the resident participant to describe what life could look like in their dream scenario
   - Reflect back a realistic vision based on what the resident participant identified and what is reasonable during the scope of your time as their case manager

3. **Orient to Goals:**
   - Set as many goals as necessary to achieve the resident participant's individual's development vision.
   - For each goal, plan to act on one task at a time. Identify the task and a date for completion

4. **Consider Time Available:**
   - Identify realistic changes or accomplishments that can be achieved given the time available.
   - Offer to remind resident participant of when tasks are due.

Administrative Tasks:

1. Create resident participant's Individual Development Plan (IDP)
2. Print the Individual Development Plan, obtain resident participant signature, include in resident participant's paper file

Workflow Step 3B: Service Planning

(Children and Youth)

Purpose:

1. Identify strategy to support the vision for children and youth.
2. Identify needs of the responsible adult with respect to children and youth.
3. Develop strategy to address family risks as appropriate.

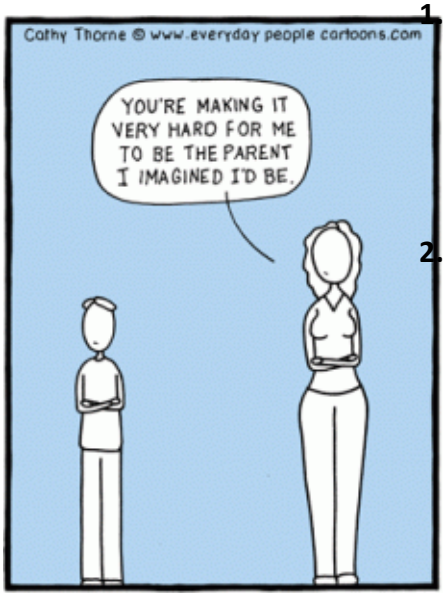
Act on the Mission:

Align the goals, tasks and timelines for members of a family so that they work in concert with each other rather than impede each other.

Exercise professional skill and judgment in utilizing:

- Family support for personal goals
- Community support for family goals
- Non-traditional rewards and incentives
- Untapped resources
- Intangible resources

Case Management Tasks:



1. **Build Trust:**
   - Take the resident participant's worries seriously.
   - Agree to work on what the resident participant wants, even if that does not appear to be the most pressing issue.

2. **Assist with Visioning:**
   - Create an opportunity for the resident participant to describe what life could look like in their dream scenario
   - Reflect back a realistic vision based on what the resident participant identified and what is reasonable during the scope of your time as their case manager

3. **Orient to Goals:**
    - Set as many goals as necessary to achieve the resident participant's family development vision.
    - For each goal, plan to act on one task at a time. Identify the task and a date for completion.

4. **Consider Time Available:**
    - Identify realistic changes or accomplishments that can be achieved given the time available.
    - Offer to remind resident participant of when tasks are due.

Administrative Tasks:

1. Create resident participant's Family Development Plan (FDP)
2. Print the Family Development Plan, obtain resident participant signature, include in resident participant's paper file

TouchPoints in LEARN to complete during Service Planning:

4a. Family Development Plan Vision

- Determine with the resident what desire he or she has for the household.
- Determine which Results Based Accountability category (area of measuring how a family is better off) the vision fits under and select from the list.
- Determine with the resident what goals need to be achieved in order to attain his/her vision and complete as many FDP vision TPs as goals stated.
- All visions and goals related to minor dependents in the household will be captured within the FDP.

4b. Family Development Plan Task

- The FDP Task TP is used to lay out the concrete steps to achieve a desired goal.

5a. Individual Development Plan Vision

- Determine with the resident what desire he or she has for himself/herself.
- Determine which Results Based Accountability category (area of measuring how a resident is better off) the Goal fits under and select from the list.
- Individual Development Plans will not be made for minor dependents, with the exception of Transition Age Youth who are not enrolled in K-12 education.

5b. Individual Development Plan Task

- The IDP Task TP is used to lay out the concrete steps to achieve a desired goal.

In the technical sense, the IDP Plan process mirrors that of the FDP (The dashboard, the Plan task, etc.) However, there is one key substantive difference:

- In FDPs, the Vision is more related to Urban's RBA Results, whereas in an IDP, the Goal is more relevant to Urban's RBA Results.
- In FDPs, the Vision will speak to a household aspiration and the Goals can be set out for individuals as well as the family unit. In IDPs, the Vision will speak to the individual aspiration and the Goals are set out for that individual only.

APPENDIX FORM B contains tips and examples for creating FDPs and IDPs

Workflow Step 4: Service Linkage

Purpose:

1. Connect resident participants to specific services that are more specialized to meet a given need
2. Address a resident participant's need that lies outside the scope of service and expertise of the case manager
3. Provide an opportunity for the resident participant to expand their personal "support system" that will exist after case management is finished

Act on the Mission:
Connect resident participants to the most effective interventions and services available

Case Management Tasks:

1. **Build Trust:**
    - Involve the resident participant in the decision-making process on where to obtain a given service when possible
    - Familiarize yourself with the process for participating in a given service
        - Eligibility standards
        - Intake process
        - Documentation needed

2. **Orient to Goals:**
    - Make the case for how a given intervention or service is related to the long-term vision of the resident participant

3. **Consider Time Available:**
    - Establish partnerships with key organizations to avoid unreasonable delays in service participation
    - Offer to remind resident participant of when tasks need to be completed to successfully participate in and complete a specified program

Administrative Tasks:

1. As a site, a guide to resources should be created and shared by site staff
2. Complete Release of Information forms with resident participant for all service linkages
3. Maintain documentation of referrals in the resident participant's paper file

TouchPoints in LEARN to complete during Service Linkage:

- This TP is taken once a referral that is associated with either an IDP or FDP is created.
- This TP is also taken at any point a resident informs us of his/her or family's participation in a service that either they or a service provider initiated.
- To access a specific Linkage area, you must choose from the list of TPs. In each Service area TP, you must choose the specific service that best fits from the provided list.

- Adults link to services to attain personal development goals.
- Adults access services to effectively carry out family responsibilities.
- Children and youth access services to succeed in educational and career pathways.
- This TP is where school enrollment information will be housed.

Service Linkage categories are as follows:

7. Service Linkage – Adult Education
7. Service Linkage – Asset Building
7. Service Linkage – Basic and Emergency Services
7. Service Linkage – Early Childhood Services
7. Service Linkage – Employment Services
7. Service Linkage – Health and Family Services
7. Service Linkage – Legal Services
7. Service Linkage – School Enrollment
7. Service Linkage – Senior and Disability Services
7. Service Linkage – Youth Services

*__APPENDIX FORM C__ contains a complete list of all the services broken down by category

Workflow Step 5: Follow up & Barrier Mitigation

Purpose: To proactively address challenges faced by resident participants that are not being addressed through another source, and are preventing a resident participant from moving forward in their completion of a goal

Act on the Mission:
Effectively supporting an individual and/or family in achieving life goals will require overcoming barriers

Case Management Tasks:

1. **Build Trust:**
   - Use a proactive approach to consider possible challenges and barriers to each service linkage and task being completed by the resident participant
   - Provide accurate information about the process for receiving barrier removal support
     - Eligibility requirements
     - Application process

2. **Orient to Goals:**
   - Make the case for how this assistance is related to the long-term vision of the resident participant

3. **Consider Time Available:**
   - Follow procedures established by the Project Manager for your site to ensure assistance for your resident participant will be provided in a timely manner

Administrative Tasks:

1. Maintain accurate physical records of all barriers removal support a resident participant receives through case management
2. Follow all barrier removal regulations set by your Project Manager pertaining to eligibility standards, application process, documentation, and follow-up support.

TouchPoints in LEARN to complete during Follow Up & Barrier Mitigation:
4c. Family Development Plan Progress Note
5c. Individual Development Plan Progress Note

- Each FDP & IDP Task TP will have corresponding Progress Note TP.
- The Progress Note is where the efforts of the Case Manager and resident participant are captured.

APPENDIX FORM D contains the benefits accrued when achieving each RBA Result
APPENDIX FORM E contains benefits to dependents from actions taken by responsible adults

Workflow Step 6: Quarterly Update

Purpose of Quarterly Update: To maintain accurate, up-to-date information on key aspects in the resident participant and/or family's life without going through an extensive re-assessment

Act on the Mission: Maintaining accurate data throughout your work with a resident participant will enable you to employ timely, relevant strategies when a resident participant's motivation to act is high

Tracking key aspects of a resident participant progress over time will allow Urban Strategies to effectively articulate the impact of case management in their lives

Case Management Tasks:

1. **Complete Quarterly Update for each household in caseload**
   - Gather updated information on the following aspects of a resident participant's life:
     - Housing stability
     - Healthy
     - Training & Employment
     - Safety
     - Children's school performance (if applicable)

2. **Orient to Goals:**
   - Update Individual and/or Family Development Plans to reflect changes
     - Update, close-out, and add goals and tasks
   - Create new service linkages to address needs not already being targeted or that lie outside the scope of your role as a case manager

Administrative Tasks:

1. Include all updated Individual Development Plans and Family Development Plans, new service linkages and Release of Information forms to household's paper file.

TouchPoints in LEARN to complete during Quarterly Update:

3. Quarterly Check-in

- Use this TP each time an attempt for a quarterly contact is made.
- Although this will not feed into the risk score or reports, it is an extremely important and required TP that will be monitored for completion
- Update all Individual Development Plans and Family Development Plans with changes
- For non-responsive residents document your attempts (3) in total (2) home visits and (1) formal letter offering services or the option to opt out of CM. In 3 months, it is required that you send a form letter via certified mail. The letter should indicate that we will keep the resident's file open

and active for two weeks past the date of the letter, and if we do not hear from him/her within that timeframe via phone or in person, we will put them on "inactive" status.

- They have the right to reactivate their file at any time before the end date of the program grant by simply making contact with his/her case manager. The Case Manager will continue to provide information to all non-responsive residents on events and updates by mail.
- Participant should be manually marked inactive (by dismissing him/her from the Case Management Program, using "Inactive" as reason) at the end of 2 weeks from the date when this notice of deactivation was sent. If this deactivation letter concerns the last remaining active adult in the household, also deactivate the Family using the "Log Change in Family Status," before dismissing this remaining adult. Set Date for Follow-Up appropriately.

- **Update Applicable Information in Corresponding Assessments**
- **Re-Calculate Family Risk Score if there are any changes on the Housing Stability, Head of Household/Adult Assessment, or Annual Youth Questionnaire**

Workflow Step 7: Re-Assessment

Purpose of Re-Assessment: To capture more comprehensive information on a household's situation at specific points during the grant period such as, relocation, re-occupancy, and the close of the grant period

Act on the Mission: Urban Strategies provides case management on a housing platform. Therefore, assessing resident participant progress at key points in the housing process provides Urban Strategies with important data on the impact of both case management and redevelopment in their lives.

Case Management Tasks:

- **Re-assess each household in caseload**
  - Complete Re-assessment at designated points during the grant period. This includes completion of all relevant assessments for the household.
  - Re-assess during relocation phase, re-occupancy phase, and close of the grant period

- **Support each household throughout major housing transition points**
  - Provide accurate and timely information throughout relocation and re-occupancy processes
  - Ensure resident participants understand the process and their options given the unique circumstances of each household
  - Ensure resident participants are able to make informed decisions with respect to their housing during each transition point

- **Orient to Goals:**
  - Update Individual and/or Family Development Plans to reflect changes
    - Update, close-out, and add goals and tasks
  - Create new service linkages to address needs not already being targeted or that lie outside the scope of your role as a case manager

Administrative Tasks:

1. Input all Re-assessment data into LEARN Database
2. Update all Individual Development Plans and Family Development Plans with changes
3. Include all updated Individual Development Plans and Family Development Plans, new service linkages and Release of Information forms in household's paper file.

TouchPoints in LEARN to complete during Re-Assessment:

- Update all relevant assessments as the circumstances change over time for the resident participant and his or her household.
- When there is an update to or change in the adult's risk factors, LEARN will provide the most recent TouchPoint values available when you select "Add Similar"

Workflow Step 8: Annual Family Review

Purpose:

1. Opportunity to update information previously collected that speaks to the Head of Household's responsibilities for minor dependents in the household.

Act on the Mission: A "Two-Generation" approach to case management recognizes both an individual's goals and aspirations, while accounting for that individual's responsibilities to the other members of the household. The Annual Family Review intentionally focuses on understanding and addressing the Head of Household's responsibilities for other members of the household.

Case Management Tasks:

1. **Assess or update information on minor household members**
   - Complete the Annual Youth Questionnaire for each minor household member in caseload

2. **Ensure Family Development Plans are accurate and addressing family's needs**
   - Update Family Development Plans to reflect needs, changes or new goals as a result of the Annual Youth Questionnaire
     - Update, close-out, and add goals and tasks
   - Create new service linkages to address needs not already being targeted or that lie outside the scope of your role as a case manager

3. **Support the healthy youth development of all minor household members**
   - School-age youth are enrolled in summer programming or youth employment
   - Parents and guardians understand their options when it comes to school choice for the coming academic year
   - Households are informed and encouraged to participate in health fairs, health screenings, and parenting support opportunities

Administrative Tasks:

1. Complete the Annual Family Review around the time of Spring Break each year
2. Input all updated data into LEARN Database
3. Update Family Development Plans with changes
4. Include all updated Family Development Plans, any new service linkages and Release of Information forms in household's paper file.

Workflow Step 9: Exit or Termination

Purpose:

1. Provide closure for the resident participant and/or family with regard to the services provided through case management

Act on the Mission:
Communicate with the resident participant that case management services will be ending, and as needed, create a plan for the transition of services and next steps

Case Management Tasks:

1. Communicate Clearly

- Communicate the reason for services to end
  - Grant period ended, therefore services are no longer available in the same way
  - Resident participant Non-compliance with Case Management program requirements
  - Resident participant is no longer eligible to receive services
- Communicate all possible options for continued support to the individual and/or family

2. Transition Planning (if continued services are needed)

Involve the resident participant in as much of this planning as possible, allowing the resident participant to lead on identifying sources for continued support

- Ensure the resident participant understands the transition plan and who they will be following up with

3. Consider time available:

- Plan ahead and be intentional with when you begin this process with resident participants on your case load. Some may need more time than others to process through this transition.

4. Attend to Emotions:

- Allow an opportunity to process through any emotional responses you or individuals on your case load may have
- Understand resident participants may experience a sense of abandonment, rejection, or loss.
- Reframe negative termination responses and shift the focus toward the progress the individual has made towards his or her goals.

Administrative Tasks:

1. Complete all documentation required when closing out a resident participant's file – both within the LEARN database and within the paper file
2. Update any outcomes and report on any additional progress obtained during the exit process

Use Internet Explorer as your default browser in "Compatibility Mode." Contact ETO Support for the latest supported version. ETO Software is only supported fully in Windows. Some features are available on the Safari browser. Use Internet Explorer 8 or above and turn off pop-up blockers. Use the ETO navigation buttons only and refrain from using the forward and back buttons in your browser. There is a timeout period to help keep the data secure. Five minutes before the automatic session logout a warning pop up winder will appear. After 60 minutes of inactivity, you will be automatically logged out of the system.

Common Terminology

Efforts are the intentional actions of the agency to support the participant within the design or logic model of the program.

Outcome is a participant based measure that shows significant change in the situation or behavior in correlation to the efforts.

Participants are the residents that our program is serving with the goal of improving their life situation. They are the subject of most of the data collection. Participants are in the ETO database once, no matter how many times they were enrolled and dismissed from programs. ETO collects the entire participant history.

Entity refers to organizations that you partner with such as schools and funders.

TouchPoints are any form that is used to collect data on participants or entities, such as program forms, assessments, questionnaires, etc.

- Each instance of case management is a TouchPoint (TP)
- TouchPoints are configured as forms that can include elements to
  - Measure behavior, knowledge, etc. on weighted scales
  - Count and calculate numeric values
  - Count answers such as Yes/No or Attendance/Absence
  - Track time spent working with participants
  - Track how many times a form has been taken over time

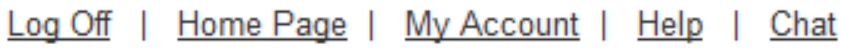
Lead Adult Participant (L.A.P.) is defined as the first adult from a household who enrolls in case management and speaks to the needs and aspirations of the household. We believe that we must use this adult's willingness to engage as an opportunity to provide a deeper level of case management that is family focused. The L.A.P can be the Head of Household or another adult. In order to calculate family risk within LEARN, there must be one record that "holds" the information on the household's other adults and minors. During relocation and re-occupancy, the Head of Household must be the one to make decisions and sign all paperwork.

Dashboards are your starting point to see information already entered in ETO or to collect new information. The most common dashboards are

My Dashboard – your landing page when you log on
Participant Dashboard – every participant has his/her own
TouchPoint Dashboard – for sub forms of a specific TouchPoint

The dashboards have been set up and customized to facilitate Case Management workflow

Navigating throughout LEARN



Log Off:

- Be sure to click this to properly log out of ETO. This keeps the site secure and data safe. Don't just exit out of your Internet Explorer browser.

Home Page:

- Use this button to route back to your homepage from any other page in the software. Be sure to submit/save your data before doing this!

My Account:

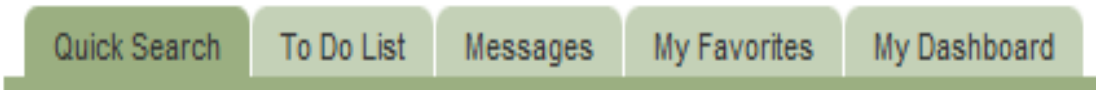
- Control your user account's settings, email address, and password under this button.

Help:

- Opens the online ETO Help Manual, providing access to helpful directions, recorded trainings, user manuals, etc.

Chat:

- Allows users to chat online with Customer Support



Quick Search:

- Allows you to search for participants in your program/site
- Offers Links for viewing or editing data when clicking on a name
- Also allows to search for entities or collections

To Do List:

- This takes you to the your personal (i.e. your user account) To Do List, which shows reminders that you set when completing TouchPoints

Messages:

- Send new messages or read received messages from other Program users. When you have a new message, this tab will turn red.

My Favorites:

- This tab allows you add features and reports that you use often. Your site administrator will build out program specific reports to add.

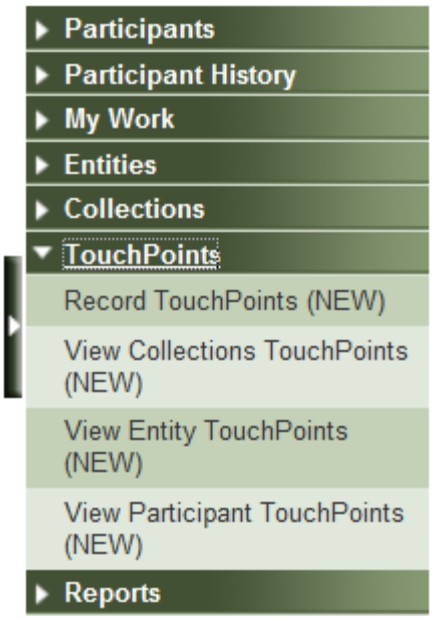
My Dashboard:

- This dashboard is YOU centric—see everything related to your work in the Program.

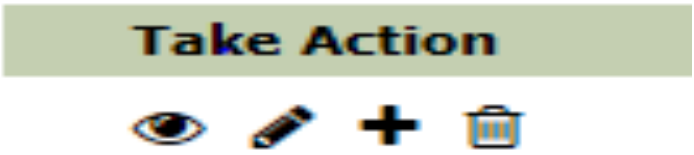
The traditional Navigation Bar is on the right-hand side of your screen.

- It may be collapsed by default; open it by clicking the black extension button
- Collapse it by clicking the button again

Most of the features for daily use that appear on this bar are available via the Dashboards and Quick Search. While you can access all features that were selected for your use, you will likely perform most actions from the Dashboards and Quick Search. The Bar on the right is an example for staff. Depending on the user's role the Navigation Bar may have more items.



In the "View Participant TouchPoints" and on the Dashboard next to each TouchPoint, you will be able to click one or more of the following icons:



- The eye-icon allows you to view your TouchPoint responses.
- The pencil-icon allows you to edit TouchPoint responses. This icon will be available for TouchPoint drafts and select final TouchPoints that allow editing before being locked. Do not use feature for updating responses.
- The plus/"Add Similar"-icon allows you to open up a blank form of the same TouchPoint form next to which you are clicking. For select TouchPoints, selecting this option will present a form with the existing TouchPoint responses already entered.
- The trash-icon allows you to delete a TouchPoint. This option is rarely available.

Adding a Participant

Before adding a new participant, perform a site wide search to make sure there is not an existing record for the resident. Use:

- Quick Search (see previous page) *or*
- Find Participant in the Navigation Bar>Participant and search for the Participant by Last name, SSN or Case Number.
- If you find the participant, click on the name and check the Program History to see where the person is or was enrolled.

To view or make changes to the demographics of an active participant in your program

- Find participant in Quick Search and click on the name
- Select in the context menu View/Edit (Participant)

DEFINITIONS OF ENROLLMENT STATUS	
For Individuals	**For Families**
Enrolled, if the participant**:** • Is eligible for services • Has completed Intake • Begun assessment OR service linkage	**Enrolled,** if the family: • Has at least one adult participant who is enrolled Where more than one adult participant is enrolled, only one of them can be designated the Lead Adult Participant, or LAP. Wherever possible, the Head of Household (HoH) should be designated the LAP.
Active, i.e., participating actively, if the participant: • Has developed either an IDP or FDP • Is responsive to case manager's follow-up services in support of IDP/FDP tasks	**Active,** i.e., participating actively, if the family: • Has at least one adult participant who is actively participating
Dismissed, if one of the following is true: • Participant is no longer eligible • Participant was terminated for cause • Participant is deceased or incarcerated • Participant has declined services • Participant is inactive, i.e., not responsive	**Dismissed,** if one of the following is true: • Family is no longer eligible • Family was enrolled, but currently has no adult participants who are active Families cannot be dismissed from the "Dismiss Participant" menu. Instead, use "Log Change in Family Status" to denote that a family is inactive. **Make certain to do this before dismissing the LAP.**

Prompts to add a reminder to your To-Do List

"Reminder to complete this TouchPoint"	"Reminder to take a new TouchPoint"
• Use this feature if you need to schedule a reminder to finish up or edit (i.e. update) this very TouchPoint form you have just filled out • Most commonly used to update the status of a Service Linkage • Also useful when TouchPoints can be saved as Draft	• Use this feature to schedule a new TouchPoint that naturally follows the form you just filled out: • E.g. if you just completed a Development Plan Task TouchPoint, you may need to follow up with a Progress Note or Service Linkage; so you set an alert to record one of the latter.

APPENDIX FORM F contains an overview of all TouchPoints
APPENDIX FORM G contains an overview of when to complete each TouchPoint
APPENDIX FORM H contains an overview of all TouchPoint settings

Expectations for Case Management Staff and Supervisors

- ***Completeness of data entry:***

Case Management Staff: Always double check against whatever data sources you are using so that all efforts and outcomes are documented without omission or oversight.
Supervisors: Monitor staff's "Task List" and "Dashboard" to monitor completeness of client records. Conduct random spot checks of caseload reports against original data sources such as sign-in sheets, graduation records or other info received from service providers.

- ***Timeliness of data entry:***

Case Management Staff: Make sure that you complete routine and annual tasks on time. Examples:

- Annual Adult Assessment updates must be on the anniversary of initial intake.
- Annual Children/Youth Assessment updates must be during the Spring Break each year.
- Referrals must be closed out within no more than a month after initiation (unless the participant is still enrolled and active in the referral program).

Supervisors: Be aware of events and milestones as they occur and instruct staff to make sure that staff enter those in., e.g., Community meetings, a graduating Construction Class, Lay-offs on the construction site. Monitor Referrals to ensure that they are not left open past 30 days. Also, send reminders to staff to complete Annual Children/Youth Assessment updates.

- ***Accuracy and Paper Trail:***

Case Management Staff: Seek clarity from supervisors on what the data sources should be for each entry into ETO. Always have a paper trail that backs up ETO entries, for audit purposes. Contact the referral partners to get complete information. Contact the client to make sure that they are still working where they last reported working.
Supervisors: Provide clear instruction on what back up is expected for job placements, job retention, referrals made, referral status checks, etc. Conduct file review to ensure quality of paper files. Ensure that paper files have appropriate back up documentation that matches ETO case file entries on all screens.

- ***Standard Urban Strategies Protocols vs. Site-based Adaptations:***

Case Management Staff: Follow standard protocols routinely; e.g., All FDP/IDPs and all referrals must be signed by the client; copy of signed documents must be in the paper files. Check with your supervisors where site-based adaptations are needed. Do not assume that site-based adaptations for one project site or one grant will automatically transfer to another project site or another grant, even in the same City.

Supervisors: Think through what site-based adaptations are necessary. Try to design a program schedule with activities that responds to local needs. E.g. Schedule trainings and job fairs around the construction schedule. Schedule summer program fairs and back to school events ahead of time based on school schedules.

Project Manager's Oversight for Completion of TouchPoints

At Baseline (Set a reasonable but clear deadline at Project Start)

1. Prior to Relocation, 2. During Re-occupancy Planning, 3.Possibly at Grant Close-out

- Housing Transitions and Choices
- Adult Assessment/Head of Household
- Senior & Disabled Adult Assessment
- Housing Stability
- Assessment of the Adults in the Household
- Household Income & Government Benefits

Quarterly

- Quarterly Check-In

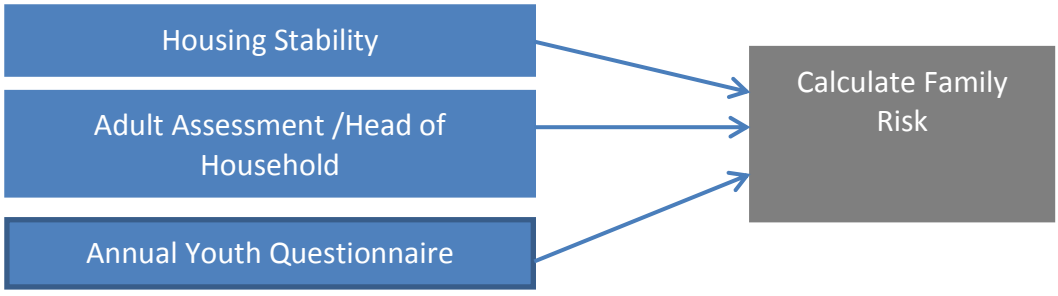
Annually (CNI Sites only)

- Assessment of the Adults in the Household

During Spring Break & at Grant Close-out

- Annual Youth Questionnaire

Family risk needs to be (re)calculated whenever updates made to the any of the following:



ETO Systems Admin: In addition to acting as the liaison with Social Solutions on all tech support issues, perform the following tasks –

1. **Database Training and Maintenance:** At a minimum, –
    a. Create and modify access levels for various users and staff. Weed out users promptly as needed.
    b. Approve and add specific referral partners under specific Service and/or Referral Category. Weed out annually in consultation with Site-Based ETO Liaison.
    c. Create and update training materials for direct service staff, supervisors and Site-Based ETO Liaisons.
    d. Communicate changes in database; enable and disable functionalities for each site as appropriate.
    e. Support the start-up of new Urban Strategies project sites.

2. **Ensure Compliance:** Monitor sites to ensure timeliness, accuracy and completeness by –
    a. Monitoring program rules around frequency and dosage
    b. Monitoring implementation of program policies and protocols
    c. Conducting data audits and sharing results with Sr. Project Manager for continuous improvement

Site-Based Liaisons: In addition to acting as the first line of tech support to direct service staff, perform the following tasks –

1. **Database Maintenance:** Support Urban's Systems Admin as follows –
    a. Create and modify caseload assignments for direct service staff.
    b. Request specific referral partners to be added under specific Service and/or Referral Category.

2. **Ensure Timeliness:** Support Systems Admin in making sure that:
    a. Referrals are not left open past 30 days (or other timeframe if more appropriate).
    b. Job Placement and Retention data are updated once each quarter.
    c. Children/Youth Assessment updates are completed annually during/close to Spring Break.
    d. Quarterly Check-Ins are updated promptly **OR** individual is marked "Inactive" after documenting appropriate procedures to attempt contact.
    e. Annual Adult Questionnaires are updated close to the yearly anniversary of Intake
    f. Set site-based rules for timely data entry as appropriate.

3. **Ensure Accuracy and Completeness:** Monitor that data is documented without omission or oversight by:

a. Providing or training staff to obtain and use appropriate sources for use in data entry, e.g., sign-in sheets, graduation records or other info received from service providers.
b. Calling attention to project milestones and events (e.g. community meetings; start and end dates for training programs) that trigger the need for data tracking and updates.
c. Conducting random spot checks against original data sources

Note: Approval of Unit Manager must be sought for site-based interpretations and adaptations of above guidelines. Do not assume that site-based adaptations of above guidelines for one project site or one grant will automatically transfer to another project site or another grant, even in the same City.

At the time of re-occupancy planning, if there are off-lease members of the household who plan to get on the lease, an FDP must be developed with the existing HoH to ensure that the HoH makes an informed decision on the wisdom of adding the new HH member, or not.

APPENDIX

FORM A - ASSESSMENT TOUCHPOINT OVERVIEW

	Participant or Family TouchPoint?	Family Members Selected For TouchPoint	Respondent
Housing Transitions and Choices	Family	All household members	Lead Adult (HoH for relocation and re-occupancy planning)
Housing Stability	Family	All adults in the household	Lead Adult (HoH for relocation and re-occupancy planning)
Adult Assessment /Head of Household	Individual	Enrolled adults or out-of-school youth 16+	Each enrolled Adult or Out-of-School Youth
Assessment of Adults in Household	Family	All adults & out-of-school youth 16+ regardless of enrollment	Lead Adult (HoH for relocation and re-occupancy planning)
Senior and Disabled Adult Assessment	Individual	Enrolled senior/disabled adult	Enrolled Senior or Disabled Adult
Annual Youth Questionnaire	Family	Lead adult, all children and in-school youth	Lead Adult
Quarterly Check-In	Individual	Adults & out-of-school youth enrolled in case management with an Adult Assessment	Each enrolled Adult Or Out-of-School Youth
Household Income & Government Benefits	Individual or Family	All household members or by individual adult	If submitted for entire family, Lead Adult
Calculate Family Risk	Individual	Lead Adult	Lead Adult

FORM C - LINKAGE AREAS & SERVICE TITLES FOR ETO

Service Linkage Area	Services
Adult Education	1. High School Credit Repair / Remedial Education 2. Adult Basic Education / Literacy Classes 3. Alternative School 4. GED Preparation/Classes 5. English as a Second Language (ESL) 6. Computer Classes 7. Vocational/Technical or Trade School Credential 8. College Prep Classes 9. Associate Degree 10. Four-Year Undergraduate Degree 11. Graduate or Professional Degree
Asset Building	1. Entrepreneurship 2. Financial Management *(Credit Repair, Credit Counseling, Credit Scoring, etc.)* 3. Homeownership 4. Individual Development Account (IDA) 5. Tax Preparation *(includes EITC, Childcare Tax Credit education, …)*
Basic and Emergency Assistance	1. Automatic Payment Deduction 2. Assisted Living Facility 3. Basic Needs Assistance *(household cleaning and personal hygiene products, etc.)* 4. Barrier Removal: Late or unpaid Union dues owed 5. Barrier Removal: Union initiation fees 6. Barrier Removal: Uniforms 7. Barrier Removal: Work clothing 8. Barrier Removal: Work-related tools or other equipment 9. Barrier Removal: Transportation to job site 10. Barrier Removal: Adult education expenses 11. Barrier Removal: Summer/After school program fees 12. Barrier Removal: Youth program equipment/supplies 13. Emergency Housing 14. Food Pantry/Meals on Wheels 15. Government Benefits *(SSI, SSDI, WIC, TANF, GA, etc.)* 16. Health Insurance Plan *(Includes ACA plans, Medicare, Medicaid, VA health insurance, etc.)* 17. Housekeeping Assistance 18. Payday Loan 19. Permanent Supportive Housing 20. Rental Assistance

	21. Safe Haven 22. Skilled Nursing 23. Single Room Occupancy (SRO) 24. Transitional Housing 25. Group Transportation Arrangement *(Vans to take participants to training program, clinic, shopping, etc.)* 26. Utility Assistance
Employment Services	1. Career Counseling *(i.e. Career exploration and planning)* 2. Customized Training *(Training that is developed to meet a specific company/organization's needs)* 3. Employment Readiness (Group) *(Jobs clubs, Job readiness workshops, Networking)* 4. Job Retention Support 5. Job Search Assistance (Individual) *(Staff assisted: job search, resume, cover letter and mock interview, etc.)* 6. Job Skills Training *(Includes Vocational training; Occupational training)* 7. Objective Assessment (Individual) *(Background checks and pre-screenings; Diagnostic testing and assessments; IEP)* 8. OJT/Transitional Jobs *(Includes Internships; May be privately or publicly funded but must be paid work)* 9. Placement Services (Referrals for job interview; Job Fairs; Job development) 10. Pre-employment Volunteer Job Experience 11. Re-entry Services *(Includes all services funded by community corrections)* 12. Self-service *(Referred to community resource for online job applications or labor market info)* 13. Upgrade/Incumbent Worker Training *(Incudes Rapid Response, Retraining and other services for dislocated workers)* 14. Vocational Rehabilitation

<table>
<tr>
<td>Early Childhood Services</td>
<td>
1. Custodial Care

2. Early Childhood Education

3. Developmental Screenings

4. Early Intervention

<table>
<tr><th colspan="2">Early Childhood Education Programs & Facilities</th></tr>
<tr><td>Type of program</td><td>Type of facility</td></tr>
<tr><td>1. HeadStart
2. Early HeadStart
3. Other</td><td>1. Pre-K classroom in public school
2. Licensed childcare center
3. Licensed childcare home
4. Unlicensed facility</td></tr>
</table>
</td>
</tr>
<tr>
<td>Health and Family Services</td>
<td>
1. Dental Care
2. Domestic Violence Prevention
3. Drug relapse prevention
(incl. NA, AA meetings)

4. Emergency / Crisis Intervention
5. Fatherhood Program
6. Family Literacy
7. Health and Safety Education (universal)
8. Health Screenings
9. Hearing
10. Hospice & Palliative Care
11. Independent Living Skills
12. Mental Health / Counseling (targeted)
(i.e., TARGETED programs based on diagnosis)

13. Parenting Education / Support
14. Physical Therapy / Assistive Devices
(e.g., Cane or crutches, Wheelchair, walker, motorized car)

15. Prenatal Care
16. Prescription Drug Assistance
17. Primary Health Care
18. Respite Care
19. Substance Abuse Treatment
20. Victim Services
(advocacy for sexual assault,…)

21. Vision
22. Wellness Services
</td>
</tr>
</table>

<table>
<tr><td>Legal Services</td><td>1. Citizenship classes
2. Drivers License Reinstatement
3. Expungement
4. Legal Aid: Housing/Tenancy
5. Legal Aid: Consumer debt/fraud
6. Legal Aid: Domestic Violence
7. Legal Aid: Divorce
8. Legal Aid: Employment/Unemployment
9. Legal Aid: Food Stamps
10. Legal Aid: SSI
11. Legal Aid: Successions
12. Legal Aid: Bankruptcy
13. Legal Aid: Homeownership Problems
14. Legal Aid: Tax disputes
15. Legal Aid: Medicaid
16. Legal Aid: Foreclosure
17. Other</td></tr>
<tr><td>School Enrollment</td><td>1. Elementary school
2. Middle school
3. High school

Additional specifications needed as below:

<table><tr><th colspan="2">Grade Level</th></tr><tr><td>1. Kindergarten
2. 1st Grade
3. 2nd Grade
4. 3rd Grade
5. 4th Grade
6. 5th Grade
7. 6th Grade</td><td>8. 7th Grade
9. 8th Grade
10. 9th Grade
11. 10th Grade
12. 11th Grade
13. 12th Grade</td></tr></table></td></tr>
<tr><td>Senior & Disability Services</td><td>1. Adult Daycare
2. Home Health/ADL Support
(i.e., help with bathing, dressing, cooking, shopping, ambulating, telephone, transportation, finances, etc.)

3. Recreational / Intergenerational Programs
4. Senior Companions
5. Emergency Response / Lifeline</td></tr>
<tr><td>Youth Services</td><td>1. Academic Support / Tutoring
(Includes study skills training, alternative schooling, credit repair and drop-out prevention)
2. After-School Program
3. Developmental Screening
4. Mentoring
(Includes guidance and counseling)</td></tr>
</table>

	5. Special Education 6. Sports, Recreation, or Cultural Program 7. Stress / Resiliency Services *(i.e., UNIVERSAL programs: trauma/grief counseling; pregnancy & other prevention programs; anti-bullying support)* 8. Summer Program 9. Summer Youth Employment *(Includes Conservation Corps, paid and unpaid work experience/internships or job shadowing, restorative justice programs)* 10. TAY Case Management *(Specific services in connection with foster care, homelessness, juvenile justice, probation or parole)* 11. Youth Leadership Development *(Includes service learning and volunteerism, e.g. AmeriCorps)*

Health & Safety Education	Mental Health/Counseling	Stress/Resiliency
General information and education to increase awareness of healthful activities, disease prevention and disease management practices. Education could be around physical health topics or behavioral health topics. Either way, if the service is informational and not therapeutic, this is where it goes.	Specific therapeutic services provided to adults after a diagnosis has been made.	Refers to prevention programs — specifically for youth, around prevention of school dropout, pregnancy, crime or violence, smoking, drug use, and any number of other undesirable behaviors that ARE caused by peer pressure, whether with or without stress or trauma being additional factors causing these behaviors. For youth who have specific diagnosis of a behavioral health condition or disorder, the case manager should refer to a therapeutic program, not a prevention program.

FORM D - LIST OF BENEFITS TO PARTICIPATING INDIVIDUAL OR FAMILY

For Use With

4a. & 5c. INDIVIDUAL or FAMILY DEVELOPMENT PLAN VISION

SORTED BY RBA RESULT
a) Live in safe, stable housing that is affordable and well maintained (Benefits to family tracked via FDP)
• Averted or reduced risk of eviction • Completed corrective actions to prevent or mitigate lease violation • Caught up with late or insufficient rental payments • Passed housekeeping or maintenance inspections
b) Work for a fair wage or be self-employed (Benefits to individual tracked via IDP)
• Participant signed up for earned income disregard (EID) • Placed into part-time employment • Placed into full-time employment • Maintained employment for 6 months or more • Secured job with increased wages • Participant became a small business owner
c) Children and youth are prepared for college and career (Benefits to family tracked via FDP)
• Child is on track to enter kindergarten ready for academic success • Dependent is on track to graduate from high school with a diploma • Child entered kindergarten ready for academic success • Dependent graduated from high school with a diploma
d) Be successful in education and workforce preparation (Benefits to individual tracked via IDP)
• Participant actively participating in high school diploma or GED program • Participant is enrolled in post-secondary education program • Participant obtained a professional license • Participant completed a certificate program (other than GED) • Participant obtained a college degree • Participant obtained a high school diploma • Participant obtained "other credential"
e) Focus on and work towards healthy lifestyles (Benefits to individual tracked via IDP)
• Participant applied for health insurance for self • Participant secured health insurance for self • Elderly participant enrolled in senior lunch program or meals on wheels • Elderly participant in need receives in-home healthcare services

- Elderly participant in need receives appropriate supportive services
- Elderly participant secured mobility assistance or assistive device(s)
- Pregnant women accessed prenatal care
- Pregnant woman accessed adequate nutritional resources
- Participant reports regularly utilizing the community's fitness amenities
- Participant regularly participates in health, fitness, and nutrition programs
- Participant reports regularly consuming fresh food and produce
- Participant received annual physical within the past 12 months
- Participant accessed annual dental care within the past 12 months
- Participant accessed vision care
- Participant accessed resources/services to help with hearing
- Participant in need accessed appropriate medical care (including preventive and palliative care)
- Participant in need participates in mental health services
- Participant in need participates in substance abuse or relapse prevention services
- Participant with history of substance use reports being clean for 30 days

f) Access opportunities to move into housing and neighborhood of choice (Benefits to family tracked via FDP)

- Participant created savings for down payment
- Participant's family moved into housing of choice
- Participant purchased a home
- Participant's credit score increased
- Participant applied for EITC within the past 12 months
- Participant applied for childcare tax credit within the past 12 months
- Participant applied for other tax credits within the past 12 months

FORM E - LIST OF BENEFITS TO DEPENDENT(S) OF ACTIONS TAKEN BY RESPONSIBLE ADULT

For Use With
4c. FAMILY DEVELOPMENT PLAN PROGRESS NOTES TP

Parent/caregiver demonstrates increased positive influence on a child/dependent in the following:
a) Academic development b) Health of a child/dependent, or c) Personal development

a) Academic development of a child/dependent	
Action Taken by Responsible Adult	**Benefit(s) to Dependent(s)**
Reports new habit of reading regularly with their child	• Child is better prepared to enter kindergarten ready for academic success
Made informed decisions on early childhood education and care	• Attends center-based or formal home-based early learning settings or programs
Made informed decision on school choice	• Enrolled in a higher performing school or school that meets specific family needs
Intervened to address discipline, behavior, or other academic concerns	• Received appropriate counseling or mental health services • Received appropriate academic intervention • Averted grade retention • Averted or mitigated suspension from school • Averted or mitigated expulsions from school
Intervened to address attendance issues	• Met school district's attendance requirements
Intervened to prevent or mitigate delinquent behavior*	• Averted incarceration or probation violation • Averted involvement with the juvenile justice system • Averted or mitigated truancy • Averted or mitigated suspension from school • Averted or mitigated expulsions from schools
Supported pregnant or parenting teen in achieving academic goals	• Averted high school drop-out
Encouraged child/dependent to pursue college and career	• Participated in college prep program • Applied to enroll in post-secondary education

Tasks marked with (*) may also contribute to housing stability goals of the family.

b) Health of a child/dependent	
Action Taken by Responsible Adult	**Benefit(s) to Dependent(s)**
Secured health insurance for child/dependent	• Child/dependent covered by health insurance
Secured developmental screenings for child/dependent	• Received early intervention services as appropriate
Secured services for child/dependent to address cognitive impairment	• Received services to address cognitive impairment
Secured preventive care for child/dependent	• Received annual physical within the past 12 months • Accessed annual dental care within the past 12 months
Intervened to address a physical health need	• Accessed vision care • Accessed services/resources to help with hearing • Received appropriate medical care for a diagnosed health condition
Intervened to address teen pregnancy	• Secured prenatal care for pregnant teen • Secured postnatal care and support for parenting teen
Intervened to address Adverse Childhood Experience a. Abuse b. Neglect c. Domestic violence d. Exposure to drug use by family member e. Exposure to mental illness of family member f. Exposure to violence or violent death g. Divorce or separation of parents h. Incarceration of family member	• Received counseling for grief or trauma • Received appropriate mental health treatment for a diagnosed behavioral health condition • Received treatment for drug or alcohol addiction
Secured and provided fresh food and produce for family	• Ate healthy meals that included fresh food and produce
Encouraged participation in health-seeking activities	• Participates in physical activities (sports, fitness or exercise programs) • Participated in nutrition education

c) Personal development of a child/dependent	
Action Taken by Responsible Adult	**Benefit(s) to Dependent(s)**
Increased involvement with children and family at home a. Increased time spent with dependent(s) b. Attended parenting class, fatherhood program or support group	Per parent/adult caregiver: • Experiences improved family relationships
Increased involvement with children and family at school a. Attended parent-teacher conference b. Attended school event c. Participated in PTA or other school support organization	Per parent/adult caregiver: • Experiences sense of belonging and/or value to family and community • Experiences optimism about the future
Modeled positive, responsible behavior(s) a. Is employed, or participates in job training or education b. Creates a safe and supportive home environment c. Knows the whereabouts of dependent(s)	Experiences optimism about the future Per parent/adult caregiver, school staff or service provider: • Experiences emotional well-being
Established clear boundaries and expectations*	• Understands rules and consequences • Expects consequences when rules are not followed
Monitors behavior of child/dependent based on established boundaries and rules*	Per parent/adult caregiver, school staff or service provider: • Demonstrated ability to resist negative peer pressure • Demonstrated ability to avoid risky behaviors or situations
Enrolled child/dependent in mentoring program	• Connected with competent and caring adult(s) through a mentoring program Per parent/adult caregiver, school staff or service provider: • Experienced sense of belonging and/or value to family and community
Encouraged positive youth development outside of school	• Participates in high quality OST program (after-school) • Participates in high quality OST program

c) Personal development of a child/dependent	
Action Taken by Responsible Adult	**Benefit(s) to Dependent(s)**
	(summer) • Participates in high quality OST program (year-round) • Participated in leadership development program
Encouraged youth to work or otherwise contribute to the community	• Participates in summer employment program • Participates in volunteer activities or community service
Monitored the change in behavior of youth who engage in positive development, work, or other community activities	Per parent/adult caregiver, school staff or service provider: • Demonstrated improvement in friendships, social skills and cultural competence • Experienced improved self-esteem • Experienced optimism about the future • Demonstrated improvement in planning and decision making skills • Demonstrated improvement in friendships, social skills and cultural competence • Experienced improved self-esteem • Demonstrated improvement in planning and decision making skills

Tasks marked with (*) may also contribute to housing stability goals of the family.

FORM G - TOUCHPOINT COMPLETION SCHEDULE

TouchPoint COMPLETION SCHEDULE F: Family TouchPoint I: Individual TouchPoint			
When?	**F/I**	**TouchPoints to be Submitted**	**Who is the Respondent?**
At Intake	F & I	* Contract Assignment	None. This is an administrative TP
	I	1a. Intake/Case Management Documents • *Consent to Participate* • *Release of Information Form*	Each participating adult or out-of-school youth 16+
	F	2b. Housing Stability	
	F	2a. Housing Transitions and Choices	
	I	3a. Adult Assessment / Head of Household	
	I	3e. Calculate Family Risk	
	I	4a. Family Development Plan Vision	
	I	4b. Family Development Plan Task	
	I	5a. Individual Development Plan Vision	
	I	5b. Individual Development Plan Task	
	F/I	1b. Income and Government Benefits	Optional
Shortly after Intake	I	1c. Relationship to Dependent in Household	Each enrolled adult or out-of-school youth 16+
	F	3b. Assessments of Adults in Household	
	I	3c. Senior and Disabled Adult Assessment	Each senior or disabled adult (ONLY if enrolled)
Once Per 90 days	I	3. Quarterly Check-In *(Leading to updates to other TouchPoints, as applicable)*	Each participating adult or out-of-school youth 16+
Spring Break		*Plans and Goals for Summer Activities:*	Each enrolled adult or out-of-school youth 16+ who has dependent(s)
	F	3d. Annual Youth Questionnaire	
	I	4a. Family Development Plan Vision	
	I	4b. Family Development Plan Task	
Summer Break		*Plans and Goals for Next School Year:*	Each enrolled adult or out-of-school youth 16+ who has dependent(s)
	F	3d. Annual Youth Questionnaire	
	I	4a. Family Development Plan Vision	
	I	4b. Family Development Plan Task	

	I I	*School Choice:* 7. Service Linkage - School Enrollment 7. Service Linkage - Early Childhood Services	
Re-occupancy Planning	F F I	2b. Housing Stability 2a. Housing Transitions and Choices 3a. Adult Assessment / Head of Household	Head of Household ONLY
	F only	1b. Household Income and Government Benefits	Head of Household ONLY (Optional)
	F	3b. Assessments of Adults in Household (F)	Head of Household ONLY
	I	3c. Senior and Disabled Adult Assessment	Enrolled Seniors and Disabled Adults Optional if HoH is not senior or disabled
	F	3d. Annual Youth Questionnaire	HoH who has pre-school aged or in-school dependent(s)
Program Close-out	F F I	2b. Housing Stability 2a. Housing Transitions and Choices 3a. Adult Assessment / Head of Household	Lead Adult
	F/I	1b. Household Income and Government Benefits	Optional
	I F	3a. Adult Assessment / Head of Household 3b. Assessments of Adults in Household	Each participating adult or out-of school youth 16+
	I	3c. Senior and Disabled Adult Assessment	Each enrolled senior or disabled adult
	F	3d. Annual Youth Questionnaire	Each participating adult or out-of-school youth 16+

FORM H - TOUCHPOINT SETTING CHART

TouchPoint	Save as Draft	Allow time between Submit and Lock	Editing without Time Limit
Contract Assignment	No	No	No
Log Change in Family Status	No	No	No
Intake/Case Management Documents	No	No	Yes
Household Income and Government Benefits	No	3 days	No
Relationship to Dependent in Household	No	No	Yes
Housing Transitions and Choices	Yes	3 days	No
Housing Stability	Yes	3 days	No
Quarterly Check-In	Yes	No	No
Adult Assessment / Head of Household	Yes	3 days	No
Assessments of Adults in Household	Yes	3 days	No
Senior and Disabled Adult Assessment	Yes	3 days	No
Annual Youth Questionnaire	Yes	3 days	No
Calculate Family Risk	No	No	No
Family/Individual Development Plan Vision	Yes	No	Yes
Family/Individual Development Plan Vision Amendment	Yes	No	Yes
Family/Individual Development Plan Task	No	No	Yes
Family/Individual Development Plan Task Progress Note	No	No	No
Case Note	No	No	No
Service Linkage	No	No	Yes