

**DISASTER CASE MANAGEMENT: DEVELOPING
A COMPREHENSIVE NATIONAL PROGRAM
FOCUSED ON OUTCOMES**

HEARING

BEFORE THE

AD HOC SUBCOMMITTEE ON DISASTER RECOVERY

OF THE

COMMITTEE ON

HOMELAND SECURITY AND

GOVERNMENTAL AFFAIRS

UNITED STATES SENATE

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WEDNESDAY, DECEMBER 2, 2009

U.S. SENATE,
AD HOC SUBCOMMITTEE ON DISASTER RECOVERY,
OF THE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:35 p.m., in room SD-342, Dirksen Senate Office Building, Hon. Mary L. Landrieu, Chairman of the Subcommittee, presiding.

Present: Senator Landrieu.

OPENING STATEMENT OF SENATOR LANDRIEU

Senator LANDRIEU. Good afternoon, and I thank everyone for your attention. Welcome to our meeting of the Subcommittee on Disaster Recovery. My Ranking Member was planning to join us and was called away to the White House for an unexpected meeting, so Senator Graham will not be with us today, but his staff is here and other Members may come in.

We have called this meeting today to discuss the ongoing efforts of the Federal Government to better coordinate the case management work associated with disasters, particularly catastrophic disasters, as was the case in the 2005 season with Hurricanes Katrina and Rita, and then followed on by Hurricanes Gustav and Ike in 2008, which really devastated the Gulf Coast. It is not the first time we have had a catastrophic natural disaster in the country, but it was one of the most significant and, of course, most recent.

So let me first begin by welcoming our panel. I am going to give very brief opening remarks and then introduce our first panel. Before I do, there are a few announcements.

I am pleased to have three Louisiana legislators with us, if you all would stand and let me recognize you all. We are always pleased to have legislators from any State, but particularly my State, so welcome. [Laughter.]

And I understand it is Beth Zimmerman's birthday today, so happy birthday, Beth. Working on her birthday. These FEMA people, they just keep working. So we appreciate you being here on your special day.

Let me just begin by saying that in the aftermath of Hurricanes Katrina and Rita, 250,000 families lost their homes. So over a

weekend, 240,000 people became unemployed. Schools, hospitals, and transportation systems ceased to operate. So did social support networks that we all count on when those things happen. Churches, community centers, and nonprofits were unable to reopen. All of this upheaval took a massive toll on the physical, mental, emotional, and financial well-being of people along the Gulf Coast.

In response to these complex and overwhelming needs, disaster relief nonprofits and government agencies launched a series of ad hoc case management programs to help families get back on their feet, because, frankly, we didn't have anything very well organized before this. The overarching objective of case management, as we know, is to return households to a state of normalcy and self-sufficiency as soon as possible. Case managers are supposed to serve as a single point of contact to help survivors access resources and services. Resources include things, as we know, like furniture, cookware, clothing, or housing, and services might be jobs, job placement, job training, child care, mental health counseling, financial counseling, or transportation to school and work, anything that would help families who have been affected get back to normal.

FEMA, HUD, HHS, and the States of Louisiana and Mississippi have all run case management programs since the 2005 hurricanes. The existence of so many programs in the same region caused a great deal of confusion among service providers and clients, but it also provided a diverse set of examples to inform the development of better models for the future.

That is what this hearing is about today. The title of the hearing refers to "Developing a Comprehensive National Program Focused on Outcomes." We are hoping that the information that is given can provide a more comprehensive approach focused not on process, but on outcomes, positive outcomes for these families in the event that this happens again, and undoubtedly, it will, someplace, somewhere in the United States, something similar.

So several startling statistics I just want to raise as we open this hearing. At one point, and I am not sure of the date of this, but at one point sometime probably within a few months of the storm, maybe within a year, a survey was taken and we found that only one-third of school-aged children at a group trailer site known as Renaissance Village in Baker, Louisiana, of which many of us are very familiar with, were attending school. That is not a good signal.

The homeless population of New Orleans, based on our understanding, has doubled since these storms, although a Herculean effort has been made, not only by our local groups but also HUD, to try to find appropriate housing. There are still thousands of people that we believe to be homeless, many of whom are residing in abandoned or vacant buildings.

Case managers and their clients use separate programs with different eligibility rules. We will learn more about that today. As a result, clients went through intake multiple times. Providers had to expend significant administrative resources. I could go on and on.

Some of the previous pilot programs seemed to focus, as I said, more on process than on outcomes. When they passed a client on to someone else, the case was closed. That doesn't necessarily mean the family was ultimately helped. It just means the case was

closed. We want to think about a system where when cases are closed, that means the family is back in a house, back in a job, the kids are back in school, and the family has regained their livelihood and self-sufficiency. Some of these families were on public assistance, but the majority never were, but most certainly needed some government aid to get back to normal after the hurricanes.

So we must continue to look at ways to improve, and that is what this hearing is about. Case managers were required to meet quotas for closing cases, which may have led to premature closures, as I said, or just passing off families that were difficult to serve.

Case management services are delivered under difficult conditions that make communication, recordkeeping, coordination, and efficiency tough. In areas like Southeast Louisiana, where housing and mental health professionals had all but disappeared, connecting people with the resources and services they needed was sometimes an impossible task. But we need to understand that this happens in a natural disaster. What can we do to improve it?

There is always tension between consistency and flexibility. We must standardize things like paper forms, data entry, and funding. But we also need to give flexibility to those trying to deliver these services in a difficult situation.

Privacy Act regulations prohibit FEMA from sharing registrants' information without written consent, so case managers knock on trailer doors and relied on word of mouth to offer their services instead of having access to reliable data. Maybe that is appropriate. Maybe it is not. We should review that.

That is what I am hoping that we can get from some of our panelists today, suggestions as to how we can improve the situation.

Let me suggest, though, in closing, that we may not have to look that far, and perhaps some of you have already looked at the models that exist, that have existed for over 30 or 40 years, that serve to help foreign refugees resettle here in the United States. In international circles, they are called refugees. But in the context of our speaking, they share a lot of similarities with people who are displaced inside of America. American citizens are displaced temporarily from their homes, and perhaps we can look at international models that are successful and shape them and modify them so we can be more helpful when thousands and thousands—tens of thousands—hundreds of thousands of families are displaced, not for a day, not for a weekend, not for a week, but for months, and some displaced for years from their homes while the community is trying to reestablish itself.

So we are hoping to get some information at this hearing about how to do that, and, of course, for the taxpayer picking up the tab for all of this, it is important that we do it efficiently and effectively so we are not wasting resources and wasting funding, and that we do it, of course, with the appropriate respect and deference to the families that we are trying to serve and the communities that we are working within.

So with that, let me submit the rest of my statement for the record and briefly introduce the first panel.¹

¹The prepared statement of Senator Landrieu appears in the Appendix on page 37.

We are very pleased that we had such a good response. Our first witness today—I am going to introduce you all and then we'll hear your testimony—again, Beth Zimmerman, our birthday person, serves as Assistant Administrator for Disaster Assistance at FEMA. She has had extensive State experience, has acted as State Coordinating Officer for numerous federally-declared disasters as well as scores of State-level disasters. We are looking forward to your testimony on this issue of case management.

David Hansell is the Principal Deputy Secretary for the Administration for Children and Families with the Department of Health and Human Services. Thank you for being here. We are looking forward to hearing your views.

Fred Tombar is a Senior Advisor to Secretary Donovan. He has probably been in New Orleans and other parts of Louisiana as many times as I have in the last few months, and we appreciate it. Being from the State of Louisiana, he is very special to us, and we are looking forward to his testimony today.

Kay Brown, our fourth witness, is Director of Education, Workforce, and Income Security at the Government Accountability Office (GAO). She will be here to discuss a report that GAO released on disaster case management, which I co-requested with Chairman Lieberman, and will shed some light on this challenge before us.

And finally, Amanda Guma is Health and Human Services Policy Director for our own Louisiana Recovery Authority, where she is overseeing our case management programs in Louisiana, and so she will be giving somewhat of the State perspective.

We have also invited our Mississippi folks to participate, as well, and some of our international NGOs are here, which won't be testifying, but that will provide input going forward.

So, Ms. Zimmerman, why don't we begin with you, and if you could each limit your testimony to 5 minutes, we will then begin the first round of questioning. Thank you.

TESTIMONY OF ELIZABETH A. ZIMMERMAN,¹ ASSISTANT ADMINISTRATOR, DISASTER ASSISTANCE, FEDERAL EMERGENCY MANAGEMENT AGENCY, U.S. DEPARTMENT OF HOMELAND SECURITY

Ms. ZIMMERMAN. Good afternoon, Chairman Landrieu. My name is Beth Zimmerman and I am FEMA's Disaster Assistance Assistant Administrator. It is a privilege to be here today on behalf of the Department of Homeland Security and the Federal Emergency Management Agency. As always, we appreciate your interest and your continued support in emergency management and especially in implementing the Disaster Case Management Program and authorities.

FEMA's goal has always been to work with the communities and assist them with their unmet disaster-related needs following a disaster so they can move forward quickly on the road to recovery, as one of these ways of achieving this goal is to help survivors to understand and to navigate through the wide array of services and programs that may be available to them to return to self-sufficiency and sustainability. As the coordinator of Federal disaster assist-

¹The prepared statement of Ms. Zimmerman appears in the Appendix on page 46.

ance, FEMA was charged with securing the delivery of disaster case management services. FEMA has been delivering disaster case management services on a very limited basis since the beginning of the Individual Assistance Recovery Programs in 1988.

Historically, these services have been very limited. They provide referrals to Federal, State, and local assistance programs, connecting the survivors to volunteer organizations through long-term recovery committees. However, the widespread devastation, as was noted, caused by Hurricanes Katrina and Rita created new challenges for the delivery and coordination of disaster recovery assistance at all levels of government.

In recognition of these challenges and the desire to expedite the comprehensive disaster recovery, Congress provided FEMA with the legal authority to implement a Disaster Case Management Services Program under the Post-Katrina Emergency Management Reform Act of 2006. Since that time, FEMA has been working very closely with our Federal, State, and local partners to pilot the delivery of several disaster case management models.

Currently, FEMA is implementing a two-phase Disaster Case Management Program model, and I am very pleased, in fact, today to announce that just this morning, we signed an interagency agreement between FEMA and the Administration for Children and Families (ACF) so that we could finalize both agencies' role in disaster case management. The agreement outlines the first phase of disaster case management, where once a State requests to have disaster case management, FEMA will notify ACF to initiate their rapid deployment of disaster case management assistance to the individuals and families in the affected disaster area.

Phase two of the program consists of a transition to the State-managed Disaster Case Management Program funded through a direct grant from FEMA to the State, and this will ensure that the State is an essential partner in the delivery of ongoing disaster case management services and the use of local service providers in the recovery of disaster survivors and the surrounding communities will be maximized. It also allows for States to build their capability and to care for their own citizens.

The delivery of timely, appropriate disaster case management services cannot be managed, as we know, at the Federal level alone. In fact, the coordination is most effective when it is on the ground, local, and close to the people affected. Many communities have such systems for coordination already in place through their established relationships among Federal, State, and local partners, the faith-based and the nonprofit organizations, the private sector, and most importantly, the disaster survivors themselves. Our goal is to build on the relationships to ensure the survivors have a holistic approach to rebuilding their lives in the wake of a disaster.

Because many of the disaster case management pilot programs are still ongoing, FEMA will be incorporating the successes and the challenges of the various models as well as the recommendations from the July 2009 Government Accountability Office report to develop the program guidance and regulations for the future to be a permanent Disaster Case Management Program.

FEMA is also committed to ensuring disaster survivors have access to the resources and services they need to help them rebuild and recover following a disaster.

But we can't do it alone. To be effective, our case management efforts have to be coordinated with experts at the Federal, State, and local levels of government and with faith-based and nonprofit organizations. FEMA will continue to fortify existing disaster case management partnerships and encourage new collaboration to ensure the implementation of a successful case management program, and I look forward to answering any questions you may have.

Senator LANDRIEU. Thank you, and congratulations on coming to that agreement. It has been something that I have asked for for a long time now, and I am very pleased that you all have taken this opportunity to make that announcement.

Mr. Hansell.

TESTIMONY OF DAVID HANSELL,¹ PRINCIPAL DEPUTY ASSISTANT SECRETARY, ADMINISTRATION FOR CHILDREN AND FAMILIES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. HANSELL. Thank you very much. Senator Landrieu, thank you for the opportunity to testify on ACF's disaster case management efforts. We share your commitment to improving the well-being of disaster survivors and appreciate your support for a well-coordinated, comprehensive disaster case management strategy. My testimony today will focus on ACF's current disaster case management efforts, the lessons we have learned, and our plans to continue and strengthen this vital work.

After the Stafford Act was amended in 2006 to authorize the President to provide funding for case management services to survivors of major disasters, ACF worked closely with FEMA, with Voluntary Organizations Active in Disaster, and States to develop a holistic disaster case management model. Our approach to disaster case management seeks to assist States in rapidly connecting children, families, the elderly, and persons with disabilities with critical services that can restore them, as you indicated, to a pre-disaster level of self-sufficiency that maintains their human dignity.

Our model is based on five principles: Self-determination, self-sufficiency, federalism, flexibility and speed, and support to States. Based on these principles, the pilot project was designed to augment existing State and local capability to provide disaster case management.

We first implemented a 2-week pilot project in September 2008 following Hurricane Gustav in Louisiana. FEMA then requested that we continue our pilot throughout the recovery process, which we have done with the support of the U.S. Public Health Service and Catholic Charities USA. In addition, we expanded the pilot to include survivors of Hurricane Ike to allow enrollment of new clients for up to 6 months post-disaster and to provide case management services for up to 12 months following enrollment. This ex-

¹The prepared statement of Mr. Hansell appears in the Appendix on page 53.

pansion from Hurricane Gustav to Hurricane Ike was seamless and resulted in no break in services to disaster survivors.

The total program across all sites is designed to run for 18 months from implementation, and to date, we have provided case management services to approximately 21,000 individuals, far greater than the 12,000 that we expected to serve. The majority of these clients had incomes below \$15,000 a year, and 35 percent of the individuals that we served were children.

To improve the program, we have evaluated our disaster case management efforts at multiple stages. We first conducted an after-action report on the initial 2-week pilot following Hurricane Gustav. This report identified strengths of the program, including the ability to initiate services within 72 hours of activation; the use of volunteers as program support and subject matter experts; the creation of effective links to health care, human services, mental health, and disaster-related resources; and the successful establishment of an intake call center for clients seeking services.

The report also identified areas requiring improvement, including the need to pre-identify case managers for deployment; to determine the availability of full-time case managers from voluntary organizations; and to establish clear team member roles and responsibilities on initial deployment.

We subsequently awarded a contract to evaluate the organizational structure and processes used for the pilot and to identify any significant implementation barriers that impacted clients' return to self-sufficiency or to access needed services. After the pilot ends, we plan to conduct an assessment of the impact and outcomes of case management services on clients' abilities to return to self-sufficiency and get back on their feet. Our focus on participant outcomes responds to the concerns cited in the GAO report and, concerns you expressed on the fact that Federal disaster case management evaluations to date have addressed process and implementation issues, but not outcome and impact issues, and we intend to do that.

I am delighted to report, as Ms. Zimmerman already indicated, that we have executed an interagency agreement with FEMA to allow for implementation of our Disaster Case Management Program after a future major disaster has been declared by the President. The agreement states that in coordination with FEMA and the States, ACF will initiate disaster case management within 72 hours of notification and for a duration of 30 to 180 days, depending on need.

At the end of the deployment period, we will transition disaster case management to either existing State resources or FEMA-funded State disaster case management programs. In exceptional situations, FEMA may authorize ACF to continue services until the State is able to assume disaster case management, while meanwhile providing States technical assistance, as needed.

Drawing on lessons learned from the pilot project and existing human services and disaster management expertise, the President's fiscal year 2010 budget request for ACF would fund the contract with Catholic Charities USA to provide a Federal disaster case management system. This contract will ensure that trained

personnel are credentialed and available when a serious disaster strikes.

Before I conclude, I would like to share just two brief stories that illustrate the significance of these efforts on the lives of individuals. One case manager helped a 49-year-old disabled man in Terrebonne Parish after his roof was damaged by Hurricane Gustav. The case manager helped him apply for Food Stamps, delivered the Food Stamp card to his home, and located AmeriCorps volunteers to assist with roof repairs.

Our case management program also assisted a single mom with five children in Saint Tammany Parish who could not evacuate their mobile home prior to Hurricane Gustav. After meeting with the case manager, this woman received immediate help with housing services, Food Stamps, clothing, crisis counseling, and disaster unemployment assistance.

These two are exemplary of thousands of other instances where disaster case management has made a significant difference in survivors' lives.

I truly appreciate the opportunity to appear before the Subcommittee and look forward to working with you on this vital effort. Thank you very much.

Senator LANDRIEU. Thank you, Mr. Hansell. Mr. Tombar.

TESTIMONY OF FREDERICK TOMBAR,¹ SENIOR ADVISOR, OFFICE OF THE SECRETARY, U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Mr. TOMBAR. Good afternoon, Chairman Landrieu, and thank you for inviting me to testify here today.

As you noted, Madam Chairman, HUD has administered case management services in the Gulf Coast for thousands of families impacted by Hurricanes Katrina, Rita, Gustav, and Ike. Under the largest of these programs, the Disaster Housing Assistance Program (DHAP)-Katrina, HUD disbursed \$63 million to public housing agencies (PHAs), to provide case management services to more than 36,000 families at a cost of \$92 per month per family. The purpose of the DHAP-Katrina case management was to help families transition to permanent housing.

Using models like HUD's HOPE VI Program and FEMA's Katrina Aid Today, a robust case management system was developed that emphasized the case manager's service connector role. Specifically, case managers completed needs assessments, establishing Individual Development Plans (IDPs) that identified the goals of each participant, primary of which was finding permanent housing. To reach these goals, case managers referred families to services that would assist in their progress.

DHAP-Katrina case management was implemented for all active DHAP-Katrina participants until February 28, 2009, the original end date for DHAP-Katrina. Between September 2007 and February 2009, case managers completed over 37,000 risk assessments and established over 34,000 IDPs. Nearly 97,000 referrals for services were made. The average case manager-to-client ratio was 1-to-

¹The prepared statement of Mr. Tombar appears in the Appendix on page 63.

28, and over 1,000 case managers were engaged in service provision.

During the transitional close-out program for DHAP-Katrina, from March 2009 to October, case management was provided in the States of Tennessee and Louisiana, with 200 case managers providing services to over 5,000 families.

While case management was being provided for DHAP-Katrina, Hurricanes Gustav and Ike struck the Gulf Coast in September 2008. HUD again worked closely with FEMA to establish DHAP-Ike. Case management services for DHAP-Ike participants began in November 2008, and PHAs received a fee of \$100 per month per family to provide case management. DHAP-Ike is scheduled to end in March 2010, and to date, \$20 million has been disbursed to PHAs to fund work of 400 case managers in providing services to over 17,000 families.

Within HUD's Office of Community Planning and Development, multiple programs provide case management and essential support services. Both traditional and disaster-related Community Development Block Grant (CDBG) program funds may be used for public services in the areas of employment, job training, child care, and other public services.

The State of Louisiana has obligated—the State of Mississippi, I am sorry, has obligated more than \$24.7 million of its disaster CDBG funding toward case management for people in its homeowners and small rental program. The State of Louisiana has similarly embedded applicant-based case management into its Housing Resource Assistance into its homeowner and small rental programs. Neither the State of Mississippi nor Louisiana has used disaster recovery CDBG money to directly provide case management services outside of those two programs.

Through the provision of DHAP case management, HUD has learned several key lessons that would assist Federal policy changes in the development of Disaster Case Management Programs. Under DHAP, high-quality case management is often provided when PHAs contract with local service providers rather than providing the services in-house. As Ms. Zimmerman testified to, local case management providers are already positioned to provide assistance and have the expertise in case management. Therefore, HUD recommends drawing on organizations that have a history of providing case management to disaster-impacted populations.

A second lesson learned is that even when utilizing local case management organizations, they may be insufficient direct post-disaster to fully serve these families. So beyond case management provisions, disaster-impacted regions are in need of increased resources for service providers.

A third lesson learned is the need to work more extensively with other Federal or nonprofit partners to link vulnerable populations to resources. For example, as DHAP-Katrina was ending, concerns arose over whether the most vulnerable clients had access to necessary resources. As a result, Housing Choice Vouchers were prioritized for elderly and disabled participants.

My final recommendation is that post-disaster case management should formally include a housing self-sufficiency function and that these services should be coordinated with HUD and the PHAs for

DHAP families. This will help clients to navigate PHAs' policies, identify families eligible for HUD's core programs, and focus clients on achieving housing self-sufficiency.

Chairman Landrieu, thank you for having me here and I look forward to your questions.

Senator LANDRIEU. Thank you very much.

Now that we have heard the agencies, FEMA, HHS, and HUD, we will now hear from our Government Accountability Office for its report on what they have done and how we can improve.

TESTIMONY OF KAY E. BROWN,¹ DIRECTOR, EDUCATION, WORKFORCE, AND INCOME SECURITY, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. BROWN. Madam Chairman, thank you for inviting me here today to discuss our work on disaster case management following Hurricanes Katrina and Rita. My remarks are based on the report you referenced, which we issued in July of this year, along with some updated information.

This afternoon, I would like to focus on three issues. First, the support Federal agencies provided for Disaster Case Management Programs. Second, the challenges faced by the agencies delivering the services. And third, the importance of learning from these experiences to improve client outcomes under the new program being developed.

First, regarding Federal agency support, as you have heard, FEMA, HUD, and HHS provided more than \$231 million to support multiple Disaster Case Management Programs. These programs provided services for as many as 116,000 families through numerous social service and voluntary organizations. However, as you can see in the graphic on my left, these programs started and stopped at different times. Sometimes they overlapped and sometimes there were breaks in funding and gaps between the programs. These gaps led some service providers to lay off workers or shut down services and may have allowed an unknown number of people in need to simply fall through the cracks.

Also, Federal agencies and case management providers had difficulties sharing timely and accurate information on who was getting or who needed services. In some cases, due to privacy policies, FEMA was unable to provide needed client-level information to service providers to help them assist those in need.

Moreover, the service providers themselves use several different and incompatible databases, making it difficult to track clients across agencies. Again, this may have resulted in some people not receiving needed services. It may also have allowed others to receive services from multiple providers.

Second, turning to the challenges faced by the agencies delivering disaster case management services, many agencies faced high staff turnover and large caseloads. Some agencies' caseloads ranged from 40 to as high as 300 cases per worker. Also, clients frequently needed help finding housing, employment, training, and other basic necessities, as you can see from our graphic on the right. But these

¹The prepared statement of Ms. Brown appears in the Appendix on page 66.

were in short supply, and FEMA-funded service providers were not permitted to provide direct financial assistance to their clients.

Unfortunately, many case management agencies conducted little, if any, coordinated outreach. As a result, those most in need may not have been offered or received services, such as those in the group trailer sites. Further, Long-Term Recovery Committees, which were intended to help marshal and direct limited resources, did not always live up to their potential. In some cases, they, too, were depleted of resources, and in others, case managers viewed the process for obtaining assistance as time consuming or confusing.

Third, regarding the importance of lessons learned to help improve client outcomes under the new program. After 4 years and more than \$231 million, we still do not know enough about whether these services actually helped storm victims. We need to better understand how well the programs met their clients' needs, and when they did, what specific factors contributed to meeting those needs.

In our July report, we recommended that FEMA conduct an outcome evaluation of the pilot programs. We understand that FEMA currently plans to glean outcome information from evaluations and use this information as it develops the model for its new Federal Disaster Case Management Program. Learning from these pilot programs is particularly important in light of the coordination and other challenges service providers faced, all of which could adversely affect client outcomes.

Given the uncertainty of when and how large the next disaster will be, we also recommended that FEMA establish a time line to hold itself accountable for progress in finalizing its new program.

In conclusion, it will be crucial to incorporate lessons learned over the past 5 years so that future disaster victims have the best chance to get their lives back on track and so government resources are put to the best use.

Madam Chairman, this concludes my prepared statement.

Senator LANDRIEU. Thank you, Ms. Brown. We really appreciate the report that you all have done. It will be very informative and already has been for us as we move forward to try to improve.

Ms. Guma.

**TESTIMONY OF AMANDA GUMA,¹ HUMAN SERVICES POLICY
DIRECTOR, LOUISIANA RECOVERY AUTHORITY**

Ms. GUMA. Thank you, Senator Landrieu, for the invitation to testify today, and thank you for your leadership in helping to secure resources for disaster case management for the State of Louisiana. We are also grateful to our Federal partners for making such an important investment in this critical activity. We appreciate the opportunity to reflect on our experiences and to talk about the challenges and make recommendations for future Disaster Case Management Programs.

Since Hurricane Katrina, funding for Disaster Case Management Pilot Programs has come down to Louisiana through various channels, to nonprofit organizations, to local entities, and to the State

¹The prepared statement of Ms. Guma appears in the Appendix on page 82.

itself. Because most of those programs have required reimbursement, local providers have assumed significant financial burdens in launching them.

One of the primary reasons why our original partners in our application for FEMA's Disaster Case Management Pilot Program withdrew was because of the lack of up-front or advance costs for the program. Having already experienced funding delays with the reimbursement under Katrina Aid Today, those partners were unwilling to take a similar risk again.

Another aspect of the Disaster Case Management Programs to date that has presented a challenge for us in Louisiana is the time lines. We remind the Subcommittee that virtually every program created for human recovery has been extended beyond its original time period. While we are grateful for the flexibility that our Federal partners have shown in extending those programs, we regret the negative impact of the changing time lines on our residents.

Last-minute decisions from Washington have made it very difficult for the State to protect its clients. We have seen thousands of families leave trailers and rental units in anticipation of upcoming deadlines, many of them turning to unsafe alternatives. We know that some have returned to damaged homes that are dangerously uninhabitable, while others are renting apartments that do not meet quality standards.

Program periods are often determined at the beginning of the recovery process and often in the absence of input from local stakeholders. In every case to date, local leaders have known that these program periods were too aggressive and not reflective of the actual pace of recovery. The ultimate impact of this has been felt most by the very people these programs have been designed to serve.

The overarching challenge, however, that the State has faced with Federal Disaster Case Management Programs is around the need for greater coordination. Federal Disaster Case Management Pilot Programs provide a critical tool to identify needs and track recovery outcomes. As these programs move forward, and certainly as they come to an end, the information gathered must be made available to those State and local government agencies that will be assuming responsibility for the long-term recovery.

The case management process creates an invaluable opportunity to translate the needs of residents into new or expanded local assistance programs, but this can only be achieved with proper coordination and information sharing.

The Louisiana Recovery authority (LRA) has spent countless hours seeking information from Federal partners on program and client status. Requests by the State for information should not get stuck in agency headquarters where legal teams debate privacy issues and the State's right to the data. Local governments need access to this information to ensure their ability to meet ongoing needs when Federal Disaster Assistance Programs end.

We thank both HUD and FEMA for working with us towards resolution on these issues, and we know that our progress has already had a positive impact. We regret, however, that greater change has not been made to date. In addition to data sharing, the coordination that we are recommending is also in terms of truly working together and collaborating on a local level. We have made

tremendous success locally, but we believe that collaboration must be institutionalized within agencies and within the program design to ensure process and success. There are and there must be more effective ways for government partners at all levels to share information and client data.

That said, we would make a few recommendations moving forward for Disaster Case Management Programs. We ask our Federal partners to explore creative ways to release funding more quickly for disaster case management, including up-front advances and preapproved grant applications. We ask our Federal partners to consult with local stakeholders when designing programs and to establish a process for reviewing progress halfway through the program period so that any extensions required can be determined well in advance of the deadline.

We recommend that at the time of a disaster declaration, the State or impacted locality be included as a partner in any inter-agency agreement. And finally, we ask our Federal partners to formalize a structure and process for working together with local partners as part of all future program guidelines.

Thank you.

Senator LANDRIEU. Thank you very much, particularly for those succinct and, I think, very excellent recommendations for improvement.

Before I get into questions, you all have the charts, I believe, on the table, and I would just like to refer you to the time line first.¹ Just to put this hearing in perspective, while we are very encouraged by the agreement, Ms. Zimmerman, between FEMA and the Department of Health and Human Services, we want to recognize by this time line the fact that actually before Hurricanes Katrina and Rita, there was virtually no case management provision in the Federal law for dealing with a disaster, as if it was not an essential component of recovery, which it is.

When you see this time line on this chart, which is represented up here, what strikes me as the hurricane hit in 2005 and the levees broke in August 2005, Mississippi didn't have its own case management pilot program started until August 2008. You think about that. Three years later before the program was even started? Well, it was phase two, I am sorry, phase two in Mississippi.

Now, Louisiana Family Recovery Corps started in January 2006, which is much sooner, but still, think about families in September and October and November and December, at some of the most critical times in these families' lives and there wasn't much to reach to. What was there was little, if anything, and very fragmented. We don't want to see this happen again.

Another very interesting graph from this report which struck me is not up on our chart, but you all at the table can see it. It is a graph of how people found out about Katrina Aid Today (KAT), which was the Federal program put together in, it looks like here, sometime late in 2005. Eighty-five percent of the clients, according to the GAO report, heard about it from word of mouth. I mean, you would think in the midst of a major disaster, people would be, of course, listening to the radio or listening to public spots on the tele-

¹The charts referred to by Senator Landrieu appear in the Appendix on page 39.

vision. To think that families had to hear about it from each other as sort of a circle of survivors, like, what is working for you? Well, this case manager helped me. Maybe she can help you. It threw me a little bit. I don't know why we can't get free radio advertisement for these services to all these families.

The other interesting chart, which is going to be part of my questions, because I am going to ask you how we are going to set up a system that actually can surge when necessary, is demonstrated by this chart, which shows the number of clients that were served. There were more clients served in Louisiana—thank you for putting that up—30,000, than all the other States combined. So Texas had 13,000 people, Mississippi had 9,000, Alabama, 2,500—I am just roughing these—Georgia, 2,500. So Louisiana had 30,000 clients that were served.

You could argue that three times as many people needed the help as ever got it and just abandoned the effort altogether. I don't know if we will ever know what those numbers were. But even assuming that these were all the families that needed help and we reached everyone, which is very wishful thinking, part of what my questions are going to focus on today, is whether the model that we are setting up can work well when only 2,000 families are looking for help? And what happens to the model when 50,000 families need help? Is the model that we are building going to be able to surge to the levels necessary to do the job that is required?

Another thing that struck me came from the GAO report. It said that the five most reported needs among the clients were housing, furniture, health and well-being, utilities, and food. I am very interested to see that jobs was not on here. I would have thought, with 240,000 people out of work, that one of the things that people might be scrambling the most for would be employment. So I am interested to know from GAO why that didn't come up more. Maybe it did in a different way. I mean, obviously, housing should be first because that is what people were scrambling the most for is shelter.

And so those are just some of the observations I wanted to point out, and let me get to my questions and I will start with those. Let us talk about, with the panelists, about the model that you are developing. First of all, Ms. Zimmerman, do you have any intention of asking HUD to be a party to this agreement, or is this something that you all are doing just with Health and Human Services? And if so, why, and if not, why not?

Ms. ZIMMERMAN. The current agreement is between us and Health and Human Services. We recognize our partners with HUD through the programs that we have used to date. One of the initiatives that is going on right now is the Long-Term Disaster Recovery Working Group that has been established through the White House, which is in conjunction with the Secretaries for HUD and the Secretary for Homeland Security. So as we are moving forward with that, it is looking at disaster recovery on the broader scale and the abilities that we have today versus where we want to take disaster recovery in the future.

So I believe one of the outcomes from that working group and our recommendations and our reports will be to incorporate all of

the partners who have a piece of the case management and what that program should look like going forward.

Senator LANDRIEU. And what is your view on that, Mr. Tombar?

Mr. TOMBAR. I, too, reference the work that the two agencies are heading in concert with, actually, all the agencies across the Federal Government with the Long-Term Disaster Recovery Working Group. I believe that out of that, we will certainly see a recommendation to the President that, in fact, there needs to be better coordination across the Federal Government in a way that we provide services for recovery and relief to families that are impacted by disasters.

Senator LANDRIEU. Right. And I think that all you really need to make that point is this particular chart, if I can find it, the one that says the thing that people needed most was housing. When you are managing cases for families—I don't know what I did with mine, but it is around here—they needed housing, I think it was the number one on the chart, and then furniture, health and well-being, utilities, and food. So we should keep that in mind.

The other question that came to mind, just thinking about regular work in regular times, how communities and how families navigate among agencies to try to help them—without disasters in mind, just normal days—they call a service 211, it is like 911, but there is a 211 service that we are trying to develop. I have been helpful in trying to start that up and fund it in many places around the country.

In addition, Public Health units sometimes do outreach in urban areas. There would be Rural Extension Services in rural areas. A lot of families will call up Rural Extension and say, I need this help or I need that. They might call Public Health offices. And they most certainly, at a volunteer level, non-government, 211 is something that I think communities are getting used to. How are we incorporating the bone structure that is already there before we build? And are we building on that? Are we paralleling some of their work? Are we using them in some case management? Or is that just a reference? Is 211 just a referral service. It is not really case management, it is referral. But could that be used in any way as we build this system? Does anybody want to comment? Mr. Hansell.

Mr. HANSELL. Yes, absolutely. One of the things that we learned from the early part of our post-Gustav pilot was that having a single toll-free call-in line for access to services responded to the concern, Chairman Landrieu, that you mentioned earlier of people not having a direct place to go to get access to the services.

What we would intend to do in the future is, where resources like 211 or other phone lines that exist, to build on and collaborate with those rather than to create something new. They don't exist in every State. They don't exist in every part of the State. But we certainly would agree that where they do exist, we would want to partner with them in building on an existing capability.

Senator LANDRIEU. And I just think that would be a smart approach, to survey what exists in the 50 States now and in the counties, measuring that against the counties, or parishes in our case, most at risk. You can just overlay that risk map pretty easily over

the assets, and when you are building a national model, build it at least on some of the things that are already there.

And let me correct myself, because I want to give credit where credit is due. The bar graphs I mentioned earlier are from the report on Katrina Aid Today by the national service provider, which in this case was the United Methodist Committee on Relief. So we thank them for this information. And then the time line, of course, was presented by GAO.

Let me ask a couple of other questions of the panel. This would be both for ACF and FEMA. Catholic Charities was awarded a 5-year nationwide case management contract as part of the task order which has not yet been funded. Catholic Charities is required to pre-identify local regional volunteers and subcontractors to be ready to deploy within 72 hours. Can you elaborate on the Department's plan for funding this contract and near-term tasks to develop a national team, and have you all identified funds to implement this contract?

Mr. HANSELL. Yes. That is our contract, so I will respond. We are awaiting the approval of our fiscal year 2010 budget to fund that contract. We are, like much of the government, operating under a Continuing Resolution right now.

Senator LANDRIEU. And what is in the budget? I mean, what is in the appropriations bill?

Mr. HANSELL. The President requested \$2 million, the bulk of which would be used to fund the contract. We designed the contract to respond to a number of the things that we learned from our initial evaluation, as I mentioned, particularly the difficulty in finding and recruiting enough qualified case managers, especially in a quick response to a surge in need. So the contract will fund Catholic Charities USA, both to be prepared to provide disaster case management services in the event of a future major disaster, but also to pre-identify and pre-certify case managers so that they will be ready and available when a disaster strikes.

Senator LANDRIEU. And I understand this was a competitive bid. Can you talk about the other organizations that competed? Catholic Charities was chosen, but are there others—

Mr. HANSELL. There were several bidders. Catholic Charities was chosen. We can provide you with a list of the bidders, if you would like. We will be happy to do that.

INFORMATION PROVIDED FOR THE RECORD

The bidders that applied for this contract were Abt Associates, Inc., Catholic Charities USA, and Louisiana Family Recovery Corps.

Mr. HANSELL. But it was an open, competitive process, open to any bidder that was interested.

Senator LANDRIEU. Does anybody else want to comment on that?

Let us talk about the privacy issue for just a minute, because this continues to come up in our review. Does anybody want to comment about the current privacy issue and why it is in place? Is it necessary? Are there modifications that we could look to so that we can better serve the individuals that we are trying to serve? And again, in disasters, these can be very poor individuals who have been a part of some kind of government help and assistance through either Medicaid, housing, or job placement. It can be

middle-class families who have never been a part of any kind of government support system and are unfamiliar with how to navigate.

So let us talk about the privacy issue. I don't know who wants to start, Ms. Zimmerman, perhaps. And I would really like to hear from you, Ms. Guma, on this.

Ms. ZIMMERMAN. Sure. I would be happy to. First off, the number one thing for FEMA is to protect the privacy rights of the individuals, the disaster survivors. But through this process, we know that we need to provide information to the service providers for the disaster case management. So it is my understanding we now have a better process in place so that when an agency requests the information, we are able to provide, working with the State and the local provider to get that information that they need to be able to service the applicants when they come in.

Senator LANDRIEU. Well, can you articulate for me the reason that we would have to keep FEMA records private? Is it that we are trying to protect them from what, from being exploited by people trying to help them, or exploited by unscrupulous salespeople, or what are we protecting them from?

Ms. ZIMMERMAN. The latter of that. We gather a lot of information when we are putting people into our database to assist them through our programs of individual assistance—Social Security numbers, a lot of personal information. Not all of that information is needed when it goes forward to the other providers for case management. So we are able to release that other information, names, addresses, and phone numbers. So we do have a process in place to do that.

Senator LANDRIEU. Yes.

Ms. ZIMMERMAN. So I believe that has improved over time.

Senator LANDRIEU. Because I most certainly can understand keeping Social Security numbers, banking information private, but information about names, number of children in the household, previous employment, if the father was a welder, that might be helpful for the case manager to know because he is looking for a job and what was his previous employment, things that would be useful to help people.

Ms. Guma, do you want to comment about that?

Ms. GUMA. Yes, I do. I want to first acknowledge that we have made tremendous progress with both FEMA and HUD in this regard. Having said that, we have gone down a very difficult journey to share information, and when we started the process of requesting information, both on households living in trailers and households in the DHAP program, even the process of getting aggregate data, which not even client level with any identifying information, in the initial phases was a struggle. We have, again, made leaps and bounds in information sharing and it now flows much more easily.

I guess one of our concerns, just speaking back to one of our recommendations, is that the process really does need to be institutionalized. It is wonderful that we have great partners now at the table with us who work really well. We can make requests and get the information so quickly and we tremendously appreciate that. But our concern is that in a new place, on a new day, at a new

time, it would perhaps be a different scenario for that government body seeking that information. So we do think it is important.

We also encountered a challenge with FEMA and HUD where there was not clarity about who was allowed to give us data, and I think that has been something that has been worked out. But when we have sought data in the past from HUD, there has been some confusion about who had the authority to release it, and I do think we have made progress on that front. But it was a big challenge for us for a very long time.

Mr. TOMBAR. If I may, Ms. Guma is right. There was a challenge with providing the data, and the data that the State was requesting was full access to all data that we had because they wanted to know as much as they possibly could about the families, and it made sense to be able to provide the comprehensive type of case management that you reference.

What we learned was that the Privacy Act prohibited HUD from being able to provide that data because we did not have the type of arrangements and agreements and approvals through the systems of record for those data to be able to provide that to the State. But in a conversation with Ms. Zimmerman and others over at DHS, we found that FEMA did, in fact, have ongoing agreements with the State and therefore was able to simply, by not making the request for the same data to HUD, but simply to FEMA, that FEMA could provide the data.

And, in fact, I am pleased to announce that for DHAP-Ike, where the State of Louisiana has made a request for data that was provided to them on behalf of families in DHAP-Katrina, just today on a conference call jointly with HUD, FEMA, and the State of Louisiana, we think that we have been able to resolve that issue so that those data will be able to flow forward to the State at some time soon.

Senator LANDRIEU. Well, I just urge you all to stay focused on finding the right solution to this issue so that we are treating people as quickly as we can, helping them with dignity. People want help. They don't want to fill out multiple forms giving their name, their Social Security information multiple times to different agencies because the law doesn't allow the agencies to talk with each other.

Now, there is a reason why some personal data should be protected, but when you are trying to help, it is imperative that local officials and local entities, the nonprofits, the State, the parishes, particularly because those locals are in some way held accountable for the outcomes, so that the Federal Government looks down on the City of New Orleans and would say, why do you have 10,000 homeless people still? That is a good question to the city. Well, if the city says, we don't even have information about these people because we can't get it other than a door-to-door daily survey, then that is a real issue. And I am sure that is true across other places in the Gulf Coast.

Let me do one or two more questions and then we are going to move to the second panel. This duplication of benefits issue, it is my understanding that Public Housing Authorities at State and local levels considered themselves to be caseworkers, which required the Mississippi Case Management Consortium to close cases

with other voluntary agencies to avoid duplication of benefits. Could you comment about this? I guess it is Fred Tombar with HUD. What are the Public Housing Agencies—will they continue to provide case management? Will this continue to be judged as a duplication of services, which is against the law? Is that the situation? Does anybody want to comment or know anything about that? Did GAO look into that at all?

Ms. BROWN. We went only as far as looking at the fact that there were stops and starts and multiple service providers at the same time. We didn't look to see whether there should be—

Senator LANDRIEU. You weren't looking for the content for the services provided, or the quality of the services provided?

Ms. BROWN. We would have liked to have looked at the quality of the services provided, but I think the information just wasn't there for us to make a judgment on that.

Mr. TOMBAR. The duplication of benefits is sort of a term of art that has multiple meanings, and you know about it well in the context of the Road Home Program and our Community Development Block Grant Program and how—

Senator LANDRIEU. Small Business Loan Program—

Mr. TOMBAR [continuing]. It is a little bit confused with it being used in this context. But my understanding is that what is at issue here is that there were agreements with one of the groups that you have testifying on your next panel, Mississippi Case Management Consortium (MCMC), to provide services on behalf of some 400 families initially. Those were families who subsequently became a part of the DHAP Program and were services by Public Housing Authorities (PHAs) in terms of the payments that were being made on their behalf.

And so what we didn't want was precisely the thing that you are critical of here, was that we had multiple service providers providing the same services on behalf of families. So that was the issue, was to not have the Public Housing Agencies duplicate services that were already being provided by an already contracted service provider.

Senator LANDRIEU. Well, I will ask the Mississippi folks to clarify that, but let me ask this final question, because I really want to get this clear with you all because it is important, I think, for those trying to create a better system.

The National Disaster Housing Strategy calls for HUD to continue providing case management services. But if FEMA and HHS have an agreement, there still is confusion among the at-large community about which agency is in charge, and so can you comment about who is the lead here on case management? Who should people be talking to? Is it FEMA? Is it Health and Human Services? Or is it HUD?

Ms. ZIMMERMAN. As of right now, FEMA has the authority in the laws to do disaster case management. With our agreement that we have right now with ACF, we have that ability to get them on the road within 72 hours to do disaster case management. And as we are moving forward to put together the permanent program—this is our interim program—then we will take that and take the lessons that we have learned and put together the program so it is comprehensive and it covers all aspects of it. So right now, a State,

if they get declared for a disaster and need disaster case management assistance, they would apply to FEMA for assistance and we would institute the program as it is today.

Senator LANDRIEU. OK. Well, I, for one, would urge you to work as quickly as you can to reach out to HUD, which is an obvious agency that needs to be included. And if you think about particular populations, the Justice Department may be another one in terms of case management. When you think about families and the status of family members, whether they were in prison when this happened, if they are on probation when this happens, for either juvenile cases or adult cases, in some of these communities and States it is thousands and thousands of people that may be affected. We haven't even looked at the coordination that is required with the Department of Justice.

But definitely with HUD, given that in case management, we are learning that what most families needed was permanent housing so that they could sort of reestablish themselves, get into a church or a synagogue, get into a school, get into a job and stabilize themselves until they could figure out when they could get back into their original community.

All right. Thank you all very much. I am going to have to move to the next panel.

As the next panel is coming up, just to save time, I am going to go ahead and do brief introductions, and again, thank you all very much.

We have, first, Rev. Larry Snyder, our first witness, who oversees Catholic Charities USA's work to reduce poverty in America. Rev. Snyder will discuss Catholic Charities' experiences under Katrina Aid Today and their work on the ACF model for disaster case management that was utilized after Hurricanes Gustav and Ike.

Next, we have Diana Rothe-Smith, who is Executive Director of the National Voluntary Organizations Active in Disaster. NVOAD is the forum through which nonprofit relief organizations share knowledge and resources. She will discuss their proposal to improve case management guidelines and programs.

Dr. Irwin Redlener is President and Co-Founder of the Children's Health Fund. Dr. Redlener has testified before this Subcommittee many times. We are happy to see him again and hear his views on case management.

Stephen Carr is a Program Director for the Mississippi Case Management Consortium. He is also a consultant to ABT Associates, through which he contributed extensively to the design and writing of the ACF-HHS model that we have just talked about.

And finally, Dr. Monteic Sizer is President and Chief Executive Officer of Louisiana Family Recovery Corps. He will discuss the Louisiana Family Recovery Corps' disaster case management work after Hurricanes Katrina and Rita and the need to develop long-term human recovery plans at the Federal level.

I look forward to all of your testimony, and thank you. Rev. Snyder, we will begin with you.

**TESTIMONY OF REV. LARRY SNYDER,¹ PRESIDENT AND CHIEF
EXECUTIVE OFFICER, CATHOLIC CHARITIES USA**

Rev. SNYDER. Thank you. Good afternoon, Chairman Landrieu. I want to thank you for the opportunity to appear before you to discuss the partnership between the Federal Government and Catholic Charities USA to provide disaster case management.

Catholic Charities agencies have a long history of serving those most in need at critical and vulnerable times. The services we provide are grounded in the fundamentals of social work practice and are delivered in accordance with sound ethics and our faith tradition. Case management is a critical component of the services provided in local Catholic Charities agencies.

In the interest of time, I would refer you to my written testimony, which details the efforts of Catholic Charities in the area of disaster response for over 40 years.

Recently, Catholic Charities USA responded to the government's competitive solicitation for a contract to provide a Federal Disaster Case Management Program and has been awarded a 5-year indefinite duration, indefinite quantity contract for these services. And while the overall agreement is for 5 years, we have only been authorized and funded to continue disaster case management services through March 31, 2010 to the victims of Hurricanes Gustav and Ike. Further funding for the implementation of the Federal Disaster Case Management Program has not been authorized.

I want to take this opportunity, though, to acknowledge the partnership Catholic Charities USA has with the Administration for Children and Families of the Department of Health and Human Services and the confidence that has been placed in our organization with the awarding of this Federal contract.

At the same time, we have faced a number of challenges throughout the process of providing these services, beginning with Hurricane Katrina until today. Each time, we have provided case management services during a disaster, the players have been different, the funding streams changed, the policies and procedures have been different, and the forms and requirements inconsistent and sometimes conflicting between and among both Federal and non-Federal partners.

Victims of disasters deserve and should receive services quickly and through a well-developed system at the national and regional levels. This can only be achieved if the resources are made available to do this work prior to a crisis.

When it became apparent that funds were not available to implement the Federal Disaster Case Management Program under the new contract, our contracting officer notified us that we would not be required to respond with a national and regional team within 72 hours should these services be authorized. My remarks, of course, were prepared before the announcement of the IAA ??? between FEMA and ACF, which is, in fact, talking about that funding, so we welcome that news today, as well.

We firmly believe that if we are to avoid the travesty of Hurricanes Katrina and Rita, where we saw thousands of people, especially those living in poverty and already marginalized, left behind,

¹The prepared statement of Rev. Snyder appears in the Appendix on page 89.

we must invest in a system that responds early with a network that can deliver the diversified services necessary to meet the needs of those affected.

Let me tell you a story about one client. James is a disabled client in Louisiana whose house was damaged by Hurricane Gustav. For an extended period of time, James did not receive his disability benefits because the support structure was not in place. Through the assistance of a case manager, James was able to obtain the documentation to apply for and receive his disability benefits. With the back payment he received, James is going to replace his roof and move back into his own home. While we were able to assist James, the process was significantly delayed.

With the infrastructure of a National Disaster Case Management Program in place, the response to James could have been far more timely. The investment to do this is small and the number of staff required to create and maintain such a structure is minimal. In fact, we estimate the total annual cost of operating this program to be a little over \$2 million.

The Federal Government historically has provided funding for the immediate needs of food and shelter following a disaster. But just as critical in the early stages of a disaster is the need for case management services. Based on the collective experience of our Catholic Charities agencies, I offer the following five recommendations to the Subcommittee.

First of all, fund a single national Disaster Case Management Program as part of disaster preparedness, including infrastructure and readiness for rapid response.

Two, establish a lead Federal agency that will have oversight and accountability for ensuring that agreed-upon outcomes are established and met.

Three, establish a consistent definition of disaster case management and policies and procedures to be adopted by both Federal and non-Federal organization.

Four, identify and implement one database for the collection of information that meets the needs of both Federal and non-Federal partners with consistency in meeting privacy requirements.

And finally, involve key stakeholders in all aspects of the National Disaster Case Management Program.

I thank you for the opportunity to testify about this important work and to make these recommendations based on our experience.

Senator LANDRIEU. Thank you very much, Rev. Snyder. Ms. Rothe-Smith.

**TESTIMONY OF DIANA ROTHE-SMITH,¹ EXECUTIVE DIRECTOR,
NATIONAL VOLUNTARY ORGANIZATIONS ACTIVE IN DISASTER**

Ms. ROTHE-SMITH. Thank you, Madam Chairman. Thank you for the opportunity to speak with you today about disaster case management and the role of voluntary agencies.

My name is Diana Rothe-Smith and I am the Executive Director with National Voluntary Organizations Active in Disaster. National VOAD, as we are more commonly known, is made up of the 49 largest disaster-focused nonprofit organizations in the country.

¹The prepared statement of Ms. Rothe-Smith appears in the Appendix on page 95.

From the American Red Cross to Catholic Charities and the United Jewish Communities, from the Salvation Army to Feeding America and Habitat for Humanity, our member organizations are the driving force behind disaster response, relief, and recovery in this country.

Historically, voluntary agencies have partnered with survivors through the recovery and have done so successfully without standardization. In recent years, however, catastrophic disasters, funding for case management, and emerging organizations providing long-term recovery services have necessitated us to look anew at how we define and implement disaster case management.

Recognizing that disaster case management is most effective when implemented by local partners as part of a coordinated effort for community recovery, the National VOAD Disaster Case Management Committee offers these standards as guidance to support disaster case management delivery systems locally. These draft standards, as they are submitted into the record, are not intended to replace organizational policies, but may be useful in policy development.

I want to tell you today about disaster case managers. Disaster case managers are the reason why recovery happens in this country. If my family and I have been through a natural disaster, I sit down with a case manager and she becomes my companion on the road to recovery. You see, before we even meet, my case manager spends her time learning the ins and outs of every resource available to people in my area. And because they are normally hired from within the community itself, disaster case managers can do so by drawing on their own existing networks and contacts.

The case manager can link me with community services and volunteer labor and can help me navigate through the maze of governmental programs. Even in the midst of my confusion and hardship, trying to put my life back together, my case manager is my resource maven, helping me plan for filling in the missing pieces of my recovery. The disaster case manager is the most important resource for many survivors.

When Hurricanes Katrina and Rita hit, several members of National VOAD participated in a first-of-its-kind case management program. By December 2005, Katrina Aid Today put case managers in jobs not only along the Gulf Coast, but around the country, in all the places where evacuees had been resettled. This program was initially funded by international donations through FEMA, which were then matched with additional nonprofit contributions. Katrina Aid Today was the most comprehensive collaborative National Disaster Case Management Program in the history of the United States. Because of its long history providing disaster case management, the United Methodist Committee on Relief was chosen as a lead agency for nine partnering faith-based and voluntary organizations.

Let me tell you about one partner in particular. Lutheran Disaster Response was given \$7 million as one of the consortium members, and per the various agreements, it matched that with \$7 million of their own donor contributions. Then the case manager hired with those dollars found over \$29 million worth of resources for their clients. That is what I call a return on investment.

As part of this testimony, I submit the Katrina Aid Today final report.

Unfortunately, in the time since Hurricane Katrina, our country has entered into a new reality. Nonprofit groups are hurting as a down economy means a dip in contributions. An increase in recent disasters also means fewer resources to go around. Two-thousand-and-eight was one of the most active disaster years on record. This means that the resources that were once available for clients have decreased or even dried up altogether. And because we know that disasters disproportionately impact communities that were already hurting, we are working in communities that were not well resourced to begin with.

For this reason, survivors of Hurricane Ike or the vast flooding in the Midwest this past year did not see the type of return on investment that was seen from Katrina Aid Today. These communities and the nonprofit partners that comprise the local long-term recovery groups are making incredible strides to meet the needs of the clients, despite these increasing hurdles. However, many of them lack the public-private partnership that made Katrina Aid Today such an overwhelming success.

And this is part of the issue. While case managers are the backbone of recovery, case management only works if there are supplies and resources to fulfill the needs of the clients, and there is only so much government systems can do to fill these resources. Much of the work is filled by the voluntary agencies and the volunteer labor and donated dollars they bring with them.

My point is this. The instinct to create further levels of bureaucracy is rarely appropriate given the power of voluntary agencies to complete the work faster, cheaper, and with a keener sense of the community's underlying needs. The more resources that find their ways to these organizations and without having to pass several layers of red tape, the more real work that can happen for the people who need it.

Thank you. This concludes my testimony, if there aren't any questions.

Senator LANDRIEU. Thank you very much. Dr. Redlener.

TESTIMONY OF IRWIN REDLENER, M.D.,¹ PROFESSOR, CLINICAL POPULATION AND FAMILY HEALTH, DIRECTOR, NATIONAL CENTER FOR DISASTER PREPAREDNESS, COLUMBIA UNIVERSITY MAILMAN SCHOOL OF PUBLIC HEALTH, AND PRESIDENT, CHILDREN'S HEALTH FUND

Dr. REDLENER. Thanks, Chairman Landrieu. I am very happy to be here. I am actually wearing three hats. I am President of the Children's Health Fund and I direct the National Center for Disaster Preparedness at Columbia University, and to avoid any unpleasant feedback from Chairman Mark Shriver, I am also a happy, active member of the National Commission on Children and Disasters.

So in the years since Hurricanes Katrina and Rita devastated the Gulf Coastal region, we learned and are still learning that many already at-risk children, perhaps 20,000 or more, may have

¹The prepared statement of Dr. Redlener appears in the Appendix on page 99.

survived the initial trauma of a major disaster only to find themselves 4 years hence still living with extraordinary uncertainty, chaos, and isolation from essential services. At the least, and as has been stated by others here, we need to learn from this unfortunate situation and make sure that future recovery efforts are not plagued, as Hurricane Katrina recovery has been, by similar levels of bureaucratic confusion and turf battles further complicated by a persistent inability to share critical information among relevant agencies, and I know you explored this in the last panel. But I would say that I would characterize this lack of sharing of information as really devastating to the needs of families and children, and we are still paying a heavy price for that.

It is also important to appreciate the fact that the additional trauma related not to the storms and flooding, but to this mismanaged and dysfunctional recovery, will have significant and long-lasting consequences for thousands of highly-vulnerable children.

So what happened? Well, in the first phase of this botched recovery, thousands of families needed help that never came. They needed obvious sustaining services that fall under the general rubric of what we have been referring to as disaster case management, and that was then. But now we are in a new phase of recovery where much more than access to basic services is needed because now we face far more difficult and, sad to say, entirely predictable challenges of restoring stability and structure and providing emotional and academic remediation when much of the damage has already been done.

As you are aware, Senator, on October 7 of this year, Children's Health Fund hosted a roundtable at LSU that involved participants from key Federal, State, and local agencies as well as many NGOs and local provider organizations. The focus of the day-long discussions was single-minded: How can we make sure that in future large-scale disasters we can do more to protect and stabilize families while they wait for renormalization of their lives and communities? And we all recognize that one of the key strategies to achieving this goal is to make sure that services and stability are provided by a cohesive and effective system of case management.

Although the Post-Katrina Emergency Management Reform Act from 2006 established a Federal responsibility for disaster case management, it has become abundantly clear that much remains to be done to strengthen the Federal disaster case management structure and functionality. To that end, we are very happy to learn that just this morning, the interagency agreement was signed between FEMA and HHS, although I did actually think it was going to be HUD on board, as well, but apparently I heard that it was FEMA and HHS, and that is a great first step.

But of greater significance is the fact that the National Recovery Framework and Stafford Act reform are now on the immediate horizon, and the goal of both of these efforts is straightforward. Let us use the experiences of the last 4 years to be certain that proposed legislative modifications and the new operational guidelines provide assurances that recovery from future disasters is much more effective and responsive to the critical needs of all survivors.

I also believe that, although local flexibility in implementing programs is clearly important, and it is, there must be overarching federally-designated case management principles which apply to all federally-funded programs. These programs need to be accountable and monitored with clear outcomes.

I just want to conclude with the recommendations that came out of our roundtable, which really coalesced around three primary recommendations for the Subcommittee's consideration in drafting any new legislation. I am going to add a fourth from my own work and experiences in the Gulf, which actually started just a few days after Hurricane Katrina. And some of these were already mentioned by Rev. Snyder.

But I think it is important that—and maybe most important—a single lead Federal agency with experience and expertise in complex case management should be designated to coordinate and direct implementation of all Disaster Case Management Programs. I still actually am not clear why this has ever been FEMA's responsibility, since it is not an area of expertise or experience that they have and we have other Federal agencies that could easily fit this into their ongoing agenda, so let us say AFC, for instance, at HHS—ACF, rather. And I know this is something that may or may not be taken up in the legislation on the table, but I think we should at least think about why FEMA in this. FEMA is a spectacularly good and capable organization, but is this a square peg in a round hole as far as case management is concerned?

Second, a single Federal model, what I refer to as overarching principles, for case management should be established that is clearly defined, comprehensive, responsive to local conditions, accountable, and, of course, fully and appropriately funded.

Third is we must have mechanisms, as you pressed hard on in the earlier panel, to ensure rapid, sufficient, and efficient sharing of client information among relevant agencies and provider organizations.

So let me just say in bringing this to a close that while this next recommendation is not part of the formal roundtable consensus, it is based on what we actually know about disaster vulnerability, population resiliency, and the challenges associated with recovery. The fact is that populations with significant pre-disaster adversity, including poverty and chronic inadequacies in health care and education, consistently and predictably fare the worst in all phases of disasters as compared to less-disadvantaged populations. So I think it is, therefore, important that a clear commitment to alleviating social and economic disparities be a central mission of long-term disaster mitigation and recovery planning.

Finally, there is much unfinished business with respect to the children of Hurricane Katrina. For example, what about those kids that were exposed to formaldehyde in the trailers? What are we doing for them? What is happening? And as we deliberate on strategies to improve recovery effectiveness in the aftermath of future disasters, that we not forget the ongoing, overwhelming challenges being faced by the children and families affected by the storms of 2005. They are still waiting.

Senator LANDRIEU. Thank you very much.

And I noticed some people are pulling their shawls a little tighter. I have noticed the room is cool. I have tried to get it warmed up. We will see if that happens.

Mr. Carr.

**TESTIMONY OF STEPHEN P. CARR,¹ PROGRAM DIRECTOR,
MISSISSIPPI CASE MANAGEMENT CONSORTIUM**

Mr. CARR. Good afternoon, Senator Landrieu. My name is Stephen Carr. I am the Program Director for the Mississippi Case Management Consortium. On behalf of the leadership and field management teams of MCMC, I thank you for the opportunity to speak with you today about the topic of disaster case management.

We are certainly proud of the accomplishments we have achieved to date and look forward to continuing our work with those individuals and families who continue to struggle toward recovery over 4 years after the impact of Hurricanes Katrina and Rita. I am prepared and welcome the opportunity to answer any questions you might have with regard to MCMC and to discuss any information that was provided to you in my written testimony.

In addition to that written record, I am thankful for the opportunity to present this opening statement to you, as well. We, the leadership team of MCMC, are often asked the question, why is it taking you so long to complete your work? This question is understandable when asked by someone who has never experienced a disaster of any form in his or her own life, and yet we know that that would be a very small group of people walking this earth. What is not understandable is when this question is asked by members of the disaster recovery community itself or even those inside Federal and State agencies whose job it is to support the efforts of projects like MCMC.

I offer in response to that particular question a very straightforward answer. The job of recovery is simply not complete.

The cases that we are currently working include the most vulnerable populations among us who have the most severe barriers to recovery to overcome. The work that we do as disaster case managers is what I refer to as messy casework. This work requires us to get our hands dirty, so to speak, and it is not work that is done by the faint of heart. The barriers that could be overcome easily have been cleared. What are left are the barriers that take the most time and coordinated effort to navigate. Easy solutions, if there ever were any, are a thing of the past, and disaster case managers are working harder now at this point in time to find creative solutions to a complex mix of problems facing disaster victims.

There were many critics of the leadership team of MCMC as we began to set up the infrastructure that would be necessary to implement the program according to the FEMA program guidance. The main source of that criticism was that the program guidance included no funding for direct services that would be used to assist case managers in meeting clients' recovery needs. And yet, as I have witnessed time and again over the last couple of years, the

¹The prepared statement of Mr. Carr appears in the Appendix on page 103.

most successful case management is done often in the absence of easily obtained resources.

Creativity, determination, and a true belief that every problem presents an opportunity for excellence to emerge are the hallmarks of high-quality disaster case managers, and those are the traits that are representative of the men and women who make up the ranks of MCMC case managers. We have shown that in spite of the many obstacles that are the legacy of Hurricane Katrina, progress can be made and recovery can be achieved, even without the presence of direct service dollars for case managers.

The leadership team of MCMC believes that striving toward perfection is a much better approach than waiting on perfection to manifest itself before acting. Had we waited for the perfect program or the perfect program guidance, we would not have been able to facilitate the recovery of so many individuals and families and we would have been standing on the sidelines watching. This was simply not an acceptable alternative.

MCMC continues to look forward and hopes to leave the State and the affiliates a platform to continue their work with clients once our period of service come to an end. To that end, we recently launched the Adopt a Family Program in order to continue to raise awareness and needed resources for the clients we all serve. More information about this program can be found on the MCMC website, www.mc-mc.org.

In closing, I want to share this story. One affiliate supervisor recently told me that she had never been a part of such an exciting and professional program in her entire 27-year career as a social worker in the public sector. She challenged me to think of ways that this model could be duplicated within the larger social service sector in order to address many of the social problems facing our country today. Indeed, a collaborative and coordinated program like the one that MCMC has been able to establish presents the possibility for States and communities all around the country to address issues like school drop-out rates, the rising number of homeless veterans, and the challenges presented as a result of illiteracy.

While that work may loom on the horizon, our immediate concern continues to be on disaster recovery. The leadership and field management teams, our affiliate organizations, and all of our case managers will not rest until we have done all that we can not only to overcome the barriers to recovery that we experience, but also to shape future programs so that when disaster strikes again, we will be ready to respond in a systematic, organized, and professional fashion that is worthy of this great nation.

Senator Landrieu, thank you once again for your time and attention to this important aspect of disaster recovery.

Senator LANDRIEU. Well, thank you, Mr. Carr, for that very passionate and inspirational testimony. We appreciate it.

Mr. Sizer.

**TESTIMONY OF MONTEIC A. SIZER, PH.D.,¹ PRESIDENT AND
CHIEF EXECUTIVE OFFICER, LOUISIANA FAMILY RECOVERY
CORPS**

Mr. SIZER. Thank you, Chairman Landrieu, for the opportunity to speak with you today about the challenges faced by Louisiana survivors, specifically those families impacted by Hurricanes Katrina, Rita, Gustav, and Ike.

I would also like to publicly thank you, Chairman Landrieu, for the remarkable support you have shown to the Louisiana Family Recovery Corps, as well as to so many disaster recovery-related organizations and nonprofits across the State of Louisiana. You have certainly been a friend to those Louisianans impacted by the various hurricanes.

Again, my name is Monteic Sizer. I am the President and CEO of the Louisiana Family Recovery Corps. The Recovery Corps was founded after Hurricane Katrina by the State of Louisiana in 2005. Since 2005, we have served more than 30,000 households, and that equates to approximately 100,000 individuals across the State of Louisiana. We have been a part of every case management program in the State of Louisiana since 2005, that the Federal Government has launched.

The Recovery Corps is on record for its advocacy on behalf of Louisiana citizens, especially the most vulnerable populations, which are comprised of children, the elderly, persons with disabilities, people with mental illness, etc. I have submitted for the record, Madam Chairman, extensive detail regarding both problems, as well as the solutions associated with what we need to do in order to help so many people who are still struggling to recover.

So for the brief time I have remaining, Madam Chairman, I would like to focus on a few things, and I would also like to talk about a few common challenges that ran across the three Federal case management programs.

Namely, there was always—and I think this has been mentioned before—late and inconsistent program guidance that came down from the Federal Government. I think it was mentioned that there is a need for an organized, systematic, outcome-based IT platform that is uniform. There are certainly challenges all of us faced, such as: Data sharing challenges, late payment for services rendered on behalf of Louisiana citizens, and cost reimbursement challenges.

Considering the fact that everything we received from the Federal Government came in late, and the fact that we were given an unreasonable timeline with stringent time frame to operate. The situation was very uncomfortable and we were not able to help people who had significant needs and multiple challenges. I would also say there was limited oversight provided, and the abrupt ending of programs essentially left Louisiana citizens in limbo. Many of them came to rely on the case managers they had, but the Federal programs had a tight time frame by which they were to end. Consequently, the case managers had ethical dilemmas; namely they had families under their care, and yet the programs were ending, so they had to let these individuals go. We continue to hear over and over again the challenges that were posed to many case man-

¹The prepared statement of Mr. Sizer appears in the Appendix on page 161.

agement providers, as well as licensed social workers, psychologists, and others who rendered services on behalf of these wonderful Louisiana citizens.

It was mentioned that success was not clearly defined as to what it is the Federal Government wanted to achieve by way of helping Louisiana, Mississippi, and Texas citizens. Many clients certainly fell through the cracks. I think you identified the time frame here. Certainly, we are one of the few organizations that provided case management, and while that money came from the Department of Social Services, we were also later involved in some of the Federal projects. We closed out Katrina Aid Today on behalf of the Federal Government. We were going to be part of D.C.M.P. phase two, but it never got off the ground.

We were one of the few organizations that actually received client data from FEMA. We had all the individuals in each trailer park disaggregated by the name, disability, age, race, you name it. We developed a rapid deployment model, with which we were ready to move forward, but the money never came. Therefore, we could not provide the services in which we were dubbed by the State of Louisiana to provide. With no money, we couldn't provide the service. We had information, we knew where people were, and we had relationships with nonprofits throughout the State due to our earlier involvement with money from the Department of Social Services.

So now that I have discussed some of the common programmatic challenges, I would like to talk about some of the structural recommendations. I guess the bottom line is, you can have wonderful things on paper, but if you don't have the proper systems and structures in place, then you are likely to receive the same results as the ones we had with the previous three case management models.

Senator LANDRIEU. You have got an additional 30 seconds to a minute, but go ahead.

Mr. SIZER. Thank you, ma'am. I will be quick. There needs to be a lead coordinating case management entity with human services experience. There needs to be a standard definition of case management. Certainly, there needs to be an identified, selected IT platform, and a modification of the Stafford Act to support case management services.

There needs to be identification and a blending of human services dollars in order to be able to assist with case management provision. Again, we need to work through the data sharing agreements between Federal agencies and State agencies.

There certainly needs to be money advanced quickly to the State to begin services after a declared disaster. Furthermore, we need to prepare and have these things in place prior to disasters, especially in disaster-prone areas.

I would also say that at the State level, we have to have integrated agency functions that work across human services entities, and have those plans tied to the Governor's Office of Homeland Security's plans. We need this because the bottom line is, these programs end. If there is nothing in place to be able to receive these individuals post-closing of programs, our citizens are likely to be in limbo. I also believe that it is part of the State's responsibility, due

to receiving taxpayers' money, to provide efficient and effective programs and services to the citizens they serve.

With that, Madam Chairman, I will be respectful of the time and conclude my remarks and welcome any questions that you may have.

Senator LANDRIEU. I have several questions, and unfortunately, we are only going to have another 10 or 15 minutes, and I am going to have to close the hearing slightly early.

But let me begin with you, Doctor, and also with you, Ms. Rothe-Smith. I tell my staff I love charts, because when you put them out in the right way, it is so clear and you just can't fudge it. And when you look at this chart,¹ there were two entities in the entire country that stood up to help people as the Federal Government just didn't have any case management systems in place, and that was, according to this, Katrina Aid Today, which stood up in December 2005, and you all did that by marshaling the resources of the 30 or so largest nonprofits in the country and put your good resources together and built a model where there was none.

And then under—because I remember when this was done under the extraordinary work of Governor Blanco in the face of having nothing offered in this particular area—the Louisiana Family Recovery Corps, which was stood up primarily with State funding, as I recall.

Mr. SIZER. Yes.

Senator LANDRIEU. Do you remember how much initial funding the State put up? Do you know how much it was?

Mr. SIZER. Through the Department of Social Services, it was about \$22 or \$26 million.

Senator LANDRIEU. Twenty-six-million dollars toward this effort. So I am going to rely on your two efforts, to really give some good information about the early days because you all were there, what people really needed in the very early days.

I am extremely impressed with what Mississippi has done, as well. Your work, from what I can tell, and from your passionate testimony, has really added a tremendous amount to this debate as we shape this program that is going to have to work much better, much more quickly, much more comprehensively.

So let me ask you, Ms. Rothe-Smith, how should we define when a case should be closed, or maybe I should say, how do we define success when we are dealing with families? Or how did you all define success so that you could report to your own donors a proper evaluation of the work that you did? How would you explain this definition and these conclusions to your donors or contributors?

Ms. ROTHE-SMITH. Our definition of success or what we define as recovered is completely determined based upon the local community and the needs of the individual client and family. So the term "recovered" is determined between the client, his or her family, and the case manager that is working with them.

Senator LANDRIEU. And what they asked for—

Ms. ROTHE-SMITH. Yes.

Senator LANDRIEU [continuing]. If they walked in and said, we need a refrigerator, you got them one, that was success?

¹The chart referred to by Senator Landrieu appears in the Appendix on page 43.

Ms. ROTHE-SMITH. Yes.

Senator LANDRIEU. OK. If they walked in and said, we need an apartment, you got it for them, that was success?

Ms. ROTHE-SMITH. Yes. A recovery plan is developed right in the beginning between the client and the case manager, and then the process by which it is achieved is what determines success.

Senator LANDRIEU. And how about you, Mr. Sizer? How did you all frame your success or your goals when you started the program?

Mr. SIZER. Yes, ma'am. We determine it in three ways. Namely, clients come in and identify what it is they believe, based on an assessment, their needs are.

Second to that, we place accountabilities on agencies we work with to ensure they help the clients meet their need objectives.

And third, we determine success by what clients actually contributed towards their own success because oftentimes, it takes some creative initiative on behalf of people who have been impacted to also do things in accordance with their desired recovery goals. So it is what individual families bring to the table. It is what the case provider does on behalf of the clients, and also what those entities do in conjunction towards the success of an identified plan. That is done between an impacted family and a case manager.

Senator LANDRIEU. Mr. Carr, let me ask you. How did you all, when you started your program, or how do you currently define success?

Mr. CARR. Sure. I want to clarify one thing, and that is that the Katrina Aid Today model had a presence in Mississippi throughout its tenure.

Senator LANDRIEU. And they had a presence in all the States, I think.

Mr. CARR. Correct. We had five affiliate agencies in Mississippi throughout the length of its operation. I began as Program Director for MCMC during phase one and then continues on to phase two. So there has not been a break in case management activity in Mississippi. What I will say is that as time goes on, the case management has gotten better. We have done a better job because we are able to focus locally. At the height of Katrina Aid Today, we had somewhere around 50 case managers in Mississippi. At the beginning of phase one for the MCMC, we had almost 300 because the need was there and we were able to document the need and be able to procure funds.

We define success based on the recovery plan. We use a holistic model. For me and what we teach in our training is that when a client is self-determined, that is a good indication of recovery. When that client is able to access resources and services on his or her own, that is a point at which case managers should consider that case for closure, when they don't need us to take them or advocate for them to HUD or for a voucher or for a refrigerator or for an apartment. When they show signs that they are able to function in that arena on their own, that is what we call self-determination, and that is when we look at case closure. We leave the client with a recovery plan that they use as a road map well beyond our involvement with that case.

Senator LANDRIEU. OK. We covered this in the first panel, but I would like your individual impressions on this privacy issue and

just some brief—each a brief suggestion as to how we might approach it, I don't know, maybe starting, Rev. Snyder, if you have something you want to add on this privacy issue, but anyone that wants to speak to it, because we have got to solve this as we move forward. Does anybody have a suggestion about how it could be done or something we should look to? Ms. Smith, would you like to comment, or Rev. Snyder?

Rev. SNYDER. I do not have a suggestion to show how we could actually solve that other than to say that, in fact, I mean, it is something that is very critical and that we do need to find a way to be more effective with how we do that. But I do not personally have a suggestion.

Ms. ROTHE-SMITH. I don't have a suggestion for the Federal family, but the way it is resolved through the voluntary agencies is usually through a technology solution called the Coordinated Assistance Network, and it is a way that the voluntary agencies provide information to one another about a client in the family through shared mechanism so that the duplication is diminished, but also the need for the client to share that information again and again, as well.

Mr. CARR. Senator Landrieu, if I could add, the sharing of a FEMA number is critical for de-duplicating effort. In the State of Mississippi, when we were asked to set up phase one, we requested data from FEMA. We got names, addresses, telephone numbers. We didn't get FEMA numbers. Identifying information such as that is critical for us. We requested information from our affiliates. We got 17,000 names. We compared that to the information that we got from FEMA, 5,000 names. Do you know how many John Smiths there are in the State of Mississippi? And a lot of them we got that didn't have phone numbers or addresses. A key identifier, a FEMA number, is critical for especially contractors.

So for me, a suggestion is that once FEMA or HHS or HUD enters into a contractual agreement with a service provider, that they give that information to that contractor, and then it is our responsibility to hold that information confidential, not sell FEMA numbers, etc. But when we are not given the trust to handle information in a way that helps us serve clients more efficiently, quite frankly, it is irresponsible.

Senator LANDRIEU. Let me ask, Rev. Snyder, if I could, because you all have the contract for responding now, Catholic Charities does, and if this issue of privacy is not worked out, I am not sure how effective that next response will be. But also, or a different subject, how do you protect against secondhand trauma to case managers, because in some instances when the situations are very difficult, we found that some of the people that needed the most help after the first couple of weeks or months were the first responders themselves, the nurses who just collapsed, or the case workers that just couldn't take it anymore. So are we thinking about how to deal with that in this whole response, psychological support and case management for the case managers?

Rev. SNYDER. I think that is an excellent point, and I guess I would go back to what our experience was after Hurricanes Katrina and Rita in that, fortunately, we did have a large network of case managers to draw upon and many of them came from

throughout the country to Baton Rouge or to New Orleans, to Biloxi. An agency would send—Albany, New York, for example, sent four or five people on a rotating basis for 6 months to Baton Rouge, which allowed the local folks, who were dealing with their own trauma, to have that time, that space.

I look at the days just beyond Hurricane Katrina at how the folks who themselves were affected also could not help themselves from working and reaching out. Until they knew there was someone else who was qualified to come in and take their place and give them the space, they wouldn't rest. So I think that is something that we have to make sure is there.

We also had some mental health services that we brought in for whole agencies that would deal with case managers. There was take a day, just 1 day a month, to try to address that. So I agree with you that is a critical piece to help prevent that burnout.

Senator LANDRIEU. And, Dr. Redlener, do you want to comment about that at all? I know your focus has been children, but it has also been mental health.

Dr. REDLENER. Yes. And actually, I would like to comment about the previous question, if I might, also, Senator.

Senator LANDRIEU. Go ahead.

Dr. REDLENER. OK. So this issue about the privacy is extraordinarily important. We face this all the time in medical practice, as well, obviously. And I think the key—there are three steps, really, that I would suggest. One is that we really have to have the concept ingrained of a one-stop shop for Federal services. That means that you enter the system and you enter then the service purview of any major agency of the Federal Government that you might need.

And second, along with that would go this standardized database, so there is one time where people fill out the data forms and that is it, and that form is shared among people.

But the third and critical step, I think, is to simply at intake ask parents for permission to share data. That is the end of the privacy problem. All you have to do is you have to sign, obviously, an appropriate form that is readable that is explained to families that says, in order to help you, we would like to be able to share your information with relevant agencies. These are the safeguards. Ninety-nine-point-nine percent of families will sign it, and to me, that is a very simple solution to what otherwise is a very complex problem that would require law changes and regulations and all sorts of things that might be very long in coming. So I would just recommend that.

Senator LANDRIEU. OK. I have got to, unfortunately, end, but I am going to give each of you 30 seconds. If there is something I didn't cover, something you want to mention, this would be the time to do it. We will start with you, Dr. Sizer.

Mr. SIZER. Again, thanks, Chairman Landrieu, for the opportunity. I will just mention the issue of reintegration. Many of our citizens were deported to other parts of the country and have yet to return. I think trying to find a way in which to identify those individuals and bring them back home and help them get reestablished will be critically important.

The second issue I will raise is the issue of cultural competency. I certainly welcome the national model to descend on the State, especially when there is a catastrophic event. However, I will also mention that understanding the local players, what transpires and what takes place, is critically important because you could have well-meaning efforts and unintended negative consequences.

So those are the other two points I would like to raise.

Senator LANDRIEU. Thank you. Mr. Carr.

Mr. CARR. Senator Landrieu, I wanted to circle back to the question that was raised with HUD about duplication of benefits. I use the term duplication of effort because that is what we are trying to prevent. And the issue that you raised was, I believe, in my written testimony where I talked about silos. Whatever we can do to prevent silo behavior, either within an agency or within Federal programs altogether, the better off we are.

The issue of one case manager per program is an example of HUD having DHAP case managers, FEMA having MCMC case managers, and others trying to serve the same client.

Senator LANDRIEU. We need one case manager per family.

Mr. CARR. Per family, that has access—

Senator LANDRIEU. One case manager per family.

Mr. CARR [continuing]. To all resources. Correct. So that was the issue that—whatever we can do to prevent silos. Families benefit. We have a consistent, systematic structure. And that is what is needed most in order to be cost effective and most impactful on the families that we are serving. Thank you.

Senator LANDRIEU. Thank you. Dr. Redlener.

Dr. REDLENER. A cautionary note about defining when a case is closed because it is a very dynamic situation and I wouldn't necessarily depend on a decision made between a family and a case manager at point X that at X-plus-6 months, the situation will be the same. And what we are learning from this prolonged dislocation and recovery is that the definition is clear. You need a stable, safe home. You need access to essential services, schools and health care. And you need some way of getting into a livelihood, returning to a livelihood.

Those should be the criteria. Those are objective criteria that could be combined with a family's understanding of what they think they need. But if they don't have stability and structure, even if today they say, things are fine, we don't need you, we have already got the refrigerator, 6 months from now, you could have a family struggling with horrible problems of poor access to health care, academic failure, and a lot of other stress and mental and emotional health issues that will need to be taken care of down the road. So I think we should be very clear about what we mean by a reestablished, renormalized situation for families.

Senator LANDRIEU. Thank you. Ms. Rothe-Smith.

Ms. ROTHE-SMITH. I want to highlight a comment that Rev. Snyder illustrated earlier, and that is that while Katrina Aid Today started in December 2005, the organizations that were part of that used a model that had been in existence for quite a long time, and the organizations like Catholic Charities USA, UMCOR, Lutheran Disaster Response, and the American Red Cross and others have been providing disaster case management for decades. So I would

strongly encourage to really look and to continue to look to them as the experts that have been doing this work and will continue to do this work regardless of the models that come out.

Senator LANDRIEU. Thank you very much. Rev. Snyder.

Rev. SNYDER. Thank you. I have already talked about my concern for the funding of a national infrastructure, so I guess I would like to end with saying that let us not lose sight of the need for flexibility, that even though we are saying 18 months of case management should be enough, in some cases, it is not. I know our local providers right now who are working on Hurricanes Gustav and Ike have written a letter and, I think, made a good case on the fact that because case management did start a little late or whatever, that it still might need a little more time. So just, again, the need for flexibility in whatever services we are trying to provide.

Senator LANDRIEU. OK. I really want to thank our FEMA Director for staying, the HUD Director for staying and listening to the testimony. We really appreciate the way these agencies are really leaning forward to work better and faster, with all the other pressures that the Administration and Congress has before it. But this Subcommittee is focused on staying on the job until the job is done, to get better laws in place, better procedures in place, better overall response and recovery.

And in that, I will announce I will be sending several staffers to the international conference on disaster response and recovery. I, myself, can't attend, but we will be sending several staffers and we will ask the Administration to send people to Kobe, Japan, which will be hosting an international conference on this and other subjects related to recoveries from disasters. That city will be celebrating its 15th year of recovery from a great earthquake. So there will be high-level individuals, elected officials, community leaders, I am assuming from all over the world.

So what we are doing here is going to help frame what we do in the United States, but we are hoping to share that information, of course, internationally to help victims of major disasters everywhere. So we thank you for your testimony and we will put it to good use.

The hearing is adjourned.

[Whereupon, at 4:29 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Opening Statement of Chairman Landrieu Subcommittee on Disaster Recovery

*Disaster Case Management: Developing a Comprehensive National Program
Focused on Outcomes*
December 2, 2009

Good afternoon, and welcome to this meeting of the Subcommittee on Disaster Recovery. In the aftermath of Hurricanes Katrina and Rita in 2005, more 275,000 families lost their homes and 240,000 people lost their jobs. Schools, hospitals, and transportation systems ceased to operate, and so did social support networks like churches, community centers, and local nonprofits that were unable to reopen. All of this upheaval took a massive toll on the physical, mental, emotional, and financial wellbeing of people along the Gulf Coast. In response to these complex and overwhelming needs, disaster relief nonprofits and government agencies launched a series of case management programs to help families get back on their feet.

The overarching objective of case management is to return households to a state of normalcy and self-sufficiency as soon as possible. Case managers serve as the single point of contact to help survivors access the resources and services they need to recover. *Resources* include things like furniture, cookware, clothing, or housing, and *services* might be job training, child care, mental health counseling, financial counseling, or transportation to school, work, or medical appointments.

FEMA, HUD, HHS, and the States of Louisiana and Mississippi have all run case management programs since the 2005 hurricanes. The existence of so many programs in the same region caused a great deal of confusion among service providers and clients. But it also provides a diverse set of examples to inform the development of a model for the future.

The title of today's hearing refers to a "Comprehensive National Program Focused on Outcomes". Unfortunately, that represents a vision for case management which has not yet been realized. Current programs are neither comprehensive, national, nor outcome-based. I hope today's discussion will underscore the need for a holistic system focused on results, and help us understand where we've been and where we're going.

Several startling statistics indicate we are not doing enough to address unmet needs. At one point, only one-third of the children at a group trailer site known as Renaissance Village in Baker, LA were attending school. The homeless population of New Orleans has doubled since Katrina according to Unity of Greater New Orleans, and 6,000 of them are believed to be living in vacant or abandoned homes.

Case managers and their clients used separate programs with different eligibility rules, forms, and procedures. As a result, clients sometimes went through intake more than once, and providers had to expend significant administrative resources. Boat People SOS, for instance, operates under all three programs from its offices in New Orleans and Houston. A single program will enhance uniformity and reduce confusion. Changing federal deadlines to vacate housing or terminate case management services also caused confusion.

Some of the previous pilot programs seemed to focus more on outputs than outcomes. Cases should not be closed when a household is simply referred to a mental health counselor, landlord, or employment agency. Service providers must follow up to ensure that individuals have actually obtained treatment, permanent housing, or a job from those sources. Programs that only provided services to individuals in federal housing units ignored the homeless and people who moved in with family members after losing their home.

Case managers were required to meet quotas for closing cases, which may have led to premature closures. In addition, client ratios often stretched them beyond capacity. NVOAD's Case Management Committee has recommended a caseload between 20 and 35, but it also stated that each disaster is different

and that ratios may require adjustment depending on circumstances. In Southeast Louisiana where needs were massive, resources were scarce, and case managers had their own lives to rebuild, caseload limits may have been excessive.

Case management services are delivered under difficult conditions that make communication, record keeping, coordination, and efficiency tough. In areas like Southeast Louisiana where housing and mental health professionals had all but disappeared, connecting people with resources and services proved to be a near impossible task.

There is tension between consistency and flexibility. We must standardize things like paper forms, data entry, funding, and intake to reduce confusion in areas where multiple providers are working and then to operate in different locations. But local VOADs know their populations and have the best information about the resources and services available in their area, so they're concerned that standardization may usurp their innovation and flexibility.

The Privacy Act prohibits FEMA from sharing registrants' information without written consent. So case managers knock on trailer doors and rely on word of mouth to offer their services, instead of doing outreach through FEMA's database. FEMA regulations were modified after Katrina to facilitate information sharing with law enforcement agencies. It may be appropriate for FEMA to consider revising its rules once again to improve provider access.

Case managers are authorized to connect families to resources, but they can't provide them directly. FEMA is supposed to provide things like furniture, cookware, bedding, and clothing through a state-matched program called Other Needs Assistance (ONA), and the agency doesn't want case management to duplicate it. Some families have fallen through the cracks as a result of this restriction though. Families who hit the \$28,000 limit on assistance after the hurricanes as a result of rent subsidies, weren't eligible for Other Needs Assistance. IT systems must ensure that ONA is in fact available if federal rules prohibit case managers from providing direct services.

Local relief organizations formed Long-Term Recovery Committees after Katrina and Rita, which pooled resources and worked together to address clients' needs. They also used a database and IT system called the Coordinated Assistance Network (CAN) to enter client information and communicate with one another. The International Refugee Committee (IRC) and Church World Service (CWS) have over thirty years of experience providing comprehensive refugee resettlement services to people who obtain asylum in the United States. The Katrina Aid Today Program adopted several elements of these models, IRC offered technical assistance to the Baton Rouge Area Foundation after Katrina and Rita, and Church World Service's Houston office assisted survivors after Hurricane Ike. I would strongly urge the witnesses who are here today to consult these models going forward.

Our witnesses today will discuss the pending Interagency Agreement, several reports that were recently issued on case management, and perspectives from program users on the ground. During the course of this meeting, we will seek to address a series of questions about case management. How should we define case management services, when should cases be closed, and when should disaster case management transition to routine social work? What is the appropriate balance between localization and standardization? Does Catholic Charities' contract from ACF include sufficient funds for training? Does the Stafford Act provide sufficient authority to support disaster case management? Should Privacy Act regulations be modified to improve access to clients? Today's hearing and expert testimony should help to answer some of these questions and improve service delivery in the future.

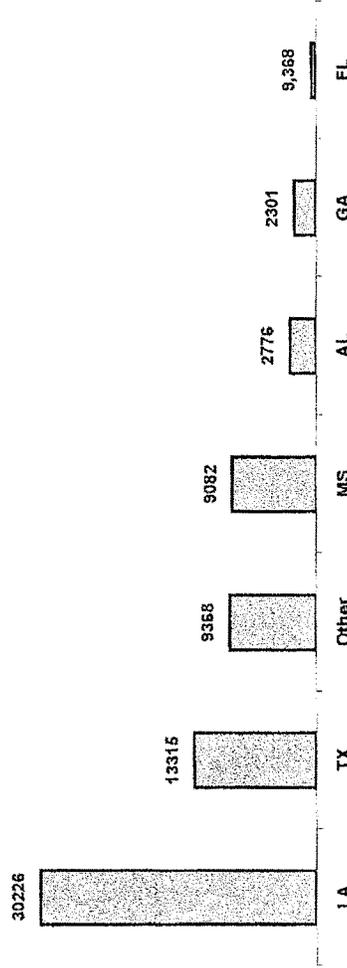
Cases by State

The greatest number of clients were served in LA, TX & MS. LA alone served more clients than combined total of all "Other" states.

KAT worked in 31 states, and Local Consortium Member (LCMs) presence included an additional 3 states for a combined total of 34 states. LCMs were grassroots KAT partners funded by UMCOR.

Chart #9

Clients were assisted in **43** states

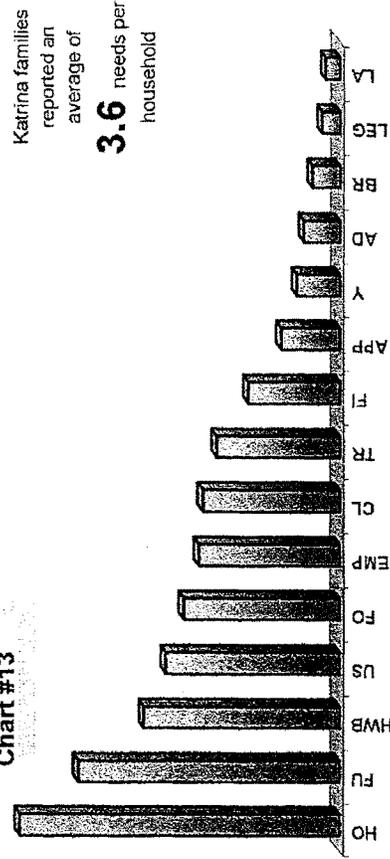


Client Needs

The case management process includes identifying client need and corresponding resources to meet these needs. Needs can be either short term or long term in nature, but meeting needs is a critical step towards achieving a client's recovery.

KAT collected client need information in order to understand disaster impacts and how to better assist client in identifying available resources to meet their needs.

Chart #13

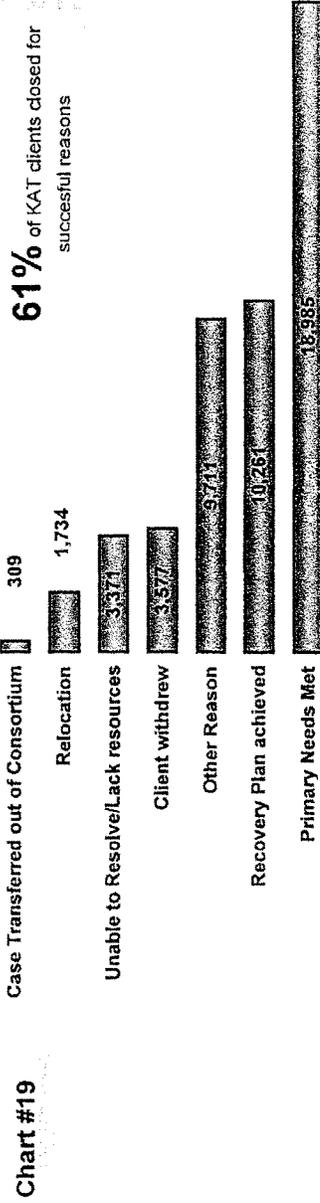


The five most reported needs amongst KAT's client population were:

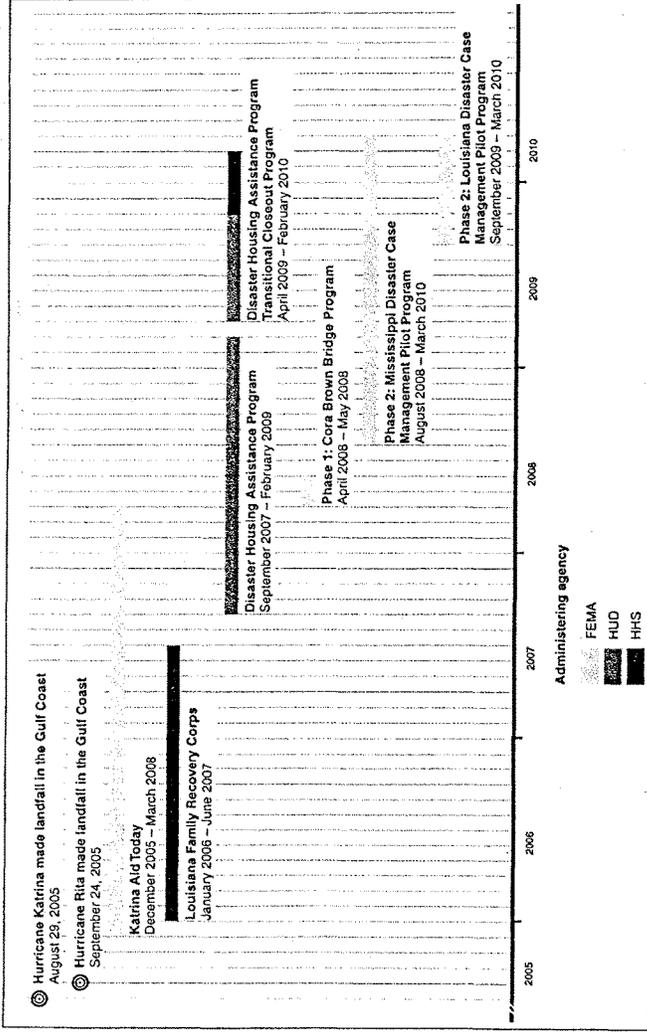
- Housing
- Furniture
- Health & Well Being
- Utilities
- Food

Reason for Closure

One of the ways Katrina Aid Today measures the success of its program is by reporting the reasons cases are closing after receiving case management services. Cases that close for "Primary Needs Met" or "Recovery Plan Achieved" are considered "successful", whereas cases that close for "Client Withdrew Request for Services" or "Other Reason" are considered "unsuccessful." Additional categories are available for reporting purposes, but are more appropriately classified as "Neutral" as they do not speak to the case management process but rather to external factors of the program.



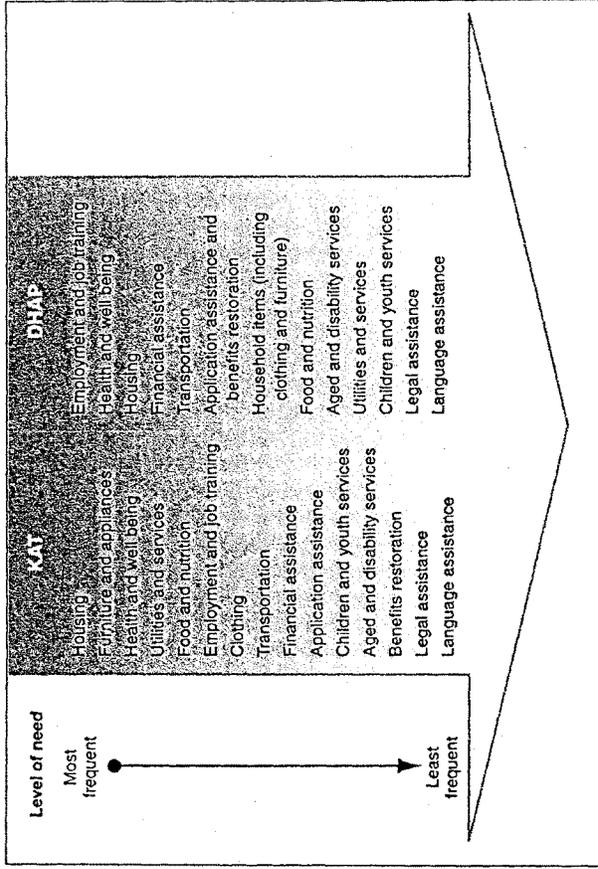
Time Line of Federally-funded Disaster Case Management Programs for Victims of Hurricanes Katrina and Rita



Notes: The program dates above represent when case management services began. Grant agreements may have been in place prior to these dates.

Louisiana received emergency block grant funding from HHS. State officials in Louisiana designated a portion of these funds for disaster case management.

Most to Least Frequently Occurring Client Need by Disaster Case Management Program

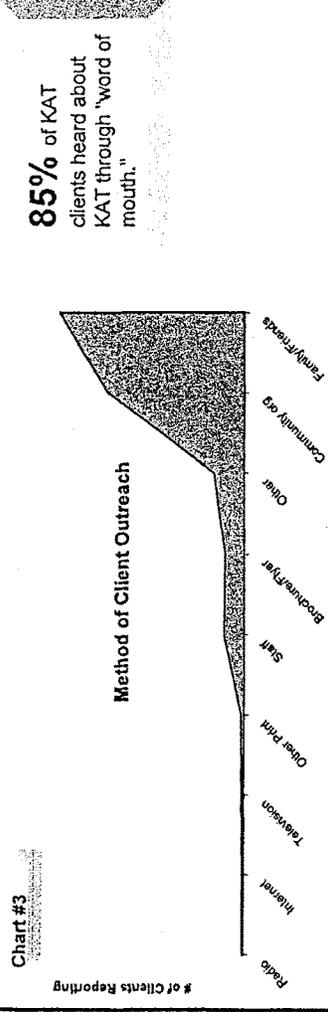


Source: GAO analysis of program data.

Note: Katrina Aid Today (KAT) program data included predefined categories of need. For the case management portion of the Disaster Housing Assistance Program (DHAP), we analyzed needs assessment data for those clients with a completed needs assessment and combined variables to create categories comparable to KAT. The DHAP needs assessment did not include individual questions for application assistance, benefits restoration, furniture and appliances, or clothing; as a result, the KAT and DHAP categories are not a one-to-one match.

Eligibility and Outreach

Informing the community and potential clients about the program is an essential component of KAT's case management process. Methods of outreach are indicated by the client during the intake process and assists the case manager purely in data collection purposes. Management on the other hand can use the information to develop strategic outreach plans specific to the community. The number of clients reporting each method of outreach are indicated in Chart #3.



Referrals made by "Family and Friends", "Staff" and "Community Organization" were the most successful methods of client outreach and likely the most cost effective.

Future planning note: With a high rate of displacement, it is imperative that housing assistance is available - not only financial assistance but a stock of housing options that are affordable, accessible and safe.

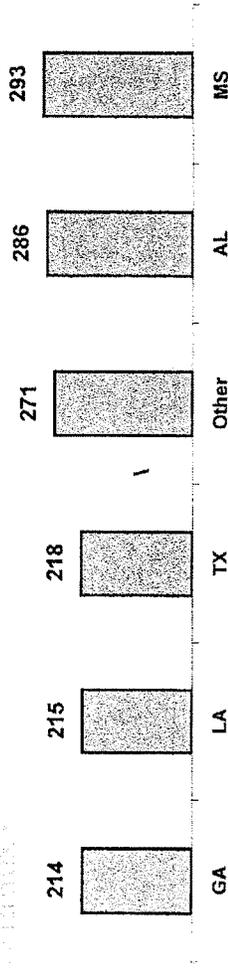
Length of Time

Post-Disaster State

The number of days a case remains open differs according to the state where the client received services.

Chart #26

Households living in MS stayed open the longest for an average of **293** days



Written Statement of

Elizabeth A. Zimmerman

**Assistant Administrator
Disaster Assistance**

**Federal Emergency Management Agency
Department of Homeland Security**



FEMA

**“Disaster Case Management: Developing a
Comprehensive National Program Focused on
Outcomes”**

Before the

**Ad hoc Subcommittee on Disaster Recovery
Committee on Homeland Security and Governmental Affairs
United States Senate
Washington, DC**

December 2, 2009

Introduction

Good afternoon, Chairman Landrieu, Ranking Member Graham, and other distinguished members of the Subcommittee. My name is Elizabeth Zimmerman, and I am the Assistant Administrator for FEMA's Disaster Assistance Directorate. It is a privilege to appear before you today on behalf of the Department of Homeland Security (DHS) and the Federal Emergency Management Agency (FEMA). As always, we appreciate your interest in and continued support of emergency management, specifically FEMA's efforts in implementing disaster case management authorities.

When an individual's home is damaged or destroyed by a disaster, the impact may be felt for weeks, months or even years, as we saw in particular during the 2005 hurricane season. For some, dealing with repairing the damage is just the beginning. In disasters where hundreds or thousands of lives have been disrupted, entire communities destroyed, and essential community services, schools and utilities rendered inoperable for days or weeks, the impact can be considerably larger.

FEMA's goal has always been to work with communities and assist them with their unmet disaster-related needs so that they can move forward on the road to recovery as quickly as possible. One of the ways of achieving that goal, particularly in a catastrophic disaster event, is to help survivors understand the wide array of services and programs that may be available to help them return to self-sufficiency and sustainability. As the coordinator of federal disaster assistance, FEMA is charged with securing delivery of case management services.

The Encyclopedia of social work defines case management as "a method whereby a professional social worker assesses the needs of a client and the client's family, when appropriate, and arranges, coordinates, monitors, evaluates and advocates for a package of multiple services to meet the specific client's complex needs." Successful case management for disaster survivors requires in-depth knowledge of how to work with individuals and families, an awareness of the public and private resources available to assist them, and knowledge of the service delivery system and how to navigate it.

The delivery of timely, appropriate disaster case management services cannot be managed at the federal level alone. In fact, this coordination is most effective when it is on the ground, local, and close to the people affected. Many communities have such systems for coordination already in place, with established collaborative relationships among federal, state and local agencies. Our goal is to build on those relationships, recognizing that effective case management requires teamwork with our federal state and local partners, voluntary and faith-based organizations, the private sector, and most importantly, the disaster survivors themselves.

An effective Disaster Case Management services program connects survivors with local providers that can target recovery services to assist them in developing and achieving short and long-term recovery goals. FEMA and our partners seek to offer disaster survivors a roadmap for navigating and maximizing the use of available federal, state,

local, non-governmental and volunteer organization disaster recovery programs. Our goal is to build on the foundation and the network of services that exists to ensure that survivors have a holistic approach to rebuilding their lives in the wake of a disaster event. Ultimately, we want to provide the needed support to disaster survivors in the swiftest and most effective way.

Historical Efforts for Case Management

FEMA has been delivering disaster case management services on a limited basis since the beginning of its Individual Assistance recovery programs in 1988. Historically, these services have been limited to providing referrals to other federal, state and local assistance programs, and connecting survivors to volunteer organizations through Long-Term Recovery Committees.

However, the widespread devastation caused by Hurricanes Katrina and Rita created new challenges for the delivery and coordination of disaster recovery assistance at all levels of government. The extent of the damage was so great that full recovery for individual disaster survivors and communities will take years. In recognition of these challenges and the desire to expedite comprehensive disaster recovery, Congress provided FEMA with the legal authority to implement a disaster case management services program under the Post Katrina Emergency Management Reform Act of 2006. This legislation includes financial assistance to government agencies or qualified nonprofits to provide such service to “identify and address unmet needs.” This provision provided a significant new program of assistance to ensure disaster assistance is more responsive to applicant’s individual needs. The goal is to connect disaster victims to a full array of disaster and other support services, including human, social, employment, legal, mental health, and medical services. Since that time, FEMA has worked closely with federal, state, and local partners to pilot the delivery of several disaster case management models.

A Disaster Case Management Program is a partnership between the case manager and the client in the development of a Disaster Recovery Plan. The Disaster Recovery Plan outlines any unmet needs based on verified, disaster-related causes; developing and develops a goal-oriented plan that outlines the steps necessary to assist with the unmet needs in order to achieve recovery; organizing and coordinating. To assist with any disaster-related unmet needs, case managers organize and coordinate information on available resources that match the disaster-caused needs; monitor the disaster survivors’ progress towards reaching their stated goals. When necessary, providing case managers also provide advocacy for the client to help ensure success.

Prior to receiving grant authority to establish a Disaster Case Management Program, FEMA made great efforts to provide similar services to Hurricane Katrina and Rita disaster survivors. In October 2005, FEMA and the United Methodist Committee on Relief (UMCOR) executed a grant agreement to provide long-term disaster case management to individuals and families impacted by Hurricane Katrina. The grant agreement was approved by the U.S. Department of State and FEMA and funded through foreign cash donations. UMCOR acted as the lead organization of a National Case

Management Consortium consisting of nine primary organizations to provide case management services to Hurricane Katrina affected populations, known as Katrina Aid Today (KAT). They served over 70,000 households in a 30-month period at a cost of approximately \$68 million. This represents an approximate average cost of around \$1,000 per household.

Because states, volunteer and faith-based organizations did not have the capacity or financial resources to continue providing case management services beyond KAT's end date of March 31, 2008, FEMA implemented a two-phase Disaster Case Management plan to provide continued funding in support of the delivery of case management services in Mississippi and Louisiana. In addition, the plan included the provision of additional funds to provide targeted case management services to disaster survivors residing in FEMA temporary housing units and hotels. Pursuant to this plan, in July 2008, FEMA awarded the Mississippi Commission for Volunteer Services (MCVS) over \$31 million to provide disaster case management services to disaster survivors, through March 2010. To date, the state has opened 3,564 case management cases, of which 2,558 (or about 71 percent) are now closed.

The Louisiana Recovery Authority (LRA) was granted up to \$9.4 million in June 2009 to provide disaster case management services to disaster survivors through March 2010. To date, the LRA has opened 1,482 cases, 102 of which have been resolved and are now closed.

Prior to the end of the KAT program, FEMA worked with HUD to establish an interagency agreement to provide continued disaster housing assistance to Hurricane Katrina and Rita disaster survivors under the Disaster Housing Assistance Program (DHAP). Under DHAP, FEMA and HUD are able to work in partnership with local volunteer organizations to deliver case management services that focused on moving disaster survivors into long-term sustainable housing. Katrina DHAP has helped more than 36,000 individuals receive housing and case management services. A similar DHAP program was also launched for the disaster survivors of Hurricanes Gustav and Ike -- more than 15,000 individuals have received housing and case management services under the program, which is set to end in March 2010.

Building on the lessons learned from KAT and the desire to move toward a standing case management services delivery program, FEMA established an interagency agreement with the U.S. Department of Health and Human Services' Administration on Children and Families (ACF) in 2007 to develop a Disaster Case Management Pilot Program. Under this pilot program, ACF researched and developed a new service delivery model. ACF is currently piloting this model, in partnership with Catholic Charities USA, in an effort to assist hurricanes Gustav and Ike disaster survivors in Louisiana. In support of the progress that ACF has made, FEMA extended the pilot program through March 2010, and has provided supplemental funding in excess of \$22 million. As of October 2009, a total of 7,507 case management cases have been opened with 2,061 of these cases having been closed.

In March 2009, the Texas Health and Human Services Commission was awarded up to \$65.2 million to provide disaster case management services to approximately 30,000 clients in Texas impacted by Hurricane Ike. Services began in May 2009 and will continue until March 2010. As of September 2009, the state has opened 7,235 case management cases and closed 453 cases.

More recently, in September 2009, Georgia was inundated with heavy rains and flooding. In response to this disaster, the State Voluntary Organizations Active in Disasters, along with FEMA Voluntary Agency Liaisons, worked with the local volunteer agency community to establish Long Term Recovery Committees across the state to assist disaster survivors with unmet needs. The United Methodist Committee on Relief also provided case management trainings for various volunteer agencies in the community. To date, the state has not requested federal assistance for disaster case management services. These services are being provided by the local volunteer agency community. FEMA also employs Individual Assistance staff, who have also been working closely with each applicant to answer questions and provide support with securing assistance to address long-term housing needs. Through this assistance, applicants may have identified unmet needs that cannot be assisted by FEMA and our programs. Therefore, FEMA and the state, along with our federal, local and volunteer agency partners continue to work closely with these households to ensure that they are aware and take advantage of any additional assistance available from the state and our various partners.

As FEMA and ACF continue to partner to provide disaster case management to eligible applicants, we are implementing lessons learned and are working together to develop an Interagency Agreement that will be used to improve case management for future disaster survivors.

Bridging the Gap and Resolving Challenges –Building a Successful Case Management Program

Currently, FEMA is implementing an interim two-phase disaster case management model. Phase I consists of the activation and deployment of ACF to initiate the implementation and delivery of disaster case management services to disaster survivors. If a state requests and is approved for Disaster Case Management, FEMA will notify ACF to implement the Disaster Case Management Program in the affected disaster area. Then, ACF will:

- Deploy the ACF National Team to initiate Disaster Case Management services to clients in the impacted area within 72 hours of notification by FEMA;
- Provide disaster case management services to individuals and households to assess unmet disaster-related needs including healthcare, mental health and human services needs that may adversely impact an individual's recovery if not addressed until the transition to the Phase II program; and
- Ensure that case managers facilitate the delivery of appropriate resources and services, work with the client to implement a recovery plan and advocate for the

client's needs to assist him/her in returning to their pre-disaster status while respecting human dignity.

Phase I may last up to 180 days depending on the state's capacity to administer the program and whether there is a continuing need for additional case management to meet disaster-related needs. ACF may continue services until such time as the state is able to assume disaster case management.

Phase II consists of a transition to a state-managed disaster case management program funded through a direct grant from FEMA to the state. This will ensure that the state is an essential partner in the development, implementation, and delivery of ongoing case management services and that the use of local service providers in the recovery for disaster survivors and their surrounding communities will be maximized.

FEMA and ACF have entered into a pre-scripted Mission Assignment for the initial implementation of disaster case management services to ensure that FEMA has the immediate ability to provide such services for a large or catastrophic event. In such instances, FEMA will fund ACF for the rapid deployment of their National Disaster Case Management Response Team (National Team) to a disaster-impacted area. This national team will coordinate disaster case management services within 72 hours of deployment.

Meanwhile, FEMA and ACF are developing a new interagency agreement for ACF to implement and administer the Disaster Case Management Program described on a temporary basis as final program guidelines and regulations are developed. This agreement will allow ACF to initiate the rapid deployment of disaster case management assistance to individuals and families impacted by a presidentially declared disaster for Individual Assistance. FEMA and ACF are working together to ensure that the agreement will incorporate lessons learned and best practices from previous disaster case management delivery models and will offer comprehensive services for disaster survivors, and a flexible model that can easily be adapted by state, local, non-governmental and volunteer organization service providers.

In a July 2009 report entitled "*Disaster Assistance: Greater Coordination and an Evaluation of Program Outcomes Could Improve Disaster Case Management*", the Government Accountability Office (GAO) issued the following recommendations for the implementation and evaluation of disaster case management services:

- Create a timeline for the establishment of the Disaster Case Management Program;
- Ensure enhanced and sustained coordination among federal and nonfederal stakeholders;
- Conduct an outcome evaluation to determine the results of previous case management efforts; and
- Facilitate information sharing with state and local providers.

FEMA will be incorporating the successes and challenges of the various disaster case management service delivery models used to date, as well as the recommendations from the July 2009 GAO report, into program guidance and regulations for a future, permanent case management program.

As we move forward with program development, we will continue to partner with federal, state, local, and volunteer agency case management service providers to establish and ensure ongoing information sharing of service delivery mechanisms. As part of this effort, FEMA has developed a streamlined process for giving volunteer organizations access to crucial information on disaster survivors. This process balances the needs of disaster survivors with the protections of the Privacy Act. FEMA has also developed guidelines and templates to ease the Privacy Act burden on organizations that need information on disaster survivors. As a result of these efforts, case management service providers are able to receive information on disaster survivors more quickly and can begin to develop targeted, comprehensive long-term individual recovery plans sooner.

Conclusion

FEMA is committed to ensuring that disaster survivors have access to the resources and services they need to help them rebuild and recover following a disaster – but we cannot do it alone. To be effective, our case management efforts have to be coordinated with experts at the local, state and federal levels of government and with volunteer and non-profit organizations. By working together, we will be able to provide a successful program that focuses on helping families and communities recover from disasters.

FEMA will continue to fortify existing disaster case management partnerships and encourage new collaboration to ensure the implementation of a successful case management program. I look forward to responding to any questions you may have at this time.



STATEMENT OF
DAVID HANSELL

PRINCIPAL DEPUTY ASSISTANT SECRETARY
ADMINISTRATION FOR CHILDREN AND FAMILIES
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON

DISASTER CASE MANAGEMENT: DEVELOPING A COMPREHENSIVE
NATIONAL PROGRAM FOCUSED ON OUTCOMES

BEFORE THE

AD HOC SUBCOMMITTEE ON DISASTER RECOVERY
COMMITTEE ON HOMELAND SECURITY AND GOVERNEMENTAL AFFAIRS
UNITED STATES SENATE

DECEMBER 2, 2009

Senator Landrieu, Senator Graham, and members of the Subcommittee, thank you for the opportunity to testify about the Administration for Children and Families' (ACF) disaster case management efforts. I share your commitment to improving the well-being of children, the elderly, persons with disabilities, and families affected by disasters, and appreciate your support for a well-coordinated comprehensive disaster case management strategy following a Presidentially-declared disaster.

ACF's approach to disaster case management seeks to help disaster survivors by assisting States in rapidly connecting individuals and families with critical services that can help them get back on their feet. In the development of our disaster case management model, we worked closely with all of our partners, including the Federal Emergency Management Agency (FEMA), the HHS Office of the Assistant Secretary for Preparedness and Response, the HHS Administration on Aging, Voluntary Organizations Active in Disaster (VOAD), and States, to incorporate a shared vision into our model design. Further, we recognize the importance of ongoing collaboration with all our partners, including FEMA and States, in order to design and manage a process that will meet the needs of individuals and families at their most vulnerable time following a disaster.

Disasters can create particularly serious difficulties for persons with special needs, including the elderly and persons with disabilities, who have their support systems and caregiver assistance disrupted or eliminated. If these supportive service needs are not met in a timely manner it can have significant consequences for both the individuals and the community health care system. A study published in the January

2009 issue of the American Journal of Managed Care revealed that New Orleans-area residents aged 65 and over who were affected by Hurricane Katrina had a post-Katrina illness rate that was four times greater than other U.S. residents in that age range. Emergency Department visits by these vulnerable and at-risk older residents increased 21 percent during the year following the hurricane, compared to the previous year.

My testimony today will focus on ACF's ongoing disaster case management (DCM) efforts and our progress to date, including the development of a disaster case management model, a program implementation guide, and a pilot project. As requested, I will share a brief overview of lessons learned from our work and assessments of the pilot project and highlight our planned steps to continue this vital work. Before discussing each of these activities in more detail, I would like to share some background on how ACF became involved in disaster case management.

Background

After Hurricanes Katrina and Rita, it became apparent that individuals and families impacted by disasters often require case management services to regain self-sufficiency. However, at the time, there was no Federal authority to fund disaster case management as part of a Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act) declaration. In response, the Stafford Act was amended by the Post Katrina Emergency Reform Act of 2006 to authorize the President to provide funding for case management services to survivors of major disasters.

ACF created the Office of Human Services Emergency Preparedness and Response in 2007 to focus attention on human services preparedness and response.

One of the primary goals of this office is to promote self-sufficiency by providing access to health care, mental health services, emergency aid, and recovery assistance. Through our work with States, individuals, families, and special needs populations are assisted prior to, during, and after disasters. A holistic disaster case management program is a key element in this process.

Efforts to Develop a Disaster Case Management Program

As one of its first efforts, ACF, with support from FEMA and the HHS Office of the Assistant Secretary for Preparedness and Response, determined that it was feasible and beneficial to develop a disaster case management program. Our first action was to reach out to Voluntary Organizations Active in Disaster to discuss the project and learn more about their efforts during previous disasters. To ensure that the work was based on the best available evidence, ACF awarded a contract to review past practices and best practices in disaster case management, and to develop, demonstrate, and evaluate a pilot project.

The ACF disaster case management model is based on five principles: self-determination, self-sufficiency, Federalism, flexibility and speed, and support to States. These principles derive from the premise that individuals and families adversely impacted by a disaster have the same rights and responsibilities as everybody else, and that government aid to individuals adversely impacted by a disaster should, therefore, seek to support their self-determination efforts as they seek access to public benefits and, if necessary, consider relocation opportunities. Disaster case management seeks

to restore children, families, the elderly, and persons with disabilities to a pre-disaster level of self-sufficiency that maintains clients' human dignity.

Based on these principles, the pilot project was designed to augment existing State and local capability to perform disaster case management following a Presidentially-declared disaster. We implemented a two-week pilot project in September 2008 following Hurricane Gustav in Louisiana. FEMA requested that we continue our work throughout the recovery process. Therefore, we extended the pilot project as requested by FEMA with the support of the United States Public Health Service and our contract with Catholic Charities USA, the organization we contract with to provide disaster case management services. In addition, we expanded the pilot to include survivors of Hurricane Ike, to allow enrollment of new clients for up to six months post-disaster and to provide case management services for up to 12 months following enrollment. This expansion from Hurricane Gustav to Hurricane Ike was seamless and resulted in no break in service to disaster survivors. The total program across all sites is designed to run for 18 months after implementation. To date, we have provided case management services to approximately 21,000 individuals, a number far greater than the 12,000 we expected to serve. The majority of the clients served had incomes below \$15,000 and were part of female-headed households; 35 percent of all individuals we served were children. Some of these clients' cases have been closed, but we will continue to support the remaining disaster survivors who need help through March 2010.

Lessons Learned

In order to improve the program, ACF has worked diligently to assess and evaluate its disaster case management efforts. Through consultations with Federal, State, and local governments, voluntary organizations, academia, and non-governmental organizations, we have gathered lessons learned from previous and ongoing case management programs, both for disaster survivors and for other clients. We also have obtained a great deal of useful feedback over the course of the last two years through our participation in conferences sponsored by the entity known as the "National Voluntary Organizations Active in Disaster" and FEMA for Emergency Support Function 6 partners.

Outside of consultation, our evaluation efforts include the preparation of an After Action Report on the initial two-week pilot period following Hurricane Gustav. This report identified numerous strengths of the program, including its ability to initiate services within 72 hours of activation. Given our ability to respond so quickly, a substantial number of clients received disaster case management services during the two-week pilot, especially clients from vulnerable populations. Other strengths include the use of volunteers as program support and subject matter experts; the creation of effective links to health care, human services, mental health, and disaster related resources; and the establishment of a call center to serve as a key point of intake for clients seeking services. The report also identified areas requiring improvement, including the need to pre-identify case managers for deployment; determine the availability of full time case managers from the voluntary organizations; and establish team member roles and responsibilities upon initial deployment. Because so many

communities lacked existing resources prior to the disaster, such as adequate housing for the poor and case management for individuals with mental illness, forging connections to available services has been an overall challenge to disaster case management efforts. In response, we now develop resource lists for every State that identify existing resources to assist case managers.

ACF's program implementation guide provides an overview and specific implementation instructions, including procedures to initiate the delivery of disaster case management services, transition services to the State, close client cases, as well as team member roles and responsibilities and staff selection and training information. We sought public comments on the working draft of the program implementation guide through a Federal Register notice in September 2009, with input from subject matter experts representing Federal, State and local governments, Voluntary Organizations Active in Disaster, and academia, and recently completed the revised version incorporating public comments. While this working draft of the program implementation guide currently serves as a directive for the pilot program, in order to strengthen this key document continually, the public comment and review process will be repeated again at the end of the program in March 2010 in coordination with FEMA.

In addition, we contracted with PricewaterhouseCoopers to evaluate the organizational structure and processes used throughout the pilot, and to identify any significant implementation barriers that may have impacted clients' return to self-sufficiency or access to needed services. After the pilot ends in March 2010, we plan to conduct an assessment of the impact and outcomes of case management services on individuals' abilities to return to self-sufficiency and get back on their feet, along with

types of case managers and programs that lead to successes and types of services provided most frequently. The focus on outcomes responds to the concerns cited in GAO's report, "Greater Coordination and an Evaluation of Programs' Outcomes Could Improve Disaster Case Management," that the Federal disaster case management evaluations conducted to date addressed only process and implementation issues, rather than participant outcomes.

Next Steps

We are working closely with FEMA on finalizing this month an Interagency Agreement (IAA) to allow for implementation of the ACF Disaster Case Management Program after a major disaster has been declared by the President, where Individual Assistance has been authorized, and the State's request for disaster case management has been approved by FEMA. The IAA states that, in coordination with FEMA and the State, ACF will initiate disaster case management within 72 hours of notification and for the duration of 30 to 180 days. At the end of the deployment period, ACF will assist with the transition of disaster case management to existing State resources or a FEMA-funded State DCM program. In exceptional situations, FEMA may authorize ACF to continue services until such time as the State is able to assume disaster case management, meanwhile continuing to provide States technical assistance as needed.

Drawing upon lessons learned from the pilot project and existing human services and disaster management networks and expertise, ACF's FY 2010 budget request would fund a contract with a voluntary organization to provide a Federal disaster case management system and technical assistance for human services. This contract would

ensure that trained personnel are credentialed and available when a serious disaster strikes.

Conclusion

As these efforts demonstrate, since funding through FEMA was provided for disaster case management, we have worked with our partners at the Federal, State, and local government level, academia, voluntary organizations, and non-governmental organizations to provide assistance to States in responding to the needs of children and families affected by major disasters.

Together, we have had a positive impact on the lives of disaster survivors and demonstrated the importance of providing disaster case management within 72 hours after a disaster. A few stories reinforce the significance of these efforts on the lives of individuals. Joe was a 49-year-old man with a disability who lived alone. The roof of his home had been damaged badly by Hurricane Gustav. He had repaired this damage with his own money, but his roof was damaged again by Hurricane Ike. Joe, who had been surviving on his own until faced with costs stemming from two hurricane disasters, now needed assistance. A case manager and an Americorps volunteer conducted a home visit, helped him apply for food stamps, and delivered the food stamp card to his home. The case manager also located a crew of Americorps volunteers to assist with roof repairs.

Case management that occurs immediately after a disaster can help mitigate cascading events that can have long-term adverse impacts on an individual's health, safety, and overall well-being. Due to lack of funds for transportation and lodging, a

single mom in St. Tammany Parish, along with her five children, did not evacuate her mobile home prior to Hurricane Gustav. The family remained in a home that was flooded and without power for several days, with windows broken and appliances and flooring damaged. After meeting with a case manager, this woman received immediate assistance through established service providers and existing disaster relief programs for food stamps, clothing, crisis counseling and disaster unemployment assistance. The client also was referred to local officials who determined that her home was unsafe and irreparable. The case manager coordinated housing services through FEMA, helping her and her children secure a safe place to live, and maintained an ongoing relationship to ensure the long-term needs of this family were met.

Another example highlights the flexibility and agility of this vital program. A young married couple had been living in a homeless shelter in New Orleans, which was closed following Hurricane Gustav. The couple moved to a Red Cross shelter in Marrero, Louisiana. The woman had multiple medical problems and was without medication. They had no money for food or transportation. A case manager met with them and, through consultation with a Red Cross mental health volunteer and a U.S. Public Health Service nurse, determined that her medical problems required immediate care. The case manager helped the woman receive attention at the local hospital, and also connected the couple to a local non-profit organization that provided housing and funds for the couple to relocate to Atlanta to reconnect with family.

These and many other examples underscore the importance of this program, which is helping thousands of individuals and families – adversely impacted by disasters – to strengthen their recovery process.

I truly appreciate the opportunity to appear before the Committee and look forward to working with you on this vital effort.

I would be pleased to address any questions you may have.

TESTIMONY OF FREDERICK TOMBAR
SENIOR ADVISOR
OFFICE OF THE SECRETARY
U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
BEFORE THE SUBCOMMITTEE ON DISASTER RECOVERY
December 2, 2009

Good afternoon, Chairwoman Landrieu and distinguished members of the Committee. I am Frederick Tombar, Senior Advisor to the Secretary at the U.S. Department of Housing and Urban Development (HUD). Thank you for inviting me to testify today.

HUD has administered case management services in the Gulf Coast for thousands of families impacted by Hurricanes Katrina, Rita, Gustav, and Ike. Under the largest of these programs, the Disaster Housing Assistance Program-Katrina (DHAP)-Katrina, disbursed \$63 million to Public Housing Agencies (PHAs) to provide case management services to more than 36,000 families. PHAs received a fee of \$92 per month for each family to provide case management services. Some PHAs chose to use this fee to provide case management services in-house, while other PHAs contracted with local service providers, including Catholic Charities and the Urban League.

The purpose of DHAP-Katrina case management was to assist families in their efforts to transition to permanent housing. With models such as HUD's HOPE VI program and FEMA's Katrina Aid Today as examples, a robust case management system was developed for DHAP-Katrina that emphasized the service connector role of the case manager. Specifically, case managers completed needs assessments with participants, using these to establish Individual Development Plans (IDPs) that identified the goals of each participant, primary of which was finding permanent housing. To reach these goals, case managers referred families to services that would assist their progress.

DHAP-Katrina case management was implemented for all active DHAP-Katrina participants until February 28, 2009, the original end date for DHAP-Katrina. Between September 2007 and February 2009, case managers completed over 37,000 risk assessments and needs assessments, and established over 34,000 IDPs for heads of household and some additional adult family members. Nearly 97,000 service referrals were made to enable participants to reach their goals. The average case manager to client ratio was 1 to 28, and over 1,000 case managers were engaged to provide these services.

During the Transitional Closeout Plan (TCP) for DHAP-Katrina, from March 2009 through October 2009, case management was provided in the states of Tennessee and Louisiana, as these were the states that submitted applications for case management funds from FEMA. During the TCP, 200 case managers provided services to over 5,000 families in Tennessee and Louisiana.

While case management was being implemented for DHAP-Katrina, Hurricanes Gustav and Ike struck the Gulf Coast, in September 2008. HUD again worked closely with FEMA to establish the DHAP-Ike. Case management services for DHAP-Ike participants began in November 2008. Similar to DHAP-Katrina, some DHAP-Ike PHAs chose to provide case management services

in-house, while others contracted out for case management. DHAP-Ike PHAs receive a fee of \$100 per month for each family to provide case management.

DHAP-Ike is scheduled to end in March 2010, and to date, \$20 million has been disbursed to PHAs to fund the work of 400 case managers in providing services to over 17,000 DHAP-Ike families. Specifically, over 16,000 heads of household and some additional adult family members have had needs assessments and IDPs established. Case managers are required to complete regular reassessments of DHAP-Ike participants, and they have completed over 37,000 assessments to date. Additionally, case managers have made over 58,000 referrals related to the goals established in the IDP.

Through the provision of DHAP case management to families impacted by Hurricanes Katrina, Rita, Ike, and Gustav, HUD has learned several key lessons that could assist Federal policy changes in the development of disaster case management programs.

Under DHAP, higher quality case management is often provided when PHAs contract with local service providers to provide case management services, rather than providing these services in-house. Local case management providers are already positioned to provide this type of assistance to families and have expertise in case management to better serve families. From this experience HUD recommends drawing on organizations that have a history of provision of case management to disaster-impacted populations.

A second lesson learned from DHAP is that even when utilizing local case management organizations, there may not be sufficient direct services in the area post-disaster to fully serve all disaster-impacted families. This happens because local service providers in impacted areas have diminished service capacities immediately following a disaster. Beyond case management provisions, disaster-impacted regions are in need of increased resources for service providers that directly provide services to the families.

A third lesson from DHAP is the need to work more extensively with other Federal partners and nonprofit organizations to link vulnerable families, such as elderly and disabled persons, to resources. For example, as DHAP-Katrina was ending, concerns arose over whether the most vulnerable clients had access to necessary resources. As a result of these concerns, Housing Choice Voucher resources were prioritized for elderly and disabled participants. Under DHAP-Ike, HUD continues to address the needs of this population by holding a series of round table discussions to bring together public housing agencies, other Federal agencies, and nonprofit groups.

A final recommendation to the Committee is that post-disaster case management should formally include a specific housing self-sufficiency function, and that these services should be coordinated with HUD and the PHAs when a family is participating in DHAP. This will help clients navigate PHA policies, identify families eligible for HUD's core programs, and focus clients on achieving *housing* self-sufficiency.

Finally, I would like to conclude by mentioning several of the other HUD programs that provide case management services to disaster-impacted families.

Within HUD's Office of Community Planning and Development (CPD), there are several programs that are able to provide case management and essential support services. Both traditional and disaster-related Community Development Block Grant (CDBG) Program funds may be used for public services in the areas of employment and job training, child care, crime prevention, health, drug abuse, education, energy conservation, fair housing counseling, , and homebuyer down-payment assistance.

The State of Mississippi has obligated approximately \$24.7 million of its disaster recovery CDBG funding toward case management within its housing programs. Case management has been used in Mississippi under the Homeowners Assistance Program, Small Rental Program, and Long-Term Workforce Housing Program.

Under the Homeowners Assistance Program, the State provided housing assistance centers throughout the disaster declared counties in the State. Under the Small Rental Program, the State provided staff and call centers to assist applicants through the entire process from application to closing. Every applicant had their own case manager to assist them through this process. Under the Long-Term Workforce Housing Program, case management is provided during the intake of applications and in determining the applicant's eligibility. Credit assessments are completed and the applicants are assisted with the mortgage application process. All applicants are required to attend a homeownership class and complete six post-purchase counseling sessions.

The State of Louisiana has similarly embedded applicant-based case management and housing resource assistance into its homeowner and rental housing assistance programs. However, neither state has used disaster-recovery CDBG to directly fund case management services for individuals and families outside of their homeowner and rental assistance programs

Other CPD programs that may be used to support case management services are:

- Emergency Solutions Grants (ESG) Program, where funds may be used to provide essential social services, and prevent homelessness;
- Supportive Housing Program, which may provide supportive services for homeless persons to assist them to move into independent living;
- Section 8 Moderate Rehabilitation Single Room Occupancy (SRO) Program, which may provide support services for the homeless individuals in SRO units;
- Shelter Plus Care Program, which provides rental assistance that must be matched by the grantee in an equal value to be used for supportive services;
- Housing Opportunities for Persons with Aids (HOPWA) Program, which may provide supportive services, including case management; and the Homeless Prevention and Rapid Re-housing Program, which is a \$1.5 billion program created under the American Recovery and Reinvestment Act of 2009.

Thank you for the opportunity to discuss the provision of case management to disaster-impacted families. I'm now happy to take any questions you have and again want to thank Chairwoman Landrieu and the Members of the Committee for the opportunity to speak with you today.

United States Government Accountability Office

GAO

Testimony
Before the Ad Hoc Subcommittee on
Disaster Recovery, Committee on
Homeland Security and Governmental
Affairs, U.S. Senate

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DISASTER ASSISTANCE

Improvements in Providing Federal Disaster Case Management Services Could Help Agencies Better Assist Victims

Statement of Kay E. Brown, Director
Education, Workforce, and Income Security



December 2, 2009

DISASTER ASSISTANCE

Improvements in Providing Federal Disaster Case Management Services Could Help Agencies Better Assist Victims



Highlights of GAO-10-278T, a testimony to the Ad Hoc Subcommittee on Disaster Recovery, Committee on Homeland Security and Governmental Affairs, U.S. Senate

Why GAO Did This Study

As a result of the damage caused by Hurricanes Katrina and Rita in 2005, the federal government funded several disaster case management programs. These programs help victims access services for disaster-related needs. This testimony addresses the following questions: 1) How did the federal government support disaster case management programs after Hurricanes Katrina and Rita, and how did federal agencies coordinate their efforts?; 2) What challenges did disaster case management agencies experience in delivering services under federally funded programs?; and 3) How will previous or existing federally funded programs be used to inform the development of a federal case management program for future disasters?

This testimony is based on a July 2009 report (GAO-09-561). To complete this report GAO reviewed federal laws, regulations, and guidance, obtained data from two programs, conducted site visits to Louisiana and Mississippi, and interviewed case management providers and federal and state officials. For this testimony, GAO updated certain information.

What GAO Recommends

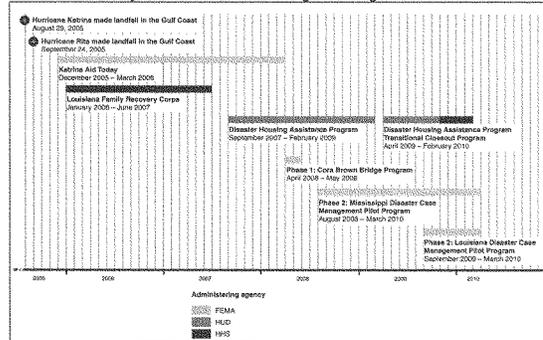
In our July 2009 report, GAO recommended that FEMA improve coordination and create a time line for its new disaster case management program, and examine pilot program outcomes to develop the program. FEMA agreed with our recommendations. GAO is making no new recommendations.

View GAO-10-278T or key components. For more information, contact Kay E. Brown at (202) 512-7215 or brownke@gao.gov.

What GAO Found

The federal government provided more than \$231 million to support disaster case management programs for victims of Hurricanes Katrina and Rita; however, breaks in federal funding hindered service delivery, and federal agencies and case management agencies faced coordination challenges. (See fig.) A lack of accurate and timely information sharing and incompatible data systems may have left some victims most in need without access to disaster case management services.

Time Line of Federally Funded Disaster Case Management Programs



Source: GAO.

Case management agencies experienced challenges in delivering federally funded disaster case management services due to staff turnover and large caseloads, limited community resources, federal funding rules, and a lack of coordinated outreach. For example, case management agencies saw the ability to provide direct financial assistance for items such as home repair, clothing, or furniture as key to helping victims, yet case management agencies that provided services under FEMA-funded programs could not provide direct financial assistance. Long-term recovery committees were a resource for case management agencies to obtain direct assistance, but utilizing these committees was sometimes unsuccessful.

Ongoing evaluations of disaster case management pilot programs will inform the development of a federal disaster case management program, but to date, little is known about program outcomes. FEMA plans to analyze third-party evaluations submitted by the agencies administering the pilot programs to determine lessons learned and best practices for the future. According to an agency official, FEMA hopes to formalize the new program in June 2010.

Madam Chairman and Members of the Subcommittee:

I appreciate the opportunity to participate in today's discussion on disaster case management and to provide highlights of our July 2009 report entitled *Disaster Assistance: Greater Coordination and an Evaluation of Programs' Outcomes Could Improve Disaster Case Management*.¹ Hurricanes Katrina and Rita caused approximately \$90 billion in property damage, destroyed over 300,000 homes, and displaced more than 1 million people from some of the poorest communities in the country when they struck the Gulf Coast in August and September 2005. To assist victims with their recovery, the federal government stepped in and, for the first time, provided more than \$231 million to states and nonprofit organizations to support several disaster case management programs. Disaster case management involves helping victims access services for a range of needs, including employment, housing, and health care. In our report, we estimated that up to 116,000 families affected by Hurricanes Katrina and Rita received federally funded disaster case management services.²

My statement today, based on our July 2009 report, addresses the following questions: 1) How did the federal government support disaster case management programs after Hurricanes Katrina and Rita, and how did federal agencies coordinate their efforts? 2) What challenges did case management agencies experience in delivering disaster case management services under federally funded programs? and 3) How will previous or existing federally funded programs be used to inform the development of a federal case management program for future disasters?

To prepare the report, we reviewed the roles and responsibilities of the federal government for disaster recovery services, as well as federal laws, regulations, and guidance for the federally funded disaster case management programs established to assist victims of Hurricanes Katrina and Rita. We interviewed federal officials from the Federal Emergency Management Agency (FEMA), the Department of Housing and Urban

¹GAO, *Disaster Assistance: Greater Coordination and an Evaluation of Programs' Outcomes Could Improve Disaster Case Management*, GAO-09-561 (Washington, D.C.: July 8, 2009).

²This estimate is based on information obtained from each of the agencies that provided federally funded disaster case management services. However, it is possible that clients may have received services from more than one case management program.

Development (HUD), and the Department of Health and Human Services (HHS). We conducted site visits to Louisiana and Mississippi and interviewed organizations involved in disaster case management in those states. We also obtained data on clients in two disaster case management programs and used only those data elements we found to be sufficiently reliable for the purposes of our work. We conducted the performance audit from May 2008 to July 2009 and updated information in November 2009, in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions. A detailed explanation of our methodology is included in our July 2009 report.

In summary, we found that FEMA, HHS, and HUD supported disaster case management programs following Hurricanes Katrina and Rita. However, breaks in federal funding and coordination challenges adversely affected the delivery of disaster case management services to some hurricane victims. Coordination challenges included a lack of accurate and timely information sharing and incompatible data systems. In addition, case management agencies experienced challenges in delivering services due to large caseloads, limited community resources, federal funding rules, and a lack of coordinated outreach. For future disasters, FEMA is developing a federal case management program based on evaluations of several disaster case management pilot programs. However, we found that FEMA had not established a time line for developing this program, and some of the evaluations had limitations, such as a lack of information on program outcomes. In our report, we recommended that FEMA establish a realistic and achievable time line for designing and implementing a single, federal, disaster case management program for future disasters, conduct an outcome evaluation to determine the results of the disaster case management pilot programs, and ensure that the federal disaster case management program it develops includes practices to enhance and sustain coordination among federal and nonfederal stakeholders. FEMA agreed with our recommendations and is taking steps to address them; FEMA hopes to finalize the federal disaster case management program in June 2010.

Background

Disaster Case Management Disaster case management is a process that assists people in identifying their service needs, locating and arranging services, and coordinating the services of multiple agencies following a disaster. While disaster case management services may include emergency relief services, they extend beyond the immediate to address long-term recovery needs,³ such as health care, employment, housing, and other social services. Disaster case management programs may directly provide assistance, make referrals to organizations that have agreed to meet specific client needs, contract with other organizations, or otherwise arrange for individuals and families to receive needed services and resources.⁴ Disaster case management agencies may also work in conjunction with long-term recovery committees to serve their clients. These committees are typically community-based organizations that bring together local leaders to coordinate recovery efforts and provide resources, as a last resort, to address the unmet needs of disaster victims.

Federal Role for Funding and Coordinating Disaster Case Management Services

The Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act),⁵ as amended, is the primary authority under which the federal government provides major disaster and emergency assistance, and FEMA is responsible for administering its provisions. At the time of Hurricanes Katrina and Rita, the Stafford Act contained no explicit authority to fund disaster case management services. However, the passage of the Post-Katrina Emergency Management Reform Act of 2006 (Post-Katrina Act),⁶ which amended the Stafford Act, granted the President the authority to provide financial assistance for case management services to victims of major disasters.

In addition to its responsibilities under the Stafford Act, FEMA has responsibility for administering and ensuring implementation of the

³Council on Accreditation. Council on Accreditation Standards: *5th Edition/Private* (August 2008). <http://www.coastandards.org> (accessed Oct. 17, 2008).

⁴*ibid.*

⁵Pub. L. No. 93-288, 88 Stat. 143 (1974).

⁶Pub. L. No. 109-295, Title VI, at §689f, codified at 42 U.S.C. §5189d. The Post-Katrina Act was passed in October 2006.

National Response Framework, which became effective in March 2008 and replaced the former National Response Plan.⁷ The Framework maintains FEMA's responsibility for coordinating human services and specifically includes disaster case management as a category of human services. Moreover, the Framework requires federal agencies involved in mass care, housing, and human services to coordinate federal response efforts with the efforts of state, local, private, nongovernmental, and faith-based organizations.

In September 2009, the President announced the formation of a Long-Term Disaster Recovery Working Group, co-chaired by the secretaries of the Department of Homeland Security (DHS) and HUD, to examine lessons learned during previous catastrophic disaster recovery efforts, and areas for improved collaboration between federal agencies and between the federal government and state and local governments and stakeholders. As part of this initiative, FEMA and HUD are co-chairing the National Disaster Recovery Framework Working Group, which will define the federal, state, local, tribal, private non-profit, private sector, and individual citizen's roles in disaster recovery; design and establish an effective coordinating structure for disaster recovery programs; identify gaps, as well as, duplications, in recovery programs and funding; and establish performance standards for the federal support of state and local recovery.

The Federal Government Supported Disaster Case Management Programs, but Breaks in Federal Funding and Coordination Challenges Hindered Assistance

Multiple federal agencies provided resources for disaster case management programs to help thousands of households cope with the devastation caused by Hurricanes Katrina and Rita, but breaks in federal funding and coordination challenges adversely affected the delivery of these services to some hurricane victims.

⁷The National Response Plan was an all-discipline, all-hazards plan establishing a single, comprehensive framework for the management of domestic incidents where federal involvement was necessary.

FEMA, HUD, and HHS Supported a Variety of Disaster Case Management Programs for Hurricane Victims, but Breaks in Federal Funding Adversely Affected Services to Some

More than \$231 million of FEMA and HHS funds have been used to support disaster case management programs to assist victims of Hurricanes Katrina and Rita. These programs include:

- Katrina Aid Today (KAT)—FEMA awarded a \$66 million grant to the United Methodist Committee on Relief, which then used the grant to establish KAT, a national consortium consisting of nine social service and voluntary organizations, to provide case management services to Hurricane Katrina victims.
- The Cora Brown Bridge Program—Following the termination of KAT, Louisiana and Mississippi received Cora Brown Funds⁸ from FEMA to continue providing services to individuals and families affected by Hurricanes Katrina and Rita.
- The Disaster Case Management Pilot Program (DCM-P)—Following the termination of the Cora Brown Bridge Program, FEMA used funds from its Disaster Relief Fund⁹ to establish a state-managed DCM-P program to serve Hurricane Katrina and Rita victims in Louisiana and Mississippi, with the primary goal of helping them achieve sustainable permanent housing.
- The Louisiana Family Recovery Corps (LFRC) case management program—HHS distributed emergency Temporary Assistance for Needy Families and Social Services Block Grant funds to Louisiana, which contracted with LFRC, to provide disaster case management services to victims of Hurricanes Katrina and Rita.
- The case management portion of the Disaster Housing Assistance Program (DHAP)—Using funding provided by FEMA, HUD designed and implemented this program to provide rental assistance to eligible victims of Hurricanes Katrina and Rita. To participate in the program, clients also had to receive case management services.
- The case management portion of the DHAP Transitional Closeout Program—Some DHAP clients continued to receive housing assistance

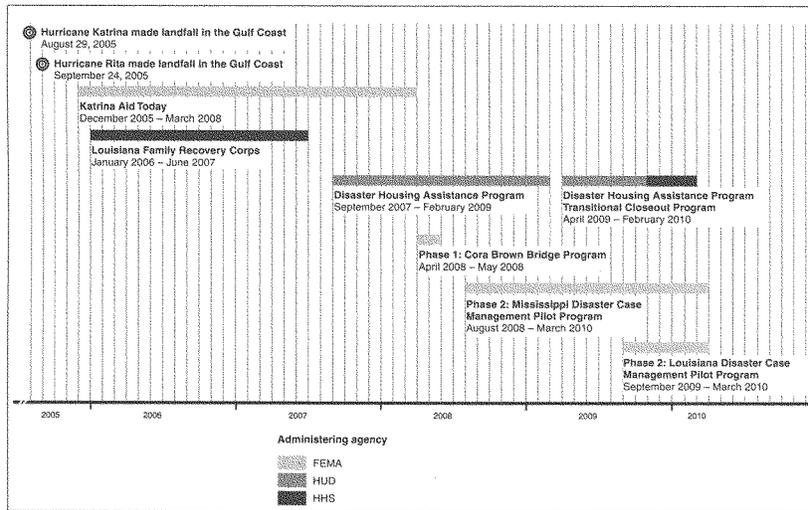
⁸The Cora Brown fund was established in 1977 when Cora C. Brown of Kansas City, Mo., left a portion of her estate to the United States to be used as a special fund solely for the relief of human suffering caused by natural disasters. It is a fund of last resort that is used to help victims of presidentially-declared disasters who have disaster-related needs that cannot be met by any other means.

⁹FEMA's Disaster Relief Fund is the major source of federal disaster recovery assistance for state and local governments when a disaster occurs.

following the completion of DHAP. In Louisiana, housing assistance was accompanied by disaster case management services. The state has used funding provided by HUD and through HHS' Social Services Block Grant program.

These programs began at different times and sometimes overlapped as federal agencies identified ongoing need for services (see fig. 1).

Figure 1: Time Line of Federally Funded Disaster Case Management Programs for Victims of Hurricanes Katrina and Rita



Source: GAO.

Notes: The program dates above represent when case management services began. Grant agreements may have been in place prior to these dates.

Louisiana received emergency block grant funding from HHS. State officials in Louisiana designated a portion of these funds for disaster case management.

Breaks in federal funding for disaster case management programs initiated after Hurricanes Katrina and Rita adversely affected case management agencies and may have left victims most in need of assistance without access to case management services. For example, as the first federally funded disaster case management program, Katrina Aid Today (KAT), drew to a close in March 2008, some case management agencies began to shut down their operations. Some cases were closed not because clients' needs had been met, but because the program was ending, and it is unknown whether these clients obtained assistance elsewhere or whether their cases were eventually reopened under the Cora Brown Bridge Program.

Clients with open cases under the Bridge program were supposed to seamlessly transition from the Bridge program into FEMA's new state managed DCM-P program. However, in Mississippi, the state-managed pilot program did not begin until approximately two months after its scheduled start date, and many of the smaller case management organizations had to lay off case managers with the hope of hiring them back once they received federal funding. In addition, in Louisiana, the state-managed pilot became operational in September 2009, approximately 15 months after it was scheduled to begin. The program will serve an estimated 3,300 households that remained in FEMA temporary housing as of April 2009.

Challenges to Coordination among Federal Agencies and Case Management Agencies Contributed to Implementation Difficulties

Initial coordination activities among federal agencies and case management agencies were minimal following the hurricanes, which may have resulted in some victims not receiving case management services and others receiving services from multiple agencies. In previous work, GAO has identified key practices to enhance and sustain coordination among federal agencies,¹⁰ and has since recommended these same key practices to strengthen partnerships between government and nonprofit organizations.¹¹ Key practices for coordination include establishing

¹⁰For the purposes of this report we defined "coordination" broadly to include interagency activities that others have previously defined as cooperation, collaboration, integration, or networking. Here, we use this definition to describe coordination among federal agencies as well as between federal agencies and nonfederal stakeholders. See GAO, *Results-Oriented Government: Practices That Can Help Enhance and Sustain Collaboration among Federal Agencies*, GAO-06-15 (Washington, D.C.: Oct. 21, 2005).

¹¹See GAO, *Nonprofit Sector: Increasing Numbers and Key Role in Delivering Federal Services*, GAO-07-1084T (Washington, D.C.: July 24, 2007).

mutually reinforcing or joint strategies and compatible policies, procedures, and other means of operating across agency boundaries.

Difficulties in coordinating disaster case management services resulted in a lack of accurate and timely information sharing between federal agencies and case management agencies. Case management agencies providing federally funded disaster case management services said they faced challenges in obtaining timely and accurate information from FEMA; however, FEMA officials said requests for information often did not meet their requirements. For example, FEMA approached HHS about serving some victims of Hurricanes Katrina and Rita under its pilot disaster case management program following Hurricanes Gustav and Ike. When the case management agency implementing the HHS pilot requested client information from FEMA, FEMA only provided aggregate data, which the case management agency found unusable. According to FEMA officials, its routine use policy precluded it from sharing client-level information for this purpose.¹² However, FEMA officials said they have fulfilled many requests for information and worked with states on how to request information. For example, FEMA provided information to the Louisiana Department of Social Services so as to prevent duplication of efforts or benefits in determining eligibility for disaster assistance.¹³ In a previous report, we identified as a lesson learned the value of standing agreements for data sharing among FEMA and state not-for-profit agencies as a means to expedite recovery services. Such agreements can clarify what data can be shared and the procedures for sharing it while protecting the data from improper disclosure.¹⁴

¹²Under the Privacy Act, an agency may disclose information without the permission of the individual to whom the information relates for a number of statutorily permitted purposes, including if it is determined to be a "routine use", or one that is compatible with the purpose for which the data was collected. The Department of Homeland Security recently revised the routine use notice regarding its Disaster Recovery Assistance system of records, amending and adding to the instances where FEMA may share data from the Disaster Recovery Assistance files. DHS/FEMA-008 Disaster Recovery Assistance Files, 74 Fed. Reg. 48763 (September 24, 2009).

¹³GAO, *Disaster Assistance: Federal Efforts to Assist Group Site Residents with Employment, Services for Families with Children, and Transportation*, GAO-09-81 (Washington, D.C.: December 11, 2008).

¹⁴GAO, *Lessons Learned for Protecting and Educating Children after the Gulf Coast Hurricanes*, GAO-06-680R (Washington, D.C.: May 11, 2006).

Federally funded case management programs used different databases, making it difficult to track clients across case management agencies, and potentially allowing hurricane victims who applied to more than one program to receive duplicate services. For example, clients who received case management services through KAT may have also received services through the LFRC disaster case management program, but because the KAT and LFRC databases were not compatible, some case management agencies for these two programs may not have been able to screen for duplication of services.

Case Management Agencies Experienced a Range of Service-Delivery Challenges, and As a Result, Some Hurricane Victims May Not Have Been Helped

Case management agencies experienced a variety of challenges in delivering federally funded disaster case management services. Some agencies had high staff turnover, and some case managers had large caseloads, making it difficult to meet client needs. Clients frequently needed housing and employment, according to case managers and program data, but these resources were limited following the hurricanes. Further, case management agencies saw the ability to provide direct financial assistance for items such as home repair, clothing, or furniture as key to helping victims, yet only one federally funded program allowed case management agencies to use federal funds for direct financial assistance.

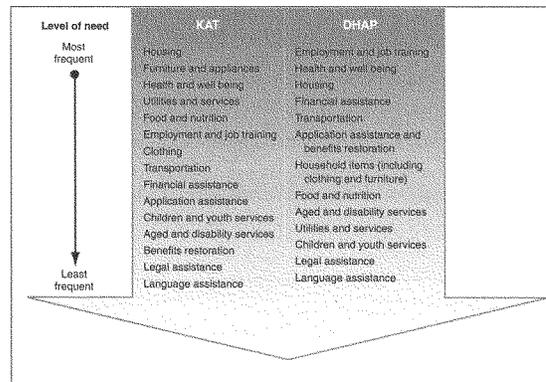
Staff Turnover and Large Caseloads Were Barriers to Meeting Clients' Needs

Some case management agencies experienced high staff turnover and large caseloads, which made it difficult to meet clients' needs. For example, one agency reported 100 percent turnover in case managers during the KAT program, which an agency official attributed to case managers' expectations of a short-term assignment or to the work being too emotionally draining. In terms of caseload size, KAT and LFRC case managers had larger caseloads than program guidance recommended. For example, KAT case managers had caseloads ranging between 40 and 300 clients even though the guidance recommended an average of 20 to 30 cases. Several factors may have contributed to high caseloads, including the magnitude of the disaster and a shortage of case managers.

Clients Needs Included Housing, Employment and Transportation; However, These Community Resources Were Limited

Case managers and program data indicated that one of the main needs of clients was housing (see fig. 2).

Figure 2. Most to Least Frequently Occurring Client Need by Disaster Case Management Program



Source: GAO analysis of program data.

Note: KAT program data included pre-defined categories of need. For the DHAP program, we analyzed needs assessment data for those clients with a completed needs assessment and combined variables to create categories comparable to KAT. The DHAP needs assessment did not include individual questions for application assistance, benefits restoration, furniture/appliances, or clothing; as a result, the KAT and DHAP categories are not a one-to-one match.

According to program data, approximately 67 percent of KAT clients were displaced from their primary residence as a result of Hurricane Katrina. As GAO recently reported, one commonly cited challenge faced by displaced households was finding affordable rental housing, since rents increased significantly following the storms in certain Gulf Coast metropolitan

areas.¹⁵ For example, HUD's fair market rent for a two-bedroom unit in the New Orleans-Metairie-Kenner metropolitan area increased from \$676 to \$1,030, or about 52 percent, between fiscal years 2005 and 2009. We also reported that disaster victims faced other obstacles in returning to permanent housing, such as insufficient financing to fund home repairs and significantly higher insurance premiums.¹⁶

Case managers said client needs also included employment and transportation, but these resources were limited. According to the Bureau of Labor Statistics, between August 2005 and August 2006, almost 128,000 jobs were lost in eight areas of Louisiana and Mississippi that were heavily affected by Hurricane Katrina. In addition, the unemployment rate in the New Orleans-Metairie-Kenner metropolitan area more than tripled between August 2005 and September 2005, and the unemployment rate remained above pre-Katrina levels until March 2006.¹⁷ We previously reported that transportation services can provide a vital link to other services and to employment for displaced persons;¹⁸ yet multiple sources stated that case management clients, particularly those living in FEMA group sites, lacked transportation following Hurricanes Katrina and Rita. Case management officials said lack of access to transportation made it difficult to connect clients living in remote group sites to services such as employment, education, and child care. Federal agencies developed the LA Moves program to provide free, statewide transit service for residents in Louisiana group sites; however, LA Moves service was limited to FEMA defined "essential services," specifically, banks, grocery stores, and pharmacies and did not include transportation to welfare-to-work sites, employment, and human and medical services.¹⁹

¹⁵GAO, *Disaster Housing: FEMA Needs More Detailed Guidance and Performance Measures to Help Ensure Effective Assistance after Major Disasters*, GAO-09-796 (Washington, D.C.: August 28, 2009).

¹⁶*ibid.*

¹⁷ The unemployment rate increased from 4.9 percent in August 2005 to more than 15.2 percent in September 2005. See GAO-09-796.

¹⁸GAO-09-81.

¹⁹*ibid.*

Case Managers Faced Challenges in Meeting Client Needs Due to Federal Funding Rules on Direct Assistance and Difficulties in Accessing Needed Resources Through the Long-Term Recovery Committee Process

Case management agencies saw the ability to provide direct financial assistance for items such as home repairs, clothing, or furniture as key to helping clients with their basic needs; yet such assistance was not always available. An official from a case management umbrella organization said that without direct service funds, short-term needs ultimately can become long-term issues, and individuals may then become dependent on government assistance rather than becoming self-sufficient. Case management agencies that were part of KAT or that provided services under FEMA-funded programs, including the state-managed DCM-P program in Mississippi and the Disaster Housing Assistance Program, were not permitted to provide direct financial assistance. According to a FEMA official, direct financial assistance was not part of these programs because FEMA already provided funding for this purpose through the Individual and Households Program. The maximum amount that an individual or household may receive through the program is \$25,000, adjusted annually to reflect changes in the Consumer Price Index; however, a FEMA official noted that the maximum amount may not be enough to meet all disaster-related needs.

While long-term recovery committees were a resource for case managers to obtain direct assistance to address clients' unmet needs, in some cases, the efforts to utilize these committees were unsuccessful. Some committees were unable to help clients since the member organizations were depleted of goods or donations to pass on to clients. In addition, case managers also cited challenges in the process of working with these committees. They said the process for obtaining assistance could be onerous, time consuming, and confusing.

Case Managers Said Program Eligibility Requirements Were a Barrier to Providing Disaster Case Management Services

Eligibility requirements for receiving disaster case management services varied depending on the funding source, which may have left some in need without services. For example, KAT services were available to victims of Hurricane Katrina but not Hurricane Rita. In addition, LFRC officials said they initially received TANF funds only, which limited their agencies to serving families with children. Lastly, programs such as the Mississippi DCM-P program were restricted to serving those receiving FEMA housing assistance. As a result of certain eligibility requirements, some programs may not have been able to assist individuals and families in need of case management services.

Case Managers Stated that a Lack of Coordinated Outreach May Have Left Some without Access to Needed Services

Many case management agencies conducted little, if any, coordinated outreach and, as a result, those most in need of case management, such as those residing in FEMA group trailer sites, may not have received services. According to LFRC officials, there was no coordinated approach for providing case management services among federally funded programs, and as a result, residents in these group sites may not have received needed case management services. According to a KAT official, KAT case management agencies were not required to conduct outreach to residents in FEMA group sites. In addition, we have previously reported that federal efforts to assist victims of Hurricanes Katrina and Rita with employment, services for families with children, and transportation generally did not target group site residents.²⁰

FEMA Plans to Use Ongoing Evaluations of Pilot Programs to Inform the Development of a Federal Disaster Case Management Program for Future Disasters; However, Early Evaluations Had Limitations

Several agencies' evaluations of the various disaster case management pilot programs are ongoing, but to date, little is known about program outcomes. FEMA and HHS completed evaluations of the initial implementation of two pilot programs, but neither of those evaluations included information on program outcomes, or results, such as the extent to which clients' disaster related needs were met and what factors contributed to client outcomes. In our July 2009 report, we recommended that FEMA conduct an outcome evaluation of the disaster case management pilot programs. FEMA does not plan to conduct its own outcome evaluation, but will determine lessons learned and best practices from third party evaluations of ongoing pilot programs submitted by each of the agencies administering a pilot program. According to a FEMA official, each of the third party evaluations will examine program outcomes.

Using information from the ongoing evaluations, FEMA will develop a model for a federal disaster case management program for future disasters. In our report, we also recommended that FEMA establish a time line for developing this program and ensure that the program includes practices to enhance and sustain coordination among federal and nonfederal stakeholders. FEMA agreed with our recommendations, and, according to a FEMA official, the agency is hoping to formalize the program in June 2010. Going forward, FEMA intends to implement disaster case management services in two phases. In the first phase, HHS will administer disaster case management services for up to 180 days using

²⁰ *ibid.*

FEMA funding. The second phase will be a state-managed disaster case management program funded by a direct grant from FEMA to the affected state. According to an agency official, FEMA is working closely with HHS on all program development requirements and plans to obtain feedback from relevant stakeholders prior to formalizing the program.

In conclusion, the federally funded disaster case management programs implemented following Hurricanes Katrina and Rita faced unprecedented challenges, yet they played a key role in assisting victims in their recovery. A critical component of future recovery efforts is FEMA's timely development of a single, federal disaster case management program. The success of those efforts will depend, in part, on whether agencies can improve coordination to help ensure that those most in need receive services, and to prevent duplication of services. The experiences of past and ongoing disaster case management pilots likely provide valuable lessons learned regarding client outcomes and contributing factors, and it is important to understand those lessons and apply them to future disaster recovery efforts.

Madam Chairman, this completes my prepared remarks. I would be happy to respond to any questions you or other members of the subcommittee may have at this time.

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**Testimony of Amanda Guma
Human Services Policy Director
Louisiana Recovery Authority**

**Senate Homeland Security Committee
Subcommittee on Disaster Recovery
December 2, 2009**

Introduction

Good afternoon, Chairwoman Landrieu and members of the Subcommittee on Disaster Recovery. My name is Amanda Guma, and I am the Human Services Policy Director for the Louisiana Recovery Authority. Thank you for the opportunity to testify today regarding the ongoing disaster recovery effort in Louisiana. We especially appreciate this hearing's focus on disaster case management, which is a critical component of the recovery process, particularly for our most vulnerable residents.

Having been struck by four hurricanes in the span of three years, the state of Louisiana has experienced devastation unparalleled in the United States. Hurricanes Katrina and Rita left us with more than 200,000 housing units suffering major or severe damage; 82,000 of these were rental units. Last year the state experienced two more devastating storms, Gustav and Ike, which caused major damage to another 9,400 homes, forcing thousands into temporary disaster housing. The crisis that continues to face our state is one of enormous magnitude – in which the damage most difficult to measure is the impact on individual lives.

We greatly appreciate your leadership, Senator Landrieu, in helping to secure resources for the critical function of disaster case management to support the recovery of Louisiana's residents. We also acknowledge and thank our federal partners – FEMA, HUD and HHS – for their commitment and partnership on these programs. While there have been challenges, we look forward to sharing lessons learned and making proactive recommendations to help prepare for future disasters.

Background of Case Management Programs

To support human recovery following hurricanes Katrina, Rita, Gustav and Ike, three federal agencies have designed and implemented disaster case management programs: FEMA, through Katrina Aid Today and the Disaster Case Management Pilot (DCMP) Program (Phases 1 and 2); HUD, through DHAP-Katrina and DHAP-Ike, and HHS through the Supplemental Social Services Block Grant and the Gustav/Ike Disaster Case Management Pilot program.

FEMA

Katrina Aid Today was the first major disaster case management effort implemented in Louisiana. The program, funded by FEMA and administered by United Methodist Committee on Relief (UMCOR), brought \$66 million to support the recovery efforts of over 70,000 Hurricane Katrina survivors. Though designed to last two years, Katrina Aid Today was extended an additional six months, ending in March 2008. This model directed federal dollars to

UMCOR, a national non-profit organization that subcontracted to nine provider agencies. As with most of the post-Katrina case management programs, the goal of KAT was to return impacted families to independence and stability, with a specific focus on permanent housing solutions. At the time of KAT's ending, nearly 2,000 cases remained open.

Recognizing the need to provide continued services to those clients, FEMA launched the first of a two-phase effort to support the continued recovery of families. Unlike the funding structure of Katrina Aid Today, this program would allocate resources directly to participating states. Phase One, supported through federal Cora Brown funds, was a short-term bridge program to assist in closing or transferring the remaining KAT cases. This effort provided \$477,000 to Louisiana agencies for a two-month program.

Phase 2 was a grant program designed to serve families still residing in FEMA-funded temporary housing units, beginning in June 2008, and to be implemented in concert with DHAP case management. At the time of initial application for the grant, more than 18,000 Louisiana residents still received FEMA temporary housing assistance, primarily in FEMA trailers. The state submitted 2 grant applications for the program – the first in July 2008 and the second in December 2008 – both of which were approved but not implemented due to reconsideration by the state's lead non-profit agencies to withdraw participation. The non-profits based these decisions upon the short timeframe for program implementation, the lack of direct services funding to pair with case management funds, and the challenges posed by the reimbursement structure on non-profit provider agencies. The state's final application for the program was submitted in June 2009 and approved in July, and the Disaster Case Management Pilot Program launched in Louisiana in September 2009. From the initial award letter to the final, the award amount decreased from \$32.5 million to \$9.4 million, with an accompanying reduction in the eligible population size from 18,000 to 3,300. With six provider agencies and one lead agency, the program currently has enrolled the participation of 1,407 families and is scheduled to end in March 2010.

HUD

Through HUD's Disaster Housing Assistance Program, eligible families impacted by hurricanes Katrina and Rita received case management services from October 2007 through October 2009. These case management services were provided in conjunction with rental assistance for displaced households, and served more than 17,000 families in Louisiana, through local public housing authorities. As with the other disaster case management programs, a primary goal for DHAP-Katrina focused on a successful transition to permanent housing. For many participants of the program, this meant transferring into the Housing Choice Voucher program. HUD estimated that approximately 7,500 Louisiana families would be eligible for these vouchers. Originally scheduled to end on February 28, 2009, DHAP-Katrina was extended for six months (and later conditionally for another two months) to ensure that all eligible families would be afforded sufficient opportunity to transition to the voucher program. While HUD agreed to continue administering the rental subsidy for families, the agency asked the state to take over the administration of the case management component. With an original caseload of nearly 15,000 clients, the state administered the remainder of the case management program through the original extension deadline of August 31, 2009, and then through the additional extension period through October 31, 2009. Recognizing that many families had lost their DHAP rental

assistance but had not necessarily transitioned safely to permanent housing, the state opened up the program to original 15,000 clients for continued case management assistance through February 28, 2010. To date, more than 2,000 former DHAP clients have registered for continued case management services which are funded through the supplemental Social Services Block Grant.

HHS

In 2006, the Louisiana Department of Social Services allocated \$18.5 million from the Supplemental Social Services Block Grant award received from HHS to the Louisiana Family Recovery Corps. These funds were used to provide case management and direct services (through the Household Establishment Fund) to impacted families. An estimated 9,500 families participated in this effort, which lasted one year.

The state has allocated another \$2 million from the Social Services Block Grant to provide extended case management services to former DHAP clients through February 28, 2010. The state invited all original DHAP-Katrina Transitional Closeout clients (nearly 15,000 families) to register for services – to date, over 2400 clients have signed up for the program.

It is important to note that HHS also made a significant contribution to the Katrina/Rita recovery process through its investment in the LA Spirit crisis counseling program. This program has served tens of thousands of families throughout the aftermath of the storms.

In September 2008, in the wake of hurricanes Gustav and Ike, HHS launched its Disaster Case Management Pilot Program in Louisiana. Like Katrina Aid Today and DHAP, the HHS model for disaster case management does not directly include the participation of state and local governments. The pilot program directs funding to a national non-profit organization (Catholic Charities USA), which then partners with local providers. The program has served approximately 8,000 households, and currently ends in March 2010.

Challenges

Having received more than \$100 million in funding for disaster case management services, the state is tremendously grateful to all of our federal partners for making this important investment. We also appreciate this opportunity to reflect on our experiences to date and to discuss some of the challenges and recommendations for disaster case management programs in the future.

Funding Structure

Accessing resources in a timely manner often presents an enormous challenge for state and local entities immediately following a disaster. Since Hurricane Katrina, funding for the disaster case management pilot programs has come down to Louisiana from Washington through various channels – to non-profit organizations, to local entities (i.e. public housing authorities) and to the state government. Because most of these programs have required reimbursement, local providers have assumed significant financial burdens in launching them. Please also remember that one of the three primary reasons for the withdrawal of our DCMP partners was the lack of funding for upfront or advance costs. Having already experienced the funding delays caused by the reimbursement process under the Katrina Aid Today program, our partners did not feel comfortable taking a similar risk again.

We recognize and appreciate that all of our federal partners here today have been very flexible and creative in helping Louisiana overcome some of these hurdles so that funding can reach our local partners more quickly. For the DHAP-Katrina extension, HUD advanced case management funding to the state based upon the anticipated caseloads for the first three months. While our subcontractors still had to provide invoices for payments under this system, this advance removed one major step from the process and thereby significantly reduced turnaround time for payment. FEMA, too, has worked with us to identify the most expeditious ways to make payments to our DCMP providers – and we commend them for allowing pre-award costs and working to streamline the process of reimbursement requests. And we highly commend HHS for creating in its disaster case management model the most expeditious means for facilitating the flow of resources (both human and monetary), which we know is critical here in Louisiana.

Timelines/Program Periods

A related challenge that we have experienced in Louisiana has been the break in funding for disaster case management programs. We note that some of these breaks have been caused by unforeseen challenges (e.g. DCMP) but ultimately they result from an insufficient understanding of the needs on the ground, and illustrate the misalignment of program timelines with actual recovery progress. We remind the members of the Subcommittee that virtually every program created to support human recovery has been extended beyond its original program period. We are grateful for the flexibility that our federal partners have demonstrated in allowing these extensions, but we regret the negative impact of these changing timelines on our residents.

The repeated extensions of the FEMA housing mission for Katrina/Rita caused incredible confusion and frustration for our families, and fostered a distrust of government aid programs. Similarly, the extension of Katrina Aid Today just three days before its sunset and the extension of DHAP-Katrina eight days before its deadline had much the same impact on many of our most vulnerable families in Louisiana. These last-minute decisions make it very difficult for the state to protect clients. We have seen thousands of families leave trailers and rental units in response to upcoming deadlines –many of them have turning to unsafe alternatives. Families have returned prematurely to damaged homes that remain dangerously uninhabitable or have moved into more affordable rental units that do not meet quality standards. And because case management programs for trailer and DHAP families have been directly tied to the housing programs, families lost eligibility for both when they moved from temporary housing units in advance of the original program deadlines. This has not only hampered our ability to accurately track the recovery process, but it has left families to fend for themselves without the opportunity to transfer safely to another program.

The impact of constantly changing program deadlines is also felt by providers who prepare to release valuable staff in anticipation of the deadline, only to discover the need to keep them on. This unpredictability has created a growing apprehension among non-profit organizations toward federal case management programs, which has impaired our ability to recruit high quality partners.

Program periods have been determined by federal agencies – often at the beginning of the recovery process and often in the absence of input from local partners. In every case to date, local stakeholders have known that these program periods were too aggressive and not reflective of the actual pace of recovery. The ultimate impact of this has been felt most by the people these programs have sought to serve.

Again, this was a critical factor in the decision of our DCMP partners to withdraw. After several months of requesting flexibility on the program timeline from FEMA, and repeatedly told that Post-Katrina Emergency Management Reform Act language prevented any timeline change, we were deeply disappointed to learn later that changes to the program period would be acceptable. This cost the state and our partners tremendous staff resources - and most unfortunately, it denied 15,000 families the chance to receive federal disaster case management services.

Coordination/Information Sharing

All of these concerns speak to the overarching challenge that the state of Louisiana has faced with federal disaster case management programs: the need for greater coordination. Federal disaster case management programs provide a critical tool to identify needs and track recovery outcomes. As these programs move forward, and certainly as they come to an end, the information gathered must be available to those state and local government agencies that will be assuming the responsibility for long-term recovery. The case management process creates the invaluable opportunity to translate the needs of residents to new or expanded local assistance programs, but this can only be achieved with proper coordination and information sharing.

The programs that do not directly engage agencies or individuals at the state level – such as Katrina Aid Today, DHAP, and now the HHS pilot – make it extremely difficult for local resources and programs to be properly designed and aligned to meet the ongoing needs of clients. The LRA has spent countless hours seeking information from federal partners on program and client status. Our experience with DHAP best depicts this challenge: after months of requests, we received the first count of Louisiana families in the program in July 2008. It then took 3 more months to receive aggregate DHAP data by parish – to give us an indication of where people were living. And not until 6 weeks before the program was scheduled to end, did we begin to receive details about the actual ongoing needs facing the 17,000 households still in the program.

Even when programs have actively engaged the state (such as DCMP and the DHAP extension), we have still struggled with collaboration. Again, DHAP provides a good example. Although HUD had separated the administrative functions of the case management and rental subsidy components, the need to share information across both was critical to ensuring that households received proper assistance. However, information on rental subsidy status and Housing Choice Voucher applications has not come easily or timely. And again, the impact has been felt most on the client level.

Requests by the state for information should not get stuck in agency headquarters, where legal teams debate privacy issues and the state's right to the data. Local governments must have access to this information to ensure their ability to meet ongoing client needs when federal disaster assistance programs end. We thank both HUD and FEMA for working with us towards

resolution on these issues, and we know that our progress has already had a positive impact. For example, the state has been able to increase funding and expand income eligibility criteria for a rental assistance program, in order to support vulnerable families exiting the DHAP program. And knowing that 80 percent of trailer residents were homeowners, we were also able to create a new pilot program to support non-profit housing rehabilitation organizations in order to get additional resources to homeowners still in trailers.

But we remind the members of the Subcommittee that coordination must occur not just in sharing data, but in working together. Locally, we have had tremendous success in these efforts, but we believe that collaboration must be institutionalized within the program design to ensure the process and success. In the absence of such a framework, however, we have still made great progress – particularly around the trailer deactivation policy. As the May trailer deadline approached, and the DCMP program had still not launched, the LRA and FEMA created an aggressive calendar of coordination meetings to ensure that no client face the risk of homelessness. This coordination continues today – with 8am meetings three days a week – and HUD now participates, as well. This level of teamwork has been instrumental in helping families transition safely out of the units, and we look forward to continuing this process for Gustav/Ike recovery efforts.

However, we do regret that federal programs have not yet established and implemented standards for closer coordination with local stakeholders. The HHS pilot program, which ends in March 2010, still operates at a distance from the state, despite regular attempts at partnership. In July, we did successfully work with HHS program staff to collect and provide information on client recovery needs to local parish governments – as funding for Gustav/Ike recovery programs will be driven on the parish, rather than state, level. These CDBG recovery programs for Gustav/Ike recovery will not be in place to meet those client needs by March - so again, we have begun the process of requesting program extensions.

There are, and there must be, more effective ways for government partners at all levels to share program and client information. We do thank FEMA and HUD for working with us over the past few years to make great improvements in coordination. We have seen tremendous progress, particularly under the new administration. We would also like to acknowledge the ongoing participation of all of our federal partners in our Disaster Housing Working Group and Disaster Case Management Subcommittee.

Recommendations

As discussed, the state recommends several policy changes that we believe would greatly enhance the recovery outcomes for clients in federal disaster case management programs:

- **Access to Funding:**
Reimbursement programs place a great hardship on small non-profit organizations that do not otherwise have access to upfront funding. We ask our federal partners to explore creative ways to release funding more quickly for disaster case management programs, including upfront advances and pre-approved grant applications.
- **Adequate Program Periods:**

Program timelines often fall short of meeting the needs of residents. We ask our federal partners to consult with local stakeholders when designing programs, and to establish a process for reviewing progress halfway through the program period so that any extensions required can be determined well in advance of the deadline.

- **Information Sharing:**
The process of requesting and receiving program/client data from federal partners must be streamlined. We recommend that at the time of a disaster declaration, the state or impacted locality be included as a partner in interagency agreements.
- **Formalized Coordination:**
Beyond data sharing, more consistent and formalized coordination among federal and local partners is essential to ensuring that appropriate programs and resources are available to clients. We ask our federal partners to formalize a structure and process for working together as part of future program guidelines.
- **Advanced Planning:**
We applaud and encourage opportunities like today's hearing and the National Response Framework Initiative to help shape program guidelines and policy recommendations for future disasters.

Closing

Thank you for the opportunity to discuss Louisiana's experiences with disaster case management programs. We appreciate your leadership on this issue and thank you for urging the ongoing commitment of our federal partners. I look forward to answering any questions you may have.

Testimony of Rev. Larry Snyder

Before U.S. Senate Committee on Homeland Security and Government Affairs, Disaster Recovery Subcommittee

Good morning, Chairwoman Landrieu and Ranking Member Graham and members of the Subcommittee on Disaster Recovery. My name is Rev. Larry Snyder and I am the President and CEO of Catholic Charities USA.

Thank you for the opportunity to appear on behalf of Catholic Charities USA to discuss the partnership between the federal government and Catholic Charities USA to provide disaster case management.

Who We Are

Every day across this country, thousands of people in our communities come to one of the local Catholic Charities agencies to seek assistance— 171 agencies with 1,668 affiliates in all 50 states and the U.S. territories. Catholic Charities agencies have a 280 year history of serving those most in need at critical and vulnerable times. Catholic Charities agencies have provided a wide range of services to families and individuals in need, including assistance with food, housing, financial education and family counseling. The provision of these services is grounded in the fundamentals of social work practice and is provided in accordance with sound ethics and our faith tradition. Case management services are critical to the effective provisions of the services provided in local Catholic Charities agencies and are fundamental from our perspective to successful outcomes for those we serve.

During times of regional or national crisis, Catholic Charities USA has helped local agencies coordinate the dissemination of information, resources, as well as expertise from other agencies around the country. Our recent experiences with Hurricanes Katrina and Rita have reinforced the fundamental mission of Catholic Charities of delivering services to the poor and marginalized in recent years. We realize that low-income communities are particularly vulnerable after a disaster occurs. Catholic Charities agencies are uniquely qualified to serve these communities because of their long history of working with individuals, families and civic leaders in those communities.

Our History with Disaster Management

For more than forty years, Catholic Charities agencies have responded to disasters in this country. In the 1980s the United States Bishops recognized the need for a more formalized structure to the American Catholic Church's response in the aftermath of Hurricane Hugo and created an agreement with Catholic Charities USA to serve as the lead Catholic agency in responding to domestic disasters.

Catholic Charities USA (CCUSA) has been on the cutting edge of disaster case management starting with our development of the first Disaster Response Guide for use by local Catholic Charities agencies in 1996. In addition, Catholic Charities USA as a national sponsor of the Council on Accreditation (COA), an accreditation body for human services providers, urged COA to create national Disaster Case Management standards. CCUSA assisted in the development of these standards which are being used as a benchmark against which disaster case management efforts are measured. You will find a copy of these standards as an addendum to my testimony. CCUSA launched a large scale response to the September 11th terrorist attacks when it provided disaster case management in 12 states and the District of Columbia. This experience and

leadership uniquely positioned Catholic Charities USA for its leadership role in responding to Hurricanes Katrina and Rita and more recently to Hurricanes Gustav and Ike.

Central to Catholic Charities USA's disaster response and case management services is a reliance on a "local response to local needs", working in partnership with local Catholic Charities agencies and providing resources to support them in local delivery of services. Catholic Charities USA is uniquely positioned to provide disaster services from the ground up, supporting local agencies in communities that are particularly familiar with local needs and trusted by the people they serve. Local Catholic Charities agencies are effective and reliable community collaborators and are familiar with the diversity of their communities and have the resources to reach out to and serve special populations in their communities. This approach to disaster response and disaster case management is extremely effective. CCUSA has been an effective community partner before the emergency and will remain a vital community partner long after the emergency is officially over.

Katrina, Rita, Gustav, and Ike

CCUSA was a partner in the first national disaster case management consortium coordinated by the United Methodist Committee on Relief (UMCOR) and known as Katrina Aid Today. CCUSA and its member agencies handled the most cases under this consortium providing services to over 17,000 households in thirteen states, organizing the efforts of over 100 paid disaster case managers and more than 90 volunteers employed by 23 local Catholic Charities agencies, including Catholic Charities of Arkansas, Diocese of Little Rock; Catholic Charities Bureau, Jacksonville Regional Office, Diocese of St. Augustine, FL; Catholic Charities of the Archdiocese of Chicago; Catholic Community Services of Baton Rouge; Catholic Social Services, Diocese of Houma-Thibodaux; Catholic Social Services, Diocese of Lafayette; Catholic Social Services, Diocese of Lake Charles; Catholic Charities, Archdiocese of New Orleans; and Catholic Charities of St. Louis- Archdiocese of St. Louis

In 2008, CCUSA provided on-the-ground support to 16 agencies responding to local disasters and over 70 disaster response grants totaling more than \$10 million. Additionally, the Federal Emergency Management Agency provided \$9.8 million to support disaster relief programs managed by Catholic Charities agencies. According Catholic Charities USA's 2008 Annual Survey, Catholic Charities agencies provided disaster related services to 331,727 consumers.

The scale and level of need generated by Hurricane Katrina changed the relationship between Catholic Charities USA and the Federal government in the provision of case management services. Our first federally funded disaster case management partnership was Katrina Aid Today. This partnership recognized the importance of non-profits in deployment of disaster case management. It reinforced the important strategies in national or regional emergency case management response. Among them, local and national partnerships are critical; diversity of organizations and expertise is key; and sharing of resources, information and coordination of services are paramount. It also recognized that:

- Local agency presence, trust within the community, local infrastructure/capacity and knowledge are important in rapid response.

- National capacity to deploy expertise, to create partnerships, and to serve as an intermediary between government and local partners will speed delivery of service.

During hurricane season 2008, Catholic Charities USA with HHS/ACF and Abt Associates (subcontractor to ACF) participated as part of a disaster case management pilot. Initially, our work was to take place in Florida as a tabletop exercise with Catholic Charities USA pulling together key partners. When Gustav hit, implementation was moved to Louisiana and partnerships of Catholic Charities USA proved critical to the program's quick start up. Following a two week pilot by Abt and Associates, pilot continuation was transferred to Catholic Charities USA, which continued through July 2009. The multi-year indefinite duration, indefinite quantity (IDIQ) contract extends the pilot services to March 2010 and positions Catholic Charities USA for future case management deployments. While the approved contract included other task orders focused on preparedness and future deployments, Catholic Charities received funding only for the continuation of the Gustav/Ike work.

As of October 2009, Catholic Charities USA and its local partners have employed 14 subcontractors operating between Lake Charles to New Orleans, LA. To date, our efforts in the region have served 21,102 people and 7,526 cases:

- 33% of cases have a disability
- 22% are elderly
- 57% report an income less than \$15,000
- 76% are female headed households

The partnership has employed 145 staff who operate from 26 service delivery sites. The staff has provided case management services through more than 10,812 home visits. Through our case management partners, it has been reported that households have been connected to over \$1.7 million in services. At the national level, Catholic Charities USA has provided technical assistance, training, contract oversight, content expertise, partnership coordination and government relations.

Based on our experience, case management is a comprehensive process involving a skilled case manager working with an individual or family to identify and overcome barriers to "recovery" through the assessment and recovery planning processes. The case manager works within the context of the "big picture" and helps the client identify the action steps needed to achieve the long term case management goal(s) set forth on the recovery plan. A case manager assesses plans, advocates, links, and monitors.

The goal of disaster case management services must be to meet the needs of a large client influx in the aftermath of emergencies and major incidents. These services are inevitably provided under difficult conditions including infrastructure losses, operation disruptions, special communication needs, and record keeping and coordination challenges. Effective disaster case management requires assessing survivors' needs first. Processing applications for their identified needs in consolidated

'one-stop centers' minimizes efforts, avoids duplications, allows streamlined intake and case management strategies, and fosters interagency human service administration in a disaster area. CCUSA plans, secures, coordinates, monitors, and advocates for unified goals and services with organizations and personnel in partnership with individuals and families in the aftermath of a disaster.

Catholic Charities USA bases its Disaster Case Management Program¹¹ on the principles of self-determination, self-sufficiency, flexibility and speed, and support to states. When the societal fabric is damaged by a disaster, individuals and families need disaster case management services to effectively provide resources and support that build on their strengths and meet their recovery needs.

CCUSA gives attention to developing collegial working relationships/partnerships with Federal, state, and local stakeholders as quickly as possible. Staff is trained to coordinate their work with these partners to comply with all relevant local, state and Federal requirements; to minimize duplication of effort; and to prevent those in need from falling through the cracks. These partnerships allow CCUSA to provide local agencies with support and financial aid if available for disaster case management services consistent with the disaster case management contract.

In CCUSA disaster case management experiences, we have learned both the strengths and weaknesses in delivering services to those living on the margins before the disasters, and whose recovery will be much more complex and long term because of lack of accessible resources. CCUSA engaged the University Texas at Austin to survey¹² case managers working in the Katrina Aid Today disaster case management response. The focus of this survey was to learn the challenges and successes, the assets and weaknesses from the perspective of those who provided the service on- the- ground. Over and over, these case managers reported their frustration with the lack of available resources; access to benefits; inconsistent information from various federal departments. We also learned of the frustration that they experienced in building capacity and expertise while in the midst of a major disaster: complications of getting needed equipment, communication devices, training resources, and policies and procedures.

As you know, the need for disaster case management as a resource and tool was identified and became part of the recommendations in improvements to the Stafford Act. While making the resources available during a disaster, funding is currently only available during a declaration leading to the same challenges faced in Katrina Aid Today.

CCUSA responded to a request for solicitation to continue the remainder of the Gustav pilot and to implement a national disaster case management team which would provide the necessary infrastructure for future deployments of disaster case management. Since this contract is what is known as an IDIQ— indefinite duration, indefinite quantity—the awards are made by task order. The current contract requires services to end on March 31, 2010. No funding to support the

national team has been made available and currently the government has modified its task order indicating that CCUSA is not expected to meet the deployment requirements of 72 hours since the necessary resources to provide the infrastructure for the national team are not funded. While CCUSA has entered into a five year contract with the government to provide the establishment of a national disaster case management program, there will be no further services provided unless the government identifies resources and makes them available via a new task order to CCUSA.

Policy Recommendations

Both the GAO report, *Disaster Assistance: Greater Coordination and an Evaluation of Programs' Outcomes Could Improve Disaster Case Management* (GAO-09-561)⁶, July, 2009, and the National Commission on Children and Disaster Interim Report of October 14, 2010⁷ (pertinent parts attached as addendum C) recommend that there must be disaster preparedness funding provided for both infrastructure and capacity building to support the disaster case management program in advance and to ensure rapid deployment of trained disaster case managers to disaster areas along with the necessary equipment that is prepositioned. The government has recognized the need to build such capacity and infrastructure with its solicitation for bids for these services. However, no funding to perform this work has been made available.

CCUSA stands ready to implement the work it has agreed to perform and that was supported by a partnership with United Way of America's 211 system and support of its national disaster response partners including National Voluntary Organizations Active in Disasters (NVOAD) Lutheran Disaster Service, and Volunteers of America.

In all other aspects of disaster response, the need to be prepared is recognized and funded. Disaster Case management as an effective and identified tool now made available under the Stafford Act should receive the support and funding necessary to fully prepare a national structure for deployment and rapid response. It is important to note that disaster case management is absolutely essential to ensuring that unlike those who were left behind in the wake of Katrina, no one will be left behind again. A well funded and fully prepared national disaster case management program addresses this by recognizing that individuals need the services of a disaster case manager as quickly as possible after a disaster occurs to stabilize them quickly and work towards their recovery. This model is a recognized model within human services and in particular within HHS/ACF, where for decades case management services have been recognized as essential in ensuring that families who experience crisis receive the services of a trained case manager who is familiar with resources and who can work with the family to devise a plan that meets each family's unique needs. So too is this model effective in quickly intervening and supporting individuals and families in developing plans, identifying resources, and supporting individuals in their recovery after the disaster is over.

Recommendations to Improve Disaster Case Management

1. Fund a single national disaster case management program including infrastructure and readiness for rapid response.
2. Establish a lead federal agency that will have oversight and accountability for ensuring that agreed upon outcomes are established and met.
3. Establish a consistent definition of disaster case management and policies and procedures to be adopted by both federal and non-federal organizations.
4. Identify and implement one database for the collection of information that meets the needs of both federal and non-federal partners with consistency in meeting privacy requirements.
5. Involve key stakeholders in all aspects of the national disaster case management program.

ⁱ Catholic Charities USA (CCUSA) and the Administration for Children and Families (ACF) in partnership with the following agencies continue to provide to provide disaster case management services for victims of Gulf Coast hurricanes: Advocacy Center, Catholic Charities Baton Rouge (CCBR), Catholic Charities Lake Charles (CCLC), Catholic Charities New Orleans (CCANO), Family and Youth Counseling Agency, ICNA Relief (ICNA), New Beginning Community Outreach (New Beginning), Operation Hope, Society Saint Vincent De Paul Baton Rouge (SVDPBR), Terrebonne Readiness and Assistance Coalition (TRAC), Volunteers of America Greater New Orleans (VOAGNO), Bayou Teche Community Health Network (ByNet), Louisiana Methodist Disaster Recovery Ministry (LDRM), and Volunteers of America Greater Baton Rouge (VOAGBR).

ⁱⁱ Catholic Charities USA. *Proposal for Disaster Case Management*. Submitted in response to HHSP2332009RFP0006 to US Department of Health and Human Services. 24 March 2009.

ⁱⁱⁱ Laura Lein, Holly Bell, Julie Beausoleil, Jennifer Karas Montez, and Elisa Vinson Borah. MID-TERM EVALUATION: KATRINA AID TODAY CASE MANAGEMENT PROGRAM, Final Report. Center for Social Work Research, The University of Texas at Austin. July 2007.

^{iv} United States Government and Accountability Office. *Disaster Assistance: Greater Coordination and an Evaluation of Programs' Outcomes Could Improve Disaster Case Management (GAO-09-561)*. July 2009.

^v National Commission on Children in Disasters. *Interim Report*. 14 Oct. 2009. Page 31-32.

Testimony of
Diana Rothe-Smith
Executive Director
National Voluntary Organizations Active in Disaster
Hearing: Disaster Case Management: Developing a Comprehensive National Program Focused
on Outcomes
December 2, 2009 2:30 PM
Room 342 Dirksen Senate Office Building
United States Senate Committee on Homeland Security and Governmental Affairs
Ad Hoc Subcommittee on Disaster Recovery

Madam Chairman and Members of the Committee:

Thank you for the opportunity to speak with you today about Disaster Case Management and the role of voluntary agencies.

My name is Diana Rothe-Smith and I am the executive director with National Voluntary Organizations Active in Disaster. National VOAD, as we are more commonly known, is made up of the 49 largest disaster focused nonprofit organizations in the country. From the American Red Cross to Catholic Charities and United Jewish Communities—from the Salvation Army to Feeding America and Habitat for Humanity—our member organizations are the driving force behind disaster of disaster response, relief and recovery in this country. There are 49 national nonprofit members, 55 State and Territory VOADs and hundreds of local and community VOADs throughout the United States.

Historically, voluntary agencies have partnered with survivors through their recovery, and have done so successfully without standardization. In recent years, however, catastrophic disasters, funding for case management, and emerging organizations providing long term recovery services have necessitated us to look anew at how we define and implement disaster case management. Recognizing that Disaster Case Management is most effective when implemented by local partners as part of a coordinated effort for community recovery, the Disaster Case Management Committee offers these Standards as guidance to support Disaster Case Management delivery systems locally. These Standards are not intended to replace organizational policies, but may be useful in policy development.

I want to tell you today about disaster case managers. Disaster case managers are the reason why recovery happens in this country. If my family and I have been through a natural disaster, I sit down with a case manager and she becomes my companion on the road to recovery. You see, before we even meet, my case manager spends her time learning the ins and outs of every resource available to people in my area. And because they are normally hired from within the community itself, disaster case managers can do so by drawing on their own existing networks and contacts. This way, when I sit down and tell my case manager about what it will take for our family to be recovered, the wheels start turning about what resources and systems I might be eligible to receive. Those resources may include support for immediate basic needs as well as construction materials. But more importantly, the case manager can link me with community services and volunteer labor, and can help me navigate through the maze of governmental

programs. Even in the midst of my confusion and hardship, trying to put my life back together, my case manager is my resource maven, helping me to plan for filling in the missing pieces of my recovery. **The disaster case manager is the most important resource for many survivors!**

When Hurricanes Katrina and Rita happened, several members of National VOAD, participated in a first-of-its-kind case management program. Katrina Aid Today put case managers in jobs not only along the Gulf Coast but around the country, in all of the places where evacuees had been re-settled. This program was initially funded by international donations through FEMA which were then matched with additional nonprofit contributions.. Katrina Aid Today was the most comprehensive, collaborative national disaster case management program in the history of the United States. Katrina Aid Today disaster case managers were hired by voluntary organizations not only along the Gulf Coast but around the country - in nearly all of the places where evacuees had been dispersed. Because of its long history providing disaster case management, the United Methodist Committee on Relief (UMCOR) was chosen as the lead agency for nine partnering faith-based and voluntary organizations.

Let me tell you about one partner in particular. Lutheran Disaster Response was given \$7 million as one of the consortium members, and per the various agreements, it matched that with \$7 million of their own donor contributions. Then, the case managers hired with those dollars found over \$29 million worth of resources for their clients. You see, Lutheran Disaster Response could have said, "Ok, we have \$14 million and 11,000 clients... let's divide it up evenly and cut everyone a check." Instead, they found valuable ways to help their clients recover, and more than doubled their resources in the process. That's what I call a return on investment, and that's the magic of disaster case management. It is important to highlight that the only tax dollars used were for linking survivors and families to FEMA grants, but the real value added is almost immeasurable. As part of this testimony, I submit the Katrina Aid Today Final Report.

Unfortunately, in the time since Katrina, our country has entered into a new reality. Non-profit groups are hurting as a down economy means a dip in contributions. An increase in recent disasters also means less resources to go around. 2008 was one of the most active disaster years on record. This means that the resources that were once available for clients have decreased, or even dried up all together. And because we know that disasters disproportionately impact communities that were already hurting, we are working in communities that were not well-resourced to begin with. For this reason, survivors of Hurricane Ike, or the vast flooding in the Midwest this past year, did not see the type of return on investment that was seen from Katrina Aid Today. These communities and the nonprofit partners that comprised the local long term recovery groups are making incredible strides to meet the needs of their clients, despite these increasing hurdles. However many of them lack the public/private partnership that made Katrina Aid Today such an overwhelming success.

Let me give you an example: In a recent meeting of the National VOAD Board of Directors, FEMA Administrator Craig Fugate talked about putting blue tarps on the roofs of homes impacted by hurricanes in Florida. When there were several thousand homes to be tarped, it made the most sense to work through the U.S. Army Corps of Engineers, who can leverage dollars for major contracts and do the work professionally and efficiently. However, when there were several hundred homes, Administrator Fugate said that he relied then on the voluntary

agencies, whose volunteers could tarp all of the roofs in the time it would take the Army Corps to put out a call for contract bids, with the same professionalism and dedication—and all for only the cost of the tarps themselves.

And this is part of the issue. While case managers are the backbone of recovery, case management only works if there are supplies and resources to fulfill the needs of the clients. And there is only so much government systems can do to fill these resources. Much of the work is filled by the voluntary agencies and the volunteer labor and donated dollars they bring with them. Again we find the public/ private partnership invaluable.

This past spring, the Yukon River flooded in Alaska. A combination of freezing flood waters and huge ice bolders wiped out several dozen villages along its banks. The conditions for recovery were extreme—with barge or plane the only mode of transport for all but one of the communities, and a window of 10 weeks for all repairs and rebuilds to be completed before the winter settled in. Through an extremely unique and collaborative partnership between local community members, Alaska based long term recovery groups and faith based organizations, national voluntary agencies, the State of Alaska and FEMA, the survivors were able to be in their new or repaired homes by the middle of September. The financial picture is clear—with FEMA providing travel for the volunteers and transport for the supplies as well as many of the supplies themselves, and the national voluntary agencies providing labor, housing, and additional financial resources. Even more, these families were able to stay in their local communities. They did not need to be housed hundreds of miles away in Fairbanks for several months. They could continue to maintain their local customs and economy.

My point is this -- the instinct to create further levels of bureaucracy is rarely appropriate given the power of voluntary agencies to complete the work faster, cheaper, and with a keener sense of the community's underlying needs. The more resources that find their way to these organizations, and without having to pass several layers of red tape, the more real work can happen for the people who need it.

Key Points:

Voluntary organizations have provided disaster case management in declared and undeclared disaster for years.

Voluntary organizations pool their services as well as their financial, material, and human resources to synergize the recovery of the individuals and families within a community.

These resources include **volunteers** who provide labor for construction, case management, volunteer coordination, and others.

Katrina Aid Today demonstrated the capacity of voluntary organizations to work collaboratively in a public/private partnership to implement a model national disaster case management program following a catastrophic disaster.

Social services, mental health, public health, children's services, employment and re-training programs, financial planning services – all of these on-going services or other community-specific resources could be resourced by federal funding following catastrophic disasters.

These services are different than DCM. Disaster Case Management is distinct from social services.

- DCM utilizes referrals to these community services so focus can continually be on the unique disaster recovery needs of survivors.
- DCM is not an entitlement program. Survivors may or may not choose to participate.
- DCM is holistic in nature
- DCM is time-limited
- DCM is client focused (not program-focused). A Disaster Case Manager is a person-to-person helper and advocate



Protecting Children and Families After Disasters: The Critical Role of Effective Case Management

**Testimony before the
Ad Hoc Subcommittee on Disaster Recovery
Committee on Homeland Security and Governmental Affairs
United States Senate
*Disaster Case Management:
Developing a Comprehensive National Program Focused on Outcomes*
December 2, 2009
Honorable Mary Landrieu, Chair
Honorable Lindsey Graham, Ranking Member**

Irwin Redlener, MD
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Director, National Center for Disaster Preparedness
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J. Redlener, MD
Subcommittee on Recovery
December 2, 2009

Thank you, Chairwoman Landrieu, Ranking Member Graham and other Senators of the Subcommittee on Disaster Recovery for convening this important hearing. I very much appreciate the opportunity to speak with you about some of the unmet challenges of effective disaster case management and its important role in safe-guarding the lives and well-being of children in communities recovering from large-scale disasters.

I am here today wearing three hats: president of the Children's Health Fund (CHF), director of the National Center for Disaster Preparedness (NCDP) at Columbia University's Mailman School of Public Health; and as a member of the National Commission on Children and Disasters (National Commission) where I chair the Subcommittee on Human Services Recovery. Each of these entities –CHF, NCDP, and the National Commission –has come to appreciate the fact that effective disaster case management is essential to ensure that children and families are protected from secondary, long-term trauma in the weeks, months and sometimes years following a major catastrophe.

In the years since Hurricanes Katrina and Rita devastated the Gulf coastal region, we have learned – and are still learning – that many already at-risk children may have survived the initial trauma of a major disaster, only to find themselves – four years hence - still living with uncertainty, chaos and isolation from essential services. At the least, we must learn from this unfortunate situation and make sure that future recovery efforts are not plagued by similar levels of bureaucratic confusion and turf battles further complicated by a persistent inability to share critical information among relevant agencies.

In the meantime, it is important to appreciate the fact that the additional trauma directly related to this mismanaged, dysfunctional recovery will have significant and long-lasting consequences for thousands of highly vulnerable children.

So, what happened?

In the first phase of this botched recovery, thousands of families needed help that never came. They needed obvious sustaining services that fall under the general rubric of "disaster case management". But we are now in a new phase of recovery, where much more than access to basic services is needed. Now we face far more difficult challenges of restoring stability and structure - and providing emotional and academic remediation when much of the damage has already been done.

We knew this was coming, and it is my hope that these hearings will set the stage for changes in our ability to help families after disasters so that we won't have more families paying a price that Katrina's children face now and in the future. In my best estimation, some 15,000 children in the Gulf are in families still enrolled in case management, but many more – perhaps another 10,000 to 20,000 - are no longer in formal programs but still need significant assistance. They are still not living in stable housing with appropriate access to essential services.

J. Redlener, MD
Subcommittee on Recovery
December 2, 2009

As Senator Landrieu is aware, on October 7, 2009, CHF hosted a roundtable on disaster case management at Louisiana State University. The Roundtable generated a report called *Reforming Disaster Case Management: National Lessons from Louisiana* that was released just yesterday. The recommendations from this report were endorsed by numerous organizations including the National Commission and many of the disaster case management provider organizations that served the people of Louisiana after Hurricanes Katrina, Rita, Gustav, and Ike. That report is submitted today for the Subcommittee's review and for inclusion in the record.

The Roundtable

The Roundtable brought together key policy makers around disaster case management including the Federal Emergency Management Agency (FEMA), the U.S. Department of Housing and Urban Development (HUD), the U.S. Department of Health and Human Services (HHS), and the Louisiana Recovery Authority (LRA), with providers and advocates for disaster case management services including the Louisiana Family Recovery Corps (LFRC), Catholic Charities, Greater New Orleans Disaster Recovery Partnership, Lutheran Social Services Disaster Response, Community Initiatives Foundation, United Methodists Committee on Relief, the United Way, the Women's Hospital, Save the Children, and the Children's Health Projects in New Orleans and Baton Rouge. Other interested parties from academia, the private sector, and foundations also attended as did representation from the National Commission. An official from the Government Accountability Agency (GAO) served as a moderator and provided an introductory presentation on their essential report on disaster case management. Louisiana's Lieutenant Governor, Mitch Landrieu, provided keynote remarks.

The goals of the Roundtable were to assess current and past disaster case management efforts in Louisiana and develop unified policy recommendations that all provider and advocacy organizations can support. The topics discussed included the nature of case management services, funding, and how government should administer disaster case management programs. The Roundtable's format offered all attendees an opportunity to speak in a closed door, media-free, not-for-attribution environment.

The report that came from the Roundtable was prepared by CHF and summarized the issues and recommendations from the Roundtable. The report leverages the roundtable's proceedings including prepared remarks by myself, the GAO, Louisiana Lieutenant Governor Mitch Landrieu, and builds on reports and recommendations on disaster case management from the GAO, Columbia University's National Center for Disaster Preparedness (NCDP), Children's Health Fund and the National Commission on Children and Disasters (NCCD). All provider and advocate organizations at the Roundtable were given an opportunity to read and comment on the report and then after the report was finalized, had the option to sign-on in support of the recommendations.

Where We Are

Although the Post Katrina Emergency Management Reform Act established a federal responsibility for disaster case management services it is abundantly clear that much remains to be done to strengthen the federal disaster case management structure and functionality. To that end, a one-year interagency agreement involving FEMA, HHS, and HUD to better provide

I. Redlener, MD
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disaster case management services is an important next step and is expected to be –and should be –executed without delay. This agreement has been substantially informed by the lessons learned in - and ongoing needs of - communities in the Gulf impacted by major storms since 2005.

Clearly, with the National Recovery Framework and Stafford Act reform on the immediate horizon, the actual experiences of the Gulf states, federal agencies and providers should also be considered and conceptually integrated into all proposed changes. The idea is straightforward: use the experiences of the last four years to be certain that proposed legislative modifications and the new operational guidelines provide assurances that recovery from future disasters is far more effective and responsive to the critical needs of all survivors.

Many at the Roundtable believe that going forward, when FEMA reviews disaster case management best practices and/or leads interagency agreements needed after the forthcoming one-year agreement between FEMA, HHS, and HUD lapses, that an expert consensus process be utilized, bypassing the costly and lengthy contractor led evaluations. In my opinion, there is room for considerable attention to local conditions and situational needs with respect to the implementation of human services programs, but there most certainly must be consensus-driven definition of what we actually mean by "disaster case management" and its goal of a rapid return to stability and structure for affected families.

Recommendations on Disaster Case Management Reform

The Roundtable coalesced around three primary recommendations for the Subcommittee's consideration in drafting any new relevant legislation. And I have added a fourth consideration based on my own experiences working in the Gulf since a few days following Hurricane Katrina.

1. **A single lead federal agency with experience and expertise in complex case management should be designated to coordinate and direct the implementation of all disaster case management programs.**
2. **A single federal model for case management should be established that is clearly defined, comprehensive, responsive to local conditions, accountable and, of course, fully – and appropriately - funded.**
3. **Mechanisms to ensure rapid, sufficient and efficient sharing of client information among relevant governmental agencies and provider organizations must be developed. And this may well require contingency-based modifications of the Privacy Act.**

...and while this next recommendation is not part of the formal Roundtable consensus, it is based on a critical insight with respect to disaster vulnerability and the challenges associated with recovery. The fact is that populations with significant pre-disaster adversity, including poverty and chronic inadequacies in health care and education consistently fare the worst in all phases of disasters as compared to less disadvantaged populations.

4. **Therefore it is important that a long-term commitment to alleviating social and economic disparities be a central mission of long-term disaster mitigation and recovery planning.**

I want to express my gratitude to Senator Landrieu and the Subcommittee for calling this hearing and for helping to keep our focus on some of the most critical challenges facing our nation. And finally, I suggest that as we deliberate on strategies to improve recovery effectiveness in the aftermath of future disasters, that we not forget the on-going and overwhelming challenges being faced by the children and families still affected by the storms of 2005.

Thank you.

**Prepared Statement of
Stephen P. Carr
Program Director
Mississippi Case Management Consortium**

This written testimony is respectfully submitted on behalf of the men and women who have worked tirelessly with disaster impacted individuals and families within the State of Mississippi. As the director of the Mississippi Case Management Consortium (MCMC), it is my intent to relay information to you that is helpful to further your understanding and aid in your investigation of not only this particular important human service project, but the other disaster case management pilot programs that have been undertaken by FEMA, HHS, and HUD, as well.

Just over four years ago, the term "case management" was understood by those who held a specialized occupation within the overall "helping" profession. Case managers have historically worked in medical, clinical counseling and public social service settings, and have not experienced a "high visibility" status. Now, in the aftermath of Katrina, the even more specialized field of "disaster case management" is being examined, discussed, and transformed in a way that underscores its importance in the overall recovery efforts of individuals, families, and State and Federal governments in the wake of a disaster. It is now apparent that disaster case management is necessary following a disaster, not only to ensure that individuals are treated humanely and fairly but also to ensure that valuable resources, such as monetary resources used for rebuilding purposes, are targeted and accessible by those who are the most vulnerable. Through the use of a systematic disaster case management program, we have the opportunity to speed up and reduce the overall cost of recovery with the use of standardized tools which assist the client and case manager in indentifying individual needs and available resources in a timely and organized manner. Without a systematic disaster case management program in place however, limited and valuable resources provided by the Federal and State governments will be less impactful and, in many cases, depleted before ever reaching their intended beneficiary, the disaster victim. It is our belief that the Mississippi Case Management Consortium approach is the most logical and impactful disaster case management pilot (DCM-P) model demonstrated to date; and yet as the program director, I know that there are key processes which need to be addressed, both internally and externally, in order for this project, or any other project of its type, to achieve the level of success for which they are intended.

In order to convey information in a structured way, I offer the following SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis from the perspective I have gained while working "on the ground."

While the following information is extensive, it certainly is not intended to be an exhaustive list of the strengths, weaknesses, opportunities, and threats. Attached to this written record, you will find examples of MCMC reporting efforts in the form of our most recent Quarterly report submission, November monthly report, an example of one of our “benchmark compliance reports,” and our original closure/transfer plan. It should be noted that, as we have been able to continue our work beyond our original period of service, we are working to finalize a closure/transfer plan which will be submitted to FEMA in January as we begin to close out the project. Finally, embedded within this testimony are some general progression charts that highlight our work with clients.

Strengths – Elements of the MCMC project that have facilitated success

1. Selecting the correct state agency to administer the project
 - a. Our greatest strength lies in the fact that funding was provided via FEMA through a state agency that had an ongoing and lasting relationship with the private non-profit sector which, according to the program guidance produced by FEMA, would be the entities asked to carry out the provision of disaster case management services. The Mississippi Commission for Volunteer Service (MCVS) is the state agency that was selected by the Governor’s office to take on this body of work, and it is this agency that was in the best position to reach out to the organizations who would eventually become affiliates of MCMC. Choosing the wrong state agency for this type of work can be detrimental to the success of such programs, due to the layers of bureaucracy and the lack of institutional knowledge that must exist concerning the faith based and non-profit providers it will be asked to partner with for the purpose of serving clients. The fact that MCVS is a member of the State of Mississippi’s Emergency response plan and an ad hoc member of the State Voluntary Agencies Active in Disaster (VOAD) group allows the leadership of the MCMC project to have access to Federal, State, and Local government officials who are often key decision makers when it comes to the distribution of disaster related resources. Without this ability to coordinate our efforts at the local affiliate, state and federal levels, the leadership team of MCMC would have struggled even more in our efforts to implement this critical project. In spite of the many obstacles that we have experienced, we are confident that our efforts have made a difference in the lives of the clients we were charged

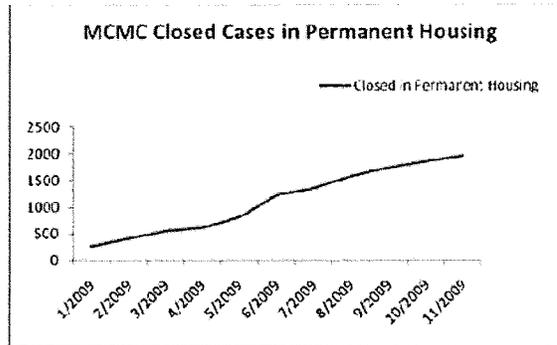
with serving, as well as the process that has been undertaken to examine the importance of disaster case management and how it is to be implemented in the future.

2. Using a “SMART” “APALM” Design

- a. *Affiliate Level*: The MCMC project was designed in a way that ensures consistency among the providers of disaster case management services. In order to achieve consistency, we focus on the acronym “SMART,” which is a reference to setting goals for the project that are Specific, Measurable, Achievable, Realistic, and Time limited. We use this approach in the recovery planning aspect of case management with clients, as well as in our overall project management. For instance, a set of policies and procedures, driven by observed best practices in the disaster case management field, were written and distributed to each of the affiliate organizations within the consortium. Tools that disaster case managers use each day with clients, including intake, assessment, recovery plan, and case note forms, were all developed for the purpose of creating consistency and uniformity among the service providers. MCMC developed a standardized budget template which included staff position ratios related to the number of case managers within each affiliate, to ensure grant compliance with both State and Federal guidelines based on program guidance issued by FEMA. This “program guidance” was developed based on lessons learned from previous disaster case management projects including the UMCOR-Katrina Aid Today (KAT) National Case Management Consortium, of which I was a staff member at the leadership level. For example, the caseload ratios for MCMC were set at 1:25, based on lessons learned from KAT, to ensure that disaster case managers were able to effectively address the overwhelmingly complicated issues related to recovery as opposed to working under an impossible caseload of several hundred active cases. This is an important marker for success in these types of projects, as there are countless examples of human service endeavors which are often mired by overworked and “burned out” staff. Based on MCMC coordination efforts with HUD and the local public housing authorities, for instance, we know that many of their personnel at the local level work with caseloads that are in excess of 100 clients each. Having worked in a public social service setting where my own caseload was well over 300 clients, I can attest to the fact that it is nearly impossible to create momentum and make real progress with clients when you are only able to visit with them every 6 to 8 weeks, or

only able to communicate by phone or in the office. The MCMC leadership, taking the complexity of the issues facing clients into account, designed a project that recognized the importance of the case manager and built administrative and support positions into the program whose sole purpose was to support the case managers' work with clients. This is an example of working from the bottom up, as opposed to focusing on the administrative aspects of the project

and leaving case managers and clients without the ability to succeed. In order to give case managers the best opportunity to succeed in their efforts with clients, MCMC continually refers to yet another acronym, "APALM," when



training and discussing the functions of a disaster case manager. You will find in your investigation of the FEMA, HHS, and HUD models that there are many different definitions of "disaster case management." From our perspective, the disaster case manager is first and foremost a problem solver. To that end, our project uses a very simple problem solving approach that I learned from my work as a case manager within a community mental health center. The acronym "APALM" is the foundation on which all of our other processes are built. Assessment, Planning, Advocacy, Linking, and Monitoring are the five primary functions of our disaster case managers, and every task that they undertake on behalf of a client on their caseload must fit into one of these five categories or functions. As you can see from the chart, MCMC has been able to document the successful completion of all the cases assigned to it by FEMA. The consortium is confident that the families who have been transitioned into permanent housing were able to do so through the use of the SMART APALM model.

- b. *Leadership Level:* MCMC also uses this approach at the leadership and field management levels in order to stay focused on our own project management work. We continually assess the environment on the ground in which we work; we plan according to the assessment that we have made of the situation(s) that we observe; we advocate for resources necessary to meet the needs of the plan we have developed; we link each other and our affiliates/clients to resources that are available to meet the needs of the developed plan; and we monitor the progress being made to achieve the goals of the developed plan. This is a continual circular process that re-assesses according to progress, or lack thereof, in accomplishing the goals of the plan. I share this information to illustrate that a systematic approach to disaster case management is essential when working with agencies at all levels of the governmental and private sectors.

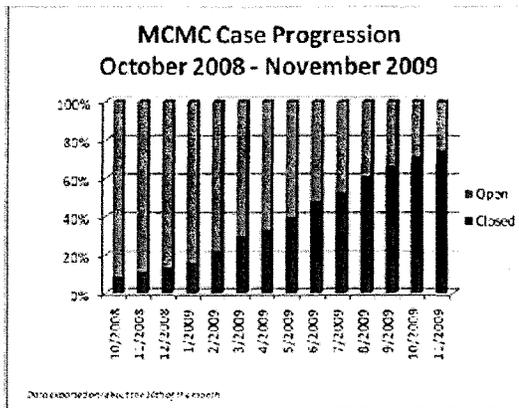
3. Consortium

- a. Another design aspect of MCMC that is a source of strength for our efforts is the use of a consortium-based model. This approach was strategically adopted in order to overcome the “silo” work that so often occurs in the field of social services and has a tendency to creep into the field of disaster recovery as well. By working together toward a common purpose, affiliates are able to openly communicate for the benefit of the client, as opposed to competing against each other for scarce resources and losing focus of client recovery needs. Leadership is provided at the state level in order to maintain an atmosphere of cooperation among affiliate organizations and to prevent unnecessary duplication of effort. Affiliates have continually expressed their willingness to participate in, and appreciation of, the partnership that exists as a result of everyone being “on the same page.” One example that highlights the benefits of a consortium model when there are scarce recovery resources is the obtainment of a grant from the Mississippi Association of Realtors by one of the MCMC Affiliates. This grant was for the provision of providing rental and utility deposits to households that had located a permanent housing situation, but that did not have the bulk funds available for deposits required prior to moving in the residence. The Affiliate immediately opened the grant up to all MCMC Affiliates rather than using the funding for their clients exclusively. As a result, over \$100,000 was provided to MCMC clients, regardless of affiliation, to move into sustainable housing situations.

4. Sound Financial System

- a. The MCMC program has been financially successful by training affiliates, monitoring their financial functioning, and evaluating the financial requirements and federal guidelines required of non-profit organizations and state operations. The MCMC financial team has worked diligently with the non-profits to teach them how to set up and maintain systems required of the program so that operations are conducted in a transparent and fiscally responsible manner. Each affiliate has been able, under the direction of the MCMC project, to build financial and programmatic capacity and stand up to invasive and thorough auditing processes without fear of non-compliance or non-understanding of laws and regulations.

The MCMC project monitors every dollar allocated to the affiliate agencies and has been successful in using the original allocation of funds, intended for a 9-month period, to operate for a 16-month period. Although part of this was as a result of the reduced number of clients expected and approved to be served under MCMC, the dedication and skill set of the MCMC team has



proven critical to the success of an efficient and effective system of operation. Despite the ongoing challenges of awards and contract modifications, MCMC has continued to show steady progress since its inception in June 2008. From the chart you can see that, even though there have been long delays in receiving feedback from FEMA on financial issues including award letters and budget submission approval, there have been no stoppages in our provision of disaster case management to clients.

Weaknesses- Factors that have prevented, or have the potential to prevent, the continued success of MCMC.

1. Definition of “Disaster Case Management”

- a. Prior to the MCMC project, the definition of disaster case management had not been standardized at the federal or state levels. As a result, there exists a role and responsibility differentiation which has caused confusion, duplication of service, and clients who have not attained recovery, simply because the provision of “disaster case management” could not be agreed upon. This confusion over “what disaster case management is” often renders the client without a sustainable and permanent housing option. MCMC uses a holistic model of identifying all barriers to recovery; housing, employment, legal, disability, etc. The holistic model allows the case manager to identify the needs and then work with the client, referring to external entities that can help meet those needs. If a client has a housing need, for example, MCMC would refer the client to a local public housing authority where the client could apply for a Housing Choice Voucher. Unfortunately, many of the housing resource centers at the local and state level also consider themselves disaster case managers and, although their focus is very narrow, MCMC had had to close cases once the client engages in those systems to avoid duplication of benefits, as outlined in federal regulations.

Solution: Define “disaster case management” as an entity which coordinates the recovery efforts of the client and refers the clients to external entities to receive the services needed to attain recovery. If this definition is used, the housing programs would not be expected to coordinate the recovery plan process of the clients, but rather focus on determining eligibility and financial ability to attain the housing solutions they were charged with coordinating.

Rationale: Defining roles and responsibilities within the disaster case management program will build specializations that will help support the overall mission rather than impede it.

2. Developing Program/Population Silos

- a. Neither MCMC nor any other disaster case management pilot program can fully succeed in its mission when Federal and State agencies continue to condone and even perpetuate the “silo” approach to their own recovery work. An uncoordinated approach only leads to unhealthy competition and “turf wars” that do nothing to serve the interests of the public and those who are in need of assistance. For example, once the Governor’s office asked the Mississippi

Commission for Volunteer Service (MCVS) to take on the disaster case management pilot program being discussed by FEMA, the MCMC leadership team submitted a formal proposal to FEMA to serve all individuals and families residing within Temporary Housing Units (THU's) in the State of Mississippi. At the time of the original proposal, there were well over 10,000 individuals residing in temporary housing that included FEMA subsidized travel trailers, mobile homes, hotels and motels; individuals and families residing in a FEMA program known as the Mississippi Alternative Housing Program (MAHP), also known as the Mississippi or Katrina Cottage program; as well as the individuals and families who were residing in FEMA subsidized HUD units under the Disaster Assistance Housing Program (DHAP), which was essentially a temporary housing voucher which HUD serviced by using FEMA provided funds. The proposal to serve all THU residents was made for the purpose of coordinating not only the disaster case management services that the clients would receive, but to also be able to coordinate the resource sharing efforts that were going to be needed in order to ensure that as many families as possible would be able to move from a temporary housing setting into a permanent housing solution.

This request was denied and, as a result, MCMC was assigned the programmatic and budgetary authority to serve only those clients identified on the prescribed client list provided from the FEMA headquarters staff in Washington, DC. This list included 5,529 names. MCMC leadership was told that the basis for the denial of our proposed scope of service was because FEMA had "already paid for case management of DHAP families," and that the MHAP program existed under a separate Federal program authority and therefore it was not the responsibility of the disaster case management pilot program to offer its services to this population of cottage residents. Unfortunately, DHAP clients within the state of Mississippi did not receive systematic disaster case management services, and many have yet to transition from their temporary voucher to the long term Housing Choice Voucher (HCV) needed to achieve recovery and their long term housing needs. In addition, the residents of the cottages have only received a financial assessment effort, the aim of which is to determine whether or not the client has the ability to purchase the cottage, and does not attempt to address the overall recovery needs of the case. These three "silos" illustrate that until there is a coordinated approach to the

delivery of disaster case management services, multiple programs will use multiple approaches to serve what are, in reality, the same clients at the end of the day.

The issue is complicated by the fact that Mississippi was able to implement its DCM-P within a matter of weeks after the first solicitation was made by FEMA, while other states struggled to work through the contractual issues. The result is that we recently discovered that many of the clients we were tasked with serving as a part of the MCMC project were also passed on to the project managers in Louisiana for inclusion in their own DCM-P project. MCMC is now working to coordinate case transfers despite the fact that our affiliates have invested countless hours in their efforts to prepare the case for a successful closure due to meeting their needs and having the client achieve recovery. Because the case was re-assigned to another entity, those projects are now making contact with the client to re-open the case. This example illustrates the problem(s) that may arise in future programs that FEMA implements due to its desire to fund state entities separately. In the event of simultaneous disaster events, FEMA may find itself trying to fund more than its three current state programs which are unaffiliated, with only minimal staff at the headquarter level to coordinate and ensure non-duplicative work processes. Individual (silo) programs will only continue to make it more difficult to achieve the goal of recovery for the client and make it impossible for necessary coordination to occur in order to reduce the overall costs associated with that recovery work. MCMC continues to strive toward a “work smarter, not harder” approach to our work, only to continually witness the complete opposite of that approach at the Federal and, many times, State leadership levels. After nearly two years in operation, and as a consequence of the issues outlined above, MCMC has now been told by our funder that the consortium cannot accept any new client referrals from any source, even clients who were eligible for case management from MCMC, who were omitted due to a data entry error at the federal level and a misinterpretation of the legislative authority that allowed MCMC to continue providing services past its original end date. The main concern at this point, as related to this one issue, is that there are many families who resided in FEMA subsidized temporary housing units who were never included in the original list of clients for MCMC to serve, and who are now being told that they are unable to receive disaster case management services from the MCMC program.

In an effort to resolve our inability to serve clients in need, a result of our limited scope of service, MCMC recently requested and received budgetary and programmatic approval from the State of Mississippi to attempt to serve those families remaining in a DHAP status. As the DHAP-Katrina program expired, families who had been unable to convert their temporary voucher to a permanent Housing Choice Voucher were in an imminent homelessness situation. The conversion process from DHAP to HCV is, quite frankly, a bureaucratic obstacle course in which experienced case managers and self proclaimed public housing experts have all been victims of confusion and dismay as they attempt to understand the individual rules that govern public housing authorities with no standardized guidance or policies to which they can refer when working with clients. Even though Senator Cochran and other members of the Congressional delegation of the State of Mississippi advocated for, and received, an allotment of additional housing vouchers which were to be used for the purpose of assisting families continuing to reside in Temporary housing units, many families have yet to be able to navigate the complex and uncoordinated systems that exist in "silos." For its part, MCMC has continued to refer clients, transport clients, and even assist clients in filling out application paperwork when necessary, to the local public housing authorities within the state who have received these additional "THU to HCV" vouchers. We will continue to work on behalf of the clients we are allowed to serve, and wish for nothing more than the ability to succeed with the mission we have undertaken.

Solution: Prevent silos by encouraging and supporting a system in which all programs collaborate, coordinate, discuss and share data and information so that all clients are served in a timely and organized manner.

Rationale: Consolidating the silos and serving multiple populations under one umbrella organization will help navigate multiple systems concurrently rather than consequently. This will help move more persons toward recovery since all options will be explored within the same recovery plan.

3. There is no federal mandate that clients living in THU's be required to participate in disaster case management process.
 - a. Clearly, the disaster victims/clients themselves have a role to play in their own recovery, and MCMC's case management model is built on the premise that our service is as much an accountability tool to be used to ensure progress toward recovery as it is a humane service that treats individuals and families in a fair and respectful manner. As was previously discussed, the "APALM" approach is proactive in nature and is designed to speed up the recovery of individuals, families, and communities. To date, however, MCMC has had 1,020 individuals and families who have refused to participate in the MCMC process and an additional 503 cases that were engaged who would not comply with the recovery planning process or would not return calls or attend appointments with the case managers. Furthermore, as we near the end of our program' allotted amount of time, our affiliates are receiving a steady stream of individual and families who are in need of services that were once on our "refused services" list of clients. As stated earlier, we also continue to receive requests from the local FEMA offices to serve clients living in temporary housing units and who were never assigned to MCMC as a part of our original scope, yet we are unable at this point in time to accept those families into our program. Overall, this "refusal" option often leads to a duplication of benefits that can put the individual or family at risk of prosecution or recoupment of benefits that were uncoordinated or not monitored effectively. This reality is an unfortunate result for the taxpayer or private donor as much as it is unfortunate for the client who was unaware of his/her options and consequences of those options and delays the recovery efforts at the state and federal level. FEMA has personnel in the field who are titled "Housing Advisors" and their function is primarily to monitor the housing plan of applicants who are living in FEMA subsidized temporary housing units. However, these personnel are not trained or required to perform the same types of tasks that disaster case managers undertake with clients. In Mississippi, housing advisors routinely cross paths with MCMC disaster case managers and their clients by virtue of their monitoring role.

Solution #1: Ensure that each individual or family that receives "Individual Assistance" from FEMA in the aftermath of a disaster, be assigned a disaster case manager who would be responsible for carrying out the recovery plan development process that is a key component of

every disaster case management model currently under development. Requiring participation as a condition of receiving a THU would allow time for a sustainable long-term solution to be put into place.

Solution #2: Review the role of the FEMA housing advisors and determine whether the role can be expanded to include functions of a disaster case manager.

Rationale: Requiring participation as a condition of receiving a THU will encourage households to look towards the future with an eye on sustainability. Due to depression and post traumatic stress syndrome, many of the families in need are making short-term decisions that may negatively impact their ability to achieve a permanent housing solution. Further, the life skills needed to look at a situation holistically rather than compartmentalized are not inherent to a number of the families. Requiring that the households living in temporary housing situations follow up with a case manager who can clearly identify all options available at the time and develop a plan to access those options will help the client see that a temporary housing situation is not a long-term housing solution.

Opportunities- Factors that have the potential of guaranteeing continued success for MCMC and future programs as well.

1. Leadership

- a. “In the absence of leadership, chaos exists.” In the aftermath of a disaster, chaos is inevitable. However, the various disaster case management models being examined and tested in the field, including the FEMA (MCMC) model as well as the HHS (Gustav) model, offer opportunities to establish a federal program that can lead to a speedy, humane, and cost effective recovery. Through the years, disaster case management occurred either in an ad hoc manner or through the efforts of voluntary organizations that sought to establish some consistent processes without the ability to adequately fund and/or support those processes. The MCMC model allows for an effective state-wide implementation option through the use of a state agency that has an historical and ongoing connection to the voluntary agency sector. The HHS model is designed in such a way as to allow flexibility and speed in the response and recovery efforts, and support deployment of personnel in the event of simultaneous and multiple disaster events. Each model has unique elements that should be carefully considered from the vantage point of the local

provider who will be asked to provide the actual disaster case management services. From this viewpoint, it is important that funding which is crucial to support the local provider be streamlined with safeguards that prevent non-compliance with Federal grant regulations. Clearly providing financial guidance, and timely feedback, is a crucial element that is currently lacking. In the MCMC project, for example, the leadership team proposed to FEMA that it be provided with a point of contact at the HQ level for questions related to financial processes. However, instead of being provided a "financial specialist" point of contact, we were forced to channel all of our finance related questions through the programmatic office in DC, which often resulted in long delays and incoherent answers to basic financial regulation questions. This problem is caused by the fact that the programmatic personnel at FEMA are not trained in Federal audit or compliance regulations and only serve as a pass through to the actual finance personnel within a regional office once they receive questions from the state. This often leads to more confusion on the ground as affiliates are paralyzed in their processes while they await an answer to questions related to everything from budget line item change request procedures, to what constitutes appropriate expenditure of indirect cost recovery funding. Future programs must ensure that the communication of finance related issues are transparent, streamlined, and of high quality. To do otherwise is no longer an opportunity, but rather a threat to success. It is also critical that leadership of the eventual disaster case management program be centered, connected, and concerned as opposed to heavily bureaucratic with third party contractors conducting grants management and evaluation. A hands-on leadership approach is what is needed most by the local providers as circumstances involved with human recovery after disaster are fluid and complex. Having a leadership team with expert holistic knowledge of how to operate a disaster case management program translates into ongoing training, connection between data and operations, and advocacy for client rights and needs at the state and federal levels. Layers of contractors and third party points of contact will only isolate local providers and prevent knowledgeable and timely feedback on barriers that they face while working with clients.

2. Coordination

- a. The models being considered by the Federal Government must have, at their core, a guiding principle that a coordinated approach is not only necessary, but vital to success in order to prevent the duplication of effort that all too often exists as discussed above. Coordination must occur at every level of government and department within the various governmental structures. Disaster case management can inform the use, and provision, of disaster related resources by identifying the most critical elements needed by individuals and families. Without the voice of disaster case managers, the funding that is made available following disasters will likely continue to be duplicated, wasted, and depleted before the most vulnerable populations are addressed. The HHS model offers an opportunity for disaster case managers to be an active part of the response efforts in order to inform the provision of resources while the FEMA-MCMC model demonstrates that disaster case management is a vital component of the long term recovery effort well beyond the initial response phase. Indeed, without disaster case management being present in Mississippi over four years following the impact of Katrina, the most vulnerable population including the elderly and disabled would be left to navigate unwieldy systems on their own with little hope of success.

3. Capacity Building

- a. The MCMC project has been singled out, by a representative of the Mississippi Attorney General's office, as a "rare example of a Federal program that has made the private sector more efficient." This comment was made after a review and discussion of reporting material generated by the MCMC leadership team that demonstrated how the private nonprofit providers were able to compete for future grant opportunities with a measure of confidence that they had not previously possessed. Through the active management of the project, the MMC leadership team has counseled, taught, and improved the performance of its affiliates and, in turn, improved the affiliates' ability to meet the needs of their clients.

Threats- Factors that contribute to ongoing barriers to recovery and may prevent success of future programs if not addressed.

1. Lack of Social Service Infrastructure

- a. Disaster case management, in order to be successful, must be supported by both short-term and long-term resources. Monetary resources that can be used for rebuilding, repairing, elevating, and rehabilitating homes are necessary in order for disaster case managers to address the housing needs of individuals and families. Further, these same monetary resources are needed in order to pay for utility and rental deposits; transportation costs associated with moving home furnishings; and routine expenses incurred when relocating to a new primary residence, like the high cost of insurance that now exists within the impacted region. While monetary assistance is usually provided through donations and fund raising efforts of recovering communities, there is a crucial component of the recovery effort that continues to go unaddressed. In states around the country, the social services infrastructure that does exist is not sufficient to meet routine demand, let alone the demands that are present on those systems in the wake of a disaster. Disaster case managers currently working in Mississippi have very few options when it comes to the long term social service needs of clients. Physical infrastructure like bridges, roads, water and sewer treatment plants, etc., are generally rebuilt following a disaster in a manner that is in concert with current building codes and laws. Social service infrastructure that includes community mental health treatment facilities, hospitals, public housing offices, early childhood intervention facilities, and senior centers are often never rebuilt in the wake of a disaster, nor are those facilities that remain intact given more resources to support the increased demand. MCMC serves many clients who are elderly, disabled, and the working poor who have long term social service needs that are a continual barrier to recovery. For example, as a result of all of the emotional trials that they have been through since Katrina, many of our clients would most likely fit the DSM criteria for Major Depressive Disorder, and yet their symptoms go untreated due to a general lack of referral options for the disaster case manager. Depression, Post Traumatic Stress, Adjustment Disorders, and a host of other emotional and mental disorders leave the client unable to make decisions. These clients often lack the energy and initiative that can lead to unemployment, and generally are not participate fully in their own recovery. Elderly clients who need ongoing support and care are often not able to access needed services, and instead rely on temporary housing, for example, provided by FEMA and other

Federal housing programs like HUD vouchers. Single parents, many of whom are unable to work due to a lack of affordable childcare, become “stuck” in temporary housing as their income level from all sources, including part-time employment, is not sufficient to pay post disaster rental rates. The client or family with a disabled child is often unable to access disability income due to a lack of capacity at agencies whose responsibility it is to process such applications, if the agency is even open and operating following a disaster. Finally, 82% of the open cases under MCMC have no more than a high school diploma and may not have the literacy levels needed to navigate the multiple bureaucracies needed to obtain the one housing solution that may be their last housing option. This critical lack of “hand off options” is a threat to the success of future disaster case management programs wherever they are implemented.

Solution: Support the social service system with federal dollars following a disaster in order to support the increased demand on those services. A seamless and integrated approach will enable the case managers to refer clients to services that will have the capacity to support their long-term needs. Focus on rebuilding and repairing physical infrastructure like bridges, roads and public buildings, as well as on those elements of a community that provide for human recovery needs as well. Bridges are never rebuilt back to their pre-disaster condition. Rather, they are generally built bigger, better, and stronger. We must be able to use this as a guiding principle when focusing on the needs of the people impacted by the same disaster that destroyed a bridge.

Rationale: In the disaster case management programs, clients with long-term social service needs are prevented from achieving recovery from the disaster, in many situations. The case managers do not have the tools, in the form of referral mechanisms, with which to work. Further, disaster case management experts do not generally occupy positions within the employment education sector, housing sector, welfare sector, veteran sector, transportation sector, older adults or disability sectors. Without proper referral mechanisms to the social service delivery systems, the disaster case managers are either forced to try to meet these specialized needs on their own, or work around those issues; neither option is viable, or realistic, in many cases.

2. Parallel systems operating to achieve the same outcome

- a. There is a real possibility that the “Federalizing” of disaster case management will drive out some of the agencies that have historically provided this service on a volunteer basis using private funding and volunteer human resources. The restraints, in the form of Federal and State laws that will be placed on service providers, will prohibit some of these faith based organizations from participating fully in future disaster case management programs. As a result, the phenomenon of parallel processes will exist. Volunteer and faith based organizations will use private funding to support their own approach to disaster case management, while the Federal government will use taxpayer dollars to support its identified approach. As a consequence, impacted individuals will likely suffer from an uncoordinated and overly costly recovery effort. This problem is likely to exist to some extent no matter what model FEMA, HHS, and HUD ultimately choose. The goal of whichever model is chosen, as it relates to this particular topic, must be to reduce and prevent as much duplication of effort and resources as possible, and to place high value on a collaborative and inclusive approach that includes a diverse mix of specialized and general service providers. Parallel programs that seek to serve the same population of people is an ongoing problem within other Federal and State programs, like the multitude of programs that exist to address homelessness for example. This must be taken into account when the time comes to endorse a particular disaster case management approach.

Solution: Whether the services are to be overseen by FEMA, HHS, HUD, or some other yet to be named department within the Federal system, they should be coordinated with, and compliment, any ongoing efforts at the local level as opposed to adding another layer of confusion within which the client in need will have to navigate.

Rationale: The non-profit community can work from the ground up, with low overhead, to assist clients in meeting their needs; often with creative or unconventional mechanisms which are unattainable by the federal and state systems due to stringent guidelines and regulations.

3. Reaction

- a. As was described above, reactionary behavior stifles any momentum that has been created toward solving a particular set of problems. A real threat to the success of any case manager –

and therefore any case management program – is the tendency to react to circumstances, as opposed to planning in order to mitigate the emergence of problems. Clear and concise implementation procedures, including how service providers will be funded and what services should be available, must be established and ready to be followed well in advance of the impact of a disaster. To this end, the FEMA model that is currently being implemented in Mississippi is one that may prove difficult to replicate in every state on a consistent basis. Each state has a unique set of factors that would seemingly make planning for disaster case management implementation very difficult. On the other hand, the HHS model relies on a National Partner organization that would deploy personnel quickly to a disaster area and begin the process of setting up a local programmatic infrastructure. This model requires a great deal of pre-planning and must be headed up by a National Partner organization that is dedicated to a collaborative and inclusive approach, as opposed to relying on its own local affiliations.

Solution: Develop a hybrid model that incorporates the best elements of the FEMA, HHS, and other disaster case management models.

Rationale: The methodical approach that has been conducted in Mississippi under the FEMA-MCMC project is an example of what could be developed on a National scale if it were to incorporate the early response elements that exist within the HHS model. I have recently heard the term “hybrid model” that would incorporate an early response component like that which exists within the HHS model, while long term implementation would take the shape of those elements being used in Mississippi. This is a very good idea, in my opinion, and serious planning needs to be undertaken sooner rather than later in order to avoid reactionary behavior that is likely to ensue following the next disaster event and that will result in a less than effective disaster case management program that is put “in the field” just for the sake of being able to say that an effort was made. This is unacceptable for the disaster victim, for the public interest, and certainly for the dedicated disaster case manager. Planning, as stated above, needs to happen quickly and should include members of the leadership teams of the projects currently being piloted. I recently learned of a working group that is made up of “subject matter experts” who are supposedly reviewing and evaluating the current disaster case management pilot programs. However, as a leader of the currently longest running disaster case management pilot program, I was not asked to be a part of the working group, nor was any other member of my

team. I point this out not as an indictment of the individuals conducting the working group, but as an indictment of the process itself, which does not generate, for me, a high level of confidence concerning the planning efforts that must occur around this topic.

Conclusion

The strengths, weaknesses, opportunities, and threats outlined above are a quick reference to key elements that need to be discussed and debated so that a coordinated system of delivery can be designed to support the disaster recovery efforts following a federally declared disaster in the future. We hope that you share this information with the working group and ask that they engage the organizations that are operating currently to further understand the best practices and lessons learned already identified on the ground. The information that has been written in this testimony represents only a fraction of the observations and lessons learned that I have experienced in my work over the last four years. There are a great many more strengths, weaknesses, opportunities, and threats surrounding this particular subject. Ultimately it is the disaster victim who needs to receive all of our best efforts at creating an approach that will prevent unnecessary hardship and burden as they pursue individual and family recovery from disaster. I pray that you will carefully consider all of the options that are being represented by the various pilot programs and guide the decision making process with the best interest of the individual receiving the services of a disaster case manager in mind.

Thank you once again for the opportunity to meet with you today and allowing me to submit this written testimony for the record of this hearing. It is our hope that pointing out barriers which exist to successful outcomes will steer all of us in the same direction and to understand the importance of a collaborative, cooperative, communicative, and coordinated approach.

Stephen P Carr, II, MA, MFT

The Mississippi Case Management Report of the DCMP-P

Data was exported on November 10, 2009

November 2009

Administration of Clients			Page 1 of 4																																									
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# of CLOSED Cases:	2698	75.1%																																										
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The Mississippi Case Management Report of the DCMP-P

Data was exported on November 10, 2009

November 2009

Demographics of Clients			Page 2 of 4		
Age of Head of Household			Educational Level		
Under 18:	7	0.2%	Less than a HS Degree:	890	25.3%
18 to 34:	418	11.7%	GED:	355	10.1%
35 to 49:	1234	34.5%	HS Degree:	1656	47.0%
50 to 65:	1405	39.3%	Associate's Degree:	377	10.7%
Over 65:	508	14.2%	Bachelors Degree:	183	5.2%
Total	3572		More than Bachelors Degree:	61	1.7%
Gender			Total		
Male:	1693	47.1%		3522	
Female:	1898	52.9%			
Total	3591				
Household Structure			Employment Status of OPEN Case		
# of Dependents in HH	2648	73.7%	FT Employed not looking:	214	23.9%
Household Size of 1:	1514	42.2%	FT Employed looking:	28	3.1%
Household Size of 2:	827	23.1%	PT Employed not looking:	48	5.4%
Household Size of 3:	478	13.3%	PT Employed looking:	33	3.7%
Household Size of 4:	390	10.9%	Unemployed not looking:	50	5.6%
Household Size of 5:	223	6.2%	Unemployed looking:	108	12.1%
Household Size of 6:	93	2.6%	Disabled not looking:	309	34.5%
Household Size of 7:	39	1.1%	Retired:	91	10.2%
Household Size of 8:	11	0.3%	Student:	0	0.0%
9 or More:	9	0.3%	Total	881	
Total	3584				

The Mississippi Case Management Report of the DCMP-P

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November 2009

This reports includes Open and Closed cases served under the MCHC program.

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Type of Household Income of OPEN Cases				
	#	%	Amount of Income Reported	#
Income from Wages	404	45.1%		873
Social Security	231	25.8%	<i>Income - Avg / case</i>	\$1,395.00
Disability	231	25.8%		
Unemployment	26	2.9%	Amount of Expenses Reported	858
Other*	247	27.6%	<i>Expenses - Avg / case</i>	\$1,280.38
# with at least one reported	3563	96.6%	Average Annual Salary	\$16,740.03
			Average Difference between Income/Expenses:	\$114.62

Ethnicity	#	%
African American/Black:	1252	35.1%
American Indian/Alaska Native:	20	0.6%
Asian:	46	1.3%
Hispanic or Latino:	29	0.8%
Hawaiian/Pacific Islander:	9	0.3%
Tribal Affiliation:	4	0.1%
Other / None of the Above:	12	0.3%
White:	2193	61.5%
Total	3565	

Impacts from Katrina/Rita		
	#	%
Grieving:	344	9.8%
Emergency Response Wkr:	206	5.9%
Mandatory Evacuation:	1880	53.7%
Physical Injury:	636	18.2%
Damage to Home:	3269	93.4%
Displaced:	3297	94.2%
Loss of Income:	1513	43.2%
Client with 1+ impact:	3499	97.4%
Avg # Impacts/Case:	3.19	

Client Needs	#	%*	# of CLOSED Cases: 2698					
			Need Met*	%*	Partially Met*	%*	Need Not Met*	%*
Aged/Disability	259	7.6%	70	2.6%	29	1.1%	10	0.4%
Application Asst.	260	7.6%	127	4.7%	5	0.2%	8	0.3%
Clothing	223	6.5%	66	2.4%	19	0.7%	18	0.7%
Employment	1766	51.8%	642	23.8%	114	4.2%	164	6.1%
Financial	2146	62.9%	704	26.1%	165	6.1%	189	7.0%
Food	708	20.8%	338	12.5%	66	2.4%	50	1.9%
Furniture/Appliances	914	26.8%	264	9.8%	81	3.0%	110	4.1%
Housing	3302	96.8%	1528	56.6%	229	8.5%	325	12.0%
Health and Well Being	735	21.5%	269	10.0%	87	3.2%	56	2.1%
Language	39	1.1%	26	1.0%	0	0.0%	1	0.0%
Legal	140	4.1%	35	1.3%	17	0.6%	15	0.6%
Other	134	3.9%	26	1.0%	6	0.2%	10	0.4%
Transportation	254	7.4%	94	3.5%	19	0.7%	32	1.2%
Utilities	517	15.2%	216	8.0%	31	1.1%	42	1.6%
Youth	96	2.8%	28	1.0%	9	0.3%	11	0.4%
Total # of Needs	11493		<i>*The above CLOSED cases were identified as having the need at the time of assessment, and now reports the degree to which that need was met.</i>					
Clients with 1+ need	3411	94.9%	<i>To use this section, choose one line and compare the Needs Met, Partially Met, and Not Met percentages. The higher the "Need Met" and the lower the "Need Not Met", the more success the agency has had in meeting that particular need.</i>					
Avg # of Needs/Case	3.37							

Needs are recorded at the time of intake and are compared to the total # of cases in CAN

"Need Met", "Need Partially Met", and "Need Not Met" are collected at the time of closure and includes cases that were assessed to have that need at the time of Assessment AND are closed.

The Mississippi Case Management Report of the DCMP-P

Data was exported on November 10, 2009

November 2009

page 4 of 4

County	# Open Cases	# Closed Cases	# Cases Went to LTRC	Total Value of LTRC	Average Presentation
Amite	6	4	0	\$0.00	\$0.00
Covington	10	15	0	\$0.00	\$0.00
Forrest	34	65	0	\$0.00	\$0.00
George	14	61	0	\$0.00	\$0.00
Greene	14	17	0	\$0.00	\$0.00
Hancock	111	377	2	\$7,329.31	\$3,664.66
Harrison	231	953	7	\$108,613.76	\$15,516.25
Hinds	1	13	0	\$0.00	\$0.00
Jackson	124	541	0	\$0.00	\$0.00
Jefferson Davis	18	10	0	\$0.00	\$0.00
Jones	29	54	0	\$0.00	\$0.00
Lamar	15	24	0	\$0.00	\$0.00
Lawrence	4	6	0	\$0.00	\$0.00
Lincoln	6	9	0	\$0.00	\$0.00
Marion	7	46	0	\$0.00	\$0.00
Pearl River	156	243	18	\$213,527.00	\$11,862.61
Perry	10	25	1	\$1,200.00	\$1,200.00
Pike	9	26	0	\$0.00	\$0.00
Simpson	2	9	0	\$0.00	\$0.00
Stone	19	63	2	\$88,898.00	\$44,449.00
Walthall	30	38	5	\$65,745.06	\$13,149.01
Wayne	7	11	0	\$0.00	\$0.00
Wilkinson	5	5	0	\$0.00	\$0.00
Other	26	56	0	\$0.00	\$0.00
None Reported	7	27	0	\$0.00	\$0.00
Total:	895	2,698			

Cases that have a county name reported, but do not report a case status, are included in the "OPEN" cases for the County

"Other" (County) includes cases that are in CAN with a county listed but is not one of the specific counties listed above. Cases that have an "Other" county reported but no case status, are included in the "OPEN" number under "Other"

"None Reported" includes cases that are in CAN but do not have a County reported. Cases that do not have a county NOR a case status indicated are included in "None Reported - Open"

OPEN column equals # of Open cases + # of Cases with a Blank Case Status

CLOSED column equals # of Closed cases



MCMC Closure/Transfer Plan

Submitted: June 29, 2009

Introduction

Thirteen affiliates have been working under the Mississippi Case Management Consortium to assist persons affected by Hurricanes Katrina/Rita identify their unresolved barriers to recovery and to help to identify strategies for meeting those needs prior to August 1, 2009. Within the short timeframe of operation, the Affiliates have made significant progress in assisting families as they move toward self-sufficiency.

The cases that remain open for unmet disaster-caused needs were reviewed in detail. At the end of this report, targeted strategies are outlined from which the MCMC affiliates are drawing on to meet the challenging housing needs in Mississippi. From this report we'll document that the housing issue is not so much a housing stock issue as it is an affordability issue and that this assessment of work warrants the assistance of the Mississippi Case Management Consortium through March 2010.

MCMC Caseload

The MCMC caseload includes two populations:

- 1) Cases that were living in FEMA subsidized housing at the beginning of the program and assigned to MCMC
- 2) Cases that were rolled over from the Bridge (Cora Brown) program

Progress to Date

Since the last MCMC Closure/Transfer Report dated April 15th, a tremendous amount of work closing cases for positive and successful reasons has taken place. Below is a snapshot of progress through key pieces of quantitative data linking the success of the MCMC program with client recovery in Mississippi:

783 cases were closed between March 1 and May 31

Since the beginning of the MCMC program:

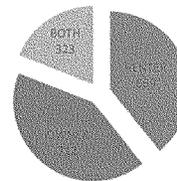
- **1870** cases have closed since the beginning of the program
- **70%**¹ were closed for achieving recovery or having their primary needs met
- **74%** of the cases that closed were moved into permanent and secure housing

Renter vs. Homeowner

Source: May 2009 Monthly Affiliate Reports

Affiliates report the current homeownership status of each of their clients in terms of what types of disaster-caused needs they have remaining, regardless of their housing situation pre-Katrina. This was done to assess current needs and client intentions. Affiliates used four designations; Renter, Homeowner, Renter and Homeowner (Both), or Neither (which also includes the cases that did not have a response or were new referrals). From this information we find that there is a slightly higher percentage of homeowners (40%) than renters (38%). An additional 18% of cases are reported as both Renters and Homeowners which means that these clients will need rental assistance until home repairs are complete.

Homeownership Status



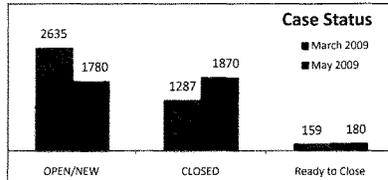
¹ 20% of the clients chose to discontinue receiving case management services; and 10% were closed for a variety of other reasons

Case Status²

Source: May 2009 Monthly Affiliate Reports

As of May 30, 2009 the following data was gathered by the Affiliates to forecast which MCMC clients with unmet disaster-caused needs will continue to require continued case management services.

Below are the statuses of the MCMC clientele in May 2009 as they were reported by the Affiliates. This information is compared to the statuses from the last Closure/Transfer plan (March 2009) to show the progress being made by the consortium.



As of May 30th:

- 1780 cases remain open for unmet disaster-caused needs (this includes new cases)
- 1870 cases have been closed
- 180 cases are being prepared for closure

Reasons Cases Cannot Close

Source: May 2009 Monthly Affiliate Reports

For each case that was open or new as of 5/1/2009 the Affiliates reported the reason preventing each case from closing. It is important to note that the agencies were not prompted to report specific categories but rather were given the liberty to report, in their own words, what prevented the clients from successfully recovering from the disasters. These reasons were coded into 3 general categories and 14 specific reasons to further understand this particular population's unmet needs. These categories are explained within this section and appear with more detail in Appendix A.

Reasons cases cannot close – General (3)

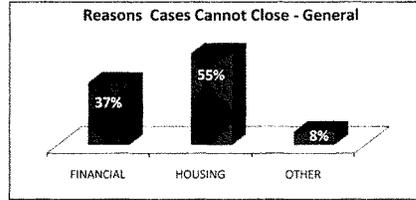
- Financial (Financial)
- Housing (Housing)
- Other (Other)

Reasons cases cannot close – Specific (14)

- Needs Affordable/Permanent Housing (Affordable Housing)
- Repair/Rebuild (Rebuild/Repair)
- Social Service (Social Service)
- Employment or Income Needs (includes lack of income, no income, fixed income) (Employment/Income)
- Trying to buy property (excludes MH or MEMA Cottage) (Buying property)
- Pending Housing Program or Grant (Pending Housing/Grant approval)
- Volunteer Labor (Volunteer Labor)
- Furniture/Appliance/Rental or Utility Deposits (Furniture/Deposits)
- Need related to a disability (Disability)
- Applying for MEMA Cottage (MEMA)
- Interest or pending Mobile Home Purchase (MH)
- Unable to Determine Reason/New Referral - included in Appendix A
- Almost Ready to Close/Monitoring/Pending Closure - included in Appendix A
- Other - included in Appendix A

² This includes currently open and closed cases only. There were additional cases assigned to MCMC; however, these cases were never opened due to the client no longer living in a FEMA housing unit, the client could not be found, or the client refused case management.

The three **general** categories, charted below, were used to capture the overall reasons cases were still open³.



Fifty-five percent of all MCMC clients have a housing need and 37% of all MCMC clients have a financial need. A client may be included in more than one category if their presenting needs covers multiple categories.

The 8% of clients that have an "Other" reasons includes cases that indicate a non-financial or non-housing related reason for not being able to close. For the MCMC population this includes legal issues, social

service needs, employment needs, disability related, furniture or income related needs. The majority of the MCMC population with a reported "Other" need also has a presenting financial or housing need⁴.

The three general categories above were broken down into **fourteen**⁵ specific areas to capture the detailed needs of these cases; the specific reasons the cases are still open.

The graph to the right reports eleven of the fourteen categories that are preventing cases from being closed.

The primary reason cases cannot close is because they cannot locate permanent and affordable housing in the state of Mississippi. This number also includes 125+ homeowners, in addition to renters, that are now looking for an affordable housing situation rather than funding for a repair/rebuild to their damaged dwelling.



A number of the clients that reported a need for affordable housing also report that they are applying for or have applied to Section 8 through HUD, a MEMA Cottage or have a pending Mobile Home purchase. With this information, MCMC estimates that the number of affordable and subsidized rental units has decreased from 971 to 938 throughout the state of Mississippi since the last Closure/Transfer Report and will continue to decrease as MCMC helps clients into creative housing alternatives. Assisting in this assessment is the number of clients that were able to purchase a MH increased during the month TSA was offering \$3,000 grants towards the cost of the Mobile Homes which is expected to increase again as FEMA begins to sell Mobile Homes and Park Models for \$1 and \$5.

The second largest reason cases cannot close is because households are awaiting funds or labor to complete repairs or a total rebuild on their Hurricane Katrina/Rita damaged property. In a few situations where agencies wrote narratives of the situations, agencies report that the client is not expected to be recovered for months or even years because they do not have funds to complete these necessary repairs to make the house habitable. Until that time, a number of these households report both a financial need as well as a housing need for when their mobile home, travel trailer, or park model is removed from their property.

³ Note: "Repair/Rebuilds" have been coded as "financial" while "Locating Permanent Housing" has been coded as "housing."
⁴ There are 57 cases that have an "Other" need indicated without a financial or housing barrier indicated.

Need by County

Source: CAN data

An assessment of Renters and Homeowners was conducted by County to determine the current location of unmet need. The ten (10) counties with the greatest number of MCMC clients are represented below while a full report of all counties can be found in *Appendix B*.

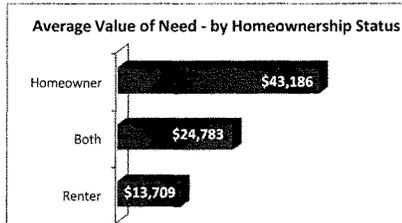
Homeownership Status by County					
County	Renter	Home Owner	Both	Unknown/ None	Total
Harrison	279	172	65	12	528
Pearl River	64	108	87	19	278
Jackson	110	127	27	5	269
Hancock	59	99	34	6	198
George	11	39	5	2	57
Forrest	17	7	30	2	56
Jones	26	7	11	1	45
Marion	13	26	2	0	41
Stone	15	14	6	6	41
Walthall	5	24	5	0	34

Estimation of Need – Repairs/Rebuilds

Source: May 2009 Monthly Affiliate Reports

Agencies submitted the financial dollar amount, when known through the Estimation process, needed to move specific cases to closure. In addition to the cases that received an Estimate, MCMC developed a formula to assess the need of renters. The formula used included the HUD-provided Fair Market Rates as well as a small allocation for moving expenses, utility and security deposits. The resulting average value of estimated need was used to forecast the amount of funding needed to help move the consortium's population of renters and homeowners into affordable housing units and/or back into their damaged dwelling.

Of the cases that reported an amount needed to move the cases to recovery (1288 cases), a forecasted amount of **\$48,529,379.62** has been determined to be the current figure needed to move, both Home Owners and Renters who are currently open and active under the Mississippi Case Management Consortium, towards recovery. Since the last report, 768 cases were closed reducing the previous estimated value of need by \$14 million dollars; through the purchase of Mobile Homes, MEMA Cottages, Vouchers, Volunteer Labor, etc.



Estimated Need - by Category of Ownership				
	Renter	Homeowner	Both	Neither
Forecasted estimated need	\$9,171,021.28	\$30,748,145.51	\$7,980,255.70	\$619,957.14
Total Need	\$48,519,379.62			

Demographics

The Hurricane Katrina/Rita populations receiving continued case management services from MCMC exhibit a number of risk factors and barriers that may cause them to become dependent on additional social services, if housing options are not quickly identified. The following demographics are the typical, average MCMC client.

- Average Annual Income: \$17,910.66
- 65% of the MCMC clients are 1 or 2 person households
- 33% are disabled
- 41% are employed
- 15% are un-employed
- 11% are retired

The MCMC population is comprised of the working poor with an average of \$224.00 in surplus income, many of whom are not yet paying rent. It will be critical to link the MCMC clientele up with the new HUD vouchers and other creative housing strategies that are coming to Mississippi.

Housing Strategies

The MCMC administration has been a key instrument in the advocacy and data collection entity for a number of housing strategies that will be the key to moving the MCMC population towards recovery. The following programs have been implemented/or will be implemented shortly. The success of these programs will directly result in the closure of more cases and the reduction of the estimated need of funding to move cases towards recovery.

- MEMA Cottages that are being made available for purchase to residents of FEMA travel trailers
- MCMC has been working to support MEMA efforts to reach and screen clients who may qualify for the MEMA Cottage program for residents of FEMA travel trailers
- An additional five (5) thousand HUD housing vouchers was authorized in the same legislation that provided for continuation of the MCMC program through to March 2010
- The Salvation Army was providing \$3,000 grants towards the purchase of FEMA Mobile Homes
- FEMA has recently announced Mobile Home and Park Model sale prices of \$1 and \$5
- Coordination with The Salvation Army to provide resources necessary for the purchase of insurance policies necessary to close the sale of MEMA cottages and FEMA Mobile Homes as needed
- Through a grant provided by Bethel Lutheran Church of Biloxi Mississippi to Lutheran Episcopal Services of Mississippi, \$44,000 was offered and will be used to pay the first year's insurance policy for 40 clients that are immediately moving into MEMA Cottages.
- Coordination with the Governor's office to impact policy decisions that are being made on the small rental housing program as well as many other housing programs it is initiating throughout the state
- Coordination with MDA to conduct a housing study of the MCMC population that has moved out of FEMA Travel Trailers
- The implementation of a Volunteer Coordination conference call and network which will match clients up with volunteer labor throughout the state
- Through a grant that was provided by the National Association of Realtors and being administered by MCMC/LESM Client Rental, Utility, and Security Deposit Grants program, has provided over 100 families with over \$100,000 in rental and utility deposits to move them into permanent housing
- MCMC designed and will administer a program called the "Adopt-A-Family" program which is being used to connect clients with repair/rebuild needs with donors around the country. This program will be web-based with client stories and updates available to the public.

Conclusion

The Mississippi Case Management Consortium is diligently working to close as many cases for meeting their recovery plans as possible; however, at this time, the consortium estimates the following statewide need for the MCMC population:

- 938 affordable/subsidized rental units
- \$48,519,379.62 in direct assistance⁶

For more information on anything on this report, please email info@mc-mc.org

⁶ Additional funding will be required for the administration of a program to manage these funds

**Appendix A –
Tables for “Reasons Cases Cannot Close”**

Reason Case Cannot Close – General
Source: May 2009 Affiliate submitted Monthly Reports (submitted 6/10/2009)

	Overall MCMC ¹	Renter	Home Owner	Both
Financial	827	66	535	197
Housing	1219	709	289	175
Other	179	123	30	19

Reason Case Cannot Close – Specific
Source: May 2009 Affiliate submitted Monthly Reports (submitted 6/10/2009)

	Overall MCMC ¹	Renter	Home Owner	Both
Affordable Housing	938	653	131	129
Rebuild/Repair	865	42	595	196
Social Service	40	33	3	1
Employment / Income	136	108	9	17
Buying Property	26	9	6	7
Pending Housing / Grant approval	54	50	2	1
Volunteers	31	2	21	8
Furniture / Deposit	34	21	7	2
Need related to Disability	11	6	2	3
Applying for MEMA Cottage	12	4	6	1
Purchase MH	120	44	31	35
Cannot Determine ²	211	92	56	11
Almost Ready to Close/Pending Closure ²	201	85	53	30
Other ²	17	9	7	1

Notes: Clients may have more than one reason reported

**Appendix B –
Table for “Homeownership Status by County”**

Homeownership Status by County
Source: CAN Data

County	Renter	Home Owner	Both	None	Total
Mississippi					
Adams		3			3
Amite	4	1	3	1	9
Clarke	2	4	0	2	8
Covington	10	1	4	2	17
Forrest	17	7	30	2	56
Franklin	2	2	0	0	4
George	11	39	5	2	57
Greene	6	5	10	1	22
Hancock	59	99	34	6	198
Harrison	279	172	65	12	528
Jackson	110	127	27	5	269
Jasper	1	1	0	1	3
Jefferson	0	4	1	0	5
Jefferson Davis	6	17	2	0	25
Jones	26	7	11	1	45
Lamar	9	6	6	1	22
Lawrence	1	2	0	0	3
Lincoln	6	2	2	2	12
Marion	13	26	2	0	41
Montgomery	1	0	0	0	1
Pearl River	64	108	87	19	278
Perry	7	4	7	1	19
Pike	7	6	6	0	19
Rankin	0	1	0	0	1
Simpson	2	0	0	0	2
Smith	1	0	0	0	1
Stone	15	14	6	6	41
Walthall	5	24	5	0	34
Wayne	1	6	4	0	11
Wilkinson	2	5	2	1	10
Unknown	0	3	0	0	3
Louisiana					
Orleans Parish	0	0	1	0	1
St. Tammany	1	1	1	0	3
Tanipahoa	1	0	0	0	1
Washington Parish	0	0	0	1	1
TOTAL	669	697	321	66	1753

Since the last report, MCMC has met the case management needs in the following counties:

- Copiah
- Mobile (AL)

¹ Includes clients that do not have a rental/ownership status
² Does not appear on Page 3



Field Management Team Affiliate Assessment

Agency:											
Date:											
Management Team Staff:											
Benchmark #1 Client Contact	Minimum Percentage Required	Percentage Outcome	Affiliate is In Compliance or Out of Compliance	If Out of Compliance List Action Steps Required to be In Compliance	Date Required	Findings Cleared yes or no	Date Cleared	Affiliate is In Compliance or Out of Compliance			
Clients files document client contact consistent with Risk Assessment											
Benchmark #2 Programmatic	Minimum Percentage Required	Percentage Outcome	Affiliate is In Compliance or Out of Compliance	If Out of Compliance List Action Steps Required to be In Compliance	Date Required	Findings Cleared yes or no	Date Cleared	Affiliate is In Compliance or Out of Compliance			
Initial Intake Completed											
Initial Assessment Completed											
Initial Recovery Plan Developed											
All MCMC Forms and Releases have required signatures											
FEMA Duplication of Benefits (DOB) in case file											

Field Management Team Affiliate Assessment

Benchmark #2 Programmatic (cont)	Minimum Percentage Required	Percentage Outcome	Affiliate is In Compliance or Out of Compliance	If Out of Compliance list Action Steps Required to be in Compliance	Date Required	Findings Cleared yes or no	Date Cleared	Affiliate is In Compliance or Out of Compliance
CAN Audit Form completed appropriately								
File Audit Form completed appropriately								
Monthly Reassessment Form completed with all required signatures								
Recovery Plan updated monthly with goals, objectives, action steps for client, short term target dates with outcomes and progression towards recovery								
Documentation is clear, concise and detailed toward recovery plan issues on case note form. In addition, case notes document monthly face-to-face home visit								
In closed case – documentation showing that the Client Satisfaction Survey was given to Client to complete and return or showing why it was not given to Client.								
Case Closure/Summary Form completed and has all required signatures – OR- documentation in case file indicating r reason signatures were not obtained								

COMMENTS and BEST PRACTICES



Mississippi Case Management Consortium "Phase II" Pilot Quarterly Report

Lead Agency: **Mississippi Commission for Volunteer Service**

Project Title: **Disaster Case Management Pilot Program, Mississippi**

Period Covered by Report: **July 1, 2009 - September 30, 2009**

Report Compiled by: **Marsha Meeks Kelly, Executive Director, Mississippi Case Management Consortium**

Program Contract Term: **June 16, 2008 - March 31, 2010**

The Mississippi Case Management Consortium is a public/private partnership made up of one Lead Agency, the Mississippi Commission for Volunteer Service (MCVS); one Management Agency, Lutheran Episcopal Services in Mississippi (MCMC/LESM) and ten (10) Affiliates operating under the same program target: *"To ensure that clients of Hurricanes Katrina and Rita with remaining disaster-caused housing needs transition from FEMA supported temporary housing to a permanent and sustainable housing solution."* The case management services of the Mississippi Case Management Consortium (MCMC) are extended throughout the entire state of Mississippi and are tailored to meet the needs of those that resided in FEMA subsidized housing (i.e. mobile homes, travel trailers, hotels/motels) and clients with unmet recovery needs from Katrina Aid Today and the Mississippi Phase I (a.k.a. Bridge) programs. Operational since August 5, 2008, the MCMC is a fully functioning Consortium with 100% expected staffing completed and 100% of attempted contact with clients made. The attached report represents the work of the Affiliates, Field Management Team, and the Lead Agency Teams under each of the following report sections:

- I. Primary Activities implemented this quarter
- II. Details of accomplishments this quarter
- III. Success Stories/Case Studies this Quarter
- IV. Challenges Experienced During the Quarter & Action Steps Taken or Planned to Overcome Challenges
- V. Remaining Challenges
- VI. Summary of Planned Activities for Next Quarter
- VII. Suggestions for Improving the MCMC Case Management System
- VIII. Suggestions for Improving the CAN system
- IX. Indicator Table of Data

I. Primary activities implemented this quarter

This section represents the activities that were conducted at the Affiliate, Field Management, and Lead Agency levels under the Mississippi Case Management Consortium's Disaster Case Management Pilot Program. Although this list does not reflect all of the work and projects of the Consortium, it represents the diversity and dedication of the staff.

A. Affiliate

- *Administration:* Quarter 5 included a variety of administrative responsibilities as each Affiliate closed out their Phase I MCMC program, applied for entry into the Continuation phase of programming, and continued to provide administrative oversight to the case management program. In the beginning of the quarter (7/1/2009), Affiliates interested in continuing to work under the Mississippi Case Management Program submitted proposals to MCMC, as outlined in the RFA (Request for Application) process designed by MCVS. The documentation that was included in the submission included: successes to date, strategies for moving clients through to recovery, a revised coverage area of service, a revised staffing plan outlining reductions to mirror the reduction in the overall client population in need of continued case management services from MCMC, revised job descriptions for all positions funded under MCMC, and policy and procedures that each agency needed to have internally. Once approved, Affiliates were required to use revised forms and reports, attend a training facilitated by MCMC to learn about the modifications being made on both the financial and programmatic elements of the program, re-focus and refresh for the next stage of operation, and begin case managing clients with increased face-to-face contact to expedite the recovery planning process. Since the Continuation phase of operation was an opportunity to collect new pieces of data and report data differently, the monthly affiliate reports were modified on two different occasions. This

posed challenges to the Affiliates as they attempted to transfer data from one template to another template, which was reported by one Affiliate as tedious and difficult; however, the data points that were modified will assist the Affiliates in preparing accurate reports with pre-calculated formulas to report out the indicators requested.

In addition to the reporting requirements for the Continuation phase of MCMC, Affiliates were asked to receive, review, and act upon a variety of lists that MCMC sent to the Affiliates of their clients. Over the quarter, MCMC received and processed lists from FEMA alerting Affiliates to which of their clients were still living in a FEMA THU, had purchased their Mobile Homes and who had failed three air quality tests; lists from HUD on clients who had attended or failed to attend appointments with the PHAs; and lists from MEMA on which clients living in FEMA THUs had been contacted to determine interest in purchasing a MEMA Cottage in specific counties in the state. The ongoing needs of this project continue to be great; however, the result is an increase in collaboration between organizations as they agree to share information in an effort to move more clients towards recovery.

The Affiliates were all required to participate in 'compliance' visits with the Field Management Team. In preparation, and as a follow-up to the visits, the Affiliates reviewed client files; made modifications to processes, procedures, standards; and, at times, facilitate trainings with their staff to meet the areas in which they were out of compliance. Affiliates report that this activity will not only help them to get their work into compliance for contracting purposes but will also improve the quality of their case management services. A few of the specific activities as well as general administrative activities this quarter include:

- a. Re-evaluated every client's risk assessment under MCMC. Once re-evaluated, the priority level and level of contact were revised accordingly.
 - b. Reviewed the case management activities and accomplishments to determine action steps necessary for improvement
 - c. Worked on developing and improving resource lists for clients
 - d. One Affiliate created a case summary for all open cases prior to the Continuation
 - e. Monitored all emails or phone calls that originated from MCMC, FEMA, HUD, and PHAs to ensure that all requests are responded to in a timely manner
 - f. One Affiliate reported receiving a \$50,000 United Way grant to assist low-income seniors and disabled households obtain permanent housing
 - g. All files in one organization were re-numbered to include the MCMC # on the outside of the file. The files, once renumbered will be organized in the filing cabinet in MCMC numerical order
 - h. Completed an inventory of all MCMC equipment prior to Continuation
- *Contacting Clients:* With the new Continuation contracts, the Affiliates were required to have at least one face-to-face contact with each client monthly in their home. Visiting with the clients monthly has proven successful to the process. Case managers are constantly in the field and can develop more actionable recovery plans. The 25:1 ratio has assisted in making this happen as this caseload is manageable and case managers can spend dedicated time with the clients.
 - *Case Management:* A tremendous amount of case management has taken place this quarter with the ten Affiliates working diligently to provide the highest quality of case management to clients, often as they collaborate with external entities and each other. Over Quarter 5, the Case Management Advisors (CMAs) and Affiliates worked together to revise a number of the forms; create new forms; and re-design the risk assessment of clients so that the clients are contacted more regularly, seen face-to-face, and met in their home. In addition to the monthly re-assessment form and new recovery plan template, the case managers are using a new Disability Assessment form to more effectively and efficiently transfer clients from one affiliate to a specialized services agency.

Case managers have been working with the clients to transition them into a Housing Choice Voucher and navigate the bureaucratic processes of Super Preference, Priority 1, Priority 2, and Priority 3. Case managers are following up with the clients to make sure they received the HUD/HCV packets; reminding clients of their appointments with PHAs (PHAs indicated a 30% increase with MCMC case managers' participation in the process as advocates); helping clients understand the letters and requests that they receive from HUD; helping to complete the paperwork; locating safe, sanitary, permanent and sustainable housing situations; requesting inspections; and helping the clients that move into a unit apply for grants for security, utility deposits, and furniture. Additional case management work conducted this quarter included:

- a. Provided FEMA with daily updates on clients (when requested by FEMA via email)
 - b. Discussed housing options and plans to transition out of the THUs into permanent and sustainable housing
 - c. Transitioned clients from the DHAP into the Housing Choice Vouchers
 - d. Reviewed bridge cases specifically
 - e. Sent out mass mailings of client surveys to ensure that all closed cases had an opportunity to review the services they received under MCMC
 - f. Accompanied Vietnamese clients to the Biloxi Housing Authority to pick up housing applications, attend eligibility interviews, and provided translation/interpretation services for the clients with the Housing Authority
 - g. Performed CAN and File Audits on closed cases
 - h. Finalized the re-assignment/transfer process of clients coming from agencies that closed, including: transferring cases to another case manager to decrease the caseload size to allow more space for new caseload; contact and conduct home visits and complete new paperwork with those clients
 - i. Reviewed files to verify that the case status reported to MCMC was still current
 - j. Completed the close-out work (finalized client list) for the end of the Phase II work; and created new client list for the start of the continuation work
 - k. Focused on ensuring that all client files with the Disability Agencies clearly document the disability need, work that was completed to meet that disability and the remaining unmet disability-focused needs
 - l. Assigned a data entry specialist to review all closed files; to ensure all paperwork was present and the CAN records were complete
 - m. Emphasized with the clients the importance of utilizing the recovery plans and following household budgets to facilitate recovery
 - n. Assisted clients to understand the FEMA Sales Program
 - o. Assisted clients with the MEMA Cottage interviews and process
 - p. Conducted in-house case management services survey on open clients
 - q. Provided Congressional offices information on constituents status and made referrals
- *CAN:* The Coordinated Assistance Network (CAN) continues to be the platform used by the MCMC program. During the quarter, Affiliates continued to utilize the data entry specialists to review and improve the data collected in the database. Case Managers are taking on more ongoing data and report-directed activities this quarter as the need for quality data increases and the staff in the field decreases. This quarter, Affiliates report having their case managers take CAN refresher courses or training case managers to take on data tasks that were previously the responsibility of data entry specialists, reviewing and continually maintaining CAN entry, and conducting file and CAN audits. One Affiliate trained staff on exporting data from CAN, completing the CAN Clean Up projects implemented by MCMC, and conducting internal audits to compare the master list of clients to a CAN export.
 - *Training:* Affiliates participated in a variety of externally provided trainings, workshop, meetings, and conference calls to better understand research, resources, and information pertaining to recovery needs and efforts throughout the state of Mississippi. A few of the activities include:
 - Attended the AMI Training; a training on how to calculate annual median income for HUD purposes
 - CAN Trainings
 - Katrina Citizen's Leadership Corps Report Release Event
 - Attended the "Mental Challenges Post-Katrina" meeting, hosted by IDTF
 - Public presentation regarding the results of a Disparities and Katrina Study, conducted by Jackson State University
 - Attended the MSVOAD Meetings
 - Attended the SMSVOAD Meetings
 - Attended the Hancock Housing Resource Weekly Meetings
 - Attended the Hancock County Long Term Recovery Meeting
 - IDTF/STEPS Coalition Reception
 - *Resources and Collaboration:* The Affiliates continue to leverage external resources to assist the MCMC clients' recovery. During Quarter 5 the Coming Home Collaborative, a project of the Gulf Coast Community Foundation, continued to receive applications, including many MCMC families. At meetings with the GCCF, the agency reports that 175 projects are expected to be funded over the next several months. MCMC is hopeful that at least one of those will be an MCMC family.

This quarter, the Volunteer Coordination Meetings continued, allowing a forum for Affiliates and external partners to meet and discuss the connection between volunteer labor and clients in need of that labor to achieve their recovery plans. This quarter 11 families have been assisted and matched with volunteer labor through this endeavor. There are an additional 20 families on a waiting list. Additional families could be assisted through this process if funding became available to help with material costs.

Additional work this quarter included revisiting current resource listings and searching for new resources that may have been introduced, gathering information from the community about what rental and housing options are available, and working with the FEMA Housing Advisors to identify resources to transition clients out of the THUs.

This quarter conversations about developing a disaster case management certificate program at University of Southern Mississippi took place. The added benefit of a program like this would be that there would be stored knowledge from programs like MCMC at a location that would be easily able to replicate the project in the event of another disaster.

While the affiliates are struggling to strategically meet all the housing and other disaster-caused needs of all their clients, and meet the new level of contact required by MCMC, there are a number of clients that have been able to achieve recovery using one or more of the following housing programs currently available. These programs and activities will continue to be leveraged until the end of the MCMC program or when the resource dissolved:

- MEMA Cottages are being made available to MCMC clients
- The Housing Choice Voucher is being opened to DHAP and Katrina/Rita Displaced individuals
- FEMA is selling Park Models and Mobile Homes for \$1 and \$5 (*stopped taking applications as of 9/18/2009*)
- The Coming Home Collaborative accepted applications and is seeking to fund 175 projects
- Various PHA's in MS opened their Section 8 waiting list between September and October 2009

While not able to meet all the clients' needs, the following resources or activities took place to work clients towards recovery:

- A number of Affiliates have been able to request and receive assistance to pay insurance policies for a year, taxes on the mobile homes, and moving costs
 - Case managers have been working closely with the FEMA sales staff to ensure a smooth process in the mobile home purchase program
 - Moved towards an intensive case management process for clients whose Travel Trailer had been removed by FEMA and who did not have a permanent housing plan or option
 - Referred clients to the WIN Job Center for employment opportunities and job training
 - Assisted clients to obtain rental assistance, security deposit and utility deposits
 - Assisted clients with the translation and collection of supporting documentation to MDA for an Elevation Grants application
 - Coordinated meetings between clients and the Back Bay Mission (Volunteer Group) during the construction of a client's house
 - Advocated with Catholic Charities (post closure from MCMC) on behalf of clients with needs for material funding
 - Assisted clients with filling out applications for rebuild/rehab assistance
 - Informed clients about assistance with school clothing and supplies through Church of Christ
- *Staffing:* The MCMC Affiliates continue to provide high quality supervision to their case managers. A few of the activities that continued through this quarter included regular staff meetings equipped with agenda and meeting notes; internally hosted training and information-sharing sessions which included resource availability, question and answer periods for questions or problems related to individual staffing of cases, DHAP vs. HCV vs. Section 8, MEMA Cottages, the importance of sustainability, and the implementation of the continuation. Individual one-on-one sessions between the case manager supervisor/director and case managers continued, if not increased, to tighten up the case management practices as increased contact with the clients was required in the beginning of the quarter. One Affiliate reported "going back to the basics" at a staff meeting. The case managers were to make their own sample files, highlight important areas, ask questions, and put together their own files to use as a reference. Another Affiliate reportedly visited all offices under their contract to meet with the supervisors, discuss operations, and review practices. Another Affiliate reported reviewing geographic coverage within their organization. While this agency had been state-wide previously, the concentration of caseloads and workloads of

each of the case manager to specific geographical areas will help improve the efficiency of the case management process. Additional staffing activities this quarter included:

- a. Several Affiliates re-staffed and re-organized internally in accordance with the Continuation caseload. For a number of Affiliates this included down-sizing to reflect the large number of cases that they closed
 - b. Supervisors continued to meet with the case managers to conduct active supervision
 - c. Supervisors started scheduling face-to-face meetings with the case managers to review the client files and situations. Case Managers also began turning in files for monthly supervisor audit/checks
 - d. In-house training with case managers took place this quarter on the following topics: case management basics, code of ethics, new MCMC forms, case manager stress/burn out and recognizing signs of trauma; reviewing and clarifying recovery plan objectives and action steps, results, and dates achieved; smart budgeting; and monthly reports
 - e. Several Affiliates transferred cases from case managers who were leaving the agency due to downsizing of staff. Home visits were then made in teams and new paperwork was discussed
- *Best Practice*: The following best practices were pulled from the Quarter 5 Affiliate Monthly Reports:
 - a. Case managers began meeting face-to-face with the supervisor to review the client file. This allowed for interaction and question-and-answer periods.
 - b. Pulled data from CAN, by case manager; then broke apart information and sent each case manager a report of all their clients and the data that is in CAN. Case managers were then responsible for updating the spreadsheet and sending back to the data specialist for entry into CAN. This expedited the process and highlighted the importance of quality data collection to the case managers.
 - c. Due to the travel cost associated with home visits, one Affiliate implemented specific days of the week for home visits. The case managers will now attempt to see as many clients as possible on these travel days. The other days of the week are set aside for office work and follow-up.
 - d. One Affiliate created a case management and supervisor action plan, similar to a recovery plan, to ensure all action steps were taken to achieve compliance with client files
 - e. One Affiliate transitioned all client files into three ring binders to allow for easier filing and retention of paperwork in files

B. Management

The field management team, MCMC/LESM (Mississippi Case Management Consortium/Lutheran Episcopal Services in Mississippi) has been providing the day to day management of the MCMC program. The main responsibility of the MCMC/LESM staff is to provide technical assistance, training and consultation to the ten (10) remaining Affiliates in the field operating in 20 offices throughout the state.

1. *Meetings and Conference Calls*: A total of 4 Supervisors' conference calls and 3 face to face meetings were held with Affiliate Case Manager Supervisors, Directors and Data Entry Specialists. Topics that were discussed including new forms, reporting process, benchmarks and compliance protocols, DHAP to HCV Transition, MEMA Cottages, etc.

The following section shows the trainings, conference calls, site visits, and workshops that the Field Management Team conducted during Quarter 5. The focus of their work has shifted from a manager role to an advisory role, placing more responsibility with the Affiliates to make decisions and guide their work.

- a. *MCMC, Summary Conference training*- The FMT took a lead role in designing and facilitating workshops at the MCMC Summer Conference for Recovery Planning, Data Entry, Assessment, and Documentation. All workshops lasted 1 ½ to 2 hours each and included a power point presentation. The workshops were a combination of lecture, question and answer, and a hands-on activity. The final day of the training included group topics on Interviewing Skills and Lessons Learned, in which the participants were allowed to present case scenarios and ask questions concerning case management issues. The FMT's role in the preparation, implementation, and evaluation of the Summary Conference included:
 - Determined on the areas to focus the conference on
 - Developed training curriculums (Outline of training session for each area, power point presentations to cover the outline, case scenarios for recovery planning activity)
 - Developed new forms (recovery plan form, recovery plan guide, monthly reassessment form, case note form, supervisor review form, disability assessment form, MCMC Release of Information Form)
 - Put packets together for distribution

- Room set up for presentations
 - Presentation of sessions
 - Hand-out and collection of evaluation forms
 - Hand out and collection of sign in sheets
 - Drafted lessons learned document for each session
 - Reviewed and documented pre - post tests
 - Engaged state speakers from MEMA, Department of Mental Health, MS Commission for Volunteer Service (state's office of volunteerism), and the Governor's Office to present during the Conference
- b. *Data Entry Conference Calls* - There were 3 DES calls this quarter with the data entry specialists in addition to the Summer Conference Training. The calls reviewed new and modified fields in CAN, new service profiles in CAN for specific services that MCMC will begin to track and report (MEMA Cottages and FEMA Mobile Home Purchases) valuing services, a review of the MCMC created documents that will aide data entry specialists in their work), and reviewing the Data entry homework assignments that the Affiliates were provided with to review the data accuracy internally and make any necessary changes. Further activities with the data entry specialists included reviewing the Master List of Clients and a CAN Export, the results of the CAN Clean Up Activity facilitated by MCMC Staff, and progress being made using the services provided fields to track the DHAP to HCV Process for the FEMA THU clients.
- c. *M&E Follow Up Visits* - M&E follow-up visits continued into Quarter 5 by the Field Management Team (FMT) to review files that had compliance issues flagged during the M & E visits during the months of January and February 2009. The purpose of the visits was to ensure any areas of discrepancies and actions steps were addressed, resolved and corrected. All visits were completed by early July 2009. At this time, the FMT will transition into the Benchmark visits, outlined below in bullet "e" for continued compliance monitoring.
- d. *Closure Assessment Visits* - The FMT conducted visits and provided assistance to the closing Affiliates that did not continue during the continuation phase of MCMC. The visits were used to determine which *open* cases were appropriate for closure and to assist in the transfer process of the reassignment of cases that would be transferred to another MCMC Affiliate. This process both aided the closing affiliate to ensure all necessary work was completed, but also allowed a smooth transition from closing to new agency.
- e. *Benchmark Visits* - The FMT conducted compliance visits with the Affiliates starting in September and October 2009 to monitor compliance with two of the 11 benchmarks outlined in the 10 Affiliates' contracts with MCVS. The two benchmarks being monitored included: "Clients files document client contacts consistent with Risk Assessment" and "Case Management Findings." The purpose of the visits is to provide first hand observation and analysis of the cases and to assist Affiliates in preparing for program closure and a possible future Office of Inspector General audit. The FMT's focus is to ensure Affiliates are in compliance with the two Programmatic Benchmarks and to assist Affiliates in reaching the benchmark outcomes in order to maintain high quality case management. The visits lasted approximately 3 - 4 hours and included file reviews. Upon completion of the visit, Affiliates were provided with a handwritten copy of the findings on the Affiliate Assessment Form in order for Affiliates to immediately initiate any steps needed to come into compliance with the set Benchmarks. Official digital copies are forwarded to the Affiliate within five days.
- f. *DHAP/HUD/HCV Process Consultations* - To support the Affiliates' participation in the Section VIII process of ensuring all eligible DHAP families apply for a Housing Choice Voucher, the FMT held a consultation meeting with the Affiliates to address program problems and where responsibility for those problems should be placed. This consultation meeting determined that not all of the problems were the fault of the PHA, or the clients. In addition, solutions for solving the problems were discussed and implemented to the betterment of the clients and the program in general.
- g. *(Group) Case Consultations* - The Field Management Team no longer hosts Group Case Consultations visits with the Affiliates. The responsibility of determining which cases are ready to close, and why, has been returned to the individual Affiliates, and under the direction of their Supervisors. The initial case consultations were a success in that case manager supervisors and case managers, through consultation by the FMT, were better able to learn how to identify which cases were ready for closure and assess whether the reason was consistent with program policy and in the client's best interest. At this time, the Case Consultation process, facilitated by the FMT is no longer operational. MCMC will be moving into individualized case consultation meetings with the Affiliates, upon request only (see next bullet).
- h. *Individual Case Consultations* - Four (4) Affiliates requested case consultations with the CMAs to review cases.
2. *Program Management & Partnerships* - During quarter 5, a number of value-added projects or case management discussions took place that were managed or monitored by the Field Management Team:

- a. *Coordination with FEMA, HUD, Region VIII, etc.* – The FMT has developed a strong relationship with the following entities which has proven successful in the sharing of information, resources, and client's recovery
1. FEMA:
 - a. Communication with FEMA at the Affiliate level and the Field Management Team level continues to be successful.
 - b. FMT coordinates with MCMC FEMA Liaison on specific client issues including Congressional inquiries. Congressional inquiries are sent forward to the Leadership Team.
 - c. Affiliates communicate directly with the MCMC FEMA Liaison regarding any client questions or concerns. The FMT is copied on all communications with FEMA.
 - d. FMT receives spreadsheets from FEMA to include clients who have purchased their mobile home, clients that failed 3 air quality tests and therefore cannot purchase their mobile home, and clients that are living in a travel trailer or mobile home, etc. This information is processed internally and then sent to the Affiliates.
 2. Region VIII:
 - a. The FMT is the liaison between the Affiliates and Region VIII. This process is working well for MCMC and Region VIII and they have an outstanding working relationship.
 - b. Affiliates with client questions regarding a Housing Choice Voucher (HCV) or Project Based Voucher (PBV) are communicated through the FMT to Region VIII.
 - c. Region VIII Leadership staff were guest speakers at two of our Supervisor Meetings this quarter. They provided guidance and instructions on the HCV process:
 - ✓ DHAP to HCV check list and instructions
 - ✓ THU to HCV check list
 - ✓ Waiting list flow chart
 - ✓ Housing Quality Standards
 - ✓ Discussed Super Preference
 - ✓ Discussed Katrina/Rita Displaced (second preference)
 3. Other Housing Authorities:
 - a. Cooperation from Region VI, Region VII and Biloxi Housing Authority
 - b. MCMC has had limited communication with other Regional and local Housing Authorities; however, efforts will continue to engage them.
- b. *Sustainability* – Housing Sustainability was a recurrent topic this quarter. One primary topic the FMT assisted the Affiliates with was defining, and teaching, the difference between sustainability and self-sufficiency. The FMT was instrumental in helping the Affiliates determine whether cases were at a stage for closure. Part of this training element focused around the clients that purchased their mobile home from FEMA but were then unable to maintain their homes sufficient to meet the standard of safe, sanitary and affordable. As we document in the challenges section below in section IV, you'll see that clients who purchased their units are still not in sustainable environment for the following reasons:
- Unable to maintain monthly utilities
 - Unable to pay insurance premiums on the mobile home
 - Unable to pay the tax costs associated with changing the title over to the client
 - Unable to afford the moving costs on the mobile home for those who could not remain where they were
 - Unable to pay the lot rents once FEMA stopped the assistance
 - Unable to afford the repairs needed on the mobile home that were not completed by FEMA prior to the sale

As a result, Affiliates continue to work with the households that purchased their units so that the case manager can continue to work with the client to meet their disaster-caused needs that were not completely met following the sale of the unit. Some Affiliates have been able to request and receive assistance for the clients in paying their insurances for a year, the taxes on the mobile home, and moving costs.

Volunteer Coordination Meeting – There were 7 conference calls this quarter. The focus of the call is to share program information, volunteer availability, and to build relationships between partners. The goal is to have this process happen on the ground without external assistance; which MCMC is pleased to see start happening. At this time, a pre-requisite for being matched with volunteer labor is that the family must have

the materials or funds for materials themselves. The VC program slowed over the summer due to low numbers of volunteers coming to the coast during the summer months (this happened even in 2006) and lack of funded projects. One outcome of the group has been the development of a list of volunteer housing resources in South Mississippi with location, capacity, cost, and contact information included. In Quarter 6, the facilitation of the Volunteer Coordination Meetings will be transferred over to MCVS so that it is facilitated in conjunction with the Adopt-A-family project.

- c. *FEMA Mobile Home Program* – The FMT monitored and worked with the Affiliates to ensure that all eligible clients would purchase their FEMA mobile home or park model, if this was the most advantageous housing solution for the client. The FEMA Mobile Home Purchase Program was a success in that it allowed 641 MCMC clients to purchase their mobile homes. This eliminated the need for the household to find another housing situation or for them to move from their current situation. The FMT provided information to Affiliates regarding the MH Purchase Program related to FEMA Mobile Home Sales and paperwork deadlines, air quality testing results, clients pending sales list, etc. The Field Management Team was also able to provide updates to the Affiliates as to where clients were in the process. Additionally, service profiles regarding services that were provided via this process (purchased MH for example) were created by the FMT for use by the Affiliate so that they were able to track data in CAN uniformly. Affiliates were also given information regarding Distribution of Rebate Letters that was distributed to clients who had previously purchased a temporary housing unit directly from FEMA.
- d. *FEMA Clients that Cannot Purchase their unit due to Air Quality Issues* - The FMT distributed to Affiliates a list of clients whose mobile homes failed 3 air quality tests (provided by FEMA TRO). As a result of the final air test, case managers were asked to assist these clients in developing an alternative housing plan. These clients were encouraged to apply for a Housing Choice Voucher under the Super Preference designation.
- e. *MEMA Cottage Survey* - The FMT staff and Affiliates participated in the MEMA Cottage Survey Training held by Haggerty Consulting at the end of Quarter 4, in which information was distributed on the requirements for the Mississippi Alternative Housing Pilot Program. Restrictions, eligibility requirements, and counties involved in the survey were given. The MEMA Cottage Survey was sent to Affiliates serving clients in George, Stone and Pearl River counties to determine if there was a need for the program and if there were clients who would qualify for the one bedroom cottages being offered. Affiliates were given a MEMA Cottage survey and survey instructions. Once surveyed, the Affiliates inputted the survey responses into a spreadsheet. The Affiliates conducted 161 surveys, submitted results to the MCMC FMT, which were then tabulated and forwarded to Haggerty Consulting Firm for further consideration. The results of what was sent to Haggerty are below:

Status of each of the 161 Surveys	Reasons for ineligibility
<ul style="list-style-type: none"> • Eligible—59 • No contact—18 • Already Served by Haggerty —6 • Ineligible—78 ** 	<ul style="list-style-type: none"> • Already Recovered/Rebuilding—32 • Purchased Mobile Home—11 • Refused to participate—11 • Cannot Sustain—2 • Too Many in Household (only one bedroom cottages available)—5 • Disabled (No Accessible Cottages available)—4 • Other (In Prison, etc.)—5 • Unknown - 8

Clients that were identified as eligible are still awaiting further information from MEMA and Haggerty Consulting. During Quarter 5 MEMA reported that it had attempted to contact clients living in the lower 6 counties to determine whether clients were eligible and interested in a MEMA Cottage. A list of clients was sent to MCMC in the beginning of Quarter 6 for review and follow-up. A report-out of that effort and any action steps will be included in the Quarter 6 report.

- f. *DHAP/HUD/HCV Survey and Process* - At the request of the Region VIII Public Housing Authority (PHA), MCMC FMT reviewed its Master List of Clients to determine those clients MCMC was currently working with and living in a Disaster Housing Assistance Program (DHAP) housing situation. The FMT was able to provide this information to the Affiliate assigned to the client so assistance, encouragement and guidance could be given to the client in applying under the DHAP Housing Choice Voucher (HCV) option. MCMC was able to act as the

conduit of information on this project. When Affiliates found that their clients had not received a packet, the PHA was notified immediately. In the end, a number of families were in the HUD database with an incorrect address, which was then corrected. Once the clients were sent an eligibility packet from the PHA they had 15 days to return the required information. As a result of MCMC Affiliate participation in this process, Region VIII saw an approximate increase of 30 % in clients returning the requested information to be considered for a DHAP HCV.

Activities are still continuing to assist clients in:

- Not allowing vouchers to expire (requesting extensions in writing before the 60 day deadline)
- Finding appropriate housing – within budget and able to pass PHA/HUD inspections
- Attending scheduled appointments

- g. *Status of Utility/Rental Deposit Program* - The program is ongoing with approximately \$80,000 available for distribution at this time. LESM has expanded the Utility and Rental Deposit Program to include clients who are purchasing their mobile homes to assist with lot deposits and utility needs (i.e., utility poles and sewerage hook ups). At this time, 60 cases have been presented for funding; of which, 53 were funded. A total of \$16,831.00 has been expended. The greatest barrier to this process currently includes incomplete applications.
3. *Case Management*: During Quarter 5, the FMT worked through two re-assignment processes in which they facilitated the transfer of ninety (90) clients from two (2) closing Affiliates to the remaining MCMC Affiliates. Cases were transferred per the new Reassignment Policy with very few difficulties.
- The PHAs throughout the State of Mississippi began accepting applications for the Super Preference and Katrina/Rita Displaced preference at the end of September 2009. The FMT plans to track all of the Super Preference families to determine which clients have applied for an HCV, which clients have received an HCV and which clients have leased up. At this time, MCMC has placed a request with HUD to provide the same information for comparative purposes; however, our request has not been answered as of this date.
4. *Data Entry* – The Data Entry Conference Calls are now being hosted monthly rather than bi-monthly and data entry specialists are now invited to the supervisor workshop so that the in-person workshops could be cancelled. These changes were made as a result of the reduction of data entry staff at both the Affiliate and Field Management levels. At this time, all data entry clean-up activities, where possible, will be conducted by the Field Management Team and provided to the Affiliates for follow-up and correction. These will be in the form of highlighted error reports to outline the specific data in CAN that needs to be corrected. During Quarter 5, two CAN Clean Up Activities took place:
- a. A comparison of the MCMC Master List of Clients and CAN took place to see whether there were any discrepancies between the two reporting systems. Any discrepancies were sent to the Affiliate to research and fix. MCMC reports approximately a 98% accuracy rate with the # of clients in CAN and on the Master List of Clients.
 - b. The FMT provided each Affiliate with a highlighted report of CAN errors. Each Affiliate received a list of their CAN data with highlights throughout, if there were any missing or inconsistent data being reported. This provided the Affiliates with a step-by-step guide to ensuring their data was correct and accurate. At this time, 100% of the Affiliates are in compliance with all benchmarks associated with CAN Data. The MCMC reflects <10% errors on 100% of the fields in CAN. These activities will continue so that the consortium can continue to have high quality data output.
5. *Policies*: Within the past quarter, three (3) new policies were developed: *Financial and Programmatic Close-out Policies*, the *Case Re-Assignment Policy* and the *Benchmark Compliance Process*.
- a. *Financial and Programmatic Closeout Policies* – MCMC developed comprehensive instructions on both the financial and programmatic requirements under the MCMC grant for those Affiliates that close-out its' MCMC operations.
 - b. *Case Re-Assignment Policy* – The Field Management Team (FMT) developed a Case Reassignment Policy and Transfer Protocol for cases that were being case managed by an Affiliate closing out of the MCMC program. The Case Reassignment Policy will be used to reassign cases for the continuation period. The policy is intended to be a comprehensive plan and includes several compliance elements. The policy is designed to assist with the reassignment of any cases with case status of "Open" to another affiliate, as all affiliate cases

are MCMC consortium cases. The reassignment process is a required element of Program Closure and must be completed prior to receiving final reimbursement for the MCMC program. The process was supported by a site visit by the FMT staff with the closing Affiliate to support them in their efforts.

- c. **Benchmark Compliance Process** - The Field Management Team (FMT) developed and implemented specific benchmark components that would be used to determine compliance with the "Case Management Findings" benchmark, one of the 11 benchmarks developed by the Mississippi Case Management Consortium (MCMC) for the Continuation phase of the program. The development of case management findings was the first time in disaster recovery case management history that an agency was provided with concrete ways of measuring high quality case management services and data entry. The benchmark will be monitored by the FMT during site visits with the Affiliates. The visits and first round of compliance monitoring started in September 2009.
- 6. **Estimators:** The Estimator positions at the Affiliate and Field Management levels were closed out of the program during the phase out of Phase I MCMC. The below data represents a summary of activity:
 - Completed over 90% of the estimates requested
 - Completed 797 construction estimates for Homeowners
 - Identified \$31,667,649.83 in unmet construction needs
 - Provided every renter with an estimated cost of 1 year's rent plus deposits and utilities
 - Assisted case managers in valuing everything from child care to FEMA Mobile Homes
- 7. **Forms** - A successful consortium will periodically review current practices and processes to ensure they are meeting the needs of clients and collecting the data metrics needed for a successful reporting system. In preparation for the Continuation work, the Field Management Team had discussions with the Case Management Directors and Case Management Supervisors from the Affiliates at the start of Quarter 5 to determine what forms the Affiliates felt needed revising and what additional forms should be created to assist in strengthening case management skills. From these discussions following visits the FMT had with the Affiliates, and following client folder reviews, 4 forms were revised and 6 new forms were developed for the Continuation Phase of the Program. The following list includes modified and created forms:

Modified Forms

- a. **Recovery Plan** - The recovery plan was re-designed to allow the case manager and client to develop a more functional recovery plan. The recovery plan no longer has prompting sections with suggested action steps since this was determined to cause more confusion than assistance. The recovery plan that is now in use allows the case manager to freely report the specific need, individualized action steps, and results of each. Case Managers are finding the new form easier to use and the FMT is finding that the case managers are more accurately able to assess outcomes and client results with this process.
- b. **Intake Form (Risk Assessment)** - The Risk Assessment component of the case management program was revisited and revised. Although all MCMC cases continue to require monthly contact, "Client has a Disability" was added as a risk factor and will now affect the level of required contact with the case manager. The Priority Levels and Level of Contact were also restructured accordingly. At this time, the following priority levels are based on the four associated risks under MCMC:

# of Risks	Priority Level	Level of Required Contact
3 or 4	4 = Highest	Weekly
2	3	Twice a Month
1	2	Twice a Month
0	1 = Lowest	Monthly

- c. **File and CAN Audit Forms** - The audit forms used by the Affiliates to review the client files and CAN records were revised to better assist the Affiliates in completing their reviews.
- d. **File Checklist** - The checklist that is found at the front of each client folder to track whether all required documentation is collected was modified to include the new forms that were created.

New Forms

- a. **Monthly Re-Assessment Form** - The Re-Assessment form was created to ensure case managers were re-assessing need and progress on a monthly basis in addition to other key element of the case management process. The form is intended to help case managers and clients stay focused on the current unmet needs and

barriers that brought them to the case management process initially. This process should ensure cases are transitioned in and out of the case management process more quickly.

- b. *Case Note Form* – The Case Notes form was changed to be more result and review focused. The prior form, used by many social and human service systems, allowed the case manager to freely report any contact or notes that pertained to the case management of the client. The new form includes space to report the same; however, the new form adds a section for the case manager to review observations and specific follow-up needed to take place (either Case Manager or Client) prior to the next visit. This will assist the process in prompting the participants in starting the next visit with notes that were taken at the last visit. The revisions will help keep the case manager and client focused on the case management and recovery process.
 - c. *Supervisor Review Form* – A form was designed to assist the supervisors in reviewing each of the client files for areas of needed supervision, errors, inconsistent information, file organization, and follow-up. Stronger supervisory reviews will ensure stronger case management.
 - d. *Disability Assessment Form* – The consortium had been utilizing the Closure/Transfer Form when transferring cases from one Affiliate to a specialized agency (disability or language assistance). After operations began, the consortium had decided collectively that the Affiliates would benefit from a form that would help them provide data to the specialized agency that would clearly detail why the transfer is needed, what work had already been completed, and what work is anticipated. When the case is transferred, the Disability Assessment form will be sent to the "receiving" agency along with the intake, assessment, and recovery plan, if already completed by the "sending" agency.
 - e. *Field Management Team Assessment Form* – The FMT Assessment form was created to document the progress of each of the Affiliates and their compliance with the benchmark component of the program. The form will be used by FMT staff as they visit and assess each Affiliate. The form was created to standardize the work.
 - f. *MCMC Release of Information Form* – The consortium had been utilizing the CAN Release of Information as a way to support the transfer of client information between Affiliates since the transferring of client information was primarily shared via the CAN records; however, when Affiliates began closing, client files were transferred to another Affiliate to continue the process; however, the consortium did not feel that the CAN Release of Information would provide the legal protection the Affiliates needed to share hard client files. As a result, the MCMC ROI was created to foster and support internal communication and collaboration.
8. *Reporting:* During Quarter 5, the following reporting activities took place;
- a. *Case Management Findings* – The FMT developed a list of 12 indicators of high quality case management. The list is used as the basis for the Compliance visits with the field and will be used to gauge whether agencies are 1) in compliance with their contract; and 2) conducting high quality case management.
 - b. *Pre & Post Test* – A Pre-Post test was developed and distributed to all of the participants at the MCMC Summer Conference. The goal was to assess their knowledge of the covered topics at the beginning and at the end of a conference. This would tell the instructors how much new information was learned during the workshops. Further, the attendees were asked to place a unique identifier on both the pre and post test so that the amount of information learned over the two days could be tracked down to the individual. The test included 22 multiple choice questions covering topics from policy & procedure to case management to financial information. The test was distributed at the opening and closing sessions. 226 completed tests were collected (pre and post test combined); of which 88 included the unique identifiers on the pre and post test, and were able to be compared for evaluative purposes. Of the 22 questions; 17 areas covered indicated an increase in knowledge obtained, 2 areas showed no increase, and 3 showed a decrease in the knowledge obtained.
 - One question with an increase in knowledge showed 76 incorrect responses on the pre test and 1 incorrect response on the post test. The content of the question was amply taught and learned during the conference.
 - A second part of the evaluation was to look at incorrect responses by Affiliate to see if any additional training was needed. One example shows that staff at one particular Affiliate had 4 incorrect answers on a question pre test and 4 incorrect on the same question post test. This shows that at the Affiliate level, there was one question that was not learned during the conference.
 - The 88 participants who completed both a pre and post test scored higher on the post test than on the pre test, indicating learning occurred.
 - c. *M&E Follow Up Compliance Visit Reports* - The field management team continued program compliance visits with each of the Affiliates in preparation for program closure. These visits utilized the Monitoring and Evaluation Site Visit Reports that were completed in January and February 2009, as a basis for their visits. These visits were followed with an official follow-up report of cleared and outstanding findings documented

for each Affiliate. As a result of preparation for these visits, the Field Management Team designed a new spreadsheet to accompany the narrative visit reports in an effort to clearly capture affiliate performance related to following up on Field Management Recommendations. The "Findings Form," which incorporated a point value system was incorporated into the M&E Follow-Up Visits and was used as a basis for developing the Benchmark Compliance visit reporting process.

- g. *Documentation* - The Field Management Team continues to document all site visits, site visit reports, communication, trends, issues, questions, concerns, participation, and changes in contact information in the Field Management Database.
 - h. *CAN Summary Reports* - The Field Management Team suggested to the Lead Agency that the CAN Summary Reports be revised to include data fields on open cases only to more accurately understand the current needs of the field. The Lead Agency implemented the suggested changes made by the Field Management Team during Quarter 5 and modified the Affiliate and MCMC CAN Summary Reports.
9. *Staffing*: Contracts with the CMPS and Data Entry Specialist were terminated due to budget cuts. Existing staff will be used to cover those job responsibilities.
10. *Best Practices - Collaboration*: MCMC has seen great improvement and interest in collaborating and sharing of information and resources between government and non-profit agencies in MS. This has led to a large number of MCMC clients being matched with programs that they may not have been successful in obtaining otherwise. MCMC has built a strong and successful partnership with MEMA, Region 8, the FEMA TRO, and the Gulf Coast Community Foundation. These relationships have developed over time and at different level of operation; however, the collaborative environment that has been developed is a significant best practice and one that MCMC hopes will continue during this disaster project as well as future disaster projects.

C. **Lead**

The Lead Agency under the direction of the Mississippi Commission for Volunteer Service (MCVS) has been working diligently to support the field management team and coordinate efforts with FEMA, HUD, MEMA, MS Development Authority, the Mississippi Governor's Office, and a variety of other stakeholders.

1. *Contract*: During Quarter 5, a total of 30 contracts/modifications were executed to take the Affiliates through the three-months of operation during Quarter 5. These contracts included a one month extension followed by a two-month extension to cover the time period while the consortium awaited final approval from FEMA, and finally a long-term contract that will take the Affiliates through March 2010. The short-term contracts were necessary since the consortium continued to use the funding from the first phase of the MCMC, with each contract preceded by an analysis of program costs to determine available funds for continuation of program. The finance and administration teams issued affiliate contracts based on the conditions outlined in the FEMA award letter received in response to the budget and programmatic proposal(s) submitted by the program director during the last quarter.

Prior to receiving written approval of a Continuation extension, the Financial and Administrative teams at the lead agency issued an RFA for continuation of programmatic activities through March 2010. The RFA process was designed to hold Affiliates accountable for complete and accurate reporting, while ensuring the information that was provided by the Affiliates would be sufficient to assist the external review team in making the difficult decisions needed to make both agency and workforce reductions. After the RFA was issued, the financial and administrative staff received the RFA proposals from Affiliates, selected a review team to review the RFA applications, worked with the selection committee to answer technical questions, consolidated reviewer scores of the RFA results, wrote contracts and budgets with the ten Affiliates that were selected to participate in the continuation period. The Affiliates will continue to serve clients based on geographical and programmatic capacities, and implement the MCMC Continuation with additional guidance, reports and trainings. The award letter from FEMA, dated September 17, 2009, included a 50% reduction in the requested costs associated with implementing the MCMC Program for the Continuation. In response to the award letter, MCMC wrote an appeal letter to FEMA in the beginning of Quarter 6 requesting reconsideration of a number of key issues.

The entire leadership and field management teams conducted a training event during the month of August with the goal of providing detailed discussion of the overall case management process as well as to review the new contracts that affiliates entered into for the purpose of the continuation period of performance. The training

workshop was mandatory for all case management and select administrative support staff from affiliates working under the MCMC project.

- a. **Benchmarks:** MCMC strives to provide high quality case management to the clients in receipt of services and developed standards for which the Affiliate's would be expected to maintain over the course of their contract with MCVS. As a result, the consortium has incorporated 11 financial and programmatic benchmarks into each of the Affiliate's Continuation contracts to further support a high quality case management program. The 11 benchmarks and expected outcomes are as follows:

Benchmark	Outcome	Tool for Measuring
Participation in all MCMC conference calls, meetings, trainings, workshops	80%	Attendance
Timely Submission of Monthly Reports, Ad hoc data requests, etc	100% *10% allowance for one-day late	On time submission of all formal and informal written report or data requests
Accuracy of Data Entry (review of 16 areas of "none reported" or Blank)	81%	Fewer than 13 of the 16 sections in CAN have a none-reported number of 10% or greater
Submission of Closure/Transfer Plan – December 15, 2009	100%	On time submission of Closure/Transfer Plan
Clients files document client contacts consistent with Risk Assessment	80%	Collected by MCMC/LESM during programmatic site visits, quarterly
Assessment Development	90%	According to CAN Summary Report, the number of cases that have an Assessment Completed
Recovery Plan Development	85%	According to CAN Summary Report, the number of cases that have a recovery plan developed
Closed Cases	Quarter 5 = July 1 – Sept 30 = 48% Quarter 6 = Oct 1 – Dec 31 = 55% Quarter 7 = Jan 1 – Mar 30 = 70% Quarter 8 = Apr 1 – June 30 = 85%	According to CAN Summary Report, the number of closed cases as compared to the number of open cases according to Quarter
Financial Review Findings	100%	All findings are cleared
Financial Compliance Findings	100%	All findings are cleared
Programmatic Compliance Findings	100%	All findings are cleared

- 2. **Program Closure** – During Quarter 5, two Affiliates entered the program close-out phase of their contracts, following the RFA process outlined above in #1. At this time, there have been three (3) Affiliates that have closed out all financial and programmatic operations and are no longer affiliated with the MCMC program. There are ten (10) Affiliates currently operating under the Consortium and there no Affiliates that are in a Program Closure phase-out of their contract with MCVS.
- 3. **Collaboration and Communication:** The MCVS/MCMC staff continues to find success in setting up meetings with a number of external partners including local and state employees and legislative representatives. The focus of the meetings continues to be to educate individuals on the importance of supporting a disaster case management program for the recovery of Mississippians as well as to encourage the exchange of information between entities. A number of meetings that were convened this quarter included:
 - a. **HUD** – Ongoing meetings with local PHA representatives, as well as state and federal level HUD representatives so as to understand the processes associated with new voucher allocations available within the state.
 - b. **Recovery Taskforce** - The Executive Director and the Program Director attended weekly workgroup meetings that included representatives from all levels of state government including state elected officials' staff, the Governor's office, the Mississippi Emergency Management Agency, FEMA, and the Mississippi Development Authority. Each attendee provides a verbal report of activities within their offices as those activities relate to recovery.
 - c. **Region IV VOAD conference calls** – The Program Director of the MCMC program continued participating on the Region IV VOAD conference calls to ensure agencies were sharing information with local agencies providing services on the ground in MS.
 - d. **MCVS Monthly Board Meetings** – The Executive Director and Program Director briefed the MCVS board members about the clients MCMC serves. The presentation included data provided by the M&E specialist, finance and accounting staff, and Field Management Staff.
 - e. **MS Recovery Partners Meetings** – The Executive Director, the Program Director, and other members of the leadership team set up and facilitate the monthly MS Recovery Partners meetings with representatives from

MEMA, MDA, FEMA, HUD, Gulf Coast Community Foundation, Housing Resource Centers, the MS Governor's office, and three Congressional leaders in MS to continue their cooperation in finding resources for Katrina clients throughout the state. These meetings continue to strengthen the cooperation between the entities to locate and make available additional resources to MCMC clients as well as clients of the other entities.

4. **Financial Compliance:** The Financial Director of MCVS has been engaged in the MCMC program processing monthly payments to affiliates; maintaining positive cash flow; and providing internal controls to ensure financial compliance.
5. **Finance:** During Quarter 5, a total of three (3) financial conference calls took place with the Affiliates. These conference calls were used to provide financial update/information, to share information and resources, and to respond to questions regarding financial implementation of MCMC. This quarter, the ongoing financial requirements of the program included: closing out thirteen (13) MCMC Affiliates for contract period ending July 31, 2009; responding to questions regarding financial implementation of MCMC; providing ongoing technical assistance to Affiliates through e-mails and phone calls; receiving, reviewing, revising (if appropriate or necessary), and recording Affiliate Cost Reimbursement Requests; submitting Affiliate Cost Reimbursement Requests to Mississippi Commission for Volunteer Service for payment; distributed funds to Affiliates; revising and continuing to develop SF 270 documentation spreadsheet for Affiliate and consolidated cost reimbursement request to FEMA; conducting on-site contract compliance reviews with all Affiliates and preparing reports with findings/recommendations; preparing SF 270s and SF 269s for submission to FEMA; regularly tracking expenditures according to budget line items; receiving, reviewing and approving Financial Close Out documentation for period ending July 31, 2009; preparing 424 series for submission to FEMA; and reviewing Affiliate and field management budgets to ensure costs are within approved budget limits.
6. **Public Relations:** The public relations staff person has been responding to requests for information as well as promoting a positive understanding of the MCMC program in the field. Over the last quarter, the Public Relations Director has continued to monitor daily Google Alerts for "MCMC," "Katrina housing," and "FEMA," and the names of each of the Affiliates, and monitored external articles written about the MCMC. This quarter, the following articles were written:
 - Cochran Reports \$5.6 million, Eight-Month Extension of Miss. Disaster Case Management Pilot Program (18 Sept. 2009) <http://yallpolitics.com/index.php/yp/post/18490/>
 - 4 Years After Katrina (publication of the Office of Gov. Haley Barbour) (August 2009) <http://www.governorbarbour.com/images/28.8.09FourYearsAfterKatrina.pdf>
 - Fewer Than 100 FEMA Trailers Remain Locally (27 July 2009) <http://www.gulflive.com/news/mississippipress/news.ssf?/base/news/1248689725259080.xml>

Quarter 5 held a variety of additional activities for the Director of Public Relations. This staff person took the lead in coordinating all activities, workshop agenda development, working with hotel and venue staff, to ensure that the MCMC Summary Conference was a success. The conference took place at the Jackson Marriott for all MCMC team leaders, Affiliates, case managers, field management staff, data entry, and financial personnel. The Director of PR also reviewed and evaluated the evaluation forms for the conference and was overwhelmed with the positive feedback and comments. Some of the results of the evaluation are as follows:

- Data Entry workshop: 4.73/5
- Recovery Planning workshop: 4.84/5
- Assessment workshop: 4.79/5
- Documentation workshop: 4.82/5
- Case Management Activity: 4.73/5
- Supervisor workshop: 4.87/5
- Financial workshop: 4.89/5

The Director of PR continues to work with the MCVS's Volunteer Center network and the 1-800-Volunteer.org initiative to coordinate volunteer activities on behalf of MCMC and MCMC clientele. At the end of Quarter 5, this position took over the facilitation of the Volunteer Coordination Conference Calls so that it can be integrated into the work of the Adopt-A-Family activities. The "Adopt a Family" project is being developed to help finish houses, linking clients up with potential donors, and will include a state of the art website that will showcase families available for "adoption" and a separate section for highlighting successful renovations/completions.

7. *Website:* The MCMC Webmaster continued this quarter answering all MCMC related emails, monitoring site statistics, and managing updates to the website. At the beginning of Quarter 5, the Webmaster was successful in locating a new and cost-effective host site to allow MCMC to expand the amount of information being shared through www.mc-mc.org. This project included reassigning email space until a new host could be secured, setting up a new hosting account for the website, recreating all staff email accounts, changing over website host DNS and managing staff's technical questions with the change, building the new site and carefully moving all content and email usage to the new site without interruption to either staff or the public using the MCMC website. The Webmaster also conducted significant work to ensure that the Adopt-A-Family project would be both professional and functional in its execution. Work related to the project included researching and registering new domain names for the Adopt-A-Family project, creating a new logo, and designing and building a new section on the MCMC website which will eventually host the Adopt-A-Family project.
8. *Monitoring and Evaluation:*
- a. *Reporting:* The M&E team continues to monitor data from three sources; FEMA, Monthly Affiliate Reports, and CAN. This quarter, the following reports were completed:
 1. Maintain Master List of Clients for consortium; updated regularly with new information provided by the Affiliates, FEMA, and other sources
 2. Continue to receive a list of cases living in FEMA THUs monthly, and continued to review the Mobile Home Sales monthly. After review each month, a short analysis was completed and submitted to the Field Management Team for review.
 3. CAN Summary Reports for Affiliates – Individual reports for the Affiliates to highlight their data entry progress and case management status for the MCMC program
 4. CAN Summary Reports for MCMC – A comprehensive report of all the Affiliate data that highlights the case management status for the MCMC program. Following this report, a short analysis of the information was completed and sent to the Field Management Team for review
 - b. *Evaluation:*
 1. *MSU -* The MCMC contract with MSU was completed, with a final report submitted to MCMC on August 31st. The report outlined the methods used and the results from each of the following projects; Case Manager Focus Groups, Case Manager Web Survey, and Client Satisfaction Survey. The report can be requested by e-mailing info@mc-mc.org.
 2. *Program Evaluation:* The MCMC team is currently developing a consortium-wide evaluation to review and respond to the qualitative and quantitative questions posed by FEMA in the Program Guidance document dated August 2008. Program Evaluation will take place during the closeout of the grant.
 3. *FMT Strategic Planning Document and M&E Responsibilities:* This quarter, the lead agency staff provided the FMT with some overview and planning documents to assist the team in review current practices and transitioning M&E responsibilities to the remaining FMT staff members. As such, two documents were created: a Strategic Planning document, and the "Field Management Team Monitoring and Evaluation Responsibilities." These documents were designed to assist the field management team as they evaluate current practices and processes, and understand the management roles and responsibilities for successful consortium activities.
 - c. *Policies and Procedures:* The lead agency staff reviewed and approved three new policies/procedures and 10 new or modified programmatic forms this quarter, developed and implemented by the FMT. Those policies are discussed in more detail under the FMT Activities section 6.
 - d. *Policy and Procedure Manual:* The MCMC Policy and Procedure Manual was revised this quarter to reflect the changes implemented during the Continuation of the MCMC program through March 2010 as well as incorporate the new policies and forms.
 - e. *Other:*
 1. *MDA Housing Study -* In July 2009, MCMC conducted a special request project with the Affiliates to assist the State of MS to better understand the current housing situation of MCMC households that had transitioned out of their Travel Trailers. The study included 504 households; MCMC was able to provide the current housing situation for 402 of those. The results were sent to MDA and incorporated into their state-wide Housing Study. The results of the study are below:

% of cases with known status	Explanation
24%	Moved back into Damaged Dwelling; repaired or unrepaired
25%	Client is living in a permanent or semi-permanent housing (apartment, house, camper) situation with no subsidies (may be paying rent, mortgage, or none if none is required)
6%	Client is living in a permanent housing (apartment or house) situation and receiving a housing subsidy from a government source (i.e. Section 8, Housing Choice Voucher)
7%	FEMA reports that the client has moved out of the FEMA Travel Trailer; however the client reports that they are still living in the FEMA Travel Trailer Housing Unit
0%	Client was not living in a Travel Trailer, client was living in a Mobile Home or Park Model OR client was in a TT but the unit was swapped with a MH/PM... and is still living in a MH/PM that has not yet been purchased
8%	Client has purchased a MH/PM (either through FEMA or otherwise)
24%	Client moved in with friends or family
4%	Client moved into a shelter or other transitional housing
In addition, there were 102 cases (20% of the names provided) for which MCMC was not able to furnish a current housing situation (not assigned to MCMC, case relocated, case was a No Contact, case was a Refused, case had been non-compliant and case managers were not able to obtain a current housing situation)	

2. *Closing out Phase I / Opening Continuation* – This quarter the Affiliates were required to consolidate a final Phase I caseload list so that the clients served prior to the Continuation would be separated from those that would continue to receive services during the Continuation phase.
3. *Instruction Documents* – MCMC revised the "Instructions to Reports" document that provides step by step instruction and associated definitions of all the new fields requested in the monthly reports from the Affiliates. A second companion document was created to specifically assist clients in closing out the Phase I program and opening the Continuation program.
4. *CAN Summary Reports* – The CAN Summary Reports underwent modifications to more accurately represent the data being presented to the Affiliates specifically and FEMA and public more generally. It was decided to report certain data points on OPEN cases only. Those fields include:
 - o # of cases with a Needs Assessment Completed
 - o # of cases with a Recovery Plan Developed
 - o Risk – No Source of Income
 - o Risk – No Long Term Housing Plan
 - o Risk – No Permanent Housing
 - o Risk – Client has a disability
 - o Level of Contact
 - o Priority Level
 - o Employment Status
 - o Types of Income
 - o Amount of Household Income
 - o Amount of Household Expenses

In addition, additional counties were added to the report. The originally list of counties used was based on the original list of cases that were assigned by FEMA in August 2008. The list of assignments has changed since that time and the CAN Summary Reports were modified to reflect those changes.

- f. *Training:* Two workshops were hosted this quarter with the Affiliates, focusing on the MCMC reports and process. The first was during the Summer Conference with Supervisors to take them through the new reporting templates, new processes, and new instructions. The second was an informal session with data entry specialists and/or supervisors to take them through the reporting templates and answer any questions. The reporting workshops were critical as the Affiliates' reviewed their list of assigned cases and worked to close out the Phase I part of their contracts before entering into the Continuation phase of programmatic operations.
9. *Administration:* During Quarter 5, all Leadership team members participated on weekly conference calls or updates and met monthly for staffing meetings. The two Administrative positions at the MCVS level have become more distinct in responsibilities and focus. One continues to be entwined in the financial work of the consortium; the staffer helped the finance team write minutes for the financial conference calls, helped manage the RFA

application and review process, arranged and compiled information in compliance with OMB Circulars, compiled financial documents for administrative files, reconciled invoices, managed payroll and processed payment mail outs, and coordinated all administrative requests and file transfers between MCMC and the MCVS Board of Directors. This position also assisted the Director of Public Relations structure the new Adopt-A-Family program for the new website.

The programmatic Administrative position was responsible for reformatting the consortium-wide calendar of MCMC meetings, conferences, and events into a two-year easy to read reference document; acted as the primary liaison for processing all website changes from the lead and field management teams as well as the info@mc-mc.org inquiries, edited and proofed correspondence and reports, and prepared the agenda and wrote the minutes for all meetings that included the lead agency staff. This quarter, this staff person continued to provide the administrative support for the MS Recovery Partnership Meetings in Gulfport, including development of the agendas and minutes. To prepare for the Continuation, the programmatic administrative assistant assisted the Program Director in preparing emails and reviewing all contracts prior to sending out to the Affiliates. The programmatic administrative assistant has begun assisting the M&E Director with reviewing and compiling the monthly affiliate narrative reports which helps to support and organize the 40 reports that make up the quarterly reports to FEMA. This work will continue next quarter.

The administrative assistants assisted the Director of PR prepare for the MCMC Summary Conference with tasks including site logistics, formatting and standardizing power point presentations, and consolidating and formatting handouts for workshops.

II. Details of accomplishments this quarter

This section focuses on the work and accomplishments as outlined by the Affiliates, Field Management Team, and Lead Agency. As a Consortium, the progress made towards accomplishing the target of the program within a very short timeframe is tremendous.

A. Affiliate

1. *Case Management:* Quarter 5 has been an opportunity to improve the quality of program supervision in the field. One Affiliate reported creating a new system where the case managers completed a calendar of activities which are then turned into their supervisor for review. This has allowed for more supervision and feedback as well as accountability.

One of the challenges of the consortium is working with clients that were not engaged in the case management process from the beginning. One of the ongoing accomplishments of the consortium is when one of its' affiliates successfully engages cases that had been previously coded as "refused" or "no contact." These clients are able to engage in the process and commence case management.

With the discussions of sustainability this quarter, one Affiliate reported contacting all their closed cases to assess sustainability. The Affiliates are being more mindful of the reason cases are closing out the program and many affiliates are reporting success in closing a large number of cases for Recovery Plans Developed and Primary Needs Met. Affiliates also report that the housing situations are being met through external partners working with the case managers including the FEMA Mobile Home Sales, The Housing Choice Vouchers, and MEMA Cottages. At this time, additional resources are needed for rebuilding and repairing damaged dwelling.

2. *Resources:* Affiliates are utilizing each other as resources. Two affiliates reviewed the list of assignments that were made following the close-out of two Affiliates and decided to swap cases between the two Affiliates based geographic coverage and budgetary (travel costs) reasons. The affiliates reported that the process was smooth and open. This is a great example of a consortium working together as opposed to work in competition.

The MCMC Affiliates are working diligently to locate resources to assist the clientele. At this point, a large number of clients are in need of repairs/rebuilds and, more importantly, locating funding to achieve these goals. This quarter, a number of resources were successfully located and utilized to move cases into permanent and affordable housing situations. One affiliate reported that they were successful in obtaining an elevation grant for a client whose home required an elevation but did not have the funding to meet the requirement. Another Affiliate reported that almost every client that they were working with has now applied for a Section 8 voucher; the only two clients that did not apply include an appeal and another client who would not be eligible for a

voucher. Another Affiliate states that a number of their clients have successfully completed job training at MS Trained and Ready Program; and that these clients will now be able to increase their earning potential and their ability to sustain their housing situation. Several Affiliates report success in locating either the funding or direct donation of bedroom or other basic furniture for families who were transitioning from a THU into permanent and sustainable housing. An additional resource was located this quarter called the "Silver Lining Mobile Home Purchase Program" which will help additional families purchase a Mobile Home.

Affiliates have been successful in helping their clients purchase their mobile home through FEMA for \$1 and \$5. Once that takes place however, clients struggle to locate funding for the large costs associated with that purchase. As a result of the mobile home clients, Affiliates advocated that the LESM Rental and Utility Deposit program be expanded to include funding for mobile home utility installation, connection, and service providers. Due to this advocacy work, LESM expanded the program and now provides utility deposit assistance for the above aforementioned costs. This resource, in collaboration with the FEMA Mobile Home Sales program has moved hundreds of clients into permanent and sustainable housing situations.

3. *Staffing:* More affiliates are reporting more interaction and supervision between the case manager and supervisor. These opportunities are improving the case management being provided as a result of the increase in supervisory oversight and feedback. One aspect of the supervisory accomplishments this quarter was the open communication between supervisor and staff, which was facilitated by the MCMC Compliance Visits. Supervisors took the opportunity to discuss the areas for needed improvement with their staff so that the group could then work together to meet the challenge and compliance issues. Open communication is a key aspect for providing high quality program management of the grant.

B. Management

1. *Case Management Findings* - The FMT has developed quality indicators for disaster case management to determine whether a program is conducting high quality case management. If these are successful in gauging programmatic success, the indicators may be replicable in future programs.

All agencies are reporting great success in getting their clients to apply for subsidized housing. One Affiliate was able to report specific outcomes to document their efforts of moving families into subsidized housing; 37% of their households that were referred for subsidized housing were approved; and of that number, 90% have moved into their units.

2. *Volunteer Coordination Conferences* - 3 families have recovered as a result of this resource facilitated initially by MCMC and now by MCVS. Of those 3 families, all have closed out of the MCMC program as a result of this resource.
3. *Benchmark Compliance* - The MCMC Field Management Team conducted Benchmark Compliance site visits during the months of September and October 2009 with all of the 10 Affiliates. The visits will continue throughout the MCMC Continuation period to assist Affiliates in meeting and then maintaining the Benchmarks that have been set for this contract period. Affiliates were provided with the Benchmark Compliance Process and the Affiliate Assessment Form that were used to document the visits with each Affiliate. Through these visits, the FMT was able to identify problem areas within the Affiliates. This helped the FMT to focus in on specific areas that the FMT can assist the Affiliates in improving. As a result of the visits, the Affiliates became more aware of the benchmarks and what problem areas were seen in their case files. They were given recommendations on how to correct the problems to avoid non-compliance in their contract with MCMC. In addition, these visits resulted in Affiliates being able to see the progress and improvements they had made since the beginning of the MCMC Pilot Program.

C. Lead

1. *Contracting:* The MCMC program was granted a continued period of performance as a result of legislative action which authorized FEMA to continue to reimburse the state for case management activities related to the recovery from Katrina. MCMC provided a programmatic and budget proposal to FEMA which was granted with certain conditions that are being appealed by MCVS in the beginning of Quarter 6. Affiliate contracts were issued based on the initial award letter and will be modified once the appeal process is complete, if necessary. MCMC was able to operate for fifteen (15) months on the budget that was approved by FEMA to support a nine (9) month case management disaster program. At the end there was a surplus of \$0.34 which was promptly returned to FEMA.

2. *Advocacy and Collaboration:* The members of the leadership and field management teams continued to advocate for the continued support of the MCMC infrastructure which has greatly enhanced the ability of the state to address complex human service issues related to Katrina/Rita recovery. An accomplishment this quarter relates to the actions taken by the state to ensure that housing vouchers which had recently been made available within the state are able to be targeted to individuals and families residing in temporary housing units (THU's). Much of the discussion that MCMC has facilitated over the last several quarters has involved the continued housing needs of clients and their inability to afford the rental options that have been built as a result of the long term workforce housing programs funded by MDA. Through reporting, discussion, and advocacy, a new initiative approved by Congress allowed for approximately 3,000 new housing vouchers to be made available through the public housing authorities within the state. MCMC advocated that these vouchers not be concentrated among the coastal counties, but be made available statewide with the option of portability so that clients are able to access the voucher no matter where they may reside within the state. This process has begun and THU occupants are now able to take advantage of a long term housing option that was unavailable just 6 months ago. MCMC, through its facilitation of recovery partner's meetings, has been able to create a sense of collaboration, not only among the consortium affiliates who are providing disaster case management services, but also among the various state and federal entities who continue to provide resources and partnership in an effort to work smarter through the recovery process.
3. *Website* -Began building a website to host the Adopt-A-Family project which will connect clients with financial needs (rebuild, repair, etc) with sponsors throughout the country.
4. *Monitoring and Evaluation:* *There were a number of accomplishments this quarter within the auspices of data and reporting.*
 - a. *Reporting* - The Affiliates moved into an automated system of data which was supported by a summary template report in Excel with built-in formulas so that the calculations of data would be made for them (# of Open Cases, # of cases with a rental need, etc). This was done to advance the way the Affiliates report data and reduce the amount of administrative time needed to consolidate MCMC required reports.
 - b. *CAN Summary Reports* - Changes made the CAN Summary Report will assist the managers as they review program information on their currently open cases under MCMC. With these changes we expect the Affiliates to utilize the reports to more accurately target specific areas of needed improvement. One area for example reviews the level of required contact. This area will assist the affiliates in ensuring the workload of the case managers remains consistent, and will assist the affiliates in identifying whether the percentage of the levels of contact under each area (weekly, twice a month, monthly) appears consistent with current level of visits with the clients. These changes will improve the quality of service and accountability of programmatic operations.

III. Success Stories/Case Studies this Quarter

Below are a few success stories from Affiliate, the Field Management Team and the Lead Agency. Each Affiliate reports unique success stories monthly which can be obtained by emailing info@mc-mc.org.

A. Affiliates

Boat People SOS: Client is a 50 year old woman who lives with her 52 year old disabled husband and 4 children in East Biloxi. They arrived in Biloxi more than 10 years ago from Vietnam. They both worked hard to support their family and put one son through college. After years of hard work and saving, she purchased a small modest home in February of 2005. Her joy and happiness did not last long as Hurricane Katrina wreaked havoc on the Gulf Coast and her home was flooded as a result of the storm surge. All of her personal items were destroyed. She did not have insurance and received little assistance from FEMA. The family resided in FEMA travel trailers for more than 3 years while she worked odd jobs to support her family and repair her home; however, her savings were only enough to purchase building materials. She could not afford to hire the contractors to do the work. BPSOS case manager coordinated with local construction volunteer groups to assist with the repair as well as securing additional funding for cabinets, flooring, appliances and furniture. Her home is now completed and she and her family have finally moved out of the FEMA trailers. After 4 years of living in temporary housing, the client and her family are living in permanent, safe, secure and sustainable housing. This family displayed courage, resolve and the "never give up" spirit that enabled them to overcome any obstacles - even the worst natural disaster in America.

East Biloxi Coordination, Relief, and Development Agency (EBCRRA): Client was renting a 2 bedroom, 1 bath house before the storm. After the storm, client did not have any plans for permanent housing. Client received \$300.00 from the American Red Cross and \$14,664.06 from FEMA. The client has used these funds to maintain his monthly living expenses and necessities since the storm. At present, client is in permanent housing subsidized by Section 8 Housing. Client is able to maintain his monthly expenses and have extra money to set aside for emergencies. The client is happy and content with his recovery and has no other unmet disaster-caused needs at this time.

Institute for Disability Services (IDS): The client was living in a FEMA trailer and got frustrated when he kept hearing from FEMA personnel that the trailer would be pulled. After the calls, the client moved out of the trailer and into an old bus on his property. He then called FEMA and asked them to pick up the trailer. The case manager was able to obtain funding from the Salvation Army for a nice used mobile home which was delivered to the client's property with all appropriate furnishings. The case manager brought him a few household items from the IDS home closet. He was extremely happy. After the process, the client, who is disabled, informed the case manager that he wants to attend school at USM to get a degree in social work. The case manager noticed that he was reading old social work text books so she helped the client complete the application. We are now waiting to hear if he has been accepted to the school.

Internal Relief and Development (IRD): The client, who was previously not working or willing to go back to school, has since enrolled in a program to complete her GED and has successfully completed a component of the program for job skills. As a result, the client is now employed and is excited to be on her way to establishing stability for herself and her two children.

Disability Resource Mississippi (DRMS/formerly MSPA): Case managers have had a difficult task of getting one client to understand the importance of getting the proper permits from the county to elevate the FEMA mobile home. After working with county and city officials on behalf of, and with, this client, the case manager assisted the client in obtaining the necessary permit three days before the mobile home purchase deadline. The client was able to purchase the mobile home for \$5.00.

Recover, Rebuild, Restore Southeast Mississippi (R3SM): Ms. N was one of many Hurricane Katrina victims who lost everything. She has since replaced most of her personal property and secured permanent housing by purchasing her FEMA mobile home. However, her recovery was incomplete because her daughter needed a bed. Thanks to the generosity of an anonymous R3SM donor and advocacy on the part of her case manager, Ms. N received a lovely queen size bed.

Client #2 is a 52-year-old female who began her road to recovery in a FEMA travel trailer. From the travel trailer, the client was able to rent a full-size mobile home in the same mobile home park through the DHAP Program. When the DHAP Program closed, the client was able to rent a one-bedroom house through the Section VIII Program. Currently, the client's share of her rent each month is \$75.00. The client is on a fixed income and is disabled. She volunteers at a Senior Day Program Monday through Friday of each week doing clerical duties, cooking, and assisting with activities. The client was very motivated during her recovery period and has kept copies of all paperwork since the storm. Her case was approved for closure recently as 'Recovery Plan Achieved'.

Recovery Assistance International (RAI): Mr. SL's case was opened on March 02, 2009 with RAI. Mr. SL is a 51 year old male who prior to Hurricane Katrina was working as a maintenance man at T. Estates where he also rented a three bedroom trailer with his wife. His trailer was damaged beyond repair during the storm and subsequently moved into a vacant trailer for approximately a month. They were forced to leave the trailer in which they were residing and sought shelter in a friend's van for a year. The SL family was able to save money and rented a trailer while Mr. SL worked in construction. When they could no longer afford the rent at the trailer they returned to living in their friend's van. Two years after Hurricane Katrina the couple received a FEMA trailer and moved to a FEMA trailer park. Mr. SL's wife passed away on January 2, 2008 from liver failure. He himself has been diagnosed with lung cancer and finished his last treatment on Friday March 13, 2009. His back injury and health prohibit him from being able to do any strenuous labor; therefore he has had a difficult time securing employment. He moved to Jubilee Inn on September 22, 2008 and was receiving assistance from FEMA with his housing and food needs. FEMA stopped assisting with his rent there on March 13, 2009 and became homeless once again and wandered from place to place.

Mr. SL's case manager attempted to secure temporary shelter for him through The Salvation Army and Back Bay Mission but he was not able to stay in a shelter because of his health condition. The case manager then attempted to secure permanent housing for him through Biloxi Housing Authority and a Blessed Francis Church affiliate; however, since he was in and out of the hospital due to several health complications, those options did not prove successful either. The case

manager then referred the client to the Biloxi Veterans Administration to speak with a patient representative and apply for disability as well as receive assistance with his health needs. Mr. SL was able to contact a patient representative and as a result has been approved for his disability and has been receiving continual assistance with his health concerns. His case manager had a difficult time maintaining regular contact with him due to the fact that he did not have an address and only limited access to a phone. However I am happy to report that as of September 17, 2009, Mr. SL has secured permanent housing renting a room from a friend. He has also attained employment at a construction company doing sheetrock work. Although he has had to overcome dire circumstances he has persevered and overcome many adversities but with continued support and assistance he has been successful. The last phase of his recovery involves him being able to secure his very own housing one day. These success stories are what case management is all about and I am glad to have played my part in it.

Waveland Citizen Fund: Maintaining Case Managers without attrition – this is critical to have until the end of the program

B. Lead Agency (MCVS)

1. *Contractual:* Program implementation in accordance with contract terms, conditions, FEMA program guidance and required OMB circulars; and successful application for continued funding through FEMA
2. *Reporting:* Consortium-wide reporting templates are an important component of programmatic operations. It is important to have a dual-reporting mechanism so that the data in one source can be compared and consolidated with a second incoming source. Using CAN exclusively will prohibit the collection and monitoring and all client data. As a result, we highlight suggest in all future disaster case management programs, that two reporting mechanisms be required.
3. *Data Entry Staff:* Data Entry Staff with the Affiliates must be maintained at a high staffing level; 15:1. This will ensure that dedicated staff is constantly working to review, monitor, and update data in CAN. There are currently 140+ required fields in CAN that all MCMC affiliates are to use. Decreasing the number of data entry staff will make accurate reporting near impossible, as case managers are required to maintain contact with their clients and may not understand the importance of quality data entry and auditing.
4. *Administration:* The MCMC Conference was remarkable. Most attendees were quite complimentary of the format and structure of the workshops and sessions. Now that the MCMC has operated for one calendar year, we are able to look back at our work to see where we can troubleshoot and better our operations. This will not only strengthen the MCMC, but provide a better national model for Disaster Case Management.
5. *Webmaster:* In response to the overwhelming email usage and uploads needed to support the MCMC program, the Webmaster created a new host environment and moved the entire website to a larger host server. The move was supported by internal help documents to assist staff in making the necessary changes to their computers and a seamless DNS change with no publicly evident issues or problems.
6. *Resources and Collaboration:* MCMC was instrumental in the facilitation of state and federal partner meetings aimed at aligning resources necessary for the recovery of the population of clients we serve. There were numerous productive meetings held between MCMC leadership, FEMA, the state, and political representatives this quarter which resulted in some viable solutions to the end of the temporary housing program administered by FEMA. Many clients were able to purchase mobile homes, access housing vouchers, and move to more permanent housing solutions as a result of the joint resource and planning meetings that were convened at the request of MCMC leadership.

IV. Challenges Experienced During the Quarter & Action Steps Taken or Planned to Overcome Challenges

Challenges Experienced during the quarter	Action steps taken or planned to overcome challenges
Affiliates:	
Case Management	
Case documentation needs to be complete, including case notes and recovery plans with outcomes and target dates	<ol style="list-style-type: none"> 1. Meet with case managers regularly and review files 2. Conduct monthly case review 3. Provide training, examples and practice 4. Use the Supervisor Review Form and File Audit for to strength case documentation
Clients agreeing to meet with their CMs according to their level of contact	<ol style="list-style-type: none"> 1. Setting up regular appointments with the clients 2. Calling ahead 3. Leaving appointment cards
Meeting required face-to-face contacts with elusive clients	<ol style="list-style-type: none"> 1. Conduct unscheduled evening visits
Assisting unmotivated clients in creating measurable, client-driven Recovery Plans	<ol style="list-style-type: none"> 1. Assist unmotivated clients in identifying specific challenges, action steps to overcome, and setting realistic target dates 2. Recognize clients who meet goals and target dates
Working with clients with felony convictions	<ol style="list-style-type: none"> 1. Explore options, unsure what resources are available
Resources and Collaboration	
To secure sustainable housing for remaining clients	<ol style="list-style-type: none"> 1. Referred clients to PHA for applications 2. Assisted clients to fill out applications as necessary 3. Met clients on regular basis to ensure clients follow up with deadlines and appointments 4. Secured funding for deposits and basic furniture for clients moving into permanent and sustainable housing 5. Referred clients to WIN Job Center for employment as a first step to increasing income
Finding resources for clients; specifically clients with mental health needs	<ol style="list-style-type: none"> 1. Researched for additional resources within the community and governmental agencies 2. Organized resource documents for case managers to utilize 3. Utilized the Housing Resource Specialist to locate resources 4. Continue discussing at meetings
Staffing	
Keeping staff motivated as they work themselves out of a job	<ol style="list-style-type: none"> 1. Kept the working environment positive 2. Continually focused on the positive results of the program
Improve time management skills	<ol style="list-style-type: none"> 1. Scheduled clerical case work days at the office 2. Scheduled weekly half-days to conduct file reviews and/or training
Getting staff to use new forms	<ol style="list-style-type: none"> 1. Provided in-service training on new forms 2. Ensured staff have access to latest version of forms
Loss of entire staff including Case Management Director, Supervisor, and Case Managers at one-Affiliate	<ol style="list-style-type: none"> 1. Hired new director with MCMC and management experience 2. Learned MCMC Continuation Requirements 3. Provided training on new processes of MCMC Continuation 4. Hired replacement case manager
CAN / Data Entry	
Services provided are not all listed in CAN	<ol style="list-style-type: none"> 1. Met with case managers to determine issues of getting information into CAN 2. Planned a day where all case managers get together and add services provided to CAN 3. Continued to add services provided in CAN as instructed by MCMC management team
High quality client data	<ol style="list-style-type: none"> 1. Conduct CAN Audits according to MCMC schedule 2. On-going monitoring of CAN data versus data in client's file
Administration	

<p>The increase in contact with the client has caused agencies to over-spend on the mileage line item</p> <p>With the extra visits and the added paperwork necessary to meet the new reporting and face-to-face contacts, it is a challenge for our CMs to complete their jobs without earning overtime, and within the travel cost line item</p> <p>Not enough funding for data specialist position</p>	<ol style="list-style-type: none"> 1. MCYS included in its appeal to FEMA an increase in the Travel Line Item Understand that the level of contact is frontloaded and will decrease over time as cases are closed 2. Worked with MCMC financial staff to move line items around to meet the travel cost needs 3. Met with case managers to troubleshoot challenges of meeting clients according to the risk assessment 4. Case managers started providing monthly calendar to supervisor 5. Used rental car when it is determined to be cheaper than personal car 6. Transferred cases to/from sister affiliate to increase efficiency 7. Attempted to keep caseload as low as possible for each case manager 8. Case Managers are completing CAN reports and updates 9. Case Managers are being trained to take on data entry assignments
<p>Finalizing the client records and CAN records for closed cases</p>	<ol style="list-style-type: none"> 1. Data Entry Specialist is review all closed cases, one at a time 2. Conduct final file closeout review 3. Conduct Program Closure File Audit 4. Conduct Program Closure CAN Audit 5. Locate and catalog all closed files as they are moved into storage
<p>Maintaining client files that meet Program Benchmark standards</p>	<ol style="list-style-type: none"> 1. Correct problems in files 2. Provide in-services for staff 3. Clean up CAN data 4. Review Benchmark Reports from FMT 5. Implement all required action steps in the Benchmark Report by the due date <ol style="list-style-type: none"> 1. Create a prompt in client spreadsheet to verify each CAN audit was completed 2. Trained case managers on file review procedures 3. Utilized the Supervisor Review Form to identify areas of concern and communicate those with the Case Managers
<p>Field Management (MCMC/LESS) Clients who purchased their Mobile Home or Park Model for \$1 or \$5, sustainability issues for some households were identified including:</p> <ul style="list-style-type: none"> • Maintaining monthly utilities • Insurance Costs on the mobile home • Tax costs on the mobile home to change the title to the client • Moving costs on the mobile home for those who could not remain where they were • Paying lot rents once FEMA stopped the assistance • Mobile homes needing some repairs not completed by FEMA prior to the sale 	<ol style="list-style-type: none"> 1. Coordinated communication between Affiliate and FEMA when said issues arose 2. Require monthly budget revisions and pre and post budgets with the clients to determine if housing solutions being offered are affordable, sustainable, and permanent
<p>The Volunteer Coordination program slowed over the summer due to low numbers of volunteer coming to the coast during the summer months (this happened even in 2006), lack of funded projects, and all of the uncertainty surrounding the continuation.</p>	<ol style="list-style-type: none"> 1. Developed a list of volunteer housing resources in South Mississippi with location, capacity, cost, and contact information. 2. Ensured that the families waiting for this resource are incorporated into the "Adopt-A-Family" project
<p>The FEMA Mobile Home Sales Program ended on/about September 18th, 2009.</p> <p>Ensuring Affiliates are meeting the required level of face-to-face contact with their clients when Affiliates do not have adequate funding to meet the requirement.</p>	<ol style="list-style-type: none"> 1. Continue to assess community resources 2. Refer clients living in a FEMA THU to alternative housing resources 3. MCYS included in its appeal to FEMA an increase in the Travel Line Item 4. Understand that the level of contact is frontloaded and will decrease over time as cases are closed 5. Share best practices of implementation with all Consortium Affiliates

<p>Lead Agency (MCVS): Received communication from FEMA that no new cases can be added to the FEMA caseload of MCMC.</p>	<p>1. Advocated for the inclusion of cases that are added to the FEMA Occupant List following April 30th</p> <p>2. Strong training</p> <p>3. Clear communication</p>
<p>Our affiliates are constantly facing sources of change in their work. The MCMC scope of practice must encompass a myriad of ideologies that tax most "on-the-ground" affiliates.</p>	<p>1. Continue to Advocate for a finalized budget</p> <p>1. Send an appeal letter to FEMA, advocating for a reinstatement of the agreed upon staffing ratios for the data entry staff</p>
<p>Implementation of program without final budget from FEMA</p>	<p>1. MCVS included in its' appeal to FEMA an increase in the Travel Line Item</p>
<p>High Quality Data Entry and Reporting with a reduction of key staff in the field to complete the necessary tasks</p>	
<p>Implementing an increase in the level of required contact with clients to facilitate the transition into permanent housing, especially as new housing resources are coming to light; however, this plan is not supported by the current budget and line item for travel with the Affiliates</p>	

V. Remaining Challenges

The following "Remaining Challenges" are the areas of the MCMC program that the Affiliates, Management Agency, and Lead Agency continue to report as areas of challenge, at all levels of the Consortium. These areas will continue to be addressed during Quarter 6.

A. Affiliate

1. To assist remaining clients secure permanent and sustainable housing
2. Finding resources for clients
3. Add data that is missing from CAN
4. Conduct CAN and file cleanup on closed cases
5. Reduce the number of errors and omissions in client files, in CAN, and on reports
6. Reduce the number of no-shows
7. Reduce travel expenses associated with face-to-face client visits
8. Raise compliance with benchmarks
9. Training staff on new processes of MCMC Continuation
10. Following clients through the process of applying, received, and leasing up with a HCV Voucher, when possible

B. Management

1. Tracking compliance with the benchmarks
2. Continuing the focus on high quality case management
3. Supporting the field and their use of the new forms and reports
4. Continuing to monitor CAN data to continue to maintain high quality data entry
5. Working with the Affiliates to develop creative strategies to assist clients with resources or housing plans

C. Lead

1. Working with reduced staffing ratios on key implementation staffing positions
2. Continuing to advocate for housing resources
3. Continuing to advocate to serve additional client populations that are not receiving case management
4. Advocating to all non-profit and government agencies that are providing disaster recovery services to the Hurricane Katrina/Rita population, to share a list of clients names and key indicators. This list could help the state of Mississippi determine the true population of clients with unmet disaster caused needs

VI. Summary of Planned Activities for Next Quarter

A. Affiliate

1. Locate affordable housing via local apartment complexes
2. Refer clients to PHA for applications
3. Refer clients for job training and employment opportunities at the WIN Job Center
4. Locate and obtain financial assistance for deposits and basic necessities
5. Continue to refer clients to the resources that we know are available
6. Network with other affiliates and agencies
7. Implement client call-ins prior to face-to-face visits on clients who avoid meetings
8. Implement standing/scheduled visits - as possible
9. Utilize new fields in CAN to track the HCV process
10. Ensure case progress is documented in file and CAN as progression of the recovery plan is made
11. Continue in-service training as issues become apparent in monthly file review
12. Continue in-service training as needed on new and revised forms
13. Data entry staff will monitor case managers' CAN entry by running weekly CAN exports
14. Continue clean-up efforts between case managers and data entry specialist
15. Conduct ongoing monthly supervisor reviews to comply to MCMC program requirements
16. Continue to re-assess client needs on a monthly basis; update CAN accordingly

B. Management

1. Continue to conduct Compliance Visits with Affiliate
2. Conduct on-site trainings with affiliates as needed
3. Continue to review policies and procedures regularly
4. Monitor supervisor function at the Affiliate level
5. Continue to conduct Data Entry conference calls monthly
6. Continue to conduct Supervisor conference calls and meetings weekly
7. Continue to build relationship and collaborations with PHAs, FEMA, and other external entities
8. Monitor the DHAP → HCV transition process; communicate with HUD regularly on process
9. Support the ten (10) Affiliates in their efforts to provide high quality case management services to the clients

C. Lead

1. The Financial Team plans to communicate more with the field to ensure proper documentation of expenditures and usage of funds.
2. Prepare for contractual and budgetary implementation of Phase II Continuation
3. Finalize contracts with Affiliates selected to participate in the Phase II Continuation
4. Review contract compliance of all Affiliates. Follow-up with any affiliate out of compliance, as outlined in their contract
5. Facilitate the Volunteer Coordination Meetings with the non-profit community to link clients with volunteer labor in a coordinated and systematic process
6. Advocate for the inclusion of all DHAP clients to be case managed by MCMC
7. Advocate for the inclusion of all MEMA Cottage cases to be case managed by MCMC
8. Continue to coordinate with HUD, FEMA, MEMA, the Governor's Office to ensure all MCMC clients are living in a safe, permanent, and sustainable housing situation at the end of the MCMC program.
9. Execute the "Adopt-A-Family" program and associated website
10. Host conference calls with financial directors, agency directors, and Adopt-A-family Affiliate points of contact
11. Support the Field Management Team in their efforts to provide high quality case management services to the Affiliates

VII. Suggestions for Improving the MCMC Case Management System

Monthly the Affiliates are requested to report suggestions they would like see made to MCMC. Each suggestion received is provided with a response by MCMC staff.

The Suggestions for Improving MCMC and CAN can be found as Attachment 2 to this report

VIII. Suggestions for Improving the CAN system

Monthly, the Affiliates are requested to report suggestions they would like see made to CAN which are then sent to CAN.

The Suggestions for Improving MCMC and CAN can be found as Attachment 2 to this report

IX. Indicator Table of Data

The MCMC CAN Summary October 2009 can be found as Attachment 1 to this report

*This report represents a consolidated submission of ten (10) MCMC Affiliates, the Field Management (MCMC/LESM), and Lead Agency (MCVS). Individual Affiliate and management team reports and attachments are kept on file at MCMC/LESM and are available upon request.

Testimony for the Ad Hoc Subcommittee on Disaster
Recovery of the Committee on Homeland Security and
Governmental Affairs of the United States Senate

Disaster Case Management: Developing a Comprehensive
National Program Focused on Outcomes

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President and Chief Executive Officer
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December 2, 2009



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INTRODUCTION

Thank you Chairman Landrieu, Ranking Member Graham, and distinguished committee members for the opportunity to speak with you today about the challenges faced by disaster survivors, specifically those Louisiana families impacted by hurricanes Katrina, Rita, Gustav, and Ike. I am extremely grateful for the tremendous amount of time this committee, and Congress as a whole, has spent looking into the recovery efforts of Louisiana and our neighbors in Mississippi and Texas. I appreciate your demand for accountability for federal taxpayer dollars spent and your insistence that Americans and the federal government become better prepared for the inevitable next catastrophic event that affects our people.

I also would like to publicly thank you, Chairman Landrieu, for the remarkable support that you have shown the Louisiana Family Recovery Corps and so many disaster recovery organizations throughout Louisiana over the past four-plus years. You have certainly been a friend to those Louisianians impacted by the hurricanes. Thank you again for everything that you have done and continue to do for our state.

As the President and CEO of the Louisiana Family Recovery Corps, I have seen first-hand the devastation and destruction caused by the hurricanes of 2005 and 2008. Many of you have also been to Louisiana and have seen for yourself the impact of those storms. But what you may not have seen during your trips to our state are the lingering affects the hurricanes have had on Louisiana's people, especially our most vulnerable populations – the elderly, those with disabilities, and families with children.

As disheartening as it may sound, there are still thousands of families throughout the state still struggling to recover. Homes remain in disrepair, entire neighborhoods still have not yet come back, post-traumatic stress syndrome has taken a toll on a large segment of impacted residents, children of the storm still struggle in the classroom, and the difficulties to cope with new realities has broken the familial structure for far too many Louisiana families.

Make no mistake, Louisiana is making progress. Roads and bridges have been rebuilt, schools are back open with great strides being made in the Recovery School District in New Orleans, parks and playgrounds have been reopened, police stations and fire houses have been rebuilt, and many other infrastructure-related projects have been completed thanks to federal disaster recovery funds allocated by the Louisiana Recovery Authority.

But too often Louisiana's families have been overlooked during this process. Rebuilding a bridge or a school or a playground is easy. Rebuilding a life is not. The Recovery Corps knows all too well the difficulty in advancing long-term human recovery. It is extremely hard work. We also recognize the very meaningful impacts made by so many in attempting to serve our citizens, and we understand the reasons why so many resources failed to either reach their intended target or have the desired impact.

The Recovery Corps has been an outspoken voice in the need for Louisiana to become the gold standard as it relates to accountability and transparency in the use of taxpayer dollars for disaster recovery services. To date, very little definitive documentation has been made public relative to the specific allocations and associated uses of funds targeted for human recovery efforts in Louisiana.



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With this lack of transparency and accountability, it is extremely likely that some of these recovery funds have been spent without any discernable positive impact on our citizens. It is also likely that some of these allocated funds remain tucked away in state and local government coffers and have yet to be spent on programs, projects, or other initiatives that can bring relief to those still struggling to rebuild their lives more than four years after Katrina.

The Recovery Corps has made every effort to abide by those principles of accountability and transparency in serving more than 30,000 families (approximately 100,000 individuals) in Louisiana since 2005. We have allocated more than \$80 million of state and federal funds to recovery efforts in Louisiana. From repairing homes to providing home furnishings and major appliances to replace those items damaged or destroyed during the hurricanes to providing case management to Louisiana citizens, the Recovery Corps is committed to demonstrating positive outcomes for people with taxpayer money while serving our citizens.

Like so many other types of services related to Louisiana's recovery, disaster case management programs struggled to meet the needs of storm-impacted families. There are a myriad of reasons for the programs' overall ineffectiveness and much blame to go around.

Certainly it was not for a lack of desire. Many otherwise capable people failed to deliver the desired impacts of these case management programs, both at the state and federal levels. And while there should be constructive dialog around the failures of the programs, spending an inordinate amount of time playing the blame game is counter-productive at this point.

Instead, we should focus on the numerous situations that caused the programs to be ineffective and then focus on ways to ensure that we have learned from the past and are prepared for the next disaster.

The following describes some of the major situations that existed in August 2005, some of which, I am sorry to say, remain unchanged today. These situations all existed in concert and helped form the environment that allowed a general breakdown in the delivery of quality case management services to the storm-impacted families of Louisiana:

SITUATION 1: No plan in place at the state or federal level for long-term human recovery post-evacuation and sheltering.

The United States has seen its share of disasters recently, both natural and man-made. From hurricanes to terrorism to fires to flooding, every region of the country is susceptible to catastrophic disasters.

Our nation is doing a better job in emergency response and the preparatory planning that goes along with such critical actions. However, our country has yet to address the long-term affects disasters can have on families and individuals who suffer through them.

Unfortunately, that was the case when Katrina and Rita struck Louisiana within a month of each other in 2005. After the initial evacuation and sheltering of our citizens, there was no plan in place to provide for an orderly, strategic return of Louisiana's citizens to their homes, nor was there a plan in place to provide for the needs of those residents once they arrived back in Louisiana.

Sadly, that reality still exists today at both the state and national levels.

Without a long-term human recovery plan, coordinated case management programs will not occur and critical issues like access to basic healthcare needs, access to educational facilities, mental health assessments, and short-term financial assistance will again be overlooked in the chaotic scramble to help bring back a sense of normalcy to devastated communities. These realities are especially true for vulnerable and rural populations.

Without a strategic plan in place, devastated areas will have what happened in Louisiana – well-meaning governmental and non-profit agencies all acting alone and making their best efforts to address critical needs. There will be no unified approach, and disaster recovery-related funds will end up being duplicated, mismanaged, or being allocated to pilot programs that may or may not work.

What we will get, in essence, is continued chaos.

SITUATION 2: Inefficiencies associated with federal disaster-recovery funds and services.

As stated, the federal government has been extremely generous with the disaster-recovery funds provided to Louisiana since the storms of 2005. Billions of dollars have been provided to assist the citizens of Louisiana rebuild their lives and their state.

However, the process of allocating those funds has at times been difficult to navigate. There were several main issues that on numerous occasions made getting federal funds in the hands of those who most needed them a trying process.

First, federal individual assistance disaster funds were allocated to Louisiana from a wide variety of federal government agencies and were directed to various state agencies. The problem with this practice is, as has been noted, Louisiana has no long-term human recovery plan in place that would account for all of the funds allocated to the state and ensure coordination among the state agencies that received the funding. Thus, each state agency acted individually in disbursing these funds, leading to inefficiencies, duplications, and, inevitably, waste.

These federal allocations without a statewide long-term human recovery plan also overburdened some state agencies, some of which were unprepared for the administration of these federal funds. Thus, various pots of federal money stacked up within state agencies, causing a silo effect that made it difficult to move those funds to the people who most needed them. Many times it was the state's vulnerable populations who ended up suffering the most from this circumstance.

Another reason the state had difficulties moving federal funds from state coffers was the numerous restrictions associated with the various pots of money. Each set of funds came with its own unique set of restrictions. While the reason for doing so is commendable, the ultimate impact of these restrictions was the inability to quickly provide funds for families and individuals struggling to recover on their own.

These restrictions also caused situations in which unused funds specified for a specific use sat in state and city coffers untapped while desperate situations existed on the ground. If unrestricted, those funds had the potential to make a great impact on the lives of families in need. Instead, they remained



unspent despite the fact that Louisianians suffered, simply because of arbitrary limits placed on the use of the recovery funds. These arbitrary restrictions could even lead to situations in which recovery funds have to be returned to the federal government because agencies are unable to spend all of the money due to the specific spending requirements.

Finally, the cost-reimbursement guidelines associated with some federal programs made it nearly impossible for non-profit service providers contracted by the state to execute their contractually-agreed upon obligations. Many non-profits and faith-based organizations provided the initial recovery resources for Louisiana families in the wake of the hurricanes. Thus, many resources of the non-profit community were tapped out early in the recovery process. Having to put up their own money in order to provide services and staff appropriately for state and federal programs made program execution difficult and slow for the non-profit and faith-based community. Not only that, but when non-profits did provide up-front money and resources, the federal government was extremely slow in making reimbursements. Some non-profits are still awaiting cost reimbursements years after the fact.

SITUATION 3: Louisiana is an "Option 1" state, meaning that the federal government oversees individual assistance disaster recovery initiatives for Louisianians.

Louisiana is considered an "Option 1" state. This means that the state has chosen to have the federal government tend to its people in the wake of a catastrophic disaster. While on paper this may be advantageous to the state, it certainly does not bode well for the people of Louisiana.

FEMA, one of the federal agencies tasked with providing individual assistance support, has clearly stated that it is not in the business of providing human services. The agency is not designed for that. Instead, it put together a series of pilot programs which in essence served as "test cases," with Louisiana citizens being the lab rats.

The federal government is not equipped, nor should it be, to execute on-the-ground programs for individuals of a state. That is the state's responsibility. However, with the state of Louisiana passing on that responsibility, Louisiana's citizens suffered.

SITUATION 4: Poor design, planning, and execution of federal case management and housing programs existed at every level.

While FEMA and HUD designed case management and housing programs to serve the storm-impacted citizens of Louisiana, the agencies counted on the state of Louisiana to contract with them for on-the-ground execution of the programs. The state, in turn, contracted with non-profits and other agencies and organizations to provide the direct services offered by the programs.

Each of these programs suffered from poor design, planning, and execution at every level. The federal government, at times, placed overburdensome restrictions and requirements within the programmatic details. Also, the funding requirements and cost-reimbursement policies associated with the programs made it almost impossible for the state's non-profits to effectively carry out the service provisions. Lastly, the federally-designed pilot programs lacked some of the fundamental programmatic capacities to fully attain the desired outcomes of the programs. In essence, the case management aspects did not fully address the needs of the people in Louisiana.



At the state level, there were difficulties engaging the non-profit sector on a timely basis. By the time the programs were in place within the state structure and agreements were in place with the non-profit service providers, the amount of time needed to actually execute an effective program was lost. Furthermore, with the state and its recovery agency, the Louisiana Recovery Authority, also inundated with so many public assistance projects, there was at times too little focus on the individual assistance side. That, disappointing outcomes associated with selected contractors and service providers, left some federal programs unable to ever get off the ground effectively and in a manner that benefitted Louisiana's citizens.

SITUATION 5: In addition to the lack of quality case management assistance, Louisiana was in the midst of a housing crisis.

Even prior to the landfall of hurricanes Katrina, Rita, Gustav, and Ike, Louisiana faced a major lack of affordable housing, especially for those families and individuals at the bottom of the economic ladder. This problem led to extensive homelessness and a large segment of the population living on the brink of homelessness as they attempted to recover from these catastrophic events.

The impacts of the hurricanes only served to transform what was once considered a mere housing shortage into a full-fledged humanitarian crisis.

Extremely hard hit by the hurricanes, Katrina especially, was Louisiana's housing stock. Hundreds of thousands of Louisiana residents were left homeless after the storms, their houses destroyed or left temporarily uninhabitable. The pre-existing lack of housing stock, along with the impact of Mother Nature, left Louisianians scrambling for housing options.

That disaster was followed by a second housing disaster -- the inability of the state and federal government to successfully execute numerous housing case management programs designed to add additional housing stock to the state. Additionally, there was an inability to successfully transition those families who relied on transitional governmental housing assistance into self-sufficiency and lessen their reliance on governmental support before the end of the housing programs.

No matter how the blame is spread, the fact is that thousands of families in Louisiana still rely on government housing assistance more than four years after the landfall of Katrina and Rita. And, while some progress has been made in recent months, available affordable housing in Louisiana is still not nearly at the levels needed to serve the population that continue to be transitioned out of government assistance programs.

But those were not the only housing issues facing Louisianians trying to recover. Many did not have homeowners' insurance prior to the hurricanes because they simply could not afford it. Thus, when their homes were destroyed or suffered major damage, they were unable to come up with the funds to repair the damages. Additionally, many state and federal home repair programs would not allow uninhabitable homes located in a flood zone to be repaired without the owner acquiring flood insurance, but the government would not sell the homeowner flood insurance to an uninhabited home. That type of run-around and other similar frustrations turned many people toward simply trying to do things themselves instead of utilizing governmental assistance which they considered overburdensome.



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Another key area affecting housing post-destruction includes fraudulent contractors who took money only to never return or who did unsatisfactory work that had to be redone, costing the homeowner thousands more.

LOOKING FORWARD

A huge setback in the recovery of Louisiana was the lack of quality case management services provided to those struggling to get back on their feet. This made recovery more expensive than it should have been and has left many Louisiana citizens still in transition.

The Recovery Corps treats case management very differently than FEMA and HUD. Our view of case management is not limited to simply supplying housing for clients. Instead, our case management model is one that promotes client self-sufficiency and reciprocal accountabilities among those providing the services and those receiving the services and is an essential aspect of any long-term human recovery plan developed by the Recovery Corps.

The Recovery Corps has conceptualized and developed a proprietary strength-based case management model called the Recovery Corps Model for Recovery Planning. It is a comprehensive case management model that is consistent with United Nations models and superior to many case management models in existence today.

The overall philosophy of our case management model is one of client self-sufficiency. One of the few fully-vetted models assessed by a reputable academic group (Berkley Policy Associates), the Recovery Corps model has improved that vetted version and now uses lessons learned from previous case management experiences and features a number of unique elements, including an outcome-based approach, Efforts to Outcomes software designed to account for specific data, direct assessment and assistance, and specific workforce requirements.

Additionally, the Recovery Corps model also includes real-time benchmarks to ensure accountability by the client and the agency and calls for the alignment of state resources to directly assist the client. Finally, the Recovery Corps model provides each client with a real opportunity for self-sufficiency by referring clients to the Louisiana Workforce Commission to be assessed for job training and placement and back to other state agencies, if needed, for any other required social services.

The Recovery Corps model addresses basic needs, but also includes employment, mental health, emotional well-being, and household re-establishment and management.

Our holistic approach:

1. Emphasizes developing and supporting household self-sufficiency;
2. Considers all aspects of the household's situations;
3. Conducts comprehensive needs and strength assessments;
4. Combines direct assistance in the form of home repairs and household re-establishment benefits with case management services;
5. Develops a meaningful recovery plan to address those needs; and
6. Remains mindful of the household's strengths and aligns those with outside resources available to support the recovery process.

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As noted, our case management model combines traditional human services with direly-needed direct assistance. Direct assistance is critical to the full recovery of the people of Louisiana. Direct services provide a vital and immediate link for those households that need limited support to bridge support gaps. Those gaps include basic needs such as security deposits, utility deposits, and move-in expenses. As the state struggles to meet these additional needs, the risk to households in transition grows.

Households that today need direct assistance to pay back utility bills or rent deposits face the very real potential of becoming homeless if these needs are not met.

The ongoing human service needs that many storm survivors still face today are immeasurable. But without a doubt, these critical supports cannot be adequately provided to households, in such a way that promotes truly sustainable and independent living, if families are on the street or focusing all of their attention and efforts on maintaining inadequate housing situations for themselves. Further, the health and welfare of populations in need of longer term case management (such as people with disabilities, seniors, and children) have been jeopardized by the failure to include meaningful case management within federal programs.

From the Cora Brown Case Management Program to the Disaster Case Management Pilot Program to DHAP, difficulties existed within each federal program relative to expertise, efficiency, effectiveness, and timeliness.

Addressing the situations discussed above will help to alleviate some of the major issues that kept case management from working in Louisiana. For future disasters, this will be critical.

Louisiana is a vibrant state filled with ingenuity and dexterity. We will be OK and we will fully recover. But do not let the suffering of the people of Louisiana go in vein. The lessons learned following the hurricanes of 2005 and 2008 should be carefully considered as we look forward and prepare for the next disaster.

The following is a list of recommendations that should be considered as we develop a roadmap for the future of case management and long-term human recovery. These recommendations come from various work products, research papers, and communiqués (see page 17 of this document) produced by the Recovery Corps since our inception.

Included in the following recommendations are general case management recommendations, but also housing recommendations (which we consider an integral partner to case management) and other general recovery recommendations associated with establishing a stable environment on the ground that is conducive to family stabilization and can help lead to an appropriate environment for developing quality, coordinated case management programs in the future:

CASE MANAGEMENT RECOMMENDATIONS

1. **Personal responsibility and reliance should be a key component of any case management model:** Regardless of individual circumstances, there should be some level of expectation that people can and should be ultimately responsible for themselves. The Recovery Corps model is intended to facilitate access to information about available services and to streamline delivery of services to people who need them and qualify for them.
2. **Employment, or employability at minimum, is key to successful case management:** Regardless of education or past experience, able-bodied adults can and should be responsible for their own livelihood and should be employed.
3. **The client should be personally invested into the process in order to achieve maximum success:** Regardless of individual circumstances, there is an expectation that everyone can and should contribute something to enhance his or her own quality of life. Government and charitable supports combined with personal investment lead to lasting quality of life.
4. **Direct services make the difference:** By combining direct services with case management, clients are more able to obtain successful outcomes. Most case management models fail to incorporate this critical element.
5. **Service providers must meet critical performance standards:** Each service provider connected to the case management model must undergo a thorough organizational assessment process to examine the agency and review its ability to meet fiscal accountability standards, best practices in social service delivery, and build capacity and meet performance standards.
6. **A successful case management model should utilize outcome-based systems:** A major component of the Recovery Corps model is the effective utilization of an outcome-based system for the purposes of improving lives through effective delivery of services to disaster-impacted people with a specific emphasis on tracking positive social impact in people's lives through data entry. In order to evaluate the various systems that are available for this task, a list of the specifications has been established. The specification list is detailed as to the tasks that need to be performed, but is not dependent on specific named systems or technologies.
7. **A three-tiered reporting system leads to self-sufficiency:** The Recovery Corps model focuses on 30-, 60-, and 120-day reporting thresholds that provide a roadmap toward self-sufficiency. Services rendered during the first 30 days, or Immediate Services, include an assessment and identification of client needs, as well as referrals if necessary. At the 60-day mark, clients will have also received Intermediate Services, including job readiness assessments and employment and family service referrals. Long-term services, which come within 120 days of being a client, focus on comprehensive services such as housing, physical health, mental health, and community integration. Case managers also work with families to assist and connect them with local and state agencies to provide continuing care. The case management goals at this stage are focused on delivering individuals to state, local, and non-profit agencies with expertise in the categories mentioned as well as other long-term needs.



HOUSING RECOMMENDATIONS

1. **Provide recovery-related funds directly to non-profits and faith-based organizations:** Make available Community Development Block Grant funds and other federal resources directly to non-profit organizations such as the Recovery Corps who have demonstrated the ability to efficiently and effectively execute home repair and rebuild programs across the state. This eliminates added layers of bureaucracy that only serve to slow and strain the process.
2. **Housing stock must be available for those exiting federal housing assistance programs:** Coordinate the availability of affordable rental units with the end of temporary housing programs.
3. **Ensure rental rates are stable and moderately priced:** Implement tenant protections such as rent stabilization, eviction protections, and right of first refusal requirements to moderate further increases in market rents, prevent the eviction of lease compliant renters from their current homes and apartments, and enable groups of tenants to acquire and cooperatively manage properties that the current owners want to sell.
4. **Eliminate housing discrimination that keeps storm-impacted families from finding suitable living situations:** Local governments, working in partnership with housing advocates and legal authorities, can help ensure that housing discrimination does not bar families from homes, apartments, and neighborhoods of their choice by focusing on effective fair housing enforcement.
5. **Prohibit discrimination based on source of income:** Disaster-impacted families who receive rental assistance from federal programs, non-profits, or faith-based organizations should not be discriminated against when attempting to rent an apartment or house for their family.
6. **Make short-term changes to zoning codes:** Update zoning codes to permit auxiliary rental units to yield a small but meaningful increase in the availability of affordable rentals in the near term.
7. **Make building code reforms:** Reform building codes to encourage low-cost designs and technologies that are safe and reduce costs.
8. **Make land acquisitions and target neighborhoods for redevelopment:** Acquire land for land banking and/or community trusts to help residents bring neighborhoods back to life. Target selected neighborhoods for comprehensive, resident-driven redevelopment.
9. **Convert vacant homes into rental properties:** Provide funding for the acquisition of vacant homes that would in turn be repaired and available as affordable rental housing in the near term.
10. **Extend use of Low-Income Housing Tax Credits:** Provide Low Income Housing Tax Credits to opportunity-rich neighborhoods and supportive housing developments to produce affordable



rental housing units in healthy, opportunity-rich communities and to projects that will produce supportive housing for the elderly or for families with special needs.

GENERAL RECOVERY RECOMMENDATIONS

1. **Create a statewide and federal long-term human recovery plan that is coordinated among all levels of government and with the public and non-profit sectors:** Just as an emergency response plan is essential to effectively respond to disasters that may strike, having a long-term human recovery plan is essential for the well-being of the citizens of impacted areas in the wake of a disaster.

The events post-Katrina and Rita, as well as those following the September 11 attacks in New York and Washington, D.C., the devastating tornado that wiped the community of Greensburg, Kan., from the map, and the 2004 Sumatra earthquake and tsunami all proved that we remain ill-prepared to undertake the critical long-term human recovery efforts necessary following a catastrophic disaster.

The failure of the state and federal government to develop and execute a coordinated long-term human recovery plan in the past is painfully obvious, as there remain tens of thousands of Louisiana residents still recovering from hurricanes Katrina and Rita more than four years after those storms made landfall. As more disasters strike, such as Gustav and Ike, the open wounds of our state are only exacerbated. Therefore, the development of a systematic long-term human recovery plan that aligns state agencies with federal resources, non-profits, and local communities is essential to ensure that Louisiana and the nation are no longer ill-equipped to provide citizens with the resources and assistance needed for human recovery.

2. **Create funding sources that are designated specifically for human recovery and are not tied to government programs:** The need for flexible funding in post-disaster situations is essential. The needs of those affected by disaster are unique to their specific scenarios and can fall outside of the traditionally defined ways in which government-financed programs are administered. Eliminating the categorical eligibility associated with government funded programs is essential in addressing disaster-affected populations that may not fit existing programmatic eligibility criteria.

Eliminating the tie to government programs such as TANF, SSBG, or Medicaid does not mean removing the involvement of agencies that administer those programs. Their expertise and infrastructure can prove beneficial in times of crisis. Designing a disaster-specific fund with clearly defined triggers and execution parameters could create a pool of resources that is only accessible in disaster situations. Because its triggers are disaster-specific, the fund usage can be defined within a disaster service context.

Another option involves funding designated for human recovery in disaster that is administered through a centralized intermediary organization, such as the Recovery Corps, with clearly defined roles and responsibilities. Such an intermediary could be operational independent of government entities or as part of an emergency preparedness plan administered by a first-responder entity.

Regardless of placement, a funding source must also come with clearly defined parameters and expectations of the responsible entity, including relevant partnerships and execution strategies that are mindful of a collaborative approach to deployment.

3. **Clearly-defined expectations are needed from FEMA in its planning, development, implementation, and management of disaster activities that provide services to people:** Mandates do not produce collaborations. However, clear assignment of specific tasks and responsibilities to other entities can provide a framework that facilitates collaboration. Clearly-identified expectations about the partners needed to engage in the early stages of planning deployment strategies can leverage the collective expertise of stakeholders while helping to ensure that well-intended solutions do not have unintended negative consequences. Assigning distinct responsibilities to other stakeholders outside of FEMA (i.e. housing to housing experts) with FEMA retaining an overall oversight of the process would provide the "permission" or means to collaborate while offering a framework in which to delegate particular tasks to other experts.

More distinct boundaries that define the triggers or "hand-off" from one entity to another are also needed. The benchmarks that signal the transition from disaster response to disaster recovery and the collective stakeholders that are a part of each phase must be more clearly defined. A need for the leadership and expertise that FEMA can provide is obvious, but must be strengthened by creating inclusion and participation during significant decision-making activities.

4. **Build a more appropriate mechanism to address the emotional well-being of people affected by disaster:** Existing approaches to mental health are not designed to be interventions for people affected by disaster. The existing model is based largely on clinical strategies to provide crisis counseling, treat mental illness, or respond to clinically diagnosed conditions. These strategies are not designed for quick assessments and helping people deal with the immediacy of disaster and its aftermath. Instead, the proper treatment for emotional well-being for those affected by disaster should include both an initial clinical screening to determine the extent of any pre-existing or new mental health conditions and efforts to re-create supportive environments and social settings that provide the safety net needed to manage crisis and stress.

A new model should be inclusive of the essential diagnostic tools, intervention strategies, and training to teach skills and techniques geared towards both grassroots types of providers and clinical experts. This approach should have the ability to be deployed through community networks -- churches, social clubs, neighborhood associations, and local organizations -- rather than solely through traditional hospital or clinic-based access points. However, for those who do display more serious mental health conditions, timely access to professionals trained to treat such conditions is imperative to long-term emotional well-being of disaster survivors. Creating a source of funding that can provide for the deployment of a revised model into communities will ensure that approaches are operational and available. Most importantly, rebuilding the emotional well-being of people affected by disaster contributes perhaps the most lasting element in rebuilding the foundation of community.

5. **Confront the emerging disparity that exists in the post-storm experience of disaster survivors in terms of access to and interest in training opportunities, employment**

opportunities, home ownership, stress management, and pre-emptive action related to ensuring a standard of well-being for children in vulnerable households: Our research shows that many viewed the recovery of Louisiana as an unprecedented opportunity to reshape the lives of those impacted in ways that would help to neutralize some of the historical disparity that existed in the state. However, the unfolding story of post-storm recovery seems to parallel some historical patterns of disparity that have prevented Louisiana from moving beyond the legacy of its past.

6. **Consider the particular needs of parishes and the composition of their impacted residents and initiate interventions that are designed to be culturally competent and relevant:** The variances in needs among impacted residents should prompt strategies that are unique to the target and household characteristics of the area. Truly understanding the level and urgency of needs in specific parishes and the types of households present within those parishes will dictate the type of approach that would be most effective.

In addition to applying proven strategies that may vary across income levels, targeted strategies should be developed for older adults, retired households, and families with and without children. Precise messaging that resonates with these groups may demand highlighting complementary, not universal, tangible benefits.

7. **Align needed services with appropriate service infrastructure and visible access points:** Impacted residents need services that fall outside of conventional service offerings and traditional eligibility criteria. The need for service spans beyond those normally served by government programs. Impacted residents often need access to one-time, money-based help rather than ongoing financial support or supportive services. Services must be available in places that residents are most likely to access – this means expanding beyond government providers.

Create services to provide one-time financial help to impacted residents and consider maximizing the availability of job training and homeownership opportunities. Utilize service providers in community-based settings to facilitate accessibility. Consider including eligibility for these services beyond basic levels of poverty to include households typically ineligible for government services.

Develop an appropriate intervention model to assist impacted residents in addressing their recovery-related stress and depression, in addition to helping manage the behavioral and emotional issues of children. Sensitivity to the wide-range of residents' characteristics and experiences should always be considered.

8. **The desire to return, or the ability to make a decision about returning, is unlikely to be sustainable without some effort to address interest and ability:** Marked efforts to provide a demonstration of interest or available resources for those wishing to return should be executed. Our research shows that less than half of displaced residents express interest in returning. As time passes, an interest in returning is likely to dwindle further. If efforts to replace not only a missing tax base, but also a viable workforce, are not materialized, their absence will mark a permanent change in the characteristics of the impacted area. An effort to prompt informed decisions can provide a path of direction for families as they weigh options for their future.

9. **Strategies designed to appeal to out-of-state residents should consider the financial and non-financial issues affecting interest levels in returning and design approaches that reflect the diverse characteristics and issues identified by resident households:** Households with differing income levels and household compositions express varying degrees of barriers related to returning home. Approaches and strategies must be diverse in their appeal and delivery. Resident households report needing access to financial resources as well as information resources. Access to cash flow is a primary factor for all segments of those displaced out-of-state.

Arguably, those with higher income levels may be better positioned to sustain living in post-disaster impacted areas, but may require as much financial help in actually making a move or paying for the remaining expenses of home repair. When the availability of housing stock improves, access to resources that can help with moving costs, rental deposits, and other “out-of-pocket” expenses needed to re-establish their household may be offered to assist in a successful transition home. Lower income households will have similar needs and may have additional challenges to sustaining post-disaster.

Concerns regarding housing and job availability, schools, and child care may be tempered slightly by providing access to needed information sources in a coordinated way that is readily-available to out-of-state residents. For example, multiple websites, phone numbers, and information brochures should exist. However, for out-of-state residents, accessing those same resource listings, websites, and phone numbers can prove challenging. Targeted outreach efforts that furnish this information may provide the needed connection points that residents need to begin a transition home.

10. **Communication efforts that speak to the realities of post-disaster life -- both the positive activity and progress and also the remaining challenges that have affected recovery -- can be important tools for residents in their decision process:** Residents living in other states do not have ready access to local information—information about their neighborhoods and accurate information about the status of recovery. These residents are often advised of developments by national news media or others that may not have ongoing or first-hand knowledge of factual information. These sources of information should not be the only ones reaching out-of-state residents. There is much progress in recovery efforts that occurs regularly, some of which is taken for granted internally and about which outsiders have little awareness. For example, progress with levees, school openings, and neighborhood revitalization may undergo tremendous progress, but these efforts may not be routinely communicated to out-of state residents. Additionally, given concern over government leadership, progress in recovery and even statements regarding the demographic composition of the area, out-of-state residents may benefit from messaging that is strategically communicated rather than simply reported. This may lend itself well to increasing the credibility of local stakeholders and, by extension, the recovery effort. It may also help to provide context to the varied perceptions that exist externally. While this information by itself is not likely to cause residents to return, its collective impact may add significant value to the decision-making process.

RECOMMENDATIONS TO ASSIST THE RECOVERY OF VULNERABLE POPULATIONS

1. **Make a concerted effort to identify the needs of the disabled during the sheltering process:** Add questions during all intake processes (shelter, American Red Cross, FEMA applications, and/or other services) that help to identify the needs and/or issues of disabled and aging individuals. This will allow for more appropriate assistance, referrals, and long-term solutions.
2. **Pre-identify persons in need and vulnerable households before a disaster hits:** Community-wide efforts should be put in place that identify persons with disabilities in need of additional services in a disaster and should be developed to link these persons to services required to either evacuate or shelter in place.
3. **Ensure systems are in place to provide transportation and sheltering of vulnerable families:** Community-wide efforts should be put in place that can identify functional supports, including accessible transportation, durable medical equipment, alternative communication systems (screen readers, sign language interpreters, personal assistive services, etc.) and accessible shelters for persons with disabilities in a disaster. Systems should be developed to link these goods and services to individuals in need of them during evacuation and in shelters. Public transit agencies should ensure that all transportation between shelters, housing, and disaster relief centers is accessible for the elderly and disabled who might otherwise lack dependable transportation.
4. **Fund non-profits:** Provide non-profit organizations that specifically deal with disability and aging issues with supplemental governmental funding to continue their critical role in the response and recovery phases of disaster.
5. **Include disability and senior groups in the planning process:** FEMA, in coordination with local and state authorities, should invite disability and senior groups to participate in planning and secure space in the emergency operations facility. To ensure that people with disabilities do not experience further difficulties during future catastrophes such as the inability to evacuate due to inaccessible transportation and the inability to receive evacuation and emergency information due to their disability, emergency plans must acknowledge and address the difficulties experienced by people with disabilities, as well as include people with disabilities in recovery and rebuilding efforts. A separate space should be available for older adults in shelters, allowing more able older adults to care for and retrieve supplies for those who are less capable.
6. **Ensure compliance with FCC policies as it relates to the dissemination of emergency information:** The FCC should immediately issue strong statements that remind video programming distributors, including broadcasters, cable operators, and satellite television services that they must comply with their obligation to make emergency information accessible to people with hearing and vision difficulties. The FCC should also acknowledge that these requirements need to continue in the recovery phase because information is still just as crucial in the aftermath as it is during the response and recovery phase. Communications should include impacted states and areas taking in the evacuees.

7. **Emergency managers and disability and aging specific organizations should engage in cross orientation/training meetings.** Use disability and aging specific organizations to strengthen responders understanding of which organizations can offer what services under what conditions and the fact that people with disabilities are not a homogenous group but rather have differing capabilities, opinions, needs, and circumstances, and no individual or organization speaks for all people with disabilities.
8. **Rebuild community services utilized by the elderly and disabled in addition to accessible homes.** Many people with disabilities who were living independently prior to the disaster did so with the assistance of these community services and, thus, cannot return home until their community's services are restored.
9. **FEMA should establish procedures to reimburse public organizations that exhaust critical resources during disasters.** Many organizations donate equipment and medical supplies to disaster victims and then are hard-pressed to meet the day-to-day needs of their clients after the disaster.
10. **Eliminate stringent restrictions within the Stafford Act that make disaster funding time-limited and restrictive.** The FEMA-sponsored psychological intervention programs should allow for funds for a comprehensive medical assessment and intensive treatment, which they currently do not.
11. **Address mental health concerns:** Mental health concerns should be integral to disaster preparedness, response, and recovery, especially for children. Mental health treatment by professional skilled in psychotherapy, psychopharmacology, or a combination thereof should be integrated into disaster relief efforts to help adults and children cope with stress, anxiety, depression, and other behavioral disorders in addition to more chronic mental health problems. Preventing emotional dysfunction or breakdown and restoring individuals to a pre-disaster level of functioning is essential to community resilience and recovery and future disaster preparedness. It is critical that mental health consideration become an integral part of disaster preparedness, response, and recovery. This should be especially true for children and others at risk in vulnerable populations.
12. **Ensure appropriate environments for children to express their feelings following catastrophic disasters:** As soon as possible after a disaster, it is essential to create opportunities for children to express their feelings and concerns, to establish an environment where children feel safe, and to re-establish for children a sense of normalcy. It is essential to provide adequate pediatric post-disaster mental health services when needed, as failure to provide this may increase the number and severity of symptoms such as PTSD and depression.
13. **Minimize exposure to repetitive images or reports of disaster on television or in other media, as it may exacerbate the psychological response of a child.** The child should have the opportunity to discuss the meaning of those reports or images with an adult.
14. **To meet the needs of children, the child care infrastructure – daycare centers, Head Start programs, and schools – must have the level of resources necessary to meet a**



new and emerging level of need. This includes increased facility capacity and availability of the full range of operational resources, including training and staff support in the identification of and intervention for typical and atypical child reactions to trauma.

15. **Of extreme importance is meeting the needs of those who are responsible for children.** Helping to meet the concrete, employment, and psychological needs of parents, guardians, teachers, and all service professionals whose mission is the well-being of children is crucial in order to expedite individual, family, and eventually community healing and recovery.



RECOVERY CORPS RESOURCES

- Louisiana Family Recovery Corps 2009 State and Federal Legislative Agenda (<http://www.recoverycorps.org/issues-legagenda.php>)
- Roadmap for a More Holistic Recovery: Recommendations for Effective Policy to Enhance Human Recovery in the Wake of Disasters (<http://www.recoverycorps.org/issues-roadmap.php>)
- Broken Homes: First-Hand Accounts of Living Through Louisiana's Housing Crisis – Part 1: Unaffordable Housing (<http://www.recoverycorps.org/media/files/brokenhomes-part1.pdf>)
- Broken Homes: First-Hand Accounts of Living Through Louisiana's Housing Crisis – Part 2: Louisiana's Vulnerable Populations (<http://www.recoverycorps.org/media/files/brokenhomes-part2.pdf>)
- Broken Homes: First-Hand Accounts of Living Through Louisiana's Housing Crisis – Part 3: Insurance Issues (<http://www.recoverycorps.org/media/files/brokenhomes-part3.pdf>)
- They are Thinking of Today, Not Tomorrow (evaluation by Berkeley Policy Associates) (<http://www.recoverycorps.org/media/files/BerkeleyEval.pdf>)
- Broken Promises, Unmet Needs Leave Louisiana Vulnerable (<http://www.recoverycorps.org/media/files/broken%20promises%201-29-09.pdf>)
- Louisiana Family Recovery Corps Programs (<http://www.recoverycorps.org/media/files/recovery%20corps%20programs%201-29-09.pdf>)
- Progress for Some, Hope and Hardships for Many (http://www.recoverycorps.org/media/files/RecBrf_May2008.pdf)
- Displaced Louisianians: Where Did They Go and Are They Coming Back (<http://www.recoverycorps.org/media/files/WhereDidTheyGo.pdf>)
- Flawed Programs will Force Louisiana into Another Humanitarian Crisis (<http://www.recoverycorps.org/editorial/09-0403-flawedprograms.php>)
- Extension or Not, Meaningful Changes Must be Adopted (<http://www.recoverycorps.org/editorial/09-0209-meaningfulchanges.php>)

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**Statement of Daniel Stoecker
Chief Operating Officer
BPSOS**

**Hearing on Disaster Case Management:
Developing a Comprehensive National
Program Focused on Outcomes**

Ad Hoc Subcommittee on Disaster Recovery

Wednesday, December 2, 2009
02:30 PM
Dirksen Senate Office Building, room 342

Distinguished Members of the Subcommittee,

Based on our extensive disaster case management experience, we would like to make the following specific recommendations, with a focus on Special Needs Populations.

BPSOS is a national, community-based organization with 29 years of experience. Through its national network of branch operations, BPSOS operates a variety of domestic programs designed to create a web of services to address the intertwining and compounding effects of unmet needs on refugee and immigrant families and communities. Since its founding, one in 10 Vietnamese Americans has received assistance from BPSOS while still in Vietnam, on the high seas, in a refugee camp, or after arriving in the United States.

Our recommendations are informed based on the following:

1. Our experience as a First Responder providing immediate relief and recovery services to disaster survivors, including developing partnerships and collaborations with FEMA, American Red Cross and local governmental and community organizations.
2. Our experience providing immediate (short term) recovery and case management services in multiple states, including coordinating activities with FEMA Disaster Recovery Centers, local VOADs and local LTRCs.
3. Our experience providing long term disaster case management (DCM) services for over 5,000 families who survived Hurricanes Katrina, Rita, Gustav and Ike.
4. Our participation as a member of the committee developing the first pilot program model under the HHS/ACF/Abt Associates Pilot project managed by Catholic Charities USA, and in our role as a member of the ESF 14 Special Needs Populations Workgroup, Office for Civil Rights and Civil Liberties U.S. Department of Homeland Security.
5. BPSOS is the only organization concurrently providing disaster case management services in three active FEMA-HHS pilot programs operating in MS, LA and TX, with over 60 funded staff dedicated to these recovery projects.

Recommendations:

1. Support implementation of a two-tiered disaster case management system for major disaster (affecting large population, inflicting significant systemic damages) relief and recovery response. BPSOS has been advocating for the development of a model similar to the one emerging as the FEMA/HHS recommendation: Short-Term and Long-Term Disaster Case Management services.
2. Ensure adequate resources are allocated for addressing Special Needs Populations as outlined in the National Response Framework, DHS, January 2008 and Special Needs Populations Impact Assessment Source Document, DHS Office for Civil Rights and Civil Liberties, October 2008.

Special needs populations are defined as individuals in need of additional response assistance may include those who have disabilities; who live in institutionalized settings; who are elderly; who are children; who are from diverse cultures; who have limited English proficiency or are

non-English speaking; or who are transportation disadvantaged. We would like to highlight the particular needs of victims of past war, torture and trauma— they are highly vulnerable to re-traumatization due to dislocation, loss of home and livelihood, and loss of the community-based support system.

All of these barriers combined are preventing many families from accessing the supplies and services they need to help them recover. It is crucial that such populations have an advocate in the community and a path through which they can access information, benefits and services. It is necessary to provide communities with access to culturally and linguistically competent services using service providers that they know, trust and can access.

3. Short Term Case Management

(a) Case management should be immediately activated in coordination with FEMA deployment.

(b) Participating agencies should be preselected. Provisions should be made to include additional participants with needed local competencies or who have relationships with underserved communities.

(c) Draw down funds should be made immediately available for contracted agencies to properly address the staffing requirements needed to serve survivors.

(d) High priority and special attention should be given to:

- populations still struggling with lack of supplies, missing or destroyed immigration documents, and to access public benefits and services.
- supporting necessary outreach activities to inform isolated or special needs populations about available recovery resources and with dedicated, trained people that will help them access those resources.
- not only helping families meet their basic needs but identifying those that will need long term assistance and preparing them for the process.

(e) Short Term DCM will operate until clients are transitioned to a functional long term case management program.

4. Long Term Case Management

(a) There is a significant disconnect between the roll out of long-term DCM services and Federal block grant funds intended to provide wrap around recovery resources.

(1) Funds intended for support services should be authorized for distribution when the long-term CM is authorized. These funds are intended for housing assistance, housing repairs, replacement of goods and for recovery services.

(2) An additional component of long-term DCM should be included to fund specialized staff to provide such necessary and highly in demand wrap around service as legal assistance, health and mental health services, and economic development - assistance for small businesses, employment needs, and reintegrating human service support in neighborhoods and other communities.

(b) Include preparedness training as a part of a client's recovery plan and an integral component of all Disaster Recovery Programs. This is important so individuals and communities gain tools and knowledge to mitigate re-traumatization, re-victimization and to develop resiliency skills.

(c) We see a significant deficiency in attention to providing funds specifically directed to immediately replacing or restoring damaged affordable rental housing for low income survivors.

5. Transition between Long-Term and Short-Term programs.

(a) Specify an integrated strategy to facilitate a coordinated transition from short term to long term case management programs that will ensure a continuity of care for active clients and communities with unmet needs.

(b) BPSOS agrees with the statement made in the above cited DHS reports: Communities that advance livability are the desired outcome of long term recovery. Such communities rebuild the infrastructure in a manner that restores the confidence of its residents and enhances the quality of life for all members of the community.

Disaster case management is not a humanitarian issue but a national security one. We look forward to working with the Administration, Congress, and the community of disaster case management service agencies to get our country ready for future human-made or natural disasters.

Thank you for your consideration.



National Council on Disability

An independent federal agency making recommendations to the President and Congress to enhance the quality of life for all Americans with disabilities and their families.

**Testimony of John R. Vaughn, Chairperson
National Council on Disability (NCD)**

Ad Hoc Subcommittee on Disaster Recovery

Homeland Security and Governmental Affairs Committee

U.S. Senate

**“Disaster Case Management: Developing a Comprehensive National Program
Focused on Outcomes”**

Wednesday, December 2, 2009
342 Dirksen Senate Office Building
2:30 P.M.

Ms. Chairwoman, Ranking Member Graham, and Members of the Senate Homeland Security and Governmental Affairs Ad Hoc Subcommittee on Disaster Recovery:

On behalf of the Members of the National Council on Disability, thank you for your consideration of the following written testimony for inclusion in the written record.

National Council on Disability

NCD is composed of 15 members, appointed by the President, with the consent of the U.S. Senate, and a staff that supports the Council's work. The purpose of NCD is to promote policies, programs, practices, and procedures that guarantee equal opportunity for all individuals with disabilities and that empower individuals with disabilities to achieve economic self-sufficiency, independent living, and integration into all aspects of society. To accomplish this, we gather stakeholder input, review federal programs and legislation, and provide advice and recommendations to the President, Congress and government agencies. Much of this advice comes from timely reports and papers NCD releases throughout each year, such as our recently released *Effective Emergency Management: Making Improvements for Communities and People with Disabilities* report.

NCD's Role in Emergency Preparedness Policy

NCD developed a keen interest in emergency preparedness policy following the September 11, 2001 attacks. Finding very little published on emergency preparedness as it pertained to the unique considerations of people with disabilities, NCD embarked on a research project that culminated in the release of a report in April 2005 entitled *Saving Lives: Including People with Disabilities in Emergency Planning* (http://www.ncd.gov/newsroom/publications/2005/saving_lives.htm). The *Saving Lives* report brought what little research existed on the topic to the fore, pairing it with stories from individuals with disabilities about their personal experiences in times of emergencies. The report also presented a "what-if" scenario of a major hurricane striking the Gulf Coast. In the report, NCD proposed steps the federal government should take to ensure that the needs of people with disabilities be appropriately incorporated into emergency preparedness, disaster relief, and homeland security plans. Hurricane Katrina struck just four months after the report's release.

Subsequent to issuing *Saving Lives*, NCD issued two other evaluations. In July 2006, NCD released a paper titled, *The Needs of People with Psychiatric Disabilities During and After Hurricanes Katrina and Rita: Position Paper and Recommendations* (<http://www.ncd.gov/newsroom/publications/2006/peopleneeds.htm>). In August 2006, NCD issued *The Impact of Hurricanes Katrina and Rita: A Look Back and Remaining Challenges* (http://www.ncd.gov/newsroom/publications/2006/hurricanes_impact.htm). In both papers, like the earlier report, while the focus is on the emergency preparedness and response to Hurricanes Katrina and Rita, many of the problems addressed are systemic in nature and were not caused solely by the hurricanes.

In 2006 the Homeland Security Appropriations bill's Post-Katrina Emergency Management Reform Act (H.R. 5441) charged the FEMA Administrator to work with NCD on specific tasks. These tasks involved: appointing a Disability Coordinator; interacting with stakeholders regarding emergency planning requirements and relief efforts in case of disaster; revising and updating guidelines for government disaster emergency preparedness; evaluating a national training program to implement the national preparedness goal; assessing the Nation's prevention capabilities; identifying and sharing best practices; coordinating and maintaining a National Disaster Housing Strategy; developing accessibility guidelines for communications and programs in, shelters, and recovery centers; and, helping all levels of government in the planning of evacuation facilities that house people with disabilities.

Based on its ongoing policy and research work in the area of homeland security, NCD identified a major gap in the government's knowledge base. That gap involves the availability and use of effective practices for community preparedness and response to the needs of people with disabilities in all types of disasters. In 2008, NCD began to review the spectrum of available studies and defined a set of best and promising practices for emergency management across the life cycle of disasters (preparedness, response, recovery, mitigation) and geographic areas (urban to rural locations). In addition, NCD collected more information about promising practices from emergency

management presentations, a public consultation, and public testimony received in writing and at Council meetings held throughout the country. On August 12, 2009 NCD released the report entitled *Effective Emergency Management: Improving Communities for People with Disabilities* at the National Citizen Corps Program annual meeting in Alexandria, VA. Since the August 12, 2009 release of that report, NCD has continued to extensively distribute the report as a resource across the country to several hundred emergency management agencies at the state and local levels.

Although the Council's recent report offers analysis and policy recommendations regarding the entire life cycle of a disaster, we limit our written testimony here to the recovery phase of a disaster and the topic of disaster case management as it affects people with disabilities. The testimony first outlines several of the areas of paramount concern to people with disabilities during the recovery phase of the disaster life cycle and explains the weighty implications each of those areas can have unique to people with disabilities. After establishing an overview of these unique concerns ripe for case management services, the testimony focuses on the topic of case management itself, making several pointed recommendations for how development of a mitigation- and recovery-oriented system of case management could ensure that the needs of people with disabilities are met.

Disaster Recovery for People with Disabilities

The recovery time period is the least well researched phase in the emergency management life cycle. Coupled with a noted dearth of studies on people with disabilities, it is not surprising that only minimal efforts have been made to address disaster recovery for this population. The technical reports, testimony, and other materials that do exist strongly suggest that the recovery phase is a problematic time for people with disabilities.

As Hurricane Katrina revealed, considerable post-disaster challenges exist for people with disabilities, including:

- Difficulty finding temporary accessible housing;
- Lack of insurance coverage for specialized disability needs;
- Gaps in Federal assistance;
- A loss of access to health care; and
- Disruption of caregiver networks upon which many rely

Housing Concerns

Perhaps surprisingly, housing is one of the least examined areas of recovery research, despite its importance. Low-income housing tends to take a disproportionate "hit" during a disaster because it is likely to be older and less likely to comply with the standards of modern building codes; located in a floodplain or other hazardous area; and less structurally able to withstand an event (such as manufactured housing). Thus, seniors

and people with disabilities at lower incomes presumably bear a higher risk of displacement from their homes.

Public housing can be problematic when it has been affected, particularly in locations that are approved through the Section 8 Housing Choice Voucher Program. Although the Department of Housing and Urban Development (HUD) maintains lists of available units across the nation, those units may not be located nearby. In past disasters, HUD and local housing authorities have identified and verified appropriate locations for replacement rentals. After the California wildfires in 2007, HUD established a new National Housing Locator System. The system invited prospective landlords and property owners to list units. Approximately 26,000 units were identified within a 300-mile radius of San Diego County. The list included the ability to search for accessible units, although additional concerns remained, including proximity to work, family, health care, transportation, banking, pharmacies, and other routinely accessed sources of support.

In New Orleans, public housing units remain unavailable while they are being rebuilt by HUD and area housing authorities. Concern has been expressed by local residents that the new units, which will be in mixed-income ranges, will displace or deter lower income residents. Finding housing near vital support systems needed by people with disabilities, the elderly, and people with medical conditions is also of concern. For example, relocation 100 miles away from a familiar senior center or dialysis center would be problematic.

After Hurricane Katrina, FEMA failed to provide temporary trailers that were accessible. In *Brou v. FEMA* (the Department of Homeland Security was also named in the suit), successful plaintiffs argued in a class action discrimination suit that the federal agency had not provided accessible trailers (e.g., with wheelchair ramps, maneuvering room, or grab bars), resulting in a longer wait for temporary housing. As another example, housing advocates have noted in conference presentations that mitigation elevations along the Gulf Coast displace people with mobility disabilities and senior citizens. Some organizations report that some of these people have been forced to choose congregate care over independent living.ⁱ *Brou v. FEMA* was one of several efforts by the disability community that have resulted in changes at FEMA when it comes to disaster response and recovery. In another example, FEMA is incorporating disability-specific ideas and language into its National Disaster Housing Strategy and Plan.

Disrupted Education for Children with Disabilities

In NCD's 2006 *The Impact of Hurricanes Katrina and Rita on People with Disabilities: A Look Back and Remaining Challenges*ⁱⁱ paper, NCD noted that Hurricane Katrina displaced approximately 247,000 students from Louisiana, 125,000 from Mississippi, and 3,000 from Alabama; additionally, Hurricane Rita displaced about 86,000 students from Texas' schools.ⁱⁱⁱ Over 200,000 school age children, 135,000 of whom are from Louisiana, have been rendered homeless because of Hurricanes Katrina and Rita.^{iv} Some estimates indicate that 12 percent of the displaced students have disabilities.^v

Advocacy, Inc., of Texas estimated that Hurricane Rita displaced about 2,200 children with disabilities under the age of five – many of those children will need early intervention services – and about 5,000 school-aged children with disabilities.^{vi} One of the most crucial challenges for disaster recovery efforts is to continue the education of student-evacuees while rebuilding educational services in the Gulf Coast.

After major disasters, many schools struggle to reopen for protracted periods of time. As a result, many student-evacuees integrate into new school systems. Nevertheless, the temporary nature of shelter or emergency housing has caused many students to be transferred from school to school numerous times.

For student-evacuees with disabilities, the transfer to other school systems has been particularly problematic. Some student-evacuees with disabilities were unable to register for school because they had not secured housing in the evacuation area and therefore could not provide documentation. However, the McKinney-Vento Homeless Assistance Act^{vii} allows students to attend school despite the lack of formal documentation. However, for many student-evacuees with disabilities who did not bring documentation about the nature of their disability or about their IEPs when they fled from the hurricanes, some schools denied them the provision of necessary special education services.^{viii}

The state of Alabama was an exception to this phenomenon. After Katrina, it decided to “take the parents at their word” and provided special education services to evacuees to the best of the schools’ abilities, despite the lack of formal documentation.^{ix} Similarly, Fort Worth district officials temporarily waived documentation requirements. Several Texas school districts hired additional staff in anticipation of an influx of students with special needs, estimating that between 10 and 15 percent of student-evacuees would have some type of learning disability.^x On a federal level, Congress and the President jump-started various efforts to help children with disabilities return to school as quickly as possible, releasing millions in aid to help displaced children.

Financial Recovery

The financial impact on people with disabilities who endure disasters is unknown, but it seems self-evident that for low-income households, which are more prevalent among people with disabilities, the impact is considerable. Hurricane Katrina, though not the typical disaster, illustrates a number of problems. Because people with disabilities were displaced and relocated throughout the country, accessing specific services—such as Medicare and Medicare Part D prescription coverage, veterans’ benefits, Social Security checks, and Supplemental Security Income (SSI)—was difficult, if not impossible in some instances. People experienced disruption of work and personal life, often the types of activities that give a sense of stability during stressful periods. People also lost access to their bank accounts to which monthly checks were being sent. The widespread displacement across the country meant that local, familiar social service and health care providers were not available. Case managers could not find their

clients. The impact and extent of the disruption is not known, but it is clear that the effects were profound.

Medical and Health Impacts

An example of the profundity of the disruption is seen in one survey among those with one or more chronic conditions. Of those surveyed, 21 percent cut back or terminated their health care.^{xi} Affected persons were usually elderly, uninsured, and/or isolated. Reasons for cutting back included the following: 41 percent lacked access to a physician; 33 percent could not afford or obtain medications; 29 percent had financial problems; and 23 percent lacked transportation to health care. The finding that these conditions affected seniors (disability prevalence increases dramatically with age) coincides with reports from caseworkers.

Other barriers to receiving health care and health problems for disaster victims include^{xii}:

- Loss of medication or medical devices
- Finding time to seek medical care
- Paying for medical care
- New health problems
- Worsening health problems

When the health care infrastructure is itself affected, barriers and poor health outcomes escalate. For instance, following Hurricane Katrina, several medical centers and hospitals were forced to close or underwent extensive staff losses. As a result, one study reported the following health concerns among adults in New Orleans two years after the storm:

- More than 4 in 10 adults reported worse access to health care.
- In Orleans Parish, one in four adults reported being uninsured.
- Seventy percent of the uninsured were black.
- More than 1 in 10 adults ranked their health as fair or poor.
- Four in 10 said they had been diagnosed with a chronic disease

Considerable disruption to medications and mental health services occurred as a result of Katrina as well as other disasters. After Hurricanes Ike and Gustav, for example, people remained away from their homes, providers, and pharmacies, and missed out on medications for weeks at a time. Under these circumstances, significant health problems can manifest from withdrawal symptoms or disrupted medication routines.^{xiii} Special needs shelters and other locations are increasingly addressing these concerns, but challenges remain at many shelter locations. Long-term studies of the consequences of these circumstances should be generated to better inform both policy

and practice. Long-term and mobile outreach to affected, displaced populations needs to be further investigated.

Disaster Case Management and People with Disabilities

All of the experiences outlined above undermine the ability of people with disabilities to recover in the short and long terms. Exacerbating these detrimental experiences, emergency managers and non-governmental organizations (NGOs) often work side by side in a disaster context to provide relief and recovery assistance, yet they often remain distant from people with disabilities and disability organizations.

A Lack of Focus on Human Recovery

Although we know that disability non-governmental organizations (NGOs) deliver services to support human recovery after disasters have ended, no formalized system of services or operating plan exists to that end. Current federal and state guidance lacks a focus on human recovery, offers virtually no protocols on how to implement human recovery (particularly for those who have the fewest resources pre-disaster), and provides little support for long-term case management. Further, disability-related NGO roles have not been formalized or integrated into local and state planning and recovery efforts. Despite Emergency Support Function (ESF) and National Incident Management System (NIMS) provisions that articulate the need for health-related services to support human recovery (e.g., ESF-6 focuses on mass care and ESF-14 on long-term recovery), there is a lack of clarity in terms of how to make this guidance operational, and there is no standard alignment of resources with these functions.

Developing a Mitigation- and Recovery-Oriented Service System and Operating Plan

NCD believes there is a great need to develop both a mitigation-oriented and recovery-specific service system and an operating plan to guide human recovery and to integrate and formalize disability-related NGO roles and responsibilities into relevant federal policies and guidance. Developing such a service system and operating plan should directly involve people with disabilities throughout all stages, and explanation of that involvement should be reflected in formal state plans.

Development of a mitigation-oriented and recovery-specific service system and operating plan would involve several steps. First, clear federal guidance or templates outlining how disability-related NGOs should be involved in the plans for human recovery via ESF-6 and ESF-14 and supported by specific language in the Stafford Act must be established. Second, case management must be specifically addressed, as it is one of the key roles and responsibilities NGOs provide is case management. Case management, as currently defined by the Stafford Act, is for "services, to victims of major disasters to identify and address unmet needs."¹

¹ 42 U.S.C. 5189d § 426, Case Management Services

Expanding the definition of case management to include direct services may help address short- and long-term recovery needs by ensuring their consistent coverage. Lawmakers could also add language to the Stafford Act to provide for disability-related NGO capacity assessment for human services, directions for state and local governments to integrate disability-related NGOs into planning and service delivery, and guidance for how to publicly fund the designated services.

Katrina Aid Today, a disaster case management approach that is unfortunately no longer funded, represented many best practices. Katrina Aid Today used local social workers and established procedures to guide individuals through the recovery process. The joint efforts of government officials and disability organizations and advocates were particularly helpful in identifying problems and recommending solutions that work.

Disability Specialist Case Managers

In addition, within such a system and operating plan, NCD recommends developing a corps of pre-identified disability specialist case managers who are uniquely equipped with both the competence of and familiarity with circumstances and service needs common to people with disabilities. This level of competence and familiarity will ensure that the demand of clients with disabilities can be met quickly and appropriately.

This corps of disability case managers should include people with disabilities from the state and/or local community affected by the disaster and could draw from established state and/or local community-based organizations (e.g., Centers for Independent Living, Protection and Advocacy Organizations). Employees of such organizations are already well-versed with the disability population of the area, local conditions, and resource networks that will play vital roles in effective human recovery.

NCD has noted in its studies that there the lack of trained support personnel is an ongoing challenge in emergency management services for people with disabilities. As a result, it will be important to ensure that the corps of disability case managers obtain the appropriate, on-going training needed to be "uniquely equipped with both the competence of and familiarity with circumstances and service needs common to people with disabilities." It will also be necessary to ensuring that the corps of disability case managers maintain their training to serve people with disabilities and that the organizations from which they provide services are able to maintain their capacity to support those disability case managers.

A National Program Focused on Outcomes

Measuring the outcomes of disaster case management, such as individual life outcomes that result from an individual having a case manager is difficult. Part of the challenge is due to the complexity of the human services system particularly one related to a natural disaster.

The federal government has spent \$231 million of FEMA and HUD funds for Post-Katrina case management work according to the Government Accountability Office (GAO).² GAO also reported that evaluations of FEM-A and HUD-funded pilot programs in the Gulf Coast for Post-Katrina case management work did not focus on program outcomes or client results,³ notwithstanding a previous recommendation by GAO to conduct an outcome evaluation of the pilot case management programs.⁴ Federal agencies have, however, reported that they will rely on third-party evaluations of the current pilot programs, and that the evaluations will include program outcomes.⁵

Measuring the outcomes of case management, such as individual life outcomes that result from an individual having a case manager, is challenging. Part of the challenge is due to the complexity of the human services system particularly one related to a natural disaster. It is hoped that the case management service effectiveness outcomes (e.g., delivering the appropriate service at the right time, decreased duplication of services, Reduction of disaster services/human services), as well as valued client outcomes (e.g., access to assistive technology, replacement of durable medical equipment, improved post-disaster health status, avoidance of institutionalization, achievement of client disaster recovery goals, client satisfaction with services and supports).

Admittedly, some outcomes may be difficult to quantify and/or prove that they are a result of case management intervention supplied through the two federally-funded pilot programs. Further, there is a risk to suggesting that case management can be accountable for program and/or client outcomes that in fact are dependent on the larger human services system (e.g., city or county wide) in which the case management service is delivered. Indicators, specific to case management then, will need to be carefully selected and implemented in order to avoid wrongly attributing to case management results that are dependent on the service system upon which the case management pilot programs rest.

Conclusion

The challenges faced by people with disabilities, seniors, and residents of low-income households following disasters often demonstrate considerable overlap. Planning for and accommodating people with disabilities throughout all phases of a disaster, including recovery, and specifically within case management, often means being better equipped to serve all people.

² Disaster Assistance: Improvements in Providing Federal Disaster Case Management Services Could Help Agencies Better Assist Victims, GAO-10-278T, p. 5, December 02, 2009

³ Ibid, page 13

⁴ Disaster Assistance: Greater Coordination and an Evaluation of Programs' Outcomes Could Improve Disaster Case Management GAO-09-561, July 8, 2009

⁵ Disaster Assistance: Improvements in Providing Federal Disaster Case Management Services Could Help Agencies Better Assist Victims, GAO-10-278T, p. 13, December 02, 2009

As a final note, in addition to the recommendations regarding case management NCD provides in this testimony, NCD's *Effective Emergency Management* report contains a plethora of additional recommendations not only for the recovery phase, but for all phases of the disaster life cycle, which may further inform this Committee's work.

On behalf of the Members of NCD, thank you again for the opportunity to contribute testimony to the written record.

ⁱ Cahill, A. (2006). *Planning tools you can use to meet the needs of people with disabilities in an emergency: What to do, what not to do, and what difference does it make?* Paper presented at the Working Conference on Emergency Management and Individuals with Disabilities and the Elderly, Washington, DC.

ⁱⁱ http://www.ncd.gov/newsroom/publications/2006/hurricanes_impact.htm

ⁱⁱⁱ Bush Administration, Congressional Republicans Mismanage Hurricane Recovery, *supra* at note 60.

^{iv} Education Rights of Displaced and Homeless Children, Council of Parent Attorneys and Advocates (September 5, 2005), <http://www.copaa.org/news/hurricane.html> (last visited July 19, 2006).

^v Principles for Preparedness, Consortium for Citizens with Disabilities (December 20, 2005), <http://www.c-c-d.org/Final%20Principles.pdf> (Last visited July 19, 2006), at note 72.

^{vi} Advocacy, Inc. Report to Texas Equal Access to Justice Foundation, Advocacy, Inc. (October 15, 2005) report on file.

^{vii} 42 USC § 11431

^{viii} Education Rights of Displaced and Homeless Children, *supra* at note 75.

^{ix} Elizabeth A. Greczek, How to Weave Through the Special Education Maze in the Wake of Hurricane Katrina, Disability Law Resource Project at ILRU (September 28, 2005), <http://www.ilru.org/html/training/webcasts/handouts/2005/09-28-Greczek/transcript.txt> (Last visited July 19, 2006)

^x Eva-Marie Ayala, CLASSROOM COPING: Schools addressing special needs of some evacuees by adding more specialized staff, Star-Telegram (September 22, 2005)

<http://www.jfanow.org/jfanow/index.php?mode=A&id=2571>

^{xi} Kessler, R. (2007). Hurricane Katrina's impact on the health care of survivors with chronic medical conditions *Journal of General Internal Medicine*, 22(9), 1225–1230.

^{xii} Curry, M. D., Larsen, P. G., Mansfield, C. J., & Leonardo, K. D. (2001). Impacts of a flood disaster on an ambulatory pediatric clinic population. *Clinical Pediatrics*, 40(10), 572.

^{xiii} Berggen, R., & Curiel, T. (2006). After the storm: Health care infrastructure in post-Katrina New Orleans. *New England Journal of Medicine*, 354(15), 1549–1552.

Questions for the Record

Disaster Case Management: Developing a Comprehensive National Program Focused on Outcomes

December 2, 2009

From Senator Mary Landrieu to Beth Zimmerman

1. It has come to my attention that delays in providing reimbursement to non-profit case management providers led Disaster Case Management Program partners to withdraw from the program.
 - Have ACF and FEMA considered allocating up front funding to non-profits that are providing disaster case management services?

Response: The Disaster Case Management Pilot Program (DCM-P) is a cost reimbursement program. As such, it is the responsibility of the State agency that has oversight of the DCM-P program to submit the Standard Form- 270, Request for Advance or Reimbursement. To-date, FEMA has responded to advance funds requests from both the Mississippi and Texas DCM-P programs. We have not received an advance funds request from the Louisiana DCM-P program.

FEMA has taken note of the DCM provider agencies concerns over pre-award costs and start up funds. The final DCM program will address these issues by providing grant funds to the State immediately after approval of their submitted proposal and budget.

2. Throughout the hearing you heard testimony from various organizations on the need to measure outcomes of a disaster case management program to determine if it has met the needs of survivors.
 - How does FEMA plan to measure the outcomes of a national disaster case management program?

Response: FEMA required each Disaster Case Management (DCM) pilot to have a third party evaluation of their program to include program outcomes. FEMA will analyze the results of each of the pilots to compile lessons learned and best practices. We are in the process of contracting with an evaluation group who will do this analysis but also provide FEMA with the evaluation tools and templates that will become part of the requirements for all DCM programs initiated in the future.

FEMA is also working closely with the Coordinated Assistance Network to capture case information on a “continuum of recovery”. This process requires the case manager to assess the level of the case, based on predetermined tiers, each time they access the case in the data system. (Tier one – cases with the highest assessed unmet needs that require contact weekly (or more) contact. Tier two – cases with lesser need who are moving towards recovery and should have contact every two weeks. Tier three – cases that require contact, at a minimum, once a month as they likely have one or two needs remaining in their recovery plan. Tier four – cases being those whose recovery needs are met.) Capturing data in this way would allow FEMA and the State to review aggregate case data which demonstrates the movement of clients through to their recovery.

3. FEMA has stated that case management funds can't be used to pay for furniture, cookware, bedding, or rent and utility deposits. The reason for this policy is that the FEMA Individual & Households Program (IHP) is supposed to meet those needs, and the agency doesn't want to create a duplicative program. Unfortunately, families sometimes hit the IHP cap before they are back on their feet. Some have fallen through the cracks as a result of the cap or lack of system connectivity between the Coordinated Assistance Network and FEMA's Individual Assistance program restrictions and were unable to obtain the additional support they needed.
 - How does FEMA plan to address this gap between case management and the IHP to ensure that survivors have access to the resources they need?

Response: Future Disaster Case Management (DCM) Programs will be implemented in two phases. The first phase will be the rapid deployment of case managers who will begin services within 72 hours of approval of the DCM Program. Working closely with the FEMA Individuals and Households Program (IHP), the disaster case managers will engage FEMA applicants in the very earliest days of their recovery. In doing so, case managers will be able to provide connections that leverage the applicant's disaster funds for materials (rebuilding and repair), provide referrals to financial management resources and to assist the family in monitoring disaster needs expenditures. Additionally, they will focus on benefit restoration (TANF, SNAP (formerly Food Stamps), etc.) for applicants who were receiving those services prior to the disaster.

The second phase of the program will be a long term recovery component in which client's records are reviewed for continuing unmet needs. DCM case managers will present cases to Long Term Recovery groups that have additional resources from faith-based members, private sector and non-governmental organizations. FEMA IHP will continue to work closely with the DCM program, throughout this phase, to identify maximum grant applicants, and those who have ongoing needs not met by Federal programs.

Senate Committee on Homeland Security and Governmental Affairs
 Ad Hoc Subcommittee on Disaster Recovery
 Disaster Case Management: Developing a Comprehensive National Program Focused on
 Outcomes
 December 2, 2009
 Questions for the Record from Chairman Mary Landrieu to David Hansell, HHS

1. On August 12, 2009, The National Council on Disability (NCD) released its report titled "*Effective Emergency Management: Making Improvements for Communities and People with Disabilities*," which included several recommendations. NCD recommends developing a corps of pre-identified disability specialist case managers who are familiar with the circumstances and service needs common to people with disabilities.
 - Do you agree such a corps should be created, or are the needs of special populations already being addressed?
 - What steps is the agency taking to ensure that the case management program will be able to thoroughly address the needs of people with disabilities?

Response: The Administration for Children and Families' (ACF) current case management efforts include capacity building to pre-identify and credential personnel nationwide. As part of this process, we will identify case managers who possess specialized skills and experience in addressing the needs of people with disabilities, the elderly, persons with language barriers, and those with other special needs, as well as families.

2. It has come to my attention that delays in providing reimbursement to non-profit case management providers led Disaster Case Management Program partners to withdraw from the program.
 - Have ACF and FEMA considered allocating up front funding to non-profits that are providing disaster case management service?

Response: While ACF is aware that concerns were expressed in the past about reimbursement delays, we are not aware of any non-profit case management providers that have withdrawn from our Disaster Case Management Program. It is our understanding the reimbursement delays were related to financial reporting issues. ACF has provided training and technical assistance to address these financial reporting issues.

3. Throughout the hearing you heard testimony from various organizations on the need to measure outcomes of a disaster case management program to determine if it has met the needs of survivors.
 - How does ACF plan to measure the outcomes of a national disaster case management program?

Response: ACF has developed a four-step approach to assessing the Disaster Case Management Program:

Step 1

We contracted with Abt Associates, Inc. to conduct an assessment of the two-week pilot period in September 2008 to determine the appropriateness of the model and the ability to deploy the model and provide immediate case management two weeks after the initial deployment of the pilot in Louisiana. Abt Associates, Inc. issued its After Action Report in December 2008, which identified program strengths and areas of improvement.

Step 2

In August 2009, ACF contracted with PriceWaterhouseCoopers in order to assess the organizational structure and processes used throughout the pilot; any significant implementation barriers that may have impacted clients' return to self-sufficiency; and strengths and areas for improvements that may impact outcomes. The final report was submitted to ACF in December 2009.

Step 3

We sought public comments on the working draft of the Disaster Case Management Implementation Guide through a *Federal Register* notice in September 2009. Subject matter experts were consulted to assist with analyzing the program implementation methods and assessing the recommended changes to the implementation guide resulting from the public comment period. The public comment recommendations were incorporated into the revised version of the implementation guide in December 2009. The public comment and review process will be repeated again at the end of the pilot project in March 2010 before finalizing the program implementation guide.

Step 4

In March 2010, near the conclusion of the pilot, we plan to conduct an assessment of the impact and outcomes of case management services on individuals' abilities to return to self-sufficiency; types of case managers and programs that lead to successes; and types of services provided most frequently. We anticipate completing this assessment by late summer 2010.

We plan to incorporate lessons learned from these four assessment efforts into our work with Catholic Charities USA to ensure that trained personnel are credentialed and available should a disaster occur. In addition, we will use the findings as the foundations for our recommendations to FEMA to develop the national case management program.

4. The International Rescue Committee (IRC) focuses on resettling refugees in the United States by employing a holistic case management approach. This organization works to connect refugee families with immediate assistance upon their arrival in the U.S, and the case managers continue to follow these families to ensure that their long-term recovery and resettlement needs are met.
 - Are you familiar with the case management model employed by IRC?

- What aspects of the holistic model do you think ACF should adopt for the disaster case management program?

Response: ACF is familiar with the IRC case management model. ACF used concepts of the refugee resettlement model as a starting point in developing its Disaster Case Management Pilot Program. Specifically, we incorporated their principles of self-sufficiency and self-determination as the foundation for our work. We also used their model of working with faith-based communities to provide case management services including using a mix of professionals and lay personnel. Our model is designed to provide 12 months of case management services. Clients are followed throughout the program to assess their recovery.

Response for the Record

Disaster Case Management: Developing a Comprehensive National Program Focused on Outcomes

January 8, 2010

From Fred Tombar to Senator Mary Landrieu

1. **Question:** Throughout the hearing you heard testimony from various organizations on the need to measure outcomes of a disaster case management program to determine if it has met the needs of survivors. How does HUD plan to measure the outcomes of a national disaster case management program?

The Department requires each Disaster Housing Assistance Program (DHAP) Grantee to report case management services through a web-based system that tracks resident needs, individual development plans (IDP), service referrals, and IDP goals completed. Public Housing Authorities (PHAs) also track self-reported income information, employment, and status toward securing permanent housing. Based on information submitted, the system creates a baseline of household characteristics for each program participant and tracks outcomes relative to this baseline over the term of the DHAP. The program is designed to help households achieve increased self-sufficiency outcomes relative to the participant's baseline of household characteristics at the beginning of their participation, and personalized based on family needs. The outcome that is considered the primary goal for all DHAP families is permanent housing. Under DHAP-Katrina over 12,000 families were provided permanent housing through the Housing Choice Voucher program. The case management tracking system, along with the Disaster Information System (DIS), are the primary tools used by HUD to measure and report outcomes of disaster case management during the term of a DHAP engagement, including the final goal of long-term permanent housing for each family.

While data mining and additional analysis of system data are being conducted by HUD's Office of Public and Indian Housing (PIH), tracking family outcomes typically involves following families for an extended period, beyond their program participation. HUD's Office of Policy Development and Research (PD&R) is currently conducting an extensive study to document DHAP-Katrina participants' outcomes and experiences with the case management strategies employed by PHAs. The study will collect survey and administrative data on participants regarding their housing, employment, income, savings/debt, and other quality of life outcomes. It will also gather data on the amount, type, intensity, and delivery type of case management received by clients in DHAP. It will track the client sample, conducting a 12-month follow-up telephone survey with the sample of DHAP Phase I/II/III families, a possible 24-month follow-up telephone survey, data analysis, and interim and final reports. These data analyses will be supplemented by a review of existing research and semi-structured telephone discussions with up to ten key individuals with knowledge of how DHAP was implemented, who will likely include FEMA and HUD staff. The study will also convene an expert panel of program administrators and case managers who were involved in providing services to DHAP clients as well as national experts in disaster recovery.

The PD&R study will fulfill three important needs for HUD and the DHAP. First, it will provide systematic information on the outcomes realized by DHAP participants. Second, it will

explore how these outcomes vary with the characteristics of clients, the services they receive, and the specific rent transition strategy applied to clients to help them achieve self-sufficiency. Third, this study will lay the groundwork for disaster housing policy discussions and the design of a housing case management model for use in responding to subsequent disasters. PD&R expects a final report by July 2011.

2. **Question:** In September, the Housing Authority of New Orleans (HANO) turned over its entire Section 8 operation to a Houston firm, Mir Fox Rodriguez. Both the DHAP and Section 8 contracts, worth a combined \$17 million, were 'no bid' contracts. My office has heard multiple complaints from landlords and tenants about Mir Fox's poor administration of DHAP. We have also been contacted by two separate local Mir Fox subcontractors with concerns over nonpayment by Mir Fox for services provided under DHAP. On October 26th, I contacted HUD regarding complaints from two Mir Fox subcontractors. Has HUD responded to this letter? Will HUD take into account both cost and previous performance when deciding whether to renew these contracts?

HUD provided a response letter on November 20, 2009 to Sen. Mary Landrieu regarding complaints from the following Mir Fox Rodriguez (MFR) sub-contractors who expressed concerns about their case management contracts in New Orleans: Gulf Coast Professional Consultants LLC (GCPC) and Odyssey House Louisiana (OHL).

Gulf Coast Professional Consultants LLC (GCPC):

In the letter, HUD explained that in December 2007, Harris County Housing Authority (HCHA) entered into a contract with HANO to provide services under DHAP-Katrina. In April 2008, HCHA contracted with GCPC to provide case management services to DHAP participants, and in December 2008, HCHA assigned the contract to MFR. The contract between HCHA and GCPC provides that "[s]ubstandard performance as determined by either HCHA or HUD, in their sole discretion, will constitute non-compliance or breach of this Agreement and may result in a forfeiture of certain fees..." The contract also states that if HUD or HCHA initiates an investigation into any matter in the contract, "HCHA may withhold all payments until the results of the investigation have been revealed."

In January 2009, after conducting reviews of GCPC's files to determine whether GCPC had met performance criteria, MFR decided that it was necessary to initiate a full compliance review. In February 2009, MFR notified GCPC that it would withhold its recommendation for payment for services until MFR could perform the audit. GCPC demanded immediate payment in March 2009, and in April 2009, sued MFR and HCHA in federal court. To date, MFR has not requested payment from HANO for GCPC's invoices for January and February 2009, nor has HANO made these payments. MFR is waiting for completion of the audit to request payment from HANO for the January and February invoices.

In November 2009, MFR and GCPC met at a settlement conference for the ongoing lawsuit. The parties agreed that MFR would continue to review files from GCPC to determine whether GCPC did the work, and whether MFR should pay the unpaid invoices.

Odyssey House Louisiana (OHL)

After HCHA's contract with HANO expired in December 2008, MFR also became the assignee of the contract between HCHA and OHL to provide case management services under DHAP-Katrina. In February 2009, MFR began a partial audit of OHL. After the audit, MFR withheld payment to OHL for January and February 2009, alleging that OHL had not complied with the performance criteria for case management under the contract. MFR has since paid the January invoice, but the February invoice remains unpaid.

In June 2009, MFR requested a further audit of OHL, and OHL responded that MFR had no right to conduct this audit. MFR replied that if OHL would not allow MFR to conduct the audit, MFR would consider OHL's previous response refusing the audit as formal notice of OHL's noncompliance. OHL did not reply to this communication, so MFR considered the matter of the unpaid February invoice to be closed.

HUD's Response

MFR alleges that both GCPC and OHL did not comply with a number of the performance criteria under the contracts between MFR and the subcontractors. The performance criteria provided that, at a minimum, the party performing case management would maintain acceptable documentation that: the average caseload ratio per case manager did not exceed 1:50, actual case management services were being provided, and a needs assessment and Individual Development Plan had been established for each adult family member. These criteria were in accordance with the mandatory elements of the DHAP-Katrina Case Management Guidelines.

This matter is ultimately a contracting dispute between the contractor and subcontractors. HUD is not a party to these contracts and therefore cannot speak to the parties' responsibilities under the contracts. Furthermore, MFR has stated that HANO is not a party to its contracts with GCPC and OHL, and that the dispute is only between MFR and its subcontractors. HUD is monitoring the situation closely and reviewing case management records to determine if further action is needed in terms of the provision of services provided by HANO through case management contractors.

Finally, as to whether HUD, specifically HANO, will take into account both cost and previous performance when deciding whether to renew the contract(s) in question, Keith Pettigrew, the Deputy General Manager of Operations at HANO, stated that HANO will take both of these criteria into account when deciding whether to renew the contract(s) with MFR. Moreover, while Mr. Pettigrew can only speak to the current leadership under the new Administrative Receiver, David Gilmore, he stated that HANO will take into account both cost and performance for any and all current and future renewals.

**Response to Post-Hearing Questions for the Record
Disaster Case Management: Developing a Comprehensive National Program
Focused on Outcomes**

**Ad Hoc Subcommittee on Disaster Recovery
Committee on Homeland Security and Governmental Affairs
United States Senate
December 2, 2009**

**Questions for Kay Brown
Director, Education, Workforce, and Income Security Issues
U.S. Government Accountability Office**

Questions for the Record Submitted by Chairman Mary L. Landrieu

- 1. In your testimony, you mentioned there were difficulties in tracking clients across case management providers because they used different databases.**
 - **Do you know if case management providers are still using separate databases, or have they developed a structure to share information?**
 - **Would GAO recommend that this be a federal requirement for future disaster case management programs?**

In our July 2009 report¹ and in the subsequent testimony,² we stated that incompatible databases made it difficult to track clients across agencies, which may have led to duplication in services for some clients. For example, clients who received case management services through the Katrina Aid Today (KAT) program may have also received services through the Louisiana Family Recovery Corps (LFRC) program, but because the KAT and LFRC databases were not compatible, some case management agencies for these two programs may not have been able to screen for duplication of services. As a result, some hurricane victims may have received case management services from more than one program. While many case management agencies have adopted use of the Coordinated Assistance Network database, for either managing their programs or for reporting, we did not determine the extent to which individual case management agencies have developed procedures for sharing data or using the same or compatible databases since the publication of our report.

¹GAO, *Disaster Assistance: Greater Coordination and an Evaluation of Programs' Outcomes Could Improve Disaster Case Management*, GAO-09-561 (Washington, D.C.: July 8, 2009).

²GAO, *Disaster Assistance: Improvements in Providing Federal Disaster Case Management Services Could Help Agencies Better Assist Victims*, GAO-10-278T (Washington, D.C.: December 2, 2009).

Because of problems we found with coordination between case management agencies—including challenges in sharing data due to incompatible databases—we recommended that FEMA ensure that the federal disaster case management program it develops for future disasters includes practices to enhance and sustain coordination among federal and nonfederal stakeholders. One such practice is to address the compatibility of data systems to operate across agency boundaries.³ While we did not specifically recommend that case management agencies be required to use the same database or make their databases compatible, FEMA is taking steps to address this issue. According to a FEMA official, FEMA and HHS are working in close coordination to assess the various systems used to collect case management information to determine whether a new system should be created, a current system should be modified, or an existing system can be used. The FEMA official stated that a contractor has been hired to evaluate the data systems, and an evaluation will be provided later this year. The results of this evaluation will help determine what data system will be used in providing disaster case management following a future disaster.

2. In your testimony, you stated that GAO recommended that FEMA conduct an outcome evaluation to determine the results of the disaster case management pilot programs. However, instead of conducting its own outcome evaluation, FEMA officials decided to rely on third party evaluations submitted by each of the agencies administering a pilot program.

- **Do you still believe that FEMA should conduct its own evaluation for purposes of developing a case management model for future disasters?**

To date, little is known about the outcomes of disaster case management programs for Hurricanes Katrina and Rita. As stated in the testimony, evaluations of disaster case management programs completed by HHS and FEMA focused on initial program implementation and did not provide information on program outcomes or results.⁴ As we stated in our July 2009 report, an understanding of program outcomes is critical to provide policymakers with the information needed to develop more effective case management programs for future disasters.⁵ As such, we recommended in our report that FEMA conduct an outcome evaluation to determine the results of disaster case management pilot programs that have assisted victims of Hurricanes Katrina and Rita, as well as pilot programs for victims of subsequent disasters in order to further inform the development of the federal disaster case management program for future disasters. However, according to FEMA, it will instead rely on evaluations of ongoing pilot programs submitted by the agencies administering these programs to obtain information on lessons learned, best practices, and program outcomes. It is unclear

³GAO, *Results-Oriented Government: Practices That Can Help Enhance and Sustain Collaboration among Federal Agencies*, GAO-06-15 (Washington, D.C.: Oct. 21, 2005).

⁴GAO-10-278T

⁵GAO-09-561

to GAO what outcomes these evaluations will measure. Regardless of who conducts the evaluations, FEMA should ensure that information is available to understand program results, including whether those most in need received services, client outcomes, factors that contribute to those outcomes, and the role of specific services such as direct assistance and long-term recovery committees. In developing the federal disaster case management for future disasters, FEMA should take steps to ensure that case management agencies are able to measure program outcomes to help determine whether the program is working.

Questions for the Record

Disaster Case Management: Developing a Comprehensive National Program Focused on Outcomes

December 2, 2009

From Senator Mary Landrieu to Amanda Guma

The Louisiana Recovery Authority has launched a \$9.4 million Disaster Case Management Pilot Program (DCM-P) to help approximately 3,000 households that are still receiving federal disaster housing assistance make a seamless transition to regular housing by March 31, 2010. I am glad to hear that the state is moving forward with allocating funds for the pilot program, and I hope this program will finally help to resettle those families whose lives were uprooted by the Hurricanes in 2005. What challenges did the LRA face in designing and implementing this pilot program and what advice would you give to other States seeking to stand up a case management system?

RESPONSE:

Thank you, Senator Landrieu, for your continued support for federal disaster case management programs. We appreciate your interest in our experience with FEMA's Disaster Case Management Pilot (DCMP) Program for families impacted by hurricanes Katrina and Rita, and we welcome this opportunity to share our knowledge and offer feedback for the future. As you know, the state of Louisiana faced tremendous challenges in implementing this program, and we do hope that the difficulties we faced and lessons we learned will be instructive to FEMA and other states in the future.

With regard to the design and launch of the DCMP program, most of the major problems we encountered were addressed in my testimony. The state submitted two grant applications for the program – the first in July 2008 and the second in December 2008 – both of which were approved but not implemented due to reconsideration by the state's lead non-profit agencies to withdraw participation. The providers based these decisions upon the challenges posed by the reimbursement structure, the lack of direct services funding and the short timeframe for program implementation.

Because most of the federal disaster case management programs in Louisiana have required reimbursement, local providers have assumed significant financial burdens in launching them. Having already experienced the funding delays caused by the reimbursement process under the Katrina Aid Today program, our partners did not feel comfortable taking a similar risk again. We know that funding for upfront or advance costs is critical for many local providers to participate in a program like DCMP. The absence of these resources caused challenges not only during the application and launch, but now in the implementation phase, where we continue to see its impact on the ability of our partners to provide services.

Another difficulty presented by the design of the Disaster Case Management Pilot Program was the lack of funding for direct services. The state of Louisiana worked very hard to allocate resources and create complementary programs (like our Non-profit Rebuild Pilot Program) to run in concert with DCMP to meet that need. Because the majority of eligible participants in the program are homeowners still struggling to rebuild their storm-damaged homes, the state strongly believed that the DCMP services needed to be directly aligned with the rebuild process. We recommended to FEMA that the DCMP program guidelines be adjusted to allow us to focus more on construction management and less on case management, so that we could meet the housing needs of those homeowners more directly. That

recommendation was not approved, and as such, efforts to help families rebuild have been more complicated. Coordination between the DCMP and NRPP programs has been quite labor-intensive for our state agencies.

Further complicating the recovery effort is the misalignment of program timelines with actual recovery progress. As you know, the Disaster Case Management Pilot Program was not launched until September 2009, denying thousands of displaced families the opportunity to participate in the program. After several months of requesting flexibility on the program timeline from FEMA, and repeatedly told that Post-Katrina Emergency Management Reform Act language prevented any timeline change, we were deeply disappointed to learn later that changes to the program period would be acceptable. This cost the state and our partners tremendous staff resources - and most unfortunately, it denied 15,000 families the chance to receive the services. While we remain grateful for the program and resources, we know that our families would have benefited much more from a longer program much earlier in the recovery process.

Having overcome these challenges, the LRA would make several recommendations to other states engaging in this process in the future. Below are a few key suggestions to ensure that disaster case management programs meet the needs of impacted families:

Identify Partners in Advance

To avoid grant application and program implementation delays, states should consider a pre-application process to identify provider agencies for a case management program at the time of a disaster. Local procurement procedures and a lengthy application approval process at FEMA can dramatically delay launching programs.

Ensure Adequate Implementation Period

Local governments typically have the most accurate knowledge regarding of the pace of recovery on the ground. As such, we strongly urge any state applying for disaster case management funding to advocate strongly for the program period that will best serve their impacted families. Particularly when housing stock has been damaged, sufficient time is needed to ensure that case management services align with housing recovery programs. Case management is an invaluable tool to connect families with resources, but program periods must be aligned to ensure that process.

Align Resources Appropriately

While case management programs cannot provide all of the funding opportunities needed to help complete the recovery process for families after a disaster, they do provide a critical opportunity to identify and assess unmet needs. We encourage states to advocate for their particular needs to federal agencies, particularly where adjustments to program guidelines will not alter the scope of work or shift focus from the stated goal.

Ensure Sufficient Funding for Launch Phase

One of the greatest barriers that our local agencies have faced in participating in disaster case management programs is limited access to funding for start-up costs. Because these programs typically operate on a reimbursement schedule, small organizations often struggle to stay afloat during the first months of launch and implementation. We therefore strongly encourage states to work with local foundations and other financial organizations to offer DCMP partner agencies access to bridge loans or lines of credit. States should actively encourage every participating partner to prepare for this need in advance of program launch.

Thank you for the opportunity to describe Louisiana's experience with FEMA's Disaster Case Management Pilot program. We appreciate your leadership on this issue and thank you for urging the ongoing commitment of our federal partners.

Questions for the Record
*Disaster Case Management:
 Developing a Comprehensive National Program Focused on Outcomes*
 December 2, 2009
 From Senator Mary Landrieu to Dr. Irwin Redlener

1. *You have testified before the Subcommittee on Disaster Recovery several times in the past about unclear standards of care and sporadic provision of aid under current case management delivery systems.*
- *What suggestions do you have for FEMA, HHS, and HUD, as they move forward with their case management programs?*

My recommendations for FEMA, HHS, and HUD as they move forward with their case management programs are outlined in the report and recommendations from the Children's Health Fund (CHF) roundtable on October 7, 2009, *Disaster Case Management in Louisiana: A Roundtable on Recovery from Hurricanes Katrina, Rita, Gustav and Ike*. The report is titled, *Reforming Disaster Case Management: National Lessons from Louisiana*, and has been submitted to the record. These recommendations are supported by my organizations –CHF and the National Center for Disaster Preparedness at Columbia University Mailman School of Public Health –as well as the National Commission on Children and Disasters, the American Academy of Pediatrics, the Louisiana Family Recovery Corps, Catholic Charities, Save the Children, the Community Initiatives Foundation, James Lee Witt Associates, the United Way, the Woman's Hospital, Louisiana State University's Stephenson Disaster Management Institute, and the Greater New Orleans Disaster Recovery Partnership. We recommend, as delineated in the report:

1. **A single lead federal agency should be designated to coordinate the implementation of all disaster case management programs.** If FEMA is to continue as the lead agency for disaster case management coordination and implementation, then appropriate professional staff must be tasked to oversee disaster case management and other agencies must respect FEMA's authority. **The National Recovery Framework should clarify all aspects of disaster case management coordination and implementation with full support and input from FEMA, HUD, and HHS.**
2. **A single federal model for case management should be established.** Currently there is not one national model for how comprehensive case management is to be implemented following a disaster. This lack of clarity and definition around programs following the hurricanes that hit the Gulf region lead to confusion and implementation barriers. It is critically important that one model be thoughtfully crafted based on experience and expertise. This program must be:
 - **Rapid and Sustainable.** Able to be implemented immediately following a disaster and continue without interruptions until clients are fully recovered;
 - **Clearly Defined.** Include a clear definition for "disaster case management" that can be used universally in disaster programs. The definition should be holistic and comprehensive in

terms of the wide ranging needs of children, families and individuals and should have a strong immediate and long-term mental health element;

- **Flexible.** A program should meet the unique needs of and be culturally sensitive to, the population affected while accounting for the existing services and infrastructure in a community;
 - **Coordinated.** Include practices to enable and sustain extensive coordination amongst multiple federal agencies, between state and federal agencies, and between government and non-governmental organizations;
 - **Local.** Rely on local provider organizations to participate in the development of program priorities;
 - **Measurable.** Include explicit procedures for the outcome evaluation of interventions and services provided. Require the use of a uniform data collection system (or multiple compatible systems) by all involved federal and state agencies as well as case management providers in order to track those affected and help enable sharing of data when necessary and appropriate. Certain fields should be required to be completed to enable quality research results. Include suggested criteria to classify a case as “closed”;
 - **Accessible.** Include specific outreach methods regarding how to educate the public about what disaster case management programs are available. It is critically important to have specific policies surrounding publicly disseminating information about these programs to ensure that those who qualify for help can receive it. For vulnerable populations, such as mentally or physically handicapped or the elderly, utilizing existing federal, state and local community based programs for outreach is recommended. Additionally, it is recommended that when victims contact FEMA for assistance, they are allowed to “opt-in” for disaster case management services in a way that authorizes FEMA to share their contact information as a referral to a case manager; and
 - **Fully and Appropriately Funded.** Ensure funding for case management includes the ability to offer direct assistance. Ensure sufficient funding to provide necessary disaster case management services as well as direct assistance funds to make critical purchases for families or individuals who qualify so as to keep short term, immediate needs from becoming longer term problems. To accomplish the inclusion of providing direct assistance fund, FEMA should consider re-assessing their interpretation of the Stafford Act prohibition on duplicative assistance. If this re-assessment can not be accomplished, then FEMA should establish a process to link the databases used by FEMA’s Individual Assistance program with federal disaster case management programs. This will help confirm and demonstrate that duplicative direct assistance funds are not being administered to clients thereby allowing federal disaster case management programs to provide direct assistance. In addition, the funding streams provided for in the contracting process are paramount to issues of equity in the case management provider community. Contracts should permit up-front funding in advance to case management agencies as was the process used by HUD.
3. **Mechanisms to ensure rapid, sufficient and efficient sharing of client information among relevant governmental agencies and provider organizations must be developed.** This may well require contingency-based modifications of the Privacy Act. The release of client data, both among and between federal agencies and/or non-governmental

organizations, is governed by the Privacy Act, and FEMA has discretion over when and how data can be released in a way that's consistent with this law. In the GAO's 2009 disaster case management report, they documented one example of how FEMA's policy on sharing information was a barrier to better serving hurricane victims. The example cited was after the Cora Brown Bridge Program ended and HHS was providing case management under its pilot to victims of Hurricanes Gustav and Ike. FEMA approached HHS and asked whether some of those services could be provided to Hurricane Katrina and Rita victims in Louisiana where the state-run pilot had not yet gotten off the ground. When HHS agreed to do that, and requested information about the population that they were to serve, FEMA provided only aggregate data on the number of mobile homes and travel trailers in each parish. This information was not sufficient for providing individual and family services. FEMA cited that its policies, based on Privacy Act regulations, precluded it from sharing client-level information. During a disaster, when victims' data may be inaccessible or even destroyed, the sharing of personal information may be necessary for providing critical services such as health and mental health treatments, reenrolling children in new schools, and securing temporary housing. Contingency-based modifications of the Privacy Act should be explored and conditions for waivers of the Privacy Act, and who has the authority to make them, should be delineated in both the Stafford Act and the National Recovery Framework.

In addition to the above recommendations from the Roundtable, I have one further:

4. **A long-term commitment to alleviating social and economic disparities should be a central mission of long-term disaster mitigation and recovery planning.** Populations with significant pre-disaster adversity, including poverty and chronic inadequacies in health care and education consistently fare the worst in all phases of disasters as compared to less disadvantaged populations.
 - *Why do you believe it is so important for federal agencies to utilize outside expert review panels to evaluate programs?*

With respect to disaster case management, the federal agencies, notably FEMA, have engaged in a protracted, expensive, and ultimately insufficient review of their programs. Many of these problems have been political and I am confident have either been resolved, or are working toward a better process. But some of the problems have had to do with a lack of experts within the agency to administer the review. This gap in expertise may prove difficult to fix as experts remain in the private-sector which is often more lucrative and politically less restrictive. This is no different than experts in defense, agriculture, medicine, or any other field where both the public and private sectors compliment one another. Using outside experts to evaluate disaster case management programs can draw on the best and brightest to evaluate programs that while funded by the federal government, are executed in large part by the private sector. Using a consensus process of outside experts can provide agencies fast, efficient, informed, and cost-effective means for evaluating programs. Using a broad collection of outside experts can diffuse political biases.

- *During the Children's Health Fund's Roundtable in October, did any of the federal agencies react to this suggestion?*

The federal agencies did react to this suggestion, and their reactions were mixed.

A FEMA representative named an organization it was planning to contract with to complete their evaluation of its Gulf disaster case management programs. However the organization they cited cannot be considered an "expert" in the same way as organizations that actually provided disaster case management services in the Gulf after Katrina and Rita. FEMA indicated they are inclined to use single contractor for evaluations as opposed to a consensus process. More encouraging, was that FEMA said when their state pilot programs end in March 2010, they expect each grantee to report back on their experiences. This reporting process can be the beginning on an external expert consensus processes.

A representative from HHS supported my suggestion of using an outside expert consensus process. The representative said, "I don't think that you need to do any more evaluation. I think that you could pull together in a consensus format or a Delphi method and get to where you need to be, and you could do it fairly rapidly, because the research has already been done. What we are trying to do at this point is to refine the way the government comes together to do it."

But there was also the issue of what exactly is being evaluated. In my suggestions for an outside expert consensus process, I have always grounded that in being a holistic evaluation of the entire program—from the federal governments funding mechanisms, to the providers services, to the evaluation itself. Yet a representative from HUD seemed to parse evaluation to its component parts, suggesting only some elements of the existing disaster case management efforts should be examined. The HUD representative said, "I think in many ways, nobody is really talking about doing an evaluation of case management, necessarily, but doing an evaluation in trying to understand how FEMA, in their new role as case management funders, needs to get their program and what information they need to provide to states...So it is really more about the structure and not the case management that is the evaluation."

Finally, I have been encouraged by FEMA's approach to gathering outside experts input to the National Recovery Framework. FEMA announced at the Roundtable, and has since delivered on, a process of national stakeholder input. Though there have been some flaws in this process, the engagement itself is encouraging and I expect that over time the process will be refined to ensure the most important information will be captured and integrated.

Questions for the Record

*Disaster Case Management: Developing a Comprehensive National Program
Focused on Outcomes*

December 2, 2009

From Senator Mary Landrieu to Stephen Carr

1. In your statement you highlight the need for HHS and FEMA to develop a hybrid model for disaster case management that would incorporate the early response component of HHS and the long-term implementation of the current FEMA/Mississippi model.
 - What elements of pre-planning have you seen Mississippi put in place for future disaster case management?
 - The establishment of relationship between the Mississippi Commission for Volunteer Service and the private, faith-based, non-profit sector agencies who implement the Mississippi Case Management Consortium project is the element of pre-planning that will enable the State of Mississippi to respond in a systematic and professional manner to future disasters that call for disaster case management services. This infrastructure, built as a result of the MCMC project, has been developed with protocols that will allow the Federal Government to fund future disaster case management services within the State in an efficient and rapid manner that will ensure that disaster victims receive assistance from disaster case managers early in the recovery process. The infrastructure for the implementation of complex contracts is critical to the success of any recovery effort. The experience that the State has gained as a result of the MCMC project will prove very beneficial from this standpoint. Without the relationships that have been established, the State would not be able to “stand up” a disaster case management project in a timely fashion and disaster victims would not receive case management intervention until well after the impact of the disaster event. This lesson is one that is very important to understand and process because the current trend seems to be to “react” to a disaster event as opposed to “plan” well in advance. The advance planning ensures that at least a skeletal infrastructure remains intact with relationships being maintained

between the Federal program offices (FEMA, HHS, HUD) and the State(s). Hurricane Ike demonstrated, in Texas, that without a preexisting infrastructure for a Human Services response, it takes many months to negotiate the contractual terms and begin implementation of a disaster case management program. On the other hand, if Hurricane Ike had impacted Mississippi directly, the State would have been able to seamlessly incorporate that scope of work into the ongoing MCMC project. Minimal administrative funds need to be made available to States for maintaining their disaster response infrastructures which include a focus on Human Services processes like disaster case management. This will ensure that each State has the ability to begin implementation of a project, based on the size and scope of the disaster event, in short order.

- The Hybrid model that I mentioned in my testimony refers to the ongoing efforts within FEMA and HHS to combine the best practice elements from each of their respective Disaster Case Management model documents. From my work on both projects, it appears evident that each entity has a role to play in the overall implementation of a disaster case management program, but each has its own definition of what constitutes a successful outcome. These definitions must be reconciled in order to ensure that a comprehensive and holistic approach is undertaken and also so that the long-term result of a disaster case management program is the self determination of the disaster victim that mitigates the impact of future disasters. It is not good enough, in my opinion, to only “get the client back to his/her pre-disaster condition” just as it is not good enough for us to build destroyed bridges back to their pre-disaster condition. A bridge that is destroyed by a disaster is never rebuilt to its pre-disaster condition. Rather, it is built bigger, better and stronger. The goal of a disaster case management program should be the same as a bridge building (infrastructure) program. We should work to make sure that individuals and families who are affected by the same disaster that destroyed the bridge are given the same professional and engineered programmatic elements that support their long term recovery.

- What elements of the bottom-up approach employed by the Mississippi disaster case management pilot program would you recommend federal agencies incorporate into a nation-wide system?
- MCMC was built on the premise that high quality disaster case management was the goal of the program. Therefore, in order to attain a high level of quality in the case management activities, we needed to build the program from the “bottom up.” This means that the first position that we wrote into our budget was the case manager position and the number of overall case managers was determined by setting a maximum active caseload number of 25 clients per case manager. This caseload maximum allows case managers to intensely focus on the work that they are doing with clients, rather than simply managing a file drawer full of open files. My own experience in case management involves me having worked for a community mental health agency that treated children and adolescents on an outpatient basis. My own caseload was over 300 clients. There was no way, realistically, that I could effectively manage these cases to resolution. Instead, I simply reacted to the issues of the day and managed paper which meant that I rarely ever was able to close any cases for successful reasons. In order to create momentum toward recovery and allow disaster case managers to feel a level of success in his/her own work, MCMC followed the program guidance written by FEMA and set caseload ratios that increased the likelihood of success. MCMC, utilizing this ratio approach to determine the number of staff needed, built an infrastructure of support around the case manager position in order to facilitate successful outcomes. For instance, the number of data entry specialist positions for which an affiliate agency would receive funding was determined by the total number of case managers within that affiliate. The ratio for this position was 1:15. Other key support positions within the budget were determined in a similar fashion. The result was that affiliates not only had case managers who were able to intensely focus on their work with clients, but funding was made available to hire appropriate support staff necessary to facilitate successful results. This standardization of the budget template greatly enhanced the ability of the leadership and field management teams’ abilities to maintain consistency in fiscal and programmatic operations. In addition, estimators, administrative assistants, case manager supervisors, and portions of the agency director salaries were tied to the number of case managers within an

organization. This allowed us to maintain a supportive environment for the case managers' work. It also ensured that the leadership and field management teams of the project were able to hold the agencies accountable for their performance by requiring routine coordination meetings, calls, trainings, and conferences whose purpose was to support the case management function and activities. It is our understanding, in contrast, that the Louisiana project was not given the opportunity to hire full-time data entry personnel and that case managers are being required to divide their time between the case management work with the client and record keeping/data entry. We also understand that this position was specifically kept out of the Louisiana DCM-P, along with the estimator position, in order to see what impact their absence from the program would have on outcomes. We found this disturbing as it appears that the Federal program offices are moving away from what *is* working well, perhaps simply to save money and create lean budgets. This seems to ignore the fact that the result of a poorly planned and staffed project will be that the project operates for a greater period of time with fewer positive results. Bottom up planning, meaning that every program begins with the case manager and the outcomes in mind, will include support positions within the budgets that are based on a specified ratio of case managers per agency. Without this type of approach, future disaster case management programs will not be as effective or comprehensive as the one that has proven successful within the State of Mississippi.

Questions for the Record

*Disaster Case Management: Developing a Comprehensive National Program
Focused on Outcomes*

December 2, 2009

From Senator Mary Landrieu to Dr. Monteic Sizer

1. In your testimony you referenced the need for both federal and state governments to develop a long term human recovery plan to allow for coordinated case management programs and to develop a system for federal agencies to synchronize efforts at State agencies to disburse disaster assistance funds.
 - Based on your personal experiences providing case management services throughout Louisiana, do you have any recommendations about what such a human recovery plan could entail?

Answer: YES

2. In your case management recommendations you mentioned that the Recovery Corps' model utilizes an outcome-based system.
 - Please elaborate on the benchmarks, that the Recovery Corps has identified to evaluate the systems success in providing services to survivors.

Answer: SEE ATTACHMENT

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Dr. Monteic A. Sizer
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May 7, 2010

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1 PROGRAM DESCRIPTION

1.1 Overview of Proposed Plan

The Recovery Corps, through its collaboration with a variety of disaster recovery organizations and human service providers, has focused on addressing the totality of human recovery needs since it was formed in the wake of the hurricanes. With programs that address a household's recovery plan, the Recovery Corps has partnered with local organizations to deliver assistance as effectively and as quickly as possible. We have allocated approximately \$80 million to recovery efforts and have assisted more than 30,000 families and individuals since January 2006. We have worked diligently across Louisiana and beyond to help drive human recovery through case management, housing, employment, child care, emotional well-being and more – all essential components in helping families re-establish their households and rebuild their lives.

About the Recovery Corps

In the fall of 2007, the Louisiana legislature recognized the need for the Recovery Corps to continue its operation and thus enacted Act 313. That act provides legislative authority for the Recovery Corps to continue to act as the coordinator of human service delivery for the state. In January of 2008, the Louisiana Recovery Authority (LRA) officially designated the Louisiana Family Recovery Corps as the lead organization on human recovery matters for the state, giving it the authority to work directly with the Federal Emergency Management Agency and the U.S. Department of Housing and Urban Development (HUD) to coordinate recovery planning services as evacuee households transition from temporary living situations to sustainable housing.

The Recovery Corps Model on Recovery Planning

The Recovery Corps strategy is a hybrid strategy based on an amalgamation of existing best in class resettlement models utilized in disasters across the world. This strategy involves the integration of the **Comprehensive Services Delivery** model, employed by the International Rescue Committee (IRC) throughout the United States, with the **International Disaster Coordination** model, employed by the United Nations Office for Coordination of Humanitarian Affairs (OCHA) during major disasters across the world.

The integration of these two models into the Recovery Corps model has enabled the coordination of provider information to be used by Family Liaisons to deliver services to displaced citizens and enables the Recovery Corps to ensure accountability among the service providers. This coordination also ensures that services are not duplicated among agencies and increases the efficiency and

effectiveness of services delivery to displaced citizens across all providers by improving the associated logistics of services delivery.

Also, in the hybrid model, the use of technology in the coordination portion of the model, extends out into the services delivery model, thereby ensuring that information is managed throughout the entire services delivery process. This will also enable the portion of the displaced population that is self sufficient to more efficiently navigate the system and receive the services they require. The Recovery Corps has been able to ensure a consistent, high quality citizen experience for citizens who have received services via a Family Liaison. The Recovery Corps' strategy in the first two years of operation has focused on providing comprehensive services to displaced citizens within the state of Louisiana as well as reaching out to Louisianans displaced outside of the state and providing information and access to resources for their return. Additional updates will be incorporated with Efforts to Outcome information.

Operational Framework

The Recovery Corps Model on Recovery Planning is a detailed framework in which the case management model is described. The Recovery Corps model is based upon the *International Rescue Committee Model* and follows a holistic approach to recovery planning. The following components are included:

- Looks at all aspects of the client's individualized situation
- Conducts a comprehensive needs and strengths assessment
- Develops a meaningful recovery plan to address those needs
- Remains mindful of the strengths the client has in place and aligns those with outside resources available to support the recovery process
- Emphasizes developing and supporting client self-sufficiency

Comprehensive Services

This is a caseworker based model where caseworkers are deployed to work one on one with displaced citizens to do a comprehensive needs analysis and use this analysis to deliver a comprehensive set of services to these individuals. In the case of the Recovery Corps, this is called **Recovery Planning** and the case workers are called **Family Liaisons**. Family Liaisons work with the displaced citizens of Louisiana to both **deliver direct services and facilitate access** to additional services offered by outside agencies. The comprehensive services delivery model includes family intake and assessment, family services plan, benefits eligibility determination, access to benefits, lost documents recovery, school enrollment for children, facilitation of mainstream services, case file

documentation and maintenance, status reports, employability assessment, housing needs assessment, personal safety assessment and orientation, community orientation and integration plan, identification of major medical concerns, referral for health screenings and immunizations, language translation, conduct temporary living arrangement visits, transportation assistance and access, food and basic support allowance, essential furnishings and household items, and providing a reconnecting on of the household to the state services and programs at the conclusion of the Recovery Corps program.

Berkeley Policy Associates Report Key Findings

From "They Are Thinking of Today, Not Tomorrow" Evaluation of the Louisiana Family Recovery Corps Case Management Program and Human Recovery Coordination (August 31, 2007, Berkeley Policy Associates)

- The Recovery Corps' case management program served over 9,500 households from January 2006 through June 2007. The caseload sharply increased in March 2007 from about 2,000 cases per month to over 3,500 cases.
- Many of the clients continued to face challenges with securing stable housing. Of the clients who enrolled in the case management program between October 2006 and June 2007, 32 percent statewide still reported living in provisional housing at the time of intake. In the Capital/Southwest service area, the number of clients living in provisional housing at intake was particularly high: those in provisional housing accounted for just over 50 percent of the caseload, with 39 percent in trailers and mobile homes.
- Housing status appeared to be correlated to clients' sense of where they were on the path to recovery. For most of the focus group participants who had secured permanent housing, recovery was well underway. They expressed a sense of progress, even though they continued to face challenges ensuring long-term stability for themselves and their families. For most of the focus group participants who were still living in a transitional trailer park site, however, recovery had not yet really begun. In particular, those who were still living in emergency trailer parks expressed high levels of frustration with limited access to resources and opportunities.
- Across the three main geographical service areas, the case management program served households with a wide range of income backgrounds. Many clients had not previously used public assistance but found themselves in need of help as a result of the storms and flood. Others had been financially vulnerable even before the storms and previously

been on public assistance. Some of the clients who had received public assistance prior to the storms appear to have lost or left these services after the storm.

- Through its statewide network of providers from January 2006 to August 2007, the Recovery Corps provided recovery planning (case management) assistance to more than 15,000 households.

1.2 Forms and Templates

The Recovery Corps' Administration and Programming Department has created new forms and refined existing agency forms for use with the Disaster Case Management Pilot Program (DCM-P).

Case Management Model

The "Model for Recovery Planning" document presents the model that the Recovery Corps will use for the disaster case management pilot program. It includes information about the Recovery Corps, its mission, the role and expectations of family liaisons, client responsibilities, the basis for the model, a detailed description of services and timeframes, resources/information, and monitoring standards/procedures.

Initial Intake

The Client Consent Form is signed by the client after they have been informed of the purpose of collecting personal information, that their information will only be shared with other service providers coordinated through the Recovery Corps, and of their right to revoke consent.

Needs Assessment

The Goal Attainment Scale (GAS) is completed by the family liaison and the client initially and then at required intervals throughout the client's participation in the program. Any areas of need are identified, in addition to the current status of each need.

Budget Assessment

The Banking/Finances Assessment will be completed with all clients for whom banking/financial planning needs are identified. The assessment is built into

ETO Software® and calculates total expenses and debt (housing, utilities, gas/fuel, credit card payments, etc.), surplus/deficit, and debt to income ratio based on client information.

Client Recovery Plan

The Recovery Plan is updated each time the Goal Attainment Scale (GAS) is completed. It requires that each need identified on the GAS has an identified goal status, activities to be completed by the client, family liaison or both in order to reach that goal, target dates for each activity and dates of actual completion.

Referral Tracking

Organizations will be required to constantly remain abreast of the availability of resources and information sources in order to refer clients appropriately. Referrals made by family liaisons will be tracked in ETO Software® and will be required to follow up with clients to determine if referrals were successful in meeting client needs.

Case Presentation Package

The Recovery Corps has developed a standard format for family liaisons to use to report on cases presented to Long Term Recovery Committees. Each committee has its own reporting requirements and packages, but this will allow standard elements of information to be collected across organizations. ETO Software® will enable the recording and tracking of the status of client cases that have been presented to committees.

Case Closure and Transfer Documents

When the client and family liaison agree that it is time to close or transfer a client, information on the reason for closure, closure date, barriers to meeting any unmet needs, and any relevant notes will be captured.

1.3 Unmet Needs Strategy

The devastation of these two catastrophic events caused considerable damage to the infrastructure of major service delivery systems in the affected parishes including hospitals, schools, community centers, banks, grocery stores, etc. Not only did we lose buildings and equipment but we lost the human resources necessary to deliver these services. Restoring a comprehensive system of service delivery has been a priority but, the task we face to repair and rebuild the

infrastructure is unprecedented. And to compound the problem, major public systems in other parishes that took up the slack are at capacity. According to a 2006 report from the *National Alliance on Mental Illness*, Louisiana's fragile infrastructure "imploded" as a result of the storms, the report notes:

"Tremendous challenges impede service delivery. Emergency rooms, already taxed before the storms, have turned into ground zero in their aftermath. In the New Orleans area, emergency rooms are deluged with individuals needing mental health care as the city has lost over 100 psychiatric inpatient beds. ...

The state's capacity to provide community services has been similarly battered. Louisiana's community system is a maze of three main service areas that include an additional eight regions for service delivery. ... Coordination and consistency of services across the state, therefore, are scattershot, contributing to the system's fragmentation and perpetuating communications challenges.

Many regions have been deluged with the influx of storm evacuees. In the months since the storms, requests to Capitol Area in Baton Rouge have increased by 40 percent - rates similar to other parts of the state. Wait times to see community providers that used to be only hours or days long are now months. Providers are doing the best they can with limited resources and capacity, but the system is in grave crisis."

The mental health service delivery system as described above is but one example of the challenges facing the state to provide adequate care and services to so many who are still in need. One response to these challenges has been the establishment of regional Long-Term Recovery Committees (LTRC). One of the goals of the LTRC is to identify and obtain resources to fill unmet needs. LTRC review cases and may provide additional resources to case management agencies. Family Liaisons may evidence needs beyond their capabilities or scope. To that end, information will be documented, reported, reviewed, and referred to necessary state agencies for proper support.

The Recovery Corps will serve as the coordinating organization to disseminate information back to the community-based organizations providing case management services on the ground with clients. The Recovery Corps will establish a protocol for monthly conference calls with sub-grantee service providers and the LTRC to ensure that all available information regarding state services is disseminated in a timely manner.

Recovery Corps Summary of Findings as of May 2008

**Note: Random sample of 2,100 families was collected for these data findings during the months of February and March of 2008*

- Only one-third of impacted residents consider themselves mostly recovered. Calcasieu and Jefferson parishes reported the highest

levels of recovery, but only about 25 percent of residents in Orleans parish consider themselves mostly recovered.

- While storm impacts were felt across Louisiana, residents of Orleans parish indicate the greatest challenges and slowest progress toward recovery, followed closely by residents in Plaquemines and St. Bernard parishes.
- Although all types of households and income levels experienced storm impacts, impacts for black households were much greater than white households, even across higher income households.
- Nearly 70 percent of all affected residents were able to return to their pre-storm living situation, but the disruption in living arrangements cut deeper for black households than for white households as nearly half of black households live someplace different, compared to only 20 percent of white households.
- Half of all impacted residents are employed, most earning the same wages as before the storms. Of those not working, most are either retired or have a disability that prevents work. Orleans and Jefferson parish have the highest rates of employed residents; while Calcasieu, followed closely by Jefferson, Plaquemines and St. Bernard parishes, has the highest representation of retired residents at a level near 60 percent.
- One-third of all residents report a recent hardship in paying their rent or mortgage, and 40 percent report difficulty paying for utility bills, household items or food. Nearly all residents report more than one type of recent hardships.
- Only 20 percent of all residents feel as though there are enough services to aid in recovery. Many feel that available services are not targeted towards the specific needs of human recovery.
- Residents cite needing help with money to pay for bills and managing the stress of recovery as most helpful – even more than needing a better job, access to training or transportation.

**“Louisiana FEMA Park Survey Interim Report” (April 2007)
Commissioned by Louisiana Family Recovery Corps, Louisiana
Department of Labor, Louisiana Recovery Authority**

- A decline of over 5,000 in the number of employers
- The state had 2,270 fewer employers one year after the Hurricanes
- Parishes most impacted by the storms continue to struggle from business failures.
- The business failure rate was 11.7 percent for the state compared to 26.5 percent for the five parish Southeast region and 14.2 percent for the Southwest region.
- Failure rates were highest among small businesses

- The largest net loss of firms can in Retail Trade and Service sectors

1.4 Special Needs Population Strategy

In order to meet the needs of populations with special needs, the State is aggressively working on a Permanent Supportive Housing program. Such a strategy provides housing units, rental subsidies and case management to households with special needs. The eligible populations for Permanent Supportive Housing are extremely low-income individuals/households (i.e., at or below 30% of AMI) who have one or more of the following conditions:

- Hurricane displaces living in the homeless shelter system or otherwise in temporary housing who need PSH services.
- The individual/household member has a substantial, long-term disabilities including any of the following:
 - Serious Mental Illness
 - Addictive Disorder, i.e., individuals in treatment/recovery from substance abuse disorder;
 - Developmental Disability (i.e., mental retardation, autism, or other disability occurring before the age of 22);
 - Physical, sensory, or cognitive disability occurring after the age of 22;
 - Disability caused by chronic illness (e.g., people living with HIV/AIDS who are no longer able to work); and
 - Age-related disability (i.e., "frail elderly").
- The household is homeless or is determined by DSS to be most-at-risk of homelessness and in need of PSH. This includes Family Services clients with a goal of reunification who are at risk of homelessness.
- The individual/household member is aging out of the state Foster Care system.

1.5 Case Management Technology

The Louisiana Family Recovery Corps has contracted with and will utilize Social Solutions' ETO (Efforts to Outcomes) Software® to provide information technology support for the DCM-P program. All sub-grantees of the organization will be required to use ETO Software® as a means of capturing data, tracking progress, monitoring programmatic standards, and reporting the outcomes related to case management efforts on a real-time basis. The following sections provide a description of ETO Software® product, its capabilities, and specific procedures to be incorporated into the DCM-P program.

Description of ETO Software®

Social Solutions is the leading provider of performance management software and services for the human services sector. Its ETO Software® helps to provide

a clear picture of which efforts are having the greatest impact so that you can reinforce what's working, adjust what isn't, and more easily report quantified successes to key stakeholders. This solution goes beyond the basic data capture and utilizes a strategic approach that connects an organization's mission to the daily work of its staff members and the expectations of its funders and supporters.

ETO Software® is a web-based performance management solution that transforms data into knowledge that you can access via a multitude of easily generated reports to monitor, measure, and optimize your impact on the lives of those in need. It is secure, comprehensive, and flexible. It was designed by human service professionals who understand the uniqueness of human service organizations and their programs. ETO Software® also supports information access via data export and through the use of web services.

Users will be assigned unique login information to ensure secure use and access to client data. Authorized users can gain access to the ETO Software® with minimal workstation requirements, needing only a Windows-based PC, an internet connection (while modem is sufficient, a broadband connection is preferable), and Internet Explorer version 5.5 or higher. ETO Software® requires no minimum workstation memory, no minimum workstation storage capacity (subject to an authorized user's need or interest in exporting a data set to save on that workstation for further review or analysis) and requires no minimum speed (in MHz).

Data Capture

The types of data typically captured with ETO Software® include:

- Intake Demographics
- Assessment Data
- Referral Data
- Attendance Data
- Case Notes
- Client History

Information Access

The core value of ETO Software® lies within its reporting capabilities. These capabilities facilitate the use of information by:

- Identifying which efforts, services, staff and programs are most effective at achieving desired outcomes
- Identifying and tracking key trends
- Monitoring participant attendance
- Managing and analyzing participant demographic data

- Analyzing assessment results
- Managing referrals
- Maintaining a comprehensive history of participant information
- Addressing multi-funder reporting obligations

In addition, ETO Software® includes several useful functions that encourage point of service professionals. These features are:

- To Do Lists
- Task Reminders
- Alerts
- Search/Query

ETO Software® also provides access to a set of best practices contained within its ETO City Repository. The inclusion and availability of these best practices are meant to supplement and enhance the use of the system.

- Samples of outcomes
- Use cases
- Analysis methods
- Report samples

Data Entry, Monitoring, and Reporting Processes:

Data Entry

To ensure timely contact with potential program participants and to expedite case management service delivery, the Recovery Corps requests the following:

- A list of **eligible** individuals/households be submitted electronically on a weekly basis to **both** the Louisiana Family Recovery Corps and its provider organizations (selected by the Recovery Corps) to provide case management. This list should be provided by PHAs, HUD DHAP, and any additional governmental agency working with these individuals to the data management personnel at the Recovery Corps and at the provider organizations.
- The list should be emailed in a format (i.e. Comma Separated Values, Excel file, or similar) appropriate for use in Microsoft Excel.
- This list should include the following data elements related to the **Head of Household** for each potential client household to be served:
 - First Name
 - Last Name
 - Social Security Number (if available)
 - Demographic Data
 - Date of Birth (DOB)
 - Gender
 - Race

- Marital status
- Current Contact Information (address, primary and alternative phone numbers)
- Name, DOB, and gender of additional household members (optional)

This data along with additional programmatic and monitoring data will be captured and reported using standardized forms and reports incorporated into ETO Software®. The program elements, along with all methods for capturing and measuring success, are identified in the table below:

Elements	Potential Client Needs	Efforts	Status (Current and Goal)
Supportive Services	Basic needs (i.e., food & clothing), education, childcare, transportation, health care, medication, mental health, substance abuse treatment, personal safety, child/adolescent adjustment	<ul style="list-style-type: none"> • Referral • Phone calls • Email contact • In-person visits • Appointments/ interviews 	<ul style="list-style-type: none"> A. Most unfavorable outcome thought likely B. Less than expected success with case management C. Expected level of case management success D. More than expected success with case management E. Best anticipated success with case management
Plans for Living Accommodations	Housing: stable form of transitional or intermediate housing, Housing: plans for permanent living arrangements, utilities, household goods, home repair	<ul style="list-style-type: none"> • Registration • Completion of paperwork, forms or other documents 	
Household Management	Application assistance/benefit restoration, legal issues/assistance, change of address, banking and financial planning, service systems experience stress	<ul style="list-style-type: none"> • Information retrieval/ research • Visit to client's home or workplace 	
Employment and/or Income	Employment training, employment assistance	<ul style="list-style-type: none"> • Other 	
Support Network	Social support, self-sufficiency	<ul style="list-style-type: none"> • Target Date • Completion Date 	

- An example of the program elements, along with all methods for capturing and measuring success using ETO Software®, is below:

Program Element	Resources/Activities/Services	Outcome Measure & Indicators	ETO Software® Tools
Linkage to Long-term Housing Services	<ul style="list-style-type: none"> ▪ Referral to local PHA for possible eligibility in HUD-DHAP program ▪ Referral to PHA for possible other subsidized housing program ▪ Referral to community agency for financial literacy and home ownership education 	<ul style="list-style-type: none"> ▪ Assessment of eligibility for HUD provided housing ▪ Track and record clients enrolled in HUD housing programs ▪ Family has savings account and budget in place ▪ Family has enrolled in first-time home buyers class 	<ul style="list-style-type: none"> ▪ Point of service effort ▪ Assessment ▪ Referrals

2 INDICATORS OF SUCCESS: State of Louisiana

To ensure and measure the success of the Disaster Case Management Pilot Program in the State of Louisiana, the following indicators will define the program's goals and objectives, and provide clear tools for maintaining the highest standards of accountability.

Goal: To strive to ensure that residents become self-sufficient resulting from effective disaster case management and services required for a successful transition successfully from temporary housing units into permanent and sustainable housing solutions.

Objectives:

Strategy Development

- Establish comprehensive strategy/model for case management to meet human service needs of impacted households.
 - Measure: model developed and implemented
- Determine staffing pattern appropriate to meet program goals.
 - Measure: case manager to client ratio within 1:25.
 - Measure: supervisor to case manager ratio within 1:7.

- Train providers and partners on case management model to ensure consistency and quality.
 - Measure: training curriculum articulates clear process for triage, referral processing, service delivery, case transfer, case closure and case management technology
 - Measure: standardized forms and templates related to Case Management Model, Initial Intake, Needs Assessment, Disaster Recovery Plan, Referrals and Case Closure
 - Measure: standardized forms and templates for supervision of cases and case managers
 - Measure: standardized forms and templates for sub-grantee reporting to grantee
- Develop strategy to meet remaining unmet needs and share with partners
 - Measure: strategy developed and shared with state, federal and nonprofit partners
 - Measure: unmet needs provided for, or reasons for failure to provide for unmet needs documented
- Develop strategy to meet special needs and share with partners
 - Measure: strategy developed and shared with state, federal and nonprofit partners
 - Measure: special needs groups identified and serviced
 - Measure: special needs provided for, or reasons for inability to provide for unmet needs documented

Technology/Data Management

- Maintain a central technology platform to assess outcomes over time and outstanding services required.
 - Measure: standard database maintained
- Maintain accurate and current information via ETO Software® to measure progress and identify gaps/needs.
 - Measure: data kept current, duplication of services identified, gaps/needs identified.
- Provide software, training and ongoing technical assistance to case management providers
 - Measure: providers utilize and maintain data using platform
- Ensure software report elements are consistent with FEMA/HUD requirements
 - Measure: reliable, consistent reports provided

Coordination/Collaboration

- Develop clear and comprehensive Communication and Coordination strategy to share information and report on progress/challenges with all providers and FEMA.
 - Measure: written communication plan developed and shared with partners

- Measure: partners understood and performed respective roles
- Measure: progress and new strategies reported in quarterly narrative
- Facilitate collaboration between sub-grantee and partners (government and nonprofit)
 - Measure: coordinated resources (meetings, conference calls, etc.)
 - Measure: new partnerships and resource collaborations documented

Performance Measurement/Accountability

- Create comprehensive plan for managing case management program
 - Establish measures of accountability and performance indicators for sub-grantee
 - Establish measures of accountability and performance indicators for all human service providers
- Employ specific internal monitoring and reporting activities on a weekly basis to evaluate the performance of sub-grantee, provider organizations, Family Liaisons and the overall program, as measured by specific performance indicators
 - Measure: update details specific case management strategies
 - Measure: staffing pattern
 - Measure: Number of clients per Family Liaison
 - Measure: Number of clients completing (and failing to complete) intake, assessments, etc. according to program guidelines (Breakdown by each provider organization site and Family Liaison)
 - Measure: Number of open, transferred, and closed cases
 - Measure: Average time of Family Liaison spent working with individual households
 - Measure: Average time of Family Liaison spent working on identified needs
 - Measure: Number and type of referrals processed (and declined) for each client household
 - Measure: Changes in identified needs and related performance measures (for both individual households and across the entire organization) at specified intervals throughout program.

Sample outcomes-based performance measures to be provided through collaboration between federal and state agencies (LFHA, DSS, HUD DHAP, DHH, and PHAs)

Housing placement and retention:

- a. Number of households placed in affordable housing in current area;
- b. Number of households placed in affordable housing in original domicile;
- c. Number of households remaining housed after three months; and
- d. Number of households remaining housed after six months

Improved health conditions: (Information to be provided by DHH and DSS)

- a. Number of households/individuals with improved health status;
- b. Number of households demonstrating substantial differences in cost of health and other services before and after intervention

Self-Sufficiency: (Information to be provided by DSS and DOL)

- a. Number of households with increased income;
- b. Number of individuals employed or participating in employment training;
- c. Number of households/individuals who have obtained SSI, SSDI, or VA benefits through assistance by program;
- d. Number of households receiving all benefits they are entitled to, including Medicaid or Medicare;
- e. Number of households with monthly incomes that have increased. (from \$_____ to \$_____ per month);
- f. Number of households recorded recipients receiving life skills training to improve self-sufficiency; and
- g. Number of households receiving Section 8 vouchers.

Cost Impact on other systems: (Information to be provided by DSS, DHH, OYD and the Department of Corrections)

- a. Number of households used emergency services such as hospitalization, substance inpatient treatment, detox, or jail for 12 months prior to assistance; and
- b. Number of households used emergency services such as hospitalization, substance inpatient treatment, detox, or jail for 12 months after receiving assistance.

- Provide quarterly financial reports to FEMA that meet all federal requirements for fiscal accountability and reporting.
 - Measure: financial details of administrative expenditures for quarter and year-to-date
 - Measure: financial details of programmatic expenditures for quarter and year-to-date
 - Measure: Standard Form 269
- Develop plan to transition remaining open cases and submit to FEMA
 - Measure: plan completed and submitted
 - Measure: plan addressed open cases and identified alternative resources and options to be shared with client
- Develop closure plan for remaining open cases
 - Measure: plan completed and submitted
 - Measure: plan addressed open cases and how reasons for non-completion.
- Provide final comprehensive report
 - Measure: detail of all activities and costs
- Provide additional reports upon request