

Service Coordination Plan

Levy House

Service Coordination Overview

The families of Levy House LH have been long-time residents of the building and the community. As with our new efforts, the work of service coordination follows the HUD Multi-family Housing program effort that meets the need of each resident. LH has been a fixture in the community and has long standing relationships with many existing community partners and stakeholders that will only assist in any service coordination work that happens with the residents.

Along with high quality property management of all of our almost twelve thousand units, POAH and its management entity POAH Communities (POAHC) has also expanded its services coordination efforts over the past seven years formalizing its Community Impact (CI) Department to work towards three targeted areas of growth for families in our property: (1) Housing Stability (2) Economic Stability/Mobility and Health and Wellness aging in place (primarily targeted toward our senior properties). The POAHC model to service coordination identifies local partners, assesses their quality capacity and collaborates to provide service coordination and/or case management as needed.

With the purchase of LH, POAHC's CI team believes the best approach to service coordination is the HUD Multi-family Housing program. Typically, this work is driven by a Resident Service Coordinator but the POAH model calls for a Community Impact Coordinator (CI/CJE) to be the one-on-one connector of this work. Additionally, we would look to partner with the Council on Jewish Elderly (CJE) to do the work of service coordination work for us at LH.

The work of service coordination under the HUD model includes some but not limited to the following principals of focus:

- a) **Advocating & Advising** – Being an advocate for the resident with other service providers, income support efforts (SSI, VA benefits, etc.) and a liaison with property management (includes referrals for well-being checks support, housekeeping, etc.)
- b) **Coaching/Motivation and Facilitation of Educational resources** – Encouraging resident vibrancy and participation in everyday living, connecting and monitoring service providers that provide specific needs supports to residents; listening to residents and identifying trainings and other educational workshops on a variety of quality of life topics.
- c) **Community Engagement/Partnerships & Resources** – Identifying and creating linkages with the appropriate community partners including local organizations, agencies and service providers; being a part of the community meetings, etc. to connect to existing resources,

Delivery of Service Coordination – Our model for the work.

The work of our blended team for the LH families has a prescribed approach to day to day service delivery and implementation must include:

- Completion of our yearly resident questionnaire (non-clinical) that determines the needs and desires of each LH resident. With this information, tracked year over year, the CI/CJE and/or CJE is able to create service plans for each individual residents.
- Recording and reporting resident data into our POAH customized databased called POAH INTegretec (PI) software system
- Assisting each resident in connecting to the appropriate resource/service and making sure the provider does follow up with the resident in addressing issues and/or all inquiries
- Overseeing and monitoring each and every service provider in their engagement with residents to ensure support is provided as needed and is a quality service.
- Offering regular workshops, trainings and other educational efforts to ensure each resident receives the appropriate educational support from healthy eating to safety in and around the community. These various trainings will be offered on a regular basis on site. Examples are listed below.
 - Home Health Services
 - Cancer Prevention and Screening
 - Diabetes Education and Prevention
 - Flu Clinic
 - Nutrition- Healthy Eating
 - Medication Disposal and Proper Intake
 - Safety Workshop with Fire Department and Police Department
 - Fraud & Scam Education & Prevention
 - Senior Wellness Workshops
- Creating and/or sustaining linkages with local partnerships with the Dept of Aging, community supportive service agencies, etc.
- Continually updating the resource guide and directory for LH on a quarterly basis.
- Creation of a LH plan to support how the residents age in place peacefully and with access to supports that assist in that effort. CI/CJE staff works in tandem with the management team to identify who might need some special attention in this area and to implement the appropriate services. For example, the team will connect residents to services such as a homemaker, access to food and social cohesion activities – all provided in a multicultural manner.

Resident Engagement – Authentic engagement of each resident is grounded in a strong outreach approach. The LH team is holistic in how it outreaches to each household. We do not do outreach merely for a resident to attend events and/or activities. Access for engagement to each LH resident comes in these forms of outreach:

- a) One on One connection on a monthly basis – The CI/CJE team does an outreach attempt in the form of a regular knock on the door as a wellness check and/or regular check-in. These regular check-ins creates a relationship between the CI/CJE and the resident. While the resident does NOT have to engage with the CI/CJE or any services offered
- b) PM connection – The Property Manager may ask the CI/CJE team to reach out to residents for various management notifications including any investor inspections, building systems check that all need to know about building operations, etc. OR.... The PM can complete formal program referrals with a specific issue and/or concern and/or immediate need the PM might see during inspections, etc.
- c) Event/Activity Outreach – Door to Door delivery of flyers, meeting and/or workshop invites, development design planning, etc.
- d) New Resident Orientations – The LH property manager and CI/CJE team work together to host new resident orientations where a letter of welcome is provided with a calendar of activities for that month, a list of services offered, etc. At that meeting, the CI/CJE sets a date with the resident to conduct a one on one where the questionnaire will be administered.
- e) Resident Associations and/or Social Groups – The LH team can offer support to any group of residents that organize themselves as a group. While the CI/CJE cannot organize and/or have an office on any council and/or group, they can offer any information requested and refer the group of residents to HUD regulations for specific directions on forming a group.

Assessing the resident – The POAHC questionnaire is conducted yearly by the CI/CJE team. The questionnaire is a thirty question tool that help us to really focus on the following topics for each resident:

Basic demo info	Extended family ER contacts	Hobbies and Interests	Health insurance	Services needed and/or desired
Resident Income	Employment	Friends, groups	Physical capabilities	

The CI/CJE team will take the questionnaires and create an Individual Service Plan for each resident that either expresses and/or exhibits needs that need to be addressed. This plan will

assist the CI/CJE team in tracking the work to be done with each resident, identifying the correct provider for support and monitoring progress of the effort.

Community Engagement and Partnerships – The LH and the CJE both have a long history with the local stakeholders in this neighborhood. An intentional connection to each one is very important.

Engagement with the Site team/Referrals – The CI/CJE team at LH works with the entire LH site team. The team will meet weekly to determine goals and objectives for the site. While the work with the resident is not necessarily shared with the PM, there is a level of coordination of efforts between the PM and the CI/CJE for the best interest of each resident. The CI/CJE team can advocate for the resident when/if they receive a lease violation and really work to mitigate the challenges with the resident.

The Property Manager will also complete referrals with the resident and provide to the CI/CJE team to assist that resident with whatever challenge identified. The CI/CJE team will be responsible for connections to the appropriate service providers, community partners, etc. that will address that specific problem with the resident. While the details of that work will NOT be shared with the management team, it will be documented and tracked by the CI/CJE team.

2) **The team** – Qualified Team members doing the work will be comprised of the following:

- POAHC Property Manager – TBD
- POAHC Community Impact Team (see attached bios)
- Potential local community partner Council on Jewish Elderly (CJE) see attached info

3) **Data Tracking and Integrity** – POAHC and the CI/CJE team take resident files and confidentiality very seriously. Information gathered via the CI/CJE team is upheld to the appropriate standards of privacy. NO information is shared with the Property Management team. Only in cases where residents have signed a consent form will information be shared. These forms will have time limits and require re-signing by the resident to ensure ongoing consent. The resident files are updated each time there is a new interaction between the CI/CJE and the resident. Each file contains at the least an intake form, the resident services plan for that resident, notes, contact information, and referrals. The files will be stored in a locked file and will remain in the possession of the CI/CJE team. The CI/CJE team will utilize the PI system to track progress.

Metrics – Outcomes and Output measures

We will work with our partner and the information gathered from the Questionnaire to determine what we will measure to determine successful support. Some metric examples include:

Housing stability - (# of housekeeping referrals, # of home visits conducted, etc.)

Economic stability/mobility - (# of rent referrals, # of income support apps completed, etc.)

Health & wellness – (# of health care workshops, # of health screenings conducted, etc.)

- 4) **Reporting** – The CI/CJE will submit weekly progress updates, monthly reports and annual progress summaries to ensure the needs of the families are being met.

DRAFT