Service Standards

Disaster Recovery Case Management

Purpose

Individuals and families who receive Disaster Recovery Case Management services access and use resources and support that build on their strengths and meet their service needs.

Definition

Disaster Recovery Case Management services are designed to stabilize the living conditions of service recipients who are victims of disaster, the goal being to re-establish their pre-disaster status to the greatest extent possible. It involves fundamental case management practices such as planning, securing, coordinating, monitoring, and advocating for unified service goals with organizations, and personnel working in close partnership with individuals and families served. Disaster Recovery Case Management services also include practices that are unique to service delivery in the aftermath of natural disasters, incidents of mass violence, and other major public emergencies. These services are delivered under difficult environmental conditions that typically result in loss of physical and technological infrastructure, disruption of operations, and other substantial communication, record keeping, coordination, and efficiency challenges. Distinct service delivery challenges are associated with the influx and simultaneous deployment of local, regional, state and federal assistance. Services may be delivered within, or separate from, a multi-service organization.
Interpretation: *This standard is unique in that it is only deployed in the aftermath of a disaster. Unlike other programs which may be operational for years, disaster recovery case management programs come into existence in response to a specific disaster and tend to be time limited, closing upon the community's recovery or when disaster specific resources have been exhausted. In light of the uniqueness of this service delivery model COA may be assesing an organization's capacity to efficiently and effectively respond when a disaster does strike. It is to the benefit of the organization, the clients, and the community for the organization to be well prepared to deploy case managers in disaster circumstances. Preparation is key to an effective and efficient response that maximizes resources and can move people to recovery as soon as possible.*

Interpretation: *Although primary or short-term disaster case management is focused on emergency relief such as food, clothing, shelter, and information and referral, organizations should provide or coordinate services to address long-term recovery needs as well.*

Note:*Please see the DRCM Reference List for the research that informed the development of these standards.*

Note:*For information about changes made in the 2020 Edition, please see the DRCM Crosswalk.*

Table of Evidence

Self Study Evidence

No Self Study Evidence

Disaster Recovery Case Management

DRCM 1: Person-Centered Logic Model

Purpose

Individuals and families who receive Disaster Recovery Case Management services access and use resources and support that build on their strengths and meet their service needs.

The organization implements a program logic model that describes how resources and program activities will support the achievement of positive outcomes.

Note: *Please see the Logic Model Template for additional guidance on this standard.?*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

Logic models have been implemented for all programs and the organization has identified at least two outcomes for all its programs.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Logic models need improvement or clarification; or
- Logic models are still under development for some of its programs, but are completed for all high-risk programs such as protective services, foster care, residential treatment, etc.; or
- At least one outcome has been identified for all of its programs.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Logic models need significant improvement; or
- Logic models are still under development for a majority of programs; or
- A logic model has not been developed for one or more high-risk programs; or
- Outcomes have not been identified for one or more programs.

4

Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- Logic models have not been developed or implemented; or
- Outcomes have not been identified for any programs.

Table of Evidence

Self Study Evidence

*	• Program logic model that includes a list of outcomes being measured	
	• See program description completed during intake	

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel

DRCM 1.01

A program logic model, or equivalent framework, identifies:

a. needs the program will address;
b. available human, financial, organizational, and community resources (i.e., inputs);
c. program activities intended to bring about desired results;
d. program outputs (i.e., the size and scope of services delivered);
e. desired outcomes (i.e., the changes you expect to see in persons served); and
f. expected long-term impact on the organization, community, and/or system.

Examples: *Please see the W.K. Kellogg Foundation Logic Model Development Guide and COA Accreditation's PQI Guide for more information on developing and using program logic models.*

Examples: *Information that may be used to inform the development of the program logic model includes, but is not limited to, the best available evidence of service effectiveness.*

DRCM 1.02

The logic model identifies desired outcomes in at least two of the following areas:

a. change in functional status;
b. connection to formal and informal support systems;
c. health, welfare, and safety;
d. achievement of individual service goals; and
e. other outcomes as appropriate to the program or service population.

Interpretation: *Outcomes data should be disaggregated to identify patterns of disparity or inequity that can be masked by aggregate data reporting. See PQI 5.02 for more information on disaggregating data to track and monitor identified outcomes.*

Interpretation: *This standard promotes program evaluation to the greatest extent possible given the challenging circumstances under which disaster recovery case management services are delivered. COA Accreditation recognizes that it may be difficult to track individual outcomes given the nature and duration of DRCM services. If individual outcomes are not being tracked, the organization must be prepared to demonstrate how program-level outputs are used to build capacity, improve programs, and positively impact persons served. Additionally, the organization may speak to how it uses community-wide outcomes data collected by outside entities to make data-informed decisions within its program when appropriate.*

Disaster Recovery Case Management

DRCM 2: Personnel

Purpose

Individuals and families who receive Disaster Recovery Case Management services access and use resources and support that build on their strengths and meet their service needs.

Program personnel have the competency and support needed to access and coordinate services and meet the needs of individuals and families.

Interpretation: *Competency can be demonstrated through education, training, or experience and may vary based on the organization's mission, programs, and requirements. Support can be provided through supervision or other learning activities to improve understanding or skill development in specific areas.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- With some exceptions, staff (direct service providers, supervisors, and program managers) possess the required qualifications, including education, experience, training, skills, temperament, etc., but the integrity of the service is not compromised; or
- Supervisors provide additional support and oversight, as needed, to the few staff without the listed qualifications; or
- Most staff who do not meet educational requirements are seeking to obtain them; or
- With few exceptions, staff have received required training, including applicable specialized training; or
- Training curricula are not fully developed or lack depth; or
- Training documentation is consistently maintained and kept up-to-date with some exceptions; or
- A substantial number of supervisors meet the requirements of the standard, and the organization provides training and/or consultation to improve competencies when needed; or
- With few exceptions, caseload sizes are consistently maintained as required by the standards or as required by internal policy when caseload has not been set by a standard; or
- Workloads are such that staff can effectively accomplish their assigned tasks and provide quality services and are adjusted as necessary; or
- Specialized services are obtained as required by the standards.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- A significant number of staff (direct service providers, supervisors, and program managers) do not possess the required qualifications, including education, experience, training, skills, temperament, etc.; and as a result, the integrity of the service may be compromised; or
- Job descriptions typically do not reflect the requirements of the standards, and/or hiring practices do not document efforts to hire staff with required qualifications when vacancies occur; or
- Supervisors do not typically provide additional support and oversight to staff without the listed qualifications; or
- A significant number of staff have not received required training, including applicable specialized training; or
- Training documentation is poorly maintained; or
- A significant number of supervisors do not meet the requirements of the standard, and the organization makes little effort to provide training and/or consultation to improve competencies; or
- There are numerous instances where caseload sizes exceed the standards' requirements or the requirements of internal policy when a caseload size is not set by the standard; or
- Workloads are excessive, and the integrity of the service may be compromised; or
- Specialized staff are typically not retained as required and/or many do not possess the required qualifications; or
- Specialized services are infrequently obtained as required by the standards.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards.

Table of Evidence

Self Study Evidence

* • Table of contents of training curricula	

* • List of program personnel that includes:
  • Title
  • Name
  • Employee, volunteer, or independent contractor
  • Degree or other qualifications
  • Time in current position
• See organizational chart submitted during application	

Site Visit Evidence

* • Sample job descriptions from across relevant job categories • Training curricula • Documentation tracking staff completion of required trainings and/or competencies • Caseload size requirements set by policy, regulation, or contract, when applicable • Documentation of current caseload size per worker

On-Site Activities

* • Interviews may include: 1. Program director 2. Relevant personnel • Review personnel files

DRCM 2.01

Case managers are qualified by completion of a disaster recovery case management specific curriculum and have the experience, personal qualities, case management skills, and current competencies to work effectively with the populations served.

Examples: *Direct service providers may be selected for their ability to handle stressful situations including personal qualities such as:*

1. *empathy, maturity, judgment, and alertness to warning signs of potential crisis;*
2. *supportiveness and a strengths focus;*
3. *sensitivity to the needs of individuals and families in crisis;*
4. *awareness of the impact of the disaster on the community; and*
5. *cultural and linguistic competence relative to the population served.*

DRCM 2.02

Supervisors of case managers are qualified by:

a. completion of a disaster recovery case management curriculum for supervisors; and
b. human services experience including at least four years of supervised experience providing case management or disaster recovery case management services.

DRCM 2.03

Case managers are trained on, or demonstrate competency in:

a. the role of case management in a disaster;
b. linking clients and making referrals to community services;
c. case advocacy and case presentation;
d. disaster relief resources, planning, and procedures;
e. disaster terminology;
f. stages of disaster response and recovery;
g. the disaster declaration process;
h. local, state and federal responses to disaster to include the “sequence of delivery” for governmental assistance;
i. long-term recovery groups;

j. methods to promote empowering client recovery efforts;
k. conducting disaster-related screening and needs assessments;
l. developing disaster recovery plans;
m. record keeping and data management for emergency situations; and
n. self care.

DRCM 2.04

Case managers are knowledgeable about current eligibility requirements and application processes, including:

a. how to determine eligibility; and
b. specific registration or procedural application sequences required to avoid duplication or loss of benefits.

NA: Eligibility requirements are not in force or do not apply.

DRCM 2.05

Supervisors prevent, identify, and address stress, anxiety, secondary traumatic stress, and vicarious trauma among direct service staff by:

a. processing and debriefing with staff following a crisis or traumatic event;
b. creating an atmosphere of problem-solving and learning;
c. providing constructive ways to approach difficult situations with service recipients; and
d. facilitating regular feedback, growth opportunities, and a structure for ongoing communication and collaboration.

DRCM 2.06

Case management supervisors monitor, communicate, and take action regarding:

a. the support and training needs and effectiveness of case management staff;
b. the prioritization of client needs, and status and support of recovery plan goals;
c. the development and processes of disaster specific resources; and
d. the need for networking and collaboration with agencies and community providers.

DRCM 2.07

A supervisor or case manager is available to provide case consultation whenever services are provided.

DRCM 2.08

Caseload sizes are sufficiently small to permit case managers to respond flexibly to differing service needs of individuals and families, including frequency of contact, and to support the achievement of client outcomes.
Examples: *Factors that may be considered when determining employee workloads include, but are not limited to:*

1. *the qualifications, competencies, and experience of the worker including the level of supervision needed;*
2. *the work and time required to accomplish assigned tasks and job responsibilities; and*
3. *service volume, accounting for assessed level of needs of individuals and families.*

Disaster Recovery Case Management

DRCM 3: Access to Service

Purpose

Individuals and families who receive Disaster Recovery Case Management services access and use resources and support that build on their strengths and meet their service needs.

The organization works with community partners and resources to minimize barriers that prevent individuals and families from accessing services.
Interpretation: *The organization should establish partnerships and cultivate relevant resources that are LGBTQ-friendly to ensure that service recipients who identify as lesbian, gay, bisexual and/or are gender non-conforming are not hindered from receiving much needed recovery services.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*
- Eligibility requirements

Site Visit Evidence

*
- Evidence of collaboration with community providers including MOUs or other formal agreements and documentation from local, state, or national disaster related community collaborators, as applicable
- Outreach strategies and informational material

On-Site Activities

*
- Interviews may include:

1. Program director
2. Relevant personnel

DRCM 3.01

Organizations affiliated with national networks that share responsibility for disaster recovery case management service delivery:

a. follow national guidelines for seeking and securing resources and collaborating with partners;
b. are clear on their local and, if applicable, national scope of responsibility; and
c. adhere to decision-making guidance from the national organization first, then locally, as needed.

NA: The organization is not affiliated with a national network.

DRCM 3.02

Local organizations with responsibility for disaster recovery case management services have formal, written agreements with other service providers which address potential barriers to access.
Examples: *Agreements that address barriers can include community arrangements for provision of care for school age children while adults participate in disaster recovery services; transportation services for persons with disabilities; and providing, or arranging for, bilingual personnel or translators.*

DRCM 3.03

Effective, culturally- and linguistically-competent outreach strategies connect potential service recipients with accurate and appropriate information about community resources, service availability, and eligibility.
Interpretation: *Case managers may receive cases through referral from another service provider or service unit within the organization that is responsible for outreach. Case managers that play no direct role in determining eligibility should, still have sufficient and current information about eligibility to provide accurate answers to service recipients' questions.*

Disaster Recovery Case Management

DRCM 4: Intake and Assessment

Purpose

Individuals and families who receive Disaster Recovery Case Management services access and use resources and support that build on their strengths and meet their service needs.

The organization's intake and assessment practices ensure that individuals and families receive prompt and responsive access to appropriate services.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- In a few rare instances, urgent needs were not prioritized; or
- For the most part, established timeframes are met; or
- Culturally responsive assessments are the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Urgent needs are often not prioritized; or
- Services are frequently not initiated in a timely manner; or
- Applicants are not receiving referrals, as appropriate; or
- Assessment and reassessment timeframes are often missed; or
- Assessments are sometimes not sufficiently individualized;
- Culturally responsive assessments are not the norm, and this is not being addressed in supervision or training; or
- Several client records are missing important information; or
- Client participation is inconsistent; or
- Intake or assessment is done by another organization or referral source and no documentation and/or summary of required information is present in case record.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- There are no written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Screening and intake procedures	
*	• Assessment procedures	
*	• Copy of assessment tool(s)	

Site Visit Evidence

*

- Community resource and referral list

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Persons served
- Review case records

DRCM 4.01

Individuals and families are screened and informed about:

a. how well their request matches the organization's services; and
b. what services will be available and when.

NA: Another organization is responsible for screening, as defined in a contract.

Examples: *Information about service availability can include an explanation of the phases of disaster recovery case management.*

DRCM 4.02 (FP)

Prompt, responsive intake practices:

a. include screening for level or intensity of service including screening for trauma exposure and/or trauma-related symptoms;
b. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary;
c. ensure equitable distribution of resources;
d. give priority to urgent needs and individual emergency situations, including early recognition of vulnerable populations;
e. support timely initiation of services; and
f. provide for placement on a waiting list or referral to appropriate resources when individuals cannot be served or cannot be served promptly.

Interpretation: *Screening and intake activities involving individuals with disabilities should be performed by staff with relevant, specialized expertise to overcome barriers to service initiation specific to this population. Common barriers include transportation, attitudinal biases on the part of collaborating/referral service providers, and facility accessibility among others.*

Interpretation: *To ensure that transgender and gender non-conforming candidates for service are treated with respect and feel safe, service recipient choice regarding their first names and pronouns should be respected and intake forms and procedures should allow individuals to self-identify their gender.*

DRCM 4.03 (FP)

The organization contributes to effective coordination, delivery, and use of disaster recovery resources by:

a. promoting and complying with the standardization of forms used for information gathering; and
b. sharing client information with necessary safeguards, including client consent for release of information to ensure confidentiality.

Examples: *Shared database technologies may be one way to improve monitoring of client goal attainment among collaborating providers and promote the efficient and effective use of disaster-related resources.*

Examples: *Sharing client information without necessary safeguards can result in identity theft and unintentional release of client information.*

DRCM 4.04

Individuals and families participate in an individualized, culturally- and linguistically-responsive assessment that is:

a. trauma-informed;
b. completed within established timeframes;
c. updated as needed based on the needs of individuals and families; and
d. focused on information pertinent to meeting service requests and objectives.

Interpretation: *Organizations that establish their own timeframes should be sensitive to the needs of individuals and families, ongoing recovery efforts and deadlines, and the need for timely development of a recovery plan.*

Interpretation: *The Assessment Matrix - Private, Public, Canadian, Network determines which level of assessment is required for COA's Service Sections. The assessment elements of the Matrix should be tailored according to the needs of specific individuals or service design.*

Examples: *The organization can support a trauma informed approach to service delivery by considering and emphasizing:*

1. *safety;*
2. *trustworthiness and transparency;*
3. *peer support;*
4. *collaboration and mutuality;*
5. *empowerment, voice, and choice; and*
6. *cultural, historical, and gender issues.*

DRCM 4.05

The organization conducts the assessment in-person, in a place of the individual's or family's choosing when possible, and:

a. includes assessment of natural supports and helping networks; and
b. promptly provides or makes arrangements for specialized assessments, as needed.

Interpretation: *Conditions may require beginning an assessment by telephone and continuing in person at a location that takes into account client and worker safety, client confidentiality, and client accessibility. In-home visits are optimal for completing a comprehensive assessment.*

DRCM 4.06

The organization uses a comprehensive, evidence-based suicide risk assessment tool to assess the following when suicide risk is identified:

a. suicidal desire;
b. capability;
c. intent; and
d. buffers/protective factors.

DRCM 4.07

A re-assessment is conducted within five working days when there is a change in the individual's or family's status or circumstances, or a new issue or resource arises.
Interpretation: *An organization that, due to contractual requirements, is unable to conduct re-assessments according to these timeframes should modify them to meet the needs and goals of individuals and families.*

Disaster Recovery Case Management

DRCM 5: Recovery Planning and Monitoring

Purpose

Individuals and families who receive Disaster Recovery Case Management services access and use resources and support that build on their strengths and meet their service needs.

Each individual or family participates in the development, implementation, and ongoing review of a recovery plan that is the basis for coordination and delivery of appropriate services and support.
Examples: *The disaster recovery plan may include:*

1. *For all individuals and families: crime victims services for victims of mass violence, applications for public benefits and insurance, crisis intervention services, and other services needed to recover optimum social, psychological, and physical functioning.*
2. *For individuals, families, and children: mental health treatment or other counseling services, group activity and/or recreation programs, volunteer or employment programs, personal care services, foster care, respite care, intergenerational support services, vocational training, child care, and tutorial programs.*
3. *For individuals with special needs: counseling, services for substance use conditions, transitional living arrangements, residential treatment or other out-of-home placement, education, day treatment or activity programs, respite care, nutrition services, vocational training or rehabilitation, and transportation services.*
4. *For older adults: mental health or other counseling services, medical and rehabilitative services, escort/transportation services, social programs, volunteer or employment programs, in-home care services, skilled nursing services, senior companion or intergenerational support services, home delivered meals, telephone reassurance services, repair services, day care and respite services, and legal and financial services.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- In a few instances, client or staff signatures are missing and/or not dated; or
- With few exceptions, staff work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc.; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- In several instances, client or staff signatures are missing and/or not dated; or
- Quarterly reviews are not being done consistently; or
- Level of care for some clients is clearly inappropriate; or
- Service planning is often done without full client participation; or
- Appropriate family involvement is not documented; or
- Documentation is routinely incomplete and/or missing; or
- Individual staff members work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc., but this is the exception.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Service planning and monitoring procedures	
*	• Procedures for referring individuals and families for services	

Site Visit Evidence

*	• Community resource and referral list

On-Site Activities

*	• Interviews may include: 1. Program director 2. Relevant personnel 3. Persons served • Review case records

DRCM 5.01

An assessment-based recovery plan is developed in a timely manner with the full participation of the individual, and their family when appropriate, and includes:

a. agreed upon goals, desired outcomes, and timeframes for achieving them;
b. time-limited, recovery plan tasks to be completed by the client or worker, with additional tasks to be accomplished through referral, assistance, or advocacy;
c. services and supports to be provided, and by whom;
d. possibilities for maintaining and strengthening family relationships and other informal social networks;
e. procedures for expedited recovery planning when crisis or urgent need is identified; and
f. the individual's or guardian's signature.

Interpretation: *When individuals and families are mobile in the aftermath of a disaster, an integrated recovery and exit plan may be initiated.*

DRCM 5.02

The organization works in active partnership with individuals and families to:

a. directly provide or arrange for services and resources identified in the recovery plan;
b. provide case coordination and monitoring of services;
c. ensure they receive appropriate advocacy support; and
d. mediate barriers to services within the service delivery system.

Examples: *The organization can encourage active participation of individuals and families by demonstrating:*

1. *sensitivity to the willingness of the person or family to be engaged;*
2. *sensitivity to differences in presentation of needs over the phases of recovery and changes in availability of resources;*
3. *a non-threatening manner;*
4. *respect for the person, his/her autonomy, culture, and confidentiality; and*
5. *flexibility.*

DRCM 5.03

The organization maintains a comprehensive, up-to-date list of community programs and services and information on how to access them.

DRCM 5.04

Service monitoring includes:

a. confirmation, usually within one or two working days, that a service has been initiated as scheduled;
b. verification, usually within 15 working days, that the service is appropriate and satisfactory;
c. follow-up every month at a minimum, or as needed; and
d. immediate response to any complaints or problems that develop in the delivery of service or with individuals and families.

Interpretation: *The organization should tailor the type and frequency of service monitoring according to the needs of persons receiving services, frequency and intensity of service provided, barriers and resources that emerge, and frequency of contact with informal caregivers and cooperating providers.*

DRCM 5.05

The worker and a supervisor, or a clinical, service, or peer team, review cases routinely, consistent with established timeframes, to assess:

a. recovery plan implementation;
b. the individual's or family's progress toward achieving goals and desired outcomes; and
c. the continuing appropriateness of service goals.

Interpretation: *When experienced workers are conducting reviews of their own cases, the worker's supervisor must review a sample of the worker's evaluations as per the requirements of the standard.*

Interpretation: *Because disaster recovery case management is time limited, case reviews should be conducted within meaningful timeframes that take into account the nature of the disaster; issues and needs of individuals and families; the frequency, duration, and intensity of services provided; and resources available.*

DRCM 5.06

The worker and individual, and his or her family when appropriate:

a. review progress toward achievement of agreed upon service goals; and
b. sign revisions to service goals and plans.

DRCM 5.07

During disaster recovery planning and implementation, the organization:

a. engages in active and collaborative participation with community recovery resource meetings, as appropriate;
b. shares information at resource meetings regarding inventories of resources, such as available staff, money, or materials; and
c. assures that organizational representatives have authority to allocate resources at the community recovery resource meetings.

Disaster Recovery Case Management

DRCM 6: Case Closing

Purpose

Individuals and families who receive Disaster Recovery Case Management services access and use resources and support that build on their strengths and meet their service needs.

The organization works with individuals and families to plan for case closing.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- In a few instances, the organization terminated services inappropriately; or
- Active client participation occurs to a considerable extent; or
- A formal case closing evaluation is not consistently provided to the public authority per the requirements of the standard.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Services are frequently terminated inappropriately; or
- Aftercare planning is not initiated early enough to ensure orderly transitions; or
- A formal case closing summary and assessment is seldom provided to the public authority per the requirements of the standard; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*

• Case closing procedures	

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*

- Interviews may include:
  1. Program director
  2. Relevant personnel
  3. Persons served

- Review case records

DRCM 6.01

Planning for case closing:

a. is a clearly defined process that includes assignment of staff responsibility;
b. begins at intake;
c. involves the worker, the individual, a parent or legal guardian, and others as appropriate to the needs and wishes of the individual.

Interpretation: *The disaster recovery goal(s) and scope of time-limited, disaster-related services and programs should inform the timing of case closing.*

DRCM 6.02

Upon case closing, the organization notifies any collaborating service providers as appropriate.

DRCM 6.03

If an individual or family has to leave the program unexpectedly, the organization makes every effort to identify other service options and link the individual or family with appropriate services.
Interpretation: *The organization must determine on a case-by-case basis its responsibility to continue providing services to persons whose third-party benefits are denied or have ended and who are in critical situations.*

DRCM 6.04

Cases are closed and transferred to an appropriate provider when:

a. a resource or time-limited program closes, resulting in termination of services; and/or
b. a transfer is requested by the client or when it is determined that transferring a case to another disaster case management organization is in the client's best interest and the individual or family concur.

Examples: *Situations that may warrant a case transfer include when a client needs specialized services that the organization can not provide directly or arrange for without the transfer, such as programs with bilingual staff, services for seniors, or services for individuals with disabilities.*

DRCM 6.05

An organization transferring and closing a case consults with the receiving organization prior to transfer to insure acceptance of the case and continuity of service.