To: mfservicecoordinator@hudgov.onmicrosoft.com
RE: LeadingAge Comments on Service Coordinator in Multifamily Housing Program Resource Guide draft
Date: November 27, 2017

On behalf of LeadingAge and its members, please accept the following comments on the Service Coordinator in Multifamily Housing Program Resource Guide draft. We appreciate the opportunity to comment on this important document. Information included in this guide is certainly welcome, as the field of service coordination has progressed significantly over the years. We commend the authors on a work well done, and provide our commentary and suggestions in hopes of further enhancing the value of the document, without any intent of undermining the effort or its intentions.

One recurrent issue or question however stands out: Is this guide intended as a recommendation for elevating the program at the discretion of the owner/operator, or articulating mandatory elements or performance standards that will be applied across the board? Wherever there is a mandate, HUD needs to be quite clear.

Otherwise, the bulk of our comments below are organized in the same order as the draft document. Due to the overlapping nature of certain issues, sometimes sequence order is not maintained. However, the chapter, section, paragraph and page are provided as often as possible.

Living *As Independently As Possible*

Chapter 1, Section A, Paragraph 1 (p.1) - we recommend modifying the phrase "obtaining supportive services they need to continue to live independently in their homes" to read "live *as* independently *as possible with or without supports* in their homes. Likewise - in the text box on "What is a Service Coordinator?" - the phrase on living independently should be similarly modified to read "live *as* independently *as possible with or without supports* and remain in their communities."

Other references to living "independently" (or "maintain their independence" (chapter 2, paragraph 1 p. 3,) should also be modified to read "maintain their independence *to the greatest extent possible*" or "independence *with or without supports".* We note with satisfaction that in Exhibit 1 (p. 3) the role of service coordinators includes being "Motivators who empower residents to be as independent as possible."

Serving Individuals in the Area Surrounding the Property

Chapter 1, Section A, Paragraph 1 (p. 1) – This paragraph closes with the sentence "Service coordinators can serve both the residents living in a federally assisted multifamily housing development and individuals living in the surrounding area of the property." However, there is no further reference to serving individuals living in the surround area anywhere in the guide – nothing on identification,

invitation, eligibility, assessment, integration into site-based programs (social, nutritional, educational or otherwise), referral, tracking, or outcomes. Are there any restrictions or requirements involved in provision of service coordination services to non-residents of the property? Are there no recommendations or best-practices suggestions, either?

Editorial Comments and Other Questions:

Chapter 1, Section A, Paragraph 3 (p. 1) – modify this sentence by adding words here in *italics* to read, "The SC may not require any elderly person or person with disabilities *to meet with or* accept any specific supportive service(s)."

Chapter 1, Section B, Paragraph 2 (p. 2) – remove the word "sole" from the second line, as HUD-assisted properties for elderly persons are never restricted to "sole" occupancy by persons aged 62 or over.

Role of Service Coordinators

Chapter 2, Paragraph 1 (p. 3) – In this discussion of doing the job of service coordination, the last sentence reads "Service coordinators *manage and provide* access to necessary supportive services in the community, provide *case management services* as needed and requested, and develop programs and resources that support wellness for the entire resident population." While many have certainly moved toward a more holistic and proactive model of services and supports, some indicate they would prefer the word "refer" to "manage" and have indicated that they do not provide case management services, which involves one on one attention and monitoring, but instead provide referrals to any resident needing case management service/s. And while many may coordinate resources, some disagree with the statement or expectation that they "*develop* the programs and resources that support wellness for the *entire* population" and remind the drafters that not all segments of any given population with mixed ages, mixed abilities and needs are likely to have uniform wellness needs.

At a minimum, HUD needs to identify if case management will be a *mandate* for everyone to follow, or if this document's focus is recommended best practices from which providers may pick and choose. However, if this is a mandate, then recognition is sought of the fact that persons undertaking assessments (even if non-clinical) *and* case management functions may require significant additional levels of training, and greater expense due to the time requirements as well as language issues in buildings where there are multiple foreign languages spoken, than the original program expectations under the initial grant and/or existing budget-based positions can currently afford.

Chapter 2, Exhibit 1 (p. 3) – modify text regarding SC role as Educator to change or expand on the phrase "provide trainings and assistance" to include "coordinate and/or" provide trainings and assistance. Additionally, while we are pleased to see that SCs are not to be "organizers or leaders of resident associations or councils," we are concerned about the statement that SCs are "Advisors who can...*consult with tenant organizations…"* (see also p. 11 comment related to working with tenant organizations.)

Chapter 2, Paragraph 2 (p. 3) – add the phase "educates residents within the scope of their expertise/training" to the list of proactive steps a service coordinator may undertake.

HUD Expectations that ALL Service Coordinators Will Follow Enhanced SC Model

Chapter 2, Paragraph 2 (p. 3) – This paragraph indicates that Chapter 2 "provides an overview of the **enhanced service coordination model** that HUD *expects* service coordinators in multifamily housing to follow." Again, it is unclear from this language whether this resource guide is to be read as containing recommendations or mandates. The linguistic choices throughout this document reflect a tendency to use permissive terms like "can", "may" or "should" and is very light on any use of the imperatives "must (or must not)" or "shall." But this statement of *expectation* raises the question as to whether this document is meant to encourage adoption of "best practices" or "next level/enhanced programs", or mandate them.

"Core Functions" of the Service Coordinator

Chapter 2, Section A, Paragraph 1 (p. 3) – In discussing the enhanced service coordination model, the document asserts that the role of service coordinator has "evolved to a more proactive level of coordination, assistance and case management services. This enhanced service coordination model reflects the evolving level of service that HUD *expects all service coordinator programs to provide to residents."*

On page 4, this section lists the Core Functions "that *all* service coordinators *should* provide" including "conducting comprehensive, non-clinical assessments of residents for wellness and social needs" and "including monitoring of services provided [after referral]". Again, the question arises, if these are recommendations or requirements.

Chapter 2, Section B, Paragraph 2 (p. 6) – inclusion of *80 percent* as the recommended target of the number of residents a service coordinator should try to reach *each month* has drawn the criticism of some as being overly high, as this would be subject to a number of variables. However, as this paragraph is recounting what "some" organizations do, and suggesting adoption of creating a metric as "many" organizations do, modification is also just a recommendation.

Service Coordinators Establishing Memorandums of Understanding (MOUs) on Behalf of Organization

The enhanced model of service coordination includes multiple fields and professionals coming together to support their client and help them to achieve their goals. So it has been explained to us that the reference here to MOUs is meant to acknowledge the regular practice of many SCs to create informal standards of communication with particular providers with whom they have frequent contact. However, as MOUs might also involve formal relationships and imply something created to engage partnering organizations in some future pursuit or current expectation or obligation to act in a much larger way that could impact or engage organizational priorities, we recommend inclusion of a statement that formal arrangements with third parties outside the organization should not be

undertaken without the involvement of others within the organization, and any true contracts should be signed by the corporate office or as identified by the company. To that end, we offer the following suggestions:

Chapter 2, Section A (top of page 5) – this section ends with reference to additional "Enhanced Functions" that well-established SC programs that may include "once [the SC] has successfully implemented all Core Functions," including "*establishing Memorandums of Understanding (MOUs)* between [the SC's] organization and community-based supportive service providers and other stakeholders." This suggests that the service coordinator is empowered to establish MOUs on behalf of the organization. While a SC may well be the one to implement the intervention, and may be the first to form a relationship with a potential provider/partner, any official document obligating one organization in any way to another should be the result of a collaborative effort between organization staff (management, owner, etc.) and the service coordinator. Though the final effort (as acknowledged appropriately in Chapter 2, Section D, Paragraph 2 (p. 8) may not be exclusively a management function, and the role that leads will likely vary by circumstance, such agreements should not be entered into unilaterally by the service coordinator alone. This concept should also be clarified and cross-referenced to Section D.

Editorial Comments and Other Questions:

NOTE: the Header on this page (starting page 3 and continuing through page 12) erroneously reads "Chapter 3: Hiring and Training". It should read "Chapter 2: Doing the Job of the Service Coordinator"

Chapter 2, Section B, Paragraph 1 (p. 5) - Line 2, change the definitive "are" to the conditional "may be" regarding assistance and services that *may be* available to [all residents], as not all services "are" going to be available to all residents, and it often takes a great deal of work to determine which programs will ultimately be best suited to which resident.

Sensitivity to Resident Preferences and Optional Participation

Chapter 2, Section B, Paragraph 3 (p. 5) - regarding new resident engagement and the recommendations/expectations for service coordinator follow-up, this would be a good time/location to reiterate that resident participation is optional. While the optional nature is referenced in other places, the guide should carefully balance repetition of SC duties/expectations and resident wishes.

Chapter 2, Section B, Paragraph 5 (p. 5) – similar to statement above, recommend modifying the first sentence to include "willing"ness of residents: "After the initial introduction, service coordinators are encouraged to develop ongoing relationships with *willing* residents.

We appreciate the well-articulated statements on page 6 that balances the statements about "engagement is not required for any residents" and "refusal of services" alongside the encouragement to create a range of engagement opportunities.

Expectations for Conducting Supportive Services Assessments and Performing Case Management

Chapter 2, Section C, Paragraph 1 (p. 6) - This paragraph discussion of how service coordinators "*can* use assessments to develop individual case management plans for residents" and how SCs "*may* provide case management services for residents who do not receive these services from other providers." Yet this is very different from the historical "refer and link" service coordinator role. Without providing any particular detail, or any examples of appropriate tools to use, the guide simply plows on to indicate that SCs "*should* try to conduct an initial assessment of each resident's abilities, functioning, social status, wants and any other additional needs" and "*should* update the assessment on a yearly basis". Yet again later in the guide (page 20), when discussing the contents of resident files, the statement is that "intake forms *should* be updated *at least annually, preferably when conducting the annual Activities of Daily Living assessment"* which is not referenced elsewhere, nor is any model form provided.

We reiterate here our concerns that the linguistic choices throughout this document reflect a tendency to use permissive terms like "can" and "may" yet are confusingly blended with the use of "should" or the term "expected" or statements like "at a minimum [Supportive Services Management Plans] should include" (p. 7). And reiterate the question as to whether this document is meant to encourage adoption of "best practices" and "next level/enhanced programs", or mandate them.

Further, without providing acceptable forms or tools, or addressing the need for additional skills or training, these kinds of efforts while well intentioned could too easily be mishandled or poorly done and seem to reinforce what may otherwise be unrealistic expectations of the "core functions" of "all" service coordinators. Additionally, in order to obtain adequately trained persons with kinds of qualifications for these newly "expected" duties that are being set forth in this draft document, many sites are likely to need increased funding to attract, train and/or retain staff capable of consistently performing at this level.

However, in Paragraph 2 (p. 6), while the caution that SCs should not make a diagnosis is appropriate, it may be helpful to indicate that SCs *can provide residents with information that may help them better understand their diagnosed condition.* And in Paragraph 1 (p. 7), it may be helpful to close the paragraph with a reminder that the resident is not mandated to complete the assessment or even meet with the SC.

Providing a Local Resource Directory

Chapter 2, Section D, Paragraph 3 (p. 8) - This section on "Maintaining a Resource Directory" articulates HUD's *expectation* that SCs will make a version of their resource directory available in a common area, and later says that "some SCs also provide information on the quality and professionalism of the services provided based on previous residents' experiences." While this may indeed be valuable information, the method and currently recommended level of information requires greater caution about appropriate methods of communicating such information, particularly where the feedback is negative or could be harmful to the provider, even if provided third-hand, can verge on making defamatory statements. We are concerned about the potential risk to the SC and to the site/management, and feel this suggestion, if included, should be clarified or expanded upon.

Additionally, the draft's discussion of the method of providing resources seems unnecessarily restrictive. Hard copy resources left in common areas have certain inherent flaws. For example, once something like that is printed out, it can quickly go out-of-date due to frequent changes in contact information and even websites of many agencies/providers. Also, hard copies "walk off", requiring a SC to reprint the information several times a year, which is really not time-efficient nor cost-effective. An alternate suggestion is putting out copies of a local resource directory or a display of local resource provider pamphlets, or posting an abbreviated list of phone numbers to local referral agencies, like the local area agency on aging, or information on the local United Way, or reminders about 2-1-1 call centers in states which have them, as this is a phone number available 24/7 where an actual person answers the phone. Such postings could also include online resources, such as a website for the local 2-1-1.

Expanding on Resources Specifically Identified

Chapter 2, Section D (p. 9) and Appendix A (p. 33) – Recommendations for online directories and supportive service websites could be significantly expanded upon. . For example, the national housing organizations list currently only identifies NLIHC and NAHRO. Groups like NLHA, NAHMA and LeadingAge (and its state affiliates) should also be added. NASUAD, NAEH, Veterans Administration and others also are easy recommendations to be included. We suggest that the list of organizations should be expanded on and further reviewed prior to final publication in this resource guide.

Additionally, particularly given HUD's recent efforts to urge housing providers to establish a homeless preference, inclusion of some information on national and/or local groups that assist the homeless may be appropriate to discuss in conjunction with "Making Contact with Community Partners" (p. 9).

Obtaining Necessary Consents for Release/Sharing of Information

Chapter 2, Section E, Paragraph 3 (p. 10) – This paragraph is confusing, starting with a potentially incomplete statement that "Service coordinators should obtain written consent for all referrals to community partners." At other places, the document discusses obtaining appropriate releases, but obtaining a release in order to make a referral doesn't make sense. Where "making a referral" of a service to a resident doesn't require a consent, release of private information on behalf of a resident to an external party or organization does.

Chapter 2, Section E, Paragraph 5 (p. 10) - This indicates that SCs "*should* pass along health and medical information to medical professionals when referrals to emergency or non-emergency medical services are made." This type of direct referral (suggesting that a SC *should* call a health service provider directly), and interceding in the contact (to the point that they are providing personal health and medical information) is concerning. There is never a guarantee that the SC will have the latest health information or an up-to-date listing of medication, and creates a great deal of liability. Emergencies need to be managed at the owners discretions and those identified by state laws. Service Coordinators should not have the responsibility to disclose information for their protection. Medication lists are not kept by the Service Coordinators for this can be a potential liability should the Services Coordinator not have current information.

This section also includes references to a "signed Consent to Release Information" when no specific form is provided, and includes reminders to safeguarding requirements under HIPAA without providing any further details.

In Section F, the document again references a signed Consent to Release Information, but the guide does not include any such form, nor does it provide an outline of what such a self-developed form (if that is the intent) should include. We suggest that the components of what should be in such a form would be helpful, if an actual form is not developed and made available.

Chapter 4, Section A, Paragraph 1 (p. 17) – In this section, the Consent to Release Information reference is bolded and italicized, again suggesting there is (or should be) a standardized form provided. Additionally, members have commented that inclusion of the recommendation to time limit resident consents for the release of information to 30 or 60 days could make ongoing case management difficult, so they recommend removing this from the guide. Some feel that it is unreasonable to have someone sign a form every time a SC needs to share their information to help them access services/resources and others specifically suggest that having a blanket consent form remaining effective for a year is ideal, as residents still have the right not to sign the form or to sign and include in it any personal preferences or limitations.

Chapter 5, Section A, Item #7 (p. 20) – the Consent to Release Information is again referenced, and this time the document addresses to some degree what should be included regarding limitation of applicability, and defining/restricting the timeframe. It is helpful that here it is clarified that a signed "consent to release information" is not required in connection with the file reviews conducted by the Quality Assurance and HUD audits.

If possible, a sample form should be developed and included in this guide, and more details given on how to safeguard information in accordance with HIPAA. It is far easier to edit and comment on the draft as it exists. However, it is our recommendation that this entire section on "Making Supportive Service Referrals" could well be expanded upon.

Additionally, more attention needs to be given to concepts of privacy v. HIPAA. Comments from members indicate they feel the need for better understanding of how HIPAA applies in affordable housing, HUD and specifically the service coordinator role/profession.

Service Coordinators Teaching Residents How to Advocate for Themselves

Chapter 2, Section F, Paragraph 2 (p. 10) – This section includes some very sensitive issues, including the statement that "an example of this is helping residents advocate for themselves with property management for reasonable accommodation requests or to make repairs or changes to the property." This section later states (paragraph 5, p. 11) that "service coordinators may provide assistance and information to resident councils as requested by the council. If the property does not have an established resident council…the SC can provide information on HUD regulations regarding the establishment of a council, information on electing officers" etc. Which seems to suggest this is the domain of the service coordinator to discuss and facilitate.

It also states in this section that "If a service coordinator is advocating for a resident, the resident needs to give the service coordinator permission to advocate on their behalf. This is usually accomplished by way of a signed Consent to Release Information that protects the service coordinator and the resident."

Too many elements of this section seem to set the service coordinator and management up as adversaries, where the intent may really have been to empower the SC to help residents help themselves. SCs should not feel unable to share resources where residents have specific individual needs or have inquired about possibilities related to resident organizing. But wherever a resident has a need related to their ability to peacefully enjoy or otherwise equally benefit from the programs and services at the site, the SC should always refer the resident to the management. Including, also discussing with management their rights to set up resident councils.

Expanded SC Engagement with Management Team on Operational Issues

Chapter 2, Section G, Paragraph 1 (p. 11) – This section on "Interfacing with Other Property Staff" begins with the statement that "it is critical that the service coordinator be an active and full member of the property's management team" and goes on to state that SC should be part of joint consideration with management staff to "discuss any changes in the resident selection plan or facility rules" and "should receive relevant written materials, memos, lease violation and eviction notices…". While the service coordinator is expressly NOT management staff, the encouragement here for the SC to interact with the management team on a regular basis and recommendations of SCs being kept well informed about changes to policies is very much to be encouraged. Expanding this section to acknowledge the important role that SC can play in meeting with the resident and making referrals or introducing services to address the violations in an effort to help the resident rectify the situation and sustain their residency would be appreciated. It may be helpful to end the section with a parallel reminder that, as the SC is "obligated to direct residents to management when management issues arise," management should also be expected to direct services and support items" to the service coordinator.

Are "Caseload" Recommendations or Programmatic Caps/Thresholds

Chapter 3, Section A, Paragraph 5 (p. 13) – This paragraph, subheaded "Caseloads", indicates that "in general, a ratio of one full-time service coordinator to 85-100 residents is a good ratio to use as an initial benchmark. In properties with large numbers of residents with mental health conditions, a smaller ratio of 50 – 85 residents per coordinator may be appropriate." Recently we have been hearing of challenges to existing Service Coordinator programs, based strictly on the ratio of staffing to residents, and without any discussion concerning the expanded role of the SC into case management or consideration for the numbers of non-residents being served in the broader community. If there are programmatic limits/thresholds, these should be clearly spelled out and source authority provided here. Additionally, availability of funding should be acknowledged as a valid factor when determining what is feasible for any given organization.

Service Coordinator Minimum Qualifications and Training Requirements

Chapter 3, Section 1, Paragraph 1 (p. 13) – The guidebook draft here states that a bachelor's degree is required, yet the Handbook allows that "individuals without a degree, but with appropriate work experience may be hired." This section should be modified for consistency.

Chapter 3, Section B, Paragraph 1 (p. 13) – We acknowledge and appreciate the introductory statement in this paragraph about training and associated travel costs for SC qualifying as eligible project expenses, and the general thrust of suggesting topics and sources found in this section in general. However, we recommend modifying and/or expanding the language on the closing sentence of that paragraph on acceptable training sources to read "flexibility in training design, delivery *method and location* by a variety of *sources* (instead of just "vendors").

Further, in the list of "sources of training for service coordinators" (p. 15), we recommend inserting the words "State and" before "National housing organizations and trade associations".

Service Coordinators are Not Service "Providers"

Chapter 4, Paragraph 1 (p. 17) – We recommend replacing the word "provision" in the closing line of this paragraph with "coordination efforts", in keeping consistent with the understanding that service coordinators are not service "providers".

Is This Document Guidance or Mandate?

Chapter 4, Section A, Paragraph 1 (p. 17) – We note here again the mixed use of permissive and mandatory terminology with these statements: "Regardless of funding source, the confidentiality and conflict of interest guidance in this chapter *should* be followed by all service coordinator programs" and "Service coordinators *must* keep all resident information confidential unless….." Is this document guidance, or are particular sections of it truly mandatory? We recommend that such issues be clarified and highlighted somewhere either at the introduction or in a supplemental appendix to the document.

Sharing Critical Information

Chapter 4, Section A, Paragraph 3 (p. 17) – The use of the permissive "may" concerning SCs sharing resident information with property management staff "if withholding it could lead to negative consequences including self-harm or harming others, activities that break the law, or violations of the lease agreement" is inappropriate. Where information addresses violations of law, the lease agreement, or could otherwise impact the safety and security of the individual, other residents or management staff, SCs should be directed that they "must" share such information with the property management staff, and should disclose this upfront when meeting with residents and discussing and assuring them of confidentiality in all other matters.

Professional Boundaries and Conflicts of Interest

Chapter 4, Section B, Paragraphs 1 and 2 (p. 19) – we acknowledge and appreciate the inclusion of the statement that "service coordinators are prohibited from accepting tips, cash, or any other monetary gifts from residents or their families, including bequests from residents' wills." This directive could be expanded to prohibit the receipt of gifts that possess a monetary value, as well, and should be identified among those elements clarified to be mandatory, in keeping with our earlier recommendation. We also acknowledge and appreciate the direct approach regarding "maintaining a professional distance when using social media" though it could perhaps be better articulated and include a reminder here about maintaining resident privacy, as well.

Resident File Contents

Chapter 5, Section A, Item #1 (p. 20) – The discussion concerning "intake form" reads "*should* be updated *at least annually,* preferably when conducting the *annual* Activities of Daily Living assessment." Yet on the next page, item #5, the "Activities of Daily Living/regular capacity/skills assessment" footnote read "ADL forms do *not* need to be updated with any specified frequency, [yet] it is *good practice* to conduct assessments *at least annually…"* Again, the permissive, mandatory and expected or recommended timeframes are rather muddled.

Chapter 5, Section A, Item #2 (p. 20) - The draft states that SCs should "develop individual case management plans for residents" and this section indicates that there is or should be a form used to document that case management services management plan. A sample document and additional guidance on this matter have been requested by some members.

Chapter 5, Section A, Item #4 (p. 20-21) – We recommend inserting the word "each" at the end of the second line, documenting "each" meeting, etc. and closing the item with a recommendation that documentation should be completed as soon as possible following each individual interaction.

Chapter 5, Section A, Item #7 (p. 21) – The suggestion here to limiting the consent to 30 or 60 days is again noted as potentially problematic for ongoing case management, as in our comment above at Chapter 4, Section A, Paragraph 1.

Chapter 5, Section C, Paragraph 4 (p. 22) – Access to resident files is also necessary for QA and SC managers, and should be noted here. Additionally, the last line of this paragraph is redundant, and should be eliminated.

Funding Service Coordination Expenses Through the Budget

Chapter 6, Section A, Paragraph 1 (p. 23) – We acknowledge and appreciate here (and repeated statements elsewhere) that "regardless of the source of funding, all service coordinator programs are expected to adhere to the same standard requirements as outlined in this guide." We ask again, however, that the elements that are mandated and those that are only recommended be carefully reviewed, clarified and highlighted, as discussed earlier in our comments. We also acknowledge and appreciate the statement (paragraph 3) that "including service coordinator expenses in the project's operating budget is the preferred method to secure ongoing funding for the SC program."

Further, on page 24, there is information on how to change the source of funding from grant to operating budget, and the statement that "HUD urges housing owners and managing agents to use budget-based funding sources to fund a Service Coordinator wherever possible." It would be helpful have this recommendation shared with HUD field offices, and for this guide to be explicitly used to remind and encourage asset management staff to support this effort.

However, at the end of this page, there is a truncated sentence that reads, "Owners with debt service savings can use……" What is it that owners with debt service savings can use? While the phrase has not been completed, we hope it *will* be finished to specifically direct and include ongoing priority and

clarified intent that debt service savings and residual receipts should first be used to fund services and coordination services, after any essential capital repair needs have been met.

Additionally, there is no mention of attending conference and trainings to maintain minimum requirements. There is no mention of mandatory education hours per year, which should be given to support sending Service Coordinators to trainings. And several members have commented on the need for additional funding to keep Licensed Social Workers on staff and support with their continued education. This information is essential, particularly for those who struggle to obtain the kind of needed increases in operational budget authority.

Chapter 6, Section B, Paragraph 1 (p. 24) – This paragraph talks about the Semi-Annual Performance Report. However, the guidance in this manual should be updated to reflect the "Standards for Success" pilot that HUD is currently doing. Given that all service coordinators who use AASC Online for documentation are automatically included in the pilot, unless they opt out, the guidance in the manual does not appropriately describe the current reporting requirements for a substantial number of folks. For instance, those in the pilot are no longer submitting the semi-annual performance report. Rather, pilot sites submit via a submission tool on AASC (not the HUD-92456) once annually in October for the previous calendar year (Oct. 1-Sept. 30). Addition of a section that includes the information found here https://www.hudexchange.info/programs/standards-for-success/ describing the pilot and then adding the specific modified reporting requirements for the significant number of folks whom this impacts would be helpful.

Quality Assurance Recommendations

Chapter 7, Paragraph 1 (p. 27) - We acknowledge and appreciate inclusion of the statement that "while not required, HUD strongly recommends that all multifamily properties with service coordinators include a Quality Assurance (QA) component." It is not until this section that that discussion of case management software and/or paper files systems are discussed. Perhaps it is expected that most QA providers will also provide the template forms and consent to release information documents that we have been recommending throughout our comments.

We appreciate and acknowledge the insert on "recommended qualifications of a Quality Assurance Professional" (p. 27), but we are a bit baffled by the inclusion of the word "advocate" in this element "demonstrated ability to advocate, organize, develop outcomes and appropriate outcomes measures, problem solve, and provide results."

Chapter 7, Section C, Paragraph 3, (p. 29) – The document states that "organizations that use a portion of their service coordinator budget for QA *must conduct AQ activities at least once annually"* and then follows with statements about what "most" organizations do (twice annually) and "some" do (review monthly reports). Yet at the top of page 30, on "Reviewing Service Coordinators' Files", the document indicates that "QA professionals *should* routinely review" active and inactive files to "ensure compliance with HUD standards." And continues to suggest that "many forms *should* be updated annually or semi-annually." The combination of imperative "must" and the suggestive again begs the question, is this

document an outline of recommendations and best practice suggestions, or is it trying to establish mandatory requirements.

This chapter further suggest use of online file systems “whenever possible” (p. 30) and other things, without providing any resources for selecting or suggestions of known and acceptable form. More discussion concerning what should be in such forms would be helpful.

Further, some members have suggested that, while the document states “QA Professionals should not serve as direct supervisors for service coordinators,” the ultimate decision should be left to the owner’s discretion as long as the funds are not use to augment a salary. The rational given is that oversite of the program and monitoring of supportive services to the Service Coordinator should fall under the person ensuring Service Coordinators are in compliance, for corrective action needs to be done to ensure program requirements are met. The function of the QA Professional lends itself to bring corrective action, ensure the program is follow, and protect the company whom supplies the Service Coordinator position to prevent from losing their funding for non-compliance.

QA Section Edits and Concepts, Miscellaneous

Chapter 7, Section C, Paragraph 2, Line 2 (p. 29) – replace word “provide” with “seek to ensure residents obtain” as service coordinators are not tasked with “providing” service to residents (this is also in keeping with language in the paragraph that follows.as directly

Chapter 7, Section C, Paragraph 4, Line 1 (p.30) – remove errant “to” between “service coordinators” and “use”.

Various sections in this chapter are frankly redundant and somewhat inconsistent, recommending or mandating various frequencies and use of regular, onboarding and/or remedial training.

HIPAA references are not consistent in their spelling (sometimes HIPPA, sometimes HIPA), yet nowhere is HIPAA authority truly summarized or clarified. We suggest the provision here of more detail on what HIPAA is and how/when it applies to collection, review and sharing of personal medical information, and what kinds of releases are appropriate to enable the Service Coordinator to work in this arena.

In Closing

Again, we commend HUD on this document but urge greater clarification of which portions are recommendations only, and which are mandates. Sample forms or more detail on what should comprise documents frequently referenced in this guide would also be helpful, to include the consent to release, and consent to obtain information, HIPAA release forms, and sample case management planning forms.

Should you have any questions about our comments, please contact Colleen Bloom at (202) 508-9483.