Integration and Intermediation: Case Management in SSN Programs and Social Services
Why do we need intermediation and integration and of services?
Countries have a variety of programs and services

- Different scope (large vs. small coverage, national vs. specific territories)
- Very specific target population
- New priority (problem), usually is faced with a new program
- Different providers for the same clients (institutions and government levels).
- Each one with their own entry, exit (when exists) and delivery rules.
- Sometimes programs are competing for the same clients – complementarities???
- Social programs in “non-social sectors”.
- It is likely that different programs serve individuals from the same family, but it is not known.
- Probably every vulnerable family has the support of something, but none has support for everything they need.
... and clients must navigate through this diversity

• Without enough information.
• Limited abilities to navigate in the services network.
• Costly navigation (money, time, energy).
• Frequent users (“flyers”) = those with more abilities, better information networks, more and better connections = usually NOT THE MOST NEEDED.
Lower quality services for poor clients

- Bad infrastructure (offices, computers, environment, waiting rooms, client bathrooms, etc.)
- Few resources (staff, budget, vehicles, etc.)
- Poor salaries
- Low status within the government
- Crowded front desk
- Complex and frustrated clients (difficult to handle)
- Stressed staff, without self-care strategies
- Fieldwork is “suspicious”
- Quantity versus quality
Progressive options for integrated service provision

A mediator assesses the specific situation of the client and provides information and intermediation through referrals to adequate benefits and services (case management).
What is Case Management
Case Management within the Delivery Chain

1. Assess Potential Demand
2. Intake & Registration
3. Assess Needs & Conditions
4. Eligibility & Enrollment
5. Determine Benefits & Service Package
6. Notification & Onboarding
7. Benefits and/or Services
8. Monitor & Manage
9. Recurring Cycle

Periodic Re-Assessment

What is Case Management

A comprehensive approach to addressing the complex challenges faced by households, which usually cannot be addressed through a single program or intervention

It seeks to make service delivery...

- Client-centered (flexible, inclusive)
- Outcome-oriented (accountable)
- Integrated (comprehensive)
- More cost-effective
- Sequenced
- Sustained
How is Case Management used?

As a **complementary intervention** to a main one, focused on a **selected group** of beneficiaries.

- Families not complying with co-responsibilities of a CCT (Peru, Panama, Brazil), Families in a graduation process from a CCT program (Jamaica).

As a **program in and of itself**, providing family support and social intermediation services (integrated package).

- Outreach Program (Jordan), Unidos (Colombia), Puente al Desarrollo (Costa Rica), Reddito di Cittadinanza (Italy). *All examples related to extreme poor families.*

As a **component** of a broader intervention

- Familias en Seguridades y Oportunidades (Chile), Programa PAIF (Brasil)
Case management requires a mediator/social worker

- Motivations
- Interests
- Abilities
- Strategies

- to face problems
- Key needs, challenges
- Priorities

- Requirements
- Timing
- Specific services delivered
- Location
- Availability
- Contact
Different objectives require different levels of intensity for mediation

<table>
<thead>
<tr>
<th>OBJECTIVE/EXPECTED RESULT</th>
<th>INFORMATION &amp; DISSEMINATION</th>
<th>REFERRAL TO SERVICES</th>
<th>SUPPLY MANAGEMENT</th>
<th>PSYCHOSOCIAL SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients have the needed information and use it properly</td>
<td>Clients have access and use services.</td>
<td>Social services are available and relevant to clients' profile.</td>
<td>Strengthened skills and behavior to cope successfully with problems</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COVERAGE</th>
<th>UNIVERSAL</th>
<th>UNIVERSAL AND/OR SELECTIVE (TARGETED)</th>
<th>SELECTIVE (TARGETED)</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTENSITY</td>
<td>LOW</td>
<td>MEDIUM</td>
<td>MEDIUM/HIGH</td>
</tr>
</tbody>
</table>

| MEDIATOR PROFILE (minimum) | COMMUNITY MONITOR/PROMOTOR WITH COMMUNICATION SKILLS | COMMUNITY MONITOR/PROMOTOR WITH RELATIONSHIP SKILLS AND FIELD WORK EXPERIENCE | TECHNICAL, PROFESSIONAL WITH RELATIONSHIP SKILLS, FIELD WORK EXPERIENCE AND NETWORK MANAGEMENT | SOCIAL WORKER (TECHNICAL, PROFESSIONAL) WITH TRAINING AND/OR EXPERIENCE IN CASE INTERVENTION |
Same social worker with different roles

- Information and dissemination
  - Program rules
  - Services offered
  - Educational community workshops

- Special follow up to non-compliers
  - Home visits
  - Follow up plan

- Referral of complex cases to specialized intervention
  - Referral protocols
  - Specialized network activation

Red de Oportunidades – Panama CCT
Juntos - Peru

**Categories:**
- **UNIVERSAL - GROUP**
- **SELECTIVE - INDIVIDUAL**
- **SPECIALIZED INTERVENTION – INDIVIDUAL** (out of the program)
Or, different social workers depending on case complexity

<table>
<thead>
<tr>
<th>Types of Social Work Interventions for MLSS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1: Basic Information and Referral</strong></td>
</tr>
<tr>
<td>Orientation, provide comprehensive information, enrollment in PATH Program, Referrals</td>
</tr>
<tr>
<td><strong>Level 2: Short Term Intervention (6 months)</strong></td>
</tr>
<tr>
<td>Application of TCP Approach combined with methodology of Bridge Program; monitor referrals; frequent follow-up</td>
</tr>
<tr>
<td><strong>Level 3: Long Term Intervention</strong></td>
</tr>
<tr>
<td>Application of TCP Approach; work closely with client over long term to ensure link with other MLSS programs (StW)/institutions (MOUs); participation in clinical team (with other ministries) and learning circle to ensure efficacy of intervention. Follow-up</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Intervention</th>
<th>Knowledge and Skills required to Intervene</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSA 1</td>
<td>Basic social worker training (para-professional)</td>
</tr>
<tr>
<td>SSA 2/PS1</td>
<td>Front desk management skills</td>
</tr>
<tr>
<td>PS1/PS2</td>
<td>Knowledge of referral programs and their eligibility requirements within the MLSS and other relevant ministries</td>
</tr>
<tr>
<td></td>
<td>Interpersonal skills</td>
</tr>
<tr>
<td></td>
<td>Interview skills</td>
</tr>
<tr>
<td></td>
<td>Basic IT knowledge</td>
</tr>
<tr>
<td></td>
<td>Trained in the development of Individual Development Plans (IDPs)</td>
</tr>
<tr>
<td></td>
<td>Problem analyzer and solver</td>
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<tr>
<td></td>
<td>Knowledge on crisis intervention</td>
</tr>
<tr>
<td></td>
<td>Ability to investigate and observe situations among clients</td>
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<tr>
<td></td>
<td>Basic family counseling knowledge and skills</td>
</tr>
<tr>
<td></td>
<td>Networking</td>
</tr>
<tr>
<td></td>
<td>BSc in Social Work Knowledge and experience with case management</td>
</tr>
<tr>
<td></td>
<td>Basic knowledge of clinical psychology/mental health issues</td>
</tr>
<tr>
<td></td>
<td>Recognition and observation of social dysfunctions, maladjustment</td>
</tr>
<tr>
<td></td>
<td>Family counseling knowledge and skills</td>
</tr>
<tr>
<td></td>
<td>Case recording and record keeping</td>
</tr>
<tr>
<td></td>
<td>Evaluation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Profile of Person to work with Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSA 1</td>
</tr>
<tr>
<td>SSA 2/PS1</td>
</tr>
<tr>
<td>PS1/PS2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal and External</td>
</tr>
<tr>
<td>Internal and External</td>
</tr>
<tr>
<td>Internal and External</td>
</tr>
</tbody>
</table>
Main Processes of Case Management: the two sides of the coin

- Planning
- Implementation
- Linkages with Service providers
- Monitoring the delivery and use of services
- Needs assessment
- Identification and prioritization of needs
- Family Plan
- Evaluation and closing
- Management of the Family Plan
- INVITATION
- Needs assessment
- Planning

PROGRAM
Case management requires a “Toolkit”

For Information & Orientation
- Opportunities Map
  (catalog of programs/benefits/services available at Parish level – internal (MLSS) + external (public, private, NGO’s, others))
- Application Forms

For the Interventions
- Social screening (manual & forms)
- Social Assessment/investigation (manual & forms)
- Home visits (manual – guidelines)
- Individual/Family Development Plan /Treatment plan (guidelines & forms)
- Protocols (by case type – including inter-agencies treatment sessions)
- Referral Manual – MOU’s

Supporting the Practice
- Practice Analysis Circles (methodology & tools)
- Self-care techniques

Prepared with/for MLSS of Jamaica
Key features of successful Case Management
Key features for a successful case management intervention

- Clear expected results and methodology
- Linkage function
- Referral mechanisms
- Staffing and caseload
- Information system
1. Clear expected results and methodology

- Results-oriented (for both clients and staff)
- Clear framework for working with clients (from initial screening to completion)
- Tailored to client’s needs and local context
- Client goals are achievable and not burdensome
- Complementary to existing programs and services
- Specific timeframe

MAIN CHALLENGE
To decide on the strategy: target group – expected results – methodology – tools
2. Linkage function

➢ Connecting clients to complementary programs and services, as part of an integrated service provision to beneficiaries.

➢ Well-established inventory of programs.

➢ Appropriate information on program capacity and enrolment conditions.

➢ Deep knowledge of clients needs.

➢ Well-developed relationship with service providers

MAIN CHALLENGES
To have a detailed and updated knowledge of available programs and services – select and prioritize services related to the expected results – identify the packages of services – formal institutional arrangements with service providers.
TURKEY
3. Referral mechanisms

➢ Well-established protocols for referring clients to complementary programs and services.
➢ Referral and counter-referral.
➢ Agreements on granted preferential access for case management clients.
➢ Timely and clear reporting, monitoring and evaluation of effectiveness of referral processes.

MAIN CHALLENGES
To have formal agreements with service providers – budget mechanisms to finance provision of services – clear and specific agreements on preferential access for referred clients – a common dashboard for monitoring results.
Types of agreements/budget arrangements

➢ *Flagged* resources in sectoral-institutional budgets – identified to finance services to case management clients – existing resources. Example: Colombia

➢ *Locked* resources in sectoral-institutional budgets – reserved to finance services to case management clients – existing resources. Example: Dominican Republic

➢ *Conditional transfers* to institutions – based on an agreement defining the type of service, unit cost, coverage, access mechanisms, accountability processes – existing and new resources. Example: Chile

➢ *New budget program/line* – allocated in one institution which manages and controls all resources – existing and new resources.

**MAIN CHALLENGE**
Optimal functioning of a coordination body – definition of members and functions is key – accountability mechanisms.
JORDAN
1. Household Information
2. Inputs into Tablet
3. Transmits Household Info
4. Transmits Client Service Referrals
5. Transmits Referrals
6. Provides Referral

CMS
- Database
- Survey Questionnaire
- Algorithms (eligibility)
- Referral decision
- Referral follow-up monitoring

MOSD service mapping, including in-depth assessment of 3-4 services

In-depth assessment of 2 third party services
- Assessment of MOSD social workers’ capacity, geographic distribution
- Assessment of current MIS and technology infrastructure in MOSD

Key steps required
- Translate the eligibility rules for the referral services into algorithms
- Test the CMIS internally and in the field with trained MOSD social workers (using designated tablets) and fix any errors

Develop one master survey questionnaire for the five (5) referral services
Some key challenges to the model:

- Disconnect between the questions asked for needs identification and the actual current or foreseeable needs of households;
  - Questionnaire was built around algorithms of the eligibility determination of several more wide-spread programs,
  - Did not take into account households’ preferences in terms of type of assistance
  - Did not account for any limiting factors that may preclude household from accepting assistance or previous attempts
- Outreach workers considered calls effective means of ensuring that beneficiaries contact service providers (86%) and ensuring that the beneficiaries actually receive support from service providers (81%).
- 39% of Ows believed that households may need additional support in connection with referrals.
- Beneficiary FGDs indicate that follow-up was sometimes irregular and initiated by beneficiaries rather than outreach workers.
- It is not also not clear how well the training of outreach workers prepared them to help households navigated the application requirements of different service providers.
- The 11 service providers were identified with supply of services but actual follow up on registration was not part of the business cycle
- Administrative data shows that of 12264 who were given referrals, only 7% (801) households were serviced by service providers.

And options for Improvement of CMS and CMIS

For the referral approach to leverage existing service providers more effectively, there need to be:
- Improved social provider mapping and expansion of the list of providers, which should be continuously updated, hopefully including well-established NGOs in addition to government entities
- Expanding the list of services to include psycho-social support capacity of social providers and instituting incentive structure in terms of additional case load they can handle, analysis of causes of capacity constraints
- Coordination and financing mechanisms that would allow increasing the capacity of service providers to service referred individuals
- Engagements with social service providers to improve their business processes
4. Staffing and caseload

➢ Well-trained (in-job training) and certified staff.
➢ Staff with strong interpersonal and communication skills.
➢ Caseloads are not burdensome.
➢ Appropriate supervision mechanism in place.
➢ Self-care strategy

**MAIN CHALLENGE**
To optimize current human resources – adjustments in actual functions – identify gaps in skills and training – new staffing as complement.
• Description:
  • Major recruitment drive to increase the number of 50 additional social workers to support the roll-out of a Graduation Strategy for the PATH CCT
  • Current staff complement of 127 social workers to work with the 130,000 PATH beneficiary households
  • Different profiles of social workers in a tiered framework with progressive responsibility:
    • SSA Social Worker 1: Basic social work training - front desk management; home visits and applications
    • SSA Social Worker 2: Advanced social work training - monitor referrals, routine client interface and follow-up; compliance monitoring and investigation; shelter management for disasters
    • PS Social Worker (1 and 2): At minimum an undergraduate degree in social work – development and monitoring of individual development plans and treatment plans; conducts social investigations and assessments; case management to at-risk families; identifies referrals
  • Standardized procedures in place:
    • Case management manual which includes ethical standards, roles and responsibilities, workflow, techniques and resources for assessments, interviews, counseling etc.
    • Case management handbook for easy reference in the field
  • Partnership with the University of the West Indies to support training and accreditation of social workers

• Challenges:
  • Social worker to beneficiary ratio: 1 per 1,000 – well above the ratio of 1 per 100 per international standards
  • Social worker assessment and case management now applied to all new PATH beneficiaries – increasing burden on already strained social work staff
  • Referral mechanisms and staff complement in other agencies not always adequate to support good information exchange and monitoring
5. Information system

➢ Well-designed MIS in place to support all processes
➢ Clear distribution of roles among users
➢ Trained staff to manage the system
➢ Sufficient resources to finance its regular maintenance and troubleshooting
➢ Interoperability among related information systems

MAIN CHALLENGES
Definition of differentiated roles and access privileges (data collection, data entry, data quality control, data cross-checking, reporting function, accountability procedures, regular data audit). Effective use of information for decision-making.
GePI is the application designed and developed to simplify the work of social workers in assisting beneficiary families of the social inclusion pillar of the Citizenship Income program (*Reddito di Cittadinanza*) in Italy.

<table>
<thead>
<tr>
<th>It Covers</th>
<th>It does not cover</th>
<th>Work in progress</th>
</tr>
</thead>
</table>
| • Case management  
• Monitoring  | • Application process | • Referrals with employment and specialized services |

**Main functionalities:**

- **For Social Workers**:
  - Simplifies their work at the municipality

- **For Municipalities**:
  - Facilitates assignment of cases to social workers

- **For the Ministry**:
  - Allows for monitoring of the RdC social pillar (dashboards)
thank you!
Questions for reflection

• What is the key objective/expected results for clients/users?
• What is their profile (needs) and what are available services?
• What are the contact/entry points at the local level? What is local level capacity like?
• What is the ideal way to organize the intervention (home vs. center-based, combination)
• What are the institutional arrangements between national/local level?
• Coordination! 😊
EXAMPLES
Jamaica – Case Management Process

- PATH Payment
- Case Managed
- Referred for Intervention e.g. Step to Work, Rehab/Comp, etc.

Walk-In Clients & Referral from External Agency

Completes PATH Application Form (REM)

- Provisionally Approved
- Verification (SSA1)
- Borderline

- Automatic Appeal

- Not Selected

- Other Appeals

- Accepted

- Sign PATH Agreement

- Registered PATH Family

- Application of CM Tools (PS1)

- Committee

- Not Selected

- Accepted for PATH

- Sign PATH Agreement

- Application of CM Tools (PS1)
Expected Results
###都需要评估/筛查

<table>
<thead>
<tr>
<th>Nombre</th>
<th>APELLIDOS</th>
<th>Edad</th>
<th>Parentesco</th>
<th>Tipo de documento</th>
<th>No. Documento</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ana</td>
<td>Asaeda</td>
<td>45</td>
<td>Hija</td>
<td>Cédula</td>
<td>77777777</td>
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<tr>
<td>Martha</td>
<td>Navarrete</td>
<td>40</td>
<td>Cónyuge</td>
<td>Cédula</td>
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<tr>
<td>Aura</td>
<td>Acosta</td>
<td>32</td>
<td>Hijo</td>
<td>Tarjeta de Ident</td>
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### RESULTADO CARACTERIZACIÓN

<table>
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<tr>
<th>METODOLOGÍA</th>
<th>RESULTADO</th>
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</thead>
<tbody>
<tr>
<td>POBREZA MULTIDIMENSIONAL - PIM</td>
<td>POBREZA HUMANA</td>
</tr>
</tbody>
</table>

### RESUMEN DE LOGROS

<table>
<thead>
<tr>
<th>Logros que aplican al hogar</th>
<th>Logros alcanzados</th>
<th>Logros por elance</th>
<th>Logros que no aplican al hogar</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>12</td>
<td>6</td>
<td>8</td>
</tr>
</tbody>
</table>

### TIPO LOGRO

<table>
<thead>
<tr>
<th>TIPO</th>
<th>LOGRO</th>
<th>ESTADO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Todos los integrantes del hogar tienen su documento de identidad.</td>
<td>Alcanzado</td>
</tr>
<tr>
<td>2.</td>
<td>Todos los integrantes del hogar están afiliados al Sistema General</td>
<td>Alcanzado</td>
</tr>
<tr>
<td></td>
<td>de Seguridad Social en Salud (SGSSS).</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Los niños y niñas del hogar menores de seis (6) años ben el</td>
<td>No aplica</td>
</tr>
<tr>
<td></td>
<td>esquema complejo de vacunación para la edad.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Los niños y niñas mayores de seis (6) meses y menores de cinco</td>
<td>No aplica</td>
</tr>
<tr>
<td></td>
<td>(5) años no presentan tampoco posicio por desnutricion aguda.</td>
<td></td>
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</table>
Referral system
Monitoring system
### Monitoreo del Sistema

**Informe de Identificación de Necesidades para la Población en Situación de Pobreza**

<table>
<thead>
<tr>
<th>Departamento</th>
<th>COLOMBIA</th>
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<table>
<thead>
<tr>
<th>Medición</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Número de hogares evaluados</td>
<td>116758</td>
</tr>
<tr>
<td>Número de hogares acompañados</td>
<td>32256</td>
</tr>
</tbody>
</table>

#### Estado de Logros

<table>
<thead>
<tr>
<th>Dimensión</th>
<th>Unidad de evaluación</th>
<th>Logros</th>
<th>Logros en el momento</th>
<th>Logros alcanzados</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identidad</td>
<td>Hombre</td>
<td>23928</td>
<td>93.47%</td>
<td>33203</td>
</tr>
<tr>
<td></td>
<td>Mujer</td>
<td>24120</td>
<td>97.34%</td>
<td>34302</td>
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<tr>
<td></td>
<td>Sexual</td>
<td>24308</td>
<td>97.86%</td>
<td>34590</td>
</tr>
<tr>
<td></td>
<td>Salud</td>
<td>24508</td>
<td>98.05%</td>
<td>34802</td>
</tr>
<tr>
<td></td>
<td>Educación</td>
<td>24708</td>
<td>98.26%</td>
<td>35002</td>
</tr>
<tr>
<td></td>
<td>Desarrollo</td>
<td>24908</td>
<td>98.47%</td>
<td>35202</td>
</tr>
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<table>
<thead>
<tr>
<th>Crecimiento</th>
<th>Hogares en el momento</th>
<th>Hogares alcanzados</th>
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<tbody>
<tr>
<td>1.</td>
<td>20210</td>
<td>24.01%</td>
</tr>
<tr>
<td>2.</td>
<td>20410</td>
<td>24.02%</td>
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<tr>
<td>3.</td>
<td>20610</td>
<td>24.03%</td>
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<td>4.</td>
<td>20810</td>
<td>24.04%</td>
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<table>
<thead>
<tr>
<th>Uso</th>
<th>Hogares</th>
<th>Hogares alcanzados</th>
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<tbody>
<tr>
<td>5.</td>
<td>21010</td>
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<tr>
<th>Participación</th>
<th>Hogares en el momento</th>
<th>Hogares alcanzados</th>
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<tr>
<td>6.</td>
<td>21210</td>
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<table>
<thead>
<tr>
<th>Logros en el momento</th>
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<tr>
<td>7.</td>
<td>21410</td>
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<table>
<thead>
<tr>
<th>Soporte</th>
<th>Hogares en el momento</th>
<th>Hogares alcanzados</th>
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<tbody>
<tr>
<td>8.</td>
<td>21610</td>
<td>24.08%</td>
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<table>
<thead>
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<th>Logros en el momento</th>
<th>Logros alcanzados</th>
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<tbody>
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<td>9.</td>
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