CROSS-JURISDICTIONAL RESOURCE NAVIGATION RESOURCES

OCTOBER 2020

These materials were prepared as part of the Rapid Response Network, a joint initiative between the **California Mental Health Services Oversight and Accountability Commission** (MHSOAC) and **Social Finance, Inc.** to support jurisdictions in fast-paced research and decision making driven by COVID-19.

The network aims to **facilitate connections** among jurisdictions facing similar challenges, and to supplement that shared experience with **support from external experts**—in order to deliver fast, customized, digestible research and analysis that strengthens local capacity.

We recognize that the pace of these responses means that they are likely to be both incomplete and imperfect. If you have suggestions for improvement or questions about these materials, we would love to hear from you. Please email Jake Segal (jsegal@socialfinance.org) or Nic Miragliuolo (nmiragliuolo@socialfinance.org).

With gratitude for the support of the Robert Wood Johnson Foundation and invaluable in-kind support from GLG, which supports the RRN through access to their expert network.

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EXECUTIVE SUMMARY

Selected takeaways from research into resource navigation and cross-jurisdictional resource sharing

What is the problem?

- Low-income and vulnerable families that move to a new county lose access to crucial social services, community resources, and employment opportunities.
- Local social service agencies do not have the systems to ensure that families who move across jurisdictional boundaries have continued access to the resources they need

What is the goal?

- Ensure all families within the region have continuity of services after moving to a new county, thereby improving life outcomes

What are some potential solutions?

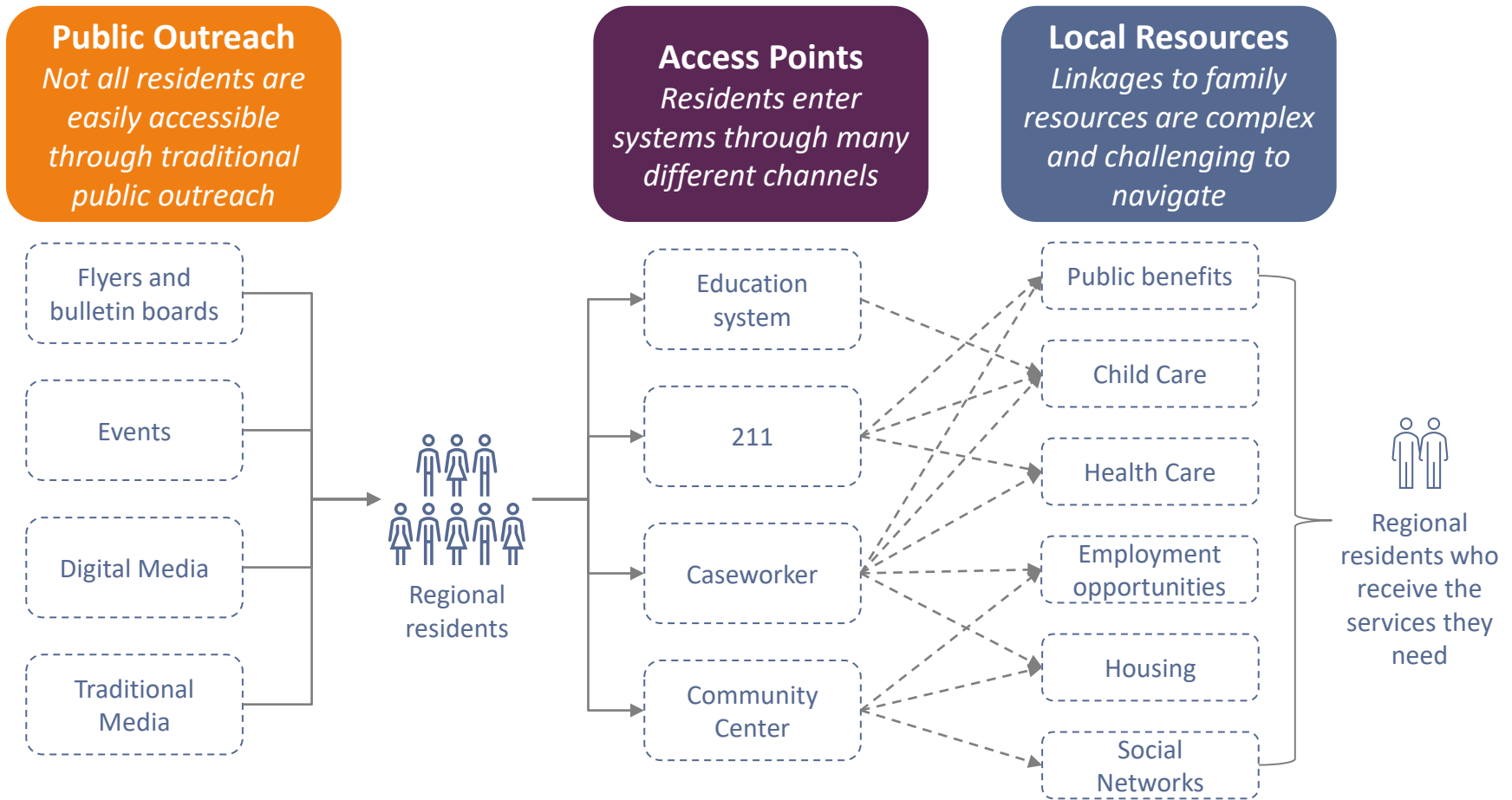| *Stronger and human-centered outreach* | - Outreach programs need be designed based on how families like to receive information including **culturally & linguistically appropriate messaging**, **multi-channel outreach**, and **strengths-based messaging.** |
No Wrong Door Initiatives	- NWD streamlines access to multiple organizations and services through **coordinated outreach, person-centered counseling**, and **streamlined program eligibility & access**
Cross-county resource navigators	- Navigators increase access to resources by **acting as a bridge** between community members and service providers - The most effective navigation programs are **designed based on community input** and must **have strong training and supports** for navigators
Cross-jurisdictional collaboration	- These collaborations can range from **informal agreements** to **highly formal agreement and even mergers.** - The scope of agreement, governance structure, and role and responsibilities **need to be defined upfront**

All footnotes herein refer to references listed within Slide 26, References
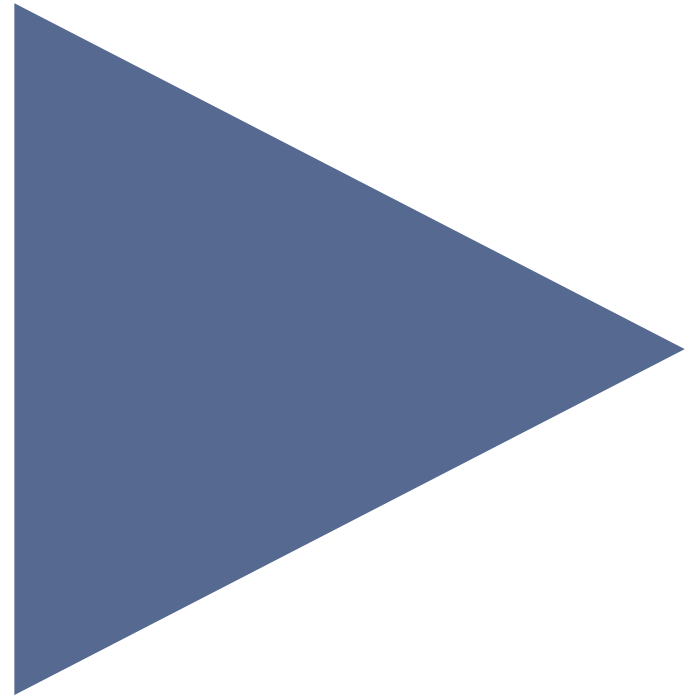
CURRENT SYSTEM FOR RESOURCE NAVIGATION

The current system is fragmented, confusing, and uncoordinated

Illustrative

Public Outreach
Not all residents are easily accessible through traditional public outreach

Access Points
Residents enter systems through many different channels

Local Resources
Linkages to family resources are complex and challenging to navigate

- Flyers and bulletin boards
- Events
- Digital Media
- Traditional Media

Regional residents

- Education system
- 211
- Caseworker
- Community Center

- Public benefits
- Child Care
- Health Care
- Employment opportunities
- Housing
- Social Networks

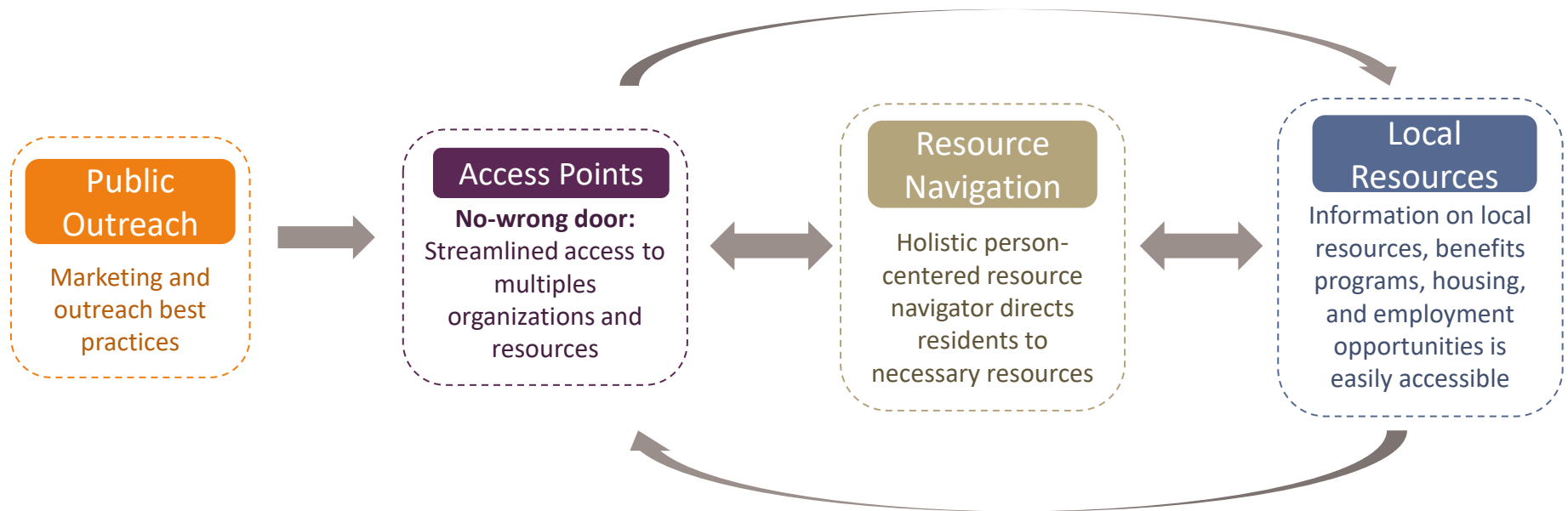Regional residents who receive the services they need

Families often fall through the cracks as they find it challenging to access resources they need in an uncoordinated system with multiple communication channels, access points, and programs

All footnotes herein refer to references listed within Slide 26, References

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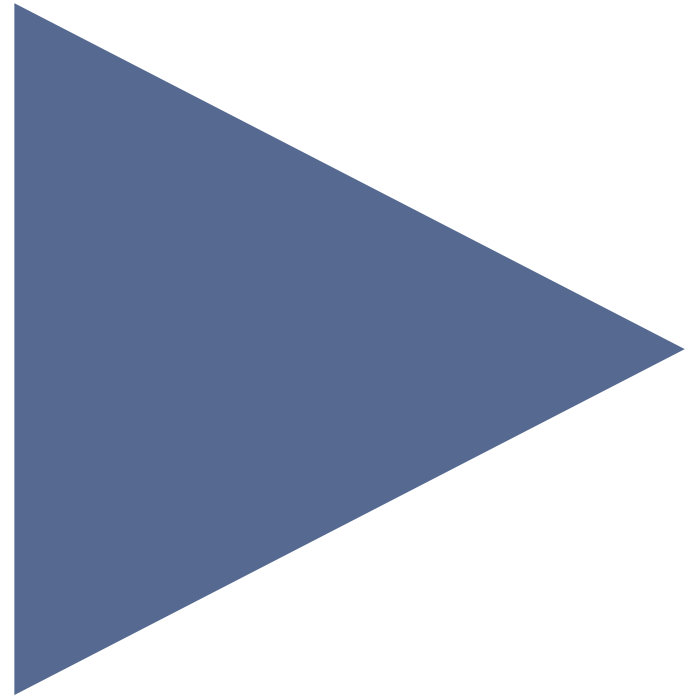
FRAMEWORK FOR IMPROVED RESOURCE NAVIGATION

Developing a cross-jurisdictional resource navigation program requires the following elements

A No-Wrong Door system combined with local resource navigators and cross-jurisdictional collaboration will ensure families have continued access to critical support services across all counties

Public Outreach

Marketing and outreach best practices

Access Points

No-wrong door: Streamlined access to multiples organizations and resources

Resource Navigation

Holistic person-centered resource navigator directs residents to necessary resources

Local Resources

Information on local resources, benefits programs, housing, and employment opportunities is easily accessible

Cross-Jurisdictional collaboration

Collaboration across jurisdictions is the foundation of an effective regional resource navigation program these collaboration can include data sharing, shared services, collective decision-making processes, and even shared staff
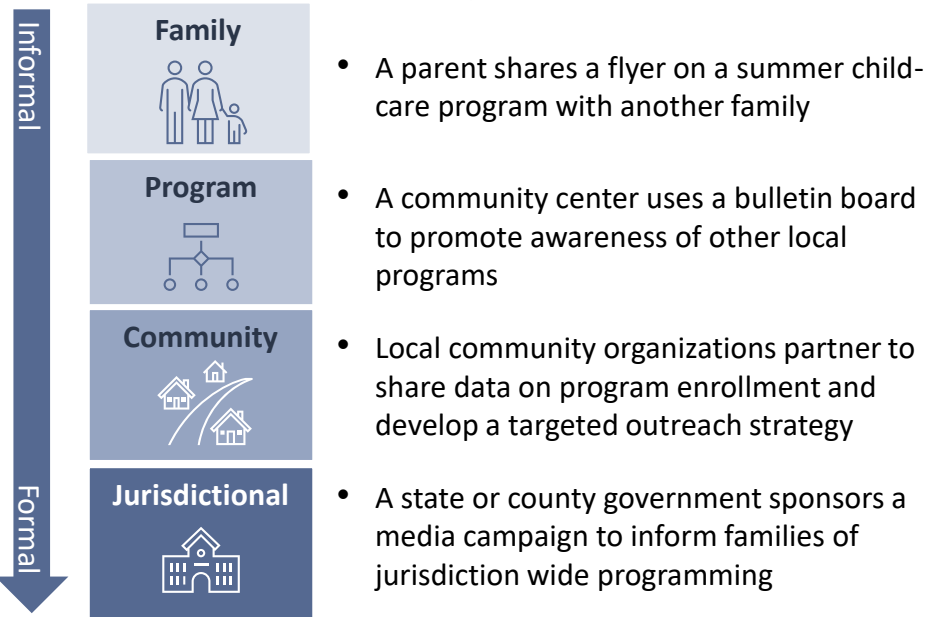
OUTREACH AND MARKETING FOR SOCIAL SERVICES

OUTREACH AND MARKETING FOR SOCIAL SERVICES[1]

Levels of Outreach

Informal → **Formal**

Family
- A parent shares a flyer on a summer child-care program with another family

Program
- A community center uses a bulletin board to promote awareness of other local programs

Community
- Local community organizations partner to share data on program enrollment and develop a targeted outreach strategy

Jurisdictional
- A state or county government sponsors a media campaign to inform families of jurisdiction wide programming

"Hard-to-Reach" families

"Families are not hard to reach. It may be that our services are hard to reach"

- Outreach programs need to shift from providing information to families to listening to families
- Families may not access services that they perceive do not meet their needs
- Families tend not to access services that are not promoted in culturally or linguistically appropriate ways

Challenges for families in accessing resources

Inadequate or Inconsistent Funding: Without enough dedicated resources outreach may not reach all potential clients

Complicated Processes: Application processes are complicated and challenging to understand for families leading to decreased enrollment

Staff competencies: Families find it challenging to access programs where staff are not well trained on listening, building relationships, or cultural competencies

Communication barriers: Materials that are not easily understood or not written in multiple languages will leave many of that hardest to reach families

Wrong channels: Marketing and outreach efforts may be located on the communication channels that match how families like to receive information

Waiting lists: Families may not even attempt to apply for or access services that have waiting lists or service delays

Perception: Families often do not know a service exists or that they are eligible for the service

STRATEGIES FOR OUTREACH AND MARKETING OF SOCIAL SERVICES[1]

Planning

- **Shared understanding:** Bring together program staff and community partners to develop a shared understanding on you approach to outreach
- **Allocate resources:** Identify existing and new funding sources for ongoing outreach. Funding organizations should include outreach as a requirement in grant applications
- **Consistency:** Inconsistent funding source hamstring outreach efforts, as outreach is an ongoing process not a one-time event

Data-informed design

- **Integrate data into communications plan:** Data should be used to identify audience segments (family types) and then communications strategies should be crafted to connect with those audiences. Data should also be connected on families that do not use services to identify communication and service gaps
- **Develop data partnerships:** Work with community partners to identify data sources, collect data, and share information
- **Evaluation and Continuous Improvement:** Communications plans should utilize ongoing evaluation procedures, outcomes targets, and continuous improvement practices

Channels

- **No-wrong door** *(see slides 12-14):* Outreach plans need to have family-friendly entry points that are both flexible to family needs while also providing access to comprehensive information
- **Multi-channel approach:**
  - Social media and websites should be used in tandem with social media as the entry-point and the website as the information source
  - For families with poor internet connectivity outreach through texting, print materials, and mass media is more effective
  - A physical presence at facilities where families congregate is also important
- **Leverage existing relationships:** Identify community leaders, cross-agency liaisons, or parent ambassadors to be outreach partners. Training may be needed to support parent ambassadors and agency staff

Messaging

- **Cultural perspectives:** Messaging need to match the cultural and language preferences of the target audience. Provide staff training on listening skills, relationship building, cultural inclusion, and language difference
- **Strengths-based messaging:** Messaging should be positive, and strengths based by highlighting that parents are effective decision makers, resourceful users of services, trusted sources of information, and community leaders
- **Use plain language:** Eighteen percent of Americans don't have the literacy and skills to search compare, contrast, and integrate information from text Messaging should follow federal plain language guidelines.

All footnotes herein refer to references listed within Slide 15, References

NO WRONG DOOR BEST PRACTICES
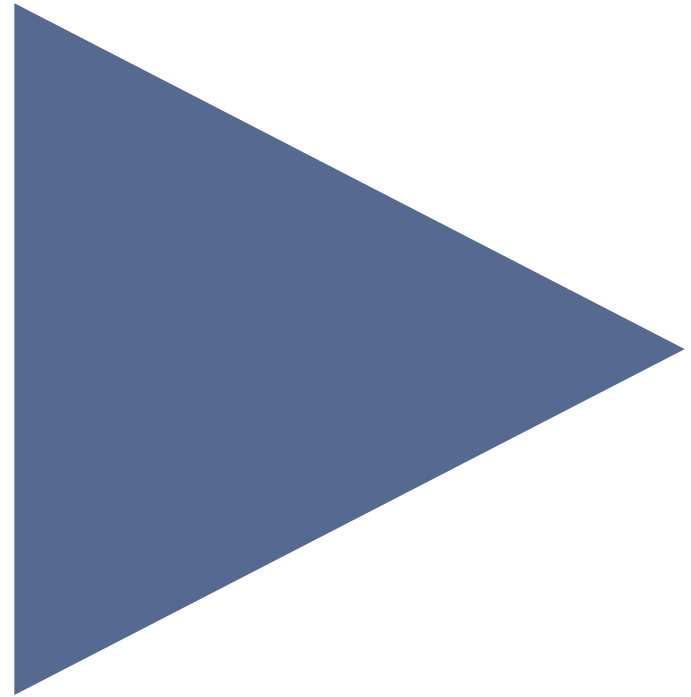
NO WRONG DOOR (NWD) SYSTEM: BEST PRACTICES[2]

> NWD is most frequently used to support individuals accessing long-term supports and services (LTSS)

Description & benefits

- Network built to support individuals **streamlining access to multiple organizations** regardless of which entry point an individual enters
- Formal participation from multiple agencies and organizations is necessary for effective operation
- **Improves consumer choice and control** and can help states create more efficient and cost-effective systems

Key elements of a NWD System

Public outreach

- Schools, community members, Local non-profits, LTSS providers, healthcare systems
- Local information and referral systems
- 1-800/211 numbers

Person-centered counseling

- Assists with immediate service needs, conducts interviews to confirm problem, key people, goals, strengths, and weakness of the individual/family in need
- Facilitates development and implementation of informed choice of options and a person-centered plan
- Helps transition from home to home, hospital to home, school to post-secondary life, etc.

Streamlined eligibility for programs

Aims to improve efficiency and effectiveness of eligibility processes across multiple public programs

- Leverages person-centered counselor to help individuals complete applications for LTSS programs
- Identifies ways to improve determination process and create a more seamless process for families

State governance & administration

- Must involve input across multiple state agencies – designate which agencies and organizations will formally play a role in managing and funding the system
- Input from external stakeholders, such as the community members, on the design, implementation and operation of the system

> More on this can be found from ACL's NWD System of Access to LTSS for all Populations and Payers

CASE STUDY: NO WRONG DOOR (NWD) SYSTEM

> ACL[i], CMS[ii], and the VHA[iii] formed a national NWD program to help **states streamline access** to long-term services and support (LTSS) via operational guidance and financial support

NWD System Grantee	**District of Columbia Health and Human Services agencies:** *received a grant from the ACL, CMS, and VHA to develop a plan to transform their current LTSS system into a NWD system for all populations and payers*
Partners	• District of Columbia Department of Disability Services • District of Columbia Office on Aging (DCOA) • Department of Behavioral Health (DBH) • Department of Health Care Finance (DHCF) • Mayor's Office of Veterans Affairs (MOVA)
Purpose	• Finalize and implement a 3-year plan to create a No Wrong Door LTSS system across government and NGOs organizations • Increase access to LTSS for seniors and those with disabilities
Programming	• Person-centered counseling (PCC) training across agencies hosted twice-monthly – facilitating cross-agency collaboration and learning • Provide one-on-one person and family-centered counseling to identify family-specific needs and relevant services • Improve cultural & linguistic competence by identifying policy, practices, and structural areas to prioritize • Commit to formal agreements for sustainable systems change
Outputs	• Developed an integrated application process to support referrals and eligibility determination – linked to the full range of LTSS across agencies and platforms • Created a user-friendly, multi-lingual, single resource portal with 1,600+ resources • Consistent cross-system person-centered and culturally-competent LTSS service approach
Challenges	• Ensuring sustainability of PCC training for agencies and current and new staff members • Effective and user-friendly tracking methods for interactions between staff and people seeking LTSS
Further Reading	• ACL report on No Wrong Door system • D.C. No Wrong Door Website • D.C. Support Link Resource Portal

Notes: (i) Administration for Community Living, (ii) Centers for Medicare & Medicaid (iii) Veterans Health Administration
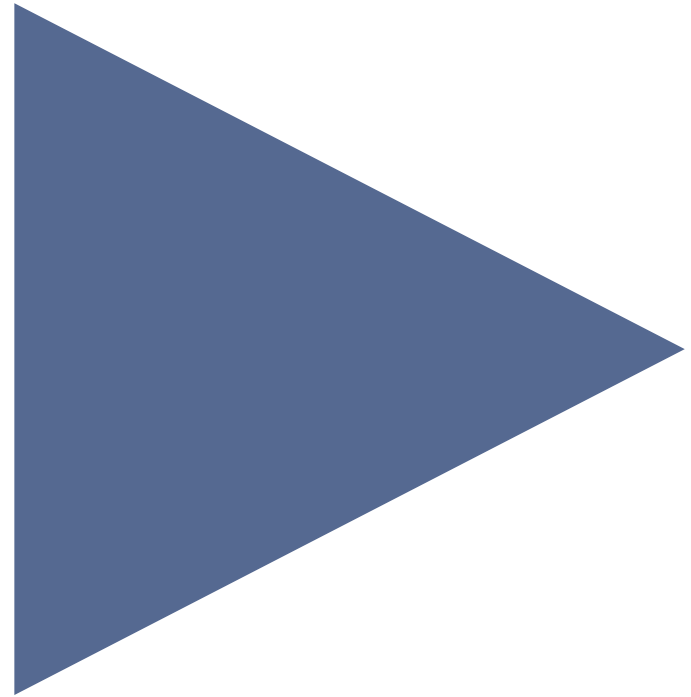All other footnotes herein refer to references listed within Slide 26, References

ENSURE THE NWD SYSTEM IS PERSON-CENTERED[3]

More on best practices here: AARP Public Policy Institute - NWD: Person- and Family-Centered Practices in LTSS

Area of practice	Action items
1. Leadership and management support	❑ Ensure managers and other key staff **buy-into the person and family-centered philosophy**, values, concepts, and practices of the NWD system to make services more consumer-driven. ❑ **Engage all parties** involved, including families and providers
2. Standards	❑ **Map the system to the statewide standards** that define person- and family centered practice
3. Basic Competencies	❑ **Train staff on basic competencies** needed to practice person and family-centered services, consistent with the Person-Centered Planning requirements in the CMS home- and community-based services settings rule.
4. Specialized Competencies	❑ **Implement the ACL National Person-Centered Counseling Curriculum** to ensure staff have the specialized skills required to: • facilitate hospital-to-home, and nursing or rehabilitation facility-to-home transitions; • transition individuals from nursing facilities back to the community; • help youth with disabilities to transition from secondary education to postsecondary life that involves options that can keep them integrated in the community; • facilitate the use of self-directed models.
5. Protocols for Developing Plans	❑ Establish protocols for the development of person and family-centered plans (e.g.
6. Variety of Organizations	❑ **Receive the buy-in from various organizations** identified by the states to practice in a person- and family-centered way to serve different populations with LTSS needs. ❑ **Develop routine collaboration and coordination processes** among all parties
7. Futures Planning and Private Pay	❑ **Create a process to facilitate access to private sector LTSS** for individuals who can pay for part of their costs and to help people plan for future LTSS needs –this can help prevent or delay costly institutional care
8. Follow-up	❑ Establish formal protocols for routine follow-up with individuals in LTSS

All footnotes herein refer to references listed within Slide 26, References

RESOURCE NAVIGATION BEST PRACTICES

PERSON-CENTERED RESOURCE NAVIGATION: BEST PRACTICES[4]

- Community resource navigators (CRNs) are individuals that act as a **bridge** between services providers and community members
- Aims to **improve access** to essential resources, thereby improving life outcomes
- **Advocates on behalf of communities**, so that services can better address the needs of the community

More on this here: [Training Handbook and Programmatic Guide for CRNs](#)

Key considerations for effective CRNs

CRN core competencies	*Implementing a CRN training program*
Deep knowledge of the local resource landscape: public, private, and non-profit services	**1** Identify methods of training (e.g. group sessions, online modules, "in the field" learning)
Advocacy skills: Knowledge on behalf of the community	**2** Develop contextualized training topics in response to community needs • Roles and Responsibilities for CRNs • Understanding the Health System • Supporting Families in the Education System • Accessing Social Benefits and Other Necessary Services • Finding Employment and Understanding Housing
Awareness of social justice: understanding of macro structures and the resulting power dynamics	**3** Determine duration and schedule of training cycle and evaluation process (e.g. quarterly)

Potential benefits of a cross-county navigator program include an improved understanding the needs of family moving cross-county, better continuation of services for families, and the ability to conduct warm transfers to zone specific CRNs

RESOURCE NAVIGATOR CASE STUDY: FAMILY SUCCESS ALLIANCE (FSA)[5]

- FSA is a place-based "collective impact" initiative in Orange County, NC aimed at improving children's life outcomes, especially focusing on the cradle-to-college-to-career pipeline
- Convenes 30+ community partners, local government agencies, non-profits, and other community leaders

Program Development Process

1 Prioritized six geographic zones through **a data- and community-driven process**, including creating a county-wide poverty index

2 After **intensive community engagement** (e.g. focus groups), all six zones applied to the FSA

3 **After developing the Advisory Council** (parents, government officials, non-profit leaders, funders), two zones were selected

4 **Conducted a gap analysis** to identify community priorities – quality childcare, school readiness, and meeting basic family needs

5 **Developed a strategic plan based on needs identified:**
1) Navigator Program
2) Summer Kindergarten Readiness Program and other summer & afterschool enrichment activities
3) Coordination & support for programming to align with family goals, provided by partner nonprofit agencies

## Navigator Program

Description:
- Peer leaders build strong relationships with families that are financially struggling
- **Navigators are part of the FSA community** – therefore, they are trusted by community members and have a deep understanding of the challenges faced by the families
- They aim to understand the family context, set goals and **connect the family with essential resources,** tools, and information

- *Goal:* For families to connect with resources to achieve goals and more effectively navigate the educational and other systems to their needs

- *Future plan:* Evolve into a more comprehensive family empowerment model to connect families together - to learn, build on strengths & knowledge, and work to better navigate systems

While FSA navigators do not function cross-county, individual counties can model their program after FSA's development process and navigator program

CROSS-JURISDICTIONAL COLLABORATION
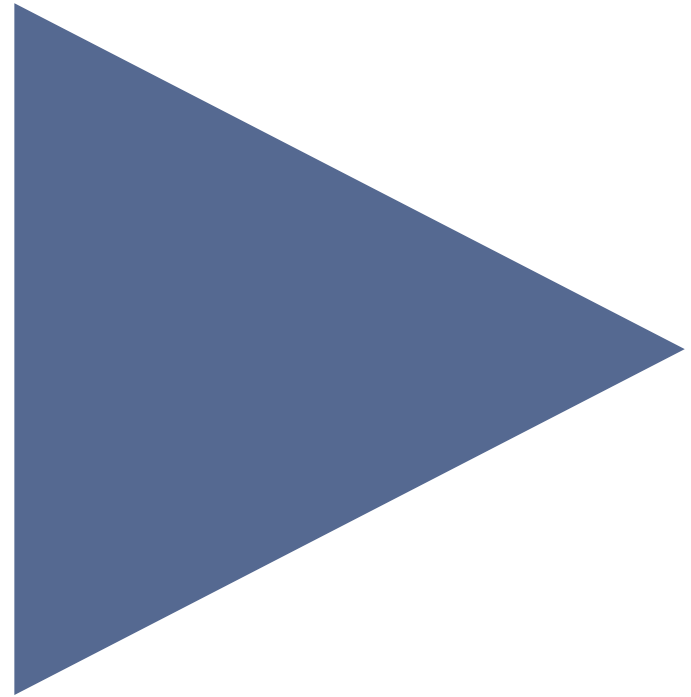
BEST PRACTICES: CROSS-JURISDICTIONAL COLLABORATION[6]

Themes

- **"Crisis creates opportunity":** Limitations caused by crises create more willingness to pursue collaborations
- **Delays squander opportunity:** Leadership turnover and recovery from crises can cause collaborations to lose momentum. Therefore, collaborative efforts should move quickly, need persistent effort, and must have systems for leadership transitions
- **Government barriers:** Resources limitations and lack of flexibility can make starting collaborations challenging

Best Practices

- **Power Sharing:** Define power-sharing and governance structure early. Successful collaborations have clear divisions of power. When jurisdictions vary in size it is still beneficial to move forward on a one entity one vote basis to encourage true collaborations
- **Structures Processes:** Follow a structured process to identify collaborative opportunities, and to determine what level of integration and resource sharing is needed
- **Stakeholder Engagement:** Involve the public during the exploration phase to ensure buy-in, and engage public officials to ensure ongoing coordination
- **Evaluation**: Establish benchmarks and metrics to track outcomes both to improve the collaboration and to show evidence of success to the public

Risks

- **Undefined roles and responsibilities:** Roles and responsibilities of participating entities must be defined upfront or the collaboration may be ineffective
- **A lack of buy-in from key partners:** The public and local jurisdictions may be afraid that cross-jurisdictional collaborations may take away power from the local community. It is imperative to make the case to the community of the benefits of collaboration and costs of not proceeding
- **Unfunded or underfunded initiatives:** Initiatives that haven't identified and secured stable funding streams will eventually run into resource challenges

PHASES OF CREATING CROSS-JURISDICTIONAL SHARING AGREEMENTS[7]

> More on this process can be found on the Comprehensive Assistance for Shared Services (COMPASS) website

1 **Explore**

- Set goals and expectations
- Define the scope of the agreement
- Identify partners and stakeholders
- Understanding the context and history

2 **Prepare and Plan**

- Governance
- Fiscal and service implications
- Logistical and workforce issues
- Legal sharing agreements & legal issues
- Communications
- Change & Performance Management
- Timeline

3 **Implement, Monitor, & Improve**

- Implementation and management
- Communication and change management
- Monitoring and improving

Goals and Expectations

Jurisdictions need to define upfront their goals and expectations. Key questions to answer include:

- What is the issue this collaboration trying to address?
- Can current internal resources address this issue?
- How will cross-jurisdictional collaboration address this issue?

Agreement Scope

The scope **should specify and define the services that will be shared,** and this scope will be used in phase 2 to develop the action plan.

- In defining the scope partners should use the spectrum of cross-jurisdictional collaborations found on the next slide

Partners & Stakeholders

It is crucial to identify key partners and stakeholders **early in the collaboration process**. Key factors that lead to strong partnerships include:

- Partners have a history of **working together**, a shared **regional identity**, or **overlapping missions**
- Partners are **bought in** to the goals of collaboration
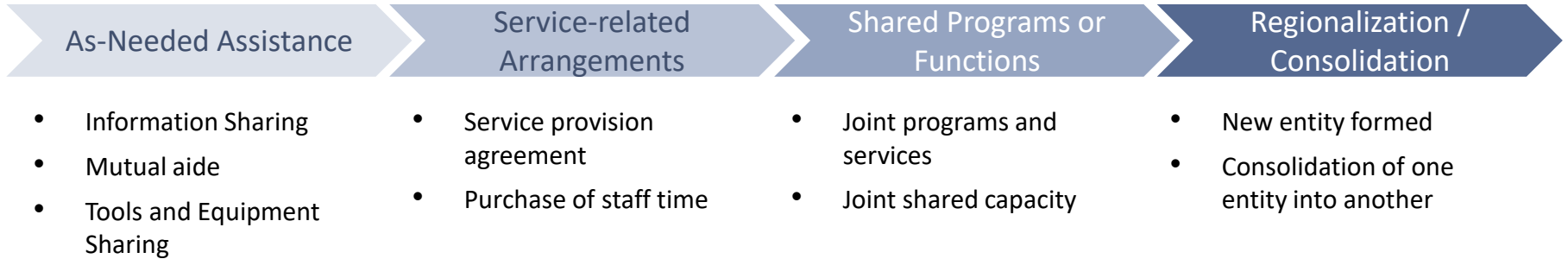
Context & History

Key contextual questions to ask when considering a CJS.

- Is this **an existing service**?
- **Why** are partners considering sharing this service?
- Are there **examples of other similar collaborative partnership**s (similar org types or services shared)?

ASSESSING NEED AND SCOPE OF COLLABORATION

Spectrum of cross-jurisdictional arrangements[7]

As-Needed Assistance	Service-related Arrangements	Shared Programs or Functions	Regionalization / Consolidation
• Information Sharing • Mutual aide • Tools and Equipment Sharing	• Service provision agreement • Purchase of staff time	• Joint programs and services • Joint shared capacity	• New entity formed • Consolidation of one entity into another

> As the level of **service integration increases** the **autonomy** of the **partners decreases**. The basic structures of the collaboration will be based upon where in the spectrum the cross-jurisdictional arrangement fits.

Public Service value chain[6]

Policy: The principles and directive put in place by and authorizing body to achieve specific outcomes or conditions *(ex. Mandatory fitness requirement for school aged children)*

Program: The service or initiative designed to accomplish to goals of the policy *(ex. Primary, middle, and high schools)*

Production: The resources (staff, systems, services) deployed in service to the program and policy goals *(ex. Fitness curriculum)*
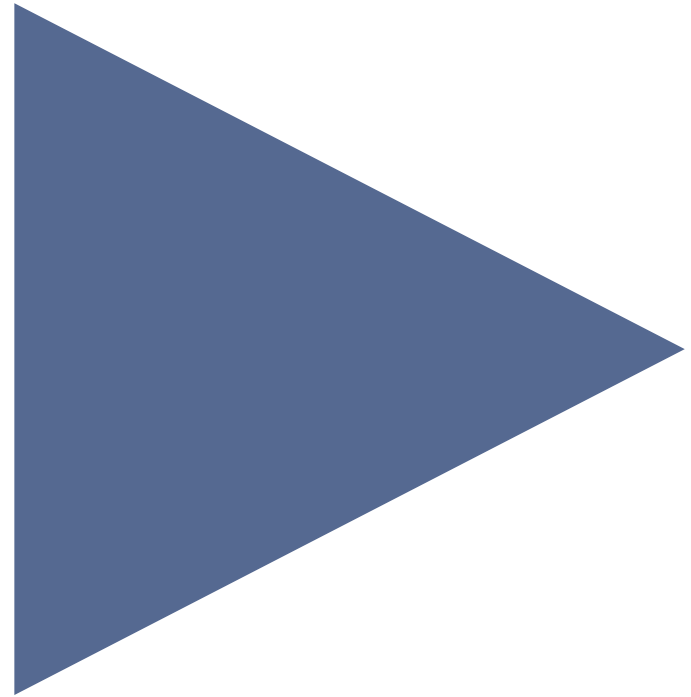
Provision: The services, product, or services delivered to a jurisdiction's constituents *(ex. Physical education teachers using the curriculum)*

*The design (governance, financial model, & operations) of a **cross-jurisdictional collaboration** should be based on where it falls on the **spectrum** (above) and the **value chain** (left).*

CASE STUDY: CROSS-JURISDICTIONAL COLLABORATION

	Kinship Navigation[8]	Camp Fire Recovery[9,10]
Partners	• Seven northeastern Ohio counties (Ashtabula, Clark, Crawford, Hardin, Lorain, Portage, & Richland Counties) • Public Children Services Association of Ohio (PCSAO) • Human Services Research Institute (HSRI)	• **Camp First Connect:** United Way of Northern California, Red Cross, & 211 • **Camp Fire Collaborative:** 50 nonprofit, for-profit, and public organizations
Purpose	• To develop **county-based kinship navigator programs** to assist caregivers in accessing support services for themselves and the children in their care	• **Connect:** Provides a trusted source of resources for survivors of the Camp Fire who had relocated outside of Butte County • **Collaborative:** To work with government agencies to identify and meet community needs during the recovery
Programming	• Community mapping to ID caregiver resources • **County navigator staff partnered with state child welfare system** to learn about resources available for kin caregivers, including information & referral services, case management, and support groups. • Navigation staff conducted **community outreach** and completed **needs assessments** with kin caregivers • Navigators attended quarterly in-person meetings that brought together navigators from all seven counties as well as PCSAO and HSRI	• **Camp Fire Connect:** Provides connections and links to available resource including mental health support, employment resources, links to the local and national 211 websites, and resources for accessing disaster case managers • **Collaborative:** Functions as a collaborative organization that brings together local leaders in all sectors to coordinate and address the needs of the community
Outcomes	• Over three years navigators served **945 families and 1,516 children** Navigators provided **400 group activities** including support groups, workshops, social events, and legal support • **85+% of caregivers** reported that the program was beneficial • As compared to children in foster care children with kin caregivers that has navigator support had **lower rates of "re-reports"**	• Population has declined from 26,000 to 2,000 • Survivors now live in more than 500 US cities • Recovery is still an ongoing effort with the success of long-term community rebuilding unclear at this time
Challenges	• **Variation in legal systems** across the seven counties including variation in fees, court philosophies, and overall processes • Continuing funding of the navigator position after the end of the grant • Failed to created effective linkages to 211 resources	• Combination of federal, state, local, and nonprofit disaster recovery efforts have made it challenging for survivors to understand where and how to access resources
Further Reading	• Project Report	• Camp Fire Connect Website • Camp Fire Collaborative

All footnotes herein refer to references listed within Slide 26, References

POTENTIAL NEXT STEPS

1 Begin with "explore" phase (*slide*) by **identifying partners**, setting **shared goals**, and then **defining the scope of collaboration**

2 Bring together partners to **map current set of resources and practices** to identify services gaps and overlaps

3 **Conduct listening sessions with local families** to identify family needs, channels for outreach, and opportunities for increased engagement. Existing needs assessments conducted by community partners can also support this work.

4 To simplify coordination and collaboration across the region, **establish shared practices and develop shared information sources** (ex. resources guides & directories) for resource navigators across all ten counties.

5 **A point person or "navigator of navigators"** should be identified to act as key individual to coordinate and share best practices across the region

6 **Convene resource navigators and other key stakeholders across the region** on a quarterly basis to share best practices, evaluate the efficacy of the resource navigation program, and identify area for continuous improvement

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Goals

Short-Term: To **maximize the impact on families** in the region through **low-cost strategies** that leverage current organizational and community resources

Long-Term: To build collaboration and shared best practices across the region that will **lay the foundation for future more formalized collaboration**

All footnotes herein refer to references listed within Slide 26, References

FURTHER READING: RESOURCE NAVIGATION AND CROSS-JURISDICTIONAL COLLABORATION

Type	Resource Link
Training Module	Comprehensive Assistance for Shared Services (COMPASS)
Training Module	Training Handbook and Programmatic Guide for Community Resource Navigators
Research: Low-income family mobility	The Atlantic, The Barriers Stopping Poor People From Moving to Better Jobs
Research: Low-income family mobility	HUD, Mobility Decisions of Very Low-Income Households
Research: Person-Center Design	Harvard Business Review, Why Design Thinking Works

▶ RESOURCES

Below resources are referenced in preceding slides by footnotes

#	SOURCE	LINK
1	National Center On Parent, Family and Community Engagement	Family Outreach Series Strategies for Outreach to All Families: Overview
2	Administration for Community Living (ACL)	NWD System of Access to LTSS for all Populations and Payers
3	AARP Public Policy Institute	No Wrong Door: Person- and Family-Centered Practices in LTSS
4	Advance Access & Delivery	Training Handbook and Programmatic Guide for Community Resource Navigators
5	Family Success Alliance	(a) Family Success Alliance website, (b) Strategic Plan
6	Accenture	Cross-Jurisdiction Collaboration New Models for State, Regional and Local Governments
7	Center for Sharing Public Health Resources	A Roadmap to Develop Cross-Jurisdictional Sharing Initiatives
8	Public Children Services association of Ohio (PCSAO)	Ohio's Fostering Connection Grant: Enhanced Kinship Navigator Project
9	Camp Fire Connect	https://www.campfireconnect.org/
10	Camp Fire Collaborative	https://www.campfire-collaborative.org/