Module 3: Coordination Strategies and Supporting Resources

Coordinating to Improve Family Experiences Toolkit: Resources for State and Local Human Services Agencies

This module includes resources and guidance to help your team choose and implement strategies to improve the experiences of families you serve who interact with multiple human services programs. For each strategy, the module includes:

- A brief description of the strategy, highlighting why it would improve families' experiences
- High-level guidance for preparing to implement it
- Tools, resources, and examples of the strategy used in the field to support implementation.

Following this introduction, two activities to support finalizing your selection of strategies and working through initial details and considerations for implementation are provided. If you would like additional guidance and considerations for identifying which strategy or strategies described in this module may fit your team's goals, needs, and context, consider turning to **Modules 1 and 2**. **Module 1** provides activities to support your team in developing an initial shared vision and goals for improving the experience for families. **Module 2** provides an overview of the different strategies in this module including how staff and families may be impacted by different strategies and related coordination and readiness strategies that may drive success.

Planning for Implementation

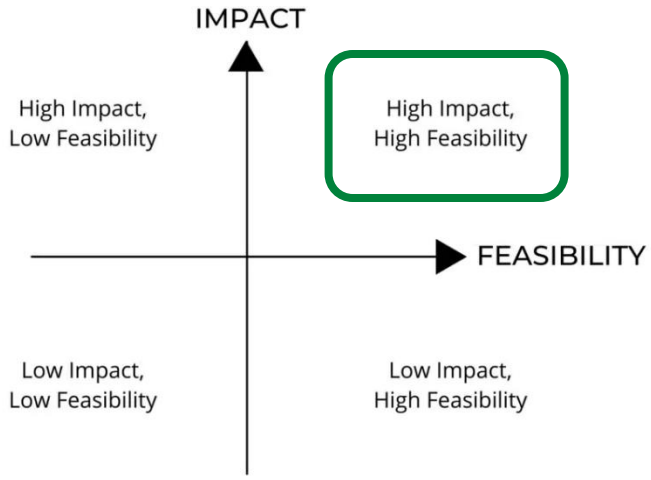
Before your team begins implementing the strategies from this module, it is critical that you:

- **Intentionally prioritize what to take on first if you are interested in taking on more than one strategy**
- **Confirm that your strategy or strategies of interest are likely to get you to your intended goal**
- **Identify potential requirements, challenges, and barriers to implementation in your context**

Activities to support each of these steps are described below.

Prioritize strategies based on their feasibility and potential impact for families

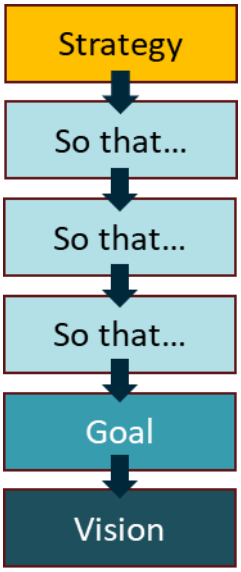
If your team is considering multiple different strategies and feeling stuck identifying which one your team should take on first, it may be helpful to consider what your team is most ready to take on and what has greatest potential benefits for families. This can be done by completing an **Impact vs Feasibility Matrix** activity. As shown in the visual to the right, strategies can be placed within four quadrants, with those closer to the top being expected to have higher impact and those closer to the right being more feasible to implement.



For this activity, **Impact** refers to the potential benefits or positive outcomes of implementing a strategy and **Feasibility** refers to the likelihood of successful strategy implementation.

If your team is completing this activity in-person, you can print out and use **Worksheet 6: Choose and Prioritize Strategies** and compare individual responses to the activity to identify priorities as a team. If you are doing this activity virtually, you can use a Mural template to capture your team's perspectives.

Check the connection between potential strategies and your goals



Your team may first want to confirm that your intended strategy can lead to your end goal, which you may have developed with support from the activities in **Module 1**. Your team can do this through a simple activity called a **"so-that" chain.** A "so-that" chain can help your team navigate what is called "the messy middle" of all the interim or short-term outcomes that connect a strategy to its end goal or long-term outcome and ultimately your overall vision for coordination. The following guide and example from the New York City's Strengthening Communities: Building Strategic Partnerships toolkit provides complete guidance for this brief, 15-minute exercise.

Like logic models, developing a "so-that" chain will help your team to build a narrative that explains how a strategy will result in an end goal and can help your team identify any gaps in your logic. *If your team is ready to develop a full logic model, you can turn to the resources in* **Module 5** *to guide this step.*

Map the future to anticipate implementation challenges and considerations in your context

A **service blueprint** allows you to visualize the interaction between families, staff, and program processes. They are helpful for mapping complex family experiences that involve multiple programs. A future-state service blueprint maps out how you ideally want services to function to better serve families. If you completed **Module 1**, you could use your team's vision statement to guide your development of a future-state blueprint as well as your current-state service blueprint. Guidance for developing a service blueprint can be found starting on **Page 9 in Module 1**.

Once you map out the ideal experience for families when interacting with programs, you can compare this to current experience and interactions that families have when navigating your services. This will help you to evaluate what is feasible, where constraints and opportunities may lie, and what other changes will need to take place to support your goals.

Navigating this Module

This module provides detailed information to support your team in finalizing your selection of coordination strategies and begin implementing them. The strategies are grouped based on whether they are **program-level changes** to the administration of programs; **application, eligibility determination, and renewal processes changes**; or **service-level changes** that directly impact families' interactions with programs.

The following page includes a table of these strategies with links to take you directly to strategies in this module that you are interested in exploring further. The list of strategies included in this module are not meant to be comprehensive and include those that were supported by existing resources and were identified by human services experts who have led and supported coordination efforts.

Coordination Strategies

Use links in the list of strategies below to jump to relevant sections of this module.

Program-Level Coordination Strategies	
Knowledge Sharing	**Develop procedures to share information about programs with staff.** Effective procedures for sharing information across programs can support efficient management practices, program improvement efforts, and the ability of front-line staff to better respond to family needs, potentially improving many dimensions of a family's experience.
	Identify, develop, and use outcome measures for tracking joint impact on family well-being. In evaluating the impact of your programs on families, your team should consider shared outcomes and indicators that capture the effect of services across multiple programs and across multiple members of a family. This will help center your effort around the common goal of improving outcomes for whole families and ensuring a family's needs are addressed more holistically.
Policy Alignment Readiness	**Inventory, share, and compare policies across programs.** Documenting rules and policies in a consistent way across programs so they can be used by administrators, managers, policy and program improvement teams, and direct service staff opens up a wide variety of opportunities to deepen coordination, with or without further changes to policies. Staff tasked with broader program improvement responsibilities may identify opportunities to streamline processes so rules are aligned and staff interacting with families can better communicate the differences and similarities in rules across programs.
	Digitize policies across programs using a "Rules as Code" approach. By creating computer-readable policy documentation, agencies can create code to provide information about how policies interact and should be interpreted. This can also improve how policies are interpreted across partners and promote policy alignment. Ultimately, this approach can improve the experiences of families by streamlining the processes and policies that drive their interactions with services.
Co-location	**Move offices and service access to the same place.** Implementing shared service locations can be an effective strategy to create more accessible programs for families.
	Build one-stop web portals for service access. One-stop web portals can be an effective way for families to access a variety of services, benefits, and important information.
	Use call center technology to integrate program connections and support. Agencies can enhance the experiences of families using call centers by implementing strategies that improve efficiency, functionality, and accessibility when interacting with more than one program.
Coordinated Outreach and Public Communication	**Establish a joint outreach and communication plan.** Outreach efforts by programs, either targeted at reaching specific families and communities or more general communication to increase public knowledge and awareness, are a key element of ensuring families are aware of the programs and services in their community.
	Develop coordinated self-screeners. Coordinated self-screeners enable families to access information about their eligibility for various programs in one location, reducing the burden on families to identify potential eligibility across many programs.

Application, Eligibility Determination, and Renewal Coordination Strategies	
Coordinated Applications	**Streamline, simplify, and integrate applications.** Integrating and simplifying applications from multiple programs into one common application is an effective way to improve the experiences of families accessing multiple programs by reducing repetitive questions.
Coordinated Eligibility Determination	**Ensure staff understand how changes in eligibility across programs may impact financial stability.** Staff who are educated about benefits cliffs across programs can help families make informed decisions as they work toward financial stability.
	Align and integrate eligibility determination processes. Integrating eligibility determination processes can make them less complicated and burdensome for applicants and may reduce the burden on staff working with families to gather necessary information and documents.
Coordinated Renewals	**Modify and align renewal periods.** Aligning renewal timelines can make the renewal process more convenient for families and decrease duplicative work for both families and staff.
	Develop integrated renewal processes. Coordinating renewals across programs can be an effective way to maintain enrollment both for individuals served across multiple programs and for families with multiple household members enrolled in multiple programs.

Service-Level Coordination Strategies	
Coordinated Intake and Referrals	**Build a joint family needs assessment.** Assessing family needs is the first step of a successful referral process and ultimately successful service delivery.
	Develop a referral system and procedures. Effective, well-documented referral procedures that align with program resources and workflows can support program staff in making important connections to other services that families may not have known were available to them.
	Establish inter-program or inter-agency referral agreements. Clearly articulated inter-program agreements or memoranda of understanding can support commitment to the referral process you've established across partners.
Coordinated Case Management	**Use coordinated case management approaches.** Coordinated case management approaches involve deeper communication among case managers from various programs who serve the same families.
	Use integrated case management approaches. Integrated case management approaches involve combining case management-related systems and staff responsibilities across programs.

Program-Level Coordination Strategies

The following strategies focus on **Program-level Coordination**—changes that improve the *context* of service delivery but do not involve changes to service delivery itself—to make it easier for families to navigate interacting with multiple human services programs. These strategies address **knowledge sharing, policy alignment, co-location**, and **outreach**. The following strategies are highlighted in this section:

- **Knowledge Sharing** strategies involve intentionally sharing knowledge about how your programs operate to provide context for larger coordination efforts. These strategies can help staff be more prepared to serve and inform the families they work with about services that meet their needs. They include:
  - Develop procedures to share information about programs with staff
  - Identify, develop, and use outcome measures for tracking joint impact on families

- **Policy Alignment Readiness** strategies involve aligning program policies and regulations, such as definitions and eligibility criteria. These strategies can set the stage for creating more consistency across programs and a less confusing experience for staff and families when navigating multiple programs and services. They include:
  - Inventory, share, and compare policies across programs
  - Digitize policies across programs using a "rules as code" approach

- **Co-location** strategies involve putting multiple programs under one roof or developing centralized virtual tools for families to learn about and manage multiple services. These strategies can create more convenient experiences for families who are engaging with multiple programs. They include:
  - Physical Co-location: Move offices and service access to the same place
  - Virtual Co-location: Build one-stop web portals for service access
  - Virtual Co-location: Use call center technology to integrate program connections and support

- **Outreach and Public Communications** strategies involve programs or agencies collaborating on outreach efforts by sharing data and building user-friendly tools for families to get information about programs. These strategies can help families be more informed about programs that could help them meet their needs and make them more likely to enroll and access these programs. They include:
  - Establish a joint outreach and communication plan
  - Develop coordinated self-screeners

Knowledge Sharing: Develop procedures to share information about programs with staff

Effective collaboration requires that programs within your partnership understand the program goals, services available, and requirements and constraints each partner faces in serving families. This information may include eligibility criteria and intake steps, details about service delivery and family timeline for engagement, and other key program details that impact families who may be engaging with more than one program at a time. Establishing processes for regularly sharing information can provide a foundation for increased coordination and integration across both program administration and direct service delivery. With concrete procedures for sharing information across programs and agencies, staff will be better equipped to share accurate information about multiple programs with families.

Suggestions for getting started: Consider starting by identifying current communication practices that have worked well with other partners or for previous projects where members of your current team worked together. Think about how those practices might look if they were adapted with the goal of establishing ongoing lines of communication between partners.

High-level implementation considerations: The appropriate level of detail, frequency, and method of information sharing are dependent on the goals and audience for the information. Teams should start by considering what would be helpful for program leadership, managers, and front-line staff to know, respectively, and then identify the appropriate methods for sharing information that align with and build off existing workflows, meetings, and trainings. Information sharing plans should also aim to build and reinforce organizational cultures around partnership and communication, and address confidentiality concerns.

Common challenges:

- *Materials created with the goal of sharing information with staff across programs can quickly become out of date.* Teams should plan for ongoing maintenance when creating new information sharing materials, including gathering feedback from regular users.
- *If organizational culture does not support and encourage communication, information sharing efforts may not have the intended impact.*
- *Not all information sharing methods meet staff needs and support increased connections across programs.* Teams may want to consider asking staff what works best and consider approaches that support interpersonal connections, like shared trainings.

Examples from the field

Resource	Navigation
The Inter-agency Information Sharing brief discusses the **importance of information sharing in collaboration efforts**. The resource includes several examples of how states engaged in TANF and child welfare coordination efforts have employed key strategies to foster successful information sharing.	See **pages 4-5** for examples of how organizational culture can foster information sharing. **Pages 5-7** discuss strategies for sharing knowledge across programs, agencies, and departments. **Pages 7-10** outline considerations related to confidentiality and privacy, data collection and reporting, and outcomes.
The Under One Roof report includes an exploration of how Neighborhood Place in Jefferson County, Kentucky **provides coordinated and co-located services to improve the well-being of families**. To strengthen their partnerships, they use several strategies to increase shared knowledge, including **regular communication and formal structures** such as committees, all-staff meetings, integrated services meetings, and emphasizing cross-program communication in new staff onboarding.	See **pages 40-41** for more details about Neighborhood Place's approach to information sharing.

Knowledge Sharing: Identify, develop, and use outcome measures for tracking joint impact on family well-being

What your program and team are tracking in terms of outcomes for families drives the behaviors and direction of staff at all levels of your organizations. One important step for aligning your efforts across programs is to assess what family outcomes you and your partners are and are not measuring and what effect you expect to have on family outcomes in your collective work together. The process of assessing and aligning what you track and incorporating additional outcomes based on how your programs are expected to impact families jointly can be helpful for guiding further coordination work and for developing shared language, goals, and missions across your team.

Your team will also want to consider developing output and outcome measures specifically associated with your coordination efforts. Consider turning to **Module 5** for guidance and examples of measures that align with strategies in this Toolkit.

Suggestions for getting started: Consider gathering all your most recent reporting on program outcomes, including both those required by funders and those developed by your program. Consider to what extent they capture the broader well-being and experiences of the families you serve - are there ways in which services provided across your team may be expected to have broader impacts on families?

High-level implementation considerations: In whole-family initiatives, programs will touch multiple members of a family or household, as well as multiple domains of life (e.g., early childhood development, economic stability, health). The choice of outcome measures should be attentive to impacts on the whole-family across areas of service delivery to capture the full picture of how programs impact families.

Common challenges:

- *Cross-program teams may be hesitant to track new outcomes beyond what is required by individual program regulations and funders*. Teams should identify how outcomes will be tracked, by whom, and how the costs of tracking those outcomes will be shared to minimize the burden on any one program.
- *Shared outcomes identified by teams may be difficult to gather data on.* Teams may need to consider new tools for measuring selected outcomes that are not currently used by participating programs, such as targeted surveys or interviews with families.

Tools and guides to support this approach

Resource	Navigation
The Making Tomorrow Better Together series of reports focuses on how policymakers and practitioners can think about child and parent outcomes for two-generation programs. • The Report of the Two-Generation Outcomes Working Group provides a breadth of information, including **guidance for identifying two-generation outcomes across various domains.** • A Guide to Outcomes for 2Gen Policymakers provides **additional guidance to policymakers for achieving two-generation outcomes and for measuring and monitoring outcomes**. The report focuses on what state agencies can do to create the conditions for successful two-generation programs and how to measure their success.	In the report, see especially pages 11-15 for a discussion of outcomes, as well as the table of common two-generation outcomes from pages 16-19. In the guide, see pages 11-16 for information on outcomes. See also pages 23-26 for a table of target two-generation outcomes.
The Advancing Mobility from Poverty: A Toolkit for Housing and Education Partnerships website provides guidance to multi-program partnerships to define and launch coordination efforts aimed at relieving poverty. Stage 3 of the toolkit focuses on Prioritizing and Developing Shared Outcomes, including case examples and recommendations for facilitating discussions to identify shared outcomes. Although this resource focuses on housing and education programs, the guidance and recommendations discussed in Stage 3 are relevant more broadly.	The toolkit includes a Shared Outcomes Discussion Guide in Appendix F, which includes a sample agenda and discussion points covering both introductions between organizations and example questions focused on shared outcomes.

Examples from the field

Resource	Navigation
The Early Childhood Systems Collective Impact Project report from the Center for the Study of Social Policy and Mathematica includes **recommendations to support alignment across programs for expectant parents, young children, and their families**. While these recommendations are directed at federal agencies, they may be helpful for **developing a framework for common outcomes across state programs and agencies**.	See recommendations related to outcomes on **pages 18-19**.

Policy Alignment Readiness: Inventory, share, and compare policies across programs

Differences in policies and regulations across programs and services that families are commonly co-enrolled in can lead to confusion and inefficiency for both families and the staff who serve them. Documenting rules and policies in a consistent way across programs for use by administrators, managers, policy and program improvement teams, and direct service staff creates opportunities to deepen coordination, with or without further changes to policies. For instance, staff tasked with broader program improvement may identify opportunities to streamline processes with aligned rules, and staff may be better able to communicate with families about the differences in rules across programs. Although eligibility determination is a common focus for policy alignment efforts, aligning other policies, such as program participation requirements, can also provide opportunities to improve families' experiences.

Policies can be brought together in a variety of formats. The examples and resources in this section include:

- **Crosswalked workbooks or databases** with elements of different programs, simple and readable descriptions, and relevant links to rules and regulations.
- **Combined policy manuals** across multiple programs, with organization and functionality that allows both staff and family users to understand differences and alignment across programs.

Suggestions for getting started: To start, your coordination team should agree on an approach for reviewing program policies, rules, and regulations, including those established at the federal, state, agency, and program level. For example, you may choose to organize a policy review board of expert representatives with in-depth understandings of your team's programs. You may also choose to use visual tools such as "crosswalks" to help with comparing policies across programs. See the Early Childhood Systems Collective Impact Project for an example crosswalk.

High-level implementation considerations: Inventorying policies and integrating documentation of those policies across programs may require extensive time from staff with technical knowledge of federal, state, and local regulations and requirements. Efforts to document current policies, their alignments, and their inconsistencies should be approached as an ongoing, rather than one-time effort, to ensure documentation stays up to date.

Common challenges:

- *Identifying opportunities for policy alignment will require additional time and expertise beyond what is needed to combine policy information in a central location.* Using policy inventories to drive policy alignment efforts will likely require further review and exploration of how flexible those policies and rules are and how changes may impact families' experiences, likely involving individuals with specialist policy knowledge.
- *Combining policy details in a central location may make them more difficult to navigate due to the large volume of information.* Teams looking to combine policies in a central location should consider their intended audiences, accessibility across those audiences, and which programs' information should be combined to meet the intended goal.

Examples from the field

Resource	Navigation
The Changing Policies to Streamline Access to Medicaid, SNAP, and Child Care Assistance report includes examples of how states combined policy manuals to assess opportunities to streamline policies and make information about the interaction between policies more available to staff assessing eligibility. For example, North Carolina created an Economic Benefits Policy Governance Board to support the streamlining of policies across programs and reviewing cross- and intra-program policy changes. The Board began by reviewing sections of individual policy manuals, assessing opportunities to streamline, and combining into a single manual along the way.	See **pages 23-24** for information on North Carolina's practices, as well as a similar review process in Idaho. See **page 25** for details on North Carolina's efforts, as well as the experiences of Idaho and South Carolina as they aimed to combine policy manuals. Additional learnings from state efforts to partner across programs to streamline and align policies can be found on **pages 26-45**.
The Early Childhood Systems Collective Impact Project supports coordination across federal programs to advance early childhood and family-wellbeing. The project produced a Catalog of federal statutes, regulations and guidance around key program elements across 36 federal programs and a Crosswalk that compares program policies across dimensions of eligibility, needs assessment, outcomes and performance measures, and well-being metrics. This project was focused on federal policies, but the same process could be undertaken at the state or local levels and include local programs and regulations.	The project also produced a Synthesis of findings, as well as a Guide for how to use these resources and a Methods report on how the catalog and crosswalk were developed.
Various chapters of Indiana's integrated Program Policy Manual for TANF, Refugee Cash Assistance, and SNAP include clear **definitions of components of these programs, particularly related to eligibility**. For example, the chapter on income provides definitions of various types of income, employment, and other related elements of eligibility. Some of these definitions are common across the programs; the manual specifies when they are not.	Chapter 1000: Introduction to Program Policy Manual provides a helpful overview of the purpose, scope, organization, and terminology of the policy manual. See Chapter 2800: Income for a discussion of income-related eligibility criteria. You may find other chapters informative depending on the focus of your effort.

Resource	Navigation
The Oregon Department of Human Services developed a single manual for eligibility staff and others supporting families navigating services that includes all of the agency's food, cash, child care, and medical programs. The manual, called Oregon Programs Eligibility Notebook (OPEN), aims to **simplify explanations of federal and state regulations**, includes **examples of how policy affects families**, and links to the state rules database. It is **organized around related program elements across programs** (application, financial and non-financial eligibility) and **services for specific populations**, rather than by programs.	Prior to implementation of the new OPEN manual in 2019, the Oregon Department of Human Services produced a Family Services Manual where the agency's program manuals were combined into one document but were not organized to support users in navigating information across programs. The old and new versions of the combined manual can be reviewed here.

Policy Alignment Readiness: Digitize policies across programs using a "Rules as Code" approach

Rules as Code is an approach to improving the quality and usability of program rules for use by frontline staff and administrators by documenting them in a format that is usable by computers in a consistent way. Creating computer-readable policy documentation allows for agencies to create code that provides logic about how those polices interact and should be interpreted. In addition to increasing the quality of polices themselves, Rules as Code approaches can help to improve how policies are interpreted across partners and how policy interactions across programs are understood, as well as make integration of processes across programs easier, including applications, eligibility determination, renewal processes, and referrals. Ultimately, this can have broad impacts on the experiences of families by creating opportunities to streamline processes and policies that drive their interactions with services.

Suggestions for getting started: Rules as Code is a new and growing approach to improving the development and use of polices. States and localities can best assess whether these approaches are something they may want to adopt and whether they have the resources and capacity needed to implement them. If your team is implementing Rules as Code, adopt best practices by learning from the most current examples through the Digital Government Hub's Rules as Code Community of Practice.

Tools and guides to support this approach

Resource	Navigation
The Benefit Eligibility Rules as Code report provides recommendations to the U.S. government for simplifying eligibility determination by **harmonizing definitions across programs and using a "Rules as Code" approach to determining eligibility**. While this resource is targeted to the federal government, **it provides other examples of how city governments and organizations have approached using "Rules as Code**."	**Pages 23-24** outline a "Rules as Code" approach for eligibility, and examples can be found on **pages 15-22.** For links to helpful resources, tools, and examples, see **pages 30-33**. To learn more about the "Rules as Code" approach and regularly updated resources, visit the Digital Government Hub's Digitizing Policy + Rules as Code topic. The Applying Rules as Code to the Social Safety Net brief provides a simple overview and ideas for how it may apply to public benefits that can be help for educating partners on this new approach.

Physical Co-location: Move offices and service access to the same place

Implementing shared service locations can be an effective strategy for creating more accessible programs for families. By centralizing multiple programs under one roof, you can improve the benefits navigation experience for families, streamline service delivery, reduce barriers to access, and improve coordination between services.

Physical co-location typically refers to services that can be accessed in the same physical space—be it the same building or same general location—but doesn't necessarily imply further integration of **shared spaces** (lobbies or staff work spaces), **staff roles and responsibility,** or **processes** for delivering services. This type of co-location provides an opportunity for increased service coordination and integration, opening opportunities for improved **communication**[1], improved **referral** processes, and other opportunities to streamline and integrate processes more fully. Different programs and services areas can refer to physical co-location using different terms, which may also be associated with different levels of integration beyond locating services in the same area. These terms include:

- Service hub
- One-stop center
- Community resource center

Suggestions for getting started: Consider starting by identifying *how* you are hoping to impact the experiences of families through physical co-location, *whose* experiences you are trying to improve (e.g., families with young children, etc.), and *what* needs to be coordinated to improve those experiences.

High-level implementation considerations: Locating service points in the same building or general location can make accessing services more convenient for families, but sharing space alone does not inherently improve the experiences of families. Co-location is most effective when accompanied by other strategies to improve families' interactions with staff and streamline other processes involved in receiving services.

Common challenges:

- *Locating, maintaining, and preparing physical space can be difficult.* If appropriate space for coordination services is identified, your team will also need to consider cost sharing for use and maintenance of the space, and potentially needing to redesign the use of space to make it easy for families to navigate.
- *Streamlining and coordinating family interactions with staff could require major changes to how front-line staff do their work.* Your team may face resistance with making major changes to staff processes with families, but working with these staff to design new service flows may increase support for changes.

[1] See the Under One Roof: Findings from the Understanding the Value of Centralized Services Study (VOCS) report for more details.

Tools and guides to support this approach

Resource	Navigation
The second module of the Rural Health Information Hub's Rural Services Integration Toolkit discusses co-location models. It provides **information, resources, and links to examples for co-locating services and implementing a "one-stop shop" approach** to service integration with a **focus on rural services**.	These sections of the module provide examples of physical co-location and considerations for implementation: • Co-location of Services Model • Co-location of Child and Family Services • One-Stop Shop Model
The Organizational Culture in TANF Offices report offers **office design strategies that human services offices can use to convey your team's values, norms, and priorities**. It also provides an overview of **options that programs may consider when designing offices for co-located services**.	**Pages 15-17** include information on office design with guidance specifically for co-located services.

Examples from the field

Resource	Navigation
The Improving Business Processes for Delivering Work Supports for Low-Income Families report highlights several **components of service co-location that states can use to improve the experiences of families accessing their services through central offices**.	See the "Lobby" section on **pages 17-18** for more information on how states organized lobbies to improve customer flow.
The U.S. Department of Agriculture examined Virginia's implementation of **one-stop career centers.** The report describes **lessons for implementation, successes, challenges**, and other important details about this effort.	Chapter II includes a literature review on one-stop service centers with important lessons learned on co-location. An overview of strategies for increasing access to work supports through one-stop centers starts on page 11. Chapter VII highlights successes, challenges, and other lessons learned on planning One-stop initiatives in rural communities.
The Coordinating Services for Families with Children from Birth to Age 5 report discusses several models that **incorporate co-location for providing services for families**. For example, some initiatives use a "centralized hub" approach where services are co-located. Others combine the "hub" approach with a "no-wrong-door" approach by co-locating some services and resources and connecting families to others in other locations.	**Page 4** includes a table with definitions of coordinated services approaches including no-wrong door, hub service, mixed hub and no-wrong-door service, focused coordination service, and light-touch virtual service approaches. **Page 6** includes conceptual models of no-wrong door and centralized hub approaches.

Resource	Navigation
The Assessing Models of Coordinated Services report examines different models that states and localities used to coordinate services, including a "hub" model, which typically uses co-location. **The report uses examples to synthesize various components of the hub model**.	**Page 21** summarizes how states and localities that used the hub model facilitated data sharing, engaged partners, and managed intake and client cases.

Virtual Co-location: Build one-stop web portals for service access

One-stop web portals can be an effective way for families to access a variety of services, benefits, and important information. These online and mobile-based tools could support families in self-screening for potential programs they may be eligible for, learn more about those programs, enroll in those that meet their needs, facilitate case management, or enable families to renew their enrollment in programs. Recently, several states have redesigned their platforms to make them more user-friendly and ensure that families can navigate multiple programs with ease.

Suggestions for getting started: To guide the development and upkeep of your web portal, consider outlining a project plan. This document can detail your goals, timeline, staffing and roles, and any guiding principles your team has identified. To help develop a project plan, use discovery questions and suggested components of a project plan from the First Five SC Toolkit included below.

High-level implementation considerations: Implementation of web portals can happen in phases. For example, the First Five South Carolina web portal started as a shared location for information about programs serving families with young children. Initially, it focused on pre-screening eligibility. Once they developed the necessary relationships, navigated program alignment and regulatory considerations, and established sustainability of the initial web portal functionality, they were able to implement an integrated application.

Common challenges:

- *One-stop web portals require dedicated funding for development and maintenance.* Your team may need to identify new funding sources for web portal design, development, and promotion, and will need to navigate shared costs of ongoing maintenance for the web portal and adaptations to reflect changes in program processes and family needs over time.

Tools and guides to support this approach

Resource	Navigation
The South Carolina Early Childhood Advisory Council's First Five SC Toolkit offers step-by-step guidance to other states looking to design and implement similar resources for families. The toolkit provides support **with planning, engaging stakeholders, securing funding, building the portal, and launching it**.	The section titled **Build the Portal** includes links to one-page resources including exploratory questions, guidance for developing a project plan, tips for building a portal, questions to help determine what programs should be included in a portal, and a user test guide.
Part 3 of the Improving Customer Service in Health and Human Services Through Technology report includes a section on developing web-based tools, including online portals. The section includes **a summary of the ideal functions of an online portal, the key features, and other helpful guidance**.	*Part 3: Best Practices by Technology* starts on **page 6** of the report and includes a checklist of key features to include in an online portal on **page 8**.

Examples from the field

Resource	Navigation
The States' Use of Technology to Improve Delivery of Benefits report describes how certain states **developed online portals to streamline human services processes for families and staff.** These portals give families access to eligibility screeners, applications, and other ways to manage their benefits. For example, **Colorado, Idaho, and Illinois created centralized online customer portals where families could track their applications and receive information about the status of their benefits**.	The *Online Application and Customer Portals* section on **page 10** includes information on the experiences of states that implemented online portals, different uses of portals, and challenges that states faced in implementing online portals.
Colorado developed PEAK (Program Eligibility & Application Kit), an **online service to learn about, screen for, apply for, and manage benefits for medical, food, cash, and early childhood assistance programs**.	The Frequently Asked Questions page is helpful for understanding what information is important to convey to families who may use your portal and where families may run into roadblocks. This brief overview gives a high-level description of PEAK.
Ohio developed Ohio Benefits, a **common interface** for medical, food, cash, early childhood assistance, and other programs. The website contains a **self-service portal for applications, office locations and hours, information on programs, links to commonly used forms, a help desk, and frequently asked questions** across these programs.	The Common Questions page is helpful for understanding what information families need in order to understand how to use the portal. The How To Videos page is a helpful resource for understanding how families navigate and experience the web portal.

Virtual Co-location: Use call center technology to integrate program connections and support

States can enhance the experience of families using call centers by implementing strategies that improve efficiency, functionality, and accessibility through centralized call centers. Providing estimated wait times in queues, offering callback options, and utilizing routing systems that connect families directly with topic experts are just some of the useful strategies to streamline service for families accessing call centers.

Suggestions for getting started: Start by exploring the array of options your team can use to improve call center functionality described in the tools below. Consider whether the needs of the families you serve would best be met through more consistent experiences for callers; process improvements to call center technology for callers on hold, in queues, or while interacting with staff; or complementary resources like web portals.

High-level implementation considerations: Integrated call center technology is frequently implemented as part of a larger effort to coordinate services. For example, integrated call centers can be implemented alongside universal case managers or cross-trained case managers who can handle less difficult calls from families asking about a range of services.

Common challenges:

- *New technology may require new funding sources and ongoing funding for maintenance of and adjustments to the new systems.*
- *Implementing call center technology to integrate program services will require extensive staff training and may require changes to staffing structures.* These changes can be disruptive to staff and may result in additional costs beyond the technology itself.

Tools and guides to support this approach

Resource	Navigation
The Call Center Strategies to Support Unwinding toolkit provides **guidance for states facing high call volumes** during Medicaid's unwinding from the COVID-19 pandemic but is applicable to other human services programs as well. It describes how agencies can work on process improvements and **provides a menu of options for improving the efficiency and functionality of call centers** for staff and families.	This resource includes sections with specific strategies on building an effective call center workforce (**page 4**), providing effective training and education for call center staff and users (**page 5**), process improvements that organizations can make to improve call centers (**pages 5-6**), and technological improvements that organizations can make.

Examples from the field

Resource	Navigation
The State Innovation in Horizontal Integration *report* discusses how states have developed varied **strategies for using call center technology to improve families' access to human services programs**. For example, Pennsylvania implements a virtual call center for its COMPASS programs, which include Medicaid, CHIP, SNAP, TANF, and LIHEAP. When families call, they are routed to staff who are cross-trained in all these programs or to more specialized staff to meet more specific needs such as language access.	**Pages 17 and 18** include more information on how different states, including Illinois, Pennsylvania, Colorado, Kentucky, and Idaho, are using call centers to better serve families.
The Promoting a Positive Organizational Culture in TANF Offices report includes a discussion of Santa Cruz County's Human Services Department's use of the "We Care" model as a **framework for customer interactions, including in call centers**. Horizontal integration is a key component of the model and influences how call center staff are meant to communicate with families, understanding that they could be seeking information on several programs.	This page of the County Welfare Directors Association of California's website has information about the We Care model and additional resources. The Staff Guide and Desk Reference are helpful resources for understanding how horizonal integration is built into client interactions during client calls.

Outreach and Public Communications: Establish a joint outreach and communication plan

Outreach efforts by programs, either targeted at reaching specific families and communities or more general communication to increase public knowledge and awareness, are a key element of ensuring families are aware of the programs and services in their community. Jointly developed outreach and communication campaigns are an opportunity for programs to work together both to efficiently reach families and to lower the burden on families to get information about multiple programs.

Engaging with families

Ideally, you would work *with* families to create your outreach plan. Families know their communities best and will be able to share how, when, where, and what is best to effectively communicate to engage families in your communities.

If you do not have an existing family consultant structure, try connecting with a local family-led organization that supports the communities you serve. Local organizations will be able to support you themselves or connect you to the right people to do so.

With these partners, consider the needs of the communities you serve, by asking questions such as:

- What are the specific languages you should be communicating in?
- What are the times of day that work best for the people in the community?
- Where are the locations in the community where people gather?

Suggestions for getting started: As you begin planning to conduct outreach, your team may want to first identify a clear campaign goal. This goal may include, for example, identifying target populations that could be better reached across your programs. You can then identify the best methods for reaching that community and what is most important to communicate to them about your programs.

High-level implementation considerations: Outreach efforts require that programs are nimble and respond to the changing needs of communities and families they are seeking to reach. Joint outreach efforts also require partners to work together continuously monitor and change their approach as needed to ensure they are reaching target families. Your team should plan to continuously work together to remain responsive to what is working and not working in terms of reaching eligible families.

Common challenges:

- *Joint outreach campaigns can be overgeneralized and fail to achieve desired goals if not carefully planned.* Articulating target communities and families for different types of outreach will result in more effective joint outreach efforts.

Tools and guides to support this approach

Resource	Navigation
The Increasing WIC Coverage Through Cross-Program Data Matching and Targeted Outreach toolkit includes a series of tools to guide programs through developing a **cross-program engagement and outreach initiative focused on targeted text message outreach approaches**. The toolkit is broken into a step-by-step process, including links to resources and guidance for developing outreach materials and messaging. While the toolkit is largely centered around WIC, its content is broadly applicable.	The "Setting Goals" section includes a planning tool that helps users identify clear goals for an outreach campaign. The "Developing a Targeted Outreach Plan" section includes a planning tool that will help your team plan for the different components of an engagement effort such as identifying a target audience, a method of outreach, and a plan for monitoring, among other important elements.
The Planning your Engagement Efforts guide **suggests steps for developing an engagement plan**. It provides guidance on framing a problem to solve, gathering a project team, and developing a communication plan. For each step, the guide includes **suggestions and considerations, as well as links to worksheets and other resources**. Although this guide does not address coordinated engagement explicitly, the steps can support the development of a shared strategy with partners.	This worksheet linked in the guide will walk you through developing an engagement plan by helping you identify your engagement goals, team members, tools, and other important considerations for implementation. The external resources page in the guide includes a link to a resource on building relationships with community members and stakeholders.

Examples from the field

Resource	Navigation
The Targeted Text Message Outreach Can Increase WIC Enrollment, Pilots Show brief evaluates text-based outreach initiatives to increase WIC enrollment in several states. They underscored that **defining the goals of an outreach campaign from the outset** helped inform key decisions down the line. Ultimately, states reported that targeted text outreach can increase enrollment for adjunctly eligible families—those already enrolled in another program with the same or a lower income eligibility threshold—or families enrolled in more than one program.	See **pages 3-10** for a discussion of lessons learned from past text-based outreach initiatives. **Pages 11-16** outline considerations for launching text-based outreach, with **page 12** including a brief description of how cross-program coordination can be leveraged in outreach efforts.

Outreach and Public Communications: Develop coordinated self-screeners

Coordinated self-screeners enable families to access information about their eligibility for various programs in one location, reducing the burden on families in identifying potential eligibility across many programs. Self-screener websites typically include additional information about programs and the services they provide alongside the self-screener.

Suggestions for getting started: Consider completing a system mapping activity to understand how each program fits into the landscape of human services in your jurisdiction. This mapping activity could outline data-sharing agreements, regulations, and policies, as well as anticipated technical challenges, funding streams, and other parties who should be involved in your effort. You can find an example of a completed mapping activity in the toolkit linked below.

High-level implementation considerations: Coordinated self-screeners can be a helpful first step in moving toward more integrated approaches to engaging families across programs. Teams interested in implementing a combined application or in streamlining access across different types of programs (community-based programs, state programs, federal programs) may want to start with a self-screener as a lower-barrier approach to bringing information about programs to one place for families.

Common challenges:

- *Technical expertise is required for developing coordinated web-based self-screeners.*
- *Self-screeners require consolidated and aligned data on program eligibility criteria.* This may require developing a crosswalk of program eligibility rules and policies across all participating programs.

Tools and guides to support this approach

Resource	Navigation
First Five South Carolina developed a comprehensive platform that allows families to access programs across the state through a single self-service portal. The portal was built using a phased approach—it started as a benefits eligibility self-screener and then later expanded to include an integrated application across participating programs. The First Five SC Toolkit, informed by their success, offers **guidance to other states wishing to develop similar comprehensive self-service portals and how self-screeners can serve as a first step for integrated applications**. While the First Five SC Toolkit is specific to early childhood services, their approach is applicable to programs serving families more broadly.	The About First Five SC webpage describes how the First Five South Carolina project implemented their self-screener tool allowing families to check their eligibility for over 40 services. The ***Laying the Groundwork*** section helps programs with a shared vision assess their priorities, map out their programs, and identify champions to support their work. The ***Build the Portal*** section outlines how teams can review existing information about eligibility criteria and screening processes and translate it into a portal. It also includes guidance for user testing.

Examples from the field

Resource	Navigation
The States' Use of Technology to Improve Delivery of Benefits report details how states participating in the *Work Support Strategies* initiative created **online screening tools for families to pre-screen for and quickly access information about programs they were eligible for**. In Colorado, the state reported that participants were able to use the tool to quickly determine eligibility. Using the tool ensured that **families who were more likely to be eligible ended up applying in their eligibility system, while ineligible families were screened out early**.	See the *Online Applications and Customer Portals* section on **pages 10-11** for a description of Colorado's eligibility screening tool. Colorado now uses the MyFriendBen screener, which screens for eligibility for over 40 programs.
The Benefit Navigator is a **benefits self-screener and benefits cliff calculator** for individuals, families, and case managers in Los Angeles to **quickly understand, access, and navigate benefits programs**. In its initial pilot, the navigator was found to help users identify and secure additional benefits, decrease the amount of time staff spent searching for benefits, and help agencies and policymakers by providing clear data.	The bottom of the webpage includes screenshots of the navigator that are helpful for visualizing what this type of tool can look like. **Slides 10-15** of the Initial Pilot Results presentation also provide high-level background information on the tool. The CSI & Imagine LA De-mystify the Social Safety Net for Working Families video also summarizes the pilot program.

Application, Eligibility Determination, and Renewal Coordination Strategies

The following strategies focus on **Application, Eligibility Determination, and Renewal Coordination**—specifically, changes to these processes to make them less burdensome for families and staff and improve family access to services. The following strategies are highlighted in this section:

- **Application** strategies involve integrating applications for multiple services into one common application. This can help decrease burden on families, making it easier for them to access programs. It includes:
  - Streamline, simplify, and integrate applications
- **Eligibility Determination** strategies involve programs and agencies working together to integrate eligibility processes and systems to create a more efficient experience for both staff and families. Programs can also work together to keep families informed about how eligibility for certain programs may change based on program participation or changes in income. These strategies include:
  - Ensure staff understand how changes in eligibility across programs may impact financial stability
  - Align and integrate eligibility determination processes
- **Renewal** strategies involve programs and agencies coordinating different elements of renewal such as timelines or systems. Coordinating renewal can help to reduce "churn" and ensure that families do not lose the services they are eligible for. These strategies include:
  - Modify and align renewal periods
  - Develop integrated renewal processes

Application: Streamline, simplify, and integrate applications

Integrating and simplifying applications from multiple programs into one common application is an effective way to improve the experience of families by reducing repetitive questions. Redesigning applications can take various forms—while some programs may want to completely integrate applications across various programs and remove or adjust duplicative questions, others may prefer to incorporate additional questions into existing applications to screen for eligibility in other programs and set up automatic referrals instead.

Suggestions for getting started: Before you can begin developing a common application, first determine the alignment of the eligibility criteria across your team's programs. Consider crosswalking or cataloguing the requirements for each program to determine which questions may only need to be asked once to determine eligibility across multiple programs and which questions will need to be asked to determine eligibility for unique criteria within a particular program.

High-level implementation considerations: Streamlining and integrating applications can help individuals and families access entry points for multiple programs simultaneously. However, it is still important for your team to ensure that applicants are successfully connected to required next steps for each program following the application, whether that be interviews, verifications, or orientations.

Common challenges:

- *Combined applications are not necessarily inherently easier for participants to complete.* Revisions to applications should be informed by human-centered design to ensure they truly decrease burden for participants (see the resources below for more information on human-centered design).
- *New application processes will likely be a major change for staff, requiring adjustment.* Consider how your rollout of new applications can ease this transition (for example, rolling out slowly or in a pilot).

Tools and guides to support this approach

Resource	Navigation
Streamlining and Coordinating Benefit Programs' Application Procedures provides guidance for simplifying and improving applications for programs for families with children such as Medicaid, SCHIP, SNAP, TANF, and child care assistance. It includes recommendations for **using applications as screening tools for other programs, developing multi-program applications, and adjusting practices to streamline processes**. For these options, the resource describes steps states can take and implementation considerations.	**Pages 1-4** provide an overview of application processes and key strategies to streamline them. **Pages 9-22** include greater detail about options for streamlining applications, including outlining specific strategies to do so.

Resource	Navigation
The *Designing Human-Centered Applications* playbook includes information on **language accessibility and translating public benefits applications**. It also includes links to **additional resources to address web content accessibility standards set by the federal government**.	See **pages 9-10** for language access and **page 11** for links to additional resources on federal accessibility standards.
The *Strategies for Improving Public Benefits Access and Retention* report includes a section on reducing program application silos. It discusses considerations for **consent to be considered for multiple programs** in a joint application and considerations for **digital and paper applications**.	See **pages 17-18** for a discussion of joint applications.

Examples from the field

Resource	Navigation
The Making Public Benefits More Accessible in Minnesota report and Building Government Capacity in Minnesota webpage describe how the state partnered with Code for America to develop a mobile-friendly portal called MNbenefits where **residents can apply for nine benefits programs at once**. This portal uses actionable language, user-friendly design, and visual cues to emphasize important information. Throughout their effort, the team **prioritized improving outcomes for clients, using data, and client feedback loops** to make informed decisions about changes.	View **page 8** of the resource for a discussion of the benefits of integrating applications. The **webpage** provides an overview of the team's approach to developing an integrated application. See especially the **Our Approach** and **Outcomes** sections. See also a demo version of the portal.
The First 5 South Carolina **common application development process and the role of family voice in the development** is described in their 2024 Stakeholder Engagement Report. This report explains the initiative's two-phase process of launching the initial website and self-screener and then building on and continuously expanding the common application. First 5 South Carolina's **common application prefills a custom application form, designed dynamically based on programs families are eligible for, with data from the self-screener**.	See **pages 2-3** for a summary of the website, screener, and application development process. See **pages 4-8** for details on how the team assessed the impact and effectiveness of the website through engagement sessions with leadership, community partners, and families and identified next steps.

Resource	Navigation
Michigan's Project Re:Form streamlined applications for the state's human services programs in partnership with Civilla. Through conversations with families and staff, **they transformed a 40-page application with over a thousand questions into a streamlined, simple application** that still met policy requirements across five programs and aligned with existing business practices. The products the team developed include: • A **core application** for common information across all programs • Supplements with program-specific information so applicants only need to supply information relevant to their needs • A standardized interview guide with more detailed questions for complex cases • An information **booklet** with program and legal information for applicants to take home and reference as needed	The Project Re:Form website includes details on the process of redesigning Michigan's application. View the application for an example of a combined application for health care, food assistance, cash assistance, child development and care, and state emergency relief. Use the icons in the top right corner to navigate between sections relevant to each program. For further details on the process for implementing the large-scale application redesign transformation, see this article.

Eligibility Determination: Ensure staff understand how changes in eligibility across programs may impact financial stability

Families navigating multiple benefits programs are typically seeking greater opportunity and stability. However, incremental improvements in income can unintentionally cause major setbacks due to benefits cliffs. Benefits cliffs occur when increases in income are offset by the resulting reduction in or loss of benefits programs and supports. Front-line staff can help families manage these challenges by understanding and communicating how changes in income or participation in certain programs may impact eligibility for other programs. By being knowledgeable, staff can assist families in making informed decisions as they work toward financial stability.

For teams looking to take further steps to implement policy changes to mitigate benefits cliffs, consider reviewing up-to-date examples on the Benefit Cliff Resource Hub maintained by the American Public Human Services Association (APHSA).

Suggestions for getting started: Start by encouraging staff to review the tools below to help them understand how changes in income or employment can affect public benefits. It will be particularly valuable for staff to be familiar with real-life examples of how families navigated benefits cliffs. Stories such as these developed by the Economic Pathways Coalition in Massachusetts could be helpful to share with staff.

High-level implementation considerations: Programs may opt to address benefits cliffs in various ways—for example, by educating individuals and families about how they may expect their benefits to change when their income changes, or by actively mitigating the effects of benefits cliffs through policy changes. This section focuses on the former, but it is important to be aware that helping individuals and families make informed decisions about their benefits does not actually mitigate benefits cliffs themselves.

Common challenges:

- *Building an understanding of benefits cliffs must be tailored to the state or local context*, since benefits cliffs change depending on the specific eligibility criteria of the programs in each state or locality.
- *Designing an approach to communicating about benefits cliffs may not have the intended impact for families if it is not grounded in how families experience those cliffs.* Not all families experiencing benefits cliffs can plan for them and may encounter them due to a shock – those families may not be well served with benefits cliff education and planning in the short term but could help them in planning for future cliff they may face.

Tools and guides to support this approach

Resource	Navigation
The Federal Reserve Bank of Atlanta developed several benefits cliff tools—the Career Ladder Identifier and Financial Forecaster (CLIFF) tools—that can be used and adapted by state and local agencies with support from the CLIFF team. The CLIFF Snapshot supports case managers and the families they serve in **understanding how changes in income and employment may affect an individual's eligibility for various human services programs and their financial stability.** Additional CLIFF tools include the CLIFF Dashboard, which supports assessments of the long-term financial implications of a new career, and the CLIFF Planner, which supports case managers in developing career, education, and budget plans.	A demo version of the CLIFF Snapshot tool can be viewed here. Accompanying training videos teach new users about the CLIFF suite of tools. Examples of customized versions of the CLIFF tools include one developed for the Connecticut Office of Early Childhood's 2-Gen Initiative and one developed for CareerSource Florida, the state's workforce policy and investment board.

Examples from the field

Resource	Navigation
Three states—Connecticut, Florida, and Maine—piloted the Federal Reserve Bank of Atlanta's CLIFF Dashboard with staff and families who were engaged with more than one human services program and were served in career center settings. The Atlanta Fed summarizes the key findings from these studies in the CLIFF Dashboard Evaluations: Insights from Three State Pilots blog post, highlighting the **overall effectiveness of the dashboard in their long-term career planning and understanding of potential loss of public assistance**.	The blog includes links to the evaluation reports produced by each of the three states: • CLIFF Dashboard: Maine Pilot Evaluation • Final Report on the Connecticut Benefit Cliff Pilot • Evaluation of the Career Ladder Identifier and Financial Forecaster (CLIFF) Dashboard: Final Research Report

Eligibility Determination: Align and integrate eligibility determination processes

When families seek services from multiple programs that do not have aligned or integrated systems, they may have to navigate multiple reporting and documentation requirements for different eligibility determination processes. Integrating eligibility determination processes can make them less complicated and burdensome for applicants and may reduce the burden on staff working with families to gather necessary information and documents. Integrating these processes can also help families gain access to more services that will help them meet their needs.

Suggestions for getting started: Consider using this interactive tool (described below) to map out the options for integrating eligibility determination processes across your team's programs. Determine which programs can send data to other programs, which programs can use information from other programs, and through which mechanisms data sharing can be accomplished. Once you understand the landscape of possible paths to eligibility determination integration, consider which steps, described in the *Opportunities to Streamline Enrollment Across Public Benefit Programs* report (described below), might address common pain points for families and staff in your context.

High-level implementation considerations: Certain programs' eligibility determinations may be more easily linked, for example through categorical eligibility. Regulatory considerations may impact whether eligibility determinations can be fully or partially integrated across your team's programs. Your team should become familiar with individual program regulations and identify where there are flexibilities and where there may be roadblocks.

Common challenges:

- *There may be federal rules and regulations that limit the ability to use certain eligibility integration approaches for some programs,* such as regulations around who is authorized to make determinations or immigrant eligibility criteria.
- *Many of the approaches to integrated eligibility determination will involve data sharing across programs and/or agencies,* which will require technical expertise, data sharing and confidentiality agreements, and ensuring that eligibility staff have access to shared data.

Tools and guides to support this approach

Resource	Navigation
The *Opportunities to Streamline Enrollment Across Public Benefit Programs* report can help state and local governments identify **opportunities to use eligibility determinations from one program to determine eligibility for other human service programs**.	**Pages 3-9** provide information on cross-program eligibility opportunities and approaches and is followed by a series of diagrams illustrating these opportunities. The accompanying interactive diagram visually presents these links. **Appendix A** on **pages 25-26** includes a checklist of cross-program eligibility linkages organized by program. **Appendix B** on **pages 27-29** provides a list of approaches that state and local governments can use to integrate enrollment, some of which are directly related to eligibility determination.
The *State Innovations in Horizontal Integration* report describes how programs can **use electronic data matching to obtain and use data to verify information about families**. Using data matching for eligibility verifications allows programs to efficiently process redeterminations and renewals. The report includes example sources of data available to human services programs for conducting data matching. It also describes how states can **use technology to streamline document processing** for eligibility determinations. These processes allow documents received by one program to be accessed by other programs processing cases in the same household.	**Pages 18-20** include high-level discussions of how states can use electronic data matching and document imaging and management to assess eligibility for families across multiple programs.
The *Matching Data Across Benefit Programs Can Increase WIC Enrollment* and *Toolkit: Increasing WIC Coverage Through Cross-Program Data Matching and Outreach* focus on increasing WIC coverage by leveraging data from other benefits programs. They offer **strategies for data sharing, data matching, and targeted outreach across WIC and other programs**. While some of the content is specific to WIC, some content is more broadly applicable, as the toolkits introduce **key considerations for data-sharing agreements, streamlining certifications, and developing action plans to support implementation**.	**Pages 15-19** of the first resource outline key considerations when developing a data-sharing agreement between WIC and other programs. The Streamlining Certification section of the toolkit discusses simplifying WIC eligibility for households enrolled in other programs. *Planning Tool 9: Streamlining Certification* is a worksheet with action steps and guiding questions for states looking to simplify the certification processes for adjunctively eligible applicants. The worksheet can also be adapted for other programs.

Examples from the field

Resource	Navigation
The *Observations from Successfully Integrated Eligibility and Enrollment Projects* case study outlines several examples of how state and federal agencies improved eligibility determination and enrollment processes for human services programs. For example, Vermont improved their online portal in three ways: • They **added a document uploader** to enable users to easily submit documents. • They made it easier for users to create an account, log in, and reset passwords. • They developed a multi-benefit application where families could apply for multiple programs in one place. Overall, this decreased the length of the eligibility determination process by 44 percent.	The Vermont case study provides more information on the eligibility and enrollment integration effort. See the entire brief case study for more details on their approach, outcomes, and implementation process.

Renewal: Modify and align renewal periods

Your team may be able to align renewal timelines by adjusting eligibility periods across one or multiple programs, synchronizing timelines across periods, and/or adopting standard renewal periods. This can make the renewal process more convenient for families and decrease duplicative work for both families and staff.

Suggestions for getting started: Start by mapping out the renewal periods for all your team's programs. Make notes of which programs have flexibilities in their renewal periods and which programs have strict regulations about renewal timelines that cannot be changed. Then, make notes of where programs' renewal periods have similar lengths, and where their renewal periods are changeable. You may choose to adapt the renewal periods for flexible programs to align with those of programs that cannot change renewal timeframes.

High-level implementation considerations: When assessing opportunities to align renewal periods, you will need to consider that other aspects of renewal may differ from program to program, such as interview or document verification requirements. Aligning renewal periods may mean that families and staff are engaging in more of these program-specific requirements simultaneously, which could concentrate the burden over a short period of time rather than reduce it overall. This should be considered as your team works toward aligning renewals.

Common challenges:

- *Some programs have strict regulations on renewal timeframes.* Your team should carefully review individual program rules and regulations to understand where there are opportunities to align renewal periods.
- *Families may not be aware of changes to renewal periods.* It is important that your agency or program implements a strong communications campaign so that both families who are initially engaging in services and those who are currently participating are informed of how aligned renewal dates may impact any actions they need to take during renewal.

Tools and guides to support this approach

Resource	Navigation
The resource *How States Can Align Benefit Renewals Across Programs* includes **guidance for adopting 12-month eligibility periods** across human services programs to minimize the burden of frequent renewals and decrease churn. It also discusses how states can **synchronize eligibility renewal timelines across programs and align eligibility periods** to eliminate duplicative reviews.	**Pages 6-7** provide guidance for adopting 12-month eligibility periods for certain programs. **Pages 7-8** provide further guidance for synchronizing eligibility renewals of multiple programs, such as renewing one program early based on information provided for another program.

Resource	Navigation
The *Paving the Way to Simpler* guide includes guidance on how states can **lengthen renewal periods for Medicaid and CHIP**. This can help **align renewal periods across programs** and ensure **case workers' renewal workloads are spread evenly** throughout the year. Some of the approaches, such as using off-cycle renewals, may be applicable to other programs as well.	**Pages 17-18** include information on lengthening renewal periods.

Examples from the field

Resource	Navigation
The *Changing Policies to Streamline Access to Medicaid, SNAP, and Child Care Assistance* report explores how Idaho and Illinois lengthened their SNAP certification periods to 12 months. Their **streamlined processes reduced the administrative burdens of renewals for staff and families**. Families were no longer required to submit similar documentation to multiple programs repeatedly, and these changes **increased retention for eligible families while reducing administrative costs and participant burden**.	**Pages 21-23** provide more information on these states' efforts to align recertification dates across programs and the benefits of these efforts.

Renewal: Develop integrated renewal processes

Coordinating renewals across programs can be an effective way to maintain enrollment both for individuals served across multiple programs and families where multiple members of the same household are enrolled in multiple programs. It can also increase the overall efficiency of programs participating in integrated renewal processes—when renewals are easier for families and staff, programs can reduce churn and decrease errors at renewal.

Suggestions for getting started: Before your team attempts to integrate renewal processes across multiple programs, it will be important to understand program rules and regulations. Take note of specific flexibilities for some programs that will make it easier to modify processes for programs to conform with other programs that have stricter rules. It will also be helpful to map out the renewal procedures and infrastructure for each program to identify opportunities for integration.

High-level implementation considerations: There are multiple approaches to integrating renewal processes across programs. For example, programs and agencies may implement auto-renewal (also known as administrative, *ex parte*, or passive renewal) using existing data from across programs or information collected while engaging in services. Other programs and agencies may develop cross-program renewal forms and applications. Ultimately, your team will want to consider these options and choose an approach or multiple approaches that work best for your context and overall vision for coordination.

Common challenges:

- *Effective and efficient renewal streamlining may require integrated or linked data systems to decrease burdens for staff as well as families.* Integrated renewal processes will require your team to find ways to share information across program staff efficiently so staff are not overburdened and families do not need to provide information multiple times.

Tools and guides to support this approach

Resource	Navigation
The How States Can Align Benefit Renewals Across Programs report provides **guidance for several different approaches to integrating renewal processes across programs,** such as using updated information from one program for other programs' renewals, allowing families to submit renewals through different means, and limiting face-to-face interviews to reduce burden on families. It also discusses **common barriers to renewal alignment** and ways to address those barriers.	**Page 3** provides a brief overview of strategies for aligning renewals. **Pages 7-10** discuss opportunities for using a customer's renewal information from one program to inform renewals for another program. **Pages 12-16** describe other strategies for reducing burden on families during renewal periods. **Table 1 on page 4** describes common barriers to renewal alignment and potential ways to address those barriers.

Examples from the field

Resource	Navigation
Michigan's Project Re:New **redesigned the state's renewal form to integrate questions across health care, food assistance, cash assistance, and child care programs**. Their redesign effort, a partnership with Civilla, resulted in the development of: • A **core form** with questions required for all applicants • Supplemental pages with program-specific, case-specific details • Examples of documents residents may need to submit to certify their eligibility • Pre-populated information the state already had on file Throughout, the effort emphasized strong design practices to guide participants through renewal efforts. The new form increased renewal submissions, saved caseworkers' time, and decreased errors.	The design section of the case study discusses the various components of the updated renewal form that promote integration and a better user experience. The pilot section discusses how Civilla worked with staff and Michigan residents to test the integrated renewal system. The implementation section provides important information on how Michigan prepared affected groups and individuals for this process change. **Page 12** of the Going Big with Human-Centered Redesign guide also includes a description of Michigan's renewal integration effort and describes outcomes data from their pilot.
The Changing Policies to Streamline Access to Medicaid, SNAP, and Child Care Assistance report describes how Idaho and Colorado adopted automated renewal systems. In Colorado, the state health agency implemented **administrative renewals for Medicaid clients using data from their SNAP renewals**. They also developed a **redetermination form that prepopulates client information from other systems**. Idaho also implemented a **passive automated renewal system** for Medicaid based on SNAP eligibility information.	**Pages 21-23** provide details about Colorado and Idaho's automated renewal systems.

Service-Level Coordination Strategies

The following strategies focus on **Service-level Coordination**—changes to how families are directly served by program staff—that specifically involve improving **intake** processes and **referrals** across programs and coordinating and integrating **case management** across programs. The following strategies are highlighted in this section:

- **Intake and Referral** strategies involve coordinating intake and referral processes across programs. These strategies can help reduce burden on families and help program staff connect families to the services that meet their needs. They include:
  - Build a joint family needs assessment
  - Develop a referral system and procedures
  - Establish inter-program or inter-agency referral agreements
- **Case Management** strategies involve coordinating or integrating case management across multiple programs. They can allow programs to work together to improve whole-family outcomes and can reduce the burden of sharing information that otherwise falls on families. They include:
  - Use coordinated case management approaches
  - Use integrated management approaches

Coordinated Intake and Referrals: Build a joint family needs assessment

Assessing family needs is the first step of a successful referral process and ultimately successful service delivery. By integrating assessments across multiple programs, your team can work with families to determine what services they are eligible for and how your services can best meet their needs across different areas of their lives. A joint assessment will also save time for both your agency and the families you serve by reducing duplicative work on assessments.

Suggestions for getting started: In addition to reviewing current assessments across programs and any required elements for each program, your team can begin by agreeing on the purpose and goals of the assessment. Consider what the assessment is trying to determine, how the information will be used, and how burdensome or invasive the assessment is for families.

High-level implementation considerations: To best screen for referrals, joint family needs assessments must capture families' status across all the areas in which they may need support. Assessments can also be more effective by using a strengths-based approach. Even as you screen for areas where families could benefit from additional supports, allow families to highlight strengths.

Common challenges:

- Given the large number of potential areas of need, *assessments may focus too narrowly on some areas* and neglect others.
- *Assessments often center program eligibility criteria and service areas, rather than the broader needs of families,* which can fail to capture non-program-specific areas of need for families, such as family caregiving responsibilities.

Examples from the field

Resource	Navigation
The Family Development Matrix from the Orange County Shelter and Hunger Partnership and the California Department of Health and Human Services is a **benchmarking tool to be used with a general assessment of family status across ten domains**, including those relevant to employment and training and several human services programs, to support identification of areas of highest need for a family.	The matrix includes a list of domains, benchmarks articulating a family as being between "thriving" and "in crisis," and descriptions of benchmark criteria in each domain.

Resource	Navigation
The Stepping Stones to Success assessment developed for TANF programs asks respondents about their level of need across 11 "life areas" such as housing, transportation, family well-being, financial health, and employment. It also includes open-ended questions to encourage respondents to bring up other concerns with staff.	View the PDF for the full list of life areas and a scale of family status from "thriving" to "area of significant need." See also the Goal4 It! Implementation Findings report for further information on the Stepping Stones assessment and how it is integrated into the larger Goal4 It! model for case management. See **page 9** for an introduction to the assessment and **pages 21-22** for a discussion of implementation findings.
The Building Strong Client Relationships brief explores how the Garrett County Community Action Committee (GCCAC) in Maryland **developed a universal basic intake process with a two-generation approach** to streamline access to services for families. **Families were actively engaged in the development and testing** of the intake process and provided input on implementation, lessons learned, and the organization's plans for ongoing assessment and improvement of the new intake process.	**Pages 1-4** gives an overview of GCCAC's two-generation approach to service delivery and provides context for understanding their approach to intake. For a detailed discussion of the GCCAC pilot, their approach to intake, and how it is different from other intake approaches see **pages 5-8**. This section also discusses how GCCAC uses information from their intake assessment to provide appropriate services for families. **Page 6** includes a table with criteria for assessing families' statuses based on several categories. **Pages 9-12** discuss lessons for improving intake processes.

Coordinated Intake and Referrals: Develop a referral system and procedures

Effective, well-documented referral procedures that align with program resources and workflows can support program staff in making important connections to other services that families may not have known were available to them.

Suggestions for getting started: Your team should start by documenting current referral processes and reflecting on successes and pain points for families. From there, you can gather recommendations for areas for improvement from staff who are responsible for sending and receiving referrals.

High-level implementation considerations: Effective referrals must be appropriate and of interest to families. Furthermore, the services they are referred to must be available. Referral procedures can include proactive supports to connect families with other services. For example, with in-person "warm handoffs," staff walk families to a nearby office or directly to a staff member for another program they are being referred to. Similarly, with "virtual handoffs," staff actively make introductions by email or phone.

Common challenges:

- *Case management and other data systems that store information necessary for more streamlined referrals may be incompatible or dated.* In these situations, your team may need to develop workarounds or more burdensome manual connections to properly coordinate and communicate about referrals and may ultimately require investments in compatible or shared referral software systems.

Tools and guides to support this approach

Resource	Navigation
The Referral to Community Partners Toolkit provides basic information to help build a referrals system including **guidance for getting started, establishing a referral process, determining how referrals will be initiated, using referral forms, documenting referrals, and continuing to build your referral system**.	**Pages 2-3** contain guidance on establishing referral processes. See example referral forms on **pages 3-6** and example electronic self-referrals on **page 7**.

Resource	Navigation
The Assessment and Mapping of Community Connections in Home Visiting report includes a **proposed prototype for a tool to support service providers in better understanding the various community connections that they may refer families to.** This may be a helpful model for designing referral resources and processes. The resource also includes lessons learned and discussions of referrals in the context of home visiting that may be helpful for your team's referrals system.	The proposed tool is described on **pages 26-44**, including screenshots of a prototype and text descriptions of features and functions. **Pages 51-52** include reflections and lessons learned by the research team about improving referral processes. **Appendix B on pages 60-71** includes stories from service providers, what they would like to see in a referral system, and how these ideas may have been addressed by the new referral tool.

Examples from the field

Resource	Navigation
The Findings from the Understanding the Value of Centralized Services Study report describes how Blackfeet Manpower identifies **client's needs and documents them in a self-sufficiency plan that drives the approach for conducting referrals**. This example also discusses **shared eligibility assessment processes and ongoing cross-training** to support the success of their referral model.	See **pages 25-26** for a brief description of Blackfeet Manpower One-Stop Center's referral processes and how it is based off their eligibility, intake, and case-planning processes.
The New Mexico Legislative Finance Committee's Improving New Mexico's Workforce Participation report, which presents an evaluation of the state's labor force participation rate and programs that contribute to it, discusses the **role of connections between partners that contribute to improved work outcomes**, such as TANF, SNAP, child support, and WIOA and other employment programs. The report provides **recommendations for strengthening referrals in conjunction with other cross-program alignment and efficiency efforts, such as co-location**. The recommendations also discuss **the implementation of an aligned case management system and cross-agency closed-loop referral system.**	**Page 18** includes a description of a "network approach" to providing referrals, which can be particularly useful in rural communities. **Pages 23-29** include a discussion of some of the challenges to streamlining New Mexico's Workforce Solutions Department's referral system and recommendations for improving the system. **Page 29** also includes a list of specific recommendations for action by different departments and partners involved in the state's workforce system.

Resource	Navigation
North Carolina launched NCCARE360, a **closed-loop referral system for health care providers, community-based service providers, and social services agencies** across the state. The Building Connections for a Healthier North Carolina case study highlights the build-out of the system, including the role of the state's 211 system in supporting implementation. Additional learnings from implementation of NCCARE360, including **opportunities, challenges, and recommendations at the client, provider, organization, and policy levels** can be found in a separate implementation report.	**Page 3** of the case study includes a description of the components of the NCCARE360 system. Table 2 in the implementation report details the opportunities, challenges, and recommendations for implementing the new comprehensive referral system. The implementation report also includes a discussion of client-level, provider-level, and organization-level considerations for adopting NCCARE360 on **pages 137-139** of the PDF version of the report.

Coordinated Intake and Referrals: Establish inter-program or inter-agency referral agreements

Clearly articulated inter-program referral agreements or memoranda of understanding can support commitment across partners to the referral process you have established. This approach allows participating programs to have a shared understanding of and formally agree to a referral process, who is involved, the general responsibilities of each partner, and expectations for confidentiality and client safety.

Suggestions for getting started: There are a lot of existing resources you can rely on to develop inter-agency referral agreements. Start by reviewing some of the templates and examples below and modify them as needed.

High-level implementation considerations: Effective referral agreements outline the responsibilities of different staff, whom those staff should communicate with at other organizations, how they should communicate, and what information should be shared as part of the referral. Consider what information your teams need to include for a successful referral, such as names, roles, or context information for key staff; what technology will be used; and any commitments by partners to report on the outcomes of a referral. Your team may also want to include detailed referral procedures in your agreements.

Common challenges:

- *Some programs may have historically avoided sharing information that could improve the effectiveness of referrals due to concerns about confidentiality and security.* Effective referral agreements should outline how programs will protect sensitive and confidential information in referrals, including monitoring personally identifiable information, not sharing highly sensitive or confidential details, and setting up safeguards to avoid security breaches

Examples from the field

Resource	Navigation
This Memorandum of Understanding for Referrals template from the Reproductive Health National Training Center can be adapted for human services programs.	The example is in an editable format that you can adapt for your team's context.
The Guide for Data Sharing Between the Arizona Head Start Association Program Members and the Arizona WIC Program includes a **memorandum of understanding (MOU) that removes the need for a release of information when sharing data for referrals.** The sample MOU includes language on referrals that may be useful to adapt for your own agreement.	See **Attachment A** from **pages 12-33** for the example MOU between the Arizona Department of Health Services; the WIC program; and Arizona Head Start Association Program Members.

Case management: Use coordinated case management approaches

Coordinated case management approaches involve deeper communication among case managers from various programs serving the same families. This approach to case management can reduce the burden on families who would otherwise be responsible for sharing information across programs. It also provides opportunities for case managers to work together to problem-solve and improve the responsiveness of services to family needs and increases efficiency of service delivery. These approaches are best implemented with clearly defined expectations and processes for coordinating and a shared vision for serving clients.

The two coordinated case approaches described in this strategy—case conferencing and team-based case management—involve case managers across teams meeting regularly to share information and identify opportunities to better support families across multiple programs. Team-based case management refers to the overall collaborative approach to case management, and case conferencing refers to the meetings in which this collaborative work take place.

Suggestions for getting started: Before choosing an approach to case coordination, consider the challenges that families face due to siloed case management practices and what the goals are for your team's new approach. You will also want to ensure that all members of your coordination team have a good understanding of the services provided by coordinating programs and any requirements or constraints related to case management. Make sure to include the staff who work directly with families throughout the process of designing and adopting a new case management approach. They will have a firsthand understanding of how this will impact them and the families they serve.

High-level implementation considerations: To better coordinate cases across programs, your team may need to change other established practices and processes — especially those related to data sharing, communication, service philosophy and approach, and service location.

Common challenges:

- Implementing a coordinated case management approach is difficult *when coordinating programs do not already have other whole-family approaches or a holistic service culture in place.* Moving to a coordinated case management approach may require culture shifts within participating programs to move toward more family-centered service delivery approaches.

Tools and guides to support this approach

Resource	Navigation
The Come Together: Using Team-Based Case Management in SNAP E&T brief provides an overview of a **team-based case management approach** and a **checklist for implementing a team-based approach** to case management. The brief also includes several case examples, focused on SNAP E&T, and resources with **additional information on team-based case management across different program contexts**.	A description of the activities involved in a team-based case management model and a checklist for implementing the model can be found on **pages 3 and 4**. Detailed case examples of the model being implemented in Kentucky, Vermont, and Washington are on **pages 5-7**.
An Overview of Case Conferencing from the Support Services for Veteran Families Program provides **guidance on logistics for planning for and hosting a case conference**, including identifying meeting attendees, meeting format and frequency, items to address in case conference meetings, and a high-level facilitation guide. This resource focuses on coordinating services for veterans experiencing homelessness, but the elements of this guide can be easily adapted for a different service or population focus.	**Page 1** includes a brief list of the primary goals for case conferencing followed by detailed guidance on logistics for organizing case conferencing.
The New York City Department of Youth and Community Development website provides a **three-step framework for implementing case conferencing**, an approach that prepares managers and other service providers to meet to address problems faced by individuals they are serving in intentionally structured meetings. This includes a set-up phase, information-gathering phase, and problem-solving and action planning phase.	An example case conferencing form, which is meant to be used in preparation for and during case conferencing meetings, is also available on this website.

Case management: Use integrated case management approaches

Integrated case management approaches involve combining systems and staff responsibilities across programs. Examples include: using a single case plan or case record to centralize documentation of family goals and service delivery; employing a case coordinator whose responsibility is to support families as they navigate services across programs; and setting up fully integrated case management, where families are working with a single case manager across multiple programs.

Suggestions for getting started: Integrating case plans and services can be a major shift for both staff and the families you serve. Your team should consider starting the process by hosting human-centered redesign events with staff and families to develop a comprehensive picture of the goals for integrating case management. This process will help your team identify who may be impacted and the larger organizational changes and investments that may be necessary for integration.

High-level implementation considerations: Fully integrating case management planning and tracking from multiple programs requires strong partnerships across agencies and programs, data sharing capabilities, and a well-defined case-management approach. Successful integration also requires clear procedures and buy-in at all levels. Case coordinators will need at least basic knowledge of each of the programs involved in joint case plan development.

Common challenges:

- *Case managers and coaches will need to navigate rules and regulations from multiple programs simultaneously.* Some of these rules may be inconsistent or even conflicting across programs, requiring additional guidance for staff.
- *Integrated case management systems across programs and agencies can introduce changes related to data sharing and management.* Your team may need to implement new processes related to customer consent for data sharing, developing data sharing agreements, and establishing robust data security measures.
- *Funding of integrated case management approaches may require navigating what is allowable across participating programs' funding sources*, which could result in the need for complicated braiding of funding for service delivery.

Tools and guides to support this approach

Resource	Navigation
The National Wraparound Initiative provides a wide range of resources that state and local government agencies can use to understand and implement **wraparound services**.	The Wraparound Implementations Guide: A Handbook for Administrators tool is a manual for administrators looking to implement a wraparound service approach.. The Wraparound Implementation and Practice Quality Standards synthesizes resources on wraparound services to provide standards for implementation including best practices for the role of a "**care coordinator**."

Examples from the field

Resource	Navigation
The State Innovations in Horizontal Integration report details how Vermont's Agency of Human Services restructured its business processes and service delivery to adopt an **integrated case management approach**. The agency oversees health, nutrition assistance, child care, housing, and a range of other human services programs. With their new approach, Vermont aimed to transition from a service provision designed around funding streams to one that is designed around the customer achieving better outcomes. Through this model, **individual households had a central case with one case manager responsible for maintaining and coordinating services across programs**.	**Pages 22-23** include a brief description of Vermont's integrated case management model and how it supports their customer-centered approach to service delivery.
The One-Stop Partnership Case Study on Anoka County's Job Training Center in Minnesota describes how the center used case management to integrate WIOA, TANF, and SNAP administration and delivery. While different programs have different case managers, e**ach client had a "system navigator" serving as the main point of contact for navigating multiple programs, receiving referrals, understanding policies and procedures, and coordinating across case managers across the three programs**.	**Pages 3-4** of the case study include a description of Anoka County's "system navigator" role. **Pages 4-5** discuss how having a shared data system across programs is integral to the "system navigator" working with families receiving multiple services.

Resource	Navigation
The One-Stop Partnership Case Study on Spokane, Washington describes how Washington uniquely situated **integrated case management** into their American Job Center's co-location effort. In their model, **each client moves through a sequence of services, regardless of the programs they are enrolled in, and are guided by coaches at each stage to complete triage and assessment, build an individualized plan, and if necessary, receive intensive and continuous coaching**. This model differs from their previous approach where coaching was based on the specific program that a client was enrolled in.	**Pages 3-4** include an explanation of Spokane's integrated coaching model.
The Montgomery County, MD's Electronic Integrated Case Management System case study describes the county's project to create a **case management data warehouse** across more than 70 human services programs. The new system was designed to **provide staff with complete real-time and historical information about each client**, the services they are interested in receiving, and those they previously received. This case example discusses the motivation, challenges, and lessons learned, as well as more technical details on scoping, system access controls, and privacy practices to consider.	**Pages vi and vii** in the executive summary outline recommendations for planning for and implementing a successful case management data system integration effort, including organizational culture shifts for staff from serving "my" client to serving "our" client across the agency.

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