Systems Navigation

"Working together to create effective referral pathways"

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05/03/2023

Who We Are

Partners in helping our Neighbors Thrive

WHO WE ARE

- United Way and 211 are trusted community partners.
- Understanding the intersection between social service/nonprofits, health care, and government services is our core competency.
- Connected to the social service ecosystem needed to address individual/family needs.

WHAT WE HAVE

- Vital resources available 24/7 through 211, accessed by millions each year.
- Connections with national, state and community partners within the SDOH sphere. Statewide database of more than 30,000 services.
- 211 staff members are highly trained and follow national standards.
- We foster and maintain robust partner networks, with a national network that is hyperlocal.

2·1·1 Get Connected. Get Help.™

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211 Wisconsin at a Glance

2022 Summary

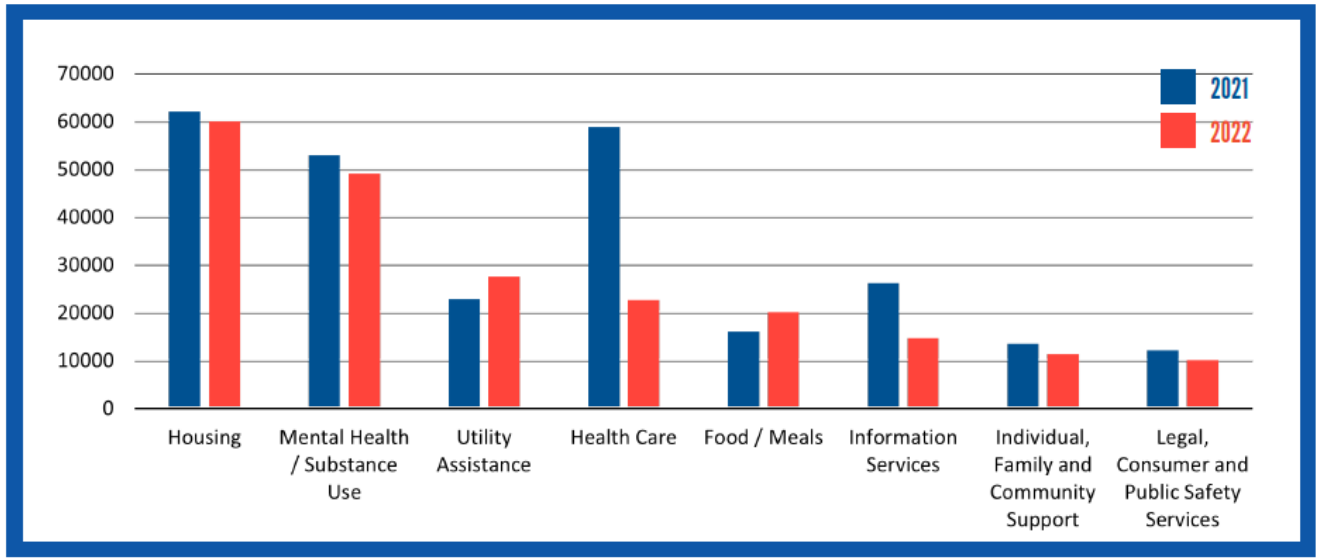
Minutes Serving Clients
1,705,133

362,166
Total Contacts

410,000
Total Referrals

Total Website Searches
260,920

Requests by Category - 2021 vs. 2022



211 Wisconsin at a Glance

Top Requests by Category - 2022

Housing	Mental Health / Substance Use	Utility Assistance	Health Care
59,964	49,049	27,544	22,701

Food / Meals	Information Services	Individual, Family, and Community Supports	Legal, Consumer, and Public Safety
20,116	17,676	11,387	10,129

TOP 10 WEB SEARCHES

1.) COVID-19 Immunization Clinics
2.) COVID-19 Vaccine Information
3.) Food Pantries
4.) Rental Payment Assistance
5.) COVID-19 Diagnostic Tests
6.) Low-Income / Subsidized Rental Assistance
7.) Rental Deposit Assistance
8.) Water Service Payment Assistance
9.) Automotive Repair and Maintenance
10.) Electric Service Payment Assistance

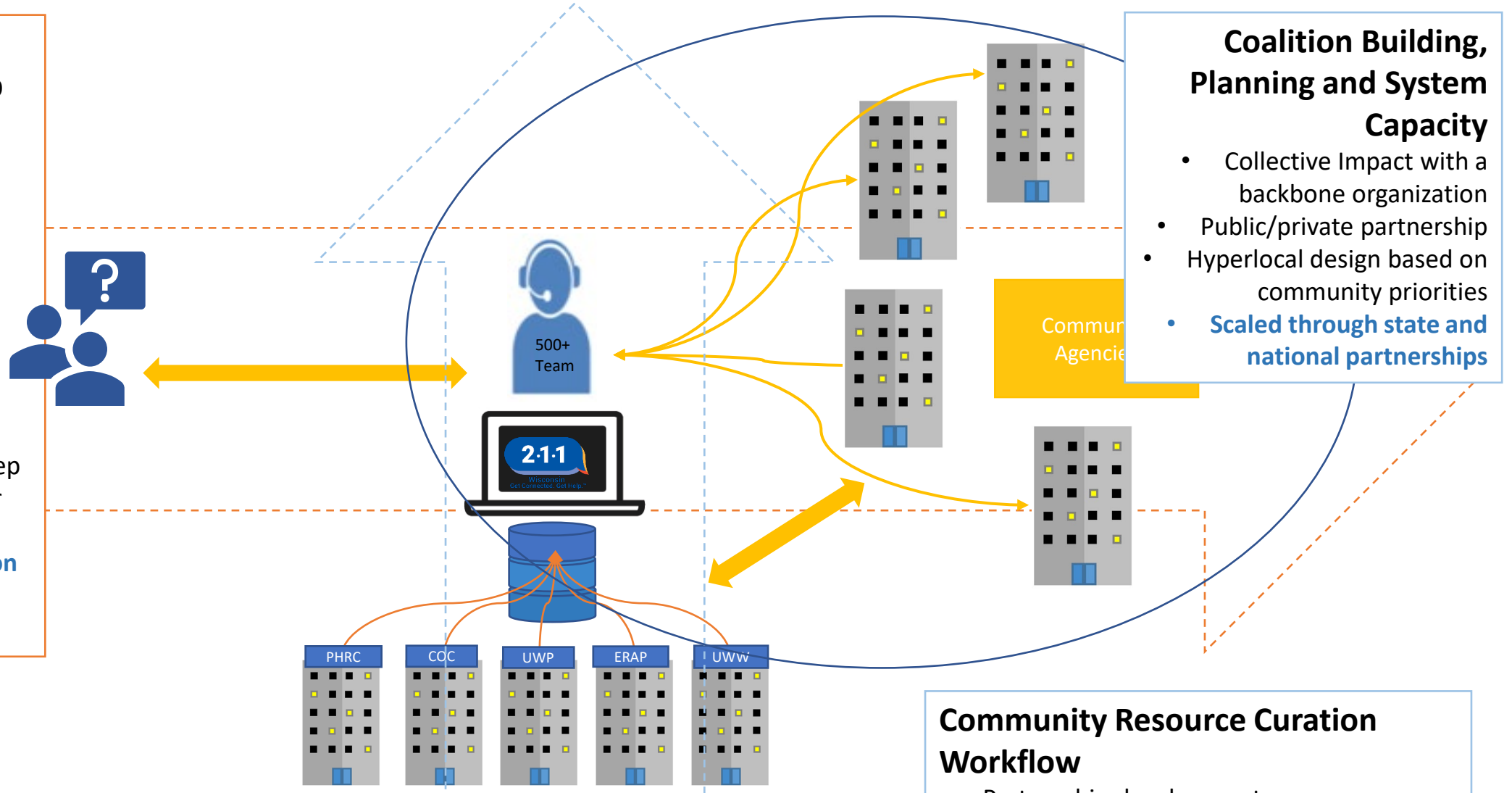
Available 24/7/365

CHAT on 211Wisconsin.org	TEXT your zipcode to 898211	SEARCH on 211Wisconsin.org	CALL 211 or (877) 947-2211

How We Work

Assessment, Referral, Follow-up (closed-loop) Workflow

- AIRs standards
- Assessment of presenting need, secondary and root needs.
- Brief Intervention
- Referral or Warm Transfer
- Assurance of next step
- Follow-up with caller or agencies
- **Local Implementation and cross-market scaling**



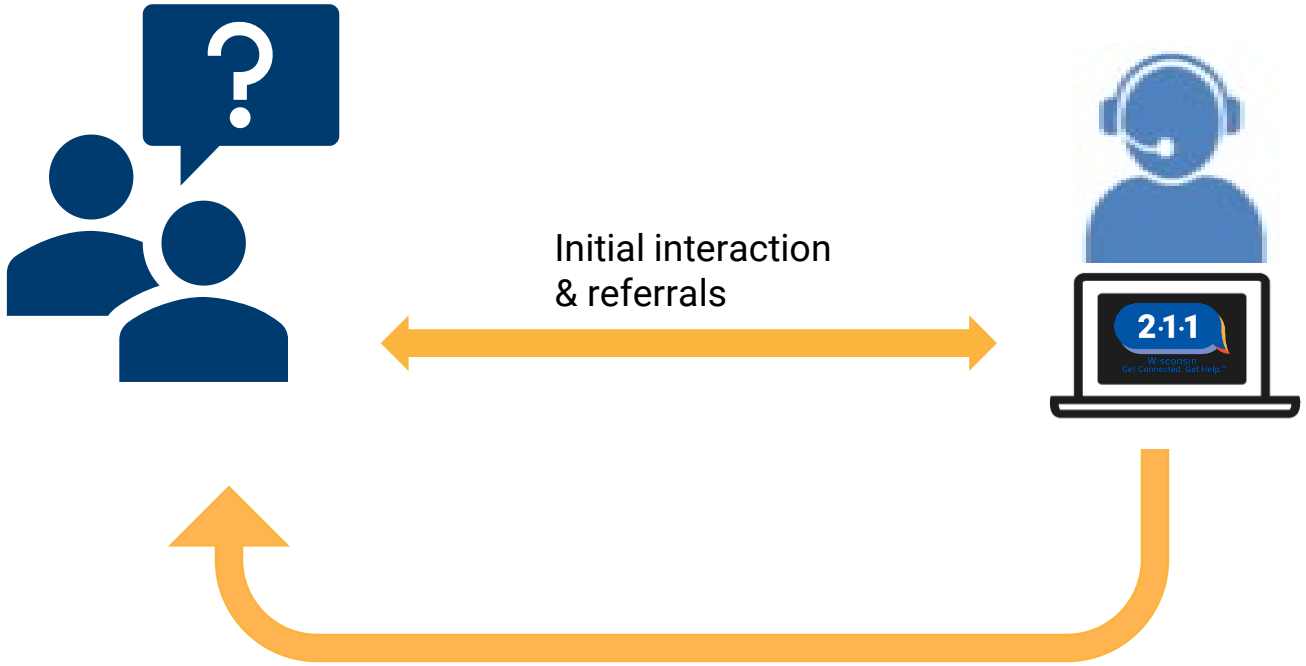
Coalition Building, Planning and System Capacity

- Collective Impact with a backbone organization
- Public/private partnership
- Hyperlocal design based on community priorities
- **Scaled through state and national partnerships**

Community Resource Curation Workflow

- Partnership development
- Agency, Site, and Service identification
- Data coding
- Verification and regular updates
- AIRs standards
- **National Database Platform today**

211 Wisconsin Follows Up with Patients



Follow up:

- Previous Referrals & Services reached/received
- Additional referrals as needed
- Assistance in overcoming barriers to reaching services
- Offer additional follow up as needed

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Public Health Region

All values (5)

Western | Southeastern | Southern | Northern | Northeastern

Call Center Site

All values (11)

Brown County | Great Rivers | Impact | Marathon | Center Not Recorded | Fox Cities | Dane County | Inner Wisconsin | St. Croix | Frontline | Statewide

Public Health Domains

All values (9)

Other | Housing | Hunger | Mental Health | Transportation | Income/Jobs | Health Care | Education | Substance Use

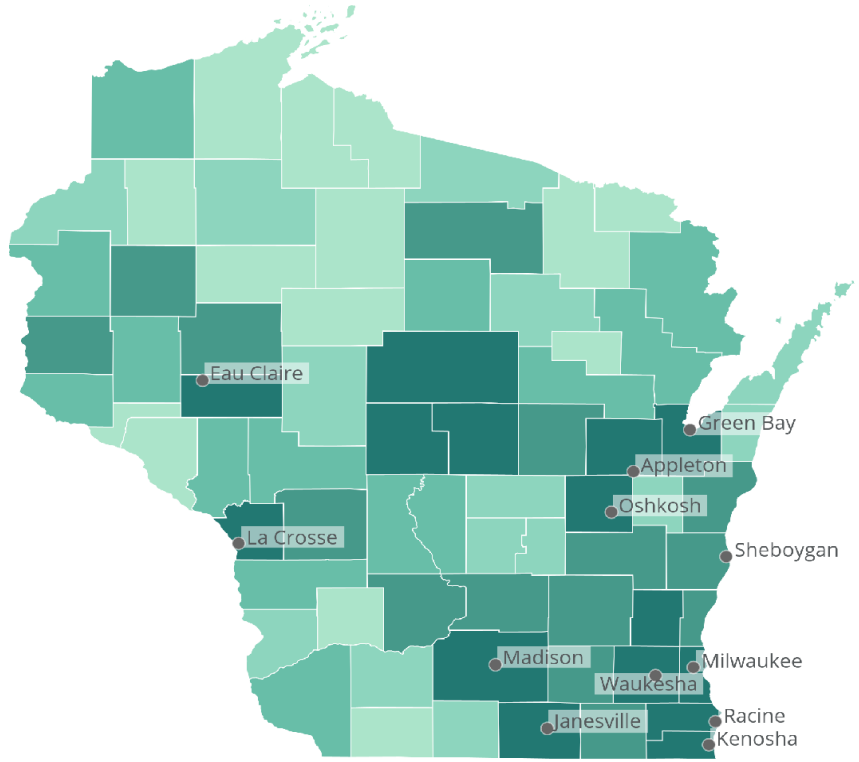
211 Problem/Needs

All values (21)

Other | Utility Assistance | Information Services | Food/Meals | Clothing/Personal/Household Needs | Mental Health / Substance Use | Arts, Culture and Recreation

Interactions by County

1M Distinct Interactions



Total

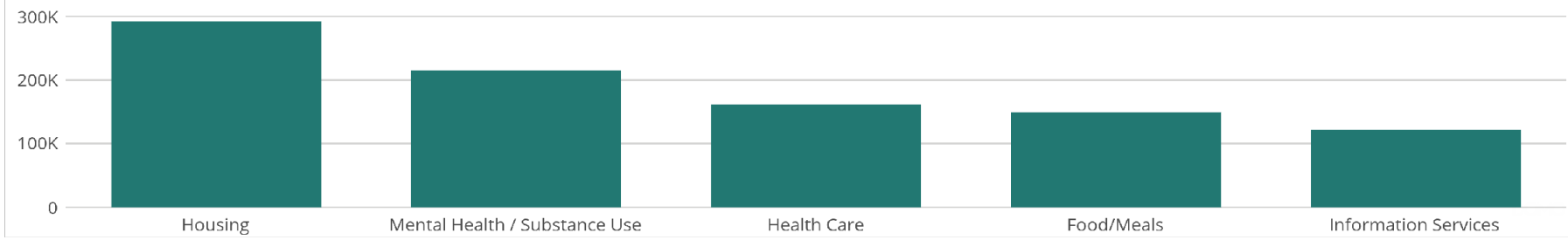
1,271,615

660,136
10,263
2,819
1,591
837
138

Unmapped Data

Top 5 Problem/Needs by Interactions

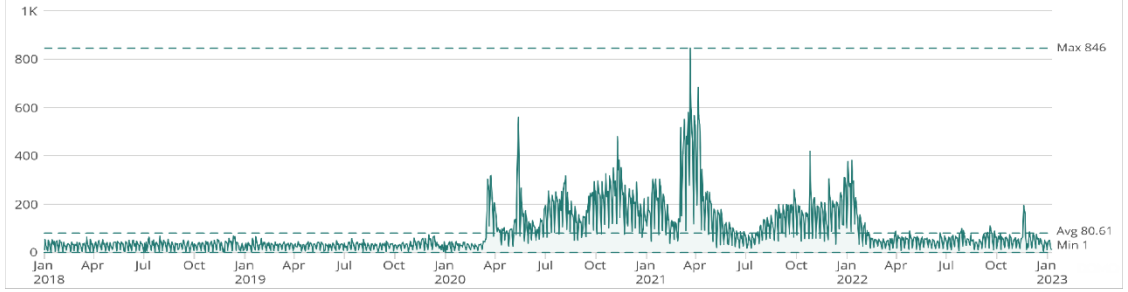
2M Distinct Referrals



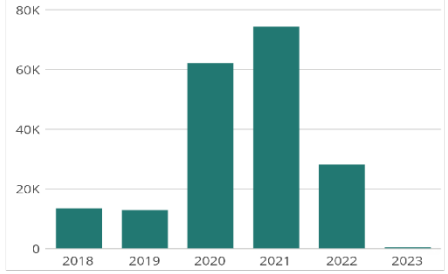
Access to Health & Clinical Care

The below graphs focus on trends related to access to health & clinical care.
Please note: certain filters exclude the referral data the graphs below use and may cause these graphs to display no values.

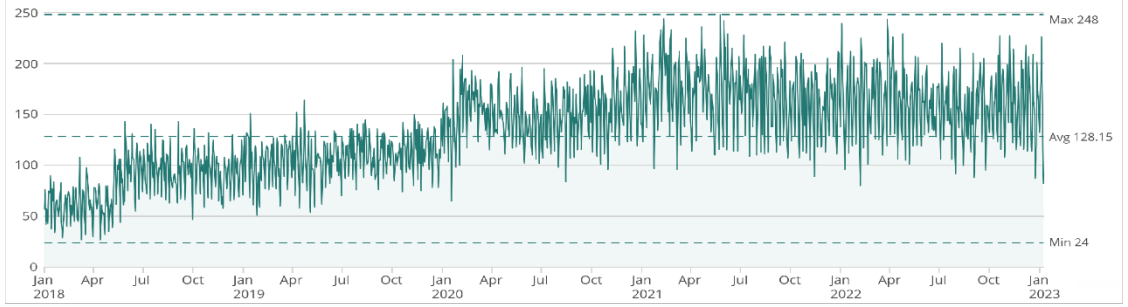
Health Care Referral Trend
191K Distinct Referrals



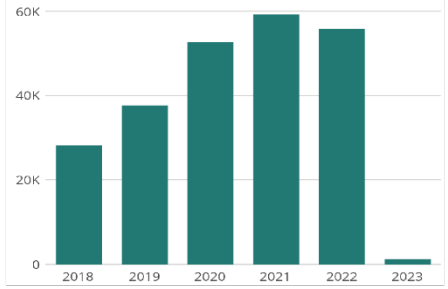
Health Care Referrals by Year
by Year
191K Distinct Referrals



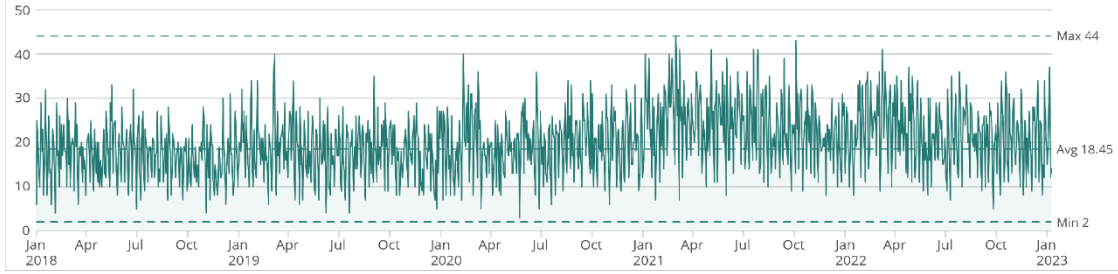
Mental Health Referral Trend
235K Distinct Referrals



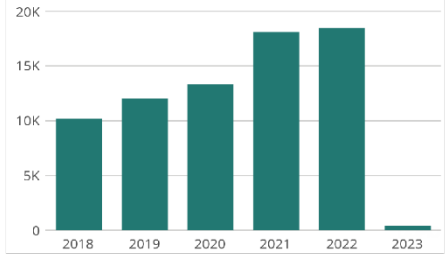
Mental Health Referrals by Year
by Year
235K Distinct Referrals



Substance Use Referral Trend
73K Distinct Referrals



Substance Use Referrals by Year
by Year
73K Distinct Referrals

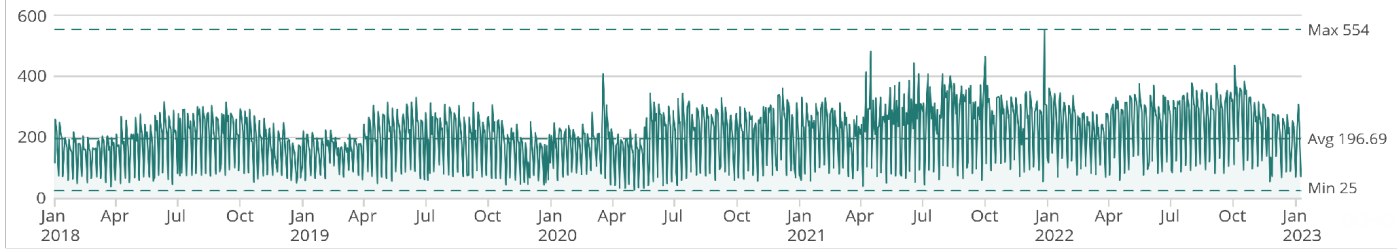


Access to Social Determinant of Health (SDOH) Care

The below graphs focus on trends related to social determinants of health and access to care for these determinants.
Please note: certain filters exclude the referral data the graphs below use and may cause these graphs to display no values.

Housing Referral Trend

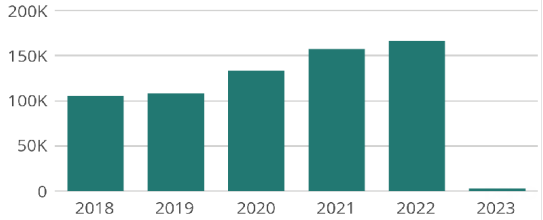
674K Distinct Referrals



Housing Referrals by Year

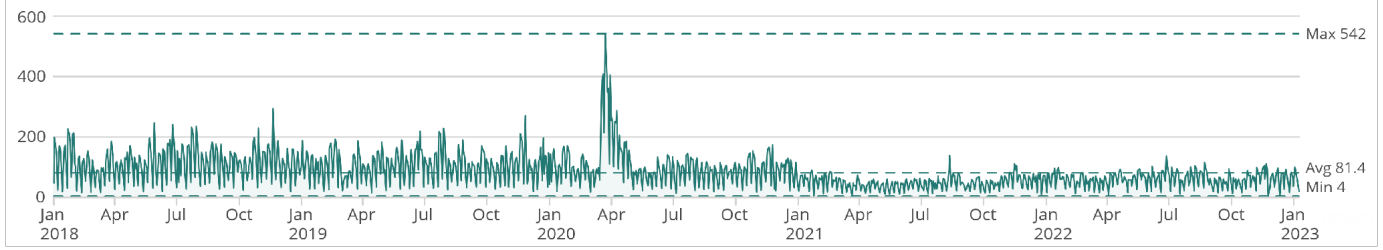
by Year

674K Distinct Referrals



Hunger Referral Trend

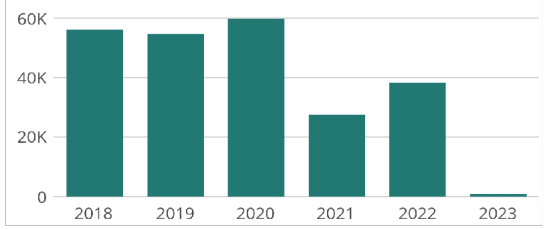
238K Distinct Referrals



Hunger Referrals by Year

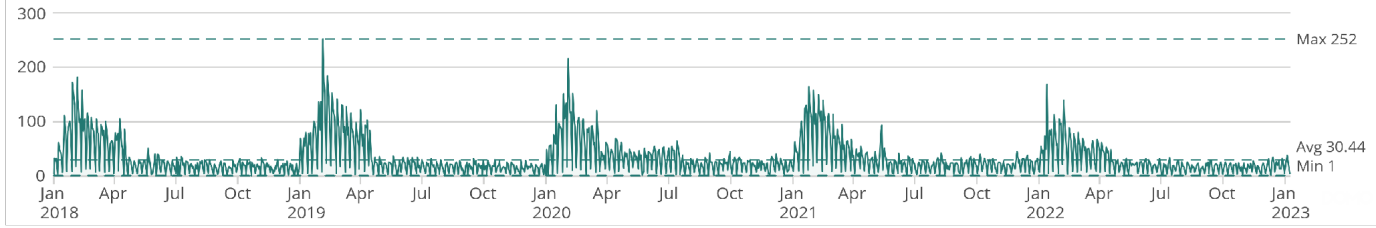
by Year

238K Distinct Referrals



Income & Jobs Referral Trend

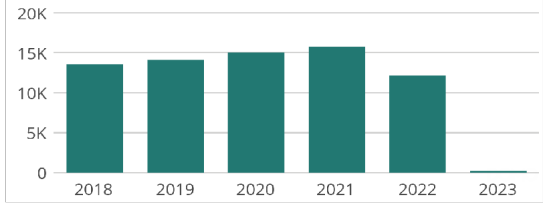
71K Distinct Referrals



Income & Jobs Referrals by Year

by Year

71K Distinct Referrals



Transportation Referral Trend

37K Distinct Referrals

Transportation Referrals by Year

by Year

37K Distinct Referrals

Results and Persisting Barriers

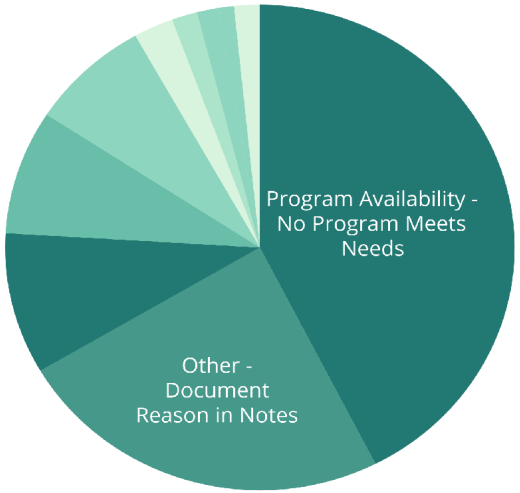
Community members can experience many barriers that limit their access to resources around them. 211 Information and Referral Specialists seek to identify and record specific unmet needs as well as the barrier that prevented the need from being met. Each unmet need is directly correlated to a problem need. *Users are encouraged to explore problem need specific unmet needs by using the filters at the top of the page.*

To further support the unmet needs data and continue to identify barriers that clients encounter, 211 offers a follow up call to those who receive referrals on our network. These follow up calls identify any previously unrecorded unmet needs as well as unforeseen barriers in contacting an organization and receiving service.

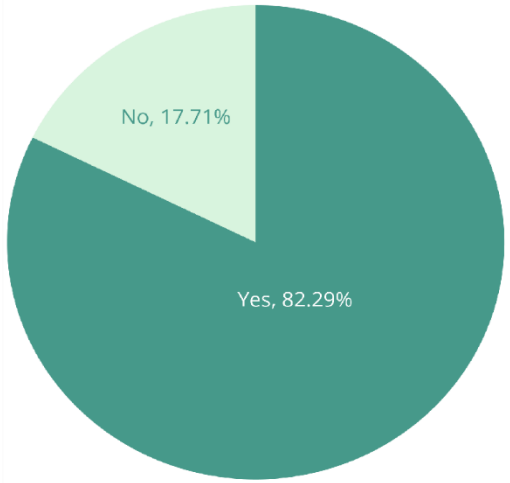
Unmet Needs

87K Distinct Interactions with Unmet Needs

Program Availability - No Program M...	38,998
Other - Document Reason in Notes	22,045
Program Availability - Program Not Ac...	8,642
Caller Refused Referral - Document R...	7,591
Ineligible - Already Served	3,780
Ineligible - Does Not Fit Program Crite...	3,242
Service Delivery - Delay in Service	2,324
Funding - Program Out of Funds	1,492
Ineligible - Household Structure Does ...	1,261
Transportation	892
Other	1,490



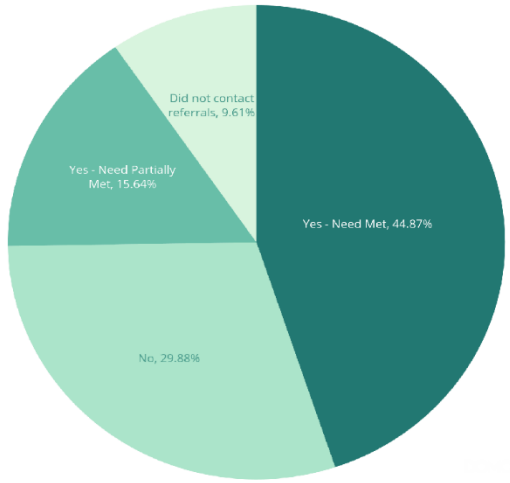
Did you contact the referrals given to you by 211?



Yes,	10,025
No,	2,158

Was one of your referrals able to help?

Yes - Need Met,	5,226
No,	3,480
Yes - Need Partially Met,	1,822
Did not contact referrals,	1,119



The Goal of Systems Change

Landscape of Data System Design: System Types

Each system's approach is differentiated by how it centers the community.

Every system or intervention has the ability to produce harm, but **the response to the harm is what creates the lasting effect on the individual and the community.**

Predatory
Profits from Oppressed

Passive
Ignores the Oppressed

Savior-Designed
Stigmatizes the Oppressed

Ally-Designed
Listens to Feedback to Support Institutional Goals and Objectives

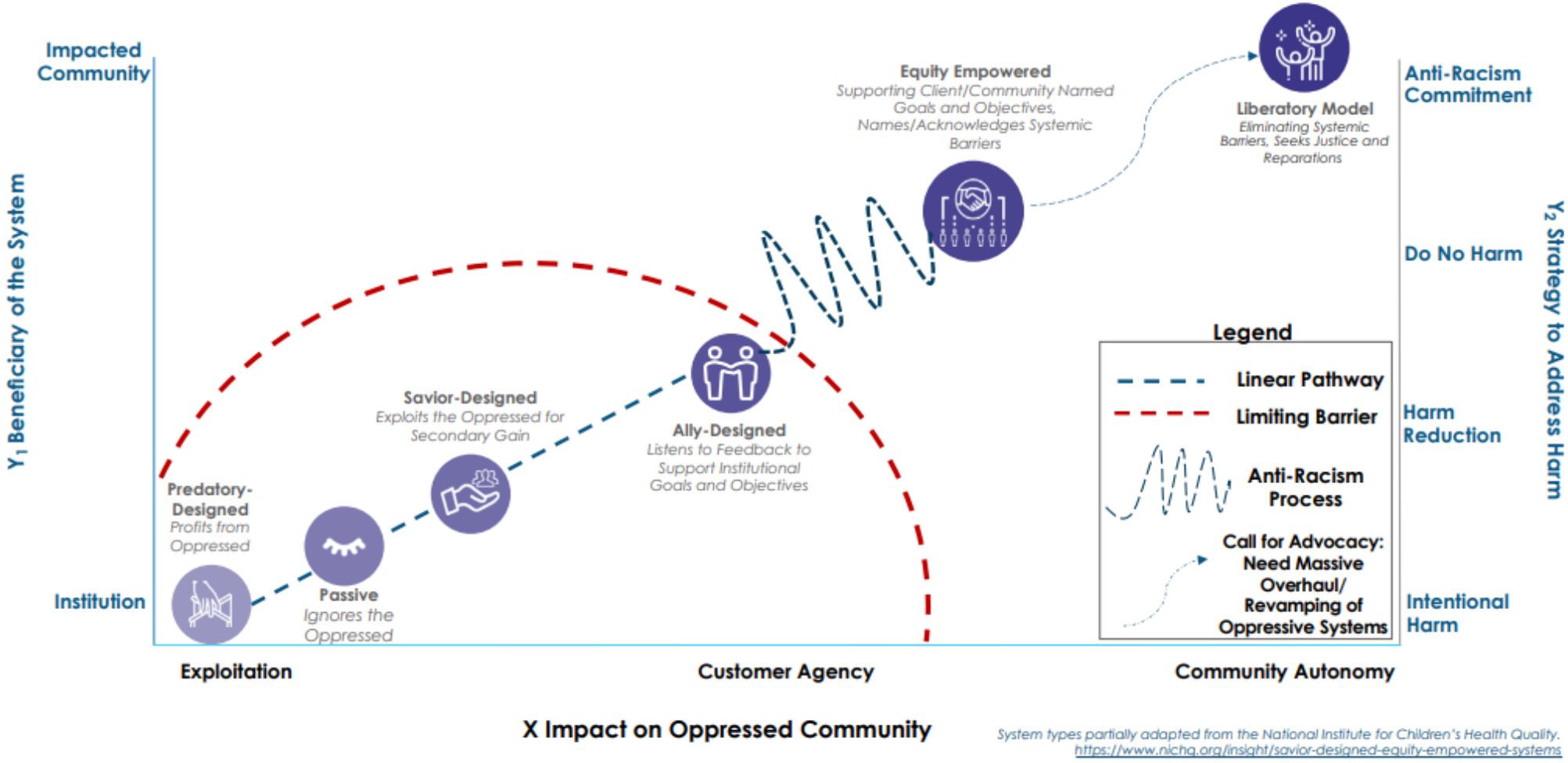
Equity-Empowered
Provides Agency and Aims to Eradicate Systematic Barriers

Liberatory Model
Seeks Restorative Justice and Reparations

System types partially adapted from the National Institute for Children's Health Quality.
https://www.nichq.org/insight/savior-designed-equity-empowered-systems

Landscape of System Design: Institutional Reflection

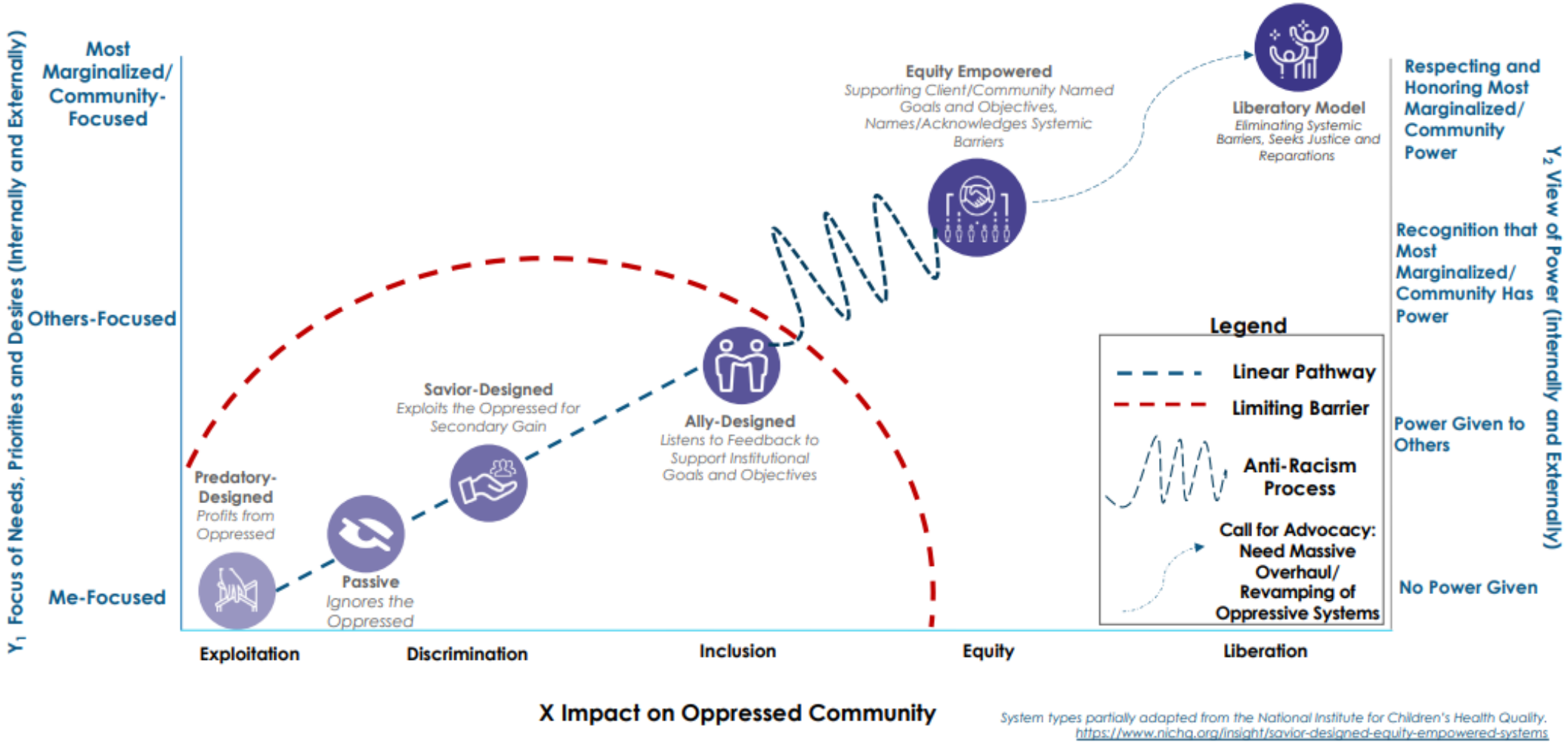
Figure 1



System types partially adapted from the National Institute for Children's Health Quality.
https://www.nichq.org/insight/savior-designed-equity-empowered-systems

Landscape of System Design: Individual Reflection

Figure 2



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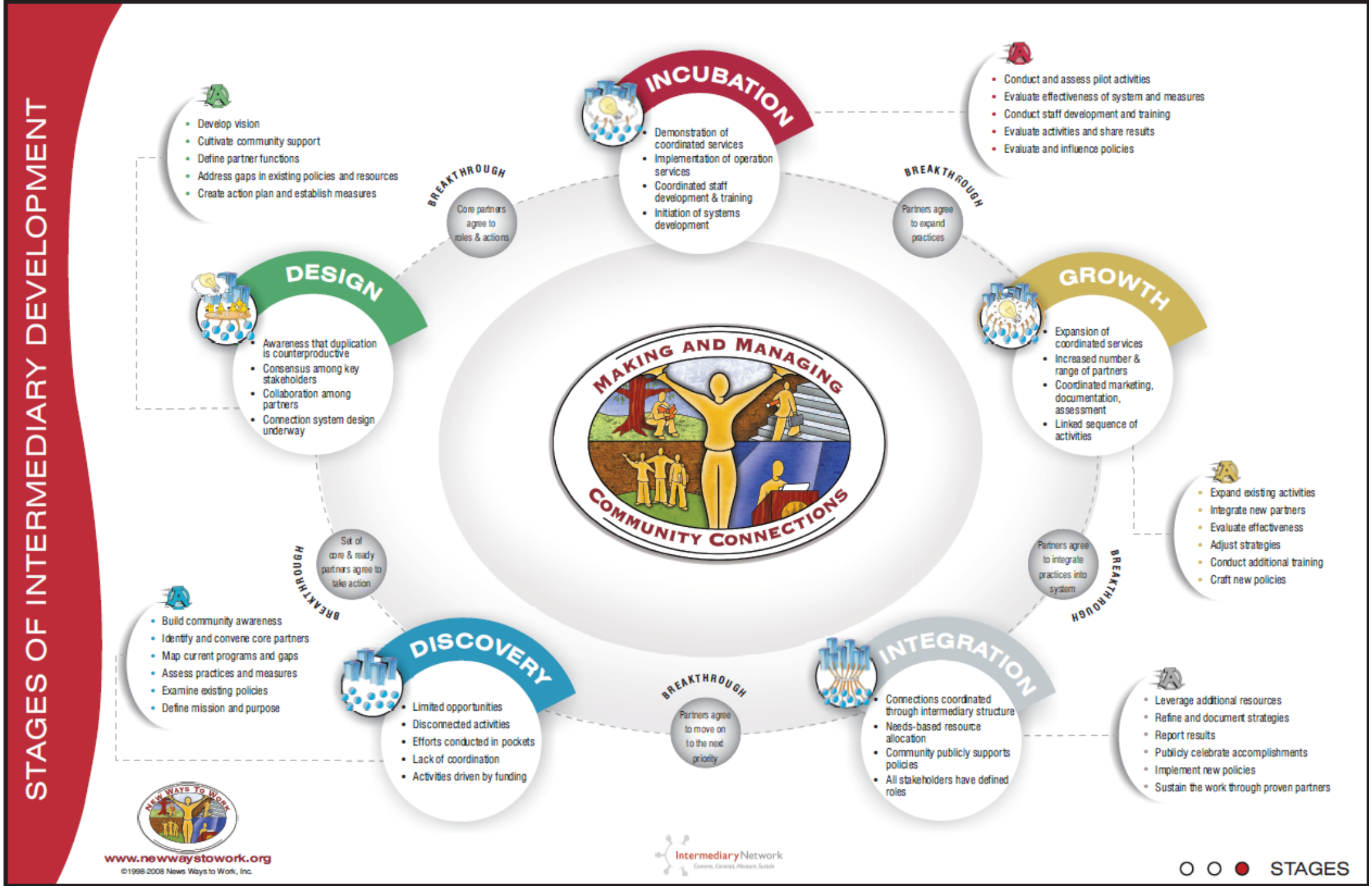
STAGES OF INTERMEDIARY DEVELOPMENT



www.newwaystowork.org

Intermediary Network

○ ○ ● STAGES

Influences on Creating Effective Referral Pathways

In your experience… What influences effective referral pathways for your clients?

In your experience… What challenges do you face when external partners ask you to partner?

Common Themes

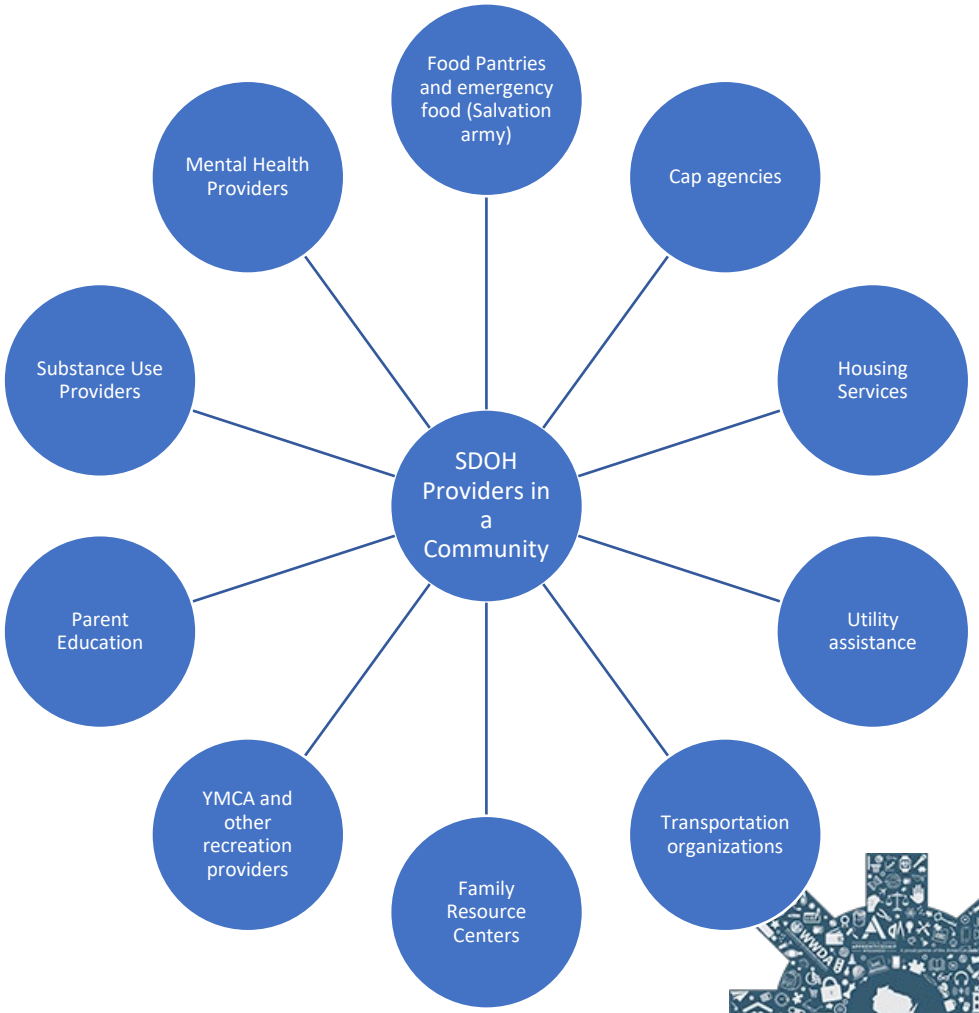
- Client data is kept in a separate funder/regulatory driven platform which leaves the referral platform a secondary tool that often requires duplicate entry.
- Over-simplification of the referral process (housing, food and mental health)
- Assumption that referral and navigation is intuitive
- Client outcome data isn't easily collected through electronic means with a provider; more success through client/patient follow-up
- Technology is driving conversations especially the idea of a centralized tool.
  - Infrastructure decisions – centralized, decentralized, federated
  - Pros and cons of each; open access is key (think airports)
- Structured professionally curated resource data (org, location, services)
  - Aggregators of data are called information & referral (211, ADRC, CCRR, Crisis)
  - Trend to assume agencies will maintain their own record. Data doesn't support it works or is accurate.
  - Simplification of taxonomy
- Unrealistic expectations of service providers and consideration of impact
  - Low participation and adoption
  - Concern over who can see data
  - Low incentives to participate

What other systems are seeking referral partnerships as a mandate or best practice?

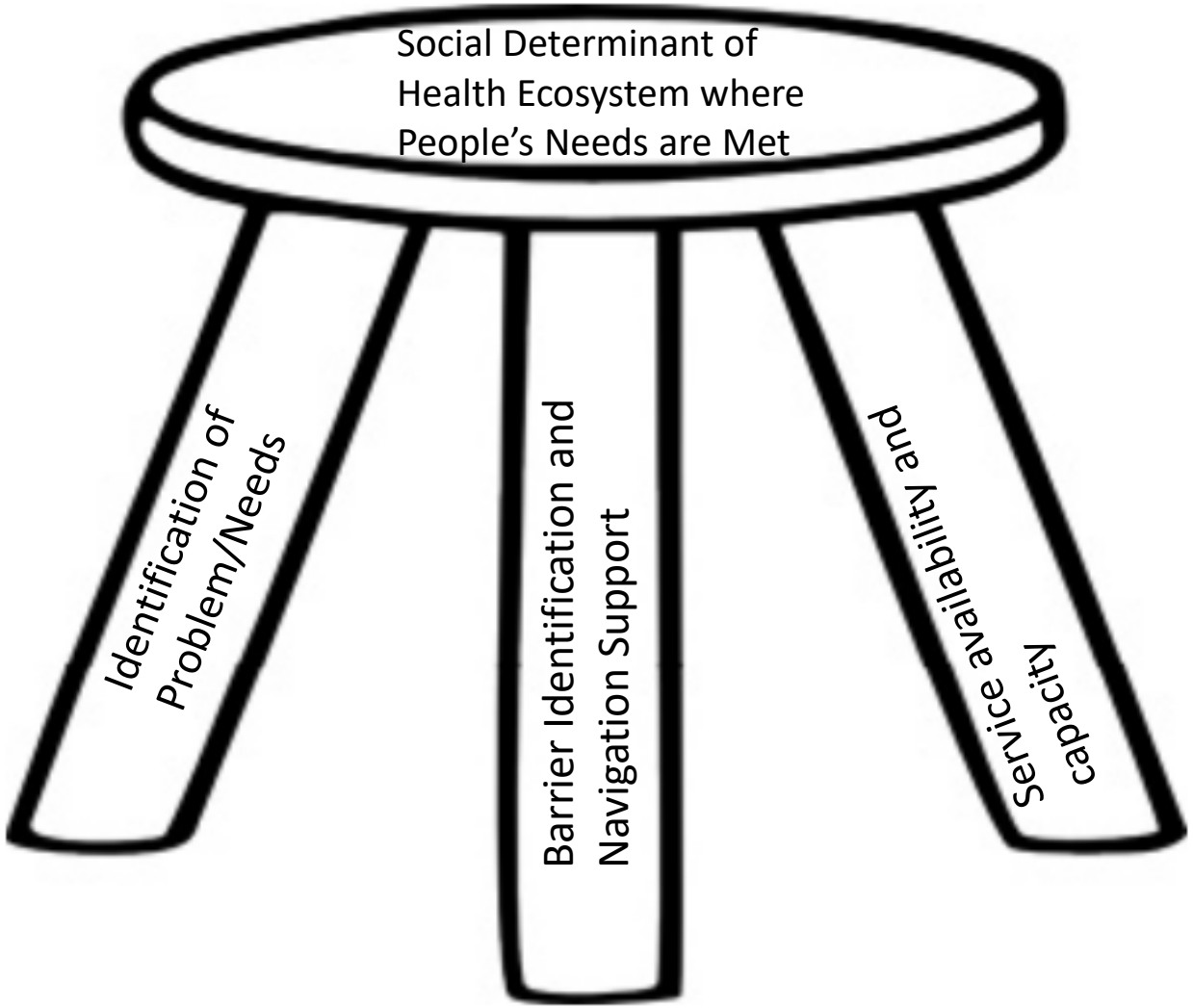
Current SDOH Landscape

Funding Sources with mandates to address SDOH (aka wrap around services)

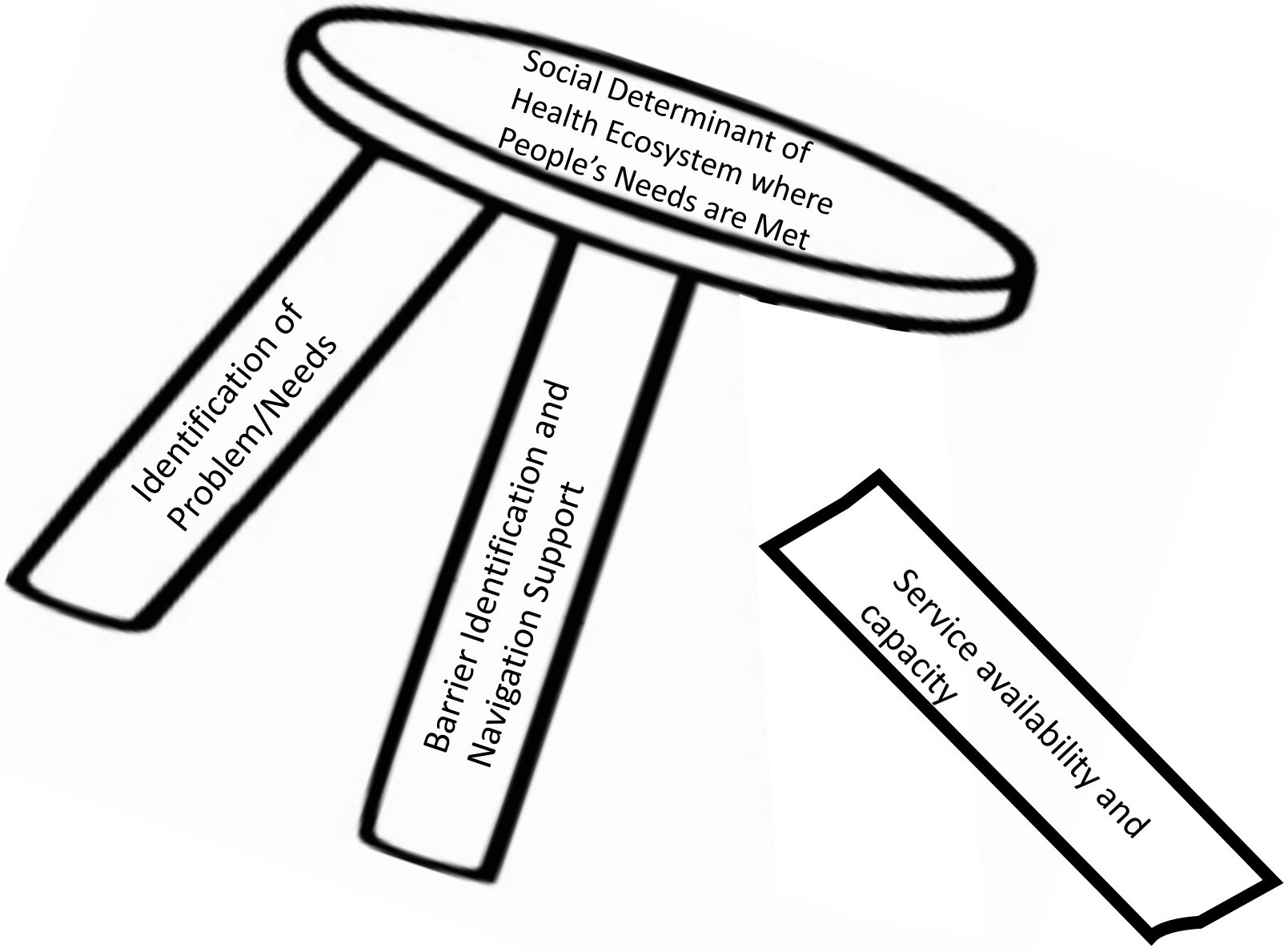
- Health Systems are required to screen for social needs (SDOH)
- Federal grants require a plan to address SDOH
  - Chronic Health (heart, diabetes, etc)
  - Mental Health
  - Substance use
  - Health Equity
  - Public Health Infrastructure
- Department of Workforce Development
- Department of Corrections
- Traditional Prevention Services (family resource centers, 211, cap agencies)
- Schools
- Others



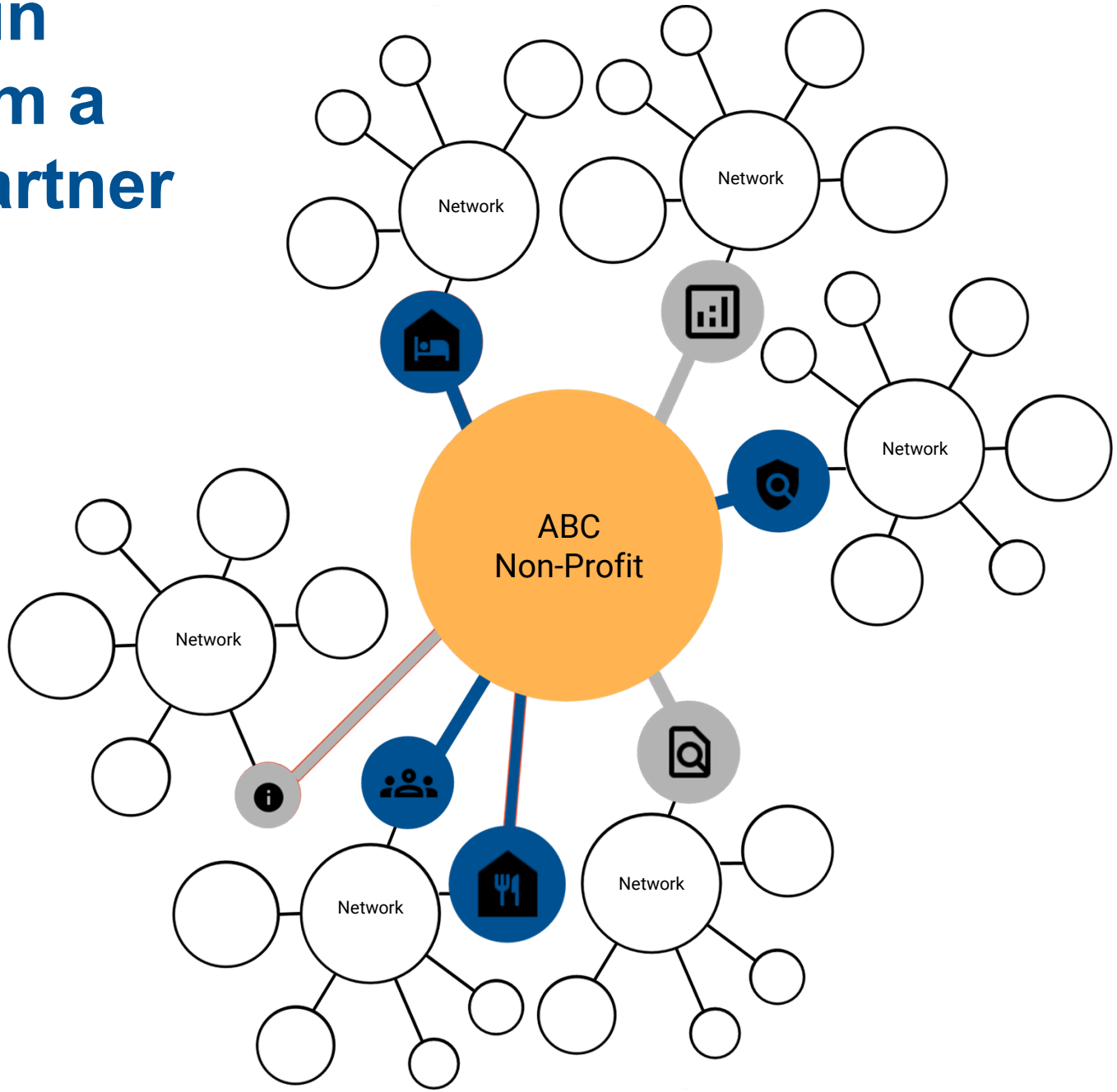
A Balanced Ecosystem



System Capacity



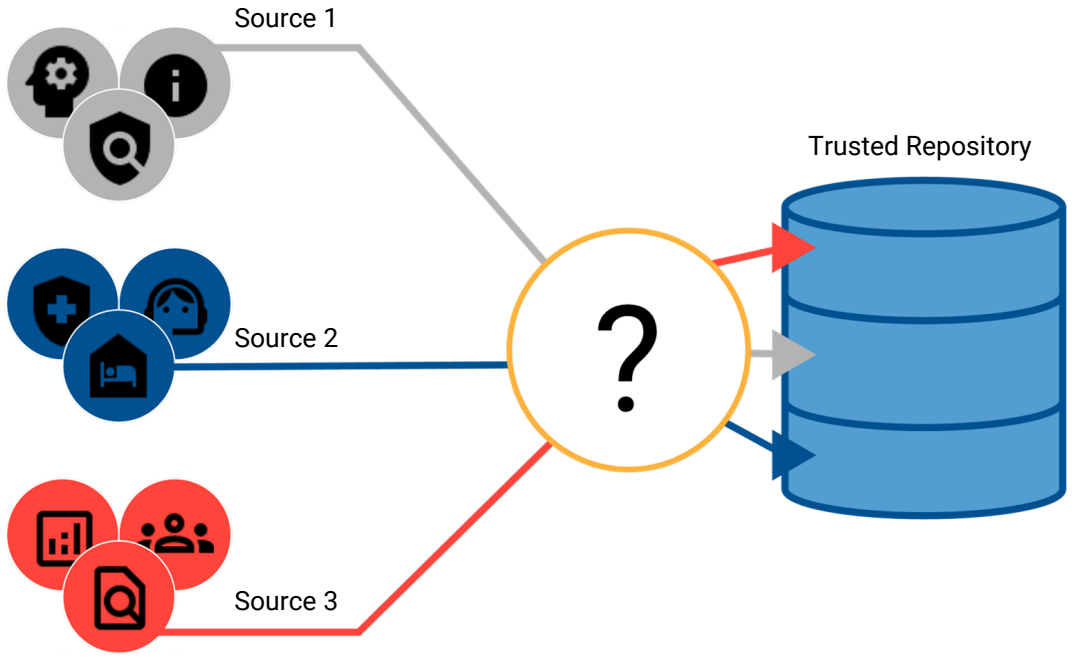
Current State in Wisconsin from a Community Partner Perspective



Current Regional SDOH Landscape

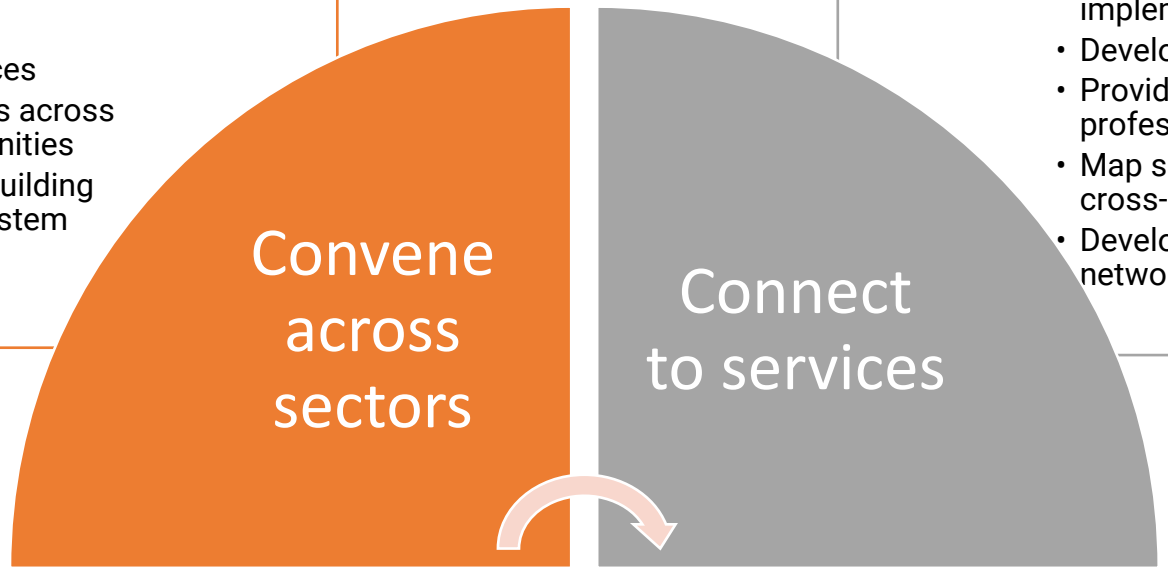
The Data Problem

- multiple directories
- multiple vendors
- proprietary formats
- non-standardized content
- multiple ways used to transmit data
- no universally accepted schema
- no authoritative “aggregator”
- no easy way for users to consume data



Creating Sustainable Referral Pathways

Elements of Referral Pathway Coordination



- Identify and engage leaders
- Address issues and opportunities
- Share quality practices
- Engage stakeholders across sectors and communities
- Create a forum for building a comprehensive system

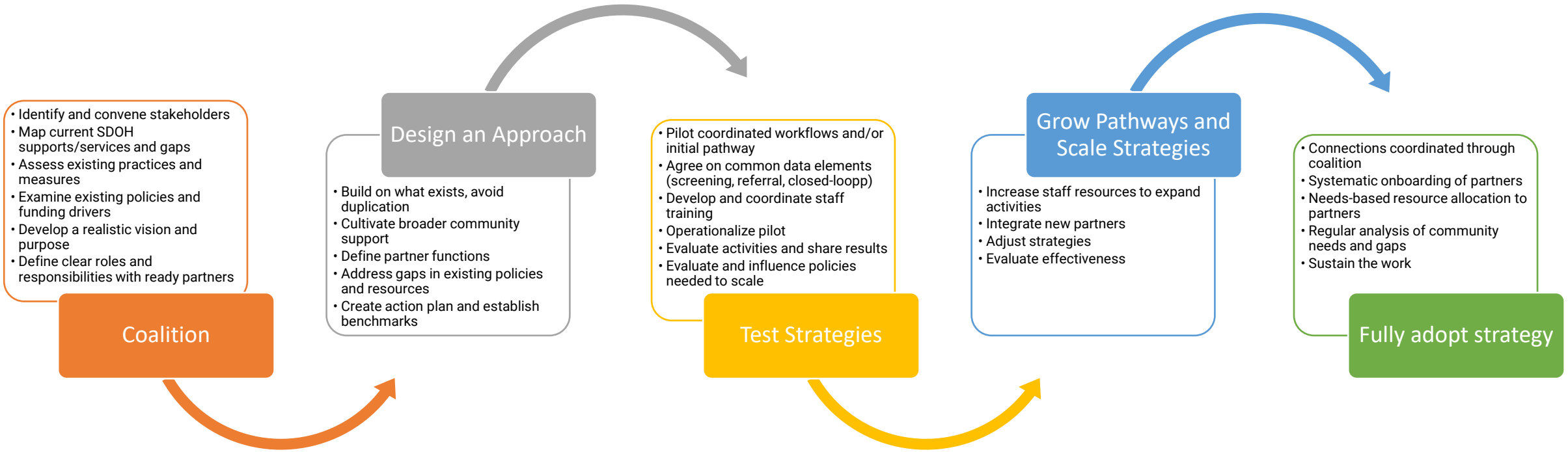
- Address partner needs and implement support
- Develop workforce scaffold
- Provide training and professional development
- Map services and foster cross-agency collaboration
- Develop workflows (in-network, out-of-network)

- Build awareness and support
- Address policy barriers
- Generate, leverage and distribute resources
- Align health, nonprofit, workforce and client goals

Set goals and measure success
- Build partner capacity
- Collect data in a sustainable manner
- Use data to improve performance and promote equity
- Set quality standards

GET CONNECTED.
GET HELP.
211

Pilot to Scale



Activity Break

What is the landscape in your community?

Instructions

- Using the worksheet list your current or potential referral partners
- How will they benefit from the referral partnership?
- What are their possible constraints?
- How can you adapt to their constraints?

Spend 5 minutes thinking about your own community and then discuss with your table group.

MACRO FORCES

Community Assessment - Social Determinants of Health/Wraparound Services

1 **Referral Partners** (Current or Potential)	2 **Referral Partner Benefits** (Known or Hypothetical)	3 **Partner Constraints** (Known or Hypothetical)	4 **How can you adapt?**

Observations?

- What were some of the driving constraints?
- Ideas to adjust your approach?

Next Steps

- Assess your organization readiness
- Study the landscape
- Identify potential partners
- Develop a coalition defined by a shared priority
- Understand existing networks (housing, food, older adult services, young family services)
- Do no harm – what is the current community organization capacity; are there already workflows in place to support this work
- Establish indicators of success
- Pilot and test
- Evaluate existing infrastructure and assess gaps
- Identify technical platforms that will enhance your plan and support interoperability with existing infrastructure

Questions

Potential Solution(S)

San Diego CIE

What is a CIE?

- Cultivates trust and capacity within the community
- Enables individual agency and understand root cause
- Drives systems change
- Community-led collaborative
- Designed to uplift and assist in providing agency to communities that experience disparities and inequities

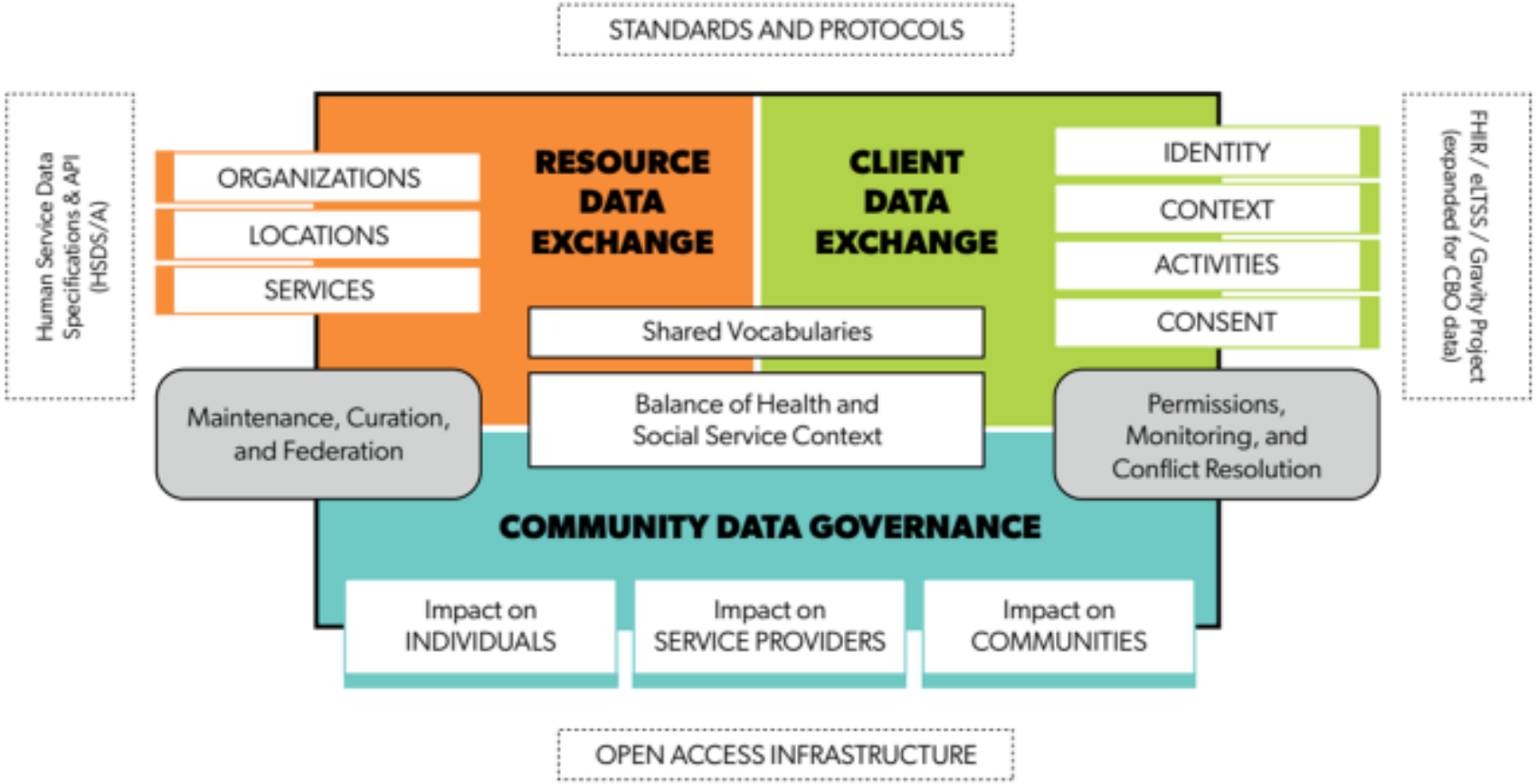
What a CIE is NOT.

- A specific technology or platform, nor is it dependent solely on tech to connect
- Generic one-size fits all solution that does not address capacity, readiness or infrastructure
- Intended to solve one issue
- Led by one organization, nor driven by one sectors needs
- Centered around institutional goals or interests

Role of United Way of Wisconsin

- Collective Impact backbone
- Guide the development of a shared vision and strategy
- Maintain a shared identity
- Expand the network of partners and funders
- Understand partner needs and workflows
- Establish shared outcomes and measurement practices
- Manage the CIE including technical development with partners
- Support aligned ongoing learning and best practice sharing (WPHCA & WPHA)

Primary Components of "Community Information Exchange"



Thank you

2·1·1
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References