PROGRAM QUALITY ROADMAP

This overview summarizes the elements of Root Cause's Program Quality Roadmap, a proven system for building equity and excellence in social service organizations, including descriptions of each of the Core Components of Quality below.

Core Components of Quality

PROGRAM ACCESSIBILITY: How do programs address barriers to participation to ensure community members can receive needed services regardless of zip code, race, gender, language spoken, disability, work schedule, household income, and other factors?

REFERRALS & PARTNERSHIP MANAGEMENT: How do programs give and receive referrals and manage partnerships that lead to seamless service coordination between programs?

STAFF SUPPORT & PERFORMANCE: How do programs support their staff to promote their well-being and enable them to provide the most effective services to participants?

TRAUMA-INFORMED PRACTICE: How are programs designed to identify and address the consequences of trauma?

DATA & MEASUREMENT CAPACITY: How does a program collect and use data to measure performance and progress towards goals and outcomes?

EVIDENCE-INFORMED PROGRAM DESIGN: How do providers use evidence-based models and available research to best meet the needs of participants?

FAMILY & COMMUNITY ENGAGEMENT: How are participants involved in the planning, design, leadership, feedback processes, and evaluations of programs designed to serve them?

Foundational Conditions

Organizational commitment to racial & economic equity. Structural racism and growing income and wealth disparities in the US mean that communities of color and those struggling to make ends meet are vastly overrepresented in populations receiving social services. High quality cannot be achieved, therefore, without a strong and explicit organization-wide commitment to racial and economic equity that translates into everyday practices for supporting these marginalized communities towards stability and wellbeing.

Organizational mission & vision are driven by an authentic understanding of community needs and strengths. A respectful and trusting relationship with the service pop-ulation shapes the core of the organization's purpose and intended impact.

Alignment between organizational mission & vision and Program Outcomes, such as in a theory of change or logic model, are foundational for high quality services. Organizational mission & vision are ultimately what quality services aim to achieve, and strong program outcomes are both the result of high quality services and a measure of quality improvement successes.

Organizational & leadership supports supply tangible and intangible resources that are necessary for high quality services. These resources include funding, commitment from leaders, physical space and materials, and billing and accounting functions, among many others. These supports enable programs to serve their community, and when they are absent program quality suffers as a result.

INTRODUCTION

For a social service program to have the greatest impact on individuals and communities, all of its different components— including services supporting physical, mental, and social-emotional health; housing stability; and financial stability—must be deeply interconnected and interdependent. The relationships among service providers are often implicit, existing simply by virtue of serving shared populations and working within the same resource landscape. These relationships can also be made explicit through intentional partnerships and referrals:

> **Partnerships** are the relationships among providers that rely on one another to deliver services to their clients, address specific challenges, and/or work towards common goals.
>
> **Referrals** are the processes by which one organization connects a client to another organization to help the client receive services to address their needs. Referrals may be made because one provider has insufficient resources to address client needs and seeks the assistance of other provider(s) to assist with or assume client care; or because the referring organization does not provide the services a client needs. The referral can happen through direct organization- organization contact, or through a referral the referring organization provides the client without engaging the receiving organization directly.

A growing body of research and practice finds that individuals and communities benefit from intentional relationships between service providers, particularly when there is strong, ongoing coordination among members. In addition, providers should consider racial disparities in social service referrals, work to understand the root causes of those disparities, and adopt best practices to reduce those disparities and mitigate the risk of occurrence.

Disparities in the referral process can be linked to disparities in outcomes. Current research suggests that racial disparities in the referral process exist in both the child welfare system[1] and in mental health referrals in the juvenile justice system[2] . When making service referrals, a provider's lack of awareness about their own biases can lead to disparities not only in how and when service recipients are referred for other services, but also disparities in outcomes. Providers should routinely engage in learning that provides practical ways to identify and address individual biases. Partnerships with organizations who share not only a common vision for the future, but a

commitment to dismantling inequities in social service delivery and in social service systems are a powerful tool to advancing racial and economic equity.

Below are practices shown to drive successful partnerships and referrals, and case studies highlighting the ways two organizations have successfully applied these practices in their own work.

Best Practices for Referrals & Partnership Management

All referrals are partnerships (ranging from loose to formal), but not all partnerships contain referral processes. Strong partnership management therefore forms the foundation for strong referral relationships. Partners with shared vision and priorities on the advancement of racial and economic equity have a unique opportunity to impact change at the systemic level, achieve better outcomes for service recipients, and reduce disparities in service delivery[3].

Best Practices for Partnership Management

Partnerships between two providers range from informal (e.g., partners working together to share resources and expertise as needed, without a documented agreement) to formal (e.g., a legal agreement between partners with a defined governance, decision-making, and resource-sharing structure), and from short- to long-term. Some providers may not have formal partnerships because they haven't had the time nor the opportunity to clearly document them, they may not be aware of the value of doing this, or they may not have the skills to execute a formal legal agreement. No matter where the partnership falls in this range, there are key characteristics found across all

Collective Action is an approach to systems change that brings together community members and grantmakers, nonprofit service providers, public agencies, and the business community in the pursuit of a common purpose for improving people's lives. The Root Cause Collective Action Framework describes what it takes to do this work. The glue holding this work together and driving it forward is strong partnership practices and processes shared among stakeholders, detailed in the "Best Practices for Partnership Management" section of this brief. For more information on how partnerships can align partners, strategies, activities, and resources towards the achievement of a common purpose, please see the Root Cause Collective Action Overview.

No matter where the partnership falls in this range, there are key characteristics found across all effective partnerships. These key characteristics are driven by partner practices that maintain, strengthen, and advance the goals of partners and of the partnership[4].

1. **Align the partnership's purpose and success criteria.** A clear and common purpose is the foundation for a strong partnership. A common purpose clarifies what partner expertises are needed, what partnership goals and linked activities should be established, and how achieving the partnership purpose benefits each partner organization. Understanding how each partner's individual goals and values align with those of the partnership overall is vital to strengthening and sustaining each organization's commitment to the partnership as it evolves. The partnership should also jointly develop a Theory of Change or Logic Model to articulate the partnership's purpose and sub-goals and the process by which partners regularly meet and assess progress.

2. **Adapt and learn with partners.** Over its lifetime, a partnership may see its needs, constraints, and opportunities evolve. Partnerships should nurture an inclusive learning environment that allows partners to identify when change is needed and how partners can use the change to grow. For example, partners may identify areas of growth needed for the success of the partnership and hold a staff training to build these new skill sets. Partners may also conduct community assessments to evaluate evolving needs and adopt/adapt partnership strategies that are more relevant to clients[5].

3. **Ensure the sustainability of the partnership.** The long-term sustainability of a partnership depends upon having sufficient resources to support the referrals and partnership frameworks. For example, staff, money, time, and organizational and leadership buy-in must all be prioritized. This ensures that organizations can continue to carry out their core services as well as meet the partnership's objectives, and also helps each organization reaffirm their cultures of learning and achieve their longer-term goals[6].

4. **Establish clear and consistent communication.** Strong communication practices must be established to build trust among partners, move the partnership's work forward, and maintain the health of the partnership. Partners should come to agreement on communication methods (e.g., technology platform, frequency of meetings, etc.) and set clear expectations (e.g., who are the points of contact, what work should be done between meetings, how agendas should be set or updates provided, etc.) This can include regular face-to-face meetings to review shared service participants, periodic meetings to discuss broader operational

and strategic goals, and emails and phone calls as needed. Established codes of conduct and communication protocols ensure that all partners are aware of what needs to be communicated, how, and how often.

5. **Share accountability for partnership responsibilities.** This begins with explicit and co-developed documentation of what work is required to achieve the partnership goals, as well as who is responsible for what. In practice, this is often done through a Memorandum of Understanding (MOU). Accountability is also shared through an inclusive and transparent decision-making process. To drive this process, goals should be aligned and a common purpose should be defined. In addition, feedback loops and performance measurement systems should be implemented to help all parties understand how their work fits into the broader objectives and how to assess progress and evaluate work quality so that all programs can coordinate existing resources and engage more effectively.

Best Practices for Referrals

A strong referral process and/or network can mean reduced wait times for clients to receive services, seamless coordination among different services, better matching of clients to services that are most relevant to their needs, and established feedback loops that strengthen the alignment of care provided by different services. Strong referrals are conducted in a timely manner as soon as the need is identified, they are relevant (linking the right service(s) to the service participant), and they are supportive and engaging in helping the service participant make new connections. Below are the best practices for strengthening program referrals, which contribute to an interconnected, sustainable system of care coordination for social service providers.

> ***It is important for referral systems and services to be accessible to staff and service participants in order to reduce disparities in referrals and program outcomes and ensure greater racial and economic equity.***

Language (including interpretation and translation), cultural competency, and service location are all important for service providers to consider when making referrals so that they can, as much as possible given community resources, help create greater equity in service access. More information about this can be found in the Program Accessibility Research Brief.

1. **Identify and manage staff biases.** Providers should acknowledge and mitigate individual biases, whether positive or negative, that may impact the referral process by providing regular training and learning opportunities

for staff. This can help reduce disparities in service participants' outcomes by ensuring clients have access to appropriate services when there is an identified need[7].

2. **Use clear and agreed-upon referral tools and processes.** Strong referral practices rely on developing and using agreed-upon referral protocols. These protocols outline when to refer clients, the steps to do so, and data both parties need to assess client needs, strengths, and relevant services. One critical component of strong referral processes is the feedback loop: By standardizing and adhering to referral feedback loops, providers help ensure that clients receive the services they need after a referral is made and that both the initiating and receiving organizations are informed of service results. In general, web-based referrals (forms that standardize information and communication between service providers electronically) more reliably ensure that referrals happen on time and with the information providers need. Wherever needed, confidentiality is ensured through ethical contracts that protect the privacy of client data. It is important that the service participant has agency to decide which services they want to connect with and if they wish to make the connection directly or have someone make the referral on their behalf[8].

A **feedback loop** is a mechanism that encourages relevant referrals to be conducted in a timely manner. Effective feedback loops involve regular interactions among service participants, social service providers, and the referring organizations. This mechanism allows the original referral request to be processed and fulfilled, follow-up support to be organized, and feedback to be gathered to ensure all referral members involved have the information they need, when they need it.

3. **Maintain up-to-date resource directories**. Providers are equipped to make relevant and timely referrals when they have easy access to up-to-date lists of providers with specific attributes (e.g., eligibility requirements location, hours)[9]. These resource directories should be easily accessible to all staff and volunteers (i.e. they could be stored in an electronic database like Salesforce) and include a formalized process for updating the directory on a regular basis by a designated person. Staff should be trained on how to use the directories and how to update them as community services change. Moreover, a version should be created that can be given to clients so they can identify services for themselves and their families. Providers should ensure that there is a diverse array of available resources, spanning diverse

lived experiences and racial, socioeconomic, geographic, gender, cultural, health (including physical, mental, and sexual health) backgrounds.

4. **Understand the service landscape in your community.** To understand the service landscape, it is important to first know what services and other resources exist in the community, so providers can refer clients to services they feel confident in and also identify service gaps. Service providers can conduct a landscape scan or a community needs assessment. Conducting a community needs assessment can help a program understand the needs of the community, identify which programs fulfill those needs, locate other programs that fulfill client needs their own services do not address, and identify remaining service gaps. However, most organizations do not have the ability to do this assessment on their own, so they can partner with others to do one and/or find one that has already been completed by another organization. A landscape scan would also serve this purpose well, and is easier to do. Through a landscape scan, organizations understand which services are available and which services are missing in their local communities, deepening their knowledge of who they can refer to and what outstanding service gaps remain. While service providers may not have the resources to launch a new program to close service gaps, they can advise clients about what is and is not available in their local community and help clients problem-solve to connect with the resources they need[10,11].

5. **Collect and analyze referral metrics.** Tracking referral metrics (such as how many referrals each organization makes, how many referrals are received, and the quality of the referrals made) allows organizations to gauge the effectiveness of the referrals and referral system. There are two types of metrics to collect. First, there are metrics about the success of each referral. These metrics reveal how quickly service recipients receive their treatment after the referral, or indicate trends in service results and client satisfaction. The second metric is about the effectiveness of the referral system as a whole. Delving into how long it takes to complete a referral, the percentage of referrals completed, client satisfaction rate and wait list time are all metrics to assess how effectively the referral system is functioning or not. Both types of metrics can help identify strengths and areas for improvement for the referral partners and the referral network[12]. To launch a referral data collection system, service providers should establish a clear data collection process, ensure all staff are trained on how to collect and input data, and analyze referral metrics on a regular basis. By establishing a baseline, upward or downward trends can be more easily tracked and organizations can better understand how many referrals were successful or why they did or did not work out[13]. Data will also help providers determine whether they are meeting the needs of their diverse communities, which populations may need more help or resources, and whether racial and other disparities in health services and outcomes are being improved or not.

Case Study: The Boston Public Health Commission and HelpSteps

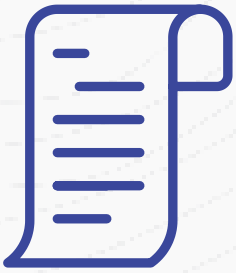
Unemployment, food insecurity, and lack of access to public health care are all inextricably linked and can have detrimental effects on people's lives, especially those experiencing racial, economic, and other disparities[14]. In 2003, Dr. Eric Fleegler, who works as a physician at Boston Children's Hospital, identified a challenge: individuals experiencing health-related social issues (such as food insecurity and housing instability) had inadequate access to both medical care and social service organizations. Alongside the Boston Public Health Commission, he created an online referral system that would help mitigate this problem.

HelpSteps is an online screening and referral system that connects people to social service providers. Dr. Fleegler identified shortcomings and inconsistencies in existing referral processes due to out-of-date, sparse lists of operational social service providers. To implement a more active and relevant system, he decided to create a web-based referral system. First, he designed an online screening questionnaire, which included questions about education, income, family, access to healthcare, and community environment. This screener identified the most relevant social services for each user based on their unique social and medical history, then guided them to the resources they needed. When HelpSteps first launched, data revealed that 32% of users came to the website due to a lack of healthcare access, 30% did so for educational purposes, and nearly 20% because of socioeconomic issues such as food insecurity or housing instability[15]. By 2019, HelpSteps had partnered with Massachusetts 211, a state hotline for critical health and human services, and received a REACH (Racial and Ethnic Approaches to Community Health) grant from the national Centers for Disease Control and Prevention (CDC) to further integrate the framework into Massachusetts' existing social services and work towards a national model. Today, the program has expanded its database to include more than 10,000 social service providers across the entire state.

With a web-based referrals platform, it was easier to ensure that each person's information was accurate, the referrals occurred on time, and provider information and other resource directories were up-to-date. In addition, confidential

data-monitoring systems were implemented to track referral metrics and create feedback loops. As a result, the progress of patients could be monitored as they moved through the health and social service systems, which helped foster more transparent and coordinated interactions between users and social service providers. Analyzing these referral metrics allowed HelpSteps to better understand community needs and the existing service landscape, in order to identify where current services were not working or required improvement.

HelpSteps started to develop formal partnerships with public health organizations to expand healthcare access and services for their users. One example is the coalition formed between HelpSteps and Roxbury Community Alliance for Health to link patients with Type 2 diabetes to community resources. By developing this partnership with the Roxbury Community Alliance for Health and maintaining open communication and shared accountability for responsibilities, HelpSteps was able to streamline their referral process, enhance resources for patients with Type 2 diabetes, and improve local community health[16].



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