Chapter 5 : OhioKAN Service Delivery

OhioKAN Service Delivery

Understand how the core components of the OhioKAN program model are operationalized such as the steps for opening a service episode, completing the BASICS, providing a referral binder, co-developing a support plan, following up with families, and closing the service episode.

OhioKAN Service Delivery Overview

Image

This section describes OhioKAN service delivery, including the primary service components of outreach, screening, assessment, service opening, service referral and support, service follow-up, and closing.

Outreach to Interested Individuals

The OhioKAN program model includes an interactive publicly available website with resources, events, and content, curated for kinship and adoptive families. The website includes a contact form for families to provide their information and to express an interest in learning more about the services. This information gathered from the contact form on the OhioKAN website feeds the Customer Relationship Management Database (CRM), which is used by OhioKAN staff to reach out to prospective kinship and adoptive families. Information collected includes the family's name, best method of contact, phone number, email, physical address, and how the person interested learned about the program.

A written procedure guides outreach by OhioKAN Staff to interested individuals listed in the Customer Relationship Management Database (CRM). The goal of this outreach is to ensure people move from expressing interest in OhioKAN to receiving services or obtaining the information they are seeking.

Outreach Assignment and Timelines

Once the information is collected in the CRM database, the family information is assigned to the regional team responsible for the area where the family lives and then to a specific navigator responsible for reaching out to the family. Typically, two outreach attempts are made through two different methods such as a phone call, text or email

within 72 hours of the assignment. Documentation of contact with the family is made when contact attempts are successful or unresponsive.

Practice Guidance for Outreach Calls & Texts

OhioKAN staff will respond to interested individuals with a warm empathetic tone and the practices established in the OhioKAN Navigator Practice Profile, which can be found below in Staffing Resources. To reduce barriers to access and build trust, the tone of the outreach conversation should be informal. The OhioKAN Staff member will begin the conversation by introducing themselves and the OhioKAN program, asking open-ended questions, allowing the person to express the reason they wanted to be contacted, then verbally summarizing and checking back with the person to ensure the initial reason for the call is clearly understood. Over the course of this conversation, OhioKAN staff will listen and document why the person wanted to connect with OhioKAN and any other relevant information in the data system.

- If the interested individual would like to receive OhioKAN services staff will move directly to screening. After eligibility is established, OhioKAN staff will move on to the BASICS or schedule an appointment to complete the BASICS.
- If the interested individual would like to learn more about the program, staff will respond to their questions to the best of their abilities and will send promotional materials or connect them with regional staff via email as needed.

In addition to kinship and adoptive families, nonprofit professionals and community service providers may call OhioKAN for general information about the program. Depending on the information needs of the caller, the OhioKAN staff may immediately answer questions, provide information about how families can access OhioKAN services, send printed or electronic informational materials, and/or arrange for a presentation of the OhioKAN program to a group or organization.

Screening

A written procedure guides the completion of the OhioKAN eligibility screening. The goal of this screening is to ensure eligible families move from initial inquiry or referral to enrollment in the OhioKAN program. Families interested in OhioKAN must meet specified eligibility criteria as defined in Ohio administrative rule 5101:2-40-10.

OhioKAN staff respond to interested individuals with a warm empathetic tone and the practices established in the OhioKAN Navigator Practice Profile. To reduce barriers to access and build trust, the tone of the screening conversation should be informal. The OhioKAN staff member will begin the conversation with active listening, allowing the person to express the reason for their call, then verbally summarizing and checking back with the person to ensure the initial reason for the call is clearly understood. Over the course of this conversation, OhioKAN staff will listen and document why the person called, members of the household, contact information and any other relevant information in the data system. The primary purpose of this initial conversation is to build rapport, collect basic information about the caller and the people who live in their home, and learn enough about the family to establish eligibility.

Once eligibility has been established the service episode should be screened in the data system. Then the conversation should move immediately to Opening an OhioKAN Service Episode. If a family is not eligible, the OhioKAN staff can assist the family by providing basic information to direct the family to the appropriate services or refer the family to 211. These cases should be screened out in the data system rather than screened in.

Screening Questions

Screening questions include the eligibility criteria related to age, location, relationship to caregiver, and other criteria. These questions are designed to clarify the information needed to make and document a screening decision. The questions do not have to be asked in any specific sequence and the Navigator should select only the areas that apply. In order to both record the response and safeguard confidentiality, the person's response to any question asked should be documented only in the data system. As soon as eligibility is established under one of the criteria, OhioKAN staff will document it in the data system and move immediately to Opening an OhioKAN Service Episode.

Opening an OhioKAN Service Episode

The next step after the Navigator has assessed for eligibility and completed the screening process is to open an OhioKAN Service Episode. A written procedure guides staff in opening a service episode which includes the following components:

A brief description of OhioKAN services

- OhioKAN Participant's Rights & Responsibilities and informed consent
- Creating a person record for all individuals involved in the service episode
- Completion of the OhioKAN Brief Assessment and Screening to Inform, Connect, and Support (BASICS).

Brief Assessment & Screening to Inform, Connect, and Support (BASICS)

Once the service episode is opened and the initial description of the program is shared with the family, the next step is to begin the BASICS with the family. Ideally, the BASICS is completed by OhioKAN Staff during the first or second conversation with the family.

Goals of the assessment include:

- Collect baseline information about family needs and resources

- Identify which referrals and/or supports to provide immediately
- Identify if the family would like additional support and is willing to create a Support Plan
    - Additional supports and resources include:
        - Warm hand-off referrals (calling an agency with a family to introduce them and begin the connection)
        - Assistance with an application
        - Flexible funds and hard goods
        - Benefits coordination (assisting families with benefits applications, appeals process, and other matters)
        - Collaboration with caseworker, state or local agencies
        - In-person services to facilitate access

Family needs and resources are collected through the BASICS, which is organized into three sections and includes nine domain areas of need.

- **Basic needs:** Housing, utilities, transportation, clothing, food, furniture
- **Legal:** Questions about custody, delinquency court, other legal services needed
- **Caregiver Social Support:** Loneliness, no time for self, respite, support groups
- **Caregiver Health:** Mental health, behavioral health, physical health, cognitive health, dental
- **Caregiver training/education:** Caregiver or Parenting training, support for children with special needs
- **Family Functioning:** Child/caregiver relationship, attachment, bonding, family relationships
- **Child Care:** Locating care, accessing care, after school or summer programs
- **Education/Child Development:** Enrolling child in school, IEP/504 plan, school supplies, Early Intervention, Head Start
- **Child Social Support:** Connections to peers and/or caring adults and mentors
- **Child Health:** Mental health, behavioral health, physical health, dental, special equipment needs

Guide for Completing the BASICS

After the adoptive parent or kinship caregiver consents and has heard their rights and responsibilities, OhioKAN staff will transition the conversation to the BASICS. The questions are formatted so that they can be read like a list. Some items have specific information about who these items may be most relevant to. Given information learned earlier in the conversation with the parent or caregiver and knowledge of the family composition, OhioKAN staff are encouraged to customize the conversation. For example, you don't have to ask a family who has a toddler about school enrollment, but instead would ask about childcare and developmental screenings.

Explaining the rating system

As the BASICS Assessment begins, the Navigator explains the rating system to the kinship or adoptive caregiver. The caregiver will select the level of challenge for each domain area in the BASICS. It is important that the Navigator refrain from assuming or suggesting a rating based on discussion for each domain. This aligns with the OhioKAN value that we believe in families.

Asking about the BASICS domains

As the person conducting the assessment, allow the OhioKAN family to choose their level of need. If the person says "challenging" you can say "would you say that is somewhat challenging or very challenging" then follow with an open-ended question like "can you tell me more about what you need in this area?" While it is important to read all the questions, it is acceptable to ask them in any order. If the person has stated a need in a specific domain during the initial rapport building and screening conversation, begin the assessment by asking them about that domain first. As the Navigator begins asking the caregiver about each domain, the first set will include a focus on caregiver and family needs followed by child needs.

State Resources

The last step includes a review of state programs families may already have in place or may be eligible for. If OhioKAN staff know a family is ineligible for a certain program based on the service episode type, they can mark it as not eligible and skip that question as they move down the list. For example, staff will not need to ask a kinship family if they participate in an adoption subsidy program only open to adoptive families. Similarly, if the family does not have a child under the age of five living in the home there is no need to ask the family about WIC. If staff are unclear whether the family is eligible for a program or not, err on the side of asking the question and documenting the caregiver's response.

After completing the BASICS, confirm the caregiver's preferred method for receiving referral information and describe additional support available with Collaborate services.

After completing the BASICS

- Ask if they would like the referrals via email or mail.
- Ask if they would like additional support accessing the referrals (such as, calling the referral agency together, help filling out an application, attending a meeting, or other support).
- If they would like additional support or resources to meet their needs, schedule a time to complete a Support Plan to identify specific supports and assistance needed, see the section 'additional support' for more information.
- If they are comfortable accessing the referrals independently, ask if there is a time within the next 30 days when they would like a follow up contact and whether they would like follow up via email, phone, or text message.
- Let them know your direct contact information will be listed on the packet and encourage them to reach out if they encounter any challenges with the referrals.

- Let them know they may be contacted by OhioKAN's evaluator.
- Send the referral binder and overview sheet of all available OhioKAN services.

Additional Support

Once you identify the family's needs in the BASICS assessment and have identified how they would like to receive their referral binder, ask the parent or caregiver if they would like additional support. Navigators may offer any of the following additional support to families:

- **Warm hand-off referrals**
  - You can offer to call an agency with a family on the phone, or call an agency on a family's behalf to make the initial introduction
- **Assistance with an application**
  - You can offer to assist a family with an application for a social service benefit (SNAP, childcare, SSI, etc.) virtually or in person if there are barriers to completing the application virtually
- **Flexible Funds and Hard Goods**
  - If a family needs hard goods like clothing, beds, car seats, etc., for their kinship or adoptive children, you can offer to directly link families to organizations and agencies for short-term assistance in obtaining these items, and follow up support
  - If you have exhausted all community-based options for a family to meet a need for funds or hard goods, you can apply for flexible funds and hard goods through OhioKAN
  - See the flexible funds section below.
- **Benefits coordination**
  - If the family has questions about eligibility, a benefits appeal process, or would like support with an application, or other benefits challenges that require more specialized expertise, you can offer to connect them with the OhioKAN Benefits Coordinator
  - See the benefits coordination section below.
- **In-person services**
  - In select situations, you can offer to join a family in a meeting with the child's school, social worker, etc. in the community to provide extra advocacy for the family
  - If there are barriers to providing virtual support, you may also offer to visit the family in their home to assist with applications, etc.
  - See the in-person services section below.
- **Collaboration with caseworker, state, or local agencies**
  - You can offer to coordinate with the family's case worker, if they have one, or reach out to local/state agency contacts to advocate alongside them

If the parent or caregiver would like additional support, ask if they have time to complete a Support Plan or would like to schedule a different time to complete it. Provide a brief overview of what to expect in creating the Support Plan so they can make an informed decision.

Referring for Support Services

This section guides the referral process to ensure OhioKAN Families receive appropriate referrals for the needs they have identified in the BASICS assessment. For further details on assessment, see section above for Opening an OhioKAN Service Episode.

Referral Resource

OhioKAN staff may use their knowledge about available services and consult the OhioKAN Information Hub to identify services matched to the needs of each OhioKAN Family. The OhioKAN Information Hub is updated regularly to ensure it provides complete and accurate information about the services available. All OhioKAN staff can edit the information in the OhioKAN Information Hub and keeping the Information Hub updated is everyone's responsibility.

Referral Considerations

The Navigator suggests service referrals that are responsive to the parent or caregiver's priority concerns and informed by the BASICS and Support Plan. If the family needs additional or different referrals, these should be chosen in collaboration and partnership with the parent or caregiver taking the family's Support Plan into consideration. The following are things to consider when making referrals:

- Refer to organizations near where the OhioKAN Family lives and/or works
- Take into consideration the participant's past experiences, whether positive or negative, with organizations in their area. If an OhioKAN Family has concerns about a referral or organization, accommodate those concerns by suggesting an alternative.
- Consider transportation access (e.g., if the participant is traveling on public transportation, select an organization that is easily accessible via public transit)
- If a warm hand-off by phone, email, or in-person is needed, ensure there is a plan or scheduled time to do so and document this in the SACWIS and in the Support Plan.
- If the family has multiple needs, provide referrals to address these needs. Then, as appropriate, build out a plan with them of when and how they will access those referrals and what support they will need (e.g., reminders, assistance filling out forms, language or transportation support). Record this all in the Support Plan, specifically in the Support Plan Table.
- Use the Support Plan to prioritize and sequence support for the most urgent referral needs first. Sequencing does not mean the referrals themselves are withheld until a later date. All referrals should be provided as soon as the need emerges. However, the advocacy support related to referrals may include a plan to target one or two

referrals at a time so that the number of initial engagements with service providers does not overwhelm the family.

Referral Conversation: Service Information and Connection

- Provide the organization name, address, phone number, and website verbally as well as documenting the organization name in the Support Plan.
- If referring to multiple organizations, pause and ask the OhioKAN Participant if they have any questions or anticipate any barriers.
    - If there are anticipated barriers, document them in the OhioKAN Information Hub and ask about them during the follow up call.
- Ask if the OhioKAN parent or caregiver would prefer to receive their referral packet via email or physical mail.
- If the referral is for a brochure or other written informational resources, be sure to specifically state that you have heard the need and will be sending information for the OhioKAN parent or caregiver to read through.
- Work with the parent or caregiver to develop a plan for how and when they can access the service taking any barriers like transportation or language into consideration.

Services Gaps

A written procedure guides the documentation of service gaps. A service gap is when a referral is needed, but no provider is available to the family. If a family identifies a need on the BASICS as "Somewhat Challenging" or "Very Challenging," but OhioKAN staff are unable to identify an appropriate provider to meet the family's current situation, this gap is documented in the data system. This information is used to identify all a family's needs and what service gaps exist in the community. This information is used to inform Regional Advisory Council and Continuous Quality Improvement efforts.

The OhioKAN staff member can document this at the same time they document other case services provided in a binder or at any time when a referral is requested, but a provider is not available or accessible.

When a family has requested a service, but the services are not available or accessible to the family, a Case Service can be added in the data system to document the need. This may also be used when a referral was provided to the family, but the Case Service had to be ended because the family could not use the provider (i.e., ineligible, provider closed)

Sometimes a service may be available, but not accessible. These instances are documented. For example:

- The available provider does not offer services in the language the family speaks.
- The person has mobility challenges, but the available provider's facility is not ADA compliant.
- The person is part of the LGBTQIA+ community and the available provider is not affirming.
- The provider is not willing or able to provide services to a child with behavioral health needs.
- This list is not exhaustive, if you are unsure about a situation where a service seems inaccessible, talk with your coach.

Completing the Initial Support Plan

A written procedure guides the completion of the OhioKAN Support Plan which is co-created with families who are asking for additional support in addition to referrals, also called the Collaborate Service Level. The goal of the Support Plan is to engage OhioKAN Families in planning and making decisions about the support they receive from OhioKAN, it also serves as a mechanism to communicate the planned activities and track progress towards goals. The initial version of the Support Plan should be co-created with families and then updated regularly at scheduled meetings.

Time for Support Plan Completion

Navigators should schedule 45-60 minutes to create a Support Plan. Depending on the number and type of needs, the actual conversation with the family takes 15-30 minutes and can be done over the phone, via virtual meeting, or in-person. The remaining time is used to prepare before the meeting, finalize the Support Plan, send follow up communication to the family, and complete documentation or other action items. The Support Plan is co-developed with the caregiver or parent and may require providing additional referrals.

Child Participation

This process may also involve the child(ren) if it is appropriate to the age of the child, the needs of the family, and relational dynamics of the situation. Before beginning the Support Plan conversation, Navigators discuss with the parent or caregiver whether the child should be involved in the planning conversation. If the parent or caregiver and the Navigator determine it is appropriate to involve the child, the Navigator describes the Support Planning process. The caregiver and Navigator decide together how best to engage the child and which part(s) of the process the child will be involved in. Some families will have multiple service episodes. The Navigator should not take child participation in a prior service episode to mean that child participation is always appropriate for the family. Instead, the Navigator should check with the parent or caregiver to determine how that child should be involved at the start of each new service episode and revisit the conversation as needed throughout the advocacy relationship. There are no circumstances where it is appropriate to involve the child in OhioKAN conversations or Support Planning without the parent or caregiver's consent. See the *Discussion Guides for Co-Developing the Kinship and Adoptive Family Collaborative Support Plan with the Family* in the Appendix for further practice guidance on engaging children in

the Support Plan.

Developing the Support Plan

The Navigator builds rapport and trust with the parent or caregiver, asks follow-up questions based on what was shared in the BASICS, and learns more about the family's circumstances to co-develop a tailored Support Plan. The Navigator's role in co-developing the Support Plan with the caregiver or parent is to facilitate their exploration of ways to address their identified needs, recognize their strengths and abilities, and identify what family and community supports they already have. The primary skills used may include appreciative inquiry and motivational interviewing. Navigators engage with families with a warm empathetic tone and the practices established in the OhioKAN Navigator Practice Profile. The *Discussion Guides for Co-Developing the Kinship and Adoptive Family Collaborative Support Plan with the Family* in the Appendix offers practical guidance and suggested questions.

The Support Plan is organized into five sections and is intentionally organized so that the family's strengths and key relationships are discussed first to inform the development of the Support Plan. While co-creating the Support Plan with the family the Navigator works with the family to specify which additional supports the family needs in addition to service referrals.

Image

Figure 5. A brief overview of each of the sections of the support plan completed with families.

Additional Support Options to Include in the Support Plan

While developing the Support Plan with the family, discuss the range of options available for additional support. Considerations in selecting the type of additional support include the unique needs and goals of the family. Navigators may offer any of the following additional support to families:

- **Warm hand-off referrals**
  - You can offer to call an agency with a family on the phone, or call an agency on a family's behalf to make the initial introduction.
- **Assistance with an application**
  - You can offer to assist a family with an application for a social service benefit (SNAP, childcare, SSI, etc.) virtually or in person if there are barriers to completing the application virtually.
- **Flexible Funds and Hard Goods**
  - If a family needs hard goods like clothing, beds, car seats, etc., for their kinship or adoptive children, you can offer to directly link families to organizations and agencies for short-term assistance in obtaining these items, and follow up support.
  - If you have exhausted all community-based options for a family to meet a need for funds or hard goods, you can apply for flexible funds and hard goods through OhioKAN.
- **Benefits coordination**
  - If the family has questions about eligibility, a benefits appeal process, or would like support with an application, or other benefits challenges that require more specialized expertise, you can offer to connect them with the OhioKAN Benefits Coordinator.
- **In-person services**
  - In select situations, you can offer to join a family in a meeting with the child's school, social worker, etc. in the community to provide extra advocacy for the family.
  - If there are barriers to providing virtual support, you may also offer to visit the family in their home to assist with applications, etc.
- **Collaboration with caseworker, state, or local agencies**
  - You can offer to coordinate with the family's case worker, if they have one, or reach out to local/state agency contacts to advocate alongside them.

Some of these supports are further described below with additional information, context and eligibility.

Flexible Funds and Hard Goods

Flexible Funds provide one-time and/or short-term financial assistance to families with needs that the community cannot immediately address and meet. This assistance can be delivered in the form of payments to third parties on behalf of families, gift cards, and access to available hard good inventory. Flexible Funds are another tool in OhioKAN's suite of navigation services to better partner with families and respond to their immediate needs. Navigators, through their engagement with families and community providers, have a first-hand view of the community's available and accessible service array. Flexible Funds provide an opportunity for OhioKAN to help bridge the gap within communities where capacity to serve kinship and adoptive families is still growing.

A written procedure guides decision-making for Flexible Funds and includes an approval process to ensure appropriate use, specific exclusions (e.g., legal fees, ongoing childcare expense, etc.), and defined funding thresholds that require additional review and approval by regional directors or program leadership.

Using Flexible Funds in Practice

Navigators initially assess for appropriateness of Flexible Fund assistance during the BASICS assessment as they learn about the family's strengths and needs. Flexible funds are only provided as part of the Collaborate-level of service when families develop a Support Plan with navigators. Through their conversations with families, navigators consider the following with regards to the appropriateness of Flexible Funds to meet the family's needs:

1. Are there available community resources that could provide services or resources for the identified need(s)?
2. If yes, have the available community resources been exhausted and no other community supports exist to support the need(s)?

Once approved, Flexible Funds are documented in the Support Plan, and the navigator and family co-develop goals and action steps to further build the family's confidence to access services and resources they need and their connections within the community for continuous support.

Benefits Coordination

Many kinship and adoptive families who engage in Collaborate Service Level qualify for local, state, or federal benefits programs, but are unaware of the programs or need support navigating the eligibility, application, and/or appeal process. The OhioKAN Benefits Coordinator provides expert support to increase access to public benefits for kinship and adoptive families

The role of the Benefits Coordinator:

- Work directly with families to navigate benefit programs and appeals
- Train Navigation staff on the basics of federal, state, and local benefit programs that support kinship and adoptive families
- Integrate benefits work throughout the program

The Benefits Coordinator assists kinship and adoptive families in finding benefits for which they may be eligible and assisting the family by navigating the application, submission, and appeal processes. The Benefits Coordinator often joins Support Plan calls along with the Navigator to listen to families' needs and offer knowledge and support around benefit programs. The Navigators can also schedule a call between a family and the Benefits Coordinator to specifically talk about benefit programs that the family needs additional support navigating. The Benefits Coordinator uses their state-wide connections, knowledge of the legal aid system, and nuances of benefit program processes to support the family in resolving their questions and needs.

The Benefits Coordinator also works to train Navigators as they are the first response to families when they call the program. The benefits Coordinator facilitates Navigators' basic understanding of public benefit programs and thereby empowers Navigators to provide direct assistance to families with routine benefits matters. Specifically, the Benefits Coordinator trains and coaches Navigators so they can learn the language and basic details of the most common public benefits programs and help families access applications. Since there are some benefit programs with complex applications and various nuances at the county level, it is difficult for Navigators to become experts in all the benefits that may support families. When Navigators need additional support helping a family with benefits, they can bring in the Benefits Coordinator to work directly with the family for this process.

The Benefits Coordinator researches and tracks all the local, state, and federal benefit programs that support kinship and adoptive families. They study programs that specifically target kinship and adoptive families, and those like Temporary Assistance for Needy Families (TANF), Medicaid, Supplemental Security Income (SSI), etc., that may support these families as well. They take time to schedule informational interviews and develop partnerships with legal aid organizations throughout the state that often support the appeals process, and benefit staff at state and county offices. The Benefits Coordinator creates overview documents of each benefit to support Navigator learning, and documents that can be sent to families as they work to apply and appeal programs.

In-Person Services

Navigators may offer in-person and in-home meetings to families in the Collaborate Service Level to families who face barriers in accessing resources and need support to connect and receive services from a community provider. The in-person meetings occur face-to-face in the community such as at a partner site, library, school, local community providers, restaurants, etc. The in-home meetings occur face-to-face in the family's home. As with every aspect of the OhioKAN program, in-person and in-home meeting services are offered to families in an equitable manner throughout the state.

Eligibility

All families utilizing Collaborate Service Level are eligible to receive OhioKAN's services in-person and in-home, but a Navigator may only offer in-person or in-home meetings to families who face significant barriers to accessing resources. When in-person and in-home meetings are scheduled, the Navigator consult with their Coach about preparation, details of the case, and plans to communicate before and after the meeting. Coaches consult with the Regional Director about each in-person and in-home meeting. Navigators have the discretion to offer in-person and in-home meetings based on the need of the family, and the Navigator's availability to conduct these types of visits.

In-Person Meetings

An in-person meeting is offered to a kinship or adoptive caregiver who faces a barrier to accessing services or has a need that can only be addressed by meeting in-person in the community with a Navigator. In-person meetings take place at a partner site location, or another neutral community location (library, school, court, local county office, restaurant, or other convenient location for the family). A partner site location, if available and applicable to the need, is the preferred option. The Navigator can offer an in-person meeting without approval by a Coach. A Coach may be asked to join the Navigator during an in-home meeting for training and supportive purposes. If a caregiver visits a partner office site unscheduled and asks to meet in-person with a Navigator who is working in the office, the Navigator starts a service episode with that individual

in-person. No additional criteria needed.

In-Home Meetings

During, or at any point after the Support Plan discussion, Navigators may offer in-home meetings to families who indicate that it would be a significant barrier to accessing services if a Navigator could not meet in their home. In-home meetings are offered secondary to in-person community meetings and need approval by a Coach.

Providing the Support Plan to the Family and Completing Documentation

The Support Plan is completed and provided to the parent or caregiver within two business days of the contact where the Support Plan was developed. Any additional referrals or relevant documentation such as activity logs should be completed within the same timeframe. The Support Plan should be sent via the parent or caregiver's preferred method of communication (email, text, or mail) and Navigators are advised to include the date and time of the next scheduled contact in the body of the message so that the parent or caregiver can reference it quickly without having to open the file.

Frequency of Support Plan Revisions

The Support Plan is updated after each scheduled contact with the parent or caregiver and sent to them via their preferred contact method. The Support Plan is saved in a secure location as specified by the program.

Support Plan Check-Ins and Revisions

The Support Plan check-in frequency and contact type (in-person, web meeting, or phone call) is determined in partnership with the OhioKAN Family upon initial development of the Support Plan. Bi-weekly check-ins are generally a good starting point. The frequency can change as the family's needs change. For example, a family may want to meet bi-weekly initially, but then decrease the frequency to monthly as the service episode progresses. Or a family who has wanted monthly contact may need more frequent support in response to an unforeseen situation.

The purpose of these check-ins is to ensure that OhioKAN Families receive appropriate advocacy support and additional referrals for the needs they have identified, and that Navigators learn about barriers to access, provide support, and verify that all needs are met. During each check-in, the Navigator confirms with the caregiver or parent if substantive changes and revisions are needed. Small updates to the plan are expected, however, revising the entire Support Plan at every check-in is not required.

Preparing to Check In

Prior to initiating a check-in with the OhioKAN caregiver or parent, the Navigator reviews the documentation for the case, paying specific attention to the needs identified on the BASICS and the Support Plan, notes from the previous check-in on the Support Plan, the household composition, and the family strengths and supports. Navigators are encouraged to use names of household members and ask strengths-based open-ended questions whenever possible. For example, instead of saying, "Does your niece like the new school?" say, "How is Brittany doing with her transition to the new school?"

During the Check-In

During the check-in, greet the caregiver or parent by name and identify yourself as a Navigator from the OhioKAN program. State the purpose of the check-in:

- To follow up on the Support Plan and check-in on identified action steps and referrals.
- To hear how their experience has been accessing or engaging with the services identified in the Support Plan.
- To see if any other needs have come up.

Priorities for the Check-In

Review the caregiver or parent's priorities for the check-in and ask which needs and referrals the caregiver or parent would like to discuss first. Due to time constraints, it may not be feasible to discuss each need and referral on the Support Plan during each check-in. It is acceptable to focus on addressing a single need during a check-in, for example spending an entire check-in completing a benefits application with a parent or caregiver. A full review of all needs should be completed once the service episode has been open for 90 days or more, see section titled Quarterly Support Plan Review.

Priority Needs and Referrals

Starting with the needs and referrals the caregiver or parent prioritized, ask about each referral made and summarize the caregiver's or parent's response in the Support Plan's Notes section. The response notes should be brief.

When discussing each referral, keep the following in mind:

- Has the person attempted to access the referral resource or take the action step?
    - If not, were there any barriers that prevented them from doing this?
    - If the person did not have time to act on the referral, help them think through a plan to do so by asking questions like, "Is there a time within the next week when you will have time to reach out to this organization?"
        - If the person has a plan to access a referral they have not yet attempted to connect with, ask them if they would like you to follow up again. Specify a best date or time of day to reach them and set yourself a reminder.

- If the caregiver or parent did attempt to access the referral resource, what was the result?
    - If the organization does not provide the service or has a waitlist, ensure this is documented and provide an alternative referral if possible. If an alternative referral is not possible because no other services are available, document this and elevate the service gap to the Regional Coordinator.
    - If the caregiver or parent was told they were not eligible for a service, clarify eligibility.

Since the last conversation, ask if any new needs have arisen.

- If new needs have arisen, document these in the Support Plan and provide additional referrals to address these needs.

Ask if the person feels all their needs have been met at this time and if no longer require Collaborate advocacy and navigation services.

- If yes, close the service episode.
- If no, explore additional needs and potential referrals with them. Document any new needs and referrals in the Support Plan.

After the Check-In

Ensure all documentation, including the Support Plan, is completed and saved in a secure HIPPA compliant location. All documentation is updated within two working days of the check-in. If revisions were made to the Support Plan, indicate the revision date on the Support Plan and share the revised Support Plan with the OhioKAN caregiver or parent within two working days by phone, electronically, or hard copy. Notes added to the Support Plan during the check-in do not constitute revisions. Be sure to document if a service gap was discovered or information needs to be added to the resource data system. Revisions are defined as substantive changes to the Support Plan, such as adding, removing, or editing the following elements: individuals involved, action steps, needs, referrals.

Quarterly Support Plan Review

When a Support Plan has been open for more than 90 calendar days, the navigator, coach, and caregiver or parent will conduct a comprehensive review of the Support Plan together to ensure that all needs have been identified and addressed with appropriate referrals and advocacy support. While similar to the structure of the Support Plan check-in process, the Quarterly Support Plan Review will revisit each aspect of the Support Plan with the family, discuss progress to date, and ensure alignment between the family's goals and the Support Plan.

Prior to Conducting the Quarterly Support Plan Review

The Navigator schedules a time to meet with the caregiver or parent to conduct the review together. A regularly scheduled Support Plan check-in may be repurposed for this activity. The Coach and Navigator review and discuss the OhioKAN Family's Support Plan to ensure understanding of the family's network of support, strengths, needs, referral history, and progress since opening their service episode. The Coach provides recommendations on how to approach specific sections and additional referral resources.

During the Quarterly Support Plan Review Meeting

The Navigator, Coach, and caregiver or parent review the summary notes from the Support Plan to confirm the Family's network of support, strengths, and needs identified when the service episode first opened. The Navigator asks if any events have occurred that have changed the make-up of the household. If yes, the navigator will update documentation accordingly.
The Navigator, with the Coach's additional support, will ask about each need and its referral(s) listed in the Support Plan to understand the following:

- How each referral addressed the identified need
- If there were any challenges or barriers to accessing each referred service
    - If the family cannot access a service, this should be documented as a service gap in the data system
    - If a family does not intend to use a referral the service should be end dated in the data system
        - Example: if the family received multiple referrals to meet the same need such as three different childcare providers, and selects one of these services, the other two should be end dated
- How the Navigator provided navigation and advocacy support to ensure the Family accessed the service
- Whether additional referrals or advocacy support were needed to address the identified need.
    - If yes, Navigator, with Coach's support, suggest additional referrals and action steps for advocacy support. Revise the Support Plan to include changes accepted by the caregiver or parent.

After reviewing each need and its referrals in the Support Plan, the Navigator asks if the Family had any needs that were not identified in the Support Plan.

- If yes, the Navigator revises the Support Plan to document these needs. The Navigator, with Coach's support, suggests referrals to address these needs and revises the Support Plan to include those accepted by the caregiver or parent.
- If no, the Navigator asks if the caregiver or parent feels all their needs have been met at this time and if they are ready to close the service episode.
    - If yes, close the service episode
    - If no, Navigator confirms that the Support Plan is accurate and includes all the Family's needs (identified prior to and during the Quarterly Support Plan Review meeting)

Referral Considerations

The Navigator suggests service referrals that are responsive to the parent or caregiver's priority concerns and informed by the BASICS and Support Plan. If the family needs additional or different referrals, these should be chosen in collaboration and partnership with the parent or caregiver taking the family's Support Plan into consideration. The following are things to consider when making referrals:

- Refer to organizations near where the OhioKAN Family lives and/or works
- Take into consideration the participant's past experiences, whether positive or negative, with organizations in their area. If an OhioKAN Family has concerns about a referral or organization, accommodate those concerns by suggesting an alternative.
- Consider transportation access (e.g., if the participant is traveling on public transportation, select an organization that is easily accessible via public transit)
- If a warm hand-off by phone, email, or in-person is needed, ensure there is a plan or scheduled time to do so and document this in the SACWIS and in the Support Plan.
- If the family has multiple needs, provide referrals to address these needs. Then, as appropriate, build out a plan with them of when and how they will access those referrals and what support they will need (e.g., reminders, assistance filling out forms, language or transportation support). Record this all in the Support Plan, specifically in the Support Plan Table.
- Use the Support Plan to prioritize and sequence support for the most urgent referral needs first. Sequencing does not mean the referrals themselves are withheld until a later date. All referrals should be provided as soon as the need emerges. However, the advocacy support related to referrals may include a plan to target one or two referrals at a time so that the number of initial engagements with service providers does not overwhelm the family.

Advocacy Supports

Targeted advocacy and navigation support to assist the caregiver and parent in achieving their Support Plan goals and accessing the services they have been referred to. The navigator may provide the following advocacy support as part of their Collaborate Service Level delivery:

- **Warm hand-off referrals**
  - You can offer to call an agency with a family on the phone, or call an agency on a family's behalf to make the initial introduction.
- **Assistance with an application**
  - You can offer to assist a family with an application for a social service benefit (SNAP, childcare, SSI, etc.) virtually or in person if there are barriers to completing the application virtually.
- **Flexible Funds and Hard Goods**
  - If a family needs hard goods like clothing, beds, car seats, etc., for their kinship or adoptive children, you can offer to directly link families to organizations and agencies for short-term assistance in obtaining these items, and follow up support.
  - If you have exhausted all community-based options for a family to meet a need for funds or hard goods, you can apply for flexible funds and hard goods through OhioKAN.
- **Benefits coordination**
  - If the family has questions about eligibility, a benefits appeal process, or would like support with an application, or other benefits challenges that require more specialized expertise, you can offer to connect them with the OhioKAN Benefits Coordinator.
- **In-person services**
  - In select situations, you can offer to join a family in a meeting with the child's school, social worker, etc. in the community to provide extra advocacy for the family.
  - If there are barriers to providing virtual support, you may also offer to visit the family in their home to assist with applications, etc.
- **Collaboration with caseworker, state, or local agencies**
  - You can offer to coordinate with the family's case worker, if they have one, or reach out to local/state agency contacts to advocate alongside them.

Referral Follow Up

A written procedure guides follow up, which happens at a convenient time for the family no more than 30 calendar days after the initial referral. The purpose of this contact is to ensure OhioKAN Families receive appropriate referrals for the needs they have identified in the BASICS assessment, learn about barriers to access, and ensure all needs are met. For further details on referral procedures, see above section on appropriate referral.

Before Following Up

Prior to dialing the OhioKAN Participant's number or sending an email, the navigator reviews the documentation for the service episode, paying specific attention to the needs identified on the BASICS assessment and the household composition. Navigators are encouraged to use names of household members whenever possible. For example, instead of saying, "how is your niece doing in her transition to the new school?" say, "how is Brittany doing in her transition to the new school?"

Follow Up Contact

Each family will receive a follow up contact as scheduled during the initial call and via their preferred method (e.g., phone call with a voicemail, text message, or email). Contacts with the family will be documented in the data system with a separate activity log for each contact. OhioKAN staff are expected to complete up to three additional contact attempts to reach a family if the originally scheduled follow-up contact is unsuccessful. These additional contact attempts should occur within five business days of

the originally scheduled follow-up contact. Additional contact attempts may involve using different contact methods (phone call, text message, or email), prioritizing the family's preferred contact method. If the family does not respond to the scheduled follow-up contact and three attempts to reach them have been made, OhioKAN staff will close the service episode 30 calendar days after the initial referrals were provided.

During the Follow-Up Contact

- Greet the person by name and identify yourself as a navigator from the OhioKAN program.
- State the purpose of the call:
  - To follow up on the referrals made during the prior call.
  - To hear about their experience accessing the service and learn if there were any barriers to service access.
  - To see if any other needs have come up.
- Ask about each referral made and document the participant's response.
  - Has the person attempted to access the referral resource?
    - If not, were there any barriers that prevented them from trying to access the service?
    - If the person did not have time to act on the referral, help them think through a plan to do so by asking questions like, "Is there a time within the next week when you will have time to reach out to this organization?"
      - If the person makes a plan to access a referral they have not yet attempted to connect with, ask them if they would like you to follow up again. Specify a best date or time of day to reach them and set yourself a reminder.
      - You may also ask the family if they need additional support in accessing a referral. If they would like additional support, ask if they have time to complete a Support Plan or would like to schedule a different time to complete it. Provide a brief overview of what to expect in creating the Support Plan so they can make an informed decision.
  - If the participant did attempt to access the referral resource, what was the result?
    - If the organization does not provide the service or has a waitlist, ensure this is documented and provide an alternative referral if possible. If an alternative referral is not possible because no other services are available, document this and elevate the service gap to the Regional Coordinator.
    - If the participant was told they were not eligible for a service, clarify eligibility.
  - Since the last conversation, have any new needs arisen?
    - If new needs have arisen, document these needs in a new BASICS and provide additional referrals to address these needs.
    - Ask the family if they would like additional information and referrals to meet these needs, or if they would like additional support.
  - Ask if the person feels all their needs have been met at this time.
    - If yes, close the service episode.
    - If no, ask open ended follow up questions to learn more, document the need, and provide additional referrals as appropriate.

Closing a Service Episode

A written procedure describes the process for when a service episode is closed. An OhioKAN staff may find out that a service episode has ended when they follow up with the family or when the family reaches back out to OhioKAN. There are three primary reasons a service episode may end, although other reasons may arise:

1. Family successfully accessed the provider.
2. Family was unable to access the provider, i.e., ineligibility, provider closed, or language barriers.
3. The need no longer exists, i.e., the child leaves the home, or the family met the need on their own.

Service Episode Closure Checklist

- Ensure all documentation in the data system is complete.
- Ensure any service gaps or issues with referrals are elevated to the proper person within your team and documented in the Info Hub if appropriate.
- Create an activity log in the data system to document the final contact.
- Use the activity log to close the service episode.

Once it has been identified that a Case Service needs to end, the OhioKAN staff should document that in the data system. How you document the end of a Case Service depends on how many providers you have linked to the Case Service. If only one provider is linked to the Case Service, you end the entire Case Service. If you have multiple providers linked to the Case Service, you end each specific provider. This allows you to keep the Case Service active if the family is still trying to access different providers or different providers have different end reasons.

Case Services automatically end when an episode is closed in the data system. If staff have no knowledge that a Service was accessed, that there were barriers, or that the family no longer needed the service then there is no need to end a Case Service or provider. This procedure only pertains to those situations in which the family has informed staff that the need for the Case Service or provider has ended.