Community Response
SARPY COUNTY

Purpose, Principles and Glossary of Terms

Administered by
LIFT UP
SARPY COUNTY

Key Purposes of Community Response (CR)

To assist agencies and individuals in creating a collaborative system of prevention.

Assist collaborations of community agencies, organizations and individuals in developing and maintaining a broad-based system of prevention services through addressing gaps and barriers and effective use of resources.

To help people in crisis access services and resources.

Assist individuals and families in accessing needed prevention services and resources in the community, especially during times of stress and crisis.

Guiding Principles of Community Response

Community Response:

- Is a voluntary system of services and support with families in a community.
- Strengthens family and community protective factors.
- Connects to isolated families that would otherwise not be able to easily access resources.
- Coordinates access to needed service by a central navigator.
- Provides supportive interaction with families to strengthen protective factors.
- Aligns agency services and effective use of community resources.
- Is culturally and linguistically competent.
- Is family centered and family driven.
- Enhances the prevention system for the well- being of the entire community.

To learn more about Protective Factors, please visit our website at liftupsarpycounty.org.

CR Target Population

Individuals and families from birth to death.

Individuals from birth to death are served through the braiding of resources and involvement of multi-sector partners in the CR system. The focus can be on the lifespan (the full age spectrum of children, individuals and partners). Risk is subjective, individual to each family, and needs to be screened in order to understand priority rating for appropriate services and supports.

Eligibility Criteria for Community Response (CR)

The family or young adult typically has one or more of the following challenges:

- No other services due to eligibility criteria causing a gap
- Receiving case managed services through an agency that is requesting specific resources to meet a gap in the case plan
- No formal/informal support system in place
- Significant barriers to connecting with a supportive network (may have previous foster care, juvenile justice, or child welfare involvement)
- Homeless/basic needs not being met (experiencing a crisis)
- Vulnerability due to age, developmental status, language barrier, or other individual circumstances
- High level of parental/caregiver frustration or stress
- Risk factors present related to trauma history or abuse history (ACEs)
- Physical and mental disabilities present (inclusive of challenging child behaviors)
- Substance abuse/Mental health
- Lack of access and/or knowledge of how to access for medical/pharmaceutical/mental health care
- High level of risk for potential CPS involvement

Glossary of Terms

Community Response (CR)

The actions a community takes to develop a system of resources and services which strengthen people by reducing risk factors and building protective factors.

The actions a community takes to develop a system of resources and services which strengthen families and promote access to resources at the primary, secondary, and tertiary levels of prevention. Families are identified as needing CR when there is one or more significant risk factors present such as potential CPS involvement or homelessness, when a single agency cannot fully meet their needs, or when a “one-time” or “crisis” results in them cycling back two or more times. CR includes an ability for providers/community members to call a Central Navigator to get information to help a family to connect to available resources in the community.

Brief Contact

One-time assistance with one resource – no follow up.

Contact that occurs when a family or individual requires one-time assistance with a single resource, or when the care coordination is in place but CR is needed to fulfill a specific identified gap, or when they require an item not covered by community prevention resources. The referral source helps to determine the initial pathway (brief or longer contact).

Longer Contact

Services provided to families with no formal or informal support systems that includes a progress review at 90 days and subsequent services as determined by the coach and the family.

The family or individual was referred by a community professional or as a self-referral and has no other services and no formal or informal support systems. They may have experienced a crisis, which results in homelessness, or near homelessness, extreme stress, are at-risk due to trauma or abuse, receiving multiple prevention services but no wrap around coordination, or required brief contact services more than twice in one year.

Central Navigation (CN)

Local agency with knowledge of available resources who manages referrals to service providers, CR data, and Flex Funds – no direct service provided to families.

CR works with communities, providers, and government agencies in the collaborative to enhance the community prevention system and respond to families' immediate crises. CN tracks Flex Funding and all referrals in and out of Community Response to identify population and community trends, develop best practices, gather and warehouse data, and identify gaps within the continuum of care. Example: A potential CR client approaches an agency but is not eligible for services. The agency assists in completing the referral form and works with the Central Navigator over the phone. The Central Navigator assesses the family's needs, including the number of brief contacts the family has had, and establishes next steps.

Coaching

Staff and volunteers of local organizations who partner with individuals and families over time to assist with connection to services and meeting goals.

Service provided to families who need shorter- term assistance with setting and meeting their goals. Building trusting relationships with the family is essential. Coaches utilize CR forms/tools to identify risks, needs, and determine desired goals, connect families to other resources and stabilization supports that increase protective factors, and provide financial case management support and skill building. Coaching can be performed by any of the CR partners and may involve referrals to other resources outside of the coaching agency.

Intensive Case Management

Wrap-around service coordination for families with more severe risk factors who require a longer time investment to become stable and self-sufficient.

Service provided to families who need intensive, high level, long term, and persistent services to achieve stability. Usually provided to families who have been in and out of higher systems of care. The focus is on family engagement, but strategies are not always family-driven.

Collaborative Partners

Local organizations, businesses, faith communities, government organizations and non-profits who commit to working in CR.

Partners involved in Community Response should have MOAS to establish common policies and practices and shared accountability.

Common Intake/Referral Form

CR Intake form used by all partners that captures key information about a family.

Helps to reduce trauma by reducing the amount of times a family must tell their "story" and provides consistency by capturing essential information for further assessment and planning at initial interview.

Enhanced Service Coordination

How CR works with other existing collaboratives.

Works with the local Continuum of Care for Housing and Homelessness for homeless or near homeless families to assure an array of quality residential housing. Also works with local Community Action Agencies and other service providers to enhance the collective work to serve individuals and families in each community.

Flex Funding

Limited funds available through the CR Navigator which can be used to pay for basic needs and to build greater stability.

Funding available through the central navigator to fill gaps where program and agency supports are limited due to funding criteria and limitations. May be used by agencies to elevate the parents' ability to reach personal goals, including support, stabilization, and basic needs. This funding is not meant to replace available basic needs funds from other agencies, and funds are not sufficient to meet all of the needs of a family or young adult.

Resource List

Mobile database of all available community resources.

List created by the community that identifies what is available in the target area (via a survey monkey, existing assessments and service array process/other community available assessments to determine known services and supports).

Service Utilization Form

Optional form used to track referral sources and services provided.

Utilized to determine where families are being referred from and whether families are coming into contact with CR early enough, and if the continuum of services and supports are in place and adequately resourced.

Shared Data System

System used by all partners providing longer contact to individuals that records and uses information about needs and goal outcomes every 6 months for CQI reports.

Intake, strength and needs, FRIENDS protective factor and satisfaction surveys, and closure forms are all included in the shared data system and help to establish need, goals, plans and outcomes. The system gaps and barriers should be captured to show family needs and barriers and should be presented in aggregate to community partners. Once entered in the system, information from coordinated case management, and intake and closure should flow back to the Central Navigator for shared accountability amongst partners and families.