Developing a Coordination Assessment Tool
For a Retaliatory Violence Victims Services Hub

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Introduction

CPSI continues to work with community partners to develop a services hub for victims of retaliatory violence. Our previous working paper, *Envisioning a Coordinated Services Hub for Victims of Violence*, is a starting point for how we imagine service coordination for violence victims. As we start to build on existing service coordination and also develop new mechanisms for coordination, an assessment tool will help us to understand how well we are doing. The focus of this paper is on the development of a coordination assessment tool.

What is a Coordination Assessment Tool (CAT)?

Service coordination can be defined as, "the deliberate organization of activities between two or more organizations to facilitate, in partnership with the family, the delivery of the right services in the right setting at the right time" (West et al., 2018). A Coordination Assessment Tool (CAT) is used to determine how well staff, programs, and resources are being coordinated across various service providers. CATs are an emerging practice, making them difficult to find. However, there has been some groundwork in this area, particularly in the child welfare and home visiting areas.

An assessment tool will help us to better understand, assess, advocate, and strengthen service delivery for victims of violence. This tool also would distinguish coordination from collaboration, streamlining, cooperation, and integration. Our understanding of coordination is grounded in Wangmann's levels of engagement model below (Figure 1) (Wilcox, 2010). In our view, at the core of service coordination are agreed upon protocols between service providers, including clear entry points for service delivery, and a focus on the victim's needs.

Figure 1: **Levels of engagement in interdisciplinary or interagency practice**

1.Service autonomy, with networking	2.Collaborative practice – formalised networking arrangements and organisational policy development	3. Streamlined referrals (incident-based processes, such as police faxbacks)	4. Cooperation (regular communication around clients and some common goals)	5. Coordination (agreed plans and protocols or a separately appointed coordinator)	6. Integration (single system with sub units and cross-unit accountability)

low levels of engagement ***high levels of engagement***

(adapted from Wangmann)

Establishment of Principles

One overarching question is whether the service coordination is being delivered with integrity – that is, living up to the commitment made by service providers (Trute, 2007)? An important first step is to establish principles to guide the work and to use as our benchmark. Guiding principles make clear the core values associated with the intervention or practice and should be developed collaboratively. This way, all stakeholders understand and agree on the most important aspects of the practice or intervention. For example, one framework identifies the following five principles for their early child home visiting service coordination: family centeredness; equity; adaptability; an inter- disciplinary perspective; and a focus on population health and well-being (West, Duggan, Gruss, Minkovitz, 2018). When working with victims of retaliatory violence, principles may include:

- victim centeredness
- accessibility
- culturally responsive services
- data-informed
- non-judgmental
- commitment to sustained, adaptive engagement
- focus on mental, physical, and emotional well-being

Once principles have been established, the development of the CAT should flow from these principles and the anticipated outcomes. We reviewed CATs and describe a few in the following section.

Existing Coordination Assessment Tools

Most people would agree that service coordination makes sense, but in practice, how do we know this is actually happening? West et al., (2018) developed a tool that includes 37 potential indicators within four overarching areas: Vision, Relationships, Infrastructure, and Authority and Accountability. As can be seen in Figure 2 below, each of these areas has specific items that then fall on a continuum, ranging from low coordination to high coordination.

Figure 2. *Coordination as a continuum*

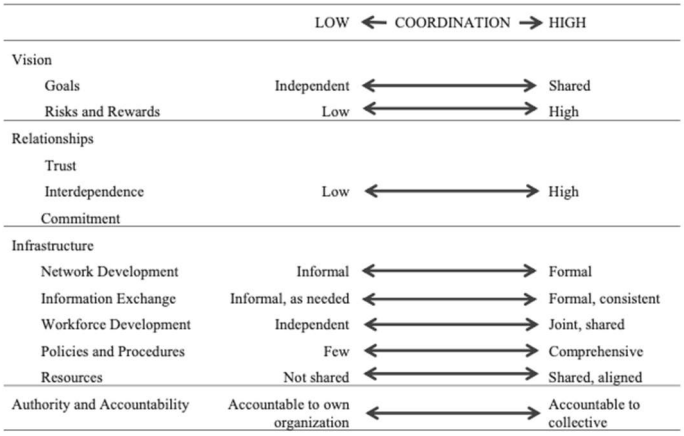


Fig. 1. Coordination as continuum.
Note. Adapted from Collins & Marshall (2006).

While this is a more qualitative approach to assessing service coordination, it raises an important point: Coordination exists across a continuum. Coordination it is not all or nothing. Rather, some aspects may be highly coordinated (e.g. protocols) while other aspects may be somewhat coordinated (e.g., staff trainings) and still other aspects may not be coordinated at all (e.g., data systems). While the ultimate goal is to have comprehensive service coordination, it is anticipated that it will take years to get to that level of coordination.

West and colleagues utilized the Delphi technique, which was developed by the RAND Corporation, to develop a CAT. The Delphi technique utilizes expert judgement (through a diverse group of experts with wide-ranging perspectives) to develop and build knowledge around an understudied issue (Niederberger & Spranger, 2020). While it is not the gold standard for assessing causality and effectiveness, it is an accepted approach when limited knowledge is available. For West and colleagues (2018), this process resulted first in agreement of the guiding principles that then led to the development of 37 service coordination indicators, associated with 15 factors (or components of service coordination). The factors are listed below.

Factors of Service Coordination	
Implementation	Staff with designated roles
	Training to assess, screen, refer, link, and follow-through
	Supervision/coaching
	Data system to support decision-making
	Policies and procedures for communication between programs and other agencies
Activities	Establish roles across organizations
	Assess family strengths and needs
	Create a goal plan
	Facilitate referrals and linkages
	Monitor, follow-up, and respond to change
	Support self-management of goals
	Align services with population needs and community resources
Short-term program outcomes	Increased family satisfaction and engagement with services
	Increased referrals to certain programs
	Increased feedback to community providers

Under each factor are more granular indicators, such as “Formal policy clearly defines accountability for measurement, reporting, and reviewing outcomes for coordination in the management information systems” and “Formal policy clearly defines WHO is responsible for assessment, screening, referral, linkage, and follow through.” Appendix A shows the comprehensive list that was developed.

Specific to family-centered services, there are some existing empirical instruments that measure process, including the Measure of the Processes of Care (MPOC) (G. King, Rosenbaum, & King, 1997; Cunningham & Rosenbaum, 2014), which assesses the parents’ perceptions of how family-centered they services they received were. The researchers behind the MPOC

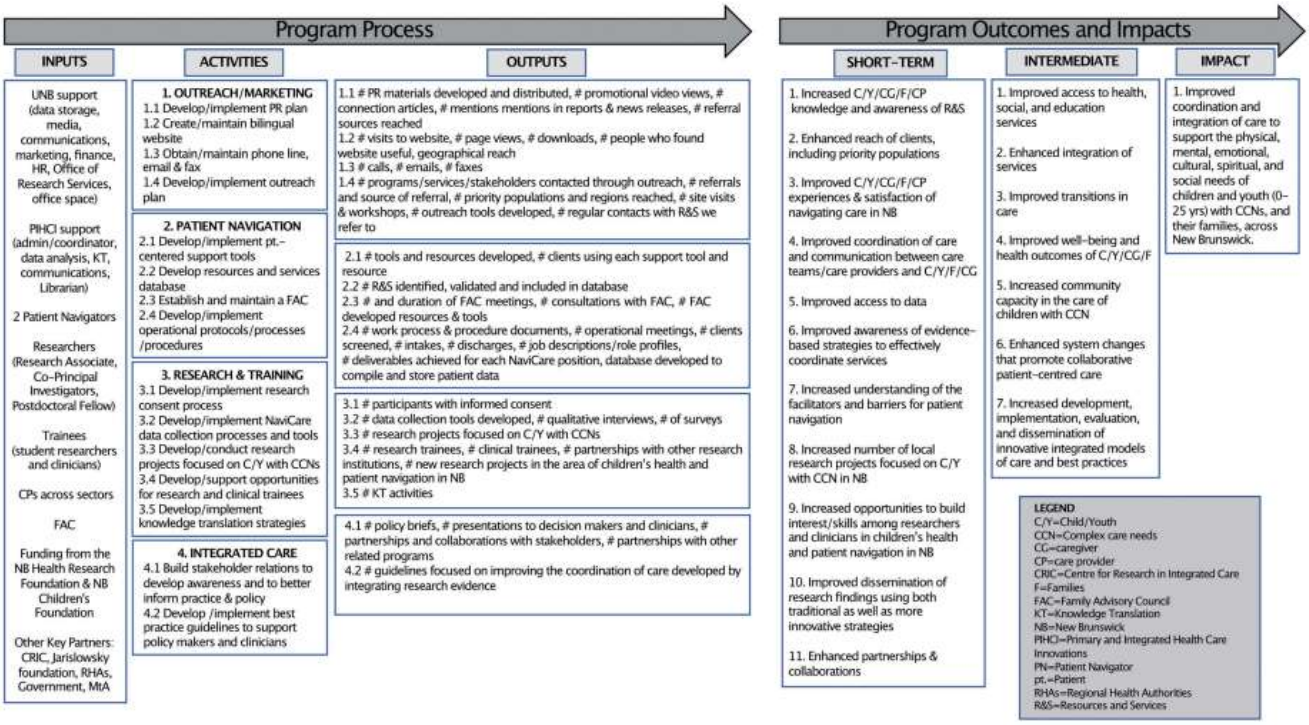
identified five components of family-centered practice: Providing General Information, Providing Specific Information about the Child, Enabling and Partnership, Coordinated and Comprehensive Care for the Child and Family, and Respectful and Supportive Care (Cunningham & Rosenbaum, 2014). Additional tools include the Helpgiving Practices Scale (Dunst, Trivette, & Hamby, 1996) and the Enabling Practices Scale (Dempsey, 1995; Vanderkerken, 2021). However, these scales are focused on family-centered practice. While service coordination for violence victims will offer services for surrogates, the main participant is the victim themselves, so these scales and underlying dimensions may not be accurate for this population.

Logic Models

An approach that could be used in tandem is the development of a logic model, which organizes the program components and shows the intended results (W.K. Kellogg Foundation, 2004). Logic models help to identify a clear cause-and-effect relationship (e.g., If we more actively engage clients in services, then clients will increase their service use), require logical thinking, and provide clarity (Funnell & Rogers, 2011; W.K. Kellogg Foundation, 2004). One of the first steps is identifying the important ingredients or inputs to successful service coordination. West and colleagues (2018) discovered that for service coordination these inputs include: shared goals, aligned resources, delegated responsibility, communication, information exchange, and accountability.

Another relevant example is Luck and colleagues' (2019) development of a logic model to guide the establishment of a navigation center for children and youth with complex needs. This model (Figure 3 below) includes inputs, activities, outputs, short- and intermediate outcomes, and overall impact. An evaluation matrix was then developed from the logic model. The columns include: short-term outcomes, evaluation questions, indicators, and data source. This information was completed for each of the four areas: outreach, patient navigation, research and training, and integrated care.

Figure 3. *Navigation Center Logic Model*



Recommendations

While there is little empirical information available on service coordination for violence victims, there is some overlap with family navigation centers and general service coordination that can be used to develop a CAT for a services hub for retaliatory violence victims. Based on the information gathered, we make the following recommendations:

(1) Agree on a definition of service coordination and how coordination is distinct from collaboration, integration, and cooperation.
(2) Collaboratively develop guiding principles and share these with the community.
(3) Describe and agree on what "success" looks like. For example, the potential benefits to coordinating services include improved treatment adherence, coordination, and follow-up; reduction in service barriers; improved problem-solving; improved patient experience, and improved well-being (Luck, Doucet, & Luke, 2019). Agency outcomes may include the potential to reduce costs due to reduction in service duplication and increasing the skills of agency staff (Wilcox, 2010). Potential community outcomes include improved service integration across systems, increased community capacity to care for violence victims, and increased trust in systems and agencies.
(4) Based on (1), (2), and (3) develop a program logic model.
(5) Review and adapt the West et al. (2018) CAT indicators to create a Violence Victims Services Hub CAT. This CAT should incorporate items (1) – (4). Consider using West et al.'s four areas: vision, relationships, infrastructure, and authority and accountability as the overarching framework.

(6) Once the CAT is developed, use the tool to assess the current state of coordination across the partners involved in the project (establish baseline).
(7) Based on all of this, then, create and implement a process evaluation plan. For example, after piloting three violence victims, utilize the newly created CAT tool to assess the service coordination. This assessment should also include input from the families and victims themselves. For example, consider adapting the Measure of Processes of Care (MPOC) to gather victims' perceptions of their services (Cunningham & Rosenbaum, 2014).

Future papers in this series will provide examples of a CAT for community-based organizations seeking to reduce violence in Rochester. Implementation of such a model should facilitate collaboration between community organizations and the aid the development of effective community-based violence interventions. When properly implemented, such approaches should reduce levels of violent victimization in Rochester.

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Appendix A. Indicators of Service Coordination (West et al., 2018)

Indicators of service coordination.

Implementation system		
Factor and defintion	#	Indicator
Staff with designated roles *Staff are provided clear expectations and accountability. Staff include home visitors, supervisors, program managers, directors, and others employed at the organization.*	I-1	Job descriptions clearly define expectations and accountability for assessment, screening, referral, linkage, and follow through. [1,7]
	I-2	Formal policy clearly defines WHO is responsible for assessment, screening, referral, linkage, and follow through.[10, 14]
Training to assess, screen, refer, link, and follow-through *Staff receive instruction regarding assessment, screening, referral, linkage and follow-up.*	I-3	Formal policy clearly defines the timing and scope of training for HV staff around assessment, screening, referral, linkage, and follow through.[1, 7, 10]
	I-4	Formal training for HV staff focuses on assessment, screening, referral, linkage, and follow-through with other service providers.[1, 7]
	I-5	HV staff are competent in using a family-centered approach when coordinating services with families with diverse background, strengths, and needs. [15]
Supervision/coaching *Oversight is readily available and of high quality.*	I-6	Supervisors support and monitor staff around assessment, screening, referral, linkage, and follow through.[1,2, 7]
	I-7	HV staff use supervision or coaching data regarding assessment, referrals, linkages, and follow-through to drive improvements in processes.[2,8]
Data system to support decision-making *Information and reporting systems inform continuous quality improvement regarding home visiting services. Information is collected regarding coordination to support improvement in policy, practice, and programs.*	I-8	Formal policy clearly defines accountability for measurement, reporting, and reviewing outcomes for coordination in the management information systems.[8, 10]
	I-9	Management information systems maintain data specific to screening, referral, linkage and follow through.[8]
	I-10	HV staff use a data system to inform decisions regarding coordinating services for families.[8]
Policies and procedures for communication between HV programs and other agencies *Formal policies or procedures specify the intended nature of communication (content, mode, frequency of interactions) between agencies.*	I-11	Formal agreements or memoranda of understanding support communication between HV programs and other agencies.[5, 14]
	I-12	Formal policy clearly defines the primacy of the family in deciding what and with whom information is shared.[14]
Activities		
Activity and defintion	#	Indicator
Establish roles across organizations. *Clear expectations delineate WHO is responsible for WHAT services or aspects of services, including service coordination.*	A-1	HV staff understand the roles of other community providers with regard to serving families.[1, 7, 9]
Assess family strengths and needs *Determine the family's strengths and needs in areas including but not limited to physical, emotional, social, psychological, and spiritual health and well-being as well as need for education, employment, peer support.*	A-2	Families participate in a comprehensive assessment of strengths and needs.[2,9]
	A-3	Family assessment includes consideration of both formal and informal supports (professional, friends, and relatives).[15]
	A-4	HV staff screen families/children for [XX] with a standardized tool.[2]
Create a goal plan *In partnership with the family, establish and maintain a goal plan that outlines the family's short- and long- term goals and steps to achieve them.*	A-5	Families have a goal plan.[1, 5, 7]
	A-6	Goal plans have clearly specified family-centered goals for home visiting.[1, 2, 7]
	A-7	Goal plans clearly document that family preferences were incorporated.[9, 13]
	A-8	Goal plans incorporate families' formal and informal supports (professionals, friends, and relatives).[14]
Facilitate referrals and linkages *Facilitate referrals and linkages by sharing pertinent information with families and providers.*	A-9	Family agreement for exchange of information about [XX] screening results is documented in record.[3]
	A-10	HV staff offer a referral to families with a positive screen for [XX] who are not already in services.[4]
	A-11	HV staff provide referral information specific to [XX] to families with positive screens for [XX].[6]
	A-12	HV staff provide key information to the family about the referral (such as logistics, nature of services provided).[7, 12]
	A-13	HV staff provide pertinent information about the family to the community provider at the time of the referral (e.g., reason for referral; family needs and preferences).[5, 7, 12]
	A-14	HV staff provide a warm-hand-off to families who receive referrals to community organizations (this refers to connecting a caregiver with a provider in real time, in person or by phone).
Monitor, follow-up and respond to change *In partnership with the family, HV staff assess progress toward service and service coordination goals on a regular basis.*	A-15	Home visiting staff follow up with families who received referrals to learn about the family's understanding and next steps.
	A-16	Home visiting staff follow up with families who received but did not complete referrals to learn why referral was not completed.[15]
	A-17	Home visitors review the goal plan monthly with families and update as needed.[13, 14]
Support self-management of goals *Tailor education and support to align with families' capacity for and preferences about involvement in their own care and to promote empowerment, self-efficacy, and engagement.*	A-18	Home visitors use specific strategies (e.g., coaching, motivational interviewing) to promote self-care, progress toward goals, and self-sufficiency.[12]
Align services with population needs and community resources *In partnership with other community organizations, adapt services to meet changing population needs and availability of other community resources.*	A-19	HV staff are actively engaged in community discussions regarding the evolving needs of the community, gaps in services, and the capacity to serve all families in need of services.[1, 7, 9, 11]
	A-20	HV staff participate in community health planning activities.
Short-term program outcomes		
Outcome and defintion	#	Indicator

Increased family satisfaction and engagement with HV services		
Families are report satisfaction and demonstrate increased participation and engagement in services.		
Increased referrals to home visiting program		
HV programs receive appropriate referrals from community organizations.		
Increased feedback to community providers		
HV programs share feedback with community providers regarding HV services families receive and progress toward achieving goals		
	OF-1	Families receive all of the expected home visits each month. [1,4,7,12]
	OF-2	Families report satisfaction with HV services. [1,7,12]
	OF-3	Families remain enrolled in HV for recommended time period. [1,7,12]
	OO-4	Number of referrals of families meeting eligibility requirements within a 6 month period.[5]
	OO-5	HV programs give feedback about family progress to community providers.

Note. XX refers to maternal depression, intimate partner violence, maternal substance use, or child development delay.

Note. Indicators were adapted from the following sources: 1) ANA (2013); 2) Antonelli et al. (2009); 3) French and Scholle (2010); 4) Mackrain (2016); 5) JBA (2014); 6) HRSA (2016); 7) McDonald et al. (2014); 8) NIRN (2015); 9) NQF (2014); 10) PEW Charitable Trusts (2015); 11) Preskill, Parkhurst, and Splansky Juster (n.d.); 12) Schultz, Pineda, Lonhart, Davies, and McDonald (2013); 13) Singer et al. (2011); 14) Snyder, Lawrence, and Dodge (2012); 15) Proposed by Expert Panel.