Example Strategies Promoting Equity in Education

Following are some example strategies for promoting equitable education outcomes. While these have been collected from the literature and are showing some promising potential, their inclusion on these pages does not imply they are a good fit for your community. Please use the links provided to learn more about the strategies. The strategies are organized into three categories:

Environment Strategies

Strategies to shift aspects of the physical, built, or social environment

Leverage existing or underutilized community resources

Repurpose vacant buildings, spaces, or lots into usable resources for marginalized communities to promote targeted equity goals. For example, transform vacant buildings into service hubs (see service hub examples above) or abandoned public spaces into parks and farming plots.

- **Example**: One neighborhood in New York City turned an abandoned elevated railway into a thriving urban park called the "High Line". http://www.thehighline.org/about
- **Example:** In Detroit, MI, vacant lots have been turned into thriving urban farming plots to promote goals around health.

Supplement existing transit resources in marginalized communities through locally driven transportation networks, for example through carpools or existing transportation resources. These efforts should be in combination with efforts to expand public transit in these neighborhoods.

- **Example: Resident carpools.** Support residents in setting up carpools to services. This not only helps address transportation needs, but also provides opportunities for residents to build relationships.
- **Example: Coordinate transportation resources through local churches.** Help residents without access to transportation get to service appointments using volunteers and church vans during weekdays when these vehicles are not being used by the church.

Adopt resident-centered, culturally informed service environments

Design resident-centered waiting rooms and service settings that promote a positive experience.

- **Example**: Jerome Belson Health Center in New York City launched a patient visit redesign effort to address long patient waiting times and staff frustration. After tracking patient flow, the redesign team made a number of changes to streamline to the process. In the redesigned system, patients make three stops per visit instead of five. Patients formerly moved from one exam room, where the nurse took vital signs, to another to meet their provider. Now, patients settle in one exam room and the nurse and provider come to them. The redesign created more communication between clerical and clinical staff, better enabling clerical staff to notify clinical staff when patients arrive and again if patients are waiting for more than 10 minutes. As a result of these and other changes, patient cycle time decreased from 68 minutes to 41 minutes. (directly cited from Gordon and Chin, 2004 https://www.brookings.edu/wp-content/uploads/2016/06/1024_medhomes_ross.pdf

- **Example**: At Mercy Hospital Fairfield in Cincinnati, Ohio, mother and baby receive high-quality, family-centered care in a setting that feels like home. Through labor, delivery, and recovery the mother, baby, and family can stay in one room.

Policy Strategies

Strategies to shift policies, practices, or procedures

Simplify enrollment processes

Simplify intake or application processes to make it easier for marginalized residents to enroll in services.
For example, create a common application form or common intake hub, reduce the number of intake step involved in the enrollment process, or develop intake applications as a phone app.

- **Example**: South Dakota simplified its application process for CHIP and Medicaid by issuing a single card for both. www.childrensdefense.org/site/PageServer?pagename=childhealth_chip_whatsworking_frontier

Create automatic enrollment processes for recurring services to simplify the process and reduce potential gaps in services.

Expand eligibility policies

Expand eligibility policies restricting marginalized residents' access to services, or advocate for expansion of policies.

- **Example**: The eligibility level for South Dakota's CHIP program was increased from 140% to 200% of the federal poverty level and significantly raised the number of children who are eligible for free or low-cost health coverage... www.childrensdefense.org/site/PageServer?pagename=childhealth_chip_whatsworking_frontier

Adopt policies and practices to support cross-sector referrals and information sharing

Develop shared intake forms to promote coordinated referrals across organizations addressing the needs of marginalized residents.

Embed coordinated assessment, early screenings, and referral processes within multiple settings that touch marginalized residents.

- **Example**: The Children's Services Council (CSC) of Palm Beach County, FL screens children from birth to early years for developmental, social, and behavioral issues using tools like the Ages and Stages Questionnaire and then connects parents to one or more of a wide array of interventions through its strong network of organizational partners (e.g., Triple P, Incredible Years, Parent-Child Home Program, Nurse-Family Partnership, Centering Pregnancy, etc.). http://www.bridgespan.org/getattachment/feb8d3d3-042c-4a7b-a828-3b5bda8283a9/Achieving-Kindergarten-Readiness-for-All-Our-Child.aspx

Create a shared consent form to give residents the opportunity to give consent to information sharing across organizations given current policies such as HIPAA and FERPA.

Develop two-way feedback loop processes to support communication about referral status among organizations and programs. Information flow is crucial to adequate and successful systemic functioning, especially related to system referrals. Two-way feedback loops help to produce information in support of adaptation and learning which is fundamental to effective implementation.

Example Strategies Promoting Access to Affordable, Healthy Food

Adopt policies and practices to support effective communication with families

Embed practice of keeping a record of 3 dependable contacts to prevent losing touch with residents. Ask marginalized residents for three contacts who will always know how to reach them despite moves and phone number changes. List these contacts on a card within the resident's file and update regularly.

Provide example questions and processes marginalized residents can use to feel comfortable and safe discussing their current needs with service providers.

- **Example**: Some communities have created packs of cards that list common barriers, needs, and aspirations families face in helping their children succeed in school. Cards can be created in categories or 'suits' that help families and providers organize their thoughts. Specific topics are written on the back of cards within categories to explore together, like "I want to be able to support my child with homework." Blank cards are also included in the deck so families can write in their own unique conversation topics. Families and professionals can use these cards to guide their conversation about overcoming these barriers and engaging in supportive change behaviors.

Allocate enough time for providers to build relationships with marginalized residents during service visits.

Engage stakeholders in positions of power in shifting policies influencing local inequities

Engage directors, executives, funders, and other relevant decision-makers in shifting policies influencing local inequities within their scope of work to align with equity goals.

Engage managers and supervisors in shifting daily procedures to align with equity goals.

Advocate for compliance with and expansion of regulations that support community needs

Work around HIPAA and FERPA policy barriers by creating a shared consent form to give marginalized residents the opportunity to give consent to information sharing across organizations.

Advocate for policies aligned with targeted changes with stakeholders in positions of power and decision-making. Consider how your efforts can advocate for needed policy changes, for example through gathering and sharing critical local information about how the regulation is contributing to current inequities, and providing ongoing feedback and recommendations.

- **Example:** The National Partnership for Women and Families supports local campaigns to expand the Family and Medical Leave Act and other policies to cover more working people and more family needs (e.g., paid leave benefits). http://www.nationalpartnership.org/issues/

Support grass-roots, resident-driven advocacy campaigns to approach local, state, or federal officials with information about needed shifts in community planning, budgeting, and infrastructure.

- **Example:** Michigan's Children Sandbox Party is the state's leading non-partisan grassroots advocacy network for children, youth and families. Their aim is to advance state policies, practices and investments that support health, development and learning from cradle to career. http://www.michigansandboxparty.org/

Example Strategies Promoting Access to Affordable, Healthy Food

Use change goals as framework for designing new policies

Use a "Health Equity in All Policies" approach where considerations related to addressing targeted health and wellness inequities are embedded into cross-sector policies and decision-making processes.

- **Example**: In Los Angeles, the city planning department considered how to promote health equity through the layout of sidewalks and parks. In Baltimore, the local government embedded health into its zoning regulations by limiting the concentration of alcohol outlets. http://www.phi.org/uploads/files/Health_in_All_Policies-A_Guide_for_State_and_Local_Governments.pdf
- **Example**: In Nashville, TN, the Metro Public Health Department worked to institutionalize their commitment to health equity. Agency leadership codified this commitment by making it a policy to incorporate health equity as a decision filter in all policy, programmatic, and practice activities. http://www.healthynashville.org/index.php

Embed practices promoting equity into existing protocols and processes

Embed targeted practices into current procedures and protocols.
For example, embed new assessment tools/questions into current intake procedures and early screenings into protocols used by providers reaching targeted families. Embed strategies into handbooks or toolkits.

Embed reminders or prompts for targeted practices.
Develop and embed reminders to help providers remember to use new practices.

Promote new expectations and accountability for practices promoting equity

Track implementation consistency.
Use a tracking system to understand how and when targeted practices are being used. Reward improvements in consistency over time. Tracking can be internal as well as shared with other organizations to promote consistency between providers.

Shift staff roles and job descriptions to support targeted practices.

Build residents' capacity to encourage accountability.
Prepare residents to ask questions with relevant stakeholders about the use of targeted practices during service visits or during meetings.

Add targeted practices into annual staff review evaluation criteria to set new expectations and promote accountability.

Provide continuing support and training for practices promoting equity

Provide coaching support to trouble-shoot implementation barriers and help stakeholders effectively carry targeted practices.

Reinforce targeted practices during annual training and orientations.
Add practices into annual training and orientations (e.g., for staff, collaborative members, councils, etc.), and embed within CEU training.

Support champions in encouraging targeted practices, including leadership, staff, and resident champions.

Example Strategies Promoting Access to Affordable, Healthy Food

Encourage peer to peer support for targeted practices, for example through communities or practice or staff reflection groups.

Advocate for needed resources

Advocate for needed community resources such as transportation, affordable housing, etc**.** Gather data from residents on local needs, and share the information with local decision-makers and authorities to advocate for needed changes.

Support grass-roots, resident-driven advocacy campaigns to approach local, state, or federal officials with information about needed shifts in community planning, budgeting, and infrastructure.
Michigan's Children Sandbox Party is the state's leading non-partisan grassroots advocacy network for children, youth and families. Their aim is to advance state policies, practices and investments that support health, development and learning from cradle to career. http://www.michigansandboxparty.org/

Create new pathways to share available data

Connect with community partners who have access to data on local inequities and community system conditions in order to bring this data into relevant decision-making processes.

- **Example**: The Louisville Metro Public Health and Wellness Department connected with resources like the University of Louisville School of Public Health and Information Sciences to obtain and analyze data related to social determinants of health like income, violence, transportation access, and healthy food access (including proximity to fast food restaurants). GIS mapping was used to identify and locate relevant indicators by ZIP code.

Embed processes to ensure 211 remains updated. For example, create automated update reminders and incentives for organizations to update their information regularly.

Develop integrated information systems where information is collected once and then made accessible to multiple organizations based on residents' consent. For example, these systems can include information from clients' intakes or on clients' progress.

Engage new funding partnerships

Leverage private sector support and pursue public-private partnerships to access additional resources to support targeted equity goals.

- **Example**: The Illinois Facilities Fund is a community lender that provides low-interest loans and technical assistance to non-profits for facility renovation and construction. Public- and private-sector resources and expertise combine to support capital improvements. Partners include the Illinois Department of Children and Family Services, the City of Chicago, national and local foundations, financial institutions, community development corporations, and child care providers.

Leverage or Reallocate existing funding

Re-appropriate funds to support targeted equity goals.

Example Strategies Promoting Access to Affordable, Healthy Food

Braid funding across efforts to create larger collective pots of funding to support cross-sector equity goals.

- **Example**: In MI, the Great Start Readiness Program, Early Childhood Special Education, and Head Start have braided funds to cover the cost of preschool classrooms. These funds can be coordinated and allocated such that they are not overlapping and are also able to fill any gaps where there may be a need for such funding. (See: http://www.michigan.gov/documents/mde/Braided_Funding_in_Early_Childhood_Education_402501_7.pdf for a table used to organize a braided funding plan)

System Strategies
Strategies to shift aspects of the community system

System Strategies address these key community system characteristics:

Connections
Relationships and exchanges between people and organizations

Align and integrate curriculum and practices across settings serving marginalized groups

Align core priorities and curriculum elements across settings and programs serving marginalized groups. For example, ensure that pre-K curriculum used by settings serving marginalized children matches the requirements within the Kindergarten curriculum those children will ultimately use when they enter school.

- **Example**: At McFerran Elementary School in Louisville, Kentucky, pre-K teachers spend the first week of every school year helping to teach kindergarten. This reminds them which skills children need by the end of pre-K. In addition, the pre-K center at McFerran uses a curriculum created by the district and connected to state standards for what students should know at fourth. grade.www.jefferson.k12.ky.us/Schools/Elementary/McFerran.html

Help settings serving marginalized groups adopt aligned transition processes to make it easier for residents to transition from one program to another.

- **Example**: In some communities, hospitals partner with the Women, Infants, and Children Program (WIC) to put practices into place to ensure continuity of breastfeeding support for low-income mothers following discharge.

Coordinate shared training across sectors serving marginalized groups to ensure providers are using aligned practices.

Align practices across service and home settings

Align capacity-building content for professionals and residents to encourage consistent practices at home and program settings.

- **Example**: McNabb Elementary School in Kentucky trains the entire school staff yearly in research-based Positive Behavioral Intervention & Support approaches to discipline and classroom management. They begin each day with a building-wide morning assembly reminding the students (and staff) of the expectation of their school. Those expectations are re-taught in the classrooms with weekly "success opportunities" to celebrate the accomplishments of the students. Once the school year begins, they orient the parents on this approach. (Directly cited from: https://www.pbis.org/school/exemplar-from-the-field/mcnabb-elementary-ky).

Expand role boundaries of potential referral sources

Engage local health care providers in "prescribing" free programs and supports promoting targeted changes to marginalized residents.

- **Example**: In New Haven, CT local health care providers prescribe residents with health risk factors to attend New Haven Farms' free 20-week Wellness Program where families work on farm plots, learn how to prepare healthy vegetable meals using the produce they've helped to grow, and engage in healthy community meals. http://www.nytimes.com/2014/11/07/giving/what-the-doctor-ordered-urban-farming-.html?_r=3#story-continues-2

Engage community stakeholders in making referrals during natural touches with marginalized residents. For example, stakeholders like clergy, hair salon stylists, grocery store check-out lines, and bank tellers can be great partners for referring families to services.

Create new settings and systems to support information sharing

Create cross-sector service teams who collaborate around shared cases (e.g., system of care approach; wrap around services).

Develop integrated electronic information systems where information is collected once and then made accessible to multiple organizations based on residents' consent. For example, these systems can include information from clients' intakes or on clients' progress.

- **Example:** Healthy Beginnings out of Palm Beach, Florida, includes an integrated data system that tracks individuals as they move between providers in the service delivery network. http://www.bridgespan.org/getattachment/feb8d3d3-042c-4a7b-a828-3b5bda8283a9/Achieving-Kindergarten-Readiness-for-All-Our-Child.aspx

Share information gathered through collaborative meetings with providers at staff meetings. Embed practice where information shared at collaborative meetings is brought back and discussed at organizations' staff meetings.

Use 211 to diffuse information about new programs or opportunities to professionals. Ensure 211 is current and professionals are aware of this resource.

Create new processes to support effective communication with families

Engage cross-sector providers and community stakeholders in sharing information during natural touches with marginalized residents. For example, stakeholders like pediatricians, clergy, hair salon stylists, grocery store check-out lines, and bank tellers can be great partners for sharing information.

Example Strategies Promoting Access to Affordable, Healthy Food

Embed practice of including information for residents into regular mailings. Talk with local businesses or organizations to embed key information about available services or targeted changes into regular communications such as gas bills, school report cards, and newsletters.

Use 211 to diffuse information about new programs or opportunities to marginalized residents. Ensure 211 is current and marginalized residents are aware of this resource.

Adopt new outreach practices of sharing information in natural traffic areas for marginalized residents, using social media, or using mass text communication to reach them in non-traditional ways.

Facilitate resident networking. Support opportunities for marginalized residents to gather together in local settings to share experiences, information, and build a social support network.

RESOURCES

Human, financial, and social resources

Embed capacity-building into existing settings and practices

Embed a focus on targeted capacities into ongoing training. Integrate necessary skills and knowledge into annual trainings and new staff orientations.

Provide cross-sector professional development to build capacity around targeted equity goals. Engage providers and leaders in the development of these capacity-building efforts.

- **Example**: The National Diaper Bank Network and The New Haven Mental Health Outreach for MotherS (MOMS) Partnership at the Yale School of Medicine collaborated to create the Basic Needs-Informed Curriculum, designed to train providers to think through how poverty-related issues like gaps in basic needs can affect wellness. The Basic Needs-Informed curriculum helps providers address poverty-related issues as part of improving their service delivery and identifying resource issues that are linked to behaviors. Social workers, doctors, nurses, teachers, and mental health professionals are encouraged to participate together. More information is available at http://nationaldiaperbanknetwork.org/about-ndbn/bnic/.
- **Example: "Service Agency Speed Dating"**. Providers from multiple agencies get together and spend 5 minutes at a time talking in pairs to educate each other about the services offered at their agency. The pairs rotate throughout the event so each person is exposed to multiple agencies. A document is created summarizing what has been learned through the event and distributed to local organizations (e.g., during staff meetings) to ensure all relevant providers have this information. These events can be scheduled quarterly.

Open up existing trainings and professional development to other relevant stakeholders.

- **Example:** Some communities have expanded professional development offered for publicly funded preschools to home-based childcare setting providers as well to ensure new practices are spread throughout multiple settings.

Provide technical assistance and coaching to encourage effective use of targeted skills and knowledge. Make sure learning continues to be reinforced after a training session ends.

Embed capacity-building into existing paperwork and processes. For example, add information on how to make referrals or share information with residents directly into the protocols and materials.

Example Strategies Promoting Access to Affordable, Healthy Food

Provide toolkits to help stakeholders use targeted practices, and ensure these materials are aligned with professional development content.

Share information relevant for implementing targeted practices gathered through collaborative meetings with providers at staff meetings. Embed practice where information shared at collaborative meetings is brought back and discussed at organizations' staff meetings.

Create mentoring partnerships

Create a feedback process for experienced providers to share feedback with new direct service providers. For example, set up mentoring processes for veteran providers to support the capacity-building of newer staff.

Set up networks to provide service staff with direct access to consultation from experts across sectors, such as from mental health, substance abuse, domestic violence, impaired parent-child relationships, and child development

Leverage 211 to share information about services

Use 211 to diffuse information about new programs or opportunities to both marginalized residents and professionals.

Ensure 211 is current and providers are aware of this resource.

Design resident-centered outreach practices

Ask marginalized resident how they would like to receive information. Do they prefer text? Facebook or other social media? Email? Would they prefer face to face interaction only? Also ask other local organizations what methods they use successfully.

Craft information about services that marginalized residents can understand and resonate with. Write information in multiple languages, make it easy to understand (no jargon, emphasize how programs are necessary, desirable, and feasible for residents to participate in.

Engage direct natural touch points in sharing information with marginalized residents

Engage community stakeholders in sharing information during natural touches with marginalized residents. For example, stakeholders like clergy, hair salon stylists, grocery store check-out lines, and bank tellers can be great partners for sharing information.

Engage cross-sector service providers in sharing information during every touch with marginalized residents by having them ask residents about other needs and sharing resources to common barriers.

- **Example**: In many communities, pediatricians prescribe new behaviors promoting school success, such as engaging in reading with their young children, and make concrete suggestions for dealing with barriers such as parents' own literacy levels and limited time. http://time.com/2934047/why-pediatricians-are-prescribing-books/

Engage respected neighborhood leaders in supporting current outreach efforts within marginalized communities.

Example Strategies Promoting Access to Affordable, Healthy Food

Adopt new non-traditional outreach practices

Use multiple mediums to get the word out. Don't depend on one method to get the word out. Use a combination of face-to-face contacts, large events, networking, and virtual interactions to let people know what's available.

Include information for marginalized residents into regular mailings. Talk with local businesses or organizations to embed key information about available services or targeted changes into regular communications such as gas bills, school report cards, and newsletters.

Adopt new outreach practice of sharing information in natural traffic areas for marginalized residents. Go to areas that receive high-traffic of residents from your target population to share information.

- **Example**: The Thirty Million Words Initiative started recruiting on public transportation systems to find families who were eligible and interested in receiving services to improve their child's school readiness.

Partner with other groups, organizations, or collaboratives with similar goals to increase visibility. Combine outreach efforts with groups pursuing similar equity goals to reach more settings and residents.
Use Enrollment campaigns similar to those used for voter and health insurance registration to promote effective outreach.

- **Example**: Voter registration and health insurance enrollment campaigns might serve as models how to enroll residents in programs. The National Council of La Raza and other Hispanic organizations have helped lead successful campaigns to register voters and enroll people in health plans. http://www.bridgespan.org/getattachment/feb8d3d3-042c-4a7b-a828-3b5bda8283a9/Achieving-Kindergarten-Readiness-for-All-Our-Child.aspx

Leverage online platforms to share updated information with marginalized residents

Use social media to communicate with marginalized residents. One school set up a twitter account that announces upcoming school events and news. Residents can organize around a Facebook group page, or another social networking site they frequent.

Use mass text communication to engage marginalized residents in nontraditional ways.

- In some communities schools use a Parent Contact Database to help teachers can send mass texts to parents letting them know what the students are working on and how they can support learning with fun home activities. Similarly, healthcare or community service providers can send out daily personalized texts asking how the client is doing or providing helpful tips or encouragement. Teachers and providers can track the responses and follow up with residents who want additional support. You can learn more in this Strategic Communications Brief from the W.K. Kellogg Foundation: https://www.wkkf.org/resource-directory/resource/2006/01/template-for-strategic-communications-plan.

Link marginalized residents with online resources to help them pursue their goals.

Create an electronic resource directory housed on every organization's website that is updated frequently.

Develop online navigation platforms that can assess for residents' needs (or link with prior assessments carried out by organization staff) and automatically generate customized reports of available services, including eligibility and enrollment information. Consider how to embed processes to update the database regularly with service changes. (See COMPASS for an example: https://www.compass.state.pa.us/Compass.Web/MenuItems/LearnAboutCompass.aspx?language=EN).

- **Example:** HealthConnect.Link is an online community of free and subsidized health care and social services designed to support and connect the area's most vulnerable and marginalized residents to care by identifying nearby organizations with the ability to provide the needed care and services in real time. (Directly cited from https://www.med.wisc.edu/news-and-events/2017/december/partnership-awards-boost-community-projects/

Provide resident capacity building

Embed resident leadership training into current settings engaging marginalized residents to build their capacity to advocate for themselves and their community.

- **Example**: In Milwaukee, the Youth Decarceration initiative engages youth from schools with highest rates of suspensions and expulsions to build their leadership skills to work with key community organizations to help "reform inequities in disciplinary systems and address root causes of trauma and social determinants of poor health. The project aims to decrease racial disparities in school suspensions and incarceration, increase financial investment in youth and produce a cohort of transformative community leaders of color for Milwaukee." (Directly cited from https://www.med.wisc.edu/news-and-events/2017/december/partnership-awards-boost-community-projects/)
- **Example**: The National Association of Community Development Corporations Association hosts skill-building sessions for neighborhood residents and leaders to attend to learn how to speak about the fair housing process. The Association puts on presentations, provides flyers and pamphlets, and preps community members on what they need to know should they choose to attend a public hearing to state their case on fair housing issues, which is a predictor of health (Directly cited from http://www.kbr.org/news/revitalizing-community-begins-its-residents).

Embed capacity-building into existing paperwork and processes. For example, add information on how to use WIC vouchers into the vouchers themselves.

Build residents' skills to help them benefit from services or change efforts. For example, if schools are implementing new learning assessments, efforts should be taken to build parents' ability to interpret the results of these assessments and use them to effectively support their child's success.

Engage local stakeholders to help deliver needed services and supports

Hire or engage local residents to help deliver needed services or supports. For example, train residents to co-facilitate programming with professionals. This can often help to meet residents' preferences for working with staff that share their background or lived experiences.

- **Example**: The Zero8 program is an incentive-based coaching program that trains local parents as coaches, where they learn how to conduct developmental screenings and support parents navigating social services. Coaches are matched with parents who have a similar background to facilitate trust. Parents are referred to coaches from trusted providers like pediatricians. Home visits or visits at sites where parents need support are recommended. Milestones are reached up to kindergarten, with graduating parents receiving a diploma and coaches track all coaching and progress in an online database. Promising program participants are then recommended to be trained as parent coaches. (the Zero8 program description can be found in the printable **download here**: http://www.wkkf.org/resource-directory/resource/2008/02/tangible-steps-toward-tomorrow-printer-friendly).
- Shasta County's Public Health Department created a Community Outreach division that hired people from the community to be advocates and organizers. www.sonoma-county.org/health/community/pdf/report.pdf

Example Strategies Promoting Access to Affordable, Healthy Food

Expand and leverage informal sources of support and services to expand the array of available services. For example, engage retirees/students in providing a variety of roles to promote the targeted changes, such as service navigation supports. Consider recruiting volunteers through settings such as colleges, AmeriCorps, faith-based settings, or Senior Citizen communities. Some communities have partnered with college professors to engage their whole classes in projects to provide needed support.

- For example, faced with a shortage of medical providers in a rural community, a healthcare organization created a role for a patient's friend or relative, in which this person is paid to attend appointments and help out at home to ensure the patient takes his or her medications.

Engage local stakeholders to help carry out change efforts

Engage new stakeholders to support efforts by expanding focus of the effort to include equity problems targeted by key partners and accommodate additional key cross-sector equity goals.

- For example, an effort focused on promoting health equity wanted to engage more partners from different social determinant of health areas, such as housing, transportation, education, and social connections. To support the engagement of these additional partners, the effort expanded its focus to include equity outcomes relevant to these sectors in its shared vision.

Put targeted equity goals on local meeting agendas. Add targeted changes to the meeting agendas of local collaboratives for them to discuss and problem-solve. (See ABLe Shared Agenda resources)

Provide multiple opportunities for people to get involved and support the change efforts - at a variety of different engagement roles and levels. For example, provide opportunities other than attending regular in-person meetings, such as using technology to share information and gather input or feedback on emerging strategy ideas.

COMPONENTS

Range, quality, effectiveness, and accessibility of services, supports, and opportunities

Expand Array of available high-quality supports and services targeting needs of marginalized residents

Embed needed services, supports, or opportunities into existing cross-sector settings/programs.
For example, ensure schools serving marginalized students provide advanced curriculum and summer learning opportunities.

- **Example: Provide after-school/out-of-school/summer opportunities** that support students in learning and retention as well as inspire discovery and interest in new areas. Such experiences are especially important for at-risk students (Smink & Reimer, 2005). https://files.eric.ed.gov/fulltext/ED485683.pdf

Expand and leverage informal sources of support and services to expand the array of available services in marginalized communities.

- **Example: F**aced with a shortage of medical providers in a rural community, a healthcare organization created a role for a patient's friend or relative, in which this person is paid to attend appointments and help out at home to ensure the patient takes his or her medications. Other communities have engaged informal supports provide early childhood programming.

Engage retirees/students in providing needed service components in marginalized communities, such as navigation supports or becoming reading buddies. Consider recruiting volunteers through settings such as colleges,

AmeriCorps, faith-based settings, or Senior Citizen communities. Some communities have partnered with college professors to engage their whole classes in projects to provide needed support.

Leverage private sector support and pursue public-private partnerships to expand the array of available services and supports in marginalized communities.

Re-appropriate funds to expand the array of available services and supports in marginalized communities.

Braid funding across efforts to create larger collective pots of funding to support expansion of needed services in marginalized communities. Consider how to bundle these services together to maximize funding (see other strategies within Components for examples).

Gather and use input from marginalized residents to design services that meet their needs, preferences

Help organizations develop new processes to engage marginalized residents as partners in designing services that meet local needs, fit with cultural traditions and preferences, and ensure family-friendly experiences in waiting rooms and service settings.

- Create a resident advisory board to give input and feedback on local service design decisions. These advisory boards can inform the decisions of one or more organizations across a community.
- Invite residents to join organizations' board of directors to directly inform decision-making processes. Make sure to build any needed capacities of residents and professionals to ensure residents can effectively engage in these processes (see Resources section for more ideas)

Use direct service touches to gather ongoing input from marginalized residents on how to design services.

- **Use a Fast Five Survey.** In Battle Creek, MI, one service agency developed a "fast-five survey" that could be filled out by families at the end of service visits. The survey included questions to inform the agency's decision-making about how to develop more responsive services and could be filled out in under five minutes. The survey questions changed each month, and over time the survey was coordinated across several agencies to provide a larger sample of family perspectives. See Engaging Diverse Perspectives section for more details.
- **Launch a Cross-sector "Pulse" survey** to gather input from residents receiving services from local agencies. Survey questions are generated collectively by partnering agencies on a quarterly basis and distributed to residents in waiting rooms and at the end of service visits.

Ensure Staff and Leaders representative of marginalized communities

Hire staff representing the demographics of targeted marginalized residents. Make experience working with underserved populations a priority in job qualifications. Align staff recruitment efforts with this goal through outreach to members of professional affinity groups and specific cultural networks.

Create job pipeline systems to attract staff representing marginalized groups. For example, develop internships with community colleges to attract skilled staff.

Adopt resident-centered culturally informed service practices

Design programs, supports, and opportunities to fit with marginalized residents' cultural traditions and preferences. Talk with residents about what cultural components would make them feel more comfortable accessing programs and services.

- **Example:** Sharing a meal is an important element of some residents' cultural traditions - some organizations provide time before a program session begins for residents to share a potluck meal.
- **Example**: Plain Talk is a neighborhood-based initiative that was implemented in Atlanta, San Diego, Seattle, New Orleans, and Hartford to help adults, parents, and community leaders communicate effectively with adolescents about reducing sexual risk-taking. Each Plain Talk community developed strategies suitable to its own cultures and circumstances. The initiative is being replicated in 19 sites in 9 states and Puerto Rico. www.plaintalk.org, www.aecf.org/Home/MajorInitiatives/PlainTalk.aspx

Co-locate Services and Providers

Co-locate multiple cross-sector providers or services in same space within marginalized communities. For example, have mental health providers work in physician offices; locate a DHS worker within the schools. Engage residents in identifying the best locations to have these providers work.

- **Example:** In Saginaw, MI, an assessment specialist from the local Community Mental Health agency was housed inside the Juvenile Court building. The worker assessed youth going through the court system and made on-the-spot referrals for needed mental health services.
- **Example:** A high school in North Carolina has partnered with local organizations to provide a resources pantry where high school students in need can anonymously access basic resources like food, hygienic products, school supplies, and clothing. http://www.huffingtonpost.com/entry/north-carolina-high-school-anonymous-pantry_56461b5be4b060377348c8da

Create Service Hubs within marginalized communities. Use neighborhood organizations or schools as community service hubs so residents can access a range of services in one location.

- **Example:** The Center for Family Life in Sunset Park, Brooklyn (New York), is the community nucleus for immigrant families who need help overcoming cultural, economic, and language barriers to help their children succeed in school. The hub provides intensive individual, family, and group counseling, neighborhood-based foster care, and emergency services such as crisis intervention, food, and clothing. Networking extends to the police, churches, and elected officials. www.cflsp.org
- **Example:** Hope Street Family Center is a public-private partnership that provides services and supports to young children and families affected by child abuse and neglect living in inner-city Los Angeles. Families receive a range of intensive services, including home visits by professional social workers and public health nurses and community-based child welfare services. www.healthychild.ucla.edu/HopeStreetFamilyCenter.asp

Have providers deliver bundled services within marginalized communities to reduce the number of service visits residents need to make and to simultaneously meet multiple needs.

- **Example:** The Santa Clara County Public Health Department awarded mini-grants to community-based organizations to provide bundled tobacco cessation services to populations at high risk for tobacco use. These grants allowed cessation counseling, referrals, and nicotine replacement therapy to be offered on site in places like health care clinics, mental health facilities, and college campuses. https://www.sccgov.org/sites/sccphd/en-us/healthproviders/tobaccoprevention/Pages/default.aspx

Hire shared staff across settings in marginalized communities. Combine resources to hire a staff that can rotate across settings.

Re-Locate Services and providers

Provide mobile services within marginalized communities to bring needed cross-sector services and supports to areas with limited access**.**

Example Strategies Promoting Access to Affordable, Healthy Food

- **Example:** Use a Mobile Clinic to bring nurses, literacy supports, and family supports to local neighborhoods.
- **Example:** The Seattle Public Library's Seattle's Children program brings a bookmobile to child-care centers around the city to support its early literacy initiative.

Create satellite offices within marginalized communities to improve access to needed services.

- **Health care access:** Children's Hospital of Milwaukee opened clinics in neighborhoods where there were too few care providers to meet the primary care and dental needs of residents. Two of their clinics are located at sites already serving low income families, including the YMCA. These sites provide health services to children AND caregivers.
- **Income:** Predatory income tax preparation services are disproportionally located in low income communities of color. The creation of VITA sites with user-friendly outreach in these areas enables residents eligible for EITC and other tax benefits to obtain these without losing a high proportion of what they should receive due to exploitative commercial services (directly cited from AECF Face Matters, p. 1). http://www.aecf.org/m/resourcedoc/aecf-RACEMATTERSsystemreformstrategies-2006.pdf

Use technology/web-based platforms to provide or supplement existing supports within marginalized communities that are easier for residents to access (compared to traveling to an office or center)**.**

- SHINE is a system which delivers personalized support messages to people completing an alcohol abuse program. Each day, users are asked to reflect on their recovery and depending on whether their responses indicate they are OK or struggling, follow up questions or contacts are made. These contacts supplement face-to-face service visits. Outcomes for SHINE users were better than those for non-system users. http://www.health.org.uk/programmes/shine-2011/projects/alcohol-relapse-prevention-programme

Leverage available Transportation supports

Coordinate transportation through resident carpools. Support families in setting up carpools to services. This not only helps address transportation needs, but also provides opportunities for residents to build relationships.

Coordinate transportation through local churches for residents without access to transportation to service appointments. Use volunteers and church vans during weekdays when these vehicles are not being used by the church.

Shift when services are offered

Extend services hours beyond traditional 9-5 schedules to make it easier for working residents to participate.

- **Example**: The Chambliss Center for Children in Chattanooga, Tennessee makes it easy for parents who work 2nd and 3rd shifts or are in school to access high quality care for their children by offering affordable, high-quality learning environments, nutritious meals, school transportation and care 24 hours a day, 7 days a week, 365 days a year, for children ranging from 6 weeks to 12 years. https://www.wkkf.org/what-we-do/featured-work/chambliss-center-for-childrens-early-learning-program-provides-affordable-child-care-for-families

Offer services during existing gathering times of marginalized groups. Offer time-limited resources, supports, and services (e.g., flu shots) during parent-teacher conferences, family nights, and other events where residents naturally gather.

Reduce barriers to participation

Provide free childcare on site to support parents' participation in services – or provide services or meeting at locations that already have childcare support in place (e.g., churches).

Reduce waitlist times so residents can more easily and efficiently access the services they need. This may require expanding the number of slots available – see the Resources section for ideas on how to do this

Support families through enrollment processes

Leverage school-wide enrollment processes to make it easy for families to sign up for other types of supports or services.

Have volunteers help marginalized residents fill out enrollment paperwork. This is particularly important for residents with low literacy levels or who speak multiple languages.

Embed service navigation supports

Engage service navigators to help residents within marginalized communities access needed services. Engage navigators through formal settings or informal networks. Navigators can also help families prioritize which programs are the best fit with their needs. Navigators can be trained volunteers, such as college students getting service hour credit.

- **Community health navigators** help connect residents with the right resources at the right time to support wellness and healthy lifestyles. They work to build awareness of neighborhood needs and challenges with a goal of improving health outcomes for children and their families.
- **The New Jersey Department of Human Services "Kinship Navigators"** help caregivers navigate through various governmental systems to find local supports and resources. Information is specifically designed for kinship caregivers and can include referrals about support groups, TANF, Medicaid benefits, child support, housing assistance, custody procedures and other legal issues, child care resources, and respite services.

Reduce Stigma

Remove separate intake processes that call out or discourage marginalized residents for using services (e.g., WIC, social services, etc.).

Reduce stigma by ensuring consistent quality across service settings. For example, ensure high quality in the facilities, equipment, personnel, and curriculum at different sites. Low-income residents should not feel that their service settings are inferior to others.

Nurture and coach trusted local family champions who have used the services, can normalize the need for services, and can openly attest to the quality and benefit of those services.

Make services more affordable

Offer sliding fee scales or scholarships for services to make it more affordable for residents to engage in needed supports and services.

Coordinate third-party payments on behalf of marginalized residents whenever possible (e.g., child care subsidies, Medicaid).

Design low-cost versions of quality supports that are more affordable to more residents.

- **Example:** Minute Clinics are available in drugstores and offer family health care including vaccines, and basic diagnosis and treatment for illness and injury at low cost with no appointment or fees for an office call.

- **Example:** Physicians are an essential source of support to pregnant women, but doulas, midwives, and nurses also play an important role in promoting physical and emotional health by engaging a natural support network.

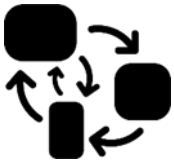
Reduce overhead to allow for lower cost options within marginalized communities. Streamline distribution, facilitate bulk purchasing by multiple stores, or find comparably priced alternatives (e.g., offering whole beans in addition to refried beans at preschool centers to promote children's health) to help local settings reduce costs of making targeted changes.

- **Example:** The Go Community Card was developed in collaboration with a group of fathers who identified community resources they could not easily afford for their families. Businesses partnered with the group to create discount cards for transport, activities, purchases, lessons and rentals. Bundle cards with continuously updated information on local activities. http://enginegroup.co.uk/work/kcc-designing-services-with-dads

MINDSETS

Shared attitudes, values, beliefs, and priorities

Create and adopt a shared vision



Hold a visioning process across diverse stakeholders, organizations, and community members to identify shared outcomes and systems changes related to equity to target in the collective work (see ABLe Change website for additional tools).

Embed a systems change approach into your community's shared vision to ensure efforts focus on shifting the system instead of putting total responsibility for change on residents.

- **Example**: One community developed the purpose ***"Help Residents Help Themselves"*** to guide its efforts to improve economic outcomes for local residents. While promoting self-sufficiency is a valuable goal, after several years leaders realized this purpose put ALL the responsibility for improving outcomes on low income residents themselves. After this realization, they worked to identify a new purpose that recognized the need to create more opportunities for residents to thrive within their community and landed on ***"Create Conditions for Residents to Thrive".*** Note how this created a different focus for the work: when focused on "helping residents help themselves" the initiative sponsored many opportunities designed to help low-income residents develop their skills and capacities. When focused on "creating conditions for residents to thrive", the initiative identified local community conditions impeding residents' success – such as lack of access to livable wage jobs – and started such efforts as an economic development campaign.

Promote mutual understanding of targeted changes among stakeholders who have different experiences, interpretations, and perspectives around the targeted problem.

- **Example:** In Montana, where 43% of the Native American adult population reports smoking, initial efforts at creating smoke-free environments failed because elders believed these policies would hinder traditional uses of tobacco, which are central to spiritual and medicinal practices. A multi-year conversation helped the anti-smoking coalition learn about traditional tobacco use and the tribal elders learn about the impact of commercial tobacco use and secondhand smoke. As a result, policies were specifically targeted at commercial tobacco use and smoke-free environments.

Shift the narrative around equity

Example Strategies Promoting Access to Affordable, Healthy Food

Shift the narrative and culture of acceptance of inequities. For example, use an equity impact assessment tool or an organizational equity culture assessment tool to create a consciousness around equity in meetings and decision-making processes.

Co-Design strategies

Build partners' buy-in by engaging them in designing change efforts. People are more likely to support efforts they had a role in developing, versus processes perceived as being brought in from the outside or forced on them.

Promote Value within conversations

Highlight the value of efforts to promote equity with colleagues. Talk about the value of targeted changes within staff meetings, local collaborative meetings, staff supervision, and professional development

Highlight the value of efforts to promote equity with residents. Embed language about the value of targeted changes into staff interactions with residents

Normalize the need for efforts to promote equity. Reduce stigma by reinforcing the message that efforts to address inequities are needed by most communities

Have trusted others (e.g., clergy, home visitors) use key talking points about the value of efforts to promote equity when engaging residents

- **Example:** Planned Parenthood trained neighborhood-based Latina adults to be "Promotoras" who share information about reproductive health and sexuality with other Latinas. Promotoras are trained to distribute non-prescription birth control, talk with peers, and escort women to the clinic. Outreach happens during "pláticas" (small talks) and in homes and other familiar settings. www.ppgg.org

Have providers make home visits to residents who have just entered services to establish positive relationships, build trust, and answer questions.

Adopt social marketing practices

Use social marketing approaches to promote local buy-in and adoption of efforts to promote equity.

Embed testimonials from local residents on relevant websites or social-media outlets to shift local perceptions about the experiences of people experiencing targeted problems and the benefits of efforts to promote equity. Be specific in what you ask from residents who would like to share examples of their positive experiences. Ask them to describe how the changes have been beneficial, with a specific example. Display them on your webpage, social media outlets, or in radio ads. Be sure you receive written consent from residents to use their stories in these outlets.

Adopt practice of using Facebook and other social media outlets to raise awareness and support for the efforts to promote equity.

Target culturally appropriate media to best reach your target audience. Working with diverse local stakeholders can help identify whether it is radio, public access TV channels, billboards, etc.

- **Example:** AOL Lifestream provides a one-stop site where you can update all your social media accounts at once to spread updates and announcements about your work. Announcements about events, policy changes, promotions, open program slots, etc. are good updates to announce this way. For people already using

services, Facebook and other social media offer ways to provide "tips and tricks" to help your audience engage in target behaviors. Sign up here: http://lifestream.aol.com/.

- **Example:** The Jefferson County Department of Health partnered with the Health Action Partnership to identify the communities that needed their smoke-free intervention most. They partnered with local stakeholders in those communities and developed a culturally appropriate radio soap opera, aired with health expert interviews, that was popular with African American audiences.

Contribute to news articles or submit letters to the editor about best practices in other communities or highlighting who locally has adopted efforts to promote equity.

Support positive media coverage of residents who have successfully adopted/benefited from targeted efforts to promote equity and achieved outcomes.

Emphasize the importance, desirability, and feasibility of efforts to promote equity when creating messages for an audience. Adapt these materials to the experiences and preferences of individuals across diverse perspective groups.

Publicly show outcomes and progress of change efforts over time in ways that are easy for people to understand. Create a public display or dashboard so people can see progress toward the targeted change.

- **Example:** The Oakland Reads 2020 initiative provides a webpage (http://blog.urbanstrategies.org/category/res/) with outcomes tracking and a comprehensive infographic dashboard to see the different targeted problems and system habits they are focused on. Take a closer look at their dashboard here: http://blog.urbanstrategies.org/wp-content/uploads/2014/04/OR-Dashboard-V8.png

Leverage Influential champions

Engage powerful leaders and respected staff as champions for your efforts to promote equity. Provide opportunities for these champions to speak at public events or at your collaborative about their support for the effort and equity goals and encourage others to buy-in. Pilot targeted changes with these powerful stakeholders, organizations, or settings to demonstrate initial small wins and build buy-in and momentum across the community.

Engage trusted local resident Champions to support residents in feeling confident in taking advantage of new opportunities or benefits, or engaging in needed services and supports**.** Ideally, these champions have similar backgrounds to targeted residents, and can meet residents in natural/informal settings (e.g., like in their living room).

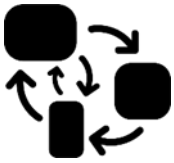
- **Example**: Engage champions who have themselves adopted or taken advantage of targeted changes. For example, experienced parents become parent coaches to help new parents feel comfortable using new services, normalize the need for services, talk about what it's like to use the services, and openly attest to the quality and benefit of those services.

Engage local initiatives and collaboratives in supporting and reinforcing efforts to promote equity.

POWER

How decisions are made, who participates, whose voice matters

Engage diverse stakeholders in decision-making



Engage marginalized residents and community members in decision-making processes

Engage marginalized residents as design partners within organizational decision-making processes to develop services and supports to ensure they meet local needs and aspirations.

- **Example**: Create a resident advisory board to give input and feedback on local decisions, and intentionally recruit marginalized residents in target population to sit on this board. These advisory boards can inform the decisions of one or more organizations across a community. Make sure to provide needed supports to help residents effectively engage in this opportunity, such as transportation, childcare, or capacity-building.
- **Example**: Invite residents to join organizations' board of directors to directly inform decision-making processes. Make sure to build any needed capacities of residents and professionals to ensure residents can effectively engage in these processes.

Create multiple action teams to engage marginalized residents, community members, and other system stakeholders in learning, decision-making, and action.

- **For example**, one community in MI created four action teams to pursue their targeted changes around supporting youth with social-emotional (SE) needs. A separate team was set up for leaders of key organizations involved in addressing the needs of youth with SE needs (Community Mental Health, Department of Human Services, School District, Juvenile Justice/Police Department, etc.), front-line providers of these organizations, family members whose children were engaged with these organizations, and youth age 14-17 who were experiencing SE needs and engaged with these organizations. The teams all independently pursued action around the same set of targeted changes using a shared agenda and action learning process.

Utilize community-driven philanthropy. Engage community members in selecting which change efforts are most important to pursue in their community.

Use Photovoice to gather marginalized resident perspectives on local conditions and potential strategies related to the targeted equity goals through photography. Residents are trained in how to use cameras and then answer questions about local conditions and their desires by taking pictures. Residents come together to share and discuss their photos, and the information is used to understand local problems and guide the design of strategies. Residents' photos can also be shown in "gallery" style exhibits to raise community awareness about local conditions.

Gather ongoing input from marginalized residents by asking questions during direct service touches.

- **Example: Use a Fast Five Survey.** In Battle Creek, MI, one service agency developed a "fast-five survey" that could be filled out by residents at the end of service visits. The survey included questions to inform the agency's decision-making about how to develop more responsive services and could be filled out in under five minutes. The survey questions changed each month, and over time the survey was coordinated across several agencies to provide a larger sample of residents' perspectives... See Engaging Diverse Perspectives section for more details.
- **Example: Launch a Cross-sector "Pulse" survey** to gather input from residents receiving services from local agencies. Survey questions are generated collectively by partnering agencies on a quarterly basis and distributed to residents in waiting rooms and at the end of service visits. It is important to include demographic information on these surveys in order to break out data from marginalized populations.

Assess and build stakeholders capacity to powerfully engage marginalized residents. Sometimes residents do not have the skills and knowledge they need to confidently and effectively engage in

decision-making processes to get their needs met with power-brokers, leaders, and service providers. Sometimes leaders and other professionals do not have the skills and knowledge they need to authentically engage marginalized residents in decision-making processes, including how to use resident feedback. Assess if these capacities are needed in relation to your targeted changes.

Engage staff representing diverse perspectives in decision-making

Help organizations create internal opportunities for staff representing diverse perspectives to provide input and engage in decision-making. For example, setting aside time during staff meetings or create action teams for staff to identify emerging issues related to targeted equity goals and design strategies to address them.

Develop community-wide action teams that engage front-line staff from organizations relevant to the targeted problem in learning, decision-making, and action (see MI example above related to Engaging Families and Community Members, and ABLe Change Action Learning resources).

Engage residents as change agents

Create resident coalitions where marginalized residents design and implement changes to promote targeted goals.

- **Example:** In Michigan, local parent coalitions serve as key partners in the Great Start Network. Parents meet to determine collective priorities, set goals for each year, and work with local services providers to design and implement collective efforts. Parent coalition members are key advocates on the issues of early childhood in their community. http://www.greatstartforkids.org/content/great-start-parent-coalition-overview
- **Example:** The Centennial Community Improvement Association is a resident-driven organization that seeks to develop the local knowledge base about the potential impact of involving community residents and a range of public, private and voluntary sector partners in comprehensive community initiatives to address the root causes of poverty in our city. The organization is governed by a constitution and by-laws developed by local residents. A key responsibility of the residents committee has been to develop a community plan for the neighborhood that identifies priorities and strategies for the renewal of the community. (Directly cited from: http://www.centennialneighbourhood.com/uploads/2/7/3/3/27338271/centennialdescription.pdf)

Support grass-roots, resident-driven advocacy campaigns to approach local, state, or federal officials with information about needed shifts in community planning, budgeting, and infrastructure.

- **Example:** Michigan's Children Sandbox Party is the state's leading non-partisan grassroots advocacy network for children, youth and families. Their aim is to advance state policies, practices and investments that support health, development and learning from cradle to career. http://www.michigansandboxparty.org/

Support resident-driven action teams where marginalized residents design and implement changes to promote targeted goals.

- **Example:** In Milwaukee, the Youth Decarceration initiative engages youth from schools with highest rates of suspensions and expulsions to build their leadership skills to work with key community organizations to help "reform inequities in disciplinary systems and address root causes of trauma and social determinants of poor health. The project aims to decrease racial disparities in school suspensions and incarceration, increase financial investment in youth and produce a cohort of transformative community leaders of color for Milwaukee." (Directly cited from https://www.med.wisc.edu/news-and-events/2017/december/partnership-awards-boost-community-projects/)
- Parent Leadership as a Catalyst for Health Equity is an initiative to develop a parent leadership cohort in which parents with lived experience will lead the design of community-based supports to address health

inequities associated with childhood abuse and neglect and how it influences health and well-being later in life — often referred to as "adverse childhood experiences." Four teams statewide will form a cohort for shared and peer learning in order to increase parent knowledge of how to prevent adverse childhood experiences, increase leadership skills and launch community-based projects to prevent them. (Directly cited from https://www.med.wisc.edu/news-and-events/2017/december/partnership-awards-boost-community-projects/)

Create partnerships between residents and organizations that engage all stakeholders in change agent roles.

National Network of Partnership Schools (NNPS) organizes teachers, parents, and administrators into action teams, plans family and community-involvement activities linked to school goals, and reaches out to involve all families. Schools using this approach report a significant increase in the percentage of students attending class, compared with similar schools that were not conducting these activities. (Sheldon, 2007). http://www.tandfonline.com/doi/pdf/10.3200/JOER.100.5.267-275

Empower parents to ask critical questions to advocate for their family

Put up posters with advocacy tips in service provider offices reminding residents of questions they can ask to help advocate for their health needs during service visits.

Engage neighborhood leaders in going door to door to **distribute placemats or magnets with questions residents can ask to advocate for their needs** during service interactions.