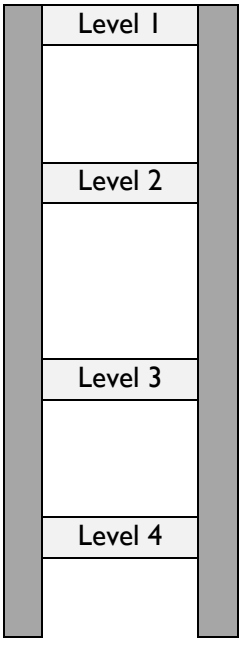
Strategy Design Resource
Example Strategies

This document provides example strategy approaches used throughout the U.S. and internationally to address local problems and inequities. Where available, references to specific sources or websites have been provided with the strategy approach descriptions. These strategies represent promising practices (not necessarily evidenced-based practices) to explore in your community.

The strategies have been organized around different types of system leverage points. Systems thinkers suggest certain "leverage points" are more powerful for shifting community patterns than others (Johnston et al., 2014; Meadows, 2008). The following ladder visual summarizes leverage points that are most powerful (level 1) to less powerful (level 4) for shifting patterns driving local problems and inequities, and includes page numbers for corresponding strategies. Consider how you can design your strategies to address leverage points across all levels of the ladder.

Example Strategies to Address System Leverage Points



Adapted from:

Johnston, L. M., Matteson, C. L., & Finegood, D. T. (2014). Systems science and obesity policy: a novel framework for analyzing and rethinking population-level planning. *American journal of public health*, *104*(7), 1270-1278.

Meadows D. Thinking in Systems: A Primer. White River Junction, VT: Chelsea Green Publishers; 2008.

LEVEL 1: PARADIGMS (Most Powerful)

- **Mindsets:** Deepest held beliefs, attitudes, values
- **Goals:** the aims and purpose of local efforts

Strategies to address MINDSETS

Attitudes, values, and beliefs (e.g., related to equity focus, systems approach, focus on social determinants of health, value of resident voice, etc.) that shape behavior

Promote new mindsets within conversations

- **Highlight the value of new approach during conversations with colleagues and residents.** Talk about the value of targeted changes within staff meetings, local collaborative meetings, staff supervision, and professional development. Embed language about the value of targeted changes into staff interactions with residents. Reduce stigma by reinforcing that efforts to address inequities are needed by most communities (Powell, 2015; Fineberg, 2012).
- **Engage trusted others (e.g., clergy, home visitors) in talking with residents during natural interactions** about the value of new approach when engaging residents. Consider providing basic talking points to help these individuals hold these conversations. (Ronald et al., 2018).
    - *Planned Parenthood trained neighborhood-based Latina adults as "Promotoras" who share information about reproductive health 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) in homes and other familiar settings. www.ppgg.org*
- **Effectively frame new approaches to resonate with multiple audiences.** For example, frame the new approach in ways that: appeal to widely held values, beliefs, and personal experiences; are consistent with the new approach itself (e.g., do not use violent tactics to convince someone that non-violence is the solution); and are inclusive and flexible enough to evolve as new information emerges (Benford & Snow, 2012).

Leverage influential champions

- **Engage powerful leaders and respected staff as champions** for new approach. Provide opportunities for these champions to speak at public events or at your collaborative about their support for the new approach/paradigm 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 (Powell, 2015).
- **Engage respected local residents as champions** for new approach. Ideally, these champions have similar backgrounds to residents in priority groups. Try to engage champions who have themselves adopted new approach/paradigm (Powell, 2015).
- **Engage local initiatives/collaboratives** as champions for new approach (Powell, 2015).

Raise Critical Consciousness

- **Embed training or experiences to raise critical consciousness.** Consider how to embed relevant information or topics (e.g., racial bias training, training on systems approach) into ongoing meetings, annual orientations, or professional development efforts (Leeman et al., 2017; (Biggs et al, 2011). Some communities engage professionals in first-hand experiences that simulate what it is like to navigate the service delivery system or support a family within poverty conditions.
- **Raise critical consciousness through using equity assessment tools**. 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 (Keleher, 2009).
- **Create opportunities for individuals with different mindsets to share ideas and understandings** (Kelly, G., 1955; Schusler et al., 2003). When/if conflicting mindsets are identified, discuss conflicts and, if possible, identify common values and/or value shifts necessary to create a unifying paradigm.

Strategies to address MINDSETS

Attitudes, values, and beliefs (e.g., related to equity focus, systems approach, focus on social determinants of health, value of resident voice, etc.) that shape behavior

Adopt social marketing practices	• **Use social marketing approaches to shift local opinions.** Community-wide social marketing campaigns use broad and highly visible approaches to shift mindsets. Successful efforts use multiple media (e.g., television, radio, Internet, social media), disseminate various messages customized to different audiences, and use opinion leaders in places of worship and community centers to influence and reinforce people's attitudes and behavior (Glickman, 2012; www.ncbi.nlm.nih.gov/pubmed/24830053). 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. Emphasize the need, benefits, and feasibility of new approach/paradigm when creating messages for an audience. Adapt these materials to the experiences and preferences of individuals across diverse perspective groups. ○ *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.* • **Use social media outlets** to raise awareness and support for new approach (Lee, 2011). • **Contribute to news articles or submit letters to the editor** about the importance and benefit of the new approach. Highlight who locally has adopted it (Glickman, 2012).
Recognize early adopters	• **Provide public recognition** of settings or individuals adopting new approach. For example, recognize settings or individuals through staff meetings, communications, or at local community events (Leeman et al., 2017; Powell, 2015).

Strategies to address GOALS

The aims and purpose of local efforts; emerge from shared mindsets and paradigms.

Create and promote 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 (Stroh, 2015).
    - *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".** 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 goals** among stakeholders with different experiences, interpretations, and perspectives around the targeted problem (Biggs et al, 2011).
    - *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.*
- **Accommodate vision or problem focus to include additional goals targeted by key partners.**
    - *For example, an effort focused on promoting health equity wanted to engage 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 (Kolkman et al, 2005).*
- **Put targeted 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)

Align Existing Goals with targeted changes

- **Align new goals and current goals with targeted changes or approaches.** Consider potential synergies across goals, and prevent goals from interfering with each other (Houston et al, 2010)
- **Design transformational goals focused on powerful leverage points.** Focus goals on the highest aspirations for the community, targeting paradigms, structure, feedback loops, and components within the community system (Sweetman et al, 2013). Ensure goals are ambitious enough to motivate efforts (Hinsz, Kalnbach, & Lorentz 1997) and achievable given the context and available resources (Zachary & Fichler, 2011), such as time, dollars, and capacity.
- **Align mission statements** with targeted changes or new approaches (Alegre, Berbegal-Mirabent, Guerrero, & Mas-Machuca, 2018).
- **Align strategic plans** with targeted changes or new approaches.

Strategies to address GOALS

The aims and purpose of local efforts; emerge from shared mindsets and paradigms.

- **Use a "Health/Equity in All Policies" approach** to embed considerations related to new approach (e.g., focusing on equity or social determinants of health) into cross-sector policies and decision-making processes (Rudolph, Caplan, Ben-Moshe, & Dillon, 2013).
    - *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*
    - *The Nashville Metro Public Health Department embedded a commitment to health equity by requiring health equity as a decision filter in all policy, programmatic, and practice activities. http://www.healthynashville.org/index.php*
    -

Set New Expectations

- **Support local and state funders set new expectations** for targeted changes or approaches by referencing them in explicit outcome expectations, requests for proposals, and grant applications prioritizing criteria.
- **Help leaders demonstrate to staff their priority** for targeted changes or approaches to help shift staff mindsets (Powell, 2015).
- **Get written commitments** from local partners to adopt targeted changes or approaches to encourage shifts in local mindsets (Powell, 2015).
- **Create an organizational culture that supports change and learning** to encourage staff to value and adopt targeted changes or approaches (Glisson, et al., 2008).
- **Add expectations into job roles/responsibilities and job performance criteria**. For example, embed expectations for practices, behaviors, or changes that support the new approach, like using an equity impact assessment during planning (Powell, 2015).

LEVEL 2: STRUCTURE

- **Power:** how decisions are made, and who participates
- **Regulations:** policies, practices, incentives, and rules
- **Connections:** relationships between people, organizations, and sub-systems

Strategies to address POWER

How decisions are made, who participates, whose voice matters, and structures to support inclusion

Engage residents and community members in decision-making processes	• **Engage residents experiencing local inequities as design partners** within organizational decision-making processes to develop services and supports to ensure they meet local needs and aspirations (Rowland, 2017). • **Create a resident advisory board** to give input and feedback on local decisions, and intentionally recruit residents in target population to sit on this board (Kegler, Lebow-Skelley, Lea, Lefevre, Diggs, Herndon, & Haardörfer, 2018). 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. • **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. • **Utilize community-driven philanthropy.** Engage community members in selecting which change efforts are most important to pursue in their community. • **Assess and build stakeholders capacity to support resident engagement** (Saegert, 2004)**.** 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 residents (especially from groups experiencing inequities) in decision-making processes, including how to use resident feedback. Assess if these capacities are needed in relation to your targeted changes.
Engage diverse staff 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 action teams engaging direct staff** from cross-sector 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; Foster-Fishman & Watson, 2011).
Engage residents as change agents	• **Engage residents in Photovoice:** Photovoice engages residents taking photographs about local conditions and aspirations. Residents come together to discuss their photos, and the information is used to understand local problems, guide the design of strategies. Residents' photos can also be shown in "gallery" style exhibits to raise community awareness about local conditions and promote local action (Wang & Burris, 1997; Foster-Fishman et al., 2005). • **Create resident coalitions or action teams** where residents design and implement changes to promote targeted goals. (Foster-Fishman & Watson, 2011). ○ *Local parent coalitions serve as key partners in Michigan's Great Start Network. Parents 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

- *The Centennial Community Improvement Association is a resident-driven group focused on building local knowledge and cross-sector partners to address the root causes of poverty. The group uses a constitution and by-laws developed by local residents, and focuses on developing community plans. (http://www.centennialneighbourhood.com/uploads/2/7/3/3/27338271/centennialdescription.pdf)*
- *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/)*

- **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 partnerships between residents and organizations** that engage all stakeholders in change agent roles (Bringle, Clayton, & Price, 2012).
  - *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 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 (Moore & Loftus, 2014).
- **Engage neighborhood leaders to distribute questions residents can ask to advocate for their needs** during service interactions (Stojicic, 2018). Some communities put these questions on placemats or magnets to make it easy for families to learn and remember.

Strategies to address REGULATIONS

Policies, practices, procedures, rules, incentives, and daily routines that shape the behavior patterns of individuals, groups, and organizations

Engage and/or advocate with stakeholders in positions of power to shift needed policies	• **Advocate and/or engage stakeholders in positions of power and decision-making (directors, executives, funders, elected officials, etc.)** to shift policies to align with goals (Van Riel, 2012). Consider how to gather and share critical local information about how the regulation is contributing to current problems/inequities, and provide ongoing feedback and recommendations. (see page 7 on supporting grass-root, resident-driven advocacy) ○ *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/* • **Engage managers and supervisors in shifting daily procedures** to align with goals.
Create incentives to adopt new changes or habits	• **Reduce fees** if person/organization adopts practices, behaviors, or changes that support the new approach (or add fees if they don't; Powell, 2015). • **Use organizational perks** to reward staff who use practices, behaviors, or changes that support the new approach (Rosenberg & Mosca, 2011). Example rewards could include prime parking spots, job promotions, or pay. • **Give vouchers** that can be redeemed for desired rewards (retail goods and services, opportunity to win prizes, etc.) to incentivize and reward practices, behaviors, or changes that support the new approach (Powell, 2015). • **Encourage funders to prioritize grant applications** that demonstrate commitment to targeted new approach (e.g., use of racial equity focus, etc.)
Reduce disincentives to adopt new changes or habits	• **Streamline or restructure work processes** to reduce time burdens associated with adopting practices, behaviors, or changes that support the new approach. For example, streamline paperwork so staff can more easily adopt new practices within their current workflow (Brown et al., 2009). • **Expand billing reimbursement categories** to allow providers and organizations to get reimbursed for new practices, behaviors, or changes. Make this easy to use by adding new categories related to the strategy into billing systems. (Powell, 2009) • **Remove conflicting incentives.** For example, incentives for meeting a quota (number of clients) vs. providing high-quality services that actually benefit residents (Powell, 2015).
Embed focus on targeted changes into existing protocols, processes, and expectations	• **Embed focus on targeted changes into annual training and orientations:** Add practices into annual training and orientations (e.g., for staff, collaborative members, councils, etc.), and embed within CEU training (Leeman et al., 2017; Powell, 2015). • **Embed new practices into existing procedures and protocols.** For example, embed new assessment questions into intake procedures, referral information into protocols, strategies into handbooks or toolkits (Braithwaite, 2017; Chambers et al., 2013). Also embed reminders or prompts to help providers remember to use new practices (Powell, 2015). • **Embed capacity-building into existing paperwork and processes** (Maras, Weston, Blacksmith, & Brophy, 2015). For example, add information on how to use WIC vouchers into the vouchers themselves. • **Shift staff roles and job descriptions** to support targeted practices (Powell, 2015). • **Add targeted practices into annual staff review evaluation criteria** to set new expectations and promote accountability (Powell, 2015).

Strategies to address REGULATIONS

Policies, practices, procedures, rules, incentives, and daily routines that shape the behavior patterns of individuals, groups, and organizations

Align and integrate policies and practices across settings

- **Align core priorities and curriculum elements** across settings and programs. For example, ensure that pre-K curriculum matches the requirements within the Kindergarten curriculum.
    - *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 adopt aligned transition processes** to make it easier for residents to transition from one program to another.
    - *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.*

Simplify and improve enrollment and service processes

- **Expand eligibility policies restricting residents' access to services**, or advocate for expansion of policies.
    - *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*
- **Remove separate intake processes** that call out or discourage groups experiencing inequities from using services (e.g., WIC, social services, etc.). (Centers for Disease Control, 2013)
- **Simplify intake or application processes** to make it easier for residents (especially those from groups experiencing inequities) to enroll in services. For example, create a common application form or common intake hub, reduce the number of intake step in the enrollment process, or develop intake applications as a phone app (Spark Policy Institute, 2013).
    - *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 (Centers for Disease Control and Prevention, 2013).
- **Leverage school-wide enrollment processes** to make it easy for families to sign up for other types of supports or services (Center for Disease Control and Prevention, 2013).
- **Have volunteers help residents fill out enrollment paperwork**. This is particularly important for residents with low literacy levels or who speak multiple languages (Center for Disease Control and Prevention, 2013).
- **Streamline service delivery processes** to provide better services and supports (*Gordon and Chin, 2004)*
    - *Jerome Belson Health Center in New York City launched efforts to address long patient waiting times. After tracking patient flow, they made changes to streamline the process including: reducing the number of stops patients have to make per visit (from 5 to 3), creating more communication between clerical and clinical staff so they can notify 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. (https://www.brookings.edu/wp-content/uploads/2016/06/1024_medhomes_ross.pdf*

Strategies to address CONNECTIONS

Relationships and exchanges between and across different actors and organizations

Support information sharing between and within organizations

- **Create a shared consent form** to give residents the opportunity to consent to information sharing across organizations given policies such as HIPAA and FERPA (Michie, et al., 2014).
- **Create cross-sector service teams** who collaborate around shared cases (e.g., system of care approach; wrap around services; Suter & Bruns, 2009).
- **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 (Shavit, 2008).
    - *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. Ensure 211 is current and people are aware of this resource.
- **Connect community partners who have access to data** with individuals who need the information to inform decision-making processes.
    - *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.*

Support information sharing with families

- **Engage cross-sector providers and community stakeholders in sharing information during natural touches with priority residents.** For example, pediatricians, clergy, hair salon stylists, grocery store check-out lines, and bank tellers.
- **Embed practice of including information for residents into regular mailings.** Talk with local businesses or organizations to embed key information into regular communications such as gas bills, school report cards, and newsletters (Taylor, 2009).
- **Adopt new outreach practices** of sharing information in natural traffic areas for priority residents, or using social media and mass text communication (WKKF, 2008).
- **Use 211 to diffuse information** about new programs or opportunities. Ensure 211 is current and people are aware of this resource.
- **Embed practice for providers to keep a record of 3 dependable contacts to prevent losing touch with residents.** Ask 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.
- **Allocate enough time for providers to build relationships with residents** during service visits to promote better communication processes.
- **Provide example questions and processes** residents can use to feel comfortable and safe discussing their current needs with service providers.
    - *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*

Strategies to address CONNECTIONS

Relationships and exchanges between and across different actors and organizations

	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.

Support cross-sector referrals	• **Develop shared intake forms** to promote coordinated referrals across organizations addressing the needs of residents (Spark Policy Institute, 2013).
	• **Embed coordinated assessment, early screenings, and referral processes** within multiple settings that touch residents (Spark Policy Institute, 2013).
	  ○ *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*
	• **Engage local health care providers in "prescribing" free programs and supports** promoting targeted changes to residents.
	  ○ *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 residents** (Wainwright & Marandet, 2016)**.** 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 staff and leadership pipelines	• **Create job pipeline systems** to help organizations attract staff and leaders representing the community, especially groups experiencing inequities (Massey, 2019). For example, develop internships with community colleges to attract skilled staff.
Create resource sharing networks	• **Create networks to connect organizations and institutions with locally sourced resources**. For example, help school connect with local farmers to provide fresh produce. • **Create networks to distribute surplus resources to settings and stakeholders who need them.** For example, create networks to redistribute surplus food resources to residents with food insecurity, or surplus learning materials to schools. ○ *In Cambridge, MA Food for Free redistributes food that otherwise would be thrown out from restaurants, college campuses, and supermarkets to food programs and directly to residents. https://www.foodforfree.org/*

LEVEL 3: FEEDBACK LOOPS

- **Interactions:** Exchanges that inform action and keep actors responsible to feedback

Strategies to address FEEDBACK LOOPS

Exchanges that inform action and keep actors responsible to that feedback

Promote critical information flows to inform action	• **Track implementation consistency.** Use a tracking system to understand how and when strategies are being used. Rapidly share this information with individuals who can use it to inform decision-making and action (Powell, 2015).
	• **Embed practice to gather feedback during staff meetings and collaborative meetings** to gather feedback on emerging needs and opportunities; rapidly share this information with individuals who can use it to inform decision-making and action (Buskermolen & Terken, 2012).
	• **Embed practice to gather feedback during direct service touches with residents (**doctors' appointments, home visits, or program sessions, etc.). Rapidly share this information with individuals who can use it to inform decision-making and action
	  ○ **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.
	  ○ **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 populations experiencing inequities.
	• **Use text messaging** to gather rapid feedback from residents (WKKF, 2008).
	• **Provide comment spaces on websites** for residents to provide feedback on targeted questions to inform decision-making and action
	• **Help organizations develop protocols and procedures** to help staff know how to rapidly share feedback from residents with relevant decision-makers.
	• **Design evaluation efforts to provide real-time feedback** on implementation and progress to inform decision-making and continuous improvement efforts (Patton, 2011).
	• **Develop two-way feedback loop processes to support communication about referral status between 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. See strategies on addressing feedback loop root causes later in this document for more details (Spark Policy Institute, 2013).

Promote accountability to feedback	• **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 (Powell, 2015). • **Create feedback loops between decision-makers and those providing feedback.** Put processes in place to share feedback with decision-makers, and for decision-makers to report how feedback was used to inform changes (Britto et al, 2014).

LEVEL 4: ELEMENTS (Less Powerful)

- **Components:** program design, quality, range, accessibility, and reach
- **Resources:** skills and knowledge, community living conditions, financial

Strategies to address COMPONENTS

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

Expand array of needed supports and services

- **Expand needed services, supports, or opportunities to meet needs of groups experiencing inequities.** For example, ensure schools serving students from priority groups provide advanced curriculum and summer learning opportunities (Fixsen, Blasé, Metz, & Van Dyke, 2013).
  - *Many communities provide after-school/out-of-school/summer opportunities to support student learning and retention. This is especially important for students experiencing inequities (Smink & Reimer, 2005). https://files.eric.ed.gov/fulltext/ED485683.pdf*
- **Embed needed services, supports, or opportunities into existing cross-sector settings/programs** (Selsky & Paker, 2010)**.** Work with settings to integrate elements into existing curriculum or programming.
- **Expand and leverage informal sources of support and services** to expand the array of available services in communities experiencing inequities (Craig, 1998).
  - *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. Other communities have engaged informal supports provide early childhood programming.*
- **Engage retirees/students in providing needed service** components in priority 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.
- **Ensure 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.

Design services to meet residents' needs, preferences

- **Engage residents as partners in designing services, supports, and opportunities** that meet local needs, fit with cultural traditions and preferences, and ensure family-friendly experiences in waiting rooms and service settings (Rowland, 2016). See page 6 for strategies to engage residents and community members in co-design/decision-making processes.
  - *Plain Talk is a neighborhood-based initiative 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*
- **Use direct service interactions to gather input from 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

Strategies to address COMPONENTS

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

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.

- **Hire staff representing the demographics of residents from groups experiencing inequities** (Wagner & Willms, 2010)**.** 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 help attract staff and leaders representing the community, especially groups experiencing inequities. For example, develop internships with community colleges to attract skilled staff. [*Note: this is a Connections strategy*]

Make service *locations* easier for residents to access

- **Co-locate multiple cross-sector providers or services in same setting.** 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 (Dziczkowski, 2011; Ginsburg, 2008).
  - *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.*
  - *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 priority communities** (Corter & Pelletier, 2010)**.** Use neighborhood organizations or schools as community service hubs so residents can access a range of services in one location.
  - *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*
  - *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** to reduce the number of service visits residents need to make and to simultaneously meet multiple needs (Fowler et al., 2013).
  - *The Santa Clara County Public Health Department helped provide bundled tobacco cessation services (cessation counseling, referrals, and nicotine replacement therapy) 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*
- **Provide mobile services** to bring needed cross-sector services and supports to priority areas with limited access**.** For example, use a Mobile Clinic to bring nurses, literacy supports, and family supports to local neighborhoods (Gillispie et al., 2016).

Strategies to address COMPONENTS

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

- **Locate offices and service in neighborhoods experiencing inequities** to improve access to needed services (Daly et al., 2002)
  - *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.*
  - *Some communities locate user-friendly tax preparation supports in neighborhoods dominated by predatory income tax preparation services (disproportionally in low income communities of color). These sites enable residents eligible for tax benefits to obtain these without losing a high proportion of what they should receive due to exploitative commercial services (Annie E. Casey Foundation, 2006). https://www.aecf.org/resources/race-matters-system-reform-strategies/*
- **Use technology/web-based platforms to provide or supplement existing supports** that are easier for residents to access (compared to traveling to an office or center; Wootton et al., 2017)**.**
  - *SHINE 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*

Make service *times* easier for residents to access

- **Extend services hours beyond traditional 9-5 schedules** to make it easier for working residents to participate.
  - *The Chambliss Center for Children in Chattanooga, Tennessee offers affordable, high-quality childcare 24 hours a day, 7 days a week, 365 days a year to make it easy for parents who work 2nd and 3rd shifts or are in school to access high quality care for their children. 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 groups from priority 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.

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 residents whenever possible (e.g., child care subsidies, Medicaid).
- **Design low-cost versions of quality supports** that are more affordable to more residents.
  - *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.*
- **Reduce overhead to allow for lower cost options.** 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.
  - *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)*

Strategies to address COMPONENTS

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

Provide engagement supports

- **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).
- **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.
- **Embed service navigators to help residents 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 (Piper, 2014).
    - *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.*

Strategies to address RESOURCES

Human, financial, community, and social resources that are used within the system

Build providers' skills and knowledge

- **Provide cross-sector, shared professional development** to build needed capacities. Engage providers and leaders in the development of these capacity-building efforts, and coordinate shared training across sectors to ensure providers are using aligned practices (Goode & Jones, 2006).
    - *The National Diaper Bank Network and The New Haven Mental Health Outreach for MotherS (MOMS) Partnership collaborated 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/.*
    - ***"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.
    - *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 build and reinforce targeted skills and knowledge. Also set up networks for staff to access consultation from experts across sectors, such as from mental health, substance abuse, domestic violence, impaired parent-child relationships, and child development Provide support on site when possible (Henderson, 2011).
- **Encourage peer to peer support** for targeted practices, for example through communities or practice, staff reflection groups, or mentoring processes for veteran providers to support the capacity-building of newer staff. (Fineberg, 2012).
- **Provide toolkits** to help stakeholders use targeted practices, and ensure these materials are aligned with professional development content.
- **Align capacity-building content for professionals and residents** to encourage consistent practices at home and program settings (Green, Malsch, Kothari, Busse, & Brennan, 2012).
    - *McNabb Elementary School in Kentucky embeds a focus on Positive Behavioral Intervention & Support approaches to discipline and classroom management into annual staff training. Once the school year begins, they orient and train parents on this same approach. (*https://www.pbis.org/school/exemplar-from-the-field/mcnabb-elementary-ky).

Build residents' skills and knowledge

- **Ask 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.
- **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.
- **Craft information that 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.
- **Include 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.

Strategies to address RESOURCES

Human, financial, community, and social resources that are used within the system

- **Use 211 to diffuse information** about new programs or opportunities to residents. Ensure 211 is current and residents are aware of this resource.
- **Share information in natural traffic areas.** Go to areas that receive high-traffic of residents from your target population to share information.
    - *The Thirty Million Words Initiative started recruiting on public transportation systems to find families who were eligible and interested in school readiness supports.*
- **Combine outreach efforts** with groups, organizations, or collaboratives pursuing similar goals to reach more settings and residents.
- **Use Enrollment campaigns** similar to those used for voter and health insurance registration to promote effective outreach.
    - *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*
- **Engage community stakeholders, neighborhood leaders, and cross-sector service providers in sharing information during natural touches** with residents**.** For example, stakeholders like clergy, hair salon stylists, grocery store check-out lines, and bank tellers can be great partners for sharing information.
    - *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/*
- **Use social media to communicate with 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 share information with residents**.
    - *Some communities use a Parent Contact Database to help teachers send mass texts to share information with parents. Similarly, healthcare or community service providers can send out daily personalized texts asking how the client is doing or providing helpful tips or encouragement. Providers can track the responses and follow up with residents who want additional support. Learn more here https://www.wkkf.org/resource-directory/resource/2006/01/template-for-strategic-communications-plan.*
- **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).
    - *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 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/)*
- **Offer capacity-building in neighborhood settings**. For example, hold resident leadership training at church settings or training for parents to interpret school learning assessment results into school settings.

Expand stakeholders to

- **Hire or engage local residents to help deliver needed services or supports.** 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

Strategies to address RESOURCES

Human, financial, community, and social resources that are used within the system

deliver services and supports

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. Other communities train residents to co-facilitate programming with professionals, which can also meet residents' preferences for working with staff that share their background or lived experiences.

- *The Zero8 program is an incentive-based coaching program that trains local parents as coaches 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. See here for more information: 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).*
- *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.*

Re-allocate or leverage existing funding

- **Leverage private sector support and public-private partnerships** to expand the array of available services and supports in communities experiencing inequities.
  - *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.*
- **Re-appropriate funds** to support targeted changes and goals.
- **Braid funding across efforts** to create larger collective pots of funding to support expansion of needed services in communities experiencing inequities. Consider how to bundle these services together to maximize funding (see other strategies within Components for examples).
  - *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)*

Shift community resources and environments to support targeted changes

- **Shift community environments to support change goals.** For example, add streetlights to discourage crime, create or improve local parks to increase opportunities for physical activity, or install bike racks to support transportation options.
- **Shift building environments to support change goals.** For example, design mixed residential-commercial spaces using a "complete streets" model, design housing to support social connections, or restructure grocery stores or cafeterias to make it easier to purchase healthier food options.
- **Repurpose vacant buildings, spaces, or lots into usable resources** to promote targeted goals. For example, transform vacant buildings into service hubs (see service hub examples in Components section) or abandoned public spaces into parks and farming plots.
  - *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*
  - *In Detroit, MI, vacant lots have been turned into thriving urban farming plots to promote goals around health (Hashim, 2015).*

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