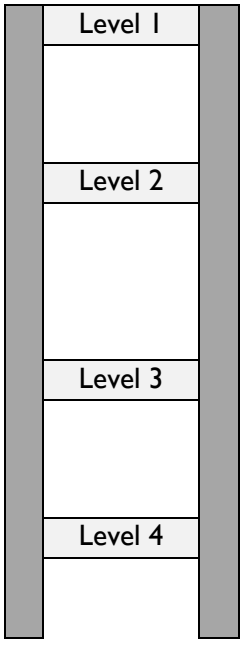
Strategy Resource Guide

This document provides example strategy approaches used throughout the U.S. and internationally to address systemic root causes contributing to 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 systemic root causes. Systems thinkers have discovered some root causes are more powerful "leverage" points than others for shifting community patterns (Johnston et al., 2014; Meadows, 2008). The following ladder visual summarizes the most powerful (level 1) to least powerful (level 4) leverage points for shifting patterns driving local problems and inequities, and includes page numbers for corresponding strategies.

Example Strategies to Address Systemic Root Causes



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 MINDSET root causes

Attitudes, values, and beliefs that shape behavior

ROOT CAUSE: Lack of buy-in around new approach or paradigm (e.g., equity focus, systems approach, focus on social determinants of health, etc.)

Promote value of new approach 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 the message that efforts to address inequities are needed by most communities
- **Engage trusted others (e.g., clergy, home visitors) in talking with residents during natural touch points** about the value of new approach when engaging residents. Consider providing basic talking points to help these individuals hold these conversations.
    - *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 (*Planned Parenthood, n.d.). *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.
- **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.
- **Engage local initiatives and collaboratives** in supporting and reinforcing new approach.

Strategies to address MINDSET root causes

Attitudes, values, and beliefs that shape behavior

Raise Critical Consciousness	• **Embed training or experiences to raise critical consciousness.** For example, consider how to embed training elements related to the new approach on topics (e.g., racial bias training, training on systems approach) into ongoing meetings, annual orientations, or professional development efforts. • **Raise critical consciousness through using 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. • **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 those conflicts and, if possible, identify common values and/or value shifts necessary to create a unifying paradigm. • **Provide powerful experience that challenge people's current mindsets** and helps them actively question previously held beliefs and information (Biggs et al, 2011). For example, 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.
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) 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. • **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.
Provide Incentives	• **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. • **Reduce fees** if person/organization adopts practices, behaviors, or changes that support the new approach (or add fees if they don't)

Strategies to address MINDSET root causes

Attitudes, values, and beliefs that shape behavior

	• **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. • **Encourage Funders to prioritize grant applications** that demonstrate commitment to targeted new approach (e.g., use of racial equity focus, etc.)
Reduce Disincentives	• **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 • **Expand billing reimbursement categories** to include practices, behaviors, or changes that support the new approach on list of actions for which providers or organizations can be reimbursed. Make this easy to use by adding new categories related to the strategy into billing systems. (Powell, 2009) • **Remove incentives conflicting with new approach.** For example, incentives for meeting a quota (number of clients) vs. providing high-quality services that actually benefit residents.
Set New Expectations	• **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. ○ *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 (Healthy Nashville, n.d.). http://www.healthynashville.org/index.php* • **Support local and state funders set new expectations** for the new approach by referencing them in explicit outcome expectations, requests for proposals, and grant applications prioritizing criteria. • **Help leaders demonstrate to staff their priority** for the new approach. • **Get written commitments** from local partners to adopt the new approach. • **Create an organizational culture that supports change and learning** to encourage staff to adopt the new approach. • **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.
Align Vision and Purpose	• **Align mission statements** with the new approach. • **Align strategic plans** with the new approach.

Strategies to address GOAL root causes

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

ROOT CAUSE: Lack of Shared Goals

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.
    - *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 who have different experiences, interpretations, and perspectives around the targeted problem.
    - *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.

ROOT CAUSE: Current Goals not Aligned with Targeted Approaches

Align Goals with Targeted Approaches

- **Align new goals and current goals with targeted 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.

LEVEL 2: STRUCTURE

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

Strategies to address CONNECTION root causes

Relationships and exchanges between and across different actors and organizations

ROOT CAUSE: Ineffective Information Sharing

Create new settings, policies, and systems to support information sharing

- **Create a shared consent form** to give residents the opportunity to consent to information sharing across organizations given policies such as HIPAA and FERPA.
- **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.
    - *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 (Pritzker, Bradach, & Kaufmann, 2015). 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 and residents. 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.*

Strategies to address CONNECTION root causes

Relationships and exchanges between and across different actors and organizations

Create new processes and practices to support effective communication 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.
- **Adopt new outreach practices** of sharing information in natural traffic areas for priority residents, or using social media and mass text communication.
- **Embed practice of keeping a record of 3 dependable contacts to prevent losing touch with residents.** Ask priority 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 priority residents** during service visits to promote better communication processes.
- **Provide example questions and processes** priority 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 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.*

ROOT CAUSE: Limited Cross-Sector Referrals

Adopt policies and practices to support cross-sector referrals

- **Develop shared intake forms** to promote coordinated referrals across organizations addressing the needs of residents.
- **Embed coordinated assessment, early screenings, and referral processes** within multiple settings that touch residents.
    - *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.).* (Pritzker, Bradach, & Kaufmann, 2015). *http://www.bridgespan.org/getattachment/feb8d3d3-042c-4a7b-a828-3b5bda8283a9/Achieving-Kindergarten-Readiness-for-All-Our-Child.aspx*
- **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. See

Strategies to address CONNECTION root causes

Relationships and exchanges between and across different actors and organizations

	strategies on addressing feedback loop root causes later in this document for more details.
Expand role boundaries of potential referral sources	• **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. (Hanc, 2014) 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.** 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.
ROOT CAUSE: Practices Not Aligned across Settings	

Align and integrate practices across settings	• **Align core priorities and curriculum elements** across settings and programs serving priority groups. 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. (Jefferson Public Schools, n.d.) grade.www.jefferson.k12.ky.us/Schools/Elementary/McFerran.html*
	• **Help settings serving priority groups 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.*
	• **Coordinate shared training** across sectors to ensure providers are using aligned practices.
	• **Align capacity-building content for professionals and residents** to encourage consistent practices at home and program settings.
	  ○ *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. (Ross, 2003) (https://www.pbis.org/school/exemplar-from-the-field/mcnabb-elementary-ky).*

Strategies to address REGULATION root causes

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

ROOT CAUSE: Policies and Procedures Not Aligned With Goals	

Engage or advocate with stakeholders in positions of power to shift needed policies	• **Engage directors, executives, funders, and other relevant decision-makers in shifting policies** within their scope of work to align with goals.
	• **Engage managers and supervisors in shifting daily procedures** to align with goals.
	• **Advocate for needed policy changes** with stakeholders in positions of power and decision-making. Consider how to gather and share critical local information about how the regulation is contributing to current inequities, and provide ongoing feedback and recommendations.
	  ○ *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). (National Partnership, n.d.) 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.
	  ○ *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.* (Lavender-Schott, 2011) *http://www.michigansandboxparty.org/*

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.
	  ○ *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. (Roudolph, Caplan, Ben-Moshe, & Dillon, 2013) http://www.phi.org/uploads/files/Health_in_All_Policies-A_Guide_for_State_and_Local_Governments.pdf*
	  ○ *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.* (Healthy Nashville, n.d.) *http://www.healthynashville.org/index.php*

ROOT CAUSE: Policies or Practices Not Implemented Consistently or Effectively	
Embed practices 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	• **Track implementation consistency.** Use a tracking system to understand how and when targeted practices are being used. Reward improvements in consistency

Strategies to address REGULATION root causes

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

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

Strategies to address POWER driving inequities

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

ROOT CAUSE: Diverse Perspectives Not Authentically Engaged in Decision-Making	
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. • **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. 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. • **Create action teams** to engage residents experiencing inequities, 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*

Strategies to address POWER driving inequities

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

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 resident perspectives** on local conditions and potential strategies related to the targeted 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 residents by asking questions during direct service touches.**
    - **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.
- **Assess and build stakeholders capacity to engage 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 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 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).

ROOT CAUSE: Diverse Perspectives Not Authentically Engaged in Taking Action

Engage residents as change agents

- **Create resident coalitions** where residents design and implement changes to promote targeted goals.
  - *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. (Great Start for Kids, n.d.) 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 for the neighborhood. (The Winnipeg Foundation, n.d.) (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.
  - *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. (Lavender-Schott, 2011) http://www.michigansandboxparty.org/*
- **Support resident-driven action teams** where residents design and implement changes to promote targeted goals.
  - *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."* (University of Wisconsin School of Medicine and Public Health, 2017) *(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*

Strategies to address POWER driving inequities

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

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. • **Engage neighborhood leaders to distribute questions residents can ask to advocate for their needs** during service interactions. Some communities put these questions on placemats or magnets to make it easy for families to learn and remember.

LEVEL 3: FEEDBACK LOOPS

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

Strategies to address FEEDBACK LOOP root causes

Exchanges that inform action and keep actors responsible to that feedback

ROOT CAUSE: Limited feedback loops in place to inform action	
Embed feedback loops into natural touch points	• **Embed practice to ask questions during staff meetings** to gather feedback from staff on emerging needs and opportunities; rapidly share this information with individuals who can use it to inform decision-making and action • **Embed practice to ask questions during collaborative meetings** to gather feedback from colleagues on emerging needs and opportunities; rapidly share this information with individuals who can use it to inform decision-making and action • **Embed practice to ask questions during direct service touches** to gather feedback from residents on emerging needs and opportunities, such as doctors' appointments, home visits, or program sessions. Rapidly share this information with individuals who can use it to inform decision-making and action. ○ In Battle Creek, MI, one service agency developed a "**fast-five survey**" residents fill out 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. • **Embed use of a Cross-sector "Pulse" survey** to gather input from residents receiving services from local agencies, and use this information to inform decision-making and action. Survey questions are generated collectively by partnering agencies on a quarterly basis and distributed in waiting rooms and at the end of service visits.
Use technology to embed feedback loops	• **Embed practice to use text messaging** to gather rapid feedback from residents • **Provide comment spaces on websites** for residents to provide feedback on targeted questions to inform decision-making and action
Create bi-directional feedback loops	• **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).
ROOT CAUSE: Delayed feedback loops	
Create needed protocols and procedures	• **Help organizations develop protocols and procedures** to help staff know how to rapidly share feedback from residents with relevant decision-makers.

	• **Embed practice for partners to share relevant feedback** at collaborative meetings
Adjust evaluation timelines	• **Design evaluation efforts to provide real-time feedback** on implementation and progress to inform decision-making and continuous improvement efforts.

LEVEL 4: ELEMENTS (Least Powerful)

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

Strategies to address COMPONENTS root causes

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

ROOT CAUSE: Services Not Available or Designed to Meet Residents' Needs, Aspirations, or Preferences

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

- **Extend and 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.
  - *Many communities 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*
- **Embed needed services, supports, or opportunities into existing cross-sector settings/programs.** 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.
  - *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.
- **Leverage private sector support and pursue public-private partnerships** to expand the array of available services and supports in communities experiencing inequities.
- **Re-appropriate funds** to expand the array of available services and supports in communities experiencing inequities.
- **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).

Strategies to address COMPONENTS root causes

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

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

- **Help organizations develop processes to engage 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 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 represent the communities they serve

- **Hire staff representing the demographics of residents from groups experiencing inequities.** 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 groups experiencing inequities. For example, develop internships with community colleges to attract skilled staff.

Strategies to address COMPONENTS root causes

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

Adopt resident-centered, culturally-informed service practices and environments

- **Design resident-centered waiting rooms and service settings** that promote a positive experience.
  - *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 to 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. (Gordon and Chin, 2004 https://www.brookings.edu/wp-content/uploads/2016/06/1024_medhomes_ross.pdf*
- **Design programs, supports, and opportunities to fit with residents' cultural traditions and preferences.** Talk with residents about what cultural components would make them feel more comfortable accessing programs and services.
  - *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. (Annie E. Casey, n.d.) www.plaintalk.org, www.aecf.org/Home/MajorInitiatives/PlainTalk.aspx*

ROOT CAUSE: Services Logistically Difficult for Residents to Access

Co-locate Services and Providers

- **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.
  - *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 (*Keady, 2015)
- **Create Service Hubs within priority communities.** 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 (Hope Street Family Center, n.d.). www.healthychild.ucla.edu/HopeStreetFamilyCenter.asp*

Strategies to address COMPONENTS root causes

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

- **Have providers deliver bundled services** to reduce the number of service visits residents need to make and to simultaneously meet multiple needs.
    - *For 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.* (Santa Clara County Public Health, 2018) https://www.sccgov.org/sites/sccphd/en-us/healthproviders/tobaccoprevention/Pages/default.aspx
- **Hire shared staff across settings.** Combine resources to hire a staff that can rotate across settings.

Re-locate services and providers

- **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.
- **Create satellite offices** 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, 2006).* *http://www.aecf.org/m/resourcedoc/aecf-RACEMATTERSsystemreformstrategies-2006.pdf*
- **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)**.**
    - *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. (Health Foundation, 2014)* *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.

Strategies to address COMPONENTS root causes

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

Shift when services are offered	• **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 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. (W.K. Kellogg Foundation, 2016) 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.
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.
ROOT CAUSE: Service Enrollment is Difficult or Stigmatizing	
Simplify enrollment processes	• **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. ○ *South Dakota simplified its application process for CHIP and Medicaid by issuing a single card for both. (Children's Defense Fund, n.d.) 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. • **Leverage school-wide enrollment processes** to make it easy for families to sign up for other types of supports or services. • **Have volunteers help 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 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. ○ *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*

Strategies to address COMPONENTS root causes

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

	support groups, TANF, Medicaid benefits, child support, housing assistance, custody procedures and other legal issues, child care resources, and respite services.
Expand eligibility policies	• **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... (Children's Defense Fund, n.d.) www.childrensdefense.org/site/PageServer?pagename=childhealth_chip_whatsworking_frontier*
Reduce stigma	• **Remove separate intake processes** that call out or discourage residents from groups experiencing inequities from 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.
ROOT CAUSE: Services Not Affordable for Residents	

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. (Engine, n.d.)(http://enginegroup.co.uk/work/kcc-designing-services-with-dads)*

Strategies to address RESOURCE root causes

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

ROOT CAUSE: Providers Lack Needed Knowledge and Skills	

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 goals. Engage providers and leaders in the development of these capacity-building efforts.
	  ○ *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. (National Diaper Bank Network, n.d.) 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 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.
	• **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	• **Use 211 to diffuse information** about new programs or opportunities to both residents and professionals. Ensure 211 is current and providers are aware of this resource.

Strategies to address RESOURCE root causes

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

ROOT CAUSE: Residents Lack Needed Knowledge And Skills	

Design resident-centered outreach practices	• **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.
	• **Craft information about services 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.
	• **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 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 residents. Ensure 211 is current and residents are aware of this resource.
	• **Adopt new outreach practice of sharing 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 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 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. (Pritzker, Bradach, & Kaufmann, 2015)* *http://www.bridgespan.org/getattachment/feb8d3d3-042c-4a7b-a828-3b5bda8283a9/Achieving-Kindergarten-Readiness-for-All-Our-Child.aspx*

Engage direct natural touch points in sharing information with residents	• **Engage community stakeholders 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. • **Engage cross-sector service providers in sharing information during every touch with residents** by having them ask residents about other needs and sharing resources to common barriers. ○ *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. (Paul, 2014)* *http://time.com/2934047/why-pediatricians-are-prescribing-books/*

Strategies to address RESOURCE root causes

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

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

Use online platforms to share information with residents	• **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 engage 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: (WK Kellogg, 2006) https://www.wkkf.org/resource-directory/resource/2006/01/template-for-strategic-communications-plan.*
	• **Link 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).
	  ○ *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 University of Wisconsin School of Medicine and Public Health, 2017) https://www.med.wisc.edu/news-and-events/2017/december/partnership-awards-boost-community-projects/*)

Embed resident capacity-building opportunities	• **Embed training opportunities into current settings** engaging residents to build their capacity. For example, embed resident leadership training opportunities into church settings or training for parents to interpret school learning assessment results into school settings. ○ *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 Kate B. Reynolds Charitable Trust, 2017) Retrieved 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.
ROOT CAUSE: Limited Staff or Partners to Implement Efforts	

Strategies to address RESOURCE root causes

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

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.
	  ○ *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. (WK Kellogg Foundation, 2008) (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).*
	• **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.
	  ○ *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	• **Expand focus of the change effort** to include problems targeted by key partners to engage new stakeholders in the work. ○ *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 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.
ROOT CAUSE: Limited Financial Resources to Support Change Goals	
Engage new funding partnerships	• **Leverage private sector support and pursue public-private partnerships** to access additional resources to support targeted equity goals.

Strategies to address RESOURCE root causes

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

	○ *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 Re-allocate Existing Funding	● **Re-appropriate funds** to support targeted equity goals. ● **Braid funding across efforts** to create larger collective pots of funding to support cross-sector equity goals. ○ *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)*
ROOT CAUSE: Lack of Community Resources or Environments to Support Health Equity	
Leverage underutilized community resources	● **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 above) 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". (Friends of the High Line, n.d.) http://www.thehighline.org/about* ○ *In Detroit, MI, vacant lots have been turned into thriving urban farming plots to promote goals around health.* ● **Supplement existing transit resources 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. ○ **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. ○ **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. ● **Redirect surplus food** from food vendors to settings reaching residents from priority groups to provide affordable fresh food to those with otherwise limited access. ○ *Food for Free, Cambridge, MA, redistributes food from restaurants, college campuses, and supermarkets that otherwise would be thrown out. (Food for Free, n.d.)* ○ *In New York City, City Harvest rescues 50 million pounds of food from restaurants, bakeries, supermarkets, manufacturers, and such that would have otherwise been wasted and delivers them for free to soup kitchens and shelters. (Tuttle, 2015) http://time.com/money/3913386/food-waste-feed-hungry/*

Strategies to address RESOURCE root causes

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

Create or shift community resources or environments	• **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.
Advocate for needed resources or environments	• **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. (Lavender-Schott, 2011)* *http://www.michigansandboxparty.org/*

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