Preparing Strategies for Action Resource Guide

This document provides example approaches being used throughout the U.S. and internationally to prepare strategies for action, including how to:

- Prepare strategies for effective implementation
- Address system misalignments with strategies

Where available, references to specific organizations/agencies and/or websites have been provided with the approach descriptions. See ABLe manual pages 249-299 for more details on preparing strategies for action.

Contents

Promote Diffusion

The following are various approaches for promoting the effective diffusion of your strategy efforts, including promoting awareness, buy-in, and scale.

Promote Awareness	

Use multiple communication channels	• **Use multiple communication channels people <u>already</u> use and trust** to communicate information about strategies, including:
	  ○ webinar or in-person presentations
	  ○ email or printed mailings
	  ○ Websites, blogs, etc.
	  ○ mass media
	  ○ social media
	  ○ interpersonal communications
	• **Help organizations develop processes to share information internally** within their organization. For example, help organizations develop ways to share new information related to strategies across their departments and across staff.
	• **Leverage and strengthen networks between local organizations** to help share and reinforce information about the strategy

Promote Buy-in	
Build Local Ownership	• **Engage partners in helping to co-design strategies.** People are more likely to support strategies they had a role in developing, versus strategies perceived as being brought in from the outside. Consider how to engage relevant implementers in developing your strategies.
Effectively communicate need, benefits, and feasibility of change	• **Highlight the value of targeted changes during conversations.** Talk about the value of targeted changes within staff meetings, local collaborative meetings, staff supervision, and professional development. • **Normalize the need for targeted changes.** Reduce stigma by reinforcing the message that the targeted changes are needed by most communities • **Use social marketing approaches** to promote local buy-in and adoption of strategies. • **Embed testimonials from local residents** on relevant websites or social-media outlets to shift local perceptions. Be specific in what you ask from residents - ask them to describe how the changes have been beneficial, with a specific example. Display them on your webpage, social media outlets, or in radio ads. Be sure you receive written consent from residents to use their stories in these outlets.

	• **Support positive media coverage** of residents who have successfully adopted/benefited from new approach/paradigm. • **Contribute to news articles or submit letters to the editor** about best practices in other communities or highlighting who locally has adopted targeted changes • **Publicly show outcomes and progress of change efforts over time** in ways that are easy for people to understand. Create a public display or dashboard so people can see progress toward the targeted change. ○ The Oakland Reads 2020 initiative provides a webpage (http://blog.urbanstrategies.org/category/res/) with outcomes tracking and a comprehensive infographic dashboard to see the different targeted problems and system habits they are focused on. Take a closer look at their dashboard here: http://blog.urbanstrategies.org/wp-content/uploads/2014/04/OR-Dashboard-V8.png • **Engage local initiatives and collaboratives** in supporting and reinforcing strategies.
Leverage Champions	• **Engage local stakeholders as influential champions** in supporting and reinforcing strategies, including decision-making leaders, staff who are seen as influential by colleagues, AND residents impacted by your efforts. Provide opportunities for these champions to speak at public events or at your collaborative about their support for the effort and change targets 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 local initiatives** in supporting and reinforcing strategies. For example, health initiatives can reinforce new referral practices within ongoing CEU training of physicians. • **Frame strategies as necessary, desirable, and feasible** for relevant stakeholders you are hoping will implement them. (See page 196 for more details) • **Model or simulate strategies**: create opportunities for relevant stakeholders to directly observe experienced stakeholders or settings successfully using from strategies.

Provide Perks	• **Provide public recognition** of settings or individuals adopting strategies
	  ○ Provide a community award for organization best at connecting families to needed services
	  ○ Recognize individuals during staff meetings or through communications

	○ Recognize individuals at local community events or functions. • **Reduce fees** if person/organization adopts strategies (or add fees if they don't) • **Use organizational perks** to reward staff who use strategies, such as prime parking spots, job promotions, or pay (Rosenberg & Mosca, 2011). • **Give vouchers** that can be redeemed for desired rewards (retail goods and services, opportunity to win prizes, etc.) to incentivize and reward new strategies and targeted changes. • **Encourage Funders to prioritize grant applications** that demonstrate commitment to strategies (e.g., use of a protective factors approach, effective family engagement practices, racial equity focus, etc.)
Reduce Disincentives	• **Phase in implementation through series of quick wins** to help stakeholders see change as less threatening and overwhelming (Rosenberg & Mosca, 2011). See quick wins chapter of ABLe manual for more details. • **Streamline or restructure work processes** to reduce time burdens associated with adopting new strategies. For example, streamline paperwork so staff can more easily adopt new practices within their current workflow • **Expand billing reimbursement categories** to include strategies 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 strategies.** For example, incentives for meeting a quota (number of clients) vs. providing quality services that actually benefit residents.
Set New Expectations	• **Use a "Health in All Policies" approach** to embed considerations related to targeted changes (e.g., social determinants of health) into cross-sector policies and decision-making processes. For example, 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 • **Support local and state funders set new expectations** for strategies by referencing them in explicit outcome expectations, requests for proposals, and grant applications prioritizing criteria. • **Help leaders demonstrate to staff their priority** for the strategy/strategies and their support for effective implementation • **Get written commitments** from local partners to adopt strategies

	• **Create an organizational culture that supports change** to encourage staff to adopt new changes and behaviors. • **Add expectations related to strategies into job roles/responsibilities and job performance criteria**. For example, embed expectations for behaviors like communicating the outcomes of referral processes to referring providers into staff job descriptions and performance criteria.
Align Vision and Purpose	• **Align mission statements** with strategies • **Design strategic plans** aligned with strategies
Promote Scale	
Leverage networks of diverse partners	• **Engage diverse partner organizations in adopting (and spreading) strategies.** Identify a diverse array of organizations or entities that could adopt particular strategy components or new behaviors. Consider how to support some of these organizations in helping to spread the strategies to other organizations. • **Utilize existing networks of organizations** to expand the reach of strategies even further**.** For example, one community engaged a large network of YMCAs in adopting new practices within their programming, expanding their reach to thousands of residents. Consider how to adapt behaviors to fit new community and organizational contexts. • **Consider how for-profit could spread strategy.** Some strategies are well-suited for use within for-profit organizations. For example, businesses have helped to scale microfinancing strategies (providing small loans to low-income entrepreneurs) across developing countries. Non-profits can help by demonstrating the viability of a strategy could fill new market or business opportunities. • **Engage supportive intermediaries.** Identify organizations that can support your scaling efforts by connecting you to new funding, resources, partners, and advocacy efforts. For example, Local Initiatives Support Corporations (LISCs) help scale up community development initiatives.
Turn Bricks to Clicks	• **Use online tools to scale vs. on-site staff.** Use online platforms to scale the adoption of new strategies instead of on-site staff. For example, an organization called KaBOOM! started using an online platform to help communities build new playgrounds instead of deploying staff to each site, and went from supporting an average of 75 playgrounds a year to over 1,300.
Dedicate staff to support implementation	• **Engage a backbone organization** to support implementation of the strategies across the community. This could be formed within an existing organization, or it could become its own organization.

Create needed infrastructure	• **Develop needed data systems to track and communicate information** across multiple settings using strategies • **Embed collaborative quality improvement system** to help multiple settings learn and support each other in using strategies.
Encourage Experimentation	• **Help settings adapt strategies to fit their context.** Instead of scaling a rigid strategy or set of behaviors, help settings experiment and adapt strategies so they fit and compliment their local context.

Support Effective Use

The following are approaches for supporting the effective and continued use of strategies

Promote Effective Use	
Make strategies easy to use	• **Design strategies to fit with existing practices or processes** to make it easier for stakeholders and settings to embed them into ongoing practice. For example, design new shared application forms to fit within organizations' overall intake processes. • **Develop easy to follow steps or processes** people can follow to adopt new strategies. For example, design simple processes for how providers can share information with other organizations. Ensure these instructions are detailed. Organizing data into easy to use tables or visuals can help people use this information to inform their decision-making • **Embed reminders or strategy prompts:** develop and embed reminders to help providers remember to use strategies • **Give people opportunities to experiment** with the strategies before needing to fully commit. For example, give parents the opportunity to experience or practice program elements during a parent-teacher conference to reduce fears related to committing to the program.
Embed into training and technical assistance	• **Embed a focus on targeted capacities into existing training efforts:** Add content to support strategies into the ongoing orientations, staff training, and CEU training. • **Embed focus on strategies into higher education** program curriculum and training processes • **Open up professional development opportunities** to diverse agencies and partner organizations.

	• **Use engaging training processes** that use multiple methods, are interactive, use adult learning principals, and cater to different learning styles and work contexts • **Create a centralized process for providing aligned technical assistance and coaching** to stakeholders and settings implementing strategies, using local personnel when possible. • **Provide training and technical assistance on site** to help stakeholders learn how to carry out strategies in their own setting • **Provide ongoing supervision** of staff carrying out strategies
Provide Supportive Tools	• **Provide toolkits** to help stakeholders use strategies • **Develop a strategy glossary** of key terms related to the strategy, including other stakeholders carrying out the strategies, to help people effectively • **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.
Support Social Learning	• **Promote peer to peer learning** by creating teams of stakeholders carrying out strategies to learn from each other, share lessons learned, and provide support; provide protected time for staff to engage in this learning and reflection process • **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
Build Local Leadership	• **Develop local adaptive leadership skills.** These skills include being able to engage stakeholders (including staff and residents) in problem-solving emerging issues. • **Develop local technical leadership skills.** These skills include settings goals, managing staff, making progress using timelines, etc. • **Find the right leaders for the right jobs.** Help organizations and partners find or position leaders with needed skills and capacities into positions where they can most effectively support the strategy.

Attract and place skilled staff	• **Create job pipelines** to attract more diverse and qualified staff. For example, develop internship with community colleges to attract skilled staff. • **Place skilled staff in appropriate positions.** Help organizations position staff with needed skills and capacities into positions where they can most effectively support strategies.
Promote Continued Use	
Embed strategies into everyday routines	• **Embed strategies into current procedures and protocols.** For example, embed new assessment tools/questions into current intake procedures used by providers. • **Bring strategies to where people live, work, and gather.** For example, hold farmers markets at factories during lunch breaks, add early childhood information and activities onto grocery carts, bring early literacy supports (e.g., reading corners) into cross-sector waiting rooms, offer services and supports at neighborhood churches, family nights, or parent-teacher conferences. • **Embed reminders or prompts** to help stakeholders remember to use strategies
Provide continuing support and training	• **Reinforce strategies during annual training and orientations:** Add strategies into annual training and orientations (e.g., for staff, collaborative members, councils, etc.), and embed within CEU training. • **Support champions in continuing to encourage strategies,** including leadership, staff, and resident champions. • **Encourage continued peer to peer support** for example through communities or practice or staff reflection groups.
Promote New Expectations and Accountability	• **Use a "Health in All Policies" approach** where considerations related to addressing targeted changes (e.g., social determinants of health) are embedded into cross-sector policies and decision-making processes. • **Align staff roles and job descriptions** with the strategies • **Build residents' capacity to encourage accountability:** prepare residents to ask questions with relevant stakeholders about the use of strategies during service visits or during meetings. • **Add strategies into annual staff review evaluation criteria** to set new expectations and promote accountability (Rosenberg & Mosca, 2011).

Promote Adaptive Sustainability	• **Track implementation consistency.** Use a tracking system to understand how and when targeted practices are being used. Reward improvements in consistency over time. Tracking can be internal as well as shared with other organizations to promote consistency between providers. • **Help organizations and partners use rapid ongoing cycles of learning and action** to quickly adapt strategies in response to shifting organizational or community contexts. This may require building the capacities and structures within settings and community to effectively engage diverse perspectives in rapid learning and action. • **Continue to align system conditions with strategies over time** to ensure emerging barriers do not hinder continued use. See page 249 for more details.

Ensure Dose

Ensure Reach	

Raise Awareness	• **Ask residents 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.
	• **Leverage <u>Direct</u> Touch Points with Residents.** Identify settings (e.g., grocery stores, hair salons), gatherings (e.g., faith-based), service interactions, or events residents naturally tend to visit in the community and work with settings to embed processes for staff to use these "direct touches" as natural opportunities to share information with residents.
	• **Leverage <u>Indirect</u> Touch Points with Residents.** Get information to residents through existing <u>indirect</u> touch points in the community by:
	  ○ Including information in newspapers or newsletters
	  ○ Seeing if local business would include information in utility bills
	  ○ Having local employers include information brochures in their cafeterias or break rooms
	  ○ Including information in school's grade report cards
	  ○ Asking faith-based leaders to include information in the church bulletin
	• **Use social marketing** disseminate messages to residents about taking advantage of new benefits or opportunities brought about by your strategies. Use local communication channels such as social media (e.g., Facebook), news media, online community forums or marketplaces such as Craigslist, online advertisements, and billboards to disseminate messages.
	• **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 early learning, 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/
	  ○ Have pediatricians ask every family about their needs and share information about available services to meet those needs
	• **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
	• **Adopt new outreach practice of sharing information at community events** (e.g., parent-teacher conferences, wellness fairs, community fairs) to talk with residents about available services and/or new targeted changes
	• **Adopt new outreach practice of sharing information in natural traffic areas for residents.** 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.
	  ○ For healthy food access, the CDC's Complete Health Equity Guide suggests working with schools (or early childhood centers) to be sites for farmers' markets on weekends or during child pick-up times to increase awareness and access for families.
	• **Leverage social media to share information with residents.** One school set up a twitter account to announce upcoming school events and news. Utilize Facebook group pages or other social networking sites residents frequent.
	• **Use 211 to diffuse information** about new programs or opportunities to residents. Ensure 211 is current and residents are aware of this resource.
	• **Use Enrollment campaigns** using strategies similar to those used for voter and health insurance registration.
	  ○ 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 Local Recruiters	• **Use a Snowball Approach.** Ask residents in targeted populations to identify or help recruit other residents in their social networks with similar demographics to take advantage of the opportunities or benefits brought about by your strategies. The residents who are recruited in this way can then start recruiting additional individuals themselves to create a chain reaction. • **Engage community leaders.** These individuals often have a lot of knowledge of how information typically gets out in their area, and can help develop and carry out approaches to raise awareness with local residents.
Reduce Access barriers	• **Seek to Understand and Address potential access barriers.** Residents can experience many barriers to participating in new opportunities or resources – they may not have transportation, service hours might not meet their needs, or how or where services are provided might not feel comfortable or safe. Ask residents you currently engage to identify common barriers they (or others they know) experience in accessing local services and work with them to identify ways to address these barriers. Talk with people inside your organization and across the community about how to address these barriers, and track whether your changes are actually increasing which residents access your services. • **Improve access using technology.** Consider how technology could help you reach more individuals with your strategies. For example, one organization expanded its local efforts to support low-income youth apply to college by developing a series of 20 Facebook apps to reach more students.

Build Trust and Buy-in	• **Partner with Trusted Others.** Hard-to-reach residents often distrust the local service system or "outsiders." Find local people trusted by these residents and partner with them to help engage residents in your efforts. Whenever possible, partner with trusted others that represent the cultural/racial groups of the residents you want to engage. Some trusted others may include:
	  ○ Faith-based leaders or elders
	  ○ Long term residents respected by many residents
	  ○ Owners of local establishments frequented by residents
	  ○ Hair dressers/barbers/manicurists
	  ○ Food or clothing donation sites
	• **Promote Resident-to-Resident Connections.** Connect new residents to other residents currently engaging with your effort's strategies or opportunities to build new relationships. These residents can become champions and support networks around engagement.
	• **Embed testimonials from local residents** on relevant websites or social-media outlets to shift local perceptions about the benefits of engaging with strategies or opportunities. Be specific in what you ask from residents who would like to share examples of their positive experiences. Ask them to describe how the changes have

	been beneficial, with a specific example. Display them on your webpage, social media outlets, or in radio ads. Be sure you receive written consent from residents to use their stories in these outlets. • **Support positive media coverage** of residents who have successfully adopted/benefited from targeted changes and achieved outcomes
Ensure Sufficient Strategy Strength	
Increase number and significance of changes	• **Embed additional supports.** Design ways to support residents in getting the most out of the health-promoting opportunities or benefits emerging from the strategies and community changes. For example, add on-site services and supports into affordable housing developments, create additional marketing materials to encourage people to take advantage of healthy food options in cafeterias and retail venues, etc. • **Create social supports.** Organize groups of residents to support and reinforce use of opportunities or benefits emerging from the strategies and community changes. For example, organize resident walking groups to utilize new walking trails more often. • **Reinforce strategy through multiple settings.** For example, embed strategies or community change into multiple settings where residents naturally go during the week (e.g., embed marketing or educational information into churches, banks, supermarkets, etc.)
Improve ratio of health promoting elements	• **Improve ratio of health to unhealthy resources and opportunities**. For example, reduce the number of unhealthy food options served compared to healthy food options.
Help residents build needed capacity to use and benefit from strategies	• **Build resident capacity to use new benefits or opportunities.** Help residents build the skills, knowledge, or social connections they need to take advantage of new opportunities or benefits brought about by our strategies. For example, some residents may need literacy skills to take advantage of new education opportunities, or they may need cooking equipment to utilize new fresh food offerings. • **Embed capacity-building into existing paperwork and processes**. For example, add information on how to use WIC vouchers into the vouchers themselves. • **Embed a two-generation approach** into interventions promoting targeted changes. For example, use approaches that address children's needs while simultaneously building parents' skills to promote their child's wellbeing. ○ PALS (Play and Learning Strategies) is a home visiting intervention that teaches parents how to help their infants and toddlers reach developmental milestones. Coaches visit families weekly for 3 months, demonstrate skills,

	have parents practice new skills, and video the parent practicing these skills to provide feedback. Some components are available on the internet and through interactive remote coaching. https://www.socio.com/eipardd07.php

Promote System Alignment with Strategies

Address MINDSETS misalignments

Attitudes, values, and beliefs that shape behavior

Critical Alignment Questions

- What current mindsets could interfere with people's **motivation** to adopt the strategies?
- What are people's (leader, staff, resident) **beliefs** about these strategies? Do they recognize the strategies as:
  - **Necessary** compared to the status quo?
  - **Feasible** to carry out?
  - **Beneficial** to themselves, local organization, and clients?
- Who might resist this strategy?

LACK OF SHARED GOALS AND PURPOSE	
Create and adopt a shared vision	• **Hold a visioning process** across diverse stakeholders and organizations to identify shared outcomes and systems changes 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 Families Help Themselves"*** to guide its efforts to improve economic outcomes for the families. 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 families themselves. After this realization, they worked to identify a new purpose that recognized the need to create more opportunities for families to thrive within their community and landed on ***"Create Conditions for Families to Thrive".*** Note how this created a different focus for the work: when focused on "helping families help themselves" the initiative sponsored many opportunities designed to help

Address MINDSETS misalignments

Attitudes, values, and beliefs that shape behavior

	low-income families develop their skills and capacities. When focused on "creating conditions for families to thrive", the initiative identified local community conditions impeding family success – such as lack of access to livable wage jobs – and started such efforts as an economic development campaign. • **Promote mutual understanding of targeted changes** among stakeholders who have different experiences, interpretations, and perspectives around the targeted problem. ○ 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.
LACK OF BUY-IN AROUND TARGETED CHANGES	
See diffusion approaches on page #	

Address COMPONENTS misalignments

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

Critical Alignment Questions

- To what extent do current services or programs provide **opportunities** for people to use these strategies?
- How **compatible** are these strategies with how services or programs are currently designed or delivered? What needs to change?

SERVICES NOT AVAILABLE TO MEET SPECIFIC COMMUNITY NEEDS	
Expand array of available supports and services	• **Expand and leverage informal sources of support and services** to expand the array of available services.

Address COMPONENTS misalignments Range, quality, effectiveness, and location of services, supports, and opportunities	
	○ For example, faced with a shortage of medical providers in a rural community, a healthcare organization created a role for a patient's friend or relative, in which this person is paid to attend appointments and help out at home to ensure the patient takes his or her medications. Other communities have engaged informal supports provide early childhood programming. • **Engage retirees/students** in providing needed service components, 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. • **Re-appropriate funds** to expand the array of available services and supports. • **Braid funding across efforts** to create larger collective pots of funding to support expansion of needed services. Consider how to bundle these services together to maximize funding (see other strategies within Components for examples)
SERVICES NOT DESIGNED TO EFFECTIVELY MEET RESIDENTS' NEEDS, ASPIRATIONS, OR PREFERENCES	
Gather and use resident input to design services	• **Help organizations develop new 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

Address COMPONENTS misalignments Range, quality, effectiveness, and location of services, supports, and opportunities	
	○ **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.
Embed evidenced-informed practices	• **Integrate promising practices** into local service and support settings to support these settings in providing more effective programming around targeted outcomes.
Adopt family-friendly practices	• **Design family-friendly waiting rooms and service settings** that promote conversations and a stress-free experience ○ At Mercy Hospital Fairfield in Cincinnati, Ohio, mother and baby receive high-quality, family-centered care in a setting that feels like home. Through labor, delivery, and recovery the mother, baby, and family can stay in one room. • **Hire staff representing the demographics of targeted residents.** Make experience working with underserved populations a priority in job qualifications. Align staff recruitment efforts with this goal through outreach to members of professional affinity groups and specific cultural networks. • **Ensure respectful interactions between staff and residents.** See strategy ideas within Regulations for some ideas**.**
Align programming with local cultural traditions	• **Design programs and strategies 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.

Address COMPONENTS misalignments Range, quality, effectiveness, and location of services, supports, and opportunities	
	○ Sharing a meal is an important element of some residents' cultural traditions - some organizations provide time before a program session begins for residents to share a potluck meal ○ Plain Talk is a neighborhood-based initiative that was implemented in Atlanta, San Diego, Seattle, New Orleans, and Hartford to help adults, parents, and community leaders communicate effectively with adolescents about reducing sexual risk-taking. Each Plain Talk community developed strategies suitable to its own cultures and circumstances. The initiative is being replicated in 19 sites in 9 states and Puerto Rico. www.plaintalk.org, www.aecf.org/Home/MajorInitiatives/PlainTalk.aspx
Raise residents' awareness of services, supports, and opportunities - and how to access them	• **Understand resident preferences for how to best reach them with information.** Gather input from residents at local settings like Kindergarten round-up, local churches, etc. • **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. • **Use direct touches** to reach residents with information about local services such as: churches, salons, grocery store check-out lines, bank tellers, etc. For example, consider how to use informal and neighborhood-based settings such as barber shops, faith-based organizations, and local businesses as information hubs. • **Use social media** can be leveraged to stay in touch 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** can help service providers engage residents in nontraditional ways. For example, using a parent database, 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. Teachers can track the responses and follow up with parents who want additional support. • **Advertise at events and natural traffic areas for families**. For example, set up a table at upcoming community events (e.g., parent-teacher conferences, wellness

Address COMPONENTS misalignments Range, quality, effectiveness, and location of services, supports, and opportunities	
	fairs, community fairs) to talk with residents about available services. Go to areas that receive high-traffic of residents from your target population to get word out about services. • **Provide tools to help residents navigate the supports available.** ○ The New Jersey Department of Human Services Kinship Navigator Program helps 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.
SERVICES LOGISTICALLY DIFFICULT FOR FAMILIES TO ACCESS	

Co-locate Services and Providers	• **Co-locate multiple cross-sector providers or services in same space.** 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.
	  ○ The Thirty Million Words Initiative has a 10 minute video intervention while mothers and babies are still in the hospital after birth. The video is shown by hospital staff, and shows parents how to talk through daily activities with their babies to stimulate language development immediately.
	  ○ 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.** 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,

Address COMPONENTS misalignments Range, quality, effectiveness, and location of services, supports, and opportunities	
	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. ○ 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. https://www.sccgov.org/sites/sccphd/en-us/healthproviders/tobaccoprevention/Pages/default.aspx • **Hire shared staff.** 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 areas with limited access. ○ Use a Mobile Clinic to bring nurses, literacy supports, and family supports to local neighborhoods. ○ The Seattle Public Library's Seattle's Children program brings a bookmobile to child-care centers around the city to support its early literacy initiative. • **Create satellite offices** in neighborhoods where residents live to improve access to needed services ○ 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.

Address COMPONENTS misalignments Range, quality, effectiveness, and location of services, supports, and opportunities	
	• **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. http://www.health.org.uk/programmes/shine-2011/projects/alcohol-relapse-prevention-programme
Leverage available transportation supports	• **Coordinate transportation through resident carpools.** Support families in setting up carpools to services. This not only helps address transportation needs, but also provides opportunities for residents to build relationships. • **Coordinate transportation through local churches** for residents without access to transportation to service appointments. Use volunteers and church vans during weekdays when these vehicles are not being used by the church.
Shift when services are offered	• **Extend services hours beyond traditional 9-5 schedules** to make it easier for working residents to participate. ○ The Chambliss Center for Children in Chattanooga, Tennessee makes it easy for parents who work 2nd and 3rd shifts or are in school to access high quality care for their children by offering affordable, high-quality learning environments, nutritious meals, school transportation and care 24 hours a day, 7 days a week, 365 days a year, for children ranging from 6 weeks to 12 years. https://www.wkkf.org/what-we-do/featured-work/chambliss-center-for-childrens-early-learning-program-provides-affordable-child-care-for-families • **Offer services during existing gathering times.** 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)

Address COMPONENTS misalignments Range, quality, effectiveness, and location of services, supports, and opportunities	
	• **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.
SERVICE ENROLLMENT IS DIFFICULT OR STIGMATIZING	
Simplify enrollment processes	• **Simplify intake or application processes** to make it easier for residents to enroll in services. For example, create a common application form or common intake hub, reduce the number of intake step involved in the enrollment process, or develop intake applications as a phone app. ○ 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 • **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**, either through formal settings or informal networks, to help residents access needed services. Navigators can also help families prioritize which programs are the best fit with their needs. Navigators can be trained volunteers, such as college students getting service hour credit.
	  ○ Community health navigators help connect residents with the right resources at the right time to support wellness and healthy lifestyles. They work to build awareness of neighborhood needs and challenges with a goal of improving health outcomes for children and their families.
	  ○ The New Jersey Department of Human Services "Kinship Navigators" help caregivers navigate through various governmental systems to find local supports and resources. Information is specifically designed for kinship caregivers and can include referrals about support groups, TANF, Medicaid benefits, child support, housing assistance, custody procedures and other legal issues, child care resources, and respite services.

Address COMPONENTS misalignments Range, quality, effectiveness, and location of services, supports, and opportunities	
	○ Pregnancy to Employment in Washington State has social workers assess the health and social service needs and resources of expectant mothers and parents of infants and connect these families to services that may include: medical care for mothers and infants; child care; transportation assistance; job preparation; and classes on parenting, child development, nutrition, family planning, and life skills.
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... www.childrensdefense.org/site/PageServer?pagename=childhealth_chip_whatsworking_frontier
Reduce Stigma	• **Remove separate intake processes** that call out or discourage certain residents for using services (e.g., WIC, social services, etc.) • **Reduce stigma by ensuring consistent quality across service settings.** For example, ensure high quality in the facilities, equipment, personnel, and curriculum at different sites. Low-income residents should not feel that their service settings are inferior to others • **Nurture and coach trusted local family champions** who have used the services, can normalize the need for services, and can openly attest to the quality and benefit of those services
SERVICES NOT AFFORDABLE FOR ALL FAMILIES	
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

Address COMPONENTS misalignments Range, quality, effectiveness, and location of services, supports, and opportunities	
	○ 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. ○ Physicians are an essential source of support to pregnant women, but doulas, midwives, and nurses also play an important role in promoting physical and emotional health by engaging a natural support network. • **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)

Address CONNECTIONS misalignments

Relationships and exchanges between and across different actors and organizations

Critical Alignment Questions

- Is needed **information or resources flowing** to the people or settings trying to adopt the strategies?
- Are needed **referrals** in place to support the strategies?

PROGRAMS AND PRACTICES NOT ALIGNED ACROSS SETTINGS	

Align and integrate curriculum and practices across service 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
	• **Embed curriculum or practices supporting change goals into cross-sector settings/programs.** For example, embed health promotion programming into childcare settings.
	  ○ Shape NC embeds health promotion elements into the curriculum of childcare centers, such as nutritional menus and use of outdoor learning environments to promote physical activity http://www.smartstart.org/shape-nc-home/
	• **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
	• **Coordinate shared training** across sectors to ensure providers are using aligned practices

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

Address CONNECTIONS misalignments Relationships and exchanges between and across different actors and organizations	
LIMITED CROSS-SECTOR REFERRAL NETWORK	
Expand role boundaries of potential referral sources	• **Engage local health care providers in "prescribing" free programs and supports** promoting targeted changes ○ 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.** 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.
Adopt policies and practices to support cross-sector referrals and information sharing	• **Develop shared intake forms** to promote coordinated referrals across organizations • **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.). http://www.bridgespan.org/getattachment/feb8d3d3-042c-4a7b-a828-3b5bda8283a9/Achieving-Kindergarten-Readiness-for-All-Our-Child.aspx • **Create a shared consent form** to give residents the opportunity to give consent to information sharing across organizations given current policies such as HIPAA and FERPA.

Address CONNECTIONS misalignments

Relationships and exchanges between and across different actors and organizations

KEY INFORMATION NOT REACHING SERVICE PROVIDERS	
Create new settings and systems to support information sharing	• **Create cross-sector service teams** who collaborate around shared cases (e.g., system of care approach; wrap around services). • **Develop integrated electronic information systems/software** that are accessible to multiple organizations based on residents' consent ○ Healthy Beginnings out of Palm Beach, Florida, includes an integrated data system that tracks individual children as they move between providers in the service delivery network. http://www.bridgespan.org/getattachment/feb8d3d3-042c-4a7b-a828-3b5bda8283a9/Achieving-Kindergarten-Readiness-for-All-Our-Child.aspx • **Share information gathered through collaborative meetings with providers at staff meetings.** Embed practice where information shared at collaborative meetings is brought back and discussed at organizations' staff meetings • **Use 211 to diffuse information** about new programs or opportunities to professionals. Ensure 211 is current and professionals are aware of this resource.
KEY INFORMATION NOT REACHING FAMILIES	

Engage natural touch points in sharing information with families	• **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 early learning, 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/
	  ○ Have pediatricians ask every family about their needs and share information about available services to meet those needs
	• **Include information for residents into regular mailings.** Talk with local businesses or organizations to embed key information about available services or

Address CONNECTIONS misalignments Relationships and exchanges between and across different actors and organizations	
	targeted changes into regular communications such as gas bills, school report cards, and newsletters • **Leverage social media to share information with residents.** One school set up a twitter account to announce upcoming school events and news. Utilize Facebook group pages or other social networking sites residents frequent.
Create new processes to support effective communication with families	• **Use mass text communication** to help providers communicate with residents in nontraditional ways. ○ Parent Contact Database is a parent database in which 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, providers can send out daily personalized texts asking how the client is doing or providing helpful tips or encouragement. Parents can respond back and the database tracks all conversations for quick reference. You can learn more in this Strategic Communications Brief from the W.K. Kellogg Foundation: https://www.wkkf.org/resource-directory/resource/2006/01/template-for-strategic-communications-plan. • **Engage cross-sector providers and community stakeholders in sharing information during natural touches with residents.** For example, stakeholders like pediatricians, clergy, hair salon stylists, grocery store check-out lines, and bank tellers can be great partners for sharing information. • **Embed practice of including information for residents into regular mailings.** Talk with local businesses or organizations to embed key information about available services or targeted changes into regular communications such as gas bills, school report cards, and newsletters • **Use 211 to diffuse information** about new programs or opportunities to residents. Ensure 211 is current and residents are aware of this resource. • **Adopt new outreach practices** of sharing information in natural traffic areas for residents, using social media, or using mass text communication to reach residents in non-traditional ways. • **Facilitate resident networking.** Support opportunities for residents to gather together in local settings to share experiences, information, and build a social support network

Address CONNECTIONS misalignments Relationships and exchanges between and across different actors and organizations	
INEFFECTIVE COMMUNICATION BETWEEN PROVIDERS AND FAMILIES	
Adopt policies and practices to support effective communication with families	• **Embed practice of keeping a record of 3 dependable contacts to prevent losing touch with residents.** Ask residents for three contacts who will always know how to reach them despite moves and phone number changes. List these contacts on a card within the resident's file and update regularly. • **Provide example questions and processes** 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 getting their children ready for school. Cards can be created in categories or 'suits' that help families and providers organize their thoughts. On the back of the cards, write specific topics within categories to explore together, like "I want to be able to support my child with homework." Make blank cards in the deck so families can write in their own unique conversation topics. Families and professionals can use these cards to guide their conversation about overcoming these barriers and engaging in supportive change behaviors. • **Allocate enough time for providers to build relationships with residents** during service visits

Address REGULATIONS misalignments

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

Critical Alignment Questions

- What current **policies, practices and procedures** might get in the way of people's **capability** or **opportunity** to use the strategies?
- What policies, practices or procedures are not in place but **are still needed** to support the strategies?

LOCAL, REGIONAL, AND STATE POLICIES AND PROCEDURES NOT ALIGNED WITH CHANGE GOALS	
Engage stakeholders in positions of power in shifting policies	• **Engage directors, executives, funders, and other relevant decision-makers in shifting policies** within their scope of work to align with change goals • **Engage managers and supervisors in shifting daily procedures** to align with change goals
Advocate for compliance with and expansion of regulations that support community needs	**Work around HIPAA and FERPA policy barriers by creating a shared consent form** to give families the opportunity to give consent to information sharing across organizations. **Advocate for policies aligned with targeted changes** with stakeholders in positions of power and decision-making. Consider how your efforts can advocate for needed policy changes, for example through gathering and sharing critical local information about how the regulation is contributing to current problems, and providing ongoing feedback and recommendations. o The National Partnership for Women and Families supports local campaigns to expand the Family and Medical Leave Act and other policies to cover more working people and more family needs (e.g., paid leave benefits). http://www.nationalpartnership.org/issues/ • **Support grass-roots, parent-driven advocacy campaigns** to approach local, state, or federal officials with information about needed shifts in community planning, budgeting, and infrastructure. o 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/

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

Use change goals as framework for designing new policies	• **Use a "Health in All Policies" approach** where considerations related to addressing targeted changes (e.g., social determinants of health) are embedded into cross-sector policies and decision-making processes.
	  ○ In Los Angeles, the city planning department considered how to promote health 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
	  ○ In Nashville, TN, the Metro Public Health Department worked to institutionalize their commitment to health equity. Agency leadership codified this commitment by making it a policy to incorporate health equity as a decision filter in all policy, programmatic, and practice activities. http://www.healthynashville.org/index.php

NEW PRACTICES NOT IMPLEMENTED EFFECTIVELY OR CONSISTENTLY	
Embed new practices into existing protocols and processes	• **Embed strategies 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, toolkits, • **Embed reminders or prompts for new practices:** develop and embed reminders to help providers remember to use new practices
Promote new expectations and accountability	• **Track implementation consistency.** Use a tracking system to understand how and when the new practice is being used. Reward improvements in consistency over time. Tracking can be internal as well as shared with other organizations to promote consistency between providers. • **Shift staff roles and job descriptions** to support the strategies and new practices • **Build residents' capacity to encourage accountability:** prepare residents to ask questions with relevant stakeholders about the use of new practices during service visits or during meetings. • **Add new practices into annual staff review evaluation criteria** to set new expectations and promote accountability.

Address REGULATIONS misalignments Policies, practices, procedures, and daily routines that shape the behavior patterns of individuals, groups, and organizations	
Provide continuing support and training	• **Provide coaching support** to trouble-shoot implementation barriers and help stakeholders effectively carry out strategies. • **Reinforce new practices during annual training and orientations:** Add new practices into annual training and orientations (e.g., for staff, collaborative members, councils, etc.), and embed within CEU training. • **Support champions in encouraging new practices,** including leadership, staff, and resident champions. • **Encourage peer to peer support** for example through communities or practice or staff reflection groups.

Address RESOURCES misalignments Human, financial, community, and social resources that are used within the system	
Critical Alignment Questions • Do leaders, program staff, families, youth, and other relevant community members have the **skills and knowledge** they need to successfully carry out or support these strategies? • Do organizations have **adequate staff** and **financial resources** to carry out these strategies? • Do organizations have needed **technology** to carry out these strategies? • Are needed **community resources** in place to support the strategies?	
STAKEHOLDERS LACK KNOWLEDGE AND SKILLS TO SUPPORT OVERALL CHANGE PROCESS	
Embed capacity-building	• **Embed resident leadership training** into current settings engaging families to build their capacity to advocate for their families and their community. ○ Several parent leadership training institutes have developed to train parents in advocacy for their children, including the prominent National Parent Leadership Institute (http://www.nationalpli.org/) which is currently in 11 states and has a parent-designed, implemented, and evaluated curriculum. For more resources on parent engagement and leadership, visit this page for

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

	a more extensive list: https://www.childwelfare.gov/topics/preventing/developing/parent-engagement-and-leadership/.
	• **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 changes. 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 at the Yale School of Medicine collaborated to create the Basic Needs-Informed Curriculum, designed to train providers to think through how poverty-related issues like gaps in basic needs can affect wellness. The Basic Needs-Informed curriculum helps providers address poverty-related issues as part of improving their service delivery and identifying resource issues that are linked to behaviors. Social workers, doctors, nurses, teachers, and mental health professionals are encouraged to participate together. More information is available at http://nationaldiaperbanknetwork.org/about-ndbn/bnic/.
	  ○ **"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.

LIMITED STAFF OR PARTNERS TO SUPPORT AND CARRY OUT STRATEGIES	
Engage local stakeholders to help carry out change efforts	• **Engage new stakeholders to support efforts** by expanding focus of the effort to include problems targeted by key partners and accommodate additional key cross-sector goals.

Address RESOURCES misalignments Human, financial, community, and social resources that are used within the system	
	○ For example, an effort focused on promoting health 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 outcomes relevant to these sectors in its shared vision. • **Put new targeted changes 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.
Engage local stakeholders to help deliver services	• **Hire or engage local residents to help deliver services.** For example, train parents to co-facilitate early childhood programming with professionals. Align this process with residents' preferences for staff that share their 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 (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) • **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 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.

Address RESOURCES misalignments Human, financial, community, and social resources that are used within the system	
	○ For example, faced with a shortage of medical providers in a rural community, a healthcare organization created a role for a patient's friend or relative, in which this person is paid to attend appointments and help out at home to ensure the patient takes his or her medications. Other communities have engaged informal supports provide early childhood programming.
COMMUNITY RESOURCES NOT IN PLACE TO SUPPORT CHANGE GOALS	
Leverage existing community resources	• **Repurpose vacant buildings, spaces, or lots** into usable resources to promote the targeted changes and/or support needed program. For example, transform vacant buildings into service hubs (see service hub examples above). ○ 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. • **Co-locate multiple cross-sector providers or services in same space.** 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. • **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 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.

Address RESOURCES misalignments Human, financial, community, and social resources that are used within the system	
	○ 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. http://time.com/money/3913386/food-waste-feed-hungry/
Advocate for needed resources	• **Advocate for needed community resources** such as transportation, affordable housing, etc. Gather data from residents on local needs, and share the information with local decision-makers and authorities to advocate for needed changes.
UPDATED INFORMATION AND DATA NOT ACCESSIBLE	
Create new pathways to share available data	• **Connect with community partners who have access to data** on local conditions in order to bring this data into relevant 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. • **Embed processes to ensure 211 remains updated.** For example, create automated update reminders and incentives for organizations to update their information regularly.
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 changes ○ 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. ○ In Michigan, the Early Childhood Investment Corporation (ECIC) uses public and private dollars to promote early childhood infrastructure development

Address RESOURCES misalignments Human, financial, community, and social resources that are used within the system	
	at the local level, and then coordinates the resulting efforts statewide. To help communities provide universal, high-quality early childhood experiences, ECIC offers grants to build community-based capacity and launch local decision-making entities called Great Start collaboratives.
Leverage or Re-allocate Existing Funding	• **Re-appropriate funds** to support targeted changes • **Braid funding across efforts** to create larger collective pots of funding to support cross-sector goals related to targeted changes. ○ 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)

Address POWER misalignments How decisions are made and who participates, whose voice matters, and the structures to support inclusion	
Critical Alignment Questions • How do the strategies **challenge the existing power** and decision-making structures? • What **new decision-making structures** will need to be developed to support the strategies? Who else will need to be included in decision-making that is currently excluded? What else within the system will need to be altered to support this new structure?	
DIVERSE PERPSECTIVES NOT AUTHENTICALLY ENGAGED IN DECISION-MAKING	
Engage residents and community	• **Engage residents as design partners within organizational decision-making processes** to develop services and supports to ensure local components meet local needs and aspirations.

Address POWER misalignments How decisions are made and who participates, whose voice matters, and the structures to support inclusion	
members in decision-making processes	○ Create a resident advisory board to give input and feedback on local 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 • **Create multiple action teams** to engage residents, community members, and other system stakeholders in learning, decision-making, and action ○ For example, one community in MI created four action teams to pursue their targeted changes around supporting youth with social-emotional (SE) needs. A separate team was set up for leaders of key organizations involved in addressing the needs of youth with SE needs (Community Mental Health, Department of Human Services, School District, Juvenile Justice/Police Department, etc.), front-line providers of these organizations, family members whose children were engaged with these organizations, and youth age 14-17 who were experiencing SE needs and engaged with these organizations. The teams all independently pursued action around the same set of targeted changes using a shared agenda and action learning process. • **Utilize community-driven philanthropy.** Engage community members in selecting which change efforts are most important to pursue in their community. ○ Detroit SOUP is a project that allows community members to fund highly-localized community projects by spending $5 on a shared dinner of soup, salad, bread, and pie, and then voting on which project they believe best helps their community. A pool of artists and activists present project proposals to the diners, who then vote on which group should receive the money that has been raised that evening. • **Use Photovoice to gather resident perspectives** on local conditions and potential strategies related to the targeted changes 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.

Address POWER misalignments How decisions are made and who participates, whose voice matters, and the structures to support inclusion	

	• **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.
	• **Assess and build stakeholders capacity to powerfully engage.** 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 diverse residents in decision-making processes, including how to use resident feedback. Assess if these capacities are needed in relation to your targeted changes.

Engage front-line staff in decision-making	• **Help organizations create internal opportunities for staff provide input and engage in decision-making.** For example, setting aside time during staff meetings or during annual review processes for staff to identify emerging issues related to targeted changes and design strategies to address them. • **Develop community-wide action teams** that engage front-line staff from organizations relevant to the targeted problem in learning, decision-making, and action (see MI example above related to Engaging Families and Community Members, and ABLe Change Action Learning resources)
Engage parents as change agents	• **Create resident coalitions** where residents design and implement changes to promote targeted changes ○ In Michigan, local parent coalitions serve as key partners in the Great Start Network. Parents meet to determine collective priorities, set goals for each

Address POWER misalignments

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

	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 • **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/
Empower parents to ask critical questions to advocate for their family	• **Put up posters with advocacy tips** for residents in service provider offices reminding residents of questions to ask to help advocate for their health needs during service visits • Engage neighborhood leaders in going door to door to **distribute placemats or magnets with questions residents can ask to advocate for their needs** during service interactions.

Improve System Flows

CREATE NEW FLOWS

Critical Questions

- How and where does **information, data, materials, people, and resources** need to flow across the system in order to support your targeted changes?
- Are there pathways currently in place to support these flows? If not, what pathways are still needed?
- To what extent is the amount of flow appropriate to support the targeted changes? In what ways does this flow need to be increased or decreased?

Improve System Flows

- Are there any delays in flows that are getting in the way of targeted changes? How can we address the root causes of these delays?

Create new referral flows	• **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 residents to services. • **Engage local health care providers in prescribing residents to engage in free programs and supports promoting targeted changes** ○ 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 residents 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
Create new information flows	**Between professionals** • Create **cross-sector service teams** who collaborate around shared family cases (e.g., system of care approach; wrap around services). Develop **integrated information systems** that are accessible to multiple organizations based on residents' consent • **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 • **Connect community partners who have access to data** on local conditions in order to bring this data into relevant 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.

Improve System Flows	
	• **Create settings or processes for stakeholders to share evaluation data** to inform decision-making **<u>Between residents and professionals</u>** • **Engage community stakeholders in sharing information during every touch 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.** For example, have pediatricians ask every family about their needs and share information about available services to meet those needs • **Include information for residents into regular mailings.** Talk with local businesses or organizations to embed key information about available services or system habits into regular communications such as gas bills, school report cards, and newsletters • **Engage respected neighborhood leaders** in **conducting outreach to recruit residents** or spread important information to residents • **Use mass text communication** to help providers communicate with residents in nontraditional ways. ○ Parent Contact Database is a parent database in which 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, providers can send out daily personalized texts asking how the client is doing or providing helpful tips or encouragement. Parents can respond back and the database tracks all conversations for quick reference. You can learn more in this Strategic Communications Brief from the W.K. Kellogg Foundation: https://www.wkkf.org/resource-directory/resource/2006/01/template-for-strategic-communications-plan.
Create new resource flows	• **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 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**

Improve System Flows	
	○ The Illinois Facilities Fund is a community lender that provides low-interest loans and technical assistance to non-profits, including child care providers, 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. ○ In Michigan, the Early Childhood Investment Corporation (ECIC) uses public and private dollars to promote early childhood infrastructure development at the local level, and then coordinates the resulting efforts statewide. To help communities provide universal, high-quality early childhood experiences, ECIC offers grants to build community-based capacity and launch local decision-making entities called Great Start collaboratives. ● **Redirect surplus resources** to settings and stakeholders who need them. ○ Food for Free, Cambridge, MA, redistributes food from restaurants, college campuses, and supermarkets that otherwise would be thrown out. 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. http://time.com/money/3913386/food-waste-feed-hungry/
SHIFT THE AMOUNT OF FLOW	
Critical Questions ● Where is the amount of information, referrals, resources, or people flowing within and between settings either too little or too much to support your strategies? ● Why is this happening? ● What is limiting needed flows? ● What capacities are needed to handle overflows?	
Revive dormant flows	● **Use root cause analysis to understand why flows went dormant**, and design strategies to either overcome these barriers or create new pathways. Refer to the example approaches for addressing system misalignments within this guide.
Increase existing flow	● **Expand eligibility rules** so more residents can apply for services ● **Re-design outreach processes** so they reach and influence more residents

Improve System Flows	
	• **Build stakeholders capacity to increase the flow**, for example by making more effective referrals or more effectively sharing information • **Ensure delivery services, times, and locations are accessible to more residents.**
Reduce or address too much flow	• **Expand staff** to better handle high flow levels • **Identify additional settings to absorb flow** that is currently overwhelming a particular setting • **Prioritize** which types of residents to refer or which type of information to share
REDUCE DELAYS IN FLOW	
Critical Questions • Where are you seeing delays in how critical information, referrals, resources, or people are flowing within and between settings? • Why are these delays happening? ○ Are all of the protocols and procedures in place to facilitate the efficient flow of information, referrals, resources, or people? What else is needed to reduce potential delays?	
Create needed protocols and procedures	• **Create a shared consent form** to give residents the opportunity to give consent to information sharing across organizations given current policies such as HIPAA and FERPA. • **Develop shared intake forms** to promote coordinated referrals across organizations • **Embed coordinated assessment, early screenings, and referral processes** within multiple settings that touch residents. • **Put processes in place so evaluation data is rapidly shared with all relevant stakeholders** so it can be used for decision-making (versus coming in too late to make a difference) • **Help organizations develop protocols and procedures** describing how staff can support flows, for example how to make referrals and share information with other organizations.

Improve System Flows	

Eliminate or reduce the number of connection points	• **Reduce the number of intake steps** involved in the enrollment process
	• **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 residents to sign up for other types of supports or services
	• **Co-locate multiple cross-sector providers or services in same space.** 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.
	• **Create Service Hubs.** 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 residents 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 residents 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.
	  ○ 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,

Improve System Flows	
	and college campuses. https://www.sccgov.org/sites/sccphd/en-us/healthproviders/tobaccoprevention/Pages/default.aspx
Create shared information sources	• **Develop integrated information systems** where information is collected once and then made accessible to multiple organizations based on residents' consent. For example, these systems can include information from clients' intakes or on clients' progress. • **Create a common birth to five application** or common intake hub.
Create more direct pathways	• **Create direct communication pathways to share critical information with front-line service providers**. Information about new services or within a community is often shared with local leaders; the actual targets for this information are the direct providers within the organization who can use this information to expand their referral options for their residents. Sometimes, the information leaders receive must flow through several system layers (e.g., Director of Community Programs, Family Support Program Manager, Family Support Program Supervisor) before it reaches (IF it ever does) the actual service providers. System delays are natural by-products of such communication flows ○ **Engage leaders in sharing information with providers at staff meetings.** Embed practice where information about available services or community changes shared at collaborative meetings is brought back and discussed at organizations' staff meetings
CREATE NEW LEARNING FEEDBACK LOOPS	
Critical Questions • Who needs to learn about whether changes are working/taking place? What information do they need? • How do we ensure this information reaches these individuals (reduce delays, make more direct feedback loops, put new feedback loops in place)?	
Gather continuous feedback during current touch points	• **Gather feedback from staff by asking questions during staff meetings** • **Gather feedback from colleagues by asking questions during collaborative meetings** • **Gather ongoing input from residents by asking questions during direct service touches**, such as doctors' appointments, home visits, or program sessions.

Improve System Flows	
	○ **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 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.
Use technology to gather feedback	• **Use text messaging** to gather rapid feedback from residents on how a service or support is working • **Provide comment spaces on websites** for residents to provide feedback on their experiences within the service delivery system
REDUCE DELAYS IN LEARNING FEEDBACK	
Create needed protocols and procedures	• **Help organizations develop protocols and procedures** to help staff know how to rapidly share feedback from residents with people or departments who can use this information to improve current efforts. • **Embed practices for organizations to share relevant feedback** at monthly 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.
Redirect Feedback Loops	• **Help organizations develop protocols and procedures to help staff** know how to rapidly share feedback from residents with people or departments who can use this information to improve current efforts.