HVCoIIN 3.0

Home Visiting Collaborative
Improvement and Innovation Network

HEALTH EQUITY

Playbook

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For questions, please contact us at hvcoiin@edc.org

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Introduction

This document presents an evidence-based and actionable playbook to support Maternal, Infant, and Early Childhood Home Visiting (MIECHV) awardees and local implementing agencies (LIAs) in advancing health equity in home visiting. Guided by the Institute for Healthcare Improvement's Achieving Health Equity: A Guide for Health Care Organizations, the following Health Equity Key Driver Diagram (KDD) and Change Package offer improvement ideas to test in home visiting.

The playbook is grounded on the concept of *intersectionality*, which recognizes that health inequities are impacted by a complex interplay of interconnected factors. The KDD and Change Package are tools that can prepare programs to confront interpersonal, institutional, and systemic racism and oppression and help to empower home visitors and caregivers to be leaders of system transformation.

The following definition of *health equity* serves as the foundation for the playbook. It was developed in collaboration with Health Equity CoIIN teams and faculty and is based on the definitions of health equity provided by Healthy People 2030 and the Robert Wood Johnson Foundation.

Definition of *Health Equity for Home Visiting*

All families served by MIECHV programs have fair and just opportunities to achieve the highest level of health and well-being. This requires that MIECHV advances and sustains family-informed practices, policies, and resources that value all home visiting participants and staff equally, and engages in focused and ongoing programmatic and societal efforts that address historical and contemporary injustices. Health equity demands that MIECHV programs remove obstacles to health—such as poverty, discrimination, and the consequences of both, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, transportation, safe environments, and health care—with the goal of eliminating inequities in the key family outcomes that home visiting aims to improve.

About This Document

The Health Equity CoIIN Playbook is made up of three critical documents. Each piece is described below.

Key Driver Diagram

The Key Driver Diagram displays a shared theory of how outcomes might improve based on information gathered from research, observation, and experience, and sets forth the collaborative's goal. The KDD presents five primary drivers that need to be in place to advance health equity. Under each primary driver is a series of secondary drivers that describe key areas of focus that will impact the primary driver. The KDD is aligned with a systems level approach that demands actions across all socio-ecological levels in order to affect meaningful change and improvements in home visiting. To learn more, visit the Health Equity Toolkit.

The Change Package

The Change Package offers strategies for your team to advance health equity in the form of change ideas (i.e., how to put primary and secondary drivers in place) and offers links to resources to support these interventions. The Change Package lays out change ideas to help home visiting programs advance health equity up to their highest levels of influence (home visiting staff, program, organization or agency, and the local community). To acknowledge the key role MIECHV awardees play in systems transformation at both the state and local levels, the Change Package also includes suggestions on how awardees can support LIAs in their efforts to achieve health equity. To learn more, visit the Health Equity Toolkit.

The Measurement System

The Measurement System Cheat Sheet lists the shared aims and set of common measures that teams will report during the collaborative. Data will be shared on run charts and tables and shared with all participants to promote shared learning.

Key Driver Diagram

Goal	Primary Driver (PD) *Critical system elements that are necessary and sufficient to achieve the goal*	Secondary Driver (SD) *Elements that will result in change in the associated primary driver*
Build MIECHV capacity to advance and sustain health equity with and for families[1] served by home visiting as demonstrated by: • Improvement in Health Equity Self-Assessment scores • Improvement in Families on Respect Index scores for one identified subgroup experiencing inequities • Reducing inequity in an identified home visiting outcome	PD1: Will and capacity to advance health equity	Ongoing professional and personal development and transformation regarding race, racism, bias, and equity
		Understanding and acknowledgment of historical and ongoing context for racism and other forms of oppression that exist within the community
		Will, commitment, and accountability to prioritize improving health equity with families at all levels of the home visiting program
	PD2: Antiracist[2] infrastructure	Data planning, collection, and analysis that centers health equity
		Staff recruitment and retention that advance workforce equity, diversity, and inclusion
		Policies and practices that explicitly challenge interpersonal, institutional, and systemic racism
		Policies, program implementation, and resource allocation that share power with families as leaders and decision-makers at all levels of the home visiting system
	PD3: Continuous quality improvement that explicitly promotes health equity	Improvement priorities driven by inequities that are meaningful to the families disproportionately affected by health inequities
		Changes tested are tailored to recognize the strengths and meet the needs of families disproportionately affected by health inequities (center in the margins[3])
		Expertise of families disproportionately affected by health inequities is centered, valued, and paid for in the co-design, implementation, and sustainability of solutions
	PD4: Antiracist service delivery	Identify and address disrespectful care and its impact on health outcomes in communications with families
		Outreach and recruitment that engages the families disproportionally impacted by health inequities
		Communication and resources that are responsive to diverse cultural beliefs and practices, preferred languages, health literacy, and other communication needs
		Culturally appropriate and linguistically responsive home visiting services and coordination that address the multiple determinants of health
	PD5: Community relationships and linkages that center families' strengths and needs	Community trust for the home visiting program
		Community collaboration that responds to the diversity of families' strengths and needs and addresses the structural and social determinants of health

[1] *Families* refers to those with lived experience as customers of home visiting. Family leaders may be parents as well as grandparents, guardians, and foster parents—anyone who is in a parenting role and has experience with and knowledge about using home visiting resources or services to strengthen their family. Family leaders should be representative of the culture, race, ethnicity, and/or gender identity of the families the program aims to serve.

[2] The term *antiracist* refers to the active process of identifying and challenging racism by changing systems, organizational structures, policies and practices, and attitudes in order to redistribute power and resources in an equitable manner.

[3] *Center in the margins* means to shift the starting point from a majority group's perspective (i.e., the usual approach) to that of a marginalized group or groups.

Change Package

PD1. Will and capacity to advance health equity

Secondary Driver	Change Ideas (for LIAs)	Potential Support from Awardees	Resources and Examples from the Field
Ongoing professional and personal development and transformation regarding race, racism, bias, and equity	1. Provide culturally and linguistically responsive professional development for staff to build their capacity to advance health equity, starting at orientation and at least quarterly thereafter. Training should include topics of cultural responsiveness and cultural humility, the history of racism, social and structural determinants of health, microaggressions, implicit bias, bias mitigation, power, privilege, and antiracist approaches related to program implementation. 2. Offer ongoing training and practice to identify and name racism, systemic oppression, and its various manifestations in conversations with families. 3. Offer formal and informal opportunities (e.g., reflective supervision, team meetings, trainings, book clubs, lunchtime table talks, lending libraries) for staff to explore, discuss, practice, and reflect on equity-related content and engage in safe and authentic conversations and activities to explore attitudes, beliefs, and values related to health equity and how racism and other forms of oppression impact their work, their lives, and the lives of the families served.	1. Identify and offer resources that build LIAs' capacity to advance health equity (e.g., training on implicit bias). 2. Work collaboratively with LIAs and model developers to set standards regarding equity training and expected workforce attendance, including initial vs. refresher training.	**Resources** • Health Equity Guide: Strategic Practice #2: Build Organizational Capacity • Beyond "Colorblind": Expert Says Awareness, Empathy Are Keys to a More Just Society, Georgetown University • University of Wisconsin-Madison: Health Equity Training Modules Examples from the field: 1. Hillsborough and Pinellas County, Florida
Understanding and acknowledgment of historical and ongoing context for racism and other forms of oppression that exist within the community	1. Learn the history of racism and oppression in both the U.S. and the community where the home visiting program is located (e.g., history of housing policy and segregation, differences in public education opportunities, policing, child welfare, immigration health inequities within the community based on zip code), along with the health inequities families are experiencing. 2. Assess your agency's historical role in perpetuating systems of racism and oppression (in policies, structures, and service delivery) and the impact of these systems on the community, and work to develop restorative strategies. 3. Use the agency's mission, vision, and values statements to communicate and support understanding of the structural and system-based inequities that contribute to adverse maternal and child health outcomes.	1. Support LIAs by sharing the agency's own history of perpetuating systems of oppression and how it now aims to dismantle these systems. 2. Provide contextual information (including the inception of MIECHV in the state) regarding how inequities are being addressed.	**Resources** • The National Collaborative for Health Equity, Community Strategies to End Racism and Support Racial Healing: The Place Matters Approach to Promoting Racial Equity • Association of American Medical Colleges: Racism and Health – A Reading List Examples from the field: 1. Saginaw County, Michigan: Developing a Community History
Will, commitment, and accountability to prioritize improving	1. Broadly share visual and experiential data (e.g., mapping, storytelling) demonstrating the root causes of inequities experienced by families in home visiting.	1. Create a clear public statement demonstrating a commitment to addressing health equity.	**Resources** • Annie E. Casey Foundation: Institutionalizing Management

Secondary Driver	Change Ideas (for LIAs)	Potential Support from Awardees	Resources and Examples from the Field
health equity with families at all levels of the home visiting program	2. Engage staff at all levels of the home visiting program in assessing readiness and developing a strategic plan to explicitly address health equity. 3. Ensure that the home visiting program's mission, vision, and values statements communicate the priority of advancing health equity and clarify the program's role in addressing health equity. 4. Establish shared equity language and definitions to ensure common understanding and use of terms. 5. Explicitly articulate health equity-specific goals at organizational, program, department, and individual levels. 6. Establish an infrastructure for health equity work, and strategically direct fiscal and human resources to support efforts to oversee and manage this work (e.g., workgroups, staff positions, a Governance Committee). 7. Program leadership and decision-makers regularly communicate about and advocate for the importance of health equity as a strategic priority and stand up for and speak out about racism and other forms of oppression.	2. Align Health Equity CoIIN efforts with ongoing statewide initiatives. 3. Participate as an active member of the LIA's HV CoIIN Health Equity improvement team. 4. Develop a health equity template communication plan with guidance for LIAs that includes the following: ○ Identified common language ○ Tools for using data to depict inequities within the context of historical and current systems of oppression ○ The home visiting program's role in addressing health equity ○ Opportunities to prioritize the values held by communities who are experiencing inequities 5. Declare racism a public health crisis and clarify how racism has contributed to the health inequities observed across communities. 6. Explicitly articulate health equity as an objective within LIA contracts, work plans, and scopes of work and in key strategy documents (e.g., CQI, evaluations, performance measurement plan).	Accountability for Equity, Diversity, and Inclusion • Race Forward & Center for Social Inclusion: Ready for Equity in Workforce Development – Racial Equity Assessment Tool • Coalition of Communities of Color: Tool for Organizational Self-Assessment Related to Racial Equity • Annie E. Casey Foundation: Race Equity and Inclusion Action Guide (Steps 1, 4, & and 5) • Center for the Study of Social Policy: Key Equity Terms and Concepts – A Glossary for Shared Understanding Examples from the field: 1. Saginaw County, Michigan: Centering a Group's Mission, Vision, and Values in Health Equity

PD2. Antiracist infrastructure

Secondary Driver	Change Ideas (for LIAs)	Support from Awardees	Resources and Examples from the Field
Data planning, collection, and analysis that centers health equity	1. Define goals for data collection and develop dissemination plans that promote transparency and family partnership. 2. Implement a standard process and training for accurate collection and entry of race, ethnicity, and language (R/E/L) data for the workforce and all home visiting participants, including ensuring that participants understand why and how R/E/L data are being collected and used (e.g., *We Ask Because*	1. Provide LIAs with on-demand access to workforce and client data stratified by REAL factors. 2. Include dedicated staff time and resources to analyze quantitative and qualitative data to identify potential inequities and foster	**Resources** • Vanderbilt University: How to Ask About Sexuality/Gender • Local and Regional Government Alliance on Race & Equity: Racial Equity Toolkit- An Opportunity to Operationalize Equity

Secondary Driver	Change Ideas (for LIAs)	Support from Awardees	Resources and Examples from the Field
	We Care initiatives). Data collection can and should extend to other dimensions of diversity, such as gender and sexual identity. 3. Disaggregate data to identify potential inequities between groups, and track progress in reducing inequities. 4. Frame program data in the context of historical and current policies and systems of oppression and community-level structural factors, using both qualitative (e.g., conversations with parents impacted by the inequity) and quantitative (e.g., Life Course Metrics, Child Opportunity Index, Index of Concentrations at the Extremes) methods that promote transparency.	the desire of community members to participate in this analysis. 3. Build and/or strengthen relationships with agencies and programs that have established systems to collect and use disaggregated data, such as Title V and Medicaid. 4. Strategically disseminate data results to further engage leadership, staff, and the community.	• PolicyLink & EcoTrust: Powering Health Equity Action with Online Data Tools -10 Design Principles. • Mass.gov, Office of Health Equity: Racial Inequity Data Roadmap • Center for the Study of Social Policy: A Guide to Anti-Racist Data Collection for – System Leaders and Data Administrators Examples from the Field: 1. Pinellas County, Florida: Data Collection 2. HV CoIIN Team: Data Planning, Collection, and Analysis
Staff recruitment and retention that advances workforce equity, diversity, and inclusion	1. Create staff recruitment and outreach action plans to reach diverse community members (e.g., reach out to former program participants, partner with local community and four-year colleges and universities to introduce the home visiting field to students). 2. Develop clear and accurate job descriptions that include home visiting competencies staff must bring to the job. 3. Reduce barriers to job entry (e.g., accept equivalent or lived experience for educational attainment; disclose the salary range; do not ask for salary history; remove names, addresses, and schools from resumes). 4. Establish a hiring process (e.g., job description responsibilities, interview questions, screening and selection criteria, diverse interview panels) that screens candidates for their sensitivity to and understanding of the root causes of health inequities and their willingness to reflect on their own culture and listening skills. 5. Honor and value bi- or multilingual skills and diversity in staff backgrounds, experiences, and perspectives. 6. Define employees' career pathways, and offer mentoring, professional development, and leadership programs to support employees in advancing along this path. 7. Offer employee resources groups and/or racial affinity groups to provide spaces for people who share a racial identity to gather, share experiences, and explore how racism may manifest in their organization. 8. Create programs, measures, and systems of accountability to monitor institutional climate and ensure that staff from diverse backgrounds feel like they belong and have the opportunity to thrive.	1. Leverage relationships with education partners (e.g., high school programs, community and four-year colleges and universities) and community jobs programs to support recruitment of qualified candidates. 2. Share existing best practices for recruitment and retention identified and implemented in programmatic reports and evaluations.	**Resources** • Healthcare Anchor Network: Inclusive, Local Hiring Toolkit • City of Madison, WI: Equitable Hiring Tool • HRSA: Infusing Cultural and Linguistic Competence into the Recruitment and Retention of Home Visitors • Pacific Southwest Mental Health Technology Transfer Center Network Resources: ○ Assessing Workforce Diversity: A Tool for Mental Health Organizations on the Path to Health Equity ○ Strategies for Advancing Diversity, Inclusion, and Equity in the Pacific Southwest's Mental Health Workforce ○ Building a Diverse Workforce from the Ground Up Webinar

Secondary Driver	Change Ideas (for LIAs)	Support from Awardees	Resources and Examples from the Field
Policies and practices that explicitly challenge interpersonal, institutional, and systemic racism	1. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints. 2. Use a racial equity impact assessment to analyze current and proposed policies, programs, activities, and norms to assess their potential inequitable impact on families and communities disproportionally impacted by health inequities and implement mitigation strategies to address any negative impacts identified. 3. Revise administrative processes, including MOAs, contracts, RFPs, and supplemental fund development, to close health equity gaps (e.g., contract with women-owned, minority-owned, or veteran-owned businesses; build community engagement into contracts, work plans, and scopes of work from the beginning of a project). 4. Conduct an internal audit to assess and respond to pay inequities. 5. Offer equitable benefits, such as affordable employee and family health insurance with no wait period, paid parental leave of at least 12 weeks, and paid time off. 6. Pay all home visiting staff a living wage.	1. Amend contracts to facilitate the promotion of health equity at the LIA level (e.g., change requirements of their grantees, provide funding for the expansion of staff, distribute funding opportunities among non-traditional partners). 2. Ensure that report reviewers are trained to apply a racial equity lens through the review process and to use data on persisting inequities to inform program supports. 3. Support the development of systems to pay higher living wages for home visitors.	**Resources** • Health Equity Guide: Strategic Practice #3 - Changing Internal Practices and Processes • Race Matters: Institute Racial Equity Impact Analysis • Racial Equity Here/ACT: A Racial Equality Tool Examples from the Field: 1. Pinellas County, Florida: Hiring
Policies, program implementation, and resource allocation that share power with families as leaders and decision-makers at all levels of the home visiting system[4]	1. Provide families with opportunities and support to partner and influence decisions at every level and in diverse ways: as their child's first teacher and best advocate, in program development and delivery, and in agency-wide culture, operations, leadership, policies, and funding. 2. Include representatives of the culture, race, and/or ethnicity and gender identity of the families the program aims to serve on boards, committees, and other decision-making bodies include family representation and that families at decision-making tables are. 3. Be transparent about how decisions get made, make information accessible, and report back to families how their feedback impacted decisions and priorities.	1. Amend or create policies and practices in formal structural documents that support parents' leadership, power, and decision-making. 2. Provide training for parent leaders to build their personal and professional capacity (e.g., facilitation training, CQI competency training, and equity training).	• **Resources** • Center for the Study of Social Policy: Manifesto for Race Equity & Parent Leadership in Early Childhood Systems • Home Visiting Collaborative Improvement and Innovation Network 2.0: Toolkit to Build Parent Leadership in Continuous Quality Improvement, HV CoIIN 2.0

[4] Changes in this driver are taken from the Center for the Study of Social Policy's *Manifesto for Race Equity & Parent Leadership in Early Childhood Systems*, *Parent Engagement and Leadership Assessment Guide and Toolkit*, and the EC-LINC Outcomes and Metrics Initiative.

Secondary Driver	Change Ideas (for LIAs)	Support from Awardees	Resources and Examples from the Field
	4. Allocate robust resources to center family leadership, including payment for families' full participation and expertise, ongoing leadership development, and hiring parents for key roles. 5. Provide staff training and opportunities to build relationships with and authentically engage families as leaders. 6. Provide family leaders with opportunities for ongoing learning and skill building, such as coaching, role-play and skills practice, and peer-to-peer connections. 7. Ensure that the agency's mission and goals include partnering with families, developing their leadership, and supporting them in building and sustaining their power to change systems.	3. Support the development of LIAs paying for parent leadership participation and reflect this in contracts.	• National Center for Families Learning: Equity in Family Engagement Toolkit Examples from the Field: 1. Desoto and Hardee Counties, Florida: Health Equality & Health Equity

PD3. Continuous quality improvement that explicitly promotes equity in home visiting outcomes

Secondary Driver	Change Ideas (for LIAs)	Support from Awardees	Resources and Examples from the Field
Improvement priorities driven by inequities that are meaningful to the families disproportionately affected by health inequities	1. Use stratified workforce, home visiting, and community data along with qualitative data to identify inequities where home visiting can have a direct impact and to prioritize CQI topics. 2. Develop and use SMARTIE (Specific, Measurable, Attainable, Realistic, Time-bound, Inclusive, and Equitable) aims that address major gaps and identifies populations who are disproportionately affected by health inequities.	1. Review state- and LIA-level data to support LIAs in identifying inequities. 2. Include SMARTIE aims to address inequities in CQI plans.	**Resources** • The Management Center: SMARTIE Goals Worksheet, The Management Center • Rural Health Information Hub: Using Data to Identify Priorities and Health Inequities
Changes tested are tailored to recognize the strengths and meet the needs of families disproportionately affected by health inequities (i.e., center in the margins)	1. When planning and testing change ideas, consider a common set of reflection questions to ensure that each change meets the needs and strengths of families disproportionately affected by health inequities, for example: ○ Are those most affected by the issue actively involved in defining the problem and shaping the solution? ○ How does this strategy improve the conditions for those communities most in need? ○ Will those most negatively affected by the problem benefit the same, less so, or more so?	Prioritize upstream policy changes to address root causes of inequities.	**Resources** • County Health Rankings and Roadmaps: Action Learning Guide – Understanding and Identifying the Root Causes of Inequities • *Advancing Health Equity Roadmap to Reduce Disparities:* ○ Step 3 Diagnosing the Disparity ○ Facilitators Guide

	○ What barriers or unintended consequences should be accounted for to make this strategy effective in underserved communities?[5] 2. Identify root causes of inequities experienced by home visiting families, and then work to address systemic barriers.		• CDC, Division of Community Health: Practitioner's Guide - Reflection Questions When Designing Strategies to Advance Health Equity Examples from the Field: 1. Miami-Dade County, Florida: Analyze root cause, including the social and structural drivers of health inequities
Expertise of families disproportionately affected by health inequities is centered, valued, and paid for in the co-design, implementation, and sustainability of solutions	1. Prepare and support home visiting families to be active members of CQI teams. 2. Engage community members and home visiting families in understanding, interpreting, and contextualizing observed inequities and data and in identifying and testing community solutions for eliminating inequities. 3. Establish compensation and decision-making procedures with parent leaders.	1. Use contractual language that allows LIAs to compensate parent leaders and engage them as partners in community work. 2. Dedicate staff to supporting parent engagement and leadership development.	**Resources** • Home Visiting Collaborative Improvement and Innovation Network 2.0: Toolkit to Build Parent Leadership in Continuous Quality Improvement, HV CoIIN 2.0 • Mass.gov: Community Engagement Guidelines for Community Health Planning • PHI Center for Wellness and Nutrition: Community Engagement Toolkit – A Participatory Action Approach Towards Health Equity and Justice

PD4. Antiracist service delivery

Secondary Drivers	Change Ideas (for LIAs)	Support from Awardees	Resources and Examples from the Field
Identify and address disrespectful care and its impact on health outcomes in communications with families	1. Listen to families to understand the impact of racism on their lives, decisions, and self-identified goals. 2. Acknowledge, validate, and support families experiencing racial trauma, including any harm that may have been done by the home visiting program. 3. Communicate that inequities are unjust and preventable, and articulate the importance of addressing the home visiting system's role in dismantling racism and other forms of oppression. 4. Normalize discussions about racism, oppression, and privilege by defining them and naming them as root causes of health inequities. 5. Establish a mechanism for partners, families, and staff to report inequitable care and episodes of miscommunication or disrespect within the home visiting program.	1. Support LIAs by providing tools for effective communication. 2. Ensure that LIAs inform relevant agencies, partners, and families of available grievance processes. 3. Offer to conduct exit interviews with families and staff or to review completed exit interviews (if given consent) in order to strengthen rapport between home visiting agencies and the communities served.	**Resources** • MIT Management, Sloan School: A 5-part framework for talking about racism at work • Mental Health America: Racial Trauma Examples from the Field: 1. Desoto and Hardee Counties, Florida

[5] From *A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease* (Centers for Disease Control and Prevention—Division of Community Health, 2013).

Secondary Drivers	Change Ideas (for LIAs)	Support from Awardees	Resources and Examples from the Field
	6. Ensure that supervisors regularly ask staff about feedback they have received from parents about equity issues, relay this feedback to agency leaders, and work to address identified issues.		
Outreach and recruitment that engages the families disproportionally impacted by health inequities	1. Determine the racially, ethnically, culturally, and linguistically diverse groups within your geographic locale; assess the degree to which these groups are accessing services and their level of satisfaction with the services received; and work to address any unmet needs. 2. Use recruitment and enrollment strategies designed to build rapport and successfully engage and empower families by acknowledging the community culture and their current situation (e.g., custody and immigration status). 3. Actively recruit families who are disproportionately affected by health inequities and who reflect the diversity of your community. 4. Ensure that program brochures and other media reflect all the cultural groups in the service area.	Use R/E/L factors to identify the populations of highest needs, as reflected in key reports.	**Resources** • Center for the Study of Social Policy: Manifesto for Race Equity & Parent Leadership in Early Childhood Systems • North Carolina Department of Health and Human Services: Historically Marginalized Populations Engagement Toolkit
Communication and resources that are responsive to diverse cultural beliefs and practices, preferred languages, health literacy, and other communication needs	1. Ensure that all online and printed materials (educational materials, screening tools, protocols, consent forms) are written in plain language, are culturally and linguistically responsive, and include images that reflect the diversity of families served. 2. Deliver home visits in the preferred language of the family when possible and provide interpretation services when home visitors who speak a family's language are not available. Ensure the competence of individuals providing language assistance. 3. Work with social or professional contacts (e.g., cultural brokers, liaisons) who can help home visitors better understand the health, mental health, and religious beliefs and practices of culturally diverse groups in the community. 4. Validate and empower parents (or family members serving in a parental role) as the ultimate decision-makers regarding services and support for their children.		**Resources** • Home Visiting Collaborative Improvement and Innovation Network 2.0: Toolkit to Build Parent Leadership in Continuous Quality Improvement, HV CoIIN 2.0 • CDC: Health Equity Guiding Principles for Inclusive Communication Examples from the Field: 1. Start Early Washington: Technology as a Tool for Empowering Parents and Driving Change
Culturally appropriate and linguistically responsive home visiting services and coordination that address the multiple determinants of health	1. Ask questions to learn about a family's cultural background and context. 2. Have programs and home visitors partner with families and the community to select and use materials and curricula that are tailored to the needs and strengths of families. 3. Offer a flexible service schedule. 4. Screen families for social determinants of health, and work collaboratively with families to select and access culturally and linguistically appropriate resources, supports, and services. 5. Ask during home visits if the family has experienced any challenges with accessing community services. Ensure that home visitors make it a priority to understand families' experiences and strive to mitigate barriers created by systemic, institutional, and individual racism.	Be proactive and strategic in identifying contractors to develop MOAs and contracts that provide equitable and appropriate services.	**Resources** • U.S. Department of Health and Human Services, Office of Minority Health: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care Examples from the Field: 1. Saginaw County, Michigan: Supporting staff in delivering antiracist family-centered service – A focus on culturally competent and mental health care

Secondary Drivers	Change Ideas (for LIAs)	Support from Awardees	Resources and Examples from the Field
			2. Hillsborough County, Florida 3. National Home Visiting Resource Center: Home Visiting for Refugee Families – Flourishing in New Places

PD5. Community relationships and linkages that center families' strengths and needs

Secondary Drivers	Change Ideas (for LIAs)	Support from Awardees	Resources and Examples from the Field
Community trust for the home visiting program	1. Participate in community events that provide opportunities to speak with and listen with humility to community members, learn about their experiences navigating the home visiting system and associated maternal and child health programs, and identify ideas for improvement. 2. Engage the community—including home visiting families, neighborhood associations, parent-led organizations, local business owners, faith-based organizations, and organizations devoted to economic development—in a community steering committee to help shape the service climate for home visiting. 3. Offer paid time off for volunteering in the community, attending community events, and supporting advocacy efforts led by parents.	Leverage state early childhood advisory council and family advocacy agencies to support LIAs in recruiting, engaging, and fostering the development of parent leaders.	**Resources** • EDC: Tips for ensuring a culturally competent collaboration • U.S. Department of Health and Human Services: The Importance of Relationships and Trust in Home Visiting Outreach and Recruitment
Community collaboration that responds to the diversity of families' needs and strengths and addresses the structural and social determinants of health	1. Identify potential service gaps (e.g., through systems maps) and resources within the community to address the needs of families. 2. Create a community-based service navigation system (e.g., Help Me Grow, 211 Child Development) that facilitates electronic referrals among medical and social service providers and improves follow-up. 3. Promote linkages between home visiting services and primary health care, including the medical home. 4. Participate in multi-sectoral (e.g., labor, transportation, education, corrections, economic development, housing, private and business sector, philanthropy, public safety) community-based coalitions to act on the complex factors that influence health equity in the community.	1. Support LIAs by sponsoring a centralized intake and referral systems for families, which may include county- or state-level programs (e.g., 211, Help Me Grow, medical homes). 2. Build relationships and foster active collaboration with federal, state, and nonprofit agencies (e.g., Early Childhood Comprehensive Systems, Title V, Medicaid, Healthy Start, Children and Youth with Special Healthcare Needs, Individuals with Disabilities Education Act, Parts B and C, Child Welfare, Head Start, School Readiness, Primary Care). 3. Support LIAs by convening or participating in multi-sectoral coalitions to support Health in All Policies. 4. Support LIAs by providing peer-to-peer learning opportunities to identify potential shared resources and address service gaps.	**Resources** • Actionable Intelligence for Social Policy: A Toolkit for Centering Racial Equity Throughout Data Integration, Toolkit Activity 2- Mapping Assets and Engaging Community • Build Healthy Places Network: Partnerships for Health Equity and Opportunity- A Healthcare Playbook for Community Developers, Four-Step Community Development Healthcare Partnership • CDC: Developing Partnerships and Coalitions to Advance Health Equity • National Home Visiting Resource Center: Strengthening Service Coordination Between Home Visitors and Pediatric Primary Care Providers • AMCHP: A Roadmap for Collaboration among Title V, Home Visiting, and Early Childhood Systems Programs

Secondary Drivers	Change Ideas (for LIAs)	Support from Awardees	Resources and Examples from the Field
		5. Consider which foundations and funding mechanisms across the state could help reduce gaps.	• Public Health Institute: Health in All Policies- A Guide for State and Local Governments • Vitalyst Health Foundation: Pre-Community Engagement—Setting the Stage for Authentic Community Engagement
			Examples from the Field: 1. Federal Hill House, Providence, Rhode Island: A Medical Home

Cheat Sheet: The Measurement System

SMART Aim:

Build MIECHV capacity to advance and sustain health equity with and for families[1] served by home visiting as demonstrated by:

- Improvement in Health Equity Self-Assessment scores
- Improvement in Families on Respect Index scores for one identified subgroup experiencing inequities
- Reducing inequity in an identified home visiting outcome

Data Collection Sources: Two quarterly surveys will be used to track progress towards the aim:

1. Health Equity Self-Assessment: HV CoIIN developed the Health Equity Assessment Tool to help home visiting programs assess their current health equity efforts, determine where to focus their work, and track their progress throughout the CoIIN. The assessment tool, aligned with the MIECHV Health Equity framework, will support your team in having conversations about where you are in addressing health equity in your system, current achievements, and where you want to go. Each quarter your team will receive a summary of your data including:
    a. **Primary Driver 1 Average:** Sum of PD1 secondary driver scores, divided by the number of secondary drivers for PD1
    b. **Primary Driver 2 Average**: Sum of PD2 secondary driver scores divided by the number of secondary drivers for PD2
    c. **Primary Driver 3 Average**: Sum of PD3 secondary driver scores divided by the number of secondary drivers for PD3
    d. **Primary Driver 4 Average:** Sum of PD4 secondary driver scores divided by the number of secondary drivers for PD4
    e. **Primary Driver 5 Average**: Sum of PD5 secondary driver scores divided by the number of secondary drivers for PD5
2. Families on Respect Index: The Families on Respect Index is a 16 item scale that assesses the nature of family-home visitor interactions and their impact on a person's sense of respect during home visiting. Instructions and resources for administering the Families on Respect Index will be reviewed during the first Learning Session. Each quarter teams will send this survey to all participating families. Each quarter your team will receive a summary of your data including:
    a. **Average total score**: Sum of total scores, divided by the total number of respondents
    b. **Average score Block A:** Sum of score for Block A questions, divided by total number respondents for Block A
    c. **Average score Block B**: Sum of score for Block B questions, divided by total number respondents for Block B
    d. **Average score Block C:** Sum of score for Block C questions, divided by total number respondents for Block C
    e. **Percent of respondents who score 67 or higher**: # of respondents with a total score of 67 or higher, divided by the total number of respondents.

In addition to these common sources of data collection, each team will identify data to support learning and improvement, specific to their driver of focus. Team planning and progress will be submitted through the Monthly Report.

Glossary of Health Equity Terms

Antiracist – An active process of identifying and challenging racism by changing systems, organizational structures, policies and practices, and attitudes in order to redistribute power and resources in an equitable manner.

Bias – Learned stereotypes and prejudices that operate *consciously* and *implicitly* when interacting with others. It is virtually impossible to live in contemporary U.S. society and not develop a bias of any sort.

Colorism – Prejudice or discrimination based on the color of one's skin; privileging those with lighter skin and more European features.

Cultural competence – The ability to understand and interact effectively with people from other cultures. Grounded in respect for and appreciation of cultural differences, cultural competence is demonstrated in the attitudes, behaviors, practices, and policies of people, organizations, and systems.

Cultural humility – A lifelong commitment to self-evaluation and self-critique. Cultural humility requires that we rectify the power imbalances in the peer-to-peer and home visitor-to-family dynamic and develop mutually beneficial and non-paternalistic partnerships that honor each community's beliefs, customs, and values.

Cultural intelligence – The capability to relate and work effectively in culturally diverse situations. It goes beyond existing notions of cultural sensitivity and awareness to highlight a theory-based set of capabilities needed to successfully and respectfully accomplish one's objectives in culturally diverse settings.

Culturally responsive – Going beyond cultural competence by having an awareness of one's own cultural identity and views about difference and being able to learn and build on families' and communities' varying cultural norms.

Culture – The languages, customs, beliefs, rules, arts, knowledge, and collective identities and memories developed by members of a particular social group.

Discrimination – Behavior that treats people unequally because of their group, class, or category, ranging from slights to hate crimes. Discriminatory behavior often begins with negative stereotypes and prejudices.

Diversity – The existence of variations of different characteristics in a group of people, such as cognitive skills; personality traits; racial, ethnic, socioeconomic, and cultural backgrounds; things that shape a person's identity (e.g., age, gender, religion, sexual orientation); lifestyles; experiences; and interests.

Ethnicity – Denotes groups that share a common identity-based ancestry, language, or culture. Ethnicity is often based on religion, beliefs, and customs, as well as memories of migration or colonization.

Health inequity – Differences in health status, mortality rates, or the distribution of health resources that are systemic, avoidable, and unjust. These differences are attributable to social, economic, and environmental conditions in which people live, work, and play.

Justice – The systematic fair treatment of people of all races that results in equitable opportunities and outcomes for everyone.

Implicit bias – A belief or attitude that affects our understanding, decision, and actions and that exists without our conscious awareness.

Inclusion – A state of belonging, when persons of different backgrounds and identities are valued, integrated, and welcomed equitably as decision-makers and collaborators. Inclusion involves people being given the opportunity to grow and to feel as if (or *know*) they belong. Diversity efforts alone do not create inclusive environments. Inclusion involves a sense of coming as you are and being accepted, rather than feeling the need to assimilate.

Intersectionality – The interconnected nature of social categorizations such as gender, race, and class that cannot be examined in isolation from one another, which creates overlapping and interdependent systems of discrimination and disadvantage.

Institutional (or systemic) racism – The practices that perpetuate racial disparities, uphold White supremacy, serve to the detriment and harm of persons of color, and keep them in negative cycles, as well as the policies that generate different outcomes for persons of different races. These laws, policies, and practices are not necessarily explicit in mentioning any racial group but work to create advantages for White persons and disadvantages for people of color.

Microaggressions – Everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely on their marginalized group memberships.

Oppression – Unjust use of power and authority for the advantage of dominant groups and the disadvantage of non-dominant groups.

Parent leader – An all-inclusive term for anyone who is in a parenting role (e.g., biological parents, grandparents, guardians, foster parents), has experience with and knowledge about using home visiting resources or services to strengthen their family, and can speak from a parent's perspective.

Power – The ability to define, set, or change situations. Power can manifest as personal or collective self-determination. Power can influence others to believe, behave, or adopt values as those in power desire.

Prejudice – A preconceived opinion or assumption about something or someone rooted in stereotypes, rather than reason or fact, leading to unfavorable bias or hostility toward another person or group of people.

Privilege – Advantages and immunities enjoyed by one (usually powerful) group or class, usually to the disadvantage of others.

Race – A socially constructed way of grouping people based on skin color and other perceived physical differences, which has *no genetic or scientific basis* but is often used to justify social and economic oppression. Race is not the same thing as *ethnicity* or *culture*.

Racism – A system of oppression based on race that uses institutional power and authority to support prejudices and enforce discriminatory behaviors in systemic ways.

Social determinants of health – Conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life risks and outcomes.

Structural racialization – The compounded impact of the systems (e.g., public policies, institutional practices, cultural representations, and other norms) that create and perpetuate disadvantage for a particular group on the basis of race. These disadvantages create barriers that deny access, resource, or participation. This allows us to recognize that people are situated differently inside existing structures.

Systems of oppression – The ways in which history, culture, ideology, public policies, institutional practices, and personal behaviors and beliefs interact to maintain a hierarchy—based on race, class, gender, sexuality, and/or other group identities—that allows the privileges associated with the dominant group and the disadvantages associated with the targeted group to endure and adapt over time

Trauma-informed – An approach based on knowledge of the impact of trauma, including racial trauma, aimed at ensuring that environments and services are welcoming and engaging for service recipients and staff.

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