

**HEALTH
EQUITY**
in **HOME
VISITING**

The HV CoIIN
Health Equity Toolkit



ACKNOWLEDGMENTS

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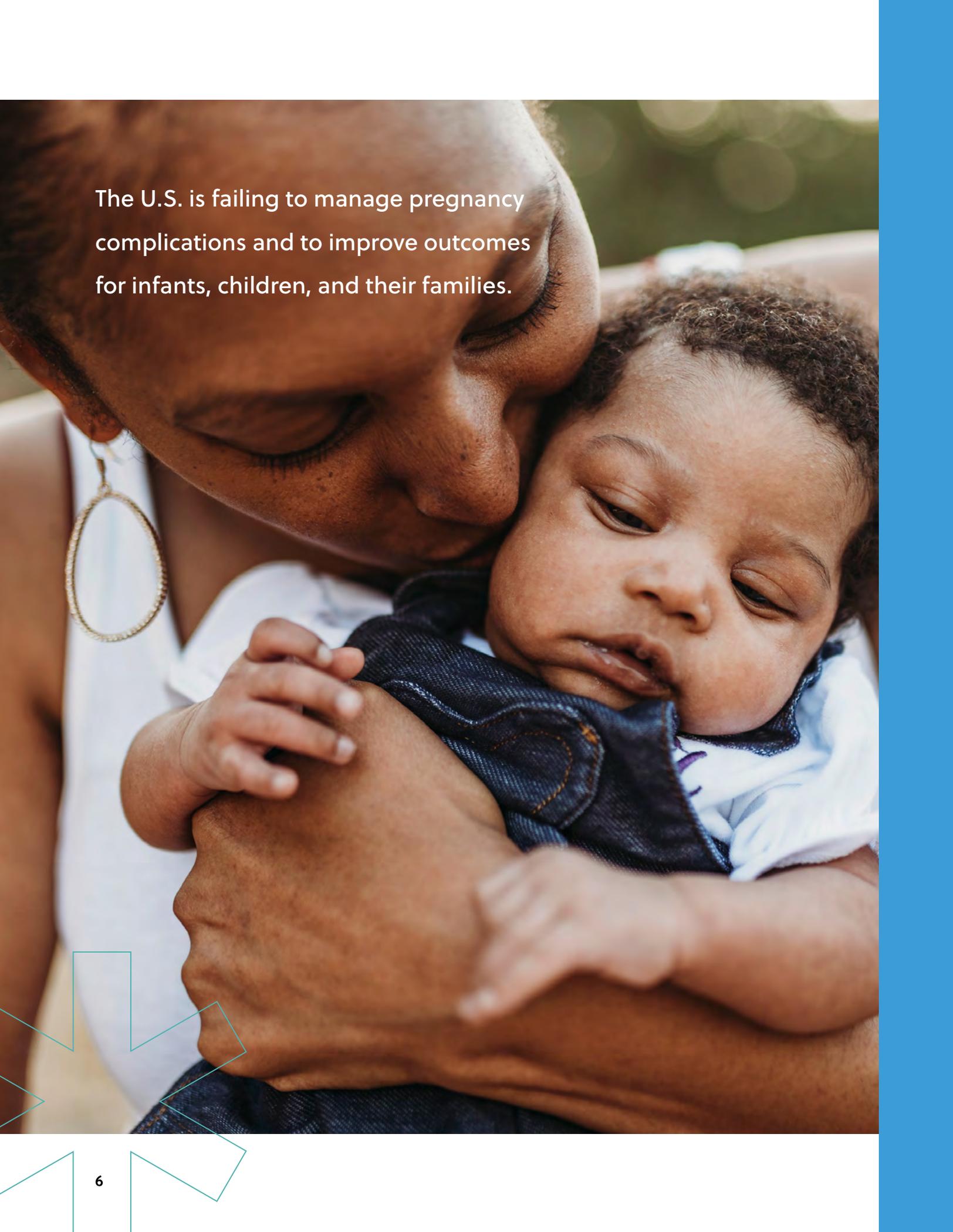
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The U.S. is failing to manage pregnancy complications and to improve outcomes for infants, children, and their families.

INTRODUCTION

Health equity means that all families served by Maternal Infant Early Childhood Home Visiting (MIECHV) programs have fair and just opportunities to achieve the highest level of health and well-being. (Braveman P et al., 2017; Health Equity in Healthy People 2030 - Healthy People 2030 | Health.Gov, n.d.) Yet, when compared to other high income countries, United States (U.S.) public health and health care systems consistently deliver the worst maternal, fetal and infant mortality rates and other priority outcomes, including prematurity, and linkage to high-quality community services. (*Addressing Maternal and Infant Health Inequities*, n.d.) Data further demonstrates that maternal, child, and family health outcomes and access to care are disproportionate across racial, ethnic, gender, socioeconomic, and geographic groups, which further accentuates the gravity of the issue. (“Eliminating Racial Disparities in Maternal and Infant Mortality,” n.d.; Malawa et al., 2021; Vilda et al., 2021)



Inequities call on us to redesign our systems by dismantling dominant narratives, policies, and practices that have historically excluded and oppressed groups of people across communities—and continue to do so.

These inequities call on us to redesign our systems by dismantling dominant narratives, policies, and practices that have historically excluded and oppressed groups of people across communities—and continue to do so. (“Eliminating Racial Disparities in Maternal and Infant Mortality,” n.d.; Malawa et al., 2021; Rachel Y. Moon, 2022; Vilda et al., 2021)

Such systems transformation requires breakthrough collaboration and change at all levels: individual, interpersonal, institutional, and environmental. Further, these system-level efforts must be grounded in history, centered in equity, and lead with the voice of families. Though home visiting cannot achieve health equity alone, as part of an early childhood system, it is uniquely positioned to diminish and eliminate health inequities faced by the families it serves. For example, studies show that home visiting increases families’ referrals and enrollment in trusted community services, including family planning, adult education, employment, and transportation services. (Lowell et al., 2011; Silovsky et al., 2011) By developing meaningful relationships with families, home visitors help to promote the health and well-being of families, empower them to build resilience, support them in navigating early childhood systems, and elevate the voice of families and communities. (Lewy, n.d.; Lowell et al., 2011) This relational power of home visiting, when combined

with culturally responsive targeted interventions in an antiracist system of care, can help to advance health equity. However, **it is critical to identify and address the underlying systemic challenges, such as racism and bias, to realize the full potential of home visiting services.**

Education Development Center, Inc., in partnership with the Health Resources and Services Administration (HRSA), Division of Home Visiting and Early Childhood Systems, embarked on the development of a framework to support MIECHV awardees and local home visiting teams in identifying and addressing priority systems that will enable equitable outcomes for all families receiving home visiting services. The HV CoIIN Health Equity Framework presented in this toolkit is adapted from the Institute for Healthcare Improvement’s *Achieving Health Equity: A Guide for Health Care Organizations*. (Wyatt R et al., 2016) The aim of the framework is to guide MIECHV awardees and their local implementing agencies (LIAs) in reflecting on historic and current practices, policies, and financial decisions that have harmed communities and to identify opportunities to redesign their shared approach, reallocate resources, and build knowledge and capacity to advance health equity in maternal and early childhood home visiting programs and across early childhood systems, with families as partners.



TIME TO TAKE ACTION

MORTALITY PER 100,000 LIVE BIRTHS

41

BLACK
WOMEN

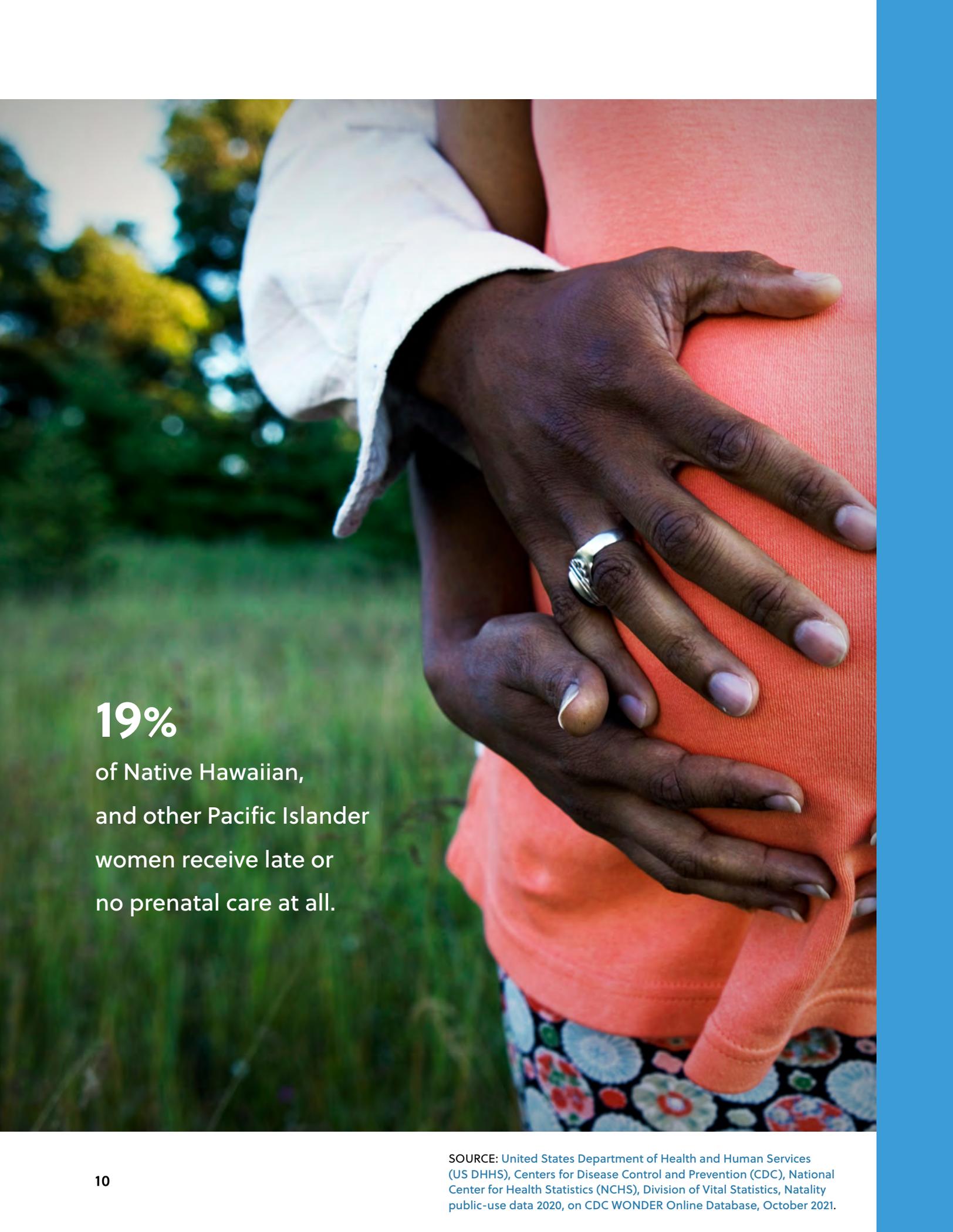
26

ALASKAN
NATIVE
WOMEN

13

WHITE
WOMEN

Black and American Indian and Alaskan Native women have pregnancy-related mortality rates that are about three and two times higher, respectively, compared to the rate for White women.



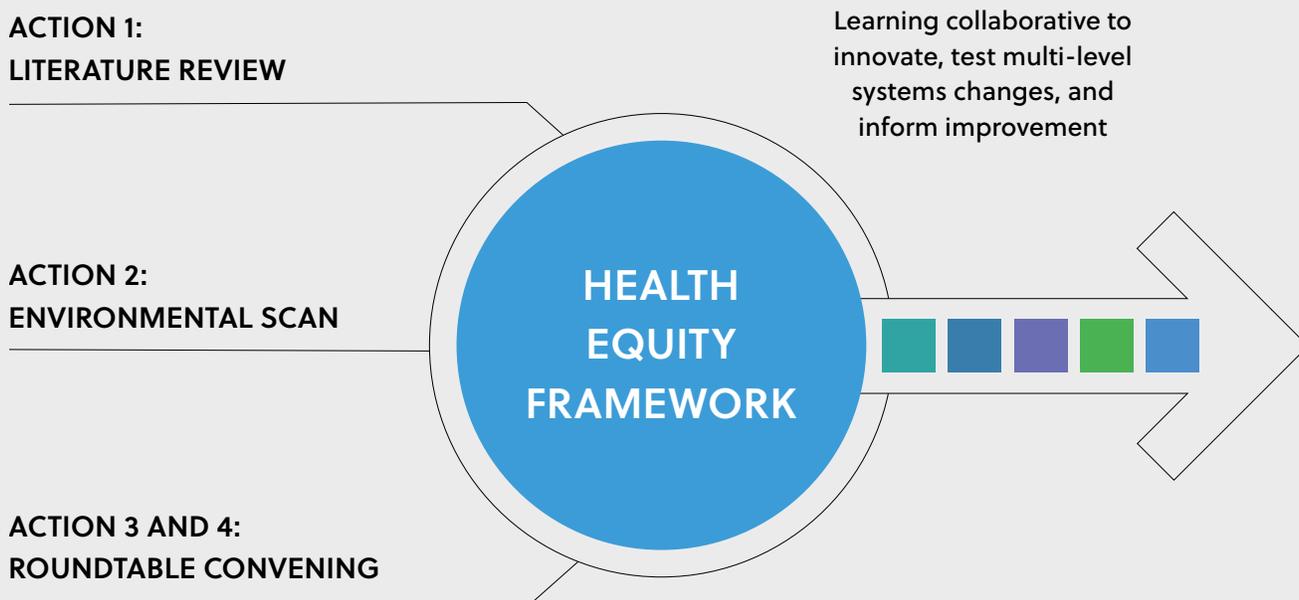
19%

of Native Hawaiian,
and other Pacific Islander
women receive late or
no prenatal care at all.

DEVELOPING THE FRAMEWORK

Developing the HV CoIIN Health Equity Framework involved four key actions (See [Figure 1](#)). Partners in the development of the framework included caregivers, MIECHV awardees, LIAs, home visiting model developers, health equity experts, and cross-system representatives from successful health equity efforts in maternal and child health. The framework was built with the understanding that progressing health equity relies on centering the lived experience of caregivers and understanding the role of social and structural determinants of health in influencing individuals' contexts, options, and behaviors—and therefore health outcomes. (Lorch & Enlow, 2016) Recognizing the impact of these factors, the framework is aligned to a social-ecological approach to understanding and advancing health equity within home visiting. (Bronfenbrenner, 1977) In order to establish each driver, change must happen across each of the socio-ecological levels. See [Figure 2](#) for examples of how some health equity strategies in the framework align with the social-ecological model.

FIGURE 1. Process for developing the Health Equity Framework



ACTION 1: We completed a literature review to understand the gaps in addressing health equity within MIECHV and to identify the social-ecological elements that are critical to addressing health equity, the drivers that need to be in place to diminish and eliminate inequities across health outcomes, and the evidence-based and promising practice interventions necessary to get the drivers in place.

ACTION 2: We conducted an environmental scan of existing public health equity frameworks to identify key elements conducive to home visiting.

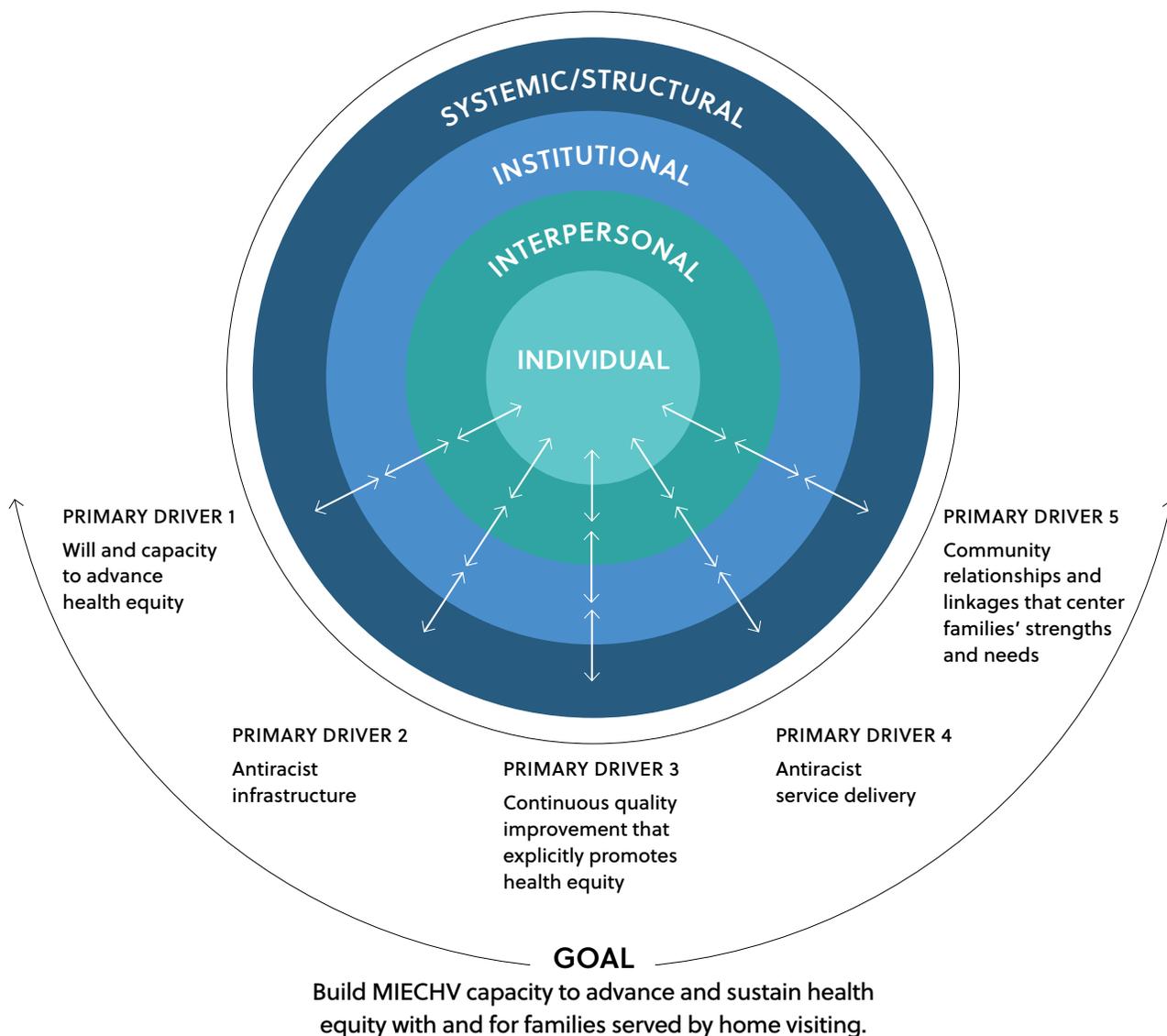
ACTION 3: We convened a small group of diverse faculty and advisors to review outcomes of the literature review and the summary of existing frameworks to narrow down the list for consideration.

ACTION 4: The Education Development Center, Inc team assembled a broader national group of experts to complete a Key Driver Diagram and Change Package, adapted for home visiting, to be tested by MIECHV awardees, cross-system partners, and local home visiting teams through an 18-month learning collaborative.

FIGURE 2. Social-Ecological Elements Impacting Health Equity

Example Strategies for Primary Driver 1 across the Socio-ecological Model

SYSTEMIC/ STRUCTURAL LEVEL	INSTITUTIONAL LEVEL	INTERPERSONAL LEVEL	INDIVIDUAL LEVEL
Local or state government declares racism a public health crisis and explains the ways in which racism has contributed to the health inequities observed across communities	Revise administrative processes, including Memorandum of Understandings (MOU), contracts, Request for Proposals (RFP), and supplemental fund development, to close health equity gaps	Engage home visiting families, staff from the community, and key community members and organizers in educating staff about the community's history, culture, and values	Ongoing reflective supervision includes staff assessing their own bias as well as organizational bias and racist and/or oppressive practices in caring for different demographics



SOURCE: Adapted from <https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/conceptual-framework-report.pdf>.

Family, maternal and infant health disparities are symptoms of broader underlying social and economic inequities that are rooted in racism and discrimination.



PURPOSE & AUDIENCE FOR THE HEALTH EQUITY TOOLKIT

Advancing health equity is an ongoing process. As the HV CoIIN team, awardees, and local home visiting agencies continue to test and refine the Health Equity Framework, preliminary resources are being shared. This working draft of the *HV CoIIN Health Equity Toolkit* is designed to support state, territory, tribal, and local teams and individuals in examining and acting toward advancing health equity in MIECHV.

This toolkit presents ideas to support teams at all stages of readiness and progress in advancing health equity.

This toolkit was designed with three goals in mind:

- Center equity at all levels of the social-ecological framework for home visiting initiatives, with a strong emphasis on antiracist, co-created design
- Ensure that home visiting services and supports are family-centered, culturally responsive, strengths-based, and evidence-based and/or -informed
- Engage home visiting decision-makers, at the state and local level, in addressing the barriers that stand in the way of families to achieve their dreams and meet the needs of their children and themselves

The Health Equity Framework calls for the engagement of home visiting families in systems transformation. Their engagement should be rooted in shifting power, shared decision-making, and prioritizing families' needs. (*Parent-Manifesto-FINAL.Pdf*, n.d.)

RESOURCE

Access the [HV CoIIN Parent Leadership Toolkit](#) and the [Manifesto for Race Equity & Parent Leadership in Early Childhood Systems](#) for more resources on leading health equity efforts with caregivers as partners.

Audience

The audience includes, but is not limited to, home visiting programs at the state, territory, tribal and local levels; administrators; directors; program managers; quality improvement leads; home visitors; families; and other service providers. This toolkit presents ideas to support teams at all stages of readiness and progress in advancing health equity.

What is included in the toolkit

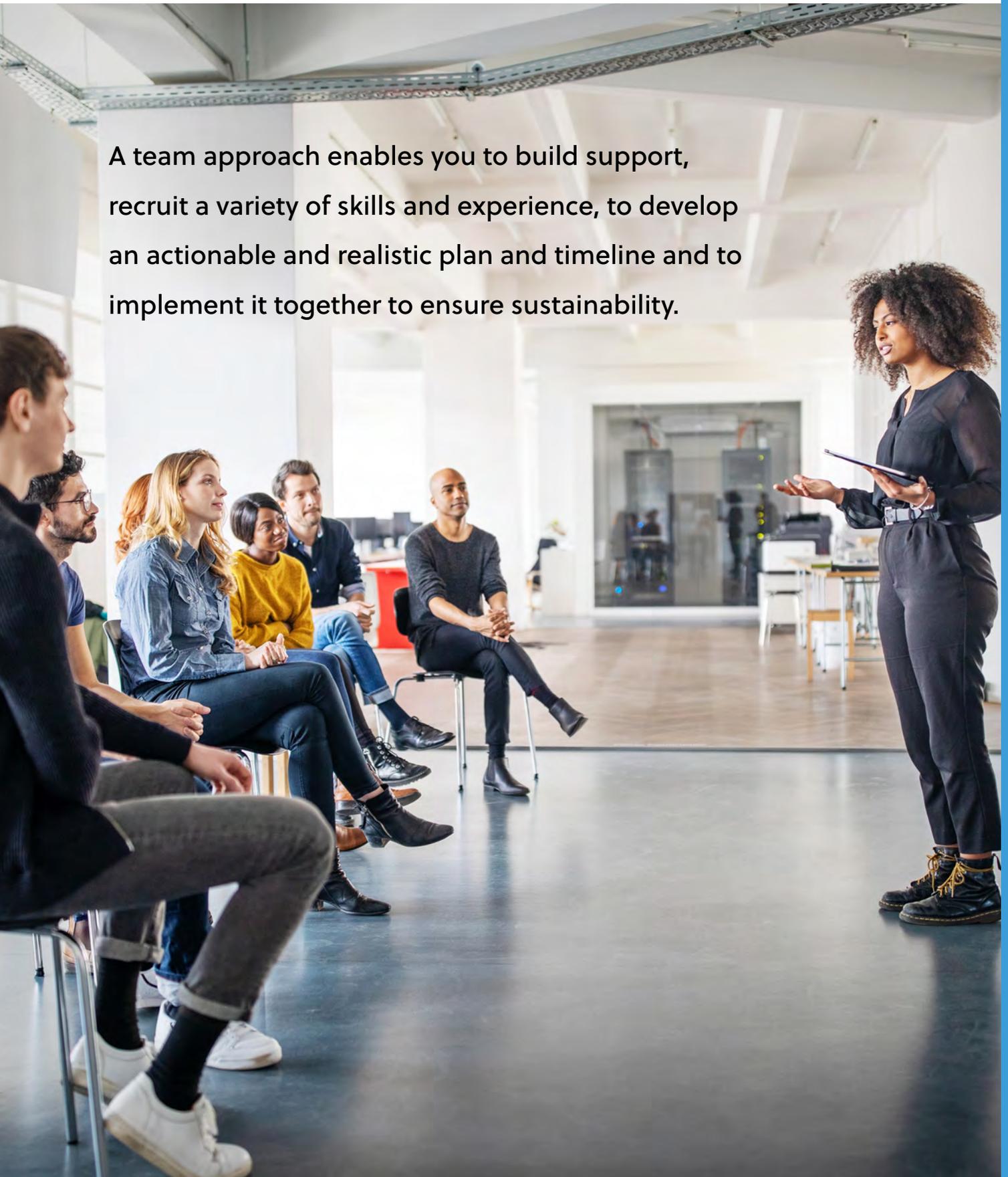
The HV CoIIN *Health Equity Toolkit* is organized into three parts:

- **PART 1:** Preparing to use the HV CoIIN *Health Equity Framework*
- **PART 2:** Introduction to the Health Equity Framework
- **PART 3:** Change Package and Examples from the Field





A team approach enables you to build support, recruit a variety of skills and experience, to develop an actionable and realistic plan and timeline and to implement it together to ensure sustainability.



PART 1: PREPARING TO USE THE HV COIIN HEALTH EQUITY FRAMEWORK

To most effectively use the HV CoIIN Health Equity Framework and complimenting Change Package, we recommend five key preparation steps. Once you have completed the five steps, engage in a reflective discussion as a team to discuss your team's key takeaways from Steps 1–5. As a team you can then move on to exploring the Health Equity Framework and Change Package presented in Parts 2 and 3.

Recommendation for Mapping out your work: Identify Key Drivers and Opportunities

STEP

1

Assemble a Health Equity Team

Take time to pull together a team of individuals with the will to explore healthy equity and an interest in doing so.

Develop a Grounding in

Health Equity Activities like developing learning agreements, establishing a shared language, and supporting each individual's development can help get your team off to a strong start.

STEP

2

STEP **1** Assemble a Health Equity Team

Before reviewing the Framework and Change Package and planning for change, take time to pull together a team of individuals with the will to explore healthy equity and an interest in doing so at the team and individual level.

Why this is important: A team approach enables you to make health equity a priority, benefit from a variety of skills and experience, and implement an actionable framework and approach.

How to do this: As you consider potential members of your team, aim for an equitable representation of racial diversity, authority, and roles that impact home visiting improvement efforts. Strive to include members who are multidisciplinary and multicultural. Include people with lived experience, individuals with QI expertise, and—where possible—individuals with different levels of seniority and decision-making power within an organization or program. Lastly consider including individuals at different stages

in their health equity journey. For example, seek to include more than colleagues who are always enthusiastic to work on health equity.

Below are reflection questions to consider as you identify and recruit team members to join you on this journey toward eliminating health inequities in home visiting:

- Does your team represent and reflect the communities you serve and those you wish to reach?
- Are you engaging a diverse community of partners who represent the interests of those you provide services to? Do they understand families' needs and the social and structural barriers that families face?
- Do you have differing levels of decision-makers who can impact policy, funding, and practice?
- Do you have members who can speak to systemic, institutional, interpersonal, and individual elements that impact health equity?
- Does your team include those with lived experience who have received or provided home visiting services?

STEP

3

Identify the History of Your Program and Communities Served

Consider your agency's historical role in perpetuating systems of racism and oppression and the impact of these systems on the community.

STEP

Explore the Structural and Social Determinants of Health Home visiting programs can identify the structural, institutional, and social drivers of health equity at the community, organizational, and individual levels.

STEP

4

STEP

5

Complete the Health Equity Assessment

Use the Health Equity Assessment to help assess your programs' current health equity efforts, determine where to focus your work, and track progress.

RESOURCE

Review the [HV CoIIN Parent Leadership in CQI Toolkit](#) for tips, strategies, and resources to meaningfully engage families in a health equity team.

The best way to get those with lived experience (such as parents and home visitors) involved in all levels of the system is to ask. Giving all parents and/or caregivers the opportunity to share their expertise is critical in designing and improving the systems and services most responsive to their needs. Throughout the Health Equity CoIIN, teams modeled what it means to work together with parents as partners, from the development of ideas to the selection of tools for data collection and as members of teams dedicated to doing the work. For instance, when narrowing the areas of focus for their work, parents were included in focus groups to better understand their priorities (e.g., childcare). Parents shared their priority needs and trusted resources in the community to support the home visiting team in their prioritization of efforts. ([Learn more about this process in the Primary Driver 3 section of this toolkit.](#))

Once you have identified individuals to join your health equity efforts, consider developing an infrastructure of support by identifying and sharing clear roles, responsibilities, and expectations for all team members. This ensures that all team members can participate not just as informants but also as co-designers and leaders in the work.

Be sure to document the following:

- What role each team member will play, your expectations, and the value they bring to the work
- When, where, and how often the team will meet
- Expectations for communication within the team and with external partners

RESOURCE

Adapt the [HV CoIIN Invitation Letter](#) to invite trusted community partner to join your team.

STEP 2 Develop a Grounding in Health Equity

Once you have identified individuals to join your health equity efforts, several grounding activities can help get your planning off to a strong start.

Why this is important: Open spaces for learning and discussion are critical for the success of health equity initiatives. Setting shared definitions, terms, and values enables the team to start their health equity work with a common understanding of key concepts.

Example Principles to Guide Your Learning

- Everyone has their own life experience; this is important wisdom that we want you to bring to the table.
- There are no “right answers” or “right ways to think.” All perspectives are welcomed and valued.
- We can use history as a tool to understand what has happened and to guide us in creating solutions for the future.

Setting shared definitions, terms, and values enables the team to start their health equity work with a common understanding of key concepts.

How to do this: Here are some tips for establishing effective and successful teams:

- **Develop agreements.** Be sure to establish learning and community agreements as a team, including accountability measures to ensure that agreements are upheld throughout the team’s time working together.
- **Establish a shared language.** Initiate the work by establishing definitions and terms, to ensure that all team members are on the same page. As a starting place, refer to the [Glossary of Health Equity Terms](#) for the words and phrases most frequently used in health equity work.
- **Nurture team connections, and support individual development.** Aim to foster a space for shared learning and growth. Build time into your meetings to support colleagues and connect with one another. Consider supporting colleagues in their individual personal growth journeys by offering trainings, reading materials, and opportunities for reflection and journaling.



Refer to our [curated list of sample Community Builders](#) to support your team in making connections.



Learning the histories of other areas and even my own city was very eye-opening because these occurrences did not happen very long ago.”
—Home visitor/LIA

Additional Tips

Creating and maintaining productive spaces for open communication, shared values, and collaborative action on health equity can be challenging. Here are some additional suggestions:

1. Use facilitation tools (e.g., Jamboard, MURAL boards, Mentimeter, Padlet) to engage colleagues in individual reflection in a way that preserves anonymity.
2. Use tools (e.g., Window of Tolerance) to help identify how team members are feeling in the moment and to learn about their state of mind to readily receive, process, and integrate information.
3. Avoid using jargon in your communication with the team.
4. Include discussions of historical context in the work. ([Primary Driver 4](#) offers examples on the importance of contextualizing your work in the history of communities and the program.)
5. Take time for reflection during meetings, and provide opportunities for vulnerability and ongoing support of staff.

STEP 3 Identify the History of your Program and Communities Served

Why this is important: A historical perspective on inequities can support us in understanding present-day inequities as constructed over time, provide much-needed context for community efforts, and help us identify the systems of advantage and disadvantage that are built into our workplaces and everyday lives. It is from a shared foundation of understanding and acknowledging context, history, and root causes of racism and oppression that home visiting programs can begin to advance health equity.

How to do this: Before using the Health Equity Key Driver Diagram and Change Package, consider your agency’s historical role in perpetuating systems of racism and oppression and the impact of these systems on the community. Consider setting up several meeting times with the team you identified in Step 1 to discuss the following questions:

- How has and does racism impact access to goods, services, opportunities, and resources over time through the lens of your community?
- In what ways have systems in your community, including the home visiting system, given advantage to White populations and disadvantaged Black and Indigenous communities and other communities of color?



Excerpts from teams' Equity History



Within our agency, we have policies and procedures that are intended as a way to ensure fair treatment and supervision of all staff. For many years, the policies and procedures have been enforced differently depending on who your supervisor is or not followed at all. There has been different treatment and different standards for staff in the same roles. Historically there are many instances of preferential treatment.”



As in other cities, redlining was used to discriminate in providing mortgages to African American and other families of color. The redlined neighborhoods in Providence continue to be the poorer sections of the city today. These discriminatory practices are still evident in the differing rates of home ownership between white, black, and Hispanic populations. As of 2014, the American Community Survey found 44% of whites owned homes while only 32% of black residents and 24% of Latino residents did.”

- Do racial/ ethnic groups live in different neighborhoods in the communities the home visiting program serves? How did the neighborhood boundaries and resources come to exist?
- What is the history of redlining? Highways? Industrial plants? What economic centers exist in your community?
- In what ways has your agency perpetuated inequity? How has your agency fought against it?

Note: You are not limited to these questions and can add additional questions as needed and appropriate for your team.

Once you have discussed the questions, identify a volunteer member of your team to write up your one- to two-page historical story. We encourage you to engage deeply in this exercise. Challenge yourself to go beyond an organizational description that you would include in proposals or marketing materials. Dig deeper and reflect on your agency’s history, influence, and power.

Once your story is complete, discuss how your state or territory and local history may impact your efforts to address health inequities within home visiting. What barriers must you overcome that have been perpetuated over time? What strengths might you build on? Take the output of this step and all others in this preparatory section to begin to create a new narrative about your community, and program through the lens of history.



You may access additional excerpts for the participating teams’ equity stories [here](#).

STEP 4 Explore the Structural and Social Determinants of Health

Because family, maternal, infant and child health outcomes are shaped by social and structural factors, home visiting programs can identify the structural, institutional, and social drivers of health equity at the community, organizational, and individual levels to help inform efforts in advancing health equity.

Why this is important: Home visiting is a two-generation strategy that offers families resources and skills to support caregivers in raising physically, socially, and emotionally healthy children who are ready to succeed. Home visiting programs play a critical role in advocating for and creating healthy communities while supporting families in navigating available resources and overcoming any barriers to accessing them.

In fiscal year 2021, HRSA reported that MIECHV served historically and present-day marginalized populations impacted by the following social determinants (*Program-Brief.Pdf*, n.d.):

68% of household incomes were at or below 100% of the Federal Poverty Guidelines

40% of the households were at or below 50% of the Federal Poverty Guidelines

Social and structural determinants of health are 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.

76% of adults and children relied on Medicaid or CHIP

60% of participating households reported a high school education or less

20% percent reported a history of child abuse and maltreatment

14% reported substance misuse

60% of all counties served were rural

As such, home visiting has an opportunity to play a critical role in supporting families in navigating the associated systems of care, mitigating the impact of negative social determinants of health, and accessing high-quality resources that will improve health outcomes for all families.

RESOURCE

How to do this: As a team, review the [list of social and structural determinants of health](#) (and any other determinants you are familiar with) to consider which are most important and feasible to address in your state and community. This will help your team focus your efforts as you review the Health Equity Framework and determine what changes to test.

 RESOURCE

You may find it helpful to use your state's community needs assessment (MIECHV and Title V), the American Community Survey Data, and/or the Child Opportunity Index to complete this exercise. The Centers for Disease Control and Prevention also provides [links to helpful data tools](#). We encourage you to map the structural and social determinants of health more relevant for your community to better contextualize the availability of and access to resources across the home visiting communities you serve.

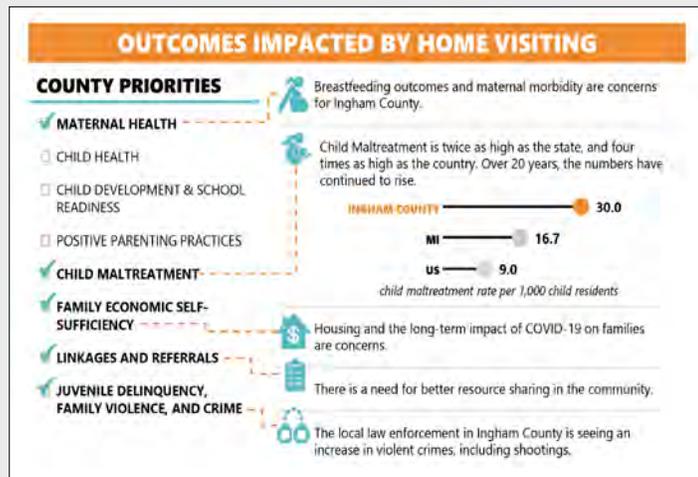
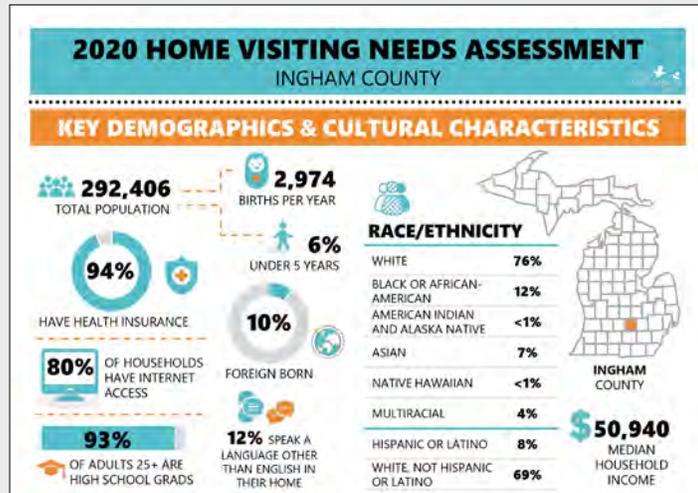
STEP **5** Complete the Health Equity Assessment

Why this is important: HV CoIN developed the [Health Equity Assessment](#) to help home visiting programs assess their current health equity efforts, determine where to focus their work, and track their participation in the Health Equity CoIN. This tool can support your team in having conversations about where you are in addressing health equity in your system, your current achievements, and where you want to go.

 RESOURCE

Community Maps for Michigan's Ingham and Saginaw Counties

Access the complete community maps for Michigan's Saginaw and Capital Area participants [here](#).



The Health Equity Assessment can support your team in having conversations about where you are in addressing health equity in your system, your current achievements, and where you want to go.

How to do this: The assessment is organized around each of the five primary drivers of the HV CoIIN Health Equity Framework. Each primary driver has a list of overarching secondary drivers with accompanying action elements—or what you may expect to see in day-to-day practice if that driver were in place.

Using a 1-to-5 scale, rate your level of progress for each element. Use the comments box for each framework component to note specific examples, achievements, challenges, questions, next steps, and any other important items.

We recommend that the entire team be involved in completing the assessment. Each team member should complete the assessment independently, then come together to review it as a team and arrive at a consensus on your team's final scores for all action elements. Review your team's current scores, and consider the following prompts in your discussion:

1. What are our strengths and current achievements in advancing health equity?
2. For which elements do we have little or no progress (i.e., elements rated a 2 or 1)?
3. For elements with a "Do not know" response:
 - Why don't we know how the organization rates on this element?
 - How can we find out the status? Whom can we engage?

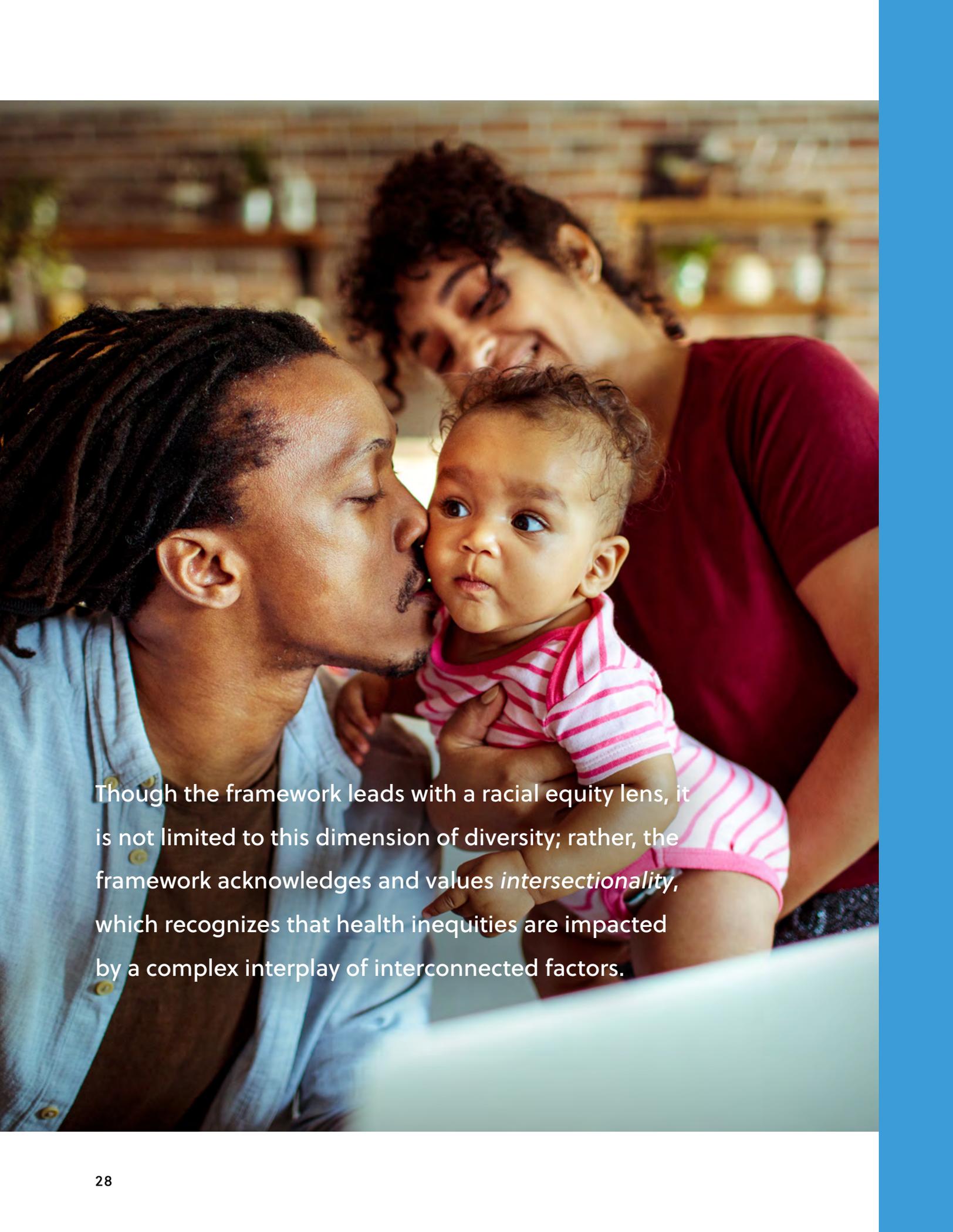
4. Considering your scores on the assessment and the learning from your team's preparation (Steps 1–4 above), which drivers offer the greatest opportunities to take action to further improve health equity? Review the sample change ideas for those drivers in Part 3 of this toolkit and plan your next steps.

Once you have completed the assessment and identified your areas of priority get started!

A note about assessing your progress:

We recommend that you revisit this assessment quarterly to help summarize your accomplishments, track progress, and determine next steps. Review your current scores and compare them to the previous quarter's. Consider the following prompts in your discussion:

1. Which elements have we made progress on?
 - What fundamental changes did we make that led to this progress?
 - How can we ensure these changes are sustained?
 - What would it take for us to rate ourselves a "5" for this element?
2. In which elements do we have little or no progress since the initial assessment? What support do we need to make progress? What additional team members or voices do we need at the table in order to take action?



Though the framework leads with a racial equity lens, it is not limited to this dimension of diversity; rather, the framework acknowledges and values *intersectionality*, which recognizes that health inequities are impacted by a complex interplay of interconnected factors.

PART 2: INTRODUCTION TO THE HV COIIN HEALTH EQUITY FRAMEWORK

The HV CoIIN Health Equity Framework provides evidence-informed and actionable guidelines to support MIECHV awardees and 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 Health Equity Framework or Key Driver Diagram (KDD) and Change Package offer improvement ideas to test in home visiting. The framework 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. These are more fully explored in the Change Package, introduced in Part 3.

FIGURE 3 The HV CoIN Health Equity Framework

GOAL

Build MIECHV capacity to advance and sustain health equity with and for families 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

PRIMARY DRIVER (PD)

Critical system elements that are necessary and sufficient to achieve the goal

PRIMARY DRIVER 1

Will and capacity to advance health equity

PRIMARY DRIVER 2

Antiracist infrastructure

SECONDARY DRIVER (SD)

Elements that will result in change in the associated primary driver

SECONDARY DRIVER 1

A. Ongoing professional and personal development and transformation regarding race, racism, bias, and equity

B. Understanding and acknowledgment of historical and ongoing context for racism and other forms of oppression that exist within the community

C. Will, commitment, and accountability to prioritize improving health equity with families at all levels of the home visiting program

SECONDARY DRIVER 2

A. Data planning, collection, and analysis that centers health equity

B. Staff recruitment and retention that advance workforce equity, diversity, and inclusion

C. Policies and practices that explicitly challenge interpersonal, institutional, and systemic racism

D. Policies, program implementation, and resource allocation that share power with families as leaders and decision-makers at all levels of the home visiting system



PRIMARY DRIVER 3

Continuous quality improvement that explicitly promotes health equity

PRIMARY DRIVER 4

Antiracist service delivery

PRIMARY DRIVER 5

Community relationships and linkages that center families' strengths and needs

SECONDARY DRIVER 3

A. Improvement priorities driven by inequities that are meaningful to the families disproportionately affected by health inequities

B. Tailoring the changes tested to recognize the strengths and meet the needs of families disproportionately affected by health inequities (i.e., center in the margins)

C. Centering, valuing, and paying for the expertise of families disproportionately affected by health inequities in the co-design, implementation, and sustainability of solutions

SECONDARY DRIVER 4

A. Identifying and addressing disrespectful care and its impact on health outcomes in communications with families

B. Outreach & recruitment that engages the families disproportionately impacted by health inequities

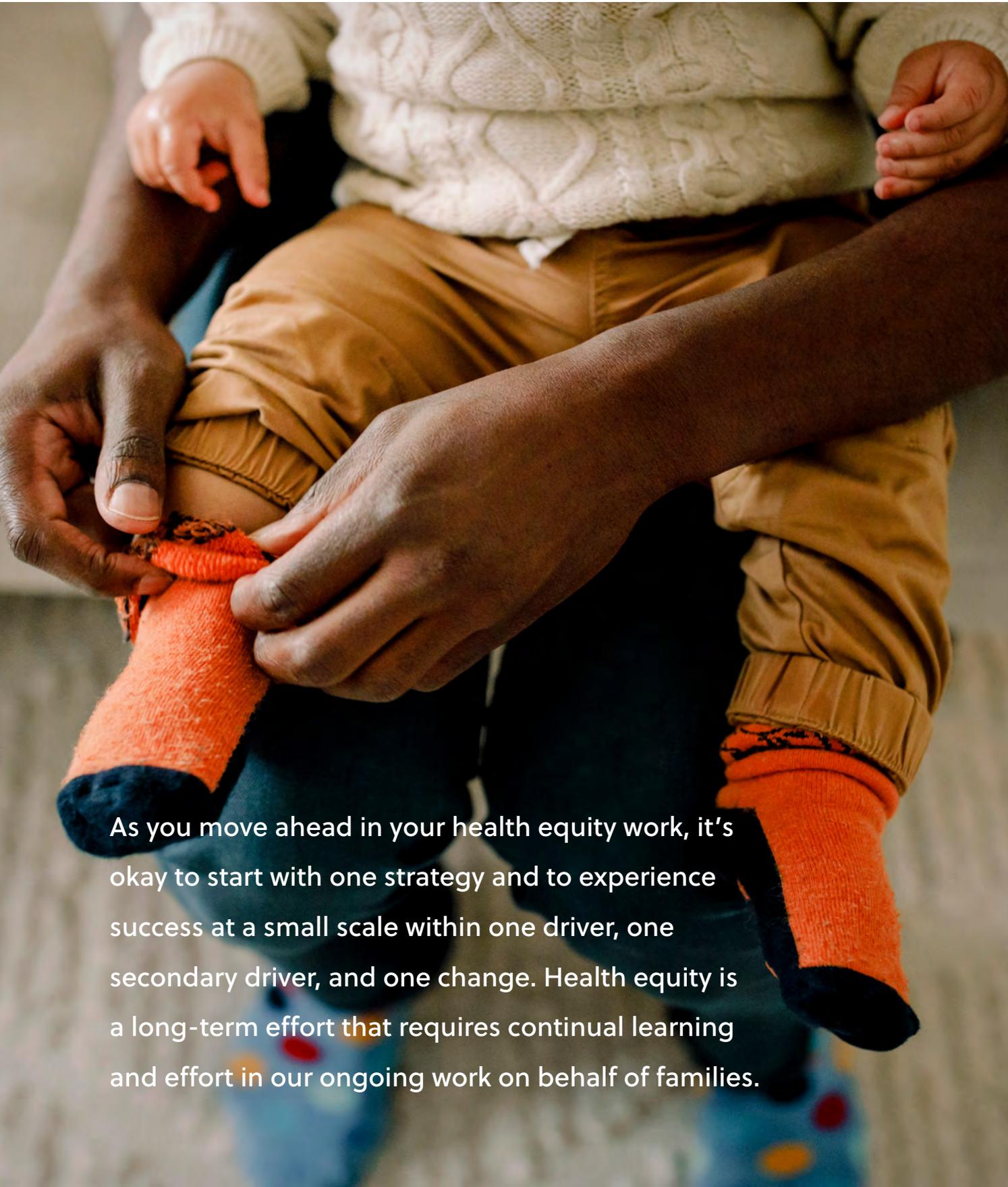
C. Communication and resources that are responsive to diverse cultural beliefs and practices, preferred languages, health literacy, and other communication needs

D. Culturally appropriate and linguistically responsive home visiting services and coordination that addresses the multiple determinants of health of health

SECONDARY DRIVER 5

A. Community trust for the home visiting program

B. Community collaboration that responds to the diversity of families' strengths and needs and addresses the structural and social determinants of health



As you move ahead in your health equity work, it's okay to start with one strategy and to experience success at a small scale within one driver, one secondary driver, and one change. Health equity is a long-term effort that requires continual learning and effort in our ongoing work on behalf of families.

PART 3: CHANGE PACKAGE AND EXAMPLES FROM THE FIELD

The Change Package offers strategies for your team as you engage in health equity planning and implementation of the framework. This section is organized by the five primary drivers. Each primary driver is briefly introduced and then followed by stories from the field to provide concrete example of what the work looks like on the ground. Change ideas (i.e., things you could do to impact the drivers) are presented under the secondary drivers. You may explore each secondary driver and the associated change ideas by navigating the tabs at the top of the page.

PRIMARY DRIVER 1:

WILL AND CAPACITY TO ADVANCE HEALTH EQUITY

MIECHV home visiting programs are a critical component of early childhood systems and as such play an important role in achieving health equity for all families. Home visiting programs must be explicit that advancing health equity is an organizational, programmatic, and staff priority, both to support appropriate resource allocation for this work and to demonstrate that the organization and home visiting program are committed to eliminating inequities experienced by the families who engage with the program. To ensure that health equity efforts are prioritized and sustainable, changes in this driver support programs in explicitly considering health equity in all aspects of their strategy, operations, and staff development.

OUR STORIES

Example from the field:
Saginaw County, Michigan



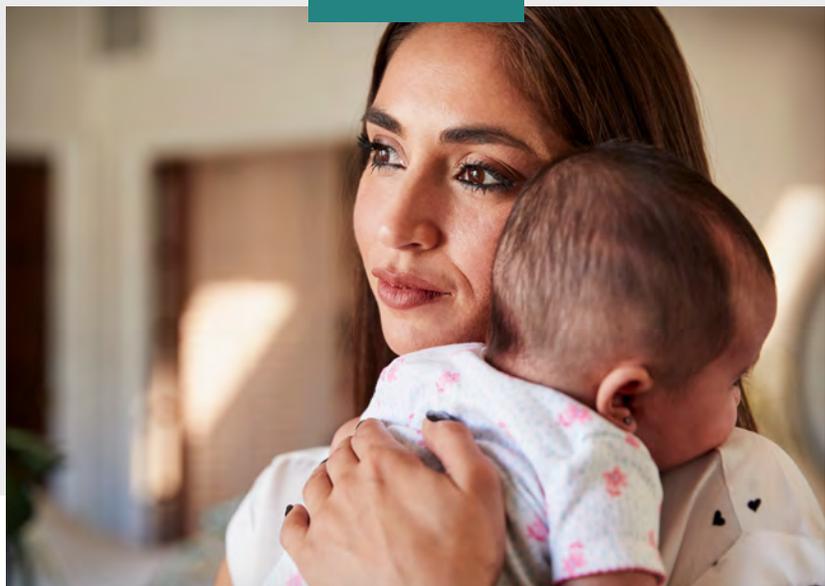
Example from the field:
Hillsborough and Pinellas,
Florida



SECONDARY DRIVER: Ongoing professional and personal development and transformation regarding race, racism, bias, and equity

Potential Changes to Test

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.



PRIMARY DRIVER 1:

WILL AND CAPACITY TO ADVANCE HEALTH EQUITY

MIECHV home visiting programs are a critical component of early childhood systems and as such play an important role in achieving health equity for all families. Home visiting programs must be explicit that advancing health equity is an organizational, programmatic, and staff priority, both to support appropriate resource allocation for this work and to demonstrate that the organization and home visiting program are committed to eliminating inequities experienced by the families who engage with the program. To ensure that health equity efforts are prioritized and sustainable, changes in this driver support programs in explicitly considering health equity in all aspects of their strategy, operations, and staff development.

OUR STORIES

Example from the field:
Saginaw County, Michigan



Example from the field:
Hillsborough and Pinellas,
Florida



SECONDARY DRIVER: 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.

Learn the history of racism and oppression in both the U.S. and the community where the home visiting program is located.



PRIMARY DRIVER 1:

WILL AND CAPACITY TO ADVANCE HEALTH EQUITY

MIECHV home visiting programs are a critical component of early childhood systems and as such play an important role in achieving health equity for all families. Home visiting programs must be explicit that advancing health equity is an organizational, programmatic, and staff priority, both to support appropriate resource allocation for this work and to demonstrate that the organization and home visiting program are committed to eliminating inequities experienced by the families who engage with the program. To ensure that health equity efforts are prioritized and sustainable, changes in this driver support programs in explicitly considering health equity in all aspects of their strategy, operations, and staff development.

OUR STORIES

Example from the field:
Saginaw County, Michigan



Example from the field:
Hillsborough and Pinellas,
Florida



SECONDARY DRIVER: Will, commitment, and accountability to prioritize improving health equity with families at all levels of the home visiting program

1. Broadly share visual and experiential data (e.g., mapping, storytelling) demonstrating the root causes of inequities experienced by families in home visiting.
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.



We decided to ask the parents some key questions about primary care, transportation, distance traveled to stores, etc. <We > talked to...families about the survey and its purpose. All this useful data what would we do with it? We decided to make a map of primary care doctors, hospitals, urgent cares, dentists that accept Medicaid in the 48911 zip code. To make the story short, we dreamed of an interactive map. Thanks to one of our home visitors and her perseverance, we now have this wonderful map for our families to utilize!"—LIA

EXAMPLE FROM THE FIELD: Saginaw County, Michigan

Developing a Community History

PRIMARY DRIVER 1:

Will and capacity to advance health equity

SECONDARY DRIVER:

Understanding and acknowledgment of historical and ongoing context for racism and other forms of oppression that exist within the community

CHANGE IDEA:

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.

Michigan's Saginaw County is vastly diverse, with more than 20% of its residents identifying as Black or African American, 8.7% identifying as Hispanic or Latino, and 4.2% identifying as more than one race. When compared to the state of Michigan, with percentages of 15.3%, 5.2%, and 3.8%, respectively, Saginaw is rich in racial and ethnic diversity. This

abundance of diversity in the county propelled the Saginaw Intermediate School District, Early Head Start, and Healthy Families America home visiting programs to come together to participate in the Health Equity CollN. Building on their years of focus on health and social equity, diversifying their workforce, and ensuring pay equity for their staff, the team sought to improve their system in order to provide family-centered home visiting services that were both culturally and linguistically responsive and antiracist.

To better understand the history of inequities in their county, the Saginaw team studied the history of racism and oppression in their community and the role of systems and policies in continuing to perpetuate health inequities. Their goal in completing this overview was to gain a deeper understanding of the context of the injustices faced by the families they serve.

Team members conducted independent research on Saginaw's history and policies. Members then shared their findings via an online portal, where they could upload resources, materials, and data relating to their topic for all to access and review.

Finally, the team met to discuss their findings and identify priority areas for intervention. Their chosen priority areas included housing, food deserts, and the proximity of liquor stores to schools and bus routes.

RESOURCE

The team's work culminated in a report titled [Policies and Procedures that Perpetuate Health Inequities](#).

Centering a Group's Mission, Vision, and Values Statement in Health Equity

PRIMARY DRIVER 1:

Will and capacity to advance health equity

SECONDARY DRIVER:

Will, commitment, and accountability to prioritize improving health equity with families at all levels of the home visiting program

CHANGE IDEA:

Explicitly articulate health equity-specific goals at organizational, program, department, and individual levels.

At the onset of the collaborative, based on the Saginaw team's conversations and guided by the HV CoIIN **Health Equity Assessment**, the team identified the need to revisit and update their organization's mission, vision, and values statement to establish health equity as a strategic priority. This offered an opportunity to build will while also creating meaningful opportunities to engage staff across the organization and to invite clients to be part of the process.

RESOURCE

To further advance their equity efforts, the team established a strong project management action plan ([updated action plan](#)) that included specific activities, the person responsible for each action item, and the date that each item would be completed. This plan allowed the team to stay on track and successfully achieve their goals.

Saginaw Independent School District, Healthy Families America and Early Head Start

Revised Vision, Mission, and Values Statement

VISION

The Saginaw Healthy Families America (HFA) and Early Head Start (EHS) programs prioritize a health equity approach through antiracist service delivery and active breakdown of system barriers with families in order to ensure positive health outcomes and achieve the programs' priorities.

MISSION

The Saginaw HFA and EHS programs empower families, the community, and staff to advance and achieve health equity by ensuring that everyone has a fair and just opportunity to attain their full potential.

VALUES STATEMENT

Together, we (home visitors, supervisors, community partners, and families) will:

- Demonstrate both compassion and respect in all efforts and for all people
- Work together to advance health equity for all families by improving access to the conditions and resources that strongly influence health and wellness for all families
- Use data and the lived experiences of families and community members to inform efforts to advance health equity
- Ensure that all have the training and resources needed to work toward advancing health equity

—The Saginaw Health Equity CoIIN Team

EXAMPLE FROM THE FIELD:

Hillsborough and Pinellas County, Florida



Hillsborough County

PRIMARY DRIVER 1:

Will and capacity to advance health equity

SECONDARY DRIVER:

Ongoing professional and personal development and transformation regarding race, racism, bias, and equity

CHANGE IDEAS:

- Offer ongoing training and practice to identify and name racism, systemic oppression, and its various manifestations in conversations with families.
 - 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.
-

As the Hillsborough team began their work in the COLLN, they decided that staff training was the first step in providing ongoing professional and personal development and transformation regarding race, racism, bias, and equity. To give staff an opportunity to reflect on and navigate through issues of race, power, and privilege in relation to families, staff explored completing an implicit-association test and engaged in ongoing discussions around implicit bias. When asked how helpful they found the test, 89% of staff reported having more knowledge about implicit bias, 89% reported having a better understanding of how implicit bias might impact service delivery, and 79% reported that completing the test helped with self-reflection on the potential bias. Staff comments included the following:

“As we strive to continue to help our clients access quality health care and achieve health equity, I found the survey is an important tool. It allows for good self-reflection and awareness of biases that could be present. When we are aware and complete trainings and surveys such as these, we are making every effort to care for our clients with an open/non-judgmental/culture-considered mind, which benefits our clients.”

“I appreciate the continued opportunities for learning and awareness our organization offers its employees. This helps us be not only better

employees but better citizens. We are also able to share this with other people in our circles.”

The Hillsborough team furthered this professional development by offering informal opportunities for staff to explore, discuss, practice, and reflect on equity-related content by creating a lending library of resources to improve education among its staff regarding racism, bias, and equity.

Pinellas County

PRIMARY DRIVER 1:

Will and capacity to advance health equity

SECONDARY DRIVER:

Ongoing professional and personal development and transformation regarding race, racism, bias, and equity

CHANGE IDEA:

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.

RESOURCE

The Pinellas team decided to focus on staff development. They began by implementing a new approach during staff meetings: having staff view videos from the series *Uncomfortable Discussions with a Black Man* and then discuss equity-related questions crafted by the team. These discussions were rich, with many staff sharing personal stories. Staff members also reflected that the video series sparked good conversations about racism and equity with their friends and families.

In collaboration with community partners, the team also expanded their racial and health equity library to provide additional meaningful resources for all staff.

PRIMARY DRIVER 2:

ANTIRACIST INFRASTRUCTURE

Developing and sustaining a health equity strategy requires home visiting programs to create and support an organizational infrastructure that fosters antiracism and can advance the work. Internal structures that need to be considered include data collection, analysis, and dissemination; hiring and recruitment; and organizational policies and practices. Changes in this driver support teams in applying an equity lens to their infrastructure.

OUR STORIES

Example from the field:
Pinellas County, Florida



Example from the field:
HV CoIIN Team



Example from the field:
Desoto and Hardee
Counties, Florida



SECONDARY DRIVER: 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 (REaL) data for the workforce and all home visiting participants, including ensuring that participants understand why and how REaL data are being collected and used (e.g., *We Ask Because 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.



PRIMARY DRIVER 2:

ANTIRACIST INFRASTRUCTURE

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OUR STORIES

Example from the field:
Pinellas County, Florida



Example from the field:
HV CoIIN Team



Example from the field:
Desoto and Hardee
Counties, Florida



SECONDARY DRIVER: 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.

Define employees' career pathways and offer mentoring, professional development, and leadership programs to support employees.

PRIMARY DRIVER 2:

ANTIRACIST INFRASTRUCTURE

Developing and sustaining a health equity strategy requires home visiting programs to create and support an organizational infrastructure that fosters antiracism and can advance the work. Internal structures that need to be considered include data collection, analysis, and dissemination; hiring and recruitment; and organizational policies and practices. Changes in this driver support teams in applying an equity lens to their infrastructure.

OUR STORIES

Example from the field:
Pinellas County, Florida



Example from the field:
HV CoIIN Team



Example from the field:
Desoto and Hardee
Counties, Florida



SECONDARY DRIVER: 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 disproportionately 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.



Pay all home visiting staff a living wage.

PRIMARY DRIVER 2:

ANTIRACIST INFRASTRUCTURE

Developing and sustaining a health equity strategy requires home visiting programs to create and support an organizational infrastructure that fosters antiracism and can advance the work. Internal structures that need to be considered include data collection, analysis, and dissemination; hiring and recruitment; and organizational policies and practices. Changes in this driver support teams in applying an equity lens to their infrastructure.

OUR STORIES

Example from the field:
Pinellas County, Florida



Example from the field:
HV CoIIN Team



Example from the field:
Desoto and Hardee
Counties, Florida



SECONDARY DRIVER: Policies, program implementation, and resource allocation that share power with families as leaders and decision-makers at all levels of the home visiting system¹

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 families 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.
3. Be transparent about how decisions get made, make information accessible, and report back to families how their feedback impacted decisions and priorities.
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.



My home visitor has been the first worker that has really listened and allowed me to be in charge of my decisions. She treats me like an active part of our time together."

¹Changes 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*.

EXAMPLE FROM THE FIELD: Pinellas County, Florida



PRIMARY DRIVER 2:

Antiracist infrastructure

SECONDARY DRIVER:

Staff recruitment and retention that advances workforce equity, diversity, and inclusion

CHANGE IDEA:

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.

PAT+ (Parents as Teachers Plus) Pinellas is a home visiting program within Healthy Start Coalition of Pinellas, Inc. (HSCPIn). In addition to the standard PAT programming, PAT+ Pinellas also includes medical and mental health services geared toward women and their families who have any substance involvement, either current or in the past. PAT+ Pinellas joined the Health Equity CoIIN as part of their commitment to understanding the significant and unique societal barriers and biases that

families of color face, which can lead to health inequities and poorer outcomes.

Women of color and their families make up roughly 15% of PAT+ Pinellas's annual clients. Before the Health Equity CoIIN, PAT+ Pinellas had no race- or ethnicity-based goals or programming. Said Linda Thielman, "[Prior to the CoIIN], our goal was to provide all families with equal services. As a program, we have learned it's more important to make sure that all families receive *equitable* services."

Since beginning their journey in the Health Equity CoIIN, the PAT+ Pinellas team have made significant progress in their efforts to advance health equity within their organization. The team focused their work on Primary Driver 2: Antiracist infrastructure that centers families' lived experience and community context. Their aim was twofold:

By July 31, 2022, PAT+ Pinellas will work to build an antiracist infrastructure, as demonstrated by the following:

3

At least three policies were revised to address inequitable impact for clients and staff.

90%

At least 90% of staff engage in formal and informal opportunities to explore, discuss, and address health equity goals.



Hiring

The PAT+ Pinellas team's journey began with a review of their new-hire interview questions. They added four health equity-related questions to their standard list of questions and integrated them into the employee selection criteria. Following numerous rounds of testing, the team and their parent company, HSCPIn, adopted the four new questions as part of their standard hiring procedure.

PRIMARY DRIVER 2:

Antiracist infrastructure

SECONDARY DRIVER:

Data planning, collection, and analysis that centers health equity

CHANGE IDEAS:

Implement a standard process and training for accurate collection and entry of race, ethnicity, and language (REAL) data for the workforce and all home visiting participants, including ensuring that participants understand why and how REAL data are being collected and used (e.g., *We Ask Because We Care* initiatives). Data collection can and should extend to other dimensions of diversity, such as gender and sexual identity.

Questions to integrate into the interview form:

1. **Please describe a situation in which you worked on a project with people who were from backgrounds other than your own.** What was challenging for you in this work? What did you do to make your work together successful? (Listen to see if the candidate has reflected on the opportunities and challenges of creating inclusive workplace cultures.)
2. **How has your culture influenced your career goals?**
3. **What opportunities have you participated in to increase your knowledge of racial equity, inclusion, or diversity?** What did you learn, and how did you apply the learning?
4. **Tell us about a situation in which you were required to provide services to a diverse group of people.**

Data Collection

The Pinellas team made several changes to their intake and referral process:

- Intake staff reviewed the importance of collecting accurate demographic information.
- The team updated their data collection process during initial contact to collect more accurate and complete demographic information, including race, ethnicity and language.
- All staff were given a script they could use to engage families in data collection.

EXAMPLE FROM THE FIELD: HV CoIIN Team



PRIMARY DRIVER 2:

Antiracist infrastructure

SECONDARY DRIVER:

Data planning, collection, and analysis that centers health equity

CHANGE IDEA:

Implement a standard process and training for accurate collection and entry of race, ethnicity, and language (REAL) data for the workforce and all home visiting participants, including ensuring that participants understand why and how REAL data are being collected and used (e.g., *We Ask Because We Care* initiatives). Data collection can and should extend to other dimensions of diversity, such as gender and sexual identity.

Data are the foundation for any effort to eliminate inequities and advance health equity. First, data are essential in understanding where injustices are present. As the work ensues, ongoing data collection enables the team to measure their progress toward achieving health equity.

The Health Equity CoIIN sought to learn and model how to explicitly embed health equity considerations throughout data planning,

collection, and analysis. Below are some key examples of how the HV CoIIN team considered and addressed equity at each step of the process.

Data Planning

A community-developed tool: We wanted to make sure we used a tool that was developed in consultation with families. We especially liked the [Mothers on Respect index \(MORi\)](#), which was developed through participatory research with community members.

Centering family experience: We knew it was important to collect data that went beyond families' satisfaction with our services; we also needed to know more about each family's experience. The MORi specifically asked families about the nature of their interactions with their care providers and the program as a whole. Were the interactions respectful? Did families experience any discrimination?

Shared decision making: We shared the MORi with parent partners and asked if the questions reflected themes that mattered to the families they served. We also engaged parent partners in tailoring the tool for home visiting. The adapted tool is the Families on Respect Index.

Data Collection

Translation: To minimize barriers based on language, we asked local teams what languages the

Why disaggregate and stratify data? Disaggregating and stratifying data by race and ethnicity can ensure that trends across the wider population are not masking trends for subgroups.

survey would need to be available in so that all their families could participate. We ultimately translated the survey into four additional languages.

Demographic data: To identify any potential inequities, we went beyond the census categories for race and ethnicity and allowed respondents to self-identify.

Transparency: Before surveys were sent out, home visitors talked with families about the purpose of collecting the data and how it would be used and answered any questions that families had.

Data Analysis

Data literacy: This was the first time that many staff members had looked at disaggregated data. We provided training and resources to build home visiting staff's capacity to interpret the data and to empower them to use the data to improve their work.

Stratified data: On a quarterly basis, the HV CoIIN provided collaborative-wide and Local Implementing Agency-level data, stratified by demographic variables. This allowed us to look for potential inequities in how services were received.

Transparency: The HV CoIIN developed a flyer for programs to share the collected data with families. This transparency also created opportunities for family input on interpreting the data and action planning.

Qualitative data: Participants were able to add comments to their survey responses. We conducted a thematic analysis of the qualitative data and included qualitative stories to help contextualize the quantitative results.



EXAMPLE FROM THE FIELD:

Desoto and Hardee Counties, Florida



PRIMARY DRIVER 2:

Antiracist infrastructure

SECONDARY DRIVER:

Policies, program implementation, and resource allocation that share power with families as leaders and decision-makers at all levels of the home visiting system²

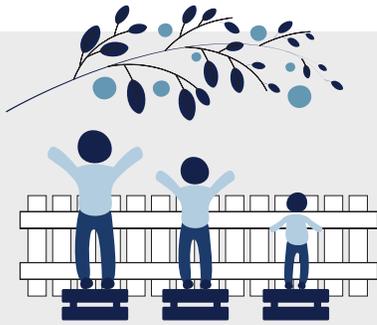
CHANGE IDEA:

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.

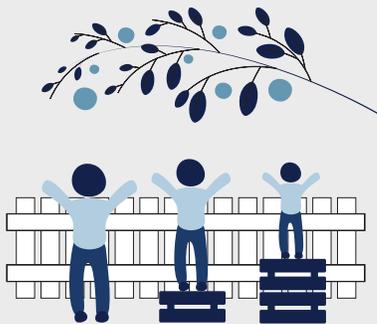
²Changes in this driver are taken from the Center for the Study of Social Policy's *Manifesto for Race Equity & Parent Leadership in Early Childhood Systems*, *Parent Engagement and Leadership Assessment Guide and Toolkit*, and the *EC-LINC Outcomes and Metrics Initiative*.

The Desoto-Hardee team acknowledged that a key factor in advancing health equity is centering service delivery around families' experiences. The team started by identifying and recruiting families to learn more about their needs. The team then worked with those families to prioritize the team's health equity efforts. This family engagement and direct communication from the onset allowed the team to engage in open conversations with families about the impact of racism on a family's health and opportunities that may exist to address related health issues. The team recruited five families to be active members of the Health Equity CoIIN team.

The Desoto-Hardee team also committed to improving the data they collected from families to better understand any specific service barriers their families faced. This allowed the team to center the expertise of families who were experiencing a disproportionate impact of health inequities and then make tailored changes to meet the needs of these families. Ultimately, the Desoto-Hardee team partnered with six agencies to streamline services and break down barriers for the families they served.

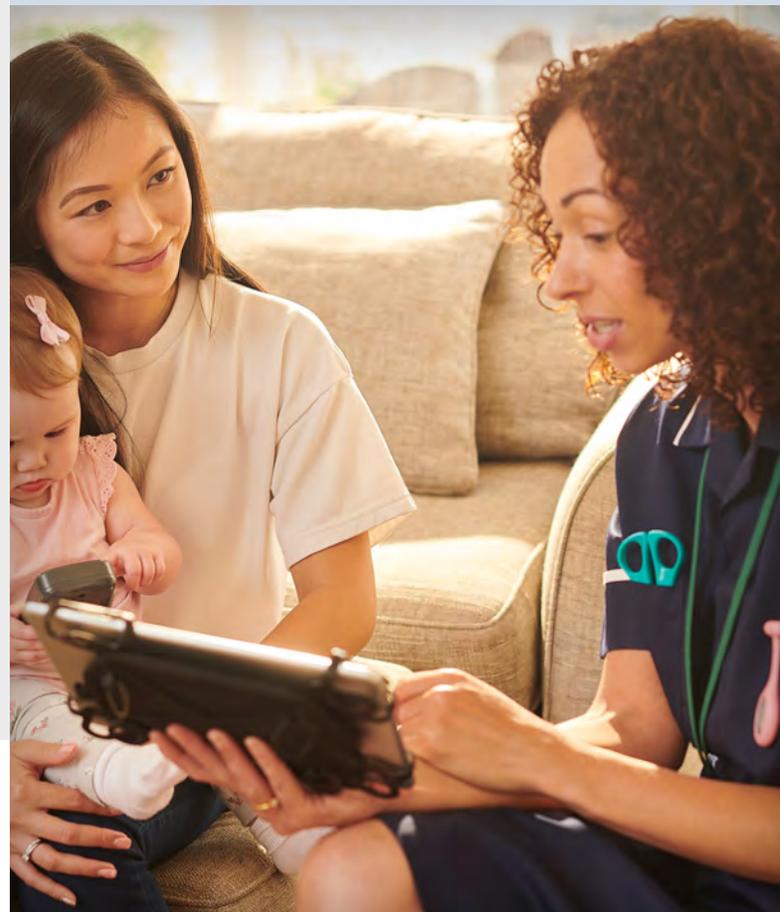


EQUALITY means that each individual or group is given the same resources and opportunities.



EQUITY recognizes that circumstances vary for each individuals and groups and allocates resources and opportunities to support them in reaching equal outcomes.

Family engagement and direct communication from the onset allowed the team to engage in open conversations with families about the impact of racism on a family's health and opportunities that may exist to address related health issues.



PRIMARY DRIVER 3:

CONTINUOUS QUALITY IMPROVEMENT THAT EXPLICITLY PROMOTES HEALTH EQUITY

While continuous quality improvement (CQI) has become a cornerstone of the MIECHV Program, CQI efforts may not benefit all populations equally. To ensure that CQI efforts do not create, maintain, or widen inequities in home visiting outcomes, teams need to explicitly consider health equity in all aspects of the CQI process.

Teams should understand the inequities that exist in the community and set specific aims to reduce those inequities. The change strategies that are tested will be most effective in promoting equity if they address root causes and are selected by and for families experiencing inequities. The secondary drivers and changes described below offer a set of tools and methods needed to promote health equity through QI efforts.

OUR STORIES

Example from the field:
Miami-Dade County, Florida



SECONDARY DRIVER: 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.



We had completed a survey, we asked families about the services they are receiving, medical provider, if they have insurance or not. After all, we were able to provide families with services from the community as Free clinic, dental clinic, Healthsource of RI. It was a great experience sharing with families the results from the survey to families and get the feedback of what they have learn.”—LIA

Specific

Measurable

Attainable

Realistic

Time-bound

Inclusive

Equitable

PRIMARY DRIVER 3:

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OUR STORIES

Example from the field:
Miami-Dade County, Florida



SECONDARY DRIVER: 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?
 - What barriers or unintended consequences should be accounted for to make this strategy effective in underserved communities?³
2. Identify root causes of inequities experienced by home visiting families, and then work to address systemic barriers.

RESOURCE

Check out the example *The 5 Why's* diagram (Figure 1) in this publication.

<https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2021.306>

³From *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).



PRIMARY DRIVER 3:

CONTINUOUS QUALITY IMPROVEMENT THAT EXPLICITLY PROMOTES HEALTH EQUITY

While continuous quality improvement (CQI) has become a cornerstone of the MIECHV Program, CQI efforts may not benefit all populations equally. To ensure that CQI efforts do not create, maintain, or widen inequities in home visiting outcomes, teams need to explicitly consider health equity in all aspects of the CQI process.

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OUR STORIES

Example from the field:
Miami-Dade County, Florida



SECONDARY DRIVER: 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.

RESOURCE

Check out the Institute for Healthcare Improvement's Equity Action Lab Implementation Guide for strategies and tools to bring together a diverse team, including people with lived experience, to make meaningful progress on a health equity goal in a short amount of time.

<https://www.ihl.org/resources/Pages/Tools/100-Million-Healthier-Lives-Advancing-Equity-Tools.aspx>



I have helped them understand health, poverty, and discrimination and in this role, I've helped them discover themselves and their voice in terms of health equity. When one of my families told me that they struggle to find work due to lack of work experience. She stated that she was treated unfairly and that she was told she was not hired because of a lack of skills. As her Family Support Specialist, I helped her gain confidence in herself by teaching her to speak up, ask the right questions, and recognize discrimination. She returned to the place where she had applied for work days later, expressed her concerns, and was hired."

—LIA/HV

EXAMPLE FROM THE FIELD:

Miami-Dade County, Florida



PRIMARY DRIVER 3:

Continuous quality improvement that explicitly promotes health equity

SECONDARY DRIVER:

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)

CHANGE IDEA:

Identify root causes of inequities experienced by home visiting families, and then work to address systemic barriers.

The Miami-Dade Health Equity CoIIN team started their journey toward health equity by focusing on CQI that explicitly promotes health equity in home visiting outcomes. Their first step was to gather data and actively seek the voices of the families they serve to better understand the experiences of these families with health inequities. Home visitors had discussions with families about key barriers they were facing in accessing community resources and services related to the social determinants of health.

Through this process, the team was able to narrow down improvement priorities that were meaningful to their families.

A related goal of this data collection was to share the results with community partners to raise awareness about inequities faced by their community. An immediate benefit of this transparency was an increased level of trust between the home visitors and their clients.

In the discussions, parents specifically reported their frustration with the inequities surrounding access to childcare. With access to affordable childcare as their top priority, the team began to explore the root causes of this issue. The team had learned from the families that a major barrier to childcare was difficulty applying for aid through the Early Learning Coalition (ELC). As noted by one home visitor:



A parent expressed that she was not able to receive services because she was not employed—but the mother was not able to find a job because she didn't have a safe place to leave her baby."

To combat this barrier, the team strove to simplify the application process by creating video tutorials to post on YouTube, in both English and Spanish, to walk parents through each step of filling out the application. They also created a checklist of documents that parents needed when applying for the ELC. In addition, the team actively built partnerships with local day-care providers to create a more accessible and trustworthy path for families in need of childcare.



The team pilot-tested the new materials with both English- and Spanish-speaking families. They received very positive feedback on the materials and moved forward with posting them on YouTube and disseminating them to families in need.

Analyze root causes, including the social and structural drivers of health inequities

Consider asking or reflecting on the following prompts:



How are families' unmet social needs contributing to the identified health inequities (e.g., food insecurity, housing instability, transportation barriers, social isolation, barriers to accessing health care)? Are there racial, linguistic, geographic (etc.) inequities in families' unmet social needs? Consider using family interviews or focus groups to assess families' unmet social needs.



How might institutional policies or practices be contributing to the inequities you have observed? What role can home visiting play in mitigate these inequities?



How are community-level, social, and geographic determinants of health—such as food deserts, housing, and other markers of structural racism and oppression (e.g., state laws, county-level policies)—contributing to the identified inequities prioritizes by families?

PRIMARY DRIVER 4:

ANTIRACIST SERVICE DELIVERY

Oppression, racism, and discrimination have been embedded in home visiting service delivery, leading to programs not meeting a wide range of families' needs. To advance health equity, home visiting programs must understand the lived experience of people in the community who are most impacted by inequities and then provide services that are respectful of and responsive to the lived experience of all individuals. Programs must look at all aspects of service delivery to assess what aspects are contributing to health inequities and where antiracist principles can be proactively applied. Home visiting staff can play an important role in acknowledging and addressing racism and removing systematic barriers that families experience.

OUR STORIES

Example from the field:
Saginaw County,
Michigan



Example from the field:
Desoto and Hardee
Counties, Florida



Example from the field:
Hillsborough, Florida



SECONDARY DRIVER: 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. Acknowledge, validate, and support families experiencing racial trauma, including any harm that may have been done by the home visiting program.
2. 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.
3. Normalize discussions about racism, oppression, and privilege by defining them and naming them as root causes of health inequities.
4. Establish a mechanism for partners, families, and staff to report inequitable care and episodes of miscommunication or disrespect within the home visiting program.
5. 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.



PRIMARY DRIVER 4:

ANTIRACIST SERVICE DELIVERY

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OUR STORIES

Example from the field:
Saginaw County,
Michigan



Example from the field:
Desoto and Hardee
Counties, Florida



Example from the field:
Hillsborough, Florida



SECONDARY DRIVER: Outreach and recruitment that engages the families disproportionately 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.

PRIMARY DRIVER 4:

ANTIRACIST SERVICE DELIVERY

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OUR STORIES

Example from the field:
Saginaw County,
Michigan



Example from the field:
Desoto and Hardee
Counties, Florida



Example from the field:
Hillsborough, Florida



SECONDARY DRIVER: 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.

PRIMARY DRIVER 4:

ANTIRACIST SERVICE DELIVERY

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OUR STORIES

Example from the field:
Saginaw County,
Michigan



Example from the field:
Desoto and Hardee
Counties, Florida



Example from the field:
Hillsborough, Florida



SECONDARY DRIVER: 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.



Thinking about the whole family! A worker that I had know for many years followed through with asking the questions that was on our encounter form and found out that the older sibling of the child that we were working with did not have a pediatrician and had not been seen by a pediatrician in some time. In the past this worker would have never asked about the older sibling or explored where the best pediatrician is located."—*Team member, LIA*

EXAMPLE FROM THE FIELD: Saginaw County, Michigan



Supporting staff in delivering antiracist family-centered service: A focus on culturally competent and mental health care

PRIMARY DRIVER 4:

Antiracist service delivery

SECONDARY DRIVER:

Culturally appropriate and linguistically responsive home visiting services and coordination that address the multiple determinants of health

CHANGE IDEA:

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.

Based on one component of their values statement (“Ensure that all have the training and resources needed to work toward advancing health equity”), the Saginaw COLLN team partnered with the Saginaw County Community Mental Health Authority (SCCMHA) to deliver mental health training to all staff to mitigate the barrier of stigma surrounding mental health and its intersectionality with culture.

The group had a long discussion about mental health stigma and how culture can impact a family’s comfort around seeking mental health services. The team agreed that the first step in addressing this concern was to ensure that all staff were adequately educated and trained.

The Saginaw COLLN team communicated with the SCCMHA to determine when the next one-day Mental Health First Aid training was set to take place. Supervisors then worked to ensure that all available staff members and home visitors from both programs registered for the training. The team found the training impactful, in particular noting the suggested strategies for working with families who are experiencing a mental health crisis or mental health concerns. The team also learned to use ALGEE as an assessment tool and action plan (see inset).

What is ALGEE?

ALGEE is a step-by-step action plan to use when providing support to someone who may be experiencing a distressing situation.

A—Approach and assess for risk of suicide or harm. Try to find a suitable time or place to start the conversation with the person, keeping their privacy and confidentiality in mind. If the person does not want to confide in you, encourage them to talk to someone they trust.

L—Listen nonjudgmentally. Many people experiencing a challenge or distress want to be heard, so let the person share without interrupting them. Try to have empathy for their situation. You can get the conversation started by saying something like, "I noticed that . . ." Try to be accepting, even if you don't agree with what the person is saying.

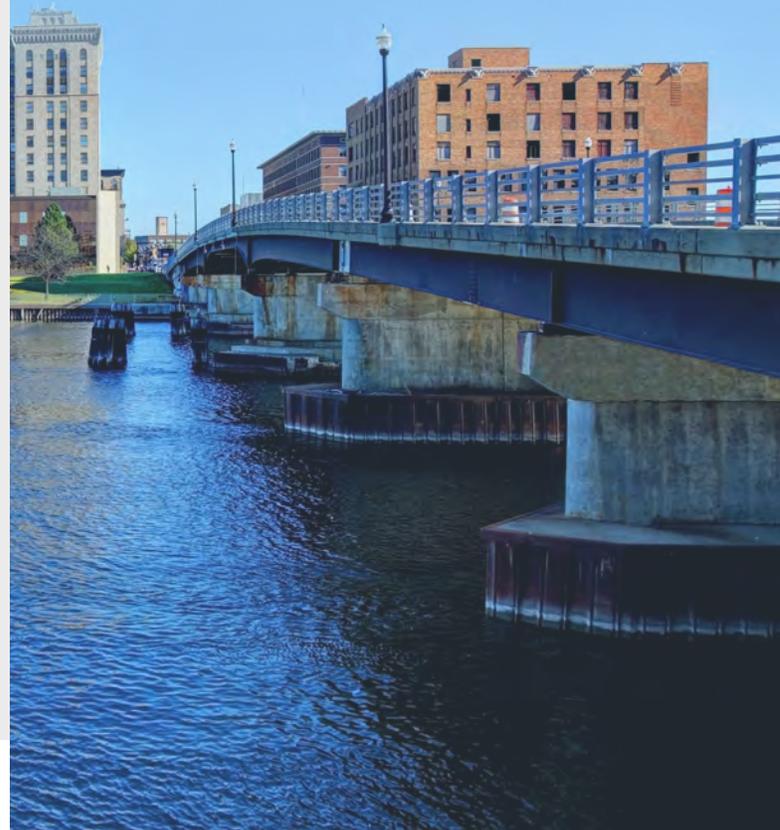
G—Give reassurance and information. After someone has shared their experiences and emotions with you, be ready to provide hope and useful facts.

E—Encourage appropriate professional help. The earlier someone gets help, the better their chances of recovery. It's important to offer to help the person learn more about the options available to them.

E—Encourage self-help and other support strategies. This includes helping them identify their support network, finding programs within the community, and creating a personalized emotional and physical self-care plan.

—From "*ALGEE: How MHFA Helps You Respond in Crisis and Non-crisis Situations*," *Mental Health First Aid*, April 15, 2021

The Saginaw CoIIN team found the training impactful, in particular noting the suggested strategies for working with families who are experiencing a mental health crisis or mental health concerns. The team also learned to use ALGEE as an assessment tool and action plan.



EXAMPLE FROM THE FIELD: Desoto and Hardee Counties, Florida



PRIMARY DRIVER 4:

Antiracist service delivery

SECONDARY DRIVER:

Identify and address disrespectful care and its impact on health outcomes in communications with families

CHANGE IDEAS:

Listen to families to understand the impact of racism on their lives, decisions, and self-identified goals.

As the Desoto and Hardee team had ongoing communication with families about racism and its impact on health, families began wanting to explore these topics further and to start the conversation about racism with their children in an age-appropriate way. To support families in this goal, the team identified children's books that specifically address topics of race and racism. Home visitors then shared a different book each month during their visits with families; the team started sharing the books at community events as well. This created a way to engage families both within and outside the home visiting program in conversations regarding racism and health inequities. Parents expressed how great these books are as a start for children to understand race and culture.

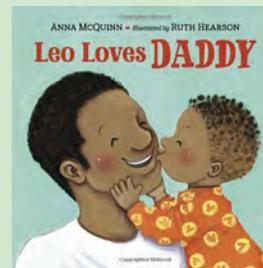
Children's Books to promote Equity



Our Skin: A First Conversation About Race (Board Book)



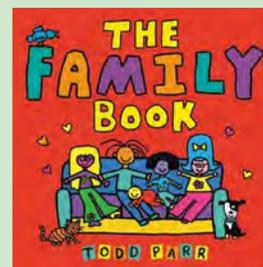
Amazing me! Sing! ¡Soy sorprendente! ¡Canto! (Bilingual, English/Spanish) (Board Book)



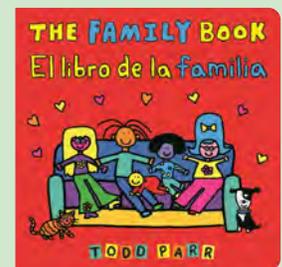
Leo Loves Daddy (Board Book)



Happy Hair (Board Book)



The Family Book (English)(Board Book)



The Family Book/ El libro de la familia (Bilingual, English/Spanish) (Board Book)



RESOURCE

During this period, the team recruited five parent leaders to join the Desoto-Hardee Health Equity team. Access the [HV CoIN Parent Leadership in CQI Toolkit](#)

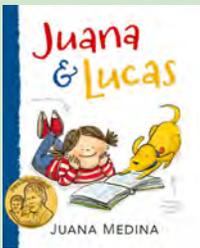
EXAMPLE FROM THE FIELD: Hillsborough, Florida



Can I Play Too?



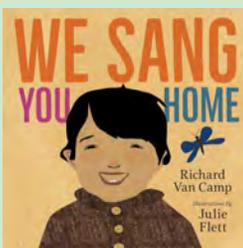
Sulwe



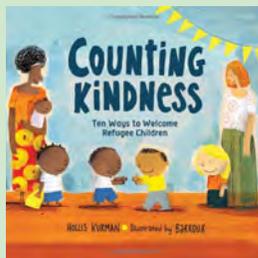
Juana & Lucas



Cool Cuts



We Sang You Home
(Board Book)



Counting Kindness:
Ten Ways to Welcome
Refugee Children



The Feelings Book/El libro de los
sentimientos (Bilingual,
English/Spanish)

PRIMARY DRIVER 4:

Antiracist Service Delivery

SECONDARY DRIVER:

Culturally appropriate and linguistically responsive home visiting services and coordination that address the multiple determinants of health

CHANGE IDEA:

Ask questions to learn about a family's cultural background and context

The team identified the need to incorporate conversations on family culture into home visits. To ensure that their chosen curriculum and programming were culturally and linguistically responsive and antiracist, the team used Nurse-Family Partnership resources to engage families in meaningful conversations on culture. The resources include a series of questions and prompts that families can respond to share more about what is important to them. These resources were incorporated into the formal home visiting curriculum between week 5 and week 7.

PRIMARY DRIVER 5:

COMMUNITY RELATIONSHIPS AND LINKAGES THAT CENTER FAMILIES' STRENGTHS AND NEEDS

One of the critical roles of home visiting is to connect families to services and supports in the community. To achieve health equity, home visiting programs must partner with trusted community organizations to address the structural and social determinants of health. This includes partnerships with, for example, health-care institutions, childcare, and community-based organizations with established relationships in the community. This driver sets forward the importance of establishing linkages across sectors and organizations and developing relationships with organizations with established trust in the community to support families with their priority needs. It also makes that case that processes, and relationships founded on trust are necessary to ensure sustainability.

OUR STORIES

Example from the field:
Federal Hill House, Providence,
Rhode Island



FEDERAL HILL HOUSE

SECONDARY DRIVER: 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.



Building community partnership with other programs and services that aligned with our goals was important to begin that transformation. Partnering with schools and daycares brought like minds together to expand our reach in the community.”—LIA

PRIMARY DRIVER 5:

COMMUNITY RELATIONSHIPS AND LINKAGES THAT CENTER FAMILIES' STRENGTHS AND NEEDS

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OUR STORIES

Example from the field:
Federal Hill House, Providence,
Rhode Island



FEDERAL HILL HOUSE

SECONDARY DRIVER: 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.



I have seen there are areas where we need to work on with families. For instance, their rights in medical homes and the racial side for participants.”—LIA

EXAMPLE FROM THE FIELD: Federal Hill House, Providence, Rhode Island



PRIMARY DRIVER 5:

Community relationships and linkages that center families' strengths and needs

SECONDARY DRIVER:

Community collaboration that responds to the diversity of families' needs and strengths and addresses the structural and social determinants of health

CHANGE IDEA:

Promote linkages between home visiting services and primary health care, including the medical home.

The overarching goal of the Federal Hill House (FHH) Health Equity CoIN team was to ensure that all of their families had medical insurance and were established in medical homes (see inset). The team decided to root their equity work within Primary Driver 5.

The team began their work with a conversation between home visitors and each family regarding the family's access to health insurance and a medical home. The team found that of the 75 families enrolled in their home visiting program, 56 (75%) had medical insurance and medical homes, 5 (6%) had a medical home but no insurance, and 14 (19%) had neither medical

insurance nor a medical home. These initial conversations enabled the team to work collaboratively with families and connect them with services to support their needs.

The team also sought to understand families' experiences with systemic, institutional, and individual racism and to help them break down any barriers. First, the team surveyed families regarding their experience with medical homes, such as the clinics' ability to provide linguistically appropriate care, information on services and patients' rights, and payment alternatives. The team then used these responses to partner with providers and advocate for their families' rights.

The team also drew on the responses to make needed improvements to their families' health care experiences. For example, the team distributed "I Speak" cards to their families, which are designed to help communicate the need for an interpreter. One side of each card is in English, and the other is in the user's primary language.

Finally, the FHH team worked to link their families directly with local providers. The team used monthly group connections to link families to different kinds of service providers, including health care, oral health, and behavioral health. These group connections also created a space to address any concerns families might have and prompted the home visiting team as well as families to discuss improvements directly with their providers.

The success of the FHH team's efforts are reflected in the Families on Respect index, a tool for collecting family-level data. At the start of the collaborative,

75% of respondents agreed that their personal experience, knowledge, and choices are respected

83% agreed that their family or cultural traditions are supported

100% of respondents agree with both statements, marking a

25% and **17%** increase, respectively.

The families that FHH is working with have never felt more respected and supported in their unique identities, thanks to the hard work of the FHH team!

RESOURCE

American Academy of Pediatrics Calls for Elimination of Race-Based Medicine"

<https://www.aap.org/en/news-room/news-releases/aap/2022/american-academy-of-pediatrics-calls-for-elimination-of-race-based-medicine/>



A Medical Home

is described by the American Academy of Pediatrics as "primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective." A medical home is not a tangible place but rather a network of coordinated and specifically tailored care for all patients. Medical homes aim to advance health equity through various aspects, including:

- improving patient trust in providers, particularly in certain communities that have a history of mistrust in and mistreatment by health care providers
- providing culturally competent and linguistically appropriate services
- providing comprehensive health care that centralizes services to prevent multiple *appointments, thus increasing accessibility*
- including REAL data in medical records in order to be aware of and proactive about disparities that could otherwise be overlooked or perpetuated

—From "How Medical Homes Can Advance Health Equity" by Ignatius Bau, April 2016



Contact HV COIIN for assistance, support, or more information on this Health Equity Toolkit (HVCoiIN@edc.org).

CONCLUSION

This HV CoIIN *Health Equity Toolkit* offers practical strategies for MIECHV awardees and their LIAs to advance health equity in home visiting. MIECHV awardees and LIAs can enter this work through any of the drivers in the Health Equity Framework. The Health Equity Assessment can help teams identify their areas of strengths and opportunities for growth.

Awardees are encouraged to reach out to the HV CoIIN team (HVCoiIN@edc.org) to learn more about upcoming cohorts and for additional support on building the will for health equity work, testing change ideas, identifying custom measures, and using CQI methods, tools, and resources.

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HV CoIIN 3.0 brings together Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program awardees and local home visiting service agencies to engage in collaborative learning, rapid testing for improvement, sharing of best practices, scaling of tested interventions and building of QI capacity.

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