FROM THE FIELD:

What Title V Agencies are Doing to Address Health Equity, Social Determinants of Health, and Racism

Priorities and Strategies Drawn from the 2022 MCH Block Grant Applications/2020 Reports

This high-level summary of priorities and strategies from State Action Plans in the Title V Information System is meant as a conversation starter. It is not a comprehensive listing of all activities conducted by the states and jurisdiction, but representative of those activities highlighted in State Action Plans. Please contact the MCH Evidence Center to learn more about how your Title V agency can integrate similar, evidence-based/informed activities into your work.

HEALTH EQUITY – 11 agencies are addressing health equity explicitly with 46 strategies		
State	**Priority Needs**	**Strategies**
AK	Promote health equity, improve social determinants of health, and identify and deconstruct systems of institutionalized oppression for maternal and child health populations.	• Provide staff training and development opportunities in health equity, implicit bias and anti-racism. • Conduct ongoing assessment of equity impacts of Title V strategies across domains. • Promote equitable use of resources to work towards elimination of structural racism. • Collect, analyze, and disseminate data and information on health equity topics.
AZ	Engage individuals, families, and communities as partners in the development and implementation of programs and policies to create people-centered programs that promote health equity.	• Place trained family advisors at all levels across the BWCH administrative offices to support MCH programming as key partners in health care decision-making. • Engage partners and stakeholders to promote and participate in the Engaging Families and Young Adult Program to place trained family advisors across all sectors.
HI	Address health equity and disparities by expanding pediatric mental health care access in rural and under-served communities.	• Refine, develop and implement pediatric mental health care access model. • Promote workforce development and training on pediatric mental health care. • Support services and linkages in communities.
ID	Improve social determinants of health and promote health equity for maternal and child health populations.	• Support topical statewide learning collaboratives for health care professionals focused on quality and practice improvement for MCH populations. • Support implementation of the Get Healthy Idaho initiative as a community led, place-based model to improve social determinants of health and health equity. • Support implementation of the Project ECHO model or similar models with the goal of increasing knowledge and capacity of Idaho health care professionals to provide best-practice specialty care to MCH populations.
IA	Infusing Health Equity with in the Title V System.	• Inclusion of health equity plan requirement language in BFH grant agreements. • Increase the percent of contractors that demonstrate application of health equity strategies.

		• Utilize Health Equity Advisory Committee (HEAC) to provide input into the health equity strategies for each NPM and SPM and local contractors. • Inclusion of health equity activities in all Title V funded BFH Staff positions. • Increase the percentage of Title V Contractors that engage diverse participant voices in program planning, decision making and implementation. • Build internal capacity within the Bureau of Family Health/Title V Program Health Equity Team; completion of an organizational assessment of equity practices, and facilitation of staff professional development and technical assistance. • Develop and implement a data analysis plan to assess distribution of Title V resources and services through a health equity lens. • Conduct an environmental scan of current contractors engagement in health equity and presence of health equity plans.
NC	Increase health equity and eliminate disparities and address social determinants of health.	• Deploy the DPH Health Equity Survey within the WCHS. • Launch DPH Health Equity Foundational Training in Learning Management System. • WCHS will identify how they are currently incorporating the five DPH Health Equity Framework strategies into their work. • WCHS will identify additional ways they can incorporate the five DPH Health Equity Framework strategies into their work. • WHB will continue to require all LHD staff, clinical and nonclinical to participate in at least one training annually focused on health equity, health disparities, or social determinants of health to support individual competencies and organizational capacity to promote health equity. This requirement is part of their agreement addenda. LHDs are provided a list of low-cost trainings or continuing education opportunities. • WCHS will work with NC CARE360 partners to identify how food insecurity screening, referrals and follow up being tracked in NC CARE 360 and conducted through LHD's can be enhanced. • Increase training to child health staff around nutrition/food insecurity; create training package; and identify audiences in WCHS and across DPH that would also benefit from these trainings and materials.
OH	Improve health equity by addressing community and social conditions and reduce environmental hazards that impact infant and child health outcomes.	• Select and implement health equity-increasing strategies in all state priority areas. • Build bureau equity workgroup. • Develop plan for improving internal MCH organization equity and staff capacity through bureau workgroup. • Develop plan to institutionalize health equity in policy, program, grant, and contract administration through bureau workgroup. • Build diversity in CMH Parent Advisory Committee.

OK	Increase health equity for the MCH population.	• Distribute preconception/interconception health materials at community events (Farmer's Markets, Community Baby Showers, etc.). • Create and provide targeted preconception health information to populations in need of the information as identified by PRAMS and other data sources. • Continue to assist all clients visiting a county health department for a preventive health visit with development of a reproductive life plan. • Develop social media messages and expand social media venues to reach reproductive age females and males.
PA	Support and effect system change by promoting policies, programs and actions that advance health equity, address social determinants of health and deconstruct systems of institutionalized oppression.	• Increase the number of youths who are receiving sexual health services and education, including effective contraception methods.
RI	Adopt social determinants of health in MCH planning and practice to improve health equity.	• Youth Advisory Council. • Health Equity Zones.
TX	Implement health equity strategies across all maternal and child health populations.	• Identify best and promising practices to increase maternal health equity and prioritize reduction and elimination of disparate outcomes in all DSHS maternal health programming. • Identify best and promising practices to increase maternal health equity and prioritize reduction and elimination of disparate outcomes in all DSHS maternal health programming. • Strengthen community engagement in health equity work. • Implement, and use continuous quality improvement and evaluation to assure, use of evidence based/evidence informed interventions to reduce disparities and increase health equity. • Develop and promote educational opportunities for health care professionals and other stakeholders on maternal health equity. • Foster partnerships, promote best and promising practices, and increase uptake of recommended health and racial equity practices. • Partner with health care organizations and provide technical assistance and support for health and racial equity quality improvement.

SOCIAL DETERMINANTS OF HEALTH (SDOH) – 8 agencies are addressing SDOH explicitly with 25 strategies		
State	**Priority Needs**	**Strategies**
FL	Address the social determinants of health that influence the relationship between health status and biology, individual behavior, health services, social factors, and policies.	• Partner with local health departments in their childhood immunization, dental clinics, and well-child visits to encourage reading using the Reach Out and Read model, where a health professional distributes books to children at a well-child visit and emphasizes key reading strategies to parents (example: the importance of reading aloud to a child daily).
ID	Improve social determinants of health and promote health equity for maternal and child health populations.	• Support topical statewide learning collaboratives for health care professionals focused on quality and practice improvement for MCH populations. • Support implementation of the Get Healthy Idaho initiative as a community led, place-based model to improve social determinants of health and health equity. • Support implementation of the Project ECHO model or similar models with the goal of increasing knowledge and capacity of Idaho health care professionals to provide best-practice specialty care to MCH populations.
MO	Address Social Determinants of Health Inequities.	• Ensure culturally and linguistically appropriate resources, education, and care are available for all women of childbearing age, mothers, children, and adolescents, including children and youth with special health care needs, and their families. • Promote breastfeeding in a culturally appropriate manner. • Educate DHSS Title V partners on the medical home approach and definition of children and youth with special health care needs. • Encourage and employ person-centered approaches to Title V programming. • Operationalize core MCH values, establish a standard level of training on the MCH Leadership Competencies, and create a plan to implement training to all Title V funded partners. • Build program and policy evaluation capacity.
NH	Increase the focus of Title V on the Social Determinants of Health and the resolution of barriers impacting the health of the MCH population.	• MCH requires all CHCs to submit a two-year ES work plan as a contract deliverable within 30 days of each contract period. • Review ES work plans and provide feedback/technical assistance as needed to ensure agencies have included specific, measurable, achievable, realistic and, timely (or time-bound) SMART objectives/goals and a target for each State Fiscal Year (SFY). • At the end of each SFY, MCH will review ES work plans outcome sections to determine the percentage of CHCs attaining their target(s). • At the end of each SFY, MCH will review and provide feedback/technical assistance as needed on the plan for improvement section(s) of CHCs not meeting their target(s).

OR	Enhanced social determinants of health.	• OCCYSHN will increase access to needed care and supports through investigation of barriers that inhibit CYSHCN and their families' timely access, and develop family-informed activities to reduce or eliminate the barriers. • Foundations - policy & systems: Strengthen economic supports for families through policy development and implementation. • Foundations - policy & systems: Develop and/or strengthen systems and partnerships to address food security and barriers to accessing food resources. • Foundations - policy & systems: Foster cross-system coordination and integration to ensure screening and referral for SDOH, and equitable access to needed services for the MCAH population • Foundations - policy & systems: Develop and implement systems that actively promote equitable, anti-racist, and trauma-informed workplaces, institutions, and services. • Foundations - policy & systems: Strengthen policies and systems that provide equitable access to safe, stable and affordable housing for the MCAH population. • Foundations - assessment & evaluation: Conduct continuous needs assessment and/or exploratory analysis to add to the SDOH, Equity, CLAS, and Trauma/ACEs knowledge base and improve effectiveness of Title V foundational interventions and innovations.
SC	Reduce disparities in SDoH, including barriers to medical care, especially behavioral and mental health care, fatherhood involvement, and racism/discrimination.	• Address SDoH by further sharing results from our public input survey SDoH questions (including reactions to racism), and reverse data walk. • Keep our partners and Advisory Committee members engaged by sharing and discussing all results from our disparity work and use it to guide future plans and activities impacting women, children and their families. • Collaborate with the SC Center for Fathers and Families to expand fatherhood engagement and support programs to additional communities across the state. • SPM 3: Implement the CDC Hear Her Campaign • SPM 4: Develop a social marketing/awareness campaign to increase families' efficacy to access available resources and services

RACISM – 5 agencies are addressing racism explicitly with 47 strategies		
State	**Priority Needs**	**Strategies**
MA	Eliminate institutional and structural racism in internal Department of Public Health programs, policies, and practices to improve maternal and child health.	• Embed into MDPH opportunities for staff to engage in ongoing learning and dialogue, such as workshops, affinity groups, and town hall meetings, to promote common language, shared understanding, and authentic support for a public health framework centered on racial equity. • Develop tools and resources to identify and address institutional racism within core elements of public health work – such as program planning, community engagement, procurement, and data collection and analysis – and build staff capacity to use them in the implementation and monitoring of MDPH-funded programs. • Provide leadership to the Cross-Department Racial Equity Collaborative, which aims to share best and promising practices for eliminating institutional racism and align related activities happening across MDPH. • Foster a workplace culture that acknowledges and addresses the impact of systems of oppression on staff, including microaggressions, to improve staff retention. • Implement changes to the hiring and recruitment process to increase employment of staff with intersectional identities, including those with disabilities, of diverse genders, and people of color.
VA	Racism: Explore and eliminate drivers of structural and institutional racism within OFHS programs, policies, and practices to improve maternal and child health.	• Engage in Healthy Beginnings with Title V: Advancing Anti-Racism in Preterm Birth prevention – Learning and Practice Cohort • Partner with Blue Ridge Health District in CityMatCH Alignment for Action Learning Collaborative • Support 35 local health districts in developing and maintaining equity-focused, data-driven workplans aligned with findings from the 2020 MCH Needs Assessment and local Community Health Assessments, to include (1) MCH equity considerations, (2) coordination with community-based organizations, (3) upstream/cross-sector strategic planning, and (4) coordination with broader systems of care for children. • Identify internal VDH partners to explore impact and define strategies across MCH population regarding Virginia's 2021 marijuana legalization.
MS	Implicit Bias/Discrimination/Racism.	• Develop structures and processes to consistently center the experiences and ideas of historically marginalized populations. • Provide education and training to strengthen clinicians' knowledge of public health and structural/social drivers of health and inequities. • Engage in cross-sector collaboration and advocacy efforts.

		• Incorporate racial equity training into individual staff training plans and minimum strategic planning requirements into subrecipient agreements. • Provide support and education to MCH Title V regional and central office staff, and interagency staff on planning and implementing MCH programs with attention to racial equity and upstream factors. • Pilot racial equity training with internal and statewide partners. • Review MCH Tile V current policies that address racial equity.
NY	Promote awareness and enhance availability, accessibility and coordination of services for families and youth, including CYSHCN, with a focus on areas impacted by systemic barriers, including racism.	• Engage youth with special health care needs (YSHCN) and their families in state and local efforts to improve systems and practices for supporting YSHCN. • Enhance care coordination, including transition support services, for children and youth with special health care needs. • Apply public health surveillance and data analysis findings to improve services and systems related to health and health care for children and youth with special health care needs. • Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact the health and well- being of children and youth with special health care needs.
	Cultivate and enhance social support and social cohesion opportunities for individuals and families who experience isolation as a result of systemic barriers including racism, across the life course.	• Incorporate specific activities to promote the wellness of adolescents across all Title V programs, including promoting and facilitating routine well visits, reproductive health care, oral health, and behavioral health. • Promote supports for adolescents to gain the knowledge, self- efficacy, and resources they need to prepare for and transition to adulthood. • Apply public health surveillance and data analysis findings to improve services and systems related to children's health and health care. • Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact adolescents' health and well-being.
	Acknowledge and address the fundamental challenges faced by families in poverty and near-poverty, including the "working poor" as a result of systemic barriers, including racism.	• Integrate specific activities across all relevant Title V programs to promote the health and wellness of people of child-bearing age, including enrollment in health insurance, routine well visits, pregnancy planning and prevention, prenatal, and postpartum care through coordination and linkages across systems of care (hospitals to community). • Strengthen coordination between birthing hospitals, outpatient health care providers, and other community services to make support for birthing parents and their families more comprehensive and continuous. • Apply public health surveillance and data analysis findings to improve services and systems related to maternal and women's health care. • Apply a health equity lens to Title V activities to address social determinants of health and reduce disparities that impact women's health and use of health care across the life course.

MI	Develop a proactive and responsive health system that equitably meets the needs of all populations, eliminating barriers related to race, culture, language, sexual orientation, age and gender identity.	• Educate the Regional Perinatal Quality Collaboratives (RPQCs) regarding low-risk Cesarean data • Regional representatives will share ongoing information with RPQCs regarding the Obstetrics Initiative (OBI) and Alliance for Innovation on Maternal Health (AIM) bundle on safe reduction of primary cesarean birth • Continue partnering with the American College of Obstetricians and Gynecologists (ACOG) Alliance for Innovation on Maternal Health (AIM) and work through MI-AIM to increase the number of birthing hospitals participating in MI-AIM • Include bias and equity training as part of the MI-AIM hospital designation criteria • Partner with MPHI to train 100 clinicians on bias and equity • Provide ongoing bias and equity training to MI-AIM Steering and Operations Committee members • Launch Maternal Infant Health (MIH) Health Equity Action Committee • Provide ongoing education and training regarding bias and equity for the Michigan Maternal Mortality Surveillance Review Committee members • Support the provision of contraception to low-income, uninsured, and underinsured people who can get pregnant in the Family Planning Program • Facilitate long-acting reversible contraceptive (LARC) training opportunities for Title X and other health care providers • Support the integration of telehealth as a service delivery tool across Family Planning's network • Translate regional learning session findings into action for people of reproductive age who can get pregnant • Convene at least one training for 50 health care professionals on systemic racism and reproductive health • Support at least 10,000 minors' and young adults' (i.e., 18 to 21 years old) access to publicly funded contraception • Translate regional learning session findings into action for minors and young adults • Obtain youth input on Family Planning's website content • Discuss reproductive life planning with at least 25,000 women in the Family Planning Program • Support the Maternal Infant Health Action Committee aimed at optimal birth spacing and healthy weight babies • Apply a reproductive justice framework within Family Planning and related maternal and infant health projects

Planning Next Steps. The MCH Evidence Center is here to support you. You can access the following resources to help you identify evidence-based/informed strategies, align your strategies to advance your NPMs, and create meaningful measurements for your strategies. You can also contact us for technical assistance.

Learn More with these Guides:

- **Accelerate with Evidence.** Identify effective strategies and adopt/adapt them to meet the needs of your populations.
- **Think Upstream to Plan.** Understand population and performance level thinking and how to plan to see results.
- **Work Together with Equity Tools.** Find the right tool at the right time to advance health equity within SDOH.

Implement What You've Learned with these Tools:

- **MCHbest Database.** Access over 175 evidence-based/informed strategies and approaches to model your ESMs on.
- **NPM Toolkits.** Use these 15 toolkits for detailed explanations of the evidence and additional resources.
- **Developing Stronger ESMs.** Follow the full RBA process to assist in developing new or reviewing current ESMs.
- **The Role of Title V in Adapting and Implementing Strategies.** Read about common strategies that Title V supports.
- **Turn-the-Curve Strategy Tool.** Use this tool to develop new strategies that align with your population needs.
- **ESM Quadrant Measurement Tool.** Use this tool to develop strong ESMs to measure your strategies.
- **ESM Checkup Tool.** Use this tool to review your current ESMs to make sure they are as strong as possible.

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