Applying a Health Equity Lens to Analyze Performance Data and Inform Continuous Quality Improvement Work

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program helps children and families get off to a better, healthier start and aims to improve the well-being of both parents and children across the lifespan.[i] Conditions in the places where people are born, live, learn, work, and play have profound effects on overall well-being and a wide range of health risks and outcomes, including many that home visiting aims to influence. Attending to these social determinants of health promotes health equity, where everyone has the opportunity to attain their full health potential and no one is vulnerable from achieving this potential because of their social position or other socially determined circumstances.[ii, iii]

MIECHV awardees can advance their health equity goals by working to understand and address the social and structural factors that affect health outcomes for the families in their state or territory home visiting program. This may require a

> **Health equity is the underlying principle motivating efforts to eliminate health disparities, which refer to the systemic health differences adversely affecting vulnerable groups.[iv] Improving health disparities is how we measure progress toward health equity.[v]**

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new approach to services that prioritizes the needs of the most vulnerable and disadvantaged populations. As the Institute for Health Care Improvement (IHI) notes, "quality improvement often focuses on populations where success is most easily achieved. But if we are going to start reducing disparities, we need to start with the 'last' population—one that may be more challenging and just not thriving…And if we can solve problems for those at the margins, we may come up with solutions that work better for all."[iv] Realizing health equity calls for a team approach, including program directors and managers, data and quality improvement staff, and home visiting staff and participants. This resources discusses how awardee teams can begin to use performance data and other information to support local implementing agencies (LIAs) to identify health disparities, interpret findings, and design interventions to improve health equity. This includes strategies for dissagregating data, meaningfully partnering with communities, and designing equity-focused continuous quality improvement (CQI) projects.

Analyzing Data to Identify Inequities

MIECHV data collection and reporting requirements provide awardees with data that can be analyzed with a health equity lens. These data can be disaggregated, or separated, by certain variables of interest, such as race, ethnicity, geography, or income to compare outcomes between groups. This type of subgroup analysis can be helpful to identify disparities in the populations you serve. It can also be a starting point to engage communities in a dialogue about health equity. For awardees and LIAs without access or capacity to disaggregate MIECHV data, consider other sources that would allow you to explore outcomes by group. This could include county health rankings, state or local administrative data, or information gathered as part of your MIECHV needs assessment.

Data Quality

First, ensure you are using quality data.[1] Quality data are critical for accurate analysis. Using data that are not high quality can lead to faulty analysis and conclusions that do not accurately represent the community or subgroup.[2] Collecting quality race and ethnicity data may be particularly challenging for MIECHV programs and can result in more missing data than expected. Some families may not identify with the categories offered through required data collection. For example, if a home visiting program serves a majority Hispanic community, it may be helpful to understand and include specific categories of Hispanic/Latino that are present in the community. The Health Research and Educational Trust Disparities Toolkit provides suggestions on overcoming barriers (e.g., how to ask questions, which categories to include) when collecting race and ethnicity data.[vii]

It is also important to look at your data collection practices and tools to understand possible reasons for incomplete data and how bias may affect your data. For example, consider how questions and response options are framed, who collects the data, in what setting, and the potential power dynamics at play. Responses may have different meanings across groups, or certain data elements may be more relevant to the community's experiences and needs. A shared understanding of the questions asked of home visiting families helps to ensure accurate responses. Engaging community stakeholders in conversations about home visiting programs can help to frame data collection in a way that empowers and resonates with the community.

Massachusetts uses a roadmap to "improve the process by which data are used to identify, contextualize, and address racial inequities in health."[vi] The roadmap is used to reframe their process of analyzing data to consider a health equity lens.

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1   Quality data are complete (all values are present), accessible (available when required), relevant (answer the proposed questions), accurate (free from errors), and reliable (data are consistent).

2   For more information on data quality, see Continuous Quality Improvement Toolkit: A Resource for Maternal, Infant, and Early Childhood Home Visiting Program Awardees, Module 2: Using Data to Drive CQI and Identify Topics.

Subgroup Analysis

When beginning to analyze your data, consider which subgroups may be experiencing different outcomes. Race, ethnicity, income, rural/urban, education level, and country of origin are common variables to consider when constructing subgroups for an analysis of equity. Use knowledge of the community your program serves, as well as families' own reflections on categories or identities that are significant to them to determine appropriate and meaningful subgroups for analysis. You may also refer to existing knowledge about health disparities among particular groups at the national level to understand if that pattern presents in the state/territory or local home visiting program. For example, in the United States, non-Hispanic black infants are less likely to ever breastfeed than non-Hispanic white and Hispanic infants.[viii] Exploring your program's breastfeeding data by race and ethnicity can reveal if these disparities exist in your community and inform next steps to better engage and support groups with lower breastfeeding rates.

One challenge with breaking out data by category is that it may result in small subgroups. In some cases, subgroups may be so small that identification of individuals is possible. To protect the privacy of families, only share or display information for subgroups of a certain size. State agencies often have set policies for appropriate sample sizes to inform your decision-making. You may also wish to increase the size of subgroups by pooling data across multiple years, by geographic region, or combining subgroups (e.g., comparing white versus nonwhite groups).

When sharing subgroup data, display the data in a way that will be easy to interpret for stakeholders with various backgrounds. This may include using a table, chart, or infographic. It may be helpful to partner with community members as you prepare the data to ensure that subgroups are named with culturally appropriate language and in a way that resonates with the community. Before sharing data publicly, consider data privacy laws and be cautious about sharing information that may be considered confidential.

North Dakota implements MIECHV with indigenous populations. By engaging the community in conversations to understand the home visiting program through a historical trauma lens, the awardee seeks to familiarize themselves with the cultural context and how it may impact the data they are collecting.

When working with American Indian and Alaska Native tribes,[3] it is important to respect their status as a sovereign nation. Tribes have ownership over their data and how data are collected, analyzed, and reported. Federally Recognized Tribes can develop specific laws and standards regarding data. Developing and sustaining relationships with tribal leaders or partnering with tribal liaisons at state agencies can assure data are used and displayed in an appropriate and meaningful way.[ix]

For various reasons, like small sample sizes or data access and analysis capacity, awardees may not be able to analyze performance data by subgroup. You can still apply a health equity lens by engaging the community in discussion around full program data. If this is the case, be transparent about potential limitations and that aggregate data can hide disparities.[ix]

Partnering with Communities

As noted previously, it is critical to engage the community to provide a comprehensive understanding of your program's data. This will ensure that data are considered in context and not misinterpreted or misused. This can be done in three steps:

1. Identify community stakeholders.
2. Convene stakeholders to discuss data.
3. Incorporate contextual/community information into quantitative data.

First, identify community stakeholders with whom it might be beneficial to share the data. Many LIAs are already engaged with their community through community advisory boards. These groups can be leveraged as a starting point to engage in community conversations. Also, try to identify families represented in the data to include in the conversation.

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3   In this resource, the term tribe refers to tribe, band, nation, pueblo, rancheria, and village.

Next, convene community stakeholders to review and discuss the data. Recommended discussion questions can be found in the "Strategies to Engage in Authentic Community Dialogue" sidebar on the next page. Awardees may also present and discuss data using approaches such as data placemats or data cafés. In this format, groups of data (in the form of graphs, charts, or infographics) are presented with probing questions to small groups to discuss. A facilitator or note taker captures the groups' reflections. Ask community members to reflect on what stengths and challenges they see in the data, what it means to them, and what they would prioritize for improvement.

Drawing on conversations with the community, incorporate their reflections and insights by adding narratives to quantitative tables, charts, or infographics. Keeping narratives succinct and using plain language can help users consume the quantitative and qualitative aspects of the data. Community stakeholders may also offer other perspectives or ways to analyze the data. In this instance, consider re-analyzing data based on the community's questions or understanding. You could also incorporate quotes from family or community members, include pictures or videos of families represented in the data, or work with local artists to create data displays. Finally, provide contact information for community members to reach out with questions or comments about the data presented.[ix]

Strategies to Engage in Authentic Community Dialogue

Engaging your community in authentic, meaningful dialogue is at the core of addressing health equity, but it can be difficult to know how to begin these conversations. Strategies to encourage meaningful conversations with the local community include the following:

- Identify community champions to partner with to engage in community dialogue.
- Partner with the community to lead the conversation. Instead of saying, "Here are the data, is this something that is happening?" try, "Let's talk about some of the data from your community. What does this mean to you?"
- Develop long-term relationships with community stakeholders to ensure that their voice is sustained through all aspects of data collection, reporting, and CQI.
- Compensate community members for their time, and select meeting times and locations that minimize barriers to participation.
- Acknowledge your place of power within the community. Attempt to be humble and build relationships based on collaboration and support, not enforcement or authority.

Once you've gathered community members, you can begin the conversation to better understand and respond to your program data. Potential questions you can ask to facilitate the conversation include:

- Which groups, if any, are doing relatively well?
- Which groups, if any, are not doing very well?
- Why might these differences exist?
- How does this compare to what you have observed in the community?
- What other information do you need?
- What do you think this indicates about the strengths and assets in the community?
- What do you think this indicates about the need for resources, intervention, or capacity building in your community?
- What areas should we prioritize for improvement?

Designing CQI Projects to Address Inequities

Following the priorities of your stakeholders, CQI processes can be used to improve disparities identified in your data. Before launching a CQI project, consider whether the following apply:

1. Improvement in this area is a high priority for your team and affected communities and will have a positive impact for the families you serve.
2. The topic aligns with your agency or program's strategic vision and mission.
3. Improvement is feasible and within your influence.

SMARTIE Aim Statement

In quality improvement, an aim statement helps to create a shared vision and builds will and excitement for the work. Typically, we use the SMART acronym (i.e., specific, measurable, attainable, relevant, and time-bound) to define the elements of an aim statement. When approaching CQI through a health equity lens, however, it is helpful to consider two additional elements—inclusion and equity.[x] Having inclusive SMART aims brings traditionally excluded people or groups into processes, activities, and decision-making in a way that shares power. Aims that are equitable include an element of fairness or justice that seeks to address systemic injustice, inequity, or oppression.

Moving from a SMART to a SMARTIE aim can help identify the specific disparity you are trying to address through CQI, as well as who needs to be included in your work to achieve the desired outcome. For example, if a team analyzed their data and identified that a smaller proportion of Hispanic families enrolled in home visiting are receiving appropriate, timely follow-up in response to positive developmental screens compared with non-Hispanic families, they could refine their aim as follows:

SMART Aim	SMARTIE Aim
By December 2020, we will increase the percentage of children enrolled in home visiting who receive timely services following a positive screen for developmental delays from 73% to 85%.	By December 2020, we will increase the percentage of Hispanic children enrolled in home visiting who receive timely services following a positive screen for developmental delays from 41% to 68%.

The SMARTIE aim clearly states what the team will achieve and focuses their CQI work on improving supports to Hispanic families with positive developmental screens. Moving forward, the team will work to identify and test out change strategies that link directly to this SMARTIE aim. The team will also continue to review their overall program data regularly. This way, if there are any signs of an unintended drop in performance for other groups while working toward their SMARTIE aim, the team can adjust and respond quickly.

Partnering with Community Stakeholders in CQI Projects

It is important to ensure that communities and families are at the center of your CQI work and partners in the CQI process. These stakeholders can lead and support efforts to define the aim statement, identify root causes of the disparity, brainstorm and test change strategies, study the results, and decide on next steps. They can also be engaged to co-design surveys, focus groups, or other tools that can be used to gather multiple perspectives and explore diverse viewpoints. Work with community stakeholders to identify change strategies that account for the specific needs and issues of the population. Strategies that are effective with more advantaged populations may require adaptation to improve outcomes for marginalized groups.[xi] Take into consideration the resources that are available and any systemic barriers that the population is facing (e.g., a lack of referral agencies with services in the population's primary language or differential access to health care based on race, income, geography, or insurance status).

The Massachusetts Home Visiting Initiative conducts CQI projects with a racial equity focus within the context of a Learning Collaborative. The Learning Collaborative meets in-person twice per year and supports home visiting teams to use stratified data to inform improvement work, discuss the historical and structural context for the racial inequities they see in their work, and engage the community in designing solutions.

Engaging stakeholders early in the process helps to promote meaningful participation and ownership. In addition, take care to create opportunities for shared influence and decision-making. Establishing financial support for the participation of parents and community members and selecting convenient meeting times and locations are important parts of the infrastructure needed to develop these partnerships. Consider reaching out to partners in other systems as well (e.g., those from education, health care, child welfare, and others). Continue to work collaboratively with stakeholders to test out and identify changes that result in improvement. Implement the effective strategies in your own systems and consider ways to share and spread them with your partners in other systems. Achieving and sustaining equity requires a collaborative effort.[v]

Summary

MIECHV awardees can use performance data and CQI projects to identify and address health disparities and promote health equity. Begin by collecting quality data and disaggregating the data using appropriate and meaningful subgroups. Engaging the community as partners provides context to quantitative data and ensures CQI topics and interventions to address disparities found in the data are relevant and appropriate. Building strong relationships and engaging in authentic conversations with the community can lay the foundation for improving health disparities.

It may sometimes feel overwhelming to initiate health equity work. However, home visiting administrators and service providers are in a unique position to cultivate partnerships with community members and other community service providers to begin a dialogue to address health equity. For more information on addressing health equity and engaging home home visiting families and other community stakeholders in this work, see the resources listed below.

Continued…

LIAs work with community advisory boards, home visiting families, and other community stakeholders on the CQI project. Early on, the LIAs involved these stakeholders in a root cause analysis to better understand what might be causing the disparities they see in the data. Utilizing the Racial Equity Institute's Groundwater Approach as framing for their work,[xii] the teams engage stakeholders in fishbone diagramming and a 5 Whys activity,[1] shifting the focus away from individual-level behaviors toward identifying the underlying structures and systems that are causing the disparity.

1 For more on fishbone diagrams and the 5 Whys, see Continuous Quality Improvement Toolkit: A Resource for MIECHV Program Awardees, Module 7: Root Cause Analysis Tools.

Additional Resources

- What is Health Equity? And What Difference Does a Definition Make? Robert Wood Johnson Foundation. 2017. https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html
- County Health Rankings & Roadmaps. Robert Wood Johnson Foundation. 2020. https://www.countyhealthrankings.org/
- Powering Health Equity Action with Online Data Tools: 10 Design Principles. Policy Link and Ecotrust. 2017. https://nationalequityatlas.org/sites/default/files/10-Design-Principles-For-Online-Data-Tools.pdf
- The Groundwater Approach: Building a Practical Understanding of Structural Racism. The Racial Equity Institute. 2018. https://www.racialequityinstitute.com/groundwaterapproach
- Race Equity and Inclusion Action Guide – Embracing Equity: 7 Steps to Advance and Embed Race Equity and Inclusion Within Your Organization. The Annie E. Casey Foundation. 2014. https://www.aecf.org/resources/race-equity-and-inclusion-action-guide/
- Parent Engagement and Leadership Assessment Guide and Toolkit. Center for the Study of Social Policy. 2019. https://cssp.org/wp-content/uploads/2019/04/Parent-Engagement-and-Leadership-Assessment-Guide-and-Toolkit-FINAL.pdf
- Partnering With Families in Continuous Quality Improvement: The Maternal, Infant, and Early Childhool Home Visiting Program. Design Options for Home Visiting 2. 2017. https://www.acf.hhs.gov/opre/resource/partnering-with-families-in-continuous-quality-improvement-the-maternal-infant-and-early-childhood-home-visiting-program
- Institute for Healthcare Improvement, Health Equity Topic. http://www.ihi.org/Topics/Health-Equity/Pages/default.aspx
- Health Research and Educational Trust Disparities Toolkit: A Toolkit for Collecting Race, Ethnicity, and Primary Language Information from Patients. 2017. http://www.hretdisparities.org/

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viii Centers for Disease Control and Prevention. (2019). Nationwide Breastfeeding Goals. Retrieved from https://www.cdc.gov/breastfeeding/data/facts.html#disparities

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xi Wyatt, R., Laderman, M., Botwinick, L., Mate, K., & J. Whittington. (2016). Achieving health equity: A guide for health care organizations. [IHI White Paper]. Cambridge, MA: Institute for Healthcare Improvement.

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