Operationalizing Racial Equity in Massachusetts Home Visiting Programs: Barriers, Facilitators, and Strategies

A Thesis Submitted By
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Abstract

This study examines how Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) programs operationalize racial equity and the structural and programmatic factors that facilitate or hinder these efforts. Utilizing a mixed-methods secondary data analysis approach, this research integrates qualitative and quantitative data to explore how home visitors engage with equity-driven strategies across three core domains: data-driven decision-making and readiness, community engagement, and bias reduction through structural supports. Findings indicate that while home visiting programs have made progress in embedding racial equity principles, particularly through Continuous Quality Improvement (CQI)-driven data practices and community partnerships, structural limitations such as workforce instability, funding disparities, and inconsistencies in equity training impede full implementation. Additionally, disparities in data literacy and limitations in racial and ethnic classification systems create challenges in accurately assessing and addressing racial disparities in service delivery. This study emphasizes the need for sustainable policy interventions, standardized workforce investments, and enhanced participatory engagement models to ensure that racial equity is not merely an aspirational goal but an embedded, systemic practice within home visiting services. By bridging research and practice, these findings contribute to the broader discourse on advancing racial equity in maternal and child health programs and offer actionable insights for policymakers, program administrators, and researchers.

Keywords: racial equity, home visiting, maternal and child health, data-driven decision-making, community engagement, bias reduction, workforce equity

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Chapter 1: Introduction

Racial and ethnic health disparities remain a pervasive issue in the United States, particularly in maternal and child health outcomes. Black, Hispanic, and Indigenous populations experience disproportionately higher rates of infant mortality and maternal health complications compared to their White counterparts (United Health Foundation, 2020). Despite Massachusetts' strong healthcare infrastructure and high national rankings in coverage and education, these disparities persist within the state, disproportionately affecting families of color (United Health Foundation, 2024).

One strategy to address these inequities is through home visiting programs, which provide voluntary, evidence- based support services to expectant parents and families with young children. Home visitors, typically nurses, social workers, or trained paraprofessionals, offer individualized guidance on parenting, child development, health promotion, and connection to community resources, all within the family's home environment (Health Resources and Services Administration [HRSA], 2023). Research shows that high-quality home visiting can improve birth outcomes, enhance early childhood development, and strengthen family resilience (Michalopoulos et al., 2019).

In Massachusetts, the Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) program plays a central role in advancing these goals. Funded through the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative and administered by the Massachusetts Department of Public Health, MA MIECHV supports the implementation of evidence-based home visiting models tailored to the needs of high-risk communities (Massachusetts Department of Public Health [MDPH], 2022). Two key models funded through MA MIECHV are Health Families Massachusetts (HFM), a program designed for first-time

young parents, and Parents as Teachers (PAT), which focuses on parent-child interaction, development-centered parenting, and family well-being (MDPH, 2022). Both programs emphasize building trusting relationships and promoting positive outcomes through culturally responsive services. However, while MA MIECHV and its affiliated models have publicly expressed a commitment to advancing racial equity, the extent to which this commitment is embedded in program practices and outcomes remains an area for critical investigation.

Problem Statement

The Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) program plays a crucial role in promoting early childhood development, strengthening parenting practices, and addressing social determinants of health. Home visiting staff work closely with families experiencing economic hardship, limited access to healthcare, and systemic barriers that disproportionately affect communities of color. Recognizing these challenges, organizations such as Children's Trust Massachusetts and the Massachusetts Department of Public Health (DPH) have taken significant steps to advance racial equity within home visiting services (Massachusetts Department of Public Health, 2020).

Through continuous quality improvement (CQI) initiatives and expanded racial equity training, these agencies have sought to integrate equity considerations into program operations. However, despite these efforts, home visiting staff continue to encounter constraints that hinder the full operationalization of racial equity principles in practice (Goldberg et al., 2020). Limited resources, inconsistencies in data utilization, and gaps in structured racial equity training contribute to disparities in service delivery. Additionally, broader systemic inequities further complicate family engagement, making it difficult to tailor services effectively to the needs of diverse communities (Goldberg et al., 2020). Understanding these ongoing challenges—and

identifying the mechanisms that facilitate racial equity within MA MIECHV programs—is critical to strengthening home visiting services and improving health outcomes for Massachusetts families.

This study seeks to explore how home-visiting staff within MA MIECHV operationalize racial equity in their work with children and families. By examining the specific strategies used to address racial and ethnic disparities, as well as the barriers and facilitators that shape these efforts, this research aims to provide a deeper understanding of equity-focused practices within home visiting programs. The findings will contribute to a broader conversation about advancing racial equity in early childhood services and inform potential policy and programmatic improvements.

Research Questions and Objectives

This study examines how home visitors within the Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) program, particularly those implementing the Healthy Families (HF) and Parents as Teachers (PAT) models, operationalize racial equity in their work with children and families. Specifically, this research explores the strategies employed to integrate racial equity into service delivery, as well as the structural and systemic factors that shape these efforts.

1. How do MA MIECHV staff operationalize racial equity in their service delivery to children and families?
2. What are the key barriers and facilitators that influence the ability of MA MIECHV staff to implement racial equity in practice?

Defining Operationalization: Translating Racial Equity into Practice in Home Visiting

In this research, operationalizing racial equity is defined as the concrete actions, policies, and measurement strategies that home visitors in MA MIECHV programs employ to address racial disparities and foster equitable health outcomes. This definition aligns with existing public health and implementation science literature, which describes operationalization as the process of translating equity commitments into structured, measurable actions within service delivery models (Home Visiting CoIIN, 2021; Manning et al.; 2022 Shelton et al., 2023). Advancing racial equity in home visiting requires integrating anti-racist policies and practices into program infrastructure, ensuring that race is no longer a predictor of family outcomes (Zero to Three, 2021).

Based on a review of the *Massachusetts MIECHV 2020 Needs Assessment* and existing research on racial equity in home visiting programs, this study identifies three primary approaches that MA MIECHV home visitors use to operationalize racial equity in their work: (1) data-driven decision-making and readiness, (2) community engagement, and (3) bias reduction through structural supports (Goldberg, 2020).

Data-driven decision-making and readiness are core components of operationalizing racial equity, ensuring that programs systematically analyze performance and assessment data disaggregated by race, ethnicity, and other demographic indicators. Research indicates that using equity-centered data enables organizations to assess disparities, refine service delivery, and create targeted interventions to improve outcomes (Home Visiting CoIIN, 2021; Shelton et al., 2023). The extent to which data informs program adjustments reflects an organization's commitment to delivering responsive and equitable services. However, effective data use depends on organizational readiness, including the training and infrastructure needed for staff to

interpret and act on racial equity data (Center for Health Care Strategies, 2022). Some programs have implemented equity dashboards and Continuous Quality Improvement (CQI) cycles to track racial disparities in retention rates, family engagement, and health outcomes, using these findings to develop targeted interventions (Goldberg, 2020).

Community engagement is also essential to operationalizing equity in home visiting programs, as it prioritizes culturally relevant approaches and partnerships with community stakeholders. Home visitors play a vital role in engaging families of color by fostering trust, co-developing culturally tailored interventions, and addressing racial equity concerns within the communities they serve (Shelton et al., 2023). Community-based participatory approaches, such as parent advisory boards and direct family involvement in program design, strengthen service relevance and effectiveness (Region X Home Visiting Workforce Study, 2019). Research highlights that centering the voices of families of color in decision-making processes ensures that services align with their lived experiences and needs, making interventions more effective and sustainable (Maybank, 2021).

Bias reduction ensures that home visitors are equipped with the knowledge and tools to engage in equity-focused work. Scholars emphasize that training in bias reduction, cultural humility, and trauma-informed practices enhances staff capacity to address racial disparities and foster meaningful relationships with families (Center for Health Care Strategies, 2022). Equity-focused workforce strategies include implicit bias training, racial affinity groups for home visitors, and mentorship programs for staff of color, all of which improve staff retention and strengthen their ability to engage with diverse families (Region X Home Visiting Workforce Study, 2019). Additionally, institutionalizing racial equity frameworks within Continuous Quality Improvement (CQI) teams, supervisor meetings, and Department of Public Health

(DPH) guidance ensures that home visitors receive the necessary resources and policy support to navigate challenges such as language barriers and systemic discrimination (Goldberg, 2020; Home Visiting CoIIN, 2021).

By examining these aspects of operationalizing racial equity, this research aims to provide a comprehensive understanding of the strategies, challenges, and structural supports that shape home visitors' efforts to advance racial equity within Massachusetts MIECHV programs. The findings from this study have the potential to inform policy improvements, enhance training programs, and strengthen support structures to promote equitable health outcomes for Massachusetts' diverse communities.

Significance of the Study

Racial equity in Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) programs is not just a policy goal–it is a moral imperative. Health and developmental disparities that disproportionately affect children and families of color are not accidental; they are the consequence of historical and structural inequities embedded in social, economic, and healthcare systems. While home visiting programs such as those under MA MIECHV play a crucial role in mitigating these inequities, their effectiveness depends on how well they operationalize racial equity in practice.

The purpose of this study is to examine how home visiting staff within the MA MIECHV program translate racial equity commitments into concrete strategies. This research explores the challenges they face, the supports that facilitate their work, and the ways in which racial equity is woven or remains absent in the fabric of home visiting service delivery. By investigating how home-visiting staff navigate equity efforts at both individual and structural levels, this study aims

to illuminate not just what is happening in the field, but also what needs to change for equity to become truly embedded in home-visiting work.

This study also recognizes that the conversation around racial equity in MA MIECHV programs is not happening in isolation. The Department of Health and Children's Trust have taken steps to address inequities. However, the journey toward true equity is ongoing, and this study acknowledges their efforts while critically assessing where additional support may be needed. It is not about identifying shortcomings alone, but about strengthening a system that is already striving to improve.

The significance of this work extends beyond Massachusetts. At a time when public discourse around racial equity is increasingly polarized–and, in some cases, actively silenced–there is a critical need for rigorous, yet emotionally attuned research that amplifies the voices of those working directly with marginalized communities. Research has increasingly emphasized the importance of incorporating emotional realities into policy and service delivery to make equity efforts more impactful (Stagner, 2020). If home visiting is about relationships–about trust, about human connection–then research on home visiting must also center the lived experiences, struggles, and triumphs of the people involved.

This study seeks to honor the deeply personal and often emotionally complex work for home visiting staff who serve families facing systemic barriers. The findings from this research have the potential to shape statewide and national conversations on equity in home visiting, inform future training and policy initiatives, and ultimately, contribute to a stronger, more just system of care for families. By bridging the gap between policy and practice, this study affirms that racial equity is not simply an administrative goal–it is the foundation upon which the health, safety, and well-being of children and families depend.

Positionality Statement

As a Caucasian, cisgender female researcher, I recognize the privilege my identity affords me, particularly in studying racial equity. I have not personally experienced systemic racism or inequity, which necessitates careful reflection on how my background shapes my perspective. While I have professional experience as a home visitor, I have never been a recipient of such services, nor am I a parent. This distance from the lived experiences of many families in home visiting programs requires me to approach my research with humility and openness to learning from participants' insights.

Though I understand the complexities of service delivery, I am mindful of the gaps in my experience and strive to center the voices of those directly affected by structural inequities. My goal is to create a collaborative and empathetic research space, amplifying the experiences of home visitors and families while remaining vigilant of potential biases. By reflecting critically on my positionality, I am committed to contributing meaningfully to the efforts to promote racial equity in home visiting programs.

Chapter 2: Literature Review

Background

Racial Health Disparities and the Case for Equity in Home Visiting Programs

Despite national advances in healthcare, racial and ethnic health disparities persist across the United States. Black, American Indian and Alaska Native women face maternal mortality rates 2.5 to 4.5 times higher than other groups, while Black infants experience low birth weight at more than twice the rate of White infants. Similarly, Black and Hispanic women experience severe maternal morbidity at disproportionately higher rates, reflecting systemic inequities in healthcare access and quality (United Health Foundation, 2020)

In Massachusetts, these disparities mirror national trends despite the state's high rankings in education and health coverage for children. Black infants face an infant mortality rate 2.6 times higher than White infants, highlighting significant racial disparities in early life outcomes. Separately, uninsured rates among Hispanic, Asian, and American Indian women aged 18–44 remain significantly higher than among White women, emphasizing persistent inequities in healthcare access across the reproductive lifespan (United Health Foundation, 2024).

The *Massachusetts MIECHV 202 Needs Assessment*, prepared by Tufts Interdisciplinary Evaluation Research (TIER), identifies these disparities as a priority focus for state-funded home visiting programs. Although Massachusetts is home to a predominantly white population (71%), children of color represent a substantial proportion of the younger demographic, with 19% identifying as Hispanic or Latino, nearly 10% as African American or Black, and 7% as Asian. The state also has one of the highest percentages of immigrant and refugee populations, further highlighting the need for culturally responsive services that address the unique challenges faced by these communities (Goldberg et al., 2020).

These demographic trends and the persistence of health disparities among racial and ethnic groups in Massachusetts provide a compelling rationale for the MA MIECHV program's commitment to advancing racial equity in maternal and child health. Additionally, state initiatives such as Title V emphasize eliminating health inequities rooted in unjust social, economic, and environmental systems, recognizing that home visitors are uniquely positioned to witness and address the inadequacies of support systems for marginalized families (Massachusetts Department of Public Health, 2020).

Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) Programs

As a state-specific adaptation of the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative, the Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program provides targeted support to at-risk families—particularly pregnant women and parents of young children—through structured home visiting services. Funded through federal grants, MA MIECHV promotes positive parent-child relationships, early childhood development, and resilience in communities disproportionately affected by structural inequities. By offering developmental screenings, early educational interventions, and connections to necessary resources, the program seeks to mitigate the long-term effects of poverty, healthcare disparities, and racial inequities on child and family well-being (Health Resources and Services Administration [HRSA], 2024).

Central to the MA MIECHV's approach is the integration of services in partnership with local healthcare, educational, and social services to create a comprehensive support system that builds family resilience while addressing immediate health and educational needs. Consistent with Title V. Priorities for 2020 to 2025 to eliminate health inequities caused by unjust social and economic systems, the MA MIECHV program extends its role beyond individual behavioral

interventions, aiming instead to address the structural barriers perpetuating inequity (Goldberg et al., 2020; Massachusetts Department of Public Health, 2020).

According to the Maternal, Infant, and Early Childhood Home Visiting Program Brief, MA MIECHV is guided by the theory that early support for families can alter life trajectories by providing resources, knowledge, and social connections within the home environment (Health Resources and Services Administration [HRSA], 2024). The *Massachusetts MIECHV 2020 Needs Assessment* highlights that many of the challenges families face stem from historical systems of oppression—including redlining, incarceration, and disenfranchisement—that have systematically disadvantaged communities of color. Recognizing that these adverse outcomes are structural rather than individual failings, the MA MIECHV program strategically directs its resources to address systemic inequities (Goldberg et al., 2020; Williams et al., 2001).

Theoretical Foundations for Racial Equity in Home Visiting

This study employs multiple theoretical frameworks to guide an equity-focused analysis of home visiting programs. Critical Race Theory (CRT), Public Health Critical Race Praxis (PHCRP), the Groundwater Approach, and Intersectionality each provide distinct yet complementary perspectives on the structural inequities affecting maternal and child health. By integrating these frameworks, this research examines the systemic factors contributing to racial disparities in home visiting programs and explores equity-driven interventions within the Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) program.

Applying a Critical Race Lens to Public Health Research

Critical Race Theory (CRT) emerged in the legal field in the late 1970s and early 1980s as a response to the limitations of traditional civil rights approaches in addressing racial inequality. Foundational scholars such as Derrick Bell, Kimberlé Crenshaw, and Richard

Delgado developed CRT to examine how laws and policies perpetuate racial disparities, even in the absence of overt discrimination. Central to CRT is the assertion that racism is not an anomaly but a foundational and institutionalized feature of society, embedded within legal and social structures (Delgado & Stefancic, 2017). This theory challenges dominant narratives that frame racial disparities as mere socioeconomic issues or the result of individual behaviors, shifting the focus to systemic and structural factors that sustain inequity.

As CRT expanded beyond the legal field, scholars in public health and education applied its principles to analyze racial disparities in health outcomes. Historically, health sciences have reinforced racial hierarchies, with early medical journals promoting racist pseudoscience that justified inequitable treatment of marginalized populations (Ford & Airhihenbuwa, 2010). These biases persisted for centuries, influencing clinical practices, research methodologies, and policy decisions that disproportionately disadvantaged communities of color. By applying CRT, public health scholars critique these narratives and highlight the need for structural interventions that directly address the root causes of health inequities.

One of the key contributions of CRT to public health is its critique of colorblind approaches that ignore the role of systemic racism in shaping health disparities. Traditional public health interventions often focus on modifying individual behaviors—such as encouraging healthier eating habits or increasing physical activity—without addressing the structural barriers that disproportionately limit access to resources in communities of color. Cunningham and Scarlato (2018) argue that such colorblind strategies fail to account for the ways in which systemic racism restricts access to quality healthcare, healthy food, stable housing, and economic opportunities, ultimately reinforcing racial disparities rather than alleviating them.

CRT also emphasizes the importance of centering the voices and experiences of marginalized communities in research and policy development. Historically, public health research has been conducted from the perspective of dominant racial and socioeconomic groups, often leading to interventions that fail to reflect the lived realities of communities of color. CRT challenges this exclusionary knowledge production process and calls for participatory research models that elevate the insights of those most affected by systemic inequities (Ford et al., 2018). This principle is particularly relevant to home visiting programs, which aim to serve families facing multiple structural barriers. By integrating CRT into their frameworks, home visiting programs move beyond deficit-based models that pathologize communities of color and instead develop strengths-based approaches that recognize families as experts in their own lives.

Public Health Critical Race Praxis (PHCRP): A Framework for Change

Building upon Critical Race Theory (CRT), Public Health Critical Race Praxis (PHCRP) provides a structured framework for applying race-conscious analyses to public health research and interventions. Developed by Ford et al. (2018), PHCRP offers practical tools for examining the impact of racism on health at multiple levels—individual, institutional, and structural. While CRT lays the theoretical foundation for understanding racial inequities, PHCRP operationalizes these concepts by guiding public health practitioners in identifying and addressing racism within research methodologies, program implementation, and policy development.

PHCRP comprises four key components: (1) contemporary racialization, (2) knowledge production, (3) conceptualization and measurement, and (4) action. The first component, *contemporary racialization*, examines how race and racism function in current social and political contexts, emphasizing that racial inequities are not static but evolve in response to shifting policies and cultural narratives. In the context of home visiting programs, this

perspective is critical for understanding how families' experiences are shaped by present-day systemic factors, including discriminatory healthcare practices, disparities in early childhood education, and immigration enforcement policies that deter families from accessing essential services (Ford et al., 2018).

The second component, *knowledge production*, critiques traditional assumptions about scientific objectivity and highlights the ways in which research often reinforces existing power structures. Ford et al. (2018) argue that public health research has historically privileged the perspectives of dominant racial groups while excluding the voices of marginalized communities, resulting in interventions that fail to address the root causes of racial disparities. PHCRP calls for a transformation in research practices, advocating for participatory models that prioritize community engagement and center the lived experiences of those most impacted by systemic inequities.

Conceptualization and measurement, the third component of PHCRP, addresses the methodological challenges of capturing racial inequities in health research. Traditional public health studies often rely on broad racial categories that obscure within-group differences and fail to account for the intersecting effects of race, socioeconomic status, and other social determinants. PHCRP promotes the use of nuanced, context-sensitive metrics that better capture the complexity of racial disparities, ensuring that data-driven strategies are aligned with the realities of affected communities. This approach is particularly relevant to the Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) Program, which has worked to refine its data collection methods by integrating racial equity indicators into program evaluations and performance measures (Goldberg et al., 2020; Manning et al., 2022).

The final component, *action,* emphasizes the need to move beyond research and implement tangible solutions that dismantle structural barriers to health equity. PHCRP calls for policies and interventions that directly address the systemic drivers of racial disparities, rather than merely documenting inequities without enacting change. Ford et al. (2018) illustrate this principle through their analysis of racialized patterns in HIV service utilization, demonstrating how PHCRP can be applied to develop more equitable public health policies. In the context of home visiting programs, this action-oriented approach aligns with MA MIECHV programs' efforts to integrate racial equity into all aspects of service delivery, from hiring practices to data-driven quality improvement initiatives (Golderberg et al., 2020).

This praxis-oriented framework reinforces the importance of ongoing reflection, adaptation, and accountability in the pursuit of racial health equity. As home visiting programs continue to evolve, PHCRP provides a critical roadmap for embedding racial justice principles into public health practice, ensuring that interventions are both structurally competent and community informed.

The Groundwater Approach: Examining Systemic Causes of Racial Disparities

Building on Critical Race Theory (CRT) and Public Health Critical Race Praxis (PHCRP), the Groundwater Approach provides a compelling framework for understanding racial inequities as the result of deeply entrenched systemic forces rather than individual behaviors. Developed in 2018 by Bayard Love and Deena Hayes-Greene of the Racial Equity Institute, the Groundwater Approach challenges reductionist explanations for racial disparities by illustrating how racism operates across multiple systems simultaneously (Hayes-Greene & Love, 2018). This framework is particularly relevant to home visiting programs, as it highlights the necessity

of addressing structural racism at the policy and institutional levels rather than solely focusing on behavioral interventions for families.

The Groundwater metaphor presents a series of scenarios involving fish, lakes, and groundwater to explain structural racism. It begins with a single fish found dead in a lake, which prompts analysis of the fish itself—similar to examining an individual's challenges in isolation, such as a student struggling in school. However, if half the fish in the lake are found dead, this signals a need to assess the lake's conditions—equivalent to investigating a systemic issue affecting groups, like students across an entire school. When similar patterns of contamination appear across multiple lakes, it becomes necessary to examine the groundwater–the foundational source feeding all lakes. This metaphor highlights that the issue is not isolated to any one individual or system but rather originates from a pervasive, underlying force: structural racism, which shapes society at all levels (Hayes-Greene & Love, 2018).

The Groundwater Approach is based on three guiding observations that help practitioners diagnose and address racial inequities. First, racial disparities appear across multiple systems, demonstrating that they are not coincidental but embedded within societal structures. Second, socioeconomic status alone does not account for these inequities, as racial disparities persist even when controlling for income and education. Third, these inequities result from systemic structures rather than cultural or behavioral characteristics of specific racial or ethnic groups. As Hayes-Greene explains, the Groundwater Approach aims to diagnose racial inequity accurately, helping practitioners understand that the root cause is structural racism. Love reinforces this, noting that "diagnosis determines treatment," and only by diagnosing systemic racism can practitioners develop effective strategies to address it (Hayes-Greene & Love, 2018).

The Groundwater Approach has been widely used in public health research to assess systemic factors contributing to racial health disparities. Scholars have applied this framework to examine racial inequities in maternal and child health, healthcare access, and early childhood development (Metzl & Hansen, 2014). Research highlights that disparities in maternal mortality, preterm birth, and childhood health outcomes are not solely attributed to genetics or lifestyle behaviors but rather emerge from broader systemic factors such as provider bias, discriminatory healthcare policies, and neighborhood-level disinvestment (Hayes-Greene & Love, 2018).

Public health initiatives using the Groundwater Approach emphasize structural competency, a concept that urges healthcare providers and social service practitioners to acknowledge how systemic inequities—such as policy decisions, institutional biases, and social determinants—affect individual health outcomes (Metzl & Hansen, 2014). This shift from individualized interventions to systemic-level solutions has influenced efforts to integrate racial equity into public health policies and program evaluations (Hayes-Greene & Love, 2018).

Intersectionality: Understanding Overlapping Barriers to Equity

The concept of intersectionality, first introduced by Kimberlé Crenshaw (1989), provides a critical framework for understanding how multiple systems of oppression—such as racism, sexism, classism, and xenophobia—interact to shape individual and collective experiences (Crenshaw, 1989). Initially developed to highlight the unique forms of discrimination faced by Black women, intersectionality has since been widely applied across various disciplines, including public health, social work, and early childhood services. Within the context of home visiting programs, this framework is particularly useful in addressing the overlapping barriers that many families experience due to their intersecting social identities.

Intersectionality challenges the common tendency to analyze racial disparities in isolation from other forms of oppression. Public health research has long documented maternal health inequities, with Black and Hispanic mothers experiencing disproportionately high rates of severe health complications. However, an intersectional perspective reveals that these disparities are compounded for individuals who also face socioeconomic disadvantages, immigration-related challenges, or gender-based discrimination (Roberts et al., 2018). For example, a Latina mother who is undocumented may face unique vulnerabilities not only due to racial identity but also as a result of exclusionary immigration policies, economic precarity, and barriers to healthcare access.

Expanding on this concept, Homan et al. (2021) introduced the framework of structural intersectionality, which examines how institutions and policies systematically disadvantage individuals with multiple marginalized identities. This perspective is particularly relevant to home visiting programs, as the barriers families face are not uniform across racial and ethnic groups. A Black mother living in a low-income neighborhood may experience significant challenges in accessing quality prenatal care due to racial discrimination in healthcare settings. At the same time, an immigrant mother from a mixed-status household may avoid early childhood services altogether due to fears that program participation could draw attention to her immigration status (HRSA, 2023). By adopting an intersectional lens, home visiting programs can more effectively tailor services to the distinct needs of families experiencing multiple layers of marginalization.

The Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) program has recognized the importance of intersectionality in addressing racial disparities, particularly as they relate to immigrant families. *The Massachusetts MIECHV 2020*

Needs Assessment highlights how the fear that accessing public services could have negative immigration consequences, prevents many eligible families from enrolling in home visiting programs, even when they qualify for services (Goldberg et al., 2020). Research indicates that mixed-status families, in which some members are undocumented while others hold legal residency or citizenship, are particularly susceptible to this effect, leading to reduced engagement with essential health and social services (Acevedo-Garcia, 2021; Heinrich et al., 2022). Without acknowledging the intersection of race, legal status, and economic precarity, home-visiting programs may fail to reach the families who need support the most.

Intersectionality is also critical in efforts to diversify the home-visiting workforce. Research by Harding et al. (2023) found that families are more likely to engage with home-visiting services when their providers share similar racial, linguistic, or cultural backgrounds. However, the experiences of home visitors of color must also be examined through an intersectional lens to understand systemic barriers in the workplace. Women of color working in the field often face systemic barriers to career advancement, including wage disparities, limited leadership opportunities, and workplace discrimination. Addressing workforce diversity therefore requires not only recruitment efforts but also policies that create equitable career pathways for home visitors from historically marginalized backgrounds. By incorporating intersectionality into racial equity strategies, home visiting programs can move beyond one-size-fits-all solutions and develop interventions that reflect the complex realities of the families they serve.

Critical Race Theory (CRT) provides a foundational lens for understanding how racism is embedded within institutional structures and policies, shaping disparities in healthcare access and outcomes. Public Health Critical Race Praxis (PHCRP) builds on CRT by offering practical tools

for public health research, emphasizing the role of knowledge production, conceptualization, and measurement in addressing racial inequities. The Groundwater Approach reinforces the need to examine racial disparities at a systemic level, illustrating how inequities in healthcare, education, and economic opportunity are interconnected and structurally reinforced. Finally, Intersectionality highlights the overlapping and compounding effects of race, gender, socioeconomic status, and other identities, underscoring the importance of holistic and inclusive approaches to racial equity.

Together, these frameworks provide a robust foundation for analyzing how racial disparities manifest in home visiting programs and inform strategies to dismantle systemic barriers. By applying these perspectives, this study contributes to the growing body of research that seeks to operationalize racial equity within maternal and child health initiatives.

Operationalizing Racial Equity in Home Visiting Programs: Strategies and Best Practices

Operationalizing racial equity in home visiting programs, including Parents as Teachers (PAT), Healthy Families America (HFA), and Healthy Families Massachusetts (HFM), requires structured, intentional strategies that embed equity principles into service delivery, workforce development, and policy design (Home Visiting CoIIN, 2021; Shelton et al., 2023). This process goes beyond abstract commitments, focusing on concrete, measurable actions that drive systemic change. Key strategies include data-driven decision-making, community engagement, and bias reduction through inclusive practices (Goldberg et al., 2020; Manning et al., 2022). These approaches aim to dismantle systemic inequities, address implicit bias, and foster meaningful community partnerships to ensure that home-visiting programs effectively serve diverse families.

Operationalizing racial equity differs from broader discussions of barriers and facilitators, as it represents the tangible ways racial equity is enacted and evaluated within program

structures. By embedding equity into program infrastructure, home visiting models can move beyond one-time initiatives toward sustained, systemic change that ensures families receive services in ways that are accessible, culturally responsive, and free from bias (Goldberg et al., 2020; Zero to Three, 2021).

Advancing Racial Equity Through Data-Driven Decision Making

To systematically address racial health disparities, home visiting programs rely on data as a central component of operationalizing equity. The Racial Equity Data Roadmap, developed by the Massachusetts Department of Public Health (MDPH), serves as a key framework guiding these efforts. Through this roadmap, programs are encouraged to set equity-centered metrics, such as SMARTIE (Specific, Measurable, Attainable, Realistic, Time-bound, Inclusive, and Equitable) goals, to track and improve outcomes like home visit completion rates among families of color. By incorporating equity-focused metrics into regular assessments, programs prioritize structural equity over individual-level metrics, refocusing on broader disparities in access and outcomes across racial and ethnic groups (Massachusetts Department of Public Health [MDPH], 2020).

Additionally, Continuous Quality Improvement (CQI) practices, particularly through Plan-Do-Study-Act (PDSA) cycles, enable programs to monitor and refine strategies over time to ensure equitable outcomes. These processes enable teams to identify disparities, refine interventions, and align program performance with equity objectives. This data-driven approach helps close gaps in service quality, moving beyond individual-level responses to address the structural barriers that families often encounter. By integrating equity metrics and CQI practices, home visiting programs align with the broader public health imperative to address and rectify systemic racial inequities (Massachusetts Department of Public Health [MDPH], 2020).

A key data-driven strategy for advancing racial equity is Root Cause Analysis (RCA), a methodology used to identify the underlying systemic and institutional drivers of racial disparities. Unlike basic data disaggregation, which only highlights disparities at the surface level, RCA identifies the policies, structural inequities, and historical patterns that contribute to racial gaps in service access and outcomes. The Massachusetts Racial Equity Data Roadmap underscores RCA as essential for ensuring that equity interventions are proactive and address the root causes of disparities, rather than treating their symptoms (Manning et al., 2022; Massachusetts Department of Public Health [MDPH], 2020).

To be effective, RCA must be integrated into CQI frameworks, ensuring that findings are used to inform program adjustments rather than remaining isolated analyses. When combined with SMARTIE goals and equity dashboards, RCA strengthens the ability of home visiting programs to target systemic issues, refine service delivery, and create measurable improvements in racial equity.

By embedding RCA, CQI practices, and SMARTIE goals into their equity frameworks, home visiting programs move beyond passive data collection to actively dismantle structural barriers that drive racial disparities. This approach ensures that racial equity strategies are not just aspirational but embedded into programmatic decision-making (Massachusetts Department of Public Health [MDPH], 2020).

Strengthening Community Engagement Through Participatory Models

Community engagement is essential to operationalizing racial equity in home visiting programs, ensuring that services are both responsive and co-created with the families and communities they serve. Community-Based Participatory Research (CBPR) and other

participatory models center marginalized voices in decision-making, enhancing the relevance, cultural resonance, and sustainability of interventions (Lykes & Scheib, 2016).

The Growbaby Research Network exemplifies participatory engagement, collaborating with Federally Qualified Health Centers (FQHCs) to co-create solutions for low-income, publicly insured families. By building academic-community partnerships, Growbaby helps bridge the gap between research institutions and community-driven solutions, illustrating how home-visiting programs can confront systemic racism and health inequities through participatory approaches (Viglione & Boynton-Jarrett, 2023). Similarly, the Maternal Health Miracle Project, a multi-level intervention designed to reduce severe maternal morbidity and mortality among African American women, actively involves community members in every stage of service delivery. By integrating anti-racism training for healthcare providers, this initiative fosters culturally inclusive and trust-based maternal healthcare (Lykes & Scheib, 2016; Viglione & Boynton-Jarrett, 2023).

Massachusetts has also institutionalized community involvement within its home visiting programs. The Massachusetts Department of Public Health (MDPH) has expanded its Community Evaluator Model, ensuring that families and community members actively participate in needs assessments and program evaluations (National Home Visiting Resource Center [NHVRC], 2022). In collaboration with Tufts Interdisciplinary Evaluation Research (TIER) and BIPOC-led organizations, the Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) program prioritizes partnerships with agencies that reflect the communities they serve (MA MIECHV Technical Assistance Resource Center, 2019).

Reducing Bias and Promoting Inclusive Practices in Service Delivery

Reducing implicit bias and fostering inclusive practices are essential to operationalizing racial equity in home visiting programs. Many programs have incorporated Critical Race Theory (CRT) and cultural humility training to encourage staff to examine power, privilege, and bias. Unlike traditional cultural competence models, which often reduce cultural knowledge to a checklist, cultural humility emphasizes continuous reflection, self-awareness, and a lifelong commitment to learning (McMillin & Carbone, 2020). These approaches equip home visitors to engage families with empathy, trauma-informed care, and an awareness that avoids assumptions based on race, class, or immigration status (Champine et al., 2022).

To further promote equity and inclusion, home visiting programs have integrated the Culturally and Linguistically Appropriate Services (CLAS) standards, which provide a structured framework for ensuring culturally responsive service delivery. However, their impact relies on sustained implementation and ongoing training (Brach & Fraser, 2016). Massachusetts has sought to embed bias reduction strategies into hiring practices, professional development, and Continuous Quality Improvement (CQI) processes, reinforcing a systematic shift away from isolated training sessions toward institutionalized racial equity strategies (National Home Visiting Resource Center [NHVRC], 2022).

Operationalizing racial equity in home visiting programs requires a systematic, intentional approach that embeds equity-driven decision-making, participatory community engagement, and inclusive service delivery into every level of program design and implementation. While Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) programs have developed tools and frameworks to support these strategies, questions remain regarding how effectively they are being implemented in practice. The

experiences of home visiting staff, the extent to which these strategies translate into equitable service delivery, and their long-term sustainability require further examination.

Despite progress, systemic challenges—such as gaps in data collection, resource limitations, workforce shortages, and community mistrust—continue to obstruct the full implementation of racial equity efforts. To ensure that these strategies lead to meaningful, sustained change, it is necessary to examine the barriers that prevent home visiting programs from fully achieving their equity goals.

Barriers to Operationalizing Racial Equity in Home Visiting Programs

Despite growing prioritization of racial equity in home visiting programs, systemic barriers persist and hinder progress. Many programs face challenges such as inconsistent data collection methods, inadequate funding for equity-focused initiatives, and difficulties in recruiting and retaining a diverse workforce. Historical and ongoing community mistrust remains a significant barrier, impeding engagement and service effectiveness. These barriers are not incidental but are deeply embedded within the institutional structures that racial equity strategies aim to reform.

A comprehensive understanding of these challenges requires examining how they manifest within core strategies such as data-driven decision-making, community engagement, and bias reduction. Just as these strategies serve as pathways to advancing racial equity, they also represent key areas where systemic barriers can prevent meaningful progress. Recognizing how these barriers function within these frameworks is crucial for developing effective facilitators that promote sustainable, equity-driven change. (Goldberg et al., 2020; Williams et al., 2019; Health Resources & Services Administration [HRSA], 2023).

Barriers to Data-Driven Equity Implementation

Advancing racial equity in home visiting programs requires accurate, comprehensive, and context-sensitive data to identify disparities, inform decision-making, and evaluate intervention impact. However, multiple barriers limit the Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) program's ability to develop and implement effective data-driven equity strategies. These challenges include gaps in measuring structural inequities, limitations in capturing implicit bias and internalized racism, and inconsistencies in data collection, disaggregation, and demographic reporting. Without addressing these barriers, home visiting programs may unintentionally perpetuate existing disparities rather than dismantling them (Williams et al., 2019; Health Resources & Services Administration [HRSA], 2023).

Challenges in Measuring Structural Inequities

One of the most significant challenges in data-driven racial equity efforts is the difficulty of measuring structural inequities effectively. Without reliable and comprehensive indicators of systemic disparities, programs struggle to develop data-informed strategies that address the root causes of racial health disparities. A critical example of this challenge is the difficulty in accurately tracking racial disparities in incarceration rates. Research highlights that misreported race and ethnicity data in the criminal justice system distort incarceration statistics, making it difficult to quantify and address systemic inequities (Finlay et al., 2024). If incarceration disparities are not accurately measured, policymakers and programs lack a complete picture of systemic challenges—a gap that extends to home visiting data collection, where undocumented or misclassified disparities can prevent interventions from addressing the root causes of inequities.

Home visiting programs rely on community data to assess risk factors and develop equity-driven interventions, yet inconsistencies in structural data reporting limit the effectiveness of these efforts. If key structural disparities—such as incarceration rates, housing discrimination, or environmental hazards—are underreported or inconsistently measured, equity strategies may not be well-informed. Atere-Roberts et al. (2024), argue that inconsistent measurement of geographic and racial disparities weakens the effectiveness of policy solutions—a similar issue exists within home visiting programs, where aggregate data can obscure localized disparities. This lack of accurate, disaggregated data makes it difficult to develop targeted interventions that address the structural barriers contributing to racial disparities in maternal and child health outcomes. In addition to structural inequities, accurately measuring implicit bias and internalized racism remains and challenge, as these factors influence institutional decision-making and service provision.

Limitations in Capturing Implicit Bias and Internalized Racism

The challenges in data-driven racial equity efforts extend beyond structural inequities to implicit bias and internalized racism, which are difficult to measure effectively. While tools exist to assess implicit bias, the correlation between these measures and actual health outcomes remains unclear, making it difficult to integrate bias reduction strategies into service delivery and workforce training (Williams et al., 2019). Without validated methods to assess how bias manifests at an institutional level, home visiting programs may struggle to create interventions that meaningfully address racial inequities in service access, engagement, and outcomes.

Furthermore, implicit bias and internalized racism influence organizational culture and service practices, yet the absence of standardized assessment tools limits the ability of programs to measure their impact and adapt policies accordingly. Addressing bias at both the individual

and institutional levels is crucial to ensuring that home visiting programs deliver equitable and culturally responsive services. Implicit bias and internalized challenge workforce practices, while limitations in data collection and disaggregation hinder accurate assessments of disparities in participation and outcomes.

Gaps in Data Collection, Disaggregation and Reporting

Another key challenge in equity-driven decision-making is gaps in data collection, disaggregation, and reporting. The *Massachusetts MIECHV 2020 Needs Assessment* found that existing methodologies do not fully capture disparities in home visiting participation, particularly among families in historically underserved communities. Aggregate data often obscure inequalities within more affluent areas, where high-need families may be overlooked. Similarly, community-specific disparities may go undetected, resulting in an incomplete or misleading representation of the needs of families of color (Goldberg et al., 2020).

Without precise, context-sensitive data, programs may underestimate disparities, resulting in interventions that fail to address systemic racial inequities in maternal and child health outcomes. Strengthening data disaggregation and local reporting is necessary to ensuring home visiting services effectively reach the communities most affected by inequities. These data collection challenges are further compounded by rigid demographic reporting standards, which limit the ability of programs to capture the full complexity of racial and ethnic identity.

Inadequacies in Racial and Ethnic Data Classification

Compounding these challenges is the rigidity of demographic data collection. The standard demographic form used in MA MIECHV programs provides a limited set of race and ethnicity categories, such as ‘American Indian or Alaska Native,’ ‘Asian,’ ‘Black or African

American,' 'Native Hawaiian or Other Pacific Islander,' 'White,' 'More than one race,' and 'Unknown/Did not Report' (MIECHV TA, n.d). While these categories create a basic racial classification framework, they fail to fully capture the complexity of racial identity, particularly for multiracial individuals, ethnic subgroups, and individuals hesitant to disclose their racial background.

This lack of specificity can lead to incomplete or inaccurate data, making it difficult for home visiting programs to tailor interventions to diverse populations. Without a more nuanced approach to demographic data collection, these programs risk underestimating the extent of racial disparities and missing opportunities to develop targeted, equity-driven strategies.

In order to advance racial equity in home visiting services, programs must confront these data limitations head-on. Addressing gaps in structural inequities data, improving bias measurement tools, strengthening data disaggregation, and refining demographic reporting are critical steps in ensuring that equity-driven decision-making is rooted in accurate, actionable insights. Without these improvements, racial equity efforts in home visiting programs may remain limited in scope, impact, and sustainability, failing to create the systemic change necessary to dismantle racial health disparities.

Structural and Economic Barriers to Community Engagement

Ensuring equitable access to home visiting programs requires addressing structural and economic barriers that disproportionately affect racially and economically marginalized families. However, systemic challenges—including language inaccessibility, immigration-related fears, financial constraints, and resource disparities—continue to limit engagement and service access. Without targeted interventions, these barriers reinforce existing inequities, preventing families

from fully benefiting from home visiting programs and widening disparities in maternal and child health outcomes (Goldberg et al., 2020).

Challenges in Linguistic and Cultural Accessibility

One of the primary barriers to equitable home visiting services is language and cultural barriers. Many families continue to encounter significant challenges in accessing linguistically and culturally appropriate care, making it difficult to fully engage in home visiting programs. The *Massachusetts MIECHV 2020 Needs Assessment* highlights that families frequently cite language barriers as a primary obstacle to fully engaging in home visiting programs. This challenge is particularly acute for Laotian, Cambodian, and Vietnamese families, who report a lack of linguistically appropriate resources and limited access to interpretation services.

A Vietnamese mother described the impact of these barriers on her ability to navigate services, stating:

> *"For me, it's a language barrier. I'm afraid to ask because I don't understand what they said fully. So I can't always know what questions to ask [next]… I wish there was a place I could go where they translated for me… It would help me create a bridge across all the different teams, to coordinate services."*

This quote illustrates how language barriers create communication gaps, leaving families without the ability to advocate for themselves or fully utilize available services. Limited access to home visiting services in one's primary language leads to delayed care, miscommunication, and decreased trust in service providers.

However, language is only one aspect of cultural inaccessibility. Even when translation services are available, families may still struggle to engage fully if home visitors lack cultural awareness or shared lived experiences. One father described this distinction:

> *"It's one thing to have someone come translate, but another to have someone visit who speaks your language and understands your culture. That might be where programs are lacking. You can't just ignore the needs of the population because of the cost of doing that. We need someone who can help us understand what services are."*

This reflects a broader challenge in ensuring that home visiting programs employ providers who are not only linguistically fluent but also culturally aligned with the communities they serve. The lack of racially and linguistically diverse home visitors limits the extent to which families feel understood, supported, and empowered within these programs.

Despite the recognized need for a more culturally representative workforce, persistent challenges remain in recruiting and retaining racially and linguistically diverse home visitors. Without sustained investment in workforce development, families from underrepresented communities may continue to experience barriers to culturally relevant and linguistically accessible home visiting services.

Immigration Fears and Policy-Driven Disengagement

For many immigrant families, barriers to community engagement in home visiting programs extend beyond language and cultural disconnection to include fears associated with immigration policies and the risk of deportation. These fears are often heightened by anti-immigrant rhetoric and restrictive policies that discourage participation in public programs.

Research indicates that many immigrant families, regardless of their legal status, avoid engaging with public services out of concern that their participation could have negative consequences in future immigration proceedings. This phenomenon, widely known as the “chilling effect,” has led to decreased enrollment in essential services such as Medicaid, SNAP, and early childhood programs, even among families who are legally eligible for these benefits (Acevedo-Garcia, 2021).

A study on the effects of an ICE workplace raid in Tennessee found that many families withdrew from Medicaid, SNAP, and other public assistance programs, despite being eligible (Heinrich et al., 2022). The chilling effect was not limited to undocumented families—many mixed-status families with U.S. citizen children also withdrew from services due to fear of drawing government attention. These fears undermine engagement with home visiting programs, as families may perceive home visitors as potential reporting agents rather than trusted sources of support.

Executive Order No. 14159, "Protecting the American People Against Invasion" (2025), exacerbates these fears by expanding immigration enforcement and revoking prior policies that safeguarded immigrant families. The order emphasizes aggressive deportation measures, expanded detention facilities, and criminal penalties for unauthorized presence, reinforcing an environment in which immigrant families may feel unsafe accessing public resources. The threat of increased removals and the elimination of prior legal safeguards may further dissuade participation in home visiting programs, particularly for families who fear interactions with state agencies could jeopardize their residency status.

Additionally, anti-immigrant movements in the U.S. have become more organized and mainstream under this administration. As noted in Rincon (2024), nativist policies and rhetoric

have historically played a central role in shaping public attitudes toward immigrants, often equating immigration with national security risks. These narratives fuel xenophobic policy shifts and encourage vigilante actions at the border, further contributing to a climate of fear among immigrant families. As a result, many families hesitate to access home visiting services, fearing that participation could expose them to immigration enforcement actions or public scrutiny.

Massachusetts has implemented progressive measures to alleviate these fears, including enhanced protections for immigrant families and expanded access to state-funded health programs. However, home-visiting programs still lack explicit guidance on how to support undocumented families, leaving individual home visitors to navigate these complex issues without formal training or policy direction (MIRA & MPI, 2020). This absence of clear protocols contributes to inconsistencies in service delivery, as some home visitors may be well-equipped to address immigration-related concerns, while others lack the resources or training to do so effectively.

Given the ongoing national climate of heightened immigration enforcement and anti-immigrant sentiment, home-visiting programs must acknowledge and address these concerns proactively. Research underscores the need for home visitors to be well-versed in immigrant rights, service eligibility, and available legal protections. Without intentional efforts to counteract fears and misinformation, many eligible families may remain disengaged from critical early childhood services, further exacerbating disparities in maternal and child health outcomes.

Economic Constraints and Structural Resource Disparities

While overcoming linguistic and immigration-related barriers is essential, economic constraints continue to shape family engagement in home-visiting programs. Limited access to transportation is one of the most significant challenges, particularly for racially marginalized

families living in under-resourced neighborhoods with inadequate public transit infrastructure (Goldberg et al., 2020). Many families face financial constraints that prevent them from maintaining a personal vehicle or affording transportation costs, making consistent participation difficult. According to Kleinman et al. (2023) logistical barriers such as transportation access significantly impact program retention rates, disproportionately affecting economically disadvantaged families. As a result, these obstacles hinder families' ability to engage fully with home visiting services, ultimately reducing the program's overall effectiveness in addressing health disparities.

Beyond transportation, technological barriers have emerged as another structural inequity in access to home visiting services. The rapid expansion of virtual home visiting and telehealth options, particularly in response to COVID-19, has improved service accessibility for some families but widened disparities for others. Families experiencing economic hardship often lack access to broadband internet, smart devices, or the digital literacy necessary to engage with remote services effectively (Goldberg et al.,2020). Shahid et al. (2023) highlight that the digital divide disproportionately affects racially and economically marginalized families, limiting the effectiveness of virtual adaptations in home visiting programs.

While telehealth and virtual home visits offer potential solutions for increasing accessibility, they fail to serve families who lack access to the necessary technology. Without intentional strategies to close the digital divide—such as subsidized internet access, technology lending programs, or digital literacy training—virtual home visiting remains an incomplete and inequitable solution for expanding access to care.

Additionally, structural inequities in resource distribution further compound these barriers. The Massachusetts Department of Public Health's Racial Equity Data Roadmap

emphasizes that historically under-resourced communities—often composed of marginalized racial groups—have fewer accessible services, restricting their ability to fully benefit from home visiting programs like MIECHV (Massachusetts Department of Public Health [MDPH], 2020) Hardy et al. (2021) further demonstrate that neighborhood inequities in resource allocation place racially marginalized children at an early developmental disadvantage.

The barriers outlined in this section—linguistic and cultural disconnection, immigration-related fears, economic constraints, and structural resource disparities—are deeply intertwined, collectively shaping families' ability to engage with home visiting programs. While each challenge presents distinct obstacles, they ultimately stem from larger systemic inequities that disproportionately affect racially and economically marginalized communities. The *Massachusetts MIECHV 2020 Needs Assessment* highlights that persistent gaps in funding, workforce diversity, and infrastructure investment continue to limit equitable access to home visiting services, reinforcing disparities in maternal and child health outcomes (Goldberg et al., 2020). Without intentional, policy-driven interventions that prioritize resource allocation for high-need communities, these barriers will remain entrenched, preventing home visiting programs from fulfilling their mission of advancing racial equity and improving outcomes for all families. Moving forward, targeted efforts to address structural barriers at both the programmatic and policy levels are essential to ensuring that racial equity in home visiting is not merely an aspiration, but an achievable, sustained reality.

Obstacles to Bias Reduction and Inclusive Service Delivery

Efforts to embed racial equity within home visiting programs require more than policy commitments; they demand structural changes that address bias, power imbalances, and workforce limitations that hinder equitable service delivery. Despite the Massachusetts Maternal,

Infant, and Early Childhood Home Visiting (MA MIECHV) program's efforts to integrate cultural humility training, trauma-informed care, and racial equity frameworks, significant barriers persist in reducing bias and fostering inclusive practices (Goldberg et al., 2020; Manning et al., 2022). These obstacles are most evident in the mistrust between families and home visitors, implicit biases that shape service delivery, and workforce constraints that undermine staff retention and professional development. Without adequate institutional support, racial equity initiatives risk becoming symbolic rather than transformative.

Power Imbalances and Mistrust Between Families and Home Visitors

A foundational barrier to bias reduction in home visiting programs is the erosion of trust between families and service providers, particularly for Black, Indigenous, People of Color (BIPOC) and immigrant families. Historical and systemic inequities in healthcare, child welfare, and social services have fostered deep-seated skepticism toward state-funded programs, leading many families to approach home visiting services with caution. This reluctance is compounded by implicit bias, power imbalances, and fears of surveillance, all of which affect family engagement and the effectiveness of home-visiting interventions.

Implicit bias–defined as unconscious attitudes and stereotypes that shape decision-making– has been well-documented in healthcare and social services as a driver of racial disparities (Macias-Konstantopoulos et al., 2023). In home visiting programs, these biases may surface when families feel judged based on parenting choices, socioeconomic status, or home environments rather than being met with empathy and support. As one mother explained:

> *"People are fearful that you're coming in and something might happen and then you'll take my kid away. It's the unknown. I'll come to you; my house is my house."*

This concern is particularly acute for Black, Indigenous, and Latinx families, who have historically faced higher rates of child welfare interventions and involuntary family separations. Many parents perceive home visitors as authority figures with the power to report them to child protection services, rather than as advocates offering support. Another participant described this power imbalance:

> *"That feeling of being believed is hard to find. It is more that a person in a position of authority is coming in; I am here to help because there is something you don't know or can't do. Power dynamics is a tricky piece."*

These fears align with broader research on racial bias in healthcare and social services, where families from marginalized backgrounds report higher levels of skepticism, perceived discrimination, and disengagement from services (Williams et al., 2019). For example, a study of 3,600 low-income minority families found that perceived systemic bias and cultural disconnect between providers and families led to decreased participation in maternal and child health services (Lion et al., 2020). Without proactive, trust-building efforts, home visiting programs risk perpetuating these systemic inequities rather than addressing them, ultimately undermining their effectiveness in advancing racial equity and improving maternal and child health outcomes.

Workforce Challenges: Retention, Compensation, and Equity Training

The ability to reduce bias and foster inclusivity in home visiting programs is hindered by workforce instability, inadequate compensation, and the lack of institutionalized racial equity training. While Massachusetts Maternal, Infant, and Early Childhood (MIECHV) programs have invested in cultural humility and bias reduction training, underfunding in staffing, workforce

development, and professional advancement opportunities has undermined the long-term sustainability of these initiatives.

Low wages and job instability contribute significantly to this issue. Home visitors in Massachusetts earn between $32,700 and $34,850 annually, a salary that is well below the state's median income and does not reflect the extensive training, experience, and responsibilities required for the role (Goldberg et al., 2020). These compensation gaps make long-term retention difficult, leading to staff shortages, high turnover, and inconsistent service delivery for marginalized families.

Beyond wages, disparities in funding allocation across Local Implementing Agencies (LIAs) – community-based organizations, health departments, and nonprofit entities responsible for delivering home visiting services under federally and state-funded MIECHV programs–create inconsistent salary structures, making it difficult to standardize pay and benefits across home visiting programs (Goldberg et al., 2020). This variation exacerbates workforce instability, contributes to high staff turnover, and limits diversity in leadership roles, ultimately weakening the capacity of home-visiting programs to develop and retain a workforce prepared to engage with diverse families and advance racial equity.

The Limits of Equity Training Without Structural Support

Workforce development constraints further exacerbate the challenge of reducing bias in service delivery. While Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) programs have invested in training programs centered on cultural humility, bias reduction, and trauma-informed care, these initiatives often become an additional burden for home visitors, who are already stretched thin by high caseloads and limited financial incentives.

According to the *Massachusetts MIECHV 2020 Needs Assessment*, program leaders emphasize the importance of structured racial equity training to help home visitors navigate difficult conversations about race, trauma, and structural inequities with families. However, because these trainings are often seen as "extra" rather than essential, many home visitors struggle to engage deeply with equity-based practices due to time constraints and job-related stress (Goldberg et al., 2020).

Even the most well-intentioned bias reduction training programs fail to create meaningful change in service delivery when coupled with low wages, high caseloads, and limited financial incentives. Without targeted funding for additional staff, competitive salaries, and long-term workforce development strategies, training opportunities alone will not fully address the systemic barriers to inclusive, equity-focused home visiting services.

Efforts to reduce bias and foster inclusive service delivery within home visiting programs will remain limited in impact unless they are supported by structural reforms that address workforce instability, racial equity training, and institutional trust-building. Crowne et al. (2022) emphasize that a well-structured training infrastructure is essential for home visitors to engage meaningfully in equity-based professional development, rather than treating it as an optional or supplemental task within an already overburdened system. Their policy recommendations highlight the need for sustainable investment in workforce development, recognizing that without competitive wages, adequate staffing, and long-term financial support, racial equity training alone is insufficient to drive meaningful change.

Without these structural supports, home visiting programs risk placing the burden of racial equity work on individual staff members—a responsibility that cannot be effectively carried out without broader organizational commitment and systemic investment. Addressing

these challenges is critical to building a workforce capable of providing racially equitable, trauma-informed, and inclusive care. In doing so, home visiting services can avoid unintentionally reinforcing existing disparities and instead serve as a transformative force for marginalized families.

Facilitators to Operationalizing Racial Equity in Home Visiting Programs

While systemic barriers impede the implementation of racial equity strategies in home visiting programs, existing research and programmatic efforts highlight key facilitators that help bridge the gap between equity commitments and real-world practice. These facilitators differ from operationalization strategies, which are defined as the concrete actions, policies, and measurement strategies used by home visitors to advance racial equity in practice (Home Visiting CoIIN, 2021; Manning et al., 2022; Shelton et al., 2023). Whereas operationalization centers on programmatic actions, facilitators provide the necessary structural supports, policy frameworks, and institutional capacity-building efforts that enable equity strategies to be effectively implemented and sustained.

For example, while equity-centered data collection is an operational strategy, facilitators such as dedicated funding for disaggregated data analysis, standardized racial equity benchmarks, and workforce training in data interpretation ensure that data-driven decision-making is successful (Goldberg et al., 2020; Manning et al., 2022). Similarly, community engagement strategies rely on facilitators such as long-term trust-building initiatives, sustainable partnerships with grassroots organizations, and representation of marginalized communities in program governance to be effective (HRSA, 2023; NHVRC, 2022). Without these structural supports, home visiting programs may struggle to move beyond surface-level commitments to racial equity and instead risk reinforcing systemic disparities.

By enhancing culturally and linguistically accessible services, investing in workforce development, and strengthening institutional accountability, home visiting programs can overcome existing challenges and move toward sustainable, equity-driven service delivery (Goldberg et al., 2020; HRSA, 2023; Manning et al., 2022). Understanding these facilitators is essential to transforming racial equity from an aspirational goal into a concrete, measurable reality, ensuring that home visiting programs effectively reach and support diverse families in meaningful ways.

Strengthening Data-Driven Equity Infrastructure

Operationalizing racial equity within home visiting programs requires an evidence-based approach grounded in accurate and comprehensive data. However, as previously outlined, limitations in data collection methodologies, difficulties in measuring structural inequities, and gaps in demographic reporting hinder efforts to systematically address racial disparities in service delivery. While Continuous Quality Improvement (CQI) and data-driven decision-making serve as core strategies for operationalizing racial equity, their effectiveness depends on the institutional supports and infrastructure that enable programs to fully integrate and sustain these efforts. Key facilitators include staff training on racial equity data, embedding equity dashboards, improving demographic data collection practices, and increasing transparency in how data is used to build trust with families (Goldberg et al., 2020). These implementation supports strengthen the ability of home visiting programs to identify disparities, set targeted goals, and develop responsive interventions that advance systemic equity.

Enhancing Equity Data Collection and Continuous Quality Improvement

A critical facilitator in strengthening data-driven racial equity efforts is improving equity data collection methodologies to ensure that disparities are accurately identified and addressed.

Establishing standardized procedures for collecting, analyzing, and utilizing equity-focused data allows programs to develop targeted interventions that reflect the needs of marginalized communities. Without these foundational improvements, racial equity efforts risk being inconsistent, fragmented, or unsupported by reliable evidence (Goldberg et al., 2020).

Achieving data readiness requires more than collecting numbers; it demands the ability to interpret, contextualize, and act upon racial equity data effectively. To support this, the Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) program has embedded racial equity into performance measurement and CQI efforts, ensuring that data inform both decision-making and accountability structures. A key facilitator in this approach is the use of Equity Dashboards and Spotlights, which disaggregate data by race, ethnicity, and language to help providers track disparities in real time, adjust practices, and implement targeted interventions (MDPH, 2020; NHVRC, 2022). By integrating these tools into daily operations, home visiting programs ensure that racial equity remains a proactive, ongoing priority rather than an abstract goal.

Another key facilitator for improving data-driven racial equity implementation is the institutionalization of SMARTIE goal-setting frameworks and Plan-Do-Study-Act (PDSA) cycles within home visiting programs. While these methodologies serve as operationalization strategies in their application, they also function as facilitators by providing the structural mechanisms needed to sustain, refine, and evaluate racial equity initiatives over time.

SMARTIE (Specific, Measurable, Attainable, Realistic, Time-bound, Inclusive, and Equitable) goals help home visiting programs establish clear equity-related objectives while ensuring accountability in meeting racial equity benchmarks (MDPH, 2020). When implemented within CQI efforts, SMARTIE goals enable programs to track progress, measure disparities, and

refine interventions based on data-driven assessments. Similarly, Plan-Do-Study-Act (PDSA) cycles, which are widely used in CQI methodologies, allow programs to pilot small changes, assess their effectiveness, and modify approaches based on real-time community needs (HRSA, 2023). These iterative processes ensure that racial equity efforts remain adaptable and responsive rather than static initiatives that fail to evolve alongside shifting program demands and disparities.

Reducing Missing Data to Strengthen Equity Initiatives

Ensuring accurate and complete racial equity data is essential for effectively tracking disparities and informing responsive programmatic adjustments. However, the *Massachusetts MIECHV 2020 Needs Assessment* highlights that high levels of missing demographic data limit home visiting programs' ability of to accurately assess racial inequities in service access and outcomes. Several factors contribute to incomplete data collection, including families opting not to disclose race or ethnicity due to concerns about privacy, home visiting staff discomfort in initiating conversations about racial identity, and the challenges of managing data collection amidst demanding caseloads. Without clear institutional supports for reducing missing data, the effectiveness of data-driven equity strategies remains constrained (Goldberg et al., 2020).

To address these challenges, home visiting programs must implement intentional strategies that strengthen the accuracy and completeness of demographic data collection. Structured training for home visitors on engaging families in transparent and affirming discussions about race can help normalize these conversations while reinforcing trust in the data collection process. Additionally, programs must ensure that demographic data collection is framed as a family-centered equity tool rather than a compliance requirement. When families understand how their racial and ethnic data informs service improvements, they may be more

willing to participate in data collection efforts. Furthermore, developing protocols that flag and address missing data rather than overlooking incomplete records can help improve data accuracy and ensure that racial equity assessments are based on comprehensive and reliable information.

Disaggregated Data and Open Conversations on Racial Identity

A significant challenge in equity-focused data collection is the reluctance of families to disclose racial and ethnic identities due to historical and ongoing experiences of racial surveillance and discrimination (Goldberg et al., 2020). Without accurate and complete racial demographic data, programs risk underestimating disparities and failing to implement equity-driven interventions effectively. To ensure that data collection practices foster trust and accuracy, home visiting programs must normalize open conversations about race rather than treating racial identity as a bureaucratic checkbox (MDPH, 2020; Manning et al., 2022). Haulcy (2024) highlights that even dedicated equity-focused professionals often struggle to engage in direct discussions about race, describing this hesitation as a "defense mechanism to avoid painful conversations" (p. 15). In home visiting, this discomfort can hinder both trust and data accuracy, particularly when families fear racial profiling or misuse of demographic information. Facilitating nonjudgmental, constructive dialogue about race within data collection practices can strengthen family trust and improve service engagement.

To address this, programs should provide structured training for home visitors on how to engage families in affirming, transparent discussions about racial identity. Haulcy (2024) discusses the podcast *Early Risers: Waking Up to Racial Equity in Early Childhood* as an effective model for debunking myths about how children learn about race and equipping caregivers with tools to navigate these discussions. Similar training for home visitors would help integrate racial identity into service provision in a way that is affirming rather than extractive.

Beyond individual training, framing demographic data collection as a family-centered equity tool rather than a compliance requirement is critical. When families understand how their racial data informs service improvements and promotes equity, they are more likely to engage openly and accurately. As Haulcy (2024) emphasizes, these conversations should be "rooted in lived experience, supported by community, and lifted up by practitioners and policymakers" (p. 16).

By shifting from passive data collection to active, equity-driven engagement, home visiting programs can cultivate more accurate demographic data, strengthen family relationships, and dismantle racial inequities within service provision. Normalizing these conversations is a critical facilitator in ensuring that racial equity strategies are grounded in comprehensive, representative data that accurately reflects the communities served.

Expanding Community Engagement and Equitable Service Delivery

Ensuring equitable access to home visiting programs requires targeted investments in infrastructure, service flexibility, and resource supports that reduce economic, linguistic, and cultural barriers to participation. While systemic inequities—such as transportation limitations, digital access disparities, and mistrust in public services—continue to hinder engagement, programmatic efforts have demonstrated effective ways to build trust and increase accessibility. Key facilitators include improving language accessibility, strengthening partnerships with community-based organizations, expanding structural resource supports, and implementing hybrid service delivery models. These efforts ensure that home visiting services center community voice, reflect families' lived experiences, and address the practical constraints that prevent marginalized families from fully engaging (Goldberg et al., 2020; Manning et al., 2020).

Enhancing Language Accessibility Through Community Partnerships

Language barriers remain a primary obstacle to home visiting participation, particularly among immigrant and linguistically diverse families who lack access to bilingual providers, interpreter services, and culturally responsive outreach materials. Research has consistently shown that when families receive services in their preferred language, engagement, trust, and overall program satisfaction improve (Brach & Fraser, 2016). While translation services can facilitate communication, true language accessibility requires proactive community partnerships, workforce diversification, and culturally responsive service delivery.

A key facilitator in expanding language accessibility is strengthening partnerships with community-based organizations (CBOs), including immigrant advocacy groups and cultural centers, that already serve linguistically diverse populations. Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) programs have collaborated with immigrant advocacy groups, community health centers, and cultural organizations to ensure that home visiting services provide interpreters, bilingual resources, and culturally appropriate outreach (Goldberg et al., 2020). By offering services in familiar, trusted spaces within immigrant and BIPOC communities, these partnerships enhance program credibility and strengthen family engagement.

Another critical approach is expanding the hiring of bilingual home visitors who reflect the linguistic and cultural backgrounds of the families they serve. Studies have shown that families feel more comfortable, share more personal information, and engage more deeply with home visitors who share their language and cultural context (HRSA, 2023). To address this, Massachusetts has implemented financial incentives for multilingual staff, specialized training

for bilingual home visitors, and targeted recruitment initiatives to diversify the home visiting workforce (MDPH, 2020).

By embedding community partnerships, hiring multilingual staffing, and implementing culturally responsive engagement strategies, home visiting programs can eliminate language barriers, making services more accessible and affirming.

Strengthening Community Partnerships and Family Leadership

Deepening formalized partnerships with trusted CBOs is a critical facilitator in bridging the gap between home visiting programs and historically underserved families. These partnerships create culturally relevant referral pathways, enhance program credibility, and increase awareness about the availability of home visiting services. Research has shown that when home visiting programs embed themselves within trusted community institutions, participation and retention rates improve significantly (Anderson et al., 2003).

A particularly impactful facilitator in centering community voice is compensating family leadership at the state level. The Massachusetts MIECHV program has formally integrated parents and caregivers into advisory and leadership roles, ensuring that those with lived experience help shape policy and service delivery (MIECHV TA Resource Center, 2022). By providing financial compensation for family leadership, the program challenges traditional power dynamics and reinforces that racial equity requires co-creation with the families it seeks to serve. Research underscores that when programs elevate family leadership, services are more responsive, effective, and sustainable (NHVRC, 2022).

By expanding partnerships with trusted organizations and compensating family leadership, home visiting programs shift toward a participatory service model that prioritizes family voice, cultural responsiveness, and shared decision-making.

Institutionalizing Privacy Protections to Reduce Immigration Barriers

For many immigrant families—particularly those in mixed-status households—fears of deportation, public charge policies, and government surveillance serve as deterrents to participation in home visiting programs (Acevedo-Garcia, 2021). Research has found that even legally eligible families avoid services due to concerns about data sharing and unintended immigration consequences (Heinrich et al., 2022). To counteract this chilling effect, home visiting programs must institutionalize clear privacy protections, establish non-reporting guarantees, and train staff on immigrant rights.

A key facilitator in building trust with immigrant families is explicitly communicating confidentiality policies and ensuring that home visitors are trained to clearly explain data privacy protections to families. Massachusetts MIECHV has implemented state-level protections ensuring that home visiting participation does not affect immigration status, public charge determinations, or eligibility for future legal proceedings (MIRA, 2020). However, further efforts are needed to train home visitors on legal protections, de-bunk misinformation, and ensure that staff can answer questions about service eligibility.

By implementing privacy protections, non-reporting guarantees, and staff training on immigrant inclusion, home visiting programs can create safe, trusted environments that affirm families' rights and reduce fear-based disengagement.

Expanding Structural Supports to Reduce Economic Participation Barriers

Beyond linguistic and immigration-related barriers, many families face structural economic constraints—including transportation limitations, digital inequities, and financial hardship—that make consistent participation in home visiting services difficult. Strategic

investments in transportation stipends, technology equity, and hybrid service models have been essential in reducing logistical obstacles to engagement.

A key facilitator in overcoming transportation barriers is the implementation of transportation stipends and subsidized travel options. Massachusetts MIECHV has expanded funding for transportation assistance for families who lack reliable vehicles or public transit access (Goldberg et al., 2020). Additionally, home visiting programs have piloted flexible scheduling models and alternative meeting locations in community centers and childcare facilities, further reducing the logistical burden on families.

Another facilitator is technology access programs that support digital inclusion. While virtual home visiting and telehealth have increased accessibility for some, they have exacerbated disparities for those without broadband internet, smart devices, or digital literacy support (Shahid et al., 2023). To address these gaps, home visiting programs have introduced broadband assistance programs, technology lending initiatives, and digital literacy training to ensure equitable participation in virtual services. Research highlights that hybrid service models, which combine in-person and virtual visits based on family needs, result in higher retention rates and improved service accessibility (Shahid et al., 2023).

By investing in transportation stipends, digital access programs, and hybrid service models, home visiting programs can eliminate structural barriers to participation, increase engagement, and ensure equitable service access for historically marginalized families.

Advancing Bias Reduction and Equitable Workforce Development

Efforts to reduce bias and promote inclusive practices within home visiting programs require more than individual awareness or isolated training initiatives. To actively counteract bias, foster trust, and sustain equitable service models, home visiting programs must

institutionalize facilitators such as cultural humility, workforce diversity, and structural protections in service delivery (Goldberg et al., 2020). These facilitators strengthen program infrastructure by ensuring that racial equity is not dependent on individual practitioners' awareness alone, but is instead sustained through ongoing learning structures, workforce retention supports, and policies that protect families from systemic harm.

To create meaningful and long-term change, programs must move beyond one-time interventions and establish institutional mechanisms that reinforce racial equity commitments over time. This section examines key facilitators that strengthen inclusive service delivery, including integrating anti-bias training into workforce development, expanding workforce diversity and retention strategies, institutionalizing privacy protections, and securing long-term funding structures that sustain equity-driven programmatic change. By embedding these facilitators into home visiting services, programs can proactively dismantle bias, enhance family trust, and ensure a stable, equity-driven workforce.

Integrating Anti-Bias Training into Workforce Development

A key facilitator in reducing bias and fostering trust is the institutionalization of comprehensive, ongoing cultural humility and anti-bias training. Unlike traditional cultural competency models, which present knowledge of different racial and ethnic groups as a fixed checklist, cultural humility training fosters lifelong learning, self-reflection, and an awareness of power dynamics within service provision (Foronda et al., 2016; Tervalon & Murray-García, 1998). These models encourage home visitors to continuously evaluate their assumptions and biases, adapt their engagement strategies, and remain responsive to the evolving needs of families.

The Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) program has recognized the importance of these approaches and has integrated racial equity, family engagement, and Continuous Quality Improvement (CQI) training into its professional development structure (HRSA, 2023; MIECHV TA Resource Center, 2022; NHVRC, 2022). These training efforts shift service delivery models away from enforcement-based or compliance-driven approaches and toward empathy-driven, trust-based engagement (Betancourt et al., 2016).

However, training alone is insufficient without institutional support to ensure that equity-based practices are consistently reinforced and applied. Programs must create structured opportunities for ongoing mentorship, leadership development, and CQI integration to ensure that bias reduction remains a foundational, rather than supplemental, component of home visiting programs (Silva, 2022). By embedding equity training into workforce development plans rather than offering it as an isolated requirement, home visiting programs can ensure that staff receive ongoing professional support to translate anti-bias learning into sustained, equity-driven service models.

Diversifying and Supporting the Workforce to Strengthen Trust

Beyond training, ensuring racial and linguistic diversity within the home visiting workforce is essential to reducing bias and strengthening trust with families. Families participating in home visiting programs have consistently emphasized their preference for home visitors who share their racial, cultural, or linguistic background, as these relationships reduce fears of judgment, increase trust, and make services more relevant (Goldberg et al., 2020). Research demonstrates that representation within service provider roles enhances engagement, improves retention, and decreases mistrust in institutional services (DeSilva et al., 2019). Early

childhood studies also suggest that infants as young as three months old demonstrate an increased preference for faces from their own racial or ethnic group, reinforcing the developmental importance of representation in service provision (Kelly et al., 2005; Kelly et al., 2007).

However, workforce diversity alone does not ensure long-term retention. Without competitive wages, career pathways, and policies that support staff advancement, recruitment efforts may be undermined by workforce turnover. Massachusetts has taken steps to address these structural challenges by integrating racial equity principles into procurement policies, ensuring that funding allocations support staff training, leadership development, and the recruitment and long-term retention of diverse home visitors (NHVRC, 2022). The Massachusetts MIECHV program has also implemented a capacity-building framework that incorporates racial equity training, family engagement strategies, and CQI practices to improve service quality and ensure equitable outcomes (HRSA, 2023).

Moving beyond recruitment, home visiting programs must prioritize structured retention and career advancement pathways to ensure that diverse home visitors are supported in long-term professional growth and leadership roles (Goldberg et al., 2020). Workforce sustainability is a significant factor in ensuring that racial equity efforts are embedded into home visiting programs rather than treated as supplemental efforts. Research has shown that low wages and high caseloads contribute to workforce instability, particularly among home visitors from marginalized backgrounds who may experience burnout and financial strain (Crowne et al., 2022). Without competitive wages, structured professional development opportunities, and leadership pathways for home visitors of color, recruitment efforts alone cannot sustain a diverse workforce.

Institutionalizing Privacy Protections to Foster Family Trust

Concerns surrounding privacy and surveillance pose significant barriers to home visiting engagement, particularly among BIPOC and immigrant families who may fear interactions with government-affiliated services due to historical and ongoing systemic harm (Williams et al., 2019). Institutionalized confidentiality policies have been identified as critical workforce supports that allow home visitors to communicate non-reporting guarantees, navigate concerns about service eligibility, and uphold families' rights to engage without fear.

The importance of formalizing privacy protections is emphasized across healthcare and human services, as maintaining confidentiality is essential to ethical care and fostering trust with marginalized populations (Gutiérrez et al., 2020). In home visiting programs specifically, scholars recommend enacting formal policies that prohibit the sharing of client data with immigrant enforcement or child protective services without explicit, informed consent (Goldberg et al., 2020). By codifying these protections into organizational protocols, home visiting services create a more secure environment that reduces fear and encourages engagement among historically marginalized families.

Additionally, research highlights the need for equipping home visitors with the skills necessary to effectively communicate confidentiality protections. Training on legal rights, program-specific privacy policies, and trauma informed engagement strategies ensures that staff can mitigate families' fears and reinforce the understanding the home visiting programs are voluntary, supportive resources rather than mechanisms of surveillance (Goldberg et al., 2020)

Securing Long-Term Funding to Institutionalize Racial Equity Initiatives

Sustaining racial equity efforts in home visiting programs requires long-term financial investment. Without dedicated funding for workforce support and program infrastructure, equity-

driven initiatives risk remaining temporary rather than becoming permanent institutional practices.

A key facilitator in sustaining racial equity initiatives is securing targeted funding to support capacity-building efforts. In Fiscal Year (FY) 2022, the MIECHV Innovation Award allocated $2 million to Massachusetts as part of a broader $15.9 million federal initiative aimed at expanding home visiting services and improving equity-driven program capacity (HRSA, 2022). These funds have supported intake process improvements, expanded access to social supports, and enhanced professional development opportunities for home visitors.

Integrating Medicaid reimbursement models into home visiting programs strengthens workforce retention by enabling salary standardization, reducing caseload burdens, and funding mentorship initiatives. This ensures long-term financial stability for home visitors while expanding access for low-income families (MDPH, 2020). Aligning Medicaid funding with workforce retention efforts—such as salary standardization, reduced caseloads, and mentorship programs—ensures that home visitors receive long-term professional and financial support.

Securing dedicated funding, integrating Medicaid reimbursement models, and ensuring workforce stability will institutionalize racial equity within home visiting programs, preventing it from being treated as a short-term initiative. These financial facilitators provide the necessary foundation to sustain anti-bias training, workforce diversity initiatives, and structural protections for families, ultimately embedding racial equity into home visiting programs as a long-term commitment rather than a time-limited intervention.

Conclusion

This literature review highlights that, despite growing attention to racial equity in home visiting programs, systemic barriers such as workforce instability, limited data infrastructure, and

historical mistrust continue to undermine these efforts. Existing research identifies promising facilitators—such as sustainable funding, community engagement, and institutionalized equity practices—but there remains a gap in understanding how these strategies are operationalized on the ground by home visitors themselves.

In particular, few studies have centered the perspectives of home visiting staff on how racial equity principles are translated into daily practice. Little is known about the real-world challenges, facilitators, and adaptations that shape equity-driven service delivery within programs like Massachusetts' MIECHV Innovation Award.

This study addresses these gaps by examining how home visitors in MA MIECHV-funded programs perceive and implement racial equity frameworks in their work. By focusing on frontline staff experiences, this research aims to deepen understanding of the operational barriers and facilitators influencing equitable outcomes, providing practical insights to inform future program design and policy development.

The following methods section outlines the mixed-methods approach used to explore these dynamics, including participant recruitment, data collection, and analysis strategies.

Chapter 3: Methods

Research Design

This study employs a mixed-methods, secondary data analysis approach to examine how Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) programs operationalize racial equity. By integrating both qualitative and quantitative data, this research provides a comprehensive analysis of the strategies, barriers, and facilitators that shape equity-focused practices within home visiting services.

This study is a secondary data analysis utilizing data originally collected through the MA MIECHV Innovation Award Evaluation, conducted by Tufts Interdisciplinary Evaluation Research (TIER) in collaboration with the Massachusetts Department of Public Health (MDPH). One goal of the original evaluation was to examine and refine how MA MIECHV programs integrated data-driven racial equity approaches in their services. This study extends the original evaluation by refining the analytical framework to answer two research questions:

(1) How do MA MIECHV staff operationalize racial equity in their service delivery to children and families?

(2) What are the key barriers and facilitators that influence the ability of MA MIECHV staff to implement racial equity in practice?

Instead of replicating the original study's methods, this research applies an adapted coding framework designed specifically to address the study's research questions. By applying a revised coding framework and integrating thematic qualitative analysis with quantitative survey data, this study provides a more focused examination of how racial equity efforts are implemented, sustained, and challenged within MA MIECHV programs on a day-to-day basis.

This mixed-methods approach captures both the depth of individual experiences and broader programmatic trends, ensuring a comprehensive analysis of racial equity implementation.

Justification for Secondary Analysis

The decision to use secondary data analysis is justified by several factors. The Innovation Award Evaluation represents a comprehensive and systematically collected dataset that captures multiple dimensions of racial equity efforts across 23 Local Implementing Agencies (LIAs). By utilizing this dataset, the study benefits from an established and rigorously conducted data collection process, eliminating the need for additional recruitment while maximizing the use of rich existing data.

Secondary data analysis allows for a more focused and refined examination of specific research questions. While the original evaluation assessed a broad range of equity and continuous quality improvement (CQI) activities, this study hones in on the specific ways in which MA MIECHV home visiting programs operationalize racial equity and the key barriers and facilitators influencing these efforts. This targeted approach provides deeper insight into the practical application of racial equity strategies and contributes to a more precise understanding of equity implementation within home visiting services.

Additionally, secondary data analysis enables longitudinal examination without the need for additional data collection. The REPDRA discussions, case studies, and Innovation Pulse Surveys were collected at multiple time points, allowing for the assessment of changes in racial equity engagement over time. The availability of both qualitative and quantitative data enhances the robustness of the study, providing a comprehensive understanding of how racial equity efforts evolved throughout the Innovation period.

Participants

The data analyzed in this study were collected from participants involved in the Innovation Award Evaluation, including home visitors, supervisors, program coordinators, and Parent Leaders from 23 Local Implementing Agencies (LIAs) across Massachusetts. These LIAs operated under three nationally recognized home visiting models: Health Families (HF), and Parents as Teachers (PAT). The inclusion of multiple home visiting models ensures that the study captures a diverse range of program structures, service delivery methods, and organizational approached to racial equity.

While the broader evaluation included all 181 LIA staff members across the 23 LIAs, the case study component of the evaluation focused on a subset of four LIAs. These sites were strategically selected to ensure representation of different MA MIECHV home visiting models, geographic diversity, and variability in data quality and implementation. The case study sites provided deeper, site-specific insights into how home visiting staff and programs integrated racial equity strategies into their work. Because this study is a secondary data analysis, no new participants were recruited, and only de-identified data from the original study were analyzed.

Data Sources

The qualitative component consists of a thematic analysis of coded transcripts from the Racial Equity Program Data Readiness Assessments (REPDRA) and Case Studies, providing in-depth insight into how home visiting staff engage with racial equity strategies in practice. The quantitative component includes Likert-scale survey responses and demographic information from the Innovation Pulse Surveys (Q1-Q4) and Pre- and Post-Training Surveys (CQI, Racial Equity, Family Engagement). These surveys track shifts in participants' engagement with equity initiatives over time, offering a broader perspective on workforce trends. Additionally, this study

analyzes the open-ended suggestions and comments provided by staff members in the Pulse Surveys and Pre- and Post-Training Surveys to capture their perspectives on the challenges and facilitators of implementing racial equity strategies in home visiting services.

Racial Equity Program Data Readiness Assessment (REPDRA)

The Racial Equity Program Data Readiness Assessments (REPDRA) were conducted to evaluate the extent to which LIA staff utilized racial equity data in their decision-making processes and programmatic adjustments. The assessment was administered at two time points to capture longitudinal shifts in racial equity engagement. The first iteration (T1) was self-administered by LIA teams in fall 2023, using a structured discussion protocol and recording their responses via Zoom. The second iteration (T2), conducted in summer 2024, was facilitated by a trained TIER research assistant to ensure consistency and depth in data collection.

For this study, only the qualitative transcripts of REPDRA discussions were analyzed. These transcripts were transcribed, de-identified, and coded thematically using NVivo to examine how LIAs engaged with racial equity, particularly in terms of data-driven decision-making and the application of disaggregated data in programmatic adjustments. The analysis focused on identifying patterns in how racial equity was operationalized and whether shifts in engagement were evident between T1 and T2. The REPDRA Facilitation Guide, which details the structured discussion protocol followed by LIAs, is included in Appendix B.

Case Studies

In addition to the REPDRA, four LIAs were selected for case studies, providing an in-depth examination of how home visiting staff operationalized racial equity in their service delivery. These case study sites were intentionally chosen to ensure the representation of

different home-visiting models, including Healthy Families (HF) and Parents as Teachers (PAT), as well as geographic diversity and variation in data engagement.

Each case study incorporated multiple data collection strategies, including semi-structured interviews with LIA leadership and supervisors, focus groups with CQI teams and Parent Leaders, observational data from LIA meetings, and a review of program documents. These discussions were recorded, transcribed, and thematically analyzed using the same refined codebook as the REPDRA discussions, ensuring consistency across both qualitative datasets. The case studies allowed for a more nuanced exploration of racial equity integration, highlighting specific strategies, challenges, and organizational dynamics that influenced equity-focused efforts. The Case Study Interview and Focus Group Guide is included in Appendix C.

Pulse Survey

The Pulse Surveys were administered quarterly (Q1-Q4) to all LIA staff throughout the Innovation period to systematically track their engagement with racial equity initiatives and CQI activities. The surveys measured participation in racial equity training, confidence in applying racial equity strategies, and perceived barriers and facilitators to implementing equity-focused approaches in home visiting programs.

Each survey iteration provided insight into how engagement with racial equity evolved over time. The final survey (Q4) focused specifically on the user experience of the Data Dashboard; a tool developed by TIER to support data-driven decision-making during the Innovation Award Evaluation. Quantitative analysis of the survey responses included descriptive statistics, bivariate analysis, and comparisons over time. The survey data had already been cleaned and organized into an Excel format before being used in this study, with Pearson

correlation analyses and other preliminary statistical tests conducted by the original research team. The Innovation Pulse Survey Questionnaire is included in Appendix D.

Pre- and Post-Training Survey

Pre- and post-training surveys were conducted to evaluate the effectiveness of three training modules: racial equity, family engagement, and CQI. These surveys measured participants' knowledge acquisition, confidence in applying new skills, and overall satisfaction with training content. The pre-training surveys established baseline measures of participants' familiarity with racial equity concepts, while the post-training surveys assessed shifts in confidence and perceived ability to integrate training content into daily practice. Quantitative analysis of survey responses included comparisons of means over time and correlation analyses to assess relationships between training participation and changes in racial equity engagement. The Pre- and Post-Training Survey Questionnaire is included in Appendix E.

Procedure

Qualitative Analysis: Codebook Refinement and Thematic Coding

This study employed a refined coding framework based on the original Innovation Award Evaluation codebook, narrowing the focus to codes directly relevant to the study's research questions. While the original evaluation aimed to assess multiple aspects of home visiting programs using both inductive and deductive coding, this study exclusively applied a deductive coding approach to analyze data through pre-established racial equity constructs from the Innovation Award Evaluation.

The refinement process involved systematically reviewing the original codebook and selecting only the parent and child codes that directly addressed the research questions on how

MA MIECHV programs operationalize racial equity and the barriers and facilitators influencing these efforts. Codes unrelated to these areas were removed to maintain analytical precision. To ensure reliability, three REPDRA transcripts were recoded using the refined codebook and compared against the original coding from the Innovation Award Evaluation. This process confirmed that the revised framework maintained alignment with prior interpretations while enhancing its specificity to racial equity operationalization. Thematic mapping was then used to organize and connect key themes with the study's two research questions, ensuring analytical consistency. The final codebook used for qualitative analysis is included in Appendix A.

Quantitative Analysis and Mixed Methods Integration

Following the qualitative analysis, key themes were compared against the quantitative survey data to examine alignment or discrepancies between the two datasets. The quantitative data from the Innovation Pulse Surveys (Q1–Q4) and Pre- and Post-Training Surveys were received after initial statistical analyses had been conducted by the original research team. These datasets were provided in a cleaned Excel format, with some statistical tests—including Pearson correlation analysis—already completed. The availability of pre-analyzed quantitative data enabled a structured comparison between qualitative findings and measurable trends in racial equity engagement.

The original evaluation employed both descriptive and inferential statistical analyses. Descriptive statistics—including means, percentages, and standard deviations—were used to summarize workforce engagement in racial equity training, confidence levels in applying racial equity strategies, and perceived barriers to implementation.

To assess individual-level change over time, the original evaluation conducted repeated measures analyses. For example, changes in staff confidence in using disaggregated racial equity

data were measured before and after training sessions using repeated measures t-tests or analysis of variance (ANOVA) to determine whether shifts in scores were statistically significant. Additionally, Pearson correlation coefficients were calculated to examine associations between key variables, such as the association between participation in racial equity training and confidence in applying racial equity strategies.

In this study, Likert-scale survey data were analyzed to track changes over time, employing descriptive statistics such as means and standard deviations. Comparative analyses between pre- and post-training measures assessed shifts in engagement, confidence levels, and the application of CQI strategies in equity work. By integrating qualitative themes with these quantitative findings, this study provides a comprehensive, mixed-methods perspective on how racial equity efforts were operationalized in MA MIECHV home visiting programs.

Triangulation of Data

To strengthen the validity and reliability of the findings, this study employs data source triangulation, a methodological approach that enhances credibility by converging information from multiple sources. The use of four distinct data sources—Racial Equity Program Data Readiness Assessments (REPDRA) transcripts, case studies, Innovation Pulse Surveys, and Pre- and Post-Training Surveys—ensures that the study captures multiple perspectives on racial equity implementation within MA MIECHV programs.

Denzin (1978) introduced the concept of triangulation as a methodological approach to enhance research validity by integrating multiple perspectives. He identified four types of triangulation: data triangulation, investigator triangulation, theory triangulation, and methodological triangulation. This study applies data triangulation, which involves analyzing multiple datasets to examine the same phenomenon—how home visiting programs operationalize

racial equity. By comparing findings from different sources, this approach reduces bias, strengthens credibility, and enhances analytical depth.

Triangulation is achieved by systematically comparing qualitative themes with quantitative patterns identified in the survey data. For example, if qualitative data suggest that home visitors increasingly use disaggregated data to inform programmatic decisions, this finding is corroborated by corresponding survey data measuring changes in staff confidence and readiness to engage with racial equity data. Additionally, where qualitative and quantitative findings diverge, further interpretation assesses whether discrepancies stem from structural barriers, inconsistencies in self-reporting, or differences in how racial equity is conceptualized at different organizational levels.

By integrating multiple data sources, this study ensures that findings are not solely dependent on a single dataset but instead reflect a comprehensive, empirically supported analysis of racial equity operationalization in MA MIECHV programs. To systematically align qualitative themes with quantitative findings, a triangulation matrix (see Table 1, 2, 3) was developed. This matrix allowed for a structured comparison of themes emerging from qualitative data with corresponding survey responses, highlighting points of convergence and divergence.

IRB Research Review

This study received a Not Human Subjects Research (NHSR) determination from the Tufts Social, Behavioral, and Educational Research Institutional Review Board (IRB) (IRB ID: STUDY00005759). The IRB determined that the research does not meet the definition of human subjects research under the Department of Health and Human Services (DHHS) and Food and Drug Administration (FDA) regulations and, therefore, does not require IRB oversight. The determination applies to the activities described in the IRB submission and does not extend to

modifications that would alter the scope of the study. If any changes to the study design were proposed that might engage human subjects, a modification request would need to be submitted to the IRB for further determination.

All data used in this study were de-identified and securely stored in Tufts Box, with access restricted to authorized research team members. Standardized transcription and coding protocols were employed, and inter-rater reliability checks were conducted to ensure coding consistency.

Chapter 4: Results

Research Question 1: How do MA MIECHV staff operationalize racial equity in their service delivery to children and families?

Shifting Decision-Making Power to Families

A core component of operationalizing racial equity within Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) programs is the intentional shift from a provider-driven model to one that actively involves Parent Leaders in decision-making. Many programs recognize the value of co-creation, ensuring that services develop with families rather than solely for them. This participatory approach enhances the relevance and responsiveness of home visiting programs to the diverse needs of the families they serve.

Qualitative findings from the REPDRA data and case studies illustrate how Parent Leaders take on active roles in shaping programmatic decisions. One participant describes how the inclusion of Parent Leaders enables them to contribute meaningfully to discussions on program improvement, stating, "Parents now see the data and contribute to the discussion" (T1, Program 13). Similarly, another program highlights the increased advocacy efforts of Parent Leaders, noting, "During this cycle, our Parent Leaders have been so active in the community, advocating for the program" (T1, Program 1). This shift toward greater parent involvement is particularly impactful in ensuring that programming addresses the lived experiences of historically marginalized families.

The integration of Parent Leaders also enhances cultural competence within programs. One program reports that a Parent Leader provides critical insight into the barriers undocumented families face in accessing health services, sharing, "Our Parent Leader gave us insights about why undocumented families might fear coming to the health center" (T1, Program

3). The lived experiences of Parent Leaders reinforce the value of this co-creation model. Staff also express how this involvement strengthens their work, with one participant emphasizing, "Just having them be a part of our team has been really invaluable" (T1, Program 21). This sentiment echoes in T2, as a program reflects on the sustained benefits of Parent Leader engagement: "I think that's been the highlight of this work—really getting [Parent Leader] involved in some decisions that we've made, the creativity end of things… So just having them be a part of our team has been really invaluable" (T2, Program 21).

Programs that successfully engage Parent Leaders note that these individuals take on specific roles that allow them to advocate on behalf of their communities. As one program describes, "Parent Leaders have had specific roles in the cycle that have activated them on behalf of something they believe in, and they have stepped up to participate" (T2, Program 1). Another participant reinforces the idea that Parent Leaders are essential to increasing outreach, sharing, "We were going to put out flyers in places where families from different communities go. She probably goes places that I don't go to, so we put flyers there, did some outreach, and branched out" (Case Study 3, T1, Parent Leader FG). These findings indicate that Parent Leaders serve not only as decision-makers but also as critical facilitators of community engagement and outreach.

Over time, staff confidence in sharing identifiable program data with Parent Leaders grows significantly, reflecting a shift toward increased transparency and collaboration. In Pulse Survey 1, only 25% of staff report feeling comfortable sharing such data, but by Pulse Survey 3, this figure rises to 43.3%. This steady increase suggests that as programs refine their approaches to data-sharing and as trust between staff and Parent Leaders deepens, hesitancy decreases. These improvements indicate progress in balancing transparency with confidentiality

considerations, demonstrating a growing recognition of Parent Leaders as integral partners in programmatic decision-making.

Demographic data from the Pulse Surveys further illustrate the strengthening of Parent Leader engagement over time. While early efforts to integrate Parent Leaders face initial challenges—evidenced by 75% of Parent Leaders having less than one year of experience in Pulse Survey 1—retention steadily improves, with this figure decreasing to 63.6% in Pulse Survey 2. By Pulse Survey 4, retention rates markedly strengthen, with 98% of programs maintaining at least one Parent Leader since the project's inception. This trend suggests that as Parent Leaders become more embedded in program structures and their roles are more clearly defined, their long-term engagement in Continuous Quality Improvement (CQI) initiatives becomes more sustainable.

These findings suggest that shifting decision-making power to families is a key strategy for operationalizing racial equity in home visiting programs. Qualitative data illustrate the value of Parent Leaders in increasing outreach, advocating for community needs, and informing culturally responsive practices, while quantitative data confirm a growing institutional commitment to Parent Leader retention. Despite these advances, challenges related to role clarity and data transparency persist, suggesting that continued structural support and refinement of Parent Leader engagement models are necessary to maximize their impact.

Building a Workforce That Reflects the Community

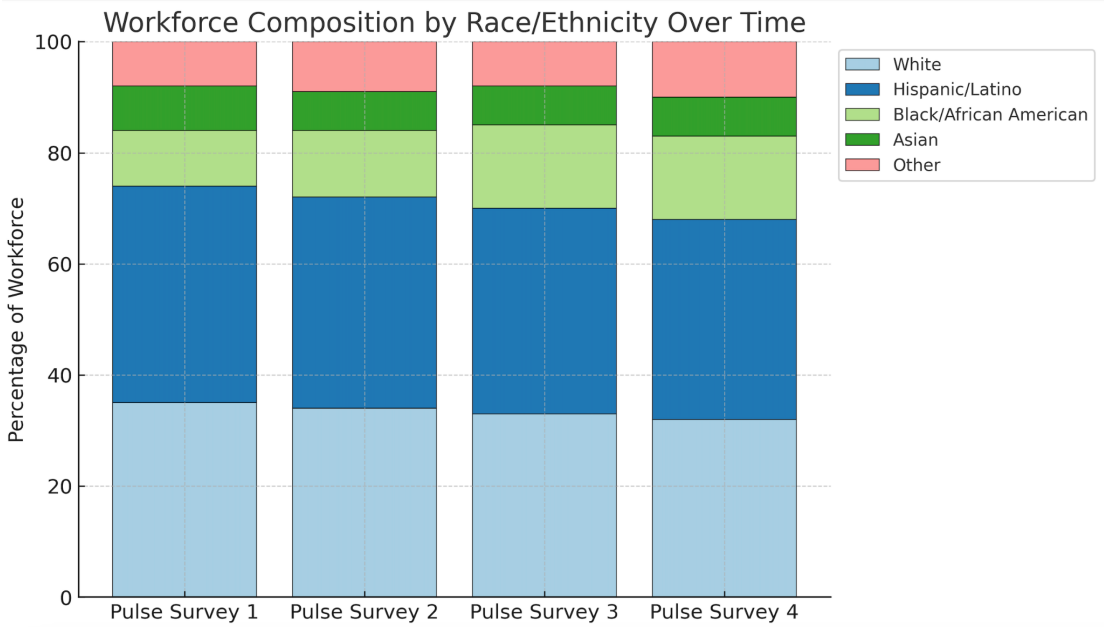
Programs that prioritize hiring bilingual and bicultural staff demonstrate a greater ability to provide equitable services and build trust with families. Many programs recognize the necessity of aligning staff demographics with the populations they serve, using data to inform hiring decisions and improve cultural responsiveness. One program describes a strategic

approach to ensuring their workforce reflects community demographics: "We are always using the data. We're always making sure that even the people that we hire reflect the community that we serve" (T1, Program 14). This data-driven approach enables programs to identify gaps in representation and take proactive steps in hiring.

The integration of bilingual staff is particularly evident in regions with a high percentage of Spanish-speaking families. One site reports that nearly every team member is now proficient in Spanish, allowing for better service delivery: "Almost every single staff member in here now speaks Spanish because that is the population that we're seeing more" (T1, Program 7). Similarly, another program uses data to adjust hiring decisions, identifying gaps in language accessibility and addressing them through targeted recruitment: "We've started breaking down our data by race and language to see if there are gaps… we noticed we need another Spanish-speaking home visitor. So, we're looking to hire one" (T2, Program 4).

Figure 1

Workforce Composition by Race/Ethnicity Over Time



This figure illustrates workforce racial diversity across four Pulse Surveys, highlighting the increase in Black/African American staff and the stabilization of Hispanic/Latino staff representation.

Demographic data from the Pulse Surveys provide further insight into workforce diversity and regional staffing trends. As shown in Figure 1, Hispanic/Latino staff consistently comprise the largest racial group, ranging from 34.9% to 39%, followed by White staff (32.5% to 38%) and Black/African American staff, whose representation increases from 9.8% in Pulse Survey 1 to 20.8% in Pulse Survey 2 before stabilizing at approximately 15%. These shifts suggest that efforts to promote workforce diversity yield improvements, with increasing representation of Black staff members over time.

Regional staffing patterns further highlight the importance of targeted recruitment strategies. Southeastern Massachusetts shows the highest staff participation in surveys (27.3%–41%), while Western Massachusetts has the lowest (13.9%–16.9%), raising considerations for

ensuring equitable access to diverse staff in all regions. Workforce composition by role and tenure also reflects strong staff engagement. Home Visitors/Parent Educators form the largest group (34.2% to 45.4%), followed by Supervisors (26.5% to 29.1%) and Coordinators (10.6% to 16.5%). Most staff have between 1–5 years of experience (54.9% to 59%), with fewer than 8.7% in their first year, indicating relative workforce stability.

In addition to hiring, some programs reassess their recruitment and onboarding processes to promote cultural humility and inclusivity. One site shares that they revise interview questions to ensure that new hires align with the program's equity goals: "We re-evaluated our interview questions when hiring candidates to ensure cultural humility" (T2, Program 20). This suggests that programs not only focus on increasing workforce diversity but also on fostering an inclusive and equity-driven workplace culture.

Taken together, these findings indicate that MA MIECHV programs make significant progress in aligning their hiring practices with the linguistic and cultural needs of families. The integration of bilingual and bicultural staff strengthens service delivery, while the use of data-driven hiring practices and equity-focused training contributes to a more representative and inclusive workforce.

Language Accessibility and Cultural Responsiveness in Service Delivery

Programs implement a range of strategies to reduce linguistic barriers, ensuring that families access services in their preferred language and within a culturally responsive framework. While hiring bilingual staff plays a role in improving language accessibility, programs also modify outreach materials, adapt service delivery, and leverage technology to enhance communication. These efforts not only increase engagement among linguistically diverse families but also foster greater trust between families and service providers.

A key component of language accessibility is the translation of program materials. One program emphasizes the importance of making information available in multiple languages to reach a broader audience: “We make the flyers now in different languages to reach more populations” (T1, Program 10). Another program recognizes the need to ensure that key developmental screenings are accessible, noting: “We had noticed that some of our Arabic-speaking families weren’t doing their ASQs in a timely manner. So we ordered Arabic ASQ tools to help families complete them” (T1, Program 3). These adaptations allow families to better understand and engage with services that directly impact their children’s development.

Beyond written materials, programs tailor service delivery to meet the linguistic and cultural needs of families. One program creates an inclusive approach to childbirth education, offering classes in Spanish and integrating voter registration support into their sessions: “We have birthing classes in Spanish, and we also partner on voter registration” (T1, Program 7). Another program adjusts the curriculum for parenting classes based on cultural feedback: “We adjusted our parenting classes for Spanish-speaking families because they wanted to focus on self-esteem and healthy relationships, while the English-speaking class was more about parenting tips” (T2, Program 18). These modifications ensure that services are not only translated but also culturally relevant.

In cases where bilingual staff are unavailable, programs utilize technology to facilitate communication. One program invests in translation devices to bridge the language gap: “We purchased translation devices to try to help break some of those barriers with the language” (T2, Program 16). Similarly, an experience with a Haitian Creole-speaking participant underscores the importance of accurate translations: “A participant who speaks Haitian Creole needed eye drops, but her translation app kept saying ‘false lashes,’ so the worker took her to the makeup

aisle. That's when we realized we needed a better system" (T2, Program 8). These anecdotes highlight the challenges of relying solely on digital translation tools and the importance of developing comprehensive language access strategies.

The impact of these efforts is reflected in the pre- and post-training survey data. Following the Family Engagement training, staff report a significant increase in their understanding of equity versus equality in family engagement (pre-training $M = 3.97$, post-training $M = 4.62$, $\Delta = +0.65$, $n = 70$), indicating a growing awareness of the need for language-accessible and culturally adapted services. Staff confidence in engaging diverse families also increases, aligning with qualitative findings on the importance of multilingual materials and bilingual staffing.

Demographic data from the Pulse Surveys further emphasize the necessity of these adaptations. While English remains the most common primary language spoken among staff (69%–73%), a significant proportion of the workforce speaks Spanish (13.7%–17.7%), with smaller but notable representation of Cape Verdean Creole speakers (3.4%–5.2%). Other languages, including Portuguese, Haitian Creole, and Vietnamese, are also present, albeit at lower frequencies. This linguistic diversity within the workforce plays a crucial role in ensuring that families from diverse backgrounds communicate with service providers in their preferred language.

Parents themselves recognize the importance of these efforts. One Parent Leader recalls their relief when language accommodations are introduced: "I was so happy to see yesterday that you guys had translation because before, we were told, if you don't speak English, you can't participate" (Case Study 3, T1, Parent Leader). Another program emphasizes the importance of matching outreach strategies to the languages spoken in the community: "We started translating

our flyer—one in Spanish, one in Haitian Creole, and a general flyer. We need to see the different communities that we serve" (Case Study 2, T1, CQI). These perspectives underscore the value of embedding language accessibility at every level of program implementation.

These findings demonstrate how MA MIECHV programs move beyond simply hiring bilingual staff to create a more linguistically inclusive service environment. By translating materials, adapting programming, and incorporating digital tools, programs make meaningful strides in reducing language barriers. These efforts not only improve engagement among diverse families but also reinforce a culture of inclusion, where all families feel welcomed and understood.

Leveraging Data to Identify and Address Racial Disparities

In T2, programs significantly expand their capacity to use disaggregated data as an operational tool to identify and address racial disparities. Unlike earlier stages of the innovation, where data serve primarily as a facilitator for racial equity discussions, T2 marks a shift toward intentional, structured data analysis that informs staffing, outreach, and service modifications. Programs leverage data tools such as the MIECHV Data Dashboard and the Equity Spotlight to uncover disparities and implement targeted interventions, demonstrating a more sophisticated approach to racial equity work.

One of the most tangible applications of disaggregated data is in workforce development. A program leader describes how data analysis directly influences hiring decisions: "We've started breaking down our data by race and language to see if there are gaps… we noticed we need another Spanish-speaking home visitor. So, we're looking to hire one" (T2, Program 4). By systematically analyzing service participation rates by race and language, programs ensure that their staffing patterns reflect the linguistic needs of their communities. Similarly, another

program uses data to identify service gaps in postpartum care: “At the beginning of our CQI project, we realized that Spanish-speaking families were not getting postpartum visits, so we focused on understanding why and what we could do to help” (T2, Program 17). This highlights how data analysis allows programs to proactively address disparities rather than reactively responding to inequities after they have already taken root.

Programs also use data to track disparities in healthcare access and service utilization. One team recognizes a critical barrier preventing families from seeking medical care: “The PDSA data really opened our eyes that a lot of our families, primarily our Spanish-speaking families, weren’t going to the doctor because their MassHealth wasn’t being renewed” (T2, Program 7). This insight leads to a targeted intervention to assist families in navigating the MassHealth renewal process, thereby improving healthcare access for Spanish-speaking participants. Another program observes differences in long-term program engagement across racial and ethnic groups: “Based on our data, Hispanic participants stay in the program much longer than non-Hispanic participants. We needed to be more creative about where we do outreach for non-Hispanic families” (T2, Program 6). This demonstrates how programs not only identify disparities but also adapt their outreach strategies to ensure equitable engagement across racial and ethnic groups.

The increased reliance on data-driven decision-making is reflected in quantitative measures of staff capacity. The CQI training results demonstrate a significant improvement in staff understanding of how data can be used to address racial inequities ($\Delta = +0.69$, $n = 83$). Additionally, staff confidence in using CQI to address racial disparities increases substantially, from a mean of 3.36 pre-training to 4.31 post-training ($\Delta = +0.95$, $n = 94$). Participants also

report stronger proficiency in applying run charts to track program improvements ($\Delta = +1.07$), indicating a growing ability to monitor equity-based outcomes.

Pulse Survey data further illustrate the progression of data engagement over time. Confidence in interpreting racial equity data, as measured by the Equity Spotlight tool, increases from 43.5% in Pulse Survey 1 to 51.3% in Pulse Survey 2. Learning related to racial equity data within the Innovation Initiative also increases, from 41.3% in Pulse 1 to 52.6% in Pulse 3, suggesting that staff develop a more nuanced understanding of how to use data to inform racial equity strategies. Additionally, exploration of the MIECHV Data Dashboard grows, from 63.3% in Pulse 3 to 72.9% in Pulse 4, reflecting increasing engagement with data visualization tools as a means of guiding programmatic decision-making.

However, as staff become more adept at using data, they also recognize limitations in how racial identity is categorized. One staff member describes how the data dashboard leads to a moment of clarity about racial misclassification: “The data dashboard for us, it was kind of like an eye opener... You need to ask the correct question because many visibly non-white families were being classified as White” (Case Study 2, T2, CQI). This acknowledgment reflects the evolving sophistication of data use in T2—not only are programs analyzing racial disparities, but they are also critically assessing whether their data collection methods accurately capture the racial identities of the families they serve.

These findings indicate a major shift in the way MA MIECHV programs operationalize data use in T2. No longer a secondary consideration, data become a central driver of racial equity work, shaping staffing decisions, outreach strategies, and service provision. The transition from T1 to T2 demonstrates the impact of increased access to disaggregated data and the growing proficiency of program staff in using CQI methodologies to address racial inequities. By

integrating qualitative insights with quantitative trends, the results illustrate how programs evolve from merely discussing equity concerns to implementing data-informed solutions that actively reduce disparities in home visiting services.

Table 1

Triangulation Matrix: Operationalizing Racial Equity

Theme	Summary of Qualitative Findings	Supporting Quantitative Data
Shifting Decision-Making to Families	Programs increasingly included Parent Leaders in decision-making, ensuring services were co-created with families rather than solely provider-driven. Parent Leaders contributed to discussions, increased advocacy, and strengthened cultural competence by sharing insights from lived experience.	Staff confidence in sharing identifiable program data with Parent Leaders increased from 25% (Pulse Survey 1) to 43.3% (Pulse Survey 3). Retention of Parent Leaders improved from 75% with less than one year of experience (Pulse 1) to 63.6% (Pulse 2) and 98% maintaining at least one Parent Leader (Pulse 4).
Hiring & Staffing to Reflect Communities	Programs used data to guide hiring and prioritized bilingual, bicultural staff to improve cultural responsiveness and service accessibility. Staff expressed the importance of hiring workers who matched the linguistic and racial backgrounds of families. Programs adjusted hiring strategies to address language accessibility gaps.	Hispanic/Latino staff increased (34.9%–39%), followed by White staff (32.5%–38%), and Black staff, whose representation increased from 9.8% (Pulse 1) to 20.8% (Pulse 2) before stabilizing at 15%.
Embedding Language Accessibility	Programs translated materials, modified service delivery, and leveraged technology to improve language access. Outreach efforts included culturally specific programming (e.g., Spanish-language birthing classes, voter registration events).	Workforce language diversity: Spanish speakers increased from 13.7% to 17.7%; Cape Verdean Creole speakers from 3.4% to 5.2%. Staff understanding of culturally responsive family engagement increased from 3.94 (pre-training) to 4.39 (post-training) $\Delta = +0.45$ (Family Engagement Training).
Using Data to Identify Racial Disparities	Programs moved from general discussions to structured, disaggregated data use in staffing, outreach, and CQI projects. Data dashboards helped identify gaps, leading to targeted interventions.	Staff confidence in using CQI to address racial disparities increased from $M = 3.36$ (pre) to $M = 4.31$ (post), $\Delta = +0.95$, $n = 94$. Engagement with the MIECHV Data Dashboard grew from 63.3% (Pulse 3) to 72.9% (Pulse 4).

This matrix systematically compares qualitative themes from transcribed REPDRA discussions and Case Study focus groups with quantitative findings from Pulse Surveys and Pre-Post Training Surveys. It illustrates how MA MIECHV programs operationalize racial equity, emphasizing shared decision-making, workforce diversity, language accessibility, and data-driven strategies.

Research Questions 2(a): What are the primary barriers that hinder MA MIECHV staff from effectively implementing racial equity in practice?

Challenges with Racial and Ethnic Data Classification

One of the most persistent barriers to operationalizing racial equity within MA MIECHV programs is the challenge of accurately classifying race and ethnicity in data collection. Despite the growing reliance on disaggregated data to inform racial equity strategies, the limitations of standardized racial and ethnic categories often lead to misclassification, obscuring disparities and complicating efforts to address inequities. Staff express frustration that the available classifications do not align with the ways in which families self-identify, leading to inaccurate or incomplete data.

Several program staff describe instances in which Latino families are categorized as White, effectively erasing their racial and ethnic identities from equity-focused analyses. One staff member highlights this issue: “Some people choose ‘white’ as their race even though they are Latino, so it makes the data inaccurate” (T1, Program 20). Another participant explains the consequences of rigid classification systems, stating, “Hispanic is not even an option under race. It says Black, White, Native American, Asian. Many of my families don’t fall under any of them” (T1, Program 12). This disconnect between standard race categories and the lived

identities of program participants results in data that does not fully reflect the communities being served.

Beyond the misclassification of Latino families, staff also encounter difficulties in categorizing individuals of Middle Eastern and North African (MENA) descent. One program reports: “Many of our families are Moroccan or Algerian, and they identify differently—some as white, some as other, some aren’t sure. The data doesn’t distinguish between a Moroccan family and a white American family” (T2, Program 3). This lack of specificity makes it challenging to identify whether these populations face unique disparities in service access and engagement. A staff member further reinforces this issue, stating, “All of these people are labeled as white, but they’re from all over the world—Mediterranean white, Hispanic white” (T1, Program 10).

While programs seek to refine data collection methods, they often face institutional constraints. One staff member notes: “We wanted to add more specific ethnicity options, but we were told we have to follow HRSA categories” (T2, Program 7). Similarly, the inability to track nuanced racial and ethnic identities limits the program’s ability to identify and address inequities, as another staff member observes: “Participants themselves can't connect to those broader categories of how they define themselves… We have traditionally gotten a lot of responses as ‘unknown,’ and that unknown data doesn’t tell us anything” (T2, Program 21). This highlights a systemic issue in racial equity work—without accurate racial and ethnic data, disparities remain hidden, making targeted interventions difficult to implement.

Despite these challenges, training initiatives improve staff capacity to engage with racial equity data. The pre- and post-training survey results demonstrate that knowledge of how to use data to address racial inequities increases ($\Delta = +0.69$, $n = 83$). However, a subset of participants (7.7%) remains uncertain about how to apply this knowledge, indicating that while training

strengthens theoretical understanding, practical implementation barriers persist. Pulse Survey data similarly reflect mixed progress. While over half of respondents in Pulse Surveys 1-3 report learning something new about data, many continue to struggle with applying this knowledge in their daily work. Moreover, while 72.9% of respondents in Pulse Survey 4 have explored the MIECHV Data Dashboard, only 24.7% have actively used it to identify racial inequities, suggesting an ongoing need for technical support and clearer application strategies.

The limitations in racial and ethnic classification are also reflected in how staff perceive the usefulness of data tools. In Pulse Survey 3, only 53.1% of respondents find the MIECHV Data Dashboard useful, though this figure increases slightly to 59.7% in Pulse Survey 4. This suggests that while engagement with data tools improves over time, their practical application for racial equity work remains uneven. A CQI team member emphasizes this gap: “We have all of these white-identifying families, but a good chunk of them weren’t white. If you guys want the correct data, then you need to ask the correct question” (Case Study 1, T2, CQI).

Overall, while programs increasingly rely on data to inform racial equity strategies in T2, persistent issues with racial and ethnic classification create obstacles to fully operationalizing these efforts. The inability of standardized racial categories to capture the diversity of families served leads to misclassification and incomplete data, complicating the identification of disparities. Although training and data tools improve staff knowledge, the findings suggest that additional steps—such as revising classification categories, offering clearer guidance on data interpretation, and integrating more nuanced racial and ethnic tracking mechanisms—are necessary to ensure that equity-driven decision-making is based on accurate and representative data.

Limited Data Literacy and Racial Equity Awareness

While many programs aim to integrate racial equity data into decision-making, the findings suggest that data literacy remains a significant barrier to fully operationalizing these efforts. Despite the increased availability of disaggregated data and training on its use, staff do not consistently apply racial equity data to their work. Although collecting racial equity data is recognized as a key strategy, its full integration into practice continues to be inconsistent across programs.

In T1, many staff members acknowledge that they had not previously examined program performance data through a racial equity lens. One staff member admits, "Before you started this project, had your program looked at performance measures data using a racial equity lens?"—to which they respond, "I don't think we did" (T1, Program 19). Another participant reflects on past practices, stating, "I wasn't thinking us. To be completely honest with you… we were putting in the information, but we weren't looking at like, oh, are we servicing only Whites? Are we servicing Hispanics? Are we servicing Blacks?" (T1, Program 18). These quotes illustrate that while programs collect racial equity data, they have not necessarily used it to inform decision-making or address disparities.

Even as programs begin to recognize the importance of racial equity data, staff often struggle with interpreting and applying it in meaningful ways. One individual notes, "I don't know that we really looked at the performance measures from a racial equity lens. We looked at them from an internal perspective—what measures are we meeting?" (T1, Program 12). This highlights a common challenge in CQI work: programs tend to focus on compliance with performance measures rather than using data to assess and address racial disparities. Another participant emphasizes the difficulty of interpreting numerical data without additional context,

stating, “Because seeing it, that goes right over my head. I mean, as far as obviously, you say, we did good here. This is, you know what I mean? I get that part, but I don't understand the whole numbers thing. I have to see it” (T1, Program 18). This suggests that for some staff, traditional data analysis methods are not accessible, reinforcing the need for more practical, hands-on approaches to data literacy.

Training initiatives aim to bridge this gap, but feedback from T2 suggests that some staff find them repetitive or ineffective. One participant states, "The trainings are fine, but a little repetitive. I want deeper dives into issues—real training, not just conversations." (T2, Program 11). While some staff express a desire for more advanced, application-based training, overall engagement in racial equity learning remains high, with over 90% of participants rating facilitation as "good." Similarly, another staff member expresses frustration with the frequency and perceived redundancy of racial equity training, saying, "We’ve had hours and hours of racial equity training over the years. We don’t need to hear the same thing 11 times" (T2, Program 19). This suggests that while training is widely valued, there is a need for evolving content that builds on prior knowledge rather than repeating foundational concepts.

The quantitative findings further reinforce these insights. While 83.5% of respondents in the pre- and post-training surveys express confidence in applying CQI concepts, 16.5% remain neutral or uncertain, indicating persistent hesitancy in data-driven decision-making. Additionally, some staff request simplified CQI frameworks for Parent Leaders, highlighting an ongoing need for practical, hands-on training that bridges the gap between theoretical knowledge and implementation.

These findings illustrate that while programs make progress in racial equity data collection and analysis, limited data literacy and awareness remain key barriers to fully

operationalizing these efforts. Although training helps improve staff knowledge, many struggle with interpreting and applying data effectively. Future efforts may need to prioritize more interactive, applied learning opportunities that allow staff to practice using racial equity data in decision-making, ensuring that it becomes a meaningful tool for addressing disparities rather than just a compliance measure.

Workforce Limitations: Staffing Shortages, High Turnover, and Time Constraints

The ability to operationalize racial equity is significantly influenced by workforce capacity, particularly in the recruitment and retention of bilingual and bicultural staff. While hiring strategies aim to reflect the racial and linguistic diversity of the communities served, persistent staffing shortages and high turnover rates create barriers to fully realizing these efforts. Time constraints further compound these challenges, limiting staff availability for racial equity training, CQI engagement, and collaboration with Parent Leaders.

Many programs struggle to recruit and retain bilingual and bicultural staff, a key factor in ensuring equitable service delivery. One program notes, “The challenge has been hiring Spanish-speaking and bicultural staff. We hire someone, and she doesn't show up for orientation. Another person stays for one month, then leaves” (T1, Program 8). This pattern of staff attrition makes it difficult for programs to provide consistent, culturally responsive care. The need for targeted hiring is particularly evident in outreach efforts to Haitian families. As one staff member explains, “One of our difficulties in reaching the Haitian community is that we don’t have a Haitian worker. It hasn’t been for lack of trying” (T1, Program 9). Similarly, a CQI team member reflects on the limited linguistic diversity within their workforce, stating, “We only have English and Spanish on the team. Anything beyond that, and we have to use the language line, which is hard. It’s not personal” (Case Study 2, T2, CQI FG). These testimonies illustrate how

staffing shortages directly impact a program's ability to engage and support families from diverse cultural and linguistic backgrounds.

Beyond recruitment challenges, existing staff face increasing workloads, exacerbating burnout and reducing the time available for racial equity work. One supervisor describes the impact of medical leave on staffing capacity, explaining, "One of our home visitors had to take a PMLA leave, so that put us a little bit backward. We're just getting back out there to what our goal was" (T1, Program 14). The strain on remaining staff is further emphasized by a participant in T2, who notes, "We need more funding for more staff. The emotional intensity of this work is a heavy load" (T2, Program 5). Another participant highlights the impact of case overload, stating, "People are carrying extra cases, so when we ask them to do more, they're like, 'Enough, we're carrying enough'" (T2, Program 8). These challenges suggest that even as programs aim to embed racial equity strategies into service delivery, limited workforce capacity constrains their ability to fully implement these efforts.

The quantitative data reinforce these concerns. The Pulse Survey results indicate that time constraints are a major barrier to staff engagement in racial equity initiatives. In Pulse Survey 1, only 40.3% of staff report having enough time to engage in racial equity activities, with only a modest increase to 49.3% in Pulse Survey 2. Similarly, scheduling conflicts between staff and Parent Leaders remain a persistent issue, with 66.3% of respondents in Pulse 1 reporting difficulties in scheduling meetings, declining slightly to 58.6% in Pulse 3. These findings highlight that while training initiatives enhance staff understanding of culturally responsive engagement, systemic workforce limitations hinder the ability to translate this knowledge into practice.

The CQI and Family Engagement training evaluations further underscore this gap between learning and implementation. While staff report significant gains in CQI competencies, including improvements in understanding PDSA cycles (Δ = +1.09) and SMARTIE aims (Δ = +1.41), these gains may be difficult to apply given staffing shortages and time constraints. Similarly, while the Family Engagement training increases participants' understanding of culturally responsive practices, it does not address the structural barriers that limit workforce diversity and sustainability.

These findings indicate that while programs make strides in recruiting diverse staff and prioritizing equity training, persistent workforce shortages and time constraints remain key barriers to fully operationalizing racial equity. Addressing these challenges will require long-term investment in workforce development, retention strategies, and structural changes that alleviate the burden on existing staff while ensuring that bilingual and bicultural hiring efforts are sustained over time.

Table 2

Triangulation Matrix: Barriers to Operationalizing Racial Equity

Theme	Summary of Qualitative Findings	Supporting Quantitative Data
Challenges with Racial and Ethnic Data Classification	Standardized racial/ethnic categories did not align with how families self-identified, leading to misclassification and inaccurate data. Staff recognized that Latino and Middle Eastern families were often incorrectly categorized.	Only 53.1% (Pulse 3) and 59.7% (Pulse 4) found the MIECHV Data Dashboard useful, reflecting challenges in applying racial equity data.
Limited Data Literacy and Racial Equity Awareness	While training increased awareness, staff struggled to apply racial equity data. Some	Only 24.7% of staff actively used the MIECHV Data Dashboard to identify

	found trainings repetitive, while others requested more hands-on learning.	disparities, and 16.5% remained unsure about applying CQI concepts.
Workforce Limitations (Staffing Shortages, Turnover, and Time Constraints)	Hiring bilingual/bicultural staff was difficult due to high turnover and low applicant pools. Staff experienced workload strain, limiting engagement in racial equity initiatives.	Only 40.3% (Pulse 1) and 49.3% (Pulse 2) of staff reported having enough time for racial equity activities. Scheduling conflicts with Parent Leaders declined but remained a concern (66.3% → 58.6%).

This matrix systematically compares qualitative themes from transcribed REPDRA discussions and Case Study focus groups with quantitative findings from Pulse Surveys and pre-post training surveys. It identifies key barriers that MA MIECHV programs encounter in operationalizing racial equity, including challenges in racial and ethnic data classification, difficulties in applying racial equity training to practice, and workforce limitations.

Research Questions 2(b): What key factors facilitate the successful implementation of racial equity within MA MIECHV home visiting programs?

Data as a Tool for Racial Equity Awareness

While the use of disaggregated racial equity data becomes fully operationalized in T2, its introduction in T1 serves as a crucial facilitator for initiating conversations about racial disparities within home visiting programs. At this early stage, staff engagement with data helps raise awareness of inequities but does not yet translate into fully integrated, data-driven decision-making. Rather than being systematically applied to inform hiring, outreach, or service delivery strategies, data in T1 functions as a tool for reflection and discussion, laying the groundwork for deeper equity-focused work in later stages of implementation.

Early experiences with racial equity data in T1 reveal both the promise and limitations of using these metrics to advance programmatic change. One participant describes the value of seeing demographic breakdowns, stating, “Seeing the data broken down by race, ethnicity, language, and gender has been helpful, but I feel like we're still learning how to use it effectively.” (T1, Program 20). At this stage, data serves primarily as a reflection tool rather than an integrated decision-making mechanism. While this sentiment highlights a growing awareness of racial disparities within service participation, it also underscores that in T1, data is used to identify potential inequities rather than systematically address them. In contrast, by T2, programs transition to actively using data to drive programmatic changes, such as hiring bilingual staff and adapting service delivery. Another staff member notes that identifying service gaps through data helps them become more strategic in their approach, explaining, “If there’s a hole, then it’s pretty obvious where the hole is, and then we can be strategic in what it is that we’re trying to do” (T1, Program 19). These reflections illustrate how, even in its early stages, data use facilitates an emerging equity lens within CQI discussions.

As programs gain familiarity with equity-focused data, some begin shifting their approach, moving from passive observation to more intentional engagement. One staff member describes this evolution, stating, “We’ve been mindful of racial equity, but we have changed our approach and are now intentionally looking for equity data” (T1, Program 8). While this shift marks an important step forward, the lack of formalized processes for integrating racial equity data into decision-making means that these efforts remain exploratory rather than systematically embedded in programmatic structures.

The quantitative data further reinforce the role of data as an early-stage facilitator rather than an operationalized practice in T1. Findings from the CQI training survey indicate that staff

make measurable gains in their understanding of data-driven equity work, as demonstrated by improvements in their ability to apply run charts ($\Delta = +1.07$) and SMARTIE aims ($\Delta = +1.41$). However, despite these improvements in knowledge, practical application remains limited. The MIECHV Data Dashboard, designed to support racial equity efforts, is explored by only 24.7% of respondents, suggesting that many staff lack the time, confidence, or institutional support to fully integrate data into their work.

Pulse Survey findings further illustrate how staff engagement with racial equity data increases over time, reflecting a growing comfort level with these discussions. The proportion of respondents reporting that they are learning about racial equity through the Innovation Initiative rises from 41.3% in Pulse Survey 1 to 52.6% in Pulse Survey 3. This suggests that while staff do not yet consistently apply data to drive programmatic changes in T1, exposure to these tools contributes to an evolving understanding of racial disparities within their service populations. These findings highlight the critical role of data in facilitating early-stage equity conversations, even before it becomes fully operationalized. By surfacing racial disparities and prompting staff to consider how services could be more equitably distributed, data serves as a catalyst for future equity work. However, the limited application of data-driven decision-making in T1 underscores the need for sustained capacity-building efforts to ensure that racial equity data moves beyond discussion and becomes embedded in programmatic practices.

Collaborating with Community Partners to Advance Equity

Community partnerships emerge as a key facilitator in advancing racial equity within home visiting programs, providing an essential support network for families and expanding program reach to historically underserved communities. While internal capacity-building efforts, such as data-driven decision-making and staffing strategies, are important in operationalizing

racial equity, external collaboration with trusted organizations helps programs establish credibility, improve service accessibility, and address broader systemic barriers affecting families.

Programs in both T1 and T2 leverage partnerships with local agencies, advocacy organizations, and cultural institutions to enhance their ability to serve diverse communities. One staff member emphasizes the significance of cross-agency collaboration, stating, "We collaborate with WIC, Healthy Families, and other agencies. The community knows of us, and they seek to work with us" (T1, Program 13). By forming strategic alliances with well-established organizations, programs reach more families and ensure that the services they provide are responsive to the specific needs of their communities. Another staff member describes how partnerships help bridge gaps in service provision, particularly in moments of heightened uncertainty for immigrant families, explaining, "We provided families with ‘Know Your Rights’ cards during the ICE crackdown to reduce fear and improve trust in our program" (T1, Program 13).

Community collaboration also plays a role in fostering cultural responsiveness and improving engagement with historically marginalized populations. Programs seek to establish a presence at local cultural events and community gatherings, strengthening relationships with families in an organic and trusted environment. One participant notes, "We join in events like Spanish Heritage Month and Juneteenth to connect with more families" (T1, Program 10), illustrating the importance of visibility in spaces that are meaningful to the communities being served. In addition to public outreach efforts, some programs engage in structured racial equity discussions with other service providers. One staff member describes their participation in broader community meetings focused on racial equity, stating, "We attend monthly community

meetings that address racial equity issues, and if gaps in service are identified, we work with partners to address them" (T1, Program 8). These convenings provide an opportunity for programs to align their equity strategies with those of other organizations, ensuring a more coordinated approach to addressing disparities.

By T2, programs further expand their collaborative efforts, strengthening direct-service partnerships that address social determinants of health beyond home visiting. One staff member describes their approach to connecting families to culturally relevant resources, explaining, "We refer our participants to these people, and in community places for those reasons specifically, where they can have a little more connection to their own personal communities" (T2, Program 20). Another program leverages its relationship with WIC to launch a new initiative aimed at addressing food insecurity, stating, "We're building a food pantry in collaboration with WIC to help families supplement their nutrition" (T2, Program 18). These examples illustrate how partnerships evolve beyond outreach efforts to include more concrete, resource-driven collaborations that directly benefit families.

The quantitative data from Pulse Surveys further support the role of community partnerships as a facilitator in racial equity work. Engagement in Learning Community discussions, which serve as a space for cross-program collaboration and shared problem-solving, increases over time. In Pulse Survey 1, 47.8% of staff report participating in racial equity discussions, a figure that rises to 77.8% by Pulse Survey 3. This increase suggests a growing commitment to engaging in collective dialogue about racial equity, reinforcing the qualitative findings that community-based collaboration is seen as an integral component of equity efforts.

Overall, these findings highlight the critical role that community partnerships play in facilitating racial equity work, particularly in T1, when programs are still developing internal

racial equity frameworks. By working with trusted organizations, participating in equity-centered discussions, and engaging in culturally relevant outreach, programs extend their impact beyond direct service provision. While internal programmatic changes are necessary for operationalizing racial equity, external partnerships provide essential reinforcement, ensuring that programs remain responsive to the evolving needs of the communities they serve.

Advancing Racial Equity Through Training and Capacity Building

Training and professional development emerge as a critical facilitator in advancing racial equity efforts, equipping staff with the necessary knowledge and frameworks to implement equity-centered practices within home visiting programs. While training alone does not fully operationalize racial equity, it plays an essential role in building foundational awareness, fostering dialogue, and preparing staff to engage with data, community partnerships, and culturally responsive service provision. Programs leverage structured training initiatives to deepen staff understanding of racial disparities, challenge implicit biases, and introduce concrete strategies for addressing inequities in service delivery.

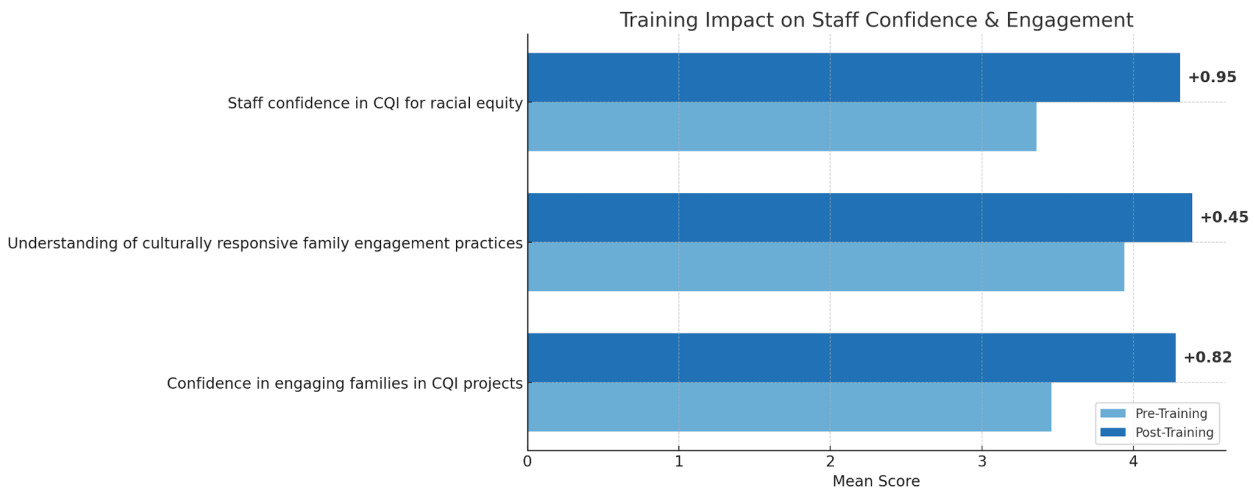
In T1, early training efforts focus primarily on raising awareness of racial equity issues. Staff frequently engage in trainings designed to improve their ability to recognize systemic barriers, as one participant notes, "As parent educators, we are constantly taking trainings to be racially aware" (T1, Program 18). Some programs introduce reflective exercises to prompt deeper self-awareness, such as implicit bias testing. One staff member recalls a particularly impactful experience, stating, "A couple of years back, they had us do the implicit bias test on the Harvard website. It was really eye-opening" (T1, Program 11). These early training efforts serve as an essential entry point into racial equity work, helping staff develop a shared language and conceptual understanding of equity principles.

By T2, training efforts expand to include more targeted and structured learning opportunities. Recognizing the need for sustainable professional development, some programs formalize partnerships with external organizations to provide ongoing training. One program describes a long-term collaboration with an equity-focused training provider, explaining, "We built a contract with an organization that provides cultural humility training for our board, managers, and direct staff" (T2, Program 16). While these trainings strengthen theoretical understanding, some staff express a desire for more practical application, particularly in data analysis and CQI integration. One participant articulates this need, stating, "Is there like a training where it talks about how to read data? I would take it if it was offered" (T2, Program 13). This feedback highlights a shift from general awareness-building to a demand for more hands-on, skill-based training that directly supports equity-focused decision-making.

Quantitative data from the pre- and post-training evaluations further reinforce the role of training as a facilitator. As shown in Figure 2, across all three major training initiatives—racial equity, CQI, and family engagement—staff report significant increases in confidence and knowledge. Specifically, participants in family engagement training report an increase in their ability to engage families in CQI projects from a mean score of 3.46 before training to 4.28 after training ($\Delta = +0.82$). Similarly, understanding of culturally responsive family engagement practices increases from 3.94 to 4.39 ($\Delta = +0.45$), while staff confidence in applying CQI to racial equity improves from 3.36 pre-training to 4.31 post-training ($\Delta = +0.95$). These gains illustrate the effectiveness of structured learning experiences in preparing staff to integrate racial equity principles into their work.

Figure 2

Pre- and Post- Training Impact



This figure illustrates changes in staff confidence and understanding across three training areas: engaging families in CQI projects, culturally responsive family engagement practices, and CQI for racial equity. Post-training scores show significant increases, reflecting the effectiveness of structured training initiatives in improving staff capacity to operationalize racial equity in home visiting programs.

While training is widely viewed as beneficial, staff feedback identifies specific components that are particularly effective in fostering engagement and comprehension. Breakout room discussions, which allow for small-group reflection and real-world application, are cited as a valuable component across multiple trainings. Data visualization techniques, particularly in the racial equity training, also emerge as a key facilitator, with maps and charts depicting racial disparities improving comprehension scores. In CQI training, SMARTIE aims and PDSA cycles provide staff with structured tools for integrating racial equity into quality improvement efforts. However, some staff, particularly Parent Leaders, express a need for simpler explanations and more relatable, real-life examples. In Pulse Survey responses, 8.7% of CQI training participants request adjustments to training materials to improve accessibility.

Overall, training and professional development serve as an essential facilitator by building racial equity awareness, introducing key concepts, and providing structured frameworks for programmatic integration. However, while training participation is high, findings suggest that additional efforts are needed to bridge the gap between theoretical knowledge and practical application. The shift in training needs from T1 to T2—from general awareness to actionable strategies—highlights the ongoing evolution of racial equity work within home visiting programs.

Guiding Racial Equity Efforts Through Leadership

Strong internal leadership and supervision emerge as a key facilitator in helping staff navigate racial equity data and translate insights into actionable strategies. While racial equity training and CQI frameworks provide essential knowledge, it is through supervision and leadership support that staff are able to contextualize data, problem-solve challenges, and integrate racial equity principles into their daily work. Effective supervision creates space for staff to critically reflect on programmatic decisions, assess barriers to equitable service delivery, and receive guidance on applying racial equity data to improve outcomes.

In T1, racial equity data is not yet fully operationalized, and many staff members initially struggle to interpret and apply the data within their work. Some staff members describe how racial equity considerations are not previously part of their program's performance measures, emphasizing the role of supervision in bridging this gap. One participant reflects on their evolving understanding, stating, "Before you started this project, had your program looked at your performance measures data using a racial equity lens? I would personally say no. I look at the numbers, but then the context comes out in supervision." (T1, Program 11). This highlights the critical role of supervision in helping staff interpret racial equity data, particularly in the early

stages when they are still developing confidence in applying it to their work. Supervision provides an opportunity for staff to engage in guided discussions, helping them shift from viewing data as a compliance measure to a tool for addressing racial disparities. As programs move into T2, these supervisory discussions become even more integral in reinforcing racial equity practices and ensuring that CQI data is actively used to drive decision-making rather than simply being reviewed for reporting purposes.

By T2, as programs gain greater access to disaggregated racial equity data, supervision continues to play a critical role in supporting staff through the process of data interpretation and decision-making. One staff member describes how their supervisor facilitates problem-solving discussions, explaining, "The assistance comes when we're in supervision—what are the barriers and making sure people have access." (T2, Program 11). This highlights the role of leadership in ensuring that racial equity data is not only collected but actively used to identify and address gaps in service provision. Supervision creates a structured environment for staff to critically examine their data, discuss emerging disparities, and strategize targeted interventions.

The impact of strong leadership on racial equity implementation is further supported by quantitative data. Findings from the CQI training indicate that over 83.5% of respondents report confidence in applying CQI concepts, suggesting that internal leadership plays an important role in reinforcing CQI principles and equity-focused decision-making. However, despite this overall confidence, 16.5% of respondents remain uncertain about how to effectively implement CQI strategies, indicating that ongoing supervisory support is needed to sustain and deepen racial equity work.

The findings suggest that while training provides staff with the knowledge to engage in racial equity efforts, supervision is a key mechanism for reinforcing learning and addressing

challenges in practical application. The iterative process of data review, reflection, and decision-making within supervision meetings allows staff to refine their understanding and strengthen their ability to integrate racial equity into their work. Moving forward, programs may benefit from continued investment in leadership development and supervision strategies that equip managers with the skills to facilitate meaningful conversations about racial equity, ensuring that data-driven decision-making is embedded across all levels of program implementation.

Table 3

Triangulation Matrix: Facilitators for Advancing Racial Equity

Themes	Summary of Qualitative Findings	Supporting Quantitative Data
Data as a Tool for Racial Equity Awareness	Early data use prompted discussions about disparities. Programs evolved from passive observation to active engagement with racial equity data	Pulse Survey results showed learning about racial equity increased from 41.3% (Pulse 1) to 52.6% (Pulse 3)
Community Partnerships & Collaboration	Collaborating with community organizations improved outreach, credibility, and service accessibility for marginalized families. Programs co-hosted cultural events, provided immigration support, and expanded referral networks.	Participation in racial equity discussions within Learning Communities rose from 47.8% (Pulse 1) to 77.8% (Pulse 3).
Training & Professional Development	Training efforts evolved from general awareness-building to skill-based training (e.g., CQI, data analysis). Staff sought practical, applied learning experiences.	Pre/post training gains: Family engagement training increased CQI project engagement (M = 3.46 → 4.28, Δ = +0.82, n = 71). CQI training improved racial equity application confidence (M = 3.36 → 4.31, Δ = +0.95, n = 94).

Strong Internal Leadership & Supervision	Leadership facilitated application of racial equity training, helping staff integrate data-driven decision-making. Supervision supported problem-solving and contextual application of data insights.	Over 83.5% of respondents reported confidence in applying CQI concepts, demonstrating the role of leadership in reinforcing training effectiveness. 90%+ of staff rated racial equity training facilitation as "good", reinforcing the role of leadership in guiding staff through learning and application.

This matrix systematically compares qualitative themes from transcribed REPDRA discussions and Case Study focus groups with quantitative findings from Pulse Surveys and pre-post training surveys. It highlights key facilitators that supported MA MIECHV programs in operationalizing racial equity, including increased data engagement, strengthened community collaboration, the evolution of training efforts, and leadership support.

Chapter 5: Discussion

Introduction

This study examines how Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) programs operationalize racial equity and the barriers and facilitators that influence this process. The findings contribute to a growing body of research on racial equity in maternal and child health, particularly within the home visiting field, by demonstrating how racial equity strategies are integrated into programmatic structures and identifying the challenges that persist in implementation.

This discussion synthesizes key findings using the three-pronged framework established in the literature review, focusing on data-driven decision-making and readiness, community engagement, bias reduction, and structural supports. Each of these pillars is analyzed in relation to previous literature, highlighting areas where the findings support, challenge, or extend existing research. The discussion also explores the broader implications for home visiting services, with particular attention to how continuous quality improvement (CQI) strategies, community partnerships, and structural reforms shape the advancement of racial equity.

Finally, the study's limitations are considered, and recommendations for future research and policy directions are outlined. These considerations emphasize the importance of embedding racial equity as an enduring principle within home visiting programs rather than approaching it as a temporary initiative.

Unpacking Data Readiness: Bridging the Gap Between Equity Metrics and Meaningful Action

A core strategy for operationalizing racial equity within Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) programs is the increased use of disaggregated data to identify racial disparities and inform decision-making. Over time, the

programs demonstrate a shift from conceptual discussions of racial equity toward a structured approach that uses data to guide hiring, outreach, and service modifications. This shift aligns with the Massachusetts Racial Equity Data Roadmap, which emphasizes the importance of equity-centered metrics, including SMARTIE (Specific, Measurable, Achievable, Realistic, Time-bound, Inclusive, and Equitable) goals and Continuous Quality Improvement (CQI) practices, to embed racial equity within programmatic decision-making rather than treating it as an aspirational goal (Massachusetts Department of Public Health [MDPH], 2020).

While many staff members acknowledge the importance of racial equity data, engagement varies significantly across programs, with some staff demonstrating confidence in using data-driven insights, while others express uncertainty about how to interpret and apply equity-related metrics. These disparities in data literacy reflect broader challenges in the measurement of structural inequities, as programs often struggle to develop data-informed strategies that address the root causes of racial disparities (Williams et al., 2019; HRSA, 2023). The Groundwater Approach, developed by the Racial Equity Institute, provides a useful framework for understanding why these challenges persist. This model illustrates how racial disparities across multiple systems—such as healthcare, education, and economic opportunity—are not isolated incidents but rather symptoms of a deeper, structural issue (Hayes-Greene & Love, 2018). Without accurate, comprehensive indicators of systemic disparities, equity efforts risk being under-informed and less effective, as they may focus on individual-level interventions rather than addressing the structural foundations of racial inequities (Finlay et al., 2024). By applying this approach to home visiting services, programs can shift their focus from simply tracking disparities to diagnosing and addressing the systemic drivers of inequity, ensuring that racial equity work extends beyond compliance-based reporting to sustained, meaningful change.

Additionally, the rigidity of racial and ethnic classification systems resulted in widespread misclassification, particularly for families who were unsure about how to self-identify or who found racial and ethnic categories unclear. While this issue affected many individuals, Latino and Middle Eastern/North African (MENA) families were frequently misclassified, given the ambiguity in federal reporting standards that do not explicitly include MENA as a racial category. In many cases, Latino families were categorized as White due to the separation of race and ethnicity in demographic reporting, which obscured disparities in service access and engagement (MIECHV TA, n.d.; Atere-Roberts et al., 2024). However, misclassification also extended to individuals from other racial and ethnic backgrounds, particularly when definitions of race versus ethnicity were unclear or when families were unfamiliar with the available categories. These classification inconsistencies reinforce concerns raised in prior research about how demographic data collection methods fail to reflect the full complexity of racial identity, leading to inaccuracies in assessing disparities and hindering equity-focused interventions (Nguyen et al., 2021; López et al., 2020).

In addition to classification inconsistencies, gaps in data literacy further complicate efforts to integrate racial equity data into programmatic decision-making. Although racial equity data is increasingly available, a gap remains between data access and meaningful utilization. Many staff members express uncertainty about how to interpret disaggregated data and apply it in CQI processes, mirroring prior research that underscores the need for enhanced staff training and technical assistance in equity-focused data analysis (Hardeman et al., 2022; Goldberg et al., 2020).

While the introduction of data visualization tools such as the MIECHV Data Dashboard and the Equity Spotlight has improved staff capacity to examine disparities, the findings suggest

that providing these tools alone is insufficient. Without structured training and organizational support, programs risk collecting racial equity data without effectively leveraging it to drive systemic change. This aligns with research emphasizing that for racial equity efforts to be effective, they must be backed by sustained institutional commitment rather than relying solely on data collection (Goldberg et al., 2020; MDPH, 2020).

The findings also reinforce Public Health Critical Race Praxis (PHCRP), which highlights the role of disaggregated data in uncovering hidden disparities and guiding interventions that address structural inequities (Ford & Airhihenbuwa, 2018). However, this study extends prior research by demonstrating that institutional constraints—including rigid racial classification systems and staff discomfort with data interpretation—can limit the effectiveness of equity-driven CQI efforts. These challenges highlight the need for both technical assistance and structural shifts to fully integrate racial equity metrics into programmatic evaluation and service delivery.

The study's findings suggest several critical steps for improving the integration of racial equity data into home visiting services. First, standardizing racial and ethnic data collection practices is essential to ensure accuracy and representation. Programs should advocate for expanded racial and ethnic categories that align with how families self-identify, reducing misclassification and enhancing the reliability of equity analyses. Second, staff require ongoing, applied training in data interpretation and its application to CQI initiatives (Goldberg et al., 2020). Introductory racial equity training has raised staff awareness, but additional technical assistance is needed to translate this knowledge into practical implementation (MDPH, 2020). Additionally, integrating racial equity metrics into CQI frameworks can help programs move beyond compliance-driven data reporting toward sustained engagement with equity-focused

performance measures. Aligning equity data with programmatic goals enhances accountability, ensuring that staff at all levels remain committed to addressing disparities in home visiting services (MDPH, 2020).

Despite these advances, barriers such as data literacy gaps, classification inconsistencies, and time constraints continue to limit progress. Strengthening institutional capacity requires a multi-level approach, including improved classification standards, enhanced training, and structural supports that enable staff to engage meaningfully with equity data. By addressing these challenges and reinforcing key facilitators—including Root Cause Analysis and the Groundwater Approach—home visiting programs can develop a sustainable, data-driven racial equity strategy that moves beyond compliance and toward meaningful, systemic change.

Community Engagement: Navigating Trust, Cultural Responsiveness, and Structural Constraints

Community engagement is a critical component in fostering trust, improving cultural responsiveness, and increasing service accessibility within the Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) program. However, the extent to which home visitors successfully implement engagement strategies varies significantly across program sites. The findings of this study reveal that while home visitors recognize the importance of culturally responsive outreach and partnerships with community-based organizations (CBOs), they often encounter systemic barriers that hinder their ability to establish and sustain meaningful engagement with families. These barriers include language inaccessibility, immigration-related fears, and structural resource disparities, all of which influence family participation and overall program effectiveness. This discussion integrates these findings with existing literature, examining the successes and limitations of community engagement within MA MIECHV and highlighting key implications for strengthening these efforts.

One of the most salient findings from this study is the inconsistency of community engagement efforts across different MA MIECHV sites. Many home visitors rely on informal relationships with local organizations to connect families with critical resources, yet these partnerships are rarely structured or institutionalized. While some home visitors successfully establish relationships with culturally specific CBOs, such as immigrant advocacy groups and faith-based organizations, these efforts are often ad hoc and dependent on individual staff initiative rather than integrated into program policy. This inconsistency underscores the need for formalized collaborations to ensure that families have equitable access to community-based resources, regardless of geographic location.

These findings align with the literature on Community-Based Participatory Research (CBPR), which emphasizes that community engagement efforts are most effective when integrated into the structural framework of service delivery rather than operating as supplementary initiatives (Viglione & Boynton-Jarrett, 2023). CBPR models advocate for equitable partnerships between service providers and communities, ensuring that families not only receive services but also play an active role in shaping service delivery (Boyd et al., 2023). The findings of this study indicate that while home visitors recognize the importance of participatory engagement, they often lack the structural supports necessary to fully implement these models. Without sustained investment in institutionalizing community partnerships, home visiting programs risk perpetuating engagement models that are inconsistent and dependent on the discretionary efforts of individual home visitors rather than on program-wide strategies.

The intersectionality framework, introduced by Crenshaw (1989), offers further insight into the barriers to engagement, particularly for families facing multiple layers of marginalization. This study finds that immigrant families, families of color, and low-income

families often experience overlapping barriers that shape their experiences with home visiting programs. Intersectionality challenges the common tendency to analyze racial disparities in isolation, highlighting how race, immigration status, and economic precarity interact to produce distinct vulnerabilities (Roberts et al., 2018).

For immigrant families, fears surrounding the public charge rule and anti-immigrant rhetoric act as deterrents to participation, with families often avoiding enrollment in home visiting programs due to concerns that providing personal information could jeopardize their residency status or lead to child welfare involvement (Acevedo-Garcia, 2021). The structural intersectionality framework, which examines how institutions systematically disadvantage individuals with multiple marginalized identities, is particularly relevant to home visiting programs (Homan et al., 2021). This study finds that mixed-status families—where some members are undocumented while others hold legal residency or citizenship—are especially susceptible to disengagement from services due to heightened fears of surveillance and exclusion (Goldberg et al., 2020; Heinrich et al., 2022). Without acknowledging the intersection of race, legal status, and economic precarity, home-visiting programs may fail to reach the families most in need of services.

In addition to trust barriers, the study highlights the significant role of language accessibility in shaping family engagement. Home visitors widely report that families are more likely to participate actively in home visiting services when served by providers who speak their language. However, bilingual home visitors are inconsistently available across program sites. Some locations employ linguistically diverse staff, while others rely on third-party interpreters who are not always trained in early childhood service delivery. Home visitors emphasize that

while interpreter services are helpful, they are often inadequate in building the deep rapport and trust required for full family engagement.

These findings reinforce existing literature, which consistently demonstrates that linguistic accessibility is a key determinant of service utilization and that families are more likely to trust and engage with providers who share their cultural and linguistic background (Goldberg et al., 2020). However, this study extends prior research by highlighting that language barriers are not just a matter of communication but are deeply intertwined with cultural competency and trust-building. Even when interpreter services are available, families often struggle to engage fully if home visitors lack cultural awareness or shared lived experiences (Brach & Fraser, 2016).

Several key implications emerge for strengthening community engagement within MA MIECHV. First, there is a clear need to institutionalize partnerships with CBOs rather than relying on individual home visitors to establish informal connections. The lack of structured collaboration currently leads to uneven service access, particularly for families in regions where home visitors have not developed strong relationships with culturally specific organizations. Establishing formal agreements with CBOs could help standardize referrals, ensure service integration, and strengthen culturally relevant programming (NHVRC, 2022).

Second, the hiring and retention of bilingual home visitors must be prioritized as a structural equity strategy. While the study confirms that families engage more when home visitors speak their language, the availability of bilingual staff remains inconsistent, contributing to inequitable service access across MA MIECHV sites. Expanding financial incentives for bilingual staff and creating professional pipelines for linguistically diverse home visitors would enhance language access and trust-building efforts (HRSA, 2023).

Additionally, explicit privacy protections and anti-surveillance policies are needed to counteract the chilling effect of immigration-related fears. Many families hesitate to engage with home visiting programs due to concerns about government surveillance and data sharing. Without clear, well-communicated policies that assure families of their privacy rights, these fears will continue to deter participation. Moreover, compensating family leadership in advisory councils would strengthen participatory engagement models by ensuring that families have a meaningful role in shaping services without facing financial burdens (Viglione & Boynton-Jarrett, 2023).

The findings of this study reinforce the literature on community engagement as a structural, rather than individual, effort. While MA MIECHV home visitors recognize the importance of culturally responsive and participatory engagement, their ability to implement these strategies is constrained by systemic limitations, funding gaps, and workforce shortages. Moving forward, institutionalizing community partnerships, expanding bilingual staffing, and strengthening privacy protections will be critical to ensuring that home visiting services are truly accessible, culturally responsive, and trusted by the families they seek to serve.

Bias Reduction and Structural Supports: Bridging Intent and Impact

Efforts to reduce bias and strengthen structural supports within the Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) program reflect a growing recognition that racial equity must be institutionalized rather than treated as an individual responsibility. While home visiting programs have incorporated cultural humility training and racial equity workshops, these initiatives remain limited in impact when not reinforced by broader structural supports. Home visitors and supervisors recognize the importance of ongoing professional development in racial equity; however, disparities in implementation, resource

allocation, and workforce stability hinder the ability of programs to create lasting change. These findings align with prior research emphasizing that without systemic reforms—such as equitable compensation structures, reflective supervision, and racial equity embedded within Continuous Quality Improvement (CQI) processes—bias reduction efforts risk becoming performative rather than transformative (Brach & Fraser, 2016; Goldberg et al., 2020; Lett et al., 2022).

A significant challenge identified in the study is the inconsistency in how racial equity training is implemented across different home-visiting sites. Some programs have well-structured racial equity initiatives embedded within hiring practices, supervision, and service delivery, while others treat such training as a one-time requirement rather than an ongoing developmental process. Home visitors described experiences where cultural humility training was presented in a way that was overly theoretical, failing to provide concrete tools for addressing racial bias in real-world service interactions. This aligns with literature demonstrating that anti-bias training alone is insufficient to change organizational culture unless paired with institutional mechanisms for accountability and reinforcement (Hardeman et al., 2022; Silva et al., 2022).

To increase the impact of training efforts, programs must adopt a multi-tiered approach that moves beyond introductory racial equity training toward advanced training on systemic racism, Critical Race Theory (CRT), and intersectionality. Research indicates that basic anti-bias training often focuses on individual awareness but does not fully equip staff to understand and challenge the structural factors that sustain racial disparities (Ford & Airhihenbuwa, 2010; Cunningham & Scarlato, 2018). CRT, which critiques colorblind approaches that ignore the role of systemic racism, provides a valuable lens for examining how policies, service structures, and funding mechanisms perpetuate racial inequities (Delgado & Stefancic, 2017). Findings from the

study suggest that some home visitors adopted a "race-blind" approach, believing that treating all families the same was the most equitable strategy. However, CRT emphasizes that acknowledging systemic racism is essential to dismantling inequities—highlighting that failing to consider racial disparities in service provision can unintentionally reinforce existing inequities (Ford et al., 2018).

Intersectionality further expands this lens by demonstrating how multiple marginalized identities—such as race, immigration status, and socioeconomic position—intersect to shape families' experiences with home visiting services. While many home visitors recognized that race influences service access, they were less likely to account for the compounded impact of racism, xenophobia, and economic precarity on families from mixed-status or low-income households (Homan et al., 2021; HRSA, 2023). Without training that explicitly addresses these interwoven barriers, home visitors may lack the tools to engage families in ways that affirm their lived experiences and address systemic disparities.

Another key finding is the role of workforce instability in limiting the effectiveness of racial equity efforts. Home visitors reported that low wages and high caseloads created burnout, making it difficult for them to fully engage in racial equity initiatives. Many participants expressed frustration that while equity training encouraged deeper engagement with families, the structural conditions of their jobs—such as limited paid time for professional development—made it difficult to apply what they learned in practice. These findings align with broader critiques of the home-visiting workforce model, which has historically been underfunded, leading to high turnover rates, limited racial diversity in leadership, and inconsistent training opportunities (Goldberg, 2020).

Research indicates that compensation disparities across Local Implementing Agencies (LIAs) exacerbate these workforce challenges, creating inconsistencies in salary structures and benefits for home visitors performing similar roles (Goldberg et al., 2020). Without standardized funding mechanisms to ensure equitable pay, programs struggle to retain staff, which in turn undermines efforts to build trust with families and sustain equity-driven service models. This instability is particularly concerning given evidence that workforce diversity improves service engagement; studies show that families are more likely to participate in home visiting programs when providers share their racial, linguistic, or cultural backgrounds (HRSA, 2023; DeSilva et al., 2019). However, without competitive wages and clear professional advancement pathways, home visitors from historically marginalized backgrounds face significant barriers to long-term retention and leadership roles (Crowne et al., 2022).

Despite these challenges, supervision discussions on racial equity emerged as a key facilitator in the study, with sites that integrated racial equity into supervisory meetings reporting higher levels of staff confidence in addressing racial bias in their work. When supervisors actively engaged in discussions on race and equity, home visitors felt more supported in translating training into practice. This finding aligns with prior research demonstrating that effective supervision plays a critical role in reinforcing racial equity efforts, particularly when supervisors model equity-centered leadership and provide structured spaces for reflective dialogue (Boyd et al., 2023; Silva et al., 2022).

While the study findings did not explicitly describe supervision as "trauma-informed," some programs incorporated supervisory discussions on racial disparities, CQI data reviews, and equity-focused problem-solving. These elements align with trauma-informed supervision models found in the literature, which emphasize psychological safety, structured reflection, and an

explicit commitment to anti-racist practice (Champine et al., 2022). Programs that adopted more structured supervision models saw higher levels of confidence among home visitors in engaging in equity-driven conversations with families, supporting the idea that supervision serves as a critical space for reinforcing racial equity efforts beyond training sessions alone.

Institutionalizing Bias Reduction Through Policy and Structural Change

While training and supervision are critical components of racial equity initiatives, the study also identified structural barriers that limit their long-term effectiveness. One major obstacle is the lack of funding for sustained workforce development, particularly in salary standardization and retention initiatives. Home visitors noted that while racial equity was discussed in training, persistent wage disparities among staff undermined efforts to create a truly equitable work environment. This aligns with the literature on workforce equity, which emphasizes that racial equity training must be accompanied by structural reforms such as salary increases, leadership pathways for BIPOC staff, and equitable hiring and promotion practices (Goldberg et al., 2020).

By institutionalizing racial equity at multiple levels—including within CQI efforts, leadership structures, and funding priorities—home visiting programs can move beyond surface-level commitments and create the conditions necessary for sustained systemic change.

Broader Implications for Policy and Practice: Institutionalizing Racial Equity

The findings from this study contribute to statewide and national discussions on racial equity in home visiting by highlighting the gap between equity commitments and their operationalization in practice. While Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) programs have made significant strides—particularly through data-driven decision-making, community engagement, and bias reduction efforts—structural barriers

continue to impede progress. These challenges are not unique to Massachusetts but reflect broader systemic issues within home visiting services, reinforcing the need for comprehensive policy interventions that move beyond training initiatives and temporary solutions toward sustainable, long-term reforms.

Embedding racial equity into home visiting services requires treating it as a structural and operational principle rather than an ancillary concern. Historically, equity efforts have often been framed as components of staff training rather than as guiding frameworks shaping service delivery, funding allocation, and workforce development. The findings from this study underscore that while training is valuable, it is insufficient in the absence of systemic supports. Without adequate funding, standardized equity-driven policies, and accountability mechanisms, racial equity risks becoming a symbolic commitment rather than a transformative practice.

Massachusetts has taken meaningful steps toward integrating racial equity within home visiting, including the use of disaggregated racial data in CQI processes, the prioritization of parent leadership in advisory roles, and the development of partnerships with community-based organizations. However, these initiatives remain limited in impact due to workforce instability, inconsistent funding, and policy gaps that prevent full integration of equity-driven service delivery. Strengthening these efforts requires moving beyond pilot initiatives and embedding equity principles within formal policy frameworks at both the state and federal levels. While these broader shifts are critical, they must be understood in light of the current political landscape where equity efforts are increasingly under attack.

Defending Racial Equity Work During Political Retrenchment

This research was conducted at a time when conversations around racial equity, diversity, and inclusion are not only underfunded but increasingly politicized and vilified. Across the

country, DEI initiatives are being dismantled, funding for social support programs is shrinking, and advocacy for marginalized communities is being reframed as divisive rather than necessary. In this environment, the work of embedding racial equity into home visiting programs is not simply about improving service delivery, it is about defending the very infrastructure that makes equitable care possible.

The findings of this study highlight strategies that can strengthen racial equity efforts, but they also underscore something deeper: the urgent need to protect and institutionalize this work against political backlash. If we treat racial equity as a temporary initiative, something to be revisited when political conditions are more favorable, we risk losing hard-won progress and leaving the most vulnerable families even further behind.

This study is not just a roadmap for future research; it is a call to action. The challenges and solutions identified here, from stabilizing the workforce to building data systems that actually reflect the families served, are not theoretical. They are solvable. But solving them requires sustained investment, structural change, and the political will to prioritize equity even when it becomes unpopular to do so.

In moments like this, when systemic support for marginalized communities is actively under attack, research must move beyond documenting problems. It must name the structural barriers, advocate for real policy shifts, and help equip service systems to weather political storms without abandoning their equity commitments. Home visiting programs have always been about building trust, supporting resilience, and creating pathways for families to thrive. Upholding racial equity is not an add-on to that mission, it is fundamental to it.

By documenting how racial equity frameworks are operationalized in practice — and where the gaps remain — this study affirms that systems can be redesigned. The path forward

demands more than acknowledgment; it demands action, advocacy, and a deep, sustained commitment to building programs where racial equity is not merely an aspiration, but a lived, protected reality. In this urgent content, it becomes even more critical to identify concrete policy actions that can institutionalize and protect racial equity in home visiting.

Policy Recommendations for Advancing Racial Equity

To ensure racial equity becomes a sustained and institutionalized component of home visiting programs, several policy recommendations emerge from this study. These recommendations focus on funding structures, data infrastructure, workforce policies, and structural protections for families, ensuring that equity commitments are reinforced through systemic change.

A primary barrier to operationalizing racial equity is inadequate and inconsistent funding. Home visitors across Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MA MIECHV) programs reported that financial constraints—high caseloads, low wages, and limited training budgets—impede their ability to sustain equity efforts. Similar disparities exist nationally, where home visiting programs serving historically marginalized communities often operate with fewer resources, reinforcing rather than addressing existing inequities. Addressing these disparities requires increasing and equitably allocating funding, prioritizing workforce retention initiatives, enhanced training and supervision models, and financial incentives for home visitors working in high-need communities. Expanding Medicaid reimbursement for home visiting services can also provide a stable funding stream, reducing reliance on short-term grants and improving program sustainability.

Strengthening racial equity data collection and accountability is equally critical. This study found that inconsistencies in racial and ethnic classification, along with gaps in staff

capacity to interpret and apply racial equity data, limit the effectiveness of equity-driven decision-making. Implementing standardized racial equity data collection guidelines can help ensure accurate representation of service populations, particularly for groups that are often misclassified or excluded. State agencies should also integrate racial equity benchmarks into program evaluations and funding structures, ensuring that home visiting services actively work toward reducing disparities rather than passively tracking them.

Workforce instability poses another major barrier to racial equity. Low wages, high turnover, and the absence of clear career advancement pathways disproportionately affect BIPOC home visitors, limiting workforce diversity and weakening long-term equity initiatives. Addressing these challenges requires standardizing salaries across home visiting models, ensuring that compensation reflects the expertise and demands of the role. Additionally, investment in leadership pathways for home visitors of color is essential to extending equity efforts beyond frontline staff to decision-making positions. Programs should also prioritize structured mentorship and supervision models that provide staff with professional support and opportunities for growth, reducing burnout and improving long-term retention.

Beyond workforce and funding reforms, the study findings emphasize the need for stronger structural protections for families engaged in home visiting services. Many immigrant families, particularly those in mixed-status households, reported hesitancy in accessing services due to fears of surveillance and immigration enforcement. To mitigate these concerns, policymakers must institutionalize privacy protections that ensure home visiting participation does not result in immigration consequences. Programs must also expand language accessibility initiatives, ensuring that multilingual staffing, interpreter services, and culturally relevant adaptations are sustained priorities rather than afterthoughts.

Ultimately, the findings reinforce that racial equity must be embedded as a core operational principle in home visiting, shaping funding, workforce policies, and accountability measures at every level. Treating equity as a short-term initiative or a component of training alone will not lead to lasting change. Instead, aligning policy and practice with sustained, systemic reforms will ensure that home visiting programs move beyond symbolic commitments to create tangible, transformative improvements in service access, quality, and outcomes for historically marginalized families.

By institutionalizing racial equity in home visiting policies, programs can ensure that all families—regardless of race, immigration status, or socioeconomic background—have access to the support and resources they need to thrive. However, even with strong policies, it is necessary to acknowledge the study's methodological limitations when interpreting its findings.

Limitations and Contextual Considerations

This study is subject to several limitations related to methodological constraints, data sources, and broader contextual considerations. Together, these limitations should be taken into account when interpreting the findings and assessing their implications for research and practice.

One key limitation is the scope inherent in secondary data analysis. Because this study relies on pre-existing data originally collected for a broader evaluation, it is restricted to the topics, questions, and depth captured during initial data collection. Certain contextual or nuanced aspects of home visiting staff experiences with racial equity may not have been explicitly documented. Additionally, variability in data quality and completeness across Local Implementing Agencies (LIAs) may have influenced the richness of qualitative responses, as differences in staff engagement, record-keeping, and discussion depth could impact the comprehensiveness of the analysis.

Another significant limitation is the absence of direct family and community perspectives. While this study focuses on home visitors' engagement with racial equity practices, it does not capture the lived experiences of families receiving services. Without incorporating family voices, the findings represent workforce perceptions rather than a holistic understanding of racial equity in service delivery. Future research incorporating family or community-based participatory approaches could provide a more complete view of equity impacts.

Potential survey response bias and self-selection effects also pose challenges. Since the Innovation Pulse Surveys and Pre- and Post-Training Surveys rely on self-reported data, there is a risk that participants provided socially desirable rather than fully candid responses. Additionally, those who chose to participate may have been more engaged in racial equity initiatives than those who did not, introducing selection bias that may skew the findings.

Qualitative thematic analysis, despite systematic coding frameworks and inter-rater reliability checks, introduces inherent subjectivity. Researcher interpretation, influenced by personal understandings and evolving discourse around racial equity, may shape the identification and categorization of themes. Although steps were taken to minimize bias, future studies could enhance rigor by including diverse coding teams and employing member-checking strategies.

Another important consideration is the study’s limited ability to assess long-term impact. While the study examines shifts in racial equity engagement over time, the evaluation timeframe may not capture the sustainability of these efforts beyond the funding and implementation period. Factors such as leadership transitions, policy changes, and funding fluctuations may influence the durability of racial equity initiatives. Longitudinal research tracking

implementation outcomes over multiple years is needed to fully understand the sustainability of these practices.

Additionally, findings from this study may have limited generalizability beyond the Massachusetts context. Racial equity implementation is highly contextual and may vary across states based on different policy environments, funding structures, and demographic compositions. Expanding future research to include multiple state-level MIECHV programs would provide broader insights into equity efforts across diverse settings.

Finally, missing or incomplete survey responses and qualitative data may have impacted the robustness of certain findings. Despite systematic data cleaning procedures, gaps in participant responses could result in the omission of important perspectives. Strengthening future research designs with strategies such as data triangulation and missing data analysis could improve methodological rigor.

Despite these limitations, this study provides important insights into the operationalization of racial equity within home visiting programs. By centering home visiting staff perspectives and employing a mixed-methods approach, the study offers valuable contributions to understanding both the barriers and facilitators shaping equity efforts in early childhood home visiting services. Future research can build on these findings by integrating family perspectives, expanding geographic diversity, and assessing long-term sustainability to deepen the evidence base for institutionalizing racial equity in early childhood systems. Recognizing these limitations, future research must build on this foundation by adopting methods that deepen and expand our understanding of racial equity implementation.

Future Research Directions: Embedding Racial Equity Through Implementation Science

This study highlights both progress and persistent challenges in operationalizing racial equity within home visiting programs. While it provides critical insights into workforce engagement, data-driven decision-making, and structural supports, several areas require further exploration. Advancing racial equity in home visiting necessitates a more robust implementation science approach to understanding how equity initiatives translate into measurable outcomes for both families and staff. Future research should go beyond staff self-reports and policy analyses to examine the direct impact of racial equity strategies on service delivery and family experiences.

A critical area for future research is the direct observation of program practices to assess how racial equity training and data utilization influence real-time decision-making and interactions with families. While this study captures home visitors' reflections on racial equity engagement, it does not include observational data on how these principles manifest in practice. Ethnographic studies, video analysis of home visits, and supervisor assessments could provide a more comprehensive understanding of whether and how home visitors integrate racial equity frameworks into their daily interactions. Incorporating real-time behavioral measures would help identify gaps between knowledge and practice and inform targeted interventions to strengthen equity-centered service delivery.

Another key direction is the long-term evaluation of racial equity training's impact on workforce attitudes and programmatic outcomes. Pre- and post-training surveys provide useful snapshots of staff learning and engagement, but they do not capture the sustainability of these efforts over time. Longitudinal studies tracking home visitors' engagement with racial equity across multiple years, alongside workforce retention rates and career advancement opportunities for staff of color, would help determine whether training initiatives lead to lasting organizational

change. Additionally, future research should examine how racial equity training intersects with other workforce development efforts, such as trauma-informed care, reflective supervision, and salary standardization, to identify the most effective strategies for sustaining an equity-driven workforce.

Beyond workforce-focused studies, research should prioritize community-centered inquiry that amplifies the voices of families receiving home visiting services. The absence of direct family perspectives in this study highlights a critical gap in understanding how racial equity efforts impact those they are designed to serve. Community-based participatory research (CBPR) models, which engage families as co-researchers rather than passive subjects, would provide deeper insights into how home visiting programs can more effectively align services with the needs and priorities of racially and linguistically diverse families. Integrating family perspectives into the evaluation of racial equity initiatives would ensure that home-visiting programs remain responsive and accountable to the communities they serve.

Future research should also explore the intersectionality of racial equity efforts with broader policy and funding structures. While this study examines the operationalization of racial equity within Massachusetts MIECHV programs, it does not fully explore how state and federal policy shifts influence home visiting programs' ability to sustain equity initiatives. Comparative studies across multiple states, examining how different policy environments shape racial equity efforts, could provide valuable lessons for strengthening national home visiting policies. Additionally, research on Medicaid reimbursement models for home visiting services could offer insights into how sustainable funding mechanisms influence program investments in racial equity training, data infrastructure, and workforce diversity initiatives (NHVRC, 20022).

Finally, as racial equity continues to evolve as a core framework in public health and early childhood interventions, future research should investigate how home visiting programs can embed racial equity as a structural, rather than supplementary, component of service delivery. Studies examining how home visiting models integrate racial equity principles into their core frameworks—rather than as optional add-ons—would contribute to a more systemic approach to reducing racial disparities in maternal and child health. Implementation science research focused on the policy and organizational changes required to institutionalize racial equity at every level of home visiting programs would be instrumental in ensuring that these efforts are sustained over time.

By addressing these unanswered questions and methodological gaps, future research can move beyond theoretical commitments to racial equity and toward tangible, measurable improvements in service delivery, workforce engagement, and family outcomes.

Chapter 6: Conclusion

This study contributes to the growing body of research on racial equity in maternal and child health by examining how home visiting staff operationalize equity principles in their work with families. Through an analysis of data-driven decision-making, community engagement, and bias reduction and inclusive practices, the findings highlight both the promising strategies and persistent challenges shaping the implementation of racial equity within Massachusetts MIECHV programs. While progress has been made in embedding equity into training, data utilization, and outreach efforts, structural barriers—such as workforce instability, funding limitations, and the inconsistent application of equity frameworks—continue to impede long-term sustainability. The study underscores the importance of continuous investment in equity-centered data practices, meaningful partnerships with communities, and systemic workforce support to ensure that racial equity is not a one-time initiative but a foundational framework for home visiting services.

At its core, the pursuit of racial equity in home visiting is a moral and social imperative. Structural racism continues to drive disparities in maternal and child health, placing families of color at disproportionate risk of adverse outcomes. Home visiting programs have the potential to serve as a powerful intervention in disrupting these inequities, but only if racial equity is fully integrated into program policies, data infrastructure, and service delivery models—rather than treated as a separate or compliance-driven effort. Given the current sociopolitical climate where equity initiatives are increasingly under threat, sustaining racial equity efforts demands even greater intentionality, investment, and structural reinforcement.

To translate these findings into lasting impact, programmatic leaders, policymakers, and researchers must work collaboratively to ensure that equity frameworks are embedded across all aspects of home visiting programs. This includes expanding data transparency and

accountability, strengthening culturally responsive engagement strategies that center family and community voices, and addressing workforce disparities through equitable compensation, leadership pathways, and ongoing bias reduction training. In particular, overcoming the tendency toward colorblind approaches to service delivery and ensuring that home visitors are equipped with critical race and intersectionality-informed training will be essential to disrupting implicit biases and fostering more equity-centered practices.

Looking forward, advancing racial equity in home visiting requires a multi-level approach—one that extends beyond the actions of individual practitioners to broader policy and funding structures that shape service delivery. Policymakers must recognize home visiting as a critical intervention in reducing racial health disparities and invest in long-term strategies that integrate racial equity into the foundation of early childhood services. Researchers must continue examining the impact of equity initiatives on both families and workforce outcomes, ensuring that best practices are documented, challenges are addressed, and new opportunities for systemic reform are identified. Program administrators must ensure that racial equity commitments are not merely aspirational but are tangible, measurable, and deeply embedded into the structures that guide hiring, training, data monitoring, and service delivery.

Ultimately, the sustainability of racial equity efforts in home visiting programs depends on an ongoing commitment to reflection, structural transformation, and community collaboration. Equity must be more than a policy statement—it must be a lived practice that informs every aspect of home visiting services. By institutionalizing racial equity as a core operational principle, home visiting programs can move beyond incremental progress and toward a future where all families—regardless of race, ethnicity, or socioeconomic status—receive the support and resources they need to thrive.

Appendix A: Codebook for Qualitative Analysis

RQ1: How do MA MIECHV operationalize racial equity in their work with children and families.

Parent Code	Child Code	Description
CQI	PDSA Cycles	Team member/ members describe use of PDSA cycles, whether hypothetical or an actual experience.
	Smartie Aims	Team member/ members describe SMARTIE aims, whether hypothetical or actual experiences.
	Using CQI to Address Racial Equity	Team member/ members shared or discussed using data to address racial inequities, whether hypothetical or actual experience
Data Use	Addressing Missing Data	Team member/ members discussed strategy/ strategies that they employ to address missing data.
	Effective Strategies that Support Data Use	Team member/ members discussed or shared a particular strategy/ strategy that help their team interpret and use data.
	Using CQI to Identify Racial Inequities	Team member/ members shared or discussed using data to identify racial inequities whether hypothetical or an actual experience.
Equity Spotlight	N/A	Used to capture mention or discussion of Equity Spotlight, a resource shared with programs by DPH that disaggregates their program data by race, ethnicity, gender, and language.
Engaging with Community Partners	Addressing Racial Equity	Described experiences addressing racial equity in collaboration with community partners

	Discussing Racial Equity	Described experiences that involved talking about racial equity with community partners.
Practice of Centering Racial Equity	Strategies	Shared an example of something they do (individual or team) to center racial equity including engagement and outreach strategies.
Staff Training	CQI Training	Mention of describe CQI training offered by DPH, double code with impression codes as needed.
	Family Engagement Training	Mention of describe family engagement training offered by DPH, double code with impression codes as needed.
	Racial Equity Training	Mention or describe racial equity training offered by DPH, double code with impression codes as needed.
DPH Supports	Email	Mention/ describes engaging in or receiving support via email by DPH, double coded with impression codes as needed.
	Group	Mentions/ describes group setting support offered by DPH, double coded with impression codes as needed.
	Individual	Mentions/ describes supports offered by DPH on an individual basis, double coded with impression codes as needed.
	Office Hours	Mentions/describes office hours offered by DPH, double-coded with impression codes as needed.

	One-on-One Meetings	Mentions/ describes one on one meetings offered by DPH, double coded with impression codes as needed.
Equity Dashboard (T2 Only)	N/A	Used to capture description of Dashboard use, double coded with impression codes as needed.

RQ2: What are the main barriers and facilitators that either support or hinder their efforts?

Parent Code	Child Code	Description
General Impressions	Barrier	Concept or sentiment shared was perceived as a barrier by team member/s. This code differs from "challenges" in that is captures instances where a team member/s recognize a concept or sentiment that stops them from being able to engage in something. For example: Trainings only offered in English, language capacities etc.
	Challenge	Concept or sentiment shared was perceived as being difficult or challenging by team member/s. This code differs from "barrier" in that it captures instances where a team member/s recognize a concept or sentiment that does NOT stop them from being able to engage in something but makes it harder to do so. For Example: limited racial/ ethnic categories on demographic intake paperwork.

Data Use	Perceived Limitations	Team member/s identified factor/s as a limitation to their abilities to interpret and use data.
Affective	Negative	Used to capture negative feelings/ sentiments. Use 'negative' if it's generally negative and double code for specific contexts/ instances.
	Confusion	Used to capture instances when individual/s appear to lack confidence/ are doubtful about the topic/ content being discussed. Opposite of 'Certainty.'
	Frustration	Used to capture individual/ team sense of frustration or dissatisfaction with topic/ content being discussed. Use as 'opposite' code of satisfaction.
	Lack of Empowerment	Used to capture instances when individual (s) lack empowerment – evident that they DO NOT feel like they have the knowledge, confidence, means or ability relative to topic/ content being discussed. Opposite of 'empowerment.'
	Uncomfortable	Team member/s appear uncomfortable engaging in the discussion about a particular topic. Includes tension. Opposite of 'Comfortable.'
	Unhelpful	Used to capture instances when individuals fine a tool/ strategy/ support unhelpful.
	Individual- Policy	Used to capture an individual's frustration with a particular policy or guideline.

Engaging with Community Partners	No Community Partner Engagement	Use to capture instance where programs explicitly state or indirectly mention the fact that they do NOT engage with community partners.
Equity	Language	Team member/s discussed specific example of language relative to equity.
	Education	Team member/s discussed specific example of equity as it relates to education.
	SES	Team member/s discusses specific example related to social welfare.
	Culture and Diversity	Intended to capture instances where team members explicitly mention “culture” or “diversity or proceed to describe terms.
Team Member Positionality	Identity	Team member describes elements of their own identity when engaging in discussions about addressing racial equity, identifying inequities etc. Double code with appropriate equity code.
Team Program Dynamic	Existing Practices	Use this code to capture instances where teams say they have “always” done something.
	General Characteristics	Use to capture general details or characteristics shared by team members, either about their team or their program (e.g., “we are a small program”). Double code with content and impression codes as needed.
	Program Flexibility	Intended to capture instance where programs appeared to demonstrate the flexibility necessary to respond/ address community needs.

Practice of Centering Racial Equity	Strategies	Team member shared an example of something they do, whether it's something they do themselves or as a team, to center racial equity. Includes engagement and outreach strategies.
	Thoughts and Perceptions	Intended to capture team member/s thoughts about practice they have or have no engaged in to center racial equity.
General Impressions	Facilitators	Concept or sentiment shared was perceived as a facilitator or positive influence by team member/ members.
Affective	Positive	Used to capture positive feelings/ sentiments.
	Appreciation	Team member/s mentioned or describes something they appreciate.
	Certainty	Used to capture instances when individual/s appear very confident/ have no doubt about the topic/ content being discussed.
	Comfortable	Individual/s appear comfortable engaging in the discussion about a particular topic.
	Empowerment	Used to capture instances when individual/s appear empowered or demonstrate feelings of empowerment- evident that they feel as though they have the knowledge, confidence, means or ability relative to topic/ content being discussed.
	Liked or enjoyed	Team member/s mentioned or describes something related to any topic that they liked or enjoyed.

	Satisfaction	Used to capture instances when individual/s appear satisfied/ happy with the topic being discussed.
	Useful	Used to capture instances when individual/s find a tool/ strategy/ support useful.
Suggestion and Recommendation	N/A	Team member/s shared suggestions or made recommendations about things that would facilitate/ support their team in racial equity practices.

Appendix B: Racial Equity Program Data Readiness Assessment: Summer 2024

Facilitation Guide

It's important to keep the following in mind as you facilitate each assessment:

• CQI teams are made up of program supervisors, coordinators, Home Visitors/ Parent Educators, and Parent Leaders.

• You do not need to ask every discussion question. Instead, it's important to follow their group discussion and assess whether a question was already covered indirectly.

Discussion questions of this kind are often answered naturally as the discussion progresses. That means you do not need to ask a question that you feel was already addressed for the sake of being consistent—a naturally flowing discussion is more important!

Introductory Script:
Thank you for taking the time to complete the Racial Equity Program Data Readiness Assessment! We are from Tufts Interdisciplinary Evaluation Research (TIER), an evaluation team at Tufts University. We are working with the Massachusetts Department of Public Health (DPH) to better understand your CQI team's experience with using data across Innovation activities.

By "Innovation activities", we mean the trainings and supports that you've received over the last year on using data to promote racial equity, address structural racism, and support family leadership throughout the process. This includes: 1) trainings (i.e., CQI, Racial Equity, and Family Engagement trainings from February to May 2023/Spring 2024), 2) Learning Communities (August 2023 to date), 3) use of equity spotlights, and 4) any other coaching or technical assistance that you've received from DPH related to the Innovation project.

CQI teams will complete this assessment together, but this time I will help facilitate the conversation. That means CQI Teams will not be asked to fill out the survey. Instead, I will complete the Qualtrics assessment for you while we discuss assessment questions.

I will share each multiple-choice question in the chat—your team will then respond with strongly disagree to strongly agree. Then we'll use the open-ended questions to reflect on your team's response.

We will provide your team with a gift card as a 'thank you' for your time. If you have not already shared your team's gift card preference OR received your gift card, please share that information with me after the assessment is complete.

Ok—a few more things to cover before we get started. First, we are recording this meeting for analytical purposes. Is everyone comfortable with that?

IF YES: INITIATE RECORDING.
IF NO: PROCEED TO TAKE NOTES—BE AS THOROUGH AS POSSIBLE IN QUALTRICS.

Finally, anything that we discuss during this meeting is completely confidential—we do not share with DPH nor will we connect your names/ program name with any data that we collect.

Any questions before we get started?

CLICK ON THE FOLLOWING LINK WHEN YOU ARE READY TO BEGIN:
https://tufts.qualtrics.com/jfe/form/SV_5yUp1rrd9PdUxmu

Assessment Script
FACILITATOR NOTE: You will always know which model program is by the calendar invite and our scheduling Excel spreadsheet. We will still fill this in at the beginning of the assessment.

What home visiting model do you represent?

• Healthy Families (HFA and HFM)
• Parents As Teachers (PAT)

QUESTION #1:

"Our program uses data to ensure that strategies and policies it implements consider potential implications for racial equity."
FACILITATOR NOTE: Paste the question in the chat and read it out loud to the team.

Prompt: Please tell me how much you agree with this statement from Strongly disagree to Strongly agree.

FACILITATOR NOTE: Allow the team some time to discuss and decide on their response. Confirm and select it in Qualtrics.

"Great—Now we have a few discussion questions to follow."

Discussion Questions:

• 1A. Do you feel like you have a good understanding of what it means to center racial equity when reviewing data? Where do you think your program is with respect to this practice (e.g., just learning, have been doing this all along, etc.)?

• Probes (use as needed): How would your team explain what it means to center racial equity?

• 1B. Beyond the CQI project you are currently engaged in as part of the Innovation activities, are there other examples of how your program has used (or is using) data to center racial equity when assessing program strategies and policies?

• 1C. Has having access to the Equity Spotlights and Dashboard changed your practice around using data to center racial equity? If so, how?

FACILITATOR NOTE: Include notes from the team's discussion of Question 1 and discussion responses.

QUESTION #2:

"Our program is comfortable using MIECHV performance measure data to develop SMARTIE aims and objectives."
FACILITATOR NOTE: Paste the question in the chat and read it out loud to the team.

Prompt: Please tell me how much you agree with this statement from Strongly disagree to Strongly agree.

FACILITATOR NOTE: Allow the team some time to discuss and decide on their response. Confirm and select it in Qualtrics.

"Great—Now we have a few discussion questions to follow."

Discussion Questions:

- 2A. How has participating in Innovation activities changed your understanding of the MIECHV performance measures, if at all?

- 2B. Has seeing the data broken out by race, ethnicity, language, and gender made the performance measures more useful to your program? Why or why not?

- 2C. Since you have been given access to the Dashboard, have you looked at performance measure data other than that related to your CQI project? If so, what are you learning about your program based on these data?

FACILITATOR NOTE: Include notes from the team's discussion of Question 2 and discussion responses.

QUESTION #3:

"Our program has CQI processes in place to reduce the amount of missing data."
FACILITATOR NOTE: Paste the question in the chat and read it out loud to the team.

Prompt: Please tell me how much you agree with this statement from Strongly disagree to Strongly agree.

FACILITATOR NOTE: Allow the team some time to discuss and decide on their response. Confirm and select it in Qualtrics.

"Great—Now we have a few discussion questions to follow."

Discussion Questions:

- 3A. How are you feeling about the processes you have in place to reduce missing data?

- Probes: Can you share some strategies that have worked/ not worked for your team? Do you feel like you've been able to improve your missing data rates?

- 3B. What have you learned from looking at missing data by race and ethnicity?

FACILITATOR NOTE: Include notes from the team's discussion of Question 3 and discussion responses.

QUESTION #4:

"Our program collaborates with community partners to understand and address racial equity in our work."

FACILITATOR NOTE: Paste the question in the chat and read it out loud to the team.
Prompt: Please tell me how much you agree with this statement from Strongly disagree to Strongly agree.

FACILITATOR NOTE: Allow the team some time to discuss and decide on their response. Confirm and select it in Qualtrics.

"Great—Now we have a few discussion questions to follow."

Discussion Questions:

• 4A. Has your program discussed Dashboard or Equity Spotlight data with community partners? If so, can you tell us more about how those discussions went?

• Probes: In what ways do you think these discussions have affected partner relationships, program practice, and/or participant outcomes? If no, is this something you wish you did more of? What would it take to get you closer to where you'd like to be?

• 4B. Are you having explicit conversations about racism and structural and systemic inequities with community partners?

• Follow-ups: Have these conversations become more or less frequent? What kinds of changes, if any, have resulted from these conversations?

FACILITATOR NOTE: Include notes from the team's discussion of Question 4 and discussion responses.

Appendix C: Innovation Case Studies

Semi- Structured Focus Group/ Interviews (T1)

Introduction
Thanks again for taking the time to chat with us today! Through this focus group, we hope to gain a deeper understanding of how CQI teams are engaging with the Innovation and what that process has looked like.

Reminders
• We will be recording the session using the recorder and taking notes, but both (recording and notes) will only be accessible by TIER.

• Anything shared with us during the focus group will be completely confidential.

Focus Group Questions
CQI Team Logistics

First, we want to hear a little bit about how this team works together.

1. Thinking back to when you first formed this team, how did that process go?

    o Probe: What about it felt easy, and what was more challenging?

2. Has the team composition changed at all since then?

3. Please tell us about your experiences with engaging in the Innovation activities as a CQI team.

    o Probes

    · How often do you meet?
    · How has your team dynamic changed over time when using data?
    · What are some strategies that you feel have enhanced your ability to work together as a team?

4. Has anything gotten in the way of your being able to do the work?

    o Probes:

    · Do you have a good understanding of what is expected of you?
    · Are the tasks manageable?

Training and Technical Assistance (TA)

Next, we have a few questions about the training and technical assistance that your team has received from DPH.

This includes training (CQI, Racial Equity, and Family Engagement trainings from February to May 2023, Learning Communities, and any other coaching or technical assistance that you've received from DPH related to the Innovation project over the last 6 months.

5. What are your general impressions of the training you have received from DPH so far?

o Probes: Which of the trainings have you already attended? Were they helpful? Were they repetitive? What are some things you learned that felt new to you?

6. How about the other forms of support DPH has provided, like the calls and office hours?

o Probes: Most helpful? Least helpful?

7. Do you think it's beneficial to meet with members of other CQI teams during training and TA opportunities?

8. Are there areas that you feel you could use more support in? What are they, and what kind of support would you like to see?

Data use and CQI

Now we'd like to learn more about how your team uses data to engage in continuous quality improvement (CQI)

9. Please tell us about your experiences with conducting PDSA cycles. In what ways are they helpful? Challenging? Motivating?

o Probes:

- What are some challenges you experienced as a team when using PDSAs?
- What are some strategies that worked well for your team?
- What are some things you learned from using PDSAs?
- Have you noticed any differences in missing data? If so, what are they?

Next, we have a few questions about the Equity Spotlights that DPH prepares for you. Equity Spotlights break down your program data by key demographics like race, ethnicity, language, and gender, to help your team identify and discuss how to address inequities.

10. What are your general impressions of your Equity Spotlight? What are some of its strengths? Shortcomings? What would you change about it?

11. What have you learned about your program through using your Equity Spotlight? Can you share some examples of inequities that you've identified through using data?

o Probe: Were any findings surprising/shocking to you? If so, what were they?

12. Can you share some instances where you used your Equity Spotlight to make a particular service decision?

Impact of the Innovation

We're almost done! We'd like to conclude our focus group by discussing you team's thoughts about the impact of the innovation as a whole.

13. How do you feel like your program is doing with your CQI project? Have you reached your goals or are you close to reaching your goals?

o Do you feel like your program uses data on a more regular basis? Can you share some examples?

o Has the work you've done as part of the Innovation influenced collaboration with community partners? How so?

- Probe: Have you worked with community partners on your CQI project?

o Has the Innovation changed your understanding of racial, structural, and systemic inequities?

o Has the innovation changed your understanding of how your program can address racial, structural, and systemic inequities?

14. Any other major takeaways (i.e., things you've learned) from the work your team has done thus far as part of the Innovation?

15. Has participation in the Innovation activities changed things for you personally?

o Probe for HV/PEs: Has your caseload varied over time as a result of things learned from Innovation activities? If so, in what ways?

16. Do you think your program will continue the work you've done as part of the Innovation once the grant period ends? What aspects of it will you continue?

17. Anything else you'd like DPH to know about the project overall?

Semi- Structured Focus Group/ Interviews (T2)

Introduction
Thanks again for taking the time to chat with us today! Through this focus group, we hope to gain a deeper understanding of how CQI teams have continued engaging with the Innovation and what that experience has been like since we last met.

Reminders
• We will be recording the session using the recorder and taking notes, but both (recording and notes) will only be accessible by TIER.

• Anything shared with us during the focus group will be completely confidential.

Focus Group Questions
CQI Team Logistics

1. Has the team composition changed at all since December 2023 / January 2024?

    o In what ways?

2. You've had this CQI team for some time now. What would you say are some of your strengths as a team? How about areas for improvement?

3. Can you tell us a bit about your experiences with engaging in the Innovation activities as a CQI team?

    o Probes:

    · How often do you meet?
    · How has your team dynamic changed over time when using data?
    · What are some strategies that you feel have enhanced your ability to work together as a team?

4. Has anything gotten in the way of your being able to do the work?

    o Probes:

    · Do you have a good understanding of what is expected of you?
    · Are the tasks manageable?

Training and Technical Assistance (TA)

Next, we have a few questions about the training and technical assistance that your team has received from DPH.

This includes trainings (i.e., CQI, Racial Equity, and Family Engagement trainings from February to May 2023 and Spring 2024, Learning Communities (1 and 2, August 2023 to date), and any other coaching or technical assistance that you've received from DPH related to the Innovation project over the last 6 months.

5. What are your general impressions of the training you have received from DPH to date?

o Probes: Were they helpful? Were they repetitive? What are some things you learned that felt new to you?

6. How about the other forms of support DPH has provided, like the Learning Communities and office hours?

o Probes: Most helpful? Least helpful?

7. What would you change, if anything, about the training/support that your team has received to date?

8. Do you think your team has benefited from having the opportunity to meet with other CQI teams during trainings/ other support opportunities? In what ways?

9. Are there areas that you feel you could use more support in? What are they, and what kind of support would you like to see?

Data Use and CQI

10. Please tell us about your experiences with conducting PDSA cycles. In what ways are they helpful? Challenging? Motivating?

o Probes:

- What are some challenges you experienced as a team when using PDSAs?
- What are some strategies that worked well for your team?
- What are some things you learned from using PDSAs?
- Have you noticed any differences in missing data? If so, what are they?

11. What are your general impressions of the Data Dashboard? What are some of its strengths? Shortcomings? What would you change about it?

12. Does your CQI team use/review the Dashboard together? If so, can you tell us a bit more about how you review/use the Data Dashboard together?

13. What have you learned about your program through using the Data Dashboard? Can you share some examples of inequities that you've identified through using data?

o Probe: Were any findings surprising to you? If so, what were they?

14. Can you share some instances where you used the Data Dashboard to make service decisions?

Impact of the Innovation

15. How do you think your program is doing with your CQI project? Have you reached your goals or are you close to reaching your goals?

o Do you feel like your program uses data on a more regular basis? Can you share some examples?

o Has the work you've done as part of the Innovation influenced collaboration with community partners? How so?

- Probe: Have you worked with community partners on your CQI project?

o Has the Innovation changed your understanding of racial, structural, and systemic inequities?

o Has the Innovation changed your understanding of how your program can address racial, structural, and systemic inequities? Do you feel like you have been able to move the needle on inequities?

16. Any other major takeaways (i.e., things you've learned) from the work your team has done thus far as part of the Innovation?

17. Has participation in the Innovation activities changed things for you personally?

o Probe for HV/PEs: Has your caseload varied over time as a result of things learned from Innovation activities? If so, in what ways?

18. Do you think your program will continue the work you've done as part of the Innovation when the grant period ends? What aspects of it will you continue?

19. Anything else you'd like DPH to know about the project overall?

Appendix D: Pulse Survey Q3 (February 2024)

**Note: These surveys were originally developed and administered using Qualtrics. The formatting has been adjusted for readability in this appendix. Although a total of four Pulse Surveys (Q1–Q4) were administered at different time points throughout the Innovation Evaluation, the survey instruments remained largely consistent across waves. Aside from minor refinements and the addition of a few Equity Dashboard–related items in Q4, the core structure and content of the surveys were stable. As such, only one representative version (Q3) is included here for reference.*

Thank you for your interest in completing the Pulse Survey! We are Tufts Interdisciplinary Evaluation Research (TIER), an evaluation team at Tufts University. We are working with the Massachusetts Department of Public Health (DPH) to better understand your experience with Innovation activities.

You are invited to complete a brief survey because you are currently (or were previously) a member of your program's Continuous Quality Improvement (CQI) team. We are asking each CQI team member to complete this survey individually.

This survey will take about 10 minutes of your time. As a thank you for your participation, we will offer you a $15 gift card at the end of the survey. Your responses will be kept completely confidential; only members from the TIER evaluation team will see them. We will present survey findings combined across all respondents. Survey findings will be used to inform how DPH supports CQI teams as they continue to engage with Innovation activities.

1. What home visiting model do you represent? (Select all that apply)

    · Healthy Families America (HFA) or Healthy Families Massachusetts (HFM)
    · Parents As Teachers (PAT)

2. Where is your program located?

    · Boston area (including Boston, Chelsea, and Revere)
    · Central MA (including Fitchburg, Southbridge, Webster, and Worcester)
    · Northeastern MA (including Everett, Lawrence, Lowell, and Lynn)
    · Southeastern MA (including Brockton, Fall River, and New Bedford)
    · Western MA (including Holyoke, North Adams, Springfield, and Pittsfield)

3. What is your role? If you have more than one role, please select the one you spend the most time on.

    · Parent Leader
    · Coordinator
    · Supervisor
    · Home visitor/Parent educator
    · Other (please specify): _____

4. If not Parent Leader: How many years have you worked at this program?

5. If Parent Leader: How long have you worked as a Parent Leader with your home visiting program?

- Less than 1 year
- 1 to 5 years
- 6 to 10 years
- 11 to 15 years
- More than 15 years

6. What is your racial and ethnic identity? (Select all that apply)

- American Indian or Alaska Native
- Black or African American
- East Asian
- Hispanic, Latino/a, Latinx
- Middle Eastern or North African
- Native Hawaiian or other Pacific Islander
- South Asian
- White
- Other (please specify): _____
- Prefer not to answer

7. What is your primary language (the language you are most comfortable speaking)?

- Arabic
- Cape Verdean Creole
- Chinese
- English
- French
- Greek
- Haitian Creole
- Italian
- Khmer
- Portuguese
- Russian
- Spanish
- Vietnamese
- Other (please specify): _____
- Prefer not to answer

8. How long have you been a member of your program's CQI team?

- Less than a month
- 2 to 4 months
- 5 to 7 months
- 8 to 10 months

- 11 months or more

9. Which Innovation activities have you participated in? (Select all that apply)

- Family Engagement training
- CQI training
- Racial Equity training
- Kickoff Learning Session: MA MIECHV Innovation Award Learning Community
- Learning Session Day 2: MA MIECHV Innovation Award Learning Community
- Learning Session Day 3: MA MIECHV Innovation Award Learning Community
- Learning Session Day 4: Celebration of Success, MA MIECHV Innovation Award Learning Community
- Action Period Call #1
- Action Period Call #2
- Action Period Call #3
- Reviewed our equity spotlight as part the CQI team
- Attended Innovation office hours
- Emailed member(s) of the DPH Innovation team to ask for support
- Other (please specify): _____

10. What is your CQI team's Learning Community topic?

- Prenatal Enrollment
- Postpartum Visit
- Well Child Visit

11. How many times have you met with your program's CQI team since November 2023? (Exclude DPH-hosted meetings)

- None
- 1 to 3 times
- 4 to 6 times
- 7 to 10 times
- More than 10 times
- Not sure

12. How have you walked through the Dashboard? (Select all that apply)

- On your own
- With your CQI team
- As part of a one-on-one training with DPH staff
- As part of a recorded training/webinar

13. For what purposes have you used the Dashboard? (Select all that apply)

- To check progress on your PDSA
- To help plan for a new PDSA

- To learn more about your program and participants
- To discuss with community partners
- Other (please specify): _____

14. Please indicate how much you agree with the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I like participating in the Innovation activities.					
I have a good understanding of what our program is doing for the Innovation.					
I see how our Innovation activities will benefit the families that our program serves.					
I see how the Innovation will help us to improve program practices.					
I am learning something new about racial equity by participating in the Innovation activities.					

15. Please indicate how much you agree with the following statements. (For non-Parent Leaders)

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

I am confident in my ability to interpret the data provided in our equity spotlight.					
I am learning something new about data by participating in the Innovation activities.					
Our program has adequate funding to support Innovation activities.					
We have enough staff time set aside to engage in Innovation activities.					
I feel like participating in the Innovation activities is a good use of my time.					

16. Please indicate how challenging you feel the following tasks are.

	A big challenge	A small challenge	Not a challenge	Unsure
Finding times to meet that work for both staff and parent leaders				
Keeping team members interested and engaged				

Ensuring meetings are productive and help advance our work				
Engaging in authentic conversations about racial equity as a team				
Developing SMARTIE aims as a team				
Completing and turning in your program's PDSA Planning Templates				
Carrying out PDSA cycles				

17. Please indicate how much you agree with the following statements about working with the parent leaders on your CQI team. (Non-Parent Leaders only)

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Parent leaders have a clear understanding of what their role on the project is.					
I believe that parent leaders bring unique expertise to the project.					

I believe in the importance of parent participation in decision-making at the program and policy levels.					
I believe that parent leaders' perspectives and opinions are as important as those of professionals.					
I believe that parent leaders bring a critical element to the team that no one else can provide.					

18. Please indicate how much you agree with the following statements about working with the parent leaders on your CQI team. (Non-Parent Leaders only)

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I work to create an environment in which parent leaders feel supported and comfortable enough to speak freely.					
I listen respectfully to the opinions of parent members.					

I feel comfortable delegating responsibility to parent leaders.					
I consistently let others know that I value the insights of parent leaders.					
I feel comfortable sharing identifiable program data (data that includes information about participants that could reveal who they are) with parent leaders.					

What can be improved about the Innovation?

_____
_____

Is there anything else you want to share?

_____
_____

Thank you for completing our survey! You can choose to receive a $15 gift card (Amazon, Walmart, or Target) for completing this survey.

Appendix E: Pre-Post Training Survey (CQI, Family Engagement, Racial Equity)

**Note: These surveys were originally developed and administered using Qualtrics. The formatting has been adjusted for readability in this appendix.*

CQI Training Survey

1. What home visiting model do you represent?

   · Healthy Families America (HFA) or Healthy Families Massachusetts (HFM)
   · Parents As Teachers (PAT)
   · Welcome Family

2. What is your role? Select all that apply.

   · Coordinator/Director
   · Home visitor/Parent educator
   · Supervisor
   · Parent Leader
   · Other (please specify): _____

3. What is your race/ethnicity? _____
4. Are you a member of your program's CQI Team?

   · Yes
   · No
   · Not sure

For each of the 9 statements listed below, please answer the first row based on how you felt **BEFORE** the training and answer the second row based on how you feel **NOW**--after completing the training.

5. Please indicate your level of agreement with the following statements (Before and After Training): Strongly disagree (1), Disagree (2), Neutral (3), Agree(4), Strongly Agree (5)

Statement	Before Training	After Training
I understand how CQI can improve program implementation and processes.		
I understand what SMARTIE aims are.		
I understand how to develop SMARTIE aims.		
I understand what PDSA cycles are.		

I understand how to design and use PDSA cycles.		
I understand how to interpret run charts to draw conclusions about improvement.		
I understand what a root cause analysis is.		
I understand how CQI can be used to identify racial inequities.		
I understand how I can use CQI to address racial inequities in my work.		

6. Please indicate how strongly you agree with the following:

Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I feel confident that I will be able to apply what I learned today to my work.					
Information shared was helpful and provided in a clear manner.					
The quality of facilitation was good.					
Workshop trainers were knowledgeable.					

7. How would you rate this training overall?

   · Very poor
   · Poor
   · Okay
   · Good
   · Excellent

8. Would you recommend this training to others?

   · Yes

- No
- Not sure

9. What was most impactful for you in this training? _____
10. What aspects can be improved? _____
11. Do you have any other comments to share? _____

Family Engagement Training Survey

1. What home visiting model do you represent?

   - Healthy Families America (HFA) or Healthy Families Massachusetts (HFM)
   - Parents As Teachers (PAT)
   - Welcome Family

2. What is your role? Select all that apply.

   - Coordinator/Director
   - Home visitor/Parent educator
   - Supervisor
   - Other (please specify): _____

3. How many years have you been working in the home visiting field?
4. What is your race/ethnicity? _____-
5. Had you ever taken an implicit bias test before this training?

   - Yes
   - No
   - Not sure

For each of the 9 statements listed below, please answer the first row based on how you felt **BEFORE** the training and answer the second row based on how you feel **NOW**--after completing the training.

6. Please indicate your level of agreement with the following statements (Before and After Training): Strongly disagree (1), Disagree (2), Neutral (3), Agree(4), Strongly Agree (5)

Statement	Before Training	After Training
I understand how to develop strong relationships between families and home visiting staff.		

I understand the difference between equity and equality in family engagement.		
I understand how to identify racial inequities in family engagement.		
I understand how to use culturally responsive family engagement practices.		
I understand how to strengthen my program's capacity to engage families.		
I understand how to engage families in program design and planning.		
I understand how to engage families in program implementation and evaluation.		
I understand how to engage families in CQI projects.		
I understand how family engagement fits into the Innovation.		

7. Please indicate how strongly you agree with the following:

Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I feel like this training has helped prepare me for engaging Parent Leaders in the Innovation work.					
I feel confident that my program has sufficient capacity to engage families in the Innovation work.					

I will be able to apply what I learned today to my work.					
Information shared was helpful and provided in a clear manner.					
The quality of facilitation was good.					
Workshop trainers were knowledgeable.					

8. How would you rate this training overall?

   · Very poor
   · Poor
   · Okay
   · Good
   · Excellent

9. Would you recommend this training to others?

   · Yes
   · No
   · Not sure

10. What was most impactful for you in this training? _____
11. What was one new thing you learned from this training? _____
12. What aspects can be improved? _____
13. Do you have any other comments to share? _____

Racial Equity Training Survey

1 What home visiting model do you represent?

   · Healthy Families America (HFA) or Healthy Families Massachusetts (HFM)
   · Parents As Teachers (PAT)
   · Welcome Family

2. What is your role? Select all that apply.

   · Coordinator/Director

- Home visitor/Parent educator
- Parent Leader
- Supervisor
- Other (please specify): _____

3. What is your race/ethnicity? _____

For each of the 9 statements listed below, please answer the first row based on how you felt **BEFORE** the training and answer the second row based on how you feel **NOW**--after completing the training.

4. Please indicate your level of agreement with the following statements (Before and After Training): Strongly disagree (1), Disagree (2), Neutral (3), Agree(4), Strongly Agree (5)

Statement	Before Training	After Training
I understand the difference between equity and equality.		
I understand what structural racism is.		
I understand the relationship between racism and health.		
I understand how data can be used to identify racial inequities.		
I understand how I can use data to address racial inequities in my work.		

5. Please indicate how strongly you agree with the following:

Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I will be able to apply what I learned today to my work.					
Information shared was helpful and provided in a clear manner.					

The quality of facilitation was good.					
Workshop trainers were knowledgeable.					

6. How would you rate this training overall?

   · Very poor
   · Poor
   · Okay
   · Good
   · Excellent

7. Would you recommend this training to others?

   · Yes
   · No
   · Not sure

8. What was most impactful for you in this training? _____
9. What aspects can be improved? _____
10. Other comments? _____

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