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I. Promote a Culture of Equity

1. Provide training and education in the social determinants of health to staff1,2
2. Provide cultural sensitivity training to staff3–7
3. Acknowledge and manage implicit and explicit personal bias8–14
4. Promote a culture of equity15–17
5. Create a disparities dashboard18–20
6. Create a culture committed to follow-through18,21

II. Identify Social Risks of Families and Provide Interventions to Prevent and Mitigate Those Risks

7. Screen all families for social risks and social support using a standardized tool22–29
8. Use electronic health records to identify patterns and inform clinical decisions27,30–32
9. Include a social worker or other social health professional on the team33,34
10. Create alliances with community organizations (clinical-community partnerships)35–44
11. Include a paralegal or attorney on the team45–47
12. Provide parenting and family support tailored to individual family strengths and needs48–51
13. Provide mental health services for families during the hospital stay52–57
14. Provide referrals for drugs, alcohol, and smoking cessation counseling and treatment58–63
15. Provide housing, meals, and transportation vouchers for families64–70
16. Provide back to sleep education71–80
17. Provide sibling care for families81,82
18. Practice family-integrated care tailored to the capabilities and needs of families51,83–85
19. Provide trauma-informed care51,86,87
20. Provide lactation support using peer counsellors and other approaches88–99
22. Provide language support and culturally appropriate translation services for families104–107

III. Take Action to Assist Families After Discharge (Transition to Home)

23. Provide discharge education and planning tailored to each family’s needs51,106,108–113
24. Begin discharge planning and teaching at admission114
25. Estimate discharge date at admission and revise regularly during the stay115–117
26. Implement a medical home model for patients and families118–123
27. Establish effective communications with the primary care provider122
28. Create a health coach program124
29. Connect families with appropriate community organizations and services18,103,125–129
30. Screen for developmental risk130
31. Provide high-risk infant follow up130–137
32. Conduct home visits before discharge and at intervals after discharge51,138–144
33. Facilitate parent support groups and peer counseling that extend beyond the stay88,98
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34. Implement strategies to identify and minimize risk for readmission
35. Provide telehealth support after discharge
36. Use technology and social media to support families
37. Facilitate access to all necessary clinical specialists after discharge
38. Provide reminders to facilitate health behaviors and keeping of appointments
39. Provide mental health and addiction services for families after the stay
40. Provide family planning education and contraception referral
41. Develop meaningful clinical-community partnerships

IV. Maintain Support for Families through Infancy

42. Use parent coaches to support families
43. Provide evidence-based early intervention programs
44. Use innovative approaches to medical visits
45. Establish a reach out and read program for patients and siblings
46. Provide medical and developmental follow-up
47. Provide resources regarding available public benefits at follow-up visits
48. Establish partnerships with pre-K programs for patients and siblings
49. Develop and support tools that use parent-reported outcomes
50. Provide access to quality high risk obstetrical care
51. Launch a fruit and vegetable prescription program

V. Develop Robust Quality Improvement Efforts to Ensure Equitable, High-Quality Hospital and Follow-through Care to All Newborns by Eliminating Modifiable Disparities

52. Establish measurable improvement aims related to social determinants of health
53. Adopt standardized measures for social determinants of health
54. Develop strategies to support QI participation by parents including economically challenged, nontraditional, and racially and ethnically diverse families
55. Include pediatricians and other primary care providers for children on QI teams
56. Establish a charter with organizational leaders setting goals and resources for family advisors
57. Provide salary support for family advisors

VI. Advocate for Social Justice at the Local, State, and National Levels

58. Conduct and disseminate research that identifies disparities in access and outcomes
59. Serve on committees and in leadership roles within the local health system and raise awareness of need for social justice in healthcare
60. Actively recruit a diverse workforce with respect to race, ethnicity, gender, age, religion, and sexual orientation
61. Educate organizational leaders about social determinants of health
62. Engage organizational leaders with a social determinants of health charter
63. Advocate for the protection and restoration of nature by forming alliances to prioritize access to green spaces, especially in minority neighborhoods.
64. Advocate, organize, inform and lobby to change policy at the local, state, and national levels.
65. Play a role in addressing global health inequities.
66. Advocate for environmental health and justice.
67. Name racism and ask, “How is racism operating here?”
68. Engage local, state, and federal agencies with responsibilities for infants and families.
69. Advocate to include population health and social justice in the organizational mission.
70. Support the establishment of a national commission to explore restitution and atonement for historical and ongoing injustices inflicted on African Americans and Native Americans.
71. Speak out!

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