NEVADA HEALTH EQUITY ACTION PLAN (HEAP)

A Resource to Help Organizations Implement Health Equity Strategies

2023

April Cruda, MPH
Nevada Office of Minority Health & Equity (NOMHE)

CDC Health Disparity Grant (July 2021 - May 2023)

Funding Attribution
This publication (journal, article, etc.) was supported by the Nevada State Division of Public and Behavioral Health through Grant Number 1 NH75OT000092-01-00 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Division nor the CDC.

Disclaimer

The Nevada Office of Minority Health & Equity recognizes the systems that have perpetuated inequities cannot easily or quickly be removed. However, there are steps that can be taken with the resources available to make an impact towards health equity. This document is meant to be a guide to help begin impacting change, but it may not be comprehensive in containing all health equity solutions or resources. We also recognize that NOMHE is still learning on our journey and we are committed to remaining in a state of openness and being action-oriented in this space. We hope that you will join us in our journey to create a more equitable and healthier future for all Nevadans.

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Acknowledgments

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Funding Acknowledgment

The Nevada Department of Health and Human Services (DHHS) through the Division of Public and Behavioral Health (DPBH) Chronic Disease Prevention and Health Promotion (CDPHP) was awarded funding from the Centers for Disease Control and Prevention (CDC) Health Disparities grant in July 2021 as part of the national initiative to address COVID-19 health disparities. NOMHE was a sub awardee of this grant. The CDC Health Disparities grant is focused on providing much needed support to directly address issues in communities that need it most, including racial and ethnic minority populations and rural communities. Receiving these dollars has made it possible for NOMHE to not only increase its workforce capacity, but also build capacity for our community stakeholder partners. These dollars have lended themselves to building resiliency, making NOMHE a viable resource to its stakeholders, and programming that serves to communicate and promote literacy on an organizational level, while culminating in the development of the statewide Health Equity Action Plan (HEAP).

CDC grant allows funding for NOMHE staff to achieve various aspects of the following key deliverables:

- Development of a **Health Equity Action Plan (HEAP)** that reflects emergency responsiveness considerations and language access planning
- Multi-sector coalition building and collaboration enhancements, specifically working with the Nevada Minority Health and Equity Coalition (NMHEC)
- Policy changes and operational improvements within NOMHE and across DHHS service providing agencies, with a focus on health equity
- Development and implementation of training on engaging at-risk and underserved populations
- Report on all activities and impacts

Nevada Office of Minority Health and Equity

Who we are

The Nevada Office of Minority Health and Equity (NOMHE) is an agency within the Director's Office of the Department of Health and Human Services (DHHS) and is codified at Nevada Revised Statutes (NRS) 232.467 through 232.484. The Office of Minority Health was created in 2005. During the 2017 Legislative Session, the title was changed to the Office of Minority Health and Equity and the definition of "minority group" at NRS 232.472 was expanded to include groups of persons with disabilities, persons that share the same sexual orientation, and persons whose gender-related identity, appearance, expression or behavior is different than that assigned at birth.

Per statute NRS 232.474, NOMHE was created for the following purposes:

1. Improve the quality of health care services for members of minority groups;
2. Increase access to health care services for members of minority groups;
3. Disseminate information to and educate the public on matters concerning health care issues of interest to members of minority groups; and
4. Develop recommendations for changes in policy and advocate on behalf of minority groups

Mission

NOMHE's mission is to reduce or reverse disproportionately experienced, health-related disparities among the state's most vulnerable, high-risk populations.

Vision

NOMHE's vision is to achieve optimal levels of health and wellness for **all** minority groups and marginalized communities across the state.

Glossary of Terms and Concepts

Glossary terms will be displayed throughout the document in blue font for easy reference.

Accessibility	The extent to which a facility, system, or service or resource is readily approachable and usable by individuals, particularly those with physical disability or limited English proficiency (LEP) (Nevada DHHS, n.d.).
Ableism	Conscious or unconscious discrimination against people with disabilities. It is based on a harmful belief system that typical abilities are superior (Cogentica, 2021).
Build Capacity	The process of developing and strengthening the skills, instincts, abilities, processes, and resources that organizations and communities need to survive, adapt, and thrive in a fast-changing world (United Nations, n.d.).
Community Health Worker	Frontline worker who represents or has a relationship with the community being served, to be a liaison between medical and social services and the community. CHWs advocate for cultural competency, improving access to quality care,, and help build community health knowledge through outreach, education, informal counseling, care coordination, and social support. The Spanish term for a CHW is promotores de salud (Health Care Access Now, 2020).
Cultural Competence	To understand society and strategies that acknowledge and respect people from diverse backgrounds (Nevada DHHS, n.d.).
Cultural Humility	Having respect for and understanding the importance of another's values, beliefs, and identities (Nevada DHHS, n.d.).
Disaggregation of Data	Analyzing data that specifies and illustrates how different subgroups perform (LA County Center for Health Equity, 2019).
Discrimination	Differential treatment of individuals and communities based on characteristics such as: race, gender, social class, sexual orientation, physical ability, religion and other categories (Vermont Department of Health, 2018).
Environmental Justice	The fair treatment and meaningful involvement of all people regardless of race, color, national origin, or income with respect to the development, implementation and enforcement of environmental laws, regulations, and policies. This goal will be

	achieved when everyone enjoys 1) the same degree of protection from environmental and health hazards, and 2) equal access to the decision-making process to have a health environment in which to live, learn and work. (EPA, 2022)
Equality	The condition under which every individual is treated in the same way, regardless of their individual differences (Nevada DHHS, n.d.).
Equity	Ensure that individuals who have been historically underserved are provided the resources that they need to have access to the same opportunities as the general population. Equity represents impartiality that evens out opportunities for all people. Conversely, equality indicates uniformity, where everything is simply evenly distributed among people (Nevada DHHS, n.d.).
Ethnicity	A group of people who share the same culture or descent in a given geographic region, including their language, heritage religion, and customs (NCI Dictionary of Cancer Terms, n.d.).
Health Disparity	Statistical differences in health that occur between groups of people, such as the burden of disease, injury, violence, or opportunities to achieve optimal health. Typically experienced by populations that are socially disadvantaged (CDC, 2017).
Health Equity	When all people have fair and just opportunity to attain the highest level of health, especially those who have experienced socioeconomic disadvantage, historical injustice, and other avoidable systemic inequalities that are often associated with social categories of race, gender, ethnicity, social position, sexual orientation, and disability (CDC, 2022)
Health Impact Note	Describes through data the negative and positive health implications of a policy or program, including those that effect the social determinants of health. (The Pew, 2020).
Health in All Policies	The integration of health considerations into policymaking across sectors to improve the health of all communities and people. Health in all policies recognizes that health is created by factors beyond healthcare and beyond the scope of traditional public health activities (such as social determinants of health) (Nevada DHHS, n.d.).
Health Inequity	These exist when avoidable inequalities lead to an uneven distribution of resources and opportunities for health; often viewed as the *cause* of a health disparity (Medi Lexicon International, n.d.)

Health Literacy	The degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions (CDC, 2022).
Implicit Bias	Unconscious or hidden bias, or negative associations automatically expressed unknowingly. Individuals may not be aware that these biases exist within themselves (Nevada DHHS, n.d.).
Inclusion	The practice or policy of providing equal access to opportunities and resources for people who have historically been excluded or marginalized, such as those who have physical or mental disabilities and members of other minority groups (Douglas & Skea, 2021).
Intersectionality	The intersection of categorizations applied to an individual or group, such as race, class, gender etc., which creates overlapping of discrimination or disadvantage (or advantage/privilege) (Merriam-Webster, n.d.).
Limited English Proficiency	Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write or understand English can be limited English proficient or "LEP". These individuals may be entitled to language assistance with respect to a particular type of service, benefit, or encounter (Nevada DHHS, n.d.).
Marginalized Populations	Groups and communities that experience disproportionate discrimination and exclusion based on unequal power across economic, political, social, and cultural dimensions. (National Collaborating Centre for Determinants of Health, n.d.)
Minority	A racial, ethnic, religious, or social subdivision of a society that is subordinated in political, financial, or social power by the dominant group, without regard to the size of these groups. (Dictionary.com, n.d.).
National CLAS Standards	Culturally and Linguistically Appropriate Services (CLAS) - A framework to deliver services that are culturally and linguistically appropriate and respectful, and that respond to patient's cultural health beliefs, preferences, and communication needs. Standards can be employed by all members of a health care organization, state, or community (Minority Health, n.d.).
Public Service Organization	A federal, state, tribal, local, private, or non-profit organization, agency, or entity that offers services to individuals, communities, the public (Legal Information Institute, n.d.).
Race	A socially constructed way of grouping people based on perceived skin color and other apparent physical differences. Race has no

	scientific or genetic basis. The concept was developed intentionally to justify social and economic oppression of people of color by whites (Nevada DHHS, n.d.).
Social Determinants of Health	The conditions in which people are born, grow, live, work, and age. The social determinants of health affect overall health, and quality of life outcomes and risks. These circumstances are often shaped by the distribution of money, power, and resources at global, national, and local levels (LA County Center for Health Equity, 2019).
Socioeconomic Status	The social standing or class of an individual or group. It is often measure as a combination of education, income, and occupation (Vermont Department of Health, 2018).
Structural Inequality	A system where different segments of the population in a specific society receive unfair or prejudicial distinction. Often rooted in law, regulations, policies, practices that result in consequences of different access to equal or fair opportunity (Artic Centre, n.d.).
Structural/Systemic Racism	The normalization and legitimization of racism in history, culture, institutions, politics, economics, interpersonal dynamics, and entire social fabric. Structural racism routinely advantages Whites while producing cumulative and chronic adverse outcomes for people of color. It is the most profound and pervasive form of racism – all other forms of racism emerge from structural racism (Nevada DHHS, n.d.).
Underserved Populations	Populations who face barriers in accessing and using services. Includes populations underserved because of geographic location, religion, sexual orientation, gender identity, underserved racial and ethnic populations, those with special needs (such as language barriers, disabilities, alienage status, or age) (Legal Information Institute, n.d.).
Upstream	An approach to address social determinants of health that focus on social and structural influences on health and health systems, governmental policies, and the factors that determine health (Bharmal et al., 2015). Not to be confused with downstream (focusing on the immediate needs of the population) and midstream (addressing the physical circumstances that affect populations and individuals) (Hanafi, et al., 2022).

List of Acronyms

Acronyms will be displayed throughout the document in blue font for easy reference.

ASL	American sign language
BIPOC	Black, indigenous, and people of color
CAB	Community advisory board
CBO	Community-based organization
CBPR	Community-based participatory research
CHW	Community health worker
CLAS	Culturally and Linguistically Appropriate Services
DEI	Diversity, equity and inclusion
DIL	Diversity and inclusion liaison
HEAP	Health equity action plan
HiAP	Health in all policies
LAP	Language Access Plan
LEP	Limited English proficiency
LGBTQ+	Lesbian, gay, transgender, queer or questioning
NGO	Non-governmental organization
NMHEC	Nevada Minority Health and Equity Coalition
NOMHE	Nevada Office of Minority Health and Equity
SDOH	Social determinants of health
SOGI	Sexual orientation and gender identity

Executive Summary

National, state, and local health data shows stark differences in health outcomes, with negative impacts on the populations that have been historically marginalized. These differences are a result of policies and systems that have been built that intentionally or unintentionally harm and leave some communities in worse shape than others. When looking at health equity, it is essential to understand the historic injustices that have occurred and take direct action in challenging the practices that perpetuate them. Public service organizations, such as state, local, tribal, and non-profit entities that work with individuals and communities, can help spark the change needed to action health equity. Because public service organizations offer access to opportunities and resources that impact quality of life, they have the potential to implement and evaluate strategies that prioritize the needs of members of minority groups. Through this action plan, organizations and individuals can discuss health inequities, root causes, and implement strategies to reverse the effects of structural inequality. By embodying equity ideals in this action plan, organizations and institutions can show commitment to improving the health and quality of life for all Nevadans.

The HEAP is designed to aide workplans to achieve health equity in Nevada. Equity must be embedded in all phases from workforce development, assessment, planning, decision-making, implementation, and evaluation. Specifically, the plan focuses on key areas to target efforts and offers strategies that can be actioned under each area. Language access and emergency preparedness considerations are featured to make future plans more resilient against crises such as the COVID-19 pandemic. The priority areas are outlined below.

Data
Improve data collection and sharing that is consistent, accessible, and will help in determining and

Build Organizational Capacity
Develop and strengthen the skills and resources of individuals and organizations that is needed to expand service delivery to members of minority groups.

Community Engagement and Partnerships
Considerations to better engage, understand, and build trust with communities.

Language Access
Develop culturally and linguistically appropriate materials for effective communication with all populations. Considerations for information dissemination to reach members of minority groups.

Policy Change and Advocacy
Focus on upstream factors to incorporate health and health equity considerations in policy and decision making.

Emergency Preparedness
Apply lessons learned from the COVID 19 pandemic to ensure equitable response for future emergencies.

Finally, while not all strategies outlined in this plan may be appropriate for every organization, it is intended to be of use in a way that will make the most impact for your organization and the communities you serve, with focus on minority groups or those who are at increased risk for chronic conditions and/or hazards. Each strategy is a step towards achieving health equity, and while each step is important, actioning one step *alone* is not enough. Our efforts must be actioned across multiple areas of work, across multiple professions, influence the social determinants of health, and must be framed for long-term, sustainable change.

Introduction

What is a Health Equity Action Plan?

A health equity action plan is a set of strategies that can be actioned to achieve health equity. It is meant to guide efforts to eliminate health disparities and meet the needs of populations that are underserved.

> *"Outlines a set of strategies and actions to focus the work and is a commitment to achieving a set of defined equity goals. Activities are designed to foster health equity and create partnerships that strive to ensure that everyone in our [community] can reach optimal health and well-being"* – Center for Health Equity, LA

Purpose

A review of health equity practices and policies was conducted to help inform understanding of health equity, root causes, and ways to implement strategies to create long-term, institutional, structural, and cultural change. The HEAP represents a step in this direction. Tailored to Nevada, the HEAP is designed as a resource for organizations to begin embedding equity into decision-making, recruitment, partner engagement, policies, and services. It serves as a framework to help individuals and leaders challenge old practices and mindsets, and to create a culture internally and externally that advocates and implements more equitable systems and practices. Agencies, organizations, and institutions in Nevada have an opportunity to work together to achieve health equity for our communities, and this action plan outlines ways to do that.

Intended Audience

Institutions and organizations throughout the state play a vital role in improving health equity and community wellness. Human service-providing organizations, or public service organizations, are typically at the forefront of identifying environmental and social factors that affect healthy life choices, developing intervention plans to address resource gaps, educating residents to facilitate life changes, providing access to essential services, and working with other community agencies to address barriers (Tulane University, 2020). Because of the essential role these organizations play in impacting the social determinants of health, it is important that strengthening and supporting organizational infrastructure is prioritized as a first step in creating a healthy future for all. This document serves as a starting point for individuals or organizations committed to the learning, hard work, and collaboration that is necessary to achieve health equity. By working together to uplift health equity in culture, practice, and implementation, we can better serve all communities in Nevada.

How to Use This Document?

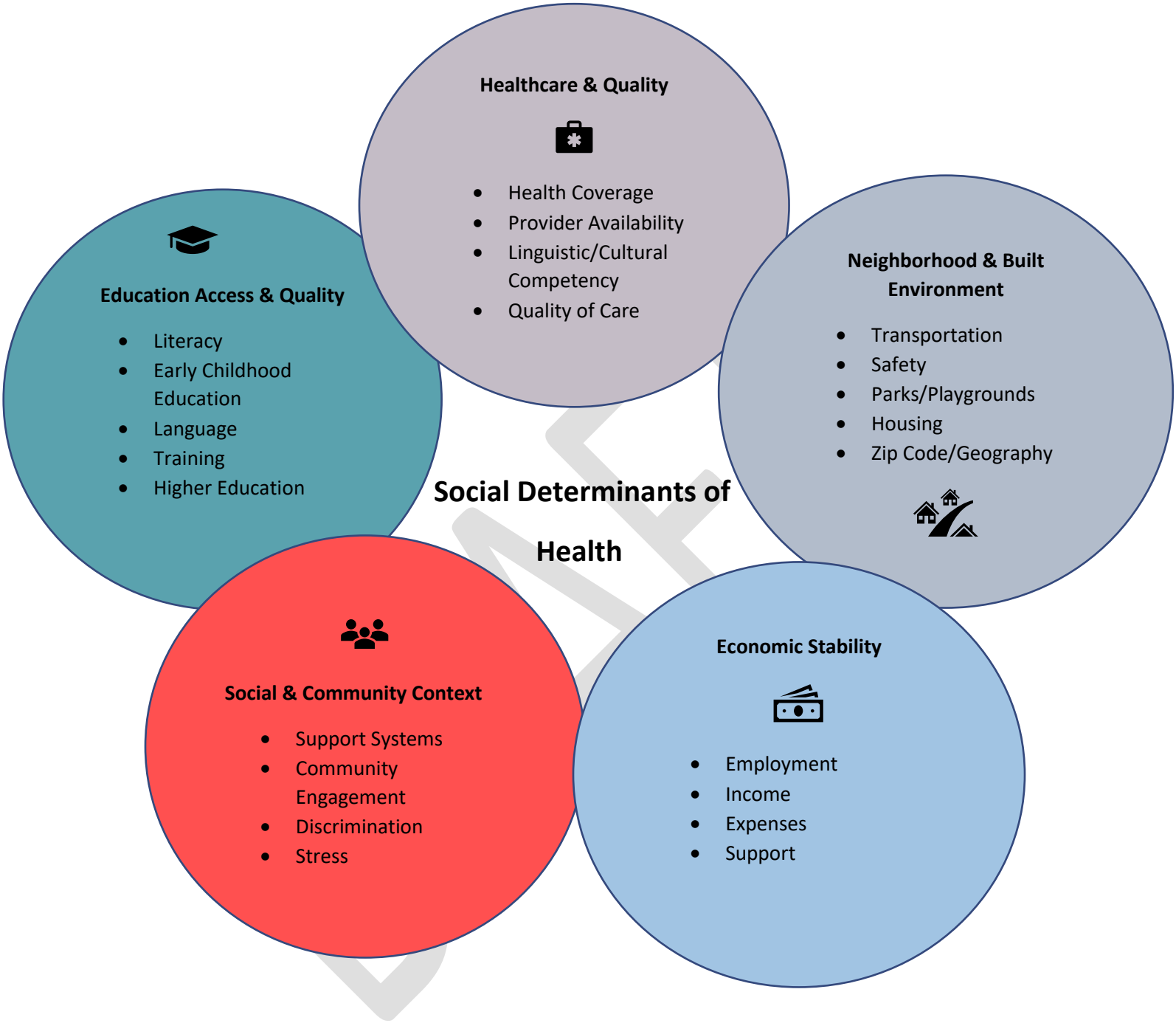
This equity plan is divided into six sections based on six key areas to improve health equity in Nevada. Each section offers ways to promote health equity in that area by providing actionable strategies and **Recommendations**. Additional tools for implementation can be found under **Additional Resources**. Readers can also learn about projects that have been successfully implemented under each **Case Study.**

Understanding Health Equity

Health Equity means that every person has the opportunity to "attain full health potential and no one is disadvantaged from achieving this potential due to social position or other socially determined circumstances" such as race, religion, sexuality, socioeconomic status, geographical area, or physical ability (CDC, 2022). While health outcomes can be attributed to biology, genetics, and individual behaviors, many health outcomes are substantially affected by social, economic, and environmental factors (NIH, 2017). In other words, health and quality of life are shaped by the conditions in which we live, learn, work, and play. These conditions are also known as the social determinants of health (SDOH) (illustrated in Figure 1)**.** The SDOH impact the resources and opportunities that allow individuals and communities to grow, thrive, and achieve optimal health. For example, if a house plant does not receive the proper amount of sunlight, water, and nutrients, then it will likely not grow. Similarly, if our communities have unequal access to opportunities, programs, and resources to be healthy (i.e., education, healthcare, employment, etc.), then they will likely experience poor health outcomes.

To achieve health equity, there must be a collective effort to impact all elements of the SDOH. Governments, schools, hospitals, community organizations, and other branches of public service play an important role in the SDOH and can incorporate equity into practice. Discriminatory practices and policies have led to inadequate distribution of resources, leaving some communities in worse shape than others. By deliberately recognizing and challenging bias and structural inequalities, organizations can develop and implement strategies to address these issues and promote health equity. Resources such as this equity action plan serve as a starting point to promote health equity by providing policy, program, and resource recommendations that can be applied to current and future practice.

FIGURE 1. THE SOCIAL DETERMINANTS OF HEALTH



EQUALITY VS EQUITY

The term equality is defined as treating every person in the same way regardless of their requirements or needs. In equality, everyone is given the same rights and responsibilities, regardless of individual differences and circumstances, such as socio-economic status, ability status, age, citizenship, etc. Equality refers to *even* distribution and provides the same and equal opportunities to everyone, while equity refers to *fair* distribution, where individual differences

are respected and provided care based on unique needs and requirements. Figure 2 illustrates the approach of equality versus equity by providing individuals with a bicycle. If everyone, despite height, age, and ability status are given the same type of bicycle (equality), then the outcomes for each individual are unequal, resulting in varying abilities to benefit from using the vehicle. Providing a different type of bicycle based on the needs of each individual (equity) allows for everyone in the entire group to reach their destination. Similarly, for the social determinants of health (SDOH), the distribution of resources, care, and opportunities must be done with intention to reach those who have been historically underserved in order to allow individuals to reach optimal levels of health and well-being, despite their starting point or circumstance.

FIGURE 2. EQUALITY VS. EQUITY

Health Inequities in the Country

Health inequities in the United States still exist by race, ethnicity, sexual orientation, gender identity, and disability, as well as geographic location, poverty status, and employment. Data shows that there are stark differences by race and ethnicity in life expectancy in the U.S., with the most significant drop among American Indian/Alaska Native people (Greenhalgh & Simmons, 2022). Between 2019 to 2021, the life expectancy for this population fell due to COVID-19 by 6.6 years while the U.S. average drop was 2.9 years (Greenhalgh & Simmons, 2022). Evidence also shows that American Indians are also 2.2 times more likely to die from COVID-19 and 3.2 times more likely to be hospitalized than other racial/ethnicity groups (Greenhalgh & Simmons, 2022). Black women in the country are also three times more likely to die of pregnancy-related complications than White women (CDC, 2022). This can be attributed to many things such as lower quality in healthcare, underlying chronic conditions, discrimination, or implicit bias (CDC, 2022). Additionally, current research shows that racial/ethnic minorities are disproportionately represented in lower socioeconomic status groups in the United States, and minority children of lower socioeconomic status are nearly twice more likely to experience obesity (Wippold & Tucker, 2016).

Examples of discrimination based on ability status, language(s) spoken, gender/gender identity, sexual orientation and other intersecting identities are also present in the country. Some examples of ableism, the conscious or unconscious discrimination against people with disabilities, are the lack of accessibility features in building designs, inaccessible facilities, medical equipment, and websites. Inadequate design affects likelihood of receiving proper treatment, preventative care, and screenings (CMS, 2022). Research has also shown a significant association between increased number of chronic health disorders and language discrimination in seeking medical care (Yoo et al., 2009). And a large body of evidence suggests that LGBTQ+ populations have a higher prevalence of poor health outcomes and behaviors such as hypertension, heart disease, and heavy drinking, due to experiencing higher levels of discrimination, stigma, and stress compared to their heterosexual counterparts (Jackson et al, 2016).

Nevada has significant health disparities that mirror those that are seen nationwide. Differences in health outcomes are seen across different factors such as income level, geographic location, age, race or ethnicity, sex or gender, or ability status. The COVID-19 pandemic exacerbated existing disparities in Nevada and further highlighted the need for health equity.

Ninety-one percent of Nevada's population resides in the urban counties Clark, Washoe, or the municipality of Carson City, and the remaining population (~8%) resides in rural, frontier or tribal communities. Majority of the land within the state is classified as either rural or frontier. Rural or frontier residents and communities often face barriers in primary health care delivery because remote areas of the state have longer travel time and distance from the nearest population center that has more specialized medical care facilities (Nevada DHHS, 2019). This results in overall lack of resources and access to things such as fresh foods, opportunities to be physically active, health care providers, and medical facilities (UNR, 2022). According to the Nevada Rural and Frontier Health Data Book, the "average distance from an acute care hospital to a next level of care or tertiary care hospital is 109 miles, and the average distance to the nearest incorporated town is 43 miles" (Griswold et al., 2021). "Driving long distances is a very daunting task to obtain emergency health care, especially in difficult seasonal weather conditions" (NVRFH, 2021).

In 2021, Black populations account for 9.1% of Nevada's population (see Figure 3) yet had significantly higher death rates due to heart disease than all other race/ethnicity groups, and higher rates of death due to diabetes compared to all other race/ethnicity groups. Black populations also had higher rates of reported cases of HIV infection than all other race/ethnicity groups each year from 2017-2021, and significantly higher death rates from homicide than other race/ethnicity groups each year from 2017-2021 (Office of Analytics, 2023).

American Indian/Alaska Native populations and Black populations experience the highest rates of infant mortality, at 10.9 and 10.8 deaths per 1,000 live births, compared to White (4.6 per 1,000), Asian (3.4 per 1,000), and Hispanic populations (5.3 per 1,000) (Office of Analytics, 2023). And among Asian/Pacific Islander populations, the number of cancer cases have increased by nearly 35% for all cancer types from 2010 to 2019 (Office of Analytics, 2023).

Race/Ethnicity Group	Count	Percent of Total
White – non-Hispanic	1,575,891	49.0%
Black – non-Hispanic	290,120	9.1%
AI/AN – non-Hispanic	36,119	1.1%
API – non-Hispanic	325,604	10.1%
Hispanic	986,526	30.7%
Total	**3,214,260**	**100.0%**

FIGURE 3. NEVADA'S POPULATION BY RACE/ETHNICITY

When COVID-19 first swept the country, Nevada's racial and ethnic minority groups and older age groups were among the hardest hit by COVID-19 in terms of infection, hospitalization, and mortality rates (The Guinn Center, 2020). A snapshot of August 2020 indicated that Hispanic/Latinos in Nevada accounted for 30.3% of the state's population and accounted for almost 40% of COVID-19 confirmed cases, compared to White populations who represent 50% of Nevada's population but accounted for 28.8% of COVID-19 cases (The Guinn Center, 2020). For hospitalizations in Clark County in August 2020, which accounted for majority of the state's population and COVID-19 cases and deaths, White populations had the lowest hospitalization rate at 120.2 hospitalizations per 100,000, compared to Black populations at 216.9 hospitalizations per 100,000 (nearly double the rate) (The Guinn Center, 2020). As of 2021, Black populations had significantly higher rates of COVID-19 cases (rate of 7,074.3) than all other race/ethnicity groups (White 5,774.6; American Indian 5,96.0; Asian 5,479.4; and Hispanic 5,285.6, respectively) (Office of Analytics, 2023).

Statistics clearly show health disparities for members of minority and marginalized groups in the country and in Nevada. The state has an opportunity to move forward in building and uplifting systems that address disparities and appropriately serve everyone. Through this plan, organizations and entities can talk about the importance of health equity, identify the gaps that exist in our state, and implement solutions to reverse the negative effects of discrimination, exclusion, and bias to promote health equity.

Methodology

To inform the health equity plan, NOMHE used a combination of primary and secondary data to identify and understand organizational factors and practices in Nevada, to frame practical and actionable recommendations, and to identify resources needed to improve health equity in Nevada. A combination of 1) literature review, 2) review of secondary data, and 3) primary data collection informed this plan. Each component of the methodology is described below.

Collect Data

Review of Reports/Literature

A review of health equity practices and policies was conducted to help inform understanding of health equity, root causes, and ways to implement strategies to create long-term, institutional, structural, and cultural change. Federal and state equity plans, equity toolkits, issue briefs, resource guides, equity action plan manuals and frameworks were used to form a foundation for how state, local, and community organizations can begin to action health equity.

Secondary Data

Existing data, such as national and state surveys, needs assessments, reports, data books, and fact sheets were reviewed to learn more about current health inequities in Nevada. Information was used to form a better understanding of Nevada and what resources are needed to reduce health disparities in Nevada's communities.

Primary Data

A semi structured interview guide was developed to learn more about work that is being done throughout the state, learn about health priorities of communities, as well as challenges and needs when servicing minority populations in Nevada (See Appendix 1). Interviews were conducted virtually via Microsoft TEAMs and recorded for later reference and data analysis. Verbatim transcripts were also retrieved from the recording feature on TEAMS.

Qualitative data was collected from 36 key informant interviews from across the state representing 26 organizations and agencies. Key informants were selected based on profession and expertise in sectors including public health, community, research, healthcare, philanthropy, academia, emergency management, as well as state, local, and tribal government entities. Additionally, a diverse set of key informants were selected to represent the voices of different

minority groups that make up the state of Nevada, including racial/ethnic groups, tribal communities, people with disabilities, older adults, LGBTQ+ populations, and rural populations.

Data Analysis

Qualitative data analysis techniques were used to interpret the findings. A combination of deductive and inductive approach was used to assess primary and secondary data. A deductive approach starts with a set of predetermined themes, and inductive approach allows for new themes to develop as data is analyzed. A review of the literature was conducted to derive a set of themes that address, support, and inform health equity activities. Similarly, interview transcripts were retrieved and reviewed for common codes and themes, while also yielding added themes.

Findings

A review of the literature and assessment of key informant interviews revealed six central themes related to health equity work. The final key themes for the plan are:

1. **Data**
2. **Build organizational capacity**
3. **Community engagement and partnerships**
4. **Language access**
5. **Policy change and advocacy**
6. **Emergency preparedness**

Key Partner Insights

Qualitative data was collected through a series of interviews with key informants. Professionals who serve or represent minority groups provided insight into gaps and barriers that currently exist, and how systems can be improved to serve these communities better. Each quote accompanying the sections below are contributed by key informants. Data analysis revealed six key focus areas**: data, build organizational capacity, community engagement, language access, policy change and advocacy, and emergency preparedness**. Each focus area is discussed in more detail below.

Data

Findings: According to the literature, data infrastructure that supports accurate and inclusive data collection is essential in identifying where disparities exist and help measure progress toward achieving greater health equity (Artiga, 2021). Data can also be used to develop targeted interventions to improve access to care and overall health for underserved populations (AHA, 2021).

Key informant interviews revealed that there are still challenges in the following: current modes of data collection and dissemination are not culturally or linguistically responsive, and there is a lack of access to aggregate data for segments of the population (including rural, Asians of different dialects, and LGBTQ+ communities). Aggregate data allows for the identification of patterns and trends. However, aggregation does not adequately show impacts on subpopulations (i.e., Asian subpopulations). Lack of robust data makes it difficult to justify the need for funding to implement interventions that target marginalized communities.

> "The biggest challenge for every Asian group is not having enough data for funding. Data and reporting are needed to receive funding for programs and services...Everyone wants to see numbers in order to fund and implement programs, so having better data access and reports [on our communities] would help us a lot."

> "Surveys that are collected to learn more about the community are done in ways that don't reach the community. For example: surveys for Hispanic people are only available in English, or people collecting data are not from the community, which leads to hesitation and mistrust. So,

data then is only pulled from a certain segment of the community that is assimilated, westernized, perhaps second generation, and obviously educated because they know how to speak English. The data set comes from that information and has nothing to do with the communities that need it the most. Then policy and funding are driven from this data as if it truly represents what the community needs, but they never spoke to community that needs the help, and chances of the community responding to surveys with a clipboard is almost zero, because of, well…mistrust. So, it just shows you the different approaches you have to take to work in those communities to get information that would be a valid representation of the needs of those communities."

Build Capacity

Findings: Consistent across the health equity literature that was reviewed, building organizational knowledge and capacity to advance health equity practice is foundational. Leadership and teams should strengthen commitment to continuous learning, self-reflection, and evaluation, and embed equity into all practices within an organization (Human Impact Partners, 2017). Strategies can be implemented to make organizational change to include equity, such as equitable recruitment, department or peer workgroups, trainings, or other opportunities to discuss equity-related content (Human Impact Partners, 2017).

Informants stated that recruiting and retaining a workforce with a diverse set of skills, knowledge, and background is essential in showcasing commitment to health equity and being better prepared for the next emergency. Cultural competence is needed to build meaningful, ongoing relationships with communities and achieve things like lead community efforts through the pandemic. Representatives from tribal, and other racial/ethnic minoritized communities noted that there is a need for a workforce that is more culturally sensitive, or that specifically represents those communities to deliver services that are needed.

> "A challenge in building capacity is not treating [health equity] as one more initiative, but rather trying to figure out how to embed health equity work into all of the work that's already being done. Rather than saying there's a group of health equity people over there working on health equity initiatives, when really, we need to change *all* of the work that we do to have a health equity lens-- and that is significant, long-term meaningful change management with cultural aspects… it is significantly harder."

> "The people who sit at the table… need to have culturally, globally well-versed individuals sitting around the table looking at policies and practices to make those decisions.

Organizational capacity for change needs to be intentional. An organization, once aware of it, needs to make a decision, are we going to check box this approach or are we going to embed this into our entire practice for systems change?"

"We need social workers, teachers, police force, and community program managers/coordinators. And these need to be our own people. That's lacking amongst our tribes is our workforce; that people who are supposed to be providing services in teaching, healing, etc., are often non-native, and that provides a cultural barrier, naturally."

Community Engagement and Partnerships

Findings: To truly assure that public health takes appropriate action and understands the experiences of minority communities, genuine engagement with the community is needed (MDH, 2022). Those who experience health inequities must exclusively be included in the development of health initiatives, such as those in poverty, American Indians, communities of color, people with disabilities, immigrant communities, and LGBTQ+ communities (MDH, 2022). Efforts will more effectively meet the needs of these communities when they are designed *with* communities, not just *for* communities. (MDH, 2020). Literature also emphasizes the importance of partnerships and working together across different sectors to solve issues in the community. Community-based organizations, healthcare organizations, and other community stakeholders must "break out of their comfort zones and work collaboratively" to achieve shared objectives (APHA, 2020).

The importance of community participation and engagement in policy and program decision-making was mentioned across all interviews. Historically there has been mistrust between communities and health authorities, which poses a challenge in building relationships today. There has also been a lack of maintaining long-term relationships with communities because building relationships is time consuming. Community informants stated that often times, relationships with the community only last for the term of a project or initiative. There is a need for more roles solely dedicated to building and maintaining long-term relationships with the community. Many informants also expressed the problem of "working in silos", where different agencies and organizations have similar goals, but are not working together to achieve them.

"Organizations get a grant or a project that they need to get accomplished and will come into neighborhoods or communities and ask communities to help, then once the project is over then

they leave. Then the new agency comes behind and says I need Native American community to participate in this, I need the Black community to participate in this, but nobody is invested in maintaining long term relationships and/or recruiting staff in such a way that those relationships are more likely to be naturally ingrained within the organization. There's a long history of well-meaning government agencies and nonprofits of dropping in and out of communities, which has raised a lot of skepticism."

"The challenge is trust, it's gonna always be trust. To overcome the challenge, be part of the community--not for the sake of an event, survey, or data. When we see you just because it's time to complete this report, it seems ingenuine. So be in community events, go to what's happening in community atmospheres and get to know people so that people know you by name, not just by program or service."

"There's no better way to communicate with native people effectively than in person. Prior to the pandemic, when it came to registering people to vote, telling people about health ailments, or getting information out about opportunities and education, the best way to do it is to have those organizations setup an information booth at powwows, or other community gatherings…they need to go where the people are."

"It's gotta all be collaborative. The CDC has their preparedness efforts, FEMA has their preparedness efforts…They're talking the same stuff and doing the same things, but we're pushing the messages from two different agencies and so it looks like we're not talking to each other. So whatever we do it's gotta be with all community, we've all got to be together in this."

"How do we make regional collaboratives in southern Nevada, Eastern Nevada, and Western Nevada? Where we get all different groups together and build relationships ahead of time and hear them ahead of time so that way we can write plans and work for them. And when we have something, we use them as partners and trusted leaders to tell us, and to help us. And we need to bring in local emergency managers, and local health authorities to be involved with that, and then the community health nurses that are in the rural local health authorities in those groups too so that we build that trust."

Language Access

Findings: A key component to health equity is "accessible and meaningful language services to those with Limited English Proficiency (LEP)" or do not speak English as their primary language and have limited ability to write, speak, read, or understand English (The Colorado Trust, 2013). Language access is a critical social determinant of health because a lack of appropriate

language services could prevent one from accessing healthcare services or contribute to lower quality of care, which can lead to worse health outcomes. Research has shown that people with LEP or lower health literacy are twice as likely to report poor health outcomes than those without these barriers (CMS, 2022).

A common challenge mentioned by key informants is the need for more culturally and linguistically accessible resources and services. Nevada has over 10 different languages spoken at home other than English, such as Spanish, American Sign Language (ASL), Tagalog, Mandarin, Cantonese, Korean, and Vietnamese. Ethnically diverse populations and those of immigrant status face challenges in accessing care that is in their spoken language or have challenges with finding materials that are appropriately translated into their language. Lack of appropriate language services widens the gap in health disparities for these particular communities.

> "One of the biggest issues we have is language. We do not speak the same language. According to census, in Nevada we cater to seven Asian ethnic groups: Filipino, Chinese, Korean, Japanese, Vietnamese, etc. That's according to the census—I know that the other communities are not filling out the census forms, or the American Community Survey…which would actually give a better look at our community…The language barrier is the number one reason for this."

> "The way I've experienced it is that the person is 'problem-thinking'. We identify the problem is that 'oh, they don't speak English', so the solution is 'let's accommodate them', and so we provide translation and interpretation, but just English to whatever language—there's no consideration beyond that. When you look at inclusion, we should think 'how do we create spaces where more than one language can be present?' And we should encourage bidirectional conversation. Anytime there's interpretation, it's always for the other language. We need to move away from direct translation and interpretation, embrace cultural humility, and we have to be willing to be really innovative with ideas for outreach and engagement."

> "Depending on what the threat or hazard is, it's delivering whatever relief through alerts… We need to be mindful in offering those in different languages and having people there that can translate and speak or walk you through what it is so that it's less frustrating for communities. When you have thousands of people who need to complete government forms for relief, and you're not able to help them, you're gonna have a lot of people who, just because of the process, aren't able to complete what they need to do to access the relief that they need, such as loans to repair homes, saving livestock, etc. There's loans or grants in a disaster that can help, but we have to think about how we make those processes more accessible. It can't just be in English…The relief is available, but we can't do that public service announcement in one language but in several languages…we need things like a translator line, things in large text, sign language interpreters or video, and outreach with flyers in different languages."

Policy Change and Advocacy

Findings: Health equity literature indicates that the most significant impact on community outcomes result from interventions on upstream systems levels and "should be at the heart of a health department's work to advance health equity at the local, state, and federal level, and with diverse partners" (Human Impact Partners, 2021). State leaders and organizations must proactively identify and address existing policy gaps while advocating for federal support on policies that promote health and health equity. The response to the COVID pandemic revealed that significant gaps remain for a range of health and social services, along with the need for more financial relief for states and communities that historically experience budget deficits (RWJF, 2020).

All key informants indicated the importance of advocating for policy and systems change to address health disparities. Organizational policies as well as public policies help guide practice, therefore it is important to assess existing policies and consider how it affects members of all intersecting vulnerable populations. Informants also expressed the need for public health/health equity considerations in all policies, legislation, funding, programs, and initiatives so that we can consistently and sustainably practice taking care of *all* communities.

> "In the state of Nevada, we have the lowest funding per capita for public health that comes directly from the state in the form of general fund dollars. A lot of the work that we do is grant funded so therefore it is in a specific bucket, so we can tackle certain issues [like health equity] as long as there is a grant but when that grant goes away then we shift our priority."

> "The public health community has come to legislature the last couple sessions to say that we need a public health fund…If you look at other states and look at the dollars per capita, Nevada is just not there…Public health wasn't as apparent until we had a pandemic…Elected officials to some degree do what the public says is important, so how do we tap into the conversation about how do we have adequate funding? All of that comes from enough momentum and energy from people to say that it's worth doing this [actioning health equity]."

> "The best way to address disparities both in populations we serve but also in the workforce, are advocacy and action. That is by doing things rather than advocating and just talking about them, and I've done both myself, no question about it. The problem we get into is sometimes policy at the state level, not for any ill reasons, but just the way things are, very much adversely affects our ability to accomplish both of those missions…such as the rates the state pays

providers has a real impact on this issue. In the healthcare universe, it's at the point where we ask who the workforce is, and how do we support them?"

Emergency Preparedness

Findings: Lessons from the COVID-19 pandemic revealed the need for more collaboration and concerted efforts during a response, as well as participation from all levels, from officials down to the individual level. Officials and leaders in the pandemic response required community voices to help inform appropriate response for each population. In turn, communities also needed support from officials to act in risk mitigation and obtain resources and education about the SARS-COV-2 virus. Preparedness also includes climate and sustainability practices, which are essential to Nevada and its resources.

Communication and relationships between all levels and sectors need to be established long before an emergency in order to build trust and improve coordination during the response and recovery phase. The pandemic also reinforced the need for appropriate designation of funding for public health and emergency resources.

> "We really struggle with surge capacity. So, when you have something like a pandemic, for our health district, 80% of staff had to shift to the pandemic response, everything else we were doing got pushed aside. It's not just money, but money that is not highly designated to a specific public health need, but rather broad-based revenue that you can use strategically, and you can use when you need to surge so that the foundational public health work doesn't get abandoned just because this is where the fire is today. We're just not adequately resourced in public health."

> "We need engagement, participation from leadership, elected officials, administrations across state/government entities, and then the very people that we're trying to reach, the most local, the community, the people, folks that are gonna need the services that we're trying to put into effect. Often times the first time they're hearing about it is when they actually need it. And there's a whole process and a whole delay in getting the information, vetting, confirming, and validating and then making use of it. So, the response is delayed just in trying to get the right information to the right people at the right time."

> "The big thing was getting locals to understand what they had to do. We had to do things [for locals] that they should have been doing but they weren't doing…How do we make it so that way they do these things, and we help support them instead of us having to step in and do it for them? We did the rural and tribal vaccinations, drove through Nevada, and went to people's

communities to increase vaccination status. It's all those things that the state did, but how do we get it so that the locals do those jobs instead of the state doing it? Like 'here are some resources you can work from' and get you what you need. That's where we fell down, was making sure that we stood up our locals and supported them and don't have to take that work away from them."

"[During the pandemic] We needed to have more contact tracers… Having the ability to rapidly stay on contact tracing is essential. We have to retain some sort of contact tracing core capacity, or 'train the trainers'--people that can teach people really quickly on how to do that as an exponential scale, for the future. We can't just let that go away."

"With water levels receding, that is a major concern and at some point in time we need to start engaging the community about better sustainability and conservation practices when it comes to water."

Health Equity Action Plan

The next section of the action plan focuses on six strategic priorities under which to organize work and partnerships to promote health equity. **Actionable recommendations** are developed from literature review and key informant insights and can be found in each chapter. Rural and tribal considerations are also highlighted, as these communities experience unique barriers compared to more urban areas. Our hope is that other organizations adopt some of these strategies and apply them in their own areas of responsibility, control, and influence so this work is amplified across multiple sectors and movements throughout the state.

Key areas include:

Data

Data allows us to understand, investigate, and quantify inequities. Data also functions as a tool to inform interventions to improve health (Human Impact Partners, 2017). Community level data shows opportunities and challenges, especially when disaggregated by race, ethnicity, income, gender, sexual orientation, neighborhood, etc. Funding opportunities often require reporting data to help inform decision-making. However, there is still a challenge in collecting and reporting data that represents a range of communities, and that clearly connects health inequities to social, racial, economic, and geographic inequities.

Data Recommendations

1. **Use secondary or primary data to identify inequities and determine where to target department/program efforts.**

2. **Establish partnerships across sectors to identify data priorities.**
   - 2.1 Form a data advisory committee to assess data needs, identify gaps in data elements, and identify communities and stakeholders to be included in data efforts.
   - 2.2 Integrate community stakeholders, such as community organizations, local health departments, hospitals, educational institutions, state programs, research institutions, etc.
   - 2.3 Work with government agencies and community partners to identify, analyze, report data.

3. **Methods of data collection**
   - 3.1 Use primary methods of data collection such as surveys or focus groups, listening sessions, one-on-one meetings, town hall meetings (Human Impact Partners, 2017).
     - 3.1.1 Incorporate demographic characteristics into department data collection and analysis: intake/registration forms, disease surveillance, performance evaluation, program evaluations, satisfaction surveys.

3.1.1.1 Collect demographic variables such as location, race/ethnicity, sexual/gender identity, ability status, language(s) spoken, etc.

3.1.1.2 Follow guidelines for collecting sexual orientation and gender identity (SOGI) data: Recommendations on the Best Practices for the Collection of Sexual Orientation and Gender Identity Data

3.1.1.3 Consider deaf, hard of hearing, and visually impaired in data collection.

3.1.2 Ensure that data collection materials are available in different languages and easily understandable so that it is accessible to the public.

3.1.3 Use innovative methods of data collection, such as community engaged approaches to ensure community voice in how data is gathered, collected, and shared.

3.1.3.1 See NMHEC's Community-Based Participatory Research (CBPR) Toolkit

3.1.4 Partner with community members and educate about data: where to access it, how to understand data, the importance of representation of minority groups in data collection, and legal protection and rights around clinical trial participation.

3.1.4.1 Example: All of Us Research Program | National Institutes of Health

3.1.5 Use a platform that allows for data entry and analysis.

3.2 Use secondary data sets to identify and map communities that need the most support (i.e., before, during, and after a hazardous event/emergency)

3.2.1 See NMHEC's CBPR Toolkit Appendix E: Secondary Data Sources

3.2.2 Example: Nevada Health Response COVID-19 Dashboard

3.2.3 Example: CDC's Social Vulnerability Index (SVI)

3.2.4 See Additional Resources

4. Data Sharing

4.1 Create a dashboard to analyze both internal agency data and external community data (Hanafi et al., 2022).

4.2 Partner with local health departments or other entities to utilize or access data.

4.2.1 Example: Healthy Southern Nevada Data | Southern Nevada Health District

4.2.2 Example: Register to be an All of Us Researcher | All of Us Research Program

5. Dissemination

5.1 Develop a dissemination plan that ensures that information is meaningful, understandable, and respectful of various audiences (Marquez et al., 2022).

5.1.1 See NMHEC's CBPR Toolkit

5.2 Ensure that data is accessible by using a website, dashboard, reports, infographics, etc.

5.2.1 Translate research and data into reports that are available in different languages and easily understandable.

5.2.2 Consider deaf and visually impaired for data dissemination.

Rural Considerations

1. Reference available secondary sources to understand inequities that exist in rural communities.
   1.1 See UNR's Nevada Rural and Frontier Health Data Book
2. Create capacity to identify ways to collect, access, and/or share data by forming or joining community coalitions/committees that convene representatives across the 14 rural/frontier communities.

Tribal Considerations

1. Refer to the Inter-Tribal Council of Arizona (which covers AZ, NV and UT) to help build tribally-driven public health and epidemiologic capacity.
   1.1 See: Tribal Epidemiology Center

Additional Resources

2022 State Report Nevada	County Health Rankings and Roadmaps
A Step-By-Step Guide to Community Based Participatory Research	NV Minority Health and Equity Coalition (NMHEC)
Applying Social Determinants of Health Indicator Data for Advancing Health Equity: A Guide for Local Health	Bay Area Regional Health Inequities Initiative (BARHII)

Department Epidemiologists and Public Health Professionals	
Behavioral Risk Factor Surveillance System (BRFSS)	Centers for Disease Control and Prevention (CDC)
Explore Health Rankings	County Health Rankings and Roadmaps
Healthy Southern Nevada Data	Southern Nevada Health District
Monitoring COVID-19 in Nevada	Nevada Health Response
Nevada Rural and Frontier Health Data Book	Office of Statewide Initiatives, UNR
Nevada Health Profiles Data Dashboard	Office of Analytics, Nevada DHHS
Recommendations on the Best Practices for the Collection of Sexual Orientation and Gender Identity Data	
Social Vulnerability Index (SVI)	Centers for Disease Control and Prevention (CDC)
Youth Risk Behavior Surveillance System (YRBSS)	Centers for Disease Control and Prevention (CDC)

Case Study: Data

All of Us Research Program

All of Us Research Program is from the National Institutes of Health (NIH) which aims to enroll one million or more participants that represent diverse backgrounds—women, people of color, people with disabilities or comorbidities, people living in rural communities and members of the LGBTQ+ community. All of Us is part of NIH's Precision Medicine Initiative. Precision Medicine provides individualized healthcare that takes into account factors like where someone lives, what they do, and family health history. This initiative will help give healthcare providers the information they need to make tailored recommendations that are relevant to people of different backgrounds, ages, or regions.

The mission is to accelerate health research, enabling individualized prevention, treatment, and care for all of us. The mission is carried out through three connected focus areas:

- Nurture partnerships for decades with at least a million participants who reflect the diversity of the U.S.
- Deliver one of the largest, richest biomedical datasets that is broadly available and secure
- Catalyze an ecosystem of communities, researchers, and funders who make All of Us an indispensable part of health research

The information gathered from participants is stored in a highly secure database only accessed by authorized researchers. Program participants are always in control of how much information they want to share. Below, Joyce Ho, PhD, Research Assistant Professor/Lead Investigator for All of Us Research Program, shares seven ways that All of Us research program is engaging a diverse pool of participants:

1. **Begin the conversation** - Trust must be built through providing honest and accurate answers to patients' questions about Precision Medicine, the privacy and security of patients' data, and more.
2. **View participants as partners -** Participants from all walks of life should be included and valued in the design of the program. Everyone plays a major role.
3. **Collaborate with communities –** There is a lot of work put into understanding how to build resources in a way that includes what different communities want so that it can really benefit the health of people who are living in this country.
4. **Go mobile -** Transportation is often a barrier to working with underrepresented communities. It can prevent patients from receiving the health care they need. Mobile clinical research units have allowed researchers to better reach these communities.
5. **Don't rush things -** It is about multiple conversations over time, and letting participants know that we aim to return health information back to them and perhaps in the future, they might decide to participate.
6. **Create awareness and trust -** One of the missions of the program is not just building 1 million people and collecting all this data. It is to have substantive conversations with people about the importance of inclusion in biomedical research to build awareness.
7. **Emphasize data security –** The program has a 1-million person database to build, so spending lots of resources to build an infrastructure that is ready to process this volume of data as well as prioritize security and privacy- is key.

Outcomes of the research program thus far:
About 80% of All of Us participants represent communities that have been historically underrepresented in medical research, and nearly 50% identify with a racial or ethnic minority group. The program started returning genetic ancestry and trait results to participants in December 2020. So far, the program has offered genetic ancestry and traits results to more than 175,000 participants and continues to return about 6,000 results each month.

"Knowledge is powerful. By returning health-related DNA information to participants, we are changing the research paradigm, turning it into a two-way street – fueling both scientific and personal discovery that could help individuals navigate their own health. This type of partnership with our participants is crucial for building trust and fulfilling the

commitment we made to drive research that can offer meaningful insights for all." - Josh Denny, M.D., M.S., Chief Executive Officer for All of Us Research Program

Build Organizational Capacity

Building capacity is defined as the process of developing and strengthening the skills, instincts, abilities, processes, and resources that organizations and communities need to survive, adapt and thrive (United Nations, n.d.). Leaders and individuals of an organization must share mutual interest and commitment to understanding equity, power, and oppression. Understanding of health equity must also be applied in decision-making across all policies, programs, interventions, and practices (United Nations, n.d.) Some strategies include equity assessments, trainings, work and support groups, and other opportunities to reflect and build on equity-related content.

Build Capacity Recommendations

1. **Develop commitment to equity-focused work at all levels of the organization (CDC, 2021).**
    - 1.1 Foster diversity and resiliency in the workplace by recruiting more staff/board members that represent the demographics of the populations that face inequities: BIPOC communities, LGBTQ+ communities, multilingual individuals (including ASL), etc.
        - 1.1.1 Create job postings that are inclusive and show value in lived experience and those who are multilingual.
        - 1.1.2 Work with academic/training institutions to spread awareness of opportunities to work in Public Health.
    - 1.2 Foster an internal work culture that supports diverse employees (i.e., embrace cultural holidays, support groups, open conversations, forums, collaborative work environments, easy access to resources, accessible equipment/wheelchair accessible).
        - 1.2.1 Utilize mentorship programs in the workplace to provide the opportunity for diverse employees to feel supported, grow their networks, and develop leadership skills.
    - 1.3 Ensure that diverse voices are present in program planning and decision making.

1.4 Appoint an equity point person/team, or diversity and inclusion liaison (DIL) for each department/program to assist in promoting communication with minority groups and promoting cultural competency in providing services to minority groups.

1.4.1 Example: Nevada DILs

1.4.2 Example: Nevada State Tribal Liaisons

2. Develop goals and tools to embed equity into organizational structure (CDC, 2021).

2.1 Develop a diversity, equity, and inclusion (DEI) Guiding Statement and an internal plan to transform health equity as a part of the organization's infrastructure that establishes long-term commitment to equitable practices (Hanafi et al., 2022).

2.2 Develop an action plan to set and achieve equity related goals.

2.2.1 See NOMHE's Amplify Equity Toolkit: Action Planning and Reporting Strategies

2.2.2 See Toolkit: Racial Equity Action Plans, Government Alliance on Race and Equity (GARE)

3. Utilize health equity tools to assess, guide, and evaluate internal policies, programs, and service delivery.

3.1 Conduct initial equity assessment on internal capacity and service delivery to gather data on baseline knowledge, skills, resources, and readiness for equity-focused work (Hanafi et al., 2022).

3.1.1 Example: Organizational Self-Assessment for Achieving Health Equity, BARHII

3.2 Consider using an equity lens tool or toolkit to integrate health equity into services, resources, outreach, communication, and decision-making.

3.2.1 See NOMHE's Health Equity Lens: Choice Point Thinking Guide

3.2.2 See Health Equity Toolkit: A Resource to Help Employers Address Health Inequities within the Organization

3.3 Use findings to develop a strategic plan to institutionalize and guide efforts (CDC).

4. **Be deliberate in building staff skills to advance health equity by offering resources and engaging in opportunities for training on diversity, equity, inclusion, cultural sensitivity, health literacy and capacity building (CDC, 2021).**

    4.1 Consider training opportunities as a requirement for all staff such as: educational resources, webinars, public health conferences, professional development (Hanafi et al., 2022).

    4.2 Examples of training resources:

        4.2.1 Nevada Public Health Training Center | Making Health Happen Courses and Trainings

        4.2.2 Nevada Minority Health and Equity Coalition (NMHEC) Building Capacity Workshop Series

        4.2.3 NOMHE's Amplify Equity Toolkit: Cultural Literacy Strategies

        4.2.4 National Association of County and City Health Officials (NACCHO) Health Equity and Social Justice Trainings

        4.2.5 Population Health Institute Health Equity Training Modules

    4.3 Incentivize employee efforts to increase skill sets.

    4.4 Follow up on training concepts regularly through check-ins, discussion, reflection, and application.

Rural Considerations

1. Build capacity by recruiting Community Health Worker (CHW)-trained staff/personnel.

    1.1 See Community Health Workers in Rural Settings

    1.2 See https://www.nvchwa.org/employers/ for more information, or contact Nevada CHW Association program manager, Jay Kolbet-Clausell, MSW

2. Support or join groups like Rural Nevada's Health Network (RNHN), which meets quarterly in a hybrid setting. Their mission is to create and sustain a healthy economy across vital throughways of rural Nevada by planning and designating an integrated and efficient health service system across all of rural Nevada's 14 counties, including tribal communities, through community mobilization, development, and advocacy.

2.1 Contact: Deborah Loesch-Griffin deb.turningpoint@gmail.com to be placed on the list serve for these meetings.

Tribal Considerations

1. Tribes and organizations work together to create land acknowledgements to honor and show respect for Indigenous communities, and to elevate the presence and voices of Native peoples of past, present, and future.
   1.1 Present land acknowledgments whenever possible (meetings, public hearings, presentations, gatherings).
2. Develop tribal youth leadership training programs and/or youth councils to build leadership skills and increase workplace preparedness (National Congress of American Indians, n.d.).

Additional Resources

Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the LGBTQ Community: A Field Guide	The Joint Commission
Advancing Racial Equity and Transforming Government: A Resource Guide to Put Ideas into Action	Government Alliance on Race and Equity (GARE
Build Organizational Capacity	Human Impact Partners Project
Building Organizational Capacity to Advance Health Equity	Centers for Disease Control and Prevention (CDC)
Diversity, Equity and Inclusion Resource Snapshot Guide	Disability Employment TA Center (DETAC)
Ensuring Equity in COVID-19 Planning, Response, and Recovery Decision Making: An Equity Lens Tool for Health Departments	Human Impact Partners
Health Equity Primer	National Association of Chronic Disease Directors
Health Equity Toolkit: A Resource to Help Employers Address Health Inequities within the Organization	Larson Institute for Health Impact and Equity School of Public Health, University of Nevada, Reno

Meyer DEI Spectrum Tool	Meyer Memorial Trust
Nevada Diversity Inclusion Liaisons	
Nevada State Tribal Liaisons	
Organizational Self-Assessment for Achieving Health Equity	Bay Area Regional Health Inequities Initiative (BARHII)
Racial Equity Action Plans: A How-To Manual	Government Alliance on Race and Equity (GARE)
Tribal Workforce Development: A Decision-Framing Toolkit	National Congress of American Indians

Case Study: Build Organizational Capacity

NOMHE Core Values Assessment and Nevada Department of Health and Human Services

On August 5th, 2020, Nevada Governor Sisolak issued a proclamation formally naming racism as a public health crisis. The purpose was to recognize at the state level the historic and continued institutional racism in the United States, including the health and human services sector, and the subsequent inequities that exist for individuals who are Black, Indigenous, and People of Color (BIPOC). Also, NOMHE received funding from the Center for Disease Control and Prevention (CDC) through a Health Disparity Grant in 2021 to help achieve infrastructure that supports underserved and at-risk communities. One of the strategies to address health disparities was through policy change and operational improvement within NOMHE and across DHHS service providing agencies, with a focus on health equity. Both events started the Core Values Assessment project in 2022.

The Core Values Assessment (CVA) is a survey created and disseminated by NOMHE across the five DHHS Divisions. The CVA aimed to assess processes that prevent equitable provision of an agency's external services to marginalized communities. It

project aimed to increase cultural competency and begin the process of policy changes and operational improvements within DHHS service-providing agencies to focus on health equity.

The CVA provided information for reflection, discussion, planning, and organizational development. Using the Communication Climate Assessment Toolkit (C-CAT) framework, the nine domains evaluated by the CVA were: 1) leadership commitment, 2) information collection, 3) community engagement, 4) workforce development, 5) individual engagement, 6) socio-cultural context, 7) language services, 8) health literacy, and 9) performance evaluation. DHHS agencies worked with NOMHE to review results of the CVA and identify priorities for action and success indicators. After three months of actioning set goals, DHHS agencies shared their progress towards success.

For example, a division within DHHS reported the following actions completed since implementation of the CVA in 2022:

- **Leadership Commitment**- Create a workgroup to review the CVA results and develop strategies to address areas of opportunity.
- **Community and Staff Engagement**- Create a series of videos to be shared on the website that explain what specialized units do related to the support they provide for diverse and marginalized communities, i.e., interviews completed by staff members called "Community Moments".
- **Socio-Cultural Context** – Increase awareness of the 211 resources and tools among staff members and clients.
- **Language Services and Access** – Educate staff who interact with customers about the tools available to help them communicate with non-English speakers.
- **Health Literacy and Workforce Development** – Increase awareness of the Minority Health Report 2023 as a resource and educational tool for staff.
- **Program Evaluation** – Customer service officer will distribute monthly reports to the management team, which will then be used to educate/train staff on appropriate processes of handling customer complaints.
- **Equitable Achievements** – Administer cultural competency training to increase awareness of equity-focused actions to be utilized in the delivery of services to minority groups and underserved populations.

The CVA is an ongoing project in collaboration between NOMHE and the Nevada DHHS to continue efforts towards DEI, cultural competency, and health equity. NOMHE will continue to work with the DHHS divisions to evaluate progress towards set goals.

Community Engagement and Partnerships

Community engagement is defined as "the process of working collaboratively with and through groups of people to address issues affecting the well-being of those people" (CDC, 2015). The premise of community engagement is uplifting the voice of communities who have been silenced throughout history. Through this effort, community members are able to identify and express their values and be actively involved in the planning, execution, and evaluation of activities that affect the health of their community. Fostering relationships in this way has the potential to break patterns of mistrust and foster safety between public organizations and communities. When done successfully, proper engagement provides the opportunity to share decision-making power with communities, reduce inequities by amplifying community voice, and empower individuals to reflect and act on values.

Another important element is engagement with stakeholders and partners across multiple sectors. Collaboration and partnerships with other public organizations allow for discussion to address priorities and determine ways to work collaboratively to achieve a common goal. In an effort to achieve health equity and address the social determinants of health, cross-sectoral partnerships are crucial. "If you want to go fast, go alone. If you want to go far, go together".

Community Engagement and Partnerships Recommendations

1. **Ensure that staff and board members reflect the diversity of the community.**
   - 1.1 Consider forming a community advisory board (CAB) consisting of community members or leaders, community organizations, businesses, and academic institutions to provide insight on community priorities, concerns, and interests for all organizational discussions and activities (Marquez et al., 2022).

2. **Build collaborative partnerships and coalitions with other organizations across sectors to amplify health equity work (CDC, 2021).**
   - 2.1 Consider establishing new and diverse partnerships outside of the formal health system across different sectors to improve community health (Chandra et al., 2016).

2.1.1 Example: Organizations working in education/youth programs, faith/religion, law enforcement, outdoor parks and recreation, athletic teams, etc.

2.2 Adopt Health in All Policies (HiAP) principles that result in the action of cross-sector policies.

2.3 Support community organizations by participating in events or activities hosted by them.

2.4 See NMHEC's CBPR Toolkit for clear action steps on how to build collaborative partnerships.

3. Build long-term relationships with the community based on trust, respect, and willingness to learn.

3.1 Understand community context, complexity, capabilities, and needs (CDC, 2021).

3.1.1 Understand history and barriers that may prevent community participation.

3.1.2 Gather knowledge about the community through assessments, interviews, focus groups, community member councils or boards, community-based participatory research, etc.

3.2 Build relationships early (before a project, survey, or an emergency) by modeling participation, consistency, safety, respect, belonging, transparency, and being learning-oriented.

3.2.1 Remain patient in building the relationship and have the intention to build long-term, ongoing commitment from everyone involved (CDC, 2021).

3.2.2 Respect languages, barriers, time, and places that are convenient for communities. Make participation easy for community members by minimizing barriers.

3.3 Consider organizational capacity to conduct engagement efforts: time, staff skills, managing priorities (CDC, 2021).

3.3.1 Have a person in position that oversees community engagement/outreach efforts (also consider community health workers or interns).

3.4 See NMHEC's CBPR Toolkit for clear action steps on building relationships with the community.

4. Continually involve community members in development of activities for health equity (CDC, 2021).

4.1 Value community needs and voices throughout all stages of program and policy development by establishing common goals, hosting regular meetings, providing updates, and increasing opportunities for engagement and input.

5. Support the community in building capacity (CDC, 2021).

4.1 Focus and enhance community assets instead of only focusing on areas of improvement.

4.2 Educate and increase community awareness on the tools, resources, and programs that are available, and where to find them.

- 4.2.1 Nevada 211
- 4.2.2 National COVID-19 Resiliency Network
- 4.2.3 Nevada DHHS Programs and Resources
- 4.2.4 NOMHE's Amplify Equity Toolkit: Outreach and Public Awareness Strategies

4.3 Have staff that can connect communities to appropriate resources (example: CHWs/promotores de salud).

4.4 Educate on health inequities that affect the community and the skills needed to intervene.

4.5 Support community members in generating their own ideas in improving the community's well-being by creating a space for people to connect, raise concerns, build power, and act in their own interests (Nexus Community Partners, 2018).

- 4.5.1 Example: local coalitions, networks, boards, or council meetings.

4.6 Build relationships not just with current community leaders but also with people with an interest or potential to be leaders (example: engage youth through pipeline training programs (Nexus Community Partners, 2018).

- 4.6.1 Examples:
  - 4.6.1.1 See Leaders in Training (LIT) Las Vegas
  - 4.6.1.2 See High Sierra Area Health Education Center (AHEC)
  - 4.6.1.3 See National Community Health Worker Association (NCHWA)

Rural Considerations

1. Build or support community coalition that includes representatives across all 14 rural/frontier counties to meet regularly (quarterly, biannually, etc.) and discuss issues, needs, solutions, and share information.
    1.1 Could also serve to discuss data gaps, policy advocacy, workforce recruitment, etc.
    1.2 Refer to Rural Nevada Health Services Network (RNHN) Meetings, and Brown Bag Information Sessions (contact Deborah Loesch-Griffin deb.turningpoint@gmail.com).
    1.3 Encourage participation across sectors (i.e., community advocates, community organizations, faith organizations, community members, education, law enforcement, etc.).
2. Engage with rural/frontier communities in-person consistently, and over a long period of time (example: mobile health clinics, dental van, mobile unit testing).
    2.1 Have authentic discussions with community members to understand the needs of the community.

Tribal Considerations

1. Engage with tribal communities in-person as much as possible and learn about their unique culture and honored traditions. (example: setting up a booth at powwows).

Additional Resources

A Step-By-Step Guide to Community Based Participatory Research	Nevada Minority Health and Equity Coalition (NMHEC)
Amplify Equity Toolkit: Outreach and Public Awareness Strategies	Nevada Office of Minority Health and Equity (NOMHE)
Catalyzing Cross-Sectoral Partnerships and Community Engagement	CDC Foundation, NACCHO, ASTHO, Big Cities Health Coalition
Changing Power Dynamics among Researchers, Local Governments, and Community Members: A Community Engagement and Racial Equity Guidebook	Urban Institute
Community Based Participatory Research (CBPR) Training: "Examples of CBPR In Action"	Nevada Minority Health and Equity Coalition (NMHEC)
Community Engagement Assessment Tool	Nexus Community Partners

Community Voice and Power Sharing Guidebook	Urban Institute
Engaging Your Community: A Toolkit for Partnership, Collaboration, and Action	John Snow, Inc. (JSI)
Inclusive Outreach and Public Engagement Guide	Race and Social Justice Initiative
Principles of Community Engagement	CDC
Shifting Power Can Help Local Governments Partner with Communities to Achieve Racial Equity	Urban Institute

Case Study: Community Engagement

Puentes, Las Vegas, Nevada

Puentes is a non-profit organization that began as a community outreach intent on providing guidance in locating and accessing fundamental social services. From its origins serving the Latino community, it has quickly broadened to embrace all under-resourced/under-represented populations. Its core programs are centered on Health and Wellness, Education, Employment and Advocacy delivered through professionals, counselors, and volunteers from within the organization as well as from more than 50 community partners. Puentes' mission is to be an innovator in the development of comprehensive, collaborative and culturally relativistic initiatives that seek to provide permanent, sustainable solutions through addressing root causes, disparities, and inequities in social order.

From founder and president, Guy Girardin, on community engagement:

"I started Puentes myself, I was alone for the first two years, and now we have almost 500 people on our list serve and partner with about 80 different organizations to increase access to the services that we provide. We are so fortunate to have great relationships with the community.

Everything we do is done directly IN the community -- nothing online or directing people to a phone number or website. When working with marginalized communities, people often have barriers like lack of access to internet, or mistrust and hesitation with accessing services; maybe they don't want to give information, maybe they don't understand process or eligibility, maybe there's language barriers, or distrust of government or the medical profession. The only way to really overcome that is to engage in person. And what's important is that the people who do the work in the communities represent the cultures we are working with. Going to a 4-hour meeting on cultural competency will not make someone culturally competent. You can't become competent in someone else's culture – it's a product of everything: their lives, their music, their food, everything is part of their culture. We tell organizations that if you want to be competent in a culture, hire someone from that culture. Don't tokenize them--give them the resources that they need to do the work they do and let them go into the communities and do their work.

Firstly, we go directly into the community, we meet people where they live, where they congregate, in trusted locations, typically with a trusted partner, and engage one-on-one. Secondly, the people that engage with the communities are from the communities so that people represent the cultures they're talking to. Thirdly, we don't go in with solutions in mind—we go in and we begin the process by simply talking and listening to people and finding out what their needs are, finding out what's important to them, what services they really do require. Then we back up and contextualize the assistance being provided to those communities based on what the needs are of those communities. It has taken 3 years to build trust with the communities to the extent that they now know Puentes and the work that we do and know that they can come to us and get help and maintain their dignity, privacy, and be dealt with in a respectful way. And anyone that we refer them to will do the same—such as clinics, counseling, etc.—they know that when they go to those places that they'll be treated with respect also.

During COVID, we were in the community conducting clinics, doing vaccinations, testing, helping people with food support. We put together a group of organizations working with 300-400 partners and delivered 260,000 meals to families for a program that the health district asked us to start to assist families who were in quarantine and who could not afford to go out and get food. We coordinated with UNLV School of Medicine to provide ongoing medical care; medical students called patients at home to check on their health, we did endless resource fairs that included COVID testing and vaccination clinics, and still to this day. We did all of this in the communities that had the highest COVID-19 case counts.

Our partnerships with other organizations are very inclusive. We want to help other organizations be more culturally sensitive and aware. We are happy to engage and share what we've learned in working with the communities so that we can all become more productive and effective at what we're doing. We love opportunities to engage."

More information at: https://www.puenteslasvegas.org/home

Language Access

Equal access to services regardless of language ability is critical to the health and safety of a community. In 2021, the Nevada Legislature enacted NRS 232.0081 relating to language access plans. Along with Federal Guidance on Title VI of the Civil Rights Act of 1964, expectations are that language should not be a barrier to accessing government programs or services. Both pieces of legislation require that government entities expand language services if needed to improve access for persons with limited English proficiency to the agency's programs and services via trained interpreters, translation services, and more.

According to key informants, despite these policies, communities still face challenges in accessing care that is responsive to linguistic needs. Some challenges due to lack of language access include decreased accessibility to necessary health screenings, poor interactions with service providers, anxiety about seeking care when needed, inaccurate or ill-informed diagnoses, and poor monitoring or treatment of chronic illness. Messaging that is trusted, accurate, and linguistically and culturally inclusive can improve health literacy and empower communities to appropriately make decisions for their health. Ensuring language accessibility is also critical for effective and equitable emergency response and was an essential service throughout the COVID-19 pandemic.

Language Access Recommendations

1. **Be aware of and accommodate the languages that are spoken in the communities you serve.**
   - 1.1 Take regular assessment of the language needs of constituents or clientele through demographic analysis, surveys, or intake information.
   - 1.2 Consider deaf and hard of hearing in language access.
   - 1.3 Accommodate languages spoken in the communities you serve by hiring, training, and fairly compensating qualified multilingual staff to become certified translators. Have them in positions that interact regularly with the public.
     - 1.3.1 To avoid burnout for multilingual staff, appoint or have staff volunteer to become certified translators and compensate them appropriately.

1.4 Develop a language access plan that includes staff training, translation, and interpreting services that effectively outlines how to offer services and translate documents in a way that is linguistically and culturally competent.

1.4.1 See: State of Nevada Language Access Toolkit

1.4.2 See: Guide to Developing a Language Access Plan

1.5 Ensure that spaces (meetings, town halls, public sessions) allow for more than one language to be present (i.e., translators, ASL interpreters, written comment, etc.) (Bridging Voices, 2022).

2. Refer to the National Culturally and Linguistically Appropriate Services (CLAS) Standards recommended by the U.S. Department of Health and Human Services.

2.1 Intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations.

3. Utilize linguistic services and resources to support language access.

3.1 Have centralized/consistent translation resources across local offices or across agencies.

3.1.1 Example: Northern Nevada International Center Language Bank (NNIC)

3.1.2 Example: National Center for Interpretation

3.1.3 Example: ASL Anywhere

3.2 Consider implementing a program that recruits, trains, and certifies members of the community or community health workers (CHWs) as translators for your department or program.

3.3 Appoint a Language Access Coordinator to assist with facilitating language access services.

3.3.1 See examples of state agency Language Access Plans (LAP) with a designated language access coordinator: https://ona.nv.gov/Programs/Language_Access/

4. Be intentional with communication by using inclusive language.

4.1 Use plain and clear language, and use formats that all members of your audience can access and understand (CDC, 2022).

4.1.1 See Flesch Kincaid Readability score

4.2 Choose culturally appropriate terms when referencing population groups and the inequities they face.

4.2.1 Avoid biases, slang, and expressions that discriminate against groups of people.

4.2.2 See Preferred Terms for Select Population Groups and Communities, CDC

4.3 Utilize features such as the inclusivity filter and accessibility check in Microsoft Word.

4.3.1 Inclusiveness editing flags words or phrases that may be offensive and/or non-inclusive (i.e., age bias, racial bias, cultural bias, ethnic slurs, gender bias, sexual orientation bias, and gender-specific language) and offers acceptable alternatives.

4.3.2 Accessibility checker identifies possible issues in your document for people who have disabilities.

5. Disseminate information in accessible places and formats.

5.1 Leverage social media, newsletters, radio (English and non-English stations), and public events.

5.2 Bring messages to communities by sharing them with trusted local partners (CMS, 2022).

5.3 Create an inclusive environment by using easy-to-understand marketing materials, images, language, and points of engagement that attract a broad and diverse audience.

5.3.1 When necessary, tailor campaigns and resources to target specific population groups. Consult with members of the community about culturally, linguistically, and visually appropriate messaging.

5.4 Consider using powerful infographics/visuals where possible (include big text) and ensure that visuals are culturally sensitive.

5.5 Ensure documents follow ADA remediation (see: https://adahelp.nv.gov/)

6. Evaluate effectiveness of language services.

6.1 Disseminate materials to limited-English proficient (LEP) communities and solicit feedback on the quality and cultural appropriateness of services.

7. **Help increase health literacy by empowering individuals to combat misinformation and be an advocate for their health.**

   7.1 See the Health Matters campaign by NOMHE and NMHEC

   7.2 Work with community-based organizations (CBOs), ethnic, or immigrant institutions to conduct outreach to LEP communities about rights to receive assistance in their language.

Tribal Considerations

1. Preserve and revitalize native language by creating and incentivizing opportunities to learn/become fluent in native dialects: https://eclkc.ohs.acf.hhs.gov/publication/tribal-language-preservation-revitalization .

Additional Resources

ASL Anywhere	
A Practical Guide to Implementing the National CLAS Standards	Centers for Medicare and Medicaid Services (CMS)/Office of Minority Health (OMH)
Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the LGBTQ Community: A Field Guide	The Joint Commission
Communication Access Resources (CAS)	Nevada DHHS Aging and Disability Services Division (ADSD)
Frequently Used Language Access Terms and Definitions	Nevada Initiative for Language Access (NILA)
Guide to Developing a Language Access Plan	Centers for Medicare and Medicaid Services (CMS)
Health Equity Guiding Principles for Inclusive Communication	Center for Disease Control and Prevention (CDC)
Implementation Checklist for the National CLAS Standards	U.S. Department of Health and Human Services Office of Minority Health

Language Justice Toolkit: Multilingual Strategies for Community Organizing	Communities Creating Health Environments (CCHE)
Languages and Country of Origin	Nevada Initiative for Language Access (NILA)
More Language Access Resources	Nevada Initiative for Language Access (NILA)
National CLAS Standards	U.S. Department of Health and Human Services Office of Minority Health
Nevada Initiative for Language Access Template	Nevada Initiative for Language Access (NILA)
Preferred Terms for Select Population Groups and Communities	Center for Disease Control and Prevention (CDC)
State of Nevada Language Access Toolkit	Nevada Initiative for Language Access (NILA)
Think Cultural Health: RESPECT Model	U.S. Department of Health and Human Services Office of Minority Health

Case Study: Language Access

#OneCommunity #OneResponse Campaign

The Nevada Vaccine Equity Collaborative (NVEC)

When COVID-19 vaccines were introduced to Nevada in December 2020, there was an inequitable distribution throughout the state. In response to Governor Sisolak's Equity and Fairness Initiative and President Joe Biden's National Strategy for the COVID-19 Response and Pandemic Preparedness, Immunize Nevada and the Nevada Minority Health & Equity Coalition formed the Nevada Vaccine Equity Collaborative (NVEC), which was comprised of public, private, state, and community partners to promote the equitable distribution of COVID-19 vaccines throughout Nevada. The purpose of the collaborative was to bring fair vaccination opportunities to communities through eliminating barriers to vaccines and developing accurate, culturally and linguistically appropriate messages. This case study highlights the effort in developing a communication framework and dissemination plan around COVID-19 vaccines in Nevada.

The NVEC prioritized community engagement at each step of the vaccine distribution planning process. Community-engaged outreach ensured that communities played an active role throughout the development and decision-making process. Bridging partnerships and understanding community context helped identify concerns, values, beliefs and attitudes of different communities. Taking these essential steps to know the community helped frame the work for developing culturally and linguistically appropriate messaging around the COVID-19 vaccine.

Below outlines some steps that were taken in this effort:

Identify your target population: Determine who is most at risk and needs the most support.

Get to know your target audience: Understand geographic, demographic, and behavioral information to help guide the creation and delivery of messaging.

Develop a communication framework and dissemination plan: Keep in mind "what needs to be communicated?" and "what is the best way to communicate this information?" Include community leaders and community members throughout the process to ensure that messaging is relevant and will resonate.

Tailor the message and other communication considerations: After careful consideration, the NVEC determined that it would be ineffective to create a universal message for all communities. Messages needed to be tailored to ensure that they reflect the diversity and uniqueness of the community for a more receptive and relevant message. Considerations also included:

- *Trusted messengers*: Leverage trusted messengers within the community to play an important role in disseminating information. Examples include physicians, faith-based leaders, barbers and hair stylists, CBOs, local business owners, and athletes.
- *Timing*: Ensure that messaging is relevant and timely to new information, especially during a public health response, where new information is being communicated regularly.

Dissemination plan: Consider which methods of dissemination are best suited for the community. Consider non-digital and digital dissemination methods.

- Non-digital methods: billboards, direct mail, in-person outreach, newsletters, oral presentations, phone calls, printed materials
- Digital materials: Email, digital newsletters, social media, text messaging, videos, websites

Through the collaborative, NMHEC developed the #ONECOMMUNITY#ONERESPONSE campaign (also in Spanish), which included art created by local artists who represent the communities that were targeted in this effort. The art contained messages and images that were culturally unique to each community. Find the COVID Art Gallery here.

Learn more about this effort through the Vaccine Equity Toolkit.

Policy Change and Advocacy

Prioritizing policy change at the local, state, federal level and within organizational infrastructure is instrumental in advancing health equity. Some ways to achieve policy change include direct and indirect advocacy in decision-making contexts, as well as strengthening staff capacity to identify and focus on influencing upstream, structural factors. Policy change also requires examining a wide range of social determinants of health, which may challenge traditional practice. Agencies and institutions statewide must support applying a health equity lens in strategic planning, prioritizing decisions, funding development processes, and ranking needs.

Policy Change and Advocacy Recommendations

1. **Develop or adopt internal organization policies, practices, and tools that explicitly address health and racial equity (Human Impact Partners, 2017).**
   - 1.1 Consider implementing or participating in health impact assessments or utilizing equity impact tools to measure how proposed policies, programs, and plans impact health equity and community health.
     - 1.1.1 Tool: NOMHE's Health Equity Lens
   - 1.2 Encourage staff to explore and understand the root causes of inequities and strengthen staff skills to identify and advocate for policy systems and environmental changes that advance equity (HIP, 2017).
   - 1.3 Promote policy that supports DEI in workplace culture to ensure that practices are institutionalized.
   - 1.4 Assess policy and physical accessibility at your facility and work to eliminate barriers for those with disabilities.
     - 1.4.1 See How to Improve Physical Accessibility at Your Health Care Facility, CMS
2. **Advocate for public policy and practices that support health equity.**
   - 2.1 Ensure that all individuals, even those with developmental and intellectual disabilities, have access to legislative information.

2.1.1 Nevada Governor's Council on Developmental Disabilities: Legislative Information

2.1.2 Track Bills through NELIS

2.2 Promote the use of health impact notes in addition to fiscal notes when seeking public funds.

2.2.1 See A User's Guide to Legislative Health Notes

2.3 Advocate for a Health in All Policies (HiAP) approach to policymaking, which integrates health considerations into all policy across sectors to improve the health of all communities and people.

2.3.1 Tool: Health Lens Analysis Tool

2.4 Develop collaborative relationships across multiple sectors to influence decision making in a way that promotes health equity.

2.4.1 Example: city, county, state agencies of labor, transportation, education, corrections, economic development, health providers, housing, transportation and public safety (HIP, 2017).

2.5 Use research and testimonies from subject matter experts to illustrate and build awareness around the direct link between health outcomes and social, environmental, and economical factors in specific communities, neighborhoods, or within other groups. Share with different audiences, including health departments, healthcare institutions, government agencies, elected officials, and community stakeholders (HIP, 2017).

2.6 Partner with local communities to understand their priorities, and direct policy change to support their priorities.

2.7 Engage or develop educational opportunities for community stakeholders to engage in policy change efforts. Ensure that all levels of government are highlighted in the training (state, local, tribal).

2.8 Find innovative ways to improve community health through supporting initiatives and partnerships outside of the formal health system.

2.8.1 Example: Park Prescriptions

2.8.2 Example: Community Wellness Hubs

Rural Considerations

1. Advocate for increased healthcare programs, workforce, and facilities in rural areas (example: home healthcare, respite care, pay the caregiver program).
   1.1 Reduce barriers for eligibility to qualify for healthcare programs (i.e., income requirements, coverage, transportation, etc.)
   1.2 Ensure adequate funding to fairly compensate the rural workforce.

Tribal Considerations

1. Include key tribal stakeholders in policy and advocacy: National Indian Health Board, Inter-Tribal Council of Nevada, Nevada Indian Commission.

Additional Resources

A Health Impact Assessment (HIA) Toolkit: A Handbook to Conducting HIA	Human Impact Partners
A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease	Centers for Disease Control and Prevention (CDC)
A User's Guide to Legislative Health Notes	The Pew Charitable Trusts, Robert Wood Johnson Foundation, Health Impact Project
Choice Point Thinking: A Guide to Applying Nevada's Health Equity Lens	NV Office of Minority Health and Equity (NOMHE)
Community Wellness Hubs: A Toolkit for Advancing Community Health and Well Being through Parks and Recreation	National Recreation and Parks Association
Framework for Health Equity 2022-2032	Centers for Medicare and Medicaid Services (CMS)
Health in All Policies: A Framework for State Leadership	Association of State and Territorial Health Officials (ASTHO)
Health in All Policies: A Guide for State and Local Governments	Public Health Institute

How to Improve Physical Accessibility at Your Health Care Facility	Centers for Medicare and Medicaid Services (CMS)
Methods and Emerging Strategies to Engage People with Lived Experience: Improving Federal Research, Policy, and Practice	Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services
Prioritize Upstream Policy Change	Human Impact Partners Project
Racial Equity Impact Assessment	Race Forward
State of Equity: Resources	Public Health Institute

Case Study: Policy Change and Advocacy

Creating Tools to Advance Health in All Policies (HiAP)
Tacoma-Pierce County Health Department, Washington

Tacoma-Pierce County Health Department secured and mobilized funds to support health equity work. First, they hired a Health Equity Coordinator in the Office of the Director to be a department-wide asset. The new coordinator then formed a health equity team that represented 12 programs across the health department for the purpose of developing strategies and recommendations, implementing programs across the department. The team consisted of the Health Equity Coordinator, Deputy Director of Health, and members from Environmental Health, Communicable Disease, Family programs and Administration, with the intention of having representation from across the department.

The team developed a report that was derived from a department-wide Health Equity Assessment. The report included each program's issue that they worked on, the scope of the problem, what the data revealed, inequities observed, and included vulnerability mapping. The final report helped create a two-pager and maps that summarized the key findings, which was then disseminated widely. The two-pager served as a tool to change the narrative about equity and the need for department shift from clinical care to social and economic factors.

The two-pager about health inequities was distributed widely across the city and county, and used to build relationships with community groups, sister city and county agencies, city government and more. The health department specifically focused on building relationships with 24 judges in the Pierce County Superior Court and the transportation and parks agencies. When meeting with government agencies, the Coordinator asked them to reflect on the connection of health to their work, with the goal of moving towards Health In All Policies (HiAP). The Coordinator also shared tools that have been helpful in their approach to better consider health:

- **Health Lens Analysis Tool** – geared toward decision makers, city managers and leaders, engineers/architects and NGOs to assess the potential impacts of policies and decisions on health and identify ways to improve impacts on social, economic, and environmental determinants of health.
- **Health Equity Inventory Tool** – helps program staff assess how equity plays out in a given process and creates opportunities to brainstorm how to do things differently (i.e., how a program engages community, which populations benefit from a program, etc.).
- **Project Planning Tool** - takes opportunities identified by the inventory tool and scores them based on the potential impact and the level of effort needed for implementation, and helps staff prioritize opportunities for action.

Outcomes:
Through this effort, the Tacoma-Pierce County Health Department continues to look for opportunities to include health considerations into as many decision-making processes and comprehensive planning efforts as possible. The department is now leading shifts in programs to be more participatory and data-based, offers technical support and collaboration on projects with sister agencies to move towards health equity in their work, and widely shares their health equity tools and resources. For example, the equity team presented data on perinatal birth inequities at a conference of maternal and child health providers in the country and used the health equity inventory tool and the project planning tool to show providers tangible strategies to take action in new ways.

Key takeaways:

- **Find champions on the inside** – To effect change, those working within their institutions are more effective at relaying the message than outsiders.
- **Make a 2-pager** – This is an elevator speech and easier to share widely. Includes clear and short messages about the roots of health inequities, statistics, and easy-to-read visuals.

- **Make the case to other agencies** – Make it clear why other agencies should be involved in social and economic policies in order to get buy-in to begin doing HiAP work.
- **Reduce barriers to agency participation** – Reduce barriers by identifying tools that are easy and user-friendly, so that others will use it to help identify health inequities (i.e., Health Lens Analysis Tool).

For more information on this case study, visit: https://healthequityguide.org/case-studies/tacoma-creates-tools-to-advance-

Emergency Preparedness

As we learned from the COVID-19 pandemic, health disparities did not only exist, but were highlighted during the crisis. Emergency preparedness demands concerted effort across all sectors, with special consideration for the most underserved populations. This section describes what can be done to prepare for an emergency using lessons learned from the COVID-19 pandemic, as to carefully avoid the continuation and exacerbation of health disparities. A special consideration for emergency response also touches on climate, which is inextricably tied to health and equity.

Emergency Preparedness Recommendations

1. **Develop and implement coordination mechanisms that include robust multisectoral partner participation (WHO, 2017).**

1.1 Involve community leaders that represent voices of population groups that have historically and disproportionately affected by a hazard/disaster (example: tribal, rural, individuals with disabilities, racial/ethnic groups).

1.1.1 Follow a similar model to that of Michigan Department of Health and Human Services – Health Equity Advisory Councils. "Councils help combat health disparities among high-risk and underserved communities… and provide a network of trusted community partners that will improve structural gaps in current and emerging health emergencies including policies, practices and resource flow related to data" (MDHHS, 2022).

1.2 Involve community-based groups in the creation of preparedness plans from the beginning of the process to develop a successful plan for those directly affected.

1.2.1 Build trust with communities by modeling accountability and transparency, making sure that community leaders are involved, and interests are being considered.

1.3 Form authentic collaborative partnerships between state agencies/public health departments and community-based organizations and messengers before an emergency to fund and support culturally informed, in-language outreach, warnings, and information sharing.

2. Assess capacities for emergency response and put plans in place to prepare for the next disaster (WHO, 2017).

2.1 Partner with academic/training institutions to establish public health workforce reserve programs to expand workforce capacity during emergencies, such as outbreak investigation centers, disease surveillance, or environmental and climate justice teams. Examples include:

2.1.1 Example: UNLV student-led Contact Tracing Team during the COVID-19 Pandemic

2.1.2 Community Health Workers (CHW) training in Nevada

2.1.2.1 Example: States Engage Community Health Workers to Combat COVID-19 and Health Inequities, National Academy for State Health Policy

2.2. Deploy CHW models to educate, advocate, and refer resources for members of their communities that are most vulnerable to the health/economic impacts of crisis.

2.3. Accumulate and reserve stock of materials necessary for emergency (i.e., PPE, etc.), and replenish as items expire.

2.4. Update preparedness plans to include environmental sustainability and emphasize considerations for people with disabilities and/or access and functional needs.

2.4.1. Example: Plan Ahead Nevada: Emergency Preparedness Guide

2.4.2. Example: Florida's Emergency Preparedness Guide

2.5. Utilize preparedness plans to make emergency kits and prepare organizations/communities for crisis.

3. Increase community engagement and support community capacity for basic preparedness well before an emergency (WHO, 2017).

3.1 Support, promote, and participate in Community Emergency Response Team (CERT) programs to help prepare citizens for disaster.

3.2 Conduct outreach and educational efforts to inform community members *before* an event of the risks and challenges that are faced based on geographical location, and/or demographic characteristics.

3.3 Increase community awareness around trainings, supply and readiness checklists, resources, and relief that is available during an emergency.

3.3.1 See ready.gov

3.3.2 See Basic Preparedness Guide

3.4 During Emergency Preparedness month (September), promote and build awareness through events, campaigns, or education around emergency events/hazards, what to do in case of emergency, how to manage an emergency for those with function and accessibility needs, older adults, person(s) who are deaf/hard of hearing, and geographically vulnerable populations.

3.4.1 Consider using infographics that are remediated and easy to read, culturally and linguistically appropriate videos, or public service announcements that are translated into different languages (including ASL).

3.5 Empower individual citizens to act in ways appropriate to fight/mitigate risk of emergency or pandemic with specific targeted actions that communities can take. Develop and share specific preparedness checklist that considers the needs of different communities (example: including medications or supplies for those with chronic illness, elderly, or special needs).

3.6 Share information on resources and aide that cost no money and where to access them: food banks, testing, vaccinations, transportation, shelter, cooling/warming centers, supplies, etc.

3.6.1 National COVID-19 Resiliency Network

3.6.2 Nevada 211

3.7 Identify alternative ways to reach underserved populations for disaster warnings: radio, telephone, flyers, posters, billboards, etc.

Rural and Tribal Considerations

1. Ensure that diagnostic facilities and surveillance capacities are consistently accessible to geographically underserved areas: rural, tribal communities (i.e., mobile testing units, vaccine pods).

Climate/Environmental Considerations

1. Utilize awareness events such as Environmental Justice Day (August 29th) to spread information and resources for Nevadans to address environmental issues in their communities (State of Nevada, 2022).

2. Promote messaging that educates on climate-related issues in the state, and how to conserve, preserve, and mitigate risks attributed to climate: extreme heat, fires, drought, flood, and other environmental hazards.

   2.1 Example: Extreme Heat Resources

   2.2 Example: State of Nevada Climate Initiative

   2.3 Example: Climate Effects on Health, CDC

Additional Resources

A Guide to Supporting Engagement and Resiliency in Rural Communities	Federal Emergency Management Agency (FEMA)
Amplify Equity Toolkit: Surveillance and Emergency Response Strategies	NV Office of Minority Health and Equity (NOMHE)
Disaster Behavioral Health Resources	Substance Abuse and Mental Health Services Administration (SAMHSA)
Emergencies, Disasters, and Climate Resilience Resources	World Institute on Disability
Emergency Operations Planning and NIMS Compliance Guide for Local Jurisdiction Emergency Planners	Division of Emergency Management (DEM)
Ensuring Equity in COVID-19 Planning, Response, and Recovery Decision Making: An Equity Lens Tool for Health Departments	Human Impact Partners
Environmental Justice Training Resources	U.S. Department of the Interior
Extreme Heat Resource Guide	State of Nevada Climate Initiative
Extreme Heat Resources	Division of Emergency Management (DEM)
Helpful Preparedness Information	Division of Emergency Management (DEM)
https://www.fema.gov/	
Plan Ahead Nevada – Preparedness Information	Division of Emergency Management (DEM)
Plan Ahead Nevada: Emergency Preparedness Guide	Division of Emergency Management (DEM)
Social Vulnerability Index (SVI)	Centers for Disease Control and Prevention (CDC)

Southern Nevada Extreme Heat Vulnerability Web map	Regional Transportation Commission (RTC) Southern Nevada
Strategic Framework for Emergency Preparedness	The World Health Organization (WHO)
Tips and Tools for Reaching Limited English Proficient Communities in Emergency Preparedness, Response, and Recovery	Federal Coordination and Compliance Section, Civil Rights Division, U.S. Department of Justice
Training Information	Division of Emergency Management (DEM)

Case Study: Emergency Preparedness

Expanding Feedback Opportunities for More Public Planning Input

City and County of Honolulu, Hawai'i

Honolulu, Hawaii took a "whole community" approach in the city's multi-hazard pre-disaster mitigation plan to address community concerns, identify risks, and propose ways to reduce those risks. The plan was designed with support from all sides of the community. The city and county of Honolulu updated the hazard mitigation plan with:

- Local, state, and federal government officials
- Community organizations and agencies
- The public across the land

The city and county Department of Emergency Management worked with community members at community meetings to gather feedback on plans and maps that would be used in the event of a hazard. Mitigation planning outreach also included informal meetings to educate the public with keynote speakers, information booths, outreach tables, and group breakout rooms which offered the public a chance to connect with one another. These events offered a chance to share mitigation ideas and discuss plan input.

The mitigation team adjusted messaging to resonate with the public more effectively. The team used different platforms, included more visuals, and targeted new (previously excluded) audiences, such as elderly and individuals with disabilities/access functional needs. The outreach materials focused on plain language to reach a broad audience. The team also created and shared surveys to learn about:

- Public knowledge about different hazards unique to their geographical area
- Concerns about risks and vulnerabilities
- Opinions on mitigation options

The team shared surveys through networks, who then sent the surveys out to their own groups (i.e., church organizations) through community gatherings, workshops, online, etc. The team learned from survey responses that there was an interest in hazard and mitigation opportunities, particularly to reduce risks due to climate change. Officials began to develop plans based on this feedback and continually held meetings to share information and gather feedback. The city held public workshops to discuss mitigation and resilience for:

- Floods, hurricanes, tsunamis
- Adaptation for climate change
- Land use policies
- Essential services and facilities
- Incentives for residential hazard mitigation and resilience

Also in participation were a few federal, state and local agencies such as: National Oceanic Atmospheric Administration (NOAA) and the National Weather Service, State of Hawaii Emergency Management Agency, State of Hawaii Department of Land and Natural Resources, Mayor's Office and City Council, Office of Climate Change, Sustainability and Resiliency. The Cross Island Communities Resilience Network also brought forth community organizations that focused on smaller-scale resilience efforts to give input on the plan. Community input helped determine priorities for mitigation projects that were most important for the community.

Key Takeaways:

1. **Keep it local and relevant:** Tap into local, state and federal partners, and partner with local agencies to provide expertise and share messages across their network.
2. **Partner with organizations that are already involved in resilience.**

3. **Provide many opportunities for the public to engage:** Residents had the opportunity to provide feedback in surveys and through a series of public workshops.

For more information on this case study, visit: https://www.fema.gov/case-study/expanding-feedback-opportunities-secures-more-public-planning-input-city-and-county

Closing Remarks

We hope this plan is an important resource or starting point for all partners in Nevada. Organizations can align their work with the overarching goals and objectives for health improvement in these priority areas or identify strategies for their own health improvement efforts. We understand that health equity work requires patience, intention, and non-traditional approaches that challenge the current systems that are in place and practiced for many years. Dismantling systemic and structural barriers requires collective effort, and agencies and institutions all play a significant role in this work.

This is a living document intended to be refined and evolved to continually support the diversity and equity commitments of state agencies and nonprofits providing services across the social determinants of health. These strategies are an important starting point in addressing the priorities, but we expect that they will continue to develop as agencies and organizations begin working to implement them. Updates to this plan will be communicated with partners and stakeholders and will be posted to the NOMHE website. NOMHE plans to conduct on-going demonstrations of how recommended policy and programming components of the plan can be activated through strategic partnerships and engagement.

A sincere thank you to the dedication of those who supported the development of this plan.

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Appendix

APPENDIX I:

- Health Equity Action Plan Key Informant Interview Questions

APPENDIX II: In our review, we have identified action plans and toolkits with health equity considerations:

Type	Program/Initiative	Focus Area							Link
		Chronic Disease	DEI	SDOH	Language Access	Emergency Preparedness	Climate/Environmental Justice	Outdoor Recreation	
Report	NOMHE Core Values Assessment Report		x						Available June 2023
Resource	NOMHE Choice Point Thinking: A Guide to Applying Nevada's Health Equity Lens								Link
Resource	NOMHE CBO Directory			x					Available June 2023
Resource	Minority Health Report 2023	x							Available February 2023
Resource	DEI Manual		x						Available June 2023
Resource	Health Equity Toolkit		x						Link
Resource	CBPR Toolkit								Link
Plan	DEI Action Plan for Nevada DHHS		x						Available June 2023
Plan	DPBH Chronic Disease Prevention and Health Promotion Strategic Plan 2023-2027	x							Link

Resource	Nevada Office of Food Security and Wellness Racial Equity Toolkit January 2023								Available February 2023
Plan	DPBH Behavioral Health Community Integration Strategic Plan 2023	x							Link
Plan	The Nevada State Plan to Address Alzheimer's Disease and Other Dementias								Link
Resource	Nevada's Framework for Equitable Integrated System of Student Supports			x					Link
Plan	Nevada's Statewide Comprehensive Outdoor Recreation Plan 2022-2026							x	Link
Toolkit	State of Nevada Language Access Toolkit				x				Link
Plan	State Agency Language Access Plans				x				Link
Report	Southern Nevada Extreme Heat Vulnerability Analysis						x		Link
Plan	Clark County Community Sustainability & Climate Action Plan						x		Available March 2023
Report	Strengthening Heat Resiliency in Communities of Color in Southern Nevada						x		Link
Plan	Nevada Emergency Response Plans					x			Link