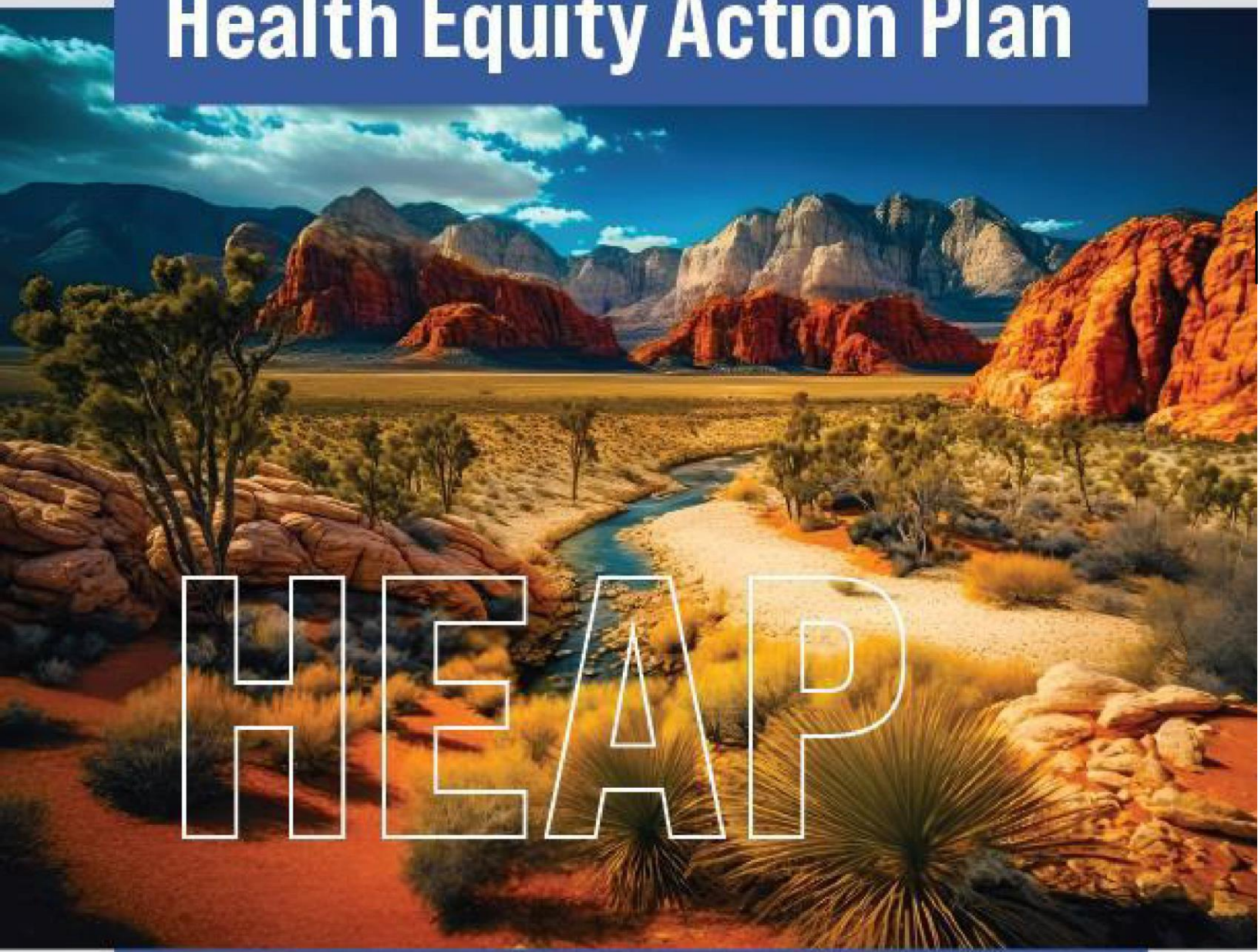
Nevada

Health Equity Action Plan



A Resource to Help
Organizations Implement Health Equity Strategies

Nevada Office of Minority Health and Equity [NOMHE]
https://dhhs.nv.gov/Programs/CHA/MH/Office_of_Minority_Health/

May 2023

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Disclaimer

We acknowledge that promoting health equity is an ongoing and complex process that requires learning, collaboration, and action. The Health Equity Action Plan (HEAP) is intended to provide a framework for organizations to integrate health equity principles into their work. However, we recognize that this is just a starting point, and we remain committed to continuous improvement and openness to feedback. We invite all stakeholders to join us in this journey towards a more equitable and healthier future for all residents of Nevada.

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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

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.).
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.).
Cultural Sensitivity	The awareness and recognition of cultural differences and nuances, and the ability to approach and interact with people from different cultures in a respectful and appropriate manner (APA, 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).
Downstream	Downstream interventions focus on treating the symptoms and consequences of problems after they have occurred, rather than addressing the underlying social, economic, and environmental factors that contribute to those problems. Examples include clinical care and medical interventions (Moving Healthcare Upstream, 2021).
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 the same degree of protection from environmental and health hazards, and equal access to the

	decision-making process to have a healthy 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	Ensures 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 (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.).
Gender Identity	A person's internal sense of their own gender, which may or may not correspond with the sex they were assigned at birth (Ontario Human Rights Commission, 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 have been 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 Assessment	A method to assess the potential health outcomes of a plan, project, or policy before it is carried out. It considers both positive and negative impacts and offers suggestions to enhance positive health effects and decrease negative health effects (CDC, 2016).
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, 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. 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.).
Midstream	Addresses the physical and social circumstances that affect populations and individuals (Hanafi, et al., 2022). This approach targets the factors and conditions that contribute to the development of a particular health problem. Examples include community-based organizations, social workers, and providing direct assistance to patients' social needs like housing and food access (Moving Healthcare Upstream, 2021).
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, and 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.).
Sexual Orientation	An inclination towards having romantic or sexual desires for individuals of the opposite gender, the same gender, or all genders (Encyclopedia Britannica, Inc., 2023).
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 (LA County Center for Health Equity, 2019). The SDOH can be grouped into 5 domains: economic stability, education, health care, neighborhood and build environment, and social and community context (Healthy People 2030, n.d.).
Socioeconomic Status	The social standing or class of an individual or group. It is often measured 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 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 white populations 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.).
Transgender	Refers to people whose gender identity and/or expression is different from the sex they were assigned at birth (Ontario Human Rights Commission, 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, immgrant status, or age) (Legal Information Institute, n.d.).
Upstream	A public health approach that focuses on addressing the underlying social, economic, and environmental factors that contribute to health problems, rather than just treating the symptoms or consequences of those problems (Bharmal et al., 2015). Focuses on prevention, early intervention, and addressing the social determinants of health in order to create long-term improvements in population health. Examples include: laws, policies, and

	regulations that support health for all people (Moving Healthcare Upstream, 2021). Separate approach from “downstream” and “midstream”.

List of Acronyms

ASL	American sign language
BIPOC	Black, indigenous, and people of color
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
LEP	Limited English proficiency
LGBTQ+	Lesbian, gay, bisexual, 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

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. Tailored to Nevada, the HEAP aims to guide organizations in integrating equity considerations into various aspects of their work, such as decision-making, recruitment, partner engagement, policies, and services. By providing a framework for examining and challenging existing practices and mindsets, the HEAP seeks to foster a culture that values and implements equitable systems and practices both internally and externally. Through collaborative efforts among agencies, organizations, and institutions, the HEAP presents actionable steps towards achieving health equity for communities in Nevada.

Intended Audience

Institutions, agencies, 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 particularly well-positioned to identify the environmental and social factors that affect healthy life choices, develop effective intervention plans, educate residents on healthy lifestyles, and provide access to essential services. By partnering with other community agencies, they can also address the barriers that prevent people from accessing resources that promote health equity (Tulane University, 2020).

Given their vital role in shaping the social determinants of health, it is essential to prioritize strengthening and supporting organizational infrastructure of these organizations as a first step towards building a healthier future for all. This document serves as a starting point for individuals or organizations committed to the learning, collaboration, and hard work that is necessary to achieve health equity. By working together to uplift health equity into organizational culture, practice, and implementation, we can better serve all communities in Nevada.

How to Use This Document?

The HEAP has been structured into six distinct sections, each focused on a key area for advancing health equity in Nevada. Within each section, actionable strategies and **recommendations** are presented to promote health equity. For those seeking to implement these recommendations, additional tools can be found in the **Additional Resources** section. Furthermore, readers can find examples of successfully implemented projects that utilize the recommendations in the **Case Study** subsections corresponding to each section.

The HEAP was designed with the intention of prioritizing populations that have been historically underserved. Many of the recommendations outlined in the plan can be applied to a diverse range of populations, including racial/ethnic minority groups, LGBTQ+ populations, those with disabilities, and those with limited English proficiency. For communities where certain recommendations may not be applicable, such as rural and tribal communities, specific considerations have been included in the recommendations to address their unique circumstances. Regrettably, the HEAP currently lacks comprehensive consideration for individuals experiencing homelessness. However, this topic will be given careful consideration during the update and refinement of the plan, particularly given Nevada's significant homeless population.

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 result from policies and systems built that intentionally or unintentionally harm and leave some communities in worse shape than others. When considering health equity, it is essential to understand the historical injustices that have occurred and take direct action to challenge 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 the 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 practicing equity ideals in this action plan, organizations and institutions can show commitment to improving the health and quality of life for all residents in Nevada.

The HEAP is designed to aide practices 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 offers strategies under data, building capacity, community engagement, language access, policy change, and emergency preparedness. The priority areas are outlined below.

Data
Improve data collection and sharing that is consistent, accessible, and will help in determining and informing program and policy priorities.

Build Organizational Capacity
Develop and strengthen the skills and resources of individuals and organizations that are 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, messaging, and service delivery for effective communication with all populations in order to improve health outcomes. 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 into 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, we hope organizations adopt strategies that make the greatest organizational and community impact. 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 and professions to influence the social determinants of health.

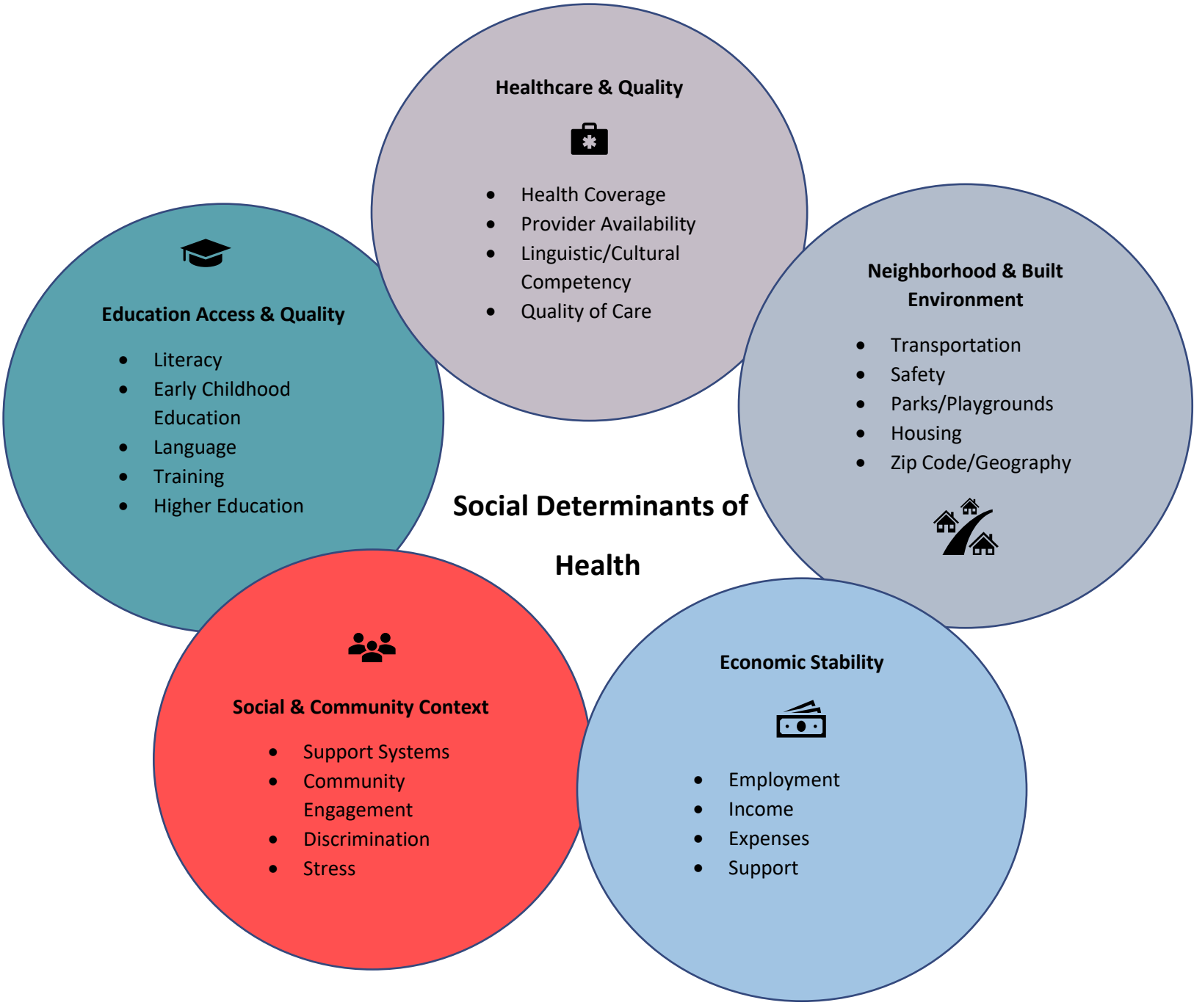
Introduction

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 essence, our health and quality of life are shaped by the conditions in which we live, learn, work, and play. These conditions are referred to as the social determinants of health (SDOH) and are illustrated in Figure 1**.** The SDOH impact the resources and opportunities that allow individuals and communities to grow, thrive, and achieve optimal health. For instance, just as a houseplant needs adequate sunlight, water, and nutrients to grow, our communities require equitable access to opportunities, programs, and resources to be healthy (such as education, healthcare, employment, etc.).

Governments, schools, hospitals, community organizations, and other public service branches have a crucial role in shaping the social determinants of health and can take steps to promote health equity in their practice. While discriminatory practices and policies have resulted in an unequal distribution of resources, organizations can still build on past successes while addressing areas that need improvement. By recognizing and challenging structural inequalities and biases, organizations can create and implement strategies to promote health equity. The Health Equity Action Plan is a resource that offers policy, program, and resource recommendations to promote health equity that can be adapted to current and future practices. By taking deliberate actions to address social determinants of health and promote equity, organizations can help individuals and communities achieve optimal health and quality of life.

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 and providing them with the same opportunities and resources. When considering 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. On the other hand, equity recognizes that individuals have

unique needs and circumstances, and provides them with what they need to achieve the same outcome as others.

FIGURE 2. EQUALITY VS. EQUITY (ROBERT WOOD JOHNSON FOUNDATION, 2022)

For instance, Figure 2 illustrates the approach of equality versus equity by providing individuals with a bicycle. Providing a bicycle to a group of people with different heights, ages, and ability statuses would require providing different types of bikes to each individual to ensure they can all reach their destination without additional barriers. The same principle applies to the social determinants of health, where resources and opportunities should be distributed equitably to ensure everyone has an equal chance to achieve optimal health and well-being, regardless of circumstance.

Health Equity in Nevada

While the United States has made significant strides in improving health outcomes for all populations, there is still work to be done to address persistent health inequities. Efforts to improve healthcare access and quality have helped to increase life expectancy and reduce health disparities for many individuals. However, data shows that certain populations continue to experience significant disparities in health outcomes.

For example, recent research has highlighted the disproportionate impact of the COVID-19 pandemic on American Indian and Alaska Native populations, who experience a decline in life expectancy (Greenhalgh & Simmons, 2022). Between 2019 to 2021, life expectancy for AI/AN populations fell 6.6 years versus 2.9 years for the U.S. average (Greenhalgh & Simmons, 2022). Similarly, Black women in the country are also 3 times more likely to die of pregnancy-related complications than White women (CDC, 2022).

It is also important to recognize the barriers faced by individuals with disabilities, those who speak languages other than English, and those who identify as LGBTQ+. While accessibility issues continue to pose challenges for individuals with disabilities, there are ongoing efforts to make healthcare settings more inclusive and welcoming. Similarly, initiatives to reduce language barriers and promote cultural competence among healthcare providers can help to improve health outcomes for individuals who speak languages other than English. Efforts to address discrimination and stigma towards LGBTQ+ individuals can also help to improve health outcomes for these populations.

Nevada is a diverse state that faces unique challenges in achieving health equity for all its residents. The state has the momentum to improve public health, access to healthcare, and social services for its residents. While

there are still significant health disparities that need to be addressed, progress has been made in providing better healthcare outcomes for all.

While urban counties Clark, Washoe, and the municipality of Carson City make up the majority of the population, Nevada has prioritized improving healthcare access in rural, frontier, and tribal communities. In rural areas, healthcare delivery can be more challenging due to the longer travel times and distances from specialized medical facilities. These remote areas also lack resources like fresh foods, opportunities for physical activity, healthcare providers, and medical facilities. Long distances to emergency healthcare present a barrier, especially in extreme weather conditions (NVRFH, 2021). However, there are initiatives to address these barriers, for instance, by increasing access to telehealth services and expanding primary care options (NVRFH, 2021).

Statistics reveal health disparities among minority and marginalized groups in Nevada, with Black populations experiencing higher rates of heart disease, diabetes, HIV infection, and homicide (Office of Analytics, 2021). American Indian/Alaska Native and Black populations also have the highest rates of infant mortality (Office of Analytics, 2021). Asian/Pacific Islander populations have seen nearly a 35% increase in all cancer types from 2010 to 2019 (Office of Analytics, 2021).

The COVID-19 pandemic also highlighted the importance of health equity, and Nevada has since taken steps to ensure that all communities have access to necessary healthcare resources. Early data showed that Black, Hispanic/Latino, and Native American communities were disproportionately affected by COVID-19 in terms of infection, hospitalization, and mortality rates. For example, in August 2020, Hispanic/Latinos accounted for almost 40% of COVID-19 confirmed cases in Nevada, even though they only represented 30.3% of the state's population (The Guinn Center, 2020). Black populations also had significantly higher hospitalization rates than White populations in Clark County (The Guinn Center, 2020). These disparities were likely due to a combination of factors, including higher rates of underlying health conditions such as diabetes and heart disease, as well as social determinants of health such as lack of access to healthcare, lower income circumstances, and crowded living conditions. Additionally, some communities may have been more likely to work in frontline jobs, increasing their risk of exposure to the virus (The Guinn Center, 2020). Today, COVID-19 cases in Nevada have a similar case distribution among different racial and ethnic groups compared to their respective shares of the population, except for Black and White populations. According to the state’s COVID-19 dashboard, Black populations make of 9.2% of the population and 10.2% of COVID-19 cases, and White populations make up 48.8% of the population and 40.3% of cases (Office of Analytics, 2023).

Despite these challenges, there is room for hope and progress. Nevada has the opportunity to address health disparities, and organizations and entities can work together to identify gaps and implement solutions 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, frame practical and actionable recommendations, and 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

Literature Review

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 A). 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 multiple 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.

Additionally, four community input sessions were held across four geographic regions in the state to further develop the plan: North, South, rural and tribal. These sessions were attended by representatives from different organizations and sectors, such as grassroots and faith-based organizations, state agencies, health services, local health departments, county and city services, non-profit organizations, academic institutions, LGTBQ+

representatives, rural health clinics, as well as several community members and advocates. The Northern Nevada session was attended by 21 individuals, while the Southern Nevada session was attended by 13 individuals representing 11 different organizations. The rural comment session was attended by 23 participants from seven different organizations, and the tribal comment session was attended by five individuals representing tribal leaders, community members, and health directors. The community input sessions provided a platform for participants to share their perspectives, concerns, and recommendations.

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.

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**

Findings

Data was collected through a review of literature, health equity resources, and a series of key informant interviews. Key informants are professionals and subject matter experts who serve or represent minority groups in Nevada and helped inform potential improvements. Each quote accompanying the sections below are contributed by key informants. Data analysis revealed six key focus areas**: data, build organizational capacity, community engagement and partnerships, language access, policy change and advocacy, and emergency preparedness**. Each focus area is discussed in more detail below.

Data

Secondary Data

The literature review suggests that using data is crucial to inform health equity efforts. Four key findings have emerged from the review. First, existing aggregated data can be used to identify where disparities exist,

enabling interventions to target underserved communities (AHA, 2021). Second, data can be used to measure the progress and impact of efforts towards health equity (Artiga, 2021). Third, processes must be put in place to collect both internal (agency) and external (public-facing/community) data to gain a more comprehensive understanding of the needs and perspectives of communities, and how an organization can work to meet those needs (AHA, 2021). Finally, using qualitative methods and community-based participatory research can bring quantitative data to life, lift community voices, and build stronger relationships with the communities being served (CDC, 2021). These findings underscore the importance of data-driven and community-centered approaches to advancing health equity.

Primary Data

According to key informant interviews, it is important to ensure that data collection is culturally and linguistically accessible in order to include populations that may be underrepresented in data. Additionally, access to disaggregated data should be increased to better understand specific subgroups of the population, such as rural communities, Asian American subgroups, and LGBTQ+ communities. To improve representation in data, attending events where communities gather, like Pride Festivals and powwows can be an effective approach to primary data collection, especially when working with traditionally marginalized or hard-to-reach populations. Overall, the interviews highlight the importance of inclusive and comprehensive data collection practices in order to accurately represent and serve diverse 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."

> "We have done surveys before, but maybe doing a needs assessment around health equity when the Pride Festival comes up. Or Gender Fest is coming up, and that's being put on by Gender Justice Nevada. You know, those days where you have a mass amount of people of those populations gathering. I noticed that somebody recommended for the tribal community, being at powwows, so going to places like that. I think that we need that same type of energy going into the [LGBTQ] community."

Build Organizational Capacity

Secondary Data

Consistently throughout the health equity literature reviewed, it is emphasized that building organizational knowledge and capacity is critical to advancing health equity practice. Organizational leadership and teams should demonstrate a strong commitment to continuous learning, self-reflection, and evaluation, and embed equity into all practices within the organization (Human Impact Partners, 2017). Implementing strategies such as equitable recruitment, department or peer workgroups, trainings, or other opportunities to discuss equity-related content can facilitate organizational change towards greater equity (Human Impact Partners, 2017).

Primary Data

According to the informants, recruiting and retaining a diverse workforce with a broad range of skills, knowledge, and backgrounds is crucial to demonstrate a commitment to health equity and prepare for future emergencies effectively. Cultural competence is essential for building strong, ongoing relationships with communities, and for providing better support during emergencies such as pandemics. Representatives from tribal, racial/ethnic minority communities, and LGBTQ+ communities emphasized the importance of a culturally sensitive workforce, including individuals who specifically represent those communities and can deliver the necessary services. The informants also stressed the significance of applying a health equity lens to all aspects of work, rather than just focusing on specific health equity projects. To promote health equity, it is essential to implement it organization-wide, particularly in decision-making, and ensure that decision-makers include individuals with cultural competence.

> "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 just 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

Secondary Data

The review of secondary data highlighted several key findings. First, it is crucial to have genuine engagement with the community to understand their experiences and perspectives (MDH, 2022). Secondly, those who face health inequities, including people in poverty, American Indians, communities of color, people with disabilities, immigrant communities, and LGBTQ+ communities, should be exclusively involved in the development of health initiatives (MDH, 2022). Designing initiatives *with* communities rather than just *for* them is more effective in meeting their needs (MDH, 2022). The literature also emphasizes the importance of partnerships and collaboration across sectors to address community issues. For example, community-based organizations, healthcare organizations, government agencies, and other stakeholders must work collaboratively to achieve shared objectives in addressing the social determinants of health (APHA, 2020).

Primary Data

In all the interviews conducted, community participation and engagement in policy and program decision-making were found to be critical. However, historical mistrust between communities and health authorities presents a challenge in building relationships today. Maintaining long-term relationships with communities has been a persistent problem due to the time and effort that it takes. Community informants highlighted that relationships often only last for the term of a project or initiative. To overcome this issue, there is a need for more roles solely dedicated to building and maintaining long-term relationships with the community. Another problem identified was the issue of "working in silos," where different agencies and organizations have similar goals but do not collaborate 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

Secondary Data

In order to achieve health equity, it is crucial to provide accessible and meaningful language services for individuals with Limited English Proficiency (LEP), who do not speak English as their primary language and may have limited ability to read, write, speak, or understand English (The Colorado Trust, 2013). In Nevada, it is noteworthy that over 10 languages, in addition to English, are spoken, highlighting the importance of providing language services that can be understood by all communities (Nevada DHHS, 2019). Language access and health literacy are important social determinants of health as inadequate language services could hinder access to healthcare services or result in lower quality care, which can contribute to negative health outcomes. Studies have revealed that individuals with LEP or lower health literacy are twice as likely to report poor health outcomes compared to those without these barriers (CMS, 2022).

Primary Data

According to key informants, there is a significant need for culturally and linguistically accessible resources in Nevada, particularly in health communication and emergency situations. With over 10 languages spoken besides English, immigrants and ethnically diverse populations face challenges in accessing care and finding materials that are effectively translated in their language. This language barrier contributes to widening the gap in health disparities in Nevada. Direct translation from English to other languages is not sufficient, and there is a need for additional efforts to address this issue. Overall, improving language access for diverse populations in Nevada is crucial for reducing health disparities and ensuring equitable access to healthcare resources.

"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

Secondary Data

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 for policies that promote health and health equity. The COVID-19 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).

Primary Data

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 funding, as well as health and 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

Secondary Data

Health equity is important in emergency response because emergencies, such as natural disasters or disease outbreaks, can disproportionately affect vulnerable populations. These vulnerable populations include persons living in low-income circumstances, racial and ethnic minorities, people with disabilities, and other marginalized groups (WHO, 2017). For example, during a natural disaster, individuals with disabilities may face additional challenges accessing emergency shelters or medical care. Racial and ethnic minorities may experience discrimination or language barriers that prevent them from receiving necessary care. Low-income individuals may lack resources to evacuate or prepare for the emergency (CMS, 2022). Prioritizing health equity in emergency response may include providing access to information, resources and medical care, as well as addressing social determinants of health, such as poverty and discrimination.

Primary Data

Despite Nevada's commendable efforts and response during the COVID-19 pandemic, key informants identified several lessons learned that will be considered in preparing for future emergencies. Key informant findings highlighted the need for increased collaboration and concerted efforts during

emergency response, with participation at all levels, including local communities and individuals. It is essential to include community voices to inform appropriate responses for each population, and for health officials to provide support and education in risk mitigation and public health information (which was essential for COVID-19 outbreaks). Additionally, climate and sustainability practices are crucial for Nevada and its resources, and emergency preparedness should include equity considerations for future climate and environmental emergencies. Finally, appropriate funding for public health and emergency resources is necessary to address these issues effectively.

> "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 on 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 following section outlines six strategic priorities for promoting health equity and actionable recommendations derived from literature reviews and expert insights. Special consideration is given to rural and tribal communities, which face unique challenges in achieving health equity. The goal is for organizations to adopt and implement these strategies within their own areas of responsibility, control, and influence so this work is amplified across multiple sectors and movements throughout the state. By doing so, we can collectively work towards a more equitable future for all.

Key areas include:

Data

Data can be a powerful tool in identifying and addressing health inequities. By collecting and analyzing disaggregated data on health outcomes, demographics, and social determinants of health, we can better understand the root causes of health disparities and develop targeted interventions to address them. Additionally, data can help us monitor progress and evaluate the effectiveness of interventions over time. It is important to use data in a responsible and ethical way, while meaningfully involving the communities most affected by health inequities in the process of data collection, analysis, and decision-making.

Data Recommendations

Data collection

1. Use existing secondary data to identify inequities and determine where to target department or program efforts and map communities that need the most support (i.e., before, during, and after a hazardous event/emergency) (Human Impact Partners, 2017). Examples:
    - 1.1 Nevada Office of Analytics Data Dashboards & Reports Catalog
    - 1.2 Nevada Community Health Profiles
    - 1.3 Nevada Office of State Epidemiology
    - 1.4 Nevada Health Response COVID-19 Dashboard
    - 1.5 Minority Health Report 2021
    - 1.6 Nevada County Health Rankings
    - 1.7 Washoe County Community Health Assessment 2022-2025
    - 1.8 Southern Nevada Community Health Assessment Report 2020/2021
    - 1.9 CDC's Social Vulnerability Index (SVI)
    - 1.10 NMHEC's CBPR Toolkit Appendix E: Secondary Data Sources
    - 1.11 See Additional Resources below
2. Primary methods of data collection
    - 2.1 Collect internal (agency) data as well as external (community/public-facing) data to measure impact and progress towards health equity (Hanafi et al., 2022).
        - 2.1.1 Internal data examples:

- Demographic data: collect and analyze data on demographics of staff (including race, ethnicity, gender, SOGI, age, education level, etc.) to help identify disparities within the organization and inform efforts to promote diversity, equity, and inclusion (DEI).
- Employee engagement surveys: conduct surveys to measure employee satisfaction, morale, and perceptions of the organization's commitment to health equity. This can help identify areas for improvement to promote a positive workplace culture.

2.1.2 External data examples:

- Patient satisfaction surveys: Conduct regular patient satisfaction surveys to measure patients' perceptions of the quality of care they receive from the organization, to help identify areas for improvement.
- Health outcomes: Collect and analyze data on health outcomes of patients/clients served by the organization, including disparities among different demographic groups, access to care, and social determinants of health. This can help identify areas where the organization's services may be falling short and inform strategies to improve health equity among constituents.

2.2 Work with a community to plan, implement, and analyze data (such as community-based participatory research).

2.2.1 See NMHEC's Community-Based Participatory Research (CBPR) Toolkit for clear steps on how to do this.

2.3 Utilize focus groups, listening sessions, one-on-one meetings, town hall meetings, and surveys to collect qualitative data to better understand people's experiences, attitudes, and behavior (Human Impact Partners, 2017).

2.4 Expand demographic data collection to collect more disaggregate information. For example: sexual orientation/gender identity, ability status, location, language(s) spoken, and social determinants of health.

2.4.1 Example: Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool

2.4.2 When collecting sexual orientation and gender identity (SOGI) data, be sure to follow appropriate guidelines: Recommendations on the Best Practices for the Collection of Sexual Orientation and Gender Identity Data

2.5 Ensure that data collection materials are culturally and linguistically appropriate and easily understandable to the public.

2.6 Consider attending events where communities gather, such as community festivals (i.e., Pride Festivals or powwows), to gather information and insights that can help inform policies and programs.

Dissemination

3. Develop a dissemination plan that ensures that information is meaningful, understandable, and respectful of various audiences (Marquez et al., 2022).
   3.1 See NMHEC's CBPR Toolkit for clear steps on how to do this.
4. Ensure that data is accessible by using a dashboard, reports, 1-2 page summaries, infographics, etc.
   4.1 Translate research and data into reports that are easily understandable and available in different languages.

Rural Considerations

1. To better understand the inequities that exist in rural communities, reference available secondary sources such as government reports and community assessments. These sources can provide valuable insights into the social determinants of health and the unique challenges faced by rural populations, including disparities in access to healthcare, education, and economic opportunities.
   1.1 See UNR's Nevada Rural and Frontier Health Data Book
   1.2 See Nevada County Health Rankings
2. Collect data by consulting with local community organizations and leaders to help identify specific issues and priorities within the rural community.

Tribal Considerations

1 If you are working on health equity for tribal communities in Arizona, Nevada, or Utah, refer to the Inter-Tribal Council of Arizona Tribal Epidemiology Center for data on the highest priority health status

objectives. This data can help guide your work and ensure that you are addressing the most pressing health issues faced by these communities.

Additional Resources

Title	Source
Applying Social Determinants of Health Indicator Data for Advancing Health Equity: A Guide for Local Health Department Epidemiologists and Public Health Professionals	Bay Area Regional Health Inequities Initiative (BARHII)
Behavioral Risk Factor Surveillance System (BRFSS)	Centers for Disease Control and Prevention (CDC)
A Step-By-Step Guide to Community Based Participatory Research	NV Minority Health and Equity Coalition (NMHEC)
Data Dashboards & Reports Catalog	Nevada Office of Analytics
Data, Publications, and Reports	Washoe County Health District
Disaggregation of Public Health Data by Race & Ethnicity: A Legal Handbook	The Network for Public Health Law
Explore Health Rankings	County Health Rankings and Roadmaps
Food Insufficiency Among Transgender Adults During the COVID-19 Pandemic	UCLA School of Law Williams Institute
Health Workforce in Nevada: A Chartbook	Nevada Health Workforce Research Center
Healthy Southern Nevada Data	Southern Nevada Health District
Minority Health Report 2021	Nevada Office of Analytics
Monitoring COVID-19 in Nevada	Nevada Health Response
Nevada Community Health Profiles Data Dashboard	Office of Analytics, Nevada DHHS
Nevada Data and Resources	County Health Rankings and Roadmaps
Nevada Rural and Frontier Health Data Book	Office of Statewide Initiatives, UNR

Physician Workforce in Nevada: A Chartbook	Nevada Health Workforce Research Center
Recommendations on the Best Practices for the Collection of Sexual Orientation and Gender Identity Data	The White House
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

Colorado Changes Data Narrative and Incorporates Equity Metrics
Colorado Department of Public Health and Environment, Office of Health Equity

The Office of Health Equity (OHE) at the Colorado Department of Public Health and Environment (CDPHE) underwent a transition in leadership, staffing, and vision in 2016. The new staff brought a commitment to health equity and environmental justice and aimed to incorporate a Health in All Policies focus into the OHE's work. Around the same time, the Health Equity and Environmental Justice Collaborative (HEEJC) gained momentum, capacity, and support to advance health equity and environmental justice. The HEEJC members acted as ambassadors across the department, identifying opportunities to address equity within their own divisions. The OHE and HEEJC also organized a health equity and environmental justice 101 training for all CDPHE staff, providing a foundation to understand health equity topics and embed equity in their day-to-day work. Extensive evidence indicated that the social and built environment are more significant predictors of health than access to health care, which enabled the OHE and HEECJ's perspective to gain momentum and help spark changes in the way that data is used.

In 2016, the Office of Health Equity began exploring the use of data to advocate for health equity. This involved examining the data already being collected, how it was being communicated, and whether it reinforced or challenged prevailing beliefs about the causes of poor health and what actions were necessary to address health disparities. In the past, CDPHE staff only provided data to the public without offering any interpretation, as they didn't want to be seen as influencing the data in any way. For instance, reports were released indicating that people of color had poorer health outcomes, but without any context or information about their social or neighborhood conditions. However, after discussions with OHE staff, CDPHE staff realized that if the public continually sees that people of color have higher rates of morbidity and mortality without any context, they may focus solely on individual behaviors rather than considering the larger societal factors.

To rectify this, OHE staff, epidemiologists, and other data experts began to examine the structural factors leading to these outcomes and incorporated that analysis into their data briefs and reports. For instance, CDPHE released a data brief on homicide rates in Colorado, and after breaking down the data, they found that males of color were the most likely to be involved in homicides. Before releasing the data, CDPHE staff held discussions about the structural factors leading to homicide and included information about the social and neighborhood factors that contribute to men of color's increased likelihood of involvement in homicide in the discussion section of the brief.

The Office of Health Equity (OHE) also initiated discussions with department staff regarding the inclusion of health equity metrics in performance and evaluation measures. OHE collaborated with staff responsible for performance monitoring and quality improvement to develop meaningful measures that ensure equitable advancement in day-to-day work. Furthermore, OHE worked with program evaluators to analyze access to department resources and services and to determine if health equity is promoted through the department's programs. For instance, instead of using traditional public health measures such as vaccination and screening rates, they aim to analyze who received these services, whether it was the population in most need, and whether community partnerships were established to expand outreach. Although metrics are sometimes defined by the federal government or funders, additional measures can be added to survey and evaluation instruments.

Outcomes and impacts:

- A framing memo is currently being developed by OHE staff, with input from epidemiologists and data analysts. Its purpose is to provide guidance on how to frame and contextualize population health data in order to avoid reinforcing a narrative of blame in data publications, and to highlight the connection between health outcomes and upstream factors more prominently.
- The Office of Health Equity has made significant strides in changing the narrative around data collection and dissemination within the health department, but there is still much work to be done. Despite federal guidelines on data collection at the state level, the OHE is working to intentionally slice and communicate data in ways that

challenge the blaming narrative and highlight upstream factors. The OHE will continue to collaborate with data analysts, epidemiologists, and program evaluators to incorporate equity metrics in ongoing performance monitoring and program evaluation.

- Additionally, the OHE plans to outreach to fiscal and grant managers to explore incorporating equity metrics into future financial plans and grant applications. Although change may be slow, the OHE remains committed to advancing health equity through thoughtful and intentional data collection and dissemination practices.

Key tips for framing population health data:

- Provide context on the neighborhood structural, environmental, and social conditions.
- Whenever possible, include data on other systemic determinants.
- Incorporate the voice of people facing inequities.
- Make data understandable.

Advice for local health departments:

- Use pre-written language to initiate conversations about health equity in various documents and communications.
- Start small by approaching department leaders and requesting the inclusion of equity language in specific documents to create a snowball effect.
- Utilize facts and data to highlight the need for addressing health inequities.
- Emphasize that the ultimate goal of public health is to promote and maintain population health and addressing health disparities is essential to achieving that goal.

To read more about this case study, click here.

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.). In order for an organization to effectively promote health equity, it is crucial that its leaders and members share a mutual interest and commitment to understanding power, oppression, and equity. Furthermore, health equity should be incorporated into decision-making for all policies, programs, interventions, and practices (United Nations, n.d.). To achieve this, organizations can utilize a range of strategies, such as conducting equity assessments, offering equity-related trainings, establishing work and support groups, and providing other opportunities for reflection and development of equity-related content.

Build Capacity Recommendations

Hiring Practices

1. To cultivate a diverse and resilient workplace, recruit staff and board members who reflect the demographics of populations that experience inequities.
    - 1.1 When creating job postings, use inclusive language and demonstrate the value of lived experiences and multilingualism to attract a diverse pool of candidates.
    - 1.2 Collaborate with academic and training institutions and people with an interest or potential to be leaders (example: engage youth through pipeline training programs) to help spread awareness of employment opportunities in public health, healthcare, and/or behavioral health and attract a more diverse pool of candidates (Nexus Community Partners, 2018).
        - 1.2.1 Examples:
            - Leaders in Training (LIT) Las Vegas
            - High Sierra Area Health Education Center (AHEC)
            - National Community Health Worker Association (NCHWA)
2. Improve employee retention rates by establishing an internal work culture that promotes and supports diversity, equity, and inclusion (DEI) among employees.
    - 2.1 Celebrate cultural holidays, encourage support groups, facilitate open conversations and forums, establish collaborative work environments, ensure easy access to resources, and

provide equipment and facilities that are accessible to individuals with disabilities, including wheelchair accessibility.

2.2 Implement mentorship programs in the workplace to provide diverse employees with the support they need, help them expand their professional networks, and develop essential leadership skills.

3. To facilitate effective communication and promote cultural competency in serving minority groups, consider appointing an equity point person/team or Diversity and Inclusion Liaison (DIL) for each department/program.

3.1 Example: Nevada DILs

3.2 Example: Nevada State Tribal Liaisons

Training

4. Build staff skills to advance health equity (CDC, 2021).

4.1 Utilize trainings, educational resources, webinars, public health conferences (Hanafi et al., 2022).

4.2 Consider topics such as: diversity, equity, inclusion (DEI); cultural sensitivity, health literacy, and capacity building.

4.3 Examples of training resources:

4.3.1 University of Nevada, Reno School of Public Health | Making Health Happen Courses and Trainings

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

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

4.3.4 Population Health Institute Health Equity Training Modules

5. Incentivize employee efforts to increase health equity focused skills (Nelson, et al., 2015).
6. To ensure that the training concepts are being effectively applied in practice, conduct regular check-ins, discussions, and reflections with employees.

Organizational Practices

7. Apply a health equity lens to all aspects of work, rather than solely focusing on individual projects.
    7.1 See Health Equity in the Workplace: A Toolkit for Advancing Equity at the Organizational Level
8. Organizational decision-makers should involve individuals who have cultural knowledge and awareness in the decision-making process.
    8.1 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).
9. Develop a diversity, equity, and inclusion (DEI) Guiding Statement to proclaim your organization's commitment to fostering an equitable and inclusive workplace (Hanafi et al., 2022).
    9.1 See How to Write a DEI Guiding Statement
10. Consider developing an action plan to set and achieve equity-related goals (CDC, 2021).
    10.1 See Racial Equity Action Plans: A How-To Manual by Government Alliance on Race & Equity (GARE)
11. Assess, guide, and evaluate internal policies, programs, and service delivery.
    11.1 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).
        11.1.1 Example: Organizational Self-Assessment for Achieving Health Equity, BARHII
    11.2 Consider using an equity lens tool or toolkit to effectively integrate and evaluate health equity in services, resources, communication, and decision-making (Nelson, et al., 2015). Examples:
        11.2.1 NOMHE's Health Equity Lens: Choice Point Thinking Guide
        11.2.2 CMS Disparities Impact Statement Worksheet
        11.2.3 GARE Racial Equity Toolkit
        11.2.4 REJI Organizational Race Equity Toolkit

Rural Considerations

1. Enhance the skills of the rural workforce by hiring and training personnel who have received training as Community Health Workers (CHWs).
   1.1 See Community Health Workers in Rural Settings
   1.2 See the NVCHWA webpage for more information, or contact Nevada CHW Association program manager, Jay Kolbet-Clausell, MSW
2. Consider supporting or collaborating with groups such as the Rural Nevada Health Network (RNHN), which convenes quarterly in a hybrid format. The RNHN gathers community members, healthcare professionals, community organizations, and different sectors to establish a comprehensive and streamlined healthcare system across all of rural Nevada's 14 counties, including tribal communities, to promote a healthy economy through community engagement, advocacy, and development efforts.
   2.1 Contact: Deborah Loesch-Griffin (deb.turningpoint@gmail.com) to be placed on the list serve for these meetings.

Tribal Considerations

1. To promote workplace readiness, strengthen workforce pipelines, and nurture leadership skills in tribal communities, consider establishing programs for tribal youth leadership training or forming youth councils (National Congress of American Indians, n.d.).
   1.1 See Tribal Workforce Development: A Decision Framing Toolkit by National Congress of American Indians for ways to identify, develop, and implement workforce development solutions for the needs of respective tribes.

Additional Resources

Title	Source
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 Technical Assistance Center (DETAC)
Equity Diversity Inclusion: A Toolkit for Organizations	American Public Health Association (APHA)
Health Equity Primer	National Association of Chronic Disease Directors
Health Equity in the Workplace: A Toolkit for Advancing Equity at the Organizational Level	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	State of Nevada
Nevada State Tribal Liaisons	State of Nevada
Organizational Race Equity Toolkit	JustLead Washington
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)
Rural Health Information Hub	
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

In August 2020, Governor Sisolak issued a proclamation formally naming racism as a public health crisis, acknowledging the institutional racism in the U.S. that affects the health and wellbeing of Black, Indigenous, and People of Color (BIPOC) communities. In 2021, the Nevada Office of Minority Health & Equity (NOMHE) received funding from the Center for Disease Control and Prevention (CDC) through the Health Disparity Grant to help achieve infrastructure that supports underserved 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. Both events led to the launch of the Core Values Assessment project in 2022.

The Core Values Assessment is a survey created and disseminated by NOMHE to the each of the divisions under the Department of Health and Human Services (DHHS) of Nevada. The goal of the CVA was to evaluate the processes that prevent equitable provision of services to marginalized communities and to identify areas for improvement within each division. The project was meant to complement other initiatives aimed at promoting diversity, equity, and inclusion (DEI) within the workplace of DHHS. Together, the projects 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 evaluated nine domains using the Communication Climate Assessment Toolkit (C-CAT) framework, including leadership commitment, information collection, community engagement, workforce development, individual engagement, socio-cultural context, language services, health literacy, and performance evaluation. DHHS agencies used the survey results to identify priorities for action and success indicators, working in collaboration with NOMHE to initiate policy changes and operational improvements that focus on health equity.

After three months of implementing set goals, DHHS divisions shared their progress towards success. For example, a division reported the following actions completed since implementation of the CVA in 2022:

- **Leadership Commitment**- Created a workgroup to review the CVA results and develop strategies to address areas of opportunity.
- **Community and Staff Engagement**- Created 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** – Increased awareness of the Nevada 211 resources and tools among staff members and clients.
- **Language Services and Access** – Educated staff who interact with customers about the tools available to help them communicate with non-English speakers.
- **Health Literacy and Workforce Development** – Increased awareness of the Minority Health Report 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 client complaints.
- **Equitable Achievements** – Administered 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 DHHS Divisions to continue efforts towards DEI, cultural competency, and health equity. NOMHE will continue to work with the DHHS divisions to evaluate further progress towards set goals.

Community Engagement and Partnerships

Community engagement refers to the collaborative process of working with groups of people to address issues that affect their well-being (CDC, 2015). This process aims to amplify the voices of historically marginalized communities, enabling them to express their values and participate actively in planning, executing, and evaluating activities that impact their health. Successful community engagement fosters relationships that break patterns of mistrust, promoting safety and empowering individuals to act on their values.

Another important aspect of engagement is the involvement of stakeholders and partners across various sectors. Collaboration and partnerships with other organizations help facilitate discussions on addressing priorities and identifying ways to work together to achieve common goals. Such cross-sectoral partnerships are essential for achieving health equity and addressing social determinants of health. As the saying goes, "If you want to go fast, go alone. If you want to go far, go together" – African Proverb.

Community Engagement and Partnerships Recommendations

Community Engagement

1. Eliminate mistrust through genuine engagement:
    - 1.1 Gather knowledge to understand community context, complexity, and needs through conversations, interviews, focus groups, community member councils or boards.
    - 1.2 Remain learning-oriented when interacting and collecting data with communities.
    - 1.3 Attend community events to build trust and establish meaningful relationships.
2. Build long-term relationships:
    - 2.1 Build relationships with community members early on in the engagement process.
    - 2.2 Model consistency, respect, and transparency in all interactions with the community.
    - 2.3 Understand that it takes time to establish trust and build relationships beyond a single project or initiative (CDC, 2021).
3. Involve the community in decision-making and program design (CDC, 2021):
    - 3.1 Value community needs and involve them in the development of activities for health equity, decision-making, initiatives, and program design.

3.2 Provide opportunities for community members to share their input and ideas through town halls, advisory boards, etc. (Nexus Community Partners, 2018).

3.3 Ensure that community members are represented in leadership and decision-making roles.

4. Go where the community gathers:
    4.1 Conduct engagement efforts where the community gathers, such as community centers, community festivals, places of worship, or local events.
    4.2 Be visible and accessible in the community.
5. Consider organizational capacity for engagement efforts (CDC, 2021):
    5.1 Ensure adequate resources and capacity of the organization when planning engagement efforts, such as time and funding.
    5.2 Consider having a person in position that oversees community engagement/outreach efforts, such as an outreach liaison, equity point person or Diversity and Inclusion Liaison (DIL) (also consider community health workers or interns).
    5.3 Ensure that staff members are trained and equipped to engage with the community effectively (i.e., cultural competency, life experience, multilingualism).

Partner Engagement

6. Eliminate working in silos:
    6.1 Join or form coalitions with other organizations working towards similar goals (CDC, 2021).
        6.1.1 Example: Nevada Minority Health & Equity Coalition (NMHEC) Partners serve as critical community champions to address health inequities in our state.
    6.2 Participate in committees or attend conferences where different professionals gather to network and collaborate.
    6.3 Look for opportunities to collaborate with partners and share resources.
7. (State/local level) Support NGOs and CBOs:
    7.1 Attend events and activities hosted by NGOs and CBOs to show support and build relationships.
    7.2 Offer your organization's expertise, knowledge, resources, and networks to support their projects and initiatives (AHA, 2020).
8. Leverage resources from other organizations:

8.1 Find ways to support projects and initiatives from other organizations and leverage your organization's expertise, knowledge, resources and networks.

8.2 Seek out partnerships where both organizations can benefit.

8.3 Foster partnerships across sectors, including healthcare, education, government, and community organizations to address health disparities and promote health equity (CDC, 2021).

9. Develop a contact list/directory of organization partners:

9.1 Create and maintain a contact list or directory of organization partners to keep track of who they are, what they do, and their contact information.

9.2 Keep the list up to date and share it with staff members who need it.

10. Use community resources:

10.1 Be aware of the organizations and resources available in the community. Examples:

- Nevada 211
- 988 Crisis Support Services of Nevada
- National COVID-19 Resiliency Network
- Nevada DHHS Programs and Resources

Rural Considerations

1. Build or support community coalition:

1.1 Establish or support a community coalition that includes representatives across all rural and frontier counties in the state.

1.2 Schedule or attend regular meetings (quarterly, biannually, etc.) and discuss issues, needs, solutions, and share information.

1.3 Refer to groups such as Rural Nevada Health Services Network (RNHN) Meetings, and Brown Bag Information Sessions for guidance (contact Deborah Loesch-Griffin deb.turningpoint@gmail.com).

1.4 Encourage participation across sectors (i.e., community members and advocates, community organizations, faith organizations, government, education, law enforcement, etc.).

2 (State/local level) Engage with rural/frontier communities in-person:

2.1 Establish consistent presence in rural communities by setting up mobile health clinics, dental vans, or mobile unit testing.

2.2 Have authentic discussions with individuals living and working in rural and tribal communities to better understand how programs and policies can meet their unique needs (CMS, 2022).

2.3 See: Respectfully engaging with rural communities

2.4 See: A Guide to Supporting Engagement and Resiliency in Rural Communities

Tribal Considerations

1. (State/local level) To improve engagement with tribal communities:

   1.1 Attend community events and meetings to learn more about the community's culture, beliefs, needs, and priorities, such as setting up a booth at powwows.

   1.2 Engage community members in the development of culturally appropriate communication materials.

   1.3 Respect tribal sovereignty and consult with tribal leaders and liaisons on any activities or communications that may affect their communities.

      1.3.1 See Nevada State Tribal Liaisons

Additional Resources

Title	Source
A Guide to Supporting Engagement and Resiliency in Rural Communities	Federal Emergency Management Agency (FEMA)
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	Centers for Disease Control and Prevention (CDC)

Case Study: Community Engagement

Puentes, Las Vegas, Nevada

Puentes is a non-profit organization that was founded with the goal of providing guidance and assistance in accessing essential social services to under-resourced and under-represented communities. Initially focused on serving the Latino population, Puentes has since expanded its scope to encompass all communities in need. At the core of Puentes' programs are Health and Wellness, Education, Employment, and Advocacy, all of which are delivered by a team of professionals, counselors, and dedicated volunteers from within the organization as well as from more than 50 community partners. Puentes strives to be an innovator in developing comprehensive, culturally sensitive initiatives that address the root causes of social disparities and inequities, with the ultimate aim of providing permanent, sustainable solutions.

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. The Nevada Legislature enacted NRS 232.0081 in 2021 relating to language access plans, and Federal Guidance on Title VI of the Civil Rights Act of 1964 states 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. Despite these policies, communities still face challenges due to lack of language access, including decreased access to health screenings, poor interactions with service providers, inaccurate diagnoses, and inadequate treatment of chronic illnesses (CMS, 2022). Therefore, accurate, culturally inclusive messaging is essential to improving health literacy and empowering individuals to make informed decisions about their health. Effective health communication also considers using plain language and disseminating information in accessible places and formats.

It is important to ensure that language access is prioritized in all areas of work, including the priority areas identified in the HEAP, such as data collection and dissemination, community engagement, and emergency preparedness. Language accessibility is vital for effective emergency response and was critical during the COVID-19 pandemic.

Language Access Recommendations

1. **Provide accessible services and resources to individuals with Limited English Proficiency (LEP) or those who may have limited ability to read, write, speak, or understand English.**
    - 1.1 Take regular assessment of the language needs of constituents or clientele through demographic analysis, surveys, or intake information. Determine if your organization or agency is meeting those needs, and if not, take measures to expand language services in order to enhance access to the services provided by your organization.
    - 1.2 For deaf/hard of hearing, be aware of resources to help communicate and advocate for the community. Examples:
        - 1.2.1 Communication Access Services (CAS)
        - 1.2.2 ASL Anywhere
        - 1.2.3 Become a Deaf Friendly Provider
        - 1.2.4 Deaf and Hard of Hearing Self-Advocacy

1.3 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).

1.4 Hire, train, and fairly compensate qualified multilingual staff to become certified translators. Have them in positions that interact regularly with the public.

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

1.5.1 See: State of Nevada Language Access Toolkit

1.5.2 See: Guide to Developing a Language Access Plan

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

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

2. **Use plain and inclusive language to appropriately communicate with diverse communities.**

2.1 Use plain language to promote health literacy and ensure everyone can understand important information (CDC, 2022).

2.1.1 See Plain Language for Public Health

2.1.2 Refer to the National Culturally and Linguistically Appropriate Services (CLAS) Standards recommended by the U.S. Department of Health and Human Services to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations.

2.1.3 Utilize resource: Flesch Kincaid Readability score

2.2 When interacting with LGBTQ+ populations, use language and terms that are culturally appropriate.

2.2.1 See A Field Guide for Effective Communication with the LGBTQ Community

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

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

2.3.2 As an initial step, consider using Microsoft Word's inclusiveness editing and accessibility checker features to scan your documents for any potential biases or accessibility issues.

Note: these features can be used as a preliminary tool but should not be the sole means of assessment.

3. **Work with community members to develop messaging around important health matters.**
    - 3.1 When necessary, tailor campaigns and resources to target specific population groups.
    - 3.2 Consult with members of the community about culturally, linguistically, and visually appropriate messaging and communication.
    - 3.3 Advocate, empower, and support communities to increase health literacy.
        - 3.3.1 Example: Health Matters Campaign

4. **Disseminate information in accessible places and formats.**
    - 4.1 Leverage social media, newsletters, radio (English and non-English stations), and public events.
    - 4.2 Bring messages to communities by sharing them with trusted local partners (CMS, 2022).
    - 4.3 Consider using powerful infographics/visuals where possible (including big text) and ensure that visuals are culturally sensitive.
    - 4.4 Ensure documents follow ADA remediation.

5. **Evaluate effectiveness of language services.**
    - 5.1 Disseminate materials to limited-English proficient (LEP) communities and solicit feedback on the quality and cultural appropriateness of services.

Rural & Tribal Considerations

1. (Tribal level) Preserve and revitalize native language by creating and incentivizing opportunities to learn/become fluent in native dialects.
2. When communicating with communities in rural areas, keep in mind that internet connectivity may be unreliable or unavailable. Consider other forms of communication such as printed materials, text messaging/phone calls, newsletters, etc.

Additional Resources

Topic	Source
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
An Implementation Checklist for the National CLAS Standards	U.S. Department of Health and Human Services Office of Minority Health
ASL Anywhere	
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)
Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the LGBTQ Community: A Field Guide	The Joint Commission
Language Justice Toolkit	Communities Creating Healthy 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
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 COVID Campaign

Nevada Minority Health & Equity Coalition

The Nevada Minority Health & Equity Coalition (NMHEC) is a collaboration of various organizations from academic, civic, and community sectors with the goal of reducing health disparities and promoting equity in Nevada through research, policy development, and capacity building. The NMHEC operates within the School of Public Health at the University of Nevada, Las Vegas.

The Nevada Minority Health and Equity Coalition received funding to educate and provide outreach to the communities in Nevada that were severely affected by COVID-19 after the United States shutdown. The coalition launched the #OneCommunity campaign to reach out to seven communities, including Asian, Black/African American, Hispanic/Latinx, Hawaiian/Pacific Islander, Native American, LGBTQ, and individuals who are deaf or hard of hearing. The coalition used a CBPR approach and collaborated with partners from each of these communities to ensure that the project was guided by their experiences and perspectives.

The #OneCommunity campaign aimed to develop culturally responsive and linguistically appropriate COVID-19 educational materials that suited the needs of different communities. To do this, the NMHEC partnered with 10 community-based organizations that served at least one of the focal communities. Before creating educational materials, the NMHEC and community partners wanted to hear directly from each community to understand how the pandemic had affected them, their knowledge, beliefs, and concerns, as well as risk mitigation strategies and first impressions about the COVID-19 vaccine. Community partners facilitated community discussions, and NMHEC staff attended to provide technical assistance. The focus groups were recorded and transcribed, and the data was analyzed. Summaries were provided back to community partners for review and feedback. NMHEC staff and community partners worked together to develop the educational materials and disseminate the information based on the communities' feedback.

Educational materials were developed to represent each of the seven communities. As materials were drafted, community partners would continuously obtain feedback from community members and make revisions to ensure cultural relevance, linguistic accuracy, and appropriate representation of the community. NMHEC also worked with local artists from a few of the communities to create additional culturally responsive materials and further honor the voice of the community.

A variety of dissemination methods were used to distribute the educational materials based on input from the focus groups, community partners, and community members:

- Social media (Facebook, Instagram, and Twitter)
- Printed Flyers
- Mailers
- Billboards
- Website
- Webinars
- TV Commercials
- Radio Commercials

The CBPR approach proved to be effective in developing culturally and linguistically responsive dissemination products through meaningful partnerships and providing valuable insights into the needs, concerns, and preferred methods of communication for each community. This approach allowed the NMHEC to create a more personalized and effective COVID-19 response.

Learn more about the #OneCommunity campaign here, and review the CBPR Toolkit for clear action steps on how to implement community-based participatory research strategies.

Find the COVID Art Gallery here.

Policy Change and Advocacy

Prioritizing policy change at the local, state, and federal levels, as well as within organizational infrastructure is instrumental for advancing health equity. Policy change can include direct and indirect advocacy efforts to influence decision-making contexts, as well as building staff capacity to identify and address upstream, structural factors that impact health outcomes. In order to achieve policy change, it is important to consider a broad range of social determinants of health, which may require shifts in traditional practices. Agencies and institutions at all levels should promote the use of a health equity lens in strategic planning, decision-making, funding development, and needs assessment processes.

Policy Change and Advocacy Recommendations

1. **Promote or implement organizational policies, programs, and practices that explicitly address health and racial equity (Human Impact Partners, 2017).**
    - 1.1 See Health Equity in the Workplace: A Toolkit for Advancing Equity at the Organizational Level for ways to address health inequities at the organizational level.
    - 1.2 Review the policies and regulations that govern your organization to ensure that resources are not perpetuating cultural prejudices, obstacles, and inequities (CDC, 2021).
        - 1.2.1 Utilize tools to assess how health equity is impacted by policies, programs, or proposals. Examples:
            - 1.2.1.1 Health Equity Inventory Tool
            - 1.2.1.2 Health Lens Analysis Tool
            - 1.2.1.3 Racial Equity Toolkit
    - 1.3 Assess policy and physical accessibility at your facility and work to eliminate barriers for those with disabilities (CMS, 2022).
        - 1.3.1 See How to Improve Physical Accessibility at Your Health Care Facility, CMS
    - 1.4 Develop policies and practices in external service delivery that prioritize and address health equity considerations. This might include policies related to language access, cultural competency training for staff, community engagement, and outreach (CMS, 2022).

1.5 Engage stakeholders, including employees, customers, and community members in the development of health equity policies. This engagement can take the form of focus groups, advisory committees, surveys, or other forms of feedback.

1.5.1 Engage in ongoing community feedback from communities you serve to ensure that your organization is continually meeting their needs and addressing health equity issues.

1.5.2 Regularly communicate with community members about the progress your organization is making towards health equity goals (CDC, 2021).

2. **Promote or inform public policy and practices that support health equity and address health disparities.**

2.1 Consider implementing or utilizing equity impact tools to measure how proposed policies, programs, and plans impact health equity and community health (HIP, 2020). Examples:

2.1.1 A Health Impact Assessment (HIA) Toolkit: A Handbook to Conducting HIA

2.1.2 Racial Equity Impact Assessment

2.1.3 NOMHE's Health Equity Lens

2.2 Promote the use of health impact notes as a tool to inform decision-making or seeking public funds. Health impact notes are similar to fiscal notes but include an assessment of the potential impact of proposed legislation on health outcomes.

2.2.1 See A User's Guide to Legislative Health Notes

2.2.2 See course: Health Notes for Policymakers

2.3 (State/local level) Advocate for a Health in All Policies (HiAP) approach to policymaking, which is an approach that integrates health considerations into decision-making across all sectors and policy areas. HiAP recognizes that social, economic, and environmental factors have a significant impact on health outcomes and seeks to address these factors through policy solutions (APHA, 2022).

2.3.1 Health in All Policies: A Guide for State and Local Governments

2.4 Build or participate in coalitions with organizations and individuals who share a commitment to health equity. This can help amplify your message and build support for policy and practice changes.

2.5 Partner with local communities to understand their priorities, and support policy change to address their priorities.

2.6 Use data to inform policy, including research or testimonies from subject matter experts on health disparities, social determinants of health, and the impact of policies on different populations. Build awareness around the direct link between health outcomes and social, environmental, and economic factors in specific communities, neighborhoods, or within other groups (HIP, 2017).

2.6.1 Share with different audiences, including health departments, healthcare institutions, government agencies, elected officials, and community stakeholders.

2.7 Engage with policymakers at the local, state, and national level to educate them about health equity issues in your community and how changes in policy can impact health equity. This can include attending town hall meetings, writing letters to elected officials, and meeting with policymakers (NACCHO, 2023).

2.7.1 See NACCHO Advocacy Toolkit

2.7.2 See training: Advocacy 101: Navigating the Nevada Legislature

2.8 Support and inform policies that allocate more resources and funding for public health, community-based programs, and social services to ensure that communities have access to the resources and support needed to achieve optimal health.

2.9 Identify and support initiatives and partnerships outside of the formal health system to address the broader social and economic factors that impact community health. Examples may include programs that promote healthy food access, increased access to outdoor recreation, safe housing, transportation, education, or environmental justice (Urban Institute, 2021). Examples:

2.9.1 Park Prescriptions

2.9.2 Community Wellness Hubs

2.9.3 Nevada State Parks Library Park Pass Program

2.10 Be aware of where to find legislative information. Examples:

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

2.10.2 Track Bills through NELIS

2.10.3 NMHEC Resources: What is Advocacy?

Rural Considerations

1. Advocate or support increased healthcare programs, workforce, and facilities in rural areas (CMS, 2022).
2. (State level) Reduce barriers for eligibility to qualify for healthcare programs (i.e., income requirements, coverage, transportation, etc.)
3. (State/local level) Ensure adequate funding to fairly compensate the rural workforce to support community members in rural areas.
4. (State level) Collaborate with federal and local groups to amplify efforts to increase the availability of high-speed internet in rural, tribal, and remote regions to overcome barriers to implementation of health information technology (such as telehealth services) (CMS, 2022).
5. Rural community members and leaders can consider partnering with mobile clinic organizations to bring pop-up clinics to their communities.

    5.1 See Remote Area Medical Volunteer Corps | Bring RAM to Your Community

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

Title	Source
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
Equitable Enforcement to Achieve Health Equity: An Introductory Guide for Policymakers and Practitioners	Change Lab Solutions
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)
Local Solutions Support Center: Resources	Local Solutions Support Center (LSSC)
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
NACCHO Advocacy Toolkit	National Association of County & City Health Officials (NACCHO)
Nevada Legislature	
Prioritize Upstream Policy Change	Human Impact Partners Project
Racial Equity Impact Assessment	Race Forward
Racial Equity Toolkit	Government Alliance on Race & Equity (GARE)
State of Equity: Resources	Public Health Institute
Track Bills Through NELIS	Nevada Electronic Legislative System
Webinar: Non-Partisan Strategies to Advance Health Policy	County Health Rankings

Case Study: Policy Change and Advocacy

Creating Tools to Advance Health in All Policies (HiAP)

Tacoma-Pierce County Health Department, Washington

In 2014, the leaders of the Tacoma-Pierce County Health Department (TPCHD) secured funding to hire a Health Equity Coordinator. This new position was intentionally placed within the Office of the Director and reports directly to the Deputy Director of Health. One of the coordinator's first tasks was to create a health equity team that represented 12 different program areas within the department. The team is responsible for developing strategies, making recommendations, and implementing programs across the department to promote health equity. The team's composition includes representation from all areas of the department, including Environmental Health, Communicable Disease, Strengthening Families, and Administration.

After forming a health equity team consisting of representatives from various programs within the department, the team's first task was to develop a Health Equity Assessment report. Each program had to develop a section of the report standardized by defining the issue they worked on, scope of the problem, data, observed inequities, and maps. The Health Equity Coordinator was the main content editor, and a communications editor reviewed the draft report. While the full report is rarely used or referenced, the report was the impetus for creating maps and a two-page summary, which have been disseminated widely. The Health Equity Assessment two-pager is a simple and straightforward document that summarizes key findings and has become a critical tool to change the narrative around equity. The document illustrates the need for the department to shift from clinical care to social and economic factors.

The Health Equity Coordinator of TPCHD used the maps and 2-pager report to build relationships with various community groups, government agencies, and city governments in Tacoma and Pierce County. Specifically, they focused on building relationships with judges of Pierce County Superior Court, along with transportation and parks agencies. During meetings, the Coordinator asked agencies to reflect on the connection between their work and community health, and encouraged them to adopt a Health in All Policies approach. They suggested using tools like the Health Lens Analysis Tool or conducting a Health Impact Assessment. As a result of these discussions, TPCHD is now working with several agencies on comprehensive land use planning and bringing health data to their decision-making processes.

The Health Equity Coordinator has collected several tools from other organizations and jurisdictions that he shares with city/county departments and agencies to put equity into action both within and outside the health department. Among the most useful tools have been the Health Lens Analysis Tool, the Health Equity Inventory Tool, and the Project Planning Tool:

- **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:

The health department has made tangible changes by shifting towards more data-based work, with authentic community engagement methods, such as prioritizing policies and services based on the highest need areas. Sister agencies have also asked for support to move towards equity in their work, and the health equity tools have helped facilitate reflection and tangible action steps. The department has identified three communities to focus on for the coming year and is committed to working collaboratively with them to address their priorities.

Advice for local health departments:

- Have champions on the inside to lead and support the change within the institution.
- Create a 2 pager that highlights the main messages and statistics about health equity in the community for easier sharing.
- Make a compelling case for why other agencies should be involved in health equity work.
- Reduce barriers to agency participation, such as using low-impact tools like the Health Lens Analysis Tool to identify potential health inequities.
- Don't wait for perfect understanding or presentation of health equity but take action with what is good enough.

To learn more about this case study, click here.

Emergency Preparedness

The COVID-19 pandemic has presented an opportunity to address existing health disparities and underscored the importance of collaboration and specific attention to underserved populations during emergency response. Valuable lessons have been learned, and successes can guide future efforts to ensure equitable response that does not exacerbate health disparities. While there were certainly challenges, the pandemic has provided an opportunity to identify areas for improvement and build upon the progress made. The successful response to COVID-19 in some communities has demonstrated that it is possible to prioritize health equity and ensure that emergency preparedness efforts are tailored to meet the unique needs of all populations.

In addition, recognizing the impact of climate on health and equity in emergency response planning is crucial for addressing future emergencies. By taking a positive, forward-thinking approach to these issues, we can continue to improve our emergency preparedness efforts and ensure that all communities are well-served.

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 been affected by a hazard/disaster, such as tribal, rural, individuals with disabilities, and racial/ethnic minority communities.
     - 1.1.1 Develop Health Equity Advisory Councils of trusted community partners that will improve structural gaps in current and emerging health emergencies.
       - 1.1.1.1 Follow a similar model to that of Michigan Department of Health and Human Services – Health Equity Advisory Councils
   - 1.2 (State/local level) 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 (State/local level) Collaborate with community-based organizations and community members to develop culturally informed, linguistically appropriate outreach, warning systems, and information sharing mechanisms.

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

2.1 (State/local level) Partner with academic and training institutions to create public health workforce reserve programs that can increase workforce capacity during emergencies, including the formation of outbreak investigation centers, disease surveillance teams, and environmental and climate justice teams. Examples:

2.1.1 Award-winning UNLV student-led Contact Tracing Team during the COVID-19 Pandemic

2.1.2 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 communities that are most vulnerable to the health/economic impacts of a crisis.

2.2.1 See the Nevada CHW Association webpage for ways to do this.

2.3 (State/local level) Secure funding for public health and emergency resources to ensure that they are well equipped to address emergencies effectively.

2.4 Accumulate and reserve stock of materials necessary for emergency (i.e., PPE, batteries, communication devices, generators, etc.), and replenish as items expire.

2.5 Emphasize considerations for people with disabilities and/or access and functional needs.

2.5.1 See: People with Access and Functional Needs

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

3.1 Implement or support Community Emergency Response Team (CERT) programs to help educate and prepare citizens for disasters or hazards where they live.

3.1.1 Southern Nevada CERT Courses

3.1.2 Washoe County Sheriff's Office CERT

3.1.3 (State/local level) Consider developing and implementing CERT programs in different languages and geographical locations to promote participation from diverse populations.

3.2 To increase community resilience during emergencies, establish and promote the use of resilience hubs, which are created as partnerships between local governments and nongovernmental organizations, usually housed in trusted, community-managed facilities such as a church or civic

center. Resilience hubs are designed to provide necessary resources and services during emergencies, establishing a safe place to go for local residents and allowing for more efficient and effective response to emergencies.

3.3 Make sure that systems and processes for seeking aid are easily accessible to Limited English Proficiency (LEP) and undocumented citizens by providing forms in multiple languages and removing any barriers that may hinder access, such as relying solely on online registration for appointments, having a website that is difficult to navigate, or requiring a social security number to receive assistance.

3.4 Conduct outreach and educational efforts *before* an incident to inform community members of the risks and challenges associated with geographical location, and/or demographic characteristics.

- 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 Increase community awareness around trainings, supply and readiness checklists, resources, and relief that are available during an emergency. Examples:

- 3.5.1 ready.gov
- 3.5.2 Nevada Division of Emergency Management
- 3.5.3 Basic Preparedness Guide
- 3.5.4 CDC Emergency Preparedness and Response

3.6 Empower individuals to take appropriate actions to mitigate the risk of emergencies or pandemics by developing and sharing targeted preparedness checklists that consider the unique needs of different communities. These checklists should include specific actions that individuals can take to prepare, such as stocking up on medications or supplies for those with chronic illnesses, older adults, and individuals with special needs. Examples:

- 3.6.1 Make a Plan | People with Disabilities
- 3.6.2 Florida's Emergency Preparedness Guide

3.7 Share information on low or no-cost resources available in the community, such as food banks, testing and vaccinations, transportation, shelter, cooling or warming centers, and emergency supplies, along with information on where and how to access these resources.

- 3.7.1 National COVID-19 Resiliency Network

3.7.2 Nevada 211

3.7.3 988 Crisis Support Services of Nevada

3.8 Utilize Emergency Preparedness month (September) as an opportunity to raise awareness and promote education through events, campaigns, and other initiatives about emergency events and hazards, appropriate emergency response, and how to manage emergencies for individuals with functional and accessibility needs, older adults, those who are deaf or hard of hearing, and those located in rural areas.

Rural and Tribal Considerations

1. Have a higher level of involvement from all levels of rural partners including local coalitions, faith communities, individuals, schools, emergency management professionals, local and regional officials, and other collaborators to assess the needs and assets of rural and tribal communities. Use the assessment to develop an effective plan that meets their needs, increases preparedness and response capabilities, and fosters community involvement and resiliency.
    1.1 See FEMA's Whole Community Approach to Emergency Management
    1.2 See FEMA's Guide to Supporting Engagement and Resiliency in Rural Communities
    1.3 See Rural Emergency Preparedness and Response Toolkit for more resources on building and supporting rural emergency preparedness.
2. (State/local level) Expand multidisciplinary disaster training of rural health professionals and community residents to enhance preparedness competencies (Haskins, et al., 2019).
    2.1 Example: expand CERT programs to rural areas.
    2.2 See: Emergency Preparedness for Rural Communities Policy Paper

Climate/Environmental Considerations

1. Utilize mapping tools to identify potential risks and vulnerable areas in relation to climate and environmental hazards. This information can then be used to develop strategies to mitigate the impact of such hazards on affected areas and communities. Examples:
    1.1 Southern Nevada Extreme Heat Vulnerability Webmap
    1.2 EPA's Environmental Justice Screening and Mapping Tool
    1.3 Tools and Information

1.4 Climate and Economic Justice Screening Tool

1.5 FEMA National Risk Index

1.6 CDC Environmental Justice Index Explorer

2. (State/local level) Integrate climate justice considerations into emergency preparedness plans. This can include planning for extreme weather events, addressing the impact of climate change on public health, and ensuring that emergency shelters are located in areas that are accessible to all. Example:

   2.1 See NOAA's Withering Daisy Report as a framework for creating and implementing a multi-sector improvement plan to address climate concerns in local jurisdictions.

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

   3.1 See Moving Forward: A Guide for Health Professionals to Build Momentum on Climate Action

4. Promote messaging that educates communities on climate-related issues in the state and how to conserve, preserve, and manage the risks associated with climate-related events such as extreme heat, fires, drought, flood, and other environmental hazards. Examples:

   4.1 Let's Talk Health and Climate: Communication Guidance for Health Professionals

   4.2 Extreme Heat Resources

   4.3 Saving Water in Nevada

   4.4 Climate Effects on Health, CDC

5. Advocate and support programs and policies that address the root causes of environmental injustice, such as clean energy and sustainable development practices that reduce environmental impacts on vulnerable communities.

Additional Resources

Title	Source
A Guide to Supporting Engagement and Resiliency in Rural Communities	Federal Emergency Management Agency (FEMA)

A Whole Community Approach to Emergency Management: Principles, Themes and Pathways for Action	Federal Emergency Management Agency (FEMA)
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 Resources	Division of Emergency Management (DEM)
Helpful Preparedness Information	Division of Emergency Management (DEM)
FEMA.gov	Federal Emergency Management Agency (FEMA)
People with Access and Functional Needs	Substance Abuse and Mental Health Services Administration (SAMHSA)
Plan Ahead Nevada – Preparedness Information	Division of Emergency Management (DEM)
Plan Ahead Nevada: Emergency Preparedness Guide	Division of Emergency Management (DEM)
Recovery Resources	Federal Emergency Management Agency (FEMA)
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

Multi-Language Warning and Information Project
Northern Nevada International Center (NNIC) and Washoe County

In 2016, the Language Bank at the Northern Nevada International Center (NNIC) collaborated with Washoe County Emergency Management to implement a Multi-Language Warning and Information Program. The purpose of this program was to deliver vital outreach and services to help people with limited or low English proficiency to become healthier, safer, and more prepared for future emergencies. The program focused on five languages: ASL, English, Spanish, Tagalog, and Mandarin/Cantonese. The project focused on public service announcements for the three most prominent hazards in the region: earthquakes, floods, and wildfires.

Recognizing the importance of interpreters in emergency situations, the project kicked off with an event called "Emergency Roles for Interpreters," where interpreters, emergency managers, and the Red Cross came together to discuss the significant role of interpreters during an emergency. At the event, interpreters also participated in workshops to help identify appropriate and effective ways to communicate messages with diverse communities.

The NNIC also conducted town halls and focus groups with members of target communities to understand how they perceived emergencies and how their local jurisdictions supported them during emergencies in the past. The focus groups revealed that infographics were the most effective way to communicate a message, as images are universally understood regardless of English proficiency. Town halls also revealed that residents from other countries did not feel the need to take action to mitigate risks because they believed the U.S. to be a very safe country that would provide adequate assistance in case of emergencies. Findings such as these became paramount to the development of informational materials and outreach to diverse communities.

Using the findings from the focus groups, NNIC developed informational materials, including infographics in plain English, as well as public service announcements in multiple languages. They continually solicited feedback from the community on what was missing and what was needed in the materials. They displayed and shared their work at existing community events with Hispanic/Latino and Asian American communities. After completing the project, they continued to share the message through visual and audio PSAs disseminated via communication channels like Chinese and Spanish radio stations.

The project was presented at the Public Information/Public Warning Nevada Statewide Training Conference in 2017 by the language access specialist of NNIC. The Multi-Language Warning and Information Project was recognized nationally and awarded by the International Association of Emergency Managers (iAEM).

Watch the public service announcement YouTube videos here.
To learn more about the Multi-Language Warning and Information Project click here.

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, institutions, and organizations 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 non-profits 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.

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Appendix A: Key Informant Interview Questions

NOMHE Health Equity Action Plan Key Informant Interview Questions

For Health Equity/DEI Experts:

Key Informant Name:
Key Informant Organization:

General Interview Questions:

- What does health equity mean to you? Your work? How do you define health equity?
- In your work, have you implemented practices, policies, or processes that work towards health equity?
    - If yes: What was it? What was successful? Challenges? Resources needed?
    - If no: Are there any areas in your work you would like to implement practices, policies, or processes that work towards health equity? What is it? Is there a reason it has not yet been implemented? (i.e., need resources, do not know how to start, etc.)
- Did COVID-19 impact your work? How? Did it cause a change in focus or delivery?
- What do you think are some guiding principles of health equity that have helped you in your practice? Please explain.
- What do you think when you hear 'Build Organizational Capacity' or 'Build Capacity of an Organization'? What do you think is needed to do this (processes, personnel, resources)? What is challenging? How do you think building organizational capacity can impact health equity?
- Do you currently work with the community in your work?
    - If YES: In what capacity - is it a dynamic partnership? What is successful? What is challenging? Do you think there is more you can do with this partnership?
    - If NO: Are there areas in your work you think you could work with the community? Why or why not?
- Are there any resources you have already used to help learn about or implement health equity in your work?

For Representatives of Diverse Groups/Community Leaders/ Those Serving Minority Groups:

Key Informant Name:
Key Informant Role/Organization:
Tell me about your organization (mission, vision, goals, services provided):

- What does health equity mean to you? Your work? How do you define health equity?
- In your work, have you implemented practices, policies, or processes that work towards health equity?
    - If yes: What was it? What was successful? Challenges? Resources needed?
    - If no: Are there any areas in your work you would like to implement practices, policies, or processes that work towards health equity? What is it? Is there a reason it has not yet been implemented? (i.e., need resources, do not know how to start, etc.)
- Who are the primary populations you serve?
- What are the top 2-3 challenges that the populations you serve have?
    - How have you worked to address these challenges? What has been successful? Challenges?
- Did COVID-19 impact your work? How? Did it cause change in focus or delivery?
    - How did your organization respond to the impacts of COVID in your community? What were some challenges? Outcome(s)?
    - What do you think are some barriers for the population you serve during an emergency?
- Do you partner with other organizations in your work?
    - If YES: In what capacity - is it a dynamic partnership? What is successful? What is challenging? Do you think there is more you can do with this partnership?
        - What has made that partnership so successful?
    - If NO: Are there areas in your work you think you could work with the community? Why or why not?

- How does your organization stay informed about the needs of the community? Do you have a process in place that helps to inform your organization about what the community needs? (Needs assessments, key informants, town halls, surveys, focus groups etc.)
    - How do people of minority/marginalized communities learn about your services? (i.e., outreach, word of mouth, advertisements in preferred language, etc.)
    - Does the community have input in how you deliver your services?
- What media, tools, methods are you using to communicate educational messages with the populations you serve? What is working? What are challenges?
- What do you think are some things the state can do to improve health outcomes for the populations you serve? (i.e., advocate for legislation, enhance partnerships/engagement, increase education/awareness, more inclusive communication, and data collection. etc.)

Additional:

- Any other groups I should talk to/engage with?
- Are there any resources you have already used to help learn about or implement health equity in your work?

Questions for Emergency Preparedness subject matter experts:

Key Informant Name:
Key Informant Role/Organization:

- What does health equity mean to you? Your work? How do you define health equity?
- What does emergency preparedness mean to you/your work? How do you define emergency preparedness?
    - What constitutes a public health emergency?
- Who is involved in emergency preparedness? Do you currently work with members of the community or other partners in your work?
    - If YES: In what capacity - is it a dynamic partnership? What is successful? What is challenging? Do you think there is more you can do with this partnership?
    - If NO: Are there areas in your work you think you could work with the community? Why or why not?
- In your work, have you implemented practices, policies, or processes that work towards health equity?
    - If yes: What was it? What was successful? Challenges? Resources needed?
    - If no: Are there any areas in your work you would like to implement practices, policies, or processes that work towards health equity? What is it? Is there a reason it has not yet been implemented?
- How did COVID-19 impact your work? Did it cause a change in focus or delivery?
    - How effective do you think was Nevada's response to COVID-19 in regards to serving the most underserved and vulnerable populations? How did it highlight health disparities in NV? What were challenges? Successes? Resources?
- In your opinion, what does public health emergency preparedness require? What are some key elements or actionable steps for emergency preparedness? What does a prepared community look like?
    - If an organization wants to prepare for an emergency, who can they contact? What are some resources, training, etc. that can help?
- What are unique considerations for emergency preparedness in your work with the state of Nevada (climate, healthcare, geography, transportation, etc.)? Challenges? Advantages? Resources?

Additional:

- In your work, how have you referenced priority populations? What does emergency response look like when considering the different groups that are disproportionately affected? What has been done to ensure that members of minority groups and underserved populations are prioritized? What is successful? Challenging? Resources?
- Are there additional subject matter experts that you believe I should talk to?
- Are there existing emergency preparedness plans in Nevada? Where can they be found?

Questions for Language Access experts:

Key Informant Name:
Key Informant Role/Organization:

- What does health equity mean to you? Your work? How do you define health equity?
- What does language access mean to you? How do you define language access?
    - Option: What are some things an organization should consider when planning for language accessibility?
- In your work, have you implemented practices, policies, or processes that work towards health equity?
    - If yes: What was it? What was successful? Challenges? Resources?
    - If no: Are there any areas in your work you would like to implement practices, policies, or processes that work towards health equity? What is it? Is there a reason it has not yet been implemented?
- Did COVID-19 impact your work? How? Did it cause a change in focus or delivery?
- Are you familiar with the National CLAS Standards? If so, how have you implemented this in your work? What has been successful? Challenges? Resources needed?
- What media, tools, methods are you using to communicate educational messages with the populations you serve? What is working? What are challenges? Resources needed?
- Do you currently work with the community in your work? Does the community have input in how you deliver your services? Do you partner with other organizations in your work?
    - If YES: In what capacity - is it a dynamic partnership? What is successful? What is challenging? Do you think there is more you can do with this partnership?
        - What has made that partnership so successful?
    - If NO: Are there areas in your work you think you could work with the community? Why or why not?
- Do you have a process in place that helps to inform your organization about the language access needs of the community? (Town halls, surveys, focus groups etc.).

Additional:

- Are there any resources you have already used to help learn about or implement health equity and/or language access in your work?
- Are there additional subject matter experts that you believe I should talk to about communication/language access for members of minority groups?

Appendix B: Resources

Resource Name	Authors	HEAP Areas Covered	Pages Referenced
Datasets, Reports, Indexes			
Behavioral Risk Factor Surveillance System (BRFSS)	Centers for Disease Control & Prevention (CDC)	Data	35
Climate and Economic Justice Screening Tool	Council on Environmental Quality	Data, Emergency Preparedness	68
Data Dashboards & Reports Catalog	Nevada Office of Analytics	Data	32, 35
Data, Publications, and Reports	Washoe County Health District	Data	35
Environmental Justice Index Explorer	Centers for Disease Control & Prevention (CDC)	Data, Emergency Preparedness	68
Environmental Justice Screening and Mapping Tool	United States Environmental Protection Agency (EPA)	Data, Emergency Preparedness	68
Food Insufficiency Among Transgender Adults During the COVID-19 Pandemic	UCLA School of Law Williams Institute	Data	35
National Risk Index	Federal Emergency Management Agency (FEMA)	Data, Emergency Preparedness	68
Health Workforce in Nevada: A Chartbook	Nevada Health Workforce Research Center	Data	35
Healthy Southern Nevada	Southern Nevada Health District	Data	35
Improving Nevada's Public Health	Nevada Office of State Epidemiology	Data	32
Minority Health Report 2021	Nevada Office of Analytics	Data	32, 35, 43
Monitoring COVID-19 in Nevada	Nevada Health Response	Data, Emergency Preparedness	32, 35
Nevada Community Health Profiles	Nevada Office of Analytics	Data	32, 35

Nevada County Health Rankings	County Health Rankings & Roadmaps	Data	32, 35
Nevada Rural and Frontier Health Data Book	Office of Statewide Initiatives, University of Nevada, Reno	Data	34
Physician Workforce in Nevada: A Chartbook	Nevada Health Workforce Research Center	Data	35
Recommendations on the Best Practices for the Collection of Sexual Orientation and Gender Identity Data	The White House	Data	35
Social Vulnerability Index (SVI)	Centers for Disease Control & Prevention (CDC)	Data, Emergency Preparedness	32, 35, 70
Southern Nevada Community Health Assessment Report 2020/2021	Southern Nevada Health District	Data	32
Southern Nevada Extreme Heat Vulnerability Webmap	Regional Transportation Commission of Southern Nevada (RTC)	Emergency Preparedness	68, 70
Tools and Information	National Integrated Heat Health Information System (NIHHIS)	Data, Emergency Preparedness	68
Washoe County Community Health Assessment 2022-2025	Washoe County Health District	Data	32
Youth Risk Behavior Surveillance System (YRBSS)	Centers for Disease Control and Prevention (CDC)	Data	35
Trainings and Courses			
Advocacy 101: Navigating the Nevada Legislature	Nevada Minority Health & Equity Coalition (NMHEC)	Policy Change and Advocacy	59
Building Capacity Workshop Series	Nevada Minority Health & Equity Coalition (NMHEC)	Building Capacity	39
Catalyzing Cross-Sectoral Partnerships and Community Engagement	CDC Foundation, NACCHO, ASTHO, Big Cities Health Coalition	Community Engagement	47
Community Based Participatory Research (CBPR) Training: Example of CBPR in Action	Nevada Minority Health & Equity Coalition (NMHEC)	Data, Community Engagement	47

Community Based Participatory Research (CBPR) Training: What is CBPR?	Nevada Minority Health & Equity Coalition (NMHEC)	Data, Community Engagement	47
Training Information	Division of Emergency Management (DEM)	Emergency Preparedness	69
Environmental Justice Training Resources	U.S. Department of the Interior	Emergency Preparedness	70
Health Equity and Social Justice Trainings	National Association of County and City Health Officials (NACCHO)	Building Capacity	39
Health Equity Training Modules	Population Health Institute	Building Capacity	39
Health Notes for Policymakers	Making Health Happen	Policy Change and Advocacy	58
Making Health Happen	School of Public Health, University of Nevada, Reno	Building Capacity	39
Southern Nevada CERT Courses	City of Las Vegas	Emergency Preparedness	66
Washoe County Sheriff's Office CERT	Washoe County Sheriff's Office	Emergency Preparedness	66
Webinar: Non-Partisan Strategies to Advance Health Policy	County Health Rankings	Policy Change and Advocacy	61
Tools, Toolkits, Frameworks, and Guides			
A Step-By-Step Guide to Community Based Participatory Research	Nevada Minority Health & Equity Coalition (NMHEC)	Data, Community Engagement	32, 33, 47, 55, 56
A Practical Guide to Implementing the National CLAS Standards	Centers for Medicare and Medicaid Services (CMS)/Office of Minority Health (OMH)	Language Access	53
A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease	Centers for Disease Control and Prevention (CDC)	Building Capacity, Community Engagement, Policy Change and Advocacy	42, 60
A Health Impact Assessment (HIA) Toolkit: A Handbook to Conducting HIA	Human Impact Partners	Policy Change and Advocacy	58

A Guide to Supporting Engagement and Resiliency in Rural Communities	Federal Emergency Management Agency (FEMA)	Community Engagement, Emergency Preparedness	48, 68
A User's Guide to Legislative Health Notes	Health Impact Project	Policy Change and Advocacy	58
A Whole Community Approach to Emergency Management	Federal Emergency Management Agency (FEMA)	Emergency Preparedness	68
Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the LGBTQ Community: A Field Guide	The Joint Commission	Language Access, Building Capacity	41, 52, 54
Advancing Racial Equity and Transforming Government: A Resource Guide to Put Ideas into Action	Government Alliance on Race and Equity (GARE)	Building Capacity	41
An Implementation Checklist for the National CLAS Standards	U.S. Department of Health and Human Services Office of Minority Health	Language Access	53
Amplify Equity Toolkit: Outreach and Public Awareness Strategies	Nevada Office of Minority Health and Equity (NOMHE)	Building Capacity, Community Engagement	47
Applying Social Determinants of Health Indicator Data for Advancing Health Equity: A Guide for Local Health Department Epidemiologists and Public Health Professionals	Bay Area Regional Health Inequities Initiative (BARHII)	Data	35
Basic Preparedness Guide	Federal Emergency Management Agency (FEMA)	Emergency Preparedness	67
Changing Power Dynamics among Researchers, Local Governments, and Community Members: A Community Engagement and Racial Equity Guidebook	Urban Institute	Community Engagement	47
Choice Point Thinking: A Guide to Applying Nevada's Health Equity Lens	Nevada Office of Minority Health & Equity (NOMHE)	Building Capacity, Policy Change and Advocacy	40, 58, 61

Community Engagement Assessment Tool	Nexus Community Partners	Community Engagement	47
Community Voice and Power Sharing Guidebook	Urban Institute	Community Engagement	47
Community Wellness Hubs: A Toolkit for Advancing Community Health and Well-Being Through Parks and Recreation	National Recreation and Parks Association	Building Capacity, Community Engagement, Policy Change and Advocacy	59
Disaggregation of Public Health Data by Race & Ethnicity: A Legal Handbook	The Network for Public Health Law	Data, Policy Change and Advocacy	35
Diversity, Equity, and Inclusion Resource Snapshot Guide	Disability Employment Technical Assistance Center (DETAC)	Building Capacity	42
Emergency Operations Planning and NIMS Compliance Guide for Local Jurisdiction Emergency Planners	Division of Emergency Management (DEM)	Emergency Preparedness	69
Engaging Your Community: A Toolkit for Partnership, Collaboration, and Action	John Snow, Inc. (JSI)	Community Engagement	47
Ensuring Equity in COVID-19 Planning, Response, and Recovery Decision Making: An Equity Lens Tool for Health Departments	Human Impact Partners	Emergency Preparedness	70
Equitable Enforcement to Achieve Health Equity: An Introductory Guide for Policymakers and Practitioners	Change Lab Solutions	Policy Change and Advocacy	60
Equity Diversity Inclusion: A Toolkit for Organizations	American Public Health Association (APHA)	Building Capacity	43
Framework for Health Equity 2022-2032	Centers for Medicare and Medicaid Services (CMS)	Policy Change and Advocacy	60
Guide to Developing a Language Access Plan	Centers for Medicare & Medicaid Services (CMS)	Language Access	52
Health Equity in the Workplace: A Toolkit for Advancing Equity at the Organizational Level	Larson Institute for Health Impact and Equity	Building Capacity, Policy Change and Advocacy	40, 42, 57

Health Equity Inventory Tool	Tacoma-Pierce County Health Department	Policy Change and Advocacy	57, 63
Health in All Policies: A Framework for State Leadership	Association of State and Territorial Health Officials (ASTHO)	Policy Change and Advocacy	60
Health in All Policies: A Guide for State and Local Governments	American Public Health Association and Public Health Institute	Policy Change and Advocacy	58
Health Lens Analysis Tool	Tacoma-Pierce County Health Department	Policy Change and Advocacy	57, 63
How to Improve Physical Accessibility at Your Health Care Facility	Centers for Medicare & Medicaid Services (CMS)	Policy Change and Advocacy	57
Inclusive Outreach and Public Engagement Guide	Race and Social Justice Initiative	Community Engagement	47
Language Justice Toolkit	Communities Creating Healthy Environments (CCHE)	Language Access	53
Let's Talk Health and Climate: Communication Guidance for Health Professionals	ecoAmerica and Climate for Health	Emergency Preparedness	69
Moving Forward: A Guide for Health Professionals to Build Momentum on Climate Action	ecoAmerica and Climate for Health	Emergency Preparedness	69
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	Data, Community Engagement, Policy Change and Advocacy	60
Meyer DEI Spectrum Tool	Meyer Memorial Trust	Building Capacity	42
NACCHO Advocacy Toolkit	National Association of County and City Health Officials (NACCHO)	Policy Change and Advocacy	59
National CLAS Standards	U.S. Department of Health and Human Services Office of Minority Health	Language Access	53
Nevada Language Access Toolkit	Nevada Initiative for Language Access (NILA)	Language Access	52

Organizational Race Equity Toolkit	JustLead Washington	Building Capacity	41, 43
Organizational Self-Assessment for Achieving Health Equity	Bay Area Regional Health Inequities Initiative (BARHII)	Building Capacity	40, 42
Plan Ahead Nevada: Emergency Preparedness Guide	Division of Emergency Management (DEM)	Emergency Preparedness	69
Principles of Community Engagement	Centers for Disease Control and Prevention (CDC)	Community Engagement	47
Racial Equity Action Plans: A How-To Manual	Government Alliance on Race & Equity (GARE)	Building Capacity, Policy Change and Advocacy	40, 42
Racial Equity Impact Assessment	Race Forward	Policy Change and Advocacy	58
Racial Equity Toolkit	Government Alliance on Race & Equity (GARE)	Building Capacity, Policy Change and Advocacy	40, 57, 61
Recommendations on the Best Practices for the Collection of Sexual Orientation and Gender Identity Data	The White House	Data	33
Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool	National Academy of Medicine	Data	33
State of Nevada Language Access Toolkit	Nevada Initiative for Language Access (NILA)	Language Access	54
Strategic Framework for Emergency Preparedness	The World Health Organization (WHO)	Emergency Preparedness	69
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	Language Access, Emergency Preparedness	69
Tribal Workforce Development: A Decision Framing Toolkit by National Congress of American Indians	National Congress of American Indians	Building Capacity	41
Withering Daisy Report	National Oceanic and Atmospheric Administration (NOAA)	Emergency Preparedness	69

Resources			
988 Crisis Support Services of Nevada		Building Capacity, Community Engagement, Emergency Preparedness	46, 68
ADA remediation	State of Nevada ADA Assistance	Language Access	53
ASL Anywhere		Language Access	51, 54
Bring RAM to Your Community	Remote Area Medical Volunteer Corps	Policy Change and Advocacy	60
Climate Effects on Health	Centers for Disease Control & Prevention (CDC)	Emergency Preparedness	69
Communication Access Resources (CAS)	Nevada DHHS Aging and Disability Services Division (ADSD)	Language Access	51, 54
COVID-19 Tribal Resource Center	National Indian Health Board	Building Capacity, Policy Change and Advocacy	60
Disaster Behavioral Health Resources	Substance Abuse and Mental Health Services Administration (SAMHSA)	Emergency Preparedness	68
Emergencies, Disasters, and Climate Resilience Resources	World Institute on Disability	Emergency Preparedness	69
Emergency Preparedness and Response	Centers for Disease Control & Prevention (CDC)	Emergency Preparedness	67
Emergency Preparedness for Rural Communities Policy Paper	National Rural Health Association (NRHA)	Emergency Preparedness	68
Extreme Heat Resources	Nevada Division of Emergency Management	Emergency Preparedness	69
FEMA.gov	Federal Emergency Management Agency (FEMA)	Emergency Preparedness	69
Frequently Used Language Access Terms and Definitions	Nevada Initiative for Language Access (NILA)	Language Access	53
Health Equity Guiding Principles for Inclusive Communication	Center for Disease Control and Prevention (CDC)	Language Access	53
HealthEquityGuide.org	Human Impact Partners	Data, Build Capacity, Community Engagement,	41, 60

		Policy Change and Advocacy	
Health Matters Campaign	Nevada Minority Health & Equity Coalition (NMHEC)	Building Capacity, Language Access	53
Helpful Preparedness Information	Division of Emergency Management (DEM)	Emergency Preparedness	69
Inter-Tribal Council of Arizona Tribal Epidemiology Center	Tribal Epidemiology Centers	Data	34
Inter-Tribal Council of Nevada	ITCN	Building Capacity, Community Engagement	59
Local Solutions Support Center: Resources	Local Solutions Support Center (LSSC)	Policy Change and Advocacy	60
Languages and Country of Origin	Nevada Initiative for Language Access (NILA)	Language Access	53
Legislative Information	Nevada Governor's Council on Developmental Disabilities	Policy Change and Advocacy	59
More Language Access Resources	Nevada Initiative for Language Access (NILA)	Language Access	53
National Community Health Worker Association (NCHWA)	NCHWA	Building Capacity, Community Engagement	38, 41, 46, 66
National COVID-19 Resiliency Network	NCRN	Building Capacity, Community Engagement, Emergency Preparedness	46, 67
Nevada 211	Nevada Department of Health and Human Services (DHHS)	Building Capacity, Community Engagement, Emergency Preparedness	43, 46, 68
Nevada Diversity and Inclusion Liaisons (DILs)	State of Nevada	Building Capacity	39, 42, 46
Nevada Division of Emergency Management	State of Nevada	Emergency Preparedness	67
Nevada Indian Commission	NIC	Building Capacity	60
Nevada Legislature	State of Nevada	Policy Change and Advocacy	60
Nevada Minority Health & Equity Coalition (NMHEC)	NMHEC	Building Capacity, Community Engagement,	32, 39, 45, 47, 56, 59

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