12-2022

Monterey County Health Department Health Equity Plan

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December 12, 2022

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Abstract

The Monterey County Health Department (MCHD) is working to create a health equity strategy that would effectively integrate equity practices and establish a roadmap for the department's long-term sustainability of health equity initiatives. Despite decades of acknowledgement of health inequalities and legislative demands to remove them, racial/ethnic minority, rural, and low-income people in the United States continue to have inadequate access to and quality of health care. Many health-care efforts intended to achieve health equity fall short due to knowledge and translation barriers. This project analyzes these inadequacies and emphasizes novel strategies that can help fill them, and also provide recommendations for furthering the area of health equity and guiding the implementation and assessment of policies that aim to reduce health inequalities by improving the quality and accessibility of services. Components will include efficiency of service delivery and support methods, equity in policies and practices, and planning and collaboration strategies that promote equity. It may also contain means for more completely developing a health equity structure within MCHD, such as a strategy for integrating a Health Equity Officer/Office structure inside MCHD to oversee MCHD's health equity activities in the future.

Keywords: health equity, gender inequity, disadvantaged, life expectancy, ethnic minority, public health

Agency & Communities Served

The Monterey County Health Department exists to enhance, protect and improve the health of the people in Monterey County. To accomplish this, the Department provides a wide variety of health-related services in the areas of public health, environmental health, behavioral health and clinic services.

Empower the community to improve health through programs, policies, and activities. Enhance community health and safety by emphasizing prevention. Ensure access to culturally and linguistically appropriate, customer friendly services. Engage Health Department workforce and improve operational functions to meet current and developing population health needs. MCHD is committed to ongoing professional development through mandatory and voluntary learning opportunities that are developed and delivered through the County's Learning and Development Network, the department itself, professional associations, and external providers.

Monterey County Health Department (MCHD) seeks to develop a health equity plan that operationalizes equity practices and provides a roadmap for the long-term sustainability of the department's health equity efforts. Components will include strategies on workforce capacity and supports, equity in policies and practices, planning and partnership approaches that strengthen equity (Monterey County 2022).

Problem Description

Problem Statement

The MCHD Framework for Health Equity serves as a solid foundation for our work as a leader and trusted partner committed to promoting health equity, extending coverage, and improving health outcomes. This involves enhancing our infrastructure for evaluation, creating economies of scope across the health care system to continue driving structural change, identifying and working together to eliminate barriers to MCHD-supported advantages, services, and insurance for communities plus individuals who are under resourced or underprivileged, as well as those who support them. Throughout our Centers and Offices, we are committing to an integrated, action-oriented strategy to advancing health equality among underserved or disadvantaged community people, providers, plans, and other organizations serving such populations (CMS, 2022). We endeavor to recognize and address systemic barriers to equity to ensure that everyone we serve has an equitable and just opportunity to achieve their optimal health, regardless of their race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes. This Foundation pushes us to make health equality and initiatives to reduce health inequalities a basic component of all of our work, in all programs, and in all communities. We are constructing, integrating, and operationalizing policies and programs that promote health for all people represented by our initiatives, minimizing preventable disparities in health outcomes encountered by individuals who are disadvantaged or underrepresented, and supplying our registrants with the care and support they require to flourish (Monterey County Health Department, 2018)

Gender inequity

Gender describes the socially constructed attributes of men, women, girls, and boys. This encompasses conventions, behaviors, and roles connected with being a woman, man, girl, or boy, as well as connections with one another. Gender, being a social construct, differs from society to society and can change over time. Gender is hierarchical, resulting in inequities that connect with other social and economic inequities. Gender discrimination connects with various forms of prejudice, including race, financial position, handicap, age, geographic location, gender identity, and sexual orientation, among others. This is referred to as intersectionality (World Health Organization, NA). Gender inequality contributes to glaring health inequities for women and LGBTQIA+ individuals throughout the world, who face particular health challenges and hurdles to care. Maternity and delivery, sexual and gender-based assault, and breast and cervical cancer are just a few of the illnesses that require specialized, high-quality treatment. However, in low-income communities, such treatment is frequently unavailable. Where it exists, disadvantaged people may be unable to use it due to a slew of impediments ranging from a lack of educational and economic opportunity to a lack of autonomy and personal safety (Partners In Health, 2020).

Race & Ethnicity

Deep racial and ethnic gaps in health and well-being have long been the standard in the United States. Black and American Indian/Alaska Native (AIAN) individuals live less years on average than white people. They are also more likely to pass away from curable diseases, to die during or after pregnancy and to experience major pregnancy-related problems, which results in losing babies in infancy. Black and AIAN persons are also more likely to have a variety of

chronic health issues, ranging from diabetes to hypertension. The COVID-19 epidemic has further exacerbated the situation, with average life expectancy for Black, Latinx/Hispanic, and, most likely, AIAN individuals declining more severely than for white people (The Commonwealth Fund, 2021). Blacks, American Indians, Native Hawaiians and other Pacific Islanders, low socioeconomic status Asian communities, and Latinos born in the United States all tumble into an unfortunate classification compared to whites. They face illnesses earlier, experience illnesses more severely, deal with more rapid progression of illnesses, and suffer higher rates of impairment and death. Many of these issues arise before people seek treatment from the health-care system. This is due to their socioeconomic situation. Hispanics earned 70 cents for every dollar earned by whites in household income, while Blacks earned only 59 cents. These economic gaps influence where individuals live, learn, work, play, and worship, and all of these variables can have an impact on health For example, if blacks or other nonwhites can only manage to reside in impoverished areas, they may be more exposed to harmful substances or have restricted access to health care or good meals (Harvard, 2015).

Disability Status

In 2016, an estimated one in every four individuals in the United States, or 61 million people, reported having a disability. People with impairments (such as limited mobility, hearing and blindness, or cognitive disabilities) confront several obstacles to maintaining optimal health and getting high-quality health care. According to 2019 data, individuals with disabilities have less access to health care, greater depression and anxiety, participate in dangerous health behaviors such as smoking, and are less physically active than people without disabilities (CDC,

2019). Although there are significant variations in health outcomes between those with and without disabilities, they are sometimes rejected with the claim that they do not represent actual inequities. The circular arguments fall into one of two categories: (1) These inequalities are created by the disease that caused the disability—"they're disabled, of course their health is bad"—or (2) the poor health was there first and then led to the functional limitation—"how can you know which happened first?" The health disparities reported in disabled groups are more complicatedly determined than these theories imply. Some of the identified discrepancies are likely attributable to the situation (causal circularity); the essential point is that a closer look is required to determine those variances within this population that are avoidable and unfair. The research available shows that disabled individuals fit all of the requirements for a disparity group. They had a history of social, economic, and environmental disadvantages in which disabled children and adults were institutionalized and neglected. They have identified variations in population health outcomes due to greater rates of unmet health care requirements, harmful lifestyle choices, mental health and chronic illnesses, and socioeconomic determinants of poor health. Finally, many of these disparities are acknowledged to be preventable and disproportionately impact this demographic (Krahn, Walker, & De-Araujo 2015).

Shorter lifespans

Gender inequity and discrimination against women and girls endangers their health and well-being. Access to health information and services is frequently more difficult for women and girls than for men and boys. Mobility restrictions; inability to have access to judgment power; relatively low literacy rates; unequal treatment of community members and healthcare

professionals; and a lack of training and consciousness among healthcare providers and health systems of the particular health requirements and difficulties of women and girls are among these barriers. As a result, women and girls are more likely to experience unwanted pregnancies, sexually transmitted illnesses such as HIV, cervical cancer, malnutrition, poor vision, respiratory infections, starvation, and elder abuse, among other things. Women and girls are also subjected to unacceptable levels of violence as a result of gender inequity and they are particularly vulnerable to harmful practices such as female genital mutilation, child, early, and forced marriage(WHO,2019). According to WHO statistics, almost one in every three women globally has suffered physical and/or sexual intimate relationship abuse or non-partner sexual violence throughout their lifespan (Year). Negative gender norms, particularly those associated with inflexible ideals of masculinity, can have a severe impact on boys' and men's health and well-being. Particular concepts of masculinity, for example, may encourage boys and men to smoke, take sexual and other health risks, abuse alcohol, and avoid seeking help or health care. Such gender norms also lead to boys and men perpetrating violence and becoming victims of violence. They may also have serious consequences for their mental health. Restrictive gender standards also harm individuals with various gender identities, who are frequently subjected to violence, stigma, and discrimination as a result, especially in hospital settings. As a result, individuals are more likely to get HIV and develop mental health issues, including suicidal ideation (WHO, 2019).

Greater likelihood of poor health and diseases.

According to the Centers for Disease Control and Prevention, preventive treatment can have a significant influence on health outcomes and life expectancy. The frequency with which people receive this crucial care varies substantially by race and ethnicity. When compared to their White counterparts, individuals of several racial and ethnic minority groups across the US have greater likelihood of poor health and disease for a variety of medical disorders, such as diabetes, hypertension, obesity, asthma, heart disease, cancer, and preterm birth. According to older statistics from 2016, around 69% of Hispanic Americans have a primary care provider, the lowest rate of any race or ethnic group. A primary care provider is used by 71% to 73% of Black, American Indian, and Asian Americans. Native Hawaiians have the greatest percentage, estimated to be over 82% (USA facts, NA). Another indicator of whether an individual is getting the appropriate preventative treatment is if they received the yearly flu shot. In 2020, the majority of white and Asian individuals received the flu vaccination, while fewer than half of all adults in every other racial or ethnic group received it. Vaccination rates varied from around 69% for Asian children to approximately 48.3% for American Indian or Alaska Native children (USA facts, 2022).

Lower rates of screening, delayed care, and difficulty accessing services.

People with disabilities have a lot to overcome, it only do they have to deal with their own disabilities but also deal with other hurdles that come with being disabled like lower rates of screening, delayed care, and more difficulty accessing services. The future of health equity studies and policies must be comprehensive and intersectional, and it must incorporate disability. Many basic reasons might obstruct the route to equity. People with disabilities may face the same

sorts of systemic hurdles to health as women, racial and ethnic minorities, and members of the lesbian, homosexual, bisexual, transgender, and queer community, such as stigma and discriminatory regulations. However, additional obstacles in access and accessibility emerge that are particular to the disability population, such as physical barriers and gaps in knowledge and collaboration. We will not achieve this aim until persons with disabilities are included in all efforts to enhance health equity (Swenor, 2021). Even though disability is widespread, health inequities for this population remain largely neglected. People with disabilities are more likely than others to be denied health treatment, and they face additional challenges and stigma while seeking care. These ongoing inequities are exacerbated in part by an outdated understanding of disability as the total opposite of health. As a result, the majority of public health and medical research efforts are focused on disability treatment and prevention. Whilst attempts to prevent and cure illnesses and ailments are always vital and necessary, this narrow emphasis fosters stigma, ableism, and injustices within the disability community. It is critical to do research targeted at improving the health and inclusion of persons with disabilities (Swenor, 2021)

Contributing Factors	**Problem**	**Consequences**
Factor 1: Gender inequity	One sentence problem definition : Health is often associated with factors such as social position, race, ethnicity, gender, religion,	Consequence 1: Shorter lifespans
Factor 2: Race & Ethnicity		Consequence 2 : Greater likelihood of poor

	sexual identity, or disability which all leads to health inequity.	health and diseases.
Factor 3: Disability Status		Consequence 3 : Lower rates of screening, delayed care, and difficulty accessing services.

Project Description

Working Title: Monterey County Health Department Health Equity Plan

Project Description

Health equity entails ensuring that everyone has an equal opportunity to be as healthy as possible. However, issues beyond a person's control, such as inequity and a lack of resources, might hinder them from attaining their optimal health. Pushing toward health equity is one strategy to address or combat these issues. Health equity is ensuring that everyone has the chance to attain optimal health.

Health is affected by various factors, including those beyond an individual's control. Thus, a person's access to and continuing use of excellent health practices and treatment can be hampered by a variety of social and environmental factors. These are health disparities. Examples of these barriers include unsafe environments, systemic racism, ableism, and gender bias. People can attain health equity by decreasing, confronting, or overcoming these barriers. This, however, is rarely something a person can accomplish for themselves. Rather, it necessitates adaptive adjustments by community and healthcare agencies, organizations, as well as governments. Which is 'why our CSUMB research team (Dr. Lopez-Littleton, Dr. Ibessaine, and Ms. Ahmed) are collaborating with Monterey County Health Department to create a health equity plan to serve as a roadmap to advance health equity on the Monterey Peninsula.

Project Justification

Minimum one paragraph on which contributing factor is being addressed and how the project will address that problem. Minimum one paragraph on why the proposed project meets best practice standards.

The COVID-19 epidemic not only highlighted the health inequalities and the injustices that have afflicted disadvantaged communities for generations, but it also illustrated how our

community can join together in innovative ways to care for our fellow citizens in need. The COVID-19 pandemic's health, social, and economic consequences continue to have an influence on the community's general well-being. According to the Census Bureau's most current Household Pulse Survey (August 2022), numerous people are struggling with a variety of issues, which include a loss of income, trouble paying for average household bills, and indications of depression or distress. Across virtually all metrics, Black and Hispanic people fared lower than White adults, with substantial inequities in several. When it comes to health care inequities, race is not the only element to consider. Vulnerable people in the United States frequently confront several hurdles to getting health care. Discrimination, a lack of affordable alternatives, and living far away from treatment clinics are all examples of such challenges (as is the case for many rural Americans). Movable health clinics, or trucks fully equipped with medical equipment, may aid in improving accessibility and thereby improving equity in rural regions. Seeking equity in healthcare frequently entails removing or lowering barriers to social and economic resources that impact a person's health (Tulane University, 2021).

Benefits

Briefly describe the benefits that will result from the project including the positive impacts for the agency and their patients/clients/individuals and communities they serve.

"Health equity" means that everyone has an equal and equitable chance to be as healthy as possible. That may appear straightforward, but it isn't since numerous things influence an individual's health. It is important to have an affordable, high-quality location to reside. A safe neighborhood, educational opportunities, enough food to eat, a job paying a "living wage," a life without fear of prejudice, and access to high-quality, comprehensive health care all play a role. When you begin to investigate any of these aspects, health equity appears to become much more difficult .

There is substantial evidence of serious health inequities both locally and globally. Inequalities in health are systematic, preventable, and unfair significant gaps in health and well-being across distinct groups of individuals. There is compelling evidence that eliminating health inequities increases life expectancy and decreases disability across the socioeconomic spectrum. Addressing health inequities is thus a critical component of increasing access to services, service quality, and mortality rates for the whole community.

Implementation Process

Monterey County Health Department (MCHD) seeks to develop a health equity plan that operationalizes equity practices and provides a roadmap for the long-term sustainability of the department's health equity efforts. Components will include strategies on workforce capacity and support, equity in policies and practices, planning and partnership approaches that strengthen equity. It may also include methods to more fully develop a health equity structure within MCHD, including a plan on how to integrate a Health Equity Officer/Office structure within MCHD to steward MCHD's health equity initiatives moving forward. A health equity task force made of staff from different MCHD Bureaus will support the plan's development during the contract period.

Assessment Plan & Expected Outcomes

The purpose of this project is to develop a health equity plan that operationalizes equity practices and provides a roadmap for the long-term sustainability of the department's health equity efforts. Components will include strategies on workforce capacity and support equity in policies and practices, planning and partnership approaches that strengthen equity. We will be organizing a google form to send out the MCHD to let us know what they think of the health equity plan we have done. We are expecting to get about 20-30 employees to participate. Staff from different MCHD Bureaus will support the plan's development during the contract period and participate in the survey we will be sending out. Alongside the google form, the assessment plan will look at data once the equity plan is put in place. Currently the project is in the creation and implementation of a health Equity Plan & will be read by the spring of 2023.

Project Results

This project will be completed by spring 2023. The measures that will be used will be looking at data to assess our projects success alongside a google form. The results as of now are still pending just because it's still an ongoing project. The method we used to gather evidence of the project's contributions to the agency were meetings, plenty of research, and round table discussions. We also reviewed peer-reviewed literature, other public health organization Websites, and state and territorial health department plans. We also conducted targeted searches of the gray literature to identify tools and recommendations for measuring health equity.

Project Results, Recommendations & Conclusion

MCHD is dedicated to putting health equity at the forefront of our efforts. MCHD will investigate health inequities through the key areas outlined in this Framework in order to identify and address the causes of inequities. MCHD must demonstrate leadership by collaborating with health care organizations and the people we serve to refine and develop our action plans, such as putting the emphasis on resolving health inequities, removing structural barriers that underpin our health-care system, and planning ahead of time throughout all MCHD programs to enhance health equity.

In every community and health care setting, MCHD plays a crucial role. However, we must collaborate with our partners and stakeholders, including health care and service providers, health systems, health plans, federal, state, territorial, tribal, and local partners, quality

improvement networks, individuals, family members, caregivers, patient advocates, health professional organizations, and community partners, in order to have the greatest impact. To achieve our common objective, we will need the commitment of each of our partners:that we have eliminated inequities in health care quality, access, and outcomes for all individuals we serve, including members of racial and ethnic communities, individuals with disabilities, members of the LGBTQ+ community, individuals with limited English proficiency, members of rural communities, and other individuals adversely affected by persistent disparities or inequity. The goal of this project is to finish and Implement Health Equity Plan and have other countries across the U.S use it as a guideline to eventually bring equity into the healthcare system.

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Appendix A

Project Implementation Plan

Activities	Deliverables	Timeline/Deadlines	Supporting Staff
Phase I: Discovery and Prep Work			
Review relevant materials (i.e., plans from other local health jurisdictions, guides to developing equity plans, etc.)	3 – 4 examples of health equity plans from other local health jurisdictions	August	Vanessa Lopez-Littleton, PhD, RN
Compile, analyze materials, and draft summary of common themes/elements	A summary of common themes/elements	August	Vanessa Lopez-Littleton, PhD, RN
Review baseline MCHD equity assessment		August	Vanessa Lopez-Littleton, PhD, RN
Phase II: Task Force Launch			
Convene a Health Equity Task Force made of MCHD leadership and frontline staff	Agenda for half-day meeting	August/September	Vanessa Lopez-Littleton, PhD, RN
Facilitate an initial half-day meeting to review MCHD's Baseline Organizational Equity Assessment (https://www.surveymonkey.com/r/YRYSBJY) with the task force and to identify top health equity priorities for each bureau.	Facilitate half-day meeting Summary of meeting outcomes	August/September	Vanessa -Lopez-Littleton, PhD, RN
Phase III: Health Equity Plan Development			
• Begin drafting plan	Final Health Equity plan, approved by MCHD Director	November/December	Vanessa Lopez-Littleton, PhD, RN
• Quarterly planning meetings		November/December	Vanessa Lopez-Littleton, PhD, RN

• Continue convening the health equity task force monthly to get feedback on draft versions of the plan.	PowerPoint summarizing plan components	November/December	Vanessa Lopez-Littleton, PhD, RN
• Once a completed draft plan is ready, give all MCHD staff a 30-day review period to comment on the plan.		November/December	Vanessa Lopez-Littleton, PhD, RN
• After the 30-day review period and staff feedback has been incorporated into the plan, send the final draft to MCHD Director for final approval.		November/December	Vanessa Lopez-Littleton, PhD, RN

MCHD Health Equity Task Force
Agenda
Nov 28, 2022 12-4 pm
Monterey County Health Department
Address: Pending

Session #1

Our Focus: Building our Equity Muscle "laying the foundation for an equitable future"

Time	Activity	Speaker(s)
12:00-12:05	Soft Landing/Welcome/Land Acknowledgement/Grounding	Vanessa Lopez-Littleton
	Community Agreements	Zahara
12:05-12:10	Overview of Project and Timeline Introductions of Facilitators	Krista & Vicente
12:10-12:30	Introductions: "What's your equity story?" (2-3 questions…pick one)	Vanessa
12:20-12:30	Introduction to the Spectrum of Community Engagement (?)	Vanessa Lopez-Littleton

12:30-12:45	Reflective Activity Pitfalls & Pearls…why this is needed or why it won't work	Zahara
1:00 - 1:30	Introduction to Targeted Universalism	Vanessa
1:30 - 1:45	Reflective Activity	Zahara
2:00 - 2:30	Laying the Foundation: ● What are the concerns/issues/data? ● What are your priorities? Equity-centered Standards from Strategic Plan	Vanessa
2:30 - 2:45	Next steps ● Who should be involved? ● How should they be involved?	Andrea
3:45 - 4:00	Exit Ticket: Critical Reflection on Next Steps	Andrea

Links to Sample Plans

1. Hamilton County Public Health
2. LA County Center for Health Equity
3. Healthy Chicago 2.0
4. CDC: A Practitioner's Guide To Health Equity

Racial Equity Task Force Plan

Activity	**Participants**	**Date/Tentative Date**
Task Force Launch	MCHD leadership and frontline staff	November 28th
MCHD's Baseline Organizational Equity Assessment ● Goal: Identify top health equity priorities for each bureau	Task Force Members Others (?)	~January 13th or 18th (2 hours) ~Provide information to Bureaus to prepare for January's session where we will begin to work to identify top health equity priorities (Krista)

Health Equity Task Force Meeting ● Goal: Spectrum of Community Engagement Presentation	Rosa Gonzalez	~February 6th or 7th (Krista to ask Rosa)
Design Day or Dialogue Session (or survey)...review the data that is currency available	Broader Community Conversation	~February 21st or 22nd
Health Equity Task Force Planning Part I ● Goal: Development of a toolkit (Resources: creating an equity lens to support the development of equitable SOW and other resources…shovel ready initiatives) ● Identification of strategies and programmatic gaps that exist ● Strengthening organizational readiness and capacity (internal equity efforts)	Task Force Members	~March 13th or 14th
Health Equity Task Force Planning Part II ● Goal: Review the framework and draft plan		~Draft Plan April 11th or April 12th
Health Equity Task Force Drafting of Plan ● Goal: Review and finalize		Late April
Draft for Review (30 days)		May 20ish