COMMUNITY ENGAGEMENT UNIT

2024-2028 Strategic Plan

NORTH Dakota | Health & Human Services

Be Legendary.

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EXECUTIVE SUMMARY

Improving health equity is an overarching goal of the North Dakota Department of Health and Human Services' (NDHHS) 2022–2024 Public Health Division Plan (Division Plan). The Community Engagement (CE) Unit has created a strategic plan to ensure alignment with the Division Plan to address and reduce inequities related to health factors such as obesity and other chronic conditions, mental health, injury and access to care among various populations in North Dakota. Specifically, the CE Unit identified the following focus populations who are disproportionately affected by socioeconomic issues and other factors:

- African Americans
- American Indian (AI) and Alaska Native (AN)
- Aging individuals
- LGBTQ2S+
- New American, Foreign-Born and Immigrants (NFI)
- Persons with disabilities
- Rural communities
- Unhoused individuals
- Youth

The development of the CE Unit Strategic Plan incorporated input from conversations, consultation and collaboration with the Public Health Division and partners such as state agencies, community leaders, partner organizations and other external stakeholders who are part of or engaged in services and supports for priority populations. The CE Unit believes it is critical to incorporate community voice and perspective into the planning process. The CE Unit Strategic Plan is dynamic and adaptive, allowing the Unit to make meaningful and measurable progress toward its goals. It will be continuously reviewed and updated as efforts unfold, and partnerships expand. While there are many things the CE Unit can include, the focus is on the work with partners and its impact on the focus populations. *We extend our gratitude to all the CE Unit partners, stakeholders and other supporters. Together, we can improve the lives of North Dakotans.*

Goals

Working with numerous thought leaders and other stakeholders, the CE Unit developed the following goals and objectives, including future and present objectives and short-term tasks.

1. Create innovative solutions, interventions and system advancements that address identified health inequities and improve health outcomes of impacted North Dakotans.
2. Invest in priority community partnerships to advance an inclusive and culturally responsive public health care system through education and communication.
3. Advance practices and systems informed by data through accountable and collaborative leadership to improve health equity.

INTRODUCTION

The CE Unit Strategic Plan is informed by, aligns with, and furthers the Division Plan and its mission "to improve the length and quality of life for all North Dakotans." Importantly, this mission is driven by a commitment to two cross-cutting goals: improving health equity and using evidence-based practices for data-driven decisions. The CE Unit Strategic Plan complies with Public Health Accreditation Board (PHAB) Version 2.0 standards and domains. PHAB, the public health accrediting body, helps state health departments develop a system-wide approach to developing a culture of health equity. PHAB also challenges us to think beyond just race and language and examine how factors like age, educational attainment, income levels, health literacy, neighborhood geography and social capital (also known as social drivers of health) may impact health.

The CE Unit Strategic Plan offers an important opportunity to reinforce integration and continuity across the two recently joined agencies that comprise NDHHS. The ultimate success of the CE Unit Strategic Plan ties to how well it reflects and supports the overall NDHHS mission, vision and values, as well as how it brings the community voices and needs of the focus populations into the process.

CE Unit Mission

The mission of the CE Unit is to understand and reduce health disparities among all North Dakotans. The primary goal is to work alongside North Dakota communities in addressing health-related needs to reduce disease rates by providing opportunities for interventions and improving access to health care. This ensures all North Dakotans can reach optimal health.

CE Unit Advisory Boards

The CE Unit coordinates various advisory boards with members who have lived experience and liaises between the communities they represent. A list of these advisory boards and descriptions is provided below.

BEYOU HEALTH BOARD (BYHB)

The BYHB's mission is to create a safe and consistent platform for the LGBTQ2S+ community to make a difference in North Dakota communities through peers to develop, promote and provide education on important initiatives and issues that improve the health of North Dakota's LGBTQ2S+ population. Members learn about and implement community-wide planning and improve leadership and transparency across the state.

NEW AMERICAN, FOREIGN BORN, AND IMMIGRANT (NFI)

The NFI Advisory Board's mission is to create a safe, transparent and consistent platform for NFI populations to make a difference in the health of North Dakotans. Members elevate suggestions, needs and ideas, provide ongoing recommendations to NDHHS and other state and local

agencies from the communities represented and inform the development and improvement of programming for NFI communities. The Board promotes and educates communities on important initiatives and issues that will improve the health of North Dakota's NFI populations and assist the NDHHS in forming community partnerships.

YOUTH ADVISORY BOARD (YAB)

The YAB's mission is to create a safe and consistent environment for youth between 15 and 21 years of age to make a difference in North Dakota communities by using peer influence to plan, implement and advise on meaningful projects and topics that will improve the health of North Dakota's youth. The YAB allows young people to learn about and put community-wide planning into action and enhance leadership skills and responsibility. Members recommend youth health issues and topics to NDHHS, ensuring youth perspectives are incorporated in state planning and decisions and forming community partnerships.

Health Equity Committee (HEC)

The HEC is a statewide leadership committee addressing health inequities, including social, economic and environmental disparities. Members are dedicated to increasing access to quality health care concerning affordability, availability, accessibility, accommodation and acceptability. The HEC promotes cultural strengthening and safety while implementing strategies founded on collaboration, data, advocacy, policy and resource alignment for all North Dakotans. Members educate, inform and advise NDHHS, ensuring that social determinants of health and health equity-related matters are adequately addressed. The HEC participated in this planning process by providing input on the Strategic Plan and developing future goals for the HEC, most importantly ***to become an independent, sustainable and impactful entity***.

THE CE UNIT STRATEGIC PLAN

This CE Unit Strategic Plan builds on the previous Strategic Plan and accounts for complex and rapidly changing environments in the aftermath of COVID-19, greater recognition of the impact of health disparities for certain North Dakotans and the need to address social determinants of health (SDOH) to improve health outcomes. The CE Unit Strategic Plan also recognizes the unique challenges of a large, rural/frontier state like North Dakota. These challenges include geography, diverse yet unevenly distributed populations and changing economic drivers. To the extent possible, the CE Unit used data to inform Strategic Plan decisions on addressing health inequities effectively and cost-efficiently.

Methodology

The approach to the CE Unit Strategic Plan was intentionally adaptive to develop an inclusive process. An adaptive approach affords flexibility and usability even in the face of unforeseen challenges to NDHHS, the Division of Public Health (DPH) and the CE Unit or its work. The Plan is inclusive in reflecting the equitably gathered input of various stakeholders. As part of this inclusive approach, meaningful engagement from a wide range of stakeholders, focus populations and experts was incorporated to create mission-oriented and evidence-based goals and manageable strategies to achieve those goals.

A Strategic Plan Steering Committee, comprised of North Dakota Public Health Division leaders and CE Unit leadership, was convened to guide, and oversee the development of the Strategic Plan. The entire CE Unit team, together, then delved into strategic issues and developed actionable recommendations for review and approval by the Steering Committee. With support from external consultants, focus groups and interviews of people with lived experiences, roles and insights about emergent public health issues that impact health equity to further inform the Strategic Plan were conducted. The resulting CE Unit Strategic Plan supports the NDHHS's and DPH's efforts toward a broad, inclusive and effective public health system prepared to address current and future health inequities. It also aligns with PHAB accreditation domains.

Additional activities implemented as part of the Strategic Planning process include:

- Conducting an analysis of existing resources, strengths and challenges
- Gaining a comprehensive understanding of the external environments affecting the work of the CE Unit
- Identifying data-driven, evidence-based strategies for meeting organizational mandates, fulfilling organizational mission and embracing organizational vision and values
- Honoring and respecting the range of ideas and community expressions by clearly reflecting them in the Plan
- Coordinating work to efficiently allocate scarce resources—including finances, human capital, time and social/political capital—to common strategic priorities
- Communicating a shared vision to internal and external audiences

Health Disparities

While North Dakota ranks favorably overall in many social factors, including air quality and education, several populations within the state experience more negative impacts on their long-term health outcomes due to various health and social factors. According to "America's Health Rankings," North Dakota is listed as 19th overall for 2022 – quite good across dozens of metrics for healthcare, including behavioral health, social and economic factors, education, the physical environment and behaviors.[1] At a more granular level, however, for many factors, North Dakota ranks much lower, including[2]:

- 38th for the number of mental health providers per 100K of the population
- 35th for access to a dedicated health care provider for individuals age 18+
- 39th for exercise and 32nd for obesity among individuals age 18+
- 26th for chlamydia cases per 100K of the population
- 36th for e-cigarette use among individuals aged 18+
- 47th for excessive drinking and 44th for non-medical drug use among those aged 18+

VULNERABLE POPULATIONS

When looking at these factors by demographics, some populations in North Dakota have specific and notable disproportionate health vulnerabilities that are even greater. For example, AI, NFI, rural communities and youth (ages 13-24). These negative health predictors and other unfavorable social factors emphasize the need for North Dakota to take a more integrated and aggressive approach to health among its most vulnerable populations.

- Childhood poverty disproportionately impacts AI communities[3]
- North Dakota ranks 46th in the U.S. for the racial disparity in premature death rates for AIs[4]
- Drug-related deaths for youth increased by 63% from 2017 to 2020[5]
- Rural counties have a disproportionate number of youth deaths[6], and youth deaths are over 3x higher in AI communities[7]
- Increases in sexually transmitted infections such as chlamydia, gonorrhea, syphilis and HIV with rates going up – nearly 6 times higher among AI and Black populations[8]

Figure 1 below shows data from the 2021 Youth Risk Behavior Survey (YRBS), conducted by the DPH, depicting the racial disparity among high school students who reported feeling sad or hopeless almost every day for more than two weeks in a row during a 12-month period.[9] AI and Latino students experience sadness and hopelessness at rates more than 18 percent, 13 percent and almost 6 percent higher, respectively, than their White counterparts.

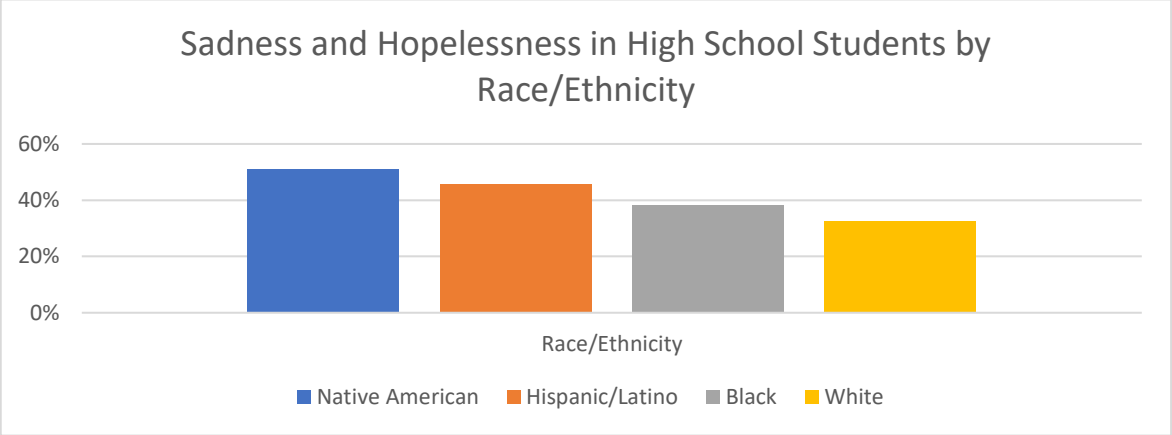


Figure 1: Percent of high school students who felt sad or hopeless almost every day for two weeks or more in a row, so they stopped doing some usual activities during the 12 months before the survey[10]

Beyond health-related issues, there are racial disparities for other social factors, such as access to the Internet, which can negatively impact healthcare, education and employment. A recent study by the North Dakota State University Center for Social Research and the Blue Cross Blue Shield of North Dakota Caring Foundation found that while the percentage of people with a broadband internet connection increased across all racial categories between 2017 and 2020, Black, AI and Hispanics (of any race) are less likely to have internet than White and Asian individuals.

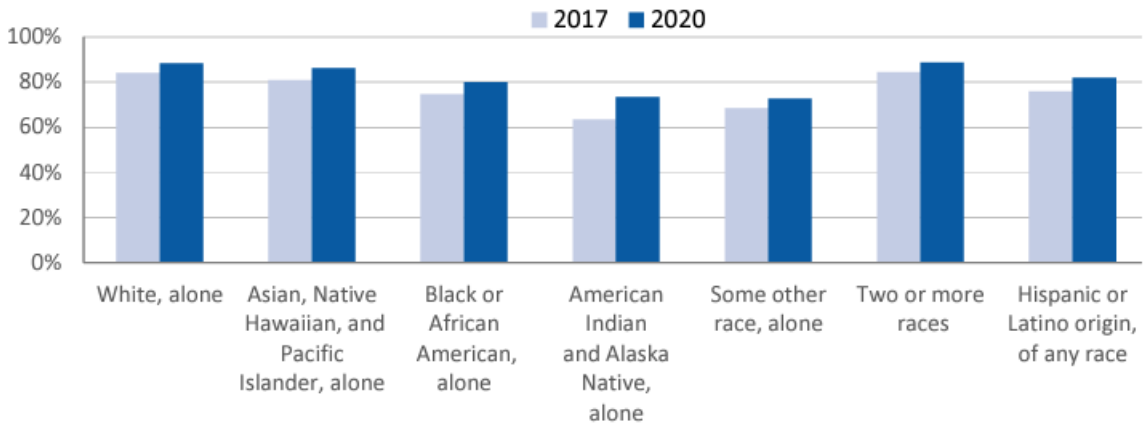


Figure 2: Individual Racial and Ethnic Population Diversity in North Dakota, 2010 and 2020.
Source: Health and Well-Being in North Dakota, 2022 A Social Determinants of Health Perspective January 2023

When it comes to the workforce, and particularly in health professions, AIs accounted for 0.6 percent of the overall U.S. workforce in 2019, according to The Fitzhugh Mullan Institute for Health Workforce Equity at George Washington University's Milken Institute School of Public Health.[11] Their representation among the 10 health professions studied ranged from zero to 0.9 percent. In 2022, the University of Washington Center for Health Workforce Studies found that while 2.9 percent of the overall U.S. population is AI/Alaska Native (AN), only 0.3 percent of all active physicians in 2018 and 0.6 percent of medical residents in 2020 reported AI/AN. AI/AN individuals have 63 percent

lower odds of applying to medical school than the general U.S. population.[12] These studies are some of the few of their kind – most labor and employment reports do not include AI/ANs in their data.

The 2021 State Health Assessment report noted that rural/frontier regions across North Dakota face increased challenges with maintaining adequate healthcare workers because of factors such as lower wages and fewer amenities than in more urban areas. These rural communities also have the lowest rates of access to needed healthcare services and are the most vulnerable to the loss of providers they do have. "Communities that do not have adequate staffing tend to be one health care provider away from experiencing shortage (University of North Dakota, 2019)."[13]

Notably, these vulnerable populations are growing in North Dakota. The 2021 North Dakota State Health Assessment Report noted that about 5 percent of residents reported having at least one immigrant parent.[14] The North Dakota State University Center for Social Research study showed that, between 2010 and 2020, the proportion of the state's population identifying as a race other than non-Hispanic white increased from 11 percent to 18 percent. The figure below from that report shows how much various populations grew over that decade, as shown in Figure 3 below.[15]

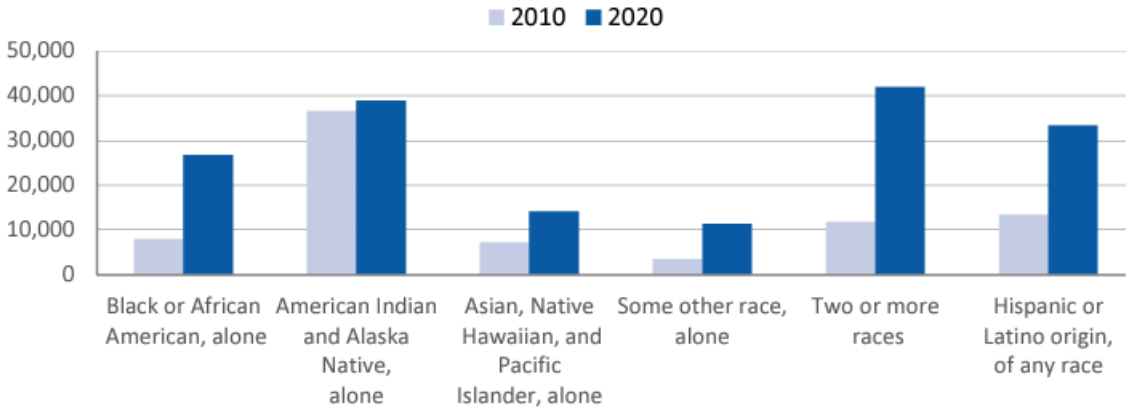


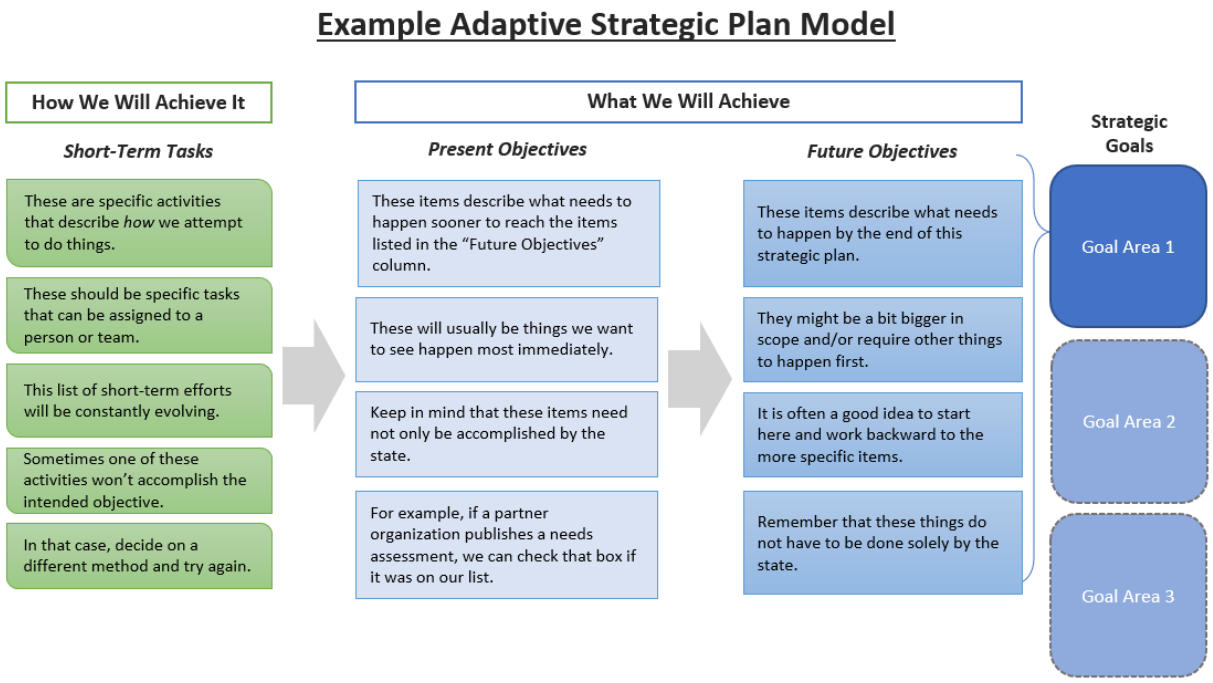
Figure 3: Individual Racial and Ethnic Population Diversity in North Dakota, 2010 and 2020.
Source: Health and Well-Being in North Dakota, 2022 A Social Determinants of Health Perspective January 2023

Given this data and the fact that these vulnerable populations are growing in the state, the CE Unit designed its Strategic Plan to include specific objectives to reduce health and social inequities among these groups.

Adaptive Strategic Planning Model

A static strategic plan that lays out the vision and an actionable roadmap over three-to-five years in an ever-changing healthcare environment is a risk. The leadership of the CE Unit recognized this imperative to be nimble and adaptable and chose an adaptive strategic planning approach. This adaptive Strategic Plan ensures flexibility and usability even in the face of unforeseen challenges or unanticipated priority shifts resulting from strategic emerging partnerships or new potential funding streams. It is inclusive because it reflects the input of a wide range of community stakeholders and key informants from all NDHHS divisions. While a traditional strategic plan typically creates a hierarchy of major goals, mid-level strategies to achieve those goals and specific activities to implement those strategies, an adaptive plan's elements are more loosely connected.

The figure below shows how the model works, reading right to left to see the components that comprise the strategic goals, future objectives, present objectives and short-term tasks. This model makes it easier to see how big strategic goals can be broken into more actionable pieces of work, making it less overwhelming to see how such goals can be achieved.



An approach grounded in Professor Ron Heifitz's "Adaptive Leadership Theory" was used to develop actionable strategic goals that establish cross-system relationships and improve population health mapped to health inequities and disparities unique to North Dakota. The Plan is designed to be responsive and adaptable to environmental shifts in the state and local health ecosystems throughout its duration. The underlying premise of an adaptive plan is that priorities change, but also there is a need for flexibility in testing new ideas, gathering evidence on impact and adjusting approaches. This approach supports rapid cycle improvement methodologies to achieve stated objectives. In short, it provides general guidance toward achieving objectives without a rigid

commitment to a set of actions. As various efforts succeed or fail to achieve the desired objectives, the CE Unit can create new tasks and objectives through an iterative process.

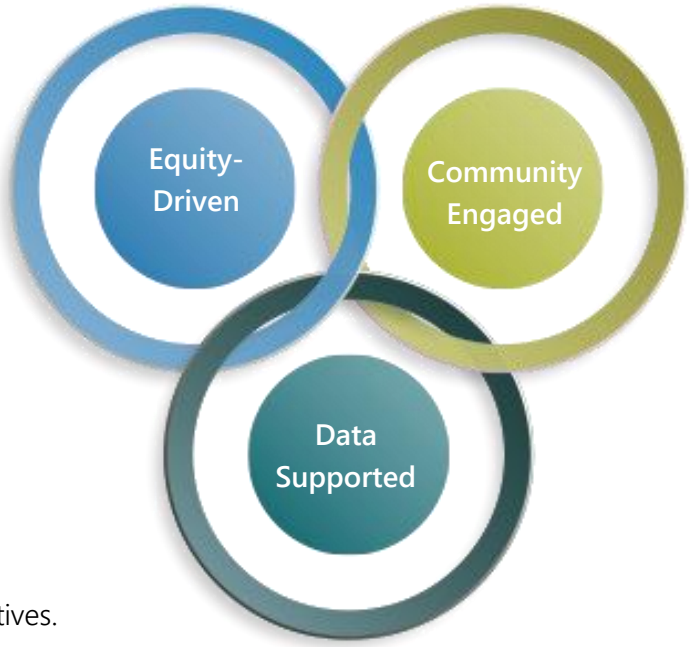
The adaptive strategic planning approach applied to the development of this Plan involved gathering contextual information to understand the CE Unit's purpose, its relevance within the DPH and the newly integrated NDHHS. The changing organizational structure will impact the CE Unit's role, such as growing influence across the larger DPH and NDHHS environment. The adaptive Strategic Plan leaves room for these and future realignments and adaptations.

GUIDING PRINCIPLES

The CE Unit's Strategic Plan Guiding Principles ensure its strategies are ethical, sustainable, reflect its core values and align with NDHHS's priorities. They support the Strategic Plan's evolution and adaptability while staying true to its core values. The CE Unit's Strategic Plan Guiding Principles are community engagement, data-supported and equity-driven. Guiding Principles allow for:

ALIGNMENT

Supports alignment toward a common purpose and values; ensures actions are consistent with the CE Unit's core beliefs.



DECISION-MAKING

Serves as a reference point in complex or ambiguous situations.

COHESION

Fosters employees' unity, belonging and cohesive organizational culture.

STRATEGIC CONSISTENCY

Provides a foundation for building goals and objectives.

TRUST

Enhances stakeholder trust, as people will likely engage and support transparency and principles.

EMPLOYEE ENGAGEMENT

Motivates and engages employees if they understand and identify with Guiding Principles, leading to increased productivity, creativity and satisfaction.

LONG-TERM VISION

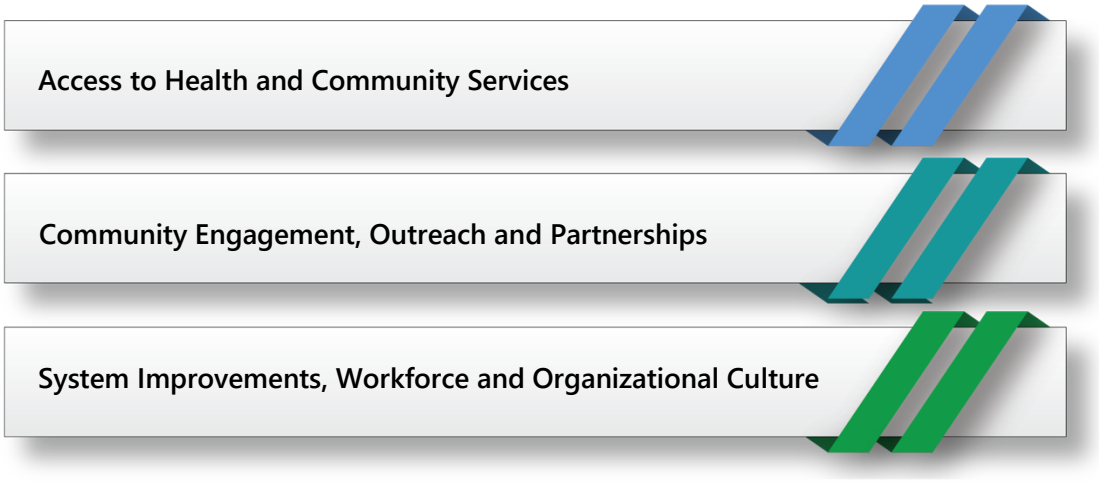
Emphasizes long-term thinking over short-term gains, which is crucial for strategic planning, as it encourages sustainable practices and investments.

ETHICAL RESPONSIBILITY

Promotes responsible practices and social awareness by incorporating ethical considerations.

STRATEGIC PRIORITIES

Strategic priorities provide a clear focus and direction for the CE Unit Strategic Plan. They create a roadmap to ensure efficient resource allocation, enable performance measurement, align efforts, facilitate adaptation to change, enhance communication and focus on the CE Unit's long-term vision. These strategic priorities were used to help define SMARTIE (specific, measurable, action-oriented, relevant, time-bound, inclusive and equitable) goals and objectives. The CE Unit developed the following three strategic priorities:



Strategic priorities also help with the following:

RESOURCE ALLOCATION

Help determine where to allocate resources for the most significant impact.

ALIGNMENT

Support alignment of the Strategic Plan Guiding Principles and goals. This alignment also fosters teamwork and collaboration toward common objectives.

ADAPTING TO CHANGE

Provide a framework that adapts to changing circumstances or unexpected events and can be adjusted as necessary.

COMMUNICATION

Provide clear strategic priorities for a concise and understandable message to stakeholders that helps communicate the Strategic Plan goals and objectives.

STRENGTHS, OPPORTUNITIES, ASPIRATIONS, AND RESULTS

A critical component of the CE Unit Strategic Plan development included conducting a SOAR analysis to offer a comprehensive and forward-looking assessment of the CE Unit's internal and external environments. SOAR stands for *Strengths*, *Opportunities*, *Aspirations*, and *Results*- representing a positive and proactive approach to strategic planning. Focusing on strengths and aspirations helps identify and leverage internal capabilities and core competencies. This introspective examination is crucial for exploring opportunities and desired results to align the Strategic Plan with the CE Unit's mission and future goals. A SOAR analysis emphasizes strengths and encourages an exploration of aspirations, fostering a strategic mindset. Employing this holistic approach facilitates the formulation of a responsive Strategic Plan to current challenges but also forward-thinking.

A series of key informant interviews and focus groups yielded considerable contextual information based on input from important government and community stakeholders (i.e., consumers, advocates, partners). For a complete list of stakeholders interviewed or participating in a focus group, please reference Appendix B. Inputs were organized by SOAR categories. This analysis and findings were critical to identifying CE Unit priorities and developing goals and objectives, serving as a roadmap to help the CE Unit deliver on its health equity value proposition. Findings include prioritizing leveraging collaborative opportunities to provide technical assistance, streamlining health equity data gathering and analytics and sustaining a focus on addressing key areas of health disparities across North Dakota. It aspires to address issues of inequity in systems, communities, and internally (CE Unit, DPH, NDHHS) by demonstrating commitment and action to change.

STRENGTHS

- Supporting Tribal populations
- Executing mission
- Collaborative, knowledgeable, cohesive and committed
- Wide community and organizational support for DEI efforts

OPPORTUNITIES

- Support NDHHS with DEI communications and messaging
- Expand areas of focus based on community needs
- Grow capacity to provide internal and external technical assistance

ASPIRATIONS

- Create cohesiveness and support for DEI initiatives across communities, the legislature, and NDHHS.
- Rebuild and strengthen trusting relationships (frayed by the COVID pandemic) with the community
- Grow organizational capacity and resources

RESULTS

- Formally establish CE Unit scope, roles and responsibilities across NDHHS
- Streamline processes to support NDHHS and statewide DEI efforts
- Establish data sources and analysis for organization-wide DEI efforts

GOALS AND OBJECTIVES

Using an adaptive model for the Strategic Plan, the CE Unit developed the following three goals and objectives. The objectives vary in specificity and detail based on available data, existing partnerships (and those that may need to be established) and current resources.

Working with numerous thought leaders and other stakeholders, the CE Unit established three, big picture strategic goals. The goals reflect a SMARTIE approach in that they are *Strategic, Measurable, Ambitious, Realistic, Time-bound, Inclusive* and *Equitable*.

Goals

The following are the CE Unit's three Strategic Plan goals to be accomplished by 2028:

1. Create innovative solutions, interventions, and system advancements that address identified health inequities and improve health outcomes of impacted North Dakotans.
2. Invest in priority community partnerships to advance an inclusive and culturally responsive public health care system through education and communication.
3. Advance practices and systems informed by data through accountable and collaborative leadership to improve health equity.

These goals represent the CE Unit's desire to address health equity and health disparities at three levels: the systems, the community and the internal CE Unit/DPH/NDHHS. This ties directly with the three Guiding Principles and three strategic priorities the CE Unit staff established at the beginning of the strategic planning process.

Objectives

The following pages contain a list of each goal with corresponding future objectives, present objectives and short-term goals with time-specified dates. These objectives also reflect the CE Unit's Guiding Principles and strategic priorities.

GOAL 1

Create innovative solutions, interventions and system advancements that address identified health inequities and improve health outcomes of impacted North Dakotans.

OBJECTIVE 1.1

Short-term Task:	Present Objectives	Future Objective
Conduct a needs assessment for sexually transmitted infections (STI) among priority populations identified by the CE Unit and the Sexually Transmitted Bloodborne Disease (STBD) Unit using qualitative and quantitative data Dec. 2026.	Support the DPH's STBD Unit to identify five new non-traditional sites to implement STBD grants to reduce STIs by Dec. 2027.	Secure ongoing impactful opportunities to reduce STIs for priority populations identified by the CE Unit by developing mutually beneficial partnerships with at least five new, non-traditional sites by Dec. 2028

OBJECTIVE 1.2

Short-term Task:	Present Objectives	Future Objective
Collaborate with the NFI and YAB to develop cultural food training at food banks and community grocery stores to shift food bank donations by Dec. 2024.	Work with the HEC, NDSU Extension and Tribal Colleges to develop a strategy, partnerships and implementation plan that build on accomplished tasks to address food insecurity across North Dakota among aging adults, NFI, Tribal members, youth and other focus groups experiencing food insecurity by Dec. 2026.	Complete and measure at least three implementation plan initiatives by Dec. 2028.
Collaborate with the Aging and Adult Service Division, Family Health and Wellness Unit and other stakeholders to develop food security and nutrition education and outreach materials for older adults by Dec. 2025.		
Work with appropriate stakeholders such as the HEC, NDSU Extension and Tribal Colleges to identify statewide		

food policies and initiatives (e.g., Food as Medicine) by June 2026.		
Partner with five rural, five urban schools and five Tribal health centers to collaborate in learning opportunities about how to improve the nutritional value of traditional meals Dec. 2025.	Consult with more than 10 Tribal Health Leaders to develop and support culturally responsive education about food and nutrition in at least 10 Tribal Communities by Dec. 2026.	
Consult with at least five Tribal Communities about access to SNAP, WIC, and available food resources (e.g., Farm to School, Tribal food distribution centers and Indigenous-owned companies) by Dec. 2025.		

OBJECTIVE 1.3

Short-term Task	Present Objectives	Future Objective
Identify an asset map of recreational venues available to youth across North Dakota by Dec. 2024.	Identify three initiatives within three identified areas in North Dakota to increase access to recreational venues for youth by Dec. 2025.	Develop metrics and measure the three initiatives for effectiveness in increasing access to recreational venues for youth by December 2026.

OBJECTIVE 1.4

Short-term Task	Present Objectives	Future Objective
Consult and collaborate with partners such as the State Broadband Office, the NTIA/BEAD program and Tribal Community Leaders to identify high-need tribal areas for expansion of broadband access by Dec. 2025.	Connect with Tribes and identify resources to increase broadband availability to support healthcare access in 25% of the identified tribes by Dec. 2026.	Partner with Tribal communities to measure the increase of tribal health facilities that provide telehealth services after attaining broadband access by Dec. 2028.

OBJECTIVE 1.5

Short-term Task:	Present Objectives	Future Objective
Identify and prioritize five high-need medical and behavioral health (BH) services for two rural and two Tribal communities that cannot be provided remotely and require regular patient transportation (i.e., dialysis, chemotherapy, dental care) or are unaffordable by March 2025.	In collaboration with Medicaid and other public health programs, identify outreach providers to partner with for transportation to high-need medical and BH services for identified Medicaid enrollees who need consistent medical care by July 2025.	Establish a partnership with Medicaid and other partners to fund a sustainable transportation program of the five prioritized high-needs medical and BH services for identified Medicaid enrollees by July 2026.

OBJECTIVE 1.6

Short-term Task:	Present Objectives	Future Objective
Consult with stakeholders (e.g., Free Through Recovery, Community Connect, Medicaid, the Division of BH) and Tribal Community programs to identify and prioritize three rural communities with high binge drinking rates or other substance use disorders (SUD) among the CE Unit focus populations who have limited access to BH programs by July 2024.	Expand partnerships with the Division of BH, Medicaid, Injury Prevention/Vision Zero, Highway Patrol, Diversity, Equity and Inclusion (DEI), Tribal Health, NDSU Extension and BH leaders to understand resource needs for addressing binge drinking and SUD among prioritized rural-focused populations by Dec. 2024.	Partner in planning four youth events in rural and Tribal Communities with high binge drinking rates on alternatives to drinking and substance misuse. SUD events will be held by Dec. 2026 and be youth-sponsored and tailored.
	Deliver needed resources to communities identified by March 2025.	Use stakeholder input to evaluate events and replicate or expand successful events by Dec. 2028.

OBJECTIVE 1.7

Short-term Task:	Present Objectives	Future Objective
Assess NDHHS working protocols and departmental relationships with the five North Dakota tribal nations and Trenton Service Area by Dec. 2025.	Invite and collaborate with two experts from the Tribal community to develop a toolkit of policies and procedures for communicating, consulting, partnering or funding tribal nations and their affiliates by June 2025.	Partner with Tribal leaders to standardize a communication protocol to work with Tribal Nations (i.e., Tribal Health, emergency management) by Dec. 2026.

GOAL 2

Invest in priority community partnerships to advance an inclusive and culturally responsive public health care system through education and communication.

OBJECTIVE 2.1

Short-term Task:	Present Objectives	Future Objective
Develop a list of key CE Unit partners that prioritize health equity training, including other NDHHS divisions, Local Public Health Units (LPHUs), Community-Based Organizations, businesses, etc., by March 2024.	Develop a Phase 2 CE Unit Health Equity training series that incorporates information to address needs identified by the training assessment and is customized to specific types of partners, e.g., other NDHHS divisions, LPHUs, CBOs, businesses, etc., by Dec. 2024.	Provide Phase 2 CE Unit Health Equity training (CE Unit trainers or CE Unit approved trainers) and formal training evaluations to 40% of stakeholders identified by the CE Unit by Dec. 2026.
Conduct a training assessment of all the key CE Unit partners to identify specific and additional health equity training needs by June 2024.		
Consult or collaborate with partners such as the Grand Forks Local Public Health or Health Equity Liaison to translate the Phase 2 CE Unit Health Equity training series into Spanish and any other languages or formats (e.g., Braille or recorded) as identified by key CE Unit partners by June 2025.	Train key CE Unit partners using the Phase 2 CE Unit Health Equity train-the-trainer model to build capacity to provide approved training to additional CBOs, agencies, businesses, etc., from Jan. 2026 to Dec. 2028.	
Develop a train-the-trainer model using the Phase 2 CE Unit Health Equity training by Dec. 2025.		
Develop an oversight and evaluation process to ensure individuals deliver Phase 2 CE Unit Health Equity training with integrity and consistency (train-the-trainer model) by Dec. 2025.	From Jan. 2026 – Dec. 2028, continuously evaluate Phase 2 CE Unit Health Equity training conducted by the CE Unit and partners to develop pre/post-tests and lessons learned to continuously improve the train-the-trainer model based on partner and trainee feedback.	
Implement a feedback and evaluation process with each Phase 2 CE Unit Health Equity training to gather input from both trainers and trainees to improve trainings by Dec. 2025.		

OBJECTIVE 2.2

Short-term Task:	Present Objectives	Future Objective
Secure funding and job description approval for a Community Relations Liaison dedicated to the CE Unit focus populations and underserved communities by July 2028.	The Community Engagement Specialist will create a specialized toolkit with materials and information for parents and guardians of youth in focus communities about mental, physical and sexual health issues/needs by July 2024.	Develop, disseminate and track the distribution of culturally relevant toolkits that parents and guardians can use for in-person discussions with youth about mental, physical and sexual health issues/needs to at least three identified focus population households by Dec. 2025.
Hire a Community Relations Liaison dedicated to the CE Unit focus populations and underserved communities by Sept. 2028.		
Identify focus populations for the parent/guardian toolkit using CE Unit /NDHHS data and key partner input by July 2024.	Complete a plan to disseminate and track the toolkit for focus population households in collaboration with key partners by Sept. 2024.	
Translate the toolkit into languages based on all need(s) identified through data by Aug. 2024.		

OBJECTIVE 2.3

Short-term Task:	Present Objectives	Future Objective
Identify at least four new partners among priority populations identified by the CE Unit and the STBD Unit to promote at-home STI testing by Aug. 2024.	Develop strategies with the four identified partners to increase at-home STI testing for individuals they serve and implement the strategies by Jan. 2026.	Increase at-home STI testing rates among focus group populations reached through the four partner organizations.
Establish processes and procedures to engage with elders and health leaders from each North Dakota Tribal Community to support STI testing and care for tribal members by June 2025.	Identify and implement one strategy to improve STI testing rates in at least one Tribal Community and/or Tribal Organization by Dec. 2026	Increase access to culturally appropriate strategies for STI reduction for at least one Tribal Community.
Collaborate with at least five organizations that work with youth and NFI youth to identify two topics of high importance to them by Sept. 2025 related to STI reduction.	Identify effective evidence-based interventions to address issues prioritized by NFI youth and implement them with at least one partner organization by Dec. 2025.	Increase access to culturally appropriate STI reduction strategies for at least one partner working with youth and one with NFI youth by Dec. 2027.

OBJECTIVE 2.4

Short-term Task:	Present Objectives	Future Objective
Research kiosk program policy, resource and potential location requirements (libraries, gas stations, tribal colleges, tribal administration buildings, etc.); document requirements for program implementation by March 2025.	Identify a pilot kiosk program plan with key partners, identified locations, resources (personnel and program funding), program and operations requirements and policies, training, an evaluation plan with desired outcomes, and a sustainability plan by Dec. 2026.	Evaluate the effectiveness of a pilot kiosk program led by peer navigators in improving confidential telehealth services and enrollment in other NDHHS programs and services, such as Medicaid, SNAP, WIC, etc., for identified focus populations and communities by Dec. 2028.
Using available data, collaborate with Tribal Leaders, LPHUs, CBOs and other stakeholders to identify potential pilot kiosk program locations by Sept. 2025.	Gather at least one year of data to evaluate the effectiveness of the pilot based on established program goals and outcomes; use data to determine if/how to keep the program running in current locations and if/how to expand by Dec. 2028.	
Identify funding to support a pilot kiosk program by March 2026.	Implement the kiosk program, including training support to launch and manage them, in at least four locations with measures to evaluate the impact on improving healthcare access for at least one focus population by Dec. 2027.	

OBJECTIVE 2.5

Short-term Task	Present Objectives	Future Objective
Use Medicaid data and Tribal Navigators and NFI stakeholder input to identify rural communities or populations with high transportation needs by March 2024.	Launch a transportation workforce incentive program with Vision Zero, Tribal Communities and NFI partners by Jan. 2025.	Collaborate with Medicaid and other partners to ensure providers in rural communities are aware of medical needs and transportation supports available to tribal and NFI Medicaid members by Dec. 2024.
Collaborate with Medicaid, Vision Zero, Tribal Community Partners and NFI stakeholders to identify operational requirements, funding and a transportation workforce incentive program evaluation by Sept. 2024.		

OBJECTIVE 2.6

Short-term Task	Present Objectives	Future Objective
All CE Unit staff will complete Medicaid training (including the application process) by Dec. 2024.	Implement outreach and engagement campaigns in focus populations and communities, including Tribal Partners, to increase Medicaid enrollment among individuals who are eligible but not enrolled. Include measures for tracking increased enrollment and access to care among focus populations, including tribal members and monitor the effectiveness of campaigns on an ongoing basis starting in Jan. 2026.	Use Medicaid and other data to increase Medicaid enrollment by at least 5% for focus populations that show decreased enrollment trends despite growing or steady need and eligibility by Dec. 2028.
Use CE Unit Medicaid and other data to identify focus populations and communities with lower-than-expected Medicaid enrollment (enrolled vs. eligible) by Dec. 2024.		
In collaboration with Medicaid and other local partners, create outreach and engagement campaigns supporting Medicaid enrollment among focus populations and communities by June 2025.		
Collaborate with Medicaid and Tribal Partners to develop strategies that maximize Tribal members' access to health services using Indian Health Service/Tribal Health resources and Medicaid by Sept. 2025.		

OBJECTIVE 2.7

Short-term Task:	Present Objectives	Future Objective
Create a process to engage with rural and urban underserved special populations communities to learn about their health needs and how the CE Unit can support them by July 2024.	Support rural and urban NFI leaders to identify health projects, offer technical assistance for identified needs, and document outcomes, successes and lessons learned starting Jan. 2026.	Identify potential financial resources in coordination with partners and provide technical assistance to address health equity needs identified by rural and urban underserved special populations by Dec. 2026.

OBJECTIVE 2.8

Short-term Task:	Present Objectives	Future Objective
Begin outreach to faith-based organizations and constituencies to establish relationships and foster trust for input on public health education and service issues in their communities by March 2024.	Establish a process with faith-based (religious and spiritual) communities to support financially or through technical assistance (TA) their identified public health education and service needs by Dec. 2025.	By Dec. 2027, document 5 public health education and service projects supported financially or with TA among faith-based partners and any program referral increases or improved health outcomes among their constituents related to such support.
Convene identified faith-based partners individually or in groups to assess their communities' public health education and service needs by Sept. 2024.		

OBJECTIVE 2.9

Short-term Task:	Present Objectives	Future Objective
Create a schedule for staffing a public health booth at identified Tribal statewide career fairs by Dec. 2024.	Consult and collaborate with Tribal elders and health partners to create a program for tribal members to work as public health interns for the state and open the program to applicants by March 2026.	In partnership with Tribal Leaders, establish a Tribal Student Intern Program for the DPH by Dec. 2027.
In consultation and collaboration with Tribal Elders and Tribal Health Partners (e.g., tribal college leaders), develop a public health careers program and present it in tribal schools by March 2025.		
Consult and collaborate with Tribal Elders and Tribal Health Partners (e.g., Tribal College and leaders) to identify what they consider "public health" work starting Jan. 2025.	Create training and resources defining public health and public health needs in tribal communities in consultation and collaboration with Tribal partners by June 2026.	
In consultation and collaboration with Tribal Elders and Tribal Health Partners (e.g., Tribal college Leaders), determine focus areas of public health engagement, workforce shortage drivers (education, financial, family, etc.), needs in health programs by Sept. 2025.		

OBJECTIVE 2.10

Short-term Task:	Present Objectives	Future Objective
Develop and implement a process for collecting community feedback (e.g., a checklist) for all appropriate CE Unit projects and initiatives by June 2024.	Share processes and tools on community input and feedback with other NDHHS divisions and units interested in promoting health equity by Dec. 2024.	Develop policies and procedures to ensure systematic representation of all North Dakota voices from start to finish in the CE Unit and NDHHS initiatives through advisory boards, Tribal Health Directors, the HEC, broad stakeholder engagement, surveys, CBOs and LPHU inputs and others by Dec. 2027.
Develop a quality review process in collaboration with NDHHS communications to ensure inclusive, person-first language in all communications by Dec. 2025.	Develop and implement a plan in partnership with NDHHS Communications to incorporate key stakeholder and community voices into Department communications products by Dec. 2026.	
Collaborate with NDHHS Communications to create ongoing health equity-focused media releases (observances, reports, new research/data) by Dec. 2025.		
Train all Communications staff on Health Equity by June 2024.		

OBJECTIVE 2.11

Short-term Tasks:	Present Objectives	Future Objective
Each CE Unit Advisory Board will develop two strategies to increase board engagement by Dec. 2024.	All advisory boards will have standardized practices to use available funds, recruit new members and increase the value of board functions for board members and the agencies and organizations supported by the boards by Dec. 2026.	All Advisory Boards, including the YAB, BeYOU and NFI Advisory Boards, will provide enhanced functionality and value to board members and the agencies and organizations they support by Dec. 2027.
Each Advisory Board will implement two new member recruitment strategies by Dec. 2024.		
CE Unit Advisory Boards will examine their community's epidemiological data to prioritize challenges by March 2025.		
Advisory Boards will host listening sessions to identify the most significant challenges and barriers in working with their communities by July 2024.	Collaborate with Advisory Boards to implement strategies to improve community engagement for strategy feedback on by Dec. 2025.	
Advisory Boards will solicit ideas on the use of existing funding, prioritize ideas, and vote on using them by Dec. 2024.		

GOAL 3

Advance practices and systems informed by data through accountable and collaborative leadership to improve health equity.

OBJECTIVE 3.1

Short-term Task:	Present Objectives	Future Objective
Identify Emergency Preparedness and Response (EPR) Unit support the CE Unit can respond to future public health emergencies by June 2024.	Identify opportunities to incorporate lessons from the COVID-19 pandemic and other emergency response activations into current public health emergency processes, highlighting ways to ensure equitable support for focus populations by Dec. 2026.	Partner with EPR to have a clearly defined plan to support CE Unit focus populations' unique needs in emergency preparedness protocols and responses to public health emergencies by Dec. 2027.
Socialize emergency preparedness public health protocols with the DPH to ensure equity is central to all strategies and actions by June 2025.		

OBJECTIVE 3.2

Short-term Task:	Present Objectives	Future Objective
Train NDHHS divisions on a framework for effective health equity messaging that combines storytelling and data by June 2024.	Identify projects that reduce disparities and test storytelling and data visualization approaches based on currently available data by Dec. 2025.	Provide thought leadership to standardize a framework, protocols and guidelines across NDHHS for public-facing storytelling that includes data and publish 10 – 12 KPIs that use stories/data to track and measure prioritized disparity gaps in North Dakota by Dec. 2028.
Identify health equity/disparity data gaps and develop strategies to address gaps by Dec. 2024		
Consult with Tribal Leaders and health agencies to determine data needs (i.e., Tribal Health Directors, Great Plains Tribal Epi Center North Dakota Interests) and incorporate input by March 2025.	Develop a plan to incorporate health equity storytelling in data (quantitative and qualitative) publicly accessible online and in print (by request) no later than Dec. 2025.	
Each year, add two new data stories to the model for 10-12 key performance indicators (KPIs) by no later than Dec. 2027.	Develop a process to ensure NDHHS website compliance with Americans with Disability Act (ADA) standards by Dec. 2023.	

OBJECTIVE 3.3

Short-term Task:	Present Objectives	Future Objective
Identify health equity/disparity data gaps in North Dakota- including race, ethnicity, disability, sexual orientation and gender identity (SOGI) data - for underserved populations and socialize them within the larger NDHHS community by Dec. 2024.	Create a workgroup to frame NDHHS's value proposition, methodology and mechanisms to collect race, ethnicity, disability and SOGI data by July 2025 while protecting Tribal Nations' data.	Leverage race, ethnicity, disability and SOGI data from NDHHS internal and external sources and publish it in public-facing reports by Dec. 2027.

OBJECTIVE 3.4

Short-term Task:	Present Objectives	Future Objective
Identify one or more epidemiologists within Health Statistics and Response responsible for supporting the CE Unit with different tasks and objectives by March 2024.	The assigned epidemiologist(s) from Health Statistics and Response will collaborate with other data staff within NDHHS to identify health equity data across the enterprise by Dec. 2025.	The epidemiologist(s) will collaborate with NDHHS data staff to create and launch internal and external health disparities dashboards by Dec. 2028.

OBJECTIVE 3.5

Short-term Tasks:	Present Objectives	Future Objective
Collaborate with the Primary Care Office (PCO) and Tribal Community Leaders to identify resources to expand the AI/AN healthcare workforce through a career pathways program by Dec. 2025.	Create and implement a career pathways program to increase healthcare-related AI/AN enrollees at high school and college levels by Dec. 2026.	Conduct two sustainable career pathways with Tribal Community Leaders (one for high schools and one for colleges) to increase the AI/AN healthcare workforce by Dec. 2027.

OBJECTIVE 3.6

Short-term Tasks:	Present Objectives	Future Objective
Develop a menu for quarterly health equity capacity-building trainings and continuing education for key partners (i.e., LPHUs, NFI stakeholders, Tribal Health Agencies, CBOs) starting Jan. 2024.	The CE Unit Director will coordinate with NDHHS leadership to identify opportunities to leverage training dollars in the CE Unit budget with those from other NDHHS division budgets to enhance and expand health equity trainings, including at	Establish CE Unit as the go-to NDHHS resource with access to long-term funding for referrals and resources to support NDHHS and public health workforce education and training on health equity

Identify and promote free training through NACCHO, ASTHO, DeBeaumont Foundation and other sources to create quarterly offerings for CE Unit staff and NDHHS employees by Jan. 2024.

least one mandatory annual health education training and one continuing education training for all CE Unit and other key NDHHS staff, by Dec. 2025.

and how to better support underserved populations by Dec. 2027.

NEXT STEPS

Continued Stakeholder Engagement

As it operationalizes this Strategic Plan, the CE Unit will continue to outreach and engage stakeholders from across North Dakota to ensure its successful implementation to improve the health of all North Dakotans, including those most vulnerable. These stakeholders include other state agencies, LPHUs, policymakers, health care systems, educational institutions, Tribes, private and non-profit organizations, communities, individuals and families and others.

Making significant and meaningful changes will require considerable buy-in from these internal and external stakeholders. Stakeholders will be critical in informing implementation decisions, identifying potential change allies, and bringing forward important challenges to change comprehensively.

Oversight and Evaluation

IMPLEMENTATION PLAN

Strategic Plan implementation requires clear, measurable and trackable implementation steps to ensure the successful execution of the CE Unit's goals and objectives. The CE Unit initiated a comprehensive review of the Strategic Plan, breaking it into specific, actionable steps in an initial Implementation Plan. Collaborating with key stakeholders, including departmental leaders, staff and external partners, the CE Unit gathered diverse perspectives and ensured alignment with broader priorities and initiatives. Developing outcome measures for each objective that are sound, reliable and valid, provides actionable information directly relevant to each. A clear timeline to enhance transparency and accountability, outlining milestones and deadlines for each implementation phase. The next steps include identifying and allocating resources - considering financial and human capital - and prioritizing initiatives based on their impact. Once initiated, this will be an ongoing process of assessment of action to ensure progress toward each objective, as well as to determine if any changes to the short-term tasks or objectives are required based on changes to the environment or circumstances within which they are working.

CE Unit staff will track and monitor the Implementation Plan quarterly for reporting to leadership and share progress through established communication channels to keep all stakeholders informed and engaged throughout the Strategic Plan's implementation. Supporting metrics and outcomes will be developed collaboratively based on each objective. Key performance indicators will measure progress and foster a culture of adaptability, encouraging feedback and adjustments to respond to changing circumstances. Continuous monitoring and evaluation mechanisms will be integrated to assess the effectiveness of the Implementation Plan and allow for timely adjustments. By adopting this collaborative, adaptive and transparent approach to the Implementation Plan, the CE Unit is well-positioned to translate the strategic vision into tangible and sustainable outcomes for the Unit, the DPH and NDHHS.

APPENDICES

APPENDIX A: INTERVIEWS

NDHHS Leadership

HMA engaged national thought leaders to discuss innovative health and social services policy and financing. The list of thought leaders and interview themes included:

Deanna Askew, *Unit Director*
Family Health and Wellness Unit
Krista Fremming, *Assistant Director*
Medical Services
Molly Howell, *Assistant Director*
Disease Control and Immunization
Kimberly Hruby, *Assistant Director*
Special Health Services Unit
Kim Mertz, *Section Director*
Healthy and Safe Communities Section
Tracey Miller, MD, *State Epidemiologist*
Health Statistics and Performance
Marie Moe, *Public Health Strategist/Local Public Health Liaison*
Systems and Performance Unit
Susan Mormann, *Unit Director*
Health Promotion & Chronic Disease Prevention Unit
Lindsey VanderBusch, *Unit Director*
Division of Sexually Transmitted and Bloodborne Diseases

Focus Group Participants

HMA engaged local thought leaders to contemplate information gathered from the national thought leaders and discuss more effective and efficient systems to support healthier individuals and communities. The local thought leaders include:

NDHHS DIVISION LEADERS

Michelle Dethloff, *Program Manager*
Division of Disease Control
George Gerhardt, *Emergency Preparedness Program Representative*
Emergency Medical Systems
Christie Massen, *Chief Laboratory Officer*
North Dakota Public Health Laboratory
Darin Meschke, *Director*
Vital Records
Brenton Nesemeier, *Director*
Field Services
Grace Njau, *Special Projects & Health Analytics Director*
North Dakota Department of Health
Kodi Pinks, *Director*
Non-Infectious Disease Surveillance & Data Management
Christopher Price, *Director*
Emergency Medical Systems
Ryan Rippley, *DOC Planning Chief*
Health Response and Licensure
Dipshikha Sharma, *State Refugee Health Coordinator*
North Dakota Department of Health and Human Services
Holly Triska-Dally, *State Refugee Coordinator*
North Dakota Department of Health and Human Services
Julie Wagendorf, *Director*
Food and Lodging

HEALTH SERVICES/HEALTH SYSTEMS

Lori Garnes, *Associate Director of Program Development*
Minot State University: North Dakota Center for Persons with Disabilities
Brad Gibbens, *Acting Director*
Center for Rural Health at the University of North Dakota
Andrew Williams, *Assistant Professor*
University of North Dakota Health Program

OTHER STATE AGENCIES

Kathleen Donahue, *Deputy Chief for Recovery and Mitigation*
Division of Homeland Security
Brad Hawk, *Deputy Director*
Indian Affairs Commission
Dave Leingang, *Transportation Planner*
ND Department of Transportation
Jana Pastir, *Deputy Director of Workforce Development*
ND Department of Commerce

COMMUNITY ORGANIZATIONS

Ray Ann Kilen, *President*
Women Empowering Women

NEW AMERICAN/FOREIGN BORN/ IMMIGRANT ADVISORY BOARD

Sahra Abdullahi
Rashid Hussein
Caprice Knapp
Ahmed Makaraan
Patricia Thornock

BEYOU ADVISORY BOARD

Kayla Hochstetler
Jacqueline Hoffarth
Barry Nelson
Cody Severson

YOUTH ADVISORY BOARD

Andrea Duah
Brynn Gaebe

APPENDIX B: COMMUNITY ENGAGEMENT STAFF

Krissie Guerard, MS
Community Engagement Director

Jorden Laducer
Community Engagement Training Coordinator

Cheyenne M. Smith
Tribal Health Liaison
Primary Standing Rock Nation, Secondary MHA (Western ND)

Alicia Belay, MPH, PhD
Community Engagement Assist. Director

Ruth Nwatu
Community Engagement Coordinator

Hunter Parisien
Tribal Health Liaison
Primary Turtle Mountain, Secondary Spirit Lake and Sisseton Wahpeton (Eastern ND)

Sara Upgren
Community Engagement Administrative Assistant III

Katarina Domitrovich
Community Engagement Specialist

Sonya Abe
Tribal Health Liaison Primary Mandan, Hidatsa & Arikara Nation (MHA), Secondary Standing Rock Nation (Western ND)

Luticia Mann
Tribal Health Liaison
Primary Spirit Lake and Sisseton Wahpeton, Secondary Turtle Mountain (Eastern ND)

GRADUATE ASSISTANTS AND INTERNS

Valentina Bamfowaa
North Dakota State University
MPH Graduate Assistant
Community Engagement Unit Intern

Juliana Antwi
North Dakota State University
MPH Graduate Assistant
Community Engagement Unit Intern

Payton Drent
North Dakota State University
Undergraduate Research Assistant
Public Health Research Intern

APPENDIX C: GLOSSARY OF KEY TERMS

Key terms in the Strategic Plan are defined below and designed to be inclusive.

Term	Definition	Reference
Behavioral Health (BH)	The promotion of mental health, resilience and well-being; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities. Behavioral health conditions and the behavioral health field have historically been financed, authorized, structured, researched and regulated differently than other health conditions.	Substance Abuse and Mental Health Services Administration (SAMHSA) https://www.samhsa.gov/sites/default/files/samhsa-behavioral-health-integration.pdf
Focus population	A population group in North Dakota identified by NDHHS as often experiencing health disparities that include but are not limited to African Americans, AI/AN, aging individuals, Homeless, LGBTQ2S+, NFI, Persons with Disabilities, Rural, Youth who are disproportionately affected by socioeconomic issues and other factors.	
Food insecurity	A lack of consistent access to enough food and the nutritional value of available foods for every person in a household to live an active, healthy life. This can be temporary or long-term due to affordability or other factors.	https://www.feedingamerica.org/hunger-in-america/food-insecurity
Health Disparities	Preventable differences in the burden of disease, injury, violence, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic and other population groups and communities.	https://www.cdc.gov/aging/disparities/index.htm
Health Equity	Health equity means everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health, such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality	https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html https://www.census.gov/library/working-papers/2021/demo/SEHSD-WP2021-03.html

	education and housing, safe environments and health care.[1,2]	
Health in All Policies	Health in All Policies (HiAP) is a collaborative approach that integrates and articulates health considerations into policymaking to improve the health of all communities and people. HiAP recognizes that health is created by a multitude of factors beyond health care and, in many cases, beyond the scope of traditional public health activities. A HiAP approach may be effective in identifying gaps in evidence and achieving health equity.	CDC https://www.cdc.gov/policy/HiAP/index.html
LGBTQ2S+	An abbreviation for lesbian, gay, bisexual, transgender, queer or questioning, and two-spirit. The plus symbol is intended as an all-encompassing representation of sexual orientations and gender identities. As the widely used and well-known acronym, LBGTQ2S+ has evolved to ensure inclusivity across all spectrums of identity and will continue to change as we progress.	
Population Health	The health of a population as measured by health status indicators and as influenced by social, economic and physical environments; personal health practices; individual capacity and coping skills; human biology; early childhood development; and health services (Dunn and Hayes 1999). Additionally, the health outcomes of a group of individuals, including the distribution of such outcomes within the group (Kindig and Stoddart 2003). A framework for thinking about why some populations are healthier than others, as well as the policy development, research agenda and resource allocation that flow from it (Young 1998).	Kindig. The Milbank Quarterly. 2007;85(1):139-61

[1] https://www.rwjf.org/en/insights/our-research/2017/05/what-is-health-equity-.html

[2] https://www.census.gov/library/ working-papers/2021/demo/SEHSD-WP2021-03.html

Public Health	"The combination of all evidence-based public and private efforts that preserve and promote health and prevent disease, disability and death at the population level." Public health is (1) a structure - government agency, (2) a function (The 10 Essential Public Health Services), and (3) a science.	Hanson, Hurd, and Levin, p. 160 CDC - The 10 Essential Public Health Services https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html
Social Drivers of Health	Social drivers of health are the conditions in which people are born, grow, work, live and age. SDOH are non-medical conditions that include social, economic, physical or other factors in people's lives. These factors have been found to directly influence health, functioning, and quality of life outcomes and risks.[3]	https://health.gov/healthypeople/priority-areas/social-determinants-health

[3] https://health.gov/healthypeople/priority-areas/social-determinants-health

APPENDIX D: END NOTES

[1] https://www.americashealthrankings.org/explore/annual/state/ND
[2] https://www.americashealthrankings.org/explore/annual/measure/Overall/state/ND
[3] https://stateofchildhoodobesity.org/states/nd/
[4] http://www.healthdata.org/united-states-north-dakota
[5] https://www.samhsa.gov/data/sites/default/files/NorthDakota_BHBarometer_Volume_4.pdf
[6] https://www.bls.gov/iif/oshstate.htm#ND
[7] https://www.census.gov/quickfacts/fact/table/ND/PST045219
[8] https://www.census.gov/quickfacts/fact/table/ND/PST045219
[9] https://www.commerce.nd.gov/uploads/26/CensusNewsletterDec2017.pdf
[10] https://www.census.gov/quickfacts/fact/table/ND/PST045219
[11] https://www.ndhealth.gov/phsp/documents/Health_Status_Assessment_Report_for_North_Dak_ota.pdf
[12] https://www.hopeinitiative.org/state/north-dakota
[13] https://www.americashealthrankings.org/explore/senior/measure/obesity_sr/state/ND
https://data.cms.gov/mapping-medicare-disparities
[15] https://ruralhealth.und.edu/assets/3694-15372/2017-2019-nd-rural-health-needs.pdf
[16] https://www.ndhealth.gov/phsp/documents/Health_Status_Assessment_Report_for_North_Dakota.pdf?v=2
[17] https://www.health.nd.gov/sites/www/files/documents/Files/OSE/YRBS/2019_NDHS_Statewide_REA_Regions.pdf
[18] https://www.ndhealth.gov/phsp/documents/Health_Status_Assessment_Report_for_North_Dakota.pdf

[2] https://www.americashealthrankings.org/explore/measures/Overall/ND
[2] https://www.americashealthrankings.org/learn/reports/2022-annual-report
[3] https://www.americashealthrankings.org/learn/reports/2021-disparities-report/state-summaries-north-dakota
[4] https://assets.americashealthrankings.org/app/uploads/allstatesummaries-ahr22.pdf
[5] https://assets.americashealthrankings.org/app/uploads/allstatesummaries-ahr22.pdf
[6] https://www.hhs.nd.gov/sites/www/files/documents/
[7] https://www.hhs.nd.gov/sites/www/files/documents/
[8] https://www.hhs.nd.gov/sites/www/files/documents/DOH%20Legacy/STI/06_NDData.pdf
[9] https://www.nd.gov/dpi/districtsschools/safety-health/youth-risk-behavior-survey
[10]https://www.nd.gov/dpi/districtsschools/safety-health/youth-risk-behavior-survey
[11]https://mediarelations.gwu.edu/blacks-latinos-and-native-americans-severely-underrepresented-health-workforce-new-
[12]https://familymedicine.uw.edu/chws/wp-content/uploads/sites/5/2022/07/2022_AI_AN_Workforce_RR_Brief.pdf
[13]https://www.hhs.nd.gov/sites/www/files/documents/
[14]https://www.hhs.nd.gov/sites/www/files/documents/
[15]https://www.bcbsnd.com/content/dam/bcbsnd/documents/brochures/caring-foundation/BCBSCF2023_FinalReport.pdf
[16]https://www.americashealthrankings.org/explore/measures/Overall/ND
[17]https://www.americashealthrankings.org/learn/reports/2022-annual-report
[18]https://www.americashealthrankings.org/learn/reports/2021-disparities-report/state-summaries-north-dakota