

California Department of Public Health Office of Health Equity

Strategic Planning Meeting Summary

Prepared by:



TSI CONSULTING PARTNERS, INC.

January 6-7, 2014

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California Department of Public Health
Office of Health Equity
Strategic Planning Meeting
Meeting Summary: January 6-7, 2014

INTRODUCTION

Jahmal Miller, Deputy Director of the California Department of Public Health’s Office of Health Equity (OHE), introduced Tim Fallon and Laurie Schulte of TSI CONSULTING PARTNERS and invited them to facilitate the strategic planning portion of the Office of Health Equity Advisory Committee meeting.

Tim Fallon provided an overview of strategic effectiveness – an organization’s ability to set the right goals and consistently achieve them.



Organizations with high strategic effectiveness:

- Quickly formulate a “good enough” strategic plan.
- Move immediately to implementation—letting implementation teach them the ways that the strategy is on target and ways it needs to be improved.
- Review progress on implementation regularly with honesty and candor.
- Make needed adjustments based on what is working, what isn’t, and how the world has changed.
- Focus on results, not activities.

Tim also outlined the agenda for the strategic planning session:

- Assess the current situation of health equity in the State of California.
- Begin to set the future direction for achieving health equity in California.
- Draft a central challenge and strategic priorities for health equity in California for the next three years.

Discussion of the process included the following points.

- The group agreed to the following assumptions.
 - The legislative mandate is directed specifically at the Office of Health Equity.
 - The future direction being developed by this group (e.g., mission, vision and strategic plan/map) are:
 - Guidance documents for the Office of Health Equity and the Department of Public Health as the OHE carries out its legislative mandate
 - A vehicle to empower individuals, organizations and communities throughout the state to work on reducing health disparities in California
 - A recommendation of the Advisory Committee to the OHE to facilitate both of these efforts
- There are several challenges facing the Office of Health Equity and its Advisory Committee as it develops a strategy for achieving health equity in California.
 - There must be a balance between broad stakeholder engagement and a reasonable time to closure on decisions.
 - The strategy must be multi-sectoral, involving a range of stakeholders across the state. This type of strategy is more difficult to implement than a strategy for a single organizational entity.
 - OHE has a mandate to bring the key assets and resources of the OHE, the Department of Public Health, and other state agencies to bear on achieving health equity. However, the work/resources required go far beyond these governmental entities and their combined resources.
- The planning group must develop a strategic, rather than a comprehensive, plan.
 - A comprehensive plan encompasses everything we could do.
 - A strategic plan focuses on the few critical things that:
 - Will have the greatest impact
 - Can be realistically accomplished given limited resources
- The Health in All Policies Task Force, which is part of the OHE, will be critical to helping ensure that the health equity strategy is successfully implemented.
- The intent of the task force is to build shared responsibility for improving health equity in California among all state government entities.
 - This is included in the statute.
 - The task force will help determine how this collaboration will happen.
 - Its purpose is to:
 - Engage other agencies, departments and offices in order to mobilize governmental resources to achieve health equity.
 - Encourage incentives and mutual benefits for others to engage.
- Outside of state government, the OHE does not have the authority to marshal resources in support of this work.
 - Its influence and partnerships will be critical to strategically engage stakeholders statewide that can contribute to achieving health equity.
 - Advisory Committee members can also influence their own constituencies.
 - The ability to secure sustainable funding will also impact implementation of the Advisory Committee's recommendations.
 - Funding could come from:
 - Federal government

- State government
 - Private foundations
 - Public/private partnerships
- It will be important to use data in the best possible way so that it:
 - Is comprehensive as well as nuanced
 - Accurately guides focused action across the state
- The group needs to develop a plan that can be widely disseminated. It will:
 - Be as inclusive as possible.
 - Include a communications plan.
 - Likely include some dimensions that are not the responsibility of the Advisory Council to impact—for example:
 - Education
 - The private sector
 - Philanthropic foundations
- The Advisory Committee needs to ensure that the health equity strategic plan is thoughtful about language and cultural competency.
- The strategic plan must be clear to those who receive services, regardless of their level of education.
- The California Reducing Disparities Plan (CRDP) is being developed in parallel with the health equity strategy.
 - We must be sure to differentiate these two important initiatives.
 - This differentiation will be important for stakeholders and the public.
- A key principle in TSI’s approach to strategic planning is to quickly develop a “good enough” strategic plan.
 - Some on the Advisory Committee disliked this notion, given its implications in a health equity context.
 - From a planning process perspective, “good enough” is never intended to be a substitute for high quality.
 - The goal is to avoid “getting stuck” in the planning process and to move forward with implementing the best possible plan we can develop at this point in time.
 - The Advisory Committee decides what is “good enough”—not the consultant.
 - We must ensure that the plan is flexible enough to be adapted to changing conditions.
 - As implementation is carried out and learning occurs, the “good enough” plan becomes better and better.
 - More appropriate language than “good enough” is the term “best possible plan.”

ASSESSING THE CURRENT SITUATION

Assessing the current situation of health equity in California is a first step in developing a strategy for improving health equity throughout the state. Participants met in small groups to complete an assessment of the current situation of health equity in California. The small groups addressed the following three questions.

- What are California’s strengths to build on in developing and implementing a health equity strategy?

- What are the critical health equity issues the strategy needs to address?
- What are the barriers/obstacles to overcome as California develops and implements its health equity strategy?

Strengths to Build On

GROUP 1: HERMIA PARKS, AARON FOX, WILLIE GRAHAM, SERGIO AGUILAR-GAXIOLA, DEXTER LOUIS

- Legislative mandate
- Demographics: minority/majority state
- Community engagement and stakeholder involvement
- Leveraging additional money
 - CACA
 - 1115 Waiver
- Existing programs, e.g. Health in All Policies
- Next generation
- Existing collaboration
- Data
- Some funding
- Patient-Centered Outcome Research Institute (PCORI)

GROUP 2: ROCCO CHENG, NEAL KOHATSU, PATRICIA RYAN, GAIL NEWEL, JEREMY CANTOR, DELPHINE BRODY

- California chose comprehensive implementation of the Affordable Care Act.
- California Reducing Disparities Plan (CRDP)
 - Population reports
 - Strategic plan
- California is a diverse state.
 - More awareness and experience
 - Progressive vision
 - Large and active disability rights movement
- MESA Proposition 63
 - Prevention
 - Early intervention
- More intersectoral work
 - Health in All Policies
 - Strategic Growth Council

GROUP 3: FRANCIS LU, ELLEN WU, SANDI GALVEZ, ALVARO GARZA, YVONNA CAZARES

- Data
- Diversity
- Momentum
- Collaboration, e.g. Health in All Policies
- CRDP
- Affordable Care Act
- Political will
 - Legislators

- Electorate
- A plus and a minus
- Improved economy
- Local Control Funding Formula (LCFF)
- Increased awareness regarding the social determinants of health

GROUP 4: CARRIE JOHNSON, LINDA WHEATON, KATHLEEN DERBY, GENERAL JEFF, CYNTHIA GOMEZ

- Diversity
- (Limited) funding
- Good models, for example:
 - San Francisco HIV
 - Leadership advocacy
- Lots of non-profits
- Force for change/urgent need
- Human resources: people who need/want change
- Data: we know a lot about the disparities
- Accessibility of technology (a plus and a minus)

Critical Health Equity Issues the Strategy Needs to Address

GROUP 1

- Social determinants
- Data
 - The right data?
 - Gaps?
 - Timely?
- Intersectoral collaboration
- Affordable Care Act
- Capacity
 - Workforce
 - Diversity
 - Culturally and linguistically competent providers, etc.
- Communication to stakeholders
- Resource availability
- Policy/legislation
- Demographic trends
- Access vs. utilization; geographic access
- Valuable to others
- Timelines
- Political climate
- Residually uninsured
- Mistrust of the system
- Engaging trusted community providers/organizations

GROUP 2

- Poverty

- Growing inequity
- Psychosocial trauma response
- Lack of education
 - Access
 - Quality
- Environmental
 - Climate
 - Built environment
- Violence
 - Exposure
 - Post-Traumatic Stress Disorder
 - IPV, institutional
- Resources
 - Financial
 - Workforce
- Food security
- Housing security
- Blame on individuals
- “Isms”
- Income disparity
- Priority setting

GROUP 3

- Institutional racism
- Education, readiness, and achievement
- Income inequality
- Create a dashboard, especially for:
 - The social determinants of health
 - Health in All Policies work
- Mental health prevention
- Mental health services
- Better data collection
 - LGBTQ
 - Disaggregation
 - Cross-tabulation
- Chronic diseases
- Coverage
- Neighborhood conditions
- Workforce diversity
 - Health
 - Mental health
- Access to care
- Culturally and linguistically appropriate services

GROUP 4

- Growing income inequality

- Lack of aggressive oversight/accountability; apathy
- Power imbalance
- Institutionalized racism
- Top heavy “solutions”; funding doesn’t reach the people
- Lack of grass roots inclusion
- Cronyism within delivery systems
- High levels of illiteracy/high school dropout rates
- Entrenched cycle of poverty
- Segregation
 - Residential
 - School-wide
- Language diversity
- Lack of culturally appropriate services
- Racial/ethnic designations are a current and future problem.
- Still a medical model/blaming the individual vs. society
- Lack of integrated care/perspective
- Lack of financial commitment to those in need, i.e. social responsibility
- Lack of caring

Barriers/Obstacles to Overcome

GROUP 1

- Financial resources
- Trust and buy-in from:
 - Community
 - Leaders
- Silos
- Culturally and Linguistically Appropriate Services (CLAS)
- Political will/climate
- Capacity
- Inertia
- Lack of education
- Fragmented data
- Changing cultures
- Effective prevention strategies/interventions
- Language

GROUP 2

- Policy and political leadership accountability/watchdog
- Gaps in representation
 - The underserved
 - The voiceless
- Sufficient funding/resources
- Meaningful:
 - Engagement
 - Outreach
 - Implementation

- Bridging the silos: shared framework
 - Mental health
 - Physical health
 - Public health
- Diversity
 - Urban
 - Rural
 - Geographic
- Program and policy evaluation
- Workforce development and capacity building
- Data missing for some specific populations
 - LGBTQ
 - Mixed race
 - Aging groups
 - Women
 - Sub-groups
- Lack of recognition
 - Peer support
 - Culturally defined practices
- What is “evidence-based?”

GROUP 3

- Few unconstrained resources
- Constraints on DPH/OHE in bureaucracy
- Political will
- Opposition
 - Industry
 - Electorate, etc.
- Leadership changes
- Leadership
- Implementation, especially at the local level
- Cross-sectoral collaboration
- The number and diversity of providers
 - Access
 - Health and mental health
- Data
- Prominence in overall state government structure (vs. Health in All Policies)

GROUP 4

- Broad scope/complexity of the interrelated barriers
- Where to start/prioritize
- Time to establish results
- Monitoring success; it's hard to prove prevention
- Competing priorities of those involved

Discussion of the assessment of the current situation included the following points.

- A “one size fits all” model will not work to reduce disparities/achieve health equity.
- Those leading this work must be brutally honest with themselves that there is no mechanism to “enforce” the strategy we develop.
 - Political will is critical, but variable.
 - We must consider short-term as well as long-term potential benefits and obstacles.
 - We need to balance acting with a sense of urgency with building sustainability of these efforts into the strategy.
- Although the BARHII framework is helpful in providing a lens for analyzing health inequities, it doesn’t include an emphasis on institutional power and its impact on health inequities.
- There is considerable overlap in the reports of the small groups – which provides the possibility of building on common ground. There are significant nuances that will require future discussion, but the reports give us a good starting point for moving forward.
- We need to have a sense of urgency and a clear understanding of how the brain power and talent of the Advisory Committee can be used to effectively address health inequities.
- We need to find the right balance between a sense of urgency and inclusive engagement of all stakeholders. This is a difficult challenge, but it’s important to get it right.
- As we develop the timeline for developing and implementing the health equity strategy, it’s important to work in a coordinated way with the Health in All Policies Task Force and the Disparities Report that is currently being developed.
- The timeline is “now!” We have a brief window of time in which to institutionalize an effective strategy for addressing health inequities, and we need to take full advantage of it.
- We need to be realistic in terms of what can be accomplished in the three years of the plan. Systemic change takes longer than three years. We need to focus on key areas where we can get meaningful traction to improve the health of communities.
- We need to make sure that we have a meaningful way to engage our constituents – such as questions and a protocol that provide guidance.

SETTING FUTURE DIRECTION

Overview of Key Elements of Future Direction

Laurie Schulte provided an overview of the key elements of an organization’s future direction.



- An organization’s mission states why it exists, its reason for being, its fundamental purpose. It’s an enduring statement that usually remains the same for many years, providing long-term continuity and direction for the organization.
- Vision articulates the long-term outcome or end-state that the organization will make a definitive contribution to creating.
- Strategy outlines what the organization needs to do at this point in its history. It is more focused and time bound than mission and vision—often looking to the next three to five years.
- An organization’s core values and/or guiding principles outline its unique approach, its norms for “how we do things” in the organization.
- An organization’s tactics outline “how to” implement its strategy.

Mission and Vision

As context for developing a health equity strategy for the State of California, participants reviewed the statute by which the Office of Health Equity was created, using guidance from the Deputy Director to focus on the following statement.

OHE MISSION/PURPOSE: STATUTE

Achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice.

After significant discussion and revision, the group agreed to the following as draft mission and vision statements for the California health equity strategic plan.

MISSION OF OHE-LED EFFORTS TO ACHIEVE HEALTH EQUITY IN CALIFORNIA

Promote equitable social, economic and environmental conditions to achieve optimal health, mental health and well-being for all.

VISION FOR OHE-LED EFFORTS TO ACHIEVE HEALTH EQUITY IN CALIFORNIA

Everyone in California has equal opportunities for optimal health and well-being.

In discussing mission, the following points were made.

- The statute is specifically directed toward the OHE. The mission and vision apply to the statewide health equity strategy. OHE will lead this work, but it cannot carry it out alone.
- The Advisory Committee advises the OHE; its members are not primary implementers of the strategy. They do, however, play a key role in:
 - Formulating and recommending to the OHE the future direction for achieving health equity in California as outlined in the statute
 - Advising the OHE as it carries out efforts to implement the plan
 - Partnering with and influencing other stakeholders to collaborate in carrying out the strategic plan
- The group discussed what constitutes the highest level of health.
 - There are different interpretations and cultural assumptions.
 - Populations generally define health for themselves—but these definitions tend to be influenced by the dominant health care/medical model.
 - Ideally, individuals and communities would define and achieve their own goals for their health.
- The group is committed to a holistic approach to health, inclusive of physical and mental/behavioral health.
- The group was purposeful in referencing the social determinants of health in the mission.
 - This context is critical to properly frame the health equity strategy.
 - The social determinants transcend physical and mental health, to include individuals, families, neighborhoods, institutions, and society.
- The group discussed focusing the mission on inequities (e.g., those conditions that are systematic, avoidable, unfair and unjust), rather than health equity.
 - This focus might be a unique niche for the work of OHE.
 - It could focus on the systems that perpetuate inequities, so that California is a state that doesn't allow them to exist.
 - Most importantly, the mission should clearly and simply define what needs to be done to improve health equity.
 - Ultimately, the group agreed to the above wording in order to keep the statements broad and aligned with the statute.
- The group was purposeful in not using the word “opportunities” in the mission/vision because that language puts the onus on individuals as primary contributors to their own health status.
- One committee member pointed out discomfort in referencing only a portion of the relevant statute passages (sections b.1 through b.4) in the mission/vision.
 - Importantly, the statements as crafted are broad and consistent with the statute.
 - The alignment will manifest itself more specifically in the strategy and its implementation.
 - After discussion, the group as a whole agreed to accept the draft statements as written above.

Central Challenge and Strategic Priorities

Participants were asked to identify – in a word or phrase – the central challenge in improving health equity in the State of California over the next three years. A summary of responses follows:

- The lack of recognition for the needs of the people at the bottom of the State of California's totem pole
- Leadership, in terms of both leadership changes and the prioritizing of this as an issue
- A clinical gaze that is colored by a white, upper class, male cultural hegemony
- Looking at the many, many health disparity issues; how diverse California is, there are so many issues, how do we narrow it down?
- Lack of resources
 - Funding
 - Staffing
 - Cultural competency services
 - Getting buy-in at the local level
- Single payor
- Lack of culturally and linguistically appropriate services (CLAS) that are both accessible and actually utilized
- The lack of political will, determination and commitment to make this happen
- The people of California lack a collective agreement and generosity to help all people regardless of their plight.
- Have leaders, stakeholders and others recognize and address the issues of health equity and the social determinants of health.
- Lack of a genuine and broad commitment to ensuring safe and healthy communities for everyone
- Relevance – why this is important
- Embedded “ism's”
- Put all marginalized individuals and communities as an actual, central concern.
- Equalizing opportunities
- Ensuring that all Californians obtain an education
- A united message with real conviction to serve the community
- Education, poverty, employment, housing – the social determinants of health
- The fear of losing power of privilege
- A lack of “we” out there

Using a one-page graphic representation of a strategic map, Tim Fallon explained the concepts of central challenge and strategic priorities.

- The oval at the top of the strategic map is the central challenge.
 - It is the focal point for strategy.
 - It focuses on what the organization needs to do in the next three years to support its mission.
- The central challenge is supported by some number of strategic priorities.
 - Strategic priorities are the few critical things we must do in order to meet our central challenge.

- The number of strategic priorities can vary, but is never fewer than three or more than six.
- There are two tests of a strategic priority:
 - Is each priority *necessary* to meet the central challenge?
 - Are the strategic priorities taken together *sufficient* to meet the challenge?

Based on participant input on the central challenge and OHE work done to-date, Tim Fallon then presented a “first draft” of a possible central challenge and strategic priorities for improving health equity in the State of California over the next three years, as follows.

**California Health Equity
Strategic Map: 2014-2016**

Draft
01/07/14



After extensive discussion, the group made the following revisions, recognizing the work was not yet complete.

**California Health Equity
Strategic Map: 2014- 2016**

Draft
01/07/14



Participants then met in small groups to further refine the central challenge and strategic priorities. They used the two drafts above, the assessment of the current situation, and other background documents to guide their work. A summary of the small group reports follows.

GROUP 1: HERMIA PARKS, AARON FOX, WILLIE GRAHAM, SERGIO AGUILAR-GAXIOLA, DEXTER LOUIS

Central Challenge

Mobilize understanding and commitment to eliminate health inequities and address the social determinants of health.

Strategic Priorities

- Evaluate/monitor/disseminate actionable information on disparities.
 - Quality data and research to address gaps
 - Translation/make it understandable
 - Education/outreach
 - Engagement
 - Urgency
 - What matters to communities?
- Strengthen meaningful stakeholder engagement in policy development and implementation, with good communication.
- Implement/embed CLAS system-wide and evaluate.
- Empower communities through disparity reduction initiatives.
 - Financial resources
- Build sustainable partnerships.
 - Shared decision-making
 - Eliminate silos.
 - Bi-directional communication and shared values
 - Interest-based bargaining
- Capitalize on the Affordable Care Act.
 - Workforce development
 - Accessing/leveraging resources
 - Outreach, education, and engagement
 - Value-driven outcomes
 - Data
 - Preventative services/utilization
 - Integrated care
 - Technical assistance to providers on CLAS

GROUP 2: ROCCO CHENG, NEAL KOHATSU, PATRICIA RYAN, GAIL NEWEL, JEREMY CANTOR, DELPHINE BRODY

Central Challenge

Build sustainable commitment to achieve fair and equitable health and well-being for all.

Strategic Priorities

- Research and data
 - Actionable information
 - Gaps
- Advocacy
- Services
- Support and empower communities.
- Sustainable leadership commitment
- Communication, education, call to action

Cross-cutting Strategic Priorities

- Financial resources
- Cross-sector collaboration
- Institutional accountability

GROUP 3: FRANCIS LU, ELLEN WU, SANDI GALVEZ, ALVARO GARZA, YVONNA CAZARES

Central Challenge

Ensure equitable social, economic and environmental conditions to achieve optimal health and mental health for all.

Strategic Priorities

- Data; ACA
- Health in All Policies/influence policy
- Leadership
 - Commitment
 - Resources
 - Institutional commitment of resources
- Services
 - Expand access to and utilization of
 - C & L
 - Access
 - Workforce diversity
- Community empowerment of voters
- Partnerships
 - Cross-sectoral collaboration
 - Existing coalitions and networks, e.g. BMOC

GROUP 4: CARRIE JOHNSON, LINDA WHEATON, KATHLEEN DERBY, GENERAL JEFF, CYNTHIA GOMEZ

Central Challenge

Achieve universal commitment to eliminate health and mental health inequities for all Californians.

Strategic Priorities

- Understand drivers of inequities.
 - Engagement
 - Research
 - Education
- Incentivize action through economic and social benefits of equity.
 - Models of benefit
 - Affordable Care Act
 - Alternative businesses
- Develop leadership buy-in and mobilization.
 - Outreach
 - Collective impact models
- Infrastructure improvement/development for action
 - Address institutional racism.
 - Culturally and linguistically appropriate services (CLAS)

Cross-cutting Strategic Priorities

- Engagement of individuals and communities facing inequities
- Resources
 - Financial
 - People
 - Tools, etc.

TSI CONSULTING PARTNERS' SYNTHESIS OF THE SMALL GROUP REPORTS

Based on analysis of the small group reports, Tim Fallon and Laurie Schulte provided the following synthesis of themes for the Advisory Committee to review.

Central Challenge

- Commitment
- All
- Health and mental health
- Ensure equitable social, economic and environmental conditions.
- Eliminate health inequity and address social determinants of health.
- Achieve fair and equitable well-being for all.
- Eliminate inequities.

Strategic Priorities

- Partnership/collaboration/engagement (cross-sector)
- Data
 - Research
 - Monitoring
- Policy/advocacy/health in all policies
- Services/culturally and linguistically appropriate services
- Community engagement/empowerment

- Leadership
 - Sustainable leadership commitment
 - Mobilization
- Resources
- Institutional accountability LIST
- Capitalize on the ACA
- Drivers of inequity
- Incentivize the benefits of equity
- Infrastructure for action
- Communication, education, call to action

The Advisory Committee agreed to use the following central challenge as the basis for developing the strategic priorities to support it.

Mobilize understanding and sustained commitment to eliminate health inequity and improve the health, mental health and well-being of all.

Tim Fallon and Laurie Schulte will use the above input to draft the strategic priorities, providing the draft to Advisory Committee members for feedback. A more complete description of this process is provided in “Next Steps” on page 20-21 below.

Discussion of the central challenge and strategic priorities included the following points.

- The group underscored the need to use language in the strategy that is accessible to those who will benefit from it.
- The group discussed whether there could be more than one central challenge.
 - In TSI’s strategic mapping methodology, a single central challenge provides the focal point for the strategy.
 - Often, this focal point is the most difficult thing for a planning group to agree on.
 - This agreement provides a strong unifying element for implementing the strategic plan.
- The group discussed the appropriate framing for the central challenge and strategic priorities.
 - Should the focus be on communicating the drivers of inequity or on incenting the benefits of equity?
 - The three-year timeframe impacts this thinking.
 - If the strategy incorporates stakeholder activity already occurring across the state, this could mobilize additional action.
- Both health and mental health should be referenced; without an explicit reference, mental health can be overlooked.
- While not included in the central challenge, a comment was made that the central focus of the strategy could be:
 - Getting communities out to vote
 - Getting communities to be leaders
- Given the role of the Affordable Care Act, a suggestion was made to add the word “access” to the central challenge. Others participants expressed concern that access is too specific for the central challenge, but it might be an appropriate strategic priority.

- The group should use care with the phrase “all Californians” and consider an alternative such as “people living in California.”
- The systemic factors/key drivers of health inequities need to be reflected in the strategy.
 - For example, the housing crisis and its predatory lending practices led to a range of negative outcomes.
 - How can the strategy be responsive to the drivers of inequities?
- The group discussed where leadership-based commitment to achieving health equity should come from, including:
 - Communities – where strong leadership is critical
 - Institutions – that need to take responsibility for their roles in perpetuating health inequities
 - Other places of influence
- The group may want to consider incorporating a statewide scan of current health equity efforts into the strategy.
 - This could include innovation, best practices, research, etc.
 - The best place to start might be to identify what California’s Department of Public Health currently has in place.
 - The scan should include the resources that are available to address health inequities.
- The complete strategic map will need to reference resource requirements. This could be a distinct strategic priority or be included within the strategic objectives that support the strategic priorities.
- The group expressed a desire to ensure that the strategic priorities aren’t overly specific; for example:
 - Data is only one way to build the capacity to identify the drivers of health disparities.
 - Health in All Policies is one way of engaging government agencies in a cross-sectoral approach to address health equity.
- The group agreed to add an option of “other” to the strategic priority list, to:
 - Recognize that the list that will be vetted is not intended to be inclusive of everything that stakeholders might want to see in the strategy.
 - Give them an opportunity to add things to the list as needed.
- It will be important to get input from the Health in all Policies Task Force on the realism of the strategy – particularly since the OHE staff and task force members will be its key implementers.
- The central challenge and strategic priorities will be vetted with a broad section of stakeholders. For that reason, the number of strategic priorities does not yet have to be compressed to what will ultimately be included in the strategic map.
- Vetting of the central challenge and strategic priorities should include:
 - Background on the process
 - Definitions of strategic map terms
 - Specifics on what the draft strategic priorities mean

NEXT STEPS

At the conclusion of the meeting, the group identified the following next steps.

Documentation

- The Advisory Committee meeting will be thoroughly documented by:
 - TSI Consulting Partners' summary of the strategic planning portion of the Advisory Committee meeting
 - The Office of Health Equity's summary of the other portions of the meeting, including the public comments throughout the meeting
- TSI will prepare a draft of the strategic priorities using the input provided by the Advisory Committee. It will include this draft with a statement of the mission, vision and central challenge included in this meeting summary.
- The draft of these statements will be vetted with the Chair and Vice Chair of the Advisory Committee.
- The goal is to ensure the statements are ready to be vetted with stakeholders, as outlined below.

Suggested Vetting Process

- The goal of the vetting is to get qualitative input on the draft statements, as follows:
 - Feedback on mission, vision, central challenge and strategic priorities using questions similar to the following:
 - Strengths
 - Issues and concerns
 - Suggestions
 - Input on specific actions that might support each strategic priority
 - The vetting process is also an opportunity to begin a scan of what health equity activities/resources already exist across the state.
- Feedback will be secured via an online survey accessible to the public. The survey will need to accommodate multiple languages – at a minimum, both English and Spanish.
- The draft statements will be provided to Advisory Committee members to share with their constituents. Advisory Committee members will:
 - Present the information to their constituents.
 - Secure feedback as appropriate.
 - Direct them to the online survey.
- TSI and the OHE will provide communications support for Advisory Committee members, including:
 - A consistent set of open ended questions to be used to secure feedback
 - A protocol for presentations/securing feedback
 - A means by which data can be captured consistently across communications opportunities
 - These approaches will be vetted with the Chair and Vice Chair of the Advisory Committee prior to the start of communications.

- A suggestion was made that community stakeholders could provide written survey responses via Family Resource Centers in many communities.
- Community forums and other modes of communication will be used later in the process of developing the health equity strategy.
 - Different strategies/approaches will be used at different points in the process.
 - The Advisory Committee must think strategically about the best ways to engage such a diverse range of stakeholders. This needs to include:
 - Considering various modes of communication and feedback at each stage of the process.
 - Being thoughtful of what is asked of whom.
 - Balancing the desire for broad input with pragmatism about what can reasonably be accomplished.
- There will be many opportunities for public input on the development of the strategy and its implementation, including the July release of the draft strategy for public review and comment.

Other

- OHE staff will provide additional clarification on the Bagley-Keene Act to committee members prior to the March Advisory Committee meeting.