TN Department of Health

HEALTH EQUITY PLAN 2023-2028

DIVISION OF FAMILY HEALTH AND WELLNESS
TENNESSEE DEPARTMENT OF HEALTH

To protect, promote, and improve the health and wellbeing of all people in Tennessee.

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I. FHW Director's Forward

Advancing Health Equity in Tennessee

Dear Colleagues and Community Partners,

I'm excited to introduce the 2023-2028 Family Health and Wellness Health Equity Plan. This document is a significant milestone in our ongoing journey toward achieving health equity for families across Tennessee. Rooted in our vision of optimal health and well-being for all Tennesseans, this plan demonstrates our collective commitment and strategic efforts to address health disparities in our communities.

This report has been a collaborative and thoughtful process, initiated by our Health Equity Committee, with representation across all FHW sections and job classifications. It reflects engagement from other Divisions at the Tennessee Department of Health and, importantly, our regional and local partners. Through this Committee's dedication, we have defined clear, actionable goals across our four priority areas: Equitable Services, Collaborations and Partnerships, Community Engagement, and Workforce Development. Each section, spearheaded by committed leaders and members, reflects our commitment to measurable and impactful change.

Elizabeth Harvey PhD, MPH
Assistant Commissioner, Title V Maternal and Child Health Director
Division of Family Health and Wellness

This report is not just an account of our work; it's a blueprint for the future. It outlines our strategies, timelines, and the steps we commit ourselves to in order to ensure equitable health services, meaningful partnerships, engaged communities, and a diverse, skilled workforce.

As we embark on this critical path, I am grateful for the support of our partners and the tireless work of our team. Together, we are building a healthier, more equitable Tennessee.

Thank you for joining us in this important endeavor.

II. Meet the Health Equity Committee

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FELLOW

Shannon De Pont

PROGRAM DIRECTOR

Acknowledgments: We extend our sincere gratitude to the dedicated teams across various departments: the Division of Health Disparities Elimination, Community Health Services, the Office of Primary Prevention, as well as our TDH Leadership and Regional Directors. We are equally grateful to the Office of Strategic Initiatives, the Health Equity Advisory Team (HEAT), and the Strategies to Repair Equity and Transform Community Health (STRETCH) team. Their unwavering commitment to health equity and invaluable guidance has been pivotal in shaping this plan. Furthermore, we extend our gratitude to the passionate staff within TDH and FHW. Their collaborative spirit and tireless efforts are not just the backbone of this project but are also crucial in steering us toward our shared vision for health equity. The collective expertise and teamwork of all these individuals and groups have greatly enriched this plan and are indispensable to the success of the goals and activities here listed.

III. Background

Tennessee has made significant strides in improving the health of its residents, yet it continues to face stark inequities in many critical health metrics. These challenges are not merely statistical but are indicative of deep-rooted disparities influenced by various factors such as geographical location, socio-economic status, education, language, race, ethnicity, and gender.

One of the most urgent issues is childhood obesity. As of 2020, the obesity rate in urban areas was 38%, while in rural areas, it stood at 41%. This issue takes on a more complex dimension when viewed through the lens of race and ethnicity: 30.4% of Latino children aged 10-17 are obese, a figure that compares to 25.2% among Black children and 17.3% among White children [1].

Maternal and infant health disparities are equally alarming. In 2021, Black women faced a maternal mortality rate that was 2.3 times higher than that of White women [2]. This disparity extends to infant health, with Black infants and children experiencing double the mortality rate of Whites [3]. Additionally, in 2020, Hispanic infants had a higher rate of deaths due to birth defects (17.8 per 10,000 live births) compared to 14 per 10,000 live births for non-Hispanic White infants [4]. Factors such as inadequate prenatal care, lower education levels, and a lack of health insurance exacerbate these issues [4].

The problem of healthcare access is further highlighted by the fact that about 33% of Tennessee counties are considered Maternity Care Deserts [2], drastically affecting maternal healthcare access. Moreover, the state has 705 census tracts (50%) identified as food deserts by the USDA, mostly in rural and suburban areas, which hinders access to healthy food options [5].

State health rankings provide additional context to these disparities. In 2023, America's Health Rankings placed Tennessee 46th in diabetes, 45th in drug overdoses, 40th in youth mental health, and 44th in both premature death and Adverse Childhood Experiences (ACEs), as well as in child poverty and teen births [6]. These rankings underscore the critical need for targeted and comprehensive strategies to address health inequalities in Tennessee.

In 2019, the Family Health and Wellness (FHW) Division responded to these disparities by forming a Health Equity Committee and developing the Health Equity Plan 2020-2022. This plan aimed to attain and sustain Health Equity (HE) across Tennessee communities by identifying and tackling the root causes of health disparities, engaging communities in improving service delivery and care systems and promoting health improvement in all policies and practices. Many achievements were reached and lessons were learned.

Building on the successes and learnings of the initial efforts, our **FHW Health Equity Plan (2023-2028)** continues to advance the crucial mission of achieving health equity in Tennessee.

IV. Introduction

Welcome to the Five-Year Health Equity Strategic Plan (2023–2028) for the Division of Family Health and Wellness (FHW) at the Tennessee Department of Health. This plan represents commitment and a vital journey toward achieving equitable health outcomes for all Tennesseans. Recognizing that Health Equity (HE) is an essential component of our FHW Strategic Plan and State Health Plan, we have placed it as one of our core priorities.

This strategic plan is a call to action in the face of persistent health disparities that affect our communities differently. It embodies our dedication to enhancing the department's capacity to champion health equity.

FHW uses the RWJF definition of **health equity** as "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 education and housing, safe environments, and health care." [7]

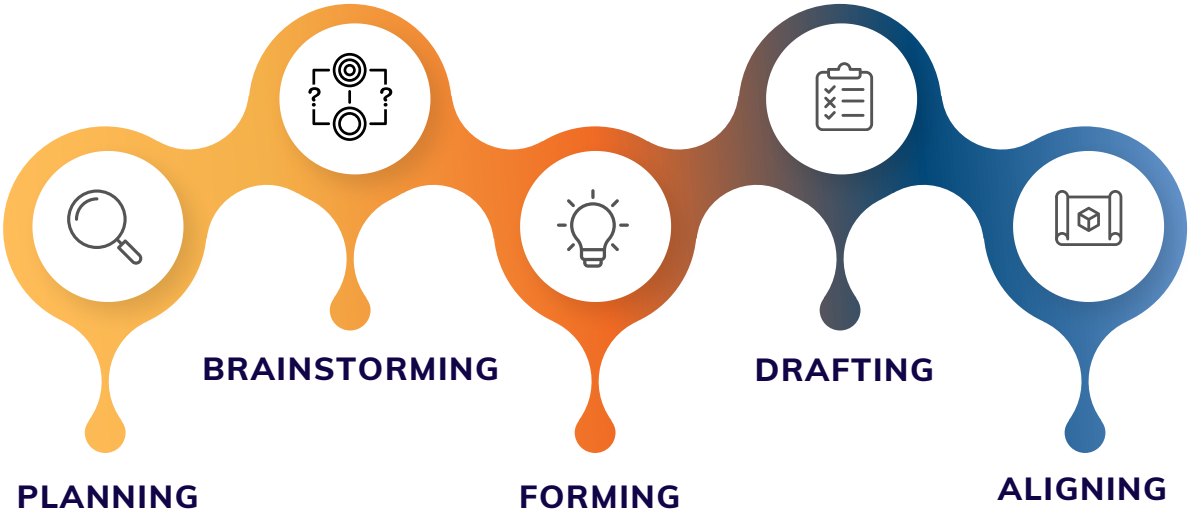
We understand that achieving this goal requires more than just intention; it necessitates a multifaceted approach encompassing active community engagement, service equity improvement, workforce development, and fostering strong, collaborative partnerships. At the core of this plan is the fundamental objective to develop, implement, and critically evaluate policies, practices, and procedures that also improve the health and well-being of every Tennessean and diligently focus on closing the health equity gap. This document lays the groundwork for a robust public health system in Tennessee, one that is adaptive, responsive, and ever-evolving to meet the diverse needs of our population.

As you navigate through this plan, you will find a strategic framework designed to guide our actions over the next five years. It is a roadmap that aligns our resources and efforts to effectively address the critical health metrics where inequities are most pronounced.

Together, through this strategic plan, we reaffirm our commitment to a healthier, more equitable future for all Tennesseans.

Source: https://www.cdc.gov/publichealthgateway/publications/resilience/all-hazards.html

VIII. Methodology



A Collaborative and Iterative Approach

1. Defining End Goals (Planning Phase)
The HE Committee, established in 2019, consists of 33 members from all sections within FHW, comprising volunteers and individuals appointed by their respective Section Chiefs. This committee defined the overarching objectives of the HE plan, along with a detailed development process, timeline, and specific responsibilities. This approach ensured a well-structured and collaborative effort in the plan's development

2. Brainstorming Vision, Mission, Principles, and Priorities
The HE Committee collaboratively crafted a unified vision, mission, and guiding principles, and outlined four key areas of focus for the HE plan through dynamic brainstorming sessions, facilitated by TDH Office of Strategic Initiatives staff. Both the vision and mission statements were presented and approved by all FHW staff.

3. Forming Priority Area Teams
Four distinct teams were organized around the identified priority areas, with members choosing their teams based on their interests. Each team had a designated facilitator, a Lead, and a Secretary, ensuring balanced representation and dedicated focus on each HE plan priority area.

4. Drafting Initial Goals and Activities
Each team dedicated efforts to developing a preliminary set of goals and activities specific to their priority area, laying the groundwork for actionable steps in the HE plan.

5. Alignment and Peer Review from Other TDH Offices
To refine the initial drafts, the teams engaged in peer review sessions and consultations with various offices within the Tennessee Department of Health. The outcome was a set of revised, harmonized goals and activities, enriched by collaborative feedback and department-wide alignment. This refined version was then adopted as the final FHW Health Equity Plan.

V. Alignment with Other TDH Strategic Plans

The FHW Health Equity Plan aligns seamlessly with the Department of Health's vision of "Healthy People, Healthy Communities, Healthy Tennessee," and health equity is a key focus area in the FHW Division's strategic plan.

Moreover, this plan adheres to the Health Equity Roadmap, formulated by the TDH's Division of Health Disparities Elimination.

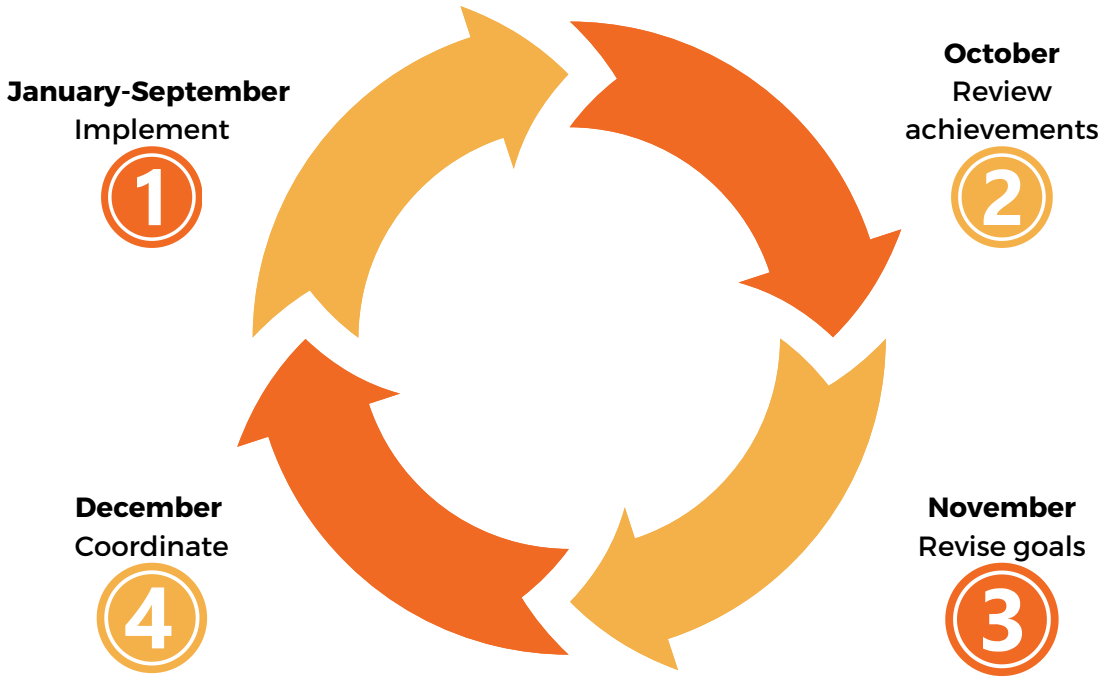
The Health Equity Roadmap advocates for policies, processes, and initiatives aligned with the Strategies to Repair Equity and Transform Community Health (STRETCH) Framework, focusing on systemic change and tackling the root causes of health disparities. In developing the FHW Health Equity Plan, we have comprehensively incorporated the five domains of the STRETCH framework. This integration includes elevating the voices of community members benefiting from FHW programs, enhancing collaboration between FHW programs and other TDH teams committed to health equity, strategically using health equity data, and boosting the capabilities and diversity of our workforce in health equity.

Through its synergy with wider health equity initiatives at TDH, the FHW Health Equity Plan is strategically positioned to make a significant contribution to a healthier and more equitable Tennessee.

IX. Annual Review and Adaptation

While the vision, mission, guiding principles, and priority areas will be the same until the end of this plan in 2028, each year, the goals and activities of the plan will be re-evaluated and adjusted to align with new realities, challenges, and opportunities. This ensures the plan remains responsive to the evolving context of health equity both within the state and nationally.

- **January Implementation Starts**: The implementation of the revised activities and goals will start in January, marking the start of the new operational year for the health equity plan.
- **End-of-October Review**: Annually, the committee will conduct a comprehensive review at the end of October. This includes assessing accomplishments, identifying challenges and barriers identified during the year, and mapping out available resources and new opportunities. Also, during this period, new members will be invited to join the health equity committee, offering fresh perspectives and expertise to the priority area teams.
- **November Goal Revision**: The committee will revisit and revise goals and activities for the forthcoming year in November. This step is crucial for maintaining the relevance and effectiveness of the Health Equity plan.
- **December Coordination with Other Offices**: The revised goals and activities will be presented and discussed with other TDH offices/divisions and FHW staff in December. This process ensures alignment and coordination across departments, reducing the risk of duplicated efforts.



This structured, cyclical process ensures that the FHW HE plan remains dynamic, adaptable, and aligned with current health equity needs and goals.

December 2023 - December 2028

Family Health and Wellness Health Equity Plan

VI. Vision, Mission and Principles

Vision

All Tennesseans have the opportunity to enjoy the highest attainable level of health and well-being.

Mission

The Division of Family Health and Wellness commits to mitigating health disparities by providing high-quality and equitable services, engaging with the communities we serve, maintaining a diverse and skilled workforce, and collaborating with internal and external partners.

PRINCIPLES

Community Engagement and Active involvement

We strive to always work with, instead of on behalf of communities, through the co-creation of programs and initiatives, the establishment of a common agenda, and taking collaborative action for systemic change to improve population-level health.

Data-Informed Program Implementation and Evaluation

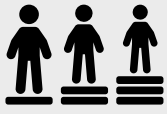
We are committed to evidence-based public health practices and strive for outstanding performance based on our community-identified standards. By collecting and analyzing relevant TDH data and using scientifically rigorous program evaluation, we ensure that our efforts are practical and meaningful with a lasting impact on the communities we serve.

Inclusive Communication

We strive to include all Tennesseans by using clear and accessible language while considering the unique needs of diverse populations (e.g., cultural, and linguistic diversity). We strive for transparency in the development and execution of programs, policies, and procedures. This helps ensure that our messages are appropriate and representative of community members, build stronger relationships, and promote informed health decisions.

Intentional Partnerships

We strive to forge meaningful and collaborative partnerships with internal and external groups and organizations to leverage resources and achieve shared goals. By working together, we can better serve communities and uplift health and well-being.



Uplift Health Equity

We firmly uphold the belief that every person and community possesses intrinsic value, dignity, and unique qualities. We actively identify and address the gaps and barriers that hinder the attainment of fair opportunities for optimal health among all individuals.

VII. Priority Areas

Collaborations and Partnerships

Proactively seek, nurture, and expand partnerships to facilitate seamless coordination of services and resources.

Equitable Services

Provide accessible, evidence-based, high-quality services through critical analysis of community and implementation needs.

Workforce Development

Prioritize intentional outreach, hiring, onboarding, training, and ongoing education initiatives to foster the growth of a diverse and highly skilled workforce.

Community Engagement

Actively involve and genuinely listen to communities we serve to gain insights about their needs and foster better partnerships.

December 2023 - December 2024

Year One

FHW HEALTH EQUITY PLAN

X. Equitable Services

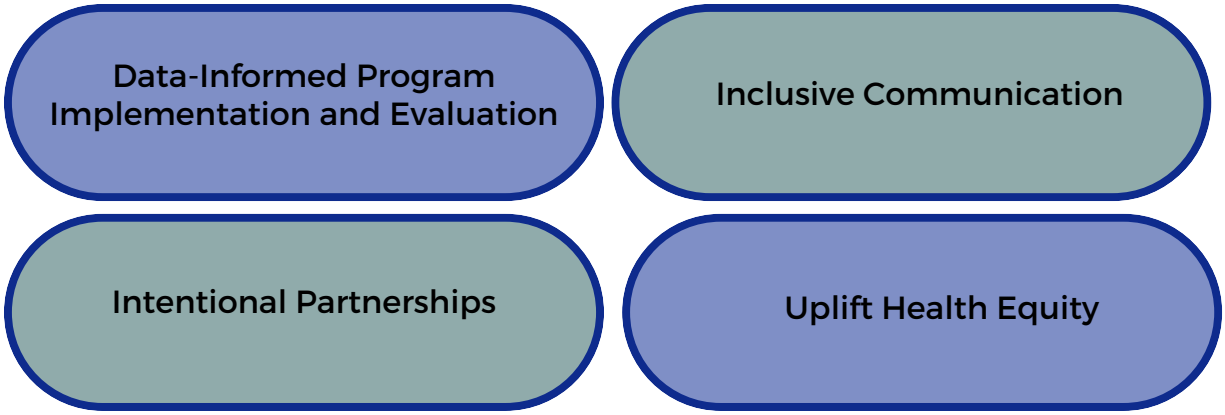
Members

Elizabeth Abram
Jackie Bonilla
Hector Carrasco (Facilitator)
Krista Cole (Lead)
Shannon De Pont
Crissy Hartsfield
Jasmine Nabaa
Michel Perry (Secretary)

Description

We are dedicated to promoting and providing accessible, evidence-based, high-quality, and equitable services to all Tennesseans. This involves examining our services critically, working with our communities to identify and prioritize their needs, and striving for excellence in the implementation of services.

Guiding Principles



Justification

"The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities" [8], an aim that aligns with the Tennessee Department of Health's mission "To protect, promote, and improve the health and wellbeing of all people in Tennessee." A task force that included the de Beaumont Foundation, the Public Health National Center for Innovations, and other public health experts, including the Centers for Disease Control and Prevention (CDC), designed the 10 Essential Public Health Services to achieve equity by diligently promoting ". . . policies, systems, and overall community conditions that enable optimal health for all and seek to remove systemic and structural barriers that have resulted in health inequities" [8]. One of the ten essential public health services is to ". . . assure an effective system that enables equitable access to the individual services and care needed to be healthy" [8]. Access and quality of care are social determinants of health that account for 20% of an individual's well-being [9]. Family Health and Wellness (FHW) has the capacity to ensure equitable access to services within its scope and positively influence Tennesseans' access and quality of care within the public health setting.

Addressing service gaps will ensure that Tennesseans and their families can access quality and equitable care and improve health outcomes. The Equitable FHW Services team will assess FHW Programs to identify service gaps and priority areas needing attention to ensure communities have access to quality and equitable care. Program participants who receive comprehensive care may help families make informed decisions and adopt healthier lifestyles. Ensuring that programs are inclusive and culturally sensitive can enhance engagement and trust among disproportionately burdened populations that exhibit disparities in outcomes related to cancer, child obesity, maternal and infant mortality, and traumatic brain injuries.

X. Equitable Services Continued

GOAL 1:

By September 2024, develop, approve, and implement a comprehensive survey to assess equitable practices within FHW program sections. Analyze gathered data to identify and prioritize areas/populations in need, presenting clear findings to each program and collaboratively formulating actionable strategies with Health Equity and Quality Improvement experts.

ACTIVITIES:

1. Develop a comprehensive survey to assess equitable practices across FHW.
- **1.1: Provide a summarized list of the FHW programs with contact information to County Health Councils. (By March 2024)**
- **1.2: Coordinate with the Division of Health Disparities Elimination and the Community Engagement team on listening sessions to ensure some of our key questions are included and to gather data on how regional offices perceive our programs and what aspects could be improved. (By March 2024)**

2. Seek and secure approval for the developed survey from FHW Senior Leadership.
- **2.1: Seek approval from the Office of Health Disparities Elimination. (By May 2024)**

3. Utilize the survey developed in Activity 2 and program director interviews to perform a detailed gap analysis for various FHW programs.
- **3.1: Examine reports generated by programs for additional context. (By June 2024)**

4: Evaluate the findings from the gap analysis to identify and prioritize areas and populations that necessitate attention.
- **4.1: Synthesize the insights drawn to produce a succinct report outlining the key areas of improvement and populations in need. (By August 2024)**
- **4.2: Prepare and present clear, concise findings to each program that participated, spotlighting areas that require improvement or adjustment ensuring comprehensive understanding. (By August 2024)**
- **4.3: Present overall findings to FHW Senior Leadership, the Division of Health Disparities Elimination, and the Health Equity Advisory Team (HEAT). (By August 2024)**

5: Align the formulated strategies meticulously with the overarching goals and objectives of the program, ensuring coherence and mutual reinforcement.
- **5.1: Prioritize strategies addressing the most critical identified needs, maximizing impact and resource efficiency. (By September 2024)**

X. Equitable Services Continued

GOAL 2:

By July 2025, systematically gather and analyze specific and relevant insights related to health equity from vendors, community partners, and service recipients of the selected FHW programs. Utilize the insights to identify and quantify areas for enhancement, realign strategies, and implement improvements, ensuring alignment with overarching health equity objectives.

ACTIVITIES:

1. Partner with the HE Community Engagement priority team to examine existing health equity-related community assessments and, if necessary, strategize and develop a cohesive community assessment to ensure a comprehensive understanding of health equity statuses and practices within the selected FHW programs. (By September 2024)

2. Obtain approval from leadership by presenting the results of the gap analysis in the FHW Quarterly Meeting/Senior Leadership Team (SLT), emphasizing the essential need for improvements in FHW Program Services and underscoring the significance of collaborating with vendors, community partners, and service recipients. (By September 2024)

3. Engage with the FHW SLT to confirm if there is a requirement for Institutional Review Board (IRB) approval, ensuring compliance with ethical standards and organizational protocols. (By September 2024)

4: Organize and conduct focus group/listening sessions/surveys revolving around HE concepts/categories and solicit any existing documents highlighting HE service gaps from partners, whom will be identified. Leverage established networks such as the Health Disparities Task Force to effectively reach and engage with community partners, whom will be identified, and acquire comprehensive insights. (By May 2025).

5: Analyze the data collected from focus groups/listening sessions to create a comprehensive report with synthesized findings.

- **5.1: Review and interpret the data gathered, focusing on the nuanced insights and common emerging threads related to equitable practices. (By July 2025)**
- **5.2: Compile and organize the findings in a coherent and accessible manner, ensuring clarity and comprehensibility for diverse stakeholders. (By July 2025)**
- **5.3: Formulate and propose actionable recommendations based on the analyzed data, aligning them with overarching health equity objectives and the specific needs and contexts of the FHW programs involved. (By July 2025)**

X. Equitable Services Continued

GOAL 3:

By December 2025, implement evidence-based health equity practices in all program sections within FHW by leveraging insights acquired through previous goals to conduct trainings, create best practice tools, and monitor progress, with the aim of reducing disparities in healthcare access and outcomes.

ACTIVITIES:

1. Generate a detailed report consolidating findings from Goals 1 and 2, and illustrating overarching best practices aimed at achieving Goal 3. This report should serve as a reference point for continuous improvement in health equity practices within FHW.

- **1.1: Synthesize findings and recommendations from Goals 1 and 2 into a cohesive document. (By August 2025)**
- **1.2: Integrate identified best practices and provide clear guidance on their implementation. (By August 2025)**
- **1.3: Distribute the report to relevant stakeholders, whom will be defined, and provide support in interpreting and implementing the outlined practices. (By August 2025)**

2. Propose and facilitate sessions/training focusing on implementing health equity practices identified through goals 1 and 2. Engage Subject Matter Experts, whom will be selected by the Team, to ensure the information's relevance and accuracy and facilitate the practical application of learned concepts.

- **2.1: Identify suitable Subject Matter Experts and coordinate schedules for training sessions. (By September 2025)**
- **2.2: Develop a comprehensive training module incorporating identified health equity practices. (By September 2025)**
- **2.3: Evaluate the effectiveness of the training sessions and adjust content as necessary based on feedback and outcomes. (By September 2025)**

3. Construct a robust best practices tool incorporating actionable elements like integrating equitable language into contracts and establishing clear, measurable standards within FHW programs.

- **3.1: Collate identified best practices and create clear, applicable standards. (By September 2025)**
- **3.2: Develop mechanisms to integrate and monitor adherence to these standards within contractual agreements and program operations. (By September 2025)**
- **3.3: Seek feedback on the tool's functionality and utility, refining it as necessary based on user experiences and needs. (By September 2025)**

X. Equitable Services Gantt Chart

Goal	Activity	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV
By September 2024, develop, approve, and implement a comprehensive survey to assess equitable practices within FHW program sections. Analyze gathered data to identify and prioritize areas/populations in need, presenting clear findings to each program and collaboratively formulating actionable strategies with Health Equity and quality improvement experts.	1.1 Develop a comprehensive, mostly quantitative survey to assess equitable practices across FHW.												
	1.1.1 Provide a summarized list of the FHW programs with contact information to County Health Councils.												
	1.1.2 Coordinate with the Division of Health Disparities Elimination and the Community Engagement Team on listening sessions to ensure some of our key questions are included and also to gather data on how regional offices perceive our programs and what aspects could be improved.												
	1.2 Seek and secure approval for the developed survey from FHW Senior Leadership.												
	1.2.1 Seek approval from the Office of Health Disparities Elimination.												
	1.3 Utilize the survey developed in Activity 2 and program director interviews to perform a detailed gap analysis for various FHW programs.												
	1.3.1 Examine reports generated by programs for additional context.												
	1.4 Evaluate the findings from the gap analysis to identify and prioritize areas and populations that necessitate attention.												
	1.4.1 Synthesize the insights drawn to produce a succinct report outlining the key areas of improvement and populations in need.												
	1.4.2 Prepare and present clear, concise findings to each program that participated, spotlighting areas that require improvement or adjustment ensuring comprehensive understanding.												
	1.4.3 Present overall findings to FHW Senior Leadership, to the Division of Health Disparities Elimination, and to the Health Equity Advisory Team (HEAT).												
	1.5.1 Align the formulated strategies meticulously with the overarching goals and objectives of the program, ensuring coherence and mutual reinforcement.												
	1.5.2 Prioritize strategies addressing the most critical identified needs, maximizing impact and resource efficiency.												
By July 30th, 2025, systematically gather and analyze specific and relevant insights related to health equity from vendors, community partners, and service recipients of the selected FHW programs. Utilize the insights to identify and quantify areas for enhancement, realign strategies, and implement improvements, ensuring alignment with overarching health equity objectives.	2.1 Partner with the HE Community Engagement priority team to examine existing health equity-related community assessments and, if necessary, strategize and develop a cohesive community assessment to ensure a comprehensive understanding of health equity statuses and practices within the selected FHW programs.												
	2.2 Obtain approval from leadership by presenting the results of the gap analysis in the FHW Quarterly Meeting/Senior Leadership Team (SLT), emphasizing the essential need for improvements in FHW Program Services and underscoring the significance of collaborating with vendors, community partners, and service recipients.												
	2.3 Engage with the SLT to confirm if there is a requirement for Institutional Review Board (IRB) approval, ensuring compliance with ethical standards and organizational protocols.												
	2.4 Organize and conduct focus group/listening sessions/surveys revolving around HE concepts/categories and solicit any existing documents highlighting HE service gaps from partners, whom will be identified. Leverage established networks such as the Health Disparities Task Force to effectively reach and engage with community partners, whom will be identified, and acquire comprehensive insights.												
	2.5 Analyze the data collected from focus groups/listening sessions to create a comprehensive report with synthesized findings.												
	2.5.1 Review and interpret the data gathered, focusing on the nuanced insights and common emerging threads related to equitable practices.												
	2.5.2 Compile and organize the findings in a coherent and accessible manner, ensuring clarity and comprehensibility for diverse stakeholders.												
	2.5.3 Formulate and propose actionable recommendations based on the analyzed data, aligning them with overarching health equity objectives and the specific needs and contexts of the FHW programs involved.												
By December 2025, implement evidence-based health equity practices in all program sections within FHW by leveraging insights acquired through previous goals to conduct trainings, create best practice tools, and monitor progress, with the aim of reducing disparities in healthcare access and outcomes.	3.1 Generate a detailed report consolidating findings from Goals 1 and 2, and illustrating overarching best practices aimed at achieving Goal 3. This report should serve as a reference point for continuous improvement in health equity practices within FHW.												
	3.1.1 Synthesize findings and recommendations from Goals 1 and 2 into a cohesive document.												
	3.1.2 Integrate identified best practices and provide clear guidance on their implementation.												
	3.1.3 Distribute the report to relevant stakeholders, whom will be defined, and provide support in interpreting and implementing the outlined practices.												
	3.2 Propose and facilitate sessions/training focusing on implementing health equity practices identified through goals 1 and 2. Engage Subject Matter Experts, whom will be selected by the Team, to ensure the information's relevance and accuracy and facilitate the practical application of learned concepts.												
	3.2.1 Identify suitable Subject Matter Experts and coordinate schedules for training sessions.												
	3.2.2 Develop a comprehensive training module incorporating identified health equity practices.												
	3.2.3 Evaluate the effectiveness of the training sessions and adjust content as necessary based on feedback and outcomes.												
	3.3 Construct a robust best practices tool incorporating actionable elements like integrating equitable language into contracts and establishing clear, measurable standards within FHW programs.												
	3.3.1 Collate identified best practices and create clear, applicable standards.												
	3.3.2 Develop mechanisms to integrate and monitor adherence to these standards within contractual agreements and program operations.												
	3.3.3 Seek feedback on the tool's functionality and utility, refining it as necessary based on user experiences and needs.												

XI. Collaborations and Partnerships

Members

Octavia Forrest (Facilitator)
Tina Herring (Secretary)
Angela Miller
Ashley Moore
Debbie Osborne
Jennifer Waldrop (Lead)
Kimothy Warren

Description

We believe that multi-sectoral collaborations and partnerships are vital for advancing health equity and addressing the disparities in social determinants of health (SDoH). We proactively seek, nurture, and expand internal and external partnerships to facilitate the seamless coordination of services and resources. By fostering these collaborative relationships, we can effectively address the complex factors influencing health outcomes and work collectively towards achieving equitable health for all.

Guiding Principles

- Community Engagement and Active Involvement
- Inclusive Communication
- Intentional Partnerships
- Uplift Health Equity

Justification

Collaborations and partnerships that are equitable and inclusive go a long way in creating resilient and healthy communities. By ensuring multidisciplinary relationships are interpersonal, individuals, organizations and agencies can rely on each other for help, feedback, and support. This allows for the individual strengths to fill gaps in skill sets while maximizing the potential to improve outcomes for the community [8].

There is an increased need to advance health equity and reduce health disparities by ensuring those supporting the same populations are aligned in efforts and priorities. Through collaborative efforts, internal and external partnerships find community-driven and creative solutions to challenging problems. This improves the confidence of the public in organizations that provide stability and de-silo themselves to achieve shared goals.

The purpose of the Collaborations and Partnerships priority team is to promote the “6 Cs”: compassion, commitment, communication, creativity, critical thinking, and culture [9]. This will increase opportunities to reach a larger audience by increasing health literacy and cultural competence, aligning strategies and plans, and utilizing existing resources. The primary goal of this priority team is to establish and maintain equitable and inclusive collaborations and partnerships statewide.

XI. Collaborations and Partnerships Continued

GOAL 1:

By June 2024, develop a FHW Partnerships Master List of established partnerships across the Division by ensuring each program and priority population is represented to allow for the understanding of existing efforts and resources.

ACTIVITIES:

1. Determine if there is an existing partnerships list for the Division of Family Health and Wellness to identify gaps and opportunities for expansion; work to establish partnerships to fill these gaps. (By January 2024)

2. Assist in the development of the Health Equity Committee Survey by adding questions pertaining to partnerships to solicit responses from priority and interested programs across the Division.

- **2.1: Encourage Section Chiefs to distribute partnerships survey to their primary contacts within their section to gather existing partnerships throughout the Division. (By January 2024)**

3. Analyze and organize survey responses by topic and/or target population. Use responses to develop a FHW Partnerships Master List. (By May 2024)

4: Distribute the FHW Partnerships Master List via the DC_FHW_ALLSTAFF listserv while promoting its usage for establishing new and expanding existing partnerships. (By June 2024)

5: Annually re-evaluate and revise the FHW Partnerships Master List to ensure all identified need are continuously met. (By October 2024)

XI. Collaborations and Partnerships Continued

GOAL 2:

By August 2024, conduct listening sessions with program's identified partnership/collaboration contact(s) to gain an understanding of the nature and maintenance of existing partnerships. Identify additional needs for expansion to advance collaborations with a health equity focus.

ACTIVITIES:

1. Utilize the survey and FHW Partnerships Master List (Objective 1 Goal 1) to identify gaps in partnerships and areas of need. (By March 2024)

2. Host virtual listening sessions with identified primary contacts to further discuss/evaluate the information submitted on the survey (deeper understanding of existing resources and process, and possible opportunities for collaboration). (By May 2024)

3. Combine feedback received from listening sessions and analysis for common themes and issues. Develop a challenges and solutions one pager, on a programmatic level, to provide an overview of the current nature of partnerships throughout the department and identify resources and opportunities/needs. (By June 2024)

4: Distribute programmatic one pager initially to Section Chiefs for their feedback and distribution among staff, via DC_FHW_ALLSTAFF. (By July 2024)

XI. Collaborations and Partnerships Continued

GOAL 3:

By September 2024, compile a list of motivational learning materials and resources for all FHW staff to effectively build successful, collaborative, and mutually beneficial relationships across Tennessee; Encourage staff to have a Health Equity mindset.

ACTIVITIES:

1. Meet with the Workforce Development Priority Team and TDH Workforce Development team to determine the quality and quantity of existing Health Equity learning opportunities - specific to collaborations and partnerships. (By January 2024)

2. Review the existing Health Equity modules and trainings within the TRAIN Learning Network and the potential to add modules, as needed for FHW Staff to access voluntarily.

- **2.1: Collaborate with the Office of Primary Prevention (OPP) to identify additional modules and trainings to add to the TRAIN Learning Network. (By February 2024)**

3. Pilot the distribution brief bi-monthly emails to FHW Staff promoting identified topics / available resources – specific to Health Equity in Collaboration and Partnerships. (By March/May 2024)

4: Create TEAMS channel for Partnerships/Collaboration. Post regular (monthly?) "Friday Facts," etc. to provide existing resources, promote individual sections' current work/current needs; maintain a light, interactive focus on this messaging for optimal engagement (surveys, images, QR codes to infographics, staff/program highlights - kudos, etc.). (By April 2024)

5: Gather feedback on the learning materials and effectiveness of the Partnerships/Collaborations Teams channel through a brief survey. (By August 2024)

XI. Collaborations and Partnerships Gantt Chart

Goal	Activity	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT
By April 2024, develop a FHW Partnerships Master List of established partnerships across the Division by ensuring each program and priority population is represented to allow for the understanding of existing efforts and resources.	1.1 Determine if there is an existing partnerships list for the Division of Family Health and Wellness to identify gaps and opportunities for expansion; work to establish partnerships to fill these gaps.											
	1.2 Assist in the development of the Health Equity Committee Survey by adding questions pertaining to partnerships to solicit responses from priority and interested programs across the Division.											
	1.2.1 Encourage Section Chiefs to distribute partnerships survey to their primary contacts within their section to gather existing partnerships throughout the Division.											
	1.3 Analyze and organize survey responses by topic and/or target population. Use responses to develop a FHW Partnerships Master List.											
	1.4 Distribute the FHW Partnerships Master List via the DC_FHW_ALLSTAFF listserv while promoting its usage for establishing new and expanding existing partnerships.											
	1.5 Annually re-evaluate and revise the FHW Partnerships Master List to ensure all identified need are continuously met.											
By August 2024, conduct listening sessions with program's identified partnership/collaboration contact(s) to gain an understanding of the nature and maintenance of existing partnerships. Identify additional needs for expansion to advance collaborations with a health equity focus.	2.1 Utilize the survey and FHW Partnerships Master List (Objective 1 Goal 1) to identify gaps in partnerships and areas of need.											
	2.2 Host virtual listening sessions with identified primary contacts to further discuss/evaluate the information submitted on the survey (deeper understanding of existing resources and process, and possible opportunities for collaboration).											
	2.3 Combine feedback received from listening sessions and analysis for common themes and issues. Develop a challenges and solutions one pager, on a programmatic level, to provide an overview of the current nature of partnerships throughout the department and identify resources and opportunities/needs.											
	2.4 Distribute programmatic one pager initially to Section Chiefs for their feedback and distribution among staff, via DC_FHW_ALLSTAFF.											
By September 2024, compile a list of motivational learning materials and resources for all FHW staff to effectively build successful, collaborative, and mutually beneficial relationships across Tennessee; Encourage staff to have an Health Equity mindset.	3.1 Meet with the Workforce Development Priority Team and TDH Workforce Development team to determine the quality and quantity of existing Health Equity learning opportunities - specific to collaborations and partnerships.											
	3.2 Review the existing Health Equity modules and trainings within the TRAIN Learning Network and the potential to add modules, as needed for FHW Staff to access voluntarily.											
	3.2.1 Collaborate with the Office of Primary Prevention (OPP) to identify additional modules and trainings to add to the TRAIN Learning Network											
	3.3 Pilot the distribution brief quarterly emails to FHW Staff promoting identified topics / available resources – specific to Health Equity in Collaboration and Partnerships.											
	3.4 Create TEAMS channel for Partnerships/Collaboration. Post regular (monthly?) "Friday Facts," etc. to provide existing resources, promote individual sections' current work/current needs; maintain a light, interactive focus on this messaging for optimal engagement (surveys, images, QR codes to infographics, staff/program highlights - kudos, etc.)											
	3.5 Gather feedback on the learning materials and effectiveness of the Partnerships/Collaborations Teams channel through a brief survey											

XII. Community Engagement

Members

Octavia Forrest (Co-Facilitator)
Ashlee Johnson
Shatonia Kenion (Facilitator)
Emily Lumley (Lead)
Jennifer Smith
Penny Stepp
Roberta White

Description

We believe that community engagement is vital in achieving health equity. By actively involving and genuinely listening to the communities we serve, we gain invaluable insights into their distinct needs, foster collaborations, and reinforce programs and initiatives that effectively address those concerns. Recognizing the power of community voice and partnership, we strive to create a lasting impact and promote equitable health outcomes for all.

Guiding Principles

- Community Engagement and Active Involvement
- Data-Informed Program Implementation and Evaluation
- Inclusive Communication
- Intentional Partnerships
- Uplift Health Equity

Justification

Emphasizing Community Engagement (CE) is crucial for advancing health equity [11]. Effective engagement with any group in the public health sector necessitates a deep understanding of and responsiveness to that community's specific needs, which cannot be achieved without active participation, input, and feedback from the community members themselves.

There is substantial evidence indicating that incorporating community engagement in public health interventions leads to improved health outcomes [12,13]. Such engagement has proven effective in shaping public health planning, altering perceptions of social support, and positively influencing health behaviors, literacy, and self-efficacy.

To promote the health and wellness of all Tennesseans and ensure health equity, it is essential to bolster community engagement. We will work to achieve that through enhanced communication, better access to relevant data, providing appropriate training, fostering partnerships, and sharing best practices.

XII. Community Engagement Continued

GOAL 1:

By May 1, 2024, assist FHW programs in assessing their current level of community engagement and understand the needs of FHW programs in improving and expanding their community engagement..

ACTIVITIES:

1. Review existing community engagement assessments and resources, identify those that might be useful for FHW. (By February 2024)

2. Develop an assessment tool for use by FHW programs. (By March 2024)

3. Distribute the tool to program leaders, instructing them on how to complete the assessment. (By April 2024)

4: Evaluate the assessments to establish a baseline level of community engagement for each program, which can be used to evaluate progress in increasing community engagement in future years. (By May 2024)

GOAL 2:

By October 1, 2024, develop a Community Engagement Toolkit to support FHW program staff in improving their skills in community engagement.

ACTIVITIES:

1. Plan the structure and content of the toolkit based in-part on information from the FHW health equity staff survey results as well as the needs identified in Goal 1. (By April 2024)

2. Identify and review reputable community engagement resources for inclusion in the toolkit. (By April 2024)

3. Pilot the toolkit with a small group to identify any issues and gather feedback. (By June 2024)

4: Distribute a finalized version of the toolkit (revised to incorporate feedback) to FHW program staff. (By September 2024)

XII. Community Engagement Continued

GOAL 3:

By October 1, 2024, increase FHW programs' knowledge of community engagement by recommending a comprehensive community engagement training program that encapsulates best practices and innovative strategies for fostering community involvement.

ACTIVITIES:

1. **Identify a community engagement framework that aligns with the needs, goals, and missions of FHW and TDH and prioritizes health equity. (By April 2024)**
2. **Ensure the training program is available on TRAIN and accessible for FHW staff, regional and local staff, external partners, and sub-contractors. (By June 2024)**
3. **Monitor training program participation in and feedback from the training to continuously improve its content and delivery. (By September 2024)**
4. **Evaluate knowledge gained by participants using pre- and post- tests in TRAIN. (By October 2024)**

GOAL 4:

By November 1, 2024, develop partnerships with County Health Councils (CHCs) to foster knowledge sharing, collaboration, facilitate data-driven decision-making, and resource allocation.

ACTIVITIES:

1. **Establish contact with the six metro CHCs (Davidson, Hamilton, Knox, Madison, Shelby, and Sullivan). (By March 2024)**
2. **Meet virtually with members of both metro and rural CHCs to foster partnership and freedom to express their opinions and concerns about program ideas. (By November 2024)**
3. **Include CHCs in program planning and implementation to establish community inclusion and equity. (By November 2024)**

XII. Community Engagement Gantt Chart

Goal	Activity	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV
By May 1, 2024, assist FHW programs in assessing their current level of community engagement and understand the needs of FHW programs in improving and expanding their community engagement.	1.1 Review existing community engagement assessments and resources, identify those that might be useful for FHW.												
	1.2 Develop an assessment tool for use by FHW programs.												
	1.3 Distribute the tool to program leaders, instructing them on how to complete the assessment.												
	1.4 Evaluate the assessments to establish a baseline level of community engagement for each program, which can be used to evaluate progress in increasing community engagement in future years.												
By October 1, 2024, develop a Community Engagement Toolkit to support FHW program staff in improving their skills in community engagement.	2.1 Plan the structure and content of the toolkit based in-part on information from the FHW health equity staff survey results as well as the needs identified in Goal 1.												
	2.2 Identify and review reputable community engagement resources for inclusion in the toolkit.												
	2.3 Pilot test the assessment tool & toolkit with a small group to identify any issues and gather feedback												
	2.4 Distribute a finalized version of the toolkit (revised to incorporate feedback) to FHW program staff.												
By November 1, 2024, increase FHW programs' knowledge of community engagement by recommending a comprehensive community engagement training program that encapsulates best practices and innovative strategies for fostering community involvement.	3.1 Identify a community engagement framework that aligns with the needs, goals, and missions of FHW and TDH and prioritizes health equity.												
	3.2 Ensure the training program is available on TRAIN and accessible for FHW staff, regional and local staff, external partners, and sub-contractors.												
	3.3 Monitor training program participation in and feedback from the training to continuously improve its content and delivery.												
	3.4 Evaluate knowledge gained by participants using pre- and post- tests in TRAIN.												
By November 1, 2024, develop partnerships with County Health Councils (CHCs) and OSI to foster knowledge sharing, collaboration, facilitate data-driven decision-making, and resource allocation.	4.1 Establish contact with the six metro CHCs (Davidson, Hamilton, Knox, Madison, Shelby, and Sullivan).												
	4.2 Meet virtually with members of both metro and rural CHCs to foster partnership and freedom to express their opinions and concerns about program ideas.												
	4.3 Include CHCs in program planning and implementation to establish community inclusion and equity.												

XIII. Workforce Development

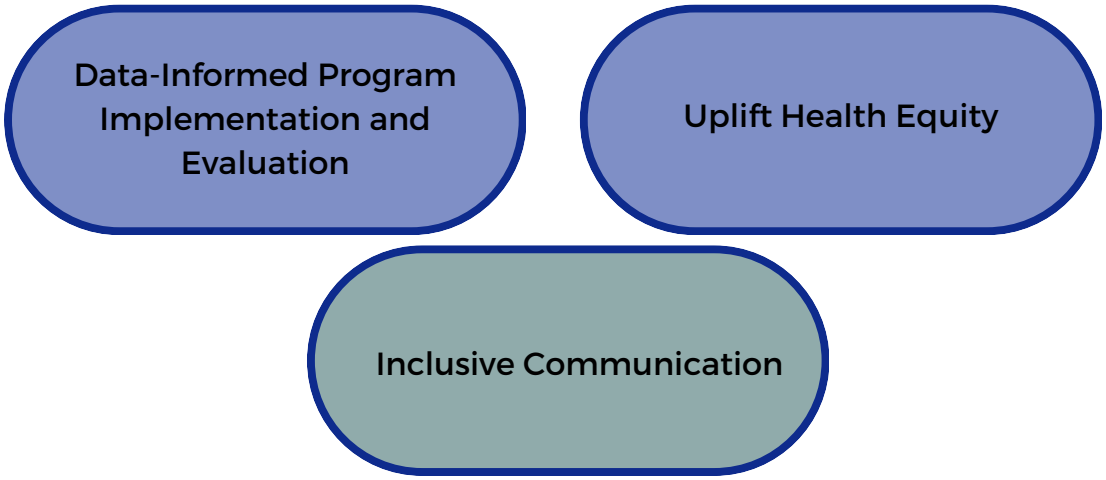
Members

Linda Clayton
Alethea Cornish (Secretary)
Miranda Givens
Olivia Hall (Facilitator)
Adrienne Hackney
Kate Lolley
Mark Lollis
Terry Love (Lead)
Kristy Miller

Description

We are committed to promoting health equity within our workforce. We prioritize intentional outreach, hiring, onboarding, training, and ongoing education initiatives to foster the growth of a diverse, competent, and highly skilled workforce. By strongly emphasizing our workforce, we ensure that our team is well-prepared to meet the unique needs of the communities we serve and provide equitable services.

Guiding Principles



Justification

The Tennessee Department of Health is dedicated to providing support for numerous high-risk and vulnerable populations within the state. These particular groups often experience more adverse health outcomes. Influential factors, including social determinants of health, geographic disparities, and racial inequities, can hinder Tennessee residents from achieving their optimal level of well-being. By addressing these foundational factors, especially socioeconomic determinants, we can make the most significant impact on public health, ensuring that everyone has an equitable opportunity for better health outcomes [10].

The Workforce Development subcommittee plans to develop health equity training and education opportunities for staff through various points of their employment with TDH. Key time points include equitable interviewing processes, health equity education and training during onboarding, and tailored continuing education opportunities. By embedding health equity education throughout the employee's timeline with FHW, staff will learn about these barriers to health and become empowered to address them within their respective programs. It is through this inter-program and inter-professional collaboration to address health equity that will truly help to move the needle towards the best health outcomes for all Tennessee residents.

XIII. Workforce Development Continued

GOAL 1:

By December 2024, coordinate with other Health Equity Committee Priority Teams to enhance and promote key health equity trainings to all FHW employees in Central, Regional, and Local health departments, through the Tennessee TRAIN Learning Management System.

ACTIVITIES:

1. Coordinate with Health Equity Committee Priority Teams to identify any specific training needs beyond the Health Equity 101 and 102 Toolkits (By December 2024).

2. Begin the health equity training migration into the Tennessee TRAIN Learning Management System. Upload the two original TDH Health Equity trainings contained in the Health Equity 102 Toolkit - Culturally and Linguistically Appropriate Services (CLAS) and Unequal Treatment in Care. (By January 2024).

3. Review current trainings available in TRAIN to determine any alignment with the competencies outlined in the Health Equity 101 Toolkit and any other training needs identified by the HE subcommittees. Update and/or augment Health Equity 101 trainings as appropriate. (By February 2024)

4. For Health Equity 101 Toolkit competencies not adequately addressed through existing trainings housed in the TRAIN learning system, reach out to external training creators for written permission to upload key health equity trainings, into the TRAIN system. As permission is received, upload trainings into the TRAIN system. (By March 2024)

5. Create and/or adapt a system to digitally track health equity training participation utilizing available TRAIN resources and/or self-reporting via Alchemer or REDCap. (By May 2024).

6. Finalize a voluntary incentive program to promote health equity training participation that provides recognition and rewards for staff who complete approved health equity training (By July 2024).

7. Disseminate information on the health equity trainings housed in TRAIN and the voluntary incentive program to all FHW Central Office staff (By August 2024).

8. Coordinate with Office of Strategic Initiatives to assist with dissemination of health equity trainings housed in TRAIN to local and regional health departments (By September 2024).

9. Disseminate information on the health equity trainings housed in TRAIN and the voluntary incentive program to all Tennessee local and regional health departments. (By December 2024).

XIII. Workforce Development Continued

GOAL 2:

By January 2027, formulate and share processes that prioritize equity and inclusion, focusing on the recruitment, retention, and development of FHW.

ACTIVITIES:

1. Identify or create health equity interview questions that assess candidate's knowledge and commitment to health equity and share with TDH FWH senior leaders and program directors involved in hiring **(By December 2023).**

2. Create and share a list of evidence-based health equity practices around hiring, staffing, and other workforce tools with TDH FHW program directors and relevant stakeholders to support employees through the entire employee lifecycle (recruitment, onboarding, and offboarding) **(By March 2024).**

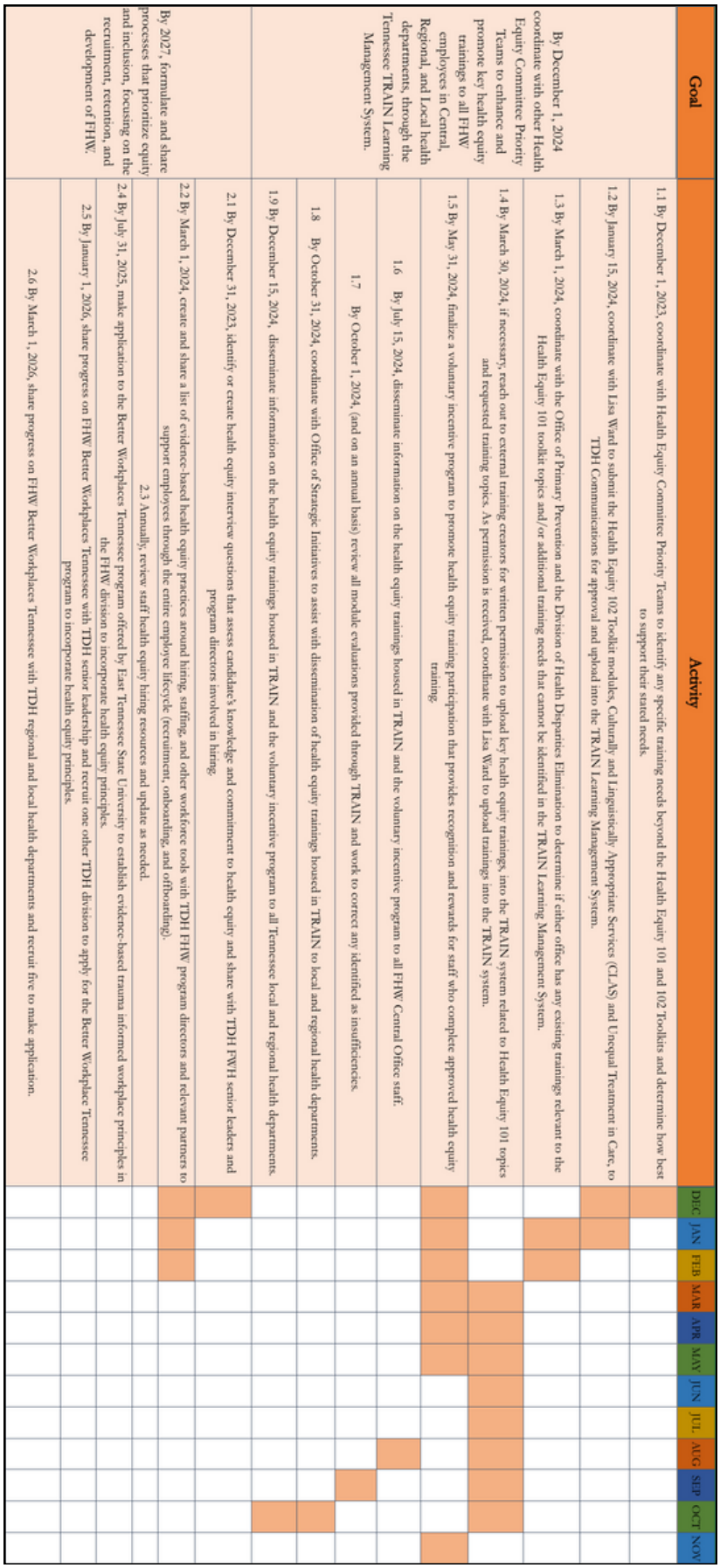
3. Annually, review staff health equity hiring resources and update as needed **(By March 2025)**

4. Make application to the Better Workplaces Tennessee program offered by East Tennessee State University to establish evidence-based trauma informed workplace principles in the FHW division to incorporate health equity principles. **(By July 2025)**

5. Share progress on FHW Better Workplaces Tennessee with TDH senior leadership and recruit one other TDH division to apply for the Better Workplace Tennessee program to incorporate health equity principles **(By January 2026).**

6. Share progress on FHW Better Workplaces Tennessee with TDH regional and local health departments and recruit five to make application. **(By March 2026).**

XIII. Workforce Development Gantt Chart



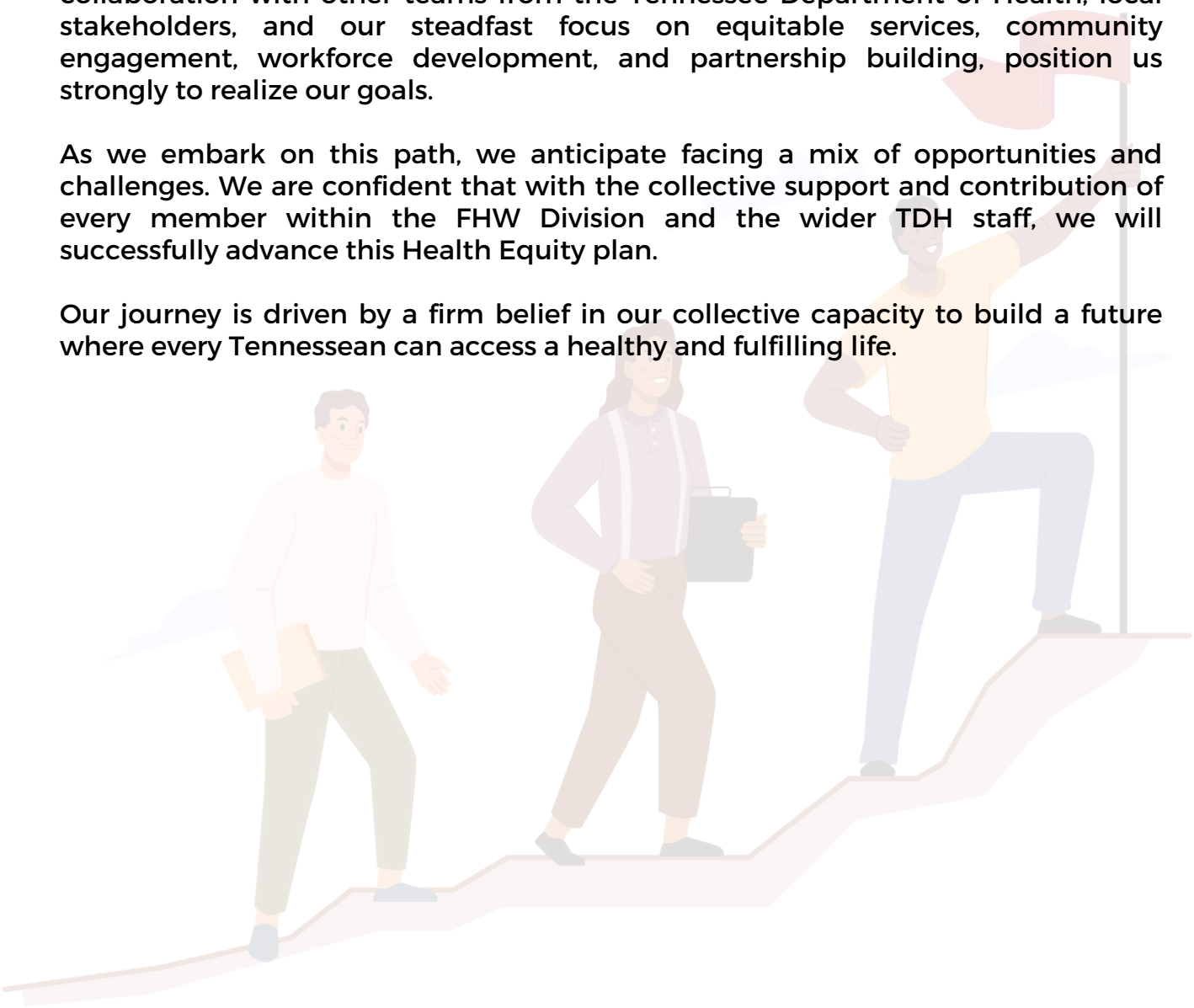
XIV. Conclusion

This plan represents both an ongoing commitment and a fresh chapter in our journey toward health equity. It embodies our unwavering dedication to ensuring equitable health outcomes for all Tennesseans, and it signals a critical stride in addressing the gaps in health equity within our communities.

The united efforts of the Family Health and Wellness (FHW) Division, in collaboration with other teams from the Tennessee Department of Health, local stakeholders, and our steadfast focus on equitable services, community engagement, workforce development, and partnership building, position us strongly to realize our goals.

As we embark on this path, we anticipate facing a mix of opportunities and challenges. We are confident that with the collective support and contribution of every member within the FHW Division and the wider TDH staff, we will successfully advance this Health Equity plan.

Our journey is driven by a firm belief in our collective capacity to build a future where every Tennessean can access a healthy and fulfilling life.



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