Health District

2025

Health Equity Strategic Plan

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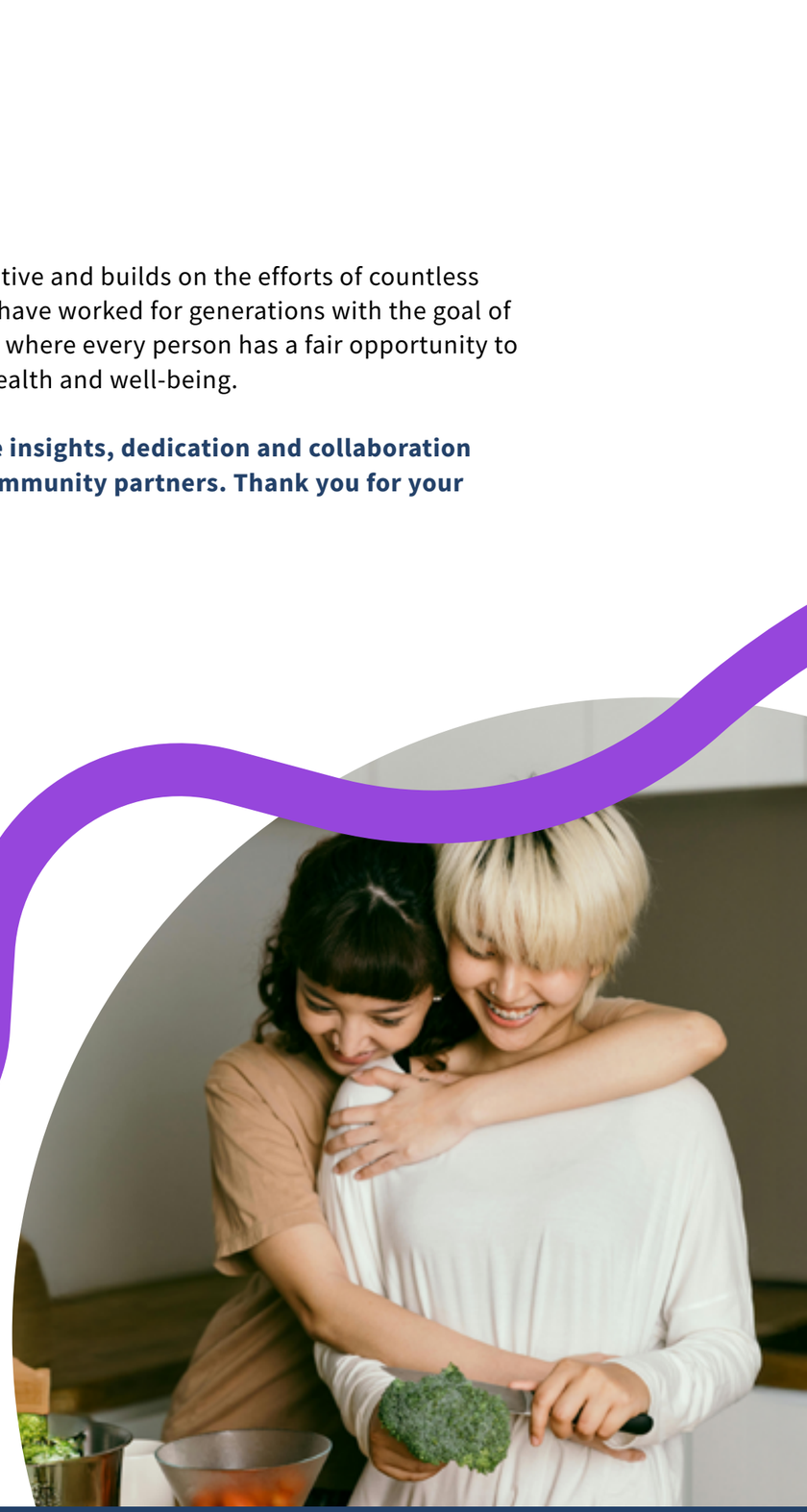
Gratitude

Health equity work is collaborative and builds on the efforts of countless people and organizations who have worked for generations with the goal of making our community a place where every person has a fair opportunity to achieve their highest level of health and well-being.

We are deeply grateful for the insights, dedication and collaboration of our incredible team and community partners. Thank you for your engagement and support.



Executive summary

Health equity is central to our mission of enhancing the health of our community. By addressing unmet needs and providing quality services, we aim to improve health outcomes across our district.

The following four themes provide a roadmap for creating a community where all district residents can reach their highest level of health and well-being.

Strengthen organizational capacity

We're committed to those we serve and our team. We'll listen, learn, act and keep improving.

Goals:

1. We value and integrate health equity as a core component of our work.
2. We recruit, promote and support diverse staff who reflect our community and those we serve.
3. We clearly communicate and understand health equity as an essential component of all internal and external communications strategies.
4. Our staff members are engaged, supported, educated and valued in health equity efforts.

Support total well-being

Many factors affect overall health and well-being. We work to provide services that meet each person's needs.

Goals:

1. We provide communication and language assistance in compliance with legal requirements, and apply Culturally and Linguistically Appropriate Services (CLAS)* standards and language justice* principles.
2. Our services and facilities are accessible.
3. Our services are integrated across our programs and coordinated with partner organizations.
4. We champion equitable solutions to health-related social needs* for those we serve and district residents.

Find and address barriers

We work to make changes to unfair systems that create barriers to better health.

Goals:

1. We implement a clear health equity impact strategy.
2. We collect accurate and reliable data about demographics, experiences, outcomes and barriers to better health.
3. We use data to drive equitable decision-making and continuous improvement.

Center community

Our community guides our work. Building trust and working together helps us improve health for everyone.

Goals:

1. We prioritize community input and foster equitable engagement.
2. We cultivate equitable partnerships that support the health and well-being of residents.
3. We champion community-driven data priorities and methodologies in alignment with data justice* principles.
4. We foster places and spaces of belonging and connection for those we serve and district residents.

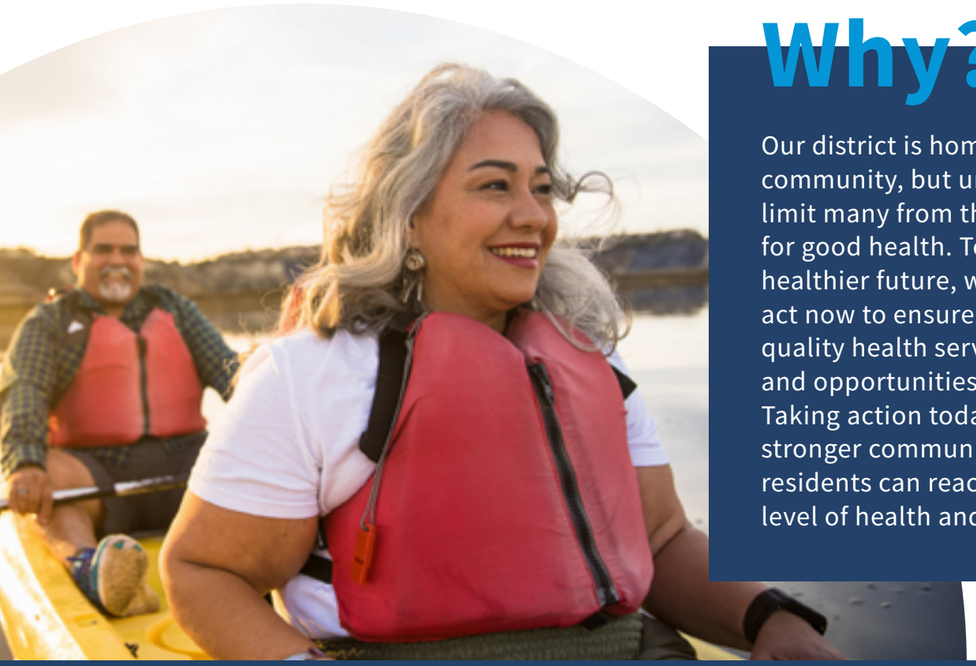
Introduction*

*Terms that are marked with an asterisk (*) are defined in the Key terms section (pg. 32).

The Health District of Northern Larimer County, established by voters in 1960, serves the health needs of the northern two-thirds of Larimer County. Although community needs have looked different through the years, the Health District currently provides dental care, behavioral health care and assistance with health insurance enrollment and literacy. We also work with partners to improve overall health by funding community-driven and community-engaged health services.

In July 2024, the Health District Board of Directors approved a strategic plan for 2024–2025[1], developed after months of collaboration with Board members, leadership and staff. The plan focuses on four priorities: Great Governance, Organizational Excellence, Partnerships and Health Equity. The first three priorities all work to support the goal of advancing health equity.

Health equity is central to our mission of enhancing the health of our community. We can't improve the health of the whole community if some groups face systemic and historical barriers to care. By addressing unmet needs and providing quality services, we aim to improve health outcomes across our district.



Why?

Our district is home to a vibrant community, but unfair systems limit many from their potential for good health. To create a healthier future, we need to act now to ensure fair access to quality health services, resources and opportunities to thrive. Taking action today creates a stronger community where all residents can reach their highest level of health and well-being.

To guide our health equity work, we created this definition:

At the Health District, health equity means that every person has a fair opportunity to achieve their highest level of health and well-being.

It's our responsibility to:

Support total well-being

Many factors affect overall health and well-being. We work to provide services that meet each person's needs.

Find and address barriers

We work to make changes to unfair systems that create barriers to better health.

Center community

Our community guides our work. Building trust and working together helps us improve health for everyone.

We're committed to those we serve and our team. We'll listen, learn, act and keep improving.

This definition was created through a collaborative process with more than 70 Health District staff members. It gives us common language and understanding, aligning our team, those we serve and partners around our health equity goals.

This Health Equity Strategic Plan is data informed and mission driven. It follows the direction outlined in our organizational strategic plan and is structured around our health equity definition, with specific goals and actions for each part.

We invite our community members and partners to share ideas, suggestions and experiences to help shape our health equity work. Your perspective is valuable—join us in creating solutions by contacting info@healthdistrict.org.

1. https://www.healthdistrict.org/strategic-plan

Historical context[2]

~12,000 Years Ago

Land is inhabited by Indigenous peoples, including the early Clovis and Folsom cultures, and Native American groups such as the Hinono'eiteen (Arapaho), Tsétsėhéstahese (Cheyenne), Nʉmʉnʉʉ (Comanche), Caiugu (Kiowa), Čariks i Čariks (Pawnee), Sosonih (Shoshone), Oc'eti S'akowin (Lakota) and Núuchiu (Ute) Peoples.

Early 1800s

European American fur trappers begin exploring the region.

1861

Larimer County is established.

1864

Present site of Fort Collins is designated as a military reservation.

1876

Colorado becomes a state.

1878

All remaining Indigenous people are required to move to reservations. All Arapaho (to Wyoming and Oklahoma), Cheyenne (to Montana and Oklahoma), Kiowa (to Oklahoma), Comanche (to Oklahoma), and Apache (to New Mexico) are removed from the state of Colorado. The Ute are placed on two reservations in southwestern Colorado.

1880

Fort Collins has 15 Black residents in 5 households, according to the 1880 census and newspaper records.

1902

Buckingham and Andersonville neighborhoods are established as sugar factory communities, originally for workers from Germany and Russia, and later for workers from Mexico.

1910s – 1930s

Immigrants from Mexico move to Larimer County, drawn by sugar beet industry jobs.

1925

Ku Klux Klan (KKK) holds a cross-burning in Fort Collins' City Park.

1940s

Housing discrimination persists with subdivisions like Circle Drive and Slade Acres excluding non-white residents. World War II veterans protest local merchants who display racially discriminatory signs.

1950s

Larimer County experiences overcrowding at the county-owned hospital and lacks the funds to address it.

1960

Voters approve the creation of the Health District, then called the Poudre Valley Hospital District, which operates Poudre Valley Hospital (PVH) from 1962 to 1994.

1960s

There is national unrest over the Vietnam War, and the Civil Rights Movement, reflected locally.

1970s

As what is now known as LGBTQ+ activism grows, Colorado State University becomes a hub with the 1971 founding of the Student Organization for Gays, Lesbians, and Bisexuals (SOGLB), later the Fort Collins Gay Alliance, one of the first recognized LGBTQ+ student groups in the U.S.

1975

The Colorado Civil Rights Act adds physical disability as a protected class.

1990

The Americans with Disabilities Act (ADA)* becomes national law.

1994

The Poudre Valley Hospital District Board forms a local, private nonprofit organization to manage the hospital's daily operations under a 50-year lease agreement. This organization is first called the Poudre Valley Health System and is now known as University of Colorado Health.

1995

Health District begins conducting a community health survey and assessment every three years.

1998

The murder of Matthew Shepard in Laramie, Wyoming, briefly makes Fort Collins the epicenter of LGBTQ+ rights issues. Shepard is transported to Poudre Valley Hospital, where he dies from his injuries.

1998

Current Health District Bristlecone campus in north Fort Collins opens.

2002

The Health District changes its name to Health District of Northern Larimer County to better reflect what we do and who we serve.

2019

Health District Equity, Diversity and Inclusion Team (EDIT) forms and begins to bring a lens of equity to the programmatic work of the Health District.

2020

COVID-19 pandemic begins, disproportionately impacting marginalized communities.

2024

Health equity is centered in the Health District's direction through the creation of a comprehensive organizational strategic plan.

Why?

Understanding the history of the land we're on and the people who have come before us is important for understanding current health challenges. Past injustices and current inequities in our community have created barriers to better health for many district residents. This history helps us direct resources where they're most needed and improve systems to ensure fair and accessible health outcomes.

2. https://history.fcgov.com/ • https://www.fcgov.com/historicpreservation/blackfortcollins/ • https://www.fcgov.com/historicpreservation/pride/ https://history.fcgov.com/ethnic/native-americans • https://history.fcgov.com/ethnic/pdf/nativetimeline.pdf • https://history.fcgov.com/explore/county-history https://www.fcgov.com/historicpreservation/pdf/n-college-historical-research-doc.pdf • https://www.fcgov.com/equity/

Our current state

Why?

Understanding the current state of our organization helps us identify successes and barriers to better health. Knowing what's working well and what can be improved upon allows us to prioritize projects and distribute resources to areas where they're most needed.

To understand the current state of the Health District, we reviewed the following inputs:

- 2024 – 2025 Health District Strategic Plan[3]
- 2025 All-Staff Health Equity Survey results
- 2025 Leadership and Management Health Equity Survey results
- 2025 Board of Directors Health Equity Survey results
- Key themes from brainstorming activities at team meetings
- Key themes from discovery sessions with program managers

These inputs informed the SWOT matrix* below, which summarizes the key factors influencing our health equity strategy.

Internal		External	
Strengths	**Weaknesses**	**Opportunities**	**Threats**
Strong understanding, experience and interest in health equity reported among staff, leadership and Board of Directors Health equity as a key priority area in our organizational strategic plan Dedicated staff position and funding to support health equity initiatives Ability to participate and invest financially in broad, cross-sector partnerships Ability to intentionally co-design* new systems and processes from the ground up	Underdeveloped internal infrastructure Limited prior training and resources specific to health equity	Willingness of community members and partners to work together to support health equity in our community Ability to learn from community partners who are also working to support health equity Growing diversity* of our community	Evolving political context at the local, state and federal levels Lack of clarity about what health equity is and what the Health District's role is in supporting it

These inputs also identified the following priority areas for this strategic plan:

Strengthen organizational capacity
- Alignment and integration
- Workforce
- Internal and external communications
- Staff engagement and education

Support total well-being
- Communication and language assistance
- Accessibility of services
- Service integration
- Health-related social needs (HRSN)*

Find and address barriers
- Data strategy
- Data collection
- Using data for decision making and improvement

Center community
- Community and client engagement
- Partnerships
- Community-driven data and accountability
- Belonging

3. https://www.healthdistrict.org/strategic-plan

Two–year action plan

(fall 2025 – winter 2027)

This action plan is structured using the themes in our health equity definition. This approach aligns our actions and commitments to support health equity. **Each theme includes goals, objectives and strategies.**

Strengthen organizational capacity

Support total well-being

Find and address barriers

Center community

Strengthen organizational capacity

We're committed to those we serve and our team. We'll listen, learn, act and keep improving.

Alignment and integration

Goal 1: We value and integrate health equity as a core component of our work.

> Objective 1.1: Staff share a common understanding of health equity and how their roles contribute to it.

Strategy 1.1.1: Define core health equity knowledge, skills and abilities for all staff members, utilizing the themes of the health equity definition.

Strategy 1.1.2: Update all position descriptions to reflect each role's responsibility in advancing the themes of the health equity definition.

Strategy 1.1.3: Incorporate assessment of health equity into performance management.

Strategy 1.1.4: Develop and implement health equity onboarding strategy for new staff members.

> Objective 1.2: Staff share a common understanding of how and why our organization works to advance health equity.

Strategy 1.2.1: Create and share physical and digital materials that highlight the organization's health equity definition and commitment to health equity.

Strategy 1.2.2: Incorporate health equity topics into team- and all-staff meetings, emphasizing the "why" behind health equity initiatives and root causes of health inequities.

Strategy 1.2.3: Develop opportunities to promote awareness of cross-team activities (e.g. shadowing, spotlight series) to support integrated, client-centered service delivery.

> Objective 1.3: Systems and processes are designed to make the equitable choice the easy choice.

Strategy 1.3.1: Identify and implement equity-centered templates and tools, including decision-making frameworks and checklists.

Strategy 1.3.2: Develop team workplans that align with and support health equity goals.

Strategy 1.3.3: Conduct an initial review of internal processes and procedures, and revise based on administrative equity* best practices.

Strategy 1.3.4: Revise Board policies to align with administrative equity* best practices.

Strategy 1.3.5: Develop and implement a procedure and policy review process that centers equity and aligns with best practices.

Strategy 1.3.6: Assess organizational readiness for the National Committee for Quality Assurance's (NCQA) Health Equity Accreditation.

Strategy 1.3.7: Assess resources needed to further integrate health equity across all programs and functions.

Workforce

Goal 2: We recruit, promote and support diverse staff who reflect our community and those we serve.

> Objective 2.1: Understand and address differences in staff experiences and needs throughout the HR lifecycle.*

Strategy 2.1.1: Assess current processes for collecting staff demographic data.*

Strategy 2.1.2: Determine evidence-based practices and next steps to strengthen staff demographic data* collection.

Strategy 2.1.3: Develop and monitor equity-centered key performance indicators (KPIs)* across the HR lifecycle.

Strategy 2.1.4: Routinely assess organizational culture and staff experiences via surveys and stay interviews.

Strategy 2.1.5: Implement incident portal for staff to report workplace incidents.

> Objective 2.2: Support the training and professional development of individuals representative of our community.

Strategy 2.2.1: Maintain and continuously improve requirements, processes and compensation for internships, externships and capstone programs.

Strategy 2.2.2: Expand trainee* recruitment and programming for individuals representative of our community.

Strategy 2.2.3: Develop resources and peer mentorship opportunities to support trainee* preceptors and supervisors.

> Objective 2.3: Recruit diverse candidates.

Strategy 2.3.1: Ensure alignment in position requirements with job-essential competencies, ensuring degree and experience requirements are demonstrably necessary for role performance.

Strategy 2.3.2: Broaden recruitment channels and outreach strategies.

Strategy 2.3.3: Work with community groups to share job openings.

Strategy 2.3.4: Use an "outside-in" approach* for recruitment messaging to listen to the needs of potential employees and communicate what is valuable to them.

Strategy 2.3.5: Advertise how bilingual proficiency impacts total compensation.[4]

> Objective 2.4: Hire diverse candidates.

Strategy 2.4.1: Implement screening practices that minimize potential bias,* such as anonymous reviews.

Strategy 2.4.2: Standardize screening and interview processes based on equity best practices.

Strategy 2.4.3: Create a bank of equity-centered interview questions that can be tailored to job functions and/or specific departments.

Strategy 2.4.4: Use standardized, equity-informed hiring tools and templates.

Strategy 2.4.5: Provide inclusive hiring training for hiring teams that focuses on bias,* accessibility and the benefits of diversity.*

> Objective 2.5: Provide ongoing resources to support the retention and development of staff.

Strategy 2.5.1: Launch internal mentorship programs, including guidance on training and career advancement.

Strategy 2.5.2: Clearly communicate and make available career ladders and promotion criteria.

Strategy 2.5.3: Make pay scales publicly available.

Strategy 2.5.4: Review and enhance employee benefits, including additional resources on how to access and use them.

Strategy 2.5.5: Explore other options to support staff with underrepresented identities.

4. This strategy was implemented during the drafting of this plan.

Internal and external communications

Goal 3: We clearly communicate and understand health equity as an essential component of all communications strategies.

> Objective 3.1: Internal communications are transparent and crafted with an equity lens.

Strategy 3.1.1: Establish a multi-pronged strategy to share equity updates, resources and initiatives across teams.

Strategy 3.1.2: Develop a calendar of culturally significant days/months with staff and community input, and integrate it into internal processes to inform inclusive planning and recognition efforts.

Strategy 3.1.3: Clearly describe how our resources and staffing are supporting health equity efforts.

Strategy 3.1.4: Integrate an equity-centered language style guide into the comprehensive brand guide.

> Objective 3.2: External communications are transparent and crafted with an equity lens.

Strategy 3.2.1: Develop a public-facing statement highlighting our commitment to supporting health equity.

Strategy 3.2.2: Develop culturally and linguistically appropriate communications and marketing strategies in collaboration with our priority populations.

Strategy 3.2.3: Develop and launch a health equity webpage.

Strategy 3.2.4: Review all new website content through an equity lens.

Strategy 3.2.5: Identify, document and commit to using best practices for translation and transcreation* of identified documents/materials.

Strategy 3.2.6: Develop and implement a health equity review process and/or criteria for public-facing communications.

Staff engagement and education

Goal 4: Our staff members are engaged, supported, educated and valued in health equity efforts.

> Objective 4.1: Staff and leadership are actively engaged in health equity through structured groups and ongoing collaboration.

Strategy 4.1.1: Formalize a collaborative, flexible framework to involve staff in advancing health equity through the Health Equity Action Team (HEAT).

Strategy 4.1.2: Identify key areas for HEAT to work to find and address root causes of key health equity challenges identified within the organization.

Strategy 4.1.3: Identify and support designated Health Equity Champions to lead education and implementation efforts.

Strategy 4.1.4: Review and implement strategies identified by HEAT to address root causes of key health equity challenges identified within the organization, as appropriate.

> Objective 4.2: Feedback from staff is valued and acted upon.

Strategy 4.2.1: Develop a regular survey cadence for staff, leadership and the Board to assess perceived health equity progress and identify areas for improvement.

Strategy 4.2.2: Implement new, and use existing, internal forums for staff to share health equity ideas, challenges and innovations.

Strategy 4.2.3: Create a transparent system to communicate how staff feedback has influenced strategic decisions.

> Objective 4.3: Provide consistent, ongoing and accessible health equity training to promote personal and professional growth, as well as whole-person care.

Strategy 4.3.1: Assess health equity competencies and training needs of staff within each team to identify gaps, establish priorities and inform strategy.

Strategy 4.3.2: Develop health equity curriculum and learning pathways.

Strategy 4.3.3: Implement a variety of training delivery methods to accommodate diverse learning styles and schedules.

Strategy 4.3.4: Monitor the efficacy of training and solicit feedback to inform continuous improvement efforts.

Strategy 4.3.5: Leverage tools and assessments to help staff understand and apply their strengths to inclusive teamwork and equitable service delivery.

Strategy 4.3.6: Develop and make available a health equity resource library.

Support total well-being

Many factors affect overall health and well-being. We work to provide services that meet each person's needs.

Communication and language assistance

Goal 1: We provide communication and language assistance in compliance with legal requirements, and apply Culturally and Linguistically Appropriate Services (CLAS)* standards and language justice* principles.

> Objective 1.1: Provide free language assistance to all individuals who have limited English proficiency* and/or other communication needs.

Strategy 1.1.1: Assess existing language assistance services* and determine how they can be more effective and efficient.

Strategy 1.1.2: Research and implement best practices for serving individuals with limited English proficiency,* reading ability or digital literacy.*

Strategy 1.1.3: Assess delivery methods for interpreter services (e.g. in-person, video, over the phone) depending on need and type of service being provided, and develop recommendations for the most appropriate delivery methods for each scenario.

> Objective 1.2: Inform all individuals of the availability of free language assistance services* in their preferred language, verbally and in writing.

Strategy 1.2.1: Standardize and train staff in language assistance procedures, including providing staff with a script and other resources.

Strategy 1.2.2: Annually evaluate current language assistance signage and update as needed.

Strategy 1.2.3: Develop and implement a multilingual multimedia strategy to promote free language assistance services.*

> Objective 1.3: Deliver high-quality interpretation services through trained interpreters who staff are proficient in working with.

Strategy 1.3.1: Require all interpreters to complete certification or competency assessments.

Strategy 1.3.2: Develop and implement educational materials for staff and external audiences about the importance of using trained interpreters.

Strategy 1.3.3: Standardize processes for requesting and billing an interpreter.

Strategy 1.3.4: Conduct program-specific trainings on how to work effectively with interpreters.

> Objective 1.4: Provide easy-to-understand print and multimedia materials in the languages commonly used in our district and among those we serve.

Strategy 1.4.1: Use data to understand which languages are most commonly spoken in our district and among those we serve.

Strategy 1.4.2: Formalize processes for translating all public-facing materials into Spanish and other identified languages.

Strategy 1.4.3: Formalize processes for evaluating the quality of translations, including testing and/or co-creating materials with target audiences.

Accessibility of services

Goal 2: Our services and facilities are accessible.

> Objective 2.1: Prioritize physical and digital accessibility in all operations and services in alignment with disability justice* principles.

Strategy 2.1.1: Conduct a website accessibility review and implement needed changes to align with most recent Web Content Accessibility Guidelines (WCAG)* standards.

Strategy 2.1.2: Review the Notice of Non-Discrimination and associated grievance procedure to ensure adherence to best practices and ADA* compliance.

Strategy 2.1.3: Apply human-centered design* principles in facility renovations and new construction, including the integrated health campus, in alignment with ADA accessibility standards.

Strategy 2.1.4: Review current dental and other client-facing equipment for accessibility and the needs of those we serve.

> Objective 2.2: Provide accommodations* for individuals with disabilities and sensory sensitivities in alignment with disability justice* principles.

Strategy 2.2.1: Establish a clear, standardized process for requesting and providing accommodations* for those we serve.

Strategy 2.2.2: Identify and implement features and tools to make spaces more sensory-friendly.*

Strategy 2.2.3: Designate and train care navigators or support staff to assist individuals needing additional support during appointments.

Strategy 2.2.4: Develop and implement a standardized procedure and signage for service animals.

> Objective 2.3: Increase service availability to better meet community needs.

Strategy 2.3.1: Conduct discovery to learn how to best implement expanded service hours, such as evenings and weekends.

Strategy 2.3.2: Increase the deployment of mobile teams, screenings and outreach to under-resourced areas and partner locations to reduce geographic and transportation barriers to care.

Strategy 2.3.3: Explore strategies to expand access and referrals to specialty care services.

Strategy 2.3.4: Determine methods to increase the accessibility of telehealth services and support those we serve with access needs, including employing methods to access digital literacy* education and partnerships with programs that help individuals and families expand their digital skills.

> Objective 2.4: Reduce administrative, financial and insurance barriers for those we serve.

Strategy 2.4.1: Utilize metrics and narrative to inform an update of eligibility criteria, including minimizing required documentation and addressing minimal insurance benefits.

Strategy 2.4.2: Streamline intake and eligibility processes through a centralized and user-friendly system.

Strategy 2.4.3: Develop clear eligibility guidelines for specialty care funding to minimize potential bias.*

Strategy 2.4.4: Implement a multipronged communications strategy explaining our payment models for staff, those we serve and other identified audiences.

Strategy 2.4.5: Explore and implement health equity best practices to track and address missed appointments.

Service integration

Goal 3: Our services are integrated across our programs and coordinated with partner organizations.

> Objective 3.1: A centralized, integrated client health campus enhances service access and coordination.

Strategy 3.1.1: Relocate existing Health District programs to a centralized and accessible facility to support integrated care and health-related social needs.*

Strategy 3.1.2: Identify and implement best practices for integrated care delivery models that support total well-being.

> Objective 3.2: Provide high-quality care coordination* and service navigation for those we serve.

Strategy 3.2.1: Analyze internal and external referral processes to identify gaps and opportunities for improvement.

Strategy 3.2.2: Document standardized workflows for internal referrals across Health District programs.

Strategy 3.2.3: Document referral protocols for external services, ensuring referrals are culturally and linguistically appropriate and inclusive.

Strategy 3.2.4: Use existing vetted community resource inventories and provider directories to support informed referrals based on client needs, insurance status, language and accessibility.

Strategy 3.2.5: Train staff on equity-centered referral and patient navigation practices, including understanding barriers to care and offering follow-up support to ensure successful connections.

> Objective 3.3: Champion culturally relevant, community-embedded programs that meet social and preventative health needs outside of traditional clinical spaces.

Strategy 3.3.1: Develop recommendations to support priority populations with chronic disease screenings, health education and community resource navigation.

Strategy 3.3.2: Collaborate with community partners to evaluate and implement recommendations to support priority populations with chronic disease screenings, health education and community resource navigation.

Health-related social needs (HRSN)*

Goal 4: We champion equitable solutions to health-related social needs* for those we serve and district residents.

> Objective 4.1: Staff and partners understand how social and historical factors shape health.

Strategy 4.1.1: Compile information and develop a report about the district's history and how it has affected residents' current health and social needs.

Strategy 4.1.2: Design, pilot, refine and implement a training module to help staff, partners and the community learn how history and systems impact health in the community.

Strategy 4.1.3: Partner with local organizations to deliver this training and promote collective action to address whole-person health.

> Objective 4.2: Identify and address the health-related social needs of those we serve.

Strategy 4.2.1: Implement a standardized screening tool to identify the health-related social needs* of those we serve, such as housing, food, transportation or financial insecurity.

Strategy 4.2.2: Train staff on standardized screening procedures for health-related social needs* screening procedures, including why screening is important for supporting the total well-being of those we serve.

Strategy 4.2.3: Develop care coordination* procedures and workflows for health-related social needs* referrals and follow-ups.

Find and address barriers

We work to make changes to unfair systems that create barriers to better health.

Data strategy

Goal 1: We implement a clear health equity impact strategy.

> Objective 1.1: Identify priority populations.

Strategy 1.1.1: Conduct an inventory of community health data sources, including data elements* and collection frequency.

Strategy 1.1.2: Analyze existing community health data to identify populations experiencing barriers to better health within organizational priority areas.

Strategy 1.1.3: Assess organizational capacity to serve identified populations.

Strategy 1.1.4: Evaluate community capacity and existing resources to serve identified populations.

Strategy 1.1.5: Document and prioritize populations based on health needs, resource gaps and organizational capacity.

> Objective 1.2: Clearly define and implement a health equity data and measurement strategy.

Strategy 1.2.1: Co-create an impact strategy with staff and impacted communities.

Strategy 1.2.2: Identify data elements* needed to accurately describe those we serve and to assess our impact.

Strategy 1.2.3: Develop a comprehensive data dictionary* explaining each data element,* its purpose and intended use.

Data collection

Goal 2: We collect accurate and reliable data about demographics, experiences, outcomes and barriers to better health.

> Objective 2.1: Routinely collect demographic data* of those we serve in alignment with health equity best practices.

Strategy 2.1.1: Assess current demographic data* collection practices across programs.

Strategy 2.1.2: Identify best practices for demographic data* collection, particularly for collecting data about our identified priority populations.

Strategy 2.1.3: Co-design* a revised demographic data* collection form with staff from one pilot program.

Strategy 2.1.4: Develop and implement training and educational materials for staff and those we serve about the revised demographic data* collection practices.

Strategy 2.1.5: Pilot, audit and refine demographic data* collection practices to improve data quality and user experience.

Strategy 2.1.6: Scale revised demographic data* collection practices to other programs.

> Objective 2.2: Routinely collect experience data from those we serve.

Strategy 2.2.1: Identify best practices for collecting experience data.

Strategy 2.2.2: Develop a core set of experience metrics.

Strategy 2.2.3: Develop and implement multiple methods to collect experience data, including surveys and semi-structured interviews.

Strategy 2.2.4: Develop and implement incentives, as appropriate, to encourage those we serve to provide experience data.

Strategy 2.2.5: Pilot, audit and refine experience data collection practices to improve data quality and user experience.

Strategy 2.2.6: Identify and begin to use journey mapping* tools to assess key touchpoints and drop-off points for those we serve.

Strategy 2.2.7: Establish procedure to address concerns identified from experience data.

> Objective 2.3: Routinely collect service utilization and outcome data about those we serve.

Strategy 2.3.1: Identify best practices for collecting service utilization and outcome data.

Strategy 2.3.2: Develop a core set of service utilization and outcome metrics.

Strategy 2.3.3: Determine and implement methodologies to assess the defined service utilization and outcome metrics.

Strategy 2.3.4: Routinely review service utilization and outcome data quality, and revise as needed.

> Objective 2.4: Routinely collect data about barriers to better health for those we serve.

Strategy 2.4.1: Identify best practices for collecting data on barriers to better health.

Strategy 2.4.2: Develop a core set of barrier metrics.

Strategy 2.4.3: Develop and implement multiple methods to gather data about barriers to better health.

Strategy 2.4.4: Develop and implement standardized incentives for those we serve to provide data about barriers to better health, as appropriate.

Strategy 2.4.5: Continuously audit and refine data collection practices for barriers to improve data quality and user experience.

Using data for decision making and improvement

Goal 3: We use data to drive equitable decision-making and continuous improvement.

> Objective 3.1: Analyze data through intersectional* and asset-based* lenses.

Strategy 3.1.1: Review demographic data* about those we serve quarterly to assess service provision to priority populations.

Strategy 3.1.2: Disaggregate* analyses, as appropriate, by demographic factors such as race, language, gender and disability status to understand how different combinations of identities may impact experiences, outcomes and barriers to better health.

Strategy 3.1.3: Incorporate asset-based* framing into analyses to recognize community strengths and resilience, not just needs.

Strategy 3.1.4: Critically assess how the identities of those analyzing and interpreting data has the potential to bias* the results, and work to reduce bias* through training and reflection.

> Objective 3.2: Data is accessible and communicated clearly.

Strategy 3.2.1: Evaluate data collection tools for usability, accessibility and key functionalities such as interoperability.*

Strategy 3.2.2: Implement data reporting tools that can accept data from multiple sources and disaggregate data by key demographic elements in ways that are broadly usable, accessible and understandable.

Strategy 3.2.3: Develop and implement a data reporting strategy with core metrics, reporting frequency, formats and audiences.

Strategy 3.2.4: Report key insights using a combination of metrics and narrative, in alignment with the data reporting strategy.

Strategy 3.2.5: Apply equitable data visualization principles to all internal and public-facing materials.

> Objective 3.3: Data informs targeted strategies to address barriers to better health.

Strategy 3.3.1: Establish universal goals* for the outcomes and experiences of those we serve in partnership with staff, community partners and the Board.

Strategy 3.3.2: Routinely use data to assess progress toward the universal goals* for various demographic groups, especially priority populations.

Strategy 3.3.3: Assess to better understand what supports or slows each group from achieving the universal goals.*

Strategy 3.3.4: Develop and implement targeted strategies, including at the systems level, for each group to reach the universal goals.*

Center community

Our community guides our work. Building trust and working together helps us improve health for everyone.

Community and client engagement

Goal 1: We prioritize community input and foster equitable engagement.

> Objective 1.1: Develop internal infrastructure to support an equitable community engagement* strategy that elevates community voices.

Strategy 1.1.1: Assess current community engagement* practices, gaps and opportunities using existing evaluation tools.

Strategy 1.1.2: Design an equitable community engagement* strategy that prioritizes building trust and relationships with community members.

Strategy 1.1.3: Allocate staff roles and time for developing and maintaining community relationships.

Strategy 1.1.4: Foster a culture of service by facilitating volunteer service days for staff each year.

Strategy 1.1.5: Develop and implement an evidence-based compensation framework for community contributors that offers equitable, flexible options.

Strategy 1.1.6: Maintain a community relationship management system* to monitor and drive improvements to outreach and engagement.

Strategy 1.1.7: Support or co-host healing-centered engagement events and messaging campaigns led by community partners.

> Objective 1.2: Support the participation and engagement of community members in Health District meetings and Board activities.

Strategy 1.2.1: Assess and document how community members prefer to receive information about the Health District, including opportunities to participate in community engagement* activities.

Strategy 1.2.2: Explore and implement pathways to improve community awareness of and participation in board meetings and elections.

Strategy 1.2.3: Promote language justice* in public meetings and meetings with partners through the use of live interpretation upon request.

Strategy 1.2.4: Research best practices for establishing a Community Advisory Board* reflective of our priority populations.

Strategy 1.2.5: Create an implementation framework and timeline for a Community Advisory Board.*

Strategy 1.2.6: Create a transparent system to communicate how feedback from community members and partners has influenced strategic decisions.

Partnerships

Goal 2: We cultivate equitable partnerships that support the health and well-being of residents.

> Objective 2.1: Support the health needs of the community through an equitable funding partnership model.

Strategy 2.1.1: Explore and develop sustainable funding partnership approaches and guiding principles to support community health needs.

Strategy 2.1.2: Implement a funding partnership model that aligns with the priority areas of the organization and strategic direction of the Board of Directors.

Strategy 2.1.3: Co-create process and outcome metrics with funded partners to understand impacts.

> Objective 2.2: Develop and implement an equitable procurement and contracting framework.

Strategy 2.2.1: Embed equity criteria into the procurement evaluation process, such as shared values and community impact.

Strategy 2.2.2: Broaden marketing channels and outreach strategies for vendor procurement.

Strategy 2.2.3: Collaborate with subject matter experts to explore and implement strategies to enhance procurement equity.

> Objective 2.3: Participate in equitable partnerships and coalitions that advance community-led health equity efforts.

Strategy 2.3.1: Identify existing community-led coalitions, networks and organizations working on health equity, community development and related issues in organizational priority areas.

Strategy 2.3.2: Participate in and/or convene cross-sector coalitions that align with our health equity goals and organizational priorities, and prioritize collective action.

Strategy 2.3.3: Use community-informed metrics to assess the effectiveness, equity and impact of partnerships, and adapt practices based on findings.

Community-driven data and accountability

Goal 3: We champion community-driven data priorities and methodologies in alignment with data justice* principles.

> Objective 3.1: Data priorities reflect the experiences, needs and goals of communities most impacted by health inequities.

Strategy 3.1.1: Facilitate community-led forums such as listening sessions to identify shared data priorities grounded in experiences, needs and goals.

Strategy 3.1.2: Develop data collection methods and initiatives that center the perspectives of those historically excluded from data processes.

> Objective 3.2: Data is community-validated, accessible and actionable for social change.

Strategy 3.2.1: Involve community members and partners in analyzing and interpreting data.

Strategy 3.2.2: Co-design* dissemination methods with community members and partners, and share findings through relevant formats and trusted community platforms.

Strategy 3.2.3: Develop an implementation framework for a regularly updated public dashboard with community-defined metrics and narratives.

Belonging

Goal 4: We foster places and spaces of belonging and connection for those we serve and district residents.

> Objective 4.1: Strengthen relationships with, and amplify the work of, Indigenous community members and partners.

Strategy 4.1.1: Learn about the history, health inequities and current contexts impacting Indigenous community members in the district.

Strategy 4.1.2: Collaborate with Indigenous-led organizations and community members to co-create a meaningful and community-informed land acknowledgment.

Strategy 4.1.3: Identify and implement concrete actions to support Indigenous-led work and health equity initiatives.

Strategy 4.1.4: Incorporate the land acknowledgment across all public platforms, including website and Board meetings.

> Objective 4.2: Promote inclusive and welcoming environments for those we serve.

Strategy 4.2.1: Display artwork from local artists that reflects community diversity* and culture.

Strategy 4.2.2: Display clinic signage and materials that affirm inclusive, respectful spaces.

Strategy 4.2.3: Provide lobby reading materials and children's books in multiple languages and cultural perspectives.

Strategy 4.2.4: Design gender-inclusive, family-friendly restrooms.

Our commitment

How we'll manage change

We believe that how we do things is as important as what we do. That's why we're committing to approaching the work outlined in this strategic plan with intention and inclusion.

We know that some of the changes we'll undertake will take time, resources and ongoing refinement. Making this level of change requires adjusting our approach as we learn and supporting our team throughout. We commit to listening, learning and taking care of each other throughout this process to build the future we want to see together.

Our change management* approach will embody our values and leverage our strengths. We will:

- Work to understand the aspirations and values of our team and community to draw personal connections to our work
- Co-create actions aligned with our values
- Describe why now is the time to act, and how our actions will enhance the health of our community

Imagine northern Larimer County in 10 years or even 50 years. We're shaping that future together now.

Why?

We want to make sure we follow through on the goals in this plan. That means tracking our progress, being honest about what's working and what's not, and keeping staff and community partners in the loop. This section explains how we'll do that.

How we'll track and communicate progress

We're committed to clear and transparent communication about what's working and what's not. This helps build trust, invites collaboration and keeps us accountable to those we serve.

Some of the ways we'll track and report progress:

- **Process metrics and outcome metrics** to describe how we're working and what we're accomplishing, including both numbers and stories to describe the impact of our work.
- **Internal tools** to clearly track actions and outcomes in real time.
- **Regular program updates** for our staff, leadership and Board.
- **Annual health equity progress report** to highlight the year's wins, challenges and opportunities.
- **Regular surveys and engagement** with staff, leadership, our Board, those we serve and community partners.

This Health Equity Strategic Plan will be updated in 2028, with community voices included in the process.

Our process

Why?

We believe in transparency. Sharing our process and the lessons we learned along the way helps us all move toward a future in which every person has a fair opportunity to achieve their highest level of health and well-being.

This strategic plan was developed with input from Health District staff and guided by best practices from organizations working to advance health equity. Building upon the Board's 2024 – 2025 strategic plan[5], which established health equity as a key strategic priority, this plan provides a comprehensive framework to advance that commitment. For more than a year, we have researched and compiled information, and more importantly, built meaningful relationships within our team. These relationships foster trust and belonging, which are essential foundations for advancing health equity.

The timeline below outlines the key steps in creating this strategic plan:

5. https://www.healthdistrict.org/strategic-plan

Health equity definition

To develop our organizational definition of health equity, we:

- Reviewed definitions and identified key themes from more than 15 external sources
- Met twice with a cross-functional, client-facing group to gain insight into current understanding of health equity, and to review a draft definition
- Presented at nine team meetings and gathered input from approximately 80% of staff

Partner research

To align with industry standards and innovations, our health equity strategist:

- Reviewed health equity strategic plans from organizations such as the American Medical Association (AMA), Colorado Department of Health Care Policy and Financing (HCPF) and Colorado Health Institute (CHI)
- Researched existing health equity resources and best practices
- Identified key themes and core components to inform our approach

Input from throughout the organization

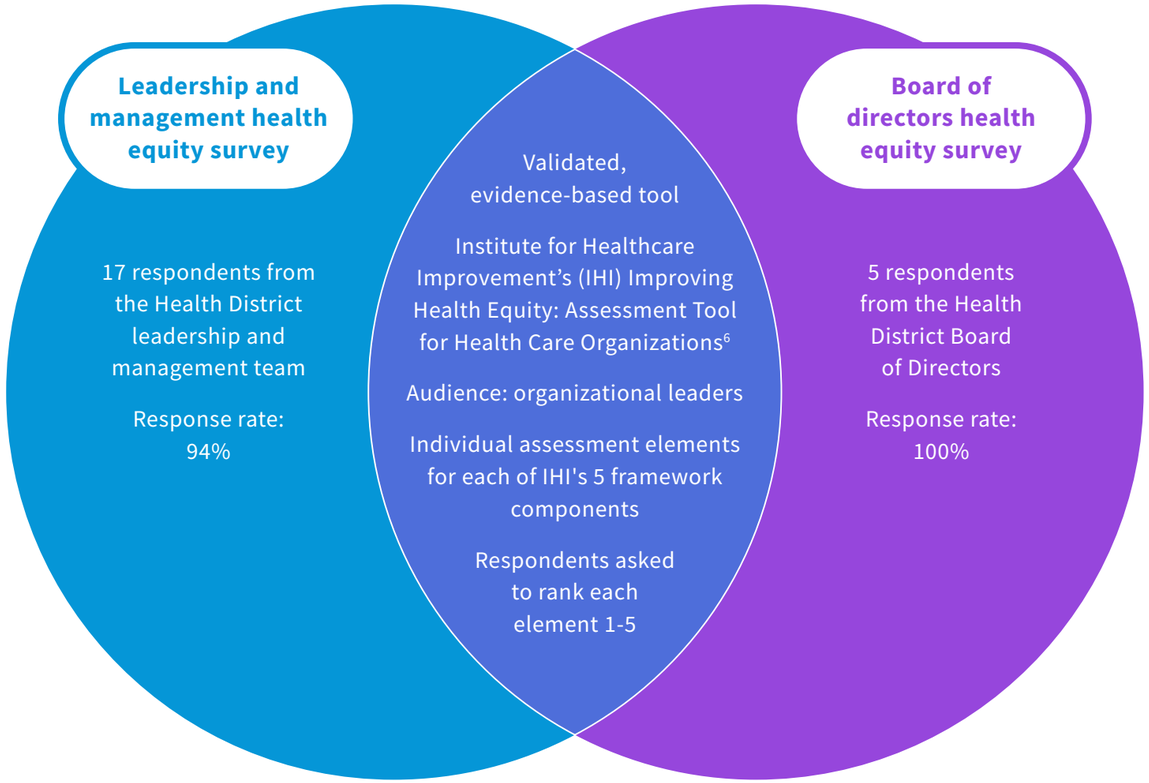
To understand the health equity wins and challenges at our organization, **we conducted three health equity surveys in early 2025:**

All surveys were anonymous and designed to:

- Understand the current state
- Inform action
- Measure progress over time

All-staff health equity survey

- 4 core questions +1 question assessing if the respondent works directly with clients
- 4-point scales from “Strongly Agree” to “Strongly Disagree”
- 5 optional open-ended questions to provide examples
- Response rate: 73%



6. https://www.ihi.org/sites/default/files/IHI_ImprovingHealthEquity_AssessmentTool.pdf

Continued input from our team

Team meetings have been a tool to build relationships, ask questions and brainstorm ways to support health equity at the Health District.

The following questions were used to generate discussion and ideas:

- What would health equity look and feel like in our community?
- What barriers are encountered by those we serve, and how can we help address them?
- What steps can we take to create a culture of health equity within our organization?
- What does successful staff engagement look and feel like?

Additional discovery sessions with managers and supervisors explored:

- Current health equity work
- Project ideas and goals through 2027
- Anticipated challenges and opportunities

Key terms

Accommodations: An adjustment made to help people access services.[7]

Administrative equity: The steps taken to address barriers to accessing information and financial resources, and ensuring that organizational structures and practices support inclusion, belonging and equitable opportunities.[8]

Americans with Disabilities Act (ADA): A federal civil rights law that prohibits discrimination against people with disabilities in everyday activities, including participation in local government programs like those at the Health District.[9]

Asset-based framing: Defines individuals and communities by their strengths before addressing challenges they may face.[10]

Bias: A natural inclination for or against an idea, object, group or individual. Biases can be conscious or unconscious — explicit or implicit. In addition, bias can be institutionalized into policies, practices and structures.[11]

Care coordination: The organization of a patient's care across multiple health care providers.[12]

Change management: How an organization describes and implements change within both its internal and external processes. This includes preparing and supporting employees, establishing the necessary steps for change and monitoring change to ensure successful implementation.[13]

Why?

It's important to be clear about the words we use. This section includes definitions for many of the terms used throughout this strategic plan. If you have feedback about terms not listed, email info@healthdistrict.org.

Co-design: A collaborative process where people work together to design products, services or systems. Co-design involves sharing power, building trust and relationships, offering multiple ways for people to participate and building new knowledge and skills for everyone involved.

Community Advisory Board (CAB): A group of community members that provide guidance to a project or initiative. CABs often help health centers set priorities, implement evidence-based care and improve outreach to residents.[14]

Community engagement: A process of working with community members to build trust, strengthen relationships and involve people in decisions that affect their lives. It ensures everyone has a voice, uses a variety of tools and strategies, and aims to create lasting, positive outcomes for the whole community.

Community relationship management system: A tool to foster collaboration with a network of partners. Instead of focusing on building more partnerships, you use data to develop a specific strategy of who you'll work with — and how you will work together — to achieve your goals best.[15]

Culturally and linguistically appropriate services (CLAS): Health services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients.[16]

Data dictionary: A document that clearly explains what each part of a dataset means and how it's organized. It helps make sure that anyone using the data understands it in the same way, so they can use it correctly and get the same results.

Data element: The smallest piece of information in a dataset that has a unique meaning. For example, in a demographic dataset, data elements might include a person's gender, race and geographic location.

Data justice: A framework that ensures data represents community needs by centering community members in decisions about how data is collected and used.[17]

Demographic data: Basic information that describes who people are. Demographic data is often used to describe a person or group of people. This can include elements such as age, gender, race, ethnicity, income level, education, occupation and geographic location.

Digital literacy: The ability to use technology to achieve one's goals.[18]

Disability justice: A framework that understands that all bodies are unique and essential; all bodies have strengths and needs that must be met; we are powerful, not despite the complexities of our bodies, but because of them; and all bodies are confined by ability, race, gender, sexuality, class, nation state, religion and more, and we cannot separate them.[19]

Disaggregate: Process of breaking down data into smaller, more specific groups to reveal patterns or differences that may not be fully reflected in aggregated data. For example, disaggregated racial and ethnic data breaks down broad categories like Asian and Hispanic into more specific subgroups like Korean or Vietnamese, and Mexican or Chilean.

Diversity: Diversity includes all the ways in which people and groups are different from each other. It's all-inclusive and recognizes everyone and every group as part of the diversity that should be valued.[20]

Health-related social needs (HRSN): Social and economic needs that affect an individual's ability to maintain their health and well-being. These include needs such as employment, affordable and stable housing, healthy food, personal safety, transportation and affordable utilities.[21]

Human-centered design: A problem-solving technique that prioritizes the audience's wants and needs during every phase of the design process.[22]

Human resources (HR) lifecycle: Encompasses all activities related to human resources, including attraction, recruitment, onboarding, performance management, development, retention and separation of employees.

Interoperability: The ability of different information systems to work together and share information.[23]

Intersectional/Intersectionality: A framework introduced by Kimberlé Crenshaw, noted advocate and scholar, that explains how different aspects of a person's identity such as race, gender, class or sexuality, work together to shape unique experiences of discrimination or privilege. It recognizes that these identities don't exist separately but combine to create overlapping systems of oppression or advantage.

Journey mapping: A technique to understand how clients or patients interact with health providers throughout their care journey. The patient journey map helps organizations understand and improve patient engagement and satisfaction.[24]

Key performance indicator (KPI): Metrics that show how well a goal is being achieved.

Language assistance services: Services that support individuals with limited English proficiency,* including interpretation and translation.

Language justice: A practice used to create shared power, practice inclusion and dismantle systems of oppression that have traditionally excluded non-English speakers. Language justice is needed to facilitate opportunity for everyone to engage and participate in their own language, and to create an inclusive and equitable space.[25]

Limited English proficiency: Limited ability to read, speak, write or understand English. Those with limited English proficiency include individuals who speak other languages fluently, including American Sign Language (ASL), and often face worse health care outcomes because of access and communication barriers.[26]

Outside-in approach: A communications approach that identifies and utilizes the wants and needs of the audience. Instead of highlighting what we can do for someone, ask what someone needs and show how we can support that.

Sensory-friendly: Environments, products or experiences designed to make environments more inclusive for everyone, especially people with sensory sensitivities. Sensory-friendly accommodations include things like soft lighting, headphones to reduce noise and fidget devices.[27]

SWOT matrix: A strategic planning tool used to identify the strengths, weaknesses, opportunities and threats related to an organization or project.

Transcreation: A combination of translation and creation. This practice involves members of the target audience to create a product that meets their cultural and language preferences and needs.

Trainee: Individual participating in a career training program such as an internship, externship, practicum or Capstone.

Universal goal: A shared aim to make sure everyone in the community has the chance to be healthy.

Web Content Accessibility Guidelines (WCAG): International standards that explain how to make websites more accessible to people with disabilities.[28]

7. https://www.youtube.com/watch?app=desktop&v=pg9tEECzc88
8. https://trailhead.institute/wp-content/uploads/2024/05/Introduction-to-Administrative-Equity-Trailhead-Institute-Spring-2024.pdf
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28. https://www.w3.org/WAI/standards-guidelines/wcag/

2025 Health District

Health Equity Strategic Plan

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