**Appendix C1 - Evidence of Health Equity Strategies Form**

Program Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Program Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The ODH is committed to the elimination of health disparities and achieving health equity for all Ohioans. The items below are requirements and recommendations for all applicants to ensure health equity is embedded within all components of the application (e.g., Goals, Program Narrative, and Objectives.)

**Please describe how applicant’s program addresses each health equity strategy in the current funding period.**

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| **Evidence of Health Equity Strategies in Program Application** | **Summarize Data of Activities Completed** |
| *ODH Required:* Identify specific groups who experience a disproportionate burden of disease, health condition or health outcome targeted by this solicitation See Ohio’s State Health Assessment Ohio’s health data |  |
| *ODH Required:* Identify geographic reference points (i.e., census tracts, census block groups or zip codes) to specify where program activities are focused. <https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/health-equity/health-improvement-zones>. |  |
| *ODH Required:* Use direct or indirect feedback from the prioritized population, community, group, or community agency to identify specific social and environmental conditions (social determinants of health) associated with health disparities and health inequities. https://data.ohio.gov/wps/portal/gov/data/view/social-determinants-of-health |  |
| *ODH Required:* Identify measurable health equity targets that demonstrate reducing disparities and improving health equity are critical goals to be achieved through program activities. This information must also be supported by data. For guidance on methodology to establish equity targets, review [2030 Target Setting Methodologies for Objectives in Healthy People 2030](https://www.healthypeople.gov/sites/default/files/TargetSettingReport-8-6-18%20FINAL.pdf). |  |
| *ODH Recommended:* Outline specific evaluation strategies to measure the impact of program activities on decreasing and/or eliminating health disparities and health inequities. |  |
| *ODH Recommended:* Link proposed activities to health equity strategies identified in local, state or national planning documents. These documents include, but are not limited to strategies, goals and objectives outlined in [Healthy People 2030](https://health.gov/healthypeople), the [State Health Improvement Plan (SHIP)](https://odh.ohio.gov/wps/portal/gov/odh/about-us/sha-ship) and local Community Health Assessments . |  |
| *ODH Recommended:* Develop staffing plans where board members, leadership and program staff reflect the race, ethnicity, background, and/or culture of the population being served. |  |
| *ODH Recommended:* Establish non-traditional partnerships among different sectors of the community (e.g., faith-based organizations, local industries, businesses, universities, businesses, healthcare) that can provide valuable insight, new perspective, and more effective ways to achieve program goals. Non-traditional partners create opportunity to collaborate across sectors and may serve as a new source of support for the program. |  |
| *Program Required:* Submit the Culturally and Linguistically Appropriate Services (CLAS) initial plan for Standards 1-15. |  |
| *Program Required:* Submit Health Equity Action Plan. (CLAS plan Standard 15). |  |
| *Program Required:* Offer direct healthcare clinic hours outside of Monday through Friday, 9am-4:30pm. |  |
| *Program Required:* Provision of comprehensive primary health care services in the same location or nearby with formal referral agreements. |  |
| *Program Required:* Offer a sliding fee scale and accept all patients, regardless of income. |  |
| *Program Required:* Ensure clients with no insurance coverage are assisted with Medicaid/insurance enrollment. |  |
| *Program Required:* Offer and promote telehealth services. |  |
| *Program Required:* Adopt and implement a local policy/practice change that will address a social determinant of health that impacts inequities in reproductive health. May do this in partnership with community. |  |
| *Program Required:* Use Program provided Dashboard or CDC Social Vulnerability Index to guide outreach and advertising. |  |
| *Program Required:* Information and Education or Advisory Committee membership is reflective of the community served. |  |
| *Optional:* Quality Improvement project focuses on health equity topic. |  |
| *Optional:* Participation in special population or faith-based organization deliverable. |  |