## Guidance for Integrating Health Equity Language Into Funding Announcements
## February 2018

This guide for integrating health equity language into funding announcements was developed by the Association of State and Territorial Health Officials (ASTHO) to serve as a resource for state and territorial health agencies that are considering incorporating health equity requirements into their funding announcements. While this guide contains information tailored to public health and healthcare organizations, it is useful for any organization or agency that seeks to advance health equity through grant programs.

Despite efforts to eliminate health disparities, many people in the United States continue to experience unsatisfactory access to healthcare, inadequate housing, unaffordable transportation options, and unequal educational opportunities.[i] ASTHO is committed to supporting state health agencies in their work to address health disparities and advance health equity. This commitment is evident in ASTHO's vison statement and 2018-2021 Strategic Map. [ii] This goal is aligned with ASTHO's 2016 President's Challenge to advance health equity and optimal health for all. [iii] Both of these initiatives helped generate momentum and concrete steps to advance the goal of achieving health equity, which ASTHO continues to support through policies, programs, and technical assistance.

According to the 2014 ASTHO Minority Health Survey, 27 states either require a health equity focus in all funding opportunities or recommend implementing such a requirement as part of their health equity strategic plans. [iv] This guide is intended to assist these and other states in their efforts to incorporate health equity into their operations.

The guide begins with a set of common abbreviations, words, and phrases used in health equity work. The list is not meant to be exhaustive, but should serve as a useful introductory glossary and reference tool. This section is followed by specific examples of health equity activities and sample request for proposals (RFP) requirements that are applicable to projects of many sizes and scopes, from local to state to federal. Finally, the document concludes with several examples of state and federal agencies that have incorporated health equity requirements in their strategic plans and RFPs.

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## Health Equity Terms

ASTHO conducted an informal survey with its employees to understand which terms are used most frequently to discuss health disparities, health equity, and minority health. This list is not all-encompassing, nor does it capture all the nuances of the terms, some of which may be more politically or culturally sensitive. Some items (e.g., adverse childhood experiences) have precise definitions, while others (e.g., LGBT, minority) are fluid. This list can be used when developing RFPs or shared with potential contractors or grantees to assist them in writing their proposals.

| Term | Definition | Additional Information |
|------|-----------|------------------------|
| Adverse Childhood Experiences (ACEs) | Adverse childhood experiences (ACEs) are traumatic events, such as abuse or neglect, occurring in a person's life before the age of 18. | ACEs have been linked to chronic health conditions, substance use disorders, social and behavioral problems, and early death. As the number of ACEs experienced by an individual increases, so does the risk for these outcomes. |
| National CLAS Standards | Culturally and Linguistically Appropriate Services (CLAS) are a set of 15 action steps "intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services."[5] | Bidder's Reference for Completing CLAS Section of the RFP (New Hampshire Department of Health and Human Services)<br><br>Making CLAS Happen: Six Areas for Action (Massachusetts Department of Public Health) |
| Community-Based Participatory Research (CBPR) | "Community-based participatory research is an approach for conducting research to improve community health. CBPR begins with a research topic of importance to the community and has the aim of combining knowledge with action and achieving social change to improve health outcomes and eliminate health disparities."[6] | Use when writing about meaningfully including communities as equal partners in public health research. |
| Culturally-Appropriate Care | A healthcare approach that understands the influence cultural values and beliefs (for the patient and provider) in health care delivery and provides care to address cultural needs. | Useful when describing health interventions, educational materials, etc. |
| Culturally Competent Care | "Cultural competence in health care is broadly defined as the ability of | Use when referring to patient care and other health services. |

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| | providers and organizations to understand and integrate factors such as race, ethnicity, language, gender, socioeconomic status, physical and mental ability, sexual orientation, and occupation into the delivery and structure of the health care system." | |
| Diversity | "The condition of having or being composed of differing elements, especially, the inclusion of different types of people (as people of different races or cultures) in a group or organization."[7] | Use when referencing the differences between cultures, races, or ethnicity. |
| Environmental Justice | "Environmental justice is the fair treatment and meaningful involvement of all people regardless of race, color, national origin, or income, with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies."[8] | Use when referring to programs or projects that deal with people and the natural or built environment. |
| Health Disparities | "A particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation; geographical location; or other characteristics historically linked to discrimination or exclusion."[9] | Use when there are significant differences in health status or outcomes between two or more groups of people. Eliminating health disparities can be seen as one goal of health equity. |
| Health Impact Assessment (HIA) | "A health impact assessment is a means of assessing the health impacts of policies, plans and projects in diverse economic sectors using quantitative, qualitative and participatory techniques. HIA helps decision-makers make choices about alternatives and improvements to prevent disease/injury and to actively promote health."[10] | Used as a tool for providing health-based recommendations to decisionmakers in a variety of sectors, including transportation, planning, housing, and energy. |

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| [Health in All Policies](#) (HiAP) | Health in All Policies is "a collaborative approach that integrates and articulates health considerations into policymaking across sectors, and all levels, to improve the health of all communities and people."[11] | Use when referring to an approach that looks at health in all sectors' policies (e.g., transportation, zoning, agriculture, education). |
| [Health Inequities/Health Inequalities](#) | Differences in health determinants and health outcomes that are the result of social and structural imbalances and are thus avoidable and preventable. | Use when emphasizing that the health status or health situation of a group of people is unjust, unfair, and preventable. |
| [Health Equity](#) | The absence of health inequities. Health equity is achieved when every person has the opportunity to attain their full health potential without disadvantage because of social position or other socially determined circumstances.[12] | Use when emphasizing why health disparities exist. Use when connecting disparities to the larger social and political context of people's lives. |
| High-Risk Populations | Population groups that have a higher risk of a certain health outcome than the general population. | Use when the health outcome is specified. While risk factors do cluster in some populations, no population should be labeled as "high risk" in a general sense without specifying the actual risk. |
| [Institutional Inequality](#) | The manifestation of inequality and discrimination within institutions or societies; describes the uneven distribution of resources along divisions of societal difference, such as race, ethnicity, and gender. | Compare to Structural Inequality (see below) |
| [LGBT](#) (Lesbian, Gay, Bisexual, Transgender) | An acronym meant to encompass non-heterosexual identities that often experience greater health threats due to social and structural inequities. | Use when referring to the populations specified or when discussing Lesbian, gay, bisexual and transgender (LGBT) citizens. |
| [Medically Underserved Areas/Populations](#) (MUA/MUP) | A designation indicating that the area or population experiences conditions that prevent access to healthcare. | The designation is calculated based on four criteria: "the population to provider ratio; the percent of the population below the federal poverty level; the percent of the population over age 65; |

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| | | and the infant mortality rate." States can request an exception for populations that do not meet the aforementioned criteria to receive a MUP designation if they can demonstrate lack of access. |
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| National Minority Health Month | During National Minority Health Month, led by the Office of Minority Health of the U. S. Department of Health and Human Services, health and health equity partners and stakeholders are encouraged to work across public and private sectors to collaborate on initiatives to reduce disparities, advance equity, and strengthen the health and well-being of all Americans. | This month is an opportunity for public health entities to raise awareness of health equity issues, engage their community and stakeholders around local and national campaigns, and promote the activities of state offices of minority health. |
| Person-First Language/ People-First Language | Phrasing that emphasizes the individual over their condition, e.g., "woman with diabetes," rather than "diabetic woman." | In general, public health entities should use person-first language whenever possible. However, not all individuals prefer person-first language; some communities, such as the deaf community, have formed around their shared identity, and some individuals within that community may prefer to emphasize that identity. Different communities and individuals have different standards and preferences. |
| Priority Populations | Population groups who are priorities for health interventions due to significant health disparities related to demographic or environmental factors. | Use when describing where efforts and resources should be concentrated for interventions or other programs. |
| Racial/Ethnic Minorities and Minority Populations | The U.S. Department of Health and Human Services defines racial and ethnic minorities as American Indian and Alaska Native, Asian, Black or African American, Hispanic or Latino, and Native Hawaiian and Other Pacific Islander.[13] | Use when referring to the populations specified or when discussing populations other than Anglo-European, White, or Caucasian populations in the United States. "Minority" in public health often refers exclusively to racial/ethnic minorities and not to other |

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| | | minority groups, e.g., disabled, LGBT, low-income, etc. |
| Social Determinants of Health (SDOH) | "The Social Determinants of Health (SDOH) are the conditions in which people are born, grow, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces, including the physical environment, economics, social policies, resources, and politics."[14] | Use when discussing social, economic, and environmental factors that affect a person's health and access to health care. |
| Social Gradient of Health | The social gradient of health describes the direct correlation between socioeconomic status and health; a patient of lower-socioeconomic status will have poorer health than an otherwise similar patient of higher socio-economic status. | Use when describing the socioeconomic impact on a person's health. |
| Socioeconomic Status (SES) | Socioeconomic status is a measure of the relative influence wielded by an individual, family, or group as a result of their income, education, and occupation. [15] | Socioeconomic status is linked to a wide range of health problems, including low birth weight, cardiovascular disease, hypertension, arthritis, diabetes, and cancer.[15] |
| Structural Inequality | The systematic, pervasive, cumulative and persistent systems of inequality and discrimination within institutions and societies. Structural inequality operates through social norms, policies, rules, and governance. | Compare to Institutional Inequality (see above) |
| Triple Aim of Health Equity | The Triple Aim of Health Equity is a three-part approach to advancing health equity that was first developed at the Minnesota Department of Health and is based on the Institute for Health Care Improvement Triple Aim. The three components are: (1) Implement Health in All Policies with Health Equity as the Goal; (2) Expand Our Understanding of What Creates Health; and (3) Strengthen the Capacity of Communities to Create Their Own Health Future. | State health agencies can click on each of the three components to get more information on related tools and guidance. |

| Underinsured Populations | "The underinsured have health insurance, but face significant cost sharing or limits on benefits that may affect its usefulness in accessing or paying for needed health services."[16] | The rate of underinsured populations varies by state. Underinsured populations face financial and health insecurity.[v] |
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| Under-Resourced Populations | Under-resourced populations do not have sufficient access to socioeconomic resources and government social services. | Similar to "underserved," but encompasses services and other resources. It does a better job of referring to the social determinants of health for this reason. |
| Vulnerable Populations | Populations who are at greater risk of experiencing poor health outcomes due to social and economic factors, such as place of residence, income, current health status, age, race/ethnicity, and distribution of wealth and resources. | Vulnerable populations are more susceptible during times of public health emergency and disaster. |

## Examples of Health Equity Activities

Health equity activities vary according to the program and purpose of each individual grant or RFP. State health agencies can ensure that their funding announcements encourage applicants to advance health equity. All state activities can be guided by the National Stakeholder Strategy for Achieving Health Equity, developed by the Office of Minority Health's National Partnership for Action. The five goals and corresponding strategies can provide a framework for thinking about health equity activities, identifying goals, and adopting the most effective strategies and action steps to help reach those goals.

Potential state health agency activities include:

**Collaborating with Diverse Communities**
- Collaborate with community- and faith-based organizations representing diverse communities, including tribal nations, to obtain the help of trusted leaders and to better understand and address the concerns of their members.
- Use mini-grants to build capacity in communities that may not have the infrastructure to apply for large funding streams.
- When smaller organizations or more diverse communities are not chosen to receive funding, conduct follow-up to discuss how they can strengthen their applications in the future.
- Partner with academic institutions to encourage them to provide training to community organizations on effective grant writing.
- Train healthcare providers in cultural, linguistic, and spiritual competencies (CLAS standards).
- Put additional practices in place that support smaller and more diverse organizations in the competitive funding process.

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**Improving Practices Within the Grant-Making Process**
- Encourage grant review boards to be diverse and truly representative of the state's priority populations.
- Incorporate national CLAS standards into funding mechanisms or policies that govern direct service agencies, and communications and language assistance services.
- Ensure that appropriate language is included to address culturally diverse communities and groups.
- Encourage community-based organizations and community-based agencies to apply for grant funding opportunities.
- Encourage larger organizations to partner with community-based organizations to help build community capacity to apply for future funding.

**Expanding Inter- and Intra-Agency Operations to Promote Health Equity**
- Work with state offices of minority health to conduct outreach to diverse communities to encourage them to apply for funding.
- Train staff in communication to improve work with minority groups and diverse communities.
- Assure that data collection for evaluation and outcomes measurement identifies and accurately captures representation of diverse population groups and emerging subpopulations.
- Adopt a Health in All Policies approach to public health policy, ensuring that other sectors, such as transportation, agriculture, and labor, address the health impacts of their work. Health impact assessments might assist in this endeavor.
- Implement health equity-informed, system- and community-driven approaches for eliminating public health disparities such as tobacco use, substance misuse, chronic conditions and low birth weight.

## Possible Requirements to Include in RFPs
There are a variety of requirements states could choose to implement in order to ensure proposals focus on reducing health disparities. These requirements could be implemented at different points in the RFP process and might be focused on the populations served, the language required in the proposal, or the way proposals are scored.

Some examples of health equity information and activities that state health agencies or other funding entities could require in RFP responses include:
- Encouraging grantees to implement the goals of the [National Stakeholder Strategy for Achieving Health Equity](#) and ensure activities are aligned with the five strategies in the plan: awareness, leadership, health system and life experience, cultural and linguistic competency, and data, research, and evaluation.
- Justifying the extent to which specific health disparities are priority areas within the health focus of the funding program and how addressing these will advance health equity.
- Proposing evidence-based solutions to the health disparities identified in the RFP.
- Demonstrating how proposed activities address specific health inequities.
- Identifying relevant social and environmental factors that impact the social determinants of health and proposing evidence-based solutions.
- Including culturally diverse communities, tribal populations, and other groups into emergency preparedness and response activities, including incorporating community engagement into

planning and ensuring that response efforts are culturally appropriate for communities served, including language assistance during emergency response.

- Assessing the effects of a disease or natural disaster in diverse populations.
- Developing RFP scoring processes that encourage greater specificity on how the proposal addresses health inequalities within stated objectives, activities, and evaluation strategies.
- Integrate health equity facts and concepts into factsheets, toolkits, issue briefs, webinars, and meetings.

## State Examples of Health Equity RFPs

The following examples illustrate how state agencies have integrated health equity language into their funding announcements. These should not be taken as endorsements of particular funding announcement language, but examples of the ways in which state agencies are already implementing health equity concepts.

## California

California's 2015 Portrait of Promise: Statewide Plan to Promote Health and Mental Health Equity is a document specifically meant to direct health equity efforts; several items address the importance of integrating health equity in funding opportunities.[17] California's plan includes the following guidance:

- Use a Health in All Policies approach to embed health and mental health equity criteria in decision-making, grant programs, guidance documents, and strategic plans.
- Recommend that health and mental health equity goals be considered during the allocation of existing funding streams.

## Hawaii

The Hawaii Department of Health's Office of Health Equity provides sample contract language for funding applicants to include in RFPs. The language suggests that the applicant collect demographic data, including on race, ethnicity, disability, sex, and geographic area. It also suggests that applicants use this data to submit an annual report on a quality improvement activity determined by the applicant. The sample language also includes definitions of health equity, health disparities, and the social determinants of health.

## Michigan

Michigan's Department of Community Health released a 2016 Minority Health Month RFP that was explicitly focused on minority health improvement projects.[18] The scope of work noted that, among other requirements, funded activities or entities should:

- Raise awareness about the challenges, opportunities, and achievements for Michigan to assure racial and ethnic minority health equity.
- Facilitate and document community conversations related to health disparities, social determinants of health, and racial and ethnic health in Michigan.

## Minnesota

Minnesota's 2014 Advancing Health Equity in Minnesota Report to the Legislature includes a number of recommendations related to the ways in which the Minnesota Department of Health (MDH) allocates its grants.[19] The recommendations suggest a shift toward engaging stakeholders and supporting them in

strengthening their own communities. Recommendations and suggested actions in Minnesota's plan include:

- Change grantmaking procedures and practices to support a wider range of organizational capacity among MDH grantees.
  - o Identify the kinds of technical assistance MDH staff and grantees need to strengthen the health equity focus of grants.
  - o Identify and improve sharing of best practices; seek additional input from existing and past grantees and test new approaches to grantee monitoring and reporting.
- Consider blending grants across program sectors within MDH and other agencies and organizations in response to the growing understanding of the complex and interrelated factors that affect health. Improve training and evaluation methods to advance health equity.
- Engage a diverse range of stakeholders in the grant development process.

**Ohio**

The Ohio Department of Health (ODH) has implemented a health equity requirement for its funding announcements. The ODH Office of Financial Affairs requires programmatic staff to meet with the Office of Health Equity for technical assistance to work collaboratively to outline how the funding opportunity addresses or plans to address health disparities and/or health inequities.[20] ODH's 2014 Grants Administration Policies and Procedures Manual provides the following instructions for prospective applicants:

- Explain the extent to which health disparities are manifested within the health status of individuals (i.e., morbidity and/or mortality) or health systems (e.g., accessibility, availability, affordability, appropriateness of health services) within the affected community.
- Identify specific group(s) experiencing a disproportionate burden of the disease or health condition addressed by this application.
- Identify specific social and environmental conditions, which lead to health disparities (i.e., social determinants) in the affected community.

ODH developed a Health Equity Module in their Grants Management Information System that links health equity initiatives in grant proposals to national health equity strategies, such as those found in *Healthy People 2020* or the *National Stakeholder Strategy for Achieving Health Equity*. Applicants are required to select goals and strategies from the module that best reflect how their particular grant proposal addresses health disparities and/or health inequities.

### Federal Examples of Health Equity RFPs

As part of the [2011 HHS Action Plan to Reduce Racial and Ethnic Disparities](#), HHS agencies, including the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Agency for Healthcare Research and Quality (AHRQ), were asked to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities; program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications." [21]

The following are examples of federal agencies that have integrated health equity language into their funding announcements or proposed legislative changes.

### Substance Abuse and Mental Health Services Administration

SAMHSA requires a [disparity impact statement](#) (DIS) for all new grant awards. [22]
These statements must include:

- The proposed number of individuals to be reached by subpopulation in the service area.
  - Example subpopulation categories include race/ethnicity, gender, and sexual orientation/identity status.
- A plan for how grantees will use data to monitor disparities and implement strategies to improve access, service use, and outcomes.
- A quality improvement plan that includes implementation of the enhanced CLAS standards.

### Agency for Healthcare Research and Quality

AHRQ lists one of its missions as "produc[ing] evidence to make health care…more accessible, equitable, and affordable."[23] A list of updated review criteria for grantmaking is featured, which include criteria for "inclusion of minorities and members of both genders" and "inclusion of priority populations." These "priority populations," listed in a separate document, include women, children, racial and ethnic minorities, populations with special healthcare needs (chronic illness, disabilities, and end of life care needs), the elderly, low-income, inner-city, and rural populations.[24] Within those priority populations, the AHRQ further focused on "research areas of interest," including:

- Explaining disparities in healthcare and clinical practice.
- Implementation of research and interventions that aim to reduce disparities in priority populations and settings.
- Addressing known gaps in research dealing with priority populations.
- Development of methods to address the heterogeneity of priority populations, small sample sizes and to improve outcomes for priority populations in AHRQ sponsored research.
- Research on cross cutting issues involving multiple priority population groups and settings (e.g., disabled children, minority women, rural maternal and child health, etc.).
- Development of innovative service delivery models for settings in which priority populations receive care.[25]

### National Institutes of Health

To address the inclusion of often overlooked populations in NIH-funded research, the NIH Policy and Guidelines on the Inclusion of Woman and Minorities as Subjects in Clinical Research requires that all NIH-funded clinical research includes individuals of both sexes/genders and diverse racial and ethnic groups in their research and trials.[26] To ensure compliance and inclusion, the guidelines further require

that such inclusion be planned at the research design phase and be explicitly addressed in the contract proposal, with a description of how the research team plans to recruit women and minorities.[27]

## Conclusion

This document is intended as a resource to assist state public health agencies in drafting funding announcements involving health equity and related concepts. A number of state and federal agencies have found ways to incorporate health equity into their funding opportunities. When potential grantees are asked to demonstrate the ways in which their proposals will address health disparities, it will result in multiple benefits such as addressing the needs of populations that the grantee's organization serves, improved health outcomes, as well as a starting point to achieving health equity in the United States. The HHS Office of Minority Health and ASTHO encourage federal, state, and local agencies to explore efforts to advance the health equity by integrating these considerations in funding opportunities.

## Additional Resources

| Title | Author(s) |
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| Checklist: Strategies for Successfully Incorporating Health Equity Language and Concepts into RFAs Across Any Health Agency Program | Directors of Health Promotion and Education |
| Contracting for Equity | Government Alliance on Race and Equity |
| The State Health Department Organizational Self-Assessment for Achieving Health Equity | National Association of Chronic Disease Directors |
| Race Reporting Guide | Race Forward |
| Washington State Business Diversity Initiative Proposed Roadmap | Washington State Business Diversity Subcabinet |

This brief was produced by the Association of State and Territorial Health Officials. Inquiries regarding this guide and corresponding template, including assistance with implementation, can be directed to Melissa Lewis, director of health equity and social determinants of health at mlewis@astho.org.

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