hpio health policy institute of ohio

Moving toward equity

An evaluation toolkit

Overview

Since 2020, 32 local governments and health departments in Ohio have declared racism a public health crisis, acknowledging the severe impact that racism has on the health of our communities. Research has also drawn connections between other forms of discrimination (such as ableism, ageism, classism, homophobia and transphobia) and health. Although there is a growing understanding that not all Ohioans have an equal opportunity to live a long and healthy life, there is much still to be done to ensure Ohioans of color, LGBTQ+ Ohioans, Ohioans with disabilities, Ohioans with low incomes, Ohioans living in urban, rural and Appalachian areas, and others can thrive in our state.

An important part of this work is to evaluate and measure if our efforts to achieve equity are successful. Evaluation tells us if what we're doing is making a difference. It gives us the information needed to understand where we need to change, refocus or intensify our approaches. Perhaps more importantly, evaluation is also a process that can build trust, collaboration and accountability.

This Toolkit is designed to provide you and your partners with information about how to use evaluation to move towards equity. It includes guidance, tools and resources on:

How to use this Toolkit

Each section of this Toolkit covers a different element of evaluation including information on how to tie evaluation into every step of assessment, planning, implementation and continuous quality improvement processes. It includes many links and is designed for you to view it online. The symbols in figure 1 are used throughout the Toolkit to indicate types of content.

Figure 1. **Toolkit symbols**

Tools

Additional resources

Tools are located in a separate workbook that is meant to be interactive and fillable, and can be accessed on the **publication page**.

Key terms (defined on page 27) are **bolded** the first time they appear.

Why is evaluation important?

Evaluation allows you to move beyond doing things that may lead to improvement to measuring if improvement is happening. It is not a one-time project or an item to check off a list, but an ongoing process of discovery about what is working and what could be improved.

Evaluation assesses how a policy or program was implemented and whether it was effective in achieving **desired outcomes**. It can be done on a smaller scale for a specific program or service, or on a bigger scale to measure results for a community, state or system.

Evaluation is critical to advance equity because it provides:
- A way to be accountable to partners and community members
- A method for tracking if policies, programs and services are working to advance equity
- Data on how your efforts can be improved to be more effective

Conducting an evaluation and sharing and using the results shows that you are invested in making an impact and are holding your organization and partners accountable for achieving measurable results.

This Toolkit was created to provide guidance on advancing equity through evaluation by answering the following questions:
- Where do I start? (see **section 1**)
- How can I approach evaluation in an equitable way? (see **section 2**)
- What are the basics of evaluation? (see **section 3**)
- How can I use evaluation results to improve outcomes? (see **section 4**)
- How can I collect the data that I need for evaluation in an equitable and culturally responsive way? (see **section 5**)

What is equity?

Equity exists when every Ohioan has the opportunity to reach their full potential. Achieving equity requires addressing historical and contemporary injustices and removing obstacles to health and well-being, such as poverty and discrimination. It is often discussed in terms of **disparities** and **inequities**.

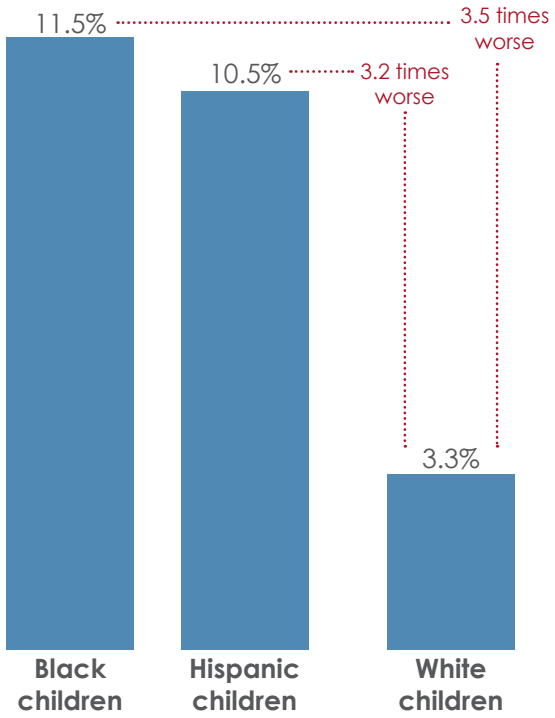
Disparities are avoidable differences in outcomes (such as infant mortality and life expectancy) that exist across population groups or communities.

Inequities are underlying drivers of disparities, including differences in the distribution of or access to social, economic, environmental and healthcare resources. Examples of such resources include health insurance, healthy foods, safe and stable housing and quality education.

Disparities and inequities are rooted in the cumulative impact of unjust and discriminatory systems, polices and beliefs. Racism, ableism, homophobia and other forms of discrimination are primary drivers of disparities and inequities.

The ***2024 Health Value Dashboard*** shows that some groups of Ohioans experience more obstacles to health than others, such as Ohioans of color, Ohioans with disabilities, LGBTQ+ Ohioans and Ohioans with lower incomes and/or less education.[1] For example, Black and Hispanic Ohio children are much more likely to experience food insecurity than their white peers (displayed in figure 2).

Figure 2. **Food insecurity among Ohio children, by race, 2018-2021**



Source: Analysis of the National Survey of Children's Health by HPIO and The Voinovich School of Leadership & Public Affairs at Ohio University

People can belong to more than one group, which can increase the cumulative impact of discrimination. For example, Ohioans who are both disabled and members of the LGBTQ+ community may experience greater disparities and inequities than members of just one group.

Equity is both an outcome to work towards and a process to get there. This Toolkit provides tools to move towards equity through evaluation (see section 3), as well as guidance to ensure that evaluation processes are equitably designed (see section 2).

Who is this Toolkit for?

This Toolkit is for anyone who is dedicated to advancing equity, passionate about achieving results, and committed to stewarding resources. This may include:

- Community coalitions
- Healthcare providers
- School-based health centers
- Health plans and Medicaid managed care organizations
- Human services nonprofits
- Local government
- Public health organizations
- Philanthropy
- Schools
- State agencies and commissions
- Other local agencies and nonprofit organizations

Section 1

Setting the stage for evaluation through assessment and planning

The best time for evaluation is…always! Rather than launching an evaluation at the end of a program or **strategy** implementation, it's best to think about evaluation during every step of the process, starting with community assessment and planning. This section includes an overview of:

- Evaluation questions to ask during community assessment and planning
- How to identify **priority populations**
- Resources for more in-depth information

Evaluation questions to ask during community assessment

Community assessment, when you collect data about your community's strengths and challenges, is a great time to start thinking about evaluation. Evaluation is more likely to be effective if it is informed by high-quality data, which can be gathered through an assessment process (**section 5** contains more information on data sources). This provides a baseline so you can measure progress over time. Assessment also provides a way to identify the root causes of disparities and inequities so that you can go further upstream and address them.

Assessments, planning and evaluation are more effective when done with partners and community members who are at an increased risk of negative outcomes. Guidance for developing an evaluation team is on pages 11 and 12 of section 2 and can also be used to develop assessment and planning teams.

Evaluation questions for you and your partners to ask yourselves during assessment include:

- What baseline data from our assessment can we use to evaluate outcomes in the future?
- Do we have disaggregated baseline data so that we can evaluate progress toward eliminating disparities and inequities?
- What are the root causes of disparities and inequities that we need to evaluate over time?
- What community partners can we collaborate with to inform our assessment and uplift lived experience?

Evaluation questions to ask when planning your priorities, objectives and strategies

Planning processes also set the stage for evaluation by designing strategies to improve outcomes and advance equity. Planning allows you to identify your priorities and objectives and define your approach to achieve them. This can ensure that you know what you are working towards, what populations you need to prioritize and what programs, policies and services are likely to achieve your goals.

Evaluation questions for you and your partners to ask yourselves during planning include:

- Will we be able to collect or compile data on a regular basis to measure progress on our objectives?
- What do previous evaluation results tell us about the potential effectiveness of a specific program or policy in our local community?
- Have we identified priority populations, and how can we engage them in our evaluation planning? (Guidance on selecting priority populations is below)

Identifying priority populations

Incorporating evaluation into the early stages of assessment and planning can ensure that you target and tailor your approach to the populations that need it the most. One way to think about this is by identifying priority populations.

Priority populations are groups that experience worse outcomes than others and often experience underlying inequities. They are generally systematically disadvantaged, meaning they are more likely to:

- Experience racism and other forms of discrimination, such as colorism, ageism, ableism, homophobia and xenophobia
- Be devalued and dis-empowered
- Have increased risk of exposure to trauma, toxic stress, violence and stigma
- Face policy and system inequities
- Live in unsafe and uninhabitable environments that do not support healthy living
- Lack access to culturally competent or linguistically appropriate services and information

Example priority populations are included in figure 3.

Figure 3. **Examples of priority populations**

Race/ethnicity
- Asian Ohioans
- Black Ohioans
- Hispanic Ohioans
- Native American Ohioans
- Native Hawaiian and Pacific Islander (NHPI) Ohioans
- Ohioans of multiple races

Age
- Infants, toddlers and young children
- School-age children and young adults
- Older adults

Education Level
- People with less than a high school diploma
- People with no post-secondary training

Socioeconomic status
- People with no health insurance
- People with low incomes
- People who are unemployed

Geography
- People in **Ohio health improvement zones**
- Residents in zip codes with higher risk of poor health outcomes
- Residents of Appalachian counties
- Residents of rural, non-Appalachian counties
- Residents of urban counties

Disability status
- Adults with a disability
- Children with a disability
- Children with special healthcare needs
- Students with a disability

Language
- English language learners
- People who speak English as a second language
- People who don't speak English

Sex, sexual orientation and gender identity
- Lesbian, gay, bisexual, transgender or queer[2] youth and adults
- Women, transgender men and others who are pregnant

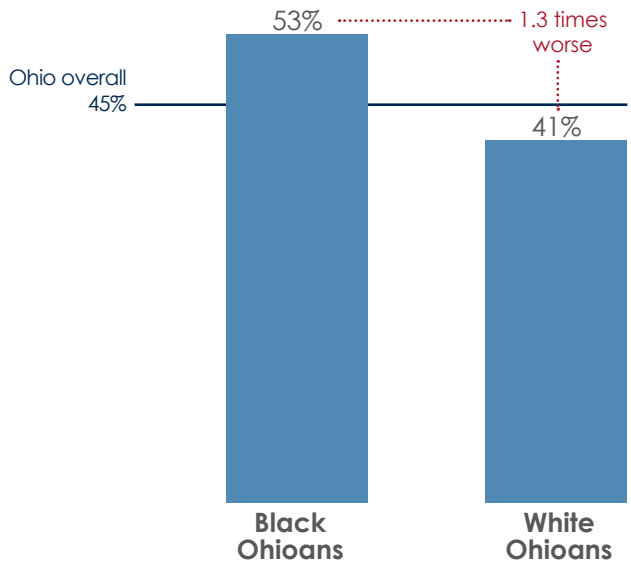
Others
- Children in foster care
- Immigration status (e.g., refugee, immigrant)
- Veterans
- Single-parent households

One way to determine priority populations is to use quantitative **disaggregated data** to identify groups that have a specified percent worse outcome than the community overall (see section 5 of this Toolkit for sources of disaggregated data). For example, in the **2020-2022 State Health Improvement Plan (SHIP)**, outcomes for priority populations were at least 10% worse than for Ohio overall. Qualitative data, collected through key informant interviews, focus groups or surveys, can also be used to identify priority populations, especially when disaggregated quantitative data is unavailable or insufficient.

Disparity ratios

Another way to identify priority populations is by using disparity ratios, which demonstrate inequities across groups. A disparity ratio is calculated by dividing the rate of a group experiencing an inequity by the rate of another group, often the group experiencing the best outcomes. For example, 53% of Black renters in Ohio experienced housing cost burden (spending over 30% of their income on housing cost) compared to 41% of white renters in Ohio. This yields a disparity ratio of 1.3 (.53/.41). This means that housing cost burden is 1.3 times worse among Black renters in Ohio compared to white renters (displayed in figure 4).

Figure 4. **Housing cost burden, by race, Ohio, 2020**



Source: Analysis of American Community Survey data by HPIO and The Voinovich School of Leadership & Public Affairs at Ohio University

Additional resources

- **Step 1: Assess Needs and Resources**, County Health Rankings and Roadmaps
- **Community Health Assessment Handbook**, Kansas Health Institute
- **Step 2: Focus on What's Important**, County Health Rankings and Roadmaps
- **Community Health Improvement Planning Handbook**, Kansas Health Institute
- **American Hospital Association Community Health Improvement (ACHI), Community Health Assessment Toolkit**, ACHI

Section 2

Equitable approaches to evaluation

To conduct an effective evaluation, it is important to tailor your evaluation plan and goals to your community and the specific program or policy you are evaluating. The process you use for planning and executing your evaluation is as important as the evaluation results themselves. When done thoughtfully, evaluation can build trust, collaboration and accountability among partners and the community.

This section focuses on the process for conducting **equitable evaluation**, including:

- Types of evaluation
- Considerations for conducting an equitable evaluation
- How to identify and engage an evaluation team
- A tool to ensure equity is incorporated in each step of an evaluation
- Resources for more in-depth information

Types of evaluation

There are many types of evaluation. The type that you choose will vary depending on available resources, other evaluation efforts in the community and which evaluation questions are most important to answer to inform next steps. It is important to think about what type of evaluation you will need and to build it out as you design your program or service.

There are two key concepts that are particularly useful when considering the type of evaluation you want to utilize for your program, service or policy:

- Process vs. outcome evaluation
- Performance accountability vs. population accountability

Process vs. outcome evaluation. Process evaluations focus on how a strategy was implemented, asking questions that answer why a strategy may or may not have achieved a desired outcome and how it can be improved. Outcome evaluations answer if the strategy achieved the desired result. Figure 5 highlights some questions a process evaluation may answer versus an outcome evaluation.

Figure 5. **Examples of process and outcome evaluation questions**

Process evaluation *How a strategy was implemented*	**Outcome evaluation** *The result or effects of a strategy*
• How many people did we reach? • With how many policymakers did we meet? • How many focus groups or community meetings were held to get public feedback on the strategy? • To what extent were resources allocated to priority populations? • Was the strategy implemented as intended? Were evidence-based models implemented with fidelity? • Were participants satisfied with the activity, and what suggestions did they have for improving it? • What barriers were faced during implementation? • What were the strengths of the implementation strategy? • How were different groups, including priority populations, engaged in the implementation process? • Was the policy or system changed as intended?	• Did we achieve our short-term and/or long-term objectives? • Did we make progress toward our **SMART objectives** (more guidance on SMART objectives is in **section 3**)? • Did we decrease disparities or inequities? • Did the program or service result in specific improvements to participant knowledge, attitudes, behavior or condition? • Was the policy or system change enacted as desired?

Performance accountability vs. population accountability

Performance accountability holds organizations responsible for specific outcomes of populations served. Population accountability assesses outcomes of an entire geographic population, such as all older adults in a community, who are served by multiple organizations and affected by other, uncontrollable factors.[3] A strong evaluation will incorporate measures of performance and population accountability, ideally aligning efforts across the community to improve overall health and well-being. Figure 6 provides example objectives demonstrating performance accountability and population accountability.

Figure 6. **Performance accountability and population accountability examples**

Performance accountability	Population accountability
SMART objective: Increase access to rental assistance programs by providing services to 600 people in Buckeye County in 2023 **Accountable organization:** Buckeye County Housing Authority, in partnership with the Buckeye County Shelter Board	**SMART objective:** Reduce housing cost burden* in Buckeye County from 45% in 2020 to 38% in 2029 **Accountable entities:** All county and local agencies, in partnership with state policymakers and other public and private organizations

*Housing cost burden is when an individual spends more than 30% of their income on housing.

Other approaches to evaluation

Evaluation is useful for a variety of purposes. Not only can it be used to assess the impact of a program or policy change, it can also be used to inform related efforts, including an advocacy agenda.[4] Evaluations can also be adapted to fit into quick-changing or unpredictable situations, such as a newly developing program or the policy environment.[5]

Considerations for conducting equitable evaluation

Equitable evaluation is an approach to conducting evaluation that addresses dynamics and practices that have historically undervalued the voices, knowledge, experiences, expertise and background of people of color and other marginalized groups.[6]

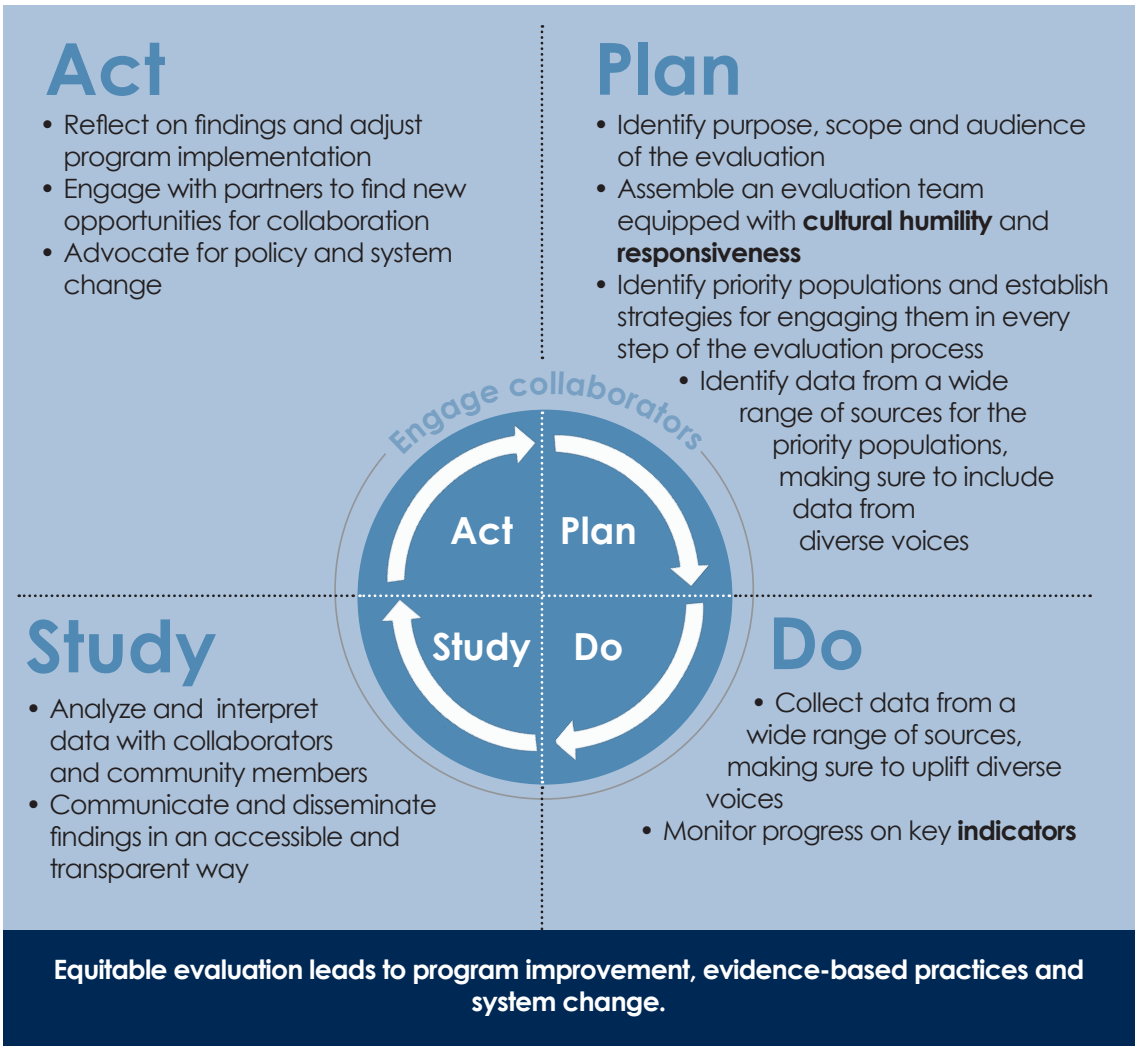
Equitable evaluation answers the following questions[7]:

- How have historical and structural policies and practices affected community conditions?
- How effective is our program/service for different populations?
- How effective is our program/service in addressing underlying inequities?
- How does cultural context (shared values, attitudes and beliefs) inform structural conditions and strategy implementation?

Effective equitable evaluation requires that you and your team consider how every decision you make, from the big ones to the everyday, will affect your community and help or hinder equitable outcomes. Building this type of evaluation requires your team to engage in **reflexivity**, sit in discomfort, ask difficult questions, understand what choices are on the table and ultimately make the best choice given all the factors. It is a process of continual growth and development.

Process and outcome evaluations rooted in equity enable evaluators to understand the nuances, disparities and inequities that could be overlooked if the focus of the evaluation was on general results. Figure 7 highlights key equitable evaluation considerations for each stage of the evaluation.

Figure 7. **Steps to conducting and implementing equitable evaluation**



Source: The Plan-Do-Study-Act model was modified with information from **Equitable Evaluation Initiative**, **Mathematica** and **RTI International**

What does equitable evaluation look like?

Equitable evaluation is designed and implemented to be[8]:

1) Representative of multiple perspectives and groups across the dimensions of diversity (age, sexual orientation and gender identity, race and ethnicity, disability status, etc.).

One way to increase representation is to collect primary data by methods such as surveys, interviews and focus groups. This can:

- Increase community participation and encourage shared learning
- Fill in gaps in existing data so that all groups are represented
- Provide additional context on how to tailor programs and services to meet the needs of priority populations

Section 5 of this Toolkit (page 25) includes resources related to primary data collection.

2) Oriented towards the needs of program/service participants. To conduct an equitable evaluation, it is important to proactively represent the needs of participants and priority populations, as well as develop strategies to address potential limitations. To this end, you can ask critical questions to challenge **implicit and explicit biases** and clarify places where there is a need to be more inclusive and culturally responsive.

One way to meet participant needs is to form a steering committee that includes representation from participants and priority populations to advise the evaluation process. For example, the steering committee could be integral in discovering new data sources, elevating new perspectives and transparently sharing evaluation findings.

During this process, it is important to reflect on power dynamics and consider ways to share power among partners and program participants. It is also important to think through potential barriers to participation (such as transportation) and brainstorm strategies to address them (such as remuneration/paying them for their time).

Tool

The **equitable evaluation checklist** is designed to incorporate an equity lens into each phase of the evaluation process. Each stage on the checklist serves as a reminder to pause, reflect and discuss your practices and values. The checklist can serve as a living document that is continually refined to reflect changes for your team or the organization.

Designing an evaluation team

There is no one size-fits-all approach to building an evaluation team. It can include a combination of people with different expertise such as internal program staff, community members, program participants, external evaluators or consultants and other collaborators. As you're assembling your team, consider factors such as expertise, budget, timeline, resources and any grant requirements.

It is important to ensure that the evaluation team includes people from priority populations and other collaborators who can co-design the evaluation plan and be engaged throughout the evaluation process. Engaging people from priority populations throughout the evaluation process can address gaps in data and provide community context. You and your evaluation team should also be reflecting on your assumptions, beliefs, values and prejudices/biases throughout the assessment, planning and evaluation processes.

Attributes of a good evaluator

- Has experience in the type of evaluation being conducted
- Understands the context of the community
- Has a history of collaboration with diverse partners
- Explicitly acknowledges their own assumptions, beliefs, values and prejudices/biases
- Has a willingness to learn from others
- Examines how the relationship between themselves, the organization they're representing and the community(ies) they serve may impact the evaluation process

To ensure effectiveness of your evaluation team, you can work to create consensus on:

- Clearly defined team member roles and responsibilities
- The purpose of the evaluation, potential audiences and dissemination strategies
- The resources and tools available to team members
- Policies and procedures for protection of human subjects, if applicable
- The power of a diverse team and the attributes that each team member brings to the table

External vs. internal evaluators

As you're assembling your evaluation team, you may decide to select a lead evaluator from inside or outside of your organization. Figure 8 provides some potential advantages and disadvantages for each type of evaluator.

Figure 8. **Considerations for external vs. internal evaluators**

Type of evaluator	Potential advantages	Potential disadvantages
External evaluator	• More objective/credible • May have more specialized technical expertise • Could bring more efficiency to the process	• Added expense • Lack of understanding of program components and priority populations
Internal evaluator	• Closer proximity to priority populations • Increases engagement and participation of program staff • Builds organizational capacity for ongoing or future evaluation	• May have less specialized technical expertise • Perceived as less objective than external evaluator

Source: Modified from the **U.S. Administration for Children & Families, Office of Planning, Research and Evaluation**

Additional resources

- **Addressing Health Equity Through Action on the Social Determinants of Health: A Global Review of Policy Outcome Evaluation Methods**, International Journal of Health Policy and Management
- **CDC Evaluation Resources**, Centers for Disease Control and Prevention
- **Doing evaluation in service of racial equity**, Every Child Thrives
- **Engage an Evaluation Team**, U.S. Administration for Children & Families, Office of Planning, Research and Evaluation
- **Equitable Evaluation Framework**, Equitable Evaluation Initiative
- **Evaluation is So White: Systemic Wrongs Reinforced by Common Practices and How to Start Righting Them**, Funder & Evaluator Affinity Network
- **Six Tips to Conduct Equitable Evaluation**, RTI International
- **Tips for Conducting Equitable and Culturally Responsive Research**, Mathematica
- **What choice do I have?**, We All Count
- **Using a Culturally Responsive and Equity Evaluation Approach to Guide Research and Evaluation**, Mathematica

Section 3

Developing an equitable evaluation plan

Evaluation ideally starts when you are designing your program, but can provide value at any point in program implementation. It should also incorporate equity into every component of the process, with community members, especially those experiencing the worst outcomes, engaged and sharing in decision-making. This will ensure that activities close gaps in outcomes for different groups of Ohioans, while also improving the overall health and well-being of the state.

You can use this section to build out an equitable evaluation plan. It includes guidance on incorporating equity into each step and is set up to work for evaluating both new and existing programs. It contains:

- Step-by-step guidance on developing each component of an evaluation plan and building equity into the components
- An overview of SMART objectives and **universal targets**
- Tools to create a logic model that can guide evaluation and for developing universal targets
- Resources for more in-depth information

Integrating equity into evaluation plans

Evaluation planning can focus your efforts and define what specific goals you aim to achieve with your program or service. One way to think about evaluation planning is to create a logic model. Developing a logic model for your evaluation demonstrates the connection between a service or program and the intended result of that intervention. Basic logic models include the following components:[9]

- **Outputs:** Tangible and countable products (i.e., policies, programs/services, practices), usually measured in terms of the amount of work completed, such as the number of classes taught, the number of materials distributed or the number of participants who completed a program.
- **Desired outcomes:** General statements about intended results, such as changes in knowledge, awareness, attitudes, beliefs, skills, behaviors or conditions.

More comprehensive models also include **inputs**, needed programmatic resources (e.g., staff, volunteers and funding) and strategies (the program or service you are going to do), and break down outcomes into short-term, intermediate and long-term. Figure 9 contains an example logic model that will be "filled in" throughout this section.

Tool

The **logic model template** is designed to help you develop a logic model for your program. It includes all the components of the example logic model in figure 9.

Figure 9. **Example logic model**

Logic model component	Inputs	Strategies	Outputs	Outcome(s) of activities	Overall goal(s)
Definition	Resources needed to support the strategy	Program or service being provided	Tangible, countable products of your work	General statement about desired results	General statement about desired results
Example	Trained providers	Health education class	Number of classes held	• Increased awareness • Increased use of skills	Improved health (universal target)

Step One: Identify outcomes

When building a logic model, desired outcomes (i.e., goals you want to achieve) should be identified first (highlighted in figure 10). This provides a focus for your efforts, but also allows you to identify what actions and resources are needed to achieve those goals.

There are several ways to select outcomes for your program and evaluation, such as aligning with:

- Findings from community assessments conducted by your organization or others
- Priorities identified by community members, such as unmet needs
- Outcomes in existing state and local plans that align with input gathered from community members (examples of plans are listed in figure 11)

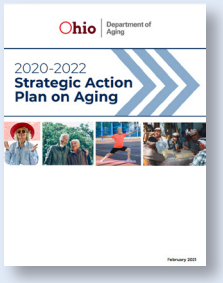
For existing programs, state and local plans may elevate your program, or programs like it, as impactful for certain outcomes. You may also be implementing a program that has identified outcomes as a part of its structure. For example, **Matter of Balance** was created to prevent falls among older adults and is elevated in Ohio's **2020-2022 Strategic Action Plan on Aging** as a falls prevention strategy.

All outcomes should be broken out by all available groups to identify disparities. You can then use this data to tailor the program or service to individual communities, close gaps in outcomes and improve overall health. More information on drafting outcomes, including setting SMART objectives and universal targets, can be found on page 17 of this section.

Figure 10. **Example logic model: Outcomes**

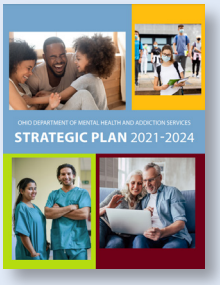
Logic model component	Inputs	Strategies	Outputs	Outcome(s) of activities	Overall goal(s)
Definition	Resources needed to support the strategy	Program or service being provided	Tangible, countable products of your work	General statement about desired results	General statement about desired results
Example	Trained providers	Health education class	Number of classes held	• Increased awareness • Increased use of skills	Improved health (universal target)

Figure 11. **Example state and local plans with which to align or review**



2020-2022 Strategic Action Plan on Aging
Ohio Department of Aging

2020-2022 State Health Improvement Plan
Ohio Department of Health



Ohio Department of Mental Health and Addiction Services Strategic Plan 2021-2024

Ohio Department of Mental Health & Addiction Services

Alcohol, Drug Addiction and Mental Health Board Community Plans

Local health department community health improvement plans

Step Two: Identify outputs and strategies

Once your desired outcomes and priority populations (guidance on priority populations is on page 6) have been identified, outputs and strategies can be identified (highlighted in figure 12). Strategies that have strong evidence of effectiveness for reducing disparities or inequities and those that have support in the communities most at risk of experiencing worse outcomes should be prioritized for inclusion in your logic model.

Strategies are the program(s), policy(ies) or service(s) you are implementing or planning to implement. The outputs are the things you are doing to implement the program, such as:

- Holding program classes
- Disseminating promotional materials
- Providing healthy meals

If you are already implementing a strategy, you already have what you need for these two components of the logic model. If you are still selecting which strategy(ies) to implement, there are several places you can look to for evidence-informed examples. The state and local plans listed in figure 11 above have identified evidence-informed strategies related to the outcomes elevated in the plan.

Other sources, such as **What Works for Health** from County Health Rankings and Roadmaps, provide information on evidence-informed strategies, including an evidence rating (the strength of the research evidence), expected and potential benefits of a strategy and information on how likely the strategy is to reduce disparities. When selecting a strategy, consider if your priority populations were included in the research behind the evidence-based strategy. Prioritize strategies that have evidence of effectiveness with your priority populations.

Figure 12. **Example logic model: Outputs and strategies**

Logic model component	Inputs	Strategies	Outputs	Outcome(s) of activities	Overall goal(s)
Definition	Resources needed to support the strategy	Program or service being provided	Tangible, countable products of your work	General statement about desired results	General statement about desired results
Example	Trained providers	Health education class	Number of classes held	• Increased awareness • Increased use of skills	Improved health (universal target)

Tailoring strategies to community

Strategies should be tailored to meet the needs of a specific community or priority population and improve outcomes. When deciding which strategy(ies) to implement, keep in mind the following:

- **Cultural and linguistic appropriateness.** What strategies need to be implemented to address barriers to optimal health and well-being in the community? What about the strategies need to be adapted to fit the culture of the community being served? Do any materials need to be translated into another language, and is a service available to complete that translation?
- **Time and location.** For strategies that require meeting with participants, is there a time of day and location that works best? For example, strategies that work with students may be best implemented during or around school hours.
- **Trusted messenger and implementor.** Who in the community has the community's trust to share information about the program? Are there members of the community that can be hired and trained to implement and/or design the strategy?

Step 3: Identify inputs

After identifying your outcomes, outputs and activities, the inputs needed for implementation can be identified (staffing, funding, etc.). Figure 13 highlights inputs in the logic model.

If you are already implementing a program or service, you can think about the things you have needed for the program to operate, including:

- **Personnel:** What staff are needed and with what type of experience (consider both technical and lived experience)? Are there any sort of advisory committees guiding implementation of the program? If so, who needs to be involved in these groups or committees?
- **Funding:** What types of funding have been used to operate the program, such as state funding, philanthropic dollars and/or federal grants?
- **Location and materials:** What location is used to operate the program, such as a community center or classroom? What materials are needed to operate the program, such as workbooks, classes/ training sessions, promotional materials?

Figure 13. **Example logic model: Inputs**

Logic model component	Inputs	Strategies	Outputs	Outcome(s) of activities	Overall goal(s)
Definition	Resources needed to support the strategy	Program or service being provided	Tangible, countable products of your work	General statement about desired results	General statement about desired results
Example	Trained providers	Health education class	Number of classes held	• Increased awareness • Increased use of skills	Improved health (universal target)

Programs, services and other resources should be targeted and allocated to priority populations to close gaps in outcomes and improve overall health and well-being. Priority populations can also be engaged as "inputs" into program implementation, for example by hiring community members as staff or by spreading awareness of programs and services through trusted community messengers, such as religious and community leaders.

Creating SMART objectives to advance equity

Once you have completed your logic model, you will want to design a way to track progress toward your outcomes over time. A great way to do that is with SMART objectives. SMART objectives describe desired outcomes that are Specific, Measurable, Achievable, Realistic, and Time-bound. They are statements of desired outcomes that balance achievability and aspiration. They include an indicator, a data source, baseline data, a target and an identified time period for achieving the target. SMART objectives should be structured to include data for both the community overall and for priority populations.

Data relevant to any desired outcomes, including data from the sources in section 5 of this Toolkit, can be used as a baseline to create SMART objectives that measure progress toward desired outcomes. An example SMART objective is included in figure 14.

If you are already implementing a program:

- Check to see if evaluation materials, including SMART objectives, have already been developed by others for the program or similar programs
- Check to see if state and local plans, such as those listed in Figure 11, have a SMART objective developed for any goals related to your program

Figure 14. **Example SMART objective**

Long-term desired outcome: Decrease the percent of Ohio renters who are spending more than 30% of their income on housing costs from 45% in 2020 to 35% in 2029.

Indicator (sources)	Baseline data (2020)	Short-term target (2023)	Intermediate target (2025)	Long-term target (2029)
Housing cost burden. Percent of renter households spending 30% or more of their income on housing costs (e.g., rent, utilities). (Source: National Equity Atlas)	45%	42%	38%	35%
Priority populations				
Black Ohioans	53%	47%	41%	35%
Native American Ohioans	57%	50%	42%	35%
Women	50%	45%	40%	35%

Note: Short-term, intermediate and long-term targets are for example only and should not be used to inform target setting.
Baseline data source: IPUMS, American Community Survey 5-year estimates as compiled by the National Equity Atlas

SMART objectives are particularly useful for:

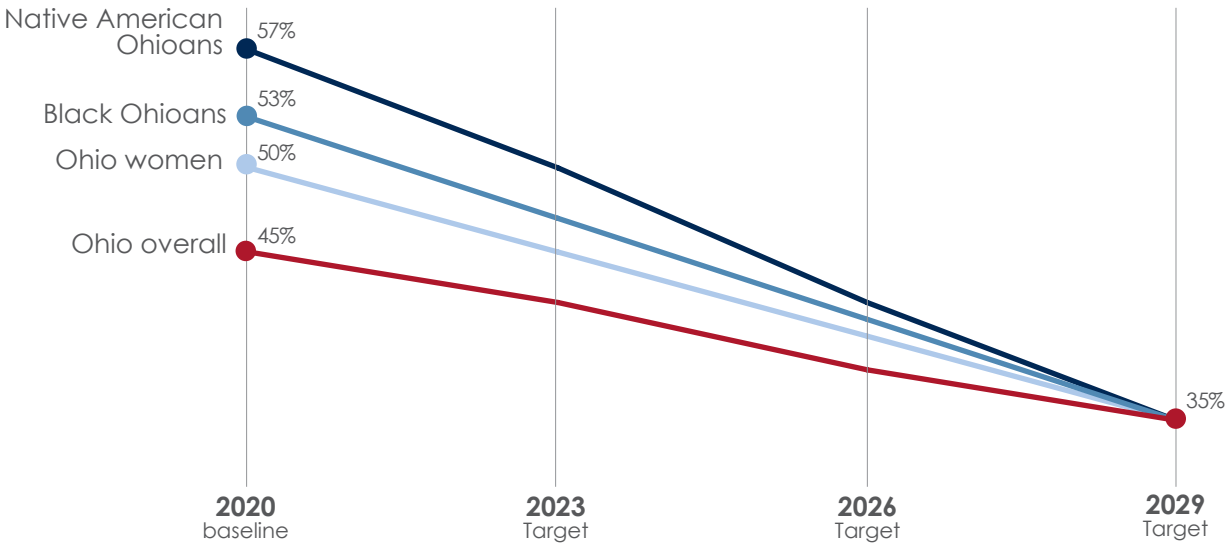
- **Advancing equity.** SMART objectives are a useful tool for eliminating disparities and inequities. SMART objectives use disaggregated data to display gaps in outcomes and set bold goals, called universal targets, with an eye toward eliminating disparities and inequities. SMART objectives that include disaggregated data and universal targets also lay the foundation for open discussions about the changes needed to ensure every member of the community thrives.
- **Fostering transparency and accountability.** SMART objectives foster transparency and hold responsible entities accountable for acting on desired outcomes. The structure of a SMART objective, specifically the use of baseline data and a target, can be used to demonstrate how progress is being made toward achieving the target (i.e., Have outcomes improved from the baseline? How close are outcomes to the target?).
- **Tracking progress.** SMART objectives track progress on specific strategies, priorities or goals. While progress toward targets will not happen overnight, tracking data over time will guide and improve strategy implementation and planning.

Setting universal targets

Universal targets provide the same long-term outcome for priority populations as the community overall. They are bold goals for achieving equity, by eliminating the disparities and inequities experienced by different groups of Ohioans.

Long-term targets may prioritize eliminating gaps in outcomes for priority populations over an ambitious target for the community overall, especially when gaps in outcomes for priority populations are particularly large. State plans like the **2020-2022 Strategic Action Plan on Aging, 2020-2022 State Health Improvement Plan** and the **2023-2027 State Oral Health Plan** use universal targets to demonstrate Ohio's commitment to achieving equity and improving the health of every Ohioan. An example universal target is displayed in figure 15.

Figure 15. **Universal target example: Housing cost burden, by race, Ohio**



Note: 2023, 2026 and 2029 data are for example only and should not be used to inform target setting.
2020 data source: IPUMS, American Community Survey 5-year estimates as compiled by the National Equity Atlas

When setting universal targets:

- Refer to similar plans from other communities (municipalities, states, counties, etc.) for comparison to set long-term targets. This can include using a similar rate of change from baseline to long-term target year as other plans. **Healthy People 2030** may also provide long-term targets for comparison.
- Understand the strengths and challenges of the community, such as those identified through a needs assessment, to identify a long-term target date and if a potential universal target is achievable by that date.
- Balance targets that are ambitious and achievable, based on data for priority populations.
- Select activities that will make the target achievable, prioritizing ones that have evidence of effectiveness for reducing disparities and/or ones that have the support of the community, specifically priority populations.

You may also find it helpful to set short-term and intermediate targets based on your universal, long-term target to track progress toward your goal. These targets can be set any number of years before your long-term goal. For example, in the 2020-2022 SHIP, long-term targets were set for 2027, and short-term and intermediate targets were set in 2023 and 2025, respectively.

There are a couple of ways to set these short and intermediate targets, including:

- Calculating the difference between the baseline data and universal target and divide by the number of years for your plan.
- Referring to similar plans from other communities (municipalities, states, counties, etc.) for comparison of what is achievable/aspirational for the community at-large.

Tool

The **target setting worksheet** is designed for you to build long-term, universal targets for your program. It can also help you set short-term and intermediate targets.

Additional resources

- **MeasureUp**, Build Healthy Places Network
- **Module 7: Good Health Counts: Measurement and Evaluation for Health Equity**, Prevention Institute
- **What are "Data" and "Measurement"?**, Build Healthy Places Network
- **What is Results-Based Accountability™?**, Clear Impact
- **Emergent Learning Questions**, Emergent Learning
- **How to write good evaluation questions**, Eval Academy
- **How to ask powerful questions**, Center for Evaluation Innovation
- **About Culturally Responsive and Equitable Evaluation** (CREE), Expanding the Bench
- **Achieving Equity with Results-Based Accountability**, Local and Regional Government Alliance on Race and Equity (GARE)

Section 4

Using evaluation results for continuous quality improvement

Evaluation should be an ongoing process—you can use the results of your evaluation to document lessons learned and identify steps to improve your program's effectiveness. This section contains guidance on **continuous quality improvement** (CQI), a cyclical process that uses evaluation results to improve programs and services. The section includes:

- Guidance on CQI and how to track progress towards goals
- Guidance for how to make meaning of evaluation findings and share with the community
- Resources for more in-depth information

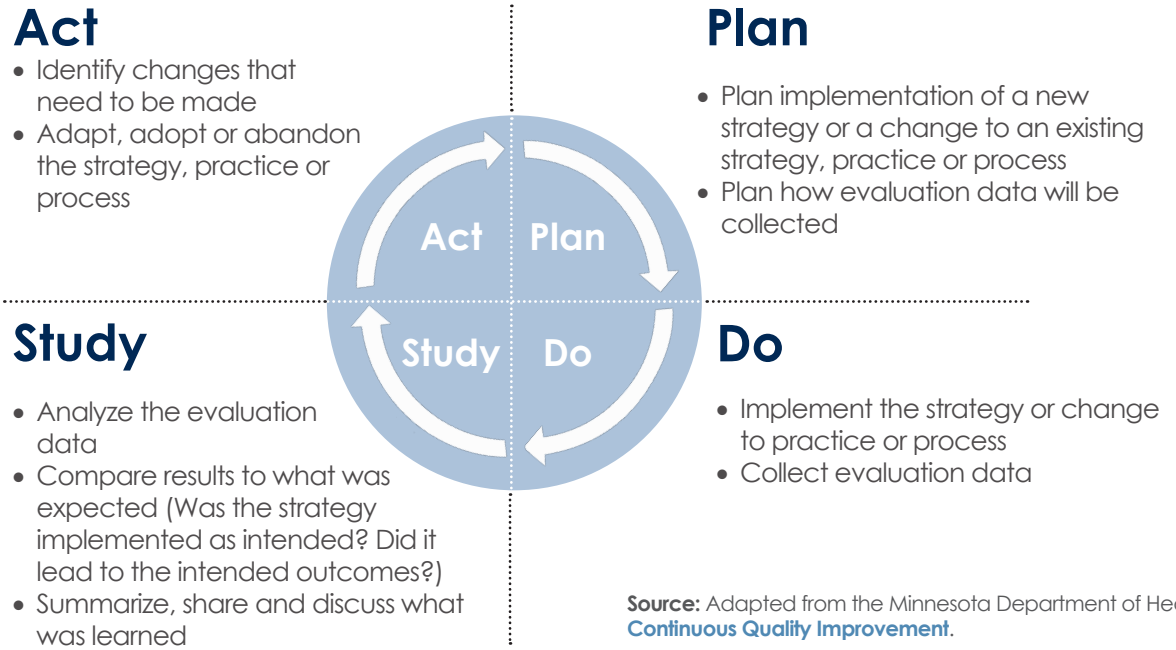
Monitoring progress towards achieving objectives and closing gaps

Progress on reducing the prevalence of disparities and inequities in the community will not happen overnight. Progress is likely to be slow. Evaluation is therefore important for measuring incremental progress along the way. Evaluation findings should also be continually used to improve planning, implementation and partnerships.

Successful CQI processes track performance on outputs (are we doing what we said we would do?) and outcomes (are things shifting the way we had hoped?). It also creates a culture that prioritizes persistence over perfection, celebrating successes during program implementation. CQI also holds partners accountable to the community, funders and other collaborators. Results should be transparently shared so that all partners can learn from the evaluation findings.

The Plan-Do-Study-Act Cycle is a framework for integrating CQI into your organization's efforts to achieve desired outcomes. This cycle is a more general version of the equitable evaluation cycle presented in figure 7 of **section 2** of this Toolkit. The general Plan-Do-Study-Act Cycle is displayed in figure 16.

Figure 16. **Plan-Do-Study-Act cycle for continuous quality improvement**



Source: Adapted from the Minnesota Department of Health, **Continuous Quality Improvement**.

Data reporting and transparency

Public reporting of progress toward your objectives is critical for accountability. Many different sectors and organizations contribute to improvements in the health of a community, so keeping all partners up-to-date on progress will contribute to effective collaboration and accountability. It is vital to not only share evaluation results that support your effort(s), but also acknowledge challenges you have faced in meeting your goals and stating how you will change, refocus or intensify your approach.

Evaluation results can be shared in brief summary reports, posters, presentations or via other means. When sharing evaluation results:

- Present and explain data at a level appropriate for all audiences
- Avoid overusing acronyms and technical jargon, including key terms and definitions where appropriate
- Consider sharing results in more than one language, ensuring that results can be shared with all members of your community
- Make documents, presentations and other information accessible for people with disabilities

The **CDC Clear Communication Index** is an evidence-informed tool to develop and assess communication materials.

Some examples of publicly available evaluation results include:

- **Healthy Beginnings at Home 1.0**, Nationwide Children's Hospital, CareSource, the University of Delaware and Health Policy Institute of Ohio
- **Title V Maternal and Child Health Block Grant data dashboard**, Health Resources and Services Administration (HRSA)

One method of tracking progress on desired outcomes is a detailed quarterly performance dashboard that underlies the SMART objectives developed in **section 3**. These types of dashboards are more granular than the SMART objectives, tracking performance on measures related to outputs and outcomes. Performance dashboards can include the following:

- **Indicators** related to outputs or outcomes that lead toward a desired outcome. For example, an output could be the number of classes hosted or number of priority population members engaged. An outcome could be the percent of participants who report increased knowledge from the class, disaggregated by priority population(s).
- **Data source** for the information, such as spreadsheets where staff input evaluation data or a survey.
- **Quarterly and/or year-end targets** that will allow you to focus your efforts more effectively, by highlighting what you hope to achieve in the year. This will also allow you to identify areas where the organization is performing well and areas where more attention is needed, which can be used to facilitate CQI conversations with staff and other collaborators.

The results of quarterly and yearly evaluation can be used to lead discussions with program staff and other partners across the community. Questions in the conversations can include:

- Which targets did we meet or exceed? What factors contributed to the successes?
- What targets were missed? What challenges did we experience that could have contributed to the missed targets?
- What steps can we take to address the challenges going forward?

An example dashboard is provided in figure 17.

Figure 17. **Example performance dashboard**

Indicator	Data source	Quarterly target	First quarter actual	Second quarter actual	Third quarter actual	Fourth quarter actual	Annual actual	Annual target
Number of classes hosted	Data spreadsheet	10	11	9	12	15	47	40
Percent of participants reporting increased knowledge	Survey	≥65%	67% avg.	59% avg.	70% avg.	65% avg.	80% avg.	≥80%

Partners from across the community can be convened for a "meaning making" session in which findings are shared with a facilitated discussion to understand the findings (e.g., why outcomes may be off track or ahead of the target) and answer any questions the data poses (e.g., unexpected data findings).

Additional resources

- **Equitable communications guide**, Innovation Network
- **Practical Strategies for Culturally Competent Evaluation: Evaluation Guide**, Centers for Disease Control and Prevention

Section 5

Collecting data for evaluation

As the previous sections have demonstrated, data is a foundational component of any evaluation and is crucial throughout all stages of the evaluation process. This section provides:

- Guidance for understanding types of data
- Methods for data collection
- Tools on 1.) sources of publicly available data, 2.) considerations for determining if data is credible and high-quality and 3.) equity considerations for primary data collection
- Considerations for equitably collecting and using qualitative and quantitative data
- Resources for more in-depth information

Role of data in achieving equity

Timely, accurate and representative data is important across all stages of an evaluation. You need data to identify priority populations, disparities and the underlying inequities that impact health outcomes. Timely and disaggregated data also allows you to measure progress over time, enhancing accountability and enabling adjustments to initiatives as needed.

Data types

Data type	Examples	Benefits of data type	Drawbacks of data type
Qualitative data: Information and concepts not represented by numbers[10]	• Interview or focus group transcripts • Photos	• Can provide a more nuanced explanation of phenomena and attitudes than quantitative data • Can provide more flexibility in research or evaluation approach • Can be more targeted	• Sample size can be a challenge or questioned for its representativeness • Rigor can be more difficult to demonstrate • Data analysis and interpretation can be time consuming
Quantitative data: Information and concepts represented numerically[11]	• U.S. Census data • County Health Rankings data • Administrative data	• Can be easier to get a large sample size • Can generalize findings to large populations • Can identify patterns and trends • Can provide statistical evidence for relationships between variables	• Does not capture in-depth understanding of individual experiences or attitudes • May not include groups with smaller populations
Primary data: Data collected for the first time (can be qualitative or quantitative)	• Conducting a survey • Conducting a focus group or key informant interview	• Can control what questions are asked and how • Can be used to fill in gaps that are identified in existing data	• Takes more time and resources to collect original data
Secondary data: Data that is collected by another source (can be qualitative or quantitative)	• Existing survey data • News articles	• Typically faster because one does not have to spend as much time and resources collecting data	• Do not have control of what questions are asked, how or from whom • May not be able to disaggregate data in a way that meets your needs

In a mixed-methods approach, qualitative and quantitative data can be paired together to provide a more nuanced analysis in your evaluation. The drawbacks of the different types of data may be able to be addressed with the benefits of other types. For example, qualitative data may be able to provide more in-depth understanding of experiences which is not captured by quantitative data.

Oversampling

Oversampling is a process by which people from populations are engaged at a higher rate than their proportion of the population. The oversample is then corrected by applying weights to the outcomes to match the population demographics. Oversampling is a useful strategy to better ensure that marginalized or systematically disadvantaged groups, particularly those with smaller population sizes, are represented in the data.

Sources of publicly available data

There are many sources of regularly updated, publicly available data that can be disaggregated for groups of Ohioans. You may find these resources particularly useful for population-level assessment and for tracking overall outcomes. The **Sources of publicly available disaggregated data** tool describes sources of publicly available data, including topic areas covered and available disaggregation categories.

As you're reviewing existing data sources, you can use the **Data quality checklist** tool to determine if the data is credible, high-quality, timely and usable to meet your needs. As you consider the quality of existing data, you should note that there is no perfect data. All data sources have limitations. It is the responsibility of the data user to weigh out these limitations when selecting the data that best meets their needs.

Institutional Review Boards (IRBs)
IRBs are committees that apply research ethics to reviews of research projects involving human participants to protect them from harm. You may not need to engage with an IRB for your evaluation efforts, but IRB approval could be needed in certain circumstances. The **Ohio Department of Health IRB** has a list of frequently asked questions about their process.

Qualitative methods for collecting primary data

Qualitative methods (like interviews and focus groups) can be a good way to engage community members in both program evaluation and community assessment. This helps you to gain a deeper understanding of how people perceive a program or community's strengths and concerns. You can also use qualitative methods to fill in gaps in existing quantitative data, particularly when specific groups are not well represented.

There are many different ways to collect qualitative data. The method(s) you choose will depend on your evaluation questions, available time and resources and community dynamics, including access to participants. No matter what methods are selected, you must consider how to approach communities with respect and dignity.

Examples of qualitative data collection methods include:

- **Arts-based methods**: The use of an art-making activity paired with a group discussion or individual interview designed to elicit context-specific information relevant to the evaluation questions.[12] Examples include photo elicitation, PhotoVoice[13], collage, drawing and poetry.
- **PhotoVoice** is a **participatory method** in which community members use photography to record and reflect their community's strengths and concerns, promote critical dialogue and knowledge, and to reach policymakers.[14]

- **Document review**: A way of collecting data by reviewing existing internal or external documents[15]
- **Focus group**: A group interview of people who share common characteristics on a predetermined set of topics.[16]
- **Key informant interview**: In-depth interview with a person who has knowledge of the topic.[17] Interviews can be structured, semi-structured or unstructured.
- **Observation**: An evaluator or researcher observes program participation, the community in their day-to-day life or in the phenomenon of interest.[18]
- **Survey**: A set of questions distributed to a sample of people. Open-ended questions can be used to collect qualitative data using a survey.

Tool

The **Equity considerations for primary data collection tool** has more information on how to embed equity as you work with participants and community members to collect new data.

Additional resources

- **Get Started with Data Disaggregation**, County Health Rankings and Roadmaps
- **Opportunity Mapping Tool**, The Ohio Housing Finance Agency and Kirwan Institute for the Study of Race and Ethnicity, Ohio State University
- **Program Evaluation Data Collection and Analysis** (CDC)
- **Data Collection Methods for Program Evaluation: Focus Groups**, Centers for Disease Control and Prevention (CDC)
- **Data Collection Methods for Program Evaluation: Questionnaires**, CDC
- **Data Collection Methods for Program Evaluation: Observations**, CDC
- **Data Collection Methods for Program Evaluation: Interviews**, CDC
- **Data Collection Methods for Program Evaluation: Document Review**, CDC
- Esposito, Jennifer, and Venus E. Evans-Winters. Introduction to Intersectional Qualitative Research. First Edition. Thousand Oaks: SAGE Publications, Inc, 2021.
- **Dimensionality and R4P: A Health Equity Framework for Research Planning and Evaluation in African American Populations**, Maternal and Child Health Journal
- **Data Equity Framework** and **Tools**, We All Count

Key terms

- **Activities:** The steps taken to achieve SMART objectives.
- **Community assessment:** The process of identifying a community's strengths and challenges, as well as the assets and resources available to meet those challenges.
- **Continuous quality improvement:** Ongoing process to review and assess performance to improve efficiency, effectiveness and accountability.
- **Cultural humility:** An ongoing process of self-reflection combined with a nonjudgmental willingness to learn about other's experiences and culture.
- **Cultural responsiveness:** The ability to learn from, understand and relate with people of one's own culture as well as those from other cultures and backgrounds.
- **Desired outcome:** An intended result, such as changes in conditions, awareness, knowledge, skills or behaviors.
- **Disaggregated data:** Data broken into segments such as race/ethnicity, income, sexual orientation and gender identity, disability status, geographic region, immigration status and age.
- **Disparities:** Avoidable differences in outcomes (such as infant mortality and life expectancy) that exist across population groups or communities.
- **Equitable evaluation:** An approach to conducting evaluation that addresses dynamics and practices that have historically undervalued the voices, knowledge, experiences, expertise and background of people of color and other marginalized groups.[19]
- **Explicit bias:** Prejudicial or unfair attitudes and beliefs about a person or group experienced on a conscious level.
- **Health equity:** The ability of everyone to achieve their full health potential. This requires addressing historical and contemporary injustices and removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments and health care.
- **Implicit bias:** Prejudicial or unfair attitudes and beliefs about a person or group that are unconscious and outside of awareness and control.
- **Inequities:** The underlying drivers of disparities, including differences in the distribution of or access to social, economic, environmental and healthcare resources.
- **Indicator:** A specific metric or measure used to quantify an outcome, typically expressed as a number, percent or rate.
- **Inputs:** Resources used to achieve SMART objectives, such as staff time, equipment, materials, supplies and volunteers.
- **Outputs:** Tangible and countable products of performed activities, usually measured in terms of the volume of work accomplished (e.g., number of classes taught, number of materials distributed or number of participants).
- **Participatory methods:** Ways to engage community collaborators in the research process, such as PhotoVoice, focus groups and community advisory groups.[20]
- **Priority populations:** Groups who are most at-risk for poor outcomes, such as higher rates of infant mortality, heart disease or depression. Priority populations are generally systematically disadvantaged groups that are more likely to experience racism and other forms of discrimination, such as ageism, ableism, homophobia and xenophobia.
- **Reflexivity:** The ability and commitment to think about what has shaped one's perspective.[21]
- **Strategy:** A policy, program or service.
- **SMART objective:** A type of objective that is Specific, Measurable, Achievable, Realistic and Time-bound. SMART objectives include several components: Indicator, data source, baseline data and target with an identified time period for achieving the target.
- **Universal targets:** Goals that reflect the objective of eliminating disparities and inequities within a specified time range, recognizing that it will take time to achieve these goals.

Notes

1. Health Policy Institute of Ohio. *2024 Health Value Dashboard*. April 2024.
2. The term queer can refer to anyone who does not identify with an established sexual identity (lesbian, gay, bisexual, straight) or people who identify outside of the gender binary (cisgender or transgender men and women).
3. Clear Impact. What is Result-Based Accountability? https://clearimpact.com/results-based-accountability/.
4. Coffman, Julia and Tanya Beer. *The Advocacy Strategy Framework: A tool for articulating and advocacy theory of change*. Center for Evaluation Innovation, 2015. https://www.evaluationinnovation.org/wp-content/uploads/2015/03/Adocacy-Strategy-Framework.pdf
5. Dozois, Elizabeth, Marc Langlois and Natasha Blanchet-Cohen. *DE 201: A Practitioner's Guide to Developmental Evaluation*. Montreal, Quebec, Canada: The J.W. McConnell Family Foundation, 2010. https://mcconnellfoundation.ca/wp-content/uploads/2017/07/DE-201-EN.pdf
6. Equitable Evaluation Initiative. Equitable Evaluation Framework. https://www.equitableeval.org/framework.
7. "EEF Expansion: Elements of the EEF-Principles." Equitable Evaluation Initiative. Accessed December 18, 2023. https://www.equitableeval.org/post/eef-expansion-principles.
8. Ibid.
9. *Logic Model Tip Sheet*. Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/sites/default/files/documents/prep-logic-model-ts_0.pdf; *2020-2022 Strategic Action Plan on Aging: Implementation Toolkit*. Columbus, OH: Ohio Department of Aging and Health Policy Institute of Ohio, 2022.
10. "Qualitative Data," National Library of Medicine, accessed December 18, 2023, https://www.nnlm.gov/guides/data-glossary/qualitative-data.
11. "Quantitative Data," National Library of Medicine, accessed December 18, 2023, https://www.nnlm.gov/guides/data-glossary/quantitative-data.
12. Lefkowich, Maya. *Arts-Based Methods in Evaluation 101*. And Implementation Consulting Inc. https://www.andimplementation.ca/post/arts-based-101
13. Ibid.
14. Caroline Wang and Mary Ann Burris, "Photovoice: Concept, Methodology, and Use for Participatory Needs Assessment," *Health Education & Behavior* 24, no. 3 (June 1, 1997): 369–87, https://doi.org/10.1177/109019819702400309.
15. CDC, "Data Collection Methods for Evaluation: Document Review," August 2018, https://www.cdc.gov/healthyyouth/evaluation/pdf/brief18.pdf.
16. CDC, "Data Collection Methods for Program Evaluation: Focus Groups," August 2018, https://www.cdc.gov/healthyyouth/evaluation/pdf/brief13.pdf.
17. UCLA Center for Health Policy Research, "Section 4: Key Informatn Interviews," accessed December 19, 2023, https://healthpolicy.ucla.edu/sites/default/files/2023-08/tw_cba23.pdf.
18. Linda Daniel, "LibGuides: Qualitative Research: Observation," accessed December 19, 2023, https://guides.library.duke.edu/c.php?g=289813&p=1934020.
19. https://www.wested.org/resources/reflections-on-applying-principles-of-equitable-evaluation/#:~:text=Equitable%20evaluation%20is%20an%20approach,color%20and%20other%20marginalized%20groups.
20. Duea, Stephanie R. et al. "A Guide to Selecting Participatory Research Methods Based on Project and Partnership Goals." *Journal of Participatory Research Methods* 3, no. 1 (2022). doi: 10.35844/001c.32605.
21. Jennifer Esposito and Venus E. Evans-Winters, *Introduction to InterSectional Qualitative Research*, First Edition (Thousand Oaks: SAGE Publications, Inc, 2021).

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