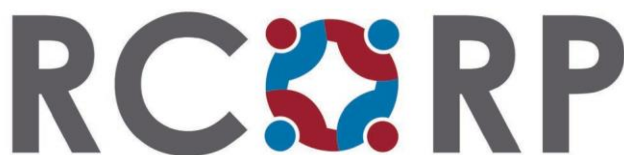


# Template: Behavioral Health Disparities Impact Statement

Last Updated April 13, 2023

This guidance is to assist in the development of the Behavioral Health Disparities Impact Statement (DIS), as outlined in the RCORP Notice of Funding Opportunities. The DIS will describe how the consortium plans to reduce behavioral health disparities in the target rural service area(s) and to continuously monitor and measure the project's impact on health disparities in order to inform process and outcome improvements. Grantees will report annually the consortium updates and progress made in the service area.

| Grantee Organization Information | | |
|---|---|---|
| **Consortium Name** | Communities of Practice for Rural Communities Opioid Response Program (COP-RCORP) | |
| **Grant Numbers** | Ohio University RCORP-BHS (FAIN: G2846290)<br>Ohio University RCORP-PS (FAIN: H7N45748)<br>Pacific Institute for Research and Evaluation (PIRE) RCORP-PS (FAIN: H7N42563) | |
| **Address: Ohio University** | Street: | 1 Ohio University |
| | City, State: | Athens, OH 45701 |
| **Address: PIRE** | Street: | 4061 Powder Mill Rd., Suite 350 |
| | City, State: | Beltsville, MD 20705 |
| **Service Area** | Ohio University RCORP-BHS: Ashtabula County, Fairfield County (Rural Zip Codes Only), Seneca County<br>Ohio University RCORP-PS: Fairfield County (Rural Zip Codes Only)<br>PIRE RCORP-PS: Sandusky County, Seneca County | |
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| **Contributing Consortium Members and Stakeholders** | Ashtabula County Mental Health Recovery Services Board<br>Ohio University RCORP-BHS (FAIN: G2846290)<br>Miriam Walton, Kaitie Park Hart, and Bridget Sherman |
|---|---|
| | Fairfield County Alcohol, Drug Addiction, and Mental Health Board<br>Ohio University RCORP-BHS (FAIN: G2846290)<br>Ohio University RCORP-PS (FAIN: H7N45748)<br>Marcy Fields, Toni Ashton, Miranda Gray, Dawn Good, and Dylan Sander |
| | Sandusky County Public Health<br>PIRE RCORP-PS (FAIN: H7N42563)<br>Charlotte Stonerook and Vidalia Halbisen |
| | Mental Health and Recovery Services Board of Seneca, Ottawa, Sandusky and Wyandot Counties<br>Ohio University RCORP-BHS (FAIN: G2846290)<br>PIRE RCORP-PS (FAIN: H7N42563)<br>Robin Reaves and Nicole Williams |
| | Ohio University: Laura Milazzo and Nicole Yandell<br>PIRE: Owen Myers |

# STEP 1–ASSESSMENT

Identify subpopulations vulnerable to behavioral health disparities within the service area and the specific behavioral health disparities experienced by these subpopulations.

- List the subpopulations in your service area vulnerable to behavioral health disparities. Subpopulations may be based on race, ethnicity, tribal entities and organizations, language, age, socioeconomic status, gender identity, sexual orientation, people who are pregnant, adolescents and youth, veterans, older adults, individuals with special needs, and other relevant factors (e.g., literacy).
- Identify the behavioral health disparities in access, use, and outcomes that currently exist within identified subpopulations.
- Select one subpopulation from your data on which to focus your work.

| Local Consortium Member | Subpopulations | Health Disparities |
|---|---|---|
| **Ashtabula County: (Substance Abuse Leadership Team)**<br>**Grant Number:**<br>Ohio University RCORP-BHS (FAIN: G2846290) | Individuals with low socio-economic status (SES) | Increased substance use and SUD treatment access among individuals with low SES; access to and affordability of physical and behavioral health care; contributing factors such as transportation and childcare; insurance complexity and underinsurance issues |
| **Fairfield County: (Prevention, Advocacy, Recovery, and Treatment Coalition)**<br>**Grant Numbers:**<br>Ohio University RCORP-BHS (FAIN: G2846290)<br>Ohio University RCORP-PS (FAIN: H7N45748) | Individuals in jail with polysubstance use | People who are in jail cannot have services billed to Medicaid, which limits access to care. They also have a disruption in continuity of care; and many have underserved mental and behavioral health care needs, along with a lack of access to physical and behavioral health care, increase in mortality risk, increase in mental health and SUD, uninsured and underinsured, and burden of disease. When moving to reentry, contributing factors include lack of transportation, housing, and employment |
| **Sandusky County: (Sandusky County Health Partners)**<br>**Grant Number:**<br>PIRE RCORP-PS (FAIN: H7N42563)<br>AND<br>**Seneca County: (Seneca County Opiate Task Force)**<br>**Grant Numbers:**<br>Ohio University RCORP-BHS (FAIN: G2846290)<br>PIRE RCORP-PS (FAIN: H7N42563) | Individuals with low socio-economic status (SES) | Increased substance use and SUD; access to physical and behavioral health care due to insurance status and contributing factors such as transportation and childcare. |

**Selected Subpopulation of Focus:**

**Ashtabula County: (Substance Abuse Leadership Team)**

**Grant Number:** Ohio University RCORP-BHS (FAIN: G2846290)

**Overview:** Located in northeast Ohio, Ashtabula County is a HRSA-designated rural county. According to the Appalachian Regional Commission, it is an Appalachian County with an at-risk economic status. Per the 2017-2021 ACS 5-year US Census estimates, Ashtabula County has a total population of 97,337. The local project leads have selected individuals with low SES in Ashtabula County as the prioritized population for this disparities impact statement.

**Economic Disparities**: The 2020 American Community Survey (ACS) estimates found that 14.9% of Ashtabula County residents were living at or below the federal poverty line. Females, particularly single parent female households, are more likely to be below the federal poverty line than males. Similarly, individuals with low-SES are likely to have lower levels of education (HS grad or below). Race and ethnicity are also associated with SES, with residents who identify as African American, Asian, or Hispanic origin being more likely to live under the federal poverty line than white residents.

**Behavioral Health/SUD Data:** The table below shows data on the prevalence and incidence of SUD and psychostimulant misuse in Ashtabula County, along with Ohio and national comparisons. These high rates, which maybe underreported, indicate the need for mental and behavioral health care services.

| **Measure** | **Ashtabula** | **Ohio** | **National** |
|---|---|---|---|
| Prevalence or Incidence of SUD By Type[1] | | | |
| Opioids | 39.20% | 38.20% | 33.70% |
| Alcohol | 27.60% | 28.10% | 29.40% |
| Psychostimulants (PS) | 13.00% | 13.00% | 16.00% |

[1]https://mha.ohio.gov/Health-Professionals/Behavioral-Health-Data-Reporting/OBHIS

Survey data collected by the Ohio Department of Mental Health and Addiction Services (OhioMHAS) on low SES populations shows disparities in substance use for them. The table below shows that adult residents of Ashtabula County who live at or below 100% of the federal poverty line had much higher rates of smoking, alcohol use, marijuana use, and prescription drug misuse compared to those living above it.

| Ashtabula County & SES | Smoke Cigarettes (currently, every & some days) | Past 30 Day Alcohol Use | Past 30 Day Marijuana Use | Past 30 Day Prescription Drug Misuse |
|---|---|---|---|---|
| Over 100% FPL | 5% | 24% | 15% | 8% |
| At or below 100% FPL | 23% | 51% | 22% | 27% |
| Total | 10% | 30% | 17% | 13% |

According to data from a 2022 Ashtabula County Health Needs Assessment, the likelihood of receiving mental health care differed by annual household income: only 5.4% of those with less than $50,000 are likely to receive mental health services, while 22.9% of those with incomes of $50,000 to $100,000 and 12.2% of those with income of $100,000 or more are likely to receive mental health services. These data indicate that those with lower SES are less likely to receive behavioral health services than those with higher SES.

**Fairfield County: (Prevention, Advocacy, Recovery, and Treatment Coalition)**

**Grant Numbers:**
Ohio University RCORP-BHS (FAIN: G2846290)

Ohio University RCORP-PS (FAIN: H7N45748)

**Overview**: Located in central Ohio, Fairfield County has a population of 161,064 (total) and 114,778 (rural) per the 2017-2021 ACS 5-year US Census estimates. Seventy five percent of Fairfield County is designated as rural. Currently, there is no way to pull data for only the rural census tracts in Fairfield County; therefore, five zip codes were used as a proxy. The local project leads have selected individuals in jail with polysubstance use as the prioritized population for this disparities impact statement.

**Behavioral Health/SUD Data:** The table below shows data on the prevalence and incidence of SUD and psychostimulant misuse in all of Fairfield County, along with Ohio and national comparisons. These high rates indicate the need for mental and behavioral health care services.

| Measure | Fairfield | Ohio | National |
|---|---|---|---|
| Prevalence or Incidence of SUD By Type[1] | | | |
| Alcohol | 19.90% | 28.10% | 29.40% |
| Psychostimulants (PS) | 15.90% | 13.00% | 16.00% |
| Opioids | 48.20% | 38.20% | 33.70% |
| Impacts of Psychostimulant Misuse/Use Disorder[1] | | | |
| Drug Overdoses Involving a PS | Suppressed | NA | NA |
| Arrests Involving a PS | 18.10% | 12.70% | 11.10% |
| Prevalence or Incidence of Psychostimulant Misuse/Use Disorder By Age[1] | | | |
| Under 18 years | 10.30% | 2.90% | 4.61% |
| 18-24 years | 12.60% | 10.00% | 16.93% |
| 25-44 years | 15.90% | 12.70% | 18.70% |
| 45-64 | 21.40% | 18.30% | 15.97% |
| 65 years and over | 0.00% | 12.10% | 7.52% |
| Prevalence or Incidence of Psychostimulant Misuse/Use Disorder by Ethnicity[1] | | | |
| Hispanic or Latino | 0.00% | 9.60% | 17.80% |
| Not Hispanic or Latino | 16.10% | 13.60% | 17.10% |
| Prevalence or Incidence of Psychostimulant Misuse/Use Disorder by Race[1] | | | |
| American Indian / Alaska Native | 0.00% | 0.00% | 20.90% |
| Asian | 0.00% | 0.00% | 23.40% |
| Black or African American | 13.90% | 16.60% | 16.00% |
| Native Hawaiian or Other Pacific Islander | 0.00% | 0.00% | 30.40% |
| White | 16.00% | 12.60% | 17.20% |
| Types of Psychostimulants in Community[2] | | | |
| Cocaine (All Forms) | 3.50% | 10.65% | |
| Methamphetamine | 43.06% | 30.85% | |
| Prescription Stimulants | >1% | >1% | |
| Ecstasy/Molly | >1% | >1% | |

[1]https://mha.ohio.gov/Health-Professionals/Behavioral-Health-Data-Reporting/OBHIS
[2]www.ohioattorneygeneral.gov/Law-Enforcement/Bureau-of-Criminal-Investigation/Laboratory-Division.aspx

**Polysubstance Use Disparities for the Local Jail Population:** According to local billing records, 454 inmates in the Fairfield County Jail accessed board services for mental health or substance use disorders in FY 2022. Among those, 179 inmates with an SUD diagnosis received medicated assisted treatment (MAT).

Current billing records only include a single diagnosis because the jail behavioral health care provider has only been recording a primary diagnosis. Modifications will be made to the system to improve accuracy in reporting multiple diagnoses

and substance misuses. In the meantime, to better estimate the proportion of inmates with more than one substance misuse, the Fairfield County ADAMH Board staff conducted anecdotal interviews with the local Quick Response Team, Jail staff, Jail behavioral health care provider, and other Criminal Justice workers. From those conversations, it is estimated that about 50% of inmates report misuse of more than one substance. In addition, according to data from the Fairfield County Municipal Court regarding substances used, 16.3% of the clients' self-report polysubstance use.

**Sandusky County: (Sandusky County Health Partners)**

**Grant Number:** PIRE RCORP-PS (FAIN: H7N42563)

AND

**Seneca County: (Seneca County Opiate Task Force)**

**Grant Numbers:** Ohio University RCORP-BHS (FAIN: G2846290) PIRE RCORP-PS (FAIN: H7N42563)

**Overview**: Sandusky and Seneca Counties are HRSA-designated rural counties in north central Ohio. Per 2019 U.S. Census Bureau data estimates, Sandusky County has a total population of 59,029 and Seneca County has a total population of 55,351. The local project leads have selected individuals with low SES in Sandusky and Seneca Counties for this disparities impact statement.

**Economic Disparities**: The 2020 American Community Survey (ACS) estimates found that 11.6% of Sandusky County residents and 12.8% of Seneca County residents were living at or below the federal poverty line. The estimates show that females, particularly single parent female households, are more likely to be below the federal poverty line than males. Similarly, individuals with low-SES are likely to have lower levels of education (HS grad or below) and to be either foreign born or naturalized citizens. Race and ethnicity are also associated with SES, with residents who identify as African-American, Asian, or Hispanic origin being more likely to live under the federal poverty line than white residents.

**Behavioral Health/SUD Data**: Survey data collected by the Ohio Department of Mental Health and Addiction Services (OhioMHAS) on low SES populations found significant disparities in substance use for them. The table below shows that adult residents of Sandusky County who live at or below 100% of the federal poverty line had significantly higher rates of smoking and marijuana use compared to those living above it. Adult residents of Seneca County who live at or below 100% of the federal poverty line had much higher rates of smoking, alcohol use, binge drinking, and marijuana use compared to those living above it.

| County & SES | | Smoke Cigarettes (currently every & some days) | Past 30 Day Alcohol Use | Past 30 Day Binge Alcohol Use | Past 30 Day Marijuana | Past 30 Day Prescription Drug Misuse |
|---|---|---|---|---|---|---|
| **Sandusky** | Over 100% FPL | 17% | 60% | 20% | 6% | 7% |
| | At or below 100% FPL | 29% | 43% | 4% | 21% | 0% |
| | Total | 18% | 58% | 18% | 8% | 7% |
| **Seneca** | Over 100% FPL | 17% | 35% | 15% | 5% | 14% |
| | At or below 100% FPL | 56% | 77% | 45% | 16% | 8% |
| | Total | 25% | 44% | 21% | 8% | 13% |

# STEP 2 –CAPACITY

Explain how you will build the capacity of the consortium, partners, and community stakeholders to address behavioral health disparities.

- Describe the overall capacity and history of collaboration in the service area to meet the behavioral health care needs of the identified subpopulation.
- What resources currently exist in your service area to address behavioral health disparities?
- What is the readiness of the consortium, partners, and community stakeholders to address behavioral health disparities in selected identification (e.g., Is there any related stigma, lack of resources, or challenges that the consortium or stakeholders will face)?
- How will you reach out to subpopulations experiencing behavioral health disparities and involve them in community-level, capacity-building efforts?

| **Ashtabula County: (Substance Abuse Leadership Team)**<br>Ohio University RCORP-BHS (FAIN: G2846290) |
|---|
| **History of Consortium**: The Substance Awareness Leadership Team has been in existence since 2017 and has provided the opportunity for local partners to collaborate on the needs of the county. In January 2023, the Consortium updated its community mental health and substance use needs assessment, focusing intently on disparities of populations served. |
| **Existing Resources**: Through the work of the local Consortium and treatment providers, the Consortium has worked to expand services at satellite offices throughout the county, including a mobile unit. The Consortium has also collaborated with partners to expand access to naloxone and has installed NaloxBoxes for improved accessibility. These efforts focus on addressing access and stigma. |
| **Community Readiness:** Through the RCORP-P and RCORP-I projects, the local consortia in Ashtabula County have increased the readiness to address gaps in services due to disparities among individuals with low-SES. The consortia will leverage its strong partnerships to address substance use disorders among the prioritized population. Systemic challenges exist, including transportation barriers and stigma around mental health and substance misuse, which puts larger community readiness to address these issues at a lower level. All strategies selected to address the prioritized population will include a focus on this community readiness. |
| **Involving Stakeholders from Priority Population in Capacity-building Efforts:** Office staff are represented on the county's Housing Council, and the Transportation Advisory Committee to help address disparities. The local consortium has also been working to expand workforce through the development of a Chemical Dependency Counselor Assistance Training Academy, two Peer Recovery Supporter trainings every year, and our regional Kent Campus recently began offering a Bachelor of Social Work Program. We continue to expand our efforts in reaching those populations experiencing disparities. For example, the Consortium is in the initial phases of starting a Recovery Coalition, which will engage persons with lived experience. In addition, the Consortium continuously collects data through surveys, key informant interviews, and focus groups to help gauge the needs and gaps of the community. |

| **Fairfield County: (Prevention, Advocacy, Recovery, and Treatment Coalition)**<br>Ohio University RCORP-BHS (FAIN: G2846290)<br>Ohio University RCORP-PS (FAIN: H7N45748) |
|---|
| **History of Consortium**: The Fairfield County ADAMH Board has been the backbone organization of the Coalition since its beginning. The Coalition has been in existence since 2009 when the opiate epidemic started to infiltrate communities. The Coalition was formed to raise awareness, collect data, implement solutions and evaluate efforts. The Coalition has members from each of the sectors from the community wheel. The Coalition has four standing sub-committees; prevention/education, recovery, treatment, and advocacy. Key partners include law enforcement, community mental health, SUD and prevention providers, government, civic groups, faith-based, business, health department, family members and QRT Team. In 2023, the board voted to rename the local coalition from Fairfield County Opiate Task Force to Fairfield County Prevention, Advocacy, Recovery, and Treatment Coalition (P.A.R.T.) Coalition. |
| **Existing Resources**: There are resources to assist the those needing assistance with SUD. The community has many providers offering services for prevention, treatment, and recovery. The Fairfield County ADAMH Board is statutorily empowered to plan, fund, and monitor the local system of mental health and addiction services in Fairfield County. The ADAMH Board funds and facilitates partnerships and relationships with organizations throughout the district to address community needs, to ensure access to care, and to respond to crisis situations. |
| **Community Readiness**: A formal community readiness assessment has not been completed so the information on community readiness is from an informal discussion of stakeholders. Stakeholder members feel that our community is at a community readiness Level of 7, which is considered stabilization. This rating is because activities are supported by administrators or community decision makes. Staff are trained and experienced. With the previous work of RCORP-Planning and RCORP-Implementation projects, the Coalition has also worked on reducing and eliminating SUD in the community. The Coalition is engaged in developing strategies and resource to impact the prioritized population of those in the jail with polysubstance use. |
| **Involving Stakeholders from Priority Population in Capacity-building Efforts**: The Coalition also has providers that work with the identified prioritized population. The Coalition has family members and friends that are associated with the identified prioritized population. The Coalition will work towards involving those that are in the prioritized population to become members of the coalition. The local Coalition will include stakeholders from the identified prioritized population in the Coalition, in sub-committees, workgroup activities and in activities and services to address substance use. |
| **Sandusky County: (Sandusky County Health Partners)**<br>PIRE RCORP-PS (FAIN: H7N42563) AND<br>**Seneca County: (Seneca County Opiate Task Force)**<br>Ohio University RCORP-BHS (FAIN: G2846290)<br>PIRE RCORP-PS (FAIN: H7N42563) |
| **History of Consortia**: The Sandusky County Public Health (SCPH) department serves as the fiscal backbone for the Sandusky Health Partners, a consortium formed in 1993. The Mental Health and Recovery Services Board of Seneca, Ottawa, Sandusky, and Wyandot Counties serves as the fiscal backbone for the Seneca County Opiate Task Force, a consortium formed in 2015. Each local consortium has key partners from multiple key sectors and focuses on building capacity addressing prevention, treatment, and recovery from substance |

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| use disorders. Key partners include emergency law enforcement, courts, local jail administration, emergency medical service, treatment and prevention providers, social service providers, faith-based leaders, hospitals, health departments, and others. |
| **Existing Resources**: Sandusky County Public Health (SCPH) works to protect and improve the health of those who live, work, and play in Sandusky County, Ohio by promoting healthy lifestyles, preventing injury, and detecting and preventing infectious diseases. Sandusky County Public Health provides educational outreach programs, clinics, recommends policy and system changes to improve population health, and works to reduce health disparities. By promoting healthcare equity, quality, and accessibility. The Mental Health and Recovery Services Board of Seneca, Ottawa, Sandusky, and Wyandot Counties is statutorily empowered to plan, develop, fund, administer and evaluate the local system of mental health and addiction services within the Board district. The Board funds and facilitates partnerships and relationships with organizations throughout the district to address community needs, to ensure access to care, and to respond to crisis situations. |
| **Community Readiness**: Through the RCORP-P and RCORP-I projects, the local consortia in Seneca and Sandusky counties have built and sustained readiness to address gaps in services due to disparities from individuals with low-SES. The consortia have had success in partnering to grow community-based approaches that address substance use disorders and will build on that experience to address the prioritized population. Systemic challenges exist, including transportation barriers and stigma around mental health and substance abuse, which puts larger community readiness to address these issues at a lower level. All strategies selected to address the prioritized population will include a focus on community readiness. |
| **Involving Stakeholders from Priority Population in Capacity-building Efforts**: Members of the Seneca and Sandusky County consortia are committed to ensuring that residents with low-SES are involved in community-level capacity building efforts. The local consortia in Seneca and Sandusky Counties view this as an ongoing and multi-layered effort, which includes encouraging direct participation in the local consortia, in workgroup activities, and in activities and services to address substance use. |

# STEP 3–PLANNING

Provide a plan for addressing behavioral health disparities in the identified subpopulation, including incorporating effective strategies to increase access to care. Please note how many individuals in the subpopulation you will reach and how you will measure that reach.

## Access:

Describe:

- Current access to care for your identified subpopulation (e.g., Are substance use disorder services providers available in the service area to treat your identified subpopulation, or do individuals have to travel for treatment? Are services affordable? Are individuals in the identified subpopulation aware of available services?)
- Current quality of care for your identified subpopulation (e.g., Are providers available to your identified subpopulation who have shared language, race, ethnicity, gender identity, and sexual orientation? Are providers engaged in ongoing educational opportunities and continuous quality improvement?)
- Strategies and culturally and linguistically appropriate services (CLAS) standards that you will use to address behavioral health disparities and to increase access to care among your identified subpopulation (Please see Attachment B.)

| **Ashtabula County: (Substance Abuse Leadership Team)**<br>Ohio University RCORP-BHS (FAIN: G2846290) |
|---|
| **Current Access to Care:** Ashtabula County has some geographic areas that are identified as Health Improvement Zones by the Ohio Department of Health, which means they have the lowest SES in the county. Some of the areas with lower SES in Ashtabula County include Ashtabula City, East Ashtabula, Geneva, and Conneaut. All have treatment providers located in those areas, and many of those treatment agencies offer sliding fee scales for uninsured or underinsured; however, workforce shortage cause waitlist issues. In addition, for individuals with low SES, affording the copays and coinsurance can make accessing care cost prohibitive. Although there has been some ongoing public education, more work is needed to ensure the prioritized population continues to be aware of services and programs available. |
| **Current Quality of Care:** Ashtabula County Providers are certified by the Ohio Department of Mental Health and Addiction services and are required to meet standards relative to cultural competency such as providing interpreters for persons whose do not speak English. To maintain licensure and certification, all providers are required to obtain continuing education. The Substance Awareness Leadership Team does not have a database of provider race/ethnicity, gender identity, or sexual orientation. |
| **Linkage to CLAS Standards:** Members of SALT have been involved in a CLAS Standards workgroup since 2020 and have worked to implement these standards across the entire systems of care in the county. Additional opportunities will be utilized to implement the CLAS standards in future community education and information activities. |
| **Involving Stakeholders from the Identified Priority Population in Planning:** The Ashtabula County SALT Consortium is committed to ensuring that the prioritized population is |

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| a constant and consistent stakeholder in planning efforts. The local consortia view this as an ongoing and multi-layered effort, which includes encouraging direct participation in the local consortia, in workgroup activities, and in activities and services to address substance use. |
| **Fairfield County: (Prevention, Advocacy, Recovery, and Treatment Coalition)**<br>Ohio University RCORP-BHS (FAIN: G2846290)<br>Ohio University RCORP-PS (FAIN: H7N45748) |
| **Current Access to Care:** The identified prioritized population has a provider available to provide services. At present, the State Opioid Response funds pays for the following services: a peer supporter in the jail and an independently licensed clinician to assess the person in jail. There is also funding to provide MAT services in the jail. There are also resources for the person as they are leaving the jail to received outpatient services and continued MAT services. Because reentry is complicated, the P.A.R.T. Coalition includes the coordinator of the Reentry Coalition to ensure efforts are coordinated. To assist in having ongoing services available, discussions around barriers are assessed and hopefully mitigated or decreased. With the shortage of Social Service Workers in Fairfield County, the Fairfield County ADAMH Board and the local P.A.R.T. Coalition are working to increase the social service workforce by having a work group dedicated to looking at this issue, providing trainings for continuing education credits, hosting peer support trainings, and providing a peer recovery supporters support group. |
| **Current Quality of Care:** Those in the Fairfield County Jail often learn about services while in the jail. They have access to a Substance Abuse Counselor and a Peer Supporter. The counselor can assess and link persons with a current or history of substance use disorder for MAT services in the jail and also continued services upon release from the jail. |
| **Linkage to CLAS Standards:** Members of the Coalition are committed to utilizing the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care as a tool to advance health equity, improve quality and help eliminate health care disparities. |
| **Involving Stakeholders from the Identified Priority Population in Planning:** The Fairfield County P.A.R.T. Coalition is committed to ensuring that the prioritized population is a constant and consistent stakeholder in planning efforts. Upon release from jail many can continue their treatment and recovery to become important and knowledgeable members of the community. |
| **Sandusky County: (Sandusky County Health Partners)**<br>PIRE RCORP-PS (FAIN: H7N42563) AND<br>**Seneca County: (Seneca County Opiate Task Force)**<br>Ohio University RCORP-BHS (FAIN: G2846290)<br>PIRE RCORP-PS (FAIN: H7N42563) |
| **Current Access to and Affordability of Care**: Access to and affordability of care are two key concerns in Seneca and Sandusky counties. Both counties are designated as HPSA areas, and each have one FQHC. They have shortages of medical and behavioral health providers, which makes it challenging for low SES residents to find providers that accept Medicaid. Behavioral health providers in the two counties are being drawn to urban areas in Ohio due to higher pay and clearer advancement opportunities. Under the COP-RCORP-Implementation grants, both counties created career ladders to use in workforce recruitment and retention efforts. In addition, both counties work to provide medical and behavioral health services at no or low cost to residents with low-SES. Although most prevention services are provided at |

| no cost to participants, the prioritized population typically need treatment and recovery providers who accept Medicaid or who offer a sliding fee. Multiple providers in the service area offer these services, including Firelands Counseling and Recovery Services (inpatient), Arrowhead Behavioral Health Services (inpatient), Rigel Recovery Services (outpatient), Bayshore Counseling Services the Zepf Center, A Renewed Mind/Ohio Guidestone and OakHouse. |
|---|
| **Current Quality of Care**: Residents with low-SES in Seneca and Sandusky Counties often learn about services and options to assist with payment for services through word of mouth, social media, or by engaging crisis services. These individuals generally are less connected to resources and advocates, may be less likely to seek services, and generally are more likely to experience waitlists/delays when seeking treatment and recovery services. |
| **Linkage to CLAS Standards**: Members of the Sandusky County Public Health and the Mental Health and Recovery Services Board of Seneca, Ottawa, Sandusky, and Wyandot Counties, along with their consortia partners, are committed to utilizing the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care as a tool to advance health equity, improve quality, and help eliminate health care disparities. |
| **Involving Stakeholders from Identified Priority Population in Planning:** Members of the local consortia in Seneca and Sandusky Counties are committed to ensuring that residents with low-SES are involved in planning efforts. The local consortia view this as an ongoing and multi-layered effort, includes encouraging direct participation in the local consortia, in workgroup activities, and in activities and services to address substance use. |

## Reach:

- *In Attachment A,* identify the number of individuals in the subpopulation your strategies anticipate reaching during the award period. Identify the data source/tool you will use to gather your data.
- *Below*, explain how you will monitor the implementation of the DIS and the reach of your strategies to decrease health disparities among the identified subpopulation.
- Describe your process for continuously collecting the Performance Improvement Management System (PIMS) demographic data on the identified subpopulation reached by your efforts and how you will work with your consortium to collect these data. Include data sources and the frequency of data collection (e.g., annual, biannual).
- How will you reach out to subpopulations experiencing behavioral health disparities and engage them in the planning process?

**Identifying Reach:** Attachment A includes three data tables, one for Ashtabula County and Fairfield County and a combination one for Sandusky and Seneca Counties. All include a total planned population reach that derives from the five-year 2017-2021 US Census estimates. This reach is due to the CLAS standards position statement (see details in the Implementation Step) that the Master Consortium adopted as a universal strategy in 2020. The data tables also include planned reach among the prioritized populations based on planned strategies for the prioritized populations. The data sources for those in each community are: Ashtabula County is using billing records from Partner Solutions; Fairfield County is using billing records from the Great Office System Helper (GOSH) and electronic medical records from the jail behavioral health care provider; and Sandusky and Seneca Counties are using Board and provider agency billing records.

**Monitoring the Implementation of the DIS and the Reach of Strategies to Decrease Health Disparities:** The implementation of the DIS and quantification of reach will be led by the Project Director and the Data Coordinator. Data collection tools will be developed in coordination with the Local Project Directors to ensure that the tools meet the needs of local context as well as any federal reporting requirements. Any data collected will be analyzed, reported, and examined primarily at the local level and where feasible and logical at the Master Consortium level to determine progress and barriers associated with achieving the desired outcomes. The Master Consortium is committed to data collection and analysis to assess need and evaluate progress.

**Process for Continuously Collecting the PIMS Demographic Data:** The COP-RCORP Master Consortium has been collecting PIMS data since being awarded two RCORP-Implementation grants in 2019. The Data Coordinator facilitates PIMS data collection through a process using an Excel template. Local Project Directors complete the template, engaging providers and program record data as needed, and then submit it to the Data Coordinator. Incoming data templates are carefully quality-checked, sent back if revisions are needed, and then aggregated for grant reporting. Data sources for the DIS are described above and at the bottom of each data table in Attachment A. Staff in each community (Ashtabula County, Fairfield County, and Sandusky/Seneca Counties) have committed to run quarterly reports for their DIS data to coincide with the PIMS reporting and a cumulative year-end report on Sep 15 for the period of service of Sep 1 to Aug 31.

The Project Directors and Data Coordinator will draw from other state-level partners who have engaged with the COP-RCORP Master Consortium on previous data collection and performance measurement reporting requirements for HRSA and national cross-site evaluations. These partners have access to data (updated annually) related to behavioral health that are not currently public and may produce county-level estimates to evaluate efforts related to the DIS. We will work closely with these partners to get outcome data cross tabulated by priority population whenever feasible and permissible.

**Process for Engaging Priority Populations Experiencing Behavioral Health Disparities:** Members of the COP-RCORP Master Consortium are committed to ensuring that members of the selected priority populations are represented on local consortia membership rosters and on local workgroups. By the end of the grant period, each local consortium will conduct at least one listening session with their prioritized population to better understand the needs of the group and whether strategies to reduce health disparities are working as intended.

# STEP 4–IMPLEMENTATION:

Implement programs, policies, and practices that focus on the identified subpopulation vulnerable to and/or experiencing behavioral health disparities. Describe:

- How you will you engage, support, and communicate with the identified subpopulation throughout implementation
- Your approach for ensuring that evidence-based programs, policies, and practices are adapted and/or tailored to meet the needs of these identified subpopulations
- How each approach (program, policy, or practice) links to an appropriate CLAS standard

| **Ashtabula County: (Substance Abuse Leadership Team)**<br>Ohio University RCORP-BHS (FAIN: G2846290) |
|---|
| **Engage, Support, and Communicate with Stakeholders from the Identified Priority Population:** The Ashtabula County MHRSB Board, the SALT Consortium, and its members are committed to ensuring that community members with low SES are involved with planning and implementing efforts. The local Consortium views this as an ongoing and multi-layered effort which includes encouraging direct participation in the local consortia, workgroup activities, and activities and services to address substance use. |
| **Ensuring EBPPs are Adapted and Tailored:** When carrying out evidence-based programs, policies, and practices under RCORP-funded activities, the prioritized population will be considered and where possible asked about how the EBPPs could be adapted or tailored. All strategies implemented will strive to provide easy-to-understand print and multimedia materials and signage in languages commonly used by populations in the service area. |
| **CLAS Standards Statement:** The Ashtabula County MHRSB Board, along with their local consortia, are committed to providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. They also are committed to conducting ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities. They will ensure that all planned and implemented activities take into consideration the needs of individuals with low SES. |
| **Fairfield County: (Prevention, Advocacy, Recovery, and Treatment Coalition)**<br>Ohio University RCORP-BHS (FAIN: G2846290)<br>Ohio University RCORP-PS (FAIN: H7N45748) |
| **Engage, Support, and Communicate with Stakeholders from the Identified Priority Population:** The Fairfield County ADAMH Board, The Fairfield County P.A.R.T. Coalition, and its members are committed to ensuring that community members with polysubstance use are involved with planning and implementing efforts. The local Coalition views this as an ongoing and multi-layered effort, which includes encouraging direct participation in the local consortia, in workgroup activities, and in activities and services to address substance use. |
| **Ensuring EBPPs are Adapted and Tailored:** The prioritized population will be considered when carrying out all evidence-based programs, policies, and practices under the RCORP- |

| |
|---|
| funded activities and where possible asked about how the EBPPs could be adapted or tailored. All strategies implemented will strive to provide easy-to-understand print and multimedia materials and signage in languages commonly used by populations in the service area. |
| **CLAS Standards Statement:** The Fairfield County ADAMH Board, along with their local consortia, are committed to providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. They also are committed to conducting ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities. They will ensure that all planned and implemented activities take into consideration the needs of individuals in jail with polysubstance use. |
| **Sandusky County: (Sandusky County Health Partners)**<br>PIRE RCORP-PS (FAIN: H7N42563) AND<br>**Seneca County: (Seneca County Opiate Task Force)**<br>Ohio University RCORP-BHS (FAIN: G2846290)<br>PIRE RCORP-PS (FAIN: H7N42563) |
| **Engage, Support, and Communicate with Stakeholders from Identified Priority Population**: Members of the Sandusky County Public Health and the Mental Health and Recovery Services Board of Seneca, Ottawa, Sandusky, and Wyandot Counties, along with their consortia partners, are committed to ensuring that residents with low-SES are involved in implementation efforts. The local consortia in Sandusky and Seneca Counties view this as an ongoing and multi-layered effort, which includes encouraging direct participation in the local consortia, in workgroup activities, and in activities and services to address substance use. |
| **Ensuring EBPPs are Adapted and Tailored**: The prioritized population will be considered when carrying out all evidence-based programs, policies, and practices under the RCORP-funded activities and where possible asked about how EBPPs could be adapted or tailored. |
| **CLAS Standards Statement**: The Sandusky County Public Health and the Mental Health and Recovery Services Board of Seneca, Ottawa, Sandusky, and Wyandot Counties, along with their local consortia, are committed to providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. They also are committed to conducting ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities. They will ensure that all planned and implemented activities take into consideration the needs of individuals with low SES. |

## Enhanced National CLAS Standards:

The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care is a tool to advance health equity, improve quality, and help eliminate health care disparities (*please see Attachment B*).

*Please check* ***two (2)*** *of the CLAS standards listed below appropriate to your identified subpopulation and to the health disparities to which they are vulnerable or experiencing.*

### Principal Standard:

☒ Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs

### Governance, Leadership, and Workforce Standards:

☐ Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resource.

☐ Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area

☐ Educate and train governance, leadership, and workforce in CLA policies and practices on an ongoing basis

### Communication and Language Assistance Standards:

☐ Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

☐ Inform all individuals of the availability of language assistance services clearly and in their preferred language, orally and in writing.

☐ Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided

☐ Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area

### Engagement, Continuous Improvement, and Accountability Standards:

☐ Establish CLA goals, policies, and management accountability and infuse them throughout the organization’s planning and operations

☒ Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities

☐ Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery

☐ Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area

☐ Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness

☐ Create conflict and grievance resolution processes that are CLA to identify, prevent, and resolve conflicts or complaints

☐ Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public

**Describe a plan to ensure adherence to the two (2) identified CLAS standards with the grant program for the provision of effective services. Examples include, but are not limited to:**

- Increasing participation from subpopulations experiencing behavioral health disparities on advisory boards and workgroups
- Developing strategic partnerships and collaborations with the goal of preventing behavioral health disparities among identified subpopulations
- Increasing the capacity and readiness of subrecipient communities to prevent behavioral health disparities among identified subpopulations
- Improving the readability level of educational materials
- Providing materials in a language easily accessible by the community

**Participation from Priority Populations Experiencing Behavioral Health Disparities:** In the listening sessions with the selected priority populations, each local consortium will include questions to ask about how to increase participation in advisory boards and workgroups.

**Developing Strategic Partnerships and Collaborations:** Work to integrate the CLAS standards into the work of the COP-RCORP Consortium has been a key (and ongoing) part of the work accomplished as part of RCORP-Implementation grants GA1RH33529 and GA1RH33532 to address RCORP-Implementation Core Activity Prevention 2. The COP-RCORP Consortium formed a CLAS standards workgroup in January 2020 and chose to break RCORP-I Core Activity P2 into two separate activities—one focused on infusing the CLAS standards into every aspect of the Consortium's work (2a) and one focused on stigma (2b). This reconceptualization allowed the COP-RCORP Consortium better focus on each of the two components of RCORP-Implementation Core Activity Prevention: (#2A) Provide and assess the impact of culturally and linguistically appropriate education to improve family members', caregivers', and the public's understanding of evidence-based treatments and prevention strategies for SUD/OUD [CLAS Standards (Policy/Procedure/Strategy)] and (#2B) to eliminate stigma associated with the disease [stigma].

**Capacity and Readiness of Subrecipient Communities:** Work by the Consortium, through the CLAS standards workgroup, used a learning community approach to focus first on creating a shared and in-depth understanding of the CLAS standards among Master Consortium members. This allowed sharing across the COP-RCORP communities about

opportunities for utilizing the CLAS standards to improve service planning and delivery across the service area. These opportunities led to early wins such adding language translation support to materials and websites. Moreover, this focus on the CLAS standards proved to be essential when the COVID-19 pandemic hit because it informed how each community pivoted their services to respond to the health emergency. COP-RCORP Communities reported that the process of learning about the CLAS standards guided them to look at their communities differently, to gather new sources of information, and to use that information to ensure that harm-reduction, housing, and other services for at-risk and indicated populations were culturally and linguistically appropriate. Local COP-RCORP consortia also engaged in action planning to identify additional ways to integrate the CLAS standards into their work.
This ongoing focus on the CLAS standards by the COP-RCORP Master Consortium CLAS standards workgroup led to the development of a master consortium position statement that was formally adopted by the COP-RCORP Consortium on May 4, 2020. This statement guides all work undertaken by COP-RCORP partners to provide SUD, mental health, and related services in the community service areas and this statement is on the COP-RCORP website and on every COP-RCORP meeting agenda. The approved statement follows below and highlights the commitment of the COP-RCORP Consortium to fully integrate both the principal standard and sub standards into every aspect of its work—at both the master consortium and local consortium levels.

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**Master Consortium Position Statement**
**Culturally and Linguistically Appropriate Services (CLAS)**

May 4, 2020

The COP-RCORP Master Consortium recognizes the importance of utilizing the CLAS Standards when implementing all RCORP OUD/SUD activities and strategic plans in five rural communities in Ohio. We strive to engage in a continuous, data-driven, and collaborative process to address health disparities and promote respectful, responsive, and accessible services. By strengthening our knowledge, skills, and awareness of culturally and linguistically appropriate services, we demonstrate our commitment to enhance health equity across the evolving continuum of care.

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**Readability Level of Educational Materials & Providing Materials in Easily Accessible Language(s):** Since developing the CLAS Standards Position Statement, the COP-RCORP Master Consortium and the local consortia continue to utilize it in all the work that we do. Because incorporation of the entire set CLAS standards is an institutionalized part of how COP-RCORP communities plan, implement, monitor, and improve SUD and related services, a separate action plan is not presented in this section of the DIS. In lieu of a plan, all parties that represent the COP-RCORP Master Consortium reiterate their commitment to ensuring that the CLAS standards guide every aspect of the work of the COP-RCORP Master Consortium and local consortia to operationalize and implement the Core Activities of the RCORP-PS and RCORP-BHS initiatives. This commitment includes ensuring an appropriate readability level of educational materials and that they are made available in easily accessible languages for the identified subpopulations.

## STEP 5–EVALUATION:

Data coordinators should use PIMS and program data to assess process and/or outcomes, with the goal of understanding if the project is having the intended impact on reducing health disparities among the identified subpopulation. Describe:

- How you will involve the identified subpopulation in the assessment process
- How you will use program and PIMS data on access, use, and outcomes to evaluate processes, make programmatic adjustments, and demonstrate your impact on behavioral health disparities experienced by the identified subpopulation
- Other ways that you intend to use programmatic data to demonstrate the impact of your efforts on behavioral health disparities among the identified subpopulation.
- If the strategies you have implemented are resulting in increased access to services for the subpopulation. If so, how, and, if not, why not?

**Process for Engaging Priority Populations Experiencing Behavioral Health Disparities:** Members of the COP-RCORP Master Consortium are committed to ensuring that members of the selected priority populations are represented on local consortia membership rosters and on local workgroups.

**Process for Using Program and PIMS Data in the Evaluation:** The Data Coordinator will analyze the program and PIMS data and put the findings into a community-friendly reporting format and share the data with COP-RCORP local consortia for discussion at the COP-RCORP Master Consortium level and local consortium level. In addition, data is consistent topic of discussion during COP-RCORP Master Consortium meetings. At key reporting periods, the COP-RCORP Master Consortium reviews PIMS and program data, discusses patterns and changes, and considers the implications for ongoing planning, implementation, and evaluation work.

**Other Ways of Using Program Data to Demonstrate Impact:** A comprehensive dissemination strategy is in place to share the impact of the COP-RCORP Master Consortium. The dissemination methods (project website; presentation and local, state, and national meetings and conferences; and journal publications) developed during the RCORP-P and RCORP-I awards will continue with the RCORP-PS and RCORP-BHS awards to support both local consortia as well as the master consortium in sharing project activities, key accomplishments, evaluation results, lessons learned, and success stories. Effective dissemination is critical to the success of the COP-RCORP Initiative as it supports the continued engagement of partners and is essential to demonstrating the community impact of working to address the RCORP-BHS and RCORP-PS Goals.

## STEP 6–CULTURAL COMPETENCE:

Describe how you will ensure that you are implementing each step of the DIS to reflect the culture, needs, and capacity of the subpopulations experiencing behavioral health disparities.

Reducing health disparities and increasing equity in SUD services and behavioral health care is central to the work being undertaken by the COP-RCORP Master Consortium. Cultural competence is foundational to the COP-RCORP Master Consortium's work to reduce disparities because it requires culturally-relevant efforts to engage priority populations in behavioral health care services and culturally-relevant efforts to provide behavioral care services. Culturally competent care respects diversity in the population and acknowledges cultural factors that can affect health and health care, such as language, communication styles, beliefs, attitudes, and behaviors.

Cultural competence will be integrated into the COP-RCORP Master Consortium's work on each of the RCORP-related Core Activities as well as the additional work to address and ameliorate health disparities as outlined in the DIS. Previous sections of this statement also highlight that cultural competence is part of each step of this Disparities Impact Statement. The approaches outlined as part of this DIS include building shared knowledge with the priority population, investing and nurturing relationships with the priority population, implementing culturally-relevant adaptations of programs and strategies, and conducting ongoing assessment to identify areas for improvement, as well as emerging needs of the priority population related to accessing and engaging behavioral health services.

In addition, this work is reinforced by the COP-RCORP Consortium's commitment to the integrating CLAS standards into all aspects of work and the Consortium's CLAS position statement, which has been institutionalized by local consortia and which serves as a reminder that for services to be effective, they must respect and honor cultural diversity both across the COP-RCORP service areas and within the selected priority populations.

# STEP 7–SUSTAINABILITY:

Describe the main barriers to sustainability of services to the identified subpopulation and provide a brief explanation of how you will ensure sustainability of services remains a high priority for this subpopulation. If applicable, grantees can reference their RCORP sustainability plan.

**Barriers to Sustainability:** Two key barriers to sustainability can occur with funded initiatives. The first occurs when local consortia think about programs, policies, and strategies too narrowly. Examples of this mindset emerge when activities are approached as a checklist to be completed or as one-time activities. The second challenge is when local consortia wait to consider how the work that is being funded will continue after the funding period.

**Ensuring Sustainability of Services Remains a High Priority:** As outlined in the proposal for each of the COP-RCORP Master Consortium's RCORP awards:

- RCORP-P [PIRE RCORP-P (FAIN: G25RH32461) and Ohio University RCORP-P (FAIN: G25RH32459],
- RCORP-I, [PIRE RCORP-I (FAIN: GA133529) and Ohio University RCORP-I (FAIN: GA133529],
- RCORP-PS [PIRE RCORP-PS (FAIN: H7N42563) and Ohio University RCORP-PS (FAIN: H7N45748)], and
- RCORP-BHS [Ohio University RCORP-BHS (FAIN: G2846290)],

the COP-RCORP Master Consortium is committed to using a broad and continual approach to sustainability. The COP-RCORP Master Consortium utilizes a research-based Initiative Sustainability Module framework for sustainability planning. The module draws on Mark Moore's Public Value Model,[1] as well as the work of Mancini & Marek[2] and Weiss, Coffman, & Bohan-Baker[3] related to initiative sustainability. This framework brings intentionality to the sustainability process, ensures sustainability goes beyond just funding considerations, and frames sustainability as an opportunity to institutionalize effective efforts. As such, the programs, policies, and strategies that the COP-RCORP Master Consortium implements for the selected priority populations of focus will be considered as an integral part of wider project/initiative sustainability efforts.

[1] Moore, M. H. (1995). *Creating public value: Strategic management in government.* Cambridge, MA: Harvard University Press.
[2] Mancini, J. A., & Marek, L. I. (2004). Sustaining community-based programs for families: Conceptualization and measurement. *Family Relations, 53*, 339-347. doi: 10.1111/j.0197-6664.2004.00040.x
[3] Weiss, H., Coffman, J., & Bohan-Baker, M. (2002). *Evaluation's role in supporting initiative sustainability.* Retrieved from Harvard Kennedy School of Government website: http://www.hks.harvard.edu/urbanpoverty/Urban%20Seminars/December2002/Weiss.pdf

# ATTACHMENT A: DIS REACH TABLE (ASHTABULA COUNTY)

*In the table below,* identify the number of individuals in the subpopulation your strategies will reach during the award period. Identify the data source/tool you will use to gather your data. Categories marked with an asterisk (*) are optional to respond.

| Ashtabula County | Total Population | FY 1 | | FY 2 | | FY 3 | | FY 4 | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Planned | Actual | Planned | Actual | Planned | Actual | Planned | Actual | Planned | Actual |
| Number to Be Reached | 97,337 | 4,003 | Enter # | 8,014 | Enter # | 8,022 | Enter # | 8,022 | Enter # | 28,601 | Enter # |
| ***By Race and Ethnicity*** | | | | | | | | | | | |
| African American | 3,796 | 265 | Enter # | 532 | Enter # | 534 | Enter # | 534 | Enter # | 1,865 | Enter # |
| American Indian/Alaska Native | 389 | 1 | Enter # | 3 | Enter # | 3 | Enter # | 3 | Enter # | 10 | Enter # |
| Asian | 487 | 5 | Enter # | 11 | Enter # | 11 | Enter # | 11 | Enter # | 38 | Enter # |
| White (non-Hispanic) | 86,241 | 3,440 | Enter # | 6,886 | Enter # | 6,887 | Enter # | 6,887 | Enter # | 24,100 | Enter # |
| Hispanic or Latino/a/e | 4,672 | 165 | Enter # | 333 | Enter # | 334 | Enter # | 334 | Enter # | 1,166 | Enter # |
| Native Hawaiian/Other Pacific Islander | 97 | 0 | Enter # | 0 | Enter # | 0 | Enter # | 0 | Enter # | 0 | Enter # |
| *Two or More Races | 2,433 | 0 | Enter # | 0 | Enter # | 0 | Enter # | 0 | Enter # | 0 | Enter # |
| Unknown | 219 | 109 | Enter # | 220 | Enter # | 221 | Enter # | 221 | Enter # | 771 | Enter # |
| ***By Gender Identity*** | | | | | | | | | | | |
| Cisgender Woman, Girl, or Female | 49,447 | 2,199 | Enter # | 4,403 | Enter # | 4,406 | Enter # | 4,406 | Enter # | 15,414 | Enter # |
| Cisgender Man, Boy, or Male | 47,890 | 1,805 | Enter # | 3,614 | Enter # | 3,619 | Enter # | 3,619 | Enter # | 12,657 | Enter # |
| *Transgender Woman, Girl, or Transfeminine (MTF) | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| *Transgender Man, Boy, or Transmasculine (FTM) | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| *Nonbinary, Gender Nonconforming, or Genderfluid | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Two-Spirit | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Intersex | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Other (*Please specify.*) | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |

| Ashtabula County | Total Population | FY 1 | | FY 2 | | FY 3 | | FY 4 | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Planned | Actual | Planned | Actual | Planned | Actual | Planned | Actual | Planned | Actual |
| Unknown | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| ***By Sexual Orientation** | | | | | | | | | | | |
| Heterosexual or Straight | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Lesbian | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Gay | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Bisexual | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| *Same Gender Loving (SGL) | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| *Queer | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| *Asexual | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| *Pansexual | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Other (*Please specify.*) | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Unknown | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |

***Data Source/Tool***

The data on this table come from two sources: 1) As a rural Appalachia Ohio community, Ashtabula County has a total population of 97,337 based on the 2017-2021 ACS 5-year US Census estimates. 2) The planned reach numbers for each year are based on billing records for board services, which Partner Solutions maintains. In FY2022 (July 2021-June 2022), the Ashtabula County Mental Health and Recovery Services Board funded behavioral health services for 8,002 residents with the following racial/ethnicity breakdown: 529 African American, 3 American Indian, 11 Asian, 6,877 White, 331 Hispanic, 32 Other, and 219 Unknown; and the following gender breakdown: 4,396 Cisgender Women/Girl/Female and 3,609 Cisgender Men/Boy/Male. For FY1, the planned reach is based on six months of service (Mar 1 to Aug 31) and an incremental increase in numbers served. FY2, FY3, and FY4 represent planned reach for 12-month time periods that parallel the grant fiscal year cycle of Sep 1 as the start to Aug 31 of the following year as the end. Cumulative year-end data will be pulled on Sept 15. NOTE: The planned numbers are based on current Medicaid coverage. Redeterminations in the program could cause a change in how the Ashtabula MHRSB board is able to cover services.

# ATTACHMENT A: DIS REACH TABLE (FAIRFIELD COUNTY)

*In the table below,* identify the number of individuals in the subpopulation your strategies will reach during the award period. Identify the data source/tool you will use to gather your data. Categories marked with an asterisk (*) are optional to respond.

| Fairfield County | Total Population | FY 1 | | FY 2 | | FY 3 | | FY 4 | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Planned | Actual | Planned | Actual | Planned | Actual | Planned | Actual | Planned | Actual |
| Number to Be Reached | 114,778 | 179 | Enter # | 454 | Enter # | 454 | Enter # | 454 | Enter # | 1,541 | Enter # |
| ***By Race and Ethnicity*** | | | | | | | | | | | |
| African American | 3,781 | 5 | Enter # | 12 | Enter # | 12 | Enter # | 12 | Enter # | 41 | Enter # |
| American Indian/Alaska Native | 119 | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Asian | 4,902 | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| White (non-Hispanic) | 98,361 | 174 | Enter # | 442 | Enter # | 442 | Enter # | 442 | Enter # | 1,500 | Enter # |
| Hispanic or Latino/a/e | 3,720 | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Native Hawaiian/Other Pacific Islander | 131 | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| *Two or More Races | 4,869 | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Unknown | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| ***By Gender Identity*** | | | | | | | | | | | |
| Cisgender Woman, Girl, or Female | 56,880 | 65 | Enter # | 163 | Enter # | 163 | Enter # | 163 | Enter # | 554 | Enter # |
| Cisgender Man, Boy, or Male | 57,898 | 114 | Enter # | 291 | Enter # | 291 | Enter # | 291 | Enter # | 987 | Enter # |
| *Transgender Woman, Girl, or Transfeminine (MTF) | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| *Transgender Man, Boy, or Transmasculine (FTM) | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| *Nonbinary, Gender Nonconforming, or Genderfluid | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Two-Spirit | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Intersex | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Other (*Please specify.*) | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |

| Fairfield County | Total Population | FY 1 | | FY 2 | | FY 3 | | FY 4 | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Planned | Actual | Planned | Actual | Planned | Actual | Planned | Actual | Planned | Actual |
| Unknown | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| ***By Sexual Orientation** | | | | | | | | | | | |
| Heterosexual or Straight | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Lesbian | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Gay | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Bisexual | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| *Same Gender Loving (SGL) | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| *Queer | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| *Asexual | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| *Pansexual | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Other (*Please specify.*) | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Unknown | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |

***Data Source/Tool***

The data on this table come from two sources: 1) As a partially rural Appalachia Ohio community, Fairfield County has a total population of 161,064 based on the 2017-2021 ACS 5-year US Census estimates. The total rural population of 114,778 is calculated from five zip codes (43017, 43112, 43130, 43148, 43150, and 43155). 2) The planned reach numbers for each year are based on board billing records from the Great Office System Helper (GOSH). For FY1, the planned reach is based on six months of service (Mar 1 to Aug 31) and an incremental increase in numbers served. FY2, FY3, and FY4 represent planned reach for 12-month time periods that parallel the grant fiscal year cycle of Sep 1 as the start to Aug 31 of the following year as the end. Cumulative year-end data will be pulled on Sept 15. NOTE: The planned numbers are based on current Medicaid coverage. Redeterminations in the program could cause a change in how the Fairfield County ADAMH Board is able to cover services. This data will be supplemented if needed by electronic health records data from the service provider funded by the Board.

# ATTACHMENT A: DIS REACH TABLE (SANDUSKY & SENECA COUNTIES)

*In the table below,* identify the number of individuals in the subpopulation your strategies will reach during the award period. Identify the data source/tool you will use to gather your data. Categories marked with an asterisk (*) are optional to respond.

| Sandusky & Seneca Counties | Total Population | FY 1 | | FY 2 | | FY 3 | | FY 4 | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Planned | Actual | Planned | Actual | Planned | Actual | Planned | Actual | Planned | Actual |
| Number to Be Reached | 109,710 | 542 | 653 | 541 | Enter # | 541 | Enter # | 541 | Enter # | 2,165 | Enter # |
| ***By Race and Ethnicity*** | | | | | | | | | | | |
| African American | 2,968 | 16 | 34 | 16 | Enter # | 17 | Enter # | 17 | Enter # | 66 | Enter # |
| American Indian/Alaska Native | 269 | 0 | 0 | 0 | Enter # | 0 | Enter # | 0 | Enter # | 0 | Enter # |
| Asian | 535 | 6 | 2 | 6 | Enter # | 6 | Enter # | 6 | Enter # | 24 | Enter # |
| White (non-Hispanic) | 101,845 | 498 | 504 | 498 | Enter # | 499 | Enter # | 499 | Enter # | 1,994 | Enter # |
| Hispanic or Latino/a/e | 8,289 | 41 | 51 | 40 | Enter # | 41 | Enter # | 41 | Enter # | 163 | Enter # |
| Native Hawaiian/Other Pacific Islander | 12 | 0 | 0 | Enter # | Enter # | 0 | Enter # | 0 | Enter # | 0 | Enter # |
| *Two or More Races | 2,482 | 0 | 62 | Enter # | Enter # | 0 | Enter # | 0 | Enter # | 0 | Enter # |
| Unknown | Enter # | 0 | 0 | Enter # | Enter # | 0 | Enter # | 0 | Enter # | 0 | Enter # |
| ***By Gender Identity*** | | | | | | | | | | | |
| Cisgender Woman, Girl, or Female | 54,992 | 270 | 274 | 271 | Enter # | 270 | Enter # | 270 | Enter # | 1,081 | Enter # |
| Cisgender Man, Boy, or Male | 54,718 | 271 | 274 | 272 | Enter # | 271 | Enter # | 271 | Enter # | 1,085 | Enter # |
| *Transgender Woman, Girl, or Transfeminine (MTF) | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| *Transgender Man, Boy, or Transmasculine (FTM) | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| *Nonbinary, Gender Nonconforming, or Genderfluid | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Two-Spirit | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Intersex | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Other (*Please specify.*) | Enter # | 0 | 105 | 0 | Enter # | 0 | Enter # | 0 | Enter # | 0 | Enter # |

| Sandusky & Seneca Counties | Total Population | FY 1 | | FY 2 | | FY 3 | | FY 4 | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Planned | Actual | Planned | Actual | Planned | Actual | Planned | Actual | Planned | Actual |
| Unknown | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| ***By Sexual Orientation** | | | | | | | | | | | |
| Heterosexual or Straight | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Lesbian | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Gay | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Bisexual | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| *Same Gender Loving (SGL) | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| *Queer | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| *Asexual | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| *Pansexual | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Other (*Please specify.*) | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |
| Unknown | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # | Enter # |

***Data Source/Tool***

Actual numbers from service records. Numbers may not total consistently across race/gender categories due to item non-response in service records. Projected service estimates above were derived from U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates for percent in poverty and from Census data on psychostimulant prevalence in Seneca and Sandusky Counties. Reach in the grant service area of Seneca and Sandusky Counties will be tracked through service provision record data for publicly supported services collected by the Mental Health and Recovery Services Board of Seneca, Ottawa, Sandusky, and Wyandot Counties for reimbursement from OhioMHAS. These data will be supplemented if needed by service provision record data from partners funded by the Board, such as school districts.

# Attachment B: Enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS)

## National CLAS Standards in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

### Principal Standard:

**1.** Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs

### Governance, Leadership, and Workforce Standards:

**2.** Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources
**3.** Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area
**4.** Educate and train governance, leadership, and workforce in CLA policies and practices on an ongoing basis

### Communication and Language Assistance Standards:

**5.** Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services
**6.** Inform all individuals of the availability of language assistance services clearly and in their preferred language, orally and in writing
**7.** Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided
**8.** Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area

### Engagement, Continuous Improvement, and Accountability Standards:

**9.** Establish CLA appropriate goals, policies, and management accountability and infuse them throughout the organization's planning and operations
**10.** Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities
**11.** Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness
14. Create conflict and grievance resolution processes that are CLA to identify, prevent, and resolve conflicts or complaints
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public

## Think Cultural Health

**Website:** https://www.thinkculturalhealth.hhs.gov/

**Email:** contact@thinkculturalhealth.hhs.gov