

Finding the Right Data to Identify Disparities:

A Case Study from Chinatown Service Center

Background

Chinatown Service Center (CSC) was founded in 1971, to help recent Chinese immigrants navigate the local and national systems for visas, citizenship, insurance, housing, and legal issues. It started as a small organization operating from a church in downtown Los Angeles. Over time, services broadened to include the larger Asian immigrant, Asian American, and Pacific Islander (AAPI) communities at five locations. Eventually, CSC became a Certified Community Behavioral Health Clinic (CCBHC) supported by a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA).

As a SAMHSA grantee, they were required to develop a Behavioral Health Disparity Impact Statement (DIS) which is a data-driven, quality improvement approach to advance equity by identifying the populations at highest risk for experiencing behavioral health disparities. The DIS requires grantees to describe the disparities in their population of focus and the actions they plan to take to address the identified gaps.

The Problem

CSC used national and state data sets which included the demographic characteristics of their catchment area to develop their DIS. The DIS reflected their intention to serve Asian Americans and Pacific Islanders, Hispanic, White, and Black/African Americans. The DIS they submitted included characteristics of the general population in their catchment area rather than the specific population that CSC serves in their local demographic of Chinatown. As their Government Program Officer (GPO) explained, “It was a generalized DIS.” This limited their ability to point to where the disparity was occurring in access, use, or health outcomes within the AAPI communities.

In ongoing conversations with the GPO about the DIS, the CSC behavioral health director reflected, “We initially saw it as a needs assessment, but then started to see it as a huge benefit to the community because it is asking about an under-resourced population.”

It was the communities’ reaction to the mass shooting in Monterey Park during Lunar New Year celebrations that highlighted the need for them to examine behavioral health needs *within* the AAPI communities and to deliver relevant and culturally specific services. This led to many questions about the extent they were meeting the diversity of needs within the community, whether services were appropriate, and what the *behavioral health and health outcomes* were among the AAPI populations.

CSC reasoned that answering these types of questions could help them shed light on disparities, or gaps, to identify where services could be improved for the communities they serve.

The Solution

The curiosity around these questions led CSC staff to ask their GPO if they could revise their DIS and use grant funding to collect the missing data within the communities they serve. After explaining the context to their GPO, their request to collect data by specific ethnic identities within the communities was approved.

As the behavioral health director of CSC explained, “Data collection from a behavioral health service organization didn't always occur. Even though we had client data, I don't think comparisons were being made using that data. The DIS sparked intriguing questions such as: ‘What kind of data should we be collecting? What data will be helpful for us as we move forward?’ We asked these questions because we do see the importance of having these different data that are being requested from us.”

In addition, the data collected within their own community would allow them to have data specific to the geographic boundaries of the area CSC serves, given that the available data sets did not exactly match the program's service area boundaries.

The Results

The revised DIS identified specific populations that experience disparate behavioral health access, use and outcomes within the local AAPI communities (i.e., Chinese, Korean, Filipino, Japanese, Taiwanese, and Vietnamese). CSC also used the data to create estimates for their target reach to the different communities in each year of the grant.

Examination of their data also motivated CSC to address the stigma of substance use when collecting data. For example, the national statistics on tobacco use among the AAPI population is low, and CSC knew from working with their clients that tobacco use is a substance widely used in the communities. However, due to social stigma, self-report of its use is low. This led to questions of how valid the national data sets are regarding the use of tobacco within AAPI communities.

“The completion of the DIS sparked a lot of ideas on how we could provide and use the data to create more services. We wanted to have a better understanding of the community needs and where we could provide more focused services where there was a gap or need.” -- Behavioral Health Director, CSC

Completing the DIS inspired CSC to seek out and use appropriate data to improve the responsiveness of their services. This involved the development of a data collection plan to yield valid and reliable data, implementation of a community wide data collection strategy, and the formation of an advisory board whose members includes peers, clients, and CSC staff. The advisory board has branched into a community project, and the board is proposing to conduct outreach to individuals in the community to increase their receptivity to mental health services.

Lessons From the Field

- ❖ It is essential to have data broken out by subpopulations to identify where disparities in access, use, and health outcomes exist.
- ❖ Although national and state data sets are informative as a starting place to understand disparities in communities, grantees may find they need to supplement existing data to have the information that is meaningful to the communities they serve.
- ❖ Grantees can identify and address barriers, such as the social determinants of health and structural discrimination, to minimize disparities in access and use of services. Organizations can help end disparities to achieve behavioral health equity.
- ❖ Both grantees and GPOs are striving to make progress toward behavioral health equity. The relationship between the GPO and grantee is very important in developing the DIS. It is within the meetings with GPOs that grantees can discuss their context, challenges, and ideas. They can collaborate to bring innovative ideas to life.
- ❖ It doesn't hurt to ask! SAMHSA appreciates grantees' curiosity and pursuit of data to identify disparities, with the end goal being to bring about improved health equity through the work of their grantees. Grantees know their communities and can seek the information they need to answer questions about disparities. GPOs are interested in ideas generated by grantees.

“One of the things that we found helpful in the beginning is providing the GPO information not just about our organization, but also the geographic area that we're providing services to and what that looks like, whether it's the population or how it's being divided, or even going as far down as transportation. Depending on the geographic area that we serve, clients can experience the transportation systems differently. We find it helpful to provide the GPO information in terms of our location, the population we serve, and the history.” -- Behavioral Health Director, CSC

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