

SAMHSA Disparity Impact Statement Services Example

Purpose

SAMHSA requires that its grant recipients prepare a Behavioral Health Disparity Impact Statement (DIS) as part of a data-driven, quality improvement approach to advance equity for all, and to identify racial, ethnic, sexual and gender minority populations at highest risk for experiencing behavioral health disparities as part of their grant projects. The purpose of the DIS is for recipients to identify, contextualize and address disparities¹ and to develop and implement a disparity reduction action plan with a quality improvement process to address and close the identified gap(s). The aim is to achieve behavioral health equity² for disparate populations and to improve systems addressing the needs of these populations. The DIS requirement aligns with expectations outlined in [Presidential Executive Order 13985: Advancing Racial Equity and Support for Underserved Communities Through the Federal Government](#), which includes identifying the needs of underserved communities and developing policies to advance (health) equity within those communities.

Background

To address behavioral health disparities, it is important to understand the role that Social Determinants of Health (SDOH)³ can have on the health of individuals and communities. SDOH are the conditions in the environment where people are born, live, work, play, worship, age and thrive that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH can be grouped into 5 domains: 1) Economic Stability; 2) Education Access and Quality; 3) Healthcare Access and Quality; 4) Neighborhood and Built Environment; and 5) Social and Community Context. The SDOH framework recognizes that cross-sectoral systems contribute to advancing equity through a lifespan perspective. Understanding the SDOH community context can help recipients identify the disparity (or problem), population of focus and inform the development of accurate measures to study and improve outcomes.

¹ Healthy People 2030 defines a health disparity as a “particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; disability; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”

² Behavioral health equity is the right to access high quality and affordable health care services and supports for all populations regardless of the individual’s race, age, ethnicity, gender (including gender identity), disability, socioeconomic status, sexual orientation, or geographical location. Advancing behavioral health equity involves ensuring that everyone has a fair and just opportunity to be as healthy as possible. In conjunction with quality services, this involves addressing social determinants of health, such as employment and housing stability, insurance status, proximity to services, and culturally responsive care – all of which have an impact on behavioral health outcomes.

³ <https://www.cdc.gov/socialdeterminants/index.htm>

The purpose of this document is to support recipients in developing measures associated with DIS. All of SAMHSA's discretionary grants are required to report Government Performance and Results Act (GPRA)⁴ data, which includes the National Outcome Measures (NOMS). Grant programs using the NOMS client-level outcomes tool uses data collected that includes demographics⁵, ICD-10 diagnostic categories, substance use and abuse, mental health and physical health functioning and other variables. There are limitations to the categories regarding certain race, ethnicity, language, and disability. For some grant programs that are collecting Infrastructure, Prevention and Promotion (IPP) indicators, demographic data are collected, but are not housed within SAMHSA's Performance Accountability and Reliability System (SPARS).

Despite these limitations, the DIS can be used to identify and demonstrate the impact of SAMHSA's investments to reduce and eliminate inequities among underserved populations. By developing the DIS, recipients will identify the population experiencing the disparity, share more specific population data that will assist in determining if SAMHSA's grant investments are reducing disparities, use data to more precisely direct resources to improve the SDOH and CLAS while moving towards outcomes that will reduce disparities among the population(s) noted.

For recipients serving distinct populations (i.e., tribes, etc.), disparities within these populations can be identified (e.g., age, gender identity, sexual orientation, disability).

As recipients collaborate within their respective organizations to complete this DIS, we hope that it will inspire and guide an approach to reducing and eliminating behavioral health disparities for the populations being served. In the following pages the modernized SAMHSA Behavioral Health Disparity Impact Statement is included as a worksheet to support completion by the recipient.

Resources, guidance, and training to support recipients in completing the DIS can be found here <https://www.samhsa.gov/grants/grants-management/disparity-impact-statement>; see also accompanying Appendices).

⁴ <https://www.samhsa.gov/grants/gpra-measurement-tools>

⁵ <https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=53>

Disparity Impact Statement Worksheet Services Example

Grantee Organization Name: ABC Community Behavioral Health Center

Grant ID (SM/TI/SP/FG): SMXXXXXX

Grant Program: Certified Community Behavioral Health Clinics-Expansion (CCBHC-Es) - **Note: this is an example and NOT a reflection of an actual CCBHC-E grantee or program.*

Project Director: Jane Doe

Grant Project Officer: Tyler Brown

SECTION I. Identifying Behavioral Health Disparities

IDENTIFY and DESCRIBE THE SCOPE of the PROBLEM

What is the disparity/problem/gap you are seeking to address as it relates to the grant program?

What is the data to support this (e.g. [SAMHSA National Survey on Drug Use and Health \(NSDUH\)](#), [CDC and OMH Minority Health Social Vulnerability Index \(SVI\)](#), [CDC/ATSDR Social Vulnerability Index \(SVI\)](#), [CDC Behavioral Risk Factor Surveillance System](#), [CDC Youth Risk Behavioral Surveillance System](#), [AHRQ National Healthcare Quality Disparities Report \(NHQRDR\)](#), [U.S. Census Bureau Data](#), [U.S. Census Bureau American Community Survey \(ACS\)](#), [Federal Register Annual Update of the HHS Poverty Guidelines](#), [CMS Informational Bulletin on 2022 Federal Poverty Level Standards](#), other federal, state, or county level data.

Note: You may frame the disparity(ies) by looking at the individual/client level, organizational level, and/or systemic level.

ABC Community Behavioral Health Center has multiple sites throughout the **state of Maroon**. We have 2 sites, one in **Cerulean County** (which includes the **city** of Sunshine) and one in **Lavender County** (predominantly **rural**). Sunshine is one of the largest cities in Maroon.

In Maroon, the annual average prevalence with Serious Mental Illness (SMI) among adults 18 and older was 4% (or 391,000), which is lower than the national average (4.8%) from 2017-2019 (NSDUH, 2020). For adults 18 and older with any mental illness (AMI) who received services in the past year increased between 2008-2010 and 2017-2019. During 2017-2019, the annual average prevalence of past-year mental health service use in Maroon among adults with AMI was 46.4% (or 827,000), which is close to the national average of 43.6%. The rates of opioid use disorders among people aged 12 and older was 0.5% (57,000), lower than the national average (0.7%). However, in Cerulean County, the rate is 0.8%, which is higher than the national average. In Lavender County, the rate is the same at 0.7% (NSDUH, 2020).

In Cerulean County (especially in the city of Sunshine), African American young adults, ages 18-25, especially among women, have a higher rate of opioid overdose compared to all other groups in these areas, which has increased during COVID compared to pre-COVID years. In Lavender County, where it is primarily rural, among White, the rate of receiving services have also decreased and the suicide rate, especially gun deaths have increased.

Other factors include the number of clients to the number of mental health providers at approximately 700:1 in Cerulean County and 500:1 in Lavender County, compared to 370:1 for the state of Maroon.

Per the requirements of the CCBHC NOFO, we completed a CCBHC Needs Assessment (as required in CCBHC Certification Criteria 1.A). Findings from the CCBHC Community Needs Assessment conducted last year per the CCBHC Certification Criteria Requirements showed that accessibility of services presented a significant impediment to services such as crisis and urgent care services. Factor impeding access included lack of transportation, lack of sufficient SUD Crisis Beds, and limited mobile crisis response services. In addition, the Needs Assessment for Cerulean County identified the barriers related to staffing and the lack of diversity representing the African American population being served. Feedback indicated that community outreach and engagement, as well as clinical and recovery support services were not always viewed as culturally responsive.

DISPARATE POPULATION(S) OF FOCUS

Identify the focus population(s) experiencing disparate access, use, and outcomes and that experience adverse SDOH with impact to behavioral health in your geographic/catchment area.

Identify data source(s) that you are using to inform the DIS for the grant program. *Grant recipients must select sound and reliable source(s) of programmatic, county, state, or national indicators the program deems best suited to the needs of this grant. Recipients may consider the same data sources listed above (e.g., ACS, NHQDR, SVI, NSDUH). The data referenced within the DIS should be in alignment with the data provided in your application.*

**Note: For client level data, SDOH Z-codes are available and can be used to collect data on disparities. It is recommended to use SDOH Z-codes more broadly and beyond the billing environment to support data collection on available determinants. For more information on SDOH Z-codes and how they are being used to narrow health disparities, please see <https://www.cms.gov/files/document/zcodesinfographic.pdf>; <https://www.cms.gov/files/document/cms-omh-january2020-zcode-data-highlightpdf.pdf>; and <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6207437/pdf/18-095.pdf>.*

Demographic Table

For the overall demographics for both counties are as follows:

- White: 58% in Cerulean County; 75% in Lavender County
- **African American: 35% in Cerulean County; 15% in Lavender County**
- Hispanic/Latino: 5%, number XX in Cerulean County; 9% in Lavender County
- Other (Asian American, Alaska Native/American Indian, Mixed race. Etc.): 2% Cerulean County; 1%, in Lavender County

ABC CMHC, historically, serves on average 3000 people a year across both locations. For this new CCBHC-E grant program, we plan to serve 600 unduplicated individuals across both sites over the entire project period per our application. In Cerulean County, our goal is to serve 350 unduplicated persons at this location. In Lavender County, our goal is to serve 250 unduplicated persons at this location.

We will increase the number of African Americans served from 27% to 35% (95 to 123) in Cerulean County and from 12% to 15% (30 to 38) in Lavender County across the entire grant period.

Historically at these two sites, **27% of our clients are African Americans at the Cerulean County site and 12% are served at the Lavender County site**, which are less than the county demographics. To increase access to mental health and substance use services, ABC CMHC will use the CCBHC-E grant to hire more providers to provide these services.

Please see the following demographics (please refer to the table in Appendix for more details).

Using grant activities, we will increase the number of screenings for mental health, substance use, and suicide risk for African American young women ages 18-25 by 5% [*Note: please determine the numbers XX or X% for your grant, this is just an example*] and the number of referrals to appropriate services by 5%. For Lavender, we will provide training to our staff on crisis services, suicide risk, and NARCAN. We will also increase depression and suicide risk screenings in Lavender by 5%. We will also be providing outpatient mental health and substance use services and targeted case management in Lavender among high-risk individuals. All of the required CCBHC-E required services will be provided at both locations but these specific ones will be implemented and monitored to focus on addressing the gaps.

Total (2 Sites Together)

	Year 1	Year 2	Year 3	Year 4	Totals	
Non-duplicated served	205	160	135	100	600	
Active # of Individuals to Be Served Per Year (can include duplicates) – <i>if applicable</i>	200	250	250	150	850	
By Race	Year 1	Year 2	Year 3	Year 4	Totals	Breakdown by Percentage
White	147	114	97	68	426	71.0%
Black or African American	49	43	37	32	161	26.83%
Multiracial	3	2	1	0	6	1.00%
American Indian/Alaska Native	2	0	0	0	2	0.33%
Asian	2	1	0	0	3	0.50%
Native Hawaiian or Other Pacific Islander	2	0	0	0	2	0.33%
Total	205	160	135	100	600	100%

Ethnicity	Year 1	Year 2	Year 3	Year 4	Totals	Breakdown by Percentage
Non-Hispanic	191	149	124	90	554	92.33%
Hispanic	14	11	11	10	46	7.67%
Total	205	160	135	100	600	100%

Gender	Year 1	Year 2	Year 3	Year 4	Totals	Breakdown by Percentage
Male	97	58	49	38	242	40.33%
Female	106	98	83	61	348	58.00%
Transgender	2	4	3	1	10	1.67%
Total	205	160	135	100	600	100%

Sexual Orientation	Year 1	Year 2	Year 3	Year 4	Totals	Breakdown by Percentage
Heterosexual	196	153	129	94	572	95.33%
Lesbian	3	1	2	2	8	1.33%
Gay	1	3	1	2	7	1.17%
Bisexual	5	3	3	2	13	2.17%
Total	199	154	131	96	600	100%

SECTION II. Addressing Disparities Using the Funding Opportunity

SOCIAL DETERMINANTS OF HEALTH⁶

Identify one or more SDOH domain(s) that your organization will work to address and improve for the identified population(s) of focus using the Notice of Award (NOA). Include a brief explanation about how your organization will address the specific domain(s) to support the reduction or elimination of disparities for the identified population.

Social Determinant of Health Domains

(Visit [Healthy People 2030](https://www.healthypeople.gov/2030) for more information on the five (5) domains.)

1. Education and Quality
2. Economic Stability
3. Health Care Access and Quality
4. Neighborhood and Built Environment
5. Social and Community Context

⁶ <https://www.ruralhealthinfo.org/toolkits/sdoh>

Our grant activities will address the SDOH domains of Economic Stability, Health Care Access and Quality, Neighborhood and Built Environment, and Social and Community Context.

The rates of violent crime and income inequality are all slightly higher than the state average. For social isolation and social trust, the rate is 9.9 in the state and Cerulean County is 15.7 and 10.9 in Lavender County for the social isolation and social trust, which is a predictor of health outcomes (Robert Wood Johnson, County Health Rankings Report, 2022).

In Sunshine City in Cerulean County, we developed a community health improvement plan that is divided by urban, suburban, and rural regions. Per the required activities for the CCBHC-E grant program, we will increase the access to mental health and substance use services and improve outcomes within our catchment areas by hiring 5 integrated care staff, 2 of whom are substance use providers, 2 are mental health clinicians and 1 is a peer support specialist or recovery support specialist. We will recruit staff who are representative of the communities and people we serve. We will also partner with local community-based organizations, food banks, places of worship, schools, law enforcement agencies, hospitals, etc. to ensure appropriate referrals and resources can be made for our clients.

We will develop a DEI Advisory Committee to develop recommendations that address the gaps in workforce diversity and cultural competence workforce training and other development activities. The program will also develop a strategic plan for adding a harm reduction site to mitigate Opioid deaths while working to further engage community members in services.

For Lavender County, the program will dedicate grant resources to expanding capacity of our mobile crisis teams and to further developing partnerships with SUD crisis beds. The grant will also develop a plan for addressing transportation barriers, including enhanced use of telehealth and provision of resources to clients that enable participation in telehealth, as well as the use of ride share services for medical appointments, and connection to peer support services, including warmlines.

Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care⁷

Using the Behavioral Health Implementation Guide, identify one or more of the CLAS standards (listed below) that your organization plans to meet, expand, or improve through this grant opportunity. Include an explanation on any activities, policies, and procedures that your organization will undertake to ensure adherence.

(Review the [Behavioral Health Implementation Guide](#) for full explanations of the overarching themes and 15 CLAS Standards with behavioral health related samples, strategies, and examples.)

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

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.

⁷ https://www.minorityhealth.hhs.gov/minority-mental-health/clas/?utm_medium=email&utm_source=govdelivery

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency (LEP) 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, verbally 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

9. Establish culturally and linguistically 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 culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all partners, constituents, and the general public.

- 1) Hire clinical staff who are from the communities of the populations being served.
- 2) Create treatment plans and medications for non-English proficient individuals in language (e.g. Spanish, Mandarin, American sign language, etc.)
- 3) Create health information materials for individuals with low health literacy.
- 4) Ensure that board members include representatives from the community, persons with lived experience, and family members who are active decision makers.
- 5) Proactively engage the community via the community needs assessment process as required for CCBHC Certification.
- 6) Expand peer support services that are reflective of and imbedded in the community.
- 7) Expand community partnerships aligned with the CCBHC Certification Criteria requirements and that are responsive to the gaps identified in the Community Needs Assessment.
- 8) Ensure that clinic hours and services are available at times and in locations that meet the community needs.

This final section of the DIS is to help you develop and implement a disparity reducing quality improvement plan as part of your DIS to address under-served population differences based on the (GPRA) data for access, use and outcomes of activities.

For example:

- Access: number of individuals served, number of outreach contacts, number of screenings, number of referrals.
- Use: number of screenings, number of referrals, retention rate, number of trainings.
- Outcomes: number of completed referrals, number of people trained, number and percentage of individuals who have demonstrated improvement in knowledge/attitudes/beliefs, number of programs/organizations/communities that implemented specific behavioral health practices or evidence-based activities.

Include activities as they relate to both the grant requirements and your application. Also mention the identified gaps, disparate/population(s) of focus, and subpopulations listed above. Be prepared to provide at a minimum, an annual update on the disparity reducing quality improvement plan (what worked, what did not work, and what modifications were made) as part of the programmatic progress reports per the NOFO. The DIS should be viewed as a living document.

IMPLEMENTATION OF ACTIVITY

Based on the responses above, identify specifically how you will address these disparities and the populations' needs with the required activities from the NOFO and within your application (using the SMART goals). Using the SMART goals, your application should be aligned with the DIS. Be sure to answer the following: What can your grant program activities do to address the disparity/ies? Address access, use, and outcomes (see Appendix C). How will you implement these activities? Who will be responsible to do so? How will you include client/peer/family/friends' voices in your program activities?

Please describe the activities that you will implement.

In Cerulean County and Lavender County, we will:

- Increase the number of screenings and referrals for trauma, mental health, substance use, and suicide risk for African American women by 5%.
- Increase the number of screenings and referrals for trauma, mental health, substance use, and suicide risk for residents of Lavender County by 5%. We will also focus on identifying signs of depression and suicide risk and address access to lethal weapons for staff training.
- Build and maintain least 3 partnerships in each county that will better support the needs of the populations to be served across the entire project period. We will offer peer and family support services.
- Review policies, procedures, and workforce as they relate to providing crisis services to improve response time and provide culturally appropriate services and care on a quarterly basis.

INTENDED OUTCOMES AND IMPACT

How will these activities improve the problem or close the disparity? How will you identify and outreach to the identified population(s) of focus in your catchment area?

(Intended outcomes and impact should be directly related to your goals and objectives.)

Through the implementation of the activities mentioned above, our intended goals and impact are to:

- Increased access to and use of mental health and substance use services in both counties to improve the provider to persons served ratio and better overall behavioral health outcomes.
- Increased number of suicide screenings and crisis interventions services with the goal of decreasing deaths by suicide.
- Increased distribution of fentanyl test strips and Nalaxone kits with the goal of reducing opioid deaths.

CLIENT/PEER/PARTNER INVOLVEMENT

How will you include client/peer and family voices and other relevant partners in your program's activities based on the identified population of focus?

Per the CCBHC Community Needs Assessment, we will engage consumers/family members and also provide enhanced training on person-/family-centered planning (per the CCBHC Certification criteria requirements). We will be hiring at least one peer support and a recovery support specialist from the community to be part of the integrated care team for the CCBHC-E grant at ABC CMHC. Clinical supervision and training will be provided to the peer specialist and recovery support specialist. In addition, the rest of the clinical staff working with peer specialist and recovery support specialist will be educating about the roles of these peer job roles. We will also ensure that appropriate Board representation and decision-making will involve peers and family members. Peers and recovery support specialists will also be part of community engagement and outreach.

TIMELINE

When will you implement these activities? How often will they be reviewed and adjusted? (Recipient should follow NOFO specific NOMs data collection timelines with DIS reporting updates.)

Per the NOFO, the implementation of activities will begin no later than 4 months of the grant award date. We will have hired our full clinical team and will begin providing trainings throughout the year, at least once a quarter. Enrolling clients and providing screenings and referrals will occur regularly in real time, throughout the project period.

MEASUREMENT/ EVALUATION

How will you measure your process, progress, and outcomes to show you were able to improve disparities (i.e., close the gap) within the identified population(s) of focus? How will you measure incremental progress achieved under this award? You should link measurement⁸ and evaluation

to goals and objectives submitted you're your application and as noted earlier in the DIS. Please refer to Appendix D for additional resources.

SUSTAINABILITY

What changes will your organization make to enable sustainability and continue the process to improve disparities? (e.g., policies, financing, budget, training, systems, environmental changes) What external systems exist that can support sustainability efforts? (e.g., Local organizations adopting service priorities to support progress made under this award, partnerships with other community organizations, etc.)

We use the CMHS National Outcome Measures – Client Level Tool in SPARS, which is administered at baseline, every 6 months, and discharge. This is conducted and collected in real time. In the NOMS questionnaire, demographic information and questions that focus on the SDOH domains are collected and updated every six months until discharge.

We also collect and report on the Infrastructure, Prevention, and Promotion Indicators (IPP) every quarter in SPARS. For the IPPs specific to the DIS, we report on WD2 (workforce development – number of staff trained in mental health or substance use interventions); S1 (number of screenings); AC1 (percent based on the number of referrals made and number of referrals completed where the client is seen).

Our evaluator will run monthly reports and present at bi-weekly staff meetings to the integrated care team to provide updates and progress on these activities. As part of the quality improvement process, we will present to agency leadership twice year on the progress for feedback.

We will also provide an update in our required programmatic progress reports to the GPO per the NoA.

ABC CMHC has strong relationships with our local hospital systems in both counties and they have supported our activities as they relate to outpatient service referrals post hospitalization for our clients. We also work with other community health providers and law enforcement agencies and created a pilot that will ensure better coordination of care across our partners for sustainability of services.

We can start working with community colleges and local universities to begin recruitment of the workforce by offering field placements, internships, and rotations at the ABC CMHC. We will work with historically black colleges and universities for these opportunities. We will also explore the option of working with the National Health Service Corps to expand the number of providers in our areas.

Our evaluator and project director will analyze our grant program outcomes to demonstrate cost effectiveness and cost savings for the CCBHC-E program. For example, if we can demonstrate increased enrollment of African Americans in both counties compared to the Emergency Department utilization rate over the course of the same time period and what those numbers looked like. We can do the same comparison as it relates to justice-involved individuals. We can highlight these successes and outcomes to various funding sources, including the state, county, and local government.

⁸ Measurement of Health Disparities, Health Inequities, and Social Determinants of Health to Support the Advancement of Health Equity. Journal of Public Health Management and Practice. 2016.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5845853/>