SAMHSA Disparity Impact Statement

Purpose

SAMHSA requires that its grant recipients prepare a Disparity Impact Statement (DIS), which is a data-driven, quality improvement approach to advance equity through grant programs. The DIS helps grantees identify underserved populations at risk of experiencing behavioral health disparities. The aim is to increase inclusion of underserved populations in SAMHSA-funded grants, achieve behavioral health equity[1] for disparity-vulnerable populations, and help systems better meet the needs of these populations.

Background

The purpose of this document is to support grant recipients in developing measures associated with DIS in order to address behavioral health disparities. Toward this end, grant recipients are encouraged to consider the Social Determinants of Health (SDOH)[2] in relation to their work and the role they 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 grant recipients identify, contextualize, and address health disparities within the communities they serve. Namely, grant recipients can identify the specific disparity (or problem) and disparity-vulnerable population(s) to inform the development of accurate measures to study and improve outcomes.

All of SAMHSA's discretionary grants are required to report Government Performance and Results Act (GPRA)[3] data, which includes the National Outcome Measures (NOMS). Grant programs using the NOMS client-level outcomes tool uses data collected that includes demographics, 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).

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[1] 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.

[2] https://www.cdc.gov/socialdeterminants/index.htm

[3] https://www.samhsa.gov/grants/gpra-measurement-tools

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, grant 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 implement the National Standards for Culturally and Linguistically Appropriate Services (CLAS) while moving towards outcomes that will reduce disparities among the population(s) noted.

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

As grant 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, a worksheet is included to support grant recipients.

Additional 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).

Disparity Impact Statement Worksheet

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? Are there additional community studies and organizational administrative and utilization data?
Note: You may frame the disparity(ies) by looking at the individual/client level, organizational level, and/or systemic level.

DISPARITY-VULNERABLE POPULATION(S)

Identify the population(s) experiencing disparate access, use, and/or 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/zcodes-infographic.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

Complete a table that provides a breakdown of the demographic details for the actual or projected number of persons served/reached/trained by the grant as indicated in the application. The table should be presented by the grant reporting period (i.e., annually) and include percentages of the total population served by the grant (Please see the example).

SECTION II. Addressing Disparities Using the Funding Opportunity

SOCIAL DETERMINANTS OF HEALTH[4]

Identify one or more SDOH domain(s) that your organization will work to address and improve for the disparity-vulnerable population(s) 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 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

[4] https://www.ruralhealthinfo.org/toolkits/sdoh

Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care [5]

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.
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.

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

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.

SECTION III. Developing a Disparity Reduction Quality Improvement Plan

This final section of the DIS addresses development and implementation of 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, disparity-vulnerable population(s), and subpopulations listed above. As part of the programmatic progress reports, an annual update on the disparity reducing quality improvement plan (what worked, what did not work, and what modifications were made) will be required 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.

INTENDED OUTCOMES AND IMPACT

How will these activities improve the problem or close the disparity? How will you identify and outreach to the selected disparity-vulnerable population(s) in your catchment area? (Intended outcomes and impact should be directly related to your goals and objectives.)

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 disparity-vulnerable population?

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.)

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 disparity-vulnerable population(s)? How will you measure incremental progress achieved under this award?

You should link measurement[6] and evaluation to goals and objectives submitted in or with 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.)?

[6] 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/

Example Demographic Table

Demographic Table

Race	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Total**	**Percentage of Total Served**
Pakistan	24	24	24	24	96	8%
Black /African American	42	42	42	42	168	14%
White	126	126	126	126	504	42%
Filipino	60	60	60	60	240	20%
Korean	12	12	12	12	48	4%
Multiracial	36	36	36	36	144	12%
TOTAL	**300**	**300**	**300**	**300**	**1200**	**100%**
Ethnicity						
Non-Hispanic	136	136	136	136	136	46%
Hispanic	164	164	164	164	164	54%
TOTAL	**300**	**300**	**300**	**300**	**1200**	**100%**
By Gender						
Female	86	86	86	86	840	70%
Male	210	210	210	210	344	29%
Transgender	4	4	4	4	16	1%
TOTAL	**300**	**300**	**300**	**300**	**100%**	**100%**
Sexual Orientation						
Straight or Heterosexual	200	200	200	200	800	67%
Homosexual (Gay or Lesbian)	55	55	55	55	220	18%
Bisexual person	45	45	45	45	180	15%
TOTAL	**300**	**300**	**300**	**300**	**1200**	**100%**