

Special Condition of Award for Behavioral Health Disparity

SAMHSA requires a disparity impact statement (DIS) for all new grant awards. Examples of a DIS for each major type of grant program: services, infrastructure, and training and technical assistance as well as an example for tribal grantees are provided in this section. These examples can be used as references for format and types of information that should be included in the DIS. The submission date and content requirements are listed in the NoA. Additional guidance may be provided by your GPO.

Disparity Impact Statement Examples

SERVICES PROGRAM EXAMPLE

1. Proposed number of individuals to be served by subpopulations in the grant service area

The numbers in the chart below reflect the proposed number of individuals to be served during the grant period and all identified subpopulations in the grant service area. The disparate populations are identified in the narrative below.

	FY 1	FY 2	FY 3	FY 4	Totals
Direct Services: Number to be served	200	175	100	125	600
<i>By Race/Ethnicity</i>					
African American	10	9	5	6	30
American Indian/Alaska Native	1	1	0	1	3
Asian	2	2	1	1	6
White (non-Hispanic)	103	91	52	65	311
Hispanic or Latino (not including Salvadoran)	32	28	16	20	96
Salvadoran	44	37	22	28	130
Native Hawaiian/Other Pacific Islander	4	3	2	2	11
Two or more Races	4	4	2	3	13
<i>By Gender</i>					
Female	110	96	55	69	330
Male	89	79	44	56	268
Transgender	1	0	1	0	2
<i>By Sexual Orientation/Identity Status</i>					
Lesbian	2	2	1	1	6
Gay	8	6	4	5	23
Bisexual	1	1	0	1	3

The population of Middle Lake, Massachusetts is predominantly represented by first- and second-generation Latino immigrants, mainly from El Salvador. There has been a recent increase of the immigrant population in the city with individuals primarily from Haiti and El Salvador. There is also a

smaller Cambodian and African American population in the city. Nearly 40% of residents speak a language other than English in their homes, and a majority of those individuals are Spanish speakers. There is a high unemployment rate, low literacy rate and high level of poverty, in particular among the Salvadoran subpopulation, putting these individuals at greater risk for behavioral health issues when compared to national trends. However, our agency has served relatively low numbers of Salvadorans. Therefore, we have chosen to focus our efforts on the Salvadoran subpopulation.

2. A Quality Improvement Plan Using Our Data

Services and activities will be designed and implemented in accordance with the cultural and linguistic needs of individuals in the community. The project team will collaborate with the community enrichment program and the county health specialist consortium in planning the design and implementation of program activities to ensure the cultural and linguistic needs of grant participants are effectively addressed, particularly the disparate population.

A continuous quality improvement approach will be used to analyze, assess and monitor key GPRA performance indicators as a mechanism to ensure high-quality and effective program operations. GPRA data will be used to monitor and manage program outcomes by race, ethnicity, and LGBT status within a quality improvement process. Programmatic adjustments will be made as indicated to address identified issues, including behavioral health disparities, across program domains.

A primary objective of the data collection and reporting will be to monitor/measure project activities in a manner that optimizes the usefulness of data for project staff and consumers; evaluation findings will be integrated into program planning and management on an ongoing basis (a “self-correcting” model of evaluation). For example, referral to enrollment, treatment completion and discharge data will be reported to staff on an ongoing basis, including analyses and discussions of who may be more or less likely to enroll and complete the program (and possible interventions). The Evaluator will meet on a bi-weekly basis with staff, providing an opportunity for staff to identify successes and barriers encountered in the process of project implementation. These meetings will be a forum for discussion of evaluation findings, allowing staff to adjust or modify project services to maximize project success.

Outcomes for all services and supports will be monitored across race and ethnicity to determine the grant’s impact on behavioral health disparities.

3. Adherence to the CLAS Standards

Our quality improvement plan will ensure adherence to the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards) in Health and Health Care. This will include attention to:

a. Diverse cultural health beliefs and practices

Training and hiring protocols will be implemented to support the culture and language of all subpopulations, with a focus on the Salvadoran subpopulation.

b. Preferred languages

Interpreters and translated materials will be used for non-English speaking clients as well as those who speak English, but prefer materials in their primary language. Key documents will be translated into Spanish.

- c. Health literacy and other communication needs of all sub-populations identified in your proposal

All services programs will be tailored to include limited English proficient individuals. Staff will receive training to ensure capacity to provide services that are culturally and linguistically appropriate.

INFRASTRUCTURE PROGRAM EXAMPLE

1. Proposed number of individuals to be reached by subpopulations in the grant service area

The numbers in the chart below reflect the proposed number of individuals to be reached during the grant period and all identified subpopulations in the grant service area. The disparate populations are identified in the narrative below.

	FY 1	FY 2	FY 3	FY 4	Totals
Number to be reached	200	175	100	125	600
<i>By Race/Ethnicity</i>					
African American	10	9	5	6	30
American Indian/Alaska Native	1	1	0	1	3
Asian	2	2	1	1	6
White (non-Hispanic)	103	91	52	65	311
Hispanic or Latino (not including Salvadoran)	32	28	16	20	96
Salvadoran	44	37	22	28	130
Native Hawaiian/Other Pacific Islander	4	3	2	2	11
Two or more Races	4	4	2	3	13
<i>By Gender</i>					
Female	110	96	55	69	330
Male	89	79	44	56	268
Transgender	1	0	1	0	2
<i>By Sexual Orientation/Identity Status</i>					
Lesbian	2	2	1	1	6
Gay	8	6	4	5	23
Bisexual	1	1	0	1	3

The population of Middle Lake, Massachusetts is predominantly represented by first- and second-generation Latino immigrants, mainly from El Salvador. There has been a recent increase of the immigrant population in the city with individuals primarily from Haiti and El Salvador. There is also a smaller Cambodian and African American population in the city. Nearly 40% of residents speak a

language other than English in their homes, and a majority of those individuals are Spanish speakers. There is a high unemployment rate, low literacy rate and high level of poverty, in particular among the Salvadoran subpopulation, putting these individuals at greater risk for behavioral health issues when compared to national trends. However, our agency has reached relatively low numbers of Salvadorans. Therefore, we have chosen to focus our efforts on the Salvadoran subpopulation.

2. A Quality Improvement Plan Using Our Data

Activities will be designed and implemented in accordance with the cultural and linguistic needs of individuals in the community. The project team will collaborate with the community enrichment program and the county health specialist consortium in planning the design and implementation of program activities to ensure the cultural and linguistic needs of grant participants are effectively addressed, particularly the disparate population.

A continuous quality improvement approach will be used to analyze, assess and monitor key GPRA performance indicators as a mechanism to ensure high-quality and effective program operations. GPRA data will be used to monitor and manage program outcomes by race, ethnicity, and LGBT status within a quality improvement process. Programmatic adjustments will be made as indicated to address identified issues, including behavioral health disparities, across program domains.

A primary objective of the data collection and reporting will be to monitor/measure project activities in a manner that optimizes the usefulness of data for project staff and consumers; evaluation findings will be integrated into program planning and management on an ongoing basis (a “self-correcting” model of evaluation). For example, screening and outreach data will be reported to staff on an ongoing basis, including analyses and discussions of who may be more or less likely to be exposed to outreach activities. The Evaluator will meet on a bi-weekly basis with staff, providing an opportunity for staff to identify successes and barriers encountered in the process of project implementation. These meetings will be a forum for discussion of evaluation findings, allowing staff to adjust or modify project services to maximize project success.

Outcomes for all activities will be monitored across race and ethnicity to determine the grant’s impact on behavioral health disparities.

3. Adherence to the CLAS Standards

Our quality improvement plan will ensure adherence to the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards) in Health and Health Care. This will include attention to:

a. Diverse cultural health beliefs and practices

Training and hiring protocols will be implemented to support the culture and language of all subpopulations, with a focus on the Salvadoran subpopulation.

b. Preferred languages

Interpreters and translated materials will be used for non-English speaking clients as well as those who speak English, but prefer materials in their primary language. Key documents will be translated into Spanish.

- c. Health literacy and other communication needs of all sub-populations identified in your proposal

All interventions will be tailored to include limited English proficient individuals. Staff will receive training to ensure capacity to provide interventions that are culturally and linguistically appropriate.

TRAINING/TECHNICAL ASSISTANCE PROGRAM EXAMPLE

1. Proposed number of individuals to be trained by subpopulations in the grant service area

The numbers in the chart below reflect the proposed number of individuals to be trained during the grant period. The disparity populations are identified in the narrative below.

	FY 1	FY 2	FY 3	FY 4	Totals
Number to be trained	200	175	100	125	600
<i>By Race/Ethnicity</i>					
African American	10	9	5	6	30
American Indian/Alaska Native	1	1	0	1	3
Asian	2	2	1	1	6
White (non-Hispanic)	103	91	52	65	311
Hispanic or Latino	32	28	16	20	96
Native Hawaiian/Other Pacific Islander	4	3	2	2	11
Two or more Races	4	4	2	3	13
<i>By Gender</i>					
Female	110	96	55	69	330
Male	89	79	44	56	268
Transgender	1	0	1	0	2
<i>By Sexual Orientation/Identity Status</i>					
Lesbian	2	2	1	1	6
Gay	8	6	4	5	23
Bisexual	1	1	0	1	3

The population of Middle Lake, Massachusetts is predominantly represented by first- and second-generation Latinos, mainly from El Salvador. There has been a recent increase of the immigrant population in the city with individuals primarily from Haiti and El Salvador. There is also a smaller Cambodian and African American population in the city. Nearly 40% of residents speak a language other than English in their homes, and a majority of those individuals are Spanish speakers. There is a high unemployment rate, low literacy rate and high level of poverty, in particular among the Salvadoran subpopulation, putting these individuals at greater risk for behavioral health issues when

compared to national trends. However, our agency does not have sufficient capacity to address the cultural and linguistic needs of the Salvadorans in the community. Therefore, we have chosen to focus our efforts on increasing staff and organizational competencies to address the disparities in behavioral health awareness and education within the Salvadoran population.

2. A Quality Improvement Plan Using Our Data

A continuous quality improvement approach will be used to analyze, assess and monitor key performance indicators as a mechanism to ensure high-quality and effective program operations. Monitoring activities will focus on:

Access: The project team will collaborate with the community enrichment program and the county health specialist consortium in planning the design and implementation of program activities to ensure the cultural and linguistic needs of training recipients are effectively addressed, particularly the disparate population.

Use: Training and technical assistance activities will be designed and implemented in accordance with the cultural and linguistic needs of individuals in the community.

Outcomes: GPRA data will be used to monitor and manage program outcomes by race, ethnicity, and LGBT status within a quality improvement process. Programmatic adjustments will be made as indicated to address identified issues, including behavioral health disparities, across program domains.

A primary objective of the data collection and reporting will be to monitor/measure project activities in a manner that optimizes the usefulness of data for project staff and consumers; evaluation findings will be integrated into program planning and management on an ongoing basis (a “self-correcting” model of evaluation). For example, training and technical assistance data will be reported to staff on an ongoing basis, including analyses and discussions of who may be more or less likely to be exposed to training and technical assistance activities. The Evaluator will meet on a bi-weekly basis with staff, providing an opportunity for staff to identify successes and barriers encountered in the process of project implementation. These meetings will be a forum for discussion of evaluation findings, allowing staff to adjust or modify project services to maximize project success.

Outcomes for all activities will be monitored across race and ethnicity to determine the grant’s impact on behavioral health disparities.

3. Adherence to the CLAS Standards

Our quality improvement plan will ensure adherence to the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards) in Health and Health Care. This will include attention to:

d. Diverse cultural health beliefs and practices

Training and hiring protocols will be implemented to support the culture and language of all subpopulations, with a focus on the Salvadoran subpopulation.

e. Preferred languages

Interpreters and translated materials will be used for non-English speaking participants as well as those who speak English, but prefer materials in their primary language. Key documents will be translated into Spanish.

f. Health literacy and other communication needs of all sub-populations identified in your proposal

All training and technical assistance activities will be tailored to include limited English proficient individuals. Staff will receive training to ensure capacity to provide services that are culturally and linguistically appropriate.

TRIBAL GRANTEE EXAMPLE

Proposed number of individuals to be reached by subpopulations in the geographic area

The numbers in the chart below reflect the proposed number of individuals to be reached during the grant period. The disparity populations are highlighted in the narrative below.

	FY 1	FY 2	FY 3	FY 4	Totals
Number to be reached	200	175	100	125	600
By Race/Ethnicity					
American Indian	173	159	83	90	505
Alaska Native	0	0	0	0	0
Two or more Races	23	14	14	33	84
Other: (Please specify)					
Hispanic or Latino	4	2	3	2	11
By Gender					
Female	110	96	55	69	330
Male	89	79	44	56	268
Transgender	1	0	1	0	2
By Sexual Orientation/Identity Status					
Lesbian	2	2	1	1	6
Gay	8	6	4	5	23
Bisexual	1	1	0	1	3

The population of “Red River Mountain reservation” consists primarily of enrolled members of the tribe. Recently, we have noticed an increase in the number of migrant farmers who have come to

work on the reservation, mainly from the central region of Mexico. Nearly 65 percent of tribal members speak a language other than English in their homes, and a majority of the migrant workers are Spanish speakers. There is a high unemployment rate, low literacy rate and high level of poverty among tribal residents. Those in the northern region have higher rates of substance misuse and abuse; are more geographically isolated from most community resources; and, are at greater risk for behavioral health issues when compared to national trends. Our tribe lacks sufficient capacity to provide prevention services that are culturally and linguistically appropriate for all residents of the reservation. Therefore, we have chosen to focus our efforts on increasing staff and organizational competencies to address the disparities in behavioral health awareness and education among the tribal residents, particularly those in the northern region.

1. A Quality Improvement Plan Using Our Data

We will design and implement activities to increase staff and organizational competencies will be designed and implemented in accordance with the cultural and linguistic needs of individuals in the community. The project team will collaborate with the tribal advisory group, leaders in high need communities and the local health specialists in planning the design and implementation of program activities to ensure the cultural and linguistic needs of grant participants are effectively addressed, particularly in the northern region where the disparities appear to be the highest.

We will use a continuous quality improvement approach to analyze, assess and monitor key performance indicators as a mechanism to ensure high-quality and effective program operations. We will use program data to monitor and manage program outcomes within a quality improvement process. We will make programmatic adjustments as indicated to address identified issues, including behavioral health disparities, across program domains.

A primary objective of our data collection and reporting will be to monitor/measure project activities to optimize the usefulness of data for project staff and consumers. We will also integrate evaluation findings into program planning and management on an ongoing basis (a “self-correcting” model of evaluation). For example, we will report screening and outreach data to staff on an ongoing basis. Our Evaluator will meet with staff on a bi-weekly basis to help identify successes and barriers encountered in project implementation. These meetings will serve as a forum for discussion of evaluation findings, allowing staff to adjust or modify project services to maximize project success.

Outcomes: We will monitor outcomes for all activities to determine the impact of our project on reducing behavioral health disparities.

2. Adherence to the CLAS Standards

Our quality improvement plan will ensure adherence to the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards) in Health and Health Care. This will include attention to:

g. Diverse cultural health beliefs and practices

We will implement training and hiring protocols to support the culture and language of all subpopulations, with a focus on the tribal residents in the Northern region.

h. Preferred languages

We will use interpreters and translated materials for non-English speaking participants, as well as for those who speak English, but prefer materials in their native language.

i. Health literacy and other communication needs of all sub-populations identified in your proposal

We will tailor all interventions to include limited English proficient individuals. Our project staff will be trained to ensure capacity to provide interventions that are culturally and linguistically appropriate.