



Part of the SS/HS Framework Implementation Toolkit

1. Plan

2. Implement

3. Sustain and Expand

Safe Schools/Healthy Students' Guidance on Developing the Behavioral Health Disparity Impact Statement/Strategy

The Disparity Impact Statement/Strategy: Substance Abuse and Mental Health Services Administration's Systems Approach to Reducing Disparities

The Department of Health and Human Services (HHS) issued the Action Plan to Reduce Racial and Ethnic Health Disparities in 2011. This Action Plan defines health disparities as differences in health conditions and health outcomes among specific populations in the United States, closely linked with social, economic, and environmental disadvantage (Office of Minority Health, 2011). The World Health Organization (2008) defines health disparities as inequalities that are considered unnecessary, avoidable, and unfair or unjust.

The HHS Action Plan described a disparity impact statement (DIS) as one systemic intervention to reduce disparities. The Substance Abuse and Mental Health Services Administration (SAMHSA) incorporated the DIS requirement into its request for applications (RFA) in July 2013 as a special condition of award, which means that SAMHSA requires grantees to submit a DIS describing how the grantee will address behavioral health disparities among racial and ethnic groups, and sexual minority stakeholders. See Appendix A for specific language about the DIS from the Safe Schools/Healthy Students (SS/HS) RFA.

The SAMHSA DIS has as a priority focus the reduction of behavioral health disparities/disproportionalities (D/D) among minority groups on the basis of race, ethnicity, and/or sexual orientation. See Appendix B, the Glossary of Terms, for definitions and distinctions between disparities and disproportionalities. Although the title of the DIS includes disparities only, disproportionalities also are often present and can be addressed within the DIS. Also, in addition to reporting on D/D affecting racial and ethnic groups, and sexual minority populations, other subpopulation variables, such as socioeconomic status and rural issues can be reported. However, it should be noted that these variables may not substitute reporting on D/D affecting racial and ethnic populations.

The DIS addresses three specific domains: **(1) access; (2) use (utilization);** and **(3) outcomes** of services, programs, and interventions. They are also defined in Appendix B.

SAMHSA is interested in reducing D/D locally. The more local the data that are available to review, the better. Strategies and interventions should focus on the particular subpopulations in the community that is being affected. National and state data are a useful comparison to the local data that are gathered, but they are not a substitute.

The DIS is based on a data-informed, quality improvement approach that requires regular monitoring, reviewing, and revising of the methods, data analysis, strategies, and benchmark goals to ensure that quality is maintained and progress is made through continuous data review and updating. Your quality improvement approach can be led by a committee at the local level made up of agency and school staff (including evaluators); family members (parents and caregivers); youth; and community and cultural leaders focused specifically on D/D reduction. This state committee can be composed of State Management Team (SMT) members and members of each of your Core Management Team (CMT) D/D committees. Your Resource Specialist, the National Resource Center's content experts, and your Federal Project Officer are all available to support and work with you throughout the process. See Appendix C for Frequently Asked Questions.

Although the DIS is a discrete requirement that should be discussed with your Federal Project Officer and submitted for formal approval, the strategies, benchmark goals, and implementation should be incorporated into your team's logic model and Comprehensive Plan in an integrated and cohesive way. It is not a stand-alone requirement. To be effective, it should be a part of your everyday implementation of the SS/HS initiative. The following step-by-step process may assist you in developing and implementing a meaningful DIS.

DIS Step by Step

Step 1: Develop a Local Committee

Develop an inclusive local committee composed of relevant stakeholders representing the diversity of the community—the DIS is meant to be locally driven. An inclusive local committee should focus on the task of developing and implementing your DIS work throughout the grant period. It can be called a “Disparities Reduction Committee” or “Diversity and Inclusion Committee,” or any other name that captures the work. As was stated above, having local committees and a state committee is best. The SMT committee may include representatives from the Disparities Reduction Committee(s) from each of your local education authority (LEA) sites. The designated committee(s) will lead the DIS effort, outlined by the following steps, which include using a data-driven, continuous quality improvement process to monitor and improve data collection, strategies implemented, and outcomes related to reducing disparities.

Step 2: Identify Subpopulations

Identify the various subpopulations that reside in your SS/HS LEAs. You may have done this already in your grant application. You can use U.S. Census data, state data, or local data. See Appendix D for sources of data. Disparity reduction is about affecting local data, thus it is important to ensure that all subpopulations are explicitly defined. Be as specific as possible so that your strategies are focused and more likely to be successful. For instance, if one of your subpopulations is Latino, identify the nationalities, such as Mexican, Mexican American, Puerto Rican, Salvadoran, etc. If they are immigrants or new Americans, specify

where they came from, how recently they arrived, and what language(s) they speak. If they are refugees, describe where they came from and what traumas they are escaping. These considerations should be applied with all subpopulations.

- Work with your evaluator throughout the process of developing your DIS, particularly in gathering and analyzing the relevant data.
- The DIS subpopulations are focused on race/ethnicity and youth who identify as LGBT, but you may also include subpopulations defined by socioeconomic or geographic terms (such as rural or very low-income individuals or families).
- [Use the ethnic/racial categories designated in the Affordable Care Act \(ACA\), Provision 4302](#). The ACA categories are a starting place. You may want to further disaggregate your subpopulations in a more granular way, for example, in addition to African American, you may also include categories for Afro-Caribbean, East African, West African, or other relevant Black subpopulations. Another example is the Latino/Hispanic category, for example, which can be further disaggregated into Mexican, Cuban, Puerto Rican, Salvadoran, Guatemalan, etc.

Step 3: Identify and Review Data

After identifying and defining subpopulations (so you know the make-up of the entire population in your expansion areas), begin to discuss with your D/D committee(s) the potential D/D you may want to explore and eventually focus on. To accomplish this, you need data such as exclusionary disciplinary practices data or access to behavioral health services data, or any other focus area your D/D committee thinks is relevant. Sometimes quantitative data are readily available through the Government Performance and Results Act (GPRA) you already collect or through national, state, or local county and school district data sets. These data sets must be disaggregated by race and ethnicity to address the effectiveness of the program and practices in addressing the needs of all intended recipients, even those who may have been unintentionally unserved or underserved previously. If you have data on youth who are LGBT, include those data also. Examples of existing data sets include:

- [Office of Civil Rights Data Collection](#)
- [Youth Risk Behavior Survey \(YRBS\)](#)
- [2015 KIDS COUNT Data Book: State Trends in Child Well-Being](#)

See Appendix D for background information on the databases listed and to find out about other resources.

Sometimes quantitative data are not readily available. Using qualitative data as well as quantitative data to inform your decision making is appropriate. Qualitative data may include focus groups and interviews that you can conduct locally in conjunction with your evaluator. This may take time to gather, but it is better to take the time to do this early in the process and have timely, local, and trusted data on which to base your determination about whether D/D exist than to have no data at all, or data that are neither local nor relevant.

Step 4: Identify D/D by Domain

Once you have identified and developed data sources, you can then review and analyze your data to determine whether a health or behavioral health D/D exists. For example:

- Do your data tell you that children and parents in one ethnic/racial group have less **access** to services and best practices than other populations? For example, is the Latino immigrant subpopulation who live primarily on the outskirts of town, (without public transportation to reach services in town) restricted in their access to services and best practices? Are the services provided at times when the caregivers are unavailable to access them?
- Do new Americans in one of your communities not **use** services, despite the fact that they live only two blocks from the agency providing services? Do you know why? Are the services being provided in the language(s) they speak? Are the services provided by individuals with whom they can identify and relate to? Have the elders in the new American community been consulted about the most culturally appropriate services to offer, where, and by whom?

These are all considerations in determining why certain populations may not have access to services or use services.

You may focus on only one domain, such as access. You may have two D/D on which you want to focus, such as one pertaining to access and one pertaining to utilization. It is recommended to focus on at least one or two domains.

After you have had time to gather data on outcomes, you can then review those data and see whether there is any D/D in outcomes among the subpopulations.

Step 5: Prioritize

If you have identified more than one D/D in access, utilization, or outcomes for a particular subpopulation, you will need to prioritize the D/D. Consider the following factors in choosing where to put your focus: family and community preferences and priorities, readiness, human and financial resources, time availability, and ability to sustain the effort.

Step 6: Disaggregate Data by Race, Ethnicity, and Sexual Orientation

You can use a table as shown below, or one of your own design to define and quantify the populations and subpopulations you will be serving each year of the grant. This is an estimate that can be revised over time.

Sample Table 1: Racial and Ethnic Group Distribution

Racial/Ethnic Groups in Your Community	% of Overall Population	Number of Children/Families to be Served by Fiscal Year				% of Children/Families to be Served by Fiscal Year			
		YR1	YR2	YR3	YR4	YR1	YR2	YR3	YR4
Hispanic/Latino/Spanish Origin									
(subpopulation example: Mexican/Mexican American or any applicable subpopulation in your area)									
(subpopulation example: Salvadoran or any applicable subpopulation in your area)									
African American or Black									
(subpopulation example: Afro-Caribbean or any applicable subpopulation in your area)									
(subpopulation example: Ethiopian or any applicable subpopulation in your area)									
Asian American									
(subpopulation example: Chinese or any applicable subpopulation in your area)									

Racial/Ethnic Groups in Your Community	% of Overall Population	Number of Children/Families to be Served by Fiscal Year				% of Children/Families to be Served by Fiscal Year			
		YR1	YR2	YR3	YR4	YR1	YR2	YR3	YR4
Asian American, cont.									
(subpopulation example: Vietnamese or any applicable subpopulation in your area)									
Native Hawaiian									
Other Pacific Islander									
American Indian									
Alaska Native									
White non-Hispanic									
Two or more races									
Totals by FY									
Female									
Male									

Step 7: Set Benchmark Goals

After identifying your subpopulations, D/D, and prioritizing them, you are ready—along with your inclusive D/D committee(s)—to set an initial benchmark goal for each D/D to reach by the end of each year. For example:

- In Community A, data indicate that 15% of the families in the community are Guatemalan, but only 5% of parents participating in the parent university or parent activity nights are Guatemalan. You may choose to set a benchmark goal of increasing Guatemalan parent participation (utilization) by 50% to 7.5% (50% of 5% = 2.5%) in the first year; and to 10% in Year 2. You continue in this manner in each of the subsequent years.
- In Community B, data indicate that African American boys make up 5% of the school district population, but comprise 20% of all children who are suspended or expelled from school. You may choose to set a benchmark goal of reducing this disproportionality by 25% to 15% (25% of 20% = 5%) in the first year; and to 10% in Year 2. You continue in this manner in each of the subsequent years.

- Community C data tell you that in the utilization domain, only 5% of the Latino immigrants in your community use services even though they make up 15% of the population. You may choose to set a benchmark goal of increasing their utilization by 50% to 7.5% (50% of 5% = 2.5%) in the first year; to 10% in Year 2. You continue in this manner in each of the subsequent years.

You may use a table like the one below to chart your benchmark goals.

Sample Table 2: Disparity/Disproportionality List

Disparity or Disproportionality	Benchmark Goals by Fiscal Year			
	FY 1	FY 2	FY 3	FY 4
#1				
#2				
#3				

You may or may not achieve your benchmark goal, but your continuous quality improvement process will be tracking your data throughout the year to let you know whether you are coming close to meeting your goal. If you are not meeting your goal, you may want to reevaluate your strategies, the goal itself, the timeframe to achieve it, or other factors that may be affecting your progress. It is okay to adjust any of these factors to put you on track to be successful with your subpopulation.

Step 8: Develop Strategies and Interventions

The DIS must include subpopulation-specific strategies and interventions to reduce the D/D and improve access, utilization, and/or outcomes for the subpopulations. These strategies and interventions are meant to specifically reduce your identified D/D. This may include changes to policies and procedures, laws, or regulations; implementation of specific practices or programs; or improvements in infrastructure, such as accessible transportation or hiring bilingual/bicultural providers.

- For example, in the previously noted subpopulation of Latinos who were not using services available to them, the following strategies could be used if the reasons for underutilization are clear: hire bilingual/bicultural providers and/or community behavioral health workers from the population itself who may have been behavioral health providers in their country of origin; adapt best practices to be culturally appropriate for and specific to the population; or conduct a culturally appropriate social marketing campaign that incorporates media, messages, and messengers that are culturally congruent with the subpopulations. Strategies for reducing disparities in expulsions might include mental health consultation to address implicit biases among teachers and administrators, or developing policies that provide alternatives to suspension.

You can make process or program adjustments to how you reach or affect the intended subpopulation experiencing a disparity; in other words, devise new ways to improve access, use, and outcomes of the subpopulation(s) experiencing disparities.

- For example, you can make changes in how you collect data to ensure that the data are accurate or make improvements in how you report access, use, and outcome measures to ensure that you are reporting what you intend to report.

Step 9: Incorporate CLAS Standards

As part of developing your strategies and interventions to reduce D/D, it is essential that you incorporate the [Culturally and Linguistically Appropriate Services \(CLAS\) Standards](#). These 15 standards focus on governance, leadership, and workforce; communication and language assistance; and engagement, continuous improvement, and accountability. Incorporate as many of the 15 standards as possible, especially those that pertain to your identified D/D.

- For example, in the case of the Latino families using services, Standard 6, “Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing,” and Standard 3, “Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area,” could apply as meaningful strategies and interventions.

Step 10: Data-Driven Quality Improvement Process

Track and monitor your progress in achieving the benchmark goal(s) you set through a data-driven quality improvement process. At least every 6 months or even more frequently, review your incoming data to see whether you are affecting the D/D with your strategies or interventions. Make course adjustments and corrections if you find that the strategies or interventions are not as effective as you had anticipated based on the data. You can then modify, change, or create new strategies or interventions after working with your committee(s) to get their insight and expertise to ensure success. Remember to integrate your disparity reduction strategies into your expansion plan so that they are an integral part of your overall SS/HS initiative. You will also be sharing your progress with your Federal Project Officer through your End of Year Progress Reports.

SAMHSA’s goal is for D/D reduction to become the “routine” as opposed to the exception.

DIS Online Training Module

The National Resource Center has developed [The Disparity Impact Statement and Strategy online training module](#), a 45-minute video that describes the steps to follow in writing your DIS, implementing your strategies, and tracking your benchmark goals. You may want to review the module as you begin your process of developing your DIS and throughout your implementation. The module includes the following sections:

- History, purpose, and definitions of D/D
- Disaggregated data
- Benchmark goals and strategies
- Quality improvement process
- Incorporation of CLAS Standards
- Resources

Appendix A

Safe Schools/Healthy Students DIS RFA Language

The following are excerpts from the Safe Schools/Healthy Students RFA No. SM-13-006 (2013) that refers to the DIS:

- “SAMHSA expects grantees to utilize their data to (1) identify subpopulations (i.e., racial, ethnic, sexual/gender minority groups, and other high-risk populations) vulnerable to disparities; (2) develop a disparities impact statement; and (3) implement strategies to decrease the differences in access, service use, and outcomes among populations. These strategies could include use of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. See Appendix H: Addressing Behavioral Health Disparities.” (RFA 2013, p. 9).
- “SAMHSA expects grantees to utilize their data to: (1) identify subpopulations (i.e., racial, ethnic, sexual/gender minority groups) vulnerable to disparities; and (2) implement strategies to decrease the differences in access, service use, and outcomes among subpopulations. A strategy for addressing health disparities is the use of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. See Appendix H: Addressing Behavioral Health Disparities.” (RFA 2013, p. 23).
- “Appendix H—Addressing Behavioral Health Disparities: In April 2011, the Department of Health and Human Services (HHS) released its [*Action Plan to Reduce Racial and Ethnic Health Disparities*](#). This plan outlines goals and actions HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to continuously assess the impact of their policies and programs on health disparities.

The number one Secretarial priority in the Action Plan is to: “**Assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities.** HHS leadership will assure that: Program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits.

To accomplish this, SAMHSA expects grantees to utilize their data to (1) identifying subpopulations (i.e., racial, ethnic, sexual/gender minority groups) vulnerable to health disparities and (2) implement strategies to decrease the differences in **access, service use, and outcomes** among those subpopulations. A strategy for addressing health disparities is use of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.”

The following are definition of terms from the Safe Schools/Healthy Students RFA No. SM-13-006 (2013) that refer to the DIS:

Health Disparities

Healthy People 2020 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; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”

Subpopulations

SAMHSA grant applicants are routinely asked to define the population they intend to serve given the focus of a particular grant program (e.g., adults with serious mental illness [SMI] at risk for chronic health conditions; young adults engaged in underage drinking; populations at risk for contracting HIV/AIDS, etc.). Within these populations of focus are *subpopulations* that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for a metabolic disorder due to lack of appropriate in-language primary care services; Native American youth may have an increased incidence of underage drinking due to coping patterns related to historical trauma within the Native American community; and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities. While these factors might not be pervasive among the general population served by a grantee, they may be predominant among subpopulations or groups vulnerable to disparities. It is imperative that grantees understand who is being served within their community in order to provide care that will yield positive outcomes, per the focus of that grant. In order for organizations to attend to the potentially disparate impact of their grant efforts, applicants are asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors:

- By race
- By ethnicity
- By gender (including transgender), as appropriate
- By sexual orientation (i.e., lesbian, gay, bisexual), as appropriate

HHS published final standards for data collection on race, ethnicity, sex, primary language, and disability status, as required by Section 4302 of the Affordable Care Act in October 2011, which can be found at:

<https://aspe.hhs.gov/sites/default/files/pdf/76331/index.pdf>.

The ability to address the quality of care provided to subpopulations served within SAMHSA's grant programs is enhanced by programmatic alignment with the federal CLAS standards.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (CLAS)

The National CLAS Standards were initially published in the *Federal Register* on December 22, 2000. Culturally and linguistically appropriate health care and services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals, is increasingly seen as essential to reducing disparities and improving health care quality. The National CLAS Standards have served as catalyst and conduit for the evolution of the field of cultural and linguistic competency over the course of the last 12 years. In recognition of these changes in the field, the HHS Office of Minority Health undertook the National CLAS Standards Enhancement Initiative from 2010 to 2012.

The enhanced National CLAS Standards seek to set a new bar in improving the quality of health to our nation's diversifying communities. Enhancements to the National CLAS Standards include the broadening of the definitions of health and culture, as well as an increased focus on institutional governance and leadership. The enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care are composed of 15 standards that provide a blueprint for health and health care organizations to implement culturally and linguistically appropriate services that will advance health equity, improve quality, and help eliminate health care disparities. You can learn more about the CLAS mandates, guidelines, and recommendations at:

<https://www.thinkculturalhealth.hhs.gov/Content/clas.asp>." (RFA 2013, pp. 72-74).

Appendix B Glossary of Terms

Disparity

In the context of the DIS, a disparity refers to disparate or inequitable treatment (how the individual is treated) or services/activities offered (type, access, quantity, quality, outcomes) provided to individuals belonging to ethnic or racial groups or sexual identity minority groups (to include lesbian, gay, bisexual, or transgendered individuals), compared to treatment or services provided to historically advantaged groups, usually the dominant or majority population. A disparity is closely linked with social, economic, and/or environmental disadvantages.

Health disparities adversely affect groups of people who have experienced systematically greater obstacles based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. You can learn more at [Healthy People 2020](#).

Disparity Example

The presence of a disparity can be determined in various ways. No one single method is required. Below is an example of how it might be done. First, look at the total population broken down proportionately by ethnicity and race in the local geographical area of focus (e.g., county). This will give you the percentages in each category. For example, in a sample community, the population demographics are 50% White (2% of which is Lebanese; 5% Syrian); 15% African American (5% of which is Afro-Caribbean; 2% Somali); 20% Latino (10% Mexican; 5% Salvadoran; 5% Puerto Rican); 10% Asian American or other Pacific Islander (5% Chinese; 3% Hmong; 2% Japanese); and 5% American Indian/Alaska Native. Your data indicate that you are serving 75% White, 5% African American, 10% Latino, 10% Asian American or other Pacific Islander, and 0% American Indian/Alaska Native. These data would indicate that you are serving more Whites (50% more) and fewer African Americans (66% less), Latinos (50% less), and American Indians (100% less) than are found in the population proportionately. Therefore, the grantee probably has a disparity in access to or use of (depending on the reasons for fewer served) services for three subpopulations. If you have more granular data regarding the subpopulation you are serving such as the Afro-Caribbean, Mexican, Chinese, subpopulations, etc., use that utilization data to further describe the subpopulations you are actually serving.

Disproportionality

A disproportionality refers to a situation in which a particular racial or ethnic group or sexual identity minority group is over- or under-represented proportionately in a system or category than in the general population. For example, a disproportionality may exist in systems such as child welfare, juvenile justice, special education, mental health, early childhood services, or another group or category where youth from ethnic or racial groups

are over-represented compared to their proportionality in the general population. It is distinct from a disparity because in a disparity we are referring to the quantity or quality of services received, whereas in a disproportionality we are referring to the numbers represented in a system or category

Disproportionality Example

The school district population in the geographical area you serve is made up of 60% White, 20% African American, 15% Latino, and 5% American Indian. The data show that 40% of African Americans, 30% of Latinos, 10% of American Indians, and 20% of Whites have been expelled from school, indicating that a disproportional amount of African American, Latino, and American Indian children are more frequently expelled (200% more) compared with White children. The raw numbers of children who come from ethnic/racial groups may be small, but the percentages are important. In this case, the children from the three ethnic/racial groups are overrepresented in the group of children who are expelled.

Domain Examples

Access: Are the services you provide accessible to all subpopulations, including “hidden” populations or what we sometimes call “invisible” populations (often missed in traditional data collection)? Examples may include Afro-Caribbean or West African families, Asian American families, immigrant/refugee families, or English Language Learners (ELL), many of whom do not access behavioral health services because of stigma or cultural or language barriers. Access to services also may be affected by distance from services, lack of transportation, lack of child care for siblings, or the time of day services are provided (only day appointments when parents or caregivers are at work). Even the location of services, such as those in government agency buildings, may deter utilization by individuals who are undocumented or have had bad experiences with such agencies.

Utilization: All subpopulations in a community may have access to parent skills training, but are they using it? If it is not being used by families from ethnic/racial backgrounds, why might that be? Is it tailored to meet the needs of each subpopulation in your community? For example, are the services provided by individuals with whom they can relate, such as those who are of the same race/ethnicity? Are they being provided in the languages they speak? Have the services been proven to work with the subpopulations elsewhere? In other words, have the practices been standardized and normed on those populations? Have the services or practices taken into consideration the values, norms, traditions, beliefs, and rituals of the subpopulations? All these considerations potentially affect whether they are used or not.

Outcomes: Are the outcomes across ethnic/racial groups comparable to one another? In other words, is everyone benefitting the same or are some subpopulations benefitting more or less than others? Is mental health consultation in early care and education producing the outcomes you want (e.g., improved quality of care and social-emotional learning, satisfied parents, etc.) in all of your subpopulations? Are some groups doing better than others? Does mental health consultation take into account the cultural and

linguistic contexts and needs of the various subpopulations in your community so that they experience the intended beneficial results related to the consultation process? For example, in some cultures, the extended family needs to be consulted before the parents or caregivers proceed with services. Is that factored into the provision of services?

Appendix C Frequently Asked Questions

- Q. What if we don't have any racial or ethnic subpopulations among our grant recipients? Do we still need to break down the population by racial and ethnic groups consistent with the application requirements?
- A. Although you may not be aware of racial or ethnic populations residing in your grant location, inevitably, even small populations of racial and ethnic subpopulations exist that are "invisible" to many, either because they are: (1) new to the area (immigrant, migrant, refugee, or other racial or ethnic group that moved in from another area); (2) have an immigration status that they believe prohibits them from seeking and receiving services or that prevents them from being in public for fear of being reported and eventually deported; (3) have a fear of deportation and only feel comfortable seeking help from people who are from or represent their community ethnicity, or cultural background, some of which may include faith-based organizations; or (4) are not regular users of community-based services, in part possibly because of the stigma associated. This would be an opportunity to learn who and how many they are so that you can include them in the grant population affected.
- Q. May we use other data that we already collect in addition to, or instead of GPRA data?
- A. Yes, you may use performance measures (GPRA) data and/or additional data (if they are more specific and local) from any reliable source as long as the data pertain to the specific population of focus and the measures pertain to access, use, and outcomes pertinent to the grant application.
- Q. If I identify subpopulations that I have not served before and/or did not describe in my grant application, am I required to provide services and activities now?
- A. If they are in your geographic location where the grant is directed and the subpopulations are part of your population of focus, then yes, you should provide them with services and activities as long as they meet the eligibility criteria of the grant consistent with the application requirements.
- Q. What if we don't meet our intended benchmark goals at the end of the year?
- A. Reducing disparities is a constant process of quality improvement. Not every grantee will meet its benchmark goals immediately. If benchmark goals are unmet, you will need to reassess your intervention strategies because the interventions may not have been designed, chosen, implemented, counted, or evaluated appropriately. You can make necessary adjustments then to revise your intended benchmark goals again with new strategies. You also may want to reassess the benchmark percentage goal you set to ensure it is a realistic goal.

Q. What is a subpopulation-specific strategy?

A. It is a specific strategy that includes intervention(s) or changes to the program that focuses on improving access, use, or outcomes for a subpopulation that was found to be experiencing a disparity. For example, improving language access by translating all materials made available to the public, including signage for Latinos or American Indians who are ELLs; partnering with culturally connected community-based organizations to further culturally and linguistically appropriate outreach to unserved or underserved populations, such as urban American Indians or Asian Americans; or using risk and/or screening tools that are sensitive to the subpopulation and not biased in their design or outcomes.

Q. What are process and/or programmatic adjustments?

A. They are changes in how the grantee reaches or affects the intended subpopulation experiencing a disparity. The grantee can make changes in how it collects data to ensure that the data are accurate; make improvements in how it reports access, use, and outcome measures data to ensure it is reporting what it intends to report; prioritize a subpopulation's needs by making necessary changes to the grant program's reach or activities; or other ways that the grantee devises to improve access to, use by, and outcomes of the subpopulation(s) experiencing disparities.

Q. Does the DIS requirement apply to populations within tribes and territories?

A. Yes, the DIS/S requirement does apply to populations within tribes and territories. Because populations within tribes and territories may be more homogeneous and less diverse ethnically, disparities may exist still among subpopulations based upon their geographic location or isolation, transportation issues, technology limitations, class or clan distinctions, language, etc. that affect access, use of services, and outcomes.

Appendix D Resources

1. [Addressing the Root Causes of Disparities in School Discipline: An Educator's Action Planning Guide](#)

This guide provides tools to assess and systematically address disparities in school discipline. It describes how to carry out a descriptive analysis of disparities and how to conduct a root cause analysis to systematically address school-based factors that contribute to disparities and systematically change policies and practices. These analyses result in knowing: (1) who is being disparately disciplined and what is happening to them; (2) the systemic causes of disparities in school discipline and why they occur; and (3) how you can reduce and eliminate disparities in school discipline.

2. [Kaiser Family Foundation. Population Distribution by Race/Ethnicity](#)

This website presents the Population Distribution by Race/Ethnicity data, which are based on the analysis of the Census Bureau's March 2015 Current Population Survey (CPS: Annual Social and Economic Supplement).

3. [Office of Civil Rights Data Collection](#)

This database provides a snapshot of data on school suspensions and expulsions for early childhood, elementary, and secondary schools.

4. [The 2015 KIDS COUNT Data Book: State Trends in Child Well-Being](#)

This is an annual publication of the Annie E. Casey Foundation that assesses child well-being nationally and across the 50 states, as well as in the District of Columbia and Puerto Rico. Using an index of 16 indicators, the report ranks states on overall child well-being and on economic well-being, education, health, and family and community.

5. [U. S. Department of Commerce, U. S. Census Bureau. 2014 Population Estimates: Current Estimates Data](#)

The population and housing unit estimates are released on a flow basis throughout each year. Each new series of data (called vintages) incorporates the latest administrative record data, geographic boundaries, and methodology. Therefore, the entire time series of estimates beginning with the most recent decennial census is revised annually.

6. [Youth Risk Behavior Surveillance System \(YRBSS\), Centers for Disease Control and Prevention](#)

The YRBSS was developed in 1990 to monitor priority health risk behaviors that contribute markedly to the leading causes of death, disability, and social problems among youth and adults in the United States. These behaviors, often established during childhood and early adolescence, include behaviors that contribute to unintentional injuries and violence; sexual behaviors that contribute to unintended

pregnancy and sexually transmitted infections, including HIV infection; alcohol and other drug use; tobacco use; unhealthy dietary behaviors; and inadequate physical activity. The YRBSS includes national, state, territorial, tribal government, and local school-based surveys of representative samples of 9th through 12th grade students. These surveys are conducted every 2 years, usually during the spring semester. From 1991 through 2013, the YRBSS has collected data from more than 2.6 million high school students in more than 1,100 separate surveys.

The YRBSS was designed to determine the prevalence of health risk behaviors; assess whether health risk behaviors increase, decrease, or stay the same over time; examine the co-occurrence of health risk behaviors; provide comparable national, state, territorial, tribal, and local data; provide comparable data among subpopulations of youth; and monitor progress toward achieving the Healthy People objectives and other program indicators.

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