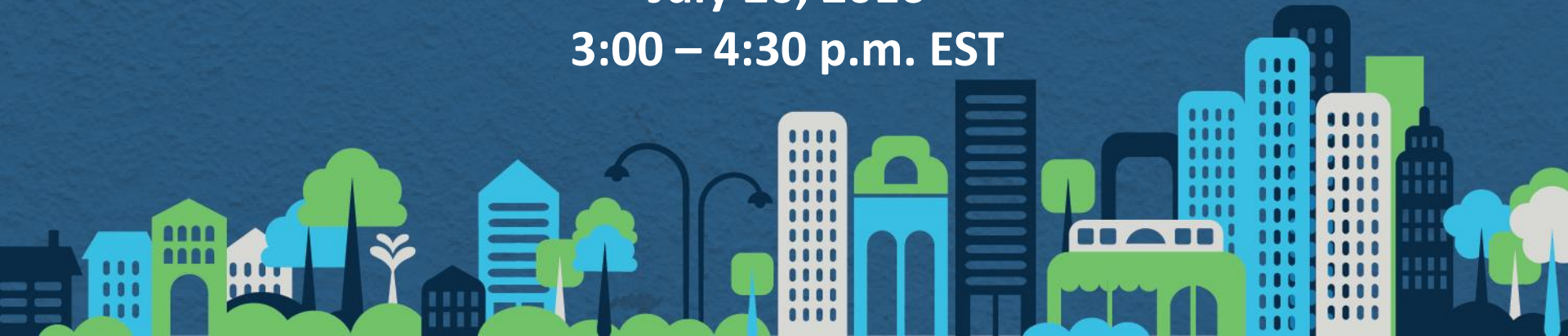# "DIS 101: HOW TO ADDRESS DISPARITIES AND DISPROPORTIONALITIES THROUGH DISPARITY IMPACT STATEMENTS"

Engage and Discover Webinar Series: *Advancing Best Practices so Children, Youth, and Families Thrive*
Dr. Ken Martinez and Dr. Larke Huang
July 20, 2016
3:00 – 4:30 p.m. EST

The National Resource Center, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), offers resources and expert support to help prevent youth violence and promote the overall well-being of children, youth, and their families.

Supports efforts serving
CHILDREN AND YOUTH
from birth to high school

The National Resource Center
SERVES:

1 _____

Safe Schools/ Healthy Students (SS/HS) grantees

+

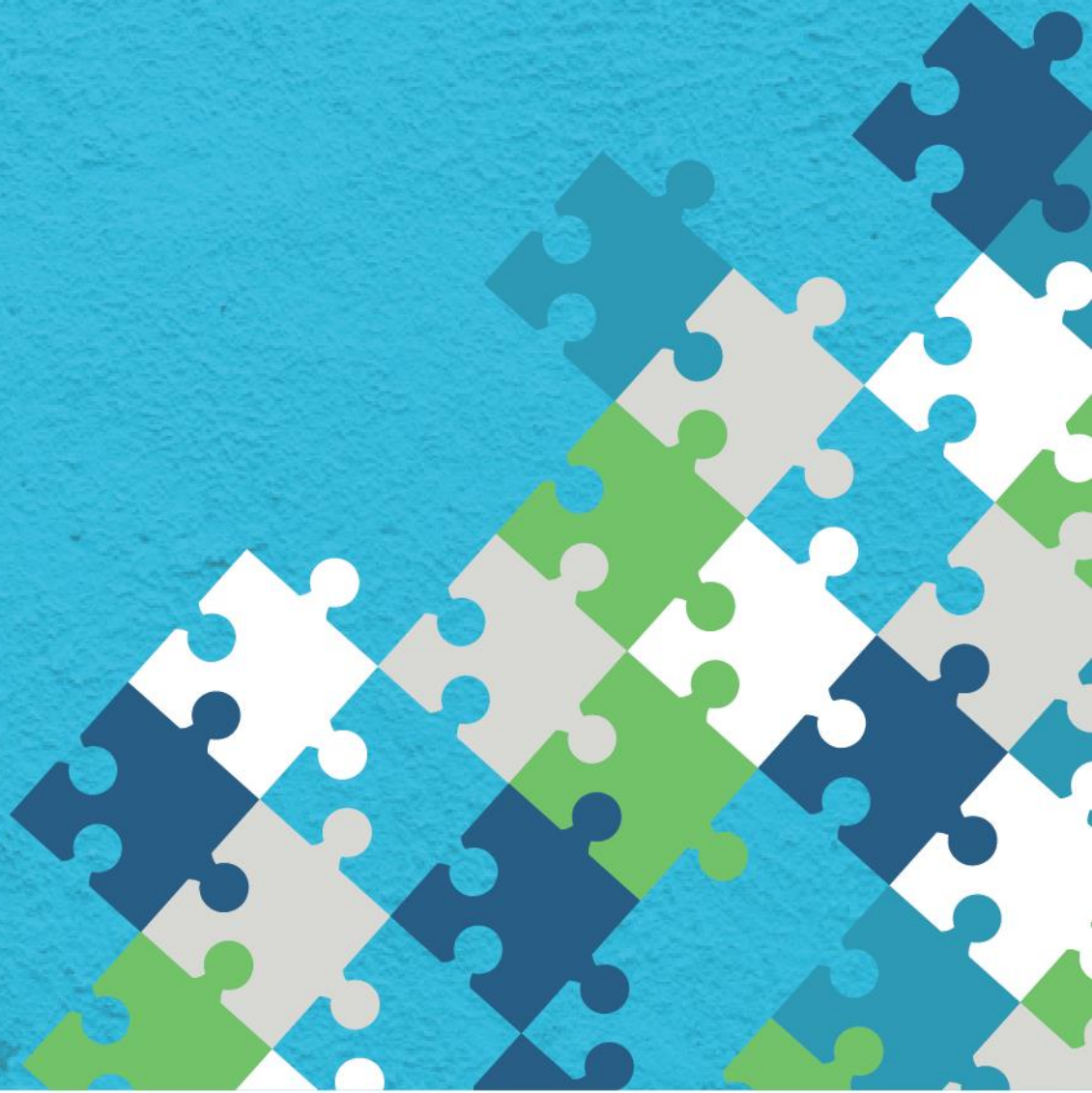**2** _____

Project LAUNCH grantees

+

3 _____

Field at-Large

Presenters

DR. KEN MARTINEZ Resource Specialist, National Resource Center for Mental Health Promotion and Youth Violence Prevention [NRC]

DR. LARKE HUANG, Director, Office of Behavioral Health Equity; Lead, Trauma and Justice Strategic Initiative; Senior Advisor – Children, Youth and Families; Administrator's Office of Policy Planning and Innovation; Substance Abuse and Mental Health Services Administration

Objectives:

Participants will learn:

1. The distinction between health disparities, health equity, and the contribution of social determinants of health

2. The prevalence of behavioral health disparities, hence the renewed urgency

3. The history of SAMHSA's Disparity Impact Statement and Strategy and the emphasis on access, utilization, and outcomes

4. A step by step process and set of strategies to address disparities

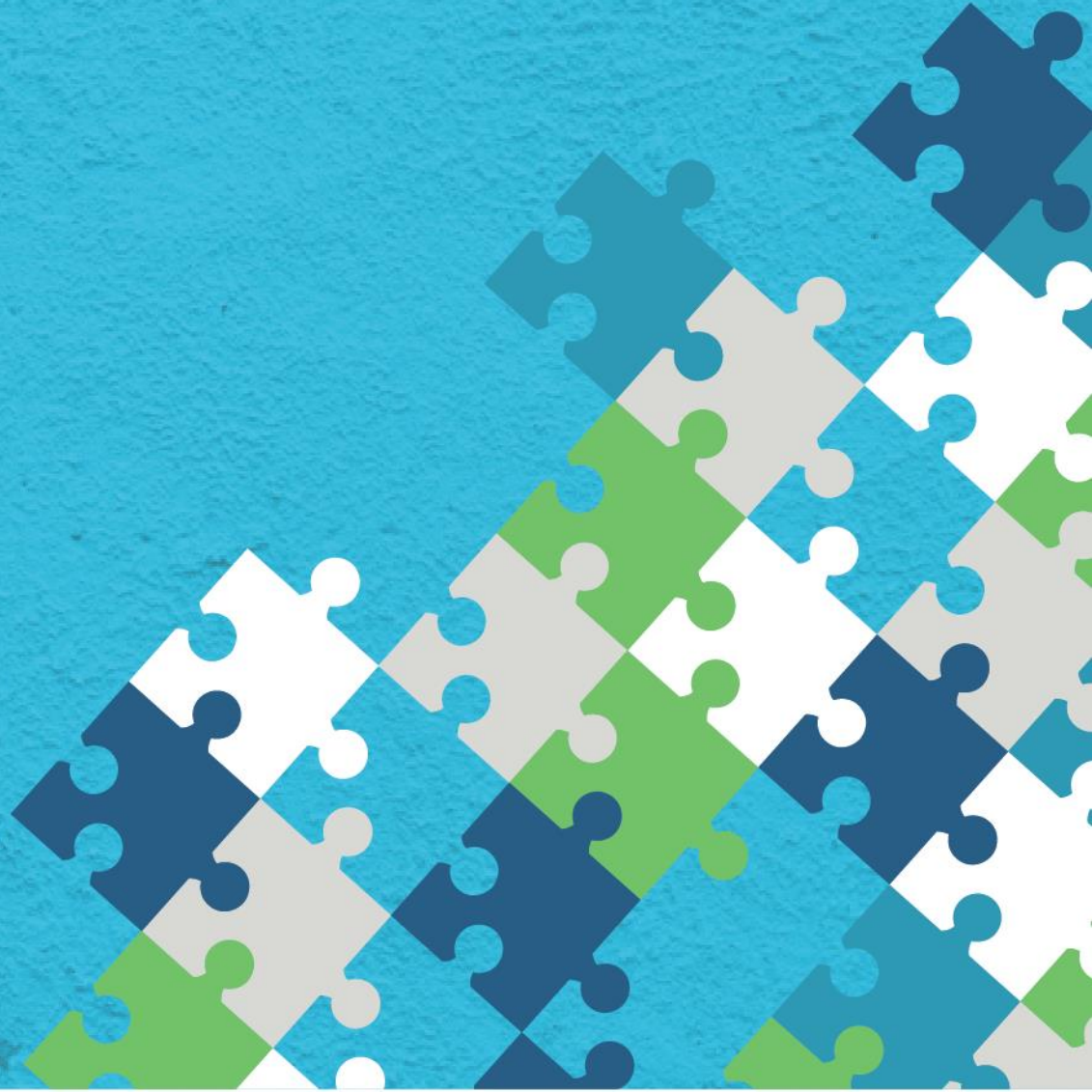5. Community examples of how disparities are being addressed

Strategies to Address Behavioral Health Disparities:
A Sense of Renewed Urgency
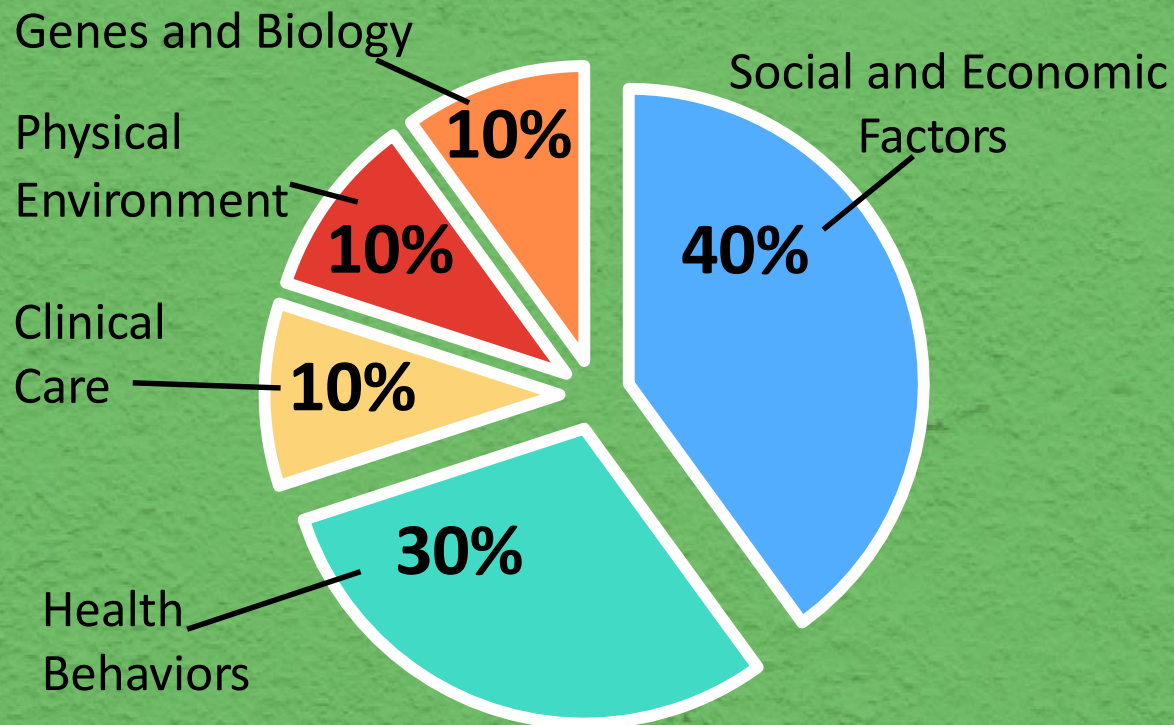
Why Are We Doing This?

- <u>How is this different and why now?</u>

  - Current Civil and Racial Unrest in Communities
  - Historical Privilege and Disadvantage
  - Personal, Community Cost
  - Financial Cost
  - Precision Care

Poll #2

Expand the Understanding of What Creates Health

Determinants of Health

- Genes and Biology — 10%
- Physical Environment — 10%
- Clinical Care — 10%
- Health Behaviors — 30%
- Social and Economic Factors — 40%

Necessary conditions for health (WHO)

- Peace
- Shelter
- Education
- Food
- Income
- Stable eco-system
- Sustainable resources
- Mobility
- Health Care
- Social justice and equity
- Trauma Reduction

Determinants of Health Model based on frameworks developed by: Tarlov AR. *Ann N Y Acad Sci* 1999; 896: 281-93; and Kindig D, Asada Y, Booske B. *JAMA* 2008; 299(17): 2081-2083.

World Health Organization. Ottawa charter for health promotion. International Conference on Health Promotion: The Move Towards a New Public Health, November 17-21, 1986 Ottawa, Ontario, Canada, 1986. Accessed July 12, 2002 at http://www.who.int/hpr/archive/docs/ottawa.html.
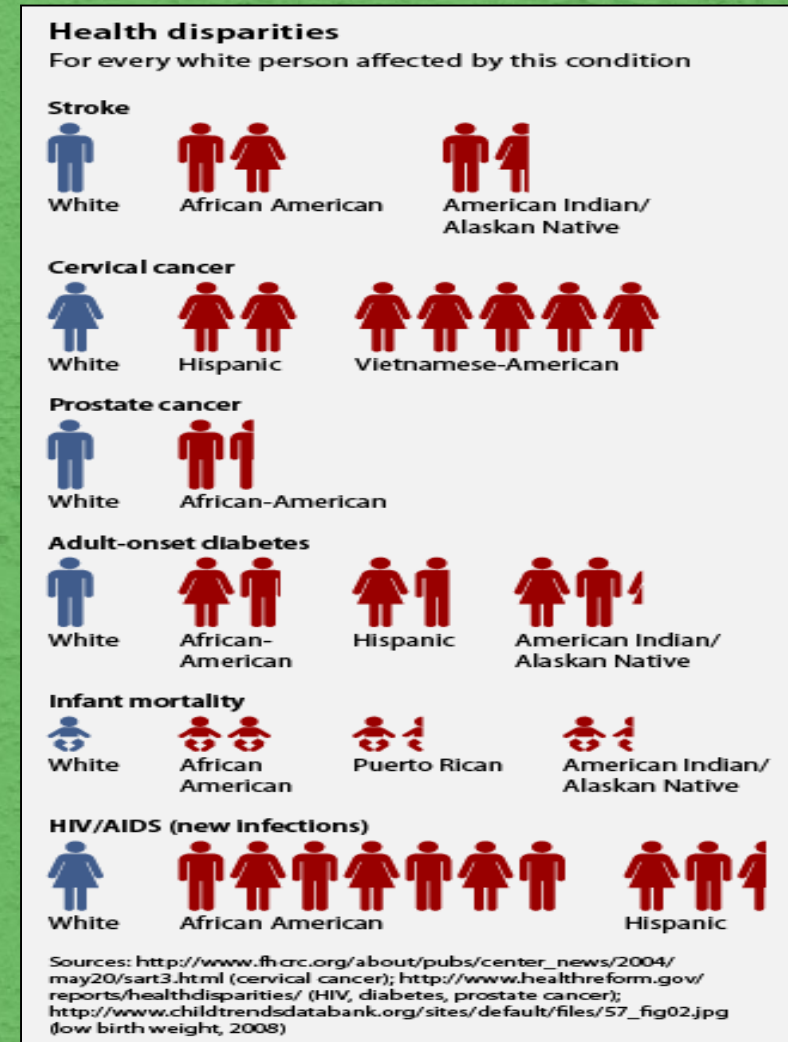
Overall Goal

Our collective goal is for disparities and disproportionalities reduction to become the "routine" as opposed to the exception
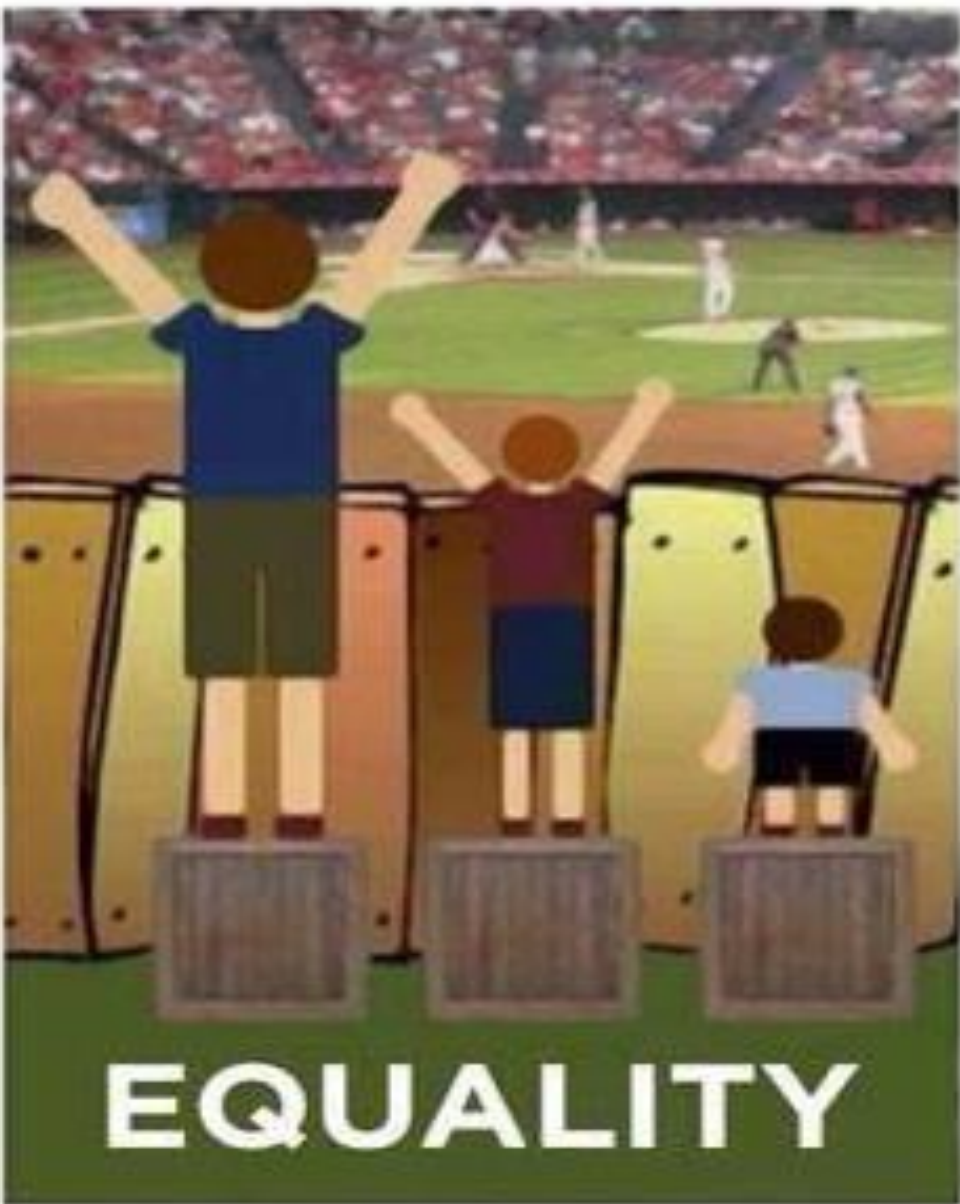
What is a Health Disparity?

"A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage."

Healthy People 2020

Health disparities
For every white person affected by this condition

Stroke
White | African American | American Indian/Alaskan Native

Cervical cancer
White | Hispanic | Vietnamese-American

Prostate cancer
White | African-American

Adult-onset diabetes
White | African-American | Hispanic | American Indian/Alaskan Native

Infant mortality
White | African American | Puerto Rican | American Indian/Alaskan Native

HIV/AIDS (new infections)
White | African American | Hispanic

Sources: http://www.fhcrc.org/about/pubs/center_news/2004/may20/sart3.html (cervical cancer); http://www.healthreform.gov/reports/healthdisparities/ (HIV, diabetes, prostate cancer); http://www.childtrendsdatabank.org/sites/default/files/57_fig02.jpg (low birth weight, 2008)

Health Equity

EQUALITY

EQUITY

Persistent Disparities

- Hispanic/Latina and Asian American female teens have the highest rates of depression
- Suicide remains the second leading cause of death for American Indian and Alaska Native youth
- Hispanic and Black adolescents are about 50% less likely than White adolescents to receive specialty mental health services (Merikangas et al., 2011)
- Youth of color are more likely than White youth to drop out of treatment (Alegria et al., 2011)
- Youth of color more likely to be charged in adult courts

Preschool Students Receiving Out-of-School Suspensions by Race/Ethnicity

FIGURE 1. PRESCHOOL STUDENTS RECEIVING OUT-OF-SCHOOL SUSPENSIONS BY RACE AND ETHNICITY
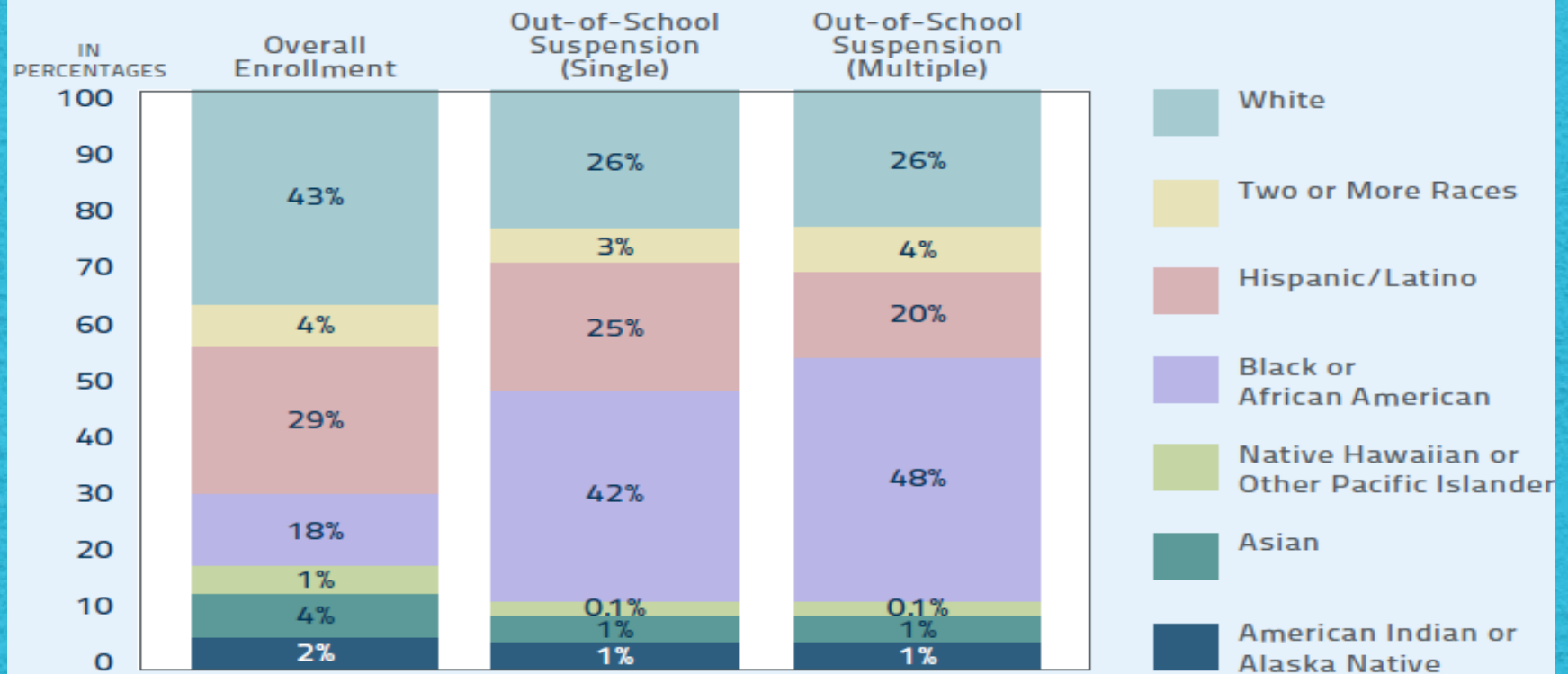
Source: U.S. Department of Education Office for Civil Rights. (2014). *Civil Rights Data Collection Data Snapshot: Early Chi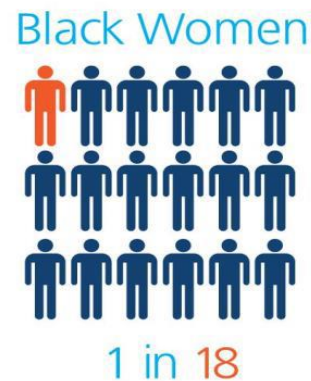l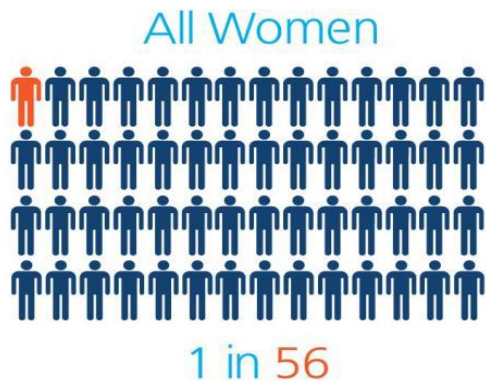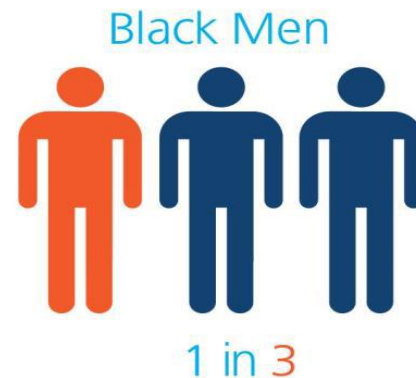dhood Education.* Washington D.C. Retrieved from http://www2.ed.gov/about/offices/list/ocr/docs/crdc-early-learning-snapshot.pdf
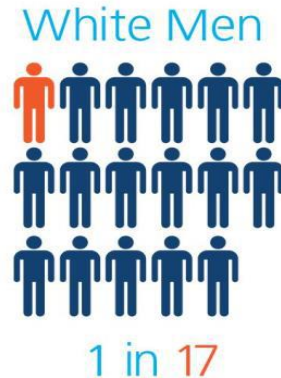
In the Educational System…

- Black preschool children account for 42% of out-of-school suspension and 48% of students with multiple out-of-school suspensions.
- Black students are suspended and expelled at three times the rate of White students.
- African American girls are more likely to be suspended
- Black and Latino students also receive fewer honors or gifted placements and more negative referrals (e.g., special education, discipline referrals) (Tenenbaum and Ruck, 2007)
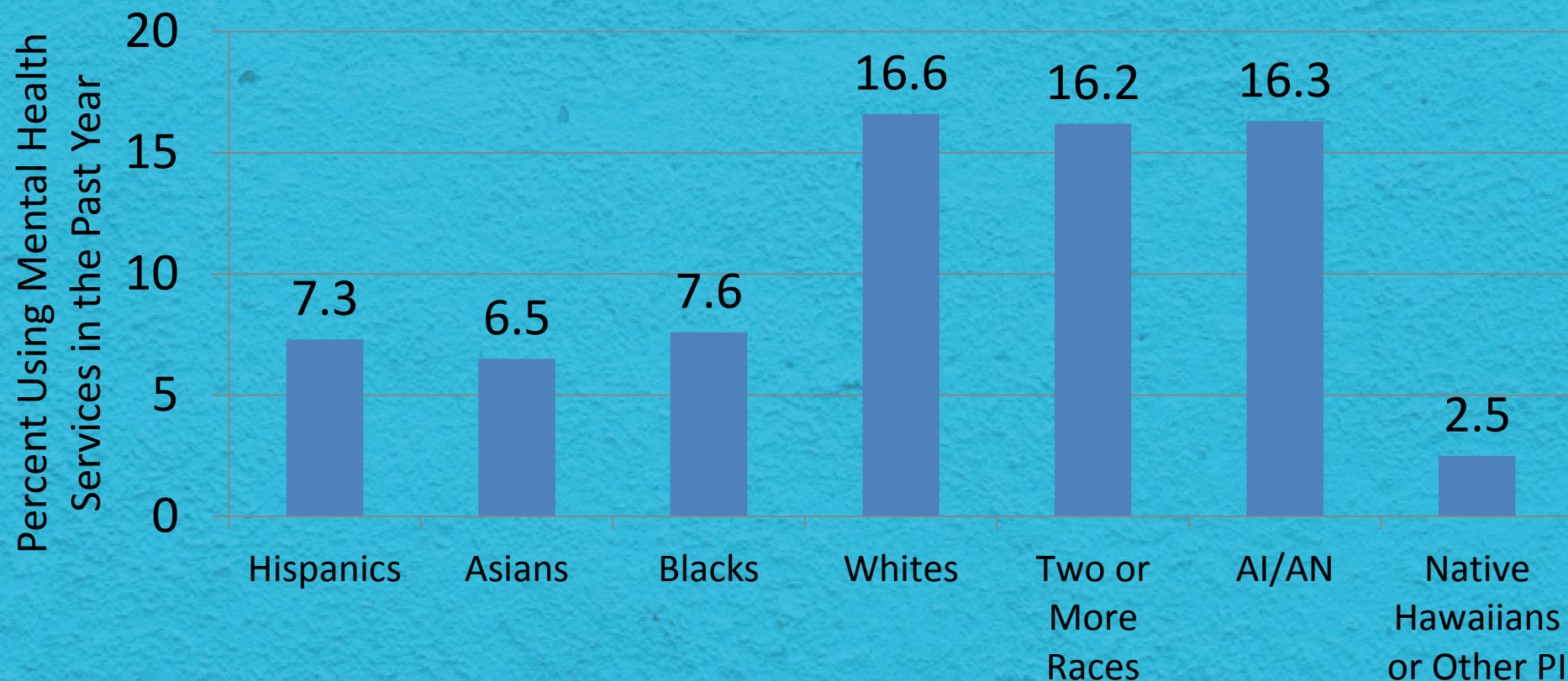
And in the Educational System…

- Latinos are four times more likely to drop out
- Black students are twice as likely to drop out compared to their white counterparts
- Graduation rates are significantly lower for African Americans, Latinos, and Native Americans
- Children in the richest school districts perform more than four grade levels above the children in the poorest school districts.
- Multiracial youth had the highest rate (13.3%) of being threatened or injured with a weapon in school and becoming involved in physical altercations, but are among the least likely to have carried a weapon in school

…And in the Justice-Involved Population

All Men	White Men	Black Men	Latino Men
1 in 9	1 in 17	1 in 3	1 in 6

All Women	White Women	Black Women	Latina Women
1 in 56	1 in 111	1 in 18	1 in 45

THE SENTENCING PROJECT

Rate of Mental Health Service Use in the Past Year Among Adults Aged 18 or Older, by Race or Ethnicity: 2011

Percent Using Mental Health Services in the Past Year

- Hispanics: 7.3
- Asians: 6.5
- Blacks: 7.6
- Whites: 16.6
- Two or More Races: 16.2
- AI/AN: 16.3
- Native Hawaiians or Other PI: 2.5

And Finally, the Financial Cost…

- Reducing disparities for ethnic/racial groups would have saved $229.4 billion in 2003-2006 (Joint Center for Political and Economic Studies, 2009)

- Eliminating disparities for racial/ethnic groups would have reduced indirect costs associated with illness, disability and premature death by more $1.24 trillion between 2003 and 2006 (Joint Center for Political and Economic Studies, 2009)

- Disparities in health cost the U.S. an estimated $60 billion in excess medical costs and $22 billion in lost productivity in 2009 (National Urban League, 2012)

Are We Getting Better?

-In 2001: *U.S. Surgeon General Report: Mental Health – Culture, Race and Ethnicity* alerted to racial and ethnic groups being underserved.

-In 2015: Racial and ethnic disparities have decreased somewhat, but still substantial. People of color are less likely than whites to use mental health services.

- – Continued underutilization of services
- – Lower treatment completion rates
- – Workforce needs
- – Culturally adapted service needs (Smith and Trimble, 2015)

    2015 Meta-analyses of 130 Research Studies

New Report:
America's Children in Brief, July 2016

- 41 key national indicators of child well-being

- Children of color fare the worst on most of the risk indicators.
    - http://www.childstats.gov/americaschildren/index.asp

Key Policy Drivers to Address Health Disparities

Healthy People 2020

Affordable Care Act 2010

National CLAS Standards

National Stakeholders Strategy for Achieving Health Equity 2011

HHS Action Plan to Reduce Racial and Ethnic Health Disparities (2011)

Secretarial Priority #1

1. Assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that:

*(c)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*

HHS Action Plan to Reduce Racial and Ethnic Health Disparities

A NATION FREE OF DISPARITIES IN HEALTH AND HEALTH CARE

Court/Jail Diversion – Access Data: Demographics of Program Enrollees

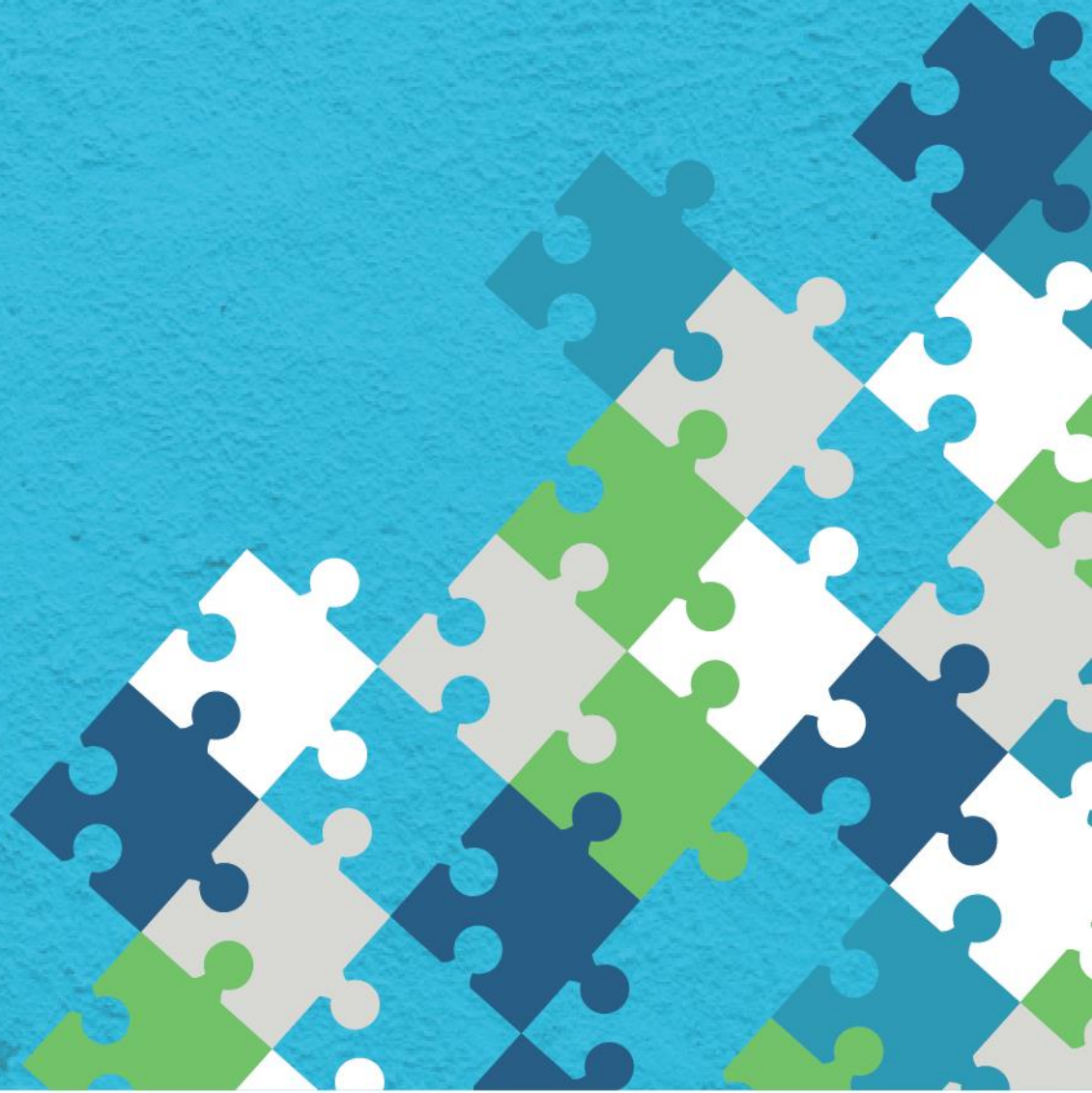|		
Race	White	69%
	African American	22%
	Multi-racial	5%
	American Indian	2%
Gender	Male	89%
Hispanic/Latino	(Yes)	15%
Age in Years	Mean	39 yrs
Education	Some college or more	51%
	High School/GED	41%
	Less than High School	8%

Baseline Data (N=642)

Enrollees in Opioid Treatment Program
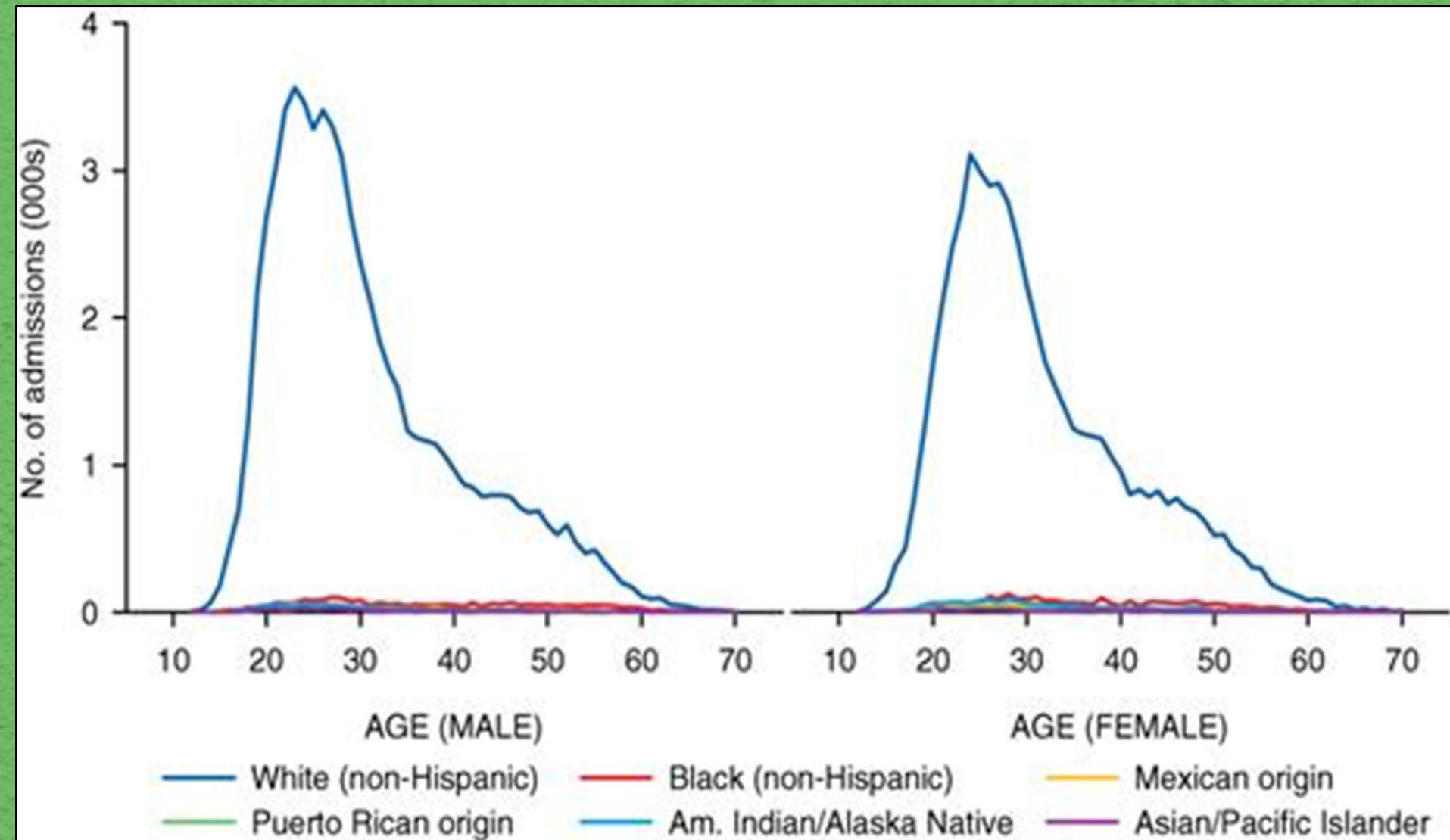
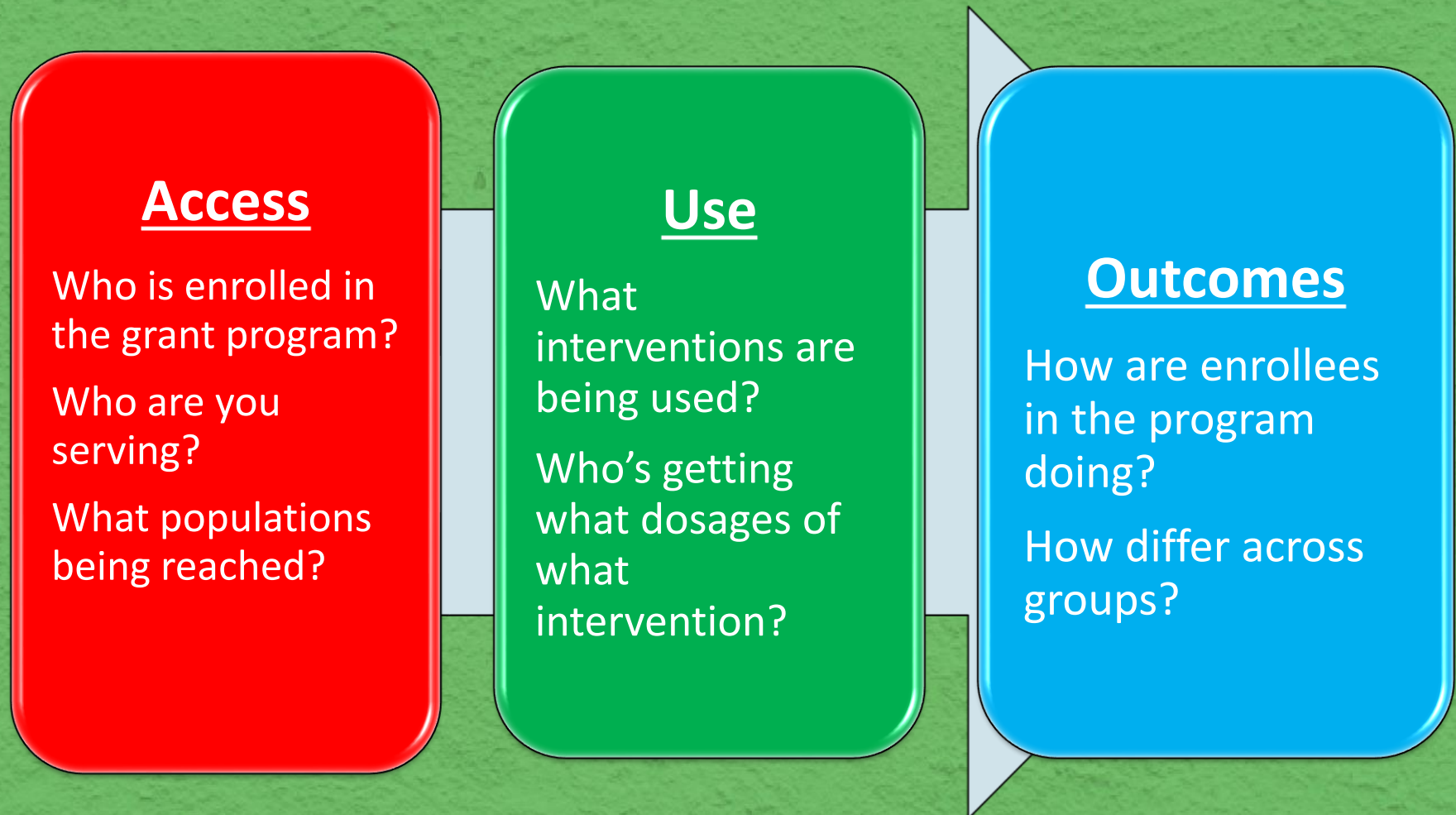# A Data-Driven Strategy:
Disparity Impact Statement

Poll #3

Disparity Impact Statement:
A Requirement in SAMHSA Grants

- Strategically focus on tracking disparities in access, use and outcomes for racial, ethnic or sexual/gender minority subpopulations.

- Use program performance data to implement a QI process.

- Leverage the National CLAS Standards as part of the QI process to ensure better access, use and outcomes for the identified disparate population(s).

Disparity Impact Strategy Framework for SAMHSA Grant Programs

Access

Who is enrolled in the grant program?

Who are you serving?

What populations being reached?

Use

What interventions are being used?

Who's getting what dosages of what intervention?

Outcomes

How are enrollees in the program doing?

How differ across groups?

GPRA Data Disaggregated by Population Groups

Why is "Access" Important?

Access: Subpopulations involved in the grant program through outreach; training and technical assistance; or timely use of individual treatment services, **including:**

- Enrolling in the behavioral health care system
- Having a behavioral health care provider in a geographically convenient location
- Having a culturally and linguistically appropriate health care provider
- Identifying disparate populations to be reached by prevention strategies
- Developing training and technical assistance for disparate subpopulations

Why is "Use" Important?

Use: Level of participation by disparate subpopulations in preventive interventions, interventions, treatment services and recovery supports to address, prevent and sustain behavioral health, **includes:**
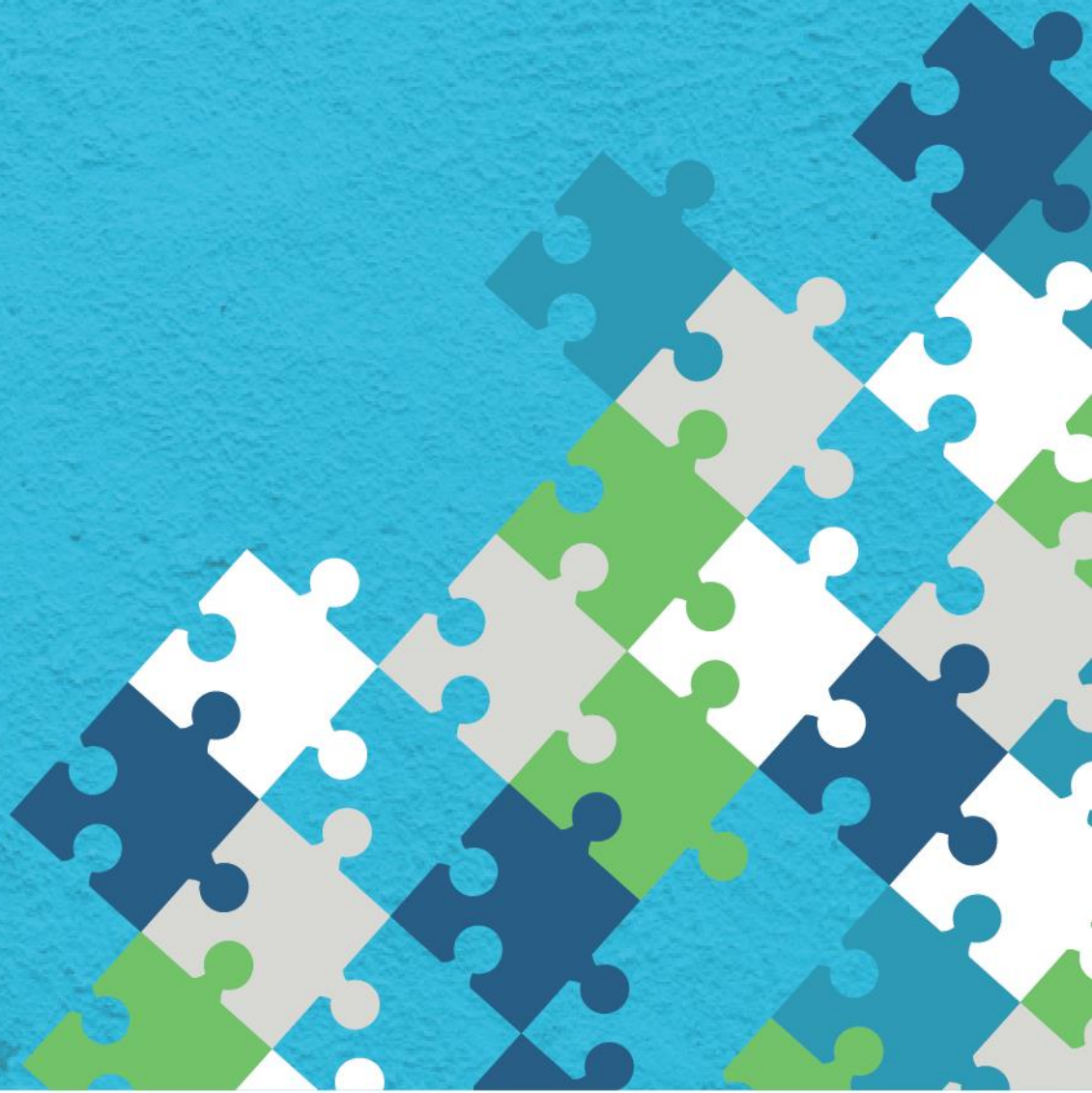
- Availability of quality treatment options that are consistent with population-specific data and free of cultural bias;

- Entering and staying in treatment;

- Receipt of information about a full range of treatment options in a manner that addresses issues of health literacy and cultural and linguistic preferences;

- Developing and maintaining partnerships to increase reach to, and retention of, disparate populations
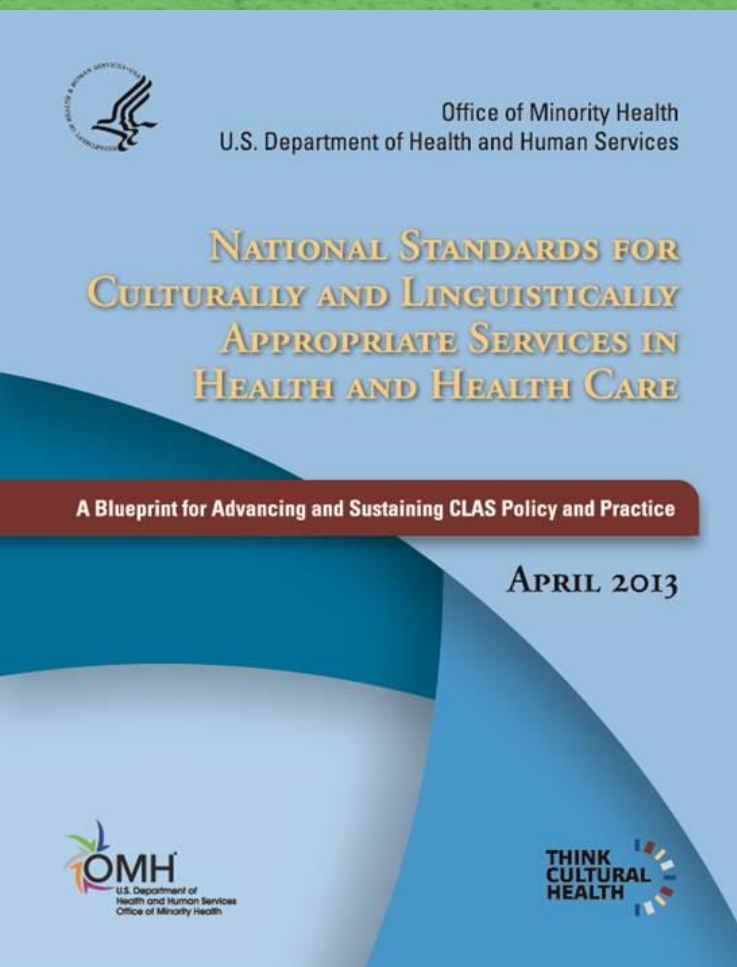
Why are "Outcomes" Important?

Outcomes: Impact of program for disparate populations

- Identifying the gaps in behavioral health services, access to utilization of interventions and treatment;

- Reaching disparate subpopulations with prevention strategies;

- Improving the quality of care for racial, ethnic and LGBT populations;

- Increasing the capacities of staff and workforce to better address the needs of the disparate populations.

Poll #4

Enhanced CLAS Standards Released by DHHS, April 2013

Office of Minority Health
U.S. Department of Health and Human Services

NATIONAL STANDARDS FOR
CULTURALLY AND LINGUISTICALLY
APPROPRIATE SERVICES IN
HEALTH AND HEALTH CARE

A Blueprint for Advancing and Sustaining CLAS Policy and Practice

APRIL 2013

OMH
U.S. Department of
Health and Human Services
Office of Minority Health

THINK
CULTURAL
HEALTH

Culturally and Linguistically Appropriate Services (CLAS) Standards

Standard 1
Principal Standard

Standards 2-4
Governance, Leadership & Workforce

Standards 5-8
Communication & Language

Standards 9-15
Engagement, Continuous Improvement & Accountability

https://www.thinkculturalhealth.hhs.gov/Content/clas.asp#clas_standard

Disparities Impact Statement/Strategy: Step by Step

- Describe population(s) and subpopulation(s) of focus demographically by race/ethnicity/LGBT status
- Align the ethnic/racial categories with the designations in the [Affordable Care Act (ACA) Provision 4302, standards](#) for data collection
- Disaggregate program performance measures (GPRA and other) data by race/ethnicity

Disparities Impact Statement/Strategy: Step by Step

- Identify disparities/disproportionalities in access, utilization and outcomes

- Prioritize the needs of the subpopulations experiencing a disparity

- Conduct a Root Cause Analysis
  - Issue → Cause → Root Cause
  - http://www.schoolturnaroundsupport.org/sites/default/files/resources/ActionPlanningGuide508.pdf

- Develop strategies and interventions

- Set an initial benchmark goal <u>for each</u> disparity to reach by the end of each year

Disparities Impact Statement/Strategy: Step by Step

- Develop a subpopulation-specific strategy(ies) to improve performance for each disparity

- Utilize a data-informed quality improvement process (eg. existing QI process, BH Disparities Committee, focus gps)

- Utilize more "precision-based" interventions and measurements

- If the disparity(ies) persists, set a new projected benchmark goal for the subsequent grant year and re-evaluate/ update/change your strategies/ interventions or make programmatic adjustments

Disparities Impact Statement/Strategy: Step by Step

- The National CLAS Standards are a tool to reduce identified disparities. They address:
  - Effective care and services that are responsive to diverse cultural beliefs and practices, preferred languages, health literacy, and other communication needs of all subpopulations
  - https://www.thinkculturalhealth.hhs.gov/Content/clas.asp#clas_standards
- Ensure that the National CLAS Standards are incorporated into your interventions/strategies and overall initiative through policies, procedures, rules, regulations, practice, and evaluation.

Example

Primary and Behavioral Health Care Integration Program

- Improves the physical health status of adults with serious mental illnesses.

- Supports communities in coordinating and integrating primary care services into community-based behavioral health settings.

- Uses physical health indicators such as blood pressure, weight, lipids, and tobacco use to measure the risk of hypertension, obesity, high cholesterol, diabetes, and other cardiovascular and respiratory diseases.

Participants by Race and Ethnic Group

Race/Ethnic Groups
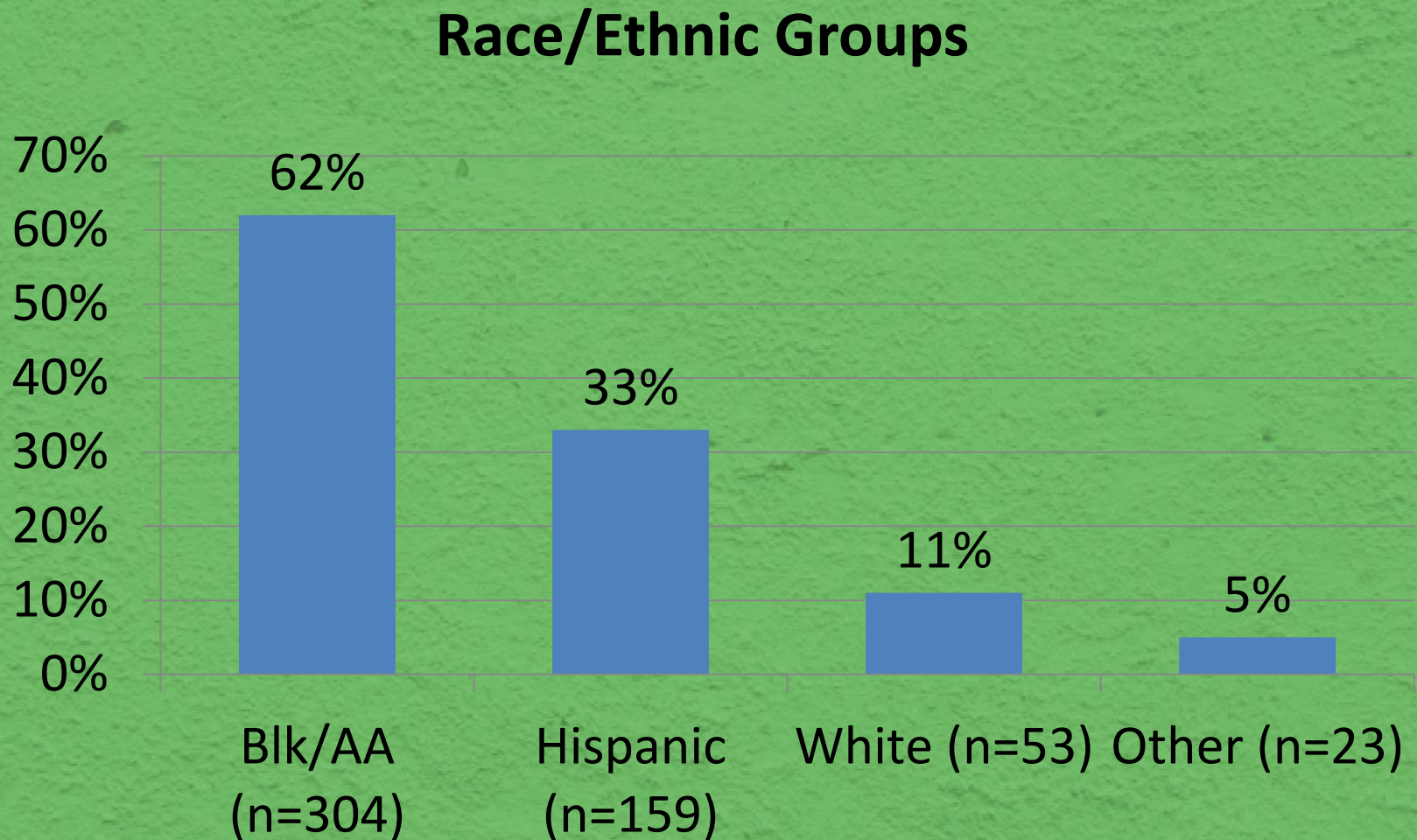
Disparity Impact Statement Monitoring

- Regular GPRA data reports to Program Project Officers using disparity data to identify areas for performance improvement

- Develop subpopulation-specific strategies to address disparities in access/use/outcomes

- Use this as opportunity to inform about CLAS Standards as a strategy to reduce disparities

Leveraging Data for Quality Improvement

- **Access** – enrollment, capacity expansion (training, partnership, collaborations), service availability, policy

- **Use** - treatment completion, screenings, referrals to specialty care, peer support, recovery support

- **Outcomes** – re-admission rates, increased awareness, health education and health literacy

Aligning Data with the National CLAS Standards

➢Standard 3: Recruitment policies aligned w/ client culture and language

➢Standard 4: Staff toolbox; employee cultural competence training

➢Standard 5: Notice of the right to receive language services written in Russian

➢Standard 6: Translation services in Russian

➢Standard 8: Health Education Materials Workbooks/Toolkits

➢Standard 9: Patient satisfaction assessments related to CLAS

➢Standard 10: Medical Risk Management Protocol

National Outcome Measures Baseline and Reassessment

Functioning – Everyday Life by cohort

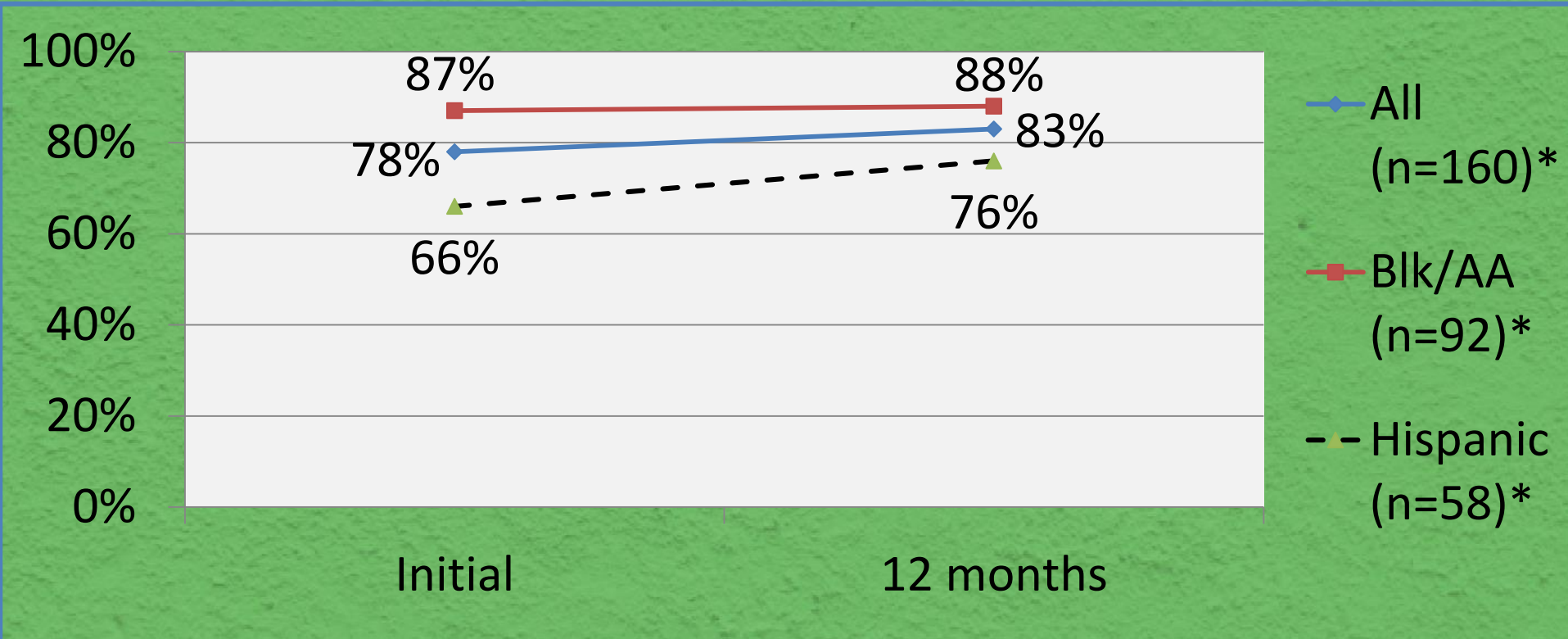Percentage of participants who reported functioning well in everyday life by cohort over time (*$p<0.05$)
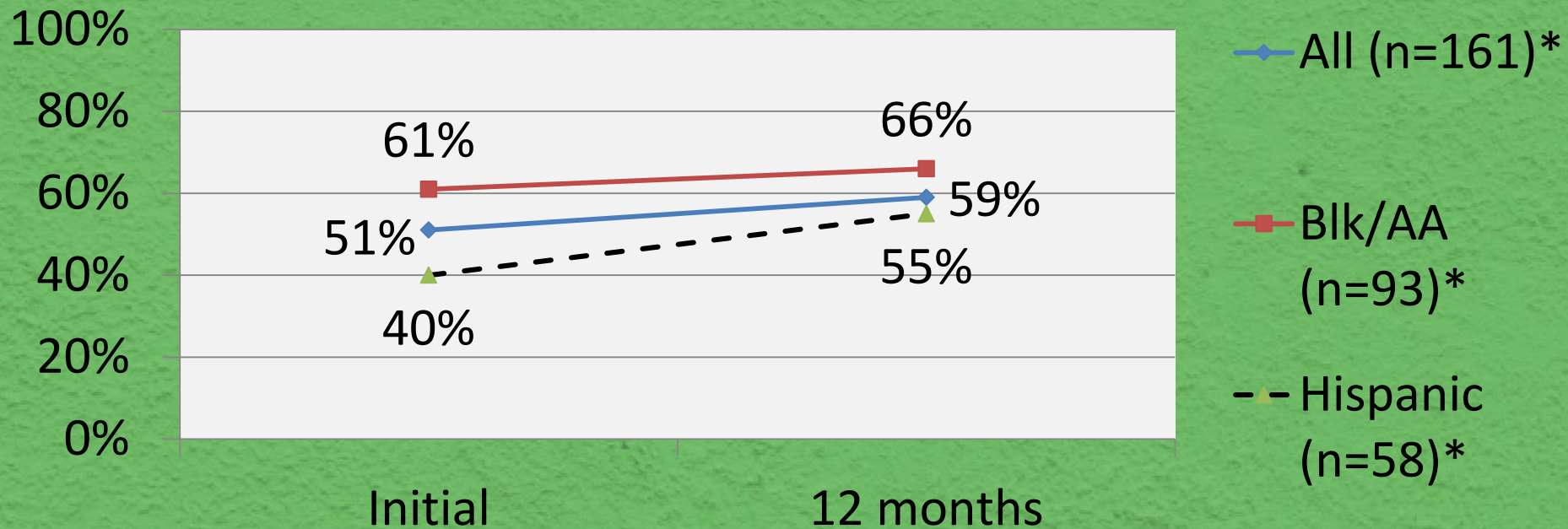
*statistically significant

National Outcome Measures Baseline and Reassessment

*Functioning – No Psychological Distress by cohort*

Percentage of participants who reported no psychological distress by cohort over time (all $p<0.05$)

Legend:
- All (n=160)*
- Blk/AA (n=92)*
- Hispanic (n=58)*

Data points:
- Initial: All 78%, Blk/AA 87%, Hispanic 66%
- 12 months: All 83%, Blk/AA 88%, Hispanic 76%

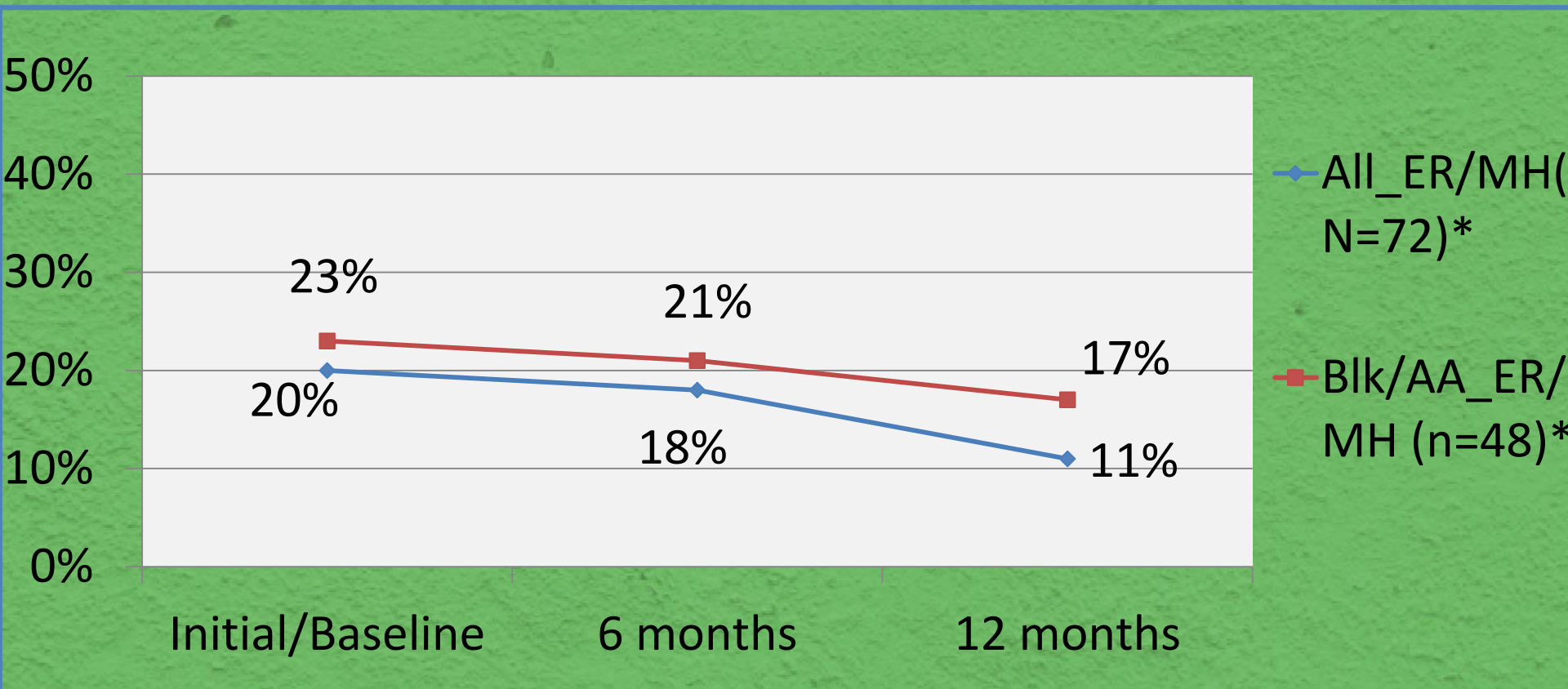# ER Visit for Physical Health Reasons

Percentage of participants with a risk of a ER visit for physical health reasons over a 3 month period, over time:
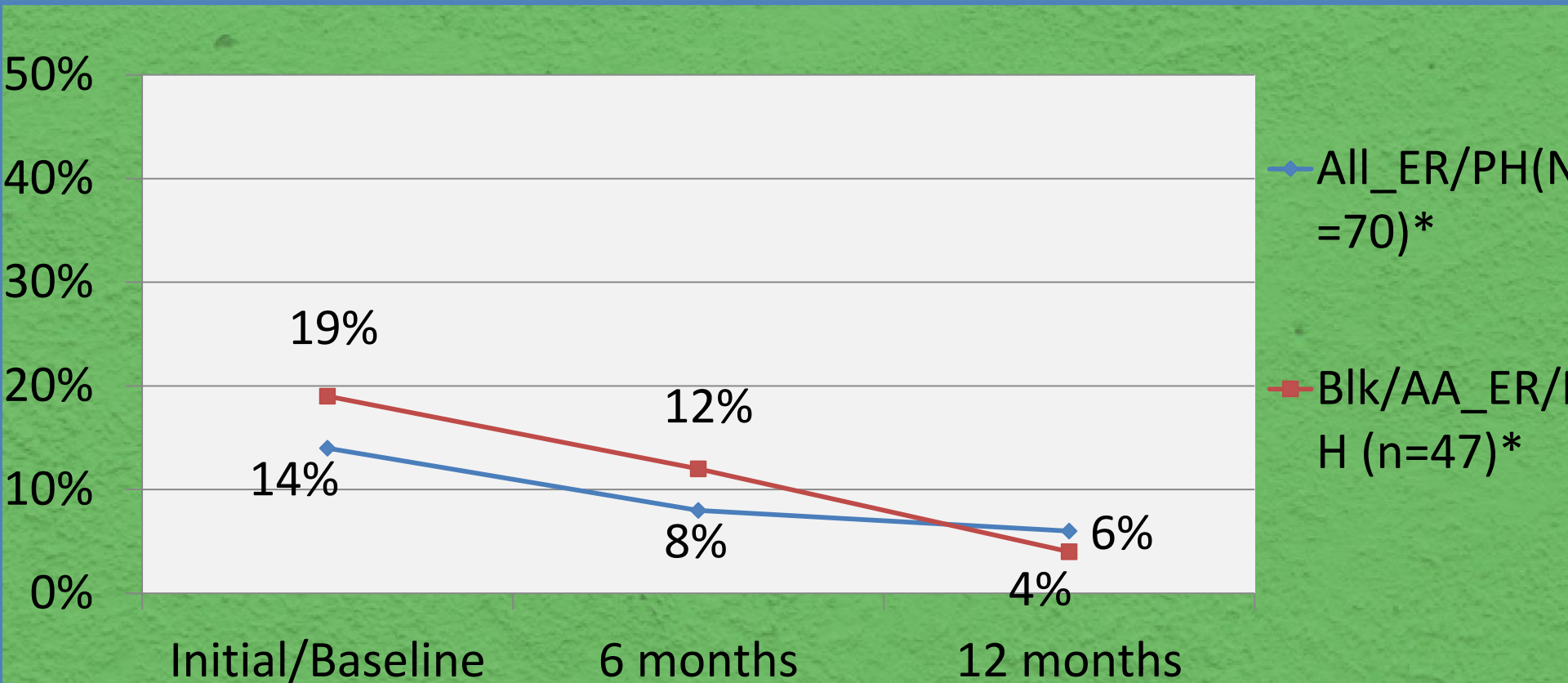
*statistically significant
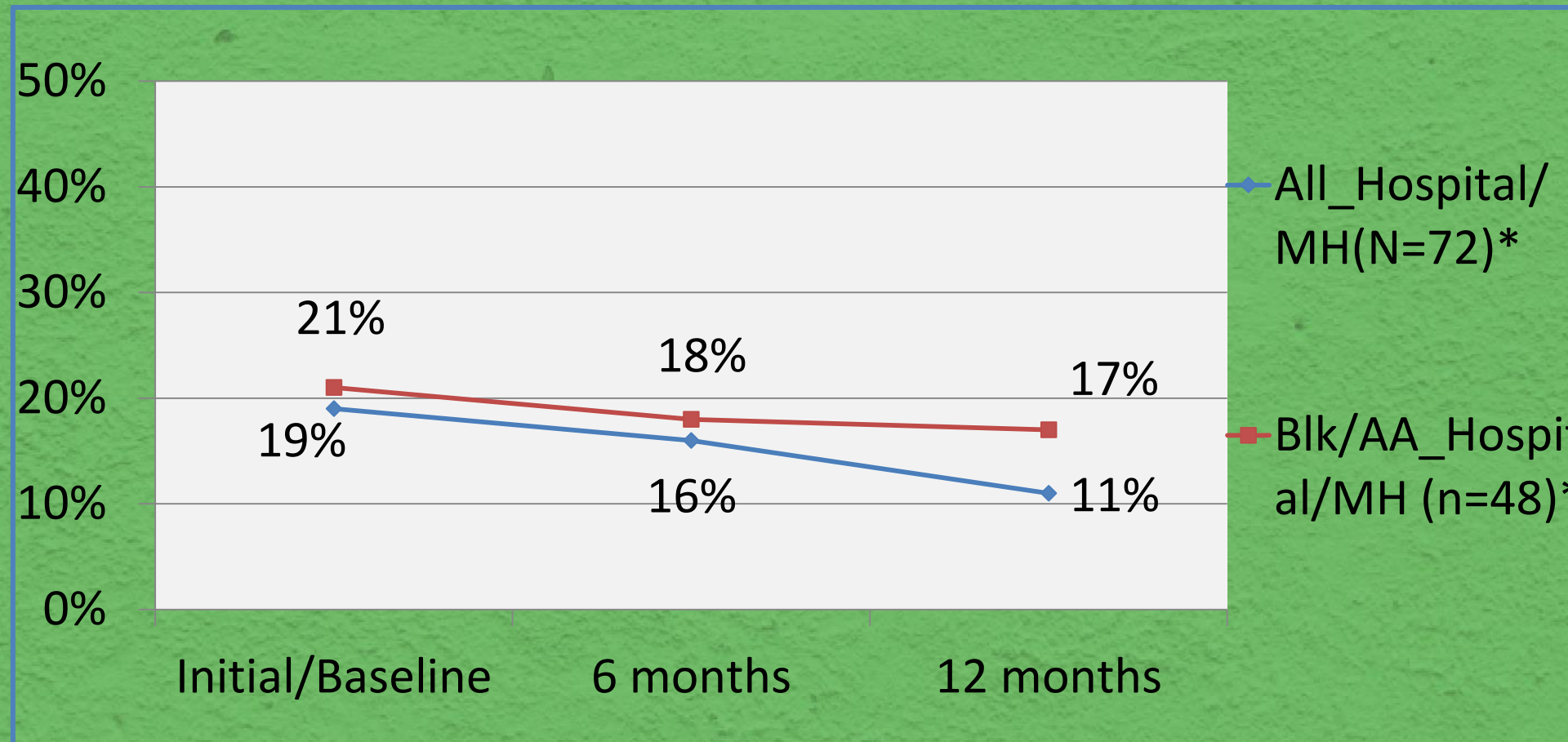
ER Visit for Mental Health Reasons

Percentage of participants with a risk of a ER visit for mental health reasons over a 3 month period, by cohort over time:

*statistically significant

Hospital Admission for Mental Health Reasons

Percentage of participants with a risk of a hospital admission for mental health reasons over a 3 month period, by cohort over time:

*statistically significant

Example

Pennsylvania: Lehigh Learning and Achievement School (IU 21) – More Restrictive Placements (Emphasis on Detention & Jail)

	2013-2014	African American	Latino/ Hispanic	Caucasian	Other	Risk Index	Risk Index	Risk Index	Risk Ratio	Risk Ratio	Total
						AA	L/H	Cauc	AA	L/H	
Psych Hospitals	10	2	1	7	0						
Detention/Jail	10	6	3	1	0	24%	0.10%	0.02%	12	5	17
Residential	2	1	0	1	0						
D&A Rehab	4	0	0	4	0						
Total	26	9	4	13	0						
	2014-2015	African American	Latino/ Hispanic	Caucasian	Other	Risk Index	Risk Index	Risk Index	Risk Ratio	Risk Ratio	Total
Psych Hospitals	11	4	3	4	0						
Detention/Jail	4	0	3	1	0	0%	0.08%	0.03%	0	2.66	2.66
Residential	3	3	0	0	0						
D&A Rehab	0	0	0	0	0						
Total	18	7	6	5	0						

Pennsylvania: Lehigh Learning and Achievement School
(IU 21) – Office Discipline Referrals (ODR)

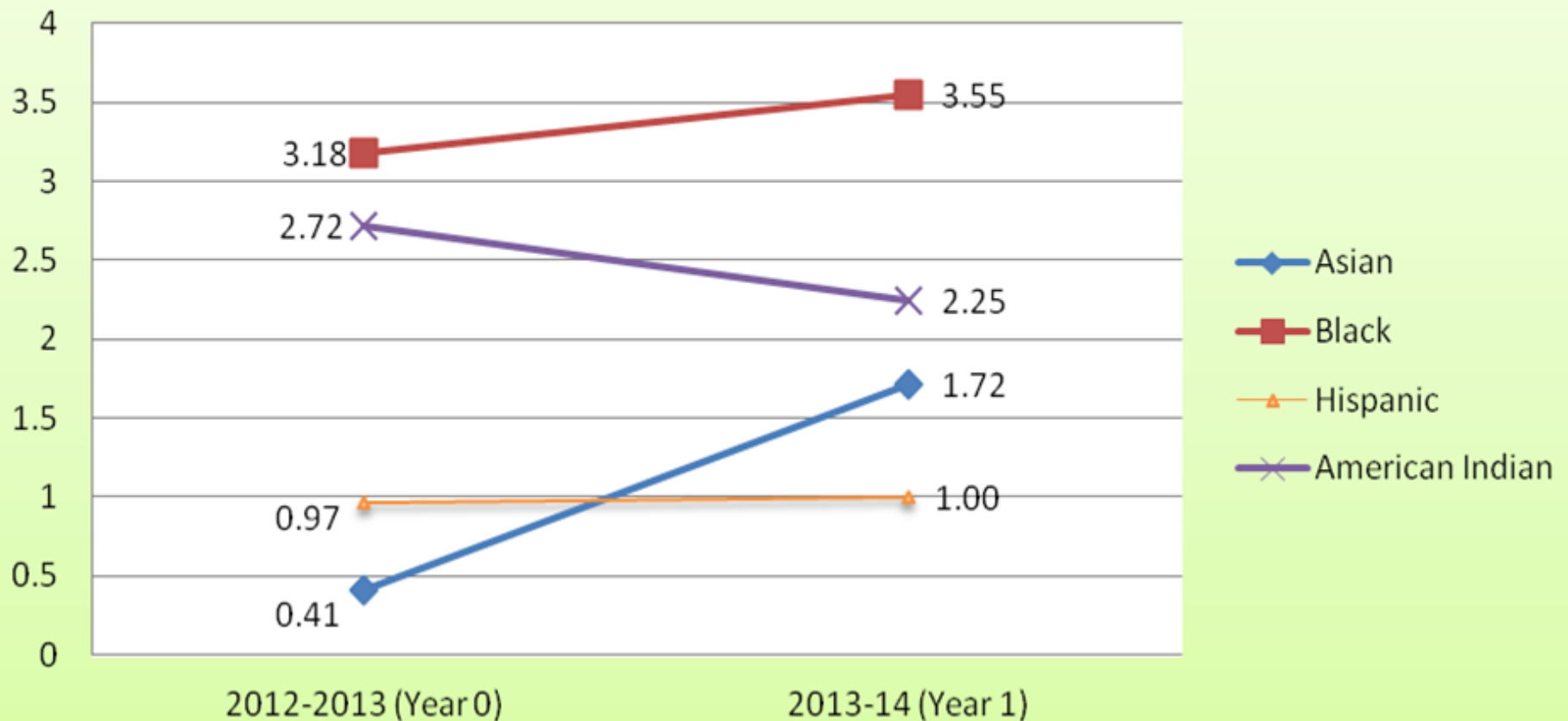| ODR Risk Ratio	2013-2014	2014-2015	2015-2016
Black/Latino	4.89	3.15	2.25

Example

Example – High School

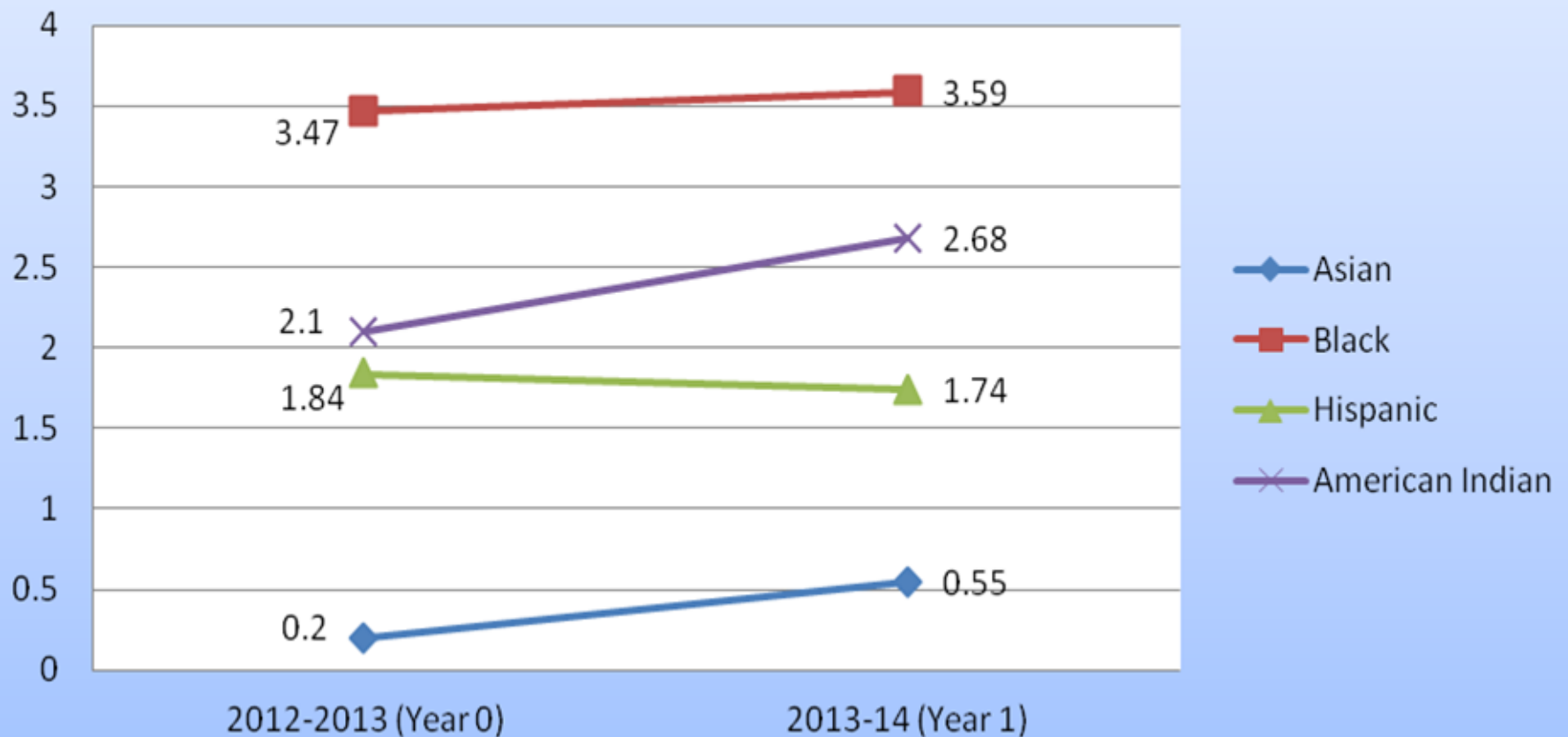Figure 1a: Rate Ratio (Exclusionary Discipline)
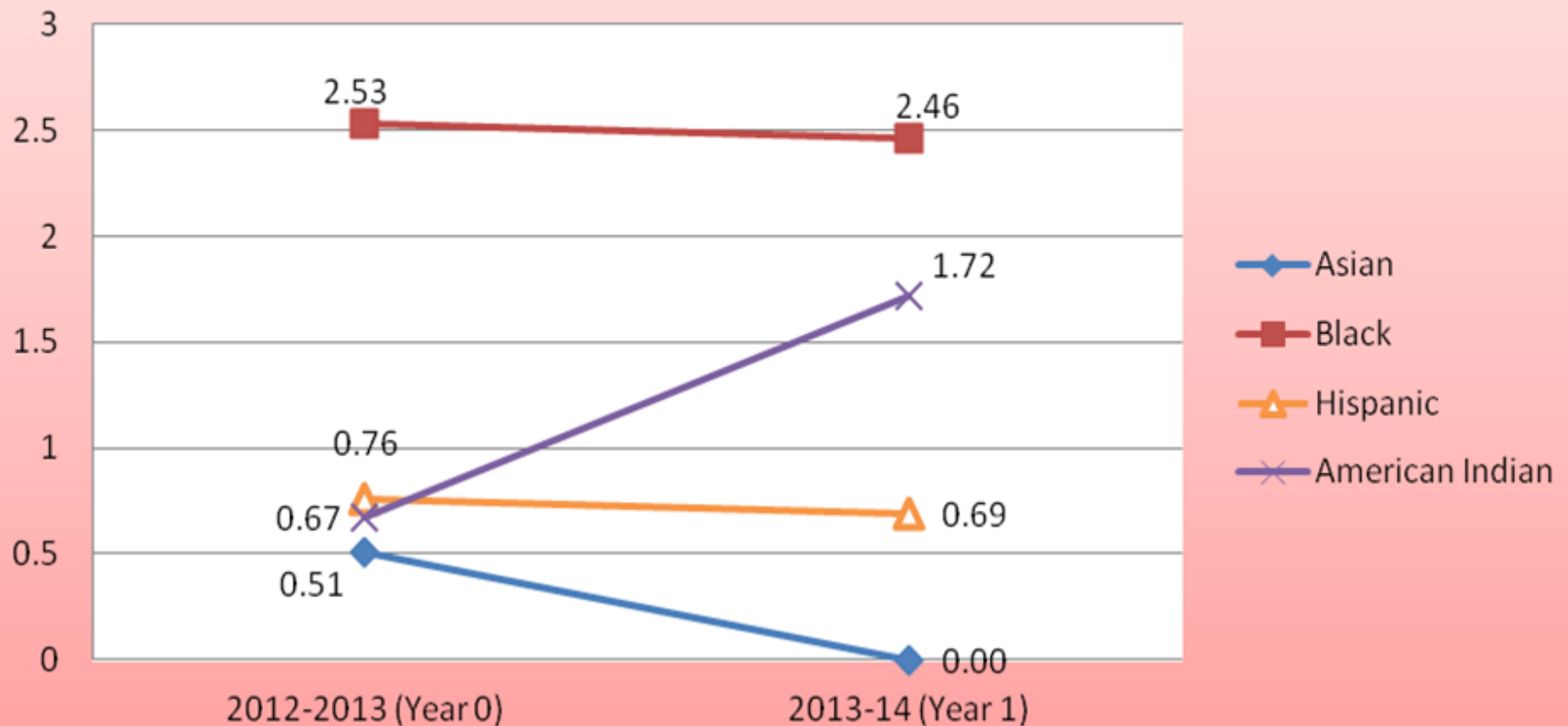
Example – Middle School

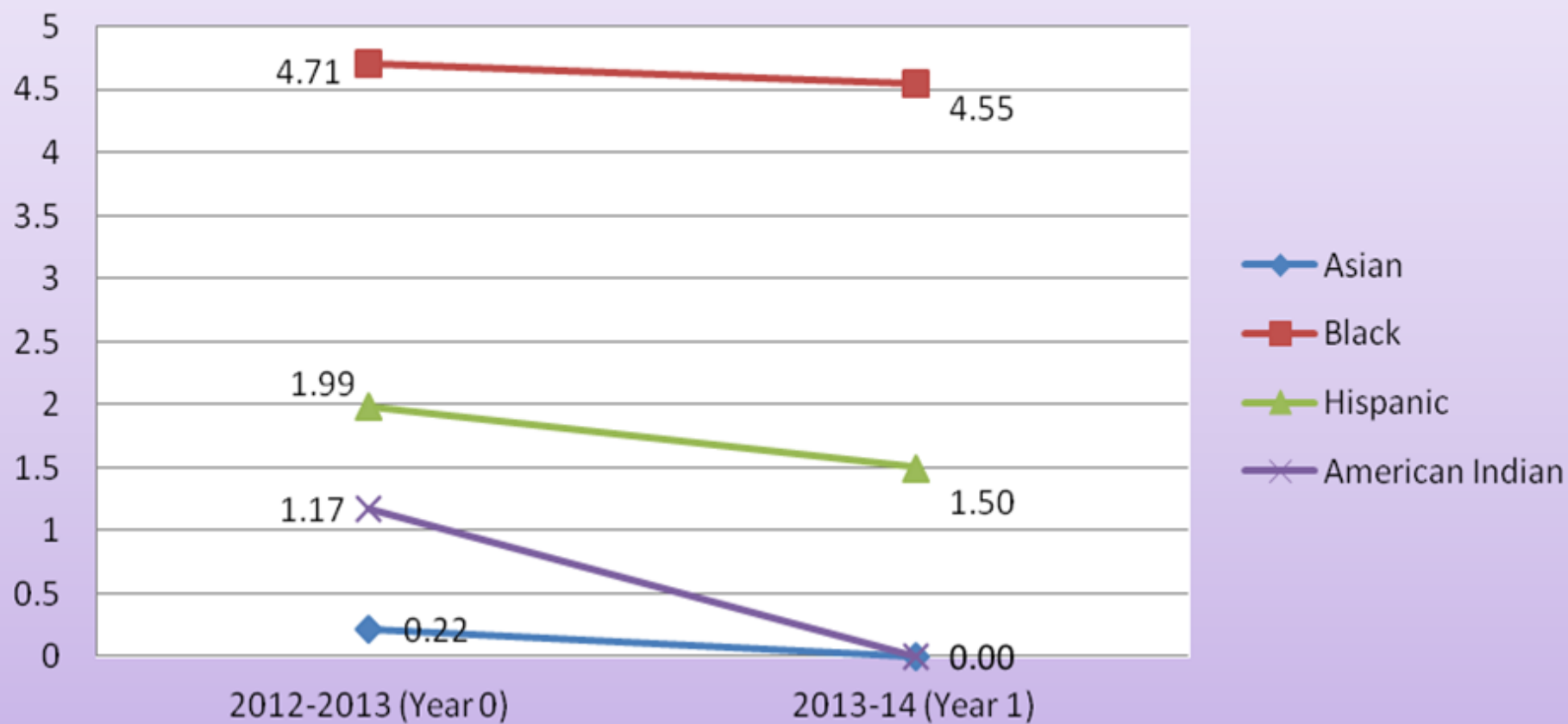Figure 1b: Rate Ratio Exclusionary Discipline

Example – High School

Figure 1c: Rate Ratio Exclusionary Discipline

Example – Middle School

Figure 1d: Rate Ratio Exclusionary Discipline

Vermont Project LAUNCH

- An opportunity to move the early childhood system towards equity;

- Its about creating an <u>environment</u> to advance racial equity;

- Focused on access, utilization, and improved outcomes;

- Hired LAUNCH direct service outreach staff from New American communities;

- Created a Health Disparities Subcommittee

Vermont PL: Five Areas of Focus

Quality Improvement

– Cultural and Linguistic Competence (CALC) Organizational Assessments;

– LAUNCH staff coaching;

– Partners share one CALC activity or challenge;

– Language Access Plan;

– Sub-contracts address continued focus and efforts on disparity reduction.

Leveraging Resources

– Potential Community Health Worker development;

– CALC trainings/assessments in following years.

Vermont PL: Five Areas of Focus

Workforce Development

- Behavioral health cultural competence training;
- Interpreter Training sessions – Basic and Advanced.

LAUNCH Team Learning

- Identifying emerging issues

Data and Evaluation

- Collecting more granular race and ethnicity data;
- The new database will collect country of origin and language spoken in the home.

"Most Significant Change"

For Grantees

- Broader inclusion of racial/ethnic populations
- "Discoveries" of un/under-served populations
- Innovative outreach and engagement strategies
- New collaborations
- Revisiting screening and assessment tools
- New exposure to CLAS standards
- New awareness of disparities/disproportionality

For Agency: Staff Initiated DIS Activities

- Administrators/evaluators working with staff on DIS data collection and intervention strategies
- Change thinking about how to use data
- Behavioral Health Disparities Online Module

For People & Communities Served

- Increased attention to vulnerable populations
- Better outreach, engagement
- Better and individualized prevention and treatment services

Asking the Right Questions is a Path to Health Equity

- What would it look like if equity was the starting point for decision-making?

- How would your work be different?

- How would you need to be organized and committed to reducing disparities and promoting equity in your work and in your workplace?

Resources

DIS Online Training Module

45 minute online training walks you through DIS process, found at:
http://airhsdlearning.airws.org/DIS/multiscreen.html
It includes:

- -History, purpose, definitions of disparities/ disproportionalities
- -Disaggregated data
- -Developing benchmark goals and strategies
- -Quality improvement process
- -Incorporation of CLAS Standards
- -Resources

Resources

-Examples of disparity impact statements:
http://beta.samhsa.gov/grants/grants-management/disparity-impact-statement

-The National Center on Safe Supportive Learning Environments (an American Institutes for Research TA Center) developed:

– "Addressing the Root Causes of Disparities in School Discipline: An Educator's Action Planning Guide"

https://safesupportivelearning.ed.gov/sites/default/files/ActionPlanningGuide508.pdf

https://safesupportivelearning.ed.gov/

Resources

-Building on Strengths: Tools for Improving Positive Outcomes Ensuring the Well-being of Boys and Young Men of Color: Factors that Promote Success and Protect Against Substance Use and Misuse. Using Prevention Research to Guide Prevention Practice SAMHSA's Center for the Application of Prevention Technologies January, 2016.

http://www.samhsa.gov/capt/sites/default/files/resources/ensuring-wellbeing-boys-young-men-of-color-factors.pdf

-National Network to Eliminate Disparities (NNED)
http://nned.net/

References

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If you would like more information about the content of this online learning event or about how the National Resource Center for Mental Health Promotion and Youth Violence Prevention can help you with the work you do, please contact **1-866-577-5787** *or via email at Healthysafechildren@air.org*

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Thank you!