

NRC Webinar
DIS 101: How to Address Disparities and Disproportionalities
Through Disparity Impact Statements and Strategies
July 20, 2016

Moderator: The National Resource Center for Mental Health Promotion and Youth Violence Prevention is funded by SAMHSA, the Substance Abuse and Mental Health Services Administration and we offer resources and expert support to states, tribes, territories and local communities to prevent youth violence and promote the overall wellbeing of children, youth, and their families. All of our resources are on the project website, healthysafechildren.org and we believe that with the right resources and support, all communities regardless of their zip code can promote positive outcomes for children, youth and families. The National Resource Center as I mentioned is funded by SAMHSA and coordinated by the American Institutes for Research and we're joined in this work by more than 10 organizations. To address the problems that I mentioned before and to improve wellbeing, we provide information and materials to support efforts for those who serve children and youth from birth through high school including in areas that are especially impacted by youth violence.

We serve two grantee programs, Safe Schools/Healthy Students, Project LAUNCH grantees and the field at large and the Safe Schools/Healthy Students initiative takes a comprehensive approach drawn on the best practices in education, justice, social services and mental health to really help communities take action to prevent youth violence. The grantees recognize that violence among young people is caused by a multitude of factors including early childhood mental health, family life, mental health and substance abuse issues and that no single action can be counted on to prevent it.

Project LAUNCH which is Linking Actions Unmet in Children's Health promotes the wellness of young children ages birth to eight by addressing the physical, social, emotional, cognitive, and behavioral aspects of their development. Throughout the webinar, if you have any questions you can use the Q&A pod which will appear on the right hand side of your screen to chat with the presenters at any point during today's event. We're going to start off with a poll today, we'd like to get to know who's joined us for the webinar.

So before I introduce the presenters if you could take just a moment to tell us what organizations you work in and what your role is and there's the poll on the screen and that'll give our presenters a sense of who they're speaking with today. [Pause]

So it looks like we have a mixture, you can see people from education, mental health, public health, some federal, I imagine federal and state government, community based organizations, universities and others as well as a mixture of different roles that people are playing particularly psychologists and administrators seem to be the ones winning at the moment. I think we'll go ahead. We have a lot of material and information that we're going to be covering today, so thank you for answering this poll.

I'd like to just take a minute to introduce you to our presenters for today's event. Dr. Larke Huang, who's the Director of the Office of Behavioral Health Equity at SAMHSA, is a clinical community psychologist and she provides leadership on national policy for mental health and substance abuse issues for youth and families. She has authored many publications on behavioral health and developed programs for underserved, culturally and linguistically diverse populations and it's a real pleasure to have Dr. Huang with us today.

Dr. Ken Martinez is a principal researcher here at the American Institutes for Research and he's a clinical psychologist who has extensive experience working with communities and states in promoting and operationalizing cultural and linguistic confidence and reducing disparities. He has authored many publications on disparities and disproportionalities and serves on SAMHSA's national advisory council. He's also a resource specialist for our Safe Schools/Healthy Students grantees.

So again, just to remind you, if you have any questions during the presentation or you'd like to chat with the presenters, feel free to enter your questions or your chat in the Q&A pod. So I'm going to turn it over now to Dr. Martinez who's going to get us started on our online learning event. Ken?

Dr. Ken Martinez: Yes, thank you, Mary. I'd like to add to Dr. Huang's introduction that she is the originator of the Disparities Impact Statement at SAMHSA. So it's a wonderful achievement for SAMHSA to be the first Department of Health and Human Services agency to include the DIS as we call it in its request for proposals and applications. So we're very pleased that Dr. Huang is our co-presenter today.

So let's get started. Welcome everyone. Good afternoon and we hope that you find this webinar helpful and be able to share with you exactly what we're talking about in terms of disparities and looking at how you might use the disparities impact statement in your work. Today we're going to learn about the distinction between health disparities, health equity and social determinants of health, statistics on the prevalence of health disparities, the history of the disparities impact statements from the Department of Health and Human Services and SAMHSA more specifically as well as a step-by-step process on how to address disparities through a disparities impact statement and strategy. Then finally we're going to jump in to community examples of how disparities are being addressed through disparities impact statements.

So I'd like to turn it over to Dr. Larke Huang to get us started on the strategies to address behavioral health disparities, a sense of renewed urgency. Dr. Huang?

Dr. Larke Huang: Thank you, Ken and good afternoon to all of you who are on this call. Thank you very much for participating. As Ken mentioned, we'll be talking about the disparity impact strategy or the disparity impact statement that we are requiring of all of our grantees at SAMHSA but it's not an effort that is peculiar only to SAMHSA or to our grantees, other agencies I've just been reviewing for CMS or Center for Medicare/Medicaid Services and they now have also incorporated the health equity statement in their grant programs and the CDC will be doing the same. So it is something we're doing at the Department of Health and Human Services but it is a strategy that can be done in almost any organization, it's a data driven strategy that we hope helps to reduce disparities and disproportionalities.

So why are we doing this and how is this different and why now? We'll tell you a little bit more about how the disparity impact strategy came about but in terms of also doing this particular webinar now, it had been planned several months ago. Obviously it takes a lot to pull it together but there is so much going on in our country right now that I think also makes this a very timely webinar. In terms of the current civil and racial unrest that we're seeing in our communities around the country heightened in the last couple of weeks with shootings and police shootings and shootings of residents, it's highlighting to us that there are certain inequities in our communities and countries that we need to think about how do we reduce this.

We've been dealing with the issues of historical privilege for some groups, historical trauma or disadvantage for other groups and we think that this might be an important

strategy to begin to chip away at this and of course there is tremendous personal and community cost if we don't address disparities. There's significant financial cost, there's significant chance that communities of color continue to get short changed and that the - it would be a loss of the social capital and the short sighted use of our resources. We know there is a financial cost and we're also moving to looking more at this idea of precision care in health delivery systems that we're really trying to, in this new era of healthcare delivery, really better target interventions to unique and specific characteristics of different populations and groups and it's only by recognizing some of the disparities among these groups that we can best align our interventions and strategies to eradicate some of these disparities. So the timely point now to really be looking at disparity and health equity issues. Next slide.

I guess it's a poll, number two. So given what is going on in the country now, has your community in the last six months experienced civil or racial unrest? If you could quickly answer that, I know in the federal government right now we have a number of initiatives going on to look specifically at communities that have experienced civil unrest. We have a new grant program to address that. We know the president has the My Brother's Keeper initiative with over 200 communities signing on to be part of the My Brother's Keeper initiative. So it looks like about 37%, 36%, a third of the communities represented on this call have had some kind of civil or racial unrest in the last six months. Then we also are asking if you have, what is your community doing to address it? I know in my community we've been having a series of town halls actually hosted for the communities by our city agencies and law enforcement. I see people - a variety of responses and then some communities not doing anything in particular or perhaps more actively ignoring it. Okay, thank you. That helps us and you can keep your responses coming in as well. Thank you.

Okay, the next slide. One of the things that's important in terms of really understanding how we get to community equity, health equity, community wellness is really beginning to better understand the determinants of health, the determinants of a community's health and wellbeing. We know that clinical care, actually clinical delivery of healthcare really accounts for almost just about 10% of the variants and health outcomes. That in fact, 40% of that variants is accounted for by social and economic factors, such things as employment, stable housing, food, security or insecurity, access to transportation, other issues around domestic violence that many of these other social and economic issues have a significant impact on the health and wellbeing of individuals and communities and in part, as

we think about addressing disparities, it isn't only the clinical care and the clinical delivery system but how do we also consider these other social economic factors that impact different communities to different degrees. Next slide.

So our overall goal as we think about reducing disparities is for disparities and disproportionalities reduction to become the routine as opposed to the exception as we think about healthcare or behavioral healthcare delivery. Next slide.

So just so that we're all on the same page in terms of how we're thinking about a health disparity, we at SAMHSA have adopted the Department of Health and Human Services Healthy People 2020 definition which states that a particular type of health difference that is closely linked with social, economic and/or environmental disadvantage is considered a health disparity. We used the Healthy People 2020 definition because it has now a specific new section on social determinants of health and we know that many states also align some of their health and public health work with the federal healthy people documents, Healthy People 2020 documents. So you can see on the right side of the slide, it says very graphically that for example in terms of strokes, African-Americans have twice as many strokes as whites, as the white population. If you look at infant mortality we see that it's two times the percentage of infant mortalities in the African-American community as the white community. So we look at these as disparities and disproportionalities because the incidence of the condition is not proportional to the representation of that population in the overall population. Next slide.

So we're really striving for health equity. We don't want populations to go to the lowest level just so we're equal across the board. We really want to ensure that we're getting the highest level of population outcomes, health outcomes across all populations and I really like this slide, I think it really shows you what the difference in terms of equality versus equity. We're not saying that all populations need the same things or equal dosage or equal resources or equal access, that different populations need different types of supports and resources in order to get to true health equity which is demonstrated on the right side of this slide. I hope you'll keep that in mind. I think it's a good pictorial, description of what we mean by health equity. Next slide.

I think I'll turn it over to Ken.

Dr. Ken Martinez: Yes, thank you. Behavioral health disparities persist and continue to persist over time for people of color and youth are particularly vulnerable, Latina and Asian-American female youth suffer with the highest rates of depression and Latina youth have the highest percentage of suicide attempts and suicide for generations has been the second leading cause of death for American-Indian and Alaskan native youth, actually, 2.5 times the national average. Yet, Latino and black youth are less likely than their white peers to receive specialty mental health services and when they do enter treatment, they are more likely to drop out. In the juvenile justice system, 82% of youth charged in adult courts are youth of color, continuing the youth of color pipeline to prisons.

Youth of color pipeline begins very, very early. Actually, it begins in infancy and in pre-school. This 2014 data indicates that 42% of black preschoolers which is in the light purple and 25% of Latino preschoolers which is in the light pink in the middle column, have experienced one out of school suspensions and 48% of black and 20% of Latino preschoolers have experienced multiple out of school suspensions which is in the third column. This is in stark contrast to the fact that 18% of preschoolers are black and overall, Latinos make up 17% of the total US population. So this is a glaring racial and ethnic disproportionality.

In the educational system, in the K-12 years, children and youth of color fair no better. Black students are suspended and expelled at three times the rate of white students. More than 33% of African-American girls have been suspended and black and Latino students receive more discipline and special education referrals compared to white and Asian students while receiving fewer honors or gifted placements.

Dropout rates for Latino and black students are twice to four times the rate of white students. The graduation rates for African-American, Latino and Native Americans are approximately 30% less than for white students and while multi-racial students are among the least likely to carry a weapon in school, they have the highest rate of being threatened or injured with a weapon and becoming involved in a fight at school.

Then in the juvenile justice system, one out of every three black men - this is justice which is criminal justice not juvenile justice, sorry. One out of every three black men and one out of every six Latino men is likely to end up in prison as compared to one out of every 17 white men. That is a pretty astounding disproportionality. And one out of every 18 black women and one out of every 45 Latinas are likely to be

imprisoned compared to one out of every 111 white women, another very large disproportionality.

The rate of mental health service use for Latino, black and Asian-American adults is less than half of that for whites, those with two or more races and American-Indian and Alaskan natives. So this says that many adults of color are going to prison instead of going to treatments.

Finally, there's the financial cost. The cost of disparities and disproportionality is enormous. This often quoted study although it appears dated is really one of the most comprehensive studies that were done and there's an update to this about the cost in dollars. If disparities and disproportionalities had been reduced, not even eliminated but just reduced for ethnic racial groups, it would have saved the US economy \$229.4 billion between the years 2003 and 2006 and eliminating disparities would have reduced indirect cost by more than \$1.24 trillion in the same period. Now, a follow-up study in 2012 found that disparities in health cost the US an estimated \$60 billion in excess medical cost and \$22 billion in lost productivity in 2009. The burden will rise to 126 billion in 2020 and to 363 billion by 2050. So as you can see, we have not invested enough in health promotion or prevention using the public health approach to avoid the human societal, cultural and financial cost brought on by disparities and disproportionalities. Larke?

Dr. Larke Huang: So the question we think about as we've been thinking/working in this area of disparities/disproportionalities for a long time and probably some of you on the call also have been doing so but the question is: are we getting better? Are we reducing any of these disparities? Well, yes in some areas and no in a lot of areas. In 2001, the Surgeon General's report, *Mental Health: Culture, Race and Ethnicity*, alerted the population to racial and ethnic groups being underserved. In a more recent follow-up study in 2015, we see that racial, ethnic disparities have decreased somewhat but they are still substantial. People of color are still less likely than the white population to use mental health services. We see continued underutilization of services, we see lowered treatment completion rates and actually in the substance abuse field we also see a lower treatment completion rate, we see ongoing workforce needs and we see significant needs for culturally adapted services as well. Next slide.

Each year the Agency for Healthcare Research and Quality puts out a national disparities report with a set number of indicators and we see that those indicators somewhat fluctuate but there are still tremendous between group disparities. Just

recently, actually just earlier this month, the federal interagency workgroup on child and family statistics put out the America's Children in Brief document which was the first time they looked at 41 key national indicators of child wellbeing, breaking them out by race and ethnicity of the children population and in most all of these indicators children of color, they're the worst. These indicators are grouped into seven domains from family and social environment to economic circumstances, to healthcare, to physical environment, to behavior education and health outcome. So I urge you to go to that link there and get this report which just came out. Next slide.

So we have different policy drivers and I've put some of the federal policy drivers to address health disparities. As I mentioned Healthy People 2020, the newest version geared for 2020 has a new section that's focusing on social determinants of health and really trying to key in on health disparities. The Affordable Care Act or what some people refer to as the Obama Care of 2010 had different sections that were really focused on trying to reduce health disparities both in terms of workforce initiative, in terms of data initiatives, in terms of even trying to standardize how we collect data and using a standard taxonomy for racial and ethnic populations.

We had the reissuance of the National CLAS or the Culturally and Linguistically Appropriate Services standards we issued in 2013, again to look at how our service sectors both in health and behavioral health prepare to deal with different and diverse population. Then the HHS office of minority health released a national stakeholder strategy for achieving health equity in 2011 which was generated by focus groups and listening sessions around the country looking at health disparities and different strategies states and communities were using. So we had a number of key policy drivers probably in the last five years that have really focused on this issue. Next slide.

In 2011, the Department of Health and Human Services Secretary, Sebelius at that time, reduced the first ever action plan to reduce racial and ethnic health disparities. This was a plan for HHS agencies to follow. The key secretarial priority number one in this plan was to assess and heighten the impact of HHS policies, programs, processes and resource decisions to reduce health disparities. We, as an agency within HHS among the other agencies as well, were required to assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements were to help inform HHS of investments and policy goals and to track how they were doing in terms of addressing disparities and better serving diverse populations. This was a really

critical call for us at SAMHSA to really look at who we're serving, what we're doing, what are the outcomes, what are the service dosage these different populations are getting. So this is a critically important report for us in terms of trying to address health disparities. Next slide.

So just to give you some samples of some of what this report kind of drove us to look at and what we found, we looked at some of our grant programs and looked at who in fact we were serving in these grant programs and this is not new data that we were getting from grant programs. As part of their performance measures, they need to tell us who is enrolled in the program by race and ethnicity and gender and a number of other performance measures. So just for example in a previous program we had, a jail diversion program, if we look at who was being served in the program, we see that 69% of the people enrolled in the program were white, 22% African-American, 5% multiracial, 15% Latino. So this was data that was presented to me and it took me aback and I thought, "Okay, this is not what the composition of our jail population looks like so why is it that in our grant programs it seems that most of those getting diverted are white females." It makes you begin to think about what are the risk measures that we're using, what is the implicit or explicit bias that occurs in decision making around who actually gets diverted and what do we need to do to make the enrollment in these programs more representative of actually the jail population and who's at risk of being jailed. Next slide.

Opioids are a critical issue, critical public health issue now. So we wanted to look at the enrollees in our opioid treatment programs. As you can see there, by race, ethnicity and age and female that most of the people enrolled in our programs were between ages 20 to 30, both males and females but most of them were predominantly white and that we were not actually doing a good job of serving populations of color in this opioid treatment program which we know does not distinguish - opioid use is not distinguished by just one population or another. So again, the Secretary's report made us really look at who we're serving in our grant programs. Next slide.

So this led us to think about how do we need to - oops, sorry. [Laughter] There's a polling question. So the question is, if you can respond, are you familiar with the disparity impact statement required in the Department of Health and Human Service grants including SAMHSA grants, CMS grants, CDC grants. Okay, well that's good to see, over half of the people participating on the call are aware of this disparity

impact statement expectations in grants. Good, well for better or worse more people are aware of it than are not. That's good to know. Okay. Next slide.

Okay. So this disparity impact statement strategy is what we consider the data driven strategy that we wanted it to really be based on data as oftentimes data is a bit more objective and it's a little bit different than doing diversity trainings or diversity measures, it's a bit different than looking at cultural competence training, those things may come later but we really wanted to see if we track data on data that we're already collecting, how could we address this requirement to collect disparity impact statements? So this requirement strategically focuses on tracking disparities and access use and outcomes for racial and ethnic populations and in grant programs where we collect sexual gender minority data, we also use it there. It was secondly using program performance data to then implement a quality improvement process. So this was not to be a punitive approach but to really look at access issues, who's being served, what are they getting, looking at performance data and where there is inequities using a quality improvement approach to reduce some of the inequities. Some of the strategies for reducing the inequities were to build off or leverage the National CLAS standard as part of the quality improvement process. So this was also to be tied to the notice of award of funding so that it was an expectation tied to your funding and it was the condition of award. Next slide.

So this was the framework for our disparity impact strategy. It was really looking at access, use and outcomes using GPRA data or Government Performance Requirement Act data which is a requirement of all grant programs in federal government and to disaggregate it by different population groups. So the access measure was really looking at who is enrolled in the grant programs, who are you serving and what populations are being reached and again that data is already required data within the grant program. Then use is looking at what interventions are being used, who's getting what dosages of what intervention, if it was a prevention program. We looked at what populations are being reached by the prevention strategies and then finally again as part of GPRA data, outcomes are measured. So how are enrollees in the program doing, how are they doing along in terms of the outcome measures that are collected and how do these outcomes differ across. So again this was no new data burden on the grantee because this is already data that they are required to collect and submit to SAMHSA but it was actually getting at how can we more proactively and with intention, use this data to address disparities in access, disparities in use of services or dosage of services and disparities in outcomes as

reported already in the grant data. Now this framework, this is the framework we used for our disparity impact statements. I think it's a framework that is generalizable to other organizations, other systems in terms of really starting to look at the access used outcomes framework and disaggregating that data by population groups to highlight where you may have disparities in any one of these variables and then that would then target where you need to address your strategies or your interventions for reducing disparities. Next slide.

So why access, why is access important? Well, the subpopulations involved in the grant programs through outreach, training and TA or the time of the use of individual treatment services including what kinds of strategies, enrolling in the behavioral healthcare system, having a behavioral healthcare provider in a geographically convenient location, having culturally and linguistically appropriate healthcare providers and identifying disparate populations to be reached by prevention strategies and developing training and technical assistance for these disparity vulnerable population. So when we first started this with our grant programs and with our staff, sometimes we would hear, "Well, we are doing a prevention program in Utah and we don't have a lot of disparity vulnerable populations or we don't have a diversity of populations." When we said, "Well, you really need to look at your census, look at your state data, look at your community data, look in your communities more strategically," and we found that our staff were saying actually there is the Somali immigrant group that we hadn't known about in Utah that we're going to really be focusing some of our prevention strategies on. It was very interesting as grantees now having to meet this requirement actually found more disparity vulnerable populations who weren't readily showing up for services or who were not necessarily highly visible in their catchment area of service. So just by having the disparity impact straightened and saying you need to think about improving access to the grant resources, to a broader population, new discoveries were made about new existing populations. Next slide.

So use. This was looking at the level of participation in the grant program or the level of services used or the dosage of services used and some of the issues in engagement strategies involved in keeping people in treatment or involved in their prevention program. As we mentioned earlier, populations of color are much more likely to discontinue treatment, have early treatment disruptions or incompletions. So we really had people focus on the quality treatment options that are consistent with population specific data, what are the strategies to engage and how do you motivate

retention and treatment and developing and maintaining partnership to increase reach to and retention of disparity vulnerable populations. So again, we said that the use is really critical because we want to know what dosages of interventions are received by different populations and how can we improve the equity of dose level and some of the strategies that came up with.

So health literacy issues, understanding cultural and linguistic preferences and really maintaining partnerships, we found that our grantees who had developed new partnerships with maybe ethnic serving community based organizations or ethnic serving outreach organizations or organizations that they were not initially familiar with who had much more increased and enriched and were really the trusted messengers or trusted providers for these disparity vulnerable populations. So that was key strategies in improving use and retention in interventions. Then finally, next slide, was really looking at outcomes and looking at the impact of the program for disparity vulnerable populations. Now when I think more and more increasingly as we're looking at precision medicine in health and public health, we're really saying that the same treatment does not always have the same outcome across different populations. So that really beginning to identify gaps in behavioral health services and access to utilization, interventions and treatment, improving the quality of care so that different dosages, different types of interventions might be needed to get equity of outcomes. Also there was a critical workforce piece here too in terms of increasing the capacities of staff or augmenting the workforce with increasing numbers of individuals who may represent the populations that are most vulnerable to disparities to really begin to better address the needs and get to better outcomes for these populations. Okay, next slide.

Okay. It looks like we have a poll here and we are asking you if your program routinely uses program data to manage the program. In our disparity impact statement and disparity impact strategy approach, it was critical that our staff begin to look at how they use all this data that staff feed back into them as part of their performance measures requirement, how they use that data to manage the program, how they use the data to see who's actually being served, who's getting what and how are the outcomes different across different population groups. So it looks like this is not anything new in terms of many - 85% of you use program data to manage the program. So the question would be: do you use program data disaggregated by different populations to come up with different strategies that are going to be more population specific. Okay. Well, that's great. 85% of you use program data. So this is a slide that

just shows the enhanced CLAS standards that were released in April 2013, re-released and there are 15 standards and they're broken into the categories you see there, the communications and language standards, five through eight, are actually required by law. They are in the civil rights law to be able to provide linguistically appropriate capacity in any health serving agency that receives scheduled services federal funding. So it's critical to think about how you use these standards to address reducing health disparities and I would encourage you to go to that link there to learn about them in more depth if you're not already familiar with the CLAS standards. Okay, next slide.

Ken, I'll turn it over to you.

Dr. Ken Martinez: All right, thank you Larke. Now the next several slides are going to be what we call the step-by-step and they are in chronological order so to speak so we're beginning at the beginning with how you might go about looking at disparities in a methodical way using the disparities impact strategies that Larke has been talking about. So the DIS as we call it - and that's probably what we'll be referring to it as - as used by SAMHSA is to assist grantees and communities and states to develop a process to identify disparities and disproportionalities and then to address them in a systematic way. So we have suggested a process that begins with defining the proposed subpopulation you'll be looking at. In other words, are you looking at African-Americans, at African-American males, at Latinos, at New Americans, at individuals who are LGBT, refugees, what is the population you're looking at? So it's always good to zero in on the population that you think you will be looking at in more depth through the disaggregated data collection process. The SAMHSA DIS subpopulations are usually focused on race and ethnicity and LGBT status because the DIS in particular as defined by SAMHSA is to reduce racial and ethnic and LGBT disparities and disproportionalities. But that doesn't mean you cannot look at other subpopulations, for example defined by socioeconomic status or geographic location, rural communities or very low income individuals and families. So you can look at any subpopulation in which you might detect a disparity or disproportionality and that could include limited English proficiency individuals or many other subgroups.

The DIS also describes why the proposed subpopulation is a behavioral health disparate or disproportional population so grantees include numbers or rates of access, those three domains that Larke was talking about: access to services, service utilization and outcomes. Those are the three major domains that we ask grantees to look at so that we can look at the disaggregated data by access utilization and

outcomes. The ethnic racial categories that we use come from the ACA section 4302 which sets the standards for data collection by race and ethnicity. We do that because we want to have a standardized way of breaking down the ethnic and racial groups. It isn't the very best way to do it because it's not very granular but it's the more standard way so that's what we choose to use. Then the DIS uses Government Performance and Results Act data or in other words GPRA data or other performance measures that are disaggregated. You notice that we keep saying disaggregated we mean by race, ethnicity, LGBT status or other parameters that you choose to disaggregate by and that's to address the effectiveness of the program in addressing the needs of all intended recipients even those who may have been unintentionally unserved or underserved previously. You noticed that Larke said that one community discovered the Somali population that they didn't even realize existed. Well, that's one purpose of the DIS is to kind of look at communities that when you wrote the grant you might not have even known existed in your community but as you got out in the community or you began to do your program development you discovered them because maybe they were very newly arrived new Americans and because they're in your catchment area so to speak it's usually incumbent upon you to serve them as well even though you may not have identified them initially in your proposal.

So look at the next slide here. So as we continue in the step-by-step progression we are using the gather data in which you identify the disparities and disproportionalities in the three domains and then you prioritize which disparities you will be focusing on because as you dig deeper usually you'll find that there are many disparities or disproportionalities and you may not be able to focus on all of them because of limited resources, limited time and so you may need to prioritize what are the top one or two or three that we have the ability to reasonably address during the time period that we have with our grant funding period with the blessing of our government project officer and so you have to do that kind of vetting to make sure that you are realistic in what you take on once you begin to delve into the disparities that may exist. And if possible you conduct a root cause analysis that is describe a disparity or disproportionality, determine the multiple causes, usually it's not caused by one issue or one factor but usually it's multiple causes yet occurring. Then investigate the possible root causes of its manifestation and there is a very handy and wonderful support tool that you can use which is at that link on the screen. It's an excellent guide to conduct root cause analyses and it was written by the National Center on Safe and Supportive Learning at the American Institute for

Research. It was unveiled at the White House last year and got an extremely positive reception. I advise you to look at that.

Then you look at - the DIS should include subpopulation specific strategies and interventions to reduce each disparity identified. Each disparity requires some specific targeted intervention that is focused on that particular disparity. It's not necessarily helpful to look at very general kind of interventions because you want to hone in as Larke called it precision medicine model where we're looking at individuals and the specific interventions that would address issues as individuals or small subgroups. Some of those interventions might include evidence-based practices or practice-based evidence, community-defined evidence that could include policies, procedures that may need to be instituted. Then you develop benchmark goals that you want to achieve annually. Certainly you can adjust those benchmark goals as you progress because you may not reach them and there may be other confounding factors that come up during the year that you had not thought about that you need to take into consideration as you revise your intervention strategies. You want to ensure that the cultural and linguistic needs of the proposed subpopulations are met. In order to track and monitor your progress in achieving the benchmark goals you set, it is helpful to have a data informed quality improvement process as Larke said. It may be a process you already have in place. We don't want you to create a brand new process for the DIS if you already have one that's working. It may be incorporated into your already existing one but maybe in the past your existing one had not looked at disaggregated data by race and ethnicity and now with this new DIS process, you want to make very specifically clear that that is one focus that you are going to zero in on.

The purpose of your quality improvement process is to make course adjustments if after reviewing your incoming data that you noticed that the interventions or the policies and the procedures are not necessarily effective in addressing the disparities that you identified. You, then, modify or change your interventions or procedures to increase the likelihood of your success in reducing them. Larke mentioned that precision-based approach to intervention and measurement, it's being used much more in medicine these days where we want to tailor interventions based on unique means and the individual differences of people and the subgroups to effectively prevent and treat physical mental illness or other issues in the community including addressing the social determinants of health. Then, of course, you've heard about the National CLAS standards and they're a useful tool also because they cover the 15

standards with the required linguistic competence ones that are included in Title VI and they are a very useful guide and if you can incorporate these National CLAS standards as a part of your intervention strategies in addressing any disparity that you come up with, I think that it's a very helpful component of your DIS.

Now, we're going to give you some examples and Larke is going to start with one.

Dr. Larke Huang: Okay. This is an example of a grantee from our Primary and Behavioral Healthcare Integration Program. This program was designed to improve the physical health status of adults with serious mental illnesses. It supports communities in coordinating and integrating primary care services into community-based behavioral healthcare. It uses physical health indicators and emergency room visits. Well, physical health indicators such as blood pressure, weight, lipids, tobacco to measure risks of those chronic diseases and also has as one of its goals is to reduce emergency department use for mental and physical healthcare conditions.

Next slide. They collected and sent data to us that identify the participants in their grant program by race and ethnic group. You can see that the majority of participants in this particular grant program are African American Black then Hispanic with a smaller percentage of Whites and other population group. This was looking at who's in their catchment area and they had also indicated to us which particular populations they wanted to increase their service use for which included African American and Hispanic.

Next slide. We use the regular GPRA data reports by the project officers to identify areas for performance improvement and to develop population specific strategies and also to use this to inform the grantees about the CLAS standards as a strategy to reduce disparities.

Next slide. Okay. This is again how they defined access, use and outcomes in their program. Access, we somewhat talked about already; use was the treatment completion, screenings, referral to specialty care. They also measured peer support and recovery support. Their outcomes were variables such as readmission rates, increased awareness, health education and health literacy.

Next slide. These were the CLAS standards, seven of the 10 CLAS standards that they decided they wanted to implement to use in their organization to address disparities.

Some of these were translations. Some of them were health education materials, recruitment policies that aligned with the specific cultural groups that they were serving.

Next slide. I'm just going to show you very quickly because I know we want to leave time for discussion too and other examples. Then they broke out their data by Black, Hispanic and then the total population. In terms of functioning, this looks at functioning level in everyday life by the different population groups. You can see that all of them improved and the improvements were statistically significant.

Next slide. This was looking at reduction in psychological distress. You can see that they all started at different points and they all improved and again broken out by different population groups.

Next slide. This is emergency room visits for physical health reasons and you can see there was a pretty dramatic decrease particularly in the African American population which started off higher at the initial baseline and decreased at a higher rate than all of the other populations together.

Next slide. Then this is ER visits for mental health reasons. Again, you could see the African American population started off at a higher rate of using the ER, the emergency room for health reasons but they also continued to decrease not to the same level as all of the populations combined but also at a statistically significant rate. Hospital admissions for mental health reasons, again, this is broken up primarily by African Americans and all populations combined and again you see reductions here. That program was actually very good in collecting data by race ethnicity, really following and tracking at different time points their data and really using the CLAS standards in ways to turn around almost sort of the culture of their organization, the governance structure, how they're going to use data and how they're going to really outreach to different populations and also retain them in treatment. Okay.

Dr. Ken Martinez: All right. Thank you, Larke. Here's another example. This is from one of our Safe Schools/Healthy Students grantees in Pennsylvania, Lehigh Learning and Achievement School. I know we have some Pennsylvania folks on the call. I'm glad that you're on and we can showcase your wonderful work. This is an alternative school in Pennsylvania so the level of risk is very high for all of the students. The

school district does not use out of school suspensions because they have this alternative school instead. Therefore, they looked at referrals to more restrictive settings such as psychiatric hospitalization, detention jail, residential treatment, drug alcohol treatment to determine if there were disparities. As you can see the numbers decreased tremendously for juvenile detention for African Americans based upon a whole series of interventions which I will describe in just a moment. I wanted to show you that data first and even though the numbers are very small, they're significant. The numbers of African American students who were put in detention or jail fell from six to zero in one year, which is the red number in the second column. Then I will show you the next slide which shows that the office discipline referrals for both Blacks and Latinos dropped significantly indicating a downward trend over three years with risk ratios going from 4.89 to 2.25.

Let me tell you a little bit about the factors that are contributing to these results. First of all, they did have a disparities impact statement that was submitted when they submitted their request for proposal - I mean when they submitted their proposal. Then, they revised it as they went along and they learned. It was focused on students of color who faced a disproportionate degree of over representation in disciplinary procedures in their school program which led to disproportionality into the juvenile and criminal justice systems. They were already using Positive Behavioral Interventions and Support, PBIS, a universal evidence-based prevention practice at schools but they did not have any other evidence-based practices for promotion prevention and intervention. They felt they needed to strongly advance their Tier 3 evidence-based practices for the higher end users.

Those were the students that were getting disciplined and being put in out of school suspension and arrested. That is what they did. They developed a strong and clear protocol to identify and choose their evidence-based practices geared toward building protective factors, reducing risk factors specifically for youth of color to embed them into their PBIS Program. They didn't abandon PBIS. That was their foundation for the Tier 1 universal intervention. They added a set of other evidence-based practices for Tier 2 and Tier 3 in that magical pyramid we always refer to from universal to indicative to selective and the different levels of evidence-based practices that fit each. They included the following evidence-based practices. I'm not going to get into the details of each of these practices just to let you know that there were several including CHAMPs, BIMAS, which you'll see in our universal screener, aggression replacement training, choices for drug and alcohol, Project

Renew for drop-out prevention, youth mental health first aid, and they also had an out-patient clinic right on their school property to refer students for treatment. All of these evidence-based practices decreased disparities by building skills and protect the factors for the youth of color.

Now, additionally and very importantly they specifically hired a new school resource officer or some folks call him school police officer. They had one before and they hired a new one as part of their intervention that completely understood and was trained in trauma, mental health, and behaviors associated with these concerns such as drug and alcohol use and who came from the perspective of building relationships and getting youth help rather than as an authority figure with power and control to arrest. The goal was to build relationships with the students, decrease arrest and co-facilitate the evidence-based practices. This individual who was a co-facilitator in the aggression replacement training so they incorporated him as a trainer in the evidence-based practices and this helped not only the students but it helped the school resource officer to understand, work with and eventually obtain services for addressing the student's drug and alcohol and mental health challenges rather than resorting to the old model of using his power and authority to intimidate and therefore take action such as arresting the students. So before the officer was hired, the school would call the police whenever there was an altercation. They would arrest the student with no attempt to deescalate or to recognize the mental health symptoms and never really got some services. So, together with the evidence-based practices embedded into the PBIS work and the school resource officer trained in and having a personality disposition that is conducive to rebuilding relationship with students, they decrease disparities and office discipline referrals and arrests for Black and Latino youth. This is some wonderful work that they've done and it has continued to show its benefit as you can tell by that trend from 4.89 to 2.25 over the three-year period. Thank you to our Pennsylvania grantee for sharing this data with us.

Let me give you another example. This example is not to show that particular interventions in this situation were particularly effective but more so to show you how the DIS data can be depicted over time. These are actual middle and high schools in the Midwest who are tracking exclusionary disciplinary data using risk ratios. They detect very early data so this is very, very preliminary and they're going to continue to collect this over time so we're going to see some actually valid kind of data coming out over time around the implementation of services. You'll notice that the data is

all over the place. In the First Communities high school, the one that is showing now, the American Indian exclusionary data shows exclusionary discipline increasing significantly and see it go from .67 to 1.72 while the Asian American numbers went down and the others showed modest changes. Here's the middle school in that same school district. You will see that it is the opposite with the Asian American students receiving more exclusionary discipline while the American Indian students receiving less and a modest increase among Black students. Here's another high school in another city not very far away. In the Second Communities high school, they all went up except for Latino students and then finally in the other middle school, the Second Communities middle school, all seem to decrease.

I showed you this not to highlight particular interventions again that they have used because they were just at the very beginning of implementing but it shows you that at the beginning there is some volatility to the data. Over time, it will stabilize. Also you need a little bit of time in order to assess the effectiveness of interventions that they will be employing. Knowing conclusions can be made about this data because it's so preliminary. But it does show how data can be used to indicate progress or lack thereof and then to consider ethnic or racial specific interventions because one intervention for all youth of color may not work. You can see that if they try to intervene with a set of evidence-based practices blanketly to say this is for all youth of color that you might not see progress because progress is going to depend on a particular ethnic or racial group and there may be a need for a specific set of interventions for each particular ethnic or racial student population.

Then, finally our last example comes from Vermont and you heard about Project LAUNCH which is one of the programs that the National Resource Center Services with TA or SAMHSA. It is a program, a SAMHSA program for children from birth to age eight. In Project LAUNCH, which has taken the DIS very much to heart, they use the DIS requirement as an opportunity to move their early childhood system towards racial equity by creating an environment to advance it. The environment is really important because you have to have a tone of acceptance, an open discussion of it at your staff meetings. It is always on the agenda and that people begin to be versed in the language, in the jargon, in the thinking about reducing disparities in every which way you can not only through formal interventions but through the infrastructure that you create - the procedures, the policies, the laws, the regulations that affect our populations of color in our grantee communities. They focused on increased access and utilization of services and improved outcomes for

the new Americans. They had an influx of immigrants from a wide variety of countries in Vermont as did many of those Northeastern states like New Hampshire and Maine. They hired a direct service outreach staff from the New American Communities themselves as well as creating a health disparities subcommittee made up of LAUNCH staff as well as community and state partners.

That's part of their infrastructure building because they went straight to the community of color, the New American Community and hired people from that community to be a part of the system, so to speak, the Project LAUNCH project, in order to address issues from an inside perspective as opposed to from an outside perspective which is many times how we intervene in communities as from the outside as opposed to bringing in people from the community in order to understand the community and not only can speak the language but know the culture. That was a very important intervention they did. They focused on five areas. First was quality improvement by conducting a cultural and linguistic competence organizational assessment of the LAUNCH partners. Most of our grantees in the SAMHSA programs have partners from the community. They based that assessment on the CLAS standards. They provided coaching following the training sessions. They created a language access subcommittee to work on a joint language access plan which they really needed for the new American communities because they came from many different countries with many different languages and dialects and then developed subcontracts with LAUNCH partners to address and continue to focus an effort on disparity reduction.

In their contracts themselves, they wrote in language that spoke to the fact that disparities is a top priority and that partners need to be a part of the solution by working on disparity reduction through their partnership with Project LAUNCH. The second was leveraging resources. They discussed how the development or they are discussing the development of a community health worker program that would be very much in line with hiring folks from the community to be a part of the solution. Community health worker programs from Crosstalk are extremely effective and popular around the country and have proven to be extremely effective in engaging the community because these folks are from the community who go back out in the community with information, knowledge and best practices to assist the program. They also do cultural and linguistic competency training and assessments in following years. Then, the last few areas are workforce development which includes more training-based on the CLAS standards as well as interpreter-training sessions. Many

times we take for granted that interpretation is something that just about anybody can do because they know that they might be able to have a conversation in a particular language and you think that they're qualified to be interpreters which is very incorrect. You need specific interpreter training especially if it's in the behavioral health field to be trained in behavioral health interpreting and how to do it well.

The fourth area is team learning to identify issues that direct staff are seeing when they are working with the Americans to identify possible system changes, very much a quality improvement process, that is effective because new things come up all the time and when you take these back to staff meetings and say, "This is what I encountered in the field this week. Have you encountered it? What are we going to do about it? How can we incorporate it into our disparities impact statement so that we can develop some sort of intervention to address it if it needs that kind of intervention?" Lastly, data and evaluation, which means collecting more granular data on race and ethnicity on the New Americans and to have a new database so it'll collect county or country of origin and language spoken in the home which they're working on now. LAUNCH, in Vermont, has moved forward significantly due to their DIS strategy and the fact that they have bought into it very well and everyone is involved in disparity reduction not just the LAUNCH staff. Larke?

Dr. Larke Huang: Okay. Thanks, Ken. Those are great examples. We're just going to sum up in these last few slides and think about, in terms of, this disparity impact statement leading to disparity impact strategies, the DIS, what did we see as the most significant change? For our grantees we found that there was a broader inclusion of diverse racial and ethnic populations and a lot of these discoveries of unserved or underserved populations that they frankly told us that if they didn't have to meet the requirements of the DIS, they wouldn't have necessarily searched for these other populations. We've learned of innovative outreach and engagement strategies, new collaborations, revisiting their screening and assessment tools. Some were familiar with the CLAS standards. For others, it was a new exposure to CLAS standards and a new awareness of the concept even of disparities and disproportionality. For our agency, for our staff that were involved in initiating the DIS activities, we found that administrators and evaluators working with staff on the DIS data collection and intervention strategies changed the thinking about how to use data and it was good to see that 80% of you on the call used data in the management of your programs or

your organizations and think about how would you use race ethnicity data to think about disparities and any one of these access, used, or outcomes framework.

Then, we actually had some development of the behavioral health disparities online modules by some of our grantees and some of the technical system providers that provide TA to them around this particular DIS topic. Of course ultimately we want to know was there any change for the people in the communities we served. It increased detention to vulnerable populations perhaps some better outreach and engagement, perhaps some better in individualized intervention in treatment services. From our perspective here as federal employees and as stewards of the public funds, we want to make sure that the resources that we are coordinating are reaching all populations and not just populations that are easier to reach where that shows up more readily in our grant programs. We want to make sure that there's equitable use and access to federal resources for the people in the communities served. We thought we were starting to make some steps towards that if you recall the earlier slides when you said we weren't really serving a very diverse population in some of our grant programs. We now have that greater expectation among not only our grantees but our staff and our leadership as well.

Next slide. I just want to leave you with these questions and think about as you're thinking about health, behavioral health equity and it's not just in the healthcare sector but as Ken mentioned there is some really critical slides about what goes on in school systems and individual school programs in school classrooms that all of those disparities issues whether it's around excessive discipline or suspensions, expulsions that these all have an impact on an individual and a community's health and well-being. If you start from the position of health equity, what would it look like in your programs and your organizations if equity was a starting point for decision-making? If you can think of equity at that slide that showed the three individuals on the boxes and not equality but if equity was a starting point, how would that change how you do your work? How would your work be different? How would you need to be organized and committed to reducing disparities in promoting equity in your work and in your workplace? If that was your goal, if that was your starting question, what are the implications for that on how you do your business and how you're organized?

Ken, I think that's it for me. I think the resource slides are your final slides.

Dr. Ken Martinez: Yes, they are. The DIS online training module is something that you can download at this link. It is approximately 45 minutes. It walks you through the DIS process but in much greater detail than we did in this presentation. It includes a little bit of history and then how do you disaggregate data, how to develop benchmark goals and strategies, QI processes etcetera so feel free to look at that and see if it might be helpful to you and your community and to your quality improvement committee or behavioral health disparity reduction committee. We also have examples of disparity impact statements at this link which is a SAMHSA link to give you an idea of what they might look like. They vary. There are some very basic components to them but every community does it a little bit differently depending upon the uniqueness and the needs of that community. Then here's the link for the root cause analysis that I mentioned before. It's a very helpful process. Then, we also have an extra one here on building strength tools for improving positive outcomes to ensure the well-being of boys and young men of color which is fairly new, January 2016 guide, put out by SAMHSA. We want to remind you about the National Network to Eliminate Disparities which Dr. Huang founded at SAMHSA. It's a partnership of many agencies and individuals across the country. Larke, you might want to say something about that.

Dr. Larke Huang: Yes. That network which you all are invited to join is a network of community-based organizations serving primarily diverse racial and ethnic communities. It also is open to individuals who have an interest, in particular, in serving these populations and addressing the issues of disparities. We started it in 2008 with 35 organizations and now I believe we're up to 850 organizations that are members of this network. It's a good resource exchange network. We do some conferences. We're doing learning collaborative. A webinar, it's a - the website is a good resource with very current issues, articles, resources related to different racial ethnic populations and behavioral health issues as well as different research articles. I encourage you to go to the website. It tells you how you can become a member. It also tells you if you want to apply for any of our training opportunities or learning collaborative opportunities. Our coordinator for that is Change Matrix. I encourage you to take a look at it.

I also want to say on the resource on the top of this page, Building on Strengths, Tools for Improving Positive Outcomes for the Well Being of Boys and Young Men of Color, that actually came out of the grant program, one of our first grant programs that really was a positive grant program when we first rolled out the disparity impact statements. Our partnerships for success prevention program. They did a tremendous

job of adopting the DIS to their grant program and then started to produce resources and tool kits that were specific to different populations of color. They took the risk in protective factors, prevention strategy and really geared it towards working with populations of boys and young men of color. That happened just after the President initiated his My Brother's Keeper initiative which was a focus on the young men and boys of color. We elevated that grantee work up to the White House who was really pleased to get a document that guided them on how to do prevention practices for this population. We're really excited in terms of some of the work that grantees have done. Just a few of which we've highlighted here and some of you may be from those grant programs on the call and we thank you for that. But they've just done some very innovative work just building on our rather simple framework of access use and outcomes and building QI strategies into that.

Dr. Ken Martinez: Larke, we have a question that you might want to address. Is there any research that measures access and use when families at risk are required to spend a portion of the treatment? For instance, on one of our areas, the drug divergent program cost includes an initial deposit of \$1,000.00. As a result, none of these lower income families were able to access these services.

Dr. Larke Huang: I don't know of any specific research addressing that. I know that one of the barriers to access that we find in our national survey is cost. We see that in terms of a lack of health insurance or lack of funds to pay for treatment. That's often one of the - at least in our survey of drug use and health - cost is the primary access barrier. I think to be putting down an initial deposit of \$1,000.00 could potentially be an access barrier. If people go to our website and look at our - it's our NSDUH, National Survey on Drug Use and Health data, you can see that cost is the number one access barrier. I don't think this approach would necessarily facilitate entry and retention and treatment but I don't know any other research besides our surveillance study.

Dr. Ken Martinez: Okay. Thank you. One of the questions in the chat box is, "Will there be a log of these questions and answers because it's good information?" I think Mary can respond to that.

Moderator: Yes. This is Mary. I can respond, Ken. Just to drop people's attention to the fact that the online learning event and the slides will be posted on healthysafekids.org and we will attach, as people have asked, a log of the questions and the answers so that people can see what the discussion was. I would also encourage people, we just

have a couple of more minutes, is that to let you know that the National Resource Center just to remind you that the website is healthysafechildren.org and that's where several of the resources that Ken and Larke just mentioned live and then there's also, if you want additional information, there's a 1-800 number and it's 1866-577-5787 and that's also on the website or you can email the National Resource Center at healthysafechildren@air.org. We'd be happy to provide additional information and answer any questions. I hope this will be the first in a series of online learning events around this topic because clearly there's a lot of interest around it. I also want to thank all of the grantees who are on and who are doing great work out in the communities. Before we end...

Dr. Ken Martinez: Could I intercept? Dulce Maria del Rio-Pineda had a question about any of these materials available in Spanish. Larke, I don't know if there's - what the SAMHSA availability is for Spanish language materials.

Dr. Larke Huang: It's really quite variable. Some of our products are in Spanish, some are not. I don't know if you're referring to the resources that we shared.

Dr. Ken Martinez: She said resources available in Spanish.

Dr. Larke Huang: We do have some in-language materials if you go to our website, www.samhsa.gov and you go to the Office of Behavioral Health Equity and then would you find under "About Us". Actually, I'm sorry. It's very hard to navigate our website but if you google Office of Behavioral Health Equity that might be the best way. Then if you google the different populations of Latino Hispanic, we do have some in-language Spanish materials on the website there. The ones that we just talked about here, the disparity impact statements and the building on strength tools, those are not in Spanish yet. Then on the NNED, I saw someone from Change Matrix on here. We do have some materials in Spanish but again it's not even. It's sometimes, sometimes not. We also on our OBHE website have some materials in some of the Asian languages as well. Some of our brief short reports, our data reports, some of our webinars around access and health insurance, we do have in Spanish and multiple Asian languages.

Moderator: Great. Thanks.

Dr. Ken Martinez: Thank you, Larke.

Moderator: Yes. Thank you. We can also put some of those links in the questions and answers when we post the materials on healthysafechildren.org. Thank you all who are typing in the chat box that you thought it was a really great webinar. We're going to ask you to please click on the link, the feedback survey, so that you can actually provide that information to us officially. If you have any suggestions or ideas for other topics, please let us know as well. I want to thank both of our presenters, Ken Martinez and Larke Huang. We really appreciate you spending time with us this afternoon.

Dr. Larke Huang: Yes. I also and Mary, again, I want to thank you for hosting this and this is Larke. I do want to thank all the participants and the grantees. We really try to tie what we thought was a very important requirement to grant expectations, grantee expectations. We've just been impressed with how many of the grantees have come up with really good strategies, have really changed around their thinking and their work. We really appreciate that and any other innovations or anything you want to share with us, we're certainly open to hearing. Thank you so much.

Dr. Ken Martinez: Thank you very much. Please take the survey before you leave.

- End of Recording -