

SAMHSA's Center for the Application of Prevention Technologies (CAPT)

**Increasing Cultural Competency to Reduce Behavioral Health Disparities:  
Approaches for States, Tribes, and Jurisdictions**

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**LaShonda:** So, we ask you to not leave but to continue to sit in here with us because it is a great presentation from Dr. Haner—he is a CAPT associate; Maria Valenti, Dr. Maria Valenti, a CAPT, a Northeast RT epidemiologist; and Molly Ferguson, the CAPT national and cohort services manager. My name LaShonda Williamson, and you will see my picture soon. I am the Southwest Resource Team associate coordinator.

So, this training was developed under Substance Abuse and Mental Health Services Administration, CAPT, the Center for the Application of Prevention Technologies, and this is for training only. We will be recording this webinar today. So, this webinar will be recorded and archived, and will be available to all webinar participants. We may also share this recording with individuals who were unable to participate in this event. Please contact the webinar facilitator if you have any questions or concerns.

Again, I am your facilitator today, LaShonda Williamson-Jennings, the associate coordinator for SAMHSA CSAP Southwest Resource Team, the CAPT Southwest Resource Team. And our presenters today—we have got a great group of people who are presenting. We first start with Dr. Haner Hernandez. He has worked for more than 20 years developing, implementing, and evaluating direct health services and leadership development programs for the Latino community. He also has extensive experience delivering training in technical assistance to support communities to address health disparities, as well as TA to support organizations

that deliver addiction and recovery services to Latino populations. Thank you for joining us today, Dr. Hernandez.

**Haner:** Thank you.

**LaShonda:** You're welcome. Up next is—we have Dr. Maria Valenti. She is an epidemiologist and a technical assistance provider for the CAPT, providing technical assistance and training on substance abuse prevention surveillance activities and data-driven decision-making, and assisting in the presentation and dissemination of epidemiological findings. Maria has a background in community psychology and program evaluation with special expertise in sexual minority health. Maria, thank you for joining us today.

**Maria:** Thanks.

**LaShonda:** And last but not least, Molly Ferguson. She is the national and cohort-based services manager for the CAPT, and you all probably see multiple emails from her and will continue to see multiple emails from her in the future. She oversees the design, development, and the delivery of virtual training and technical assistance services delivered to CSAP grantees. Molly also serves as a training and technical assistance liaison for the CAPT Central Resource Team. She brings to her work extensive experience in transitional science and health education, specifically in the area of behavioral health, and has delivered multiple trainings on addressing behavioral health disparity.

Our objectives for today ... there are three of them. It is to describe the connections among behavioral health disparities, cultural competency, and other key terminologies; also describe approaches for identifying behavioral health disparities and access use, and outcomes throughout SAMHSA's Strategic Prevention Framework process; and then, finally, provide examples of strategies for addressing behavioral health disparities, including implementation of the culturally- and linguistically-appropriate services, the CLAS Standard.

And, we have a short poll for you all. What is the most confusing thing about addressing behavioral health disparity? Please type that into your chat box. What is the most confusing thing about addressing behavioral health disparities? What makes you scratch your head? I see some answers popping in. All the different

terms—most definitely. What are health disparities? What is behavioral health? What are we talking about? A clear, universally-understood definition. So, there are folks who are looking for just “give me a clear definition.” Selecting the best intervention. Clear, universally understood definition. Again, I am seeing that. How to address them. You all are typing quickly. Selecting the best interventions, trying to figure out how to measure it, applying social determinants to behavioral health, knowing what the specific disparities in a specific area are. So, it's data, prioritizing the data—and today we will talk about data you all. Measuring small numbers—so small n's, right? How to address them equitably, but not get overwhelmed. Too many disparities and not enough ways to address them.

So, these are all great answers—all great answers. So, keep them coming. I want to take a pause. Somebody else has another one that they would like to share. Priorities in reaching who—who next? So, once I reach one—one group, who is the next group that we are going to reach and meet with? Great. How to fit into the current framework and processes. How do I track what I am doing? All good questions. The absence of data to identify populations vulnerable to health disparities so that we can understand their behavioral health needs. Oh, man, that is exactly an issue that many folks will have, and we will touch on some of this today.

We will touch on defining this. We will touch on the data piece. We will even hear from somebody who talks about what they have done in their own state around building capacity, around health disparities at the community level. What a great job, you all.

We will move on to our next slide. I would like to turn the time over to Molly Ferguson.

**Molly:** Great. Thank you so much, LaShonda. So, it sounded like a lot of you have some—some of the things that you were confused about were kind of the “what” of addressing behavioral health disparity. So, how can we really unpack and understand the language, right? So, before we get into even identifying or addressing disparities, we have to understand what we are talking about, and there are a lot of terms that are thrown around when talking about how to address disparities in general and, specifically, behavioral health disparities, things like cultural competency, health equity disparities, etc.; and so, we are going to spend a little bit of time talking through that just to get all on the same page about how these terms

relate to one another.

So, here is a definition of behavioral health disparities from Healthy People 2020. This is the definition that SAMHSA and CSAP use, so it is helpful to have on hand, and we will be providing a handout in follow-up resources for this training that provides a little bit more information on all these definitions I will be walking through, as well as where to access information on those.

So, Healthy People 2020 defines a disparity as a particular type of health difference that is closely linked with a social, economic, and/or environmental disadvantage. So, if you think about that, there is the—there is a social component. There is potentially a socioeconomic component, and then there are environmental pieces that are associated with that; and so, as we talk through these different definitions, we will have these various icons that we will use to show you how they relate to one another.

So, here is the definition of health disparities, and so, we have—let's say we have a behavioral health disparity experienced by a vulnerable population that you have identified. Well, how does that relate to health equity? So, according to the U.S. Department of Health and Human Services, eliminating disparities between these populations that we have identified will help assist us in moving our nation towards health equity. So, simply put, a reduction in those disparities we have identified leads to increased behavioral health equity.

So, instead of the reduction in the disparity necessarily being the goal, we are thinking of this increased or positive association with increasing behavioral health equity as the ultimate goal, and reduction in disparities helps us get there.

So, here is a picture that some of you may be familiar with but helps us really understand the issue of the health equity and what it is. And so, how does equity and equality differ? And, I think a lot of times those terms are used interchangeably but they are very different.

So, as you see in this image, there are three children who are watching a baseball game, and on the left, it represents equality where they are each standing on the same size box. However, you can see that because of height—which in this case is meant to kind of be a metaphor for one of those social or economic, or environmental disadvantages—all of them are not able to see to the same extent, and one of them

is not able to see at all. That is equality in the sense that, yes, they are all getting given the same, “boost,” but it doesn't fit them in the same way because some of them may have had an additional disadvantage related to their height or, in the case of our work, related to a disparity that helps it so, even with that boost, all being equal, they are not able to get to the point where they can see the game or achieve health.

In health equity, you will see they are all at the same level and can all watch the game, but in order to get there, there is additional support needed. And so, that is what a lot of our work in prevention around how to reduce disparities to lead us to health equity relates around, which is this idea that there needs to be sometimes additional prevention efforts, additional programming, additional acknowledgement or support geared towards those populations that need it, in order to create health equity.

So, this is something that we will have these slides and will give them to you and you can use them in talking with your local level providers, as well, which will help them understand that difference.

So, if we're thinking again now, based on that—on the connection between disparities and health equity—if you have a behavioral health disparity that you have identified that is experienced by a vulnerable population ... so if for example, if you have identified that African American use among the ages of 12 to 17 have a higher rate of a certain abuse of a substance in your community, and that is the disparity that you have identified, presumably, if you implement an approach that is aimed towards reducing that disparity, you will see that reduction and you will get to that increased health equity. But what we have here is: What is that approach?

And so, that is what we are going to be talking a little bit about today, is one of the approaches that you can use to reducing behavioral health disparities that helps get you on that track to increase behavioral health equity, and, in this case, we are thinking of cultural competency.

So, cultural competency, according to SAMHSA, CSAP—and there is some evidence in the research literature, as well, particularly in other health fields outside of substance abuse—is that there is ... the role of cultural competency in reducing health disparities is that it, itself, is a tool or a mechanism that can help you improve

the reach of your prevention efforts, improve access used in outcomes that helps to lead to a reduction in disparities and, therefore, an increase in equity. So, we know what cultural competence is, those of us who are familiar with the SPF. We implement it throughout each step, and so, this really serves as an anchor for us when we are thinking about how we can use cultural competency, which we are already using in each step of the SPF to specifically address health disparities. And that is what we will be walking through a little bit further today.

Many of you, as PFS 2013 and 2014 grantees, have created disparity impact statements. So, thinking back to when you first got your PFS grant and, in the first sixty days or so, you had to turn in a disparity impact statement. And part of that was a quality improvement plan that looked at how you could address access use and outcomes to address a behavioral health disparity among the identified subpopulation that you have identified in your grants. And so, just like you have had identified high- need communities, what are those vulnerable subpopulations within those high-need communities that you identified that are experiencing disparities related to your priority problem? So, whether it is underage drinking, prescription drug abuse, etc., and how can you go about implementing a quality improvement plan to address those? And so, we will be weaving throughout this presentation, not only addressing disparities throughout this bid process but how that connects to that quality improvement plan. And we will be showing you, at the very end, how that connection is played out across each step of SPF but, as a brief introduction to that, we want to know, from an access perspective: What does that look like?

Well, that looks at identifying: What are those prevention needs of your identified vulnerable population? So, in the example I just gave: What are the prevention needs of African American youths among ages 12 to 17 across your high-need communities that you have identified, and how can you involve those populations in your prevention efforts?

When it gets down to use, we are thinking about the availability of prevention services for those populations and not only is the availability, but are your prevention efforts reaching them? So, are they accessing them? So, are they available, and what is the breadth and depth of that, and are they really reaching those that you want them to reach?

And then, what are the outcomes of your prevention effort? So, many of you talked

about: How can I track what I am doing to see if it made a difference? And that is where this comes in. So, both what are the—how can you track the processes and those process outcomes and those different changes you made along the way to address disparities among those vulnerable populations, and then, how can you demonstrate that you made an impact? And so, that is that outcome piece, and so we will be talking about that throughout this presentation, as well.

And here you will see how that relates to the SPF process. So, if you look, the colors kind of match up, and this is a graphic that was originally developed by CSAP and is a wonderful representation of how we can see the overlap throughout that process of, just like the SPF, being—how it is not linear, it is cyclical. It is really in and off itself a quality improvement process. So should be that plan that you are implementing and how you are thinking about addressing disparities.

Okay, and so, with that I will turn it over to Maria.

**Maria:** Thanks, Molly. Now, I am going to talk a little bit about how you can begin to address the health disparities in your community by integrating cultural competency in the Strategic Prevention Framework, the SPF process, and so, the next slide.

So, the first step of the SPF, as you probably all know, is assessment. And I know, during that discussion a little while ago, many of you discussed the problem of the limited data, and I just want to mention that. We are going to get into that a little bit. We have a case example in the future slide, so just hold on.

So, okay, so going back to the webinar, this is an example of data from an institution. And pretty much an institution, I mean, a specific population defined by a school, military base, campus, or other institutional setting. And this is military data from the 2011 Health Related Behavior Survey of Active Duty Military Personnel Report, and it presents findings on the health of the Armed Forces—meaning the Army, the Navy, Marine Corps, Air Force and the Coast Guard active duty, And what we see here is that approximately one-third, 33.1 percent of active-duty service members, reported binge-drinking in the past 30 days—which is higher than the civilian estimate of 27.1 percent. And, just an FYI, according to the report, the Marine Corps reports the highest rate of binge-drinking at 48.6 percent, and the Air Force reports the lowest rate at 22.9 percent. So, this is diversity within that you might need to consider.

And so, I am going to move on to the next slide.

And here is another data example that looks at race and ethnicity, and this is community-level, and it is high school data—data that a local community or coalition might look at. What this data suggests is that 24.9 percent of students who are Hispanic reported taking a prescription drug without a doctor's prescription compared to 10.9 percent of students who are white. And I would like to mention, also, that the term Hispanic is broad and encompasses various nationalities and ethnicities. So, there is diversity within the diversity. So, you want to unpack that even further if you can, perhaps doing research with qualitative interviews or focus groups.

And for my next slide ... this is a geographic example, and looking at rural versus urban areas. This is data from the Treatment Episode Data Set, commonly called TEDS. That was part of a report published in 2012, used to explore characteristics of rural and urban admissions at substance abuse treatment centers, and you can see here a comparison with admissions at treatment facilities located in the most rural areas and admissions receiving treatment at facilitated—at facilities, I'm sorry—located in the most urban areas.

So, what does the data tell us? That rural admissions were more likely than urban admissions to report primary abuse of alcohol. So, 49.5 percent versus 36.1 percent, or non-heroin opiates, at 10.6 versus 4 percent. Urban admissions are more likely than rural admissions to report primary abuse of heroin, 21.8 versus 3.1 percent, or cocaine, 11.9 versus 5.6 percent.

And now I would like to introduce the case example in the next slide. So, let's see here. So, we are going to talk about Anytown, USA for our case study, and we are going to tell you a little bit about Anytown.

So, the community is located within a state that has identified lesbian, gay, bisexual, queer, and questioning youth as a population of focus. This state funded nine high-need communities that include a mix of rural and urban settings, and one tribal community that are focused on prevention of prescription drug misuse among 12- to 25 –year-olds. So, let's look at their data a bit.

So, let's go to the next slide. Alright. So, here is some data, and it is from—this data is actually from a national study, and it is used as a proxy for what is going on in

Anytown. And what this graph shows is the percentage of 12- to 17-year-olds and 18- to 23-year-olds who reported misuse of prescription drugs in the past year. If you wanted to know more about this study, there will be references so you can look at the methodology—but anyway ... so let's see.

The orangish color are the participants who identified as completely heterosexual, and the reddish color are the percentage of participants who identified as lesbians. Okay. As you can see, the participants who reported—who identified as lesbian and gay—were more likely to report use for both age groups than participants who identified as completely heterosexual. And there is a difference there. So, people who identify as lesbians and gay seem to misuse more than their peers who identify as heterosexual.

Just one more thing before I move on. You may notice that there isn't a “T” included, meaning “transgendered,” and this is purposeful because in this study, I just referenced that—because, in the study I just referenced, they were not included in the sample. Also, I want to mention that gender identity and sexual orientation identity are not necessarily synonymous. So, people who are transgendered may have a different experience due to their gender expression and not necessarily their sexual orientation.

So, moving onward, we learn more about Anytown in the next slide. So, let's see. Anytown has been chosen to be funded by the state's PFS grant. And what we know is that schools in the state do collect student survey data about every two years about youth prescription drug misuse—and it looks at some subgroups like race and ethnic populations, gender, and grade level—but there has been a little pushback about including questions about sexual orientation identity. There are questions involving experiences with bullying and safety. Anytown recently formed a task force and to specifically address the rising rates of NMUPD—nonmedical use of prescription drugs—used by students, particularly those identifying as lesbian or gay, and the task force includes a few parents, youth, healthcare professionals—being local hospitals and outpatient clinics in Anytown—as well as health educators and the vice principal of Anytown High School.

So, that is the case example of Anytown, and what I am going to do is pass it on to LaShonda.

**LaShonda:** Thanks, Maria. There is a quick question in the chat box, and it looks

like Molly has addressed that question. And so, Sarah, we will get back to your question, but our question for our case study today, based on your experience: What advice would you give to Anytown, the Anytown Task Force, that approaches—about approaches it could use to fill gaps in data on prescription drug misuse, LGBTQ populations in Anytown? What are some approaches Anytown could use to include representatives from LGBTQ populations in data collection and dissemination efforts?

Focus groups. Thank you, Annemarie Goldhorn. Reach out to local LGBTQ centers.

Develop LGBTQ youth empowerment groups. Thank you, Paul. You see some other folks who are typing in.

Based on your experience, what advice would you give Anytown about approaches they could use to fill gaps in data in prescription drug use/misuse among LGBTQ populations in Anytown? What advice? Reach out to the populations in schools. Partner with community groups that may be stronger advocates for LGBTQ and data collection. Thank you, Paul. Thank you, Kelly. Thank you, Ben and Annemarie and Mary. These are great. It looks like there are more people. Key leader interviews. Sarah—thanks. Those are important. It is: How do we get to the community? Look at the scoreboard to stress importance of including these questions. Conduct focus groups with LGBTQ populations and key informant surveys of providers who work with the LGBTQ population.

We have one more question. I see Sandra Del Sesto 26:13) is going to answer, and Linda Barovier, welcome to the call. Conduct focus group of LGBTQ populations and key informant surveys with providers who work with LGBTQ communities. Exactly. So, it sounds like a lot of folks are saying “let's” to drill down at that community level, “let's begin to look at some of our qualitative data sets.” Let's collect data in focus groups, key leader interviews. Let's reach out to that population any way we know how at that community level.

Our next question that popped up: What are some approaches Anytown could use to include representatives from the LGBTQ population in data collection and dissemination efforts? So, that is the question. What are some approaches Anytown could use to include representatives from LGBTQ populations in data collection and dissemination efforts? What are your approaches? Work with local LGBTQ

community groups and centers. Exactly. LGBTQ populations help create survey questions. Ah, “nothing about without us.”

Thank you, Rachel. Focus group questions. Okay. I see a few more people who are typing in.

I really like what folks are saying here. Nicole Shainborn—she wrote, “Train LGBT /LGBTQ youth to help with survey admission.”

Wow, that's great. So, how do we get the population to help collect the data? So, not simply just collecting data on you or about you, but involving you in what actually Rachel is saying: Let's involve you in creating these questions. And then, Nicole says, “You know what? Let's involve those same youths in disseminating the survey so that we can get these surveys back.”

There is a trusted individual who is there helping to administer the survey.

Claudia, she shared, “Hold town hall meetings and invite various groups. Go to LGBTQ events where they are.”

Okay. So, meet people where they are. Don't come to us. We are not expecting you to come to our agency. We are going to go where you are to collect this data.

Ashanti Corey, she shares, “If a community stakeholder has identified themselves as LGBTQ, ask for their participation in developing a survey to include that sector of the population.”

And then, I think our—it looks like our final person to respond is Linda Barovier. “Ask the LGBTQ community or provider network to help with analysis or findings of assessment data. Tell the story as they experience it.”

Wow—testimonials. I love it. Involve that population at every point in this data collection process. Go to where they are and involve them.

You guys are—those are great responses. I am going to—we are going to move on from those responses. Know that there are going to be more opportunities in which we are going to ask you all to participate with us.

So, good job in responding to those questions.

Next we are going to turn time over to Dr. Haner.

**Haner:** Thank you, LaShonda, and thank all of you for your participation thus far. I am really happy to be here, and in terms of capacity, access and use are the two areas that we are talking about here. In terms of accessing and building capacity to address disparities, we should be thinking about resources and readiness. And so, here in the area of resources, what do you have and still need to address to the identified disparity? Think about the funding that you currently have but other resources that you might need or have. What materials are available? What does your staffing look like? Is it representative of that client population or community that we are talking about? What does the data say about that population? What partnerships are in place within that community in relationship to what we are talking about and even the facilities in which we work within become resources, as well.

And then that followed by the next question, how ready are you and your funded communities to address this disparity and when you think about readiness, or when we think about readiness, is your staff trained? Is there buy-in at the staff level or at the organizational level?

Remember, many times programs are embedded within large organizations, and there has to be buy-in from the larger group, as well. Does everyone understand what the funding is for and what the goal of the interventions is all about? And do we have gatekeepers on board and stakeholders that are at their ready? And we know that resources plus readiness equals capacity to address whatever health disparity we are dealing with. And when thinking about all these things, we should be thinking about infusing cultural competency and involving the priority population in efforts to raise awareness, engaging stakeholders, and strengthening collaborative groups.

And so, you have been mentioning engaging stakeholders in the priority populations in all of your comments, and it is so good to hear that. But we should be thinking of involving those from the priority population at all levels: in planning, in implementation, in evaluation, in all efforts, right? And when we are talking about engagement, we understand that engagement is ongoing. It doesn't happen as a one-shot deal, right?

And then, by way of collaborative groups, so are we talking about partnerships, and are those formal partnerships? Do we have memorandums of agreement— memorandums of understanding in place so that there is sustainability involved in what we are talking about, right? So, this is a model for understanding capacity.

I am going to talk through the case study in terms of Anytown's capacity to address the identified disparity. And we should all understand that the task force had the support of involved parents and some local school staff to address youth prescription drug misuse with a focus on lesbian, gay, bisexual, queer and questioning youths, and several community partners that have emerged, including local prescribers and pharmacists, right?

Additionally, focus groups— the focus group data reveals that Anytown residents largely do not believe that prescription drugs are as harmful as other substances. So, a few things here, right? In terms of the involved parents, right, it says there are involved parents and some local leaders. One question that I always ask myself in these types of things: So, who is not involved? Who is not at the table? Who do I need to be thinking about in addition to the people who are involved?

In terms of partnerships ... partnerships are great, but how can we use them to leverage new ones, right? So, how can we use existing ones to leverage new ones?

And then, we are talking about community attitudes, and these behaviors and norms, right? And so, how do we begin to address and change them over the course of the intervention and then support it throughout?

So, those are some of the things that I think of when I think about these areas in presenting this case study. And so, I am going to transition us back to LaShonda, who is now going to take us to a poll.

**LaShonda:** Thank you, Haner. We have a few questions for you all. The first question is: What are examples of resources—human, fiscal, and organizational—that are still needed to address prescription drug misuse among LGBT or LGBQ youth?

I will say it again: What are examples of resources that are still needed to address prescription drug misuse among LGBQ youth? And then, second question, please

feel free to type into the chat box: How ready is the community to address the problem of prescription drug misuse among LGBQ youth? How ready is the community to address the problem of prescription drug misuse among LGBQ youth?

So, I see one answer. Feel free, please, just to type in. So, in terms of our question, what are examples of resources needed to address prescription drug misuse among LGBQ youth in Anytown?

The answers that are popping up: support from the high-level school staff, health care providers who are sensitive to LGBQ youth. That is important, is to have those healthcare providers who understand the issue that an LGBQ youth may have. Certainly working with the LGBQ organizations—those people who are already in the trenches, who are already advocates to the population—they are certainly a resource. Medical community, including pediatricians. Oh, certainly. Mental healthcare providers, too, for sure. The youths themselves. They are certainly a resource that is needed, right? Law enforcement. Media support. The media support—they do a great job in helping us to destigmatize LGBQ youths in our community and those issues around nonmedical use prescription drugs.

How ready is the community?

Let's move over here. This is becoming an active polling box, as well.

How ready is the community to address the problem of prescription drug misuse? Folks are saying, due to lack of awareness, they may not be ready. It seems like some are partway there, but they still have a ways to go. Other folks are saying they are not ready at all. They need more awareness, and increased perception of risk and harm, and there is still pretty low-level readiness based on the statement above.

It varies by community. Needless to say, some are more ahead than others; schools, community-based and faith-based organizations must become even more involved. Training is needed and particularly in the area of stigma.

Thank you for sharing that. That is important. We have to build some capacity here.

Other folks are saying: If the community's residents don't see this as an issue, it may be very hard for them to engage in culturally-sensitive or culturally-specific prevention work. So true. It may be difficult in the beginning to do that work. I think that that statement really closely marries with this other statement, which is: And how do we build this readiness? We need to begin educating the community.

So, I am seeing quite a few folks who are saying this community just does not seem ready at the moment, but that the community, you know, that there are some examples of resources that they need to mobilize within the community and those resources are the medical professionals, college age youth and high school youth who are in the area, high level school staff in the area, awareness of higher rates of depression, suicide attempts and other mental health issues among LGBTQ population, getting our medical health providers involved, the youths themselves, law enforcement, and media support.

So, we are seeing that there are some resources that we know we should get mobilized at the community level, but there is this place where we are seeing, gosh, when your community is not ready. And what I am hearing you all say is: This community is just not ready. Then I hear somebody else here who says that the community just needs more education on the issue.

So great job, you all, answering those two questions. I am going to turn the time back over to Haner.

**Haner:** Yes, and to continue on the case example ... so Anytown Task Force collected additional focus group data and reviewed research literature to identify gaps and prioritize the following risk and protective factors for substance abuse among this youth population; and so here, in terms of risk factors, they have identified harassment, victimization, bullying at the schools. And, obviously, we are looking to reduce those risk factors, correct? And, in terms of protective factors, we have identified positive school climate, anti-bullying policies, and Gay-Straight Alliance clubs they have identified.

Now, I want you to think ... because there might be others in terms of risk and protective factors, and specifically around cultural values and beliefs. So, you must always be thinking about what those mean, right? And, moving on, I want to present, in the area of planning, some key considerations in selecting strategies, and this is

planning obviously in the area of use.

In terms of fidelity, here are some key questions that we encourage organizations to ask themselves in working with any population but very specifically with this one, and those are the following: What are the core elements of the evidence-based practice that we are implementing? Are we following intervention as designed? Are our staff trained and supervised on an ongoing basis and receive support? Do we have the materials that are culturally appropriate in the area of fidelity?

In the area of adaptability, “Do we understand the culture elements of the priority population?” would be a question that we would encourage people to think about. How we adapt and tailor with fidelity—and that is where the rubber hits the road in terms of any intervention that we are trying to implement, like adaptation and tailoring with fidelity—and do we have the staff and the resources at the ready to be able to implement, right?

And, in terms of feasibility, we have talked a great deal about this, and we have actually made several recommendations about this. What do the partnerships look like? What do the resources look like? Do we have collaborations? What are the locations that we are proposing to provide the intervention? And our facilities also become very important. Are there safe zones for the population that we are working with? And, in the area of sustainability ... and in here we think about sustainability and respect throughout the entire process ... but this is really to help us focus on do we have MOU's [Memorandums of Understanding]? Do we have MOA's [Memorandums of Agreement]? Is there community buy-in? Do we have partnerships? Our work is always, I think, about relationships, right? And how well do we know those cultural elements of that population and the relationships? I can't say enough about the relationships moving forward. We need to maintain them, expand them, and support people in those processes.

So here—those are some key considerations in selecting strategies, right?

Back to the case example ... selecting an intervention for Anytown, USA. The priority problem is prescription drug misuse amongst youth with a focus on lesbian, gay, bisexual, questioning or queer youth, and the risk factors that we have identified here are: harassment, victimization, and bullying at the school; and so, the possible interventions are listed here.

Number one is to develop and deliver a school-based social bargaining campaign to address school climate issues; and so, think about that as a possible intervention and how well would that address the risk factors that we are talking about here or the second one: to deliver a parent education program aimed at increasing perception of harm. Again, think about the risk factors in the priority population.

And finally, number three: push the school board to update the student survey questionnaire to include more questions focused on lesbian, gay, bisexual, questioning and queer youth issues. And so, those are the three possible interventions.

We really want you to think about the risk factors and the priority problem that has been identified, and then to select the most appropriate.

I am going to give it back to LaShonda for a poll.

**LaShonda:** Thank you, Haner. So, given what Haner just said—and the priority problem is prescription drug misuse among youth and the risk factor is harassment, victimization, bullying—would you please share with us what possible intervention should they begin to implement? So, considering what you know about this youth—this youth in Anytown—and prescription drug misuse, including among the LGBTQ community, or youth, which strategy would you select to implement? And then, below it is: Why did you select that?

So, it looks like lots of folks are saying: develop and deliver a school-based social marketing campaign to address school climate issues. A couple of people are saying: deliver parent education program aimed at increasing perception of harm. And then, we have [others] saying: Push the school board to update the school survey questionnaire to include more questions focused on LGBTQ issues.

There we are, 17 folks, and, please below, tell us why you selected the strategy that you wanted to select today? Why did you select that strategy? We already have Linda Barovier typing in, telling us why she selected the strategy she selected today. It looks like we have 20 people who are reporting: Develop and deliver a school-based marketing campaign to address school climate issues. Three folks are saying: Deliver a parent education program aimed at increasing perception of harm, and

then we have eight: Push the school board to update the student survey questionnaire to include more questions focused on LGBTQ issues.

So, down to the why. Minami stated, “We need to have baseline data before implementing intervention.”

Okay. She said we need to get the data before we implement any intervention. That is correct. We always should: this is a data-driven decision-making process.

“I wouldn't select only strategy, in reality,” is what Paul is saying. So, he thinks he would use multiple strategies in working with this population.

Linda Barovier says, “I wish we could pick the first and the last because I think the data would be helpful, but it seems like the harassment and bullying are the identified factors, and that is a climate issue.

Claudio is saying, “I would have recommended communication training, such as motivational interviewing for the LGBTQ to empower them.

Annemarie, I agree that we have more data—that we need to have more data. And then Ben, if the data shows that risk from drug use is associated with bullying at school, that is where we need to begin. We need to streamline our resources for best efficiency and stated also, we seem to agree that awareness was an issue. So, we must begin there, thus start with social marketing and other awareness activities.

Jen, the youth are the ones experiencing the risk factors—peers, also youths, are the ones also implementing the harassment, bullying, etc.: climate issues. So, they want to deal with the climate, and she agreed with Paul, what he said, is that he wouldn't want to select just one strategy, in reality.

And then there is Roseann ... multiple people who were typing agree with a minimum of two or three strategies are necessary, not one single strategy. I think that is important to add: that we know that we definitely benefit when there are multiple strategies among multiple people—sectors within our community—but just for this one, we are looking just for one answer. And so, it looks like, I know we pushed most people into a box, and they did select the school-based marketing campaign.

Roseanne: she agrees with a minimum of two strategies. Michelle: strategies to reduce bullying are all over the place and none seem to be making a huge impact for any population in schools. I think parents need to be able to see what's going on so they can bring it to the surface. It doesn't appear that a school policy change is going to occur.

And then Sarah said that she agreed with Linda Barovier's statement, which is: I wish we could pick more than one.

Great job, you all.

It looks like no one else is typing into the chat box. I would like to turn the time—I appreciate you all for always participating. I would like to shift the time back to Haner.

**Haner:** Thank you. And, in terms of a model for infusing cultural competency, we would like us to think about stages of cultural adaptation. And this is in the area of implementation, obviously the dealing with use and outcomes. And I just want to talk a little bit further through this model, and the cultural adaptation to intervention is social marketing, as most of you selected, and, in terms of information gathering, we are talking about here: interview staff that have implemented a similar social marketing campaign in a nearby school district.

Preliminary adaptation is to tailor a campaign to fit specific community characteristics and experiences, and then we should be doing some pilot testing, right, to test the campaign messages with a student focus group or two. We need to then go back and refine the adaptation, incorporate feedback from community members, and then do a cultural adaptation trial by way of rolling out the campaign to the school community. And so, this is a model to help us do that, and another really important tool that is available to all of us are the national standards for Culturally and Linguistically Appropriate Services, also known as CLAS. Again, here we are talking about the implementation, use, and outcomes. We should know that the CLAS Standards intend to help equity, improve quality, and help eliminate healthcare disparities.

They are structured as follows: There are a number of standards, and standard 1, which is the principal standard, provides effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural, health,

beliefs and practices, preferred languages, health literacy, and other communication needs. So, that you find in standard No.1.

In terms of governance, in standards 2–4 you will find governance, leadership, and workforce—and we are talking what organizations look like by way of their governance and their leadership, but also the workforce that are responsible for implementing, evaluating, planning interventions, those sorts of things. And then communication and language assistance, and those are found in standards 5–8, and there we are talking about everything that has to do with communication information to the public, both by way of talk information but also materials that are distributed and even what the organizations look like when people walk through the door: What does the signage look like? What are the photographs on the walls, and what messages do those convey? Followed by engagement, continuous improvement, and accountability—and those are found in standards 9–15.

And one point that I want to say here is, hopefully, most people on this call, you seem like very well-studied individuals in the area of prevention. If you haven't seen the CLAS Standards, if you haven't gone to that website, you have information in the resources as a link. We want to encourage people to use these moving forward in terms of planning interventions and developing appropriate outcomes for folks, or helping to develop appropriate outcomes.

Here in the next slide, I have the case example implementing the CLAS Standards in Anytown, USA. So, in terms of governance, leadership and workforce standards 2–4, identify and engage non-traditional community partnership prevention efforts, and the examples here are engaging the lesbian, gay, bisexual, queer and questioning youths, the Anytown Coalition for Violence Prevention, and many of the other ideas that you had in terms of engagement.

Communication, language assistance—those are standards 5–8—and here we are talking about customizing pictures and terminology on the task force prevention program materials to be inclusive of the LGBTQ youth. So, there you have it in terms of communication language assistance. And this is followed by engagement, continuous improvement, and accountability, and those standards are 9–15. And here, more in terms of what you talked about, collecting data on approaches to implement the CLAS Standards and share results with the Anytown LGBTQ community. And this is really important, and many of you mentioned these in your

chat boxes, right, in terms of not just collecting the data and involving people from that community in developing the questions and collecting the data, but here we are talking about analyzing the data as well as sharing the results with that community.

In other words, we are not in any community to collect data and then leave with the results and publish papers. We are there to share that information and to share power, and when we are talking about disparities and developing equity and addressing disparities, that is a very critical component to any of this. I am going to transition this now to LaShonda, who is going to introduce the next presenter in our webinar. Thank you.

**LaShonda:** Thank you, Haner. Next, you all, we are going to hear from Dr. John Bartkowski, who is an evaluator for the state of Mississippi. He is going to talk about his experience training community level providers to implement the CLAS Standards in Mississippi. Dr. John Bartkowski, I would like to turn the time over to you.

**John:** Thank you, LaShonda. I am just going to talk for a couple of minutes about what we have done in Mississippi with regard to the CLAS Standards.

So, I evaluate a number of different grants in Mississippi and have had various opportunities to implement and assess the implementation of the CLAS Standards among, often among subgrantees but also within the state-at-large. If you could turn to the next slide, I would appreciate it. Thank you.

So, CLAS—and I guess more broadly, cultural competence—is thought of best as a three-legged stool in Mississippi, and why don't you go ahead and populate each of the legs of the stool, please. Thanks.

The first leg is training. The second is policy or protocol development, and central to that is a health disparity statement, and the third is program evaluation. So, I am just going to talk for a quick minute about each of these.

First, with respect to training, every grant in which Mississippi—that Mississippi receives from SAMHSA or from other sources—is accompanied by extensive training in culturally and linguistically appropriate services, more broadly cultural competence. So, for instance, in several grants that I evaluate with some evaluation colleagues,

we will periodically provide training in cultural competence, whether that is a SPF grant or another grant that is maybe more treatment-oriented.

That training, actually, is done in a couple of different ways. But the primary mechanism for that is, first of all, exposing everybody to the culturally and linguistically appropriate service standards that were just discussed, and then, when we reconvene at various points, inquiring about how subgrantees have tried to infuse CLAS Standards in their agencies and in their program service delivery.

For instance, I was just training last week in Mississippi and was able to facilitate, I guess, one of those reconvenings, and was amazed at some of the stories that were told and the experiences that were shared among the subgrantees. On this particular grant, services are delivered to a homeless population and treatment services are actually provided to them, and one of the agencies was discussing how they were addressing the needs of a hearing-impaired client and how they were able to secure various resources to be able to make sure that the services were able to be delivered to this client in a timely and equitable fashion.

So, they talked about actually learning sign language on their staff. And they said they only had still a rudimentary understanding of sign language, but that they were progressing well in their ability to learn sign language to communicate with this particular client. They also said that texting was actually very, very helpful in terms of communication because that was something obviously visual, and written forms of communication have long been used to communicate with people who have various hearing impairments, and this worked out very well for them.

Policy of protocol development is the second leg of the three-legged stool of cultural competence in Mississippi. And I will say this, I have been really, really impressed by the way that the State Department of Mental Health has really just taken the baton and run with it in terms of developing a health disparity statement and ensuring that health disparities are front and center in any grants or grant proposals that they receive from communities.

So, if there is ever a competitive process whereby various agencies are trying to bid for particular subgrants, health disparities are a key element of those proposals, and that is one domain on which the various agencies are assessed. Those proposals are graded and scored in a way that reflects the importance of cultural competence in Mississippi.

And then, finally, with respect to program evaluation, we are always sure, in conducting the evaluation— both the process evaluation and the outcome evaluation—that cultural competence and, more sophisticatedly, Culturally and Linguistically Appropriate Services standards are adhered to and reported on. So, if there are disparities that emerge in terms of access or utilization of services with respect to a process evaluation, we are quick to turn those around back to the State Department of Mental Health or maybe the agency that is providing the services, as well, to ensure that equity can be restored and established in that type of circumstance.

I will say that there are just some—a couple of unique features that I want to point out about cultural competence in Mississippi. One is that, given the kind of struggle for civil rights in Mississippi, there is a real commitment to cultural competence in Mississippi which I think is admirable and probably even a bit atypical in terms of Mississippi overcoming some of the maybe past inequities for which it, some people would say, is notorious. But the point is that a lot of the great workers in the Department of Mental Health and at the local agencies and community mental health centers really, really bend over backwards and make every effort to ensure that health equity is something that is taken seriously in every facet of the work that they do. So, I had to just kind of say that in a way that I think the history of Mississippi actually works to its advantage in terms of being very, very aware of the potential for health inequities and taking a proactive strategy or approach to overcoming them.

The second thing I will say is there are some maybe more socially conservative elements of life and culture in Mississippi, particularly in rural areas. So, while cultural competence often means tolerance and inclusion for groups that have historically been excluded, I also feel like I have learned something about cultural competence serving as an evaluator in Mississippi where there are school districts, for example, that have more conservative values and, when I am conducting surveys in schools, or when statewide surveys are conducted in those schools, the Department of Education needs to sign off on any measures that are on those surveys.

So, we have been trying to encourage—maybe coax or cajole might be a better phrase—the Department of Education to include a sexual minority identifier on its statewide SmartTrack Survey for several years now and have not been able to get that measure included. So, while as a kind of somebody who really promotes cultural

competence and recognizes the importance of sexual minority vulnerability to various risk factors, I would like to see that included in the survey.

I feel like I also—cultural competence also requires me to be respectful of the values that are sometimes exhibited, again, particularly in maybe the more conservative rural communities where the state Department of Education feels that a question like that could pose challenges or issues if it was included on a survey. So, we continue to encourage the inclusion of that particular item, but we have not yet been successful there. But I will say, we have developed a young adult survey in Mississippi that will be circulated through colleges and universities and that will have a sexual minority identifier on it.

So, those are a few examples from, I guess, the practice and just the approach that has been used with respect to cultural competence in Mississippi. LaShonda, I will turn it back over to you. Thanks so much.

**LaShonda:** Thank you for sharing your experience in Mississippi, Dr. Bartkowski. You all, since we have Dr. Bartkowski on the phone right now, please, in the chat box, feel free to ask him a question. What questions bubble up for you after hearing Dr. Bartkowski talk about his experience in Mississippi?

I will give you all just a second. It looks Paul is typing in. Dr. Bartkowski, this is LaShonda obviously, I do think that it is interesting that, even though you could not get the Department of Ed. to sign off on a sexual identifier in the survey, that you all shifted to asking questions to college students. So, what sort of motivated you all to shift your attention to college students in your state in asking questions around sexual identification?

**John:** So, a lot of grants are now requiring—even if they are youth-oriented grants—they are defining youth broadly to include what are often called emerging adults or young adults, as they are more commonly known. So, that was a real gap. When we conducted an assessment of the data infrastructure in Mississippi, one of the gaps that we identified was the lack of data that we had available from young adults, and so, we basically moved on developing a survey.

Right now, it is kind of in a SurveyMonkey™ format, but we are looking at various options and platforms for fielding that survey. And it actually contains many of the

items that are featured on SmartTrack because they are national outcome measures, but we recognized that with a gap and we also recognized, because we were not reliant on the Department of Education for college and university students, that including a sexual minority identifier would not be a problem on that particular survey.

One of the things we have discussed with the Department of Ed., also, is that maybe they would be more comfortable with a sexual minority identifier on the high school version of SmartTrack, as opposed to the middle school version. So, we are still kind of talking and in negotiations basically to figure how this can be resolved, but I think it just illustrates the importance of balancing various interests when considering cultural competence.

**LaShonda:** How many years have you been attempting to get the sexual minority identifier into the survey?

**John:** We have written a couple of letters to the state superintendent of education because there was a little bit of turnover there, and we are planning to very possibly revisit that issue very soon. So, this would be kind of the third try, and maybe the third time is the charm, we are hoping.

**LaShonda:** I hope so, too. It does frequently take time. Dr. Bartkowski, we have a few questions here in the chat box. One came from Paul, and he says, “Can you share your health disparity statement from Mississippi?”

**John:** I am not at liberty to share that, but I will inquire with Mississippi about whether they would be willing to share that. So, I can't speak for them as a state contractor. Generally, they have a pretty open—in fact quite an open, you know—sharing orientation. So, let me check with them, and then I could be back in touch with you.

I will say one other thing with the health disparity statement is, when something happens at the state level, we try to set that up as a model that communities can develop. So, when communities are funded by the state, the next phase is for them to develop health disparity statements, and many of them have, and they include them typically as either an appendix or a portion of a grant proposal if they are writing for flow-through funds that have come from a federal source, and then are

subgranted through the state.

**LaShonda:** Well, that is a fantastic idea. Thank you, and I am sure Molly will be in contact with you about the response if Mississippi is willing to share, you know, the state or the community level, any of those, health disparity statements.

The next question for you, Dr. Bartkowski, comes from Linda Barovier, “Have you tried any systematic, qualitative data collection to augment the young adult qualitative data collection?”

**John:** So, the young adult quantitative survey that we use—we have not yet or have not begun trying any qualitative data collection. That is something I wouldn't mind pursuing at all, for instance, through focus groups or whatnot, but our first order of business is to make sure that the survey is pretested, fielded, and with validated items. We are confident in the validity of the items, but we want to make sure that the platform is ready for that survey, and, actually, the Partnerships for Success 2015 grant is going to be the venue, I guess, for the finalization of that survey and the actual fielding of that young adult survey. So, qualitative data collection could figure into that very possibly.

I also see there is a question about tools to recommend? I could speak to that if you would like.

**-LaShonda:** Oh, we would love you to. Go ahead.

**John:** Okay. To be honest, I obviously deal a lot with quantitative data as an evaluator. I was trained principally as a qualitative researcher and even an ethnographer, so somebody who conducts a lot of participant observation. So, to me, the best way to analyze or assess cultural competence—I mean, there are some good ways to kind of think about it and, frankly, the SPF SIG survey, the—I think it is the grantee level instrument of SPF SIG—had some good questions or items that kind of were administered as a state- or tribe-, or jurisdiction-level, as a pre/post. So, there are some good tools on like a SPF SIG survey, the GLI [Grantee Level Instrument], I guess it is called.

And then, I would say, though I really, really like the idea—and I have used it a lot—of engaging in more of a qualitative assessment through a kind of facilitated

discussion with key stakeholders. So, the meeting that I had last week in Mississippi was with subgrantees on a particular grant where they had been introduced about four or five months earlier to the CLAS Standards. And then this was kind of a reconvening where we were able to talk about—just revisit—the CLAS Standards quickly because they had already been trained on them. And then I learned from them, as an evaluator, about their experiences—what they have tried at their agency and what they have instituted in their program service delivery—and I have to say, that to me is probably one of the more rewarding aspects of being an evaluator, is to hear people who are providing services speak in a very empowered way about creative strategies or innovative approaches that they have used to infuse cultural competence into their agency or to become more culturally competent service providers.

**LaShonda:** Very good. I think that part certainly got at the heart of what Linda Barovier was asking. She said she meant to say quantitative.

**John:** Yes. I figured, actually, that she had meant quantitative.

**LaShonda:**” I read that and I thought, “ah.” So, what have you done in terms of quantitative, and that is great. So, you used key leader interviews. It goes back to one of our earlier survey questions or poll questions and that is exactly what folks said that they wanted to do. We really want to drill down into the community level and to the people. If we can't collect the data through survey responses, then how do we have key leader interview or focus groups or other ways of getting data so that we can figure out how to help people in those communities?

So, I appreciate your time, Dr. Bartkowski, and we certainly have enjoyed hearing about Mississippi's training of their communities around the CLAS Standards. So, thank you.

**John:** Thank you.

**LaShonda:** And I would like to turn the time over to Maria Valenti.

**Maria:** Thanks, LaShonda. I am going to continue talking about evaluation. Thanks for that introduction, Dr. Bartkowski. So, evaluation was backing the SPF, as you all probably are aware, and there are various types of evaluation, but two main types,

and, again, you have heard them before: process and evaluation.

So process—just a quick review—involves pretty much documenting the implementation from the beginning. Did you do what you had planned to do and, if you did, how did you do it? That is the process evaluation piece, and it is important to document what we have done and how in order to provide assurance that you are following the plan. And it also lets you check in. By doing the continuous evaluation, you can begin to use the data that you are collecting to make adjustments—refine the activities to better focus to meet your outcomes.

And for outcome evaluation, we are looking at any changes from the initial assessment data, so reflecting back to what was the beginning assessment, and did you move that needle? Are you seeing an impact from the activities that you are implementing? And while you are doing this evaluation, you really need to think about infusing cultural competency, and some of the things we have already discussed so far, but I just want to reiterate ... is continually keep the community representative in the process, so asking for their [his or her] feedback.

Looking at the data collection tools that you are using, do they reflect the community that you want participation from? Use [a] culturally competent evaluator perhaps, getting someone who really knows the community very well and, again, being respectful of the data, obtain permission to disseminate the findings. Get permission from the organization that you are working with or the entity implementing the intervention, just so you know that it is okay to share their data and that they are okay with it.

I want to return back to Anytown, so on to the next slide. And so, let's take a look at what Anytown did regarding evaluation. They conducted pre- and post-surveys, and conducted a focus group to discuss the impacts of the social marketing campaign. They also did some process evaluation and tracked adaptations made to the programs and used CLAS Standards. They conducted key informant interviews on the impact of efforts to customize the task force images and terminology in order to be inclusive of lesbian, gay, bisexual, queer, and questioning youths.

Regarding outcomes, they determined that there was an increase in the number of students reporting that they felt safe in school based on the school survey, and they also saw a small reduction in prescription drug misuse among lesbian, gay, bisexual

queer, and questioning students. So, they were a little—they were successful in moving that needle a little. So, I am going to pass it on to Molly.

**Molly:** Great. Thank you so much, Maria. So, just in summary, as we talked through the piece about the quality improvement plan as part of the disparity impact statement through the SPF process and access use and outcomes, and Dr. Bartkowski kind of gave us an example of how they have worked with their disparity impact statement to integrate that into their approaches at both the state and the local level.

I wanted to summarize here how that really connects with how we have talked about addressing disparities throughout the SPF process. So, if we are thinking of assessment, you know, identifying those subpopulations vulnerable to disparities, assessing existing disparities and gaps in the data that we talked about. So, what are the disparities, but also what do we not know because it is hard to fully know the picture unless you have that additional data. So, how can you help fill in some of those gaps with qualitative data, etc., and that really speaks to that access piece and connects to the assessment process.

If we are thinking about that piece of access related to capacity, we are really thinking about developing those new partnerships to expand resources and improve readiness to address health disparities, utilizing the CLAS Standards to increase access to culturally competent prevention services as a part of that. Moving into use—and that is still overlapping with capacity—we are really thinking about how can you engage those populations experiencing disparities in your prevention planning efforts which connect to then ultimately their increased potential use of those prevention services.

How that connects with planning, then, is we are thinking about, in terms of use, providing T/TA for prevention providers on strategies to address health disparity. So, similarly to what Dr. Bartkowski talked about: How can we help them understand the role of cultural competency in that work, and then, moving into culturally adapting or tailoring evidence-based practices as a part of implementation, which also overlaps with the use piece because that is going to increase the likelihood that those interventions will reach, and not only be available for, but reach those target populations.

Moving and continuing through implementation, and connecting to outcomes, we are thinking of really how do we not only involve those populations experiencing disparities in implementation but track any adaptations we made to those—to our interventions to be culturally relevant and also tracking, kind of, use—to how we used the CLAS Standards to increase cultural competency through implementation.

And then, finally, with evaluation, that is that tracking piece for the process as well as allocating additional evaluation resources for adapting and tailoring evidence-based practices and really understanding whether the project is having the intended impact on behavioral health disparities by documenting the reduction in the priority problem not only among—in general among—the populations that you are targeting but among those experiencing disparities.

So, just to kind of wrap up thinking about this issue, I am wondering if you could please share. So, thinking about your disparity impact statement, your quality improvement plan as a part of that, and the content we covered today, what is one approach you think you can take in the next three to six months, so potentially some of that low-hanging fruit that will help you get on the road to addressing behavioral health disparities among those populations you have identified, experiencing them in your state, tribe, or jurisdiction?

So, take a moment to think about this. Think about some of the things Dr. Bartkowski shared, some of the components of the case example, and think about what you can do as a first step towards continuing to move towards that work and keeping that as a continuous process throughout your efforts as you are in [the] planning and implementation stages of your grants.

I know this is a heavy one, but really just, you know, making some realistic goals for yourself. That first step can often be the hardest. I know many of you are already doing this work, but it is easy to get kind of caught up in just implementing the SPF process and really addressing our priority problems without thinking about being deliberate about this piece, and really checking back in with those quality improvement plans and those statements. And so, we want to get you to kind of help thinking—making that sort of statement and promise to yourself on how you can make that approach in the next three to six months to move forward.

So exactly, Roseann, keeping it as a regular agenda topic, which elevates its level of

importance, just keeps it on your mind, keeps it on the forefront of discussion, is a huge—a huge step that you can take to make sure that it doesn't fall off your radar.

Orienting sub-recipients to the CLAS Standards to ensure the implementation of strategies that reflect those standards—exactly. That is a great way to help sort of build the capacity of those at the local level to do this work.

Incidentally, we are providing kind of a similar version of this webinar, but targeted towards community level providers, on the 10th. And so, you all will receive a reminder about that again tomorrow, but make sure to pass that on to your community-level providers if you would like them to attend kind of an inter-webinar from us to help get that conversation going, as well.

So, Melissa says they have trained their grantees on prioritizing high-risk populations, but the idea of doing that facilitated discussion in a few months to see how far they have come would really close the loop. So, that's a great point.

Including disparities in the upcoming learning institutes for our funded coalition. So, it sounds like a lot of people are thinking about how can we continue to address this issue, continue to have this topic on our minds but also really keep it at the forefront of our subrecipients' and community-level grantees' minds. And so, that is great, and I think Dr. Bartkowski definitely sparked a lot of that interest in all of you. So, those are some ideas that the rest of you who didn't share can also kind of steal for yourselves in thinking about some next steps for you to take.

I think we can go back to the slides, and I will turn it over to LaShonda to wrap up.

**LaShonda:** That was a great hour and a half, almost, you all, and I feel like we have learned a lot. I think that it is important that we share this information with our community members come September 10<sup>th</sup>. And, like Molly said, tomorrow there will be emails that go out inviting you all to please invite your community members to participate on September 10th in a very similar webinar on health disparities.

So, Molly Ferguson—she is the contact for us. We had a great experience hearing from Haner, Maria, Molly, and certainly Dr. Bartkowski. John, we certainly thank you for sharing an on-the-ground, state-level feel of what you have done in Mississippi, and so, hopefully, there are folks who can continue to have conversations about what you have done and what they have done.

You will notice that, on your screen, we have an evaluation. It is on the right side, and it says, "Please click the link below to provide feedback for this event."

So, we certainly appreciate feedback for this event. We certainly enjoy and appreciate that you all gave this so much energy. We know that this is a highly-interactive presentation, and so, you all were certainly a big part of making this the success that it is, and we appreciate you all for joining us today.

You will also notice that to the left you will see a handout, as well as a PowerPoint, and the PowerPoint that you see is for today's presentation. The handout is on data and there is also a handout on definition that will be coming. So, if you don't click this today, certainly know that there is an opportunity for you to receive this information—that it will be coming. And so, we appreciate your time. We appreciate your energy.

Again, there is—Molly has typed into the SurveyMonkey™ evaluation links. Please fill out that evaluation, and we appreciate your time, and your attention, and your energy for today's webinar. You will notice on the next few slides are resources that we have used and resources that you can use. And so, I know that that is a quick flip-through of those resources, but those resources will be included in the handouts that you receive either by clicking the files to the left or waiting simply until tomorrow when the CAPT sends those materials out to all of you.

So, without anything else being said, thank you very much for your time today. Take care. Bye.

**Haner:** Thank you.

**LaShonda:** Thank you.

End of webinar

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