

The Disparity Impact Statement: A Condition of Award for SAMHSA Grantees

A guidance tool for SAMHSA grantees and staff from the SAMHSA Office of Behavioral Health Equity

September 2022

The Substance Abuse and Mental Health Services Administration (SAMHSA) leads efforts to advance behavioral health equity for the nation. To this end, the SAMHSA Disparity Impact Statement (DIS) is a data-driven approach to quality improvement aimed at advancing equity for all. As a grant requirement, DIS helps grantees¹ identify racial, ethnic, sexual, and gender groups as well as rural populations at the highest risk of experiencing behavioral health disparities. This document provides guidance on the DIS, which was updated in September 2022. In addition to general guidance, this document includes three appendices: Appendix A offers guidance on linking goals and objectives to outcomes; Appendix B provides a glossary of key terms; and Appendix C lists additional resources.

What is the DIS, and what is its purpose?

The DIS is a condition of award for SAMHSA grants, including those for services, infrastructure, training, and technical assistance; it is a first step toward identifying whether a grantee is working with underserved groups and the extent to which that grantee will address health disparities. The DIS helps grantees identify, contextualize, address disparities, and develop and implement a quality improvement plan that reduces disparities and addresses the identified gap(s). The aim of the DIS is to achieve behavioral health equity and improve systems that address the needs of populations experiencing disparities. The DIS deadline is outlined in the notice of award; it should be viewed as a living document that is updated annually by the grantee and discussed regularly with government project officers (GPOs).

What is the history of the DIS?

Use of the DIS has been a long-standing practice at SAMHSA. It originated as a Department of Health and Human Services (HHS) secretarial priority in the 2011 [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#). The objective of the secretarial priority was to reduce health disparities by assessing and improving the impact of HHS policies, programs, processes, and resource decisions. To accomplish this, program grantees were required to submit a DIS as part of their grant applications. At the time, the secretarial priority focused on underserved racial and ethnic minority populations. The SAMHSA Office of Behavioral Health Equity (OBHE) also added lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) populations as an underserved group experiencing disparities at that time.

In recent years, the prioritization of health equity at SAMHSA and HHS led to efforts to update the DIS. In 2021, the Biden administration issued [Executive Order 13985](#) on advancing racial equity, which emphasizes identifying the needs of underserved communities and developing policies to advance equity within those communities. This was followed by the [HHS Equity Action Plan](#) in April 2022. Accordingly,

¹ SAMHSA uses the terms “grantee” and “grant recipient” interchangeably.

SAMHSA's Office of Behavioral Health Equity collaborated across the agency to develop and release an updated DIS with accompanying guidance and training.

What are the sections of the DIS?

The DIS has three main sections:

1. Identify and describe the behavioral health disparity aligns with the grant program and the population(s) of focus.
2. Identify the social determinants of health (SDOH) domains and the Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) Standards that the grantee organization will work to address and improve for the identified population(s) of focus.
3. Develop a disparity reduction quality improvement action plan to address behavioral health disparities based on the available data on access, use, and outcomes.

The DIS references three aspects of equity: (1) access, (2) use, and (3) outcomes. Specifically, grantees are asked to consider the following:

- **Access:** Which people or programs does the grant serve? Consider the number of people or programs served and information about the people served, including demographics, outreach, screening, and referrals.
- **Use:** What types of services do different groups use? Service use includes treatment services, prevention services, and, depending on the grant type, other activities such as technical assistance. Consider the different forms of services and trainings as well as dosage and retention rates.
- **Outcomes:** How do the program's specified outcomes vary by population group? Consider relevant program outcomes, such as the number or percentage of people who have demonstrated an improvement in knowledge, attitudes, or beliefs; the number of organizations that implemented specific behavioral health practices or evidence-based activities; or outcomes related to behavioral health, mental health, or substance use.

Where can grantees find data for the DIS?

To complete the DIS, grantees should use existing data sources to identify disparities. In addition to using any existing [Government Performance and Results Act \(GPRA\)](#) data, grantees should consider federal, state, or local data sources.

Examples of federal data sources include:

- The [National Survey on Drug Use and Health \(NSDUH\)](#)
- The U.S. [Census Bureau](#) and the [American Community Survey \(ACS\)](#)
- Other data from the [Center for Behavioral Health Statistics and Quality](#)

Examples of state data sources include:

- Behavioral health agencies
- Public health agencies
- [State criminal justice data centers](#)

- Other state agencies

Examples of local or community data sources include:

- Community needs assessments
- [County health rankings](#)
- Law enforcement or judicial data
- Hospital or emergency medical services

Using these and other sources, grantees can examine disparities in access, use, and outcomes across population groups and as relevant to the grant. Disaggregating the data by population groups can help grantees begin to identify ways to target interventions to address these disparities. To measure disparities, grantees should identify a reference point that is relevant to their context and outcomes of interest. The reference point is typically the population group with the best health outcomes and is used for comparison with the other groups.

What is the demographic table and how do we complete it?

The demographic table focuses on the grantee's program or intervention and the populations served. Specifically, the table should clearly indicate:

- Who will be served
- Demographic information about the population served (expressed as percentages of the total population)
- Time period (when these populations will be served, such as by grant year, quarterly, monthly, etc.)
- Information collected through the GPRA, such as data on National Outcome Measures (NOMs)

At the end of the table, please explain and indicate the selected underserved population(s) and the justification for why they are selected (including data sources) as it relates to the grant.

What is a disparity reduction quality improvement plan?

The disparity reduction quality improvement plan is the third section of the DIS. Its goal is to ensure grantees have an actionable plan for addressing disparities. The quality improvement plan should include strategies to improve access, use, and outcomes for the underserved population(s) identified.

Continuous quality improvement is also a central aspect of the CLAS Standards, including conducting ongoing assessments of the grantee's CLAS-related activities and integrating CLAS-related measures into quality improvement measurements. Grantees should develop their quality improvement plans using the SMART goals framework. SMART goals and objectives are **s**pecific, **m**easurable, **a**chievable, **r**elevant, and **t**ime-bound (see appendix A and the DIS worksheet for more information).

The quality improvement plan consists of six main tasks:

1. Describe implementation using SMART goals and objectives
2. Identify intended outcomes and impact
3. Describe the inclusion of clients, peers, and partners
4. Develop a timeline for activities

5. Identify the measurement and evaluation methods that will be used to indicate progress
6. Outline plans for sustainability

Grantees should be prepared to share annual (at a minimum, or more frequent) updates to their quality improvement plans.

Although disparity reduction quality improvement plans should be specific to each grantee's context and proposed work (i.e., the grant application), they may include specific plans for the following activities:

- Training staff on culturally responsive and equitable practices
- Improving language accessibility by providing interpreters and translated materials
- Strengthening the health literacy and other communication needs of subgroups in the proposed geographic region
- Hiring staff with lived experience who may have more effective approaches to outreach and engagement
- Partnering with community-based organizations and community leaders to engage their communities in efforts to examine and address disparities

See Appendix A for key questions to consider when developing a quality improvement plan.

Is the DIS part of monitoring and managing the grant?

Grantees should work with their GPO to submit the DIS via the National Institute of Health's (NIH) online system, [eRA Commons](#). As part of the terms and conditions of the grant, the DIS must be submitted through this system; the grant project director, the grants management specialist (GMS), and the GPO monitor the grant submission. Grantees and GPOs should use the DIS as a basis for regular check-ins and for performance reports submitted to the GPO. By tracking the GPRA data on access, use, and outcomes, the grant project director, and the GPO will be able to determine further changes or adaptations to better serve the identified underserved population of focus. As previously mentioned, the DIS should be updated annually.

What should grantees know about SDOH and National CLAS Standards?

[Healthy People 2030](#) defines the SDOH as “the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.” The SDOH are generally grouped into five domains: (1) education access and quality, (2) economic stability, (3) neighborhood and built environment, (4) health care access and quality, and (5) social and community context. The SDOH are known to contribute to health disparities. For example, lack of access to quality health services in neighborhoods may contribute to poor behavioral health outcomes for residents. Similarly, people living in food deserts face negative impacts on their nutrition and overall health. Understanding the SDOH community context can help grantees recognize the disparity (or problem), identify the focus population, and inform the development of accurate measures to study and improve outcomes

By establishing a blueprint for health and health care organizations to implement culturally and linguistically appropriate services, the National CLAS Standards aim to improve quality of care, advance

health equity, and help eliminate health care disparities. In 2013, the HHS Office of Minority Health released the enhanced National CLAS Standards, a comprehensive set of 15 guidelines to inform and facilitate practices related to culturally and linguistically appropriate health services. The enhanced standards consider the nation's increasing population diversity, significant growth in the fields of cultural and linguistic competency, emerging governmental considerations around health equity, and growing interest from health plans and providers. SAMHSA collaborated with the HHS Office of Minority Health to release the [Behavioral Health Implementation Guide for the National CLAS Standards](#) which provides specific and systematic guidance for implementing each standard and to promote behavioral health equity. For more details on the development of each standard, see the [Think Cultural Health](#) website.

Several resources are available to support grantee knowledge and capacity building related to SDOH and CLAS Standards. For a complete list, please see Appendix C.

Where can we find examples of the DIS?

Examples are available on the [SAMHSA Disparity Impact Statement website](#) and should only be used as a reference. The DIS should be developed based on the context, programs, and services of each grant.

Where can we find more information about the DIS?

Grantees should review information about the DIS in their original Notice of Funding Opportunity, their Notice of Award, and their application. Grantees can find general information about the DIS, including a DIS 101 training, on the [SAMHSA Disparity Impact Statement website](#). Specific questions about the DIS should be directed to the GPO.

Appendix A. Additional DIS guidance: Linking appropriate goals and objectives with intended outcome measures

A **goal** is a broad statement about a grantee’s long-term expectations for a grant program. A goal is a desired result, and grantees achieve it through project objectives and activities.

To develop effective goals, grantees should:

- Focus on key outcomes (not the process for achieving outcomes)
- Describe the behavior or condition in the community that is expected to change
- Describe who the grant or program will impact

Tip #1: Consult collaborating agencies and community partners before setting goals and objectives.

Grantees should ensure that goals are concise and lead to one or more measurable results.

Objectives describe the results to be achieved and the way they will be achieved. Multiple objectives are generally needed to address a single goal. Objectives help establish program priorities and benchmarks for progress and accountability. When defining objectives, avoid verbs with vague meanings (such as “understand” or “know”) because they may prove difficult to measure. Instead, use verbs that clearly define actions and language that specifies expected results, such as: “By the end of 2022, 75 percent of program participants will be placed in permanent housing.”

Linking program goals and objectives with measurable outcomes can be a challenge for grantees. However, goals and objectives must be aligned with measurable outcomes to document whether a program is making an impact. When goals and objectives are not clearly connected to specific outcomes, grantees may not be able to describe a program’s progress or how it addresses disparities. To help outline the connections among program goals, objectives, activities, and outcomes, grantees can create a simple visual map using a table, a figure with arrows, or a basic logic model.

Tip #2: A basic logic model is a visual tool for outlining program goals, objectives, and activities and the ways they connect to measurable short- and long-term outcomes. Appendix C provides additional resources on logic models including guides, examples, and templates.

To ensure goals are appropriate and connected to measurable outcomes, this appendix provides guidance on (1) setting SMART goals and objectives and (2) developing a strong quality improvement plan.

Set SMART goals and objectives

Setting specific, measurable, achievable, relevant, and time-bound (SMART) goals and objectives can help grantees plan ways to meet the long-term goals in their grants and shift from ideas to action.

SMART element	Weak example	Strong example
Specific means including the “who” and “what” of program activities and using an action verb.	“Outreach workers will use their skills to reach out to drug users on the street.”	“Outreach workers will administer the HIV risk assessment tool to at least 100 injection drug users in the focus population.”

SMART element	Weak example	Strong example
Measurable means indicating how much change is expected so that grantees can quantify the activity or results.	“Increase the number of 8th, 9th, and 10th grade students who disapprove of marijuana use.”	“By September 2022, increase the number of 8th, 9th, and 10th grade students who disapprove of marijuana use by 10 percent, as measured by the annual school youth survey.”
Achievable means objectives are attainable within a given time frame and with available program resources.	“All teenage mothers in our area will learn about proper nutrition.”	“The new part-time nutritionist will meet with seven teenage mothers each week to design a complete dietary plan for them.”
Relevant means objectives are within the scope of the project and propose reasonable steps that can be implemented within a specific time frame to achieve intended outcomes.	“Though not directly related to program goals, we will also address gang violence in the community.”	“To address our goal on reducing gang violence, two ex-gang members will each make one school presentation each week for two months.”
Time-bound means grantees provide a time frame indicating when the objective will be measured or a time frame indicating when the objective will be met.	“New peer educators will be hired.”	“Five new peer educators will be recruited by the end of the second quarter of the first funding year.”

(adapted from [Developing a Competitive SAMHSA Grant Application](#))

Key questions to consider when developing objectives and outcomes

- How would you know if outcomes occur as expected?
- What do you expect to change? Is the change measurable in any way?
- How can you monitor progress toward the objectives and goals?
- Do anticipated outcomes align with staff expectations, community needs, and existing information about disparities?
- What access do you have to relevant and high-quality data?

Long-term impact versus short-term outcomes

- Can outcomes change demonstrably within a time frame you can observe?
- Is the change something that might happen later, such as in 5 or 10 years?

Connections to the program and its implementation

- Can observed changes be clearly attributed to the program or planned activities?
- What other factors may impact changes in outcomes? Would it be hard to distinguish these other effects from your program impact?

Developing a strong disparity reduction quality improvement plan

The disparity reducing quality improvement plan (QIP) helps grantees create an actionable plan to address disparities documented in the DIS, document improvements over time, and support sustainability. Although disparity reduction QIPs may vary in approach and methods, as a basic underlying principle, they involve continuous activity (not a one-time action). Grantees can learn from quality improvement

data and then, as needed, shift their strategy, or try new interventions as they work continuously toward their disparity-reducing goals and objectives.

To develop a disparity reduction quality improvement plan, grantees should use SMART goals, objectives, and outcomes as well as ongoing measurement and/or evaluation procedures. It requires six steps, as described in the previous section on disparity reduction quality improvement plans in this document.

Disparity reduction QIPs should also be viewed as part of a larger cyclical effort to advance behavioral health equity by continuously improving interventions and to ensure sustainability of those efforts.

Plan, Do, Study, Act

One approach to quality improvement is the Plan, Do, Study, Act cycle,² a structured series of steps for learning about an intervention or process and then working at its continual improvement. The main steps are outlined below.

1. **Plan.** Create a plan; this includes identifying goals, formulating interventions or a theory of change, defining metrics of success, and developing an evaluation plan.
2. **Do.** Implement the plan and its components.
3. **Study.** Monitor outcomes for signs of progress and success, problems or challenges, and areas for improvement.
4. **Act.** Integrate the learning generated by the process to adjust goals, change methods, or even reformulate an intervention or improvement initiative altogether.

Measurement and evaluation

Key questions to consider when developing the disparity reduction quality improvement plans

- What steps will you take to accomplish each objective? What coordination, training, information systems changes, business process changes, or other initiatives are needed?
 - Have subject matter experts—including those with lived experience—shared their ideas on needed solutions, proposed objectives, or planned steps?
 - Are all components responsive to the needs and cultures of the focus populations or communities?
 - Do the proposed steps address social determinants of health (SDOH) or National CLAS Standards?
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Strong disparity reduction QIPs include ongoing measurement and/or evaluation plans that help grantees determine the best cadence, methods, and metrics of success for their programs. Grantees should explain how they will collect measurement data and ensure that data collection is feasible for their program. A baseline measurement is required to document change (for example, to measure the percentage increase or decrease). Grantees that plan to use specific measurement instruments should specify them in their

² Adapted from the Agency for Healthcare Research and Quality Consumer Assessment of Healthcare Providers and Systems (CAHPS) page on quality improvement: <https://www.ahrq.gov/cahps/quality-improvement/improvement-guide/4-approach-qi-process/index.html>

goals and objectives. As part of the disparity reduction QIP, grantees should provide the elements outlined below for their measurement and evaluation plans.

- **Measures:** Identify outcome measures or indicators that can be used to track progress over time. These measures may be individual, community level, or both. Monitoring these measures helps grantees assess whether trends are developing in the expected direction or require course corrections. If possible, grantees should identify specific measurement tools in the QIP.
- **Time period:** Evaluations focus on whether programs or policies attain their goals within a defined time period. The time period identified in the SMART goals should mirror the time period established for measurement and evaluation. When choosing measures for monitoring and evaluation, consider focusing on short-term indicators that are ultimately related to the desired short- or longer-term outcomes.
- **Equity:** Data, research, and evaluation efforts often do not include the communities and individuals most affected by the issue in question. Thus, the measurement or evaluation team should consider how to make the evaluation culturally responsive and equitable. This could include, for example, ensuring measurement tools or data collection instruments are accepted across cultures, incorporating the perspectives of those with lived experience, or reflecting on the biases and privileges of the research team.³
- **Dissemination:** When developing dissemination strategies, the evaluation team should consider who will see the data (for example, internal staff, funders, the community) and the best approaches to dissemination. Grantees can engage in ongoing meetings, such as quality improvement check-ins, or conduct larger dissemination strategies as needed.
- **Acting on changes:** Finally, a core component of quality improvement is using the information gained from measurement and evaluation to make changes and improvements to the program or intervention. Accordingly, teams should create processes to support ongoing program improvements.

Tip #3: Grantees should identify who is responsible for measurement and evaluation activities, including internal and external evaluators, data analysts, or other key staff.

³ To learn more, visit the [Equitable Evaluation Initiative website](#) or read a brief on [culturally responsive and equitable evaluation](#).

Appendix B. Glossary of key terms

This glossary provides an alphabetic listing of key terms used throughout this guidance as well as related concepts.

Baseline data: Basic information or data that grantees can collect before a project begins. This data serves as a reference point for comparisons with data collected later in the project; it helps grantees determine if there have been any changes in specific conditions over time (adapted from the manual, [Developing a Competitive SAMHSA Grant Application](#)).

Behavioral health equity: The right of all individuals, regardless of race, age, ethnicity, gender (including gender identity), disability, socioeconomic status, sexual orientation, or geographical location, to access high-quality and affordable health care services and supports. Advancing behavioral health equity means working to ensure that every individual has the opportunity to be as healthy as possible. In conjunction with access to quality services, this involves addressing social determinants of health—such as employment and housing stability, insurance status, proximity to services, and culturally responsive care—all of which have an impact on behavioral health outcomes.

Culturally and Linguistically Appropriate Services (CLAS): The National CLAS Standards are a set of 15 action steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.

Disparity: A particular type of difference that is closely linked to social, economic, or environmental disadvantages and/or other characteristics historically linked to systemic barriers or exclusion. Disparities adversely affect groups of people who have systematically experienced greater obstacles to well-being based on factors such as their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; or geographic location (adapted from the [Health Equity Style Guide of the Centers for Disease Control and Prevention \[CDC\]](#)).

Equity: The consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, queer, and intersexed (LGBTQI+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality (adapted from [Executive Order 13985](#)). Equity is achieved when every person has the opportunity to “attain their full potential,” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances” (adapted from [CDC definition of health equity](#)).

Government Project Officer (GPO): At SAMHSA, the GPO is responsible for the programmatic and technical aspects of a grant. The GPO works in partnership with grants management staff on post-award administration, including progress report review, site visit participation, and other activities.

Government Performance and Results Act (GPRA): Enacted in 1993, the GPRA is one of a series of laws designed to improve government performance management. The GPRA requires agencies to engage in performance management tasks, such as setting goals, measuring results, and reporting progress ([GPRA Fact Sheet](#)).

Grants Management Specialist (GMS): At SAMHSA, the GMS is responsible for overseeing day-to-day business and other non-programmatic aspects of a grant. These activities include, but are not limited to, evaluating applications for administrative content and compliance with statutes, regulations, and guidelines; negotiating grants; providing information and technical assistance to grantees; and administering grants after award.

Grant Management Officer (GMO): At SAMHSA, the GMO is responsible for the business management aspects of grants and cooperative agreements, including review, negotiation, award, and administration. The GMO is also responsible for interpreting grant administration policies and provisions and has the delegated authority to obligate SAMHSA to fund expenditures and to permit changes to approved projects on behalf of SAMHSA.

Health disparity: A particular type of health difference that is closely linked to social, economic, and/or environmental disadvantages. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health care based on their racial or ethnic group; religion; socioeconomic status; gender; age; disability; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion ([Healthy People 2030](#)).

Implicit bias: Attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner (adapted from [Combating Implicit Bias and Stereotypes](#), HHS Office of Minority Health).

Intersectionality: People belong to more than one group and may experience overlapping health and social inequities as well as overlapping strengths and assets (adapted from the CDC's [Health Equity Guiding Principles](#)).

Lived experience: Representation and understanding of an individual's human experiences, choices, and options and, based on their own life, the ways those factors influence that person's perceptions or knowledge. Lived experience provides insight into patterns, common behaviors, challenges, and barriers among individuals who share similar experiences (adapted from [Methods and Emerging Strategies to Engage People with Lived Experience](#), HHS Office of the Assistant Secretary for Planning and Evaluation).

Social Determinants of Health (SDOH): The conditions in the environment where people are born, live, work, play, worship, age, and thrive that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH are grouped into five domains: (1) economic stability, (2) education access and quality, (3) healthcare access and quality, (4) neighborhood and built environment, and (5) social and community context. The SDOH framework recognizes that cross-sectoral systems help advance equity through a lifespan perspective (adapted from [Social Determinants of Health: Know What Affects Health](#), CDC).

Underserved communities: Populations or geographic communities that share a particular characteristic and have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life as exemplified by the list in the definition of "equity" above ([Executive Order 13985](#)).

Appendix C. Additional Resources

Social determinants of health and health equity resources

- [Actionable Intelligence for Social Policy: A Toolkit for Centering Racial Equity Throughout Data Integration](#) (University of Pennsylvania)
- [Healthy People 2030](#) on the social determinants of health (HHS Office of Disease Prevention and Health Promotion)
- SAMHSA website for [behavioral health equity](#)
- [National Network to Eliminate Disparities in Behavioral Health \(NNED\)](#)
- [Improving Cultural Competence TIP 59 \(SAMHSA\)](#)

National CLAS Standards Resources

- [An Implementation Checklist for the National CLAS Standards](#) (HHS Office of Minority Health [OMH])
- E-Learning Program: [Improving Cultural Competency for Behavioral Health Professionals](#) (OMH)
- [Development of a Long-Term Evaluation Framework for the National Standards for Culturally and Linguistically Appropriate Services \(CLAS\) in Health and Health Care](#) (OMH)
- [National CLAS Standards Blueprint](#) (OMH)

SMART goals and logic models

- SAMHSA [SMART goals fact sheet](#)
- CDC [guide on writing SMART objectives](#)
- [Logic models for community and substance use programs](#) (Education Development Center)
- HHS ACF guidance [on logic models](#)
- HHS CDC [program evaluation framework \(logic model step\)](#)
- [An introduction to logic models](#) by The W. K. Kellogg Foundation
- [Designing programs and logic models](#) by University of Wisconsin – Madison (Program development and evaluation)
- Example logic model on [youth tobacco prevention and youth](#)
- Example logic model on [reducing underage drinking](#)
- [Logic model templates, examples, and additional references](#) by University of Wisconsin – Madison (Program development and evaluation)

Limited English proficiency and interpretation resources

- [Limited English Proficiency \(LEP\) Resources for Effective Communication](#) (HHS)
- [National Council on Interpreting in Health Care](#)
- [The National Board of Certification for Medical Interpreters](#)
- [Certification Commission for Healthcare Interpreters](#)