

SAMHSA Disparity Impact Statement

Purpose

SAMHSA requires that its grant recipients prepare a Behavioral Health Disparity Impact Statement (DIS) as part of a data-driven, quality improvement approach to advance equity for all, and to identify racial, ethnic, sexual and gender minority populations at highest risk for experiencing behavioral health disparities as part of their grant projects. The purpose of the DIS is for grant recipients to identify, contextualize and address disparities¹ and to develop and implement a disparity reduction action plan with a quality improvement process to address and close the identified gap(s). The aim is to achieve behavioral health equity² for disparate populations and to improve systems addressing the needs of these populations. The DIS requirement aligns with expectations outlined in [Presidential Executive Order 13985: Advancing Racial Equity and Support for Underserved Communities Through the Federal Government](#), which includes identifying the needs of underserved communities and developing policies to advance (health) equity within those communities.

Background

To address behavioral health disparities, it is important to understand the role that Social Determinants of Health (SDOH)³ can have on the health of individuals and communities. SDOH are 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 can be grouped into 5 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 contribute to advancing equity through a lifespan perspective. Understanding the SDOH community context can help recipients identify the disparity (or problem), population of focus and inform the development of accurate measures to study and improve outcomes.

The purpose of this document is to support grant recipients in developing measures associated with DIS. All of SAMHSA's discretionary grants are required to report Government Performance

¹ Healthy People 2030 defines a health disparity as a “particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; disability; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”

² Behavioral health equity is the right to access high quality and affordable health care services and supports for all populations regardless of the individual's race, age, ethnicity, gender (including gender identity), disability, socioeconomic status, sexual orientation, or geographical location. Advancing behavioral health equity involves ensuring that everyone has a fair and just opportunity to be as healthy as possible. In conjunction with 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.

³ <https://www.cdc.gov/socialdeterminants/index.htm>

and Results Act (GPRA)⁴ data, which includes the National Outcome Measures (NOMS). Grant programs using the NOMS client-level outcomes tool uses data collected that includes demographics⁵, ICD-10 diagnostic categories, substance use and abuse, mental health and physical health functioning and other variables. There are limitations to the categories regarding certain race, ethnicity, language, and disability. For some grant programs that are collecting Infrastructure, Prevention and Promotion (IPP) indicators, demographic data are collected, but are not housed within SAMHSA's Performance Accountability and Reliability System (SPARS).

Despite these limitations, the DIS can be used to identify and demonstrate the impact of SAMHSA's investments to reduce and eliminate inequities among underserved populations. By developing the DIS, recipients will identify the population experiencing the disparity, share more specific population data that will assist in determining if SAMHSA's grant investments are reducing disparities, use data to more precisely direct resources to improve the SDOH and CLAS while moving towards outcomes that will reduce disparities among the population(s) noted.

For recipients serving distinct populations (i.e., tribes, etc.), disparities within these populations can be identified (e.g., age, gender identity, sexual orientation, disability).

As recipients collaborate within their respective organizations to complete this DIS, we hope that it will inspire and guide an approach to reducing and eliminating behavioral health disparities for the populations being served. In the following pages the modernized SAMHSA Behavioral Health Disparity Impact Statement is included as a worksheet to support completion by the recipient.

Resources, guidance, and training to support recipients in completing the DIS can be found here [<https://www.samhsa.gov/grants/grants-management/disparity-impact-statement>]; see also accompanying Appendices).

⁴ <https://www.samhsa.gov/grants/gpra-measurement-tools>

⁵ <https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=53>

Disparity Impact Statement Worksheet

SECTION I. Identifying Behavioral Health Disparities

IDENTIFY and DESCRIBE THE SCOPE of the PROBLEM

What is the disparity/problem/gap you are seeking to address as it relates to the grant program?

What is the data to support this (e.g. [SAMHSA National Survey on Drug Use and Health \(NSDUH\)](#), [CDC and OMH Minority Health Social Vulnerability Index \(SVI\)](#), [CDC/ATSDR Social Vulnerability Index \(SVI\)](#), [CDC Behavioral Risk Factor Surveillance System](#), [CDC Youth Risk Behavioral Surveillance System](#), [AHRQ National Healthcare Quality Disparities Report \(NHQRDR\)](#), [U.S. Census Bureau Data](#), [U.S. Census Bureau American Community Survey \(ACS\)](#), [Federal Register Annual Update of the HHS Poverty Guidelines](#), [CMS Informational Bulletin on 2022 Federal Poverty Level Standards](#), other federal, state, or county level data.

Note: You may frame the disparity(ies) by looking at the individual/client level, organizational level, and/or systemic level.

DISPARATE POPULATION(S) OF FOCUS

Identify the focus population(s) experiencing disparate access, use, and outcomes and that experience adverse SDOH with impact to behavioral health in your geographic/catchment area.

Identify data source(s) that you are using to inform the DIS for the grant program. *Grant recipients must select sound and reliable source(s) of programmatic, county, state, or national indicators the program deems best suited to the needs of this grant. Recipients may consider the same data sources listed above (e.g., ACS, NHQRDR, SVI, NSDUH). The data referenced within the DIS should be in alignment with the data provided in your application.*

**Note: For client level data, SDOH Z-codes are available and can be used to collect data on disparities. It is recommended to use SDOH Z-codes more broadly and beyond the billing environment to support data collection on available determinants. For more information on SDOH Z-codes and how they are being used to narrow health disparities, please see <https://www.cms.gov/files/document/zcodesinfographic.pdf>; <https://www.cms.gov/files/document/cms-omh-january2020-zcode-data-highlightpdf.pdf>; and <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6207437/pdf/18-095.pdf>.*

Demographic Table

Complete a table that includes the disparity (the gap or difference) at the individual/client, organizational, or systemic level as it relates to the grant data collection requirements: NOMs, IPP, or both related to access, use and outcomes. *For examples, including the use of a table, please see Appendix A.*

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SECTION II. Addressing Disparities Using the Funding Opportunity

SOCIAL DETERMINANTS OF HEALTH⁶

Identify one or more SDOH domain(s) that your organization will work to address and improve for the identified population(s) of focus using the Notice of Award (NOA). Include a brief explanation about how your organization will address the specific domain(s) to support the reduction or elimination of disparities for the identified population.

Social Determinant of Health Domains

(Visit [Healthy People 2030](https://www.healthypeople.gov/2030) for more information on the five (5) domains.)

1. Education and Quality
2. Economic Stability
3. Health Care Access and Quality
4. Neighborhood and Built Environment
5. Social and Community Context

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⁶ <https://www.ruralhealthinfo.org/toolkits/sdoh>

Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care⁷

Using the Behavioral Health Implementation Guide, identify one or more of the CLAS standards (listed below) that your organization plans to meet, expand, or improve through this grant opportunity. Include an explanation on any activities, policies, and procedures that your organization will undertake to ensure adherence.

(Review the [Behavioral Health Implementation Guide](#) for full explanations of the overarching themes and 15 CLAS Standards with behavioral health related samples, strategies, and examples.)

Principal Standard

1. Provide 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.

Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency (LEP) and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

⁷ https://www.minorityhealth.hhs.gov/minority-mental-health/clas/?utm_medium=email&utm_source=govdelivery

13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all partners, constituents, and the general public.



SECTION III. Developing a Disparity Reduction Quality Improvement Plan

This final section of the DIS addresses development and implementation of a disparity reducing quality improvement plan as part of your DIS to address under-served population differences based on the (GPRA) data for access, use and outcomes of activities.

For example:

- Access: number of individuals served, number of outreach contacts, number of screenings, number of referrals.
- Use: number of screenings, number of referrals, retention rate, number of trainings.
- Outcomes: number of completed referrals, number of people trained, number and percentage of individuals who have demonstrated improvement in knowledge/attitudes/beliefs, number of programs/organizations/communities that implemented specific behavioral health practices or evidence-based activities.

Include activities as they relate to both the grant requirements and your application. Also mention the identified gaps, disparate/population(s) of focus, and subpopulations listed above. As part of the programmatic progress reports, an annual update on the disparity reducing quality improvement plan (what worked, what did not work, and what modifications were made) will be required per the NOFO. The DIS should be viewed as a living document.

IMPLEMENTATION OF ACTIVITY

Based on the responses above, identify specifically how you will address these disparities and the populations' needs with the required activities from the NOFO and within your application (using the SMART goals). Using the SMART goals, your application should be aligned with the DIS. Be sure to answer the following: What can your grant program activities do to address the disparity/ies? Address access, use, and outcomes (see Appendix C). How will you implement these activities? Who will be responsible to do so? How will you include client/peer/family/friends' voices in your program activities?

Please describe the activities that you will implement.

INTENDED OUTCOMES AND IMPACT

*How will these activities improve the problem or close the disparity? How will you identify and outreach to the selected population(s) of focus in your catchment area?
(Intended outcomes and impact should be directly related to your goals and objectives.)*

CLIENT/PEER/PARTNER INVOLVEMENT

How will you include client/peer and family voices and other relevant partners in your program's activities based on the identified population of focus?

TIMELINE

When will you implement these activities? How often will they be reviewed and adjusted? (Recipient should follow NOFO specific NOMs data collection timelines with DIS reporting updates.)

MEASUREMENT/ EVALUATION

How will you measure your process, progress, and outcomes to show you were able to improve disparities (i.e., close the gap) within the identified population(s) of focus? How will you measure incremental progress achieved under this award?

You should link measurement⁸ and evaluation to goals and objectives submitted in or with your application and as noted earlier in the DIS. Please refer to Appendix D for additional resources.

SUSTAINABILITY

What changes will your organization make to enable sustainability and continue the process to improve disparities? (e.g., policies, financing, budget, training, systems, environmental changes) What external systems exist that can support sustainability efforts? (e.g., Local organizations adopting service priorities to support progress made under this award, partnerships with other community organizations, etc.).

⁸ Measurement of Health Disparities, Health Inequities, and Social Determinants of Health to Support the Advancement of Health Equity. Journal of Public Health Management and Practice. 2016. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5845853/>