
Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)
1992-2012
20
YEARS STRONG
Behavioral Health is Essential To Health
Prevention Works
Treatment is Effective
People Recover


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YEARS STRONG
SAMHSA's New Requirement for Addressing Health Disparities
2013 Grantee Meeting
September 25, 2013
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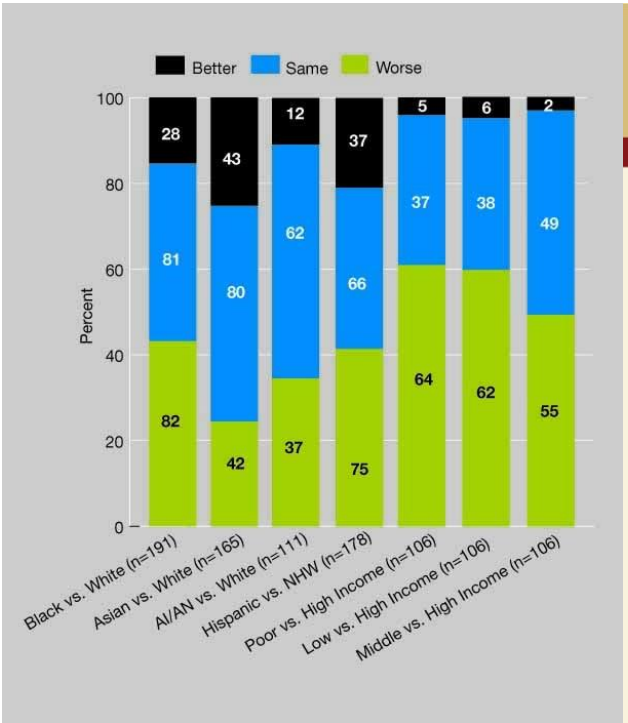

Number and proportion of all quality measures for which members of selected groups experienced better, same, or worse quality of care compared with reference

Disparities in quality of care are common

- Blacks received worse care than Whites, and Hispanics received worse care than non-Hispanic Whites for about 40% of quality measures.
- American Indians and Alaska Natives (AI/ANs) received worse care than Whites for one-third of quality measures.
- Asians received worse care than Whites for about one-quarter of quality measures but better care than Whites for a similar proportion of quality measures.

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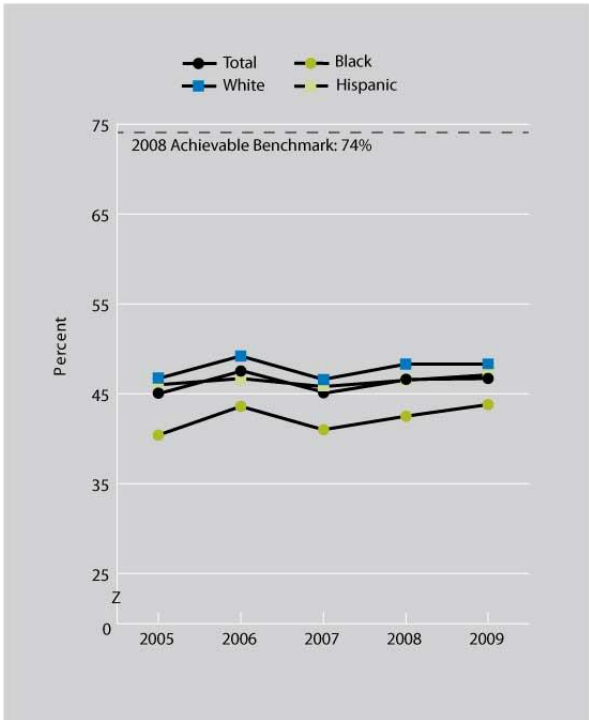

People age 12 and over treated for substance abuse who completed treatment course, by race/ethnicity, 2005-2009

- **Except in 2009, Blacks who were treated for substance abuse were significantly less likely than Whites to complete treatment.**
- **The 2008 top 5 State achievable benchmark was 74%. Only Blacks showed progress toward the benchmark but would not reach it for more than 50 years.**

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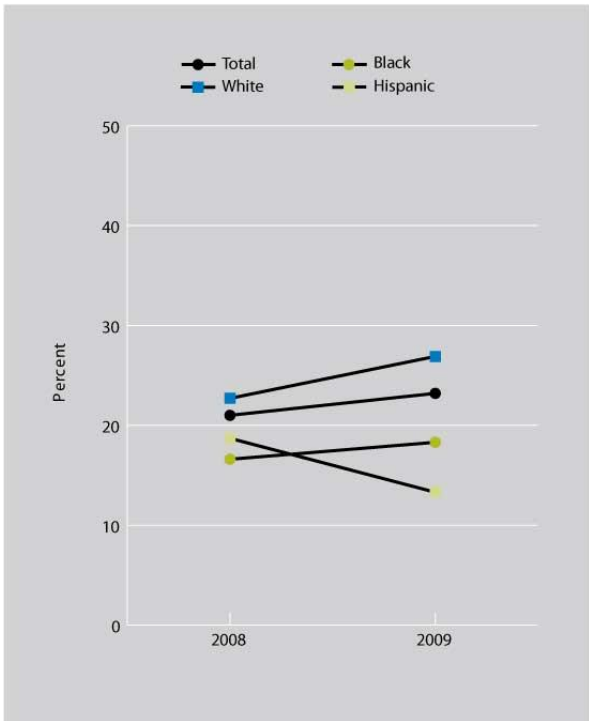
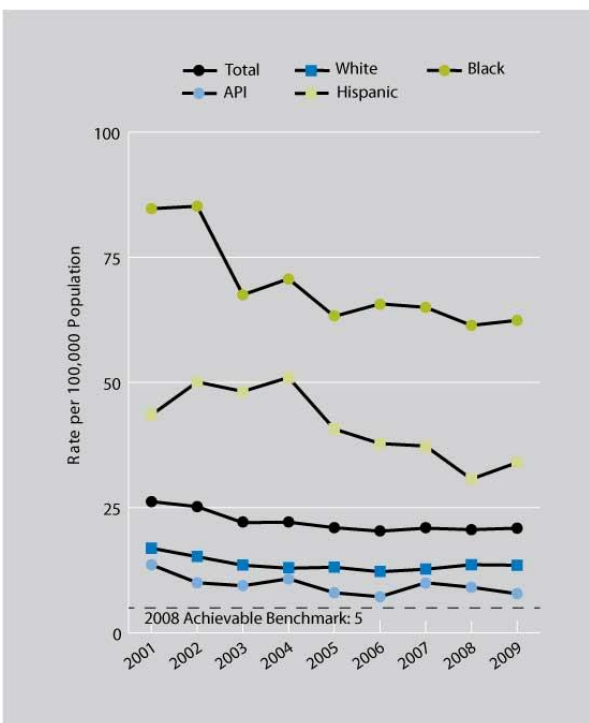
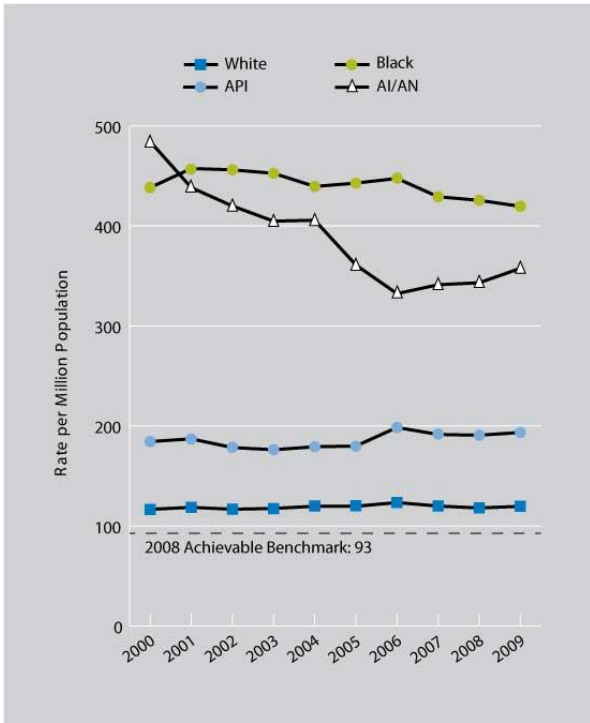


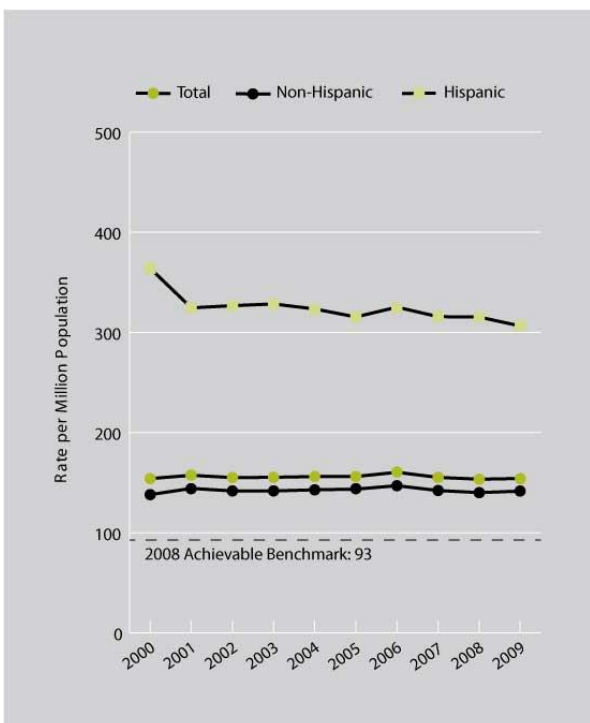
Adults age 40 and over with diagnosed diabetes who reported receiving four recommended services for diabetes in the calendar year (2+ hemoglobin A1c tests, foot exam, dilated eye exam, and flu shot)



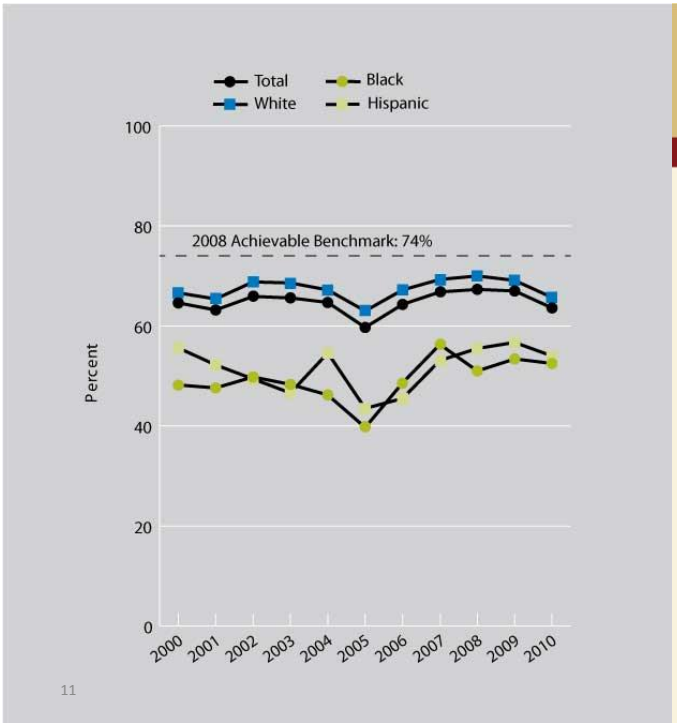
Hospital admissions for uncontrolled diabetes per 100,000 population, age 18 and over, by race/ethnicity, 2001-2009



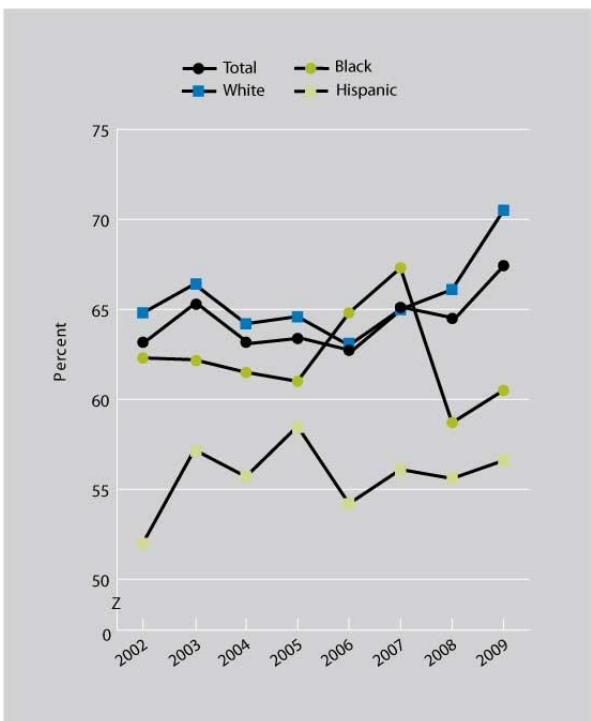
End stage renal disease due to diabetes per million population, by race and ethnicity, 2000-2009



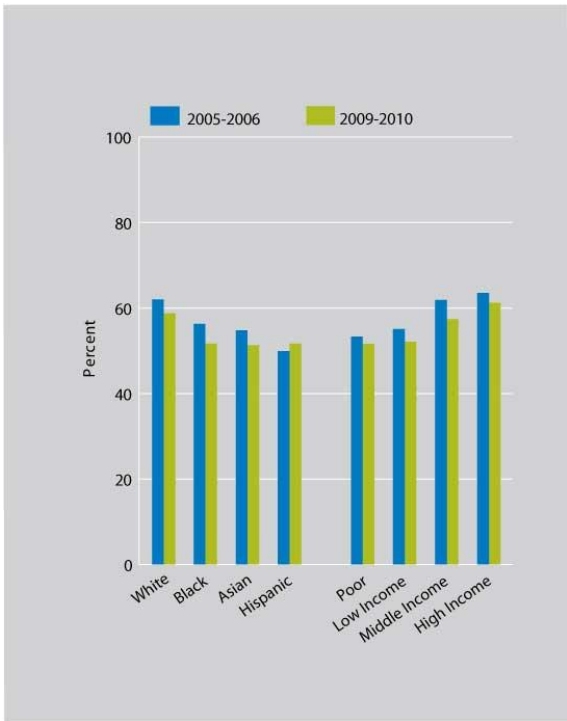
End stage renal disease due to diabetes per million population, by race and ethnicity, 2000-2009



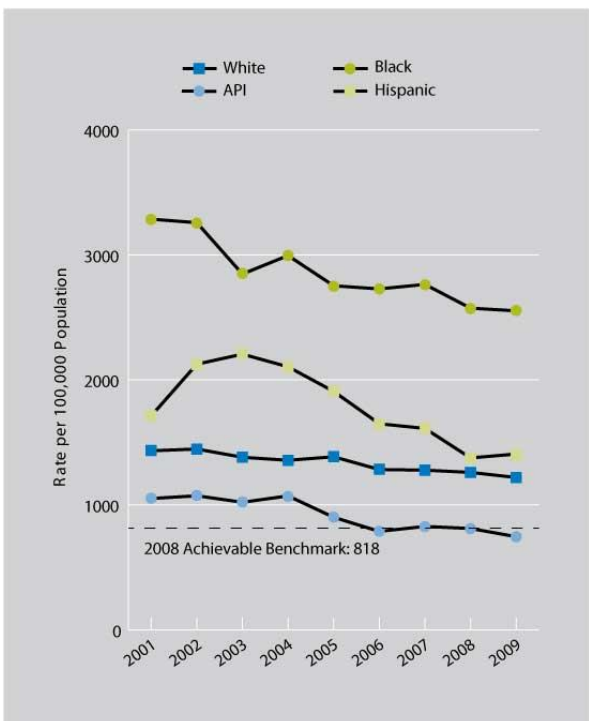
Adults age 65 and over who reported having influenza vaccination in the past 12 months, by race/ethnicity, 2000-2010



Adult current smokers with a checkup in the last 12 months who received advice from a doctor to quit smoking, by race/ethnicity, 2002-2009



Effective care coordination among children with special health care needs, by race/ethnicity and income, 2005-2006 and 2009-2010



Potentially avoidable hospitalization rates for adults, by race/ethnicity, 2001-2009

SAMHSA'S DISPARITIES IMPACT STRATEGY:

BACKGROUND/DRIVERS

HHS Action Plan to Reduce Racial and Ethnic Health Disparities: Secretarial Priority 1 (Pg 12)

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

   (c)Program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, in some instances, could be used to score grant applications if underlying program authority permits

Potential Impact of "Health Disparity Impact Statements" On Agency Work

- Create a more ***strategic focus*** on racial and ethnic populations in SAMHSA investments
- Use a ***data-informed quality improvement*** approach to address racial and ethnic disparities in SAMHSA programs
- Utilize this secretarial priority to influence ***how SAMHSA does it work***, e.g., its grant-making operations

SAMHSA Disparity Impact Statement (DIS) Development Process

I. Measure Development

- SAMHSA is using the following definition to guide development of DIS work:
  - *"A population is a health disparity population if there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates in the population as compared to the health status of the general population."*

    Minority Health and Health Disparities Research and Education Act *United States Public Law 106-525* (2000), p. 2498
- Focus on disparities in access, use, and outcomes

Key Measures: Disaggregated by Race and Ethnicity

- Who is enrolled in the grant program? Who are you serving? *(access)*
- What services are being used? *(service use)*
- How are enrollees in the program doing (by agency- and grant-specific selected outcome measures)? *(outcomes)*

Data to be Tracked at Grantee Level

- Disparities across racial and ethnic populations in the grantee in terms of:
  - Access (# enrolled in grant program; grantees required to project # served in total and #specific to racial ethnic populations as percentage of their service catchment area)
  - Use (#services used, reassessment rates)
  - Outcomes (# retained; performance on outcome measures disaggregated by race/ethnicity)
- *Referent Group*:
  - Highest performing group?
  - Total population average?
  - Comparison with majority population?

II. Quality Improvement Efforts

Objective: Strategies for how grant programs can improve performance for racial/ethnic subpopulations

1. Regular GPRA data reports to Program Project Officers using disparity data to identify areas for performance improvement
2. Develop subpopulation-specific strategies to address disparities in access/use/outcomes
3. Use this as opportunity to inform about CLAS standards as a strategy to reduce disparities

SAMHSA's Pilot: Addressing Behavioral Health Disparities

SAMHSA grant applicants are routinely asked to define the population they intend to serve given the focus of a particular grant program. Within these populations are ***subpopulations*** that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation.

For example,

- Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services
- Native American youth may have an increased incidence of underage drinking due to coping patterns related to historical trauma within the Native American community
- African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

SAMHSA's Pilot: Addressing Behavioral Health Disparities

Applicants are asked to address access, use and outcomes for subpopulations, which can be defined by the following factors:

- By race
- By ethnicity
- By gender (including transgender), as appropriate
- By sexual orientation (i.e., lesbian, gay, bisexual), as appropriate

Applicants must address their health disparity impact statement with responses across their applications, including information on their

- Population of Focus and Statement of Need
- Proposed Evidence-Based Service/Practice
- Proposed Implementation Approach
- Staff and Organizational Experience
- Performance Assessment and Data

SAMHSA's Pilot: Addressing Behavioral Health Disparities

Terms and Conditions

- **Targets re Access, Use, and Outcomes**
- **Policies and procedures to ensure the cultural and linguistic needs of all sub-populations identified in your proposal**
- **Plan for use of data for outcomes regarding race, ethnicity and LGB or T status, across the following domains: Data collection activities; Program services and activities development and implementation; and Data reporting, including access, service use and outcomes measures**
- **Adherence to the National Culturally and Linguistically Appropriate Services (CLAS) Standards (diverse cultural health beliefs and practices; preferred languages, including meaningful access by limited English proficient (LEP) persons; and health literacy and other communication needs of all sub-populations within the proposed geographic region.)**

PROPOSED POPULATIONS	Total	FY1	FY2	FY3	FY4	Cumulative
Direct Services: Number to be served						
By Race/Ethnicity						
Hispanic or Latino						
Black or African American						
Asian						
Native Hawaiian or other Pacific Islander						
Alaska Native						
White						
American Indian						
Two or more Races						
By Gender						
Female						
Male						
Transgender						

Enrollment Goals (Access)

Grant Information	Previous Grant Year Consumers Served	Previous Grant Year Annual Goal	Previous Grant Year Rate	Current Grant Year Consumers Served	Current Grant Year Rate	Cumulative To Date Goal	Cumulative to Date Rate
Total							
Hispanic or Latino							
Black or African American							
Asian							
Native Hawaiian or other Pacific Islander							
Alaska Native							
White							
American Indian							
Two or more Races							
Program Summary							

Grant Information	FFY 12 Received	FFY12 Due	FFY12 Rate	FFY13 Received	FFY13 Due	FFY13 Rate
Total						
Hispanic or Latino						
Black or African American						
Asian						
Native Hawaiian or other Pacific Islander						
Alaska Native						
White						
American Indian						
Two or more Races						
Program Summary						

Reassessment Rates (Use)

Enhanced National CLAS

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.**

Enhanced National CLAS

Communication and Language Assistance:

5. **Offer language assistance to individuals who have limited English proficiency 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.**

Enhanced National CLAS

Engagement, Continuous Improvement, and Accountability:

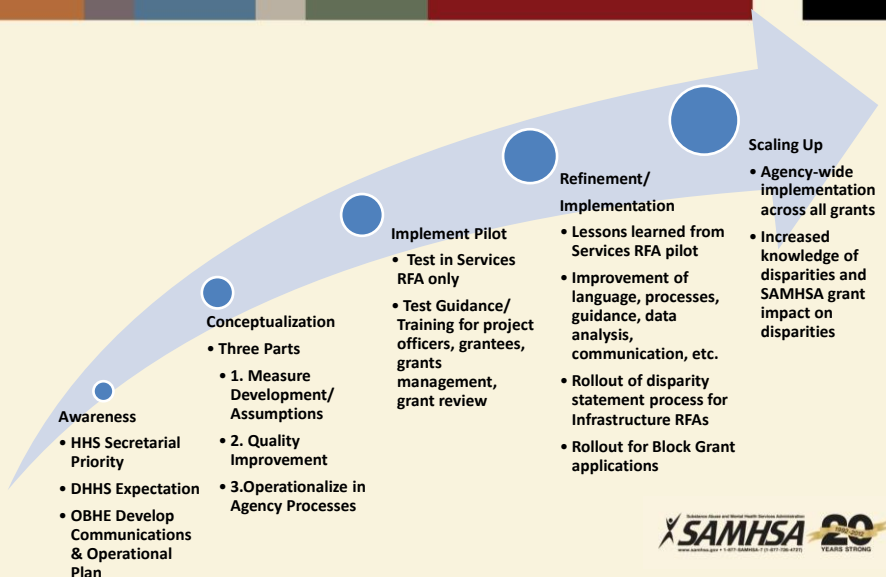
9. **Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.**
10. **Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement 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.**

Enhanced National CLAS

Engagement, Continuous Improvement, and Accountability:

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 stakeholders, constituents, and the general public.**

Next steps for SAMHSA



What does this look like for reals?

Case Example: ICL (Brooklyn, NY)