

# Plan for Behavioral Health Disparities Impact Statement

**#1: Propose the number of individuals to be served by subpopulations in the grant implementation area (should be provided in a table that covers the entire grant period.) The disparate population(s) should be identified in a narrative that includes a description of the population and rationale for how the determination was made.**

The [redacted] serves a diverse adult population in the [redacted] area. The three [redacted] licensed mental health (MH) treatment programs identified for the focus of this grant are located in [redacted] communities as follows: the [redacted], [redacted] and an integrated treatment/rehabilitation program [redacted], both located in [redacted].

The chart below is based on the demographics at the three sites and outlines our proposal for the clients we will serve over the grant period. The censuses at these sites

	Total	FY1	FY2	FY3	FY4
<b>Direct Services: Number to be served</b>	750	200	185	185	180
<b>By Race/Ethnicity</b>					
African American	387	103	96	95	93
Hispanic or Latino	253	67	62	63	61
Caucasian*	80	21	20	20	19
Other	30	9	7	7	7
<b>By Gender</b>					
Female	434	116	107	107	104
Male	316	84	78	78	76
<b>By Sexual Orientation/Identity Status</b>					
Lesbian	unknown	unknown	unknown	unknown	Unknown
Gay	unknown	unknown	unknown	unknown	Unknown
Bisexual	unknown	unknown	unknown	unknown	Unknown

\*Of the Caucasian group, we hope to enroll at least 5 Russian-only speakers per year. Consistent data on client sexual orientation is not currently available. A question about sexual orientation will be added to the Demographics section of the NOMS so that an estimate of LGBT clients served will be available for future reports.

A number of interventions will be implemented to increase access to services and improve service use for Latino/Hispanic, African American and Russian-speaking participants, including translation of all communications materials into both Spanish and Russian, and efforts to include culturally diverse activities and foods in wellness programming.

Person-centered planning is fundamental to the way [REDACTED] provides health services. All program participants complete a person-centered survey assessing goals and desired services. Service preferences such as language, time, place, frequency, individual or group format and unisex or co-ed participants will be elicited. Program participants will also have the opportunity to comment on any cultural and spiritual needs.

Survey data will be sorted by race, ethnicity, gender and sexual orientation. Information gleaned from the survey will help guide the development of new services and activities. A satisfaction survey will be administered 3 months after the new service and/or activity has been offered as a way to obtain feedback in the reassessment process.

Furthermore, program participants will be provided a Personalized Health Report (PHR) in line with their Treatment Plan Review/Individualized Personal Plan. The BHC and/or PCP/NCM/MT will review the PHR with the program participant in their preferred language. The PHR will inform program participants of normal and abnormal health indicators that will lead to developing appropriate health goals and action steps. Follow-up PHR will include baseline and current health indicators for comparison. Positive changes will be noted and reinforced. Areas where change is still needed will trigger reassessment of health goals and action steps.

Descriptive and comparative statistical analyses will be run separately for Latino/Hispanic and African American participant groups, to determine at baseline and over time whether differential change is seen in these groups when compared with the total sample. Projected health outcomes for Latino/Hispanic and African American program participants include a statistically significant decrease in weight for 10% of program participants, as well as a 10% increase in the proportion of participants who have blood pressure and cholesterol in the normal range over a 1-year period.

**#2: Describe the quality improvement plan for how you will use your program (GPRA) data on access, use, and outcomes to monitor and manage program outcomes by race, ethnicity, and LGBT status, when possible. The quality improvement plan should include strategies for how processes and/or programmatic adjustments will support efforts to reduce disparities for the identified sub-populations.**

The following policies and procedures have been or will be established to ensure that the cultural and communication needs of underserved sub-populations are met, including adherence to CLAS standards.

1. All [REDACTED] employees receive training on cultural competence during new employee orientation.
2. During the psychosocial assessment conducted at intake, all clients are asked to identify their cultural background and needs, as well as linguistic needs.
3. In general, [REDACTED] hires staff whose culture and language abilities are reflective of the populations served. Specifically, at [REDACTED] there are staff members who can provide services in Russian. At [REDACTED] and [REDACTED], there are staff members who can provide services in Spanish. These are the primary non-English languages spoken by clients at the respective sites. [REDACTED] will make efforts to improve posted signage in the relevant languages.
4. [REDACTED] has created workbooks that teach self-management for diabetes and overall health. Workbooks are written at a fifth-grade reading level and available in Russian and Spanish.
5. The mental health clinics will be able to use additional materials on health-related topics published by the [REDACTED] Department of Health and Mental Hygiene. These materials have been translated into Russian, Spanish, and other key languages.

6. Food demonstrations providing information on healthy food choices are held at the clinics. These demonstrations are sensitive to the cultural food preferences and financial constraints of individuals served.
7. Outreach to senior centers and other community settings serving older adults in the [REDACTED] area are conducted. The approach to the elderly Russian population will be done in a culturally sensitive manner.
8. Peer health coaches provide additional support in treatment integration and referrals to specialty providers and services for individuals served. Part of the selection process of peers is evaluating their ability to bridge cultural and communication barriers.

**A plan of how to review data for outcomes, regarding race, ethnicity, and LGBT status:**

At intake, individuals' responses to questions regarding race, ethnicity, gender, age, and primary language are recorded in the EHR. A question regarding sexual orientation will be added to the intake form. Data from participants' EHR will be exported to a SPSS database.

Descriptive and comparative statistical analyses on section H data will be run separately for Latino/Hispanic and African American participant groups, to determine at baseline and over time whether differential change in health outcomes is seen in these groups when compared with the total sample.

Focus groups will be conducted by evaluation specialists at each of the program sites with an oversample of African American, Latino/Hispanic and Russian participants. Data will be transcribed and analyzed with particular attention to differences in responses by race/ethnicity, gender and sexual orientation. Satisfaction surveys will be also be administered to program participants, and data will be similarly sorted by demographic group.

Quarterly outcomes summaries will be generated to inform programs and participants of changes in behavioral health outcomes for Latino/Hispanic and African American program participants, as well as for the total group.

**#3: The quality improvement plan should include methods for the development and implementation of policies and procedures to enhance adherence to the Enhanced Culturally and Linguistically Appropriate Services (CLAS) Standards and the provision of effective care and services that are responsive to: a) Diverse cultural health beliefs and practices; b) Preferred languages; and c) Health literacy and other communication needs of all sub-populations within the proposed geographic region.**

[REDACTED] has successfully implemented CLAS Standards 1-4, 6, 8, 10, 11, 13 and 14. For Standard 9, the agency does do patient satisfaction assessments related to CLAS. For Standard 5, the [REDACTED] clinic uses a notice written in Russian of the right to receive language services. However, a similar notice written in Spanish is needed and will be implemented in the next quarter. [REDACTED] offers patient-related materials in Russian and Spanish, but will need to improve implementation of Standard 7 by developing more signage in these languages. These signs are currently being developed.