MICHIGAN:
HEALTH DISPARITIES IMPACT STATEMENTS (DIS)
CHECKLIST

This guidance is to assist in the development of your DIS as outlined in the special terms and conditions included in the Notice of Award. Each grantee should review: the health disparities information included in your application and develop a DIS that addresses the concerns stated in the checklist. Ideally, the DIS will consist of a chart outlining the identified sub-populations experiencing behavioral health disparities with numbers to be reached and a narrative description of the grantee HD process.

DATA:

The first step is to provide documentation of how sub-populations experiencing behavioral health disparities are determined, and confirm that you can provide sufficient data to support this documentation. Ensure that the following is addressed:

- ☐ *What are the substance abuse prevention priorities you are addressing through your PFS grant?*

  Michigan's PFS project will enhance community-level infrastructure to link with primary care in order to foster change in targeted communities that are underserved and in high need of evidence-based programs to address underage drinking among persons age 12-20 and prescription drug misuse and abuse among persons age 12-25.

- ☐ *How do you define High Need Communities (HNC)? Geographically? By culture, ethnicity, or occupation? By institution (e.g. military, schools)? Please explain.*

  Various indicators were utilized to determine underserved and high need communities for this project. These indicators included overall health disparities; past 30-day and binge use of alcohol among those age 12-20; nonmedical use of pain relievers; unintentional poisoning and overdose deaths among youth and young adults; substance abuse treatment admission data; suicide rates; and Medicaid eligibility. As a result, the following high need communities were identified: counties of Muskegon, Mason, Oceana, St. Joseph, Bay, Macomb, Genesee and Wayne.

- ☐ *Provide demographic data on the sub-population (s) experiencing behavioral health disparities to be reached within the HNC*
  - *Demographic data: Race, ethnicity, tribal entities and organizations, language, age, socioeconomic status, sexual identify (sexual orientation & gender identity), and other relevant factors such as literacy.*
  - *What is the source of this data?*

  Populations in underserved areas of the state targeted in this grant include individuals who are low income, uninsured, underinsured, elderly, minority, migrant and seasonal farmworkers, and the homeless. Health disparity issues were some of the indicators used in identifying target communities for this PFS project. Coalitions involved in this project will be required to gather specific information on these sub-populations in their target county as part of their needs assessment process.

OROSC requires PIHPs, contractors and sub-contractors administering and providing prevention and treatment services to abide by the September 30, 2003 Federal Register (45 CFR part 96) Charitable Choice regulations. The regulations require: that the designation of religious organizations be based on the organization's self-identification as religious; that these organizations are eligible to be providers on a provider panel; that a program service recipient from a religious organization who objects to the religious character of a program has a right to notice, referral and alternative services that meet the standards of timeliness, capacity, accessibility and equivalency at an alternative provider; and other requirements including the exclusion of inherently religious activities and non-discrimination. Contractors, those who are sub-recipients and sub-grantees of this project, providing services through the PFS grant will also be required to comply with all applicable requirements of the Charitable Choice regulations. The model notice contained in the federal regulations states that no provider of substance abuse services receiving federal funds from SAMHSA may discriminate against someone on the basis of religious belief, a refusal to hold religious belief, or a refusal to actively participate in a religious practice.

The selection and identification of high need communities began with the review of various data available either at county or regional level. As described in Section B.4.b. of the original application, a weighting mechanism was devised to place special emphasis on the data collected for indicators related to alcohol use among persons aged 12 to 20, as well as prescription drug abuse among persons aged 12 to 25. The following table describes specific community level data relevant to the selection of communities with high need.

County	2011-2014 Ratio of Rx drugs to total treatment admits	2013 OHSP: Drinking drivers crashes (12-20) / Total number of alcohol-related crashes	2007-2011 Age-Adjusted Suicide Rate	2011-2013 Rx Drug Deaths Rate (12-20)	2011-2013 Rx Drug Deaths Rate (21+)	2014 County Health Rankings: Health Outcomes Rank	2014 County Health Rankings: Health Factors Rank
Bay	0.47	11.0	12.9	0.3	10.9	52	37
Genesee	0.25	8.1	11.9	0.5	10.9	81	72
St. Joseph	0.25	10.2	15.1	0.0	4.4	59	29
Muskegon	0.30	11.5	12.2	0.4	14.4	67	65
Oceana	0.40	12.9	NA	1.3	11.4	66	74
Macomb	0.35	12.2	13.5	0.2	5.7	39	28
Mason	0.45	9.1	20.6	1.2	4.7	46	32
Wayne	0.36	9.7	10.6	0.1	5.7	82	82

The Michigan Profile for Healthy Youth (MiPHY) survey, which aligns with the Michigan Youth Risk Behavior Survey (MiYRBS) and is offered in alternate years, was used to examine prevalence rates of alcohol use, prescription drug use, and painkiller use among high school students. The MiYRBS collects life time experience of taking prescription drugs without a doctor's prescription. The 2013 MiYRBS survey showed that16.2% of Michigan high school students reported ever taking prescription drugs without a doctor's prescription. The 2014 results of MiPHY on prevalence rates of past month alcohol use, past month binge alcohol use past month prescription drug use, and past month painkillers use are shown in the table below.

County	Past 30-day alcohol use	Past 30-day Binge alcohol use	Past 30-day prescription drug use w/o prescription	Past 30-day painkillers use w/o prescription
Bay	23.1	12.3	4.8	5.8
Genesee	19.2	10.3	3.9	5.9
St. Joseph	24.6	14.5	5.4	7.1
Muskegon	19.3	10.6	5.3	6.3
Oceana	17.0	8.6	4.7	5.5
Macomb	22.7	11.9	6.3	6.1
Mason	19.0	8.7	6.3	7.1
Wayne	21.5	12.3	5.7	6.7

Source: Michigan Department of Education, 2014 Michigan Profile for Healthy Youth

In 2014, approximately, 9.9 million people lived in Michigan, 81.0% were White, 15.0% were African American, 0.9% American Indian, and 3.2% Asian and Pacific Islander. The population estimates by race, gender, and age (specifically for 12 to 25) for all selected high need communities in 2014 as follows:

County	Age Group	White		Black		American Indian		Asian and Pacific Islander	
		Male	Female	Male	Female	Male	Female	Male	Female
Bay	12-20	5,529	5,062	235	227	51	53	44	54
	21-25	3,308	3,184	140	126	35	35	40	32
Genesee	12-20	18,171	16,954	6,768	6,891	231	237	312	280
	21-25	9,699	9,795	3,544	3,979	151	137	192	204
St. Joseph	12-20	3,465	3,305	180	171	32	28	33	37

	21-25	1,773	1,679	90	88	21	13	12	29
Muskegon	12-20	8,223	7,820	2,123	2,018	147	141	105	119
	21-25	4,515	4,376	1,252	1,076	92	73	54	58
Oceana	12-20	1,481	1,404	34	29	39	29	7	13
	21-25	708	645	14	8	15	12	6	2
Macomb	12-20	39,774	37,255	8,042	7,520	299	287	2,207	2,025
	21-25	22,569	22,093	4,571	4,962	159	168	1,190	1,099
Mason	12-20	1,499	1,342	42	30	21	26	8	12
	21-25	799	761	24	10	14	10	5	9
Wayne	12-20	56,090	53,465	47,810	47,328	811	891	3,898	3,577
	21-25	32,444	32,200	30,583	32,817	487	562	2,059	2,325
Michigan	12-20	480,885	456,699	109,934	106,493	6,845	6,887	21,970	21,278
	21-25	277,241	266,568	68,757	69,318	3,874	3,852	14,711	13,941

Source: Division for Vital Records and Health Statistics, MDHHS using Population Estimates (latest update 6/20/15) released by the National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.

In 2014, an estimated 4.8% of Michigan residents were persons of Hispanic origin. According to 2009-2013 American Community Survey, 9.1% of Michigan population speak a language other than English in their homes, nearly 3% of those individuals are Spanish speakers, followed by 3.0% of Indo-European and 1.5% Asian languages. In 2013, the overall Michigan's unemployment was 8.8% and 24% of children under age 18 were in poverty. In addition, 13% of Michigan population under age 65 had no health insurance in 2012.

County	Uninsured[1]	Unemployment[1]	Children in poverty[1]	Speak a language other than English at home[2]	Hispanic Origin[3]
Bay	12	9.1	23	3.4	5.0
Genesee	12	9.7	33	3.4	3.2
St. Joseph	15	7.7	26	9.9	7.3
Muskegon	13	9.0	28	4.2	5.3
Oceana	19	11.5	31	11.5	14.4
Macomb	14	9.1	20	13.6	2.5
Mason	15	9.2	27	4.4	4.6
Wayne	16	10.5	37	12.6	5.7

Source: [1] University of Wisconsin Population Health Institute, 2015 County Health Rankings

[2] U.S. Census Bureau, 2009-2013 American Community Survey

[3] Division for Vital Records and Health Statistics, MDHHS using Population Estimates (latest update 6/20/15) released by ~~the~~The National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and

Human Services.

According to the 2013 MiYRBS, 4.1% of Michigan high school students reported having sexual contact with males and females during their life, while 6.1% of students described themselves as gay or lesbian or bisexual. The 2014 results of MiPHY on same sex sexual contact and sexual identity are shown in the table below.

County	Students who had ever had same sex sexual contact	Students who identify as gay, lesbian, or bisexual
Bay	2.2	5.9
Genesee	6.5	8.1
St. Joseph	4.5	5.7
Muskegon	4.4	6.0
Oceana	3.4	5.7
Macomb	5.0	6.5
Mason	0.0	3.4
Wayne	6.8	8.8

Source: Michigan Department of Education, 2014 Michigan Profile for Healthy Youth

☐ *What data gaps on sub-populations experiencing behavioral health disparities have you identified, and what is your plan for filling them?*

Despite the solid infrastructure in place, there is the need to enhance and increase the capacity to implement, sustain and improve effective substance abuse prevention services to address underage drinking among persons aged 12 to 20 and prescription drug misuse and abuse among persons aged 12 to 25. The following data needs or gaps for sub-populations experiencing health disparities have been identified by the State Epidemiology Outcomes Workgroup (SEOW) and the Transformation Steerig Committee-Prevention Workgroup (TSC-PW):

- **The lack of adequate data on specific demographic subsets of Michigan's population (e.g., Native Americans, Hispanics, Arab Americans, lesbian/gay/bisexual/transgender, etc.). Since significant differences on alcohol, tobacco and other drug (ATOD) rates and consequences often exist between racial and cultural groups, it is important to improve the collection of this data for all Michigan ATOD indicators. Although progress has been made in recent years, there is room for continued improvement. Progress and Plan: Michigan Behavioral Risk Factor Survey (MiBRFS) estimates are more representative by oversampling Hispanics, which also allows for precise estimates. Results from the 2012 Michigan Hispanic/Latino standalone survey and the 2013 Michigan Arab/Chaldean standalone survey will be released in the near future according to MiBRFS.**

- **Limited data being collected on specific drugs (e.g., methamphetamine, prescription and over-the-counter drugs, etc.) or other specific variables that may be correlated (e.g., the link between child health and maternal alcohol consumption related to fetal alcohol spectrum disorders or potential mental health indicators, the link between substance use/abuse and child abuse and neglect cases, etc.). Progress and Plan: MiYRBS is tracking lifetime prescription drug use and past 30 day painkiller use of high school students.**

- **Local level risk and protective factor data related to family, school, community, and individual domains, as well as among specific populations (e.g., college students, adjudicated youth, LGBT, the elderly, etc.) Progress and Plan: The SEOW and the TSC-PW will continue to work with MiPHY staff to increase participation in the MiPHY, especially in high need communities.**

- **Limited access to the Michigan Automated Prescription Monitoring Systems (MAPS) data for local coalitions, providers, and communities. Although somewhat limited by law, there are some statewide totals available to the general public. To access regional or county-level data requires a special request to the Michigan Department of Licensing and Regulatory Affairs (LARA). Some community coalitions are not aware of this option, and the ability to fulfill special requests is determined by LARA staff member time. Progress and Plan: Collaboration between OROSC and MAPS produced *A Profile of Drug Overdose Deaths Using the MAPS.* In addition, the Governor's Prescription Drug Task Force recently released their recommendations to address prescription and opioid drug abuse in Michigan. Many of the recommendations were related to updating the MAPS, and MDHHS will be part of those efforts.**

- **The need to strengthen partnerships (at both the local and state level) with specific primary care providers, dentists, and pharmacies. Although the medical disciplines are somewhat aware of issues related to prescription drug misuse and abuse, they have a limited understanding of their role in reducing access, as well as other community partners that are available to assist in their efforts. Progress and Plan: The previous PFS II project allowed building and enhancing community level collaboration with primary care providers. These collaborative efforts will continue to build as part of this project in a more focused manner.**

ACCESS:

☐ *Describe the overall policies, practices, and/or programs that will be implemented to address the priority problems at the state/tribe/jurisdiction and community levels.*

As previously noted, the counties of Muskegon, Mason, Oceana, St. Joseph, Bay, Wayne, Macomb and Genesee were selected to participate in this project. Regional Prepaid Inpatient Health Plans (PIHPs) are the identified sub-recipients (sub-state entity) of this project, and they in turn will contract with community coalitions in each of the target counties as their sub-grantee to implement the program in their respective target county.

This project will focus on community coalitions collaborating with primary care entities such as Federally Qualified Health Centers (FQHCs) and other primary care agencies, such as hospitals, local public health departments (LPHDs) clinics and school-based health centers to: (1) employ Screening, Brief Intervention and Referral to Treatment (SBIRT) to youth and young adults at risk for substance use disorders; (2) refer youth and young adults to evidence-based practices proven to be effective in reducing substance use disorders, primarily, underage drinking and prescription drug and illicit opioid misuse and abuse; and (3) administer evidence-based practices.

SBIRT, an evidence-based practice used to identify, reduce and prevent problematic use, abuse and dependence on alcohol and illicit drugs will be a key component in this project. The SBIRT model was incited by an Institute of Medicine (IOM) recommendation that called for community-based screening for health risk behaviors, including substance use. Three major components are

involved in SBIRT: (1) Screening—a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools; (2) Brief Intervention—a health care professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice; and (3) Referral—a healthcare professional provides referral to additional services, if needed. SBIRT has more recently been applied to identify and prevent risky substance use among adolescents, and has been shown to be effective in reducing substance abuse in this population.

As part of this project's purpose, building the capacity to refer selective and indicated populations identified through screening to evidence-based prevention services, and implementing such services, is essential. Consequently, sub-recipient PIHPs and their sub-grantee coalitions in the target communities will determine their community's level of readiness to link with primary care providers. Based on this determination of readiness, environmental change programs will be implemented to build or strengthen this capacity and infrastructure. Level 1 communities, those needing to develop community driven coalitions and infrastructure at the base level, can choose between Communities that Care (CTC) or Community Trials (CT). Level 2 communities, those with an existing coalition but needing to build infrastructure and capacity with primary care, can choose between CT or Communities Mobilizing for Change (CMCA). In Level 3 communities, where the sub-recipient PIHP and coalition determines there are already existing strong relationships with primary care providers, the focus will be on building infrastructure and capacity to enhance collaborative efforts and implement processes for screening to occur in primary care settings. This may include training of primary care providers on SBIRT techniques and processes, developing memoranda of understanding, implementing standard forms, identifying and increasing referral options, etc. in order for screening to occur on a consistent basis as part of standard care in the primary care setting.

Based on preliminary information received as one of the first deliverables of this project, the PIHPs have already identified the following anticipated level of readiness and subsequent estimation of which level the target community in their region will be as outlined in the table below:

Region	Target County	Anticipated Baseline Readiness Level		
		1: Develop Base Infrastructure (CTC or CT)	2: Existing Infrastructure but build capacity with primary care and other stakeholders (CT or CMCA)	3: Strong relationships with primary care; need to implement process for screening (CRAFFT or NIAAA; then SF or P4L)
3	Muskegon			X
	Mason	X		
	Oceana	X		
4	St. Joseph		X	
5	Bay		X	
7	Wayne- Detroit		X	
	Wayne- Taylor			X
9	Macomb		X	

10	**Genesee**			**X**

The target communities identified for this project are a mix of urban and rural with varying levels of readiness, infrastructure and resources. As such, flexibility will be provided to best meet the community's need to incorporate screening into primary care settings, the overarching goal of the project. Implementation of SBIRT will be achieved in all communities as they reach Level 3. As the SBIRT process is being developed and implemented, in some communities it may be best for a primary care provider to actually administer the screening tool. In other communities, it may be best for prevention professional to administer or review the results of the screening tool and determine next steps. As part of the SBIRT process, the specific screening tools to be utilized will be either the CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble), National Institute on Alcohol Abuse and Alcoholism (NIAAA) Screening, or Rapid Assessment for Adolescent Preventive Services (RAAPS). Individuals identified in either indicated or selective populations as a result of this screening will be referred to individual or family level interventions chosen as most appropriate for this community. Unless otherwise identified and approved, these two program choices would be either Strengthening Families (SF) or Prime for Life (P4L).

☐ *Describe the specific strategies that will be implemented to address behavioral health disparities among identified sub-populations?*

As part of this grant process the state will develop tools and strategies to help PIHPs and coalitions selected improve data collection and access to services for sub-populations identified. The OROSC will work with PIHPs and coalitions to narrow down the specific strategies within the first year, and develop and implement these strategies over the 5 year grant period.

***Require that all PIPHs/coalitions update data collection tools to include tracking items for all sub-populations. OROSC may assist with the development of tools if needed.**

*** Promote the utilization of recruitment tools targeting sub-populations via TA on recruiting.**

*** Require a Statement of Health Disparities Impact - a brief assessment of disparities beyond the data we have. Identify coalitions and providers to speak with and get their view on the work plan and their openness and plans for working with sub-populations.**

*** Target communities will be required to develop plans to work with sub-populations, including securing representation of sub-populations on their coalitions, and additional outreach activities they will engage in.**

***Promote Culturally and Linguistically Appropriate Services (CLAS) workshops provided by state, track any participation by target communities in the CLAS workshops and any Cultural Competency trainings.**

☐ *If you will implement the SPF process, describe the purpose and ultimate goal of implementation of the SPF, including how you will integrate your approach to preventing behavioral health disparities among identified sub-populations throughout each step of the process.*

Over ten years ago, with the original SPF SIG grant, the SPF 5-step process was institutionalized in the Michigan at the state, regional and community level. As a result, not only will the SPF process be utilized

to build necessary infrastructure to address and prevent behavioral health disparities among identified sub-populations in high need communities of this project, sub-recipients and sub-grantees are familiar with the process. Examples of how it will be integrated with behavioral health disparities among sub-populations are:

1. **Assess needs: State and target communities will assess community needs based on epidemiological data, identify barriers, and assess resources to address behavioral health disparities.**
2. **Build capacity: Through the numerous training, technical assistance and community meetings, target communities will build its capacity to be culturally competent to their identified sub-populations, and assure these efforts are sustainable.**
3. **Plan: Communities will develop specific work plan to meet their needs based on the level of readiness (i.e., Level 1 to Level 3). OROSC will provide a guideline to assist each community to maintain grant activities and to achieve expected outcomes.**
4. **Implement: Each community will implement selected intervention program and the progress will be monitored via quarterly reports.**
5. **Evaluation: Process and outcomes evaluation will be built in the work plan for each community.**

☐ *Describe a plan to develop and implement policies/procedures to ensure adherence to the Enhanced Culturally and Linguistically Appropriate Service (CLAS) Standards with the grant program for the provision of effective services. This can include but is not limited to:*

- *Increasing participation from sub-populations experiencing behavioral health disparities on advisory boards and workgroups*
- *Developing strategic partnerships and collaborations with the goal of preventing behavioral health disparities among identified sub-populations*
- *Increasing the capacity and readiness of sub-recipient communities to prevent behavioral health disparities among identified sub-populations*

Ensure that the following categories are addressed:

- *Diverse cultural health beliefs and practices;*
- *Preferred languages; and*
- *Health literacy and other communication needs of all sub-populations within the proposed high-need community.*

OROSC is committed to developing a culturally competent substance use disorder service delivery system and the proposed activities will be implemented and monitored in adherence to the National Standards for Culturally and Linguistic Appropriate Services (CLAS) in Health and Health Care. Best practices in the performance of our service delivery, regulatory, and business functions necessitates responding to clients, customers, communities and employees in a culturally appropriate manner, which includes the recognition that race historically has played a major role in health and economic disparities. OROSC understands that these disparities continue today.

OROSC relies on a document called *Transforming Cultural and Linguistic Theory into Action: A Toolkit for Communities* that identifies cultural competency as an integral component to the OROSC strategic plan and system. Core components of this document must be infused into routine business practices and operations, requires continuous quality improvement, must be data driven, must be administratively friendly versus burdensome, and need to identify roles and responsibilities throughout the system. In addition, six key implementation principles

were identified: inclusion, diversity, respect, excellence, relationships, and accountability. This document and more information are available on the OROSC website at www.michigan.gov/bhrecovery.http://www.michigan.gov/documents/mdch/Transform_Cultural-Linguistic_Theory_into_Action_390866_7.pdf. This document has already been provided to all PIHPs and other key stakeholders, and compliments the National Standards for CLAS in Health and Health Care.

The 14 CLAS Standards, as well as the OROSC toolkit, will again be provided to all PIHPs and coalitions working in the target communities at the beginning of the project. In addition, discussion and practical implications and implementation of the key principles will be on the agenda for the first sub-recipient/sub-grantee meeting. The state is committed through our Health Disparities Reduction & Minority Health Section, to ensuring "a persistent and continuing focus on assuring health equity and eliminating health disparities among Michigan's populations of color." As such, training entitled *'Applying a Health Equity Framework to the Enhanced CLAS Standards'* is being offered early this year and can be replicated for our sub-recipients as needed. Monitoring for adherence will be part of the strategic plans submitted by each of the target communities, and will be monitored during site visits conducted by the project coordinator and evaluator.

Language and literacy will be addressed in the following manner: Linguistic competence has been defined by OROSC as the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency (LEP), those who have low literacy level or are not literate, individuals with disabilities, and those who are deaf or hard of hearing.

OROSC requires PIHPs, contractors and sub-contractors to ensure through documentation that a current LEP policy is in place and in practice. The policies must include the following: 1) procedures for identifying and addressing the language need of the PIHP, contractors and geographic area served based on current local and regional census data; 2) identified range of oral language assistance options appropriate to the PIHPs circumstances; 3) how the PIHP provides notice to LEP persons in their primary language and of the right to free language assistance; 4) what staff training and program monitoring is performed related to LEP policies; 5) provisions for written language other than English where a significant number of or percentage of the affected populations needs services or information in a language other than English to communicate; 6) provisions for language interpreters; 7) statements explaining time assistance; 8) statements explaining there would be no charge to the recipient for LEP services; and 9) provisions regarding use of family member and/or friend as a language interpreter must not be required. The choice of a consumer to use a family member and/or friend as an interpreter must be documented in writing; however, the use of family members and/or friends as translators will not waive other LEP requirements. Additionally, the EBPs targeting individuals which sub-recipients can chose from have multiple translations of materials.

Sexual Identity– sexual orientation and gender identity will be addressed in the following manner: In the performance of any contract, OROSC requires that the contractor complies with all federal statutes relating to nondiscrimination including any nondiscrimination provisions in the specific statute(s) under which this application for federal assistance is being

made. Sexual orientation and sexual identity are also included in the OROSC toolkit, *Transforming Cultural and Linguistic Theory into Action*; with one of the ideals being to establish, increase, and strengthen components and resources such as infrastructure, staffing, and funding to ensure specific attention to potential barriers and health disparities among this special population. Sub-recipients and their sub-grantees will be required to follow the principles as put forth in this toolkit.

Disability will be addressed in the following manner: OROSC requires PIHPs, contractors and sub-contractors to comply with the applicable provision of the Americans with Disabilities Act as provided in the publication, *Nondiscrimination on the Basis of Disability in State and Local Government Services.* United States Code of Federal Regulations, Title 28, Part 35, Washington, D.C. (1991). Monitoring of this and other provisions outlined above are addressed during regional site visits from MDCH to the PIHP, as well as their monitoring of their provider network.

Although veterans and military families are not specifically identified as a sub-population to be addressed with this PFS project, veterans are community members of many Michigan towns and villages. Within the BHDDA there is a Departmental Analyst position that serves as the primary link between BHDDA and the Michigan Veterans Affairs Agency (MVAA) to ensure efficient and quality behavioral health care for all Veteran's statewide. As BHDDA is the MDCH administration under which OROSC operates, there are both formal and informal lines of communication to assure veteran's and their family member needs are identified and addressed as appropriate for all programs and services offered. If veterans or their family members are part of coalition activities or are being identified through SBIRT as in need of Strengthening Families or Prime for Life in the target communities, the BHDDA Departmental Analyst will be informed so this program can be identified as an additional resource for the MVAA.

As part of the needs assessment process target communities embark on during the initial phase of this project, they will be tasked with looking at local data to identify sub-populations within the 12-20 age range for underage drinking and 12-25 age range for prescription drug misuse and abuse at highest risk. Minimally, they will look in detail at the specific health factor risks and health factor outcomes rankings from the County Health Rankings for these age groups. In addition, as much as possible given existing data, target communities will be tasked with identifying language and literacy, sexual orientation and sexual identity, disabilities, and veteran/military family demographics within their county. By the end of the first project year, all target county sub-grantees will have identified these (and others, if any) sub-populations within their communities; as well as their specific county health factor risks and outcomes. The project epidemiologist, evaluator and SEOW will be available to provide assistance of this effort. As high-risk sub-populations are identified, they will be encouraged to participate at the state level on the SEOW as well as the TSC-PW, the state-level advisory committee for this project. In addition, target communities will assure the identified high-risk sub-populations are represented as members of their local coalitions.

USE/REACH

- ☐ *Describe your process for collecting data (demographic data) on sub-populations reached? Include data sources and the frequency of data collection (annual, bi-annual, etc.)*

The project team will collaborate with the State Epidemiological Outcomes Workgroup in collecting and monitoring demographic data on sub-populations reached on an on-going basis. The project will require that all PIHPs and coalitions update data collection tools to include tracking items for all sub-populations. OROSC may assist with the development of tools if needed.

The following table shows data sources and the frequency of data collection for the grant program.

Data Sources	Measures	Frequency of data collection
National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services	Population estimates by age, gender, rage, and ethnicity	Annual
American Community Survey	Language spoken other than English at home	Annual (Multi-year estimates will be used)
Michigan Youth Risk Behavior Survey	State estimates on underage drinking, prescription drug use, sexual behavior, and sexual identity	Bi-Annual (Odd year)
Michigan Profile for Healthy Youth	County estimates on underage drinking, prescription drug use, sexual behavior, and sexual identity	Bi-Annual (Even year)
County Health Rankings	Uninsured, Unemployment, Children in poverty	Annual

- ☐ *How will you monitor the implementation of the grant and the use/reach of your policies, practices, and/or programs to identified sub-populations in the grant program?*

The OROSC and Wayne State University evaluator will work closely with the identified high need communities in planning and implementing of program activities to ensure the needs of sub-population experiencing behavioral health disparities are effectively addressed. The OROSC has access to the demographic data including race, ethnicity, language, age, socioeconomic status, sexual identify (sexual orientation & gender identity described in previous sections of this document).

OUTCOME

- ☐ *Describe how you will use data on outcomes regarding sub-populations experiencing behavioral health disparities (race, ethnicity, LBGT status, etc.) to evaluate processes and/or make programmatic adjustments to address identified priorities and issues (high need, underage drinking, prescription drug abuse)*

    - *Describe other ways that you intend to utilize programmatic data to demonstrate the impact of your efforts on behavioral health disparities among identified sub-populations (e.g. tracking and monitoring the impact of the implementation of the Enhanced CLAS standards)*

In conjunction with the Project Director and evaluator, the SEOW will be charged with the following:

- **Review data as available to assess change by OROSC. This will be addressed at least quarterly at SEOW meetings.**
    - **Where specific data is not currently available, the SEOW will prioritize cost-effective ways to gather at least preliminary information. This may include targeted focus groups, key informant interviews, etc.**
- **Qualitative assessment of the Health Disparities work will be completed via an annual survey to PIHPs and target communities to assess their progress on work proposed in plans developed by sub-grantees to reduce health disparities. This survey will also assess need for training and TA, which will be included in the states' overall implementation plan for training.**
- **Track numbers of sub-population members who receive services, including screenings and family programming.**