Disparity Impact Statement Worksheet

Grantee Organization Name: Department of Mental Health Mississippi

Award Number: 1H79SM087620-01

Grant Program: Certified Community Behavioral Health Clinic (CCBHC) Planning

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SECTION I. Identifying Behavioral Health Disparities

IDENTIFY and DESCRIBE THE SCOPE of the PROBLEM

Mississippi is the fourth most rural U.S. state, with 60.0% of its 2.9 million residents residing in rural areas. According to the U.S. Census Bureau, 65 of Mississippi's 82 County are considered rural, which means that they have a population density of less than 1,000 people per square mile. These counties are home to about 79% of the state's population. The rural areas of Mississippi are characterized by small towns and farms. The economy of these areas is based on agriculture, forestry, and manufacturing. As a result, people in rural areas may have to travel long distances to receive mental health care, or they may not be able to afford it at all. Rural populations experience higher poverty levels than their urban counterparts (20.5% vs. 16.7%, respectively). Mississippi is ranked 49th in the U.S. for poverty and 19.4% (vs. 12.8% nationally) of Mississippi households live below the federal poverty line (FPL) In addition, African American (31.3%) and Native American (36.1%) populations experience higher levels of poverty compared to White populations (12.1%). A disproportionate number of African American families reside in rural areas where the poverty rates are among the highest in the state and the country.

In the 2010 US Census, Black or African American alone made up 37.4% of the population of Mississippi. The rest of the population breaks down as follows: White alone accounted for 58.8% of the population; Hispanic or Latino of any race (6.6 %); Asian alone (1.1 %); and American Indian and Alaska Native alone (0.6%). The high percentage of people of color in Mississippi has significant impact on the state's economy, culture, and politics. People of color are disproportionately affected by mental health disparities in Mississippi. This is due to several factors, including racism, discrimination, and poverty. According to the Commonwealth Fund's Health Equity Scorecard, Mississippi's Health Score (based on a composite of indicators/dimensions) is the lowest in the nation for all groups. Mississippians face barriers to health due to their socioeconomic status, transportation limitations, race, ethnicity, sexual orientation, and other characteristics (SDOH) linked to exclusion. Catastrophic events, including hurricanes, tropical storms, and the COVID pandemic, disproportionately impact those groups already negatively influenced by SDOH. The Commonwealth Fund noted "deep-seated" racial health disparities are more pronounced in Mississippi than any other state with cost and affordability as major contributors. Disparities in nearly all categories were more pronounced for Mississippi's African American population.

Mississippi ranks 47th nationally in access to mental health care. Between 2018-2019, over half (59.3%) of adults with any mental illness reported they did not receive treatment. Gaps in care are especially high for youth with SED. In that same year, 70% of children in Mississippi with major depression did not receive treatment, compared to 60.3% nationally. Yet the need for care has grown. Between 2020 and 2021, DMH saw an increase of about 66% in the number of people contacting the agency's 24/7 Help- line. Lack of access to care is related to multiple issues, including service gaps, coverage, cost, and transportation

barriers. The State Mental Health Authority's (SMHA's) delivery of mental health services reflects the gaps in care described above. According to the 2020 SAMHSA Uniform Reporting System (URS), SMHA served 100,881 individuals in Mississippi—48.2% of which were Black and 46.9% were White. In comparison to the racial breakdown in the state, Black people (38.0%) are over-represented and Whites (58.5%). URS reported 32.1% were youth aged 17 and under; 5.9% were aged 65 and over. Roughly 51% of recipients were female. The vast majority (89,479) were designated as having SMI or SED, with 95% of adults meeting federal definition for SMI, and 99% of youth meeting federal definition for SED. Among these, 20.0% of adults and 2% of youth also had a co-occurring MH and Alcohol and Other Drugs (AOD) disorder. Of those with SMI/SED, 33.7% were aged 17 or under and 6.1% are elderly aged 65 and older; 51.6% are female; 49.1 % are Black and 46.1% are White. Among those with SMI/SED served in community settings, only 3.0% (n=37) were youth aged 17 or under, a substantial under representation given the 33.7% share of the SMI/SED population. This highlights an area of significant unmet need among all SED youth. Overall admission rates to State Psychiatric Hospitals were similar for children and adults (0.89 vs 0.90). By contrast, admission rates to community programs were much lower for both children and adults (0.22 and 0.18), again suggesting much higher unmet community-based needs. Among the 96,280 served with known funding status, approximately half had Medicaid only and half had non-Medicaid only funding. The proportion of non-Medicaid only receipts is much higher than the national average (28%), reflecting the state's status as a non-Medicaid expansion state.

The data demonstrates the impact of chronic workforce shortages on the state's ability to meet the current demand for community BH services. Although CCBHCs provide all required services, a lack of staffing and financial resources inhibits the state's ability to meet demand. CCBHC funds will support expansion of critical community-based services. Mississippi has a significant healthcare workforce shortage, which contributes to the service gap. Over 80% of Mississippians live in a community experiencing a shortage of health professionals. The US Health Resources and Services Administration (HRSA) reports approximately 50% of Mississippians live in medically underserved counties with greater than 2,000 persons per primary care physician. As is the case nationwide, services gaps are particularly acute in rural areas. The lack of BH providers is especially problematic. In 2021, Mississippi had 213 mental health providers per capita (vs. 318 nationwide). In 2022, Mississippi also has a lower number of psychiatric physicians per capita, nearly half the number compared to the rest of the country (14 vs. 27 per 100,000). Because of these shortages, according to DMH, 25 individuals waited in a jail cell for a psychiatric hospital bed on any given day in 2022. The National Center for Health Workforce Analysis notes the healthcare workforce of Mississippi was only at 61% adequacy in 2020 and the gap continues to grow.

Lack of insurance coverage and the prohibitive cost of care for the uninsured is a significant barrier to accessing care. According to the Behavioral Risk Factor Surveil- lance System (BRFSS), approximately 21.3% of adults in Mississippi did not have health insurance in 2019, compared to 18.2% nationwide. Because Mississippi did not expand Medicaid, individuals with SMI, SED, and SUD are often classified as indigent. CMHCs are thereby mandated to provide unfunded services to uninsured (21.3%) and underinsured Mississippians without an adequate workforce or Medi- caid revenue to sufficiently close the gap on unmet care needs. Even the 8.2% of children with private insurance lack coverage for mental or emotional problems. In a 2021 NAMI survey, 47.9% of Mississippi residents with BH symptoms said cost prevented them from seeking services. A 2019 article in the Clarion Ledger reported that resident's access BH care in the most expensive environments (e.g., EDs, psychiatric hospitals, the justice system) because they lack insurance. Even when insured residents seek care, they are more than three times as likely as their national counterparts to be forced to go out of network, making it less affordable and more difficult to access.

Transportation is a significant barrier in rural areas. Telehealth has been used as a means of increasing access to BH services in many states, but the costs of the technology are prohibitive for many Mississippians. Between 2016-2020, 13.5% of the state's households did not have a computer and 24.2% did

not have a broadband subscription. For poor, rural residents who typically must travel over two hours to access in-person care, this limits their ability to receive needed services via telepsychiatry and teletherapy.

Mississippi selected two CMCHs to initiate the program during the Planning Grant period based on their representation of some of Mississippi's most impoverished and culturally diverse rural and urban populations. Both sites evidence high levels of need, particularly among ethnic and racial minorities. And both sites' clients' struggle with access to services due to workforce shortages and the lack of consistent service availability across CMHCs. The Region 6 and Region 14 CMHCs are in the Delta and Gulf Coast cultural regions of the state, respectively. Both have demonstrated experience providing comprehensive, high quality BH services and provide the full range and CCBHC required services to diverse populations.

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, NHQDR, 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/zcodes-infographic.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.

SECTION II. Addressing Disparities Using the Funding Opportunity

In the 2010 US Census, Black or African American alone made up 37.4% of the population of Mississippi. The rest of the population breaks down as follows: White alone accounted for 58.8% of the population; Hispanic or Latino of any race (6.6 %); Asian alone (1.1 %); and American Indian and Alaska Native alone (0.6%).

Region 6 CMHC Life Help: Region 6 currently administers services for 12 counties in the heart of Mississippi's Delta region (four additional counties will be added in February of 2023). The entire catchment area is rural, and all 12 counties are in Opportunity Zones. The Delta is one of Mississippi's most culturally diverse, rural, and poorest regions. Lack of access to care and underlying health problems are both highly correlated with systemic and structural race-related barriers. Region 6 CMHC served a total of 8,710 unduplicated individuals in 2021. Most Region 6 clients are African American and come from poor backgrounds. According to the most recent U.S. Census Bureau, approximately 28% of individuals residing in the Region 6 CMHC catchment live in poverty. The US Commission on Civil Rights reports about one-third of Mississippi's Black population resides in the Delta region. In Region 6, about 64% of residents are Black, 33% White, 2.3% Hispanic, and less than 1% are Asian or Native American. 30% of residents are living in poverty. Of the 18% of residents over age 65, 16.2% are disabled. The Delta region is also facing a hospital crisis - while about 38 hospitals cross the state are at risk of closing, the Delta region is threatened by the closing of up to 40% of its hospitals[lxiii] in 2023.

Region 14 CMHC Singing River Services: Region 14 administers services for two counties -George and Jackson – which are located on the Mississippi Gulf Coast. It is the largest BH provider in the region, serving 2,930 unduplicated individuals (74% adults; 26% children/adolescents) in 2021 with SMI, SED, SUD and/or COD. About 7.7% of George and 21.7% of Jackson counties residents are Black; 3.0% and 6.8% His- panic, and 89.7% and 73.3% White, respectively. An average of almost 16% are below the FPL. Jackson county is in Mississippi's Pascagoula metropolitan statistical area. Both Jackson and George counties are classified as medically underserved areas with a high concentration of BH disparities, suicide fatalities, and overdose deaths.[lxii] Singing River is a CCBHC grantee.

[lxii] Singing River Disparities Statement

[lxiii] Baumgaertner, E. (2022, December 13). *A Rural Hospital's Excruciating Choice: $3.2 Million a Year or Inpatient Care?* The New York Times. Retrieved December 15, 2022, from https://www.nytimes.com/2022/12/09/health/rural-hospital-clo- sures.html

SOCIAL DETERMINANTS OF HEALTH[1]

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 for more information on the five (5) domains.)

1. Education and Quality
2. Economic Stability

[1] https://www.ruralhealthinfo.org/toolkits/sdoh

3. Health Care Access and Quality
4. Neighborhood and Built Environment
5. Social and Community Context

Social Determinant of Health Domains (Healthy People 2030)	Activities
Education and Quality: Children from low-income families, children with disabilities, and children who routinely experience forms of social discrimination — like bullying — are more likely to struggle with math and reading. They're also less likely to graduate from high school or go to college. The stress of living in poverty can also affect children's brain development, making it harder for them to do well in school. *(Healthy People 2030).* Mississippi is ranked 49th in the U.S. for poverty and 19.4% (vs. 12.8% nationally) of Mississippi households live below the federal poverty line (FPL). In addition, African American (31.3%) and Native American (36.1%) populations experience higher levels of poverty compared to White populations (12.1%). A disproportionate number of African American families reside in rural areas where the poverty rates are among the highest in the state and the country. .	• We will build upon our current school-based services model and collaborate with our statewide network of school-based and school-linked health care services to expand access to CCBHCs. To do this, Mississippi state law (MS Code 1972 37-3-91), allows the State Board of Education to establish regional BH "instates" "for the purpose of providing state-of-the-art training to teachers and administrators in discipline and classroom management strategies and BH screenings for students." This law also encourages districts to establish school-based or school-linked mental health promotion and intervention programs. This will include working with the Mississippi Department of Education, which partners with the University of Mississippi Medical Center to offer physical and mental telehealth services to children. • All CMHCs house master's-level clinicians in area public schools. They provide a range of services from individual and family therapy to crisis service. They continue to offer services during the summer for continuity of care. This will be a continued service in the CCBHCs. • DMH's Division of Children and Youth Services is partnering with UMMC, the Mississippi Department of Education, Families As Allies, and the University of Southern Mississippi to optimize SAMHSA resources to develop a sustainable infrastructure for school-based mental health programs and services, based on a public health model that advances mental health promotion, awareness, prevention, and intervention activities to ensure that students have access and are connected to appropriate and effective BH services. • To enhance CCBHC care management: DMH is utilizing federal funding to add six ICSS for children and adolescents at all 12 CMHCs. This will allow CMHCs to offer ICSS for adults and children/adolescents. ICS promotes independence and quality of life through the coordination of appropriate services and the provision of constant and ongoing support as needed. For children/adolescents, the ICSS will coordinate required services from across the mental health system as well as other systems such as the local school, Child Protection Ser- vices, Youth Court, crisis response, and or/ substance use services to reduce recidivism of children and youth being placed in inpatient psychiatric care. • To support youth and young adult participation in the CCBHC stakeholder engagement effort: Open Up Mississippi is a statewide leadership council whose mission is to engage youth and young adults as they break down barriers to gain mental wellness and utilize their strengths and voice against the stigma of mental health. Open Up Mississippi is dedicated

	to ensuring youth and young adults use their voices to empower other youth and young adults to openly talk about mental health without stigma, and improve the response of parents, mental health practitioners, and first responders who engage with youth and young adults. These activities include hosting listening sessions, webinars, and virtual presentations, participating in community events, and presenting at state level mental health conferences.
Economic Stability: Many people in the United States don't get the health care services they need. Healthy People 2030 focuses on improving health by helping people get timely, high-quality health care services. *(Healthy People 2030)* Mississippi ranks 49th in the nation in per capita spending on mental health services. Increasing funding would allow the state to expand access to services, such as therapy, medication, and support groups. Mental health affects the sustainability of rural communities and access to mental health services is a significant challenge for rural patients (Holland, 2018). These limited resources in the Mississippi's rural areas make it difficult for some centers to remain viable and provide much-needed mental health services (Smith, 2019). The Mississippi Delta region is not only one of the poorest in Mississippi, but also one of the poorest in the nation. Smith (2019) reports that in 2018, mental health centers in Mississippi provided over $33 million in uncompensated indigent services to underinsured and uninsured individual.	• Mississippi's planned participation in the CCBHC Demonstration will expand the capacity, access, and availability of BH services to children, youth, and adults throughout Mississippi. The CCBHC requires availability and accessibility of services, including crisis management services that are available and accessible 24 hours a day, the use of a sliding scale for payment, and no rejection for services or limiting of services based on a patient's ability to pay or a place of residence.
Health Care Access and Quality: Many people in the United States don't get the health care services they need. Sometimes people don't get recommended health care services because they live too far away from the health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need. *(Healthy People 2030)*	• Mississippi's planned participation in the CCBHC Demonstration will expand the capacity, access, and availability of BH services to children, youth, and adults throughout Mississippi. • Mississippi selected two CMCHs to initiate the program during the Planning Grant period based on their representation of some of Mississippi's most impoverished and culturally diverse rural and urban populations. Both sites evidence high levels of need, particularly among ethnic and racial minorities. And both sites' clients' struggle with access to services due to workforce shortages and the lack of consistent service availability across CMHCs. • One of Mississippi's greatest challenges will be overcoming

Mississippi is the fourth most rural U.S. state, with 60.0% of its 2.9 million residents residing in rural areas. According to the U.S. Census Bureau, 65 of Mississippi's 82 County are considered rural, which means that they have a population density of less than 1,000 people per square mile. These counties are home to about 79% of the state's population. As a result, people in rural areas may have to travel long distances to receive mental health care, or they may not be able to afford it at all. There is a shortage of mental healthcare providers in Mississippi, particularly in the Delta region.	the BH workforce shortages. These shortages are particularly acute in rural areas. The State will use the Planning Grant to engage stakeholders to mitigate workforce shortages through an array of interventions: targeted wage in- creases, partnerships with local universities (such as the University of Mississippi Medical Center School of Medicine and the state's six HBCUs), optimizing the recently approved certification process to credential mental health professionals who are not independently licensed to allow non-licensed staff to bill for non-clinical but critical supports, and expanding the use of telehealth.
Neighborhood and Built Environment: Many people in the United States live in neighborhoods with high rates of violence, unsafe air or water, and other health and safety risks. Racial/ethnic minorities and people with low incomes are more likely to live in places with these risks. *(Healthy People 2030).* Mississippi is ranked 49th in the U.S. for poverty and 19.4% (vs. 12.8% nationally) of Mississippi households live below the federal poverty line (FPL). In addition, African American (31.3%) and Native American (36.1%) populations experience higher levels of poverty compared to White populations (12.1%).	• Mississippi's planned participation in the CCBHC Demonstration will expand the capacity, access, and availability of BH services to children, youth, and adults throughout Mississippi. The CCBHC provides a safe, functional, clean, sanitary, and welcoming environment.
Social and Community Context: People's relationships and interactions with family, friends, co-workers, and community members can have a major impact on their health and well-being. Positive relationships at home, at work, and in the community can help reduce these negative impacts. But some people — like children whose parents are in jail and adolescents who are bullied — often don't get support from loved ones or others. Interventions to help people get the social and community support they need are critical for improving health and well-being. *(Healthy People 2030)*	• Our plan will expand access to our state's extensive peer support services. • We will target coordination with hospital EDs to share data that can support ED and hospital diversion and feature options for local access points where individuals can receive care "outside the clinic walls" in hospitals, schools, churches, and other civic and community-based settings where those in need are already engaged and where trusted local leaders can facilitate access to services. • Our stakeholder engagement will include representation by our CMHC/CCBHC grantees and non-grantee CMHCs. We will also include representation from the Medicaid CCOs, the Choctaw Nation, and state agency representatives, including those responsible for health and hospitals, homeless services, income assistance, child welfare, adult protection, and criminal jus- tice. Other key stakeholders

DMH has made it a priority to engage directly with community stakeholders on an ongoing basis in the design, implementation, and maintenance of all major BH and policy initiatives (e.g., 988, CEMP, Systems of Resiliency and Recovery). This includes gathering input from organizations representing service recipients and peers, family members, substance use and mental health providers, local government, advocates, academics, veterans, and tribal nations.	include the Association of Mississippi Peer Support Specialists, NAMI MS, and the Mental Health Association of South Mississippi. We will also include other key stakeholders with valuable experience, such as those who supported our recent 988 design process, current PATH grantees addressing housing insecurity and the needs of those who are experiencing homelessness, and cultural organizations serving unique underserved populations, such as the Vietnamese refugees residing in Region 14. • Mississippi will convene a CCBHC Steering Committee to work in alignment with input from adult, youth, and family consumer representatives from across the State. The Steering Committee will establish issue-focused working groups, as appropriate, representing critical stakeholders, advocates, providers, and consumers and their family members. • The Advisory Council will also meet quarterly with the Community Advisory Boards (CABs) representing the state's CCBHC grantees (which includes the Region 14 Pilot Planning Grant site) and the other (Region 6) Pilot Planning Grant sites (once established). The CABs will provide the Committee with the perspectives of their communities, to build authentic community relationships and trust across Mississippi with DMH.

Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care [2]

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.

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

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.
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 public.

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.
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.
5. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
6. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

7. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.
8. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
9. 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.
10. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
11. Communicate the organization's progress in implementing and sustaining CLAS to all partners, constituents, and the 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.

The Mississippi Department of Mental Health (DMH) is committed to meeting the needs of Mississippians in all their diversity. DMH will leverage the State Plan for Cultural Competency to guide its CCBHC activities in 2023-2024. The State Plan for Cultural Competency was created by DMH's Cultural Competency Plan Workgroup. The workgroup consists of members from the Bureau of Community Services, Bureau of Alcohol and Drug Services, Bureau of Administration, Office of Incident Management, Bureau of Intellectual and Developmental Disabilities, and Mississippi State Hospital. The State Plan represents cumulative efforts of the workgroup's approach to short-range and long- range planning for a comprehensive cultural competency system-wide approach and to decrease disparities in service. The Plan encompasses identification of services and resources needed, implementation of strategies to address those needs (i.e., through training and public information campaigns), and assessment of outcomes of service provided. The plan is informed by CLAS standards, federal mandates, regulations, and or/guidelines regarding non-discrimination and equal opportunity. We will work with the CCBHC Learning Community to implement the following activities that align to the State's Plan:

Implement policies and guidelines to support the implementation of culturally and linguistically competent services and supports.

- Update the State's Plan for Cultural Competency to include a training plan for all CCBHC employed and contract staff. The CCBHC training plan will align with the National Standards for Culturally and Linguistically Appropriate Services (CLAS). This plan will include training on:
    - Evidence-based practices
    - Culture Competency
    - Person-centered and family-centered, recovery-oriented planning and services
    - Trauma-informed care
    - Policies and procedures for continuity of operations/disasters and integration and coordination with primary care
    - Care for co-occurring mental health and substance use disorders.
    - Annual training on risk assessment; suicide and overdoes prevention and response; and the roles of family and peer staff.
- Update any Mississippi Department of Mental Health (DMH) Division of Professional Licensure and Certification (PLACE) course materials, study manuals, exams, etc. to reflect all CCBHC training plan requirements.
- Update the DMH monitoring checklist with CCBHC Training plan requirements, including capturing how the CCBHCs regularly assesses and captures personnel records on the skills and competence of any CCBHC employed and contract staff.
- Review the CCBHC training plan with the CCBHC Family/Client Advisory Councils to get input on recommended training.

Collect and analyze disparity data.

- DMH and the CCBHC Learning Committee will review disparity data and information from the community needs assessment to develop recommended interventions based on data, including any necessary updates to the State's Plan for Cultural Competency, and the CCBHC training plan and activities.
- Share data and needs assessment results with the CCBHC Community Advisory Board (CAB) Councils to get input on recommended training and interventions.

Develop a workforce that is trained in providing culturally competent services and support.

- Recruit and hire CCBHC staff from the communities of the populations being served.

- Fund training for staff and community partners, including expanding access to DMH's e-learning system, Relias.
- Gather input and recommendations from the CCBHC Community Advisory Board (CAB) Councils on training, staff competencies, and workforce development.
- Engage the MS Community College Board to develop or update any certifications to include CLAS standards.

Implement social marketing strategies for advancing cultural competency.

- Ensure CLAS standards are posted and promoted on DMH website.
- Fund The Glenn Foundation to work with Regions 6 and 14 to develop a Minority Outreach and Engagement Plan.
- Secure and use recommendations from the CCBHC Community Advisory Board (CAB) Councils and Peer Support professionals on social marketing messages and activities.

Implement referral services and resources for embedding culturally competent services and supports.

- Review and update access to current list of linguistic translators and interpreters.
- Use disparity data and community needs assessment findings to identify gaps and remediation activities to ensure access to linguistic translators and interpreters.
- Develop guidelines to boost literacy levels for health information materials.
- Expand peer support services that are reflective of and embedded in the community.
- Secure and promote policies and procedures for securing translation and interpreter services for Medicaid enrolled populations.
- Train CCBHC staff and contractors and Community Advisory Boards (CAB) on policies and procedures for securing translation and interpreter services for Medicaid enrolled populations.

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.)

- 100% of updates made to all CCBHC policies and guidelines.
- Training completed for 100% staff and contractors working with Mississippians accessing CCBHC services in Regions 6 and 14.
- Access to training increased by 100% for all staff and contractors working with Mississippians accessing CCBHC services.
- 75% of CCBHC Steering Committee, Learning Collaborative and Community Advisory Board (CAB) members provide input on CCBHC training plans, services, interventions, outreach strategies and materials.
- Baseline disparity and needs assessment data established.
- 75% of CCBHC staff are hired from the communities being served.
- 100% increase in social marketing strategies for advancing cultural competency.
- 95% accuracy reported on the current list of linguistic translators and interpreters.
- Increase in peer support services in Regions 6 and 14 (a specific % will be identified during the Planning grant).
- Establish baseline data for health literacy levels.
- All gaps identified for linguistic translators and interpreters.

- Develop guidelines to boost literacy levels for health information materials.
- Inventory of all policies and procedures for securing translation and interpreter services for Medicaid enrolled populations gathered and published on the DMH website and on other online client and family resources.

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?

- Review the CCBHC training plan with the CCBHC Family/Client Advisory Councils to get input on recommended training.
- Share data and needs assessment results with the CCBHC Community Advisory Board (CAB) Councils to get input on recommended training and interventions.
- Fund training for staff and community partners, including expanding access to DMH's e-learning system, Relias.
- Gather input and recommendations from the CCBHC Community Advisory Board (CAB) Councils on training, staff competencies, and workforce development.
- Fund The Glenn Foundation to work with Regions 6 and 14 to develop a Minority Outreach and Engagement Plan.
- Secure and use recommendations from the CCBHC Community Advisory Board (CAB) Councils and Peer Support professionals on social marketing messages and activities.
- Review and update access to current list of linguistic translators and interpreters.
- Use disparity data and community needs assessment findings to identify gaps and remediation activities to ensure access to linguistic translators and interpreters.
- Develop guidelines to boost literacy levels for health information materials.
- Expand peer support services that are reflective of and embedded in the community.
- Secure and promote policies and procedures for securing translation and interpreter services for Medicaid enrolled populations.

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.)

July thru September

- Update the State's Plan for Cultural Competency to include a training plan for all CCBHC employed and contract staff. The CCBHC training plan will align with the National Standards for Culturally and Linguistically Appropriate Services (CLAS). This plan will include training on:
    - Evidence-based practices
    - Culture Competency
    - Person-centered and family-centered, recovery-oriented planning and services
    - Trauma-informed care
    - Policies and procedures for continuity of operations/disasters and integration and coordination with primary care
    - Care for co-occurring mental health and substance use disorders.
    - Annual training on risk assessment; suicide and overdoes prevention and response; and the roles of family and peer staff.

- Review the CCBHC training plan with the CCBHC Family/Client Advisory Councils to get input on recommended training.
- Gather disparity and community needs assessment data.
- Recruit and hire CCBHC staff from the communities of the populations being served.
- Fund training for staff and community partners, including expanding access to DMH's e-learning system, Relias.
- Gather input and recommendations from the CCBHC Community Advisory Board (CAB) Councils on training, staff competencies, and workforce development.
- Engage the MS Community College Board to develop or update any certifications to include CLAS standards.
- Fund The Glenn Foundation to work with Regions 6 and 14 to develop a Minority Outreach and Engagement Plan.
- Ensure CLAS standards are posted and promoted on DMH website.
- Review and update access to current list of linguistic translators and interpreters.
- Secure and use recommendations from the CCBHC Community Advisory Board (CAB) Councils and Peer Support professionals on social marketing messages and activities.
- Secure and promote policies and procedures for securing translation and interpreter services for Medicaid enrolled populations.

September thru December

- Update any Mississippi Department of Mental Health (DMH) Division of Professional Licensure and Certification (PLACE) course materials, study manuals, exams, etc. to reflect all CCBHC training plan requirements.
- DMH and the CCBHC Learning Committee will review disparity data and information from the community needs assessment to develop recommended interventions based on data, including any necessary updates to the State's Plan for Cultural Competency, and the CCBHC training plan and activities.
- Share data and needs assessment results with the CCBHC Community Advisory Board (CAB) Councils to get input on recommended training and interventions.
- Recruit and hire CCBHC staff from the communities of the populations being served.
- Implement social marketing strategies for advancing cultural competency.
- Use disparity data and community needs assessment findings to identify gaps and remediation activities to ensure access to linguistic translators and interpreters.
- Train CCBHC staff and contractors on policies and procedures for securing translation and interpreter services for Medicaid enrolled populations.

January thru March

- Update the DMH monitoring checklist with CCBHC Training plan requirements, including capturing how the CCBHCs regularly assesses and captures personnel records on the skills and competence of any CCBHC employed and contract staff.
- Recruit and hire CCBHC staff from the communities of the populations being served.
- Implement social marketing strategies for advancing cultural competency.
- Use disparity data and community needs assessment findings to identify gaps and remediation activities to ensure access to linguistic translators and interpreters.
- Develop guidelines to boost literacy levels for health information materials.
- Expand peer support services that are reflective of and embedded in the community.
- Share information with Community Advisory Boards on policies and procedures for securing translation and interpreter services for Medicaid enrolled populations.

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 measurement[3] 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.

We will obtain baseline numbers of individuals currently served prior to the establishment of the CCBHCs, numbers of outreach contacts for the areas served, numbers of screenings currently being done, and number of referrals currently being done for the area being served. Improved outcomes will be noted by measuring baseline completed referrals, number of people trained, number and percentage of individuals who have demonstrated improvement in cultural competence, as well as those who have implemented specific behavioral health practices and/or evidence-based practices. This baseline information will be obtained through the CMHCs which currently serve the target areas. Our target goals are to see a 10% improvement (numbers increase) by the end of the first year, and an additional 10% for each year following.

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.).

Mississippi's Certified Community Behavioral Health Clinic (CCBHC) program will support the redesign of the state's behavioral health (BH) delivery system to meet the needs of all Mississippians. The CCBHC program will:

- Improve access to and delivery of community-based behavioral health services.
- Address gaps or barriers to care in Mississippi.
- Establish sustainable funding for additional investment in quality, evidence-based mental health, and substance use services.
- Offer more competitive wages because of the cost-based reimbursement that can aid in alleviating workforce shortages.
- Hold CMHCs accountable for quality outcomes.
- Engage stakeholders and consumers of mental health services, including youth, family members, and community leaders, to provide input on a customizable approach to care that increases responsiveness to the needs of Mississippians.

To support Mississippi's efforts to create a sustainable and equitable BH System of care, DMH will also make every effort to collaborate with states currently participating in CCBHC Demonstration programs to cross share successes, adapt successful solutions to address local challenges, and to inform the national evaluation efforts. This might include the identification and development of performance metrics and/or outcomes that may be more meaningful for informing improvements to CCBHC care delivery, especially for underserved priority populations.

[3] 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/