HMA

HEALTH MANAGEMENT ASSOCIATES

Behavioral Health Gap Analysis

PREPARED FOR

GRAYS HARBOR COUNTY
PUBLIC HEALTH

BY

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Executive Summary

In July 2022, Grays Harbor Public Health completed the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). Through the process of engaging the community in this work, Grays Harbor Public Health recognized that behavioral health services in Grays Harbor represented an area of significant need in the community. As a follow up to the CHIP and CHA, Grays Harbor embarked on an initiative to partner with a consulting firm, Health Management Associates, to conduct a thorough analysis of the gaps that the community is experiencing regarding mental health and substance use disorder treatment services. The assessment provides Grays Harbor Public Health with information necessary to set community priorities and to embark on strategic planning efforts to address the gaps identified in the community. While the assessment aims to be comprehensive, no assessment can adequately represent all populations of interest and these information gaps might, in some ways limit the ability to assess all behavioral health needs in the region. For example, agencies that serve unhoused individuals were included in the provider survey, and all community residents were invited to participate in the survey, however, it is often difficult for unhoused individuals to participate in forums or surveys. The survey was offered in Spanish as well as English, and the second community forum offered a Spanish speaking focus group. However, the rate of participation in either format by Spanish speaking community members was low.

In recognition of the work that the state of WA led in 2016 to integrate the management of substance use disorder and mental health treatment services into one category of care referred to as behavioral health care, this report will refer to behavioral health services (BH) when referring to trends that impact both types of care unless there are gaps that specifically refer to mental health (MH) or substance use disorder (SUD) treatment services.

A mixed method design was used to gather data about the community and the behavioral health supports in Grays Harbor County. Through the use of surveys, forums, provider focus groups, key informant interviews and data analysis, HMA examined the behavioral health system of care both quantitatively and qualitatively. The amount of engagement by both the community and the providers was excellent. This, combined with the data that is measured by scorecards from a variety of publicly available sources including the Healthier WA Score card, the University of Washington's Addictions, Drug and Alcohol Institute and WA's Healthy Youth Survey from 2021 supplied a snapshot of the behavioral health outcomes that Grays Harbor currently experiences. The results of the scorecards were congruent with the feedback obtained through surveys, key informant interviews, community and provider forums and surveys of both providers and community members. This gives us a high degree of confidence in the gaps and strengths identified in the report.

Key Findings

The table below describes performance measures by population domain and compares Grays Harbor County with the rest of Washington state. Data illustrates that of 19 data points examined, Grays Harbor is under performing on 11, or 58% of the metrics. This suggests that the gaps that were identified in the

gap analysis are having an impact on the overall behavioral health of the community. Areas where Grays Harbor is outperforming the state include timely follow up care for people who have been hospitalized or who have been seen in an emergency department for a mental health condition, and engagement in substance use disorder treatment for those who have been diagnosed with a substance use disorder. Areas where Grays Harbor performed better than the state average are noted in **Table 1** below with a check mark.

Table 1 Key Performance Indicators for Behavioral Health in Grays Harbor

Domain	Indicator	Grays Harbor	WA State	GH is doing better than WA State ✓ = True ⊘ = Not True
Alcohol or other drug use follow up care (Higher is better)[1]	Follow up appointment with a behavioral health provider after ED visit for alcohol or other drug use dependence	**21%**	**22%**	⊘
Criminal justice involvement/ arrests (Lower is better)[1]	Percent of population that is arrested	**7%** of population	**5%** of population	⊘
Emergency Department visits (Lower is better)[1]	All Cause ED Visits	**47** per 1,000 member months	**39** per 1,000 member months	⊘
Mental health treatment engagement (Higher is better)[1]	Mental health penetration rate = the percentage of individuals with an identified MH need who received at least one MH service in the past year	**50%** of individuals with an identified MH need	**54%**	⊘
Mental health follow-up care (Higher is better)[1]	Follow up with a behavioral health provider after ED visit for mental health condition	**68%**	**56%**	✓
Mental health follow-up after hospitalization (Higher is better)[1]	Follow up after inpatient hospitalization for	**54%**	**52%**	✓

[1]Healthier Washington Dashboard. Washington State Health Care Authority. Data refreshed June 17, 2022. https://hca-tableau.watech.wa.gov/t/51/views/HealthierWashingtonDashboard/FrontPage?%3AisGuestRedirectFromVizportal=y&%3Aembed=y

Domain	Indicator	Grays Harbor	WA State	GH is doing better than WA State ✓ = True ⊘ = Not True
	mental health condition			
Houselessness/ Homelessness (Lower is better)[1]	Percentage of population unhoused	**3%**	**3%**	**Same**
Substance use disorder engagement (Higher is better)[1]	Substance use disorder penetration rate = the percentage of individuals with an identified SUD need who received at least one SUD service in the past year	**46%**	**38%**	✓
Methamphetamine Use (Lower is better)[2]	Deaths involving methamphetamine drugs per 100,000 residents	**28.35**	**13.20**	⊘
Opioid deaths (Lower is better)[2]	Deaths involving opioids per 100,000 residents	**25.24**	**16.16**	⊘
Youth risk factors (Lower is better)[3]	Lifetime Sexual Abuse	**Grade 8: 9%** **Grade 10: 12%** **Grade 12: 30%**	**Grade 8: 10%** **Grade 10: 14%** **Grade 12: 22%**	✓ ✓ ⊘
Youth risk factors (Lower is better)[3]	Contemplation of Suicide	**Grade 8: 21%** **Grade 10: 21%** **Grade 12: 22%**	**Grade 8: 19%** **Grade 10: 14%** **Grade 12: 20%**	⊘ ⊘ ⊘
Youth Protective factors (Higher is better)[3]	Report having someone in the community to talk to	**Grade 8: 61%** **Grade 10: 57%** **Grade 12: 66%**	**Grade 8: 66%** **Grade 10: 65%** **Grade 12: 65%**	⊘ ⊘ ✓
Youth gender identity - Important to note re: need for LGBTQIA+ supports in community	Gender identity/ sexual orientation	GH had similar to slightly higher rates of youth identifying as more than one gender identity or questioning	GH had similar rates of youth who identified as gay/ lesbian, bisexual, questioning or something else	n/a

[2] University of Washington Addictions, Drug and Alcohol Institute. https://adai.uw.edu/wadata/opiate_home.htm

[3] WA State Healthy Youth Survey 2021

Domain	Indicator	Grays Harbor	WA State	GH is doing better than WA State ✓ = True ⊘ = Not True
		compared to state averages	to the rest of the state	

Through community input, key informant interviews and geo-mapping, the assessment goes beyond these key performance indicators and seeks to understand components of the behavioral health system of care in Grays Harbor County. This will help leaders understand the root causes and opportunities for interventions that will have the largest potential for impacting community outcomes.

Key Gap in Tools to Support System Improvements:

A significant gap noted in the assessment is a lack of key data points for system measurement and feedback for leaders and the community. The region experiences several gaps in data that make it difficult to quantify the true accessibility of behavioral health services in the county. In key informant interviews, we learned that there is not currently an entity that is measuring time to first available appointments for behavioral health entities either for the region or on a statewide basis. This leaves the county with a missing data point regarding a key metric for behavioral health access.

Community perception, first responder input and referring social service agency feedback consistently shows a lack of timely access to behavioral health care in the region. Providers shared that some have a practice of open access on certain days of the week, or early in the day. However, community feedback consistently shows that these access points are insufficient to meet the needs of the community. Members in forums stated that people who are in crisis are not often able to wait for a certain day of the week or cannot arrive early in the day to get one of the scarce available open access appointments.

Several states across the United States measure and share data with their communities about this key data point. California and Hawaii both have dashboards that are publicly available which show data regarding access to care standards, the results of reviews of health plans regarding their access to routine behavioral health care and other key data such as the number of hospitalizations per 1,000, and the numbers and types of complaints received and resolved. See **Appendix D** for links to dashboards.

Strengths identified include:

1. High level of engagement of both the community and providers
2. Strong commitment on the part of stakeholders to build capacity and close BH system gaps
3. Planned increased capacity with Quinault Wellness Center
4. Strong support and relationships between Grays Harbor Public Health and Health Care Authority and Great Rivers Behavioral Health Organization
5. Therapeutic treatment courts for people with substance use disorders/ deferred prosecution

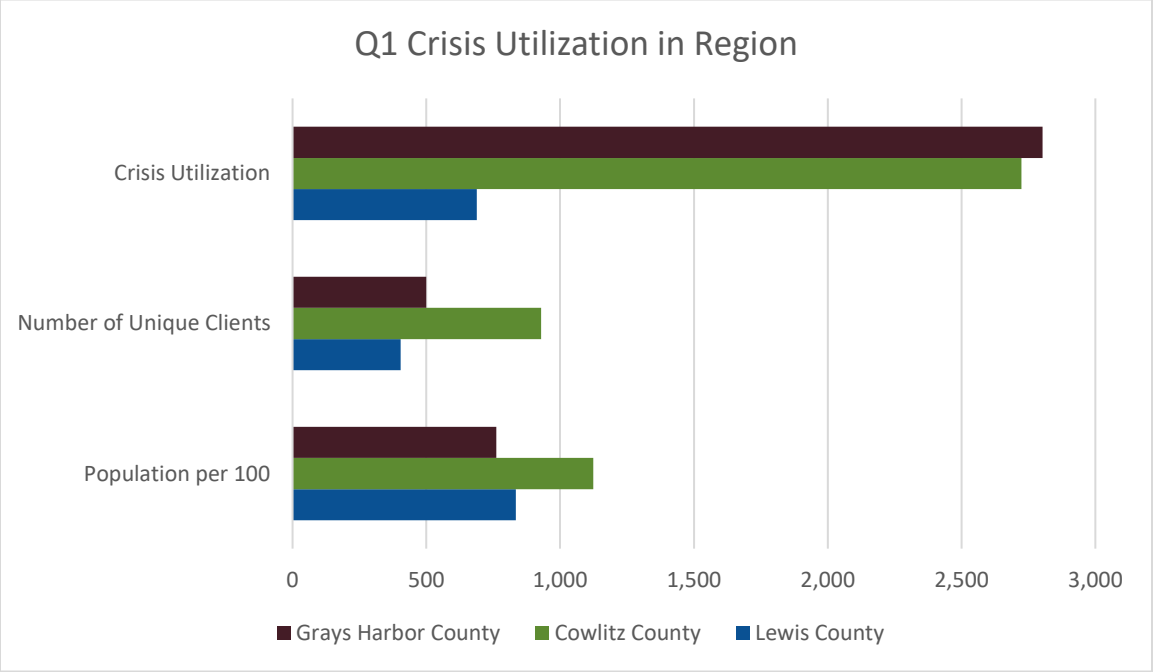
Gaps Impact County and Region:

Despite these strengths, Grays Harbor consistently uses more crisis services per capita than other counties in the same region. **Table 2**, illustrates the trends for the first quarter of 2022, including key metrics:

- Grays Harbor used more mobile crisis services than any other county in the five-county region.
- As the third largest county in the region, their utilization of 41% of the total usage for the region was a significant outlier.
- Despite having a population that is 10% smaller than Lewis County, Grays Harbor regularly uses between 22 and 50% more crisis resources than its slightly larger neighbor.
- Strikingly, Grays Harbor is using a comparable amount, and at times more mobile crisis time than its much larger neighbor, Cowlitz County:
    - Cowlitz County's population is 47% larger than Grays Harbor.
    - Throughout 2021 and 2022, Grays Harbor required a mobile crisis team response at the same or higher rate to Cowlitz County.
    - In March of 2022, Grays Harbor's mobile crisis utilization was 17% higher than Cowlitz County's usage.

Analysis of the trends shows that a high percentage of the responses are to clients who are familiar users of crisis services. This suggests that post crisis interventions could have a significant impact on reducing the overuse of crisis care in the County.

Table 2 Q1 Crisis Utilization Patterns for the Region



Gaps identified

The assessment identified several categories of gaps in Grays Harbor. These include:

- Stigma
- Youth services
- Community awareness of resources
- Transportation
- Access
- Workforce
- Transitions of care
- Culturally, linguistically appropriate services and vulnerable populations

Impacts of Gaps

In the context of population health approaches to conditions, including behavioral health, it is important to note that gaps in one area can have cascading impacts on other areas in the overall health of a community. For example, if prevention efforts are not able to have a significant impact on helping community members avoid drug and alcohol use, the community will see a higher rate of use that will, in turn, result in more people who need intervention services. Likewise, when treatment and recovery supports are unavailable to help people receive care before a crisis occurs, a community will experience the gaps in the form of higher emergency department utilization.

There are numerous studies that explore the impact of untreated behavioral health conditions on the overall cost of healthcare. A 2015 study in the *Journal of* Mental *Health* (Pratt, S. et al, 2015) discusses the reduction in emergency department and high-cost inpatient care for people who are diagnosed with serious mental illnesses when they are able to consistently engage in routine care, such as tele-health appointments. [4] This, and other studies of its kind, illustrate the power of investing in less invasive, less expensive prevention, early intervention and routine care options. **Figure 1** below describes the interplay between levels of intervention.

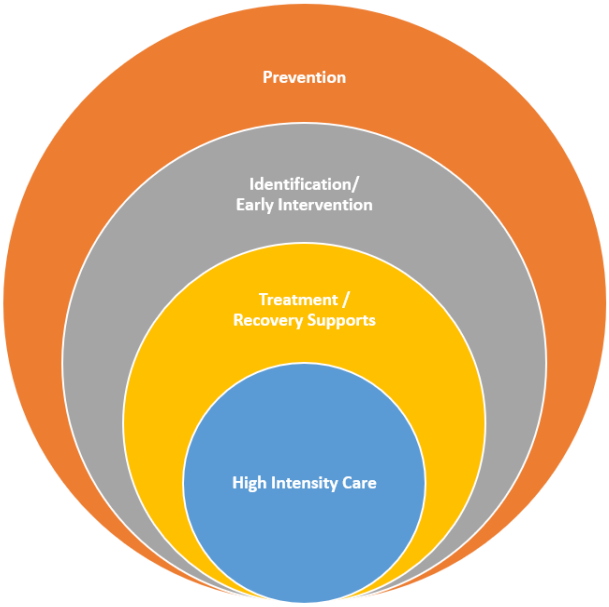
Preventative care is the least expensive approach that can be provided to the largest number of community members. Early intervention and identification can still be provided at a relatively low cost for a substantial percentage of the community. Treatment and recovery supports, while more expensive than prevention or early intervention, can prevent the need for higher cost and more invasive interventions such as involuntary commitment or long-term hospitalizations.

The crisis use patterns for Grays Harbor indicate that a higher percentage of time, resources and financial investments are being needed at the highest end of the care continuum. This is the result of gaps in the system of routine and early intervention care and is exacerbated of community members' reluctance to seek care stemming from a widely held perception of stigma associated with receiving behavioral health care. A key recommendation for the community is that Grays Harbor invest time and resources in developing more support options in all areas of the care continuum. This will help ensure

[4] Pratt, S. I., Naslund, J. A., Wolfe, R. S., Santos, M., & Bartels, S. J. (2015). Automated telehealth for managing psychiatric instability in people with serious mental illness. *Journal of mental health (Abingdon, England)*, *24*(5), 261–265. https://doi.org/10.3109/09638237.2014.928403https://pubmed.ncbi.nlm.nih.gov/24988132/

that crisis services remain available for those who most need them, while encouraging a shift in use patterns to higher utilization of routine behavioral health care and prevention services.

Figure 1



Future Considerations

Lastly, the gap analysis concludes with a set of recommendations that are a combination of innovative ideas that were shared by the community as well as evidence based and promising practices that are being used in other regions and states to address similar health, social, geographic issues and needs.

Table 3 gives a preview of the types of approaches that will be detailed in the future considerations section at the end of the report.

Table 3 Preview of Future Considerations

Gap Area	Potential Approaches/ Solutions
Youth services	• Offer capacity building grants to incentivize hiring new staff (funding for sign on bonuses, relocation packages, etc.)
Community awareness of resources	• Resource directory – paper or electronic • Community resource events
Transportation	• Create a system that offers transportation to BH appointments • Wellness center plans to offer this for individuals with SUD diagnoses.

Access	• Need a resource that is available beyond normal business hours for intake/ assessment • Increased open access at multiple sites • Crisis Triage Center (with police and first responder drop off capabilities) • CCBHC Model that incorporates provider network
Workforce – challenges hiring	• Engage with workforce work that is being done by WA BH Council, BHI, • Consider funding clinical supervision for agency affiliated counselors (could be done through tele/ remote support) • Need more housing for BH staff in community
Stigma	• Anti-stigma education campaigns
Transitions of care	• Consider peer bridger model for post ED follow up, post hospital follow-up
Culturally, linguistically appropriate and vulnerable populations	• Increase the number of culturally diverse treatment providers to the region, through outreach, training, and apprenticeship programs, etc.
Jail and Criminal Justice System	• Mapping of gaps for behavioral health care that is available to those who have criminal justice involvement including people who are in the County and City jails who need behavioral health care and transition supports for reintegration to the community (this was outside of the scope of this BH Gap analysis project).

Introduction

Grays Harbor engaged with Health Management Associates to conduct a behavioral health gap assessment for the community over the course of a three-month period. This assessment included stakeholder engagement through key informant interviews with 15 organizations, two surveys, one for providers and one for community members, two community forums and two provider forums. Additional assessment was conducted through geo-mapping and data analysis of the key demographic data sets and the key performance indicators available through the Healthier Washington scorecard, the University of Washington's Addictions, Drug and Alcohol Institute dashboards and the WA State Healthy Youth Survey.

Grays Harbor County Public Health completed a Community Health Assessment and Community Health Improvement Plan earlier in 20222. Issues related to behavioral health were identified throughout the assessment, including:

- A majority (73%) of survey respondents were "most concerned" about availability of behavioral health providers

- Stigma reduction related to behavioral health was cited as a "high need" by 77% of individuals completing the survey
- 82% felt substance misuse was a priority health concern in the community

Leading out of the CHA, four strategic priorities with associated goals were identified as part of the CHIP. All four of these priorities were used to inform our gap assessment, with specific focus on access to services. The four priorities and goals include:

1. **Access to behavioral and physical health services** (Provide strategic leadership to increase community members' access to health care)
2. **Physical activities and healthy activities** (Improve access to physical activity and positive social engagement)
3. **Access to safe and affordable housing** (Collaborate with community partners to focus on housing as a Social Determinant of Health (SDoH)
4. **Culturally appropriate mass-reach health communication and education** (Increase the availability of culturally appropriate mass-reach health communications and health education materials for non-white and Spanish speaking community members)

Background and Methodology

A mixed method design was used to gather data about the community and the behavioral health supports in Grays Harbor County. HMA used the following methods to learn about the services, gaps, and perceptions of the behavioral health system of care in Grays Harbor County. HMA, in collaboration with Grays Harbor Public Health:

- Designed and deployed two community surveys, one in English one in Spanish,
- Designed and deployed a provider survey for social service agencies, healthcare providers and community based behavioral health agencies,
- Hosted two community forums
    - One was held in person with a virtual option, (approximately 60 participants)
    - One was entirely virtual – with a Spanish speaking option for the virtual forum (approximately 16 participants),
- Conducted two provider focus groups,
- Conducted 15 key informant interviews with hospitals, law enforcement, first responders, the Health Care Authority of WA, Great Rivers Behavioral Health Administrative Organization, The Quinault Wellness Center, multiple behavioral health provider agencies, Grays Harbor Public Health staff, and community service agencies.

Additionally, the Health Management Associates team reviewed the following sources:

- 2022 CHIP and CHA,
- Reports and data from the region's Behavioral Health Administrative Services Organization (BHASO),
- Data that is measured by scorecards from a variety of publicly available sources including:

- The Healthier WA Score card,
- The University of Washington's Addictions, Drug and Alcohol Institute
- WA's Healthy Youth Survey from 2021

Lastly, the HMA team examined the Grays Harbor Community from a geo-mapping lens that included publicly available information regarding census tract information, community based behavioral health agency and Federally Qualified Health Center and Indian Health Center locations.

HMA examined the behavioral health system of care both quantitatively and qualitatively. The amount of engagement by both the community and the providers was excellent. This, combined with the results of the scorecards were congruent with the feedback obtained through surveys, key informant interviews, community and provider forums and surveys of both providers and community members. This gives us a high degree of confidence in the gaps and strengths identified in the report.

Overall Methodology

Forums and Key Informant Interviews

A diverse set of qualitative data was collected through provider and community forums. Two provider forums were conducted virtually during the Community Partner Coalition meetings. Two community forums were conducted, with the first offered both virtually and in person in English and the second offered virtually in both Spanish and English. Forums and interviews were semi-structured and guided by a set of questions developed to understand the current status of behavioral health care in Grays Harbor County and opportunities for change. Detailed interview notes were taken in each interview and forum and subsequently reviewed for themes, which are summarized in the results section below.

Surveys

Two surveys were developed and administered as part of the gap analysis: a provider survey and a community survey. Both were administered online through the Qualtrics platform. Copies of the surveys are included in **Appendix A**. Survey participants were recruited through a variety of means, including direct emails to providers, advertisement through Grays Harbor County Public Health, and through discussion at community and provider forums.

Provider Survey

The provider survey was advertised to a broad range of behavioral health and allied providers (e.g., other health and human services) and focused on understanding the provider's current service array, as well as needs and opportunities to improve behavioral health care in Grays Harbor County. The provider survey was completed by individuals representing 18 organizations. Of those completing the survey, 56% reported that their organization offers mental health services, 33% reported that their organization offers SUD services, and 50% reported that their organization offer allied community services (housing and food support, early childhood services, workforce development, etc.) or health care services (primary care, dental care, community health workers, etc.). Surveys were completed by individuals with a variety of roles, with 72% describing their role as executive leader, program manager/director, or

other supervisory role and 28% describing their role as an individual contributor (therapist, physician, peer, etc.). Responding organizations reported serving individuals across the age spectrum (see **Table 4**). Primary service areas for responding organizations were distributed throughout the county, with a greater representation in the Central area (see **Table 5**).

Table 4 Age groups service by provider survey respondents.

Age Group	Percentage Serving this Group
Children 0 to 12	83%
Adolescents 13 to 18 years	94%
Young adults 19 to 24 years	18%
Adults 25 to 64 years	72%
Older adults 65 years or older	72%

Table 5 Primary service areas endorsed by provider survey respondents

Geographic Area	Percentage Endorsed
North Beach	50%
South Beach	50%
Central	89%
East County	72%
Other (Oakville, Amanda Park, etc.)	44%
Quinault Nation	11%
Confederated Tribes of the Chehalis Nation	17%

Community Survey

The community survey was offered in both English and Spanish. There was a total of 144 completed responses to the community survey. Three quarters of the survey respondents (75%) identified as women, 22% as men. The remainder self-identified with another gender (1%) or preferred not to answer (2%). The majority of survey respondents identified as White (85%). Five percent (5%) indicated that they identified as a race not included in the survey options, and 7% indicated that they preferred not to self-identify their race. The remaining 3% of respondents included individuals identifying American Indian or Alaska Native (1%), Black or African American (1%), and Asian (1%). Four percent (4%) of survey respondents reported having served in the US military.

The survey was offered in both English and Spanish, there was only one completed response to the Spanish survey. While we did complete one key informant interview in Spanish, we recognize the limitations of this low response rate in our capacity to speak to behavioral health gaps for Spanish Speaking individuals. Given a high response rate of the Spanish speaking community on the prior referenced Community Health Assessment, it is possible that this low response rate may at least partially reflect fear or stigma about speaking about behavioral health for this community. Additional demographics of the community survey respondents are included below.

Table 6. Age of Survey Respondents

Age	Percent Endorsed
13 to 18	1%
19 to 24	4%
25 to 64	52%
Older than 65 years	6%
Prefer Not to Answer	33%
No Response	4%

Table 7. Sexuality of Survey Respondents

Sexuality	Percent Endorsed
Heterosexual or Straight	81%
Bisexual	5%
Gay	1%
Asexual	3%
Queer	1%
Prefer Not to Answer	8%
None of the Above	1%

Table 8. Insurance Type of Survey Respondents

Insurance Type	Percent Endorsed
Commercial Insurance	47%
Medicaid	14%
Medicare	13%
Other	13%
Prefer Not to Answer	12%
No Response	1%

Secondary Data Analysis and Dashboard

By examining publicly available information from Census tracks, and subscription-based data sets, along with the addresses and locations of providers in the region, we were able to create a dashboard for the community. Using this map of the population centers by demographic type, combined with the pinpoint locations of the agencies, we were able to analyze where specific gaps exist in the behavioral health offerings within Grays Harbor. This was particularly useful in the context of feedback that lack of access to transportation is a gap area in the region. This data can also inform efforts to improve the access to resources in targeted regions that experience the most access issues.

Results of the BH Gap Assessment

Analysis from the Data Dashboard

This data analysis offers several opportunities for further evaluation and potential intervention. However, two geographic areas seem most affected by gaps in the provider network. Oakville and Ocean Shores are both areas that have a high prevalence of people experiencing poverty and few to no available behavioral health services. The Oakville area has only one behavioral health provider that provides mental health and SUD services. Ocean Shores currently has one behavioral health treatment provider location; however, the location has not been able to provide services for more than two years at this site due to behavioral health clinician vacancies.

Themes Shared by Community Providers and Key Informants

Youth services

- **Counseling Services in General:** Providers and community-based agencies noted a lack of counseling services, in general, for youth. Some excellent school-based services were recognized by community members who requested access to more of these services in the County.
- **Providers who serve youth with special needs:** A common theme was the lack of specialty youth providers, such as those who serve youth who have co-morbid autism spectrum disorders with behavioral health conditions or those who have intellectual and developmental disabilities in addition to a behavioral health condition.
- **Child and Adolescent Psychiatrists:** Another gap that was shared was the lack of child/ adolescent psychiatrists and advance practice practitioners such as advanced nurse practitioners or physician assistants in the region who will prescribe psychotropic medications for children and youth. Many pediatricians have had to step into the gap and prescribe these kinds of medications to young people in Grays Harbor due to the lack of this key resource.
- **Youth and Adolescent Substance Use Disorder Treatment:** Providers note the lack of treatment options for young people who need treatment for substance use disorders.

Community awareness of resources

Providers noted a lack of awareness of community resources, including basic needs and behavioral health supports. There are some agencies and individuals who have knowledge of specific resources. However, the knowledge is not readily available to agencies or members of the community in an easily accessible way. Not every community member has access to a community navigator. This creates inequity regarding community access to the existing resources. Providers noted a particular need for promotional materials accessible in other languages such as Spanish.

Transportation

Lack of access to transportation and the distance required to travel to access services were identified as predominant themes in the forums, key informant interviews and surveys. One new resource that is scheduled to open soon in Grays Harbor that will support some transportation needs is the Quinault Wellness Center. This facility reports that it plans to offer transportation to appointments for any clients served by the Center. This will have a positive impact on those who are eligible for and receive care at the Center. However, the scope of the Center's care is limited to those who have a diagnosed substance use disorder. This will leave a significant part of the population without adequate transportation to mental health treatment.

Access

Access issues were identified in several different forms. These include access to routine and post emergency care and access to emergent behavioral health evaluation and care. It is significant to note that there is a discrepancy regarding initial access to routine care between the perspective of behavioral health providers in the community and that of first responders, social service agencies that refer community members to care, and the general public. The lack of data at the community, region, and state level regarding the average time that a community member must wait to access routine behavioral health care complicates the analysis of this issue.

- **Community initial access:** Several counseling centers report that they have open access to initial appointments. A Managed Care Organization (MCO) survey that involved agencies self-reporting their access status to MCOs in the region suggests that there is adequate access to initial appointments in the region. However, health professionals, referring social service agencies and community members in surveys, key informant interviews and forums are all aligned in their feedback that there is not enough access to initial behavioral health care appointments in Grays Harbor. While the efforts to offer some open accesses are useful, as evidenced by their filling up on a regular basis, community members who are unable to arrive on the set day of the week or early enough in the morning to access one of the slots, report having to wait weeks and months for a next available intake. For a person who is looking for behavioral healthcare to prevent or follow up from a crisis, this access is inadequate.
- **Access for Behavioral Health Emergencies:** First responders, providers, social service agencies and community members are in consensus with one another that there is not adequate emergency access for people who are experiencing an acute behavioral health emergency in

Grays Harbor. The consensus feedback is that the emergency department is often on divert status or until recently, would not hold patients who met involuntary detention (ITA) criteria due to a lack of available beds. This means that community members who are found to be of life-threatening danger to themselves, others or gravely disabled are released back into the community due to a lack of beds in the area to treat their conditions. This results in an overuse of the mobile crisis system and many individuals experience exacerbations of their conditions which result in their incarceration by law enforcement. A recent change that was led by the Great Rivers Behavioral Health Administrative Services Organization (BHASO) has allowed the emergency departments to hold individuals who meet ITA criteria in the emergency department on a special single bed certification order while they wait for the next available inpatient psychiatric bed. However, if the emergency department is on divert, the ambulance cannot even arrive with a patient to receive assessment or care. Further complicating the issue is the requirement of most inpatient psychiatric units that a person be medically cleared by an emergency department prior to admission. When the emergency department is on divert and unable to examine and clear community members, they have to seek this clearance outside of Grays Harbor. This barrier can have the unintended consequence of discouraging community members who might otherwise seek voluntary inpatient psychiatric care to intervene in a rising risk psychiatric crisis before it becomes a life-threatening emergency.

One component of behavioral health access is the number and types of service providers in Grays Harbor. Below is a table of the publicly available behavioral health services in the County:

Table 9 Agencies that Offer Behavioral Health Care in Grays Harbor

Type of Agency (Community based Behavioral Health, Federally Qualified Health Center, Indian Health Services, Veteran BH Services, etc.)	**BH Services Offered** **SUD/ MH/ Both**	**Age Groups served**	**Modalities offered (including any Evidence Based Practices listed)**	**# of Agencies serving this population**
Community Behavioral Health	Both SUD and MH (no MAT)	All ages	DBT, CBT, Trauma informed care, Moral Reconation Therapy	4
Community Behavioral Health	Both	All ages	Forensic focus – FACT, Ind, Group, transition support from Western State Hospital	1
Community Behavioral Health	SUD Primary with some MH	Youth only	IOP, Ind, Group	1

Community Behavioral Health	SUD Primary with some MH	All ages	Group, Case Management, Sober Coaching	1
Community Behavioral Health	MH only	All ages	WISe, Outpatient MH, Ind, Group, Housing supports	1
Federally Qualified Health Center	Both SUD and MH	Adults only	SUD, Family Therapy	2
Community Behavioral Health	Both SUD and MH with MAT	Adults only	MAT, DBT, CBT, OTP	1
Hospital based clinic	MAT	Adults only	MAT	1
Indian Health Services	Both	All		1
Indian Health Services	SUD or co-occurring only, will not serve MH only	Adults only	MAT, IOP, Groups, Dental, Primary Care, Transportation, Care Coordination	1* To open soon
Rural Health Clinic	MH and Primary Care	Children up to 22 years		2
Skilled Nursing Facility	MH and skilled nursing care	Seniors	Skilled nursing care with mental health supports	1
Evaluation and Treatment Center	Mental Health inpatient treatment	Adults	Mental Health inpatient treatment (includes involuntary level of care)	1 (16 beds)

Analysis of this outpatient service array shows that there are no agencies that list specialty care for youth regarding LGBTQIA issues, special needs such as co-morbid BH and autism spectrum disorders or intellectual/ developmental disabilities. Six agencies report offering services to youth with substance use disorder needs. However, the community notes that there are no inpatient substance use disorder treatment options for youth in the region.

Veterans report that they must travel to Pierce County to find veteran behavioral health care options. This supports the concerns raised by forum participants about the distance, time, and lack of transportation options for this underserved population in Grays Harbor.

Three organizations report offering medication assisted treatment options in the County and another agency plans to open soon. Overall, the gaps regarding behavioral health care agencies and offerings appear to center around these key areas:

- A lack of available care in specific geographic regions such as Oakville and Ocean Shores,

- Lack of services that support historically underserved populations such as veterans, community members who speak Spanish, those who identify as LGBTQIA and communities of color such as the BIPOC community,
- Lack of specialty services for youth with comorbid neurocognitive disorders,
- Lack of psychiatry prescribing access (psychiatrists, advance practice practitioners) for adults and youth
- Lack of workforce to fill open behavioral health positions (see workforce section)

Workforce

Providers note that there is a significant shortage of behavioral health staff at all levels from administrative staff to peer support specialists, therapists and prescribing staff including psychiatrists and advance practice practitioners. When asked on the provider survey to indicate the top three greatest challenges their organization is facing to meet its goals for service access, delivery, and outcomes, **100% of respondents for whom the question was relevant selected "Available workforce" as the number one challenge**. When asked about the most significant challenge facing their organization today, 50% of providers responding to the survey identified one of the two workforce options (40% workforce recruitment and retention, 10% Recruiting and maintaining staff with needed experience and training in evidence-based models to support services).

The workforce issues stem from multiple root causes. One provider noted the need for “honest conversations regarding barriers to attract service providers to the region”. Some identified include low wages for these roles due to low reimbursement rates paid for the services provided, lack of available housing in the region, long hours, high caseloads, and a high level of administrative tasks/ burden associated with the work. Providers noted a need to address the workforce pipeline and support individuals who have a desire to stay within Grays Harbor to access the professional development and training opportunities to move forward in their careers, obtain necessary licensure, etc.

Stigma

Community members, first responders and social service agencies report a high level of stigma surrounding behavioral health care. It was noted that the stigma regarding substance use disorders is especially high in the community. This serves as a deterrent to community members who might like to seek treatment for these conditions but who fear risking negative consequences for identifying as someone who might need this kind of support or whose recovery journey is more complex. Providers noted a need for education around service delivery “that may reduce nimbyism.” “NIMBY,” or “Not In My Back Yard” is a term that is often used to describe the stigmatizing phenomenon of not wanting to have to see or experience an issue in one’s general vicinity.

Transitions of care

As noted in the BHASO crisis data, Grays Harbor is an outlier in its use of crisis services. Some of this stems from the lack of access to routine care, the lack of transportation to behavioral health care that is available in the region and the lack of emergency care for those who are in crisis. However, another factor that was identified is the lack of support for individuals after they have been seen in the emergency department or an inpatient unit for emergency behavioral health treatment. As one example, a provider noted:

> *{We need} more concentration on the prevention of escalations and stabilization after a crisis. We focus a lot on the actual crisis. Also, the perceived inability to share information with other stakeholders. I believe there is a way and have seen it work where they then discuss cases and make care plans.*

The Healthier Washington score card shows that Grays Harbor residents who are admitted to an inpatient unit have a slightly better than the state average chance of being seen for follow-up care. On the surface, this data is encouraging. However, because access to emergency care is an issue in Grays Harbor, the need for follow-up post crisis to support their connection to an outpatient provider becomes essential. The numbers of individuals who have become well known to the crisis system is a more relevant indication metric for the region. On this scale, Grays Harbor's crisis utilization metrics demonstrate that care transition support following a behavioral health crisis is a serious gap area.

Culturally, linguistically appropriate services and services targeted toward vulnerable populations

Community providers, social service agencies, first responders and community members note that there is a lack of specialty providers who support traditionally underserved populations such as black, indigenous, people of color (BIPOC), veterans, people who identify as lesbian, gay, bisexual, transgender, queer/ questioning, intersex and asexual (LGBTQIA), and people who speak Spanish. The healthy youth survey suggests that a segment of youth in the community would benefit from having access to behavioral health services that are sensitive to individuals who identify as LGBTQIA. Currently, community members who identify with any of these traditionally underserved population groups in the community must travel outside of Grays Harbor to access support services that are specially designed to serve their needs. This becomes a significant health disparity as there is limited to no access to affordable transportation to specialty community providers outside of the region.

Themes from Community

Stigma

In the forums the theme of stigma came up as a key theme. Members stated that there is a high degree of stigma regarding substance use disorders. Several community members shared that they felt uncomfortable seeking care in the small region due to shame and stigma associated with both mental health and substance use related conditions. For those who are unable to obtain transportation to other communities, this means that they choose to delay or avoid care until it becomes an emergency.

Youth services

Examples of youth service needs identified in community survey:

- *Mental health for autistic children. Ability to diagnose autism and other behaviors*
- *Available, affordable services for youth and families. Including group therapy, school services, and parent support*
- *More mental health support for our grade school, middle school, and high school students.*
- *More pediatric and youth mental health services, with integrated family supports and services.*

Community awareness of resources

Notably, when asked whether they would know where to go if they or their family member had a behavioral health need, 53% of community respondents indicated no. Community members shared the need for "accurate up-to-date information about where to go for what, where, when how" and the urgency for access to "knowledge on HOW to help someone, and where to go". In both the community survey and forum, community members identified the need for a routinely updated behavioral health resource hub.

Transportation

In the community forums, community members shared that people who live further away from the population centers of Grays Harbor have great difficulty accessing the behavioral health services that are mainly located in the regions that are more densely populated, such as Aberdeen. The lack of treatment providers in Oakville and Ocean Shores was noted as these areas are further away from established behavioral health care clinics and there is little to no available transportation for routine care in these areas.

Access

- *Families report having to drive several counties away to obtain specialized services for their children with these special needs.*
- *Easy scheduling or registration. Flexible hours.*
- *Accessible outpatient supports (more than just one day walk-in hours).*
- *Timely access to psychiatric care, the wait to see a psychiatrist in most, if not all, of our local mental health programs is incredibly long*
- *Mismatch in definition of "timely access"* – State defines timely routine access as within 14 days (about 2 weeks), community members expect access within a few days.

Workforce

The need for more behavioral health staff was cited frequently throughout the community survey, including a focus on a lack of providers for youth and those who can provide linguistically and culturally competent care for the range of Grays Harbor County residents.

Community survey respondents also noted concerns about their interactions with community providers, with multiple individuals noting the need for additional support for providers to become more trauma-informed and individuals noting experiences with providers where they felt a lack of caring, compassionate support. As mentioned in previous sections, potential for staff burnout is high which can affect quality of care

- *Agencies that provide consistent care - providers that stay.*
- *Long-term/stable work force (less turnover)*

Transitions of care

Several community members shared stories of family members being discharged from inpatient settings with little notice and few to no post hospital follow-up plans. Follow up from emergency department care was noted to be a gap when an inpatient bed cannot be found for a community member who needs this level of care, and they are sent home from the emergency department.

Culturally, linguistically appropriate services and vulnerable populations

- *Providers that can deliver culturally relevant services to the various communities in Grays Harbor (Latino and native for instance).*
- *Forum participants expressed the complete lack of counselors and behavioral health care providers that specialize in LGBTQ issues in Grays Harbor County.*

Considerations for Future State

Stigma

Stigma surrounding mental health and substance use disorders is infused in the beliefs and thoughts of community members and providers. As a result, efforts to reduce stigma need to be developed and

targeted to impact multiple stakeholders. These can be grouped into efforts with government leadership, providers, and community members. To address stigma, a shared basic knowledge and understanding of addiction and other behavioral health disorders such as chronic brain diseases is essential. Research has shown that changing the language used to address these conditions can reduce stigma, and these changes can be modeled throughout the community.

Encourage the dissemination of positive recovery stories from individuals who have used various pathways to recovery. During a provider forum, we learned that Summit Pacific produced a local documentary, highlighting the voices of people in recovery. Based on the number of times and the consistency of feedback about the negative impacts of and the pervasiveness of stigma in the community, through the surveys, forums, and key informant interviews, it is our recommendation that the community would benefit more of such programs. Additionally, Grays Harbor would benefit from a systemic approach to reducing stigma that includes training for every level of the community. This includes leaders and decision makers, providers and first responders and the community at large. By including targeted training for all members, Grays Harbor can develop shared understandings and language that begins to reduce the stigma associated with behavioral health conditions. This can have a positive impact on the community's willingness to fund, support and engage in behavioral health treatment that can prevent the overuse of crisis resources.

A few key resources to consider:

- Education, such as Addiction 101: Understanding the Biology of Addiction
- Words Matter

- Free CME/CE for professional on reducing stigmatizing language when talking about substance use disorders
- https://www.rcorp-ta.org/resources/anti-stigma-toolkit-guide-reducing-addiction-related-stigma
- https://www.rcorp-ta.org/sites/default/files/2020-02/Danya_Anti-Stigma_Toolkit_Updated_2020.v2.pdf

Youth services

Explore opportunities to increase the capacity of other child and family serving providers to integrate promotion and prevention activities to address gaps in access to behavioral health care for children and youth through existing workforce development structures in Washington.

Enhance partnerships with leading educational agencies to increase access to school-based mental health services.

- SAMHSA school-based mental health promotion – SAMHSA released multiple grant opportunities for supporting youth mental health in school-based settings (see **Appendix F** for details).
- Deeper dive into school-based mental health programming that is working well within Grays Harbor County

Community awareness of resources

Several opportunities exist to address the current experience of both professionals and community members that they are not aware of available resources in the community. In many cases there is a general knowledge that services are provided, but a detailed understanding is lacking.

- Development of a Community Resource Directory. Participants suggested this should include normal contact details, but also specific descriptions of services offered, included, and excluded populations of service, and details of how to begin accessing services. This directory could be available online and should include a mechanism for updating information.
- Currently there are multiple meetings with varying frequency and composition to allow providers to meet and coordinate services. A more formalized structured system of meetings to allow all interested providers to participate would likely increase participation and result in more structured outcomes.
- Community members specifically requested more resource fairs and events to help spread the word about available resources regarding basic needs and behavioral health resources.

Transportation

Difficulties accessing transportation was identified as a significant barrier to effective treatment throughout our analysis. Solutions to transportation ultimately involve uniting the patient with the needed resources, so can include efforts to bring services to the individual, such as telehealth, or improved efforts to provide options for transporting the patient to services.

- Expanded use of telehealth

- Mapping of existing services, with potential for enhancement (i.e., Coordination of public transportation to provide service from outlying areas with provider coordinated appointment times)
- Exploration of use of ride share apps such as Uber Health and Lyft Healthcare. Potentially this provides transportation and income potential
- Exploration of additional payment to patient's family or friend for transportation outside established Paratransit services
- Regular public interface through community forums to get feedback on the transit plans and long-range transportation plans
- Development of a public transit toolkit for providers and community members
- Access to secure transportation is another key issue that impacts first responders – currently, the transport of a person who is detained or who is on a police-hold pending evaluation for detention can only be done by police or ambulance. Adding to the toolkit for this level of care will require cross sector collaborations and changes in policies, regulations, and payment methodologies.
- Some additional resources that Grays Harbor County might want to consider include:
  - https://www.ruralhealthinfo.org/search?q=transportation
  - https://rupri.org/
  - https://www.ruralhealthinfo.org/search?q=transportation+innovation+Behavioral+health&s=Models+%26+Innovations

Access

Based on the analysis, access issues require a multipronged approach. Crisis care needs can be met with a variety of models including a Crisis Triage Center (with police and first responder drop off capabilities).

- Need to offer some behavioral health resources that are available beyond normal business hours for intake/ assessment
- Increased open access at multiple sites
- CCBHC Model that incorporates provider network
- Crisis Triage Center (with police and first responder drop off capabilities)

Access For Behavioral Health Emergencies:

Multiple communities both in and outside of Washington have developed crisis triage centers. These community resources include multiple components that would help close some of the biggest gaps that were identified in Grays Harbor. Triage Centers in Pierce County, Whatcom County and Snohomish County accept admissions from police and EMS via a drop off. These centers provide immediate assistance to people who are experiencing a behavioral health crisis that is serious but does not require hospitalization. Individuals are assessed, supported to stabilize, and connected to follow up resources as a part of their recovery journey.

Arizona and New Mexico have also used these types of crisis centers to help people avoid emergency department visits for behavioral health emergencies. This reduces the strain on emergency departments and offers a more conducive, less stigmatizing environment for people to engage in treatment for behavioral health conditions. An added benefit to first responders of these models is the "police/ first responder" drop off component. The models support quick warm handoffs for first responders who bring community members in need of crisis triage and stabilization. This allows first responders to return to the community to respond to other crisis situations quickly, while knowing that the individual is in a safe environment.

Another approach to the concept of having a centralized location or hub for behavioral health care in a community is the Certified Behavioral Health Centers (CCBHC). This SAMSHA funded model is designed to establish cooperative/ collaboration agreements between a main entity that provides key services and the supporting agencies that make up the network of comprehensive care. A recent webinar by the National Association of Counties described this approach as:

> "Counties are partnering with health care providers to establish crisis triage centers that offer in-person treatment and services to people experiencing a behavioral health emergency. These centers may offer short-term treatment, group and individual therapy, medical assessment, peer respite, medication administration and rehabilitation services, among other ongoing support options. In many counties, crisis triage centers are federally funded Certified Community Behavioral Health Clinics (CCBHCs) that provide integrated and evidence-based services to residents."[5]

Benchmarks:

In Washington
Snohomish County and Whatcom County https://www.compasshealth.org/services/crisis-triage-stabilization/
Pierce County https://www.piercecountywa.gov/5889/Crisis-Recovery-Center
Kitsap County https://www.kitsapmentalhealth.org/get-help/crisis-24-7-services/crisis-triage-center/
Yakima https://comphc.org/locations/crisis-triage-center-yakima/

In Other States
Arizona https://talk.crisisnow.com/wp-content/uploads/2021/06/19-The-Arizona-Model-of-Crisis-Receiving-Centers.pdf
South Dakota, Virginia, Minnesota https://www.naco.org/events/somewhere-go-during-behavioral-health-emergency-crisis-triage-centers-and-behavioral-health

[5] National Association of Counties Webinar: APRIL 4, 2022 https://www.naco.org/events/somewhere-go-during-behavioral-health-emergency-crisis-triage-centers-and-behavioral-health

Nevada https://westcarenevada.com/las-vegas-community-triage-center/
South Dakota & Minnesota: https://www.naco.org/events/somewhere-go-during-behavioral-health-emergency-crisis-triage-centers-and-behavioral-health

Access for Routine Behavioral Health Care

Grays Harbor has several options to consider in address in the need to increase access to outpatient care. These include potential solutions such as:

- Adding outpatient providers in Oakville and Ocean Shores
- Adding additional staff to existing agencies, particularly staff who bring cultural, linguistic and other kinds of diversity to the network.
- Working with providers to offer incentives for increased open access availability across the community – could consider having 1-2 access centers that are staffed by rotating agencies' staff to ensure that access is available throughout the week and at various times throughout the day
- Using an intake triage system that greets and screens intakes, then triages to application-based care platforms for low acuity needs, groups for moderate acuity and immediate one to one treatment for those with rising and higher acuity needs
- Increased integration of integrated behavioral health and primary care models to support primary care clinics in their work to treat mild to moderate behavioral health conditions via the Collaborative Care model.[6]
- Increased access to office based opioid treatment care in primary care
- Consider collaborating with BHASO, MCO's and other partners to develop value-based arrangements to incentivize the region to reduce use of crisis services with shared savings

Improved specialized Supports for addressing Methamphetamine Use

Based on the ADAI data, Grays Harbor has a need for increased specialized support for individuals who are dealing with substance use disorders associated with methamphetamine use. Supports that a 2021 National Institutes of Health[7] study recommend include:

- Cognitive behavioral therapy,

[6] National Institute of Health Care Management Webinar May 4, 2022
https://nihcm.org/publications/mental-health-solutions-improving-care

[7] NIDA. 2021, April 13. What treatments are effective for people who misuse methamphetamine? Retrieved from https://nida.nih.gov/publications/research-reports/methamphetamine/what-treatments-are-effective-people-who-misuse-methamphetamine on 2022, September 25
https://www.naco.org/events/somewhere-go-during-behavioral-health-emergency-crisis-triage-centers-and-behavioral-health

- Matrix Model,
- Contingency management interventions, which provide tangible incentives in exchange for engaging in treatment and maintaining abstinence
- Motivational Incentives for Enhancing Drug Abuse Recovery (MIEDAR), an incentive-based method for promoting cocaine and methamphetamine abstinence

Workforce

Behavioral Health workforce shortages have been an area of concern in Washington state for several years, particularly in rural communities. Post pandemic, workforce shortages are being seen nationally and across healthcare sectors. These shortages have impacts on access to care, quality outcomes and contribute to further burn out and turnover among those workers who remain and have to carry the caseloads and workloads of unfilled positions. There are several efforts in the state to address the shortages and build capacity in the behavioral health workforce. See Appendix: for links to reports from the Washington Workforce Board and a presentation that was given by the Board to the WA State Legislature in 2021. These reports list priorities that include advocacy recommendations and programmatic solutions such as building capacity for supervision of unlicensed, agency affiliated staff.

Local solutions can include:

- Developing partnerships to build training opportunities for students of technical, trade and colleges to learn about the behavioral health field through placements, internships and apprenticeships
- Work with local high schools to develop career fairs and events that share the benefits and rewards of working in social service fields
- Braid local, state, and federal funding and efforts on workforce development to build the talent pipeline within Grays Harbor
- Explore contracting for/ funding supervision options

Workforce Development Efforts in Washington
https://app.leg.wa.gov/committeeschedules/Home/Document/236520
https://www.wtb.wa.gov/wp-content/uploads/2021/12/BHWAC-Preliminary-Report-Final-Draft.pdf
https://socialwork.uw.edu/news/first-cohort-under-washington%E2%80%99s-behavioral-health-workforce-development-initiative-ready-fill
http://hca.wa.gov/assets/program/cybhwg-proposed-recommendations-2022.pdf
https://healthcareapprenticeship.org/bh-apprenticeships/
Initiatives in other states:
Oregon: https://www.oregon.gov/OHA/HSD/AMH/Pages/Workforce-Initiative.aspx
Utah: https://ruralhealth.health.utah.gov/behavioral-health-workforce-loan-repayment-program/
Massachusetts: https://www.mass.gov/news/the-commonwealth-invests-in-primary-and-behavioral-health-care-workers-across-

massachusetts#:~:text=MassHealth%20will%20repay%20loans%20for%20more%20than%20100,recruited%20to%20work%20in%20MassHealth%20Community%20Partner%20organizations.

Transitions of care

Follow up after crisis and support for those individuals who are leaving inpatient levels of care has been shown to reduce readmissions to emergency departments and to support individual connecting with the outpatient care that will improve their behavioral health outcomes. There are several programs that have been shown to have promising outcomes in this work, the Peer:

Transitions of Care Promising Practices
Peers in the Emergency Department – Pierce County (MultiCare and Greater Lakes 2015-2017)
Peers in the Emergency Department Massachusetts https://www.rizema.org/view-from-the-field-maximizing-the-impact-of-peer-support-in-emergency-rooms/
Emergency Response to Suicide Prevention program: https://www.hca.wa.gov/assets/program/fact-sheet-emergency-response-suicide-grant-2022.pdf
Peer Bridger program in Newy York: https://www.nyaprs.org/peer-bridger ;
Peer Bridger Program in Pierce County, WA: https://riinternational.com/listing/peer-bridgers-washington/

Culturally, linguistically appropriate services and vulnerable populations

There are several strategies that can be explored to address the lack of culturally and linguistically appropriate services that was noted by both providers and community members. Potential interventions include:

- Connect to workforce development efforts in WA to increase number of BIPOC providers.
- Explore additional opportunities for increasing the capacity for interpretation services.
- Investment in resource materials (particularly in resource hubs) in multiple languages.
- Add more diverse counselors to existing agencies in the region

Immediate/ Short term Options	Mid-term Options	Long Term Options
•Anti-stigma Campaign/ training for all levels of community •Resource Directory •Community marketing campaign and/or training on how to assess need and refer to resources •Increase resource and marketing material availability in other languages •Increase community fairs/ events to educate public about available resources •Engage in conversationsa nd partnerships re: building workforce pipeline •Build on momentum from BH Gap Assessment to engage providers, MCO's, BHASO and others in developing collaborative solutions- convene stakeholders in a series of solution building forums. •Learn about current efforts in WA State re: workforce development and rural workforce initiatives •Reach out to Office of Public Instruction to learn more about their plans for youth based mental health grant opportunities and potential collaborative efforts Grays Harbor can join. •Map gaps in behavioral health care for justice involved/ incarcerated individuals •Connect with Office of Public Instruction to learn about their plans for federal school based mental health support funding in the region	•Fund, support the development of a Peer Bridger/ Peers in ED/ ERSP program for care transitions •Develop and implement initiatives such as a transportation program, community resource navigator or Peer Bridger Program •Consider working with BHASO/ MCOs on value-based purchasing/ shared savings contracting to incentivize activites that reduce the use of ED and Crisis services •Fund/support the development of outpatient intake/screening center(s) - CCBHC model or something similar with co-located services to greet, screen, and refer •Add youth service capacity across the continuum •Support and incentivize a diverse workforce in terms of language, cultural background, and specialty services for vulnerable populations	•Crisis Stabilization/ Triage Unit •Advocacy re: loan forgiveness programs in WA State similar to Massachusetts, Utah and Oregon •Add behavioral health capacity to Oakville, Ocean Shores regions •Advocacy to increase availability and accessibility to actionable data such as access to care standards •Initiatives to increase workforce housing

APPENDIX A: Surveys

Grays Harbor Provider Survey

Please enter the name of your organization

Q1 Can we contact you for any follow-up questions?

- Yes
- No
-

Q1a Please provide contact information.

Q2 In what capacity are you responding to this survey?

- On behalf of a contracted Medicaid provider agency or organization that provides mental health, substance use treatment or both
- On behalf of a non-Medicaid mental health and/or substance use provider agency or organization
- On behalf of a free-standing evaluation and treatment center
- As an individual or independent mental health and/or substance use provider who may or may not accept Medicaid
- On behalf of a social or human services agency (e.g., housing, food, or other basic needs; care coordination)
- On behalf of an advocacy group (ex: NAMI)
- On behalf of a community of faith
- On behalf of a tribal entity
- On behalf of a veteran's service organization
- On behalf of a hospital without an inpatient SUD or psychiatric unit
- Other (Please specify) _____

Q3 What is your role with the above organization?

- Executive leader
- Program manager/director
- Other supervisory role
- Individual contributor (therapist, physician, case manager, peer, etc.)

Q4 What are your organization's funding sources? Select all that apply.

- Medicaid
- Medicare
- Commercial Insurance
- County or local government funds
- Tricare
- IHS/ Tribal/ Urban funds
- Discretionary/time-limited grants
- Endowment/other foundation support
- Other, please specify _____

Q5 What age groups does your organization serve? Select all that apply.

- Children 0 to 12
- Adolescents 13 to 18 years
- Young adults 19 to 24 years
- Adults 25 to 64 years
- Older adults 65 years or older

Q6 Please select the regions of the county that are "primary service areas" for your organization Primary service areas are places where you have largest concentration of services across the continuum. Please check all that apply.

- North Beach
- South Beach
- Central
- East County
- Other (Oakville, Amanda Park, etc.)
- Quinault Nation
- Confederated Tribes of the Chehalis Nation

The following questions focus on understanding your current service array, including the mental health services continuum, the substance use services continuum, allied community services and health care services, and other services offered (e.g., Evidence Based Practices). If a question set is not applicable to you and/or organization, please respond with "No" to offering said services and you will be directed to the next question set.

Q7 Does your organization offer mental health services?

- Yes
- No

Q8 Please check all that apply for ***mental health*** services currently offered within your organization. For service sites please enter a number as indicated.

	We do not offer these services anywhere (check if applicable)	Number of Unique Service Locations (provide number of sites)	This is a service we would like to offer and/or expand, but we experience barriers to doing so (check if yes)	Covered by our contracts with MCOs for Apple Health/ Medicaid	Covered by Medicare	Covered by our contracts with private insurance	Provided on a sliding scale
Therapeutic Adult Family Home							
Day Treatment/ Psych Rehab							
Peer Support Services							
Crisis Stabilization Program							

	We do not offer these services anywhere (check if applicable)	Number of Unique Service Locations (provide number of sites)	This is a service we would like to offer and/or expand, but we experience barriers to doing so (check if yes)	Covered by our contracts with MCOs for Apple Health/ Medicaid	Covered by Medicare	Covered by our contracts with private insurance	Provided on a sliding scale
Outpatient Psychotherapy							
School-based Behavioral Health Services							
Home-based Behavioral Health Services							
Dialectical Behavioral Therapy (DBT)							
Program for Assertive Community Treatment (PACT)							

	We do not offer these services anywhere (check if applicable)	Number of Unique Service Locations (provide number of sites)	This is a service we would like to offer and/or expand, but we experience barriers to doing so (check if yes)	Covered by our contracts with MCOs for Apple Health/ Medicaid	Covered by Medicare	Covered by our contracts with private insurance	Provided on a sliding scale
MH Case Management							
Therapeutic Foster Care							
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)							
Wraparound with Intensive Services (WISe)							

Q9 If applicable, please note any mental health services currently offered that were not listed above:

Q10 If you noted services above that your organization would like to expand but experience barriers to doing so, please provide more information below:

Q11 Does your organization offer ***substance use services***?

- Yes
- No

Q12 Please check all that apply for substance use disorder (SUD) services currently offered within your organization. For service sites please enter a number as indicated.

	We do not offer these services anywhere (check if applicable)	Number of unique service locations (provide number of sites)	This is a service we would like to offer and/or expand, but we experience barriers to doing so (check if yes)	Covered by our contracts with MCOs for Apple Health/ Medicaid	Covered by Medicare	Covered by our contracts with private insurance	Provided on a sliding scale
SUD Outpatient (OP) Therapy (ASAM 1.0)							
SUD Intensive Outpatient (IOP) Therapy (ASAM 2.1)							
SUD Partial Hospitalization (ASAM 2.5)							
SUD Clinically Managed Low-Intensity Residential (ASAM 3.1)							

	We do not offer these services anywhere (check if applicable)	Number of unique service locations (provide number of sites)	This is a service we would like to offer and/or expand, but we experience barriers to doing so (check if yes)	Covered by our contracts with MCOs for Apple Health/ Medicaid	Covered by Medicare	Covered by our contracts with private insurance	Provided on a sliding scale
SUD Clinically Managed Population-Specific High-Intensity Residential (ASAM 3.3)							
SUD Clinically Managed High-Intensity Residential (ASAM 3.5)							
SUD Medically Monitored Intensive Inpatient (ASAM 3.7)							
SUD Targeted Case Management							

	We do not offer these services anywhere (check if applicable)	Number of unique service locations (provide number of sites)	This is a service we would like to offer and/or expand, but we experience barriers to doing so (check if yes)	Covered by our contracts with MCOs for Apple Health/ Medicaid	Covered by Medicare	Covered by our contracts with private insurance	Provided on a sliding scale
Medication Assisted Treatment (MAT)							
SUD Certified Behavioral Health Peer Support Services (CBHPSS) - Adult							

Q13 If applicable, please note any substance use disorder services currently offered that were not listed above:

Q14 If you noted services above that your organization would like to expand but experience barriers to doing so, please provide more information below:

Q15 Does your organization offer ***allied community services*** (housing and food support, early childhood services, workforce development, etc.) or ***health care services*** (primary care, dental care, community health workers, etc.)?

- Yes
- No

Q16 Please check all that apply for allied community services or health services currently offered within your organization. For service sites please enter a number as indicated.

	We do not offer these services anywhere (check if applicable)	Number of unique service locations (provide number of sites)	This is a service we would like to offer and/or expand, but we experience barriers to doing so (check if yes)
Housing and Housing Support			
Shelter			
Food Bank			
K-12 Education or Educational Support			
Child Welfare			
Health Care Navigator/Community Health Workers			

	We do not offer these services anywhere (check if applicable)	Number of unique service locations (provide number of sites)	This is a service we would like to offer and/or expand, but we experience barriers to doing so (check if yes)
Primary Care			
Dental Care			
Spiritual or Faith-Based Support, Spiritual Counseling			
Veterans Services			
Advocacy			
Support Groups			
Clothing/Furniture/Other Basic Needs			

	We do not offer these services anywhere (check if applicable)	Number of unique service locations (provide number of sites)	This is a service we would like to offer and/or expand, but we experience barriers to doing so (check if yes)
Culturally Specific Services			
LGBTQIA-Focused Programming			
Tribal Support			
Senior Center or other Support for Older Adults			
Parenting Support			

	We do not offer these services anywhere (check if applicable)	Number of unique service locations (provide number of sites)	This is a service we would like to offer and/or expand, but we experience barriers to doing so (check if yes)
Supported Employment/Supported Education			
Acute Care Medical/ Emergency Department Services			

Q17 If applicable, please note any allied community services or health services currently offered by your organization that were not listed above:

Q18 If you noted services above that your organization would like to expand but experience barriers to doing so, please provide more information below:

Q19 What **Crisis Services** does your organization provide? (Check all that apply)

- None
- 24/7 crisis hotline services
- Walk in crisis center
- Co-responder with law enforcement/EMS
- Mobile crisis services
- Jail diversion
- Peer based crisis services
- 23-hour crisis stabilization unit
- Community crisis stabilization
- Crisis stabilization unit
- Emergency Department
- Other (please specify)

Q20 Please share any other services your organization provides that are not captured in previous sections. Check all that apply or describe in "Other":

- None
- Jail-Based mental health treatment
- Jail-Based SUD treatment (MAT, etc.)
- Mental health court (Diversion services)
- Drug court (Diversion services)
- Other diversion services (please specify)
- Use of technology such as treatment extender, screening support, case management outreach (please specify)
- Crisis Intervention Training
- Training in Evidence Based Practices
- Other Q21 Please indicate which evidence-based practices below are currently offered by your organization. Please select all that apply.
- None
- 5 A's for Tobacco Cessation
- Assertive Community Treatment (ACT)
- Behavior Activation (BA
- Crisis Intervention Training (CIT)
- Cognitive Behavioral Therapy (CBT)
- Cognitive Behavioral Therapy for Suicide prevention
- Community Reinforcement plus Incentives
- Collaborative Care Integrated Care
- Contingency Management/Motivational Incentives
- Dialectical Behavior Therapy (DBT)
- Electroconvulsive therapy (ECT)

- Eye Movement Desensitization and Reprocessing (EMDR)
- Coordinated Specialty Care (CSC)
- Functional Family Therapy
- Housing First
- Individual Placement and Support (Supported Employment)
- Integrated Dual Diagnosis Treatment Model
- Long-Acting Antipsychotic Injectables
- Living in Balance (LIB)
- Mapping-Enhanced Counseling (MEC)
- Matrix Model
- Medication Assisted Treatment (MAT)
- Mental Health First Aid Training
- Moral Reconation Therapy (MRT)
- Motivational Enhancement Therapy (MET)
- Motivational Interviewing (MI)
- Multi-systemic Therapy (MST)
- Nicotine Replacement Therapy (NRT)
- Parent Child Interaction Therapy (PCIT)
- PAX Good Behavior Game
- Positive Psychology
- Problem Solving Therapy
- Seeking Safety
- Solution Focused Brief Therapy
- Strategies for Self-Improvement and Change
- Supported Housing
- SBIRT - Screening Brief Intervention and Referral to Treatment
- Therapeutic Communities (TC)
- Thinking for Change
- Trauma Focused CBT
- Trauma Informed Approaches
- Zero Suicide Framework
- Other (please list)

Q22 If you are a primary care provider, please check which integrated services you provide (check all that apply in the continuum of integrated behavioral healthcare below):

- Not a primary care provider
- Screening of BH in primary care
- Co-located traditional psychotherapy in primary care
- Co-located psychiatric medication services in primary care
- Co-located MAT in primary care
- Fully integrated Collaborative Care

- We bill Medicaid Collaborative Care codes

Q23 If you are a Behavioral Health care provider, please check which integrated services you provide (check all that apply):

- Not a behavioral health care provider
- Primary Care screenings
- Hired Primary care providers
- Training of mental health and substance use staff in physical health conditions
- Training of mental health and substance use staff in care management/care coordination for physical health services
- Training of mental health and substance use staff on self-management for chronic health conditions such as diabetes, hypertension, etc.
- Physical health vitals as part of routine care in behavioral health clinics
- Care coordination or case management with physical health providers (activities such as shared treatment planning, communication and updates, and coordination of services)

Q24 What is the most significant challenge facing your organization *today*? (Select only one)

- Incomplete system or continuum of care
- Lack of collaboration with stakeholders
- Lack of enough peers to support outreach and engagement in services
- Lack of licensure status for service levels in demand
- Limited ability to use data to drive program decisions
- Limited staff with necessary experience and training in evidence-based models to support services
- Meeting the demand for services
- Recruiting and maintaining staff with needed experience and training in evidence-based models to support services
- Sustainable funding for service
- Waitlist/wait times to access programs and services
- Workforce recruitment and retention
- None
- I don't know
- Other _____

Q25 What are the barriers that you experience in accessing behavioral health care for the people you serve?

- Timely access to care (choice box- which of these areas is timely access a challenge- routine services within 14 days, emergent services within 24 hours)
- Lack of culturally and linguistically appropriate care
- Lack of veteran-specific services
- Lack of culturally responsive services for LGBTQIA+ people

- Distance
- Other_____

Q26 Please indicate the top THREE greatest challenges your organization is facing to meet its goals for service access, delivery, and outcomes. Select up to THREE options.

- Available workforce
- Lack of training in evidence-based treatments and strategies
- Inadequate training/preparation for emerging public mental health and/or substance use workforce
- Information sharing obstacles between Primary Care Providers and behavioral health providers
- Physical separation between Primary Care Providers and behavioral health providers
- Support from community stakeholders
- Payer reimbursement methodologies (FFS/bundled payment vs. value-based payment opportunities)
- Reimbursement administrative burden (prior authorization requirements, denials, and protests)
- Administrative burden for admissions and referrals
- Reimbursement rates for services
- Data collection and reporting capabilities
- Lack of electronic health record (EHR) or insufficient EHR capabilities
- I don't know
- Other _____

Q27 Please provide an estimate of current full-time equivalents (FTEs) of mental health and/or SUD clinical /treatment staff employed by your organization.

- None
- 1 to 5
- 6 to 10
- 11 to 20
- 21 to 50
- 51 to 100
- More than 100

Q28 What do you think would improve the behavioral health system of care in Grays Harbor?

Q29 Of these ideas, what would be the top 2 things that would have the most impact on behavioral health in Grays Harbor?

Q30 Please share any other thoughts or comments regarding the system of care for those in need of substance use and/or mental health services and supports in Grays Harbor.

Grays Harbor Community Survey

Demographics

Self

Zip Code_____

Age

- 13 to 18 years
- 19 to 24 years
- 25 to 64 years
- Older than 65 years
- Prefer Not to Answer

Gender Identity

- Woman
- Man
- Prefer Not to Answer
- Prefer to Self-Describe

Sexuality

- Heterosexual or straight
- Bisexual
- Asexual
- Queer
- Gay
- Prefer Not to Answer
- None of the Above, Please Specify

Race/Ethnicity

- American Indian or Alaska Native
- Black or African American
- Asian
- White
- Prefer Not to Answer
- Other

What is your primary language? _____

Have you ever served on active duty in the U.S. Armed Forces, military Reserves, or National Guard?

- Yes
- No
- Prefer Not to Answer

What insurance do you currently have?

- Medicaid
- Medicare
- Commercial Insurance
- Tricare
- No Insurance
- Other: Please Specify
- Prefer Not to Answer

This survey will include questions about your experience seeking behavioral health services for your child or adolescent. If you have this experience, please complete the questions below to provide a little more information about the child or adolescent for whom you have sought services.

Child (if answering on behalf of seeking behavioral health services for a child

Zip Code_____

Age bracket

- 0 to 12 years
- 13 to 18 years
- Prefer Not to Answer

Gender Identity

- Girl
- Boy
- Prefer Not to Answer
- Prefer to Self-Describe

Sexuality

- Heterosexual or straight
- Bisexual
- Asexual
- Queer
- Gay
- Prefer Not to Answer
- None of the Above, Please Specify

Race/Ethnicity

- American Indian or Alaska Native
- Black or African American
- Asian
- White
- Prefer Not to Answer
- Other

What is your child's primary language? _____

What insurance does your child currently have?

- Medicaid
- Medicare
- Commercial Insurance
- Tricare
- No Insurance
- Other: Please Specify
- Prefer Not to Answer

Experience with Accessing or attempting to access care

1. Have you tried to access Behavioral Health care in Grays Harbor (mental health/ substance use services) for yourself, a family member or a friend or neighbor? Select all that apply

Service	Myself	A Child or Family Member	A friend or neighbor
Mental health			
Substance use disorder treatment			
None			

2. If you or a family member had a behavioral health need (mental health or substance use services), would you know where to go or where to recommend that they go? Yes/ No

If Yes, sought services:

Rate your experience of the following items on a scale

	Disagree Strongly	Disagree	Neutral	Agree	Agree Strongly	N/A
I was able to find a provider in Grays Harbor						

I was able to be seen for non-emergency care within 2 weeks						
I was able to be seen for emergency care within 24 hours						
I was able to receive care from a provider who supported my cultural and language needs						
The care I received was appropriate considering my gender and sexual identity						
The care I received was appropriate considering any veteran specific needs						
I was satisfied by the quality of the care I received						

Access Timeline Questions:

If you received care for a mental health or substance use condition, how long did it take for you to receive a first service?

Service	Same Day	Within a week of request for service	1-2 weeks	More than 2 weeks
Mental health Routine				
Mental health Emergency				
Substance use disorder Routine				
Substance use disorder Emergency				

If you or your family member needed behavioral health care but did not receive care in Grays Harbor, please help us understand what the barriers to care were:

Check all that apply

- ○ Lack of transportation
- ○ Cost of care
- ○ Lack of providers who take my insurance
- ○ Lack of providers with specialized knowledge or experience
- ○ Lack of culturally appropriate providers
- ○ Lack of providers who speak my language
- ○ Distance/ travel needed to get to treatment
- ○ Wait time for care was too long
- ○ Previous bad experience with seeking care
- ○ Lack of available care for my age group
- ○ Lack of available care for my family member's age group
- ○ Lack of services that were appropriate for my gender or sexual identity
- ○ Lack of veteran's specific services
- ○ Lack of services that are tailored to American Indians and Alaska Natives
- ○ Stigma or discomfort with seeking care for BH condition
- ○ Concerns about quality of the services available to me
- ○ Concerns about confidentiality of sensitive health information
- ○ Other: please list_____

Overall Community

We would like to learn more about what behavioral health care services you or someone you know would benefit from having in our community:

Service	This is a service I or someone I know needs	Is this care available in Grays Harbor currently?
Mental health outpatient care	○	Y N Don't know
Substance use outpatient treatment	○	Y N Don't know
Detoxification/ withdrawal management	○	Y N Don't know
Inpatient psychiatric hospital	○	Y N Don't know
Residential treatment for substance use disorders	○	Y N Don't know
School based mental health treatment for youth	○	Y N Don't know
School based substance use treatment for youth	○	Y N Don't know

Other Please list: _____

Outside of your immediate family, are you aware of others in the community who would benefit from behavioral health but who do not seek care due to barriers? Y/N

If Yes, what prevents them from seeking care:

Check all that apply

- Lack of transportation
- Cost of care
- Lack of providers who take my insurance
- Lack of providers with specialized knowledge or experience
- Lack of culturally appropriate providers
- Lack of providers who speak my language
- Distance/ travel needed to get to treatment
- Wait time for care was too long
- Previous bad experience with seeking care
- Lack of available care for my age group
- Lack of available care for my family member's age group
- Lack of services that were appropriate for my gender or sexual identity
- Lack of veteran's specific services
- Lack of services that are tailored to American Indians and Alaska Natives
- Stigma or discomfort with seeking care for BH condition
- Concerns about quality of the services available to me
- Concerns about confidentiality of sensitive health information
- Other: please list_____

Ways to Improve Behavioral Health Care in Grays Harbor

1) What are the top three things that Grays Harbor needs in the community to support behavioral health (mental health and substance use)?
   _____

2) What is the most useful/ helpful behavioral health support in Grays Harbor right now? What is so helpful about this service _____

3) Is there any BH service, program or support that is deserving of recognition at this time? What is it and why? _____

4) Is there anything you have seen in another community that you would like to see in Grays Harbor – what is it and where is the program located? _____

Comments:

Is there anything else about the mental health and substance use disorder supports in Grays Harbor that you would like us to know? _____

_____

Are you interested in being contacted by a member of the Gap analysis team for follow up discussion regarding your answers? Y N

If yes – please share your name and contact information below:

Name: _____

Contact email/ phone: _____

APPENDIX B: List of Acronyms

Acronym	Meaning
ACH	Accountable Community of Health
AAC	Agency Affiliated Counselor
APP	Advanced Practice Practitioners (includes Advance Practice Nurses and Physician Assistants)
ACS	American Community Survey
ARNP	Advanced Nurse Practitioner
ASD	Autism Spectrum Disorders
BH	Behavioral Health (refers to both mental health and substance use disorder conditions and treatment)
BHASO	Behavioral Health Administrative Services Organization (entity that manages behavioral health crisis services for a region)
BIPOC	Black, Indigenous, People of Color
CCBHC	Certified Community Behavioral Health Center
CBO	Community Based Organization
CHA	Community Health Assessment
CHIP	Community Health Improvement Plan
DCR	Designated Crisis Responder
EBP	Evidence Based Practices
ED	Emergency Department
E&T	Evaluation and Treatment Center – licensed to treat people who have been detained for mental health care under the involuntary treatment act
HCA	Health Care Authority of Washington
HMA	Health Management Associates
IDD	Intellectual or Developmental Disabilities
ITA	Involuntary Treatment Act 71.05
LGBTQIA	Lesbian, Gay, Bisexual, Transgender, Queer/ questioning, Intersex and Asexual
LICSW	Licensed Independent Clinical Social Worker
LMHC	Licensed Mental Health Counselor
LMFT	Licensed Marriage and Family Therapist
MCO	Managed Care Organization
MH	Mental Health
MHP	Mental Health Professional
MAT	Medication Assisted Treatment
MOUD	Medications for Opioid Use Disorder
PA	Physician Assistants
PACT	Program for Assertive Community Treatment
PP	Promising Practices
SAMHSA	SAMHSA Substance Abuse and Mental Health Services Administration
SDoH	Social Determinants of Health
SUD	Substance Use Disorder
SWM	Secure Withdrawal Management facility (formerly known as detoxification treatment)
TAY	Transition Aged Youth
VA	Veteran's Administration
WISe	Wraparound with Intensive Services

APPENDIX C: Publicly available Behavioral Health Data Dashboard links

California:

https://dmhc.ca.gov/Portals/0/Docs/OPM/MY2020TAR.pdf
https://www.dhcs.ca.gov/dataandstats/reports/Documents/MC_Performance_Dashboard/MC-Performance-Monitoring-Dashboard.pdf
https://www.dmhc.ca.gov/Portals/0/Docs/DO/2021ARFinalAccessible.pdf

Hawaii:

https://www.hawaii.edu/news/2021/05/10/behavioral-health-dashboard/

APPENDIX D: Methodology Secondary Data Analysis and Dashboard

Publicly available data sets were obtained online for 2016-2020 American Community Survey (ACS) 5-Year Estimates. The ACS is one of the most frequently used public datasets for research about US population characteristics. Since the survey's introduction in 2005, it has become the standard publicly available data source for understanding neighborhood-level demographics. Data from the ACS survey is published annually.

Subscription-based market potential data sets were obtained using Esri's Community Analyst. Esri's market potential data provides information about the likely demand for specific services in an area. The data available through Community Analyst encompasses a wide variety of datasets that are updated quarterly, semiannually, and annually.

Behavioral health and Indian Health Service provider locations were obtained from Grays Harbor and HMA, respectively. Additional provider types were obtained online from HRSA Data Explorer.

Data visualization was performed with Tableau 2020.4 using geospatial maps, scatter plots, and comparison data tables.

Bivariate choropleth maps were created using a color encoding for every tract that represents two different, but related values, allowing to more easily evaluate how two attributes change with relationship to each other. Race and ethnicity categories were associated with the Medicaid population, excluding American Indians. The American Indian population is eligible for Indian Health Service; therefore, its relationship was evaluated with poverty instead of Medicaid.

Race and ethnicity for the population 20-64 years, Medicaid 19-64 years, and the population below poverty stratified by the American Indian population were categorized as "low", "medium", and "high" by placing an approximately equal number of tracts in each category.

With a bivariate choropleth map, the race and ethnicity for the population 20-64 years and Medicaid 19-64 years (or below poverty for the American Indian population) were visualized, combining both attributes and using colors to quickly spot areas where both attributes were "high" (the dark blue shade), where both were "low" (the lightest grey shade), or where one is "high" and the other is "low" (the bright blue or bright orange shades).

Scatter plots were utilized to display two attributes contrasted at the tract level allowing for the examination of their potential association and outliers.

Data tables were displayed to compare data across multiple geographies that include high-high tracts (the dark blue shade displayed on maps), Grays Harbor, Cowlitz County, and the Great River ASO group of counties excluding Grays Harbor. The Great River ASO counties include Cowlitz, Lewis, Pacific, and Wahkiakum.

Secondary Data Analysis and Dashboard

Two-variable choropleth maps display areas of high need at a glance.

- High-high tracts for American Indians and poverty were in Aberdeen, Taholah, and Oakville.
- High-high tracts for Blacks and Medicaid were in Aberdeen and Ocean Shores. There is only one provider in Ocean Shores.
- High-high tracts for Hispanics and Medicaid were in Aberdeen.
- High-high tracts for Whites and Medicaid were in Aberdeen, Ocean Shores, and Oakville. There is only one provider in Ocean Shores.

In general, scatter plots showed strong positive relationships between attributes at the tract level.

- American Indian and poverty were positively associated.
- Black and Medicaid were positively associated after removing a high outlier for the black population.
- Both White and Hispanic were positively associated with Medicaid.

Comparison tables provide an opportunity to examine high-high tracts benchmarked to Grays Harbor and other counties. Key differences between high-high tracts and Grays Harbor County overall were noted.

- American Indian high-high tracts have a higher population with no health insurance (difference 3.75%) and a lower percentage of vacant housing units (difference -5.1%).
- High-high tracts have a much lower black population percentage below poverty (difference -12.01%).
- Hispanic high-high tracts have a lower percentage of vacant housing units (-4.23%).
- In general, White high-high tracts were similar.

Appendix E Provider Survey Respondents

Community Integrated Health Services
Capital Region ESD 113
The Salvation Army of Grays Harbor
Behavioral Health Resources
Summit Pacific Medical Center
Harbor Include
Summit Pacific Medical Center
Community Integrated Health Services
Grays Harbor County Public Health
Grays Harbor County Public Health Children and Youth with Special Healthcare Needs
Women's Justice Circle / Circulo de Mujeres para la Justicia
Hoquiam, Aberdeen, and Cosmopolis Police Departments
Parents As Teachers/Smart Team/Children and Youth with Special health care needs
Grays Harbor College
Harbor Strong Coalition
Summit Pacific Medical Center
Grays Harbor EMS and Trauma Care Council
Harbor Alternate Living Association

Appendix F Federal Funding for Youth Behavioral Health Supports:

https://www.hhs.gov/about/news/2022/03/09/hhs-announces-nearly-35-million-strengthen-mental-health-support-children-young-adults.html

The Federal grant programs to support youth mental health care: ***SAMHSA***

- **Project AWARE (Advancing Wellness and Resiliency in Education):** This grant program develops sustainable infrastructure for school-based mental health programs and services. Grant recipients will build a collaborative partnership that includes the State Education Agency, the Local Education Agency, the State Mental Health Agency, community-based providers of behavioral health care services, school personnel, community organizations, families, and school-aged youth. This grant will fund up to $5.4 million from the American Rescue Plan over 5 years for up to three grant awards.

- **Garrett Lee Smith Campus Suicide Prevention (GLS):** This grant program enhances mental health services for all college students, including those at risk for suicide, depression, serious mental illness, serious emotional disturbances, or substance use. This grant program will fund up to $2.2 million, including $102,000 from the American Rescue Plan, over three years for up to 22 grant awards.

- **GLS State/Tribal Youth Suicide Prevention and Early Intervention Program:** This grant program supports states and tribes with implementing youth suicide prevention and early intervention strategies in schools and educational institutions, substance use and mental health programs, foster care systems, and other child- and youth-serving organizations. This grant program will fund up to $4.4 million over five years, including $3.7 million from the American Rescue Plan, for up to six grantees.

- **Statewide Family Network (SFN) Program: This grant program** enhances the capacity of statewide mental health family-controlled organizations (i.e., organizations where families help other families improve their lives) to support families and caregivers who are raising children, youths, and young adults with serious emotional disturbances. This program will serve as a catalyst for transforming mental health and related systems in states by strengthening coalitions led by family-controlled organizations, and between family members, policy makers, and service providers. This grant program will fund up to $1.6 million over three years for up to 13 grant awards.

- **Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (SED):** This grant program, also known as the System of Care (SOC) Expansion and Sustainability Grants, improves mental health outcomes for children and youth who have SED, from birth through age 21, and their families. This program will help create sustainable infrastructure and services that are required as part of the Comprehensive Community Mental Health Services for Children and their Families Program (also known as the Children's Mental Health Initiative or CMHI). The grant program will fund up to $10.4 million over four years, for up to 10 grantees.

- **The Community Programs for Outreach and Intervention with Youth and Young Adults at Clinical High Risk for Psychosis (CHR-P):** This grant program helps to identify youth and young adults no older than 25 who are at clinical high risk for psychosis and provide evidence-based interventions in a trauma-informed manner to prevent the onset of these conditions. The grant program will fund up to $7.2 million over four years, for up to 18 grantees.