An Analysis of Trends in Behavioral Health of Residents in Benton & Franklin Counties

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INSTITUTE FOR PUBLIC POLICY AND ECONOMIC ANALYSIS

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Executive Summary

Benton Franklin Health District (BFHD) participates in a local process to assess community wide health priorities in collaboration with a multitude of community partners. An important dimension of a Community Health Needs Assessment (CHNA) is the development of a Community Health Improvement Plan (CHIP) to address the issues identified through the CHNA. One of the primary health issues in the community as identified in the 2019 CHNA is behavioral health. This report includes activities related to addressing community behavioral health challenges, particularly those that were articulated at two Behavioral Health Forums in May of 2022. Bringing together representatives from community service providers, health care agencies, business partners, non-profit organizations, government agencies, and community members, these sessions were an opportunity to review relevant data and share unique perspectives in an attempt to identify current needs and gaps in community behavioral health.

Key findings from the behavioral health forums include:

- Significant workforce shortages, more services, more providers, more coordination across organizations and broader social supports are important behavioral health needs in the community today.

Key findings from the data presentation include:

- In adults and youth data alike, rates of mental health issues, substance use, and the need for treatment is undeniable. If left untreated, many of these issues can lead to higher rates of thoughts of suicide and reliance on substances.
- Suicide rates for the total population have grown increased slightly over past 25 years while youth suicides and attempts have likely grown over past 20 years. Depression in adults and youth alike are rising, and the rate of proscribing depression medication is growing, at least among the Medicaid population.
- On a positive note, there has been a steep drop in alcohol and marijuana usage in 10th graders, & rates of binge drinking in adults have slightly decreased.
- Opioid prescribing has declined steeply over past few years, although the lethality of the drugs appears to have climbed.
- Community protective factors declined to 50% in Benton County in 2021, which is 10% lower than WA benchmark. On the other hand, School and Family protective factors have shown overall increases through 2010-2021 in Benton County and WA.

Key findings from the survey of mental health providers include:

- Issues with insurance companies significantly impair the ability of providers to care for their patients.
- Survey respondents expressed a strong desire for more coordination across organizations to help reduce significant wait times they are currently experiencing.

1. The scope of the project

Benton Franklin Health District (BFHD) participates in a local process to assess community wide health priorities in collaboration with a multitude of community partners. A result of this process is a report called a Community Health Needs Assessment (CHNA). The goal is to determine what the greatest health needs are for the community in collaboration with all four healthcare systems in the region and the Benton Franklin Community Health Alliance. Having a current CHNA is required for BFHD to maintain national accreditation as a public health agency.

An important dimension of a CHNA is the development of a Community Health Improvement Plan (CHIP) to address the issues identified through the CHNA. The CHIP delegates all goals and strategies to various community partners involved in the process, providing accountability and metrics to measure health improvement. Specifically, the Benton-Franklin Community Health Improvement Plan (CHIP) is a three-year plan to address community health issues that were identified during the comprehensive Community Health Needs Assessment (CHNA).

One of the primary health issues in the community as identified in the 2019 CHNA is behavioral health. This report includes activities related to addressing community behavioral health challenges, particularly those that were articulated at two Behavioral Health Forums in May of 2022. Bringing together representatives from community service providers, health care agencies, business partners, non-profit organizations, government agencies, and community members, these sessions were an opportunity to review relevant data and share unique perspectives in an attempt to identify current needs and gaps in community behavioral health.

The following document is the result of this collaboration of community stakeholders and is organized as follows. The most important outcome of the forums was the identification of the top behavior health needs in the community. Participants were prompted at the start of the session and then again at the conclusion to articulate pressing behavioral health concerns through their individual lenses. A summary of the key discussions that arose is presented first. Next, relevant community behavioral health data is presented that was used to inform the discussions. Lastly, the results of an online survey of behavioral health providers is presented to provide insight into current behavioral health resources in the community and challenges they are facing.

2. Overview of the two convening sessions and outline of project

Two Behavior Health Forums coordinated by the Benton-Franklin Health District were held at the United Way Building in Kennewick, Washington on Tuesday, May 17, 2022 and Wednesday, May 25th, 2022. The purpose of the convenings of community stakeholders was to gather data to be included in the 2022 Community Health Needs Assessment (CHNA) and to inform the prioritization of goals, objectives and action steps in the 2023 Community Health Improvement Plan (CHIP). According to Kelly Harnish, a public health educator and co-facilitator of the forums along with Carla Prock, senior manager of Healthy People & Communities, Greater Kennewick, “The CHIP belongs to all of us, so your input in its formation will ensure that it’s a useful guide in our collective, ongoing work. We will continue to keep you informed and involved throughout the CHNA/CHIP process.”

Participants in the forums included representatives from a wide variety of groups including the police & fire departments, local medical centers, private health care providers, the city and county governments, government programs / agencies, local schools, financial institutions, charities and other non-profit organizations. A list of participants can be found in Appendix B.

The forums involved passionate, engaged members of the community who were willing to come to the table and talk about behavior health concerns from their unique experiences. As a result, during the forums, needs and gaps were identified, as were opportunities for changes at various levels. At both the start of the meetings and at the conclusion, participants were asked: "What is the top behavioral health need in this community?" Although comprehensive lists of answers are provided in Appendices C & D, there were five broad categories that responses fell into: (1) Workforce issues, (2) Need for more services, (3) Need for more providers, (4) Need for social supports and (5) Need for more co-ordination.

2.a. Workforce issues

A large number of participants reported that workforce shortages present a significant barrier to the delivery of behavioral health for the community. The economic disruptions of the global pandemic likely made the conditions worse. In particular, not only is there a shortage across a wide variety of positions, there is also a specific need for more bilingual and culturally matched providers.

Proposed solutions to the lack of qualified behavioral health workers included increased pay to help recruit and retain workers. Additionally, more training opportunities and continuing education to facilitate upward mobility of workers could be an option to better match employees with available positions. It was suggested that connections be made with new graduates to provide ongoing care. Eastern Washington University (EWU) has recently announced plans for a nursing program and with outreach, graduates could find employment in the greater Tri-Cities area starting in the next 2-4 years. Another proposal was to use peer mentors to a larger degree and to provide a route to certification of peer mentors and support for peer mentors who can assist existing behavioral health providers.

2.b. Need for more services

Recognizing that behavioral health includes a wide variety of conditions and treatments, participants expressed a desire for more specialized services. Numerous participants recommended that improved crisis response and care should be a priority. In particular, much of the concern was addressed toward youth to include more youth crisis resources and especially services and reach for youth who are no longer attending school and are thus unable to access school district services. An increasing area of concern was mental health support for gender transition therapy.

Some proposed solutions included more long-term inpatient facilities for youth as well as greater support for helping people transition out of institutions and become self-sufficient. An increased availability of psychiatric access and medications was also deemed a significant need for behavioral health in the community. Some concern was expressed for a place for

people with significant mental or behavioral health issues to be able to go during the day if they are not able to hold full-time employment. A community center that is capable of supporting people with mental / behavioral health conditions would be a welcomed addition to the community.

2.c. Need for more providers

Closely related to issues of workforce shortages and the need for more services is the need for more behavioral health providers. EMS reported that oftentimes they needed some place to take people with behavioral health issues rather than to jail. As evidence of the need for more providers, there was a consensus that wait times are already very long and getting longer. For individuals and/or families who use Medicare / Medicaid or Apple Health, it is even harder to find providers. Although the recent global pandemic forced many providers to rely on telehealth as a means of health care delivery, many participants were concerned that access to the technology necessary for telehealth participation might exclude people from getting the behavioral health care they need. Lastly, participants recommended that there be more prescribers of mental health medications in particular.

2.d. Need for social support

Other pressing needs for behavioral health in the community included community education and increased awareness to reduce the stigma for those with mental illness and to possibly recruit new workers into the field. Not only do families of people with mental illnesses need support systems and services, but by having community support organizations already in place, some behavioral health issues might be prevented. Data is provided later in the report on these community preventative factors. Widespread knowledge of where to get counseling, especially for domestic violence survivors and grief counseling, might serve to prevent individuals from needing other types of behavioral health care down the road.

Overall, participants felt that if there were more affordable childcare, improved access to healthy food, and access to safe and affordable housing, that people in the community would have improved levels of behavioral health.

2.e. Need for more coordination

Participants at both convenings shared a sentiment that because behavioral health is so important, it requires a great deal of coordination across various organizations throughout the community. Suggestions were made for improved coordination to achieve efficiency gains and to make access to care more widely known. In particular, it was suggested that there be better coordination between primary care and behavioral health providers when “handing off” clients. Overall, the development of a collaborative network of resources, referrals and case management would improve community behavioral health.

Specific solutions proposed including using integrated health care whereby behavioral health providers would work with other medical providers, such as primary care doctors, in devising optimal health care plans for individuals. Record-keeping would be coordinated so as

to be accessible to all providers for an individual. Also, participants desired a resource guide that lists all of the various providers in the community and the types of services provided so patients can be directed to appropriate providers in a more efficient manner.

3. Presentation of behavioral health data from Washington's Healthy Youth Survey (HYS)

3.a. Description of Washington's Healthy Youth Survey (HYS)

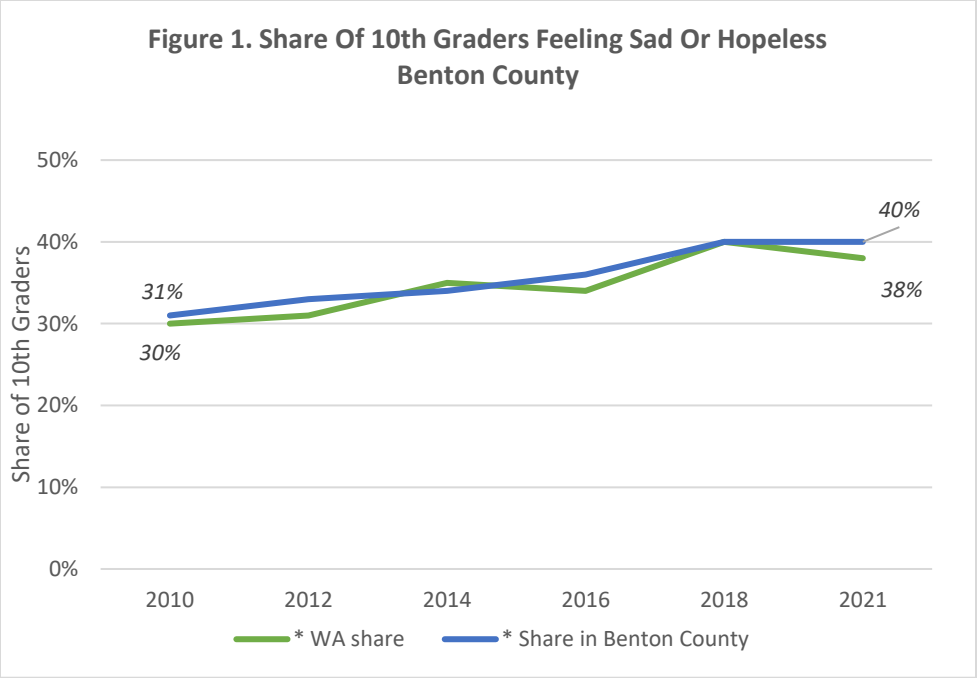
The Healthy Youth Survey (HYS) is a collaborative effort of the Office of the Superintendent of Public Instruction, the Department of Health, the Health Care Authority - Division of Behavioral Health and Recovery, and the Liquor and Cannabis Board. The Healthy Youth Survey provides important survey results about the health of adolescents in Washington. County prevention coordinators, community mobilization coalitions, community public health and safety networks, and others use this information to guide policy and programs that serve youth.

Every two years Washington State asks public school students in grades 6, 8, 10 & 12 to complete a survey which asks about their physical, and mental health as well as drug and alcohol use. Sarah Mariani, of the Washington Healthcare Authority, one of the agencies behind the survey, says the survey is a snapshot into the well-being of Washington's middle and high school students.

One of the limitations of the survey results is that not all school districts are required to have their students participate in the survey. In the case of Franklin County, this meant that results were not reported because of a lack of participation by all the school districts. Therefore, the HYS results that follow are from Benton County only. For purposes of analysis, only 10th grade results are presented here. Full results for middle school students (grades 6 & 8) as well as 12th graders can be found at the HYS website: https://www.askhys.net/

3.b. Depression in 10th Graders

Turning first to data on the youth population of the community, we see that 10th graders are feeling sad or hopeless at an increasing rate compared to over a decade ago. This indicator asks students if they are experiencing feelings of sadness, helplessness and hopelessness that lingers over time. If untreated, this could lead to alcohol abuse and even suicide.

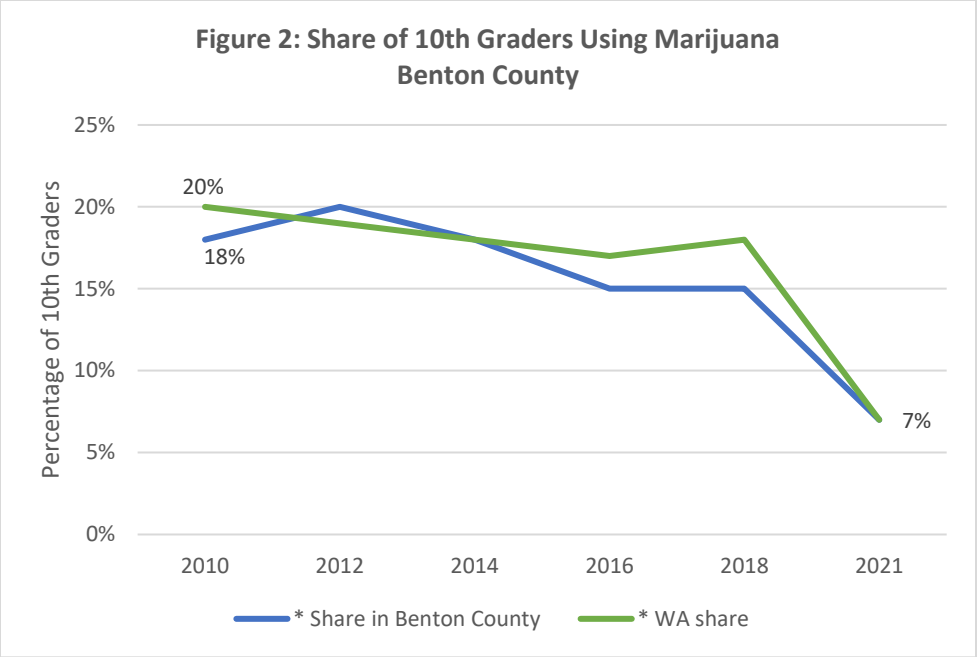


Source: [Healthy Youth Survey, Washington]

As the graph shows, depression in 10th graders in Benton County as well as across the state on average has been trending upward from about three out of every ten students to three out of every eight students.

3.c. Marijuana Use by 10th Graders

Another question asked of current 10th grades is about their use of marijuana. This graph represents the share of students are who currently and regularly using marijuana. Current marijuana use is defined as the past 30 days. Washington state was one of the first states to legalize the use of recreational marijuana and in doing so there were concerns that this might increase access for youth. However, as the results of the Healthy Youth Survey report, there has been a steep drop in the share of 10th graders reporting current and regular marijuana use since 2010 – for both Benton County and the state overall. The share of Benton County 10th graders who are current, regular marijuana users has fallen from 18% to 7% -- matching the state average in 2021.

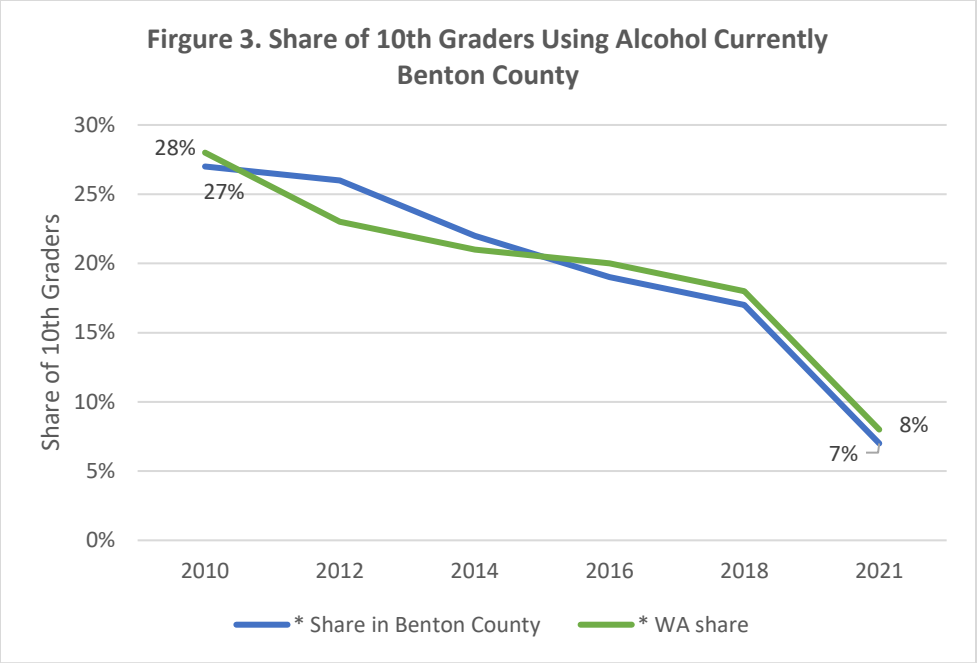


Source: [Healthy Youth Survey, Washington]

Although the drop off in marijuana use by 10th graders signals an improvement, it could be that teenagers are turning to other recreational drugs, perhaps even more deadly ones like opioids. Data on opioid use and tobacco use / vaping is provided later.

3.d. Alcohol Use by 10th Graders

Like marijuana, alcohol sales in Washington state are restricted to adults over the age of 21. However, that does not stop alcohol from falling into the hands of minors. According to data collected in the Healthy Youth Survey, the share of 10th graders who currently and regularly drink alcohol has been falling for both Benton County and the state more broadly. Some of the significant decline between 2018 & 2021 could be due to stay-at-home restrictions and the move to remote learning for many students during the pandemic. With both parents and students learning and working from home, access to alcohol for minors was likely more restricted.



Source: [Healthy Youth Survey, Washington]

4. **Presentation of behavioral health data from Behavioral Risk Factors Surveillance System (BRFSS)**

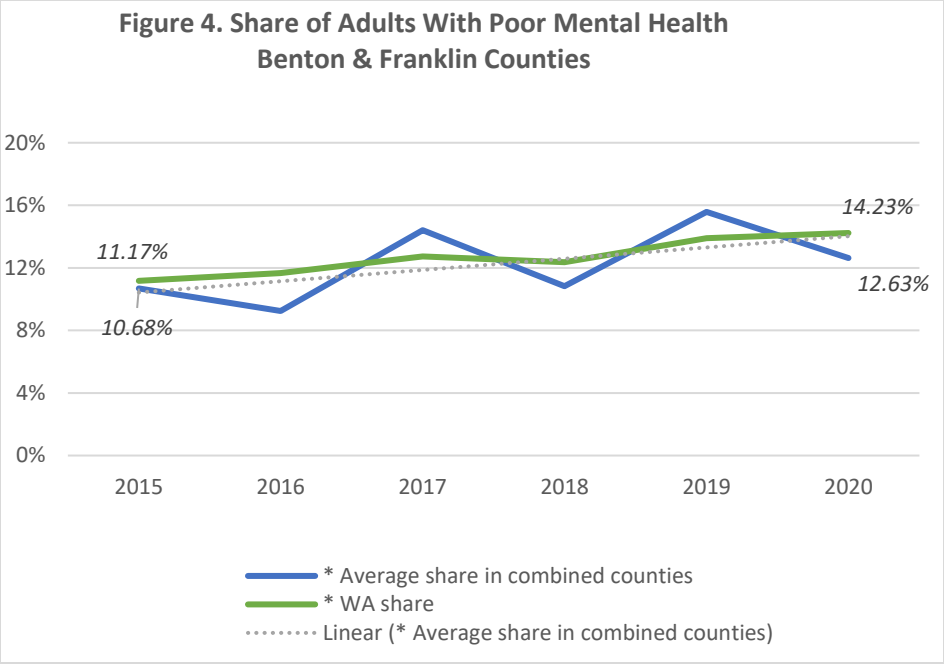
4.a Description of BRFSS data and collection

The Behavioral Risk Factor Surveillance System (BRFSS) conducted by the Centers for Disease Control (CDC) is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. Established in 1984 with 15 states, BRFSS now collects data in all 50 states as well as the District of Columbia and three U.S. territories. BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world. By collecting behavioral health risk data at the state and local level, BRFSS has become a powerful tool for targeting and building health promotion activities.

CHAT provides a secure, online query system for population health-based data sets maintained by the Washington State Department of Health. The tool allows users to conduct analyses for community health assessment. CHAT contains detailed information on a series of topics with statistics related to the data topic. The data topics in CHAT cover a variety of Washington state population health-based datasets that include county and statewide results of surveys through BRFSS. For purposes of analysis, the results of both Benton & Franklin county were aggregated.

4.b. Adult Poor Mental Health

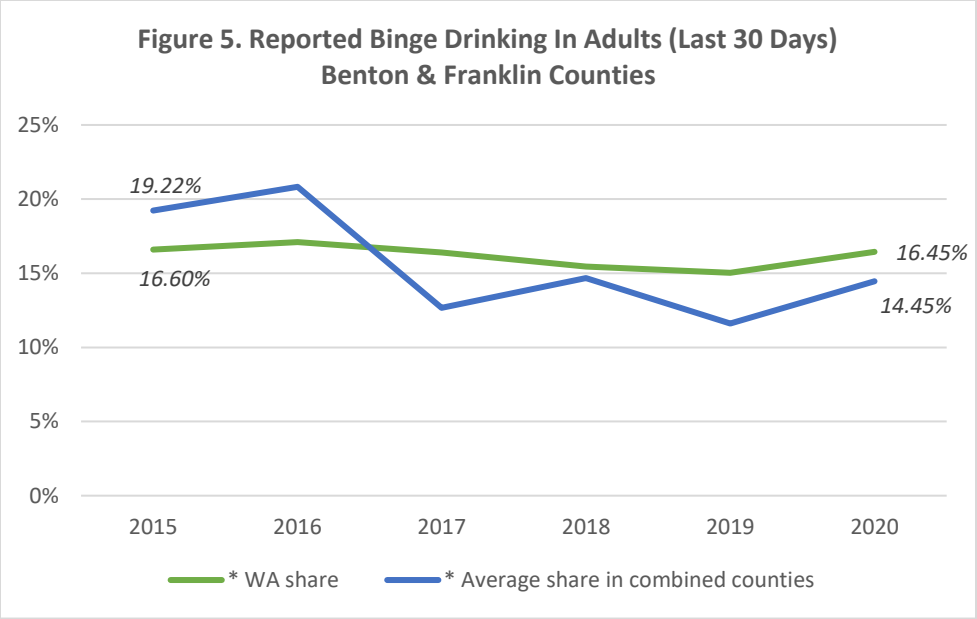
This indicator measures the share of adults who have reported having difficulty managing thoughts, emotions or actions for at least 14 out of the prior 30 days (previous month). The combined counties have seen a slight uptick over the past five years in the share of adults reporting poor mental health from approximately one in nine adults to one in eight adults. Washington state, on average, also increased, albeit at a slightly higher rate.



Source: [Community Health Assessment Tool (CHAT), Washington Department of Health]

4.c. Adult Binge Drinking

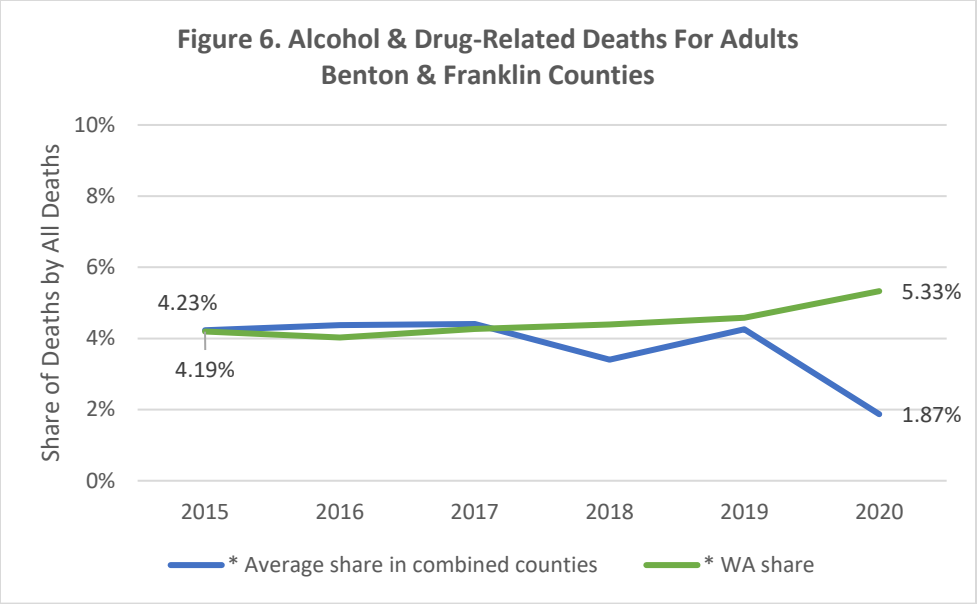
This measure of behavioral health reports the share of males who have consumed five or more alcoholic drinks or females who have consumed four or more drinks on one occasion in the past 30 days. Since 2015, binge drinking has fallen from about 19% to 14% in the combined counties. Not surprisingly, there was a slight increase from 2019 to 2020 perhaps due to the challenges of the global pandemic and more people working remotely with greater access to alcohol during the typical workday. Since 2015, the state average has remained flat at around 16% so that currently the greater Tri-Cities has a lower level of adult binge drinking than the state, on average.



Source: [Community Health Assessment Tool (CHAT), Washington Department of Health]

4.d. Alcohol & Drug-Related Deaths

This measure of behavioral health includes all alcohol-related deaths from dependent and non-dependent use of alcohol, as well as accidental poisoning by alcohol. Drug-related deaths are deaths from illegal and legal drug usage. Total deaths from alcohol and drug use is expressed as a share of all deaths. In 2015, alcohol and drug-related deaths made up around 4% of all deaths across the state as well as across the combined Benton & Franklin Counties. From 2015 to 2019, this share of all deaths remained flat until 2020 when there was a sharp drop to around 2%. Some of this could be the result of Covid-19 restrictions that saw more people staying close to home and not frequenting places where large amounts of alcohol might be consumed. Also, in staying closer to home, access to recreational drugs was likely restricted as well. Surprisingly, the state share of alcohol and drug-related deaths increased slightly by one percentage point. It will be interesting to see what the most recent survey results show for 2021 as they would likely reflect a return to a new normal with less restrictions due to Covid-19.



Source: [Community Health Assessment Tool (CHAT), Washington Department of Health]

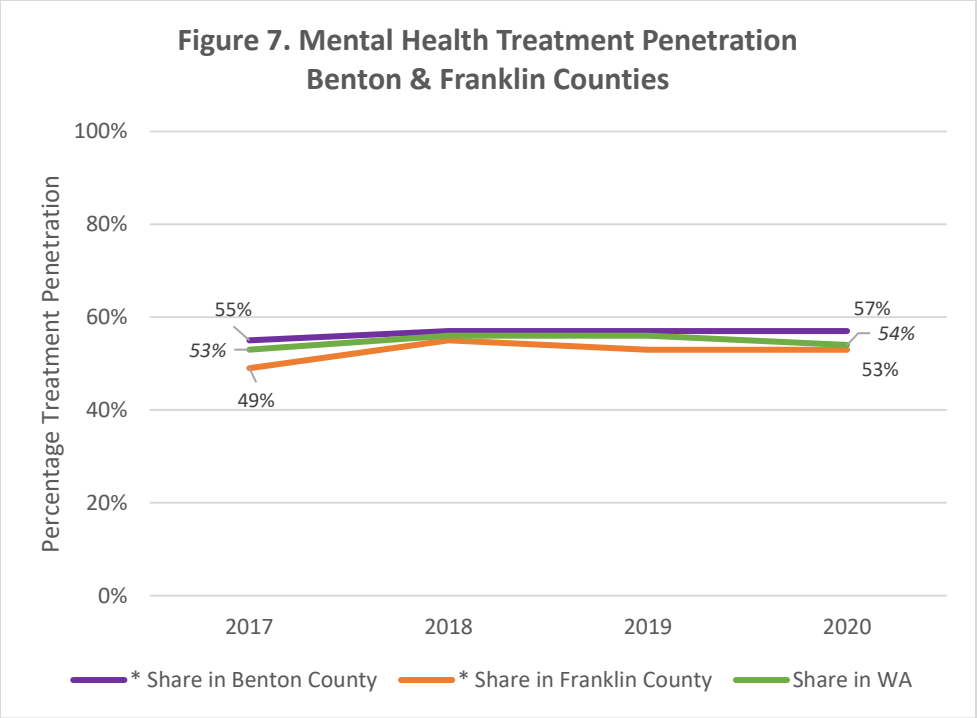
5. Presentation of behavioral health data from WA Health Care Authority

The Washington State Health Care Authority (HCA) is committed to whole-person care, integrating physical health and behavioral health services for better results and healthier residents. HCA purchases health care for more than 2.5 million Washington residents through Apple Health (Medicaid), the Public Employees Benefits Board (PEBB) Program, the School Employees Benefits Board (SEBB) Program, and the COFA Islander Health Care Program. As the largest health care purchaser in the state, the HCA leads the effort to transform health care, helping ensure Washington residents have access to better health and better care at a lower cost.

5.a. Mental Health Treatment Penetration (Medicaid Population)

The following measures of behavioral health reflect data from the Washington Health Care Authority and specifically assess the Medicaid population. Mental health treatment penetration for the Medicaid population is defined as the percentage of Medicaid beneficiaries (6 years and older) with a mental health service need identified within the past two years who received at least one qualifying service during the measurement year.

Figure 7 shows the data for Benton & Franklin Counties, separately, as well as the state average for Washington. All three jurisdictions have not seen significant change since 2015 and just over half of all Medicaid beneficiaries ages 6 and older who have a mental health service need in the past two years have received at least one qualifying service during the measurement year.

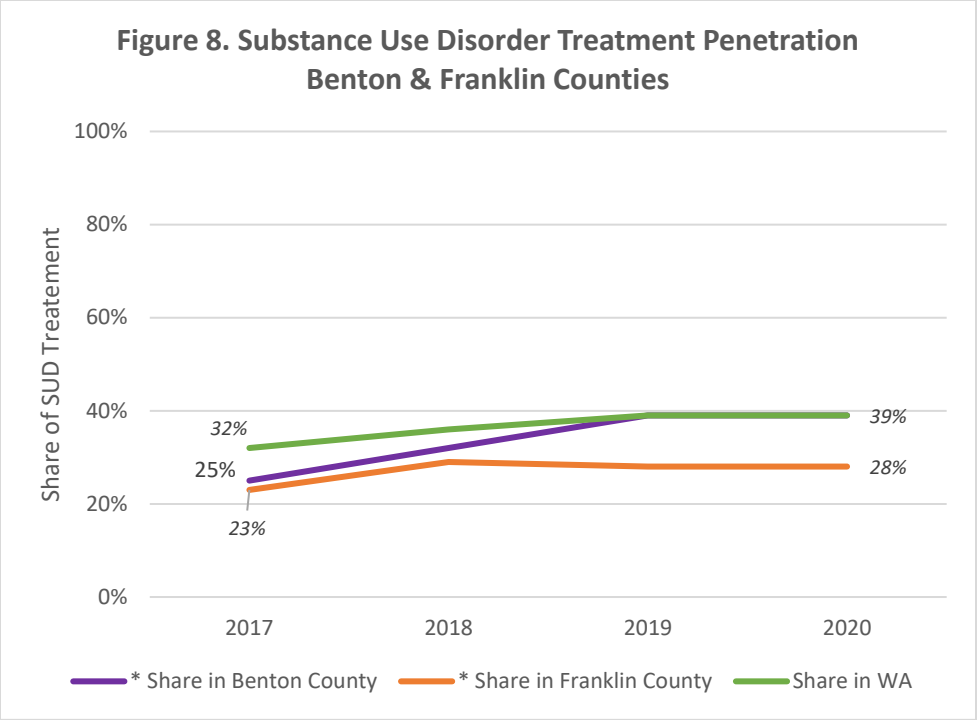


Source: [Washington State Health Care Authority]

5.b. Substance Abuse Disorder (SUD) Treatment Penetration

Treatment penetration for Substance Abuse Disorder (SUD) for Medicaid beneficiaries (12 years and older) is measured as patients with a substance abuse disorder need identified in the past two years who received at least one qualifying substance use disorder treatment during the measurement year.

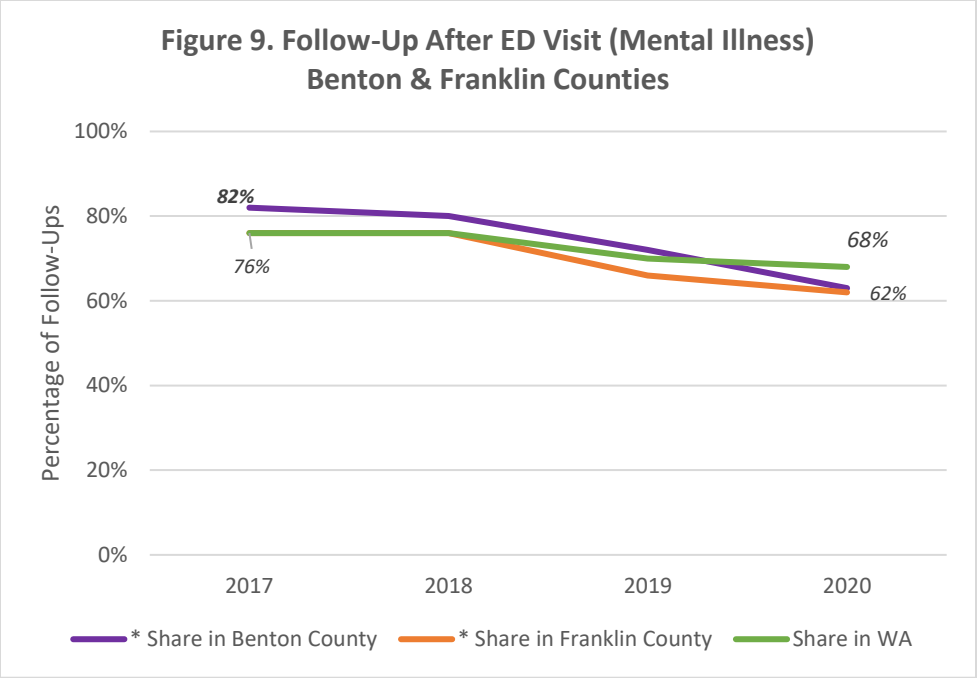
Both Benton & Franklin Counties have seen a slight increase in treatment penetration for SUD for Medicaid patients 12 years and older. However, whereas both counties had similar penetration rates of about one-in-four in 2015; since then, Franklin County has increased by more than Benton County and currently matches the state average of nearly 40%. In 2020, Benton County's penetration rate was lower at only 28%.



Source: [Washington State Health Care Authority]

5.c. Follow-Up After Emergency Department Visit for Mental Health

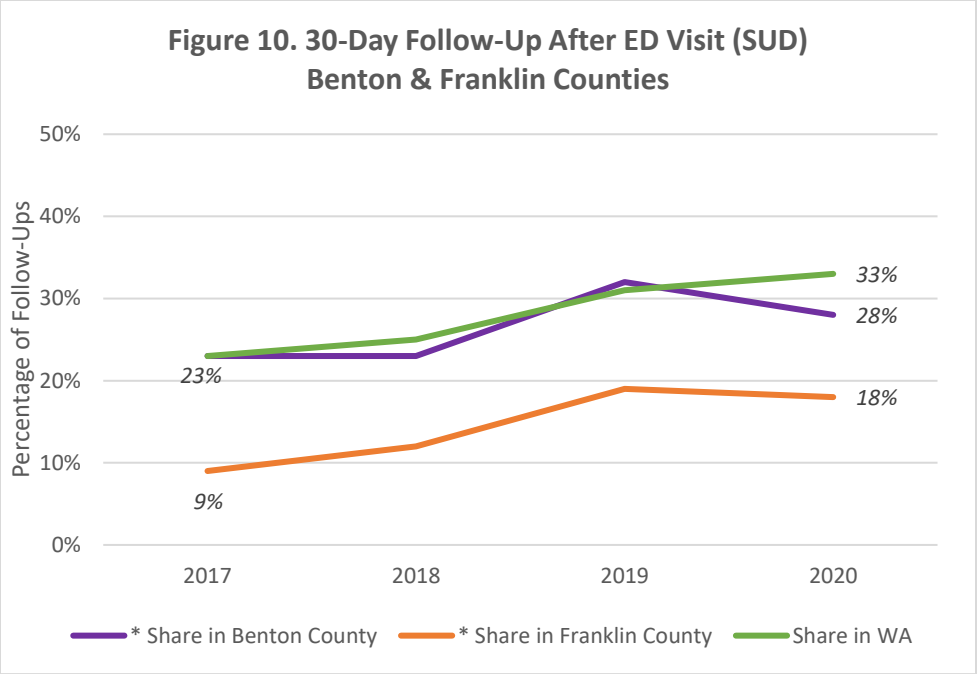
The share of Medicaid patients (over six years old) who visited an emergency department with a diagnosis of mental illness and who received a follow-up visit for a mental illness within 30 days is shown in Figure 9. Since 2017, both Benton & Franklin Counties have seen a drop in the share of Medicaid patients with a mental illness who received a follow-up visit after an emergency department visit. Whereas over three-fourths of patients received a follow-up visit in 2017, by 2020, the share had dropped to three out of every five patients. Currently, both counties are slightly below the state average of two-thirds.



Source: [Washington State Health Care Authority]

5.d. Follow-Up After Emergency Department Visit for Substance Use Disorder (SUD)

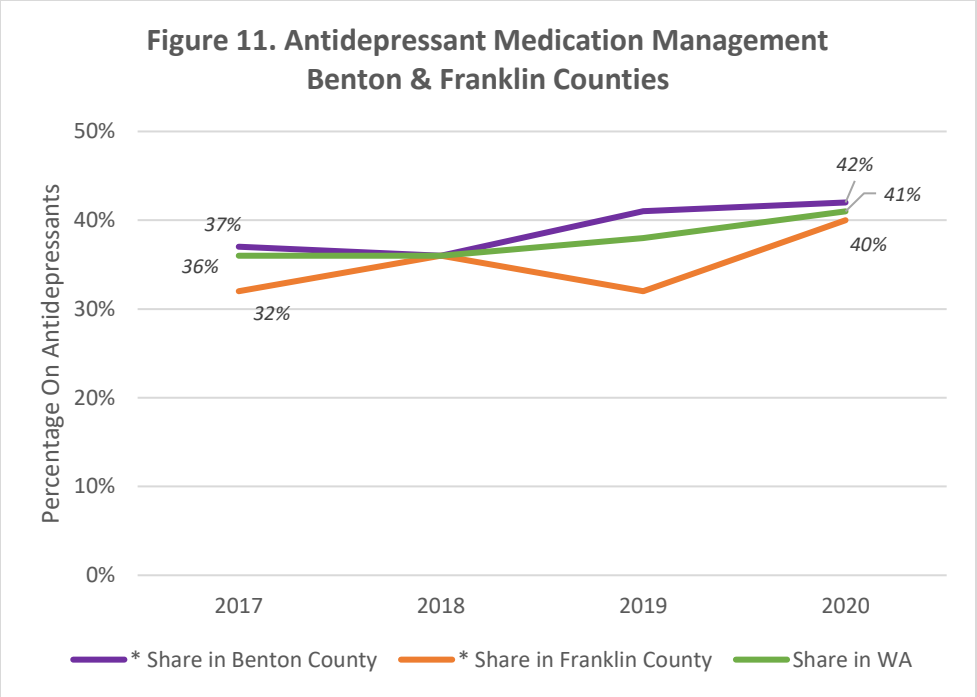
This indicator is much like the previous one and considers only the share of Medicaid patients (18-64) who visited an emergency department with a diagnosis of SUD and who received a follow-up visit for SUD within 30 days. Since 2017, Franklin County has seen the most progress, doubling their rate from 9% to 18%, although this is still below both Benton County and the state average. Benton County has trended much more closely to the state average increasing from 23% to 28%. Presently the state average is 33%.



Source: [Washington State Health Care Authority]

5.e. Anti-Depressant Management

This indicator measures adult Medicaid beneficiaries who remain on antidepressant medication for at least 180 days. Since 2017, both counties, as well as the state overall, have seen an increase in sustained use of antidepressant medication. Presently, around 40% of all Medicaid patients remain on their antidepressant medications for at least 180 days.



Source: [Washington State Health Care Authority]

6. **Presentation of behavioral health data from WA Department of Health**

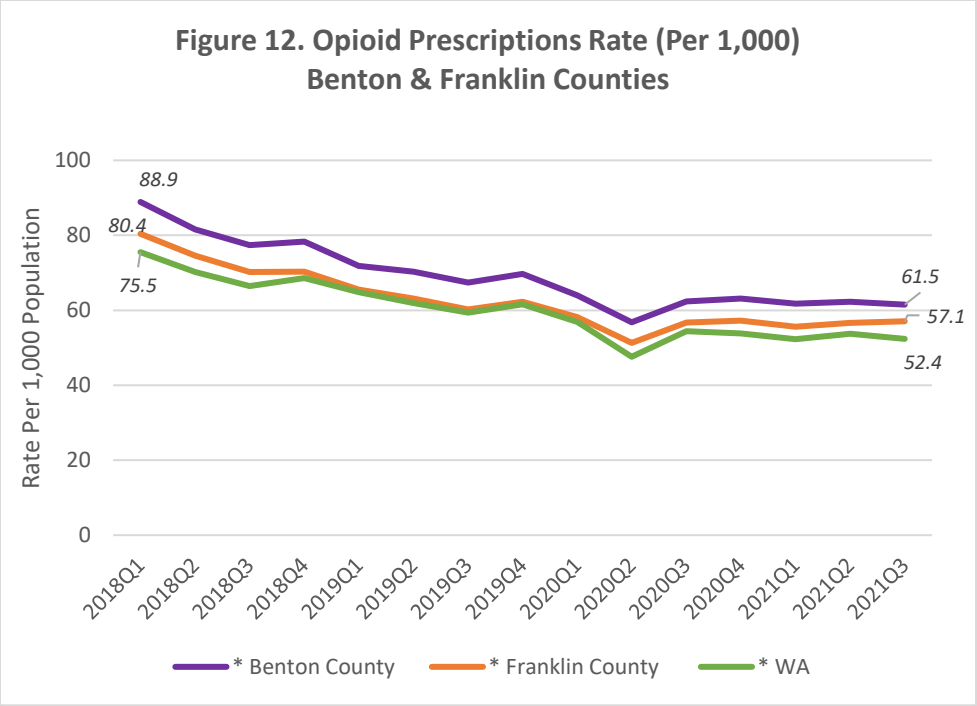
6.a. Description of drug & opioid data

Opioids-- including prescription pain medication, heroin, and synthetic opioids such as fentanyl—are causing a serious public health and community crisis across the nation. Each day about two people die of an opioid-related overdose in Washington; thousands more struggle with addiction. Opioid misuse and addiction can cause serious medical, social and financial problems.

The Department of Health is joining with partners across the state to implement a State Opioid Response Plan (PDF) focusing our efforts on four priority goals: Prevent opioid misuse and abuse - Identify and treat opioid use disorder - Prevent deaths from overdose - Use data to detect opioid misuse/abuse, monitor illness, injury and death, and evaluate interventions.

6.b. Opioid Prescription Rate

In response to the opioid crisis in Washington State and across the country, the legislature directed five prescribing boards and commissions to develop and adopt new opioid prescribing requirements. Prescription opioids are used to block pain signals between the brain and the body and are typically prescribed to treat moderate to severe pain. This graph shows the rate of opioid prescriptions per 1,000 population in Benton & Franklin Counties benchmarked against Washington State.

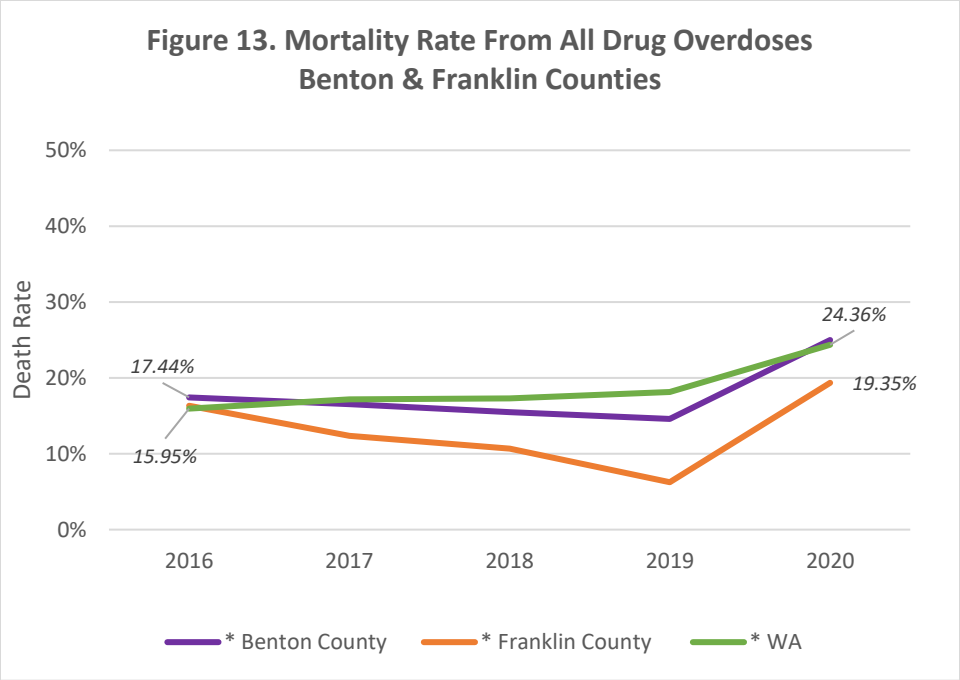


Source: [Washington State Department of Health, Opioid Data]

As seen in Figure 12, since 2018, the opioid prescription rate for both Benton & Franklin County as well as for the state average has been falling in response to state policy actions. Benton Franklin has seen nearly a 30-point drop (from 90 prescriptions per 1,000 people to only 60 prescriptions per 1,000 people) over 3.5 years. Franklin County has fallen from 80 prescriptions to nearly 50 prescriptions per 1,000 people. Both counties are above the state average, but have trending the same as the state.

6.c. Drug Overdose Deaths

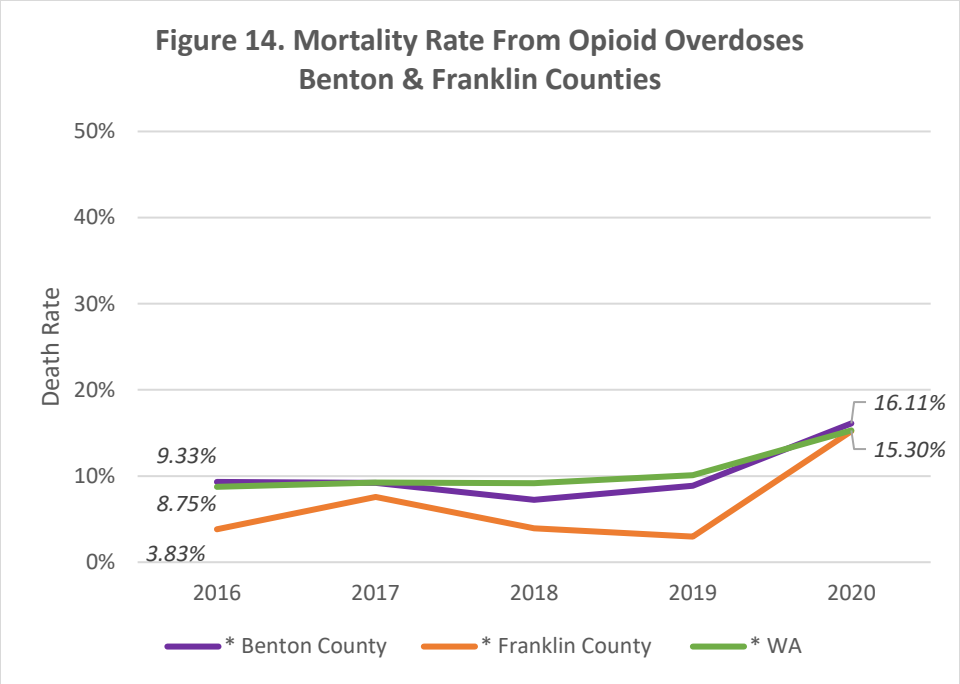
The Washington Department of Health tracks data on drug overdose deaths as a percentage of all drug overdoses. This captures the probability of an individual dying from a drug overdose. From 2016 to 2019, the state average mortality rate from all drug overdoses stayed relatively unchanged between 17-18%. During that same time period, Franklin County saw an improvement from 16% to under 10% in 2019 while Benton County only improved slightly by about 1 percentage point. The effect of the global pandemic caused a sharp increase in both counties and the state overall as well. As communities return to a new normal post-Covid environment, it is possible the mortality rate from all drug overdoses will drop slightly.



Source: [Community Health Assessment Tool (CHAT), Washington Department of Health]

6.d. Opioid Overdose Deaths

Turning specifically to opioid overdose deaths, this graph shows the mortality rate of opioid overdoses as a percentage of all drug overdoses. This shows the probability of an individual dying from opioid overdoses compared to all other drug overdoses. Since 2016, Benton Franklin has trended right along with the state average, remaining flat at around 10% -- implying that one in ten drug overdoses was due to opioids. In 2019, the rate spiked slightly to over 15% due to the pandemic. In 2016, Franklin County saw fewer opioid deaths as a percentage of all drug overdose deaths than Benton County or the state as a whole, with an opioid mortality rate of only 4% of all drug overdose deaths. However, the pandemic had a stronger impact on Franklin County. By 2020, the Franklin County rate of opioid overdose deaths as a percentage of all drug overdose deaths had converged with both Benton County and the state at around 15%.



Source: [Community Health Assessment Tool (CHAT), Washington Department of Health]

7. Presentation of behavioral health data from Benton Franklin Trends

7.a. Description of Benton Franklin Trends

Two measures of behavior health outcomes are tracked at [Benton Franklin Trends].

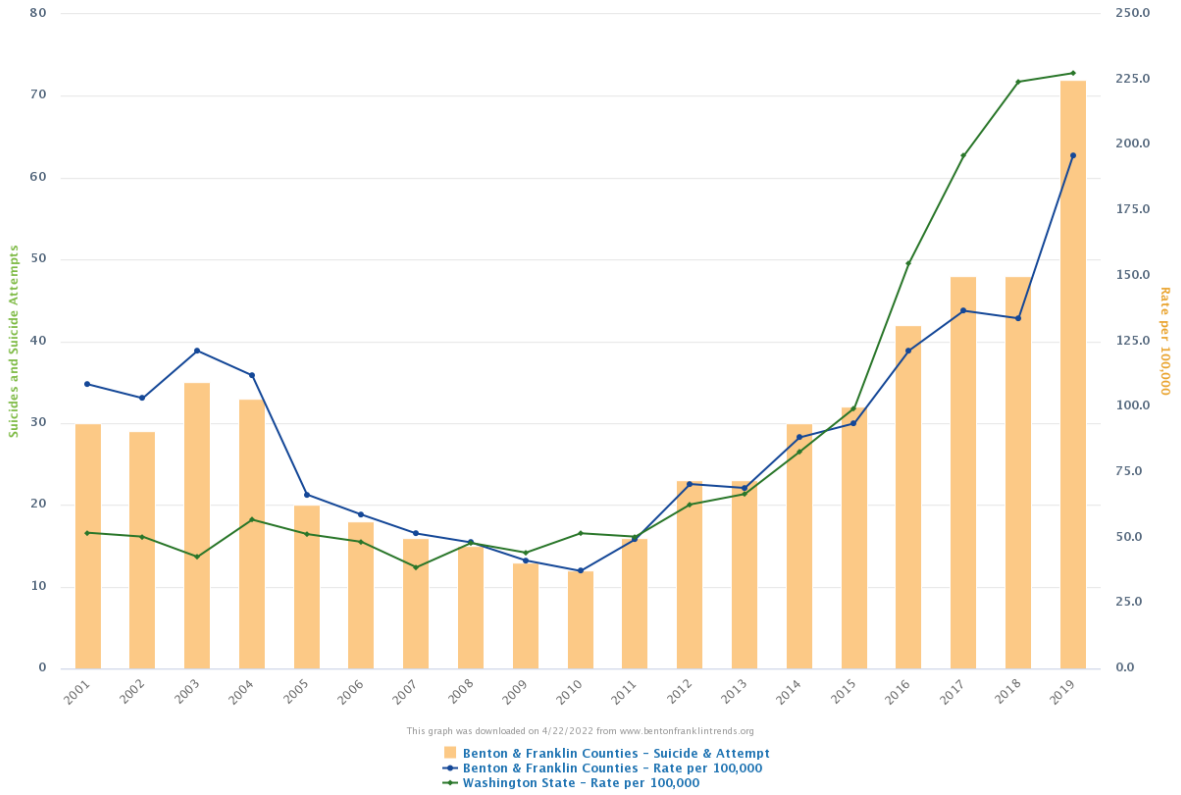
7.b. Youth Suicide & Suicide Attempts

According to the American Academy of Child & Adolescent Psychiatry, teenagers often experience strong feelings of things like stress, confusion, self-doubt, depression, pressures of all sorts, and different fears. Significant life events, such as divorce of parents or moving to a new community, can intensify some of these feelings. Depression and suicidal thoughts can be diagnosed and treated with professional mental health intervention.

Using hospital admissions and Washington Department of Health data, Benton Franklin Trends (BFT) indicator [6.2.4 Total Number of Suicide and Suicide Attempts & Rate per Youth Ages 10-17] shows both the total number of suicides and attempts along with a rate per 100,000 population for Benton & Franklin Counties benchmarked against Washington State. Much of the growth stemmed from better reporting of attempts by hospitals and not necessarily an increase in suicide deaths.

As Figure 15 shows, both the total number of suicides and suicide attempts amongst youth ages 10-17 has increased since 2015 for both the combined counties and the state average, with the sharpest increase between 2018 to 2019, the most recent data available. Early evidence suggests that because of the pandemic, suicides and suicide attempts in youth for 2020 will likely be high as well and that perhaps a slight decline might occur in the post-Covid-19 environment.

Figure 15. Total Number of Suicides & Suicide Attempts & Rate, Youth Ages 10-17



Source: [Benton Franklin Trends]

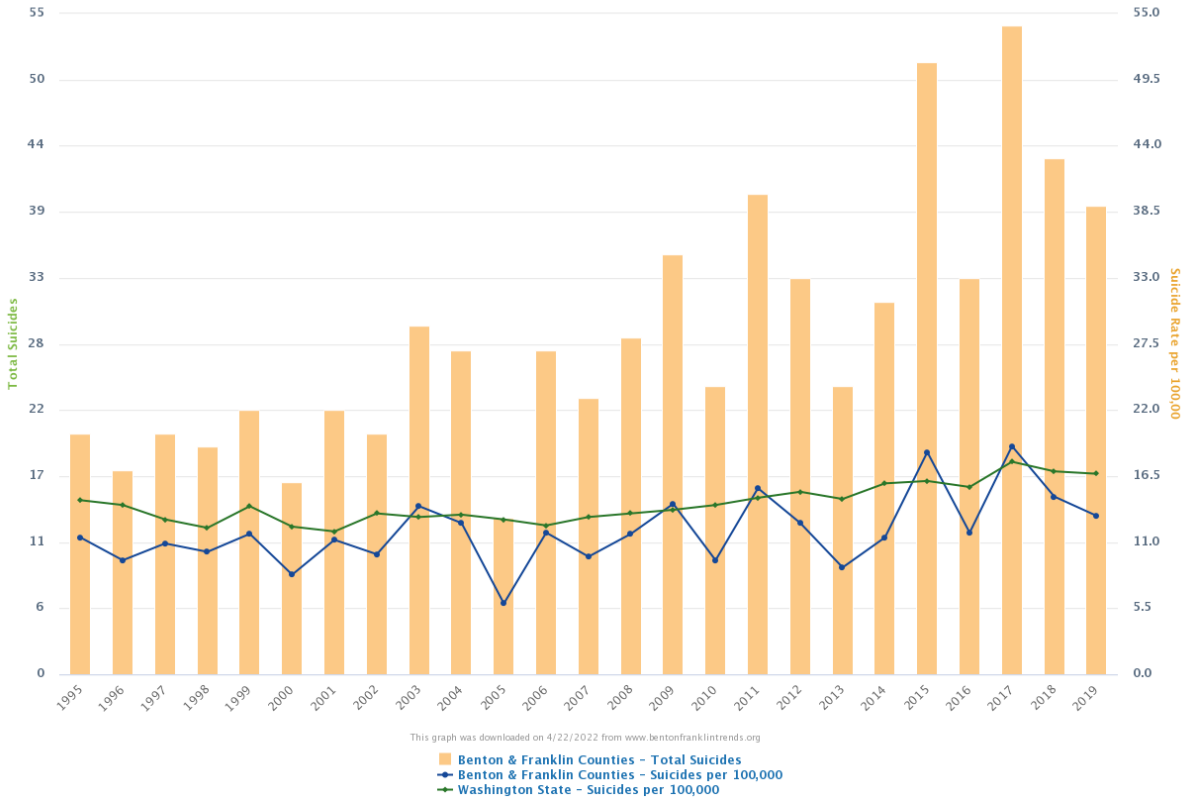
7.c. Total Suicides & Rate Per 100,000 Residents

Deaths, no matter what the causes are, bring grief to friends and loved ones of the deceased. Deaths from suicide, however, may leave those left behind with added feelings of sadness or even guilt because of what might have been missed opportunities to prevent the tragic outcome through treatment or other actions.

Reasons for committing suicide vary, but are often linked to mental health disorders such as depression, bipolar disorder, schizophrenia, substance abuse, and post-traumatic stress disorder. Suicide is among the leading causes of death worldwide for both the young and old. Risk factors for suicide may include feeling alone, history of depression or other mental health issues, substance abuse, physical illness, and family history of suicide or violence. Depression and suicidal thoughts can be diagnosed and treated with professional mental health intervention.

Turning to all suicides, BFT 6.1.8 tracks total suicides and suicides per 100,000 residents from 1995 to 2019 (most recent data available.) Although the yellow bars show a rise in the total number of suicides over the past 25 years, the rate has shown only a slight increase. Interestingly, just prior to the pandemic, there was a drop in total suicides in 2018 and 2019. It will be interesting to see what happened during the pandemic. The rate in the greater Tri-Cities is consistently below the state average.

Figure 16. Total Suicides and Suicides Per 100,000 Residents



Source: [Benton Franklin Trends]

8. Presentation of Behavior Health Protective Factors

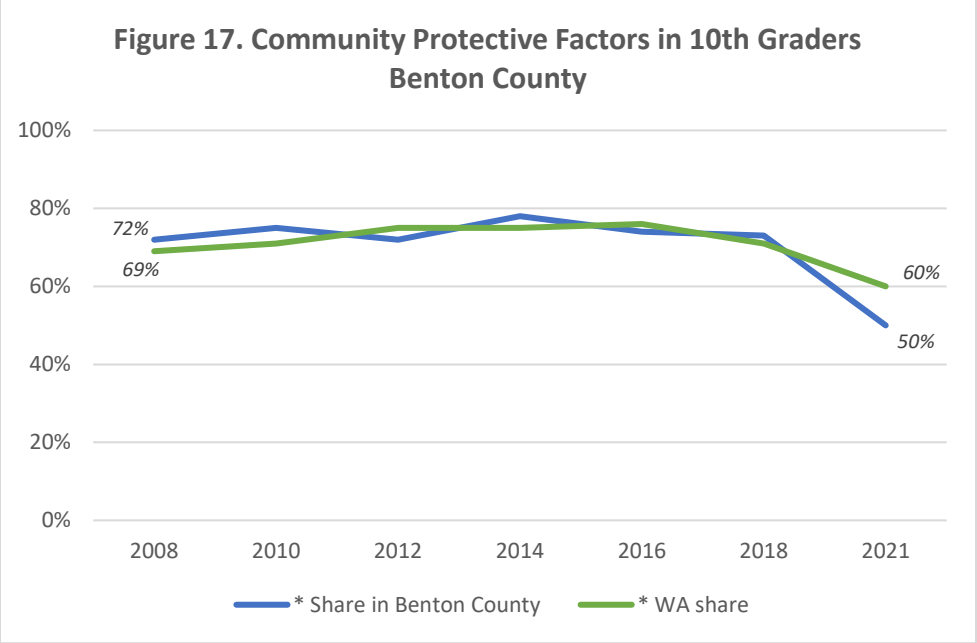
8.a. What are behavioral health protective factors?

In addition to the behavioral health outcomes that have been presented previously, this section focuses on prevention. In particular, protective factors are conditions or attributes in communities, families and schools that promote the health and well-being of children, ultimately leading to the development of healthy young adults in the community. Early research found that being a good student, getting along with others, and participation in activities reducing the risk of behavior health disorders (Rae-Grant, 1989). In 2019, Sharma, et.

al. found potential protective effects of religiosity, parental monitoring, and neighborhood collective efficacy on life stress and behavioral health outcomes. Following is data collected around community, family, and school protective factors.

8.b. What are *community* protective factors?

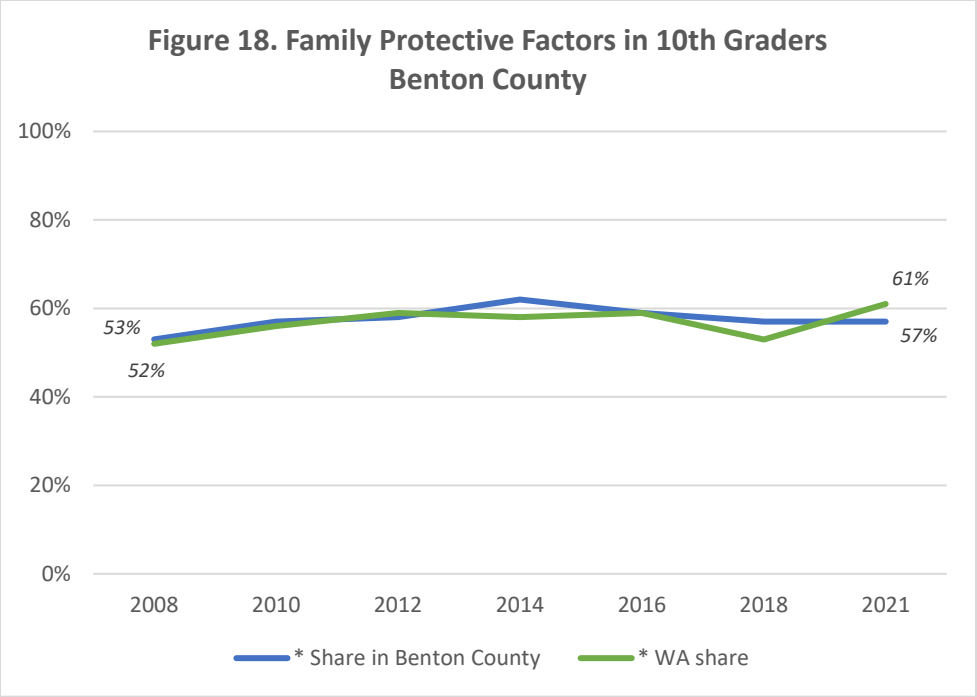
While it is important to consider data showing behavioral health outcomes, it is also insightful to consider community protective factors. These are conditions or attributes in communities that promote the health and well-being of children, ultimately leading to the development of healthy young adults in the community. Specifically, these factors include access to economic and financial resources, safe and stable housing, safe childcare, along with medical care and mental health services. Using data from the Washington Healthy Youth Survey, the share of tenth graders having these community protective factors has fallen off since the previous survey period.



Source: [Healthy Youth Survey, Washington]

8.c. What are *family* protective factors?

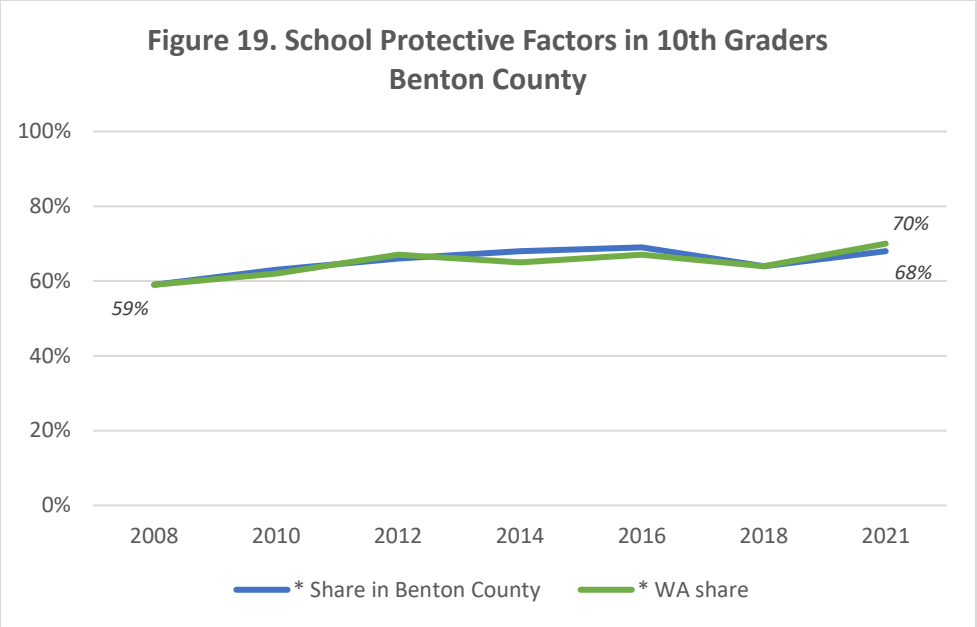
In addition of strong community support factors, there are family protective factors that can contribute to promoting the health and well-being of children. Social connections, concrete support in times of need, social and emotional competence of children, knowledge of parenting and child development can all foster the growth of healthy children and young adults. Using data from the Washington Healthy Youth Survey, the analysis shows that the share of tenth graders having family protective factors has increased slightly since the previous survey period and is consistent with the state average (benchmark).



Source: [Healthy Youth Survey, Washington]

8.d. What are *school* protective factors?

Lastly, schools have an important role in supporting and promoting the health and well-being of children. Conditions or attributes of schools such as after-school activities, positive school climate, clear behavior and bullying policies, mental health services, policies for children to be able to safely raise problems are captured in the Healthy Youth Survey. Using data from the Washington Healthy Youth Survey, the share of tenth graders having these school protective factors has risen slightly from around 60% to two-thirds since the previous survey period. Presently, Benton County (68%) is just below the state average of 70%.



Source: [Healthy Youth Survey, Washington]

9. Summary of key findings from the data presentation

Below are some key findings from the data section of this report:

- In adults and youth data alike, mental health issues, substance use, and the need for treatment are undeniable; if left untreated, many of these issues can lead to higher rates of thoughts of suicide and reliance on substances.
- Suicide rates for the total population have grown increased slightly over past 25 years while youth suicides and attempts have likely grown over past 20 years.
- Depression in adults and youth alike is rising, and the rate of proscribing depression medication is growing, at least among the Medicaid population.
- A positive note is that there has been a steep drop in alcohol and marijuana usage in 10th graders, & rates of binge drinking in adults have slightly decreased.
- Unfortunately, Benton Franklin rates of follow-up treatments after an ED discharge for diagnoses mental illness and substance use disorder are behind the state average.
- Opioid prescribing has declined steeply over past few years, although the lethality of the drugs appears to have climbed.
- Community protective factors declined to 50% in Benton County in 2021, which is 10% lower than WA benchmark.
- On a positive note: School and family protective factors have shown overall increases through 2010-2021 in Benton County and WA.

10. Presentation of findings from a survey of capacity and use at Tri-Cities providers of services for mental health and substance abuse disorders

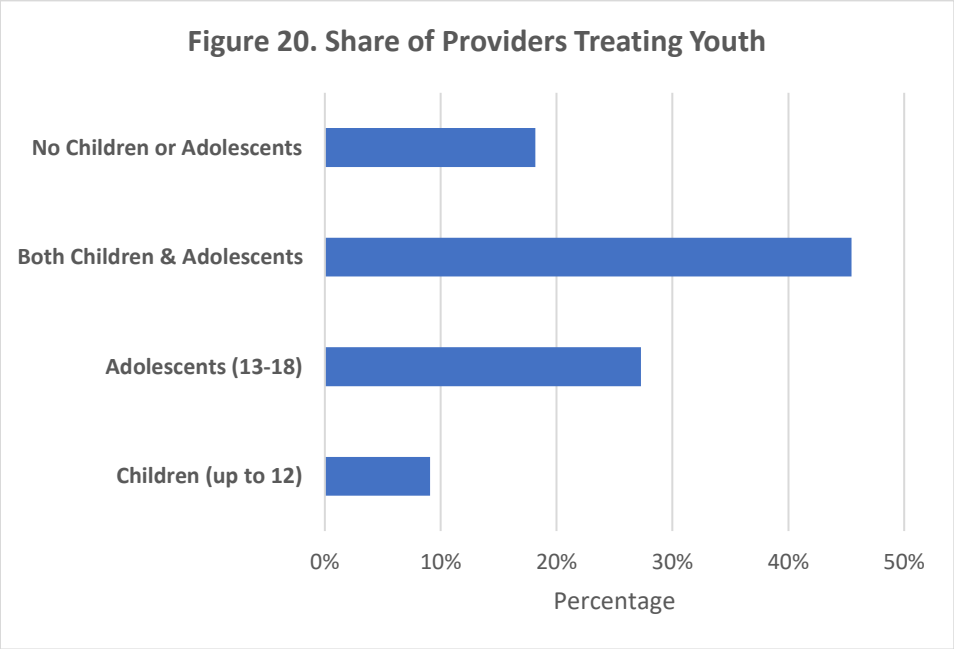
10.a. Survey design & implementation

In consultation with the Benton Franklin Health District, a survey was designed and administered online to providers of mental health services. The purpose of the survey was to collect data about the capacity and usage of facilities in the greater Tri-Cities area. Both the questions and summary results are presented in Appendix E.

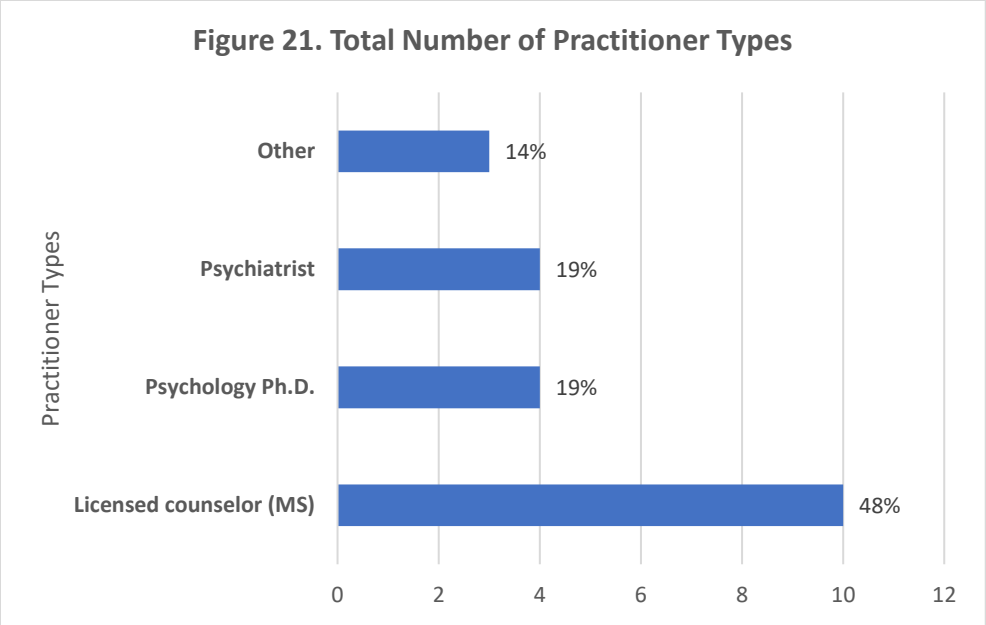
10.b. Description of the sample

Invitations were sent out from the Benton Franklin Health District to a list of providers, along with a follow up request to participate. Participants were asked to complete the survey of 25 questions in Survey Monkey. There were only 12 complete responses from offices, although each office l had multiple providers.

The sample consisted of nine offices that specifically targeted mental health and three of the offices reported targeting both mental health and substance abuse disorder. The average number of providers per office for respondents was approximately four and the average number of patients per office was 262. One-fourth of the offices in the sample are currently accepting new patients and two-thirds of offices currently have a waiting list of new patients, with an average wait time of 66 days.



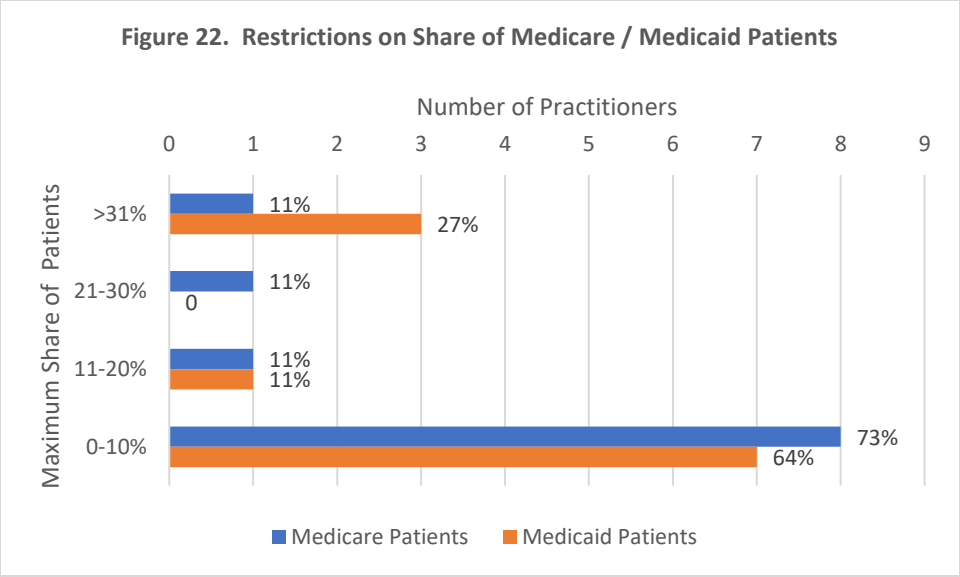
Source: EWU IPPEA, [Unpublished raw data], 2022



Source: EWU IPPEA, [Unpublished raw data], 2022

10.c. Medicare / Medicaid Coverage

Respondents were asked whether there were any limits to the number of Medicare & Medicaid patients that they accept. While one-third of the offices survey reported that do accept Medicare patients, many had restrictions on the maximum share of total patients that could be Medicare / Medicaid patients. Nearly three-fourths of the practitioners who accepted Medicare patients limited the share to under ten percent of total patients. There seemed to be less restrictions on Medicaid patients across our sample. While 64% of the office who accept Medicaid patients did in fact limit the share to under ten percent, over one-fourth either had no restriction or the restriction was above 30% of total patients.

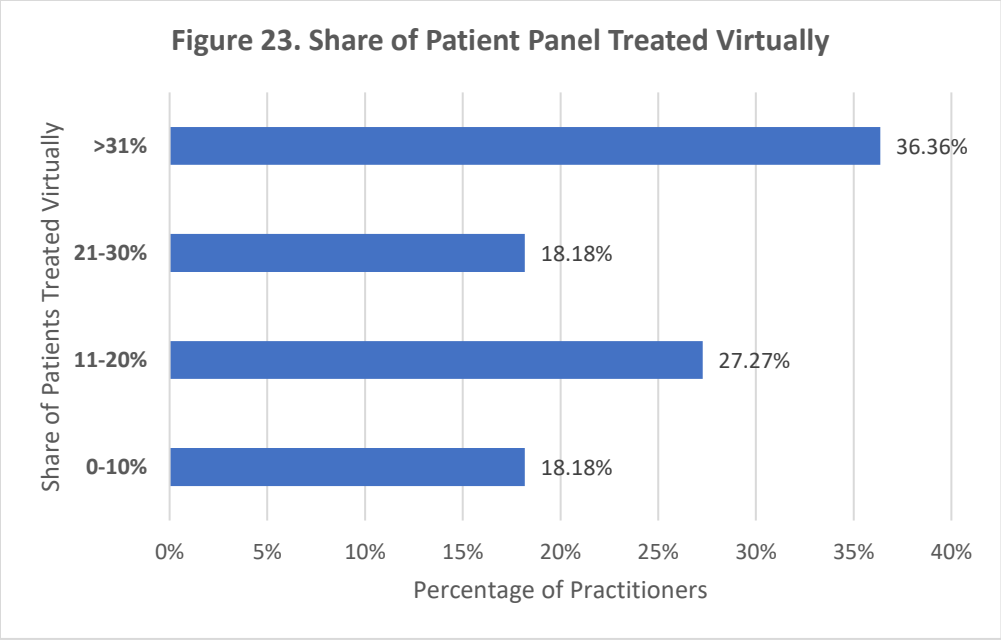


Source: EWU IPPEA, [Unpublished raw data], 2022

10.d. Use of Telehealth

According to the New England Journal of Medicine, Telehealth is defined as the delivery and facilitation of health and health-related services including medical care, provider and patient education, health information services, and self-care via telecommunications and digital communication technologies. Live video conferencing, mobile health apps, "store and forward" electronic transmission, and remote patient monitoring (RPM) are examples of technologies used in telehealth.

Thanks to improvements in technology, the move to telehealth as a means of healthcare delivery has been increasing and it is likely this transformation was sped up by the global pandemic. According to the survey of local behavioral health offices, over 90% of responding offices use telehealth for clinical visits to varying degrees as shown in Figure 22. Of the respondents, one-fourth find that there are payers that do not reimburse for telehealth services.



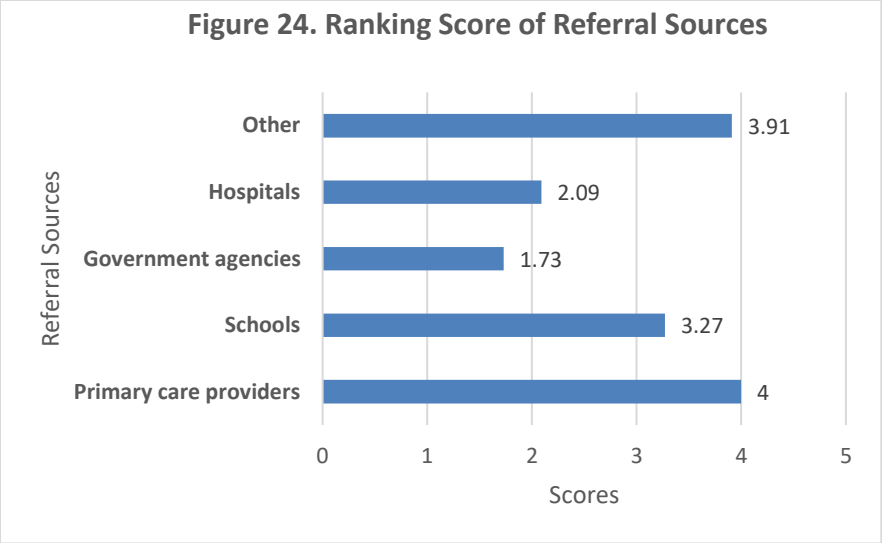
Source: EWU IPPEA, [Unpublished raw data], 2022

According to a study by CVS Health Company published in the Journal of General Internal Medicine, 95 percent of patients "were highly satisfied with the quality of care they received, the ease with which telehealth technology was integrated into the visit, and the timeliness and convenience of their care" (Polinski 2016).

However, there are also challenges to telehealth as a means of delivery of behavioral health care. In particular, patients need technology in the form of a cellphone, tablet or computer with reliable internet access that would permit streaming for an entire appointment. Additionally, some patients might prefer the personal interactions of in-person visits. Lastly, coverage by insurance companies of telehealth vary.

10.e. Referral Sources: Where are the health providers getting referrals from?

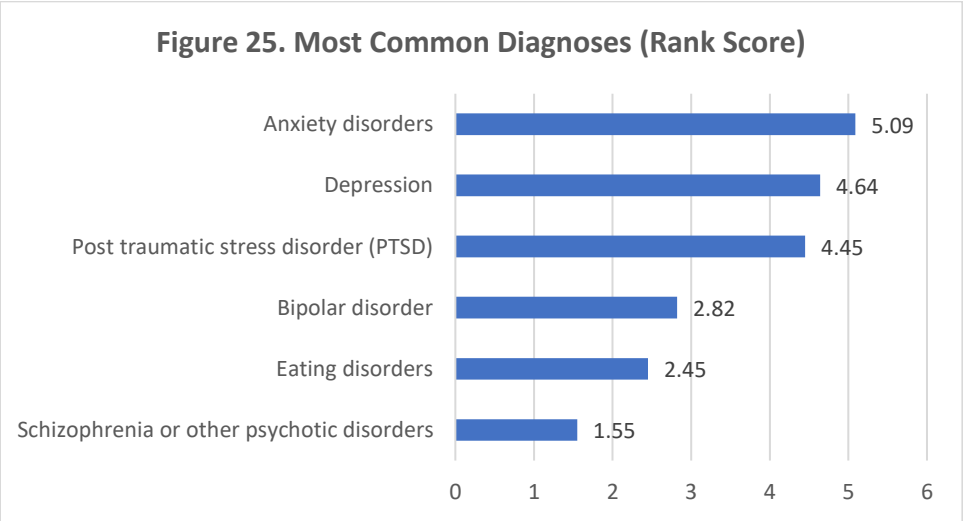
Patients often find their way to behavioral health providers through referrals from other sources. When asked in the survey about the most common source of referrals, respondents indicated that they get most of their referrals from primary care providers but other common sources include schools, hospitals, government agencies, insurance companies, law enforcement, churches, advertising and even from other behavioral health providers.



Source: EWU IPPEA, [Unpublished raw data], 2022

10.f. Diagnosis Profile: What are the most common diagnoses?

Behavioral health providers were asked in the survey to rank the most common diagnoses for their patients. These were then weighted to produce the listing below. Currently, anxiety disorders, depression, and post traumatic stress disorder (PTSD) are the most common amongst the respondents in the survey. Other diagnoses that behavioral health providers in the greater Tri-Cities area are making include substance abuse disorders (SUD), obsessive compulsive disorders (OCD), attention deficit / hyperactivity disorders (ADHD), autism / neurodivergence, and oppositional defiant disorder (ODD).



Source: EWU IPPEA, [Unpublished raw data], 2022

10.g. How has the pandemic changed things for local behavioral health providers?

One of the major impacts of the disruptions from the global pandemic is the increase in the number of patients being seen by behavioral health offices. On average, offices reported an increase of 44% in patients. Fortunately, the additional workload has not led to thoughts of leaving the practice.

10.h. What one barrier, if overcome, would most help the practice?

For the last question, survey participants were asked to comment on a significant barrier that if overcome would most help the practice. This was a free response question and as a result solicited a variety of general and very specific recommendations. Comments can be found in Appendix B.

Quite a few respondents reported that insurance issues create barriers for them in effectively providing services. For example, having access to other Medicaid insurance carriers like Amerigroup and Molina, along with greater accessibility to medications from insurance companies, were mentioned. Additionally, some providers had specific concerns that some mental health issues not being recognized by insurance companies for treatment. And even when insurance companies are willing to work with providers, there are delays in reimbursements and complications with filing paperwork.

Some respondents expressed a desire for greater access to referrals to other mental health providers and the ability to recruit potential therapists to join their practice. There seemed to be frustration with waitlists everywhere to get clients seen.

Some providers were impacted by Covid-19. For example, one reported: “I have had to reduce my services by approximately 20% due to increased case difficulties and personal stress related to the pandemic, frequent client crisis, transition to telehealth as primary modality.”

Although the responses were very specific to some organizations, there appeared to be a general frustration with workforce issues and coordination with other providers that is resulting in longer waitlists and frustrated patients. This is very consistent with the earlier discussions at the convenings.

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APPENDIX A

SELECTED SURVEY RESPONSES

"What one barrier, if overcome, would most help your practice?"

- "Being able to get on the network of other Medicaid insurances like Amerigroup and Molina."
- "Better accessibility to medications from insurance companies."
- "I work with relationship trauma and the DSM doesn't recognize this as a valid health issue. As such, my clients pay for health insurance, yet their insurance will not pay for relational therapy or support. I am a private pay therapist, and many clients can't receive the help they need due to insurance not covering attachment and relational issues such."
- "Coverage or reimbursement from insurance agencies when clients submit superbills"
- "It would help if more therapists were trained in play therapy to work with children under 12. My waitlist is over 40 children currently."
- More referral sources for patients not appropriate for my panel.
- "Having more access for referrals to other mental health providers who don't have a waitlist. It is so hard to return phone calls when I have no options of where to send people that they haven't already tried or that have openings. It's sad."
- "There is a lack of intense services for private pay insurance especially surrounding detox services
- "To be able to connect with potential therapists that may wish to join my practice."
- "More access to higher level of care facilities. Some clients need more support than what I can provide, and unless client has state insurance, we are very limited to who we can refer to programs such as WISe. Day Program was also very helpful at Lourdes for school aged students, but without it, there is a need for students to have there mental health support outside of school setting, which ahs upped the demand for private practice providers. It would also be helpful to have more options for assessment and diagnostic providers for Autism and related disorders."
- "I have had to reduce my services by approximately 20% due to increased case difficulties and personal stress related to the pandemic, frequent client crisis, transition to telehealth as primary modality."
- "ASO reducing number of providers locally to "regionalize" their services to provider who is unwilling to take all uninsured/underinsured"

APPENDIX B

BEHAVIORAL HEALTH FORUM PARTICIPANTS

May 17, 2022 (1:30 pm)

Behavioral Health Forum	Meghann	Barker
Behavioral Health Forum	Joel	Chavez
Behavioral Health Forum	Lee	Ferguson
Behavioral Health Forum	Tracy	Gowan
Behavioral Health Forum	Chris	Guerrero
Behavioral Health Forum	Kelly	Harnish
Behavioral Health Forum	Spencer	Harris
Behavioral Health Forum	Diana	Henning
Behavioral Health Forum	Paul	Klein
Behavioral Health Forum	Lorie	MacIsaac
Behavioral Health Forum	VJ	Meadows
Behavioral Health Forum	Enelida	Navarrete
Behavioral Health Forum	Melanie	Olson
Behavioral Health Forum	Andrea	Peyton
Behavioral Health Forum	Shannon	Snapp

May 25, 2020 (8:30 am)

Behavioral Health Forum	Laura	Cox
Behavioral Health Forum	Matt	Sammons
Behavioral Health Forum	Robin	Buck
Behavioral Health Forum	Angela	Combs
Behavioral Health Forum	Ansley	Gerhard Roberts
Behavioral Health Forum	Douglas	Hughes
Behavioral Health Forum	Jay	Hungerford
Behavioral Health Forum	Lidia	Lippold
Behavioral Health Forum	Adriana	Mercado
Behavioral Health Forum	Kendra	Palomarez
Behavioral Health Forum	Cynthia	Preszler
Behavioral Health Forum	TOBASKI	SNIPES
Behavioral Health Forum	Michael	Van Beek
Behavioral Health Forum	Gina	Vasquez
Behavioral Health Forum	Stacy	Waldvogel
Behavioral Health Forum	David	Wang
Behavioral Health Forum	Ryan	Washburn
Behavioral Health Forum	William	Waters

APPENDIX C

Notes from Behavioral Health Forum	**May 17, 2022**
Note taker: Kelly Harnish	
Question: What is the top behavioral health need in this community?	

- Something other than jail
- Services and reach for kids that aren't in school
- More prescribers of mental health medications
- Workforce shortage of behavioral health practitioners
- Need more workforce training for BH providers
- Bilingual/culturally matched providers
- Integrated care (BH integration into medical, for example)
- Collaborative network of resources, referrals, and case management
- More intensive youth BH services, both inpatient and outpatient
- Medically supervised substance use treatment (residential)
- Community education and awareness to reduce stigma for those with mental illness and to recruit people into the field
- Support systems and services for families of people with mental illnesses
- Knowledge of where to go and how to sign up for counseling
- Perinatal mental health support
- More providers who will take Apple Health
- Reduce lag time to see a provider
- Elderly who use Medicare have trouble getting a provider
- Reduce hospital stays for those who are admitted due to mental illness
- Services for crisis support for youth and families
- Connections for new graduates to provide ongoing care
- Allow providers with BS degree to provide reimbursable services

APPENDIX D

Notes from Behavioral Health Forum	**May 25, 2022**
Note taker: Kelly Harnish	
Question: What is the top behavioral health need in this community?	

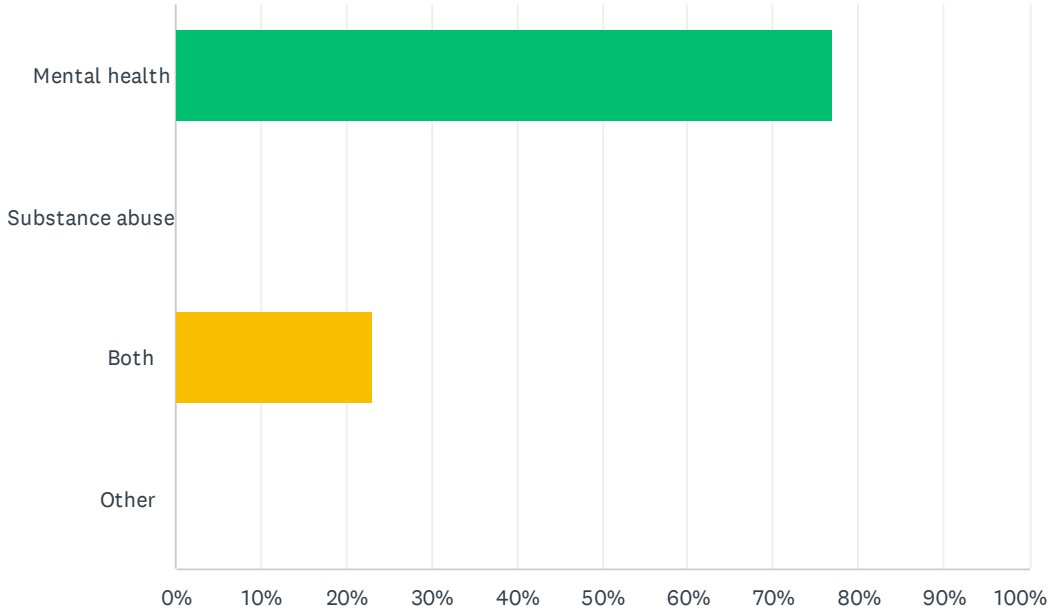
- Inpatient crisis services
- Grief support and stress training to prepare people "grief inoculation"
- Better integration of resources and awareness of resources
- A resource guide
- Overall improved access to community care. Therapy should be a community service
- Mental health support for gender transition therapy
- Behavioral health and primary care coordination
- Help people transition out of institutions and become self-sufficient
- Keep healthy people healthy
- Need more community health workers
- Better and more youth crisis resources
- Affordable childcare, improved access to healthy food, access to safe and affordable housing. Basic needs met = reduced stress.
- Need more providers who will work in community mental health, not go to telehealth
- Reduce family trauma from poverty, domestic violence, etc.
- Psychiatric access and medication
- Reduce wait times for those on Medicaid, it's inequitable
- Immediate inpatient care
- Housing with case management
- Long-term inpatient facility for youth
- Need people in the community to care about each other
- Offer a certificate in peer support for peer mentors
- Need peer support/mentors to be paid a reasonable amount
- Better crisis response and high quality treatment
- Access to involuntary treatment for those who didn't break the law (that's what it currently takes to get someone to go into involuntary treatment)
- Better pay for all behavioral health providers
- Resolve reimbursement issues
- Innovation to stem the tide, a new approach to handling this problem
- Better acceptance of Medicaid and Medicare
- Eligibility for intensive care needs to be lower
- An adult clubhouse for those with mental illness. A safe place to go for the day with no requirements/memberships.
- More money and more resources

Q1 Please enter the name of your organization here.

Answered: 13 Skipped: 0

Q2 Please indicate your general specialty.

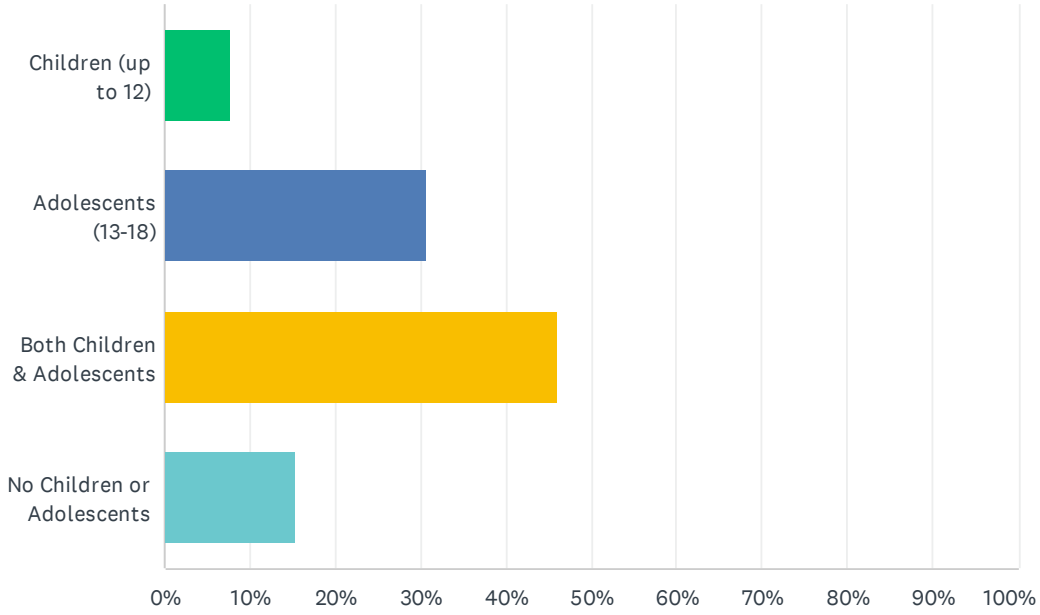
Answered: 13 Skipped: 0



ANSWER CHOICES	RESPONSES	
Mental health	76.92%	10
Substance abuse	0.00%	0
Both	23.08%	3
Other	0.00%	0
TOTAL		13

Q3 Does your office see youth?

Answered: 13 Skipped: 0



ANSWER CHOICES	RESPONSES	
Children (up to 12)	7.69%	1
Adolescents (13-18)	30.77%	4
Both Children & Adolescents	46.15%	6
No Children or Adolescents	15.38%	2
TOTAL		13

Q4 How many practitioners are in your office?

Answered: 13 Skipped: 0

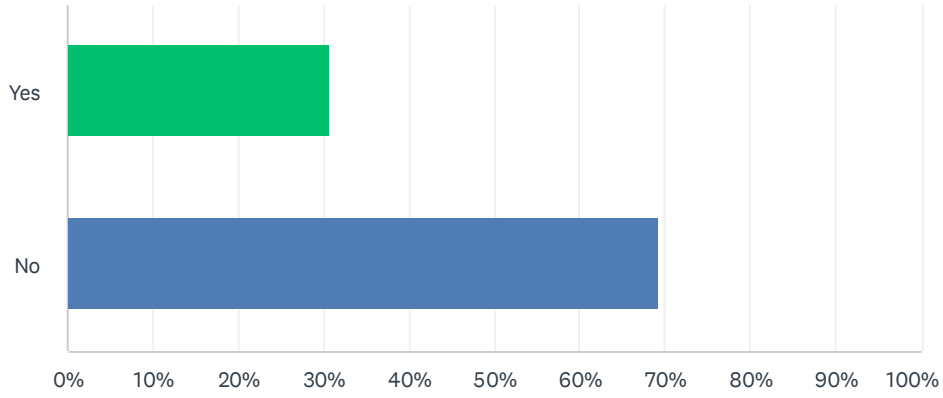
ANSWER CHOICES	RESPONSES	
Licensed counselor (MS)	84.62%	11
Psychology Ph.D.	30.77%	4
Psychiatrist	30.77%	4
Other	30.77%	4

Q5 Approximately how many patients are in your office’s panel?

Answered: 13 Skipped: 0

Q6 If your office accepting new patients at this moment?

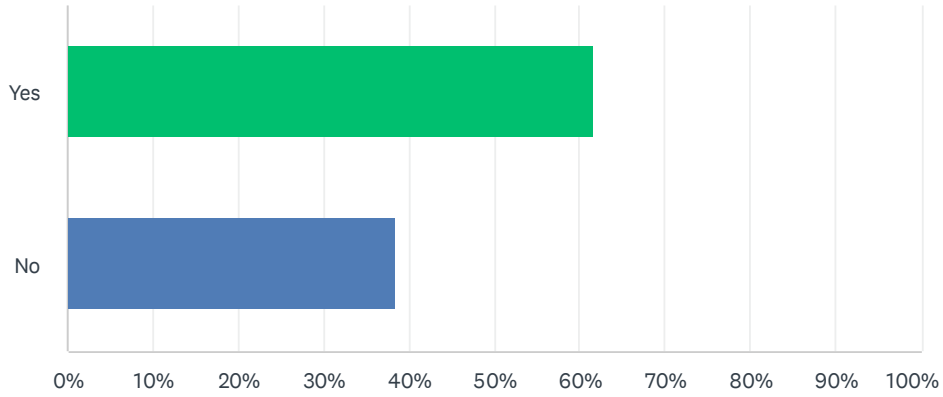
Answered: 13 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	30.77%	4
No	69.23%	9
TOTAL		13

Q7 If your office is not accepting new patients, is there a waiting list for patients to receive care from your office?

Answered: 13 Skipped: 0



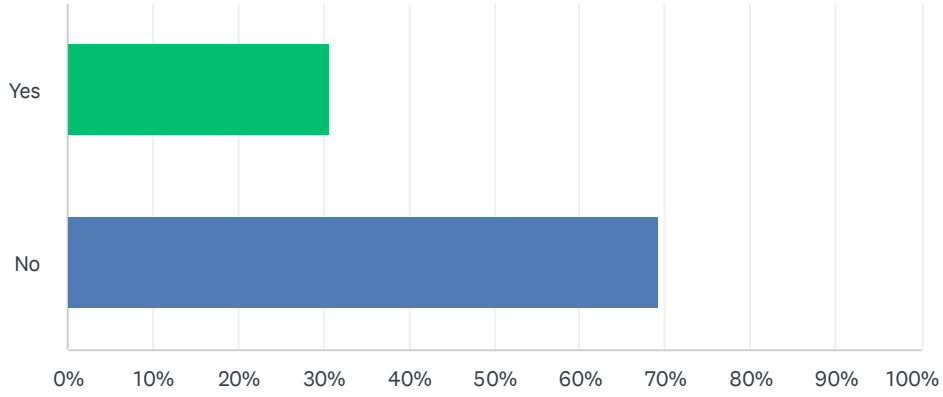
ANSWER CHOICES	RESPONSES	
Yes	61.54%	8
No	38.46%	5
TOTAL		13

Q8 If your office is not accepting new patients, can you tell us the current average length of the wait? (In days)

Answered: 12 Skipped: 1

Q9 Does your office accept Medicare patients?

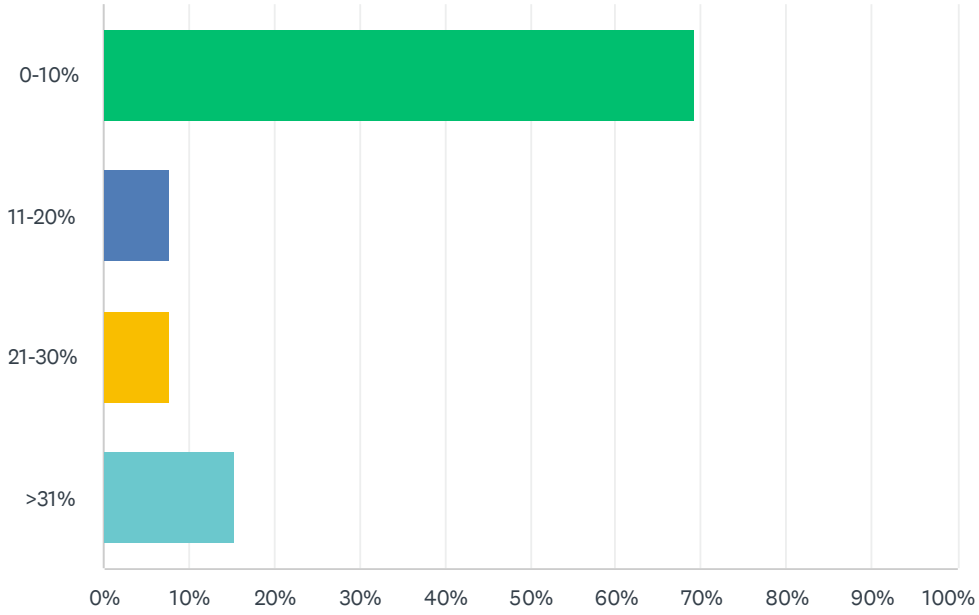
Answered: 13 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	30.77%	4
No	69.23%	9
TOTAL		13

Q10 If so, do you have a policy on the maximum share of Medicare patients in your total panel?

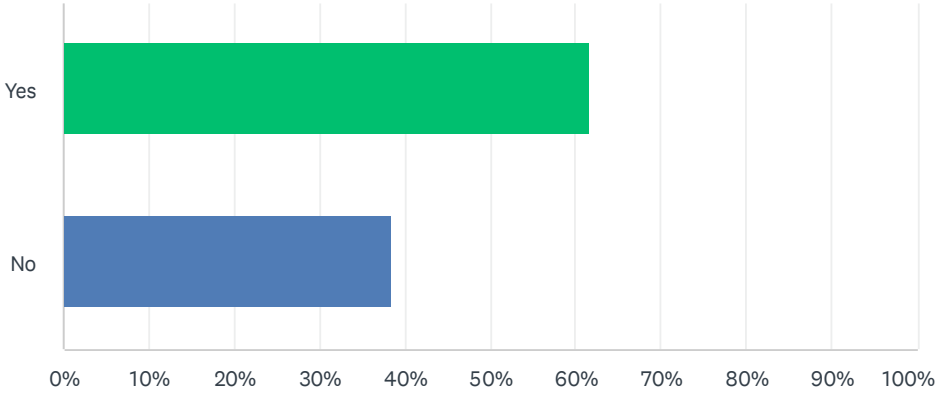
Answered: 13 Skipped: 0



ANSWER CHOICES	RESPONSES	
0-10%	69.23%	9
11-20%	7.69%	1
21-30%	7.69%	1
>31%	15.38%	2
TOTAL		13

Q11 Does your office accept Medicaid patients?

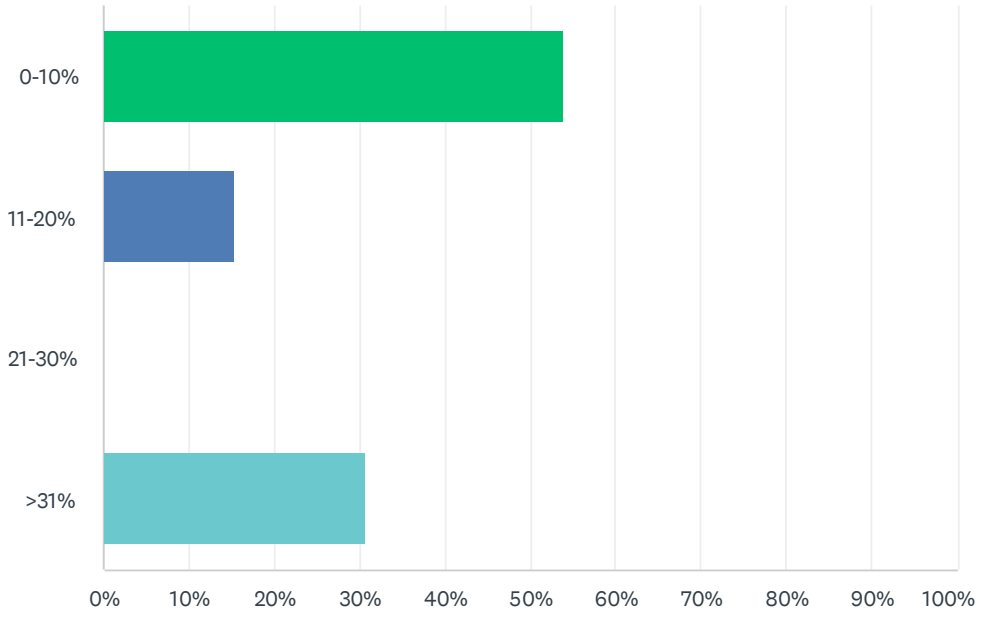
Answered: 13 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	61.54%	8
No	38.46%	5
TOTAL		13

Q12 If so, do you have a policy on the maximum share of Medicaid patients in your total panel?

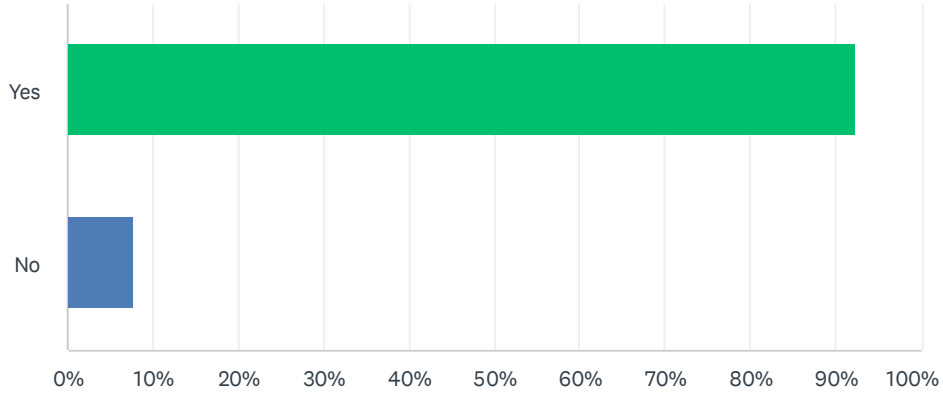
Answered: 13 Skipped: 0



ANSWER CHOICES	RESPONSES	
0-10%	53.85%	7
11-20%	15.38%	2
21-30%	0.00%	0
>31%	30.77%	4
TOTAL		13

Q13 Does your office interact with patients virtually?

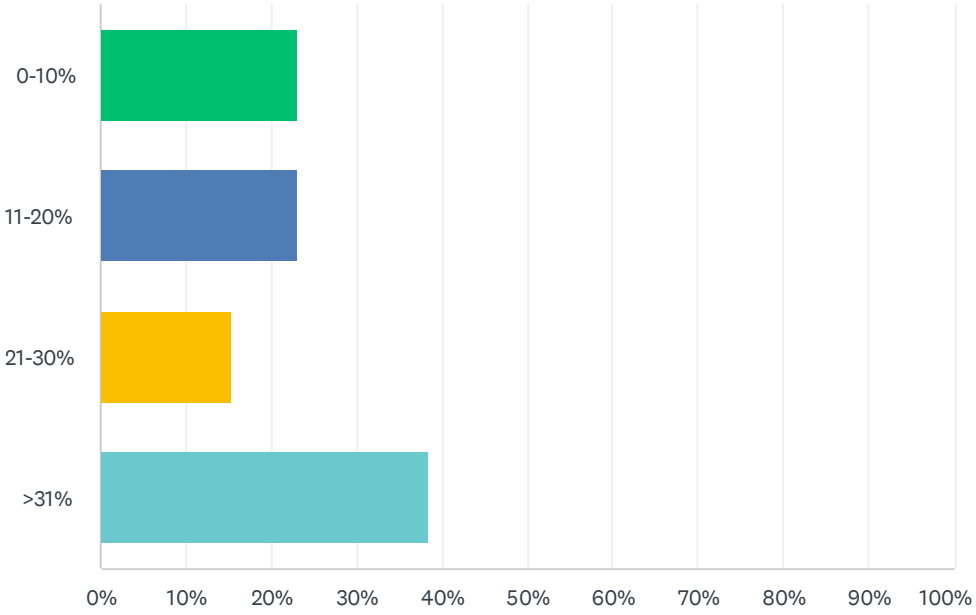
Answered: 13 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	92.31%	12
No	7.69%	1
TOTAL		13

Q14 If your office interacts with patients virtually, can you tell us the share of patient panel that is treated virtually?

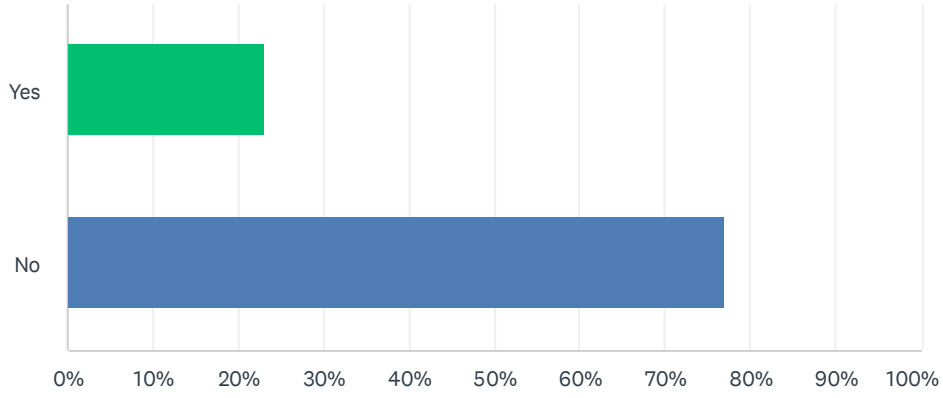
Answered: 13 Skipped: 0



ANSWER CHOICES	RESPONSES	
0-10%	23.08%	3
11-20%	23.08%	3
21-30%	15.38%	2
>31%	38.46%	5
TOTAL		13

Q15 Are there some payors that do not reimburse for virtual sessions?

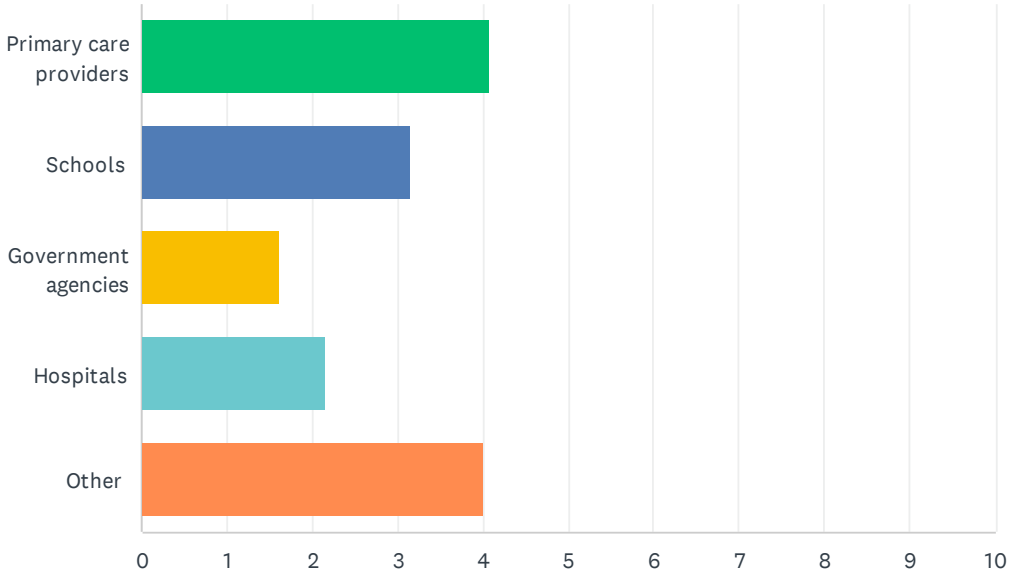
Answered: 13 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	23.08%	3
No	76.92%	10
TOTAL		13

Q16 Please rank the top sources of referrals to your office.

Answered: 13 Skipped: 0



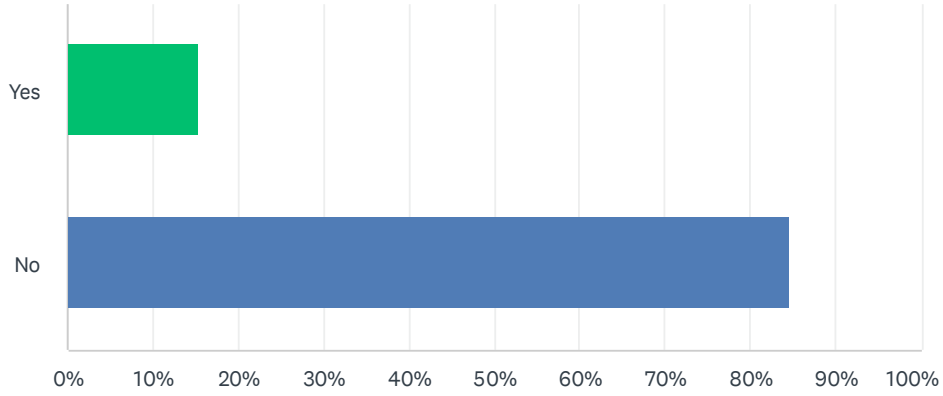
	1	2	3	4	5	TOTAL	SCORE
Primary care providers	23.08% 3	61.54% 8	15.38% 2	0.00% 0	0.00% 0	13	4.08
Schools	23.08% 3	15.38% 2	23.08% 3	30.77% 4	7.69% 1	13	3.15
Government agencies	0.00% 0	0.00% 0	15.38% 2	30.77% 4	53.85% 7	13	1.62
Hospitals	0.00% 0	7.69% 1	30.77% 4	30.77% 4	30.77% 4	13	2.15
Other	53.85% 7	15.38% 2	15.38% 2	7.69% 1	7.69% 1	13	4.00

Q17 If there is a source of referral to your office not listed above, please describe it here.

Answered: 12 Skipped: 1

Q18 Does your office prescribe medications?

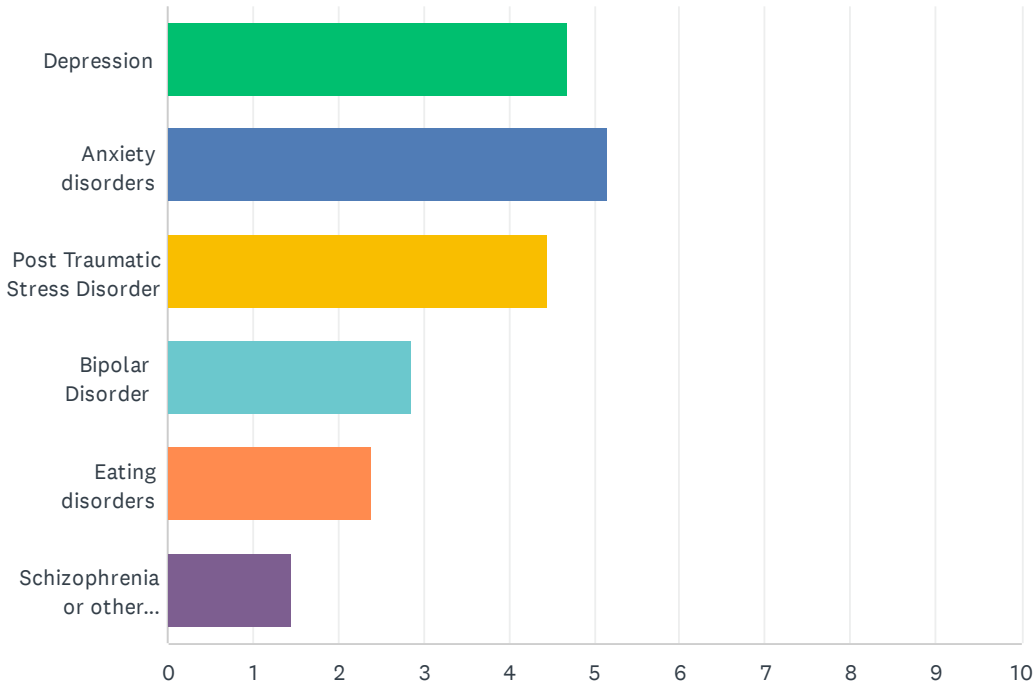
Answered: 13 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	15.38%	2
No	84.62%	11
TOTAL		13

Q19 Please rank the most common diagnoses seen in your patients.

Answered: 13 Skipped: 0



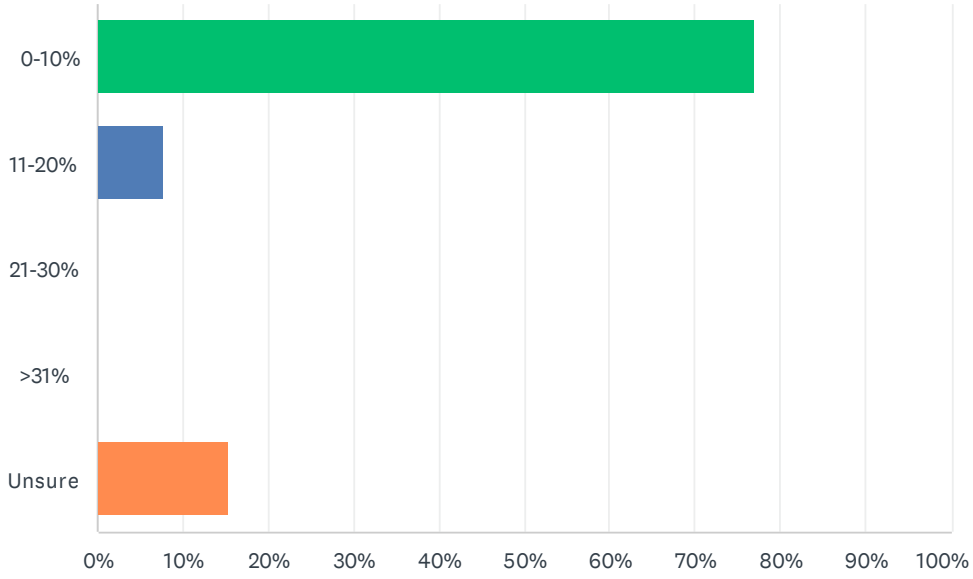
	1	2	3	4	5	6	TOTAL	SCORE
Depression	30.77% 4	30.77% 4	30.77% 4	0.00% 0	0.00% 0	7.69% 1	13	4.69
Anxiety disorders	46.15% 6	38.46% 5	7.69% 1	0.00% 0	7.69% 1	0.00% 0	13	5.15
Post Traumatic Stress Disorder	15.38% 2	23.08% 3	53.85% 7	7.69% 1	0.00% 0	0.00% 0	13	4.46
Bipolar Disorder	0.00% 0	0.00% 0	7.69% 1	69.23% 9	23.08% 3	0.00% 0	13	2.85
Eating disorders	7.69% 1	0.00% 0	0.00% 0	23.08% 3	53.85% 7	15.38% 2	13	2.38
Schizophrenia or other psychotic disorders	0.00% 0	7.69% 1	0.00% 0	0.00% 0	15.38% 2	76.92% 10	13	1.46

Q20 If there is a common diagnoses in your patients not listed above, please describe it here.

Answered: 8 Skipped: 5

Q21 What percentage of your patient mix is homeless?

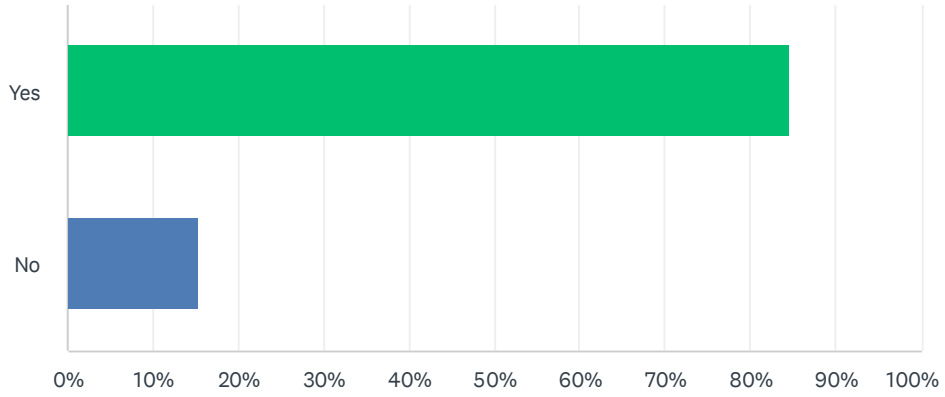
Answered: 13 Skipped: 0



ANSWER CHOICES	RESPONSES	
0-10%	76.92%	10
11-20%	7.69%	1
21-30%	0.00%	0
>31%	0.00%	0
Unsure	15.38%	2
TOTAL		13

Q22 Has the pandemic increased the number of patients seen by your office?

Answered: 13 Skipped: 0



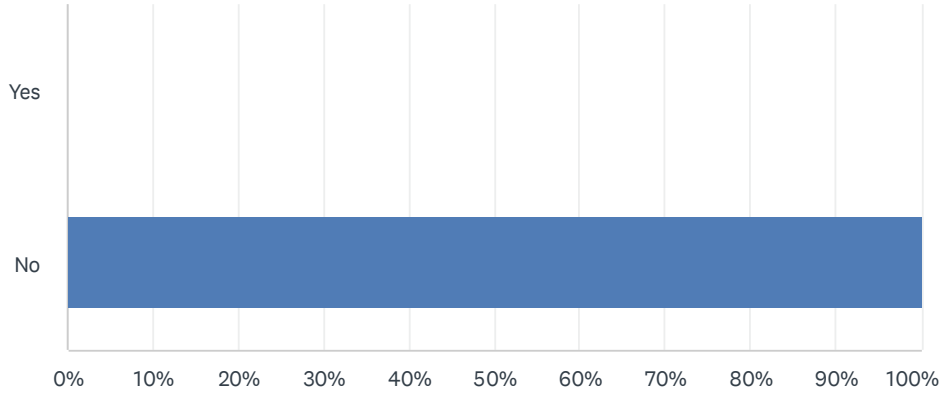
ANSWER CHOICES	RESPONSES	
Yes	84.62%	11
No	15.38%	2
TOTAL		13

Q23 If so, by approximately what percentage?

Answered: 9 Skipped: 4

Q24 If so, has the additional workload led you to consider leaving your practice?

Answered: 13 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	0.00%	0
No	100.00%	13
TOTAL		13

Q25 What is the one challenge, that if overcome, would help you and your practice? Please elaborate.

Answered: 13 Skipped: 0