



Access to Behavioral Health Care

DATA & TRENDS IN THE BETTER HEALTH TOGETHER REGION

August 2020



Compiled by Community Health Strategies, LLC and
Providence CORE

EXECUTIVE SUMMARY

This report summarizes data about the behavioral health system and issues affecting access to behavioral health care in the region served by Better Health Together, one of Washington's nine Accountable Communities of Health (ACH). Designed to provide a broad overview rather than a comprehensive account, this report can be used by a range of stakeholders— behavioral health providers, partners in other systems, local and state policy makers, advocates, and others—to help build a picture of behavioral health needs and access for the region and to consider options for future alignment, investment, or strategic action.

A range of data and topics are covered including: regional variations in behavioral health need and treatment, trends in prescription opioid use, public spending on behavioral health by service type, provider-to-population ratios, and behavioral health workforce composition. There is a strong emphasis on publicly-funded care and access to behavioral health services for Medicaid beneficiaries. While data in this report come from before COVID-19, discussion of how the pandemic is anticipated to exacerbate behavioral health needs and how the policy response is affecting access to care is interspersed throughout. Finally, **focused subsections** of the report provide more in-depth data on: 1) racial/ethnic disparities in behavioral health care access; 2) community behavioral health; and 3) transportation and geographic access to care.

In reviewing some preliminary data from this report with BHT's partners and behavioral health stakeholders, a few particular issues emerged as potential opportunities for collaborative action:

Addressing access disparities by race & ethnicity. This report identifies a number of disparities in behavioral health diagnoses and service utilization for different racial and ethnic groups in the BHT region. In keeping with its commitment to anti-racism work, BHT supports policy and practice changes intended to address racial inequities in behavioral health services and outcomes. These include efforts to diversify the behavioral health workforce and improve providers' cultural and language competency; increasing the availability of culturally-specific care; and close examination of organizations and systems to identify and addresses oppressive or racist policies and practices.

Maintaining recent expansions telehealth for behavioral health services. In the face of the novel Coronavirus, Washington State and national health care authorities moved quickly to expand access to behavioral health through use of telemedicine and telehealth. Medicare and Medicaid flexibilities introduced in response to the pandemic include some increased payment parity for telehealth visits; waivers for regulations that typically require assessments or other services to be provided in-person; and expansions to the types of clinics and providers that can bill for telehealth services. If maintained, these changes have the potential to significantly increase access to behavioral health care, especially in rural communities such as those in northeastern Washington.

Sustaining expansions in telehealth for behavioral health care will require re-evaluation of regulations and reimbursement models, support for providers to develop new skills and workflows, and parallel work to ensure equitable access to broadband internet and personal computing devices. BHT will work in partnership with behavioral health stakeholders,

government entities, and provider partners to help preserve recent policy changes for telehealth and support efforts to ensure equitable access to internet, broadband, and technological capacity.

Supporting peers as part of the behavioral health workforce. A 2017 Behavioral Health Workforce Assessment for Washington State contains more than a dozen recommendations for expanding and supporting the behavioral health workforce to improve access to care. One of those recommendations that was echoed by BHT region stakeholders is to increase the use of peer counselors and other community-based workers. Particularly in rural communities where knowledge of community resources and social supports is critical and where recruiting individuals with more formal education can be difficult, peers can offer mentoring, connections, and support for individuals' recovery goals. Expanded use of peers and other workers from communities that are historically under-represented in health care professions can also contribute to the important task of diversifying the behavioral health workforce.

Increasing use of peers and other community-based workers will require continued efforts to ensure that their services can be reimbursed, education for health and social service agencies about how to collaborate with and support peers, and additional training capacity.

Better workforce data. Many important aspects of access to behavioral health care are not covered in this report due to the lack of publicly-available data. One data limitation noted by BHT region stakeholders is the variety of ways that behavioral health occupations are titled, tracked, and coded in different data systems. For example, Medicaid provider enrollment or health plan provider credentialing systems may use occupational categories that do not align with clinical roles or titles. Physician licensing data in Washington does not identify doctors by specialty, so enumerating psychiatric specialists is difficult, and data on the race and ethnicity of health care providers is frequently not available. All this makes it very challenging to assess the size, skills, and representativeness of the workforce that is available to address behavioral health needs. More consistent and better quality data on each occupation's supply, distribution, work status, education, experience, specialties, practice setting, services provided, payment forms, and demographics would allow policy makers to craft precision interventions to remedy behavioral health care access issues.

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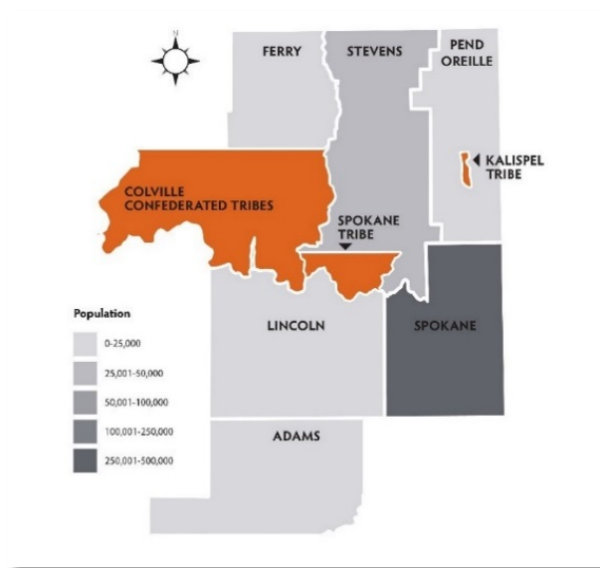
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REGIONAL BACKGROUND

BHT ACH has a large service region, which covers 12,273 square miles and is largely rural. An urban center exists in Spokane and there is a surrounding suburban commuting area. 84% of the region's population lives in Spokane County and many areas in Ferry, Lincoln, and Adams counties are classified as isolated, as shown in the map in figure 1.¹

As of 2016, the ACH had approximately 196,000 Medicaid members, which represents a higher proportion of the population than the state as a whole (33% Medicaid coverage vs. 28% statewide).¹ The region's Medicaid population is more likely to be white; less likely to be Hispanic; and more likely to give English as their preferred language than the state Medicaid population.

Figure 1 – Better Health Together (BHT) region



BEHAVIORAL HEALTH AS A REGIONAL PRIORITY

Substance use and mental health issues impact millions of adolescents and adults in the United States each year and have been noted to be the leading cause of disease burden in the United States.²

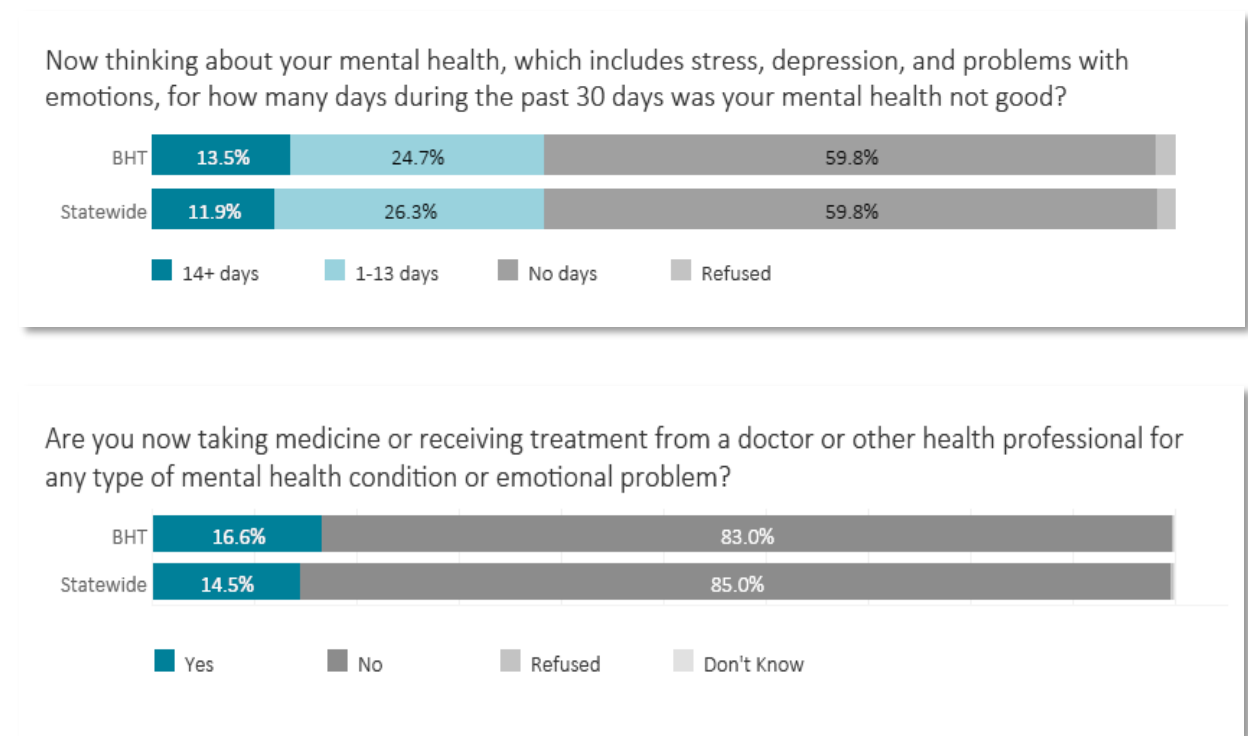
Mental health (MH) illness is defined by the American Psychiatry Association as health conditions involving changes in emotion, thinking or behavior (or a combination of these).³ Nearly 1.3 million adults, or 22.8% of Washington's state population, are experiencing a mental health concern. Today, Washington ranks 48 out of 51 (D.C. included) states in terms of those with the highest prevalence of mental illness and lowest rates of access to care overall.⁴

Substance Use Disorders (SUD) are defined as the recurrent use of alcohol and/or drugs that causes clinically significant impairment.⁵ Washington State had the 10th highest prevalence in the nation of adults reporting an SUD in 2017-2018; this is nearly half a million adults.⁴

Taken together, these two health conditions are referred to by the Substance Abuse and Mental Health Services Administrations (SAMSHA) broadly as behavioral health (BH) or mental and emotional well-being and the actions that affect wellness.⁶ Behavioral health problems include substance use disorders, alcohol and drug addiction, and serious psychological distress, suicide and mental health disorders. This definition also describes the service systems that encompass emotional health promotion, prevention and recovery support.

Population health surveys suggest that almost 40% of adults in the BHT region suffer from poor mental health or mental distress at least one day a month, but only 17% are currently receiving treatment (Figure 2).⁷

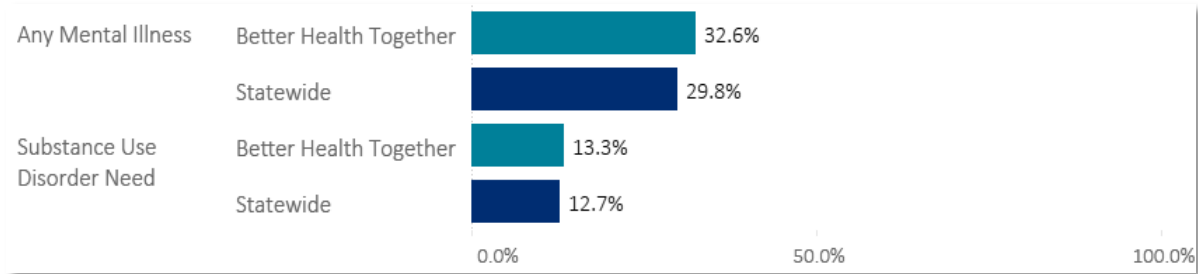
Figure 2 – Reported Mental Health Status among Adults, BHT and Statewide



Source: WA Behavioral Health Risk Factor Surveillance Survey (BRFSS), 2015-18 combined data.

Nearly 536,500 adult Medicaid beneficiaries in the BHT region (almost 33%) have been diagnosed with a mental health need, compared to 30% statewide. Approximately 20% of Medicaid adults aged 18-64 have a diagnosis of depression, compared with 16% statewide. Approximately 15,000 (13%) have had a substance use disorder diagnosis, similar to rates at the state level (Figure 3).⁸

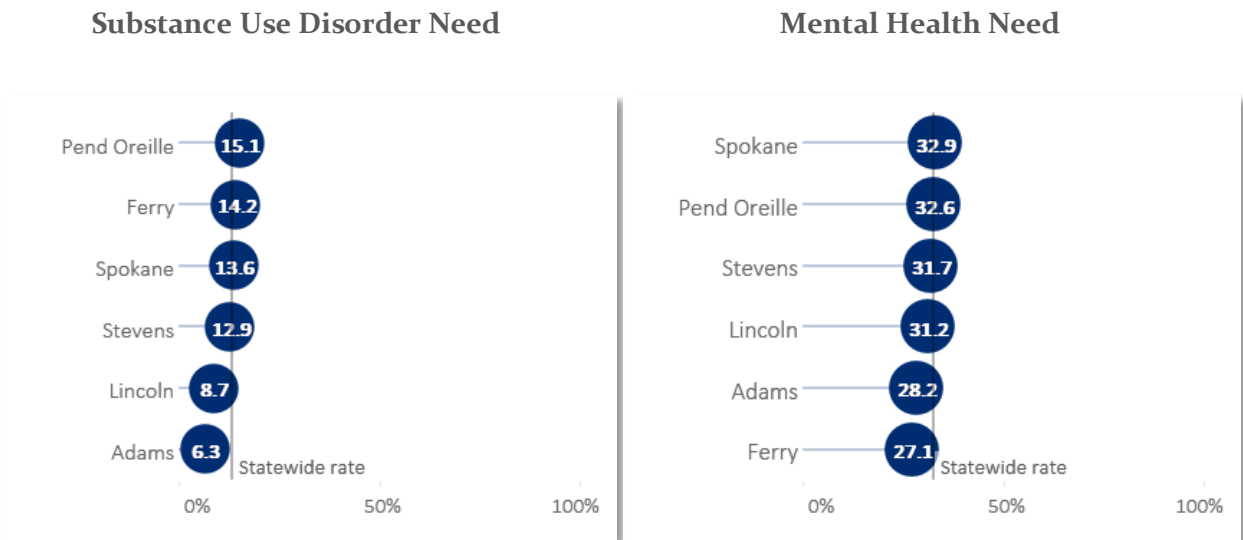
Figure 3 – Regional & Statewide Prevalence of Mental Health and Substance Use Disorders Among Adults on Medicaid, April 2018 – March 2019



Source: Derived from Healthier Washington Dashboard data

Estimated rates of mental health need among Medicaid beneficiaries are fairly similar across BHT’s six counties, but estimated need for SUD treatment among Medicaid beneficiaries varies from a low of 6% in Adams County (which has a markedly younger Medicaid population) to a high of 15% in Pend Oreille County (Figure 4).

Figure 4 – Rates of SUD or Mental Health Treatment Need in the Adult Medicaid Population, by County, April 2018 – March 2019



Source: Healthier Washington Dashboard, <https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboards>

The interconnected nature of mental health and substance use disorders can be difficult to assess, though co-occurrence is fairly common. One national study found that roughly 20% of people with a current substance use disorder had at least one current independent (i.e., non-substance-induced) mood disorder, and 18% had at least one current independent anxiety disorder.⁹ Though the symptoms of one may predate the other, mental health and substance use disorders tend to exacerbate one another, making treatment more challenging.¹⁰ In the BHT region, Medicaid data

from 2016 suggest that about 8% of BHT region Medicaid enrollees (more than 12,000 individuals) had both a mental health and SUD diagnosis, vs. 7% of Medicaid enrollees statewide.¹¹

A high prevalence of behavioral health complexities has led to an increasing focus on the issue for the region in recent years. In 2018, 529 stakeholders from across Spokane County participated in 13 meetings to develop the regional Community Health Needs Assessment (CHNA) for 2019 – 2021. One of the top 3 priorities identified and prioritized through the process led by Providence Sacred Heart Medical Center and Children’s Hospital and Providence Holy Family Hospital was to increase access to mental health and substance abuse services.¹²

COVID-19 and Behavioral Health Needs

At the time this report was being developed, the novel Coronavirus took root in the United States, altering patterns of health care access and delivery across the country and in Washington State. According to the Washington State Department of Health’s *Summary Forecast on COVID-19 and Behavioral Health Impacts* the pandemic has caused “a surge in behavioral health symptoms across the state”, and this trend is likely to continue. Data following disasters and critical events indicate that just one month after an initial event such as an outbreak, 10-33% of individuals experience symptoms of acute stress and 4-5% (roughly 380,000 Washingtonians) develop symptoms of PTSD. The report estimates that between two and three million people in the state will experience behavioral health symptoms—most commonly depression, anxiety, and acute stress—in the second half of 2020.¹³

Emergency Departments, Hospitalization, and Behavioral Health

Emergency Departments (EDs) see a large number of patients with behavioral health needs: nationally, one in eight ED visits involves a behavioral health condition.¹⁴ In communities where access to behavioral health care is limited, EDs are often where patients await the availability of an appropriate inpatient psychiatric bed, sometimes for many hours or even days.¹⁵ In 2018, 8.6% of emergency visits by Medicaid enrollees residing in the BHT region had a primary diagnosis of a mental health disorder or substance related disorder, vs. 7% statewide (Figure 5a).¹⁶ In the same year, behavioral health issues accounted for 25.3% of BHT Medicaid enrollee hospital admissions compared to 20.5% statewide, not including pregnancy/childbirth related admissions (Figure 5b).

Figure 5a - Medicaid Enrollee Emergency Department Visits with Behavioral Health Diagnosis, 2018



Figure 5b - Medicaid Enrollee Hospital Admissions with Behavioral Health Diagnosis, 2018



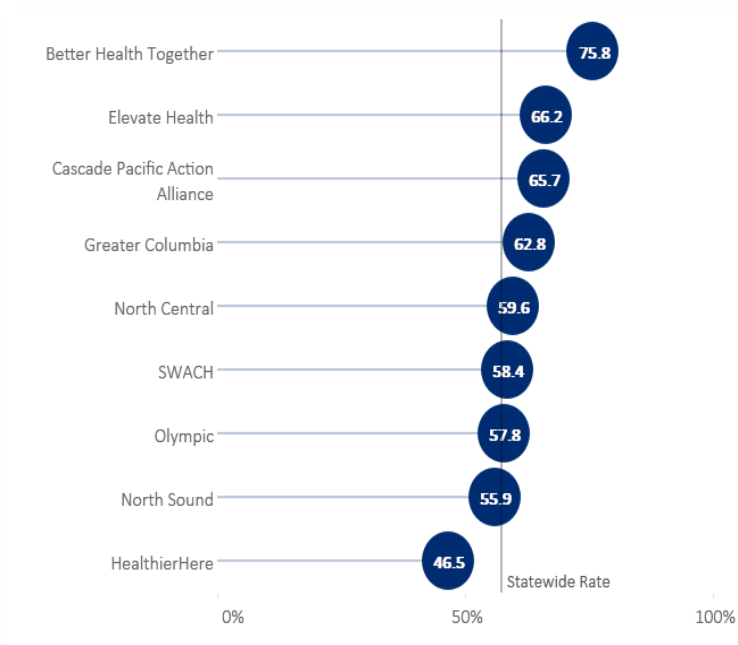
Source: Derived from WA Health Care Authority Inpatient Facility dashboard, <https://hca-tableau.watech.wa.gov/t/51/views/AIMDashboardSuite/DSMain?isGuestRedirectFromVizportal=y&embed=y>

Opioids

Nationally, over the last decade there have been significant increases in opioid-related emergency department visits and hospitalizations,¹⁷ neonatal abstinence syndrome (NAS), and pregnant women with opioid use disorder (OUD).¹⁸ Medicaid beneficiaries have been disproportionately affected by this epidemic, accounting for roughly half of all opioid-related overdose deaths in some states. In Washington, every day two people die of an opioid-related overdose, and thousands more struggle with addiction.¹⁹

Based on prescriptions submitted to the Washington State Prescription Monitoring Program, the BHT region has the highest prevalence of prescription opioid use in Washington. In the third quarter of 2019, almost 76 out of 1,000 people in the BHT region have an opioid prescription, vs. 57 for every 1,000 statewide. Seven of every thousand have high-dose, chronic opioid prescriptions (at least 60 days supply at a dose of at least 50 morphine milligram equivalents per day), vs. 4.8 per 1,000 statewide. In almost all of BHT's counties, opioid prescriptions are written and filled at a higher rate than the average for Washington state.²⁰

Figure 6 – Rate of Any Opioid Prescription per 1,000 Residents, by ACH Region, 2019 Q3



Source: WA Department of Health Opioid Awareness Dashboards

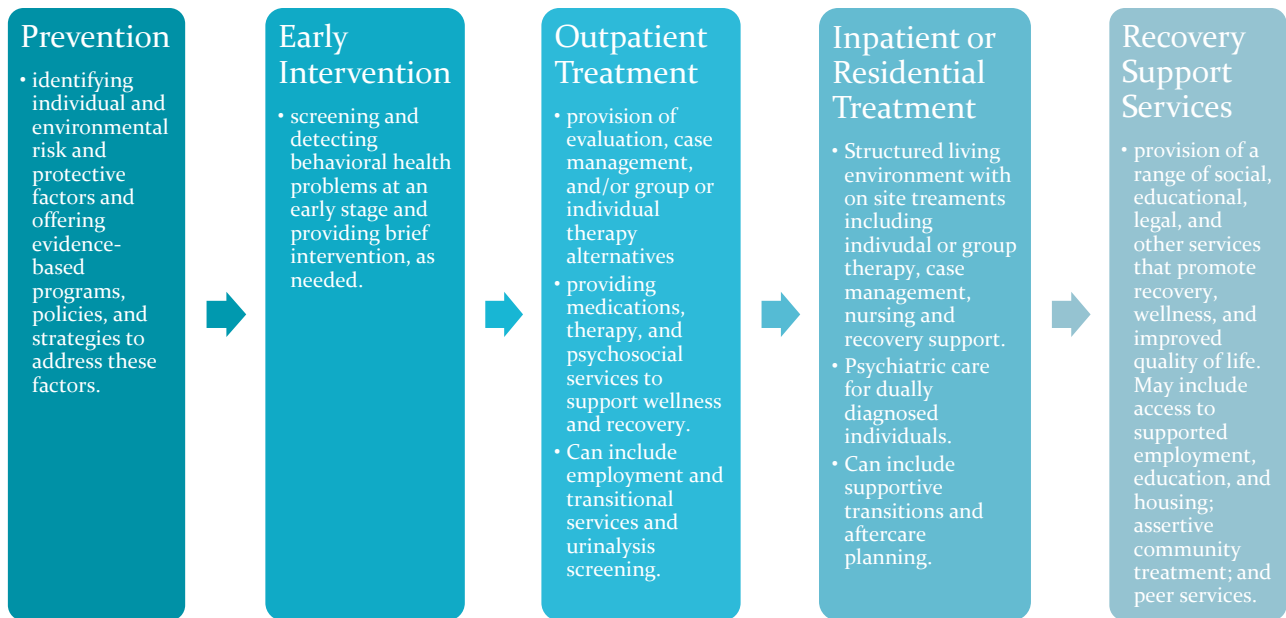
<https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/OpioidPrescriptionsandDrugOverdosesACHsData>

Beyond opioids, use of marijuana in Washington State appears to have increased since legalization of recreational use in late 2012, according to 2011-2016 data from the Behavioral Risk Factor Surveillance Survey.²¹ But it is not possible to distinguish use from abuse in those data.

TREATMENT FOR BEHAVIORAL HEALTH

Services to address behavioral health fall along a spectrum depending on intervention point, setting, and severity of need. A number of different frameworks for exist to describe the behavioral health continuum of care; most include some version of the following categories:^{22 23}

Figure 7 – Services Along the Behavioral Health Continuum of Care



Treatment for behavioral health issues is delivered by a combination of primary care, mental health providers, and/or behavioral health specialists who provide a blend of services such as pharmacotherapy, individual and/or group psychotherapy, detoxification, culturally- or spiritually-specific care, and other treatment in a variety of settings including inpatient, outpatient, or residential.^{24 25} Crisis services in particular can fall in a variety of places on the continuum.

Individuals' ability to access SUD and mental health treatment varies by geography, race, ethnicity, age, gender, and other factors. Forty percent (40%) of counties across the United States do not have an addiction treatment facility that provides outpatient care and also accepts Medicaid.²⁴ Nationally, only half of patients with major depressive disorders are identified accurately in primary care, and of those only half who are referred to specialty mental health care will make it to an appointment.²⁵ When treated in primary care, patients may face barriers including infrequent appointments, delays in medication adjustments, and discontinuation of antidepressants.²⁵ Lack of culturally-specific providers or insurance for culturally-specific treatment modalities can also be a barrier.

COVID-19 may further complicate access to care, in part because more individuals in the state are expected to have new or more severe behavioral health needs. Trauma-related resources and services may be particularly in demand because of the pandemic. To support the influx of potential demand for care, the State has recommended that behavioral health systems and providers begin to consider methods to activate community supports and increase social connection, develop communication strategies around the waves of this pandemic, and promote the idea that there is a disaster response cycle.¹³

Treatment access for Medicaid Enrollees in the BHT region

How well are treatment services meeting the need for behavioral health care in the BHT region? For **Medicaid populations** specifically, about half of Medicaid enrollees with a mental health need are receiving services and only about a third of those with an SUD treatment need are currently getting care. Data from the Healthier Washington Dashboard⁸ for the period of July 2018 – June 2019 show that:

- BHT ACH slightly exceeds the statewide average for getting services to Medicaid beneficiaries who have a mental health diagnosis (52% vs. 50%) and matches the state for getting substance abuse treatment services to those with an SUD diagnosis (37% for both BHT and the state).
- About a quarter (24%) of Medicaid beneficiaries in the BHT region who visited the emergency department with an alcohol or drug-related issue had a follow-up visit within 7 days. This figure is low but is substantially higher than the state average of 16%. Rates of follow up after substance abuse-related hospital or ED events have been improving in the BHT region in recent quarters.
- Follow-up after ED visits or hospitalizations happens more frequently when mental health is a primary diagnosis instead of substance use disorder. BHT's rates are fairly similar to statewide rates:
 - 62% of ED visits among Medicaid clients where mental illness was the primary diagnosis had a follow-up visit within 7 days; the statewide figure is very close at 61%
 - 62% of hospitalizations where mental illness was the primary diagnosis had a follow-up visit within 7 days, vs. 58% statewide
- With respect to opioid treatment, BHT ACH is slightly below the state average for Medicaid opioid users receiving medication-assisted treatment (34.0% vs. 36.0% statewide) but matches the state rate of 7% for users initiating treatment, as of Q3 2019.²⁶

Treatment access measures within the BHT region vary by county and over time. For example, since 2017 Adams County has greatly increased the proportion of Medicaid members with a mental health need who are getting served. Rates of treatment for those with an SUD need have been declining somewhat in Lincoln County, in contrast to a slow increase for the region as a whole.⁸ Figures 8a and 8b show county-level trends in mental health and SUD treatment for Medicaid beneficiaries, using a rolling 12-month measurement period from 2017 through the 1st quarter of 2019.

Access to behavioral health treatment in the BHT region also varies by race and ethnicity. See Focus Section #1 for more detailed data and discussion of these disparities.

Figure 8a – Percent of Medicaid Beneficiaries Age 6+ with a **Mental Health Need** Who Received Services, by County

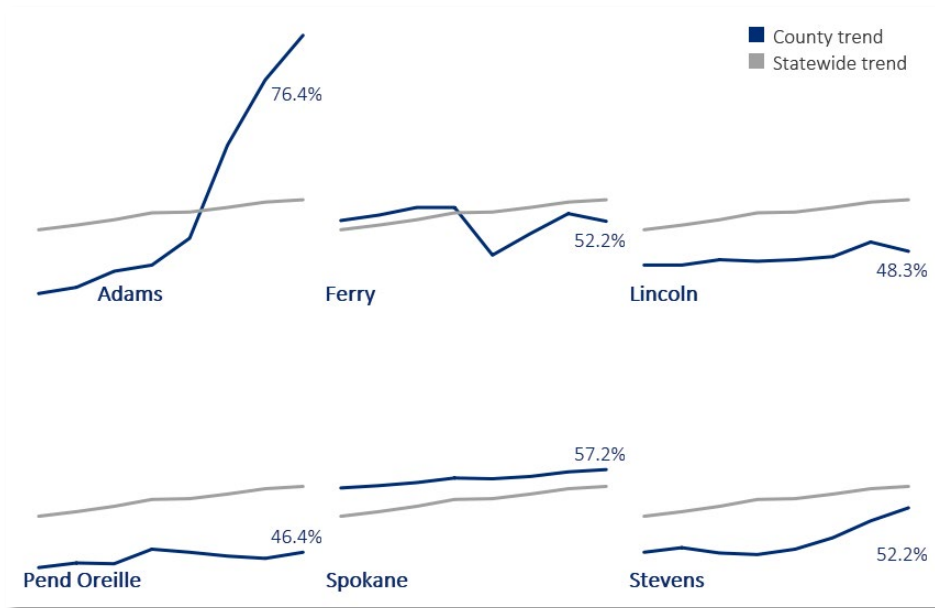
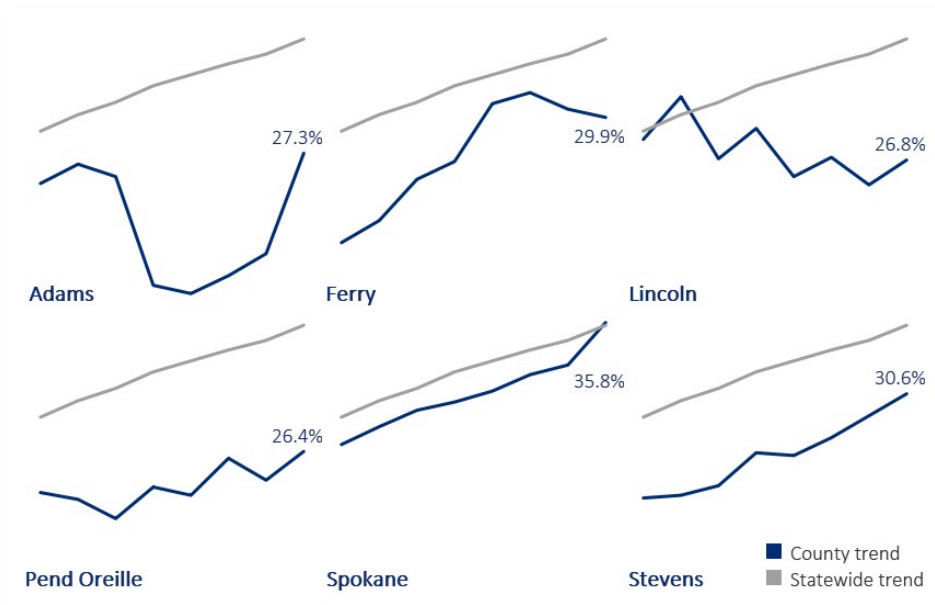


Figure 8b - Percent of Medicaid Beneficiaries Age 12+ with a **Substance Abuse Disorder Need** Who Received Services, by County

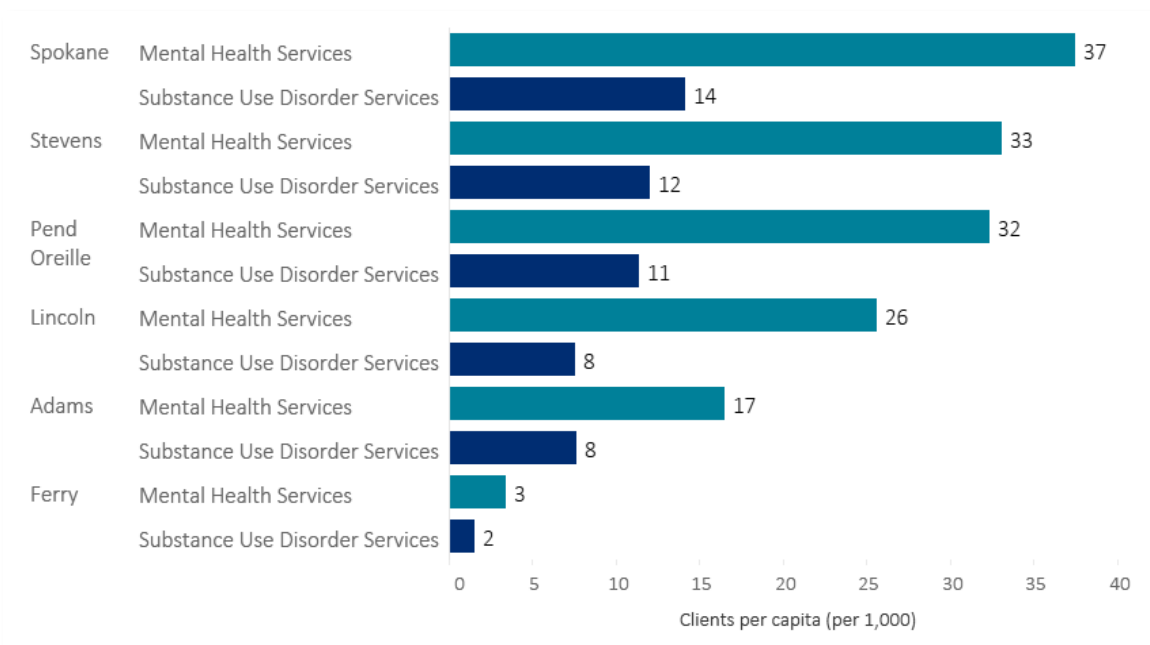


Source for both Figures: HCA Healthier Washington Dashboard: <https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboards>

DSHS Behavioral Health Program Usage

In addition to Medicaid services administered through the state's Health Care Authority, Washington funds a variety of behavioral health services via the Department of Health and Social Services (DSHS). These include care provided at the Eastern State Hospital and the Child Study & Treatment Center, as well as forensic and community behavioral health services. In 2016-17, approximately 21,500 people in the BHT region (roughly 3.5% of the population) received DSHS-paid mental health services and 8,100 (roughly 1% of the population) received DSHS-paid substance use disorder services. (Note that the mental health and SUD figures cannot be added together because some individuals may have received services in both categories.) In almost every county, the number of clients receiving DSHS-paid mental health services is substantially larger than the number receiving SUD services.²⁷

Figure 9 – DSHS Behavioral Health clients per 1,000 population, 2016-17



Source: WA Department of Health and Social Services Client Data Reports <http://clientdata.rda.dshs.wa.gov/>

While these data paint one picture of treatment access and utilization in the region, it is certainly not complete. This is largely due to a lack of publicly available data beyond the Medicaid population and state-sponsored programs. For example, we do not have a good understanding of behavioral health needs or treatment utilization for populations with employer-sponsored or private insurance coverage. Additionally, there is little public data available on utilization of crisis services as part of the spectrum of treatment options, nor is there easily accessible information pertaining to behavioral health access points available in schools or other locations not funded by the state.

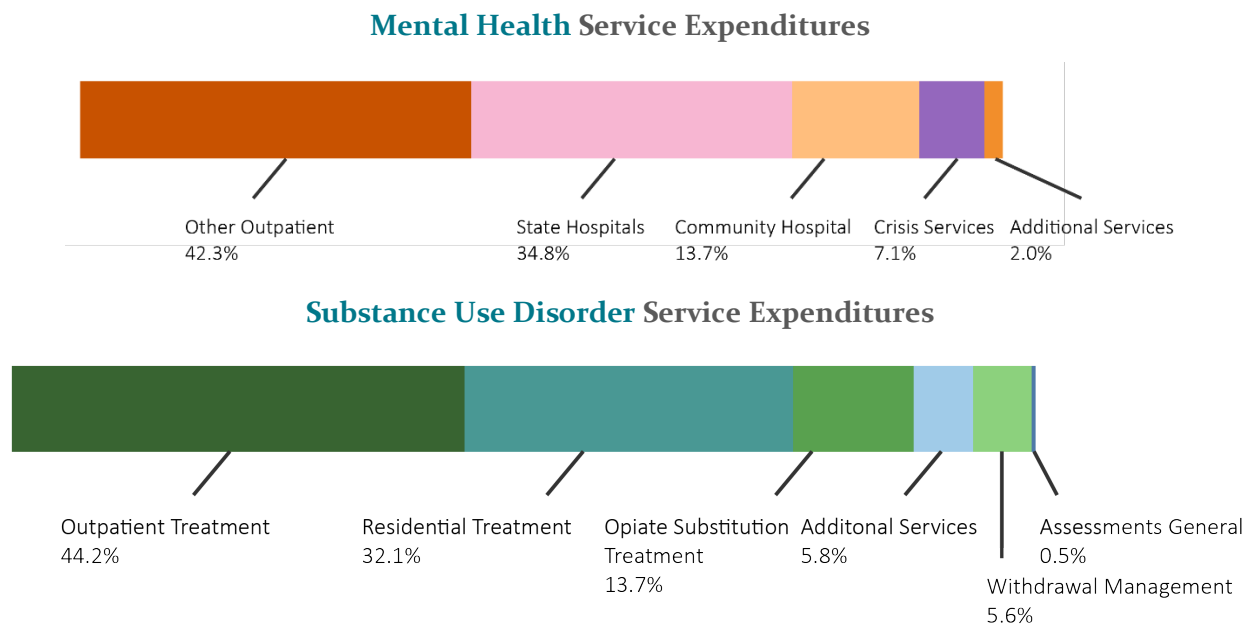
SPENDING AND FINANCING FOR BEHAVIORAL HEALTH CARE

In each state, the governor and state legislature make decisions regarding how much of the budget should go to behavioral health programs, and how much to education, corrections, roads and bridges, and other state projects. The percentage of the total budget allocated to behavioral health programs in a state can be a measure of prioritization of this issue relative to others in the state according to elected officials. In Washington and the Spokane region, a few chief entities exist to oversee behavioral health financing, administration, provision of services, technical assistance, and/or licensing and credentialing. Those are further described in Appendix A.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) is striving to ensure that behavioral health is incorporated within the context of health promotion and health care delivery and financing, as these conditions have historically been financed and regulated differently than other health conditions.²⁸

Data on DSHS-paid behavioral health services indicate that outpatient treatment makes up the largest share of state spending for both mental health and SUD services in the BHT region. But inpatient treatment (e.g. residential SUD care, or state hospital spending) still represents a significant component of costs in both sectors (Figure 10).

Figure 10 - Distribution of DSHS Behavioral Health expenditures in the BHT region, 2016-17



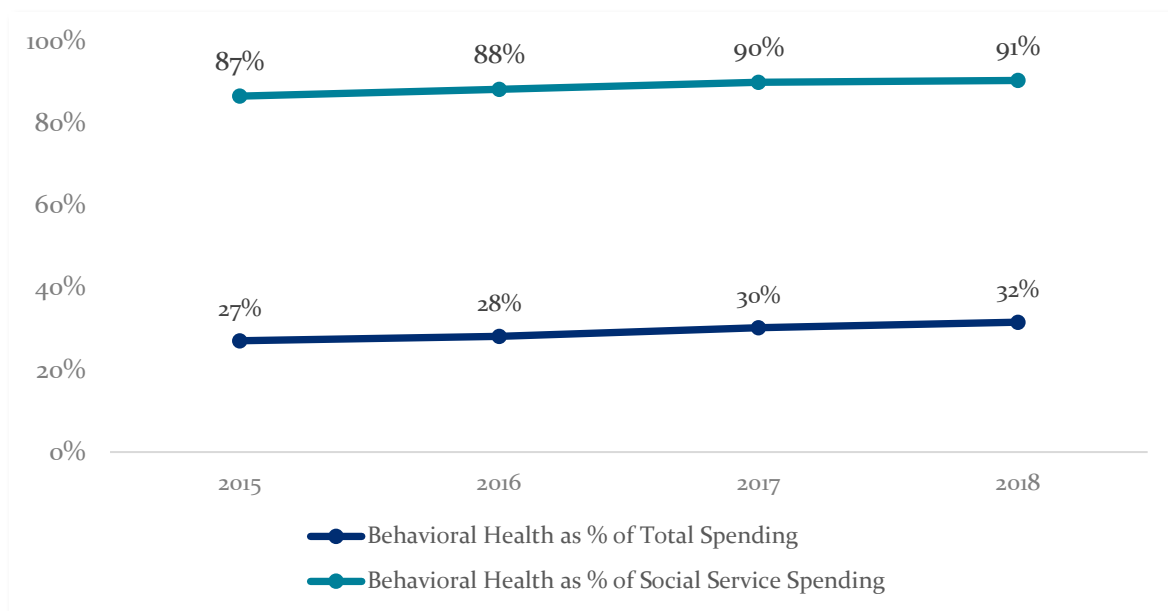
Source: WA Department of Health and Social Services Client Data Reports <http://clientdata.rda.dshs.wa.gov/>

In 2016-17, DSHS spent about \$182 million on mental health services and \$27 million on SUD disorder services in the BHT region. This translates to approximately \$3,300 per client for SUD services and \$8,500 per client for mental health services.²⁷

Indian Health Service, Tribal, and/or urban Indian health providers (I/T/U system of care) also deliver behavioral health services to American Indians and Alaska Natives in the BHT region. Spending is difficult to aggregate across the different I/T/U components but the FY 2017 Indian Health Services (IHS) budget allocated approximately \$218 million for alcohol and substance abuse services and \$94 million for mental health services in the Portland Area IHS region, which includes Washington, Idaho, and Oregon.²⁹

Turning to county-level expenditures, data reported annually to the State Auditor’s Office demonstrate that BHT’s counties have been increasing their spending for behavioral health services in the past several years. Per capita, reported spending on mental health and chemical dependency services among BHT counties rose from \$218 in 2015 to \$296 in 2018. The *proportion* of county spending on behavioral health care also increased. The chart below shows behavioral health as a proportion of social service spending, and as a proportion of total county expenditures, over a four year period.³⁰ Note that Ferry County did not report any mental health and chemical dependency expenditures for the years shown.

Figure 11 – Mental Health and Chemical Dependency Expenditures as proportion of Total Spending by BHT Counties, except Ferry County



Source: Washington State Auditor’s Financial Intelligence Tool (FIT) <https://portal.sao.wa.gov/FIT/>

Policy Implementation

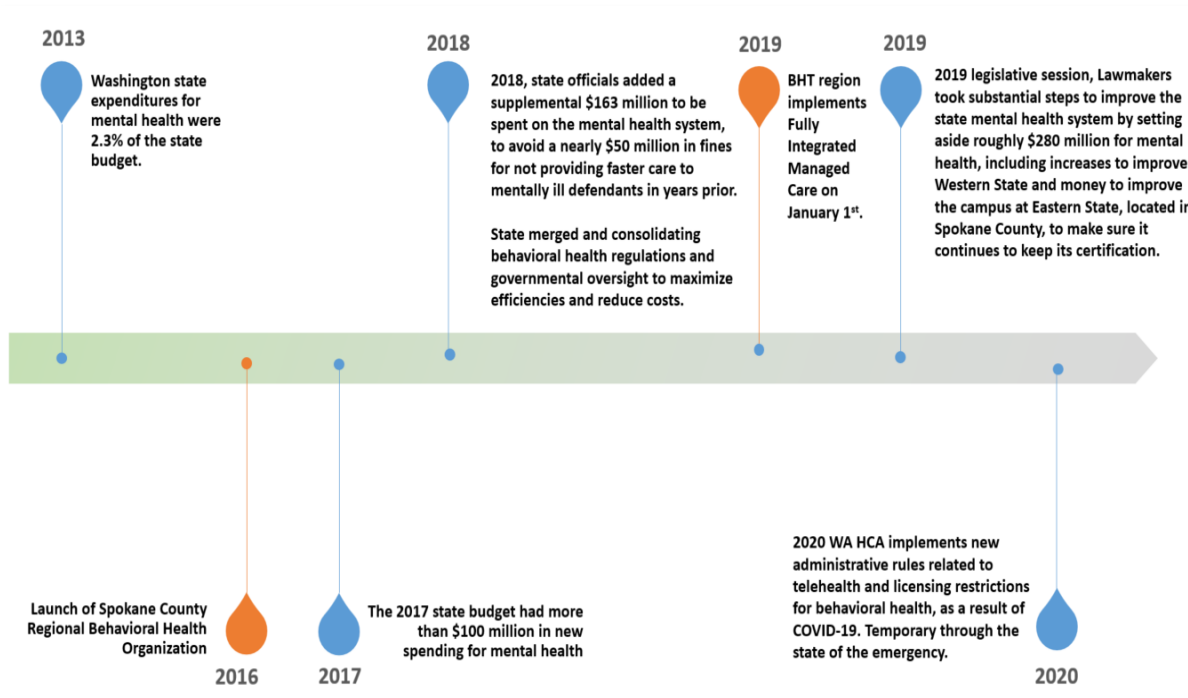
Among a range of policy issues in behavioral health, financing and payment integration have been areas of active experimentation in recent years.^{31,32} Evidence for improved patient outcomes achieved through integrating behavioral health and primary care is accumulating,³³ and recent

studies have demonstrated significant reduction in health care costs associated with this integration.^{34,35} However, financing integration efforts remains a barrier to widespread adoption.³⁶

In an effort to support integration, Washington has transitioned to fully integrated managed care (FIMC) for state Medicaid programs. Legislation passed in 2014 (SB 6312) required the change, with different regions of the state adopting FIMC on a rolling basis between 2014 and 2020. The BHT region implemented FIMC on January 1, 2019. Prior to FIMC, responsibility for Medicaid behavioral health care was split: Behavioral Health Organizations (BHOs) provided mental health services for those with serious mental illness and most forms of SUD treatment, whereas Managed Care Organizations (MCOs) provided physical health care, mental health services for those without serious illness, all psychotropic medications, and SUD treatment medication except methadone.³⁷ FIMC consolidated physical and behavioral health services for most Medicaid enrollees* under MCOs, with the goal of improving coordination and experience of care for beneficiaries with physical and behavioral health comorbidities, increasing access to needed services, and reducing potentially avoidable health care costs.

Alongside the transition to fully integrated managed care in Medicaid, Washington’s Legislature has been active in passing legislation and allocating funding for behavioral health over the past several years:

Figure 12 – Washington Behavioral Health-Related Policy Timeline (2013 – 2020)



Sources and additional information: Behavioral health related bills in Washington during the 2019 Session can be found in Appendix B.³⁸

*American Indian and Alaska Native Medicaid beneficiaries have the choice of receiving behavioral health services either through managed care or through the Apple Health fee-for-service program.

COVID-19 policy changes

On a federal level, one policy component of the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act has the potential to make behavioral health integration and care coordination easier for SUD providers and clients in particular. Existing confidentiality regulations known as 42 CFR Part 2 generally require written patient consent for *each* disclosure of patient SUD records. Because of it can be difficult to separate out different parts of someone's electronic health record, the Part 2 regulations sometimes prevent agencies and providers from sharing *any* patient data for individuals who have received SUD services, even if the data that needs to be shared does not pertain to the receipt of SUD services. The CARES Act still requires written patient consent for a first disclosure, but allows subsequent re-disclosures to qualified health care entities for purposes of treatment, payment, or operations, as long as the patient does not revoke consent.³⁹

At a state level, Washington Administrative Rules related to behavioral health were relaxed in some scenarios to promote access and treatment swiftly in response to the COVID-19 pandemic. Most notably:

- The Department of Health is waiving certain behavioral health agency licensing and certification requirements that impose an obligation on licensed behavioral health agencies to provide certain assessments and services “in person” or “face-to-face.”⁴⁰
- The Medicaid program has, and continues to, reimburse telehealth at the same rate as in-person care. COVID-specific 1135 waiver request summary changes include: expanding telehealth codes, broadly waiving any face-to-face patient/provider requirements for reimbursement, and allowing Medicaid emergency financing approaches for provider sustainability, particularly for smaller and more vulnerable behavioral health, home care and Tribal health providers.⁴¹
- Removal of requirements regarding documentation of history and/or physical exam in the medical record when providing telemedicine or telehealth.⁴²
- Waiving restrictions on what needs to be done “in person,” and redefining originating site including reimbursement for BH and other providers.⁴³

It should be noted that these changes are temporary for the duration of the emergency.

FOCUS SECTION #1: DISPARITIES BY RACE & ETHNICITY

Behavioral health disparities refer to differences in access to services and outcomes related to mental health and substance misuse experienced by groups based on their social, ethnic and economic status.⁴⁴ Behavioral health disparities can be found in the U.S. based on age, gender, income, disability status, sexual orientation, language, geographic location and other factors. Many mental health diagnoses are associated with a reduction in life expectancy by up to 24 years compared to individuals without such disorders.⁴⁵ The BHT region is largely rural and, while the prevalence of behavioral health conditions is usually similar across rural and urban communities,

rural populations are less likely to receive sufficient levels of treatment in part due to lack of access and less anonymity for those seeking care in small communities.⁴⁶

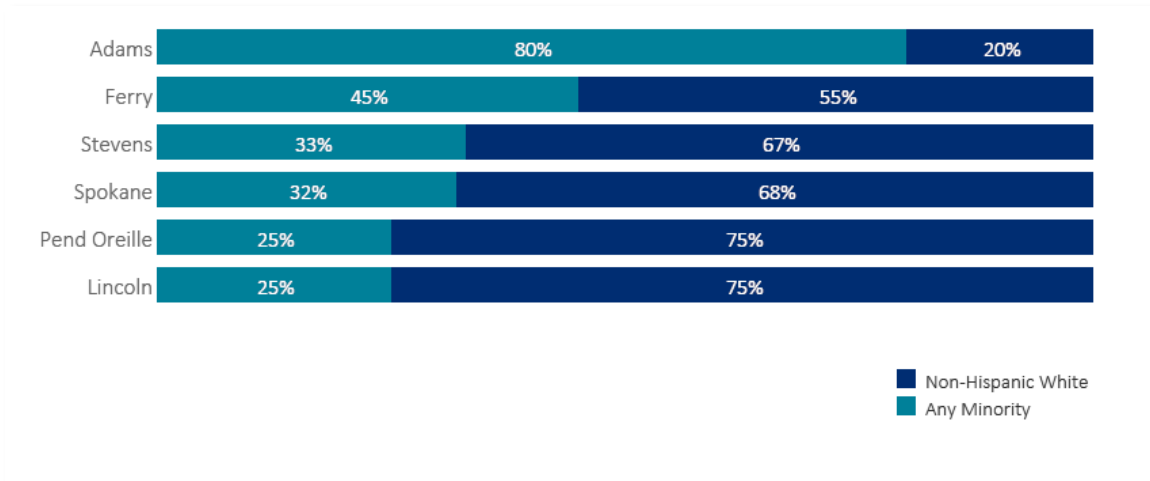
Disparities in access to and outcomes of behavioral health services are particularly acute for communities of color. According to the National Institute of Mental Health, “members of racial and ethnic minority groups in the U.S. are less likely to have access to mental health services, less likely to use community mental health services, more likely to use inpatient hospitalization and emergency rooms, and more likely to receive lower quality care.”⁴⁷ Scholars focused on stress recognize that people of color and those from lower socioeconomic backgrounds, including Indigenous people, are differentially exposed to stressors that increase risk for poor health status and mortality compared to the overall population.⁴⁸ For Black, Indigenous, and other people of color, the experiences of discrimination, cultural assaults,⁴⁹ and other stressors tend to occur together and accumulate over time, leading to negative health consequences not experienced by those with economic and social advantage.⁵⁰

In addition to access barriers that exist for all groups, barriers that prevent Black, Indigenous, and other people of color from accessing needed behavioral health services include: lack of service availability, particularly for culturally-specific care; a system weighted heavily towards white-dominant values, norms, and educational training; language barriers and an insufficient number of providers/interpretive services; and racism, bias and discrimination in treatment settings.⁵¹

As a population, American Indians and Alaska Natives experience some of the most profound health inequities compared to other racial/ethnic groups.⁵² For the three federally-recognized Tribes in the BHT region--the Colville Tribe, the Kalispel Tribe of Indians, and the Spokane Tribe of Indians—one report noted the following identified priorities for Natives 50 and older living in the area: addressing substance abuse related issues, improving cultural competence of staff, and improving the provision of trauma informed care.⁵³ Recommendations for the FY2020 national Indian Health Services budget developed by federally-recognized Tribes in Washington, Oregon, and Idaho called for an additional \$70 million to support mental health and suicide prevention, alcohol and substance abuse treatment and after-care, and services for women who have experienced sexual assault or intimate partner violence.⁵⁴

In the BHT region overall, 31%-33% of clients who received DSHS-paid behavioral health services in 2016-17 were people of color, but the figures vary by county (Figure 13).²⁷ In most counties, people of color make up a larger portion of state SUD and MH program clients than they do of the general population.²⁷ More recent data for the Medicaid population are similar; 26% of BHT region Medicaid clients in 2018-29 were identified as non-white, and 5% as unknown race/ethnicity.⁸

Figure 13 – Clients receiving state-supported behavioral health services by County and Race/Ethnicity, 2016-17

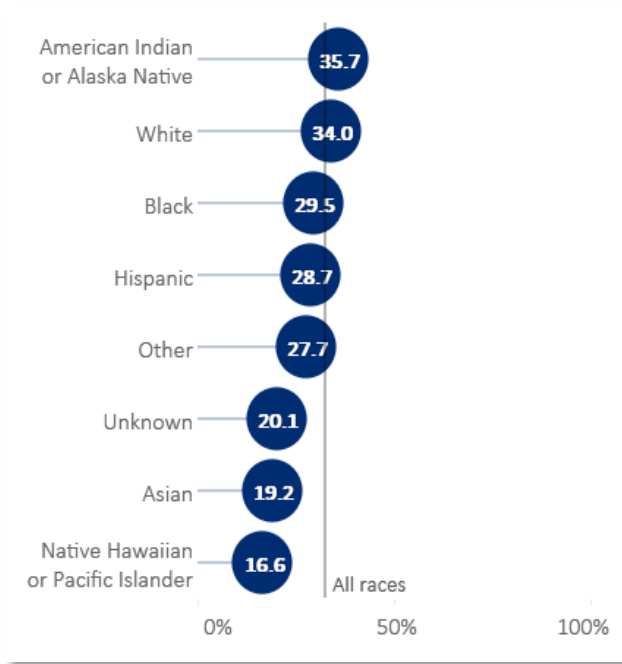


Source: WA Department of Health and Social Services Client Data Reports <http://clientdata.rda.dshs.wa.gov/>

Data for Medicaid-covered individuals, derived from the Healthier WA dashboard,⁸ highlight racial inequities in mental health and SUD needs as well as inequities in receipt of services (Figures 14 and 15, below).

Figure 14 – Mental Health Need and Rate of Treatment among BHT Region Medicaid Adults by Race/Ethnicity, 2018-19

BHT Region Medicaid Mental Health Need



BHT Region Medicaid Rate of Treatment Among those with Identified MH Need

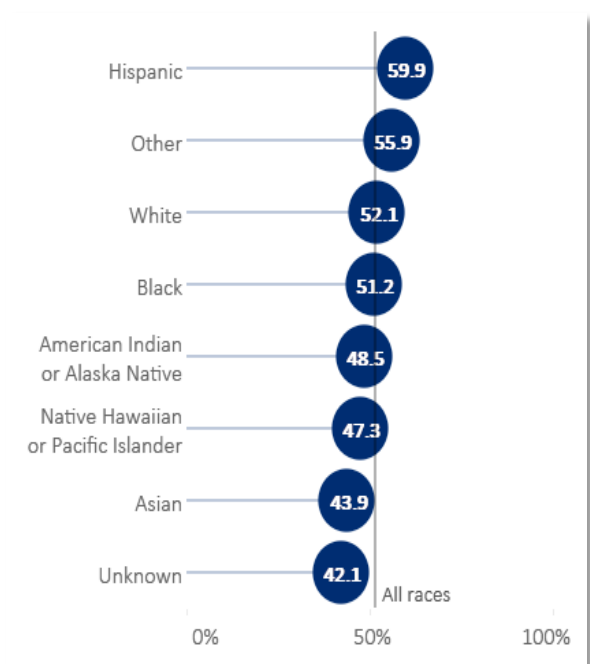
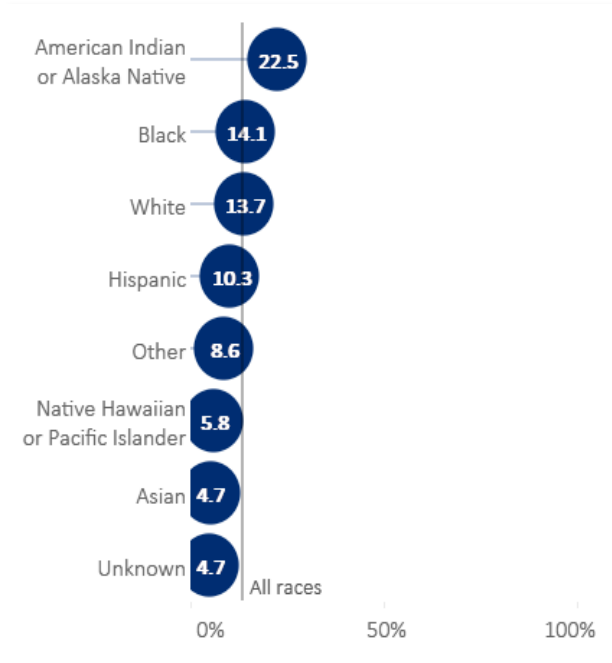
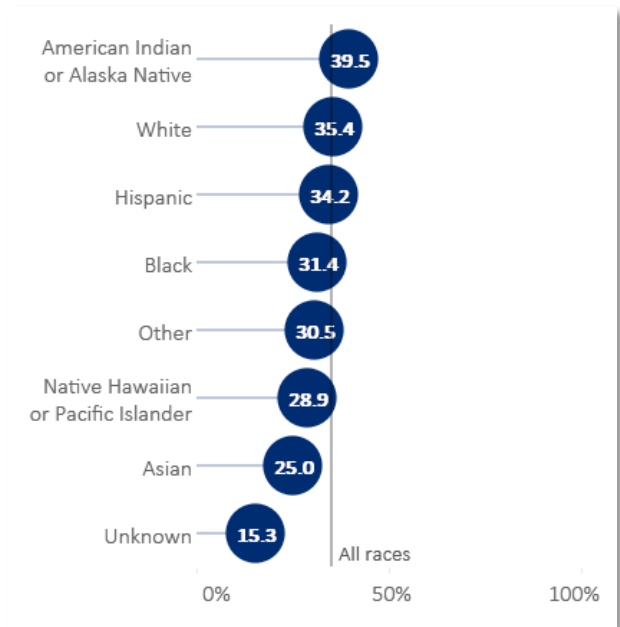


Figure 15 – SUD Treatment Need and Rate of Treatment among BHT Region Medicaid Adults by Race/Ethnicity, 2018-19

BHT Region Medicaid SUD Need



BHT Region Medicaid Rate of Treatment Among those with Identified SUD Need



Source: Derived from Healthier Washington Dashboard data

Of note: Because Figures 14 and 15 estimate need based on a 2-year diagnostic history in Medicaid data, the figures only represent enrollees who have obtained enough care through Medicaid to have at least received a diagnosis. The estimates may be lower than true ‘need’ as a result of lack of access to care.

For Medicaid adults age 18 – 64 in the BHT region, the highest estimated *need* for both mental health and SUD care is among American Indians or Alaska Natives (AI/AN) (Figures 14 and 15, left-hand charts). Looking at *receipt of treatment* among those with an identified need (Figures 14 and 15, right-hand charts), Medicaid enrollees who are Black, Native Hawaiian or Pacific Islander, Asian, or of ‘Unknown’ race are less likely to receive needed behavioral health treatment than Whites. There is a spread of almost 20 percentage points in the BHT region between the groups most and least likely to receive needed mental health care (60% of Hispanic enrollees receiving needed care vs. 42% of ‘Unknown’ race enrollees). This is a wider disparity than almost all other ACH regions, with the exception of North Central.⁸ For receipt of needed SUD treatment, the spread is even larger: about 40% of American Indians and Alaska Natives and only 15% of enrollees of ‘Unknown’ race are receiving treatment for identified SUD concerns. This degree of difference can be observed for several ACH regions.

Similar figures that include statewide rates can be found in Appendix C. Appendix C also contains data by race and ethnicity for some additional measures of behavioral health access for BHT’s

Medicaid population: rates of follow-up after an ED visit for either mental illness or SUD; and rates of follow-up after a hospitalization for mental illness.

FOCUS SECTION #2: COMMUNITY BEHAVIORAL HEALTH

The provision of comprehensive mental health and addictions services is the goal of community-based behavioral health organizations today. Prior to federal legislation in 1963, people with mental illnesses were typically confined to hospitals and institutions to receive care. The Community Mental Health Act signed by President John F. Kennedy, enacted programming showing that mental illnesses could be treated more effectively and in a more cost-effective manner in community settings than in traditional psychiatric hospitals, allowing people to move back into their communities for treatment.⁵⁵

Community-based mental health and addiction care is more effective than institutionalization, both in improving access to quality care and holding down costs to the public and private payers.⁵⁶ That said, organizations providing these services have evolved. Today community-based behavioral healthcare is delivered by a mix of government and county-operated organizations, Tribal and urban Indian organizations, as well as private nonprofit and for-profit organizations. These mental health and addiction services are funded by a patchwork of sources, including Medicaid, Medicare; county, state, and federal programs; private insurance; and self-pay.

The Washington Department of Health licenses and regulates professionals, facilities, and agencies that provide behavioral health services including mental health providers, SUD providers, and problem gambling programs.⁵⁷ The agency's January 2020 directory⁵⁸ lists about 60 agencies in BHT's six county region, some with multiple clinic sites or physical locations, plus the Eastern State Psychiatric Hospital. The vast majority of those agencies are in Spokane County.

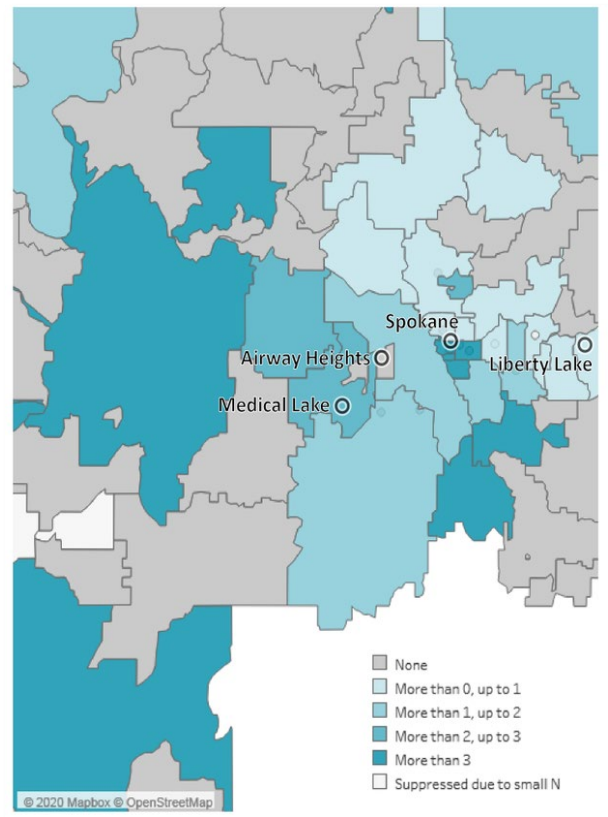
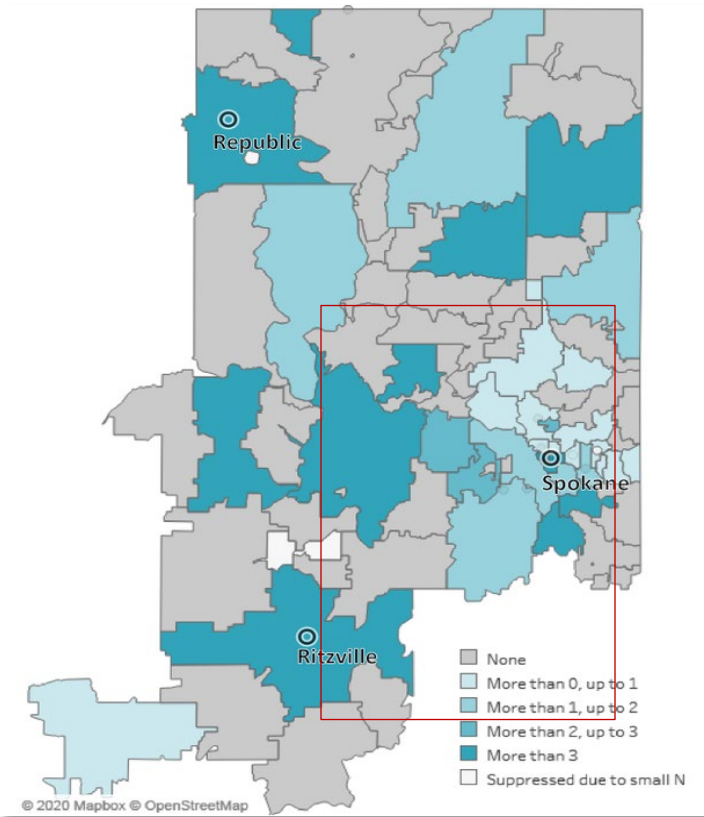
Culturally-specific behavioral health services are offered by a small number of agencies in the BHT region including The Healing Lodge and The NATIVE Project in Spokane County, the Kalispel Tribe's Camas Path Behavioral Health Services, and others.

In addition to certified behavioral health agencies, individual providers or group practices may provide behavioral health services. Those who serve Medicaid beneficiaries must be enrolled Medicaid providers. The maps on the following page show the number of Medicaid-enrolled behavioral health providers per 1,000 Medicaid beneficiaries in the BHT region, with a second map focused on the Spokane area in particular.

Figure 16 – Medicaid-enrolled behavioral health providers per 1,000 Medicaid Beneficiaries

BHT region by zip code

Spokane region by zip code



Source(s): ProviderOne (Medicaid Behavioral Health providers) and WA All-Payer Claims Database for Medicaid beneficiaries

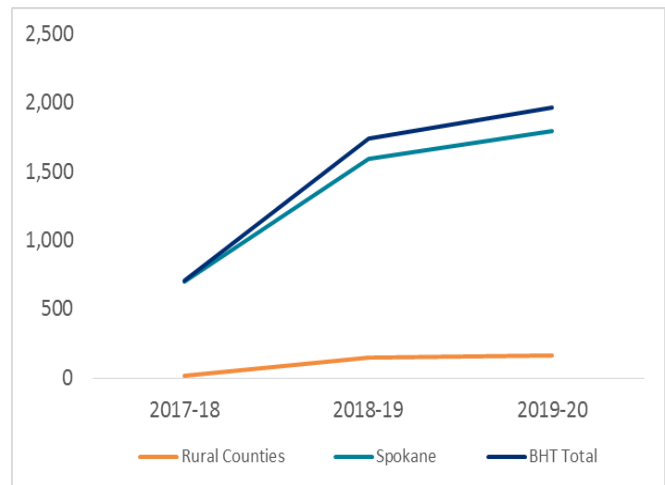
Community Behavioral Health Workforce

Behavioral health services are provided by a wide array of licensed, certified, and non-certified individuals including but not limited to: counselors, psychiatrists, psychologists, licensed clinical social workers, chemical dependency professionals, designated crisis responders, marriage and family therapists, traditional Native healers, behavior analysts and technicians, peer specialists and recovery coaches, and advanced practice nurses. Nationally, the number of behavioral health providers has improved over the last few years. However, projections from the Health Resources and Services Administration (HRSA) still indicate an immense shortage of mental health and substance use treatment providers to meet the demand projected by 2030.⁵⁹

The number of behavioral health providers serving Medicaid beneficiaries in the BHT region is growing, according to Medicaid provider enrollment data.⁶⁰ That source lists roughly 2,000 behavioral health professionals providing services in BHT's six counties as of May 2020, a substantial increase from two years prior. As Figure 14 shows, however, the overwhelming majority of those providers are in Spokane County.

Figure 17 – Medicaid-enrolled Behavioral Health Providers in the BHT region, 2017 - 20

Provider Type	2019-20
Counselors	1,242
Social Workers	361
Marriage & Family Therapists	55
Behavior Analyst	157
Behavior Technician	73
Psychologist	70
Clinical Neuropsychologist	4
Total	1,962



Source: Derived from WA HCA Provider Dashboard

<https://www.hca.wa.gov/about-hca/provider-data-dashboard>. Numbers shown count “servicing” providers only, not billing providers.

The Medicaid provider enrollment data shown in Figure 17 but do not include every provider type and do not clearly distinguish mental health vs. SUD treatment professionals. 2017 data from Washington health care professional licensing boards and certification bodies, compiled by the University of Washington’s Center for Health Workforce Studies,⁶¹ contain some more specific categories such as Chemical Dependency Professional or Mental Health Counselor. A summary of these 2017 data, comparing provider availability in the BHT region and statewide, can be found in Appendix D. Note also that SUD professional licensing and/or credentialing can be complex and varies substantially from state to state.⁶²

Only a subset of behavioral health providers can independently prescribe and manage medications (e.g. physicians, nurse practitioners, physician assistants), which is a critical part of treatment for many. In the context of earlier data on the high rate of opioid prescriptions in the BHT region (see Figure 6), increasing the availability of professionals who can prescribe medication assisted treatment (MAT) for individuals with opioid use disorder (OUD) is particularly important. MAT prescription authority requires additional training and a federal waiver to deliver MAT outside the context of an official opioid treatment program. As of Q3 2019, the BHT region had only 24.0 M.A.T. providers per every 1,000 Medicaid enrollees with OUD, substantially lower than the state average of 46.1 per 1,000. Adams and Stevens County were much closer to the state average, whereas Ferry, Lincoln, Pend Oreille, and Spokane Counties had lower numbers of providers able to offer MAT.⁶³

In May 2018, BHT asked its behavioral health partners to respond a survey that included questions regarding staff composition. The data in Table 1, representing 34 clinics sites at 27 organizations, demonstrate that community behavioral health agencies in the region rely heavily on non-physicians and clinical support staff to care for those with behavioral health needs.

Table 1 – Average Number of Care Team Members at BHT Partner Agencies Offering Behavioral health Services, 2018

Average number of physicians	1.3
Average number of other clinicians (e.g. nurses)	19.6
Average number of clinical support staff (e.g. case managers, MAs, etc.)	15.3
Average number of admin staff	5.6
Average total staff	48.2

Source: BHT Medicaid Transformation Project Capacity Assessment Survey, May 2018. About half of the agencies surveyed offered both mental health and SUD services; 35% were mental health only, and 15% were SUD only.

Peer support and Community Health Workers are an increasingly important component of the behavioral health workforce. Certified Peer Counselors are credentialed by HCA and, as of July 1 2019, peer support services for both mental health and substance abuse disorders are Medicaid reimbursable when provided through appropriately licensed behavioral health agencies.⁶⁴ Both peer counselors and Community Health Workers may also be used to support or facilitate the work of care coordinators, without being directly reimbursable. The service flexibilities and reimbursement pathways implemented by Apple Health in response to COVID-19 include Medicaid-covered peer services.

In 2017, there were close to 2,500 Certified Peer Counselors in Washington State, but only 207 in the BHT region.⁶⁵ Legislation in 2019 called for a report on peer programs in Washington and HCA is currently conducting a survey to learn more about the locations and number of individuals served by peers. The number of Community Health Workers (CHWs) or those similar roles is more difficult to quantify, as there is no formal certification in Washington. As of July 2017, almost 1,500 residents had completed the Department of Health CHW training, but it was estimated that only 10% or so were doing work in a behavioral health agency.⁶⁶ Twelve of BHT’s clinical partners have chosen to work towards increased use of peers and/or CHWs as part of their 2019-20 Medicaid transformation contracts with BHT.

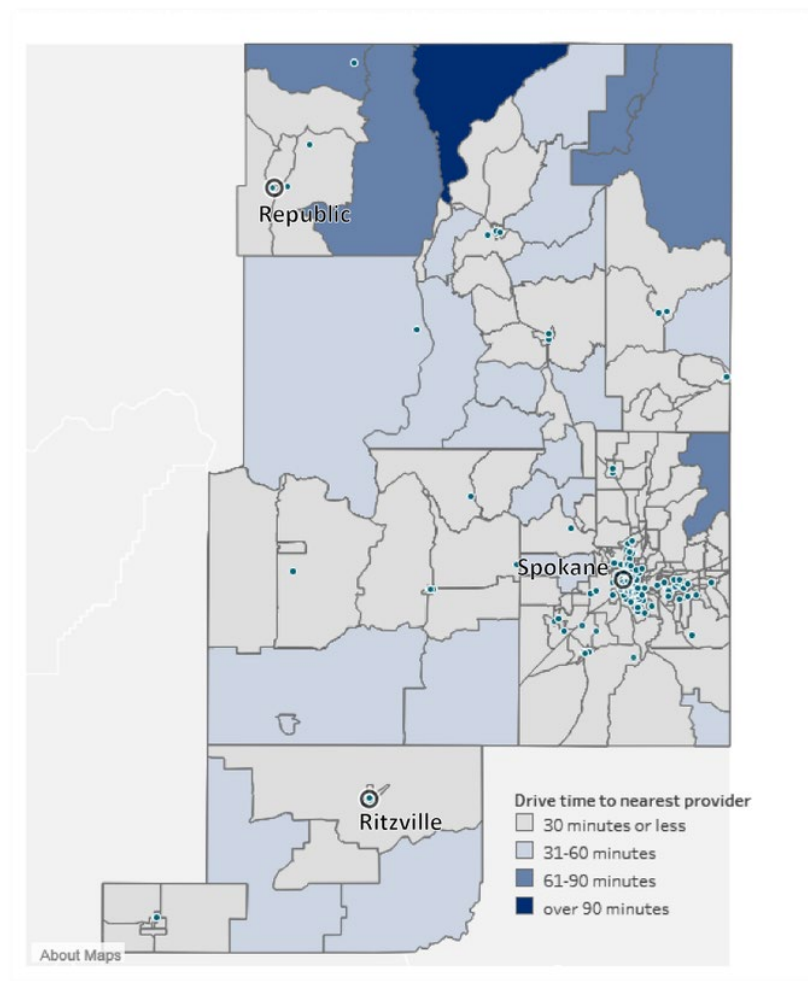
Demand in Washington for a qualified behavioral health workforce continues to grow. While the state has many highly competent and committed professionals working hard to deliver behavioral health services, barriers to educational attainment, professional recruitment, and long-term retention may limit the state’s ability to provide sufficient behavioral healthcare to its residents. One 2019 report indicated that since 2016, mental health counselors and substance use disorder professionals (formerly chemical dependency professionals) were identified as the top two positions with “exceptionally long vacancies” by behavioral health facilities; social workers were consistently named among the top four positions with exceptionally long vacancies in these settings.⁶⁷

FOCUS SECTION #3: TRANSPORTATION AND GEOGRAPHIC ACCESS TO BEHAVIORAL HEALTH CARE

As mental illness and addiction are chronic health conditions, access to non-emergency medical transportation is crucial. As with other chronic illness, people experiencing mental illness and addiction require transportation assistance so they can engage in long-term treatment and recovery support services.

Access to reliable transportation is a concern for low-income populations, disabled individuals, and people living in rural areas, among others. Figure 15 shows the average drive time to the nearest Medicaid behavioral health provider by census block group in the BHT region. Areas in the north and east portions of the BHT region experience the longest travel times (more than 1 hour) to the nearest point of behavioral health care. Provider locations are the small blue dots on the map.

Figure 18 – Drive Time to the Nearest Medicaid-Enrolled Behavioral Health Provider by Census Block Group, 2020



Source: Provider address extracted from HCA's Medicaid ProviderOne public directory:

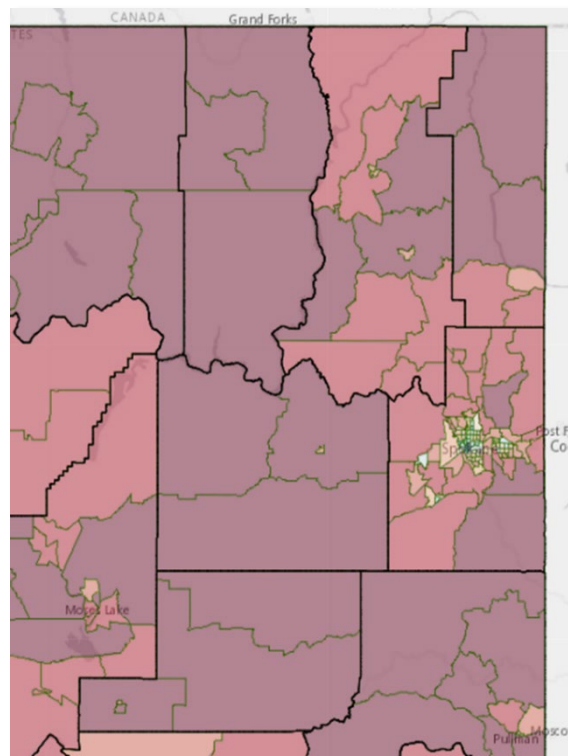
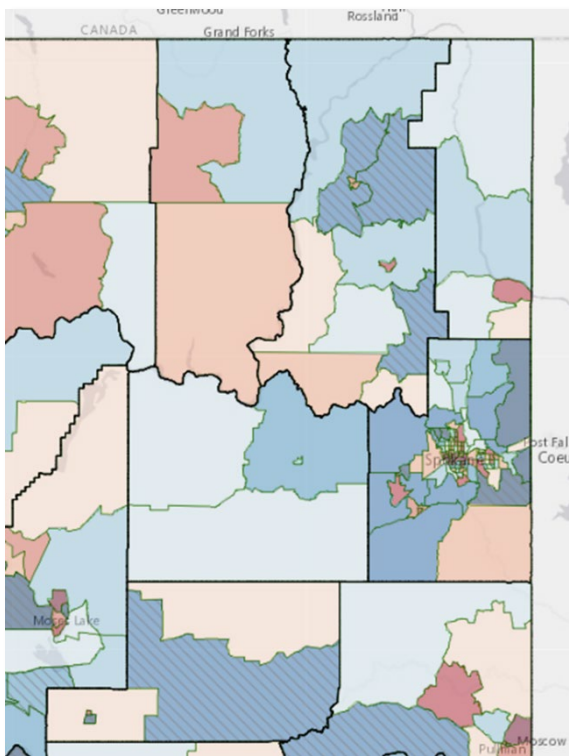
<https://fortress.wa.gov/hca/pifindaprovider/>. Drive time is calculated based on the time needed to drive from the geometric center of the Census Block Group using road speed data from TomTom. A more detailed explanation of how the times are calculated can be found here: <https://help.alteryx.com/current/designer/distance-tool>.

The vast majority of the BHT region BHT is classified as rural or frontier. The maps below show disparities in access to a private vehicle and in the amount of household income spent on transportation costs in the BHT region. Shading in these maps is based on where the area sits in the *statewide distribution* for each measure; a pink or red shade means that the area has a higher number of households with no car than is typical for the state as a whole, or spend a greater portion of their income on transportation, when considered against the overall state distribution. Spokane area maps for these same measures can be found in Appendix C.

Figure 19 – Regional Transportation Access Barriers, 2019

No Access to a Private Vehicle

Percent of Income Spent on Transportation



Source: Washington Tracking Network, data obtained from US Census American Community Survey:

<https://www.doh.wa.gov/DataandStatisticalReports/WashingtonTrackingNetworkWTN/InformationbyLocation>

Telehealth

Tele-health services can help mitigate the barriers that distance and lack of transportation present for access to care. The use of tele-health has skyrocketed during the COVID-19 crisis as providers seek ways to continue offering services while protecting patients and themselves from viral exposure. Pre-COVID, in the fall of 2019, only about a third of BHT's contracted behavioral health partners (20 total were surveyed) reported offering tele-health or telemedicine, although 70% were interested in starting or expanding such services. Lack of technology/equipment, reimbursement, and licensing or regulatory issues were the most frequently cited barriers to starting or expanding tele-health services among BHT's behavioral health partners. Other concerns included privacy and security of communications, and lack of time to develop protocols and train staff.⁶⁸

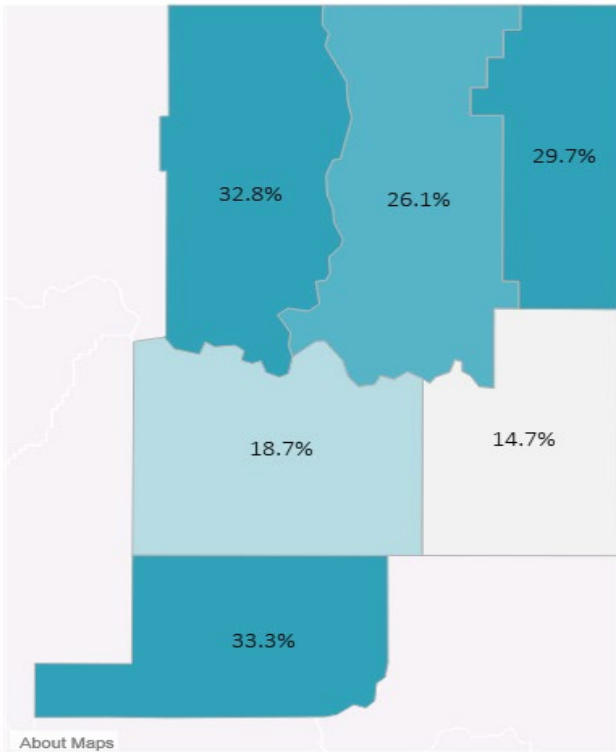
"We could push all sorts of Medicine Management services out to patients RAPIDLY via tele-health if not bogged down with requirements for "assessments before any interventions" as required in Washington's administrative rules."

- BHT October 2019 Partner Report

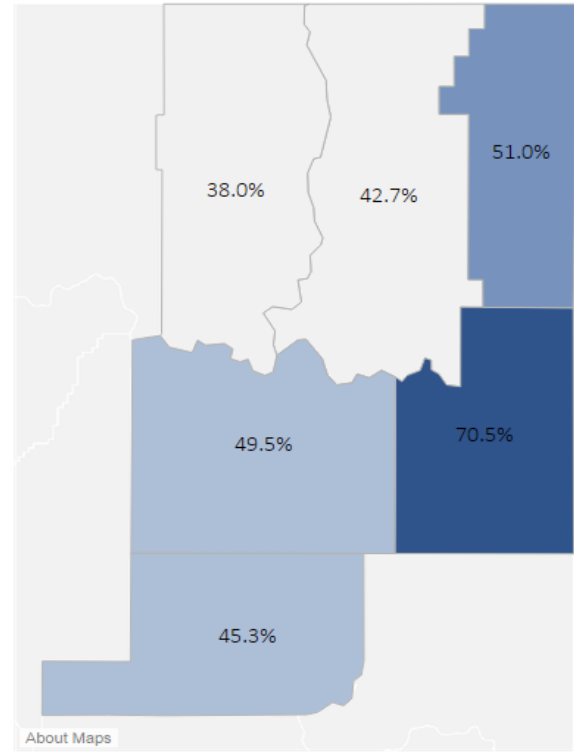
Reliable internet is a prerequisite for most telehealth services, especially because Medicare has traditionally limited reimbursement for audio-only telehealth. But not all communities have consistent access (Figure 20). Between 2014 and 2018, the proportion of households in the BHT region without an internet subscription of any kind is as high as 33% in Adams and Ferry Counties (margin of error: +/- 5%). The proportion of households with broadband internet access varied from a high of about 70% in Spokane County (less than 1% margin of error) to a low of 38% in Ferry County (margin of error: +/- 4%).

Figure 20 – Internet Access in the BHT Region, 2014-2018

Percent of Households with no Internet Subscription



Percent of Households with Broadband Internet (such as cable, fiber optic or DSL)



Source: American Community Survey, 2018 5-year pooled estimates, Table ID S2801: <https://www.census.gov/programs-surveys/acs>

Since COVID-19, a number of telehealth policy changes and flexibilities have been introduced that will likely have a significant impact on people seeking care and behavioral health providers in the BHT region. While these are largely temporary changes due to the crisis, tracking updates and positive outcomes will be important for sustained policy implementation. A recent provider needs assessment and report by the Behavioral Health Institute at the University of Washington survey outlines a number of potential steps for addressing remaining barriers to telehealth and sustaining recent improvements.⁶⁹

APPENDICES

Appendix A – Brief list of entities with responsibility for administration, financing, or regulation of behavioral health in Washington State

Entity	Role
Department of Health	Licenses and regulates a number of the professionals, facilities, and agencies that provide behavioral health services. ⁷⁰
Department of Social and Health Services' (DSHS) Behavioral Health Administration (BHA)	Funds prevention and intervention services for youth and families, and treatment and recovery support for youth and adults with addiction and mental health conditions. ⁷¹ It operates three state psychiatric hospitals and the Office of Forensic Mental Health Services.
Health Care Authority (HCA)	<p>Integrates state-funded (Medicaid) services for substance use, mental health and problem gambling.</p> <p>Manages provider enrollment for Medicaid, and set and oversee network adequacy requirements for MCOs / FIMC plans.</p> <p>Provides funding, training, and technical assistance to community-based providers for prevention, intervention, treatment, and recovery support services to people in need.⁷²</p> <p>Implements a number of programs related to BH including: Block grants, Children's Mental Health Lawsuit and Agreement, Medicaid waivers, Ricky's Law: Involuntary Treatment Act (ITA), State Opioid Response (SOR) grant, State Youth Treatment - Implementation (SYT-I) Project, Substance abuse prevention and mental health promotion, Washington Screening, Brief Interventions, and Referrals to Treatment (WASBIRT-PCI) Project, Washington State Hub and Spoke Project.</p> <p>Recently awarded funding from the Federal Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) act, which aims to increase the treatment capacity of Medicaid providers to deliver substance use disorder treatment and recovery services. States receive 18 months of planning with a chance at a subsequent 36 months of demonstration dollars, including enhanced FMAP for SUD services.⁷³</p>
Indian Health Service, Tribal Health Services,	Elements of the delivery system by which the federal government carries out its trust responsibility for American Indians and Alaska Natives. Federally supported behavioral health services (among others) may be provided by the Indian Health Service, by Tribally-

and Urban Indian (I/T/U) health programs	operated or contracted programs, by Urban Indian health programs, or by private providers.
Medical Commission and Board of Nursing	Licensure of psychiatrists and nurse practitioners; including psychiatric nurse practitioners.
Spokane County Regional Behavioral Health (Administrative Services Organization) BH- ASO	Spokane County Community Services, Housing, and Community Development Department (CSHCD) is a public behavioral health administrator for crisis services, including involuntary treatment act evaluations, for all regional residents. Also as an administrator for all behavioral health services for non-Medicaid individuals on Less Restrictive Alternative Court Orders or Conditional Release, and non-crisis behavioral health services for individuals who are not Medicaid-eligible and at or below the 220% Federal Poverty Level (FPL) in the Spokane Regional Service Area (RSA). ⁷⁴

Appendix B – Behavioral Health Related Bills in Washington 2019 Session

[Senate Bill 5444](#) makes changes intended to speed up competency evaluations for defendants in jail by boosting staff and starting diversion and outpatient restoration services.

[House Bill 1394](#) creates two new types of treatment facilities that can be placed in communities. One is for people with intensive needs, like some of the patients waiting to be discharged from Western State. The other type, called a peer respite center, is intended to give short-term, voluntary treatment to people. These alternatives could help people considered a harm to themselves or others, but who don't meet the legal threshold to be involuntarily detained through the civil courts process.

[Senate Bill 5054](#) directs the state to establish a reciprocity program for chemical dependency professionals, psychologists, mental-health counselors and others moving into the state. That would allow the state to grant a probationary license so qualified professionals can begin working here while they get their Washington licenses.

Lawmakers also passed [House Bill 1668](#), which encourages behavioral-health workers to take jobs in underserved areas by offering a student-loan repayment program.

Terminology and scopes of practices adjusted in [HB 1768](#) to better align with Substance Use Disorder recovery and breadth of treatment, co-occurring disorder support, and clarifying requirements for these roles.

2020 WA HCA implements new administrative rules related to [telehealth](#) and licensing restrictions for behavioral health, as a result of COVID-19. Temporary through the state of the emergency.

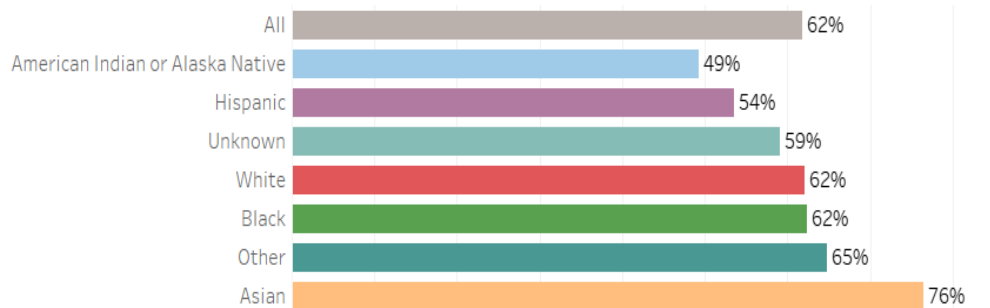
Sources:

- Washington Behavioral Health Institute (BHI). Rapid Response: Sustaining Improved Access to Behavioral Telehealth. Executive Summary and Summary of Relaxed Regulations by Topic. Working document, draft as of 6/1/20. Available via BHT's COVID-19 resources page, see: <http://www.betterhealthtogether.org/bold-solutions-content/sustaining-telehealth>.
- Seattle Times. May 5, 2019. Washington Lawmakers Approved an Ambitious Plan to Fix the Mental Health System. <https://www.seattletimes.com/seattle-news/politics/weve-never-had-a-plan-before-washington-lawmakers-approve-new-money-new-approach-to-mental-health-care/>
- Washington Legislature website: <https://app.leg.wa.gov/billssummary?BillNumber=5444&Initiative=false&Year=2019>

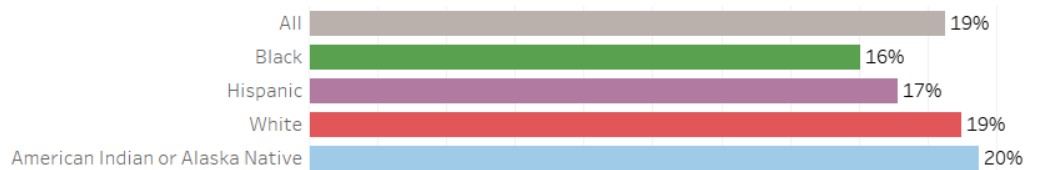
Appendix C – Supplementary Data

1. Follow-up after ED Visits or Hospitalizations for Behavioral Health Diagnoses among BHT region Medicaid enrollees, by Race/Ethnicity, April 2018 – March 2019

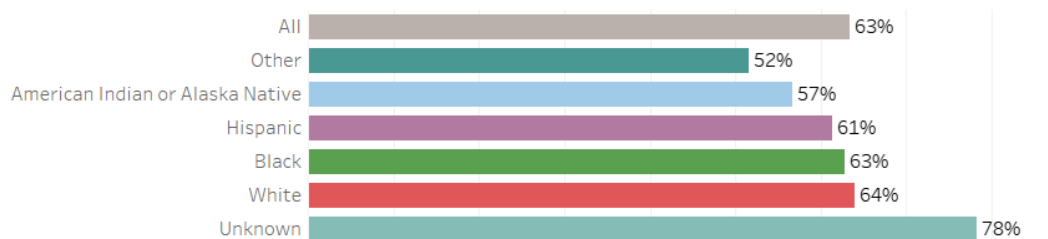
Follow-up After Hospitalization for Mental Illness: 7 days by Race Ethnicity for the Better Health Together Region



Follow-Up After ED for Alcohol and Other Drug Abuse or Dependence: 7 Days by Race Ethnicity for the Better Health Together Region



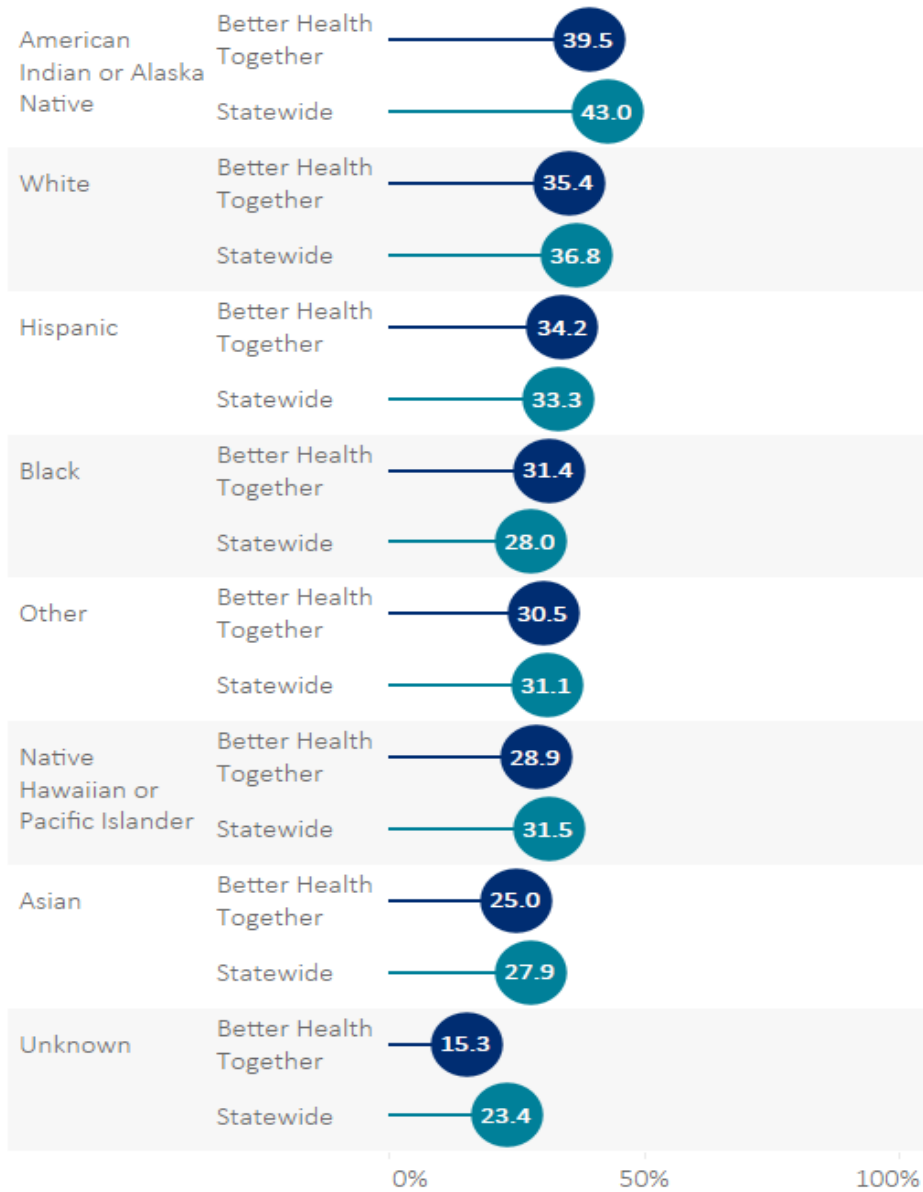
Follow-Up After ED for Mental Illness: 7 Days by Race Ethnicity for the Better Health Together Region



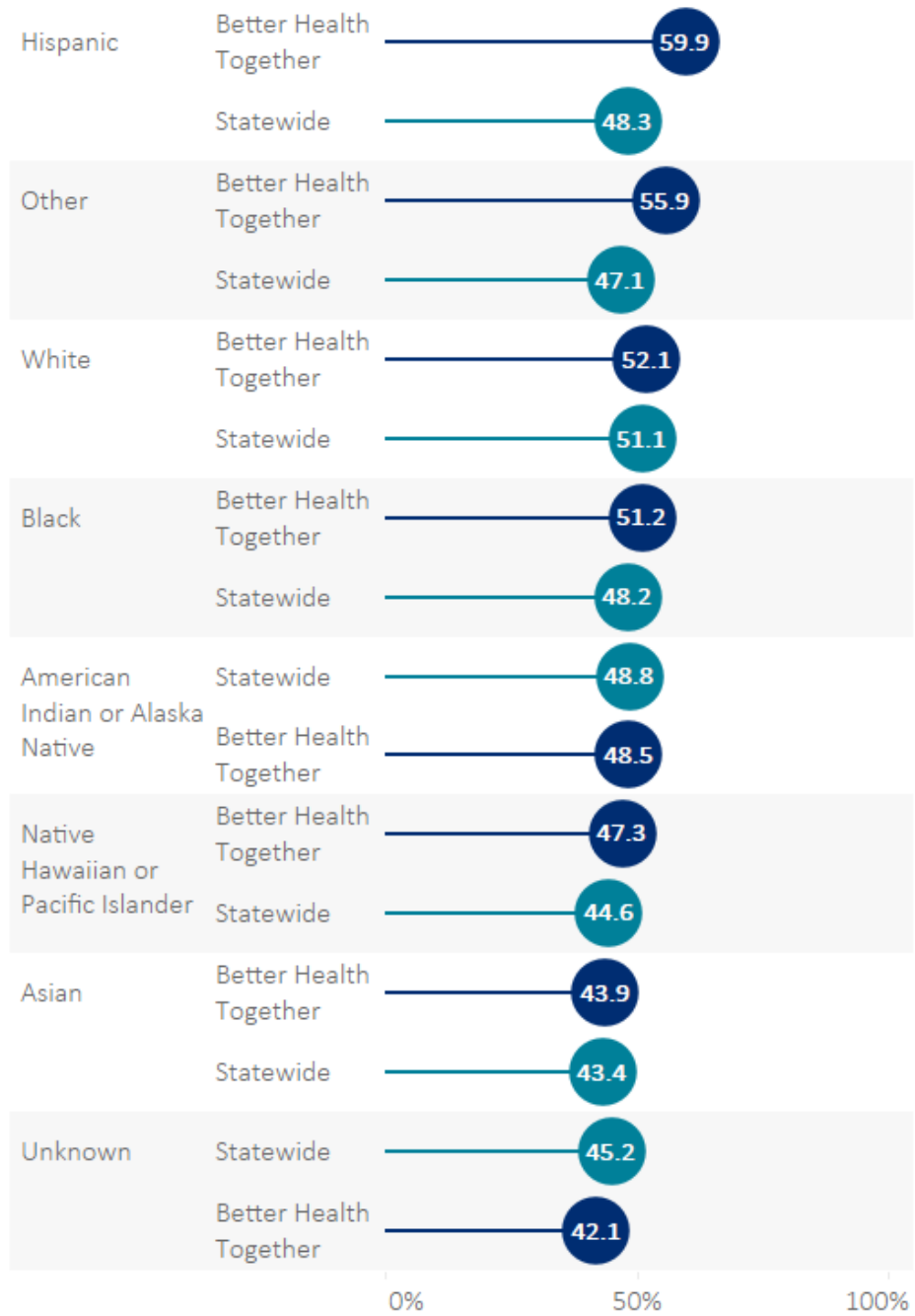
Source: Healthier Washington Dashboard, <https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboards>

2. Rates of Treatment among BHT Region Medicaid Enrollees with Identified Behavioral Health Needs, by Race/Ethnicity, April 2018 – March 2019

Rate of Treatment among those with Identified SUD Need

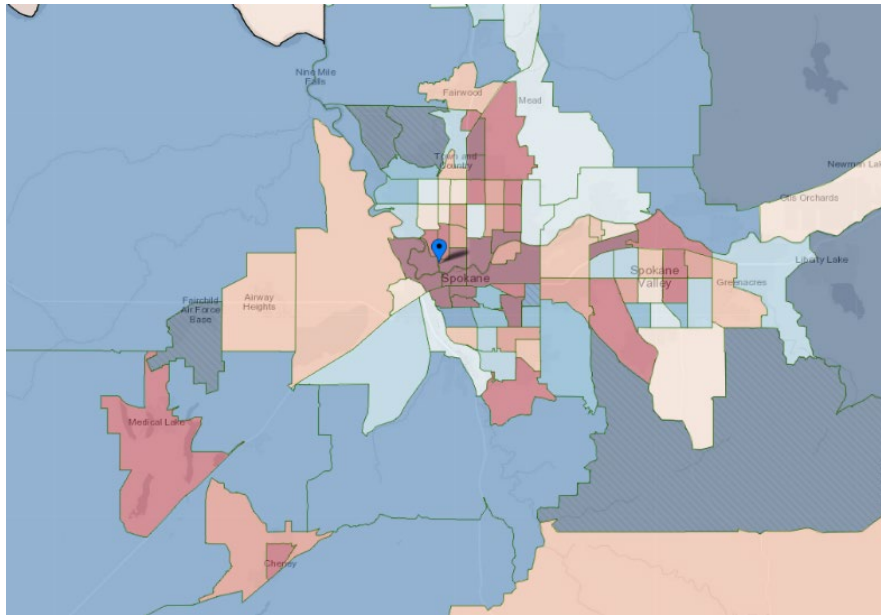


Rate of Treatment among those with Identified Mental Health Need

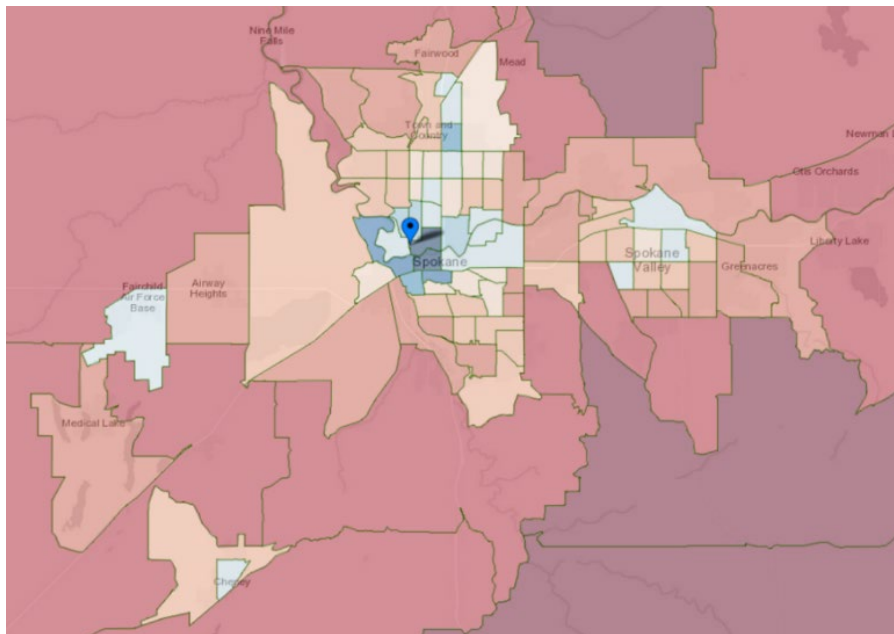


3. Transportation barriers in Spokane and surrounding areas

No access to a private vehicle



Percent of income spent on transportation



Shading in these maps is based on where the area sits in the *statewide distribution* for each measure; a pink or red shade means that the area has a higher number of households with no car than is typical for the state as a whole, or that households in the area spend a greater portion of their income on transportation, when considered against the overall state distribution. Source: Washington Tracking Network, data obtained from US Census American Community Survey:

<https://www.doh.wa.gov/DataandStatisticalReports/WashingtonTrackingNetworkWTN/InformationbyLocation>

Appendix D – Workforce Data for Selected Behavioral Health Professionals – BHT Region and Statewide (2016-2017)

Selected Behavioral Health Professions	Better Health Together				Statewide			
	N	Per 100K pop.	Mean Age	% 55+ years	N	Per 100K pop.	Mean Age	% 55+ years
Chemical Dependency Professionals	357	60.7	50	39%	2,629	36.6	51	44%
Chemical Dependency Professional trainees	176	29.9	40	15%	1,522	21.2	41	16%
Licensed Advanced Social Worker (LASW) – non clinical	8	1.4	47	25%	77	1.1	49	31%
Licensed Independent Clinical Social Worker (LICSW)	20	3.4	46	30%	207	2.9	44	25%
Marriage and Family Therapists	63	10.7	56	62%	1,387	19.3	51	44%
Marriage and Family Therapist Associates	36	6.1	37	11%	535	7.4	39	12%
Mental Health Counselors	585	99.5	50	44%	5,923	85.5	52	46%
Mental Health Counselor Associates	123	20.9	38	15%	1,790	24.9	41	17%
DBHR-certified Peer Counselors	207	35.2	--	--	2,346	32.7	--	--
Psychiatrists	15	--	51	--	727	10.1	55	56%
Psychiatric ARNPs	41	7.0	54	54%	530	7.4	53	52%
Psychologists	154	26.2	54	51%	2,295	31.9	52	46%

Sources: Except for psychiatrists in BHT region, data come from the UW Center for Health Workforce Studies – Washington State Behavioral Health Profiles. Profiles largely contain 2017 data. See: <https://depts.washington.edu/fammed/chws/publications/washington-states-behavioral-health-workforce/>. Figures for psychiatrists in BHT's region are estimates developed by OFM based on insurance company network adequacy reports; see: https://www.ofm.wa.gov/sites/default/files/public/dataresearch/healthcare/workforce/physician_supply_2016.pdf

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- ⁵ Substance Abuse and Mental Health Services Administration (SAMSHA). March 2020. Mental Health and Substance Use Disorders. <https://www.samhsa.gov/find-help/disorders>
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