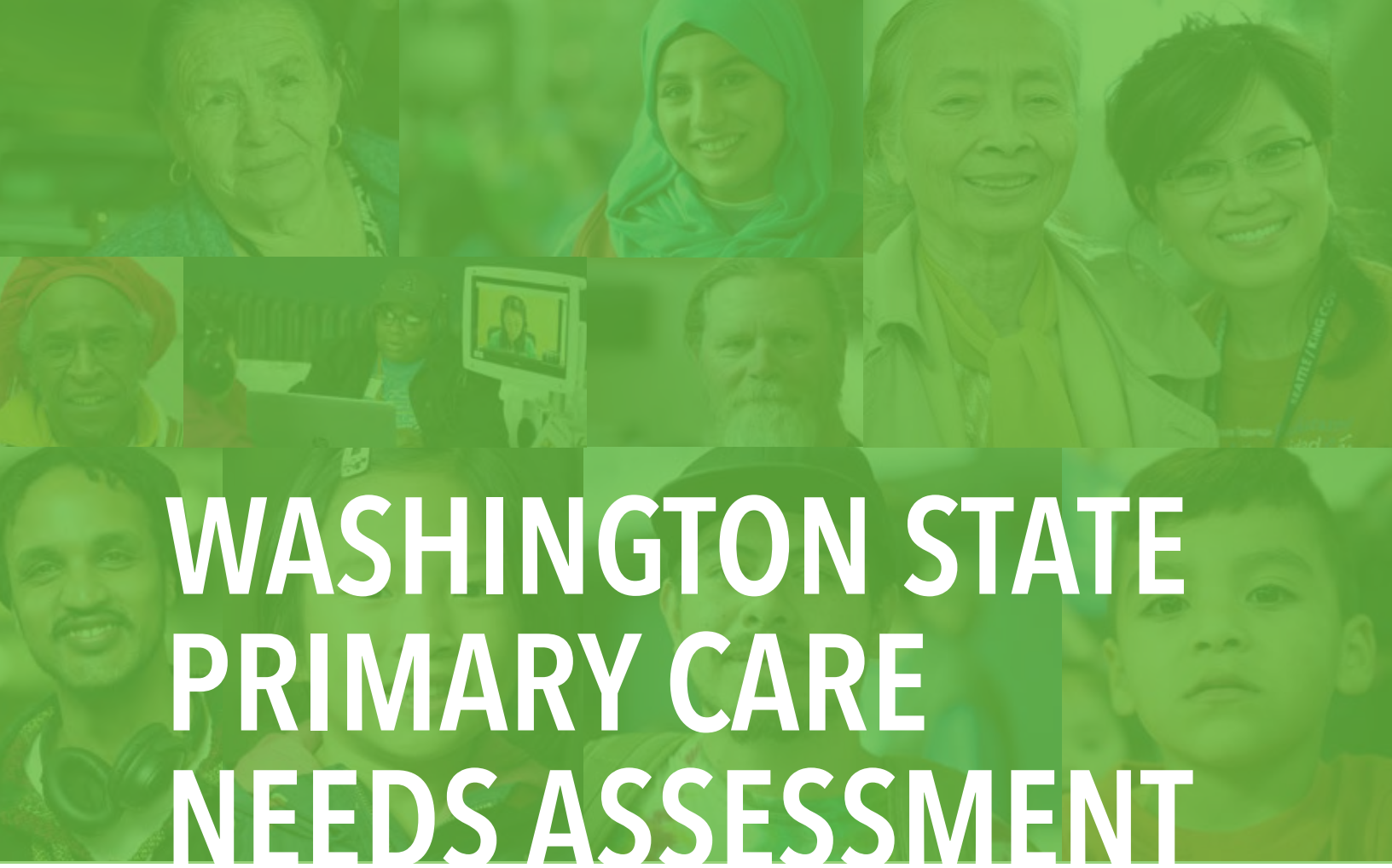


WASHINGTON STATE PRIMARY CARE NEEDS ASSESSMENT

AHECWW

AREA HEALTH EDUCATION CENTER

WHAA

washington healthcare access alliance

CONTENTS

Land Acknowledgment

We recognize that what we now call Washington State is on the ancestral lands of indigenous peoples including the Confederated Tribes of the Chehalis Reservation, the Confederated Tribes of the Colville Reservation, the Cowlitz Indian Tribe, the Hoh Indian Tribe, the Jamestown S'Klallam Tribe, the Kalispel Tribe of Indians, the Lower Elwha Klallam Tribe, the Lummi Nation, the Makah Tribe, the Muckleshoot Indian Tribe, the Nisqually Indian Tribe, the Nooksack Indian Tribe, the Port Gamble S'Klallam Tribe, the Puyallup Tribe of Indians, the Quileute Tribe, the Quinault Indian Nation, the Samish Indian Nation, the Sauk-Suiattle Indian Tribe, the Shoalwater Bay Tribe, the Skokomish Indian Tribe, the Snoqualmie Indian Tribe, the Spokane Tribe of Indians, the Squaxin Island Tribe, the Stillaguamish Tribe of Indians, the Suquamish Tribe, the Swinomish Indian Tribal Community, the Tulalip Tribes, the Upper Skagit Tribe, the Confederated Tribes and Bands of the Yakama Nation, and indigenous groups who still exist but who do not have formal recognition from state or local governments. These communities continue to honor their ancient heritages and to care for the land, water, and air that we now share. We acknowledge the federally recognized tribes of Washington as sovereign nations and affirm our responsibility in repairing and rebuilding relationships with Native peoples. This is one small statement, but we hope our collective impact will be greater.

Objectives

The ***Washington State Primary Care Needs Assessment*** has been created in partnership by the Area Health Education Center for Western Washington and Washington Healthcare Access Alliance with support and leadership from the Washington State Department of Health Primary Care Office. This report provides an overview of primary care capacity in Washington and identifies priorities for programming and legislation. An advisory committee of diverse area experts was consulted in regard to structure, content, and sources. Data included were collected from a wide range of public, private, and for-profit and nonprofit partners in the fields of healthcare, economics, education, and social services.

Data Sources and Limitations

Information included in this report is publicly accessible. Some data referenced was sourced directly from authoring organizations. In some instances, data referenced was voluntarily contributed through surveys and may not be statistically representative of the population. Additionally, underreporting may affect data for marginalized populations, including racial minorities, LGBTQ+ individuals, immigrants, and refugees. Comparative data is provided where available.

The full impact of the ongoing global public health emergency of COVID-19 will take years to unfold. Measures taken to address the virus have substantially affected every aspect of our lives, including primary care, and significant, long-term impacts related to loss of employment, health insurance, and public funding are certain. Due to the time required to collect and report data, this assessment draws primarily from sources available prior to the start of the pandemic.

The authors of this report recognize that as we rebuild the economy, resources and funding will be limited. It is recommended that the Washington Recovery Group map out the gaps in services, hot spots exposed prior to and during the COVID-19 pandemic, and contributing factors to a healthy economy to identify cross-sectoral projects that improve the efficiency of statewide investment and public-private partnerships. In a healthy Washington, a healthy economy thrives.

EXECUTIVE SUMMARY

Findings

In Washington State, multiple barriers to primary care access, including socioeconomic inequality, rising costs, healthcare policy demands, and the distribution of healthcare resources and economic opportunity across the state, persist. COVID-19 will exacerbate many of these conditions. Despite these numerous challenges, innovative and replicable solutions continue to emerge.

Between zip codes and counties, health disparities remain. Wealth and economic opportunity are unevenly distributed. Residents of Washington's small, rural counties experience disproportionately high levels of poverty and unemployment and have fewer healthcare resources and professional opportunities than residents of larger, urban counties.

Rental housing affordability is also a significant challenge for Washington State residents. As of 2018, Washington State had the fifth highest rate of homelessness and the most regressive tax system in the nation.

Due to Washington's geography and inadequate rural public transportation, travel between communities to access healthcare or employment can be difficult. Additionally, several rural counties lack the sufficient internet connectivity necessary for utilizing telehealth systems to expand access to care. These factors impact health and healthcare access, particularly for low-income residents with challenges to travel.

Racial and ethnic minority groups, who have lower levels of health insurance, are disproportionately underserved by the healthcare system and thus show poorer health outcomes than other demographic groups. Even in safety net settings, the racial distribution of patients seeking healthcare does not reflect the racial distribution of the population, nor do the demographics of healthcare providers. Statewide data collection and reporting has improved understanding of the impact of "race and place" on the health of Washington residents.

Between zip codes and counties, health disparities remain. Wealth and economic opportunity are unevenly distributed. Residents of Washington's small, rural counties experience disproportionately high levels of poverty and unemployment and have fewer healthcare resources and professional opportunities than residents of larger, urban counties.

Healthcare providers are unequally distributed across Washington, resulting in large rural areas without an adequate healthcare workforce. Barriers to mental and dental healthcare, including a lack of providers willing to accept Medicaid patients and provider shortages, persist statewide but are particularly acute in rural communities.

Washington State has recently made investments in identifying, reporting, and addressing root causes of health disparities. As a result, innovative partnerships and programs continue to develop. Examples of this include the growth of Washington's Accountable Communities of Health and the state's prioritization of health equity.

Additionally, recent bipartisan legislation promises improved protections for Washington's migrant workers, a group both vital to the state's economy and disproportionately facing barriers to healthcare.

This document and the following recommendations are intended to support the work of decision and policy makers challenged to understand the state of healthcare in Washington:

1. Prioritize healthcare system and safety net investments for the state's most underserved communities.
2. Expand state-funded healthcare insurance coverage to include all income eligible residents, regardless of immigration status.
3. Increase Medicaid reimbursement rates for behavioral health, medical and dental care.
4. Mitigate socioeconomic status as a social determinant of health by addressing Washington's regressive tax system.
5. Implement Workforce Training and Education Coordinating Board recommendations, including those from the Behavioral Health Workforce report to address current and projected healthcare workforce needs.
6. Expand investments in educational pathways to build a healthcare workforce that reflects the communities they serve.

WASHINGTON STATE CHARACTERISTICS

Washington State sits in the northwest corner of the lower 48 United States and is bordered to the north by Canada and to the west by the Pacific Ocean. The state is divided by the Cascade Mountain Range into areas referred to as Eastern Washington and Western Washington. The western side of the Cascades is characterized by a temperate, precipitous climate, with population density centered in the Puget Sound region. Eastern Washington's semi-arid climate supports a booming agricultural center where over 300 different crops are grown. Sixty percent of the state's population resides in Western Washington; rural communities are scattered throughout the state, with the majority located in Eastern Washington *(Office of Financial Management, 2020a).*

Washington's history has been shaped by a tradition of distinct, local governance and a diversity of geography and population. Since the 1980s, the international diversification of agriculture and the growth of software industry giants have transformed Washington *(Municipal Research and Services Center of Washington, 2007).*

In addition to the state Department of Health, Washington's public health system includes 31 county health departments, three multi-county health districts, and two city-county health departments that serve its 39 counties. Washington's 10-member Board of Health provides a public forum for policies that promote health goals. Washington State and the American Indian tribes located in Washington collaborate government-to-government to address public health issues with a locally relevant and culturally appropriate approach. Additional public health entities and regional healthcare coalitions partner across the state to serve public health interests *(Washington State Department of Health, 2020b).*

Population & Demographics

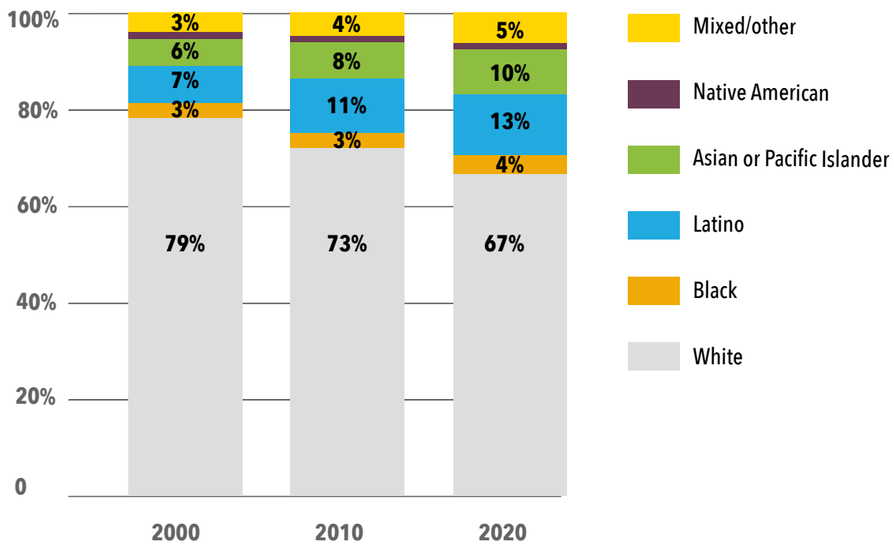
Washington's population has consistently grown since the 1900s and has surpassed the projected 2020 estimate of 7.5 million. As of April 1, 2019, the Washington State Office of Financial Management estimated Washington's population to be 7,546,400. This is a 6.85% increase from 2015 to 2019, far exceeding the national growth rate of 2.42% for the same period.

New residents moving into Washington drives population growth, accounting for 76% of the state's population increase between 2018 and 2019 *(Office of Financial Management, 2019f)*. Moreover, Washington has long been home to immigrants, including refugees. According to the American Immigration Council, one in seven people in Washington was born abroad; of those individuals, 49% are naturalized US citizens.

The top countries of origin for immigrants are Mexico, India, China, the Philippines, and Vietnam. In 2019, Washington resettled 1,900 refugees, more than any state other than Texas *(Pew Research, 2019)*. One in five workers in Washington is an immigrant, including over half of farmers and fishers *(American Immigration Council, 2020)*.

Washington is home to 29 federally recognized indigenous tribes and more than 200,000 American Indians and Alaska Natives *(Washington Tribes, 2020)*. Seattle is named after Chief Si'ahl (pronounced See-ahlth) of the Suquamish and Duwamish tribes. Duwamish lands make up the metropolitan Seattle area of which Native peoples are 0.8% of the population. Though the Duwamish are among tribes with a long history in Washington, they are not recognized by the federal government *(American Library Association,*

Demographic changes in Washington



Source: *US Census, Woods & Poole Economics Inc.*

For deaths officially attributed to COVID-19 in Washington, White populations have the lowest rates among all race and ethnicity groups. In contrast, Native Hawaiian and other Pacific Islanders experienced death rates six times higher while American Indian and Alaska Native communities had death rates four times higher than Whites.

2019). While the majority of tribes are located around the Puget Sound Region and Pacific Coast, the largest tribal lands are in south central Washington, where the Yakama Indian Reservation includes more than 1.3 million acres and 10,800 members, and northeast Washington, where the Confederated Tribes of the Colville Reservation own 1.4 million acres and have over 9,500 enrolled members *(Northwest Portland Area Indian Health Board, 2015)*.

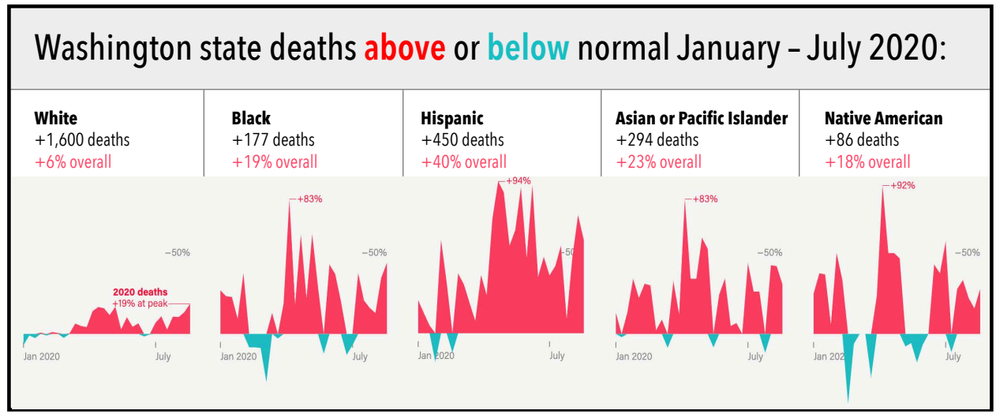
Washington has a higher percentage of White, non-Hispanic residents than the national average at 67.5% versus 60.1% *(U.S. Census, 2019b)*. Long-term trends show increased percentages of African American, American Indian and Alaskan Native, Asian and Pacific Islander, and Hispanic residents *(Office of Financial Management, 2019b)*.

Washington's median age was 38 years in 2017, with the White population's median age being 43 years and that of people of color, 29 years. In 2019, 15.9% of Washington's population was 65 years old or older *(U.S. Census, 2019b)*.

Early data regarding COVID-19 reveal that communities of color bear a disproportionate burden from the pandemic. Given the difficulty of accessing COVID-19 testing in the United States throughout 2020, an accurate picture of the pandemic is only still developing.

According to an analysis of early March to mid-October records from 5.8 million people nationally with COVID-19, Black individuals were 37% more likely to die from COVID-19 than Whites, American Indians and Native Alaskans were 26% more likely to die, Latinos were 16% more likely to die and ethnic Asian and Pacific Islanders were 53% more likely to die. However, this too may be an undercount: no survival information was found for hospitalized patients for 36% of Latinos, 29% of Blacks, 26% of ethnic Asians and Pacific Islanders, and 24% of Whites *(Keating, et, al, 2020)*.

For the period from the start of the pandemic to December 7, 2020, Native Hawaiian and other Pacific Islanders in Washington were hospitalized due to COVID-19 at rates 12 times higher than White populations while Hispanic



Source: *The Marshall Project, 2018 U.S. Census, CDC weekly death estimates by race and Hispanic origin*. The data is provisional and likely undercounts true numbers of deaths in some cases. Due to differences in estimation methodologies, summing counts over demographic groups does not provide an accurate estimate of total deaths.

populations were hospitalized at rates six times higher. For deaths officially attributed to COVID-19 in Washington, White populations have the lowest rates among all race and ethnicity groups. In contrast, Native Hawaiian and other Pacific Islanders experienced death rates six times higher while American Indian and Alaska Native communities had death rates four times higher than Whites *(Washington State Department of Health, 2020a).*

Within categories, there are still shocking disparities: Native Hawaiians and Pacific Islanders (NHPI) endure the highest COVID-19 case rates in 14 of the 21 states that report data for the demographic. NHPI communities suffer highest death rates in 11 of the 16 states that report disaggregated data for the demographic *(Ramirez, 2020).* In Spokane County, people from the Marshall Islands make up less than 1% of the population, but accounted for over 30% of COVID-19 cases by June 24th *(Keating, et, al, 2020).* Of the 3,000 individuals from the Marshall Islands in the county, more than 590 had tested positive by December 13, and eight had died *(Spokane Regional Health District, 2020).*

However, public health experts acknowledge that some pandemic related deaths, especially earlier in the outbreak, were mistakenly ascribed to other causes. Additionally, fear of and restrictions around COVID-19 likely discouraged or prevented people from seeking needed medical attention. The CDC reported that 215,000 more people died in the US during the first seven months of 2020 than the same period of the prior year. Although people of color are only 38% of the US population, they constituted 52% of the "excess deaths" nationally. In Washington State, the demographic disparities were stark: Native Americans faced an 18% increase in deaths over this period last year and the Black community endured a 19% increase, while White individuals experienced a 6% increase. Moreover, the ethnically Asian and Pacific Islander community suffered a 23% increase in deaths while the Hispanic community experienced a staggering 40% increase *(Flagg, et al. 2020).*

Data collection challenges and disparities are also reflected in deaths among healthcare workers. As of December 17, the CDC reported 928 medical worker deaths in the US; however, at least 2,921 were identified by *Kaiser Health News* and *The Guardian*. Of the 500 deaths for which ethnicity data is available, 65% were people of color, though communities of color comprise less than 40% of the US population *(Jewett, 2020).*

Population Distribution

There are 30 rural counties in Washington, defined as having a density of less than 100 people per square mile or of being smaller than 225 square miles *(Office of Financial Management, 2020b).* Nearly a quarter of Washington's population lives in rural communities *(Washington Student Achievement Council, 2020).*

King, Pierce, Snohomish, Spokane, and Clark are the five most populous counties in the state. The five counties with the smallest populations are Garfield, Columbia, Wahkiakum, Ferry, and Lincoln. Seattle is Washington's largest city with 761,100 residents in 2020. The next largest cities are Spokane (223,600), Tacoma (213,300), Vancouver (189,700), Bellevue (148,100), and Kent (130,500) *(Office of Financial Management, 2020a).*

POLITICAL AND ECONOMIC CLIMATE

Cost of Living

Washington State has a high cost of living. Most common expenditures are higher in the state than the national average. Housing costs in Washington are particularly expensive compared to the rest of the country, at nearly twice the national average *(Sperling's Best Places, 2019).*

In 2021, the minimum wage in Washington rose to $13.69 an hour. Despite being well above the national minimum wage of $7.25 per hour, the state hourly rate still likely falls short of what an individual must earn for a living wage. The Massachusetts Institute of Technology Living Wage Calculator for Washington State indicates that for a single adult with no dependents, $13.47 is the hourly wage necessary to cover basic expenses. However, for a family of four with one adult working, the hourly wage necessary to cover basic expenses is $41.46 *(Massachusetts Institute of Technology, 2020).*

The United Way's ALICE (Asset Limited, Income Constrained, Employed) Report on Washington State focuses on households with incomes above the federal poverty level ($12,140 for a single adult and $25,100 for a family of four in 2018), but below the basic cost of living. ALICE households represent a segment of the population that may be vulnerable to unexpected expenses and unable to invest in the future. The percentage of households below the ALICE threshold between Washington counties varies dramatically from 27% in Kitsap and Island Counties up to 52% in Adams County. In Washington, the number of ALICE households and households in poverty increased from 26% in 2007 to 33% in 2018 *(United Ways of the Pacific Northwest, 2020*).

Above average income growth for lower-income households in Washington has not been enough to keep pace with rent inflation, resulting in more people with restricted budgets being pushed into homelessness.

High housing prices in Washington continue to be a barrier preventing middle- and low-income families from purchasing homes, building equity, and gaining long-term economic stability. As of the first quarter of 2020, the statewide median price for a single family home was $415,000, 10.8% higher than the same time in 2019 *(Washington Center for Real Estate Research, 2020).* The national average home value was $274,600 during the same period *(National Association of Realtors, 2020).*

Housing prices in Washington vary significantly. The highest median price in the state was in King County at $689,900 in the first quarter of 2020, and the lowest median price was seen in Lincoln County at $154,000, but the highest relative increase was 33% in Klickitat. According to the Washington Center for Real Estate Research, housing affordability is an issue in 29 of Washington's 39 counties, primarily among those in the Puget Sound area.

Rental housing affordability in the state also continues to be a growing problem. Between 2012 and 2018, Washington experienced 30% rent inflation, moving the state from having the 12th highest rents in the nation to the seventh highest. In order to afford Fair Market Rent (FMR) for a two-bedroom apartment at $1,445, without paying more than 30% of income on housing, a household must earn $4,815 monthly or $57,783 annually. For a household earning minimum wage to afford a two-bedroom rental home at FMR, they would have to work 93 hours a week or hold 2.3 full-time jobs *(National Low Income Housing Coalition, 2019).*

Above average income growth for lower-income households in Washington, has not been enough to keep pace with rent inflation, resulting in more people with restricted budgets being pushed into homelessness. Washington State now has the fifth highest prevalence of homelessness in the nation (*Department of Housing and Urban Development, 2018).* As COVID-19 is expected to exacerbate this challenge, a statewide moratorium on evictions was put in place in March for default payment of rent and extended through the end of 2020 *(Washington Governor, 2020).* The CDC issued a similar moratorium through December 2020, though it does not prohibit fees or penalties *(Federal Register, 2020).*

Income Distribution

Income inequality has increased in every state since the 1970s, and Washington ranks among the worst, having moved from being the 12th worst in 2013 to currently being the state with the 10th widest income gap in the country. Washington's top 1% earn an average of $1.38 million annually, 24 times more than the bottom 99% who earn an average of $57,000 per year *(Economic Policy Institute, 2018).*

The distribution of wealth largely reflects geographic disparities across the state, with significantly higher levels of poverty in Eastern Washington than in Western Washington. Poverty rates in 2018 ranged from 26.8% in Whitman County to 7.8% in Wahkiakum County. Unemployment rates show similar disparity in professional opportunity from county to county, ranging from 10.0% unemployment in Grays Harbor County to 4.8% in Asotin County in September 2020.

During the initial years following the Great Recession, Washington State led the way in economic recovery, doubling the U.S. personal income growth rate of 1.9%. Nonetheless, the majority of income growth went to the wealthiest residents. Washington experienced an 11.3% jump in the top 1% share from 1973 to 2015.

The economic fallout of the COVID-19 global pandemic is still unfolding. The number of individuals in the U.S. living in poverty grew by eight million from May 2020 to September 2020 *(Parolin, et al, 2020).* By contrast, during the first seven months of the pandemic, the total wealth of billionaires in the U.S. grew by $931 billion – a dramatic increase of 32%. Three of the top 10 billionaires live in Washington and account for $132.5 billion of that growth *(Americans for Tax Fairness, 2020.)*

Since the outbreak of COVID-19, Washington State has suffered historically high unemployment with a peak of 16.1% in April 2020. By September 2020, the employment decline statewide was still 30% greater than the lowest point in the Great Recession *(Washington State Department of Commerce, 2020).* The economic fallout of COVID-19 is expected to exacerbate economic disparities, especially for minority populations. Nationally, 85% of rural Black or Hispanic households reported serious financial challenges during the pandemic outbreak contrasted with 36% of rural White households *(Harvard, et. al., 2020).* As of August 23, 2020, 16.3% of Pacific Islander workers filed continued unemployment claims as did 10.2% of Black workers, in contrast to 6% to 7% of White, Hispanic, American Indian, and ethnically Asian workers *(Takahama, 2020).*

Percentages of individuals in poverty and unemployed in Washington State, by county:

COUNTY	% of poverty	% unemployment	COUNTY	% of poverty	% unemployment
Adams	25.2	5.1	Lewis	14.4	8.1
Asotin	13.0	4.8	Lincoln	12.9	5.4
Benton	12.8	6.4	Mason	15.0	9.2
Chelan	11.6	6.1	Okanogan	20.6	7.6
Clallam	15.9	8.4	Pacific	17.4	9.5
Clark	9.3	8.1	Pend Oreille	15.3	9.5
Columbia	11.6	5.9	Pierce	11.2	8.6
Cowlitz	16.0	8.4	San Juan	11.4	6.7
Douglas	13.3	6.2	Skagit	12.8	8.2
Ferry	18.8	9.5	Skamania	13.5	8.9
Franklin	15.7	6.6	Snohomish	8.1	7.5
Garfield	11.6	7.2	Spokane	14.4	7.7
Grant	14.4	6.9	Stevens	15.6	7.8
Grays Harbor	15.9	10.0	Thurston	11.0	7.1
Island	8.6	7.4	Wahkiakum	7.8	8.4
Jefferson	13.3	7.8	Walla Walla	13.8	5.8
King	9.5	7.0	Whatcom	15.0	8.0
Kitsap	9.7	6.8	Whitman	26.8	5.4
Kittitas	19.0	7.0	Yakima	18.2	7.2
Klickitat	15.0	6.7			

2014–2018 US Census estimate, OFM email. September 2020, https://esd.wa.gov/labormarketinfo/monthly-employment-report

Despite economic growth over the past four decades, wages and income for working and middle-class families in Washington have decreased or stagnated. Across the United States, the gaps in income between upper-income and middle- or lower-income households are increasing, and the share held by middle- or lower-income households is decreasing *(Pew Research Center, 2020).*

Washington's regressive system of taxation exacerbates the unequal distribution of wealth in the state, as the poorest fifth of households paid five times more of its income in taxes than the top 1% due to the absence of an income tax *(Institute on Taxation and Economic Policy, 2018).*

According to Washington's Office of Financial Management, 10.3% of Washington's residents were living in poverty in 2018, compared to the national rate of 13.1% *(Office of Financial Management, 2019c).* However, the only age group in the state that has shown a significant long-term decline in poverty since 1969 is the elderly population. For this group, rates of poverty have dropped from 23% in 1969 to 7.2% in 2018 due to the expansion of Social Security and Medicare benefits and indexing those benefits to inflation.

Immigration

Anti-immigrant rhetoric and the rise of hate crimes in recent years have increased barriers to accessing resources and opportunities. This has had a devastating effect on immigrants accessing healthcare, regardless of status. Nationally, only 44% of immigrants who had lived in the U.S. for fewer than 10 years and only 63% of immigrants who had lived in the U.S. for more than a decade reported having healthcare insurance *(International Journal of Health Services, 2018).*

Recently, being potentially unable to access healthcare has been used as a reason to block immigration into the United States. A presidential proclamation suspending and limiting entry into the United States was signed in early October 2019, denying entry to legal immigrants who cannot prove they will be able to afford health insurance within 30 days of their arrival.

However, the economic reality is that immigrants are a key strength of national and local economies. Immigrants constitute a vital part of Washington state's workforce as 19% of the labor force. The top three industries for immigrant workers are healthcare and social assistance; professional, scientific, and technical services; and retail trade. In 2018, households led by immigrants in Washington contributed state and local taxes of $3.9 billion and $9.7 billion in federal taxes. That year, immigrant entrepreneurs generated $2.3 billion in business income in Washington and accounted for 19% of all self-employed Washingtonians. Immigrants comprise one in 10 business owners statewide and 31% of business owners in the Seattle/Tacoma/Bellevue metro. *(American Immigration Council, 2020).*

Despite a number of expansions to healthcare access under the Patient Protection and Affordable Care Act, many immigrants with documentation are still excluded from Medicaid. Individuals who lack insurance are more likely to delay seeking care until symptoms become unbearable, exacerbating health problems that could have been avoided or reduced if healthcare had been accessible early on.

Potential County Based Solutions

To address gaps in coverage and to increase access to healthcare services for adult immigrants, regardless of status, Northwest Health Law Advocates proposed county-based healthcare insurance coverage in Washington State similar to that in California, Maryland, Nevada, and New York. Establishing statewide programs is increasingly challenging because of budgetary constraints and the lack of federal funding supporting immigrant groups. Any county-based program would also need to be designed in a manner that is sensitive to the fear many in immigrant communities experience when interacting with government institutions.

The numbers of low-income and uninsured populations, as well as the types and accessibility of health system infrastructures, vary widely across Washington. A county-based healthcare insurance program, rather than the current statewide approach, could more easily tailor programming to the needs and services available locally. An economic analysis identified King and Yakima as counties potentially having populations of 35,430 and 15,563, respectively, of eligible individuals who could benefit from a county-based program *(Northwest Health Law Advocates, 2018).* The assessment identified dental care, diagnostic tests and labs, vision, behavioral healthcare, prescription medications, diabetic supplies, specialty care, interpreter services, and travel and transportation in rural areas as the services least accessible to low-income immigrants.

Currently, local governments bear the cost of many health and social services for low-income residents. At the county level, both the recognition of the economic and social value of supporting low-income residents and the potential savings and funding sources that could support program sustainability may create momentum to act *(Northwest Health Law Advocates, 2018).* Counties could expect the creation of healthcare insurance programs for low-income immigrants to result in benefits similar to the Affordable Care Act's reduction in uncompensated care.

INFRASTRUCTURE IMPACTING ACCESS TO HEALTH

Internet Connectivity

Telehealth provides remote access to services and healthcare. Online patient portals, virtual appointments, and health apps for cell phones surged in popularity during the outbreak of COVID-19, providing opportunities to make healthcare more efficient, better coordinated, and accessible with less physical contact. Only 22% of Medicare beneficiaries reported that their usual healthcare providers offered telemedicine appointments prior to the pandemic; by the summer of 2020, 60% reported that their provider offered telephone or video appointments *(Centers for Medicare & Medicaid Services, 2020)*

Although telehealth greatly expanded during the early months of the COVID-19 public health emergency, the reach of telehealth services remains limited by a lack of internet connectivity and access to technology. Washington is ranked as the 16th most connected state in the country; however, a number of rural counties remain significantly underserved, including Adams, Garfield, and Wahkiakum counties. In addition, 332,000 people in Washington are without access to a wired connection capable of 25 mbps download speeds and another 102,000 are without any wired internet providers where they live *(Broadband Now, 2019)*. Much of the rural population that would benefit most from improved access to care are limited by poor connectivity to high speed internet necessary for video.

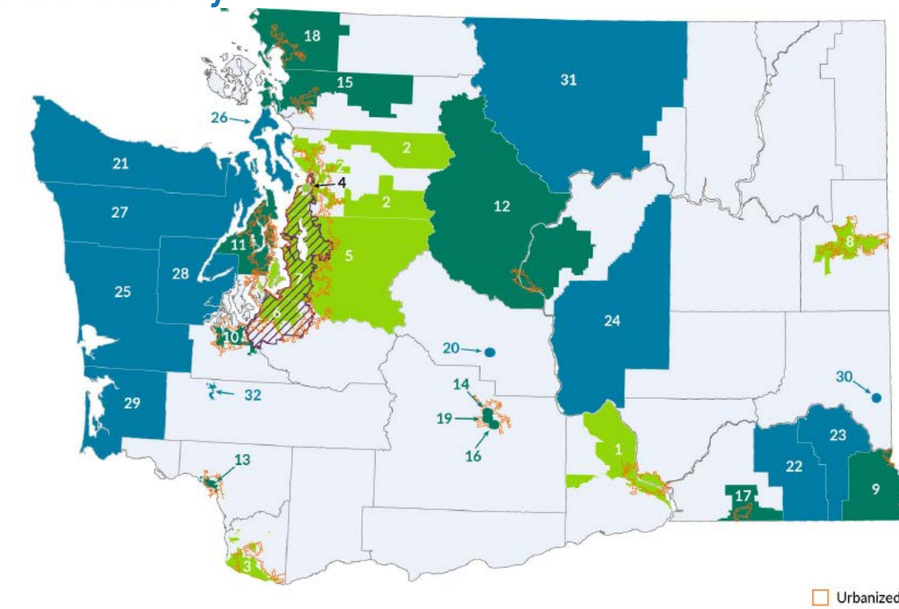
Transportation

Due to lack of population and employment density, rural areas are significantly limited by the cost to build, maintain, and operate public transit, leading to few routes and infrequent accessibility *(Washington State Department of Transportation, 2016)*. Tribal transportation is also cited as a need for Native populations to access jobs and vital services on and off tribal lands.

For rural residents who need to access healthcare at a facility located miles away, limited transportation options present daunting challenges. For patients for whom driving is not an option, infrequent transportation schedules can result in their return trips being unavailable until the next day, requiring potential, additional costs for lodging and meals *(Washington State Department of Transportation, 2016)*.

Health express shuttles have been implemented in Grant and Adams County to provide a low cost, reliable, and frequent mode of transportation to participating medical facilities. From 2004 to 2015, ridership increased to more than 3,000 trips per year, primarily for cancer patients requiring radiation therapy from small towns that in which such treatment was unavailable *(Washington State Department of Transportation, 2016)*. Additionally, the state-supported Gold Line Bus Service connects rural communities in Eastern Washington to transportation hubs in Spokane. However, vast areas of the state are still not covered by any transit authority, leaving many rural communities with only limited access to healthcare.

Public Transit Systems



Urban

1. Ben Franklin Transit
2. Community Transit
3. C-Tran
4. Everett Transit
5. King County Metro
6. Pierce Transit
7. Sound Transit
8. Spokane Transit Authority

Small Urban

9. Asotin County Transit
10. Intercity Transit
11. Kitsap Transit
12. Link Transit
13. RiverCities Transit
14. Selah Transit
15. Skagit Transit
16. Union Gap Transit
17. Valley Transit
18. Whatcom Transportation Authority
19. Yakima Transit

Rural

20. Central Transit
21. Clallam Transit System
22. Columbia County Transportation Authority
23. Garfield County Transportation Authority
24. Grant Transit Authority
25. Grays Harbor Transportation Authority
26. Island Transit
27. Jefferson Transit Authority
28. Mason County Transportation Authority
29. Pacific Transit System
30. Pullman Transit
31. TranGo
32. Twin Transit

Washington State Public Transit Authorities Map, courtesy Washington DOT

Safe Drinking Water

The American Society of Civil Engineers' 2019 report card for Washington infrastructure rated the state's drinking water a C minus, noting a clear divide between Washington's well-funded large-to-medium sized public water systems (PWS) and small-to-very-small PWS. Larger PWS comply with water quality regulations and are able to effectively maintain and operate infrastructure, whereas smaller PWS, often in rural areas, have difficulty meeting regulatory requirements. Smaller PWS struggle to maintain adequate capacity and have a higher risk of failure *(American Society of Civil Engineers, 2019).*

Though fluoridating drinking water has been shown to improve oral health outcomes, only 46% of Washington residents receive fluoride treated drinking water *(Washington State Health Assessment, 2018).*

Some areas of the state have naturally occurring fluoride, whereas others have public water systems that fluoridate drinking water. The distribution of fluoridated drinking water is uneven across the state. In 2016, Clark, Cowlitz, Franklin, King, Snohomish, Wahkiakum, and Whitman counties had a higher percentage of the population receiving fluoridated drinking water than the state average. Clallam, Grays Harbor, Island, Kitsap, Kittitas, Lewis, Pacific, Pierce, Skagit, Spokane, Whatcom, and Yakima counties had a lower percentage.

Adams, Grant, Okanogan, and Chelan counties may not have fluoride available despite high percentages of priority populations, including people of color, children under age 19, and low-income residents *(Washington State Health Assessment, 2018).*

Medicaid Reimbursement

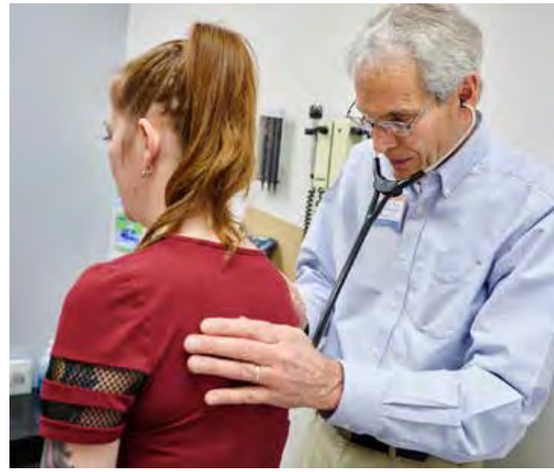
In 2015, the Affordable Care Act's 2013 and 2014 increase in reimbursement rates for primary care services to Medicaid patients expired. Since that time, access to quality healthcare has been a growing challenge for the state's Medicaid patients, a population that includes more than one in five Washington State residents.

According to a report by the Medicaid and CHIP Payment and Access Commission [Children's Health Insurance Program], the national average Medicaid reimbursement rate is 72% of what Medicare reimburses, which is still lower than private insurance. While reimbursement rates vary across states, the report shows a correlation between Medicaid acceptance rates and Medicaid-to-Medicare payment ratios. Physicians in states with a high Medicaid-to-Medicare payment ratio averaged an acceptance rate of 81.1%. Physicians in states with a low Medicaid-to-Medicare payment ratio averaged an acceptance rate of only 64.5% *(Urban Institute, 2019).* Low reimbursement rates are cited as a primary reason for physician reluctance to provide care to Medicaid patients.

The number of physicians available to Medicaid patients is limited, decreasing beneficiaries' access to healthcare. This dynamic is particularly challenging in rural areas, where provider choice is already constrained.

To address growing barriers to access, the state contracted with the Centers for Medicare & Medicaid Services in 2017 to find new ways to improve Medicaid. The five-year contract provides up to $1.5 billion in federal funds to support regional health systems' transformation projects that should benefit Medicaid clients. To date, the project has identified three key initiatives: (1) transformation of the Medicaid delivery system through Accountable Communities of Health; (2) expanding options for people receiving long-term services and supports at home; and (3) supporting broader health needs through supportive housing and supported employment *(Washington State Health Care Authority, 2019a).*

Additionally, the state adopted a value-based payment strategy. Instead of paying by volume of service, the system will reward quality and outcomes, potentially increasing physician participation in Medicaid. Washington aims to move 90% of state-financed healthcare, public and private, to value-based payment by 2021 *(Washington State Health Care Authority, 2019b).*



Low reimbursement rates are cited as a primary reason for physician reluctance to provide care to Medicaid patients.

SPECIAL POPULATIONS IN WASHINGTON STATE

Socioeconomic inequality and geography are barriers that affect primary care access in Washington State and thus impact health outcomes. Because of such barriers, across the state and between population groups, health disparities persist.

The writers of this report wish to acknowledge the complexity of individual identities and experiences. The descriptions below do not cover all the barriers to accessing care nor all populations.

Communities of Color

Residential segregation by race persists in Washington, particularly in populous areas where red-lining was legal and common before implementation of the Fair Housing Act. Historically, predominantly non-White neighborhoods have not received the resources needed to support healthy living, such as investments necessary for safety, walkability, and access to fresh food. As a result, health disparities are apparent between neighborhoods. Washington State's prioritization of health equity has generated significant data that demonstrate the interdependence of "race and place" as determinants of health. Indeed, health status and zip code are closely related in Washington *(Washington State Department of Health, 2019b).*

Data from the Behavioral Risk Factor Surveillance System (BRFSS) show a smaller percentage of Washington State adults report fair or poor health status than those in the rest of the United States. In 2014, 16% of Washington adults reported fair or poor health compared to 18% nationally *(Washington State Department of Health, 2016).* However, data from 2012 to 2014 revealed that reporting fair or poor health was significantly more likely among Hispanic (36%) and American Indian/Alaska Native (30%) adults than for the state as a whole (16%). Fewer ethnically Asian adults reported fair or poor health (12%) compared to adults in all other racial and ethnic groups. People of color constitute 29.2% of Washington residents: 12.9% identify as Latino, 9.3% as ethnically Asian, 4.3% as Black, 1.9% as American Indian/Alaska Native, and 0.8% as Native Hawaiian or other Pacific Islander. However, communities of color are disproportionately underserved by Washington's healthcare system.

The racial distribution of patients seeking care in safety net settings does not reflect the racial distribution of the population of the state, suggesting inequities in access to care. Although 79.1% of Washington State residents identify as White, only 56.81% of patients seeking care in federally qualified community health centers self-identify as White *(Washington Association for Community Health, 2019),* and only 20.7% of patients attending a 2018 free clinic event in Seattle identified as White *(Seattle Center Foundation, 2019).* This disproportionate representation suggests not only significant barriers to care for patients of color, but, additionally, barriers to care between levels of safety net entities, with federally qualified community health centers providing a wider scope of consistently available healthcare services than a four-day free clinic event.

Immigrants & Refugees

Imigrants and refugees make up a significant share of Washington's population. According to the Office of Financial Management, approximately one million of the state's population, or 14%, were first generation immigrants in 2017. Many have since obtained citizenship through naturalization, though approximately half remain non-citizens.

While healthcare coverage for the state as a whole has made gains, federal programs like the Affordable Care Act (ACA) have greatly reduced the number of uninsured, but also have strict eligibility criteria for citizenship and legal immigrant status. As a result, glaring disparities in access to health coverage exist between U.S.-born citizens and various immigrant populations including naturalized citizens, legal immigrants, and undocumented immigrants within Washington State.

Prior to the ACA, uninsured rates for U.S.-born citizens, naturalized citizens, legal immigrants, and undocumented immigrants were all high, though with significant variations between the groups. U.S.-born citizens had the lowest rates at 17%, followed by naturalized citizens (20%), legal immigrants (close to 30%), and undocumented immigrants (above 55%). Since the implementation of the ACA, the uninsured rates for both U.S.-born and naturalized citizens fell to 5.7% in 2017, the legal immigrant group dropped to 12.9%, and the undocumented immigrant group, to 40.7% *(Office of Financial Management, 2019g).*

Despite the decrease in uninsured rates across all groups, gains in health coverage were not similar among the various immigrant groups when compared to U.S.-born citizens. Prior to implementation of the ACA, uninsured rates for naturalized citizens were 1.2 to 1.3 times higher than those of U.S.-born citizens. The ratios remained similar between 2014 and 2017. Legal immigrants are still two times as likely to be uninsured than U.S.-born citizens.

The gap widened considerably, however, for the undocumented immigrant group whose uninsured rate was 3.3 times higher than those of U.S.-born citizens in 2013, grew to 5.1 in 2014, and continued climbing to 7.2 in 2017. This means the gap between the uninsured rate for the undocumented immigrant group and the U.S.-born citizen group more than doubled between 2013 and 2017 *(Office of Financial Management, 2019a).*

Migrant Workers

In 2018, there were an estimated three million agricultural workers in the United States, 16% of whom identified as migrating and 84% as seasonal workers. The majority of workers were foreign born and many reported limited English-speaking ability. Economically, agricultural workers represent some of the most disadvantaged people in the nation with more than 30% subsisting at income levels below the national poverty guidelines. A mere 8% of farm workers report being covered by employer-provided health insurance *(National Center for Farmworker Health, 2018).* At the same time, according to the U.S. Bureau of Labor Statistics, agriculture is frequently ranked as one of the most high-risk industries in the nation where injuries and illnesses result from exposure to the elements, farm equipment, and interaction with pesticides.

In addition to aerospace, technology, and entrepreneurship, Washington has a multi-billion-dollar agriculture industry and is one of the highest food-producing state in the nation *(American Immigration Council, 2020).* While the exact population total for migrant and seasonal workers in Washington State is difficult to estimate, the number of H-2A workers, a program that enables agricultural employees to legally hire foreign workers, has steadily climbed, since 2010, from 2,981 workers to more than 12,000 in 2015. In central Washington's Chelan County alone, where the state's fruit production is concentrated, farm owners employed 7,900 seasonal workers in 2012. During the spring 2020 COVID-19 outbreak, at least 240 people working in food and agriculture in the Yakima Valley tested positive by the end of April including more than half the workers on one farm. At that time Yakima County had more than 1,600 confirmed cases and nearly 60 deaths – the highest infection rate of all west coast counties.

Glaring disparities in access to health coverage exist between U.S.-born citizens and various immigrant populations including naturalized citizens, legal immigrants, and undocumented immigrants within Washington State.

Tribal Communities

Native Americans make up approximately 2% of the total population in the United States. Unlike other racial and ethnic minorities, Native Americans have rights to federal healthcare services through a series of acts that resulted in the formation of the federal agency known today as the Indian Health Service. Healthcare services are provided to federally recognized tribes, of which there are 573 throughout the United States; there are also an estimated 245 tribes that are not federally recognized.

Despite legal rights, Native Americans contend with numerous barriers to receiving quality healthcare including cultural barriers, discrimination, geographic isolation, and disparate poverty. As a result, Native Americans are disproportionately impacted by health disparities. Thirty percent of Native Americans in Washington report being in fair or poor health compared to just 14% of their White counterparts *(Washington State Department of Health, 2016).* In Washington, American Indians and Alaska Natives report experiencing worse health than other racial and ethnic groups across 27 key health issues identified in the Washington State Health Assessment *(Washington State Department of Health, 2018).*

Native Americans also have higher overall mortality rates, a greater share of disease burden, and live with mental health disorders and related conditions at higher rates when compared with the general U.S. population.

Compared to their White counterparts, Native Americans suffer mortality at a 50% higher rate and an infant mortality rate that is 1.6 times the rate of White populations *(U.S. Department of Health and Human Services Office of Minority Health, 2019).*

Native Americans endure higher rates of chronic disease when compared to all other racial and ethnic groups. At 16%, more Native American adults have diabetes per capita than any other ethnicity *(Centers for Disease Control and Prevention),* and the tuberculosis rate in 2017 for Native Americans was nearly four times higher than for the White population *(U.S. Department of Health and Human Services Office of Minority Health, 2019).*

Within Washington State, where there are 29 federally-recognized Native American tribes, the all-cause mortality rate for American Indians and Alaskan Natives is about 71% higher than the rate for non-Hispanic Whites. Leading causes of death include cardiovascular disease (23.5%), cancer (19.4%), unintentional injury or accident (11.4%), chronic liver, and chronic lower respiratory disease (6.1% and 5.9%, respectively). High rates of poor mental health and depression coupled with limited access to treatment have led to higher rates of suicide for Native Americans *(American Indian Health Commission for Washington State, 2017).*

Even though America's problematic treatment of Native Americans has created barriers, tribal communities have made advances in health and well-being. In Washington, there are 31 ambulatory primary care clinics operated by tribes, two operated by Urban Indian Health Programs, and four by the Indian Health Service which have added specialty care options to address community specific needs including traditional healing practices, naturopathy, and nephrology.

Tribal advocacy led to the passing of the Dental Health Aide Therapy Law in 2017, which helped Indian healthcare providers expand dental services as part of their integrated system of care. This was an important victory in addressing oral health disparities in tribal communities. American Indian and Alaskan Native children in Washington are three times more likely to experience tooth decay than their White counterparts, and adults experience twice the prevalence of untreated cavities than the general population (*American Indian Health Commission for Washington State, 2017).*

In 2019, the Washington Indian Health Improvement Act was passed, funding tribal healthcare systems. Each tribal government is an independent, sovereign nation and has its own governmental public health system. Additionally, other agencies also serve these tribes and tribal peoples in various ways.

The Northwest Portland Area Indian Health Board is a non-profit tribal advisory organization that serves the 43 federally recognized tribes of Oregon, Washington, and Idaho though its engagement in many areas of Indian health, including legislation, health promotion, and disease prevention as well as data surveillance and research via the Northwest Tribal Epidemiology Center (The EpiCenter). The EpiCenter collaborates with northwest American Indian tribes to provide health-related research, surveillance, training, and technical assistance to improve the quality of American Indians' and Alaskan Natives' healthcare. Current projects funded by the EpiCenter are aimed at addressing various morbidities such as Hepatitis C and diabetes, in addition to preventive and public health initiatives. The EpiCenter also posts guidance regarding respectful ways to engage in research in Indian Country in order to be sensitive to local culture, traditions, research priorities, and lifestyles of American Indian and Alaskan Native communities *(Northwest Portland Area Indian Health Board, 2019).*

The Seattle Indian Health Board's Urban Indian Health Institute (UIHI) works to decolonize data, for indigenous people, by indigenous people. UIHI is a Tribal Epidemiology Center, managing public health information research and data for urban American Indian and Alaska Native communities *(The Urban Indian Health Institute, 2019).* This and the EpiCenter are two of the 12 Tribal Epidemiology Centers in the country and are Tribal Public Health Authorities, providing key research and assessment for and with the tribes and urban Indian health programs.

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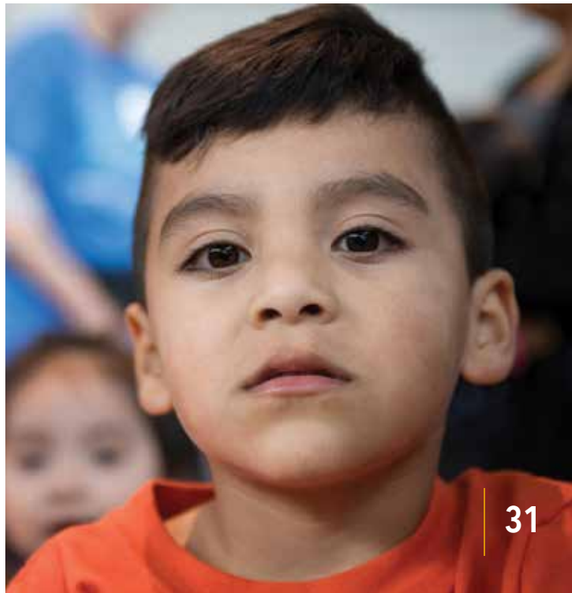


Under & Uninsured

The percentage of the population of Washington without insurance is lower than the national average, 7.5% compared to 8.5% nationally. Of those uninsured nationally, 45% cite the high cost of insurance as the main reason they lack coverage *(Kaiser Family Foundation, 2018),* and the lowest income residents are the least likely of any income group to have health insurance. The same study cites uninsured non-elderly adults as being twice as likely to have problems paying medical bills as their insured counterparts. Since most of the uninsured population have low or moderate incomes, medical bills quickly turn into medical debt.

Although lack of health insurance coverage exists among all population demographics, the disparities are greater for people of color, low-income, and immigrant and refugee populations. Hispanic residents are most likely to be uninsured at 17.7%, followed by American Indian or Alaska Native residents at 14.8%. White residents have the lowest uninsured rate at 5.1% *(Office of Financial Management, 2019g).*

For foreign-born Washington residents who have not gained citizenship, the share of the total uninsured population increased from 22.1% in 2013 to 34.7% in 2017. In contrast, foreign-born residents of Washington who have become American citizens show a significantly lower rate at 12.9%.

Families below 100% of the Federal Poverty Level have an uninsured rate of 10.3%, over three times the rate of more affluent families: only 2.8% of those above 400% of the Federal Poverty Level are uninsured *(Office of Financial Management, 2019e).*

Washington's uninsured population data compared to national percentages

HEALTH PROFILE	% NATIONAL	% WASHINGTON
UNINSURED BY RACE:		
White	5.4%	5.1%
Hispanic	17.8%	17.7%
Black	9.7%	9.5%
American Indian/ Alaska Native	not available	14.8%
Asian/Native Hawaiian & Pacific Islander	6.8%	5.1%
Two or more Races	not available	5.0%
UNINSURED BY FEDERAL POVERTY LEVEL:		
Under 100%	16.3%	10.3%
100-199%	13.6%	9.4%
200-399%	9.6%	8.6%
400%+	3.4%	2.8%

Note: U.S. Census Bureau, 2019 and Office of Financial Management, 2019.

Elderly

In 2016, more than 1,073,000 people -- 15% of Washington's population -- were aged 65 or older. By 2040, the elderly population is forecast to reach nearly two million, or 22% of the state's total population, and by 2030, the population over the age of 85 is expected to double. Washington is aging faster than the nation as a whole.

Washington's physician shortage disproportionately burdens the elderly. Among the states, Washington is ranked 26th with just 270 physicians per 100,000 residents. This means longer wait times and scattered services, especially in Washington's rural and island communities where the majority of the state's aging population resides. It is projected that by 2030, over 30% of the population in 12 rural counties will be older than 65 years *(Washington State Department of Health, 2018).*

Low-income seniors often seek healthcare in Washington's safety net system. In 2018, 8.25% of the patient population at the Washington Association for Community Health was age 65 or older *(Washington Association for Community Health, 2018).* Compared to other populations, the elderly population is increasing much more rapidly than other demographics served by the Washington Association for Community Health. Of the 2018 Seattle/King County Clinic event patients, 14% reported their age as 65 or older, up from 11.4% in 2014 *(Seattle Center Foundation, 2019).*

For seniors, income level correlates with oral health. Arcora Foundation survey respondents with higher incomes reported higher rates of dental visits, higher rates of having all their original teeth and healthy gums and teeth, and having dental insurance that covered the cost of appointments. These patients also reported being in better health overall. Low-income seniors are significantly more likely to be affected by dental disease and are the least likely to have dental insurance *(Arcora Foundation, 2017).*

LGBTQ+

While sexual and gender minorities have many of the same health concerns as the general population, they experience certain health challenges at higher rates and often face additional barriers in accessing care. Major health concerns include increased development of chronic conditions and higher prevalence and earlier onset of disabilities, HIV/AIDS, and sexual and physical violence *(Kates, et al, 2015).* Across income ranges, 15% of LGBTQ+ people in the U.S. were uninsured in 2017 compared to 7% of the non-LGBTQ+ population *(Center for American Progress, 2017)*. High school students who identify as lesbian, gay, or bisexual are nearly five times more likely to attempt suicide than their heterosexual peers. And 48% of all transgender adults report that they have considered attempting suicide, compared to 4% of the overall population. Lesbian, gay, and bisexual adults are more than twice as likely as heterosexual adults to live with mental illness. LGBTQ+ individuals also face increased risk for substance abuse and homelessness *(National LGBT Health Education Center, 2018).*

Safety concerns with when and how to disclose identity status to doctors create additional barriers for LGBTQ+ individuals when accessing healthcare. This means it is likely that health centers are serving many more LGBTQ+ people than data accounts for (*National LGBT Health Education Center, 2018)*. In 2017, 8% of LGBTQ+ people and 29% of transgender people reported a healthcare provider refused to see them due to their sexual orientation or gender identity in the past year *(Center for American Progress, 2018)*. Medical training often does not include LGBTQ+ health and cultural competency

State protections specifically for LGBTQ+ residents include legislation addressing housing, legal marriage, employment, hate crimes, public accommodations, anti-bullying, education, gender marker change, and transgender healthcare coverage. In 2019, Washington became one of 19 states that passed laws forbidding discrimination in healthcare based on gender identity or sex stereotypes.

Veterans

Washington has the 12th largest veteran population in the country, with a total of 552,291 veterans *(U.S. Department of Veterans Affairs, 2018).*

More veterans residing in Washington are female than the national average, and Washington has a higher rate of unemployment for veterans: 6.4% in Washington compared to 5.3% in the U.S.

Even though a higher percentage of the veterans in the state have a service-connected disability, a lower percentage of them use Veterans Administration healthcare than they do nationally. This utilization is also lower than in states with comparable veteran populations. With only 26 VA facilities in the state, Washington lags behind states that have comparable veteran populations but host between 30 and 37 facilities.

The total Veterans Administration medical expenditures in Washington State were over $1.5 billion for fiscal year 2018 *(U.S. Department of Veterans Affairs, 2018).* This is 35% of the Washington State's Veterans Administration expenditure. In states with comparable veteran populations, medical expenditures made up a larger percentage. In Tennessee, which has a small population of veterans, 40% of expenditures went to medical care. In Illinois, with a larger population of veterans, 52% went to medical care. This is a lower level of spending per Washington State veteran than is reported in states with comparable veteran populations.

Individuals experiencing homelessness

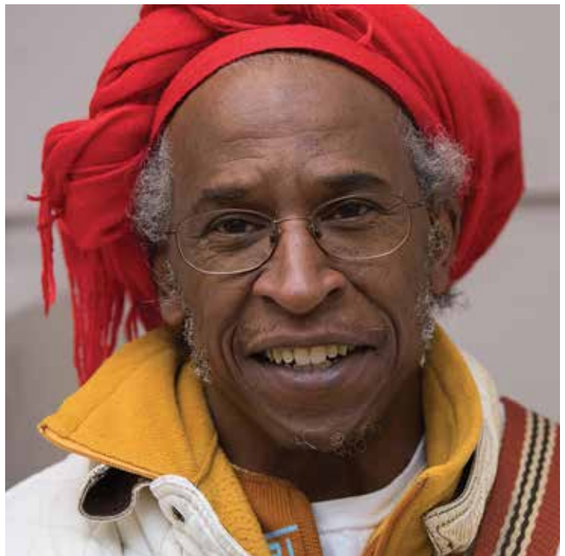
Washington has the fifth highest prevalence of homelessness in the nation, with more than 22,000 homeless individuals identified during the state's one-night count *(U.S. Department of Housing and Urban Development, 2018).* Within this population, an estimated 2,451 individuals were in families with children, 1,089 individuals were unaccompanied youth and young adults, and 830 identified as veterans.

In 2015, a state of emergency was declared by the mayor of Seattle. Since then, the homeless population in King County grew year after year, from 10,047 in 2016 up to 12,112 in 2018. In 2019, for the first time since the state of emergency was declared, the number of individuals experiencing homelessness decreased by 8%, to 11,199 individuals. The number of unsheltered persons living on the street or in parks, tents, vehicles, or other places not meant for human habitation decreased from 52% of the population in 2018 to 47% in 2019 *(Seattle/King County Continuum of Care, 2019).*

Among homeless individuals, LGBTQ+ youth are disproportionately overrepresented. A report in partnership with the Department of Commerce, found that between 22% and 24% of homeless youth in Washington identified as LGBTQ+ *(A Way Home Washington, 2016).* YouthCare, an organization serving homeless youth in Washington, estimates that 23% of their client population is LGTBQ+; this is down from 40% in 2014 (*Youthcare, 2018).*

According to the Count Us In survey of unhoused individuals, 64% of respondents reported living with at least one health condition. Psychiatric or emotional (36%) disorders were the most frequently reported conditions, followed by post-traumatic stress disorder (35%) and drug or alcohol abuse (32%). Chronic health problems (27%) and physical disability (23%) were also reported.

Although these data demonstrate that a significant number of individuals experiencing homelessness need care, individuals from this group face some of the steepest barriers to accessing care. Nearly 9% of patients attending the Seattle/King County Clinic in 2018 reported living in a shelter, on the street, in a vehicle, or in transitional or supportive housing *(Seattle Center Foundation, 2019).* With limited access to healthcare, the number of deaths among King County's homeless population has risen for the fourth year in a row, from 124 in 2015 to 194 in 2018 *(King County Medical Examiner's Office, 2018).*



Youth Exiting Foster Care

Washington is one of 25 states and the District of Columbia to sign into law the Fostering Connections to Success and Increasing Adoptions Act of 2008, effectively extending foster care support beyond 18 years of age.

Within Washington's foster care system, 19% of the population are age 14 and up. Of that 19%, 28% are transition age, 18 years of age and older. Compared to national percentages, Washington has more female youth in foster care: 54% compared to 49% nationally *(Annie E. Casey Foundation, 2018).*

Foster youth often lack the safety nets and support systems needed to help them navigate the transition period of becoming independent at higher rates than their peers. Called "emerging adulthood" in a report by the National Conference of State Legislatures, the transition from adolescence to adulthood is complex and lengthy, not a direct jump. For many, achieving full adulthood may not take place until their late 20s *(National Conference of State Legislatures, 2015).*

It has become commonplace for young adults to weather this period with their parents. According to the U.S. Census Bureau Report, more than one third of young adults, ages 18 to 34, are living in their parents' home *(U.S. Census, 2017)*. By virtue of being discharged from foster care at age 18, foster youth are required to find housing, secure a job, attend higher education, and enroll in health insurance often without adequate support. Foster youth in Washington are able to remain on Medicaid until age 21. The state also offers federally funded transition services such as employment programs and vocational training, educational financial assistance, and room and board assistance.

Despite services, outcomes for young adults in Washington who experienced foster care are worse than their peers in the general population and in the U.S. foster care population. Only 39% of Washington's foster care population attain employment by the time they turn 21, compared to 49% of the U.S. foster care population and 63% of the state's general population. In addition, 30% of the state's foster care population become young parents by age 21 (*Annie E. Casey Foundation, 2018).*

Formerly Incarcerated Individuals

Many formerly incarcerated individuals leave prison with at least one chronic problem with physical health, mental health, or substance abuse *(Urban Institute, 2018).* In conjunction with either lack of health insurance or access to health services, such ailments can make it harder for these individuals to reintegrate into the community, reducing their ability to maintain employment, housing, relationships, sobriety, and, thus, to avoid recidivism.

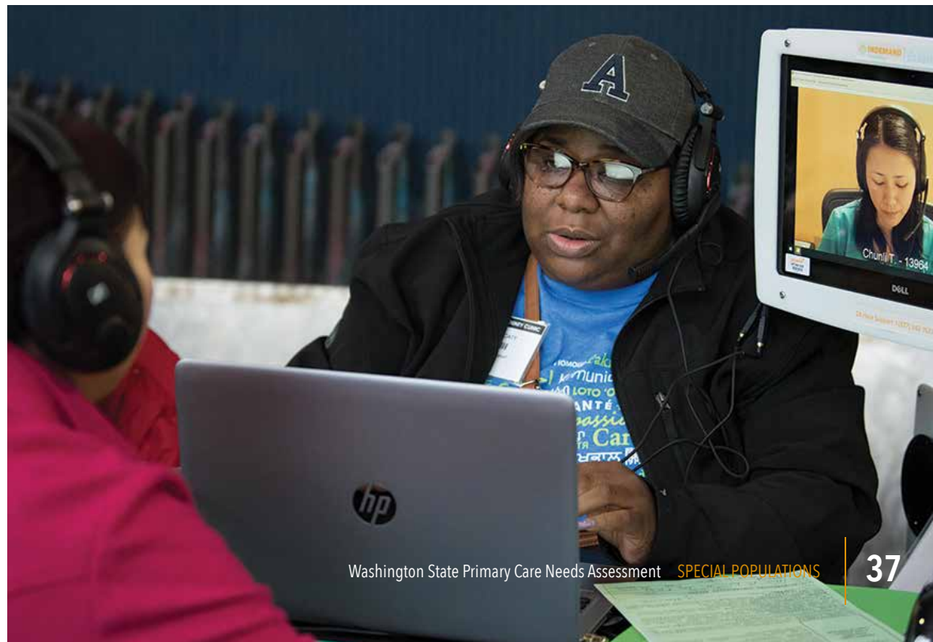
According to the U.S. Department of Health and Human Services, 64% of jail inmates, 56% of state prisoners, and 45% of federal prisoners were found to have mental health challenges *(Commonwealth Fund, 2019).*

Under the Affordable Care Act and Medicaid expansion, many states are connecting formerly incarcerated individuals with health coverage. In July of 2017, the Washington State Health Care Authority revised its scope of coverage regarding justice-involved individuals. Previously, Medicaid coverage was terminated when a person became incarcerated. Now, healthcare coverage is suspended at the time of incarceration, limiting coverage to inpatient hospitalizations lasting longer than 24 hours while incarcerated and reinstated once the individual is released *(Washington State Health Care Authority, 2017).*

Even with reinstated healthcare coverage, providers who have worked with formerly incarcerated individuals note a tendency of these individuals to be wary of engagement with healthcare providers, reflecting their mistrust of institutions *(Commonwealth Fund, 2019).* Community Health Workers in the Transitions Clinic Networks are helping to break down this barrier.

Transitions Clinic Network is a national network operating in 11 states and Puerto Rico. Located in communities most impacted by incarceration, the Transitions Clinic Network is geared toward individuals with chronic diseases recently released from incarceration. Their model employs a community health worker and an individual with a history of incarceration as part of the clinical team, reflecting a philosophy that people closest to the problem are also closest to the solution. Country Doctor Community Health Center in Seattle is a participating member of Transitions Clinic Network.

Findings from a randomized control trial found that Transitions Clinic Network programs significantly reduced emergency room visits and patients had fewer and shorter preventable hospitalizations and fewer parole and probation violations *(Northwest Regional Primary Care Association, 2018).*



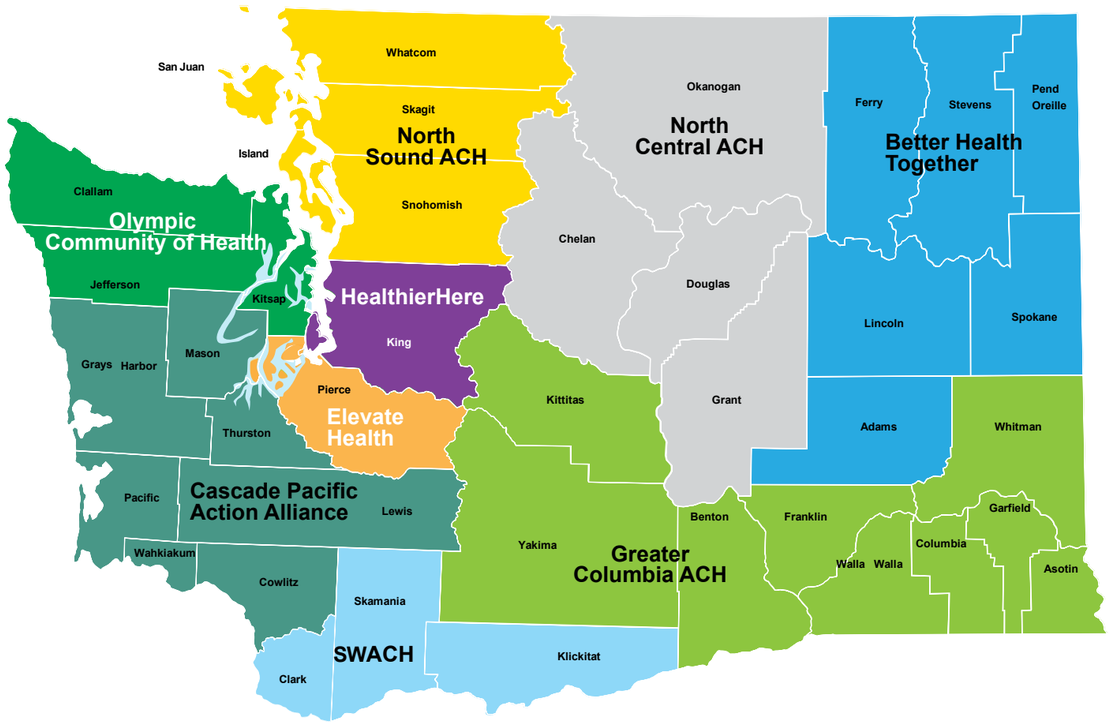
GEOGRAPHIC AREAS OF CONCENTRATED UNMET NEED

According to the 2018 Washington State Health Assessment, overall, Washington has "similar or better health outcomes, similar or lower risk factor prevalence, and similar or higher protective factor prevalence" compared to national data *(2018)*. However, across most of the 27 health indicators assessed in this report, American Indians and Alaska Natives experience worse health outcomes than other racial and ethnic groups, and across several indicators, African American and Hispanic residents experience poorer health compared to Whites. Additionally, Washington has a higher breast cancer incidence, higher suicide rate, lower percentage of population reporting a personal healthcare provider, and higher percentage of women reporting lifetime sexual violence than national averages. The state has identified the following priority health issues as areas of focus: child immunization, diabetes, drug and alcohol abuse, healthcare access, healthy weight with a focus on healthy eating and active living, housing and homelessness, mental health, and tobacco use.

Washington State began designating pilot Accountable Communities of Health (ACHs) in 2015 to bring better health, higher quality care, and lower costs to communities across the state. The ACH model provides a framework for identifying and understanding the highest areas of unmet need, and is being used by the Washington State Primary Care Office to designate Rational Service Areas and Health Provider Shortage Areas throughout the state.

Washington has nine Accountable Communities of Health, each aligned with the geographic boundaries of the state's Medicaid regional service areas. Approaches vary across ACHs in order to address regional differences. While each ACH is working to transform health in its region, some face additional barriers. Three ACHs contain nine of the state's ten counties ranked lowest for overall health outcomes: Better Health Together, Greater Columbia, and Cascade Pacific Action Alliance. These ACHs contain areas of unmet need requiring more focused resource planning and investment.

Accountable Community of Health (ACHs) regions



Okanogan and Klickitat are transitional counties based on Medicaid regional service areas. HCA 82-008 (5/20)

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Better Health Together

Composed of six counties, the Spokane and Kalispel tribes, and some of the lands of the confederated Colville tribes, the Better Health Together Accountable Community of Health (BHT) serves a wide variety of communities within its designated region.

Though BHT's Medicaid population as a whole is more likely to be White (75% vs. 67% statewide) and more likely to list English as the preferred language than the rest of the state (94% vs. 83% statewide), the population of Adams County is 78% Hispanic *(Better Health Together, 2017)*. Ten percent of Medicaid enrollees in Stevens county and 27% in Ferry county identify as American Indian or Alaska Native.

BHT's northern counties have some of the highest unemployment rates in the state alongside a higher-than-average proportion of children in poverty. BHT contains both Ferry, with the highest percentage of unemployment in Washington at 9.5%, and Lincoln, which had one of the lowest unemployment rates in the state at 5.4% in September 2020. Three counties in BHT are ranked in the bottom 10 for overall health outcomes by the Robert Wood Johnson Foundation's 2019 county health rankings for Washington State: Ferry (39 out of 39), Pend Oreille (35), and Adams (33). In 2016, Adams County had the highest mortality rate of any county in the state *(Washington State Department of Health, 2019)*. Thirty percent of BHT's Medicaid members have been diagnosed with a mental illness, and 12% have a substance abuse treatment need reflecting a larger segment of the population than for Washington as a whole *(Better Health Together, 2017)*.

All BHT counties have shortages of healthcare providers with the exception of Spokane County. Though BHT had the second highest number of nurse practitioners in practice in 2019, only 6% worked in rural areas *(Stubbs & Skillman, 2020)*. Spokane has two significant challenges: youth enter foster care at nearly double the state average and both jail and emergency systems are over-utilized by behavioral health patients *(Better Health Together, 2017)*.

BHT has selected four projects to improve healthcare:

1. ***Bi-directional Integration:***
   for Medicaid patients with both a behavioral health issue and a chronic disease.
2. ***Community-based Care Coordination:***
   for people transitioning out of jail.
3. ***Chronic Disease Management:***
   for Medicaid adults with diabetes, Medicaid children with asthma, and Medicaid beneficiaries with chronic behavioral health issues.
4. ***Opioid Response:***
   coordinate efforts to promote prevention, access treatment, and recovery.

Photo courtesy Washington DOH

Greater Columbia Accountable Community of Health

The Greater Columbia Accountable Community of Health (GCACH) spans nine counties, the greatest number of counties of any ACH in Washington. This region also includes one tribal nation, the Yakama Tribe, the largest tribal nation in the state with approximately 11,000 members. Nearly 35% of GCACH's population uses Medicaid, compared to 25% in Washington State as a whole.

Hispanic residents comprise the largest minority group in GCACH and 50% of the Medicaid population, the largest concentration of any ACH in Washington. Most organizations in GCACH report serving fewer than 5% African American clients. Two counties within GCACH are ranked within the bottom 10 in Washington for overall health outcomes by the Robert Wood Johnson Foundation's 2019 county health rankings: Columbia (38 out of 39) and Yakima (32). While Columbia County ranks well in social and economic factors as well as physical environment, the county nevertheless has one of the highest instances of premature death, and 16% of adults report being in fair or poor health. More than 20% of Yakima County adults report being in fair or poor health, and 32% of adults are obese. Yakima County is ranked 37 out of Washington's 39 counties for access to clinical care. The ratio of population to primary care physicians is an abysmal 1,580:1. Access to dental care, while improving, is still 1,490:1 *(Robert Wood Johnson Foundation, 2019).*

In Asotin, Columbia, and Garfield counties, an Opioid Resource Network is being developed to coordinate systemic responses to the complex issues of addiction. In Yakima County, the Community Resilience Campaign is increasing knowledge of trauma-informed practices to mitigate the effects of adverse childhood experiences (ACEs) in the region. Covering such a large geographic region presents challenges in aligning resources and activities to improve health and health equity.

GCACH is implementing projects in the following areas as well as dedicating additional resources to Asotin, Columbia, Garfield, and Yakima counties, which experience greater disparities in health outcomes:

1. ***Bi-directional Integration:*** *integrating behavioral and physical healthcare for Medicaid patients with both a behavioral health issue and a chronic disease.*
2. ***Transitional Care:***
   reducing hospital readmissions and avoidable healthcare spending through coordinated transitional care as patients move from one healthcare setting to another during recovery.
3. ***Chronic Disease Management:*** *for Medicaid adults with diabetes, Medicaid children with asthma, and Medicaid beneficiaries with chronic behavioral health issues.*
4. ***Opioid Response:***
   oordinating efforts to promote prevention, access treatment, and recovery.

Photo courtesy Washington DOH

Photo courtesy Washington DOH

Cascade Pacific Action Alliance

The Cascade Pacific Action Alliance ACH (CPAA) covers seven counties and 600,000 people across 8,322 square miles. The Confederated Tribes of the Chehalis, Cowlitz Indian Tribe, Nisqually Indian Tribe, Quinault Indian Nation, Shoalwater Bay Tribe, Skokomish Indian Tribe, and Squaxin Island Tribe are located in the CPAA region.

CPAA counties have a higher unemployment rate than the whole of Washington State. The same is true for chronic disease prevalence, with higher rates of cancer, arthritis, health disease, and diabetes in these counties. Asthma was the only chronic disease with a lower prevalence in CPAA counties than the Washington State average.

All seven CPAA counties report higher instances of adult diabetes and equal or greater percentages of food insecurity than Washington State as a whole. CPAA counties also report higher rates of adult and youth cigarette smoking *(Cascade Pacific Action Alliance, 2017).*

Four counties within CPAA are ranked within the bottom 10 for overall health outcomes by the Robert Wood Johnson Foundation's county health rankings for Washington State: Pacific (37 out of 39), Grays Harbor (36), Cowlitz (31), and Lewis (30) *(Washington State Department of Health, 2018).*

To address the needs across all seven counties, CPAA is implementing projects and programs on multiple fronts. CPAA's Regional Health Improvement Plan includes goals to prevent and mitigate ACEs and to prevent marijuana abuse for youth.

CPAA's Medicaid transformation projects are:

1. ***Bi-directional Integration:***
   integrating behavioral and physical healthcare for Medicaid patients with both a behavioral health issue and a chronic disease.
2. ***Community Based Care Coordination:***
   connecting Medicaid patients with complex needs to interventions and services to improve health.
3. ***Transitional Care:***
   reducing hospital readmissions and avoidable healthcare spending through coordinated transitional care as patients move from one healthcare setting to another during recovery.
4. ***Chronic Disease Prevention & Control:***
   for Medicaid adults with diabetes, Medicaid children with asthma, and Medicaid beneficiaries with chronic behavioral health issues.
5. ***Opioid Response:***
   coordinating efforts to promote prevention, access treatment, and recovery.
6. ***Reproductive, Maternal & Child Health:***
   improving access to reproductive, maternal, and child health services.

ACCESS TO CARE & WORKFORCE STRATEGIES

Access to healthcare influences well-being, and quality of life. When barriers--such as lack of insurance coverage, high cost of care, lack of available providers whom individuals feel comfortable accessing--impede access to care, wellness suffers. Obstacles to healthcare treatment can lead to delays in receiving care, impediments to preventive services, financial burdens, and preventable hospitalizations *(Healthy People, 2020).* In 2016, only 74% of adults reported having a primary healthcare provider *(Washington State Health Assessment, 2018)*. These disparities in access are intensified in the rural areas of Washington.

In Washington, an uneven distribution of health professionals reduces access to care. The Health Professional Shortage Area (HPSA) designations indicates shortages of primary, mental, or dental providers.

Access to Care: Primary Care

Washington's rate of primary care physicians per capita is comparable to national levels. However, the simple number of physicians per capita does not fully represent Washingtonians' access to care. The growth rate of the profession remains stagnant and will not meet the increasing needs of the state's aging population. Distribution of providers and whether they accept Medicaid also play significant roles in patients' ability to access care.

There are vast differences between urban and rural areas of the state in the distribution of physicians, with significantly fewer family medicine physicians and generalist physicians in rural areas. Correspondingly, there are differences in distribution between the more rural eastern and more urban western areas of the state, with generally fewer physicians per capita on the eastern side of the state. Overall, the physician workforce grew on both sides of the state between 2014 and 2016, to 2.4% in Eastern Washington and 4.5% in Western Washington, as did the numbers per capita. Yet the per capita rate of primary care physicians providing direct patient care has remained flat in Eastern Washington while growing by 4% on the west side of the state *(Skillman & Dahal, 2017)*.

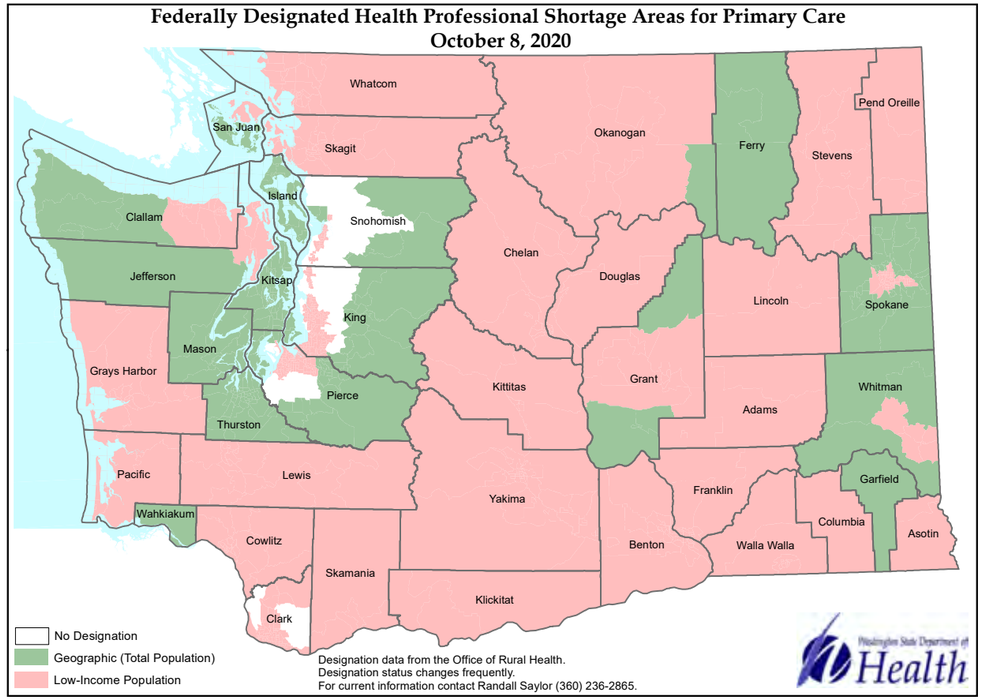
Healthcare infrastructure is generally more precarious in rural areas in Washington State.

Healthcare infrastructure is generally more precarious in rural areas in Washington State. Smaller and less diverse local economies can inhibit health investment, leading to fewer providers and more barriers to access in these areas. During the COVID-19 outbreak, almost one in four rural households nationally reported that someone in their house was unable to access healthcare for a serious problem *(Harvard, et. al., 2020)*. Throughout the state, geography and weather also create additional access barriers, along with isolation from larger populations and services.

The mean age of Washington's practicing physicians is 51 years, slightly younger than reported in 2014. Still, a significant percentage of Washington's primary care workforce is nearing retirement age. Coupled with the state's aging population, these conditions suggest an increasing imbalance between supply and demand.

The pandemic will likely also have a disproportionate impact on health care staff. Of the 1,718 healthcare worker COVID-19 deaths in 2020 as of September 16, an estimated 213 were registered nurses. Of these nurses lost, 58.2 are people of color despite fewer than quarter of nurses identifying as people of color. Black individuals are 12.4% of nurses in the US but 18.7% of nurses who died from COVID-19. While only 4% of nurses are Filipino, they suffered 31% of COVID-19 deaths. *(National Nurses United, 2020)*

In 2001, to address growing concerns about Washington's healthcare personnel shortages, the state's workforce board created a task force that is now called the Health Workforce Council. In their 2018 annual report, the council identified registered nurses (RNs), medical assistants, family medicine physicians, dental assistants, and licensed practical nurses (LPNs) among the occupations most frequently experiencing long vacancies *(Washington Workforce Training & Education Coordinating Board, 2019b)*. The reasons for difficulty recruiting personnel in rural areas, as well as for high turnover and retention challenges, include salaries being significantly lower than in urban areas and a lack of career advancement opportunities. In 2019, more RNs practiced per 100,000 people in urban areas (888) compared with rural areas (560); this was more pronounced in Eastern Washington



(513) than the western side of the state (599) *(Stubbs & Skillman, 2020c)*. Statewide, fewer than 11% of LPNs and 9% of Washington's practicing ARNPs reported working in a rural area in 2019 *(Stubbs & Skillman, 2020a and b)*.

In addition to having fewer physicians providing direct care per capita, rural regions also have a higher percentage of physicians age 55 or older. The highest percentages of physicians aged 55 or older are in Washington's most rural counties. In 2016, at least two-thirds of all physicians providing direct patient care in Garfield, Ferry, Columbia, Clallam, Pacific, San Juan, and Skamania counties were 55 or older *(Skillman & Dahal, 2017)*.

These disparities and shortages influence primary care access statewide. Access to primary care for all age groups in Washington is below the national 50th percentile. Looking at both commercially insured populations and Medicaid covered populations reveals further disparities: The percentages of commercially insured patient populations accessing primary care ranged from 96%, for those ages 65 years and older, to 90% of those 12 to 19 years old. However, only 39% of commercially insured adolescents and 68% of infants in their first 15 months received well child visits. For the Medicaid population, access to primary care fluctuated from 94% of toddlers aged 12 to 24 months to 73% of adults 20 to 44 years old. Only 37% of Medicaid-covered adolescents and 50% of infants in their first 15 months received well child visits *(2020 Community Checkup)*.

Access to Care: Behavioral Health

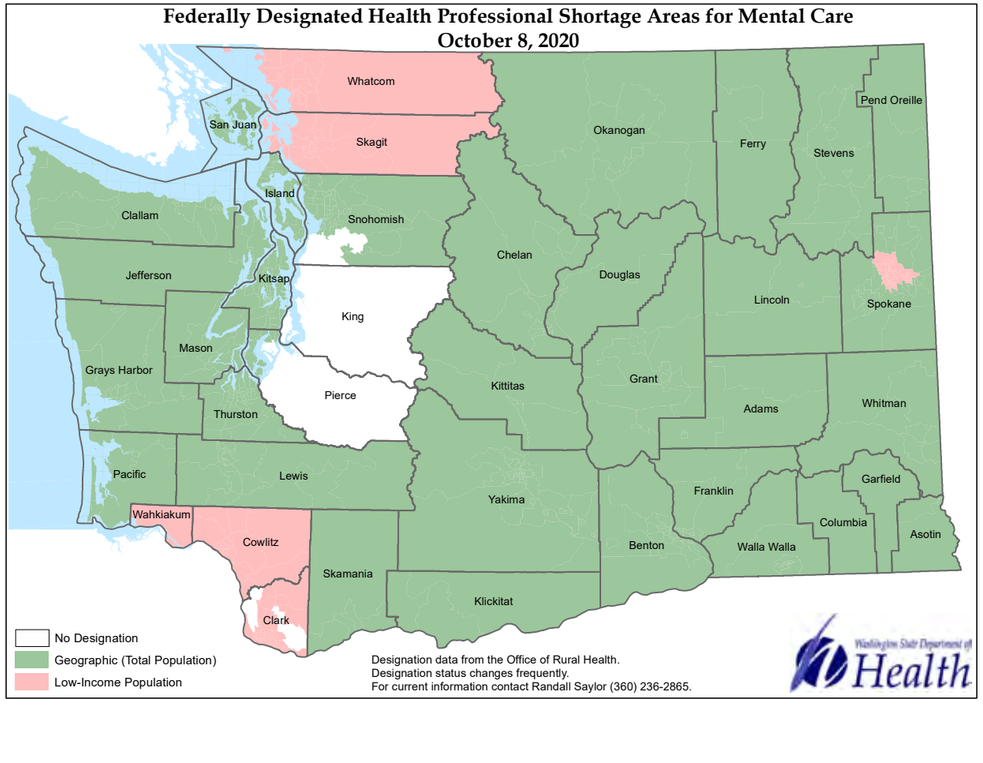
Although Washington State has made improvements in access to behavioral healthcare, both adults and youth report living with a mental illness at higher rates than the national average. Using 15 measures, the State of Mental Health America 2021 ranks Washington 31th out of 51 (including the District of Columbia), with a higher prevalence of mental illness and lower rates of access to care -- this despite the state's ranking 16th out of 51 for mental healthcare access *(Mental Health America, 2020)*.

Since 2016, Washington has seen a substantial decrease -- from 23.9% to 10.6% -- in the prevalence of uninsured adults with a mental illness; this is still 140,000 individuals and 32nd in the nation. Coverage for youth also improved during this period. In 2016, the percentage of children with private insurance that did not cover mental or emotional problems was 5.4%. In the 2020 report, the percentage dropped to 5.2%, ranking Washington as eighth best in the nation for this metric *(Mental Health America, 2020)*.

Despite the increase in health insurance covering behavioral healthcare, 53.5% of adults in Washington with a mental health illness reported receiving no treatment; and for students identified as having an emotional disturbance for an individualized education program, Washington ranked 40th *(Mental Health America, 2020)*.

One of the state's priorities to improve healthcare is the integration of physical and behavioral health treatment services in the Medicaid program. Primary components of the state's strategy are providing training and technical assistance in support of this transformation and expanding mental healthcare delivery via telehealth. All Accountable Communities of Health in Washington are required to work on Medicaid Transformation Projects related to the integration of physical and behavioral health *(Washington State Health Care Authority, 2018a)*.

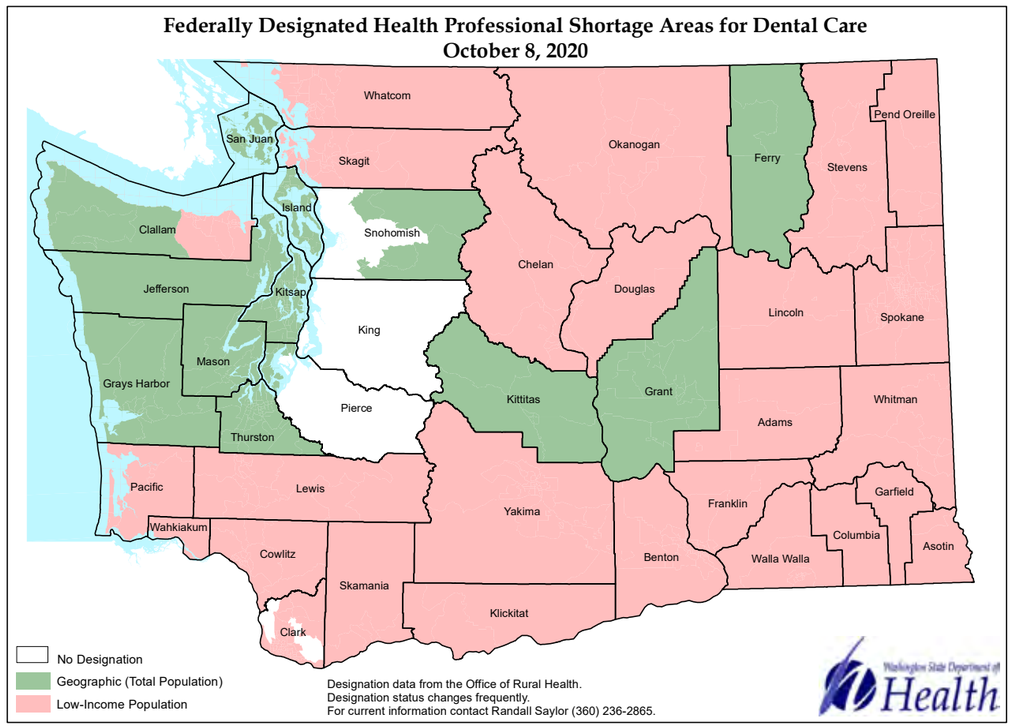
Shortages of mental health providers exist throughout Washington. As of October 2020, 33 of Washington's 39 counties were either partially or wholly designated Health



Professional Shortage Areas (HPSA) for Mental Healthcare with five additional counties meeting that designation for low-income populations. A HPSA designation for a geographic area requires a population-to-psychiatry ratio of 30,000:1, and travel time must be at least 20 minutes.

There were no practicing psychiatrists in Washington zip codes considered "isolated, small, rural" in 2016 and fewer than five non-federally funded employed psychiatrists under the age of 75 practicing per 100,000 residents in rural areas, a 2.5% decrease since 2014. This compares to 11.6 non-federally employed psychiatrists under age 75 practicing per 100,000 residents in urban Washington zip codes *(Skillman & Dahal, 2016)*. Although a lack of psychiatrists can be a significant challenge in meeting a community's behavioral health needs, psychiatrists make up only a small segment of the behavioral health workforce, which includes other professions ranging from those with shorter-term training, such as certified peer counselors, through doctorate-level providers. Adding to the shortage of mental health providers in Washington, the statewide distribution of psychiatric ARNPs is 7.4 per 100,000 population *(McCarty & Skillman, 2017)*.

Washington is investing in mental health. In May 2019, Governor Jay Inslee signed into law four bills intended to improve Washington's mental health system and reshape how and where patients receive acute mental healthcare by introducing more community-based facilities, establishing a University of Washington behavioral health teaching hospital, including a network of smaller facilities around the state, ensuring patients receive care closer to their support systems, and integrating a more holistic model of behavioral healthcare *(Washington Governor, 2019)*. In response to the COVID-19 pandemic, Washington launched a crisis counseling program called Washington Listens for non-clinical support via toll-free telephone (1-833-681-0211, 711 for the relay service), text, and video call, with language access available.



Access to Care: Oral Health

For low-income adults seeking dental health services in Washington, shortages of dentists willing to accept Medicaid, fewer dental health professionals in underserved areas, and high out-of-pocket expenses are steep barriers. For children in Washington, tooth decay remains a major concern.

The number of dentists licensed in Washington State increased 8.5% in nine years from 5,830 in 2007 to 6,325 in 2016, raising the number of dentists per population slightly (from 71 per 100,000 in 2007 to 74 per 100,000 in 2016). Yet, distribution of dentists per capita varies greatly across the state, ranging from a high of 109 dentists per 100,000 population in urban King County and a low of 51 in rural North Central counties *(Patterson, et. al., 2017)*.

Even though the statewide number of dentists has increased, the number of Washington counties designated as Dental Health Professional Shortage Areas has risen. From 2013 to 2019, counties either partly or wholly designated as such increased from 27 to all 39 counties, indicating expanding dental provider shortages for underserved and uninsured populations *(Rural Health Information Hub, 2019b)*.

Many patients insured by Medicaid are unable to obtain care due to the small number of dentists willing to accept Medicaid in Washington. Statewide, there is drastic variation between counties when comparing Medicaid dental utilization by eligible users.

In the 2015-2016 Smile Survey administered by the Washington State Department of Health, the rate for untreated tooth decay was 12% for elementary school children. This is the most common chronic disease for children, but one that is preventable. Although disease prevalence has decreased since the 2005 Smile Survey, dropping from 60% to 53% for third graders, large disparities continue to exist in oral health for children by race, income, ethnicity, and language barriers *(Washington State Department of Health, 2017)*.

Of the one out of five Medicare beneficiaries who reported forgoing health care due to COVID-19, 43% said they did not access dental care due to the pandemic *(Centers for Medicare & Medicaid Services, 2020)*.

Workforce Strategies: Primary Care Providers

In addition to emphasizing recruiting and retaining key professionals, workforce interventions, such as loan repayment programs, need to target underserved rural and urban areas identified as having the greatest need. Educational incentives should continue to be coupled with obligations to provide periods of service in rural and underserved urban locations.

The Washington State Health Assessment notes that Washington's aging population with their complex health needs will be best served by a range of services such as home health, hospice, and care for chronic illnesses. Recruiting providers to fill these service needs will be vitally important for the health of our communities and for healthcare teams themselves.

To retain primary care providers already serving rural areas and to attract additional providers to underserved areas, Washington State needs to implement payment model innovations that will reward quality over quantity. Traditional payment models reliant on quantity disincentivize primary care providers from working in rural areas where populations are less concentrated. The Washington Health Care Authority introduced a value-based payment methodology in Medicaid for federally qualified community health centers and rural health clinics. The hope is that the state's purchasing power through Medicaid and public employee plans will drive change in the payment structure in the commercial market as well. Paying for value rather than for volume can support providers and communities by fostering increased provider capacity, efficiency in service delivery, expansion of primary care teams, and personalized care that includes multiple provider types within a team *(Washington State Health Care Authority, 2019b).*

Workforce Strategies: Behavioral Health Providers

Integrating behavioral and physical health services for whole person care, regional investments in integrated clinical models, and increased availability of technology solutions, such as telemedicine, could increase access to behavioral health providers in rural areas. To encourage this evolution, resources from Washington's Medicaid Transformation Project are supporting staffing and workforce development to address professional shortages in addition to the development of information technology infrastructure for better information sharing between provider teams *(Washington State Health Assessment, 2018).*

Workforce Strategies: Oral Health Providers

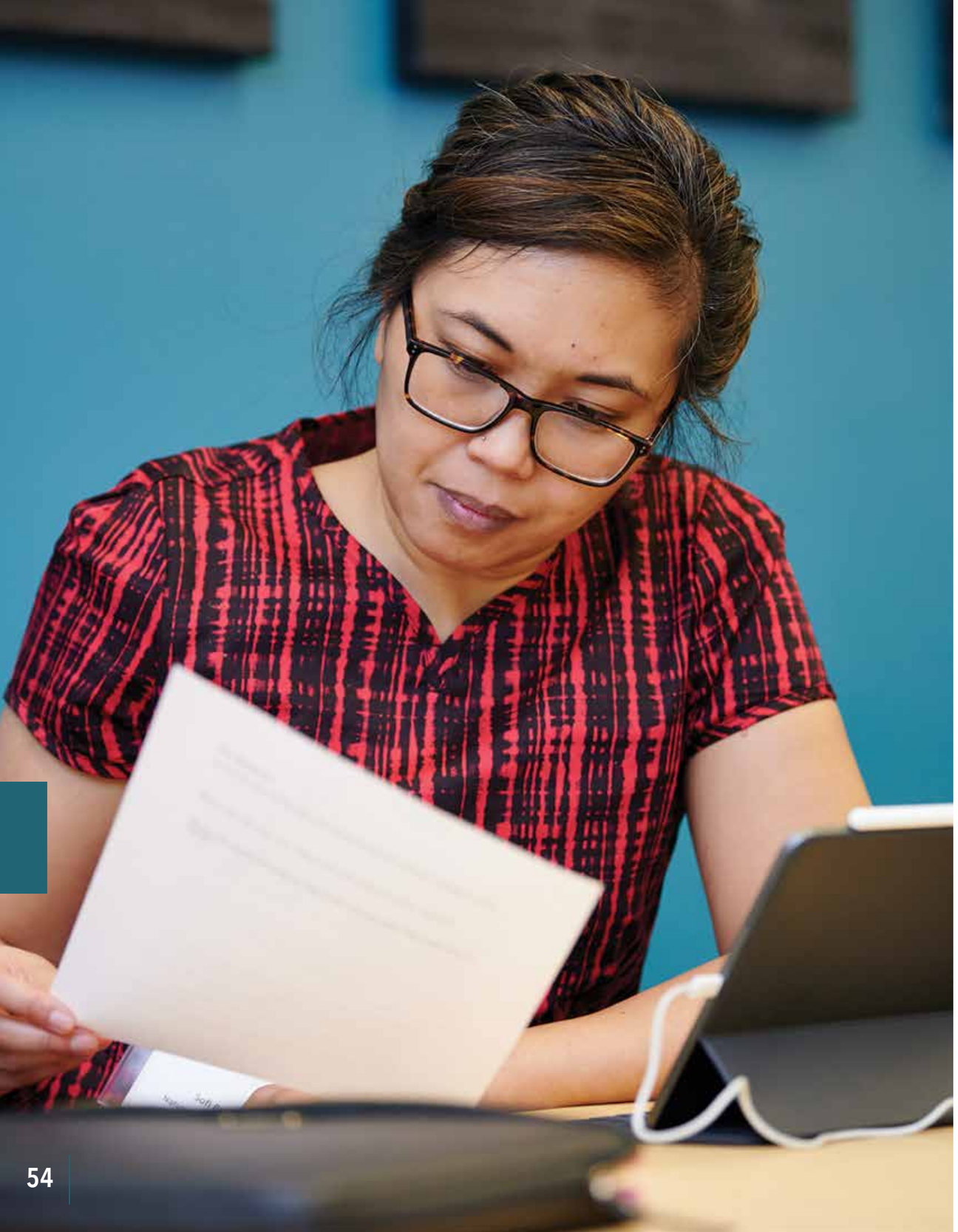
Innovative and inter-professional programs are being implemented across Washington State to increase the number of oral health professionals.

To better serve American Indian/Alaskan Native populations, Washington State passed legislation in 2017 that authorizes tribes to hire dental health aide therapists (DHATs), mid-level dental providers. Based on Alaska's DHAT model, which has been in place for over 10 years, the two-year training provides 3,000 hours of clinical education and 400 hours of dentist-supervised practice hours *(University of Washington School of Public Health, March 2019).*

The Yukon Kuskokwim Health Corporation established DHATs to address high rates of dental disease among Alaska Native populations, especially children. Over the past decade, the DHAT program has expanded access to dental care and decreased the need for invasive dental treatment. A 10-year study by the University of Washington (2017) found that increased dental therapist treatment days was positively associated with preventive care for children and adults and showed an association with a decrease in the number of extractions for children and adults.

While the Alaska Native Tribal Health Consortium was the only DHAT training program in the country, six students from Washington State tribes graduated from the program in 2019, along with six from Oregon, all of whom planned to return home to serve their respective tribes *(University of Washington School of Public Health, March 2019).* In summer 2021, Skagit Valley College will open a second DHAT training program where students will be able to complete their clinical training at the Swinomish Dental Clinic.

This new provider model, along with innovative educational programming with an emphasis on rural areas, is increasing dental healthcare access. Replicating and scaling such models could further increase Washington's dental healthcare workforce.



WORKFORCE DEVELOPMENT SOLUTIONS

Healthcare Workforce Recruitment and Retention

No single effort can create the ideal healthcare workforce; accordingly, Washington has adopted a multi-pronged approach to improve the size and distribution of the primary care workforce.

Washington's recruitment and retention efforts include coordinated planning, pipeline and education efforts, support for service programs, and employer technical assistance programs. Clinician retention is woven into much of the recruitment programming. Great efforts are made to provide clear communication of and exposure to the unique challenges and rewards that rural and underserved clinical opportunities can bring.

Coordination of Workforce Planning

Washington's Health Workforce Council serves as the main planning and leadership body around healthcare workforce issues for the state. The Council publishes an annual report to inform policy and programming.

One of the Council's ongoing projects, in partnership with Washington's Workforce Board and the University of Washington's Center for Health Workforce Studies, is the Health Workforce Sentinel Network. Launched in 2013, the network is a cross-sector collaborative working to identify and respond to changing demand for healthcare workers and identifying emerging skills and roles required by employers *(Health Workforce Council, 2018)*. The Sentinel Network also provides a data hub on health workforce data, trends, and industry results in workforce development: *WASentinelNetwork.org*. Initially, the Sentinel Network was funded by the Healthier Washington Initiative and the Governor's Office; in 2018, the Legislature then passed ongoing funding that began in 2019.

Recommendations in the 2018 Health Workforce Council annual report included ongoing support for information needs for state health workforce planning, strengthening the dental health workforce pipeline, promoting integrated care through the creation of a Washington Center for Interprofessional Practice and Education, and establishing a Care Worker initiative to develop multi-disciplinary career pathways for frontline workers *(Health Workforce Council, 2018)*.

Northwest Health Career Path Project

A substantial number of outreach programs throughout the Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) region help create a healthcare workforce that more accurately reflects the population by bridging gaps for underrepresented students in college level training in the health sciences. The Northwest Health Career Path Project coordinates efforts among a spectrum of career outreach programs in order to form career pathways. The project maps the current landscape of where, how, and at what levels health sciences career pathway programs function throughout the WWAMI region *(Northwest Health Career Path, 2019).*

Programs Targeting Students Grades 8 through 12

Roots to Wings is a transformative co-mentoring health sciences education pathway program for Native American and Mexican American students in grades 6 through 12 and osteopathic medical students. The collaborative program involves Mt. Adams School District (MASD), Yakama Nation Tribal School (YNTS), Chief Leschi School (CLS), Heritage University (HU), and Pacific Northwest University of Health Sciences *(Pacific Northwest University of Health Science, 2020).*

The Health Occupations Preparatory Experience program (Project H.O.P.E.), administered by the Eastern Washington Area Health Education Center, is one of the most robust experiential learning opportunities for high school students in the state.

Project H.O.P.E. is a four-week, paid summer internship for high school students at healthcare facilities within the student's local community. The program targets students who are first generation college-bound and from rural areas or from populations that are underrepresented in the health professions.

Student interns rotate through several settings within one facility to gain exposure to a variety of health professions and document their activities in the healthcare setting in a journal. Project H.O.P.E. interns are provided a stipend at the end of the internship *(Eastern Washington University, 2019).*

Hosted by Area Health Education Centers, Scrubs Camp is a one-day, hands-on, experiential workshop for high school students to explore a variety of health careers and learn about educational pathways to enter into those professions.

To encourage high school students to explore healthcare careers, Health Professions Affinity Community facilitates activities including presentations by healthcare professionals, field trips, and tutoring at participating high schools. Students also create and implement projects that address public health concerns in their communities, then present their results at a "Health Scholars Fair" *(Area Health Education Center for Western Washington, 2020).*

The Na-ha-shnee Summer Institute, hosted by Washington State University, is a 12-day, free summer camp for Native American and Alaskan Native students currently in the 9th, 10th, and 11th grades. The program encourages youth to explore careers in the health sciences by providing hands-on learning experiences taught by healthcare providers, faculty at WSU Spokane, and health sciences college students *(Washington State University, 2020).*

Doctor for a Day exposes, inspires, and cultivates under-represented middle and high school students in Seattle to enter careers in healthcare through monthly workshops run by medical students, residents, fellow therapists, and faculty. Day-long, hands-on workshops provide students with education and mentorship. Doctor for a Day is a collaboration with University of Washington School of Medicine Center for Equity, Diversity and Inclusion, Student National Medical Association, Network for Underrepresented Residents and Fellows, and Department of Surgery Diversity Council *(Center for Health Equity, Diversity & Inclusion, 2020).*

Beginning in middle school, College Success Foundation engages low- to moderate-income students -- many aspiring first-generation college goers, or students of color -- in college awareness and readiness activities. In high school, College Success Foundation focuses students on goal setting, academic engagement, and college prep through advisors, case management, college visits, leadership development, and scholarships *(College Success Foundation, 2020).*

Tacoma Summer Jobs 253 Program offers public school junior and seniors an opportunity to earn high school credits for graduation, college credits, and work experience through a paid summer employment program. The program is a workforce development initiative first launched in 2013 and is a joint effort between the City of Tacoma and Tacoma Public Schools, managed by the REACH Center *(City of Tacoma, 2020).*

Starting in elementary school, Rainier Scholars is a 12-year program paving a pathway to college graduation for low-income students of color in Seattle. The program provides academic preparation, leadership development, and personalized support (*Rainier Scholars, 2020).*

Programs Targeting College Students

The Targeted Rural and Underserved Track (TRUST) program was developed at the University of Washington to provide a connection between underserved communities, medical education, and the health professional. The TRUST program creates a workforce pipeline by guiding qualified students through a curriculum that connects underserved communities in Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) to the University of Washington School of Medicine and its affiliated residency programs.

Beginning in the summer before medical school, TRUST scholars participate in clinical and classroom experiences, discussions, and conferences. Scholars gain a clear understanding of the benefits and challenges of a practice in rural and underserved areas. TRUST match data show promising results in building a sustainable rural primary care workforce: over 51% of WWAMI TRUST graduates, from the first graduates in 2012 to the current 2019 graduates, have matched into rural primary care *(University of Washington, 2020).*

Established in 1996, the WWAMI Rural Integrated Training Experience (WRITE) program at the University of Washington School of Medicine is a clinical medical education program designed to help meet the needs for rural physicians in the WWAMI region. Students in their third year of medical education participate in 22 to 24 weeks of clinical education experience at a rural teaching site. In addition to gaining broad clinical experience, students gain a deeper understanding of components of rural care such as longitudinal diagnosis, treatment and management of care for community members, and integration with the rural community and its resources. As a workforce program, WRITE aims to bring students back to rural and underserved communities within the WWAMI region for future practice after medical school to meet the unique needs of the communities served. As of September 2019, 66.7% of WRITE graduates had returned to one of the five WWAMI states after residency or a fellowship. Since 2018, Washington has been home to 10 WRITE sites.

The Rural Underserved Opportunities Program (RUOP) is a four-week rural immersion program for University of Washington students between their first and second years of medical school. This program is supported by the Area Health Education Centers and RUOP coordinators throughout the WWAMI region. Students are placed with a preceptor in a rural or underserved clinical site to participate in hands-on clinical learning. This program was developed to encourage primary care careers in clinical practice and expose students to a rural or underserved community.

In RUOP, students receive broad clinical experiences and contact with the community. They may complete histories and physicals, assist with office procedures, attend births, and assist in surgery.

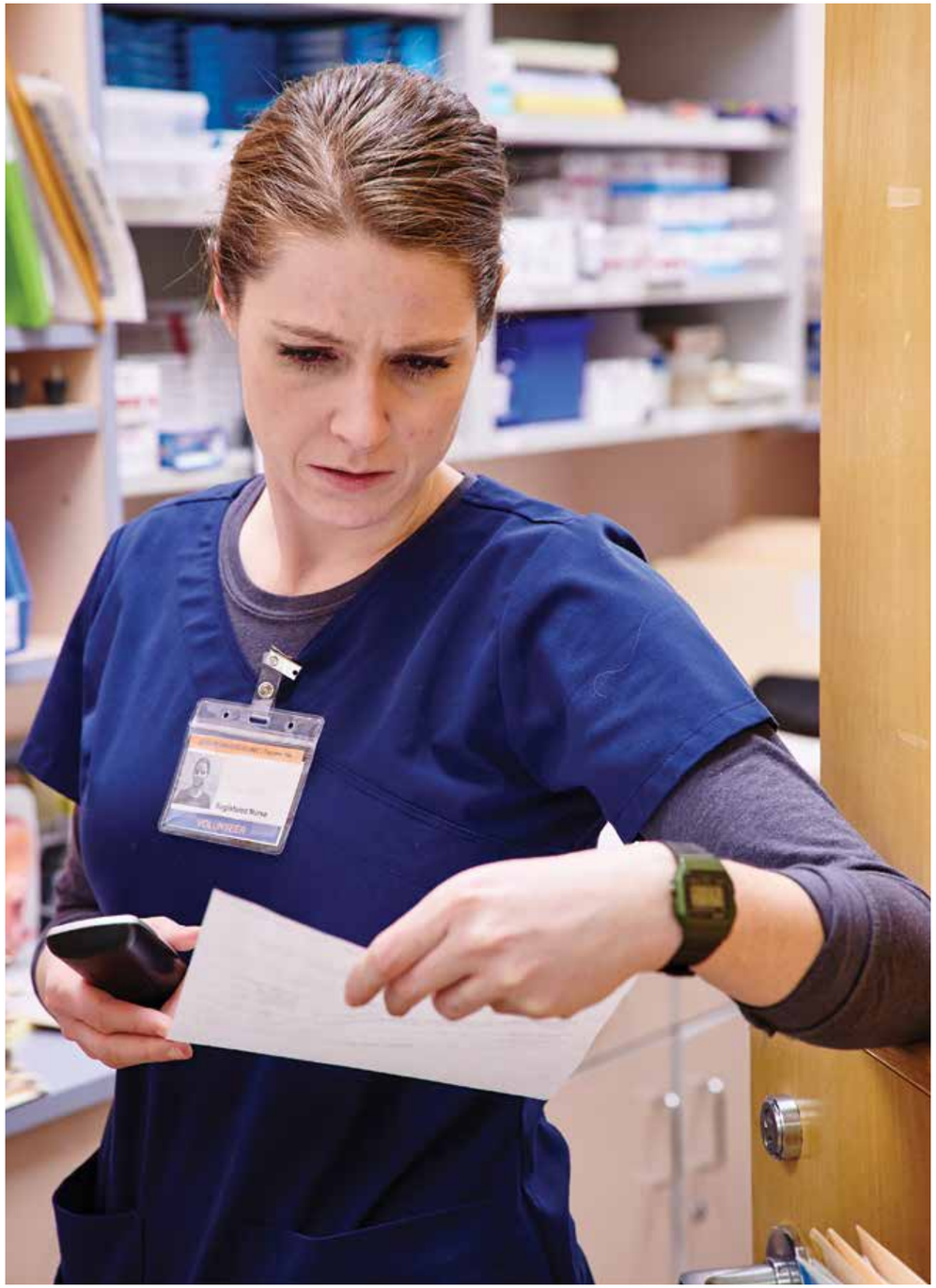
Students also receive funds for travel and assistance in locating and paying for housing via partnership with Area Health Education Centers *(University of Washington, 2019b).*

The Community-focused Urban Scholars Program (CUSP) at the University of Washington School of Medicine trains physicians who reflect urban underserved communities and are committed to serving as providers. CUSP is a four-year longitudinal program incorporating clinical care, personal and professional development, and population health components into students' education. Students also participate in team-based activities and service-learning projects. CUSP students go beyond the graduation requirements of the UWSOM and complete multiple clinical rotations in underserved urban settings *(University of Washington, 2019a).*

Within the Center for Health Equity, Diversity, and Inclusion, the University of Washington also has numerous programs for research and enrichment including Summer Health Professions Education Program, UW Health Professions Academy, Chicanos/Latinos for Community Medicine, and the Minority Association of Pre-Health Students.

The WWAMI Area Health Education Centers (AHEC) program works through a variety of programs to address the persistent health workforce shortages and poor health outcomes of urban underserved and rural communities and to develop a diverse, interdisciplinary health workforce. Since 2018, the WWAMI AHECs include a program called AHEC Scholars among their other offerings. AHEC Scholars are students from a variety of health education programs participating in additional didactic and community/experiential/clinical learning over the course of a two-year certificate program. Students gain valuable education in topics that will support them in providing team-based, culturally sensitive, patient-centered care for rural and underserved communities *(Washington, Wyoming, Alaska, Montana, and Idaho Area Health Education Center, 2018).*

In 2017, Washington State University opened its doors to a new Elson S. Floyd College of Medicine which was created to fill critical healthcare gaps across the state. The community-based clinical training model employed at the college helps students gain experience in healthcare settings in communities with the greatest need. The college attracts students with significant ties to Washington, both urban and rural, which increases the likelihood of their remaining in the state to practice medicine after graduation *(Washington State University, 2019).*



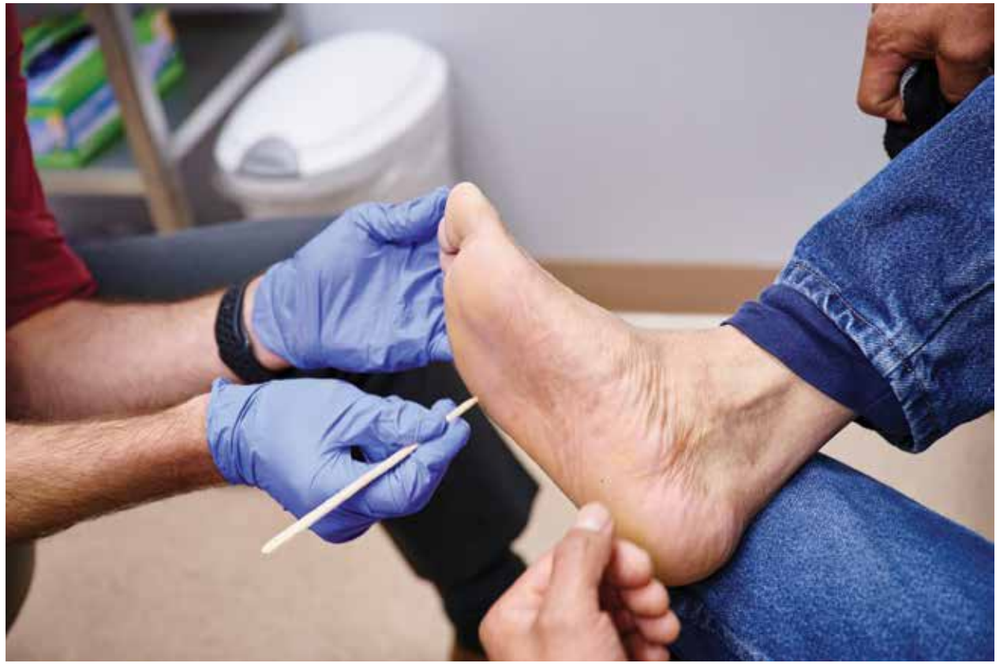
Registered Apprenticeship Programs

Washington State Department of Labor and Industries operates the registered apprenticeship program through their Washington State Apprenticeship and Training Council (WSATC). Registered apprenticeships offer on-the-job training for skilled workers under professional supervision, along with classroom instruction, to develop a highly skilled professional workforce. Apprenticeship results in a nationally-recognized professional credential. Apprentices are paid during their training, making the apprenticeship model an accessible avenue to education when income is an essential. Registered apprenticeships also require a sponsoring organization such as employer, union, or employer association to oversee the apprenticeship program *(Washington State Department of Labor & Industries, 2019).*

Apprenticeship training in healthcare is helpful for workforce development because it can assist with retaining an incumbent workforce of people who would like to progress within their organization or facility and add to their job satisfaction. Apprenticeships also provide a pathway for new entrants into the workforce. As primary care works to address its workforce distribution needs and challenges, apprenticeship can be one mode to target specific professions and locations in need of increased workforce.

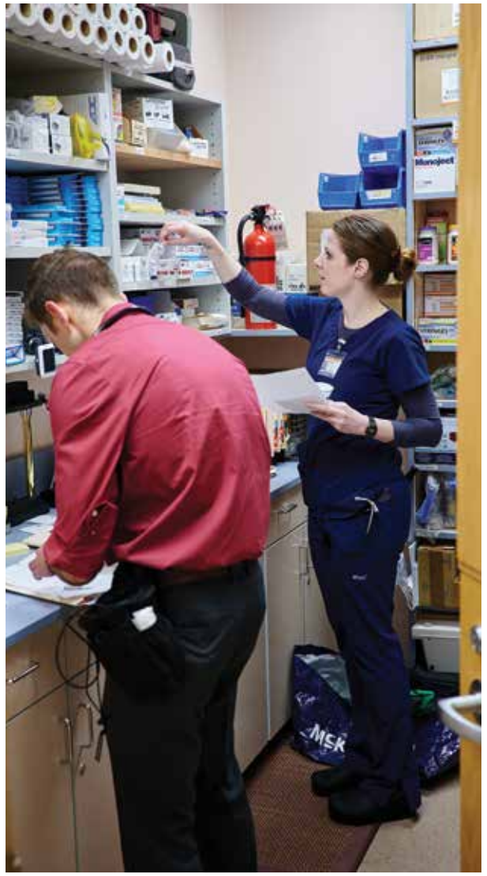
The Washington Association for Community Health created a new apprenticeship model to increase the medical assistant workforce through a stipend, 12-month program. The Registered Medical Assistant Apprenticeship Program, offered through the Institute for Rethinking Education & Careers in Healthcare (IN-REACH), prepares students to take the Certified Clinical Medical Assistant (CMAA) exam through 2,000 hours of on-the-job training, 410 hours of supplements coursework, and in-person lab days to demonstrate mastery of hands-on technical skills. In addition, completion of the apprenticeship program counts toward college credit. To date, 403 apprentices have graduated from the program. Since 2017, the program has achieved a 99% CMAA exam pass rate, and apprentices have earned over 9,600 college credit hours.

The Washington Association for Community Health, in addition to sponsoring the Medical Assistant



apprenticeship program, also has adapted the dental assisting curriculum into a stand-alone training that employers can use to train staff. Similar to an apprenticeship program, the curriculum can be accessed online via module-based learning. The Association also offers training and technical support as needed *(Washington Association for Community Health, 2019).*

The Healthcare Apprenticeship Consortium under SEIU Healthcare 1199NW Multi-Employer Training Fund, is a multi-union, multi-employer partnership sponsoring healthcare apprenticeship programs such as Medical Assistant and Central Sterile Processing Technician programs to provide all Washington State healthcare employers access to skilled training for their workforce.



Additional Resources

The Area Health Education Center for Western Washington conducted an assessment of needs and possibilities for a distance-learning program to train talent and address nursing shortages and distinctive healthcare needs. The culminating report, *Strengthening the Local Nursing Workforce for Rural and Tribal Communities*, published December 2018, concluded that addressing these needs and challenges will require collaboration across education, healthcare providers, and a range of other supporting agencies. The approach suggested included multiple lines of action taken up by a coordinated consortium of workforce, education, labor, and industry partners to create place-based learning and professional development in rural and tribal communities *(Zabihi, 2018).*

The Washington Rural Palliative Care Initiative (WRPCI), led by the Washington State Office of Rural Health at the Washington State Department of Health, is a pilot effort to better serve patients with serious illness in rural communities. The initiative uses public-private partnership to integrate palliative care in multiple settings. Seven rural communities are currently participating in the initiative *(Healthier Washington Collaboration Portal, 2020).*

The Palliative Care Institute at Western Washington University, in partnership with Northwest Life Passages Coalition and others, seeks to transform palliative care in Whatcom County. Among their other work, the Institute's leadership made a presentation to the Joint Legislative Executive Committee on Aging and Disability in 2016 to advocate for special healthcare that would improve quality of life for those with serious illnesses *(Western Washington University, 2016).*

HEALTHCARE SAFETY NET INFRASTRUCTURE

Washington's healthcare safety net is a vital source of care for low-income, vulnerable, under- and uninsured patients in the state. The following describes both direct service care and programming to establish, support, and build workforce infrastructure within the system.

Federally Qualified Community Health Centers

Washington's community health centers are federally qualified, nonprofit clinics designated to provide care for low-income and medically underserved communities. Washington State is served by 28 community health center systems and 320 community health center sites. Washington's federally qualified community health centers reported treating 1,150,000 patients in 2018 *(Washington Association for Community Health, 2019)*.

According to the Washington Association for Community Health (2019), 57% of the patients seen in community health centers in 2018 were at or below the federal poverty level. Most reported being either uninsured or receiving government subsidized insurance benefits. The patient population served by Washington's federally qualified community health centers is more racially and ethnically diverse than the population of Washington State. In addition to medical, dental, and behavioral healthcare, many community health clinics also provide social services.

Free and Charitable Clinics

Free and charitable clinics are defined as safety net healthcare organizations that utilize a primarily volunteer staff model to provide a range of medical, dental, pharmacy, vision, and/or behavioral health services to individuals who are economically disadvantaged. Such clinics are 501(c)(3) tax-exempt organizations, or operate as a program component or affiliate of a 501(c)(3) organization *(National Association of Free and Charitable Clinics, 2019).*

Entities that otherwise meet the above definition, but charge a nominal fee to patients, may still be considered free or charitable clinics if essential services are delivered regardless of a patient's ability to pay. Free or charitable clinics typically restrict eligibility for their services to individuals who are uninsured, underinsured, and/or have limited or no access to primary, specialty, or prescription healthcare.

The association of free clinics in Washington State, Washington Healthcare Access Alliance, is among the youngest in the country, created in 2006 when a small number of free clinic leaders in Washington first met to network and share resources. Washington Free Clinic Association was formally established in 2008 and was renamed Washington Healthcare Access Alliance in 2012 to reflect a broader view of healthcare safety net partnerships *(Washington Healthcare Access Alliance, 2019a).*

As of November 2019, there are 77 free and charitable clinics in Washington. Most of these clinics focus on primary care, but dental, vision, and behavioral healthcare are also provided at some sites, as well as disease management, social services, specialty care referrals, prescription assistance, chronic pain management, and health education programming.

Washington's free clinics are geographically clustered around the Interstate 5 corridor, running north and south, with fewer clinics located in the rural coastal, central, or eastern portions of the state. Most of the clinics are site-based, though some are mobile or provide a mobile service component, which helps to meet the needs of isolated rural communities, unsheltered populations, and groups without access to transportation.

Free clinic leaders report a significant need for additional mental healthcare support for their patients. A 2019 Washington State free clinic survey found that more than half of all respondent clinics were exploring, developing, or expanding mental healthcare services *(Washington Healthcare Access Alliance, 2019).*

Rural Health Clinics

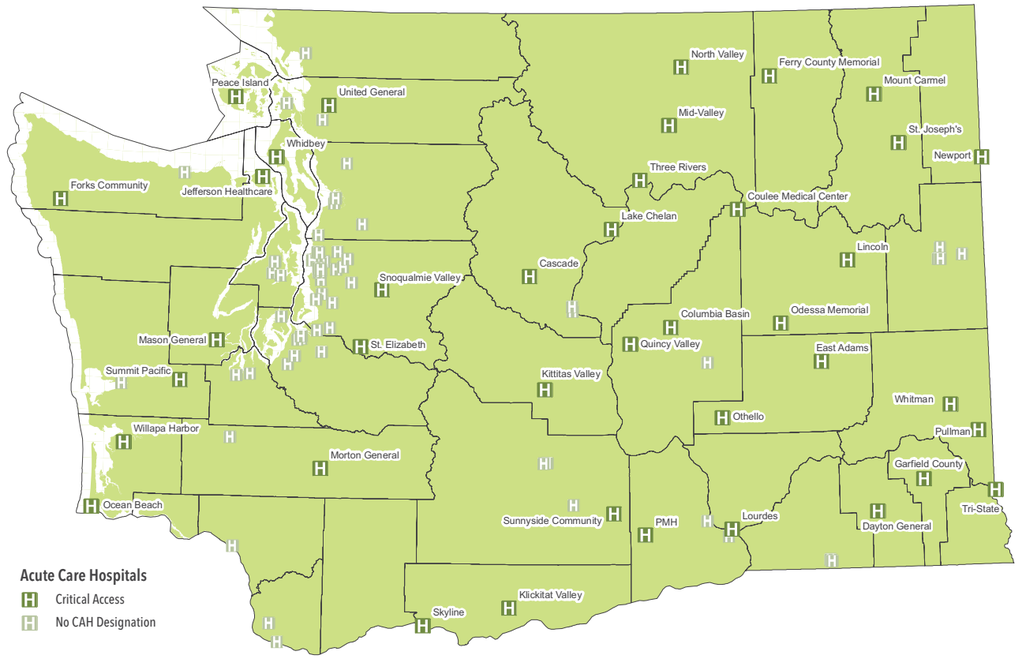
Washington's Rural Health Clinic (RHC) program was established to provide reliable access to outpatient primary care in underserved rural areas. These clinics must be located in a rural or non-urbanized area that qualifies as either a Health Professional Shortage Area or a Medically Underserved Area. Rural or non-urbanized areas must meet the criteria defined by the U.S. Census Bureau. Additional requirements include provision of primary care services at least 51% of the time the clinic is in operation. Under the program, the U.S. Centers for Medicare & Medicaid Services designate those private and nonprofit clinics that meet the conditions for certification as rural health clinics. RHCs are eligible for enhanced Medicare and Medicaid reimbursement for primary care services.

The Office of Rural Health within the Washington State Department of Health provides technical assistance to certified RHCs as well as to clinics interested in pursuing RHC certification. All RHCs in Washington are surveyed periodically by a separate office of the Department of Health to ensure they meet federal requirements *(Washington State Department of Health, 2019c).*

The size and composition of Washington's RHCs vary greatly, from a single, advanced practitioner practicing mostly independently with limited physician oversight to a group practice composed of multiple physicians, advanced practitioners, and ancillary staff. Several RHCs offer specialty services, either regularly or on a rotating basis. Rural settings often face challenges such as provider recruitment and retention and lower payment rates for Medicaid and Medicare patients who often face medical and economic challenges.

As of May 2019, there are 115 RHCs in Washington State. This is a loss of three rural health clinics in three years.

Washington State Critical Access Hospitals



Critical Access Hospitals & Public Hospital Districts

Critical access hospitals (CAHs) are federally designated to ensure that people in rural areas enrolled in Medicare have access to healthcare services, particularly hospital care. CAHs are small hospitals with fewer than 25 beds, intended to serve rural communities. Not all rural hospitals hold the CAH designation.

As of November 2019, there are 40 CAHs in Washington. In at least eight areas of the state, the CAH is the only healthcare provider in the community. CAHs provide primary care, long-term care, physical and occupational therapy, cardiac rehabilitation, and other services in addition to emergency room and acute care *(Rural Health Information Hub, 2019).* Several are transitioning from an acute care model to a more integrated healthcare delivery system, with 27 CAHs operating one or more rural health clinics.

While CAHs are viewed as lifelines in rural areas, they face distinct challenges. In 2017, the Washington Rural Health Access Preservation project released a report identifying 14 CAHs at risk of closure. The main challenge was identified as operating deficits due to high infrastructure costs and low patient volume. Many of these CAHs rely on precarious levies and grants to sustain operations. A number are actively developing new strategies to keep their doors open. Without critical access hospitals, many rural residents would be left without access to critical medical services.

Public hospital districts (PHDs) in Washington operate 31 CAHs. Nearly half of Washington's 90 hospitals are public hospital districts. First authorized in 1945 by the Washington State legislature, public hospital districts deliver services to help people stay healthy -- physically, socially, and mentally -- and are tailored to meet the unique needs of their community *(UW Medicine, Valley Medical Center, 2019).* Fifty-eight local communities in Washington have established PHDs; 44 have hospitals, and the others provide critical services such as ambulance transport, urgent care, and nursing home services.

Veterans Health Administration Facilities

The Veterans Administration (VA) is the largest integrated healthcare system in the US. As of 2019 in Washington State, VA Puget Sound has three medical centers, 11 vet centers, and 10 community-based outpatient clinics. Of the 10 outpatient clinics, seven are located west of the Cascade Mountains *(U.S. Department of Veterans Affairs, 2019).* The number of total outpatient resources for veterans in Washington is significantly lower than in states with comparable veteran populations.

VA Puget Sound, located in Seattle, uses a telehealth system to provide more than 50 care specialties to veterans located in rural communities. Services include mental health, pain management, podiatry, amputee, and lung transplant care. VA Puget Sound's telehealth services served 17,000 patients *(U.S. Department of Veterans Affairs, 2019).*

Although specific VA healthcare access data is difficult to find, there are indications that timely access to care within the system is a challenge for patients. The office of U.S. Senator Patty Murray of Washington State, an outspoken veterans' advocate, assists veterans seeking care in the VA healthcare system. Among the questions included on Senator Murray's Request Assistance FAQ is this: "I have been waiting to be assigned to a primary care provider for over a year now and the VA told me it could be another six months before I get assigned to a doctor. What could possibly be taking so long?" *(U.S. Senator Murray, 2020).*

Project Access

Project Access is a model of donated specialty care through which a primary organization recruits healthcare volunteers who agree to serve a specified volume of patients with specific services for free. These services are provided in the healthcare professional's office. All care, including screening, preliminary lab work, and follow-up is coordinated and supported by the Project Access organization.

Project Access patients receive case management to ensure that barriers to care, such as transportation, language interpretation, and child care, are addressed. Project Access Northwest reports their patient no-show rates at 6%, significantly lower than the 40% of similar populations. The Project Access model has been successful in securing complex healthcare services and maintaining networks of volunteers willing to provide this significant support within a structured agreement. *(Project Access Northwest, 2020)*

Project Access organizations in Washington operate primarily in collaboration with free clinics and community health centers, which provide patient referrals. One Project Access organization is located within a free clinic (Free Clinic of Southwest Washington, located in Vancouver). Project Access organizations currently serve King, Pierce, Snohomish, Kitsap, and Clark Counties.

Tribal Health Clinics

In 1989, the governor of Washington State and the federally recognized tribes signed the Centennial Accord *(Governor's Office of Indian Affairs, 2019)*. The intent of the accord is to enhance the government-to-government relationship between the tribes and the state, stressing the importance of state agencies and the legislative branch working with tribes to develop and implement policy affecting tribal communities.

In Washington State, tribes and urban Indian health clinics have formal working relationships to advance tribal-state collaboration on the delivery of healthcare services. The involvement of tribes in the development of public health and human services policy promotes locally relevant and culturally appropriate approaches to issues of mutual interest or concern.

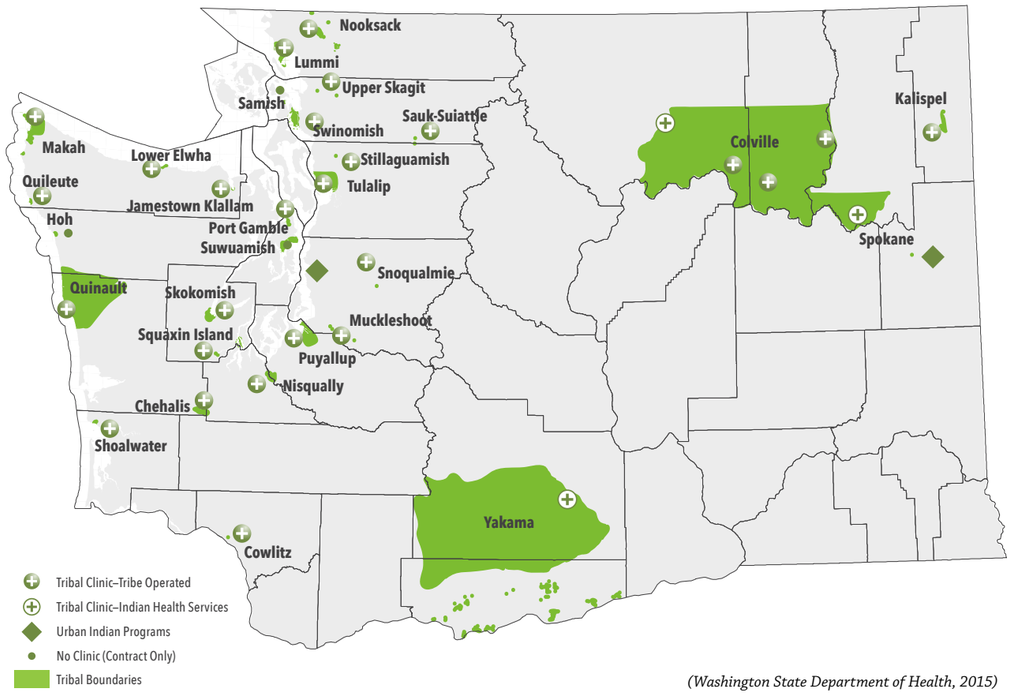
In 2017, the Washington State Health Care Authority set aside $19.9 million for Indian Healthcare Provider Medicaid Expansion Projects. All 29 tribes and both Urban Indian Health Programs are participating. Projects will utilize culturally relevant practices to address the significant health disparities experienced by American Indians and Alaskan Natives, high mortality rates, and historical and intergenerational trauma. The planning phases resulted in a report detailing the Indian healthcare delivery system in Washington State, identified capacity among Indian healthcare providers, inventoried existing services already in place, and highlighted practices that work for American Indian and Alaskan Native populations. Implementation will run through the end of 2020 *(American Indian Health Commission for Washington State, 2019)*.

The Washington State Department of Health reports that there are a total of 36 tribal clinics in Washington; of these, four are Indian Health Service clinics. There are also two urban Indian programs, one each in Seattle and Spokane. Tribal health clinics are leaders in implementing innovative models of integrative medicine. They provide a broad range of services, which may include medical, dental, traditional medicine, mental health, chemical dependency, pharmacy, and WIC programming.

Although some services and programs are only offered to eligible indigenous patients, many tribal health clinics provide primary care services to anyone, regardless of tribal affiliation. The Seattle Indian Health Board in Seattle, for example, serves all patients and offers discounted fees to those who qualify *(Seattle Indian Health Board, 2019)*.

A number of Washington State tribes additionally participate in an assistance program for tribal members that allows a tribe to pay insurance premiums on behalf of eligible members *(Washington Health Benefit Exchange, 2020)*.

Washington State Tribes and Tribal Health Clinics



(Washington State Department of Health, 2015)

Service Incentives: Washington Health Corps

Washington State incentivizes licensed primary care health professionals to serve in critical shortage areas by providing financial assistance through either academic scholarship or loan repayment. Established in 1990, the program has funded over 1,000 professionals serving in 38 Washington counties. In 2019, approximately 100 scholarship and loan repayment program participants worked in underserved areas of Washington through this program.

The loan repayment portion of the program includes two options: a federal-state program, which uses matching federal grant funds for awards, and the Washington State Health Professional Loan Repayment Program, which uses state dollars alone for awards. These programs have different award amounts and contract lengths. The goals are both to meet immediate community healthcare needs and to increase the likelihood of continued service within the placement site as providers develop relationships within the community.

The Washington State Health Professional Loan Repayment Program offers specific retention awards and uses factors correlated with increased likelihood of retention when making award decisions. In the most recent application cycles, the number of applications has far exceeded the state's ability to make awards. Out of 344 applications in 2019, 93 were awarded.

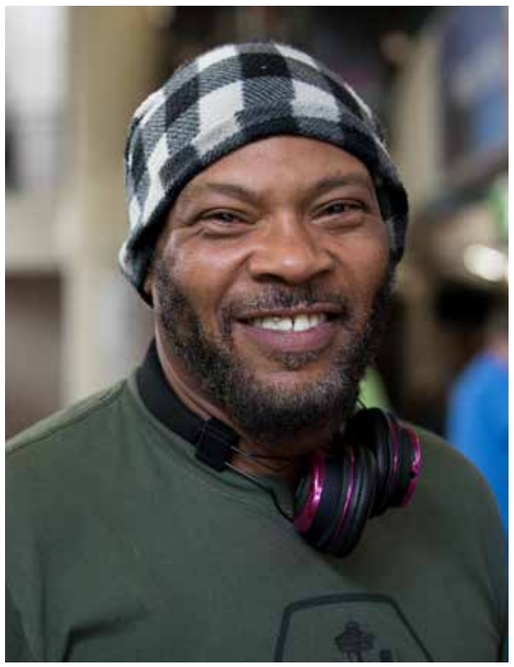
Washington Health Corps was established by the 2019 legislature as an umbrella over the state and federal loan repayment programs, which are administered by the Washington Student Achievement Council, a cabinet-level state agency that works to support increased student success and higher educational attainment for students in Washington. The same legislation also established a subprogram with $2 million in funding for incentivizing behavioral health providers under the loan repayment program *(Washington Student Achievement Council, 2019)*.

Service Incentives: Washington Health Workforce Gateway

The Washington Health Workforce Gateway is a collaborative between the Washington Student Achievement Council, Area Health Education Centers, the Washington State Department of Health, Washington Association for Community Health, and the National Health Service Corps. Formerly known as the Washington Resources Group, this collaborative assists individuals in navigating their health career opportunities, state and federal scholarship and loan repayment programs, and J-1 Visa Waiver programs for those working in rural and underserved areas *(Washington Health Workforce Gateway, 2019)*.

Service Incentives: J-1 Physician Visa Waiver

The Washington State Department of Health also administers a J-1 Visa Waiver for Physicians program with the aim to increase the number of physicians available to work in rural and underserved areas of the state. The program is considered a secondary tool in recruitment, used when efforts to recruit U.S. trained physicians have been unsuccessful for an extended period of time. Washington sponsors 30 waivers per federal fiscal year. At least 20 of the total waivers are available to primary care physicians. Up to 10 of the total waivers are available to specialists *(Washington State Department of Health, 2019)*.



The Role of Volunteerism in Washington's Safety Net

Washington State law authorizes the Volunteer and Retired Providers (VRP) Program, which promotes healthcare volunteerism by addressing barriers for licensed healthcare volunteers. Program benefits include free malpractice insurance for work in approved settings and fee-free license renewal for healthcare volunteers who only use their license for unpaid work *(Washington Healthcare Access Alliance, 2019).*

The program was established in 1992 when nine retired healthcare professionals advocated for malpractice insurance coverage to support their volunteer work. The program was written into law that year, with the explicit goal of leveraging the power of healthcare volunteerism to serve low-income and underserved patients.

The VRP Program is the staffing backbone of Washington's free and charitable clinics and also serves other safety net entities that utilize healthcare volunteers, such as rural health clinics, camps with a healthcare component, and federally qualified health centers. Washington Healthcare Access Alliance has administered the program since 2017.

The VRP Program has grown dramatically since its inception. A 2019 program survey of 137 sites and 2,291 volunteers showed an average reported contribution to the safety net of 82.4 volunteer hours per provider with a total of 43,854 patient care hours and 594,827 patient visits reported by program participants *(Washington Healthcare Access Alliance, 2019).*

Washington's expanded Good Samaritan Law provides additional protection from liability for uncompensated healthcare volunteers *(Washington State Legislature, 2019).*

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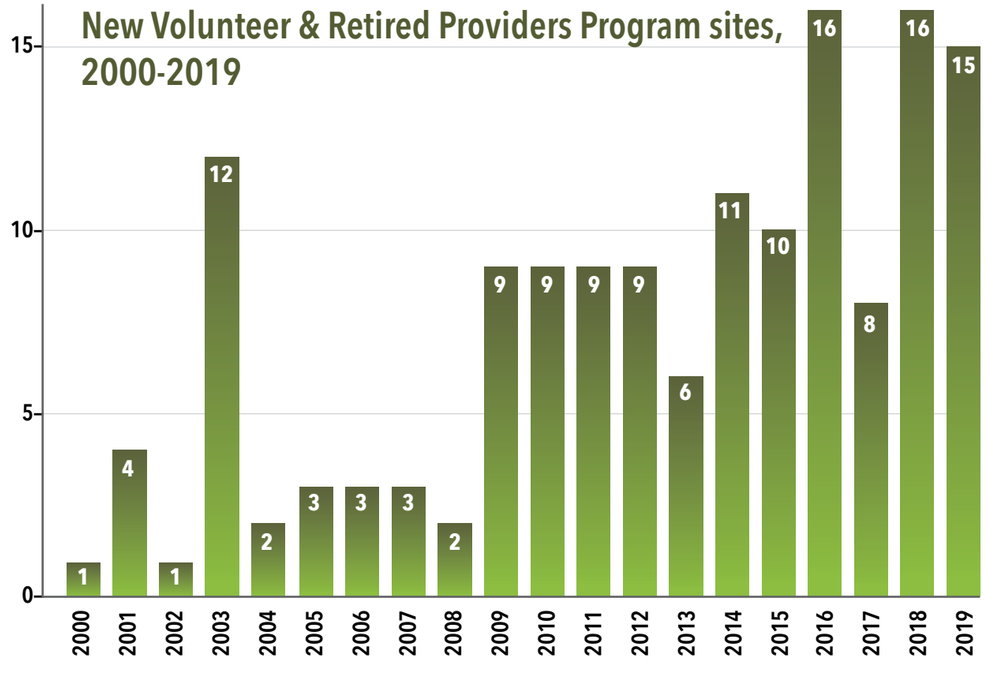

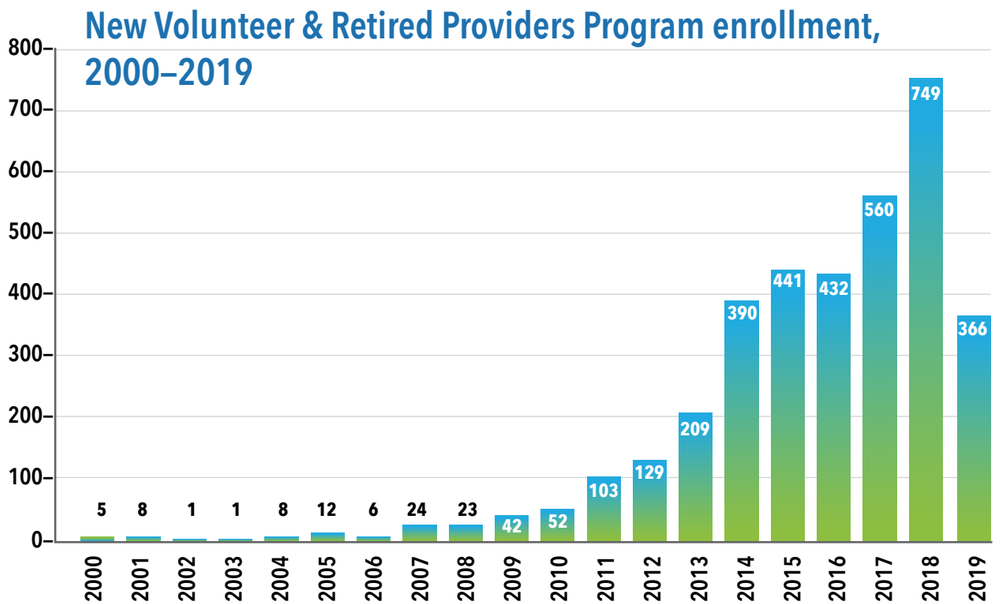

CONCLUSION & RECOMMENDATIONS

Given the complexities of the inequities involved in healthcare in Washington, a collaborative approach is required to address the significant and persistent gaps in the state's health care system. Population data expose the disparities that exist between communities and regions in the state. Consensus is growing that cross-sector alignment across many systems -- physical healthcare, behavioral health, public health, education, and social services -- would promote better health among all segments of the population, as well as generate a more efficient use of resources that could result in programs that have longer lasting impacts.

As hotspots have emerged in vulnerable communities across Washington, the country, and the globe, early lessons from COVID-19 have reaffirmed the need for continued investment in the social safety net and related infrastructure. The pandemic has exacerbated the extensive health inequities that Black, Hispanic, Indigenous, and Asian populations experience, with all communities of color in Washington facing significantly higher death rates than Whites. COVID-19's disproportionate effect on people of color is due to a myriad of factors: People of color are more likely to rely on public transportation, be essential workers, lack basic resources such as food and water, live in crowded housing with multigenerational family members, and lack access to health insurance.

Since the passage of the Affordable Care Act, Washington had successfully reduced the uninsured rate to 7.5%; however, this rate is now beginning to grow as COVID-19-related unemployment rates increase. The viability of the healthcare safety net depends on the stability of funding and the complex effects of the pandemic threaten that stability. For example, losses of jobs and businesses reduce household incomes and, thus, the flow of revenue to the state and some healthcare organizations. Smaller and more rural healthcare organizations are particularly vulnerable to a volatile market such as the one now emerging from the effects of COVID-19 on the economic well-being of the population and the state.

The pandemic has widened the economic disparity gap. While Washington has seen historic numbers of unemployment claims since the outbreak of COVID-19, the wealth of the richest individuals in the state has grown. Residents of Washington's small, rural counties experience disproportionately high levels of poverty and unemployment and have fewer healthcare resources and employment opportunities than residents of larger, urban counties. As the state engages in economic recovery plans, an opportunity arises to address Washington's regressive tax system through the bipartisan Washington Recovery Group.

In addition, as the Washington State Legislature works across the aisle to address economic recovery, it also has an opportunity to improve healthcare access. As detailed in this report, health is tied directly to community infrastructure. These issues have been exacerbated by COVID-19, revealing long-standing gaps in services related to internet, transportation, housing, and the distribution of healthcare facilities and the services they provide. There is growing concern about the impact on community health with a transition to many services provided online, audio-based, and hybrid tele-services, which have underscored challenges in connectivity. Though many of these services were intended to be short-term, the ways we now must access care have changed and these changes will likely shape things in years to come.

Transportation access and rental housing affordability are two other growing and significant challenges for Washington residents as the state faces post-COVID economic recovery. As of 2018, Washington State had the fifth highest rate of homelessness in the country, and homelessness is likely to be exacerbated by the pandemic. This reality reaffirms the urgency for health policy makers to re-evaluate public utilities and social services, to expand our definition of what constitutes the healthcare system.

A strong healthcare system depends upon having a large and diverse healthcare workforce to serve the growing and changing needs of Washington's population. The Workforce Training and Education Coordinating Board, and its allies, continue to address problems underlying policy issues and investments in healthcare training, licensing, and education. Recent events have provided insight into opportunities for continuing education, and undergraduate curricula should include more content and clinical experiences in emergency, critical care, and public health nursing; disaster preparedness; and basic principles of epidemiology. Workforce education and pathway programs will continue to be faced with the challenges of providing quality healthcare training in a system that is stressed by burn-out, crisis management, and workforce shortages. Continued investment in coordinated efforts will be important to support ongoing innovations highlighted in this report and beyond.

Expanding investments in educational pathways to build a representative healthcare workforce within Washington State is an investment not only in healthcare but also in our education system, elevating existing programs and addressing gaps through innovative ideas.

Washington has increased cross-sectoral collaboration through practice transformation, value-based purchasing, and Accountable Communities of Health to move the healthcare system toward whole person care with customized regional approaches. Additionally, the connection between community health and a strong economy necessitates public and private investments, addressing the social determinants of health, strengthening infrastructure, and improving the quality of care available to all Washington residents.

The following recommendations are intended to support the work of community leaders and policy makers as they navigate current challenges in meeting the healthcare needs of Washington State residents.

1. Prioritize healthcare system and safety net investments for the state's most underserved communities.
2. Expand state-funded healthcare insurance coverage to include all income eligible residents, regardless of immigration status.
3. Increase Medicaid reimbursement rates for behavioral health, medical and dental care.
4. Mitigate socioeconomic status as a social determinant of health by addressing Washington's regressive tax system.
5. Implement Workforce Training and Education Coordinating Board recommendations, including those from the Behavioral Health Workforce report to address current and projected healthcare workforce needs.
6. Expand investments in educational pathways to build a healthcare workforce that reflects the communities they serve.

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ACKNOWLEDGEMENTS

The Area Health Education Center for Western Washington wishes to acknowledge Whatcom Community College for support and leadership, the Washington State Board for Community and Technical Colleges for support, and the Primary Care Office at the Washington State Department of Health for support and leadership.

THE FOLLOWING INDIVIDUALS PROVIDED SIGNIFICANT ASSISTANCE:

Sam Watson-Alván, MES, Director, Primary Care Office Washington State Department of Health
Cori Garcia Hansen, BA, BS, CMA, Director, Area Health Education Center for Western Washington
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