Dane County Department of Human Services
Behavioral Health Resource Center

Annual Report

January 2021 – December 2021

Executive Summary

Dane County's Behavioral Health Resource Center is commemorating its first full year of service with an annual report, which summarizes its exponential growth over the last year, its current operations, and what barriers Dane County residents continue to face when trying to access behavioral health services. Below are key findings that summarize the current state of the BHRC, the community members contacting the BHRC for assistance, and system-wide observations about behavioral health services and accessibility in Dane County.

Table 1. Summary of Key Findings

Key Findings
• The majority of those contacting the BHRC are consumers or concerned others (67.8%) • The BHRC opened 1,942 cases and served 1,881 people in 2021 • The number of contacts to the BHRC grew continuously in 2021. Contact volume grew 107% from January to December, with a peak growth rate of 255% from January to July 2021. • October 2021 showed the largest number of cases opened (222) and closed (251) • Barriers to access continue to be a driving force behind consumers contacting the BHRC. Common barriers to access include waitlists, insurance coverage, location/transportation, and poor communication from providers. • The majority of those contacting the BHRC identified mental health as a primary concern (65%), followed by substance use (27.3%). • The BHRC made nearly 5,000 referrals in 2021 to almost 400 providers and professional organizations in Dane County. • Older adults (age 60+) and children present a unique challenge in Dane County – both populations have limited services available and require specific diagnoses and acuity levels for insurance to cover intensive services. • The BHRC distributed a Satisfaction Survey in 2021 – results indicate that consumers are consistently satisfied with the service the BHRC is providing and report feeling supported, validated, and respected by BHRC staff. • In 2022, the BHRC is prioritizing outreach efforts, including the initial development of a Dane Resource Network and piloting a Liaison Partnership between the BHRC and organizations that are not otherwise connected to behavioral health resources.

Suggestions for Increasing Access

The BHRC has been ambitious since its start in November 2020. With continued community support and engagement, we hope to live up to our goals in 2022 to advocate for better access to behavioral health services for all Dane County residents. The following suggestions are to build on consumer feedback and BHRC staff observation regarding access to behavioral health services in our community. In this spirit, we encourage our county and community partners to lean in, challenge the status quo, and find ways to increase access to behavioral health services in our community. Some actions we hope our partners consider include:

Table 2. Suggestions for Increasing Consumer Access to Care

Suggestions
• Update your websites regularly. If you do not have current openings, please consider indicating it on your site. • Maintain connection and build engagement while people wait - call to check in with consumers on your waitlist or offer groups and other supports for consumers on waitlists • Be prepared, willing, equipped, and able to accept referrals for non-English speaking residents by utilizing services such as the language line, the interpreters Co-op, etc. • Increase willingness and capacity to serve consumers with multiple and/or complex needs and various insurance statuses • Engage in warm handoffs across systems of care • Offer pro bono services for uninsured or underinsured consumers • Offer group services and time-limited counseling services to maximize capacity and increase availability • Offer counseling and psychiatry for Medicare recipients • Advocate for Peer Support Services in your agency/organization • Advocate for case management services for Medicare recipients • Advocate for the addition of Peer-Led Services • Advocate for case management through commercial insurance plans

Introduction to the BHRC

Nearly 52 million Americans (1 in 6) have experienced mental illness in their lifetimes and almost 20 million Americans (1 in 15) have experienced a substance use disorder.[1] However, only 44.8% of U.S. adults with a mental illness or substance use disorder received treatment in 2019.[2] The COVID-19 pandemic has only exacerbated these outcomes. More people than ever before are reporting higher levels of anxiety, depression, substance use, sleep deprivation, isolation, and worsening of chronic conditions.[3] While we hear often about the bed shortages in the local hospitals, limited access to behavioral health services has received comparatively little coverage. As more people begin to seek mental health and substance use services that have been exacerbated by the pandemic, systems of care have had to serve more people in the last two years than ever before. Dane County's Behavioral Health Resource Center (BHRC) set out to directly address this need, by bridging the gap between Dane County residents and their access to behavioral health services and treatment.

The BHRC is a voluntary person- and family-centered service designed to help any Dane County resident access behavioral health services in Dane County, regardless of insurance status, financial status, age, identity, ability, or legal status. The BHRC assists Dane County residents from all ages, backgrounds, and walks of life. BHRC services are consumer-led and consumer-driven, meaning that the individual and family are the expert regarding their needs.

Table 3. 2021 Accomplishments and 2022 Goals

2021 Accomplishments	2022 Goals
✓ Staff doubled from three to six	✓ Four additional staff in 2022
✓ Client Satisfaction Survey	✓ Dane Resource Network
✓ Launched After-Hours Line	✓ Liaison Partnership pilot
✓ Adjusted hours to support warm handoffs	✓ UW-Madison Social Work student internship placements
✓ Redesign of IT platform	✓ Continued updates to IT platform

[1] National Alliance on Mental Health "Mental Health by the Numbers" 2021, https://www.nami.org/mhstats.
[2] Ibid.
[3] Kaiser Family Foundation, "March 2021 Health Tracking Poll" July 27, 2020, https://www.kff.org/coronavirus-covid-19/report/kff-health-tracking-poll-july-2020/.

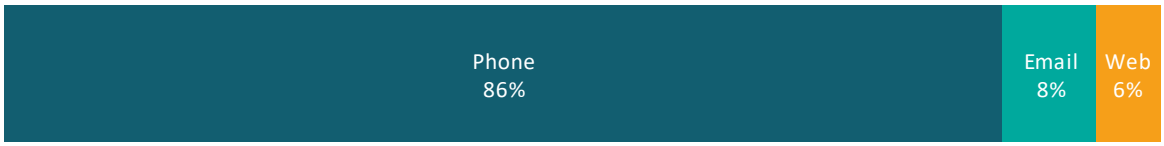
Who is Contacting the BHRC?

1,942 cases opened

1,881 people served

7,789 consumer contacts

The majority of contacts to the BHRC occurred via phone (86%), followed by email (8%) and online web form (6%).

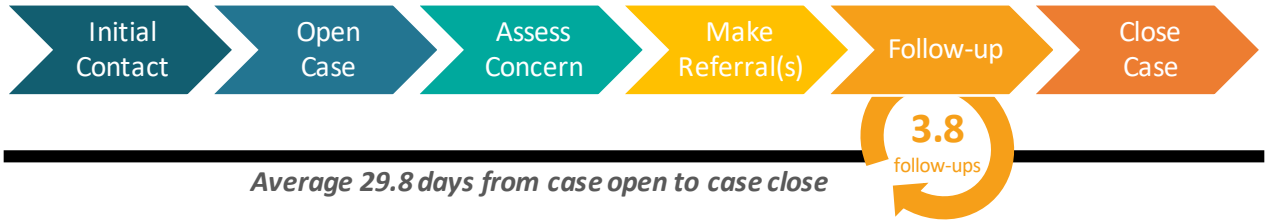


The BHRC staff use several tools to evaluate a person's needs and provide appropriate resources and referrals. A key component of this evaluation is determining *who* is contacting the BHRC and for *what reasons*. In April 2021, the BHRC created "Person Accounts," where staff could specify the type of person contacting the BHRC.[4] The categories include:

44.6% Consumers	23.2% Concerned Others	24.3% Third-Party Professionals
A person seeking resources or services for themselves	A person seeking resources or services for someone they care about such as a significant other, family member, or friend	A professional (case manager, healthcare provider, school staff, etc.) in the community seeking resources or services on behalf of their client or patient

[4] There were 2,044 total cases in 2021. Of those, 492 cases were not specified by person-type because the case occurred prior to April 2021 when specific person-types were available. For the percentages listed below, they are calculated based on a denominator of 1,552.

A Typical Case



When a consumer or a concerned other connects with the BHRC, staff begin by walking the individual through a general assessment to evaluate their clinical needs and any barriers they are facing to accessing care. The assessment includes identifying presenting concerns (e.g. mental health, substance use, dual diagnosis, crisis, etc.). The staff collects the following information from consumers:

- Current and past diagnoses
- Current and past treatment
- Insurance status
- Housing status
- Family context
- Supports and strengths
- Substance use and history
- Specific needs
- Barriers to access
- Additional relevant information

It is possible (and in most cases, likely) that not all of this information can be collected. The BHRC staff prioritize supporting the consumer to make informed decisions about what information they feel comfortable providing and allowing the consumers to guide the direction of their assessment. As such, consumers can provide as much or as little personal information as they choose. This emphasizes ***honoring and respecting the customer's voice and choice as they seek services***.

"The people [who] work there are incredible. I was in a rough place, but the person I talked to was very supportive and followed up with me to make sure I was on track to getting help." - Consumer

After this information is collected, the BHRC will help identify if: 1) further assessment and screening is needed and 2) which providers will best match onto the identified needs, insurance status, preferences, and strengths of the client. The BHRC then provides direct referrals to providers and offers to assist in a warm hand off.[5] The BHRC made ***4,655 referrals*** in 2021. On average, BHRC staff provided 3 formal referrals per consumer in 2021, although additional resources are often provided. The BHRC tries to complete at least one follow-up with the consumer to determine if they pursued the referral(s), and if not, whether there were additional barriers that could still be resolved with

3 referrals per case on average

[5] Agency for Healthcare Research and Quality, "Warm Handoff: Intervention," April 2017. https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html#:~:text=A%20warm%20handoff%20is%20a,of%20the%20patient%20and%20family.

the help of the BHRC. BHRC staff respect if a consumer declines any scheduled follow up and encourages consumers to reach back out to the BHRC if further assistance is needed.

"BHRC has passionate and amazing people who care about supporting individuals and connecting them to the appropriate resources" - Consumer

The majority of consumers have given positive feedback regarding the BHRC assessment process. One consumer wrote, ***"[t]he initial questionnaire addressed a wide range of important needs, including housing and food security. [Staff] were extremely empathetic and supportive, and gave me about 8 difference resources to reach out to…"*** Many felt heard and supported during their initial contact, demonstrating how the BHRC values a person-centered approach to accessing care.

Staffing and Funding

[BHRC staff] was extremely helpful! He listened carefully to my situation, asked excellent questions, and guided me through the intake protocol. He was very clear in his communication was both clear and compassionate. He followed up with me by email and by phone and I was able to secure an appointment with a provider within 7 days of my first call to BHRC. The appointment was for 6 weeks out but I was able to secure it very quickly with BHRC's help. BHRC is an incredible resource. Thank you!!!" - Consumer

The BHRC staff serve as front-line workers to those who reach out for assistance. The scope of their contacts with community members varies significantly in their day-to-day work flow. In just one day, BHRC staff can field calls from people in crisis seeking immediate assistance, a consumer seeking residential substance use services, a parent asking for mental health support for their child who experienced a traumatic event, a consumer reaching out with severe and persistent mental illness that has become debilitating and unmanageable, and a third-party professional such as a school social worker reaching out for information regarding providers that serve families in a rural town of Dane County. Staff regularly bear witness to the tremendous pain, trauma, and difficulty consumers experience as they seek behavioral health services access services and support.

The BHRC is currently staffed and supported by several Behavioral Health Specialists, Behavioral Health Case Managers, and contracted Peer Support and Recovery Coaches. Like any new program, the BHRC has experienced staff turnover throughout their first year of growth and adjustment. The 2022 Dane County budget approved $440,000 in additional funds to the BHRC to bring on four more staff members, including a Peer Support Coordinator, Outreach Coordinator, a Lead Worker, and an additional case manager. With these new positions beginning in 2022, the BHRC hopes to expand services throughout the next year.

"I recently connected with the BHRC […], the individual who helped me, was truly outstanding. I would not have been able to access the care I needed without his help. I am extremely grateful for BHRC and I wanted to take a moment to offer my thanks." – Consumer

The BHRC office is co-located with Joining Forces for Families (JFF), Immigration Affairs, Community Restorative Court, and National Alliance on Mental Health (NAMI), and adjacent to Centro Hispano, Madison College, and Madison Metro South Transfer Point. The BHRC plans to resume in-person operations in June 2022.

BHRC's Continued Growth

Contact Volume

2,185 inbound contacts

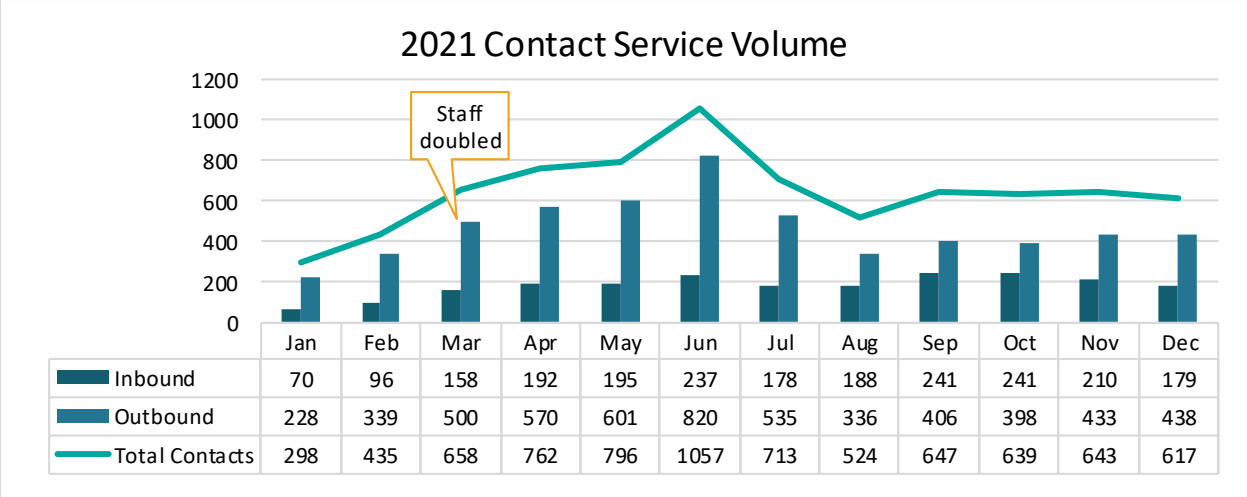
5,604 outbound contacts

6,699 phone calls

1,915 emails

The Behavioral Health Resource Center opened November 23, 2020. Three staff provided behavioral health consultation, resources, and referrals throughout the year. In March 2021 the staff doubled to six. Contact volume grew 107% from January 2021 to December 2021, with a ***peak growth rate of 255% from January to July 2021.***[6]

Figure 1. 2021 Number of Inbound, Outbound, and Total Contacts



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Inbound	70	96	158	192	195	237	178	188	241	241	210	179
Outbound	228	339	500	570	601	820	535	336	406	398	433	438
Total Contacts	298	435	658	762	796	1057	713	524	647	639	643	617

The disparity between inbound and outbound contacts in the chart above illustrates the effort that goes into following up with people who have contacted the BHRC. The chart to the right shows the high volume of contacts *each* staff member balances in a given month.

BHRC staff manage roughly 175 active cases at one time

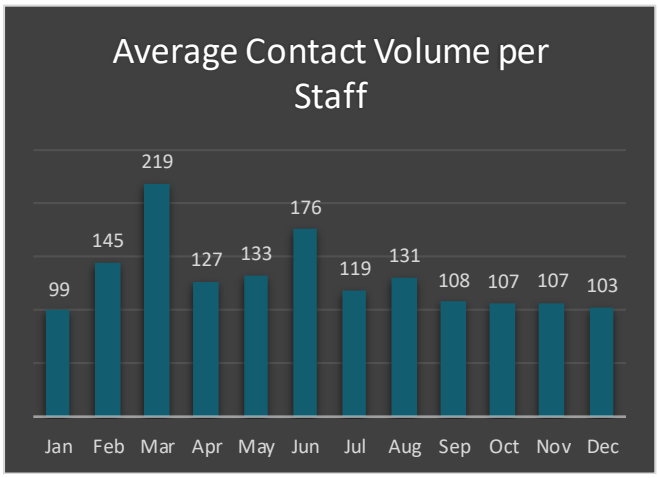


Figure 2. Average Number of Contacts per Month per Staff

[6] "Information Only" cases were created in September 2021. This accounts for some of the decrease in outbound contacts since September because many information-only cases do not require any follow-up contacts.

Figure 3. Number of Cases Opened and Closed per Month in 2021

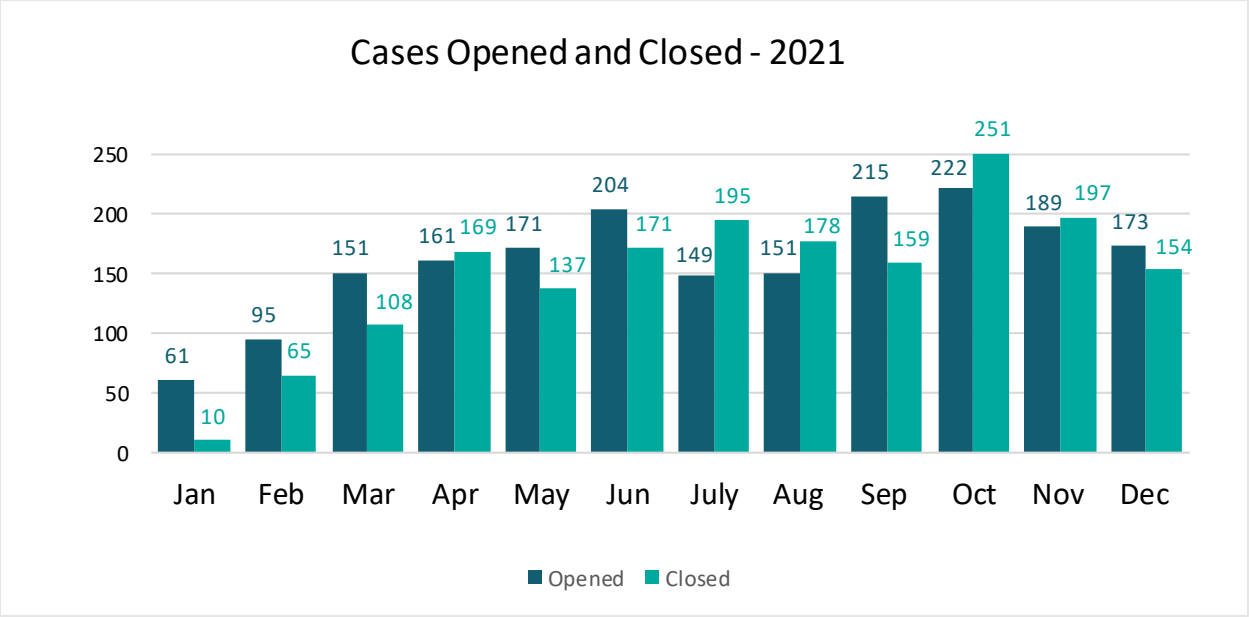
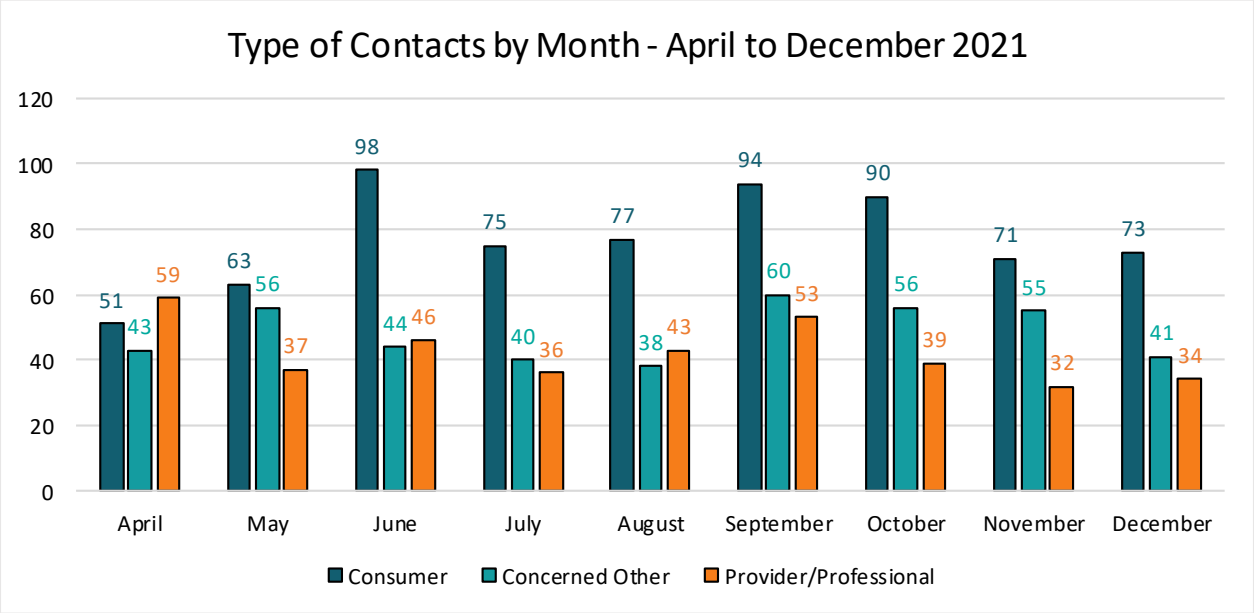


Figure 3 above counts the number of cases opened and closed by month in 2021. The figure below represents the number of inbound contacts received by consumers, concerned others, and third-party professionals since May 2021.[7] The number of contacts by professionals has remained relatively consistent throughout 2021, making up about 25% of calls by December. Consumers represented about 50% of total contacts, followed by concerned others (23%).

Figure 4. Type of Contact by Month, April to December 2021

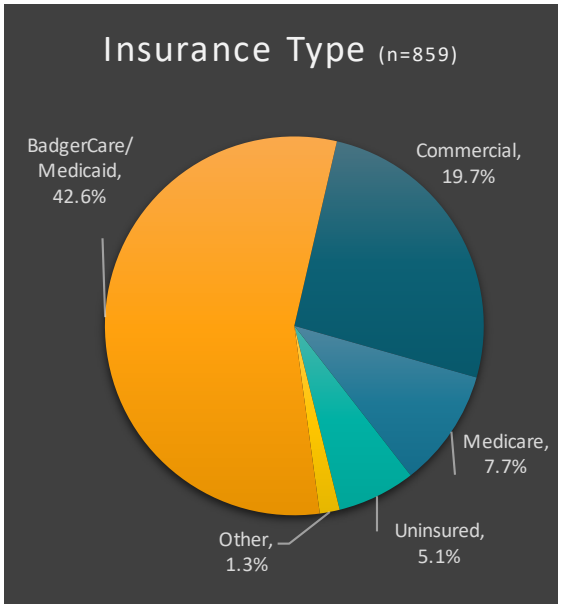


[7] Prior to April, accounts were only labeled as "Person" accounts. Staff did not distinguish contact type. Beginning in mid-April, the three contact person types were added (consumer, concerned other, third-party professional).

Case Descriptions

While the contact volume data are easily retrievable from the BHRC database, other measures of who the BHRC is serving are currently less reliable. Although the database is capable of storing the results of assessment in addition to numerous demographic fields, the following content reflects the consumer's level of comfort with disclosure. In the spirit of ***honoring and respecting the customer's voice and choice as they seek services***, the BHRC allows the person to share as much or as little identifying information as they want. This means that if the person chooses, they can receive support from the BHRC while remaining relatively anonymous. Importantly, the BHRC acknowledges the balance between collecting data accurately and consistently. While collecting data is important, the BHRC does not pressure a consumer into sharing information that could otherwise jeopardize their trust in the BHRC to be a safe place to seek help. In honoring this core value, only basic demographic information can be shared at this time.[8]

Figure 5. Insurance Plan Type



Nearly half of individuals stated their insurance was Medicaid, followed by commercial (19.7%), Medicare (7.7%), and other insurance (1.3%). Notably, 5.1% of those who contacted the BHRC were uninsured. Women made up about 60% of contacts to the BHRC and about 23% of consumers and concerned others identified as non-white. Provider preference is a combination of identified preference for gender, race, and ethnicity of provider. 197 individuals specified a gender preference, 8 specified a race preference, and 19 specified an ethnicity preference. Roughly 13% of consumers disclosed they were either homeless or did not have secure housing.

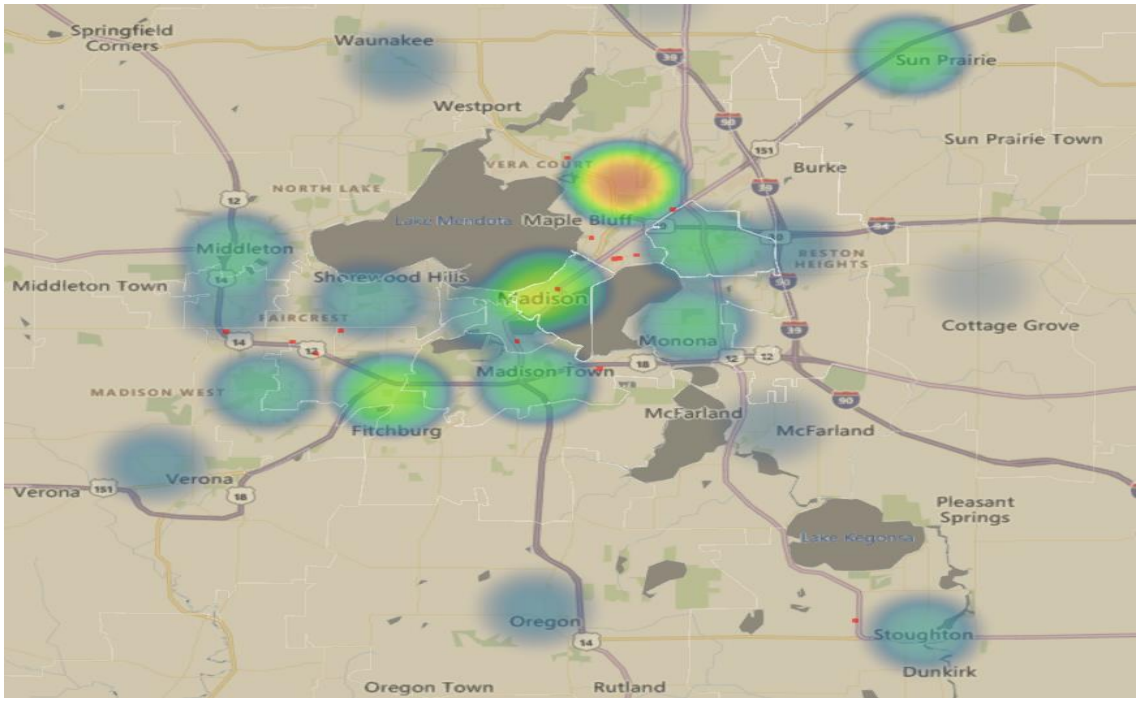
Table 4. Demographic Information for Consumers and Concerned Others.

Demographics – 2021 Cases						
Gender (n=1,023)		**Race[9] (n=157)**		**Provider Preference (n=2,184)**	**Housing Insecure (n=1,941)**	**Uninsured (n=1,092)**
Male	Female	White	Non-White			
41.1%	58.4%	77%	23%	10.3%	13%	5.1%

[8] N sizes for demographic information are inconsistent and significantly smaller than the number of cases BHRC has opened. The data below may not be representative of the overall population served by the BHRC in 2021 and should be interpreted with caution.

[9] See Appendix A for a more detailed description of Race and Ethnicity data.

The heat map below displays the call volume across Dane County. The largest call volume comes from Madison's north side followed by the downtown Madison area. The heat map shows that the BHRC reaches beyond the bounds of just Madison, with consumers contacting from surrounding cities like Fitchburg, Sun Prairie, and Middleton, in addition to smaller towns like Waunakee, Cottage Grove, and Oregon. The BHRC has also received **58 contacts from other counties in Wisconsin and 12 contacts from outside the state of Wisconsin.**



Barriers to Access

Dane County residents report feeling overwhelmed by the barriers they face when trying to access behavioral health care in our community. Consumers may have to jump through hoops and act as a "middle man" between their insurance company and their health care providers. Consumers are also caught in paradox, where there appears to be an overwhelming amount of options to choose from regarding type of care, provider, and location, and yet there is little or no availability or accessibility for those with complex needs or with specific insurance plans. In addition to these logistical barriers, consumers continue to face mounting insurance premiums and out-of-pocket expenses for their health care. When talking with BHRC staff about their access to care, consumers report the following additional barriers to accessing behavioral health services:

Table 5. Barriers to Accessing Care

Barriers to Accessing Care – 2021 Cases (n=1,941)							
Insurance	Waitlist	Transportation, Location, and/or Scheduling	Cost	Housing Insecurity	High Acuity[10]	Other	Language
29.8%	20.2%	14.1%	11%	7.2%	7.0%	9.9%	0.8%

[10] Acuity Level means the amount of the medically related support needs of an individual. High acuity means the consumers has several needs that will need to be addressed either simultaneously or in a specific order to best meet the consumer's goals.

The BHRC works with individuals and families to address these barriers. The BHRC is expanding access, choice, and community connection to behavioral health care and services. Guided by their founding principles and values, BHRC staff aim to provide warm hand-offs that connect people and families to the right care and services to help with mental health, substance use, and related needs. The BHRC helps people navigate the complex network of insurance, agencies, service providers, and waitlists in order to remove barriers and increase access to behavioral health care and services.

"For the 3 previous times I contacted Dane County my daughter's situation fell through the cracks completely at a time when she really needed help. But this time, number 4, based on my interaction with BHRC, I am hopeful that my daughter will be able to receive the help she desperately needs." – Concerned Other

BHRC Website and Google Analytics

10,904 website unique visitors

25% viewing on a mobile device

80 seconds average spent on website

"Resources" Most Viewed Page

The BHRC website serves as an important, ongoing tool for increasing awareness and understanding of the BHRC, as well as providing self-serve resource and referral information. The goal is to continuously refine the website to make sure it meets consumers' needs. This can be done by tracking metrics and gathering customer feedback.

We know websites are important to the "customer journey," which can be thought about as *what actions someone took in order to get in contact with the BHRC.* Monitoring web metrics helps track strengths, weakness, and improvement opportunities across the BHRC's web presence. Insights from these metrics are one contributor to identifying needed change. To create more robust and reliable web tracking, Google Analytics was activated on July 7, 2021. Google Analytics provides website owners with statistics and basic analytical tools to improve search engine optimization and marketing development. The below data represent metrics collected by Google Analytics on the BHRC website (and all of its pages) since July 2021[11]:

In addition to switching to Google Analytics, the BHRC has continued to update the website to increase usability for community members. Some of the most significant changes include:

- Creating a children's mental health resources page
- Adding resources and tools to find a provider
- Adding contact information for local HMO Behavioral Health services
- Adding information and resources for obtaining insurance if the consumer is currently uninsured
- Adding self-guided wellness resources

[11] Google Analytics cannot detect who is visiting the website. Therefore, any time a BHRC staff member visits the website, it is included in the overall total number of website visits.

After Hours Support

In December 2021, the BHRC began contracting with Protocall, a national after-hours behavioral health program, to expand BHRC services beyond standard business hours. The after-hours phone line is not a crisis service; rather, Protocall staff provide brief support to callers until the BHRC staff can follow up during business hours. Providing this after-hours service allows the BHRC to seamlessly serve Dane County residents and provide follow-up communication to callers who reach out at times when the main BHRC office is closed.

Warm Hand-Offs

There was no existing example to copy when envisioning how consumers would navigate from the BHRC to recommended providers and services. The BHRC and its stakeholders engaged in educated collaboration and innovation to identify the most efficient ways to connect consumers to providers and other professionals. One way this unfolds is through warm hand-offs. A warm hand-off is an approach the BHRC uses where staff offer a warm connection between the consumer and the receiving agency. BHRC staff may provide a brief introduction or summary of the consumer's needs before the receiving clinic completes their intake process. Many times, this occurs when the BHRC staff and the consumer call the provider together through a three-way call.

"I have had a great experience with BHRC staff every time that I have reached out. They are very responsive to the barriers, what kind of resource you are looking for, etc. It was really reassuring to have someone to call to get assistance when I do not have the answer as a professional. The families we supported this way also shared very positive feedback." – Third-Party Professional

Warm hand-offs benefit the consumer and the receiving agency in the following ways:

1) Providing a clear, shared understanding of the needs of the consumer
2) Modeling to the consumer what a clear, concise description of their needs can look like
3) Advocating that the consumer voice and choice is understood, honored, and prioritized in the process

"BHRC staff are doing an excellent job of getting back to providers and patients. They are also helpful for connecting patients with therapy services in the community which can be time intensive." – Third-Party Professional

"I am so glad to have this resource available when helping to connect students and families I work with to providers in the area. BHRC makes it so fast and easy to find resources to refer parents to. Creating a case is so simple and the follow-up I have received (same day email responses as well as phone calls) is really incredible. I have used this resource with several families already and have directed coworkers towards it, too." – Provider

Behavioral Health Observations

Mental Health - Presenting Concerns

In 2021, the most common presenting concern to the BHRC was general mental health.[12] Approximately 65% of cases were identified as having a mental health concern component.[13] Just over 50% of cases identified mental health as the primary concern. Other common presenting concerns included:

Table 6. Self-Reported Presenting Concerns

Presenting Concerns – 2021 Cases							
Mental Health	**Substance Use**	**Dual Diagnosis**	**Problems with Coping**	**Marital or Family Problems**	**Social-Interpersonal Problems**	**Medical**	**Other Concerns**
65%	27.3%	4.1%	4.2%	5.6%	2.6%	1.1%	7.2%

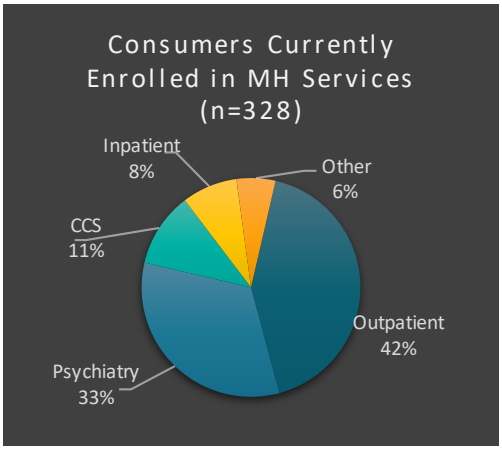


Figure 6. Consumers Currently Enrolled in Mental Health Services

The majority of consumers who contacted the BHRC were not currently receiving any mental health services.[14] Of those who disclosed they were currently receiving at least one mental health-related service (n=328), 36% were in outpatient therapy (including intensive outpatient) and 28% were receiving psychiatry services. Other services identified by consumers included inpatient hospitalization or residential treatment, targeted case management (TCM), Peer Support, or other services.

About 12% of contacts reported prior mental health diagnosis, the most common being depressive and anxiety disorders. Of 359 cases where BHRC staff identified whether or not the consumer had access to necessary medication, 34.2% of consumers did not have access to needed medication. This means that about one-third of consumers who contacted the BHRC are struggling to obtain medication necessary for their mental health. Of those who did not have access to needed

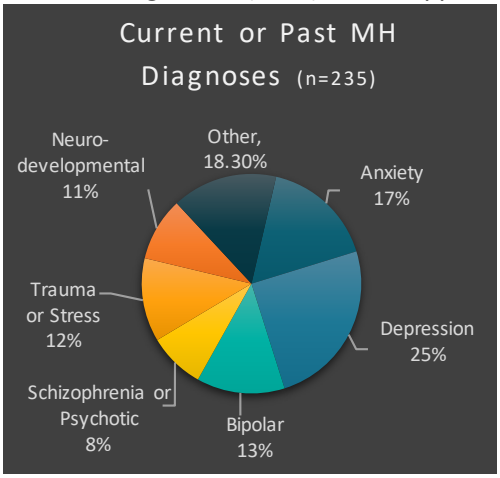


Figure 7. Current or Past Mental Health Diagnoses

[12] 20% of total cases did not identify any presenting concern. This could be reflected by "Information Only" cases, where the full assessment tool was not utilized. Therefore, the numbers below reflect a denominator of 1,741 cases, representing all cases that had at least one presenting concern identified.

[13] To be included in these totals, a case must have documented mental health as at least one of the presenting concerns. Cases were included that listed more than one presenting concern as long as one of the concerns was mental health-related.

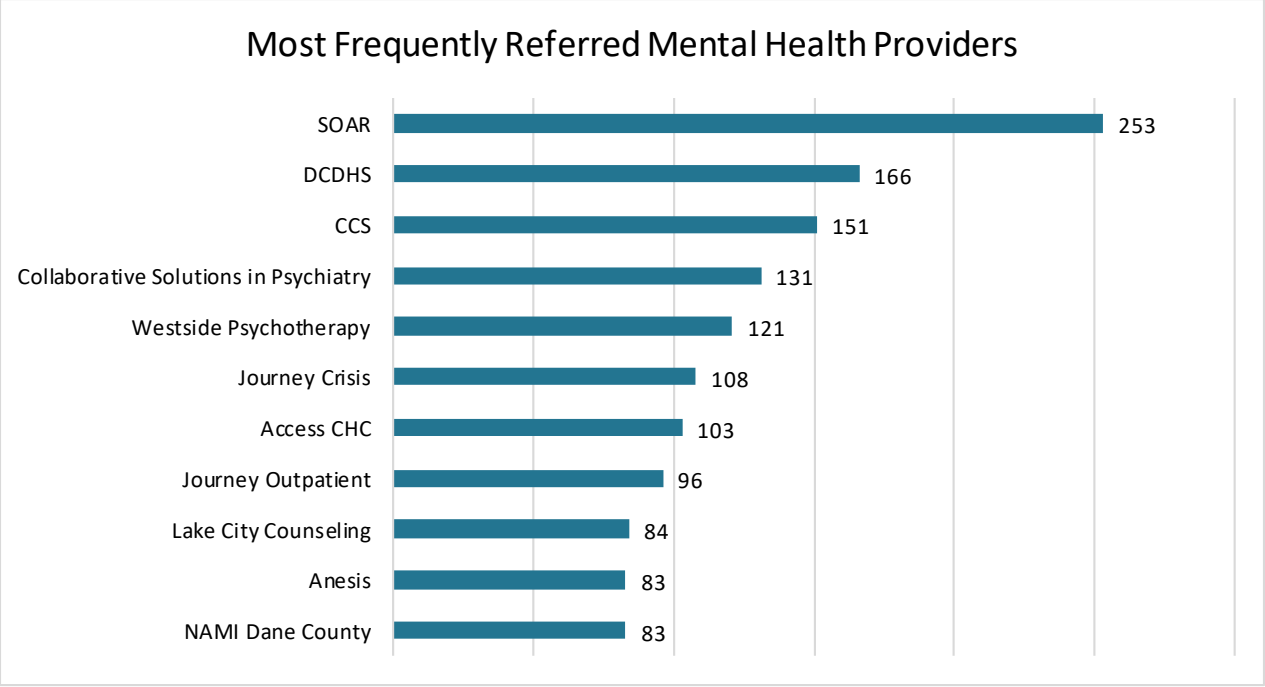
[14] 1,453 cases did not have any indicators showing whether or not the consumer is currently receiving services.

medication and who identified at least one barrier to accessing care (n=123), nearly 70% identified cost and/or insurance coverage as a barrier to care.

Mental Health Referrals

As part of the BHRC's goal to improve care coordination and access for consumers, staff regularly make referrals to medical offices, agencies, organizations, non-profits, and county offices across Dane County. Over the last year, the BHRC has referred residents to nearly 400 different entities.[15] Referrals do not necessarily indicate that the consumer successfully connected with the service. It simply means that the BHRC initiated a referral. Waitlists and provider availability impact the success of those referrals. Below are the most common referrals made for consumers who contacted the BHRC for mental health services and support.

Figure 8. Most Frequently Referred Mental Health Treatment Providers in 2021



The BHRC's most frequent referral organization is to Journey Mental Health Center (JMHC) (n=393). JMHC is a very large organization that offers a broad range of services, including outpatient services, clinical assessments, crisis services, and more. JMHC also offers population-specific service such as Clinica Latino and Ujima. Therefore, Journey referrals are broken down by area, such as Crisis (n=108), Outpatient (n=96), Psychiatry (n=39), and other Journey programs (n=43).

[15] Dane County Department of Human Services (DCDHS) referrals can include a number of programs, including Targeted Case Management (TCM), Aging and Disability Resource Center (ADRC), substance use services, etc.

Substance Use Presenting Concerns

Of 1,942 total new cases in 2021, 27% were identified as having a substance use concern component.[16] Alcohol was the highest reported used substance, followed by heroin and other opioids, cocaine/crack, and marijuana.

5.4% of these consumers reported currently receiving any substance use-related services. Of those (n=104), 62.5% were in outpatient therapy (including IOP), 14.4% were in inpatient or residential treatment, 13.4% were utilizing medication-assisted treatment (MAT), and 13.4% were using various other treatment services, such as support groups or group treatment.

The vast majority (92%) of those who contacted the BHRC did not report a substance use service history. Of those who did (n=150), most identified utilizing detox (39.3%), followed by residential treatment (29.3%), intensive outpatient or day treatment (28%), standard outpatient therapy (22%), medicated-assisted treatment (14.7%), or other services (18%).

Figure 9. Reported Substance Use

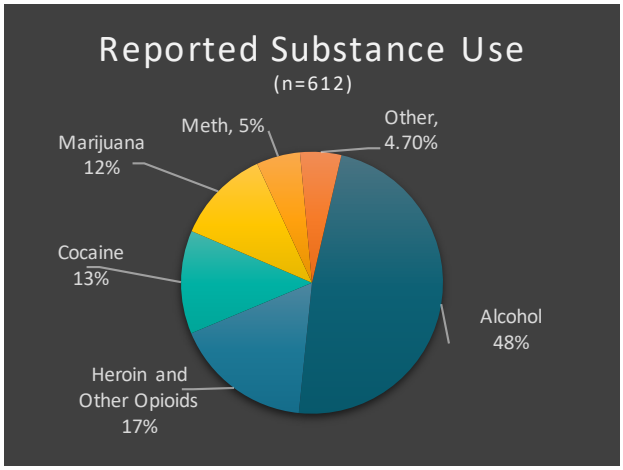
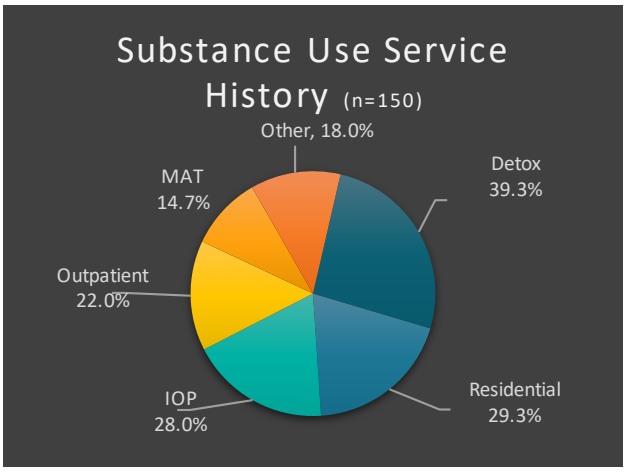


Figure 10. Substance Use Services History

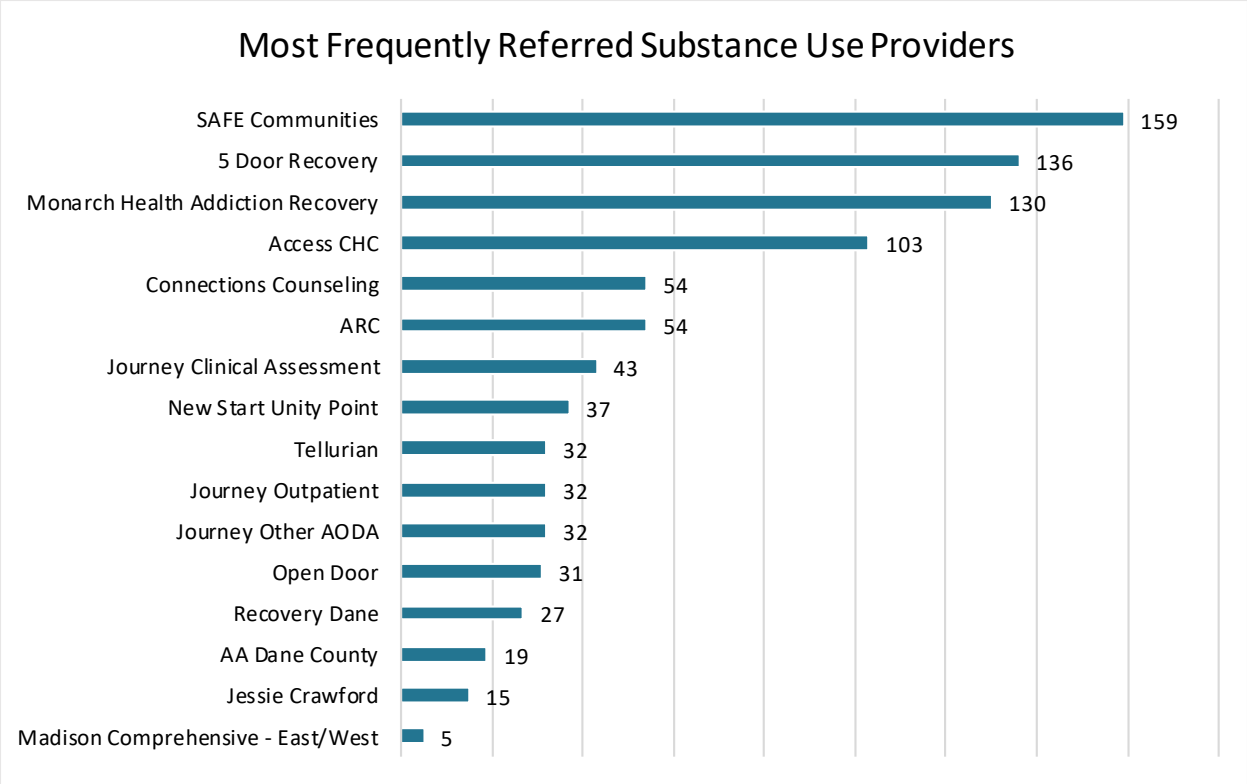


Substance Use Referrals

When experiencing a Substance Use Disorder (SUD), there is a common assumption that the only way to pursue recovery is by receiving treatment at a residential facility. People calling the BHRC about SUD issues are ready to get clean now – "*if I don't do it now I never will*." And they strongly want residential care – "*if all other distractions are taken away then I can focus on my addiction and beat it.*" The BHRC is helping people understand the full spectrum of their options. It can take weeks for a spot to open up in residential treatment, losing the momentum of now. The BHRC educates people on outpatient treatment options such as groups, medication-assisted treatment, and wraparound approaches that mimic residential treatment without staying in a facility. Presenting these options empowers the consumer to consider what the best fit is for them and allows them to make the choice that they feel is best. The figure below shows the number of referrals made to service providers in Dane County that specialize in substance use and addiction treatment.

[16] To be included in these totals, a case must have documented substance use as at least one of the presenting concerns. Cases were included that listed more than one presenting concern as long as one of the concerns was substance use-related.

Figure 11. Most Frequently Referred Substance Use Treatment Providers in 2021



Peer Support and Recovery Coaching

Peer Support and Recovery Coaching have become a growing resource for those seeking substance use support services. A peer specialist is a person who uses their personal experiences to provide support, encouragement, socialization, hope, and practice skill building to a person seeking support and recovery assistance.[17] Peer support is a mutual relationship with no hierarchy and is built on the values of respect, safety, non-judgement, and hope.[18] A peer support specialist can provide a range of support, including talking through treatment options, providing emotional and physical support in one's journey to recovery, giving practical skills and advice that have helped them succeed, or be a listening ear when in need.

The BHRC staff have made over 500 referrals for Peer Support and Recovery Coaching Services in 2021. Some of the most common referrals made are to SOAR for 1:1 peer support, peer led groups, and their "warm-line," NAMI for peer-led groups, Safe Communities for 1:1 recovery coaching, and Alcoholics Anonymous (AA) for recovering coaching and general support.

Over 500 Peer Support and Recovery Coaching referrals in 2021

[17] SOAR Recovery Dane, https://soarcms.org/programs/recovery-dane.
[18] Ibid.

Satisfaction Survey Summary

As the BHRC approached one calendar year in operation, a consumer satisfaction survey was administered to better understand who is seeking resources, how helpful the BHRC was in connecting consumers to resources, and whether or not clients were pursuing services as a direct result of their connection with the BHRC. Key findings from the survey are discussed below. For a full discussion of the Satisfaction Survey results, please see our Satisfaction Survey Report.

"[The BHRC] made me feel heard and like I was a priority, not just another name on a list" - Consumer

33% Consumers

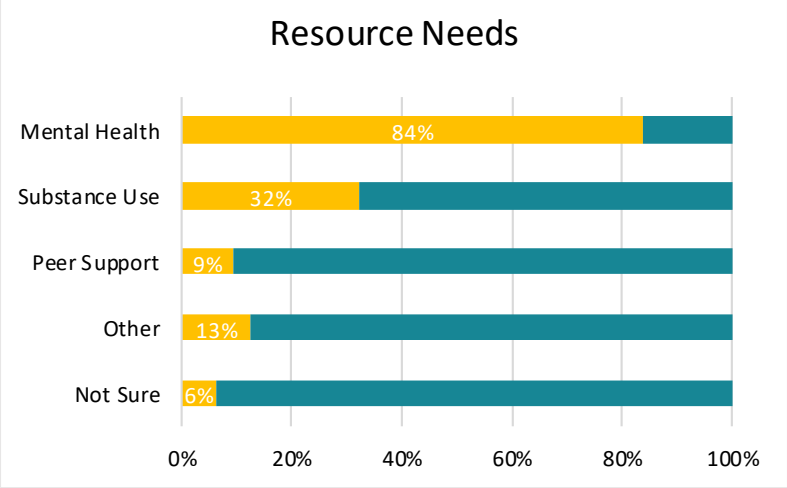
36% Concerned Others

31% Professionals

Resource Needs

The majority of respondents reached out about mental health resources and referral needs. Nearly one-third were seeking substance abuse services (n=42) and 9.2% sought peer support. Another nearly 20% of respondents were either seeking other services and support or were not sure what resources they were seeking when they contacted the BHRC.

Figure 12. Percent of Respondents' Identified Resource Needs



Helpfulness

Consumers and Concerned Others were asked: 1) How helpful was the BHRC staff in connecting you with resources or information? and 2) How helpful were the resources or information provided to you by the BHRC? Nearly three-quarters of consumers and concerned others thought the BHRC staff were very or extremely helpful in connecting them with resources and information (73%, n=66).

73% of respondents believed the BHRC staff were very or extremely helpful

Service Utilization

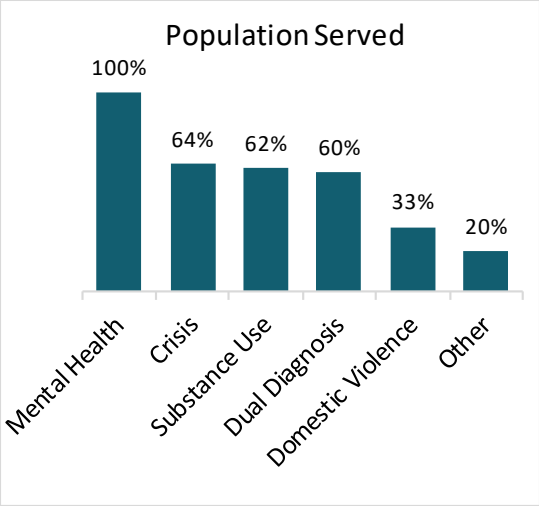
Nearly two-thirds of consumers and concerned others reported either receiving behavioral health services or were waiting for their first appointment to receive services after contacting the BHRC (64.4%, n=58).

Third-Party Professionals

When the BHRC opened its doors in November of 2020, staff expected to be fielding contacts from community members seeking assistance identifying and accessing behavioral health resources in Dane County. While consumers and concerned others continue to make up the majority of the BHRC's contacts, providers and third-party professionals have also been utilizing the BHRC for resources and information for their clients.

Third-party professionals identified the population(s) they serve. All professionals identified working with individuals with mental health problems. Over half reported working in crisis, substance use, and dual diagnosis. About 50% of professionals reported working with adults, followed by adolescents/teens (38%) and older adults (35%). Nearly three-quarters of surveyed professionals worked either in schools (35%, n=14) or in a community agency (35%, n=14)

Figure 13. Age Groups of Population Served by Provider Respondents



Overall Satisfaction

Of all survey responses across consumers, concerned others, and third party professionals, 83% (n=108) reported being 'Satisfied' or 'Very Satisfied' with their experience working with the BHRC. When asked if the respondent would reach out to the BHRC again in the future, 77% (n=100) said they are 'Very Likely' or 'Extremely Likely' to reach out again. The majority of respondents were also very or extremely likely to recommend or refer someone they know to the BHRC (77%; n=100).

"I had no idea where to turn to for help. My probation officer gave me one of your fliers. I called and talked to the most kind and considerate, professional person I can imagine. She gave me information on the resources I needed. I was accepted for treatment and have now completed my program." - Consumer

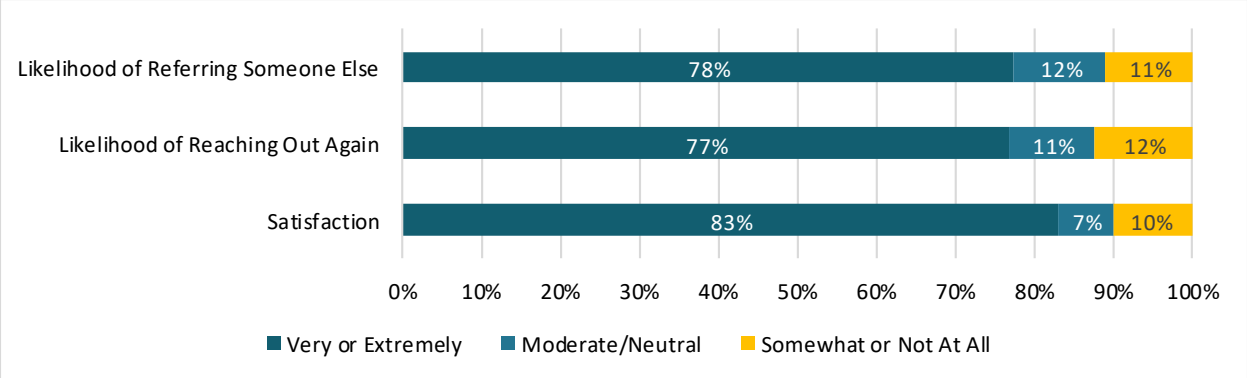


Figure 14. Percentage of Respondents Reporting "Very" or "Extremely" for Overall Satisfaction Scales.

Systemic Barriers to Behavioral Health Services

Complexities of Care	The BHRC continues to help consumers navigate through the complexities of behavioral health care and care coordination. Consumers must navigate insurance claims and billing, costs, waitlists, appointments and scheduling, and "middle man" communication between the insurance company and their provider. In the midst of all of this, consumers are expected to be fully engaged in the treatment process. The administrative burden, coupled with an "assembly line" approach to receiving care, creates overwhelming barriers for consumers trying to access behavioral health care. A rising concern for consumers is the divergence in insurance coverage between standard health care and behavioral health care. Ideally, insurance companies are enforcing mental health parity,[19] meaning that insurance benefits for behavioral health care are equal to coverage for other types of health care. For example, an insurance plan covers doctor visits for a chronic condition like diabetes at the same rate and allowance as for a chronic mental health condition such as depression or schizophrenia. While some health plans do enforce coverage parity, others do not.[20] Consequently, consumers trying to access behavioral health care face confusion about what services are covered by their health plan and are fearful of surprise bills after receiving care. The BHRC continues to be a bridge between consumers and providers to address these barriers. For example, the BHRC uses an assessment tool to determine a consumer's presenting concerns and needs as well as their insurance status and prior treatment history. With this information, the BHRC helps consumers identify types of treatment and services that may work for them and helps them find a provider that is covered by their insurance. By taking this first step with the consumer, the BHRC removes one barrier on the path to receiving care.

Under-served and vulnerable populations	**The older adult (age 60+) population** continues to rise in Dane County. Residents over the age of 60 will have risen from 74,000 in 2010 to 137,000 by 2030, a nearly two-fold increase.[21] While there are agencies that specifically serve the older adult population (e.g. Dane County's Aging and Disability Resource Center), many older adults struggle to access care through their Medicare coverage or private insurance. In 2021, the BHRC worked with 195 Dane County residents over age 60. Older consumers identified cost (12.8%) and transportation/location

[19] National Alliance on Mental Health, "What is Mental Health Parity?" n.d. https://www.nami.org/NAMI/media/NAMI-Media/Infographics/MHParity10-23-15.pdf.

[20] Per NAMI (citation above), health plans that are not required to follow federal parity laws include Medicaid Fee for Service plans, some Medicare plans, individual and group health plans purchased before March of 2010, employer-sponsored plans that received an exemption based on increase of costs related to parity, and some government employee health plans.

[21] David Egan-Robertson, "Wisconsin's Future Population: Projections for the State, Its Counties and Municipalities, 2010 – 2040." December 2013, https://doa.wi.gov/DIR/FinalProjs2040_Publication.pdf.

(10.7%) as major barriers to accessing care. There is a unique vulnerability for older adults who are not yet 65 years old. These older adults are not utilizing Medicare and may not have adequate insurance coverage that supports their needs. For example, they want help but may not see their condition as "bad enough" to request help. Others are looking for more supportive services such as case management, but their private insurance does not cover these more intensive services. Of 195 adults over age 60 that reached out to the BHRC, only 5 (2.5%) reported not having insurance. Of those who did have insurance (n=190), about 25% reached out regarding general mental health services, 22% for substance use services, and 14.2% for psychiatry services. Older adults using BadgerCare coverage also face significant challenges in Dane County. For example, BadgerCare SSI recently began offering a new HMO provider to Dane County residents. A resident reached out to the BHRC looking for assistance because this new BadgerCare SSI insurance plan was not an accepted plan at any physical health or behavioral health clinics within a 100 mile radius of Dane County. Additionally, older adults are also more likely to live in isolation, whether that be because of distance away from family, physical limitations on their ability to travel, or from COVID-19. Coupled with insurance limitations, older adults face unique obstacles to accessing services.

Children's mental health needs have grown substantially in the past decade. In the US, 17% of youth experience a mental health disorder.[22] According to the 2021 Dane County Youth Assessment, 21.5% of high school youth experience depression and 32.2% have anxiety.[23] LGBTQ+ youth are disproportionately impacted, with reported rates of depression (58.2%) and anxiety (77.5%) at least double compared to their heterosexual, cis-gender peers.[24] BIPOC female youth are also disproportionately more likely to self-report depression (33.7%) and anxiety (43.3%) compared to their white peers.[25] The COVID-19 pandemic has only exacerbated these concerns. The CDC reports a rise in suicide attempts among children and youth under age 18.[26] A study examining pediatric insurance claims filed in 2020 found a sharp increase in mental health-related problems, especially for anxiety, major depressive disorders, and intentional self-harm.[27] Concerned parents are calling on behalf of children as young as 3 years old. Many express concern about their children's mental health and their ability to cope with the impacts of COVID-19, the influence of social media, and the pressures their children face from peers. To compound this further, children's mental health/trauma treatment services are experiencing a significant bottleneck. Some providers have a waitlist while waitlists for other specialized care for children are full and closed. There are not enough service providers offering specialized trauma treatment services to children. Expanding capacity among current providers and identifying additional providers is vital to getting services in a timely manner. In 2021, the BHRC fielded 255 contacts from concerned others and professionals seeking resources and referrals for a child under the age of 17.[28]

[22] National Alliance on Mental Health "Mental Health by the Numbers" 2021, https://www.nami.org/mhstats.
[23] Dane County Youth Commission, "Dane County Youth Assessment 2021," July 21, 2021, https://www.dcdhs.com/About-Us/Commissions-Boards-and-Committees/Youth-Commission/Youth-Assessment.
[24] Ibid.
[25] Ibid.
[26] Yard et al., Centers for Disease Control and Prevention (CDC), "Emergency Department Visits for Suspected Suicide Attempts among Persons Aged 12–25 Years Before and During the COVID-19 Pandemic — United States, January 2019–May 2021," June 18, 2021, https://www.cdc.gov/mmwr/volumes/70/wr/mm7024e1.htm.
[27] FAIR Health, "The Impact of COVID-19 on Pediatric Mental Health: A Study on Private Healthcare Claims," March 2,2021, https://s3.amazonaws.com/media2.fairhealth.org/whitepaper/asset/The%20Impact%20of%20COVID-19%20on%20Pediatric%20Mental%20Health%20-%20A%20Study%20of%20Private%20Healthcare%20Claims%20-%20A%20FAIR%20Health%20White%20Paper.pdf.
[28] This number is very conservative. In many cases the age of the child was not specified in the case description. Therefore, this number represents only cases where the child could be confirmed as under age 17.

Those who identify as BIPOC and LGBTQ+ also face unique barriers to culturally competent service. Those who identify as LGBTQ+ are more than twice as likely to experience a mental health condition. Dane County residents who identify as two or more races are most likely to report a mental illness in the past year (25%), followed by American Indian/Alaskan Native (22.7%), White (19%), and Black (16.8%) residents. 77% of therapists in Dane County are white and 70% identify as female.[29] Working with a provider who understands a consumer's life experience and cultural context around trauma and oppression are key to feeling safe, respected, and cared for during treatment. While cultural competency and cultural humility are important for providing adequate care to underrepresented groups, cultural competency training cannot replace racial, gender and sexual orientation, language, and ability status representation in the clinician population. Tara Wilhelmi from EOTO Culturally Rooted, a community recovery organization in Dane County, summarizes this point by saying, "[clinicians] might know the modality, but [they] don't know the people."[30] Providers who do not share identity characteristics with those they work with, especially those who have experienced systemic oppression and marginalization, cannot truly understand the experiences of these communities. Expanding the diversity of practitioners and Peer Support Specialists will better serve these groups.

Rural populations also face unique challenges accessing behavioral health services. For those seeking behavioral health care in rural communities, residents must either see a primary care physician for general behavioral health care or travel to connect to a specialty provider. This requires rural residents to have access to reliable transportation and a flexible work schedule, both of which are not always possible. Behavioral health care providers are also less likely to work in rural areas due to billing restrictions for certain provider types under Medicaid, Medicare, and some private insurance.[31] 90% of physicians who are approved to prescribe buprenorphine – a medication used to treat opioid addiction – are located in urban areas.[32] Over 50% of rural counties do not have a physician who can prescribe buprenorphine at all.[33] Additionally, people living in rural areas where treatment centers are small face an added barrier of stigma and lack of anonymity when seeking services. A provider may be a family friend. The receptionist may be a neighbor. Another consumer in the waiting room may be a local teacher or business owner. This challenge can create a strong social stigma that prevents someone from seeking help when they need it most.

Waitlists and Service Accessibility

In Dane County and across the country, waitlists for behavioral health care continue to grow without reprieve. COVID-19 has only exacerbated health care staff shortages and increased consumers' need for care. The national average wait time for behavioral health services is 48 days.[34] In Dane County, BHRC staff and consumers report variability in provider waitlists

[29] NAMI Dane County, "What BIPOC Communities Need from Mental Health Care," August 19, 2021, https://www.namidanecounty.org/blog/2021/8/18/tu410bo1wjssh1mljbdmupnsd3ic0w.

[30] Ibid.

[31] Reimbursement rates for mental health services, especially under Medicaid and private insurance, are often low. This makes it difficult to recruit and retain providers in rural areas. Source: Rural Health Information Hub, n.d., https://www.ruralhealthinfo.org/toolkits/mental-health/1/barriers and Muskie School of Public Service, Main Rural Health Research Center, "Encouraging Rural Health Clinics to Provide Mental Health Services: What are the Options?" May 2010, http://muskie.usm.maine.edu/Publications/rural/pb/mental-health-services-Rural-Health-Clinics.pdf

[32] Hancock et al., 2017. National Rural Health Association. "Treating the Rural Opioid Epidemic" February 2017. https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/Treating-the-Rural-Opioid-Epidemic_Feb-2017_NRHA-Policy-Paper.pdf.

[33] Ibid.

[34] Current wait times for Dane County were not available at the time this report was written.

depending on service-type. Current wait times have a very real impact on consumer behavior and their willingness to pursue services. Providers lose 1% of individuals for every one day of wait time.[35] That means that if there is 21-day wait for services, 21% of the consumers seeking care will give up on pursuing services further. In 2021, 392 consumers (20.2% of all cases in 2021) reported waitlists as a barriers to accessing care.

Substance use treatment and support services have become especially difficult to access. Many SUD providers have waitlists that are weeks or even months long. Waitlists are even longer for those seeking residential services, and yet that is the single most frequently requested service for consumers with substance use concerns. While telehealth has broken down some barriers to access, such as transportation or geographical limitations, it has not increased the number of providers or appointments available for new consumers. Additionally, some who struggle with substance use also have co-existing mental health concerns. When a person is diagnosed with both a substance use disorder and a mental health disorder, it is known as "dual diagnosis." Studies have shown individuals diagnosed with both a substance use and mental health disorder are less likely to receive treatment than those with *only* a substance use *or* mental health disorder.[36] Treatment accessibility is also compounded by a lack of programs that can provide adequate treatment for dual diagnosis. In 2018, only 18% of substance use programs and 9% of mental health programs were equipped to adequately treat co-occurring disorders.[37]

The solutions to waitlists are complex and difficult to change. The current health care worker shortage is a significant driver of growing waitlists, but many other factors, including the effects of COVID-19, are impacting everyone's ability to access care and provide care. One solution to address waitlists is using applications of Queuing theory, which is used to maximize queue length in other large-scale business operations, such as air traffic control and manufacturing.[38] Queuing theory prioritizes looking at waitlists not from a capacity or resource problem, but from the "lens of flow." For example, if there is a wait to get into an arena for a concert, there will still be seats available for all once everyone with a ticket is admitted. However, the line to get into the building makes it appear as though the concert may be oversold. In reality, there is just a bottle neck at the entry to the show. Queuing theory would suggest that the venue temporarily increase admittance locations, staff, and resources to address the bottleneck; then, once the bottleneck is resolved, concert goers can walk right into the admit area with no wait. This could be reflected directly into behavioral health care services. A temporary increase in resources and funding has the potential to clear the backlog of consumers waiting for service and make real-time, same-week or even same-day service a reality.

"Help people get faster appointments. My son had expressed suicidal ideation, and in spite of having excellent insurance/resources, it still took 6 weeks to get him in to a counselor."

[35] Cindy Dampier, Chicago Tribune, "Mental Health Care Appointments Often Come With a Long Wait. Three Ways to Cope While Help is Delayed." October 25, 2018. https://www.chicagotribune.com/lifestyles/sc-fam-mental-health-wait-times-1030-story.html.

[36] Preister et al., Journal of Substance Abuse Treatment, "Treatment Access Barriers and Disparities Among Individuals with Co-occurring Mental Health and Substance Use Disorders: An Integrative Literature Review" October 31, 2015, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4695242/.

[37] National Institute on Drug Abuse, "Common Comorbidities with Substance Use Disorders Research Report" See Part 4: Barriers to Comprehensive Treatment for Individuals with Co-Occurring Disorders. April 2020. https://www.drugabuse.gov/download/1155/common-comorbidities-substance-use-disorders-research-report.pdf?v=5d6a5983e0e9353d46d01767fb20354b.

[38] Canadian Centre for Policy Alternatives. "Public Solutions to Health Care Wait Lists." December 2005, https://www.heu.org/sites/default/files/2021-06/Public%20Solutions_Health_Care_Waitlists_1.pdf.

Costs of Health Care	Financial barriers represent another systemic barrier to accessing care. United States health care spending increased 4.6% in 2019, topping $3.8 trillion.[39] Spending on hospital care, physician and clinician services, and retail cost for prescription drugs have continued to rise while insurance coverage has improved only marginally and employer-sponsored private health insurance premiums have risen.[40] American households' health care spending grew 4.5% in 2019, with the largest share of increase through out-of-pocket expenses. The BHRC works with consumers every day who struggle to afford health care. Some consumers have no insurance at all, while others have limited plans with high deductibles and inadequate coverage for their needs.[41] In 2021, 55 consumers who were uninsured reached out to the BHRC for assistance. Options for care are limited for individuals without health insurance. Primary care is extremely difficult to access for the uninsured, with limited days and hours or a lottery system for appointments. Providers of behavioral health treatment and psychiatric services stand out as being especially limited for the uninsured, who are disproportionately non-white.[42] Financial assistance is extremely difficult to obtain for those who are uninsured, but options become even fewer and farther between for those who are underinsured.[43] Specialized treatments and mandated treatments may not be available based on a person's insurance plan, putting consumers in the difficult position of paying out-of-pocket for treatments or, even worse, choosing not to pursue treatment at all because of cost. Of 507 consumers who reported having insurance but were still struggling with other barriers to care, 26.4% (n=134) identified cost and insurance coverage as a barrier to access. The BHRC has partnered with a local psychotherapy provider who offers pro-bono services to those who reach out through the BHRC. While this is helping a few of those who would otherwise not be able to receive treatment, it is only one small component of trying to remedy a system-wide barrier to care. Insurance companies and service providers must work together to achieve mental health parity in insurance coverage and cost, while also building out options for those who are uninsured and in need of care.

[39] Centers for Medicare and Medicaid Services (CMS), "National Health Expenditures 2019 Highlights," n.d. https://www.cms.gov/files/document/highlights.pdf.

[40] Household contributions to employer-sponsored private health insurance premiums rose 6.3% in 2019 per CMS National Health Expenditures (See Footnote 39).

[41] 4.9% of Dane County residents under age 65 are uninsured. This rate is roughly half of the national rate (10.8%).

[42] Dane County-specific data is not available, but national data indicates that racial minorities show consistently higher rates of being uninsured. American Indians have the highest uninsured rate (28%), followed by Hispanic or Latino (22%), Black (12%), Native Hawaiian, Other Pacific Islander, and Asian (9%), and White (7%). Source: Assistant Secretary for Planning and Evaluation (ASPE), Office of Health Policy. "Trends in the U.S. Uninsured Population, 2010-2020." February 11, 2021, https://aspe.hhs.gov/sites/default/files/private/pdf/265041/trends-in-the-us-uninsured.pdf.

[43] A consumer who is underinsured means that they have insurance, but the components of their insurance make their ability to afford treatment and services difficult. For example, a consumer may have a very high deductible insurance plan, where most (if not all) of their treatment is paid for before their deductible is met. This means that they are paying for their services without any assistance from their insurance. This financial barrier limits their ability to access care.

BHRC Future: Prioritizing Outreach and Consumer Voice

2022 Outreach Efforts

The BHRC plans to build on existing outreach efforts in 2022, primarily through three avenues: 1) creating a Dane Resource Network; 2) piloting a liaison partnership with providers and third-party professionals; and 3) adding UW School of Social Work interns to BHRC staff. Expanding outreach efforts, especially with providers and third-party professionals, will improve the BHRC's ability to complete warm hand-offs together with consumers and providers, as well as improve the consumers' overall experience with their care coordination.

Dane County Resource Network

Liaison Partnership Pilot

UW Student Internships

In 2022, the BHRC plans to mobilize community partners in a collaborative effort to create a Dane Resource Network (DRN). The resource network will address one of the largest criticisms of the Dane County behavioral health care system: fragmentation of the consumer's care coordination between multiple service providers. The goal of the DRN is to build a coalition where providers and third-party professionals can share information and resources about their services and specialties with other professionals. This will include current DCDHS-contracted providers as well as other local agencies and organizations. The DRN will become a funnel for other behavioral health professionals in Dane County to learn about other services and treatment options for their clients. Through the resource network, professionals and providers alike will better serve their clients as a more unified health care team, while fostering faster and more reliable care coordination across provider networks. This becomes especially important for consumers whose needs transcend one behavioral health category area, such as those seeking mental health services as well as substance use services, or those who are housing insecure and in need of long-term mental health treatment. By uniting professionals in the same space to share resources, Dane County consumers can receive care more efficiently and without as many barriers.

The BHRC will also be piloting a liaison partnership program, where staff can build an ongoing relationship with organizations and agencies who serve especially vulnerable populations and do not have access to behavioral health expertise in their organization. The BHRC liaison would serve as a resource for troubleshooting complex cases with multi-system involvement and would be a point of contact for general questions about county behavioral health services and processes. This project is in the development stage and will be piloted beginning in 2022.

The last major project for 2022 is adding interns to the BHRC team. The BHRC is excited to explore partnering with the UW-Madison School of Social Work to oversee field placements for Master's-level social work students. Interns will work directly with consumers and providers and assist with connecting them to resources and referrals in Dane County. Interns will learn about access and care coordination barriers consumers routinely face when seeking behavioral health services and will participate in hands-on, direct contact with consumers, concerned others, and professionals in Dane County. The BHRC is excited to participate in training the next generation of social workers to better understand the complexities of accessing and maintaining behavioral health care services in their communities.

Appendix A: Race and Ethnicity

There are three sources of race and ethnicity data used in this report. The first are the respondent results from the Satisfaction Survey. Respondents were asked to identify their racial identity through a "check box" system, where a respondent could check only one of several race groups, including: White or Caucasian, Black or African American, Asian, American Indian or Alaskan Native, Native Hawaiian or Other Pacific Islander, Multiracial, Other, or Prefer Not to Answer. Respondents were also asked whether or not their ethnicity was Hispanic or Latino.

The second source of race and ethnicity data used in this report is from the United States Census Bureau data explorer – source American Community Survey.[44] The American Community Survey categorizes race and ethnicity into the following groups – White alone, White alone Not Hispanic or Latino, Black or African American alone, American Indian and Alaska Native alone, Asian alone, Native Hawaiian and Other Pacific Islander alone, Some Other Race alone, Two or More Races, Hispanic or Latino.

The third source of race and ethnicity data used is from the BHRC IT platform. The IT platform houses all BHRC data. BHRC staff use the "check box" system. However, unlike the Satisfaction Survey, staff can check as many boxes as needed.

BHRC survey participants were assigned to one race/ethnic category using the following criteria:

- If ethnicity is Hispanic or Latino, then the participant is grouped into Hispanic or Latino regardless of their race
- If the participant has only one race and their ethnicity is Not Hispanic or Latino, then they were grouped into that one race
- If the participant did not answer or chose "Prefer Not to Answer," then they were not grouped into any racial or ethnic group.

For the survey results portion of the report, this results in a single race/ethnicity category per participant that is used in this report.

Because race information from the IT platform was so limited in quantity, the data were aggregated to either White or non-white. Non-white includes any identification with a race or ethnicity other than White.

Language Used

In order to conduct analyses, we must group people together in actionable ways and ways that form groups that are large enough to draw conclusions when possible. To do this, two things happen: (1) race and ethnicity identity options are often limited at the time of data collection and/or (2) more specific and detailed identities are merged into more general groups at time of analysis and reporting. For example, someone who identifies as more than one race or ethnicity may be reported as only one race/ethnicity or

[44] United States Census Bureau, "Explore Census Tables" https://data.census.gov/cedsci/. Retrieved December 28, 2021.

broadly as "multiracial." Additionally, a respondent who identified as multiracial cannot be grouped into just one other racial group, as their specific racial identities are not known.

Language in the text of the report are the DCDHS Planning & Evaluation Team's best approach at accurate, inclusive language. Labels in charts and graphs have been shortened due to space restrictions. Note that the terms used in the text of this report may not match the terms used in data collection. Additionally, the BHRC Satisfaction Survey was distributed before the Planning and Evaluation Team updated the language used in reports regarding race and ethnicity. As such, racial and ethnic categories provided in the survey do not match directly onto U.S. Census categories or the Planning and Evaluation Team's revised language guidelines. In the future, the BHRC will use the Planning and Evaluation team's updated language guidelines.

Table 7. Race and Ethnicity Crosswalk to Mentions in Text

Table and Chart Label	Text	Data Sources
White	White	White
Asian	Asian, Native Hawaiian, or Pacific Islander	Asian; Asian alone
Black	Black or African American	Black or African American; Black or African American alone
Hispanic	Hispanic or Latino	Hispanic or Latino
American Indian	Native American or Alaska Native	American Indian/Alaska Native
Non-White	Non-White	Any identification with a non-white racial or ethnic identity