

# Introduction to GRAT

**The Geriatric Regional Assessment Team**  
**[grat@soundgenerations.org](mailto:grat@soundgenerations.org)**

# Who Is GRAT?

- A team of 4 licensed behavioral health professionals (clinicians), an Intake Coordinator, and a clinical supervisor; periodically joined by an MSW student for their advanced field practicum.
- Part of Sound Generations, a multi-service nonprofit partnering with older adults to provide accessible and inclusive services so they can age their way.
- Operating 9am-5pm Mon-Friday, closed weekends and federal holidays, with no on-call or after-hours availability.

# What is GRAT?

From our funding contract with King County:

"A home-visiting team of behavioral health and human services intervention experts who will provide seniors 55 and older living in King County comprehensive behavioral health and cognitive assessment, evaluation, intervention and connections to services and resources. Their work will emphasize populations likely to struggle with access to traditional healthcare avenues."

# Focus on Early Intervention & Prevention

- "By providing outreach, assessment, and early intervention, this program will reduce the likelihood of seniors experiencing acute behavioral health crises and reduce the need for high-cost crisis services."
- "[S]upport VSHSL result area of healthy living by enabling seniors living in King County to have positive health outcomes in a more sustainable system and emphasizes prevention of crises."
- "[C]ontributing to impact the MIDD policy goal of 'divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals.'"

# Focus on Assessment

- To help clarify a person's situation – what needs are unmet, what barriers and risks will affect future well-being, what strengths and supports exist, what beliefs and experience making meaning of the situation, what factors are changeable – and provide tailored guidance for support services and resources.
- To provide a "roadmap" for care so that clients (and their support systems) can navigate current challenges and opportunities to improve their quality of life.

# How Do We Succeed?

- Collaboration with referral source to clarify the purpose of assessment and desired outcomes.
- Building rapport with clients and exploring their goals/concerns to develop a plan that they endorse.
- Active communication and coordination with other service providers, especially healthcare providers.
- Drawing on existing supports in family and community.
- Identifying strengths and protective factors that can reduce safety issues.
- Following up to ensure continuity of care and a “warm hand-off.”

# What GRAT Is Not

- The “old” GRAT, which was a program of Evergreen Health until it was discontinued in 2017.
- Neither an emergency nor a crisis response team.
- A treatment program.
- A case management program.

# Who We Serve

- Adults 55 and older
- Live in King County
- Experiencing a behavioral health issue in which mental health, substance use, and/or cognitive issues are likely contributing to safety risks and disrupting everyday functioning
- Must be able to receive support services at home
- Not already receiving a comparable service or higher level of care



# Who Is Not Eligible

- GRAT cannot serve:
  - Actively suicidal or homicidal older adults with a plan and intent
  - Unhoused older adults
  - Those receiving comparable behavioral health services
  - Those receiving a higher level of care while residing in an assisted setting (ALF/AFH/SNF) or an inpatient setting (hospital care, psych or detox program)
  - Those able to self-refer and navigate services independently

## Better Served by Other Services

- Acuity of behavioral health issues merits Designated Crisis Responder (DCR) involvement
- Acuity of health issues requires medical care and stabilization
- Duplication of services (i.e., clinical assessment is redundant)
- Resource needs only (i.e., clinical assessment is not needed)
- Older adult has been previously assessed by GRAT with no new changes to clinical presentation

# Demonstration

Using the Professional Referral Form

# Case Example

70-something Spanish-speaking woman referred by a health care provider for "distress" affecting her ability to manage finances, medication, and obtaining food. Reportedly has no family or community support in area.

One of our clinicians outreached the woman with an in-person interpreter to complete the assessment interview. During the interview, the client reported not having any food and lack of funds as well as having her phone turned off for an unpaid bill. The clinician used client need funds to pay for a week of groceries and the outstanding phone bill (a significant barrier to coordinating services). They also developed a care plan with the client that included connecting her to financial and food services.

The clinician connected the woman to a Spanish-speaking Case Manager at Neighborhood House and a Spanish-speaking Social Worker at a local Senior Center for ongoing support. The clinician was able to share assessment info with all the providers (including the original referent) to better tailor services.

# Questions?

# Contact Information

Phone number: 206-448-5730

**\*\*If not answered live, please leave a message\*\***

Email: [GRAT@soundgenerations.org](mailto:GRAT@soundgenerations.org)

**\*\*To ensure privacy, only send client information with an encrypted email\*\***

For service navigation, contact Pathways Information and Assistance:  
206-448-3110 or 1-888-435-3377

Thank You!