“A Crisis in Mental Health and Substance Use Disorder Care:

Closing Gaps in Access by Bringing Care and Prevention to Communities”

United States Senate Committee on Health, Education, Labor and Pensions

Subcommittee on Primary Health and Retirement Security

May 17, 2023

Maria G. Celli, Psy.D.

Deputy CEO

Brockton Neighborhood Health Center

Brockton, Massachusetts

Introduction:

Chairman Markey, Ranking Member Marshall, and members of the Committee, thank you for the opportunity to testify on the critical topic of mental health and substance use disorders. My name is Maria Celli, and I am a psychologist and the Deputy CEO at Brockton Neighborhood Health Center, a federally qualified health center located in Brockton, MA, a city 24 miles south of Boston. BNHC serves over 37,000 unique patients and conducted over 200,000 visits in 2022.

While I am currently the Deputy CEO of BNHC, I have previously served as a COO and Director of Behavioral Health and Social Services at BNHC and as a Director of Behavioral Health at a Boston-based FQHC. As a psychologist, my areas of clinical work have focused on behavioral health-primary care integration and working with individuals who have experienced trauma. I have trained in early childhood mental health and perinatal care, and I continue to be attentive to the needs of our youngest patients because they are our future, and I am aware that the ills I see in our adult patients were, in many ways, impacted by their experiences as young children. I am eager to promote the well-being of children to reduce their risk of developing pathologies later in life.

From my clinical care and administrative perspectives, I have observed the current state of behavioral health and substance use needs and care access from the patient level through to systems level. In Massachusetts, we are fortunate that the State's Executive Office of Health and Human Services has committed to improving access to behavioral health and substance use disorder services, through the development of a Behavioral Health Roadmap, which is a blueprint for creating accessible and equitable access to behavioral health and substance use disorder services across the state. Introduced in 2021 and implemented in 2023, this roadmap included the design and launch of 24 Community Behavioral Health Centers across the commonwealth. We, at BNHC, are thankful that one of the 24 CBHC's is located within the city of Brockton; and we leverage this and every other resource in Brockton's behavioral health ecosystem to try to address our patients' and community's needs. Despite these improvements in access, we are still witnessing a demand for services that exceed our supply of resources. We were concerned about our staff and community's mental health and wellness prior to COVID. However, the needs have risen throughout the pandemic and remain high.

I have professionally witnessed the negative impact that the pandemic had on the mental health and well-being of our patient population. More specifically, the trauma of COVID has triggered exacerbations of what were once subthreshold mental health conditions. The demand for behavioral health services is enormous – outstripping our community-wide supply of resources. Unfortunately, the acuity of patient needs is also worse, meaning that patients who might have once sufficed with outpatient therapy, are now reporting symptoms requiring more intensive or even inpatient care due to imminent risk concerns.

From my own professional experience, and as the representative on behalf of providers and patients whose voices are not here, I propose four opportunities for continued or additional

support to improve community-level access to behavioral health and substance use disorder services:

1. **Increasing support for integrated care team models:** Integrated primary care team models co-locate and integrate licensed behavioral health clinicians, Community Health Workers, Peer Recovery Coaches, and sometimes other disciplines to work alongside primary care providers so that health-related social needs and behavioral health screenings and treatment are universally available to any patient as part of their general medical care. This model of care is foundational to how FQHCs' practice and its expansion is essential to improving access.
2. **Leveraging Mobile Medical Units and continued use of Telehealth Services:** I propose support for care for hard-to-reach patients through support for unique and flexible models of care, including mobile medical units that can strategically deliver integrated primary care services to vulnerable individuals who are not engaging in their primary health care such as those struggling with homelessness, seniors and individuals with transportation or mobility barriers. Similarly, it is essential to continue to strategically use telehealth services for otherwise hard-to-reach populations.
3. **Prioritizing Pediatrics:** We must ensure that all pediatric patients have universal access to behavioral health screenings, assessments, and treatments throughout their development, especially in their first 5 years of life.
4. **Workforce Development:** Finally, we must continue to invest in developing the healthcare workforce to serve these behavioral health and substance use disorder needs, through support for existing professional pipeline projects.

Increasing Community Access through Primary Care-Behavioral Health Integration:

BNHC operates four clinical sites (including one in a homeless shelter and one mobile unit). BNHC provides the full spectrum of primary care services including adult medical, behavioral health, OB/GYN, pediatrics, nutrition, oral health, optometry, cancer screenings, on-site pharmacy, radiology, diagnostic laboratory, infectious disease screening and care, substance use disorder screening and treatment. We serve patients with extraordinarily complex medical and social needs, including poverty, food insecurity, homelessness, trauma, and difficulty accessing transportation and employment. We serve all people regardless of their insurance status or ability to pay.

Like many other Community Health Centers across the country, we serve our patients holistically, meaning that we provide healthcare that pays attention to and aims to address all aspects of a person's life, as they all impact their health. We screen, assess and address their care across multiple levels and domains of need addressing everything from food access to disease management. We practice this way because it is our mission to do so, and it is a way to promote wellness for individuals who might not otherwise engage in preventative services. This strategy is beneficial to the patients and restrains costs to the medical system, as the patient's

engagement in our integrated primary care teams can reduce unnecessary utilization of higher levels of care.

One recent example of this is the case of a 21-year-old male with multiple medical conditions, including seizure disorder, who was in and out of the hospital due to seizures. Unfortunately, he was not engaging in his medical treatment due to undiagnosed severe depression. After becoming aware of his medical disengagement and his frequent trips to the hospital, his primary care provider at BNHC engaged the integrated behavioral health clinician, who was able to begin to build trust with this traumatized young individual. Together, the primary care provider, behavioral health clinician, and patient began to make slow but steady progress in his participation with his healthcare. The patient has not visited the emergency room since the holistic treatment team has collectively engaged him. Now that he has built trust with this team, he is willing to meet with specialists who can stabilize his medical condition. Given his many needs, the behavioral health team is also working with his family and friends to know how to support his health and wellness. This is a person who was in a revolving door pattern of medical exacerbation to the emergency department – until he was engaged by his primary care provider and an integrated behavioral health clinician. Now, he is stabilized and moving towards illness management and an improved quality of life.

At BNHC, like many other health centers, the integrated model of care is foundational to how we provide primary care services. Our patients are universally screened for health-related social needs (i.e. social drivers of health), as well as risky substance use and depression. Just as we measure vital signs such as blood pressure, temperature, and weight, we ask them about the social conditions that impact their health and wellness; and we have staff on the team who assist with addressing the issues that patients report. This universal screening and team-based approach to access is crucial because it communicates that health-related social needs, substance use and behavioral health concerns are all part of their primary care. It destigmatizes these issues and creates easy access to needed services that improve their health, well-being, and effective participation in their own treatment, in their own lives and in their communities.

Another illustrative example of the benefits of Primary Care- Behavioral Health Integration and universal screening for BH and SUD conditions is the story of Gloria, a 73-year-old woman who had recently moved to our service area and was a newer patient. She completed our standard, universal screening process and was found to have an elevated score on the depression screening tool. Her response on the screening indicated suicidal ideation, and the PCP was planning to complete a Section 12 for the patient, meaning sending her to the hospital for inpatient hospitalization. However, because of the integrated model of care, the PCP reported the result to the integrated BH clinician, who met with the patient and carefully assessed the patient's risk. Rather than hospitalizing the patient, the integrated clinician was able to make a referral to one of our in-house psychiatric providers, who consulted with the PCP to start psychotropic medications. The BHI clinician helped the patient to connect with other resources in the community because the patient had acknowledged that the primary drivers for her

current state were loneliness and hopelessness due to multiple losses, including loss of employment.

This patient did not need a hospital. She needed connection. The integrated care team model, which is a cornerstone for how BNHC and so many other CHCs around the country operate, made those connections possible. We strive, train, practice, commit and recommit to seeing the whole person. And in doing so, we are privileged to know the patients and support them through accessing what they need to cope more effectively with the many stressors associated with their lives. Access to effective behavioral health and substance use disorder screening and treatment within the community and through the primary care doorway is an essential strategy for maximizing access in this time of tremendous need.

Increasing Access through Mobile Units and Telehealth Services:

Another fundamental way that Community Health Centers operate is that we are innovative and driven to meet the needs of our community. Additionally, we are committed to our communities' health and our patients' care, whether the patient is attending visits or not. We continuously track population health level data to monitor who is in or out of care, whose healthcare metrics (such as blood pressures or A1c's are out of control or have not been checked recently enough) etc. We launch population health text and mail campaigns to outreach and engage patients who are out of care. We mobilize community health and outreach workers to locate and reconnect these patients to their trusted medical home. However, many individuals remain disconnected, and it has worsened throughout the pandemic. We have observed that this has been particularly true for certain vulnerable populations, such as those experiencing homelessness, children, and seniors.

BNHC was fortunate to be awarded a grant in 2020 that yielded our first mobile health unit. The "Community Care in Reach" mobile unit provides services specifically to those experiencing homelessness, as well as people who use drugs. Started in 2021, this mobile unit can provide primary care, some acute care services, peer recovery coaching, and referrals to specialty services – all occurring where the patients are located. According to the CDC, there were over 100,000 drug-related overdose deaths in 2021 alone, which has steadily increased over the last 5 years. The screening, education and interventions provided on this mobile unit have undoubtedly saved lives! Additionally, it offers a patient-centered approach to high-quality, evidence-based care while also serving to contain costs through the reduction of ED utilization for services that are offered on the unit.

In addition to a mental health and substance use crisis in those who use drugs and in individuals experiencing homelessness, we have observed and measured an incredible increase in the behavioral health needs of our pediatric patients during and coming out of the pandemic. BNHC is actively seeking funding to acquire another mobile unit serve the pediatric populations of the city as a school-based service site. The integrated care team would include a full-time Nurse Practitioner, as well as a Behavioral Health Clinician, community health workers and Peer

Recovery Coach. While not yet operational, this model (across any willing school system) can bring necessary and easily accessible resources to kids who are falling through the cracks, despite the school, parents' and health centers' best efforts.

On the other end of the age spectrum, I have also professionally observed and have been informed by behavioral health providers across the City of Brockton and the state that there is great concern for the mental health and wellbeing of many seniors. Having been more socially isolated during COVID (in order to protect themselves), they are now struggling to re-emerge, including struggling to re-engage with their health care providers.

I am privileged to treat a senior struggling with depression, who has said to me that she is deeply lonely, but is scared to leave her home without certain trusted individuals (her adult children). Despite the best efforts to coordinate transportation and engage her family, there are times when she simply does not feel well enough to leave the street on which she lives. She has missed appointments as a result. And like her, there are many others! BNHC is hoping to acquire a mobile unit that can visit senior centers, senior housing sites, the council on aging and potentially other locations (as determined by data) to bring integrated care, including screening and treatment for behavioral health and substance use disorder to their living space. Making care accessible reduces inefficiencies in the system, is cost-effective, and, most importantly, promotes patients' health and well-being.

I am so appreciative that last year this Committee recognized the value of mobile care units when it passed the MOBILE Health Care Act by unanimous consent to make it easier for health centers to finance mobile health units. These mobile units can offer primary or dental care or provide behavioral health services to sparsely populated rural areas or underserved urban populations. While the MOBILE Health Care Act provided the necessary flexibility to health centers to use federal funding for mobile units, it did not provide any additional New Access Point dollars to take advantage of this flexibility. Additional New Access Point funding is necessary for health centers to take advantage of this unique opportunity. With this funding, health centers, like BNHC, can provide easier access to patients who are not engaging in their integrated primary care homes. This prevents the worsening of their conditions, thus improving their health and well-being while being cost-effective.

In addition to launching mobile clinical units to provide integrated care services to the homeless, at schools, and for seniors, I strongly support permanently extending the telehealth flexibilities, including audio only telehealth care, implemented during the COVID-19 public health emergency. Telehealth has been particularly effective in creating and maintaining access to behavioral health and substance use disorder treatment. This should remain an option to maximize access to services so critically needed by so many. We are experiencing a mental health crisis, and our providers feel it. When 1 in 5 adults and 1 in 2 adolescents live with a mental health illness, these nimble and flexible strategies can save lives, prevent the need for higher levels of care and promote wellbeing.

Prioritizing Pediatrics:

While I spoke about children generally, I would like to call out the critical importance of early childhood mental health. At BNHC, our experienced pediatric providers are deeply disturbed and overwhelmed by the number of children with symptoms of psychological distress. Senior pediatricians who have worked with our patient population for decades, are reporting a particular concern about seeing young children (0-5 years old) exhibiting symptoms that are consistent with Autism Spectrum Disorder but having difficulty accessing diagnostic evaluations due to a limited supply of professionals (psychologists and psychiatrists) trained in these assessment protocols, particularly to serve patients who are uninsured or underinsured.

Fortunately, at BNHC, we have had a robust primary care-behavioral health integration program for years, but we expanded in 2019 with the help of a private grant through the Transforming and Expanding Access to Mental Health Care in Urban Pediatrics (TEAM UP for children) program. TEAM UP is an initiative to build the capacity of 7 Community Health Centers in MA to deliver high-quality, evidence-based, integrated behavioral health care to children and families. The TEAM UP transformation model is rooted in three principles: transforming care, strengthening foundations, and creating a learning community. BNHC has been implementing the TEAM UP model since 2019 and continues to transform to meet the behavioral health needs of its early childhood, pediatric population through integration of behavioral health and social services into primary care. A study of the utilization of services for children who have engaged with TEAM UP sites showed an increase in access to behavioral health services for Medicaid-enrolled children[1]. The mental health needs of our pediatric patients are enormous, and Community Health Centers have innovative and proven strategies to increase access to mental health services. I strongly support investments in health center service expansions, as health centers are well-positioned to meet the needs of our children, who continue to demonstrate the repercussions of the traumatic effects of the last three years.

Workforce Development:

Nationally and locally, workforce recruitment and retention pose major barriers to maximizing access to services that can address this mental health crisis we are experiencing. According to HRSA estimates based on national benchmarks, nearly one-third of Americans live in a federally designated Mental Health Professional Shortage Area, 7.7 million health center patients are currently going without needed mental health care, and 4.9 million health center patients are going without needed substance use disorder treatment. The models of care to maximize access exist and can be leveraged to meet these needs. However, staffing is critical to addressing this mental health crisis.

In full awareness of our challenge, BNHC has designed and launched a number of grant-funded professional pipeline projects, including one designed for the training, recruitment, and

---

[1] Association of Integrating Mental Health into Pediatric Primary Care at Federally Qualified Health Centers with Utilization and Follow- Up Care. Jihye Kim, PhD1; R. Christopher Sheldrick, PhD2; Kerrin Gallagher, MPH2; et al

retention of behavioral health clinicians. In this program, BNHC commits to accepting, training, supervising and paying stipends to a cohort of behavioral health students completing their Masters degrees. Additionally, BNHC will pay a recruitment bonus to new hires, and a retention bonus to Behavioral Health Clinicians who have been with the organization for two years or more. Our intention is to incentivize training at and hopefully also working at BNHC, or another Community Health Center. We would love for this committee to provide more flexible funding to support a project like ours. These projects encourage training and working at community health centers, thus increasing the supply of trained behavioral health clinicians to meet the needs of this mental health crisis.

According to a survey by the National Association of Community Health Centers, behavioral health staff are in the top three categories for the highest rate of job loss for health centers. Competition from other employers and burnout from the pandemic are the most common reasons for staff departure. Additional federal funding would help recruitment and retention. Another top priority impacting retention of staff are wellness programs and other interventions for employees to mitigate employment-related stress. I appreciate that last year, the HELP committee passed the Lorna Breen Act by unanimous consent, which authorized funding for provider burnout. These programs are valuable because our staff are extraordinarily burnt out. As the Deputy CEO of BNHC, and a psychologist, I have the privilege and responsibility of listening to a lot of staff, and many of them have reported that they have “never felt worse”.

We genuinely appreciate any support that our staff can receive to remain well in their roles as they continue to work daily to save lives and serve as the healthcare heroes who have been heralded throughout the pandemic. While not fighting COVID, they are fighting to address the effects of COVID including increased overdose deaths and substance use as well as serious mental health concerns.

Conclusion:

Health centers like Brockton Neighborhood Health Center need long-term, sustainable, and predictable funding to meet our patients’ behavioral health and substance use disorder needs. I recognize the difficult decisions Congress must make to balance funding levels with the need to maintain our Nation’s fiscal health. Still, medical inflation has outpaced health centers’ funding increases since 2015, leading to a 9.3% decrease in actual funding levels. Decades of research show that federal investments in health centers reduce overall health spending by expanding access to efficient and effective primary care. Patients who access primary care at health centers show positive health outcomes and reduced use of emergency departments and hospital stays.

I appreciate that this budget environment makes additional investments challenging. Still, millions of patients could benefit by expanding access to mental health and substance use disorder care at the health centers where they are already receiving primary care. For example, the National Association of Community Health Centers estimates that an additional investment

of $500 million over five years would allow health centers to hire more than 2,500 behavioral health specialists and reach more than 5 million additional patients. This level of commitment by Congress would leverage the existing network of care and build on a proven model that saves the health system billions of dollars.

Chairman Markey, Ranking Member Marshall, and members of the Committee, thank you for allowing me to share the great work my team at BNHC is doing to fight the mental health and substance use disorder crisis in our country. With this Committee's support, we will continue to find new ways to provide affordable, accessible, and high-quality care to the communities we serve. I look forward to your questions.