

**Examining Our COVID-19 Response:
Using Lessons Learned to Address
Mental Health and Substance Use Disorders**

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Health, Education, Labor and Pensions**

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Introduction

Chairwoman Murray, Ranking Member Burr, 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 Jonathan Muther and I am the Vice President of Behavioral Health at Salud Family Health Centers, a federally qualified health system with 13 community health clinics in 8 mostly rural counties throughout Colorado.

As a psychologist, I have spent my entire career to date in a primary care community health setting. As a behavioral health clinician, I have seen first-hand the impact of COVID-19 on our communities, including and especially the worsening of both the frequency and severity of mental illness and substance use disorders. From this perspective, and the experiences of countless patients, I will be sharing my testimony today. There are three elements for improving healthcare I would like to put forth, these include:

1. Primary care is the backbone of health care in this country and properly addressing mental, emotional, and behavioral demands in this setting is essential to achieving better health, containing costs, and relieving inequities.
2. We must look at new models of care, including behavioral health specialists working in concert with primary care medical providers, in order to meet the demand for behavioral health care that has grown exponentially since the onset of COVID-19.
3. Opportunities exist to further transform behavioral health service delivery in a meaningful way that include telehealth, advancing payment models, and enhancing our workforce.

Salud is one of 1,400 Community Health Center organizations spread across 14,000 rural and urban communities serving over 30 million Americans. Health centers are the family doctor to people of all ages and walks of life – newborns, the seniors, the homeless, veterans, and agricultural workers. Health centers are problem-solvers, protectors of public health, and innovators in illness prevention, even in unprecedented pandemics like COVID-19. Health centers provide easy access to services that individuals would otherwise find unaffordable and unattainable. We look beyond the medical chart for answers that not only prevent illness but address the environmental and social factors that can make people sick – lack of nutrition, exercise, homelessness, and most certainly mental health, and addiction. In providing access to affordable care for people least likely to have it, unnecessary hospitalizations and ER visits are significantly reduced and so are costs to the American taxpayer.

Community Health Centers across the country have stepped up to meet the needs of the communities they serve first through continued care for underlying health conditions, as well as COVID-19 testing and vaccinations. Since the onset of the pandemic, health centers across the country have tested over 10 million patients and conducted over 3.6 million vaccinations. Nearly half of the patients vaccinated are racial or ethnic minorities.

Health centers have been able to thrive in communities because of the ongoing support you have shown for Federally Qualified Community Health Centers (FQHC). For example, the three-year extension of the mandatory Community Health Center Fund has provided multi-year certainty for my health center and others across the country. Additionally, the COVID funding

from last year, along with the \$7.6 billion from the American Rescue Plan is enabling health centers to care for their patients during this difficult time. Salud has received over \$16 million from this funding and will now be better positioned to test, vaccinate and care for our patients. We are using this funding to hire staff for vaccine clinics, to develop, maintain, or resurrect programs related to quality improvement, and to develop meaningful changes the pandemic has brought on such as ensuring separate clinic space for sick and well patients. Most importantly, we seek to shrink the disparities that have always impacted communities of color that were made worse by the COVID pandemic.

A conversation about behavioral health (which includes mental illness and substance use disorders) is a conversation about *health*. There is no health without mental health. We know, from clinical experience and decades of research, that wellness promotion, improving mental health, and reducing risk for substance abuse, improves all health outcomes. **However, access to behavioral health treatment is, in and of itself, a health disparity.** Our current system allows for inadequate attention to be afforded to behavioral health treatment, coverage, and policy, as compared to medical care. This needs to change.

Background

A model of integrated care involves a team of clinicians from various professions all working together to meet the healthcare needs of individuals and families. In a traditional model, you go to your doctor's office when you have a cold, and a separate dentist office for a toothache. And if one of these providers is able to identify a concern, or less likely, the patient is able to recognize they might be experiencing symptoms of depression or anxiety, there might be a referral placed for a third visit in yet another clinic at another time. With each separate visit, patients face the added burden of transportation, time away from work or caring for children, another copay, and navigating a system that is confusing and disjointed because these treating providers cannot communicate with one another. In an integrated model, each of these concerns can be addressed in the same place on the same day. A visit to the doctor also includes a structurally embedded visit with a behavioral health provider – whether the patient is seeking this service or not. Just as height, weight, blood pressure and other routine information is gathered for the medical visit, so too are questions relating to mood, stress and substance use to inform the behavioral health part of the visit. This allows members of the care team to achieve a global picture of the presenting concern, and for the individual seeking care to know every aspect of their health is being addressed.

I oversee a team of about 40 behavioral health clinicians at Salud Family Health Centers that are dedicated to increasing access to behavioral health services for Coloradans every day. Each clinician conducts between 8-12 brief encounters per day, most often in the context of a medical visit, alongside a primary care provider, regardless of whether an individual has requested – or is even expecting – behavioral health as part of their care. Behavioral health providers coordinate, collaborate, and consult with medical providers to treat mental illness and substance use disorders, create health behavioral interventions for chronic physical health conditions, and most commonly, address comorbidities that often go untreated. We are seamless with patients receiving mental health treatment where they go to fill their medications, receive their COVID-19 vaccination, and get their annual physical.

However, we still face barriers – challenges that are driven by the fragmented system we operate in. The COVID-19 pandemic has exposed and exacerbated longstanding difficulties for individuals experiencing mental illness and/or substance use disorders. The challenges are many. However, I would like to focus my testimony on the *opportunities* we have to do better for the individuals and families of this country.

We must look at innovative practices that focus on integrating behavioral health and primary care as a means to reducing the silos that have historically existed within our healthcare system. We have decades of reports and evidence that integrating mental health into places like primary care works. And while these models still are a novelty and not so much the standard of care, we should pursue a system that prioritizes a whole-person approach, in which addressing an individual’s entire health needs, be it behavioral & emotional, oral, medical, or social, begin and end in one place – ideally the place of the person’s choosing.

The Value of Integrated Care over Traditional “Siloed” Care

A set of professionals from various disciplines working together in one place increases efficiency, has demonstrated cost-effectiveness, and improves health outcomes. The integration of behavioral health and primary care is the linchpin to resolving our inadequate system of care for both behavioral and physical health outcomes. We can no longer afford, neither fiscally nor in reduced quality of life; neither in untold healthcare spending nor well-intended grant dollars; neither in increasing rates of deaths by suicide nor other deaths of despair, to maintain the outdated, entrenched silos that separate physical and behavioral health.

Like all health-related concerns, we know that individuals with mental illness or substance use disorders are most likely to initially present for help at their doctor’s office. A model of integrated primary care allows for brief behavioral health assessments and interventions offered in real-time, at the point of contact with one’s primary care provider. This model is effective, efficient, and suitable to consumer needs and preferences.

I want to share the story of “Marco”, a 38-year-old man and patient at Salud Family Health Centers, living in a 600 square foot shipping container repurposed as a rudimentary home in rural Colorado. He has no running water and a small wood-burning stove for heat. He had previously been employed in the food service industry until he was forced out of work last April. During a screening phone call by a Salud behavioral health provider – a routine outreach effort to assess need and “normalize” behavioral health as part of care, Marco stated, **“I’m so surprised and glad to hear from someone, this is exactly what I need right now.”** He then endorsed multiple symptoms of depression, anxiety, alcohol abuse, and thoughts of ending his life. The patient acknowledged, **“this is the first I’ve spoken to someone in days and I never would have known what to do had you not called.”** Waiting for individuals like Marco to ask for help is too late. Expecting Marco to know where to receive help from a system with uncertain points of entry is unrealistic. We have to equip our clinics with behavioral health clinicians who can proactively outreach individuals experiencing the many barriers to care.

This model needs to be incorporated in all clinical settings. Primary care and school settings are the most likely starting points for accessing behavioral health services for adults and children, respectively. Placing behavioral health providers where individuals are most likely to be allows

clinicians to proactively address the rising rates of mental illness and substance abuse risk factors. Integrated models must be the norm in other settings as well, including specialty medical clinics, hospitals, and emergency departments. Imagine an avoidable emergency department visits because of a timely intervention when an individual disclosed stress to their primary care doctor.

Prevalence of Behavioral Health

Even prior to the COVID-19 pandemic, there was a mental health crisis in the country related to unmet need, in which the demand for services far exceeded our capacity to adequately address the rates of distress. **Over half of American youth and adults living with a mental illness or substance use disorder report receiving no treatment.** Pre-COVID, rates of adult mental illness of any type were about 19% on average (ranging from 16-25%).¹ Over 20 million Americans aged 12 or older in this country experience addiction and substance dependence.² Of these adult individuals who report a mental illness, as many as 57% report receiving no treatment. Of the nearly 14% of youth experiencing symptoms of depression, almost 60% did not receive any mental health treatment. Adults experiencing a substance use disorder fared even worse, with as many as 80% reporting they did not receive treatment.

Furthermore, since the onset of the pandemic, rates of mental illness have multiplied, and the unmet need is now further burdening a system already cracking at the seams. Even more alarming is the mental health impact on our nation following the pandemic will last far beyond the physical health impact and into future generations.

No segment of our population is immune to the toll that necessary disease mitigation efforts have had on our collective psyche. Social isolation, financial uncertainty, job loss, and loss of a loved one are risk factors for mental illness and substance use disorders. The very measures needed to keep our communities safe, including physical distancing, stay-at-home orders, school closures, and others, have unintentionally increased the risk and put forth new challenges on our behavioral health system.

Unsurprisingly, prevalence rates for mental illness and substance use disorders are rising at a staggering rate. **US adults with symptoms of an anxiety disorder and/or depressive disorder has at least quadrupled since before the pandemic.**³ The CDC has reported rates of anxiety to be three times higher and rates of depression four times higher in 2020 as compared to the year before the pandemic. That makes 30-40% of our population currently experiencing these symptoms as compared to 11% in 2019.

We cannot ignore the fact that these rising rates of mental illness and substance use are disproportionately affecting specific populations of our country. Younger adults (18-26 years old), racial/ethnic minorities, essential workers, and unpaid adult caregivers reported having experienced disproportionately worse mental health outcomes, increased substance use, and elevated suicidal ideation as a result of the pandemic.

Redesigning Behavioral Health Post COVID-19

First, we need to ensure that telehealth continues to be a core platform of health care delivery. Prior to 2020, only 1% of mental health was via telehealth and skyrocketed to 75% of visits

during 2020.⁴ The increased presence of telehealth during the pandemic has been a saving grace. It has allowed us to maintain a rate of service delivery roughly on par with rates of delivery pre-pandemic, but in a way that decreases barriers to care. Like utilization rates for all healthcare, behavioral health utilization fell. However, the behavioral health utilization soon came back to rates equal to that or higher than rates seen in 2019 because of the deployment of telehealth. **Yet we must remember, the gap of unmet need has still widened further because of the dramatic increase in prevalence rates due to COVID stressors.**

Therefore, we need to continue to utilize smart technologies in innovative ways and think beyond the realm of a traditional therapy session. Examples include more frequent symptom screenings, periodic check-ins with clinicians (e.g., brief instant messaging) in addition to a typical in-clinic visit, and virtual group visits and group chats, all designed to maximize interventions and extend the availability of our limited number of licensed clinicians.

Second, we need to build on the existing advancements of alternative payment models. Marco's experience reminds us of the importance of a meaningful intervention that occurs because of proactive outreach to patients. We can no longer force a patient to experience the barriers of limited transportation, high cost of care with insurance that does not cover behavioral health treatment equitably, long wait lists, and stigma. This is especially true for those whose first language is something other than English.

But payment without addressing coverage is only telling part of the story. We know that many patients avoid care because of the cost, and despite mental health parity being a federal law for decades, we still have limited enforcement. In fact, under current law, the United States Department of Labor lacks the ability to assess civil monetary penalties against health issuers and plan sponsors for violations of the Mental Health Parity and Addiction Equity Act (MHPAEA), which requires insurers to cover illnesses of the brain, such as depression or opioid use disorder, no more restrictively than illnesses of the body, such as diabetes or cancer. Without this power, USDOL can only require plans to reimburse consumers for wrongly denied coverage of care that was nevertheless provided. Such meager authority is not enough and is unlikely to change plans' coverage practices. USDOL must finally be able to hold plan issuers and sponsors accountable for illegal denials of mental health and substance use coverage more than 12 years after enactment of the MHPAEA.

The types of clinical encounters that I have described may not be billable at all. If these services are reimbursable, then it may be at an extremely low rate, and/or require only certain credentials to obtain reimbursement under current payment models and governance structures. These are exactly the types of clinical encounters that are meaningful for the patient, efficient for the clinician, and a perfect example of the type of flexibility in service delivery that service organizations are seeking to provide under alternative payment models that reward outcomes and value over volume. We need to pursue other encounter types such as brief screens and check-ins with patients, commensurate with their clinical needs and not bound by outdated payment and regulatory constraints. **This is attainable for the vast majority of those needing behavioral health services.** We must reform our billing and reimbursement models if we are to prevent an ongoing undercurrent to this current pandemic for generations to come.

Prior to the pandemic, clinics like mine were not able to bill for telehealth services in any capacity. Congressional action through the CARES Act and other state-based initiatives have enhanced flexibility in payment for telehealth services allowed us to switch our clinical approach, quite literally overnight, to an approach that is easy and effective for both clinicians and consumers of behavioral health. But we need more. **Telehealth services must be here to stay if we want progress in closing the gap between unmet need and service acquisition.** Telehealth services, regardless of mode/platform (phone, video conference, face-to-face in-person) should all be reimbursed and at the same rate. As a result, I would encourage you to continue the telehealth flexibilities that the Public Health Emergency has enabled, including recognizing health centers as distant site providers and removing originating site restrictions, as well as allowing the use of audio-only encounters.

We must also increase the workforce and invest in a robust pipeline that supports recruitment and retention of individuals of diverse backgrounds into mental health training programs through loan forgiveness programs and other financial incentives to make this career attractive and sustainable.

At Salud, we have a training program bringing in highly skilled clinicians from Puerto Rico to help meet the needs of a culturally and linguistically diverse community. Once the pipeline has been created and our healthcare system is attracting and supporting behavioral health-trained clinicians, we must also broaden the workforce to be more inclusive of other roles like peer specialists (individuals with lived experience of mental illness and/or substance use disorders), community health workers, mental health first responders, and others.

Health centers have tripled their behavioral health staffs over the last 10 years, performing evidence-based screenings and intervention, including Medication Assisted Treatment and referral. However, demand remains very high with nearly a five-fold increase in patients seeking treatment for opioid addiction and other substance use disorders. **The recent investment of \$1 billion for the National Health Service Corps and the Nurse Corps is an example of the large-scale commitment to the health care workforce that is needed to address severe and chronic workforce challenges at the community level.** Let's continue this line of investment and seek to train this new workforce in mental health as well.

What cannot be overstated, is **the allocation and distribution of our workforce needs to be where presenting concerns are most evident**, namely primary care and schools. Another example, the mental health first responder, often termed the "co-responder" model, is among the most innovative and should be expanded. This enables the provider to appropriately address the needs of the patient at the first point of contact, averting expensive emergency department visits. It also avoids the "criminalization" of mental illness and prevents unnecessary involvement with law enforcement and corrections, which unfortunately has become the "de-facto" mental health system.

Lastly, I would like to fully endorse the work done by the Bipartisan Policy Center (BPC) and the recommendations included in BPC's recent report entitled, [Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration](#). I believe the report offers a clear

distillation of the current challenges and provides additional recommendations to chart a new path forward.

Conclusion

The concerns are rising. The need is clear. We know what will happen if we expect our current system to accommodate the quadrupling of need. More than 1 out of 3 of our fellow citizens right now are experiencing the effects of increased substance use, feelings of worsening anxiety, and/or significant impacts on their mood as a result of depression.

The good news is that health centers are a proven model of care and are staffed with dedicated professionals who know how to help. We know where to be so that we can ask the right questions and offer the right help and make the right recommendations. We have shown that we can improve the health of our communities by making it normal to treat the emotional toll of stress and illness when you go to school or see your primary care doctor. We have the road map, but now need to ensure we have the resources, so the roads are sturdy and equipped to handle the increase in traffic needed to get to our destination of improved health and wellbeing for us all.

Again, Chairwoman Murray and Ranking Member Burr thank you for allowing me to share my thoughts and experiences from Salud Family Health Centers. I appreciate your commitment to these issues and would welcome any questions that you may have.

Citations:

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