community health centers OF BURLINGTON

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The Community Health Centers of Burlington is a Federally Qualified Health Center serving 27,000 patients with medical, dental, and behavioral health services at eight locations throughout Chittenden County and southern Grand Isle County. We have had an integrated Behavioral Health Program since 2001 and now employ 18 Licensed Clinical Social Workers (most dually licensed or credentialed as alcohol and drug counselors), two Social Work Case Managers, three Medication Assisted Treatment Teams (each with an RN and LADC), two part-time Psychiatrists, and four Psychiatric Nurse Practitioners.

CHCB offers a Stepped Care Model, starting with our primary care Behavioral Health services, where Behavioral Health Consultants (BHCs) are embedded with the medical teams. With this integrated medical team, we can identify patients with mental health and substance use concerns through our SBIRT (Screening Brief Intervention and Refer to Treatment) Model. We identified and provided contact in the past year to 3,231 patients with Depression and other mood disorders; 1,367 patients with a substance use disorder; 2,771 patients with an Anxiety disorder, including Post Traumatic Stress Disorder.

Nurses and Medical Assistants provide universal screening of depression and substance use. Positive initial screens identify patients who need more follow up. Our BHCs provide secondary screening, brief intervention at the point of the medical visit, and referral to treatment for those who need specialty treatment. Our BHCs refer to our in-house specialty services, including our co-occurring counseling unit for brief treatment or longer-term treatment for depression, anxiety, post-traumatic stress, or substance use disorders. Our BHCs can also refer to psychiatry services, to our Medicated Assisted Treatment services, and to case management.

Through this stepped care approach, we can serve more patients with behavioral health services than we could if we only provided traditional counseling. If we provided only traditional counseling, we might help 200 – 300 people per year. But with a Stepped Care Model, **CHCB provided intervention and counseling to over 2,500 Behavioral Health counseling patients last year, with 10,000 encounters.**

Our model allows us to engage in prevention services. Experts now know that many individuals who die by suicide have recently had a primary care visit (1):

- 45% of those who suicided were seen within a month
- 20% were seen within 24 hours
- 73% of the elderly were seen within a month

With Behavioral Health integrated into primary care, we can identify those with severe depression and prevent suicide through early identification, intervention, and follow up counseling. We can refer the more complex patients to our in-house psychiatry team. Our psychiatry team saw 2,234 patients in 7,553 visits (through scheduled appointments and psychiatry walk in clinic).

Using an SBIRT approach, we also have an opportunity to prevent substance misuse and to offer treatment to those who already have a problem. At CHCB, we are treating approximately 365 people with Buprenorphine and counseling in our Office Based Opioid Treatment Program (OBOT). We offer both brief treatment and longer outpatient counseling for substance use problems.

We also collaborate with our community partners regarding mental health and substance abuse risk and complexity. While we have the ability to provide significant MH/SA services within CHCB, we keep in mind the Four Quadrant Clinical Interpretation Model (SAMSHA) in working with the designated mental health agency. (2) We work closely with Howard Center's crisis programs, CRT Program, Developmental Services, and with the Chittenden Center.

Despite the fact that we can offer comprehensive on-site Behavioral Health services, there are gaps and challenges.

- CHCB cares for a large refugee population. Seven percent of our patients are Nepali-speaking. As a first step to their well-being, they need assistance in acclimating to their new environment and in navigating the health care system. **Community Health Workers** would be beneficial to helping our refugee patients access the medical/dental/behavioral health services they need, yet funding for this service is hard to obtain.

- People with mental health and substance use problems face other socio-economic challenges and often need help with care coordination. Yet, again **case management** is hard to fund, even though it is a very important service for our patients.

- Our **MAT Teams** are stretched in trying to provide support to our patients with Opioid Use Disorder because funding comes solely from Medicaid vs. commercial insurers. A third of our patients receiving MAT treatment now have commercial insurance.

In addition to therapy and clinical intervention, other case management supports are much needed by our patients. The challenge is that there are limited funds to employ case managers or care coordinators.

In conclusion, CHCB, as a nonprofit and Federally Qualified Health Center, has the benefit of a strong model. In general, our operations are sustainable. But in order to fulfill our mission and obligation to community health in the region, our organization must continue to offer programmatic pieces that are "non-billable." In other words, many of the enabling and support services we offer (and want to offer in the future) are necessary, but are also a costly piece which we provide without insurance reimbursement. We offer them because that's what is needed to keep our community healthy, and we believe these preventative services save cost to the health care system.

1.) Luoma, Martin, &Person, 2002. Pirkis & Burgess, 1998. Juurlink et al., 2004

2.) https://www.samhsa.gov/sites/default/files/programs_campaigns/samhsa_hrsa/four-quadrant-model.pdf