AMERICAN PSYCHIATRIC ASSOCIATION

800 Maine Avenue, S.W.
Suite 900
Washington, D.C. 20024

March 20, 2023

The Honorable Bernard Sanders
Chair
HELP Committee
United States Senate
Washington, DC 20510

The Honorable Bill Cassidy, MD
Ranking Member
HELP Committee
United States Senate
Washington, DC 20515

Dear Chair Sanders and Ranking Member Cassidy:

On behalf of the American Psychiatric Association (APA), the national medical specialty society representing over 38,000 psychiatric physicians who treat mental health (MH) and substance use disorders (SUD), I write in response to your stakeholder Request for Information (RFI) regarding our nation's health care workforce shortages.

The COVID-19 pandemic has exposed gaps in our country's health workforce, imposed significant disruptions on the clinician pipeline, and highlighted the immediate need to strengthen our broader health care infrastructure. The Health, Education, Labor, and Pensions (HELP) Committee has a strong and longstanding track record of bipartisan leadership in these areas, and the APA looks forward to collaborating with the Committee to support policies that will enhance our health workforce and increase patient access to care. Through the HELP Committee's leadership, Congress can ensure that federal agencies have the resources and authorities they need to enable existing and new programs to support our health care workforce and improve the health of people everywhere. With that objective in mind, we offer the recommendations below.

Reauthorize and Strengthen Workforce Building Programs

Given the sharp rise in overdose deaths brought about by the pandemic, it is imperative that Congress continue to focus on building our MH/SUD workforce. Data from the Health Resources and Services Administration (HRSA**)** show that an estimated 157 million Americans, or 47% of the population, lived in one of 6,469 mental Health Professional Shortage Areas (HPSAs) as of December 2022, and the nation needs an additional 7,902 mental health providers to fill these shortage gaps.[1] To help ensure those in need of care can readily access it now, and in the future, **the APA strongly encourages the committee to prioritize reauthorization and expansion of the following workforce building programs administered by the HRSA.**

[1] https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport

- In 2018 Congress enacted Loan Repayment Program for Substance Use Disorder Treatment Workforce as part of the SUPPORT for Patients and Communities Act, to address the severe shortage of physicians and other health care professionals who treat individuals living with addiction. **HRSAs Substance Use Disorder Treatment and Recovery (STAR) Loan Repayment Program** promotes the expansion of the substance abuse treatment workforce by providing up to $250,000 in loan repayment for substance use disorder professionals working in high-need communities or federally designated mental health professional shortage areas. **APA strongly supports efforts to augment and reauthorize this critical program, including the Mental Health Professionals Workforce Shortage Loan Repayment Act of 2023 (*S. 462)*, which would expand the program's eligibility to mental health professionals and increase the annual authorization to $50 million**.

- **APA likewise supports strengthening HRSAs Pediatric Subspecialty Loan Repayment Program (PSLRP)**. PSLRP provides up to $35,000 annually for a maximum of three years to pediatric subspecialties, including mental health providers, who agree to practice in an underserved area. This important program helps improve patient access to care and bolster the health care workforce in shortage areas.

- 41 states have what the American Academy of Child and Adolescent Psychiatry has characterized as severe child and adolescent psychiatrists (CAPs) shortages.[2] **With these acute shortages in mind, APA strongly encourages the committee to reauthorize, and increase support for, the Children's Hospitals Graduate Medical Education Program (CHGME).** The CHGME program, administered by HRSA, is the only national program focused on the training of pediatricians and pediatric subspecialists. Each year, CHGME-funded children's hospitals train thousands of general pediatricians and pediatric specialists, including child and adolescent psychiatrists. Beyond sustaining a critical supply of pediatricians, CHGME has enabled children's hospitals and their residents to provide significant value to the patients and communities they serve by advancing the quality of pediatric medical education, providing care for vulnerable and underserved children, and pioneering community-based pediatric training.

- Through the National Health Service Corps (NHSC) program, over 11.4 million patients at NHSC-approved health care sites in urban and rural areas have access to mental health, dental and primary care services. The NHSC provides important funding to help ease the shortage and maldistribution of health professionals, while meeting the health care needs of underserved communities. Although demand for the program has grown over the past decade (as measured by number of applications), the NHSC budget has remained flat. To further support this critical workforce building program, **APA urges the Committee to increase funding authorization for the NHSC.**

Support Evidence Based Integrated Care Models

The integration of primary care and behavioral health has proven effective in expanding the footprint of our existing behavioral health workforce and essential to improving patient access. The Collaborative Care Model (CoCM) is a behavioral health integration model that enhances primary care by including

[2] https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx

behavioral care management support, regular psychiatric inter-specialty consultation, and the use of a team that includes the Behavioral Health Care Manager, the Psychiatric Consultant, and the Treating (Billing) Practitioner. The evidence and population based CoCM can help improve outcomes and alleviate existing workforce shortages by enabling a primary care provider (PCP) to leverage the expertise of a psychiatric consultant to provide treatment recommendations for a panel of 50-60 patients in as little as 1-2 hours per week. Meeting patients where they are, in their PCP's office, ensures that physical and behavioral health care is integrated, often without requiring the patient to make a second appointment or visit a separate mental health specialist. Primary care clinicians likewise report that the CoCM model has reduced burnout and increased their comfort level in treating patients with MH/SUD. By treating more people and getting them better faster, the CoCM is a proven strategy to enhance the efficient use of existing clinicians and, therefore, to help address the behavioral health workforce crisis over the near-term as we work to train additional clinicians.

To better leverage the existing behavioral health workforce, APA urges continued consideration of methods to promote uptake of proven models, including the CoCM. Specifically, we recommend enhanced authorization for SAMHSAs Promoting Integration of Primary and Behavioral Health Care (PIPBHC) program, which promotes full integration and collaboration of behavioral and primary healthcare in clinical settings to provide essential primary care services to adults with serious mental illness. Because of this program, more than 100,000 individuals living with a serious mental health and SUD have been screened and treated for co-occurring physical health conditions and chronic diseases at grantee sites in 40 states. Likewise, while not within the committee's jurisdiction, APA supports efforts to help incentivize use of these proven models, such as temporary increases in Medicare payment rates for behavioral health integration services, as proposed last year by the Senate Finance Committee.

Expand Access to Tele-Behavioral Health Services

For individuals residing in rural areas, the realty of potentially having to travel long distances for behavioral health services often serves as a deterrent to receiving care. Telehealth can help alleviate the gaps exposed by workforce maldistribution, including in urban underserved areas, by providing a linkage between clients in their home communities and behavioral health providers in other locations. The current telehealth flexibilities passed by Congress and implemented by past and current Administrations have been a lifeline for patients in need of MH/SUD services. We have seen strong patient-clinician satisfaction with telehealth services, and a decrease in no-show rates, both critical issues for patients in crisis to begin and continue appropriate treatment. Last year, the FY23 Omnibus extended multiple telehealth flexibilities implemented in response to the ongoing Public Health Emergency (PHE) until January 2025. The legislation critically allowed audio-only services for behavioral health services, and delayed implementation of the 6-month in-person requirement for mental telehealth services until December 31, 2024. At a time of unprecedented demand, it is imperative that we remove unnecessary barriers and ensure the continuity of care for those seeking MH/SUD services. **APA strongly encourages permanent removal of the 6-month in-person requirement for mental telehealth services.**

Diversify the Workforce

For almost 50 years, the Substance Abuse and Mental Health Services Administration (SAMHSA) Minority Fellowship Program (MFP) has helped improve behavioral health care outcomes for racial and ethnic

populations by growing the number of diverse behavioral healthcare providers in the nation's workforce. The program seeks to reduce health disparities and improve behavioral health care outcomes by providing experiential learning experiences and coursework for psychiatry trainees, thus enhancing their ability to provide culturally competent, quality mental health and substance use disorder services within medically underserved communities. **APA supports further investing in this important program to not only help to strengthen diversity in the mental health profession, but also help address current and projected behavioral health workforce shortages and promote needed training for providers to address health disparities**.

Address Burnout

Psychiatrists, behavioral health clinicians, and other practitioners have been working grueling hours during the pandemic in attempts to meet the growing needs of patients with MH/SUD Increasing our workforce numbers across the continuum of care reduces the number of extra shifts current workers must take on to meet demand, and overall alleviates the strain on the health care system when demand greatly outpaces supply. However, health care employers need to also invest in more robust and supportive employee assistance programs to help their healthcare staff get the help they need when they do experience burnout or other mental health or SUD conditions without fear of job loss or career repercussions when asking for help. Last year's passage of the Dr. Lorna Breen Health Care Provider Protection Act, funding grants to health care practitioners and systems to improve mental and behavioral health among health care workers, is a good first step in tackling the issue of health care worker burnout. **APA encourages the committee to build on this important effort and to simultaneously address root causes of burnout by working to limit administrative burdens (prior authorizations, credentialing, limits on the number of visits). We also encourage the committee to explore possible strategies that might incentivize more states to modify their state licensure questions to remove questions that stigmatize mental health and stoke fear among clinicians who need care but are afraid to seek it for fear of losing their livelihoods.**

Expand Graduate Medical Education

HRSA estimates that by 2025, there will be a shortage of over 250,000 mental health professionals, including psychiatrists, mental health and substance abuse social workers, clinical and school psychologists, and school counselors. The gap between need and access is especially pronounced in psychiatry, with more than half of U.S. counties lacking a single psychiatrist.[3] Projections show the country will be short between 14,280 and 31,109 psychiatrists by 2025.[4] This severe shortage in the near- and long-term merits swift and aggressive action. The Fiscal Year 2023 Consolidated Appropriations Act (FY23 Omnibus) added 200 new graduate medical education (GME) residency slots with 100 of these slots going directly to psychiatry or psychiatric subspecialties beginning in 2026. **APA urges Congress to build on this investment by supporting additional new Medicare-GME slots for psychiatry and psychiatric**

[3] https://behavioralhealthworkforce.org/wp-content/uploads/2019/02/Y3-FA2-P2-Psych-Sub_Full-Report-FINAL2.19.2019.pdf

[4] https://pubmed.ncbi.nlm.nih.gov/29540118/

subspecialties with residencies spread geographically in rural and urban areas, alike. Such an investment in the psychiatric workforce would help our nation begin to chip away now at the workforce shortage and better position us to address the growing crisis of access to mental health and substance use-related care and treatment.

Support Access to Care by International Medical Graduates

International medical graduates (IMGs) are vital contributors to our nation's workforce and can play a critical role in helping to fill the behavioral health workforce gap, particularly in mental health professional shortage areas where nearly 120 million Americans live. IMGs make up almost a quarter of the total resident and practicing physician workforce. Currently, most resident physicians from other countries working in the U.S. on J-1 visas are required to return to their home country for two years after their residency has ended before they can apply for another visa or green card. The Conrad 30 program allows these physicians to remain in the U.S. without having to return home if they agree to practice in an underserved area for three years. In many communities, IMGs provide vital access to care during and beyond that three-year commitment. **While not within the committee's jurisdiction, reauthorization of the Conrad State 30 J-1 visa waiver program would boost the workforce of physicians available to treat mental illness and addiction in rural and other medically underserved areas. APA strongly supports the recently introduced Conrad State 30 and Physician Access Reauthorization Act (S.655).**

We appreciate your timely, bipartisan focus on identifying additional legislative steps Congress should take to address ongoing health care workforce shortages. The APA is eager to aid your efforts. If you have any questions, please contact Daniel "Trip" Stanford at dstanford@psych.org or (315) 706-4582.

Sincerely,

Saul Levin, MD, MPA, FRCP-E, FRCPsych
CEO and Medical Director