Greetings to all members of the Behavioral Health Commission for Adult Mental Health.

My name is Erin Crown and I live and practice in Sate College, PA. I am a Certified Physician Assistant in general Psychiatry providing medication management to individuals age 5 and older. I am co-owner and managing member of Oasis LifeCare, LLC where we provide psychiatric medication management, psychotherapy, first episode psychosis services, primary care and obesity medicine. It is my distinct honor to testify today as a representative of Centre County, rural communities, those that work in the behavioral health field within these communities, and those that we serve.

I commend the state of Pennsylvania for allocating $100 million from the American Rescue Plan Act for funding adult mental health programs. This is an impressive action that has potential to significantly impact the way services can be accessed, delivered and sustainable for Pennsylvanians in need of mental health and substance use treatment.

Like many rural communities, Centre County is struggling to meet the demands of individuals that need timely access to mental health and substance use care. As I have considered various ways to markedly impact our system, I have chosen to elaborate on one area that could have immediate impact, one that would require some time and infrastructure but have lasting benefits, and one that would ensure that we are planning for our future. These are evidence-based approaches to improve access to and delivery of care across the state in sustainable ways. They are in no way the only options, and I would be happy to discuss alternatives and additional ideas in other areas of interest to this group should it please the commission.

In September 2019, in the Western Journal of Emergency Medicine, Kimberly Nordstrom, MD and colleagues published an article online titled Boarding of Mentally Ill Patients in Emergency Departments: American Psychiatric Association Resource Document. This paper discusses the shift in mental health care over the last 50 years, described as deinstitutionalization, and explains how patient-centered intent for community-based care having been met with budget-driven cuts in public hospital beds, a profit-driven managed care system, and under-recognition of the fact that some severely mentally ill patients require years of intensive support and services to successfully transition to the community, have resulted in a mental health system that often leaves large numbers of people without sufficient outpatient mental health and substance use services seeking care in emergency departments.

Emergency departments are not designed to meet the needs of these individuals, but we find all too often that patients are boarded in EDs for days, or even weeks at a time searching for an inpatient bed to transfer to. This comes at a significant cost to the patient, staff and ultimately to the system. It is reported that 6-10% of all ED visits are for psychiatric reasons and that these patients have been found to occupy 42% more time in the emergency room than non-psychiatric visits. They result in higher rates of admissions and transfers as well as a higher rate of self-pay or charity pay visits. It is estimated that 21.5% of all psychiatric ED patients are boarded and odds of boarding is nearly 5 times higher than non-psychiatric patients.

Across the country, we are beginning to see psychiatric EDs being created. While services within these settings vary, patients typically have access to consultation and medication management via telehealth, and a social worker to connect them to outpatient services. I propose that the state of Pennsylvania set a higher standard for such settings. I believe that a properly staffed and supported psychiatric emergency department has potential to ultimately divert an inpatient stay. If psychiatric patients had access to consultation and medication management via telehealth, a therapist to process with while in the ED and a social worker to connect them to outpatient services, the time spent boarding in the emergency department has not been a mere consumption of time, space, and money, but has provided therapeutic services that could divert or shorten an inpatient stay, thus ultimately saving money.

Another issue we face is that we are living and working in a very broken system that is particularly difficult to navigate. Sometimes the issue is not simply that we do not have adequate resources to meet the demand, it is also that people do not know how to access the services we do have.

Drawing again from approaches already in practice and recognizing that a significant portion of the population seeking mental health and substance use treatments are a younger group, it seems emphasis on use of technology and maximizing its capacity to collect information, sort data and make algorithmic recommendations makes sense.

There is a program that serves all of Canada called “Wellness Together Canada” that is a technology-based system where an individual can go to a website, input information, answer some questions and the system will connect them to appropriate resources. This considers not only the particulars about the patient, but the resources that can be accessed within their community. I have heard this described as a virtual case manager, and I think it is an incredible way to get information to those in need when we are simultaneously facing a significant work-force shortage. Investment into a system such as this within the state of Pennsylvania would be transformational for those in rural communities seeking care.

Finally, to provide adequate care and resources, there must be attention given to recruitment and retention efforts. In 2016 The National Council for Behavioral Health (now National Council for Mental Wellbeing) reported that more than 60% of our practicing psychiatrists were over the age of 60 and 40% of our practicing psychiatrists were in cash only clinics, thus limiting access to care for individuals that cannot afford a cash-based system of delivery. They reported that the number of psychiatry residency seats was not adequate to replace the number of providers that would be lost to retirement over the next 10-15 years and suggested that we need to look to other professions to fill the gap. One of the professions discussed was my own – looking to Physician Assistants to provide psychiatry services to patients with mental health and substance use disorders.

In the US, there are approximately 10,000 PAs graduating and entering the workforce annually. In 2016, a practice analysis completed by NCCPA, the certifying body for Physician Assistants,

revealed that while only about 1% of certified PAs practice in psychiatry as a specialty, more than 60% see patients with mental health and substance use disorders regularly. At that time, the NCCPA Health Foundation launched a mental health initiative and drew the PA profession together to determine how the profession could increase the number of PAs practicing in psychiatry. Since the start of that initiative, the number of PAs claiming psychiatry as a discipline has more than doubled, but it is still a very small number.

Pennsylvania has the second most PA programs in the US and the third most number of practicing PAs in the country per capita. I believe there is an opportunity here to leverage this situation and incentivize PAs in this state to claim psychiatry as their area of specialty. PAs are trained in the medical model and are therefore uniquely equipped to not only provide mental health and substance use services, but also primary care. The question to answer is this: How do we increase the number of Certified PAs working in psychiatry?

First, there can be discrepancy in reimbursement between physicians and PAs, with reimbursement being sometimes only 80% of the physician rate. Providing reimbursement for services at the same rate that a physician would be reimbursed could incentivize outpatient clinics and facilities to hire more PAs, thus expanding access to care.

Second, offering student loan repayment for those Physician Assistants entering psychiatry may increase awareness among students ready to graduate, or early career PAs that psychiatry is a career option, and it may incentivize them to seek such positions. Loan forgiveness in federally qualified shortage areas is already an option in the field of mental health, however many communities in need do not meet the strict criteria for this designation, and therefore cannot take advantage of loan forgiveness as a recruitment and retention strategy. Allocation of funds for student loan repayment would allow PAs anywhere in Pennsylvania to accept positions in psychiatry, increasing access within communities where employers take advantage of the opportunity.

Third, there was recent legislative action whereby CAQ became a requirement for PAs to be permitted to deliver care via telepsych (HB2419 – became Act 76 of 2022). There is no other requirement for CAQ in any other state or in any other discipline of medicine, and this is not what CAQ was designed for. Additionally, given it is only available in 8 disciplines of medicine, it cannot be standardized and enforced across the profession. This places a heavier burden on PAs that choose psychiatry as a profession and there is no evidence that it improves competency compared to those that practice psychiatry that do not hold the CAQ certification. Removing the CAQ requirement for telepsych would increase the number of PAs able to provide care virtually.

Finally, as a business owner, reimbursement for telepsychiatry services at the same rate as in-person services will be necessary for us to choose to provide access to visits in this way for our patients. There is no incentive for a practice to provide a hybrid approach to visits if there is a discrepancy in payment, as we are already facing challenges related to operational costs. As

legislators consider the benefits of access to care via telemedicine, I encourage them to consider that the cost to deliver the care is still there and not markedly different than when delivering care in person. The pandemic clearly showed that access to telemedicine is a benefit to the patient and to the system. While I believe it is a necessary modality, it must be affordable for clinics to continue to provide. Reduction of rates for virtual visits will likely result in one of two things; clinics not offering telehealth visits to avoid the reduced revenue generation, clinics suffering financial hardship as a result of reduced income related to lower reimbursement.

In addition to recruiting those near entry to the profession, or early in the profession, there are opportunities to begin recruitment as early as middle or high school. One of our professional organizations, The Physician Assistant Education Association (PAEA) has developed Project Access as an outreach recruitment tool to attract and prepare minority students to the PA profession. Efforts such as this could help to develop talented young people interested in a career in medicine and provide access to needed support and resources for them to be successful, and incentives may be offered for them to return to their communities as leaders and care providers.

While the pandemic put a spotlight on mental health and substance use disorder needs, it also raised awareness about the possibilities technology holds for us as we seek to improve methods by which care can be delivered. From a digital case manager to delivery of services, technology can be leveraged to improve overall outcomes. And when we need more than a digital case manager, PAs are one option for improving access to care – whether in an ED, an outpatient psychiatric or substance use disorder clinic, acute or extended care inpatient setting, substance rehabilitation facility, or primary care practice – PAs are well trained, cost-effective and ready to provide care in person or via telemedicine.

Resources

Nordstrom, K. MD, et al. Boarding of Mentally Ill Patients in Emergency Departments: American Psychiatric Association Resource Document. *Western Journal of Emergency Medicine.* 2019. 20(5): 690-695. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6754202/

Kalter, L. Treating Mental Illness in the ED. *AAMC News.* 2019. https://www.aamc.org/news-insights/treating-mental-illness-ed

Zeller, S. Hospital-Level Psychiatric Emergency Department Models. *Psychiatric Times.* 2019. 36(12). https://www.psychiatrictimes.com/view/hospital-level-psychiatric-emergency-department-models

PAEA. Project Access Toolkit. https://paeaonline.org/resources/public-resources/project-access-toolkit