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Thank you for allowing me to offer testimony on how to improve our healthcare system for people with mental illness and addiction. We have all seen the devastation caused by mental illness and addiction to our communities, and likely known someone who has suffered – a family member or friend. Good mental health care and addiction care can prevent suicide and overdose deaths. In the Capital region, Community Health Needs Assessments conducted by Penn State Health along with other health systems in the area have repeatedly identified Behavioral Health as one of the top three needs in the area.

The COVID-19 pandemic has exacerbated the longstanding problem of a shortage of behavioral health professionals to provide desperately-needed mental health care. In addition, there are many barriers to access and it is estimated that less than half of patients referred to a psychiatrist, psychologist, psychotherapist or other behavioral health clinicians will even make the first appointment. According to the ***2022 State of Mental Health in America***, more than half of adults with mental illness do not receive treatment and over 60% of youth with depression do not receive treatment (Reinert, M, Fritze, D. & Nguyen, T. (October 2021). "The State of Mental Health in America 2022" Mental Health America, Alexandria VA.). Part of the barriers to access are due to lack of availability of appointments and care settings. Barriers to care frustrate people wanting help, and healthcare providers who are trying to get people help. When they can't help from within the healthcare system, the healthcare worker suffers moral injury which leads to burnout.

To improve care, we need to promote reaching out into the community to provide that care. We need to make it easy to coordinate across care settings and have easy access of care. Flexibility for providing care arrangements should be tailored to the level of support a patient may need. The care continuum begins in the primary care office with access to psychiatric/psychological/addiction specialty programs when needed. At times of crisis, inpatient and residential care may be needed. The key is that we need to build a health care system in the Commonwealth that provides access at all levels, including care for people at the time they are the most ill.

The COVID-19 pandemic has stressed the health care system and workforce shortages continue to be a challenge for all healthcare organizations in the Commonwealth. That said, structural improvements can be made to our system to improve care. The proposed improvements will provide care that will reach the most people, and by doing so, will assist the workers in our healthcare system to feel that they are able to do the right thing for patients. This helps families and our community, along with reducing moral injury in healthcare workers.

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How do we improve the continuum of care and maximize the reach of our treatments? Mandating payment models that support collaborative and integrated care to include care coordination, peer recovery specialists, tele-education models (ECHO), and alternate care models such as e-consultation and better coverage for existing treatments that maximize reach including group therapies and telehealth.

Collaborative and integrated care are effective, evidence-based methods to provide mental healthcare for depression, anxiety, ADHD and other psychiatric illnesses directly in the comfortable and familiar primary care setting. These models provide screening and brief, focused intervention in primary care settings with connection to specialty care for more complicated cases. **Collaborative and integrated care are incredibly powerful tools which use care coordinators, peer recovery specialists, group treatment and telehealth tools to maximize their reach to the community.**

Collaborative care is a patient-centered, team-based approach consisting of the patient's primary care provider, a behavioral health care manager/therapist/social worker and a psychiatrist consultant working together to provide state-of-the-art mental health care. Collaborative care has shown better patient outcomes, provider and patient satisfaction, and reduced healthcare costs compared to "care as usual" in over 80 randomized controlled trials (Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. Cochrane Database Syst Rev. 2012;10:CD006525.) In our clinics, we have effectively implemented collaborative and integrated care for depression, anxiety and ADHD and have effectively treated patients in primary care while reducing the need for transfer to specialty care and to the Emergency Department. In a study conducted with Highmark, we found that the adult program reduced the total cost of care by 7%.

Collaboration and integration can be effective across health systems. Penn State Health has been pleased to partner with the Commonwealth and other healthcare systems and organizations in two collaborative programs – the **Telephonic Psychiatric Consultation Service Program (TiPS)** and the **Pennsylvania Coordinated Medication Assisted Treatment (PACMAT)** program.

TiPS has been an innovative, effective program implemented by the Commonwealth to provide primary care physicians with support for treating children with psychiatric and behavioral challenges. A primary care physician can have immediate access to a behavioral care coordinator, a therapist and/or a psychiatrist to ask for help when a patient and their family are in the office. The TiPS team has expertise in the resources available in the local area for the physician and the family and can offer a connection to specialty care at a tertiary care center if necessary. The program has now assisted physicians in helping thousands of children, and referrals state-wide to the TIPS program increased dramatically in 2021. (https://www.dhs.pa.gov/providers/Providers/Pages/TiPS.aspx)

The **PacMAT** program has been extraordinarily successful at reaching patients with addiction. In Central Pennsylvania, the Penn State PacMAT program has reached over 3,000 patients and trained 86 providers in how to administer medication-assisted treatment. The key to the Penn State PacMAT program has been the coordination provided by peer-support specialists. By funding two peer recovery specialists, care for the uninsured and underinsured, transportation to and from appointments, training support between hub specialists and spoke providers at primary care sites and emergency departments, and “bridge visits” for individuals initiating MOUD (Medications for Opioid Use Disorder) at the hub and then later moving to a spoke site, Penn State was able to improve treatment retention rates by 55-95% depending on medication type.

The **Project ECHO model** (Extension for Community Healthcare Outcomes: https://ctsi.psu.edu/echo/) has been used successfully by Penn State and others in both the TiPS and PacMAT programs. This tool allows a tele-education program to connect specialists to community clinicians and community health workers to discuss cases and to provide knowledge and support. In contrast to a typical continuing education event, the Project ECHO model has been shown to greatly increase the feeling of camaraderie and professional support for community health workers. In time, the community clinicians and health workers become experts themselves and teach others.

Penn State Health Milton S. Hershey Medical Center has also been a site for the AAMC **e-consultation model** (https://www.aamc.org/what-we-do/mission-areas/health-care/project-core). We have successfully implemented a model to deliver electronic consultation to primary care physicians for certain psychiatric and behavioral health questions. This model allows psychiatric specialists to provide guidance on many more patient care questions than can be provided in a one-on-one office consultation setting. Additionally, the collaboration between psychiatrists and primary care supports continuous learning between the specialties.

Each of these collaborative and integrated care models is a way of supporting patients as they seek help. To ensure the best care is provided, access to specialty care must be available when needed. By supporting **group therapies and provision of telehealth**, expertise can be maximized whether in the outpatient setting, intensive outpatient or partial hospital setting.

Support for Inpatient level care: There is a crisis in Pennsylvania in providing psychiatric beds to patients who are the most ill. These patients are vulnerable to being denied admission to typically-designed psychiatric wards due to fear for safety of patients and health care workers. However, this has led to long wait times for these patients in Emergency Departments and inpatient medical/surgical units. Investment in supporting high-intensity inpatient psychiatric care at a sustainable level is desperately needed. Hospitals cannot fund and staff beds at ICU levels because the reimbursement for that level of care does not cover costs. We need to recognize that ICU level care is needed, and appropriately create units throughout PA that can provide safe, effective, life-saving care. This would be best funded as a supplemental grant to programs that can take some of their beds, make them safe, and increase staffing to the levels needed

The Commonwealth of Pennsylvania has access to world-class psychiatric and behavioral health care. Let's strengthen the system of care in a way that allows for the residents to be the focus. Thank you again for the opportunity to provide testimony on this very important and timely issue. I'd be happy to address any questions.