PennState Health

House Human Services Committee
Public Hearing – Mental Health and the Impacts of the COVID-19 Pandemic
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Good morning Chairman Murt, Chairman Cruz, and members of the House Human Services Committee. Thank you for allowing me to testify today.

As we are sitting here today, over 100,000 Pennsylvanians have fallen ill with the Coronavirus and over 7,000 have passed away. Along with the tragedy of deaths directly attributable to the coronavirus, additional tragedies are unfolding since our world has been changed in early March. The impact on people with mental illness, addiction and intellectual disabilities has been profound due to disruption in services and community social supports. The stress on our workers in front-line industries like food service, transportation, public safety, and health care has created a second epidemic of distress and despair.

Mental illness and addiction were at epidemic proportions in Pennsylvania prior to the start of COVID-19. One in five Pennsylvanians is affected by mental illness every year. Chances are, that every person in this room has a family member, loved one or friend affected by mental illness or addiction. I have. I have seen the devastation caused by mental illness and addiction on a personal as well as professional level, including the impact on families, generation after generation, the ravages of addiction and trauma, families torn apart, the despair caused by loss to suicide, and un-treated illness leading to early death.

One of the most tragic consequences of mental illness is death by suicide. Ninety percent of people who die by suicide have a mental illness. The suicide rate in Dauphin County and surrounding counties increased by 25% in 10 years, and 20-25% in the Commonwealth. Suicide is the 11th leading cause of death in the Commonwealth.

In addition, during the pandemic, overdose deaths are rising across America and in Pennsylvania. In many counties that had seen falling numbers of overdose deaths, the isolation and strain of the past 5 months have taken its toll.

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 region.

We can treat mental illness. Mental illness and addiction are brain illnesses. Because the brain is the affected organ, mental illness and addiction affects how we think, act, feel and communicate. It affects every aspect of life. However, we have many effective treatments that can be delivered safely.

Mental illness can affect people at any time in their life, however, many illnesses start during adolescent and young adult life. By intervening and treating during this time, we can help young people continue their education, enter the workforce, build loving and stable families and provide innumerable benefits to us all. By treating the elderly when mental illness strikes later in life, we can improve the ability of our older generation to give back to their families, friends and the community.

So, we have started with the significant issue of addressing mental health in the Commonwealth even prior to COVID-19. How has COVID-19 affected us?

- People engaged in psychiatric, mental health and addiction care have had more trouble accessing care.
- Social supports have been less available, leading to social isolation, homelessness, and food insecurity.
- Fear has kept people from accessing the medical treatment that they need.
- The stress of the pandemic has caused front-line workers and their loved ones to have immense amounts of stress that have exacerbated mental illness and addiction.

We are just starting to see the impacts which will be with us for years to come.

How have we responded to the crisis and kept treating the people who need us?

As the pandemic started in March and it became clear that we needed to close ambulatory psychiatric and addiction clinics to reduce spread, we launched a program of telehealth. We were able to transition about three-quarters of our visits quickly to a telehealth platform. We swiftly heard good feedback – people were extremely grateful to be able to connect with their treatment team while staying safe at home. After a few weeks, gratitude was intermingled with the stress of staying at home and the growing impact of isolation and loss of community support.

Let me tell you about some of the patients I have talked to or seen recently:

- A woman in her 60's with renal failure, high blood pressure and severe bipolar disorder who lives over an hour away from clinic. She was afraid to come to our office for usual in-person appointments because she is at risk of severe illness if she contracts COVID-19. She had been doing well, but became depressed in early April, at least partially because she couldn't engage in her usual social activities. Because of the telehealth waiver, we were able to see her for her March and April visits by telephone, and have alternated with in-person visits because our clinic has the ability to provide enough space and supplies for good infection prevention practices. We have adjusted her medication and she is feeling better.
    - We are only able to practice good infection prevention because about 60% of our patients are still being seen remotely through telehealth.

- A young mother with school-aged children who became depressed, in part due to the stress of having family members who were front-line health-care workers caring for COVID patients. She required a stay in the hospital to prevent death by suicide. We were able to provide intensive after-care by telehealth.

- Anonymous feedback from a patient: "The virtual visit was a godsend... we live very rural and its 60 miles one way to the clinic. Being spared that drive time was wonderful. My son (the patient) is autistic and doesn't always travel well. I know this virtual visit was because of the pandemic, but if we could do a virtual visit even just one out of every four visits it would be fantastic!!"

However, even with telehealth, the more severe illnesses require in-hospital treatment that can still be hard to access. For example, a teenaged boy with autism spectrum disorder and agitation who needs to be in a safe setting. He was unable to get into a psychiatric hospital for 5 days and was in the Emergency Department during that time because going home was unsafe for him and his family. His care was delayed and illness worsened during that time.

We are both faced and facing exacerbations of the problems that plague our mental health care system before COVID, including lack of care due to closure of clinics, closure of crisis services, lack of access to hospital beds. In addition, fear is keeping people away of needed in-person services. The telehealth waiver has been enormously helpful, however we still struggle because many patients do not have access to the technology or internet/cellular service to use technology for telehealth; and COVID has caused worsened problems with access to inpatient care for the most severely ill.

What else have we used to assist patients during this time? We have launched tele-educational efforts for providers to learn how to treat patients with COVID-19 and mental illness using the ECHO (Extension for Community Healthcare Outcomes) platform. We have used the Pennsylvania Coordinated Medication-Assisted Treatment Program (PACMAT) to continue connecting patients with opioid use disorder with treatment, and the PA Autism ASERT group has put out web-based programs such as how to help people with autism spectrum disorder to be comfortable wearing masks.

What will we need to continue to provide excellent person-centered mental health and addiction care to the residents of the Commonwealth?

We need flexibility to provide the right care to the right person in the right way at the right time:

We suggest continuing the ability to practice telehealth as is currently provided under the waiver for emergency declaration. This will include:

- Safe and accessible care -- We need to be able to provide care in a safe and accessible way for all people who seek it, and we need to have the flexibility to provide that care in the best way for them. Requiring people and their families to travel long distances to a site when care can be delivered through televideo or telephone does not benefit anyone. This includes removing limitations around originating site and geographical restrictions for mental health services.
- Providing comprehensive care: Include all services on the expanded Medicare-approved telehealth list, including group psychotherapy.

- Supporting the ability of providers to deliver care: Maintain coverage of and increased payment for telephone evaluation and management (E/M) services that matches reimbursement for traditional outpatient E/M services that may be provided in-person or via telehealth. Maintain payment structures that allow support of infrastructure and staff needed to provide telehealth. This may include allowing hospitals to bill a facility fee when the patient is an established patient of an outpatient department and receives the service at their home via telehealth.
- Allow for the use of audio-only (telephone) communications for E/M and behavioral health services, including care for opioid use disorders, when it is in the patient's best interest. In addition, reimbursement for audio-only care should be no less than what was established during the emergency. This is vital for situations in which people are unable to come to the office.
- Remove frequency limitations for existing telehealth services in inpatient settings and nursing facilities.
- Allow teaching physicians to provide direct supervision of medical residents remotely through telehealth.
- State Licensure/Practitioner Locations: Remove Medicare and Medicaid requirements that physicians and non-physician practitioners be licensed in the state where they are providing telehealth services to allow payment across state lines. This becomes increasingly important in the era of travel restrictions for the pandemic, and as patients travel to care for loved ones who are ill.
- Payment for telehealth services in rural health clinics and federally qualified health clinics: Paying for telehealth services provided by rural health clinics and federally qualified health clinics, Medicare beneficiaries will have more options to access care from their home.
- Supporting mental health care for patients in primary care offices. The integration of mental and physical health care for low-complexity and common illnesses provides for the best outcomes for patients and families.

We need to protect our most vulnerable residents with the most severe psychiatric illnesses and those in crisis:

- We need increased funding for county crisis teams. COVID has impeded our county crisis teams – we need to identify how crisis care can be safely delivered during the pandemic. County crisis teams are a backbone of how we provide excellent care in Pennsylvania and need to have the resources to reach patients in their time of need.
- We need uniform interpretation of the Mental Health Procedures Act, especially around committing patients for care when they are a danger to themselves or others and they don't recognize that they need help. Lack of uniform commitment proceedings across the state fragments care and puts the patient at the center of a struggle between counties, physicians, and doing what is right. This has been exacerbated during COVID and remains a significant challenge that affects patients and families in the most difficult of times - when there is a mental health crisis and families, providers, friends are trying to prevent a person from dying from their psychiatric illness.
- We need housing for our severely and persistently mentally ill population. Homelessness is the fastest way to create a cascade and spiral of events and situations that dramatically worsens health and wellbeing.

We need a larger workforce with more qualified psychiatrists in the state:

The Commonwealth of Pennsylvania is home to several world-class medical schools, hospitals and health systems that are at the cutting edge of providing the best medicine, discovering new treatments and innovations to improve health care. We have 13 graduate training programs for psychiatry in the Commonwealth of Pennsylvania. The fastest way to grow our psychiatry workforce is to invest in the training of psychiatrists. By investing in training good psychiatrists, you can prevent the consequences of severe psychiatric and addictive illnesses, including suicide, premature death, the destruction of families, the destruction of lives, and the lost productivity in the workplace.

- What can we do?
    - Fund graduate training spots in psychiatric training programs.
    - Create a robust loan forgiveness program for psychiatrists who continue to serve the Commonwealth after graduation.

When people are at their most ill, we need to have a way to treat them:

This is especially true for psychiatric patients with medical illness and patients with aggression that cannot be handled in a typically-designed psychiatric ward. Currently, patients who are denied from psychiatric hospitals because of medical illness or aggression end up staying in the Emergency Department for multiple days at a time, and in hospital wards when they need specialized psychiatric care. In these settings, they are treated by medical teams who may or may not have access to psychiatric/behavioral health specialty expertise. In the best of settings, the ability of the psychiatric/behavioral health team to provide support is much too limited. The goal in these settings is to keep the patients (and staff) safe, but not to truly heal the patients. Why can't we design settings for the most severely ill psychiatric patients? The barrier remains the cost of care. The cost of setting up a medical psychiatric unit or intensive psychiatric hospital unit is a barrier that is too high for most healthcare settings. This leaves our most vulnerable patients in settings where they cannot receive intensive care from a specialty team of interdisciplinary professionals.

- What can we do? Fund medical psychiatry units and intensive care psychiatry units at a rate that can support the infrastructure and staff needed to provide safe, effective and life-saving care.

In short, the Commonwealth of Pennsylvania has access to world-class psychiatric and behavioral health care. The challenge is to strengthen the systems of care in a way that allows for the residents who need care to be the focus.