

JOINT STATE GOVERNMENT COMMISSION

General Assembly of the Commonwealth of Pennsylvania

PENNSYLVANIA MENTAL HEALTH CARE WORKFORCE SHORTAGE: CHALLENGES AND SOLUTIONS

A STAFF STUDY

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REPORT

Pennsylvania Mental Health Care Workforce Shortage: Challenges and Solutions

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The Joint State Government Commission was created in 1937 as the primary and central non-partisan, bicameral research and policy development agency for the General Assembly of Pennsylvania.¹

A fourteen-member Executive Committee comprised of the leadership of both the House of Representatives and the Senate oversees the Commission. The seven Executive Committee members from the House of Representatives are the Speaker, the Majority and Minority Leaders, the Majority and Minority Whips, and the Majority and Minority Caucus Chairs. The seven Executive Committee members from the Senate are the President Pro Tempore, the Majority and Minority Leaders, the Majority and Minority Whips, and the Majority and Minority Caucus Chairs. By statute, the Executive Committee selects a chairman of the Commission from among the members of the General Assembly. Historically, the Executive Committee has also selected a Vice-Chair or Treasurer, or both, for the Commission.

The studies conducted by the Commission are authorized by statute or by a simple or joint resolution. In general, the Commission has the power to conduct investigations, study issues, and gather information as directed by the General Assembly. The Commission provides in-depth research on a variety of topics, crafts recommendations to improve public policy and statutory law, and works closely with legislators and their staff.

A Commission study may involve the appointment of a legislative task force, composed of a specified number of legislators from the House of Representatives or the Senate, or both, as set forth in the enabling statute or resolution. In addition to following the progress of a particular study, the principal role of a task force is to determine whether to authorize the publication of any report resulting from the study and the introduction of any proposed legislation contained in the report. However, task force authorization does not necessarily reflect endorsement of all the findings and recommendations contained in a report.

Some studies involve an appointed advisory committee of professionals or interested parties from across the Commonwealth with expertise in a particular topic; others are managed exclusively by Commission staff with the informal involvement of representatives of those entities that can provide insight and information regarding the particular topic. When a study involves an advisory committee, the Commission seeks consensus among the members.² Although an advisory committee member may represent a particular department, agency, association, or group, such representation does not necessarily reflect the endorsement of the department, agency, association, or group of all the findings and recommendations contained in a study report.

¹ Act of July 1, 1937 (P.L.2460, No.459); 46 P.S. §§ 65–69.

² Consensus does not necessarily reflect unanimity among the advisory committee members on each individual policy or legislative recommendation. At a minimum, it reflects the views of a substantial majority of the advisory committee, gained after lengthy review and discussion.

Over the years, nearly one thousand individuals from across the Commonwealth have served as members of the Commission's numerous advisory committees or have assisted the Commission with its studies. Members of advisory committees bring a wide range of knowledge and experience to deliberations involving a particular study. Individuals from countless backgrounds have contributed to the work of the Commission, such as attorneys, judges, professors and other educators, state and local officials, physicians and other health care professionals, business and community leaders, service providers, administrators and other professionals, law enforcement personnel, and concerned citizens. In addition, members of advisory committees donate their time to serve the public good; they are not compensated for their service as members. Consequently, the Commonwealth receives the financial benefit of such volunteerism, along with their shared expertise in developing statutory language and public policy recommendations to improve the law in Pennsylvania.

The Commission periodically reports its findings and recommendations, along with any proposed legislation, to the General Assembly. Certain studies have specific timelines for the publication of a report, as in the case of a discrete or timely topic; other studies, given their complex or considerable nature, are ongoing and involve the publication of periodic reports. Completion of a study, or a particular aspect of an ongoing study, generally results in the publication of a report setting forth background material, policy recommendations, and proposed legislation. However, the release of a report by the Commission does not necessarily reflect the endorsement by the members of the Executive Committee, or the Chair or Vice-Chair of the Commission, of all the findings, recommendations, or conclusions contained in the report. A report containing proposed legislation may also contain official comments, which may be used to construe or apply its provisions.³

Since its inception, the Commission has published almost 400 reports on a sweeping range of topics, including administrative law and procedure; agriculture; athletics and sports; banks and banking; commerce and trade; the commercial code; crimes and offenses; decedents, estates, and fiduciaries; detectives and private police; domestic relations; education; elections; eminent domain; environmental resources; escheats; fish; forests, waters, and state parks; game; health and safety; historical sites and museums; insolvency and assignments; insurance; the judiciary and judicial procedure; labor; law and justice; the legislature; liquor; mechanics' liens; mental health; military affairs; mines and mining; municipalities; prisons and parole; procurement; state-licensed professions and occupations; public utilities; public welfare; real and personal property; state government; taxation and fiscal affairs; transportation; vehicles; and workers' compensation.

Following the completion of a report, subsequent action on the part of the Commission may be required, and, as necessary, the Commission will draft legislation and statutory amendments, update research, track legislation through the legislative process, attend hearings, and answer questions from legislators, legislative staff, interest groups, and constituents.

³ 1 Pa.C.S. § 1939.



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To the Members of the General Assembly of Pennsylvania:

Pursuant to 2019 House Resolution 193 (Pr.'s No. 1814), we are pleased to release *Pennsylvania Mental Health Care Workforce Shortage: Challenges and Solutions*. HR193 directed the Commission to conduct a staff study of the shortage of mental health care professionals in the commonwealth. The report includes a comprehensive discussion of the different occupations that are parts of the workforce. It provides in-depth examinations of the factors that led to the current shortages across each of these fields. The report presents recommendations for the General Assembly to consider as potential solutions for the shortages.

This is the fourth report that the Commission has released on health care shortages in *Pennsylvania*. *Professional Bedside Nursing in Pennsylvania*, *The Physician Shortage in Pennsylvania*, *Pennsylvania Health Care Workforce Needs*, and this report are available on our website at: <http://jsg.legis.state.pa.us>.

Respectfully submitted,

Glenn J. Pasewicz
Executive Director

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INTRODUCTION

Within the Commonwealth and the entire nation, policy makers, professional organizations, and health care providers are taking notice of a peculiar trend. Although the demand for mental health treatment is on an upward trajectory, there is an apparent paucity of mental health care providers. This observation is backed by some worrying data.

According to data identified in House Resolution 193 of 2019 (HR 193), more than half of adults suffering from a mental illness in the Commonwealth did not receive treatment as of 2017. The Commonwealth has a below-average number of mental health care providers per capita, and given that a large percentage of its residents are 65 of age or older, the lack of adequate mental health care providers has impacted this group disproportionately, with roughly two-thirds of older adults in Pennsylvania not able to receive appropriate treatment. Further, this trend is only continuing, as both the Commonwealth's population and the mental health care workforce increases in average age.⁴

In light of the circumstances identified above, HR 193 directed the Joint State Government Commission (the Commission) to prepare a report, that at minimum:

- (1) Identifies the factors behind the mental health care provider shortage within the Commonwealth;
- (2) Makes projections on the number of mental health care providers in Pennsylvania in five and ten years;
- (3) Determines how telemedicine can be used to extend the mental health care workforce in rural communities;
- (4) Determines how state government entities can encourage more individuals to enter and remain in the mental health care workforce; and
- (5) Makes recommendations regarding the disparity in the number of mental health care providers in rural counties compared to urban and suburban counties, along with any other recommendations to address the mental health care provider shortage in the Commonwealth.⁵

⁴ House Resolution 193 of 2019.

⁵ *Id.*

In response to the directives of House Resolution 193, the Commission has prepared this report, which begins by identifying those professionals who fall within the scope of the Commonwealth’s “mental health care workforce.” The report then discusses the current state of this workforce, utilizing data from the Health Resources and Services Administration and the Bureau of Labor Statistics — federal agencies which collect data on the health care workforce — as well as other sources. The Commission also analyzed data from these sources to project employment in certain professions within the Commonwealth’s mental health care workforce five and ten years from calendar year 2020.

The report also addresses the issues believed by researchers, academics, and clinicians to be behind the shortage of mental health care professionals. These include the impact of burnout experienced by mental health care professionals, student loan debt as a barrier to new entrants in the health care professions (particularly in psychiatry and psychology), a lack of training sites and faculty necessary to increase the number of mental health care professionals in the workforce, lower rates of reimbursement and a lack of parity of insurance coverage for mental health issues (which may drive practitioners away from their field), and restrictive regulations impeding the sharing of clinical information between health care providers.

In addition, the report also discusses solutions and proposes recommendations to stop, reverse, or otherwise mitigate the shortage of mental health care professionals in the Commonwealth. These solutions include creating new psychiatric residency programs and positions, increasing the use of psychiatric advance practice nurses and psychiatric physician assistants, including undertaking reforms to support nurse-managed health centers and designate more facilities as federally certified Rural Health Clinics. Further, this report recommends easing the burden of student loan debt on new graduates in psychiatry, psychology, and allied health fields by increasing awards made under the Commonwealth’s student loan repayment program as well as holding down tuition at state-owned and state-related universities and colleges. The report also recommends undertaking reforms to allow wider use of telemedicine and telepsychiatry.

Summary of Recommendations

The following is a brief summation of the Commission’s recommendations. A more detailed explanation of these recommendations can be found in Solutions and Recommendations, beginning on page 93.

Encourage the Use of Integrated Care Models

Integrated care is essentially having mental health care practitioners providing care in the same setting as primary care physicians, such that a patient can consult both practitioners in one visit. Integrated care models are an ideal way to increase access to mental health care, as primary care settings are often the first place people seek help for mental health problems.

Integrated care models have been shown to be effective at increasing access to mental health services, but a stumbling block to wider adaptation of integrated care models has been financial reimbursement. Providers need predictable ways to cover start-up and operational costs, as well as technical and institutional support that helps their practices change how the health care providers work.

The General Assembly should consider providing tax incentives to any health system, provider, or insurance company which begins providing (or begins reimbursing for) integrated medical and mental health services. Additionally, because many of those who would benefit most from an integrated care model are Medicaid or Medicare recipients, the General Assembly should direct the Department of Human Services to study participation in the federal Centers for Medicaid and Medicare Services Health Homes Model.

Encourage the Use of Certified Registered Nurse Practitioners and Physician Assistants

Building on the Commission's recommendation from the 2019 report *Pennsylvania Health Care Workforce Needs* to give greater autonomy to the health care teams employing nurse practitioners and physician assistants to determine the scope of their practice, the Commission recommends that regulations which may restrict the use of PAs or NPs be either eliminated or amended to better facilitate the provision of care.

It is recommended that to encourage better use of the Commonwealth's nurse-managed health clinics, and to promote the inclusion of nurse practitioners and physician assistants on health care delivery teams more generally, the General Assembly should consider enacting "any willing provider" legislation. Such legislation generally prohibits insurance carriers from limiting membership within their provider network and have been used by other states to expand private insurance reimbursement to providers such as nurse practitioners and physician assistants.

Further, the General Assembly should consider allowing Psychiatric-Mental Health nurse practitioners to conduct psychiatric evaluations of patients on Medical Assistance — the Commonwealth's term for Medicaid — so long as the collaboration agreement with a supervising psychiatrist allows it and the supervising psychiatrist reviews the evaluation. Currently, applicable regulations state that only psychiatrists may conduct an evaluation of a patient receiving Medical Assistance.

Additionally, to make better use of available federal resources, the Department of Health should consider working with providers to determine whether they would benefit from becoming federally certified as a Rural Health Clinic.

Develop Additional Psychiatric Residency Positions

In the Commission's 2019 report *Pennsylvania Health Care Workforce Needs*, it was recommended that the Pennsylvania Department of Health and other governmental bodies of the Commonwealth should make a concerted effort to expand residencies within Pennsylvania. The Commission reiterates that recommendation here as it relates to psychiatric residencies. Although the number of psychiatric residencies both in the Commonwealth and nationally have increased in

the past decade, one of the impediments to obtaining psychiatric care is the geographical distribution of psychiatrists across the Commonwealth. Pennsylvania's psychiatric residencies are clustered in five geographic areas and the future employment of the psychiatric residents is usually linked to those geographic areas once they complete their training.

In order to better provide psychiatric care to underserved areas — and particularly rural areas where there may be few providers — it may be necessary to establish more psychiatric residencies in these communities. To that end, it is recommended that the General Assembly should direct the Department of Health to invest in psychiatric residencies in rural areas by providing the up-front costs of starting a residency program to facilities willing and able to accommodate such a program.

Increase Funding and Availability of Tuition Repayment Programs and Consider Limiting Increases in Tuition at Pennsylvania State System of Higher Education Schools

Another recommendation from the Commission's 2019 report *Pennsylvania Health Care Workforce Needs* reiterated here is to increase the number of awards made under the Commonwealth's Primary Care Loan Repayment Program as well as to increase the amount of each award in order to account for the recent and rapid rise in tuition.

Further, it is recommended that the General Assembly implement policies to hold down tuition at the fourteen state owned and operated institutions of higher education that compose the Pennsylvania State System of Higher Education (PASSHE). This should be done via an amendment to Article XX-a of the Public School Code of 1949. An amendment to this provision could provide, for instance, that future tuition increases be limited to an increase in the U.S. Bureau of Labor Statistic's Consumer Price Index (CPI). The General Assembly could alternatively (or additionally) condition any future funding increases from the state budget on tuition freezes or rollbacks.

Encourage Educational Institutions to Recruit Students from Communities That Are Underserved

Researchers who have studied the issue of geographic maldistribution in health care systems have generally concluded that students who are drawn from rural or urban underserved communities are more likely to return to those communities once they finish their education and enter the health care workforce. Building on a recommendation from the Commission's 2019 report *Pennsylvania's Health Care Workforce Needs*, it is recommended that the Commonwealth implement a more formal statewide "pipeline" program to introduce high school students from these underserved communities to educational opportunities leading to careers in the medical profession.

Whether it is done through a formal state-sponsored pipeline program, increased grant funding to existing programs, or other policies, the Commonwealth should incentivize educational institutions to recruit from both rural and urban underserved populations.

Encourage the Use of Telepsychiatry

Telemedicine has the ability to improve access to health care in the Commonwealth — especially in rural regions — because it eliminates many of the common access barriers found in underserved areas. An impediment to wider adoption of telepsychiatry is the reluctance of insurers to pay the same rate for telepsychiatry services as for in-person services. It is therefore recommended that the General Assembly prohibit the exclusion of a health care service provided through telemedicine if the insurer reimburses the same participating provider for the same service through an in-person encounter. Further, the rate paid for in-person consultations and telepsychiatry consultations should be equivalent. Providing parity of payment for telepsychiatry services has the potential to encourage skilled mental health practitioners to provide telepsychiatry services in the Commonwealth, as it would provide confidence that they will receive the same compensation for telepsychiatry services as they would receive for in-person visits.

DEFINING PENNSYLVANIA'S MENTAL HEALTH CARE WORKFORCE

Before addressing the issues that have resulted in a shortage of mental health care professionals, it is first necessary to determine which professionals and para-professionals constitute the Commonwealth's mental health care workforce. House Resolution 193 of 2019 is the starting point for this definition, identifying psychiatrists, psychologists, marriage and family therapists, licensed clinical social workers, and professional counselors as mental health care professions to address. However, the Resolution is not limited to those professions. To better identify other roles within the mental health care workforce, Commission staff consulted a number of other federal and state resources to further define the scope of Pennsylvania's mental health care workforce.

U.S. Department of Labor, Bureau of Labor Statistics

Among other econometric responsibilities, the U.S. Bureau of Labor Statistics (BLS) collects, analyzes, organizes, and publishes information on various occupations and their requisite education as well as their compensation and projected outlook. This information is published online in the BLS' Occupational Outlook Handbook,⁶ which breaks down specific occupations into various occupation groups. Several mental health care occupations are featured in the "Healthcare" occupation group. These occupations include psychiatric technicians and aides, nurse practitioners, registered nurses, pharmacists, physician assistants, and physicians and surgeons.⁷ However, several other mental health occupations are in the "Community and Social Service" group or the "Life, Physical, and Social Science" group. The above-mentioned occupations are not further broken down by specialty. For instance, psychiatrists, which are a specialty subcategory of "physicians and surgeons," are not mentioned separately. However, the BLS does count psychiatrists separately in its Occupational Employment Statistics.

U.S. Department of Health and Human Services

The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, conducts analyses of the mental health and substance abuse disorder workforce. The HRSA also conducts national-level workforce projections for the mental health care workforce for addiction counselors, marriage and family therapists, mental health and school counselors, psychiatric technicians and aides, psychiatric nurse practitioners and

⁶ U.S. Department of Labor, Bureau of Labor Statistics, "Home," *Occupational Outlook Handbook*.
<https://www.bls.gov/ooh/>.

⁷ U.S. Department of Labor, Bureau of Labor Statistics, "Healthcare," *Occupational Outlook Handbook*.
<https://www.bls.gov/ooh/healthcare/home.htm>.

psychiatric physician assistants, psychiatrists, psychologists, and social workers.⁸ In the view of the HRSA, these are the professions which constitute the nation’s mental health care workforce.

Pennsylvania Department of State

The Pennsylvania Department of State (DOS) is responsible for providing administrative, logistical, and legal support to the various professional and occupational licensing boards and commissions within the Commonwealth. It oversees the licensure of nurses (including nurse practitioners), psychiatrists (through both the Board of Medicine and the Board of Osteopathic Medicine), pharmacists, psychologists, licensed clinical social workers, marriage and family therapists, and professional counselors.⁹ Although the DOS does not provide a definition of the “mental health care workforce” or attempt to categorize certain professions as belonging to the mental health care workforce, through its regulation and licensing of some mental health care providers it shapes and delimits the scope of each role, and is discussed in greater detail in the section discussing the current state of Pennsylvania’s mental health care workforce beginning on page 13.

National Alliance on Mental Illness

The National Alliance on Mental Illness (NAMI) is a nationwide grassroots mental health advocacy organization that works to raise awareness of mental health issues, educate the public regarding mental health, and advocate for those suffering from mental illness.¹⁰ NAMI considers the following to be mental health care professionals: psychologists; licensed professional counselors; licensed marriage and family therapists; licensed clinical alcohol and drug abuse counselors; psychiatrists; psychiatric nurse practitioners; primary care physicians; family nurse practitioners; psychiatric pharmacists; certified peer specialists; social workers; and pastoral counselors.¹¹

NAMI’s categorization includes practitioners who may see mental health patients but who do not work primarily or exclusively with mental health issues. For instance, a primary care physician or family medicine physician may have patients who have mental health diagnoses, but he or she would typically see patients for their general health concerns. These professionals include family physicians, family nurse practitioners, and social workers. NAMI also includes more informal resources such as peer counselors and priests or pastors.¹²

⁸ U.S. Department of Health and Human Services, Health Resources and Services Administration, “Behavioral Health Workforce Projections.” <https://bhw.hrsa.gov/health-workforce-analysis/research/projections/behavioral-health-workforce-projections>.

⁹ See Pennsylvania Department of State, “Boards & Commissions.”

<https://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Pages/default.aspx>.

¹⁰ National Alliance on Mental Illness, “About NAMI.” <https://www.nami.org/About-NAMI>.

¹¹ National Alliance on Mental Illness, “Types of Mental Health Professionals, (Apr. 2019).

<https://www.nami.org/Learn-More/Treatment/Mental-Health-Care-Professionals>.

¹² *Id.*

Mental Health America

Mental Health America (MHA) is a “community-based nonprofit dedicated to addressing the needs of those living with mental illness and to promoting the overall mental health of all Americans.”¹³ MHA defines the mental health workforce as including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in mental health care. It includes mental health providers that treat alcohol and drug abuse in its definition.¹⁴ As its source, MHA cites *County Health Rankings*, a website run by the non-profit Robert Wood Johnson Foundation, which in turn cites data collected by the Centers for Medicare and Medicaid Services.

World Health Organization

The World Health Organization (WHO), an agency of the United Nations working on international public health, categorizes the mental health workforce by working environment rather than job title, duties, or function within the mental health care system. One environment is mental health services which are integrated into the general health system, which can be broadly described as those professionals in primary care and general hospitals.¹⁵ The services offered in these settings includes those provided by general practitioners, nurses, and other staff in primary care clinics.¹⁶

The second environment identified by the WHO are formal and informal community mental health services, which include rehabilitation services, hospital diversion programs, mobile crisis teams, and therapeutic and residential services. These services work best when they are closely linked to primary care services, general hospitals, and mental hospitals.¹⁷ The last environment identified is “institutional mental health services.” This would encompass what would traditionally be viewed as core mental health providers, including outpatient clinics, inpatient mental facilities, and dedicated mental hospitals which provide long-term residence.¹⁸

Other Sources

The Probate, Estates, and Fiduciaries Code contains a provision statutorily defining “mental health care provider” as “[a] person who is licensed, certified or otherwise authorized by the laws of this Commonwealth to administer or provide mental health care in the ordinary course of business or practice of a profession.”¹⁹ This definition contemplates a narrower scope for “mental health care provider” by limiting this categorization to those health care providers who render mental health care as part of their ordinary course of practice, as opposed to family physicians or general practitioners, EMT staff, or emergency room staff.

¹³ Mental Health America, “Who We Are.” <https://www.mentalhealthamerica.net/who-we-are>.

¹⁴ Mental Health America, “Mental Health in America – Glossary and Citations.” <https://www.mentalhealthamerica.net/issues/mental-health-america-glossary-and-citations>.

¹⁵ World Health Organization, “Organization of Services for Mental Health,” (2003), p. 2. https://www.who.int/mental_health/policy/services/4_organisation%20services_WEB_07.pdf.

¹⁶ *Id.*

¹⁷ *Id.* at p. 3.

¹⁸ *Id.* at p. 4.

¹⁹ 20 Pa. C.S.A. § 5802.

The Probate, Estates, and Fiduciaries Code also further defines “mental health treatment professional” as “[a] licensed physician who has successfully completed a residency program in psychiatry or a person trained and licensed in social work, psychology or nursing who has a graduate degree and clinical experience in mental health.”²⁰ This term is narrower than, and encompassed within, the description of a “mental health care provider.”

The Probate, Estates, and Fiduciaries Code contains definitions for “mental health care provider” and “mental health treatment professional” because of provisions in the statute governing mental health care powers of attorney and mental health declarations in documents governing trusts and estates.

The mental health care workforce includes many specialty or sub-specialty roles within other health care occupations. Examples of these include psychiatric registered nurses, psychiatric nurse practitioners, psychiatric physician assistants, and board-certified psychiatric pharmacists. Psychiatrists are a specialty type of physician, and within the field of psychiatry there are sub-specialties such as child and adolescent psychiatry and geriatric psychiatry. The Probate, Estates, and Fiduciaries Code’s definition of “mental health care provider” operates according to the type of health care delivered to patients and recognizes the specialty nature of the mental health care workforce.

The federal government also provides a definition of the mental health care workforce. Within regulations governing the Department of Health and Human Services, “mental health practitioner” is defined as “a mental health professional who, by virtue of education, credentials, and experience, is permitted by law to evaluate and care for patients within the scope of his or her professional practice.”²¹ In this definition, the mental health care workforce consists of any health care workers who are permitted and able to diagnose or treat mental health conditions. This definition is not limited to the HHS, as it is also found in the federal regulations governing standards for providing health care in adult prisons and jails.²²

Scope of “Mental Health Care Workforce” For Purposes of This Report

Although there is not one definitive list of the professions that constitute the mental health care workforce, the definition found in the Probate, Estates, and Fiduciaries Code is the most fitting, as it defines the mental health workforce by reference to whether the health care professional provides mental health care as a regular part of their practice. Other health care professionals, who may from time to time render mental health care or have patients presenting with mental illness but are nonetheless not exclusively or predominately treating mental health issues, are outside the scope of this report. While their contributions to healthcare in the Commonwealth are undeniable, such practitioners are outside of the core of what constitutes the mental health care workforce. Where appropriate, their role within certain aspects of the mental health care field will be touched upon throughout this report.

²⁰ *Id.*

²¹ 45 CFR § 411.5.

²² 28 CFR § 115.5.

The professions that will be considered as part of the Commonwealth's mental health care workforce are:

- Psychiatrists
- Psychologists
- Social Workers
 - Licensed Social Worker
 - Licensed Clinical Social Worker
 - Licensed Bachelor Social Workers
- Counselors
 - Marriage and Family Therapists
 - Licensed Professional Counselors
 - School Counselors
- Nurses
 - Psychiatric Registered Nurses
 - Psychiatric Advanced Practice Nurses (Nurse Practitioners)
- Pharmacists
 - Board-Certified Psychiatric Pharmacists

CURRENT STATE OF PENNSYLVANIA'S MENTAL HEALTH CARE WORKFORCE

National Trend

An alarming trend has rapidly made its way across the American health landscape — the rise in demand for mental health care services in the midst of a largely static, and in some cases, diminishing mental health provider workforce. Reinforcing the existence of the rise in demand for mental health services is the fact that nearly one in five U.S. adults aged 18 years and older (roughly 46.6 million individuals) live with a mental illness.²³ This figure is an increase from a 2015 U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) estimate of 43.4 million adults.²⁴ Inadequate supply of mental health professionals to meet this rise in demand is evidenced by national projections from 2016 indicating that the supply of workers in selected behavioral health professions could be approximately 250,000 workers short of the 2025 projected demand for such services.²⁵ A dearth in the supply of mental health professionals could signal trouble ahead, considering that the *Journal of the American Medical Association* reported in 2015 that the disease burden (the impact of a health problem as measured by financial cost, death rates, disability, and other measures) of mental health and substance use disorders was higher than that of any other health condition in the U.S.²⁶

The rising shortage of mental health professionals is most acute in America's rural regions. A 2018 study found that about 27 percent of metropolitan counties lacked a single psychiatrist, compared with 65 percent of non-metropolitan counties.²⁷ Moreover, the same study found that about 19 percent of metropolitan counties lacked a psychologist, compared with 47 percent of non-

²³ National Institute of Mental Health (NAMI), "Mental Illness," (Feb. 2019), https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part_154785.

²⁴ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, "Key Substance Use and Mental Health Indicators in the United States: Results from the 2015 National Survey on Drug Use and Health," HHS Publication No. SMA16-4984, NSDUH Series H-51, (Sept. 2016), p. 2, [https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015.pdf](https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.pdf).

²⁵ David Levine, "What's the Answer to the Shortage of Mental Health Care Providers?" *U.S. News & World Report*, (May 25, 2018) *citing* U.S. Department of Health and Human Services, Health Resources and Services Administration, "National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025," (Nov. 2016), pp. 19-20, <https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/behavioral-health2013-2025.pdf>. This figure appears to include professions such as school counselors, substance abuse counselors, and social workers in addition to mental health practitioners in psychiatry, psychology, and nursing.

²⁶ Cynthia Cox and Bradley Sawyer, "What Do We Know about the Burden of Disease in the U.S.?" Peterson-Kaiser Health System Tracker, (May 22, 2017), <https://www.healthsystemtracker.org/chart-collection/know-burden-disease-u-s/#item-start>.

²⁷ C. Holly A. Andrilla, MS, *et al.*, "Geographic Variation in the Supply of Selected Behavioral Health Providers," *American Journal of Preventive Medicine*, 54 no. 6 S3, (Jun. 2018): S199 – S207, at S200.

metropolitan counties.²⁸ Further, 42 percent of metropolitan counties lacked a psychiatric nurse practitioner, compared to 81 percent of non-metropolitan counties.²⁹ The study used U.S. Census Bureau definitions of metropolitan and non-metropolitan area.

Statewide Trend

In 2015, it was estimated that more than one million adults in Pennsylvania had experienced serious psychological distress within the past 12-month period.³⁰ Data from SAMHSA have suggested that 17.98 percent of Pennsylvanians 18 years of age and older have experienced some form of mental illness in a 12-month period.³¹ Of those individuals, only 16.39 percent received any mental health services within the year prior to being surveyed.³²

Pursuant to federal regulation, in order to be considered as having a shortage of psychiatrists, an area must have a population-to-psychiatrist ratio of or exceeding 30,000 to one. According to Health Resources and Services Administration (HRSA) data from 2019, Pennsylvania has 131 such areas containing 1.7 million people, and that these areas designated as Health Professional Shortage Areas (HPSAs) were only meeting 38.42 percent of the demand for psychiatric care under the population-to-psychiatrist ratio formula.³³ This is a deterioration from 2015, when Pennsylvania's HPSAs met between 50.51 to 64.11 percent of the demand for psychiatrists under the same rubric.³⁴

Mental Health Professional Shortage Areas

A Health Professional Shortage Area (HPSA) designation indicates that the U.S. Health Resources and Services Administration (HRSA), an agency within the Department of Health and Human Services, has designated a “geographic area, population, or facility with a shortage of

²⁸ *Id.*

²⁹ *Id.*

³⁰ Hanke Heun-Johnson, *et al.*, “The Cost of Mental Illness: Pennsylvania Facts and Figures,” USC Schaeffer Center for Health Policy & Economics, (Feb. 2017), p. 9.

³¹ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, “National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia) 2016-2017,” n.d., Table 28 p. 57, <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaePercentsExcelCSVs2017/NSDUHsaePercents2017.pdf>.

³² *Id.* at p. 59. “Mental health services” for the purposes of the referenced survey was defined as having inpatient treatment/counseling or having used prescription medication for problems with emotions, nerves, or mental health. Respondents in the survey were not to include treatment for drug or alcohol use.

³³ Kaiser Family Foundation, “Mental Health Care Health Professional Shortage Areas (HPSAs),” (Sept. 30, 2019), <https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22all%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

³⁴ National Council for Behavioral Health, “The Psychiatric Shortage: Causes and Solutions,” (Mar. 28, 2017), p. 17, https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage_National-Council-.pdf.

primary care, dental, or mental health providers and services” based on general designation criteria and additional criteria specific to the particular type of designation.³⁵ The HRSA designates three different types of HPSAs: primary care, dental, and mental health. HPSA designations may be applied to any of the following:

- (1) Population groups - a shortage of providers for a specific population group(s) within a defined geographic area such as low income individuals, migrant workers, and others;
- (2) Geographic areas - a shortage of providers for the entire population within a defined geographic area; or
- (3) Facilities - public or non-profit private medical facilities serving a population or geographic area designated as an HPSA with a shortage of health providers, state or county hospitals with a shortage of psychiatric professionals, and other facilities.³⁶

The calculations involved in designating HPSAs can be complicated. Calculation methodology and thresholds for qualification as an HPSA can also vary depending on the basis for the designation. Mental health designations may qualify for HPSA designation based on the population to psychiatrist ratio, the population to “core mental health provider” (psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists) ratio, or the population to both psychiatrist and core mental health provider ratios.³⁷

For mental health geographic area designations based on the ratio of population to psychiatrists, the geographic area must meet or exceed a ratio of 30,000 to 1. For mental health population group designations or geographic area designations in regions with “unusually high needs,” the threshold ratio becomes 20,000 to 1. For mental health geographic area designations based on the ratio of population to core mental health providers, the designated area must have a ratio of 9,000 to 1, while for mental health population designations or geographic designations in areas with “unusually high needs,” the threshold ratio becomes 6,000 to 1. For mental health geographic designations based on the ratios of both population to psychiatrist and population to core mental health providers, the designation must meet or exceed ratios of 20,000 to 1 (psychiatrists) and 6,000 to 1 (core mental health providers). Furthermore, mental health population designations or geographic designations in areas with “unusually high needs” have threshold ratios of 15,000 to 1 (psychiatrists) and 4,500 to 1 (core mental health providers).³⁸

³⁵ U.S. Department of Health and Human Services, Health Resources Services Administration, “Health Professional Shortage Area (HPSA) Application and Scoring Process,” <https://bhwh.hrsa.gov/shortage-designation/hpsa-process>.

³⁶ U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, “Health Professional Shortage Areas (HPSAs),” (May 30, 2019), <https://bhwh.hrsa.gov/shortage-designation/hpsas>.

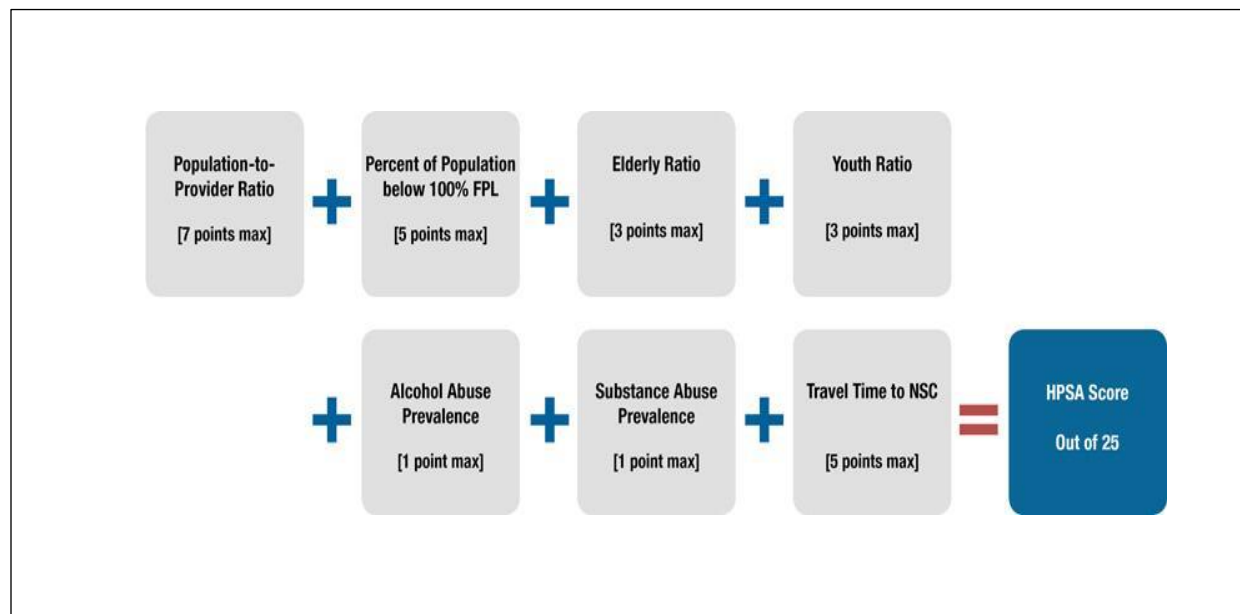
³⁷ U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, “Designated Health Professional Shortage Areas Statistics, Third Quarter Fiscal Year 2019, Designated HPSA Quarterly Summary,” (Jun. 30, 2019), p. 14 fn. 6.

³⁸ *Id.*

For facilities, such as state mental hospitals, the calculation used to determine the existence of an HPSA is based on workload units within the facility. Workload units are a function of the average daily inpatient census and the number and type of admissions. For correctional facilities and state mental hospitals, psychiatrists are the only provider type HRSA counts in making its designation determinations.³⁹ While mental health HPSA designations can include core mental health providers in addition to psychiatrists, most mental health HPSA designations are based solely on the ratio of psychiatrists to population as is the case with facilities-based designations at correctional facilities and state mental hospitals.⁴⁰

Once Mental Health HPSAs are designated, HRSA scores them on a scale of 0 to 25 (with higher scores indicating the greater need).⁴¹ Below in **Figure 1** is a broad overview HRSA provides to illustrate the seven components it utilizes in its Mental Health HPSA scoring:

Figure 1
Mental Health HPSA Scoring Scale



Source: Health Resources and Services Administration, Bureau of Health Workforce, “Health Professional Shortage Area (HPSA) Application and Scoring Process,” (Jun. 2019), <https://bhw.hrsa.gov/shortage-designation/hpsa-process>.

³⁹ *Id.*

⁴⁰ Henry J. Kaiser Family Foundation, “Mental Health Care Professional Shortage Areas (HPSAs),” (Dec. 31, 2018), <https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?activeTab=map¤tTimeframe=0&selectedDistributions=population-of-designated-hpsas&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

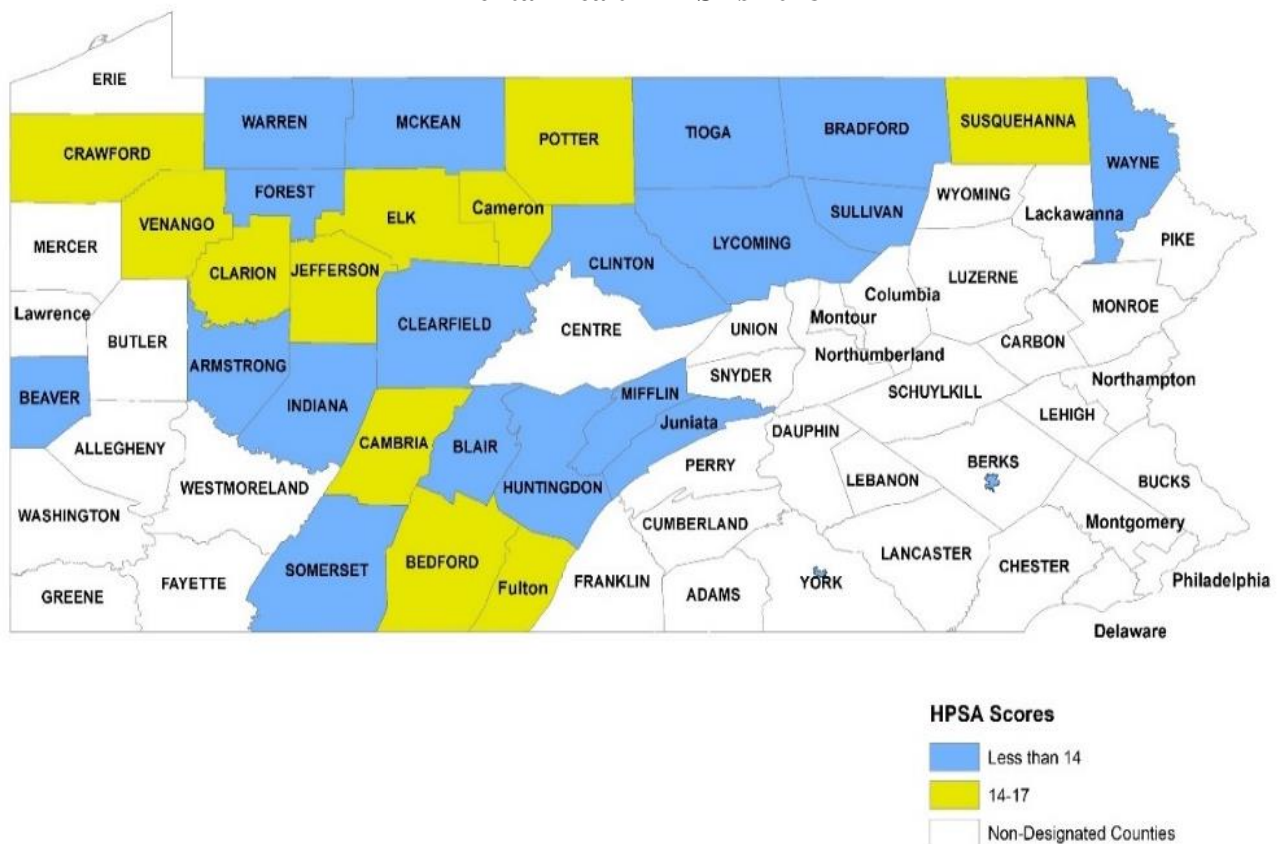
⁴¹ U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, “Health Professional Shortage Area (HPSA) Application and Scoring Process,” (Jun. 2019), <https://bhw.hrsa.gov/shortage-designation/hpsa-process>.

As of February 2020, the U.S. had a total of 5,522 Mental Health Care HPSAs nationwide covering a population of approximately 117 million individuals.⁴² According to the HRSA, it would take an additional 6,357 practitioners to eliminate all designated shortage areas.⁴³

Like many other states, Pennsylvania has a significant shortage of mental health practitioners, especially within its rural communities. Virtually all the Commonwealth’s mental health geographical area and population group HPSA designations were located in its rural counties as shown in **Map 1** below. Facility designations were more evenly dispersed throughout Pennsylvania as shown in **Map 2**.

Map 1

Mental Health HPSAs 2018



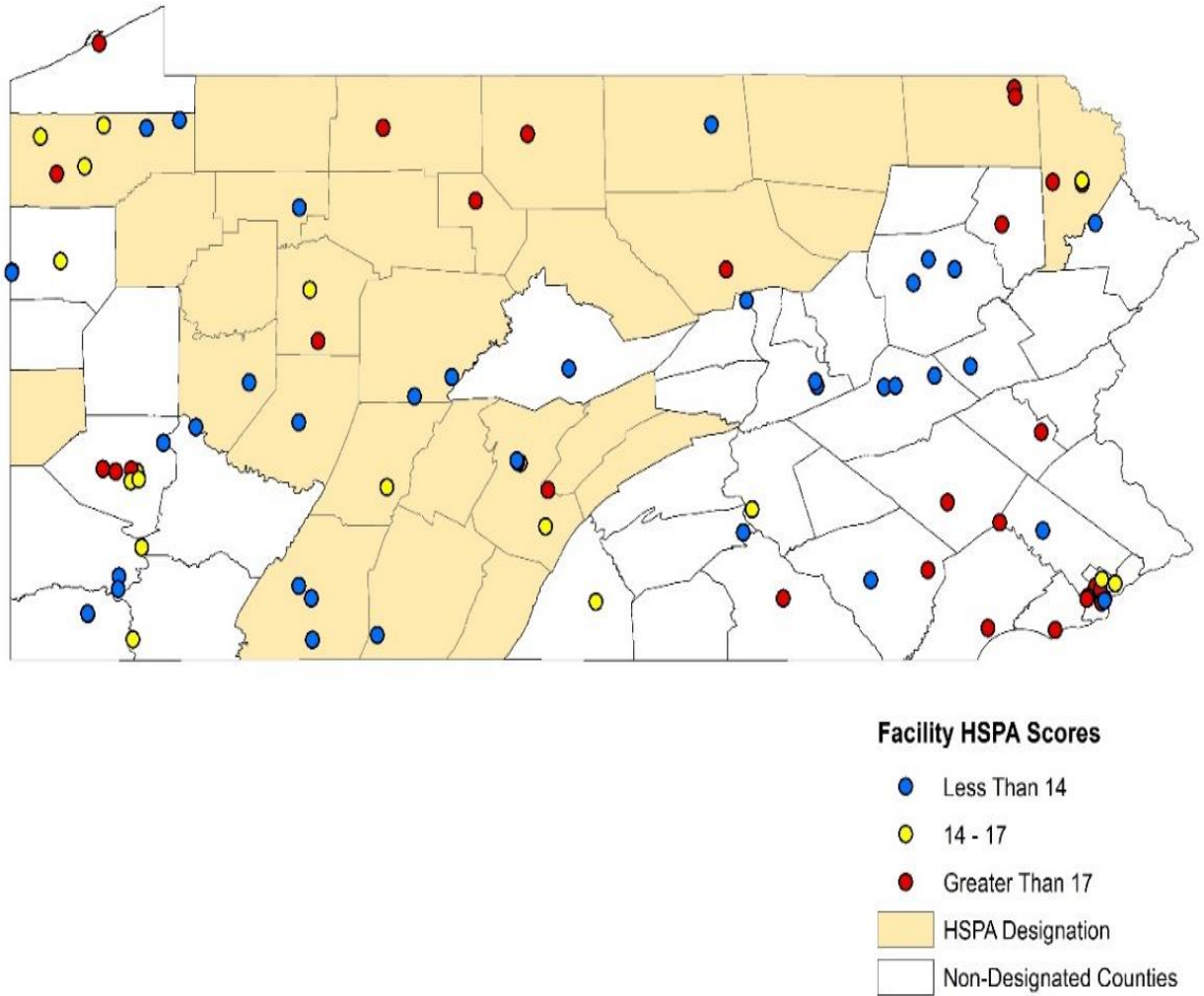
Source: Created by Pennsylvania Department of Health from data compiled by Health Resources and Services Administration, Data Warehouse, “Mental — Geographic or Population HPSAs as of July 2018,” <https://www.health.pa.gov/topics/Documents/Health%20Planning/Mental%20Geo%20or%20Pop%20and%20Facility%20HPSA%20Map.pdf>.

⁴² U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, “Shortage Areas,” accessed Feb. 18, 2020, <https://data.hrsa.gov/topics/health-workforce/shortage-areas>.

⁴³ *Id.*

Map 2

Mental Health Facility HSPAs 2018



Source: Created by Pennsylvania Department of Health from data compiled by Health Resources and Services Administration, Data Warehouse, "Mental — Geographic or Population HPSAs as of July 2018," <https://www.health.pa.gov/topics/Documents/Health%20Planning/Mental%20Geo%20or%20Pop%20and%20Facility%20HSPA%20Map.pdf>.

As of December 2019, Pennsylvania has 131 Mental Health Care HPSA designations.⁴⁴ **Table 1** illustrates how Pennsylvania’s supply of mental health professionals compares to other states’ supplies.

| Table 1 | | | | |
|--|---------------------------|---------------------------------------|----------------------------|--|
| Mental Health Care Professional Shortage Areas, by State, as of December 31, 2019 | | | | |
| State/National | Total Designations | Population of Designated HPSAs | Percent of Need Met | Practitioners Needed to Remove Designations |
| U.S. | 6,117 | 116,555,174 | 27 | 6,335 |
| Alabama | 63 | 2,927,845 | 24 | 156 |
| Alaska | 269 | 276,673 | 22 | 10 |
| Arizona | 212 | 2,862,704 | 11 | 181 |
| Arkansas | 48 | 1,257,964 | 33 | 61 |
| California | 545 | 8,019,970 | 29 | 407 |
| Colorado | 77 | 2,574,969 | 31 | 123 |
| Connecticut | 34 | 1,120,922 | 14 | 61 |
| Delaware | 9 | 88,697 | 19 | 15 |
| Florida | 210 | 6,737,545 | 16 | 407 |
| Georgia | 96 | 4,910,050 | 39 | 192 |
| Hawaii | 28 | 524,343 | 21 | 25 |
| Idaho | 65 | 1,274,325 | 24 | 55 |
| Illinois | 173 | 4,873,491 | 23 | 219 |
| Indiana | 93 | 4,236,967 | 31 | 188 |
| Iowa | 116 | 1,739,098 | 39 | 55 |
| Kansas | 132 | 1,393,455 | 32 | 54 |
| Kentucky | 131 | 2,149,202 | 30 | 114 |
| Louisiana | 153 | 3,431,039 | 25 | 161 |
| Maine | 60 | 260,862 | 33 | 29 |
| Maryland | 41 | 1,051,515 | 34 | 46 |
| Massachusetts | 57 | 273,138 | 32 | 17 |
| Michigan | 299 | 4,226,604 | 23 | 207 |
| Minnesota | 107 | 1,992,941 | 33 | 75 |
| Mississippi | 84 | 2,375,345 | 26 | 269 |
| Missouri | 266 | 1,871,798 | 3 | 143 |
| Montana | 113 | 573,311 | 12 | 71 |
| Nebraska | 101 | 1,037,974 | 51 | 26 |
| Nevada | 60 | 2,445,591 | 35 | 111 |

⁴⁴ “Health Professional Shortage Areas,” *supra* n. 36.

Table 1
Mental Health Care Professional Shortage Areas, by State, as of December 31, 2019

| State/National | Total Designations | Population of Designated HPSAs | Percent of Need Met | Practitioners Needed to Remove Designations |
|-----------------------|---------------------------|---------------------------------------|----------------------------|--|
| New Hampshire | 22 | 92,600 | 45 | 3 |
| New Jersey | 35 | 39,712 | 69 | 13 |
| New Mexico | 85 | 1,383,791 | 12 | 79 |
| New York | 173 | 4,102,718 | 21 | 315 |
| North Carolina | 187 | 2,886,009 | 14 | 157 |
| North Dakota | 85 | 372,793 | 15 | 24 |
| Ohio | 115 | 2,340,301 | 39 | 107 |
| Oklahoma | 150 | 1,513,597 | 28 | 72 |
| Oregon | 123 | 1,416,803 | 21 | 74 |
| Pennsylvania | 131 | 1,710,580 | 38 | 101 |
| Rhode Island | 12 | 424,008 | 69 | 9 |
| South Carolina | 71 | 2,244,211 | 35 | 108 |
| South Dakota | 71 | 425,450 | 11 | 35 |
| Tennessee | 84 | 3,557,661 | 11 | 367 |
| Texas | 431 | 14,036,080 | 36 | 604 |
| Utah | 55 | 2,708,763 | 46 | 87 |
| Vermont | 20 | N/A | N/A | N/A |
| Virginia | 76 | 2,202,533 | 42 | 107 |
| Washington | 187 | 2,836,438 | 12 | 150 |
| West Virginia | 109 | 708,078 | 17 | 122 |
| Wisconsin | 148 | 2,230,231 | 32 | 107 |
| Wyoming | 30 | 561,187 | 31 | 25 |

Source: Compiled by the Commission from data provided by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce “Designated Health Professional Shortage Areas Statistics, First Quarter of Fiscal Year 2020” (Dec. 31, 2019), pp. 11-13.

Although the Commonwealth’s mental health professional supply is not among the worst in the U.S., it is severe enough to impact approximately 1,710,580 individuals and warrant the need for 101 additional practitioners to eliminate its 131 mental health HPSAs.

Specific Mental Health Professionals

Psychiatrists

Pennsylvania is among the 43 states struggling with a shortage of psychiatrists.⁴⁵ Psychiatrists are medical doctors trained to assess and treat mental, emotional, and behavioral illnesses through a combination of psychotherapy, psychoanalysis, hospitalization, and medication.⁴⁶ Psychiatrists are the only professional that specializes in mental health and can also prescribe medications.⁴⁷ To become a psychiatrist, one must complete a four-year residency program after medical school.⁴⁸ Some psychiatrists also complete additional specialized fellowship training in sub-specialties such as child and adolescent psychiatry, geriatric psychiatry, and forensic psychiatry.⁴⁹ In Pennsylvania, psychiatrists are licensed through the Pennsylvania State Board of Medicine or through the State Board of Osteopathic Medicine within the Pennsylvania Department of State, depending on whether they graduated from an allopathic or osteopathic school of medicine, respectively.⁵⁰

According to the U.S. Bureau of Labor Statistics (BLS) there were over 25,000 psychiatrists nationwide as of 2018, the bulk of whom were employed in physician offices, psychiatric and substance abuse hospitals, and general medical and surgical hospitals.⁵¹ As of 2018, the latest year for which BLS's occupational employment and wage data were available, New York, California, and Florida were the states with the most psychiatrists. Pennsylvania had 1,140 psychiatrists.⁵²

Based on 2017 survey data cited by the National Council for Behavioral Health (NCBH) on the population identifying a treatment need, the demand for psychiatry in the U.S. may outstrip supply by anywhere from 6,090 to 15,600 psychiatrists in 2025.⁵³ In 2018, the HRSA reported that under one of its model scenarios assuming workforce equilibrium, the psychiatrist shortfall could increase to 17,990 by 2030, while another model accounting for unmet needs indicated the shortfall could increase to 21,150 by the same year.⁵⁴ According to a 2018 HRSA supply and

⁴⁵ The Psychiatric Shortage: Causes and Solutions, *supra* n. 34 at p. 15.

⁴⁶ U.S. Department of Health and Human Services, Health Resources and Services Administration, "Behavioral Health Workforce Projections, 2016-2030: Psychiatrists (Adult), Child and Adolescent Psychiatrists," (2018), <https://bhwh.hrsa.gov/sites/default/files/bhw/nchwa/projections/psychiatrists-2018.pdf>.

⁴⁷ *Id.*

⁴⁸ Accreditation Council for Graduate Medical Education, ACGME Program Requirements for Graduate Medical Education in Psychiatry," (2017), p. 1, https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_2017-07-01.pdf.

⁴⁹ American Psychiatric Association, "What is Psychiatry?" <https://www.psychiatry.org/patients-families/what-is-psychiatry>.

⁵⁰ Pennsylvania Department of State, "State Board of Medicine," (2019), <https://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Medicine/Pages/default.aspx>.

⁵¹ U.S. Department of Labor, Bureau of Labor Statistics, "Occupational Employment Statistics, Occupational Employment and Wages, May 2018," <https://www.bls.gov/oes/current/oes291066.htm>.

⁵² *Id.*

⁵³ The Psychiatric Shortage: Causes and Solutions, *supra* n. 34 at p. 15.

⁵⁴ Behavioral Health Workforce Projections, 2016-2030: Psychiatrists (Adult), Child and Adolescent Psychiatrists, *supra* n. 46.

demand model, 37 states were currently experiencing a shortage of psychiatrists, with three states (Texas, Florida, and Michigan) having estimated shortages of more than 700 full-time equivalents (FTEs).⁵⁵ Another HRSA model used in that same study estimated that a total of 40 states have estimated shortages, with five states (Texas, Florida, Michigan, Ohio, and Indiana) having shortages of more than 700 FTE psychiatrists.⁵⁶ Under these same models, Pennsylvania is estimated to have had a shortage in 2016 of 230 psychiatrists under one model and a shortage of 380 under the other.⁵⁷

According to the HRSA’s 2030 projections formulated under the same two models, the Commonwealth could be looking at an estimated increase in the psychiatrist shortfall of 580 in one model and an estimated shortfall of 730 in the other.⁵⁸ Both HRSA model scenarios for Pennsylvania are charted below. Note that the HRSA’s estimate of practicing psychiatrists in the Commonwealth for 2016 is radically different from the U.S. Department of Labor’s estimate in 2018, and the HRSA’s 2030 projection of a “decline” to 1,600 psychiatrists would still be almost 500 psychiatrists more than are currently practicing in Pennsylvania according to the U.S. Department of Labor’s figures.

| Pennsylvania Psychiatrist Supply and Demand Totals for 2016 | | | | |
|--|---------------------|---------------------|---------------------------|---------------------|
| Supply | Demand | | Adequacy of Supply | |
| | Scenario One | Scenario Two | Scenario One | Scenario Two |
| 2,040 | 2,270 | 2,420 | (230) | (380) |

Source: U.S. Department of Health and Human Services, Health Resources and Service Administration, Bureau of Health Workforce, “State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030,” Table 1: Total Psychiatrist Supply and Demand, 2016 by State, (Sep. 2018), p. 7.

⁵⁵ U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, “State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030,” (Sep. 2018), p. 7. For details on HRSA Supply and Demand Models concerning scenarios one and two, see U.S. Department of Health and Human Services, Health Resources and Services Administration, “Technical Documentation for HRSA’s Health Workforce Simulation Model,” <https://bhwa.hrsa.gov/sites/default/files/bhw/nchwa/projections/hwsm-technical-report-to-dea.pdf>.

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.* at p. 8.

| Pennsylvania Psychiatrist Supply and Demand Projections for 2030 | | | | |
|--|--------------|--------------|--------------------|--------------|
| Supply | Demand | | Adequacy of Supply | |
| | Scenario One | Scenario Two | Scenario One | Scenario Two |
| 1,600 | 2,180 | 2,330 | (580) | (730) |

Source: U.S. Department of Health and Human Services, Health Resources and Service Administration, Bureau of Health Workforce, “State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030,” Table 2: Total Psychiatrist Supply and Demand, 2030 by State, (Sep. 2018), p. 8.

A number of factors have contributed to the shortage of psychiatrists across the U.S., although one major factor in particular is the difficulty in attracting individuals to join the field of mental health in large part because mental health providers are frequently reimbursed at lower rates than physical health providers and are more frequently employed by institutions struggling to cover salaries.⁵⁹ Psychiatrists also face high levels of burnout within their field which the NCBH has attributed primarily to the following administrative burdens:

- Regulatory restrictions on sharing information that can better coordinate care.
- Limited time with patients to explain their conditions, assess the impacts of psychiatric medications, and support the patient and family.
- Increased requirements for documentation and data entry into the electronic medical record (EMR).
- Minimal support resources to organize medical records, conduct routine medical assessments, arrange for scheduling and complete required documentation.
- Schedules that do not allow for collegial sharing, supervision of staff and consultation with colleagues.⁶⁰

⁵⁹ The Psychiatric Shortage: Causes and Solutions, *supra* n. 34 at p. 19.

⁶⁰ *Id.* at p. 18.

The NCBH has also indicated that the aging of the current psychiatrist workforce is partially responsible for the overall decline of psychiatrists within the U.S.⁶¹ Psychiatry is the third oldest health specialty in the U.S.,⁶² with approximately 60 percent of its total actively practicing physicians aged 55 years and older according to data provided by the Association of American Medical Colleges in 2015.⁶³

Psychologists

Psychologists are trained mental health professionals that help people learn to cope more effectively with life events and mental health problems.⁶⁴ Through their training, psychologists evaluate a person's mental health through the use of clinical interviews, psychological evaluations, and testing.⁶⁵ The most common method of treatment used by psychologists is therapy (often referred to as psychotherapy or talk therapy). Other types of therapy administered by psychologists to treat patients include cognitive, behavioral, cognitive-behavioral, interpersonal, humanistic, psychodynamic, or even a combination of multiple therapy types.⁶⁶ While there are various styles of therapy, psychologists choose the type that best addresses the patient's problem and best fits the patient's characteristics and preferences. Psychologists also have the authority to make diagnoses and provide individual and group therapy.⁶⁷

Licensed psychologists generally hold a doctoral degree in clinical psychology or another specialty such as counseling or education.⁶⁸ According to the American Psychological Association (APA), a doctoral degree to practice psychology requires at least four to six years of full-time study after completing an undergraduate degree.⁶⁹ Coursework includes subjects such as ethics, statistics, individual differences and the biological, cognitive-affective and social bases of behavior. Students hoping to become psychologists must also obtain specific training in psychological assessment and therapy.⁷⁰

Psychologists receive their licensure to practice through the licensing board of the state in which they choose to practice. In Pennsylvania, the State Board of Psychology regulates the practice and licensure of psychologists.⁷¹ Furthermore, the Board reviews an applicant's qualifications and fitness for licensure and ultimately has the authority to determine whether to

⁶¹ *Id.* at p. 5.

⁶² Adam M. Brenner *et al.*, "Psychiatry Workforce and Psychiatry Recruitment: Two Intertwined Challenges," *Academic Psychiatry*, 41 no. 2, (Apr. 2017): 202-206.

⁶³ Association of American Medical Colleges, "Active Physicians by Age and Specialty, 2015," Table 1.4, (Dec. 2015), <https://www.aamc.org/data/workforce/reports/458494/1-4-chart.html>. The AAMC excluded 1,981 active physicians whose age was unknown.

⁶⁴ American Psychological Association, "What do Practicing Psychologists do?" (Jul. 2014), <https://www.apa.org/helpcenter/about-psychologists>.

⁶⁵ National Alliance on Mental Illness, "Types of Mental Health Professionals," (Apr. 2019), <https://www.nami.org/Learn-More/Treatment/Mental-Health-Care-Professionals>.

⁶⁶ *Id.*

⁶⁷ What Do Practicing Psychologists Do?, *supra* n. 64.

⁶⁸ Types of Mental Health Professionals, *supra* n. 65.

⁶⁹ What Do Practicing Psychologists Do?, *supra* n. 64.

⁷⁰ *Id.*

⁷¹ 49 Pa. Code § 41.1 *et seq.*

issue, deny, suspend, revoke, restrict, or renew licenses for psychologists.⁷² The Board also promulgates an ethics code for which psychologists must adhere to if practicing within the Commonwealth.⁷³ In order to qualify for licensure as a psychologist, Pennsylvania requires an applicant to satisfy the following requirements:

- (1) Complete the educational requirements for licensure under Section 6 of the Professional Psychologists Practice Act (PPPA), 63 P.S. § 1206, which requires a doctoral degree in psychology or a field related to psychology as defined by Chapter 41 of the Pennsylvania Code;
- (2) Complete the experience requirements under Section 6 of the PPPA which require the completion of one year of acceptable postdoctoral supervised experience;
- (3) Obtain a passing score on the Examination for Professional Practice in Psychology and the Pennsylvania Psychology Law Examination;
- (4) Submit to the Board sealed envelope, signed by the primary supervisors on the envelope flap, verification of post-doctoral experience form, quarterly evaluations/progress reports, which include objectives, prepared during the course of supervision, and a letter describing the supervisory interactions and the supervisor's judgment of the applicant's potential as a psychologist;
- (5) Submit to the Board an updated criminal history records information report unless submitted within 90 days of the application for licensure under § 41.11(a)(3) (relating to licenses); and
- (6) Submit to the Board updated Child Abuse History Clearance unless submitted within 90 days of the application for licensure under § 41.11(a)(3).⁷⁴

According to the BLS there were 166,600 psychologists nationwide as of 2016, with some working independently conducting research, consulting with clients, or working with patients.⁷⁵ Some psychologists were also employed as part of a health care team, collaborating with physicians and social workers, or in school settings working with students, teachers, parents, and other educators.⁷⁶ Approximately 147,500 psychologists were employed as clinical, counseling, and school psychologists, while approximately 1,700 were employed as industrial-organizational psychologists.⁷⁷ There were roughly 17,400 psychologists employed in “all other” employment

⁷² Pennsylvania Department of State, “State Board of Psychology,”

<https://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Psychology/Pages/default.aspx>.

⁷³ 49 Pa. Code § 41.61.

⁷⁴ 49 Pa. Code §41.30.

⁷⁵ U.S. Department of Labor, Bureau of Labor Statistics, “Psychologists,” *Occupational Outlook Handbook*, (Apr. 12, 2019), <https://www.bls.gov/ooh/life-physical-and-social-science/psychologists.htm>.

⁷⁶ *Id.*

⁷⁷ U.S. Department of Labor, Bureau of Labor Statistics, “Psychologists – Work Environment,” *Occupational Outlook Handbook*, (Apr. 12, 2019), <https://www.bls.gov/ooh/life-physical-and-social-science/psychologists.htm#tab-3>.

settings — a category established by the BLS.⁷⁸ The largest employers of psychologists in 2016 were as follows:

| Largest Employers of Psychologists in 2016 | |
|---|-------------------|
| Employers | Percentage |
| Elementary and secondary schools; state, local, and private | 27% |
| Self-employed workers | 24% |
| Ambulatory healthcare services | 18% |
| Government | 10% |
| Hospitals; state, local, and private | 7% |

Source: Data compiled by the Commission from U.S. Bureau of Labor Statistics, “Psychologists – Work Environment,” *Occupational Outlook Handbook*, (Apr. 12, 2019), <https://www.bls.gov/ooh/life-physical-and-social-science/psychologists.htm#tab-3>.

The APA’s Center for Workforce Studies cited a different national total of psychologists than the BLS. According to the APA’s report *Demographics of the U.S. Psychology Workforce*, as of 2016 there were approximately 94,000 active psychologists nationwide, which the APA defined as “individuals in the workforce with an occupation of psychologist and who held a doctoral or professional degree (in any field).”⁷⁹ The APA noted that there were also 8,100 psychologists who were retired, and 7,400 who were semi-retired.⁸⁰ The APA’s report based these figures on the results of the U.S. Census Bureau’s 2016 American Community Survey (ACS).

In its report, the APA acknowledged that the estimated total based on the ACS survey data “is an undercount of the entire psychology workforce, as it only reflects the portion of individuals (with doctoral/professional degrees) who are identified in the occupation of ‘psychologist.’”⁸¹ The ACS survey did not include doctoral-level psychologists coded in occupations such as “post-secondary teachers” or “survey researchers.”⁸² The APA report also noted that between 2007 and 2016 the number of actively practicing psychologists within the U.S. has increased by 24 percent, despite an 88 percent increase in the number of retired psychologists.⁸³ The BLS’s Occupational

⁷⁸ *Id.*

⁷⁹ Luona Lin, Karen Stamm, Peggy Christidis, “Demographics of the U.S. Psychology Workforce: Findings from the 2007-16 American Community Survey,” American Psychological Association Center for Workforce Studies, (May 2018), p. 3, <https://www.apa.org/workforce/publications/16-demographics/report.pdf>.

⁸⁰ *Id.*

⁸¹ *Id.* at fn. 2.

⁸² *Id.*

⁸³ *Id.* at pp. 2-3.

Outlook Handbook projects a continued growth in the psychologist workforce of about 14 percent between 2016 and 2026.⁸⁴

In 2016, the HRSA estimated that there were approximately 92,990 active psychologists in the U.S. workforce.⁸⁵ Furthermore, the HRSA projected that by 2030, “the supply of psychologists is expected to increase by approximately 13 percent given the number of psychologists entering, leaving, and changing work hours.”⁸⁶ Under one HRSA model scenario assuming supply and demand were in equilibrium, the demand for psychologists is expected to increase by seven percent to 99,090 FTEs by 2030. The HRSA attributed the increase in demand to population growth and an aging population.⁸⁷ However, under the same scenario, the HRSA projected that the supply of psychologists will grow faster than the demand, resulting in an estimated surplus of 5,530 FTE psychologists by 2030.⁸⁸ Under a second HRSA model scenario, which adjusts for current and projected demand based on estimates of unmet need from recent studies (which reported a 20 percent unmet need due to barriers in receiving care), demand for psychologists is projected to increase by approximately seven percent to 118,920 FTEs, which would produce an estimated shortage of 14,300 FTE psychologists by 2030.⁸⁹

The psychologist supply within Pennsylvania in 2016 was estimated by the HRSA to be approximately 4,800, which under both HRSA scenario models indicated a surplus of psychologists. Under the first model (assuming equilibrium), the surplus tallied 820 psychologists. Under the second HRSA scenario model (accounting for unmet needs), the HRSA counted 20 surplus psychologists.⁹⁰ Under the same two model scenarios the HRSA projected that by 2030 Pennsylvania would have a surplus of 1,190 and 410 psychologists, respectively.⁹¹ Both HRSA model scenarios for Pennsylvania are charted below.

⁸⁴ U.S. Department of Labor, Bureau of Labor Statistics, Psychologists, *supra* n. 75.

⁸⁵ U.S. Department of Health and Human Services, Health Resources and Services Administration, “Behavioral Health Workforce Projections, 2016-2030: Clinical, Counseling and School Psychologists,” (2018), p. 2, <https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/psychologists-2018.pdf>. The model used for HRSA supply and demand scenarios “uses a micro-simulation approach where supply is projected based on the simulation of career choices of individual health workers. Demand for health care services is simulated for a representative sample of the current and future U.S. population based on each person’s demographic and socioeconomic characteristics, health behavior, and health risk factors that affect health care utilization patterns.” For more information on its Health Workforce Simulation Model (HWSM) data and methods, HRSA recommends a review of the following: <https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/hwsm-technical-report-to-dea.pdf>.

⁸⁶ *Id.* at p. 3.

⁸⁷ *Id.* at p. 2.

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030, *supra* n. 55 at p. 27.

⁹¹ *Id.* at p. 28.

Pennsylvania Psychologist Supply and Demand Totals for 2016

| Supply | Demand | | Adequacy of Supply | |
|--------|--------------|--------------|--------------------|--------------|
| | Scenario One | Scenario Two | Scenario One | Scenario Two |
| 4,800 | 3,980 | 4,780 | +820 | +20 |

Source: U.S. Department of Health and Human Services, Bureau of Health Workforce, National Center for Health Workforce Analysis, “State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030,” Table 11: Psychologist Supply and Demand, 2016 by State, (Sep. 2018), p. 27.

Pennsylvania Psychologist Supply and Demand Projections for 2030

| Supply | Demand | | Adequacy of Supply | |
|--------|--------------|--------------|--------------------|--------------|
| | Scenario One | Scenario Two | Scenario One | Scenario Two |
| 5,090 | 3,900 | 4,680 | +1,190 | +410 |

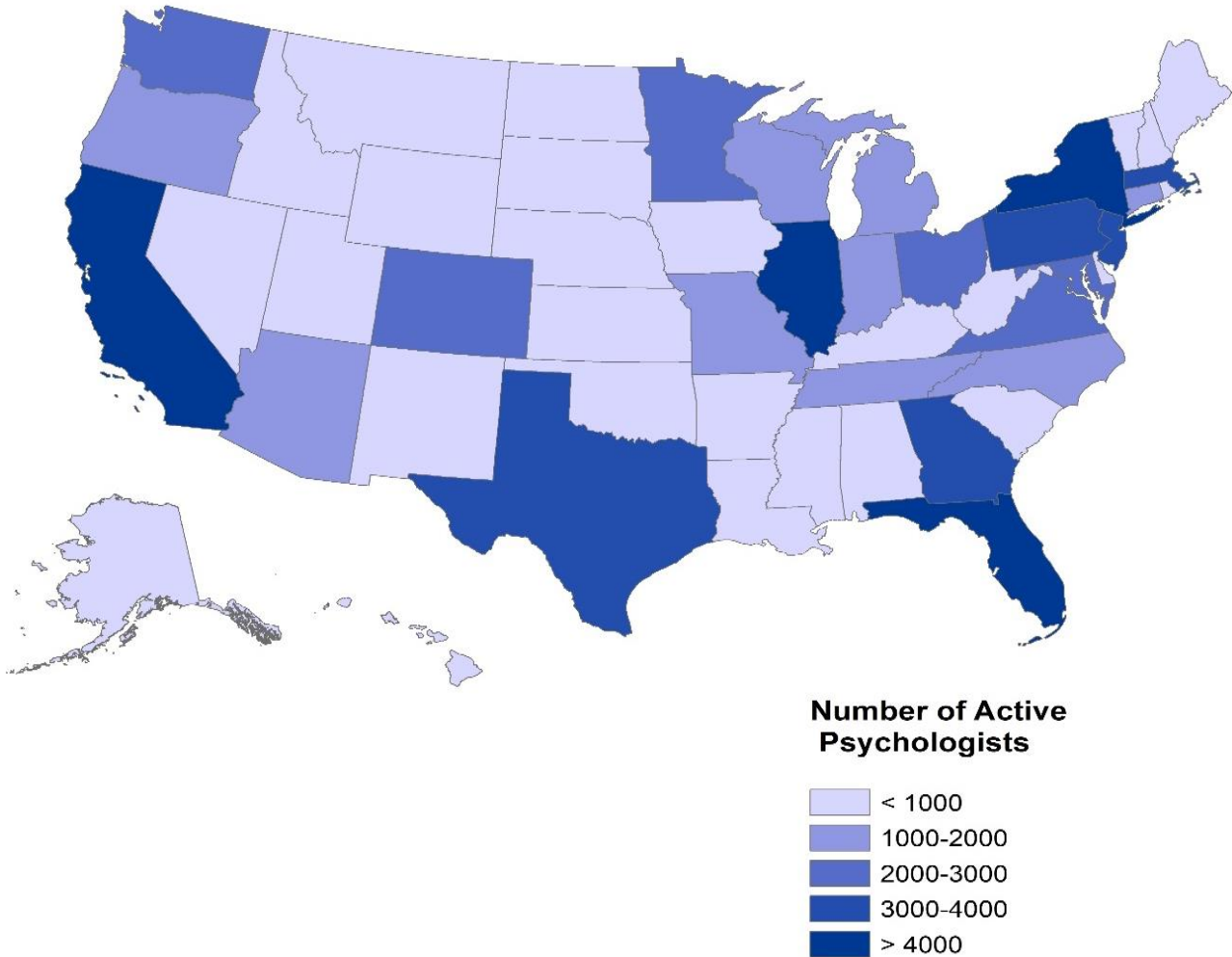
Source: U.S. Department of Health and Human Services, Bureau of Health Workforce, National Center for Health Workforce Analysis, “State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030,” Table 12: Psychologist Supply and Demand, 2030 by State, (Sep. 2018), p. 28.

According to the APA’s Center for Workforce Studies 2016 report, Pennsylvania had between 3,000 and 4,000 active psychologists working within the Commonwealth.⁹² The study reported that the states with the highest number of active psychologists for that same year included California (15,300), New York (10,500), Illinois (5,200), Florida (4,400), and Texas (4,200).⁹³ **Map 3** illustrates how Pennsylvania measures up to other states regarding its supply of active psychologists according to the study.

⁹² Demographics of the U.S. Psychology Workforce, *supra* n. 79 at p. 4.
⁹³ *Id.*

Map 3

Distribution of Active Psychologists by State 2016



Source: Luona Lin, Karen Stamm, and Peggy Christidis, “Demographics of the U.S. Psychology Workforce: Findings from the 207-16 American Community Survey,” American Psychological Association Center for Workforce Studies, (May 2018), p 4.

Licensed Clinical Social Workers

Clinical social work is a specialty practice area within the larger social work field which focuses primarily on the assessment, diagnosis, treatment, and prevention of mental illness, emotional, and other behavioral disturbances.⁹⁴ A licensed clinical social worker is a licensed professional qualified to diagnose and treat mental, behavioral, and emotional issues.⁹⁵ In addition,

⁹⁴ National Association of Social Workers, “Clinical Social Work,” <https://www.socialworkers.org/Practice/Clinical-Social-Work>.

⁹⁵ U.S. Department of Labor, Bureau of Labor Statistics, “Social Workers,” *Occupational Outlook Handbook*, (Jun. 18, 2019), <https://www.bls.gov/ooh/community-and-social-service/social-workers.htm>.

these professionals are also qualified to prepare forensic reports in legal cases, determine whether a patient is a danger to self or others requiring involuntary treatment, and make bio-psychosocial assessments of patients.⁹⁶ Clinical social workers do not prescribe psychotropic medication, but often work closely with physicians and nurse practitioners when medication is needed in combination with psychotherapy services.⁹⁷ Clinical social workers perform services in numerous different work settings including private practice, hospitals, community mental health, primary care, and agencies.⁹⁸

In Pennsylvania, clinical social workers are licensed by the State Board of Social Workers, Marriage and Family Therapists, and Professional Counselors.⁹⁹ To be qualified for a license to be a clinical social worker in Pennsylvania, an applicant must submit proof to the Board that:

- (1) The applicant is of good moral character.
- (2) The applicant has successfully met both of the following requirements:
 - a. Holds a master's degree in social work or social welfare or a doctoral degree in social work from an accredited school of social work as recognized by the board.
 - b. Is licensed under the Social Workers, Marriage and Family Therapists and Professional Counselors Act (SWMFTPCA) as a social worker.
- (3) The applicant has completed at least 3,000 hours of supervised clinical experience or holds an Academy of Certified Social Workers certificate issued prior to January 1, 2001, by the National Association of Social Workers or otherwise meets the supervision expectation in a fashion acceptable to the board as determined by regulation after completion of the master's degree in social work.
- (4) The applicant has passed a clinical social work examination adopted by the board.
- (5) The applicant has submitted an application accompanied by the application fee.
- (6) The applicant has not been convicted of a felony under The Controlled Substance, Drug, Device and Cosmetic Act or of an offense under the laws of another jurisdiction which, if committed in this Commonwealth, would be a felony under The Controlled Substance, Drug, Device and Cosmetic Act unless:
 - a. At least ten years have elapsed from the date of conviction;
 - b. The applicant satisfactorily demonstrated to the board that the applicant has made significant progress in personal rehabilitation since the conviction such

⁹⁶ State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030, *supra* n. 55 at p. 42.

⁹⁷ *Id.*

⁹⁸ Clinical Social Work, *supra* n. 94.

⁹⁹ Act of July 9, 1987 (P.L. 220, No. 39, § 6); 63 P.S. § 1906.

that licensure of the applicant should not be expected to create a substantial risk of harm to the health and safety of clients or the public or a substantial risk of further criminal violations; and

- c. The applicant otherwise satisfies the qualifications contained in or authorized by the SWMFTPCA.¹⁰⁰

In 2016, the BLS estimated that there were more than 680,000 social workers employed in the U.S.¹⁰¹ Like its projections for psychiatrists and psychologists, the HRSA prepared supply and demand projections for social workers based on the two model scenarios mentioned previously in this report (one model scenario assuming equilibrium, while the other considered unmet needs). According to the first HRSA model scenario, a total of 32 states had an estimated shortage of social workers as of 2016, with three states having shortages of more than 2,000 FTEs.¹⁰² These states were Texas with 8,080 FTEs, Florida with 4,700 FTEs, and Georgia with 2,810 FTEs.¹⁰³ Alternatively, the same scenario model estimated that as of 2016, seven states had more than 2,000 FTEs in surplus, including New York with 12,860 FTEs and Massachusetts with 4,220 FTEs.¹⁰⁴ Pennsylvania was estimated to have a surplus of 390 FTEs as of 2016.¹⁰⁵ The results of the HRSA's second model scenario showed that as of 2016, a total of 38 states had estimated shortages of social workers, with ten states having shortages of more than 2,000 FTEs.¹⁰⁶ Under this scenario model, the Commonwealth was estimated to have a shortfall of 1,630 social workers.¹⁰⁷

By 2030, the HRSA estimates that due to faster growth in supply than in demand, the projected supply of social workers will be larger than the demand for both model scenarios.¹⁰⁸ For instance, under its first scenario model, all states except Arkansas would have a surplus of social workers, with the largest surplus in New York with 36,030 FTEs.¹⁰⁹ Under this model the HRSA projected Pennsylvania will have a surplus of 10,880 FTEs.¹¹⁰ Under the second model scenario, all states would still be projected as having surpluses except Arkansas.¹¹¹ Pennsylvania's projected surplus by 2030 was estimated at 8,720 FTEs.¹¹² Both HRSA model scenarios for Pennsylvania are charted below.

¹⁰⁰ Act of July 9, 1987 (P.L. 220, No. 39, § 7); 63 P.S. § 1907(d).

¹⁰¹ U.S. Department of Labor, Bureau of Labor Statistics, "Social Workers," *Occupational Outlook Handbook*, (Jun. 18, 2019), <https://www.bls.gov/ooh/community-and-social-service/social-workers.htm>.

¹⁰² State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030, *supra* n. 55 at p. 42.

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ *Id.* at p. 43.

¹⁰⁶ *Id.* at p. 42.

¹⁰⁷ *Id.* at p. 43.

¹⁰⁸ *Id.* at p. 42.

¹⁰⁹ *Id.*

¹¹⁰ *Id.* at p. 44.

¹¹¹ *Id.* at p. 43.

¹¹² *Id.* at p. 44.

| Pennsylvania Social Worker Supply and Demand Totals for 2016 | | | | |
|---|---------------------|---------------------|---------------------------|---------------------|
| Supply | Demand | | Adequacy of Supply | |
| | Scenario One | Scenario Two | Scenario One | Scenario Two |
| 10,490 | 10,100 | 12,120 | +390 | (1,630) |

Source: U.S. Department of Health and Human Services, Bureau of Health Workforce, National Center for Health Workforce Analysis, “State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030,” Table 19: Social Worker Supply and Demand, 2016 by State, (Sep. 2018), p. 43.

| Pennsylvania Social Worker Supply and Demand Projections for 2030 | | | | |
|--|---------------------|---------------------|---------------------------|---------------------|
| Supply | Demand | | Adequacy of Supply | |
| | Scenario One | Scenario Two | Scenario One | Scenario Two |
| 21,660 | 10,780 | 12,940 | +10,880 | +8,720 |

Source: U.S. Department of Health and Human Services, Bureau of Health Workforce, National Center for Health Workforce Analysis, “State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030,” Table 20: Social Worker Supply and Demand, 2030 by State, (Sep. 2018), p. 44.

It should be noted that due to limitations in data, both HRSA model scenarios were utilized “for all social workers trained at the master’s level or higher — a broader scope than just mental health and substance abuse social workers alone.”¹¹³

A 2015 study analyzed age-based projected changes in population and came to a radically different conclusion than that of the HRSA regarding social worker supply and demand projections. The study concluded that the continued growth of social worker supply will be unable to keep pace with the anticipated demand by 2030.¹¹⁴ Specifically, this study found that by 2030 approximately 30 states are likely to have a shortfall of social workers with a total national shortfall

¹¹³ *Id.* at p. 42.

¹¹⁴ Vernon W. Lin, Joyce Lin, and Xiaoming Zhang, “U.S. Social Worker Workforce Report Card: Forecasting Nationwide Shortages,” *Social Work* 61, no. 1 (Jan. 2016): pp. 7-15. doi: 10.1093/sw/swv047.

of over 195,000.¹¹⁵ The authors of the study established a grading scale of A to F for each state based on the study’s numerical projections. According to the study, “the most severe shortages occur in the southern and western states, and the states in those regions account for the majority (15 out of 19) of the lowest letter grades (D or F) given.”¹¹⁶ Although the study gave Pennsylvania a “B” grade as of 2012, Pennsylvania received a C+ grade based on 2030 projections which indicated a shortfall of an estimated 4,798 social workers.¹¹⁷

The study concluded that its projections “necessitate collaborative action on national and local levels to ameliorate the impending shortage.”¹¹⁸ The study also noted that the increasing senior populations, along with the increase in social diversity within the nation’s population is increasing the demand for social workers.¹¹⁹ Other issues that may aggravate the need for social workers according to the study are the obstacles in preparing a sufficient workforce to meet the growing demand, such as budget cuts, low wages, and higher caseloads leading to burnout.¹²⁰ However, one limitation of this study is that it was examining all social workers, not the much narrower field of clinical social workers in the mental health field.¹²¹

Marriage and Family Therapists

Marriage and family therapists (MFTs) are health professionals who diagnose and treat mental and emotional disorders within a marital or familial setting.¹²² MFTs work with patients to address issues such as low self-esteem, stress, substance abuse, eating disorders, and chronic illness that lead to marital and family distress.¹²³ MFTs are employed in mental health centers, substance abuse treatment centers, hospitals, colleges, private practices, and employee assistance programs.¹²⁴ In Pennsylvania, the Social Workers, Marriage and Family Therapists and Professional Counselors Act (SWMFTPCA) defines “licensed marriage and family therapist” as “an individual who engages in or offers to engage in the practice of marriage and family therapy and who holds a current license....”¹²⁵ The act further defines “marriage and family therapist assessment” as:

[t]he professional application of psychotherapeutic and family systems theories and techniques to evaluate and identify psychosocial and behavioral problems in the context of significant interpersonal relationships between individuals, couples, families and groups for the purpose of treatment. The term includes, but is

¹¹⁵ *Id.* at p. 9.

¹¹⁶ *Id.*

¹¹⁷ *Id.* at p. 10.

¹¹⁸ *Id.* at p. 9.

¹¹⁹ *Id.* at p. 7.

¹²⁰ *Id.*

¹²¹ *Id.*

¹²² State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030, *supra* n. 53 at p. 46.

¹²³ *Id.*

¹²⁴ *Id.*

¹²⁵ Act of July 9, 1987 (P.L. 220, No. 39, § 3); 63 P.S. § 1903.

not limited to, a mental health examination and psychological history.¹²⁶

As is the case with Pennsylvania's clinical social workers, the licensing of MFTs is overseen by the State Board of Social Workers, Marriage and Family Therapists, and Professional Counselors under the Bureau of Professional and Occupational Affairs. Only individuals who have successfully obtained licenses as MFTs may style themselves as licensed MFTs and use the letters "L.M.F.T." or "M.F.T." in connection with their names.¹²⁷ Some exceptions to this include persons employed as school marriage and family therapists in a public or private school in the Commonwealth and a person working to meet the supervised experience requirement to become an MFT and whose duties are supervised by a licensed MFT or other licensed mental health professional, as long as the person does not represent himself or herself as a licensed marriage and family therapist.¹²⁸

To be qualified to obtain a Pennsylvania MFT license, an applicant must submit proof satisfactory to the State Board all of the following:

- (1) The applicant is of good moral character.
- (2) The applicant has successfully met certain educational requirements under the Section 1907(e)(2) of the SWMFTPCA.
- (3) The applicant has complied with the experience requirement as follows:
 - a. An individual meeting the educational requirements of paragraph (2)(i) or (ii) must have completed at least 3,000 hours of supervised clinical experience, acceptable to the board as determined by regulation, obtained after being granted a master's degree.
 - b. An individual meeting the educational requirements of paragraph (2)(iii) must have completed at least 2,400 hours of supervised clinical experience, acceptable to the board as determined by regulation, 1,200 hours of which was obtained subsequent to the granting of the doctoral degree.
- (4) The applicant has passed an examination adopted by the board.
- (5) The application has been accompanied by the application fee.
- (6) The applicant has not been convicted of a felony under The Controlled Substance, Drug, Device and Cosmetic Act or of an offense under the laws of another jurisdiction which if committed in this Commonwealth would be a felony under the Controlled Substance, Drug, Device and Cosmetic Act unless:

¹²⁶ *Id.*

¹²⁷ Act of July 9, 1987 (P.L. 220, No. 39, § 16.2); 63 P.S. § 1916.2(a).

¹²⁸ Act of July 9, 1987 (P.L. 220, No. 39, § 16.2); 63 P.S. § 1916.2(b).

- a. At least ten years have elapsed from the date of conviction;
- b. The applicant satisfactorily demonstrates to the board that the applicant has made significant progress in personal rehabilitation since the conviction such that licensure of the applicant should not be expected to create a substantial risk of harm to the health and safety of clients or the public or a substantial risk of further criminal violation; and
- c. The applicant otherwise satisfies the qualifications contained in or authorized by this act.¹²⁹

According to the HRSA, an estimated 52,860 MFTs were practicing nationwide in 2016, with the Commonwealth having an estimated workforce of 2,510 MFTs.¹³⁰ Under the HRSA model scenario assuming equilibrium, a total of 24 states had an estimated shortage of MFTs as of 2016, with two states having shortages of more than 500 FTEs (Texas with 770 FTEs and Florida with 580 FTEs).¹³¹ New York was the only state reported to have a surplus of more than 500 FTEs. This model scenario estimated Pennsylvania to have a surplus of 230 FTEs.¹³² Under the other HRSA model scenario accounting for unmet needs, a total of 34 states were reported to have estimated shortages of MFTs in 2016, with Pennsylvania having an estimated shortfall of 230 FTEs.¹³³

For 2030, the first HRSA model scenario projected that a total of ten states would have estimated shortages of MFTs, with Wisconsin having the largest shortfall at 210 FTEs.¹³⁴ Under this model scenario, Pennsylvania was projected to have a surplus of 890 FTEs by 2030.¹³⁵ HRSA's second model scenario projected that a total of 21 states will have MFT shortages by 2030, with the largest projected shortage being in Texas with 1,020 FTEs.¹³⁶ Pennsylvania was projected to have a surplus of 400 MFTs by 2030 under this model scenario.¹³⁷

¹²⁹ ¹²⁹ Act of July 9, 1987 (P.L. 220, No. 39, § 7); 63 P.S. § 1907(e).

¹³⁰ State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030, *supra* n. 55 at p. 47.

¹³¹ *Id.* at p. 46.

¹³² *Id.* at p. 47.

¹³³ *Id.* at pp. 46-47.

¹³⁴ *Id.* at p. 46.

¹³⁵ *Id.* at p. 48.

¹³⁶ *Id.* at p. 46.

¹³⁷ *Id.* at p. 48.

| Pennsylvania Marriage and Family Therapist Supply and Demand Totals for 2016 | | | | |
|---|---------------------|---------------------|---------------------------|---------------------|
| Supply | Demand | | Adequacy of Supply | |
| | Scenario One | Scenario Two | Scenario One | Scenario Two |
| 2,510 | 2,280 | 2,740 | +230 | (230) |

Source: U.S. Department of Health and Human Services, Bureau of Health Workforce, National Center for Health Workforce Analysis, “State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030,” Table 21: Marriage & Family Therapist Supply and Demand, 2016 by State, (Sep. 2018), p. 47.

| Pennsylvania Marriage and Family Therapist Supply and Demand Projections for 2030 | | | | |
|--|---------------------|---------------------|---------------------------|---------------------|
| Supply | Demand | | Adequacy of Supply | |
| | Scenario One | Scenario Two | Scenario One | Scenario Two |
| 3,310 | 2,420 | 2,910 | +890 | +400 |

Source: U.S. Department of Health and Human Services, Bureau of Health Workforce, National Center for Health Workforce Analysis, “State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030,” Table 22: Marriage & Family Therapist Supply and Demand, 2030 by State, (Sep. 2018), p. 48.

The BLS estimated that as of May 2018, there were 48,520 MFTs nationwide.¹³⁸ According to the BLS, industries with the highest levels of employment of MFTs include individual and family services, offices of other health practitioners, outpatient care centers, state government (excluding schools and hospitals), and residential intellectual and developmental disability, mental health, and substance abuse facilities.¹³⁹ The BLS reported that Pennsylvania had the fourth highest employment of MFTs in 2018 with 2,090, behind California, New Jersey, and Florida.¹⁴⁰

¹³⁸ U.S. Department of Labor, Bureau of Labor Statistics, “Occupational Employment Statistics: Marriage and Family Therapists,” (May 2018), <https://www.bls.gov/oes/current/oes211013.htm>.

¹³⁹ *Id.*

¹⁴⁰ *Id.*

Counselors

With a role similar in scope to marriage and family therapists and social workers, counselors are also an important component of the Commonwealth's mental health care workforce. Like marriage and family therapists and social workers, counselors must be licensed by the State Board of Social Workers, Marriage and Family Therapists, and Professional Counselors.¹⁴¹ The Professions and Occupations Code defines a "Licensed Professional Counselor" as one who "engages in or advertises to engage in the practice of social work and who holds a current license under [the Professions and Occupations Code]."¹⁴² The "practice of professional counseling" is further defined as:

- (1) The application of principles and practices of counseling, mental health and human development to evaluate and facilitate human growth and adjustment throughout the life span and to prevent and treat mental, emotional or behavioral disorders and associated stresses which interfere with mental health and normal human growth and development.
- (2) The evaluation, assessment, diagnosis and treatment of normal and abnormal mental, emotional, social, educational, vocational, family and behavioral functioning throughout the life span; individual, group, family counseling and psychotherapy; crisis intervention, career counseling and educational and vocational counseling; functional assessment of persons with disabilities; and professional consulting.
- (3) Professional counselors' utilization of verbal and nonverbal approaches and specialization in the use of arts-based therapeutic approaches, such as art, dance, music or drama, to accomplish treatment objectives.¹⁴³

To be eligible to become licensed as a professional counselor in Pennsylvania, an applicant must:

- (1) Satisfy the General Conditions of Licensure, including being of good moral character and not having committed a felony under The Controlled Substance, Drug, Device and Cosmetic Act within the previous 10 years (with certain exceptions).
- (2) Pass one of the seven listed examinations provided in the Pennsylvania Code.¹⁴⁴
- (3) Meet one of the following education requirements:
 - a. Have successfully completed a planned program of 60 semester hours or 90 quarter hours of graduate coursework in counseling or a field closely related to the practice of professional counseling, including:

¹⁴¹ Act of July 9, 1987 (P.L. 220, No. 39, § 6); 63 P.S. § 1906.

¹⁴² Act of July 9, 1987 (P.L. 220, No. 39, § 3); 63 P.S. § 1903.

¹⁴³ *Id.*

¹⁴⁴ *See* 49 Pa. Code § 49.11.

- i. A master’s degree granted on or before June 30, 2009 in professional counseling or in a field closely related to the practice of professional counseling from an accredited educational institution; or
 - ii. A 48 semester hour or 72 quarter hour master’s degree in professional counseling or a field closely related to the practice of professional counseling from an accredited educational institution.
- b. Hold a doctoral degree in counseling or a field closely related to the practice of professional counseling from an accredited educational institution.

(4) Meet one of the following experience requirements:

- a. 3,000 hours of supervised clinical experience for those with a master’s degree; or
- b. 2,400 hours of supervised clinical experience for those with a doctoral degree, 1,200 of which was obtained subsequent to the granting of the doctoral degree.¹⁴⁵

Additionally, an applicant for licensure as a professional counselor must have taken coursework in human growth and development, social and cultural foundations, helping relationships, group work, career and lifestyle development, appraisal, research and program evaluation, professional orientation, and clinical instruction.¹⁴⁶

Neither the Public School statute nor the Professions and Occupations statute explicitly define what a “school counselor” encompasses. Given the regulations governing schools in the Pennsylvania Code — the Commonwealth’s official publication of rules and regulations — it appears that “school counselors” are a profession that is broader than “professional counselor.” The required developmental services to be provided to students includes “guidance counseling” and “psychological services,” which are to “support students in addressing their academic, behavioral health, personal and social development issues.”¹⁴⁷

The regulations governing schools in the Pennsylvania Code gives the Pennsylvania Department of Education (PDE) the responsibility to designate professional titles for school personnel.¹⁴⁸ Pursuant to this responsibility, the PDE has described the role of a school counselor as a professional who counsels all students in grades Pre-K to 12 in the areas of academics, career planning, and personal-social development.¹⁴⁹ Further, the Commonwealth Court has determined

¹⁴⁵ 49 Pa. Code § 49.13.

¹⁴⁶ 49 Pa. Code § 49.2.

¹⁴⁷ 22 Pa. Code § 12.41(b)(1).

¹⁴⁸ 22 Pa. Code § 49.13(b)(2).

¹⁴⁹ Pennsylvania Department of Education, “CSPG 76 - Elementary and Secondary School Counselor (PK-12),” Staffing Guidelines, (Oct. 1, 2019), <https://www.education.pa.gov/Educators/Certification/Staffing%20Guidelines/Pages/CSPG76.aspx>.

that “school counselor” can encompass psychologists, who are licensed and regulated separately from professional counselors.¹⁵⁰

Because “school counselor” can incorporate non-mental health care-related duties, this report will focus on mental health counselors, who have been termed “Licensed Professional Counselors” by the Commonwealth’s Professions and Occupations statute. As with psychiatrists, psychiatric nurse practitioners, psychiatric physician assistants, social workers, and marriage and family therapists, the Health Resources and Services Administration (HRSA) has published a projection of supply and demand for mental health counselors as part of its 2018 study on mental health workforce needs.

As with the other listed professions, when calculating its supply and demand projections for 2030 the HRSA utilized two distinct methodologies — under the first scenario, the baseline demand for a professional was assumed to be in equilibrium with supply in 2016, while under the second scenario, the HRSA assumed an unmet need as of 2016.¹⁵¹ The HRSA applied its model to both national and state-level workforces.

The HRSA calculated that, nationwide, there were 140,400 mental health counselors in 2016 with an estimated unmet need — or shortage — of 28,090 under the second methodology.¹⁵² The first methodology assumes an equilibrium between supply and demand in 2016. However, by 2030, the HRSA estimates that there will be 159,320 mental health counselors nationwide, with a projected shortfall of 6,870 mental health counselors under scenario one and 40,140 under scenario two.¹⁵³

| National Mental Health Counselor Supply and Demand for 2030 | | | | |
|--|---------------------|---------------------|---------------------------|---------------------|
| Supply | Demand | | Adequacy of Supply | |
| | Scenario One | Scenario Two | Scenario One | Scenario Two |
| 159,320 | 166,190 | 199,460 | (6,870) | (40,140) |

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, State-Level Supply and Demand for Behavioral Health Occupations: 2016-2030.

¹⁵⁰ *McCoy v. Lincoln Intermediate Unit No. 12*, 391 A. 2d 1119 (Pa. Cmwlth. 1978) (“School psychologist” is a type of “school counselor” under the Public School Code).

¹⁵¹ State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030, *supra* n. 55 at p. 5.

¹⁵² *Id.* at p. 36.

¹⁵³ *Id.* at p. 37.

The HRSA estimates that, as of 2016, Pennsylvania had 13,250 mental health counselors and had a surplus of 5,630 under its model assuming unmet need.¹⁵⁴ The HRSA predicts that by 2030 the number of mental health counselors in the Commonwealth will decline to 10,810, leaving a surplus of 3,810 under scenario one (assuming equilibrium) or 2,410 under scenario two (assuming unmet needs).¹⁵⁵

| Pennsylvania Mental Health Counselor Supply and Demand for 2030 | | | | |
|--|---------------------|---------------------|---------------------------|---------------------|
| Supply | Demand | | Adequacy of Supply | |
| | Scenario One | Scenario Two | Scenario One | Scenario Two |
| 10,810 | 7,000 | 8,400 | +3,810 | +2,410 |

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, State-Level Supply and Demand for Behavioral Health Occupations: 2016-2030.

The U.S. Department of Labor’s Bureau of Labor Statistics estimates that there are a total of 139,820 mental health counselors in the U.S. as of 2018.¹⁵⁶ Pennsylvania is estimated to have 13,020, the second-highest number of mental health counselors after California and the third-highest per capita after Virginia and Montana.¹⁵⁷ As can be seen in the figures above, when compared to the rest of the country, Pennsylvania is in a better than average position, with a projected 2030 supply in excess of demand, as compared to a projected 2030 supply shortfall for the rest of the country.

The HRSA estimate of projected trends in the mental health counselor workforce is the only assessment available. Unfortunately, there is a lack of good sources of data regarding the licensed professional counselor workforce in the Commonwealth and elsewhere. Part of the lack of data involves determining which roles constitute the profession of “counselor,” as different states use different terms for the role occupied by the licensed professional counselor in the Commonwealth. Some jurisdictions differ in the scope of practice given to counselors. For instance, Pennsylvania allows licensed professional counselors to make diagnoses. Further, some datasets include substance and alcohol abuse counselors or school counselors along with mental health counselors. The U.S. Department of Labor’s Bureau of Labor Statistics treats “Substance

¹⁵⁴ *Id.* at p. 35.

¹⁵⁵ *Id.* at p. 36.

¹⁵⁶ U.S. Department of Labor Bureau of Labor Statistics, “21-1014 Mental Health Counselors,” *Occupational Employment and Wages*, (May, 2016), <https://www.bls.gov/oes/2016/may/oes211014.htm>.

¹⁵⁷ *Id.*

Abuse, Behavioral Disorder, and Mental Health Counselors” as one profession in its occupational outlook handbook, for instance.¹⁵⁸

Board Certified Psychiatric Pharmacists

One mental health care profession that generally receives less attention is that of the board certified psychiatric pharmacist (BCPP). A BCPP is a pharmacist who focuses on pharmacotherapy for psychiatric patients. The specialization of psychiatric pharmacy began in the early 1970s with meetings of “mental health pharmacists” which progressed into a special interest group on mental health pharmacy within the American Society of Health-System Pharmacists (ASHP). The first psychiatric pharmacy residency program was created in 1972. In 1980, the ASHP began accrediting psychiatric pharmacy residency programs. By 1992, psychiatric pharmacy was recognized as a specialty by the Board of Pharmacy Specialties.¹⁵⁹ The College of Psychiatric and Neurologic Pharmacists (CPNP) was founded in 1998 and had a membership of 2,057 as of 2016, with 70 percent of those members being BCPPs.¹⁶⁰ According to the Board of Pharmacy Specialties, there are 1,186 BCPPs nationwide as of 2018.¹⁶¹

Regarding pharmacists in general, Pennsylvania has a total employment of 14,610 spread throughout the state according to the U.S. Bureau of Labor Statistics. This makes the Commonwealth fifth in terms of total number of employed pharmacists.¹⁶² However, due to the small number of specialty pharmacists, it is not known how many BCPPs are employed in Pennsylvania.

Although pharmacists are licensed and regulated by the State Board of Pharmacy, a private organization, the Board of Pharmacy Specialties, establishes standards for and grants certification to pharmacists in recognized pharmacy practice specialties.¹⁶³ As of 2019, there are thirteen specialties including psychiatric pharmacy.¹⁶⁴

To become licensed as a pharmacist in the Commonwealth, an applicant must have graduated with a B.S. degree or an advanced degree in pharmacy granted by an Accreditation Council for Pharmacy Education-accredited school or college, submit affidavits of internship experience gained prior to submitting the application, and pass the North American Pharmacist

¹⁵⁸ U.S. Department of Labor Bureau of Labor Statistics, “Substance Abuse, Behavioral Disorder, and Mental Health Counselors,” *Occupational Outlook Handbook*, (Sept. 4, 2019), <https://www.bls.gov/ooh/community-and-social-service/substance-abuse-behavioral-disorder-and-mental-health-counselors.htm#tab-1>.

¹⁵⁹ Glen L. Stimmel, “Psychiatric Pharmacy,” *American Journal of Health-System Pharmacy* 70 (Feb. 15, 2013): 366-367.

¹⁶⁰ The College of Psychiatric and Neurologic Pharmacists, “CPNP 2017 Sponsor Prospectus,” (2017). https://cpnp.org/_docs/ed/meeting/2017/supporter/prospectus.pdf.

¹⁶¹ Board of Pharmacy Specialists, “BPS Board Certified Pharmacists 2018 Annual Report,” (2018), p. 27.

¹⁶² U.S. Department of Labor, Bureau of Labor Statistics, “Occupational Employment and Wages, May 2018 29-1051 Pharmacists,” *Occupational Employment Statistics*, <https://www.bls.gov/oes/current/oes291051.htm>

¹⁶³ Board of Pharmacy Specialties, “What We Do,” accessed August 29, 2019, <https://www.bpsweb.org/about-bps/what-we-do/>.

¹⁶⁴ Board of Pharmacy Specialties, “BPS Specialties,” accessed August 29, 2019, <https://www.bpsweb.org/bps-specialties/>.

Licensure Examination (NAPLEX) and the Multistate Pharmacy Jurisprudence Examination (MPJE).¹⁶⁵ In Pennsylvania, pharmacists must renew their license biennially.¹⁶⁶

Pharmacists can undertake residencies much like physicians do, however it is not a requirement to complete residency training in order to obtain a license to practice pharmacy. Pharmacy residencies are two years in duration, with the first year offering more generalized training and the second year emphasizing a specific area of training, such as psychiatry.¹⁶⁷ The only medical facility offering psychiatric pharmacy residencies in the Commonwealth is the UPMC Western Psychiatric Hospital in Pittsburgh, which offers three residency positions.¹⁶⁸

For psychiatric pharmacists, collaboration is a hallmark of their profession. Medication management is an important component of treatment for those being treated for mental illness, and the medications that are used to help treat psychiatric patients are varied with oftentimes complex drug regimens.¹⁶⁹ The chronic nature of mental illness and the fact that its treatment often relies on pharmaceuticals necessitates a close working relationship between the BCPP and other members of the mental health care team. BCPPs also provide direct patient care, including treatment assessment and medication management activities, although they do not interact with patients to the extent that counselors, psychologists, or psychiatrists might.¹⁷⁰

In 2012, the National Alliance on Mental Illness (NAMI), an advocacy group for people affected by mental illness, in collaboration with the CPNP, conducted a survey to gauge the attitudes and perspectives of individuals with mental health conditions about the services they receive from and the relationships they have with their pharmacist. The survey asked survey respondents to rate on a scale of one to five, with one being “never” and five being “almost always,” the extent to which their educational or informational needs were being met by their pharmacist.¹⁷¹ The survey was not exclusive to BCPPs, but rather whichever pharmacist the survey respondents frequented to fulfill their prescriptions.

The survey results indicated that many people with mental health medication have an overall positive experience with their pharmacist. For instance, approximately 75 percent of respondents indicated that they get information about their medication from their pharmacist at least sometimes, nearly 70 percent receive general assistance with medication issues at least sometimes, and about 66 percent receive information regarding medication costs and generic options at least sometimes.¹⁷²

¹⁶⁵ 49 Pa. Code § 27.21.

¹⁶⁶ 49 Pa. Code § 27.31.

¹⁶⁷ American College of Clinical Pharmacy, “What is a Residency,” <https://www.accp.com/stunet/compass/residency.aspx#pgy-1>.

¹⁶⁸ College of Psychiatric and Neurologic Pharmacists, “Psychiatric Pharmacy Residency Programs – Pennsylvania,” accessed August 30, 2019, <https://cpnp.org/career/residencies>.

¹⁶⁹ American Pharmacists Association, “What Psychiatric Pharmacy Is, What We Do, and How We Treat Patients,” *Student Pharmacist Magazine* 10 no. 4 (Mar. 18, 2014).

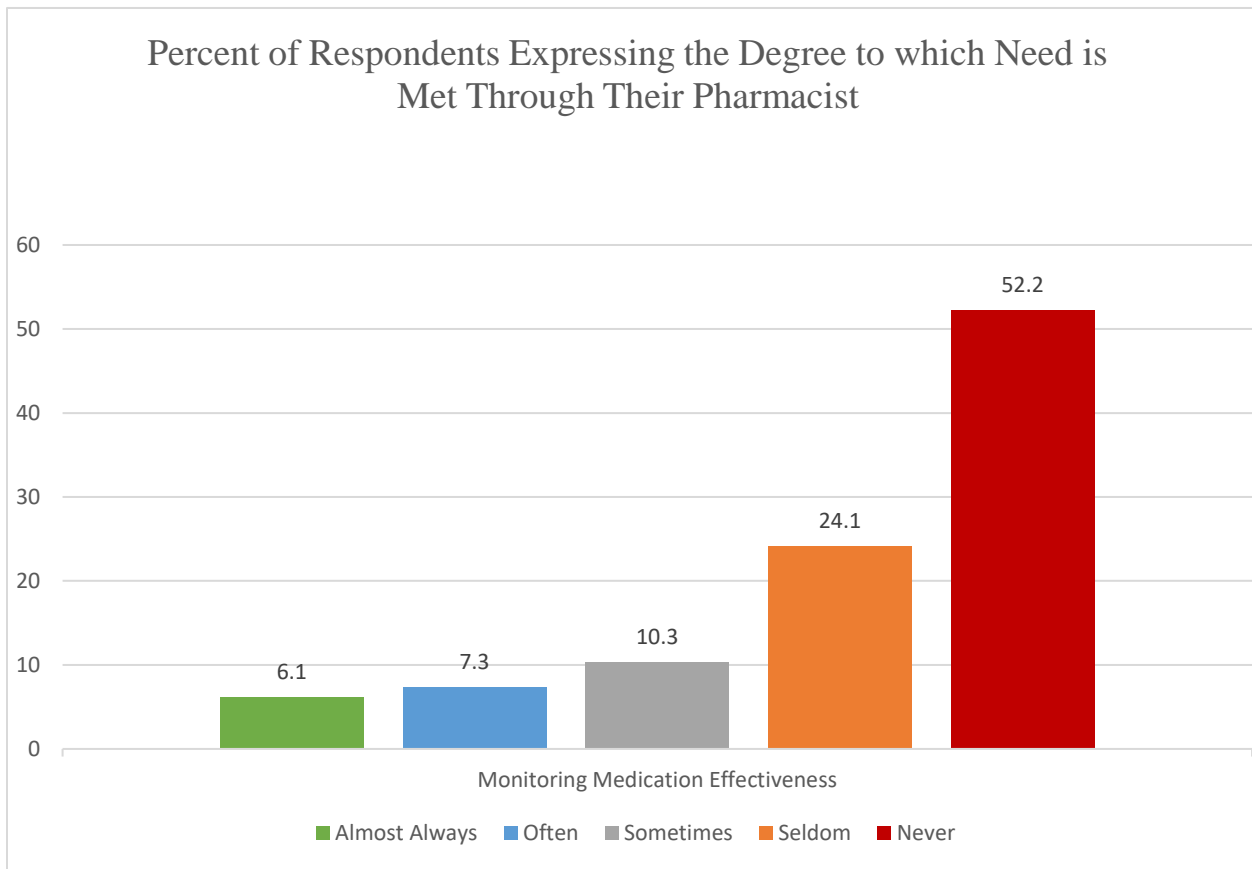
¹⁷⁰ *Id.*

¹⁷¹ National Alliance on Mental Illness, “Characterizing the Relationship Between Individuals with Mental Health Conditions and Community Pharmacists,” (Dec. 2012), <https://www.nami.org/About-NAMI/Publications-Reports/Survey-Reports/nami-cpnp-survey-report2012.pdf>.

¹⁷² *Id.* at p. 6.

However, respondents also gave some negative feedback to the survey. According to the survey, only roughly 53 percent of individuals taking mental health medications have a strong professional relationship with their pharmacist, while 43 percent responded that they did not have such a relationship.¹⁷³ Further, a majority — 52 percent — responded that their need for monitoring medication effectiveness is “never” met by their pharmacist, and only about 23 percent responded that such a need is met by their pharmacist “sometimes” or more frequently.¹⁷⁴ See **Table 2** below.

Table 2



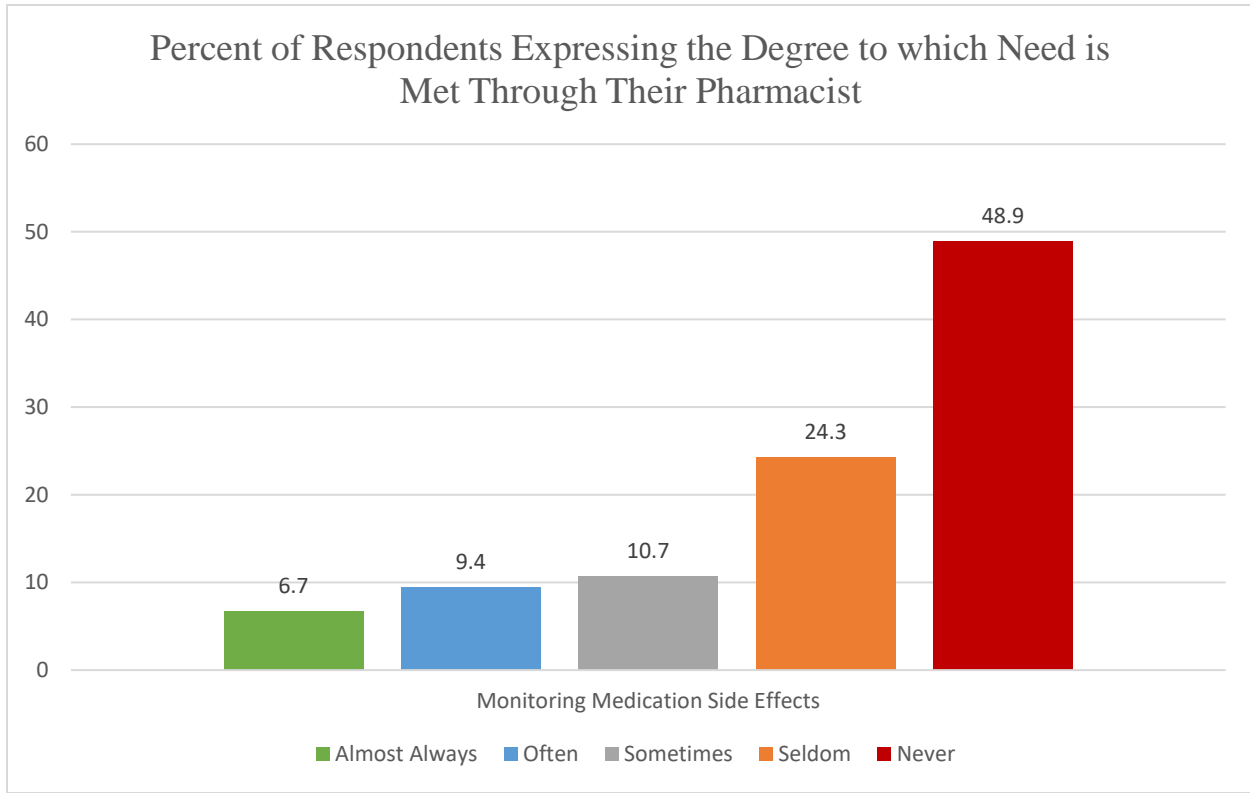
Similar replies were given for whether the respondents thought their pharmacist was meeting their need for monitoring the side effects of medication.¹⁷⁵

¹⁷³ *Id.* at p. 8.

¹⁷⁴ *Id.* at p. 9.

¹⁷⁵ *Id.*

Table 3



The overall results of this survey indicate that while mental health patients receiving medications are generally comfortable with their pharmacists, they do not utilize the pharmacist in the active management of their medication or condition. In the view of the patients surveyed, the pharmacist simply dispenses the drugs.

There were several obstacles to better medication management by pharmacists identified by the patients. One hindrance was the difficulty of accessing the pharmacist at a retail location, as store design and construction has the pharmacist workspace at a higher level than the customer area. Other obstacles identified included the fact that pharmacy technicians are the primary interface for prescription pick-up, a lack of private space to discuss medication issues, and the pharmacist being too busy to interrupt. Survey respondents also articulated a lack of confidence about their pharmacist's knowledge about mental illnesses or their sensitivity towards individuals with a mental health condition.¹⁷⁶

¹⁷⁶ *Id.* at p. 9-10.

According to NAMI, the survey results suggest that pharmacists can be a better utilized part of the health system, as they are on the front lines of medication-based treatment for mental illness. The pharmacist is in a good position to identify issues with medication management for further discussion with the patient's physician before such issues result in adverse outcomes. By directly interacting with patients or their family members and providing information about their medications, the pharmacist can serve as an active partner in managing patient treatment.¹⁷⁷

Mental Health Nursing

Psychiatric-mental health nursing encompasses both psychiatric mental health registered nurses (PMH RNs) as well as advanced practice nurses who specialize in mental health. Psychiatric and mental health nursing has been defined as “a specialized area of nursing practice committed to promoting mental health through the assessment, diagnosis, and treatment of human responses to mental health problems and psychiatric disorders,” employing a wide range of nursing, psychosocial, and neurobiological theories and research evidence.¹⁷⁸

The PMH RN may engage in direct care, management, and communication tasks such as designing and implementing treatment plans for patients, organizing, accessing, negotiating, coordinating, and integrating services and benefits for individuals and families, and managing the effects of mental illness through teaching and counselling.¹⁷⁹ The Center for Mental Health Services, a part of the Substance Abuse and Mental Health Services Administration within the Department of Health and Human Services, has recognized psychiatric nursing as one of the five core mental health disciplines.¹⁸⁰

Psychiatric-mental health nurses – both RNs and advanced practice nurses – work in a variety of settings, including psychiatric facilities, community mental health centers, psychiatric units in general hospitals, residential facilities, and private practice, as well as primary care clinics, schools, prisons, managed care facilities, emergency departments, nursing homes, hospices, and shelters.¹⁸¹ According to the American Psychiatric Nurses Association (APNA), PMH RNs specifically provide services such as:

- Health promotion and maintenance;
- Intake screening, evaluation, and triage;
- Case management;
- Teaching self-care activities;
- Administration and monitoring of psychobiological treatment regimens;
- Crisis intervention and stabilization efforts;
- Psychiatric rehabilitation and intervention;
- Educating patients, families, and communities; and

¹⁷⁷ *Id.* at p. 11.

¹⁷⁸ Gail Wiscarz Stuart, *Principles and Practice of Psychiatric Nursing* (St. Louis: Mosby, 2013), p. 6.

¹⁷⁹ *Id.* at p. 7.

¹⁸⁰ *Id.* at p. 6.

¹⁸¹ *Id.* at p. 9.

- Coordinating care¹⁸²

However, the role of the PMH RN in any psychiatric or mental health setting depends on the philosophy, mission, values, and goals of the treatment setting, along with the definitions of mental health and mental illness that prevail at the setting, needs of the patients of the particular service provider, availability of resources, organizational structure of the service provider, and reporting relationships.¹⁸³

Before someone can become a psychiatric-mental health nurse, they must receive some form of education, which can range from a formal hospital-based diploma program to a Masters-level degree depending on their specific role. In Pennsylvania, the State Board of Nursing sets and oversees their training requirements.

To become an RN, an applicant for licensure must have graduated from an educational program approved by the State Board of Nursing. The required program can be either a diploma-granting program, an associate's degree program, or a bachelor's degree program. As of March 2019, there were 25 associate's degree programs, 42 bachelor's degree programs, and 16 diploma programs approved in Pennsylvania.¹⁸⁴ An applicant must then take and pass an examination.¹⁸⁵

Advanced practice nurses in Pennsylvania are known as either Certified Registered Nurse Practitioners (CRNP or NP) or Clinical Nurse Specialists (CNS). A CRNP is a professional nurse who is certified by the State Board of Nursing in a specialty and who performs acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with a physician.¹⁸⁶

A CRNP must possess a master's or post-master's level degree from an approved board-accredited program.¹⁸⁷ As with the approved RN programs, the Pennsylvania Department of State maintains a list of approved CRNP programs. As of March 2019, there are 87 approved CRNP educational programs which span multiple nursing specialties and institutions.¹⁸⁸ There are seven CRNP masters-level or post-master's programs that focus on psychiatric-mental health nursing as well as two separate BSN to Doctor of Nursing Practice (DNP) programs (Robert Morris University and University of Pittsburgh), which are for bachelor's degree-holding RNs to obtain a

¹⁸² American Psychiatric Nurses Association, "Expanding Mental Health Care Services in America: The Pivotal Role of Psychiatric-Mental Health Nurses," (Apr. 2019), p. 4.
https://www.apna.org/files/public/Resources/Workforce_Development_Report_Final_Draft_6_25.pdf.

¹⁸³ Principles and Practice of Psychiatric Nursing, *supra* n. 178 at p. 9.

¹⁸⁴ Pennsylvania Department of State, "State Board of Nursing Approved Programs," (Mar. 2019),
<https://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Nursing/Documents/Applications%20and%20Forms/RN%20Programs.pdf>.

¹⁸⁵ 49 Pa. Code § 21.21.

¹⁸⁶ 49 Pa. Code § 21.251.

¹⁸⁷ 49 Pa. Code § 21.271.

¹⁸⁸ Pennsylvania Department of State, "Board Approved Certified Registered Nurse Practitioner Programs," (Mar. 2019),
<https://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Nursing/Documents/Applications%20and%20Forms/CRNP%20Programs.pdf>.

doctorate in nursing with a focus on mental health.¹⁸⁹

According to the APNA, psychiatric or mental health NPs perform duties such as:

- Educating patients and families;
- Providing psychotherapy;
- Prescribing medication;
- Diagnosing, treating, and managing acute and chronic illness;
- Making referrals; and
- Providing care coordination¹⁹⁰

According to BLS data, there were 148,520 RNs employed in Pennsylvania as of May 2018.¹⁹¹ Nationwide, the BLS estimates that approximately 39,000 RNs are employed in psychiatric and substance abuse hospitals.¹⁹² However, the BLS does not estimate how many RNs are employed in psychiatric and substance abuse hospitals within the Commonwealth. The National Council of State Boards of Nursing (NCSBN) estimates that there are 227,327 active RN licenses in Pennsylvania.¹⁹³ However, this data is likely to include nurses who have retired or are otherwise not working as an RN but who still hold a license to practice. The NCSBN did not include further information about the RNs it surveyed.

Psychiatric-Mental Health RNs are not considered to be a separate profession from other RNs (unlike Clinical Nurse Specialists and NPs). Becoming a PMH RN does not require any formal educational training, unlike NPs who are required to undertake formal graduate education. However, the American Nurses Credentialing Center (ANCC) offers a Psychiatric-Mental Health nursing certification for RNs. This certification is accredited by the Accreditation Board for Specialty Nursing Certification (ABSNC) and is comprised of a competency-based examination that provides a valid and reliable assessment of the entry-level clinical knowledge and skills of RNs in the psychiatric-mental health specialty.¹⁹⁴

To be eligible to be certified by the ABSNC as a PMH RN, an applicant must hold an active license to practice nursing in at least one jurisdiction, must have two years' experience working as an RN, have a minimum of 2,000 hours of clinical practice in psychiatric-mental health nursing within the last 3 years, and have completed 30 hours of continuing education in psychiatric-mental health nursing within the last 3 years. Nurses who successfully complete these requirements are awarded the credential of "RN-BC."¹⁹⁵ The State Board of Nursing does not require obtaining certification as a psychiatric-mental health RN as a prerequisite to working as a psychiatric-mental

¹⁸⁹ *Id.*

¹⁹⁰ The Pivotal Role of Psychiatric Mental Health Nurses, *supra* n. 182 at p. 5.

¹⁹¹ U.S. Department of Labor, Bureau of Labor Statistics, "Occupational Employment and Wages, May 2018, 29-1141 Registered Nurses," *Occupational Employment Statistics*, <https://www.bls.gov/oes/current/oes291141.htm>.

¹⁹² *Id.*

¹⁹³ National Council of State Boards of Nursing, "Number of Active RN Licenses by State," (Aug. 10, 2019), <https://www.ncsbn.org/Aggregate-RNActiveLicensesTable.pdf>.

¹⁹⁴ American Nurses Credentialing Center, "Psychiatric-Mental Health Nursing Certification (RN-BC)," <https://www.nursingworld.org/our-certifications/psychiatric-mental-health-nursing-certification/>.

¹⁹⁵ *Id.* The title stands for "Registered Nurse – Board Certified."

health RN.¹⁹⁶

Because the PMH RN can either be an RN with or without certification or work within or outside of a psychiatric setting, the PMH RN workforce may be defined in a number of ways. These definitions would include:

- RNs who provide mental health care in non-psychiatric settings, such as in a primary care office;
- RNs who work in a psychiatric setting but provide non-mental health services;
- RNs who self-identify as PMH RNs, including those who may not work in a psychiatric setting but who belong to a professional organization such as the APNA; and
- RNs who have received formal certification as PMH RNs.

Naturally, the variety of ways to define the PMH RN workforce has led to difficulty in obtaining standardized data about this workforce. Government agencies, academics, health systems, and the nursing profession itself may all use different definitions of who is a PMH RN and thereby impede accurate workforce data collection. Further, much of the data on this facet of the mental health workforce is unpublished, and conclusions drawn by different sources diverge based not only on how the PMH RN workforce is defined but also on sampling methods and on the biases inherent in using licensing or certification data to represent the PMH RN population.

A 2019 study attempts to define and describe the PMH RN workforce as those providing care for persons with mental health and substance abuse disorders by evaluating multiple sources of relevant data, much of which is unpublished. These sources include:

- The National Council of State Boards of Nursing and the National Forum of Nursing Workforce Centers 2013 and 2015 National Nursing Workforce Survey data on a representative sample of nationwide RNs who reported working in a psychiatric, mental health, or substance abuse setting;
- The American Nurses Credentialing Center data on persons who have obtained certification at the RN or APRN level; and
- Membership figures for the American Psychiatric Nurses Association (APNA).¹⁹⁷

According to the data gathered by this study, there have been 10,346 nurses who have received the RN-BC certification from the ANCC. Although this figure includes some RNs who went on to become APRNs, it is indicative of the nationwide PMH RN workforce as those nurses who hold the RN-BC certification are a group that has demonstrated a clear commitment to the mental health field within nursing.¹⁹⁸

¹⁹⁶ See 49 Pa. Code § 21.1 *et seq.* The only nursing specialty requiring certification is nurse anesthetist.

¹⁹⁷ Bethany J. Phoenix, “The Current Psychiatric Mental Health Registered Nurse Workforce,” *Journal of the American Psychiatric Nurses Association* 25 no. 1 (Jan./Feb. 2019): 38-48.

¹⁹⁸ *Id.* at p. 39.

The 2013 National Nursing Workforce Survey estimated that four percent of all RNs nationwide worked in a psychiatric, mental health, or substance abuse role.¹⁹⁹ The 2015 National Nursing Workforce Survey estimated that approximately 134,000 RN licenses were held by persons identifying psychiatric, mental health, or substance abuse environments as their primary work setting.²⁰⁰ However, this data includes some individuals who hold multiple licenses. As a result, it is estimated that the actual number of PMH RNs is closer to between 120,000 and 125,000.²⁰¹

One limitation of the data generated from the 2013 and 2015 National Nursing Workforce Surveys is that it is an estimation of RNs working specifically in those settings. As noted earlier, not all PMH RNs work in a psychiatric, mental health, or substance abuse setting – and not all are certified as PMH RNs holding the RN-BC designation. Thus, the 2013 and 2015 surveys may be under-inclusive in that they do not count PMH RNs working outside of those settings.

Although PMH RNs may not all work in a mental health setting, according to data from the ANCC of the PMH RNs who are certified the overwhelming majority work in mental health settings such as hospitals, mental health facilities, military or Veterans Administration hospitals, long-term care, and managed-care organizations. Eight percent work in community health settings such as private and group practice. Only one percent work in general health care settings such as emergency departments or urgent care centers, and an additional one percent work in schools of nursing.²⁰²

ANCC data cited in the 2019 study also included demographic information of the current PMH RN workforce. These data reveal that two-thirds of PMH RNs are over 45 years of age, with 21 percent aged 46 to 55, 31 percent aged 56 to 65, and 13 percent over 65 years of age.²⁰³ Although it would appear from the above data that this nursing workforce is aging quickly, there is evidence indicating that it will not simply retire out of existence. As discussed in more depth in Commission’s April 2019 report *Pennsylvania Health Care Workforce Needs*, nursing program graduates have more than doubled from roughly 70,000 in 2001 to approximately 155,000 in 2013, and by 2017 there were nearly 160,000 U.S.-educated first-time NCLEX takers (which is a good approximation of future nursing workforce entrants).²⁰⁴ This would indicate that Pennsylvania is well-positioned for a stable supply of nurses heading into the next decade, as it currently has the fifth-highest number of RNs of any state²⁰⁵ and, by one estimate, may have an oversupply of RNs. However, as discussed in more detail in *Pennsylvania Health Care Workforce Needs*, other researchers have indicated that the Commonwealth may experience a shortage of RNs.²⁰⁶

¹⁹⁹ The National Council of State Boards of Nursing, “The 2013 National Nursing Workforce Survey of Registered Nurses,” *Journal of Nursing Regulation* 4, no. 2 Supplement (July 2013): S3-S65 at S35.

²⁰⁰ Phoenix, *supra* n. 197 at p. 40.

²⁰¹ *Id.*

²⁰² *Id.*

²⁰³ *Id.* at p. 41.

²⁰⁴ Joint State Government Commission, “Pennsylvania Health Care Workforce Needs,” (Apr. 2019).

²⁰⁵ Occupational Employment Statistics – Registered Nurses, *supra* n. 16. As of May 2018, 148,520 RNs are employed in the Commonwealth.

²⁰⁶ Pennsylvania Health Care Workforce Needs, *supra* n. 204 at p. 20.

Psychiatric-mental health advanced practice nurses (PMH APRNs or PMH NPs) are more easily classifiable, as advanced practice nursing has more demarcation between nursing specialties. There are an estimated 17,534 psychiatric-mental health APRNs nationwide.²⁰⁷ Like PMH RNs, there is a certification that PMH NPs can obtain from the ANCC. To be eligible for this designation, an NP must have a masters, postgraduate, or doctoral degree from a psychiatric-mental health nurse practitioner program accredited by the Commission on Collegiate Nursing Education (CCNE) or the Accreditation Commission for Education in Nursing (ACEN).²⁰⁸ Unlike with education for registered nurses, the education of advance practice nurses can be, and often is, compartmentalized into specialties. This makes those who want to practice in a certain field (such as mental health) self-selecting — they do not attend a general NP program but rather a specialized PMH NP program.

However, as with PMH RNs, there are still conflicting definitions for this particular workforce. The Health Resources and Services Administration (HRSA), in its 2016 report refers to “Behavioral Health Nurse Practitioners,” a term that is not widely used by other institutions engaged in researching the mental health workforce. The HRSA’s 2016 report defines behavioral health nurse practitioners as NPs who “diagnose and treat acute, episodic, or chronic behavioral health-related illness, independently or as part of a broader health care team.”²⁰⁹ This broad definition encompasses NPs who work with patients who have behavioral health-related illnesses, including outside of a behavioral health setting such as in the office as a primary care provider.

Although general health care practitioners who treat their patients’ mental illness play an important role, the HRSA’s definition is broad and makes data collection on the mental health care workforce difficult by obscuring exactly which practitioners are delineated as having mental health care workforce roles. Nonetheless, the HRSA has made projections about the behavioral health NP workforce into 2025.

Under its “baseline” scenario, which assumes supply and demand are in equilibrium in 2013, the HRSA estimates that there will be a nationwide glut of roughly 4,800 behavioral health NPs by 2025, with 12,960 trained for such a role but only 8,120 demanded by patients.²¹⁰ Under its “alternative” scenario, the HRSA estimates that the oversupply of behavioral health NPs will be a mere 2,800, representing 12,960 supplied for that position and 10,160 demanded.²¹¹

²⁰⁷ Phoenix, *supra* n. 197 at p. 39.

²⁰⁸ American Nurses Credentialing Center, “Psychiatric-Mental Health Nurse Practitioner (Across the Lifespan) Certification (PMHNP-BC),” <https://www.nursingworld.org/our-certifications/psychiatric-mental-health-nurse-practitioner/>.

²⁰⁹ National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025, *supra* n. 25 at pp. 26-27.

²¹⁰ *Id.* at p. 18, Exhibit 10.

²¹¹ *Id.* at p. 19, Exhibit 11.

| National Behavioral Health NP Supply and Demand for 2025 | | | | |
|---|---------------------|---------------------|---------------------------|---------------------|
| Supply | Demand | | Adequacy of Supply | |
| | Scenario One | Scenario Two | Scenario One | Scenario Two |
| 12,960 | 8,120 | 10,160 | +4,800 | +2,800 |

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025.

In a later projection by the HRSA (referred to as the “2018 projection”), the agency undertook a national-level supply and demand projection for PMH NPs from 2016 through 2030. In this projection, the HRSA narrowed the scope of the professionals studied to “psychiatric NPs” who “earn advanced degrees in psychiatric-mental health nursing, and apply the nursing process to treat individuals with psychiatric disorders.” The HRSA again calculated the supply and demand balance using two different scenarios. Under “Scenario One,” the HRSA assumed that supply and demand for PMH NPs was in equilibrium in 2016. Under “Scenario Two,” the HRSA adjusted current and projected demand based on estimates of unmet need from current studies.²¹²

In “Scenario One” of the 2018 projection, the HRSA estimated that there would be 16,940 PMH NPs in 2030, representing a 65 percent increase in supply, and a projected demand of 12,100 PMH NPs in 2030, representing an 18 percent increase in demand, with the result being an oversupply of 4,840 PMH NPs. In “Scenario Two,” the projected supply remains the same at 16,940, but the projected demand is greater, with 14,500 PMH NPs demanded by 2030. This projection results in an excess of 2,440 PMH NPs by 2030.²¹³

²¹² U.S. Department of Health and Human Services, Health Resources and Services Administration, “Behavioral Health Workforce Projections, 2016-2030: Psychiatric Nurse Practitioners, Psychiatric Physician Assistants,” (2018), <https://bhwa.hrsa.gov/sites/default/files/bhw/nchwa/projections/psychiatric-nurse-practitioners-physician-assistants-2018.pdf>.

²¹³ *Id.*

| National PMH NP Supply and Demand for 2030 | | | | |
|---|---------------------|---------------------|---------------------------|---------------------|
| Supply | Demand | | Adequacy of Supply | |
| | Scenario One | Scenario Two | Scenario One | Scenario Two |
| 16,940 | 12,100 | 14,500 | +4,840 | +2,240 |

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Behavioral Health Workforce Projections, 2016-2030: Psychiatric Nurse Practitioners, Psychiatric Physician Assistants.

The HRSA has also published state-level projections for PMH NP supply and demand for the year 2030. Much like the nationwide 2016 and 2018 projections, the state-level projection covers two different scenarios – one scenario assumes equilibrium between supply and demand in the base year of 2016, and the other assumes that there was unmet need in the base year. Under both scenarios, Pennsylvania is expected to have 590 PMH NPs. Under the assumed equilibrium scenario, the Commonwealth is projected to need 540 of these practitioners, leaving Pennsylvania with a surplus of 50 PMH NPs. However, under the unmet needs scenario, Pennsylvania is projected to have a demand of 650 PMH NPs, resulting in a deficit of 60 practitioners.²¹⁴

| Pennsylvania PMH NP Supply and Demand for 2030 | | | | |
|---|---------------------|---------------------|---------------------------|---------------------|
| Supply | Demand | | Adequacy of Supply | |
| | Scenario One | Scenario Two | Scenario One | Scenario Two |
| 590 | 540 | 650 | +50 | (60) |

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, State-Level Supply and Demand for Behavioral Health Occupations: 2016-2030.

²¹⁴ U.S. Department of Health and Human Services, Health Resources and Services Administration, “State-Level Supply and Demand for Behavioral Health Occupations: 2016-2030,” p. 20, Table 8, (Sept. 2018), <https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/state-level-estimates-report-2018.pdf>.

It should be reiterated that the HRSA’s nationwide projection in its 2016 report is based on a definition of mental health advanced practice nursing that includes those NPs who are not formally certified as PMH APRNs. Thus, the data in the two tables above reflect a narrower definition of “mental health NP.” Additionally, this estimation was “approximated based on the distribution of NPs across states,” meaning the HRSA simply divided all PMH NPs in the country by the proportion of non-psychiatric NPs practicing in each state. Further, there is a great deal of uncertainty present in any attempt to predict how many mental health NPs will be needed, however defined, because such a role can be interchangeable with other mental health care professionals — particularly physician assistants but also psychiatrists, psychologists, and counselors.

What is more predictable is the number of PMH APRNs who will be trained in the future — the supply — as these data are readily available from professional organizations and academics. These data show that the PMH NP profession is quickly growing. According to data from the American Association of Colleges of Nursing (AACN), there were 6,377 students enrolled in PMH NP programs in 2017, a 63 percent increase over the 3,039 enrolled in such programs in 2014. In 2016, roughly 1,500 students graduated from a PMH NP program, a 56 percent increase over 2014. New PMH NP certifications stood at 1,563 in 2017, representing a 12 percent increase over the previous year. Growth in the number of available PMH NP programs has also been strong. Between 2015 and 2018, 29 new programs have opened across the country, bringing the total to 150.²¹⁵

This strong growth in PMH NPs entering the workforce has led an academic researcher studying the issue to conclude that this particular profession within the mental health care workforce will increase in the coming years. To account for projected future retirements, the researcher calculated the number of current PMH NPs who were 60 years of age or older. This figure is currently 21 percent of the current workforce, or approximately 6,400 people. This is the number of people who would be likely to retire within the next five years. However, the researcher concluded that this loss would be offset by an increase of 1,500 new PMH NPs per year, or 7,500 over five years, leading to an overall increase in the nationwide PMH NP workforce.²¹⁶

As was discussed in the Commission’s earlier report *Pennsylvania Health Care Workforce Needs*, NPs have the potential to fill the gaps left by shortages of other providers, and this is no less true in the field of mental health than it is for primary care and other specialties.²¹⁷ There are roughly 13,700 CRNPs in the Commonwealth according to the Pennsylvania Coalition of Nurse Practitioners.²¹⁸ The Kaiser Family Foundation estimates that there are 7,003 NPs in Pennsylvania as of March 2019.²¹⁹ The Pennsylvania Psychological Association estimates that there are 386

²¹⁵ Kathleen R. Delaney and Dawn Vanderhoef, “The Psychiatric Mental Health Advanced Practice Registered Nurse Workforce: Charting the Future,” *Journal of the American Psychiatric Nurses Association* 25 no. 1 (Jan./Feb 2019): 11-18, at 12.

²¹⁶ *Id.* at p. 13.

²¹⁷ Pennsylvania Health Care Workforce Needs, *supra* n. 204 at p. 93.

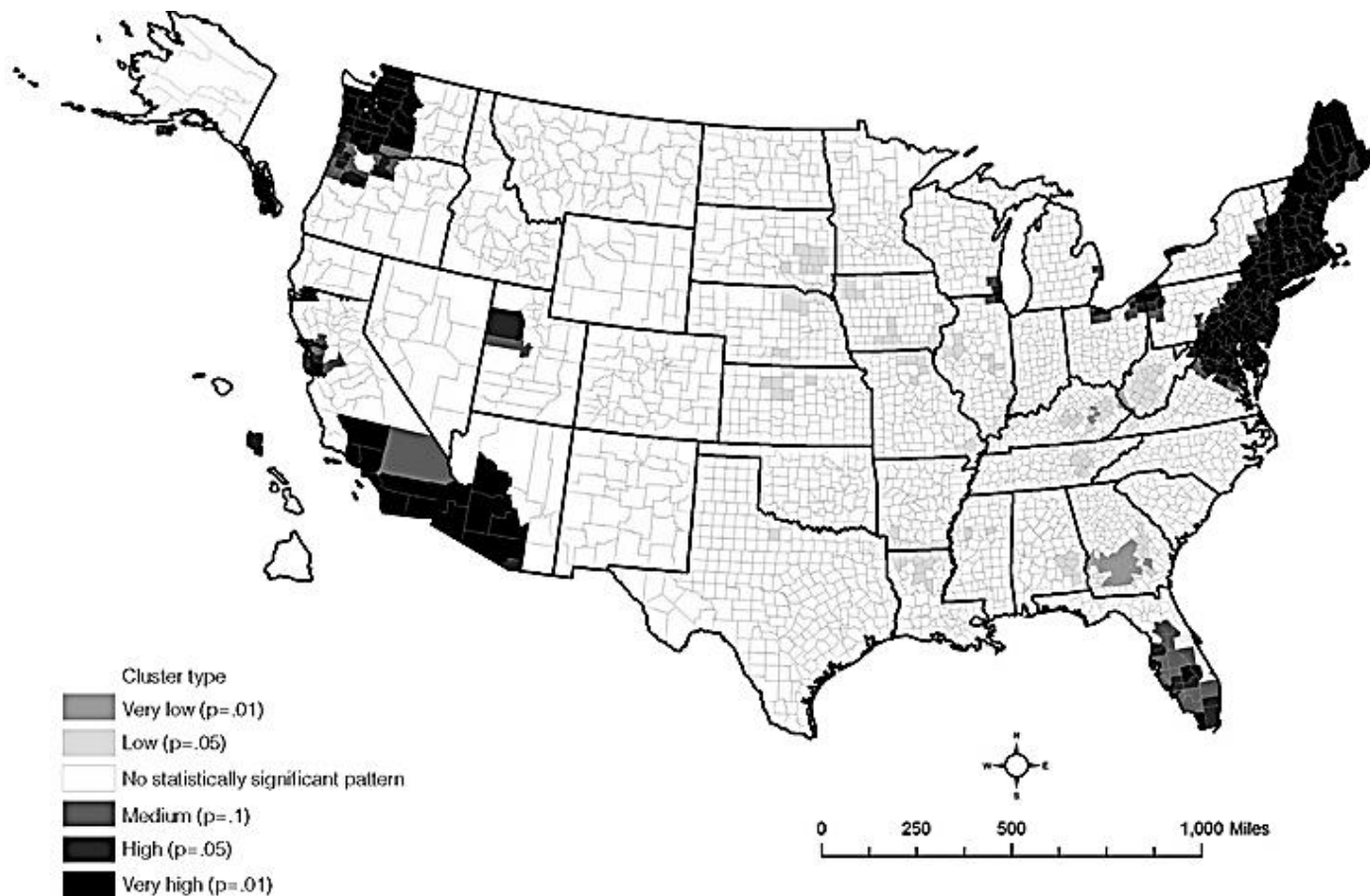
²¹⁸ Pennsylvania Coalition of Nurse Practitioners, “Home Page,” accessed Feb. 11, 2020, <https://www.pacnp.org/>.

²¹⁹ Kaiser Family Foundation, “Total Number of Nurse Practitioners,” accessed Feb. 11, 2020, <https://www.kff.org/other/state-indicator/total-number-of-nurse-practitioners/?activeTab=map¤tTimeframe=0&selectedDistributions=total&selectedRows=%7B%22states%22:%7B%22all%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

psychiatric NPs in Pennsylvania.²²⁰ Neither Pennsylvania Department of Health nor the Pennsylvania Department of State appear to keep or publish data on the number of PMH NPs licensed or practicing in the Commonwealth.

Nationally, PMH NPs are clustered in the Northeast along the I-95 corridor, south Florida, the Pacific Northwest, and a few other urban areas (as shown below on **Map 4**).²²¹

Map 4



Source: Debarchana Ghosh et al., “Geospatial Study of Psychiatric Mental Health-Advance Practice Registered Nurses (PMH-APRNs) in the United States,” *Psychiatric Services* 62 No. 12 (Dec. 2011): 1506-1509.

²²⁰ Pennsylvania Psychological Association communication with Commission staff, Feb 28, 2020.

²²¹ Debarchana Ghosh et al., “Geospatial Study of Psychiatric Mental Health-Advance Practice Registered Nurses (PMH-APRNs) in the United States,” *Psychiatric Services* 62 No. 12 (Dec. 2011): 1506-1509, doi: 10.1176/appi.ps.000532011.

The researchers who conducted the study showing the clustering of PMH NPs concluded that there was a shortage of these professionals.²²² However, it had also been suggested by one researcher that a maldistribution rather than a shortage is the real issue and that an increase of PMH NPs in practice will not alter the lack of such professionals in rural areas, as any new PMH NPs will gravitate toward the more densely populated and more affluent coasts and major urban areas where PMH NPs are already overrepresented. This researcher argued that in “medically underserved areas where recruitment and retention of mental health practitioners is a challenge, provision of training to existing primary care practitioners, consultation via telemedicine, and introduction of incentives for mental health specialists of all backgrounds would be far more effective.”²²³

Psychiatric Physician Assistants

One role that is becoming more common both in the mental health care field and in the health care field more generally is the physician assistant (PA). Created by Dr. Eugene A. Stead of the Duke University Medical Center in 1965, the physician assistant role was developed to relieve a shortage of physicians at the time. For his first class of PAs, Dr. Stead selected four Navy Corpsmen who had received medical training during their military careers and based the curriculum of his PA program on the training that was used for fast-track doctors during the Second World War.²²⁴

Although there were only four former Navy Corpsmen in Dr. Stead’s first graduating class, today there are approximately 131,000 PAs nationwide. Pennsylvania is ahead of the trend – with 8,818 PAs as of 2018, the Commonwealth is third behind only New York and California in the total number of PAs and second after Alaska in the ratio of PAs per capita.²²⁵ This represents an increase of 7.7 percent over the 8,184 practicing PAs in the Commonwealth in 2017.²²⁶

Generally, PAs have graduate degrees. To be eligible to be licensed as a PA in Pennsylvania, an applicant must have graduated from a PA program recognized by either the State Board of Medicine or the State Board of Osteopathic Medicine (collectively referred to as “the Boards”), depending on which body regulates their supervising physician.²²⁷ The State Board of Medicine’s regulations recognize PA education programs accredited by the American Medical Association’s Committee on Allied Health Education and Accreditation (CAHEA), the Commission on Accreditation of Allied Health Education Programs (CAAHEP), Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), or a successor

²²² *Id.*

²²³ Michael Bernstein, “Shortage or Maldistribution?,” *Psychiatric Services* 63 No. 3 (Mar. 2012): 293, doi: 10.1176/appi.ps.20120p293b.

²²⁴ American Association of Physician Assistants, “History of the PA Profession,” <https://www.aapa.org/about/history/>.

²²⁵ National Commission on Certification of Physician Assistants, “2018 Statistical Profile of Certified Physician Assistants,” p. 8, Apr. 2019, <http://prodcmsstoragesa.blob.core.windows.net/uploads/files/2018StatisticalProfileofCertifiedPhysiciaAssistants.pdf>

²²⁶ National Commission on Certification of Physician Assistants, “2017 Statistical Profile of Certified Physician Assistants,” p. 8, <https://prodcmsstoragesa.blob.core.windows.net/uploads/files/2017StatisticalProfileofCertifiedPhysicianAssistants%206.27.pdf>.

²²⁷ 49 Pa. Code § 18.141 (State Board of Medicine); 49 Pa. Code § 25.161 (State Board of Osteopathic Medicine).

organization.²²⁸ However, the State Board of Osteopathic Medicine regulations only recognize PA educational programs accredited by the CAHEA.²²⁹

The current accrediting body for the Boards is ARC-PA, because it is the successor organization to CAAHEP and because only graduates of ARC-PA accredited programs are eligible to sit for the national PA certification examination known as the Physician Assistant National Certifying Exam, or PANCE. The State Board of Osteopathic Medicine has specifically required that PA license applicants take and pass the PANCE, while the regulations of the State Board of Medicine simply state that an applicant for a PA license must pass “the physician assistant examination.”²³⁰

Pursuant to state statute, PAs must be supervised by a physician and have a written agreement with each supervising physician outlining the manner in which the PA will be assisting each supervising physician as well as describing the nature and degree of supervision and direction each supervising physician will provide to the PA.²³¹ The written agreement must be provided to and approved by the Board of Medicine and stipulate that the supervising physician must countersign patients’ records within ten days of being seen by the PA.²³²

Although a plurality of PAs work in primary care, they can and do specialize into certain areas of practice, much like physicians. According to the National Commission on Certification of Physician Assistants (NCCPA), psychiatric PAs accounted for only 1,470 of the total PA workforce as of 2018. This equates to roughly 1.5 percent of all PAs throughout the United States.²³³ However, this number may not accurately reflect the number of PAs working in psychiatric care, as it is not a requirement of any governing body for a PA to formally specialize in a field before working in it.

However, if a PA wanted to formally specialize in psychiatric practice, he or she must obtain a Certificate of Added Qualifications (CAQ) from the NCCPA, the same organization that administers the PANCE exam. In the six years preceding the exam to obtain the CAQ, a PA must earn 150 hours of Continuing Medical Education (CME) credits focused on psychiatry, with 50 of those hours earned within the two years prior to taking the exam.²³⁴

Additionally, PAs seeking the psychiatry CAQ must have gained at least 2,000 hours of experience working as a PA in that specialty within the same six year period. They must have documentation substantiating their work experience. Attestation is required from a supervising physician who works in the specialty and is familiar with the applicant’s practice and experience that the applicant is able to apply the appropriate knowledge and skills needed for practice in

²²⁸ 49 Pa. Code § 18.131.

²²⁹ 49 Pa. Code § 25.151. The CAHEA has since merged with the CAAHEP. See ARC-PA, “ARC-PA History,” <http://www.arc-pa.org/about/arc-pa-history/>.

²³⁰ Pennsylvania Health Care Workforce Needs, *supra* n. 204 at p. 104, (Apr. 2019).

²³¹ Act of December 20, 1985, (P.L. 457 No. 112, § 13); 63 P.S. § 422.13(f).

²³² 49 Pa. Code § 18.142.

²³³ 2018 Statistical Profile of Certified Physician Assistants, *supra* n. 225 at p. 14.

²³⁴ National Commission on Certification of Physician Assistants, “Psychiatry CAQ.” <https://www.nccpa.net/psychiatry>.

psychiatry. The psychiatry CAQ applicant must also take an exam.²³⁵ The Commonwealth does not have any statutory or regulatory requirements for licensed PAs who work in a specialty field of practice.

The average rate of psychiatric PAs to the general population is 0.4 psychiatric PAs per 100,000 people. Compared with other states, Pennsylvania has an above-average rate of psychiatric PAs to the general population.²³⁶ As of 2018, Pennsylvania had a total of 91 psychiatric PAs, the third highest total number after Texas and North Carolina.²³⁷

As for future supply and demand, the HRSA has published its estimation on what the psychiatric PA workforce will look like in 2030, as well as projected future demand for their services. The HRSA calculated two different projections – one assuming an equilibrium between supply and demand for psychiatric PAs as of 2016, and one assuming an unmet need for psychiatric PAs. Under the assumed equilibrium scenario, by 2030 there will be 2,560 psychiatric PAs across the country, with a demand of 1,530, leaving a surplus of 1,030 psychiatric PAs. Under the unmet need scenario, the HRSA projects a supply of 2,560 psychiatric PAs but a demand of 1,920, narrowing the anticipated surplus to 640.²³⁸

| National Psychiatric PA Supply and Demand for 2030 | | | | |
|---|---------------------|---------------------|---------------------------|---------------------|
| Supply | Demand | | Adequacy of Supply | |
| | Scenario One | Scenario Two | Scenario One | Scenario Two |
| 2,560 | 1,530 | 1,030 | +1,920 | +640 |

Source: U.S. Department of Health and Human Services, Health Resources and Service Administration, Behavioral Health Workforce Projections, 2016-2030: Psychiatric Nurse Practitioners, Psychiatric Physician Assistants.

²³⁵ *Id.*

²³⁶ National Commission on Certification of Physician Assistants, “2017 Specialty Report,” p. 116, <https://prodcmstorgesas.blob.core.windows.net/uploads/files/2017StatisticalProfilebySpecialty.pdf>.

²³⁷ Angela J. Beck et al., “Mapping Supply of the U.S. Psychiatric Workforce,” University of Michigan School of Public Health, Behavioral Health Workforce Research Center (Oct. 2018). <http://www.behavioralhealthworkforce.org/wp-content/uploads/2019/01/Y3-FA1-P2-Psych-Mapping-Full-Report-with-Appendix.pdf>.

²³⁸ U.S. Department of Health and Human Services, Health Resources and Service Administration, “Behavioral Health Workforce Projections, 2016-2030: Psychiatric Nurse Practitioners, Psychiatric Physician Assistants,” (2018), <https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/psychiatric-nurse-practitioners-physician-assistants-2018.pdf>.

The HRSA has also projected psychiatric PA supply and demand in 2030 by state. The HRSA utilized the same two-scenario approach to calculating future supply and demand on the state level as it did on the national level. Using this method, the HRSA estimates that there will be 130 psychiatric PAs working in the Commonwealth by 2030, with a projected demand of 60 and 80 under the assumed equilibrium and unmet needs scenarios, respectively. This would result in a surplus of 70 and 50 under the different scenarios.²³⁹

| Pennsylvania Psychiatric PA Supply and Demand for 2030 | | | | |
|---|---------------------|---------------------|---------------------------|---------------------|
| Supply | Demand | | Adequacy of Supply | |
| | Scenario One | Scenario Two | Scenario One | Scenario Two |
| 130 | 60 | 80 | +70 | +50 |

Source: U.S. Department of Health and Human Services, Health Resources and Service Administration, Behavioral Health Workforce Projections, 2016-2030: Psychiatric Nurse Practitioners, Psychiatric Physician Assistants.

Although they make up a small portion of the mental health workforce both within the Commonwealth and throughout the country, they have the potential to fill needed gaps in mental health care, particularly in underserved areas. Nationwide, roughly 37 percent of psychiatric PAs accepted Medicaid, 25 percent accepted Medicare, and 10 percent rendered uncompensated care.²⁴⁰ This is a much greater ratio than psychiatrists, who are more likely to accept private insurance or cash payment only.

²³⁹ U.S. Department of Health and Human Services, Health Resources and Services Administration, “State-Level Supply and Demand for Behavioral Health Occupations: 2016-2030,” p. 24, Table 10, (Sept. 2018), <https://bhwa.hrsa.gov/sites/default/files/bhw/nchwa/projections/state-level-estimates-report-2018.pdf>.

²⁴⁰ 2017 Specialty Report, *supra* n. 236 at p. 118.

FACTORS CONTRIBUTING TO THE SHORTAGE OF MENTAL HEALTH CARE PROVIDERS IN PENNSYLVANIA

The supply of mental health care providers within the Commonwealth is failing to keep pace with the rising demand of mental health services. Before solutions to this failure can be proposed, it is important to first pinpoint the factors responsible for producing the shortage.

Burnout in the Psychology and Psychiatry Professions

One key factor commonly found throughout literature analyzing the mental health provider shortage has been the prevalence of burnout among both psychiatrists and psychologists. While a phenomena like burnout is not solely responsible for the undersupply of mental health professionals, many mental health stakeholders, including the National Council of Behavioral Health (NCBH) believe that it has had a negative influence on those currently practicing within the mental health workforce, and those potentially considering careers in mental health.²⁴¹

Defining Burnout

While the definition of the term “burnout” has varied since its inception, a plurality of researchers tend to favor the definition initially developed by University of California – Berkeley professor Christina Maslach and Rutgers University professor Susan E. Jackson.²⁴² According to Maslach and Jackson, the term “burnout” refers to a “psychological syndrome emerging as a prolonged response to chronic interpersonal stressors on the job.”²⁴³ Prolonged responses under this definition include overwhelming exhaustion, feelings of cynicism and detachment from the job, a sense of ineffectiveness and lack of accomplishment or any combination thereof.²⁴⁴ These three responses are viewed as reliable measurements of burnout because they place “the individual stress experience within a social context and involve[] the person’s conception of both self and others.”²⁴⁵ From this definition came the Maslach Burnout Inventory (MBI) and the Maslach Burnout Inventory – Human Service Scale (MBI-HSS), two of the most commonly-used

²⁴¹ The Psychiatric Shortage: Causes and Solutions, *supra* n. 34.

²⁴² Ian J. Deary, Raymond M. Agius, Andrew Sadler, “Personality and Stress in Consultant Psychiatrists,” *International Journal of Social Psychiatry*, 42 No. 2, (Jun. 1996), <https://doi.org/10.1177/002076409604200205>.

²⁴³ Christina Maslach and Michael P. Leiter, “Understanding the Burnout Experience: Recent Research and its Implications for Psychiatry,” *World Psychiatry*, 15 No. 2, (Jun. 2016): pp. 103-111.

²⁴⁴ *Id.*

²⁴⁵ *Id.*

instruments to measure levels of burnout among employed individuals.²⁴⁶ Both scales have been utilized in 31 percent and 34.5 percent respectively of available studies on burnout.²⁴⁷

Effects of Burnout

By-and-large, burnout is considered a “work-related mental health” impairment that is often linked with episodes of anxiety and depression.²⁴⁸ While burnout can have a profound impact on one’s personal mental state, it can also spawn a litany of physical symptoms such as fatigue, exhaustion, somatization, social withdrawal, and the inability to regulate the expression of emotion.²⁴⁹ These symptoms can adversely affect an individual’s ability to continue functioning in the workplace. For instance, exhaustion and social withdrawal can lead to absenteeism, lowered morale, and reduced efficiency and job performance.²⁵⁰ The aforementioned physical symptoms can be extremely harmful when exhibited by psychiatrists and psychologists – individuals often charged with the professional responsibility of tending to a vulnerable population. For instance, “the depersonalization dimension of burnout can lead to the emotional distancing and disengagement of a psychologist from their clients.”²⁵¹

Prevalence of Burnout among Psychiatrists and Psychologists

Burnout among health professionals in general has become an emergent concern across the U.S. and within the Commonwealth. A 2015 report on a study of physicians experiencing burnout in 2011 and 2014 found an identifiable increase in burnout from 40 percent in 2011 to 48 percent in 2014, which was coupled with a reduction in work satisfaction from 58 percent to 50 percent respectively.²⁵² According to a 2018 update, burnout levels slightly improved by 2017, with an average of approximately 43 percent physicians reporting burnout, with a modest increase in job satisfaction for the same year when compared to 2014. However, physician job satisfaction was still lower than 2011 levels reported in the original report.²⁵³

Burnout levels have been found to be significantly high among mental health providers. Several U.S. studies have indicated that 21 to 67 percent of mental health workers nationally may be experiencing burnout in their jobs.²⁵⁴ A study in Northern California surveyed 151 community mental health workers and found that 54 percent had significant levels of burnout resulting from high emotional exhaustion, while 38 percent reported feelings of burnout attributable to high

²⁴⁶ Hannah M. McCormick *et al.*, “The Prevalence and Cause(s) of Burnout among Applied Psychologists: A Systematic Review,” *Frontiers in Psychology*, 9, No. 1897, (Oct. 16, 2018): p. 2, doi: 10.3389/fpsyg.2018.01897.

²⁴⁷ *Id.*

²⁴⁸ *Id.*

²⁴⁹ *Id.*

²⁵⁰ *Id.*

²⁵¹ *Id.*

²⁵² Tait D. Shanafelt *et al.*, “Changes in Burnout and Satisfaction with Work-Life Balance in Physicians and the General U.S. Working Population between 2011 and 2014,” *Mayo Clinic Proceedings*, (Dec. 2015).

²⁵³ Tait D. Shanafelt *et al.*, “Changes in Burnout and Satisfaction with Work-Life Balance in Physicians and the General U.S. Working Population between 2011 and 2017,” *Mayo Clinic Proceedings*, (Oct. 2018), <https://doi.org/10.1016/j.mayocp.2018.10.023>.

²⁵⁴ Gary Morse *et al.*, “Burnout in Mental Health Services: A Review of the Problem and its Remediation,” *Administrative Policy Mental Health*, 39 No. 5, (Sep. 2012): pp. 341-352, doi: 10.1007/s10488-011-0352-1.

depersonalization rates.²⁵⁵ A study surveying 29 directors of community mental health centers in Iowa found that over two-thirds of the surveyed directors reported having high burnout as a result of emotional exhaustion and low personal accomplishment.²⁵⁶

Similarly, international studies have consistently found that psychiatrists experience high levels of burnout.²⁵⁷ For instance, several studies within the United Kingdom reported a range of 21 percent to 48 percent of psychiatrists having a high level of burnout attributable to emotional exhaustion.²⁵⁸ Another study performed in Italy found that psychiatrists generally experience burnout at a higher level than other physicians.²⁵⁹ Moreover, higher levels of emotional exhaustion and severe depression were found among psychiatrists than other physicians practicing in Scotland, while psychiatric nurses experienced higher levels of work-related exhaustion than other nurses in Sweden.²⁶⁰ It is important to note that the psychiatrists in the Scotland study did not report more overall work-related stress than physicians and surgeons.²⁶¹

A 1988 study analyzing burnout in psychologists found that prevalence of burnout can vary depending on age and experience of the provider.²⁶² The study found that younger psychologists reported burnout at higher levels than their older peers.²⁶³ The study opined that such a finding may be attributable to the notion that with age, psychologists have developed the ability to conserve their emotional energy so that it is not depleted.²⁶⁴ The correlation between age and burnout level was further supported in a subsequent 1999 study which concluded that age accounted for 8.4 percent of reports of emotional exhaustion and 9.4 percent of the variance in depersonalization in counseling psychologists.²⁶⁵ Moreover, a 2013 study went even further and concluded that age appeared to be the only demographic factor that could distinguish between high and low burnout among psychologists.²⁶⁶

²⁵⁵ *Id.*

²⁵⁶ *Id.*

²⁵⁷ Hector A. Garcia *et al.*, “Burnout among Psychiatrists in the Veterans Health Administration,” *Burnout Research*, 2, No. 4, (Dec. 2015): pp. 108-114, <https://doi.org/10.1016/j.burn.2015.10.001>.

²⁵⁸ Gary Morse, *supra* n. 254.

²⁵⁹ C. Bressi *et al.*, “Burnout among Psychiatrists in Milan: A Multicenter Survey,” *Psychiatric Services*, 60 No. 7, (Jul. 2009): 985-988.

²⁶⁰ Ian J. Deary, Raymond M. Agius, Andrew Sadler, “Personality and Stress in Consultant Psychiatrists,” *International Journal of Social Psychiatry*, 42 No. 2, (Jun. 1996): pp. 112-123, <https://doi.org/10.1177/002076409604200205>; S. Thomsen *et al.*, “Feelings of Professional Fulfillment and Exhaustion in Mental Health Personnel: The Importance of Organizational and Individual Factors,” *Psychotherapy and Psychosomatics*, 68 No. 3, (1999): pp. 157-164, <https://doi.org/10.1159/000012325>.

²⁶¹ Personality and Stress in Consultant Psychiatrists, *supra* n. 260.

²⁶² G. Ackerley *et al.*, “Burnout among Licensed Psychologists,” *Professional Psychology-Research and Practice*, 19 No. 624, (1988), doi: 10.1037/0735-7028.19.6.624.

²⁶³ *Id.*

²⁶⁴ *Id.*

²⁶⁵ L. Vredenburg, A. Carlozzi, L. Stein, “Burnout in Counseling psychologists: Types of Practice Setting and Pertinent Demographics,” *Counseling Psychology*, (2015): pp. 293-302, doi: 10.1080/095150799082540.

²⁶⁶ P. Hardiman, J.G. Simmonds, “Spiritual Well-Being, Burnout and Trauma in Counsellors and Psychotherapists,” *Mental Health, Religion, and Culture*, No. 16, pp. 1044-1055, doi: 10.1080/13674676.2012.732560.

Sources of Burnout in Psychiatry and Psychology

The sources generally attributable to the dimensional responses linked to burnout often include one or more of the following: extreme workload (too much work, without enough resources; control (micromanagement, lack of influence, and/or accountability without power); lack of reward (not enough pay, acknowledgement, or satisfaction); community (isolation, conflict, disrespect); fairness (discrimination, favoritism); and values (ethical conflicts, meaningless tasks).²⁶⁷ Sources of burnout are not strictly limited to the above list, as burnout can also result from situational factors such as “a mismatch between the individual and the work environment.”²⁶⁸

While there are many sources of burnout in the workforce generally, some reports have honed in on some very specific causes of burnout within the psychiatry and psychology professions. In a 2017 report the NCBH pinpointed a host of specific administrative burdens on psychiatrists working in public community behavioral health centers that often lead to burnout.²⁶⁹ According to the NCBH, these burdens include the following:

- Regulatory restrictions on sharing information that can better coordinate care.
- Limited time with patients to explain their conditions, assess the impacts of psychiatric medications, and support the patient and family.
- Increased requirements for documentation and data entry into the electronic medical record (EMR).
- Minimal support resources to organize medical records, conduct routine medical assessments, arrange for scheduling and complete required documentation.
- Schedules that do not allow for collegial sharing, supervision of staff, and consultation with colleagues.²⁷⁰

According to the NCBH report, the specific burdens listed above have contributed significantly to decreased feelings of personal accomplishment, emotional exhaustion, and a feeling of extreme workload among psychiatrists.²⁷¹ An example of increased requirements for documentation found in the report was the fact that psychiatrists in high-volume outpatient settings are experiencing increased demands for documentation and collateral activities involving medication prescription that often “impedes the efficient use of [psychiatrists’] time...”²⁷² Another study reported that new documentation requirements have also increased emotional exhaustion and decreased personal accomplishment among psychologists.²⁷³

²⁶⁷ Personality and Stress in Consultant Psychiatrists, *supra* n. 260.

²⁶⁸ *Id.*

²⁶⁹ “The Psychiatric Shortage: Causes and Solutions,” *supra* n. 34 at p. 17.

²⁷⁰ *Id.* at pp. 17-18.

²⁷¹ *Id.*

²⁷² *Id.* at p. 20.

²⁷³ Hannah M. McCormick *et al.*, *supra* n. 246 at p. 12.

Studies have also found that “[p]sychologists are potentially predisposed to burnout through putting others needs before their own and despite the knowledge that social support can buffer against the negative effects of burnout, many psychologists themselves are reluctant to seek their own professional help.”²⁷⁴ In many cases, high levels of burnout among psychologists have been attributable to emotional exhaustion resulting from high work demands and a lack of autonomy.²⁷⁵ A prime example of this was revealed in a study surveying school psychologists in the public sector. The study concluded that burnout from extreme workload was far more prevalent among school psychologists who served multiple schools versus those who served only one school. Consequently, psychologists with higher patient-volumes, longer work hours, and a lack of autonomy tend to experience higher levels of emotional exhaustion that contribute to burnout.²⁷⁶

In addition, psychologists working in the private sector, where they tended to exert more control and flexibility over clients, hours worked, and case variability (as opposed to working in the public sector like many school psychologists), have reported lower levels of burnout than those working in the public sector.²⁷⁷ An example of this private-public sector difference was found in a report that analyzed both psychiatrists and psychologists who worked within the U.S. Department of Veterans Affairs (VA), which oversees the largest integrated mental health care system in the U.S. and psychiatrists make up a significant portion its mental health workforce – more than 3,000 psychiatrists according to 2014 data.²⁷⁸ A 2015 study of psychiatrists within the VA found extremely high levels of occupational burnout, with 86 percent of psychiatrists reporting high exhaustion and 90 percent reporting high cynicism.²⁷⁹ Military mental health providers reported that providers who had a greater number of patients per week experienced decreased feelings of personal accomplishment.²⁸⁰

Impact on the Mental Health Workforce Shortage

Given its profound effects, employee burnout has been linked to frequent absenteeism and even job turnover. Studies have found that high levels of burnout “increased the risk of absence related to mental and behavioral disorders, as well as diseases of the circulatory, respiratory, and musculoskeletal systems.”²⁸¹ Further, studies have found that in the mental health field, “staff absences and turnover are correlated with reduced fidelity to evidence-based practices and increase the costs of recruiting and training new staff” for health facilities.²⁸² While the need for burnout prevention and interventions for mental health providers has been acknowledged by researchers for quite some time, an insufficient amount of attention has been directed at addressing the need. Without appropriate efforts to reduce its prevalence and eliminate its sources, burnout will continue to be a contributing factor fueling the growing shortage of mental health care providers within the Commonwealth.

²⁷⁴ *Id.* at p. 13.

²⁷⁵ *Id.* at p. 12.

²⁷⁶ *Id.*

²⁷⁷ *Id.*

²⁷⁸ Hector A. Garcia *et al.*, *supra* n. 257.

²⁷⁹ *Id.*

²⁸⁰ *Id.*

²⁸¹ Gary Morse, *supra* n. 254.

²⁸² *Id.*

Inadequate Enforcement of Mental Health Parity Laws

Another factor that appears to be aggravating the mental health provider shortage both on a national level and within the Commonwealth is the inadequate enforcement of the laws and regulations governing mental health insurance parity. While mental health insurance parity is mandated under federal and state law, Pennsylvania continues to grapple with the disparate treatment of mental health coverage by insurance carriers. The consequence of this disparate treatment is lower insurance reimbursement to mental health providers and oftentimes fewer individuals seeking needed mental health treatment. Both of these consequences often deter individuals from pursuing a career in the mental health field according to a 2017 National Council for Behavioral Health report.²⁸³

Traditional Treatment of Coverage

The concept of mental health insurance parity has been discussed since the early 1960s.²⁸⁴ It is the notion that mental health conditions and substance use disorders be treated equally within health insurance plans.²⁸⁵ In other words, insurance companies must provide the same level of benefits for mental illness or substance abuse as it does for other physical disorders and diseases. Equal application of benefits would include visit limits, deductibles, copayments, as well as lifetime and annual limits.

Insurers and employers have traditionally covered treatment for mental health conditions differently than treatment for physical conditions. For instance, mental health care coverage had its own (usually higher) cost-sharing structure, higher restrictions limiting the number of inpatient days and outpatient visits permitted, separate annual and lifetime caps on coverage, and different prior authorization requirements than coverage for other medical care.²⁸⁶ These restrictive coverage rules had the effect of making mental health benefits “substantially less generous than benefits for physical health conditions.”²⁸⁷

Federal Legislative Efforts

Recognizing the unequal treatment of mental health conditions over the years, both Congress and a number of presidential administrations sought solutions through federal legislation and policies. According to the U.S. Department of Health and Human Services (HHS), President John F. Kennedy first sought to implement a parity policy within the Civil Service Commission (now known today as the Office of Personnel Management). However, this policy had been scaled back in the mid-1970s. During the 1970s, many individual states began enacting parity laws, mostly limited to small group health plans, while others applied to certain individual policies.

²⁸³ The Psychiatric Shortage: Causes and Solutions, *supra* n. 34 at p. 37.

²⁸⁴ U.S. Department of Health and Human Services, “Parity Policy and Implementation,” (Dec. 27, 2018), <https://www.hhs.gov/about/agencies/advisory-committees/mental-health-parity/task-force/resources/index.html>.

²⁸⁵ National Alliance on Mental Illness, “What is Mental Health Parity?” <https://www.nami.org/find-support/living-with-a-mental-health-condition/understanding-health-insurance/what-is-mental-health-parity>.

²⁸⁶ Sarah Goodell, “Health Policy Brief: Mental Health Parity,” *Health Affairs*, (Apr. 3, 2014), <https://www.healthaffairs.org/doi/10.1377/hpb20140403.871424/full/>.

²⁸⁷ *Id.*

Some states established minimum benefit level requirements for both mental health and substance use disorders.²⁸⁸

In 1992, Senators Pete Domenici and John Danforth introduced the first federal parity legislation in Congress known as the Equitable Health Care for Severe Mental Illnesses Act (S.2696).²⁸⁹ This proposed legislation was referred to the Committee of Labor and Human Resources on May 12, 1992. However, the bill never became law.²⁹⁰

In 1996, the Mental Health Parity Act (MHPA), championed by Senators Paul Wellstone and Pete Domenici, was enacted to prohibit large group health plans from imposing annual or lifetime dollar limits on mental health benefits that are less favorable than those limits imposed on other medical or surgical benefits. The MHPA applied to fully insured group health plans and self-insured group health plans. The law contained an exemption that permitted group health plans to waive some of its key requirements if the plans were able to demonstrate that compliance would result in cost increases of at least one percent. The MHPA did not outright mandate coverage for mental health treatment. Instead, its parity requirements only applied to group health plans that provided mental health coverage.²⁹¹

With the promise of making both mental health and substance abuse treatment just as accessible as care for other physical health conditions, the U.S. enacted the federal law formally known as the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).²⁹² In general, the MHPAEA was designed to prevent group health plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on other medical or surgical benefits. The MHPAEA essentially preserves the already in-place MHPA protections and added significant new protections, most notably extending the parity requirements to substance use disorders.²⁹³

Initially the MHPAEA only applied to group health plans and group health insurance coverage, but it was later amended by the Affordable Care Act and again by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the ACA) to apply to individual health insurance coverage. It did so by adding mental health and substance use disorder services to the ten Essential Health Benefit categories that all new small group and individual market plans are required to cover by 2014.²⁹⁴

²⁸⁸ Parity Policy and Implementation, *supra* n. 284.

²⁸⁹ *Id.*

²⁹⁰ Congress.Gov, “S.2696 – Equitable Health Care for Severe Mental Illnesses Act of 1992,” 102nd Congress (1991-1992), <https://www.congress.gov/bill/102nd-congress/senate-bill/2696>.

²⁹¹ U.S. H.R. 4058 (104th Congress, 2nd Sess.), Sept. 11, 1996.

²⁹² The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 enacted on October 3, 2008 as sections 511 and 512 of the Tax Extenders and Alternative Minimum Tax Relief Act of 2008 (Division C of Pub. L. 110-343); 29 U.S.C. §1185a.

²⁹³ Centers for Medicare and Medicaid Services, Center for Consumer Information & Insurance Oversight, “The Mental Health Parity and Addiction Equity Act (MHPAEA),” https://www.cms.gov/ccii/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html.

²⁹⁴ *Id.*

The following Table is a comprehensive list of federal parity policies and legislation that have been implemented since 1961.

Table 4

| Timeline of Federal Parity Policies from 1961 – 2016 | |
|---|--|
| Year | Policy Event |
| 1961 | President John F. Kennedy directed the Civil Service Commission (now known as the Office of Personnel Management) to implement parity. |
| 1992 | The first federal parity legislation (S.2696) was introduced in Congress by U.S. Senators Pete Domenici and John Danforth. |
| 1996 | Congress enacted the Mental Health Parity Act, which required comparable annual and lifetime dollar limits on mental health and medical coverage in large group health plans including employer-sponsored group health plans. |
| 1999 | President Bill Clinton directed the Office of Personnel Management to implement parity in the Federal Employee Health Benefit Plan (FEHBP). |
| 2003 | President George W. Bush’s administration established the New Freedom Commission on Mental Health which included a recommendation regarding parity in the Commission’s Final Report. |
| 2008 | Congress enacted the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), which applied to large group health plans including employer-sponsored plans and was effective for most plans starting in 2010. |
| 2009 | Congress enacted the Children’s Health Insurance Program Reauthorization Act which required parity within CHIP plans. In the same year, CMS released a State Official letter providing additional guidance regarding the MHPAEA’s application to CHIP. |
| 2010 | Interim final rules were issued to implement the MHPAEA – effective for most policies and plans in 2011. |
| 2013 | Final rules were issued to implement the MHPAEA – effective for most policies and plans in 2015. Final rules on Essential Health Benefit (EHB) Plans were issued, implementing mental health and substance use disorder as a |

| | |
|--|--|
| <p style="text-align: center;">2013 <i>continued</i></p> | <p>category of EHB and extending MHPAEA final rule parity requirements to small group insurance and individual insurance plans starting in 2015.</p> <p>Final rules on Alternative Benefit Plans were issued providing further guidance regarding MHPAEA’s application to EHBs in this Medicaid program.</p> <p>Medicaid State Health Officials letter was published providing guidance on the application of MHPAEA requirements to Medicaid managed care organizations, Medicaid Alternative Benefits Plans, and CHIP.</p> |
| <p style="text-align: center;">2016</p> | <p>TRICARE (formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)) issued a proposed rule that levels cost sharing between medical-surgical and behavioral health care and eliminates treatment limits for mental health and substance use disorder care.</p> <p>Final regulations issued on parity in Medical managed care organizations, Medical Alternative Benefits Plans, and CHIP.</p> |

Source: Data Timeline adapted by the Commission from U.S. Department of Health and Human Services, “Parity Policy and Implementation,” (last updated Dec. 27, 2018), <https://www.hhs.gov/about/agencies/advisory-committees/mental-health-parity/task-force/resources/index.html>.

State Legislative Efforts

Individual states began enacting laws intending to achieve mental health insurance parity in the 1970s. Many of these states’ laws varied to some degree. Some laws applied solely for small group health plans, while others applied to individual policies. Employer-sponsored group health plans have generally been exempted under state established parity laws.²⁹⁵

Numerous states have enacted purely equal coverage laws while essentially expanding the definition of mental health care. These types of laws vary throughout the U.S., ranging from limited (requiring coverage of only a few specific mental illnesses) to comprehensive (requiring broad coverage for all mental illnesses) which under certain state laws includes substance abuse disorders.²⁹⁶ Parity of covered benefits under these laws often include duration or frequency of coverage, dollar amount of coverage, and beneficiary financial requirements. Some of the states with equal coverage parity laws include Arkansas,²⁹⁷ Connecticut,²⁹⁸ Delaware,²⁹⁹ and New Jersey.³⁰⁰

²⁹⁵ National Conference of State Legislatures, “Mental Health Benefits: State Laws Mandating or Regulating,” (Dec. 30, 2015 — updated May 30, 2017), <http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx>.

²⁹⁶ *Id.*

²⁹⁷ 1997 Ark. Legis. Serv. 1020; Ark. Code Ann. § 23-99-501 *et seq.*

²⁹⁸ Conn. Gen. Stat. Ann. § 38a-514.

²⁹⁹ Del. Code Ann. Tit. 18 § 3343.

³⁰⁰ 2019 N.J. Laws Ch. 58, No. 2031; N.J. Stat. Ann. 17:48-6v.

Other states have established minimum benefit level requirements for mental health and substance use disorders. These laws require that there be some minimum level of coverage for mental illnesses or substance use disorders if coverage for those types of conditions is being provided. An example of these minimum benefits would be equal copayments and deductibles up to the required level of benefits provided by the carrier.³⁰¹ Currently Pennsylvania has minimum mandated benefits requirements for “alcohol or drug abuse.”³⁰² Other states with currently enacted minimum mandated benefits requirements include Alaska,³⁰³ California,³⁰⁴ and Maine.³⁰⁵

Mandated offering laws generally require that an insurance carrier provide an option of coverage for mental illness, serious mental illness, substance abuse, or a combination thereof. The insured individual can either accept or reject the option. Moreover, these laws also typically require that if mental health coverage benefits are offered they must be equal to non-mental health benefits. Alabama’s mental health parity law is one example of a mandated offering law that requires all group health benefit plans offer to provide, at a minimum, additional mental health benefits for a person receiving medical treatment for certain mental illnesses diagnosed by an appropriately licensed provider.³⁰⁶

In an effort to promote greater transparency and accountability, some states have enacted parity laws requiring annual reporting from insurance carriers to ensure mental health parity compliance and to strengthen overall enforcement. Generally, reporting requirements direct insurance providers to file an annual report with the state’s insurance enforcement agency containing a description of the process used to develop or select the medical necessity criteria for mental illness, drug and alcohol dependency benefits, and medical and surgical benefits, along with other processes utilized by the insurance provider to comply with the MHPAEA.³⁰⁷ Jurisdictions with annual reporting requirements include Colorado,³⁰⁸ Delaware,³⁰⁹ District of Columbia,³¹⁰ Illinois,³¹¹ New Jersey,³¹² and New York.³¹³ The Pennsylvania Department of Insurance is also working on developing regulations for attestation and documentation requirements for health insurers that are required to comply with existing mental health and substance use disorder parity laws.³¹⁴

³⁰¹ NCSL Mental Health Benefits: State Laws Mandating or Regulating, *supra* n. 295.

³⁰² Act of Dec. 22, 1989 (P.L. 755, No. 106, § 8); 40 P.S. §§ 908-1—908-8.

³⁰³ Alaska Stat. § 21.55.110.

³⁰⁴ Cal. Ins. Code § 10112.27.

³⁰⁵ ME. Rev. Stat. tit. 24-A § 4234-A.

³⁰⁶ Ala. Code § 27-54-4.

³⁰⁷ See Delaware S.B. 230, 149th General Assembly (2017-2018); 18 Del. C. § 3343.

³⁰⁸ Colo. Rev. Stat. Ann. § 10-16-147.

³⁰⁹ Del. Code Ann. Tit. 18 § 3343(g).

³¹⁰ D.C. Code § 31-3175.03.

³¹¹ 215 Ill. Comp. Stat. 5/370c.1(k).

³¹² 2019 N.J. Laws Ch. 58, No. 2031.

³¹³ N.Y. Ins. Law § 343.

³¹⁴ Proposed Rulemaking, Insurance Department, Mental Health Parity Analysis Documentation, 50 Pa. B. 798 (Feb. 8, 2020).

Ineffective Enforcement

Despite the enactment of federal and state legislative measures mentioned above, many states, including Pennsylvania, are failing to achieve true mental health parity. Furthermore, states are only just starting to enact laws to strengthen enforcement of parity, such as annual reporting requirements. One of the key reasons that true mental health parity has continued to evade Pennsylvania, along with many other states, is lack of effective enforcement tools. To fully understand the issue of enforcement as it relates to mental health parity, it is critical to understand the interplay between federal parity requirements and the role of the states.

While mental health parity is mandated under federal law (the MHPAEA), states are given primary enforcement authority for health plans entered into within their jurisdiction (individual and small group health plans, fully insured large group health plans, and Medicaid plans), while the federal government through the Department of Labor enforces parity among self-insured employer plans known as ERISA plans.³¹⁵ State enforcement of the MHPAEA is usually administered through a state's respective insurance departments or state banking agencies.

Under the final rules of the MHPAEA, any processes, strategies, evidentiary standards, and other factors used by an insurance carrier in managing mental health and substance abuse benefits must be comparable to, and applied no more stringently than, those used in managing other medical or surgical benefits.³¹⁶ This also includes medical management standards, prescription drug formulary design, network adequacy, provider fee levels, and step therapies, among other processes. These standards and processes are known under the MHPAEA as non-quantitative treatment limitations (NQTLs).³¹⁷ State insurance departments often have to examine these NQTLs to determine compliance with the MHPAEA by conducting a careful qualitative review of a plan's or health plan issuer's care management protocols. Due to the complexity of the NQTLs, competent clinical and legal professionals must conduct these reviews.³¹⁸ Unfortunately, studies have revealed that state review of NQTLs has not paved the way for parity.

According to a report commissioned by the Mental Health Treatment and Research Institute, there are still identifiable disparities in both out-of-network utilization and reimbursement rates for other medical or surgical providers when compared to mental health care providers. For example, the report highlighted that between 2013 and 2015, the proportion of inpatient facility services for mental health care that were provided out-of-network was 2.8 to 4.2 times higher than for other medical or surgical services. Moreover, the proportion of out-of-

³¹⁵ Lindsey Vuolo, Robyn Oster, Ellen Weber, "Evaluating the Promise and Potential of the Parity Act on its Tenth Anniversary," *Health Affairs* (blog), (Oct. 10, 2018), doi: 10.1377/hblog20181009.356245.

³¹⁶ Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program, Fed. Reg. 68240, (Nov. 13, 2013) (to be codified at 45 C.F.R. Parts 146 and 147), <https://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf>.

³¹⁷ Stephen P. Melek *et al.*, Milliman Research Report, "Addiction and Mental Health vs. Physical Health: Analyzing Disparities in Network Use and Provider Reimbursement Rates," Mental Health Treatment and Research Institute LLC, (Dec. 2017), p. 1, <http://www.milliman.com/uploadedFiles/insight/2017/NQTLDisparityAnalysis.pdf>.

³¹⁸ Mental Health Partnerships, "Advocacy — Insurance Equity in Pennsylvania," (accessed Dec, 16, 2019), <https://www.mentalhealthpartnerships.org/insurance-equity-pa/>.

network outpatient facility services for mental health care was 3.0 to 5.8 times higher than for other medical or surgical services, and the proportion of out-of-network mental health care office visits was 4.8 to 5.1 times higher than for other medical or surgical primary care office visits.³¹⁹

Regarding reimbursement rates, the report ascertained that between 2013 and 2015, primary care providers were paid 20.7 percent to 22 percent higher rates for office visits than mental health care providers, while medical and surgical specialty care providers were paid 17.1 percent to 19.1 percent higher rates for other office visits than were mental health care providers.³²⁰ Further evidence supporting the notion that the current rates offered by insurance providers are below the actual market value of the mental health care services provided is that 40 percent of psychiatrists across the country have opted to run cash-only practices in order to avoid the low insurance reimbursement.³²¹

It should be emphasized that parity of provider reimbursement rates for mental health care services is not required under the MHPAEA. However, the MHPAEA does require process parity in the establishment of reimbursement rates, meaning that the process by which the payer establishes the reimbursement rates for mental health services must be comparable to that of the process for other medical or surgical reimbursement rates.³²² The large disparities illustrated in the statistics above between mental health care services and other medical or surgical services leaves open the question of whether insurance companies are complying with the MHPAEA, and further, whether state-level insurance departments are adequately enforcing the law's provisions.

State insurance regulators who are directed to enforce parity for state-regulated commercial plans often “rely on traditional tools, such as form review and consumer complaints, which are reactive and insufficient for parity enforcement.” Overreliance on consumer complaints is an ineffective way of enforcing parity laws because patients may be unaware of the MHPAEA or its state law equivalent, may not understand the intricacies of the law or what constitutes a violation, and may not be aware of any rights they afford or the path necessary to enforce those rights. Essentially, many “[c]onsumers are generally unable and uninterested in navigating a burdensome and confusing complaint process in the midst of a health crisis.” It is this lack of effective enforcement at the state level which has the effect of making even strong parity laws toothless.³²³

The unequal patterns of coverage for mental health care are often the result of poorly enforced parity laws. This unequal reimbursement pattern is at least partially responsible for the lower salaries of psychiatrists when compared to other medical specialties. At least one study in the literature found higher wages for mental health care providers in areas where mental health parity is enforced.³²⁴ A lack of effective enforcement, however, has precipitated a steady stream

³¹⁹ Milliman Research Report, *supra* n. 317 at pp. 1-2.

³²⁰ *Id.* at p. 2.

³²¹ The Psychiatric Shortage: Causes and Solutions, *supra* n. 34.

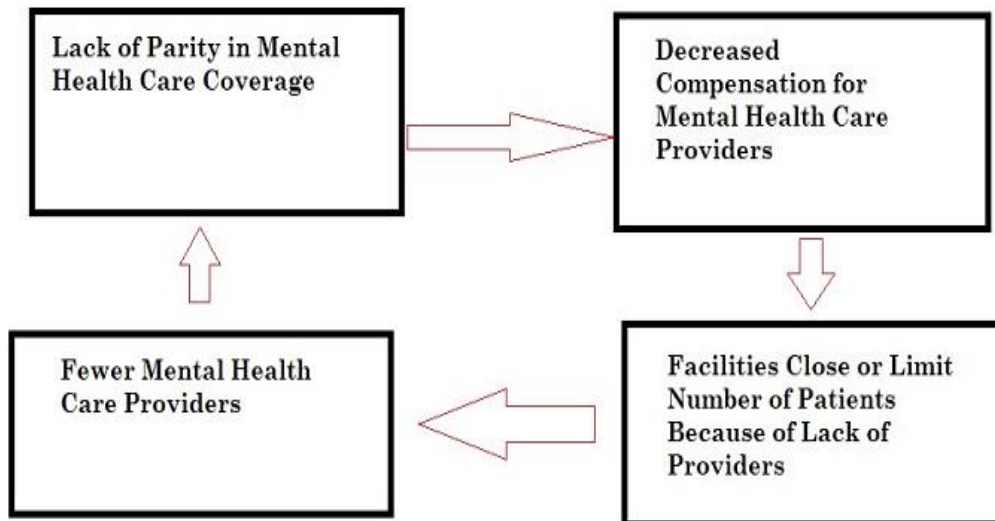
³²² Tim Clement *et al.*, “The ‘Six-Step’ Parity Compliance Guide for Non-Qualitative Treatment Limitation (NQTL) Requirements,” *Kennedy Forum Issue Brief*, (Sept. 2017), p. 86, <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/faq-38/00018.pdf>.

³²³ Evaluating the Promise and Potential of the Parity Act, *supra* n. 315.

³²⁴ E. Golberstein and S.H. Busch, “Mental Health Insurance Parity and Provider Wages,” *Journal of Mental Health Policy and Economics* 20 no. 2 (Jun. 2017): 75-82.

of psychiatric unit closures due to an inability to recruit and retain psychiatrists.³²⁵ Continued low reimbursement rates and mental health facility closures will likely aggravate the shortage of mental health professionals within the Commonwealth. This downward spiral of negative outcomes is represented in **Figure 2**.

Figure 2



The illustration above is representative of the effect a lack of parity in mental health care coverage has on other aspects of the mental health care system. It is not intended to represent all factors contributing to facility closures or a shortage of mental health care providers, as there are other factors affecting these occurrences.

One study surveying the perspective of primary care physicians (PCPs) on the barriers that patients encounter in gaining access to mental health services found that “shortage of providers” was just as common a barrier to outpatient mental health services as “lack of or inadequate coverage” (at 59 percent of PCPs so reporting). The data further indicated that PCPs in states with parity laws were more likely than PCPs in states with no parity laws to report problems due to a shortage of providers. This would indicate that parity laws may exacerbate problems with provider shortages if parity laws — or more effective enforcement of such laws — have the effect of increasing demand for services and there is no concurrent rise in the number of providers.³²⁶

³²⁵ Milliman Research Report, *supra* n. 317 at p. 19.

³²⁶ Peter J. Cunningham, “Beyond Parity: Primary Care Physicians’ Perspectives on Access to Mental Health Care,” *Health Affairs* 28 no. 3 (Apr. 14, 2009), doi: 10.1377/hlthaff.28.3.w490. The survey took place in 2008, before the implementation of the federal MHPAEA.

This study also found that PCPs in states with mandatory parity were 8 percent less likely to report access problems due to health plan barriers and five percent less likely to report problems arising from inadequate coverage. Overall, more effective enforcement parity laws benefits patients and providers and may be part of the solution in easing a mental health care provider shortage.³²⁷

Restrictions on Mental Health Information Sharing

Another factor contributing to concerning workforce numbers within Pennsylvania's mental health care workforce is the regulatory restrictions placed on information sharing.³²⁸ According to the NCBH, confidentiality regulations regarding psychiatric information (related to both mental health and substance use disorders) have created substantial barriers to access psychiatric services and have impeded the ability for practitioners to share information.³²⁹ While maintaining the confidentiality of a patient's mental health information is universally viewed as important, state regulations aiming to safeguard such information from disclosure have been seen by many practitioners as overbroad. Such confidentiality rules may hamper a practitioner's ability to obtain and exchange critical information expeditiously with other mental health care professionals. The resulting frustrations among mental health care professionals can contribute to burnout among professionals already within the field and can stir second thoughts among those prospectively exploring careers in mental health.

Federal Regulations

Regulatory barriers on psychiatric information sharing are found at both the federal and state levels. At the federal level, the Health Insurance Portability and Accountability Act (HIPAA) prescribes the minimum standard for maintaining the privacy of an individual's protected health information.³³⁰ HIPAA included administrative simplification provisions that required the U.S. Department of Health and Human Services (HHS) to issue the provisions for what is now known as the "Privacy Rule," which HHS published in December 2000 and subsequently modified in August 2002. This rule sets national standards for protecting identifiable health information of individuals and sets limits and conditions on its use and disclosures without patient authorization by three types of covered entities: health plans, health care clearinghouses, and health care providers who conduct standard health care transactions electronically.³³¹ The regulations also expressly state that "[w]here provided, the standards, requirements, and implementation specifications adopted under this subchapter apply to a covered entity's business associate."³³²

³²⁷ *Id.*

³²⁸ The Psychiatric Shortage: Causes and Solutions, *supra* n. 34 at pp. 17-18.

³²⁹ *Id.* at p. 39.

³³⁰ Health Insurance Portability and Accountability Act of 1996, PL 104-191, 110 Stat 1936.

³³¹ HHS.gov, "HIPAA for Professionals," United States Department of Health and Human Services, <https://www.hhs.gov/hipaa/for-professionals/index.html>; HHS.gov, "Health Information Privacy," United States Department of Health and Human Services, <https://www.hhs.gov/hipaa/for-professionals/privacy/index.html>; 45 C.F.R. Part 160 *et seq.*

³³² 45 C.F.R. § 160.102(a)(1)-(3), (b).

The Privacy Rule protects all “individually identifiable health information” held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral.³³³ Individually Identifiable Health Information according to HIPAA regulations is information that is a subset of health information,³³⁴ including demographic information collected from an individual, and:

- (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
- (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and;
- (3) Identifies the individual; or
- (4) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.³³⁵

However, HIPAA permits disclosure of mental health information without a patient’s consent if the covered entity is disclosing the information for the following purposes: disclosure to the individual (unless required for access or accounting of disclosures); disclosure for treatment, payment, and health care operations; disclosure pursuant to an agreement; disclosure for any reason incident to an otherwise permitted use and disclosure; disclosure for the public interest and benefit activities; and disclosure for limited data set for the purposes of research, public health, or health care operations.³³⁶

Another set of federal regulations regarding the protection of individual mental health information pertains specifically to confidentiality of substance use disorder patient records.³³⁷ This set of regulations sets a relatively high standard for the protection of substance use disorder information and is intended to prohibit the disclosure and use of such patient records without patient consent except under certain circumstances which include medical emergencies, research, and certain audits and evaluations.³³⁸ The protections provided under these regulations apply to federally assisted “Part 2 programs,” which includes a majority of the drug and substance abuse

³³³ HHS.gov, “Health Information Privacy Summary of the HIPAA Privacy Rule,” United States Department of Health and Human Services, <https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html>.

³³⁴ Health Information is defined under 45 C.F.R. §160.103 as “any information, including genetic information, whether oral or recorded in any form or medium, that: (1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

³³⁵ 45 C.F.R. § 160.103.

³³⁶ 45 C.F.R. § 164.502(a)(1); U.S. Department of Health and Human Services, “Health Information Privacy,” (Jul. 26, 2013), <https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html>.

³³⁷ 42 C.F.R. Part 2.

³³⁸ 42 C.F.R. §§ 2.2(b), 2.51, 2.52, 2.53; *See also* John Petril, “Clinical Practice and Information Sharing: HIPAA, State Confidentiality Laws and Other Legal Issues,” (Dec. 3, 2013), <http://www.pacenterofexcellence.pitt.edu/documents/HIPAA%20Harrisburg%20Presentation.pdf>.

treatment centers.³³⁹ Exceptions to these covered programs are the U.S. Department of Veterans Affairs and the U.S. Armed Forces.³⁴⁰

State Regulations

While federal laws like those listed above set the minimum standards for mental health information confidentiality, states are free to pass laws that are more restrictive. State laws generally tend to be more restrictive than HIPAA regulations in general, but are rarely stricter than the disclosure restrictions for substance use disorders.³⁴¹

With respect to mental health records, the Mental Health Procedures Act (MHPA) provides that all documents regarding individuals in treatment shall be confidential and, without the individual's written consent, may not be released or their contents disclosed to anyone. However, there are exceptions which allow disclosure of treatment records for "those engaged in providing treatment for the person."³⁴² Regulations implemented pursuant to the MHPA also allow a Pennsylvania practitioner to disclose patients' mental health information, without consent, to "those actively engaged in treating the individual, or to persons at other facilities ... when the person is being referred to the facility and a summary or portion of the record is necessary to provide for continuity of proper care and treatment."³⁴³ Although the MHPA and its accompanying regulations only apply to inpatient facilities and involuntary outpatient treatment, its regulations regarding confidentiality have been incorporated by reference into the licensing regulations for outpatient psychiatric clinics and partial hospitalization programs.³⁴⁴

Pennsylvania has stricter disclosure restrictions regarding drug and alcohol abuse health information than for mental health information, and these restrictions are also more stringent than the corresponding federal provisions. The Pennsylvania Drug and Alcohol Abuse Control Act (PDAACA) requires that:

All patient records (including all records relating to any commitment proceeding) ... shall remain confidential, and may be disclosed only with the patient's consent and only (i) to medical personnel exclusively for purposes of diagnosis and treatment of the patient or (ii) to government or other officials exclusively for the purpose of obtaining benefits due the patient as a result of his drug or alcohol abuse or drug or alcohol dependence except that in emergency medical situations where the patient's life is in immediate jeopardy, patient records may be released without the patient's consent to proper medical authorities solely for the purpose of providing medical treatment to the patient. Disclosure may be made for purposes unrelated to such treatment or benefits only upon

³³⁹ 42 C.F.R. § 2.11.

³⁴⁰ 42 C.F.R. § 2.12.

³⁴¹ Clinical Practice and Information Sharing, *supra* n. 338.

³⁴² Act of July 9, 1976 (P.L. 817, No. 143, § 111); 50 P.S. § 7111(a)(1).

³⁴³ 55 Pa. Code § 5100.32(a)(1).

³⁴⁴ 55 Pa. Code §§ 5200.41(c) and 5210.56.

an order of a court of common pleas after application showing good cause therefor.³⁴⁵

Unlike the federal regulations regarding drug and alcohol abuse health information, the PDAACA essentially requires a patient's consent to disclose such information and only allows disclosure without patient consent in an emergency medical situation where the patient's life is in immediate jeopardy. Aside from this scenario, a psychiatrist would have to obtain a court order permitting disclosure, which can leave a psychiatrist few options when attempting to coordinate care with a patient's other providers.³⁴⁶ This can become an issue where a psychiatrist is treating a patient with substance use disorder.

According to the 2017 NCBH report, confidentiality regulations that are more restrictive for psychiatric information than for general medical information can have a harmful impact on psychiatrists and their work environment. Specifically, the report concluded that such restrictions make it less likely that general medical providers will have access to psychiatric assessments and recommendations regarding a patient, which can lead to duplicative referrals for additional and potentially unnecessary psychiatric assessments. Consequently, health care providers are left with a substantial disincentive to add psychiatric services to their health care organization's services.³⁴⁷

Confidentiality regulations can also impede a psychiatrist's ability to obtain critical information about a patient in a timely manner, which could have life-threatening consequences for psychiatric patients. Because psychiatrists often spend a great deal of time building relationships with their patients, the inability to properly treat and help their patient due to regulatory barriers such as strict confidentiality regulations can and often does negatively impact their desire to stay within their area of practice.

The NCBH recommended revising state confidentiality regulations so that restrictions on mental health and substance use disorder records like the ones found in these statutes are aligned more equally with HIPAA and the regulations governing substance use disorder information under federal regulations.³⁴⁸ The lessening of restrictions on information sharing at the state level will also help reduce the barriers the regulations create to a timely exchange of electronic health records, which is critical for effective interventions and collaborations with others.³⁴⁹ Revising Pennsylvania's health information confidentiality laws, including the PDAACA, to be more aligned with HIPAA and federal regulations on substance abuse information could eliminate barriers to efficient coordinated care while still maintaining a reasonable level of patient confidentiality.

However, loosening the regulations governing confidentiality of mental health and substance use disorder patients is not universally supported. One argument is that allowing more easily sharable mental health and substance use disorder records will discourage those who avoid seeking treatment out of concern about stigma and the possibility of their private medical

³⁴⁵ 71 P.S. § 1690.108(b).

³⁴⁶ *Id.*

³⁴⁷ The Psychiatric Shortage: Causes and Solutions, *supra* n. 34 at p. 39.

³⁴⁸ *Id.*

³⁴⁹ *Id.* at p. 33.

information being leaked or otherwise improperly accessed. SAMHSA, for instance, agrees that while “behavioral health information should be integrated with physical health information to support improved care coordination,” practitioners must respect the privacy and security of patients’ sensitive information. SAMHSA instead recommends health information exchanges or networks, and provides examples of pilot projects that facilitate provider-to-provider communication while complying with existing federal law regarding privacy.³⁵⁰

Currently, the Mental Health Procedures Act (MHPA) allows a Pennsylvania practitioner to disclose patients’ mental health information, without consent, to “those actively engaged in treating the individual, or to persons at other facilities ... when the person is being referred to the facility and a summary or portion of the record is necessary to provide for continuity of proper care and treatment.”³⁵¹ Further, the MHPA allows exceptions to the confidentiality of treatment records for “those engaged in providing treatment for the person.”³⁵² Although the MHPA and its accompanying regulations only apply to inpatient facilities and involuntary outpatient treatment, its regulations regarding confidentiality have been incorporated by reference into the licensing regulations for outpatient psychiatric clinics and partial hospitalization programs.³⁵³

Student Loan Debt

In the Commission’s 2019 report *Pennsylvania Health Care Workforce Needs*, it was recommended that the Commonwealth expand its programs for student loan repayment for certain health care professionals who agree to work in underserved areas. Specifically, it was recommended that the number of recent graduates receiving aid under the program be increased, as well as the amount provided for repayment. Further, it was recommended to increase the length of time required to work in an underserved community in exchange for the loan repayment in order to incentivize health care professionals to practice in underserved areas and remain there once their loan forgiveness commitment period is over.³⁵⁴

As of November 2019, the aggregate outstanding student loan debt across the country was \$1.5 trillion and surpassed all other forms of outstanding debt with the exception of mortgages.³⁵⁵ Debt from loans undertaken to pursue education is still an issue affecting the health care workforce, and the subset of professionals making up the mental health care workforce are no less impacted. The mental health care workforce is more affected by student loan debt than most other sectors of the workforce, as many roles require some form of graduate education such as a master’s degree, a doctoral degree, or a medical degree.

³⁵⁰ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, “The Current State of Sharing Behavioral Health Information in Health Information Exchanges,” (Sept. 2014), https://www.integration.samhsa.gov/operations-administration/HIE_paper_FINAL.pdf.

³⁵¹ 55 Pa. Code § 5100.32(a)(1).

³⁵² Act of July 9, 1976 (P.L. 817, No. 143, § 111); 50 P.S. § 7111(a)(1).

³⁵³ 55 Pa. Code §§ 5200.41(c) and 5210.56.

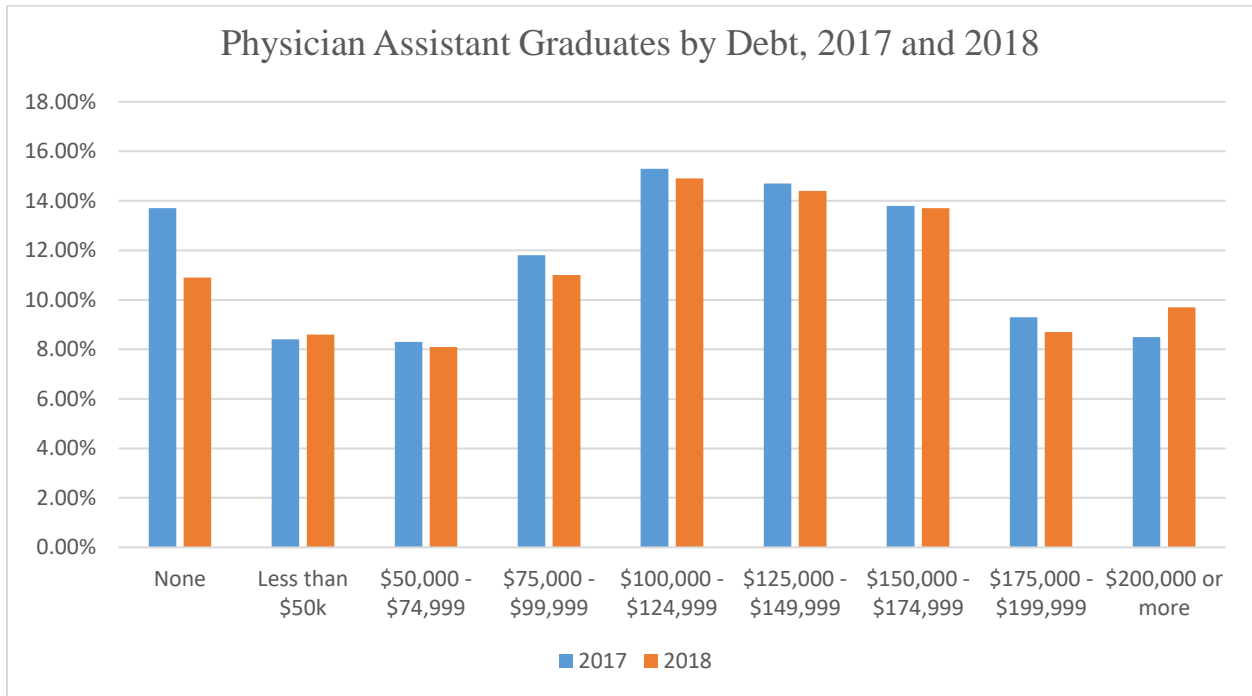
³⁵⁴ Pennsylvania Health Care Workforce Needs, *supra* n. 204 at p. 51.

³⁵⁵ Federal Reserve Bank of New York, Center for Microeconomic Data, “Quarterly Report on Household Debt and Credit 2019 Q3,” (Nov. 2019), https://www.newyorkfed.org/medialibrary/interactives/householdcredit/data/pdf/HHDC_2019Q3.pdf.

Physician Assistants

Although PAs are a small part of the mental health care workforce, the rapid growth in this profession within the last decade makes them an important contributor to the overall health care workforce. These professionals are primed to take on a bigger role in the mental health care field, as they have prescribing privileges in Pennsylvania (under supervision by a physician). Physician assistants who graduated from their PA programs in 2018 — the last year for which such data are available — have an average of \$114,488 in student debt, including undergraduate debt.³⁵⁶ Interestingly, this is down from the 2017 figure reported in the Commission’s *Pennsylvania Health Care Workforce Needs*, which was \$127,188.³⁵⁷ Although the average amount of debt held by graduating PAs has fallen, there has been a drop in the number of graduates reporting no student debt and an increase in graduates reporting student debt of \$200,000 or more, which now includes nearly 10 percent of graduates. See **Table 5** below for a comparison.

Table 5



Source: Compiled by Commission Staff from National Commission on Certification of Physician Assistants 2017 and 2018 Statistical Profiles of Certified Physician Assistants by Specialty.

³⁵⁶ National Commission on Certification of Physician Assistants, “2018 Specialty Report,” p. 8, <https://prodcmsstoragesa.blob.core.windows.net/uploads/files/2018StatisticalProfileofCertifiedPAsbySpecialty1.pdf>.

³⁵⁷ Pennsylvania Health Care Workforce Needs, *supra* n. 204 at p. 42.

Nurses and Nurse Practitioners

There is no data differentiating the student loan debt of nurses and nurse practitioners who work in the mental health care field from those who work in primary care or other specialties. As was discussed in the section on mental health nurses and mental health nurse practitioners, the line between a nurse working in primary care and a nurse working with mental health can sometimes be blurred.

According to data from the September 2017 National Student Nurse Association New RN Graduate Survey, the average student loan debt incurred by newly graduated nurses was \$29,000. In Pennsylvania, the average amount was \$38,000.³⁵⁸ Nationwide, most recent nurses' student loan debts fall into the \$20,000 to \$40,000 range. Approximately one in five have student debt in the \$40,001 to \$80,000 range, and a further five percent have debt in the \$80,001 to \$120,000 range. A small number even have educational debt in excess of \$120,000. However, the largest range of student loan debt held by new nursing graduates is in the \$0 to \$5,000 range, with nearly one-third holding this smaller level of indebtedness.³⁵⁹

For nurse practitioners, who must complete graduate education to practice in their field, average student loan debt is greater. According to survey data collected in 2016 by the American Association of Colleges of Nursing, 74 percent of all nurse practitioners have undertaken some amount of student loan debt. The median amount anticipated to be borrowed upon program completion was between \$40,000 and \$54,999. The survey respondents were still in school during the survey, so the borrowed amount is the students' estimates of how much they will borrow at the conclusion of their education.³⁶⁰

Pharmacists

Although there is a very small number of board-certified psychiatric pharmacists in the Commonwealth and across the country, pharmacists in general are an important component of the mental health care system, as they are on the frontlines of dispensing medications necessary to treat many mental health issues. In 2004, the average pharmacy graduate left school with \$42,600 in student debt. By 2014, that amount had swelled to \$108,407.³⁶¹

A 2019 study analyzing the responses of doctor of pharmacy students to a survey about their finances, debt, and career decision-making found that the average amount of student debt held by survey respondents was \$162,747. Further, the study found that the students' perceived debt pressure and influence predicted their intention to enter direct practice (as opposed to

³⁵⁸ Veronica Feeg and Diane J. Mancino, National Student Nurses Association, "New Graduates' First Jobs and Future Plans: Debt, Employers, and Education Prospects," *Dean's Notes* 40 no. 1 (Summer 2018), <https://www.ajj.com/sites/default/files/services/publishing/deansnotes/summer2018.pdf>.

³⁵⁹ Veronica Feeg and Diane J. Mancino, National Student Nurses Association, "Loan Debt for New Graduates in Nursing: How Employment Post Graduation and Student Loan Debt are Affected Over Time," *Dean's Notes* 41 no. 1 (Summer 2019), <https://www.ajj.com/sites/default/files/services/publishing/deansnotes/summer2019.pdf>.

³⁶⁰ American Association of Colleges of Nursing, "The Numbers Behind the Degree: Financing Graduate Nursing Education," (Oct. 2017), https://www.aacnnursing.org/Portals/42/Policy/PDF/Debt_Report.pdf.

³⁶¹ American Association of Colleges of Pharmacy, "2014 National Pharmacist Workforce Survey," (Apr. 8, 2015), p. 71, <https://www.aacp.org/sites/default/files/finalreportofthenationalpharmacistworkforcestudy2014.pdf>.

undergoing postgraduate training) and to work for a chain pharmacy (as opposed to a hospital pharmacy).³⁶²

The issues of student loan debt is particularly acute within the pharmacist profession. As was addressed in the Commission's 2019 report *Pennsylvania Health Care Workforce Needs*, there has been a rapid growth in pharmacy schools and pharmacy graduates in the last two decades, with the number of new pharmacy graduates increasing faster than the number of available pharmacist positions. Additionally, the U.S. Department of Labor's Bureau of Labor Statistics has projected that between 2016 and 2026, the pharmacy profession will grow slower than all professions as well as all "health diagnosing and treating practitioner" professions.³⁶³

Another 2019 study on the pharmacist workforce noted that the consolidation of chain retail pharmacies has also put pressure on the supply-demand balance of newly licensed pharmacists, threatening the workforce with a supply of pharmacists that greatly exceeds demand.³⁶⁴

Psychiatrists

Amongst all physician specialties, psychiatrists have the highest debt-to-income ratio, carrying higher levels of student debt and earning less than their colleagues in other specialties. In 2016, the median medical school debt held by medical school graduates who go on to specialize in psychiatry was \$190,000 with an interquartile range of \$126,500 to \$250,000. This was the second-highest median medical educational debt among all specialties after emergency medicine, which had a reported median medical school debt of \$200,000. This is markedly different from data collected in 2010, which indicated that psychiatrists (median medical school debt of \$164,850) were similarly situated to other primary care specialties in terms of medical school debt such as internal medicine (\$164,850) and pediatrics (\$164,850).³⁶⁵

Psychologists

The burden of student loan debt weighs heavily on psychology graduate students. In the 1970s, nearly 30 percent of clinical psychology doctoral students funded their training through federal grants. By the 2000s, federal grants supported the education of fewer than four percent of full-time psychology graduate students. By 2007, nearly 80 percent of psychology doctorate students had some level of debt related to their graduate training.³⁶⁶

Data on graduate student loans in the late 2000s was collected in 2009 by the American Psychological Association. For the surveyed 2009 cohort, the median debt for clinical Doctor of

³⁶² Nicholas E. Hagemeyer, et al., "Student Pharmacists' Personal Finance Perceptions, Projected Indebtedness Upon Graduation, and Career Decision-making," *American Journal of Pharmaceutical Education* 83 no. 4 (May 2019): 580-586.

³⁶³ Pennsylvania Health Care Workforce Needs, *supra* n. 204 at pp. 160-161.

³⁶⁴ Lisa Lebovitz and Natalie D. Eddington, "Trends in the Pharmacist Workforce and Pharmacy Education," *American Journal of Pharmaceutical Education* 83 no. 1 (Feb. 2019): 4-11.

³⁶⁵ Justin Grischkan et al., "Distribution of Medical Education Debt by Specialty, 2010-2016," *JAMA Internal Medicine* 177 no. 10 (2017):1532-1535, doi:10.1001/jamainternmed.2017.4023.

³⁶⁶ Jennifer M. Doran et al., "Graduate Debt in Psychology: A Quantitative Analysis," *Training and Education in Professional Psychology* 10 no. 1 (2016): 3-13.

Psychology (PsyD) students was \$120,000 (with one-third having in excess of \$150,000 in debt) and \$68,000 for clinical PhD students. The PhD students pursuing a research sub-field had markedly lower levels of debt, with the median being \$38,500. Nearly 60 percent of PsyD graduates owed more than \$100,000 compared to less than 17 percent of PhDs.³⁶⁷ Students studying for a Doctor of Psychology degree typically enter clinical psychology practice, whereas PhD (or Doctor of Philosophy) students are more likely to pursue academic and research positions (although there are many clinicians with PhDs). Those who pursue a PhD are typically funded by their institution and pay no tuition.³⁶⁸

A newer study conducted in 2016 surveyed then-current psychology graduate students as well as early career psychologists (ECPs) about their educational debt. The data collected in this survey revealed that 73.7 percent of all respondents took out student loans to finance their graduate education. Average current debt for students actively enrolled was roughly \$100,000, with an anticipated final debt level of \$130,000. ECPs fared only slightly better, with an average graduate school debt load of approximately \$99,000. To be clear, these figures reflect only educational debt related to the respondents' graduate education. Total educational debt (which would include undergraduate as well as graduate school) averaged \$141,000 for still-enrolled psychology graduate students and \$108,000 for ECPs.³⁶⁹

A further breakdown of this data reveals that doctor of psychology students had the highest anticipated debt load, with an average of \$173,000 and a median of \$160,000, followed by "health service psychology doctoral-level students" with an average of \$136,000 and a median of \$120,000 in debt. "Research-oriented doctoral-level students" had an average of \$76,000 and a median of \$73,000 in student debt. These figures are for graduate debt only.³⁷⁰

These figures represent a significant increase in student loan debt. In just seven years, doctor of psychology students added \$40,000 to their median debt for graduate school. Total educational debt related to pursuing a graduate degree in psychology, including undergraduate study, commonly runs into the six figure range. Although the psychology profession can often be financially rewarding, the debt-to-income ratio of new graduates "may call into question the financial viability of pursuing a doctoral degree in psychology," according to the publishers of the survey data.³⁷¹

When accounting for salaries, recently-graduated psychologists can expect to spend between 16 and 30 percent of their pretax monthly income on paying back student loan debt absent enrollment in a loan forgiveness program. Roughly 69 percent of graduate students surveyed did not expect to enroll in a loan forgiveness or repayment programs. Given the financial burden of loan repayment, it is perhaps not surprising that 32 percent of surveyed students and 36 percent of

³⁶⁷ Danial Michalski, Jessica Kohout, Marlene Wicherski, Brittany Hart, "2009: Doctorate Employment Survey," American Psychological Association, APA Center for Workforce Studies, (Jun. 2011), <https://www.apa.org/workforce/publications/09-doc-empl/>.

³⁶⁸ Jonathan Golding and Anne Lippert, "Choosing Between a PhD and PsyD: Some Factors to Consider," *Psychology Today*, (Mar. 2, 2016), <https://www.psychologytoday.com/us/blog/careers-in-psych/201603/choosing-between-phd-and-psyd-some-factors-consider>.

³⁶⁹ Graduate Debt in Psychology: A Quantitative Analysis, *supra* n. 366 at p. 8.

³⁷⁰ *Id.* at p. 9.

³⁷¹ *Id.* at p. 10.

ECPs indicated that they would not, or were not sure if they would, choose psychology as a career again.³⁷²

Marriage and Family Therapists, Counselors, and Social Workers

The professions of marriage and family therapist, counselor, and social worker are less well-studied and there is less data regarding student debt for those entering these professions. However, with a median salary of \$38,440 in Pennsylvania for “mental health and substance abuse social workers”³⁷³ (and \$58,400 for marriage and family therapists)³⁷⁴ and degree programs that can cost up to six figures, it would not be unreasonable to conclude that marriage and family therapists and social workers are also facing a burdensome amount of student loan debt.

A paper investigating the effect of student loans on marriage and family therapists gathered data by interviewing five practicing marriage and family therapists in Riverside County, California. Those who were interviewed attempted to avoid student loans by loading up on credits during each semester, going to the least expensive school they were accepted into, taking time off from school to work, working while attending school, and using scholarships or grants. One practicing marriage and family therapist mentioned that \$558 of her \$600 monthly student loan payment goes toward interest. These educated professionals were aware that student loans present a nearly insurmountable barrier to their own fiscal solvency, and recommended living with parents after graduation and taking advantage of government repayment plans which allow borrowers to pay a portion of their income every month for a set number of years rather than the full amount owed.³⁷⁵

One survey of 260 masters in social work (MSW) students indicated that the average amount of debt for those undertaking federal student loans was \$25,000 and rose to \$30,000 for those who had also borrowed from private sources. More than one-quarter will have at least \$40,000 in student loan debt upon completion of their MSW. These amounts reflect debt undertaken to pursue the MSW degree, and do not include undergraduate degree debt. Approximately 30 percent of the respondents had borrowed at least \$30,000 for their undergraduate education in addition to their MSW-related debt.³⁷⁶

When it comes to professions such as marriage and family therapists, counselors, and social workers, the burden of student loan debt must also be considered in the context of salary and other compensation. With high debt-to-income ratios, these professions are susceptible to burnout as well as incentivized by student loan forgiveness programs. One study investigating how compensation affects job satisfaction and turnover for social workers noted that recent graduates in the sample were carrying substantial student loan debt when compared to the salaries they

³⁷² *Id.* at pp. 8 and 10.

³⁷³ U.S. Department of Labor, Bureau of Labor Statistics, “21-1023 Mental health and Substance Abuse Social Workers,” *Occupational Employment and Wages*, (May 2018), <https://www.bls.gov/oes/current/oes211023.htm>.

³⁷⁴ U.S. Department of Labor, Bureau of Labor Statistics, “21-1013 Marriage and Family Therapists,” *Occupational Employment and Wages*, (May 2018), <https://www.bls.gov/oes/current/oes211013.htm>.

³⁷⁵ Anthony Cook, “Perceptions of Marriage and Family Therapists Regarding the Alleviation of Graduate School Stress,” dissertation, (2016).

³⁷⁶ Intae Yoon, “Debt Burdens Among MSW Graduates: A National Cross-Sectional Study,” *Journal of Social Work Education* 48 no. 1 (Winter 2012): 105-125, doi: 10.5175/JSWE.2012.201000058.

received. The researchers went on to find that, while monetary gain was not a primary motivator for individuals who become social workers, inadequate compensation strongly contributed to job dissatisfaction and burnout.³⁷⁷ A separate study examining the role of student loan forgiveness on turnover among social workers in Massachusetts suggested that student loan forgiveness programs were associated with lower turnover.³⁷⁸

Federal and State Student Loan Debt Relief Programs

Both the federal government and the Commonwealth offer programs which provide indebted health care professionals the opportunity to have their loans repaid or forgiven by the government. Most of these programs tie the offer of loan forgiveness or state repayment to commitments by the health care professional to work in a certain area or with certain patients for a predetermined amount of time. The available programs and their requirements are listed below.

Pennsylvania Primary Care Loan Repayment Program (LRP). This program, run by the Pennsylvania Department of Health, provides loan repayment as an incentive for primary care providers to commit to practicing in a federally designated HPSA within the Commonwealth. The program offers full-time and half-time two-year contracts. For physicians, the repayment offered is up to \$100,000 for full-time and \$50,000 for half-time, and \$60,000 and \$30,000 for full-time and part-time non-physicians, respectively. The mental health care professions which are eligible for the program are:

- Allopathic (MD) and Osteopathic (DO) Physicians (including psychiatrists);
- Certified Registered Nurse Practitioners;
- Physician Assistants;
- Licensed Clinical Social Workers;
- Licensed Professional Counselors;
- Marriage and Family Therapists; and
- Psychologists³⁷⁹

As was discussed in further detail in the Commission's 2019 report *Pennsylvania Health Care Workforce Needs*, this program is highly competitive. In 2017, the Pennsylvania Primary Care Loan Repayment Program received 264 applicants, but made only 37 awards.³⁸⁰

Federal Perkins Loan Cancellation. The Department of Education allows certain professionals, such as teachers, public defenders, firefighters, and nurses, to cancel the federal Perkins student loan. Nurses are eligible to have their federal Perkins loans cancelled after five years of eligible service. The government will cancel 15 percent of the original principal loan amount for each of

³⁷⁷ Don Schweitzer, Terry Chianello, Brian Kothari, "Compensation in Social Work: Critical for Satisfaction and a Sustainable Profession," *Administration in Social Work* 37 no. 2 (Apr. 1, 2013): 137-157, doi: 10.1080/03643107.2012.669335.

³⁷⁸ SB Fakunmoju and RC Kersting, "Perceived Effects of Student Loan Forgiveness on Turnover Intention among Social Workers in Massachusetts," *Social Work* 61 no. 4 (Oct. 2016): 3331-3339, DOI: 10.1093/sw/sww051.

³⁷⁹ Pennsylvania Department of Health, "Pennsylvania Primary Care Loan Repayment Program (LRP)," (Nov. 2019), <https://www.health.pa.gov/topics/Health-Planning/Pages/Loan-Repayment.aspx>.

³⁸⁰ Pennsylvania Health Care Workforce Needs, *supra* n. 204 at pp. 48-49.

the first and second years of qualifying full-time service, 20 percent of the original principal loan amount for each of the third and fourth years, and the remaining 30 percent in the fifth year. It does not cancel, repay, or discharge accrued interest. The application for cancellation must be made to the school that disbursed the loan or to the school's Perkins loan servicer.³⁸¹

Federal Nurse Corps Loan Repayment Program. Administered by the Bureau of Health Workforce of the U.S. Department of Health and Human Services, this program will pay up to 60 percent of a nurse's total qualifying educational loan balance in exchange for a two-year service commitment at a Critical Shortage Facility within an HPSA. These facilities include Critical Access Hospitals, Disproportionate Share Hospitals, public hospitals, private non-profit hospitals, and Certified Community Behavioral Health Clinics, among others. There also exists an option for the nurse to extend the commitment an additional year in exchange for an additional 25 percent of the nurse's qualifying educational loan balance.³⁸²

The qualifying loans are government and private loans with existing balances and exclude Parent PLUS loans, Nurse Faculty Loan Program loans that are subject to cancellation, and Perkins Loans. Only RNs and APRNs are eligible to participate and loans obtained for training in vocational or practical nursing do not qualify.³⁸³

National Health Service Corps Loan Repayment Program. This program, offered by the HRSA, allows practitioners of primary care medicine, dental care, and behavioral and mental health care to receive funds to repay outstanding qualifying educational loans. The mental health care disciplines which are eligible for the repayment program are psychiatrists, health service psychologists, licensed clinical social workers, psychiatric nurse specialists, marriage and family therapists, licensed professional counselors, and nurse practitioners and physician assistants who work in mental health and psychiatry.

The eligible participants may receive up to \$50,000 for a two-year commitment at a site with an HPSA score of 14 or greater (up to \$25,000 if working half-time), or up to \$30,000 for a two-year commitment at a site with an HPSA score of 13 or less (up to \$15,000 if working half-time). Once a practitioner completes the initial two-year service contract, they may become eligible to apply for additional loan repayment funds through one-year continuation service contracts. However, there is no guarantee that a continuation contract will be available. Not everyone who applies will be accepted into the loan repayment program.³⁸⁴

Federal Public Service Loan Forgiveness. This program allows a debtor to have certain federal student loans forgiven after making 120 payments toward their student debt under a qualified plan while working full-time for a qualified employer. Qualified employers are non-profits or the

³⁸¹ U.S. Department of Education, Federal Student Aid, "Perkins Loan Cancellation and Discharge," accessed Dec. 23, 2019, <https://studentaid.gov/manage-loans/forgiveness-cancellation/perkins>.

³⁸² U.S. Department of Health and Human Services, HRSA Nurse Corps, "Nurse Corps Loan Repayment Program Fiscal Year 2019 Application and Program Guidance," (Feb. 2019), <https://bhw.hrsa.gov/sites/default/files/bhw/nursecorps-lrp-guidance.pdf>

³⁸³ *Id.*

³⁸⁴ U.S. Department of Health and Human Services, Health Resources and Services Administration, National Health Service Corps, "NHSC Loan Repayment Program," accessed Dec. 26, 2019, <https://nhsc.hrsa.gov/loan-repayment/nhsc-loan-repayment-program.html>.

government — those employed by for-profit hospitals or health care facilities are not eligible. The eligible loans are those received under the Federal Direct Loan Program, and loans from the Federal Family Education Loan Program and the Perkins Loan Program are not eligible for forgiveness. However, they may become eligible if a participant consolidates them into a federal Direct Consolidation Loan. In that case, only loans made in service of the Direct Consolidation Loan will count toward the 120 payments needed for loan forgiveness.³⁸⁵

Income-Driven Repayment Plans. These plans are designed to make a borrower’s debt load more manageable. They are not forgiveness, repayment, or scholarship programs. Income-Driven Repayment plans are intended for borrowers who cannot afford to make payments toward their student loans under a normal repayment schedule, who do not qualify for Public Service Loan Forgiveness, and who have a high debt-to-income ratio.

There are four different Income-Driven Repayment plans currently offered by the U.S. Department of Education — Revised Pay As You Earn, Pay as You Earn, Income-Based Repayment, and Income-Contingent Repayment. Each requires that the borrower pay a certain percentage of his disposable income — between 10 and 20 percent depending on the specific plan — every month. Not every loan is eligible for an income-driven repayment plan, and each plan covers different federal loans. For instance, only direct federal loans are eligible for inclusion in the Revised Pay As You Earn plan, while Income-Contingent Repayment allows for inclusion of Parent PLUS loans if they are first consolidated into a Direct Consolidation Loan.³⁸⁶

Overall, studies have found an association between financial factors (such as debt or incentive programs) with practicing in an underserved or rural area.³⁸⁷ While such programs are helpful for encouraging and incentivizing some students to pursue careers in geographic areas with shortages of health care professionals, they do not address the root cause of high student loan debt — the high cost of education. The Federal Reserve Bank of Kansas City, one of the twelve regional reserve banks which comprise the Federal Reserve System, has recognized that “[a]n important factor in the recent climb in student loan debt ... is the rising cost of higher education.”³⁸⁸

There is some evidence that subsidies — such as federal student loans — lead to an increase in tuition over the long run. According to one economist, this is because schools compete in a zero-sum game for students and prestige. The availability of aid in the form of federal student loans allows schools to raise tuition, which in turn is used to invest in new buildings, more faculty and administrators, smaller class sizes, expanded majors and course offerings, and nicer amenities.

³⁸⁵ U.S. Department of Education, “Public Service Loan Forgiveness (PSLF),” accessed Dec. 26, 2019, <https://studentaid.gov/manage-loans/forgiveness-cancellation/public-service>.

³⁸⁶ U.S. Department of Education, “Income-Driven Repayment (IDR) Plan Request,” accessed Dec. 26, 2019, <https://studentaid.gov/app/ibrInstructions.action>.

³⁸⁷ A. Goodfellow et al., “Predictors of Primary Care Physician Practice Location in Underserved Urban or Rural Areas in the United States: A Systematic Literature Review,” *Academic Medicine* 91 no. 9 (Sept. 2016): 1313-1321, doi: 10.1097/ACM.0000000000001203.

³⁸⁸ Kelly D. Edmiston, Lara Brooks, Steven Shepelwich, The Federal Reserve Bank of Kansas City, “Student Loans: Overview and Issues (Update),” *Research Working Papers* (Apr. 2013), p. 12, <https://www.kansascityfed.org/publicat/reswkpap/pdf/rwp%2012-05.pdf>.

These new investments raise the overall cost of the school's operation, necessitating future tuition increases.³⁸⁹

Another researcher has noted that behavioral responses to government programs can undermine their intended effects. Examining the institutional price response to federal student aid, it was discovered that instead of raising tuition for all students, the studied institutions engaged in strategic price discrimination by giving more institutional scholarship funds to more competitive students. The consequence was that some students paid more than others as the institutions became more selective with their own aid awards.³⁹⁰

In some cases, it is the schools themselves that are tackling the student loan issue. In 2018, New York University School of Medicine announced that for its graduating class of 2022 and for all classes thereafter, the medical school would be tuition-free for all students.³⁹¹ In an interview with the *Wall Street Journal*, Dr. Robert I. Grossman, the dean of the medical school, explained the reasoning behind eliminating tuition for New York University medical students:

There's a significant training period after medical school. That could be three years and then beyond. In that period, you're paid a relatively small sum of money — \$50,000 to \$70,000 a year — and, you are, in most cases, working very hard. It's an 80-hour workweek. Then it's a very long path until you build up your own practice. Those are formative years where a lot of people are starting families, having partnerships. There are tremendous opportunity costs.³⁹²

In Pennsylvania, Geisinger Health System will offer free tuition for 40 medical students in each class at its Geisinger Commonwealth School of Medicine. The students who accept the tuition-free offer must commit to work in primary care with Geisinger after graduation.³⁹³

The high cost of education for mental health care professionals, who usually possess advanced degrees, has led to a marked increase in the student loan debt for these professionals. Carrying a high debt load has been observed to affect the career choices of medical students, with a lower debt load being associated with a higher likelihood of practicing primary care medicine.³⁹⁴

³⁸⁹ Andrew Gillen, Center for College Affordability and Productivity, "Introducing Bennett Hypothesis 2.0," (Feb. 2012), <https://files.eric.ed.gov/fulltext/ED536151.pdf>.

³⁹⁰ Nick Turner, "Who Benefits from Student Aid? The Economic Incidence of Tax-Based Federal Student Aid," working paper, University of California San Diego, (Oct. 20, 2010), <https://escholarship.org/content/qt7g0888mj/qt7g0888mj.pdf>.

³⁹¹ NYU Langone Health, "NYU School of Medicine Offers Full-Tuition Scholarships to All New & Current Medical Students," press release (Aug. 16, 2018), <https://nyulangone.org/news/nyu-school-medicine-offers-full-tuition-scholarships-all-new-current-medical-students>.

³⁹² Sarah Toy, "Why NYU is Making its Medical School Tuition-Free," *Wall Street Journal*, (Oct. 30, 2018).

³⁹³ Alia Paavola, "Geisinger to Offer Free Med School Tuition for 40 Students per Year," *Beckers Hospital Review* (Nov. 6, 2019), <https://www.beckershospitalreview.com/hospital-physician-relationships/geisinger-free-med-school-tuition-aims-to-curb-primary-care-physician-shortage.html>.

³⁹⁴ JP Phillips, SM Petterson, AW Bazemore, RL Phillips, "A Retrospective Analysis of the Relationship Between Medical Student Debt and Primary Care Practice in the United States," *Annals of Family Medicine* 12 no. 6 (Nov. 2014): 542-549, doi: 10.1370/afm.1697.

Possessing a greater amount of student debt relative to peers has been associated with choosing specialties offering higher average annual incomes.³⁹⁵

For some professionals, such as social workers, marriage and family therapists, and counselors, the amount of debt undertaken can be difficult to repay given the debt-to-income ratio of such professions. For psychiatrists, a high educational cost is offset by a high salary when compared to other mental health professionals, but psychiatrists have one of the worst debt-to-income ratios of all physicians. Many mental health care professionals may rely on loan repayment programs or income-driven repayment plans in order to afford repaying the government for their student loans, depending on each individual's circumstance. Innovative solutions to ever-increasing indebtedness of the Commonwealth's mental health care professionals should be considered.

Lack of Faculty and Training Opportunities

When discussing the shortage of mental health care professionals, the solution of educating and training more such professionals is usually at the forefront. However, the process of educating and training mental health professionals can itself present challenges. One of these challenges is that institutional capacity to educate and train can be constrained by an inability to find faculty or clinical training sites. The lack of clinical training opportunities has particularly affected psychologists. An inability to attract faculty has also affected nursing schools, which is relevant to this study because of the ability of nurse practitioners to prescribe psychotropic medication and who can be a valuable bulwark against a shortage of mental health care professionals.

Clinical Training Sites for Psychologists

To become a practicing psychologist, a doctoral psychology graduate must complete one year of postdoctoral supervised experience.³⁹⁶ Although there is no regulatory requirement that the postdoctoral supervised experience be at a facility accredited by any organization, the American Psychological Association's Commission on Accreditation (APA COA) evaluates doctoral, internship, and postdoctoral "residency" programs in professional psychology. The latter programs are typically fellowships focused on training and mentorship to allow the new graduate to accrue supervised experience.³⁹⁷ There are three APA COA accredited postdoctoral fellowship programs in Pennsylvania, according to the APA.³⁹⁸

³⁹⁵ J. Rohlfig et al., "Medical Student Debt and Major Life Choices Other Than Specialty," *Medical Education Online* 11 no. 19 (Nov. 2014): 25603, doi: 10.3402/meo.v19.25603 (electronically published).

³⁹⁶ 49 Pa. Code § 41.32.

³⁹⁷ Patty Kuo, "Four Ways to Find a Postdoc," *Monitor on Psychology* (Jul./Aug. 2012): 76. <https://www.apa.org/monitor/2012/07-08/postdoc>.

³⁹⁸ American Psychological Association Commission on Accreditation, "Accredited Postdoctoral Programs for Training in Health Service Psychology: 2018," <https://www.apa.org/ed/accreditation/programs/postdoctoral.pdf>.

The Association of Psychology Postdoctoral and Internship Centers (APPIC) also provides an organized, centralized system for applying to postdoctoral fellowships. APPIC operates more like the National Resident Matching Program — the organization responsible for matching medical school students with post-graduate residency positions. Through APPIC, psychology doctoral graduates apply to programs, interview, and receive offers within a specific time period. As of October 2019, there were 42 such fellowships available in the Commonwealth.³⁹⁹

Many positions, however, are more informal and are operated by health care organizations which employ fully-licensed psychologists. There is no national “match” or registry for such positions for new psychologists to obtain supervised experience. Obtaining postdoctoral supervised experience is more akin to finding a first job out of school. The APA advises recent or soon-to-be psychology doctoral graduates to join listservs, network with professional contacts, professors, and at conferences (as many postdoctoral training positions are never formally advertised), and utilize Internet sources such as Indeed, LinkedIn, and the APA’s job listing site.⁴⁰⁰

A search of the APA’s job listing site, however, only turned up three open positions in Pennsylvania for “internship” or “entry level” jobs, two of which were fellowships.⁴⁰¹ A Google search for “psychology postdoctoral residency” in Pennsylvania yielded nine openings for psychologists who are not yet licensed and need supervised experience in order to obtain licensure.⁴⁰²

In addition to the need to secure a postdoctoral position offering supervised experience, psychology doctoral students need to complete a year-long internship during their doctoral coursework and training. This has been a significant hindrance to training for psychology doctoral students this decade. Over time, the number of internships available were exceeded by the number of students who needed an internship. This imbalance has been correcting itself more recently, but this is due largely to a smaller number of psychology students who need an internship. Effectively, there has been a disparity in the ratio of internship applicants to available internships.

To illustrate, in 2014 there were 4,335 applicants who applied to 3,501 positions — meaning that only 81 percent of applicants were able to obtain an internship that year. Over 800 students were left without an internship position. Further, only 60 percent of applicants were placed in an internship accredited by the APA, which is required for employment in place such as the Department of Veterans Affairs and most correctional facilities. According to APPIC data

³⁹⁹ Association of Psychology Postdoctoral and Internship Centers, “Universal Psychology Postdoctoral Directory — Pennsylvania,” (Oct. 2019), <https://www.appic.org/Postdocs/Universal-Psychology-Postdoctoral-Directory/SearchResults>.

⁴⁰⁰ Kuo, Four Ways to Find a Postdoc, *supra* n. 397.

⁴⁰¹ American Psychological Association, *PsycCareers*, “Jobs in Pennsylvania — Entry Level or Internship,” accessed Nov. 1, 2019, https://www.psyccareers.com/index.php?action=advanced_search&page=search&keywords=Psychologist&industry=&country=United+States&state%5B%5D=Pennsylvania&city=&zip=&zip_radius=&position_type=&min_salary=&max_salary=&salary_type=&experience_level%5B%5D=Internship&experience_level%5B%5D=Entry+Level.

⁴⁰² Google, “Psychology Postdoctoral Residency Programs in Pennsylvania,” accessed Nov. 1, 2019, https://www.google.com/search?client=firefox-b-1-d&q=Psychology+Postdoctoral+Residency+Programs+in+Pennsylvania&ibp=htl;jobs&sa=X&ved=2ahUKEwixrtDIrNHIAhUJ01kKHZf0B6kQiYsCKAB6BAGHEAM#fpstate=tldetail&htidocid=uEpe5LXySNTys3_pAAAAAA%3D%3D&htivrt=jobs.

from 2014, while both the number of psychology graduate students needing an internship placement and the number of internships has been growing in the preceding 15 years, the growth in applicants has outpaced the growth in placements available.⁴⁰³

The impact of a student being unable to secure an internship position cannot be understated in its impact on both the student and the overall psychologist workforce. Perhaps most poignant is that graduation and entry into the workforce are delayed by at least one year if a student cannot obtain an internship. On a more personal level, unmatched students must pay for an additional year of tuition, may need to obtain alternative employment, may postpone marriage and family formation, and some may even question their career goals.⁴⁰⁴

What makes this phenomenon even more concerning is that many psychology doctoral students obtain their post-graduate employment through their internships, and fewer internships could translate into fewer entry-level positions for newly-minted psychologists who must be supervised before becoming licensed.

In recent years the number of unmatched students across the U.S. has been declining. During the 2015 application cycle, 436 students were unmatched.⁴⁰⁵ In 2016, there were more internship positions available than there were applicants. However, 274 psychology students eligible to take an internship withdrew or did not submit an application for one. Had they all done so, there would have still been a deficit of 199 internship positions. Further, in 2016, there were 3,999 applicants, down from 4,435 in 2012.⁴⁰⁶

In 2018, there were 3,906 internship slots, a 22 percent increase over 2012. Of the 3,779 students who applied for an internship, 3,163 received one after an initial period of application. At the time these data were published, graduate psychology students were still in the process of finalizing their internship plans, and it was predicted that those who were unmatched for an internship position would receive one. In 2018, only 184 applicants either withdrew or did not submit an application for an internship. It should be noted that the improvement in the number of applicants finding internships was due partially to a reduction in the number of applicants. However, this is still a move in the right direction, as both the overall number of applicants and proportion of applications obtaining an internship increased in 2018 relative to 2012.⁴⁰⁷

One of the largest providers of internship and postdoctoral fellowships is the U.S. Department of Veterans Affairs (VA). As of 2018, the VA provided 711 psychology internship positions across 133 internship programs and had a presence in every state. The VA also provided 450 postdoctoral fellowship positions at 145 VA medical centers, allowing new psychologists to

⁴⁰³ Mike C. Parent et al., “‘Worst Experience of My Life’: The Internship Crisis and its Impact on Students,” *Journal of Clinical Psychology* 72 no. 7 (2016): 714-742, at 715.

⁴⁰⁴ Rebecca L. Brock et al., “Addressing the Psychology Internship Crisis: Converging Perspectives of the Psychology Community,” n.d., at pp. 3-4.

https://www.academia.edu/21640044/Addressing_the_Psychology_Internship_Crisis_Converging_Perspectives_of_the_Psychology_Community.

⁴⁰⁵ *Id.* at p. 3.

⁴⁰⁶ Kim I. Mills, “More Internships Than Interns,” *gradPSYCH Magazine* no. 4 (2016), p. 6.

⁴⁰⁷ Rebecca A. Clay, “More Good News for Internship Seekers,” *Monitor on Psychology* 49 no. 5 (2018): 24.

obtain the supervised experience to become licensed. The number of these training positions at the VA has nearly tripled in the past decade.⁴⁰⁸

Anecdotally, it has been reported that Torrance State Hospital's psychiatry internship program has ended. The internship once provided psychology students with training in conducting competency to stand trial evaluations, among other things. The primary reason that it ended was because the facility could not find qualified professionals to run the program and supervise interns.⁴⁰⁹ Torrance State Hospital is a mental hospital operated by the Pennsylvania Department of Human Services and is located in Westmoreland County.

Nursing Faculty

Initially, one would not think that a difficulty in recruiting nursing faculty would have an impact on the overall mental health care workforce. However, mental health nurses and nurse practitioners are drawn from the general population of nursing school graduates, so a lack of faculty, preceptors, or other educational opportunities could also be considered an impediment to the growth of the overall mental health care workforce. In the Commission's report *Pennsylvania Health Care Workforce Needs*, published in 2019, it was noted that in 2016 baccalaureate and graduate nursing programs across the country turned away approximately 64,000 qualified applicants due in part to a lack of faculty and preceptors.⁴¹⁰ However, since that time the problem has been exacerbated, with roughly 75,000 qualified applicants having been turned away from baccalaureate and graduate nursing programs in 2018 due to an insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints.⁴¹¹

According to a survey prepared by the American Association of Colleges of Nursing, there were 1,637 full-time vacancies for nursing faculty for the 2019-2020 academic year. Additionally, 475 of the surveyed nursing schools had a vacant full-time faculty position open, representing approximately 53 percent of all institutions responding to the survey. A further 134 (or 15 percent) of schools surveyed reported that while they do not have vacant full-time faculty positions they are in need of additional faculty. The remaining 284 schools reported that they do not have vacant full-time positions and do not need additional faculty.⁴¹² See **Table 6** below for a year-by-year comparison.

⁴⁰⁸ Amy Novotney, "The VA is Hiring," *Monitor on Psychology* 49 no. 9 (Oct. 2018): 64.

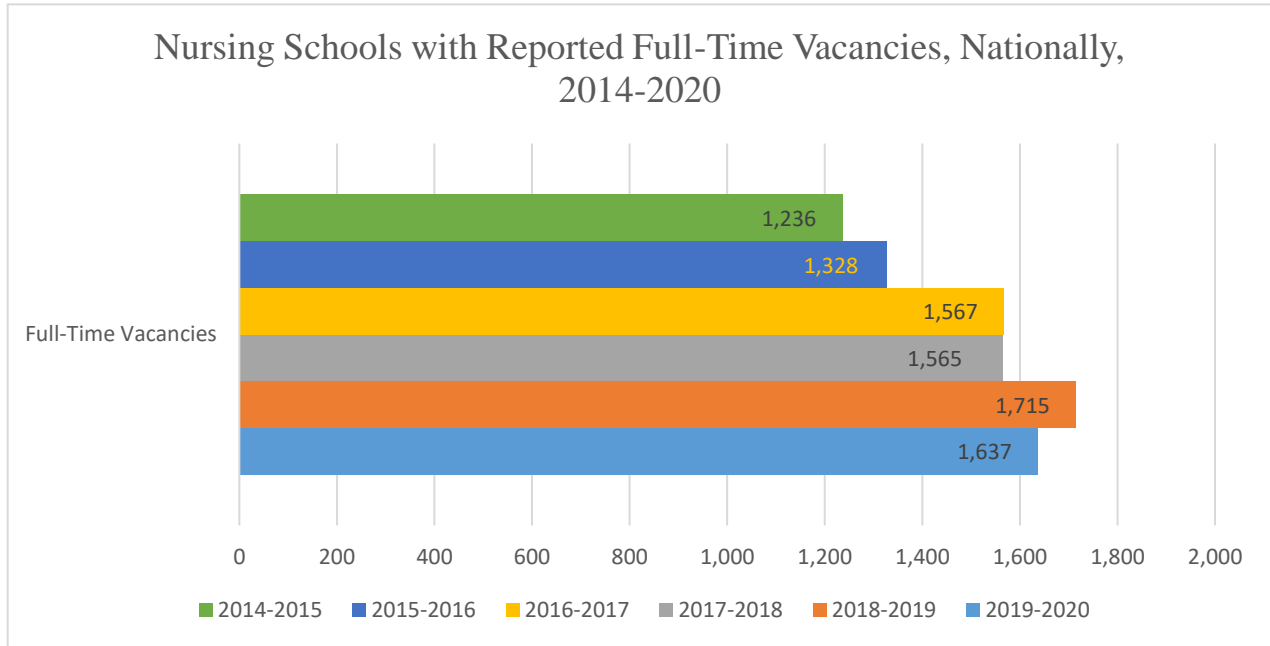
⁴⁰⁹ Letter from the Pennsylvania Psychological Association to Joint State Government Commission Staff, (Oct. 8 2019).

⁴¹⁰ Pennsylvania Health Care Workforce Needs, *supra* n. 204 at p. 22.

⁴¹¹ American Association of Colleges of Nursing, "Fact Sheet: Nursing Faculty Shortage," (Apr. 2019), <https://www.aacnnursing.org/Portals/42/News/Factsheets/Faculty-Shortage-Factsheet.pdf>.

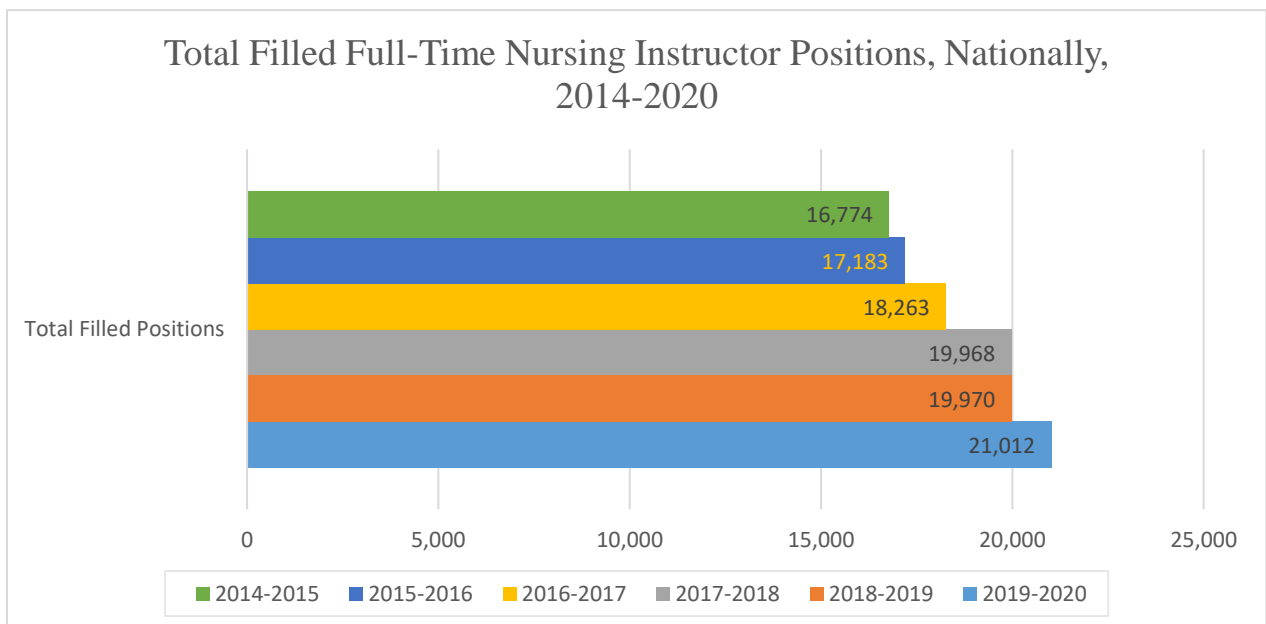
⁴¹² Jenny Keyt, Yan Li, Di Fang, "Special Survey on Vacant Faculty Positions for Academic Year 2019-2020," *American Association of Colleges of Nursing*, accessed Nov. 12, 2019, <https://www.aacnnursing.org/Portals/42/News/Surveys-Data/Vacancy19.pdf>.

Table 6



Source: Compiled by JSGC Staff from data taken from the American Association of Colleges of Nursing Research and Data Center, Special Surveys on Vacant Faculty Positions for Academic years 2014-2015 through 2019-2020. <https://www.aacnnursing.org/News-Information/Research-Data>.

Table 7

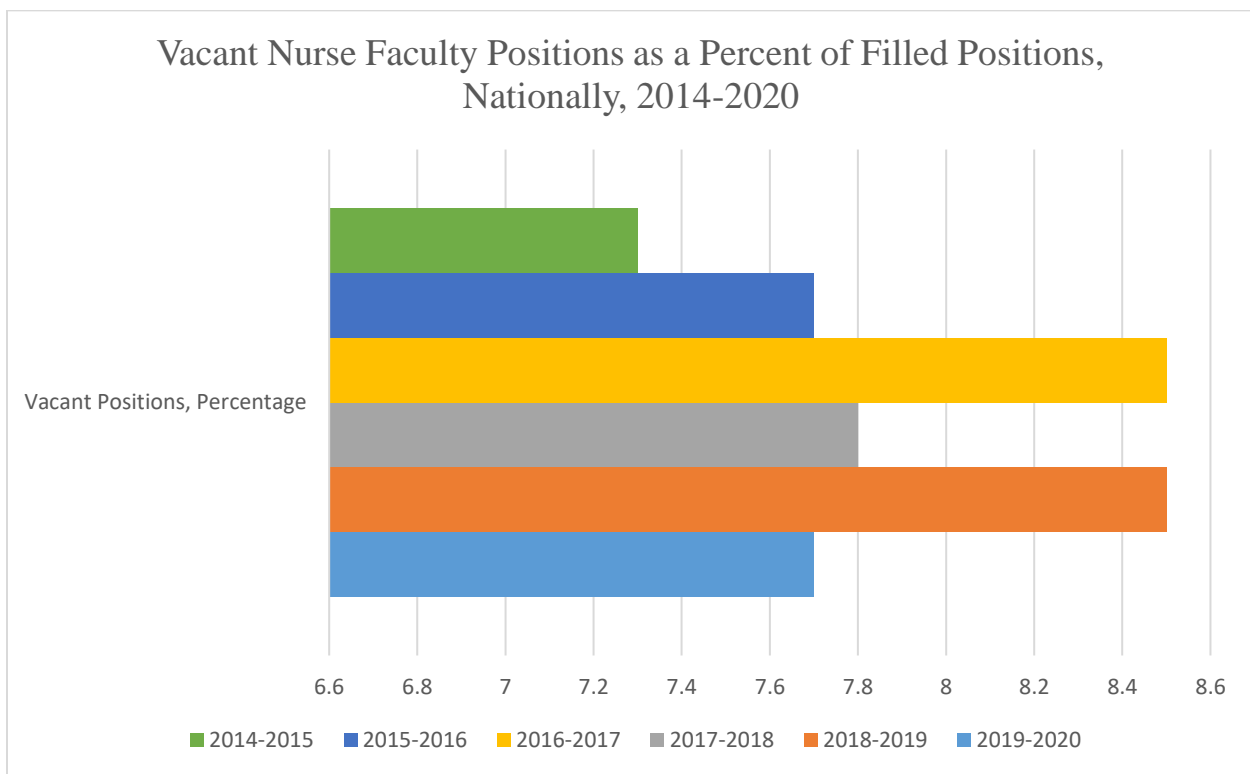


Source: Data compiled by JSGC Staff from the American Association of Colleges of Nursing Research and Data Center, Special Surveys on Vacant Faculty Positions for Academic years 2014-2015 through 2019-2020. <https://www.aacnnursing.org/News-Information/Research-Data>.

The most commonly reported issues with faculty recruitment for the 2019-2020 academic year are the noncompetitive salary of such positions (61.2 percent of survey respondents), an inability to find faculty with the right specialty (58.3 percent), and a limited pool of faculty with doctoral degrees (53.5 percent).⁴¹³ Other issues regarding the difficulty of attracting faculty that were noted by the nursing schools included challenging geographic area (such as rural location or high cost of living), institutional budget cuts, and cultural fit.⁴¹⁴

As can be seen in the tables above, the number of vacant or unfilled faculty positions has risen every year since the 2014-2015 academic year. The only exception is a decline in the number of vacant positions in academic year 2019-2020 from 2018-2019. However, the number of filled full-time nursing faculty positions has also increased during that time period, growing by over 20 percent. Although the overall increase in nurse faculty is a bright spot, the inability to fill nurse faculty positions is becoming a significant barrier in the production of college-educated nurses. This is further evidenced by the amount of unfilled positions as a percentage of filled positions, which has increased since the 2014-2015 academic year as is shown in the chart below.

Table 8



Source: Data compiled by JSGC Staff from the American Association of Colleges of Nursing Research and Data Center, Special Surveys on Vacant Faculty Positions for Academic years 2014-2015 through 2019-2020. <https://www.aacnursing.org/News-Information/Research-Data>.

⁴¹³ *Id.* at p. 14.

⁴¹⁴ *Id.* at p. 16.

In Pennsylvania, RN faculty are required to possess a graduate degree in nursing, a license to practice nursing in Pennsylvania, and have expertise in their area of instruction.⁴¹⁵ An RN with a bachelor's degree may teach as a "faculty assistant" under the direct guidance of a faculty member as long as he or she possesses a license to practice nursing in Pennsylvania. A baccalaureate-educated RN may teach as a faculty assistant for a maximum cumulative period of five years.⁴¹⁶

The Pennsylvania Department of Health conducted a study of the nursing workforce in 2014 which also addressed nursing faculty within the Commonwealth. In 2014, there were 4,342 RN faculty members, of whom 4,340 (or 99.9 percent) met the faculty requirements or were working towards completing the requirements.⁴¹⁷

There has been tremendous growth in the number of nursing faculty in the Commonwealth. According to data from the Pennsylvania Department of Health, in 2003, there were 977 faculty members teaching in RN bachelor's degree-granting programs. By 2014, there were 2,590. In 2003, there were 335 faculty teaching RN diploma programs. By 2014, there were 364. In 2003, there were 649 faculty teaching in RN associate's degree-granting programs. By 2014, there were 1,388 faculty members teaching in such programs.⁴¹⁸

Although a lack of nursing faculty is a nationwide problem, the Commonwealth's nursing programs appear to struggle more with securing clinical training sites for its students. Bachelor's degree-granting RN programs reported that they only admitted 49 percent of their qualified applicants into their programs, and limited clinical capacity was the most frequently reported reason for not admitting all qualified applicants.⁴¹⁹

Of the 21 responding baccalaureate nursing programs, 15 (or 71 percent) indicated that clinical capacity was the reason for not admitting all qualified applicants. However, 10 (or 48 percent) also cited being at faculty capacity as a reason for not admitting all qualified applicants. A further 13 (or 62 percent) indicated that physical capacity prevented the program from admitting more students. Responding programs could select for than one reason why their program was unable to admit all qualified applicants.⁴²⁰

⁴¹⁵ 49 Pa. Code § 21.71(c)(1).

⁴¹⁶ 49 Pa. Code § 21.71(c)(2).

⁴¹⁷ Pennsylvania Department of Health, Bureau of Health Planning, "Nursing Education Programs in Pennsylvania — Data From 2014 Nursing Education Program Annual Reports," (2017), p. 12, <https://www.health.pa.gov/topics/Documents/Programs/Workforce%20Reports/2014%20Nursing%20Education%20Report.pdf>.

⁴¹⁸ *Id.* at p. 12.

⁴¹⁹ *Id.* at p. 14.

⁴²⁰ *Id.* at p. 15.

SOLUTIONS AND RECOMMENDATIONS

Although issues like ensuring mental health parity of insurance coverage, student loan debt, and alleviating burnout in the medical professions seem like insurmountable issues, there are some policies that the General Assembly could pursue which would help ease the strain on the Commonwealth's mental health care system caused by a shortage of providers.

Encourage the Use of Integrated Care Models

One of the solutions to a shortage of providers is to develop new models for delivering care with the goal of making more efficient use of existing resources. An example of this is the nurse-managed health clinics discussed below — a model to increase the availability of health care using nurse practitioners that could be better supported and expanded throughout the Commonwealth. Another example is the integrated care model.

Integrated care is the “the systematic coordination of general and behavioral healthcare.” In practice, this generally means having mental health care practitioners providing care in the same setting as primary care physicians, such that a patient can consult both practitioners in one visit. This can be accomplished through team-based care or through telephonic or Internet-enabled consultations (i.e. telepsychiatry). Primary care settings are often the first place people seek help for mental health problems, making the integration of mental health care with primary care an ideal way to increase the availability of mental health care to patients.⁴²¹

There have been numerous studies investigating integrated care models, with these studies generally showing the effectiveness of these models in improving mental health care access and mental health outcomes as compared to usual primary care.⁴²² The volume of randomized controlled trials and other studies is so great that literature reviews may provide better examples of the benefits of integrated care. One review of the existing literature looked at whether integrated behavioral health and primary care for children and adolescents improved behavioral health outcomes as compared to usual models of care. The study authors concluded that “[b]enefits of integrated medical-behavioral treatment were observed for interventions that target diverse mental health problems (depression, anxiety, and behavior),” calculating a 73 percent probability that a randomly selected youth would have a better outcome after receiving integrated care than a randomly selected youth receiving usual care. The authors came to this conclusion after reviewing

⁴²¹ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, “What is Integrated Care?,” <https://www.integration.samhsa.gov/about-us/what-is-integrated-care>, accessed Feb. 7, 2020.

⁴²² Wayne Katon, Jurgen Unutzer, Kenneth Wells, Loretta Jones, “Collaborative Depression Care: History, Evaluation and Ways to Enhance Dissemination and Sustainability,” *General Hospital Psychiatry* 32 no. 5 (Sept./Oct. 2010): 456-464, doi: 10.1016/j.genhosppsy.2010.04.001.

31 studies and engaging in their own statistical analysis. According to the authors, this is the first known meta-analysis of the effects of integrated behavioral and primary care in the adolescent population.⁴²³

Another study examined data from 79 randomized controlled trials of integrated care for patients with depression or anxiety. The data analyzed consisted of 24,308 patients in total. The researchers discovered “significantly greater improvement in depression outcomes for adults with depression treated with the collaborative care model in the short-term ... and long-term,” as well as “significantly greater improvement in anxiety outcomes for adults with anxiety treated with the collaborative care model in the short-term ... medium-term ... and long-term.”⁴²⁴ In this study the authors use the term “collaborative care,” which is effectively a synonym of “integrated care.” However, the National Institute of Mental Health separately defines “collaborative care” as a form of integrated care which “adds two new types of services to usual primary care: behavioral health care management and consultations with a mental health specialist.”⁴²⁵

Studies typically used a qualitative metric, such as the PHQ-9 (a 9-question survey given to patients to measure the presence and severity of depression), to gauge the effectiveness of integrated care models.⁴²⁶ For instance, a study of an integrated model where mental and medical health care needs were “coordinated by co-locating a Behavioral Health Consultant (BHC) within a primary care setting” concluded that the model led to improvement in the condition of mood disordered patients. This was determined by giving PHQ-9 depression screening surveys to existing primary care patients before and after the introduction of the integrated care model.⁴²⁷

Another study, evaluating the cost-effectiveness of a collaborative treatment program as compared to usual primary care for outpatients with depression and poorly controlled diabetes mellitus or coronary heart disease, found that the patients treated in the collaborative treatment program had lower mean outpatient costs and markedly improved quality-adjusted life-years than patients treated with usual primary care. The study followed 214 adults over a period of 24 months and evaluated depressive symptoms, systolic blood pressure, low-density lipoprotein cholesterol, and hemoglobin A1c levels at 12 and 24 month intervals.⁴²⁸

⁴²³ Joan Rosenbaum Asarnow, et al., “Integrated Medical-Behavioral Care Compared With Usual Primary Care for Child and Adolescent Behavioral Health, A Meta-Analysis,” *JAMA Pediatrics* 169 no. 10 (Oct. 2015): 929-937, doi: 10.1001/jamapediatrics.2015.1141.

⁴²⁴ Janine Archer, et al., “Collaborative Care for Depression and Anxiety Problems,” *The Cochrane Database of Systematic Reviews* (Oct. 17 2012).

⁴²⁵ U.S. Department of Health and Human Services, National Institute of Mental Health, “Integrated Care,” accessed Feb. 10, 2020, <https://www.nimh.nih.gov/health/topics/integrated-care/index.shtml>.

⁴²⁶ The PHQ-9 is a patient questionnaire used for screening, diagnosing, monitoring, and measuring the severity of depression. Center for Quality Assessment and Improvement in Mental Health, “The Patient Health Questionnaire (PHQ-9),” accessed Apr. 20, 2020, http://www.cqaimh.org/pdf/tool_phq9.pdf.

⁴²⁷ Bill McFeature and Thomas W. Pierce, “Primary Care Behavioral Health Consultation Reduces Depression Levels among Mood-Disordered Patients,” *Journal of Health Disparities Research and Practice* 5 no. 2 (Summer 2012): 36-44.

⁴²⁸ Wayne Katon et al., “Cost-Effectiveness of a Multicondition Collaborative Care Intervention — A Randomized Controlled Trial,” *Archives of General Psychiatry* 69 no. 5 (May 2012): 506-514, doi: 10.1001/archgenpsychiatry.2011.1548.

The Medicaid Health Home model is another example of integrated care. Established by the Affordable Care Act of 2010, Health Homes are “an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions.”⁴²⁹ People who have one “serious and persistent mental health condition” are eligible to participate in a Medicaid Health Home, and participating states can target the Health Home model to particular geographic areas. Health Home services include:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care/follow-up;
- Patient and family support; and
- Referral to community and social support services

States that participate in the Medicaid Health Home option receive a 90 percent enhanced Federal Medical Assistance Percentage for the Health Home services provided, although the match does not apply to the underlying Medicaid services also provided to people enrolled in a Health Home.⁴³⁰ As of fiscal year 2019, Pennsylvania does not participate in the Medicaid Health Home option.⁴³¹

Integrated care models are not new, and they are being implemented by some providers — with reportedly successful outcomes — around the Commonwealth. For instance, Children’s Hospital of Philadelphia (CHOP) co-locates its primary care and behavioral care practitioners within one practice setting. Currently, six offices have been integrated this way. According to CHOP, this integrated care model is “convenient for families and reduces stigma.”⁴³²

Additionally, CHOP offers a call-in center for primary care physicians to consult with a psychiatrist. Known as the Telephonic Psychiatric Consultation Service Program, or TiPS, the call center is staffed by psychiatrists and other members of CHOP’s behavioral health care team. TiPS gives pediatricians and other primary care providers access to expertise which allows them to handle their patients’ mental health care needs, such as medication management. In addition to providing immediate “troubleshooting” for patients presenting to primary care physicians with behavioral health concerns, it helps primary care providers feel more comfortable handling their patients’ behavioral health issues on their own. Currently, TiPS is available to physicians treating

⁴²⁹ Centers for Medicare and Medicaid Services, “Health Homes,” accessed Feb. 11, 2020, <https://www.medicare.gov/medicaid/long-term-services-supports/health-homes/index.html>.

⁴³⁰ *Id.*

⁴³¹ Kaiser Family Foundation, “States That Reported Health Homes in Place, SFY 2015-2019, Pennsylvania,” <https://www.kff.org/medicaid/state-indicator/states-that-reported-health-homes-in-place/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

⁴³² Children’s Hospital of Philadelphia, “Innovative Solutions at CHOP are Removing Barriers to Mental Health Care,” (Jun. 18, 2018), <https://www.chop.edu/news/innovative-solutions-chop-are-removing-barriers-mental-health-care>.

Medicaid patients from the five-county Philadelphia region, which encompasses 400,000 children.⁴³³

Impediments to wider adoption of integrated care models are generally not driven by questions surrounding its clinical efficacy but rather practical concerns about its implementation and financial reimbursement for services. In the words of one study researching organized efforts to disseminate integrated care models, providers “need predictable ways to cover program startup and operational costs” as well as technical and institutional support that helps their practices change how the health care providers work.⁴³⁴ In an effort to support implementation of integrated care models by providers, several regional and national purchasing and quality improvement collaboratives have been organized. These include the Pittsburgh Regional Health Initiative, Institute for Clinical Systems Improvement, The California Endowment’s Integrated Behavioral Health Project, and the John A. Hartford Foundation.⁴³⁵

The Department of Veterans Affairs (VA) has been utilizing an integrated care model for over a decade, adding several hundred staff to transition to collaborative care for depression in its primary care clinics throughout the VA system. Kaiser Permanente has been able to successfully implement integrated behavioral care into its primary care system for patients with cardiovascular and other chronic medical conditions in southern California. However, researchers have conceded that smaller providers who bill a large number of different health insurance plans in a fee-for-service model have had a more difficult time with the integrated care model and that this model of care works best in large capitated health care organizations like the VA or Kaiser Permanente.⁴³⁶

Pennsylvania has already been proactive in supporting alternative models to increase the efficiency, expand access to, and lower the cost of health care. For instance, the Pennsylvania Rural Health Model provides “global payments” — a lump sum of money to cover all inpatient and hospital-based outpatient services for certain patients — to service providers at participating rural hospitals.⁴³⁷ Although the Pennsylvania Rural Health Model is a CMS-sponsored program, it demonstrates a willingness to pursue alternative health care models and long-term goals.

To encourage large health systems, smaller providers, and insurance companies alike to adopt integrated care models, the General Assembly should provide tax incentives to any health system, provider, or insurance company which begins providing (or begins reimbursing for) integrated medical and mental health services. For instance, an incentive could take the form of a tax deduction for the initial costs of integrating care or developing payment structures.

⁴³³ *Id.* Note that there are five TiPS centers across the Commonwealth which are divided by region. See Pennsylvania Department of Human Services, “Telephonic Psychiatric Consultation Service Program (TiPS),” accessed Feb. 12, 2020, <https://www.dhs.pa.gov/providers/Providers/Pages/TiPS.aspx>.

⁴³⁴ Katon et al., Collaborative Depression Care, *supra* n. 428.

⁴³⁵ *Id.*

⁴³⁶ *Id.*

⁴³⁷ Centers for Medicare and Medicaid Services, “Pennsylvania Rural Health Model,” (updated Jan. 16, 2020), <https://innovation.cms.gov/initiatives/pa-rural-health-model/>.

Additionally or alternatively, because many of the patients who would benefit most from integrating medical and mental health care are receiving Medicare or Medicaid, the General Assembly should consider directing the Department of Human Services to investigate whether it would be feasible and cost-effective for the Commonwealth to participate in CMS's Health Home option.

Further, the General Assembly should consider directing the Pennsylvania Department of Human Services to coordinate with CMS on devising an approved model for delivering integrated care to Medicare and Medicaid beneficiaries. Kaiser Permanente of Southern California, mentioned above, was the recipient of \$18 million in funds from CMS to provide integrated care to Medicare and Medicaid recipients.⁴³⁸ If CMS-sponsored integrated health care models can be implemented in southern California, they can also be implemented in Pennsylvania.

Encourage the Use of Certified Registered Nurse Practitioners and Physician Assistants

In the Commission's 2019 report *Pennsylvania Health Care Workforce Needs*, we addressed the academic literature covering nurse practitioners and physician assistants, discussed the growth of these professions and their potential to be part of the solution in addressing the primary care needs of the Commonwealth. The Commission made a recommendation to give greater autonomy to the health care teams employing them to determine the scope of practice of the nurse practitioner or physician assistant rather than trying to define by way of regulation the contours of the advanced practice professional-physician-patient relationship.⁴³⁹ For instance, PAs are required to have their physician supervision agreements approved by the Board of Medicine.⁴⁴⁰ The Commission recommended that this, and other regulations which may restrict the use of PAs or NPs, be either eliminated or amended to better facilitate the provision of care.⁴⁴¹ In this example, PAs could simply be required to file their physician supervision agreements with the Board, instead of needing to have them be approved. In this report we are additionally recommending that the Commonwealth facilitate better use of nurse-managed health clinics and federally-certified Rural Health Clinics, as is discussed below.

Nurse-Managed Health Clinics

In the Commission's 2019 report, nurse-managed health clinics (NMHCs) were mentioned as one modality of delivering health care to underserved populations — primarily in urban areas, but also in rural areas. The NMHC model predates the passage of the Affordable Care Act of 2010, but that law federally funded NMHCs with grants provided by the HRSA. However, the

⁴³⁸ Sara Klein and Martha Hostetter, "In Focus: Integrating Behavioral Health and Primary Care," The Commonwealth Fund, (Aug. 28, 2014), <https://www.commonwealthfund.org/publications/newsletter-article/2014/aug/focus-integrating-behavioral-health-and-primary-care>.

⁴³⁹ Pennsylvania Health Care Workforce Needs, *supra* n. 204 at pp. 93-109.

⁴⁴⁰ 49 Pa. Code § 18.142.

⁴⁴¹ Pennsylvania Health Care Workforce Needs, *supra* n. 204 at pp. 108-109.

grant program ended in 2013.⁴⁴² There are 32 NMHCs in the Commonwealth, with a large concentration in Philadelphia and its suburbs. York, Monroe, Greene, Centre, and Columbia counties also have NMHCs.⁴⁴³

Although the core focus of NMHCs is to provide primary care to underserved populations, behavioral health services are also sometimes offered as well. For example, the Sheller 11th Street Family Health Services Center in Philadelphia provides behavioral health care as well as primary care services.⁴⁴⁴ The Center utilizes “an integrative approach ... and addresses the full range of physical, emotional, mental, social, spiritual, and environmental influences that affect a person’s health.”⁴⁴⁵

From an organizational perspective, there is nothing preventing an NMHC offering mental health care services in addition to preventative primary care services. Further, there is nothing inherent in the practice model preventing NMHCs from expanding in number in rural locations — the practice model has been successfully implemented in numerous places across the state. The impediments to such an expansion of NMHCs across the Commonwealth are regulatory and financial ones.

Because many NMHCs are affiliated with schools of nursing or are run by non-profits, they are generally ineligible to be designated as a Federally Qualified Health Center (FQHC) and are thus ineligible for federal funding.⁴⁴⁶ Further, many managed care organizations are unwilling to credential nurse practitioners as primary care providers, thereby limiting the ability of NMHCs to receive reimbursement from private insurers.⁴⁴⁷ This is not driven by federal regulations but rather the individual managed care organizations (MCOs) which set their own policies regarding reimbursement. According to data collected in 2017, approximately one-quarter of all MCOs in the country do not contract with nurse practitioners, and in Pennsylvania that figure rises to between one-half and three-quarters of MCOs.⁴⁴⁸

⁴⁴² U.S. Department of Health and Human Services, Health Resources and Services Administration, “Affordable Care Act Nurse Managed Health Clinics (NMHC) Frequently Asked Questions,” p. 3, <https://www.hrsa.gov/sites/default/files/grants/healthprofessions/acafaq.pdf>.

⁴⁴³ National Nurse-Led Care Consortium, “Nurse-Managed Health Clinics in Pennsylvania,” (Apr. 2017), <https://nurseledcare.phmc.org/images/pdf/policy/NNCC-NMHCs-in-Pennsylvania.pdf/>.

⁴⁴⁴ Drexel University College of Nursing and Health Professions, “Stephen and Sandra Sheller 11th Street Family Health Services,” (accessed Jan. 21, 2020), <https://drexel.edu/cnhp/practices/11th-street/>.

⁴⁴⁵ Tine Hansen-Turton, Susan Sherman, Eunice S. King, eds., *Nurse-Led Health Clinics: Operations, Policy, and Opportunities* (Springer 2015), 150.

⁴⁴⁶ Tine Hansen-Turton, “Nurse-Managed Health Clinics Provide Badly Needed Primary Care - But Without Funding, They and Their Patients are at Risk,” Robert Wood Johnson Foundation, *Culture of Health* blog, (Jan. 27, 2012), <https://www.rwjf.org/en/blog/2012/01/nurse-managed-health-clinics-provided-badly-needed-primary-carebut-without-funding-they-and-their-patients-are-at-risk.html>.

⁴⁴⁷ Jennifer Bellot et al., “Does Contracting with Managed Care Organizations Remain a Barrier for Nurse Practitioners?,” *Nursing Economics* 35 No. 2 (Mar.-Apr. 2017): 57-63, <https://www.nursingconomics.net/necfiles/2017/MA17/57.pdf>.

⁴⁴⁸ *Id.* at p. 60

Both Medicare and Medicaid will reimburse for services provided by NPs, but these funding sources are likely to be insufficient to cover all expenses of running a clinic given that 40 percent of the patients seen by NMHCs within the Commonwealth are eligible for Medicaid, 30 percent are eligible for Medicare, and 15 percent are uninsured.⁴⁴⁹ According to an analysis published in the *DePaul Journal of Health Care Law*, “NMHCs are generally unable to break even and are unprofitable.” Further, “thirty-nine percent of the 70 grantees that received federal funding to establish [an] NMHC from 1993 to 2001 have closed.”⁴⁵⁰ The Sheller 11th Street Family Health Services Center mentioned above solicits charitable donations to help fund its operations.⁴⁵¹ One study of NMHCs noted that “without a stable source of funding, many NMHCs have had to close.”⁴⁵²

NMHCs have a track record of providing health care to underserved populations within the Commonwealth, but suffer from a lack of sustainable funding sources. To encourage better use of the Commonwealth’s NMHCs, the General Assembly should consider enacting “any willing provider” legislation. Such legislation generally prohibits “insurance carriers from limiting membership within their provider network,” and have been used by other states to expand private insurance reimbursement to allied health professionals such as optometrists and podiatrists.⁴⁵³ A total of 27 states have enacted some form of “any willing provider” legislation. For instance, Arkansas’ any willing provider law covers “other health care practitioners,” which includes advanced practice nurses.⁴⁵⁴ Utah also has a broad any willing provider statute, which requires that “any health care provider licensed to treat any illness or injury within the scope of [their] practice” be permitted to be designated as a preferred health care provider by an insurer. “Health care provider” is defined to include NPs and PAs, as well as psychologists.⁴⁵⁵

To increase mental health services in underserved areas, “any willing provider” legislation could be narrowly tailored to apply to health clinics staffed by NPs or physician assistants in rural and other underserved areas which offer mental health services in addition to primary care preventative services. The mental health services must still be provided by a properly licensed and trained specialist in mental health, whether a psychiatrist, psychologist, PMH NP, or a specialist psychiatric PA. The any willing provider legislation should cover all of the medical staff of the health clinics.

To further facilitate the use of PMH NPs, whether at an NMHC or elsewhere, the General Assembly should consider allowing PMH NPs to conduct psychiatric evaluations of patients on Medical Assistance, so long as the collaboration agreement with a supervising psychiatrist allows

⁴⁴⁹ Nurse-Managed Health Clinics in Pennsylvania, *supra* n. 443.

⁴⁵⁰ Joy Luchico Austria, “Urging a Practical Beginning: Reimbursement Reform, Nurse-Managed Health Clinics, and Complete Professional Autonomy for Primary Care Nurse Practitioners,” 17 *DePaul Journal of Health Care Law* (2015), <https://via.library.depaul.edu/cgi/viewcontent.cgi?article=1320&context=jhcl>.

⁴⁵¹ Drexel University, Stephen and Sandra Sheller 11th Street Family Health Services, *supra* n. 444.

⁴⁵² J. Margo Brooks Carthon, Hilary Barnes, Danielle Altares Sarik, “Federal Policies Influence Access to Primary Care and Nurse Practitioner Workforce,” *The Journal for Nurse Practitioners* 11 No. 5 (May 2015): 526-530, doi: 10.1016/j.nurpra.2015.01.028.

⁴⁵³ National Conference of State Legislatures, “Any Willing or Authorized Providers,” (Nov. 5, 2014), <https://www.ncsl.org/research/health/any-willing-or-authorized-providers.aspx>.

⁴⁵⁴ Ark. Code Ann. §§ 23-99-801 and 802.

⁴⁵⁵ Utah Code Ann. § 31A-22-617; Utah Code Ann. § 78B-3-403(12) (defining “health care provider”).

it and the supervising psychiatrist reviews the evaluation. Currently, applicable regulations state that only psychiatrists may conduct an evaluation of a patient receiving Medical Assistance.⁴⁵⁶

Alternatively or additionally, the General Assembly could consider providing additional appropriations for, or direct the Department of Health to provide funding out of its existing budget, to NMHCs and other similar clinics in rural or other underserved areas which provide mental health services.

Rural Health Clinics

Adopting physician assistants into a team-based integrated care model would also be feasible. Both professions provide similar functions within the healthcare system and both have similar physician oversight rules. The use of PAs in this capacity is already occurring at federally-certified Rural Health Clinics (RHCs). The Commonwealth already hosts 74 RHCs,⁴⁵⁷ which are “required to use a team approach of physicians working with non-physician providers such as nurse practitioners, physician assistants, and certified nurse midwives to provide services.”⁴⁵⁸

To qualify as an RHC, a clinic must be in a U.S. Census Bureau-defined non-urbanized area, be a primary care geographic HPSA, population group HPSA, a medically underserved area, or a Governor-designated and Secretary-certified shortage area. RHCs cannot be “primarily a mental disease treatment facility or a rehabilitation agency.” However, RHCs may provide “general behavioral health integration” and mental health care as part of a “psychiatric collaborative care model.”⁴⁵⁹ Integration of behavioral health care services with primary care services can be an important component of the mental health care system in rural areas in particular, given the lack of unaffiliated behavioral health care providers in such areas.

The main benefit to being designated as an RHC is enhanced Medicare and Medicaid reimbursement paid at an “all-inclusive rate” for “medically necessary, face-to-face primary health services and qualified preventative health services furnished by an RHC practitioner.” Psychologists and clinical social workers may be designated as RHC practitioners.⁴⁶⁰

It is possible that there are facilities in the Commonwealth that could qualify as RHCs but are not certified as an RHC with the Centers for Medicare and Medicaid Services. To make better use of available federal resources, the Department of Health should consider working with providers to determine whether they would benefit from becoming federally certified as an RHC.

⁴⁵⁶ 55 Pa. Code § 1153.2 (definition); 55 Pa. Code §1153.52 (detailing payment conditions).

⁴⁵⁷ Pennsylvania Department of Health, “Health Care Facilities, Rural Health Clinics,” accessed Jan. 24, 2020, <https://sais.health.pa.gov/commonpoc/content/publiccommonpoc/normalSearch.asp>.

⁴⁵⁸ Rural Health Information Hub, “Rural Health Clinics (RHCs),” <https://www.ruralhealthinfo.org/topics/rural-health-clinics>.

⁴⁵⁹ Center for Medicare and Medicaid Services, “Rural Health Clinic,” *MLN Fact Sheet*, (May 2019), <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinfactsht.pdf>.

⁴⁶⁰ *Id.*

Develop Additional Psychiatric Residency Positions

In the Commission’s 2019 report *Pennsylvania Health Care Workforce Needs*, it was recommended that “the Pennsylvania Department of Health and other governmental bodies of the Commonwealth should make a concerted effort to expand residencies within Pennsylvania.”⁴⁶¹ The Commission reiterates that recommendation here as it relates to psychiatric residencies.

As was detailed in that report, medical students begin a period of training, known as graduate medical education or residency, where they practice under the guidance and supervision of more experienced physicians. Students select and interview for residencies during their final year of medical school. Most residencies are funded by Medicare, and a 1997 law caps the amount of residencies at 1996 levels. However, residencies funded by other federal agencies or charitable, university, hospital, or state sources are not affected, and an increasing number of residencies receive funding from those sources. Because of the way Medicare funds residencies, Pennsylvania has the third highest number of residency programs and the fourth highest number of residency positions of all states.⁴⁶²

According to data from the National Resident Matching Program (NRMP), the organization responsible for connecting medical school graduates with residency positions, there were 298 psychiatry residency programs and 1,740 psychiatry residency positions in 2019. Nearly all (98.9 percent or 1,720) of the residency positions were filled.⁴⁶³ The number of psychiatric residency positions available in 2019 across the country are up roughly 28 percent from 2015, when there were 1,353 such positions.⁴⁶⁴

In Pennsylvania, there were 78 psychiatric residency positions offered and all 78 of them were filled, according to 2018 data from the NRMP. There were an additional two child psychiatry residency positions and two psychiatry/family medicine combination residency positions offered in the Commonwealth and all four of those positions were filled, for a total of 82 residencies.⁴⁶⁵ This is an increase from previous years. See **Table 9** below for a comparison.

| Table 9 | | | | | | | | | |
|---|--------|-------------|--------|-------------|--------|-------------|--------|-------------|--------|
| Number of Psychiatry Residencies in Pennsylvania, Selected Years | | | | | | | | | |
| 2018 | | 2015 | | 2010 | | 2005 | | 2002 | |
| Offered | Filled | Offered | Filled | Offered | Filled | Offered | Filled | Offered | Filled |
| 82 | 82 | 72 | 72 | 60 | 59 | 53 | 49 | 52 | 49 |

Source: National Resident Matching Program, Main Residency Match Results by State, Specialty, and Applicant Type, 2018, 2015, 2010, 2005, 2002. Available at <https://www.nrmp.org/report-archives/>.

⁴⁶¹ Pennsylvania Health Care Workforce Needs, *supra* n. 204 at p. 57.

⁴⁶² *Id.* at pp. 51-57.

⁴⁶³ National Resident Matching Program, “Results and Data — 2019 Main Residency Match,” (Apr. 2019), p. 8, Table 2.

⁴⁶⁴ *Id.* at p. 12, Table 3

⁴⁶⁵ National Resident Matching Program, “2018 NRMP Main Residency Match: Match Rates by Specialty and State,” (2018), p. 13.

An increase in the number of psychiatric residents from 49 to 82 in the past 15 years is an undoubtedly positive development. In 2018, Pennsylvania had 82 of the 1,540 psychiatric residencies across the country, accounting for 5.3 percent of all such residencies.⁴⁶⁶ This makes Pennsylvania well-represented in the total number of psychiatric residencies available throughout the country. However, those residency positions are clustered in a handful of programs, which are located in five areas — Pittsburgh, Philadelphia, Hershey, Danville, and Scranton. See **Map 5** on the next page for a visual reference.⁴⁶⁷

As was mentioned earlier in this report, one of the impediments to obtaining psychiatric care is the geographical distribution of psychiatrists across the Commonwealth. Pennsylvania's high number of psychiatry residents are clustered in five geographic areas, and their future employment may be linked to those geographic areas. According to the University of Michigan's Behavioral Health Workforce Research Center, "[w]here psychiatrists practice is strongly associated with where they completed their residency."⁴⁶⁸

In order to better provide psychiatric care to underserved areas — and particularly rural areas where there may be few providers — it may be necessary to establish more psychiatric residencies in these communities. The General Assembly could direct the Department of Health to invest in psychiatric residencies in rural areas by providing the up-front costs of starting a residency program to facilities willing and able to accommodate such a program. This investment could be done as a grant program, with no expectation that the funds provided by the Department of Health will be repaid by the facility. Alternatively, such an investment into new psychiatry residents could include an expectation that the facility will reimburse the Department of Health when insurance companies are billed for the use of residents' time.

If the Commonwealth were to fund new psychiatric residencies, it would not be the only state to do so. For instance, Delaware funds psychiatric residencies through its Division of Substance Abuse and Mental Health, and has done so since 1950.⁴⁶⁹ California, through its 2005 Mental Health Services Act, also provided some funding for psychiatry residencies.⁴⁷⁰ In 2019, the governor of Iowa proposed state funding for four new psychiatry residencies.⁴⁷¹

⁴⁶⁶ National Resident Matching Program, "Results and Data — 2018 Main Residency Match," (Apr. 2018), p. 8.

⁴⁶⁷ MedMap, "Medical Residency and Fellowship Map — Psychiatry," accessed Mar. 2, 2020, <https://www.medmap.io/specialty/Psychiatry>.

⁴⁶⁸ Angela J. Beck, et al., "Estimating the Distribution of the U.S. Psychiatric Subspecialist Workforce," University of Michigan School of Public Health Behavioral Health Workforce Research Center, (Dec. 2018), http://www.behavioralhealthworkforce.org/wp-content/uploads/2019/02/Y3-FA2-P2-Psych-Sub_Full-Report-FINAL2.19.2019.pdf.

⁴⁶⁹ Delaware Division of Substance Abuse and Mental Health, "Delaware Psychiatry Residency Program — Introduction," accessed Mar. 3, 2020, <https://dhss.delaware.gov/dhss/dsamh/residency/introduction.html/>.

⁴⁷⁰ Los Angeles County Department of Mental Health, "WET Plan Components," accessed Mar. 3, 2020, <https://dmh.lacounty.gov/about/mhsa/wet/components/>.

⁴⁷¹ Gabriela Vidal, "Governor Proposes Funding New Psychiatry Positions in UI Residency Program," (Jan. 15, 2019), <https://cbs2iowa.com/news/local/governor-proposes-funding-new-psychiatry-positions-in-ui-residency-program>.

Map 5



Source: MedMap, “Medical Residency and Fellowship Map — Psychiatry,” accessed Mar. 2, 2020. <https://www.medmap.io/specialty/Psychiatry>.

**Increase Funding and Availability of Tuition Repayment Programs
and Consider Limiting Increases in Tuition
at Pennsylvania State System of Higher Education Schools**

One recommendation from the Commission’s 2019 report entitled *Pennsylvania Health Care Workforce Needs* reiterated here is to increase the number of awards made under the Commonwealth’s Primary Care Loan Repayment Program as well as to increase the amount of each award in order to account for the recent and rapid rise in tuition.⁴⁷² These increases in aid should be offset by increasing the length of service time the recipient must commit to working in an underserved area, from the current two years to four years. This way, the Department of Health’s Primary Care Loan Repayment Program can better attract new graduates who are more likely to commit to a career in primary care in an underserved part of the state.

Another recommendation is for the General Assembly to implement policies to hold down tuition at the fourteen state owned and operated institutions of higher education that compose the Pennsylvania State System of Higher Education (PASSHE). This should be done via an amendment to Article XX-a of the Public School Code of 1949. Currently, Article XX-a — the provision governing the State System of Higher Education — accords the Board of Governors the power “[t]o fix the levels of tuition fees.”⁴⁷³ An amendment to this provision could provide, for instance, that future tuition increases be limited to an increase in the U.S. Bureau of Labor Statistic’s Consumer Price Index (CPI). The General Assembly could alternatively (or additionally) condition any future funding increases from the state budget on tuition freezes or rollbacks.

Another possible policy action could be to have the Department of the Auditor General determine the actual cost to each of the 14 universities in the Pennsylvania State System of Higher Education for their various graduate programs in health care fields, and amend the Public School Code to charge the Board of Governors with limiting the tuition of those programs to the actual cost of providing the program. The Commission publishes a report annually on the required information disclosures of the state-related institutions. However, this information is self-reported by the institutions and does not contain a breakdown of expenses for graduate programs in health care fields, although it does provide expenses by department.⁴⁷⁴ Holding tuition in check for important mental health care professional programs would set an example and potentially catalyze tuition freezes at private institutions as they compete for students.

If the Commonwealth implemented one or more of these policies it would not be the only state pursuing such out-of-the-box solutions to rising tuition costs and its resulting student debt proliferation. Missouri ties tuition to the CPI. Washington State’s legislature enacted a tuition rollback in 2016. Kansas froze tuition. Maryland has a tuition stabilization fund which receives

⁴⁷² Pennsylvania Health Care Workforce Needs, *supra* n. 204 at pp. 48-49.

⁴⁷³ Act of March 10, 1949 (P.L. 30, No. 14, art. XX-A, § 2006-A); 24 P.S. § 20-2006-A(a)(11).

⁴⁷⁴ See Joint State Government Commission, “Information Disclosure of the State-Related Universities — Staff Analysis of the 2018-19 Data Reported Under Section 2004-D of the Public School Code of 1949,” (Feb. 2020).

corporate income tax money and aims to limit tuition increases to no more than the three-year rolling average of increases in the state’s median income.⁴⁷⁵

As detailed in this report, young professionals entering our Commonwealth’s mental health care workforce are facing burdensome educational expenses for which they must take out loans to pay. Because these positions require advanced degrees, the student loan issue is particularly acute for those entering the mental health care workforce as well as the broader health care workforce.

Encourage Educational Institutions to Recruit Students from Communities That Are Underserved

Another policy solution which may help alleviate shortages of mental health professionals in underserved areas — including both underserved urban communities and rural areas — is to recruit students from those communities. Researchers who have studied this issue have generally concluded that students who are drawn from rural or urban underserved communities are more likely to return to those communities once they finish their education and enter the health care workforce.

For instance, an Australian study of a pipeline program for encouraging rural high school students to enter the medical field found that medical students “who have lived in rural communities, attended rural schools and participated in rurally based recreational activities before entering medical school ... were more likely to express an intention to become rural practitioners.” This article also cited several other studies which indicated that living in a rural area “prior to entry into medical school is the strongest predictor of a career in rural medicine after graduating.”⁴⁷⁶

Further, a review of the literature published by the HRSA noted that “[t]hirteen separate studies have documented that minority physicians tend to provide a disproportionately large share of health care for patients from their own racial and ethnic backgrounds.” The HRSA concluded that these studies provided “overwhelming” support to the hypothesis that “minority health professionals are more likely than non-minorities to serve both minority and other underserved populations, including the poor and uninsured.”⁴⁷⁷

In two of the Commission’s reports this past decade, recommendations were put forth to increase the number of people entering health care professions from underserved communities. In the Commission’s 2019 report *Pennsylvania Health Care Workforce Needs*, it was recommended that the General Assembly consider implementing a more formal statewide “pipeline” program to introduce high school students from these underserved communities to educational opportunities leading to careers in the medical profession. The report further recommended that the

⁴⁷⁵ Roger Fillion, “Tackling College Tuition,” *State Legislatures Magazine*, (Mar. 1, 2016).
<https://www.ncsl.org/bookstore/state-legislatures-magazine/tackling-tuition.aspx>.

⁴⁷⁶ John Henry, Brian Edwards, Brendan Crotty, “Why Do Medical Graduates Choose Rural Careers?,” *Rural and Remote Health* 9 no. 1, (Feb. 28, 2009): 1083.

⁴⁷⁷ U.S. Department of Health and Human Services, Health Resources and Services Administration, “The Rationale for Diversity in the Health Professions: A Review of the Evidence,” (Oct. 2006), p. 9,
<https://pdfs.semanticscholar.org/6df3/f71b73df07800b82250c2bf87ce594bbf667.pdf>.

Commonwealth should expand grant monies to existing pipeline programs.⁴⁷⁸ The Commission's 2015 report *The Physician Shortage in Pennsylvania* made the same recommendations.⁴⁷⁹

Whether it is done through a formal state-sponsored pipeline program, increased grant funding to existing programs, or other policies, the Commonwealth should incentivize educational institutions to recruit from both rural and urban underserved populations. The goal of such policies would be to entice people familiar with such communities to become medical professionals, as they are more likely to return and serve those communities once they graduate. The strategy is different from loan repayment programs, which are designed to entice new graduates to work in underserved areas, a path they may not have considered absent the incentive of loan repayment.

Encourage the Use of Telepsychiatry

In the Commission's 2019 report *Pennsylvania Health Care Workforce Needs*, it was recommended that Pennsylvania "enact parity legislation that will ensure that health insurers reimburse health care providers for telemedicine services at the same rate they would for face-to-face consultations." The Commission concluded that such legislation "is essential to encouraging the practice of telemedicine and will likely encourage more physicians to practice in Pennsylvania, knowing that they may be able to expand the scope of their practice and the depth of their skills through telemedicine while receiving appropriate reimbursement."⁴⁸⁰ This report reiterates this recommendation while expanding its application to telepsychiatry practices.

Defining the Practice of Telemedicine and Telepsychiatry

The practice of telemedicine is defined as "the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration." The electronic communication reference within the definition refers to the use of interactive telecommunication equipment which includes at a minimum audio and video equipment, but may also include videoconferencing, store-and-forward imaging, streaming media, and terrestrial and wireless communications. Currently, there are three main types of telemedicine: remote patient monitoring; store-and-forward; and interactive services.⁴⁸¹

Telemedicine is not a new concept. In fact, the idea originated many years ago as a product of early telecommunications technology such as the telegraph, radio, and telephone. Shortly after the introduction of these innovations, American inventor, writer, editor, and magazine publisher Dr. Hugo Gernsback wrote about a future device he called the "teledactyl," a device that would make it possible for doctors to visually inspect their patients through a view-screen and physically touch them from miles away with robotic arms.⁴⁸²

⁴⁷⁸ Pennsylvania Health Care Workforce Needs, *supra* n. 204 at pp. 33-40.

⁴⁷⁹ Joint State Government Commission, "The Physician Shortage in Pennsylvania," (Apr. 2015), pp. 24-26.

⁴⁸⁰ Pennsylvania Health Care Workforce Needs, *supra* n. 204 at p. 122.

⁴⁸¹ *Id.* at p. 109.

⁴⁸² *Id.*

The use of telemedicine services for mental health treatment is generally referred to as “telepsychiatry.” The American Psychiatric Association (APA) has identified telepsychiatry as a subset of telemedicine. According to the APA, telepsychiatry can provide “a range of services including psychiatric evaluations, therapy (individual therapy, group therapy, family therapy), patient education and medication management.” Telepsychiatry can involve direct interaction between a psychiatrist and the patient. The practice itself also encompasses psychiatrists supporting primary care providers with mental health care consultation and expertise.⁴⁸³

As telemedicine advanced, the practice of telepsychiatry became more commonly used to treat mental health needs. For example, the U.S. Department of Veterans Affairs (VA) began using interactive, RPM, and store-and-forward telemedicine to provide psychotherapy, psychiatric diagnostic interview examinations, and medication management to veterans battling depression and post-traumatic stress disorder (PTSD) as well for those with end stage conditions such as renal disease.⁴⁸⁴ Secondary schools have also started utilizing telemedicine to address the mental health conditions showing up in adolescents.⁴⁸⁵

Growing Demand for Telepsychiatry

Telemedicine has the ability to improve access to health care in the Commonwealth — especially in rural regions — because it eliminates many of the common access barriers found in underserved areas such as lack of primary care physicians and specialists, sparse population, geographic remoteness, limited financial resources, and inclement weather.⁴⁸⁶ However, telemedicine is particularly well suited for the provision of mental health services. Telepsychiatry offers additional benefits beyond improving access to psychiatric care.

For instance, while one limitation of telemedicine in other contexts tends to be the lack of in-person contact between patient and provider, mental health diagnosis and therapy are generally conducted by interview without a physical examination. Therefore, the general absence of a need to undergo a physical examination makes telemedicine an ideal practice for mental health care.

Further, telepsychiatry can bring the provider to the patient, and “the ease of accessing a provider at a nearby facility or even in the home can facilitate treatment initiation and engagement.”⁴⁸⁷ Telemedicine provided directly to a patient while the patient is in the comfort and privacy of their own home can alleviate a patient’s fear of potential public stigma associated with venturing out to a hospital or mental health facility.

⁴⁸³ American Psychiatric Association, “What is Telepsychiatry?” (Jan. 2017), <https://www.psychiatry.org/patients-families/what-is-telepsychiatry>.

⁴⁸⁴ America’s Health Insurance Plans, “Telehealth Connects Patients and Doctors in Real Time,” Issue Brief, (Nov. 2017), p. 4, https://www.ahip.org/wp-content/uploads/2017/11/Telehealth_IssueBrief_11.20.17.pdf.

⁴⁸⁵ Pennsylvania Health Care Workforce Needs, *supra* n. 204 at p. 112

⁴⁸⁶ *Id.* at p. 109.

⁴⁸⁷ Michael L. Barnett and Haiden A. Huskamp, “Telemedicine for Mental Health in the United States: Making Progress, Still a Long Way to Go,” *Psychiatry Online* 71 no. 2, (Dec. 18, 2019): 197-198, doi: 10.1176/appi.ps.201900555.

Other benefits of telepsychiatry include reducing delays in care, reducing needed trips to the emergency room for mental health issues, improving the continuity of care and physician follow-up, reducing the need to take time off from work or school or find childcare, and potentially helping to integrate primary medical care with mental health care.⁴⁸⁸

The benefits of telemedicine use in mental health care appear to be resonating with patients nationwide. A recent study reviewing millions of privately insured enrollees from 2005 to 2017 found that “the majority of telemedicine visits were for mental health, with over 50% annual compound growth in the number of tele-mental health service visits over more than a decade, although overall use rates were less than two visits per 1,000 enrollees annually.”⁴⁸⁹ Telemedicine use was found to be much higher among populations with serious illnesses.⁴⁹⁰

Parity Legislation in Other States

While there is ample evidence that telepsychiatry can bridge the gap in access to mental health care, one large obstacle remains — insurance reimbursement to providers. At the federal level, Medicare allows for reimbursement of telemedicine services provided through an interactive audio and video telecommunications system permitting real-time communication between a patient at a distant site and the physician at the originating site. However, Medicare will not reimburse for asynchronous communications such as store-and-forward services or RPM for chronic diseases, except when said services are rendered within Alaska or Hawaii.⁴⁹¹

In 2015, the U.S. Congress was considering a nationwide telemedicine parity law called the Medicare Telehealth Parity Act.⁴⁹² Never enacted, the legislation was intended to modernize the method by which Medicare reimburses telemedicine services and also sought to expand coverage for Medicare beneficiaries.⁴⁹³

States have enacted legislation to address the issue of reimbursement for telemedicine services, for both their Medicaid programs as well as for private insurers. The most common form of telemedicine reimbursement legislation across the U.S. is coverage through Medicaid. Currently, 49 states and the District of Columbia provide some form of Medicaid reimbursement for telemedicine services.⁴⁹⁴ Pennsylvania reimburses for RPM telemedicine services through its Department of Aging.⁴⁹⁵

⁴⁸⁸ What is Telepsychiatry?, *supra* n. 483.

⁴⁸⁹ Michael L. Barnett *et al.*, “Trends in Telemedicine Use in a Large Commercially Insured Population, 2005–2017,” *JAMA* 320 no. 20 (Nov. 27, 2018): 2147–2149, Research Letter, doi:10.1001/jama.2018.12354.

⁴⁹⁰ A. Mehotra *et al.*, “Rapid Growth in Mental Health Telemedicine Use among Rural Medicare Beneficiaries, Wide Variation Across States,” *Health Affairs* 36, no. 5 (May 1, 2017): 909–917, doi: 10.1377/hlthaff.2016.1461.

⁴⁹¹ Medicare Learning Network, “Telehealth Services,” Center for Medicare & Medicaid Services, (Feb. 2018), p. 4, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsh.pdf>.

⁴⁹² United States Congress, Medicare Telehealth Parity Act of 2015, H.R. 2948 (114th Congress), <https://www.congress.gov/bill/114th-congress/house-bill/2948>.

⁴⁹³ *Id.*

⁴⁹⁴ Pennsylvania Health Care Workforce Needs, *supra*, n. 204 at p. 116.

⁴⁹⁵ *Id.*

Many states have also started enacting what are known as telemedicine “parity laws,” a topic discussed at great length in the Commission’s 2019 report *Pennsylvania Healthcare Workforce Needs*. As noted in that report, telemedicine parity laws generally require reimbursement through health plans for telemedicine services at the same or equivalent rate as paid for in-person services. Many states have recognized that the difficulty of providing telehealth services in a legal environment without parity laws for telemedicine is that private insurers can reimburse for telemedicine services at lower rate than what they would pay for in-person services, or even decide to not reimburse for telehealth at all.

Further, if insurance providers have no obligation to reimburse for reasonable telemedicine services at the same rate as in-person services, the incentive for health care professionals to offer and provide such services will evaporate and those isolated in rural and underserved areas will continue to lack access to needed health care.⁴⁹⁶ In other words, the lack of a legal requirement for insurers to reimburse a given telehealth service at the same rate as its in-person counterpart is the paramount barrier preventing the more widespread adoption of telemedicine and telepsychiatry.

Since 2017, forty states and the District of Columbia have adopted substantive policies or received awards to expand telemedicine coverage and reimbursement. In addition, 36 states and the District of Columbia have parity laws that cover private insurers and reimbursement for telemedicine services. As of 2019, 28 states have Medicaid payment parity policies; only 16 mandate payment parity for private payers.⁴⁹⁷

A 2019 survey found that “both state and federal lawmakers increasingly support coverage for mental health services provided via remote technology.”⁴⁹⁸ At a federal level, home-based telepsychiatry health has bipartisan support in Congress in the Mental Health Telemedicine Expansion Act, which was reintroduced early 2019.⁴⁹⁹ In the same year, Massachusetts approved coverage of telehealth services for its 1.9 million Medicaid members seeking access to psychologists, psychiatrists, psychoanalysts, clinical social workers, behavioral health nurses, nurse practitioners, and professional counselors.⁵⁰⁰ Kentucky likewise adopted legislation permitting telehealth visits to take place in a patient’s home, while Arizona expanded its telemedicine law to include coverage of treatment services for substance-abuse disorders.⁵⁰¹

⁴⁹⁶ *Id.*

⁴⁹⁷ American Telemedicine Association, “2019 State of the States Report: Coverage and Reimbursement,” (2019), <https://www.americantelemed.org/in-the-news/ata-releases-2019-update-of-state-by-state-telehealth-report-cards/>.

⁴⁹⁸ Jeff Lagasse, “Telehealth Laws and Regulations in 2019 Have Set the Stage for Increased Access and Use,” *Healthcare Finance*, (Dec. 11, 2019), <https://www.healthcarefinancenews.com/news/telehealth-laws-and-regulations-2019-have-set-stage-increased-access-and-use>.

⁴⁹⁹ United States Congress, Mental Health Telemedicine Expansion Act of 2019, H.R. 1301 (116th Congress), <https://www.congress.gov/bill/116th-congress/house-bill/1301/text>.

⁵⁰⁰ Massachusetts Executive Office of Health and Human Services, “MassHealth Expands Access to Behavioral Health Care for Members through Telehealth,” Press Release, (Feb. 8, 2019), <https://www.mass.gov/news/masshealth-expands-access-to-behavioral-health-care-for-members-through-telehealth>.

⁵⁰¹ Telehealth Laws and Regulations in 2019, *supra* n. 498.

Proposed Legislation in Pennsylvania

While numerous bills have been proposed, Pennsylvania does not currently have a telemedicine parity law. The Commission's *Pennsylvania Health Care Workforce* report discussed Senate Bill 780 of 2017 (SB 780) which defined telemedicine and provided a host of regulatory requirements for health care providers who engage in telemedicine.⁵⁰² SB 780 also required that all insurance policies issued, delivered, executed, or renewed within the Commonwealth provide coverage for medically necessary telemedicine delivered by a participating network provider who provides a covered service through telemedicine consistent with the insurer's medical policies. Further, SB 780 prohibited such health insurance policy from excluding a health care service provided through telemedicine. In other words, the health insurer must reimburse the health care provider for a telemedicine service if the health insurer reimburses the same participating provider for the same service through an in-person encounter.⁵⁰³ SB 780 was never enacted.

In September of 2019, Senate Bill 857 of 2019 (SB 857), also known as the Telemedicine Act, was introduced. Like SB 780, SB 857 establishes definitions for telemedicine, offers guidelines outlining who can provide telemedicine services, and provides clarity around insurance company reimbursement for these services. For instance, the bill provides that a health insurance policy must provide coverage "for medically necessary telemedicine delivered by a participating network provider who provides a covered service via telemedicine consistent with the insurer's medical policies." Senate Bill 857 prohibits exclusion of a health care service provided through telemedicine if the insurer reimburses the same participating provider for the same service through an in-person encounter, just as SB 780 had proposed. It is important to note that although the legislation requires payments for telemedicine services, the bill provides that actual payments be directly established between the provider and insurer. The bill also gives state licensure boards up to two years to draft permanent rules and regulations.⁵⁰⁴ The bill was signed in the House on April 21, 2020 and vetoed by the governor on April 29, becoming Veto 4 of the 2019-2020 session.⁵⁰⁵

Inclusion of Telepsychiatry

With the ongoing Coronavirus (COVID-19) pandemic and its unprecedented impact on the U.S. and the world, the ability to use telemedicine is needed now more than ever. In addition, the rise in mental health care needs and the shortage in mental health care professionals warrant telemedicine parity legislation that requires equal reimbursement for telepsychiatry practices.

Pennsylvania has taken steps to encourage increased use of telemedicine over the past few years. For example, the Pennsylvania Department of Health and several other stakeholders established a telemedicine advisory committee tasked with developing a strategic plan to implement telemedicine in Pennsylvania, and these efforts are supported through grant money provided by the Mid-Atlantic Telehealth Resource Center.⁵⁰⁶ However, more can be accomplished

⁵⁰² Pennsylvania Senate, S.B. 780, P.N. 1997, Regular Session 2017-2018.

⁵⁰³ *Id.*; See also Pennsylvania Health Care Workforce Needs, *supra*, n. 204 at p. 118.

⁵⁰⁴ Pennsylvania Senate, S.B. 857, P.N. 1388, Regular Session 2019-2020.

⁵⁰⁵ Pennsylvania General Assembly, "Regular Session 2019-2020 — SB 857 — Bill Information," <https://www.legis.state.pa.us/cfdocs/billInfo/billInfo.cfm?sYear=2019&sInd=0&body=S&type=B&bn=0857>.

⁵⁰⁶ Pennsylvania Health Care Workforce Needs, *supra*, n. 204 at p. 122.

through parity legislation that includes equal reimbursement for telepsychiatry. Such legislation can help ensure that health insurers reimburse health care providers for telepsychiatry services at the same rate they would for face-to-face consultations which can help mitigate the mental health professional shortage, while increasing access to mental health care for those who need it most.

Telepsychiatry parity also has the potential to encourage skilled mental health practitioners to provide telepsychiatry services in the Commonwealth by instilling in them confidence that they will receive the same compensation for telepsychiatry services as they would receive for in-person visits. For the same reason, parity legislation inclusive of telepsychiatry could encourage more individuals to pursue careers in the mental health field.

Five- and Ten-Year Projections

House Resolution 193 of 2019 requested that the Commission “[m]ake projections on the number of mental health care providers in 5 and 10 years.” Projections of the number of psychiatrists, psychologists, mental health counselors, and marriage and family therapists (MFTs) are found in this section. However, projections of psychiatric-mental health registered nurses (PMH RNs), psychiatric-mental health nurse practitioners (PMH NPs), psychiatric physician assistants, and licensed clinical social workers (LCSWs) cannot be honestly forecasted. As discussed previously, there is too much fluidity in the role of RNs who work in a mental health capacity to garner an accurate headcount. Although there are PMH RNs, not every RN who works in a mental health care capacity holds the PMH designation, and not every RN who works in a mental health care capacity does so every hour of every shift.

There are too few psychiatric physician assistants to quantitatively predict the future growth of this specialty role of the physician assistant. Similarly, while the growth in the PMH NP profession has undoubtedly been high in the past few years given the increasing number of graduates from PMH NP programs, the expansion of this profession has been a fairly recent trend. This, combined with incomplete data on the number of such providers already practicing in the Commonwealth, make a quantitative projection of employment in five and ten years’ time impractical.

As for LCSWs, the BLS’ categorization of this profession does not comport with the Commonwealth’s regulations defining and governing these providers. The BLS data would include LCSWs in its “mental health and substance abuse social worker” category — a category which would also include those who are not licensed in the Commonwealth, those who hold only a bachelor’s degree, and those who treat substance abuse issues exclusively.

For the four professions covered in this section, the analysis will look back 10 years (to 2010) for the 5-year forward projection and 20 years (to 2000) for the 10-year forward projection. This is done to assess the potential direction of employment in these fields. Two methodologies are then used to calculate the projections for the 5-year and 10-year periods. The first methodology averages the year-over-year percent change in employment for the entire look-back period, and projects it into the future. For instance, if there is a five percent increase in employment in a

profession in year one, then a two percent increase in year two, and a 1 percent decrease in year three, this methodology would result in a projection of an average of two percent per year. This methodology is a “best guess” of the number of mental health care providers the Commonwealth may have at the end of the 5- and 10-year projection periods.

A variation of the first methodology would be to account for the percent change in growth and project that into the future. This variation is useful for showing the acceleration or deceleration of growth in the supply of a particular profession. However, if this variation were used to project future employment in mental health providers in the Commonwealth, it would show an ever-increasing rate of growth with each year adding more mental health providers than the last — a confounding result. There are other problems with using this approach. One issue is that the data available goes back only to 2000, making the data set fairly limited. Another is that the total number of mental health providers in many professions is fairly small, leading to large percent changes in growth if a score of people enter or leave that profession on net in a given year.

The second methodology will be to associate the growth of a mental health profession with a causative variable that can be calculated independently. This variable is the number of persons studying or training to enter a particular mental health care provider. According to the Committee to Study the Role of Allied Health Personnel of the Institute of Medicine (now known as the National Academy of Medicine), “there is no unifying and systematic method for projections on the supply side. The supply of workers in an occupation is affected by two factors ... the inflow of trainees and persons who acquire the necessary skills ... and the outflow of persons retiring, dropping out of the labor force temporarily, dying, or transferring to other occupations.”⁵⁰⁷ As such, for the second methodology data is taken from educational sources, specifically the American Nurses Credentialing Center (ANCC) and the National Resident Matching Program (NRMP).

Additional sources include the U.S. Department of Labor’s Bureau of Labor Statistics (BLS), the Health Resources and Services Administration of the U.S. Department of Health and Human Services (HRSA), and the National Plan and Provider Enumeration System of the Centers for Medicare and Medicaid Services (NPPES). The BLS “publishes 10-year projections of national employment by industry and occupation based on analysis of historical and current economic data for the labor market, the macroeconomy, and industrial activity.”⁵⁰⁸

The NPPES is a national database of medical providers.⁵⁰⁹ Both individual providers and organizations are required by federal regulation to have a unique 10-digit National Provider Identifier.⁵¹⁰ However, the NPPES only provides data on currently registered providers. No information is given regarding whether the registered providers are still practicing, nor does the NPPES provide data longitudinally. In other words, it does not account for retirements or organize data by year to show entrants and exits of providers in the workforce.

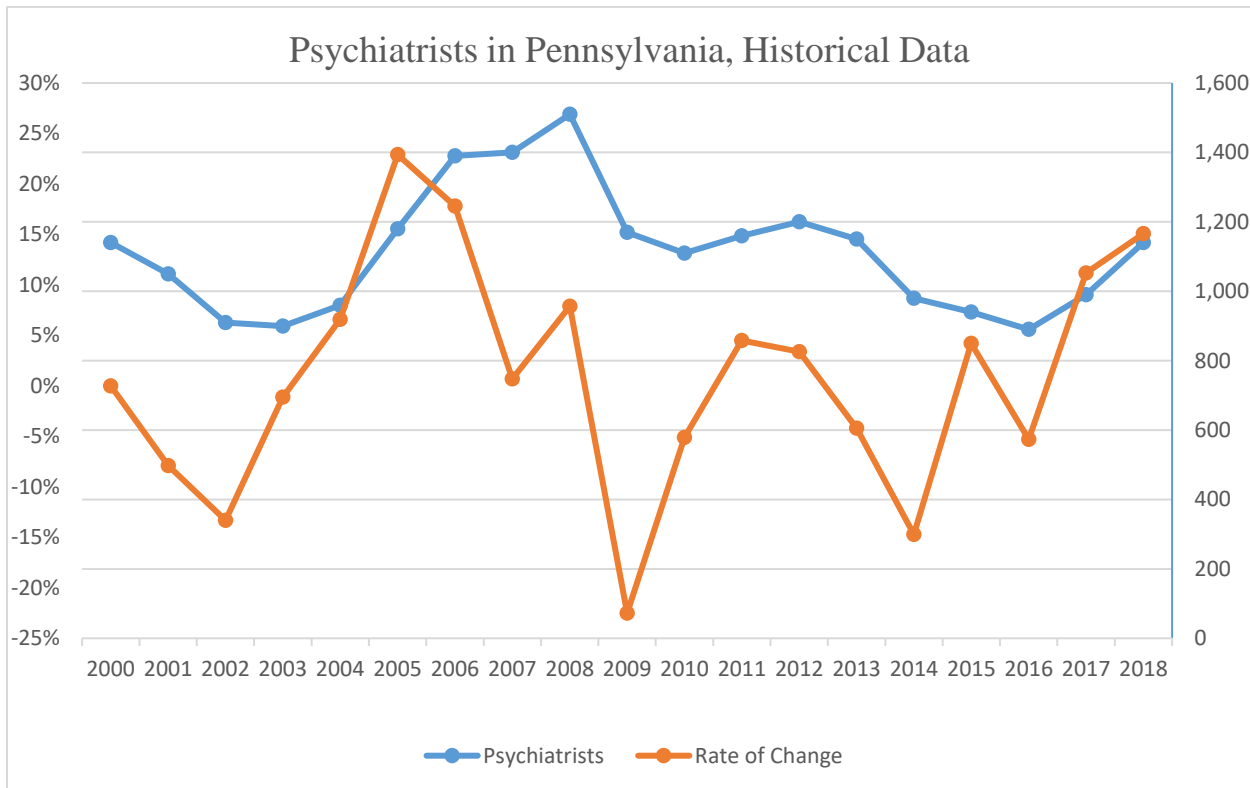
⁵⁰⁷ Institute of Medicine, Committee to Study the Role of Allied Health Personnel. *Allied Health Services: Avoiding Crises* (Washington, D.C.: National Academies Press, 1989), Appendix E.

⁵⁰⁸ U.S. Department of Labor, Bureau of Labor Statistics, “Handbook of Methods,” (Sept. 4, 2019), <https://www.bls.gov/opub/hom/emp/home.htm>.

⁵⁰⁹ Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System, accessed Mar. 12, 2020, <https://npiregistry.cms.hhs.gov/registry/>.

⁵¹⁰ 45 CFR § 162.410.

Chart 1



Source: Compiled by Commission Staff from data collected by the U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics 2000-2018. Available at <https://www.bls.gov/oes/tables.htm>.

The HRSA publishes its own health care workforce projections using its own methodology. The HRSA’s methodology accounts for the supply of a given profession group by adding new entrants adjusted for workforce participation hours (from data taken from professional associations, among other sources) and subtracting retirements, deaths, and career changes, then adding this figure to the previous year’s supply. The HRSA also models projected demand for these professionals using a more complex formula. While the HRSA supply and demand projections are not included here and do not form the basis of the projections made by Commission staff in this section, they are addressed in the section on the current state of Pennsylvania’s mental health care workforce beginning on page 11.

Psychiatrists

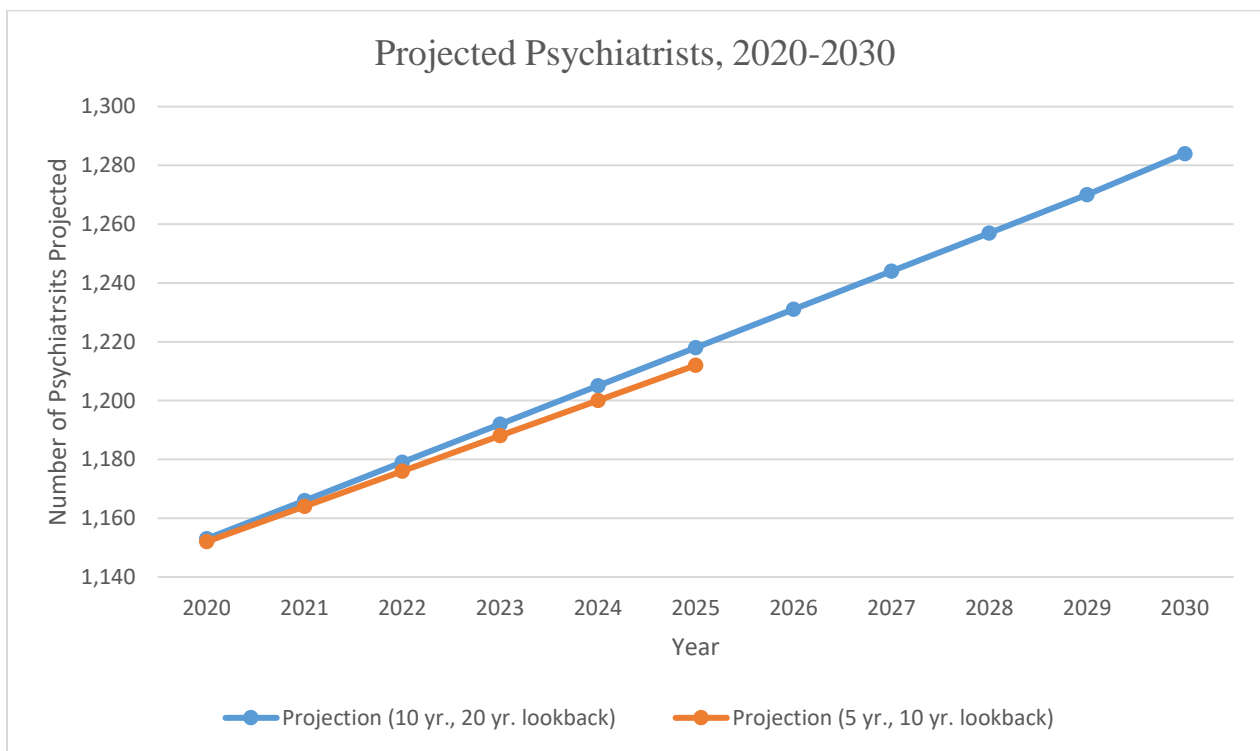
The following charts project the number of psychiatrists who will be practicing in the Commonwealth in 2025 and 2030. The data used is taken from the BLS’s historical occupational employment statistics. **Chart 1** shows the historical trend in changes to the supply of psychiatrists in the Commonwealth. **Chart 2** shows 5- and 10- year projections using the first methodology, while **Chart 4** shows 5- and 10- year projections using the second methodology.

As can be seen in **Chart 1** above, the number of psychiatrists in the Commonwealth peaked in 2008 before bottoming out in 2016, and has enjoyed double-digit growth in percentage terms

for the past two years data was available. There has been substantial volatility in employment in psychiatry over the past 18 years, magnified by the relatively small number of psychiatrists in the Commonwealth compared to other health professions. This can make projecting future trends in employment challenging, and may result in unreliable figures.

As can be seen below in **Chart 2**, the overall trend for the past two decades has been slow growth, notwithstanding drops in overall psychiatrist employment in the early 2000s and the post-2008 financial crisis period. In the period 2000 to 2018, the overall growth rate averaged 1.12 percent, with large swings in the percent change in the number of psychiatrists, as seen in the chart above. However, in the past 5 years, the growth was much faster, with growth averaging 6.3 percent in the years 2015 through 2018. Data for 2019 and 2020 were not available as of the time of publication. Although not represented on the chart below, if the psychiatrist workforce grew at this rate from 2020 through 2025, the Commonwealth would end 2025 with 1,613 psychiatrists, far more than the 5- and 10-year projections with longer lookback periods.

Chart 2

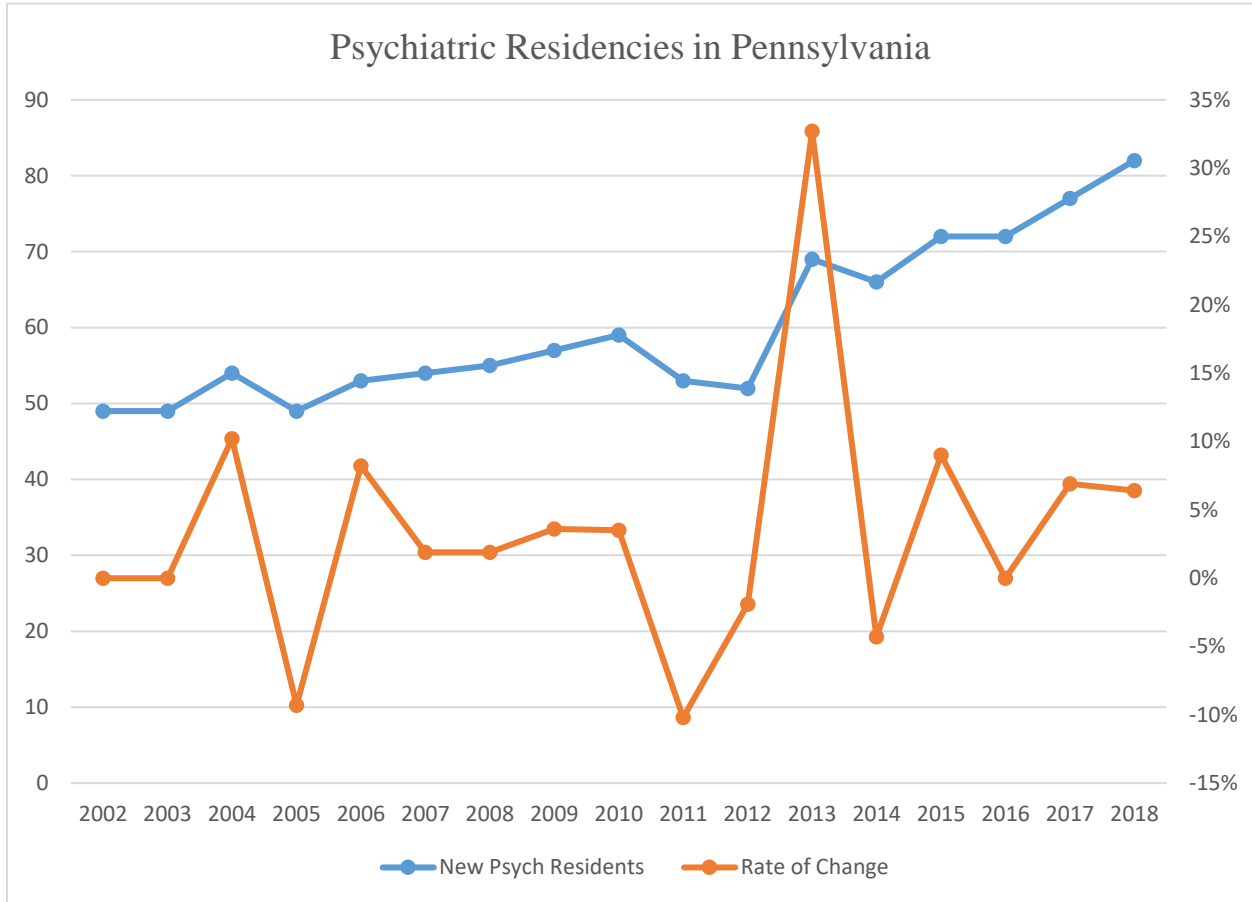


Source: Compiled by Commission Staff from data collected by the U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics 2000-2018. Available at <https://www.bls.gov/oes/tables.htm>.

The second methodology projects supply by subtracting five percent of the previous year’s practicing psychiatrists to account for retirements and then adding the number of new psychiatric residents in the Commonwealth. The retirement rate for psychiatrists in the Commonwealth in any given year may be higher or lower than five percent and this five percent rate is simply an estimate used to discount the new entrants into the profession, as it would be inaccurate to account

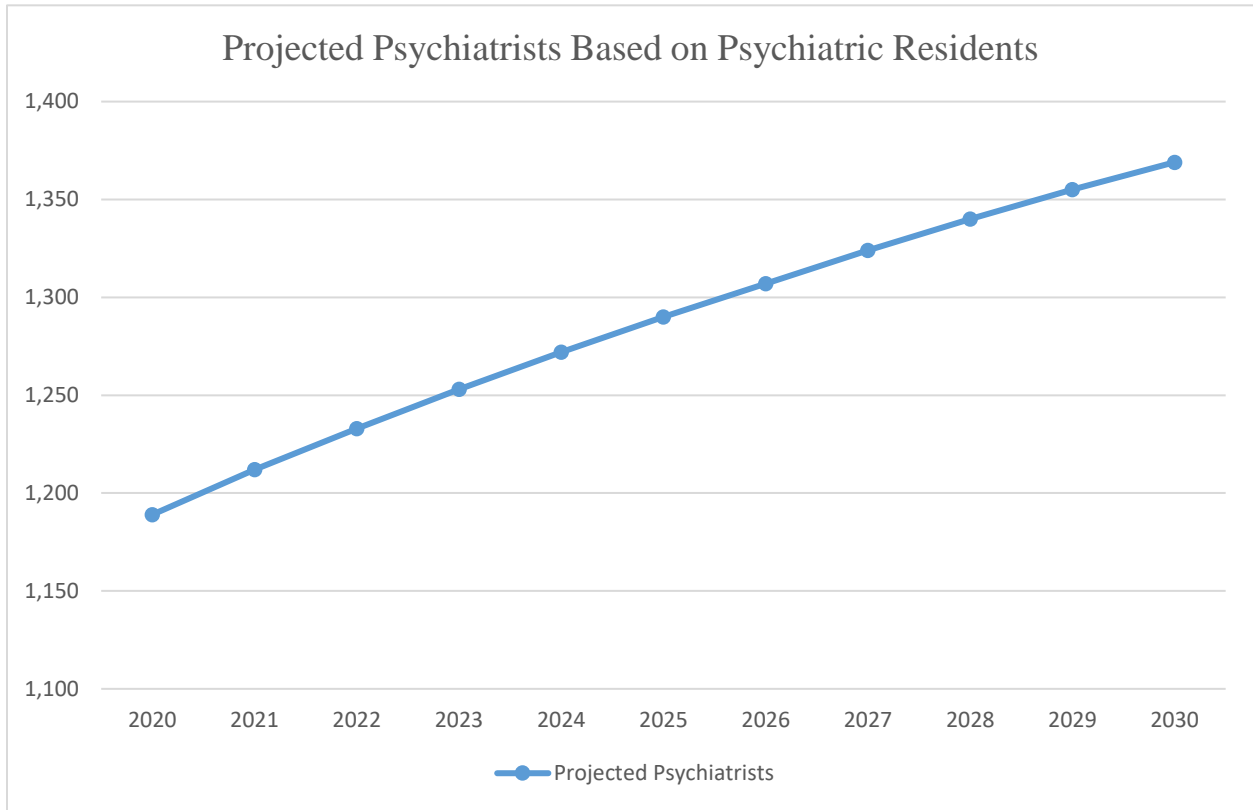
for new entrants but fail to even attempt to account for retirements. Further, this model does not account for psychiatric residents who leave the Commonwealth at the end of their residency or move into the Commonwealth. However, it should be noted that these occurrences are captured in the BLS’s employment data used as the basis for the five- and ten-year projections in the first model.

Chart 3



Source: Compiled by Commission staff from data collected by the National Resident Matching Program, Main Residency Match Results by State, Specialty, and Applicant Type, 2002-2018. Available at <https://www.nrmp.org/report-archives>.

Chart 4



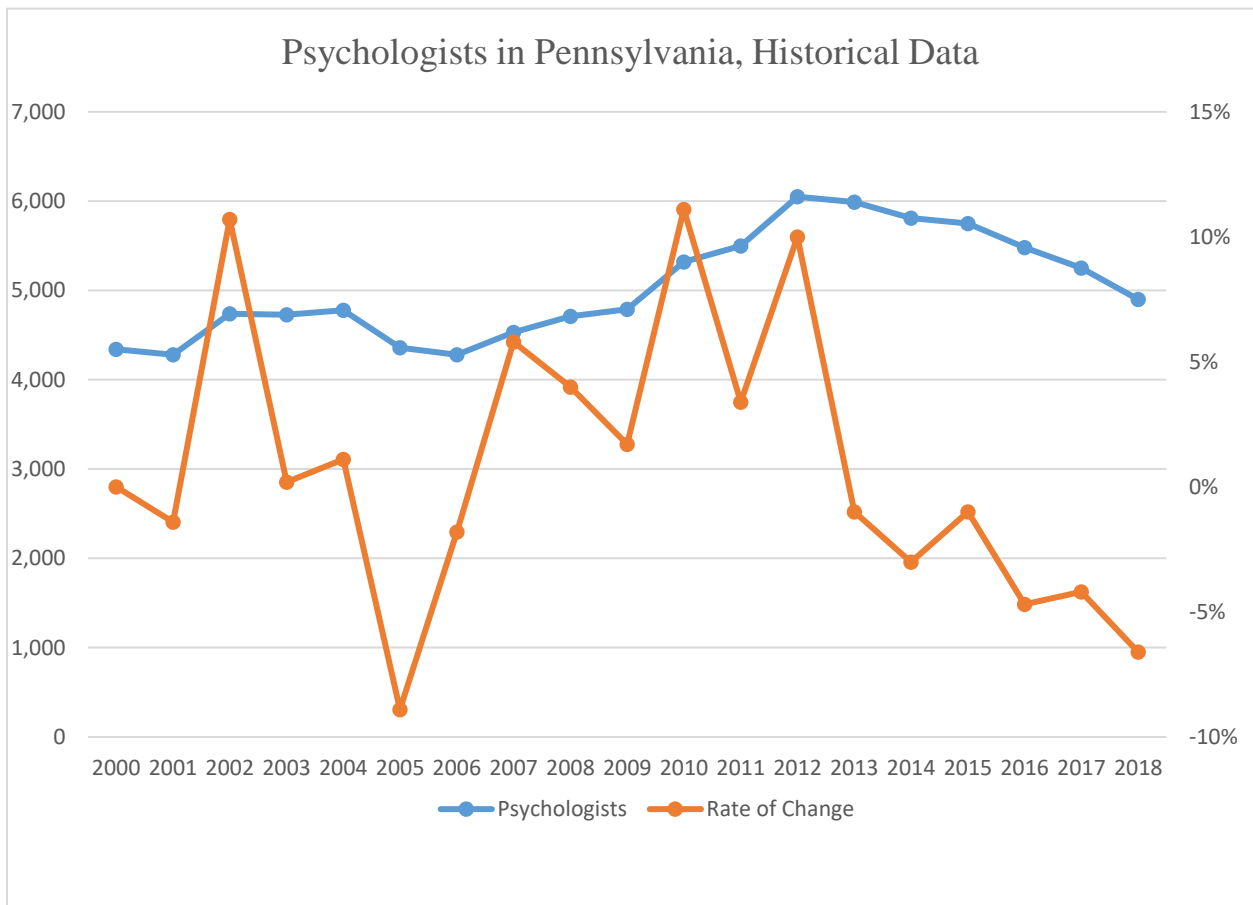
Source: Compiled by Commission staff from data collected by the National Resident Matching Program, Main Residency Match Results by State, Specialty, and Applicant Type, 2002-2018. Available at <https://www.nrmp.org/report-archives>.

As can be seen above, the number of new psychiatric residents per year has trended upwards for the 15 years for which data were available. Last year, there were a total of 82 new psychiatric residents, with every new position occupied. Assuming no new residencies are created and no residency positions are eliminated, there would be 82 new residents per year. Further assuming a five percent per year retirement rate of existing Pennsylvania psychiatrists, **Chart 4** shows a projection of new psychiatrists (including those in residency) that the Commonwealth can expect to have. It should be further noted that the calculation used in this projection does not account for psychiatrists moving out of state, new psychiatrists moving into the state, deaths, and career changes.

Psychologists

As can be seen in **Chart 5** below, the number of psychologists peaked around 2012, with over 6,000 of these mental health professionals practicing throughout the Commonwealth. This figure stands at around 4,900, the lowest since 2009 according to BLS figures. Those used as the basis for the projections in this Section do not include “industrial and organizational psychologists,” a small number of whom practice in Pennsylvania and direct their services toward businesses rather than individuals. The BLS occupation categories used for the historical data tally and the five- and ten- year projection are “clinical, counseling, and school psychologists” and “psychologists — all other.”

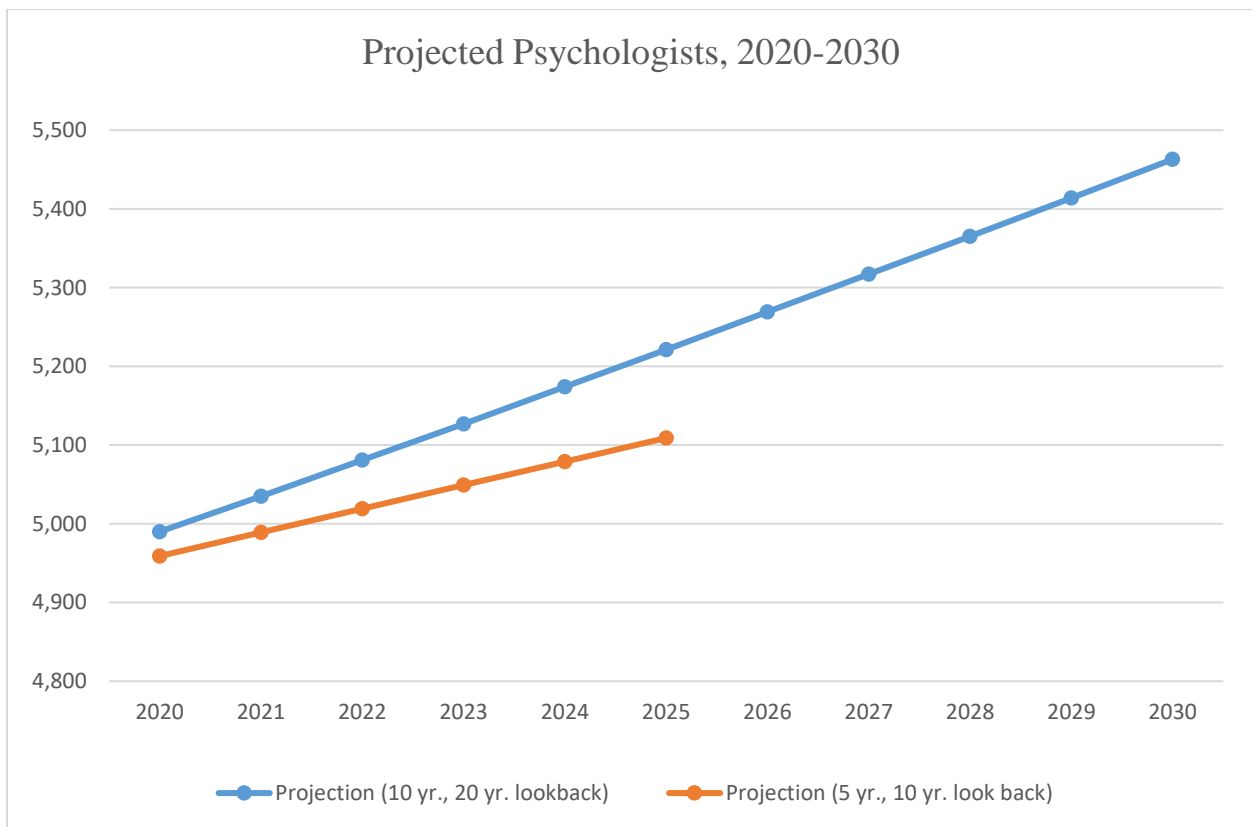
Chart 5



Source: Compiled by Commission Staff from data collected by the U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics 2000-2018. Available at <https://www.bls.gov/oes/tables.htm>

Like employment of psychiatrists, employment of psychologists in the Commonwealth has fluctuated over the past two decades. After a slight dip in the mid-2000, the number of psychologists grew steadily until 2012, when their number began a half-decade decline. In some years, their growth in percentage terms grew by double-digits, but in the past three years for which the BLS has gathered data, their numbers have declined more precipitously. Over the past 18 years for which data were available, the average growth rate for psychologists was just 0.91 percent. Over the past ten years, that rate was 0.6 percent and includes the recent decline in psychologists as well as two years of double-digit growth. The projection for future employment based on these figures is found below in **Chart 6**.

Chart 6



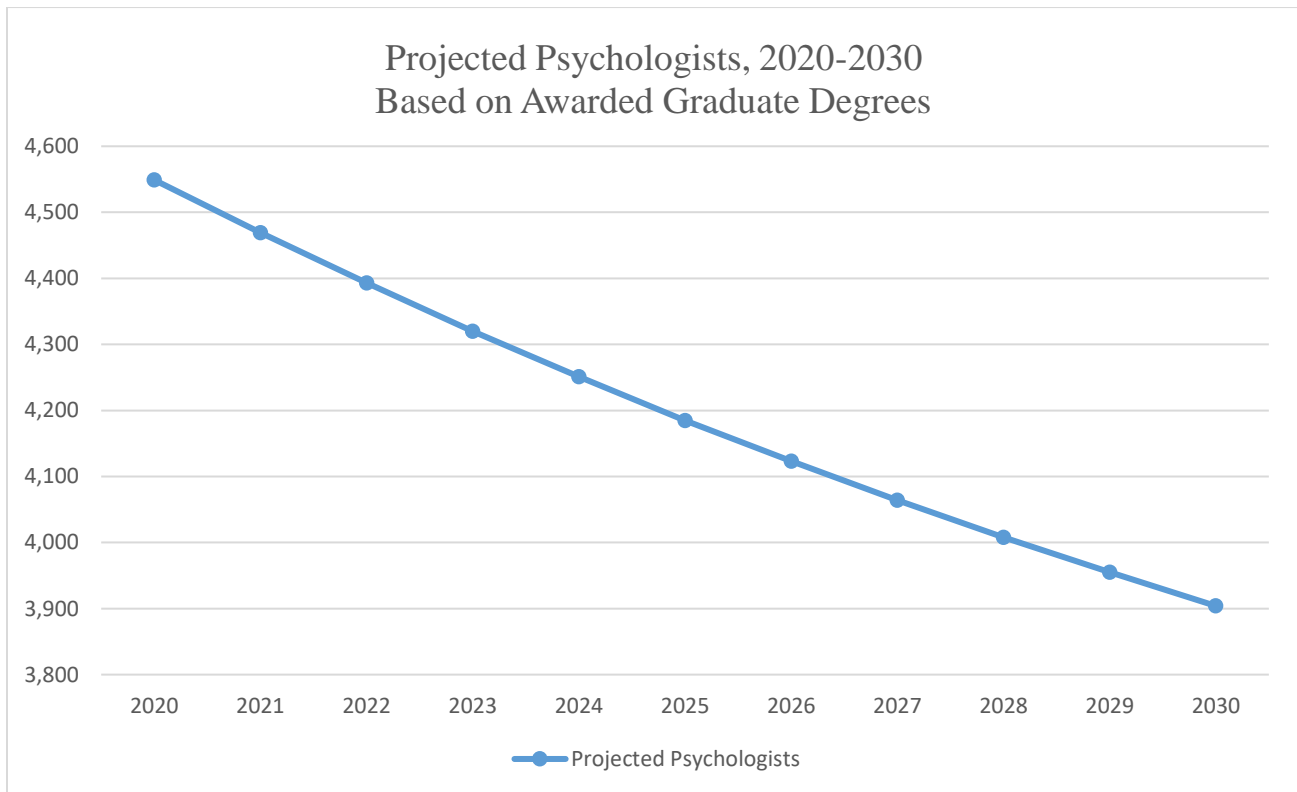
Source: Compiled by Commission Staff from data collected by the U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics 2000-2018. Available at <https://www.bls.gov/oes/tables.htm>.

Data regarding year-over-year psychology doctorate-level graduations comes from the National Science Foundation’s National Center for Science and Engineering Statistics.⁵¹¹ The National Science Foundation (NSF) data forms the basis of the five- and ten-year employment forecasts for psychologists in the Commonwealth, represented in **Chart 7** below.

⁵¹¹ National Science Foundation, National Center for Science and Engineering Statistics, “Survey of Earned Doctorates,” Table 7, for the years 2008 through 2018. <https://www.nsf.gov/statistics/srvydoctorates/#tabs-2>.

While the NSF is not the only source of data, it has a complete data set regarding psychology doctorate degree awards by state going back over a decade. Other sources have differing data but also lack year-over-year data. For instance, the American Psychological Association’s Center for Workforce Studies has estimated that there were 289 psychology doctoral graduates in Pennsylvania in 2004 and by 2013 that figure had risen to 329, a 14 percent growth in just under a decade. However, 2004 and 2013 were the only two data points referencing graduates by year that were provided in the report analyzing psychology graduate data across multiple states and specialties, so it is not possible to extrapolate a general trend.⁵¹² Separately, the APA estimates that there will be 5,000 full-time equivalent (FTE) psychologists in Pennsylvania by 2025, and 5,220 by 2030 under a baseline scenario that accounts for normal retirement and new entrants.⁵¹³

Chart 7



Source: Compiled by Commission staff from data collected by the National Science Foundation, National Center for Science and Engineering Statistics, Survey of Earned Doctorates, Table 7, for the years 2008 through 2018. Available at <https://www.nsf.gov/statistics/srvydoctorates/#tabs-2>.

⁵¹² Peggy Christidis, Karen Stamm, Luona Limm, “Psychology Master’s and Doctoral Degrees Awarded by Broad Field, Subfield, Institution Type and State (2004-2013),” American Psychological Association Center for Workforce Studies, (Dec. 2016), p. 27. <https://www.apa.org/workforce/publications/2016-postsecondary-data/report.pdf>.

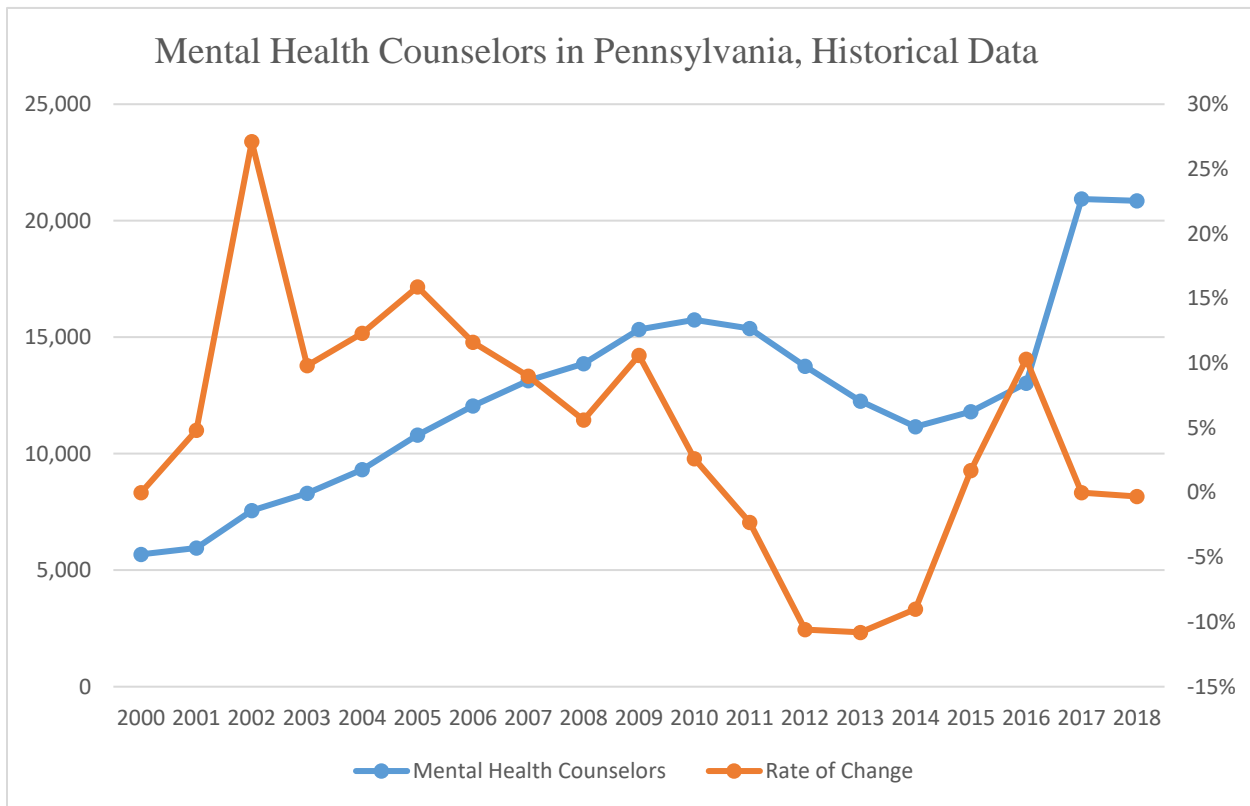
⁵¹³ American Psychological Association Center for Workforce Studies, “CWS Data Tool: State-Level Maps for Psychologist Workforce Projections, 2015-30,” accessed Mar. 20, 2020. <https://www.apa.org/workforce/data-tools/interactive-state-level>.

As with the projections regarding future employment of psychiatrists in the Commonwealth, the future supply of psychologists is projected by subtracting five percent of the previous year’s practicing psychologists to account for retirements and then adding the number of new graduate psychology degrees awarded in the Commonwealth.

Mental Health Counselors

Data from the BLS’s occupational category of “Substance Abuse, Behavioral Disorder, and Mental Health Counselor” is used as the basis for the projections on mental health counselors in the Commonwealth. This category encompasses a greater range of mental health care professionals than the narrower grouping of licensed professional counselors. However, the BLS’s data regarding mental health counselors is the largest and most complete data set for these providers, even though its use will likely result in an over count of providers.

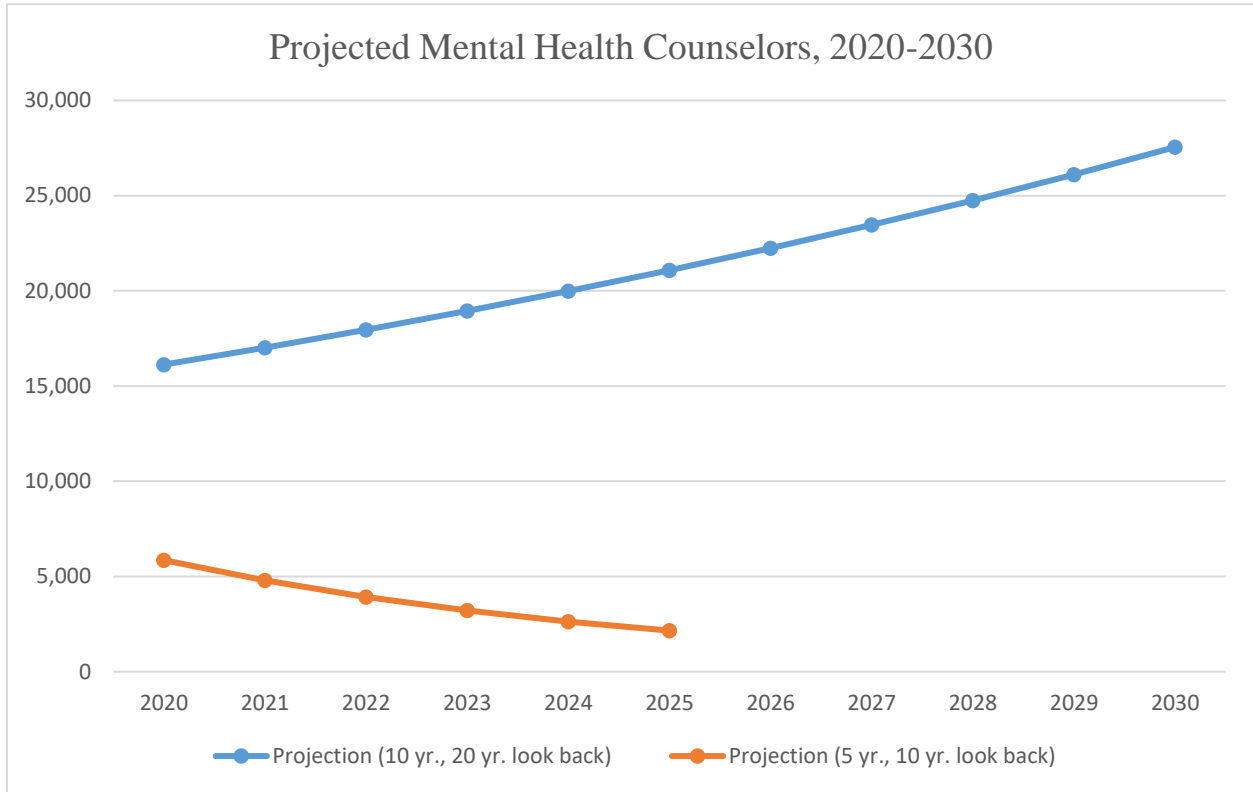
Chart 8



Source: Compiled by Commission Staff from data collected by the U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics 2000-2018. Available at <https://www.bls.gov/oes/tables.htm>.

From 2000 to 2016, the BLS tabulated data for “mental health counselors” as a separate occupation. This is the data Commission staff used for those years. For 2017 and 2018, Commission staff used the newly-created “substance abuse, behavioral disorder, and mental health counselors” category, which explains the sudden and precipitous rise in employment in that time period.

Chart 9



Source: Compiled by Commission Staff from data collected by the U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics 2000-2018. Available at <https://www.bls.gov/oes/tables.htm>.

The projections for mental health counselors have strikingly different trajectories based upon whether the growth rate is calculated by looking back 20 years (for the 10 year projection) or 10 years (for the 5 year projection). One of the reasons for this discrepancy is the rapid growth in the numbers of mental health counselors in the early part of the 2000s — this profession had a double-digit percentage growth rate for five consecutive years. Averaged over the entire look-back period (in this case, 2000 to 2016), growth averaged 5.5 percent. However, this growth peaked in 2010 and sharply contracted until 2014. From that point growth resumed, albeit less quickly. During this shorter look-back period (2016 to 2010), growth averaged negative 18.1 percent.

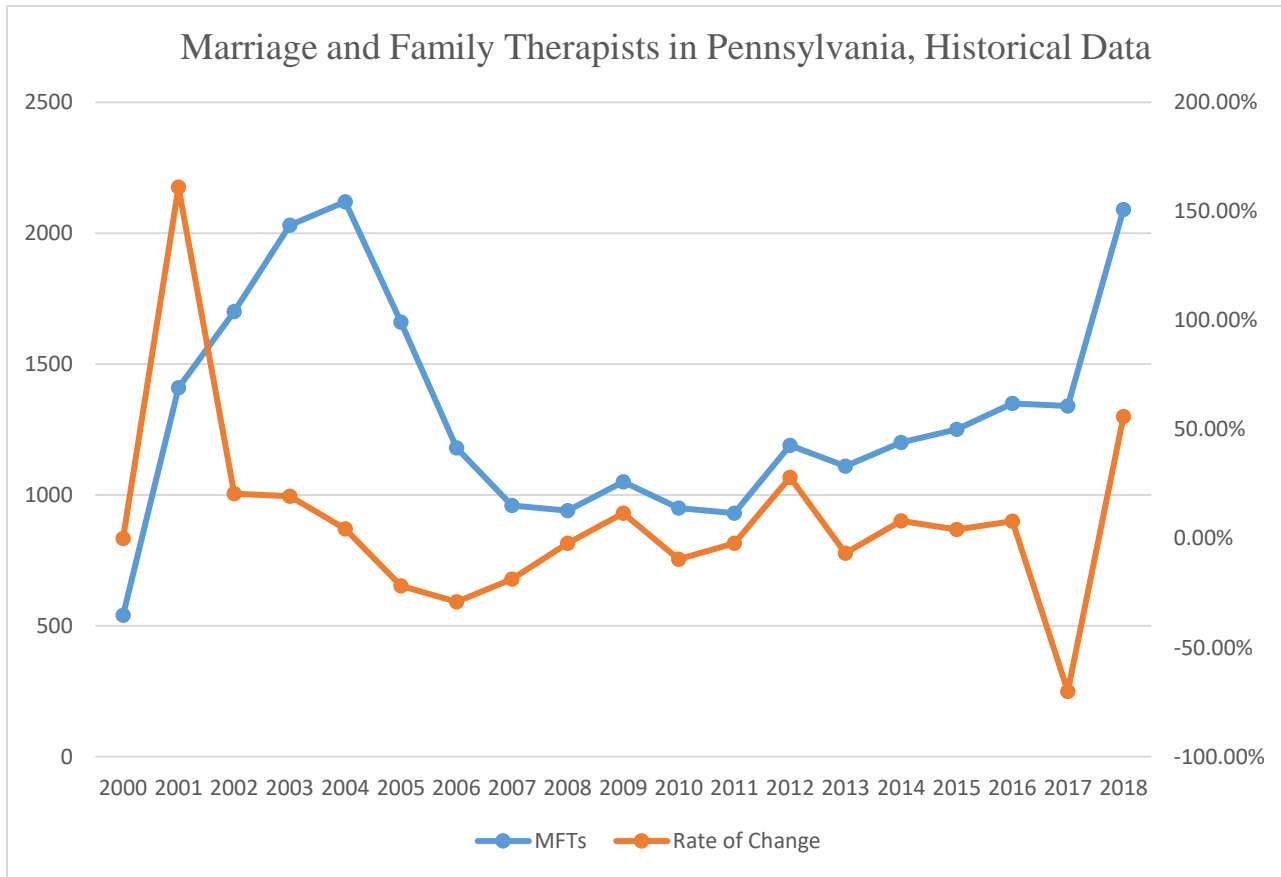
Further, the look-back period used for the calculation of growth rates began with 2016, as 2017 and 2018 use a broader employment category to count mental health counselors. Projecting growth of a profession 14 years from the date of the latest data point — from 2016 to 2030 — can yield atypical results.

Of note here is that there is no projection of mental health counselors or licensed professional counselors based on new degrees awarded in the various counseling fields. The reason for this is two-fold. The first is that there is simply incomplete data on master's degrees awarded in these fields from institutions of higher education in Pennsylvania. The second is that these degrees lead to a more fluid career path than a psychiatric residency or a doctorate degree in psychology. A person with a degree in counseling would be eligible to become a licensed professional counselor, a social worker, or a marriage and family therapist.

Marriage and Family Therapists

Marriage and family therapists (MFTs) are one of the four mental health provider professions to be projected in this section because the BLS maintains complete year-over-year data going back over 20 years. Further, how the BLS's defines "marriage and family therapist" is a close fit with the Commonwealth's definition. The BLS excludes all types of social worker and psychologist from their tabulation of MFTs, making their data sufficiently narrow to capture only these providers. The BLS also recognizes that MFTs must be licensed. This recognition lessens the chance that the BLS is including in its data those who hold a master's degree in marriage and family therapy or a related field and who offer counseling to the public but are not licensed to hold themselves out as MFTs.

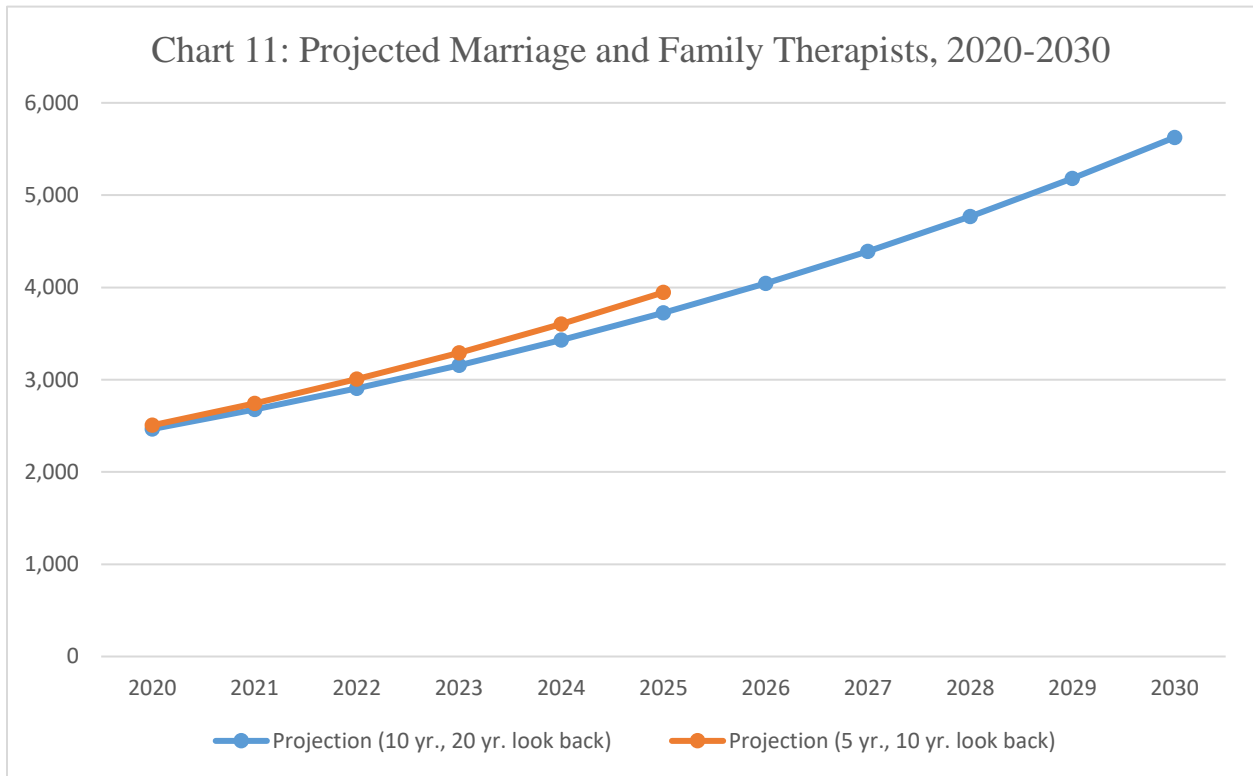
Chart 10



Source: Compiled by Commission Staff from data collected by the U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics 2000-2018. Available at <https://www.bls.gov/oes/tables.htm>.

As can be seen in **Chart 10** above, MFTs experienced a rapid increase in numbers in the Commonwealth early in the millennium, which was promptly followed by an equally rapid decline. These providers numbered less than 1000 for a few years until 2012, when they began a slow growth. This persisted until 2018 when the number of MFTs in the Commonwealth skyrocketed by over 50 percent. Employment as an MFT appears to have a fairly low barrier to entry, as many people entered then left this profession over the past 20 years.

Chart 11



Source: Compiled by Commission Staff from data collected by the U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics 2000-2018. Available at <https://www.bls.gov/oes/tables.htm>.

The average annual growth rate of MFTs was 8.6 percent between 2000 and 2018. Between 2010 and 2018, that growth rate was approximately 9.5 percent. Although this projection shows employment growing quickly, as is represented in **Chart 10** the historical data suggest that this profession is prone to sharp swings in the number of these providers.

It should be noted that, as with mental health counselors, there is no complete source for data on MFT degrees awarded in the Commonwealth. Additionally, multiple degrees may make one eligible for licensure as an MFT. Consequently, linking a projection of employment of MFTs with MFT degrees awarded could not provide an accurate picture of the future of this profession in the Commonwealth.

HOUSE RESOLUTION 193

PRIOR PRINTER'S NO. 1189

PRINTER'S NO. 1814

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE RESOLUTION

No. 193 Session of
2019

INTRODUCED BY McNEILL, READSHAW, HILL-EVANS, SCHLOSSBERG,
FREEMAN, KINSEY, D. MILLER, LONGIETTI, DAVIDSON, MURT,
NEILSON, DeLUCA, MIZGORSKI, CIRESI, SIMMONS, SIMS, TOOHIL,
THOMAS, MARKOSEK, T. DAVIS, HOWARD, KORTZ AND STURLA,
APRIL 5, 2019

AS REPORTED FROM COMMITTEE ON HUMAN SERVICES, HOUSE OF
REPRESENTATIVES, AS AMENDED, MAY 14, 2019

A RESOLUTION

1 Directing the Joint State Government Commission to conduct a
2 study on the mental health CARE provider shortage in this <--
3 Commonwealth and to issue a report.

4 WHEREAS, The National Survey on Drug Use and Health estimates
5 that approximately 18.76% of adults in Pennsylvania, or
6 1,861,000 individuals, have a mental illness; and

7 WHEREAS, The National Survey on Drug Use and Health also
8 estimates that approximately 4.2% of adults in Pennsylvania, or
9 416,000 individuals, have a serious mental illness; and

10 WHEREAS, Mental health CARE providers, including <--
11 psychiatrists, psychologists, MARRIAGE AND FAMILY THERAPISTS, <--
12 clinical social workers and professional counselors, render
13 crucial services to residents across this Commonwealth; and

14 WHEREAS, Adequate access to mental health care is essential
15 to maintaining the mental health of Pennsylvanians; and

16 WHEREAS, Despite the growing demand for mental health

1 treatment across the United States, a mental health CARE <--
2 workforce crisis has been developing, largely due to a shortage
3 of mental health CARE providers; and <--
4 WHEREAS, Pennsylvania ranks 35 out of all 50 states and
5 Washington, DC, for mental health CARE workforce availability, <--
6 with a patient to mental health care worker ratio of 600 to 1;
7 and
8 WHEREAS, Pennsylvania has a Statewide average of 179 mental
9 health CARE providers per 100,000 people, which is below the <--
10 national average of 214 providers per 100,000 people; and
11 WHEREAS, The lack of readily available mental health CARE <--
12 providers in Pennsylvania has negatively impacted access to
13 mental health care for a countless number of residents; and
14 WHEREAS, An estimated 53.2% of the adult population with a
15 mental illness in Pennsylvania did not receive treatment for
16 their mental illness in 2017; and
17 WHEREAS, Other factors contributing toward the mental health
18 CARE workforce crisis include higher demand for mental health <--
19 CARE providers, high turnover rates, an aging workforce and low <--
20 compensation for workers in the field; and
21 WHEREAS, The mental health CARE provider shortage has led to <--
22 an over-burdening of current mental health CARE providers to <--
23 make up for insufficient staffing, lower quality of care for
24 consumers and a lack of stability for patients due to frequent
25 staff turnover; and
26 WHEREAS, The shortage of mental health CARE providers also <--
27 has direct and indirect costs on the economy, including a loss
28 of efficiency and productivity for employees and employers; and
29 WHEREAS, It is estimated that over the next five years, the
30 shortage of ~~psychiatrists~~ MENTAL HEALTH CARE PROVIDERS in the <--

1 United States will result in more than 4.2 million lost or less
2 productive workdays each month, which is a major cost to
3 employers; and

4 WHEREAS, The ~~psychiatrist~~ MENTAL HEALTH CARE PROVIDER <--
5 shortage in Pennsylvania alone is estimated to result in over
6 163,000 lost or less productive workdays each month over the
7 next five years; and

8 WHEREAS, Untreated mental illness in the United States costs
9 the nation more than \$70 billion annually, solely due to lost
10 productivity; and

11 WHEREAS, When accounting for the diverted resources of
12 individuals in law enforcement, education and health care who
13 are often the first responders to individuals experiencing
14 mental health emergencies, the cost of untreated mental illness
15 in the United States increases to more than \$193 billion per
16 year; and

17 WHEREAS, The prevalence of mental illness in an individual
18 can impact their overall health, as individuals with serious
19 mental illness face an increased risk of having chronic medical
20 conditions; and

21 WHEREAS, Adults in the United States living with a serious
22 mental illness die on average 25 years earlier than those
23 without, largely due to treatable medical conditions; and

24 WHEREAS, Research has identified a definite connection
25 between mental health and the use of addictive substances, as
26 many patients with disruptive or uncomfortable mental health
27 symptoms tend to self-medicate by using alcohol, drugs or
28 tobacco; and

29 WHEREAS, Unfortunately, the use of drugs and alcohol does not
30 address the underlying mental health symptoms and often causes

1 additional health and wellness problems for the patient, while
2 also increasing the severity of the original mental health
3 symptoms; and

4 WHEREAS, The mental health CARE provider shortage is <--
5 considerably more prevalent in rural counties and a significant
6 discrepancy exists between access to mental health care in rural
7 counties compared to urban and suburban counties; and

8 WHEREAS, Pennsylvania counties that are considered
9 predominantly rural have some of the fewest mental health CARE <--
10 providers per 100,000 people, with some counties only having a
11 small number of working providers; and

12 WHEREAS, While the mental health CARE provider shortage is <--
13 pervasive, it impacts certain populations to a larger extent;
14 and

15 WHEREAS, In 2015, among adults with any mental illness, 48%
16 of Caucasians received mental health CARE services, compared <--
17 with 31% of African Americans and Hispanics and 22% of Asians;
18 and

19 WHEREAS, One in four older adults experience a mental health
20 issue such as depression, anxiety, schizophrenia or dementia,
21 which is expected to double to 15 million older adults by 2030;
22 and

23 WHEREAS, Adults 85 years of age and older have the highest
24 suicide rate of any age group, especially among older Caucasian
25 men who have a suicide rate almost six times that of the general
26 population; and

27 WHEREAS, Two-thirds of older adults with mental health
28 problems do not receive the treatment they need and have limited
29 access to current preventative services; and

30 WHEREAS, It is believed that telemedicine, which involves the

1 use of electronic communications and software to provide
2 clinical services to patients without an in-person visit, will
3 expand the mental health CARE workforce by offering flexibility <--
4 to work from home and will enable collaboration between
5 ~~psychiatrists~~ MENTAL HEALTH CARE PROVIDERS and primary care <--
6 providers; and

7 WHEREAS, Increased access to more varied client populations
8 through telemedicine can decrease provider burnout and improve
9 mental health CARE workforce retention; and <--

10 WHEREAS, The National Council for Behavioral Health
11 identifies six broad areas that require change to address the
12 shortage of ~~psychiatrists~~ MENTAL HEALTH CARE PROVIDERS, which <--
13 include:

14 (1) Expanding the workforce providing ~~psychiatric~~ MENTAL <--
15 HEALTH CARE PROVIDER services.

16 (2) Increasing efficiency of delivery of ~~psychiatric~~ <--
17 MENTAL HEALTH CARE PROVIDER services. <--

18 (3) Implementing innovative models of integrated
19 delivery of primary care and ~~psychiatric~~ MENTAL HEALTH care <--
20 in more settings that have the potential to impact the total
21 cost of care for high-risk patient populations with co-
22 occurring medical and behavioral health conditions.

23 (4) Training ~~psychiatric~~ MENTAL HEALTH CARE residents <--
24 and the existing workforce in delivering new models of care.

25 (5) Adopting effective payment structures that
26 adequately reimburse ~~psychiatric~~ MENTAL HEALTH CARE providers <--
27 for improved outcomes of care.

28 (6) Reducing the portion of ~~psychiatric~~ MENTAL HEALTH <--
29 CARE providers who engage in exclusive, private, cash-only
30 practices;

1 and

2 WHEREAS, Encouraging the growth and retention of the mental
3 health CARE workforce in Pennsylvania will ensure that more <--
4 individuals have access to timely and adequate mental health
5 screening and treatment for mental illnesses; therefore be it

6 RESOLVED, That the House of Representatives direct the Joint
7 State Government Commission to conduct a study on the mental
8 health CARE provider shortage in this Commonwealth; and be it <--
9 further

10 RESOLVED, That the Joint State Government Commission prepare
11 a report of its findings that shall, at a minimum:

12 (1) Identify the factors behind the mental health CARE <--
13 provider shortage in this Commonwealth.

14 (2) Make projections on the number of mental health CARE <--
15 providers in Pennsylvania in 5 and 10 years.

16 (3) Determine how telemedicine can be used to extend the
17 mental health CARE workforce in rural counties. <--

18 (4) Determine how Pennsylvania government entities can
19 encourage more individuals to enter and remain in the mental
20 health CARE workforce. <--

21 (5) Make recommendations regarding:

22 (i) How to solve the disparity in the number of
23 mental health CARE providers in rural counties compared <--
24 to urban and suburban counties.

25 (ii) Any other solutions to stop and reverse the
26 mental health CARE provider shortage in Pennsylvania; <--

27 and be it further

28 RESOLVED, That the Joint State Government Commission report
29 its findings and recommendations to the House of Representatives
30 no later than one year after the adoption of this resolution.