



June 25, 2021

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United State Senate
Washington, D.C. 20510

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the American Academy of Family Physicians (AAFP) and the 133,500 family physicians and medical students we represent, I applaud the committee for its consideration of the mental health challenges in the U.S. I write in response to the hearing: “Mental Health Care in America: Addressing Root Causes and Identifying Policy Solutions” to share the family physician perspective and the AAFP’s policy recommendations for ensuring all patients who need mental health care are able to access it.

Mental illness is highly prevalent in the United States and is associated with an increased risk of morbidity and mortality. There are significant gaps in the provision of mental health care services in the U.S., especially related to vulnerable populations. While psychiatric and other mental health professionals can play an important role in the provision of high-quality mental health care services, primary care physicians are the main providers for the majority of patients. Most people with poor mental health will be diagnosed and treated in the primary care setting. Mental illness also complicates other medical conditions, making them more challenging and more expensive to manage. Together, this makes mental health an important issue for primary care physicians.

Screening for mental illness is not new to family medicine but has more recently been linked to quality metrics and payment. Screening for mental illness can be an important strategy for decreasing morbidity, as well as preventing adverse maternal and child health outcomes associated with perinatal depressive symptoms, postpartum depression, or maternal suicide.^{i, ii, iii} While important, screening in a busy practice can seem overwhelming, but practices can leverage technology, empower staff, and utilize wellness visits to complete this screening.^{iv}

Integrating mental health into primary care settings, as well as the blending of primary and preventive medicine into traditional mental health settings, represents a more holistic approach to treatment than the traditional consultative and referral models. Integrating primary care and mental health services increases access for patients by making mental health services available in their regular primary care clinics. When integrated into primary care, mental health clinicians can impact the care of more patients than in the specialty mental health referral sector.^v In the primary care setting, mental health clinicians take on a more consultative and team-based role and focus on helping primary care physicians treat mental health disorders. In this context, mental health clinicians typically reach more

STRONG MEDICINE FOR AMERICA

President Ada Stewart, MD <i>Columbia, SC</i>	President-elect Sterling Ransone, MD <i>Deltaville, VA</i>	Board Chair Gary LeRoy, MD <i>Dayton, OH</i>	Directors James Ellzy, MD, <i>Washington, DC</i> Dennis Gingrich, MD, <i>Hershey, PA</i> Tochi Iroku-Malize, MD, <i>Bay Shore, NY</i> Andrew Carroll, MD, <i>Chandler, AZ</i> Steven Furr, MD, <i>Jackson, AL</i> Margot Savoy, MD, <i>Media, PA</i>	Jennifer Brull, MD, <i>Plainville, KS</i> Mary Campagnolo, MD, <i>Borderrtown, NJ</i> Todd Shaffer, MD, <i>Lee's Summit, MO</i> Danielle Carter, MD (New Physician Member), <i>Jacksonville, FL</i> Anna Askari, MD (Resident Member), <i>Palm Desert, CA</i> Cynthia Ciccotelli (Student Member), <i>Yardley, PA</i>
Speaker Alan Schwartzstein, MD <i>Oregon, WI</i>	Vice Speaker Russell Kohl, MD <i>Stilwell, KS</i>	Executive Vice President R. Shawn Martin <i>Leawood, KS</i>		

patients, and have shorter and more problem-focused encounters than in the context of traditional specialty mental health.

The Collaborative Care Model, supported by various organizations including the AAFP and the American Psychiatric Association, is a model for the successful integration of primary care and behavioral and mental health.^{vi} At its core, the idea of collaborative care is anchored in team-based care, often in the context of a medical home, and steered by primary care physicians. It involves behavioral health specialists and consulting mental health professionals delivering evidence-based care that is patient-centered.

The collaborative care model at its core is: 1) team driven, 2) population focused, 3) measurement guided, and 4) evidence based. These four elements, when combined, can allow for a fifth guiding principal to emerge—accountability and quality improvement. Collaborative care is team-driven, led by a primary care clinician with support from a “care manager” and consultation from a psychiatrist who provides treatment recommendations for patients who are not achieving clinical goals. Other mental health professionals can contribute to the Collaborative Care Model. Collaborative care is population focused, using a registry to monitor treatment engagement and response to care. Collaborative care is measurement guided with a consistent dedication to patient-reported outcomes and it utilizes evidence-based approaches to achieve those outcomes. Care remains patient centered with proactive outreach to engage, activate, promote self-management and treatment adherence, and coordinate services.^{vii}

The AAFP urges Congress to support the adoption of the Collaborative Care Model by funding grant programs for primary care practices and encouraging Center for Medicare and Medicaid Innovation models for behavioral health integration.

Telemedicine for mental health is a growing interest in primary care and telehealth initiatives for mental health care are expanding rapidly. While the research is limited on this topic, there are a growing number of studies assessing the benefits, comparative effectiveness with face-to-face visits, and cost comparisons. From January to March 2020, at the beginning of the COVID-19 pandemic, telehealth visits increased by 135% compared to that time period in 2019, and 93% of those visits were for non-COVID concerns.^{viii} In addition, mental health concerns increased rapidly during the pandemic. Four in ten adults reported symptoms of anxiety, an increase from one in ten the year prior, and more than half of all young adults ages 18-24 reported symptoms of anxiety and depression and were more likely than other age groups to report substance use and suicidal thoughts.^{ix} Other trends should a disproportionate effect on mental health for communities of color, mothers, and essential workers.^x The AAFP is supportive of efforts to expand access to mental health services via telehealth and encourage Congress to address the legislative barriers outlined in our [previous testimony](#) and [Joint Principles for Telehealth Policy](#). In particular, the AAFP strongly believes that the permanent expansion of telehealth services should be done in a way that advances care continuity and the patient-physician relationship. Telehealth for mental health can help address the shortage of over 6,000 mental health professionals in the U.S., particularly for rural and underserved areas that face a disproportionate impact of the shortage.^{xi}

Trauma-informed care, an approach to engaging individuals with a history of trauma that recognizes their traumatic experiences, and how it affects their lives, is a promising practice that may facilitate healing and help prevent the consequences of exposure to trauma.^{xii, xiii} An estimated 60% of adults in the U.S. have experienced a traumatic event at least once in their lives.^{xiv} Exposure to trauma, such as intimate partner violence, sexual abuse, rape, neglect, terrorism, war, natural disasters, and street violence predisposes those affected to poor physical and mental health outcomes.^{xv} The principles of trauma-informed care include: realizing that there is a high prevalence of trauma and it has serious effects; recognizing the signs and symptoms of trauma; responding to the high prevalence by

integrating knowledge about trauma into practices, procedures, and policies; and avoiding retraumatizing individuals by using best-practices in screening and history taking.^{xvi}

Disparities are pervasive in all aspects of health, including mental health conditions. While mental health conditions can affect everyone, regardless of culture, race, ethnicity, gender or sexual orientation, some populations experience those conditions at a higher rate.

- American Indian and Alaska Natives (28.3%) experience higher rates of mental illness than white (19.3%), black (18.6%), Hispanic (16.3%), or Asian (13.9%) adults.^{xvii}
- Individuals from the lesbian, gay, bisexual, transgender, and questioning (LGBTQ) community are two or more times as likely as heterosexual individuals to have a mental health condition¹ and LGBTQ youth are two to three times more likely to attempt suicide than heterosexual youth.^{xviii}
- Nearly one-fifth (18.5%) of the veterans who returned from serving in either Iraq or Afghanistan suffer from either major depression or post-traumatic stress disorder.^{xix}
- The prevalence of mental illness is similar for individuals living in either rural or metropolitan areas, but the mental health care needs are more often unmet in rural communities due to inadequate services.^{xx}

Disparities in mental health illness and mental health care are related to coverage and availability of care, quality of care, rates of health insurance, stigma, cultural insensitivity, racism, bias, homophobia, discrimination in treatment settings, and language barriers.^{xxi}

College students face unique mental health concerns, such as non-suicidal self-injury and serious suicidal ideation.^{xxii} There are approximately 20 million students enrolled in U.S. colleges and universities, and the rates of serious mental health concerns is rising in this population.^{xxiii, xxiv} According to the Center for Collegiate Mental Health's 2017 Annual Report, 52.7% of students attended counseling for mental health concerns; 34.2% took a medication for mental health concerns; 9.8% were hospitalized for a mental health concern; 27% purposely injured themselves without suicidal intent; and 34.2% seriously considered attempting suicide, with 10% making a suicide attempt.^{xxv} In fact, some data suggest that suicide may be the most common cause of death in college students.^{xxvi}

Attention-deficit/hyperactivity disorder (ADHD) is another prevalent disorder in college students that family physicians may encounter. ADHD's prevalence is estimated to be between 2-8% among college students, and this condition is frequently associated with other psychiatric comorbidities and increases individuals' risk of psychosocial and substance-use problems.^{xxvii}

Tobacco use is prominent among individuals living with mental illness. Thirty-six percent of adults with any mental illness use tobacco products, compared with 25.3% for adults without a mental illness.^{xxviii} In addition, people who have any mental illness are only half as likely to quit smoking compared to individuals without a mental illness.^{xxix} One study found that nearly half of all deaths were tobacco-related for persons who received substance abuse services, or who received both substance abuse and mental health services.^{xxx} Therefore, addressing tobacco addiction among individuals living with mental illness is an important strategy for decreasing preventable mortality and morbidity among individuals living with a mental illness.

The AAFP has position papers that detail [substance use disorders](#) and addiction and [tobacco prevention](#) and cessation.

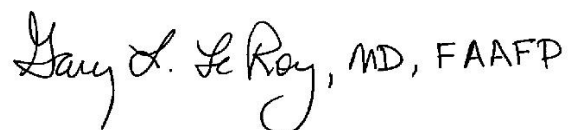
Payment for primary care physicians has historically been inadequate for office visits for mental health diagnoses. This limitation in reimbursement interfered with the family physician's ability to offer comprehensive care and management of mental health conditions, as well as the ability to integrate,

from a business perspective, with behavioral health services. However, new coverage policies adopted by the Centers for Medicare & Medicaid Services (CMS) are more promising and may incentivize primary care physicians to provide treatment for mental and behavioral health conditions.^{xxx} These policies, effective January 1, 2017, emphasize collaborative care, where primary care physicians are expected to work in partnership with a behavioral health care manager, and consult with mental health specialists. While targeting populations with Medicare, these policies may also encourage private insurers to offer similar options and may incentivize more family physicians to offer behavioral and mental health care to other populations.

Health care for all people with mental illness should be “affordable, nondiscriminatory, and includes coverage for the most effective and appropriate treatment.”^{xxxii} Coverage for mental illness should be equal in scope to coverage for other illnesses and all clinically-effective treatments appropriate to the needs of individuals with mental illness should be covered

Thank you for the opportunity to provide testimony on this important issue. For further questions, please contact Erica Cischke, Senior Manager, Legislative and Regulatory Affairs at ecischke@aafp.org.

Sincerely,



Gary L. LeRoy, MD, FAAFP
Board Chair, American Academy of Family Physicians

ⁱ LeFevre ML, U.S. Preventive Services Task Force. Screening for Suicide Risk in Adolescents, Adults, and Older Adults in Primary Care: U.S. Preventive Services Task Force Recommendation Statement. *Ann Intern Med.* 2014;160(10):719.

ⁱⁱ Kendig S, Keats JP, Hoffman MC, et al. Consensus bundle on maternal mental health: perinatal depression and anxiety. *Obstet Gynecol.* 2017;129(3):422-430.

ⁱⁱⁱ Yonkers KA, Wisner KL, Stewart DE, et al. The management of depression during pregnancy: a report from the American Psychiatric Association and the American College of Obstetricians and Gynecologists. *Obstet Gynecol.* 2009;114(3):703-713.

^{iv} Savoy M, O'Gurek DT. Screening your adult patients for depression. *Fam Pract Manag.* 2016;23(2):16-20.

^v Collins C, Hewson DL, Munger R, Wade T. Evolving models of behavioral health integration in primary care. Milbank Memorial Fund. 2010. Accessed January 22, 2018.

^{vi} American Psychiatric Association Academy of Psychosomatic Medicine. Dissemination of integrated care within adult primary care settings. Accessed January 22, 2018

^{vii} Ibid.

-
- viii Koonin LM. Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic — United States, January–March 2020. *MMWR Morb Mortal Wkly Rep.* 2020;69. doi:10.15585/mmwr.mm6943a3
- ix Panchal N, Kamal R, 2021. The Implications of COVID-19 for Mental Health and Substance Use. KFF. Published February 10, 2021. Accessed June 17, 2021. <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>
- x Ibid.
- xi Mental Health Care Health Professional Shortage Areas (HPSAs). KFF. Published November 5, 2020. Accessed June 17, 2021. <https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/>
- xii Oral R, Ramirez M, Coohy C, et al. Adverse childhood experiences and trauma informed care: the future of health care. *Pediatr Res.* 2016;79(1-2):227-233.
- xiii Decker MR, Flessa S, Pillai R V., et al. Implementing trauma-informed partner violence assessment in family planning clinics. *J Women's Heal.* April 2017:jwh.2016.6093
- xiv National Council for Behavioral Health. Trauma-informed approaches learning communities. Accessed January 22, 2018.
- xv Agency for Healthcare Research and Quality. [Trauma-informed care.](#) Accessed January 22, 2018.
- xvi Ibid.
- xvii National Alliance on Mental Illness. [Mental health by the numbers.](#) Accessed January 22, 2018.
- xviii Ibid.
- xix Tanielian T, Jaycox LH, Schell T, et al. Invisible wounds. Mental health and cognitive care needs of America's returning veterans. RAND Corporation. 2008. Accessed January 22, 2018.
- xx Substance Abuse and Mental Health Services Administration. [Results from the 2015 National Survey On Drug Use And Health: detailed tables.](#) Prevalence estimates, standard errors, P values, and sample sizes. 2016. Accessed January 22, 2018.
- xxi National Alliance on Mental Illness. [Mental health by the numbers.](#) Accessed January 22, 2018.
- xxii Center for Collegiate Mental Health. [2017 Annual Report.](#) Accessed January 22, 2018.
- xxiii Ibid.
- xxiv National Center for Education Statistics. Fast facts. [Back to school statistics.](#) Accessed January 22, 2018.
- xxv Center for Collegiate Mental Health. [2017 Annual Report.](#) Accessed January 22, 2018.
- xxvi Turner JC, Ke 384 Iler A. Leading causes of mortality among American college students at 4-year institutions. Conference Paper: American Public Health Association 139th Annual Meeting and Exposition. Washington, D.C. 2011. Accessed January 22, 2018.
- xxvii Unwin BK, Goodie J, Reamy B v., Quinlan J. Care of the college student. *Am Fam Physician.* 2013;88(9):596-604.
- xxviii Centers for Disease Control and Prevention. [Tobacco use among adults with mental illness and substance use disorders.](#) Accessed January 22, 2018.
- xxix Centers for Disease Control and Prevention. Vital signs: current cigarette smoking among adults aged ≥ 18 years with mental illness — United States, 2009-2011. *MMWR.* 2013;62(05):81-87.
- xxx Bandiera FC, Anteneh B, Le T, Delucchi K, Guydish J. Tobacco-related mortality among persons with mental health and substance abuse problems. *PLoS One.* 2015;10(3):e0120581.
- xxxi Press MJ, Howe R, Schoenbaum M, et al. Medicare payment for behavioral health integration. *N Engl J Med.* 2017;376(5):405-407.
- xxxii National Alliance on Mental Illness. [Public policy platform of the National Alliance on Mental Illness.](#) Twelfth Edition. 2016. Accessed January 22, 2018.