National Association for Behavioral Healthcare

Access. Care. Recovery.

Sen. Bernie Sanders, Chair
Senate HELP Committee
428 Dirksen Senate Office Building
Washington, DC 20510

Sen. Bill Cassidy, M.D., Ranking Member
Senate HELP Committee
428 Dirksen Senate Office Building
Washington, DC 20510

20 March 2023

Dear Sens. Cassidy and Sanders:

Thank you for seeking information from healthcare providers about the root causes of the nation's current healthcare workforce shortage and potential solutions to address this critical problem.

This letter summarizes comments we at the National Association for Behavioral Healthcare (NABH) received from our members nationwide. NABH represents provider systems that treat children, adolescents, adults, and older adults with mental health and substance use disorders (SUD) in inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive outpatient programs, medication assisted treatment centers, specialty outpatient behavioral healthcare programs, and recovery support services in 49 states and Washington, D.C.

Background:

America's behavioral healthcare workforce shortage, a perennial problem for the field, has reached a crisis point. The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that among adults aged 18 or older in 2021, **57.8 million people (22.8% of the population) had any mental illness** (AMI) in the past year, and among people 12 or older in 2021, **61.2 million people (or 21.9% of the population) used illicit drugs** in the past year.[1]

Meanwhile, more than **150 million people live in federally designated mental health professional shortage areas**[2] at a time when the U.S. psychiatrist workforce will contract through 2024 to a projected low of 38,821, which is equal to a shortage of between 14,280 and 31,091 psychiatrists.[3]

The COVID-19 pandemic only increased the nation's supply-demand gap for behavioral healthcare services, as there was a three-fold increase in depression symptoms among U.S. adults during the pandemic,[4] and the Centers for Disease Control and Prevention (CDC) estimates there were 107,622 drug overdose deaths in 2021, an increase of nearly 15% from the 93,655 deaths estimated in 2020.[5]

In addition, SAMHSA reports that 67.3 million people (or 24.5% of people aged 12 or older) in 2021 experienced delays or cancellations in medical appointments or preventive services; an estimated 23.2 million people (8.5%) experienced delays in getting prescriptions; and **14.2 million Americans (5.2%) were unable to access needed medical care resulting in a perceived moderate to severe impact on**

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[1] SAMHSA: *2021 National Survey on Drug Use and Health* (NSDUH).
[2] Kaiser Family Foundation: *Mental Health Care Professional Shortage Areas*.
[3] *Projected Workforce of Psychiatrists in the United States: A Population Analysis*.
[4] JAMA: *Prevalence of Depression Symptoms in US Adults Before and During the COVID-19 Pandemic*.
[5] CDC: *U.S. Overdose Deaths In 2021 Increased Half as Much as in 2020-But Are Still Up 15%*.

health. “That 14.2 million people whose health was negatively affected because they were unable to access needed medical care is particularly concerning,” SAMHSA noted.[6]

As behavioral healthcare providers work to provide much-needed care, they do so at a time when 77% of behavioral healthcare leaders report staffing will be their No. 1 financial strain in 2023.[7] Reasons for this include the retiring Baby Boom workforce, fewer qualified professionals entering the field, the existence and threat of workplace violence, increased burnout risk inherent in caring for high-acuity behavioral health patients, and an increasingly competitive workforce that offers better-paying jobs in less stressful workplace environments outside behavioral healthcare.

Behavioral healthcare providers are navigating these challenges as they face another dire issue: While the percentage of the U.S. populace reporting serious psychological distress—an indicator of need for inpatient psychiatric services—has risen to 13% in 2020 from 4% in 2018, the nation’s psychiatric facilities have experienced disrupted continuity in operations and reduced bed capacity— for example, by converting double-occupancy rooms to single-occupancy rooms to reduce viral spread during the pandemic.[8] Equally troubling is that the American Psychiatric Association reports that amid America’s mental health crisis, communities have no effective means to assess how many beds they need to meet demand in their population.[9]

The field also faces challenges related to a limited information technology infrastructure and over-regulation of inpatient behavioral healthcare facilities, both of which create inefficiencies for clinicians that often have a negative effect on the patient experience. NABH explores these issues later in this letter.

Against this grim backdrop is a hopeful reality: a crisis point is the time when a situation can get better or worse. It is a decisive moment. Our members—who represent the entire behavioral healthcare spectrum—face myriad challenges noted below. They also offer reasonable, practical solutions that we hope you will consider seriously and help our members work to achieve.

Challenges:

Diminished Candidate Pool & Limited Employee Pipeline:
America’s retiring Baby Boomer generation, ongoing nursing shortage, healthcare workforce burnout from the COVID-19 pandemic, and lack of candidates entering the field after high school have each contributed to the behavioral healthcare field’s increasing acute workforce shortage.

Nearly across the board, NABH members shared comments about a shortage of registered nurses (RNs), licensed practical nurses (LPNs), therapists, and social workers. Travel nursing programs force employers to pay higher wages to remain competitive. Meanwhile, for non-clinical positions, non-behavioral healthcare positions often offer better salaries in less stressful environments, making it hard for behavioral healthcare providers to retain staff.

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[6] *NSDUH*, p. 71.
[7] *Behavioral Health Business*, Feb. 7, 2023.
[8] JAMA Psychiatry: *Estimating Psychiatric Bed Shortages in the US*, Feb. 16, 2022.
[9] American Psychiatric Association: *The Psychiatric Bed Crisis in the U.S.*

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Workplace Violence:

The existence and looming risk of workplace violence is a critical and often dangerous problem in the United States today, including in the behavioral healthcare sector. Psychiatrists report object aggression more frequently than other healthcare professionals,[10] and research indicates that workplace violence in U.S. inpatient psychiatric settings is a widespread problem, with 25–85% of survey respondents reporting an incident of physical aggression within the year prior to survey, and statewide workers' compensation findings indicating two to seven claims due to assault per 100,000 employee hours.[11] These statistics explain why it is difficult to attract and retain qualified employees.

Lack of Electronic Health Records (EHR) in Behavioral Healthcare:

From the moment the *Health Information Technology for Economic and Clinical Health Act* (HITECH) passed in 2009, behavioral healthcare providers were excluded from meaningful use incentives for EHR, a missed opportunity which has led to extremely low EHR utilization in the behavioral healthcare space. This has led to significant workforce and other challenges due to the limitations of paper-based charting.

Only **6%** of behavioral healthcare facilities and **29%** of SUD treatment centers use EHRs compared with more than 80% of hospitals, according to the Medicaid and CHIP Payment and Access Commission's (MACPAC) June 2022 report.[12] "Due to narrow operating margins, behavioral health providers often have little capital available to invest in the expensive hardware, software, and training needed to use EHRs," the report noted.

As of 2019, acute psychiatric hospitals had modestly higher EHR utilization at **42%,** based on data from CMS' Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program.[13]

Paper-based charting poses numerous challenges, from patient safety to problems with continuity of care to patient-experience limitations. This method also affects provider experience, recruiting, and retention. One NABH member shared this comment from a behavioral healthcare nurse:

"Most new nurse employment declination has been solely on the fact that they are not willing to explore the paper charting option… Some responses I've gotten for leaving are the following: 'I don't like the fact that I must spend too much time writing.' 'I have a hard time understanding others' writing and I am afraid to make a mistake.'"

Lastly, because psychiatric residency programs typically take place in integrated academic medical centers with access to medically funded EHR, psychiatrists and other clinician candidates often have no experience with paper-based clinical operations. This creates challenges both for recruiting and establishing partnerships with academic institutions.

Over-Regulation:

Another especially challenging and solvable problem for behavioral healthcare providers is over-regulation, which reduces the efficiency of the current workforce and ultimately negatively affects the patient experience.

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[10] Psychiatric Services: *Workplace Violence and Burnout Among Mental Health Workers*, Oct. 23, 2019.

[11] International Journal of Mental Health Nursing: *Frequency of violence towards healthcare workers in the United States' inpatient psychiatric hospitals: A systematic review of literature*, Nov. 4, 2020.

[12] MACPAC: *Report to Congress on Medicaid and CHIP*, June 2022, pgs. 84-85.

[13] *IPFQR Program FY 2019 Data Review*

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For instance, inpatient psychiatric facilities must satisfy the Conditions of Participation (CoP) that apply to all general hospitals, as well as Special Conditions of Participation sometimes referred to as "B-tags." These requirements not only have little value and constrain a clinician's professional judgment, they also impose an immense administrative burden on staff.

In addition, these requirements have not been updated since the 1960s-1980s. According to NABH's 2019 report, *The High Cost of Compliance: Assessing the Regulatory Burden on Inpatient Psychiatric Facilities*, compliance costs for the B-tags are approximately $625.9 million annually, accounting for about 1.8% of all-payer revenue for inpatient psychiatric services.[14]

Competitive Workforce & Employee Satisfaction

More behavioral healthcare employees, similar to workers in other sectors in a post COVID-19 world, seek flexible work hours, remote work environments, and greater work-life balance—demands that are often not conducive to healthcare organizations.

Several NABH members also expressed serious concerns about a lack of accountability and loyalty to employers in younger generations of employees.

And nearly across the board, members said additional reimbursement for more training, leadership development, and wellness programs would help contribute to both recruiting qualified staff and retaining employees after they have been hired.

Potential Solutions:

Reimbursement at Parity:

NABH urges the Senate HELP Committee to employ all its resources to ensure that behavioral healthcare services exist on an equal legislative playing field with other healthcare services, starting with adequate funding.

A first step is to address any instance in which behavioral healthcare providers are excluded, such as the *HITECH Act. As* described above, paper-based charting results in problems related to patient safety and employee recruitment and retention. NABH members ask to be included in federal funding that their medical-surgical counterparts received years ago. Proper funding would also allow the field to invest in technologies other than EHR, including Artificial Intelligence (AI) initiatives.

Sufficient reimbursement would help behavioral healthcare providers offer more competitive salaries to attract qualified nurses, therapists, social workers, SUD counselors, peer specialists, techs, residential aides, maintenance professionals, and housekeeping and dietary staff.

Increased reimbursement would also allow behavioral healthcare employers to offer student loan reimbursement, sign-on incentives, retention bonuses, leadership development programs, staff appreciation events, and worker wellness programs.

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[14] NABH: *The High Cost of Compliance: Assessing the Regulatory Burden on Inpatient Psychiatric Facilities*

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Additional Training Programs:

Additional public funding is required to develop the behavioral healthcare sector's pipeline of new clinicians in the areas of new institution establishment, student tuition support and loans, continuing education support, and additional graduate medical education programs.

Additional funding could also urge providers to partner with and offer incentives to local high schools, vocational schools, and higher education systems to help educate students and promote career options in behavioral healthcare.

Federal funding could also be used to develop behavioral healthcare training programs for primary care physicians, particularly in the areas of depression and anxiety, to provide relief to the behavioral healthcare system. These front-line providers are essential in helping improve access to patients in need.

And funding is essential to train behavioral healthcare employers in workplace safety protocols to ensure they know how to manage patients and emergency situations proficiently.

Deregulation:

Behavioral healthcare providers could concentrate more on patient care if lawmakers would help ease the segment's regulatory burden, especially those pertaining to the following B-tag requirements, a detailed set of standards for patient evaluations, medical records, and staffing in inpatient psychiatric facilities:

Tag B147: Several B-tags require psychiatric facilities to appoint various "director"-level positions. B147 relates to the director of nursing, who must be either: (1) "a registered nurse who has a master's degree in psychiatric or mental health nursing" or an equivalent degree from an accredited nursing school; or (2) a person who is otherwise "qualified by education and experience in the care of the mentally ill." Surveyors have a clear preference for specific academic credentials which is at odds with present-day realities in two respects. First, candidates with a master's degree in psychiatric nursing are in short supply. Many individuals who possess such a degree go on to become advanced practice clinicians rather than hospital administrators. Second, advanced practice nurses may gain years of experience working in psychiatric facilities even if they do not have a degree in psychiatric nursing. Moreover, a registered nurse with psychiatric experience can make an excellent director of nursing, especially if the nurse holds a bachelor's degree in a relevant subject like hospital management or business administration.

Tag B110: Upon admission, each patient must receive a psychiatric evaluation. Some surveyors require that this evaluation be conducted by a psychiatrist, even if the evaluation falls within the scope of practice for an advanced practice clinician (APC), such as a nurse practitioner (NP) or physician assistant.

Tag B121: This B-tag specifies that a treatment plan should list patients' short- and long-term goals, but the interpretive guidance expressly states that in a "short-term treatment" scenario, "there may be only one timeframe for treatment goals." Many surveyors expect to see multiple short- and long-term goals, irrespective of the patient's expected length of stay. In a short-term stay, multiple highly specified goals can distract the team from focusing on the reasons for the patient's admission or on how to assess readiness for discharge. This leads to treatment plans that focus on patient-identified goals such as "patient will focus on three new ways of coping with his boss," rather than more substantive movement toward discharge

criteria. The B-tags prohibit the use of stock language in the treatment plans, even if a care pathway defines clinician roles that do not meaningfully vary from patient to patient, e.g., psychiatrists prescribe medications, nurses administer medications, social workers assist with discharge planning, and so on. Because of this limitation clinicians must spend time crafting highly tailored free-text plans and progress notes. Often, these documents must be written out by hand because many freestanding psychiatric hospitals do not have electronic health records (see previous section).

Tags B125 & B126: The regulations state that "the frequency of progress notes is determined by the condition of the patient but must be recorded at least weekly for the first 2 months and at least once a month thereafter." (42 C.F.R. § 482.61(d)). However, the interpretive guidance says that progress notes may be "shift notes, weekly notes, or monthly notes," but should be written with "greater frequency when patients are more acutely ill and/or in a crisis." The result, as identified in the 2019 report, is many surveyors expect to see progress notes every day and expect those notes to connect each therapeutic intervention back to the goals in the treatment plan. Again, these documentations are often written out by hand due to the lack of EHR.

Thank you for considering the needs and concerns of our members. On my behalf of our members and Washington-based team, we are eager to work with you both and your staff to help our members continue providing quality behavioral healthcare services to the millions of Americans who need treatment.

If you have any questions or would like to discuss the information in this letter, please contact me directly at 202.393.6700, ext. 101, or by e-mail at shawn@nabh.org.

Sincerely,

Shawn Coughlin
President and CEO