AAPA
American Academy of Physician Assistants

October 9, 2015

The Honorable Lamar Alexander
Chairman
Senate Committee on Health,
Education, Labor & Pensions
428 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Patty Murray
Ranking Member
Senate Committee on Health,
Education, Labor & Pensions
835 Hart Senate Office Building
Washington, D.C. 20510

Dear Chairman Alexander and Ranking Member Murray:

On behalf of the more than 104,000 nationally-certified physician assistants (PAs) represented by the American Academy of Physician Assistants (AAPA), I am writing to express our strong support for the Committee's work to increase patient access to mental and behavioral healthcare. While AAPA believes that the Mental Health Awareness and Improvement Act represents a good start, we urge the Committee to also address the root of the access problem – the growing provider shortage in psychiatry and the current lack of integration between primary care and mental and behavioral healthcare. PAs can be an integral part of the solution to both of these concerns.

Millions of Americans struggle with mental illnesses and addictive disorders, and many of them are unable to receive the treatment they need. This is especially true in rural and medically-underserved areas, where the U.S. Department of Health and Human Services recently estimated that more than 90 million people lack access to mental health professionals. Given this outlook, as well as the historical use of PAs to alleviate healthcare provider shortages, AAPA believes that PAs should be better utilized and integrated in the mental healthcare field.

Many of the mental health reform bills before Congress include providers like psychiatric nurse practitioners, clinical social workers, and mental health peer-support specialists, but leave out PAs. This is an oversight which should be corrected. PAs receive a broad medical education which includes coursework in anatomy, physiology, biochemistry, pharmacology, physical diagnosis, behavioral sciences, clinical laboratory sciences, and medical ethics. They also participate in more than 2,000 hours of clinical rotations which include instruction in specialty areas like psychiatry, emergency medicine, and family medicine, among others. As a result, PAs are qualified to provide a full spectrum of care including conducting patient histories and examinations, performing psychiatric evaluations and assessments, ordering and interpreting diagnostic tests, establishing and managing treatment plans, prescribing medications (including medications to treat opioid addiction when appropriate), and order referrals.

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In addition to their rigorous educational backgrounds, PAs are unique because they often work on the "front lines" of caring for the underserved. Those trained in behavioral health have the ability to assess and treat the whole patient, whether they are in need of mental healthcare, emergency/primary care, or both, consulting with an offsite psychologist or psychiatrist as needed. There are clear links between physical and mental health, and as a result, patients presenting with the effects of untreated or unmanaged mental illness will often have other, unaddressed, health conditions. Likewise, PAs' training in both physical and mental health positions them to recognize and diagnose unmet mental health needs regardless of the setting. This type of integration is already used successfully in rural and inner-city health centers, jails and prisons, nursing homes, addiction treatment centers, and other facilities where primary care and mental healthcare needs often overlap. As such, AAPA recommends that this model be replicated in proposals which are aimed to increase access to mental healthcare.

AAPA strongly supports fully integrating PAs into mental healthcare. PAs play an important role within the care team when it comes to treating patients with multiple conditions, both physical and mental, and they must be able to treat these patients to the extent allowed under state laws, especially in mental health shortage areas. This includes allowing them to use their broad prescriptive authority to prescribe buprenorphine for the treatment of opioid drug addiction. PAs are currently permitted to prescribe Schedule III, IV, and V drugs in all 50 states and the District of Columbia; 41 states and D.C. also allow PAs to prescribe Schedule II drugs. Yet, the Drug Addiction Treatment Act of 2000, which allows physicians to prescribe Schedule III buprenorphine for this purpose, does not include PAs. In light of the shortage of physicians specializing in mental health and addiction medicine, AAPA strongly recommends that PAs be allowed to prescribe buprenorphine to treat opioid addiction in states where they are already permitted to prescribe similarly-scheduled medications.

PAs are versatile healthcare providers who are qualified to provide comprehensive patient care, and they are already serving as a valuable part of the healthcare team at behavioral health facilities, rural health clinics, and other settings. We are hopeful that the Committee will consider AAPA's recommendations for including PAs in upcoming mental health legislation, and we look forward to working with you as you move forward. Should you have any questions, please do not hesitate to have your staff contact Sandy Harding, AAPA Senior Director of Federal Advocacy, at 571-319-4338 or sharding@aapa.org.

Sincerely,

Jennifer L. Dorn
Chief Executive Officer