



A driving force for health equity

Transmitted via electronic mail

October 29, 2021

The Honorable Ron Wyden
Chairman
Committee on Finance
219 Senate Dirksen Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
219 Senate Dirksen Office Building
Washington, DC 20510

Re: Recommendations to Advance Equity While Addressing Unmet Behavioral and Mental Health Needs

Dear Chair Wyden and Ranking Member Crapo:

On behalf of OCHIN, we applaud your leadership and focus on addressing the unmet behavioral and mental health patient needs across the nation. OCHIN is a [national nonprofit health information technology and research network](#) that offers technology solutions, informatics, evidence-based research, and policy insights for providers in underserved communities. Addressing behavioral and mental health needs is an urgent priority, as the COVID-19 public health emergency has exacerbated health disparities and has challenged the resources and capacity of community-based providers. Community clinics continue to play a central role in delivering services at the convergence of the COVID-19, mental health, and substance use disorder public health emergencies. For too long, mental and behavioral health have not been on equal footing to health care services to treat physical manifestations of disease or other bodily injury even though lack of treatment for these medical needs increase overall health care costs and can exacerbate other health conditions and increase risk of death.¹

OCHIN serves nearly 1,000 community health care sites with 21,000 providers in 47 states, reaching nearly six million patients. In addition to federally qualified health centers (FQHCs) and other community clinics, including in rural areas, we support certified community behavioral health clinics (CCBHC), complex specialty mental health organizations, local public health agencies, corrections, school-based mental health programs, and youth authorities.

OCHIN welcomes the opportunity to work with the U.S. Senate Committee on Finance (Committee) to advance concrete policies that dismantle structural inequality and improve whole patient care sustainably. Globally, OCHIN strongly supports policies that expand access to mental and behavioral health services, particularly substance use disorder services, in underserved communities, including tribal

¹ Mental illness, especially depression, increases the risk for many types of physical health problems, particularly long-lasting conditions like stroke, type 2 diabetes, and heart disease. Similarly, the presence of chronic conditions can increase the risk for mental illness. [Chronic Illness & Mental Health External](#). Bethesda, MD: National Institutes of Health, National Institute of Mental Health (2015).

communities and justice impacted patients. The following are key recommendations to accelerate equitable access:

1. Given significant access barriers, particularly in rural areas, fund the **development of a virtual specialty telehealth network that integrates and coordinates with primary care providers to expand access to behavioral, mental health, and substance use disorder services** among underserved communities.
2. **Modernize and improve health information technology infrastructure**, including electronic health records, interoperability (facilitated by national data standards), health information exchange, and tools for mental health and behavioral health providers in underserved communities as well as public health agencies, tribal providers, and justice organizations (for adults and youth). This will help improve access through care coordination and continuity of care, research, public health, and sustainable payment and delivery transformation.
3. Ensure that mental and behavioral health providers can **access technical assistance to support health information technology adoption, interoperability, and shared learning**.
4. **Advance payment parity** for mental health, behavioral health, and substance use disorder services that accounts for actual costs of services including direct and indirect operational costs.
5. **Extend permanent coverage and reimbursement parity of telehealth (including audio-only) behavioral and mental health services as well as services for substance use disorder without onerous requirements, such as mandated in-person encounters before or after virtual visits.** This is particularly important for FQHCs and rural health clinics serving patients who face persistent structural inequality that hinders access to in-person health care. Medicare and Medicaid policies that permanently extend telehealth and other virtual service flexibilities to providers in underserved areas will reduce use in higher-cost care sites (such as emergency departments), while minimizing care delays that can lead to more acute or emergent events.
6. **Strengthen loan repayment programs for providers in underserved communities and fund professional development and workforce apprenticeship programs among behavioral and mental health providers in underserved communities.** This will contribute to a larger pool of providers and technical staff with language and cultural competence.
7. **Expand significantly investments in an integrated approach between justice impacted patients both while incarcerated and post release to improve care continuity and coordination for behavioral and mental health services and for substance use disorder treatment.** Fragmentation and lack of care post-release for conditions such as substance use disorder remain the norm despite significant demonstrated benefit to overall recovery and lower recidivism when there is care continuity.
8. **Authorize separate coverage and payment parity for eConsults when initiated by FQHCs and rural health clinics (RHCs).** The Centers for Medicare and Medicaid Services has informed state Medicaid programs that eConsults cannot be separately covered, which creates disparate adverse impacts on underserved communities. It also drives structural inequality, as other providers are able to bill for eConsults.²
9. **Prioritize development, testing, technical assistance and provider education on the importance of national health care digital mental health and behavioral health, demographic, and social**

² See California Governor Newsom [veto message](#) to passed state bill authorizing Medi-Cal coverage of e-consults for FQHCs and RHCs, specifically citing CMS communication that “e-consult services are not separately reimbursable to FQHCs and RHCs because a patient is not included *during* the encounter.” (Emphasis added.)

determinants of health data standards. This will help improve health outcomes (particularly for the underserved), scale 21st Century public health, enhance health care delivery, and expand population health capabilities. It will also improve data quality, research, and policy.

10. **Strengthen federal, state, and local public health information technology systems and interoperability with health care providers to address the mental health and substance use disorder public health emergencies.** While COVID-19 has resulted in significant increases in funding to improve public health agency health information technology systems, it is critical that such systems are securely interoperable with health care providers.

We have enclosed additional detailed recommendations. Thank you for allowing us to share input. Please contact me at stollj@ochin.org, as we welcome the opportunity to support your efforts.

Sincerely,

A handwritten signature in blue ink, reading "Jennifer Stoll". The signature is cursive and fluid, with the first name "Jennifer" written in a larger, more prominent script than the last name "Stoll".

Jennifer Stoll
Executive Vice President
Government Relations & Public Affairs

ADDENDUM WITH EXPANDED RECOMMENDATIONS

Questions Posed by Senate Finance

Increasing integration, coordination, and access to care

Fund Telehealth Specialty Network for Providers in Underserved Communities and Cover eConsults for FQHCs and RHCs Separately and At Parity. Primary care providers and their patients require streamlined access into a specialty care network for behavioral and mental health services and substance use disorder services.³ In underserved areas, it is critical that a primary care provider or other clinician (such as a social worker) be able to consult with a specialist. For example, clinicians need to be consult or refer a patient to ensure patients are able to obtain or make changes to a prescription from a psychiatrist. Improving access to mental and behavioral health care and substantive use disorder services means not only providing the opportunity to use eConsults, but also ensuring that these encounters are covered and reimbursed at parity. Currently, eConsults are not covered for FQHCs or RHCs by state Medicaid agencies.

Ensure Mental and Behavioral Health Providers Have 21st Century Health Information Technology. There remains a sharp divide between behavioral and mental health providers and primary care providers as the former lack access to secure electronic health record systems. As a result, health information exchange and interoperability does not occur among these providers. We urge Congress to invest in the infrastructure that behavioral and mental health providers need through financial support and incentives to facilitate adoption of electronic health record systems. This will help drive improved care coordination and whole patient care; while advancing public health capabilities, research, and transitions to new payment and delivery reform models that require secure bi-directional communication and advanced analytics to navigate population health and risk-based models essential to whole patient care.

Ensure Technical Assistance and Digital Tools. Beyond an investment to accelerate adoption of modernized health information technology systems—which would allow behavioral and mental health providers to deliver virtual appointments—access to technological assistance is necessary to ensure that these providers can adjust workflows, overcome technical difficulties, and help patients understand how to interact with new technology. Patients similarly require technology for connectivity, such as smart phones and laptops.

Social Determinants of Health to Drive Equity. Authorize coverage and payment for SDOH assessments, evaluations, and care coordination and referrals among community-based behavioral and mental health providers—including through new payment and delivery models, and existing quality performance programs. Currently, providers of Medicare beneficiaries have reportedly low SDOH evaluation rates. Rates are comparatively higher in the OCHIN network, but widespread uptake and clear payment for evaluation is needed. This is particularly true among providers in underserved communities, where these essential evaluations may be more time intensive.

Care Continuity and Coordination for Justice Impacted Patients. More investment in an integrated approach between incarcerated patients both while incarcerated and post release to access to mental

³ It is estimated that more than one-third of Americans live in an area without enough mental health providers available.

and physical health specifically mental and SUD treatment. According to the Oregon Center for Behavioral Health and Justice Center which was launched in 2019, 50% of people jailed have one or more behavioral health diagnosis and 60% have a substance use disorder. We need to improve the processes and programs between the medical and legal communities with a continuity of care approach to reduce the cycle of recidivism and improve health outcomes for patients.

Support Adoption of a National Unique Patient Identifier. We urge Congress to ensure HHS is able to develop and adopt a national unique patient identifier. Varied patient identifiers and methods currently used to identify a patient negatively impact electronic exchange; increase administrative complexity and cost; and undermine patient safety, public health, and clinical research. In the last state legislative session, for example, a state legislature considered mandating a state-specific “solution” to uniquely identify patients. Multiple “unique” identifiers for patients who move among states, providers, health plans, and public health jurisdictions would undermine efforts to improve not only interoperability but also privacy, security, patient safety, and equity. In the OCHIN network, mismatching and duplication disproportionately affect communities of color, thus undermining health equity and contributing to structural inequality.

Resource the Development and Scaling of a National Health Data Framework to Reduce Cost, Complexity, and Data Silos. Prioritize the development, testing, and use of national data standards related to behavioral and mental health, patient demographic information, and social determinants of health. This undertaking should be informed and anchored in the work of the U.S. Department of Health & Human Services’ Office of the National Coordinator’s **United States Core Data for Interoperability (USCDI) Initiative**. This roadmap should include components that ensure **harmonization of varied federal agency data standards and outreach to states, to help reduce conflicting standards.**⁴

National Privacy Framework and Whole Patient Care. Establish a unified national privacy and security framework to ensure that patients—and more broadly consumers, particularly those most vulnerable to discriminatory or other adverse consequences—are not harmed through disclosure of patient clinical information. This includes mental and behavioral health-related information; and SDOH data shared by entities that are not subject to the Health Insurance Portability and Accountability Act (HIPAA), and which are not bound by ethical obligations to patients. On the other hand, there remain restrictions on the secured exchange of substance use disorder (SUD) clinical information even in the context of HIPAA. This undermines patient safety, because clinicians do not have access to medical information that impacts care. It also hampers exchange of relevant clinical data, as some regional health information exchanges prohibit inclusion of this information. OCHIN urges Congress to consider amending or repealing this section so that once 42 CFR Part 2 data is transmitted or retransmitted, there is no requirement to segregate a patient’s 42 CFR Part 2 data from the rest of a HIPAA database.



Ensuring parity between behavioral and physical health care

⁴ All state planning SDOH programs and initiatives should be tied to national SDOH data standards and federal interoperability requirements.

Ensure Equitable Prospective Payment System (PPS) Payment for Behavioral and Mental Health Group Encounters. Currently, certain states do not pay the full PPS rate for behavioral health and other services delivered in a group setting. For example, health centers offering group counseling to clinic users with substance use disorders (SUDs) receive either fee-for-service rates covered under the Medicaid benefit, or no payment whatsoever. Neither of these payment methodologies complies with the requirement to pay the FQHC PPS. OCHIN recommends that Congress direct CMS to issue guidance to state Medicaid agencies clarifying that Medicaid is required to pay PPS to FQHCs for all group services when provided by an FQHC professional.

Incentivize Same-Day Billing. States allowing same-day payment for behavioral health and other services—such as medical or dental services—is central to promoting integrated care. Although this is already required in Medicare’s FQHC regulations, and allowed in several state Medicaid programs, it is not specifically stated in Medicaid FQHC law. OCHIN recommends that Congress direct CMS to provide clear guidance to states stipulating that state programs should reimburse an FQHC’s medical and mental health visits on the same day.

Expanding Covered Clinicians for FQHCs. OCHIN urges the Committee to amend the definition and statute of FQHC core providers to include more behavioral health practitioners. The statute should authorize an expanded group of practitioners eligible to provide behavioral health services, making it clear that these additional services are covered and reimbursed as FQHC services and billable as FQHC visits. This includes adding Licensed Marriage and Family therapists (MFTs), Licensed Addiction Counselors, Peer Support Specialists, Community Health Workers (CHW), Licensed Professional Counselors (LPC), and Mental Health Counselors (MHC) to the list of Medicare and Medicaid-covered providers, which can help health centers expand access to care. The currently limited list of reimbursable behavioral health providers is a particular barrier to expanding behavioral health care in rural areas.

Furthering the use of telehealth

Federal Health Care Program Public Health Emergency (PHE) Flexibilities. Rolling back current federal health care program coverage and payment parity for telehealth—including audio-only telehealth, particularly for FQHCs and RHCs—would dismantle a lifeline to essential and medically necessary health care services among underserved patients. From the outset of the COVID-19 public health emergency, OCHIN has been actively working with our members to reconfigure the care delivery system, especially where behavioral and mental health services are involved.

To illustrate: Among members utilizing OCHIN Epic, 99% of their behavioral health and mental health encounters were conducted via telehealth at the outset of the COVID-19 public health emergency in April 2020. While in-person visits have since returned to levels more consistent with pre-pandemic figures, telemental health encounters have increased overall during this time. For example, telemental health encounters accounted for .003% of all behavioral health encounters in September of 2019, but **44% in September of 2021**. This underscores the ongoing need to ensure that this behavioral and mental health delivery modality remains readily available, particularly in underserved communities. Making sure this modality is an option for patients reduces no-shows, increases the opportunity for provider connection, and improves patient satisfaction. Telehealth expansion does not occur in a vacuum, however, and requires several overlapping solutions.

Policies that limit coverage and reimbursement parity while rescinding FQHC and RHC coverage for telehealth (including audio-only telehealth) would **negatively impact patient outcomes and overall costs, creating a structural disadvantage for community clinics and the patients they serve.** OCHIN's analysis of 2020 data underscores how telehealth (including audio-only) dismantles the structural inequality that is a feature of in-person only services. It's especially important to note that telehealth in general, and audio-only in particular, are often the only options available for patients displaced by environmental and natural disasters. These patients often need to connect with their established providers to maintain continuity of care. This is particularly true for medically complex patients who, for example, may need medication replacement or ongoing active therapeutic management.

As telehealth is a modality (and not a service) distinct from what is billed when delivered in-person, deciding whether to use this modality for service delivery is a clinical practice determination. Accordingly, regulating medical practice through coverage policy by limiting access based upon originating or distant site of service—or whether the encounter was preceded by an in-person encounter—does not reflect clinical best practice. Clinicians and patients must evaluate a range of patient-centered and clinical factors when determining the appropriate modality. A significant evidence base existed prior to the COVID-19 PHE, which included clinical practice guidelines based upon specialty and service type.⁵ The COVID-19 PHE has expanded the data-driven evidence base around appropriate clinical use.⁶ As a result, numerous provider and clinician organizations have leveraged lessons learned to develop best practices for implementation, scaling, and continual quality improvement. For example, the California Telehealth Resource Center (CTRC) is distributing *[A Healthy Balance: Hybrid Virtual Care Models for Optimal Patient Experience](#)*. This document reflects continuous learning and best practices for deployment in primary care clinical settings that drive improved access and patient outcomes. Prior to the COVID-19 PHE, the American Medical Association (AMA) developed guidance for telehealth deployment in clinical practice and launched the [Telehealth Initiative](#) to improve access to quality health care. The number of clinical practice guidelines that inform clinician use of telehealth (including audio-only services) also continues to grow in primary care, plus areas such as behavioral and mental health. [Community clinics](#) continue to report that coverage and payment for this modality are needed to overcome structural inequalities, thereby providing access to patients facing the most significant barriers to care.⁷

An increase in telemental health service utilization coincides with a well-documented mental and behavioral health crisis that is itself rapidly becoming a public health emergency.⁸ Utilization therefore reflects an increased medical necessity, as opposed to inappropriate use. Additionally, telemental

⁵ See, for example, [The Evidence Base for Telehealth: Reassurance in the Face of Rapid Expansion During the COVID-19 Pandemic](#), A White Paper Commentary on an AHRQ Evidence Report, May 14, 2020.

⁶ See, for example, Holcomb D, Faucher MA, Bouzid J, Quint-Bouzid M, Nelson DB, Duryea E. *[Patient Perspectives on Audio-Only Virtual Prenatal Visits Amidst the Severe Acute Respiratory Syndrome Coronavirus 2 \(SARS-CoV-2\) Pandemic](#)*. *Obstet Gynecol.* 2020 Aug;136(2):317-322; *[Telehealth Interventions to Improve Obstetric and Gynecologic Health Outcomes: A Systematic Review](#)*, *Obstetrics & Gynecology*: February 2020 - Volume 135 - Issue 2.

⁷ See, also, Zachrisson KS, Yan Z, Sequist T, Licurse A, Tan-McGrory A, Erskine A, Schwamm LH. *[Patient characteristics associated with the successful transition to virtual care: Lessons learned from the first million patients](#)*. *J Telemed Telecare.* 2021 Jun 13:1357633X211015547.

⁸ *[Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic—United States](#)*, June 24–30, 2020 *Weekly / August 14, 2020 / 69(32)*; 1049–1057, Centers for Disease Control and Prevention (CDC); and, *[Medi-Cal Behavioral Health Services: Demand Exceeds Supply Despite Expansions](#)*, California Health Care Almanac, California Health Care Foundation, September 2021.

services have an established evidence base to support their use.⁹ For all telehealth modalities, clinicians must typically review the patient’s medical history, conduct an exam, assess the patient, and determine testing and treatment needs. Reporting and documentation requirements are similarly consistent. The clinician remains responsible for care coordination and appointment follow-up. This may involve support staff services, particularly when utilizing telehealth. **Thus, the cost of care is comparable.**

To facilitate transition to new payment and delivery models, FQHCs and RHCs need a pathway to expand telehealth as part of an integrated continuum of care. This modality represents a proven means to address key social determinants of health, such as lack of transportation and homelessness, that negatively impact access and outcomes. **Community clinics need time to fully integrate learnings and experience with this modality, and rescinding coverage places FQHCs and RHCs at a disadvantage. Limiting access to telehealth over time will drive higher costs when patients who are clinically and socially complex are not able to access care early—before conditions become chronic, acute, or emergent.** Establishing telehealth payment parity and audio-only coverage for all Medicare and Medicaid beneficiaries is necessary to drive health equity and delivery modernization, thereby paving the way for improved patient health and further practice transformation.

Remove In-Person Coverage Requirement. While we supported congressional action to make post-pandemic access to telemental health services permanent—regardless of a patient’s geographic or physical location—OCHIN, like most other stakeholders, was concerned that the Consolidated Appropriations Act *seemed* to impose an in-person evaluation prior to certain telemental services once the PHE expires. **We urge Congress to remove this requirement altogether.** It offers no clinical benefit and, based upon OCHIN data, there is compelling evidence that patients in underserved communities utilize telehealth to sustain mental health service access. In addition, given the clinical evidence and utilization patterns among underserved patients, OCHIN does not support the initial requirement of an in-person visit within six months of the telemental visit. Likewise, we do not support requiring an in-person visit every six months thereafter. This will create substantial barriers to care for the most underserved patients.

Expand Covered Clinicians Due to Intractable Shortages. When a different practitioner in the same practice may need to offer services to an eligible telehealth individual, the patient should not be penalized due to a clinician’s lack of availability. We urge Congress to ensure **that CMS clarifies that patients may see any clinician who is part of the same practice in federal health care programs.** Again, patients in underserved communities and their providers have access to limited resources and are disparately impacted by clinician shortages.

Audio-Only Coverage Essential to Dismantle Structural Inequality. OCHIN strongly supports coverage and reimbursement parity for audio-only services. In the analysis of California member patient telehealth utilization, OCHIN found that roughly 26% of patients served used audio-only telehealth in 2020. Among these patients:

- 36% of audio-only encounters were for patients best served in a language other than English.
- 51% of audio-only encounters were by Latinx/Hispanic patients.

⁹ See, for example, *Best Practices in Video-conferencing-based telemental health*, American Psychiatry Association and American Telemedicine Association, April 1, 2018; Practice Guidelines for Telemental Health with Children and Adolescents, ATA, March 1, 2017. See, also, Samuels EA, Clark SA, Wunsch C, et al. *Innovation During COVID-19: Improving Addiction Treatment Access*. J Addict Med. 2020.

- Patients experiencing housing insecurity were 10% more likely to have an audio-only visit compared to those without housing insecurity.
- Patients with transportation needs were almost three times as likely to have an audio-only visit compared to those without transportation needs.

The foregoing underscores that parity for audio-only telehealth encounters is crucial to achieving equitable access.

As previously noted, clinicians must review the patient’s medical history, conduct an exam, assess the patient, and determine testing and treatment needs for all telehealth modalities. Reporting and documentation requirements are similarly consistent. The clinician remains responsible for care coordination and appointment follow-up. This may involve support staff services, particularly when utilizing telehealth. Thus, the cost of care is comparable. Implementing differential reimbursement will negatively impact those providers and their patients who rely on audio-only services to sustain access.

Improving access to behavioral health care for children and young people

The COVID-19 public health emergency has had a negative effect on children’s mental health. The Centers for Disease Control and Prevention (CDC) released data indicating that the proportion of emergency department (ED) visits related to mental health crises has increased markedly for young children and adolescents since the pandemic started. From March through October 2020, the share of mental health-related hospital emergency department visits rose 24% for children aged five to 11, and 31% among adolescents aged 12 to 17, when compared to the same period in 2019.¹⁰ In addition, a survey by Mental Health America in September 2020 found that:

- The number of young people seeking help with mental health is increasing. Throughout the COVID-19 pandemic, youths aged 11 to 17 have been more likely than any other age group to score for moderate to severe symptoms of anxiety and depression.
- Rates of suicidal ideation are highest among youth.¹¹
- In September 2020, over half of youths aged 11 to 17 reported having thoughts of suicide or self-harm more than half or nearly every day of the previous two weeks.¹²

Children’s mental health during public health emergencies can have both short-term and long-term consequences to their overall health and well-being.¹³ A telehealth model for providing integrated mental health services in a school-based health clinic has the potential to increase access to specialized care for the most vulnerable young people.

¹⁰ [Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020](#), CDC, accessed October 28, 2021.

¹¹ <https://mhanational.org/issues/state-mental-health-america>

¹² Id.

¹³ Substance Abuse and Mental Health Services Administration. Disaster Technical Assistance Center supplemental research bulletin: Behavioral Health Conditions in Children and Youth Exposed to Natural Disasters (2018)

- Even prior to the COVID-19 pandemic, many families struggled to get mental and behavioral health care for their children if they lacked access to school-based clinics and telehealth.¹⁴ Nationally, nearly one in five children have a mental, emotional, or behavioral disorder.¹⁵ Children with these disorders benefit from early diagnosis and treatment. Unfortunately, only about 20% of children with mental, emotional, or behavioral disorders receive care from a specialized mental health care provider.¹⁶
- Clinician shortages remain intractable. As a result, parents and children must travel long distances or wait for extended periods of time for care if they do not have access to school-based clinic services and telehealth options. School-based clinics also improve care quality at a lower cost of between \$40 and \$969 per visit.¹⁷
- School-based clinics improve access to treatment and referral services for children and adolescents with identified behavioral health conditions through telehealth—especially those living in rural and other underserved areas. In rural communities, about 70% of children and adolescents identified with a psychiatric disorder never receive treatment.¹⁸

In response to the COVID-19 pandemic and its associated mental health impact, the CDC has concluded that:

- Ensuring availability of, and access to, developmentally appropriate mental health services for children outside the in-person ED setting will be important as communities adjust mitigation strategies.¹⁹
- Implementation of technology-based, remote mental health services and prevention activities to enhance healthy coping and resilience in children might effectively support their well-being throughout COVID-19 response and recovery periods.²⁰

Strengthening the workforce

Support Equity in Workforce Training and Investment by Creating Opportunities at the Intersection of Health Care and Technology Among Providers in Underserved Communities. Prioritize closing the digital divide by investing in community-based health workforce development expansion that emphasizes

¹⁴ www.cdc.gov/childrensmentalhealth/access.html

¹⁵ National Research Council and Institute of Medicine. (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. E. O'Connell, T. Boat, & K. E. Warner Eds. Washington, DC. The National Academic Press.

¹⁶ Martini R, Hilt R, Marx L, et al. *Best Principles for Integration of Child Psychiatry into the Pediatric Health Home*. American Academy of Child and Adolescent Psychiatry.

¹⁷ www.thecommunityguide.org/sites/default/files/publications/he-ajpm-ecrev-sbhc.pdf

¹⁸ Pradhan T, Six-Workman EA, Law KB. *An Innovative Approach to Care: Integrating Mental Health Services Through Telemedicine in Rural School-Based Health Centers*. Psychiatr Serv. 2019 Mar 1;70(3):239-242. doi: 10.1176/appi.ps.201800252. Epub 2018 Dec 17. PMID: 30554561.

¹⁹ Dolan MA, Fein JA; Committee on Pediatric Emergency Medicine. *Pediatric and adolescent mental health emergencies in the emergency medical services system*. Pediatrics 2011;127:e1356–66.

²⁰ Golberstein E, Wen H, Miller BF. *Coronavirus disease 2019 (COVID-19) and mental health for children and adolescents*. JAMA Pediatr 2020;174:819–20; and Gurwitch RH, Salem H, Nelson MM, Comer JS. *Leveraging parent-child interaction therapy and telehealth capacities to address the unique needs of young children during the COVID-19 public health crisis*. Psychol Trauma 2020;12(S1):S82–4.

connections to community providers and technology training. Apprenticeship and training programs that provide opportunity at the entry level of health IT offer individuals a ladder of potential professional progression in three fields: health care, information technology, and health IT. Further, establishing programs that recruit and develop individuals and staff in community-based settings will increase the diversity and cultural/linguistic competence of this essential 21st Century workforce, building community resiliency.

Support Workforce Development Programs which will build the health care workforce of tomorrow by creating apprenticeships, internships, and work-study programs for those interested in the health sector. The medical and technology industries share a legacy of discrimination that has reduced opportunities for people of color. Risk factors for infection disproportionately experienced in Black, Latino, and Indigenous communities include living or working in close quarters, residing in a COVID-19 hotspot county, and having a service sector job with no work-from-home option.²¹ Another major impact of the pandemic is loss of employment; where again, people of color have been hit hardest.^{22,23} Past recessions show that it takes minority households longer to recover from economic downturns. The same pattern is almost certain to repeat in the current economic crisis without smart investment in both health and economic equity.²⁴

The nation's community health centers, public health departments, rural health centers, and critical access hospitals can provide exceptional job training opportunities to help address the triple challenge of health equity for patients, economic recovery for under-resourced communities, and career training opportunities for underrepresented people in the health care sector. The time is now to invest in today's workforce while preparing the next generation, thereby upholding the mission of these organizations to provide quality care for underserved patients across the country.

²¹ <https://www.americanprogress.org/issues/race/news/2020/04/14/483125/economic-fallout-coronavirus-people-color/>

²² <https://carsey.unh.edu/publication/inequities-job-loss-recovery-amid-COVID-pandemic>

²³ <https://www.cbpp.org/research/full-employment/the-impact-of-the-covid19-recession-on-the-jobs-and-incomes-of-persons-of>

²⁴ <https://www.epi.org/publication/black-workers-covid/>