April 9, 2013
Senate Health Care and Human Services Committee
Testimony by David A. Pollack, MD
Regarding SB 823

I have worked as a public and community psychiatrist in Oregon since 1973. My current title is Professor for Public Policy for the departments of Psychiatry, Family Medicine, Public Health and Preventive Medicine, and the Division of Management at OHSU. I trained at OHSU, worked in the community mental health system for many years, and served as the medical director for the AMH Division. I have been the psychiatrist most involved in health reform in Oregon, from the development and implementation of the Oregon Health Plan in the 1990s, to the current health reform initiatives over the past 6 years. I have worked with various OHA committees and offices to address the development of primary care home standards, the health system's prioritized list, the integration of mental health and primary care, and the overall health care workforce development agenda that the state must pursue to meet the future needs of our comprehensive and progressive health care system. I list these credentials not only to underscore my knowledge of and commitment to Oregon's systems of care, but also to validate how important SB823 is to the overall health of the state of Oregon.

As many have noted, in the wake of overcrowding of the acute and state psychiatric hospitals, the limited services in the community, the too frequent involvement of police in dealing with mental illness issues, and some of the mass shooting tragedies that have plagued our communities, Oregon's mental health system is fragmented and woefully inadequate to effectively and efficiently meet the needs of those who experience mental health and substance abuse challenges. The proposed new and expanded mental health services, authorized by SB823, are extremely important programs. If implemented and fully funded, they should substantially improve access to and quality of mental health and addiction services for children, adolescents, and adults, especially within the community-based mental health and addiction service system.

Some of the proposed programs reinstate critical services that had been reduced due to recession driven budget cuts since 2003, resulting in insufficient crisis, housing, and employment services that would have otherwise kept people out of

the hospital and on to paths to recovery and increased functioning. Some of the provisions expand services statewide that have only operated in limited areas of the state but which have proven to be effective in preventing the onset or deterioration of various psychiatric problems. Some of the programs fill serious gaps in service with new programs that draw upon the best contemporary thinking and evidence-based research for improving the quality of mental health and addiction services. The child mental health prevention provisions dovetail nicely with Senator Courtney's landmark "Safe Families" legislation enacted in 2010.

While SB823 provides absolutely essential relief and improvement for our mental health system, I have two concerns about issues that the bill does not fully address: workforce impacts and integration of mental health and primary care.

Workforce Issues: The proposals do not identify the resulting workforce development implications and costs if such proposals are initiated. The Oregon Healthcare Workforce Committee, in its most recent report to the Oregon Health Policy Board, acknowledged this problem and recommends that the OHA "require a "**healthcare workforce impact assessment**" as part of large-scale reform initiatives, grant projects, or system changes sponsored or funded by OHA. The implementing entity should be required to consider, assess, and report on the workforce needs and impacts of any relevant project or proposal, in order to assure that workforce implications of potential healthcare system changes are being identified and documented." The main training related proposal in the current bill enhances the mental health prevention and promotion capacity for children, adolescents, and young adults. The actual overall workforce and training implications of the bill may be more than the current workforce development infrastructure can accommodate. AMH should be asked to clarify what training or workforce development needs will be created by these initiatives.

Integration of Behavioral Health and Primary Care: The health reforms being implemented in Oregon and nationally depend upon a service delivery system that is much more primary care focused. The reforms anticipate that relevant specialty services will be integrated with primary (or general medical) care. The most pressing specialty need (acknowledged by most primary care providers, health policy experts, and Governor Kitzhaber) is for the **integration of behavioral**

health (i.e., mental health and addiction) services within primary care. This means providing enough well prepared behavioral health providers to meet the needs of integrated primary care settings, e.g., the 300+ Patient-Centered Primary Care Homes (PCPCH) that OHA and the CCOs are in the process of promoting and implementing. The shortage of adequately prepared mental health professionals, especially psychiatrists, whose participation in integrated care is essential, is one of the most striking limitations to achieving sufficient quality of behavioral health care in integrated settings. The value of providing psychiatric consultation to primary care providers (PCPs) is well-established in relation to improving the PCP's ability to assess and treat certain kinds of psychiatric conditions as well as knowing when and how to refer more complex patients for specialty psychiatric care. The important and laudable proposals in SB823 do not (with the exception of Section 1, 5, a) address the substantial and progressively increasing amount of behavioral health services provided in primary care settings.

Recommendations: To address the access and training needs, the following initiatives should be considered. Although these recommendations are focused on psychiatric providers and their training, there may be justification for similar initiatives for certain other mental health professional disciplines.

1. Provide adequate psychiatric consultation resources to primary care and other integrated care settings, especially the PCPCHs that are being implemented, throughout the state.
    i. Eliminate the billing and payment barriers that currently prevent such consultation, e.g., to allow consultants to meet with and advise primary care providers, in addition to providing direct care to patients, which is currently the only reimbursable/billable service.
    ii. Require CCOs to implement payment reforms that would support psychiatric consultation directly with primary care providers and their teams rather than just for direct patient care.
    iii. Support the expansion of telehealth mediated access to psychiatric consultants for rural and frontier area PCPCHs.
    iv. Create an adult version of OPAL-K (Section 1, 5, a) that would provide primary care providers access to consultation from adult psychiatrists regarding the assessment and treatment of

persons with psychiatric conditions. The infrastructure for doing such a consultation service is in place at OHSU, but the lack of reimbursement methods, just as in the case of OPAL-K, has blocked the implementation of such a service in a sustainable way.

v. Encourage/require CCOs to demonstrate that they have adequate psychiatric provider resources within their panel of providers, including psychiatric consultants to serve the PCPCHs within their system of care. This may involve refining the OHA PCPCH standards to assess the level of sufficiency of PCPCH behavioral health services by more explicitly describing the range of behavioral health personnel utilized.

2. Promote and support the expansion of training of psychiatric providers to work in integrated care settings.
    i. Facilitate or require OHA to work with academic health programs to provide psychiatric consultation to PCPCHs including practicum training experiences for psychiatric residents to work in PCPCHs as psychiatric consultants. Unless and until resident physicians work in such settings, they will not be sufficiently competent to carry on such work when they graduate from the residency training program.
    ii. Provide subsidies for the academic supervision of psychiatric trainees in integrated care settings.

SB823 may be able to be amended to include some of these ideas, e.g., the psychiatric help line for primary care providers who work with adult patients and the provision of telehealth psychiatric consultation. The other recommendations may be better addressed vis a vis the CCOs and academic health programs. Fortunately, the new Health Systems Transformation Center, which was created to provide technical assistance to the CCOs and to foster linkages between the clinical delivery system and healthcare training institutions (e.g., OHSU), may be ideally suited for such actions. It is still up to the legislature, in its regulatory and oversight role, to require OHA to assure that these remaining issues are addressed, thus making the continuum of mental health and addictions services in Oregon as seamless and comprehensive as possible.