Doernbecher
Children's Hospital

Division of Child and
Adolescent Psychiatry

Department of Psychiatry

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RE: Written Testimony Opposed to HB 3355 "Prescribing Authority for Psychologists"

Dear Co-Chairs Representative Smith-Warner, Senator Monroe and distinguished members of the Joint Education Committee:

My name is Dr. Ajit Jetmalani and I am a Clinical Professor of Psychiatry and Head of OHSU's Division of Child and Adolescent Psychiatry. I also serve as a consultant to the Oregon Health Authority's Health Services Division and am a past president of the Oregon Council of Child and Adolescent Psychiatry. During my 29 year career I have participated in the training of over 80 adult psychiatry residents and 58 child psychiatrists. I have reviewed thousands of medical records as a medical director at Providence Health Plan for 10 years (1990-2000) and in my current role at Oregon Health Authority. I understand what it takes to train a safe and competent health care provider and know the pitfalls of poor training and the challenges in delivering mental health care across Oregon. **I am representing Oregon Council of Child and Adolescent Psychiatry during today's testimony.**

I support improved access to high quality mental health services in Oregon and have spent my career as a clinician, educator and public health advocate pursuing this goal. I am against HB 3355, because, while well intended, it does not adequately assure the safety of the public. I also believe that it is not solving the access problem that is most severe. **W*e need more high quality therapists, not more prescriptions for the people we serve, especially children.***

This bill fails to offer effective guidance for a safe strategy. At the heart of this is the failure to go back to the drawing board and really think about the core elements of medical training in a collaborative process with Physicians. Medical training programs should not assume the best…they must have structures that are vigilant, rigorous and prepared for the worst situation, include measurable goals and have oversight that is authoritative and informed. Its graduates should be able to function if oversight fails and know what to look for to avoid adverse health outcomes when gaps of oversight occur.

You have an awesome responsibility and opportunity as legislators and I imagine some of you are uncomfortable or fed up with the diverging advice you are receiving. I hope you will read my testimony none the less:

Here are 10 reasons that I do not support this bill:

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1. Psychologists are unlikely move to remote rural environments in significant numbers once they get this training to work with underserved populations, including people insured by Medicaid. If they were willing to do so, we could really use their typically excellent psychotherapy skills.
2. There are no medications that just affect the mind and not the brain and the body (there are no "mental health drugs"). It may be an inadvertent form of mental health stigma that these medications are somehow thought of differently than any other medical prescription.
3. Accepting a prescription from someone who has not learned how to complete a medical history and physical exam… or seen severe adverse health outcomes….but who recommends a medication that can cause changes in blood pressure, weight, blood sugar, seizures, gastrointestinal functions, heart rate, kidney functions etc…does not make common sense; but many consumers will not know the difference as these providers will be "doctors" as well.
4. Providers, who can't order or interpret lab tests because there their training does not prepare for that, should not be able to prescribe *any* medication.
5. Not all primary care offices are consistently highly functional and not every providers work will always be closely overseen. Nor can we assume that they will always discuss all the patients that are seen during each visit. People get busy, they get sick, and providers come and go.
6. These providers won't always know when they are witnessing a medication side effect or emergence of a health condition that would make the previously safe medication no longer safe… because they have never treated serious health conditions themselves.
7. If a provider only had a list of a few medications they might be authorized to use, they may try medicines from that short list rather than recommending seeing another expert.
8. Any medical provider should be overseen by the BME or other medical board not a board without any experience in the myriad of things that can go wrong in medical care.
9. Any medical oversight committee should be constructed with physicians in charge as the experts and psychologists as advisors. This should be a safety-based oversight structure, not a political structure.
10. A training program cannot be developed by the trainee as suggested in this bill. A training program must be certain to capture underperforming students, have a clear set of basic education prerequisites, competency measures, clear time requirements, clear description of patient populations, paid directors of training and oversight by state and national credentialing programs.

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Here are some suggested strategies: if our state does not have the will or the way to expand training for psychiatrists and other areas of health care provider workforce challenges (as recommended in HB 3085):

1. Dedicate startup funding to create a pilot program for 3-5 slots utilizing a modified PA program curriculum. Expect premed requirements to be completed as is true for PAs. Hire a program director, define the training (some of the content may be covered by the masters in prescribing but that would need to be reviewed), provide history and physical exam training and direct experience treating health conditions in the primary care and other health care settings. The final step would be completion of a well-defined competency based clinical program in managing mental health conditions in the primary care setting. This would not be free or easy to do, but that is what is needed for a safe training to practice medicine even within the context of the primary care medical home.
2. The program should be developed by physicians who have worked within accredited training programs and understand competency based medical education. It would make sense to be developed in a large institution where a range of experts would be available as educators and mentors / preceptors.
3. Incentivize graduates to practice for a number of years in underserved settings where they would work with colleagues who trust their judgement and feel safe in their collaboration.
4. Graduates should be overseen by the BME so that the public (and you) would be reassured that Oregonian's safety is ensured.

INCREASE ABILITY OF PRIMARY CARE TO MANAGE THEIR PATIENTS

EXPANDED OPAL K (Oregon Psychiatric Access line about Kids):

This service is currently funded by the legislature (since 2014) and provides immediate or same day phone consultation by child psychiatrists to primary care clinicians across the state (see attachment). Current annual expense is $750,000K.

The program also supports the state mandates for oversight of prescribing practices for youth in foster care and will soon participate in an OHA initiative to oversee prescribing of antipsychotics for youth in Medicaid under the age of 10.

Adding telemedicine evaluations would increase the opportunity for direct patient consultation and would add about 300k to the annual budget. There is no *direct* clinical revenue offset for the program. Oregon has seen a decrease of initial antipsychotic prescriptions for the under 18 age group of 50 percent over the past five years. OPAL K has an important place in the range of factors that have led to this decline (changing prescribing practices based on intensive efforts to educate providers in Oregon via the DHS psychotropic prescribing oversight and OSU College of Pharmacy/ OHA information campaign, national prescribing trends, consultation with providers via OPAL K consultations and trainings). This may have saved the state substantial pharmacy costs, metabolic monitoring expenses and lowered the long term metabolic and neurologic risk for those youth. Each call offers direct support to primary care clinicians' patient management and this informs decision making for other patients in the providers panel. This leads to expanded competency and capacity in the primary care medical home. Massachusetts funds a similar service by charging all insurers @ 18 cents PMPM but their programming includes face-to-face and one-time evaluations via telemedicine.

OPAL A (Oregon Psychiatric Access Line about Adults):

Develop a consultation program designed with the same structure as OPAL K but for adults. The ideal model is consultation to primary care and integrated psychotherapy services providers. The estimated cost is $1 million annually for phone consultation services and approximately $1.6 million if telemedicine services are included.

ECHO Expansion

ECHO (Extension for Community Healthcare Outcomes) trains primary care clinicians to provide specialty care services. Funds provided through this bill could be used to expand ECHO mental health, developmental health and substance use disorder training for child and adult Primary Care Providers.

IF THIS BILL GOES FORWARD DESPITE TESTIMONY AGAINST IT:

Amendment One: Patient Protections

1. Prescribing psychologists may prescribe only to clients between ages of 17 and 65; cannot prescribe to certain groups (pregnant women, intellectual disabilities, serious medical issues.)

2. Prescribing Psychologists may only prescribe the medications for the treatment of mental health disease or illness the collaborating physician generally provides to his or her patients in the normal course of his or her clinical practices. They may not prescribe Scheduled II-V controlled substances.

Amendment Two: Regulatory Oversight and Training

1. The Oregon Medical Board have oversight over the advisory committee comprised of 9 individuals: three licensed psychologists, one of whom is a member of the State Board of Psychologist Examiners and one of whom has completed the clinical residency program, one member of the public, The Oregon Medical Board shall appoint four prescribing physicians, alt least two of whom are psychiatrists, and two primary care physicians. The State Board of Pharmacy shall appoint one licensed pharmacist with expertise in psychotropic medications. The advisory committee shall be staffed by a licensed physician.

2. All psychologists with prescriptive authority report to the Oregon Medical Board

3. All psychologists with prescriptive authority must have completed Premedical Undergraduate Studies, Medical Basic Science education (Integrating Masters in Psychopharmacology training here) and Broad Clinical Experiences commensurate both in time and scope with Physician Assistant Training. Subsequent supervised clinical training in prescribing psychotropic medications in the primary care setting shall be competency based education and meet minimum standards related to time and experience.

4. The Oregon Medical Board shall report to the Oregon Legislature every biennium on the status of the program, including number of psychologist prescribers in both urban and rural areas.

Thank you very much for taking the time to understand and consider the significant ramifications of this bill and alternate strategies to improving access to care in Oregon.

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Executive Committee Member

Oregon Councel of Child and Adolescent Psychiatry