June 13, 2017

Testimony against Oregon HB 3355 to the

Joint Committee On Ways and Means SubCommittee On Education

To: CoChairs Senator Rod Monroe and Representative Barbara Smith Warner,

Senators Arnie Roblan and Chuck Thomsen, and

Representatives Diego Hernandez, John Lively, Julie Parrish, and Gene Whisnant:

Testimony submitted by Maureen C. Nash, MD, MS, FAPA, FACP.

Diplomate, American Board of Internal Medicine,
Diplomate, American Board of Psychiatry and Neurology,
Fellow of the American College of Physicians,
Fellow of the American Psychiatric Association (APA),
Affiliate Assistant Professor of Psychiatry, Oregon Health and Sciences University,
Member APA Council on Geriatric Psychiatry.

I am the Former Chair of the American Association for Geriatric Psychiatry Clinical Practice Committee and the Former Medical Director of the Tuality Center for Geriatric Psychiatry. Currently I serve as the Medical Director of Providence ElderPlace Oregon, a Program of All-Inclusive Care for the Elderly. I serve on the Oregon Partnership to Improve Dementia Care, the OHA/DHS Older Adult/People with Disabilities Behavioral Health Advisory Council and on the State Plan for Alzheimer's Disease and Related Dementias in Oregon.

Today I am speaking for myself as an internal medicine physician and a geriatric psychiatrist as well as a very concerned citizen of the great state of Oregon and an advocate for those with mental illness and other behavioral disorders. I am not speaking on behalf of any other entity.

This is not a guild issue nor about various professionals fighting over turf. This is really about the safety of very vulnerable citizens-those with concerns about how their brain is functioning and seeking safe effective relief from mental suffering due to mental illness. I have supervised and worked with adult/family/geriatric/psychiatric mental health nurse practitioners, physician assistants, as well as students in these fields and medical residents. I have worked with and supervised PharmD's and social workers. I have worked with psychologists but have not been in a supervisory role with them. I have great respect for the skills of those in all of these professions and refer to them when appropriate and when they are available. It has been extremely difficult to find any psychologists who are willing to work with older adults and accept Medicaid or even Medicare. I would hate to see this shortage worsened by people leaving psychotherapy practice to prescribe medications.

Thank you for allowing me this opportunity to testify against HB 3355.

***Oregon has a shortage of mental health providers at all levels*.** This shortage is especially keen in the rural areas of the state. The Oregon Health Authority's Addictions and Mental Health Services supports the **OPAL – K** program in collaboration with Oregon Health and Science University (OHSU), Oregon Council of Child and Adolescent Psychiatry (OCCAP) and the Oregon Pediatric Society (OPS). OPAL-K provides free, same-day, Monday through Friday,

child psychiatric phone consultation to primary care providers in Oregon. The program expands the availability of high-quality mental health treatment to Oregon youth via timely psychiatric consultation, medical practitioner education, and connections with mental health professionals throughout the state. OHA has worked with OHSU to develop **Project ECHO** (Extension for Community Healthcare Outcomes) to provide consultations to rural, frontier and underserved communities in Oregon first for adult mental health then around children's mental health issues. OHA is currently hoping to move forward with a similar service for geriatric psychiatry consultations. Project ECHO (Extension for Community Healthcare Outcomes) is an evidence-based tele-mentoring model. Primary care providers learn from specialty providers over a live video conference. These are proven established programs that offer safe, well trained, knowledgeable clinicians to provide mental health care and/or to train primary care providers to do so with adequate access to assistance. It is not only prescribers that are in short supply though.

There is a shortage of trained psychotherapists and psychologists in these same areas as well. This bill will not increase the number of people who can treat those with mental illness, it only changes highly trained therapists into inconsistently trained prescribers. There is no reason to think that psychologists would move to rural, frontier or underserved areas. There is no evidence this has happened in the few states that have allowed psychologists to prescribe medications*. **OHA and others are actively working to increase access to quality mental healthcare in rural, frontier and underserved areas.***

Challenges with the training alluded to in HB 3355:

The bare bones proposal in HB 3355 is not based on a model of care with a significant evidence base. In fact, it is asking for a volunteer group of individuals who may have little or no training in designing sophisticated training programs to do exactly this. The military spent a number of years and over $600,000 per person to train psychologists to prescribe psychiatric medications. This program was shut down for a number of reasons. This program essentially provided the equivalent of 2 years of medical school training then years of training with primary care providers and psychiatrists. They only treated relatively healthy members of the armed services between the ages of 18 and 65. My late colleague Scott Armstrong, MD was one of the psychiatrists supervising several of these psychologists at Walter Reed Army Medical Center. He had grave concerns after observation and training them about their ability to learn and utilize the medical model and medical thought process needed to prescribe and monitor medications as well as knowledge on how to use and interpret the laboratory and other tests needed for safe prescribing. Because he unexpectedly died a few days after we had spent several hours reviewing his experiences and concerns in 2010, the conversations remain fresh in my mind. He reported several specific instances and examples of problems to me. Once, they were consulted for a "depressed" patient. The psychologist could not recognize the severe thyroid disease that was leading to the symptoms. Notably, the internist also missed this and that is why they consulted psychiatry. The psychologist told Scott – "they consulted us for depression so we should prescribe Prozac." He failed to grasp all the many medical illnesses which can mask as depression or to understand how to think about this diagnostically because he had not had any medical training though he had spent several years (many more hours than is proposed in this legislation) in study. Very few people were ever trained or worked as psychologists who prescribe in the military.

There is a clear confusion in the media and the public about the difference between a psychologist (PhD or PsyD) and a psychiatrist (MD or DO). I believe that this confusion leads

people to believe the 2 professions are similar in training and experience. That is not accurate in any way. A PhD in psychology is usually a 3-6-year program after a bachelor's degree. Medical school training is 4 years in medicine and surgery while psychiatric residency is 4 additional years which include between 6-12 months of internal medicine and neurology training. The content of the 2 types of training have little in common. The types of thought processes that are required for these roles have little in common. They are very different skill sets. I spent approximately 8000 hours in patient care and training while in medical school and over 25,000 hours in patient care in residency. I saw thousands of patients every year and followed hundreds in my primary care and adult, child, and geriatric psychiatry clinics. Family medicine and other primary care disciplines have similar training. I am sure that those in a PsyD program or a PhD program in psychology also have hundreds of patient contacts. But these contacts are in individual, group or family therapy sessions and in neuropsychological testing.

To successfully practice medicine, the most important thing is to be able to realize when I do not know enough at this moment for this patient, to recognize when I do not know what I need to know. This key skill is learned in medical school and refined in residency. It is also learned, albeit differently, by registered nurses. This skill is why RNs can become safe prescribers as nurse practitioners. This skill requires thousands of hours of patient care. It allows us to call for assistance or send a patient to a colleague with the correct training and experience

Psychologists may have a better skill set for the diagnosis of some mental illnesses then a family medicine doctor. I have not seen direct evidence of the difference on this point. However, the skill set they need to safely prescribe is around all the other areas involved in medical care. Knowledge about medications, renal and hepatic metabolism of medications, how medications affect heart rate, blood pressure, blood glucose levels, bone marrow production etc. That is why a physician assistant program is a much safer route to becoming a prescriber then an online course tailored to and run by psychologists. It is not the specialization in psychopharmacology that is the central part of the challenge, it is the effects of all medical interventions on all organs of the body as well as easily and quickly differentiating between a side effect, the worsening of the underlying mental illness or the occurrence of a new illness. The reason that American Board of Psychiatry and Neurology is responsible for both specialties is because every neurological disease can present with psychiatric symptoms and vice versa. One third of board questions on the Psychiatry certification exams are neurological and likewise one third of board questions on the Neurology certification exams are psychiatric. It is not just the finding of mental illness but also the exclusion of all other types of illnesses that is essential for safe prescribing and treatment.

About modern medical education in the US

Medical education in the US developed into the current system after the Flexner Report was published in 1910 under the aegis of the Carnegie Foundation. Prior to the Flexner Report, there was no standard curricula, method of assessment, nor requirements for admission or graduation in US medical schools. US medical schools were not affiliated with a college or university. Laboratory work and hands on training across multiple disciplines was not required. Regulation by state governments was minimal or nonexistent. Instructors were local doctors teaching part-time and had varied training themselves. Medical education and residency training has been based on and evolved from the findings in this seminal work. This is what has produced the American medical education system which is viewed as one of the best in the

world. The training outlined in HB 3355 has striking similarities to the medical education system prior to the Flexner report.

Dr. Ajit Jetmalani, a child psychiatrist, submitted testimony on 4/5/2017 that outlined basic requirements for educating psychologists in a modified Physician's Assistant (PA) program to safely prescribe. I do not know if he was aware that the program of study he described follows in the mold of the Flexner Report, but clearly he understands how modern medical education is designed. The program outlined in this bill does not an evidence base supporting it and having each individual submit their own training program with the committee having extremely tight deadlines for approving or denying them would take medical education back over 100 years. The military training for psychologists was much more robust, structured and supervised then what is described in HB 3355.

Concerns about some of the information provided by the Oregon Psychological Association and about the language in the bill:

A diagram entitled "Education and Training to Prescribe in Oregon" would lead you to believe that a psychologist who is licensed to prescribe would have several more years of education and training around prescribing then do physicians. This is clearly untrue and makes me wonder about the veracity of any claims they may make.

Also, the language in the bill is unusual. They chose to call the new discipline they are creating "prescribing psychologists" then rename physicians as "prescribing physicians." This creates the mental illusion that the two professions are equivalent. One does not need to refer to physicians as prescribing physicians. All physicians have a license to practice medicine and surgery which includes prescribing medications among many other treatments. Neither trying to mislead people about the years spent training nor trying to set up a false equivalence with language is essential to the argument at hand. If the rationale for the bill is sound, it should be judged on its merits, not by trying to mislead people.

Concern about the populations HB 3355 covers:

Treating children, pregnant/nursing mothers and geriatric patients as well as those with complex medical conditions requires many years of experience gathered under close supervision. Suggesting that 3 months of any type of training would be sufficient is alarming. What evidence suggests this would be safe? Waiting until someone in one of these categories is seriously injured or killed before deciding more training is needed is not acceptable. Discerning between delirium, dementia, geriatric depression with executive dysfunction, cognitive symptoms of respiratory or cardiac illness or medication side effects is quite difficult. The training program outlined in the bill and described in the literature is nowhere near sufficient. How can one even begin to master this with 3 months of training? In residency, an intern I was working with nearly killed a woman with a single dose of 0.25 mg of lorazepam. This would be a trivial dose for most people but not given her other health conditions. Because the intern was still in training (only his 5th year), the patient was in a position where we could do rapid interventions to prevent a tragedy. Are you willing to expose vulnerable Oregonians to this type of risk?

Concern about allowing the Board of Psychologists to oversee prescribers:

In the few states that have implemented this new discipline of psychologists who prescribe despite the nature of their original training there have been a number of different models. I am quite concerned about putting oversight of this program under the Board of Psychology rather

than the Oregon Medical Board which oversees physicians and physician's assistants. Nurse practitioner's are currently under the Board of Nursing. In Iowa, they placed supervision of this new discipline of prescribing psychologist's under the Board of Medicine. In Louisiana, this group of people originally were regulated by the Board of Psychology but after a few years of experience, this was changed. I would strongly advocate for the Oregon Board of Medicine having supervision and oversight. The Oregon Medical Board has experience with oversight of physicians, medical assistants and physician assistants. The oversight of malpractice and monitoring of prescriber's has minimal overlap with the current oversight the Board of Psychology performs because of the vastly different roles/jobs involved. This is not a small addition to the treatment options for psychologists but it is adding significant new safety risks for citizens and a significant new responsibility to the psychologists who choose this new profession.

Details about the military prescribing training and program used for psychologists:

In April 1997, the US General Accounting Office filed a report GAO/HEHS-97-83 entitled: Defense health care: Need for more prescribing psychologist is not adequately justified. Tenderness program psychologists did not prescribe independently. They were supervised by psychiatrists. Below are excerpts from their report

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> The role of psychiatrists and clinical psychologists in meeting the MHSS medical readiness mission is to provide mental health care that helps military active-duty personnel perform their duties before, during, and after combat or some other military operation. Both psychiatrists and clinical psychologists, whether in the military or civilian sector, provide a variety of mental health services, some of which are similar. Both can diagnose mental conditions and treat these conditions with psychotherapy. A degree in medicine is required to practice psychiatry, however, so psychiatrists may treat mental disorders medically, that is, with medication. **Because medical training is not required to practice clinical psychology, psychologists are not qualified to prescribe medication. (emphasis mine)**
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> To practice medicine, psychiatrists complete 4 years of medical school and a 1-year clinical internship during which they are trained to evaluate and treat all types of organic conditions and to perform general surgery. After this, they complete a 3-year psychiatric residency during which they learn to evaluate and treat mental conditions and the organic conditions associated with them. Because psychiatrists practice medicine, they can diagnose organic as well as mental conditions and treat each with medication. They consider a full range of possible organic causes for abnormal behavior when diagnosing a condition. Therefore, they can distinguish between mental conditions with an organic cause, such as schizophrenia and bipolar disorder, and organic conditions, such as diabetes and thyroid disease, which have symptoms that mimic a mental disorder. Organic mental disorders are best treated through a combination of medication and psychotherapy, according to DOD officials.
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> Clinical psychologists, on the other hand, practice psychology, not

medicine. Typically, they complete 6 years of graduate school leading to a doctoral degree and 1 to 2 years of postdoctoral clinical experience. Clinical psychologists are trained in theories of human development and behavior, so their general approach to diagnosing and treating mental illness is psychosocial rather than medical. They are trained to diagnose and treat all mental conditions and rely on the behavior a patient displays to diagnose these conditions.

…

The Army's Office of the Surgeon General was tasked with designing and implementing the PDP. A blue ribbon panel was formed by the Army Surgeon General in February 1990 to determine the best method for implementing the PDP. After considering various models, the panel endorsed a training model that included course work at the Uniformed Services University for the Health Sciences (USUHS). In February 1991, the Chairmen of the Senate and House Subcommittees on Defense of the respective Committees on Appropriations then recommended that DOD develop a 2-year training model for the PDP in accordance with the panel's recommendations. DOD later formed a committee to develop a suitable training program to provide clinical psychologists with the knowledge required for safely and effectively using a limited list or formulary of psychotropic medication. This committee recommended a special 3-year postdoctoral fellowship program for the PDP with (1) 2 years of course work at USUHS, followed by (2) 1 year of clinical experience at Walter Reed Army Medical Center.

This training began in August 1991 with four participants. For subsequent classes, however, the PDP consisted of 2 years of training—1 year of classroom and 1 year of clinical training. Classroom training included courses at USUHS in subjects such as anatomy, pharmacology, and physiology. PDP participants' clinical experience took place on inpatient wards and outpatient clinics at Walter Reed Army Medical Center in Washington, D.C., or the Malcolm Grow Medical Center at Andrews Air Force Base in Maryland. There, participants were trained to take medical histories and incorporate them into treatment plans and to prescribe medication for patients with certain types of mental disorders. After their clinical year, participants received a certificate of "Fellowship in Psychopharmacology for Psychologists" and became known as"prescribing psychologists."

Once PDP participants graduated from training, they completed 1 year of supervised or proctored practice; their respective services assigned participants to military medical facilities for this 1 year of practice. These facilities authorized participants to prescribe a specified formulary of psychotropic drugs. Although the medical education received under the PDP qualified clinical psychologists to treat mental conditions with medication, it was less extensive than psychiatrists' medical training. Therefore, the MHSS limits prescribing psychologists' scope of practice. **They may only treat patients between the ages of 18 and 65 who have mental conditions without medical complications as determined by their**

supervisors. (emphasis mine)

ACNP helped develop and evaluate the PDP. ACNP is a professional association of about 600 scientists from disciplines such as behavioral pharmacology, neurology, pharmacology, psychiatry, and psychology. ACNP's principal functions are research and education. It conducted several assessments of the PDP under contract to the Army and made a number of recommendations on the project's goals and implementation. One of them was for DOD to establish a PDP Advisory Council to help develop criteria and procedures on implementing the PDP. DOD established this council in 1994.

The American Psychiatric Association, American Psychological Association, and literature on this topic have noted the possible advantages or disadvantages of allowing psychologists in the civilian sector to prescribe medication. One article has suggested that training psychologists to prescribe psychotropic medication could be particularly beneficial if they were permitted to practice this skill in clinical settings such as nursing homes, mental institutions, or medically underserved areas. Some have suggested that using prescribing psychologists could reduce the cost of care and maintain the continuity of patient care by eliminating the need to switch patients from psychologists to psychiatrists when drug therapy is indicated. On the other hand, because prescribing psychologists would receive only partial training in medicine, some are concerned about the quality of care these psychologists would be able to provide.

…

The duration, content, and sequencing of PDP training continued to change after the project began. Originally, PDP training was intended to last for 2 years and consist of both course work and clinical experience during each year. **An additional year of clinical experience was added for the first class after it began the program, however, because the participants were not receiving enough clinical experience (emphasis mine)**. Subsequent classes received 2 years of training as originally planned: the first dedicated exclusively to course work at USUHS, the second, to clinical practice.

In addition, the curriculum content and sequencing of the courses changed after the project began…. The panel said at that time that the curriculum needed to be thought through more thoroughly, using the final scope of practice and formulary as a starting point. The panel also noted that assessing the adequacy of the curriculum was difficult because it changed frequently. The panel saw a need for a well-organized, structured approach to the design of courses as well as the selection of participants. It recommended
at that time that unless the MHSS addressed these concerns satisfactorily, the project should end.

…

The MHSS has not decided who should supervise prescribing psychologists. In 1994, the MHSS decided that after prescribing psychologists had

> completed their clinical year, they would spend the next year practicing under a psychiatrist's supervision. The MHSS originally anticipated that these psychologists would ultimately function independently. All of the PDP graduates, however, continue to practice under the supervision of a psychiatrist, and whether they will ever prescribe independently is unclear.
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> [Reportedly, now several psychologists may have independent prescribing practices at the current time-see below]

A June 13, 2017 blog post in Navy Medicine Live accessed 6/13/2017 at http://navymedicine.navylive.dodlive.mil/archives/7867 indicates that there are currently 2 active duty psychologists who are prescribing currently though there are reportedly four more in training. According to this blog post the Navy has produced more psychology prescribers than any other branch of the military.

Conclusions:

In summary, I am very concerned about the safety of Oregonians. I believe that subjecting those with mental illness to be the only group of people who are prescribed psychoactive medications outside of the medical/nursing sphere is discriminatory. Psychologists have multiple avenues to pursue the ability to safely prescribe. They do not need a special one for themselves only. Following a plan like the one outlined by Dr. Jetmalani is quite different from what is in the current bill but would allow the development of a curriculum that is more evidence based and would allow those following it to become safe prescribers as Physician Assistants.

I ask you to consider the above points and to not send this bill out of your subcommittee.

Sincerely,

Maureen Nash, MD, MS, FACP, FAPA

REFERENCES:

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