15.0348.02000

FISCAL NOTE
Requested by Legislative Council
01/14/2015

Bill/Resolution No.: HB 1272

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues		$500		$500		$500
Expenditures		$10,000		$5,000		$5,000
Appropriations						

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

Establishes prescriptive rights for psychologists.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Requires State Board of Medical Examiners to develop rules for annually certifying and disciplining medical psychologists. Note is based on certifying five medical psychologists. Costs of $5,000.00 are for database development and rules publishing in the first biennium. $5,000.00 per year thereafter for apportioned staff time.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

Assuming certifying 5 medical psychologists and charging $100.00 per certification.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Note is based on certifying five medical psychologists. Costs of $5,000.00 are for database development and rules publishing in the first biennium. $5,000.00 per year thereafter for apportioned staff time.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

Name: Duane Houdek
Agency: State Board of Medical Examiners
Telephone: 701.328.6500
Date Prepared: 01/25/2015

2015 HOUSE HUMAN SERVICES

HB 1272

2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1272
1/28/2015
Job #22768

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

Certification of medical psychologists.

Minutes: See Testimony 1-20

Chairman Weisz opened the hearing on HB 1272.

Rep. Alan Fehr: From District 36 introduced and supported the bill. (See Testimony #1)

15:55
Chairman Weisz: When there becomes an issue who is in charge of what?

Rep. Fehr: They are licensed under the board of psychology examiners as psychologists with their authority to practice psychology through that board. The licensure through the board of medical examiners is strictly for the prescription side of it.

Chairman Weisz: If there is an issue that comes up, how do you decide which board jurisdiction over that individual?

Rep. Fehr: If there is a complaint or allegation filed, I assume it would go to one of the boards. If it is relating to prescriptions it would go to the board of medicine. If it relates to the practice of psychology it would go to the board of psychology.

Rep. Mooney: To become a certified psychiatrist with the capability of prescriptions they have to go through medical school training. Is that correct?

Rep. Fehr: Yes. Psychologists are medical doctors who have gone through medical school.

Rep. Mooney: A psychologist has the proper training for the psychiatry aspect of that without going through the medical school process.

Rep. Fehr: They would be required to complete a training program that is approximately two years and then a supervised practice which is approximately two years and take a

national exam. The rules would be developed by the board of medical examiners. They will have to have a collaborative agreement with a physician in their primary care setting.

19:37
Mike Tilus: Medical Psychologist testified in support of the bill. (See Testimony #2) (Handout #3) (Handout #4)

47:15
Paul Kolstoe: A licensed psychologist testified in support of the bill. (See Testimony #5)

50:30
Anthony Tranchita: A U.S. Public Health Service Officer testified in support of the bill. (See Testimony #6)

59:23
Rep. Rich Becker: With the overwhelming support data and personal experiences can you offer a personal statement on why it has taken so long to get this process going?

Tranchita: In many states there are few of us that show up in support and many show up who are against it.

Rep. Fehr: Can you talk about your training? You mentioned your master's degree that was from Alliant. Can you talk about Alliant and other programs around the country you may be aware of?

Tranchita: There are 5 programs, Alliant International University is where I choose to do mine and it is in San Francisco, CA. Dickinson University in New Jersey, Nova Southeastern in Florida, New Mexico State University and a program in Hawaii. I n terms of what is offered, in my case I had to do everything long distance. Two days every three weeks were listing to course and engaging in course work. Those courses took about two and half years to complete. I believe if you do that as a full time student it takes about a year to complete.

Rep. Fehr: Once you have that you then you have a period of supervised experience. Could you describe that?

Tranchita: There is an 80 hour medical experience of working in a family practice clinic with a family practice doctor. Then we had to have 100 patients and 400 hours supervised patient contact supervised by a physician. It took me 2 years to complete that. Every change in medication and prescriptions I wrote had to be co-signed by the physician at that point and time. I think that was more an Air Force driven rule which worked out fine. In the end I had to submit paper work on all of those patients and all of our supervision hours to the board of New Mexico.

1:05
Bonnie Staiger: Representing the ND Psychological Association testified in support of the bill. (See Testimony #7)

OPPOSITION

1:07
Duane Houdek: Executive Secretary to the ND State Board of Medical Examiners. Referred to the testimony he handed in of Dr. Robert Olson a psychiatrist practicing in Fargo in opposition of the bill. (See Testimony #8) This bill would divert psychologist from their highest and best use. The one in which they are best trained; that is to provide much needed expert psychotherapy to prescribing which is perhaps their least. The question is, is it the best use of this resource. Our position is that it clearly is not. This is not a turf war. It is a matter of training. You don't replace years of training with two years of training on line. There was talk of no complaints and no one being disciplined. You will notice that most are practicing in the federal system. I've had problems with regulations in the federal from a licensing standpoint. You can get a license anywhere in the country and then practice anywhere in the federal system. A Florida doctor practices in ND. How closely is Florida actually watching that physician? To say we would just accept this slice of a practice and say that is our only reach; that would be inconsistent with the way we do business. I don't think it would be good for the public safety. If we are involved and it involves prescribing, we would have to govern the entire package.

Rep. Fehr: If the bill goes through just the way it is and goes into law, what would be the response of the medical board?

Houdek: If it is a law, we will follow the law, we will do it. We would write the rules and I don't think the exams these gentlemen were talking about would meet the board's approval. I don't know if the drug exam from the American Psychological Association is in anyway equivalent to the pharmacology exams that occur from the USMLE or from the physician assistant certification process. I can't tell you if the board would accept their 100 patients or 400 hours.

Rep. Rich Becker: I appreciate your point of view. After listening to these two gentlemen there is serious medical training to get to where they are today, but I also see a matter from the heart and a willingness to serve underserved areas and particularly in Reservation areas. We don't have enough people that are willing and have adequate training to service all the people that need help. If 1274 is approved it certainly is going to encourage more people to become available in underserved areas. If you have a comment on that, I would appreciate hearing it.

Houdek: Whenever there is a shortage of access the temptation is to broaden or lower the standards. Get more people in the game. I don't think that is the answer here.

1:23
Courtney Koebele: Represented both the ND Psychiatric Society and the ND Medical Association testified in opposition to the bill. (See Testimony #9)

1:26
Rachel Fleissner: A medical doctor testified in opposition to the bill. (See Testimony #10)

1:31
Rep. Oversen: Do you have to be licensed in psychiatry or have that additional training to prescribe medications or can a general practitioner prescribe also?

Fleissner: With a medical degree you can prescribe medications.

1:32
Rachel Fleissner: Read the testimony of Dr. Cheryl Huber testified in opposition of the bill. (See Testimony #11)

1:34
Gabriela Balf-Soran: Testified in opposition to the bill. (See Testimony #12)

1:40
Laura Kroetsch: A psychiatrist and medical director of the ND human service centers testified in opposition to the bill. (Testimony #13)

1:48
Kevin Damon: Child Adolescence Psychiatry at St. Alexius Medical Center in Bismarck testified in opposition to the bill. Went through all of the process to become a psychiatrist. Compared his brother-in-law who is a Navy Seal and the requirements to be one and what would happen if they loosened those requirements with a psychiatrist's requirements vs the psychologist's. The two Bismarck hospitals have hired more child psychologists. Stated suicide rate went down on reservation when he worked there. His point was there is no comparison of the education and training he went through with what the psychologist do to prescribe medications. He urged the committee to vote no on the bill.

1:57
Dan Hannaher: Sanford Health stands in opposition to this bill.

Carlotta McCleary: Executive Director of Mental Health America of ND testified in opposition to the bill. (See Testimony #14)

Chairman Weisz closed the hearing.

Handed in Testimony in Opposition

Dr. Saul Levin: In opposition of the bill. (See Testimony #15)

Dr. James Madara: In opposition of the bill. (See Testimony #16)

Jon C. Ulven, PhD., L.P.: In opposition of the bill. (See Testimony #17)

Handed in Testimony in Support

Harlan AJ. Gilbetson: Licensed psychologist in support. (See Testimony #18)

David Shearer, Phd: Prescribing psychologist in support. (See Testimony #19)

Glenn A. Ally, Ph.D, M.P.: Medical psychologist in support. (See Testimony #20)

2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1272
2/16/2015
Job # 23923

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Marlys Kienzle

Minutes: Attachment #1

Chairman Weisz: Let's look at HB 1272.

Rep. Fehr: (Distributed amendment 02002. Attachment #1)
What this is doing by turning it into a Study is address the concerns what Licensor Board this may fit under and to review it and get an opinion. This is converting the Licensor into a study under the School of Medicine and Health Sciences Advisory Council. They have agreed to do the study through an interim bases.

Chairman Weisz: Is that a motion?

Rep. Fehr: Yes. I move amendment 02002.

Chairman Weisz: I see this is a Study.

Rep. Rich Becker: Second.

Rep. Fehr: Since this is not asking Legislative Management to study it, they would only receive a report. So it would only be a shell study.

Rep. Rich Becker: Is there cost to the Medical School to conduct this study?

Rep. Fehr: This is a council that regularly meets now, so they would take this on additionally, on quarterly bases.

Rep. Mooney: The School of Medicine and Health Sciences Advisory Council, were they in agreement with this process?

Rep. Fehr: This was suggested to me by the Director, Dr. Winn.

Voice Vote Carried

Rep. D Anderson: Made a motion of DO PASS AS AMENDED for 1272

Rep. Mooney: Seconded the motion.

DO PASS AS AMENDED VOTE YES 12 NO 1 ABSENT 0

Carrier is Rep Overson.

15.0348.02002
Title.03000

Prepared by the Legislative Council staff for
Representative Fehr
February 13, 2015

2/17/15

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1272

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a report to the legislative management regarding medical psychologist licensure.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. SCHOOL OF MEDICINE AND HEALTH SCIENCES ADVISORY COUNCIL - STUDY OF MEDICAL PSYCHOLOGIST LICENSURE - REPORT TO LEGISLATIVE MANAGEMENT. During the 2015-16 interim, the university of North Dakota school of medicine and health sciences advisory council shall study the feasibility and desirability of licensing medical psychologists. The study must include evaluation of whether licensure of medical psychologists would integrate behavioral health into primary care and whether the practice of medical psychology would result in safe and effective treatment of patients with behavioral health concerns. If the school of medicine and health sciences advisory council determines it is feasible and desirable to license medical psychologists in this state, the study must include consideration of licensure requirements, scope of practice, which licensure board would be best suited to license medical psychologists, and terminology. Before July 1, 2016, the school of medicine and health sciences advisory council shall report the outcome of the study, recommendations, and related proposed legislation to a legislative management committee charged with studying human services-related topics."

Renumber accordingly

Date: 2-16-15
Roll Call Vote #: 1

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES 1272
BILL/RESOLUTION NO.

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15. 0348.02002

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Fehr Seconded By Rich Becker

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz			Rep. Mooney		
Vice-Chair Hofstad			Rep. Muscha		
Rep. Bert Anderson			Rep. Oversen		
Rep. Dick Anderson					
Rep. Rich S. Becker					
Rep. Damschen					
Rep. Fehr					
Rep. Kiefert					
Rep. Porter					
Rep. Seibel					

Motion Carried

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-16-15
Roll Call Vote #: 2

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES 1272
BILL/RESOLUTION NO.

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15.0348.02002

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By D Anderson Seconded By Mooney

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz	✓		Rep. Mooney	✓	
Vice-Chair Hofstad	✓		Rep. Muscha	✓	
Rep. Bert Anderson	✓		Rep. Oversen	✓	
Rep. Dick Anderson	✓				
Rep. Rich S. Becker	✓				
Rep. Damschen	✓				
Rep. Fehr	✓				
Rep. Kiefert		✓			
Rep. Porter	✓				
Rep. Seibel	✓				

Total (Yes) 12 No 1

Absent 0

Floor Assignment Rep. Oversen

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1272: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (12 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). HB 1272 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a report to the legislative management regarding medical psychologist licensure.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. SCHOOL OF MEDICINE AND HEALTH SCIENCES ADVISORY COUNCIL - STUDY OF MEDICAL PSYCHOLOGIST LICENSURE - REPORT TO LEGISLATIVE MANAGEMENT. During the 2015-16 interim, the university of North Dakota school of medicine and health sciences advisory council shall study the feasibility and desirability of licensing medical psychologists. The study must include evaluation of whether licensure of medical psychologists would integrate behavioral health into primary care and whether the practice of medical psychology would result in safe and effective treatment of patients with behavioral health concerns. If the school of medicine and health sciences advisory council determines it is feasible and desirable to license medical psychologists in this state, the study must include consideration of licensure requirements, scope of practice, which licensure board would be best suited to license medical psychologists, and terminology. Before July 1, 2016, the school of medicine and health sciences advisory council shall report the outcome of the study, recommendations, and related proposed legislation to a legislative management committee charged with studying human services-related topics."

Renumber accordingly

2015 SENATE HUMAN SERVICES

HB 1272

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1272
3/23/2015
25231

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill to provide a report to the legislative management regarding medical psychologist licensure

Minutes:

Attach #1: Testimony by Rep. Alan Fehr
Attach #2: Written Testimony by Glenn A. Ally
Attach #3: Written Testimony by David Shearer
Attach #4: Written Testimony by Mike Tilus
Attach #5: Written Testimony by Harlan Gilbertson
Attach #6: Written Testimony by American Psychiatric Assocation - Saul Levin
Attach #7: Written Testimony by Harjinder Virdee
Attach #8: Testimony by Bonnie Staiger
Attach #9: Testimony by Courtney Koebele
Attach #10: Testimony by Dr. Ron Burd
Attach #11: Testimony by Cr. Cheryl Huber
Attach #12: Testimony by Carlotta McCleary
Attach #13: Powerpoint Presentation by Dr. Gabriela Balf

Representative Alan Fehr introduced HB 1272 to the Senate Human Services Committee. Representative Fehr provided five attachments:

- Testimony by Representative Alan Fehr (attach #1)
- Written testimony by Glenn A. Ally, Ph.D., M.P. (attach #2)
- Written testimony by David Shearer, PhD (attach #3)
- Written testimony by Mike Tilus, Medical Psychologist (attach #4)
- Written testimony by Harlan J. Gilbertson, MS PsyD MSCP LP (attach #5)

(17:50)
Senator Warner asked can you compare the pharmacological training that the prescribing psychologist received regarding quantity relative to a medical doctor.

Representative Fehr indicated a medical doctor is someone who has gone through a medical school and is licensed to practice general medicine. They have received pharmacological training because they are licensed to practice a very wide range of medications and treat a wide range of conditions.

Senator Warner commented that the human body has integrated systems and not just psychological ones. Would it be useful to have some information about how a psychotropic drug might interfere with something else going on in the body?

Representative Fehr stated one of the essential parts of looking at this licensure is they are not in a clinic operating on their own; they are in a primary care clinic in a collaborative practice agreement working with physicians who have had that broader training.

Senator Warner asked why would they need the prescribing authority for psychotropic drugs if they are already working with a physician who had that ability as well, and it is a collaborative practice.

Representative Fehr answered we don't have behavioral health in primary care clinics today. There are some places where they do have psychologists or social workers or someone. If this licensure was in existence, clinics would be much more likely to hire and put these behavioral health professionals in their clinics because they would be seen as having more to offer. The authority to prescribe medications is also the same authority to take them off of medications. Compared to other medical providers, medical psychologists are probably somewhat less likely initially put somebody on a psychotropic medication, but in fact may try something else, or may even take them off of medication. They still do prescribe, but they also have the authority and background to look at other options.

Chairman Judy Lee referred to Representative Fehr's handout, which is a chart that talks about various professions and how much training they have in this area, which continues to point out how important pharmacists are in this loop.

Senator Howard Anderson, Jr. asked how a PhD psychologist practices now. Who is he licensed under now?

Representative Fehr responded there is a board of psychology examiners that licenses psychologists, industrial organizational psychologists, behavioral analysts, but it does not license school psychologists.

Senator Howard Anderson, Jr. commented that a couple of letters that you have submitted along with your testimony are not just from PhD psychologists but also advanced practice clinical psychologists who have taken additional training. How do you look at that comparing with licensing all psychologists to prescribe and only the advance practice ones that we have a letter from?

Representative Fehr answered there is no effort to license all psychologists to prescribe medication. The medical psychologist is only for those psychologists who go through the additional training.

Senator Dever commented that Representative Fehr mentioned 3 different medical psychologists practicing in North Dakota. In the absence of regulation in North Dakota, are they then subject to regulation from the states in which they are licensed?

Representative Fehr responded yes. To work in the federal systems, you have to be licensed someplace. So then you are under that licensure. You get psychologists who get the medical psychologist licensure, for example in New Mexico, and then have to follow their law and maintain their licensure there. Under that that law, the prescriptive part that they do here on reservations or federal land.

V. Chairman Oley Larsen asked if a nurse practitioner can prescribe certain medications now, such as Zolaf?

Representative Fehr confirmed yes.

Chairman Judy Lee stated there is a specialty certification for advanced practice nurses in psychiatric care behavioral health care as well.

Bonnie Staiger, representing the North Dakota Psychological Association, testified IN FAVOR of HB 1272 (attach #8) (25:00-26:49)

Chairman Judy Lee stated that she has great confidence in the advisory council for the medical school, but is the fox guarding the henhouse in this situation. Are we asking a medical model advisory council to decide what a psychological / counseling model should have? I'm not saying they shouldn't do it. Perhaps there should be other people included and that the advisory council would be requested to include a representation of others as well, and not just the physicians.

Ms. Staiger supported that the advisory council will likely recommend a procedure at which that will be promulgated. She deferred to Representative Fehr, as he has served on the state board for psychologist examiners, and he may be able to provide additional insight on how they go about.

Chairman Judy Lee stated her concern is not about the board of psychologist examiners so much as it is the fact that the advisory council for the medical school is the one who is told to do the survey. She does want the expertise there, but as Representative Fehr stated in his testimony, there are really two models of treatment. We are looking at more of a receptive attitude about integrating some of these things particularly with our huge workforce challenges that we have in the state and all over the country. Do you think it would be appropriate to consider including but not limited to representation on the task force that would allow someone from your organization to participate or the board or other entities that would be very familiar with that area of care?

Ms. Staiger responded absolutely, and she can't imagine they would pursue the charge without having those folks at the table. Not necessarily the North Dakota psychological association but certainly the state board of psychologist examiners, and probably bring in medical psychologists from other areas to consult.

Chairman Judy Lee asked if there was any discussion in the House on this?

Ms. Staiger responded that the conversation never got that far.

Chairman Judy Lee made it clear that she has confidence in the advisory board.

Senator Warner asked if this council has legislators on it.

Chairman Judy Lee responded yes, four: Senator Mathern, Senator Kilzer, Representative John Nelson, and Representative Delmore.

Senator Warner mentioned that it seemed relevant if medical decisions within a political arena that it makes sense to have legislative representation.

OPPOSITION TO HB 1272
Electronic testimony IN OPPOSITION was received by:
- Saul Levin, M.D., MPA, American Psychiatric Association (attach #6)
- Harjinder Virdee, M.D. (attach #7)

Courtenay Koebele, representing North Dakota Psychiatric Society, testified OPPOSED to HB 1272 (attach #9)(32:20-34:09)

Dr. Ron Burd, a psychiatrist, testified in OPPOSITION to HB 1272 (attach #10)(34:45-43:01)

Chairman Judy Lee asked why is it a bad idea to study something. Why wouldn't we want to find out that it wouldn't be a bad idea? Chairman Judy Lee is also very knowledgeable about the Schulte report.

Dr. Burd stated just because you can do something doesn't mean you should do something. It has been done before in other locations and it was decided not to move forward. There are things that can be done, UND school medicine, expanding our residency, creating more slots, working on the telemedicine and tele-psychiatry regulations as board of medical examiners are doings, and making sure that we can reach out get out the technology safely and effectively distributed across the state.

Chairman Judy Lee was here when Nurse Practitioners were part of the devil. This year we've had some blood in the room with dentists, and also athletic trainers, physical therapy, occupational therapists, Licensed Marriage and Family Therapists, Podiatrists, etc. We have a large amount of silos with specific scopes of practice which are making sure that the folks who are licensed in whatever the field is, are meeting the criteria for that field. Both the orthopedic person and the podiatrist can actually work on the leg. This is not a new conversation for this committee that there will be disputes among professions because each of them thinks they are the only one who can do something. Psychologists and psychiatrists each have a role to play. But it concerns her when extremely capable highly regarded professionals such as you are don't think there is any reason why we would figure out if there is a way to provide additional professional services because right now we have one psychiatrist in Dickinson who is the only one in the western part of the state. We can't do everything from telemedicine, even though she is a big fan of this. How do we make sure that we are able to come up with people, such as the primary clinics, that we should at least examine whether a medical psychologist is a part of primary care clinic has a role to play? Maybe they don't. But not talking about it bothers her.

Dr. Burd stated the health care delivery payment methodologies are in a constant change of flux. Certainly in his role as an educator, working with residents, working with medical students, working with physician assistants, supervisor of nurse practitioners, we recognize it takes a team, including psychologists and psychiatrists. We also have our specialties as part of that team. What is your training to do what you do best? We need to remove barriers, and inducements to get the people out.

Chairman Judy Lee asked Dr. Burd to explain the barriers and inducements.

Dr. Burd stated some of those we addressed with other level providers, for example LIC's in terms of financial inducements, loan forgiveness, those type of things to manage to keep and retain the people that we train here. He would like to see more training local Physician Assistants.

Chairman Judy Lee stated that nurse practitioners have more education than physician assistants, but you mentioned just the physician assistant. Is there a reason for that? I'm hearing you say physician assistants could have a role in the delivery of services, so why not medical prescriptive psychologists?

Dr. Burd offered his opinion that the work of a psychologist is ongoing just as the work of a physician in terms of keeping up your CEU's or CME's. To dilute the skillset and knowledge of a psychologist when we have other ways to provide that, he does not see as being beneficial to the system or to his patients.

Dr. Cheryl Huber, a psychiatrist with Sanford, testified in OPPOSITION to HB 1272 (attach #11)(51:11-53:05)

Senator Howard Anderson, Jr. asked Dr. Huber to explain what happens now when someone comes in now for psychologists and the psychologist ascertains that a prescriptive drug could help.

Dr. Huber indicated a psychologist would communicate with her and with her nursing staff to arrange an appointment to see that patient. If it was deemed to be more critical, then there could be some discussion about going to the emergency department or hospitalization.

Senator Howard Anderson, Jr. asked how long does this take?

Dr. Huber indicated it depends on the level of severity. For routine matters, it would be an additional 2 to 3 weeks. For crisis situations, within 1 week.

Chairman Judy Lee asked what do they do in rural North Dakota, like Turtle Lake?

Dr. Huber answered typically in rural setting, they would have to come to the major urban areas, Bismarck or Minot with Turtle Lake.

Chairman Judy Lee talked about the telemedicine bill. What do we do about the fact that there are not services in 40% of the state - west.

Dr. Huber stated telemedicine will help. She has patients who travels from all over the state including the western portions of the state to come to her office to not only see her but the other practitioners.

Chairman Judy Lee stated that not everybody can do this.

V. Chairman Oley Larsen commented about the timeframe, in western North Dakota, can I go to a walk-in clinic and can a nurse practitioner prescribe antidepressant, rather than waiting for 3 week wait.

Dr. Huber stated it could be possible, depending on the severity of the condition. Because of the time to evaluate somebody, we try to keep some time for triage for critical need if it's deemed not to be critical nature, we may ask that person to wait longer for services. Three weeks for prescribers in the clinic is okay.

Chairman Judy Lee stated that two weeks ago, five middle school students in the Pine Indian Reservation died of suicide, the youngest being 10 years old. They can't wait three weeks.

Dr. Huber that is the reason for triage.

Senator Dever commented that Dr. Huber discussed the shortage of psychologists, how are we sitting for psychiatrists?

Dr. Huber answered we could always use more. We are down psychiatrists from where we were from 10 to 15 years ago. Getting good people has been difficult. We have been able to use Advanced Practice Nurses in some situations to help.

Dr. Gabriela Balf testified IN OPPOSITION to HB 1272 (attach #13)(58:48-1:07:45).
Argument #1: We will serve the underserved
Argument #2: We will treat the person as a whole.
Argument #3: We will treat mental Illness.
Argument #4: 400 hours of preparation is enough
Argument #5: Patients will be safe

There are safe alternatives for our people. She has been practicing tele-psychiatry in the past 16 months. She disagrees that there is only one psychiatrist in Dickinson, as she is there through tele-psychiatry. She does treat all variety of ages. The DOD when they trained those folks, they put very clear criteria, 18 through 65, fairly healthy people that the prescribing psychologists were allowed to treat. What she proposes is Nurse Practitioners tele-psychiatry, expanding the existing programs of CNS, this would be a great way and cheaper way to go. Psychologists are extremely valuable. I'm not sure we realize that. There is a huge shortage of psychologists who do their job.

Senator Dever asked when you do tele-psychiatry, are you working with a medical professional on the other end?

Dr. Balf answered no. She did field trips to Dickenson and established agreements 16 months ago, and we said with primary care that these are the conditions that we can help you, and so she only needs the nurse in the room with the patient. If someone needs medical attention, she will pick up the phone but physically she does not need anyone over there. There are a lot of states where you can have home-based tele-psychiatry so that is an accepted location for practice also.

Chairman Judy Lee asked how many hours do you spend with tele-psychiatry in western North Dakota?

Dr. Balf indicated Wednesday and Friday afternoons. Her wait time for Dickinson would be three weeks, and if it is a crisis, she will fit them in on Wednesday or Friday afternoons. The sole limitation is their space, not her.

Chairman Judy Lee asked if there are any others doing this?

Dr. Balf indicated there is one other for child psychiatry, and others have expressed interest.

Dr. Jon Ulvan, a psychiatrist at Sanford, testified IN OPPOSITON to HB 1272. They are integrated. He practices in internal medicine and he is a primary care provider as a psychologist. They have their providers in pediatrics, family medicine, specialty mental health both in the hospital and outpatient side of things, our psychologists in women's health, oncology, and then general hospital services. Our focus is on team based integrated care. Dr. Ulvan voiced his opposition to the bill for the following reasons: granting psych prescription privileges does not play to their strengths as psychologists. It will burden them with the responsibilities from what they do best, and that is psychotherapy. We've had previous testimony today to talk about how hard it is to get patients into see psychologists already. In their role in healthcare, we would have substantial evidence and support to show how we can help people with mental health issues, substance abuse and chronic conditions, like diabetes, COPD, heart issues, as well as preventing and treating obesity. We used evidence supported strategies to bring about the change. We have over 40 years of evidence in the United States that demonstrates the effectiveness of this care. Our treatments do not have side effects. Our treatments do not interact with other drugs that are in the body. They are effective and can be very efficient. For example, for most types of insomnia, talk based intervention is more effective than medication. When you look at mild to moderate depression, talk based intervention has a longer effect on the individual than medication does. So there are numerous other places where there is information like this. Our interventions improve the way our brains function. In an integrated setting, he does other things as well. We have a very high-burnout profession as health care providers. One of the roles that he takes on in the clinics and health care system is he puts together presentations, he works with group of people to decrease burnout, to help the healthcare providers notice burnout in each other, and to intervene. He teaches the physicians, the nursing staff, how to better engage patients in their care. The old days of going to see the doctor, where the doctor tells you what it is that you should be

doing and the patient leaves, doesn't happen. You have to engage your patients differently. That is what he teaches with some evidence supported strategies for this. We have multiple roles in healthcare. There are roles to help protect and ensure the health of the people providing the care as well as intervene with the patients. Dr. Burd, as an example, who used to do some therapy is no longer doing therapy because that is not the reason he is paid as a psychiatrist. He has nothing to suggest that psychologist would go this same direction. And we would be losing out on the things they do the best. Dr. Ulvan provided an example of a patient, with stress related illnesses. He reiterated he is opposed to the study because they have better things to do with their time. Psychologists are busy. In rural areas, we can better partner with each other.

Chairman Judy Lee stated we don't need a study to tell how to collaborate, but the systems in which they work should be encouraged. She thinks the study should be done by the specialists in the health care system and how to go across the hall - there should not be a study to do that.

Dr. Ulvan stated we need to look at the ability to bill for collaboration - what are some effective rural demonstrations that have worked with that model. The ability of just adding prescriptive authority to psychologists does not solve the issue.

Chairman Judy Lee still thinks they need to work with other providers. The state is not the only reimbursement. Collaborative practice back to the health care providers because you need to figure out how to work together.

Dr. Ulvan stated he doesn't want to have his employer to do this.

Carlotta McCleary, Executive Director of Mental Health America of North Dakota (attach #12)(1:22:24-1:26:27)

Chairman Judy Lee asked if her national organization have a position on prescribing or medical psychologists, or is their position improving access to care as well as quality.

Ms. McCleary indicated they have not taken a position.

NEUTRAL FOR HB 1272
No Neutral testimony

Chairman Judy Lee closed public hearing.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1272
3/23/2015
25285

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill to provide a report to the legislative management regarding medical psychologist licensure

Minutes: No attachments

The Senate Human Services Committee met on March 23, 2015 to discuss HB 1272 for committee work.

Chairman Judy Lee indicated its calling for a study for medical psychologists. It calls for the advisory council for the UND medical school to do the study, and while they are extremely capable and competent to do the study, they all have other real jobs. It is a periodically meeting, where the Centers for Rural Health - that is their job. Would that feasible for Centers for Rural Health do some work on this effort?

Mr. Joshua Winn, Vice President for Health Affairs at the University of North Dakota, and Dean of the School of Medicine and Health Sciences, is aware of this bill, and he has no opinion of the bill itself. The school of medicine and health sciences advisory council is a 15 member group, and the legislature has defined the membership on that committee. It includes 4 members from the legislature, 4 members that he appoints which is one from each campus, and other interested health care providers. You have charged it in advising the school, the legislature, and the member groups regarding matters of health care policy. It was suggested that this group could do the study, and they could. We typically meet quarterly, although only required to meet twice a year. But with all the health care issues, we tend to meet quarterly. The advisory council could do the study, but he concurs that the Centers for Rural Health might be better positioned to do the study. They have done other studies in the past, and he thinks that would be a reasonable demand for the them to do the study. The Centers for Rural Health depends on grant funding, so resources are quite limited. So his only hesitation to the question is how much other work they have to do.

Chairman Judy Lee would like to ask Mr. Gibbens if he sees a barrier to doing the study. She does not see large funding for the study but someone to facilitate the groups who are interested. The psychologist association supports the idea of the study. The psychiatrists

and some of the other psychologists are opposed to even studying it. Having people provide information to some neutral group would be good. She trusts the advisory council to do fine work with that, but there could be potential for being perceived as biased because it is much more of a psychiatrist perspective rather than a psychologist perspective on the issue.

Senator Howard Anderson, Jr. asked is it possible that if we left it with the council that they could use the resources for the centers for rural health.

Mr. Winn indicated yes.

Chairman Judy Lee asked if we leave it as it is and amended in the resources for the centers for rural health.

Mr. Winn indicated that would be appreciated. Mr. Gibbens does report to Mr. Winn, but would like to see his workload. **Chairman Judy Lee** asked if Mr. Winn could chat with Mr. Gibbens to make sure the work is doable.

Senator Warner commented the way this is worded, it doesn't do the triage process through legislative management. Think it is a mandated study. Are there grant numbers that would help for funding to help with the study? They have a full workload already.

Mr. Winn indicated that when he heard about the bill, it was discussed with the chair of the advisory council. Since we would be charging ourselves, we felt comfortable that we could carry it out. He appreciates the centers for rural health is on a different setting and some grant financial help would be appreciated. If it is a few hours, they will be fine. If it is more, they would have resistance without financial support.

Chairman Judy Lee stated part of the discussion this morning was integration with primary care. They were talking about collaborative agreements with primary care provider. The advisory council will be an important player as well.

Mr. Winn recognizes the challenges to the behavioral health issue - to the extent that it could help with the problem, we are for that. It is very complicated. There is no consensus on how it will be done.

Senator Howard Anderson, Jr. asked what the amount is without having attention by the appropriations committee.

Senator Dever believes it is $5,000.

Senator Howard Anderson, Jr. stated this would be helpful, even if it is small.

Chairman Judy Lee assigned the intern, Femi, to validate if $5,000 for expenses could be allocated to the advisory council using the Centers for Rural Health.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1272
3/24/2015
25333

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill to provide a report to the legislative management regarding medical psychologist licensure

Minutes:

Attach #1: Bill draft with proposed amendments

The Senate Human Services Committee met on March 24, 2015 for HB 1272 committee work.

Senator Howard Anderson, Jr. suggested language on line 6. (attach #1)

Senator Howard Anderson, Jr. moved to ADOPT AMENDMENT, as per attach #1. The motion was seconded by **V. Chairman Oley Larsen**. No Discussion

Roll Call Vote to ADOPT AMENDMENT
6 Yes, 0 No, 0 Absent. Motion passes.

Chairman Judy Lee provided the status to Courtney Koebele.
- Included the Center for Rural Health in the study
- Provided some money for expenses involved for the study.

Ms. Koebele voiced her continued opposition to the bill.

Chairman Judy Lee stated what is interesting is that not all the psychologists don't agree.

Ms. Koebele stated if it does pass, they will want to be involved in the study.

Chairman Judy Lee indicated there had been other suggestions of others who could be engaged in the study, which we did not include. The could be perhaps a practicing medical psychologist could talk about it from their perspective and someone from the association. We would like to see a broad representation. There is a biased to the medical group right now.

Ms. Koebele in all repsect, correct, but there are others.

Senator Howard Anderson, Jr. moved the Senate Human Services Committee DO PASS HB 1272 AS AMENDED. The motion was seconded by **V. Chairman Oley Larsen**. No discussion.

Roll Call Vote to DO PASS AS AMENDED
4 Yes, 2 No, 0 Absent. Motion passes.

V. Chairman Oley Larsen will carry HB 1272 to the floor.

It was noted that this is a mandatory report.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1272
3/25/2015
25396

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill to provide a report to the legislative management regarding medical psychologist licensure

Minutes: No attachments

The Senate Human Services Committee met on March 25, 2015 to possibly reconsider HB 1272 in committee work.

Chairman Judy Lee indicated that Bonnie Staiger had suggested additional people to include in the medical psychologist study. Is there any interest in reconsidering the bill? Ideas to include were a medical psychologist who is licensed in another state, a member of the North Dakota State Board of Psychologist Examiners, and maybe a North Dakota practicing psychologist who may have interest in receiving training and pursuing medical psychology.

Senator Howard Anderson, Jr. stated that he has no problem including additional people, but those are examples that the study group may want to look for as a resource. He doesn't care for the person who may be pursuing - it may be hard to find that individual. And someone licensed in another state, the study group should be looking to see what is going on in other states as part of their study, so we wouldn't necessarily have to pick someone like that and point them to our group.

Chairman Judy Lee stated the idea included a medical psychologist in licensed in another state, and a member of the North Dakota State Board of Psychologist Examiners. The thing that is awkward about doing it this way is the House gave this job to the Medical School advisory council, and we added the Center for Rural Health. So if we are going to do it, then we need to develop language that they would call on those resources, but we could also ask the Rural Health and Advisory Council to just include those people.

Senator Howard Anderson, Jr. thinks one of the advantages of including the Centers for Rural Health is that they are very good at looking at things from a global perspective. He

would agree having a person from the North Dakota Board of Psychology Examiners, but the others are outside of the scope. They need to be asked to participate.

Chairman Judy Lee asked do you think that you want to Reconsider the bill to add a member of the Board?

V. Chairman Oley Larsen spoke that he discussed the bill with constituents and if it is reconsidered, he may not be able to support the bill.

The committee decided not to reconsider HB 1272.

15.0348.03001
Title.04000

Adopted by the Human Services Committee

March 24, 2015

TD
3/24/15

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1272

Page 1, line 2, after "licensure" insert "; and to provide an appropriation"

Page 1, line 7, after "shall" insert "use the resources of the university of North Dakota school of medicine and health sciences center for rural health to"

Page 1, after line 17, insert:

"**SECTION 2. APPROPRIATION.** There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $5,000, or so much of the sum as may be necessary, to the university of North Dakota school of medicine and health sciences for the purpose of conducting the study under section 1 of this Act, for the biennium beginning July 1, 2015, and ending June 30, 2017."

Renumber accordingly

Date: 03/24 2015
Roll Call Vote #: 1

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1272

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15.0348.03001 Title 04000

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Sen Anderson Seconded By Sen. Larsen

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larsen (V-Chair)	✓		Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 03/24 2015
Roll Call Vote #: 2

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1272

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15.0348.03001 Title 04000

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Sen. Anderson Seconded By Sen. Larsen

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness		✓
Senator Oley Larsen (V-Chair)	✓		Senator John M. Warner		✓
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	✓				

Total (Yes) 4 No 2

Absent 0

Floor Assignment Sen. Larsen

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1272, as engrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (4 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1272 was placed on the Sixth order on the calendar.

Page 1, line 2, after "licensure" insert "; and to provide an appropriation"

Page 1, line 7, after "shall" insert "use the resources of the university of North Dakota school of medicine and health sciences center for rural health to"

Page 1, after line 17, insert:

"**SECTION 2. APPROPRIATION.** There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $5,000, or so much of the sum as may be necessary, to the university of North Dakota school of medicine and health sciences for the purpose of conducting the study under section 1 of this Act, for the biennium beginning July 1, 2015, and ending June 30, 2017."

Renumber accordingly

2015 TESTIMONY

HB 1272

1-28-15

#1

Testimony on HB 1272
Rep Alan Fehr, District 36

Mr Chairman and members of the Human Services Committee, I am Representative Alan Fehr of District 36.

I am here to introduce HB 1272, which would create a new profession in this state – the profession of "medical psychologist." This is equivalent to the licensure in some states of "prescribing psychologist." It involves a licensed psychologist that has additional training and certification in psychopharmacology and has a limited authority to prescribe medicine.

Today's hearing on this bill will be a lively debate and this new profession is opposed by psychiatrists and the medical profession.

In my testimony I am going to outline for you what this new profession is, why it is needed, and how it provides services that are safe and effective. I will present written information from prescribing psychologists in other states, which will provide historical context. I will be followed by two prescribing psychologists who have experience working in North Dakota.

First, let me give you the bigger picture of why this is needed.

As with other states, there are many short-comings to our system of behavior health care. There are severe challenges for accessing care, including whether people will ask for professional help in a timely manner. All too often, people avoid seeking behavior health services until there is a crisis and the situation is urgent. Also, people often do not follow through on services but discontinue prematurely when their crisis is improved.

We need to improve our system of behavior health care to identify, intervene, treat, and support individuals as quickly and effectively as possible. This would require a consideration of how and where behavior health professionals are available and accessible. I believe that we should think about "touch points" for accessing care. I submit that the most prime points are schools, medical clinics, and law enforcement. I believe we need more social workers and counselors in schools, psychologists in primary care clinics, and social workers in law enforcement settings.

It is useful to consider the systems of care that provide treatment for behavior health services. Let me point out that I am using the term "behavior health" synonymous with the more traditional term "mental health."

In a very general sense, there are systems of care centered on medical treatment and intervention using medications, and there are systems of care centered on counseling and psychotherapy. These two systems might communicate, might work together, but very often

do not. Sometimes the care between the systems is coordinated but is rarely integrated, despite many research studies that report the best behavior health care is a combined approach of medications and psychotherapy. Over the past few decades we have seen substantial improvement in treatments. Psychotropic medications have become more targeted on specific symptoms with a reduction in side effects. Psychotherapies have also become more advanced and tailored to specific conditions.

The type of treatment a consumer receives is largely determined by how and where they access help. If a person goes to their family physician because of difficulties and feeling depressed, that person will probably leave the clinic with a prescription for a medication, probably an antidepressant. If the same person contacts a counselor or psychologist, the treatment offered is probably a form of counseling or therapy.

Both forms of treatment have their pros and cons. One advantage of the medical system is that access to care has become increasingly timely, especially with the popularity of walk-in clinics. A person could walk out of this hearing, go to a walk-in clinic, be seen by a medical provider, and probably have a prescription this afternoon. It would likely be for an antidepressant. Even though it takes a week to several weeks for an antidepressant to work, the person may feel some relief immediately, knowing that help has arrived.

Conversely, if a person calls a counselor or psychologist's office today, there would probably be some time delay, as they would need to schedule an appointment. On the day of the appointment the person would be seen for an hour or longer to discuss their situation in a fair degree of detail. Some people feel some immediate relief and benefit from their 1st appointment. They may feel supported and validated that someone listened in a non-judgmental manner to their description of a situation for which they may have carried shame and guilt for years.

A benefit of counseling and therapy is that successful intervention can have long-term, relatively permanent benefit by helping people to change their counter-productive behavior, negative thinking, and learn to adopt a heathier attitude towards life. It can involve learning resilience skills that people can use and receive benefit for the rest of life. It is a skills-building process that is often life-altering without the risk of side effects that we may see with medications.

The truth is that we need both systems of behavior health care – the medical and non-medical. Most importantly, we need them to work together to be more integrated and collaborative.

Medicine is primarily schooled in the Medical Model. The model basically involves a linear approach that progresses from the patient complaint, to history taking and testing to identify symptoms, to determining a diagnosis, and concluding with a prescribed course of treatment and follow-up.

Non-medical behavior health providers are schooled in the Medical Model and other ways to conceptualize people and their problems. For example, an alternative approach is Systems Theory. Systems theory focuses on the interaction of an organism within its environment. Therefore, to understand a person from a System's perspective, we need to look at the person in context of their social environment, especially what is happening in family relationships. Psychologists, social workers, and counselors are trained in both a traditional Medical Model and to actively look for the social context that may underlie a person's difficulties.

When a patient comes to the office of a medical professional, the essential process is to conclude a diagnosis and determine an appropriate medical treatment. From the moment of meeting a patient, the medical provider is considering what medication to prescribe.

A non-medical approach with a psychologist may be quite different, such as looking for ways to help the client change their behavior, reactions, thought patterns, and relationships to succeed in ways that are consistent with the client's goals.

While neither approach is inherently right or wrong, one approach may be better suited to a particular person's problems. For example, a more severe or long-term disturbance, such as Schizophrenia or Bipolar Disorder, may be better described by the Medical Model, is more biologically based, and is best treated primarily with medication. A short-term, reactive problem, such as dealing with a divorce or loss, is an example of a disrupted interpersonal system, as seen from a Systems model. In this case counseling or therapy may be the preferred treatment.

This licensure process with medical psychologists is a specific way we can integrate the medical and non-medical behavior health systems of care by placing skilled behavior health professionals in positions where they are easily accessible to the public and link the two systems. This bill creates a professional who is a hybrid in a primary care setting – a behavior health professional with extensive knowledge and experience in assessment, counseling, and psychotherapy who can complement and assist the primary care providers by prescribing psychotropic medications.

Most prescriptions for psychotropic medications, especially for the less severe conditions, are by primary care physicians – family practice, pediatricians, OB/GYNs, and internists. If these physicians had a medical psychologist in their practice, just down the hall, they could refer their patients with behavior health concerns, which would make it relatively easy to make a "warm hand-off." Their patients would be much more likely to accept a referral to a behavior health provider down the hall as opposed to seeing someone across town. This will help to reduce the stigma that many feel when considering care from a behavior health professional.

Under this bill, medical psychologists are psychologists who have a limited prescription privilege and work in a primary care clinic. Since they are first trained as psychologists, medical psychologists have doctorate degrees in psychology, which involves graduate and post-

graduate training in assessment, counseling, and psychotherapy. They will have completed licensure to practice psychology.

Next, a medical psychologist must complete a training program, supervised work experience, and national exam as approved by the Board of Medical Examiners. The training programs generally take about two years. The supervised work experience also takes about two years.

In HB 1072 a medical psychologist is defined on page 3, lines 30-31 as being licensed by the Board of Psychology Examiners and certified by the Board of Medical Examiners. I have also attached with my testimony an amendment to this bill that would further clarify that this licensure is focused on employment in a primary care clinic by restricting the employment to that setting. Since this is a dual licensure, this definition is in both Board of Medical Examiners code on page 3 and the Board of Psychologist Examiners code on page 8, lines 26-27.

The heart of this bill starts on page 6, line 18, and continues to the top of page 8. A medical psychologist must have a collaborating physician and the collaborative practice agreement must be written and acceptable to the Board of Medical Examiners.

A medical psychologist will have a limited prescriptive authority to prescribe medication to treat "a psychiatric, mental, cognitive, nervous, emotional, or behavioral disorder." The Board of Medical Examiners will develop rules regarding the educational requirement, the supervised work experience, and the examination required.

Medical psychologists will not replace psychiatrists and will probably have little effect on the profession of psychiatry. Instead, medical psychologists will provide services in primary care clinics, will see a wide variety of patients and situations, and will make referrals to psychiatrists, psychologists, and other professionals as needed.

There are currently three other states that have a similar licensure, although there is some variation between the three states, including the title being either "medical psychologist" or "prescribing psychologist." New Mexico and Louisiana have had such a licensure for over 10 years. New Mexico passed a prescriptive law in 2002 and Louisiana followed suit in 2004. Illinois passed a licensure law last year. These prescribing psychologists have a track record of safely and effectively prescribing medications. In fact, to date, there has not been one complaint lodged against a medical or prescribing psychologist in any of these three states.

Many other states have considered legislation to license medical psychologists or prescribing psychologists. The efforts have been opposed by medical groups, primarily psychiatry, alleging that medical psychologists are not adequately trained. The list of states considering licensure legislation includes Montana and Minnesota.

Included with my testimony is a letter of support by a Minnesota psychologist, Dr Harlan Gilbertson, who has completed a masters degree in clinical psychopharmacology and is licensed in Minnesota and New Mexico. His letter includes a chart that compares training between

psychiatric nurse practitioners, physicians, and medical psychologists. While medical psychologists have very extensive training in psychotherapy, they also have substantial training in biochemistry and neuroscience, pharmacology, and clinical practicums.

Some of the medical or prescribing psychologists that are licensed in these states are working on military bases or tribal reservations. I've included a letter from Dr Glenn Ally, a medical psychologist licensed in Louisiana. Dr Ally's letter provides us with a rich history of the licensure process and he specifically addresses a few key points: Need, access, rural access, and safety. I would encourage you to read his letter.

I've also included a letter of support and an information paper by Dr David Shearer, a prescribing psychologist in the state of Washington. He is licensed in New Mexico but works at Madigan Hospital, which is on an Army base, Ft Lewis, Washington. His information paper is titled "Prescribing Psychologists Embedded in Primary Care Clinics." It describes the impact, utility, and safety of Madigan's model of integrating prescribing psychologists in primary care.

Despite not having a licensure law, North Dakota is not a stranger to prescribing psychologists. Our first prescribing psychologist, Dr Mike Tilus, became licensed through the New Mexico licensure law and was formerly employed with Indian Health Service at Fort Totten by Devils Lake. He has since moved to Montana, where he continues to work as a prescribing psychologist. He is here today to share his experiences. He is currently the president of Division 55 of the American Psychological Association, which is the American Society for the Advancement of Pharmacotherapy.

A second prescribing psychologist in North Dakota is also here to testify today, Dr Anthony Tranchita. Dr Tranchita is currently stationed at the Grand Forks Air Force Base.

Thank you for your consideration of HB 1072. I welcome your questions.

15.0348.02001
Title.

Prepared by the Legislative Council staff for
Representative Fehr
January 27, 2015

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1272

Page 7, line 31, after the underscored period insert "A medical psychologist's prescriptive authority under a collaborative agreement is limited in scope to the medical psychologist's practice at a primary care clinic setting."

Renumber accordingly

#2

1/28/2015

Michael R. Tilus, PsyD, MP
President, APA Division 55

TESTIMONY OF SUPPORT
HB- 1272

Mr. Chairman and Members of the Human Services Committee. I am Mike Tilus, Medical Psychologist, currently working at the Crow/Northern Cheyenne Indian Health Service Hospital, Crow Agency, Montana. I am on leave from my active duty job with the United States Public Health Service.

It is my honor and pleasure to submit personal testimony in support of advancing the prescriptive authority to specially trained psychologists here in the Great State of North Dakota. As a Disclaimer: I am here on personal leave representing myself. My expressed opinions are solely mine and do not reflect the Health and Human Services, the U S Public Health Service, the Indian Health Service, or the Crow/Northern Cheyenne Indian Health Service Hospital.

In addition to offering my strong support for this prescriptive initiative, I would like to first provide my own personal experience as I sought training and eventual license and certification as a medical psychologist initially here in North Dakota, and now in Montana. Secondly, I would like to provide information from a national level perspective that will update the members of this committee on recent research and publication concerning prescriptive authority and primary care integration as the new Gold Standard of Care.

By way of introduction, I am a Prescribing Medical Psychologist in Montana and have had prescriptive authority for the past seven years. Prior to having prescriptive authority, my specialty was broad based. I am trained and licensed to be a clinical psychologist, marriage and family therapist, and Board-Certified Chaplain. I have been, and am, a licensed and ordained minister for the past 35 years, with 12 years served as a Chaplain in the North Dakota Army National Guard, the Army Reserves in CA, and then on active duty in the Army as a Combat Veteran Chaplain during the first Gulf War. As an active-duty Public Health Service Officer in the U. S. Public Health Service, my wife and I have served 13 years in remote, frontier, medically underserved Indian country- in Washington, Arizona, North Dakota, and now Montana.

My first duty assignment was to serve an isolated Indian community of approximately 680 people on a one and a half mile wide reservation. I was treating a young boy who suffered from Fetal Alcohol Spectrum, ADHD, and depression. He was oh so faithful to come to his therapy where we were working together in advancing his coping skills and 'thinking' better. For four years I tried to get my young patient seen by the only part-time psychiatrist who visited a

neighboring town's mental health department one day a week. For four years I was unsuccessful.

I received messages that the psychiatrist was full; my patient didn't have the right insurance; his name was accidently dropped off the roll; I would be called soon; and yes, they were willing to help. This young man continued to be a shadow sufferer, accustomed to being ignored, lied to, and forgotten. When my wife and I made the decision to accept a new position, I apologized to my young patient for my lack of ability to break through a ceiling that, appeared to me, to be racially colored and glazed. For two years I tried to get this young man seen. I was unsuccessful. Shortly after that I heard about a new program my ala mater was starting- Clinical Psychopharmacology. I consulted with my wife and discussed the seriousness nature of this study; the time, energy, and financial commitment it would cost us; and my willingness to increase my skills. With her blessing, I started my training in 2003. When my wife and I left this duty station after four years of service, none of my Native American patients ever received a psychiatric appointment. With tears, I apologized as I left this young man, and made him a promise that I would get trained so that in the future, I could help other young men like him somewhere else. He smiled and said, "That's nice." His childlike acceptance of toxic nourishment surrounding him was to become a common mantra my wife and I would see as we continued to elect to serve in America's frontier, isolated, medically-underserved Indian communities.

The path to prescribing is a deeply personal one that has marked my person and my profession. For me and others, it has a spiritual calling like element. I now have convictions about prescribing that have poisoned the old psychological and spiritual self of who I thought I was; how I thought I should be with people; and how they impacted the 'us.' I've changed since I became a prescriber. I hope you get a taste of that as you hear my heart's voice.

Where did it start? My personal experience of gaining prescriptive authority mirrors many psychologists who elected to do the hard work of passing a rigorous post-doctoral MS Degree Program in Clinical Psychopharmacology; passing the National PEP Exam; and completing multiple clinical preceptorship and internships under the direct supervision of a medical physician. While working full time and commuting to classes, I required an additional five plus years to meet all the requirements, and spent an additional 25T of my own money on student loans and carved money from our family budget.

I have sat in legislative hearings for bills intended to authorize prescriptive authority for psychologists, and heard that the training offered to psychologists in preparation for prescriptive authority is insufficient; not rigorous enough; and should be done in medical school.

In a recent publication, Dr's Muse and McGrath (The Journal of Clinical Psychology, Vol. 66(1), 96-103, 2010) reviewed the training comparison among three professions prescribing psychoactive medications: psychiatric nurse practitioners, physicians, and pharmacologically trained psychologists. The authors summarized one of their findings by stating, "An analysis of these statistics substantiates the assertion that pharmacologically trained psychologists are well prepared academically to incorporate prescriptive authority within their competencies. Indeed, the statistics point to multiple content areas in which the other professions are relatively deficit in comparison to pharmacologically trained psychologist's preparation" (pg. 103).

Dr. Bob McGrath, PhD, who is the Director of the Clinical Psychopharmacology at Farleigh Dickinson University (among other things) is famous for responding to the question "Is the training sufficient?" with his challenged comeback: "I have challenged people for years to identify a single topic essential to prescribing not covered in the training. I'm still waiting." Used the same medical textbooks; have some of the same instructors; but it is insufficient? This recent Muse and McGrath comparison suggests that appropriately trained psychologists have as much or more education in psychopharmacology as to other entry-level prescribers, including physicians. In fact, in the majority of content areas pertaining to the prescribing of psychoactive medications to behavioral health patients, medical psychologists are better prepared than the other prescribing professions included in their study.

Dr. McGrath goes on to say the National standard in Britain for non-physician prescribers is 208 didactic hours, 96 clinical hours (Br J Clin Pharmacology, 2012). Our standard is 450 didactic hours and 400 clinical hours.

Is medical training a required benchmark? Medical training is wasteful unless you can demonstrate better outcomes and greater safety. Physicians have objected to EVERY non-physician expansion of scope of practice on grounds of insufficient training- dentists, optometrists, nurse practitioners, physician assistants. They have been wrong EVERY TIME.

When I hear these arguments, I wonder where the antagonists practice. They must not have the same kind of rural patients I see every day. The grassroots emergence of the prescribing medical psychologist grew in the Northern Plains with the desire for increased access to Behavioral Health Care; increased need to serve the underserved populations; increased psychiatric services; wrap-around coverage.

Dr. Elaine LeVine is the first prescribing psychologist in New Mexico and has administered the clinical psychopharmacological training program there for the past 20 years. She writes:

"Dear Dr. Fehr:

I am the first prescribing psychologist in New Mexico and a member of the team that spearheaded the New Mexico effort for psychologists with appropriate postdoctoral training in psychopharmacology to be licensed to prescribe medications for their patients. I am writing you because I am so pleased to hear about your bringing forth RxP Bill HB 1271. At the present in New Mexico, we have 42 prescribing psychologists and almost all of them are working with underserved populations in rural areas, poor urban areas, in the military and on our Indian reservations. There are less than 100 psychiatrists within our entire State; and a majority of them do not see Medicaid patients. Moreover, they are in such limited supply that they seldom complete psychotherapy as well as medication management. The prescribing psychologists in New Mexico are providing integrated care; what we say is from a psychobiosocial model of care. The patient's needs, interests, preferences are central to all we do and we use just enough medication to allow our patients to access their own strength. In addition to this quality of care, we have increased the number of those providing services by 50%! We still need many more providers but there can be no doubt that the prescribing psychologists are offering a very valuable service in our State.

Please let me know if there is any other information I could provide for you that would assist you in furthering your important RxP Bill." (Dr. Elaine LeVine).

In North Dakota, I completed my clinical preceptorship and 2-year internship under the supervision of a Native American physician who was both the clinical director and a family practice physician. As a prescriber, I was credentialed and privileged as a full voting member of the Medical Staff. I ordered my own labs and EKG; reviewed findings; consulted with primary care providers; and started an integrated BH practice that was eventually selected by the Indian Health Service as the Gold Standard of Integrated Behavioral Health Care Model.

As is normal for any Indian Health Service Behavioral Health, you treat whatever walks in the door. Most patients I served were comorbid with general medical conditions, substance abuse, and multiple psychiatric conditions. Coordination of all resources, constant consultation and collaboration with all the various medical providers were a norm. But, as the clinical psychopharmacologist, I continued to provide the other required elements of a behavioral health practitioner who serves in these kinds of communities. I provided emergency psychiatric evaluations for psychotic and suicidal patients; intervened with children and families who reported childhood sexual abuse and trauma; received 'hand-off's from medical providers during the day who were demonstrating comorbid BH behavior or issues that the medical provider thought was influencing and contributing to their poor medical conditions. Patient's cases often required complex social work and sister agency referrals. And, as crises slowed down and patients were returning for depth therapy, I scheduled intensive, regularly, Cognitive Behavioral

Therapy or Dialectical Behavioral Therapy, in addition to managing their psychopharmacology. ADHD children received behavioral therapy and skill training, in addition to their psychostimulant trial. "No pills without skills" is a standard of care.

These are all common professional activities for medical psychologists who see patients more often; are skilled at closely monitoring medications effectiveness and side effects; and have the therapeutic relationship that is more likely to provide a healing presence than a 10-minute medication check.

Following my initial practice of medical psychology in North Dakota, I accepted a new position in Montana. At this service unit, we have a fairly large hospital with a full Emergency Room, outpatient primary medical care, express clinic, and outpatient behavioral health clinic. In addition, this hospital has two small medical health aid stations on the far edges of the reservation. The three medical psychologists who serve here provide integrated BH care in the primary care clinic; emergency psychiatric evaluations to the ER; maintain a standard outpatient BH clinic for both evaluation and short-term or extended psychotherapy with or without medication treatment. We all have full medical privileges and are credentialed and privileged to practice within the full scope of our licenses. One of our Medical Psychologist served as the BH Director; during his tenure there, he was elected to serve as the Chief Medical Officer, Acting Clinical Director, and Acting CEO.

The physician who manages our ER and is on the Board of Medical Examiners for Montana testified on behalf of, and in support of our previous MT RxP bill. So did a pediatrician, internists, family practice physician, and advanced nurse practitioner. In my seven years as a prescriber, the medical professionals I have worked with personally have been supportive of me as a medical psychologist. We were all in this together, trying to do our best with what we had, to very needy patient population, with limited resources and tired hearts.

Another answer offered by opposition to this bill is that medical psychologists are unsafe; don't know enough medicine; telepsychiatry will meet all the needs; and that 'we' don't need more providers. I wonder where these unsafe medical psychologists are. I know a lot of them, and they don't fit the bill. And it doesn't fit the data.

I wonder why 'they' distrust the medical professionals I worked every day, who see my notes every day, read my lab findings, note my consultation requests, and answer my collaborative treatment plans with their shared medical treatment goals. Since prescribing psychology and primary care share such complimentary paths around the patients' medical home, wouldn't they know if we were incompetent, unprofessional, or unsafe? My medical colleagues are the ones who voluntarily offer testimony for prescribing medical psychology legislation; gladly seek out our expertise, both in psychotherapy and psychopharmacotherapy; avidly work together to seek

additional resources, family interventions, exercise, prayer, and cultural healing ceremonies; and ultimately, credential and privilege us to the fullest extent of our scope of practice.

They review our notes; the same quality control applies to us as it does to them; we have a growing body of knowledge that establishes aspirational and ethical standards of care. Primary care providers are often the first one who sees a suicidal patient; they prescribe the most psychotropics initially and now have a resource to 'pass of' difficult, complex, comorbid cases that typically involve active substance abuse and severe characterological impaired patients.

Psychiatry has generally given up all interventions except medication. Medical psychologists practice both medicine and psychology. They have the authority to prescribe, and the authority to unprescribe. Medicine doesn't cure everything.

Another new piece of research that is full of meaning for this legislation, Dr's McGrath and Sammons authored the piece "Prescribing and Primary Care Psychology: Complementary Paths for Professional Psychology" (Professional Psychology: Research and Practice, 2011, Vol. 42, No. 2, 113-120). They quote a worthy, but brief list of functions the primary care prescribing psychologist can do:

"1. Identifying and addressing emotional concomitants to medical disorders.
2. Consulting to the PCP about how best to interact with the medical patient who is difficult to manage because of, for example, severe mental illness or personality-based resistance.
3. Determining whether the patient's emotional needs exceed the services available at the site and overseeing referral for specialty services in psychopharmacotherapy, psychotherapy, or health psychology.
4. Screening for depressive, substance abuse, cognitive impairment, personality disorders, and other psychobiosocial disorders that are potentially overlooked in primary care evaluations.
5. Providing supportive services to patients who are finding it difficult to participate in their care effectively.
6. Offering specialized treatments for smoking, obesity, and other common behavioral disorders in the general primary care population.
7. Offering behavioral interventions for individuals who primary medical diagnosis calls for a treatment with a substantial behavioral component. Examples would include individuals with diabetes, asthma, chronic infectious disease, and heart disease.
8. Developing outcomes assessment and program evaluation systems as called for by outside agencies.
9. Aiding in the design of research protocols."

From my real practice situations, I would add these:

10. Prescribing an appropriate exercise program for mild to moderate anxiety or depressive conditions.
11. Participate with my patient in their exercise program as a coach and motivational counseling.
12. Seek for positive religious, spiritual, or cultural ceremonies that the patient has found wellness, peace, forgiveness, resiliency, repentance, systems of change, and 'prescribe', prescribe, prescribe.
13. Prescribe substance abuse maintenance, i.e., AA and its affiliates; cultural substance abuse support groups.
14. Prescribe safety and security in all things.
15. Prescribe and advocate for the voiceless, sexually abused children and adolescents who struggle to find meaning in their life every day.
16. Prescribe hope.
17. Prescribe faith.

Telepsychiatry the answer? In my real world, I have seen multiple efforts to sell the ability of psychiatry to meet the rural need with this network. The agency I work for does use telepsychiatry, but the problem is still insufficient to handle the mental health needs. There just aren't enough psychiatrists. What makes people think that psychiatrist have 'extra time' to do telepsychiatry? There are only so many hours in a day, so either they have to see fewer patients' fact to face or have no time for telepsychiatry. Ten minute appointments become 9, then 8, then…what?

Telepsychiatry demands tech savvy people on both side of the line. Paying top dollar for a tele psychiatrist and losing 10 minutes of your scheduled 15 minutes is not productive or cost effective. In many places where I have served, the psychiatrist was not native to the USA and had such a language barrier that both the professional staff and the patient were unable to communicate meaningfully.

In real life, telepsychiatry doesn't work unless you have prescribers to man the phones; nurses to take the vitals; direct severely mentally disturbed people to the lab for blood draws; keep a paranoid schizophrenic patient focused and not disturbed in a small room, looking at a TV screen, with a strange person asking him or her questions. Try that….

And yet I personally support telepsychiatry. We need all the services we can get to meet the need of North Dakotans.

It is well known that the numbers of psychiatrists are dropping with projections of a collapse in the next 10-15 years. In these legislative settings, the antagonistic typically propose additional training to the already burdened and overworked primary care providers.

Antagonists have proposed that increasing the medication training for general practice, family practice, advanced nurse practitioners will be another alternative to telepsychiatry. It may be easier to teach these medical professionals advanced psychopharmacology. But, that does not mean they have the training, competence, or ability to diagnoses various forms of mental illness. How long will it take to teach not only the psychopharmacology, but the psychopathology and the subtleties between various diagnoses?

Why not use the doctoral level professional that has both- expertise in psychopathology and psychopharmacology, AND, the critical added bonus of psychotherapy?

Daniel Carlat, a psychiatrist, is quoted in his published article on this very subject when Dr. Carlat asked a primary care doc about the idea that they will fill the shortfall in psychiatrists, and the response was "that donkey is already overloaded!" Anybody who works in primary care knows how painful this joke really is.

I have never personally seen any medical psychologist take a job from a psychiatrist. If you work in the trenches like I have done for the past 13 years, like the average medical psychologist, you know there is so much need and so few resources. North Dakota needs more drug and alcohol counselors; social workers; marriage and family therapists; psychiatric nurse practitioners; internists; family practice doc's; pediatricians; psychiatrists; and medical psychologists.

Shifting gears now, I wish to give some broad brush strokes. As President and on behalf of the American Psychological Association (APA) Division 55 Board of Directors, I wish to submit their unanimous support of HB 1272. In the professional delivery of psychology and medicine, the evidence is overwhelming in support of an integrated mental and behavioral health services into primary care as being more cost-effective while enhancing the quality of care. These patient-centered care initiatives document the higher patient and provider satisfaction along with better outcomes. HB-1272 mirrors the Gold Standard of Behavioral Health in Integrated Primary Care.

A key health care provider in this new Gold Standard of Delivery is the Prescribing Medical Psychologist. This hybrid health care provider finds its natural home in the integrated primary care model, and is able to provide the best in psychotherapy as well as pharmacotherapy. APA Division 55 has prescribing medical psychologists already serving in integrated primary care clinics in rural, frontier, medically-underserved populations in multiple states; at Federally

Qualified Health Centers (FQHC); in Indian Country (in particular, North Dakota, South Dakota, Montana, Oregon, and New Mexico); all branches of the Department of Defense; the United States Public Health Service; and in states that have passed appropriate legislation- NM, LA, and Ill.

Some national summary points:

- Psychologists with prescriptive authority have now been safely prescribing psychotropic medications in the US military for more than 20 years and in New Mexico and Louisiana for more than 10 years.
- This past year, Illinois passed legislation allowing appropriately trained psychologists to prescribe. However since the Illinois status is new, there is no history upon which to reliably reach conclusions.
- We have medical psychologists prescribing in the Indian Health Service, in the U.S. Public Health Service, and in all Departments of Defense.
- Medical psychologists have collaborated with our medical colleagues in providing safe and effective care now for more than twenty years with an estimated more-than one million-prescriptions written without an adverse action.
- NOT A SINGLE MALPRACTICE LAIM; NOT A SINGLE COMPLAINT TO A LICENSING BOARD IN TWENTY YEARS.
- What evidence or data do you have that psychologists with prescriptive authority are indeed not safe prescribers?
- Could you provide evidence of any 10-20 year history in your profession without complaint regarding prescribing medications?
- As a Recruiter for the Indian Health Service and US Public Health Service, and as the President of APA Division 55, I know countless medical psychologists who when they qualified for this enlarged scope of practice, accepted new employment and elected to re-locate their practice to Louisiana or New Mexico (states which were provider-friendly and had legal authority to prescribe); joined the Department of Defense as either on active duty or as a federal civilian; joined the US Public Health Service with a Mission-Identifier as a Medical Psychologist, able to serve in various federal agencies; or found a place to serve in the Indian Health Service.
- Most medical psychologists practice in various forms of integrated behavioral health care within a primary care setting.
- The medical psychology movement grew as a grassroots movement in the Upper Northern Plains, out of the desire to provide increased care to rural frontier America.
- "Results indicate family medicine providers agree that having a prescribing psychologist embedded in the family medicine clinic is helpful to their practice, safe for patients, convenient for providers and for patients, and improves patient care." (*The Primary Care Prescribing Psychologist Model: Medical Provider Ratings of the Safety, Impact and*

Utility of Prescribing Psychology in a Primary Care Setting. David S. Shearer, S. Cory Harmon, Brian M. Seavey & Alvin Y. Tiu. Journal of Clinical Psychology in Medical Settings, 27 November 2012, Springer Sciences).

Medical psychologists must 'count the cost', using my religious verbiage. As it is family and personal expensive to take on the added burden and expense of being qualified and trained to prescribe. Working in this field demands the utmost of personal and family self-care. Caring, truly investing in the rural populations we are called to serve sometimes shows up on our own developing general medical conditions; high blood pressure; diabetes; depression; and relational distress.

Division 55 and the medical psychologist community have lost two of its members by murder over the past few years. On 5 November 2009, U.S. Army Major , Psychiatrist, and in my opinion Islamic Terrorist, Dr. Nidal Malik Hasan shot and killed 13 people at Fort Hood, Texas. Among the murdered was Army Reservist and medical psychologist MAJOR (Dr.) Eduardo Caraveo.

On 7 January 2015, Dr. Timothy Fjordback was shot and killed by a VA patient at the El Paso VA Health Clinic. Tim was a neuropsychologist who left his long established private practice following the 9-11 Terrorist Attack and decided to serve returning veterans. Tim had completed his MS Degree in Clinical Psychopharmacology and his practicums. He was awaiting his conditional prescribing psychology certificate from the New Mexico Board of Psychology Examiners before he was killed.

These men reflect the kind of character and leadership that I have found in the medical psychology movement. Gifted, of unusual strong character, qualified leaders of people and agencies, multi-skill sets, large hearts, compassionate, sturdy, and seasoned. These are the kind of psychological leaders that can change communities and raise their families on dirt roads.

I strongly urge you and the Human Service Center Committee to endorse HB 1272 as a 'Mission Multiplier' for recruiting and retaining Medical Psychologists to serve in an integrated primary care clinics in the great state of North Dakota!

I have no doubt- "If you pass it, they will come!"

It's been an honor to be here today. I will answer any questions.

Training Comparison Among Three Professions Prescribing Psychoactive Medications: Psychiatric Nurse Practitioners, Physicians, and Pharmacologically Trained Psychologists

Mark Muse
Muse Psychological Associates

Robert E. McGrath
Fairleigh Dickinson University

Academic training leading to prescriptive authority is compared among psychiatric nurse practitioners, physicians, and pharmacologically trained psychologists. Statistics are presented on the relative emphasis that programs serving each discipline place on the preparation of their respective students in academic and clinical content areas that are relevant to the prescribing of psychoactive medication for the mental health population. An analysis of these statistics substantiates the assertion that pharmacologically trained psychologists are well prepared academically to incorporate prescriptive authority within their competencies. Indeed, the statistics point to multiple content areas in which the other professions are relatively deficient in comparison to pharmacologically trained psychologists' preparation. © 2009 Wiley Periodicals, Inc. J Clin Psychol 66: 96–103, 2010.

Keywords: psychopharmacology; pharmacotherapy; prescriptive authority; medical psychologist; prescribing psychologist; pharmacologically-trained psychologist; R×P

Pharmacologically trained psychologists are alternately referred to as *prescribing psychologists*, as in the state licensing law of New Mexico, or *medical psychologists*, as is the case in the Louisiana licensing law. Medical psychologist is the term under which the Drug Enforcement Administration (DEA) issues a Controlled Substance Registration Certificate. The term *pharmacologically trained psychologist* is used preferentially in this article as it encompasses not only those psychologists who are licensed prescribers but also those who consult with prescribers-physicians and nurse practitioners and recommend medications to such prescribers in jurisdictions where prescribing laws have not been enacted (Muse, Brown, Cothran-Ross, & Kapalka, in press).

Correspondence concerning this article should be addressed to: Mark Muse, Muse Psychological Associates, 604 Crocus Dr., Rockville, MD 20850; e-mail: drmarkmusel@yahoo.com

JOURNAL OF CLINICAL PSYCHOLOGY, Vol. 66(1), 96–103 (2010)
Published online in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/jclp.20623

The comparison of pharmacologically trained psychologists'[1] training with other prescribing professionals is a necessary step in establishing the relative preparedness of providers whose behavioral health interventions include medication (Muse & McGrath, in press). A previous study (Speer & Bess, 2003) compared the training of physicians, nurse practitioners, clinical pharmacy specialists, and physician assistants. Speer and Bess concluded in that study that physicians' training in pharmacology was equivalent to that of pharmacy specialists, but physicians' training in pharmacokinetics and therapeutics was less than that of clinical pharmacists. The study, however, was limited to institutions granting entry-level prescribing degrees within the State of Tennessee. Within psychology, a preliminary comparison (Post, Ally, & Quillin, 2002) was made among pharmacologically trained psychologists, physicians, nurse practitioners, dentists, podiatrists, and optometrists; the authors concluded that pharmacologically trained psychologists' training is comparable or superior to other prescribing professionals. However, this last study represented a limited survey of institutions granting graduate degrees within the State of Louisiana (Glenn A. Ally, personal communication, January 29, 2009).

Method

The current study sought to compare the training of psychologists who are competent to prescribe medication to the training of psychiatric nurse practitioners and physicians in key content areas directly relevant to the prescribing of psychoactive medications: biochemistry and neuroscience; pharmacology; clinical practicum; research and statistics required to critically evaluate the effectiveness of pharmacological agents and other therapeutic interventions; behavioral assessment and diagnosis, including the use of psychometrics; psychosocial interventions, psychotherapy and other nonpharmacological therapeutic options; and foundations in mental health and the behavioral sciences. This comparison required gathering data from multiple sources because no single document exists that specifies a universal curriculum for any of the three professions. In making the present analysis, we have relied on two types of documents: (a) curriculum guidelines issued by national organizations for the three professions and (b) actual curricula currently used in training students within the three professions. The latter involved a small national sampling of academic facilities granting entry-level qualifying degrees for the prescription of psychoactive medication. In all cases, this information was derived from the institutions' respective Web sites as of January 1, 2009.

Psychiatric Nurse Practitioners' Preparation to Prescribe Psychotropic Medications

There are over 530 nurse specialist boards, of which 102 pertain to prescriptive authority (Kenward, 2007). Proposed training models for the various specialties within nursing have been promulgated by several national organizations independently or under the auspices of the United States Department of Health and Human Services (DHHS). Most relevant to the current question are those curriculum guidelines aimed at programs training nurse practitioners within the specialties of primary care and psychiatric nursing. Guidelines for adding prescriptive authority to nursing credentials include graduate courses in various areas of nursing leading to a master's degree and recommendations that nurse practitioners be instructed by doctoral-level professors in the pharmacokinetics and pharmacodynamics of pharmacotherapeutics (DHHS/Public Health Service et al., 1998). However, the

2

specific number of credit hours in any area of instruction is not specified but left to the individual faculties to determine.

Guidelines by national organizations for the inclusion of a mental health curriculum in the training of primary care nurse practitioners (DHHS et al., 2002) include broad yet relatively vague competencies to assess and treat mental health concerns within the different populations served by such practitioners; namely, pediatric, adult, geriatric, family, and women. No specific curriculum is promoted to cover these end-of-training, entry-level expectations. Recommendations for the preparation of psychiatric nurse practitioners (National Panel for Psychiatric-Mental Health NP Competencies, 2002) include developing more detailed competence in the assessment and diagnosis of psychiatric disorders as well as in psychosocial and pharmacotherapy treatment of such disorders, but do not specify particular topics within each domain or the number of training hours to be dedicated to each.

The actual curriculum leading to prescriptive authority taught at nursing programs in the United States varies in its emphasis on the acquisition of mental health competencies. Although nurse practitioners in a variety of specialties may be granted authority to prescribe psychoactive medications, there is no evidence to suggest that nurse practitioners are extensively involved in the treatment of mental disorders unless they have received specialty training. Accordingly, the curriculum comparison was restricted to programs offering specialty training in psychiatric nursing. A survey of five psychiatric nurse practitioner programs provided the data presented in Table 1.

Physicians' Preparation to Prescribe Psychotropics

Although national organizations such as the Association of American Medical Colleges suggest that content of courses offered at medical school should be made explicit (Liaison Committee on Medical Education, 2008), it is largely left up to the individual medical school to determine specific content and to interpret which areas of medical training receive emphasis (American Osteopathic Association, 2009). In general, there is less didactic preparation than in other clinical graduate studies, such as pharmacy, nursing, and psychology; although the first two years of medical school generally focus on didactic instruction, the last two years are dedicated primarily to clinical experience through rotations among the medical specialties. In this respect, medical school, in keeping with its historical roots, is largely built on an apprenticeship model with overlapping academic preparation (Cook, Irby, Sullivan, & Ludmerer, 2006).

Medical school is not usually structured around semester credits and their equivalence in contact hours. It is, therefore, difficult to discern the number of hours allotted to particular content domains, as there is not generally an equivalent of the traditional graduate class assigned credit hours according to hours spent in the lecture hall, laboratory, or in practicum experience (Muse, 2009). To assign contact hour equivalents, the following procedure was used: Curricula were reviewed for the content domain of interest. For any semester in which the topic seemed to be covered, the number of contact hours for that topic was estimated by assuming a standard load of 15 credits per semester, dividing that number by the number of content domains covered in the semester, and then multiplying the resulting number of credits by 15, based on the standard ratio of 15 contact hours per academic credit. The resulting mean estimate across five medical schools is provided in Table 1.

3

Table 1
Comparison of Entry-Level Training Models Leading to Prescriptive Authority

Profession	Minimum years post-baccalaureate	Graduate contact hours mean (and standard deviation)						
		Biochemistry-neuroscience	Pharmacology	Clinical practicum	Research-statistics	Behavioral assessment/diagnosis & psychometrics	Psychosocial interventions-psychotherapy	Other mental health/psychology course work
Psychiatric nurse practitioner[a]	2.5	48 (7)	56 (7)	146 (33)	99 (41)	30 (23)	32 (29)	128 (77)
Medicine[b]	4	216 (20)	59 (28)	855 (101)	33 (20)	18 (25)	9 (20)	15 (21)
Psychology[c]	6.5	161 (43)	288 (63)	680 (83)	225 (64)	267 (61)	255 (161)	351 (152)

Note. Values were computed equating one academic credit with 15 contact hours.
[a]Based on nurse practitioner master's degree programs at the Medical University of North Carolina, St. Joseph's College, University of Virginia, Vanderbilt University, and Yale University.
[b]Based on M.D. or D.O. programs, without further specialization residency, at the Mayo College of Medicine, Yale University, Tufts University, Stanford University, and A.T. Still University.
[c]Based on Ph.D., Ed.D., or Psy.D. programs plus the postdoctoral M.S. program at Alliant University, Fairleigh Dickinson University, the Massachusetts School of Professional Psychology, New Mexico State University, and NOVA Southeastern University.

Journal of Clinical Psychology DOI: 10.1002/jclp

The curriculum materials used for the comparison reflected training necessary to achieve legal recognition of competence to prescribe psychotropics. In the case of physicians, this occurs at the end of medical school. Because specialization in psychiatry is not a legal requirement for the diagnosis and pharmacological treatment of mental disorders—and, in fact, research consistently demonstrates that the bulk of medical care for individuals with mental disorders is provided by physicians without specialty training in psychiatry (Pincus et al., 1998)—, the general medical school curriculum is used in the comparison.

Pharmacologically Trained Psychologists' Preparation to Prescribe Psychotropics

A model curriculum for the training of psychologists in psychopharmacology has been set down by the American Psychological Association (1996) and requires that the training be undertaken as postdoctoral studies encompassing the following content areas: neurosciences, pharmacology and psychopharmacology, physiology and pathophysiology, physical and laboratory assessment, clinical pharmacotherapeutics, and clinical practicum in psychopharmacology. Such specialty training is subsequent to a clinically based doctoral program in which content areas include coursework in mental health assessment and treatment, clinical research methods, foundation studies in the behavioral sciences, and a clinical internship. Currently, only five programs in the country offer a postdoctoral master's degree programs in clinical psychopharmacology for psychologists. All training programs in preparation for prescriptive authority require doctoral-level licensure as a psychologist prior to matriculation. All, except one, are located within the same college or school of psychology that provides doctoral training in clinical psychology. For New Mexico State University, the program is housed instead within the College of Education, which offers a doctoral program in counseling psychology. Table 1 presents the total graduate contact hours required to qualify for the postdoctoral Master of Science degree in clinical psychopharmacology; these hours include graduate study to earn a doctoral degree in psychology and the postdoctoral master's degree.

Comparisons

Because there are only five institutions in the country that currently offer the M.S. in clinical psychopharmacology in preparation for prescriptive authority for psychologists, the entire population of such programs was sampled. To provide a comparison, five medical schools and five nursing schools were also selected from their respective larger populations. In an attempt to cover the breadth of training among the latter institutions, those medical school programs selected included two programs housed in institutions ranked among the top 10 research universities by *US News and World Report* (2009), two mid-level clinically oriented universities, and one unranked university granting the doctorate of osteopathy degree rather than the doctorate of medicine. Five nurse practitioner programs were also chosen for comparison, including two from top 10 ranked schools, two mid-level schools, and one unranked school. Candidates for inclusion were reviewed to ensure that sufficient information on their respective Web sites was available to allow the computations presented in this article.

Results

A comparison across all three professions' current training practices yields data on the relative strengths and weakness of each of the three disciplines involved in

5

prescribing psychoactive medications at the entry level. Physicians graduating from the institutions reviewed receive somewhat greater didactic instruction in biochemistry and neuroscience than pharmacologically trained psychologists or nurse practitioners, and they receive greater clinical experience because of the nature of their curriculum. In all other content areas critical to prescribing psychoactive medication, the pharmacologically trained psychologist receives more extensive preparation than either the physician or the psychiatric nurse practitioner attending the programs sampled. Psychologists preparing for prescriptive authority, for example, receive more than four times as much instruction in pharmacology than physicians and more than six times the training that psychiatric nurse practitioners receive. In the diagnosis of mental health disorders and use of psychometrics as well as in behavioral health assessment in general, psychologists receive 15 times more preparation than physicians and eight times the preparation of psychiatric nurse practitioners. With respect to therapeutic interventions other than medication, that is, psychosocial interventions, psychologists receive 27 times the graduate-level preparation than physicians and eight times the preparation of psychiatric nurse practitioners. Pharmacologically trained psychologists receive 23 times more postgraduate preparation in the foundations of psychology and mental health than physicians and nearly three times that of psychiatric nurse practitioners. In the area of research design and interpretation of research results, the pharmacologically trained psychologist has more than twice the training as the psychiatric nurse practitioner and seven times that of physicians. Finally, psychologists preparing for entry-level prescriptive authority receive 2.5 to 4 years more of graduate instruction than do their entry-level prescribing counterparts. During this extended training period, pharmacologically trained psychologists are exposed to greater didactic material in those content areas most relevant to the incorporation of pharmacotherapy in the clinical treatment of mental, emotional, and behavioral conditions.

Discussion

The purpose of the present study has been to consider the argument, often raised in legislative hearings for bills intended to authorize prescriptive authority for psychologists (Tilus, 2009), that the training offered to psychologists in preparation for prescriptive authority is insufficient. The results suggest that pharmacologically trained psychologists have as much or more education in psychopharmacology as do other *entry-level* prescribers, including physicians. Of course, there is nothing to prevent a pharmacologically trained psychologist from completing further specialty training and board certification (see www.amphome.org/abmp.html) after obtaining entry-level prescriptive authority, in the same way that aspiring psychiatrists continue their education in residency *after* having obtained entry-level prescription authority with their basic medical degree.

A second criticism sometimes leveled at pharmacologically trained psychologists is that their didactic training is less rigorous because it is largely accomplished through distant learning modules that offer academic material online, augmenting electronic transmittal of lectures with readings, live chats, and periodic classroom experience. Given that prescribing psychologist (R×P) training occurs post-licensure, so that participants typically are employed full-time in clinical practice and are geographically dispersed, it is not surprising that these programs rely heavily on distance education as a method of instruction. In response to this concern, it may be noted that, at least in terms of learning outcomes, distance education courses tend to slightly outperform

6

traditional didactic instruction (Allen et al., 2004), and medical schools are also increasingly relying upon distance education in their training (see www.ivimeds.org).

A limitation of the present study is its small sample size, reflecting the small number of graduate colleges that offer the postdoctoral master's degree in clinical psychopharmacology. The use of the same size sample to represent nursing and medical training could be faulted. In response, it is noteworthy that despite the purposeful selection of a variety of types of training sites and the small sample sizes, the standard deviations are all small relative to the mean number of hours. In the key domains of biochemistry-neurochemistry, pharmacology, and clinical practicum, values for the coefficient of variation (standard deviation divided by the mean) varied between .09 and .47, with a mean of .20. That is, on average the standard deviation was only one fifth of the mean. The finding suggests relatively little variability across programs in the amount of time devoted to these knowledge domains.

The present study reflects the young yet burgeoning R×P movement and, as such, reflects the inherent limitations of the movement at this time. It is a much-needed study that is meant to serve as a beginning point for further comparisons in the future as the movement continues to grow. Changes that may need to be taken into account in the future include the outcome of a current debate (Ax, Fagan, & Resnick, 2009) over whether psychopharmacology training should be offered, at least in part, in psychology doctoral programs. This debate, however, has only recently emerged and appears to be considerable distance away from altering the current statistics offered in this article, particularly because the American Psychological Association (2008) has recently renewed its commitment to R×P training as a postdoctoral activity. It should also be mentioned that a significant number of nurse practitioner programs are preparing to increase required credit hours with the implementation of the Doctor of Nursing Practice degree (American Association of Colleges of Nursing, 2004), but this process is not expected to have an effect on the minimum requirements for nurses to prescribe.

Conclusions

The present study undermines the argument that psychologists who extend their formal training to obtain the postdoctoral Master of Science degree in clinical psychopharmacology are inferior to other entry-level professions in terms of preparedness for prescribing psychoactive medications to the mental health population. In the majority of content areas pertaining to the prescribing of psychoactive medication to mental health clientele, pharmacologically trained psychologists are better prepared than practitioners in other prescribing professions trained in the programs included in these analyses. The substantial preparation that pharmacologically trained psychologists receive in the diagnosis and treatment of behavioral disorders, including pharmacotherapy, places this profession at the forefront of prescribing mental health providers. The results of this study also suggest that psychiatric nurse practitioners are better prepared at the entry level in many of the content areas most relevant to prescribing medication with the mental health population than are physicians prior to specialty-training as a resident in psychiatry.

References

Allen, M., Mabrey, E., Mattrey, M., Bourhis, J., Titsworth, S., & Burrell, N. (2004). Evaluating the effectiveness of distance learning: a comparison using meta-analysis. Journal of Communication, 55, 402–420.

7

American Association of Colleges of Nursing. (2004). AACN position statement on the practice doctorate in nursing. Washington, DC: Author. Available at http://www.aacn.nche.edu/DNP/pdf/DNP.pdf

American Osteopathic Association. (2009). Becoming a D.O. Chicago: Author. Available at http://www.osteopathic.org/index.cfm?PageID = ost_becomedo

American Psychological Association. (1996). Recommended postdoctoral training in psychopharmacology for prescription privileges. Washington, DC: Author.

American Psychological Association. (2008). Recommended postdoctoral education and training program in psychopharmacology for prescriptive authority. Washington, DC: Author.

Ax, R.K., Fagan, T.J., & Resnick, R.J. (2009). Predoctoral prescriptive authority training: The rationale and a combined model. Psychological Services, 6, 85–95.

Cook, M., Irby, D.M., Sullivan, W., & Ludmerer, K.M. (2006). American medical education 100 years after the Flexner Report. New England Journal of Medicine, 28, 1330–1344.

Department of Health and Human Services, in collaboration with National Organization of Nurse Practitioner Faculties and The American Association of Colleges of Nursing. (2002). Primary care competencies in specialty areas: Adult, family, gerontological, pediatric, and women's health. Rockville, MD: Department of Health and Human Services.

Department of Health and Human Services/Public Health Service, in collaboration with National Council of State Boards of Nursing, and National Organization of Nurse Practitioner Faculties. (1998). Curriculum guidelines & regulatory criteria for family nurse practitioners seeking prescriptive authority to manage pharmacotherapeutics in primary care: Summary report. Rockville, MD: Department of Health and Human Services.

Kenward, K. (2007). Role delineation study of nurse practitioners and clinical nurse specialists. Chicago: National Council of State Boards of Nursing.

Liaison Committee on Medical Education. (2008). Functions and structure of a medical school: Standards for accreditation of medical education programs leading to the M.D. degree. Washington, DC: Association of American Medical Colleges.

Muse, M. (2009). Untangling the "Psychologists should go to medical school" debate: Counting academic hours for comparing medical training to R×P training. The Tablet, 10, 2.

Muse, M., Brown, S., Cothran-Ross, T., & Kapalka, G. (in press). Psychopharmacotherapy and pediatrics: When to treat and when to refer. In G. Kapalka's (Ed.), Collaboration between pediatricians and pharmacologically-trained psychologists. New York: Springer.

Muse, M., & McGrath, R.E. (in press). Making the case for prescriptive authority, In R.E. McGrath & B.A. Moore (Eds.), Professional issues in pharmacotherapy for psychologists. Washington, DC: APA Books.

National Panel for Psychiatric-Mental Health NP Competencies. (2002). Psychiatric-mental health nurse practitioner competencies. Washington, DC: National Organization of Nurse Practitioner Faculties.

Pincus, H.A., Tanielian, T.L., Marcus, S.C., Olfson, M., Zarin, D.A., Thomason, J., et al. (1998). Prescribing trends in psychotropic medications: Primary care, psychiatry, and other medical specialties. Journal of American Medical Association, 279, 526–531.

Post, D., Ally, G., & Quillin, J. (2002). R × P (slide presentation). Baton Rouge: LA. Louisiana Academy of Medical Psychologists.

Speer, A., & Bess, D.T. (2003). Evaluation of compensation of nonphysician providers. American Journal of Health-System Pharmacists, 60, 78-80. Available at http://medgenmed.medscape.com/viewarticle/448333_print

Tilus, M. (2009). Update on legislative efforts in R×P in North Dakota. Tablet, 10, 7–16.

1-28-15 #4

Professional Psychology: Research and Practice
2011, Vol. 42, No. 2, 113–120

0735-7028/11/$12.00 DOI: 10.1037/a0022649

Prescribing and Primary Care Psychology: Complementary Paths for Professional Psychology

Robert E. McGrath
Fairleigh Dickinson University

Morgan Sammons
Alliant University

Two paths have been suggested for the future evolution of professional psychology. Prescribing psychology has already been legally authorized in two states, the military, and the Indian Health Service. Primary care psychology does not require legal recognition and has been slowly growing as a career option for psychologists across the nation. Both paths have their obstacles and limitations, but both are also associated with great potential. This article provides a brief summary of the strengths and weaknesses of each path and suggests an integrated perspective for planning the future of the profession. Each is seen as complementary to the other and providing a basis for pursuing the other.

Keywords: primary care, integrated primary care, prescriptive authority, healthcare systems

Doctoral-level healthcare psychology faces several serious threats to its status quo and perhaps even its survival. The first comes from the pressures all healthcare professions are experiencing from managed care and other third-party reimbursement systems. Involvement in managed care has been associated in psychologists with longer working hours, larger caseloads, less participation in supervision, greater stress, higher rates of premature termination, reduced flexibility, and greater pressure to compromise quality of care (Chambliss, Pinto, & McGuigan, 1997; Cohen, Marecek, & Gillham, 2006; Gold & Shapiro, 1995; Murphy, DeBernardo, & Shoemaker, 1998; Rothbaum, Bernstein, Haller, Phelps, & Kohout, 1998; Rupert & Baird, 2004). Although some of this literature can be criticized as potentially out of date, revelations in the past year about conflicts of interest in the setting of usual and customary fees for providers (Hakim & Abelson, 2009), and recent revelations of substantial increases in health insurance premiums in the face of record profits by certain managed care entities (Department of Health and Human Services, 2010), suggest psychologists will experience continuing pressure from third-party payers attempting to improve profit margins.

The second threat is the growing number of masters-level providers of psychotherapy. According to the *Occupational Outlook Handbook* (2008–2009; http://www.bls.gov/oco), there were over 200,000 counselors in 2006 in the fields of mental health, substance abuse and behavioral disorders, and marriage and family therapy, as well as more than 120,000 social workers in mental health and substance abuse. Manderscheid and Henderson (2004) estimated in 2002 that there were approximately 18,269 psychiatric nurses. The number of nondoctoral mental health workers is expected to grow another 30% by 2016. In contrast, the 150,000 school, clinical, and counseling psychologists are expected to grow by only half that much (U.S. Department of Labor, 2008). The rapid growth in the number of masters-level providers partly reflects the creation of new professional identities in response to increased demand for mental health services. It also reflects the preference in managed care organizations for the cheapest provider, a preference reinforced by a lack of evidence suggesting that doctoral-level providers are associated with better psychotherapy outcomes than masters-level providers (Bickman, 1999; Lambert & Ogles, 2004; Seligman, 1995). This failure to find consistent evidence of an advantage for doctoral-level care could be a generally valid finding for traditional psychosocial mental health services, but it may also reflect the more restricted range of pathology commonly seen by professionals in private practice settings.

Finally, the model of the solo independent practitioner that has defined much of mental health practice for the last 40 years has come under closer scrutiny. This model emerged out of a fee-for-service system of reimbursement that rewarded specialty services and maximizing the level of care provided. There are at least two initiatives in progress that challenge the existing fee-for-service system. Pilot testing has begun evaluating an episode-based alternative in which a treatment team receives bundled payment for the complete treatment of a condition (Robert Wood Johnson Foundation, 2009). Unlike traditional service-based fee-for-service or population-based capitation, a diagnosis-based system allows the

ROBERT E. MCGRATH received his PhD in clinical psychology from Auburn University. He is a Professor of Psychology, Director of the PhD Program in Clinical Psychology, and Director of the MS Program in Clinical Psychopharmacology at Fairleigh Dickinson University. His areas of research include psychological assessment and measurement and professional issues in healthcare psychology.

MORGAN T. SAMMONS received his PhD in clinical psychology from Arizona State University. He is a retired Captain in the US Navy and is one of the first graduates of the U. S. Department of Defense's Psychopharmacology Project. He is currently the Dean of the California School of Professional Psychology at Alliant International University and is a diplomate of the American Board of Professional Psychology (Clinical). He contributes frequently to the professional literature. He is an associate editor of the APA journal *Psychological Services*. He lectures and contributes to the professional literature on issues pertaining to prescriptive authority and the professional practice of psychology.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Robert E. McGrath, School of Psychology T-WH1-01, Fairleigh Dickinson University, Teaneck, NJ 07666. E-mail: mcgrath@fdu.edu

insurer greater precision in the projection of costs per episode. This is a feature likely to make episodic reimbursement very attractive to insurers.

The second factor is growing interest in the concept of a medical home (American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association, 2007), in which a personal primary-care physician becomes responsible for the coordination and integration of care across specialists and ancillary care providers. There is growing interest in establishing the medical home as the focus of healthcare services. This interest is demonstrated in the development of standards for the medical home by the National Committee for Quality Assurance (www.ncqa.org/tabid/1034/Default.aspx); the formation of an organization dedicated to the topic, the Patient Centered Primary Care Collaborative (www.pcpcc.net), which enrolled over 500 member organizations in 5 years; and extensive discussion of the topic in other organizations devoted to healthcare policy such as the Collaborative Family Healthcare Association (www.cfha.net). The recently enacted Patient Protection and Affordable Care Act includes several sections demonstrating a preference for the development of integrated healthcare practices, e.g., in awarding of loans for the establishment of nonprofit health insurers and in various demonstration projects. Episodic reimbursement and collaborative healthcare are clearly complementary initiatives (de Brantes, Gosfield, Emery, Rastogi, & D'Andrea, 2009), and the widespread adoption of either would dramatically increase pressure for psychologists to join multidisciplinary teams, usually under the control of physicians.

Other healthcare professions have responded to the flux in the system by pursuing expansion in their scope of practice and enhancement of their status. Nurses are attempting to expand the roles of specialty practitioners such as advanced practice nurses and nurse anesthetists. A recent survey finds the latter group is attracting higher salaries than primary care physicians (Kavilanz, 2010). Nurses are also pursuing independent practice as primary care providers (PCPs) through the Doctor of Nursing Practice degree. Optometrists are similarly expanding their formulary in some states, and in others they are pursuing the authority to perform surgical procedures (see Fox et al., 2009, for a review of advances by nonphysician health care providers relative to psychologists). Masters-level mental health providers are vigorously pursuing authorization to engage in activities that were previously considered doctoral-level such as independent diagnosis and assessment.

The challenge professional psychology faces is whether to maintain its current stance within the healthcare system or whether to move aggressively into new markets. The former option must be seriously considered. It is clear there remains a tremendous need for traditional mental health services. Mental disorders have joined the list of the five most costly conditions (Soni, 2009), and it has been argued that the growing number of masters-level providers involved in the treatment of mental health issues is required to fill the unmet need (Annapolis Coalition on the Behavioral Health Workforce, 2007). Furthermore, there is growing evidence that psychotherapy is effective as an alternative or adjunct to medications (e.g., Hollon et al., 2005; Jensen et al., 2007; Kennard, Silva, Vitiello, Curry, & Kratochvil, 2009). It is therefore possible that the market for psychotherapy services will continue to grow for quite some time and provide enough opportunity for all.

At the same time, some worrisome statistics can be noted. Olfson and Marcus (2009, 2010) presented evidence that although the number of individuals receiving psychotherapy since the late 1990s has increased, the role of psychotherapy in the treatment of mental disorders is declining, resulting in a net decline in total expenditures for psychotherapy. Although the proportion of gross domestic product devoted to healthcare more than doubled in the period from 1970 to 2003, the proportion devoted to mental health care remained flat at less than 1% (Frank & Glied, 2006). Troubling findings specific to psychology indicate it was the only one of four professions (psychiatrists, nurses, and counselors being the other three) in which the number working in community mental health centers was declining (Cypres, Landsberg, & Spellmann, 1997), suggesting a growing emphasis on medication management concurrent with a shift in therapy services to masters-level providers. So long as the healthcare system is largely governed by professions based in biomedicine, there is the danger that psychotherapy will continue to be treated as a secondary alternative to biological interventions regardless of the evidence. The increasing reliance on masters-level therapists could further undermine the status of psychosocial interventions relative to medical procedures that continue to be offered primarily by doctoral-level providers. A recent statistical analysis concluded that only 18% of U.S. counties needed additional nonprescribing mental health providers (Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009). Finally, data from the *Occupational Outlook Handbook* (Bureau of Labor Statistics, 2010) reveals that psychologists have the lowest median income of any of the doctoral-level healthcare professions. Increased competition from masters-level providers can only dampen those salaries further.

If simply maintaining the status quo is not an option, or does not adequately ensure the future of the profession, then psychologists should aggressively pursue new professional opportunities. Two such opportunities have been discussed, involving increased participation in primary care and acquiring prescriptive authority. So far, these initiatives have been pursued in relative isolation from each other. The purpose of this article is to suggest primary care psychology and prescribing psychology as complementary approaches to the future of the profession and to describe how they can be combined to create a flexible model of advocacy for the future of the profession. The next two sections will briefly review key issues in primary care and prescribing psychology.

Primary Care Psychology

Primary care represents the most common site of treatment for individuals with mental disorders (Kessler et al., 2005). Between the years 1998 and 2003, the percentage of patients receiving mental health care only in medical settings increased 154%, and the number of patients treated in community health centers for mental health or substance abuse issues increased from 210,000 to 800,000 annually (Mauer & Druss, 2009, April 2). Among people who successfully committed suicide, far more saw a PCP in the year before their deaths than saw a mental health professional (Luoma, Martin, & Pearson, 2002), and some studies suggest more than 50% of patients seen in primary care settings meet criteria for a mental disorder (Spitzer et al., 1994; Toft et al., 2005). At the same time, a survey of PCPs indicated that the barriers to accessing mental health care for their patients exceed those for other spe-

cialty services, for a variety of reasons (Cunningham, 2009). As a result, various governmental agencies are encouraging greater sensitivity to behavioral and mental health issues in the primary care setting (e.g., Kates, Ackerman, Crustolo, & Mach, 2006; Kirkcaldy & Tynes, 2006; Power & Chawla, 2008).

Blount (2003) offered three dimensions for characterizing collaborative activities between psychologists and PCPs. The first dimension has to do with the relationship between providers, and he described three types of relationship. *Coordinated care* occurs when the psychologist and PCP operate independently of each other but share information, *colocated care* when the psychologist and PCP share physical space, and *integrated care* when the psychologist and PCP serve together as part of a team responsible for treatment planning. The second dimension has to do with the population being treated. A *targeted* population means cases are preselected for collaborative treatment, usually because of the presence of a specific diagnosis or problem. The population is *nontargeted* when collaborative care is offered to any patient for whom initial evaluation suggests behavioral or mental health services would contribute to outcome. The third dimension has to do with the type of treatment offered by the psychologist through the collaboration. A *specified* treatment program means a preestablished treatment program is offered to all patients, whereas an *unspecified* treatment program involves an individualized decision about what form of behavioral intervention would be most helpful.

In traditional mental health practice, psychologists' collaboration with PCPs is usually restricted to coordinated or in some cases, colocated care. That is, the patient is seen by both the psychologist and a PCP who share information as necessary. Colocation can offer some advantages over coordination in terms of ease of referral and information-sharing, but the primary care and mental health treatments proceed in relative isolation from each other.

The emergence of health psychology created the potential for integrated care models combining psychologists and PCPs. However, the health psychology model has often involved a specified treatment (e.g, relaxation training for individuals with various medical diagnoses), a targeted population (e.g., individuals with sleep disorders), or both (e.g., a structured program for the treatment of chronic pain).

Primary care psychology is distinct from the mental health and health psychology models in that it involves *integrated care* (psychologists and PCPs determining care together) using an *unspecified treatment* (whatever clinical tools are appropriate for a patient) for a *nontargeted population* (any patient for which psychological interventions could be helpful). Gruber (2010) indicated that primary care psychology can be further distinguished from more traditional psychological models by a relatively greater emphasis on the treatment of individuals with acute problems. To summarize, the primary care psychologist is a full participant in the primary medical care, providing varying interventions for patients with various types of problems including acute medical conditions.

Given the frequency of psychological, interpersonal, or behavioral difficulties in the primary care patient, the primary care psychologist has the potential to become an integral element of the primary care practice. However, successful integration into the primary care setting will in part require demonstration that this integration results in cost reductions, clear improvements in healthcare outcomes, or both. Although some research suggests that the cost of incorporating behavioral interventions into primary care is more than offset by reduced healthcare use (Chiles, Lambert, & Hatch, 2002), there is still insufficient data available to conclude that the integration of psychologists into primary care is cost effective.

The medical home model also implicitly acknowledges the importance of integrating psychological and behavioral services into the primary care setting. Although the statement of principles developed to describe the medical home refers to *whole person* care, the document does not mention that achieving such a level of care would require a broad range of evaluation and treatment options including behavioral, mental health, and substance abuse services. For example, as part of its efforts to integrate the medical home model into its primary care services, a Health Behavior Coordinator will be hired for every one of the Department of Veterans Affairs' 153 medical centers. This will likely have a significant impact on the implementation of the medical home in other settings as well.

A brief list of functions the primary care psychologist can fill includes the following (see also McDaniel & Fogarty, 2009), many of which combine the traditional skills of the psychologist with new skills relevant to the primary care setting:

1. Identifying and addressing emotional concomitants to medical disorders.
2. Consulting to the PCP about how best to interact with the medical patient who is difficult to manage because of, for example, severe mental illness or personality-based resistance.
3. Determining whether the patient's emotional needs exceed the services available at the site and overseeing referral for specialty services in psychopharmacotherapy, psychotherapy, or health psychology.
4. Screening for depression, substance abuse, cognitive impairment, personality disorders, and other psychobiosocial disorders that are potentially overlooked in primary care evaluations.
5. Providing supportive services to patients who are finding it difficult to participate in their care effectively.
6. Offering specialized treatments for smoking, obesity, and other common behavioral disorders in the general primary care population.
7. Offering behavioral interventions for individuals whose primary medical diagnosis calls for a treatment with a substantial behavioral component. Examples would include individuals with diabetes, asthma, chronic infectious disease, and heart disease.
8. Developing outcomes assessment and program evaluation systems as called for by outside agencies.
9. Aiding in the design of research protocols.

These activities require that the psychologist become embedded within the primary care practice, although it is possible in the future that some of this embedding will be accomplished through telehealth options.

The work regimen of the primary care psychologist is quite different than that of the psychologist providing psychotherapy. The primary care psychologist often serves as a consultant to PCPs as well as a direct care provider. Treatment is often time limited both in duration and in length of sessions: a patient may be seen for no more than 15 min at a time with long intervals between contacts. The primary care psychologist needs the flexibility to handle cases immediately when the PCP concludes a behavioral or

psychological consult is warranted. Psychotherapy is a specialty activity, much like a medical specialty, for which the primary care psychologist serves as the coordinator and referral source rather than as the therapist.

Despite the potential opportunities for integrating psychologists into primary care settings, achieving this integration can be difficult for several reasons. A very important one is the current character of the training received by psychologists, which is often singularly focused on the traditional weekly 50-min hour of psychotherapy. Admittedly, this is universally acknowledged among psychologists as a difficult skill to master. However, the degree of focus on this single activity leaves little additional time for mastery of nontraditional skill sets. As a result, few psychologists have much understanding of the knowledge and skills needed in the primary care setting (O'Donohue, Cummings, & Cummings, 2009). For example, many psychologists are largely unaware of the economics of healthcare in systems that traditionally do not tend to incorporate mental health services, such as large capitated practices and community health centers. In fact, many psychologists have never heard of community health centers, although they provide primary healthcare services for 19 million Americans. Psychologists also receive little training in basic medical concepts, in healthcare terminology outside the mental health arena, in providing consultation to and collaborating with other professionals, and in basic clinical medicine. In response to this gap, various authors have provided lists of the core competencies needed for psychologists to practice effectively in primary care (e.g., Robinson & Reiter, 2007) and have described elements of training programs of varying lengths (McDaniel, Hargrove, Belar, Schroeder, & Freeman, 2004; O'Donohue, 2009), although few psychologists currently pursue this training.

Another factor that will slow the process of integration into primary care is the lack of coordination between healthcare entities in the United States. Convincing healthcare agencies to hire psychologists must be accomplished one primary care agency at a time.

There are also reimbursement barriers to successful integration of psychologists into primary care. These include restrictions on billing for multiple professionals in a single day, a policy that reinforces the role of nonphysicians in primary care either as physician extenders or as ancillary service providers who require a separate contact. There are also restrictions on the Current Procedural Terminology codes accessible by psychologists working in settings that rely on insurance reimbursement. The existence of the health and behavior codes acknowledges the role psychologists can play in the treatment of individuals with primary physical illnesses, but insurers vary in their willingness to reimburse these codes. Psychologists also remain unable to use evaluation and management codes, a policy that institutionalizes their distinction from primary treatment coordinators in healthcare settings.

Other economic factors create obstacles to the growth of primary care psychology. Medical cost offset can be perceived as a long-term, and therefore only potential, gain when compared with the immediate increase in cost resulting from treatment by multiple providers. Furthermore, the case for offset is clearest for those patients with the highest rate of medical service use. More normative integrated care, such as expanded screening for mental health problems, the dissemination of treatment guidelines, and the colocation of mental health specialists in primary care settings have not resulted in desired improvements in care (Thielke, Vannoy, & Unutzer, 2007). Accordingly, psychologists should be selective in their assertions about the cost savings resulting from psychologists' integration into primary care or risk outcomes that undermine the enterprise in the future.

One final and extremely important barrier is the competition psychologists face from other mental health providers who have also indicated interest in increasing their presence in the primary care setting (e.g., Claiborne & Vandenburgh, 2001; Schneider & Levenson, 2008). This competition is particularly acute with masters-level providers, who tend to be cheaper alternatives to psychologists.

In offering a rationale for psychologists in particular as psychosocial partners in primary care, two factors stand out. One is that psychological treatments are not restricted to psychotherapy or even the treatment of psychological disorders but encompass a variety of interventions that are relevant to treatment of individuals seen in primary care settings (Barlow, 2004). Increasingly, psychologists join the workforce with an understanding of behavioral medicine and/or neuropsychology that sets them apart from other providers whose training is restricted to mental health. The second factor that can potentially play an important role in identifying the psychologist as a desirable alternative to the masters-level provider or to the more expensive psychiatrist in the primary care setting is prescriptive authority.

Prescribing Psychology

A great deal of progress has been made toward establishing an infrastructure for prescribing psychology over the last 10 years, primarily because of the efforts of the American Psychological Association. This has included the development of education and training standards, the creation of a system for designating programs consistent with those standards, and the underwriting of a competency examination called the Psychopharmacology Examination for Psychologists (McGrath, 2010). It is estimated that approximately 1500 psychologists have already completed postdoctoral didactic coursework in preparation for prescribing (Ax, Fagan, & Resnick, 2009), whereas approximately 60 psychologists were prescribing in New Mexico and Louisiana as of Fall 2008 (LeVine & Wiggins, 2010). Psychologists are also prescribing in all three branches of the military with healthcare services and in the Public and Indian Health Services.

Even in the absence of prescriptive authority, increased training in the use of psychopharmacological agents will inevitably influence the practice of pharmacotherapy. A recent study found that approximately 60% of prescriptions for a psychotropic medication are written by primary care physicians (Mark, Levit, & Buck, 2009), even though more than 60% of family medicine residencies offer no formal training in clinical pharmacology let alone clinical psychopharmacology (Bazaldua et al., 2005). Psychologists with little formal training are already called upon to provide advice to PCPs on an appropriate medication regimen; psychologists with advanced training in pharmacotherapy will increasingly find physicians using their expertise.

So far, 14 states have explicitly defined consultation with prescribers on medication decision-making as within the scope of practice of psychology (McGrath, 2010). The appropriateness of psychologists with advanced training in pharmacotherapy serving

4

as medication consultants in other states is uncertain. Even when the authority to engage in this type of collaboration has not been explicitly defined, however, psychologists with advanced training will find themselves in situations where they believe they are ethically obliged to advise physicians who have little or no formal training in either psychopharmacology or psychodiagnosis.

Given the central role awarded to medication in the treatment of mental disorders in the current healthcare system, even if large numbers of psychologists start to prescribe, they are likely to have little effect on the rate at which the services of psychiatrists are accessed. Where psychologists will probably have their greatest impact is on the use of psychotropic medications in primary care. Current laws authorizing psychologists to prescribe in New Mexico and Louisiana actually contribute to the creation of stable relationships with PCPs by mandating collaborative relationships, at least under certain circumstances.

The psychologist with prescriptive authority represents the only mental health professional who has received extensive training in all modalities appropriate to the amelioration of mental conditions. Familiarity with both psychosocial and biological interventions, combined with training in the critical evaluation of research, can potentially help psychologists resist excessive reliance on medications and use of medications without consideration of its interpersonal and experiential context. The prescribing psychologist should also be more effective than the general practitioner at determining when psychosocial versus biological interventions are warranted and at informing the patient about the potential benefits of psychosocial intervention. In this way, the prescribing psychologist can actually enhance participation in psychotherapy.

Prescriptive authority allows psychologists to address a compelling and demonstrable need. The same analysis that concluded most counties across the nation have enough nonprescribing mental health professionals also found that 96% of counties face a shortage of prescribers competent to address psychological and behavioral disorders (Thomas et al., 2009). In those states where psychologists can prescribe, the shape of clinical practice has already started to change. Among the roles prescribing psychologists are now filling, or are filling in ways very different than in the past, are the following (Ally, 2009):

1. Sharing on-call duties with psychiatrists in both agency and private practice settings.
2. Contracting for difficult-to-fill positions formerly reserved for psychiatrists.
3. Providing voluntary care to the indigent.
4. Providing administrative services in state agencies.
5. Serving as officers and even owners in hospitals.
6. Becoming involved in policy making at the state level.
7. Participating in pharmaceutical research.

As was true for primary care psychology, the traditional skills of the psychologist contribute to the quality of care offered by the prescribing psychologist in various ways. Training in the critical analysis of research, assessment and psychodiagnosis that includes contextual and cultural considerations, complex multidimensional disorders, outcomes assessment, research design, and understanding the psychosocial aspects of the interpersonal relationships, all of these will contribute to psychologists' effectiveness at developing a model of prescriptive practice that can distinguish psychology from the other prescribing professions.

Prescribing psychology is also similar to primary care psychology in its increasing the likelihood of brief intermittent interactions with patients, some of whom are not intimately familiar to the psychologist. The practice of pharmacotherapy also means a greater emphasis in sessions on the biological as well as psychosocial, on clinical medicine as well as clinical psychology. However, conversations with prescribing psychologists indicate patients adapt well to the seamless transition between one and the other. The sharp distinction providers draw between pharmacotherapy and psychotherapy services has more to do with the reality of the provider, who is traditionally trained almost exclusively in one or the other, than with that of the patient.

The most serious obstacle to the advance of prescriptive authority is opposition both within and outside the profession. Psychologists opposed to prescriptive authority have raised concerns about whether prescribing will undermine the traditional psychosocial roots of the discipline, whether the additional training is sufficient, whether prescribing psychologists in the long run will be able to resist pressures to become medication managers, and whether prescriptive authority as an advanced authority will create two tiers of psychologists (e.g., Robiner et al., 2002). McGrath (2010) provided responses to many of these arguments, noting that the creation of advanced practice nursing has not undermined the traditional identity of the nurse, the greater focus on psychosocial factors in the undergraduate and graduate preparation of psychologists, and the continuing critical analysis of medications by psychologists who are not prescribing (McGrath, 2005) as potential protective factors.

Psychiatrists see prescriptive authority for psychologists as a potential threat to the survival of their profession, so it is not surprising to find they are adamantly opposed. As a result, physicians have mounted aggressive resistance to enabling legislation across the country. It took 30 years to achieve licensure for psychologists in every U.S. state and 30 years to achieve licensure in every Canadian province (Reaves, 2006), so it is reasonable to anticipate that prescriptive authority for all appropriately trained psychologists may not be achieved until at least 2030 in the United States.

Complementary Agendas

Prescribing psychology and primary care psychology represent complementary paths to re-engineering the future of professional healthcare practice in psychology. The greatest advantage of primary care psychology over prescribing psychology as a goal is its reliance on the traditional tools of the psychologist as a psychosocial care provider, making it more palatable to key audiences within psychology and medicine. Furthermore, it requires no legislative action.

On the other hand, prescriptive authority involves service to the same patient population that is most familiar to psychologists. Although the legislative barriers can be daunting, once overcome, the shift in psychologists' roles is inevitable. There is an existing funding stream for medication management that becomes available to psychologists through third-party payers so that the authorized prescribers can quickly create practice opportunities.

Both paths would substantially enhance the reach of psychology in terms of patient populations and potential for enhancing public health. Each can also be treated as a stepping stone to the other.

This complementarity creates an opportunity for a flexible approach to advancing the profession.

The optimal balance between the two agendas will vary from state to state. In some cases, a vigorous effort to achieve prescriptive authority has already emerged. If the number of states authorizing psychologists to prescribe reaches a critical mass, and if research demonstrates that prescribing psychologists reduce costs and are safe and effective as has been the case with other nonphysician prescribers (Lenz, Mundinger, Kane, Hopkins, & Lin, 2004; Speer & Bess, 2003), these efforts are likely to become more successful. Given the inevitable outcomes once legislation is enacted, pursuit of prescriptive authority represents the most efficient option for enhancing clinical practice.

Even so, once prescriptive authority is achieved, there are good reasons to pursue increased involvement in primary care as the next phase in the evolution of the profession. First, the exclusive biological focus in psychiatry in part emerged in response to external pressures such as managed care (Luhrmann, 2000). Despite the protective factors noted earlier, it is reasonable to assume prescribing psychologists will eventually be confronted with the same pressures. One potential offshoot of psychologists' becoming involved in integrated primary care is enhanced status for psychosocial interventions in healthcare in general.

Involvement in primary care also opens access to new populations of patients. This has potential economic benefits. It also has implications for the profession's contribution to the public good through the enhancement of services for individuals with emotional and behavioral concomitants to their physical disorders.

Finally, the combination of prescriptive authority, an understanding of psychosocial diagnosis and intervention, and behavioral management skills will enhance the attractiveness of psychologists as partners to PCPs. The ability to prescribe will allow the PCP to feel comfortable transferring more of the care for individuals with concomitant psychological disorders to the psychologist, whether the psychologist ultimately prescribes medication or not. Furthermore, psychologists with expertise in neuropsychology, treatment of substance abuse, and/or behavioral medicine can contribute to the establishment of true integrated care for primarily medical patients as well as better care for primarily mental health patients.

In other states where it is not deemed realistic to achieve passage of authorizing legislation in the foreseeable future, psychologists may be better served by turning their attentions to enhanced integration into primary care. This process begins by educating primary care entities such as the state primary care association about the roles the psychologist can fill. In the case of psychologists with advanced training in pharmacotherapy, those roles can include collaboration with PCPs on medication decision-making. However, conversations with psychologists involved in primary care around the country suggest this role has to be addressed with some sensitivity because reactions have been quite mixed. Some report they found primary care organizations very interested in the opportunity, whereas other organizations have rejected this option to avoid involvement in the debate over prescriptive authority for psychologists.

In some cases, offering traditional colocated mental health services in primary care settings may provide the foot in the door from which psychologists can move to discussing integrated healthcare services. This approach may be particularly effective in training settings where there is a preference for the use of doctoral-level mental health providers or in communities where there are few alternative mental health resources. In others, psychologists may find that primary care entities are more interested in employing masters-level providers to provide mental health services, in which case psychologists must make their case for integration directly on the basis of their behavioral services for patients with traditional medical disorders.

Once psychologists are participating in primary care, the contribution they can make to the medication management of patients will start to emerge. Through improved diagnosis of mental health conditions, comprehensive treatment planning, and direct advice on appropriate medication management by psychologists who have also received postdoctoral training in psychopharmacology, PCPs can learn about the value of allowing psychologists a greater role in this arena. This strategy has been used to great effect in Hawaii and several other states where the placement of psychologists knowledgeable in pharmacotherapy in primary care settings has been ongoing for a number of years.

Whichever approach psychologists pursue, both prescribing and primary care psychology will have predictable effects on the field. Psychologists will be working with sicker, more medically complex, needier, and more culturally diverse populations than they have in the past. Although medicine is likely to remain the dominant profession in primary care settings, psychologists can adopt greater leadership in the management and design of healthcare systems. This will be particularly true for psychologists who combine prescriptive authority with work in a primary care setting. This role will allow psychologists to advocate more effectively for the increased use of psychosocial intervention even as traditional weekly psychotherapy becomes more of a specialty service; for enhanced use of assessment and psychological principles to predict treatment adherence and to identify the emotional and behavioral concomitants of medical illness; and for the development of treatment plans that truly considers the needs of the whole person.

Preparing psychologists to pursue these opportunities will require creating additional educational opportunities for psychologists. Doctoral-level training will need to evolve if it is to remain relevant to the survival of the practitioner. It is noteworthy that the current accreditation documents in doctoral-level psychology do not even mention several topics that are essential to behavioral healthcare, including training in substance abuse, psychopharmacology, or clinical medicine.

Even in the absence of change in the curriculum, there are opportunities for preparing students through practica. Advanced-level practicum experiences in primary care settings provide a cost-effective method for both preparing psychologists in primary care psychology and exposing PCPs to the roles psychologists can fill in those settings. The main obstacle slowing the progress of such placements (beyond lack of awareness among psychologists) is a shortage of psychologists who can supervise in the primary-care setting. This is slowly changing, but in the meantime, some training programs are providing the supervision services themselves to make the opportunity available. At the same time, supervisors for all levels of psychology students should be discussing medication in any case where it is a consideration or where the patient is currently receiving medication. Students in healthcare psychology are rarely encouraged to consider the extent to which their patients' medications are actually working because this is

considered the task of the prescriber. Such reflections can contribute to a more objective evaluation of the appropriate role for medication in clinical practice. Primary care placements will enhance these opportunities to discuss medication issues. At the same time, postdoctoral programs in pharmacotherapy for psychologists should acknowledge and prepare their students for a future involving greater collaboration with PCPs.

Conclusions

The profession of psychology must evolve or risks withering. The healthcare system can benefit from the emergence of a discipline with a strong empiricist tradition that examines health from a psychobiosocial rather than a biopsychosocial model (LeVine & Foster, 2010). Psychologists will help identify circumstances in which biological interventions should be ancillary to the psychosocial rather than vice versa, teach patients to advocate for themselves, and understand why this patient behaved this way in this situation and how the doctor can behave differently to achieve the desired end.

The pressures identified at the beginning of this article created a troubling picture for the future of psychology. With lower-cost providers competing effectively with psychologists, psychology could well become increasingly marginalized, a profession perhaps respected by other healthcare providers but offering a boutique service.

Alternatively, psychology can work to redefine what is meant by doctoral-level psychological care. Doing so will require formidable effort. To summarize the various actions mentioned in this article, it will require addressing limitations in same-day billing, educating stakeholders in the primary care community about the role psychologists can play in the medical home, training psychologists to work in these settings, increasing the number of psychologists collaborating with physicians on medication decision-making, and convincing legislators that psychologists can prescribe. Psychologists will have to get used to dealing with medically complex patients and more severely mentally ill individuals, working collaboratively with other professionals, and understanding the practices of primary care. We believe these changes are necessary if we are to secure the future of our profession.

References

Ally, G. A. (2009, August). *RxP psychologists: New skills, new roles.* Presented at the Annual Convention of the American Psychological Association, Toronto ON.

American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. (2007). *Joint principles of the patient-centered medical home.* Retrieved from http://www.medicalhomeinfo.org/joint%20Statement.pdf

Annapolis Coalition on the Behavioral Health Workforce. (2007). *An action plan for behavioral health workforce development.* Washington, DC: Substance Abuse and Mental Health Administration.

Ax, R. K., Fagan, T. J., & Resnick, R. J. (2009). Predoctoral prescriptive authority training: The rationale and a combined model. *Psychological Services, 6,* 85–95.

Barlow, D. (2004). Psychological treatments. *American Psychologist, 59,* 869–878.

Bazaldua, O., Ables, A. Z., Dickerson, L. M., Hansen, L., Harris, I., Hoehns, J., & Saseen, J. J. (2005). Suggested guidelines for pharmacotherapy curricula in family medicine residency training: Recommendations from the Society of Teachers of Family Medicine Group on Pharmacotherapy. *Family Medicine, 37,* 99–104.

Bickman, L. (1999). Practice makes perfect and other myths about mental health services. *American Psychologist, 54,* 965–978.

Blount, A. (2003). Integrated primary care: Organizing the evidence. *Families, Systems & Health, 21,* 121–133.

Bureau of Labor Statistics, U.S. Department of Labor. (2010). *Occupational outlook handbook: 2010* (11th ed.). Washington, DC: Bureau of Labor Statistics, U.S. Department of Labor. Retrieved from http://www.bls.gov/oco

Chambliss, C., Pinto, D., & McGuigan, J. (1997). Reactions to managed care among psychologists and social workers. *Psychological Reports, 80,* 147–154.

Chiles, J., Lambert, M., & Hatch, A. (2002). Medical cost offset: A review of the impact of psychological interventions on medical utilization over the past three decades. In N. A. Cummings, W. T. O'Donohue, & K. E. Ferguson (Eds.), *The impact of medical cost offset on practice and research: Making it work for you: A report of the First Reno Conference on Medical Cost Offset* (pp. 47–56). Reno, NV: Context Press.

Claiborne, N., & Vandenburgh, H. (2001). Social workers' role in disease management. *Health & Social Work, 26,* 217–225.

Cohen, J., Marecek, J., & Gillham, J. (2006). Is three a crowd? Clients, clinicians, and managed care. *American Journal of Orthopsychiatry, 76,* 251–259.

Cunningham, P. J. (2009). Beyond parity: Primary care physicians' perspectives on access to mental health care. *Health Affairs, 28,* w490–w501.

Cypres, A., Landsberg, G., & Spellmann, M. (1997). The impact of managed care on community mental health outpatient services in New York State. *Administration and Policy in Mental Health, 24,* 509–521.

de Brantes, F., Gosfield, A. G., Emery, D., Rastogi, A., & D'Andrea, G. (2009). Sustaining the medical home: How PROMETHEUS Payment© can revitalize primary care. Retrieved from http://www.prometheuspayment.org/publications/pdf/STMH%20Full%20with%20Apps.pdf

Department of Health and Human Services. (2010). *Sebelius calls on Anthem Blue Cross to publicly justify 39 percent premium increase.* Retrieved from http://www.hhs.gov/news/press/2010pres/02/20100208c.html

Fox, R. E., DeLeon, P. H., Newman, R., Sammons, M. T., Dunivin, D. L., & Baker, D. C. (2009). Prescriptive authority and psychology: A status report. *American Psychologist, 64,* 257–268. doi:10.1037/a0015938

Frank, R. G., & Glied, S. A. (2006). *Better but not well: Mental health policy in the United States since 1950.* Baltimore: Johns Hopkins University Press.

Gold, S. N., & Shapiro, A. E. (1995). Impact of managed care on private practice psychologists: Florida study. *Psychotherapy in Private Practice, 14,* 43–55.

Gruber, A. R. (2010). Psychologists in primary care. In R. E. McGrath & B. A. Moore (Eds.), *Pharmacotherapy for psychologists: Prescribing and collaborative roles* (pp. 173–187). Washington, DC: APA Books.

Hakim, D., & Abelson, R. (2009, January 13). Big health insurer agrees to update its fee data. *New York Times,* p. B1.

Hollon, S. D., Jarrett, R. B., Nieremberg, A. A., Thase, M. E., Trivedi, M., & Rush, A. J. (2005). Psychotherapy and medication in the treatment of adult and geriatric depression: Which monotherapy or combined treatment? *Journal of Clinical Psychiatry, 66,* 455–468.

Jensen, P. S., Arnold, L. E., Swanson, J., Vitiello, B., Abikoff, H. B., Greenhill, L. L., . . . Hur, K. (2007). Follow-up of the NIMH MTA study at 36 months after randomization. *Journal of the American Academy of Child and Adolescent Psychiatry, 46,* 989–1002.

Kates, N., Ackerman, S., Crustolo, A. M., & Mach, M. (2006). *Collaboration between mental health and primary care services: A planning and implementation toolkit for health care providers and planners.* Mississauga, ON: Canadian Collaborative Mental Health Initiative.

Kavilanz, P. (2010, March 11). *Some nurses paid more than family doctors.*

Retrieved from http://money.cnn.com/2010/03/11/news/economy/health_care_doctor_incomes

Kennard, B. D., Silva, S., Vitiello, B., Curry, J., & Kratochvil, C. (2009). Readmission and residual symptoms after acute treatment of adolescents with major depressive disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 48,* 186–195.

Kessler, R. C., Demler, O., Frank, R. G., Olfson, M., Pincus, H. A., Walters, E. E., . . . Zaslavsky, A. M. (2005). Prevalence and treatment of mental disorders, 1990 to 2003. *New England Journal of Medicine, 352,* 2515–2523.

Kirkcaldy, R. D., & Tynes, L. L. (2006). Best practices: Depression screening in a VA primary care clinic. *Psychiatric Services, 57,* 1694–1696.

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 139–193). New York: Wiley.

Lenz, E. R., Mundinger, M. O., Kane, R. L., Hopkins, S. C., & Lin, S. X. (2004). Primary care outcomes in patients treated by nurse practitioners or physicians: Two-year follow-up. *Medical Care Research and Review, 61,* 332–351.

LeVine, E. S., & Foster, E. O. (2010). Integration of psychotherapy and pharmacotherapy by prescribing-medical psychologists: A psychobiosocial model of care. In R. E. McGrath & B. A. Moore (Eds.), *Pharmacotherapy for psychologists: Prescribing and collaborative roles* (pp. 105–131). Washington, DC: APA Books.

LeVine, E. S., & Wiggins, J. (2010). In the private practice setting: A survey on the experiences of prescribing psychologists. In R. E. McGrath & B. A. Moore (Eds.). *Pharmacotherapy for psychologists: Prescribing and collaborative roles* (pp. 153–171). Washington, DC: APA Books.

Luhrmann, T. M. (2000). *Of two minds: The growing disorder in American psychiatry.* New York: Knopf.

Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry, 159,* 909–916.

Manderscheid, R. W., & Henderson, M. J. (2004). *Mental health, United States, 2002.* Rockville, MD: U.S. Department of Health and Human Services.

Mark, T. L., Levit, K. R., & Buck, J. A. (2009). Psychotropic drug prescriptions by medical specialty. *Psychiatric Services, 60,* 1167.

Mauer, B. J., & Druss, B. G. (2009, April 2). Mind and body reunited: Improving care at the behavioral and primary care interface. *Journal of Behavioral Health Services and Research.* doi:10.1007/s11414-009-9176-0

McDaniel, S. H., & Fogarty, C. T. (2009). What primary care psychology has to offer the patient-centered medical home. *Professional Psychology: Research and Practice, 40,* 483–492.

McDaniel, S. H., Hargrove, D. S., Belar, C. D., Schroeder, C., & Freeman, E. L. (2004). Recommendations for education and training in primary care psychology. In R. G. Frank, S. H. McDaniel, J. H. Bray, & M. Heldring (Eds.), *Primary care psychology* (pp. 63–92). Washington, DC: APA Books.

McGrath, R. E. (2005). Saving our psychosocial souls. *American Psychologist, 59,* 644–648.

McGrath, R. E. (2010). Prescriptive authority for psychologists. *Annual Review of Clinical Psychology, 6,* 21–47.

Murphy, M. J., DeBernardo, C. R., & Shoemaker, W. E. (1998). Impact of managed care on independent practice and professional ethics: A survey of independent practitioners. *Professional Psychology: Research and Practice, 29,* 43–51.

Olfson, M., & Marcus, S. C. (2009). National patterns in antidepressant medication treatment. *Archives of General Psychiatry, 66,* 848–856.

Olfson, M., & Marcus, S. C. (2010). National trends in outpatient psychotherapy. *American Journal of Psychiatry.* doi:10.1176/appi.ajp.2010.10040570

O'Donohue, W. T. (2009). Integrated care: Whom to hire and how to train. In L. C. James & W. T. O'Donohue (Eds.), *The primary care toolkit* (pp. 41–51). New York: Springer.

O'Donohue, W. T., Cummings, N. A., & Cummings, J. L. (2009). The unmet educational agenda in integrated care. *Journal of Clinical Psychology in Medical Settings, 16,* 94–100.

Power, A., & Chawla, N. (2008). Transformations in collaborative healthcare. *Families, Systems, & Health, 26,* 459–465.

Reaves, R. P. (2006). The history of licensure of psychologists in the United States and Canada. In T. J. Vaughn (Ed.), *Psychology licensure and certification* (pp. 17–26). Washington, DC: American Psychological Association.

Robert Wood Johnson Foundation. (2009). *What are Evidence-Informed Case Rates (ECRs®)?* Retrieved from http://www.rwjf.org/files/research/prometheuswhatareecrs2009.pdf

Robiner, W. N., Bearman, D. L., Berman, M., Grove, W. M., Colón, E., Armstrong, J., & Mareck, S. (2002). Prescriptive authority for psychologists: A looming health hazard? *Clinical Psychology: Science and Practice, 9,* 231–248.

Robinson, P. J., & Reiter, J. T. (2007). *Behavioral consultation and primary care: A guide to integrating services.* New York: Springer.

Rothbaum, P. A., Bernstein, D. M., Haller, O., Phelps, R., & Kohout, J. (1998). New Jersey psychologists' report on managed mental health care. *Professional Psychology: Research and Practice, 29,* 37–42.

Rupert, P. A., & Baird, K. A. (2004). Managed care and the independent practice of psychology. *Professional Psychology: Research and Practice, 35,* 185–193.

Schneider, R. K., & Levenson, J. L. (2008). *Psychiatric essentials for primary care.* Philadelphia: American College of Physicians.

Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The *Consumer Reports* study. *American Psychologist, 50,* 965–974.

Soni, A. (2009). *The five most costly conditions, 1996 and 2006: Estimates for the U.S. civilian noninstitutionalized population. Statistical Brief #248. July 2009.* Rockville, MD: Agency for Healthcare Research and Quality.

Speer, A., & Bess, D. (2003). Evaluation of compensation of nonphysician providers. *American Journal of Health-System Pharmacy, 60,* 78–80.

Spitzer, R., Williams, J., Kroenke, K., Linzer, M., deGruy, F. V., III, Hahn, S. R., . . . Johnson, J. G. (1994). Utility of a new procedure for diagnosing mental disorders in primary care: The PRIME-MD 1000 study. *Journal of the American Medical Association: Journal of the American Medical Association, 272,* 1749–1756.

Thielke, S., Vannoy, S., & Unutzer, J. (2007). Integrating mental health and primary care. *Primary Care: Clinics in Office Practice, 34,* 571–592.

Thomas, K. C., Ellis, A. R., Konrad, T. R., Holzer, C. E., & Morrissey, J. P. (2009). County-level estimates of mental health professional shortage in the United States. *Psychiatric Services, 60,* 1323–1328.

Toft, T., Fink, P., Oernboel, E., Christensen, K., Frostholm, L., & Olesen, F. (2005). Mental disorders in primary care: Prevalence and comorbidity among disorders: Results from the Functional Illness in Primary care (FIP) study. *Psychological Medicine, 35,* 1175–1184.

U.S. Department of Labor. (2008). *Occupational outlook handbook, 2008–2009.* St. Paul, MN: Jist Works.

Received June 2, 2010
Revision received October 4, 2010
Accepted November 5, 2010 ■

#5

Testimony on HB1272 – Bill to Create Medical Psychologists
ND State Board of Psychologist Examiners
Human Services Committee
Representative Robin Weisz, Chairman
January 28, 2015 - 11:00 am

Chairman Weisz, members of the House Human Services Committee, I am Dr. Paul Kolstoe, a Psychologist, licensed under Chapter 43-32 of the ND Century Code and representing the Board of Psychologist Examiners today. I am here today to testify about the position of the Board of Psychologist Examiners on the proposed changes to the statutes regarding the practice of psychology that you depend upon the Board to implement.

As you know, the Board of Psychologist Examiners is charged with regulating the professions of both psychology and behavior analysis on behalf of the people of North Dakota. The Board supports the intent of the legislation proposed in House Bill 1272 to create medical psychologists, a role in which appropriately trained psychologists would prescribe psychotropic medications. While the specific role as a prescriber would be regulated by another board, we support these efforts without reservation.

Psychologists are behavioral health specialists with extensive training in the evaluation and treatment of human behavior. Beyond the four-year undergraduate degree, there is a highly competitive selection process to get into graduate school for specialized training in human behavior and psychopathology. Graduate school lasts four years or more, followed by a rigorous structured internship practice year. Finally, the candidate must pass a national written examination, an oral examination by the Licensing Board, and complete one more year of behavioral health practice under full supervision before a license may be granted.

Medical psychologists, in the proposed legislation, must then complete an addition equivalent of a Masters degree specific to prescribing psychotropic medications. The Bill also requires extensive supervised practice before a medical psychologist could independently prescribe such medications.

Because psychiatrists have become scarce throughout the country, especially in rural areas such as North Dakota, there is increasing dependence on other medical practitioners who have been given limited prescribing authority in many areas. Such collaborative arrangements have appeared to work well when the demands and needs are outpacing the currently available prescribing providers.

This Bill attempts to remedy the scarcity of prescribing professionals and to do so by authorizing highly trained professionals to provide a necessary service to the citizens of our state. Medical psychologists, as proposed in the bill, have extensive and standardized training, and have been recognized by three states, the Department of Defense, and other respected entities as being qualified for prescribing.

It makes sense that psychologists completing a nationally recognized prescribing training program, who are well-trained in evaluating and treating mental illness in a comparable level as psychiatrists, should be authorized to engage in collaborative professional relationships with already regulated prescribing professionals to be able to prescribe psychotropic medications. In fact, North Dakota citizens with mental illness deserve access to qualified mental health prescribers, which this bill provides.

I would be happy to answer any questions.

1-28-15 #6

Good morning Mr. Chairman, and Human Services Committee. My name is Anthony Tranchita, and I am here to provide testimony in support of House Bill 1272 relating to the possible certification of medical psychologists in the State of North Dakota.

I am a United States Public Health Service Officer, currently serving in the rank of Commander, our equivalent of Lt Col if you are not familiar with that rank system, at Grand Forks Air Force Base. However, to be clear, I am here as a private citizen today to testify, I am not representing the opinion of any Federal Government entity.

To give some further background on myself, my PhD was completed at Utah State University. Starting in 2003, I served 4 years with the United States Air Force at Wright-Patterson Air Force Base in Ohio and Altus Air Force Base in Oklahoma. I then switched to the United States Public Health Service, with whom I have had two assignments. First, I worked at the Aberdeen Area Youth Regional Treatment Center in South Dakota, an Indian Health Service facility on the Standing Rock reservation between Mobridge and Wakpala where we treated adolescents with diagnosed substance abuse disorders. As you are likely aware, since that time the name has changed to the Great Plains Area, rather than Aberdeen Area. In December 2009, I changed station to Grand Forks Air Force Base here in North Dakota, serving as the Behavioral Health Flight Commander for most of that time, meaning I have oversight of all mental health, domestic violence and substance abuse services for Grand Forks Air Force Base. Most recently, I returned just over a month ago from a deployment to Liberia where I served as the Behavioral Health Lead for the Monrovia Medical Unit, an Ebola Treatment Unit staffed completely by US Public Health Service Officers. I am licensed in both the State of Wisconsin and the State of New Mexico.

While working on the Standing Rock Reservation, an opportunity came along to obtain training in Psychopharmacology as part of an Indian Health Services Cohort. Early in my career, that was not training that interested me. The Air Force offered similar training in psychopharmacology to become a prescribing/medical psychologist, and I remember thinking "why would I want to do that". However, my experiences with serving in the Aberdeen Area changed my mind. We served adolescents from throughout the Aberdeen Area which includes North Dakota, South Dakota, Nebraska and Iowa, and on occasion served Native Americans from outside the Area as well.

It became clear to me that the distance to get to mental health prescribers was a significant barrier for many of the Native families we served. There were few I.H.S. facilities with psychiatry as an offered service, which meant that mental health prescribers were often more than a 100 mile drive away. Therefore, if follow-up was scheduled, often families did not have the resources to allocate to obtaining that service. This meant that at best follow-up was conducted with Primary Care, and often was not followed up on at all. This had obvious implications for long-term health and mental health stability of those patients. Therefore, I decided that the addition of prescribing psychologists into the healthcare

system made a great deal of sense particularly in rural settings, and that I would take the next step to engage in that process myself.

I began coursework in January of 2009, and completed a Post-Doctoral Master's Degree in Psychopharmacology in May of 2011 which included 29 Credit Hours of Distance Education courses through Alliant International University.

To meet criteria for New Mexico state licensure I have completed an 80 hour practicum in clinical assessment and pathophysiology supervised by a Board Certified Family Practice doctor, as well as a 100 patient/400 hour psychopharmacology practicum supervised by the same doctor. The practicum was conducted in the Family Practice clinic. My practicum supervision involved co-signatures for all new prescriptions, and weekly meetings for supervision. I wrote my first prescription under supervision in December of 2011.

On March 25th, 2013 I passed the Psychopharmacology Exam for Psychologists or PEP. This is a 3 hour, 150 question multiple choice licensure exam for prescribing/medical psychologists developed by the American Psychological Association. Per the PEP Candidate Guide, the PEP "measures didactic knowledge associated with the safe and effective practice of psychology involving prescribing of psychotropic medications or collaborating with those who prescribe such medications". The PEP questions are designed to tap into 11 knowledge-based content areas to include the following:

1) **Integrating clinical psychopharmacology with the practice of psychology**
2) **Neuroscience**
3) **Nervous system pathology**
4) **Physiology and pathophysiology**
5) **Biopsychosocial and pharmacological assessment and monitoring**
6) **Differential diagnosis**
7) **Pharmacology**
8) **Clinical Psychopharmacology**
9) **Research**
10) **Professional, legal, ethical, and interprofessional issues**
11) **Diversity Factors**

I will tell you that preparing for this exam was an arduous process, one which required significant study. The best study resource that I found for this exam was a book written as study material for preparation for the Psychiatry board exam.

In July 2013, I completed all requirements for the prescription certificate licensure for New Mexico, and am now under what they call "Conditional" Licensure status. This licensure status lasts two years, and entails weekly supervision with a physician, conducted in this case by my Chief of Medical Staff at the Air Force Base, also a Board Certified Family Practice physician.

As I am here as a private citizen, not representing the Air Force Base, I am not in a position where the presentation of data would be appropriate. However, there are several things I can say without reservation. All of the patients I have seen for medication therapy have been active duty or retired Air Force members, or their family members. It is my opinion that my ability to see these patients for medication therapy has a significant positive impact on access to mental health care in our facility, and improved the integration of our services with Primary Care. This is due to the very significant fact that it is much more likely to have follow up occur when a physician identifies a mental health issue and walks that person down the hall, and vice-versa when I as a prescribing psychologist identify a possible medical issue I know I have a collaborative relationship with their PCM.

It is also my opinion that having a mental health prescriber in the MTF has had a significant impact on the quality of care for our active duty population. There are numerous military specific rules about mental health medications and deployability and the need for MEBs. These rules are often not known by psychiatrists "downtown" and sometimes not even known fully by the PCMs working in our MTF given the breadth of conditions they need to treat and track for deployability impact.

In the past year, I recommended to the leadership of the Psychologist Professional Advisory Group (PsyPAG) for the US Public Health Service that we should have a Special Interest Group for medical psychologists within our service. I did this because my experience has taught me how arduous the path was to licensure, particularly when practicing in a State without prescription priviledges, or a training program to rely upon, and wanted to do what I could to broaden the impact of the medical psychologists in the US Public Health Service. I was just informed last week that this Special Interest Group will continue for this coming year, and I will continue to serve as Chair.

The above experience leads me to several conclusions about the viability of licensing prescribing psychologists.

First, that we can practice safely. You have heard the quantity of education and supervision I have received to get to this point, and you have heard the complexity of our licensure exam which has as its basic tenet to determine that we can practice safely and effectively. It has been my experience that the educational requirements, supervision requirements, and use of the PEP has prepared myself and other psychologists to be able to safely treat patients with psychotropic medication.

Second, prescribing psychologists can have a real and demonstrable impact on two very important aspects of behavioral health: improved access and improved integration of behavioral health services. There still exist today multiple gaps in the behavioral health system. Passage of this bill does not fill all of them, nowhere near it, but it is a step toward increased integration, and having trained mental health prescribers in places like Primary Care clinics in small communities, where mental health issues are most likely to be identified.

As such, I am strongly recommending passage of a bill for prescribing psychologists in the State of North Dakota. I view it as a step that can be taken to better address the mental health needs of the State.

Mr. Chairman, I thank you and the members of the committee for your time and attention, are there any questions?

#7

28 Jan 2015

House Human Services Committee

Testimony in support of HB 1272

Chairman Weisz and members of the committee,

For the record my name is Bonnie Staiger (#158) representing the North Dakota Psychological Association on this bill. NDPA has a formal position in support of prescriptive authority for appropriately trained psychologists and with the understanding that they be regulated by the ND State Board of Psychologist Examiners (NDCC Chapter 43-32).

However, we have concerns and do not support the placement of this practice specialty under the regulation of the ND State Board of Medical Examiners (NDCC 43-17). This creates confusion of regulatory jurisdiction for a professional scope of practice that should be housed within psychological and behavioral interventions and treatment.

#8

HOUSE HUMAN SERVICES COMMITTEE

HOUSE BILL NO. 1272

Testimony of Robert J. Olson, M.D.
January 28, 2015

Chairman Weisz and members of the House Human Services Committee, my name is Dr. Robert Olson. I am a psychiatrist practicing in Fargo for over 25 years and a member of the North Dakota State Board of Medical Examiners. I am providing this testimony in opposition to House Bill No. 1272. I am indeed sorry I cannot attend the committee hearing in person but my schedule does not allow.

There can be no doubt that North Dakota needs more behavioral health providers, especially in the rapidly growing western part of our state. As a long time North Dakotan that grew up in Williston, I am keenly aware of that need. But this bill, which would permit psychologists to prescribe, is not the proper solution. In fact, it may be counterproductive.

In my opinion, this bill would divert psychologists from their area of greatest strength – providing much needed expert psychotherapy to our growing population – to an area of great weakness – prescribing psychotropic drugs. Please understand, we are short in both areas of mental health treatment, therapy and prescribers. More prescribers alone is not the answer; we need more of everything in the behavioral health field.

As a geriatric psychiatrist, I use my general medical and neurological knowledge every day to assess the impacts and the contraindications, the multiple medical conditions including kidney functions, cardiac limitations, and others as well as drug interactions and side effect interpretation. Computer programs provide some assistance but have many flaws and further expertise is needed to interpret based on a clinical situation. Many times I must stop or adjust medications because of these purely physical factors. Medical prescribing is a complex task that can't be learned from some crash courses including pharmacology without a strong medical knowledge base. Physicians, advance practice nurses, physician assistants, have these years of medical background. Psychologists simply do not.

I know and work with many psychologists. They are partners in patient care. The vast majority recognize their medical limitations and, frankly, have no interest in deviating from the much needed service they now provide.

I urge you to give this bill a "do not pass" recommendation. If I can provide further information or be of assistance to the committee in any way, please let me know. Thank you for your consideration.

Robert Obmascher

#9

NDMA
Est.1887 NORTH DAKOTA MEDICAL ASSOCIATION

House Human Services Committee
HB 1272
January 28, 2015

Good morning Chairman Weisz and Committee Members. I'm Courtney Koebele and I represent both the North Dakota Psychiatric Society and the North Dakota Medical Association.

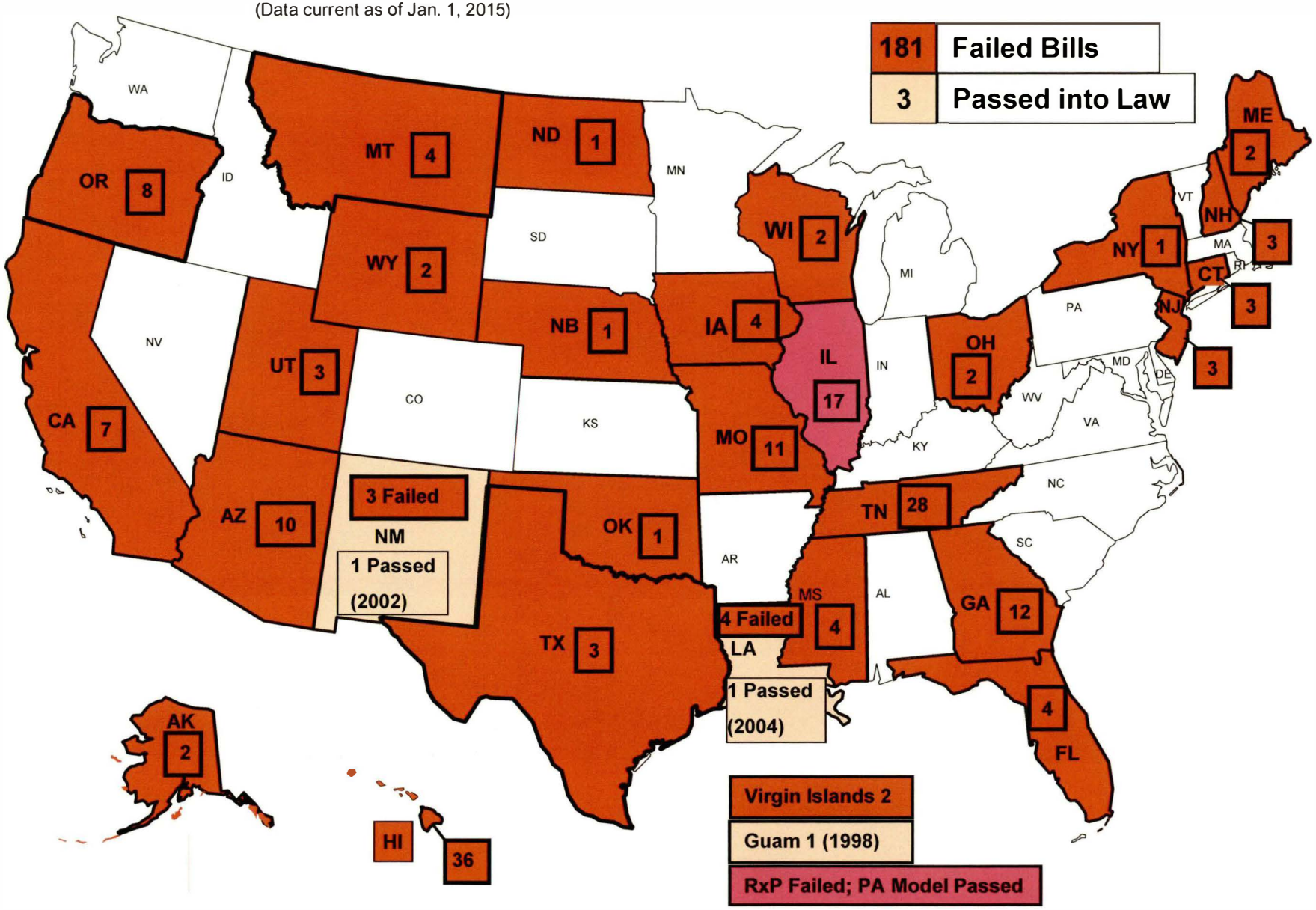
Both physician organizations oppose HB 1272, which would allow a "medical psychologist" to prescribe medications. As you can see on the attached graphic,181 bills similar to this one have been defeated in 28 states over the last 20 years. However, three of those 28 states have passed highly restricted bills into law, but that took a combined 24 attempts.

In congruence with the other 46 states who have defeated these attempts or choose to not pursue this course of action, the North Dakota Psychiatric Society and the North Dakota Medical Association oppose permitting psychologists – who are not medically trained and who are not physicians – to prescribe psychotropic medications.

With me today are Dr. Rachel Fleissner, Dr. Cheryl Huber, Dr. Gabriella Balf, Dr. Laura Kroetsch, Dr. Diane Nelson, and Dr. Kevin Dahmen, psychiatrists who are here to testify on behalf the North Dakota Psychiatric Society.

Psychologist Prescriptive Authority Legislative Bills 1995-2015

(Data current as of Jan. 1, 2015)



POPPP: Psychologists Opposed to Prescription Privileges for Psychologists

#10

House Human Services Committee
HB 1272
January 28, 2015

Chairman Weisz and Committee Members, I am Rachel Fleissner. I am a Medical Doctor. I am Board Certified in Adult Psychiatry and I am also Board Certified in Child and Adolescent Psychiatry and I strongly urge you **oppose HB 1272.**

Psychologists are **not** physicians and **do not** have the **medical training** necessary to safely prescribe medications. Prescribing privileges for psychologists are **not** supported by The National Alliance on Mental Illness (NAMI).

While it is certainly true that there is a shortage of professionals to care for patients with mental illness, including psychiatrists trained to treat adult patients and psychiatrists trained to treat children and adolescents, allowing psychologists to prescribe powerful psychotropic medications will not provide access to quality health care but instead will compromise the safety of patients in North Dakota.

The issues of access for patients will mental illnesses are being addressed in other bills which have been written in joint collaboration of all mental health care providers. I am proud to say that the psychiatrists in the state are working with their primary care colleagues- setting up collaborative enterprises and utilizing technology and integrative care programs to address the needs of the North Dakota citizens with mental health needs.

Psychiatrists are medical doctors who have received at least 4 years of extra training **after** medical school. Child and adolescent psychiatrists are medical doctors who have received an extra five years of training **after** medical school. The post medical school training for a psychiatrist includes 10,000 to 12,000 hours of training in pharmacology in order to treat mental health disorders.

Psychologists are not trained to understand, assess, and monitor a patient's medical condition as a whole. Research has shown a consistent lack of evidence about the safety of granting psychologists prescription privileges. Mental illnesses are medical illnesses and therefore need to be treated by a medical practitioner. Mental illnesses do not just reside in a patient's head; their whole medical physiology is part of these illnesses.

Programs that have attempted to train psychologists to prescribe medications have not been effective. A great example of this is the Department of Defense who set up a program to train 10 psychologists to prescribe. To train these psychologists to the level the department of defense felt was good enough for their members cost more than $6 million dollars. This is a cost of roughly $600,000 per psychologist. The department of defense did not feel that this was cost effective and closed this program.

Psychotropic medications used to treat mental illnesses are among the most powerful in medicine and affect all parts of the body not just the brain (just as cancer agents affect all the body not just the tumor). These medications can have serious medical side effects if they are prescribed inappropriately such as convulsions, heart arrhythmia, loss of ability to fight infection, movement disorders, even coma and death.

In addition, studies show that over half of all people taking a psychotropic for a mental illness have at least one other physical illness for which they are taking other medication prescribed to them by a medical professional and this creates a high potential for serious and complicated drug interactions which a medical training is necessary to understand and manage.

Because psychiatrists are medical doctors they have the training, knowledge, and ability to understand a patient's complex medical history, perform a medical exam, make a fully integrated diagnosis, and prescribe appropriate medication at a safe and appropriate dose.

Psychologists do not have the medical training obtained during and after medical school. Unless they are prepared to return to go medical school to obtain the medical training and then continue with the 4 to 5 year post medical school training we should not be legislating a "quick and dirty" way for them to obtain a medical degree and we should not be placing the population of North Dakota at risk in obtaining medical services from a practitioner with no medical background and insufficient knowledge to understand the complexity of the job.

For all the reasons I have listed above I urge you for the safety and well-being of the population of North Dakota to **oppose HB 1272**. Thank you for your time. I will gladly stand for any questions.

#1

House Human Services Committee
HB 1272
January 28, 2015

Good morning, Chairman Weisz and Committee members.

I'm Dr. Cheryl Huber, a board certified psychiatrist with Sanford Medical Center in Bismarck and a member of the North Dakota Psychiatric Society. It's good to see a lot of attention being paid to the mental health needs of the residents of North Dakota during this legislative session, and hopefully the outcome will be improved access to mental health services. However, I am here in opposition of HB 1272.

You have already heard the testimony of Dr. Fleissner, and I don't intend to repeat that. I will comment that I think access to medically trained professionals who can prescribe medications is one of our lesser worries. Training in prescribing medications for mental health reasons is already incorporated into residency programs for family practice and internal medicine physicians. Nurse practitioners also have this training as part of their program and can take on extra training to specialize in mental health. With expansion of technology such as telemedicine, this will increase access to psychiatrists for patients and for practitioners in rural areas seeking consultation.

What we have a shortage of are competent well-trained psychologists and social workers who provide therapies that are also needed and indicated for mental illness. There are numerous studies demonstrating proven efficacy of cognitive-behavioral therapy, interpersonal therapy, dialectical-behavioral therapy, and other therapies for conditions such as depression, anxiety, and other mental illnesses. I can't provide this treatment. I have basic training in these therapies, but my psychology colleagues have much more. It's not just medication that makes people better, but helping people identify different ways of thinking or approaching the problems in their lives. This works best when psychiatrists and

psychologists work together, using their different skill sets to help people reach their goals.

I am opposed to HB 1272. I am accompanied today by several of my psychiatry colleagues who are opposed to this bill because it really doesn't address the mental health problems in North Dakota, and it has the potential to cause harm. I encourage you to oppose it as well.

Thank you for your time.

#12

House Human Services Committee

HB 1272

January 28, 2015

Good morning, Chairman Weisz and Committee members.

I am here as a psychiatrist and internist and I ask you to prevent likely mistakes and probable deaths by opposing bill 1272.

You have heard from my colleagues numbers that reflect the science on why letting a person without biomedical background prescribe medications is not a good idea.

Allow me to present two practical arguments that illustrate this idea.

1. Polypharmacy

Americans are taking an increased number of prescription medications: **by age 65 they take an average of 5 pills a day, 12% of them take an average of 10 pills a day.** As a psychiatrist or nurse practitioner, I have to know these medications prescribed by the primary doctor or specialists: how they interact with my meds, if the person experiences psychiatric side effects from medical medications - prednisone can make you psychotic for instance, certain heart medications can make you tired and look depressed. **One hospital admission in 10 is due to adverse drug reactions** so polypharmacy is not a small problem.

So not only I have to remember from my pharmacology classes, I also have to keep up with the newest meds and guidelines in the medical world.

In the very close future, I will brush up on my genetics classes because personalized medicine is coming fast! I can already tailor what medications to prescribe to your anxious elderly family members based on a simple genetic test.

I practiced as an internist for 9 years. Not any longer, since I became a psychiatrist. Why? Because I cannot keep up with the exciting progress in medicine and psychiatry. **The volume of knowledge in medicine doubles every 2 years! How do you keep up with that?**

I occasionally prescribe an antibiotic to my patients who would not go to doctors and I often pick up the phone to talk with the primary doc, the cardiologist or the pain specialist to coordinate our treatment.

Which brings me to the second practical argument.

2. The mental health provider may be the sole provider for the mentally ill.

I have patients who only see me as a medical person. They don't go to doctors because of their mental illness - we all know how people with schizophrenia don't have the habit to doctor diligently. Yet they are on potent medications, sometimes many of them, and I am the only one who watches over their health. I send my schizophrenic smokers to get checked out when they are coughing out blood or cannot walk because they are short of breath, I urge my female substance abusers to get care when they get pregnant and so forth. Did you know that **people with schizophrenia live 20 years less that the general population**? Because they don't or can't take care of themselves and die of heart problems or diabetes complications. Not on my watch though. I check their labs periodically and I am on the watch for medical complications.

So when I listen to a physical complaint, my frame of mind is different than a provider's with a psychology background.

I always keep in mind that the complaints could be due to a medical problem. If my anxious patient complains about chest pain, I will ask some targeted questions and depending on the answer I will send them to the ER or increase their Zoloft. **Mentally ill patients get heart attacks too.**

In sum, I believe that medicine has expanded too much and is too complex to be mastered as an additional specialty. Let's be mindful of our limits and do best what we were meant to do when we went to school. And let us call to be reimbursed for our efforts properly, otherwise we may all drop our training and practice worries and go work to McDonalds.

Thank you for listening.

Gabriela Balf-Soran, MD, MPH
Sanford Psychiatry Dept Chair
Phone (701) 323 6543
Fax (701) 323 5492
Email gabriela.balf@aya.yale.edu

#13

House Human Service Committee
HB 1272
January 28, 2015

Dear Chairman Weisz and Members of the Committee,

My name is Laura Kroetsch and I am a board certified psychiatrist and medical director of one of the state human service centers in North Dakota. I am writing to you not on behalf of my employer, but as a psychiatrist and citizen in North Dakota. I urge you to vote No on HB 1272. HB 1272 would allow psychologists to prescribe psychotropic medications without appropriate medical training. Prescription of psychiatric drugs is not just learning the psychiatric medications, but starts first with evaluation for medical illness. Many medical problems can masquerade as psychiatric illness. Individuals who prescribe psychotropic medications also need to be able to monitor for medical side effects such as worsening high blood pressure, weight gain, diabetes, high cholesterol, and kidney failure. Without careful prescribing and appropriate monitoring, the most serious side effects can result in death.

We need medically trained professionals to prescribe these medications. In addition to psychiatrists, primary care physicians, nurse practitioners, and physician assistants can all currently prescribe psychiatric medications. These training programs and licensing boards already exist. We do not need to create a new training program to meet the needs of the citizens of North Dakota. The state is already working to enhance collaboration between psychiatrists and these other medically trained professionals. For example, Family Healthcare in Fargo recently received a grant to implement a mental health track within their primary care clinic. I am currently providing psychiatric collaboration twice monthly and as needed to their advanced practice nurse. As we expand programs and collaboration like this we will effectively increase the number of our already licensed practitioners who feel confident treating and prescribing medications for our citizens with mental illness.

Our state has also already approved expanding our psychiatry residency training program from 16 to 20 psychiatric residents. With this expansion, there will be "rural training" that emphasizes using telepsychiatry to reach rural areas via polycom/computer to provide psychiatric care.

HB 1272 Will Not Improve Access to Appropriate Mental Health Care Services. It will only create new problems and new risks. Please vote "NO" on HB 1272 to protect our existing collaborative (and proven) approach to caring for patients with mental illness!

I would be happy to talk with you if you have any questions.

#14

Testimony HB 1272
House Human Services Committee
Representative Weisz, Chairman
January 28, 2015

Chairman Weisz, members of the House Human Committee, I am Carlotta McCleary, Executive Director of Mental Health America of North Dakota (MHAND), whose mission is to promote mental health through education, advocacy, understanding, and access to quality care for all individuals.

Today I am here to express concerns that MHAND has regarding HB 1272. While MHAND agrees that North Dakota is in need of additional mental health professionals we are just as concerned with the quality of care the individuals with mental health needs receive. Today individuals with mental health needs are experiencing poor health outcomes. Currently there are recommendations that we need to do a better job of integrating the physical health with the mental health treatment that individuals receive to improve their health outcomes.

We are concerned that the medical training would not be enough to safely treat individuals with mental health needs. There are many times symptoms may be similar to a mental health issue when in fact it may be a different medical issue. There are also serious side effects that need to be monitored while someone is being treated with medications. Again, we don't believe this would provide psychologist with enough medical training to address these potential concerns.

MHAND believes we need to improve access to care as well as increase the quality of care. Thank you for your time.

Carlotta McCleary, Executive Director
Mental Health America of North Dakota
(701) 255-3692

1-28-15 #15

American Psychiatric Association

1000 Wilson Boulevard
Suite 1825
Arlington, VA 22209
Telephone 703.907.7300
Fax 703.907.1085
E-mail apa@psych.org
Internet: www.psychiatry.org

January 27, 2015

Representative Robin Weisz
Chairman, Human Services Committee
State Capitol
600 East Boulevard Avenue
Bismarck, ND 58505

Dear Chairman Weisz and Members of the Committee:

I am writing on behalf of the American Psychiatric Associations (APA), the medical specialty society representing more than 36,000 psychiatric physicians as well as their patients and families, to urge you to vote "No/Do Not Pass" on HB 1272, a proposal that puts the health and safety of North Dakotans with mental illness and substance use disorders in serious jeopardy. HB 1272 seeks to establish a certification process that would allow "medical psychologists" to prescribe powerful psychotropic drugs to individuals who are likely to suffer from co-occurring medical conditions, e.g., diabetes, depression, and hypertension, that must be managed by qualified clinicians with appropriate training and expertise. It is a dangerous bill with an extremely misleading premise.

Clinical psychologists are behavioral professionals with competencies in behavior analysis and psychotherapy treatments. Psychologists and psychiatrists work together every day, and it is clear that psychologists have an important collaborative role in the mental health delivery system. However, psychologists have no core biomedical scientific training or required basic educational coursework (e.g., biochemistry, anatomy, physiology) in any level of their undergraduate or graduate study. They are not trained to assess the entire person and to understand the effect of pharmaceutical and other medical treatments on diseases and conditions that afflict the systems of the body. This is a simple fact that cannot be addressed by a haphazard online course consisting of as little as 400 hours of questionable instruction—the standard amount of contact hours recommended by the American Psychological Association Training Program for Prescriptive Authority. This legislation would enact a dangerously low bar for what passes as state-sponsored practice of medicine when compared with the 12 or more years that psychiatrists and other physicians spend in medical training.

As you review HB 1272, please take the following into consideration:

- Powerful psychotropic medications do not stop at the patient's brain. They affect many systems of the body. There can be seriously disabling or deadly side-effects if improperly prescribed and managed.

- Patients needing multiple medications for other physical conditions, such as heart disease or diabetes, are at risk for potentially serious drug interactions. It is very important to understand that over 50% of individuals with a mental disorder have a medical co-morbidity. The clinicians who treat these patients must be trained to understand and treat all systems of the body in order to recognize and appreciate the warning signs of adverse effects.

- Sound, alternative, biomedical education and training pathways already exist in North Dakota and are available to psychologists.

In contrast to the claims of proponents, the dangerous pathway proposed in HB 1272 would also not solve any rural needs given that experience elsewhere (i.e., the two out of three states with available data) has shown that psychologists do not relocate into rural areas when given prescriptive capability. Further, the proposal would contribute to the fragmentation of the North Dakota health care system by decreasing the availability of behavioral therapy that integrated mental health care teams have come to rely on from psychologists. By contrast, coordinated, team-based care in which every member is relied on for their training and expertise is the model of practice that is being embraced by policymakers on a federal and state level – HB 1272 would undermine this movement in North Dakota.

In summary, the practice of medicine is a serious responsibility that requires thorough and relevant education and training. Allowing crash course prescribing by psychologists through certification after cursory study and experience presents a serious and avoidable danger to your constituents. We urge you to vote No/Do Not Pass on HB 1272 and would welcome the opportunity to work with you through our North Dakota Psychiatric Society to promote scientifically sound programs that will help improve treatment for individuals suffering from mental illness and substance use disorders.

Thank you for the opportunity to share our concerns. If you have any questions regarding our comments, please contact Janice Brannon, Deputy Director, State Affairs at jbrannon@psych.org or (703) 907-7800.

Sincerely,

Saul Levin, MD, MPA

Saul Levin, M.D., M.P.A.
C.E.O. and Medical Director
American Psychiatric Association

#16

AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

January 28, 2015

The Honorable Robin Weisz
Chair
Human Services Committee
North Dakota House of Representatives
2639 First Street, SE
Hurdsfield, ND 58451

Re: House Bill 1272

Dear Chairperson Weisz:

On behalf of the American Medical Association (AMA) and our physician and medical student members, I write in **opposition to House Bill (H.B.) 1272**, which would inappropriately grant prescriptive authority to psychologists and unprecedented powers to the North Dakota State Board of Psychologist Examiners. While the AMA values the role that psychologists play in our nation's health care system, we do not believe that granting prescriptive authority to a new category of "medical psychologists" is in the best interests of North Dakota's patients.

Psychologists lack the education and training to prescribe psychotropic medication
Physicians have more than 10,000 hours and seven-to-11 years of clinical education and training to enable them to correctly diagnose, treat and manage patients' health care needs. In comparison, psychologists are only required to have one year of patient care experience during their training— training that is focused entirely on non-medical therapies.

In sharp contrast to psychology training, at each stage of a medical student's education and training, medical students learn how pharmacotherapy integrates into all branches of medicine, such as family medicine and psychiatry, including child and adolescent psychiatry. Physicians are tested on this knowledge as part of the medical licensure process, with particular emphasis on pharmacotherapy in the third and fourth part of the United States Medical Licensing Exam—a series of four examinations that physicians must take and pass in order to be licensed to practice medicine in the United States.

After graduation from medical school, psychiatric resident physicians spend more than four years learning the complexities related to appropriate prescribing in multiple clinical situations and settings— gaining in-depth knowledge essential to their chosen specialty. Such medical

education and training are essential to safely treat patients and independently prescribe psychotropic medications that are used to treat mental illness and other conditions.

There is no equivalent in psychologists' education and training, even with the additional pharmacologic educational requirements anticipated in the proposal at issue.

H.B. 1272 grants the psychology board unprecedented prescriptive authority
Furthermore, we are greatly concerned that H.B. 1272 would grant the North Dakota State Board of Psychologist Examiners the unlimited authority to craft the educational requirements of "medical psychologists" and authorize non-medically trained persons to prescribe some of the world's most powerful medications, despite the lack of any requirement that members of the board have any direct experience prescribing these powerful medications. By granting such widespread authority, H.B. 1272 would do a grave disservice to North Dakota's patients.

North Dakota's psychiatrists and psychologists practice in same locations
Finally, a review of the practice locations of psychiatrists and other primary care physicians to psychologists clearly shows that there is no shortage of prescribing professionals in urban areas of North Dakota. I have attached a map that depicts this for your consideration. We agree that patients need greater access to care in rural areas, but the data show that psychologists are not any better geographically situated to serve rural populations than psychiatrists and other primary care physicians in North Dakota. While we encourage you to continue a dialogue on access to care in rural North Dakota, we strongly believe H.B. 1272 does nothing to address these complex issues.

For these reasons, the AMA opposes H.B. 1272. If you have any questions, please contact Kristin Schleiter, JD, LLM, Senior Legislative Attorney, Advocacy Resource Center, at kristin.schleiter@ama-assn.org or (312) 464-4783.

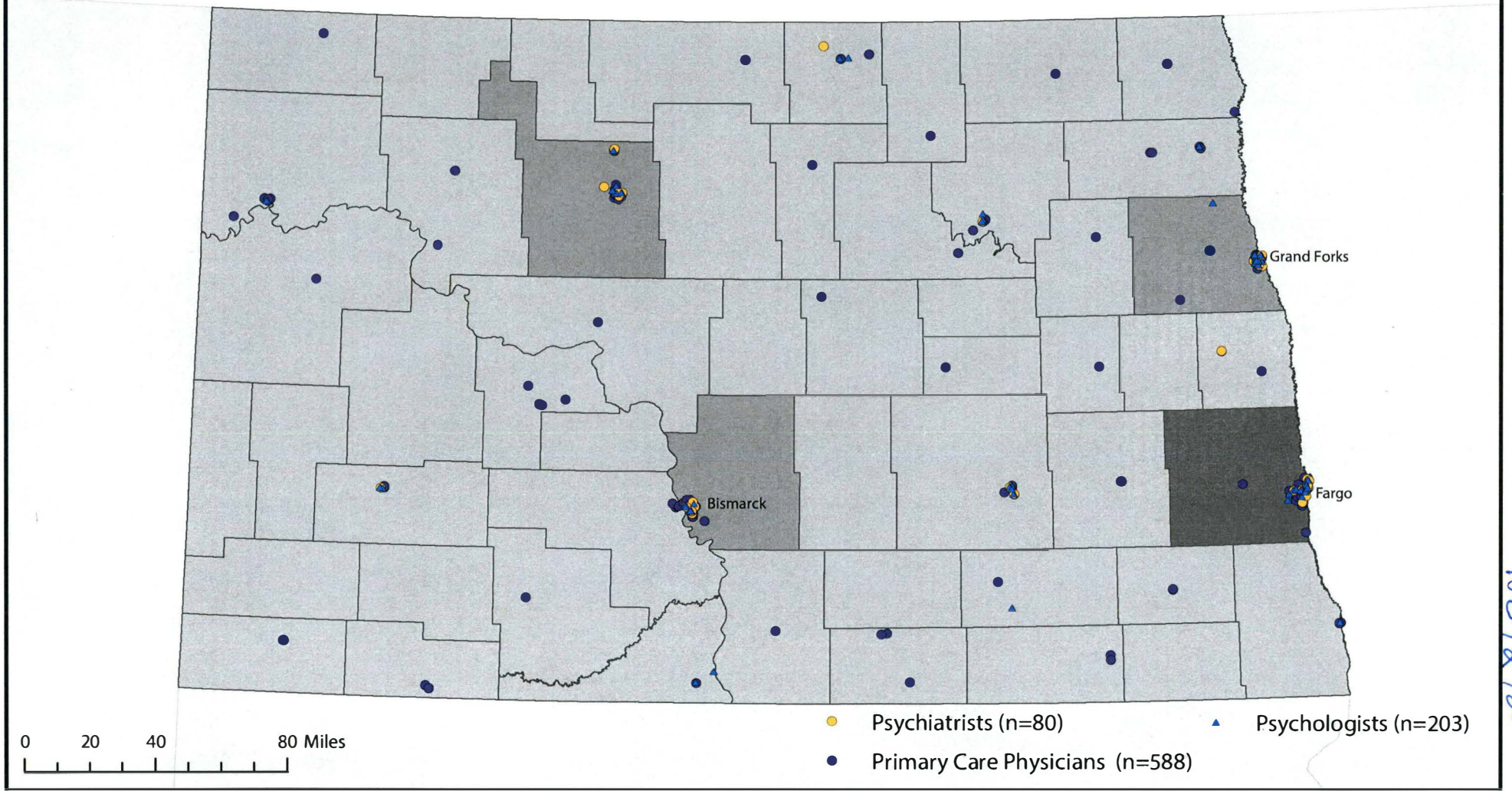
Sincerely,

James L. Madara, MD

Attachments
cc: North Dakota Medical Association
American Psychiatric Association

Psychiatrists and Primary Care Physicians to Psychologists

North Dakota



Population per square mile

Source: 2012 American Community Survey

<=25 | 26 - 75 | 76 - 250 | 251 - 1,000 | >1,000

Source Notes: AMA Physician Masterfile 2013; Centers for Medicare and Medicaid Services' National Plan and Provider Enumeration System 2013; US Census county and state shapefiles 2010

Created by The Robert Graham Center

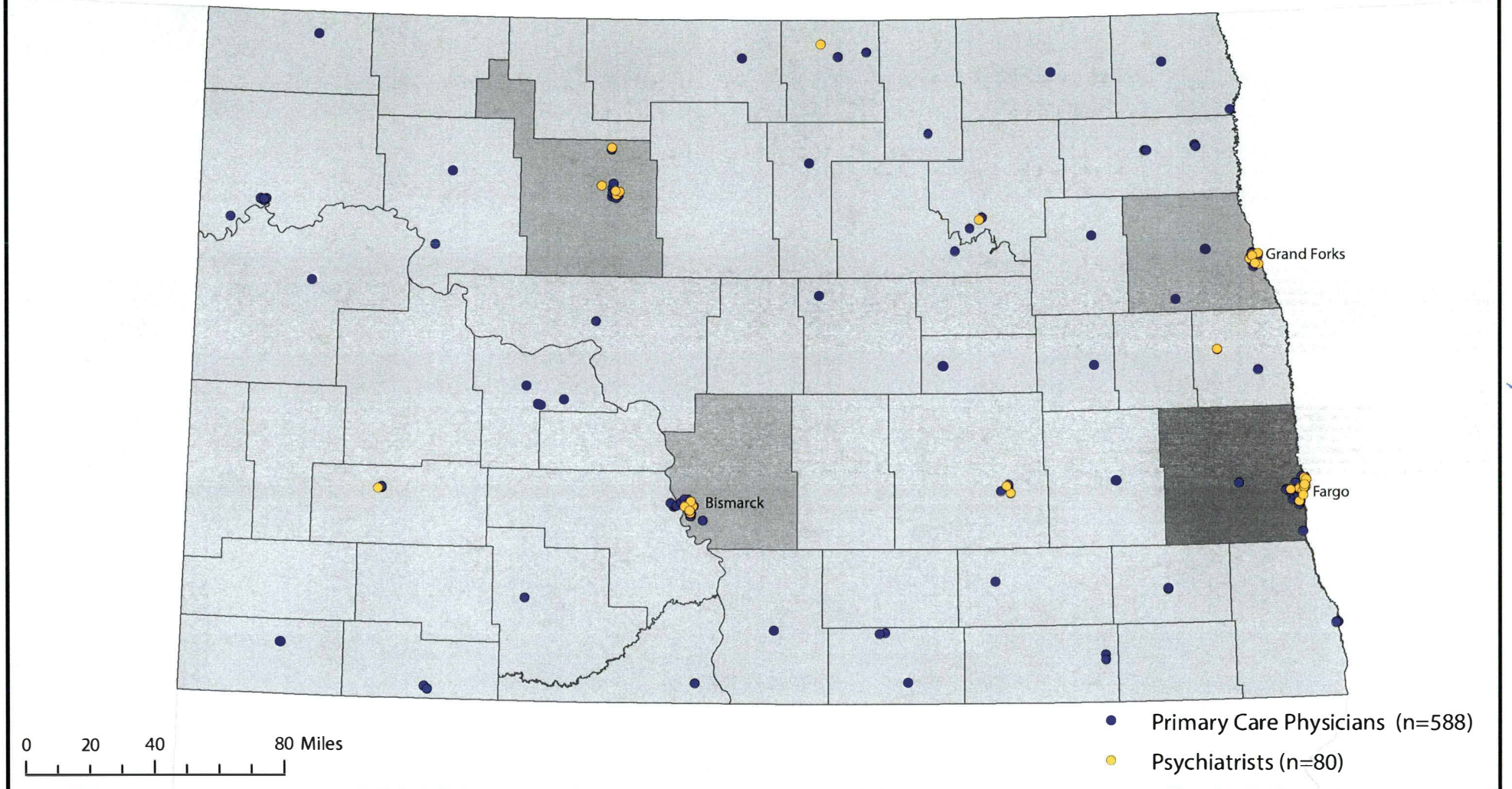
3

HB 1272

AMA
AMERICAN MEDICAL ASSOCIATION

Primary Care Physicians and Psychiatrists

North Dakota



Population per square mile

Source: 2012 American Community Survey

<=25 | 26 - 75 | 76 - 250 | 251 - 1,000 | >1,000

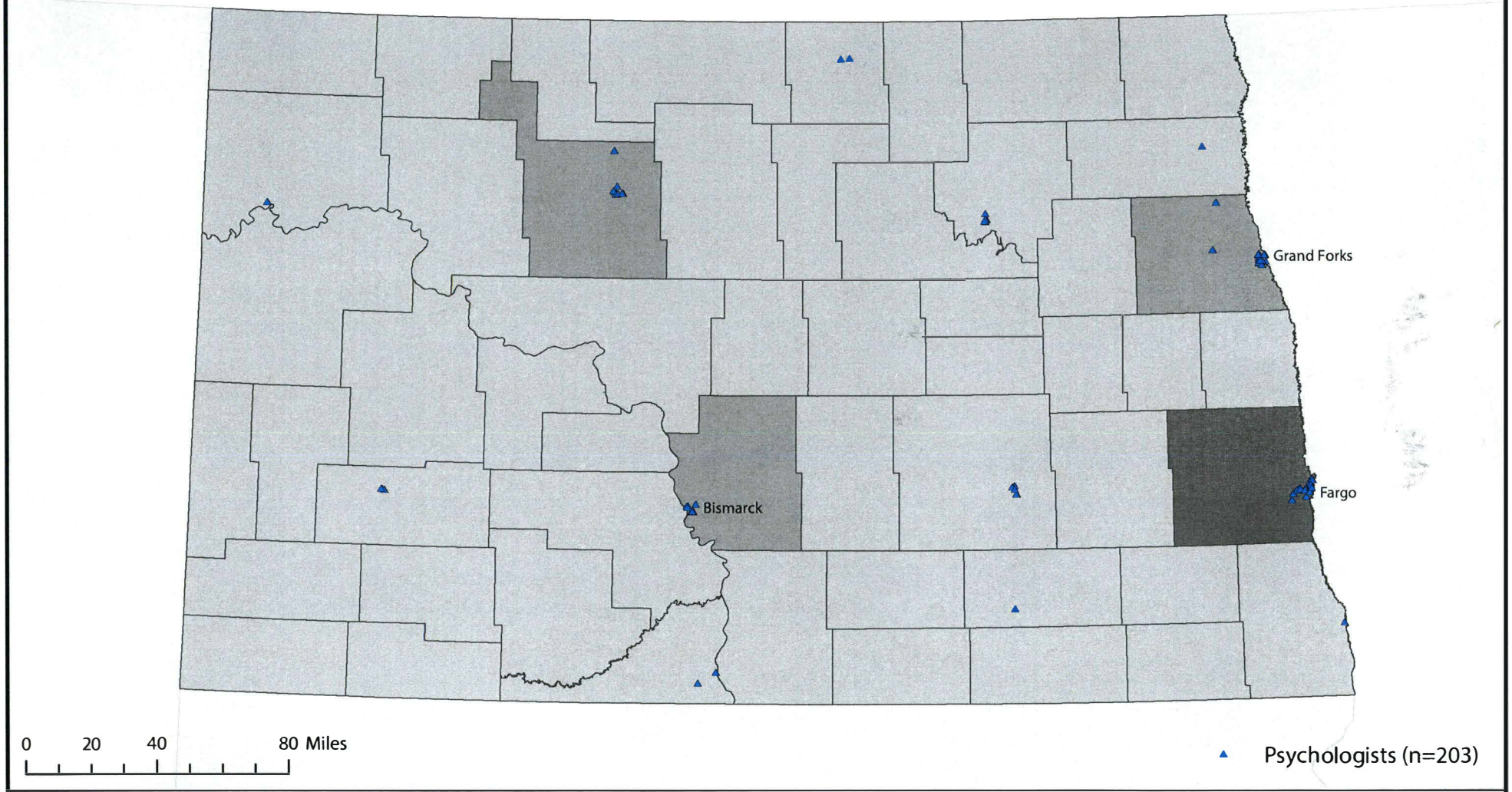
Source Notes: AMA Physician Masterfile 2013; US Census county and state shapefiles 2010

Created by The Robert Graham Center

AMA AMERICAN MEDICAL ASSOCIATION

Psychologists

North Dakota



Population per square mile

Source: 2012 American Community Survey

<=25 | 26 - 75 | 76 - 250 | 251 - 1,000 | >1,000

Source Notes: Centers for Medicare and Medicaid Services' National Plan and Provider Enumeration System 2013; US Census county and state shapefiles 2010

Created by The Robert Graham Center

#17

HOUSE HUMAN SERVICES COMMITTEE

HB 1272

January 28, 2015

Chairman Weisz and members of the committee, my name is Jon C. Ulven, PhD. I am a licensed as a psychologist in the state of ND for 10 years.

I am opposed to HB 1272 for the following reasons:

1) Psychologists have an important role in our health systems and our communities to effectively treat mental health/substance abuse issues and assist in the treatment of obesity, diabetes, heart disease, COPD and multiple other conditions. We have 40 years of data to support that our profession can deliver our care efficiently and effectively with evidence-supported care. We need to focus on what we do well as psychologists already, instead of get bogged down with an aspect of care that we will not do as well. We have a US culture that is often focused on the "easy fix" with medications. Psychiatrists used to do psychotherapy, and now they primarily prescribe psychotropic medications. We would eventually go the way of psychiatry and be doing less of the work that makes our profession uniquely of value.

2) Psychiatrists and primary care providers possess a medical degree that allows them to grasp an understanding of the functioning of the human body, let alone be aware of the complex interplay of other medications. 80% of psychotropic medications are prescribed by primary care providers nationally. These medical providers are equipped to identify and respond to individuals with potentially lethal reactions to medications or situations in which an individual's co-morbid health conditions would contraindicate psychotropic medication. This bill does not adequately spell out the training that would be necessary for a psychologist to have prescription privileges, nor does this bill specify what class of psychotropic drugs we would be able to prescribe. Given the vague nature of the bill and the medical complexity in prescribing, I do not believe that our profession of psychology could do this safely, and it would be a mistake to grant our profession this privilege.

3) We need better relationships in healthcare to address the health needs of the people of North Dakota. I commonly work in concert with primary care physicians and psychiatrists to safely offer our patients psychotropic medications. I regularly get continuing education related to psychotropic medications (I had 15 hours last year). I work with patients to monitor reactions to medications, adherence to plans to take medications, but I leave the prescribing up to my colleagues who have medical degrees. Authorizing psychologists to prescribe would cut down on partnerships, would isolate care, and make our patients more susceptible to medical errors as a result.

Sincerely,

Jon C. Ulven, Ph.D., L.P.
Licensed Psychologist
Department Lead of Adult Psychology

HB 1272 #18
Hearing January 28, 2015

MORA PSYCHOLOGICAL SERVICES, PLLC
630 Union Street South
Mora, MN 55051

HARLAN J. GILBERTSON, MS PsyD MSCP LP
MSCP (Postdoctoral Master of Science in Clinical Psychopharmacology)
Licensed Psychologist (in Minnesota and New Mexico)

January 19, 2015

Alan Fehr, PhD LP North Dakota Representative

RE: National Mental Health Crisis

Dear Dr. Fehr:

As you are aware, there is a national mental health crisis due to declining availability of psychiatric treatment as the number of medical residents pursuing psychiatric training continues to decline. As a result, the current trend is to use nurse practitioners with Master's Degrees. However, there is now an increasing trend of relying upon Physician Assistants or PA-C's prescribing medication following a 2-year degree program. Not only is this substandard to address the complexity of psychiatric, chemical use, and/or neurocognitive deficits, their 4-year degree does not necessarily require a medical or psychiatrically or psychologically-related undergraduate degree for admission to these programs.

Compare this to the more advanced education for psychologists consistent with the biopsychosocial treatment model identified by the psychiatric/psychological community and the DSM-V. Specifically, 9 years of education + 2.5 years of more advanced education in clinical psychopharmacology; supervised 80-hour medical practicum; supervised preceptorship consisting of treating 100 patients over a minimum of 400 hours across 6 months; passing of the nationally-recognized American Psychological Association Psychopharmacology Examination for Psychologists (PEP); and conditional licensure under supervision for at least one year. Some psychologists have also pursued advanced pathophysiological and medical assessment training to become board certified medical psychologists. With all due respect to the other prescribing professions, the disparity between psychologists and other clinicians is exemplified below:

Comparison of Entry-Level Models Leading to Prescriptive Authority
Mean Number of Graduate Contact Hours

Profession	Minimum Yrs. Post-Bachelors	Biochemistry / Neuroscience	Pharmacology	Clinical Practicums	Tx Research/ Statistics	Behavioral assessment/ diagnoses	Psychotherapy
NP	2.5	48	56	146	99	30	32
MD/DO	4	216	59	855	33	18	9
MSCP	6.5	161	288	680	225	267	255

Training Comparison among Three Professions Prescribing Psychoactive Medications: Psychiatric Nurse Practitioners (NP), Physicians (MD/DO) and Pharmacologically Train Psychologists (MSCP). Mark Muse & Robert McGrath 2010

Perhaps the greatest tragedy is the loss of psychiatric services in rural states such as North Dakota as well as Minnesota. A recent example in East Central Minnesota was the unexpected closure of the local mental health center after nearly 50 years of service. This resulted in approximately 3000 individuals losing access to psychiatric, psychological, crisis intervention and ARMHS worker services. As a result, local rural hospitals and emergency rooms were inundated with the need for complex psychiatric assessment, treatment and medication management.

I believe rural America has a much more efficient and cost effective intervention available to our citizens. While it may take several years to achieve, I believe it would be beneficial for your state to assist with and/or support legislation allowing properly trained doctoral level psychologists to prescribe in North Dakota.

There are, and will always be significantly more psychologists than psychiatrists and advanced nurse practitioner/PACs with the ability to evaluate, treat, medicate and/or 'un-medicate' individuals. While I am uncertain of those psychologists in North Dakota that might pursue this education and training, Minnesota has approximately 3500 psychologists. If even 10% of these clinicians completed training and began prescribing this would add 350 prescribing clinicians to our state. It is my impression that psychologists in North Dakota could provide similar services, especially in your most isolated areas.

Unbeknownst to many, psychologists have been prescribing successfully in Guam, Louisiana and New Mexico, Indian Health Services, and Federal Health and Human Services as well as the military without any document complaints, adverse effects or deaths despite approximately 250,000 scripts written to date. In addition, legislation recently passed in Illinois allowing limited script writing by psychologists with more complex prescriptive legislation in New Jersey likely to pass within the next year.

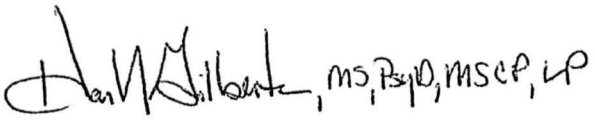
Perhaps of greatest concern is the increasing identification of medical complications arising from treatment with psychotropic medication. While the historical treatment model has included initiation of medication with monitoring every 3, 6 or 12-months, this is contraindicated given the often subtle yet progressive and potentially life-threatening side effects of these medications. Prescribing psychologists have the opportunity to provide ongoing psychotherapy while pharmacologically-treating these individuals with close monitoring of benefits as well as adverse physiological impact. This is the quality of care each and every individual deserves, especially this most vulnerable population with psychiatric and/or chemical use disorders.

In addition to significantly advanced education, psychologists are trained to facilitate collaborative relationships between people (e.g. interdisciplinary treatment teams). Psychologists could also singly provide multiple complex services including diagnostic assessments, psychometric testing, administration and modification of psychotropic interventions/medications, as well as, individual and group psychotherapies while also serving as a team lead. Just imagine the significant cost reduction in psychiatric care and treatment in your communities. Furthermore, such psychologists are well prepared to assist the local medical community in triaging the complexity of psychiatric and chemical use disorders.

Should your state chose to establish such legislation, it also provides an opportunity for prescribing psychologists from other states and/or arenas to migrate to North Dakota to provide these life changing services. This would quickly enhance access to complex treatment services in rural communities by one clinician working with members of an interdisciplinary treatment team, whether in acute, medical and/or residential settings.

If you have any additional questions or comment please contact me at 612-390-8269.

Respectfully Submitted,



Harlan J. Gilbertson, MS PsyD MSCP LP
MSCP (Postdoctoral Master of Science in Clinical Psychopharmacology)
Licensed Psychologist (in Minnesota and New Mexico)

#19 HB1272
Hearing January 28, 2015

14 January 2015

To the Chair of the Human Service Committee:

I am a prescribing psychologist and I am writing to express my support for legislation allowing appropriately trained psychologists to prescribe psychotropic medications in North Dakota. I have been successfully prescribing psychiatric medications in a large Northwestern hospital as an employee of the Department of Defense for the past six years. My practice is integrated into a large primary care clinic with over fifty medical providers with whom I work closely to provide comprehensive, wrap-around behavioral health and medical care to our active duty soldiers, veterans and their families. In my six years of practice I have never had any major adverse event or complaint. In fact, I have solicited anonymous and confidential feedback from almost fifty medical providers who have worked closely with me over the years. The results of this survey, which were published in a prominent professional journal, show that primary care doctors who have worked with prescribing psychologists rate them as safe, effective and skilled in prescribing psychiatric medications. There was overwhelming agreement that having a prescribing psychologist in a primary care setting dramatically improved access to behavioral health care, availability of behavioral health consultation services for busy primary care providers, quality of behavioral health care, and access to services for a patient population that is often neglected.

Integration of prescribing psychologists into primary care settings is ideal as primary care providers are often the first to identify and treat behavioral health problems. In my view, rural communities with limited behavioral health access would benefit greatly from this intuitive and practical partnering of primary care providers and prescribing psychologists. I strongly recommend that North Dakota legislators support passage of a bill that would permit psychologist to prescribe psychotropic medications. Please feel free to contact me if you have any questions.

Respectfully Submitted,

David Shearer, PhD
Licensed Clinical and Prescribing Psychologist
7416 Beaver Creek Lane, Gig Harbor, WA 98335
253.365.1595
fiveshearers@hotmail.com

INFORMATION PAPER

SUBJECT: Prescribing Psychologists Embedded in Primary Care Clinics

ARTICLE:

Shearer, D.S., Harmon, C.S., Seavey, B.M., & Tiu, A.Y. (2012). The primary care prescribing psychologist model: Medical provider ratings of the safety, impact and utility of prescribing psychologist in a primary care settings. Journal of Clinical Psychology in Medical Settings, 19(4), 420-429.

1. Purpose. To summarize impressions of the impact, utility, and safety of Madigan's model of integrating prescribing psychologists in primary care

2. Background. In 1991, The Department of Defense began a demonstration project of training psychologists to prescribe psychotropic medication. Despite good outcomes, the appropriateness of utilizing psychologists with advanced training as prescribing clinicians has been questioned in the past. Department of Army policy provides for a path for credentialing psychologists to provide psychotropic medications. A prescribing psychologist has been integrated in a Family Medicine clinic at Madigan since 2008. A recent study published in the peer reviewed *Journal of Clinical Psychology in Medical Settings* describes Madigan's model and provides indications of its strengths and weaknesses as reported by medical providers who have utilized the model for over two years.

3. Facts.

a. Published studies indicate nearly two thirds of patients seen in primary care are experiencing emotional and behavioral problems and the majority of prescriptions for psychotropic medications are written by primary care providers.

b. Madigan developed a Primary Care Prescribing Psychologist model in which a prescribing psychologist works side by side in the same shared space as primary care providers to facilitate staff consultation and improved patient care.

c. Forty-seven medical providers in the Department of Family Medicine completed an anonymous survey approved by the Madigan IRB assessing their impressions of the impact, safety, and utility of the model.

d. Providers reported the prescribing psychologist model is beneficial; 95.6% reported consultation is helpful, 93.6% are confident in the ability of the prescribing psychologist to make appropriate referral decisions and prescribe appropriate medications and dosages (95.7%), 87.2% reported the model has improved patient care, and 93.6% are confident it is safe to refer patients to a prescribing psychologist.

e. Providers report more confidence in handling crisis situations when a prescribing psychologist is on site.

f. Providers identified improved patient access to behavioral health care as a "large benefit" of the model.

g. More than a third of providers reported the main problem with the model is that there are not enough prescribing psychologists available.

4. Conclusion. The model of integrating prescribing psychologists in primary care has been well-received by primary care providers and has the promise of further applicability beyond Madigan

Part of David Shearer testimony #19 HB 1272

Enclosure to Prescribing Psychologist Information Paper, Summary of Survey Results

Survey Respondents

Total	47
Staff Physician	22
Resident	12
Nurse Practitioner	7
Physician Assistant	4
Other	2

	Strongly Disagree n (%)	Disagree n (%)	Neither* n (%)	Agree n (%)	Strongly Agree n (%)
I find it helpful to consult with a prescribing psychologist about patients with psychiatric issues.**	0	1 (2.2)	1 (2.2)	18 (39.1)	26 (56.5)
I am confident in the ability of a prescribing psychologist to identify when patients need to be referred for additional medical evaluation.	0	0	3 (6.4)	14 (29.8)	30 (63.8)
I am confident managing a mental health crisis in my clinic.	0	8 (17.0)	14 (29.8)	22 (46.8)	3 (6.4)
I believe the prescribing psychologist has adequate knowledge of medical terminology.	0	0	1 (2.1)	18 (38.3)	28 (59.6)
I am confident it is safe to refer my patients to a prescribing psychologist for psychotropic medication management.	0	1 (2.1)	2 (4.3)	14 (29.8)	30 (63.8)
I believe my patients' care has NOT improved as a result of the availability of a prescribing psychologist in the family medicine clinic.	25 (53.2)	16 (34.0)	5 (10.6)	1 (2.1)	0
I am confident managing a mental health crisis in my clinic when consultation with a prescribing psychologist is available.	0	1 (2.1)	3 (6.4)	23 (48.9)	20 (42.6)
I am concerned patients will be prescribed inappropriate medications and/or dosages if I refer them to a prescribing psychologist.	23 (48.9)	22 (46.8)	0	2 (4.3)	0

*Neither Agree nor Disagree

*One respondent indicated "NA-I have not consulted with a prescribing psychologist."

Please rate the following potential benefits of having a prescribing psychologist embedded in the family medicine clinic.	**Undecided n (%)**	**No Benefit *n* (%)**	**Small Benefit *n* (%)**	**Moderate Benefit *n* (%)**	**Large Benefit *n* (%)**
Improves patient care	0	0	2 (4.3)	10 (21.3)	35 (74.5)
Decreases time I spend managing patients with psychiatric symptoms	1 (2.1)	0	8 (17.0)	8 (17.0)	30 (63.8)
Improves access to Behavioral Health care	0	0	1 (2.1)	5 (10.6)	41 (87.2)
Decreases number of patients I refer out for psychiatric care in the community	0	1 (2.1)	2 (4.3)	12 (25.5)	32 (68.1)
Improves ease of access for me to obtain psychiatric consultation	0	0	6 (12.8)	6 (12.8)	35 (74.5)

	Less Skilled n (%)	**Similarly Skilled n (%)**	**More Skilled n (%)**
Compared to other **mental health <u>prescribers</u>**, prescribing psychologists provide care that is:	3 (6.4)	30 (63.8)	14 (29.8)

1-28-15 #20

Glenn A. Ally, Ph.D., M.P.
(A Professional Psychology Corporation)
Advanced Practice Medical Psychologist
Clinical Neuropsychologist
155 Hospital Drive, Suite 200
Lafayette, Louisiana
70503

(337) 235-8304

TRANSMITTED VIA EMAIL

Dr. Alan Fehr
North Dakota Representative
afehr@nd.gov

Dear Dr. Fehr:

It is my honor and pleasure to submit a letter in support of your bill, HB 1272, to grant prescriptive authority to specially trained psychologists. In addition to offering my strong support for this proposal I would like to take this opportunity to provide information on the history and progress of prescriptive authority for specially trained psychologists in Louisiana.
At this point, I am sure you are aware that psychologists with prescriptive authority have been safely prescribing psychotropic medications in the US military for more than 20 year now and in New Mexico and Louisiana for more than 10 years. This past year, Illinois passed legislation allowing trained psychologists to prescribe. However, since the Illinois statute is new, there is no history upon which to rely in reaching conclusions regarding how this proposal may help in address some of the mental health needs in North Dakota.

By way of introduction, I am a Medical Psychologist in Louisiana and have had prescriptive authority for the past 10 years. Prior to having prescriptive authority, my specialty was and continues to be neuropsychology. I have had a private practice from approximately 35 years. In addition, I have had a hospital practice for approximately the same amount of time. In that hospital practice, I provided services throughout the hospital and particularly on the physical medicine and rehabilitation unit. In that regard, I have had the opportunity to work with medically compromised patients. Since gaining prescriptive authority I have continued in those capacities, albeit now devoting only one day a week to my private practice. After gaining prescriptive authority, I have provided services to our Community Mental Health Center and integrated mental health services to a large cancer center affiliated with our 350 bed community owned, non-profit hospital. So, in all settings I continue to provide services to patients with co-morbid medical conditions and medically compromised patients. From the ICU to outpatient mental health clinic, I and other medical psychologists have been comfortable providing mental health services, and, most importantly, our physician colleagues have become extremely comfortable relying on the care that medical psychologists provide. Finally, I am a past member of the Louisiana State Board of Examiners of Psychologists (psychology licensing board), and I am currently a member of the Medical Psychology Advisory Committee to the Louisiana State Board of Medical Examiners (medical licensing board).

In May of 2004, Louisiana passed its first statute granting prescriptive authority to specially trained psychologists. This statute allowed the psychology board to grant a "Certificate of Prescriptive Authority" to Medical Psychologists. Medical Psychologists were authorized to prescribe all medications normally used in the pharmacologic treatment of mental illness and to prescribe medications that are generally used for routine side effects. Additionally, Medical Psychologists were authorized to order tests necessary for diagnosis and/or monitoring the effects of the medications prescribed. In exercising that prescriptive authority, Medical Psychologists were mandated to "consultation, collaboration, and concurrence" with the patient's primary care physician *prior* to writing the prescription. This safeguard was thought to be not only a good safety measure, but simply good practice. However, our experience taught us that this was cumbersome for the primary care physician, the medical psychologist, and the patient to have all of this occur *before* the prescription was written. This was especially true on an inpatient basis. Typically what we heard by physicians when attempting to reach them for concurrence was, "That's why I consulted you in the first place, to prescribe the best medication…no need to call me."

In 2009, the Louisiana legislature passed Act 251 that transferred regulatory authority for Medical Psychologists to the medical board. This statute provided for several factors. First, it eliminated the Certificate of Prescriptive Authority and established in law a new, hybrid profession, the Medical Psychologist. The Medical Psychologist is now a licensed professional, a psychologist that has the expertise to not only prescribe psychotropic medications but to manage the mental health care of patients requiring such care. Secondly, Act 251 established two tiers of Medical Psychologists; those who are newly licensed and who must continue to provide *prior* "consultation, collaboration, and concurrence" as before and Advanced Practice Medical Psychologists who function more independently. Collaboration with the patient's primary care physician is still mandated, but that collaboration can take place during the normal course of provider interaction rather than being mandated before a prescription can be written for the patient needing psychotropic medication. The requirements for both Medical Psychologists and Advanced Practice Medical Psychologists are spelled out in the Louisiana statute and I am sure you have been informed of those requirements.

Initially, opposition to Medical Psychologists had taken the familiar approach that I am sure you have heard multiple times. I will briefly address those common points of opposition.

Need: The opposition has suggested that there is no need for another prescriber. Perhaps North Dakota has found the means to provide all the quality mental health care that the State requires. If you have then I need go no further.

Having psychologists with prescriptive authority will not be THE answer to North Dakota's mental health needs, but they will be quality help and a step in the right direction for North Dakota. At present there are 88 Medical Psychologists in Louisiana and we are adding more each year. We have Medical Psychologists licensed in Louisiana who are currently prescribing in the US military and the US Public Health Service. We are not only adding Medical Psychologists from within Louisiana. We have had psychologists with appropriate training move from surrounding states in order to be licensed in Louisiana as Medical Psychologists. Our Medical Psychologists are in a variety of settings, inpatient and outpatient, public sector and

private sector, solo practices, group practices, and integrate health practices, in both rural and urban communities.

Access: Perhaps this has been the most persuasive argument **FOR** psychologists with prescriptive authority. All parties concerned have acknowledged that there is an access problem for those needing mental health services. There are far too few psychiatrists and nurse practitioners to provide sufficient, quality services, and the number of psychiatrists in training is becoming smaller, not greater. There is certainly an access problem to those who are indigent and in rural communities. However, those who are in urban areas often experience access problems in the form of excessive wait times for new patients or increasingly fewer providers accepting certain insurances.

The impact by Medical Psychologists on access in Louisiana has been significant. For those who are in private practice exclusively, access may not have increased a great deal. There are only so many hours in a day and the practitioner can only see so many people, regardless if the practitioner prescribes or does not prescribe. So, if you are in private practice and work 8 hours a day, you probably will not see more patients simply because you prescribe...although some have. In Louisiana, psychologists are not eligible for outpatient Medicaid reimbursement. Consequently, unless the psychologist works in a facility where the facility bills for services, and pays the psychologist in some manner, Louisiana psychologists are not likely to accept Medicaid outpatients. Where the greatest increase in access has been realized with Medical Psychologists is in the public sector...Community Mental Health Centers, State hospitals and clinics. While psychologists worked at these facilities previously, they were there mostly to do a limited amount of psychological testing. Most of the "psychotherapy" was being performed by social workers and Licensed Professional Counselors that the State can hire much more cheaply. Psychiatrists have traditionally been the medication managers. While there are psychiatrists at these facilities, there have been numerous vacancies for psychiatrists that remain unfilled. Louisiana attempted to fill these vacancies with retired internal medicine physicians, but that has not always worked out. Some of the vacancies had been available for more than 5-10 years. Medical Psychologists began filling this void and increasing access to many indigent patients in the State system. My partner and I were among the first in Louisiana to take such positions. We split the hours of a full-time psychiatrist position at our Community Mental Health Center. Soon, other CMHCs began contracting with Medical Psychologists, and at least one has been hired one full time. Likewise, Medical Psychologists have been contracted and hired in the State hospital system. We have a couple of Medical Psychologists at VA centers, but they are not yet allowed to prescribe in the VA system.

Rural Access: Another criticism by the opposition has been that psychologists are essentially in no greater numbers in rural areas than psychiatrists. While it may be true in some states that the physical location or residence for many tend to be in more populated areas, that does not mean that Medical Psychologists in Louisiana do not serve rural populations. For example, the CMHC where I work covers a seven parish (county) area. That area includes significant rural areas with satellite clinics, etc. So, we do see a large number of indigent and patients from rural areas. And, as mentioned above, there have been shortages of psychiatrists willing to serve in these State facilities, particularly in more rural areas. New Orleans, Baton Rouge, and Shreveport tend to have an abundance of psychiatrists because the medical schools are located there, and New Orleans has a psychiatric residency program. But, outside of those areas, psychiatrists are just

not filling such positions. Psychiatry has proposed "telepsychiatry" in lieu of prescriptive authority for specially trained psychologist. We have been hearing about the benefits to access by telepsychiatry for more than 10 years in Louisiana. That promise has not been realized. Instead, there are fewer psychiatrists who are providing less access as more and more are abandoning general hospital practice so they do not have to "take call" and accept indigent or "no pay" patients in their practices. And, more psychiatrists are abandoning those patients with managed care insurance coverage.

Keep in mind, Medical Psychologists are trained as psychologists first and have the skills and expertise to provide a variety of psychotherapies in addition to psychopharmacology. Most psychiatrists have limited their expertise to psychopharmacology only. *It only makes sense to provide the treatment modality that best fits patients' needs rather than trying to force patients' needs into the only treatment modality that one profession may have.* The Medical Psychologist is perhaps the only doctoral level professional that can provide both modalities.

Safety: Recognize that this issue, safety, has been an all too familiar cry by those in the medical community opposed to any expansion in scope of practice. Many years ago, physicians held that only physicians could use "needles" to puncture the body. Reluctantly and citing safety as an issue, physicians relented and only Registered Nurses were allowed to puncture a vein to start an IV. Now, someone with a high school education and three months of training as a phlebotomist is allowed to puncture a vein with a needle and draw blood. Such "turf" issues are frequent and "safety" is almost always cited as a reason to deny expansion of scope of practice for disciplines other than physicians.

At this point, the argument against psychologists with special training having prescriptive authority that cites "safety" as the reason is simply a fear tactic to protect turf. There is now a 20 year history of psychologists prescribing in the US military and a 10 year history of medical psychologists prescribing SAFELY in two states. In more than 20 years of prescribing, there have been **no formal complaints** against psychologists with prescriptive authority for their use of medications. Again, I have served on the State psychology board and on the Medical Psychology Advisory Committee and am quite familiar with this data. When this issue is brought up by the opposition, and it will be, you should ask two questions of the opposition. First, "What evidence or data do you have that psychologists with prescriptive authority are indeed not safe prescribers?" While opponents often come up with anecdotal, often fabricated, stories of safety issues, they cannot provide any data whatsoever, because it does not exist…this, in light of the extensive history of psychologists prescribing safely. A second question should be asked, "Would you provide evidence of any 10-20 year history in your profession without complaint regarding prescribing medications?" Medical psychologists have been, and continue, prescribing safely for patients in need of medication for mental health issues. In fact, in 2009, when Louisiana passed Act 251, the Executive Director of the medical board testified in favor of the bill, and in doing so, he said, "We recognize that they (Medical Psychologists) are very safe prescribers."

Finally, I would like to briefly address another advantage of psychologists with prescriptive authority that is not generally discussed. Medical Psychologists are more likely to work in integrated health care settings. There are few, if any, psychiatrists in Louisiana involved in the integrated care model. As I noted previously, I work at a large cancer center and provide my services there two days a week. I have a physical office in the cancer center and assist six (6)

oncologists and five (5) nurse practitioners in providing for the mental health needs and psychotropic medications for their cancer patients. The oncologists and their nurse practitioners certainly welcome the help. I regularly meet with the oncologists and nurse practitioners both formally and informally. In addition to scheduled appointments with our cancer patients, I often get the "hallway handoff" of patients and families who may have just been diagnosed with cancer. By the same token, I am able to provide group therapy to patients with breast cancer and other groups of cancer. There is a tremendous need for mental health care with cancer patients and their families, the patients welcome the opportunity to avail themselves of my services while in the same facility. There are other Medical Psychologists in integrated care settings who are providing not only additional expertise to our physician colleagues, but also greater access to patients who probably would not have gotten such services were it not for the working relationship between Medical Psychologists and physicians that is typically not seen with psychiatry. Psychologists with prescriptive authority are proving to be valuable members of integrated health care teams that seek to address the mental health care needs of their patients.

Thank you for allowing me the opportunity to provide information about the advantages of having psychologists with prescriptive authority. There are currently approximately 88 medical psychologists in Louisiana who are adding access to the full range of quality mental health services in our State, and they are doing so in a safe and effective manner. I would encourage you to continue your support for HB1272 in the most positive manner. It will truly make a positive difference to the citizens of North Dakota. If I can be of any further assistance to you, please do not hesitate to contact me. I would be happy to address any questions or concerns that you or the Legislature may have regarding our experiences in Louisiana.

Sincerely,

Glenn A. Ally, PhD, MP
Advanced Practice Medical Psychologist
Clinical Neuropsychologist

2/16/15 Attachment 1

15.0348.02002
Title.

Prepared by the Legislative Council staff for 2/16/15
Representative Fehr
February 13, 2015

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1272

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a report to the legislative management regarding medical psychologist licensure.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. SCHOOL OF MEDICINE AND HEALTH SCIENCES ADVISORY COUNCIL - STUDY OF MEDICAL PSYCHOLOGIST LICENSURE - REPORT TO LEGISLATIVE MANAGEMENT. During the 2015-16 interim, the university of North Dakota school of medicine and health sciences advisory council shall study the feasibility and desirability of licensing medical psychologists. The study must include evaluation of whether licensure of medical psychologists would integrate behavioral health into primary care and whether the practice of medical psychology would result in safe and effective treatment of patients with behavioral health concerns. If the school of medicine and health sciences advisory council determines it is feasible and desirable to license medical psychologists in this state, the study must include consideration of licensure requirements, scope of practice, which licensure board would be best suited to license medical psychologists, and terminology. Before July 1, 2016, the school of medicine and health sciences advisory council shall report the outcome of the study, recommendations, and related proposed legislation to a legislative management committee charged with studying human services-related topics."

Renumber accordingly

Attach #1
HB 1272
03/23/2015
J#25231

Testimony on HB 1272
Rep Alan Fehr, District 36

Madam Chair and members of the Senate Human Services Committee, I am Representative Alan Fehr of District 36.

I am here to introduce HB 1272, which calls for a study of medical psychologists as a new licensed profession in this state. The original version of this bill would have licensed this new profession.

The bill before you calls for a study by the UND School of Medicine and Health Sciences Advisory Council. The Council is a 15 member group, consisting of members from the ND Senate and House of Representatives, along with representatives from the Department of Human Services, State Board of Higher Education, the Department of Health, the ND Medical Association, the ND Hospital Association, the Veterans Administration Hospital, the UND Center for Rural Health, and the UND School of Medicine and Health Sciences.

The bill calls for the study to examine the feasibility and desirability of licensing medical psychologists. The study must include evaluation of whether licensure of medical psychologists would integrate behavioral health into primary care and whether the practice of medical psychology would result in safe and effective treatment of patients with behavioral health concerns. In addition, it can look at issues of licensure requirements, scope of practice, which licensure board would be best suited to license medical psychologists, and terminology.

"Medical psychologist" is equivalent to the licensure in some states of "prescribing psychologist." It involves licensed psychologist with additional training and certification in psychopharmacology being licensed to have a limited authority to prescribe medicine.

In my testimony I am going to outline for you what this new profession is, why it is needed, and how it provides services that are safe and effective. I will present written information from prescribing psychologists in other states, which will provide historical context.

First, let me give you the bigger picture of why this is needed.

As with other states, there are many short-comings to our system of behavior health care. There are severe challenges for accessing care, including whether people will ask for professional help in a timely manner. All too often, people avoid seeking behavior health services until there is a crisis and the situation is urgent. Also, people often do not follow through on services but discontinue prematurely when their crisis is improved.

We need to improve our system of behavior health care to identify, intervene, treat, and support individuals as quickly and effectively as possible. This would require a consideration of

how and where behavior health professionals are available and accessible. I believe that we should think about "touch points" for accessing care. I believe that the most prime touch points are at schools, medical clinics, and by law enforcement. Most people needing behavior health services pass through these three arenas and there are tremendous opportunities to improve our ability for early intervention. In terms of personnel, we need more social workers and counselors in schools, psychologists in primary care clinics, and social workers in law enforcement settings.

It is useful to consider the systems of care that provide treatment for behavior health services. Let me point out that I am using the term "behavior health" synonymous with the more traditional term "mental health."

In a very general sense, there are systems of care centered on medical treatment and intervention using medications, and there are systems of care centered on counseling and psychotherapy. These two systems might communicate, might work together, but very often do not. Sometimes the care between the systems is coordinated but is rarely integrated, despite many research studies that report the best behavior health care is a combined approach of medications and psychotherapy. Over the past few decades we have seen substantial improvement in treatments. Psychotropic medications have become more targeted on specific symptoms with a reduction in side effects. Psychotherapies have also become more advanced and tailored to specific conditions. We have not seen substantial improvements in how to integrate these two systems of treatment.

The type of treatment a consumer receives is largely determined by how and where they access help. If a person goes to their family physician because of emotional, social, and behavioral difficulties, that person will probably leave the clinic with a prescription for a medication, probably an antidepressant. If the same person contacts a counselor or psychologist, the treatment offered is probably a form of counseling or therapy.

Both forms of treatment have their pros and cons. One advantage of the medical system is that access to care has become increasingly timely, especially with the popularity of walk-in clinics. A person could walk out of this hearing, go to a walk-in clinic, be seen by a medical provider, and probably have a prescription this afternoon. It would likely be for an antidepressant. Even though it takes a week to several weeks for an antidepressant to work, the person may feel some relief immediately, knowing that help has arrived.

Conversely, if a person calls a counselor or psychologist's office today, there would probably be some time delay, as they would need to schedule an appointment. On the day of the appointment the person would be seen for an hour or longer to discuss their situation in a fair degree of detail. Some people feel some immediate relief and benefit from their 1st appointment. They may feel supported and validated that someone listened in a non-judgmental manner to their description of a situation for which they may have carried shame and guilt for years.

A benefit of counseling and therapy is that successful intervention can have long-term, relatively permanent benefit by helping people to change their counter-productive behavior, negative thinking, and learn to adopt a heathier attitude towards life. It can involve learning resilience skills that people can use and receive benefit for the rest of life. It is a skills-building process that is often life-altering without the risk of side effects that we may see with medications.

The truth is that we need both systems of behavior health care – the medical and non-medical. Most importantly, we need them to work together to be more integrated and collaborative.

Medicine is primarily schooled in the Medical Model. The Medical Model basically involves a linear approach that progresses from the patient complaint, to history taking and testing to identify symptoms, to determining a diagnosis, and concluding with a prescribed course of treatment and follow-up.

Non-medical behavior health providers are schooled in the Medical Model and other ways to conceptualize people and their problems. For example, an alternative approach is Systems Theory. Systems theory focuses on the interaction of an organism within its environment. Therefore, to understand a person from a System's perspective, we need to look at the person in context of their social environment, especially what is happening in family relationships. Psychologists, social workers, and counselors are trained in both a traditional Medical Model and to actively look for the social context that may underlie a person's difficulties.

When a patient comes to the office of a medical professional, the essential process is to conclude a diagnosis and determine an appropriate medical treatment. From the moment of meeting a patient, the medical provider is considering what medication to prescribe.

A non-medical approach with a psychologist may be quite different, such as looking for ways to help the client change their behavior, reactions, thought patterns, and relationships to succeed in ways that are consistent with the client's goals.

While neither approach is inherently right or wrong, one approach may be better suited to a particular person's problems. For example, a more severe or long-term disturbance, such as Schizophrenia or Bipolar Disorder, may be better described by the Medical Model, is more biologically based, and is best treated primarily with medication. A short-term, reactive problem, such as dealing with a divorce or loss, is an example of a disrupted interpersonal system, as seen from a Systems model. In this case counseling or therapy may be the preferred treatment.

This licensure process with medical psychologists is a specific way we can integrate the medical and non-medical behavior health systems of care by placing skilled behavior health professionals in positions where they are easily accessible to the public and link the two systems. The medical psychologist licensure creates a professional who is a hybrid in a primary care setting – a behavior health professional with extensive knowledge and experience in

assessment, counseling, and psychotherapy who can complement and assist the primary care providers by prescribing psychotropic medications.

Most prescriptions for psychotropic medications, especially for the less severe conditions, are by primary care physicians – family practice, pediatricians, OB/GYNs, and internists. If these physicians had a medical psychologist in their practice, just down the hall, they could refer their patients with behavior health concerns, which would make it relatively easy to make a "warm hand-off." Their patients would be much more likely to accept a referral to a behavior health provider down the hall as opposed to seeing someone across town. This will help to reduce the stigma that many feel when considering care from a behavior health professional.

Under this bill, medical psychologists are psychologists who have a limited prescription privilege and work in a primary care clinic. Since they are first trained as psychologists, medical psychologists have doctorate degrees in psychology, which involves graduate and post-graduate training in assessment, counseling, and psychotherapy. They will have completed licensure to practice psychology.

Next, a medical psychologist must complete a training program, supervised work experience, and national exam. The training programs generally take about two years. The supervised work experience also takes about two years.

In the proposed design a medical psychologist works within a primary care clinic and sees those patients that currently are being prescribed antidepressants and other psychoactive medications by their primary care physicians. The primary care physicians maintain their care involvement but can refer the behavior health treatment and care to a medical psychologist. Medical psychologists must have a collaborating physician and a written collaborative practice agreements as a condition of licensure.

A medical psychologist will have a limited prescriptive authority to prescribe medication to treat "a psychiatric, mental, cognitive, nervous, emotional, or behavioral disorder." Rules regarding the educational requirement, the supervised work experience, and the examination will be developed by the licensing board.

Medical psychologists will not replace psychiatrists and will probably have little effect on the profession of psychiatry. Instead, medical psychologists will provide services in primary care clinics, will see a wide variety of patients and situations, and will make referrals to psychiatrists, psychologists, and other professionals as needed.

There are currently three other states that have a similar licensure, although there is some variation between the three states, including the title being either "medical psychologist" or "prescribing psychologist." New Mexico and Louisiana have had such a licensure for over 10 years. New Mexico passed a prescriptive law in 2002 and Louisiana followed suit in 2004. Illinois passed a licensure law last year. These prescribing psychologists have a track record of

safely and effectively prescribing medications. In fact, to date, there has not been one complaint lodged against a medical or prescribing psychologist in any of these three states.

Many other states have considered legislation to license medical psychologists or prescribing psychologists. The efforts have been opposed by medical groups, primarily psychiatry, alleging that medical psychologists are not adequately trained. The list of states considering licensure legislation includes Montana and Minnesota.

Included with my testimony is a letter of support by a Minnesota psychologist, Dr Harlan Gilbertson, who has completed a masters degree in clinical psychopharmacology and is licensed in Minnesota and New Mexico. His letter includes a chart that compares training between psychiatric nurse practitioners, physicians, and medical psychologists. While medical psychologists have very extensive training in psychotherapy, they also have substantial training in biochemistry and neuroscience, pharmacology, and clinical practicums.

Some of the medical or prescribing psychologists that are licensed in these states are working on military bases or tribal reservations. I've included a letter from Dr Glenn Ally, a medical psychologist licensed in Louisiana. Dr Ally's letter provides us with a rich history of the licensure process and he specifically addresses a few key points: Need, access, rural access, and safety. I would encourage you to read his letter.

I've also included a letter of support and an information paper by Dr David Shearer, a prescribing psychologist in the state of Washington. He is licensed in New Mexico but works at Madigan Hospital, which is on an Army base, Ft Lewis, Washington. His information paper is titled "Prescribing Psychologists Embedded in Primary Care Clinics." It describes the impact, utility, and safety of Madigan's model of integrating prescribing psychologists in primary care.

Despite not having a licensure law, North Dakota is not a stranger to prescribing psychologists. Our first prescribing psychologist, Dr Mike Tilus, became licensed through the New Mexico licensure law and was formerly employed with Indian Health Service at Fort Totten by Devils Lake. He has since moved to Montana, where he continues to work as a prescribing psychologist. He is currently the president of Division 55 of the American Psychological Association, which is the American Society for the Advancement of Pharmacotherapy.

A second prescribing psychologist in North Dakota, Dr Anthony Tranchita, is currently stationed at the Grand Forks Air Force Base. A third prescribing psychologist is at Standing Rock.

Thank you for your positive consideration of HB 1272. I welcome your questions.

Attach#2
HB 1272
03/23/2015
J#25231

Glenn A. Ally, Ph.D., M.P.
(A Professional Psychology Corporation)
Advanced Practice Medical Psychologist
Clinical Neuropsychologist
155 Hospital Drive, Suite 200
Lafayette, Louisiana
70503

(337) 235-8304

TRANSMITTED VIA EMAIL

Dr. Alan Fehr
North Dakota Representative
afehr@nd.gov

Dear Dr. Fehr:

It is my honor and pleasure to submit a letter in support of your bill, HB 1272, to grant prescriptive authority to specially trained psychologists. In addition to offering my strong support for this proposal I would like to take this opportunity to provide information on the history and progress of prescriptive authority for specially trained psychologists in Louisiana.
At this point, I am sure you are aware that psychologists with prescriptive authority have been safely prescribing psychotropic medications in the US military for more than 20 year now and in New Mexico and Louisiana for more than 10 years. This past year, Illinois passed legislation allowing trained psychologists to prescribe. However, since the Illinois statute is new, there is no history upon which to rely in reaching conclusions regarding how this proposal may help in address some of the mental health needs in North Dakota.

By way of introduction, I am a Medical Psychologist in Louisiana and have had prescriptive authority for the past 10 years. Prior to having prescriptive authority, my specialty was and continues to be neuropsychology. I have had a private practice from approximately 35 years. In addition, I have had a hospital practice for approximately the same amount of time. In that hospital practice, I provided services throughout the hospital and particularly on the physical medicine and rehabilitation unit. In that regard, I have had the opportunity to work with medically compromised patients. Since gaining prescriptive authority I have continued in those capacities, albeit now devoting only one day a week to my private practice. After gaining prescriptive authority, I have provided services to our Community Mental Health Center and integrated mental health services to a large cancer center affiliated with our 350 bed community owned, non-profit hospital. So, in all settings I continue to provide services to patients with co-morbid medical conditions and medically compromised patients. From the ICU to outpatient mental health clinic, I and other medical psychologists have been comfortable providing mental health services, and, most importantly, our physician colleagues have become extremely comfortable relying on the care that medical psychologists provide. Finally, I am a past member of the Louisiana State Board of Examiners of Psychologists (psychology licensing board), and I am currently a member of the Medical Psychology Advisory Committee to the Louisiana State Board of Medical Examiners (medical licensing board).

In May of 2004, Louisiana passed its first statute granting prescriptive authority to specially trained psychologists. This statute allowed the psychology board to grant a "Certificate of Prescriptive Authority" to Medical Psychologists. Medical Psychologists were authorized to prescribe all medications normally used in the pharmacologic treatment of mental illness and to prescribe medications that are generally used for routine side effects. Additionally, Medical Psychologists were authorized to order tests necessary for diagnosis and/or monitoring the effects of the medications prescribed. In exercising that prescriptive authority, Medical Psychologists were mandated to "consultation, collaboration, and concurrence" with the patient's primary care physician *prior* to writing the prescription. This safeguard was thought to be not only a good safety measure, but simply good practice. However, our experience taught us that this was cumbersome for the primary care physician, the medical psychologist, and the patient to have all of this occur *before* the prescription was written. This was especially true on an inpatient basis. Typically what we heard by physicians when attempting to reach them for concurrence was, "That's why I consulted you in the first place, to prescribe the best medication…no need to call me."

In 2009, the Louisiana legislature passed Act 251 that transferred regulatory authority for Medical Psychologists to the medical board. This statute provided for several factors. First, it eliminated the Certificate of Prescriptive Authority and established in law a new, hybrid profession, the Medical Psychologist. The Medical Psychologist is now a licensed professional, a psychologist that has the expertise to not only prescribe psychotropic medications but to manage the mental health care of patients requiring such care. Secondly, Act 251 established two tiers of Medical Psychologists; those who are newly licensed and who must continue to provide *prior* "consultation, collaboration, and concurrence" as before and Advanced Practice Medical Psychologists who function more independently. Collaboration with the patient's primary care physician is still mandated, but that collaboration can take place during the normal course of provider interaction rather than being mandated before a prescription can be written for the patient needing psychotropic medication. The requirements for both Medical Psychologists and Advanced Practice Medical Psychologists are spelled out in the Louisiana statute and I am sure you have been informed of those requirements.

Initially, opposition to Medical Psychologists had taken the familiar approach that I am sure you have heard multiple times. I will briefly address those common points of opposition.

Need: The opposition has suggested that there is no need for another prescriber. Perhaps North Dakota has found the means to provide all the quality mental health care that the State requires. If you have then I need go no further.

Having psychologists with prescriptive authority will not be THE answer to North Dakota's mental health needs, but they will be quality help and a step in the right direction for North Dakota. At present there are 88 Medical Psychologists in Louisiana and we are adding more each year. We have Medical Psychologists licensed in Louisiana who are currently prescribing in the US military and the US Public Health Service. We are not only adding Medical Psychologists from within Louisiana. We have had psychologists with appropriate training move from surrounding states in order to be licensed in Louisiana as Medical Psychologists. Our Medical Psychologists are in a variety of settings, inpatient and outpatient, public sector and

private sector, solo practices, group practices, and integrate health practices, in both rural and urban communities.

Access: Perhaps this has been the most persuasive argument **FOR** psychologists with prescriptive authority. All parties concerned have acknowledged that there is an access problem for those needing mental health services. There are far too few psychiatrists and nurse practitioners to provide sufficient, quality services, and the number of psychiatrists in training is becoming smaller, not greater. There is certainly an access problem to those who are indigent and in rural communities. However, those who are in urban areas often experience access problems in the form of excessive wait times for new patients or increasingly fewer providers accepting certain insurances.

The impact by Medical Psychologists on access in Louisiana has been significant. For those who are in private practice exclusively, access may not have increased a great deal. There are only so many hours in a day and the practitioner can only see so many people, regardless if the practitioner prescribes or does not prescribe. So, if you are in private practice and work 8 hours a day, you probably will not see more patients simply because you prescribe...although some have. In Louisiana, psychologists are not eligible for outpatient Medicaid reimbursement. Consequently, unless the psychologist works in a facility where the facility bills for services, and pays the psychologist in some manner, Louisiana psychologists are not likely to accept Medicaid outpatients. Where the greatest increase in access has been realized with Medical Psychologists is in the public sector...Community Mental Health Centers, State hospitals and clinics. While psychologists worked at these facilities previously, they were there mostly to do a limited amount of psychological testing. Most of the "psychotherapy" was being performed by social workers and Licensed Professional Counselors that the State can hire much more cheaply. Psychiatrists have traditionally been the medication managers. While there are psychiatrists at these facilities, there have been numerous vacancies for psychiatrists that remain unfilled. Louisiana attempted to fill these vacancies with retired internal medicine physicians, but that has not always worked out. Some of the vacancies had been available for more than 5-10 years. Medical Psychologists began filling this void and increasing access to many indigent patients in the State system. My partner and I were among the first in Louisiana to take such positions. We split the hours of a full-time psychiatrist position at our Community Mental Health Center. Soon, other CMHCs began contracting with Medical Psychologists, and at least one has been hired one full time. Likewise, Medical Psychologists have been contracted and hired in the State hospital system. We have a couple of Medical Psychologists at VA centers, but they are not yet allowed to prescribe in the VA system.

Rural Access: Another criticism by the opposition has been that psychologists are essentially in no greater numbers in rural areas than psychiatrists. While it may be true in some states that the physical location or residence for many tend to be in more populated areas, that does not mean that Medical Psychologists in Louisiana do not serve rural populations. For example, the CMHC where I work covers a seven parish (county) area. That area includes significant rural areas with satellite clinics, etc. So, we do see a large number of indigent and patients from rural areas. And, as mentioned above, there have been shortages of psychiatrists willing to serve in these State facilities, particularly in more rural areas. New Orleans, Baton Rouge, and Shreveport tend to have an abundance of psychiatrists because the medical schools are located there, and New Orleans has a psychiatric residency program. But, outside of those areas, psychiatrists are just

not filling such positions. Psychiatry has proposed "telepsychiatry" in lieu of prescriptive authority for specially trained psychologist. We have been hearing about the benefits to access by telepsychiatry for more than 10 years in Louisiana. That promise has not been realized. Instead, there are fewer psychiatrists who are providing less access as more and more are abandoning general hospital practice so they do not have to "take call" and accept indigent or "no pay" patients in their practices. And, more psychiatrists are abandoning those patients with managed care insurance coverage.

Keep in mind, Medical Psychologists are trained as psychologists first and have the skills and expertise to provide a variety of psychotherapies in addition to psychopharmacology. Most psychiatrists have limited their expertise to psychopharmacology only. *It only makes sense to provide the treatment modality that best fits patients' needs rather than trying to force patients' needs into the only treatment modality that one profession may have.* The Medical Psychologist is perhaps the only doctoral level professional that can provide both modalities.

Safety: Recognize that this issue, safety, has been an all too familiar cry by those in the medical community opposed to any expansion in scope of practice. Many years ago, physicians held that only physicians could use "needles" to puncture the body. Reluctantly and citing safety as an issue, physicians relented and only Registered Nurses were allowed to puncture a vein to start an IV. Now, someone with a high school education and three months of training as a phlebotomist is allowed to puncture a vein with a needle and draw blood. Such "turf" issues are frequent and "safety" is almost always cited as a reason to deny expansion of scope of practice for disciplines other than physicians.

At this point, the argument against psychologists with special training having prescriptive authority that cites "safety" as the reason is simply a fear tactic to protect turf. There is now a 20 year history of psychologists prescribing in the US military and a 10 year history of medical psychologists prescribing SAFELY in two states. In more than 20 years of prescribing, there have been **no formal complaints** against psychologists with prescriptive authority for their use of medications. Again, I have served on the State psychology board and on the Medical Psychology Advisory Committee and am quite familiar with this data. When this issue is brought up by the opposition, and it will be, you should ask two questions of the opposition. First, "What evidence or data do you have that psychologists with prescriptive authority are indeed not safe prescribers?" While opponents often come up with anecdotal, often fabricated, stories of safety issues, they cannot provide any data whatsoever, because it does not exist…this, in light of the extensive history of psychologists prescribing safely. A second question should be asked, "Would you provide evidence of any 10-20 year history in your profession without complaint regarding prescribing medications?" Medical psychologists have been, and continue, prescribing safely for patients in need of medication for mental health issues. In fact, in 2009, when Louisiana passed Act 251, the Executive Director of the medical board testified in favor of the bill, and in doing so, he said, "We recognize that they (Medical Psychologists) are very safe prescribers."

Finally, I would like to briefly address another advantage of psychologists with prescriptive authority that is not generally discussed. Medical Psychologists are more likely to work in integrated health care settings. There are few, if any, psychiatrists in Louisiana involved in the integrated care model. As I noted previously, I work at a large cancer center and provide my services there two days a week. I have a physical office in the cancer center and assist six (6)

oncologists and five (5) nurse practitioners in providing for the mental health needs and psychotropic medications for their cancer patients. The oncologists and their nurse practitioners certainly welcome the help. I regularly meet with the oncologists and nurse practitioners both formally and informally. In addition to scheduled appointments with our cancer patients, I often get the "hallway handoff" of patients and families who may have just been diagnosed with cancer. By the same token, I am able to provide group therapy to patients with breast cancer and other groups of cancer. There is a tremendous need for mental health care with cancer patients and their families, the patients welcome the opportunity to avail themselves of my services while in the same facility. There are other Medical Psychologists in integrated care settings who are providing not only additional expertise to our physician colleagues, but also greater access to patients who probably would not have gotten such services were it not for the working relationship between Medical Psychologists and physicians that is typically not seen with psychiatry. Psychologists with prescriptive authority are proving to be valuable members of integrated health care teams that seek to address the mental health care needs of their patients.

Thank you for allowing me the opportunity to provide information about the advantages of having psychologists with prescriptive authority. There are currently approximately 88 medical psychologists in Louisiana who are adding access to the full range of quality mental health services in our State, and they are doing so in a safe and effective manner. I would encourage you to continue your support for HB1272 in the most positive manner. It will truly make a positive difference to the citizens of North Dakota. If I can be of any further assistance to you, please do not hesitate to contact me. I would be happy to address any questions or concerns that you or the Legislature may have regarding our experiences in Louisiana.

Sincerely,

Glenn A. Ally, PhD, MP
Advanced Practice Medical Psychologist
Clinical Neuropsychologist

Attach #3
HB 1272
03/23/2015
J# 25231

14 January 2015

To the Chair of the Human Service Committee:

I am a prescribing psychologist and I am writing to express my support for legislation allowing appropriately trained psychologists to prescribe psychotropic medications in North Dakota. I have been successfully prescribing psychiatric medications in a large Northwestern hospital as an employee of the Department of Defense for the past six years. My practice is integrated into a large primary care clinic with over fifty medical providers with whom I work closely to provide comprehensive, wrap-around behavioral health and medical care to our active duty soldiers, veterans and their families. In my six years of practice I have never had any major adverse event or complaint. In fact, I have solicited anonymous and confidential feedback from almost fifty medical providers who have worked closely with me over the years. The results of this survey, which were published in a prominent professional journal, show that primary care doctors who have worked with prescribing psychologists rate them as safe, effective and skilled in prescribing psychiatric medications. There was overwhelming agreement that having a prescribing psychologist in a primary care setting dramatically improved access to behavioral health care, availability of behavioral health consultation services for busy primary care providers, quality of behavioral health care, and access to services for a patient population that is often neglected.

Integration of prescribing psychologists into primary care settings is ideal as primary care providers are often the first to identify and treat behavioral health problems. In my view, rural communities with limited behavioral health access would benefit greatly from this intuitive and practical partnering of primary care providers and prescribing psychologists. I strongly recommend that North Dakota legislators support passage of a bill that would permit psychologist to prescribe psychotropic medications. Please feel free to contact me if you have any questions.

Respectfully Submitted,

David Shearer, PhD
Licensed Clinical and Prescribing Psychologist
7416 Beaver Creek Lane, Gig Harbor, WA 98335
253.365.1595
fiveshearers@hotmail.com

INFORMATION PAPER

SUBJECT: Prescribing Psychologists Embedded in Primary Care Clinics

ARTICLE:

Shearer, D.S., Harmon, C.S., Seavey, B.M., & Tiu, A.Y. (2012). The primary care prescribing psychologist model: Medical provider ratings of the safety, impact and utility of prescribing psychologist in a primary care settings. Journal of Clinical Psychology in Medical Settings, 19(4), 420-429.

1. Purpose. To summarize impressions of the impact, utility, and safety of Madigan's model of integrating prescribing psychologists in primary care

2. Background. In 1991, The Department of Defense began a demonstration project of training psychologists to prescribe psychotropic medication. Despite good outcomes, the appropriateness of utilizing psychologists with advanced training as prescribing clinicians has been questioned in the past. Department of Army policy provides for a path for credentialing psychologists to provide psychotropic medications. A prescribing psychologist has been integrated in a Family Medicine clinic at Madigan since 2008. A recent study published in the peer reviewed *Journal of Clinical Psychology in Medical Settings* describes Madigan's model and provides indications of its strengths and weaknesses as reported by medical providers who have utilized the model for over two years.

3. Facts.

a. Published studies indicate nearly two thirds of patients seen in primary care are experiencing emotional and behavioral problems and the majority of prescriptions for psychotropic medications are written by primary care providers.

b. Madigan developed a Primary Care Prescribing Psychologist model in which a prescribing psychologist works side by side in the same shared space as primary care providers to facilitate staff consultation and improved patient care.

c. Forty-seven medical providers in the Department of Family Medicine completed an anonymous survey approved by the Madigan IRB assessing their impressions of the impact, safety, and utility of the model.

d. Providers reported the prescribing psychologist model is beneficial; 95.6% reported consultation is helpful, 93.6% are confident in the ability of the prescribing psychologist to make appropriate referral decisions and prescribe appropriate medications and dosages (95.7%), 87.2% reported the model has improved patient care, and 93.6% are confident it is safe to refer patients to a prescribing psychologist.

e. Providers report more confidence in handling crisis situations when a prescribing psychologist is on site.

f. Providers identified improved patient access to behavioral health care as a "large benefit" of the model.

g. More than a third of providers reported the main problem with the model is that there are not enough prescribing psychologists available.

4. Conclusion. The model of integrating prescribing psychologists in primary care has been well-received by primary care providers and has the promise of further applicability beyond Madigan

Enclosure to Prescribing Psychologist Information Paper, Summary of Survey Results

Survey Respondents

Total	47
Staff Physician	22
Resident	12
Nurse Practitioner	7
Physician Assistant	4
Other	2

	Strongly Disagree n (%)	Disagree n (%)	Neither* n (%)	Agree n (%)	Strongly Agree n (%)
I find it helpful to consult with a prescribing psychologist about patients with psychiatric issues.**	0	1 (2.2)	1 (2.2)	18 (39.1)	26 (56.5)
I am confident in the ability of a prescribing psychologist to identify when patients need to be referred for additional medical evaluation.	0	0	3 (6.4)	14 (29.8)	30 (63.8)
I am confident managing a mental health crisis in my clinic.	0	8 (17.0)	14 (29.8)	22 (46.8)	3 (6.4)
I believe the prescribing psychologist has adequate knowledge of medical terminology.	0	0	1 (2.1)	18 (38.3)	28 (59.6)
I am confident it is safe to refer my patients to a prescribing psychologist for psychotropic medication management.	0	1 (2.1)	2 (4.3)	14 (29.8)	30 (63.8)
I believe my patients' care has NOT improved as a result of the availability of a prescribing psychologist in the family medicine clinic.	25 (53.2)	16 (34.0)	5 (10.6)	1 (2.1)	0
I am confident managing a mental health crisis in my clinic when consultation with a prescribing psychologist is available.	0	1 (2.1)	3 (6.4)	23 (48.9)	20 (42.6)
I am concerned patients will be prescribed inappropriate medications and/or dosages if I refer them to a prescribing psychologist.	23 (48.9)	22 (46.8)	0	2 (4.3)	0

*Neither Agree nor Disagree

*One respondent indicated "NA-I have not consulted with a prescribing psychologist."

Please rate the following potential benefits of having a prescribing psychologist embedded in the family medicine clinic.	**Undecided n (%)**	**No Benefit *n* (%)**	**Small Benefit *n* (%)**	**Moderate Benefit *n* (%)**	**Large Benefit *n* (%)**
Improves patient care	0	0	2 (4.3)	10 (21.3)	35 (74.5)
Decreases time I spend managing patients with psychiatric symptoms	1 (2.1)	0	8 (17.0)	8 (17.0)	30 (63.8)
Improves access to Behavioral Health care	0	0	1 (2.1)	5 (10.6)	41 (87.2)
Decreases number of patients I refer out for psychiatric care in the community	0	1 (2.1)	2 (4.3)	12 (25.5)	32 (68.1)
Improves ease of access for me to obtain psychiatric consultation	0	0	6 (12.8)	6 (12.8)	35 (74.5)

	Less Skilled n (%)	**Similarly Skilled n (%)**	**More Skilled n (%)**
Compared to other **mental health <u>prescribers</u>**, prescribing psychologists provide care that is:	3 (6.4)	30 (63.8)	14 (29.8)

Attach #4
HB 1272
03/23/2015
JH 25231

1/28/2015

Michael R. Tilus, PsyD, MP
President, APA Division 55

TESTIMONY OF SUPPORT
HB- 1272

Mr. Chairman and Members of the Human Services Committee. I am Mike Tilus, Medical Psychologist, currently working at the Crow/Northern Cheyenne Indian Health Service Hospital, Crow Agency, Montana. I am on leave from my active duty job with the United States Public Health Service.

It is my honor and pleasure to submit personal testimony in support of advancing the prescriptive authority to specially trained psychologists here in the Great State of North Dakota. As a Disclaimer: I am here on personal leave representing myself. My expressed opinions are solely mine and do not reflect the Health and Human Services, the U S Public Health Service, the Indian Health Service, or the Crow/Northern Cheyenne Indian Health Service Hospital.

In addition to offering my strong support for this prescriptive initiative, I would like to first provide my own personal experience as I sought training and eventual license and certification as a medical psychologist initially here in North Dakota, and now in Montana. Secondly, I would like to provide information from a national level perspective that will update the members of this committee on recent research and publication concerning prescriptive authority and primary care integration as the new Gold Standard of Care.

By way of introduction, I am a Prescribing Medical Psychologist in Montana and have had prescriptive authority for the past seven years. Prior to having prescriptive authority, my specialty was broad based. I am trained and licensed to be a clinical psychologist, marriage and family therapist, and Board-Certified Chaplain. I have been, and am, a licensed and ordained minister for the past 35 years, with 12 years served as a Chaplain in the North Dakota Army National Guard, the Army Reserves in CA, and then on active duty in the Army as a Combat Veteran Chaplain during the first Gulf War. As an active-duty Public Health Service Officer in the U. S. Public Health Service, my wife and I have served 13 years in remote, frontier, medically underserved Indian country- in Washington, Arizona, North Dakota, and now Montana.

My first duty assignment was to serve an isolated Indian community of approximately 680 people on a one and a half mile wide reservation. I was treating a young boy who suffered from Fetal Alcohol Spectrum, ADHD, and depression. He was oh so faithful to come to his therapy where we were working together in advancing his coping skills and 'thinking' better. For four years I tried to get my young patient seen by the only part-time psychiatrist who visited a

neighboring town's mental health department one day a week. For four years I was unsuccessful.

I received messages that the psychiatrist was full; my patient didn't have the right insurance; his name was accidently dropped off the roll; I would be called soon; and yes, they were willing to help. This young man continued to be a shadow sufferer, accustomed to being ignored, lied to, and forgotten. When my wife and I made the decision to accept a new position, I apologized to my young patient for my lack of ability to break through a ceiling that, appeared to me, to be racially colored and glazed. For two years I tried to get this young man seen. I was unsuccessful. Shortly after that I heard about a new program my ala mater was starting- Clinical Psychopharmacology. I consulted with my wife and discussed the seriousness nature of this study; the time, energy, and financial commitment it would cost us; and my willingness to increase my skills. With her blessing, I started my training in 2003. When my wife and I left this duty station after four years of service, none of my Native American patients ever received a psychiatric appointment. With tears, I apologized as I left this young man, and made him a promise that I would get trained so that in the future, I could help other young men like him somewhere else. He smiled and said, "That's nice." His childlike acceptance of toxic nourishment surrounding him was to become a common mantra my wife and I would see as we continued to elect to serve in America's frontier, isolated, medically-underserved Indian communities.

The path to prescribing is a deeply personal one that has marked my person and my profession. For me and others, it has a spiritual calling like element. I now have convictions about prescribing that have poisoned the old psychological and spiritual self of who I thought I was; how I thought I should be with people; and how they impacted the 'us.' I've changed since I became a prescriber. I hope you get a taste of that as you hear my heart's voice.

Where did it start? My personal experience of gaining prescriptive authority mirrors many psychologists who elected to do the hard work of passing a rigorous post-doctoral MS Degree Program in Clinical Psychopharmacology; passing the National PEP Exam; and completing multiple clinical preceptorship and internships under the direct supervision of a medical physician. While working full time and commuting to classes, I required an additional five plus years to meet all the requirements, and spent an additional 25T of my own money on student loans and carved money from our family budget.

I have sat in legislative hearings for bills intended to authorize prescriptive authority for psychologists, and heard that the training offered to psychologists in preparation for prescriptive authority is insufficient; not rigorous enough; and should be done in medical school.

In a recent publication, Dr's Muse and McGrath (The Journal of Clinical Psychology, Vol. 66(1), 96-103, 2010) reviewed the training comparison among three professions prescribing psychoactive medications: psychiatric nurse practitioners, physicians, and pharmacologically trained psychologists. The authors summarized one of their findings by stating, "An analysis of these statistics substantiates the assertion that pharmacologically trained psychologists are well prepared academically to incorporate prescriptive authority within their competencies. Indeed, the statistics point to multiple content areas in which the other professions are relatively deficit in comparison to pharmacologically trained psychologist's preparation" (pg. 103).

Dr. Bob McGrath, PhD, who is the Director of the Clinical Psychopharmacology at Farleigh Dickinson University (among other things) is famous for responding to the question "Is the training sufficient?" with his challenged comeback: "I have challenged people for years to identify a single topic essential to prescribing not covered in the training. I'm still waiting." Used the same medical textbooks; have some of the same instructors; but it is insufficient? This recent Muse and McGrath comparison suggests that appropriately trained psychologists have as much or more education in psychopharmacology as to other entry-level prescribers, including physicians. In fact, in the majority of content areas pertaining to the prescribing of psychoactive medications to behavioral health patients, medical psychologists are better prepared than the other prescribing professions included in their study.

Dr. McGrath goes on to say the National standard in Britain for non-physician prescribers is 208 didactic hours, 96 clinical hours (Br J Clin Pharmacology, 2012). Our standard is 450 didactic hours and 400 clinical hours.

Is medical training a required benchmark? Medical training is wasteful unless you can demonstrate better outcomes and greater safety. Physicians have objected to EVERY non-physician expansion of scope of practice on grounds of insufficient training- dentists, optometrists, nurse practitioners, physician assistants. They have been wrong EVERY TIME.

When I hear these arguments, I wonder where the antagonists practice. They must not have the same kind of rural patients I see every day. The grassroots emergence of the prescribing medical psychologist grew in the Northern Plains with the desire for increased access to Behavioral Health Care; increased need to serve the underserved populations; increased psychiatric services; wrap-around coverage.

Dr. Elaine LeVine is the first prescribing psychologist in New Mexico and has administered the clinical psychopharmacological training program there for the past 20 years. She writes:

"Dear Dr. Fehr:

I am the first prescribing psychologist in New Mexico and a member of the team that spearheaded the New Mexico effort for psychologists with appropriate postdoctoral training in psychopharmacology to be licensed to prescribe medications for their patients. I am writing you because I am so pleased to hear about your bringing forth RxP Bill HB 1271. At the present in New Mexico, we have 42 prescribing psychologists and almost all of them are working with underserved populations in rural areas, poor urban areas, in the military and on our Indian reservations. There are less than 100 psychiatrists within our entire State; and a majority of them do not see Medicaid patients. Moreover, they are in such limited supply that they seldom complete psychotherapy as well as medication management. The prescribing psychologists in New Mexico are providing integrated care; what we say is from a psychobiosocial model of care. The patient's needs, interests, preferences are central to all we do and we use just enough medication to allow our patients to access their own strength. In addition to this quality of care, we have increased the number of those providing services by 50%! We still need many more providers but there can be no doubt that the prescribing psychologists are offering a very valuable service in our State.

Please let me know if there is any other information I could provide for you that would assist you in furthering your important RxP Bill." (Dr. Elaine LeVine).

In North Dakota, I completed my clinical preceptorship and 2-year internship under the supervision of a Native American physician who was both the clinical director and a family practice physician. As a prescriber, I was credentialed and privileged as a full voting member of the Medical Staff. I ordered my own labs and EKG; reviewed findings; consulted with primary care providers; and started an integrated BH practice that was eventually selected by the Indian Health Service as the Gold Standard of Integrated Behavioral Health Care Model.

As is normal for any Indian Health Service Behavioral Health, you treat whatever walks in the door. Most patients I served were comorbid with general medical conditions, substance abuse, and multiple psychiatric conditions. Coordination of all resources, constant consultation and collaboration with all the various medical providers were a norm. But, as the clinical psychopharmacologist, I continued to provide the other required elements of a behavioral health practitioner who serves in these kinds of communities. I provided emergency psychiatric evaluations for psychotic and suicidal patients; intervened with children and families who reported childhood sexual abuse and trauma; received 'hand-off's from medical providers during the day who were demonstrating comorbid BH behavior or issues that the medical provider thought was influencing and contributing to their poor medical conditions. Patient's cases often required complex social work and sister agency referrals. And, as crises slowed down and patients were returning for depth therapy, I scheduled intensive, regularly, Cognitive Behavioral

Therapy or Dialectical Behavioral Therapy, in addition to managing their psychopharmacology. ADHD children received behavioral therapy and skill training, in addition to their psychostimulant trial. "No pills without skills" is a standard of care.

These are all common professional activities for medical psychologists who see patients more often; are skilled at closely monitoring medications effectiveness and side effects; and have the therapeutic relationship that is more likely to provide a healing presence than a 10-minute medication check.

Following my initial practice of medical psychology in North Dakota, I accepted a new position in Montana. At this service unit, we have a fairly large hospital with a full Emergency Room, outpatient primary medical care, express clinic, and outpatient behavioral health clinic. In addition, this hospital has two small medical health aid stations on the far edges of the reservation. The three medical psychologists who serve here provide integrated BH care in the primary care clinic; emergency psychiatric evaluations to the ER; maintain a standard outpatient BH clinic for both evaluation and short-term or extended psychotherapy with or without medication treatment. We all have full medical privileges and are credentialed and privileged to practice within the full scope of our licenses. One of our Medical Psychologist served as the BH Director; during his tenure there, he was elected to serve as the Chief Medical Officer, Acting Clinical Director, and Acting CEO.

The physician who manages our ER and is on the Board of Medical Examiners for Montana testified on behalf of, and in support of our previous MT RxP bill. So did a pediatrician, internists, family practice physician, and advanced nurse practitioner. In my seven years as a prescriber, the medical professionals I have worked with personally have been supportive of me as a medical psychologist. We were all in this together, trying to do our best with what we had, to very needy patient population, with limited resources and tired hearts.

Another answer offered by opposition to this bill is that medical psychologists are unsafe; don't know enough medicine; telepsychiatry will meet all the needs; and that 'we' don't need more providers. I wonder where these unsafe medical psychologists are. I know a lot of them, and they don't fit the bill. And it doesn't fit the data.

I wonder why 'they' distrust the medical professionals I worked every day, who see my notes every day, read my lab findings, note my consultation requests, and answer my collaborative treatment plans with their shared medical treatment goals. Since prescribing psychology and primary care share such complimentary paths around the patients' medical home, wouldn't they know if we were incompetent, unprofessional, or unsafe? My medical colleagues are the ones who voluntarily offer testimony for prescribing medical psychology legislation; gladly seek out our expertise, both in psychotherapy and psychopharmacotherapy; avidly work together to seek

additional resources, family interventions, exercise, prayer, and cultural healing ceremonies; and ultimately, credential and privilege us to the fullest extent of our scope of practice.

They review our notes; the same quality control applies to us as it does to them; we have a growing body of knowledge that establishes aspirational and ethical standards of care. Primary care providers are often the first one who sees a suicidal patient; they prescribe the most psychotropics initially and now have a resource to 'pass of' difficult, complex, comorbid cases that typically involve active substance abuse and severe characterological impaired patients.

Psychiatry has generally given up all interventions except medication. Medical psychologists practice both medicine and psychology. They have the authority to prescribe, and the authority to unprescribe. Medicine doesn't cure everything.

Another new piece of research that is full of meaning for this legislation, Dr's McGrath and Sammons authored the piece "Prescribing and Primary Care Psychology: Complementary Paths for Professional Psychology" (Professional Psychology: Research and Practice, 2011, Vol. 42, No. 2, 113-120). They quote a worthy, but brief list of functions the primary care prescribing psychologist can do:

"1. Identifying and addressing emotional concomitants to medical disorders.
2. Consulting to the PCP about how best to interact with the medical patient who is difficult to manage because of, for example, severe mental illness or personality-based resistance.
3. Determining whether the patient's emotional needs exceed the services available at the site and overseeing referral for specialty services in psychopharmacotherapy, psychotherapy, or health psychology.
4. Screening for depressive, substance abuse, cognitive impairment, personality disorders, and other psychobiosocial disorders that are potentially overlooked in primary care evaluations.
5. Providing supportive services to patients who are finding it difficult to participate in their care effectively.
6. Offering specialized treatments for smoking, obesity, and other common behavioral disorders in the general primary care population.
7. Offering behavioral interventions for individuals who primary medical diagnosis calls for a treatment with a substantial behavioral component. Examples would include individuals with diabetes, asthma, chronic infectious disease, and heart disease.
8. Developing outcomes assessment and program evaluation systems as called for by outside agencies.
9. Aiding in the design of research protocols."

From my real practice situations, I would add these:

10. Prescribing an appropriate exercise program for mild to moderate anxiety or depressive conditions.
11. Participate with my patient in their exercise program as a coach and motivational counseling.
12. Seek for positive religious, spiritual, or cultural ceremonies that the patient has found wellness, peace, forgiveness, resiliency, repentance, systems of change, and 'prescribe', prescribe, prescribe.
13. Prescribe substance abuse maintenance, i.e., AA and its affiliates; cultural substance abuse support groups.
14. Prescribe safety and security in all things.
15. Prescribe and advocate for the voiceless, sexually abused children and adolescents who struggle to find meaning in their life every day.
16. Prescribe hope.
17. Prescribe faith.

Telepsychiatry the answer? In my real world, I have seen multiple efforts to sell the ability of psychiatry to meet the rural need with this network. The agency I work for does use telepsychiatry, but the problem is still insufficient to handle the mental health needs. There just aren't enough psychiatrists. What makes people think that psychiatrist have 'extra time' to do telepsychiatry? There are only so many hours in a day, so either they have to see fewer patients' fact to face or have no time for telepsychiatry. Ten minute appointments become 9, then 8, then…what?

Telepsychiatry demands tech savvy people on both side of the line. Paying top dollar for a tele psychiatrist and losing 10 minutes of your scheduled 15 minutes is not productive or cost effective. In many places where I have served, the psychiatrist was not native to the USA and had such a language barrier that both the professional staff and the patient were unable to communicate meaningfully.

In real life, telepsychiatry doesn't work unless you have prescribers to man the phones; nurses to take the vitals; direct severely mentally disturbed people to the lab for blood draws; keep a paranoid schizophrenic patient focused and not disturbed in a small room, looking at a TV screen, with a strange person asking him or her questions. Try that….

And yet I personally support telepsychiatry. We need all the services we can get to meet the need of North Dakotans.

It is well known that the numbers of psychiatrists are dropping with projections of a collapse in the next 10-15 years. In these legislative settings, the antagonistic typically propose additional training to the already burdened and overworked primary care providers.

Antagonists have proposed that increasing the medication training for general practice, family practice, advanced nurse practitioners will be another alternative to telepsychiatry. It may be easier to teach these medical professionals advanced psychopharmacology. But, that does not mean they have the training, competence, or ability to diagnoses various forms of mental illness. How long will it take to teach not only the psychopharmacology, but the psychopathology and the subtleties between various diagnoses?

Why not use the doctoral level professional that has both- expertise in psychopathology and psychopharmacology, AND, the critical added bonus of psychotherapy?

Daniel Carlat, a psychiatrist, is quoted in his published article on this very subject when Dr. Carlat asked a primary care doc about the idea that they will fill the shortfall in psychiatrists, and the response was "that donkey is already overloaded!" Anybody who works in primary care knows how painful this joke really is.

I have never personally seen any medical psychologist take a job from a psychiatrist. If you work in the trenches like I have done for the past 13 years, like the average medical psychologist, you know there is so much need and so few resources. North Dakota needs more drug and alcohol counselors; social workers; marriage and family therapists; psychiatric nurse practitioners; internists; family practice doc's; pediatricians; psychiatrists; and medical psychologists.

Shifting gears now, I wish to give some broad brush strokes. As President and on behalf of the American Psychological Association (APA) Division 55 Board of Directors, I wish to submit their unanimous support of HB 1272. In the professional delivery of psychology and medicine, the evidence is overwhelming in support of an integrated mental and behavioral health services into primary care as being more cost-effective while enhancing the quality of care. These patient-centered care initiatives document the higher patient and provider satisfaction along with better outcomes. HB-1272 mirrors the Gold Standard of Behavioral Health in Integrated Primary Care.

A key health care provider in this new Gold Standard of Delivery is the Prescribing Medical Psychologist. This hybrid health care provider finds its natural home in the integrated primary care model, and is able to provide the best in psychotherapy as well as pharmacotherapy. APA Division 55 has prescribing medical psychologists already serving in integrated primary care clinics in rural, frontier, medically-underserved populations in multiple states; at Federally

Qualified Health Centers (FQHC); in Indian Country (in particular, North Dakota, South Dakota, Montana, Oregon, and New Mexico); all branches of the Department of Defense; the United States Public Health Service; and in states that have passed appropriate legislation- NM, LA, and Ill.

Some national summary points:

- Psychologists with prescriptive authority have now been safely prescribing psychotropic medications in the US military for more than 20 years and in New Mexico and Louisiana for more than 10 years.
- This past year, Illinois passed legislation allowing appropriately trained psychologists to prescribe. However since the Illinois status is new, there is no history upon which to reliably reach conclusions.
- We have medical psychologists prescribing in the Indian Health Service, in the U.S. Public Health Service, and in all Departments of Defense.
- Medical psychologists have collaborated with our medical colleagues in providing safe and effective care now for more than twenty years with an estimated more-than one million-prescriptions written without an adverse action.
- NOT A SINGLE MALPRACTICE CLAIM; NOT A SINGLE COMPLAINT TO A LICENSING BOARD IN TWENTY YEARS.
- What evidence or data do you have that psychologists with prescriptive authority are indeed not safe prescribers?
- Could you provide evidence of any 10-20 year history in your profession without complaint regarding prescribing medications?
- As a Recruiter for the Indian Health Service and US Public Health Service, and as the President of APA Division 55, I know countless medical psychologists who when they qualified for this enlarged scope of practice, accepted new employment and elected to re-locate their practice to Louisiana or New Mexico (states which were provider-friendly and had legal authority to prescribe); joined the Department of Defense as either on active duty or as a federal civilian; joined the US Public Health Service with a Mission-Identifier as a Medical Psychologist, able to serve in various federal agencies; or found a place to serve in the Indian Health Service.
- Most medical psychologists practice in various forms of integrated behavioral health care within a primary care setting.
- The medical psychology movement grew as a grassroots movement in the Upper Northern Plains, out of the desire to provide increased care to rural frontier America.
- "Results indicate family medicine providers agree that having a prescribing psychologist embedded in the family medicine clinic is helpful to their practice, safe for patients, convenient for providers and for patients, and improves patient care." (*The Primary Care Prescribing Psychologist Model: Medical Provider Ratings of the Safety, Impact and*

Utility of Prescribing Psychology in a Primary Care Setting. David S. Shearer, S. Cory Harmon, Brian M. Seavey & Alvin Y. Tiu. Journal of Clinical Psychology in Medical Settings, 27 November 2012, Springer Sciences).

Medical psychologists must 'count the cost', using my religious verbiage. As it is family and personal expensive to take on the added burden and expense of being qualified and trained to prescribe. Working in this field demands the utmost of personal and family self-care. Caring, truly investing in the rural populations we are called to serve sometimes shows up on our own developing general medical conditions; high blood pressure; diabetes; depression; and relational distress.

Division 55 and the medical psychologist community have lost two of its members by murder over the past few years. On 5 November 2009, U.S. Army Major , Psychiatrist, and in my opinion Islamic Terrorist, Dr. Nidal Malik Hasan shot and killed 13 people at Fort Hood, Texas. Among the murdered was Army Reservist and medical psychologist MAJOR (Dr.) Eduardo Caraveo.

On 7 January 2015, Dr. Timothy Fjordback was shot and killed by a VA patient at the El Paso VA Health Clinic. Tim was a neuropsychologist who left his long established private practice following the 9-11 Terrorist Attack and decided to serve returning veterans. Tim had completed his MS Degree in Clinical Psychopharmacology and his practicums. He was awaiting his conditional prescribing psychology certificate from the New Mexico Board of Psychology Examiners before he was killed.

These men reflect the kind of character and leadership that I have found in the medical psychology movement. Gifted, of unusual strong character, qualified leaders of people and agencies, multi-skill sets, large hearts, compassionate, sturdy, and seasoned. These are the kind of psychological leaders that can change communities and raise their families on dirt roads.

I strongly urge you and the Human Service Center Committee to endorse HB 1272 as a 'Mission Multiplier' for recruiting and retaining Medical Psychologists to serve in an integrated primary care clinics in the great state of North Dakota!

I have no doubt- "If you pass it, they will come!"

It's been an honor to be here today. I will answer any questions.

Attach #5
HB 1272
03/23/2015
J#25231

MORA PSYCHOLOGICAL SERVICES, PLLC
630 Union Street South
Mora, MN 55051

HARLAN J. GILBERTSON, MS PsyD MSCP LP
MSCP (Postdoctoral Master of Science in Clinical Psychopharmacology)
Licensed Psychologist (in Minnesota and New Mexico)

January 19, 2015

Alan Fehr, PhD LP North Dakota Representative

RE: National Mental Health Crisis

Dear Dr. Fehr:

As you are aware, there is a national mental health crisis due to declining availability of psychiatric treatment as the number of medical residents pursuing psychiatric training continues to decline. As a result, the current trend is to use nurse practitioners with Master's Degrees. However, there is now an increasing trend of relying upon Physician Assistants or PA-C's prescribing medication following a 2-year degree program. Not only is this substandard to address the complexity of psychiatric, chemical use, and/or neurocognitive deficits, their 4-year degree does not necessarily require a medical or psychiatrically or psychologically-related undergraduate degree for admission to these programs.

Compare this to the more advanced education for psychologists consistent with the biopsychosocial treatment model identified by the psychiatric/psychological community and the DSM-V. Specifically, 9 years of education + 2.5 years of more advanced education in clinical psychopharmacology; supervised 80-hour medical practicum; supervised preceptorship consisting of treating 100 patients over a minimum of 400 hours across 6 months; passing of the nationally-recognized American Psychological Association Psychopharmacology Examination for Psychologists (PEP); and conditional licensure under supervision for at least one year. Some psychologists have also pursued advanced pathophysiological and medical assessment training to become board certified medical psychologists. With all due respect to the other prescribing professions, the disparity between psychologists and other clinicians is exemplified below:

Comparison of Entry-Level Models Leading to Prescriptive Authority
Mean Number of Graduate Contact Hours

Profession	Minimum Yrs. Post-Bachelors	Biochemistry / Neuroscience	Pharmacology	Clinical Practicums	Tx Research/ Statistics	Behavioral assessment/ diagnoses	Psychotherapy
NP	2.5	48	56	146	99	30	32
MD/DO	4	216	59	855	33	18	9
MSCP	6.5	161	288	680	225	267	255

Training Comparison among Three Professions Prescribing Psychoactive Medications: Psychiatric Nurse Practitioners (NP), Physicians (MD/DO) and Pharmacologically Train Psychologists (MSCP). Mark Muse & Robert McGrath 2010

Perhaps the greatest tragedy is the loss of psychiatric services in rural states such as North Dakota as well as Minnesota. A recent example in East Central Minnesota was the unexpected closure of the local mental health center after nearly 50 years of service. This resulted in approximately 3000 individuals losing access to psychiatric, psychological, crisis intervention and ARMHS worker services. As a result, local rural hospitals and emergency rooms were inundated with the need for complex psychiatric assessment, treatment and medication management.

I believe rural America has a much more efficient and cost effective intervention available to our citizens. While it may take several years to achieve, I believe it would be beneficial for your state to assist with and/or support legislation allowing properly trained doctoral level psychologists to prescribe in North Dakota.

There are, and will always be significantly more psychologists than psychiatrists and advanced nurse practitioner/PACs with the ability to evaluate, treat, medicate and/or 'un-medicate' individuals. While I am uncertain of those psychologists in North Dakota that might pursue this education and training, Minnesota has approximately 3500 psychologists. If even 10% of these clinicians completed training and began prescribing this would add 350 prescribing clinicians to our state. It is my impression that psychologists in North Dakota could provide similar services, especially in your most isolated areas.

Unbeknownst to many, psychologists have been prescribing successfully in Guam, Louisiana and New Mexico, Indian Health Services, and Federal Health and Human Services as well as the military without any document complaints, adverse effects or deaths despite approximately 250,000 scripts written to date. In addition, legislation recently passed in Illinois allowing limited script writing by psychologists with more complex prescriptive legislation in New Jersey likely to pass within the next year.

Perhaps of greatest concern is the increasing identification of medical complications arising from treatment with psychotropic medication. While the historical treatment model has included initiation of medication with monitoring every 3, 6 or 12-months, this is contraindicated given the often subtle yet progressive and potentially life-threatening side effects of these medications. Prescribing psychologists have the opportunity to provide ongoing psychotherapy while pharmacologically-treating these individuals with close monitoring of benefits as well as adverse physiological impact. This is the quality of care each and every individual deserves, especially this most vulnerable population with psychiatric and/or chemical use disorders.

In addition to significantly advanced education, psychologists are trained to facilitate collaborative relationships between people (e.g. interdisciplinary treatment teams). Psychologists could also singly provide multiple complex services including diagnostic assessments, psychometric testing, administration and modification of psychotropic interventions/medications, as well as, individual and group psychotherapies while also serving as a team lead. Just imagine the significant cost reduction in psychiatric care and treatment in your communities. Furthermore, such psychologists are well prepared to assist the local medical community in triaging the complexity of psychiatric and chemical use disorders.

Should your state chose to establish such legislation, it also provides an opportunity for prescribing psychologists from other states and/or arenas to migrate to North Dakota to provide these life changing services. This would quickly enhance access to complex treatment services in rural communities by one clinician working with members of an interdisciplinary treatment team, whether in acute, medical and/or residential settings.

If you have any additional questions or comment please contact me at 612-390-8269.

Respectfully Submitted,

Harlan J. Gilbertson, MS, PsyD, MSCP, LP

Harlan J. Gilbertson, MS PsyD MSCP LP
MSCP (Postdoctoral Master of Science in Clinical Psychopharmacology)
Licensed Psychologist (in Minnesota and New Mexico)

HB 1272
03/23/15
Attach #6
J# 25231

American Psychiatric Association

1000 Wilson Boulevard
Suite 1825
Arlington, VA 22209
Telephone 703.907.7300
Fax 703.907.1085
E-mail apa@psych.org
Internet: www.psychiatry.org

March 20, 2015

Honorable Judy Lee
Chairman, Senate Human Services Committee
State Capitol
600 East Boulevard Avenue
Bismarck, ND 58505

Dear Chairman Lee and Members of the Human Services Committee:

I am writing on behalf of the American Psychiatric Association (APA), the medical specialty society representing more than 36,000 psychiatric physicians as well as their patients and families, to urge you to vote "**No/Do Not Pass**" **on HB 1272**. This bill would require the commission of a feasibility study on whether psychologists could integrate behavioral health into primary care and whether giving psychologists the ability to prescribe powerful medications might have unsafe, dangerous consequences for North Dakotans suffering from mental illnesses.

APA urges the Committee members to vote "no" on this measure because this study is unnecessary. These questions have been asked and answered countless times over the past 25 years. Year after year, states have rejected these requests from the vocal minority of psychologists that have asked legislatures to grant them this authority that would shortcut the education and training that is necessary to safely treat patients.

Psychotropic medications do not stop in the patient's brain. They affect many parts of the body and can cause seriously disabling or deadly side-effects if improperly prescribed. For example, there can be potentially serious drug interactions if a patient is taking multiple medications for other physical ailments such as heart disease or diabetes. As you may know, over 50% of individuals with a mental disorder have medical co-morbidities. Informed clinical judgment is necessary to properly diagnose and treat these patients as a whole. This requires proper undergraduate and graduate medical education and training that cannot be taught in a silo for medication treatment of only mental disorders.

Furthermore, contrary to assertions made by proponents of this legislation, it is important to note that granting prescriptive authority to psychologists does not solve the mental health needs of rural communities according to available evidence. Despite promises made for purposes of advancing prescribing authority, psychologists have not and will not move their practices to serve the rural communities.

Solutions

APA recommends leveraging the skilled mental health professionals who are already providing care in communities of need in North Dakota in order to improve access to appropriate treatment. Our national office and APA's North Dakota state affiliate offer ourselves as a resource to work

6.2

with you in order to facilitate the adoption of programs that improve the mental health training of primary care providers, expand telepsychiatry access, and support the latest practices in integrated, patient-centered collaborative care. These improvements represent meaningful and clinically-appropriate access improvements for your constituents. Please consider this in contrast to HB 1272's exploration of creating professional silos and fragmentation of care.

In summary, we urge the Human Services Committee to vote "No/Do Not Pass" on HB 1272 and instead let us work with you through our North Dakota Psychiatric Society to facilitate evidence-based, proven programs that can truly assist our children, families and friends suffering from mental illness and substance use disorders in North Dakota.

Thank you for the opportunity to submit this statement. If you have any questions, please do not hesitate to contact Janice Brannon, Deputy Director, State Affairs at jbrannon@psych.org.

Sincerely,

Saul Levin, MD, MPA

Saul Levin, M.D., M.P.A.
C.E.O. and Medical Director
American Psychiatric Association

HB 1272
03/23/15
Attach #1
J# 25231

From: Dr. Virdee [mailto:drvirdee@qwestoffice.net]
Sent: Monday, March 23, 2015 8:08 AM
To: Lee, Judy E.
Subject: VOTE NO on HB 1272
Importance: High

Dear Senator Lee,
I understand you are on the Senate Human Services Committee. I am a full-time psychiatrist in Fargo. I have been in practice since 1977. Needless to say, I am aware of dangers of prescribing without adequate background in understanding of the whole body.
I am seeing the creation of a "Medical" Psychologist to introduce a prescribing method for the central nervous system without considering the rest of the human body. Today you will be voting for a plan for H.B. 1272 - requiring a feasibility study on giving psychologists the right to prescribe powerful medications which can have serious consequences and make it legal for them to do.
I would strongly ask you **TO REJECT - HB 1272.**

Please look below at the drawbacks that we have discussed as physicians about our concerns regarding harm to patients.
I will be available at 701-799-0750 if any consultation is required.

VOTE NO on HB 1272

- Psychologists have neither the basic health science education nor medical training necessary to safely prescribe medications.

- While it is true that there is a shortage of professionals to care for patients with mental illness , including psychiatrists and psychologists, allowing psychologists to prescribe powerful psychotropic medications will not provide access to quality psychiatric care but instead will compromise the safety of patients in North Dakota.

- The issues of access for patients with mental illnesses are being addressed through telemedicine, and new collaboration models.

- We need psychologists to do what they are trained to do – assessments, psychotherapy and behavioural treatment planning

- Psychiatrists are medical doctors who have received at least 4 years of extra training after medical school. The post-medical school training for a psychiatrist includes 10,000 to 12,000 hours of supervised experience in treating mental health disorders and dealing with the complications and side effects of that treatment.

- Psychotropic medications used to treat mental illnesses potentially affect all parts of the body, not just the brain. These medications can have serious medical side effects if they are prescribed inappropriately such as convulsions, heart arrhythmia, loss of ability to fight infection, movement disorders, even coma and death.

- The professionals allowed to prescribe need to have the highest training for safety of North Dakota patients.

Thank you

Harjinder Virdee, M.D.

Attach #8
HB 1272
03/23/15
J# 25231

North Dakota Psychological Association

23 Mar 2015

Senate Human Services Committee

Testimony in support of HB 1272

Bonnie Staiger (#158)

Chairman Lee and members of the committee,

For the record my name is Bonnie Staiger. I am here today representing the North Dakota Psychological Association. NDPA has a formal position in support of prescriptive authority for appropriately trained psychologists and with the understanding that they be regulated by the ND State Board of Psychologist Examiners (NDCC Chapter 43-32).

In the House, we did not support the placement of this growing practice specialty under the regulation of the ND State Board of Medical Examiners (NDCC 43-17). This would have created confusion of regulatory jurisdiction for a professional scope of practice that should be housed within psychological and behavioral interventions and treatment.

Prescriptive authority for psychologists is a concept worthy of rational and data-driven exploration. Too often, thoughtful discussions of who may legitimately acquire prescriptive authority, and how such authority may be properly acquired, have been derailed by emotional rhetoric, leaving this important issue to be arbitrarily adjudicated in several state's legislative arenas, including North Dakota. An interim study, as crafted by your House counterparts and amended into the engrossed bill, will allow for an extended examination of this issue under circumstances which favor a more dispassionate discussion of what actions will best serve the citizens of North Dakota. We urge you to support this bill.

P.O. Box 7370 • Bismarck, ND 58507-7370 • 701-223-9045

NDMA
Est.1887 NORTH DAKOTA MEDICAL ASSOCIATION

Attach #9
HB1272
03/23/2015
J# 25231

Senate Human Services Committee
HB 1272
March 23, 2015

Good morning Chairperson Lee and Committee Members. I'm Courtney Koebele and I represent both the North Dakota Psychiatric Society and the North Dakota Medical Association.

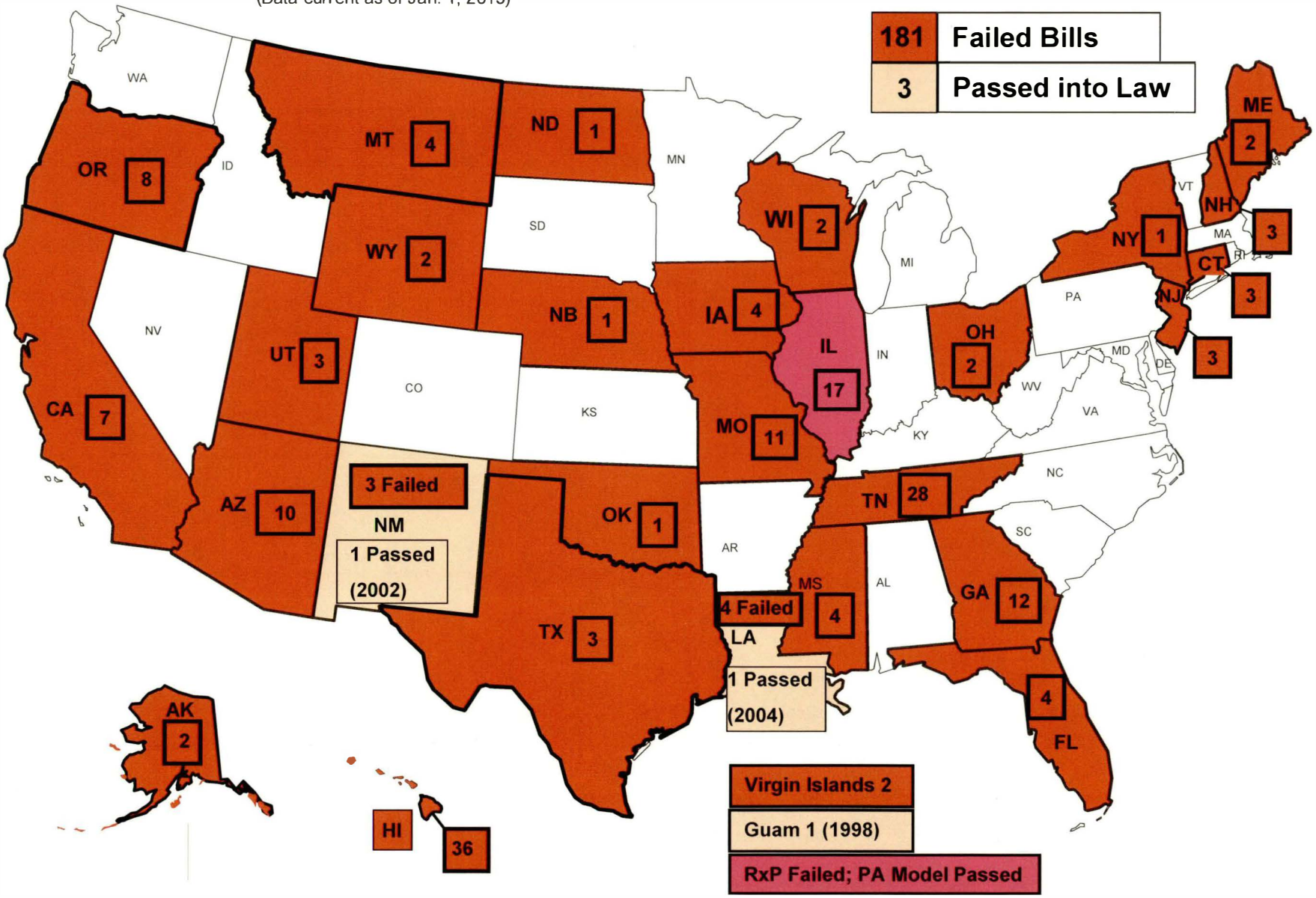
Both organizations oppose HB 1272, which directs the Medical School Advisory council to study the feasibility and desirability of licensing medical psychologists. It is NDMA's and NDPS's position that the study would not be beneficial to the state.

With me today are Dr. Ronald Burd, Dr. Cheryl Huber, and Dr. Gabriella Balf, psychiatrists who are here to testify. They will be discussing the issue in more detail.

Thank you for your time today.

Psychologist Prescriptive Authority Legislative Bills 1995-2015

(Data current as of Jan. 1, 2015)



POPPP: Psychologists Opposed to Prescription Privileges for Psychologists

9.2

Attach #10
HB 1272
03/23/2015
Jt# 25231

Chairperson Lee, members of the Senate Human Services Committee, I am Dr Ron Burd, a psychiatrist. I am here today representing the North Dakota Psychiatric Society, offering testimony on HB 1272.

I graduated Concordia College, majoring in Biology and Chemistry, medical school at the University of Utah, psychiatric residency at Mayo and have practiced in psychiatry since 1986 in Fargo. I currently work for Sanford, where I am the Inpatient Medical Director. Over the years I have had numerous experiences including clinical faculty with UND teaching medical students and psychiatric residents, teaching physician's assistants through MeritCare/Sanford, seeing patients through SEHSC, and working as Medical Director with BCBS-ND. By way of full disclosure, I am a long-time member of the American Psychiatric Association, the North Dakota Psychiatric Society, the American Medical Association and the North Dakota Medical Society.

I am here asking you to please vote "Do Not Pass" on HB 1272.

Psychologist prescribing got its start when Pat DeLeon, PhD was a member of the staff of Senator Daniel Inouye. Senator Inouye was the chairman of the Senate Appropriations Committee and its Defense Subcommittee. There was no study that identified this need, nor public outcry that it was necessary. Nonetheless, in 1991 the first of 13 psychologists entered the Psychopharmacology Demonstration Project, the Department of Defense pilot program. Their scope of practice was substantially limited (ex. active-duty military, 18-65, screened medically and found to be healthy). The U.S. General Accounting Office found that the program cost over $600,000 per psychologist who completed it and appropriately entitled their report "Need for Prescribing Psychologists Is Not Adequately Justified".

In 1995 the American Psychological Association Council of Representatives passed policy to support prescriptive authority for psychologists. That policy remains hotly contested within the organization (American Psychological Association). Nonetheless, since 1996 there have been nearly 200 prescriptive bills introduced. The result of this effort has been that 3 states (NM, LA and IL) and 1 territory (Guam) currently recognize this authority. In addition to practicing within those locales, psychologists with such licenses may

practice within the Indian Health Service and the U.S. Public Health Service (ex. licensed in New Mexico as a prescribing psychologist but working in North Dakota for IHS). After 25 years of this effort, "... the best available estimate is that there are 120 psychologists licensed to prescribe in the United States under this training model." (Tumlin RT and Klepac RK "The Long-Running Failure of the American Psychological Association's Campaign for Prescription Privileges: When Is Enough Enough?" The Behavior Therapist Vol 37, No. 6 Sept 2014, p 149.)

The American Psychological Association and especially Division 55 of the organization continue to push this agenda. The President of the Division (Michael Tilus, Psy D, New Mexico license, working in Montana) was present and gave testimony on HB 1272 in the House Human Services Committee!

Consistently the argument for prescriptive privileges for psychologists has been to improve access for the underserved.

There are considerable concerns about the safety of granting these privileges to psychologists including a lack of education in basic sciences (Biology, Chemistry, and Physics), the adequacy of proposed training in prescribing medication (given that medications are distributed throughout the body, not just to the brain), certification of initial competency and on-going credentialing and certification needs. The absence of evidence of harm in those locales where they can prescribe is not the same as evidence of absence of harm.

Psychologists in general are no more likely to live in rural areas than are psychiatrists and do not re-locate to those areas when granted prescriptive authority. Tele-psychiatry is increasingly embraced and accepted as a preferred healthcare delivery system by patients and healthcare providers. The technology continues to improve, regulatory barriers continue to be resolved, and specific training programs for psychiatrists in tele-psychiatry are coming on-line. This is true not only for individual patient care, but also for care delivered through integrated treatment arrangements by other collaborating providers.

It is arguably more cost-efficient to expand programs for our current prescribers (medical school, advanced nursing programs and physician assistant training, psychiatric residency) and to create inducements to retain their service to our area than to "grand-father in" new and under-trained prescribers.

Furthermore, there is clearly a need for psychologists to practice in the area of their expertise. We need psychologists to do assessments, provide psychotherapy and craft behavioral treatment programs in our group homes and nursing homes.

I am clearly not in favor of the concept of psychologist prescribing.

Do we need to study the feasibility and desirability of granting prescriptive authority to psychologists as this bill proposes?

The concept has been advanced and defeated on nearly 200 occasions in over 20 different states, including previously in North Dakota.

The Canadian Psychological Association's Task Force on Prescriptive Authority for Psychologist in Canada (2010) recommended after 3 years of study that prescriptive authority for psychologists not be pursued.

The North Dakota legislature commissioned a study of the state's behavioral health system. That study was done by Schulte Consulting and presented as "Behavioral Health Planning – Final Report" in 2014. The report specifically identifies service shortages and a need to expand the workforce. It offers 51 strategies to implement change across the system. Not one of those strategies includes psychologist prescriptive authority.

In summary, the idea of prescriptive authority for psychologists is a bad one. We have other, better strategies to pursue. To further study this issue is a waste of time and resources we should be putting to better use.

I repeat my message, please vote "Do Not Pass" on HB 1272.

Thank you for your consideration of my testimony.

Attach #11
HB 1272
03/23/2015
J# 25231

Senate Human Services Committee
HB 1272
March 23, 2015

Chairperson Lee, members of the Senate Human Services Committee, I am Dr. Cheryl Huber, a psychiatrist with Sanford Bismarck Medical Center, Medcenter One prior to that, since 1996. I am here today to testify in opposition to HB 1272, which contains a provision mandating the study of the feasibility and desirability of licensing medical psychologists.

I'm not going to repeat Dr. Burd's excellent testimony, but I would like to speak about my own concerns. North Dakota has a shortage of competent well-trained psychologists who provide therapies that are needed and indicated for mental illness. I took a poll of the receptionists in my office this morning. The current wait time for a person seeking a first-time appointment with a psychologist is 4 weeks, longer if that person is under the age of 18. "Medical psychology" does nothing to fix this critical shortage. There are numerous studies demonstrating proven efficacy of cognitive-behavioral therapy, interpersonal therapy, dialectical-behavioral therapy, and other therapies for conditions such as depression, anxiety, and other mental illnesses. I can't provide this treatment. I have basic training in these therapies, but my psychology colleagues have much more. It's not just medication that makes people better, but helping people identify different ways of thinking or approaching the problems in their lives. This works best when psychiatrists and psychologists work together, using their different skill sets, to help people reach their goals.

Please vote "Do Not Pass" on HB 1272.

Thank you for your time.

Attach # 12
HB 1272
03/23/2015
Jt # 25231

Testimony HB 1272
Senate Human Services Committee
Senator Lee, Chairman
March 23, 2015

Chairman Lee, members of the Senate Human Committee, I am Carlotta McCleary, Executive Director of Mental Health America of North Dakota (MHAND), whose mission is to promote mental health through education, advocacy, understanding, and access to quality care for all individuals.

Today I am here to express concerns that MHAND has regarding HB 1272. Even though the bill is now a study, we still have concerns. While MHAND agrees that North Dakota is in need of additional mental health professionals we are just as concerned with the quality of care the individuals with mental health needs receive. Today individuals with mental health needs are experiencing poor health outcomes. Currently there are recommendations that we need to do a better job of integrating the physical health with the mental health treatment that individuals receive to improve their health outcomes.

We are concerned that the medical training would not be enough to safely treat individuals with mental health needs. There are many times symptoms may be similar to a mental health issue when in fact it may be a different medical issue. There are also serious side effects that need to be monitored while someone is being treated with medications. Again, we don't believe this would provide psychologists with enough medical training to address these potential concerns.

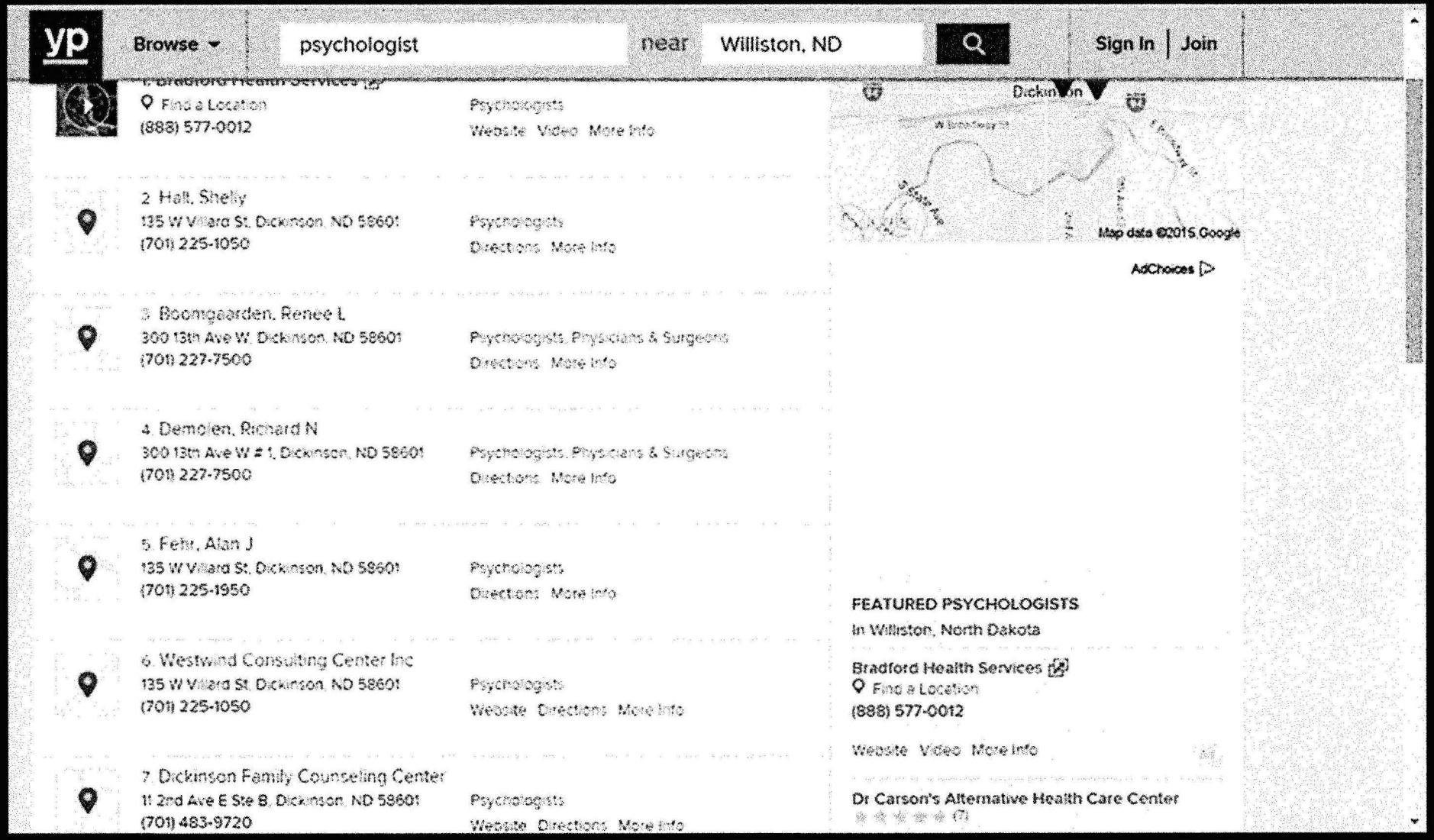
MHAND believes we need to improve access to care as well as increase the quality of care. Thank you for your time.

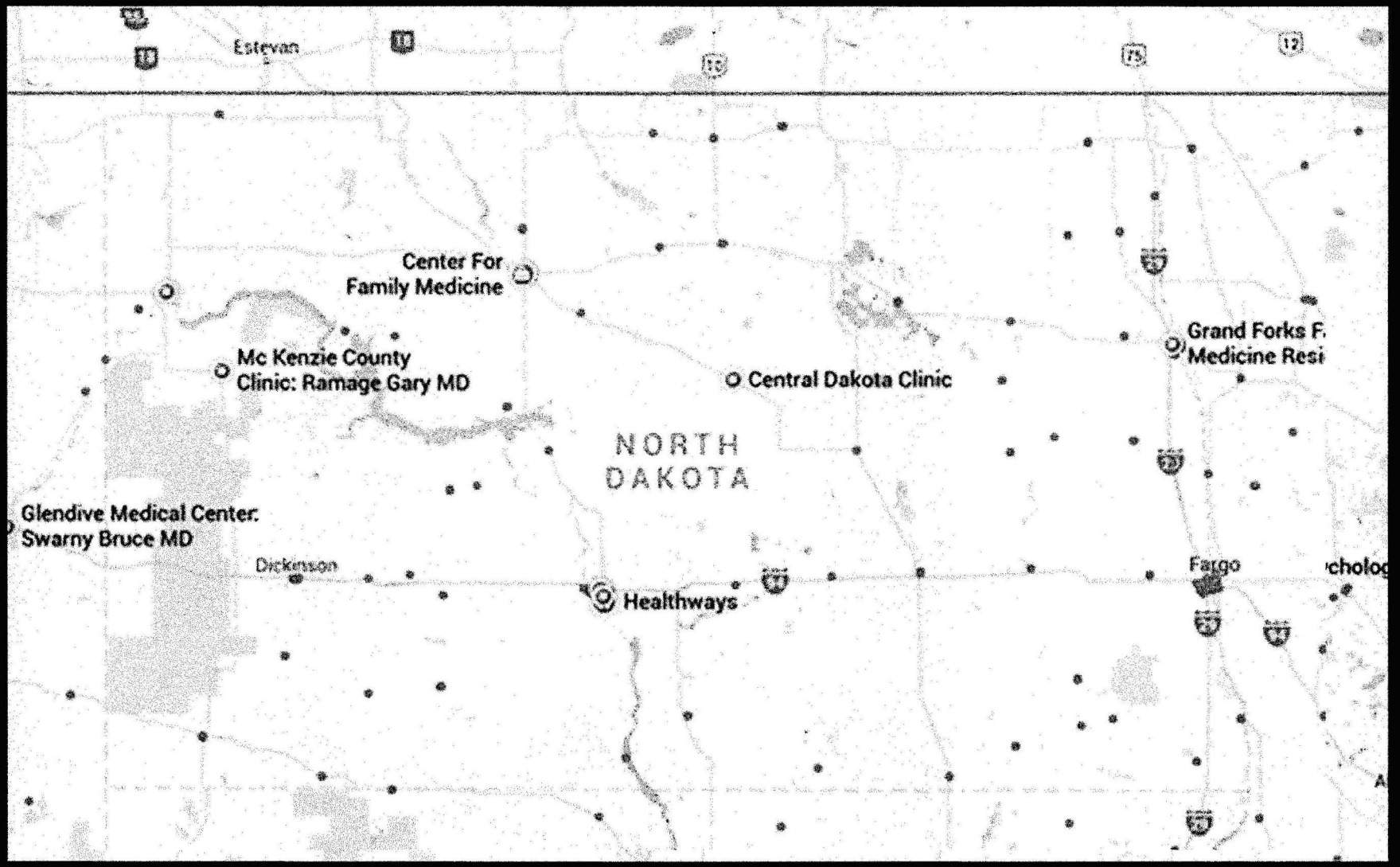
Carlotta McCleary, Executive Director

Att #13
HB 1272
03/23/2015
J# 25231

Dr. Gabriela Batf

Argument #1. We will serve the underserved


yp
Browse
psychologist
near
Williston, ND
Sign In | Join
Find a Location
(888) 577-0012
Psychologists
Website Video More Info
2 Hall, Shelly
135 W Villard St, Dickinson, ND 58601
(701) 225-1050
Psychologists
Directions More Info
3 Boomgaarden, Renee L
300 13th Ave W, Dickinson, ND 58601
(701) 227-7500
Psychologists, Physicians & Surgeons
Directions More Info
4 Demolen, Richard N
300 13th Ave W # 1, Dickinson, ND 58601
(701) 227-7500
Psychologists, Physicians & Surgeons
Directions More Info
5 Fehr, Alan J
135 W Villard St, Dickinson, ND 58601
(701) 225-1950
Psychologists
Directions More Info
6 Westwind Consulting Center Inc
135 W Villard St, Dickinson, ND 58601
(701) 225-1050
Psychologists
Website Directions More Info
7 Dickinson Family Counseling Center
11 2nd Ave E Ste B, Dickinson, ND 58601
(701) 483-9720
Psychologists
Website Directions More Info
Dickinson
Map data ©2015 Google
AdChoices
FEATURED PSYCHOLOGISTS
In Williston, North Dakota
Bradford Health Services
Find a Location
(888) 577-0012
Website Video More Info
Dr Carson's Alternative Health Care Center


Estevan
Center For
Family Medicine
Mc Kenzie County
Clinic: Ramage Gary MD
Central Dakota Clinic
Grand Forks F.
Medicine Resi
NORTH
DAKOTA
Glendive Medical Center:
Swarny Bruce MD
Dickenson
Healthways
Fargo

Argument #2. We will treat the person as a whole

- 2005 Gov survey – 11% psychiatrists provide therapy
- $150 / 45 min vs $90/45 min

Argument #3. We will treat mental illness

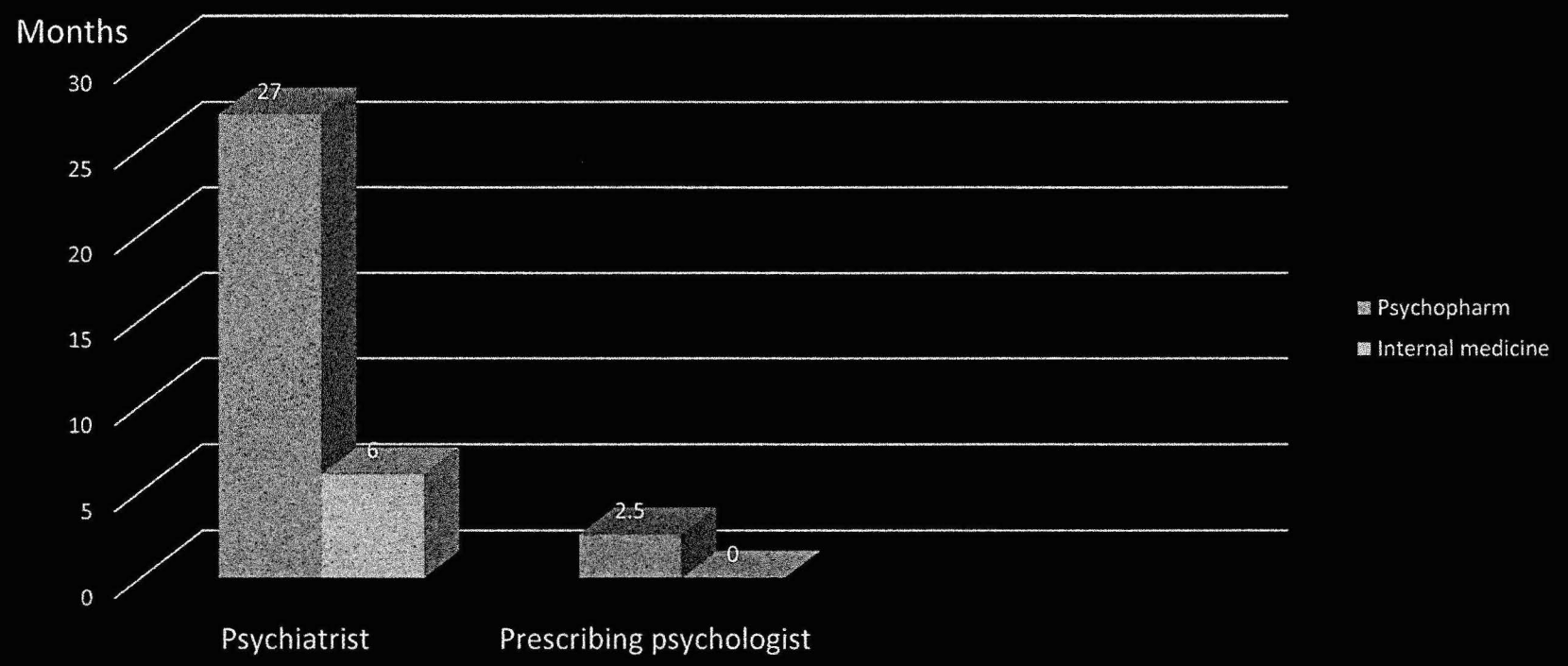
DoD prescribers:

adjustment disorders
anxiety disorders
depressive disorders

- Only one trainee treated patients with more serious or acute psychiatric conditions in an inpatient setting.

ACNP study - 1998

Argument #4. 400 hours of preparation is enough

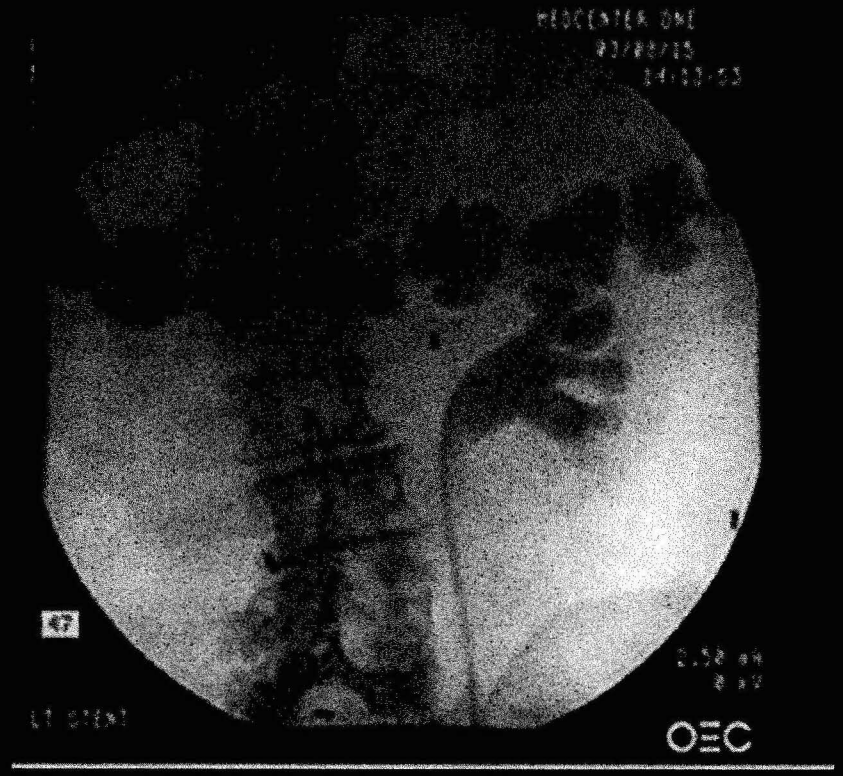


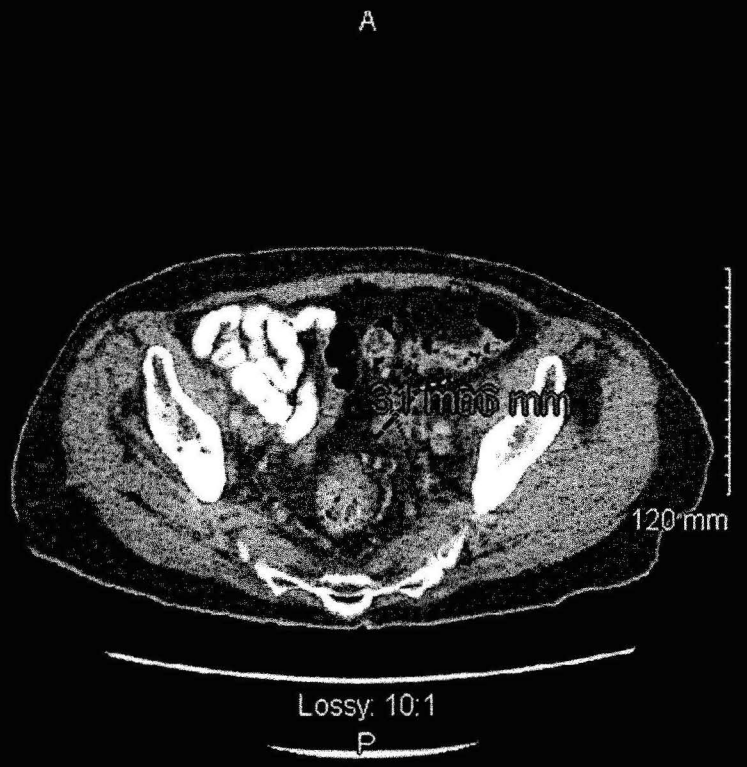
- amphetamine-dextroamphetamine (ADDERALL XR, 30MG,) 30 MG extended release capsule
- ABILIFY 15 MG tablet
- morphine sulfate (MS-IR) 30 MG tablet
- gabapentin (NEURONTIN) 400 mg capsule
- traZODone (DESYREL) 150 mg tablet
- verapamil (CALAN SR, ISOPTIN SR) 180 mg SR tablet
- zolpidem (AMBIEN CR) 12.5 mg CR tablet
- traMADol (ULTRAM) 50 mg tablet
- TREXIMET 85-500 MG tablet
- hydrochlorothiazide 25 mg tablet
- spironolactone (ALDACTONE) 25 mg tablet
- clonazePAM (KLONOPIN) 1 mg tablet
- pramipexole (MIRAPEX) 0.5 mg tablet
- furosemide (LASIX) 20 mg tablet
- multivitamin (CENTRUM) tablet
- CELEBREX 200 MG capsule
- VIIBRYD 40 MG TABS
- budesonide-formoterol (SYMBICORT) 80-4.5 mcg/puff inhaler
- fluticasone (FLONASE) 50 mcg/spray nasal spray
- tiZANidine (ZANAFLEX) 4 mg tablet
- levothyroxine 200 mcg tablet
- immune globulin, human,, GAMUNEX liquid, 2.5 gm/25 mL SOLN
- promethazine (PHENERGAN) 25 mg tablet
- levalbuterol (XOPENEX HFA) 45 MCG/ACT inhaler
- CPAP/BiPAP therapy
- nebulizer MISC
- naproxen (ANAPROX DS) 550 mg tablet
- Estradiol Cypionate (DEPO-ESTRADIOL IM)
- Cholecalciferol (VITAMIN D-3 PO)
- magnesium oxide (CVS MAGNESIUM) 250 mg tablet
- Probiotic Product (ACIDOPHILUS PEARLS) CAPS
- esomeprazole (NEXIUM) 40 mg capsule
- CVS GLUCOSAMINE-CHONDROITIN PO
- predniSONE 20 mg tablet
- cyproheptadine (PERIACTIN) 4 mg tablet
- aspirin (ADULT ASPIRIN LOW STRENGTH) 81 MG TBDP

No current facility-administered medications for this visit.

13,7

Argument #5. Patients will be safe





There are safe alternatives for our people

Please encourage psychologists to do their hugely valuable work

HB 1272
Attach #1
03/24/15
J#25333

HB 1272 DRAFT AMENDMENT

A BILL for an Act to provide for a report to the legislative management regarding medical psychologist licensure.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. SCHOOL OF MEDICINE AND HEALTH SCIENCES ADVISORY COUNCIL -STUDY OF MEDICAL PSYCHOLOGIST LICENSURE - REPORT TO LEGISLATIVE MANAGEMENT. During the 2015-16 interim, the university of North Dakota school of medicine and health sciences advisory council shall use the resources of the university of North Dakota school of medicine and health sciences center for rural health to study the feasibility and desirability of licensing medical psychologists. The study must include evaluation of whether licensure of medical psychologists would integrate behavioral health into primary care and whether the practice of medical psychology would result in safe and effective treatment of patients with behavioral health concerns. If the ~~school of medicine and health sciences~~ advisory council determines it is feasible and desirable to license medical psychologists in this state, the study must include consideration of licensure requirements, scope of practice, which licensure board would be best suited to license medical psychologists, and terminology. Before July 1, 2016, the ~~school of medicine and health sciences~~ advisory council shall report the outcome of the study, recommendations, and related proposed legislation to a legislative management committee charged with studying human services-related topics.

SECTION 2. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $5,000, or so much of the sum as may be necessary, to the university of North Dakota school of medicine and health

sciences for the purpose of conducting the study under section 1 of this Act, for the biennium beginning July 1, 2015, and ending June 30, 2017.

Prepared by Intern