REPORT OF RECOMMENDATIONS AND FINDINGS

By the Psychology Prescribing
Technical Review Committee

To the Nebraska State Board of Health, the
Director of the Division of Public Health, Department of Health and
Human Services, and the Members of the Health and Human
Services Committee of the Legislature

August 30, 2017

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Part One: Preliminary Information

Introduction

The Credentialing Review Program is a review process advisory to the Legislature which is designed to assess the need for state regulation of health professionals. The credentialing review statute requires that review bodies assess the need for credentialing proposals by examining whether such proposals are in the public interest.

The law directs those health occupations and professions seeking credentialing or a change in scope of practice to submit an application for review to the Department of Health and Human Services, Division of Public Health. The Director of this Division will then appoint an appropriate technical review committee to review the application and make recommendations regarding whether or not the application in question should be approved. These recommendations are made in accordance with statutory criteria contained in Section 71-6221 of the Nebraska Revised Statutes. These criteria focus the attention of committee members on the public health, safety, and welfare.

The recommendations of technical review committees take the form of written reports that are submitted to the State Board of Health and the Director of the Division along with any other materials requested by these review bodies. These two review bodies formulate their own independent reports on credentialing proposals. All reports that are generated by the program are submitted to the Legislature to assist state senators in their review of proposed legislation pertinent to the credentialing of health care professions.

List of Members of the Psychology Prescribing Technical Review Committee (March, 2017)

Debra Parsow, Chairperson

Judith Lee Kissell, PhD
Retired, Professor of Medical Ethics, Creighton University

Wendy McCarty, EdD
College Instructor, University of Nebraska at Kearney

Mary C. Sneckenberg

Liane Connelly, Ph.D., R.N., NEA-BC

Allison Dering-Anderson, Pharm.D., R.P.

Robert Sandstrom, Ph.D., P.T.

Part Two: Summary of Committee Recommendations

A majority of the members of the technical review committee recommended approval of the applicants' proposal.

Part Three: Summary of the Applicants' Proposal

The applicant's proposal calls for the creation of a prescription certificate for licensed psychologists with specialized postdoctoral training in clinical psychopharmacology, which would enable them to prescribe medications when treating mental disorders. Licensed psychologists with postdoctoral clinical psychopharmacology training have been certified to prescribe psychotropic medications in two states for over ten years and in specific agencies within the federal system for over twenty years. More recently, the states of Illinois and Iowa have passed legislation to certify psychologists with specialized training to prescribe mental health medications. The applicant's proposal to create a prescription certificate is provided in Appendix B (pages 48-54) of this application and summarized below.

The prescription certificate would enable the licensed psychologist to prescribe psychotropic (mental health) medications and order laboratory studies as necessary when treating mental disorders. The prescribing psychologist would communicate with the patient's primary health care practitioner who oversees the patient's general medical care. This is to promote better integrated patient care in treating medical and mental health issues.

This communication between the patient's prescribing psychologist and primary health care practitioner would ensure that necessary medical examinations are conducted, the psychotropic medication is not contra-indicated for the patient's medical condition, and significant changes in the patient's medical or psychological condition are addressed. This communication would ensure an unusually high level of safety in patient care. The proposal also defines limits of practice for the prescribing psychologists pertaining to the formulary of medications falling under the prescription certificate, and treatment of patients with certain co-morbid conditions.

The new credential would be administered by the department and board of psychologists and subcommittee consisting of a psychiatrist (or other qualified physician), university affiliated pharmacist with a doctoral degree and expertise in clinical psychopharmacology, and psychologists who completed postdoctoral degrees in clinical psychopharmacology. The Board of Psychology already participates in the regulation of multiple credentials beyond the license to practice psychology. The prescription certificate would add to the list of credentials for the board and department to regulate.

The licensed psychologist applying for a provisional prescription certificate would have completed a postdoctoral master's degree in clinical psychopharmacology, physician supervised health assessment practicum, passed a national examination, and completed an additional supervised practicum with a minimum of one hundred patients under the

supervision of a psychiatrist or other qualified physician, and/or a prescribing psychologist with an unrestricted prescription certificate. The licensed psychologist with the provisional prescription certificate would then need to successfully complete a minimum two years of practice under the supervision of a physician before being considered for an unrestricted prescription certificate. A prescribing psychologist with an unrestricted prescription certificate would not require physician supervision. The prescribing psychologist with an unrestricted prescription certificate would continue to engage in communication with each patient's primary health care practitioner to deliver a high level of coordinated care in the best interests of the patient.

The department and board of psychology would develop regulations regarding continuing competency requirements for the prescribing psychologists to renew prescription certificates. The prescribing psychologist would be required to present evidence to the department of completing forty hours of continuing competency programming relevant to safe and effective prescribing practices. The prescribing psychologist would also be required to maintain their license to practice psychology which requires completing a minimum twenty-four hours of continuing competency training for renewal, every two years, of the psychology license. In total the prescribing psychologists would present evidence to the department of sixty-four hours of continuing competency training hours to maintain the psychology license and prescription certificate.

The information in Part Three, above, can be found under the Licensed Practical Nurses' subject area on the credentialing review program link at http://dhhs.ne.gov/licensure/Pages/credentialing-review.aspx under 'Applicants' Proposal'.

Part Four: Discussion on the issues

Applicant Comments regarding Need for versus Potential Harm from the Proposal

The problem this proposal addresses is the critical shortage in the supply of behavioral health prescribers (Behavioral Health Education Center of Nebraska FY 2014-2015 Legislative Report). Per this legislative report many of the current prescribers of mental health medications in the state are at or near retirement age. There has also been the concern about a shrinking number of psychiatrists in Nebraska.

The lack of behavioral health prescribers in Nebraska worsens the existing problem that only one in three Americans with a mental disorder receives minimally adequate treatment, and nearly sixty percent don't receive any treatment from a mental health specialist.

Licensed psychologists with specialized postdoctoral education in clinical psychopharmacology, physician supervised practical, passing a national competency examination, and period of supervision with a conditional prescription certificate could step in to help address the shortage of behavioral health prescribers, as has been the case in federal agencies and some states. The number of licensed psychologists in Nebraska increased by 28% from 2006-2016. In addition, a large number of early career psychologists in Nebraska are available to replace psychologists who will retire.

Many consumers benefit from the judicious use of psychotropic medications and psychotherapy. At present licensed psychologists in Nebraska, even if they obtain the specialized training, cannot become credentialed to prescribe, and thus help their patients who need the combination of psychotherapy and mental health medications.

There are over twice as many psychologists as psychiatrists in Nebraska, and psychologists are located in over twice as many counties as psychiatrists. Adding two or three prescribing psychologists in the panhandle of Nebraska would double the number of doctoral level behavioral health prescribers.

Appendix C in the proposal (Prescribing Psychologists Meet the Need) provides convergent data on how prescribing psychologists have made a major impact in New Mexico and Louisiana in addressing unmet needs of behavioral health care consumers. The data come from a mix of providers that include: psychiatric and family physicians, prescribing psychologists, clinical pharmacist specialists, and CEO of a Federally Qualified Health Center.

A 2013 survey in New Mexico examined the impact of prescribing psychologist on mental health disparities. The conclusions from the survey were as follows:

"New Mexico psychologists with prescriptive authority, though still small in number of practitioners, are collectively making a significant impact on reducing mental health disparities among rural and low-income patients. More than 90% of prescribing psychologists surveyed accept Medicaid payments and 62.9 percent of patients served are living in rural areas with limited access to other behavioral health prescribers. This survey demonstrates that the grass roots efforts for psychologists' prescriptive authority highlighting the mental health disparity in rural and low income communities has been successful in getting trained prescribers to help serve those most in need."[22]

Appendix M in the proposal displays the distribution of prescribing psychologists licensed through New Mexico in 2016. The reader can see that prescribing psychologists are located throughout the state, including critical shortage areas of the state.

Applicant Group Public Hearing Testimony

Criterion One: The health, safety, and welfare of the public are inadequately addressed by the present scope of practice or limitations on the scope of practice.

The fact that Nebraskans around the state are grossly underserved by a lack of appropriately trained prescribing practitioners is clearly not a point of contention. Meeting criteria one is comparatively easy, but let me provide the hard data on the severity and extent of the problem, which has particular but not necessarily unique relevance for those of us providing services in rural areas. These data demonstrate the point that the health, safety, and welfare of Nebraska residents are inadequately addressed by the inability of specially trained and qualified psychologists to practice as prescribing psychologists as you will see defined in the detailed proposal we have submitted. These data lay the groundwork for demonstrating how expanding psychotropic prescribers with prescribing psychologists will address that need and be of measurable benefit to the public welfare.

My colleagues and I are faced with this shortage every single day. We have multiple gut wrenching stories to tell you that describe the distress our consumers experience, the adverse, sometimes life-threatening impact on their safety and well-being, and the cost to their communities and the state when their condition deteriorates, they get sicker and non-functioning, and end up unemployed, suffer avoidable complex medical and social consequences such as seeking disability, losing their children to state custody, and sometimes incarceration.

In just the last month, as an example, I was presented with a young woman in an untreated psychotic state for nearly six months who had been unable to see a psychiatrist, and had been misdiagnosed despite the best intentions of her primary care provider who was desperate to get her help. She ended up hospitalized and treated, but the hospitalization could have been prevented. A couple of weeks ago, a woman presented in a disorganized and decompensated state seeking now unavoidable disability determination after having no access to psychiatry consultation and being taken off the medications that had managed her symptoms by a non-physician prescriber who had misunderstood her diagnosis within a 15 minute medication check. That person then lost her job, became homeless, and was fighting overwhelming suicidal ideations other examples include children dropped back into their community returning from residential care with a fistful of prescriptions they can't get refilled or reviewed by a psychiatrist for two to three months.

The rural areas of Nebraska are not the only regions affected by a severe shortage of psychotropic prescribers. Just the other day, I spoke with a colleague at the Lincoln Regional Center who told me there is a desperate shortage of psychiatric prescribers in Omaha. Lincoln Regional Center predominantly serves Regions five and six. They cannot discharge patients to Omaha because of a six-month wait. They have patients lingering at LRC for six months at a

cost of $20,000 a month because they can't discharge them without a psychotropic provider. A recent discharge referral was stalled because the wait for a psychiatrist was until April 2018.

These examples are a mere handful from the past month to share with you in making these desperate situations as vivid as possible. The reasons for these desperate stories are abundantly clear.

In my area, Scottsbluff and the panhandle of Nebraska and much of western Nebraska, we have just two hardworking psychiatrists serving the entirety of western NE. 71 Nebraska counties have NO psychiatrist in residence, including none in any county other than Scotts Bluff in the panhandle, none in the counties I mentioned earlier, none in the Sandhills, and none between Scottsbluff and North Platte. Recruitment and retention of psychiatrists has been a tremendous statewide problem. The number of psychiatrists is declining, now down to 158 at last count. The national average of psychiatrists per capita is 9.5 per 100, 000 residents. Nebraska ranks low in the nation at 39th with 6.1 per 100,000. The number of psychiatrists has dropped by 3 percent. In the panhandle we have two psychiatrists covering a population of not only the approximately 88,000 residents but much of the population of those counties west of North Platte and northern central Nebraska. During my thirty years in the panhandle I have seen close to 30 psychiatrists come and go.

What this means for our consumers are wait times of two to three months on average, not only for an initial appointment, but for follow-up. These clients may have to travel long distances, including 70-100 miles or more. Blizzard conditions, other inclement weather, or childcare and transportation obstacles leading to cancellations often means additional long delays in rescheduling. An initial appointment might be a half hour, 45 minutes or an hour, with follow-appointments being 15 minutes, which is rarely enough time for individuals and parents of high needs children to get their concerns across or their questions answered. Our clinicians can tell you about multiple white knuckle situations staying on call with a high risk high needs patient we can't get in to see a psychiatrist, or who has phoned in a destabilized crisis because they ran out of a needed prescription, and we are desperately seeking alternatives with non-psychiatry providers who depend on us to provide them with information and consultation.

On the website and within the application process, you will see numerous letters of concern regarding the unmet need from beleaguered clinicians of all disciplines wanting you to know their daily struggle with obtaining appropriate psychotropic medication management for their patients.

I can share with you my own experiences of clients from all over struggling to deal with unmanageable symptoms that impede their function and their well-being, sometimes on multiple medications they might not need as a result of fragmented and uncoordinated care with multiple providers they have sought out, dealing with side effects such as weight gain and other metabolic issues, unmanaged behavior that harms their ability to comply with medical treatment recommendations, anxious parents struggling to know whether agreeing to this or that medication is right for their child, and destabilized and worsening symptoms that place individuals and other people in serious jeopardy.

But in addition to the experiences and concerns you will hear about and read from clinicians, we also have completed surveys from Nebraska residents across the state, including 252 from the Scottsbluff area alone. We have additional survey data from Beatrice residents. We surveyed consumers in several different settings, including primary care clinics, specialty clinics, and

therapy offices so they can tell you directly of their struggles in obtaining needed psychotropic management of their symptoms. Forty eight percent of the respondents reported problems getting an appointment with a prescriber who understands their mental health needs. Eighty percent want their psychotropic medications and their psychotherapy managed by the same provider. Eighty seven percent of the respondents support permitting qualified and specially trained psychologists to prescribe. The responses from people who completed the survey in Scottsbluff in two separate clinics are overwhelmingly in accord with what people tell me. On the website, you will see similar survey data from rural areas in Eastern Nebraska and also from a Lincoln clinic. The following are examples of the shortcomings of the current situation:

- Kids returning from residential treatment who can't get an appointment to get their prescriptions renewed, get destabilized and regress to a pre-treatment state
- Unnecessary emergency room visits for psychiatric emergencies that could have been prevented with appropriate medication management
- Parents complaining of not enough time to get their concerns across or ask questions because of a 15 minutes time slot they had to wait three months to get
- Running out of meds because of delays in prescription renewals
- Over-medication or the wrong medication because of a missed or misunderstood diagnosis
- Lack of coordinated care on complex medical cases in which health behavior problems are adversely affected by misunderstood mental health issues
- Being unable to find a PCP who will serve as a back-up because they are uneasy with their lack of training, experience, and time.
- Building a relationship with a psychiatrist only to have that person leave.

Criterion Two: Enactment of the proposed change in scope of practice would benefit the health, safety, or welfare of the public.

First let's begin with correcting a sometimes misunderstood or ignored fact: psychologists are *already* licensed doctoral clinicians with extensive training and experience in diagnosis and treatment, clinical research, consultation, team collaboration, teaching, and development and evaluation of evidence-based clinical practice. We are established life-long learners with strong academic credentials trained to carefully analyze and apply data to clinical training and practice. Psychologists are the leading researchers on effective behavioral interventions. We publish scientific data, often in collaboration with other doctoral level researchers and clinicians, including psychiatrists. Psychologists are at the forefront with other disciplines in neuroscience research. Psychiatrists send us their clients with complex diagnostic behavioral health issues for comprehensive evaluation and treatment recommendations. We are NOT talking about unlicensed psychologists or new graduates with their Ph.D. degree in one hand and prescription pad in the other. We are talking about specially trained doctoral, licensed, clinicians who already have an earned an advanced clinical degree (post-doctoral). As a Nebraska pediatrician, Dr. Reyes, points out in a strongly worded letter of support, stakeholders should review the training

comparison chart that show the advanced number of hours of science-based clinical training psychologists receive compared to other clinicians, including psychiatrists, nurse practitioners, and physician assistants. Dr. Reyes wanted her letter read out loud at this hearing, as she is unable to attend today. The letter is provided as an exhibit with this written testimony.

From that perspective of having already completed rigorous training and with the expectation of being held to high ethical and science-based standards, psychologists identified both the need and the specialized training that would meet that need. Specially trained psychologists are exceptionally well-prepared to help fill the gap and reduce the suffering described under criterion one.

We have strong and compelling data that prescribing psychologists in practice in the military, the Indian Health Service for over twenty years, and now in at least two states over the past twelve years that show the effectiveness of this combination of rigorous clinical training at the outset with additional rigorous training for prescriptive privileges. My colleagues will discuss the safety and the rigor of the training in the next sections in more detail under the six criteria format for your review, but we want you all to consider here the documentation we have showing how well this proposal can work.

As you have already heard, we quickly learned from our first attempt at a technical review process that we needed to do make our case more vivid, visual, and compelling. So we travelled to these other states and talked to their prescribing psychologists, to the colleagues with whom they work, to people involved in the training, and to clients they have served.

New Mexico was the first state to allow specially trained psychologists to prescribe psychotropic medication now over 12 years ago, followed by Louisiana, Illinois, and (most recently) Iowa and Idaho. A legislative bill may soon pass in Oregon.

New Mexico, in particular, has a number of similarities to Nebraska that became even more apparent in our travels around their state. We observed and interviewed prescribing psychologists in integrated clinic settings, as well as their physician colleagues in primary care and psychiatry, pharmacists, medical residents in training, and consumers. We have extensive footage and film clips of those interviews documenting the resounding success of allowing prescriptive authority for psychologists has had in meeting the need. We have strong testimonials from primary care physicians, psychiatry, doctors of pharmacy, nurse practitioners, and consumers in 100 percent support of prescriptive authority, including some who might have been skeptics. Dr. John Andazola, Medical Director of the Southern New Mexico Family Medicine Residency Program in Las Cruces, NM has worked with prescribing psychologists for over ten years. Not only does Dr. Andazola strongly endorse the health behavior consulting role of psychologists in a primary care clinic, he wholeheartedly endorses prescriptive authority for psychologists. Dr. Andazola pointedly challenges the notion that only physicians can prescribe with the point that the idea is an outdated notion with no evidence to support it. In fact, Dr. Andazola gives a compelling description of the rigors of the training for psychologists to obtain prescriptive authority in the film clip we have provided on the website. Dr. Donald Fineberg, a Yale trained psychiatrist in Santa Fe, also knocks down the argument that some of his colleagues have made against prescriptive authority with the point that not only has it been a benefit, prescriptive authority for psychologists in NM has become essential.

New Mexico has credentialed approximately 57 prescribing psychologists, most of whom treat underserved patients on Medicaid and both prescribe and provide psychotherapy. Louisiana has credentialed approximately twice as many psychologists with prescriptive authority. Dr.

Elaine LeVine, one of the first prescribing psychologists, tells you this is a model patients both like and prefer. These psychologists are meeting the need all around New Mexico, and are doing it effectively and safely. They are universally respected by their colleagues in medicine, pharmacy, and nursing. Many of those colleagues can tell you on film their impressions of the rigors of the training, the effectiveness and collaborative efficiency of the treatment provided, and the fact that it is safe. Dr. Fineberg makes the point that his colleagues who are most interested in providing care are those who strongly support prescriptive authority. Interviews and other data from Louisiana show the same multidisciplinary support from psychiatry and other medical specialties.

Committee members have asked appropriate questions about how this can work in Nebraska. We have provided the data on the fact that psychologists are steadily increasing in number around the state. We already live and work in rural communities, where we typically stay rooted and committed to those communities. There are more than twice as many psychologists as psychiatrists in NE and, unlike psychiatry; the number of psychologists is increasing. Psychologists are also in over twice as many counties as psychiatrists. In 2016, there were 576 Nebraska licensed psychologists, an increase of 127 representing an increase of 28 percent in the preceding ten years. 45 of that group are early career psychologists beginning with a provisional license. A 2009 survey of Nebraska psychologists showed 73 percent support for prescriptive authority. My own base region, the Nebraska Panhandle has at least 12 psychologists, with at least one pre-doctoral psychologist close to completion of requirements for licensure. The majority of us have lived and worked in western NE for over ten years, with early career psychologists who are from rural Nebraska settled in with families and a career that includes remaining in the area. That is six times the number of psychiatrists we have at the present. One of our panhandle psychologists has already completed the post-doctoral master's degree in psychopharmacology. A second is poised to begin the training with the unflinching support of his administrators and physician colleagues who are ready to provide clinical supervision and training. Since the 2009 survey, support from Nebraska psychologists has grown, especially in response to learning more about the effectiveness and training, the potential for a 20 percent increase in income, and the opportunity to serve more need. The fact that Iowa passed a law allowing prescriptive authority has many psychologists in the eastern part of Nebraska considering both the training and an Iowa license.

We have additional testimonials and letters of support from primary care physicians around the state. Obtaining support from these physicians, APRNs, and other primary care practitioners has been comparatively smooth, especially once they learn about the specialized post-doctoral training. They already know how we can work with them and they need the help.

Because of this unmet need, many clients, despite complex mental health issues requiring complex medication and treatment interventions, get their prescriptions from their primary care practitioner. In fact, over 60-80 percent of psychotropic medications are prescribed by general medical practitioners. We psychologists work closely with those practitioners on many of those cases. As psychologists, we *already* do careful review of medical and medication histories and collaborate with primary care practitioners and other specialty physicians. We *already* do that. We are *already* trained to carefully consider physical health factors contributing to behavioral disorders. Working with complex medical problems is **not** new to us. We *already* provide consultation to medical practitioners on health behavior issues associated with compliance, cognitive barriers, and difficult behaviors. Psychologists are *already* in integrated medical practices in both urban and rural settings. Psychologists in Nebraska, especially in rural areas are overwhelmingly Medicaid and Medicare providers. Much like in New Mexico and Louisiana prescribing psychologists are the predominant Medicaid prescribers.

The clients who have a psychologist providing diagnostic and behavioral consultation are in a better position to have an appropriate assessment for an accurate diagnosis, and then get the right medication, but many of the people getting prescriptions from a primary care practitioner in our experience have never had an appropriate diagnostic evaluation needed for appropriate medication management. These primary care practitioners will tell you they are often overloaded with the demand, lack the depth of training to meet that need, and are often in the same 15 minute appointment grind that doesn't allow them the time needed to go into all the symptoms, concerns, questions clients and their families will have.

The benefits to Nebraska consumers are clear: reduced wait times for an appointment, expanded choice for behavioral healthcare, medication and psychotherapy in one appointment, guaranteed coordination of medical care, and reduction in overall cost and travel time. The benefits to the state include not only improvements in consumer health, safety, and welfare, but also the fact that this additional training does not cost the state and the coordinated services prescribing psychologists provide means a reduction in overall Medicaid costs.

Criterion Three: The proposed change in scope of practice does not create a significant new danger to the health, safety, or welfare of the public.

New Mexico Licensing Division

New Mexico was the first state to enact prescriptive authority for licensed psychologists in 2002. Psychologists with prescriptive authority in New Mexico are required to maintain their license as a psychologist and also complete the following advanced training components: postdoctoral master's degree in clinical psychopharmacology or equivalent, physician-supervised practical, and a two year period where the psychologist practices with a conditional prescription certificate under physician supervision.

The state licensing division conducted a thorough sunset review of prescriptive authority for qualified psychologists in 2015 and there was no complaint or discipline listed related to psychologists practicing with prescriptive authority (pp 5-6). A copy of the "New Mexico sunset report" was posted on the 407 website in relation to the current application. The report included the following reference to prescribing psychologists and meeting the needs of the public:

> "Our board has also continued to license psychologists who are training for prescriptive authority on a provisional basis and on an unrestricted basis following the completion of the requirements set out by the board's rules and statutes. In the process, our state has added many new prescriptive providers to meet the demand for mental health services across rural and metropolitan areas of the state." (p 4)

New Mexico 2017 Legislative Session

The New Mexico legislature voted on a bill that would help to expand the number of prescribing psychologists in the state by redefining which medical professionals can supervise psychologists seeking prescriptive authority. The definition of qualified supervisors would be broadened to include nurse practitioners and clinical nurse specialists. The Senate voted 37 in favor of the bill (S90) with zero nay votes. The House voted 51 in favor of the bill with zero nay

votes. Senator Peter Wirth made comments about the bill that directly address prescribing psychologists and public safety (time code 12:44:30 to 12:51:40). A link to the archived floor discussion on S90 is provided that contains the Senator's remarks as quoted below.
Link to video archive:
http://sg001-harmony.sliq.net/00293/Harmony/en/PowerBrowser/PowerBrowserV2/20170217/-1/32251

> "I don't need the sponsor to yield. I just wanted to stand up and make a comment because I have always been real hesitant about these scope of practice bills. We deal with them over and over again, and I have tended to defer to not expanding the scope of practice. And I realize this is something we did 14 or 15 years ago. I just wanted to say in this particular case my physician, my treating physician, and I had a chance to visit with him about this particular bill and the psychologists having the prescribing authority. He basically said to me, the services they are providing is really needed and they are filling the gap that is incredibly important, so I really appreciate that that compromise was reached here, but I also just want to mention that this is one of those areas where we did, we were first in the nation to expand this scope of practice. The testimony in the judiciary there hasn't been, hasn't been a single complaint and incident as a result of this, and I just think this is one when we filled in an area where we needed some additional coverage, so I again I appreciate this a compromise was reached here, and I stand certainly in support of the treating physicians and psychologists in this case."

Louisiana and Medical Psychologists

The first bill, in Louisiana, authorizing prescriptive authority to licensed psychologists with advanced training, was enacted in 2004. Medical psychologists were not independent in their prescriptive authority and were required to obtain concurrence from the patient's medical health care provider when treating the patient's mental disorder with medication. The safe prescriptive practices of Medical Psychologists was a factor when Louisiana, in 2009, decided to authorize independent prescriptive authority to Medical Psychologists who met certain requirement that included three years of experience as a Medical Psychologist, treating a minimum of one hundred patients, and the recommendation of two collaborating physicians who are familiar with the applicant's competence to practice medical psychology.

New Mexico and Louisiana
These states do not prohibit psychologists with prescriptive authority from treating special populations (e.g., children, elderly, or individuals with co-morbid conditions) with mental health medications. The psychologists were already required, legally and ethically, to provide services within the boundaries of their competence, based on their education, training, and supervised experience.

The Department of Defense Evaluation of 10 Prescribing Psychologists (trained in the 1990's)

> "Overwhelmingly, the officials with whom we spoke, including each of the graduates' clinical supervisors, and an outside panel of psychiatrists and psychologists who evaluated each of the graduates rated the graduates' quality of care as good to excellent. Further, we found no evidence of quality problems in the graduates'

credential files." **General Accounting Office Report to the Committee on Armed Services, U.S. Senate, June 1999**

I would like to again emphasize that in locations where psychologists have been allowed to prescribe to date there has been no evidence of increased risk of harm. Why is there such a great record of safety? It is in part likely due to the fact that this type of training and expertise is voluntary. Psychologists who seek this additional training are those who are interested in this area and desirous of the additional training. The self-selection aspect helps avoid providers who are uncomfortable or simply don't want to prescribe, from entering this sub-specialty area. Psychology as a profession has a history already of providers choosing to gain additional training in neuropsychology, or forensic psychology, with no added risk and no harm to the profession. his added credential carries a greater degree of sensitivity, which is why we are requesting the added credential, but is still a self-selected sub-specialty.

What we do know is that the number of professionals who are trained and willing to prescribe medicines for mental health conditions is being rapidly outpaced by the number of patients in need of this treatment. More patients than the current system has capacity to treat is likely to cause harm. Allowing psychologists to prescribe is an important and vital step for the state of Nebraska to improve access to quality care in a timely manner.

Criterion Four: The current education and training for the health profession adequately prepares practitioners to perform the new skill or service.

In addition to all the requirements for a Nebraska license in psychology, the proposed legislation would require earning a postdoctoral master's degree in clinical psychopharmacology, two practical, passing a national competency examination in clinical psychopharmacology, and a two year period with a provisional prescription certificate under physician supervision. Appendix H, pages 70-74, of the application, addresses the demanding training requirements for a psychologist seeking prescriptive authority. The education and training requirements in the proposal are consistent with the national training standards published in 2009 by the American Psychological Association. In addition, the education and training requirements in the proposal parallel the requirements in New Mexico and Louisiana where psychologists with advanced training have been prescribing mental health medications for over a decade.

The proposal requires that the institution providing the postdoctoral training in clinical psychopharmacology be accredited by one of the six regional bodies recognized by the United States Department of Education's Council on Postsecondary Accreditation (see page 52 of the application).

In addition to accreditation requirement for the institution, the training program shall meet national training standards of the American Psychological Association for postdoctoral education and training in psychopharmacology for prescriptive authority (see page 52 of the application). The national training standards are provided in detail on pages 27-28 of the application and cover didactic content areas, supervised clinical experience, capstone competency evaluation, certification of completion, and lifelong learning. There are other requirements for a training program seeking designation status. For example, the program must have qualified and competent administrators, faculty, and supervisors. The program must meet standards pertinent to admissions, transfer of credits, ethical standards, program resources, quality assurance, and regular program self-evaluation. The length of designation status is three

or five years, with a specified number of reports from the training program. The committee that reviews applications from training programs seeking designation status currently has a psychiatrist member. The review committee determines whether a program is granted or denied a 3 or 5-year designation status, or a designation status could be revoked. A designation status may be granted on a probationary basis. The designation criteria and review process can be found using the following link, http://www.apa.org/education/grad/psychopharmacology.aspx

The postdoctoral training curriculum, as specified in the national standards, includes instruction in each of the following areas: biochemistry; neurochemistry; neuroanatomy; neuropathology; anatomy and physiology; pharmacology; psychopharmacology; developmental psychopharmacology; combined therapies; computer-based aids to practice; pharmaco-epidemiology; pharmaco-genetics; clinical medicine; pathophysiology (with an emphasis on cardiac, renal, hepatic, neurologic, gastrointestinal, hematologic, dermatologic and endocrine systems); physical assessment; laboratory and radiological assessment; medical terminology and documentation; differential diagnosis; substance-related and co-occurring disorders; chronic pain management; FDA drug development and other regulatory processes; and ethical/legal issues. Basic science courses are covered in the postdoctoral training programs. Applicants with a strong background in the basic sciences may be eligible to transfer some graduate level basic science course credits.

In addition, the postdoctoral master's degree program provides opportunities to present and discuss case examples representing a broad range of clinical psychopathologies, medical conditions presenting as psychiatric conditions, complicating medical conditions, choice of medications, diagnostic questions, side effects, and compliance problems.

Lastly, per the application and proposal, the Department (i.e., Division of Public Health) and Board of Psychology would have ultimate authority regarding the approval of training programs. The Department and Board of Psychology would receive recommendations from an advisory committee regarding the approval or non-approval of training programs. The advisory committee would include a psychiatrist or other qualified physician and a doctoral-level pharmacist with expertise in clinical psychopharmacology.

The question was asked whether it would be possible to complete the postdoctoral degree in as little as ten weeks. The postdoctoral degree could not be completed in such a brief amount of time. It would take a licensed psychologist two and one-half years to complete all the requirements.

Questions were asked about the type and length of the practicum, the number of patients, the number of hours, and who would oversee this component of the education and training. Overall, there would be five years of training. Physicians would oversee all of this training until such time when there are prescribing psychologists who are qualified to share in the responsibility of providing oversight. Any psychologist would be required to successfully complete all of the education and training under this program and have at least five full years of unrestricted practice before they would be allowed to serve as a supervisor. The Department and the Board of Psychology would always determine who could serve as a supervisor in this program.

Criterion Five: There are appropriate post-professional programs and competence assessment measures available to ensure that the practitioner is competent to perform the new skill or service in a safe manner.

Currently there are four university-based postdoctoral programs in clinical psychopharmacology that meet national training standards. Idaho, which passed prescriptive authority for qualified psychologists in 2017, will have their own postdoctoral training program, and per the legislation, the program shall satisfy the requirements to become a designated program per the American Psychological Association standards. The designated programs prepare licensed doctoral psychologists for prescriptive authority. The following is the link to the training programs that have thus far met the quality assurance standards developed by the American Psychological Association, http://www.apa.org/education/grad/designation.aspx

Members of the applicant group visited the clinical psychopharmacology training program at New Mexico State University, located in Las Cruces. Program administrators (e.g., associate dean at NMSU) are very interested in working with Nebraska to establish a branch program in Nebraska to train licensed psychologists for prescriptive authority. This would provide for timely and local training, and the possibility of eventually growing our own training program in the state. The NMSU postdoctoral training program has maintained designation status since 2010.

National training standards were developed by the American Psychological Association based on the findings of interdisciplinary task forces that included psychiatrists and other physicians, prescribing psychologists, nurse practitioners, pharmacists with expertise in psychopharmacology, dually licensed professionals (e.g., physician/psychologist) and members of the public. See Appendix N, pages 80-83, of the application, for a description of the development of university-based postdoctoral training programs for psychologists, written by Dr. Randall Tackett, Professor of Pharmacology and Toxicology, University of Georgia College of Pharmacy.

The quality assurance criteria for a designated program are posted on the above webpage. A prerequisite for entering the postdoctoral training program, per the criteria, is possession of a doctoral degree in psychology and state license as a psychologist. The program applying for designation status must have an identifiable organization, curriculum and faculty, program resources to provide for stability, and continuity of faculty allowing for sufficient opportunities to teach, supervise, and evaluate each student. The standards require the “frequent evaluation of students’ knowledge and application of that knowledge and feedback to students of the outcomes.” The standards specify a minimum number of contact hours for the didactic curriculum. Moreover, per the standards, the “supervised clinical experience encompasses mastery of clinical competencies” that include the following: physical exam and mental status, review of systems, medical history interview and documentation, differential diagnosis, integrated treatment planning, consultation and collaboration with other treating professionals, and treatment management. The program must specify a process by which supervisors are identified, approved, and overseen by the program. There must be a mechanism for ensuring the range of supervised clinical experience balances diversity, developmental considerations, and appropriateness to the student’s practice. The standards require a capstone competency evaluation that addresses “integration of the knowledge, skills, and attitudes the psychologist is expected to master during their matriculation in the program.” In addition, the program must identify how it prepares students for lifelong learning; for example, preparing psychologists to evaluate future advances in psychopharmacological knowledge.

In addition to the training program standards, there is a national competency examination. The clinical psychopharmacology examination covers multiple content areas associated with the content required of postdoctoral training programs for prescriptive authority for psychologists. The national competency examination was developed by an interdisciplinary panel of experts. This exam is evolving and is now managed by the Association of State and Provincial Psychology Boards (ASPPB), which has vast experience conducting practice studies of psychologists that inform the development of the national competency examination for doctoral psychologists seeking licensure, and license mobility certification standards. Like other state and provincial licensing boards for psychologists, the Nebraska Board of Psychologists is already a member of ASPPB.

A prescribing psychologist can recoup the money invested in the postdoctoral training, and any cost for supervision, within a year or two of being credentialed. A survey of private practice psychologists in New Mexico and Louisiana, referenced in the application, found that practitioners with the expanded scope of practice boosted annual income "minimally about $20,000 per year." The increased costs related to prescriptive practice, according to the survey of prescribing or medical psychologists, more than offset any increased costs related to prescriptive authority. The prediction that psychologists would face a huge increase in the cost of malpractice insurance was wrong. Malpractice rates only increased approximately 15% for psychologists that added prescriptive authority, which translates to about a $150 increase in an annual insurance premium. The increase in the insurance rate only applies to psychologists with prescriptive authority. Of course, the small increase in malpractice insurance for psychologists with prescriptive authority reflects favorably on the safety record of these practitioners.

Criterion Six: There are adequate measures to assess whether practitioners are competently performing the new skill or service and to take appropriate action if they are not performing competently.

Monitoring competency to perform this new skill is something that our proposal takes quite seriously. This monitoring begins well before the individual has the capability to prescribe independently. In fact, the current proposal begins with competency evaluations even before the provisional certificate. Prior to beginning the provisional period with a prescription certificate, the psychologist must provide evidence of completing postdoctoral training in preparation for prescriptive authority, two practical, and have passed a national competency examination. The physician(s) who supervised the practical for a psychologist, per the application, will have verified the psychologist is competent to enter practice with the new skill set, and qualifying the psychologist for a provisional prescription certificate.

The practical referenced above, which again must be completed prior to entering the provisional period with a prescription certificate, the psychologist must complete the practical that will require experience with hundreds of patient encounters, under the supervision of a physician. For example, during the 80-hour practicum the psychologist would be working with the physician supervisor, one day a week, for at least a three-month period. The physician could be seeing four patients and hour. Over three months that adds up to hundreds of patient encounters. The clinical experience would be transitional in nature starting with observing the physician performing clinical assessments to then having the psychologist perform the assessments while the physician observes and evaluates the psychologist's clinical assessment skills. The purpose of this practicum is not to prepare psychologists to perform all the functions of a physician, but is rather to familiarize them with some of the basic procedures and processes, while also

evaluating the potential prescribing psychologist's competency with some basic physical assessments and interpretations of relevant assessments.

Thereafter, there would be the 400 hour/100 patient practicum. These would be 100 unique patients with mental disorders where medication has been considered as a treatment option. This period of evaluation is the greatest opportunity for the supervising physician to assess the competency of the psychologist to select appropriate medication options as well as develop appropriate treatment planning involving medication.

Once these preliminary competency assessments have been completed and the applicant has met the requirements to the satisfaction of his/her supervisors, they are then eligible to enter into the minimum two-year period where the psychologist is supervised by a physician to assess the psychologist's competence with the new set of skills. The supervisor, who provides at minimum one hour of supervision a week, must verify the psychologist has safely prescribed drugs, as defined in the statute and regulations. The supervisor must verify the applicant continues to demonstrate competence in review of systems, medical history, physical examination, interpretation of medical tests, differential diagnosis, integrated treatment planning, collaboration with health care practitioners, and management of complications and drug side effects. An applicant for a prescribing psychologist certificate, who specializes in the care of children, elderly, or other special populations shall complete at least one year, of the minimum two years, prescribing psychotropic medications to such populations. Per the application, the applicant will maintain a log on patients seen during the period of holding a provisional prescription certificate. The log shall include a coded identification number for each patient, demographic information on each patient, and other information as determined by the Board and Department. The log shall be available to the Board and Department upon request. The log shall contain the name and signature of the supervisor.

The proposal for the prescription certificate (Appendix B, pages 49-55) includes the afore mentioned steps to assess competency as well as, mechanisms to review and act on complaints that build on the existing statutory and regulatory mechanisms for licensed psychologists in Nebraska.

Licensed psychologists are currently subject to the complaint, investigation, and discipline provisions of the Uniform Credentialing Act, and the application would extend those protections to the provisional prescription certificate and prescription certificate. Per the application, "regulations shall address denying, modifying, suspending, or revoking a provisional prescription certificate or prescription certificate (p 55)."

The psychologist with a prescription certificate would be required to follow Nebraska mandatory reporting requirements (172 NAC 5). For example, the prescribing psychologist would be required to file a report with DHHS within 30 days of adverse actions to include the following: loss of clinical privileges, resignation from staff, loss of employment, loss of membership in a professional organization, adverse action pertaining to liability coverage, discipline in any state or jurisdiction, and conviction of a felony or misdemeanor in any state or jurisdiction. The adverse actions would be due to alleged incompetence, negligence, unethical or unprofessional conduct, or physical, mental, or chemical impairment.

The application also addresses the continuing competency requirements to be established for the prescription certificate (pp 54-55). Specifically, the application requires, "each candidate for renewal of the prescription certificate or provisional prescription certificate shall present satisfactory evidence to the Department demonstrating continuing competency training relevant

to effective and safe prescribing practices. The applicant for renewal of the prescription certificate or provisional prescription certificate shall present evidence of no fewer than 40 hours of continuing competency hours completed within the 24 months prior to the renewal deadline, as established by the Department."

In addition, the psychologist who qualified for prescriptive authority "shall also meet the continuing competency requirements for renewal of the psychology license. Renewal of the psychology license requires 24 hours of continuing competency for each two year renewal period.

Opponent Public Hearing Testimony

Criterion One: The health, safety, and welfare of the public are inadequately addressed by the present scope of practice or limitations on the scope of practice.

One opponent testifier commented that the problem with the current situation is not access to medications but rather an insufficient number of mental health providers including psychologists, mental health counselors, and psychiatrists. The opponents stated that such providers as internists, family practice physicians, and pediatricians are able to prescribe the medications in question for those who need them. Comment was made that tele-health is making great strides in addressing access to care issues and that its use is steadily increasing.

Another opponent testifier commented that the current crisis in mental health care is not solely due to a dearth of prescribers. Another serious problem is the fact that too many providers tend to isolate themselves from other practitioners rather than utilize a team-oriented approach to treating mental illness. This testifier stated that there are massive gaps in levels of care for mental disorders and many patients do not receive the support and treatment continuity they need to transition back into a normal life. The current mental health delivery system fails to consistently provide integrated multidisciplinary care resulting in costly and ineffective delivery of care with recurring cycles of hospitalization and out-of-control costs.

Another opponent testifier commented that the applicants' contention that 71 counties in Nebraska do not have access to a psychiatric prescriber is simply not true. Family physicians are qualified to provide this kind of care. This testifier went on to comment on the applicant assertion that additional office visits will be necessary if psychologists continue to be disallowed to prescribe medications by stating that this argument is simply not valid. Family physicians are qualified to prescribe all necessary medications to meet the needs of mental health patients without having to schedule additional office visits for this purpose.

An opponent testifier representing physician assistants commented that as they observe the current mental health situation the greatest shortcoming vis-a-vis access to care lies in the long waiting lists for those who need to get access to cognitive behavioral therapy. It is not unusual for patients in urban areas to wait two to three months to get access to this care. It is not unusual for patients in rural areas to wait four to six months to get access to this care.

Criterion two: Enactment of the proposed change in scope of practice would benefit the health, safety, or welfare of the public.

One opponent testifier commented that there are four types of patients with mental illness, and they are as follows: 1) severe and persistent: these patients need to be treated by a psychiatrist. Their treatment often requires the use of strong medications, 2) children: treatment for these patients involves cooperation between pediatricians and family medicine practitioners, and sometimes school psychologists and / or child psychologists, 3) non-severe patients are typically treated by primary care physicians and /or mental health counselors and typically do not require use of medications, and 4) patients with acute and situational issues are best treated by counseling, and though they often do show up with physical symptoms, they often don't need medications. Typically, they need counseling to help them work through their issues.

For all but category one above prescribing medications for treatment should be done only as a last resort, or, in other words, after all other viable options have been exhausted. Physicians know best when to use and when not to use medications for treatment, whereas Psychologists have very little knowledge or experience that would help them render good judgment in this regard.

Another opponent testifier commented that by focusing on a certain category of treatment modalities in isolation from broader, more interdisciplinary approaches the applicants' proposal makes itself part of the problem in this regard rather than the solution.

Another opponent testifier commented that the current trend in mental health care is towards collaboration between a wide variety of professionals, the use of telemedicine, and regular consultation with other qualified prescribers to address the needs of those who suffer from mental illnesses. Psychologists' contribution to this team approach is in the area of assessment and psychotherapy, not vis-a-vis pharmacology or prescribing. The latter should be left to those who are well-trained in these areas of care.

Criterion three: The proposed change in scope of practice does not create a significant new danger to the health, safety, or welfare of the public.

There are dangers associated with the use of medications in the treatment of mental health conditions. These dangers include side effects, drug interactions, and inaccurate medication reconciliation, not counting the danger of a medication itself. The tendency is for a given practitioner to isolate themselves from teammates as they try to determine what is best for "their patient". Drugs have side effects. People who take multiple drugs have more side effects than those who don't. There are multiple effects of drugs and the more drugs a patient takes the more complex are the impact of these drugs on the patient. Furthermore, patients don't always tell their health care provider about all the drugs they are taking. If Psychologists become involved in prescribing there would inevitably be additional referral back and forth between them and primary care physicians resulting in unnecessary additional office visits and tests.

Another testifier commented that the category of "mental, nervous, emotional, behavioral, substance abuse, and cognitive disorders" in the proposal is incredibly broad. This testifier asked, rhetorically, whether there is any limit to the types of disease processes that a psychologist—under the terms of the proposal—would be allowed to treat? Hypothetically, the proposal would allow psychologists to treat a wide range of psychiatric disorders including

symptoms associated with the illicit use of controlled substances, per se, by prescribing other controlled substances as ketamine, dronabinol, methadone, and cocaine, for example. The potential for harming the patient in such a scenario is clear.

The proposal's apparent lack of clarity and consistency regarding proposed new training to provide the expanded scope of practice is also concerning and potentially dangerous. There is nothing in the proposal that indicates that psychologists would be adequately prepared to treat patients with opioid use disorders, for example. Treatments for such disorders require an interdisciplinary team approach that considers and evaluates both pharmacological treatments as well as non-pharmacological treatments in a coordinated, comprehensive care plan for the patient.

Pertinent to the collaborative model of care described in the proposal another opponent testifier commented that such a multiple provider approach to care risks a situation wherein serious miscommunications and / or misunderstandings are likely to occur between the providers and between the providers and the patient, for example. By adding another prescriber over and above the primary care provider the prescribing psychologist who is acting independently and informing other prescribers only at their discretion heightens the danger of breakdowns in communication regarding diagnosis, lab findings, and medications to be used in treatment. What is needed to improve care is increased access to the kinds of treatments that psychologists are already good at which is counseling. Unfortunately, the proposal, by casting psychologists in the role of prescribing physician, actually mitigates against access to good counseling services.

Another testifier commented that psychotropic medications affect more than simply the neurological pathways. These medications lack the ideal specificity that antibiotics exert when treating bacterial infections, for example. Antipsychotic, antidepressant, mood stabilizing, psycho-stimulant, antianxiety, and hypnotic medications can be powerful and have potentially serious, even deadly consequences. Effective prescribing of such medications requires extensive medical training as does the ability to recognize the physical health disorders that can cause neuropsychiatric disorders and / or masquerade as behavioral disorders. Many mental health patients have co-occurring medical conditions, and often the medications prescribed for these disorders interact with those prescribed for their mental health condition. Such drug-to-drug interactions require that they be managed by the best trained and educated providers. Additionally, it is just as important to know when not to prescribe as it is to know when to prescribe. Psychiatrists are well trained to exercise these kinds of judgments, psychologists are not.

A testifier representing physician assistants commented that the applicants' proposal does not clearly define how psychologists and physicians would collaborate. The proposal provides no specifics to define how this collaboration would actually work. This lack of clarity makes the proposal a potential source of additional harm to the public.

Criterion four: The current education and training for the health profession adequately prepares practitioners to perform the new skill or service.

One testifier stated that the educational program described in the proposal is vague and doesn't clarify vital clinical aspects of training. There's nothing in this training as described that includes a patient care dimension. Even the didactic aspects are limited and insufficient—not every type

of patient, and not every type of diagnosis is covered. Additionally, the aspects of the training pertinent to the monitoring of patients seems to be inadequate. Additionally, the review and evaluation of medications aspect of this training would ask physicians to give some of their time for this new aspect of Psychology practice, and even if they were to be reimbursed this would still be time away from their own patients thereby decreasing their own patient's access to care.

Another testifier commented that the education and training described in the proposal is substandard, and poses a potential danger to public safety. This testifier went on to state that the proposal includes a didactic portion that involves frequent evaluation of students' knowledge and the ability to apply their knowledge as well as feedback to students regarding outcomes. This testifier continued by stating that it is hard to envision how such a didactic course could provide meaningful feedback regarding patient care. This testifier went on to state that the proposed 80-hour practicum in clinical assessment and patho-physiolopgy attempts to provide the same competencies that a physician acquires over a period of several years in a period of about two weeks.

This testifier concluded his remarks by characterizing the proposal as a movement to begin unnecessary and inadequate medical training based on the argument that providing substandard medical training to students is justified so that more drugs can be provided to patients and to get them to patients quickly.

Another opponent testifier commented that the psychopharmacology curriculum for Psychologists is largely an on-line and as such is not equivalent to that experienced by resident physicians in psychiatry during their four years in medical school. When a resident chooses to specialize in psychiatry they receive extensive didactic education and carefully supervised clinical rotations which include a minimum of four months of primary care and two months of neurology. The education and training described in the applicant's proposal falls far short of this.

Criterion five: There are appropriate post-professional programs and competence assessment measures available to assure that the practitioner is competent to perform the new skill of service in a safe manner.

Testing is available but as of now there is no way of knowing what the test in question includes or what it looks like or how it relates to what is being requested. The mentoring or monitoring programs seem to be very sketchy and not at all clear as to how they would perform.

Criterion six: There are adequate measures to assess whether practitioners are competently performing the new skill or service and to take appropriate action if they are not performing competently.

The formulary committee proposed by the applicants is vague as to how it would actually work. What matters in prescribing is how a patient responds to a medication and the complications they experience with their medications. Also, the proposal would surely increase the stress level on busy primary care physicians who are already hard pressed to deal with the problems of their own patients without having to take their time to help other providers deal with the problems of their patients too. The overall impact of this proposal is to increase patient risk. There are options that would help us provide better access to mental health care including tele-

health, for example. Tele-health has proven itself as a means of addressing access to care problems, and we need to increase the use of this approach to improving access to care.

My opinion and that of the organizations I represent is that we need more mental health professionals especially in the more rural areas of the Nebraska and where low income populations are located. We believe that the expansion of tele-health will help improve access to mental health services. However, we don't need another group with limited training trying to treat patients with drugs rather than using the skills they already have and can excel at using.

I know an individual who has several medical problems, sees five different well trained sub-specialists along with her primary care physician who had her second knee replaced this spring. Shortly after returning home, she started to feel anxious, nervous, was nauseated and couldn't sleep. All of these can be signs of anxiety. Suppose she had gone to see a psychologist who had taken the 80 hours of physical assessment and the on-line courses (which I couldn't find clearly outlined in the proposal) and even passed the test and received the certificate that is requested in this application. With all her symptoms, it would have seemed logical to give her some medicine to help her calm down while trying to figure out the cause of her anxiety. The problem is that her anxiety was caused by the medications she was already being given and more medicine would have made her worse not better. By her doctors making some changes in her meds she was better within two days. And yet with the limited training, testing, and mentoring of psychologists proposed in this application she could have easily been treated inappropriately. We don't want to put patients at a higher risk of medication side effects and complications by letting someone with the limited training in this application prescribe potentially dangerous medications that may cause more harm than good.

The Following are Questions from Committee Members and Responses to these Questions from Interested Parties to the Review:

Applicant responses to Questions from Dr. Sandstrom, PhD, PT, Posted on-line:

Clarifying Questions about Response to Q. 9 of the Proposal (pp. 24- 25 of the proposal) For the following questions, please consider the effect of this proposal on "vulnerable" populations e.g. children or elderly individuals, who may not have the ability to self-protect:

Psychologists currently work with special populations and individuals for whom a guardian is involved in decision-making and providing consent. Nebraska regulations that define unprofessional conduct by a psychologist indicate the following: "A psychologist shall obtain from a client or his or her legal representative informed and voluntary consent before providing or assisting in the care of treatment of the client. Failure to do so shall constitute unprofessional conduct."

For a prescribing psychologist, informed consent involves an extra component. Specifically, the client, and his or her guardian, would need to authorize the release of medical records from the client's primary care practitioner, and permit the release of information from the prescribing psychologist to the PCP. The prescribing psychologist could not prescribe without the

authorization to exchange information. The prescribing psychologist would obtain information from the PCP in advance of developing a treatment plan involving the use of psychotropic medication.

1. **Define any limits on psychotropic medications in the authority of a prescribing psychologist.**

Prescriptive authority, as defined in the application (p. 50), involves drugs approved by the federal Food and Drug Administration (FDA) for the treatment of mental disorders. Some drugs are commonly used in the treatment of various mental disorders, but do not have an FDA indication for treatment for a specific mental disorder. Therefore, the prescribing psychologist could also consult from recent editions of Drug Facts and Comparisons or the most recent edition of the American Hospital Formulary Service, which serve as resources for evidence-based practice in the use of medications (psychotropics).

The certificate itself would not include a list of specific psychotropic medications. Any given practitioner is always limited in some way based on his/her training, experience, and competence. Nebraska regulations defining unprofessional conduct by a psychologist would apply to the psychologist with prescriptive authority, and these standards indicate, "A psychologist shall not provide services or use techniques for which he or she is not trained and experienced." These are legally binding standards. A prescribing psychologist would be subject to discipline for exceeding the boundaries of his/her competence. Psychologists are also legally bound to the Ethical Principles of Psychologists and Code of Conduct that specifies the following enforceable requirements:

1. Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.
2. Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals…

2. **Define any limits on "adjunctive" medications in the scope of practice of a prescribing psychologist.**

Adjunctive medications would be limited to those with an evidence base for managing known side effects when there is a documented reason for not switching to another medication. In addition, medications with an FDA indication or other standard based practice, for treating side effects, would be the only medications considered.

3. **Explain the ability of a prescribing psychologist to make a "differential diagnosis". What are the limits of the ability of a prescribing psychologist to make a diagnosis?**

Psychologists without prescriptive authority are currently charged with making differential diagnosis to ensure that non-psychiatric conditions are appropriately referred to a primary care

provider. In these situations, as with prescribing psychologists, the diagnosis of non-psychiatric conditions is formally made, and treatment managed, by a primary care provider.

a. **Is the list of conditions on p. 51 of the proposal exhaustive?**

The conditions listed on page 51 are not exhaustive and extend to any non-psychiatric illness, disorder, or illness which may be the primary etiology of a mental health concern.

b. **Given that self- referrals are the most common form of entry to a prescribing psychologist (p. 32) are the tests and measures permitted in the proposal adequate for a prescribing psychologist to identify prohibited or co- morbid conditions identified on p. 51?**

The tests and measures described are adequate to ensure that an appropriate differential diagnosis is made. The most important and useful assessment is collecting a thorough history. This is a skill that psychologists already focus on during their doctoral training and which is developed with greater skill and direction towards medical concerns during the post-doctoral training described in the application. The prescribing psychologist, when considering the use of medication, would be required to obtain a release of information from the patient or guardian to obtain information on the patient's medical conditions from the primary care provider.

It is unlikely that self-referrals will be the most common form of entry to a prescribing psychologist in the near future. More psychologists are entering integrated practices. Also, prescribing psychologists in New Mexico and medical psychologists in Louisiana are receiving an increasing proportion of referrals from physicians who value and trust the type of services provided by these psychologists.

4. **Define any limits on laboratory tests that can be ordered or performed in the office of a prescribing psychologist.**

The only limitations placed would be for providers to clearly document the rationale for the laboratory test(s), as well as documenting the sharing of the results with the patient and, when needed, with the patient's primary care provider. With respect to evidence-based practice in clinical psychopharmacology, there is a range of laboratory tests used before and after prescribing a given drug. These laboratory tests are covered in the training program, during the physician-supervised practica, during practice with the provisional prescription certificate.

5. **Can a prescribing psychologist order imaging studies?**

The prescription certificate would not explicitly authorize the ordering of imaging studies, and need for these relative to a prescribing psychologist's practice would be handled by referral to a primary care provider or other qualified provider. This would not, however, serve to preclude any psychologist currently working in a field where they are credentialed to order imaging studies (i.e. a neuropsychologist working in a TBI clinic may be credentialed by that facility to order a CT scan or MRI relative to a head injury).

6. **Are prescribing psychologists required to consult with primary health care practitioners each time they prescribe? Only when an abnormal physiologic finding is identified? At set periodic intervals?**

The prescribing psychologist will consult with the primary care provider during the formulation of the treatment, when there are any changes in the medication regimen outside of the treatment plan, and at any point when there are abnormal laboratory findings or other information or assessments indicative of a non-psychiatric illness.

7. Define any limits on the ability to a prescribing psychologist to prescribe medications for "side effects" of the primary treatment. Define the ability of a prescribing psychologist to accurately identify and treat a "side effect" vs. a separate pathology.

The only limitations on prescribing psychologists would be those of competence and the use of agents identified as approved treatments for side effects. Prescribing psychologists are trained in identifying side effects. Specific hallmarks are the timing of the side effect symptoms and lists of known side effects to a medication. In addition, with most psychotropic agents, there are multiple agents within each class, therefore the initial step could be to withdraw the assumed offending agent (or modify the dose) and monitor the side effects to determine if they diminish, then to introduce a new medication from the class, to assess if the side effects return.

8. Describe how the training and experiential requirements in the proposal mitigate any risks in Q. 1- 7.

The training involves expanding on the breadth of knowledge that a doctoral level provider already has regarding differential diagnosis, taking a medical history and using appropriate psychological assessments (many of which are already designed to aid in separating psychiatric and non-psychiatric disorders), and developing a depth of knowledge focusing solely on the pharmacological treatment modality. In addition, the experiential portions of the training requirements allow psychologists to gain experience under the supervision of a prescriber. This experiential portion gives the prescribing psychologist the opportunity to hone the didactic skills in an environment that maintains patient safety. This is the same model used for practitioners of most medical professions.

The training and experiential components, as defined in the proposal, include the follow requirements (pp. 52-54).

a. The postdoctoral training program must cover diversity and lifespan factors, special populations, and management of side effects from medications.
b. The supervised practicum shall involve the assessment and treatment of children and other special populations if appropriate to the current and anticipated practice of the trainee. The trainee would need to recommend safe and effective pharmacological interventions for the one hundred patients, with prescriptions being issued by the supervisor or other licensed practitioner with prescriptive authority. This experience is intensively supervised with the trainee receiving a minimum of one hour supervision for every eight hours of patient face-to-face time. In addition, the supervisor must verify the trainee collaborated with each patient's primary health care practitioner.
c. Once issued a provisional prescription certificate, the psychologist would be supervised for a minimum of two years by a physician. Per the proposal, an applicant for a prescription certificate who specializes in the care of children, elderly, or other special populations shall complete at least one year, of the minimum two years, working with such populations, under the supervision of a physician.

9. **Clarify if the proposal is like the Louisiana, military, New Mexico/ Idaho/ Iowa or Illinois models (p. 31).**

The Nebraska proposal is similar to all the states mentioned, and the military, in requiring the postdoctoral degree or certificate and passing a national competency examination, en route to prescriptive authority. Another commonality is the requirement that prescriptive authority only applies to professionals who are first licensed as doctoral psychologists.

The Nebraska proposal is similar to New Mexico, Iowa, and Idaho regarding the specific experiential requirements. The current proposal most closely matches the New Mexico statute and regulations.

a. **How does the reciprocity clause of the proposal work in Nebraska if the limits on practice in other states differs from Nebraska (p. 55)?**

Reciprocity would be handled much the way that it is for a non-prescribing psychologist, in that while practicing in Nebraska under the individual's Nebraska license, the prescribing psychologist would be held to the standards of our state. If the individual held a dual license and was practicing in another jurisdiction, he/she would be held to those regulations.

10. Has there been communication with insurers regarding the ability to bill for prescriptive services provided by psychologists? Medicaid/Federal Exchanges?

This question is partially addressed on page 24 of the application. The activity of prescribing psychologists is recognized by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association through the CPT (Current Procedural Terminology) codes which are numbers assigned to every task and service a practitioner may provide a patient. Prescribing psychologists use an add-on CPT code for medication management when providing psychotherapy. Prescribing psychologists are able to use Evaluation and Management codes (99 codes) that allow them to bill for services also provided by physicians and midlevel providers who are engaged in treating mental disorders.

In New Mexico, there are four managed care organizations managing Medicaid funds. Prescribing psychologists are recognized in the Medicaid system and have an add-on code (90863) for management of medications when performed with psychotherapy services. Private in-state insurers have followed that practice in New Mexico. About five years ago, the prescribing psychologists were granted the 99 billing codes used by physicians and midlevel practitioners.

11. Has there been discussion about mal-distribution of psychologists? It would appear that large areas of the state would continue to have shortages/access issues even if psychologists have prescriptive authority based on the map provided.

There are psychologists who travel to multiple counties to provide behavioral health services. One psychologist in the panhandle travels to seven counties to provide services, and one of the covered counties is similar in size to Connecticut. One of the applicants listed in the application has a behavioral health clinic that serves surrounding counties, and providers who travel to surrounding counties.
As indicated in the application, there are over twice as many psychologists as psychiatrists in Nebraska, and psychologists are located in over twice as many counties. There are 45

psychology internship positions in Nebraska each year and interns serve in several rural areas of the state.
As indicated in the application, Louisiana and New Mexico have attracted psychologists to their states due to the opportunity for prescriptive authority. An example was Dr. Marlin Hoover, who addressed the committee in May. He lives in Illinois and travels to Las Cruces, New Mexico to practice as a prescribing psychologist. There are many more examples, and some of those will be shared prior to the July 20th meeting with the technical review committee via an additional posting on the 407 website.
Psychologists utilize telecommunication technologies, as do other professions, to expand services across Nebraska counties. The American Psychological Association has published guidelines for psychologists who engage in telepsychology. The practice of telepsychology involves knowledge of ethical standards, legal requirements, telecommunication technologies, and agency policies. As indicated in the application, the percentage of licensed psychologist increased 28% from 2006 to 2016. Although many of these psychologists have a residence in an urban area, that will not limit their potential impact on the provision of services to rural areas.

12. **The question has already been posed, and I agree, about the real time "on the ground" implementation of a weekly session with supervising MD. And how will the provision to have an urgent prescription access (p. 51) potentially be a safety issue if the medication prescribed is not appropriately contraindicated.**

    The management of psychiatric emergencies is already a component of training for psychologists and that training is expanded in the postdoctoral training programs. In the case of prescribing psychologists, there would be a supervisory agreement between the psychologist and physician regarding the scheduled supervision sessions and management of emergencies. It is common practice to have a back-up supervisor. As well, psychologists are experienced in making judgments regarding when a patient requires admission to an inpatient service.

    Urgent situations with patients can be managed on an outpatient basis, such as, when a patient needs to resume taking a medication to manage symptoms associated with severe mental illness. Unfortunately, it is not uncommon for patients to stop taking their psychotropic medication(s) after becoming stable. A patient may not follow the treatment plan, and not take a maintenance dose of a medication to prevent a relapse of symptoms. Resuming the medication that resulted in stabilization of the mental disorder could well prevent the need for inpatient hospitalization. The patient cannot wait weeks for an outpatient appointment under these conditions. An inpatient hospitalization can have many unwanted effects, such as large medical bills, lost wages or loss of employment, and disruption to the patient's family.

13. **I would like to have more information about the willingness of MDs to take on this additional responsibility and the cost to take this responsibility.**

    Prescribing psychologists in New Mexico have a state organization called the State Psychological Association. This organization conducted a survey of prescribing psychologists and found that the average salary of a full-time prescribing psychologist is $150,000. Psychologists in private practice pay for supervision services from a physician. In an agency, the psychologist would accept an adjusted salary if the agency provided a supervising physician. Once the psychologist has been issued the conditional prescription

certificate, the psychologist can obtain the higher rate of reimbursements, and these monies easily cover the cost of supervision. The psychologist cannot prescribe during the practica, prior to receiving the conditional prescription certificate, so the cost of supervision can be a financial stress for the psychologists during this limited time frame.

The money invested in the postdoctoral training, and any cost for supervision, is recouped within a year or two of being credentialed as a prescribing psychologist. Another advantage to prescribing psychologists is the higher income aids in paying off debt from obtaining the doctoral training. It has been a win-win for patients and psychologists. The patients can have their psychotherapy and mental health medications managed in a single appointment. The psychologists earn a higher income and worry less about paying off student loans.

14. Has anyone inquired whether UNMC might provide courses, and at least partly online?

The applicant group has not inquired with UNMC about providing coursework for psychologists seeking the advanced training to prescribe mental health medications for their patients. The strongest opposition to prescriptive authority for psychologists with advanced training in clinical psychopharmacology has come from psychiatry departments in medical schools. The American Psychiatric Association and the American Medical Association have strongly opposed RxP. This situation creates a barrier to developing RxP training programs within medical schools.

However, the applicant group would welcome discussions with UNMC. A starting point could be a presentation from directors of postdoctoral training programs in clinical psychopharmacology. The existing training programs have extensive experience training psychologists en route to prescriptive authority. For instance, Dr. Luis Vasquez, with New Mexico State University, has offered to reach out to the University Nebraska and provide information on their RxP training program. In addition, Dr. Alan Lincoln, with Alliant University, would likely be available for discussions with UNMC. Dr. Lincoln is from Omaha.

Applicant responses to Questions from Allison Dering-Anderson, PharmD, RP, and Liane Connelly, APRN, RN, Posted on-line:

<u>Criterion #1</u>: We heard 1 presenter tell us that 72 counties in Nebraska have no way for patients to get mental health drugs. We heard a member of the audience say that primary care providers are, in fact, writing for these drugs. Which is accurate?

1. The applicants quote data from Nebraska sources on shortage areas in the state; for example, on page 4 of the application where it is noted that 71 counties, according to the Behavioral Health Education Center of Nebraska report to the legislature, do not have a psychiatric prescriber (psychiatrist, psychiatric nurse practitioner, or psychiatric physician assistant). The state has provided funding for expanding the number of psychiatric prescribers: our application, if implemented, would do just that. Moreover, the proposal is more than about getting mental health mediations to consumers, as prescribing psychologists provide additional services such as psychotherapy and other psychological interventions, which is important to many patients with mental disorders.

2. The intent and impact of the proposal is reflected on page 26 of the application. Table 1 estimates the impact of the implementing the prescription certificate. After ten years there could be 22% additional psychiatric prescribers.

3. In our application we have not claimed that patients currently have absolutely no access to psychotropic medications, especially if they are willing to wait long enough, or obtain psychotropic medications from a provider without a specialized training in behavioral health. http://dhhs.ne.gov/publichealth/licensure/documents/ConsumerAshleyLetter.pdf

4. We quote data from retail pharmacies, on page 23, that "the vast majority of psychotropic medications are provided by general practitioners, obstetrician-gynecologists, and pediatricians. A New Mexico psychiatrist, Dr. Fineberg, indicated that these are "very busy and overworked doctors." Dr. Fineberg, based on his considerable experience with prescribing psychologists, stated that, "These doctors have confided in me over the years that they are pleased that psychologists have prescriptive authority because when they make the referral, not only do they know that their patient gets good psychological care, but that their psychotropic medication will be managed by someone who understands the subtleties of the psychological changes that occur when the medicine is prescribed."

5. Data from Nebraska indicates there is a shortage of primary care providers. These practitioners seek out psychologists for appropriate diagnosis and recommendations for their patients. There are a growing number of psychologists working in integrated care practices around the state, and these psychologists can be of even more support the primary care providers in taking care of complex behavioral health cases, by implementing the proposal contained in the application.

Criterion #2: Is there a chance that during the training period that availability of psychologists would actually go down in some areas? I understand that this could be done evenings and weekends, but do we know that it will?

1. Because the training is self-funded, the psychologists will need to maintain their clinical practices to pay for this postdoctoral degree.

2. The postdoctoral coursework can count as continuing education for license renewal. That creates some efficiency for the psychologists in training.

3. The students are eager to use the training to improve services for their existing patients. The coursework requires the students to review actual cases, and this is not a problem for a licensed psychologist with an active practice.

4. Much of the time in training is spent working under physician supervision with existing patients; for example, during the two years of physician-supervised practice with a provisional prescription certificate, when the psychologist trainee would be working with his/her existing patient caseload. In addition, the physician supervisor would be referring patients to the psychologist.

5. As noted on page 4 of the application there was an increase of 127 licensed psychologists from 2006 to 2016.

6. New Mexico and Louisiana have experienced psychologists moving to their state because they can better serve patients with this additional credential. Please see the video short by Dr. Marlin Hoover regarding the expansion of services in New Mexico, https://www.youtube.com/watch?v=teRwQ3iXOeY&feature=youtu.be

Criterion #2: We have been presented with data from New Mexico as an exemplar and I don't understand how many additional providers their law produced in the public setting. I appreciate the gentleman from the Air Force, but he's not available to the general public. My question is, did the New Mexico law add providers, especially in rural and underserved areas.

1. New Mexico examined the impact of passing prescriptive authority in the Sunset Report of 2015. To quote from the Sunset Report which is posted on the 407 website: "Our board has also continued to license psychologists who are training for prescriptive authority on a provisional basis and on an unrestricted basis following the completion of the requirements set out by the board's rules and statutes. In the process, our state has added many new prescriptive providers to meet the demand for mental health services across rural and metropolitan areas of the state."

2. Additional data provided on page 79 of the application reflects a map of locations where prescribing psychologists work throughout the state of New Mexico. The data is from the director of the New Mexico State University RxP training program that tracks where prescribing psychologists are providing services, including in rural areas. Members of the applicant group traveled to New Mexico and spoke directly to prescribing psychologists working in rural areas of the state; such as the towns of Farmington and Grants.

3. Dr. Robert Sherrill, a prescribing psychologist in Farmington, New Mexico, provided the committee with a letter describing the difference prescribing psychology had on the state. His letter is posted on the 407 website.

4. Dr. Glenn Ally, a Louisiana medical psychologist, provided information on prescribing (medical) psychologists filling long vacant positions in state facilities and rural areas. Dr. Ally has worked at a Community Health Center that covers rural parishes (counties).

5. A 2013 survey from New Mexico, on page 35 of the application, noted that more than 90% of prescribing psychologists accept Medicaid. This is particularly important to note since there is data indicating that "40% of practicing psychiatrists do not take any insurance." (Source: The Psychiatric Shortage: Causes and Solutions, National Council for Behavioral Health, March 28, 2017).

Criterion #2: In am intrigued that prescribing psychologists are not the first choice for solving provider shortages in the report from the Medical Director Institute at the National Council for Behavioral Health. I would like to hear some discussion on this report and how it relates to the proposal under consideration.

1. The report from the Medical Director Institute at the National Council for Behavioral Health utilized a panel of experts. The applicant group does not see any members on the panel from the American Psychological Association. There were two representatives from the American Psychiatric Association, and this organization has strongly opposed prescriptive authority for psychologists with advanced training.
2. It would be interesting to see how the report would have been impacted if the family physicians, Drs. Andazola and Ewing, had been on the expert panel. In addition, it would be interesting if the panel of experts included Dr. Fineberg (psychiatrist from New Mexico), a representative from the Louisiana Board of Medicine and Surgery that oversee medical psychologists, or representatives from clinics in New Mexico and Louisiana that are utilizing psychologists with prescriptive authority.

3. The applicant group would be pleased to discuss this report further at our next meeting.

Criterion #3: How will members of the public and other health care professionals know who can prescribe and who cannot? Confusion may or may not constitute a "significant" danger, but it is a concern.

1. The regulations for the prescription certificate would require that psychologists, who have earned the additional credential, to identify their status as possessing a prescription certificate.

2. As is standard practice now for psychologists, the prescribing psychologist would include information about his/her prescriptive authority in his/her consent form that is reviewed with each patient prior to the initiation of treatment services.

3. When other licensed professions in Nebraska expanded their scope of practice there was educational information developed to share with patients about the new credential and scope of practice.

Criterion #3: Current Uniform Credentialing Act restrictions will prohibit psychologists from prescribing controlled substances for themselves or members of their families and households. Given the nature of the conditions treated by this group, is there any concern about self-prescribing of non-controlled substances?

1. The existing Nebraska regulations defining Unprofessional Conduct by a Psychologist (Chapter 156), and the Code of Professional Conduct for the Practice of Psychology (Chapter 157) would prohibit a psychologist from providing treatment to him/herself or members of his/her family. The psychologist with a prescription certificate must maintain his/her psychology license, so Chapters 156 and 157 would be enforced.

2. The standards forbid multiple relationships when a psychologist has an intimate relationship with another party.

3. The standards would forbid self-prescribing, per the section on Personal Problems and Conflicts, which requires psychologists to seek professional consultation for problems that may interfere with performing their duties.

4. There is another level of protection per the proposal. The applicant for a provisional prescription certificate must have an unrestricted license to practice psychology in Nebraska. A licensed psychologist disciplined for violations of Chapter 156 and 157 would not qualify for a prescription certificate.

Criterion 6: I recall that there was a great deal of discussion about the expense of investigations in mental health cases years ago during the credentialing reform process. Has anyone estimated the cost of this new credential? Will that cost be a deterrent to psychologists who want to prescribe?

1. The applicant group asked Dr. Robert Sherrill to address this type of question in advance, and he provided information via his letter to the technical review committee, that is posted on the 407 website. His response is copied below. Dr. Sherrill was chair of the psychology licensing board when prescriptive authority passed in New Mexico and was a member of the administrative body that had to set the licensing fee and track expenses over time.
    a. "It has not been a financial burden on the state for New Mexico to implement its prescribing psychologist statute. The Psychologist Board is entirely self-supporting by fees from its licenses. The Board simply added categories for prescribing psychologist trainees and prescribers to our licensing procedures, developed a new form to document the additional training of a licensee applying for prescription privileges, and instituted an additional licensing fee of $150 every two years. It was not necessary to add staff at the Board's office, or to increase fees for licenses who are not prescribers. Similarly, the additional malpractice insurance coverage in order to prescribe has not been a great burden on us; on my most recent insurance renewal in May 2014, I paid an additional $188 to be a prescriber, which is about an 11% increase over the basic premium for New Mexico."

Criterion #2: How will authorizing "RxP" certification help with retention of psychiatrists? Psychologists?

1. In Louisiana, Medical (prescribing) Psychologists on the medical staffs at general hospitals assist with taking "on-call" and can assist with "in-house" consults, which lessens the burden on psychiatrists.

2. There are private practices where psychiatrists and Medical (prescribing) Psychologists work together. The ability of Medical Psychologists to provide not only mediation but also psychotherapy has expanded some of the psychiatry clinics' services. Psychologists also bring skills that include neuropsychological testing, personality testing, behavior management programming, and forensic assessment skills.
3. In Louisiana, Medical (prescribing) Psychologists have filled positions that psychiatrists have not taken for years because of the shortage of psychiatrists. It has taken pressure off of psychiatry to take on more than they can reasonably handle.

4. In short, for psychiatrists the perception of working in a region where there is a release valve for referring patients who cannot be cared for immediately allows for a more manageable workload. Additionally, knowing that patient care can be covered during periods of absence can improve a sense of wellbeing. Most providers do not like the circumstance of making patients wait months for an initial consultation. We know that treatment outcomes are vastly improved by rapid treatment.

5. Regarding psychologists, there will, of course, be improved retention due to providers being given the opportunity to provide “one-stop” mental health care for patients. Beyond that, even providers who do not elect to pursue the credential will feel the benefit from ease of access to pharmacological treatment. When a patient is in need of this level of care it can be extremely draining on a therapist to helplessly watch the decompensation that occurs when a patient is deprived of required care due to lack of access.

6. From a practical business perspective, a psychologist who obtains this credential and desires to be in private practice could quickly identify vast areas in rural Nebraska where there is a need that is not currently being provided for. In other words, it would not require a tremendous overhead to be able to develop a vibrant practice.

7. Finally, prescribing psychologists, with the expanded scope of practice, have experienced an increase in their income, which improves retention and covers the cost of the training.

Criterion #2: Are current psychology services reimbursed by Medicaid? Medicare? What about for prescribing psychologists? Have the applicants approach Nebraska educational institutions about establishing in-state training for prescriptive authority?

1. Nebraska psychologists have been providers under the Medicaid program for many years. In New Mexico, prescription activities are covered by Medicaid for psychologists with the prescription certificate. As indicated in the application, nearly every prescribing psychologist in New Mexico takes patients with Medicaid, and this has been helpful to the state since some psychiatric specialists have stopped taking Medicaid.

2. Psychologists have been providers under the Medicare program for many years; however, there is not a billing code for prescriptive activity yet.

3. The applicant group has met with faculty in psychology departments to discuss developing an in-state training program. The discussion touched on the national training standards for RxP, the independent review process for RxP training programs, the rigorous national competency examination, and the type of faculty needed for such a training program. There was some interest; however, programs are understandably hesitant to move further while the question remains of whether there will be a credential in Nebraska to enable practice with the additional skills.

Questions and Concerns Raised During Noticed TRC Meetings and Applicant Responses to Them

1. Ms. Parsow asked applicant representative Dr. Michael Merritt to describe how he became credentialed to provide prescriptive services. Dr. Michael Merritt responded by stating that he received a pharmacology degree from the University of New Mexico and clinical training in prescribing under the auspices of the United States Department of Defense, wherein he had to take and pass a pharmacology exam.

2. Dr. Dering-Anderson questioned the use of the term "formulary" in the text of the proposal, expressing the concern that the proposal seems to establish a specific list of medications that practitioners would use. Dr. Dering-Anderson continued by stating that such lists become obsolete very fast.

3. Dr. Dering-Anderson also questioned the rationale for creating a special advisory body pertinent to the administration of medications for their profession. An applicant representative responded by stating that the advisory body in question would assist psychology prescribers by giving them the benefit of input and advice from members of other health care professions regarding case management as well as matters pertinent to application of rules and regulations, for example. This representative clarified that this advisory body would not be a formulary committee, per se.

4. Dr. Dering-Anderson commented that she did not appreciate all the acronyms in the proposal and that she likes to have things spelled out. Dr. Dering-Anderson went on to state that the training process for the proposed scope of practice needs clarification. This committee member went on to ask the applicants whether the proposed new training requirements might delay entry into the profession. This committee member continued by asking the applicants whether more traditional psychology counseling services might be 'short-changed' as a result of this proposed expansion of psychology into medical kinds of services. Dr. Ullman responded by stating that data shows that the profession of psychology is growing rapidly at this time, and that there is no reason to believe that the proposal would in any way result in diminishing or diluting psychology services.

5. Dr. Liane Connelly, R.N., asked the applicants whether there is information regarding how many psychologists are interested in providing the proposed scope of practice. Dr. Ullman responded by stating that a survey of psychology practitioners he conducted indicated high interest among psychology practitioners in the proposed addition to psychology scope of practice.

6. Dr. Wendy McCarty asked the applicants whether the additional education and training requirements associated with the proposal would create a significant burden for psychology practitioners as regards the costs of this additional training and/or the accessibility of this additional training. An applicant representative responded that accessibility of this training can be addressed through the utilization of weekend course venues. Dr. McCarty continued by asking about the accessibility of the clinical component of this training. Dr. Talbot, respond for the applicant group, stated that in New Mexico primary care physicians have provided both venues and oversight for such clinical training.

7. Dr. Judith Kissell asked the applicants whether the proposed expansion in services would be covered by Medicare and Medicaid. Dr. Ullman responded that in New Mexico Medicaid covers these services. Dr. Kissell then asked how many states have this expanded service concept. Dr. Ullman replied that there are five states that have approved this service concept. Dr. Kissell asked whether there is a national competency examination. Dr. Ullman replied in the affirmative, adding that we knew this would be important to have, and we saw to it that we had one ready to be used.

8. Dr. Sandstrom expressed the concern that the proposal is not entirely clear as to what specific maladies psychologists would be treating, and what specific medications they would be using to treat them. Dr. Sandstrom asked where the boundary is between psychology prescribing and prescribing by a physician. Dr. Sandstrom continued his comments by asking the applicants about vulnerable persons who might not have a physician and who might not have the ability to clearly communicate their health care needs without assistance. He added that he's going to need more information from the applicant group about how the proposed inter-professional relationship among psychologists, pharmacists, and physicians would work in real time patient care situations.

9. Dr. Chelsea Chesen, M.D., commented that the current applicants' proposal is a much improved version compared to the one they submitted several years ago, but that there are still questions and concerns that need to be addressed. Dr. Beth Ann Brooks, M.D., commented that each of the five states that have approved psychology prescribing have different requirements than what is being proposed for Nebraska. Furthermore, while psychology prescribing bills have been passed in Illinois, Iowa, and Idaho, they are not yet operational in these states. Dr. Brooks went on to add that the Nebraska proposal differs from the Iowa and Illinois proposal by calling for prescriptive authority for Schedule 11-V drugs. The Illinois law allows only Schedule 111-V drugs including no benzodiazepines, while the Iowa law does not permit prescribing narcotics. Dr. Brooks went on to say that she has queried whether the four Masters psychopharmacology programs identified in the applicants' proposal were still admitting students, adding that her understanding is that one or more of them might no longer be accepting students.

10. Dr. Dering-Anderson asked the applicants how their proposal would address access to care issues in underserved areas of Nebraska. Dr. Hoover responded to her question by stating that data from New Mexico indicates that there has been an improvement in access to services in that state since the passage of their psychology prescribing legislation. He added that there is a map that shows the increased availability of prescribing practitioners in that state.

11. Dr. Sandstrom asked the applicants what the role of the proposed formulary committee would be in the administration of the proposal if it were to pass, and exactly what would be the limitations on psychology prescribing pertinent to specific medications given specific patient conditions and criteria, for example. Dr. Hoover responded that in New Mexico the rules and regulations define these kinds of parameters.

12. Dr. Dering-Anderson asked the applicants how a given pharmacist could know whether or not a given psychologist does or does not have permission to prescribe medications. Dr. Hoover indicated that in New Mexico once the proposal was implemented pertinent information is to be included on the records of each psychology licensee who satisfies the requirements to prescribe showing that they have permission to prescribe.

13. Dr. Sandstrom asked whether there would be any time based delimiters for psychology prescribing for the prescribing of drugs that have only been on the market for a short time. He also asked about the ability of psychologists to assess the overall health condition of a patient. Dr. Hoover responded that prescribing psychologists would work closely with physicians in such matters. He added that primary care physicians would be their partners in helping prescribing psychologists assess and or diagnose their patient's overall health condition. Dr. Ann Talbot added that after the passage of the proposal each prescribing psychologist would form a practice agreement with a physician for purposes of collaboration on such matters.

14. Dr. Sandstrom asked how such consultation between a prescribing psychologist and a physician would actually work, specifically, if there were a disagreement between them regarding what to prescribe, for example. Dr. Hoover responded that there would need to be agreement between consulting practitioners, or, if not, nothing would be prescribed until there was agreement.

15. Dr. Sandstrom asked about the 80-hour clinical practicum defined in the proposal, commenting that this would play out to no more than two weeks of training, and wondering if this is adequate for ensure competency. Dr. Hoover responded that this aspect of training is well supervised and that testing is involved. He added that there is also a 400-hour clinical component that occurs over the course of an entire year that also comes into play.

16. Committee member Liane Connelly asked the applicants how willing are primary care physicians going to be to take their time to partner with psychologists. Dr. Talbot responded that the experience of New Mexico indicates that physicians are very willing to cooperate in this endeavor because they know it helps patients receive more timely care. Dr. Mercer responded that family practice physicians are very cooperative, but as for psychiatrists, they are more skeptical.

17. Dr. McCarty asked the applicants how many current psychology practitioners are going to be interested enough in prescribing that they're going to actually incur the costs and time expended to become qualified to do this. Dr. Dering-Anderson asked the applicants how much time away from patients would the training in question take for those who undertake it.

18. Dr. Kissell asked about the professional ethical issues and whether the examination for psychology prescribing would deal with such subjects, specifically, about the ever-increasing influence of pharmaceutical companies in influencing pharmacists to buy their products regardless of safety issues.

19. At this juncture Dr. Chelsea Chesen, MD, came forward to comment on the proposed 80-hour practicum, commenting that this course does not compare to the thousands of hours that a medical student preparing to be a psychiatrist invests in their education and training.

20. Dr. Robert Wetzell, MD, came forward and asked the applicants if there is data to support the contention that delayed access to care is a major cause of patient death. Dr. Merritt responded that there's not good data on this, but that intuitively a quality health care service or profession cannot afford to create the impression that delays in providing

care don't matter. Dr. Wetzell then commented that accidental poisoning associated with prescribing drugs that are inappropriate or prescribing an inappropriate dosage of a drug is a far more serious matter than whether or not there are delays in access to prescribing.

21. Dr. Wetzell then asked for more clarification on how medical oversight of the training of psychology prescribing trainees would work, expressing concern that under the terms of the proposal physician supervisors may opt out of directly examining a patient being treated by one of their trainees, and, in this circumstance, the physician would never see the patient. Dr. Hoover responded that there would never be an instance in which a supervising physician would 'never see the patient' because the patient would already have seen the physician before said treatment had even gotten underway. Dr. Wetzell responded that the current proposal does not make this clear.

22. Dr. Chesen questioned whether the proposal would be able to significantly impact the timeliness of care because now, instead of seeing one practitioner, a physician, the patient must now see two health care providers.

23. Dr. Beth Ann Brooks, MD, came forward to ask about the availability of Masters level training programs for the proposed new credential. Dr. Brooks stated that at least two of the training programs identified by the applicant group might no longer be providing the training anymore, one of these being the New Mexico program. Dr. Hoover responded that the New Mexico program is not shutting down, but rather is in transition and is waiting for the New Mexico legislature to approve legislation that would make changes in the program.

24. Dr. Dering-Anderson wanted more clarification regarding the impact on patients when their psychologist decides to undergo training to provide prescriptive services. This committee member also wanted more information about self-prescribing under the terms of the proposed new scope of psychology practice.

Opponent Concerns and Applicant Responses:

Four general themes were identified in the letters of opposition posted on the 407 website. The applicants provide a response to each of the themes below.

Opposition theme #1: Physicians receive over 10,000 hours of supervised prescribing experience while prescribing psychologists get only 80 hours (the equivalent of one week of medical residency training).

1. *There is a serious misunderstanding of the requirements to obtain the proposed prescription certificate*; for example, the psychologist brings to the advanced prescriptive training program years of supervised experience earning a doctoral degree and state licensure, which includes clinical practicums, internship, and postdoctoral supervised experience with a provisional psychology license. Psychologists bring to the advanced prescriptive training thousands of hours of supervised experience treating mental disorders. Appendix I in the application provides a visual comparison of the behavioral health training of prescribing psychologists, psychiatrists, psychiatric nurse practitioners, and psychiatric physician assistants. In regards to the 10,000 hours of supervised, it is commonly known that physicians can prescribe the full range of U.S. Food and Drug Administration (FDA) approved drugs after completing four years of medical school and one or two years supervised practice. Physicians are not required to complete a 10,000 hour residency program to begin prescribing drugs. The public is familiar with medical residents being able to “moonlight” and prescribe drugs during a residency program.

2. *This criticism entirely ignores the fact that the supervised experience for prescribing psychologists starts during the postdoctoral master’s degree program*. Per the national training standards for prescribing psychologists, the trainee is required to learn how to conduct health assessments, interpret laboratory assessments, work with special populations and a range of clinical disorders, understand complicating medical conditions presenting as psychiatric illness, and make choices of medications and manage side effects from medications. These requirements are described in detail in Appendix B (see application, pp. 51-55).

3. *The 80 hour physician supervised practicum is just one component in a series of supervised experiences for eventual prescriptive authority.* The 80 hour practicum can be viewed as a capstone assessment of specific skills listed on page 53 of the application. This practicum includes adequately taking vital signs and demonstrating competence in health assessment skills acquired during the postdoctoral training program.

4. *The critics don’t mention the minimum 400 hour, 100 patient practicum specific to treating mental disorders with medications (application, p. 53), or the two year physician-supervised experience performed under a provisional certificate.*

5. As outlined in the application, the training for the prescribing psychologist is approximately five years in length. This RxP training is in addition to the 6+ years, post-bachelor’s degree, graduate level training and supervised experienced required in becoming an independently licensed psychologist prior to entering the postdoctoral master’s degree program. The prescribing psychologist would have a combined 11 years, post-bachelor’s degree, that is intensively focused on the diagnosis and treatment

of mental health conditions. By comparison, the psychiatrist (with a residency) would have 4 years of mental health specific training, less for the psychiatric nurse practitioner, and one year of specialized training in mental health for the psychiatric physician assistant. For the general family medicine or pediatric providers, MDs, DOs, PAs, who also currently diagnose and treat mental health disorders, are often the first-line prescribers for individuals in rural areas, and training in mental health conditions could be as little as one semester of didactic training and a one month rotation clinical experience. [https://www.unmc.edu/alliedhealth/education/pa/about/curriculum.html]

6. The videos of physicians experienced with supervising prescribing psychologists, available through a link on the 407 website, should help address the misunderstanding about the rigors of the training process for the prescribing psychologist. Dr. Andazola, family medicine residency director, provides a helpful overview of different training models for professionals with prescriptive authority.

7. Dr. Andazola accurately describes the role of the prescribing psychologist in comparison to other medical professionals. *For example, the prescribing psychologist's scope of practice is limited to approximately 100 medications associated with the treatment of mental disorders.* In contrast, general medical practitioners can prescribe from the full range of medications approved by the U.S. Food and Drug Administration. Also, the training of the general medical practitioner includes a variety of medical procedures (e.g., delivering babies, suturing a wound, surgeries) that is unrelated to the practice of a prescribing psychiatric medications.

8. It was very disappointing to read letters that claim the application is for current licensed psychologists to obtain prescriptive authority, presumably as-is without additional training. That is a complete falsehood. Reading only the first page of the application would prevent someone from making the error of believing the application intends to change the scope of practice for the psychology license. The wording on the first page states that the prescription certificate would be: "*A voluntary, supplemental credential for licensed psychologists who complete postdoctoral training, supervised practical, national competency examination, and two-year physician supervised conditional certification period*."

9. Lastly, letters of opposition try to portray this as psychologists supervising psychologists to gain prescriptive authority. Reading only the first page of the application again would clarify that the training involves physician supervision. Reading the proposed regulatory language in Appendix B specifies that physicians supervise different components of the training. *A psychologist must be supervised by physicians, and these physicians would need to verify the prescribing psychologist is a competent and safe prescriber.* Assuming the critics have trust in members of their own profession, if they were to review and understand the full application it is anticipated they would have confidence knowing that close supervision is required in the proposal for the prescription certificate.

Opposition theme #2: Psychotropic medications are very powerful with many potentially dangerous side effects, and RxP training is not sufficient to recognize these side effects and possible drug interactions.

7. The safety record of prescribing psychologists is addressed in the application and specifically in Appendix F, Prescribing Psychologists' Safety Record, pp. 65-68. Opponents have predicted serious harm to the public by permitting psychologists, with advanced training, prescriptive authority. However, the outcome data described in the application has not supported the claims of dire outcomes.

8. The objective data demonstrates the lack of safety incidents by prescribing psychologists for more than twenty years. The safety data includes the ratings of physicians who clearly indicate prescribing psychologists have been practicing safely in their communities.

9. The videos of physicians and others experienced with prescribing psychologists make some interesting observations about the reasons for the strong safety record of prescribing psychologists.
    a. Dr. Andazola, director of a family medicine residency, wishes more specialists would coordinate care with the patient's primary care provider. The prescribing psychologist is required to communicate and collaborate with the patient' primary care provider.
    b. Dr. LeVine, prescribing psychologist in New Mexico, noted that prescribing psychologists see their patients more often and can carefully increase the dose of a medication as the effects and side effects are monitored. Contrast this with much of the status quo where the medication dosage is prescribed and a follow up appointment is in four weeks.
    c. Prescribing psychologists are trained to take vital signs, review bodily systems at each visit, and detect when there could be a harmful reaction to a drug or possible presence of a general medical condition that requires intervention by the PCP or other medical provider.
    d. The physicians experienced with prescribing psychologists, that includes the psychiatrist Dr. Fineberg, noted that psychologists are safe because they frequently end up taking patients off medications that are not needed, and the prescribing psychologists have a wide range of psychological treatments to utilize instead of pills.

10. The claim by the opposition that the RxP training is not sufficient to recognize drug side effects and interactions is false. The postdoctoral master's program, per the application, would include, at minimum, 400 hours of intensive didactic education in the following areas: anatomy and physiology; biochemistry; neurosciences to include neuroanatomy, neuropathology, neurophysiology, neurochemistry and neuroimaging; pharmacology; psychopharmacology; clinical medicine and pathophysiology; health assessment, including relevant physical and laboratory assessment; diversity and lifespan factors, special populations; case reviews that cover a broad range of clinical psychopathologies, complicating medical conditions presenting as psychiatric illness, diagnostic questions, choice of medications, management of untoward side effects from medications, compliance problems, and the alternative treatment approaches. Additionally, the clinical practicum supervised by the physician will ensure the applicant for a prescription certificate has demonstrated competency in assessing a significantly ill medical population, assessing vital signs, observing the progression of

illness and continuity of care of individual patients, laboratory assessment, as well as physical health assessment techniques.

11. The safety of patients is ensured by the thorough training and supervision in the postdoctoral master's program, and through the required integrated care between the prescribing psychologist and the primary health care practitioner. When prescribing drugs for patient, the prescribing psychologist shall maintain ongoing communication with the primary health care practitioner who oversees the patient's general medical care. The prescribing psychologist shall provide the primary health care practitioner a summary of the treatment plan and follow up reports as dictated by the patient's condition. The purpose of the communication includes ensuring that necessary medical examinations are conducted, and determining whether a drug prescribed by the prescribing psychologist is not contraindicated for the patient's medical condition.

Opposition theme #3: Psychologists are clustered in the same population areas as psychiatrists and RxP will not address the shortage of mental health providers in rural areas. Telepsychiatry, collaboration with primary care doctors, and the use of physician assistants and nurse practitioners are a better solution to the shortage without putting patients at risk with substandard care.

4. As discussed earlier, there is no evidence that prescribing psychologists provided substandard care or present a safety risk.

5. Dr. Daniel Carlat, editor in chief of the Carlat Psychiatry Report, addressed the options, listed above, in a Psychiatric Times article (2010), that discussed the shortage of psychiatrists. Dr. Carlat's views were covered somewhat in the application on pages 6 and 37. Dr. Carlat pointed out that primary care providers are already overloaded, have long waiting lists, are trying to cope with a vast array of illnesses, and can experience double the mental health dropout rate compared to psychiatrists. Dr. Carlat also explored the option of training more advanced nurse practitioners and physician assistants, and thought the economics work in favor of this option; however, he noted these professionals receive "very little training in psychology or psychotherapy – limiting their ability to properly diagnose and treat tough cases."

6. The American Academy of Family Physician's position paper on mental health care indicated PCPs spend 13 minutes on average with a patient, and the average patient presents with six problems. Given that timeframe, how well could the overloaded PCP manage serious behavioral health conditions? Psychologists already work with complex and serious major mental illnesses that require frequent therapy sessions, use of psychological diagnostic instruments, management of a behavioral health crisis, intervention with the patient's social supports, and time spent contacting agencies/providers involved with the patient. A major advantage with adding prescribing psychologists to the team of prescribing professionals is the patient is seen more frequently and the effect and side effects of medications can be more closely monitored.

7. Would the PCP, NP, or PA have the time and skill set to provide combined treatments (psychotherapy, psychopharmacology) when indicated for a given patient? For example, take a patient who presents in your office having been on antidepressant and a mood stabilizing medications for years. This patient complains of unstable relationships with family members that sometime end up with the patient engaging in self-cutting

behaviors. The prescribing psychologist, in developing a treatment plan questions the need for the mood stabilizing medication. The medical record indicated a bipolar disorder for your patient; however, psychological testing does not support a bipolar disorder, and instead testing raises concerns about the presence of substance abuse and a personality disorder involving major social skill deficits. The prescribing psychologist, with the patient's permission, contacts a family member and finds out there is no family history of bipolar disorder, and no family member has witnessed manic or hypomanic episodes with the patient. Research indicates that the reliability of ruling in or out a bipolar disorder improves when gathering information from family members. Contacting family members takes time. The patient is interested in trying to get off the mood stabilizing medication, but wants to do a slow taper off. The prescribing psychologist, after communicating in with the patient's PCP (see application, pp. 50-51), could manage the medications and institute a reduction in the mood stabilizing medication, while frequently monitoring the impact during weekly therapy sessions and also address the substance abuse problems and social skill deficits that likely account for the reports of "mood swings." The patient presents with a history of depressive episodes and prefers to remain on the antidepressant medication while the taper is instituted with the mood stabilizing medication. The patient wants to later address the need for the antidepressant medication after a course of psychotherapy to reach a goal of abstinence from substances of abuse and improved relations with family and other members of his/her social support system. It is not uncommon to learn sometime during therapy that the patient experienced some type of trauma, abuse, or other major adverse event in a patient's background. In this example, the patient eventually discloses a history of physical and sexual abuse that pre-dated the development of the identified mental disorders. The patient is relieved to finally talk about the abuse. This course of treatment is unlikely to have taken place with any provider other than a prescribing psychologist. The consumer survey data provided to the technical review committee indicated 72% of respondents indicated: "I would like to have my therapy and mental health medications managed by the same professional (i.e., being able to talk at length about my problems and mental health medications in the same appointment)."

8. To indicate "the use of physician assistants and nurse practitioners are a better solution to the shortage without putting patients at risk with substandard care" entirely ignores the specialized training psychologists go through as part of their doctoral program and supervised experience, which is the use of standardized psychological testing to arrive at a diagnosis that is supported by data. There is little to no training for physician assistants or nurse practitioners in the science of statistical analysis applied to psychometric testing and differential diagnosis. As a result, there can be a high degree of subjectivity in diagnosing mental disorders. As any healthcare provider knows, the right treatment starts with the right diagnosis. Given the absence of lab tests to diagnosis mental disorders, non-psychologist providers commonly refer their patients to psychologists when it comes to arriving at an accurate diagnosis. Psychologists with extensive training in psychometric testing, non-medication treatments such as psychotherapy, and now with advanced training in psychopharmacology, represents a practitioner with the broadest base of training specific to mental health disorders, than existing disciplines today.

9. A related concern to #3 is the fact that presently there is a shortage of primary care providers in Nebraska. According to documents, half of the counties in Nebraska meet the federal designation for medically underserved primary care areas. Also, according to the Nebraska Office of Rural Health, in 2016, 58 counties in Nebraska qualified as

shortage areas for family practice physicians. See the attached map and report. Due to these shortages, it seems likely that most primary care providers are already overburdened, and do not need to add more responsibilities to their day. Prescribing psychologists can lighten the burden for physicians by taking complex, time-consuming, behavioral health cases.

10. Dr. Fineberg, a psychiatrist who was the physician member of the state (licensing) board in New Mexico overseeing the credentialing of prescribing psychologists, shared the following observations regarding the value of adding prescriptive authority for qualified psychologists in meeting the needs of the underserved. The following quotes are from a recorded interview with Dr. Fineberg, May 7, 2016. A link to this interview is posted on the 407 website.
    a. "One of the problems that people have in the field of psychotropic medicine is that many people who need it don't get it, but many people who don't need it have it prescribed. It's a paradox, but one of the things that I'm really pleased about the training for the psychologists for prescriptive authority in New Mexico is that they work very hard about that difference. Because the prescriptive authority to be able to prescribe medicine also gives the authority not to give it when it's not indicated."
    b. "The real answer is the continuity of care is both simplified and made more effective when the person doing the diagnosing, doing the psychotherapy, can in fact also prescribe the medication. Every psychiatrist knows that that's true and I'm quite confident that any general practitioner who's uncomfortable with the level of their diagnostic acumen for a specific mental illness would be very pleased if the psychologist who was able to make the diagnosis had the training and ability to then prescribe the appropriate medication."
    c. "You know it's not unusual nowadays that non-physicians prescribe medication. Nurse practitioners prescribe and they prescribed in New Mexico before psychologists. Physician assistants prescribed also prior to prescriptive authority for psychologists. They had a general focus on their medical training, and for whom they would prescribe. There is a major difference for psychologists for prescriptive authority. The major difference is this: When it comes to psychotropic medication it is not merely a certain condition, a certain disease. You know it's not like an infection where the doctor prescribes antibiotics and then it's his drugs against your bugs. It's not like a cancer where the surgeon's scalpel or the chemotherapy is pitted against this neoplasm. This is a case when understanding of the person and the personality and the condition of the persons' mental health needs to be understood thoroughly. There is no one in the medical profession apart from psychiatrists who are actually trained to do that with the same thoroughness diagnostically and empathically as psychologists. So the real point here is who do you want to have a prescription pad their hands when it comes to mental health? Somebody who understands the condition, who has diagnosed the condition, who works with the patients who have the condition? Or somebody who's training has not given them that level of depth and understanding for prescribing?

11. The application provides data on the number of psychologists in Nebraska and their distribution across the state by county. As indicated in the application, this data is from a pubic source, the Nebraska Health and Human Services, Regulation and Licensing Division. Anyone can access that data on licensed and provisionally licensed psychologists and see that the number of psychologists is increasing. Also, the data on

the number of psychology internships (distributed through the state) is also from a public source that lists internship positions throughout the United States. It is true that the largest percentage of psychologists is located in urban areas. However, there are areas of the underserved even in urban areas. Telepsychiatry was mentioned as an option. Telehealth technology is also used by psychologists, so prescribing psychologists in urban areas can be available to provide care and/or consultation from urban areas.

12. There really are 11 psychologists in Scottsbluff. One has been through the postdoctoral training and another has the support of his agency to take the training necessary for prescriptive authority. There are at least two more psychologists who have expressed a strong interest in prescriptive authority. This would increase by four the number of doctoral level psychiatric prescribers in the panhandle without having to spend taxpayer money to provide incentives for new providers to move to Scottsbluff. There is nothing hypothetical about the increase in services to rural areas this proposal would provide.

13. The applicants provided consumer survey data from Scottsbluff involving a total of 252 respondents. Several respondents were receiving mental health medications from a psychiatrist, other physician, nurse practitioner, or physician assistant. The survey results, posted on the 407 website, indicated that 42% of the respondents reported difficulty getting an appointment with someone, "who understands my mental health needs, or the mental health needs of my family member(s)." The locations where these surveys were distributed have psychologists motivated to take the training for prescriptive authority to meet the need, as expressed by the consumers.

14. The Medical Director Institute that advises the National Council for Behavioral Health, and recently (March 28, 2017) released a report to develop "concrete solutions" to the problem of the "ongoing difficulties communities face providing adequate access to basic psychiatric services" (p. 1). The report describes the difficulty for the psychiatrists working in the community settings who are often limited to "a series of brief medication management appointments, some as short as 15 minutes, with patients who have severe, persistent and chronic mental health disorder. This cramped schedule leaves limited time for in-depth assessment and limits their ability to perform other critical activities, such a leading and participating in care teams, consulting with primary care clinicians, engaging in problem-solving with other health professionals on complex cases and providing clinical supervision" (p. 11). Psychologists are uniquely poised to provide the in-depth assessments and comprehensive treatment needed, as is standard for the longer and more frequent appointment times with patients. The report also notes that rural communities suffer a "severe shortage of psychiatrists" (p.26). One of the primary recommendations of the report is to expand the psychiatric workforce. The report noted that, "over the past 20 years, many other health professionals gained additional capacity to participate in the mental health and substance use disorder field as prescribers and clinicians" (p. 57). (https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage_National-Council.pdf)

15. There was a 28 percent increase in licensed and provisionally licensed psychologists in Nebraska from 2006 to 2016, based on data from the Nebraska Department of Health and Human Services. In 2006 there were 449 psychologists licensed through Nebraska. In 2016 there were 576 Nebraska licensed psychologists. That is an increase of 127 licensed psychologists in ten years (see application, p. 4). These psychologists are an important asset to the state in meeting the need of behavioral health patients.

Opposition theme #4: Physicians receive far more training in the basic sciences that are the foundation for psychopharmacology.

1. Appendix A in the application addresses this concern. In the appendix it was noted that some medical schools are taking students without the prerequisite basic science courses, and then provide the basic science courses within their curriculum.

2. The postdoctoral training programs for psychologists, per the national standards, must ensure that the basic sciences are covered in the postdoctoral master's degree curriculum. Therefore, the psychologist is receiving graduate (not undergraduate) level basic science courses. The field of psychology is recognized as making significant contributions to the neurosciences, and some psychologists have a substantial background in basic sciences and neurosciences, prior to receiving their doctorate. The postdoctoral training program may accept some graduate level basic science credits from other schools.

All sources used to create Part Four of this report can be found on the credentialing review program link under Licensed Practice Nurses at http://dhhs.ne.gov/licensure/Pages/credentialing-review.aspx

Part Five: Technical Review Committee Recommendations

Committee Discussion:

Committee Actions Taken on the Six Statutory Criteria for scope of practice reviews:

Criterion one: The health, safety, and welfare of the public are inadequately addressed by the present scope of practice or limitations on the scope of practice.

Voting yes were Connelly, McCarty, Sandstrom, and Dering-Anderson. Voting no were Kissell and Sneckenberg. By this vote a majority of the committee members agreed that the proposal satisfies criterion one.

There was no discussion on this criterion.

Criterion two: Enactment of the proposed change in scope of practice would benefit the health, safety, or welfare of the public.

Voting yes were Connelly, McCarty, Sandstrom, Dering-Anderson, Kissell and Sneckenberg. By this vote a majority of the committee members agreed that the proposal satisfies criterion two.

Dr. Connelly commented that there are other mental health providers available to play a role in providing the services in question, and that these professionals have not been considered during the course of this review. Dr. Kissell asked if psychologists would have difficulty getting reimbursed for the expanded functions if the proposal were approved. Dr. Dering-Anderson replied to Dr. Kissell that her experience has been that reimbursement in these kinds of situations has not been a problem. Dr. Dering-Anderson went on to comment that what appeals to her most about the proposal is that it offers hope of a “one-stop” approach to mental health care in that perhaps for the first time patients might receive the benefit of traditional mental health counseling therapy and a prescribed medication without having to visit two different providers, one for the counseling and the other for the medication.

Criterion three: The proposed change in scope of practice does not create a significant new danger to the health, safety, or welfare of the public.

Voting yes were Connelly, McCarty, Dering-Anderson, and Sneckenberg. Voting no were Kissell and Sandstom. By this vote a majority of the committee members agreed that the proposal satisfies criterion three.

Pertaining to this criterion Dr. Dering-Anderson commented that medications don’t know or care who prescribes them, and that they will have the same impact on the patient

regardless of who the prescriber is.

Dr. Sandstrom commented that passing this proposal would certainly create new risk of harm to patients, but the question is how much new risk would be involved. This is what's hard to determine. Dr. Sandstrom went on to express concerns about the applicants' argument that potential new risk of harm can be ameliorated by the psychologist working closely with medical doctors whenever prescriptive medications are being considered as part of treatment. Dr. Sandstrom questioned whether a physician is going to be willing to participate in such a treatment plan once he or she considers that they might be held liable if there were a bad outcome. He questioned whether in such a scenario a participating physician would even get to see the patient, for example. Dr. Sandstrom commented that there is a need for physician input on any board that would oversee this proposed new scope of practice, and that the current proposal does not adequately provide for such input.

Criterion four: The current education and training for the health profession adequately prepares practitioners to perform the new skill or service.

Voting no were Connelly, McCarty, Dering-Anderson, Sneckenberg, Kissell and Sandstrom. There were no yes votes. By this vote a majority of the committee members agreed that the proposal does not satisfy criterion four.

Dr. Sandstrom commented that his review of the proposed additional education and training indicates sufficient didactic preparation, but that in the area of clinical training it is very inadequate. Dr. Sandstrom added that the Legislature should codify the didactic educational standards in the proposal to ensure that Board(s) can evaluate whether those applying for a credential satisfy a consistent educational standard. Dr.Kissell asked whether psychiatrists or other medical doctors would be willing to provide the kind of cooperation necessary for the proposal to be implemented if it were approved by lawmakers.

Criterion five: There are appropriate post-professional programs and competence assessment measures available to assure that the practitioner is competent to perform the new skill of service in a safe manner.

Voting yes were Connelly, McCarty, Dering-Anderson, Sneckenberg, and Sandstrom. Dr. Kissell voted no. By this vote a majority of the committee members agreed that the proposal satisfies criterion five.

Dr. Sandstrom repeated his concerns about the inadequacy of the clinical training being proposed and commented that the proposal does not clarify how the proposed clinical training would be supervised or evaluated.

Criterion six: There are adequate measures to assess whether practitioners are competently performing the new skill or service and to take appropriate action if they are not performing competently.

Voting yes were Connelly, McCarty, Dering-Anderson, Sneckenberg, Kissell, and Sandstrom. By this vote a majority of the committee members agreed that the proposal satisfies criterion six.

Dr. Connelly made the observation that nursing students receive more training in the area of physical assessment than do psychologists.

Action taken on the entire proposal was as follows:

Voting yes were Connelly, McCarty, Dering-Anderson, Sneckenberg, and Kissell. Dr. Sandstrom voted no. By this vote a majority of the committee members agreed to recommend approval of the applicants' proposal.

During the ensuing discussion several committee members offered the following advice to the applicant group:

Dr. Dering-Anderson stated that any legislative version of the proposal should clarify that self-prescribing be prohibited.

Dr. Sandstrom stated that clinical training needs to be expanded to include more emphasis on physical assessment and clarified regarding oversight and ensuring quality training.

Dr. Sandstrom stated that the applicants should consider the idea of creating a practice agreement between prescribing psychologists and medical doctors.

Dr. Sandstrom stated that the proposed Prescribing Psychology Advisory Committee should have a statutorily defined relationship with the Board of Medicine and Surgery requiring approval of their regulations by this Board.

Dr. McCarty stated that psychology education and training programs need to tighten up their standards so that quality is emphasized at each step in the process not just accumulating a certain number of clock hours.

Dr. Kissell commented that the educational portion of the proposal should specifically include instruction on professionalism and the relationship between patient and clinician as it might be affected by the clinician's relationship with pharmaceutical companies.