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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

DIRECTOR'S REPORT ON THE PROPOSAL EXPAND PSYCHOLOGY SCOPE OF PRACTICE TO INCLUDE PRESCRIPTIVE AUTHORITY

Date: December 1, 2017

To: The Speaker of the Nebraska Legislature
The Chairperson of the Executive Board of the Legislature
The Chairperson and Members of the Legislative Health and Human Services Committee

From: Thomas L. Williams, MD
Chief Medical Officer
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Department of Health and Human Services

Introduction

The Regulation of Health Professions Act (as defined in Neb. Rev. Stat., Section 71-6201, et. seq.) is commonly referred to as the Credentialing Review Program. The Department of Health and Human Services Division of Public Health administers the Act. As Director of this Division, I am presenting this report under the authority of this Act.

Description of the Issue under Review

The applicant group is seeking to expand Psychology scope of practice to include prescribing psycho-tropics. A full summary is enclosed as follows:

> 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 is intended to 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, and ensure 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 psychology 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.

Summary of Technical Committee and Board of Health Recommendations

The technical review committee members recommended in favor of the applicants' proposal.

The Board of Health recommended against of the applicants' proposal.

The Director's Recommendations on the Proposal

Action taken on the six criteria:

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.

Action taken: I recommend against the proposal on this criterion.

Comments: Please see comments below.

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

Action taken: I recommend against the proposal on this criterion.

Comments: Please see comments below.

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.

Action taken: I recommend against the proposal on this criterion.

Comments: Please see comments below.

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

Action taken: I recommend against the proposal on this criterion.

Comments: Please see comments below.

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.

Action taken: I recommend against the proposal on this criterion.

Comments: Please see comments below.

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.

Action taken: I recommend against the proposal on this criterion.

Comments: Please see comments below.

Action taken on the entire proposal: I recommend against the proposal.

Comments:

All submitted enduring materials, including all letters, were reviewed. In addition, a literature review was conducted via internet (Google) search. Letters where cited, are referenced in the text. I have tried to cite and reference those comments and views which seemed most of value to me.

"The Proposal" in this document: refers to the submitted proposal, Prescription Certificate

Training in Nebraska (The Proposal):

The proposal is modeled after New Mexico and complies with the American Psychological Association guidance. Training and preparation are not re-summarized here, and are stated succinctly within The Proposal, pages 7-9, and elaborated as example in letter (1) . It is important to consider that the psychologist prescribing authority effort ("RxP") has a lengthy and controversial scientific, political, and certification history, spanning nearly 30 years, with an extensive literature which influences my decisions. ("RxP" has come to denote the psychologist prescribing movement). These considerations are by and large not fully represented within The Proposal and comments made and received.

Re-stated in brief, the evolution of RxP and psychologist prescribing is lengthy and complex. For example, Google "psychologist prescribing" and you get 560,000 hits. This is a national "movement" and it is now focused on Nebraska. The American Psychological Association adopted it as a policy goal in 1995. RxP was born in Hawaii

in 1984, and has been studied in depth there (See (2) which is very well written)—although Hawaii has not adopted RxP.

What have other states done?

Many states have deferred or delayed regulations for RxP and many bills have been submitted.

Dr. McGrath, a self-described proponent, notes (in 2010), "…..in the typical year, 7-8 states submit bills and a recent tally suggested that to date 88 prescriptive authority bills have been submitted in 21 jurisdictions (Fox et al. 2009). One reference summarizes total activity as 181 bills introduced in over half of all states, with now 5 approving. (3) Now including with Iowa approving prescriptive authority in June 2016 and Illinois in June 2014. (4) And Idaho this year. "As of July 2017, …bills have been slowed or their introduction deferred in Florida, Kentucky, Minnesota, New Jersey, New York, North Dakota, Ohio, Texas and Vermont, among others.." (5) The Illinois bill is unpopular with RxP proponents for being too restrictive, "…requiring extensive undergraduate prerequisite science courses and medical training comparable to that of a physician assistant, with severe restrictions on the types of patients who can be seen and drugs that can be prescribed (6). Prescribing has not yet initiated in Iowa and Illinois. Therefore, private practice performance in communities / states assessment data is not available except for Louisiana and New Mexico.

What is done internationally?

Psychologists in **Canada** do not have prescribing authority. A study by the Canadian Psychological Association in 2010 advocated for a stronger curriculum on psychopharmacology but made "no specific advocacy recommendation" (7).

Psychologists in the **United Kingdom** do not have prescribing authority (www.ocduk.org/glossary-psychologists). In spite of enormous mental health challenges (See: "Children's tsar savages NHS over 'unacceptable' mental health care" (Front page story, Guardian, October 15, 2017) and "NHS bosses warn of mental health crisis with long waits for treatment" (Front page story, Guardian, July 6, 2017).

How did RxP actually begin: The Department of Defense

There are concerns that the military experience is non-transferrable to a community practice environment.

The Department of Defense funded the Psychopharmacology Demonstration Project in 1989, and it survived 9 years (until 1997). This was the first experiment in psychologist prescriptive authority, and 10 psychologists were trained and were assigned to military hospitals and clinics. The initial cohort began training equivalent to a physician's assistant, however the three years required were determined to be too long, and the curriculum was cut from 1365 to 660 hours in the last two cohorts. An assessment (cited by the American College of Neuropsychopharmacology) of the program found that it was clinically very successful. The assessment did note that virtually all the graduates were skeptical of programs that abbreviated the training even further. The program was terminated due to cost and lack of need. ((4) most, which constitutes a detailed historical reference on RxP, circa 2010).).

There are concerns that the military experience is non-transferrable to a community practice environment. Patients treated included "...active military, retirees, and dependents ranging from 18 to 65. Many graduates had an initial practice primarily consisting of medically healthy active duty military personnel.... Medically healthy or uncomplicated, noting that individuals with complicated medical diagnoses were excluded from their practice." (2) The participants all had a doctorate in psychology and "...clinical experience ranging from a few to more than ten years prior to entering the program. The achievements suggested to the evaluation panel that the selection standards for any similar psychopharmacology training program should be 'high' " . "A full-time year of clinical experience, emphasizing inpatients, was deemed indispensable by most PDP graduates." (2)

Opponents contend that case complexity and comorbidities in many patients in their practices are a practical concern, complicating care.

RxP is described by its own supporters as a "movement":

One opponent notes,"The 407 committee has a difficult task to recognize the national scale on which the psychology prescribing movement, also known as RxP, is evolving and its current attempt to enter an allegedly vulnerable rural Nebraska....." (8) "As trailblazers in this realm, your decision on this bill will set the tone for other states that are considering this option as a way to improve access to care. (9)

Categorizing those opposed to RxP as a "small fringe group" (10) and The Proposal (Page 47) seems very disingenuous to the enormous and controversial literature on this topic over the last 30 years, in my opinion. A letter from the POPPP in opposition to

New Jersey's Prescriptive Authority bill (A2170) is signed by over 200 psychologists from throughout the United States. (11)

The psychologist (educational and curriculum) model and the medical model are different

Psychology ..... has been conceptualized as a discipline that rejects the medical model of emotional distress in favour of non-drug holistic, patient centred care." (4) Robert E. McGrath, a proponent of RxP, uses the term "movement" a number of times in his lengthy article reviewing the (then) 25 year history of the effort to obtain prescriptive authority for psychologists. In the same article he notes, "...most healthcare psychologists were educated in psychological models beginning at the undergraduate level, and pursued a career in psychology based on t heir attraction to these traditions. In contrast, medical students are primarily interested in biological intervention". (4) "In 2012 a textbook titled 'Handbook of Clinical Psychopharmacology for Psychologists' was published ..... In its forward titled 'Integrating Care: A forward on Changing Times' the authors touted the Affordable Care Act as an ideal vehicle for the expansion of their ideology that has taken its latest form in the Nebraska 407 proposal. 'The handbook...is an excellent treatise written for psychologists by psychologists; it is not a book written for physicians—though they may well learn from it—nor should it be. *RxP is not a mere replication of the medical curriculum; rather it fulfills the medical curriculum and surpasses it....it is, in fact, a unique integration and one that we believe is superior to the medical model.'* " (8) (Italics mine). This seems an exceptionally bold claim, given the limited empirical evidence available at this time.

Does the Medical Model (of education) matter?

As noted elsewhere in my comments, the approach to training for the prescribing psychologist departs from the "medical model", which is that followed for *all other prescribers* (various professions—italics mine) to date. Psychology has been conceptualized as a discipline that rejects the medical model of emotional distress in favour of non-drug holistic, patient centred care." (4) The biologic sciences are not an undergraduate or focus necessity for entry into the psychological field. The RxP model begins with an accredited post doctoral masters program provided by one of (now) four programs. A widely touted and experienced program is described (1) by Dr. Tackett. Further information is available on the course web site, including venues—this is "distance learning" (videotaped lectures, online resources, online chats and discussion boards, traditional readings, case formulation and presentation), 10 courses of 45 credits each, and base fees ($1,440 per course + additional) and a one hour each week chat. The course work takes 24 months and most students spend 6 – 20 hours per week it is said (website). The program overall is summarized in The Proposal (Page 7 and 8). Paragraph 6, page 7 details the course content which is daunting (basically

medical school). For some subjects, e.g "neuropathology", it is difficult for me as a pathologist to imagine what the relevant content could be for the near-non scientist—given that neuropathology is generally considered *by pathologists* to be one of the most difficult pathology subspecialties, requiring some of the most astute tissue microscopy skills in the entire field of anatomic pathology. One opponent offers concerns as follows, "Allowing psychologists to prescribe with the ability to "learn" to prescribe to doing a clinical rotation in 80 hours (what amounts to 1 week of residency for physicians, less than 0.05% of the time in an adult psychiatry residency alone) and seeing only 100 patients will cause Nebraskans to suffer . Even pharmaceutical representatives have 12 weeks of full time training for each drug and condition they are promoting. ..Many of our mentally ill patients have comorbid medical disorders… To be able to prescribe adjunct medications not specifically FDA approved in patients is also concerning." (12) Another opponent, a psychologist, reminds that, "More than half of the 30 most commonly prescribed medication for mental health conditions carry the FDA's strong "black box" warning, which cautions prescribers of the risk of serious…. deadly side effects." (13) In Louisiana, Medical psychologists may not prescribe narcotics. In Nebraska, narcotic prescribing would be permitted. ((2), p. 31) A letter from the POPPP in opposition to New Jersey's Prescriptive Authority bill (A2170) is signed by over 200 psychologists from throughout the United States. (11)

The hours and stages are well described in The Proposal.

How safe is RxP

Louisiana and New Mexico proponents pronounce the approach extremely safe, and effective.

Please see The Proposal which offers many testimonials, sincere. Represented testimonies pronounce RxP a remarkable and complete success.

However, there are confounding opinions and some early data to suggest otherwise. There is a very large data set https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/PartD2015.html from which prescriber patterns can be researched. Opponents reviewing the above argue that RxP has produced out of scope medications prescribing including warfarin, metoprolol, simvastatin, among others. I have not independently confirmed these allegations directly from the data set. In Louisiana, there have been lawsuits, as a matter of public record, and a reprimand by the Louisiana State Board of Medical Examiners.

Nicholas Cummings, former president of the American Psychological Association (asserts) …that when psychologists obtain prescribing rights "it remains to be seen …whether they abandon the hard work of psychotherapy for the expediency of the prescription pad." Dr. McGrath, an RxP proponent also writes, "The most serious concerns associated with RxP have to do with the potential for co-optation of the

profession by managed care, pressures to prescribe, and the hunt for an easy solution; and concerns about whether psychologists will be safe and effective prescribers. These are serious objections. In particular, the concern about loss of identity should not be taken lightly..." (4) There are a small number of prescribing psychologists worldwide and little research has been done on their practice and prescribing rates." (14) A recent article (15) supports prescribing safety, but the data set is limited (24 medical colleagues and 27 prescribing psychologists). The article also notes that 2/3 of prescribing psychologists experienced increased income.

Others ask, are medications synonymous with mental health care? A recent article (16) reports medications produced poorer long term outcomes in treating depression with antidepressants, suggesting that these are prescribed too heavily, and should not be relied upon.

American Psychological Association as certifying authority is unique in healthcare certification:

This is highly unusual, if not unique, in healthcare. The Nebraska Medical Association states that it is unprecedented conflict of interest in medicine to allow a member-supported professional association to accredit and oversee those members. (17) The American Psychiatric Association states that no other voluntary, dues paying membership organization in any medical specialty (e.g. cardiology, obstetrics and gynecology, psychiatry) has created such an exam—or do national professional advocacy associations for nurses and physician assistants accredit their graduate programs. (18)

The Proposal notes that , "The national competency examination for prescribing psychologists is evolving and will be managed next by the Association of State and Provincial Psychology Boards, " (ASPPB) which provides certifying examinations for clinical psychology—in other words the usual model. At this time the ASPPB does not offer a position statement or commentary regarding RxP, at least that I am able to find on www.asppb.net/), nor does the American Board of Professional Psychology which certifies approved specialty areas of psychology (www.abppp.org).

For the record, there are PhD's who actually DO have an extensive background in clinical test development and performance, and in some of their practices likely make rounds and definitely provide clinical consultation to providers, regarding aspects of laboratory test interpretation. Their principal professional organization, the American Association for Clinical Chemistry of which I was a member for decades, offers certificates of special competence, but does not *board* certify directly; a separate certifying entity, the American Board of Clinical Chemistry does.

Laboratory Tests Are Medical:

As a pathologist subspecialized in Chemical Pathology, factually there are no laboratory tests directly assessing psychiatric disorders. Although, very many tests assess medical parameters which indirectly can produce mental signs and symptoms. An oft quoted phrase is that, "70% of medical decisions are laboratory related". Furthermore, some commonly ordered tests are not simple for physicians to interpret, even with medical backgrounds and having been educated within the standard (educational) "medical model": thyroid function assays being one example. All tests require medical assessment for interpretive purposes, and some test results require a decision *quickly.* Over time, medical practitioners can and I believe do develop "unconscious competence" not just with abnormal results, but abnormal results that they find new or unexpected in *a specific patient.* Meaning, the results may be startling in one patient, but not another, given recent medical findings or situational changes. In other words, some results are abnormal, and some are *shockingly* abnormal. The "shock value" is medical and experiential for the practitioner. A temporal relationship between the test result and a medically trained brain can matter.

The physician is not always involved before prescribing in the U.S.

In Louisiana, "...Advanced Practice Medical Psychologists ....function more independently. Collaboration with the patient's primary care physician is still mandated but that collaboration can take place during the normal course of provider interaction rather than being mandated before a prescription can be written" (Act 251, 2009) (19)

The access question:

Testimonies and reports are in conflict. New Mexico has experienced increased access according to The Proposal p. 56-59 (numerous positive testimonies). Conversely, it is claimed that, "There is no evidence to suggest that prescribing and medical psychologists in New Mexico and Louisiana have significantly addressed rural access issues as less than 7 percent of those prescribers practice in non-metro areas across both states (Tompkins and Johnson, 2016)". (13) "Evidence from New Mexico and Louisiana, which have had prescribing laws on the books since, 2002 and 2004, respectively, show little, if an, expansion of access to mental health care in rural or other underserved areas..." (5) One opponent opines that the data within the proposal derive from "... an opinion survey and individual quotes." (20) Opinions and testimonials from Nebraska also conflict, generally with psychologists expressing concern ((21) and (22) are especially well written letters, and those deriving from primary care and psychiatrists

articulating opposing views and solutions ((23) from panhandle psychiatrists. One opponent cites "The most recent study from the US Department of Health and Human Services shows that when compared to our neighboring state, and the US in general, the numbers of mental health providers Nebraska has puts us as one of the highest ranking states. Nebraska is also one of the highest ranking states for tele-psychiatry services." (20) The Office of Program Policy Analysis and Government Accountability (Florida Legislature) published April 2009, is titled, "Limited Evidence on Other States' Experiences That Allowing Psychologists to Prescribe Psychotropic Drugs Improves Access to Mental Health Services" (Report No. 09-26).

How does the integrated care model fit?

Both proponents and opponents advocate an integrated care model, although this seems reflected more consistently in the opponents' material. Thus, ideally a patient in need of mental health care would receive a warm handoff to a psychologist embedded within or proximate to the medical practice. There seems to be relatively minimal overt attention in the proposal to referrals for complex psychological / psychiatric care. Psychiatric nursing includes training specifically targeting when to refer, but the phrase "referral..." or "refer to a psychiatrist" in is not found in The Proposal. Although The Proposal does reference referral to other professions or specialty care. One could be concerned that the proposed model could be understood (or misunderstood ?) to be represented in the formula: "prescribing psychologist + medical MD = psychiatrist".

Tele-health expansion is in Nebraska's future:

I attended a full day session on Project Echo along with Behavioral Health personnel and other largely behavioral health related entities at the College of Public Health, May 18, 2017. Project Echo uses a hub and spoke model to distribute specialty care to underserved areas. Suggestion, Google "project echo". It is actively being actively pursued by Behavioral Health DHHS and UNMC at this time (specifically focusing on opioids). (Personal Communication, Sheri Dawson and Tamara Gavin, NE DHHS, Nov. 2017). Telepsychiatry is also active in Nebraska, with one provider noting providing several hours per week of telepsychiatric services via Amercan Well ™. (12) (Google "Amwell").

Summary Comments:

This proposal offers promise and pitfalls. At its very base, there are proposed benefits including psychiatric medication access by enabling psychologists to prescribe, after a post-doctoral "medical school-like" didactic and experiential curriculum. Which raises medical practice safety concerns. Versus, the current model of medical prescribing, without the full behavioral health training implicit within clinical psychology, which conjures appropriateness of treatment concerns.

The proposal is thorough and detailed, and the proponents should be commended for their efforts and passion. The proposal is however, the result of a movement which came to Nebraska. It did not arise here.

The access considerations are intriguing but by testimony and limited accumulated data, outcomes are controversial.

The Proposal cites very favorable data regarding safety, but as noted above, the community experience to date resides within two states, overall data are limited, and the experience has not been flawless.

In spite of extensive legislative efforts consisting of numerous bills, in multiple states, the majority of states have proven gun-shy.

I am concerned about the confidence exuded by proponents defecting from the traditional model of healthcare education in the United States. That is not to say that the post-doctoral model *can't* work. But it is to say that this represents a fundamental departure, unique among our professions prescribing in healthcare today. It is, to a degree, arguably, experimental.

There are other PhD's today, who have extensive knowledge in physiology, medical diseases, laboratory test nuances and interpretation. As a chemical pathologist, I have worked with many fine PhD Clinical Chemists, who work in laboratories and health care organizations, as well as industry. Quite a few years ago, at a professional chemistry meeting dinner, my wife, then a practicing academic radiologist at UNMC, and I had an enjoyable evening with a nationally renowned PhD clinical chemist. We talked extensively, discussing laboratory tests and medical disorders, in addition to small talk. Afterward, I asked Sue, "What did you think of Bill?" (Not his real name). Her answer stunned me. She said simply and emphatically, "He doesn't think like a doctor." This statement may or may not be relevant here, but that uncertainty is troubling. Prescribing does require medical thinking, sometimes unexpectedly.

One consistent message, agreed upon by all, is that we need psychologists to be psychologists. Clinical and academic psychology's contributions to healthcare have been and will continue to be critical.

References:

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15. Linda WP , McGrath RE. The Current Status of Prescribing Psychologists: Practice Patterns and Medical Professional Evaluations. Professional Psychology: Research and Practice 2017, vol. 48, No. 1, 38-45.

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17. Letter, Nebraska Medical Association

18. Letter, American Psychiatric Association

19. Letter, Ally

20. Letter, Wetzel

21. Letter, Schaffer

22. Letter, Talbot

23. Letter, Michael and Scanlan