March 10, 2020

Dear Chairman Pendergrass and Honorable Members of the Committee:

RE: Support – HB 1461: Behavioral Health Programs – Outpatient Mental Health Centers –Medical and Clinical Directors

My name is Sanaz Kumar, and I am a licensed physician who is triple board certified in adult, child and forensic psychiatry. I practice medicine at an Outpatient Mental Health Center in Maryland. I am writing to express my support for HB1461 which requires that a medical director of an Outpatient Mental Health Clinic (OMHC) be a licensed physician.

I would highlight the following points in support of HB 1461.

1) Physicians are uniquely trained to lead multi-disciplinary medical teams. The training that psychiatrists, who are medical doctors, have is not equivalent to that of nurse practitioners.

The Code of Maryland Regulations (COMAR) § 10.21.20.10 requires that *medical directors* of OMHCs establish and maintain appropriate standards for diagnosis and treatment, including therapeutic modalities and prescribing practices. Medical directors are also responsible for medical aspects of quality management and ensuring adequate clinical supervision of treatment staff. These responsibilities are precisely what medical training prepares us physicians to do: use our extensive, detailed medical knowledge to ensure that health systems are implementing safe, evidence-based protocols when managing patients with various disease states.

Physicians must follow a standardized and highly regulated path before we can obtain medical licensure and practice independently; our rigorous training uniquely prepares us to lead multi-disciplinary medical treatment teams.

During medical training, physicians acquire approximately 15,000-20,000 hours of clinical experience. By contrast, nurse practitioners may accrue as few as 500 hours of clinical experience during their training. Before practicing independently, a board-certified child and adult psychiatrist likely has completed 14-years of training (four years of college, four years of medical school, six years of combined residency and fellowship); meanwhile, a psychiatric nurse practitioner may have as few as five to six years of training (four years of nursing school, 15-24 months of an online nurse practitioner degree) before entering practice.

Physician Training

Aspiring physicians must first complete an undergraduate degree, including a course load heavy in the basic sciences. We must score competitively on the Medical College Admissions Test (MCAT) in order to secure admission to a medical school. While attending a four-year medical school at a brick and mortar institution, we must pass three national licensing examinations. Upon graduation, physicians who elect to specialize in psychiatry must complete at minimum a four-year residency in general adult psychiatry. Residencies are rigorous apprenticeships. During

residency, psychiatric physicians may work as many as 80 hours per week, diagnosing patients with a range of conditions (e.g., schizophrenia, bipolar disorder, neurodevelopmental disorders, substance use disorders). We also develop complex treatment plans, prescribe medications, and manage suicidal patients across a range of settings (e.g., inpatient, outpatient, drug rehabilitation centers). Psychiatrists who wish to then specialize in child-psychiatry must complete an additional two-year fellowship in this subspecialty.

These many years of training are necessary because it is during this time that we, psychiatrists, learn (1) how medical disease states and associated medications affect patients with psychiatric illness and (2) how psychiatric illness and medications affect other medical illnesses. Further, it is during these years that we, physicians, are trained to critically evaluate medical literature so that we can practice evidence-based care and optimize patient outcomes.

Nurse Practitioner Training

Nurse practitioner training is not standardized, and there is a great deal of variance among program requirements. For example, Vanderbilt's nurse practitioner program does not require registered nurse (RN) clinical experience and Georgetown's program does not require an applicant pass the GRE. US News and World Report recently published an article highlighting at least 14 nurse graduate programs with 100% acceptance rates (Kowarski, 2019). Moreover, some nurse practitioner programs are now online while others are not. There is variability in the curriculum and structure these nurse practitioner training programs offer.

An individual can become a nurse practitioner after earning bachelor's degree in nursing and attending a 15 - 24 month online training program. Clinical exposure during nurse practitioner school is limited to shadowing or observing providers; in this way their training is different from the apprenticeship experience of a residency. Further, nurse practitioner training is not designed to prepare students to develop clinic policies, critically evaluate medical literature, and lead and supervise medical treatment teams. Nurse practitioners may be integral to the medical team, but their role is not interchangeable with physicians, who are trained for more than one decade to serve in medical leadership roles.

2) Patients want and trust physician-led care.

Patients consistently report a preference for physician-led care. Nurse practitioners are an integral part of a medical team; however, patients feel most comfortable when their treatment team is directed by physicians. In recent surveys conducted by the American Medical Association (AMA), ***75% of respondents reported that patients benefit when a physician leads the health care team*** (AMA, 2018). Further, 88% of respondents affirmed their belief that "while nurse practitioners are essential to the health care team, they should assist the physician, who should take the lead role in determining the type and level of care to be administered" (AMA, 2018). Finally, 70% of respondents asserted that "nurse practitioners should not be able to practice independent of physicians, without physician supervision, collaboration or oversight" (AMA, 2018). Patient preferences are clear and unambiguous: patients seek and trust physician-led treatment.

3) Psychiatric patients are more likely to have chronic medical illnesses and die prematurely than the general population. Therefore, these patients need the expertise offered guaranteed by physician-led care.

Research consistently demonstrates that patients with severe mental disorders have greater medical needs than the general population. The World Health Organization (WHO, 2016) reports that there is a 10 to 25-year life expectancy reduction in patients with severe mental disorders. (WHO, 2016). Further, studies show that 68% of adults with mental disorders have other medical conditions (Druss and Walker, 2011). For example, patients who have depression are at increased risk of coronary artery disease, diabetes, stroke and other chronic illnesses (NIMH). The converse is also true: patients with chronic medical conditions (e.g., cancer, coronary artery disease, diabetes, epilepsy, and some auto-immune disease) are more likely to experience depression (NIMH).

Further, many psychotropic medications which are used to stabilize mood and treat psychosis can cause or exacerbate chronic medical conditions including hypertension, hyperlipidemia, diabetes, obesity, and risk of coronary heart disease. Some of these medications can also cause permanent involuntary movements (tardive dyskinesia), breast tissue development (gynecomastia), and other serious adverse medical effects. Alternatively, medical illnesses and medications can exacerbate psychiatric illness (e.g., steroids can induce manic states). Understanding how disease processes affect one another and complex drug-drug interactions is crucial for patient safety.

Prescribing for children presents unique challenges; the medications we prescribe directly affect developing brains and thus require an abundance of caution. Because less research and medical literature to guide these prescribing practices, it is so important for medical directors to be well-trained with a deep understanding of current standards of care.

Patients with severe mental disorders comprise a particularly medically vulnerable segment of our population. Physicians are uniquely trained to understand disease processes and complex medication interactions because of their extensive training. Accordingly, to ensure patient safety, physicians must direct care in outpatient medical settings.

4) Code of Maryland Regulations (COMAR) consistently defines medical directors as licensed physicians. It is discriminatory for outpatient mental health centers to have a different standard.

Throughout COMAR, medical directors in various facilities (e.g., nursing homes, dialysis centers, hospice centers, opioid treatment centers, etc.) are defined as licensed physicians, not nurse practitioners. It is discriminatory for outpatient mental health clinics, which serve patients with psychiatric illness, to have a different standard than other medical settings. Psychiatric illnesses have a biological basis -- just as diabetes, hypertension and coronary artery disease do. Medical facilities which serve patients with psychiatric illnesses should not be held to a different standard. COMAR recognizes the importance of physician training and accordingly defines medical directors as physicians throughout the regulations. Failure to apply the same standard to medical leadership in outpatient mental health centers is be discriminatory towards patients with

psychiatric illness. Mental health parity is crucial, particularly as we are in the midst of a mental health crisis.

5) There is no shortage of psychiatrists in Maryland.

Maryland ranks within the top 10 states for both number of psychiatrists and concentration of psychiatrists (Beck 2020). This is true across psychiatric subspecialties including adult psychiatrists, child psychiatrists, and addiction psychiatrists. There are licensed board-certified psychiatrists state-wide who are able to meet the mental health needs of Maryland residents.

Also, of note, Washington DC has the highest ratio of psychiatrists compared to all fifty states, with approximately 50 psychiatrists per 100,000 population (Beck, 2020). Many psychiatrists in Washington DC commute across city lines to treat patients in Maryland. For example, although I am a resident of Washington DC, I have exclusively practiced at a Maryland Outpatient Mental Health Clinic for several years. There is a large pool of licensed, board-certified physicians in Washington DC who can also treat the mental health needs of Maryland residents if provided an opportunity.

6) Telepsychiatry removes geographic barriers within the state and improves access to care in rural areas.

Psychiatrists throughout the state of Maryland can serve as medical directors in remote and underserved areas using telehealth technology. In 2019, the Maryland General Assembly passed SB0178/CH0275, authorizing medical directors of outpatient mental health centers to serve their role through telehealth, rather than on-site. This law gives the large pool of Maryland psychiatrists access to patients in the most underserved and remote areas.

Telehealth allows physicians and other providers to safely and effectively assess patients who are miles away. For example, psychiatrists at the Outpatient Mental Health Clinic (OMHC) where I work see patients living in Cecil County from their home offices, which are hours away. I have psychiatrist colleagues who live in Baltimore suburbs, but have treated patients on the Eastern shore for many years through telepsychiatry. Telehealth has great promise, and unfortunately, it is currently underutilized in Maryland.

7) Despite the supply of psychiatrists in Maryland and the telehealth capacities, OMHCs in Maryland are not making a bona fide effort to hire psychiatrists.

The unfortunate reality is that Outpatient Mental Health Clinics are not making a bona fide effort to hire psychiatrists. Since nurse practitioners were given independent practice privileges, the number of physician recruitment ads placed with Maryland Psychiatric Society (MPS) has sharply decreased. For example, during a hearing on civil commitment, Dorchester General and Fredrick Memorial reported that they were unable to hire psychiatrists. Neither of these facilities placed a recruitment ad with MPS. Further, I have been told of cases where OMHCs are offering prohibitively low physician compensation packages and then hiring a nurse practitioner instead. In Maryland, we can fill medical directorship positions in outpatient OMHCs if positions are appropriately advertised and fairly compensated.

8) Solutions: Hiring regional medical directors and implementing telepsychiatry appropriately will facilitate access to care.

Those who oppose HB1461 will argue that access to care is their primary concern. Maryland boasts a high number of psychiatrists, including those with subspecialty in child psychiatry and addiction psychiatry. These physicians can effectively provide medical directorship using telehealth technology. There are economic ways to make this work as well. For example, hiring a regional medical director who oversees a multiple local OMHCs could reduce cost and improve access. Safe, appropriate alternatives should be explored. Psychiatric patients want and deserve physician leadership just as patients with physical illnesses do.

For all the above reasons, I ask for a favorable report on HB 1461. Please feel free to contact me directly with any questions about this testimony at sanazkumar@gmail.com.

Respectfully submitted,
Sanaz Kumar, MD

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