Alvord | Baker & Associates, LLC

3200 Tower Oaks Blvd Suite 200 Rockville MD 20852
p 301.593.6554 f 301.255.0461

8401 Connecticut Ave Suite 1120 Chevy Chase MD 20815
p 301.593.6554 f 301.754.1034

February 11, 2021

The Honorable Paul G. Pinsky, Chair
The Honorable Cheryl C. Kagan, Vice-Chair
2 West
Miller Senate Office Building
Annapolis, MD 21401

RE: SB 500 – PSYCHOLOGY INTERJURISDICTIONAL COMPACT

Dear Senators Pinsky and Kagan, and Members of the Education, Health, and Environmental Affairs Committee,

I am a constituent and am writing to ask you to **support SB 500, the Psychology Interjurisdictional Compact**. I own a home in Legislative district 14, own an office condo in Legislative district 17 where I practice, and lease office space for our second practice location, in District 18. Prior to private practice in Montgomery County, I worked in Calvert County as part of the Cheltenham Tri-County Outreach Program (now RICA - Southern MD) and later worked at RICA-Rockville.

I have been Licensed as a Psychologist since 1979. I am the Director of a large group practice with offices in Rockville and Chevy Chase and have been providing and advocating for telehealth for more than a decade. I co-chaired the Telehealth and New Technologies committee at the American Psychological Association from 2011-2013. I am defining telehealth as real-time, audio and visual video conferencing.

Since mid-March 2020, I have trained about 10,000 mental health practitioners in ethical and effective telehealth. While everyone had to pivot to telehealth during the pandemic, it is imperative that this process continue with fewer barriers to increase access to mental health care and continuity of care after the Public Health Emergency ends.

My experience and that of my practice with telehealth will be outlined here. Of note, our Rockville office is near Virginia and our Chevy Chase office is about 2 miles from Washington DC. Our clients, while primarily Maryland residents, include children, adolescents, families, and individual adults who live and work in multiple jurisdictions. Currently, on behalf of my Maryland clients, I hold temporary licenses in Texas, Maine, and Massachusetts and have been allowed to also telehealth into Pennsylvania, Washington DC, and Arizona. These temporary licenses will end once the emergency orders cease.

Observations.

(1) Telehealth is here to stay.
(2) Client mobility from state to state is here to stay.
(3) Divorced parents living in different states is here to stay.
(4) Some client having dual residences is here to stay.

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(5) Maryland needs to protect its citizens and allow them to sustain treatment with a licensed doctoral-level Psychologist of their choice.

Due to the fact that nearby jurisdictions (and many across the country) have allowed temporary licensure (typically with no fees), we have been able to provide continuity of care during the pandemic. During the pandemic, most college students who were to go to their respective campuses, but instead stayed home, or who perhaps went and were sent back home shortly after due to a COVID19 outbreak on campus were able to continue therapy in most (not all) jurisdictions. The uncertainty associated with where they would be increased anxiety and exacerbated the mental state we and they were dealing with. It has been a lifesaver to have been able to provide care wherever they might have been located.

Scenarios presented below represent true cases based on submission from the 15 psychologists and 4 clinical social workers in the practice over the past 9+ years. All identifying information has been removed. Some examples relate to multiple cases:

Affordability. If a client must take several hours of leave to come to an appointment, they would lose pay. Partly affects those who are hourly workers.

Short check-in. Sometimes the best therapeutic intervention means a short check-in or "booster" session. The most efficient approach is to do a session via telehealth. This allows for short, 20-minute check-in sessions or longer exposures whenever and wherever they are relevant. Clients are increasingly mobile providing challenges to do this legally out-of-state.

Children living with parents who are located in two different jurisdictions. Some divorced parents live in MD and while the other parent may live in DC, VA, or another state. Many children split their weeks between households. I had several cases in which the weekly appointment resulted in the child being in DC. In these cases, pre-pandemic, I was not able to provide telehealth services when the child was not with the parent in MD.

Temporary or ongoing physical mobility challenges. A client who lives in DC had surgery and was unable to drive for more than a month. The client had been driving to one of our offices to have therapy sessions in person. We could not provide services to this client during that period of time. Another client developed a neurological condition that made mobility difficult. It was worth driving for the 45-minute session. However, when we reduced frequency of sessions and finally did "booster" sessions of 20 minutes, it took more time than that for this client to get into the car due to physical difficulties.

Equity. A client who misses a significant amount of time from school to attend appointments (several hours a week for travel and session) because the client lives in an area of DC without adequate mental health specialty services. During the pandemic, the telehealth option has allowed the client to continue therapy without the added stress of missing class time and incurring make up work.

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Weather. Over the years, when the weather has been predicted to be inclement, we have posted a notice on our website that if someone is not comfortable getting to our office, they could call their clinician and set up a telehealth appointment. While client response was extremely positive, this posed a problem for those of us not licensed in DC or VA. We are also limited by not being able to run the many Resilience Builder Program® groups if weather is poor when even **one** child or teen is from another nearby jurisdiction.

Transportation. If a child or teen who lives in DC or VA at the last minute cannot get a ride to the appointment, bus or metro travel would take too long unless it were pre-planned. Under these circumstances, the client would miss the appointment and likely be charged for that time.

Work in jurisdiction outside of MD, while living in MD. When providing family therapy, one parent may be located in MD while another is in another jurisdiction. The problem/question is whether the parent in the other jurisdiction, say, DC or VA, can be included in the telehealth session.

Being in the DC metropolitan area puts us on the border of three jurisdictions where clients often cross boundaries for work. Clients have sometimes had to skip therapy sessions due to lack of time to travel for appointments, forcing them to choose between work and healthcare. We should continue to support measures that remove barriers to treatment and increase accessibility.

Homes in two states: A client living in Maryland may also have a home in Delaware at the beach (we have many of these). Without interjurisdictional practice, we have to coordinate schedules for them to be in Maryland. Some drive to the Maryland border and sit in their car or find another private space. What do we do if they are in Delaware for an extended time? Continuity of care is the issue.

College students: This represents a frequent problem in which, either as a transition (until they find services in college) or for longer term treatment, the student would like continuity of care while attending college out of state. College students in this situation provide a particular challenge to us as psychologists, as there are waitlists at the university counseling centers and often a limited number of sessions allowed. What we frequently face is that despite significant effort to find a new local therapist, the client remains on several provider waitlists. Student health services often offer inconsistent support due to the high demand for mental health services. In addition to asking clients to relinquish the therapeutic relationship, there are also major barriers with provider availability in some areas.

In addition, there are numerous breaks (fall, winter break) when the students might be home for more than a month. Further, there might not be specialists either at the university or in the nearby community who are trained in evidence-based therapies, such as treatment for Obsessive-Compulsive Disorder. The question/problem is how to provide continuity of care?

Specialty expertise. We specialize in evidence-based services and offer Cognitive Behavior Therapy (CBT) for Obsessive-Compulsive Disorder (OCD), exposure and response prevention, Trauma-Focused

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CBT, tics, trichotillomania, Selective Mutism, Parent Child Interaction Therapy (PCI), Autism Spectrum Disorders, Gender issues, and LGBTIA issues.

Language barriers (foreign and ASL). Telehealth offers the ability for continuity of care for a multilingual clinician and/or including others to serve as interpreters (language and ASL). State lines limit those possibilities.

Co-morbidities (multiple diagnoses). We have many young adult clients with multiple diagnoses. We support them through whatever the transition process might be, but we have had a client for example, who landed their first job – a job which has them working in multiple states. As this job is their first, they want continuity of care. Further, it is difficult to find a new psychologist that would be able to meet all of the requirements of expertise and who is allowed to practice in all (or even many) of those states.

In another situation, we worked with a child newly diagnosed with Autism Spectrum Disorder. The family suddenly moved to another state due to the parent's job requirements. It was incredibly stressful for them because they were moving to a state where they had no connections or knowledge of any system. It would have helped this child's transition if continuous care could have been provided as they settled.

In another case of a child client with several developmental disorders and anxiety, the parents relocated to another state. They needed to leverage family support for distance learning, and their own need for respite care. Due to the long, demanding drive and the adjustment issues, there were critical care issues that emerged and required support and continuity of care until new services were found.

Waitlists. For people who need Exposure/Response Prevention for CD or other specific therapies, waitlists create a lapse in treatment when another provider is not immediately available in another state. Waitlists have become the norm for evidence-based practices. Thus, it makes it challenging to transfer a client within a short timeline if they move out of state. We would like to help transition them.

Temporary Licenses. Pre-pandemic and during the pandemic, for those states that require a formal temporary license, the process typically has taken weeks for approval, leaving the clients without services until the temporary license is approved.

In addition, one does not always know when treatment might be ended or whether the client has other concerns to address. The investment in the relationship of trust and understanding makes it easier and preferable to see the same psychologist for different concerns over time --- even when client and clinician are no longer in the same jurisdiction. The challenges of obtaining temporary licensure act as a barrier to continuity of care and provide the risk that the client might not seek help or spend more time in treatment if a new therapeutic relationship has to be built.

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Gender affirming. Case example: "They" refused to see other therapists, as "they" felt I understood "them" and "their" history well. It would be "too much of a loss," to stop seeing the clinician. "They" said. "They" would drive every week to a parking lot on the border between X and MD.

These are just a few examples of the many challenges that clients have faced over the years because interjurisdictional practice has been not been possible without Psychologists becoming licensed in multiple states. This is especially critical for our clients who live or work in bordering states. Remote working, remote learning and mobility is on the increase. Maryland can be a model state supporting interjurisdictional practice while maintaining high standards for their residents and those seeking services from Maryland providers. Telehealth decreases barriers and therefore, increases access to care. Mental wellness leads to resilience of individuals and our communities. Continuity of care is the greatest advantage secured by telehealth by qualified psychologists and interjurisdictional practice.

Respectfully submitted,

Mary K. Alvord, Ph.D.