The legislative calendar had a hiatus due to needed repairs at the Capitol Building as well as to make sure that there was a clear majority in the house. Elections to fill vacant seats and a patch to a leaky ceiling are now complete, and the business of government continues.

We provided written testimony before a joint meeting of the House Committees of Health and Professional Licensure, designed to address problems with access. The PA Medical Society provided effective in-person testimony as well, highlighting the importance of comprehensive training as received by physicians (including psychiatrists). Much of the meeting was centered around independent practice for nurse practitioners, but the possible prescribing psychologist bill (HB 1000) also received some attention. At this point, we are cautiously optimistic that the Professional Licensing Committee will not proceed with the current bill. We stand ready to talk with other stakeholders about real concerns that need to be addressed.

There is an effort being made by the administration to loosen the requirements of in-person psychiatrist time in licensed psychiatric clinics. It is a bit muddled, but currently there is a requirement that there be two hours of psychiatric time for every clinician in an outpatient clinic. The wording is unclear—it also references supervision as well as a requirement for the "direction" of a psychiatrist. We have been working with the Rehabilitation and Community Providers Association, which has been working with OMHSAS to get more time for telehealth spelled out.

There is also an effort to allow more time to be provided by Advanced Practice Professionals (Certified Registered Nurse Practitioners and Physicians’ Assistants) in lieu of a psychiatrist. The very real problem many agencies have in recruiting sufficient psychiatrists needs to be addressed.

We are working on a compromise that acknowledges the need for our knowledge and skills. We are hoping to include reference to a collaborative agreement with a psychiatrist and explicit reference to the provision of psychiatric time in outpatient mental health clinics.

Collaborative care continues to be a high priority as a means of addressing the problem of access. We are hoping that next year’s budget will recognize the need for state help in advancing collaborative care. Whether this needs to be done by a specific piece of legislation or by budget wrangling remains to be seen.

We are cautiously optimistic that our efforts to address the shortage of psychiatrists in the commonwealth may be close to bearing fruit. We are working with several members of the house and senate to introduce legislation modeled on what was done in New Jersey—state funding for an additional residency slot in each existing residency program over the four years of training. PA did this last year with family medicine—it is time for psychiatry.

Please contact me, or any other member of the committee, to discuss concerns. I again urge everyone to be engaged in the process by meeting with their own legislator. As we spoke about at last month’s advocacy webinar, elected representatives want to hear from informed constituents; we can help them.
We’re hoping that members will take seriously our ongoing call to be in touch with their elected representatives. There is a tip sheet on Grassroots Outreach prepared by our lobbyist Lois Hagarty, who knows well what works and what does not. This article will highlight our main advocacy objectives, with brief talking points. It is hard to over-emphasize how important this is.

Many of the items mentioned in the fall article continue to be at issue. HB 1000 on psychologist prescribing sits in the Professional Licensure Committee. HB 849, trying to get back the $100M allocated in the June 2022 budget for adult mental health has gone nowhere in the Senate, and we still face a 3.4% Medicare cut in physician reimbursement (federal I know, but infuriating, and one more reason to be careful about single payer.)

There are some new things: Governor Shapiro has appointed a Behavioral Health Council (www.governor.pa.gov/newsroom/governor-shapiro-signs-executive-order-streamlining-mental-health-substance-use-disorder-efforts-to-improve-accessibility-across-the-commonwealth) which takes up where the Behavioral Health Commission left off. That was the Commission that recommended how the $100M should be spent; their recommendations were shelved in favor of a mental health counselor in every school. There is also an advisory committee to the Council. We are counting on several of our PaPS members who are in these groups, as well as our allies (e.g. Rep. Mike Schlossberg, D-Lehigh County) to be advocates for our policies.

The state House of Representatives is very evenly divided, such that a resignation to run for higher office, or an illness or death, can have out-sized implications. Neither the House nor Senate are in session, though committees can meet, and are doing so. We do not expect the House to return to session until March; very shortly after that the budget wrangling will start. Unclear how that will go this year, with such evenly divided government, but last year was fairly smooth. Much of the harder negotiations happened afterwards, when the fiscal code bills (which say exactly how the money is to be spent) were voted.

HB1000 (Frankel) calling for psychology prescribing continues to be a major focus. We are engaged in a discussion with the committee and staff about areas we might compromise with the sponsors on, and expect this to continue. After all, psychologists would be able to prescribe if they went to medical school, or got a nurse practitioner or PA certification. Talking points:

1. Access to mental health services does not mean access to mental health medication. There is a shortage of psychologists as well as psychiatrists.
2. Current psychological training requires no knowledge of medicine. To get up to minimal competency will take a lot of time and effort.
3. There are fewer than 250 psychologist prescribers in the country despite more than 30 years of efforts, and 6 states with authority; most psychologists value what they do well and have no interest in trying something they are likely to do less well.
4. Psychotropic medications affect the entire body, and many medical conditions can require changes to prescribing.
5. Psychologists will always need to coordinate care with patients’ primary care physicians, who are in the best position to handle the medications; no need for another person writing prescriptions. Patients need psychologists’ to give input, not prescriptions.
6. There are better, safer ways to increase access to mental health services, such as increased funding for collaborative care and more psychiatry residency slots.

Collaborative care funding SB 465 (Farry) and HB 24 (Struzzi). Talking points:

1. Collaborative care is a form of structured consultation to primary care offices by psychiatrists, who share a medical record, review notes from embedded behavioral health clinicians, and make recommendations for care without necessarily seeing the patient.
2. There are already charge codes to reimburse practices for this service, but the startup costs are a difficult hurdle.
3. These bills would appropriate funds to cover these costs, as well as fund technical support.

Increase in number of psychiatry residency slots. We are in the process of developing a bill to get state funding for additional residency slots. Talking points:

1. This was done in New Jersey (one extra for each program there).
2. Last session the legislature approved funding for more family medicine residency positions.
3. Funding out of Washington through CMS has increased some (through strong APA efforts) but more needs to be done.
Involuntary commitment for substance use disorders SB 962 (Laughlin/Williams). Concern over opioid overdose deaths has led some to suggest that an overdose requiring Narcan should trigger involuntary treatment for addiction.

Talking points:

1. The bill is unclear where and how this commitment would take place.

2. Psychiatric units are already in short supply, and are set up to manage serious mental illness such as psychosis/schizophrenia and depression/bipolar disorder/suicide attempts; addiction treatment is very different.

3. There is no data suggesting that involuntary treatment, except in cases where jail is the alternative, has any impact.

4. Many people would hesitate to get overdose treatment for themselves or a loved one if it could mean involuntary confinement, even for treatment.

Please talk to your elected representative. They are (nearly) all hard working smart individuals who are doing their best to make Pennsylvania a better place. They can use our help to make this happen.

Grassroots Advocacy

Legislators represent people based on where they live, not where they work. Use the General Assembly’s Find Your Legislator - PA General Assembly (state.pa.us). Read up on your legislators via their public profile on the Pa. General Assembly website. Know what Committees your legislator serves on, Caucuses they serve on, particular interests, their political party, and terms in office.

The Meeting

Meet in person with your legislator in their district office. If they offer a staff person instead, go ahead and meet with the staff person. If you do not have time to go to their office, schedule a virtual meeting. Email is not an effective advocacy strategy. A letter is better than e-mail, but an in-person meeting is most effective.

If you have not met you legislator previously introduce yourself and explain the Pennsylvania Psychiatric Society, and if needed how a psychiatrist differs from a psychologist, social worker, and other allied mental health care professionals.

Emphasize being a resource to the legislator and staff on mental health issues now and in the future.

Focus on 2 or 3 issues only. If you are going to discuss a bill, make sure you have read the bill beforehand and bring the bill and talking points with you. Use the Bills and Amendments - PA General Assembly (state.pa.us) on the General Assembly Website. Be prepared to discuss the position of the opposition.

Thank the legislator.

Follow Up

Send a thank you note that includes a brief summary that reinforces the major points that you discussed during the meeting.

Advise the Co-Chairs of the Government Relations Committee of the result of the meeting.
Psychologist prescribing is being pursued in Pennsylvania, one of several states the American Psychological Association has targeted for such efforts. A bill (HB1000) has been introduced in the General Assembly by Representative Dan Frankel, a Democrat from Pittsburgh who touts it as a way to help solve access to mental health services.

The Pennsylvania Psychiatric Society has been working against the bill as written in various venues. Even at the level of the co-sponsorship memo Rep. Frankel sent around in April, we notified the legislators of our belief that this will do nothing to help with access—there is a shortage of all forms of mental health workers, and psychologist skills are desperately needed without this enhancement—and the training that is being proposed, as well as the coordination with the patient’s health care team is inadequate to the task.

We, and our excellent lobbyist Lois Hagarty, have met with many members of the house and senate committees of jurisdiction, and have been coordinating efforts with the Pennsylvania Medical Society and other medical societies. (Anyone who doubts the value of medical society membership, come see me. They have been great.) We have reached out to members of the Psychiatric Society who are constituents of legislators on the House Professional Licensure committee, asking that they request to meet (in person, by zoom or by phone) to talk about the issue.

At the request of the Committee Chair, Frank Burns, we have offered to meet with representatives of the psychologists to discuss ways we might be able to agree to something that would help with addressing the problem of access to care, including possible amendments to HB1000. We have spoken with committee member Dr. Arvind Venkat, an emergency physician from the Pittsburgh area and member of the Pa Medical Society, about what concerns might resonate with the committee, and appropriate ways to address them.

I hope that members reading this will be energized to reach out to your own member of the General Assembly, as well as state senator, to let them know you have concerns about this, and other matters of concern to psychiatry. We are smart, hard-working physicians who have expertise which they can use, and which we should offer. Lobbying does not come easily, but offering to educate elected representatives about our work should not be that hard. We have something they need. Our staff have a spreadsheet of each PaPS member’s representatives in Harrisburg and Washington, and are happy to provide with the contact information needed to secure an appointment with them. Emails are of some use, but direct contact is much more effective.

The members of the PA House Professional Licensure committee are:

Democrats: Frank Burns, Chair; Kosierowski, Bridget M., Secretary; Markosek, Brandon J., Vice Chair; Burgos, Danilo; Gallagher, Pat; Guenst, Nancy; Guzman, Manuel, Jr.; Malagari, Steven R.; Merski, Robert E.; Mullins, Kyle J.; Munroe, Brian; Steele, Mandy; Venkat, Arvind; Williams, Dan K.

Republican: Metzgar, Carl Walker, Republican Chair; Ecker, Torren C., Republican Vice Chair; Marcelli, Kristin, Republican Secretary; Gaydos, Valerie S.; Klunk, Kate A.; Kuzma, Andrew; Lawrence, John A.; Mako, Zachary; Mehaffie, Thomas L., III; Scheuren, Donna; Tomlinson, Kathleen C.

Our hope is to prevent the current bill from being reported out of committee, which is why we are targeting these individuals. If reported out, then the entire House would need to act on it. Since the Democrats are in control of the House, it is imperative that our members are in contact with their representatives, especially if the rep is a Democrat (the caucus tries to vote as a block.) Keeping Republicans in opposition is important as well, since we cannot always count on reflexive “if it is a D bill, I will oppose since I am an R” (though this runs true more than we’d like.)

We will bargain with psychologists as we are able, without sacrificing the principles of patient safety, educational requirements, and monitoring of the program by appropriate authorities. The professional licensure committee likes to work by consensus; we are going to try to reach a reasonable compromise if we can. Please reach out if you have any ideas about how to increase access safely, what all of us care about.

As we envision ways to increase access, we are working with a coalition in the legislature to restore the $100M earmarked for Adult Mental Health in last year’s budget. As you may remember, the Behavioral Health Commission came up with a number of recommendations, which included money to help with the rollout of the Collaborative Care Model. The budget passed in June swapped this for $100M to fund putting a mental health worker in every school. Currently, fiscal code bills are being introduced to put the budget into effect, and in this way there is a chance we can get some or all of the Behavioral Health Commission’s recommendations to be enacted, including the $10M for Collaborative Care.
It has been a wild couple of weeks on the budget front in Harrisburg, and it’s not over yet. The good news is that nothing is yet resolved. The bad news is that the money we had been hoping for to expand collaborative care, as well as to fund other programs to expand workforce, appears to have been cut from the budget in favor of putting mental health workers in schools.

It is disappointing, since last year $100M had been earmarked to enhance adult mental health. A behavioral health commission was empaneled and made recommendations on exactly how it was to be spent. Of particular interest to us was $10M for Collaborative Care support, as well as money for training, loan forgiveness, and 988. This all appears to have vanished in the final budget, in the interest of fulfilling the pledge Governor Shapiro made in his inaugural address to put mental health workers in every school.

The current impasse stems from a deal on school vouchers (referred to as Lifeline Scholarships) which Senate Republicans had thought they had with the governor. House Democrats refused to go along with it, so the governor promised to line item veto the Lifeline Scholarships. Senate Rs cried foul, and are vowing to refuse to sign the budget (whatever that means.) Lots of bad blood, which means a (slight) chance that we can recover some of the mental health money for Collaborative Care. Otherwise we will need to hope for a stand-alone bill (which was introduced several months ago but was swept up in the budget.) The reality is that there are billions of dollars in a rainy day fund in Harrisburg, much of it left over from the American Recovery Plan Act for COVID (where the $100M last year was supposedly to come from) but prudent, stingy (take your pick) Rs in the state house do not want to overspend.

Another major issue is the recently introduced psychologist prescribing bill. This has been on our radar for several months, and have sent letters explaining our opposition even before it was introduced. The government relations committee is aware that there are some members who do not think this is such a bad thing, might increase access, better trained than some Physician’s Assistants and Nurse Practitioners who have limited prescriptive authority. The lack of medical background is the main differentiating factor, which cannot be achieved in an 18 month part time course. And we are not always that pleased with what other Non-Physician Providers (the CMS term) do. Access is not likely to be impacted in any meaningful way (after 20 years fewer than 300 prescribing psychologists nationwide, most not actively prescribing, and all in exactly the same geographic locations as psychiatrists.) We will be testifying on Aug 7 at a hearing in Pittsburgh.

House Bill 106 sets minimum staffing requirements for nurses on hospital units. On psychiatry units this is supposed to be 4:1. This seems both unachievable and unnecessary, since it does not consider mental health techs, creative arts therapists, social workers and others who are closely involved in patient care on our psychiatry units. We are not in support.

There is a movement to ban “step therapy” in the Commonwealth, meaning that “fail-first” protocols would not be allowed; no more requirement that one prove that the patient has tried certain tier one drugs before tier 3 will be approved. As attractive as this may sound, our committee is concerned that it would mean every patient would be given the latest and greatest drug for no particular reason (imagine everyone on Vraylar or Viibryd) unnecessarily. We will be part of a discussion on 8/24 with the likely sponsor Rep. Boyle from Philadelphia. Anyone with strong feelings on this subject should be in touch with me or another member of the committee, or our exec Robbi Cook.

Please keep in mind that the nearly equal balance of power in Harrisburg makes every member’s voice very important. It would be useful to our profession if you got to know your state rep and state senator so that when things come up, they ask your opinion (or listen if you offer it.) Please consider this.
PaPS government relations efforts have centered on navigating the power shift in Harrisburg, with Democrats taking control of the House. This means new committee structures: chairs, members, and staff. The Shapiro administration has taken charge of the budget and regulatory process, with the potential for changes welcomed by psychiatry.

The $100M earmarked for adult mental health last session remains, but exactly how it is to be spent is uncertain. The Behavioral Health Commission report set priorities which funded assistance to set up the Collaborative Care Model, as well as tuition reimbursement and loan forgiveness programs. There are bills being offered which will likely carry this forward, but details differ and how much is coming straight from Harrisburg and how much gets sent to the counties with relatively less direct oversight remains to be seen.

Access to care is still top of mind for the legislature. We at PaPS are in agreement, and so are hoping more funding to set up collaborations between psychiatrists and primary care practices will answer this need (and are hoping that our members will step up and join in such collaborations.) Telehealth is another mechanism for extending the reach of all physicians, and how things will play out as the Public Health Emergency ends is being closely watched.

Many of the telehealth changes have been addressed at the federal level, mainly affecting Medicare. There is an FAQ on the APA website which I recommend to everyone; it is dizzyingly complicated: www.psychiatry.org/psychiatrists/practice/telepsychiatry/covid-19-and-telepsychiatry-frequently-asked-quest.

One area that has yet to be clarified has to do with telehealth and controlled substances. DEA has signaled that it will end the waiver of a requirement for a separate DEA member for each state to which a telehealth practitioner wants to prescribe controlled substances. PaPS sent comments pointing out the impracticality of such a system, since currently the only way to get a DEA number for a different state is to have a physical presence in that state. We are hoping that having a valid DEA for Pennsylvania will be enough to prescribe in a different state, assuming the psychiatrist has a valid medical license to practice in that state.

Another approach to managing access to mental health care is of course extending prescribing privileges to psychologists. A co-sponsorship memorandum has been circulated by Dan Frankel, without a bill yet, though most likely, similar to the bill Wendi Thomas introduced the last session (2607 which we were able to keep from even a hearing.) We have been meeting with various members of the house, including Mike Schlossberg (chair Mental Health Caucus) and Frank Burns (chair of Professional Licensure committee) and sent a preliminary letter opposing the sentiments outlined in the co-sponsorship memo.

Our main points should be well known to this group, but essentially:

1. psychologists have no fundamental training in medicine, and a crash course in prescribing is inadequate and dangerous;
2. there is a great need for the skills psychologists possess by their current training, nothing is gained in additional behavioral health access by trying to graft on this additional, imperfect authority;
3. psychologists and psychiatrists are located in exactly the same places, nothing is gained by access to rural care by doing this;
4. it is a tiny, vocal minority of psychologists asking for this privilege; despite more than 20 years of availability in some states, fewer than 300 prescribing psychologists exist;
5. the expense of setting up and tracking such an enterprise is considerable, with so few practitioners added and too much risk to be prudent.

Finally, a courageous co-sponsorship memorandum from Representative Jenn O’Mara announced her efforts to get Extreme Risk Protection Orders established in the Commonwealth. She told of her father’s suicide, and that such an order might have saved his life by enabling his family to have his guns taken during his period of dangerousness.

PaPS has worked for passage for such a bill for years, with no success in a gun-loving state such as Pennsylvania. It is an uphill battle, but we are again doing what we can to help prevent the suicide of our patients. Every state where such a bill has been passed has seen a decline; sometimes small, but meaningful for those families.

I again encourage every member to be familiar with their state representative and state senator, as well as member of Congress, ideally making some contact, so we can effectively take our policies and get them enacted for the betterment of the profession and the public.
Much of the work of the PaPS government relations committee this quarter has been making sure that the final days of the legislative session did no harm and tried to do some good. There were a few key issues.

100 Million Dollars for Mental Health:
In the final throes of the commonwealth budget negotiations in June, the legislature set aside this amount from the state’s leftover America Rescue Plan Act money ($6.15 billion) to address “the mental health crisis” related to COVID. A Behavioral Health Commission (BHC) was set up to make suggestions to the legislature. We focused our efforts in trying to get funding to advance the Collaborative Care Model, which most should be familiar with (psychiatrist consults to a primary care practice, with a behavioral health worker embedded in practice. Does not see patients directly, provides input to the PCP.) This is the mechanism APA has been touting as the best way to manage the problem of access, while ensuring that psychiatric expertise is available. The BHC met through August and September, issuing a report which included a recommendation that money for CCM be included. A sticking point was whether other sorts of behavioral health access expansion, not involving psychiatry, be included (the Primary Care Behavioral Health model, which essentially is co-location of therapists of various sorts in primary care practices.) We have been trying to hone in on CCM, since the other model is viewed as a stalking horse for expanded scope.

Other uses for money were recommended, including tuition assistance and forgiveness for behavioral health workers, increased compensation for front line staff, expansion of co-response teams for behavioral health emergencies, added money for correctional psychiatry, and others. There was not enough consensus or time for the legislation to be drafted in the last legislative session, but we are planning on giving testimony in January at new hearings. One thing to keep in mind is that this is one-time funding, so ongoing programs are not being considered. Another big consideration is exactly how the money will be doled out: will it be directly from the state to programs, or will the state send it to the county authorities for them to distribute.

Opioid Settlement:
Another pot of money that the Commonwealth is figuring out how to spend is the Opioid Settlement money ($2 billion) from lawsuits against CVS, Walgreens, Walmart, Endo, Purdue, et al. Discussions are ongoing about how much for agencies that provided services, how much to add services, and workforce development. We are hoping to persuade the fund administrators to increase slots for addiction psychiatry training, as well making sure that medication management is not downplayed.

Scope of Practice:
The representative (Wendy Thomas) who introduced the bill to support the Collaborative Care Model also introduced a bill to give psychologists prescriptive authority (we had hoped to persuade her that CCM was a better solution to the access problem she worried about, but were not successful.) Fortunately, we were able to keep the bill from seeing any action, and it is now dead (like everything else from the last session).

New Guidelines on 302 Timelines:
On November 29th the Office of Mental Health and Substance Abuse Services (OMHSAS) issued a bulletin clarifying the process and importantly the timelines for the 120 hours of the emergency commitment. It was an attempt to create uniformity across the Commonwealth, since each county appears to have a different take on how the Mental Health Procedures Act is interpreted. It was heavily focused on the “deprivation of liberty” and limiting this as much as possible. In particular, it states that the clock starts ticking on the 120 hours as soon as the warrant is issued (approved by the Office of Mental Health) which is rather bizarre, since the prospective patient may not even be found within that time. It also says that the 302 exam must be done when the patient is brought in for care, even if there is significant medical impairment making an exam impossible (tubed and vented, for example.) The expectation is that the service will have to file for continuances on the 303 petition until the patient is medically cleared. We have asked for a meeting with Dr. Dale Adair of OMHSAS.

Election Results:
Every Pennsylvanian should be aware of the significant developments in the legislature as a result of the November election. The senate remains in Republican control, but the House is destined for narrow Democratic control. The margin is so thin that the death of one member (Tony Deluca), and departure of the new lieutenant governor Austin Davis and congresswoman Summer Lee, mean that until special elections are held Republicans were still in control. The election of a democrat, Mark Rozzi, as speaker, and his subsequent decision to become an independent, added a new twist to the process. Until this plays out we still do not know who the committee chairs will be.

One of our great champions on the issue of gun safety, Todd Stephens, lost by a handful of votes; he will be missed.

It is important for all members who care about what the state is doing (which should be everyone) to have some relationship with their legislators. To find your legislator click here.