Minnesota Psychiatric Society

Improving Minnesota's mental health care through education, advocacy, and sound psychiatric practice, and achieving health equity.

February 2024

Dear Legislators:

The Minnesota Psychiatric Society (MPS) strongly opposes House File 3494/Senate File 4214. This legislation seeks to remove current psychiatric collaboration requirements for physician assistants when providing ongoing psychiatric treatment for children with severe emotional disturbances and adults with serious mental illness.

Just four years ago the compromise language of Minnesota Statute 147.09, subdivision 5, which this bill would repeal, was agreed to by physician assistants and psychiatry, psychology, and the mental health advocacy community, including NAMI and Mental Health Minnesota. Under this law, physician assistants can currently see patients for any mental health disorder other than the most serious and complex mental illnesses for adults and severe emotional disorders in children. Proponents of the bill have baldly stated that hospital systems have been confused by this statute and asked for changes. The hospitals reported to be asking for a change (HCMC and CentraCare) specifically **deny any need for change**. We have been unable to locate any hospital systems with these concerns nor have been contacted by any of their lawyers inquiring about subd. 5.

MPS has strong concerns specific to potential harm if these important protections are removed. PAs have minimal training in psychiatry. According to their websites Augsburg trained PAs only have 1 out of 31 courses devoted to psychiatry whereas Mayo has 2 out of 30 courses devoted to psychiatry. Advocates of eliminating this safety provision claim that PAs have adequate supervision via practice agreements with their primary care physicians. According to Psychology Today (12/20), with about one-half of all health care involving mental disorders, should curriculum time parallel this? It's an open question right now, but we know instinctively that the curriculum time commitment is at least 10 times more than the 5.1 weeks medical students now receive (even less in residencies), which is about 2.5% of total medical school and residency training time for U.S. graduates. This suggests we would need to increase our mental health curricula to at least 25% of total teaching time. Don't forget that we are talking about treating the patients with the most severe, complex and treatment resistant disorders.

The physician assistant group lobbying to remove this connection says that every PA is well trained to know their limitations, always ask for help whenever necessary, and never do harm. Physicians, advocates and families are well aware of cases where patients have been harmed. Given the stigma and shame that still exist around mental illnesses and substance use disorders, patients and families don't want to see their names and issues in the media and clinicians don't want publicity about harms to patients. This prevents a lot of people from filing or publicizing

lawsuits.

A psychiatrist tells the story of her brother who is cared for by a PA connected with a primary care physician. The patient has alcohol dependency and bipolar disorder. After being hospitalized he was stabilized on naltrexone to limit his cravings and drug/alcohol abuse. He's also on Lithium to prevent manic episodes. The PA has repeatedly stopped the naloxone, eventually her brother relapses, and when abusing, stops his Lithium and then gets manic causing financial problems, marital problems, DUI's, repeat hospital visits, etc. Another psychiatrist who is a medical director has been administratively involved with 4-5 PAs in two systems of care. The harms to patients have included missing tardive dyskinesia, not noticing side effects of antipsychotics and causing Parkinson's like symptoms in a patient, and giving meds that can harm (causing cleft palate) in babies to pregnant women.

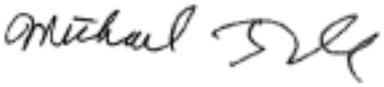
The current law is the result of intensive advocacy and legislative efforts to create safeguards for a small group and should not be degraded – their care and safety are at stake and should not be traded for the sake of expediency. Our perspective is that PAs are very valuable clinicians who are tremendous assets to our care teams and that things generally go well when there are psychiatrists available to provide oversight, advice, and to catch comorbidities, side effects, worsening of the underlying conditions etc. The zones where we are aware of problems is when PAs are practicing with a PCP where neither has timely access to psychiatric expertise/advice. The PAs are proposing that the solution is to eliminate the requirement for patients with the most severe tough to treat diseases to get psychiatric help. We vehemently disagree.

MPS along with Minnesota Medical Association, and the Minnesota Academy of Family Practice have been promoting increasing utilization of an evidenced based (> 90 peer reviewed articles) model of care called **Collaborative Care Management** (CoCM). This model is based in the primary care clinic and education, navigation, coordination, psychiatric advice is wrapped around the primary care clinicians. It shows better and faster outcomes, increased patient and caregiver satisfaction and cost savings. It currently is covered by Medicare and private health plans but not Minnesota MA. Instead of regressing by removing crucial expertise please help us pass CoCM.

Thank you for your time and attention on this important matter and we look forward to hearing from you.

If you have any questions please contact Linda Vukelich, Executive Director, Minnesota Psychiatric Society (l.vukelich@comcast.net) or Bill Amberg, Government Relations Counsel, Minnesota Psychiatric Society (Bill@amberglawoffice.com).

Sincerely yours,



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