

LD 531 - An Act to Specify Qualifications for the Director of the Office of Mental Health Services within the Department of Health and Human Services

Testimony - Health and Human Services Committee

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Julie K. Pease, M.D., President, Maine Association of Psychiatric Physicians

Senator McCormick, Representative Strang Burgess and members of the Health and Human Services Committee, thank you for hearing my testimony today. I am a physician and a psychiatrist, and I have practiced in Maine since 1987. I am here on behalf of Maine Association of Psychiatric Physicians, the professional organization of psychiatrists in this state.

I am speaking in support of LD531, which seeks to place a psychiatrist at the level of Director of the Office of Adult Mental Health Services (OAMHS). If this legislation were enacted, this would be accomplished in one of two ways:

- 1) A psychiatrist is appointed to be the Director of OAMHS
- 2) If a non-psychiatrist were appointed to be the Director of OAMHS, a psychiatrist Chief of Clinical Services responsible for all clinical and medical decisions for adult mental health services would be appointed by the commissioner.

At least 39 states in the U.S. have psychiatrist-physician medical directors in their departments of Mental Health Services. Several more have psychiatrists in the commissioner position itself.

A psychiatrist is uniquely qualified to navigate our complicated medical and mental healthcare systems, by virtue of his or her leadership role as a physician, their training in medicine as well as psychosocial and rehabilitative therapies, and their familiarity of the field of healthcare across all specialties and disciplines. As a physician, a psychiatrist is able to liaise between the private, public health systems, organized medical associations and specialty societies more effectively than a non-physician. Linkages with the professional school of pharmacy, nursing, Mainecare, and with the medical directors of the contracting agencies, are all areas that are most efficiently managed and encouraged with strong medical leadership and planning.

Physicians and others providing direct patient care need to have a clearly identified gateway into the DHHS bureaucracy. Maine's clinicians, mental health organizations and professional societies need to have an identified clinical leader with whom they can communicate on a personal and organizational level.

The Chief of Clinical Services' role is to ensure quality care at all levels, from the organizational and policy level to the level of review of individual clinical cases that come to the attention of the DHHS commissioner or the Director of OAMHS. The Chief of Clinical Services will provide support and guidance to the Medical Directors of

Riverview and Dorothea Dix hospitals. Those psychiatrists would continue their current roles. The Chief of Clinical Services will assume a lead role in coordination of care and uniformity of clinical and administrative policies within all mental health services within DHHS.

A priority of the Chief of Clinical Services is to ensure that continuity of care is maintained, and that patients are not left behind in the organizational shifts that may occur with funding or policy changes within DHHS. The Chief of Clinical Services will oversee publicly funded mental health and substance abuse services in Maine, including outpatient services and residential services. S/he also consults, advising on behavioral health-care issues, with community mental health centers and local providers of substance abuse services.

Having a psychiatrist as Director or as Chief of Clinical Services is critical to the ongoing provision of patient and public safety, in addition to the efforts toward prevention and treatment of illness with a focus on recovery, promotion of wellness, and quality of life.

In an era of increasing prescription drug abuse, it should become a key responsibility of the psychiatric medical director to ensure development of policies, and to coordinate and provide clinical leadership to programs that will turn this problem around. Maine has the advantage of a number of private-public partnerships underway at the present.

Although the Chief of Clinical Services will reside within OAMHS, MAPP envisions a broader advisory role across DHHS on behavioral health issues. The Chief of Clinical Services will serve on work groups that seek to improve the integration of primary health care and behavioral health care. S/he will be involved in all clinical aspects of behavioral health issues including contract requirements, development and monitoring of rules and policies, professional education opportunities, and will serve as a liaison with state agencies' leadership.

As with all positions within the department, fundamental is the responsibility to deliver the highest quality healthcare to the most seriously and persistently mentally ill, and to increase access for the most vulnerable of Maine citizens.

It is the consensus of my professional organization that the responsibilities of Chief of Clinical Services should not be added to the responsibilities of the Medical Directors of Riverview Psychiatric Institute or Dorothea Dix Hospital, because it would spread the many responsibilities too thin. It is MAPP's opinion that a full-time presence within OAMHS is necessary to ensure oversight and effectiveness of the many community services that come under the purview of the OAMHS. The National Association of State Mental Health Program Directors (NASHMPD) supports this opinion. In December, 2009, the Association issued a report, which recommended that "State Mental Health Authorities should have a full time medical director". This report observes that no other health care delivery systems of a similar scale and complexity attempt to operate without a full time clinical chief, and that large medical and mental health bureaucracies with full time medical directors are known to perform better than those without them. In response

to a June 2010 survey of gubernatorial candidates, Governor LePage also indicated his support for a psychiatrist in the role of a medical director within DHHS.

Finally, I am aware of the need fiscally responsibility, and that the DHHS budget is under close scrutiny. Our research in 2010 revealed that federal matching funds could be used to pay for 75% of the cost of a medical director if DHHS would apply for them. Furthermore, the Chief of Clinical Services will have a responsibility to contain costs in the delivery of mental health care statewide, to oversee the provision and/or the contracting of medical and pharmacy services, to weigh in on fiscal policies that affect care, and to make sure that the our tax dollars are used for essential clinical services for those in need, and not for unnecessary administrative overhead. Having a psychiatrist in a leadership and oversight position will save DHHS and the taxpayers from paying for expensive outside contractors to achieve this level of oversight. Further reduction of costs can be obtained via streamlining of existing programs and via elimination of programs that do not demonstrate clinical effectiveness or value. MAPP anticipates that a psychiatrist focused on the development of clinically and fiscally sound programs will result in savings in excess of the cost for the position.

I am submitting a copy of the National Association of Mental Health Directors report for your information, and also a list of some of the accomplishments of previous psychiatric medical directors at DHHS.

Thank you again for the opportunity to speak to you today.

I urge your support for LD 531.

Julie K. Pease, M.D., President
Maine Association of Psychiatric Physicians

Accomplishments of previous psychiatric medical directors at DHHS

- Increased communication with MAPP, Maine Medical Association and other clinical professional organizations. Having a stable point of contact made a huge difference for MAPP's ability to interact and communicate with the DHHS bureaucracy. Brokered the process whereby MAPP and the professional organization for Emergency Room Physicians agreed on procedures for medical clearance of the mentally ill prior to hospital admission.
- Worked on advising and communicating with physicians and providers about new MaineCare medication rules.
- Started a quarterly meeting of agency medical directors with connections to the medical director at APS. The meetings have increased clinical input into administrative decision-making at contracted agencies and improved accountability for services provided.
- Increased attention to critical incidents, analysis, reporting and policy recommendations, and presented these data to the professional medical community, which improved public safety
- Brought national and international recognition to DHHS for work on Safe Medications for Maine and unused medication disposal.
- Increased attention and awareness of patient abandonment by providers, which also reduced costs by preventing the consequent movement of services to Emergency Departments
- Provided input into APS decisions that were not adequately clinically informed, thus *improving patient care and saving money*.
- Worked with MaineCare/Program Integrity on difficult cases to reduce waste or duplication of care
- Provided policy input on Crisis reorganization, and other Adult MH programs, which will provide clinically informed MH services in the future.
- Provided direct involvement in critical incident review and review of patient and family complaints, leading to improved coordination of care and improved relationships between OAMHS, patients and providers.
- Research on clinical evidence to demonstrate effectiveness (or lack thereof) of clinical programs
- Research on psychotropic prescribing practices to demonstrate effectiveness, assess prescribing patterns, work with DUR, DEA
- Supported prescription drug return program development
- Supported MAPP's Consultation Project, which provides free psychiatric guidance on patient care to primary care physicians/providers in Maine.