Northeast Ohio
MEDICAL UNIVERSITY

20 May 2024

To: Jerry C. Cirino
Chair
Workforce and Higher Education Committee
Ohio State Senate

From: John Stilliana
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Northeast Ohio Medical University

Re: Concerns about the proposed curriculum for the Certified Mental Health Assistant

Chairman Cirino, Ranking Member Ingram and members of the Senate Workforce and Higher Education Committee, Thank you for allowing me to testify as a proponent of SB 60.

- In 2020 the United States had 38,600 psychiatrists which was approximately 87% of what was needed.

- Because of an increasing demand for psychiatric services and an aging population of psychiatrists, by 2035 the US will have only 70% of the psychiatrists it needs. There will be a national gap of approximately 14,000 psychiatrists.
    - https://data.hrsa.gov/topics/health-workforce/workforce-projections

- The situation is worse in Ohio. Between 2016 and 2030 Ohio is projected to lose over 300 psychiatrists leaving us with only 1060 psychiatrists when approximately 2020 are required to meet the mental health needs of Ohioans. We will have only 52% of the psychiatrists we need.
    - https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/state-level-estimates-report-2018.pdf

- We can expect an increase in Psychiatric Nurse Practitioners and Psychiatric Physicians Assistants but by 2030 there will not be enough of them to meet the needs for those disciplines much less fill the growing gap of psychiatrists.

After reviewing the proposed curriculum for the Certified Mental Health Assistant (CMHA), representatives from the Ohio State Medical Association forwarded questions about the proposed curriculum. I would like to address some of their concerns.

- About the quantity of neurology training received by the CMHA.
    - The draft curriculum includes approximately 13 hours of lectures reviewing neuroanatomy and neurology, 16 hours of lectures discussing the neurobiology of mental illnesses and substance use disorders, 3 hours reviewing indications for and

results from neuroimaging, and 10 hours discussing neurology-based clinical cases.
    - Training for CMHAs includes 12-months of supervised clinical care on inpatient psychiatric units, substance use disorder clinics, and outpatient clinics. These experiences will provide additional opportunities for CMHAs to work with patients with neurological disease.
    - As the initial evaluation and diagnosis of patients managed by CMHAs will be conducted by physicians, they will identify any existing neurological disorders impacting the patient's care.

- About the need for CMHA to receive a broader introduction into general medical systems, especially the impact of medications on those systems.
    - The training of CMHAs focuses intentionally on the knowledge required to manage mental illness and substance use disorders. As the initial evaluation and diagnoses will be made by physicians, and there will be ongoing supervision of all patients treated by CMHAs, the supervising physician will identify any existing medical conditions that might be affected by ongoing treatment.
    - In addition to this safeguard, the draft curriculum includes approximately 83 hours of class time focused on pharmacology, especially the pharmacology of psychiatric medications. This will include discussions of side effects and drug-drug interactions. There is an additional 40 hours spent discussing the anatomy and physiology of the organ systems most likely to be impacted by psychiatric medications.
    - Training for CMHAs includes 12-months of supervised clinical care on inpatient psychiatric units, substance use disorder clinics, and outpatient clinics. These experiences will provide additional opportunities for CMHAs to understand and manage the overall impact of the medications they prescribe.

- About which community partners would be responsible for the CMHAs clinical training.
    - We have had discussions with local health care systems who are very interested in providing training locations with the hope that CMHAs will eventually augment their understaffed, overworked providers.

- About the need for BLS/ACLS training
    - This would likely be a requirement of the specific health care system where they work but would be a good addition to their training.

- About the assessment of CMHAs and their readiness to begin supervised clinical practice.
    - Each semester CMHA students would be required to pass weekly quizzes, demonstrate adequate performance on verbal/observational tests of knowledge and skills, and pass 3 standardized patient encounters. They would be evaluated by clinical supervisors regarding their interactions with and management of patients.

- About the need for CMHA students to rotate on consultation liaison services, emergency departments and substance use rehabilitation centers.

    - Facilities focusing exclusively on substance use disorders can be included in the clinical year as sites are available.
    - The CMHA will not have breadth of general medical knowledge to work on consultation and liaison services or emergency departments. They are being trained to provide ongoing care to patients with physician-diagnosed mental illness and substance use disorders.

- About the need for experiences with a 24-hour continuum of care
    - The potential benefits of night float or on-call responsibilities can be considered as the program is being developed. As the CMHA is being trained to provide ongoing care under a physician who makes the initial diagnosis, it would require that physician to be in the hospital as well.

- About the training a CMHA would receive before being allowed to prescribe medications.
    - A physician would make the initial diagnosis and refer the patient to the CMHA. The CMHA would be trained to review diagnostic criteria, medical records, and auxiliary studies to confirm the diagnosis, which is standard when assuming care of a patient. Discrepancies in diagnosis would be discussed with the supervising physician. The CMHA would use existing clinical practice guidelines, treatment algorithms, or the best available evidence-based approaches to manage the patient's care. The referring physician will likely have made some treatment recommendations, and the CMHA's ongoing treatment plan will be reviewed as part of the mandatory, weekly supervision.

- About the need for insurance companies to agree to cover services provided by the CMHA.
    - Without a scope of care approved by the legislature, it would be impossible to obtain specific language from insurance companies about paying for services provided by the CMHA.

- About the need for malpractice insurers to cover the work of CMHAs.
    - Without a scope of care approved by the legislature, it would be impossible to obtain specific language from insurance companies about medical malpractice coverage. It was determined that obtaining the scope of care should be the first step.

- About the CMHA being allowed to refer patients to athletic trainers of physical therapy.
    - Numerous studies have shown the benefits of physical exercise in reducing and/or preventing depressive and anxiety symptoms. While referrals to ATs or PTs might be rare, maintaining activity can be an important aspect of comprehensive behavioral health treatment.

- About the state medical board being allowed to establish other specifics about the CMHA scope of practice.

    - We have discussed the CMHA proposal with the State Medical Board and these concerns were not raised by them. We would be happy to work with the state medical board to clarify these issues as the program advances.

- About the supervising physician not being required to be a psychiatrist.
    - The expectation is that CMHAs could work with primary care physicians as well as psychiatrists. The training and clinical experiences of the CMHA would likely augment or enhance the level of care currently provided by primary care physicians.

- About the need for a physician to always be physically present wherever a CMHA is working.
    - This would greatly limit the ability of CMHAs to provide care in the locations where the need for behavioral health care is greatest, e.g. rural settings. Each physician would be free to set their own level of comfort, but an ever-increasing number of physicians are becoming comfortable providing virtual care and virtual supervision.

- About the need for a standardized quality assurance program for all CMHAs.
    - While there are certainly benefits from a standardized program, we were allowing the supervising physicians the flexibility to adapt their programs to the strengths and needs of the individual CMHAs with whom they are working with.