TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

House Select Committee on Mental Health
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Presented by Thomas J Kim, MD, MPH

Good day, Chairman Price and members of the committee. My name is Dr. Thomas Kim. I'm an internist and psychiatrist here in Austin who develops, evaluates, and practices telehealth care solutions. Today I'm testifying on behalf of the Texas Medical Association (TMA), representing more than 49,000 physicians and medical students across our state. My hope is to offer you some insight into one, admittedly atypical, physician's perspective on mental health, the challenges with its care delivery, and a potential path forward.

It has been about 10 years since I finished the 25th grade which included a combined residency in Internal Medicine and Psychiatry. During medical school, I aspired to care for the whole patient and believed I would pursue one of the primary care residency tracks. Very quickly, I came to understand the virtue of having a sound mind in a sound body and pursued an unconventional choice of completing two residencies.

The experience of working across two disciplines highlighted an unintended consequence of the phenomenal medical advances of our time through specialization. The consequence is that most physicians typically seek a sound part of either the mind or body. This is far from terrible as my colleagues can do some pretty amazing things to address both illnesses and injuries.

For my psychiatric colleagues, tremendous progress followed the "Decade of the Brain" in the 1990s which led to wide ranging advances in the understanding and treatment of mental disorders at a neurochemical level. Coupled to the tradition of talk therapy which dates back to Ancient Greece, research demonstrates that this two pronged approach offers the most promising treatment impact for those who suffer from mental illness.

The field of Psychiatry, however, struggles with unique challenges not typically found in other specialties. Perhaps the two most significant challenges for the purpose of these proceedings are Stigma and Parity.

Stigma speaks to the unfortunate popular opinion that mental illness is akin to a character failing to be shunned or shamed in some way. This has subsequently led to processes that restrict and seclude communication about mental health for fear of public disclosure. And so despite our increasing understanding of the biologic processes of mental illness and effective treatment options, I believe there remain too many people who are too guarded when it comes to talking about mental health.

Stigma is also a primary driver for the challenge of Parity in mental health care. Payers have historically attempted to create alternative payments models that resulted in benefits that either indirectly limited care by capping the number of allowable encounters or directly limited reimbursement in some other way. Fortunately, the 2008 Mental Health Parity Act sought to correct this inequity and effectively viewed mental health care properly as a primary care service. That being said, true parity is still an unrealized goal for many people throughout Texas and the country.

So within this landscape of Stigma and DISparity, psychiatrists typically pursue work within large health systems focused on downstream acute crisis intervention or upstream outpatient work focused on wellness maintenance that include private practice physicians.

I was informed that the committee wanted to better understand private practice as one entry point into the mental health care system. One caveat before proceeding is to clarify that I am unusual. My professional dedication to telehealth represents a choice to reject the two paths described earlier in favor of a bushwhacked third path. But keep in mind that what I do share with my private practice colleagues is an emphasis on wellness maintenance.

Private practice psychiatrists by my estimation are an endangered species. I do not mean to suggest that private practice is headed for extinction, but rather a number of inter-related factors create a headwind that will make pursuing private practice less attractive moving forward. This headwind can be broadly described as the product of modern residency training, downward pressures with reimbursement, and HIPAA.

In training, psychiatrists are taught to primarily address mental illness with medications. The medications available are quite good and largely work as designed. And with the increasingly complex nature of psychopharmacology, adequate training is necessary in order to utilize medications effectively. What is not always emphasized is that there is no cure at the bottom of a pill bottle in psychiatry. Moreover, with residency curriculum requirements what they are, training in talk therapy has become more of a luxury with deferment to other mental health specialties like psychology, social work, and the clergy to manage the delivery of talk therapy. Unfortunately, this deferment comes with a near absence of coordination which limits any potential benefit.

Getting paid as a private practice psychiatrist has been an exercise in frustration for most of my colleagues as the rules to get paid continually change and the amount reimbursed continually falls despite the increased time and effort required to get paid. Perhaps the most troublesome payer relationship is with Medicaid which tends to pay the least of them all. The result is a rising number of psychiatrists who simply opt out of insurance plans all together in order to keep the lights on. Our current system also financially compensates medication management more than talk therapy per unit of time which results in a surprise to no one that maintaining a viable psychiatric private practice leads to brief encounters that are often less than satisfying and a likelihood of leaving with more prescriptions in hand than when you arrived. To this point, I believe we undervalue therapy and not that we over pay for medication management.

Finally, in an effort to protect personal health information by creating portability standards for the transmission of such information, HIPAA was enacted in 1996. For reasons that most people understand in principle if not by statute, psychotherapy notes enjoy special protection and specific authorizations before information can be shared. Unfortunately, these protections simply reinforce the information silos that the digitization of healthcare information was hoping to solve. Somewhere along the line, we seem to have forgotten that Portability is the P in HIPAA.

So, taken together…more and more private practice psychiatrists are not accepting insurance resulting in greater access to care challenges for patients despite the ACA's success in covering 16.4 million more lives than 5 years ago. For those patients who are able to see a psychiatrist, they continue to struggle with the fractured nature of our specialized care system often resulting in unsatisfying polypharmacy and continued difficulty in receiving equally effective psychotherapy resources.

Placing the private practice experience in a broader context, people seeking to maintain their mental health find it increasingly more difficult for many more reasons than I mentioned. The result is more severe and debilitating presentations of mental illness when entering the care system at significantly greater costs. And while grateful for my colleagues who specialize in acute care and to the Legislature who have increased mental health funding in multiple ways, patients often find themselves back to square one after a hospitalization unable to find a psychiatrist who can support their continued well-being.

Given the demoralizing, apocalyptic scenario I just described, you may be surprised that most people who first meet me find me naively optimistic. I consider this high praise. In a world too full of chaos, I find that "reality" fuels my desire to try for better. I remind myself almost daily that:

500,000 Texans struggle with serious and persistent mental illness
1.6 million Texans are dependent on alcohol or other illicit substance
1 in 3 Texan prisoners have one or more serious mental illnesses
3,047 Texans committed suicide in 2013
70,000 Veterans call Texas home yet more and more of them are becoming homeless.

I could go on highlighting the areas where our attention and resources continue to be drawn to the most expensive, most fractured, and least helpful aspects of our health care system, but I would rather turn toward potential solutions.

We all have a vision of a health care system that delivers on the promise of timely, cost-effective, high quality care. The problem is that we also recognize that resources are limited and currently far from meeting our actual need. So, the path forward will require creative, critical thinking towards new models of care and better uses of limited resources. Throwing more money that we don't have at systems that don't work will not get us there.

Some ideas to consider include:

Broadening Problem Focused Care Models
Substance Use disorders, for example, are perhaps one of the costliest issues facing Texans today. Solving this issue will require more than a pill or one more provider. Constructing a coordinated and comprehensive plan addressing a problem across multiple domains will likely improve outcomes. This is largely the logic behind the medical home where appreciating a patients most pressing issues no matter where that patient may be across the care system will increase the likelihood of maintaining wellness rather than responding to crisis.

Realigning Stakeholder Focused Care Models
As mentioned earlier, there are a number of caregivers all of whom represent a unique skillset capable of supporting those who struggle with mental illness. Unfortunately, this has historically resulted in disconnected care models that continually grapple with scope of practice concerns. Finding ways to do more together rather than less apart will require collaborative teamwork. My experiences as an internist and psychiatrist suggests to me that what I do between my ears can absolutely be accomplished with multi-disciplinary teams. Moreover, team based approaches also increase our capacity to care for patients by making better use of time and resources.

Nurturing Resource Focused Care Models
I am a telehealth provider. While having a 5 second commute from the coffee machine in my kitchen to my home office is a big reason I do this, the primary reason is that I am able to care for vulnerable patient populations in ways my conventional peers cannot. On any given day, it is more than possible for me to respond to a suicidal incarcerated juvenile in Louisiana prior to seeing active duty military personnel out of Fort Hood followed by supporting a care team within a substance abuse treatment center in North Austin. Free of the limitations that conventional jobs would impose, I am able to direct my finite number of work hours to places where I have the greatest impact. I believe it is time to recognize providers, particularly mental health providers, as a resource to be optimized rather than a cost center to be tolerated. I recently testified about the potential of telehealth to Chairwoman Crownover and the Public Health committee. If interested I am sure one of my colleagues at the TMA can help you get a copy. In short, I believe the time is now to establish telehealth as more than a fascination at the periphery of health care. Telehealth offers meaningful solutions to make the best use of our limited resources towards supporting patients in need earlier rather than later. Towards that objective, I believe the Legislature can serve a

central role towards the development of appropriate regulations and guardrails to preserve public welfare while allowing for the further maturation of this innovative approach to care.

In conclusion, I am extremely gratified to see this committee exploring ways to meaningfully address the mental health needs of Texans. As Dr. David Lakey, the former Texas commissioner of health, told the TMA: "(T)here is no greater challenge to the health and well-being of Texans than mental illness and substance abuse."[1]

The challenges before us are great, but so are the opportunities.

I wish to once again thank Chairman Price and this committee for convening this gathering and I'd be happy to answer any questions at this time.

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[1] Texas Medicine, *No Greater Challenge*, February 2015.