# Testimony: PA HR Bill 1000

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My name is Marci Zsamboky. I am a doctorally prepared nursing faculty at Duquesne University. I am the director of the Psychiatric Mental Health Nurse Practitioner program here. I have almost 4 decades of nursing experience, and I've been a psychiatric nurse for 37 years. I have taught nursing in various capacities since 1994. I have been teaching in a Psychiatric Mental Health Nurse Practitioner program since 2017. I am starting my fifth year as a PMHNP Program Director. My first 3 years as a director was at Vanderbilt University School of Nursing, where our program was consistently ranked as 1st or 2nd in the country. I am beginning my second year as a program director here at Duquesne University. I've practiced for the past 5 years as a Psychiatric Mental Health Nurse Practitioner in a federally qualified health center. In 2021 I received a $1.9 million HRSA Education and Training Grant to expand the advanced practice nursing mental health workforce in rural and underserved areas in Tennessee. **Today my focus is on meeting the complex needs of patients with mental health disorders who are being treated with psychiatric medications.**

## I. Integrated Care

The first thing to address is integrated care. Integrated care can be conceptualized as the product and process of medical and mental health professionals working collaboratively and coherently toward optimizing patient health (Byrd, Donahue, & Cummings, 2016, p.2). Integrated care has the potential to broaden the scope of practice if implemented correctly. This is no small task, however, and requires a team effort to produce positive outcomes (Byrd et al., p. 3). It appears the PA HR Bill 1000 is using integrated care as an infrastructure, whereas the Primary Care Physician provides a "home base," sends patients to a prescribing psychologist for

mental health treatment, provides collaboration with the prescribing psychologist to identify and treat comorbidities, and maintains ongoing communication with the prescribing psychologist throughout the length of the patient's treatment. Theoretically this may sound helpful in addressing access to mental health care, but it is not sustainable due to 3 important factors. These factors are (1) primary care's workforce burden (2) limited interprofessional collaboration education in psychology, and (3) the gravity of the comorbid conditions that impact psychopharmacologic treatment.

**II. Interprofessional Collaboration (IPC)**

According to the World Health Organization (2023), "Collaborative practice happens when multiple health workers from different professional backgrounds work together with patients, families, caregivers, and communities to deliver the highest quality of care across settings." Key elements of successful interprofessional collaboration (IPC) include education programs, healthcare infrastructures, and policy and governance structures. **I want to speak specifically to IPC and education.** In 2010, the Institute for Healthcare Improvement urged academic health institutions to implement IPC training to prepare health professional trainees to work effectively together in collaborative practice. Research has demonstrated that the integration of IPC activities in healthcare education enhance the quality of clinical collaborations and team-based care involving the current workforce, while readying the next generation.

In a systematic review on IPC in psychology training, Lamparyk and colleagues (Lamparyk et al., 2021), found limited literature on this topic. In fact, the authors

conclude their discussion of this by stating “Our findings are a call to action for greater psychology involvement in IPE.” Based on this review, there is concern about the likelihood of prescribing psychologists to engage in collaborative practice.

**III. Complex Needs of Patients Receiving Mental Health Treatments**

Mental health has rapidly become a high priority issue for national, state, and local agencies. The rise of reported mental illness, substance abuse, and suicidality has been seen throughout the country. The current health care landscape requires us to reevaluate our models of health care delivery and to devise new, innovative models, if necessary. Most patients seen for treatment of a specific mental health disorder have comorbid psychiatric conditions. I am certain that psychologists are well aware of the diagnostic and treatment complexities that occur as a result of the common psychiatric comorbidities. **I am more concerned with the potentially life-threatening physical comorbidities that occur as part and parcel of treatment with psychiatric medications**. According to the Agency for Healthcare Research and Quality (2023), “The co-occurrence of physical health conditions and mental health / substance use disorders is high. When physical health conditions and mental health / substance use disorders occur together, they may complicate diagnosis, treatment, and disease progression. Conditions often go undiagnosed among patients with co-occurring physical and mental illnesses. For example, COPD and heart failure may mask or mirror symptoms of depression, anxiety, and posttraumatic stress disorder, making their recognition and diagnosis less likely. Additionally, physical health conditions can increase risk of psychological distress, exacerbate mental

disorders, and compound functional impairment. Likewise, individuals with a severe mental disorder have higher rates of chronic conditions, including hypertension and diabetes."

People with serious mental illness (SMI), including schizophrenia-spectrum disorders, bipolar disorder, and persistent major depressive disorder, experience high rates of early mortality predominately caused by comorbid chronic medical conditions such as heart disease, diabetes mellitus, hypertension, asthma, and emphysema (Behan et al., 2015; De Hert et al., 2011). **These co-occurring chronic health conditions are associated with a shorter life expectancy of approximately 12–20 years compared with the general population** (Behan et al., 2015; De Hert et al., 2011; Druss, Zhao, Von Esenwein, Morrato, & Marcus, 2011; Walker, McGee, & Druss, 2015). This health disparity is likely to be compounded for people with severe mental illness who live in rural areas because they are more likely to experience poverty and have difficulties accessing safe housing, transportation, and health care services (Rural Information Hub, 2019).

**IV. Complexity of Prescribing Psychiatric Medications**

Prescribing medication requires a deep knowledge of body systems, medication mechanism of action, potential medication and food interactions, contraindications, and common as well as rare adverse effects. The medications used to treat mental health illnesses often times lead to metabolic syndrome, cardiac issues, sexual dysfunction (in itself a reason for nonadherence), and frequently, movement disorders that can be irreversible. Students must be required to have enough clinical practicum experiences to be able to confidently

assess for, diagnose, and treat or make referrals for treatment for these iatrogenic conditions. Important components of Psychiatric Mental Health Nurse Practitioner curricula include leadership skill development, advanced psychopharmacology and neuroscience knowledge and application, integrated health training addressing the management of multiple chronic co-morbidities, high acuity circumstances, crisis management, risk-mitigation strategies, self-reflection, and application of technology, such as telehealth, amidst a strong foundation in cultural competence. Clinical education training must also include content that addresses complex care delivery and health promotion for at-risk populations.

**V. Complex Case Presentation**

I'd like to close my testimony by presenting a very complex patient. "Tina" is a 50 y/o female I've seen for years. This is a patient who was referred to mental health by primary care because of the complexities associated with her treatment. She has 3 psychiatric diagnoses, 4 medical diagnoses, 9 drug allergies, 13 previously trialed psychiatric medications, 4 current psychiatric medications, and 14 current medications (including the psychiatric medications). She functions well and has shown great improvement despite having experienced significant side effects from the psychiatric medications, including akathisia. Because of her physical comorbidities, her allergies, and her previously trialed medications, she requires a great deal of office time, working together to decide the best treatment for her. She has developed hypothyroidism and reversible leukocystosis due to treatment with lithium. She has also developed metabolic syndrome because of treatment with an atypical antipsychotic. I routinely order her lab work and follow-up with

her PCP. **There is a constant risk / benefit analysis that I complete with both the PCP and the patient to determine best strategies for her treatment.**

In conclusion, I hope you are in agreement that safe patient outcomes in this vulnerable population require identification of and commitment to addressing the gaps in PA HR Bill 1000.