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Testimony in Support of SB 1503
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Senate Health Care Committee
Madeleine Simmons RN, MN, PMHNP

Chair Monnes Anderson, Members of the Committee,

Thank you for the opportunity to submit testimony in support of SB 1503. I am a psychiatric mental health nurse practitioner from Bend OR. I serve clients ranging in age from 10 to 87 in the private practice I've run for 9 years, and come to encourage strong support of removing the sunset clause from Oregon's Nurse Practitioner parity law. I spoke with you in 2013 when you were considering billing code parity for nurse practitioners, and have included some of the core issues in my written testimony. I'll focus my time with you on what's happened since parity.

NP parity encourages small businesses and makes it easier for practitioners to run viable businesses. With parity, I've been able to incur the costs of business upgrades including electronic prescribing of controlled substances and an electronic charting system shared by mental health providers across the state. I've grown my business enough to hire help with the administrative parts of my practice, allowing for a more intense focus on client care. Parity makes it possible for nurse practitioners to run independent businesses and meet the rising costs that all businesses incur.

Parity also makes it easier to recruit psychiatric nurse practitioners into the field. Just recently one of my former nursing students, after a couple years of recruiting, opted to leave her psychiatric NP position at the county to start her own business. Our consultation group welcomed her, send a ton of referrals her way, and support her in building a much needed business in Bend. Her position at the County was filled by a psychiatrist from the State Hospital, bringing another provider to a community short on psychiatric care.

In the Central Oregon psychiatric community we don't have the provider numbers to draw distinct lines between people providing general mental health care to the community. When one community psychiatrist passed suddenly this summer, several NPs and psychiatrists stepped up to provide continuing care to her clients. We have the opportunity to refer among ourselves based on speciality interests and personality fit. Over the years I've been in practice, I've had both an MD with a child psychiatry focus and an DO with a child psychiatry practice hand a large part of their practice off to me before they moved or took teaching positions elsewhere.

Pay parity in 2014 has made it possible for me to participate in more continuing education programs. I've attended specialized conferences at Harvard on eating disorders and autism, and to consider a national integrated mental health conference in Washington DC in the fall.

Over the last 3 years I've attended Oregon Psychiatric Physician's Association conferences (formerly Oregon Psychiatric Association) Ashland and Portland, allowing for broader conversations about how mental health providers might best come together to serve Oregonians. The reality is that one needs to be able to afford the cost of travel and conference fees and to initiate and participate in conversations about collaboratively improving mental health care in Oregon.

Since parity, I've had the flexibility to serve on the board of Central Oregon Mental Health Professionals Alliance, and work to build the first Independent Practice Association for mental health providers in the country. Equal pay for equal billing codes validates the work I do, and, in turn, encourages volunteer hours in service of health care reform.

Parity has made it possible for the nurse practitioners in my consultation group to serve Medicare clients. Medicare reimbursement rates in Oregon are some of the lowest in the country; pay parity makes it possible to include geriatric clients in our client mix.

Additionally, parity provides incentives to tackle challenging cases that require more thought and intensive collaboration with a number of specialities. While the extreme shortage of providers allows for psychiatrists and NPs to limit case loads to "easy, pleasant clients," this is not what Oregonians need. We all need to pitch in, and parity helps!

Finally, NP pay parity has helped ease some of the salary discrepancies between men and women in Oregon. While we are currently attracting a mix of genders into nursing and medical schools, offering equal pay for equal billing code gets us a step closer to equal pay for equal work for Oregonians who started their careers in decades when opportunity was at times linked to gender.

Thank you so much for your work on behalf of the mental health of Oregonians!

Background information and topics covered in previous testimony

I have eleven years of post-secondary education, including a Master's degree focusing on adolescents and substance abuse and a 2-year post-Masters certificate allowing me to prescribe psychiatric medications for children and adults. I have served in faculty positions at Central Oregon Community College and the University of Washington and have spent a decade developing programs to best serve high school students with specific needs. I have also worked in inpatient settings at a major trauma hospital and participate in continuing education to support my clinical work.

My patients range in age from 9 to 90. Many are high school or college students with mental health concerns that impact their school efforts. They benefit from my specialized training in adolescent mental health, and familiarity with their academic learning environments. My adult clients appreciate my inclination to address major health concerns directly and integrate their mental health care into a broader approach to wellness.

Shortage of psychiatric providers for kids

As a psychiatric mental health nurse practitioner licensed to see both children and adults, I see a lot of children and adolescents from the Bend/Redmond/ Prineville area in my Bend and Redmond offices. Twice during the 7 years I've been in private practice, child psychiatrists have left town and turned some of their more complicated cases over to me. The less complex kids received continuing care from their primary care providers while those needing closer psychiatric management joined my caseload. I met with the psychiatrists before they left to review cases in an effort to provide a smooth transition. I still have many of these young adults on my caseload.

In central Oregon we have one child psychiatrist who takes insurance, and one who consults with primary care physicians but does not providing ongoing care. One other child psychiatrist takes cash only. Four psychiatric nurse practitioners and local primary care doctors serve the remaining child psychiatry needs in the community. Unfortunately, we don't have enough prescribers in Central Oregon to see kids in a timely fashion, and many turn to the ER in crisis before being able to be evaluated by a prescriber.

New billing codes allow for differing levels of complexity

Since January 2013, mental health providers nationally are required to use billing codes that more accurately describe the services we provide. Prescribers now must differentiate complex clients from easier ones, and bill accordingly. I bill using Evaluation and Management codes for complexity designed by the American Medical Association in addition to a code for how much psychotherapy time I spend with a client. This allows me to differentiate a 55 minute session with a mildly depressed woman doing well on her antidepressant who seeks assistance with relationship issues, from a hour spent with an actively psychotic client hearing voices that tell her to kill herself with her gun after she decides to stop taking her medications because she is afraid of being labeled mentally ill and losing her right to bear arms. While both clients might take an hour of time, the psychotic one with a long history of serious suicide attempts clearly demands more intensive services, a review of more systems, and more immediate interventions.

Insurers perhaps incorrectly assume that psychiatrists see all the complex clients and that nurse practitioners see the easy ones. One of my colleagues uses a charting program (ICANOTES) that generates billing codes based on her charting. Her complicated clients generate the codes for the highest levels of complexity (and reimbursement). In Bend, psychiatrists at the large psychiatric practice are encouraged to see upwards of 40 clients a day doing primarily medication management, whereas the NPs in private practices might choose to see 12 clients daily and offer a combination of medication management and therapy to most clients. Differences in total reimbursement are obviously still significant. To be fair, the difference should be based on volume of clients seen and on the complexity of the specific clients, not on more inaccurate assumptions that psychiatrists see more challenging clients and NP's see the easy ones.

Reimbursement cuts for NPs

Pay cuts for NPs by insurance companies in 2009 significantly impacted my practice. My reimbursement rates from major insurers decreased by 25 percent, while psychiatrists billing the same codes maintained their reimbursement rates. These pay cuts primarily affected my ability to see kids in my practice. While trained to care for adolescents with complex psychiatric concerns, I chose to limit the number I see knowing that I can't fill my practice with these kids and keep my doors open. I've declined inclusion on several major insurance

panels because the reimbursement rates offered to NPs don't adequately cover my business expenses.