MADELEINE SIMMONS RN, PMHNP

1012 SW Emkay Drive Bend, OR 97702

Phone: (541) 330-1975 Fax: (541) 388-5110

E-mail: msimmonspmhnp@gmail.com

Testimony in Support of HB 2902 A
May 9, 2013
Senate Health Care and Human Services Committee
Madeleine Simmons RN, MN, PMHNP

Chair Monnes Anderson, Members of the Committee,

Thank you for the opportunity to submit testimony in support of HB 2902 A. I am a psychiatric mental health nurse practitioner. 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.

Patient Example
I see a 15-year old boy I've known since his child psychiatrist left town six years ago. He has Tourette's syndrome with symptoms of anxiety, ADHD, and verbal and physical tics that have a significant impact on his life. He has an IQ of 69 and qualifies as moderately mentally

retarded. Since I've known him he's grown from 50 pounds to 6'3" and his tics now include an impulse to run into traffic; requiring his petite mom to hold his hand when out in public. We've tried multiple medications to manage his tics. He's had his tonsils out to address sleep issues that impact focusing, concentration and mood. We've arranged psychiatric consultation in Portland, waiting months to get in with a child psychiatrist. A long awaited appointment with a geneticist produced recommendations for genetic testing for Marfan syndrome that insurance is currently refusing to do. In the meantime, I'm doing my best to manage his tics using medications that would not negatively impact someone with Marfan syndrome. I coordinate care with family, therapist, school, and specialists in Portland, while lobbying his insurance company to allow the services he needs.

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.

Some of the fee schedules I've received from insurance companies since January list only the two easiest complexity codes for NPs and leave out the two codes used to describe more complex cases. In central Oregon, clients often transfer between psychiatrists and NPs based on personal fit, location and availability, and they don't automatically get easier just because they walk into an NP's office.

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've chosen 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.

As a professional I know that skilled intervention as mental illness symptoms emerge can radically alter outcomes, earning capacity, life expectancy and one's ability to contribute to the community over a lifespan. NPs should be welcomed onto teams providing quality care to Oregon's young people with equal pay for equal work.

Please support the passage of HB 2902 A.