

VIRGINIA HEALTH CARE FOUNDATION (VHCF)
BEHAVIORAL HEALTH WORKFORCE INITIATIVE
Highlights: Survey of Nurse Practitioners
January 2013

During the fall of 2012, VHCF conducted research on Behavioral Health (BH) workforce capacity in Virginia to provide information that can be used by the Foundation for strategic planning purposes. Data were gathered from licensed Psych-Mental Health Nurse Practitioners (PMHNPs) and other Nurse Practitioners providing BH services through mailed and electronic surveys designed and compiled by an independent contractor. (*For details on survey methods, see page three.*)

The following information highlights and summarizes the 72 responses received, and is divided into three sections: (1) NP demographic information and credentials; (2) employment and practice characteristics; and, (3) insurance credentialing and payment issues. (**Note:** *percentages rounded to the closest whole number.*)

Section I: Demographic Information & Credentials

A. Relationship with Virginia

Most (94%) respondents were living and working in Virginia. The exceptions were one individual who lives in Virginia and works in another state (FL); and, two NPs who work in Virginia but live in another state (WV).

B. Education, Certification & Licensing

With regard to **educational preparation** in PMH and as NPs: 41% completed masters-level PMH Clinical Nurse Specialist (CNS) programs; 39% completed masters-level NP (adult or family) programs; and, 32% completed post-masters PMH NP programs. Another 18% completed masters-level PMH NP programs, 7% were currently enrolled in PMH post-masters certificate or Doctor of Nursing Practice (DNP) programs, 6% completed PMH NP or CNS concentrations in DNP programs, and 3% completed post-masters ANP programs.

Respondents were **nationally certified** as PMH NPs (56%), PMH CNSs (42%), FNPs (32%), and, ANPs (11%). Other certifications (7%) included: Neonatal NP; Substance Abuse/Addictions; Asthma, Allergy and Smoking Cessation Education; and, Clinical Social Worker. Forty-four percent (44%) of these respondents had more than one national-level certification. CNSs in Virginia do not have prescriptive authority (*unlike most other states*), so they need the NP credential to obtain that privilege. It is therefore not surprising that 71% (22 individuals) of those with dual certification had both PMH CNS and PMH NP credentials. The remaining 29% (9 individuals) were certified as Adult or Family NPs and PMHNPs (5 individuals) or PMHCNSs (4).

Just over half (51%) of the respondents were **licensed in Virginia** as PMH NPs, with most of the others licensed as other types of NPs (usually FNP or ANP). There were several respondents who completed formal PMH NP programs, but were not licensed as PMHNPs, either because they were new graduates or their current positions did not require the additional licensure. There is no separate licensure for CNSs in Virginia,

although the Board of Nursing keeps general information about those RNs with CNS certification (but not by specialty).

Section II. Employment Status & Work Settings

A. Employment Status & Salary

Most respondents were employed full-time (76%), averaging 40 hours per week. Full-time equivalent salaries/employment income ranged from <\$71,000 to >\$120,000, with an average of about \$87,591. Those with formal education in PMH were more likely to work full-time (80%) and earn slightly higher average salaries (\$89, 226).

B. Primary Work Settings

Overall, respondents were most likely to work in a/an: group practice (32%); Community Health Center, Free Clinic, or other nonprofit organization (15%); Community Services Board (9%); inpatient mental health facility (9%); outpatient mental health facility (7%); academic medical center (7%); higher education (6%); or, long-term care facility (4%). Another 13% worked in “other” settings, including University student health, psychiatric residential treatment facility, military treatment facility, primary care, correctional facility, and palliative care.

Those with formal education in PMH were more likely to work in group practice (36%), in CSBs (11%), and in inpatient mental health facilities (12%); and, they were less likely to work in long-term care facilities (0%).

Section III. Patient Populations & Services Provided

A. Patient Populations

Most respondents indicated that they had a general adult behavioral health practice (66%). Another 24% had a general family behavioral health practice, and 11% had a general child behavioral health practice. Substance abuse was the practice focus for 24% of respondents, and 16% had “other” types of practices. The other practices included a variety of subspecialty populations and conditions, such as geriatric, college health and PTSD combat veterans. Those with formal education in PMH were much more likely to concentrate on adults (74%) and slightly more likely to have patients with substance abuse disorders (26%).

B. BH Services Provided

Respondents typically provided a full range of BH services, including: psychotropic medication management (80%); consultation with psychiatrists (67%); psycho-education/lifestyle modification (67%); diagnostic and functional evaluation (62%); brief individual counseling (61%); and, consult with other BH (61%) or other health professionals (61%). They were less likely to provide: BH screening (49%); extended individual counseling (32%); case management (27%); group treatment/counseling (12%); or psychological testing (12%).

Those with formal education in PMH were more likely to provide diagnostic evaluation (76%), lifestyle modification (74%), brief counseling (71%), and case management (33%).

Section IV. Insurance Credentialing & Payment Issues

A. Credentialing Issues

Sixty-three percent (63%) of respondents stated that they either had no difficulty or knew of no difficulties in getting credentialed by insurers. Those who did indicate problems most often had them with Medicaid managed care organizations (MCOs; 21%), commercial insurers (14%), or Medicare (7%).

Specific issues mentioned included: Anthem does not credential NPs; Aetna does not recognize PMH NPs; and, some commercial insurers will not allow a NP to be the admitting/attending provider for BH hospitalizations.

B. Payment Issues

Most respondents (55%) were not sure what the differential rates were for NP BH services vs. same/similar services provided by a psychiatrist/other physician. Those who did know indicated that the payment rate was anywhere from 20-33% less than the MD rate, depending on the coding used and the payment source. For example: Medicare pays NPs at 75% of the psychiatrist rate (vs. 85% in primary care).

Specific payer concerns included: Anthem requires an initial evaluation by a psychiatrist on all patients, which delays care; also, Anthem only pays NPs "incident to" care by a physician; Medicaid pre-authorization for certain psychotropic drugs can be a long and time-consuming process; and, United Health Care requires that a patient in crisis be seen the same day, which may not be possible in a small practice.

Nurse Practitioner Survey Methods

In August 2012, a 16-item survey was mailed to the 106 Psych-Mental Health Nurse Practitioners (PMHNPs) living in Virginia, who were on the Virginia Board of Nursing's list of licensees: 37 responses were received and three surveys were undeliverable, for a return rate of 36% (37/103).

To obtain information from additional NPs, a link to the same survey was emailed to members of the Virginia Council of Nurse Practitioners in September 2012: There were 45 responses to the electronic survey, 35 of which could be used. *(Ten surveys were eliminated because the respondents were either not providing BH services, had retired or had moved out of state.)* The electronic survey group contained both licensed PMHNPs and other NPs providing BH services.

Next Steps

THANK YOU for your participation in this survey. During 2013, VHCF staff will use the survey results and other research to explore ways to build behavioral health capacity in Virginia's health care safety-net.