

PUBLIC HEALTH COMMITTEE
PUBLIC HEARING March 20, 2013

H.B. No. 6391 AN ACT CONCERNING THE PRACTICE OF ADVANCED PRACTICE REGISTERED NURSES

Testimony of Mary D. Moller, APRN. CT State Chapter of the American Psychiatric Nurses Association (APNA). Member, CT APRN Coalition.

Senator Gerratana, Representative Johnson, and members of the Committee. Thank you for the opportunity to provide testimony in support of H.B. 6391, an act to remove the regulatory requirement of a mandatory collaborative practice agreement signed by a physician in order for an APRN to engage in the provision of advanced practice nursing.

My name is Mary Denise Moller. I am an Associate Professor of Nursing and Director of the Psychiatric Nurse Practitioner program at the Yale School of Nursing. Today I am representing the CT State Chapter of the APNA as the psychiatric-mental health representative to the CT APRN coalition. I have been an Advanced Practice Psychiatric Nurse since 1982, licensed in WA State since 1993 where Advanced Practice Nurses have been allowed to practice independently within the full extent of education since 1978. This legal authority has allowed patients full access to psychiatric and primary care services. WA, like 24 other states is far ahead of CT in implementing recommendations of the recent 2010 Institute of Medicine report on the Future of Nursing.

My testimony today reflects on how I CANNOT practice in CT like I can in WA (where I remain licensed and continue to see former patients via telehealth) and the types of patient care I have NOT been able to provide because of the antiquated mandatory collaborative practice agreement.

I was owner of a group practice that included four PMH-APRNs, one child/adolescent counselor, and one MSW specializing in substance abuse. Collectively we provided between 8,000 and 10,000 visits/year. We specialized in caring for individuals with serious and persistent mental illness. We researched, developed and implemented a unique model of care that has been replicated in 15 states and two countries. This model, a wellness-based treatment program, reduced psychiatric rehospitalization by 93.5% and saved the State of WA millions of dollars/year (Moller and Murphy, 1997). Additional outcomes included patients completing educational programs and getting off welfare. We provided this care for 16 years without any physician oversight. Rather, we collaborated in a collegial manner on a regular basis with each other as well as psychiatrists, endocrinologist, internists, etc. depending on the nature and acuity of existing co-morbid conditions.

It was impossible for me to replicate this in CT because I had no relationship with any physician when moving here and even today, 4 years later, I have not found a physician who would be willing to 'sanction' this type of practice. With the existing, everyone loses.

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Moller, M.D. & Murphy, M. F. (1997). The Three R's rehabilitation program: a prevention approach for the management of relapse symptoms associated with psychiatric diagnoses. *Journal of Psychiatric Rehabilitation*, 20, 3, 42-48.