To the Office of the Healthcare Advocate,

My name is Mary Denise Moller. I am a psychiatric-mental health APRN dually certified as an adult clinical nurse specialist and as a psychiatric rehabilitation practitioner. I am dually licensed as an APRN in CT and as an ARNP (Advanced Registered Nurse Practitioner) in WA State and have worked in the field of psychiatry since 1978. I am an Associate Professor at the Yale University School of Nursing where I have been the director of the Psychiatric-Mental Health Nurse Practitioner program since January of 2009. In this capacity I visit psychiatric sites around the state securing clinical placements for our APRN students. This has afforded me a comprehensive snapshot of services in Connecticut. Prior to 2009 I was the owner, clinical director and a staff provider at the first APRN independently owned and operated outpatient psychiatric clinic in the US located in Spokane, WA. A state that has a nurse practice act that allows for autonomous practice—that is, no physician collaboration or supervision is required. I am currently in practice one day a week at the Yale Behavioral Health Services of Hamden, a state and city funded community mental health center serving the public sector patient. I am a former president of the American Psychiatric Nurses Association and serve as the psychiatric-mental health APRN representative on the Connecticut APRN Coalition. Thank you for the opportunity to provide testimony on behalf of the Psychiatric-Mental Health APRN community. I surveyed the APRN community and have compiled the responses for this testimony. The responses grouped under 5 major concerns.

What is clear is that there is a small, but committed Psychiatric Mental Health APRN workforce standing ready to serve the population with psychiatric needs across the lifespan throughout this state. In the US there are approximately 93,000 psychiatric registered nurses; of this number approximately 16,000 are certified as APRNs with a mean age of 51. There are approximately 750 active in CT. Annually APRN programs graduate around 375 students. In the United States there are 3,712 Mental Health Professional Shortage Areas with 87.7 million people living in them. It would take 5,834 practitioners to meet their need for mental health providers (a population to practitioner ratio of 10,000:1). In CT 5 of the 8 counties fall into this category.

The first major issue impeding public access to the APRN is the lack of available physicians willing to enter into the legislatively mandated collaborative relationship. The collaborative relationship requires unnecessary duplication of services and decreases time that could be spent seeing patients. As a result, many CT APRN graduates leave the state after graduation and move to surrounding states that have eliminated this antiquated legislation allowing the APRN to practice independently in the full scope of the role as highlighted by the recent Institute of Medicine Report on the Future of Nursing. This issue is being addressed, once again, with the recent APRN submission to the Scope of Practice committee in yet another attempt over the past 20 years to remove the collaborative practice agreement. This would bring Connecticut into the 21st century along with 27 other states, and foster a climate that would encourage APRN creativity in developing a treatment resource like I did in WA State.

The second major issue is the lack of continuity in reimbursement forcing a two-tier system of care as has occurred in all other states. These tiers are the private insurance company reimbursement versus the public sector Medicaid and Medicare reimbursement. These two tiers obviously do not serve the uninsured who are not eligible for entitlement programs leaving many thousands without access to mental health care. Additionally, not all insurance companies reimburse the APRN who is an out-of-network provider, in particular, the federal employees health program.

Although CT actually has developed Medicaid protocols through the various Husky programs that allow for sufficient outpatient psychiatric visits in comparison to many states--including the state I came from that often limited Medicaid patients to only 12 visits per year. The difference is the reimbursement rate is so low that many providers cannot afford to provide the necessary services-for example, Husky D only reimburses a mental health center $25 for a visit. This low reimbursement has created an inefficient form of psychiatric care called split therapy in which a prescriber is forced to see a patient for only 15 minutes, to generate a modicum of revenue, while the therapy is provided by a social worker that may not even be in the same office as the psychiatric provider.

A third major concern is the lack of planning for community-based care for thousands of patients who have been deinstitutionalized as well as lack of provision for acute-care services when these individuals experience a relapse of their chronic psychiatric condition. The consequences of the reduction in CT inpatient beds to less than 741 beds (175 for children/adolescents) for a population of over 3 million are staggering. An example of the effect of this is what recently happened on October 12 when both Yale New Haven Psychiatric Hospital and St. Raphael's were on diversion and patients had to be sent to Bridgeport due to lack of available beds. Additionally, I am concerned about the increase in the prison population of individuals with mental illness. Nationally this is on the rise and to me; the criminalization of those with mental illness is an appalling commentary on the failure of deinstitutionalization. In fact, the largest inpatient psychiatric treatment center in the United States is the Los Angeles County Jail. Connecticut is one of only six states that do not authorize involuntary treatment in the community, often called "assisted outpatient treatment (AOT) " or "outpatient commitment." Such laws often make it possible for people with mental illness to receive medical care before they are so ill they require hospitalization or experience other consequences of non-treatment.

A fourth major concern is the dramatic decreases in state budget funding for community based care. For example, at Connecticut Mental Health Center the caseload per clinician is on average 45 patients. The clinician is responsible for medication management and case management since there are no case managers due to the lack of reimbursement for case management. While a clinician could handle a larger caseload, the complexity of the case management needs severely delimits the ability to handle more patients. For instance, it is not unusual to be on hold for 45-60 minutes waiting for insurance pre-authorization for needed medications or filling out forms to access free medications from various pharmaceutical patient assistance programs, not to mention the time spent trying to find emergency housing, food stamps, etc. Each treatment team is at maximum capacity and they often have to stop taking new patients. One of my faculty members provided emergency assessments one

afternoon/evening a week, but her position and two others were recently cut—further decreasing the available clinicians. The STEP program (an early intervention program for people diagnosed with psychosis) has been closed recently due to State budget constraints. There is no Intensive Outpatient Program for uninsured patients forcing these patients to emergency departments to receive care. Patients with substance abuse issues have the ACCESS program, however, underlying psychiatric problems are not addressed in this program. These kinds of funding cuts were responsible for the closing of my psychiatric clinic in WA leaving nearly 1000 patients in need of finding services. In fact I am still providing services via telehealth to several patients who could not find a provider when I left.

A fifth major concern is the serious deficit in providers trained in children's psychiatric care. Many of those who are specialized in this population take only private pay due to the lack of reimbursement. Recognizing that 75% of psychiatric illnesses have their onset before age 18, significant adult psychiatric impairment could be reduced by early childhood prevention and intervention. It is not uncommon for a family to have a 6 month waiting period to be seen by a child/adolescent psychiatrist or psychiatric APRN. There are some school districts that employ a Psychiatric APRN in a school-based clinic, however, this is dependent on the availability of a collaborating physician.

I am committed to advocacy for those who do not have a voice—those citizens of our state who suffer with a serious mental illness who do not have the luxury of insurance or the ability to pay out of pocket. Since I moved to Connecticut I have provided pro bono services at Fair Haven CHC and now at Yale Behavioral Health in Hamden because neither of these facilities have any money to pay for psychiatric providers. I am able to do this because I serve as a preceptor for our students and am salaried by my University. Several of my graduate students have accompanied me because they are concerned about the welfare, resources, and access to care for the patients and families they will soon be serving as APRNs. I know they are committed to improving the system and I am grateful for their dedication to this most underserved population. Thank you for providing this forum and for allowing me to present this testimony.