

**TESTIMONY SUBMITTED IN SUPPORT OF HB 5751: An Act Establishing A
Pilot Project for Family Nurse Practitioners
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Good morning, Senator Handley, Representative Sayers, and members of the Public Health Committee. Thank you for this opportunity to speak on behalf of HB 5751: An Act Establishing a Pilot Project for Family Nurse Practitioners. My name is Margaret Flinter; I am the Vice President and Clinical Director of Community Health Center, Inc, an Advanced Practice Registered Nurse and board-certified family nurse practitioner.

I am here today to speak to the issues of health care access and delivery, now and in the future. I am here to speak in support of an innovation that is timely and feasible, and that will help our neediest and sickest citizens have access to expert primary care providers in our safety net system. I ask the support of our legislature to support the country's first formal residency training program for family nurse practitioners. The problem:

- Our federally qualified health centers care for special and underserved populations who experience significant health disparities, poor health outcomes, and challenging issues in prevention, acute care, and chronic care.
- The numbers of FQHCs and their patients are growing
- A full time primary care provider is needed for every 1200-1800 people.

In the face of these problems, devoting more money to recruiting and training physicians has been the only response, yet:

- Our federally qualified health centers struggle with both recruitment and retention of primary care physicians.
- The number of applicants seeking admission to US medical schools has decreased
- The Council of Graduate Medical Education stated in 2005 that there will be a shortage of not fewer than 90,000 full time physicians by 2020.
- A Continuing decline in the number of family physicians may lead to renewed shortages of safety net and rural physicians
- There is a declining ability to recruit qualified medical students from rural and underserved areas, coupled with greater difficulty on the part of community health centers and to attract adequate personnel

Perhaps we are looking in the wrong direction?

Nurse practitioners are uniquely suited for a central clinical practice and leadership role in community health centers, and indeed, those now in practice in our FQHCs have risen to the challenge and are a critical element of our primary care workforce.. They bring a full range of clinical competency which goes beyond the medical model to include a holistic approach to patients and the communities in which they live.

However, unlike physicians, nurse practitioners are disadvantaged by the absence of formal, post graduate residency training program specific to the intended practice area. For years, FQHCs and new NPs have informally struggled to create a "residency like" environment for new practitioners. The pace, the demands, and the complexity make this

impossible today. It is time to create formal residencies, with salaried positions for the residents, dedicated faculty and preceptors, and an intensive program of progressive training that addresses those health care problems that we know to be most critical in the FQHC setting.

Over the past three years, the Community Health Center has worked to plan the program design, curriculum, and evaluation plan to launch a residency program this fall. I have copies of an article I have published on this subject for those wishing more detail.

Let me give you just a quick historical perspective. About forty years ago, we began a new era in health care with Medicare and Medicaid, the first community/neighborhood health centers, and the development of the nurse practitioner role. The creators of Medicare addressed the need for additional training of new physicians to care for all of these newly insured elderly and funded graduate medical education (GME).

The world has changed. Those legislators could not have imagined the transition to outpatient care, the impact of chronic diseases and aging populations, the changes in health care professions and practice. I am very proud that Connecticut has always been a leader in recognizing the role and contribution of nurse practitioners both by licensure scope and in mandating that nurse practitioners be recognized as primary care providers in our state Medicaid and Husky programs.

One of the most important consequences of an NP residency Program is that the larger, more developed FQHCs would serve as training sites capable of sending forth NP graduates to other FQHCs, rural or urban, new or established, fully prepared for practice. Thus, although the pilot program would be located at CHC, Inc., the benefit of the training even before the model spreads to other sites would accrue to multiple other health centers.

Who should pay, and can this be sustained? Changing federal GME legislation is one answer, but Medicare still represents the smallest group of patients seen in community health centers. Medicaid, in contrast, is likely to be the more significant beneficiary of this innovation as it is the largest "customer" of community health centers. Incorporating the cost of a NP residency program into the calculated reimbursement rates for a sponsoring FQHC is, in the long run, the logical step

The benefits of a formal FQHC residency program ultimately accrues to the patients of these centers. Every significant innovation in health care needs a champion to support start up and implementation. We look to Connecticut to exercise vision and creativity in seeing that Connecticut leads the way in developing the country's first NP residency program as a logical and effective way to help meet the health care needs of our residents.

Thank you.