

Waterbury Medical Association

P.O. Box 30 • One Regency Drive • Bloomfield, CT 06002
Telephone (203) 753-4888 • Fax (860) 286-0787 • Email myokose@ssmgt.com

Statement in Opposition to

Governor's Senate Bill 36 – An Act Concerning the Governor's Recommendations to Improve Access to Healthcare

Public Health Committee

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This statement is being submitted on behalf of the Waterbury Medical Association in strong opposition to Governor's Senate Bill 36 – An Act Concerning the Governor's Recommendations to Improve Access to Healthcare. We find the bill to be bad patient care.

The medical home concept is being recognized as a patient centered team approach to primary care. This is supported by the Affordable Care Act and integral to the development of Accountable Care Organizations. The team approach to care is more proactive in management of preventive health care and chronic disease management – reaching out to patients for improved care. It requires the organization to monitor the quality of care. Other innovations like group visits, email communication with patients and same day visits may help meet patient needs. One of the key principles of a patient centered medical home is that each member of the health care team has to work to the full extent of their license. For physicians, this means stepping back from the full control of each aspect of the medical care. For APRNs and other mid-level providers, this will include a larger role in wellness care and chronic disease management. To provide APRNs full independence would help undermine the patient centered team approach to care. A certain percentage of APRNs would divorce themselves from the team model to continue the current model of fractionation of care and increased use of specialists.

With 30 million Americans gaining insurance coverage, we need more primary health care providers - more nurses *and* more doctors - working together in coordinated, integrated health care teams. Providing care in underserved parts of our country requires us all to work together creatively to build and implement new and better models of team-based care. Each layer of the patient-centered medical team must build on each other, and not stand isolated. The physician-led, team-based approach ensures that the patient gets the right care from the right health care professional at the right time.

Several studies have established that having a regular source of care and continuous care with the same physician over time leads to better health outcomes as well as lower costs, and medical homes are designed to provide this type of care. A recent survey by the Commonwealth Fund concluded that adults who have medical homes have enhanced access to care and receive better quality care. The survey defined medical homes as regular health care providers that offer timely, well-organized care and enhanced access. Given the benefits of the medical home, we question if APRNs would have any interest in joining a medical home if they were in independent practice. There would be no reason for them to be part of such a type of care.

Many of us are teachers as well as physicians, so we recognize that what physicians do is not easy. On occasion, an intern has not been able to complete his or her residency because he or she just did not have what it takes to take care of patients independently. That is, despite the fact that they completed four years of college and four years of medical school and had more clinical training than an APRN would have when finished with all of their training, they just were not meant to practice independently. It is not

easy to recognize at the beginning stages of education and training who will be a competent practitioner later in the process. It takes years of hands on training backed up with a medical school education to become a competent independent practitioner. In order to provide the best possible health care and protect the public, we think it is essential that anyone practicing independently have the highest education and training. We do not believe that the educational and training requirements of an APRN are designed to allow for independent practice.

Physicians' education is standardized such that the didactics, training and experience are consistent throughout the country. The education of APNs, on the other hand, may or may not include a bachelor's degree, a master's degree, or a doctorate, and the clinical training can be almost non-existent or even online. Physicians have four times the amount of clinical training as APNs so bring a broader and deeper expertise to the diagnosis and treatment of all health problems our patients face. A physician cannot be simply replaced by another member of the team without creating different classes of care. While each member of the health care team has a role, they are not interchangeable. According to the American Association of Colleges of Nursing, there will 260,000 too few nurses by 2025. The primary care shortage is not resolved by fragmenting care with more independent groups.

It is ironic that many graduating medical students go into sub-specialty training because they are overwhelmed by the wide scope of primary care medicine and are concerned that they will not be able to be competent after four years of medical school and three years of residency training. It is difficult to fit in all the required core curriculum conferences within the three years of residency training never mind the much shorter programs designed to educate APRNs. When we have graduates of medical schools that are not quite as good as UCONN, we end up spending a lot of time going back over the basics. In addition, it takes a long time to develop the skill of knowing when and what you don't know. It can only be learned through experience and now that residents are restricted by the 80 hour work week, it is hard to ensure that they develop this skill (but impossible to ensure that graduating APRNs will have this skill).

Patients need to be able to trust that medical professionals are well trained and competent to practice in an independent setting.

For more information, please contact:

Ann Marie Conti-Kelly, M.D., President
Mary Yokose, Executive Director
(203) 753-4888