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"Addressing Primary Care Access and Workforce Challenges: Voices from the Field"

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Good morning, Chairman Sanders, Senator Burr, and distinguished members of the Subcommittee on Primary Health and Aging. It is an honor to speak to you today on the issues of healthcare access and workforce challenges across the United States.

Thank you, too, Senator Murphy for your kind introduction, and for all of your efforts to ensure access to high-quality health care for all Americans, first as our State Representative in Connecticut, then as a Congressman, and now as a U.S. Senator.

I am Margaret Flinter of the Community Health Center of Connecticut, and primary care has been the defining focus of my career, first as a young public health nurse in rural Connecticut and rural Georgia, then as a family nurse practitioner, primary care provider, and executive leader of one of the country's finest community health centers. I came to the Community Health Center, Inc. in 1980, newly graduated from the Yale School of Nursing as a family nurse practitioner and ready to begin my "service obligation" as a National Health Service Corps scholar. It was my great good fortune that the NHSC assigned me to what was then a small storefront on Main Street in Middletown, Connecticut, where I found a small band of visionary and passionate community organizers and clinicians, like founder and CEO Mark Masselli, and family physician Dr. Carl Lecce, all of whom shared my own vision and passion for primary care and community health.

We put our shoulders to the wheel in building a remarkable community health center first in Middletown, but over time and in response to requests from community leaders in cities all over Connecticut, we developed community health centers in twelve cities across our state. Through our W.Y.A. or "Wherever You Are" philosophy of going where the need is, we have also pioneered the expansion of state-wide, school-based health centers and primary care services in homeless shelters. Today, our Community Health Center has over 130,000 active patients throughout the state. We are known for our clinical excellence but also for our commitment to innovation in addressing complex issues in primary care; for our formal research; and for training the next generation of qualified health care providers.

Today I want to address three questions that are the focus of much of my work and your area of interest today. First: who wants to be a primary care provider? And what must we do, now, to support those who make the affirmative commitment to become primary care providers? Second: how do we entice those providers to practice in underserved areas, both rural and urban, to care for our most vulnerable populations? Third, and just as important: how do we retain these talented, brilliant, and committed individuals in community health centers over the long haul? In answering these questions, I will speak to what we can and are doing, "in the field," and also, how you are, and can, help us continue to do so.

First, let me address the workforce issue, and particularly the shortage of primary care providers. You are hearing compelling testimony today from my colleagues on this subject, and in

particular, the need and strategies for attracting, training, and retaining more physicians in primary care. I support their recommendations and testimony. I am particularly supportive of the Teaching Health Center reauthorization and program, which recognizes, as I will emphasize in my testimony, that we must train the next generation not only to the clinical complexity of primary care in community health centers, but to our model of care -- and that is best accomplished by FQHC-based residency training. You are well familiar with the many challenges that contribute to the shortage of primary care physicians - the low percentage of medical school graduates who choose primary care vs. specialties, the salary discrepancies between primary care and specialties, the burden of debt, and the deep frustration with primary care practice of the past few decades, which I believe we are fully capable of reversing -- and I will speak to strategies to address that shortly.

But I want to step back. Instead of asking only why more physicians don't choose primary care, why not ask this broader question: Who else wants to be a primary care provider, and how can we support them in that choice and ensure that they will stick with it-particularly in the complex setting of community health centers?

My response is that nurse practitioners still overwhelmingly choose primary care as their preferred specialty, and we can attract, support, and assure their successful transition to the role of primary care provider in community health centers and other complex settings by giving them the opportunity for formal, post-graduate residency training programs in federally qualified health centers and nurse managed health clinics.

In 2007, I and my colleagues at CHC, Inc. launched the country's first formal post-graduate residency training program for new nurse practitioners who aspire to practice careers as primary care providers in community health centers. We did this after many years of observing the very difficult transition of brilliantly educated and fiercely committed new NPs as novice primary care providers in the very busy, immensely complicated settings of community health centers. The need and call for residency training for new NPs had been written about, talked about, and studied for years but the brick wall of GME legislative language failed to include NP residency training and impeded its development. We cannot afford to lose new NPs in community health centers - or deter them from coming to our setting - simply because we have not done the work required to facilitate their successful transition from university to practice.

We decided that someone had to build the model for NP residency training, and so we did. This NP Residency Training Program is full time for twelve months. It is very intensive training that addresses the clinical complexity of health problems suffered by often uninsured, low-income health center patients, and trains these NPs to a model of high performance primary care - team based, and integrated with behavioral health; person-focused but also driven by actionable data to achieve better and better outcomes.

We are now in our 7th year and have expanded to 8 residents per year. Our applicants come from all over the country -- we have had applicants from all but two states -- and I can tell you that 27 of our 28 graduates to date are practicing as primary care providers in community health centers and safety net settings all across America, from Louisiana to Iowa, as well as in Illinois, Massachusetts, California and Washington State.

From the time we started and in response to our first published article on the model, we have been asked by others to help them develop NP residency training programs. Today there are fifteen NP residency training programs for primary care NPs across the country, and fourteen more that will come on line in 2014. They include community health centers, nurse managed health clinics, and the Veterans Administration's Five Centers of Excellence in Primary Care Education – plus the Jesse Brown VA Medical Center in Chicago. We have over 60 organizational members nationwide, with six participating facilities in Massachusetts alone – in Belmont, Boston, Cambridge, Charlestown, Leominster and Worcester; another NP residency training site has been established at the Fay Whitney School at the University of Wyoming in Laramie; and now even large health/hospital systems such as the Carolinas Healthcare System in Senator Burr's home state – with six NP residency training sites -- are joining this national movement.

To advance the model of NP residencies, I and my colleagues created the National Nurse Practitioner Residency Training Consortium, which has brought together the leaders of the movement to advance the development of NP residency training nationwide. Our goal is to set and maintain appropriate standards for these residencies and work for a sustainable stream of federal funding similar to that available for physicians and dentists under GME. In short, we seek a legislative commitment to NP residencies, and we believe we are almost there. In 2010, Congress gave the Secretary of HHS the ability to award grants of up to $600,000 a year to eligible health centers seeking to implement NP residency training programs. However, that authorization expires this year and no grants have ever been awarded because the program was authorized but never funded. It is our request that, this year, the previously-enacted provision be reauthorized and funded for another five years, because this program is absolutely critical to address the looming primary care workforce shortage we face over at least the next ten years. While our consortium is growing due to the tremendous need in our communities, many of the existing participants advise that they may be unable to continue the training without the provision of federal funds moving forward. For example, the nationally-renowned Penobscot Community Health Center in Bangor, Maine, just advised me that although they will maintain the program next year, it will be cut by two-thirds. They implemented the program and spread information concerning NP residencies within the state but unfortunately say they will be educating at reduced capacity, compared to what they could have done, due to lack of funding.

My second question asked how we can recruit providers to underserved areas, both rural and urban. The National Health Service Corps, originally and brilliantly championed by Senator Warren G. Magnuson of Washington State, has stood the test of time as an effective, efficient, and elegant way to meet multiple critical needs: the need of the new clinician to obtain financial support; the need of the newly graduated clinician to obtain help with loan repayment; and the dire need of communities to acquire primary care providers. Since 1972, the Corps has done just this. I know this first hand. When I made the decision, after several years as a public health nurse, to attend graduate school at Yale, the financial challenge was daunting. In 1978, I was fortunate that the NHSC accepted me as a NHSC scholar, and I gratefully committed myself to a future period of obligated service. Why wouldn't I? All I wanted - as I have seen with subsequent generations of NHSC scholars and loan forgiveness recipients - was a chance to practice, as a primary care provider, with people and in a community that needed my care.

In preparing for today's testimony, it occurred to me that I really didn't have a firm handle on how many members of my medical, dental, and behavioral health staffs had ever been in the NHSC during their careers. I posed that question by email to the staff and invited people to share the "where and when" of their service - but also what it meant to them. Time does not permit me to read all 40 of the responses I received. These respondents are all "alums" of the NHSC and include physicians, nurse practitioners (both primary care and psychiatric specialist), PAs, Licensed Clinical Social Workers, Licensed Clinical Psychologists, Dentists and Dental Hygienists. Perhaps most tellingly, while some are currently in their period of obligated service, the majority completed their NHSC service many years ago but chose to stay and work in primary care. As one NP wrote "in my experience, the NHSC provided me with the financial support that allowed me to focus my attention directly on the clinical concerns of my patients and connected me with other like-minded clinicians. I remain forever grateful for the opportunity afforded to me by the Corps. For this reason, I would encourage all efforts to increase ongoing support for this wonderful program, and I applaud the NHSC for taking so many steps in recent years to "modernize" their rules, procedures and policies to reflect changing times.

Finally, I would like to answer my third question: what do we need to do to retain the best and the brightest, the most committed clinicians in primary care? For this, we must look to the cutting edge innovations and opportunities that create an exciting, stimulating, and vibrant career path for clinicians choosing primary care in community health centers. We can't have a path that says to practice primary care in a community health center, you must forego any thoughts about research, teaching, and mastery of complex challenges through on-going exposure to the best specialists that academic medical centers might offer. Instead, our health centers provide exactly that rich environment. I have had the opportunity to see this through the creation of our Weitzman Institute, founded in 2005 as the Weitzman Center for Innovation in Primary Care, which is an institute with a core focus on delivery system research, applying the science of quality improvement in primary care, and training. And I have seen how powerful a force it is for us at CHC in both attracting - and retaining - our best clinicians.

Finally, I want to speak to overcoming the isolation that can be inherent in primary care as we face some of the most vexing problems. One example is "Project ECHO" - an evidence-based, distance learning approach developed by Dr. Sanjeev Arora at the University of New Mexico and replicated by CHC for FQHCs around the country. Project ECHO-CT. connects a team of specialists, by video, with groups of primary care providers all over the country. Practitioners in the field present their most challenging cases and get expert clinical guidance by telemedicine and, in the process, become expert over time themselves. Nowhere is this more important than in two critical areas of primary care: the diagnosis and management of chronic pain and - sadly, but closely related - the management of heroin and opioid addiction. We all recognize the danger and precipitous rise in death by opioid overdose, both prescription pill and heroin, in our communities. Dealing with issues like this - alone and without expert support and guidance - is the kind of isolating and frustrating experience that drives people out of primary care. Connecting primary care providers with specialists and each other to treat and manage these complexities is of enormous value, and I would be happy to speak more about this if time permits.

In summary, I answer my three questions again. Who wants to be a primary care provider? Nurse practitioners do, and seek the opportunity for further intensive training appropriate to the complex setting of community health centers. How can we attract the best, brightest and most committed young providers across the medical/dental/behavioral health disciplines? By growing the National Health Service Corps. And finally, how do we retain these providers? Our responsibility, in the field, is to make our health centers not JUST centers of clinical excellence, but also the loci of research, training, and the advancement of science in primary care.

We greatly appreciate your leadership and look forward to your continued support for these initiatives.

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