



**Statement for the Record to the
Senate Health, Education, Labor, and Pensions Committee,
Hearing
Encouraging Healthy Communities: Perspective from the U.S. Surgeon General
November 15, 2017**

On behalf of the American Academy of Family Physicians (AAFP) thank you for the opportunity to submit this Statement for the Record for the U.S. Senate Health, Education, Labor, and Pensions Committee's hearing, *Encouraging Healthy Communities: Perspectives from the U.S. Surgeon General*.

The AAFP appreciates the Committee's interest in examining health through the lens of community health. Consistent with the World Health Organization's definition, the AAFP believes that health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." As the largest society of primary care physicians, we are committed to helping patients achieve health and in supporting initiatives that build healthy communities. It is also our view that community health does not occur by coincidence. Healthy communities develop through robust research as well as investments from citizens, community-based organizations, educational institutions, governments, and the private sector.

Primary Care is Associated with Healthier Communities

The AAFP acknowledges that physicians play an important role in community health, both as clinicians, but also as community partners who understand that what takes place outside of the doctor's office (the social determinants of health) impacts patients' health and the health of a community. Still, primary care (comprehensive, first contact, whole person, continuing care) is the foundation of an efficient health system. It is not limited to a single disease or condition, and can be accessed in a variety of settings. Primary care (family medicine, general internal medicine and general pediatrics) is provided and managed by a personal physician, based on a strong physician-patient relationship, and requires communication and coordination with other health professionals and medical specialists. The benefits of primary care do not just accrue to the individual patient. Primary care also translates into healthier communities.¹ For instance, U.S. states with higher ratios of primary care physician-to-population ratios have better health outcomes, including lower rates of all causes of mortality: mortality from heart disease, cancer, or stroke; infant mortality; low birth weight; and poor self-reported health. This is true even after controlling for sociodemographic measures (percentages of elderly, urban, and minority; education; income; unemployment; pollution) and lifestyle factors (seatbelt use, obesity, and smoking).²

The dose of primary care can even be measured – an increase of one primary care physician per 10,000 people is associated with an average mortality reduction of 5.3%, or 49 fewer deaths per 100,000 per year.³ High quality primary care is necessary to achieve the triple aim of improving population health, enhancing the patient experience and lowering per capita costs.⁴

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Patients, particularly the elderly, with a usual source of care are healthier and have lower medical costs because they use fewer health care resources and can resolve their health needs more efficiently.⁵ In contrast, those without a usual source of care have more problems getting health care and more often do not receive appropriate medical help when it is necessary.⁶ Patients who gain a usual source of care have fewer expensive emergency room visits, unnecessary tests and procedures. They also enjoy better care coordination.⁷ We believe it is in the national interest to support programs with the potential to help improve patient access for this population.

The Nation's Primary Care Shortage is a Community Health Issue

The current physician shortage and uneven distribution of physicians impacts population health. A U.S. Centers for Disease Control and Prevention study indicated that patients in rural areas tend to have shorter life spans, and access to health care is one of several factors contributing to rural health disparities.⁸ The report recommended greater patient access to basic primary care interventions such as high blood pressure screening, early disease intervention, and health promotion (tobacco cessation, physical activity, healthy eating).⁹ The findings highlighted in the CDC's report are consistent with numerous others on health equity, including a longitudinal study published in *JAMA Internal Medicine*, indicating that a person's zip code may have as much influence on their health and life expectancy as their genetic code.¹⁰ Therefore, it is imperative that physician care is accessible for all.

The current primary care physician shortage and its maldistribution remain significant physician workforce challenges. An *Annals of Family Medicine* study¹¹ projects that the changing needs of the U.S. population will require an additional 33,000 practicing primary care physicians by 2035. A 2017 Government Accountability Office (GAO) report indicates that physician maldistribution significantly impacts rural communities.¹² The patient-to- primary care physician ratio in rural areas is only 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas.¹³ According to GAO, one of the major drivers of physician maldistribution is that medical residents are highly concentrated in very few parts of the country. The report stated that graduate medication education (GME) training remained concentrated in the Northeast and in urban areas, which continue to house 99% of medical residents.¹⁴ The GAO also indicated that while the total number of residents increased by 13.6% from 2001 to 2010, the number expected to enter primary care decreased by 6.3%.¹⁵

Primary care workforce programs, such as the Teaching Health Center Graduate Medical Education Program and the National Health Service Corp Program, are essential resources to begin to increase the number of primary care physicians and to ensure they work in communities that need them most. The THCGME program appropriately trains residents who then stay in the community. THCGME residents are trained in delivery system models using electronic health records, providing culturally competent care, and following care coordination protocols.¹⁶ Some are also able to operate in environments where they are trained in mental health, drug and substance use treatment, and chronic pain management.¹⁷ Residents who train in underserved communities are likely to continue practicing in those same environments.¹⁸

American Medical Association Physician Masterfile data confirms that a majority of family medicine residents practice within 100 miles of their residency training location.¹⁹ By comparison, fewer than 5% of physicians who complete training in hospital-based GME programs provide direct patient care in rural areas.²⁰ Thus, the most effective way to encourage family and other primary-care physicians to practice in rural and underserved areas is not to

recruit them from remote academic medical centers but to train them in these settings. Similarly, the National Health Care Corps (NHSC) offers financial assistance to recruit and retain health care providers to meet the workforce needs of communities across the nation designated as health professional shortage areas (HPSAs). The NHSC is vital for supporting the needs of our nation's vulnerable communities. The AAFP believes building the primary care workforce is an important return on investment. We also believe that workforce programs help ensure high quality, efficient medical care is more readily available. By reducing physician shortages and attracting physicians to serve in communities that need them, these programs also help improve the way care is delivered and help meet the nation's health care goals.

Disease Prevention and Population Health

Mental Health and Substance Use Issues

Family physicians have traditionally focused on treating the whole patient, and recognize the mind, body and spirit connection. Promotion of mental health, diagnosis and treatment of mental illness in the individual and family context are integral components of family medicine. Mental health is also fundamental for patient and health and community well-being. The AAFP believes that access to increased mental health and substance use funding is a national imperative. According to SAMHSA's 2014 National Survey on Drug Use and Health (NSDUH), an estimated 43.6 million (18.1%) Americans ages 18 and up experienced some form of mental illness.²¹ In the past year, 20.2 million adults (8.4%) had a substance use disorder. Of these, 7.9 million people had both a mental disorder and substance use disorder.²²

Social factors, such as early life experiences, poverty, racial and ethnic minority status, and exposure to violence, put patients at greater risk of developing mental illnesses. Mental illness is associated with increased occurrence of chronic diseases such as cardiovascular disease, diabetes, obesity.²³ Research found that among elderly patients with high depressive scores, the risk of coronary heart disease increased 40% while the risk of death increased 60% compared with elderly patients with the lowest mean depressive scores.²⁴

The AAFP commends Congress mental health reform efforts, but there is still significant progress needed to fully implement the *Mental Health Parity and Addiction Equity Act* and to eliminate barriers for primary care and behavioral health integration. People with mental or substance abuse disorders were more likely to get treatment from a primary care physician/nurse or other general medical doctor.²⁵ We urge continued progress to address this issue.

The AAFP shares the administration's commitment to addressing the nation's opioid crisis through public education, substance use treatment, overdose prevention, and improved prescription drug monitoring. In 2015, the AAFP joined partners in the public and private sector in announcing a unified effort to address the nation's epidemic of opioid abuse and heroin use. The AAFP, along with the more than 40 stakeholder groups, pledged to increase opioid abuse prevention, treatment, and related activities. Over the next few years, medical and health stakeholders have committed to having more than 540,000 physicians and health care professionals complete opioid prescriber training in the next two years; double the number of physicians certified to prescribe buprenorphine for opioid use disorder treatment -- from 30,000 to 60,000 -- in the next three years; double the number of clinicians who prescribe naloxone; double the number of physicians and health care professionals registered with their State Prescription Drug Monitoring Programs in the next two years; and, reach more than 4 million physicians and health care professionals with awareness messaging about opioid abuse.

Chronic Diseases

Chronic diseases are the leading causes of mortality and morbidity in the United States adult population. According to the CDC, the leading chronic conditions are heart disease, cancers, stroke, obesity, diabetes, and arthritis.²⁶ As of 2012, about half of all adults—117 million people—had one or more chronic health conditions.²⁷ One in four adults had two or more chronic health conditions and seven of the top 10 causes of death in 2014 were chronic diseases.²⁸ Two of these chronic diseases—heart disease and cancer—together accounted for nearly 46% of all deaths.²⁹ These conditions are mostly preventable; therefore, it is vital that as a country we invest in preventive health efforts.

Preventive health is essential for adults, especially with the aging of the U.S. population. By the year 2050, the number of people 65 years of age and older will nearly double increasing the population of Medicare patients, 82% of whom have chronic health conditions.³⁰ As a country, we will only succeed at caring for this population by strengthening primary care, a specialty that is highly skilled in addressing the needs of patients with chronic diseases and multiple conditions. Better chronic care management is associated with fewer trips to the hospital and appropriate utilization of less expensive medical care.³¹ Making strides in this area will require a serious commitment to patient education, health care access, and community support. Programs, such as those that increase access to healthy foods and to increase opportunities to walk through improvements to the built environment have the capacity to help lower the risk of disease such as heart disease, stroke, and diabetes.

Tobacco use is the single largest cause of preventable disease in the United States. Cigarette smoking kills more than 480,000 Americans each year, with more than 41,000 of these deaths from exposure to secondhand smoke.³² The AAFP supports these initiatives through its *Tar Wars Program*, a community-based effort to encourage family physicians to educate school-age youth about the dangers of smoking. The program began and has been particularly supportive of programs to reduce smoking and to increase access to cessation programs. The AAFP has also supported the *Family Smoking Prevention and Tobacco Control Act's* full implementation, including efforts to restrict adolescents from using tobacco programs. The AAFP supports restrictions on the sales of specialty and flavored tobacco products, regulations on electronic nicotine delivery devices, and prohibits on the sale of tobacco products for those under 21 years of age.

Immunization and Infectious Diseases

Immunizations are a 21st century public health success, yet 42,000 adults and 300 children in the United States die each year from vaccine-preventable diseases.³³ A 2016 report published in *Health Affairs* indicates that the economic costs of vaccine-preventable disease for adults is between \$4.7 billion and \$14 billion per year.³⁴ Although vaccines are available in many different locations, such as pharmacies and in workplaces, primary care physicians play an important role as immunizers. The doctor-patient relationship can be instrumental in helping patients overcome their hesitancy or educating them when new immunizations are recommended. Doctors also understand patients' medical histories and risk factors. For example, primary care physicians can help diabetes mellitus patients understand how the condition compromises their immune system and why their vaccinations should be up-to-date. Health experts also agree that global cooperation is an important value, but it is also important note that infectious disease knows no boundaries. The AAFP supports programs that increase access to vaccines, such as the CDC's Section 317 Immunization Grant program. The program provides funding to states to immunize underserved populations. The AAFP also supports policies to improve immunization

information system interoperability to allow physicians to access state databases and to allow for better interstate communication.

The AAFP recognizes the importance of addressing the spread of antibiotic resistant bacteria. AAFP has committed to reducing the use of unnecessary antibiotics in medicine, but there is still significant progress needed within animal agriculture. Currently, 70 percent of the antibiotics used in the US are used for food-producing animals. It is our hope that progress continues under the U.S. Food and Drug Administration's current initiatives to reduce the over-utilization of antibiotics in animals.

Child health

Disease prevention is an important issue for pediatric populations. Children are not little adults, which means that their health needs are unique. Most children are healthy and spending on this population represents a small portion of overall healthcare investments, but supporting child well-being can ensure that our nation has a healthier future. Initiatives that build health early in life include pro-conception care, home visiting, early nutrition, vaccine access, health care, child care, and early education. Medicaid is particularly vital for children because it provides coverage for such a large proportion of the child population (close to one in three US children are covered by Medicaid or CHIP). Child patients with Medicaid coverage are also entitled to any benefit that is "medically necessary," which includes hospital care, physician services immunizations and early, periodic, screening, diagnostic, and treatment (EPSDT) for those under the age of 21³⁵ Medicaid also covers family planning, and other maternal health services for women across the country. Medicaid is also the predominant source of health coverage for children in the foster care system. These are among the most vulnerable children in society because of their unique social and emotional needs.

Violence prevention is an important child health and lifespan issue.³⁶ An estimated 702,000 children were confirmed by child protective services as being victims of abuse and neglect in 2014.³⁷ At least one in four children have experienced child neglect or abuse (including physical, emotional, and sexual) at some point in their lives, and one in seven children experienced abuse or neglect in the last year.³⁸ Children who have suffered abuse or neglect may develop a variety of short- or long-term behavioral and functional problems including conduct disorders, poor academic performance, decreased cognitive functioning, emotional instability, depression, a tendency to be aggressive or violent with others, post-traumatic stress disorder (PTSD), sleep disturbances, anxiety, oppositional behavior, and others³⁹

According to the landmark Adverse Childhood Experience Study (ACES), children who are exposed to traumatic life experiences are more likely to experience adult diseases later in life.⁴⁰ The Among those adults who had experienced the highest levels of childhood trauma and thus had the highest "ACES" score, those individuals were: five times more likely to have been alcoholic; nine times more likely to have abused illegal drugs; three times more likely to be clinically depressed; four times more likely to smoke; seventeen times more likely to have attempted suicide; three times more likely to have an unintended pregnancy; three times more likely to report more than 50 sexual partners; two times more likely to develop heart disease; and two times more likely to be obese.⁴¹

Violence prevention is not only a child health issue, as many children survive violence in the home that has impacts across their lifespan. It is important to invest in initiatives that reduce violence and promote child well-being such as domestic violence prevention, parenting education, evidence-based home visiting, and early childhood support. Furthermore, there is a

growing movement within the medical community to address these issues, like toxic stress, and to help patients access mental health and trauma-informed services. In addition, gun safety policies have the potential to decrease accidents and violence that result in thousands of injuries, disabilities, and deaths each year. The AAFP supports research and common-sense policies, such as improved background checks, to reduce the risk individuals may pose to themselves or to others within their communities.

Equity and Health Barriers

The mission of the AAFP is to improve the health of patients, families, and communities by serving the needs of members with professionalism and creativity. In their patient-centered practices, family physicians identify and address the social determinants of health for individuals and families, incorporating this information in the bio psychosocial model to promote continuous healing relationships, whole-person orientation, family and community context, and comprehensive care. Social determinants of health are the conditions under which people are born, grow, live, work, and age. To that end, the AAFP established its Center for Diversity and Health Equity to provide opportunities to become a more thoughtful and visible leader for diversity and health equity.

Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health. Experts agree that successfully achieving measurable outcomes is possible with a "health in all policies" strategy that examines the multiple factors that contribute to or detract from a patient's health. We must seek to understand how issues such as race, ethnicity, sex, age, disability, economic status, and geographic location influence health, but also acknowledge that access to housing, safe drinking water, and clean air also impact our patients.

The AAFP believes federal, state, and local policy makers should acquaint themselves with these social determinants of health and embrace equality as vital to community health. Policy makers should also eliminate barriers that prevent individuals from accessing the care, information, and social supports that they need to reach optimal health. One barrier that raises concerns for health equity is the persistent passage of federal laws that interfere with the doctor/patient relationship. These efforts often manifest in policies that create barriers for women's ability to access contraception and abortion. The AAFP opposes legislative interference in the doctor/patient relationship its replacement of scientific evidence and its undermining of patient autonomy.

The AAFP is also concerned about the state of federal funding and the implications for patients' health, safety and access to care. Growing federal funding cuts potentially create a domino effect of damage that ultimately will harm the health of America on both an individual and community-wide basis. Reducing funding for agencies that oversee the health care industry -- 17 percent of the U.S. economy -- destabilizes the foundation of services on which patients depend. Damage to one agency can impact the viability and effectiveness of others. The system is only as strong as the agencies and programs that undergird it. The AAFP encourages Congress to ensure stability of programs that are foundational to an effective, efficient health care system.

Health care access is also a significant barrier, especially for low-income individuals. The AAFP first adopted a policy supporting health care coverage for all in 1989. For the past 28 years the AAFP has advanced and supported policies that would ensure a greater number of Americans had health care coverage. The AAFP appreciates the bipartisan support for the *Medicare*

Access and CHIP Reauthorization Act's (MACRA) landmark reforms that have the potential for improving patient care outcomes by emphasizing value over fee-for-service. We welcome the opportunity to work with policymakers to evaluate MACRA's implementation process, enactment and the potential to improve patient outcomes.

It is also important to acknowledge that passage of the *Patient Protection and Affordable Care Act* represented a sea change for millions of patients. We are pleased the committee has engaged in bipartisan hearings on how to improve individual market as well as proposals to maintain the cost-sharing reduction payments. Medicaid expansion and the law's Essential Health Benefits were particularly important for vulnerable populations. Medicaid assists the most vulnerable patients who are members of minority groups, homeless, formerly incarcerated, foster and former foster youth, mentally ill, addicted, and military families. Insurance coverage rates among minorities are lower than rates among the non-Hispanic white population.⁴² Minorities experience disproportionate rates of illness, premature death, and disability compared to the general population.⁴³ In addition, virtually all of the estimated individuals nationally who are homeless could be eligible for Medicaid. Many in this population would benefit from the mental health and addiction treatment requirement included under the law.⁴⁴ Forty percent of our nation's veterans who are under 65 years of age have incomes that could qualify them for Medicaid under the ACA's expanded coverage.⁴⁵ In general, family members of veterans are not covered by the Veteran's Administration, but may seek coverage through Medicaid or the marketplace.⁴⁶ Many patients in this category are unaware that they qualify for health benefits.

A *New England Journal of Medicine* article indicates that the law's coverage expansion was associated with higher rates of having a usual source of care, greater access to primary care access, and, higher rates of preventive health screenings.⁴⁷ Anecdotal evidence among family physicians also reveal that health care access is saving lives and improving patient health for those who are accessing much-needed care for chronic diseases or detecting conditions in the initial stages. Again, achieving optimal health does not occur by accident. Realizing the vision of healthy communities, like other national priorities, requires that we identify goals, invest resources, and eliminate barriers, especially for vulnerable citizens.

Conclusion

The AAFP appreciates the opportunity to share these comments on community health and welcomes the opportunity to work with policy makers to achieve positive outcomes on these and other policies. For more information, please contact Sonya Clay, Government Relations Representative, at 202-232-9033 or sclay@aafp.org.

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