Testimony of
James King, MD, FAAFP
Board Chair
American Academy of Family Physicians

To the
Committee on Small Business
U.S. House of Representatives

Wednesday, September 9, 2009

Thank you, Chairwoman Velázquez and Ranking Member Graves and members of this committee, for your invitation to testify today about the potential effects of a major outbreak of H1N1 influenza on America's health providers. On behalf of the nearly 95,000 members of the American Academy of Family Physicians, many of whom work in solo or small group practices, we appreciate this opportunity to explore with you the potentially adverse effects of the H1N1 virus on the economic health of the nation.

Family physicians are affected by outbreaks of diseases like H1N1 in two very important ways. First of all, they are on the front line of diagnosis and treatment of the disease. Patients who are succumbing to it will often present themselves to their personal physician when they are beginning to experience symptoms. Often, then, it is the primary care physician who begins to notice the pattern of infection. Once the outbreak is determined, it will be the primary care physician who will be the conduit of health care services for both the infected patients and the "worried well" patients who need to be assured and educated.

Family physician practices will be affected in a second important way. A family medicine practice, especially in rural areas and underserved city areas, will often consist of one or two physicians and a small clinical and administrative staff. When staff members begin to show H1N1 symptoms, it is vital to the health of the practice's patients that the potentially symptomatic staff stays away from the practice's office. As a result, if an influenza outbreak infects just a few members of the practice, the ability of that practice to function would cease. And it is likely to be for a considerable length of time, since the usual recommendation for health care workers is to remain out of the office for seven days from the onset of symptoms.

This reduction in workforce will be occurring, of course, just as the workload is dramatically increasing. Most other business operations will be faced with the loss of staff, but usually it will not coincide with the increase in workload.

In many rural communities, family physicians are also the public health official, coroner, nursing home physician which means a symptomatic physician removes a key player from many community health care functions.

Preparation for Influenza Outbreaks

Family physicians and AAFP are taking the threat of an H1N1 outbreak very seriously and are engaged in extensive preparations. We see it as our fundamental responsibility to provide patients with the right information at the earliest possible time. We are also there to treat those patients who require medical intervention such as prescription of antiviral medicines or treatment of the complications of influenza. And of course many of our members will be involved in the administration of the novel H1N1 vaccine. During an outbreak, correct information, reliably and swiftly delivered to concerned patients, is essential. Those patients who do not need to be seen in a medical setting need to know this so they do not overwhelm the system. Those for whom evaluation and treatment is crucial—those at highest risk of complications—also need to get the information that will lead them to treatment.

The AAFP within a day of the first word of the H1N1 outbreak last spring began updating its website to provide links to crucial information from the Centers for Disease Control and Prevention (CDC), the larger HHS site and the World Health Organization. We have linked our members with the important guidance being issued by the CDC through frequent updates -- both on our H1N1 website and through our electronic postings of stories and our electronic newsletter, *AAFP News Now*, provided to our members.

We have been updating our various AAFP guidance documents as well such as the Checklist to Prepare Doctor's Office for Pandemic Influenza. The revised checklist should be posted later this week.

The CDC also asked AAFP to assist them in a variety of their activities including addressing the needs of pregnant women, children, primary care practice, immunization recommendations, and the financial issues relating to the administration of H1N1 vaccine.

We have also been urging our state chapters to work closely with their health departments since so many of the important decisions will occur at the local level. One silver lining in this whole affair is that the public health community and the primary care community are working together and learning about the ways they can help each other protect the public.

Individual practices are taking this information and organizing their own worksites and coordinating with community resources, like the local hospitals, community health clinics and other physician practices to appropriately handle the diagnosis and treatment of both seasonal influenza and H1N1 pandemic flu patients, including vaccination. Family medicine practices are encouraged to either provide their own website or link to a reliable local website (like that of a hospital or major clinic) for H1N1 flu information. Such a website should be updated daily or as necessary when the CDC information is updated. Some practices that maintain the e-mail addresses

of their patients will be able to send informational e-mails to them, in addition to making the information available to their patients through hand-outs at the office.

The Patient-Centered Medical Home and Service Outside of the Office

A large outbreak of H1N1 exposes a major deficiency in our health care system, namely the lack of coordination. For example, patients can access vaccinations at multiple sites – retail health clinics, work site clinics, health fairs, pharmacies and school based clinics. While this widespread availability makes the immunization convenient for the patient, it contributes to large systemic inefficiencies, like the oversupply of the vaccine and fragmentation in patient care. The production of more vaccines than are in demand leads to waste in the health care system and higher costs eventually for patients and payers. Importantly, fragmentation in care – in this case vaccinations administered outside of the patient's medical home – makes it very difficult for a practice to ensure that all of its patients have received the necessary shots without expending considerable staff effort.

The AAFP, along with the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association, have all recommended the implementation of the patient-centered medical home to address precisely this sort of deficiency. If everyone had a medical home, the health care site that provided the immunization would be expected to notify the patient's medical home that the patient had received the necessary immunization. Then the practice would have the technological capability to track that information and provide health care authorities with reliable figures of immunizations. This would help the practice direct its efforts to patients who need to be immunized and would minimize the overproduction and maldistribution of vaccines.

The patient-centered medical home also would connect primary and public health, especially in areas in which the medical home functions and public health functions are more tightly integrated in the community and connected to practices. This is the case, for example, in Vermont's Blueprint for Health and North Carolina's Community Care Medicaid program. In these communities, the medical home is more than about the practice, it is about coordinating community health, too.

There is another failure in our health care system that is obvious during an outbreak. Above all, it makes sense to keep symptomatic patients at home. Therefore, many health care activities, like monitoring of symptoms and tracking of how the patient is taking necessary drugs, should be accomplished by phone or e-mail. These billable services are currently not covered by most payers, but they take considerable staff time and effort. This is another reason that primary care physicians have urged Congress to follow the lead of many private sector providers in implementing patient-centered medical home initiatives. They allow all patients (not just the high-need patients specified in HR 3200) access to a medical home that will provide physician practices with a per-patient per-month fee for services including but not limited to telephone consultations (that would help keep patients out of the emergency rooms) and e-mail communications that will provide more

immediate monitoring for the practice and more useful and timely information for the patient.

Diversion of Resources from Non-Influenza Infected Patients

During a significant influenza outbreak, physicians may have to defer service to patients who are managing other chronic diseases or who should receive preventive health services. This is understandable in a widespread emergency situation and such a diversion of resources is temporary and necessary. However, even before H1N1 becomes a pandemic emergency, family physician practices will pay a price for the nation's underinvestment in primary care physicians. As the number of infections increases, family physicians in small and solo practices will find themselves overwhelmed by the number of patients, simply because the there is no where else that patients can go for sustained, reliable non-emergency health care. These practices, which usually serve rural and inner city populations, will have few extra resources to handle the growing number of infected patients. That is why it is imperative that as Congress considers health reform legislation it address this disastrous chronic underinvestment in the education and training of primary care physicians. The AAFP has recommended, for example, that Congress consider increasing Medicare's Graduate Medical Education (GME) payment for primary care residency slots to provide appropriate incentive to the nation's teaching hospitals to invest in primary care residencies. In addition, AAFP is suggesting experimenting with directing GME funds to primary care residency programs that would then contract with hospitals or teaching centers to train more primary care physicians.

Conclusion

Family physicians across the country, whether in rural, urban, frontier or suburban practices, are preparing to address the nation's health care needs during any serious and widespread outbreak of H1N1 or other strain of influenza. However, they and their patients will feel the brunt of the deficiencies in the nation's fragmented health care system that does not take seriously the need for a better investment in primary care. Family physicians will meet the challenge. We hope that Congress does as well.