

**Statement for the Record to the
Senate Health, Education, Labor, and Pensions Committee
Hearing
Access to Care: Health Centers and Providers in Underserved Communities
January 29, 2019**

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, *Access to Care: Health Centers and Providers in Underserved Communities*.

The AAFP appreciates the Committee's interest in examining health care access and underserved communities. 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 family physicians play an important role in community health, both as clinicians, but also as community partners who understand that factors outside of the doctor's office (the social determinants of health) impact patient 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. 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 tobacco use).¹

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.² High quality primary care is necessary to achieve the triple aim of improving population health, enhancing the patient experience and lowering per capita costs.³

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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.⁴ In contrast, those without a usual source of care have more problems accessing health care and more often do not receive appropriate medical help when it is necessary.⁵ Patients with a usual source of care have fewer expensive emergency room visits, unnecessary tests and procedures. They also enjoy better care coordination.⁶ We believe it is in the national interest to support programs with the potential to help improve patient access for primary medical care, particularly for vulnerable populations.

Primary Care Workforce and Underserved Communities

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.⁷ 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).⁸ 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.⁹ Therefore, it is imperative that physician care is accessible to all.

The current primary care physician shortage and maldistribution remain significant physician workforce challenges. An *Annals of Family Medicine* study projects that the changing needs of the U.S. population will require an additional 33,000 practicing primary care physicians by 2035.¹⁰ A 2017 Government Accountability Office (GAO) report indicates that physician maldistribution significantly impacts rural communities.¹¹ 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.¹² 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 medical education (GME) training remained concentrated in the Northeast and in urban areas, which continue to house 99% of medical residents.¹³ 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%.¹⁴

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.¹⁵ Some are also able to operate in environments where they are trained in mental health, drug and substance use treatment, and chronic pain management.¹⁶ Residents who train in underserved communities are likely to continue practicing in those same environments.¹⁷

American Medical Association Physician Masterfile data confirms that a majority of family medicine residents practice within 100 miles of their residency training location.¹⁸ By comparison, **fewer than 5% of physicians who complete training in hospital-based GME programs provide direct patient care in rural areas.**¹⁹ 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 Service 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.

Community health centers (CHCs) play an important role in primary care graduate medical education as well. The nation's 9,800 CHCs provide care for 25 million patients, 71 percent of whom are low-income.²⁰ CHC facilities, along with other safety net providers, are also valuable training settings for THCGME residents who care for patients like those they are likely to treat in primary care outpatient settings. Residents who train in CHCs also have the unique opportunity to be trained in delivery system models using electronic health records, providing culturally competent care, and following care coordination protocols.²¹ Some are also able to operate in environments where they are trained in mental health, drug and substance use treatment, and chronic pain management.²² Residents who train in underserved communities are likely to continue practicing in those same environments.²³ An important, but unique element within the THCGME program is that its accountability measures require an evaluation of the number of physicians who continue practicing after residency and if they continue serving in rural and underserved communities.

We appreciate Senators Lamar Alexander and Patty Murray's leadership in introducing S. 192, a bill that will reauthorize the Teaching Health Center Graduate Medical Education program, National Health Service Corps program, and Community Health Centers programs. This five-year reauthorization will help lay the foundation for much-needed stability and funding adequacy for these important programs.

Family Physicians and Health Care for All

The AAFP also supports health care for all, consistent with the public health mission of the specialty of family medicine. The AAFP promotes [health care for all](#) in the form of a primary care benefit design featuring the patient-centered medical home, and a payment system to support it for everyone in the United States.²⁴ AAFP believes that all Americans should have access to primary care services (e.g. in the case of infants and children, immunizations and other evidence-based preventive services, prenatal care, and well-child care), without cost sharing. The AAFP believes that health care for all should also include services outside the medical home (e.g. hospitalizations) with reasonable and appropriate cost sharing allowed, but with protections from financial hardship. Supporting access to care for everyone in the United States is consistent with the "triple aim" of improving patient experience, improving population health, and lowering the total cost of health care. Having both health insurance and a usual source of care (e.g., through an ongoing relationship with a family physician) contributes to better health outcomes, reduced disparities along socioeconomic lines, and reduced costs.²⁵

The AAFP urges each and every one of its members to become involved personally in improving the health of people from minority and socioeconomically disadvantaged groups. The Academy supports: cooperation between local family physicians and community health centers; promotion of health education in schools, faith-based organizations, and community groups;

continuation of beneficial programs that serve to promote health and disease prevention; simplified regulations and improved payment to encourage the establishment and success²⁶ of physician practices in underserved areas; and development of programs to encourage the provision of services by physicians and other health care professionals in underserved areas.

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 three decades ago. For the past 28 years the AAFP has advanced and supported policies that ensure a greater number of Americans enjoy the security of 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 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 to examine ways to improve the individual market as well as proposals to maintain 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 often members of minority groups, homeless, formerly incarcerated, foster and former foster youth, mentally ill, addicted, and/or in military families. Insurance coverage rates among minorities are lower than rates among the non-Hispanic white population.²⁷ Minorities experience disproportionate rates of illness, premature death, and disability compared to the general population.²⁸ 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.²⁹ 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.³⁰ In general, family members of veterans are not covered by the Veteran's Administration, but may seek coverage through Medicaid or the marketplace.³¹ 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.³² Anecdotal evidence among family physicians also reveals that health care access is saving lives and improving patient health for those who are accessing much-needed care for chronic diseases or detecting health challenges in their 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 health access and vulnerable communities 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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