Testimony before Primary Health and Aging Sub-Committee
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Good morning, Ranking Member Burr and Chairman Sanders, and members of the Subcommittee. My name is Dr. George Rust, and I am a Professor of Family Medicine and Co-Director of the National Center for Primary Care at Morehouse School of Medicine.

My testimony will focus on the importance of primary care in assuring the nation's health, the benefits of supporting a robust primary care capacity (especially in underserved communities), and the ways in which we can support medical schools to produce the primary care physicians that America needs.

Why is primary care so important? Published studies have demonstrated the positive impact of primary care on a variety of health outcomes, including decreased mortality (death rates) from cancer, heart disease, stroke, and all-causes combined. Primary care clinician capacity is also associated with fewer low birth weight births, increased life expectancy, and improved self-rated health. The dose of primary care can even be measured -- an increase of one primary care physician per 10,000 population was associated with an average mortality reduction of 5.3 percent, or 49 per 100,000 per year.[1]

Primary care is where you go for your flu shots and blood pressure treatment, and where your kids go for school physicals and immunizations, but it's also where you go to say *"Doc, I just don't feel right. Something's wrong."* Research by Dr. Barbara Starfield and others has shown for decades that the more primary care a community has, the better people's health outcomes are, and the more cost-effective the healthcare system is. In other words, **primary care matters**!

A June 2009 article in the *Journal of the American Medical Association* opens with this statement: *"Primary care is the essential foundation for an effective, efficient, and equitable health care system."* [2]

Think of the **successes we have achieved as a nation in improving America's health**. Death rates due to heart attack and stroke have declined by more than 50 percent. Public health outreach and screening campaigns related to blood pressure as "the silent killer" were clearly a part of the success story, but only when coupled with the routine screening and treatment of high blood pressure all day long in primary care practices all across the country. Cervical cancer death rates have declined by more than 75 percent, a success attributable in large part to nurse practitioners and nurse midwives and physician assistants and doctors in primary care practices doing Pap smears and finding pre-cancers that can be eliminated even before cancer takes hold.

In our own research at the National Center for Primary Care, we analyzed <u>all</u> the major successes in America's health over the last half-century. Among all the leading causes of death from 1950 to 2000, we found nine major causes of death that showed at least a 50% reduction in death rates from their 50-year peak level. Seven of those nine conditions demonstrated a pattern that we called **triangulating on success**[3] – three major components, including **<u>research innovation</u>** distributed through both medical care (especially **<u>primary care</u>**) **and <u>public health</u>**. Similar outcomes were achieved by our nation triangulating on success for heart attack and stroke, for cervical cancer, for TB and syphilis, for influenza and pneumonia, and for HIV/AIDS.

We have also studied how primary care can prevent unnecessary use of the emergency department. Using data from the National Health Interview Survey, we showed that people who experience simple barriers in timely access to primary care, such as difficulty getting through on the telephone or getting an appointment during an acute illness, were significantly more likely to have an emergency room visit.[4] **The emergency room becomes the safety valve when primary care access or capacity is inadequate.**

This is even more important for underserved segments of the population, which benefit most from access to primary care, especially the kind of primary care offered by community health centers – comprehensive, community-owned, culturally-relevant, team-based care. We compared rural counties in Georgia that had a community health center clinic site with those that did not, and found that there was a 33% higher rate of **uninsured** emergency department visit rates in counties without a community health center. Some of this could be considered emergency department diversion – acute illness events or injuries treated in the community health center rather than the emergency department. But some of the difference also represented **emergency department prevention, not diversion**. ED visit rates for ambulatory care sensitive conditions (including chronic conditions such as asthma, hypertension, and diabetes) showed a 37% excess in communities with no CHC.

This not only benefits the uninsured clients who are getting more of the right care in the right setting at the right time, but also benefits the community hospitals which reduce their indigent care costs, which could mean the difference between a rural hospital thriving or closing its doors. Using HCUP data from the Agency for Healthcare Research and Quality (AHRQ), we can estimate hospital charges due to uninsured hospitalizations across the nation to be $64.8 billion per year. Reducing this by a third in every community across the country which does not have a community health center or has inadequate primary care capacity, could potentially save tens of billions of dollars per year. **Primary care matters!**

The same is true in urban areas.[5] Over half of visits to an urban public hospital's emergency department are for primary care treatable or primary care preventable conditions. In other words**, a primary care health home helps assure that each patient gets the right care in the right setting at the right time.** Instead of treating a stroke in the ICU, we can treat high blood pressure right in the patient's own neighborhood. This primary care must be team-based care to achieve better outcomes for the whole patient. This includes re-connecting the head & the heart, by integrating mental health / behavioral health and primary care. Several years ago, our Morehouse School of Medicine National Center for Primary Care sponsored a summit of best-practice champions at the request of over a dozen federal agencies, in order to bring this model to wide-spread adoption, which is now happening all across the country. Community-Oriented Primary Care (COPC) combines the one-on-one caring for patients in a primary care clinical practice with the larger perspective of improving overall community health outcomes.

I had the privilege of working as a family physician of a HRSA-funded, community-owned migrant and community health center for six years in Central Florida early in my career. My career commitment to primary care in an underserved setting was nurtured and protected by a National Health Service Corps scholarship, and sustained by section 329/330 health center funding. As medical director, I dealt with incredible challenges in recruiting and retaining clinicians to meet the community's needs when the Corps was de-funded in the 1980's, and so I am thrilled to see a revitalization of the National Health Service Corps, with a new flexibility in recruiting and a stronger commitment to retention.

This primary care workforce is essential, and we must connect them with the communities where they are needed most. I was blessed to receive my residency training in Chicago's Cook County Hospital family medicine residency training program, which helped me to become an expert in primary care for the underserved and for culturally diverse populations. That program was supported by HRSA primary care residency training grants as well as primary care faculty development grants. They nurtured my idealism and fine-tuned my clinical skills in one of the earliest and best examples of **a teaching community health center**. My residency primary care continuity clinic experience was delivered in a federally-funded community health center that served a culturally diverse, high-volume, low-income patient population. I was fortunate to train in a setting where primary care was a team sport, delivered in partnership with physician assistants and nurse practitioners and pharmacists and social workers and psychologists.

For the past 21 years, I have had the privilege to teach and research primary care and community health at **the Morehouse School of Medicine, which was recently ranked #1 in the nation in social mission, based on our track record of producing the doctors that America really needs** – doctors that practice primary care, doctors that serve in underserved rural and inner city communities, and doctors that better represent the diversity of the American people.

Training primary care clinicians is broader than just training physicians, but medical schools are an expensive and essential component, so for the moment let me focus on what it takes for Morehouse School of Medicine and other institutions to be medical schools that excel in training the doctors America actually needs. **How do we do it?** On the positive side, we work hard to find the right students in the admissions process – students with reality-tested idealism, a track record of community service, and a commitment to making a difference in the world. We train students from day one in the community as well as in the classroom, and we nurture their commitment to serve and to make a difference. We have state-of-the art clinical training labs with actors as standardized patients to assure that students have both the clinical skills and people skills to deliver humane and effective care. We nurture and value our primary care faculty, cultivate partnerships with local community health centers in our neighborhoods, and we work together to build excellence in models of the patient-centered primary care medical home.

At the same time, our medical school is swimming upstream against incredible obstacles and financial incentives which lead most medical schools to run away from such a mission. Morehouse School of Medicine relies heavily on HRSA-funded primary care and diversity training grants, which have experienced significant cuts. Our training grants provide 8% indirect overhead cost rates, while NIH research grants offer indirect cost rates of 40-50% -- so the financial incentive is to expand investigator-initiated research, not to expand primary care training programs. Sub-specialist faculty can generate dramatically higher clinical revenues than primary care faculty – so which should our school hire more of? Graduate medical education support comes through hospital-based Medicare IME/DME payments – so where is the support for community-based residency education that keeps people out of the hospital? Is it any surprise that only one out of third-year internal medicine residents plan to practice as general internists after graduation? The rest will choose to pursue sub-specialty fellowships in specialties that are already over-subscribed, or if they remain generalists, to do hospitalist medicine, rather than outpatient primary care? It takes a moral commitment for a medical school to train primary care physicians for underserved areas, because every decision to do the right thing flies directly in the face of the financial incentives built into the largest sources of medical education funding. **Do we choose mission over margin? Do we risk the very survival of our**

own institution in order to keep our commitment to train primary care clinicians for communities in need? Is that a choice America wants us to have to make?

It is not by accident that the top ten schools for research funding are not in the top ten for training diverse students to become primary care physicians serving communities in need. Medical school research and medical school training has too often become disconnected from the real world community-based primary care clinical practice, and disconnected from training the doctors we most need for the communities where they are most needed. Our research must translate into real results – so we need more primary care and patient-centered research. To quote Dr. Larry Green, "if we want more evidence-based practice, we must generate more practice-based evidence." Translational research, whether funded by NCATS or other institutes, must find a more even balance between bench-to-bedside T1 translation and the T2 real-world implementation research that moves innovation out to curbside and countryside, where the free-range humans live.

Ultimately we need to rebalance our professional compensation scales so that there is not a ***"half-the-pay for twice the work"*** penalty associated with being a primary care physician. We need to reward patient care and community health outcomes more than we reward cranking out high-volume visits and procedures, so that primary care is not hamster-wheel medicine (running from exam room to exam room all day to achieve 30-40 visits), but rather is practiced in a humane, caring, and effective manner to achieve optimal care and outcomes for all our patients.

We also need to radically re-configure our financial support for medical schools to assure that we are getting an excellent return on our taxpayers' investment, as measured by training the kind of doctors America needs for the communities that need them most. We can no longer maintain the disproportion of hospital-based GME funding at 20-times the levels at which we fund Title VII and Title VIII primary care training programs. We need new mechanisms that train physicians to practice in teams in community-based settings to provide the right care in the right setting at the right time. COGME has suggested that Title VII needs to jump ten-fold from $50 million to $500 million, and still it would represent only 5% of the amount currently passed through Medicare to hospitals for GME. So we must test ways to disconnect the CMS graduate medical education payments from hospital-based specialty care, and fund community-based outpatient training programs that train clinicians to offer the right care in the right setting at the right time. **Why pay to train doctors we don't need to practice in places where they are not needed?**

Finally, we need to re-connect academic medical centers with real-world primary care and community health outcomes. A good start would be robust funding of the **teaching community health centers model**, connecting training and service for every medical student in schools that receive federal funding. Health professions funding should have a directly measurable ROI, and I can even imagine funding formulas pro-rated to the production of the clinicians America actually needs, clinicians who represent the diversity of the American people, who engage in community-oriented, team-based primary care, and who serve in communities of greatest need. Morehouse School of Medicine and other leading institutions have taken heroic risks with their own survival to prove that it can be done. **Let's train the clinicians America actually needs. Let's be smart about paying for health professions education that gives us a good return on our investment, and then reap the benefits in lower healthcare spending, more appropriate care, and better health for all Americans.**

Thank you.

TABLE 1—Adjusted Mortality Rates (per 100 000) for Selected Conditions: United States, 1950–2000

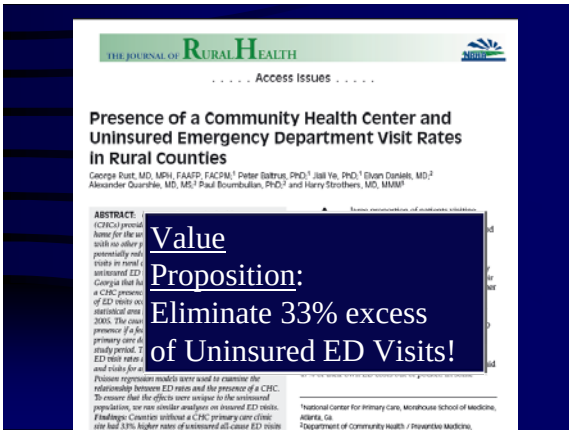
	Year 1950 Rate	Highest Rate (Peak Year)	Lowest Rate (Trough Year)	Year 2000 Rate	Decline From Peak Year, %
Stroke	180.7	180.7 (1950)	60.9 (2000)	60.9	66.3
Heart disease	586.8	586.8 (1950)	257.6 (2000)	257.6	56.1
Uterine and cervical cancer	26.2	26.2 (1950)	7.2 (2000)	7.2	72.5
Gastric cancer	24.2	24.2 (1950)	4.6 (2000)	4.6	81.0
HIV	. . .	16.3 (1995)	5.2 (2000)	5.2	67.9
Tuberculosis	25.5	25.5 (1950)	0.2 (2000)	0.2	91.4
Syphilis	6.1	6.1 (1950)	0.0 (2000)	0.0	100
Influenza and pneumonia	48.1	48.1 (1950)	23.7 (2000)	23.7	50.7
Unintentional injuries	78.0	78.0 (1950)	34.9 (2000)	34.9	55.3

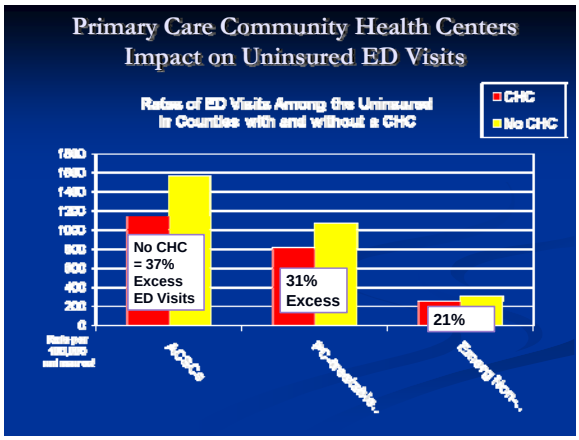
Triangulating on Success in America's Health

Research Discovery & Innovation

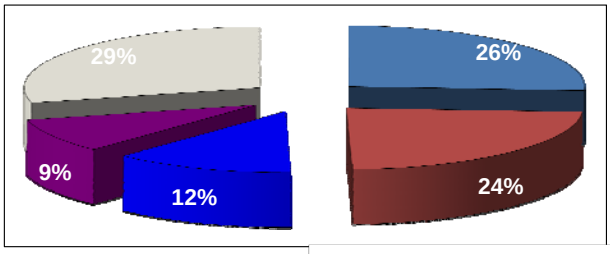
Public Health & Health Promotion

Primary Care Real-World Delivery





Hospital Discharge / ED Visit Data



Preventable or Treatable Visits to Grady Emergency Dept

60,876 ED visits during 6 months from July 1 to Dec 31, 2002 , using Billings algorithm

- **Non-Emergent**
- **Emergent, PC Treatable**
- **Emergent, PC Preventable**
- **Emergent, Non-Preventable**
- **Other Visits**

[1] Macinko J, Starfield B, Shi L. Quantifying the health benefits of primary care physician supply in the United States. *Int J Health Serv*. 2007;37(1):111-26.

[2] Grumbach K, Mold JW. A health care cooperative extension service: transforming primary care and community health. *JAMA* 2009; 301(24): 2589-90.

[3] Rust G, Satcher D, Fryer GE, Levine RS, Blumenthal DS. Triangulating on success: innovation, public health, medical care, and cause-specific US mortality rates over a half century (1950-2000). Am J Public Health. 2010 Apr 1;100 Suppl 1:S95-104. doi: 10.2105/AJPH.2009.164350. Epub 2010 Feb 10.

[4] Rust G, Ye J, Baltrus P, Daniels E, Adesunloye B, Fryer GE. Practical barriers to timely primary care access: impact on adult use of emergency department services. Arch Intern Med. 2008 Aug 11;168(15):1705-10. doi:10.1001/archinte.168.15.1705.

[5] Rust G, Baltrus P, Ye J, Daniels E, Quarshie A, Boumbulian P, Strothers H. Presence of a community health center and uninsured emergency department visit rates in rural counties. *J Rural Health*. 2009 Winter;25(1):8-16.