AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Testimony of

John S. Meigs, Jr, MD, FAAFP

President

American Academy of Family Physicians

Before the

House Energy and Commerce Committee

Subcommittee on Health

Examining the U.S. Preventive Services Task Force

November 30, 2016

AAFP Headquarters
11400 Tomahawk Creek Pkwy.
Leawood, KS 66211-2680
800.274.2237 • 913.906.6000
fp@aafp.org

AAFP Washington Office
1133 Connecticut Avenue, NW, Ste. 1100
Washington, DC 20036-1011
202.232.9033 • Fax: 202.232.9044
capitol@aafp.org

Chairman Pitts, Ranking Member Green, and members of the House Energy and Commerce Committee, Subcommittee on Health, thank you for the opportunity to testify today on behalf of the American Academy of Family Physicians (AAFP). The AAFP is the largest primary care organization in the United States with a membership representing 124,900 family physicians, residents, and medical students.

My name is John Meigs, Jr., and I am honored to serve as the president of the AAFP. I am a practicing family physician in Centreville, Alabama, with a population of 2,700, and currently serve as the Chief of Staff at the Bibb Medical Center.

In addition to my role as an AAFP leader, I am here representing family physicians, like myself, who see patients of every age, socioeconomic background, and health status. One out of every five office visits in the U.S. is with a family physician. Family physicians care for men, women, and children throughout their lifespan. We see patients with diverse needs. Some are suffering from acute conditions, like influenza or lower back injury, and want immediate relief. We see others who are checking in to review how well they achieved their diabetic, blood pressure, cholesterol, and weight loss goals, and maybe they are also experiencing some depression. We build long-lasting relationships with our patients and their families, promote healthy behaviors, detect problems early, manage chronic diseases, and work closely with subspecialists when clinically necessary. Additionally, the primary care team is the patient's gateway to the health system, assisting them and their caregivers in engaging with a very complex health care delivery system, as appropriate. Primary care physicians rely heavily on evidence-based recommendations for guidance on how to provide the highest quality health care for our diverse patient populations, and engage in shared decision-making with our patients that produces the best possible clinical outcomes with the fewest risks.

My work and that of hundreds of thousands of primary care physicians relies on the integrity of the U.S. Preventive Services Task Force (USPSTF or the Task Force). The Task Force was designed to be, and has been, a non-partisan, independent body of physicians and other health professionals who make valuable recommendations for primary care. Many recommendations within H.R. 1151, the *USPSTF Transparency and Accountability Act*, in our opinion, would undermine the work and progress that has been achieved since the Task Force was established in the early 1980's.

Primary Care and the U.S. Health Care System

It is important to note that the cornerstone of optimal individual and population health depends on the existence of a robust primary care and preventive health system. A primary care practice like mine serves as the patient's first point of entry into the health care system and is a consistent source of care. This is especially critical in rural communities like mine. Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, and the diagnosis and treatment of acute and chronic illnesses in a variety of health care settings.[1] Primary care physicians are specifically trained for and skilled in comprehensive, first contact, and continuing care for persons whose conditions are undifferentiated upon arrival and not limited by problem origin (such as biological, behavioral, or social), by organ system being treated, or by diagnosis.[2]

Research shows that preventive care, care coordination, and continuity of care—all hallmarks of primary care medicine—can achieve better health outcomes and cost savings. The benefits also

translate into healthier communities.[3] For instance, U.S. states with higher ratios of primary care physicians to population 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, even after controlling for sociodemographic measures (such as percentages of elderly, urban, and minority patient populations; education; income; unemployment; pollution) and lifestyle factors (seatbelt use, obesity, and smoking).[4] Even after accounting for all of these measures and factors, states with higher ratios of primary care physicians to population have better health outcomes.

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 percent, or 49 per 100,000 per year.[5] In addition, high quality primary care is necessary to achieve the triple aim of improving population health, enhancing the patient experience, and lowering costs.[6]

US Preventive Service Task Force and Primary Care

There is no one-size-fits-all manual to the practice of medicine or the delivery of medical care. Evidenced-based recommendations developed and advanced from the Task Force are critical to help physicians frame discussions with patients who are at risk for disease, guiding them to make an informed decision based upon timely scientific information and their personal preferences. The Task Force analyzes outcomes that affect a patient's quality of life and life expectancy, not merely a lab value or X-ray result. The Task Force publicizes what risks are possible as a result of screening, so that physicians and patients can make informed and better choices together that account for the good and the bad of a particular preventive service.

For example, when the U.S. Preventive Services Task Force made a 2009 decision about mammography screenings for women 40 years and older, I saw patients who were concerned. I discussed with these women what the recommendations meant for them as individuals, considering their health status, family history, and personal preferences. My patients had differing responses. Some wanted to screen no matter what. Others declined to test and wanted to continue the conversation. Still others wanted more information before making a decision. Such conversations between patients and their family physician are crucial and important to better health, smarter health care spending, and the avoidance of unnecessary care that may actually be harmful. This is why the Task Force is so critical to delivering better primary care.

Another example is colorectal cancer screening. The U.S. has focused on colonoscopy as the preferred screening method, but it is not right for everyone and evidence does not support its use as the best method of screening in all instances. In rural communities, there is often limited access to the procedure. But even with access, patients frequently do not want to undergo the procedure. Some people do not tolerate the prep needed. Some do not want to take the time away from work or do not want to undergo anesthesia. Some have heard about a bad experience from a friend. The Task Force explains the different screening options and the evidence behind them so that I can offer alternatives to my patients. This helps increase overall screening in primary care with evidence-based tests based upon patient preferences. This is what delivering patient-centered care is all about.

Currently, four family physicians serve on the Task Force, and the AAFP has one liaison that attends the in-person meetings, reviews the evidence reports, and participates in quarterly calls. The AAFP has a standing subcommittee of experts who review the Agency for Healthcare

Research and Quality evidence summary and Task Force recommendation statement. In most cases, we agree with and adopt Task Force recommendations. But on occasion, we reserve the right to disagree with the Task Force and develop our own statement that we disseminate to our members, along with the Task Force recommendations.

Balancing Risks and Harms

Task Force recommendations involve an assessment of benefits, risks, and harms. This creates important value for family physicians like me, our patients, and the nation. The Task Force focuses on outcomes that matter to our patients and considers all potential harms. Consider this example—fifty years ago, cervical cancer was the leading cause of death for women. The Pap smear, as a cervical cancer screening test, has had a dramatic effect on reducing the incidence and mortality of this disease. In recent years, the medical community performed Pap smears every year on all women starting at an early age. Young women, however, especially those under 21, have a high rate of abnormal Pap smears, which are false positives as cancer is incredibly rare in this age group. So young women were undergoing an uncomfortable exam, additional painful procedures, and receiving treatments with potential risks, without obtaining a comparable benefit.

Evidence has since shown that this frequent screening was not necessary to impact cervical cancer. Through our enthusiasm to prevent the disease, we inadvertently caused harm from invasive procedures that subjected patients to possible bleeding, infections, and other conditions that left them at risk for future miscarriages and pre-term delivery. Research clarified and provided guidance so that we now optimize the benefits while minimizing the harms. This is the type of informed and timely decision-making that is at stake if Congress attempts to alter the Task Force.

Preventive care is essential to improving the health of our population and reducing the ever-increasing cost of medical care. With all of the care that family doctors provide, we need to know what preventive services are best positioned to improve the health of our patients. In our continuous pursuit of prevention and wellness, we must remain mindful that some medical services have little impact on patients' well-being and may actually cause short and long-term harm.

Concerns about H.R. 1151, the USPSTF Transparency and Accountability Act

The AAFP has come to rely on the existence of an entity that makes objective, rigorous assessment of scientific and medical evidence. It is our opinion that this process works best when the participating physicians and scientists, as well as the Task Force itself, are insulated from commercial and political pressures.

H.R. 1151, in our opinion, undermines the Task Force by making its work to identify, evaluate, and implement patient-centered guidance more difficult. First, the legislation would dramatically alter the composition of the Task Force by creating a "balanced representation" of primary care experts and specialty care physicians. The AAFP believes that the current composition of the Task Force, which includes primary care clinicians and those with expertise in the critical appraisal of evidence, is appropriate and should not change. Primary care physicians, due to the diversity and complexity of the patients we care for, are uniquely situated to provide a comprehensive and whole-person perspective to the Task Force, as compared to physicians

and clinicians who care for a single disease process or organ system. Emerging research on the social determinants of health suggests that family and community factors are particularly impactful on preventive health and well-being in ways that were not well understood previously. Family physicians and other primary care physicians are well-versed in these important issues.

Specialty physicians play an essential and critical role in our health care system and primary care physicians rely upon their expertise and skills daily. While we have the highest level of respect for our specialty and subspecialty colleagues, their role in treating specific conditions and organ systems is not the same as developing guidelines to prevent such conditions. The Task Force was established to create evidence-based guidelines for preventive services in primary care. These guidelines should be developed by experts in primary care. In addition, the Task Force plays a valuable role in highlighting research gaps necessary to improve preventive health.

Importantly, subspecialists already contribute to the Task Force process in a number of ways. Subspecialists (and the societies representing them) may nominate topics for consideration. In addition, subspecialists work with the Task Force to develop research plans—they help determine what questions should be asked, what is the patient population a treatment option is intended for, and what interventions should be considered. Specialty physicians and their societies may comment on these draft research plans, which are published online. Subspecialists work with the Task Force team during the evidence review process and provide input on draft recommendation statements during the comment period. In other words, their expertise is consulted every step of the way, but the final vote is left to those with expertise in primary care and evidence-based medicine of primary care.

Second, the legislation would require input from the broader health care industry. We are deeply concerned that this provision would disrupt the objectivity of the Task Force, changing it from an evidence-based body to a group influenced by concerns about financial and political interests. This change would deeply undermine trust in the Task Force's clinical recommendations by members of primary care organizations like the AAFP. In recent years, we know that Task Force members and even our AAFP liaisons to the Task Force have been subjected to intensive lobbying from professional societies, as well as pharmaceutical and medical device companies that have significant economic interests in the recommendations of the Task Force. I have no doubt that pressure from these groups would only increase if H.R. 1151 were to be signed into law. Evidence-based guidance must be based on an objective and <u>independent</u> review of the evidence. If physicians and medical societies are unable to trust the objectivity of the Task Force, family physicians and other primary care clinicians will have far less trust in its recommendations, and they and their patients will be left adrift.

Third, the legislation would require the Task Force to assess how its decisions or grades would impact access to a health service, device, federal program, or private health insurance coverage. The AAFP strongly supports the evidence-based process and function of the Task Force and believes that the Task Force's recommendations should be independent of cost and access considerations. However, AAFP does support and favor current federal requirements that make preventive services available without co-pay or deductibles for all types of insurance. We strongly urge the Congress to support current coverage requirements for these important preventive services.

Conclusion

As physicians, our first and only objective should be the improvement of the health and well-being of our patients. This patient-first focus must also guide the work of the Task Force. In the opinion of the AAFP, the Task Force is best positioned to meet this patient-first objective through its current composition and its explicit rejection of external entities and persons who have economic interests in the Task Force's decisions. The Task Force has served our nation and health care system extremely well since its inception and continues to do so today. Its work to identify and deploy evidence-based preventive guidelines is important and any movement to alter this work should be avoided.

As the Committee considers the recommendations put forth in H.R. 1151 and other policy proposals, we strongly urge you to not undermine primary care. As I mentioned earlier in my testimony, primary care is the foundation of America's health care system. Primary care plays an essential role in our nation's health care, and in achieving better patient outcomes, lower costs, and better patient satisfaction. For decades, we have relied on and continue to rely on the Task Force's evidence-based recommendations to assist us in providing quality primary care. The best course of action would be a "do no harm" approach that does not change the composition in ways that undermine preventive care.

We also request that Congress maintain patient access to evidence-based preventive health care services. We believe that any changes to the Task Force should be focused on patient-centered outcomes—that is, what is in the best interests of patients and population health. The research tells us what screenings and tests are necessary. It also tells us when exams are unnecessary, or even harmful. Family physicians play a significant role in supporting preventive health efforts, but we also rely on research and utilizing our public health system that compliments the care we provide. As a family physician, I may screen for overweight and obesity, but the evidence is clear that we must also eliminate barriers to good health, such as making communities safer and more walkable, increasing access to nutritious food, and supporting public awareness efforts. The same applies to many other aspects of preventive care. We must continue to embrace rigorous support for evidence-based prevention and primary care, such as through the important and independent work of the Task Force, or we will miss out on the best opportunities to achieve optimal health care for all.

Again, I thank you for inviting me to testify and would be happy to answer your questions.

---

[1] Donaldson MS, Yordy KD, Lohr KN, Vanselow NA. Primary care: America's health in a new era. Washington, D.C.: National Academy Press; 1996.

[2] Institute of Medicine. A manpower policy for primary health care. Washington, D.C: National Academy of Sciences; 1978.

[3] Shi L, Macinko J, Starfield B, Politzer R, Wulu J, Xu J. Primary care, social inequalities, and all-cause, heart disease, and cancer mortality in US counties, 1990. *Am J Public Health*. 2005;95(4):674–680.

[4] Shi L. The relationship between primary care and life chances. *J Health Care Poor Underserved*. 1992;3(2):321-335

[5] 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):111-126.

[6] Shi L, Starfield B. Primary care, income inequality, and self-rated health in the United States: a mixed-level analysis. *Int J Health Serv*. 2000;30(3):541-555.