

The Robert Graham Center
Policy Studies in Family Medicine and Primary Care

Sixth Year Annual Report
June 2005



BACKGROUND

The Robert Graham Center: Policy Studies in Family Medicine and Primary Care is a research center created and operated to bring a family medicine and primary care perspective to policy deliberations at a federal and state level.

The Center is sponsored by the American Academy of Family Physicians, and its \$1.1 million expense budget is part of the regular operating budget of the Academy. This stable funding mechanism permits a concentration on production, instead of fundraising, and agile responsiveness to needs and opportunities. The Center generates revenues through grants and contracts that change from time to time and presently involve the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, the Fairfax Family Medicine Residency Program, Georgetown University, and the University of Colorado.

In addition to its research endeavors, the Center operates the Washington Primary Care Forum and the Graham Center Internship Program, and collaborates with Georgetown University in fellowship training.

At the end of its sixth year of operation, the Graham Center's staff is comprised of 5 full time positions, one half-time position, and a Senior Scholar in Residence. Lisa Klein administers the Center and provides research assistance. Jackie McGee works half time, assisting Lisa and providing reception functions. There are two analysts: Jessica McCann, an analytic geographer; and Martey Doodoo, a senior economist and demographer. There are two physicians at the Center, the assistant director, Andrew Bazemore, and Bob Phillips, the director. In addition to this regular staff, the Center contracts with Larry Green at the University of Colorado as our Senior Scholar in Residence. The Center is hopefully nearing the end of a search for a new senior health policy analyst. The Center continues to support interns and fellows. The Center enjoys expert information technology support from the AAFP staff in Kansas City and Washington, D.C, including support for the Center's website. The AAFP also provides organizational support including communications assistance and human resources.

The Center is advised by a national advisory committee as listed in appendix 1. This diverse group of experts guides overall directions of the center and offers critique of its work. Clyde Evans and Mary Jane England have rotated off the advisory board this year, and Francois DeBrantes of General Electric, has joined.

REVIEW OF YEAR SIX

The Graham Center continues to offer a visiting internship program, which provides outstanding junior scholars with an immersion experience in health policy while broadening and enriching Graham Center ideas and projects. The Center hosted 6 interns this year, representing a broad array of skills and interests:

Name	Topic	Affiliation
Amar Duggirala, MD	Childhood Obesity	Georgetown University and Johns Hopkins University
Grace Kuo, PharmD	Medication Errors	University of Texas Houston
Ahmad von Schlegell, MD	Intra-specialty differences in medication prescribing	University of Chicago
Lorraine Wallace, PhD	Health Literacy	University of Tennessee
Margaret Eberl, MD, MPH	Breast Cancer in Primary Care	University of Buffalo
Denise Young, MD	Patients with High Risk for AIDS	UMDNJ/Robert Wood Johnson Medical School

The Center continued its partnership with Georgetown University in 2004-05, hosting its fourth consecutive Health Policy Fellow, and additionally supporting the work of a policy-interested Community Health Fellow.

Name	Project Interest	Current Status
Charles Ellington, MD	Malpractice Reform	Faculty, University of Illinois
Ginger Ruddy, MD	Access and CHC's, Workforce	Community Health Center, Washington State

Approximately 25 of the Graham Center interns and fellows met in October at the annual meeting of the North American Primary Care Research Group in Orlando, Florida and shared career developments and work in progress.

The Center held eight Washington DC Primary Care Forums at the Cosmos Club:

Forum Number	Topic	Speaker
Primary Care Forum #38	Americanization of the UK Health System: Risks & Benefits	Ann Louise Kinmonth MA, MB, Bchir, MSc, MD
Primary Care Forum #39	The Election and the Uninsured	Judy Feder, PhD
Primary Care Forum #40	Improving The Care of People with Chronic Illnesses	Ed H. Wagner, M.D., M.P.H., F.A.C.P.
Primary Care Forum #41	The Future of Rural Health Care: Focus on Workforce	Mary Wakfield, PhD, RN, FAAN Howard Rabinowitz, MD
Primary Care Forum #42	Does Efficacy or Equity Save More Lives: An Analysis of Deaths in the United States	Steven Woolf, MD, MPH
Primary Care Forum #43	Medicaid Realities and Responses: Perspectives of Stats and the Healthcare Safety-Net	Matt Salo Dan Hawkins

Attendance at these breakfast presentations and discussions typically included about 30 individuals from government (HRSA, AHRQ), academia (Georgetown University, George Washington University), professional societies (AMA, ACP, AAP, AAFP, nursing, psychology), and advocacy groups. RWJF Policy fellows attended prior to starting their Hill assignments, and there are usually a few attendees from out of town.

The Center's location and connectivity permit it serving as a meeting place for various groups and events. Many visitors from around the country and internationally visit the Center with and without appointments, bringing updates and concerns of relevance to family medicine and primary care. Reciprocally, the staff of the Center present and consult with other research and professional groups across the United States and internationally, e.g. New Zealand, Canada, Australia, and the UK. This has most recently included collaboration with the National Primary Care Research and Development Centre in Manchester, England to understand the outcomes of "pay-for-performance" in the UK and to further patient safety in primary care.

Four themes continued to guide the work of the Center: The Value of Primary Care, Health Access & Equity, Delivery & Scope of the Medical Home; and Healthcare Quality and Safety. The written word remains the primary product of the Graham Center, and since last year's report, 17 manuscripts/editorials, 1 one-pager, and two books were published. A synopsis of these publications is provided in appendix 2.

MANUSCRIPTS:

1. **Green LA.** How family physicians are funded in the United States. *Med J Aus* 2004;181:113-114.
2. Woolf SH, Kuzel AJ, **Dovey SM, Phillips RL.** A string of mistakes: The importance of cascade analysis in describing, counting, and preventing medical errors. *Ann Fam Med* 2004;2:318-327.
3. Duane M , **Dovey SM, Klein LS, Green LA.** Follow-up on family practice residents' perspectives on length and content of training. *J Am Board of Fam Pract* 2004;17:377-384.
4. Rust G, **Fryer GE, Phillips RL,** Daniels E, Strothers H, Satcher D. Modifiable determinants of healthcare utilization within the African-American population. *JNMA* 2004; 96:1169-1177.
5. Bliss EB, Meyers DS, **Phillips RL, Fryer GE, Dovey SM, Green LA.** Variation in participation in health care settings associated with race and ethnicity. *J Gen Intern Med* 2004;19:931-936.
6. Mold JW, **Fryer GE,** Roberts AM. When do older patients change primary care physicians? *J Am Board Fam Pract* 2004;17:453-460.
7. Woolf SH, Johnson RE, **Fryer GE,** Rust G, Satcher D. The health impact of resolving racial disparities: An analysis of US mortality data. *Am J Public Health* 2004;12:2078-2081.
8. Kibbe DC, **Phillips RL, Green LA.** The continuity of care record. *Am Fam Physician* 2004; 7:1220-1223.
9. Tilyard M, **Dovey SM,** Hall K. Avoiding and fixing medical errors in general practice: Prevention strategies reported in the Linnaeus Collaboration's Primary Care International Study of Medical Errors. *New Zealand Medical Journal* 2005; 118:
10. **Phillips RL, Dodoo MS, Green LA.** Adding more specialists is not likely to improve population health: Is anybody listening. *Health Affs* 2005; March 15 (web exclusive).
11. Satcher D, **Fryer GE, McCann J,** Troutman A, Woolf SH, Rust G. What if we were equal? A comparison of the black-white mortality gap in 1960 and 2000. *Health Affs* 2005; 24:459-464.
12. **Phillips RL, Dodoo M,** Jaen CR, **Green LA.** COGME's 16th Report to Congress: Too many physicians could be worse than wasted., *Ann Fam Med* 2005; 3:268-270.
13. **Dodoo MS and Bazemore A.** Overcoming obstacles in US health care delivery with a new practice model for family practice. *Virtual Mentor.* 2005;7(6). Available at <http://www.ama-assn.org/ama/pub/category/15106.html>.

14. Yawn BP, **Fryer GE, Phillips RL, Dovey SM, Lanier D, Green LA**. Using the ecology model to describe the impact of asthma on patterns of health care. *BMV Pulmonary Medicine* 2005, 5:7.
15. Duane M, **Phillips RL**. Four-year residency training for the next generation of family physicians. *Virtual Mentor* 2005; 7(5). Available at <http://www.ama-assn.org/ama/pub/category/15104.html>.
16. Pathman DE, **Fryer GE, Green LA and Phillips RL**. Changes in age-adjusted mortality rates and disparities for rural physician shortage areas staffed by the National Health Service Corps: 1984-1998. *J Rural Health* 2005;21:214-220.
17. **Phillips RL, McCann J**. Cost-effective roles for nurse practitioners in secondary prevention. *BMJ* 2005;E357-E358.

ONE-PAGERS:

Number	Title
29	The Robert Graham Center (Phillips RL, Proser M, Green LA, Fryer GE, McCann J, Dodoo MS.) The importance of having a health insurance and a usual source of care. <i>Am Fam Physician</i> 2004 70:1035.

BOOKS:

1. Green LA, Dodoo MS, Ruddy G, Fryer GE, Phillips RL, McCann JL, et al. The physician workforce of the United States: a family medicine perspective. Washington, D.C.: Robert Graham Center, 2004.
2. Phillips RL, Dodoo MS, McCann JL, Bazemore A, Fryer GE, Klein LS, Green LA. Report to the task force on the Care of Children by Family Physicians. Washington, D.C.; Robert Graham Center, 2005.

IMPACT

There is growing belief that the physician workforce in the United States is insufficient to meet demand and is particularly deficient in subspecialists. This popular opinion is driving the current expansion of medical schools and efforts to expand residency training as well. The evidence underpinning this movement is focused on market-supply data and does not account for demand data or any theory of what health outcome goals are desirable for the population. The Graham Center has been one of the more potent sources of evidence and ideas to help shape policy related to workforce. The AAFP is currently considering both Graham Center workforce studies and potential changes to their own workforce policies.

This year, *Knowledge Bought Dearly*, a Graham Center publication and AAFP policy document, influenced the development of federal legislation aimed at chronic care management. This legislation was introduced by Senator Blanche Lincoln (D-AR), **S.2593 Title: A bill to amend title XVIII of the Social Security Act to provide Medicare beneficiaries with access to geriatric assessments and chronic care management, and for other purposes.** (HR 4689 was identical House Bill)

Radiologists attempted to restrict Medicare payments for imaging studies to their specialty. Maps produced by the Graham Center of the number of U.S. Counties without radiologists helped in defeating this effort in 2005.

The Graham Center held an international conference on patient safety taxonomies with support from AHRQ last October that generated a new consensus taxonomy, which led to involvement to a general patient safety taxonomy by the National Quality Forum, and the WONCA International Classification Committee to begin consideration of patient safety classification within a clinical classification system.

Early research efforts in patient safety and investment by the AAFP produced a functioning web-based error-reporting system that has been used in subsequent studies. This error-reporting system and the capacity for analyzing errors now housed within the Academy have poised it to consider becoming a Patient Safety Organization. The Academy has so strongly considered this option that it advocated for Patient Safety Organization legislation that recently became law.

YEAR SEVEN

Staffing of the Graham Center has been a significant focus of our energies and time this year. Year seven will see finalization of a substantial change in the staffing of the Graham Center. This change has brought considerable economic analysis capacity in Dr. Martey Dodoo whose foci this year will include understanding pay-for-performance lessons from the United Kingdom, supporting behavior-change research funded by Robert Wood Johnson Foundation, and understanding the basic financial model of primary care practice and what will be needed to sustain new models of care. We have hired a new assistant director, Dr. Andrew Bazemore, from the University of Cincinnati. Dr. Bazemore will be assuming

management of the internship program and has already taken on a leadership role in developing our web-based mapping tool in conjunction with the University of Cincinnati. Lisa Klein is a new mother and while we missed her in the Graham Center for several months, she is back full-time and taking on more research and project management support roles. Jackie McGee joined us just prior to Lisa's maternity leave and carried us very ably through that difficult period. She continues to assist Lisa. Jessica McCann, our analytic geographer, is also helping lead key pieces of our web-based mapping tool and is preparing the first tool elements and datasets that will be available to our clients. She also assumed a major role in our Title VII study with the University of San Francisco and HRSA. We are very close to announcing a new senior health policy researcher who will expand our research capacity and use of large datasets.

With two very large studies of workforce completed, we are turning back to smaller research projects and focused collaborations. Completing residual publications from our workforce studies will gradually give way to a broader agenda to include health economic topics, health disparities, and inter-specialty variations that suggest options for efficiency. Patient safety collaborations with the AAFP Developing Center for Excellence in Patient Safety (AHRQ-funded) are producing publications; one of which is now accepted for publication and will receive an award at NAPCRG in October, 2005.

The Graham Center's capacity for doing rapid, complex analyses relevant to timely policy issues has produced a demand that outstrips our capacity. We now not only provide data or evidence for national topics, but are asked by many state chapters or even local policy-makers for help. The Academy recognized our need to be able to serve up data to such end-users in an easier fashion and has generously funded our development of a web-based mapping tool. The Center will leverage Academy dollars through a partnership with the University of Cincinnati, which successfully obtained funding to develop a product with similar goals. This tool will initially permit registered users to draw on multiple data-sets housed at the Graham Center to tailor-make maps or data tables. This will begin as a limited set of analytic functions based on some of our most-demanded work. Our next hope is to translate our work with the mapping of health center service areas into a function for all community and rural health centers. The goal is to provide them with functional maps to drive clinic and health outreach development, and to produce a planning tool for health center development across the country. It will likely also have research potential. The initial tool is being developed in partnership with the University of Cincinnati Institute for Health Policy and Health Services Research and the Health Foundation of Greater Cincinnati. The latter efforts will be done in conjunction with the National Association of Community Health Centers with pursuit of funding from the Robert Wood Johnson Foundation and the National Library of Medicine.

KEY GOALS FOR YEAR SEVEN INCLUDE:

KEY GOALS FOR YEAR SEVEN INCLUDE:

1. Develop and beta-test a web-based mapping tool.

The Graham Center is attempting to break free of the restrictions of our staff size to provide guided access to our data and analyses. This tool will allow users to create maps and tables that meet their needs but driven by data and methods prepared by the Graham Center. This tool will also become a source of how data can be used by different audiences. It has the potential to fit under all of our themes, but will begin under the value of primary care as users will be able to generate customized FP-withdrawal maps, residency footprints (impact on community) and locate physician bonus payment areas. Together with partners from the University of Cincinnati, we will work with an outside contractor to build a web-based mapping tool capable of customizing our ongoing mapping project efforts to individual users nationwide.

2. Secure funding for the expansion of the web-based mapping tool for clinic-level data analysis.

In addition to producing maps and tables from existing data, the Graham Center will be pursuing an expansion of the tool to map clinical data to reveal clinical service areas and penetration rates within communities. We will begin with community health centers with whom we have partnered in piloting this project, to help them identify their patient communities and where they might look to expand their services in areas of unmet need. This function will further demonstrate the value of primary care providers to their communities and the critical role they play in providing access to underserved communities. It also has the capacity to address access and equity in healthcare. We will seek external funding for this expansion.

3. Continue to provide evidence-based arguments for rational physician workforce planning.

The Graham Center is unlikely to do much in the way of workforce research but will continue to disseminate our findings and communicate with the physician workforce research community. This work may address all of our themes as we respond to efforts that threaten the primary care workforce, and collaborate with others interested in transforming healthcare.

4. Establish a track-record for sound economic analysis related to healthcare financing and new models of primary care practice.

Primary care lacks of rigorous economic arguments and financing models for the care it provides. Under the leadership of our health economist, the Graham Center will do economic research that informs the transition to new model practice, reveals the return on investment for choosing primary care, and that evaluates new financing proposals for primary care. This area of work will likely address most of our themes.

5. Seek support for the evolution of the health policy fellowship with Georgetown to stabilize funding support and a two year program with a terminal degree.

The health policy fellowship co-hosted by the Graham Center with Georgetown has matured over the past 5 years and met its goal of producing young leaders in primary care. Georgetown has asked that the Academy solidify this program and our relationship by bringing the fellowship within the Academy. We support this progression and have suggested that it become a two year program with a terminal degree to permit them greater leeway in their next career moves.

6. Support the development of researchers and research infrastructure in family medicine.

Our internship program has hosted more than 40 people of various ages and experience, nearly all of whom have produced publications or other products. Andrew Bazemore, our new Assistant Director, has assumed leadership of this program and is doing some needed upgrades as well. We have also accepted some small subcontracts and agreements that permit us to make important contributions to research projects and educational efforts within at least five academic institutions. We will continue to look for ways to leverage our resources to help family medicine departments do more than they otherwise could.

7. Help foster clinical classification standards in the U.S. that are more supportive of primary care.

What we call things in primary care and how we measure episodes of care matters if we are to use primary care clinical data to study and improve care. The transition from ICD9 to ICD10 creates an opportunity in which The Graham Center can exert some leadership and provide evidence that can support the use of primary care clinical classifications. This includes applying to host an international conference on clinical classifications, publishing evidence about such classifications, and promoting the inclusion of patient safety taxonomies within such classifications. This relates most strongly to our theme on improving quality and safety, but in the long run will be much more revealing of the value of primary care.

CONCLUSION

The Graham Center has begun to have more visible impact on policy issues within the Academy and in legislative arenas. We have ventured into larger studies and monograph publication, and are poised to produce broader data service tools for our clients. Publishing and maintaining our credibility as an editorially-independent research center that is embedded within a professional organization is also of key importance. We have undergone significant staffing changes but are now configured to manage our original mission while exploring new evidence dissemination options.

Appendix 1

The Robert Graham Center: Policy Studies in Family Medicine and Primary Care

Advisory Board Members

Chuck M. Cutler, M.D., M.S.
Aetna National Quality Management
Blue Bell, PA

Francois DeBrantes
General Electric Company
Fairfield, CT

Paul B. Ginsburg, Ph.D.
Center for Studying Health System Change
Washington, D.C.

Ann-Louise Kinmonth
Professor of General Practice & Primary Care
University of Cambridge
Cambridge, England

Richard D. Lamm
Institute for Public Policy
Former Governor of Colorado
Denver, CO

Alma Littles, M.D.
Florida State University
Tallahassee, FL

Ed O'Neil, Ph.D.
Center for Health Professions
University of California
San Francisco, CA

David Satcher, M.D., Ph.D.
National Center for Primary Care
Morehouse School of Medicine
Atlanta, GA

Appendix 2

MANUSCRIPTS

Green LA. How family physicians are funded in the United States. Med J Aus 2004;181:113-114.

This invited editorial reported on the payment structure in the U.S. for Family Physicians. The current system undervalues family medicine and primary care and states that the current system will probably become untenable in 10-20 years. The editorial discusses the new model of family medicine.

Woolf SH, Kuzel AJ, Dovey SM, Phillips RL. A string of mistakes: The importance of cascade analysis in describing, counting, and preventing medical errors. Ann Fam Med 2004;2:318-327.

Notions about the most common errors in medicine currently rest on conjecture and weak epidemiologic evidence. This study sought to determine whether cascade analysis is of value in clarifying the epidemiology and causes of errors and whether physician reports are sensitive to the impact of errors on patients.

Duane M , Dovey SM, Klein LS, Green LA. Follow-up on family practice residents' perspectives on length and content of training. J Am Board of Fam Pract 2004;17:377-384.

This study is a follow-up to a study published in 2002 on the length and content of family practice residencies. The study resurveyed 442 third-year family practice residents who had participated in the 2000 study to determine whether their opinions about the length and content of residency had changed and whether they would still choose to be a physician and a family physician. Although most surveyed residents favored a 3-year residency program, a minority still supported extending training to 4 years, and the majority would still choose to enter family medicine programs if they were extended.

Rust G, Fryer GE, Phillips RL, Daniels E, Strothers H, Satcher D. Modifiable determinants of healthcare utilization within the African-American population. JNMA 2004; 96:1169-1177.

This study looked at disparities in access to and utilization of healthcare by African Americans. The analysis looked at the differential effects of modifiable risk factors (such as health insurance, usual source of care, and poverty) from personal characteristics (age, gender, rural residence) on healthcare utilization. This was a secondary data analysis using the 1999 MEPS Household file. There was significant variation in the number of office visits, outpatient clinic visits, hospital discharges, days hospitalized, and fills of prescribed medication. The three modifiable factors of poverty, uninsurance, and having a primary care medical home have a dramatic effect on patterns of care for African-American patients and could be independently targeted for intervention.

Bliss EB, Meyers DS, Phillips RL, Fryer GE, Dovey SM, Green LA. Variation in participation in health care settings associated with race and ethnicity. J Gen Intern Med 2004;19:931-936.

This study sought to use the ecology model of health care to contrast participation of black, non-Hispanics (blacks); white, non-Hispanics (whites); and Hispanics of any race (Hispanics) in 5 health care settings and determine whether disparities between those individuals exist among places where they receive care. The 1996 MEPS panel survey data were used to estimate the number of black, white, and Hispanic people per 1,000 receiving health care in each setting. Fewer blacks and Hispanics than whites received health care in physicians' offices, outpatient clinics, and emergency departments in contrast to hospitals and home care. Research and programs aimed at reducing disparities in receipt of care specifically in the outpatient setting may have an important role in the quest to reduce racial and ethnic disparities in health.

Mold JW, Fryer GE, Roberts AM. When do older patients change primary care physicians? J Am Board Fam Pract 2004;17:453-460.

The purpose of this study was to look at the reasons that older patients give for changing primary care physicians (PCPs) and to look at relationships between the duration of the PCP-patient relationship and the perceived quality of primary care received. Data collected during the first 2 years of a longitudinal study of primary care patients 65 years of age and older was analyzed. Older patients, particularly those who are older and have more education and income, tend to stay with their PCPs until they are forced to change. The longer they stay in the relationship the better they feel about the quality of the primary services they receive. Changes in the health care system may have increased the number of patients forced to change PCP.

Woolf SH, Johnson RE, Fryer GE, Rust G, Satcher D. The health impact of resolving racial disparities: An analysis of US mortality data. Am J Public Health 2004;12:2078-2081.

The US health care system spends far more on the "technology" of care (e.g. drugs, devices) than on achieving equity in its delivery. For 1991 to 2000, the study used data from the National Center for Health Statistics to estimate the maximum number of deaths averted by improving the technology of care and the number of avoidable deaths had African-Americans experienced the age-adjusted mortality rates of Whites. Medical advances averted 176,633 deaths, but equalizing the mortality rates of Whites and African Americans would have averted 886,202 deaths. Achieving equity may do more for health than perfecting the technology of care.

Kibbe DC, Phillips RL, Green LA. The continuity of care record. Am Fam Physician 2004; 7:1220-1223.

This invited editorial discussing the benefit of having a continuity of care record (CCR). The CCR is a document standard for basic health information, using XML (extensible mark-up language). It is being developed jointly by ASTM International, the Massachusetts Medical Society, the Health Information Management and Systems Society, the American Academy of Pediatrics, and the American Academy of Family Physicians. The CCR is intended to foster and improve continuity of patient care, reduce medical errors, increase patients' roles in managing their health, enable epidemic monitoring and public health research, and ensure at least a minimum standard of secure health information transportability. It is not an electronic health record or proprietary software. It is compatible with other efforts to standardize health information systems and can actually work across these efforts.

Tilyard M, Dovey SM, Hall K. Avoiding and fixing medical errors in general practice: Prevention strategies reported in the Linnaeus Collaboration's Primary Care International Study of Medical Errors. New Zealand Medical Journal 2005; 118:

This study looks at how to report tactics for avoiding and remedying medical errors observed by general practitioners in New Zealand and five other countries. The Primary Care International Study of Medical Errors collected 66 reports of medical errors in New Zealand and 363 reports from general practitioners in Australia, Canada, England, the Netherlands, and the United States. Strategies for avoiding and overcoming errors were grouped by themes, for New Zealand and the five other countries combined. General practitioners' medical errors reports suggest a culture of individual blame is more evident than recognised need for systems design. Error reporting systems may be a practical way to generate innovative solutions to potentially harmful problems facing general practice patients.

Phillips RL, Dodoo MS, Green LA. Adding more specialists is not likely to improve population health: Is anybody listening. Health Affs 2005; March 15 (web exclusive).

This invited editorial was in response to Barbara Starfield's paper titled: "The Effects Of Specialist Supply On Populations' Health: Assessing The Evidence" published on March 15. The editorial states that before a shortage of physicians, and particularly subspecialists, in the United States is declared, it is worth reviewing the considerable evidence that calls into question whether further specialization automatically improves health. Starfield's research reveals that having more specialists may not be a good thing. The current workforce functions well as an economic engine, but continued emphasis on market demand will likely widen disparities in workforce distribution and population health.

Phillips RL, Dodoo M, Jaen CR, Green LA. COGME's 16th Report to Congress: Too many physicians could be worse than wasted., Ann Fam Med 2005; 3:268-270.

Departing from past reports, the latest Council on Graduate Medical Education (COGME) report warns of a physician deficit of 85,000 by 2020 and recommends increases in medical school and residency output. COMGE notes that contribution of other clinicians and changes in how medical care is delivered in the future would likely offset physician deficits but chose not to modify their recommendations. Great caution should be exercised in expanding the workforce. Producing a physician surplus could be far worse than wasted, because the investment required and resulting rise in health care cost may harm, not help, the health of people in the United States. Instead, these resources could be applied in ways that improve health.

Satcher D, Fryer GE, McCann J, Troutman A, Woolf SH, Rust G. What if we were equal? A comparison of the black-white mortality gap in 1960 and 2000. Health Affs 2005; 24:459-464.

The United States has made progress in decreasing the black-white gap in civil rights, housing, education, and income since 1960, but health inequalities persist. We examined trends in black-white standardized mortality ratios (SMRs) for each age-sex group from 1960 to 2000. The black-white gap measured by SMR changed very little between 1960 and 2000 and actually worsened for infants and for African American men age thirty-five and older. In contrast, SMR improved in African American women. Using 2002 data, an estimated 83,570 excess deaths each year could be prevented in the United States if this black-white mortality gap could be eliminated.

Dodoo MS and Bazemore A. Overcoming obstacles in US health care delivery with a new practice model for family practice. Virtual Mentor. 2005;7(6). Available at <http://www.ama-assn.org/ama/pub/category/15106.html>.

This invited commentary highlights some of the hurdles and obstacles that have hindered physicians in the delivery of health care and present brief summaries of some proposals currently being discussed to overcome them. Despite brisk advances in science and technology and a bounty of medical knowledge, tools, and techniques to enhance patient care, US physicians still labor daily to provide the highest quality care to their patients at reasonable cost. They struggle against a complex collection of economic and business hurdles and obstacles imposed by the health care system. These challenges have made the current system unworkable for many physicians. Policy analysts have argued that the system cannot continue this way for much longer and have speculated that health care service delivery in the US will soon become a crisis unless it undergoes a major overhaul.

Pathman DE, Fryer GE, Green LA and Phillips RL. Changes in age-adjusted mortality rates and disparities for rural physician shortage areas staffed by the National Health Service Corps: 1984-1998. J Rural Health 2005;21:214-220.

This study assesses whether the National Health Service Corps's legislated goals to see health improve and health disparities lessen are being met in rural health professional shortage areas for a key population health indicator: age-adjusted mortality. From the early 1980s through the mid-1990s, the NHSC's goal to see health improve in rural health professional shortage areas was met, but its goal to diminish geographical health disparities was not.

Yawn BP, Fryer GE, Phillips RL, Dovey SM, Lanier D, Green LA. Using the ecology model to describe the impact of asthma on patterns of health care. BMJ Pulmonary Medicine 2005, 5:7.

This is a case-control study comparing the ecology of medical care for adults and school-aged children with asthma to the ecology of care for adults and school-aged children without any known chronic, life threatening or mental health conditions. The cases and controls were selected from participants in the 1999 MEPS. The ecology of medical care for school-aged children and young adults with self-reported asthma reveals a pattern of health care contacts that is distinctly different from those without priority conditions and identifies a group that may be the victim of health care disparities.

Duane M, Phillips RL. Four-year residency training for the next generation of family physicians. Virtual Mentor 2005; 7(5). Available at <http://www.ama-assn.org/ama/pub/category/15104.html>.

The current 3-year model has effectively and efficiently prepared nearly 70,000 family physicians whose care is associated with beneficial outcomes. With the new challenges we face and the specialty's commitment to a new model of care, it is time to consider transforming the manner and length of time in which we train family physicians. It is highly doubtful that a reduction in training time is an option if family medicine is to grow as a specialty and respond to the desire of many Americans for a new relationship with the health care system. Reducing the training time of family physicians would be a retreat from current trends and opportunities. What is needed is a period of purposeful innovation, with desired training outcomes geared to a new model of delivering care.

Phillips RL, McCann J. BMJ, Jun 2005; 330: E357 - E358. Cost-effective roles for nurse practitioners in secondary prevention

A study by Raftery et al on a cost-effectiveness of nurse-led secondary prevention for coronary heart disease offers evidence for an enhanced nursing role in primary care, but the differing locations of the cost and the savings may make implementation difficult in the US. This is not a study about disease management or pay-for-performance, however it is central to the need to find ways to improve secondary preventive care and supports an increased focus on team-based care that is patient-centered and breaks free from physician visits as the locus of care.

One Pagers

29: The importance of having a health insurance and a usual source of care. Am Fam Physician 2004 70:1035. (Phillips RL, Proser M, Green LA, Fryer GE, McCann J, Dodoo MS.)

The effects of insurance and having a usual source of care are additive. As the public prepares for the next round of providing health care coverage for all persons, it is important to recognize that everyone needs insurance and a medical home.