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

2008 Annual Report

ROBERT GRAHAM CENTER

AAFP Center for Policy Studies

The Robert Graham Center exists to improve individual and population health by enhancing the delivery of primary care. The Center aims to achieve this mission through the generation or synthesis of evidence that brings a family medicine and primary care perspective to health policy deliberations from the local to international levels. For more information, please visit www.graham-center.org

Letter from the Director

On the eve of a new administration, candidates promise that 2008-09 will be a year of great change. So too begins our 10th year at the Graham Center. Together with our parent organization, the American Academy of Family Physicians (AAFP), we have navigated significant restructuring that affected both our core staff and our funding model. Nonetheless, the Graham Center enjoyed a prolific year, and the resulting products and partnerships find us well-positioned to inform decision-making for primary care in the critical political season just ahead.

Moving forward, the Center will continue to be sponsored by the AAFP, which has emerged from a year of restructuring committed to Advocacy as its primary strategic aim. The AAFP's ongoing contributions to the Graham Center's $1.4 million budget offer the stability required for the Center to continue its abundant production of timely, policy-relevant research products. Recognizing the challenges to sustainable programs faced by the AAFP and other associations, however, the Center has increased its focus on generating revenue through grants and contracts. These presently involve work for the Josiah Macy Jr. Foundation, the American Association of Retired Persons (AARP), the National Association of Community Health Centers, George Washington University, John Snow Inc. on behalf of the Health Resources and Services Administration, the University of Colorado on behalf of the Agency for Healthcare Research and Quality, the Fairfax Family Medicine Residency Program, and Georgetown University. While having a smaller staff spend more time pursuing revenue from grants and contracts may impact productivity and responsiveness to a degree, the Center will work diligently to ensure that it remains an important source of evidence about the value of and opportunities for family medicine, primary care, and public health. We will also

continue our pursuit of evidence that is not only published and presented in a national forum, but that is also digestible and 'democratized'. For the AAFP to succeed in its primary strategic aim, we find it even more essential to arm primary care advocates with policy-relevant information and tools capable of customization.

Data and evidence resources:

- The RGC Update: Our core set of slides that present frequently requested data and analyses received a planned annual update in July 2008. It is available on our website, and widely disseminated with each update.

- HealthLandscape: Launched in April 2007, our customizable health mapping tool, www.healthlandscape.org now has more than 1500 registered users. In the past year, it has received praise not only from primary care, health center, and public health users, but also recognition from the software and mapping world as a unique and innovative product, being showcased at the GIS industry's two largest international gatherings. During that time, it has also proved an essential bridge for our center to collaborations and contracts with federal agencies, state chapters, community health centers and their associations, and to other health services researchers. These collaborations not only benefit our center's aims, but add layers and functionality to the tool that benefit all of its users. We plan continued expansion of this unique resource to ensure its relevance and usability by advocates, planners, and policy makers.

- One-pagers and Policy Briefs. One-pagers are published in *American Family Physician* and offer concise summaries of Graham Center analyses pertinent to family medicine and primary care. The Center produced seven such analyses and briefs in the past year, which continue to be distributed widely among grassroots advocates, AAFP leaders and staff, as well as policymakers. Additionally, the Center works with our Advocacy staff to help them shape evidence-driven policy briefs.

Scholars Program and Fellowship:

Interest in the Larry A. Green Visiting Scholar Program is very strong and positions are consistently filled a year in advance. It is a critical part of our mission and function, and among the most productive of our programs. We are very grateful to our partner, the Pisacano Leadership Foundation, which has graciously taken on

financial support for the program. Pisacano Scholars have been some of our most valuable visitors and most productive participants. The scholars program remains a source of 25-50% of our products, a teaching/mentoring outlet for our staff, and a tremendous source of pride.

The Australian Primary Health Care Research Institute (APHCRI) competitive visiting scholars program, with funding from the Australian Government, will allow another Australian primary care researcher to spend October and November 2008 in residence at the Graham Center.

KEY GOALS FOR YEAR NINE:

- Reinvent our website to become a more active source of policy-relevant information. The Graham Center website is our face to the world, one long in need of a makeover. We will use limited redesign resources efficiently this year, enhancing not only the aesthetic but also the functional dimensions of our site. Specifically, we aim to transform a site laudable mostly as an archive of our past products into a more dynamic window into Graham Center labors past, present and future.

- Release an update to our set of "core" articles. More than 100 articles long, the set of core articles offers evidence that is frequently requested of us. It will be accessible via the web with hyperlinks to article location or citation in our new website.

- Explore and define the impact of debt and other factors on physician trainees' choice of specialty and location of practice.

- Continue to explore the primary care workforce required for new models of practice, for alleviating distributional disparities, and for accommodating the growing staffing requirements of American's health care safety net, the community health centers.

- Assess access to care for neighborhoods, for the underserved, and for Medicare beneficiaries.

Bob Phillips, MD MSPH
Director

2007-2008 Highlights

Nine Larry A. Green Visiting Scholars

Four Washington DC Primary Care Fora

Five Manuscripts/editorials published

- Business Economics
- Family Medicine
- Journal of Rural Health
- Family Practice Management
- Quality and Safety in Health Care

Two Book Chapters published

Three Special Reports

- Access Granted: The Primary Care Payoff
- The Patient Centered Medical Home: History, Seven Core Features, Evidence and Transformational Change
- Impact of Proposed Rule on Designation of Medically Underserved Populations and Health Professional Shortage Areas: 73 Fed. Reg. 11232, et seq (February 29,2008)

Thirty Conference Presentations

- AcademyHealth
- North American Primary Care Research Group
- American Public Health Association
- NACHC Policy and Issues Forum
- American Association of Geographers
- AHRQ Annual PBRN Research Conference
- Association of Departments of Family Medicine Winter Meeting
- International Conference on Health Policy Statistics

Ten Consultations/Invited Seminars

Seven Committees/Service

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At Alma Ata in 1978, global leaders asserted that primary care is the central function and main focus of any just society's health care system. Despite this, primary care in the United States is in a state of crisis, in part due to public confusion over its role within the health care system. Through its research efforts, the Robert Graham Center seeks to demonstrate the value of primary care and identify options for enhancing its value.

The Value of Primary Care

Seeking a Replacement for the Medicare Physician Services Payment Method: A New Approach Improves Health Outcomes and Achieves Budgetary Savings

Business and government spending on physician services have soared over the last few decades. Most payers for services traditionally peg their payment rates to Medicare. However, most consider the current Medicare single payment rate flawed because it fails to improve health outcomes or control spending. Everyone wants to replace it, but good replacements have not been identified.

Under the guidance of PI, Martey Dodoo, the Graham Center estimated elasticities of the single-payment rate with respect to several of its determinants, proposed a replacement--a service-specific payment rate--for the single-payment rate, and estimated the budget implications of this replacement. Key findings are that the single-payment rate is relatively inelastic to the Sustained Growth Rate (SGR) and expenditure levels and that the proposed service-specific payment rate promotes primary care, controls spending, and saves money.

Reference: Dodoo, MS, Phillips, RL, Green, LA. Seeking a replacement for the Medicare physician services payment method: a new approach improves health outcomes and achieves budgetary savings. Business Economics. 2007;42:3.

Nonemergency Medicine-Trained Physician Coverage in Rural Emergency Departments

Rural areas have fewer physicians compared to urban areas, and rural emergency departments often rely on community or contracted providers for staffing. The emergency department workforce is composed of a variety of physician specialties and clinicians.

The Robert Graham Center collaborated with former Graham Center visiting scholar, Lars Peterson, to determine the distribution of emergency department clinicians and the proportion of care they provide across the rural-urban continuum.

The distribution of clinicians who provide emergency department care by county was determined using the 2003 Area Resource File. The percentage of emergency department care provided by clinician type was determined using 2003 Medicare claims data. Logistic regression analyses assessed the odds of being seen by different clinicians with a patient's rurality when presenting to the emergency department.

Board-certified emergency physicians provide 75% of all emergency department care, but only 48% for Medicare beneficiaries of the most rural of counties. The bulk of the remainder of emergency department care is largely provided by family physicians and general internists, with the percentage increasing with rurality. The likelihood of being seen by an emergency physician in the emergency department decreases 5-fold as rurality increases, while being seen by a family physician increases 7-fold.

Nonemergency physicians provide a significant portion of emergency department care, particularly in rural areas. Medical specialties must cooperate to ensure the availability of high-quality emergency department care to all Americans regardless of physician specialty.

Reference: Peterson LE, Dodoo M, Bennett KJ, Bazemore A, Phillips RL Jr. Nonemergency medicine-trained physician coverage in rural emergency departments. J Rural Health. 2008 Spring;24 (2):183-8.

Medicare's (un)sustainable growth rate.

Bob Phillips co-authored this editorial with Steven Wilk, MD. Addressing the failed SGR system and the potential insolvency of Medicare itself, Wilk and Phillips admonish family physicians to "gain a better understanding of how Medicare is funded and how it determines payment for Medicare services, and then talk with their legislators about the issues involved."

Reference: Wilk S and Phillips RL Jr. Medicare's (un)sustainable growth rate. *Fam Pract Manag.* 2008 May;15(5):9-10.

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Despite leading the world in healthcare expenditures, resources and technology, the United States lags behind other developed countries in most measures of population health. Overcoming this gap will require some fundamental level of access to all people in the United States. Through its research efforts, the Robert Graham Center seeks to inform policy that removes barriers to accessing healthcare and leads to a more equitable system of healthcare for all.

Health Access and Equity

Residency footprints: assessing the impact of training programs on the local physician workforce and communities.

National workforce models fail to capture the regional effect of residency programs, despite local control over decisions to open or close training sites. In the last 5 years, 37 (nearly 8% of total) family medicine residency programs have closed. The Graham Center collaborated with Valerie Reese and Jessica McCann to report on a novel approach to measuring the regional effect of residency training programs closures using a combination of quantitative and spatial methods.

American Medical Association Physician Masterfile records and residency graduate registries for 22 of 37 family medicine residency programs that closed between 2000-2006 were analyzed to determine regional patterns of physician practice, as well as the effect of graduates from closed programs on areas that otherwise would be Health Professional Shortage Areas (HPSAs). Program graduate data from two sampled programs were mapped using geographic information system software to display the distribution "footprint" of graduates regionally.

Of the 1,545 graduates of the 22 programs, 21% of graduates practice in rural locations, and 68% are in full-county or partial-county HPSAs. Without the graduates of these programs, there would have been 150 additional full HPSA counties in 15 states. The spatial distribution of the graduates of two closed pro-

grams demonstrates their effect across multiple counties and states.

The effect of closing family medicine residency programs is likely to go undetected for many years. Decisions regarding the fate of family medicine programs are often made without benefit of a full assessment. Local and regional effects on physician access are often recognized only after the fact. Novel approaches to analysis and display of local effects of closures are essential for policy decisions concerning physician workforce training.

Reference: Reese VF, McCann JL, Bazemore AW, Phillips RL Jr. Residency Footprints: Assessing the Impact of Training Programs on the Local Physician Workforce and Communities. *Family Medicine*. 2008;40 (5):339-344.

Access Granted: The Primary Care Payoff

Over 40 years ago, Community Health Centers began delivering health care to the medically underserved. 1,100 Community Health Centers now serve more than 16 million people in 6,000 plus sites located in all 50 states and U.S. territories. Community Health Centers never turn anyone away for care – regardless of insurance status or ability to pay. They are local, non-profit, community-owned and federally-supported.

This study, conducted by NACHC, the Robert Graham Center, and Capital Link, finds that Community Health Centers are a smart investment for a nation desperate for high quality, accessible and affordable health care.

Reference: National Association of Community Health Centers, Robert Graham Center, and Capital Link. *Access Granted: The Primary Care Payoff,* 2007. Available at: http://www.graham-center.org/x570.xml

Impact of Proposed Rule on Designation of Medically Underserved Populations and Health Professional Shortage Areas: 73 Fed. Reg. 11232, et seq (February 29, 2008)

When the Department of Health and Human Services proposed to restructure the primary care shortage area designation process in Spring 2008, the Graham Center worked to determine how the proposed legislation would affect physicians and patients. Using data from Dr. Tom Ricketts, our preliminary analyses pointed to dramatic impact on the landscape of shortage areas, with loss of designation for areas containing 31.8 million persons and 31,000 primary care physicians, and gains for 11.5 million persons and 5,100 primary care physicians. The current shortage designation process may be broken, but the proposed method was too complicated for anyone to be certain of its impact.

Reference: Stephen Petterson, PhD, Andrew Bazemore, MD MPH, Imam Xierali, PhD, Robert L Phillips, Jr., MD MSPH . *Impact of Proposed Rule on Designation of Medically Underserved Populations and Health Professional Shortage Areas: 73 Fed. Reg. 11232, et seq (February 29, 2008).* Available at http://www.aafp.org

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Health Access and Equity

Going Global: Considerations for Introducing Global Health into Family Medicine Training Programs

Medical students and residents have shown increasing interest in international health experiences. Before attempting to establish a global health training program in a family medicine residency, program faculty must consider the goals of the international program, whether there are champions to support the program, the resources available, and the specific type of program that best fits with the residency. The program itself should include didactics, peer education, experiential learning in international and domestic settings, and methods for preparing learners and evaluating program outcomes. Several hurdles can be anticipated in developing global health programs, including finances, meeting curricular and supervision requirements, and issues related to employment law, liability, and sustainability.

Reference: Evert J, Bazemore AW, Hixon A, Withy K. Going Global: Considerations for Introducing Global Health Into Family Medicine Training Programs. *Fam Med* 2007;39(9):659-65.

The Shoulder to Shoulder Model - Channeling Medical Volunteerism Toward Sustainable Health Change

Rapid growth in medical volunteerism in resource-poor countries presents an opportunity for improving global health. The challenge is to ensure that the good intentions of volunteers

are channeled effectively into endeavors that generate locally acceptable, sustainable changes in health. Started in Honduras in 1990, Shoulder to Shoulder is a network of partnerships between family medicine training programs and communities in Honduras and other resource-poor countries. The program involves short-term volunteering by US health professionals collaborating with community health boards in the host countries. The program has been implemented in seven US family medicine training programs and is supported by a small international staff.

During the 16 years of program operation, more than 1,400 volunteers have made visits to host countries, which include Honduras, Ecuador, and Tanzania. Clinics have been established, school-based food programs and community-based water filtration programs developed, and cancer screening and pregnancy-care programs put in place. These and other programs have been implemented on a budget of less than $400,000, raised through donations and small grants.

The Shoulder to Shoulder model allows health care professionals to channel short-term medical volunteerism into sustainable health partnerships with resource-poor communities. The resulting network of partnerships offers a powerful resource available to governments and foundations, poised to provide innovative interventions and cost-effective services directly to poor communities.

Reference: Heck JE, Bazemore A, Diller P. The Shoulder to Shoulder Model - Channeling Medical Volunteerism Toward Sustainable Health Change. *Fam Med* 2007;39(9):644-50.

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The United States must refocus on the delivery of safe, high quality healthcare, a lesson made clear in the Institute of Medicine reports, "To Err is Human" and "Crossing the Quality Chasm." Nowhere is this more critical than within the primary care setting, where most Americans receive the majority of their healthcare. Through its research, the Robert Graham Center seeks to reduce threats to patient safety and improve quality of healthcare.

Healthcare Quality and Safety

Testing process errors and their harms and consequences reported from family medicine practices: a study of the American Academy of Family Physicians National Research Network.

Little is known about the types and outcomes of errors related to tests done in primary care offices. The Graham Center has a long history of patient safety research and collaborated with the AAFP's National Research Network to study the types, predictors and outcomes of testing errors reported by family physicians and office staff. Events were reported anonymously and each office completed a survey describing their testing processes prior to event reporting. The offices submitted 590 event reports with 966 testing process errors. While significant physical harm was rare, adverse consequences for patients were common. The higher prevalence of harm and adverse consequences for minority patients is a troubling disparity needing further investigation.

Reference: Hickner J, Graham DG, Elder NC, Brandt E, Emsermann CB, Dovey S, Phillips R. Testing process errors and their harms and consequences reported from family medicine practices: a study of the American Academy of Family Physicians National Research Network. *Qual Saf Health Care.* 2008;17:194–200.

The Healthcare Policy Context. ABC of Patient Safety

Approaches to improving patient safety have been slow to develop, but there is now a

global programme for the development of patient safety policy. Major policy initiatives include the implementation of incident reporting systems and computerisation of healthcare processes. Advancing quality is a broader strategy, more positive in its focus, and likely better for marshalling resources and passion than safety in the long run; however, improving safety should be retained as a specific component of this effort.

Reference: Phillips RL. The Healthcare Policy Context. In: Sandars J, Cook G, eds. ABC of Patient Safety. Oxford: Blackwell BMJ Books; 2007.

Practice Based Research Networks. The Learning Healthcare System

A 'learning healthcare system' can learn a great deal from practice-based research networks (PBRNs), particularly for ambulatory care—the bulk of their clinical enterprise, the location most neglected by research and quality improvement efforts, and the setting where most Americans receive medical care. The clinicians who participate in PBRNs have natural connections to the entities that form the traditional research infrastructure but these connections lack the resources to support learning communities, to support practice-based research, and to translate research into practice. Even if the practices in a learning health care system are not organized into formal PBRNs, they will need to share some of the same characteristics and have some of the same resources to be successful. These include (1) expert clinician scientists who are financially supported to stay in practice while formulating researchable questions and executing studies, (2) modernized institutional review board policies, and (3) stabilized funding that is not tied to a particular study, but rather that sustains operations and communication systems across and between research projects.

Reference: Phillips RL Jr, Mold J, Peterson K. Practice Based Research Networks. The Learning Healthcare System. Workshop Summary (IOM Roundtable on Evidence-Based Medicine). Olsen L, McGinnis JM Eds. National Academies Press (Washington, DC). 2007

The essential features of family medicine include its comprehensive scope, its continuity, and its emphasis on family and community health. The Future of Family Medicine Report calls for a medical home that has these features and can deliver a consistent set of services. Through its research, the Robert Graham Center seeks to clarify the functions of the medical home and how to support them.

Delivery and Scope of the Medical Home

The Patient Centered Medical Home: History, Seven Core Features, Evidence and Transformational Change

The Patient Centered Medical Home (PCMH) is a model of care articulated by principles that embrace the aspirations of the Institute of Medicine, the design of the Future of Family Medicine new model of care and The Wagner Care Model, and the relationship desired by some of this country's largest employers for their employees. It is also a political construct that takes advantage of a 40 year-old name and organizing these previous articulations into a mutually agreeable model that has now begun to capture the collective psyche of Federal and State Government, employers and health plans. It is likely to be the best opportunity for aligning physician and patient frustration, demonstrated models for improving care, and private and public payment systems to produce the most profound transformation of the health care system in anyone's memory.

This paper is an effort to organize some of the evidence that is foundational to the concept. It is also an effort to identify key elements of a medical home for delivering a patient-centered experience.

Reference: The Robert Graham Center for Policy Studies in Family Medicine and Primary Care. The Patient Centered Medical Home: History, Seven Core Features, Evidence and Transformational Change. November 2007. Available at http://www.graham center.org/x570.xml

Washington Primary Care Forum

The Graham Center held four Washington DC Primary Care Forums at the Cosmos Club. These breakfast forums draw 20-40 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 often attend, and there are usually a few attendees from out of town. The series has been so successful that it inspired the US Agency for Healthcare Research and Quality to develop a parallel series of forums and we now coordinate schedules, topics and invitation lists.

- Forum #55: Greg Feero, MD, PhD - How Will Primary Care Manage the Genomic Revolution?
- Forum #56: Rachael Bornstein and Elizabeth K. Ziegler - What Will the Congressional Health Caucuses be Addressing in 2008?
- Forum #57: Mary Jane England, MD and Bob Phillips, MD, MSPH - Making Room for Mental Health in the Medical Home.
- Forum #58: Cathy Schoen, MS - Brakes for a Runaway Train?: The Medical Home's Role in Containing U.S. Health Care Expenditures.

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One-Pagers offer succinct summaries of research pertinent to family practice advocacy. These documents are distributed to congressional staff, AAFP leaders and staff, other family practice leaders and chapter executives. The One-Pagers are also published in *American Family Physician*.

Graham Center One-Pagers

Will Medical School Expansion Help Diversify the Physician Workforce?
The racial/ethnic composition of U.S. medical schools does not reflect the U.S. population. With proper planning, the current medical school expansion could improve physician diversity and reduce health disparities. Lindsay D, Bazemore AW, Bowman R, Petterson S, Green LA, Phillips RL. Will medical school expansion help to diversify the physician workforce? *Am Fam Physician* 2007; 76:38.

Rural Origins and Choosing Family Medicine Predict Future Rural Practice
The shortage of physicians in U.S. rural practice may impact access to health care for one in five citizens. Two medical student characteristics that predict eventual practice in rural settings are clear: being born in a rural county and choosing a residency in family medicine. Hyer J, Bazemore A, Bowman R, Zhang X, Petterson S, Phillips R. Rural Origins and Choosing Family Medicine Predict Future Rural Practice**.** *Am Fam Physician* 2007; 76:207.

Medical School Expansion: An Immediate Opportunity to Meet Rural Health Care Needs
The first expansion of allopathic medical education in 35 years is under way; this could eliminate rural physician shortage areas if students more likely to practice in rural areas are preferentially admitted and supported. Hyer J, Bazemore A, Bowman R, Zhang X, Petterson S, Phillips R. Medical School Expansion: An Immediate Opportunity to Meet Rural Health Care Needs. *Am Fam Physician* 2007; 76:207.

Behavioral Change Counseling in the Medical Home

Health-related behavioral counseling can and should be a central offering in the medical home. Primary care practices currently address unhealthy behaviors with their patients, but most practices lack the integrated approaches needed to effectively change these behaviors. Revisions in practice and financing are necessary to fully realize this capacity, which could affect the millions of patients served by the largest health care delivery platform in the United States. Balasubramanian BA, Cohen DJ, Dodoo MS, Bazemore AW, Green LA. Behavioral Change Counseling in the Medical Home. *Am Fam Physician* 2007; 76:1472.

Why There Must be Room for Mental Health in the Medical Home

Most people with poor mental health are cared for in primary care settings, despite many barriers. Efforts to provide everyone a medical home will require the inclusion of mental health care if it is to succeed in improving care and reducing costs. Petterson S, Phillips RL, Bazemore A, Dodoo MS, Zhang X, Green LA. Why There Must be Room for Mental Health in the Medical Home. *Am Fam Physician* 2008; 77:757.

Physician Distribution and Access: Workforce Priorities

Most Primary Care Health Professional Shortage Areas (HPSAs) exceed federal population-to-physician designation criteria, yet struggle to maintain access to primary care physicians. Policy options for recruiting and retaining primary care physicians to HPSAs, and new HPSA criteria that support access to primary care practices, should be considered. Zhang X, Phillips RL, Bazemore AW, Dodoo MS, Petterson S, Xierali I, and Green LA. Physician Distribution and Access: Workforce Priorities. *Am Fam Physician* 2008; 77: 1378.

A Perfect Storm: Changes Impacting Medicare Threaten Primary Care Access in Underserved Areas

A convergence of three policies could reduce physician Medicare payments by 14.9 to 22.3 percent in 2008, which could jeopardize access for Medicare beneficiaries in underserved areas. Congress and the Executive Branch should coordinate their roles in setting Medicare payment policy, because their overlapping decisions can have additive impact. Xierali I, Bazemore AW, Phillips RL, Petterson S, Dodoo MS, and Teevan B. A Perfect Storm: Changes Impacting Medicare Threaten Primary Care Access in Underserved Areas. *Am Fam Physician* 2008; 12: 1738.

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"I see this less as a one time visiting position and more as a beginning to a long standing collaboration." - Rebecca Etz, Ph.D.

"The ability to meet with AAFP and NACHC staff members, as well as legislators and their staffers from my home state, gave me a new understanding and appreciation of the political process. Thank you very much for this opportunity." - Karen Wildman, MD

"This experience was life-changing and has solidified my desire to pursue a career in health policy research." - Eddie J. Turner, MD

Larry A. Green Visiting Scholar Program and Health Policy Fellowship

The Graham Center continues to offer a visiting scholar program, which provides outstanding junior scholars with an immersion experience in health policy while broadening and enriching Graham Center ideas and projects. One of the goals of the scholars program, confirmed by testimonials from past scholars, is to seed primary care with leaders and researchers who experience and have an understanding of evidence-based policy development. Scholars work directly with staff on original research projects of interest to them, towards a goal of a national publication and dissemination.

As of June 2008, this program is supported through a generous grant from the Pisacano Leadership Foundation, the philanthropic foundation of the American Board of Family Medicine.

Health Policy Fellowship

The Graham Center continued its partnership with Georgetown University in 2007-08, hosting its sixth Health Policy Fellow, Dr. Anne Gaglioti. Dr. Gaglioti spent her fellowship year conducting scholarly research on the association between obesity and primary care physician density while serving as an attending physician at the District of Columbia Department of Corrections Central Detention Facility, teaching Georgetown University medical students, and precepting at the Georgetown University/Providence Hospital Family Medicine Residency Program.

The Center hosted nine Larry A. Green scholars this year, one Harkness Fellow, and an Australian Primary Health Care Research Institute (APHCRI)/Robert Graham Center Visiting Fellow, representing a broad array of skills and interests:

- Sean Lucan, Yale University - Perceptions of family medicine at the NIH
- Seema Modi, Eastern Carolina University Department of Family Medicine - Primary care case management and the medical home
- Eddie Turner, Baylor University - Minority entry in primary care
- Ruth McDonald, University of Manchester, U.K. (Harkness Fellow) - Financial incentives for quality in primary care
- Paul Grinzi, University of Melbourne, Australia (APHCRI/Robert Graham Center Visiting Fellow)- HealthLandscape and GIS: Lessons for Australian primary care
- Karen Wildman, University of Wyoming - Funding of educational health centers
- Jessica McIntyre, Georgetown University - Using GIS to teach community medicine
- Rebecca Etz, UMDNJ - Robert Wood Johnson School of Medicine - Mixed method investigation of a primary care data model
- Lenny Lesser, Tufts University - Nutrition policy and primary care
- Sarah Lesko, University of Washington - Medicare patient access to outpatient physicians
- Sharmila Chatterjee, Boston University School of Public Health and ENRM Veterans Hospital - Building the community health center workforce

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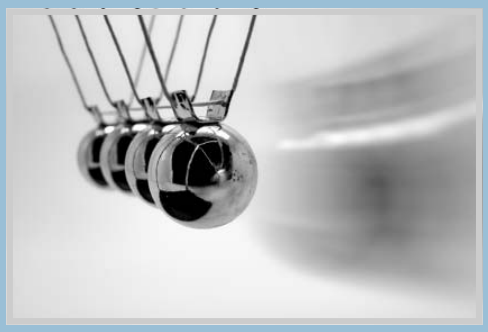

Each year, the Graham Center receives numerous requests for information from state chapters, family physicians, departments of family medicine and residency programs, AAFP staff and board members, and the media. Graham Center staff also serve on national committees and are invited to speak to a variety of audiences. The following is a sample of the ways in which Graham Center staff have assisted the family medicine and primary care community over the past year.

Impact

Advisees:

- **Grace Kuo, PharmD**, AHRQ K08 Baylor University
- **John Orzano, MD**, AHRQ K08 UMDNJ/RWJ Medical School
- **Jennifer Devoe, MD DPhil**, AHRQ K08 Oregon Health Sciences University

Requests for assistance/information:

- State Chapters
- Universities/Departments of Family Medicine
- Northwest Health Services, Inc.
  St. Joseph, MO
- Truman Medical Center Lakewood
  Kansas City, MO
- HRSA, Bureau of Health Professions
  Division of Medicine and Dentistry Division of State and Community Public Health
- Michigan BCBS Practice Transformation Institute
- Commission on Family Medicine, Colorado Assoc. Family Medicine Residencies
- The Mary Ann and J. Milburn Smith Child Health Research Program, Children's Memorial Research Center

Consultations/Invited Seminars

- National Center for Health Statistics, Division of Health Interview Statistics Data Analysis and Quality Assurance Branch - “Analyses of the NHIS data and information on the Access Deprivation Index”
- Bureau of Primary Health Care (HRSA) All-Grantee Meeting - “Staffing the Primary Care Office of the Future”
- Dartmouth College - “The Art of Physician Shortage Designation”
- HRSA Bureau of Health Professions Advisory Committee on Training in the Primary Care Medicine and Dentistry - “Training for the Patient-Centered Medical Home”
- American Cancer Society Primary Care Advisory Committee - “HealthLandscape: Identifying and Visualizing Healthcare Access”
- Family Medicine Congressional Conference - “HealthLandscape as a Lobbying Tool”
- George Washington University - “Health Care Policy and Community Oriented Primary Care”
- University of Cincinnati
- The Australian Government Department of Health and Ageing - “GIS and General Practice” by Dr. Paul Grinzi, APHCRI/Robert Graham Center Visiting Fellow

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Selected Media/Press:

- **AHRQ Releases 'How-to' Guide on Patient Registries. *U.S. Registries Inadequate, Says AAFP's Graham Center.*** *AAFP News Now.* June 20, 2007

- **Centers Claim Big Savings From Delivering Primary Care.** John Reichard. Centers Claim Big Savings From Delivering Primary Care. *CQ Healthbeat News*. August 6, 2007

- **HealthLandscape Empowers Health Planners with Online Mapping Tools.** *ESRI Healthy GIS Newsletter.* Fall 2007

- **The primary problem: Dwindling primary care doctors may mean worse health care for U.S., Utah.** *The Salt Lake Tribune.* November 25, 2007

- **Primary care gets short shrift in health IT standards push, doctors say.** Nancy Ferris. Primary care gets short shrift in health IT standards push, doctors say. *Government Health IT.* January 9, 2008

- **Report: Congress Should Increase Funding for Community Health Centers** - Leah Nylen. Report: Congress Should Increase Funding for Community Health Centers. *CQ Healthbeat News*. March 19, 2008

- **The doctor can't see you now**. Rachel Gotbaum. The doctor can't see you now. WBUR: Inside out documentaries, 2008. http://www.insideout.org/documentaries/primarycare

Committees/Service:

NAPCRG	Board, Committee on Advancing the Science of Family Medicine
Northeast Regional STFM	2008 Conference Planning Committee Kickoff Meeting Host
US Council on Graduate Medical Education	Vice Chair
Institute of Medicine	Committee on Parental Depression
National Business Group on Health	Evidence Based Benefit Design Committee and Primary Care Working Group
Medical Education Futures Study	Advisory Board
National Association of Community Health Centers	Research Advisory Board

Robert Wood Johnson Foundation

Drs. Green and Dodoo continued their roles in the Prescription for Health research program and translating findings for general use.

Practice Based Research Networks and Academic Primary Care Research

We are contractual partners with the Colorado Developing Evidence to Inform Decisions about Effectiveness (DEcIDE) Research Center (AHRQ funded) and this past year worked with them to develop the "Distributed Ambulatory Research Network" (DARTNet) using electronic health record data from eight organizations representing over 200 clinicians and over 350,000 patients.

We continue to do cross-sectional analyses of national datasets, practice-mapping, analyses of primary data, and other support functions for practice based research networks across the US. Dr. Bazemore also serves on the Board of the local CAPRICORN network, Dr. Dodoo advises the New Jersey Family Physicians Research Network.

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Robert Graham Center Staff

Robert Phillips, Jr., MD, MSPH
Director

Robert L. Phillips, Jr., MD, MSPH joined the Graham Center in 2000. Dr. Phillips has faculty appointments at Georgetown University, George Washington University and Virginia Commonwealth University. He is a graduate of the University of Florida College Of Medicine, and did residency training at the University of Missouri-Columbia. He completed a two- year NRSA research fellowship and practiced in a federal housing FQHC in Boone County, Missouri. He now practices in a community-based residency program in Fairfax, Va. Dr. Phillips is currently Vice-Chair of the Council on Graduate Medical Education which recently recommended expansion of physician training in health centers.

Andrew Bazemore, MD, MPH
Assistant Director

Andrew Bazemore, MD, MPH joined the Graham Center as its Assistant Director in July 2005. Dr. Bazemore has faculty appointments at the Department of Family Medicine at Georgetown University, George Washington University, and the University of Cincinnati. Prior to joining the Graham Center, Dr. Bazemore served as an Assistant Professor in the University of Cincinnati's Department of Family Medicine, where he also completed his residency training and faculty development fellowship. As a member of the Research Division as well as Director of the International Health Program, Dr. Bazemore devel-

oped interests in access to care for underserved populations both domestically and internationally and on the application of geographic information systems to the study of the U.S. safety net.

Dr. Bazemore received his B.A. degree from Davidson College, his M.D. from the University of North Carolina, and completed his M.P.H. at Harvard University.

Martey Dodoo, Ph.D.
Senior Economist

Martey S. Dodoo is the economic and demographic analyst at The Robert Graham Center. He has held previous economist and statistician positions with the PSC: Western Integrity Center, New Jersey Department of Health and Senior Services, and MDRC in New York. His current research interests are in health access and coverage, workforce, labor and demographic economics, program evaluation, patient safety and health quality, utilization, cost and fiscal impact analysis.

He earned his Ph.D. (Demography and Economics) degree from the University of Pennsylvania. He also has graduate degrees in Economics from the University of Western Ontario (Canada), the University of Ghana, and an undergraduate degree in Biochemistry. He is a member of the International Health Economics Association, the Society of Government Economists, and the Society for Clinical Data Management.

Stephen Petterson, Ph.D.
Senior Health Policy Researcher

Stephen Petterson is a Senior Health Policy Researcher at the Robert Graham Center. Previously, as a sociologist and social statistician he was on the faculty at the University of Virginia and a researcher at the Southeastern Rural Mental Health Research Center.

His research interests are in national and state health policy, access to care and health insurance, the relationship between primary care and mental health treatment and global health. He has a particular interest in understanding the barriers faced by disadvantaged populations in the health care system.

He earned his Ph.D. (1993, Sociology) from the University of Wisconsin and an undergraduate degree from Haverford College (1984, Sociology and Anthropology).

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Imam Xierali, Ph.D.
Health Geographer and Research Scientist

Imam Xierali is a Health Geographer and Research Scientist at the Robert Graham Center. Previously, he was a Statistical Analyst at Georgia Division of Public Health, actively participating in enterprise GIS management and applying Geographic Information Systems and spatial statistics into public health policy research.

His research interests are in spatial disparities in health and health care, geospatial technologies for health applications, statistical modeling, and spatial statistics. He is particularly interested in combining geospatial analytical tools and statistical modeling to study the spatial relationships between health and environment, health outcomes and primary care access and delivery.

He earned his Ph.D. in geography (2006) and M.A. in GIS (2004) from the University of Cincinnati. He also has an M.A. in political science (2003) from the University of Cincinnati. He is a member of the Association of American Geographers (AAG), American Public Health Association (APHA), Georgia Public Health Association (GPHA), and Pi Sigma Alpha.

Bridget Teevan, MIS
Office and Research Coordinator

Bridget Teevan joined the Graham Center as Office and Research Coordinator in April 2007 following the completion of her master's degree

in international studies. She has particular interests in global health policy and decision theory. In addition to coordinating the center's daily operations, Bridget manages the Robert Graham Center's research portfolio and administers the scholars and fellows programs.

Bridget received a B.S. in Chemistry (1997) from Florida State University and a master's degree in International Studies from North Carolina State University (2006). She will soon complete a graduate certificate in Field Epidemiology at the University of North Carolina School of Public Health. She is a member of Phi Beta Kappa.

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AAFP Center for Policy Studies

Address

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

1350 Connecticut Ave NW
Suite 201
Washington, DC 20036
Tel: (202) 331-3360
Fax: (202) 331-3374
Email: Policy@aafp.org

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