Population Health Advisory Committee Meeting

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Advisory Committee Meeting Summary:

The Robert Graham Center, HealthLandscape, American Board of Family Medicine, and Community Health Center, Inc. collaborated to develop a population health curriculum for health care professionals, in a project funded by the Health Resources and Services Administration (HRSA). The goal of the curriculum is to teach professionals to integrate community and clinical data and identify local resources to address social determinants of health and improve the health of patients and populations. The sub-goals are to: 1) demonstrate competency in using population health tools, 2) articulate the impact of social determinants on health, and 3) list resources to address social determinants. Through key informants, we invited thirteen population health experts to participate in an Advisory Committee for the curriculum. These included providers, policy makers, and researchers with experience in state and national public health funding, population health education, rural practice, and public health research.

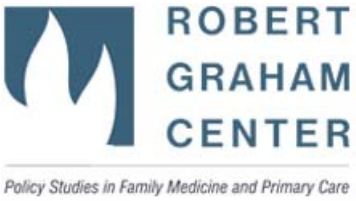
The Advisory Committee meeting took place on February 27, 2017 and included additional observers and participants from HRSA. The goal of the meeting was to gather perspectives from a diverse group of stakeholders in order to provide direction for the curriculum. The sub-goals were to: 1) validate the target audience, 2) incorporate feedback regarding the population health curricular needs of providers and learners, and 3) foster support for the curriculum from the Advisory Committee members.

Several themes emerged from this meeting.

- **The provider cannot do all of the work.** The participants acknowledged that providers are already burdened with meeting quality measures and electronic entry of data. Absent prior interest, they are unlikely to engage in this material without assistance from team members. The participants recommended including a wide range of team members in the training process.
- **To increase adoption, we must engage team members and practice facilitators.** Additional team members such as community health workers and medical assistants would be ideal advocates for this curriculum. Furthermore, practice facilitators can enhance adoption.
- **The activities within the tool should be tiered depending on the user.** The curriculum and tool require varying levels of interest, expertise, and data. Materials should be tailored to multiple types of users.
- **Curriculum implies that we have all of the answers regarding use of the tools. A platform may be a more appropriate model for what we are trying to build.** The participants reported that we will need to learn from end users regarding how the tools are being used.
- **How do we get the tool to help clinics think about care outside their walls**? The participants asked us to consider how to get end users to change the way care is delivered.

- **The tool and curriculum will have to be refined through an iterative process.** Using feedback from end users, we will need to add new use cases and modify the content of the curriculum.

Population Health Assessment Tool Advisory Committee Meeting Agenda



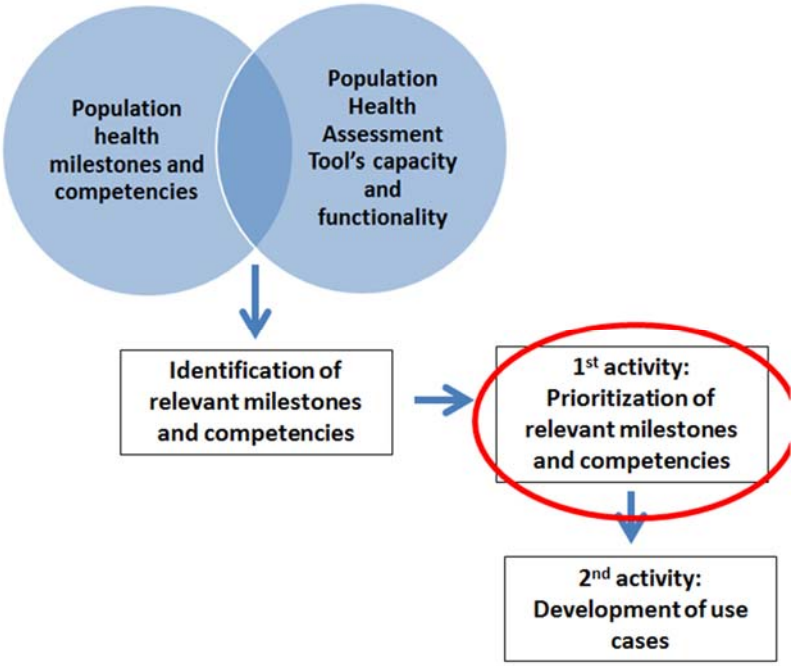
February 21, 2017
Robert Graham Center
1133 Connecticut Ave, NW
Washington, DC 20036

8:30 AM	Breakfast and registration
8:45 AM	Welcome and meeting overview
9:00 AM	Participant introductions
9:30 AM	Population Health Assessment Tool Background
10:15 AM	Questions, reactions, and feedback
10:30 AM	Break (10 minutes)
10:40 AM	Milestone and competency prioritization introduction
10:50 AM	Milestone and competency small group activity
11:35 AM	Small group report out
11:50 AM	Large group discussion
12:20 PM	Lunch Break (45 minutes)
1:05 PM	Developing use cases introduction
1:15 PM	Developing use cases small group
2:15 PM	Afternoon Snack Break (10 minutes)
2:25 PM	Developing use cases report out
2:55 PM	Developing use cases large group discussion
3:10 PM	Meeting Wrap-up and Next Steps
3:30 PM	Adjourn

Introduction

During this convening, we sought to identify and prioritize the family medicine milestones and nurse practitioner competencies that would be relevant to the curriculum. We plan to build a curriculum around meeting these milestones and competencies. Given the novelty of population health tools, we sought to generate examples for how practitioners may use these tools.

Figure 1: Logic Model Describing the Advisory Committee Meeting Activities



Milestone and Competency Prioritization

For the first group activity, participants were divided into three groups and given family medicine milestones and nurse practitioner competencies relevant to population health. We divided 56 family medicine milestones and 36 nurse practitioner competencies evenly across the three groups. Within each group, they were asked to individually select the 3 family medicine milestones and 3 nurse practitioner competencies most relevant to this curriculum and discuss their reasons for selecting those specific milestones and competencies. Each small group then discussed the individual selections and came to a consensus about the top 3 family medicine milestones and 3 nurse practitioner competencies selected. A spokesperson reported and justified those selections to the larger group.

Group 1:

Brian Freeman

Winston Liaw

Tyler Barreto

Julie Wood

Alek Shybut

Denise Koo

Emilia De Marchis

Family Medicine List (bolded terms indicate modifications):

1) Integrates practice and community data to improve population health
2) Integrates in-depth medical and personal knowledge of patient, family and community to decide, develop and implement treatment plans **and prevention**
3) **Mobilize team members and** facilitates patients' and families' efforts at self-management of their chronic conditions, including use of community resources and services.

Nurse Practitioner List:

1) Develop and evaluate care delivery approaches **within a team (clinical and community)** that meet current and future needs of patient populations based on scientific findings…
2) Anticipates variation in practice and is proactive in implementing interventions to ensure quality **using clinical and community data.**
3) Synthesizes concepts, including psychosocial dimensions and culture diversity, related to clinical prevention and population health in developing, implementing and evaluating interventions to address health promotion/disease prevention efforts, imporve health status/access pattersn, and/or address gaps in care of indiviuals, aggregates, populations **and community resources.**

Group 2:

Charise Corsino

Marissa Levine

Lloyd Michener

Jennifer Rankin

Virginia Watson

Joe Brodine

Family Medicine List:

1) Demonstrates leadership in a cultural proficiency, understanding of health disparities and SDH.
2) Collaborates with other practices, public health, and community-based organizations to education the public, guide policies, and implement and evaluate community initiatives.
3) Identifies health inequities and SDH and their impact on individual and family health.

Nurse Practitioner List:

1) Demonstrate the conceptual ability and technical skills to develop and execute an evaluation plan involving data extraction and practice transformation systems and databases.
2) Demonstrate leadership in the development and implementation of institutional, local, state, federal, and/or international health policies
3) Provides leadership to foster collaboration with multiple stakeholders to improve health care.

Group 3:

Bob Phillips

Alyssa Shell

Charlie Homer

Daniel McCorry

Joan Stanley

CJ Peek

Family Medicine List:

1) Uses an organized method, such as a registry, to assess and manage population health
2) Recognizes inefficiencies, inequities, variation and quality gaps in health care delivery
3) Engages the appropriate care team to provide accountable, team-based, coordinated care centered on individual patient needs.

Nurse Practitioner List:

1) Facilitates the development of health care systems that address the needs of culturally diverse populations, providers and other stakeholders

2) Lead interprofessional teams in the analysis of complex practice and organizational issues
3) Analyzes organizational structure, functions and resources to improve the delivery of care

Voting process:

To prioritize this list of milestones and competencies, each participant voted on the 2 family medicine milestones and 2 nurse practitioner competencies most relevant to the curriculum.

Family Medicine Top 2 Milestones:

1) Integrates practice and community data to improve population health
2) Collaborates with other practices, public health, and community-based organizations to education the public, guide policies, and implement and evaluate community initiatives.

Nurse Practitioner Top 2 Competencies:

1) Provides leadership to foster collaboration with multiple stakeholders to improve health care.
2) Facilitates the development of health care systems that address the needs of culturally diverse populations, providers and other stakeholders

Table 1: Family Medicine Milestone Prioritization and Use Cases

			Used in Stories		
Group	Family Medicine Milestones	Votes	Group 1	Group 2	Group 3
1	Integrates practice and community data to improve population health.	17		1	1
2	Collaborates with other practices, public health, and community- based organizations to educate the public, guide policies, and implement and evaluate community initiatives.	7		1	
3	Uses an organized method, such as a registry, to assess and manage population health.	6	1	1	1
1	Facilitates patients' and families' efforts at self- management of their chronic conditions, including use of community resources and services.	3	1		
2	Demonstrates leadership and mentorship in applying shared standards and ethical principles, including the priority of responsiveness to patient needs above self-interest across the health care team.	3		1	
2	Identifies specific community characteristics that impact specific patients' health.	1	1	1	1
3	Engages the appropriate care team to provide accountable, team-based, coordinated care centered on individual patient needs.	1	1	1	
1	Integrates in-depth medical and personal knowledge of patient, family and community to decide, develop, and implement treatment plans.	0	1	1	
3	Recognizes inefficiencies, inequities, variation, and quality gaps in health care delivery.	0		1	1

Table 2: Nurse Practitioner Competency Prioritization and Use Cases

			Used in Stories		
Group	Competency	Votes	Group 1	Group 2	Group 3
2	Provides leadership to foster collaboration with multiple stakeholders (e.g. patients, community, integrated	11	1	1	1
3	Facilitates the development of health care systems that address the needs of culturally diverse populations, providers, and other stakeholders.	9	1	1	1
2	Demonstrate the conceptual ability and technical skills to develop and execute an evaluation plan involving data extraction from practice information systems and databases.	6			
1	Synthesize concepts, including psychosocial dimensions and cultural diversity, related to clinical prevention and population health in developing, implementing, and evaluating interventions to address health promotion/disease prevention efforts, improve health status/access patterns, and/or address gaps in care of individuals, aggregates, or populations.	4	1		
1	Develop and evaluate care delivery approaches that meet current and future needs of patient populations based on scientific findings in nursing and other clinical sciences, as well as organizational, political, and economic sciences.	4			
1	Anticipates variations in practice and is proactive in implementing interventions to ensure quality	2			
2	Demonstrate leadership in the development and implementation of institutional, local, state, federal, and/or international health policy.	1			1
3	Leads interprofessional teams in the analysis of complex practice and organizational issues.	1	1	1	
3	Analyzes organizational structure, functions and resources to improve the delivery of care.	0			

Developing Use Cases

To better understand how these population health tools may be used in practice, we asked participants to individually write a story about how a learner or provider uses the tool, meeting milestones and competencies in the process. Within the small groups, the participants shared and then combined their stories into a single narrative. As a group, they told that narrative to the larger group and also reported which milestones and competencies were met as a result of the activities in the story.

Group 1:

The team uses the tool in clinic team meeting and is using the tool for population management. At the team meetings, the group is looking at community vital signs and identifying potential problems and resource poor communities. They are engaging the patient advisory council in their conversations to perform community needs assessment and community-oriented primary care.

During the course of the meeting, three providers discuss how they are using the tool.

Brian is a primary care physician who wants to better understand his hemoglobin A1cs. His metrics demonstrate that 30% of his patients have an A1c greater than 9. His salary is tied to these metrics. He engages with quality personnel at the clinic and uses the tool to determine the number of patients in food deserts without access to transportation. He uses the case manager to inform patients of transportation options available through insurance and direct them to community resources such as Meals on Wheels.

Winston is another primary care physician with two patients that are clinically worsening. Maezie is an 85 year old female with depression and heart disease. Her depression is getting worse, and this has resulted in multiple ED visits. Margot is an 80 year old female with similar symptoms. The clinic decides to map loneliness scores and identifies hot spots of loneliness. Winston works with the community health worker to talk to community leaders and identify

differences between communities with high and low loneliness scores. The low loneliness score communities had partnered with a non-profit organization which starts classes for elderly lonely adults. The clinic connects patients with this organization and tracks loneliness scores over time. They identify community factors associated with high loneliness scores and try to proactively identify communities and patients at high risk for loneliness.

Julie becomes a tool super user and brings the innovation to a state chapter meeting. By introducing the tool and providing use cases, other providers adopt the tool.

Group 2:

I'm an intern rotating through a community health clinic in Washington dc. After the first week of seeing patients, I feel like I've seen a lot of unplanned pregnancies. I mention this observation to the medical director who says that he had actually received a system flag for this outcome and we decide to investigate.

At the morning huddle, we raise this issue to our team, and the lead provider delegates a team member to investigate. That member uses the tool to determine that most of the patients that the clinic serves are in a specific area. Those areas are associated with <200% of the FPL, increased rates of smoking, increased prematurity, LBW, and infant mortality.

I also note that the incidence of <21 pregnancy is increased, and the placement of long-acting reversible contraception (LARCs) is below the national average.

This leads to a discussion with local academic partner and community partners. The graduate students work with those community partners to investigate whether any policy changes or any community factors had changed had prior to the finding of increase pregnancy. Preliminary findings suggest that there is increased incidence of depression and social isolation amongst this group.

While that investigation continues, our clinic staff agrees that we should include screening that comes up automatically for women of child bearing age (WOCBAs) that asks if they are currently interested in pregnancy and depending on their answer, routinely offer family planning support through our support staff or a community based group learning experience (like centering).

Our team also notes that the tool tells us that many are uninsured/underinsured, so we reach out to our board of directors that includes community stakeholders to ask how to support women who are not interested in becoming pregnant avoid pregnancy.

Our board members volunteer to take the data (underinsured, impoverished, incidence of unplanned pregnancy) to the city councilman who works with other policy makers to subsidize the cost of LARCs for those patients who are interested in contraception.

We conduct a focused assessment of our WOCBA patients to determine if they are satisfied with the clinic's response to the number of unplanned pregnancies, and discover that patients are upset that nothing has been done for those women who are newly pregnant and do not

possess the means to sustain proper nutrition/housing/smoking cessation/prenatal care during their pregnancy.

We work with our community health worker and social worker to design a questionnaire (assessment tool) to look at how we can get data from those patients to report into PHAsT. We plan to use that information to address additional housing and nutrition concerns within the local government.

Group 3:

This use case centers around multiple tool applications within a single clinic.

A care coordinator has panel management meetings to identify hot spots of poor health and specific patients who are not receiving needed care.

A resident asks her preceptor how to interpret the community vital signs data. In response, the preceptor recommends tools such as PCAM and community engagement to explore what, if anything, is needed to care for the patient.

The providers also participate in a weekly meeting where they pool patient data and discuss community trends and needs.

Finally, a resident sees an African American boy with multiple asthma exacerbations and wants to prevent future episodes. She refers the boy and his family to community resources (to help his mother quit smoking and to get supplies to treat mold in the apartment). She has other patients with similar patterns and live in the same community. These patterns make her wonder what is going on. Using the tool, she sees a pattern by race, age, and neighborhood. She is inspired to action, demonstrates leadership skills, and engages a care team to better understand these patterns. She partners with local organizations to investigate what might be contributing to higher asthma rates in these hot spots and discovers that a nearby plant reduces air quality. There are also high smoking rates in public spaces in the community housing complexes. She collaborates with the health department, school, and mobilize residents in the neighborhood to develop interventions to help reduce exposure to triggers.

Appendix: 2017 Robert Graham Center Population Health Assessment Tool Advisory Committee Meeting Attendee Biographies

Candice Chen, MD, MPH, is the Director of the Division of Medicine and Dentistry in the Bureau of Health Workforce at the Health Resources and Services Administration. The Division of Medicine and Dentistry funds programs to enhance training in primary care, oral health, and geriatrics; and provides support for graduate medical education in children's hospitals and teaching health centers. Prior to joining HRSA, Dr. Chen was an Assistant Research Professor in the Department of Health Policy in the School of Public Health and Health Services at the George Washington University, where she studied the role of medical education in producing a health workforce matched to the needs of communities. She is a board certified pediatrician.

She received her medical degree from Baylor College of Medicine and her Masters of Public Health from the George Washington University with a concentration in Community Oriented Primary Care.

Charise Corsino, MA, is the Program Manager for CHCI's Nurse Practitioner Residency Training Program. In this role Charise manages the operations, development, and growth of CHCI's NP Residency program of 10 Residents across 5 CHCI locations. Charise joined CHCI in 2010 as the Program Manager for the Statewide Mobile Program and Community Wellness Programs, overseeing the organization's in-school dental program, Community HealthCorps program, and a portfolio community wellness programs. In 2012, Charise became the Director of Middlesex County Sites, managing the daily operations of three of CHC's primary care health center locations. She joined the Weitzman Institute in 2014 in her current role as Program Manager. In addition, Charise has completed training at the Dartmouth Institute and is a certified Clinical Microsystems coach.

Charise earned a Bachelor of Science in Health Care Management from the University of Connecticut's School of Business and a Masters of Arts in Health Communication from Emerson College in collaboration with Tufts University School of Medicine.

Brian A. Freeman MD, MPH, is the Lead Physician at Bedford Community Health Center in Bedford, VA and an Adjunct Clinical Professor of Family Medicine at Liberty University. A recent graduate of the VCU/Fairfax Family Medicine Residency, he is also a National Health Service Corps Students' to Service loan repayment recipient. Passionate about the intersection of public health and medicine, Dr. Freeman seeks to improve populations by understanding how social determinants affect health and its delivery. He holds a BS in Biomedical Engineering from the University of Virginia, a MPH from Virginia Commonwealth University, and a MD from the University of Louisville.

Laura Gottlieb, MD, MPH, is an Associate Professor of Family and Community Medicine at UCSF, based at the Center for Health and Community. She is founding director of the Social Interventions Research and Evaluation Network (SIREN), a national initiative supported by Kaiser Community Benefit and the Robert Wood Johnson Foundation that brings together researchers across the U.S. to synthesize, disseminate, and catalyze research at the intersection of social and medical care. A former National Health Services Scholar and safety-net family physician with fellowship training in social determinants of health, Dr. Gottlieb now serves as Principal Investigator on multiple grant-supported studies focused on understanding the impacts of integrated social and medical service delivery. These projects range from large randomized clinical trials of Health Navigator programs to projects examining policy, incentives, and other infrastructure necessary to augment social service delivery capacity in medical care.

Dr. Gottlieb also is Associate Director of the Robert Wood Johnson National Program Office *Evidence for Action* grants program based at UCSF. She also currently serves on the Advisory Panel for the Health Leads-Kaiser Permanente multi-year evaluation, and on the Advisory Committee of the OCHIN-Kaiser Permanente ASSESS&DO trial focused on the integration of social determinants measures in electronic health records. Dr. Gottlieb is the Director of the San Francisco General Hospital Training and Education Programs for Urban Populations (STEP

UP), a cross-disciplinary initiative at the county's public hospital to improve training for physician residents and allied health professional trainees in advocacy, community engagement, leadership, and health policy.

Michael Hagen, MD, completed medical school and family medicine residency training at the University of Missouri-Columbia. Following residency, he practiced for several years in the Missouri Ozarks before joining the faculty at the University of Kentucky (UK) Department of Family and Community Medicine in 1981. At UK he has served as Residency Director, Clinic Director, Clerkship Director, Research Director, Associate Chair, and Chair. He took a leave of absence to complete a National Library of Medicine fellowship in Medical Informatics at New England Medical Center from 1987-1989. Dr. Hagen served a five-year term on the American Board of Family Medicine (ABFM) from 1991-1996, serving as President in his final year on the Board. He has led the ABFM's clinical simulation project since 1996, first as a part-time appointment and then full-time since 1998.

Dr. Hagen currently serves as ABFM Senior Vice President and has primary responsibility for ABFM's continuing certification activities. He teaches part-time at the University of Kentucky, where he holds the rank of Professor in the Department of Family and Community Medicine. He remains a Diplomate of the American Board of Family Medicine and a Clinical Informatics Diplomate of the American Board of Preventive Medicine and participates actively in ABFM's and ABPM's continuing certification processes. He is married with two daughters and has been licensed as a hand radio operator for 55 years.

Charlie Homer, MD, recently (12/2016) completed his service as the Deputy Assistant Secretary for Human Services Policy, Office of the Assistant Secretary for Planning and Evaluation/HHS. Prior to this, he co-founded the National Institute for Children's Health Quality (NICHQ) in July 1999, and served as the organization's president and CEO. He led NICHQ to focus not only on clinical quality, but also on the broad social conditions that contribute to childhood obesity and infant mortality. He is an Associate Clinical Professor of Pediatrics at Harvard Medical School and of Social and Behavioral Science at the Harvard School of Public Health. He is a past member of the third US Preventive Services Taskforce, the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children as well as numerous panels devoted to child health, health care and quality measurement. Charlie obtained his bachelor's degree from Yale University, his medical degree from the University of Pennsylvania, and a master's degree in public health from the University of North Carolina at Chapel Hill.

Denise Koo, MD, MPH, recently retired from her position as Advisor to the Associate Director for Policy at the Centers for Disease Control and Prevention. In that role she was the chief architect of the CDC Community Health Improvement Navigator (www.cdc.gov/chinav), a unifying framework and tools for stakeholders interested in improving the health of their communities, and led the development of an innovative tool for accelerating learning about social determinants of health, the Health and Well-Being for All Meeting-in-a-box (www.cdcfoundation.org/health-in-a-box).

Dr. Koo has a BA in biochemical sciences from Harvard University, an MPH in epidemiology from University of California, Berkeley, and an MD from University of California, San Francisco. She completed a residency in internal medicine at the Brigham and Women's Hospital in Boston. Dr. Koo held several leadership positions during her 25 years at the CDC, including as Chief of the National Notifiable Diseases Surveillance System, Director of the Division of Public Health Surveillance and Informatics, and Director of the Division of Scientific Education and Professional Development. As part of a 6-month assignment in 2015 with Dr. Karen DeSalvo, Acting Assistant Secretary for Health, U.S. Department of Health and Human Services, Dr. Koo helped launch the current Public Health 3.0 initiative. She is also Adjunct Professor of Epidemiology and of Global Health at Rollins School of Public Health, Emory University, and Consulting Professor of Family and Community Medicine, Duke University School of Medicine.

Dr. Marissa Levine, MD, MPH, FAAFP, was appointed Virginia State Health Commissioner by Governor Terry McAuliffe effective March 14, 2014. Dr. Levine previously held the positions of Chief Deputy Commissioner for Public Health and Preparedness and Deputy Commissioner for Public Health and Preparedness since February 2009. Prior to this role, Dr. Levine directed local health departments in two districts within Virginia since 2002.

Dr. Levine is a board-certified family physician who also received a Masters of Public Health (MPH) degree from the Johns Hopkins Bloomberg School of Public Health. She received her MD from the Albert Einstein College of Medicine in Bronx, NY and completed family practice residency training at the University of Virginia in Charlottesville. Dr. Levine started her career in private medical practice in Pennsylvania. She subsequently joined the staff of an academic medical center and became the director of a family practice residency training program in northwestern Pennsylvania. While in Pennsylvania, Dr. Levine was also very involved in community health improvement efforts and was a member of the local board of health.

J. Lloyd Michener, MD, is Professor and Chairman of the Department of Community and Family Medicine at Duke School of Medicine. He has spent his entire professional career at the interface between communities and health systems, focusing on finding ways of making health care more effective (and often more cost effective) through teams, community engagement and practice redesign. His work has demonstrated that health outcomes can be improved and costs can often be reduced when health care is built on local strengths, and responds to local needs.

Dr. Michener directs a national program for the "Practical Playbook" which facilitates the integration of Primary Care and Public Health, supported by the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the de Beaumont Foundation. He also leads the technical support service of "The BUILD Health Challenge", a national competitive award program aimed at increasing the number and effectiveness of hospital, community, and public health collaborations that improve health, supported by the de Beaumont Foundation, The Advisory Board Company, the Kresge Foundation, The Colorado Health Care Foundation, and the Robert Wood Johnson Foundation. He has overseen the Obesity/Chronic Disease Prevention Programs of the Kate B. Reynolds Trust, a program designed to lower chronic disease rates in low-income minority communities across North

Carolina, and the obesity prevention programs of the North Carolina Health and Wellness Trust Fund.

Dr. Michener has also served as an advisor to the CDC/CMS Million Hearts program, and as a member of the Institute of Medicine Committee that led to the publication of “Primary Care and Public Health: Exploring Integration to Improve Population Health”. In addition, Dr. Michener has served as President of the Association for Prevention Teaching & Research, Chair of the Council of Academic Societies and as a member of the Board of the Association of Academic Medical Colleges, the Association of Departments of Family Medicine, and the National Patient Safety Foundation Board of Governors. He has also served as a member of the Council of the National Center for Complementary and Alternative Medicine of the NIH, the National Academic Affiliations Advisory Council of the Department of Veterans Affairs, and the North Carolina Institute of Medicine, and as co-chair of the Community Engagement Key Function Committee for the Clinical Translation Science Awards of the National Institutes of Health, and leader of the annual NIH-funded meeting on community engagement in research.

Dr. Michener graduated from Oberlin College, received his MD from Harvard Medical School, and completed his family medicine residency and fellowship at Duke University Medical Center. Notable professional awards and recognition have included Phi Beta Kappa (Oberlin), Mead Johnson Award for Graduate Education in Family Medicine (American Academy of Family Physicians), Kellogg Family Medicine Faculty Fellowship, Alpha Omega Alpha (Duke School of Medicine), and Duncan Clark Award (Association for Prevention Teaching and Research).

C.J. Peek, PhD, is Professor in the Department of Family Medicine and Community Health at the University of Minnesota Medical School. He has worked toward better integration of behavioral health and medical care as psychologist member of primary care and other medical teams; hiring, training, and supervision of behavioral health clinicians; setting up integrated behavioral health within medical clinics, and facilitating system wide change. He has published and presented and consulted widely on a blend of clinical, organizational, and leadership topics required to bring about care system change, including productive conversations across disciplines and development of shared lexicons and usable common language in emerging fields. He has been part of research teams and expert panels, including at AHRQ.

Dr. Robert Phillips, MD, MSPH, is well known throughout the health policy community as an effective leader, communicator, and investigator. Under his leadership, the Robert Graham Center emerged as an authoritative source of information to guide policy, particularly as it relates to primary care and all of its features that are crucial to improving the cost-effectiveness of health care. In 2012, Dr. Phillips moved to the American Board of Family Medicine Vice President for Research and Policy to contribute to the research base underpinning primary care improvement, and to continue as a translator of evidence into policy.

Dr. Phillips has deep experience in designing and implementing health services research pertinent to policy development and a history of prodigious productivity. His passion for underserved populations is born of growing up in a rural community that is both a Health Professions Shortage Area and Medically Underserved Area, currently served by two Rural Health Clinics. It was bolstered by working in a Federally Qualified Health Center imbedded in a

Federal Housing Project. Dr. Phillips' research and policy experience led him to his selection by the Secretary of Health and Human Services to serve on a Federal Negotiated Rule Making Committee for the redesignation of shortage and underservice areas. Dr. Phillips also served as Vice-Chair of the US Council on Graduate Medical Education and continues to advise Federal and State governments on health education policy. His led physician workforce studies for AHRQ that produced primary care workforce estimates for the Federal Government and he recently served as principal investigator on a study of Graduate Medical Education accountability measures which will inform issues of stewardship related to $13 billion spent on these programs annually.

Dr. Phillips completed a month-long consultation to the Australian National University and Australian Government on the data systems they need to implement new geographically-organized population health systems, and was a Fulbright Specialist to the Netherlands in 2012 consulting on general practice research translation for policy. Dr. Phillips is a graduate of the Missouri University of Science and Technology and the University Of Florida College Of Medicine. He completed residency training in family medicine as well as health services research and public health training at the University of Missouri. He was elected to the Institute of Medicine of the National Academies of Science in 2010.

Alek Shybut, MPH, is a Health Education Specialist with Health Resources & Services Administration's (HRSA) Bureau of Primary Health Care (BPHC) in the Office of Quality Improvement's (OQI) Quality Division. Alek previously served two years serving in AmeriCorps tutoring and mentoring underserved youth as part of the Federal Way Public Schools program in Washington state. He then received his Master of Public Health (MPH) from Emory University and spent two years in Mozambique as a Health Volunteer for the Peace Corps. Alek now works to improve the quality of the Patient-Centered Medical Home initiative at HRSA through increased access to trainings, funding sources, and evidence-based data.

Joan M. Stanley, PhD, CRNP, FAAN, FAANP, is Chief Academic Officer at the American Association of Colleges of Nursing. Dr. Stanley serves as AACN's representative to numerous nursing education initiatives including the National Task Force on Quality Nurse Practitioner Education and the APRN Consensus Process which developed the national Model for APRN Regulation: Licensure, Accreditation, Certification and Education. Dr. Stanley has provided leadership for the development of the Essentials that delineate the curricular expectations for baccalaureate, master's and doctoral nursing education, as well as many major position statements on a variety of nursing education issues, including the Research-Focused Doctorate, the move of Advanced Nursing Practice to the Doctor of Nursing Practice degree, and the creation of a master's prepared nurse – the Clinical Nurse Leader.

Dr. Stanley serves as the PI on the CDC Collaboration with Academia to Strengthen Public Health Workforce Capacity Cooperative Agreement. Dr. Stanley held a faculty position, 1977-1982, in the Adult Primary Care NP Program at the University of Maryland. Since 1973, Dr. Stanley has continued to practice as an Adult NP at the University of Maryland Medical System. Dr. Stanley received her BSN from Duke University, an MS in Nursing from the University of

Maryland at Baltimore, and a PhD in Higher Education Policy and Organization from the University of Maryland at College Park.

Virginia Watson specializes in designing and developing learning environments that help people transform their thinking. Most recently she completed *Health and Well-Being For All*, a meeting-in-a-box for small groups to explore all the elements that effect health, the so-called "social determinants of health." This was a grant-funded Legacy Project based on her experience as Program Coordinator with a medical student fellowship at the Centers for Disease Control and Prevention (CDC) in Atlanta.

Virginia is also the lead writer/editor of Success Stories for The Practical Playbook, an online resource helping public health and primary care work together to improve population health.

After graduating with degrees in Economics and Journalism from Georgia State University, Virginia began her career as a medical writer and editor, specializing in a range of public health topics including epidemiology, reproductive health, violence prevention, immunization, global health, and HIV/TB. In this capacity, she won several prestigious national awards for analytic and investigative reporting from various organizations, including the National Press Club. After realizing she wanted help alleviate problems rather than simply report about them, Virginia earned a master's degree in instructional systems design and development from Georgia State University. Since then she has been involved in many educational projects for organizations such as CDC, CARE International, the Christian Children's Fund, and the Coca Cola Company.

Julie K. Wood, MD, MPH, FAAFP, became the Senior Vice President for Health of the Public and Interprofessional Activities in 2013 after a lengthy period of member service with the AAFP, including serving on its Board of Directors.She has oversight responsibilities for the public health, scientific, and research activities of the AAFP, as well as the AAFP's relationships with other medical organizations in the United States and abroad. Through these relationships, Wood facilitates the continued development of family medicine and coordinates the AAFP's global activities.

Under Wood's direction, the AAFP helps lead family physicians in health promotion, disease prevention, and chronic disease management as outlined in the AAFP's mission and strategic plan. She directs the AAFP's efforts to explore collaborative opportunities in additional areas related to the health of the public, such as health disparities and health equity, patient education, and social determinants of health. Science staff develops clinical policies and supports, conducts, and disseminates practice-based primary care research with the aim of improving health and health care for patients, their families, and communities.

As Senior Vice President, Wood also helps direct organization-wide strategy and policy-development activities in addition to participating actively in the work of the AAFP Board of Directors. She is based at the AAFP's headquarters office in Leawood, Kansas. Wood practiced family medicine for several years, including solo rural practice as well as in the academic setting of a residency program faculty. She has a breadth of experience in family medicine, serving a diverse range of patient populations

Wood earned her undergraduate degree and her medical degree from the University of Missouri Kansas City. She then completed her residency at Via Christi-St. Francis Family Medicine Residency Program in Wichita, Kansas and her MPH at the University of West Florida. She is board certified by the American Board of Family Medicine and has the AAFP Degree of Fellow, an earned degree awarded to family physicians for distinguished service and continuing medical education.

Andrew Bazemore, **MD, MPH**, joined the Robert Graham Center in 2005, and currently serves as its Director. He oversees research and projects related to access to care for underserved populations, health workforce, spatial analysis and health, and other topics. Prior to joining the Center, he was a member of the Faculty for the University of Cincinnati's Department of Family Medicine, where he also completed his residency training and fellowship, and where he remains an Associate Professor. Andrew also serves on the faculties of the Departments of Family Medicine at Georgetown University and VCU, and in the Department of Health Policy at George Washington University School of Public Health. He practices weekly and teaches students and residents at VCU-Fairfax Family Medicine Residency program. Dr. Bazemore received his BA degree from Davidson College, his MD from the University of North Carolina, and his MPH from Harvard University.

Winston Liaw, MD, MPH, joined the Robert Graham Center in 2016 and currently serves as the Medical Director. In this role, he oversees the visiting scholars and fellowship programs and conducts research on workforce, access, practice transformation, and the integration of public health and primary care. Prior to joining the Center, he was faculty at the Virginia Commonwealth University, Fairfax Family Medicine Residency Program. In that role, he taught residents and medical students, directed the residency's Global and Community Health Track, and served on the boards for his practice's accountable care organization and a community health center in northern Virginia. Dr. Liaw received a BA degree from Rice University, an MD from Baylor College of Medicine, an MPH from the Harvard School of Public Health, family medicine residency training from Virginia Commonwealth University, and health policy fellowship training from the Robert Graham Center.

Tyler Barreto, MD, originally from Indiana, earned her undergraduate degree in biochemistry from Grinnell College, and completed medical school and residency training at Michigan State University making her a long time Midwesterner. Dr. Barreto has the classic family medicine problem of being interested in a wide variety of topics, including population health, innovative health models, obesity, point of care ultrasound, and underserved populations. Her father was born in Cuba and Tyler has lived in the Dominican Republic, Costa Rica, Honduras, and Puerto Rico, She is fluent in Spanish and has a special interest and broad understanding of Latino issues. Dr. Barreto has been an active researcher throughout her training and early career. One of her studies was named the Poster of Distinction at Obesity Week in 2015, and she was awarded the AFMRD/NAPCRG Family Medicine Resident Award for Scholarship. As a Robert L. Phillips Jr. Health Policy Fellow, Dr. Barreto's work focuses on obstetric workforce shortages, identifying key variables in successful innovative care models, addressing behavioral health shortages, and assessing workforce demographics in low value care.

Joe Brodine is currently a 4th year medical student at Georgetown University School of Medicine completing his rotation as a visiting scholar at the Robert Graham Center. Prior to medical school, he had worked as a clinical researcher with a cohort of AIDS-defined patients studying long-term ocular complications of HIV, and then went on to work as a registered nurse in the neurological critical care unit at the Johns Hopkins Hospital. He decided to enter medicine after earning his graduate degree in public health, and now plans to train as a Family Medicine physician upon completion of medical school.

As a medical student, Joe has been involved with the AAFP national leadership as the student member for the Commission on Governmental Advocacy. He has also helped to lead a group of medical students and residents studying burnout and wellness among medical students through FMA Health. These experiences have led him to recognized the discipline of Family Medicine as the specialty that would enable him to become an effective clinician while pursuing his passion for population health.

Megan Coffman, MS, joined the Robert Graham Center in February 2013 as the Health Policy Administrator. Her work at includes project, budget, and grant management. Prior to joining the Robert Graham Center, Megan managed projects for educational and health nonprofits. She got her start in public health as a Peace Corps volunteer in Mauritania and Mali. In 2010, Megan received her Master of Science in Health Communication from Tufts University, and holds a BA in Political Science from Butler University.

Emilia De Marchis, MD, grew up in Vermont, Emilia spent her time skiing and soaking up the liberal politics of her fine state. While in college at UVM, she became interested in international relations and public health, focusing her research in African and European nations. Realizing she wanted to do more on the ground to influence health policy and human rights, she completed a post-bacc at Johns Hopkins while fiddling in a neuropath lab and taking classes at the school of public health. Medical school was a perfect venue to continue exploring ever changing interests, dabbling in global health, pathology, health policy, clinical research, and medical education, all of which finally brought her to family medicine.

During residency, she has kept her research interests going alongside the clinical work, most excited by how we can transform primary care to meet our patients' social needs, while fostering a sustainable work force. Emilia will be a UCSF Primary Care Research fellow after residency, and is excited to keep working at the General and having more time to explore the incredible work being done at UCSF to improve our healthcare system. Outside of medicine, she thrives on running the endless bay area trails, skiing, eating, and spending time with friends.

Daniel McCorry, is fourth year medical student at Georgetown University. Originally from Michigan, he has a degree in Biology and Philosophy from the University of Dayton. In 2014, he completed a Graduate Fellowship in Health Policy Research with The Heritage Foundation, where he published a policy white paper on Direct Primary Care. He is currently also a President Emeritus with the Benjamin Rush Institute and a Frédéric Bastiat Fellow with the Mercatus Center at George Mason University. Outside of health policy, some of his favorite things are golfing, college basketball, and Bao Bao the panda. He plans to do residency in family medicine after graduation.

Jennifer Rankin, MHA, MS, PhD, joined HealthLandscape in March 2015. Prior to this, she served as the Geospatial Informatics Senior Analyst for the Robert Graham Center. She directs all geospatial projects for HealthLandscape, most notably the UDS Mapper. Her career has focused on issues related to primary care and access to care, with a special interest in the geography of access to health care. She has worked with the HRSA Maternal and Child Health Bureau, the Texas Association of Community Health Centers, and the Association of State and Territorial Health Officials. Jennifer earned her Master of Health Administration from the Tulane School of Public Health and Tropical Medicine, as well as her Master of Science in Health Information Sciences and Master of Public Health and PhD in Public Health Informatics from The University of Texas Health Science Center at Houston.

Alyssa Shell, MD, PhD, is a second year resident in Family Medicine at MAHEC in Asheville, NC. She received an MD/PhD in Population Health from the Department of Preventive Medicine and Community Health at the University of Texas Medical Branch in Galveston, Texas. Prior to medical school, she attended Harvard University where she received an AB in Social Studies and completed a Certificate in Public Health. She is currently a Pisacano scholar through the American Board of Family Medicine and Resident Director for the North Carolina Academy of Family Physicians.