

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

Fifth Year Annual Report
June 2004



BACKGROUND

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

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

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

At the end of its fifth year of operation, the Graham Center's staff is comprised of 6 full time positions and one half time position. Lisa Klein administers the Center and provides research assistance. Arnita Wilson works half time, assisting Lisa and providing reception functions. There are three analysts: Ed Fryer, the senior and founding analyst; Jessica McCann, an analytic geographer; and Martey Dodoo, a demographer and economist. There are two physicians at the Center, the assistant director, Robert Phillips, and Larry Green, the director. In addition to this regular staff, the Center contracts with Tom Miyoshi at the University of Colorado for database management support and with Susan Dovey at the University of Otago for continuing consultation concerning patient safety and other research. The Center's Scholar in Residence Program was discontinued, but volunteer scholars continue to work with the Center, as do numerous former interns and other investigators sharing the Center's mission. The Center enjoys expert information technology support from the AAFP staff in Kansas City and Washington, D.C, including support for the Center's website. The AAFP also provides organizational support including communications assistance and human resources.

The Center is advised by a national advisory committee as listed in appendix 1. This diverse group of experts guides overall directions of the center and offers critique of its work. Lauren LeRoy, Kerr White and Karen Ignagni have rotated off the advisory board this past year, and David Satcher, Paul Ginsburg, Richard Lamm and Chuck Cutler have joined.

The Center's work includes primary data collection, but more often secondary analyses of existing data sets. The Center holds multiple data sets as shown in appendix 2. Some of these data sets have been linked to cover various time periods and to each other to create powerful analytic opportunities that would not otherwise exist.

REVIEW OF YEAR FIVE

The Center relocated to slightly larger space in the same building in Washington DC, prompted by space needs of another building tenant. This move precipitated a new lease directly with the building's management for five years with the option to renew for another five years. Substantial upgrades of the Center's computing capacity were implemented with the move. The Center ended the year under its expense budget, exceeding its revenue budget, with its endowment account reaching approximately \$130,000.

In accordance with recommendations from the Future of Family Medicine project, the Center changed its name to use the word "Medicine" instead of "Practice." Market research indicated public confusion and disrespect associated with the word "practice" and a strong association of the word "medicine" with science and knowledge. Academic departments of family medicine nationwide and the American Board of Family Practice are proceeding similarly.

Personnel changes included Susan Dovey's return home to New Zealand while continuing as a part-time consultant to the Center and the arrival of new analysts Jessica McCann and Martey Doodoo and a part time administrative assistant, Arnita Wilson.

April Everett was this year's policy fellow. Besides becoming a mother, her primary foci were surveying all states to estimate the amount of state funding for family medicine educational programs, and distilling evidence about the impact of Title VII funding for family medicine into an advocacy document with the AAFP and STFM.

There were 8 interns this year:

Name	Topic	Affiliation
Donna Cohen	FPs and Obstetrics	Boston University Dept of Family Medicine
Amanda Morris	International Medical Graduate FPs	Ball Memorial Family Practice Program
Valerie Reese	Residency Footprint	San Antonio
Elizabeth Dowling	Obesity	Brown University School of Public Health
Mary Stock-Keister	The Public and Primary Care (Future of Family Medicine)	Andrews Air Force Base Residency Program
Stacey Bank	Hospice & End of Life Care	University of Utah Department of Family Medicine
Ginger Ruddy	Physician Workforce	University of Washington
Hillary Johnson	The impact of work hour restrictions on FP residency programs	Washington University

Approximately 20 of the Graham Center interns and fellows met together at the annual meeting of the North American Primary Care Research Group in Banff, Canada and shared career developments and work in progress.

The Center held 8 DC Primary Care Forums at the Cosmos Club:

Forum Number	Topic	Speaker
Primary Care Forum #30	The Open Source HER: Questions and Answers	David C. Kibbe, MD, MBA
Primary Care Forum #31	Why Should Anyone in D.C. Care about Primary Care	Kurt C. Stange, MD, PhD
Primary Care Forum #32	The Future of Family Medicine	James C. Martin, MD, FAAFP
Primary Care Forum #33	What CMS is Thinking About How to Help Primary Care Be Better?	Sean R. Tunis, MD, MSc William C. Rollow, MD, MPH
Primary Care Forum #34	The Future of General Internal Medicine	Harold Sox, MD Mary T. Herald, MD, FACP
Primary Care Forum #35	Outdoor Recreation in America Today: At the Front Lines in the Battle for Public Health	Michael Suk, MD, JD, MPH
Primary Care Forum #36	The Troubled Relationship Between Academic Health Centers and Primary Care	Roger J. Bulger, MD
Primary Care Forum #37	Computerization of Front Line Practices: Success in New Zealand	Susan M. Dovey, Ph.D.

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

From time to time, the Center's location and connectivity permit it serving as a meeting place for various groups and events. For example, the International Brisbane Collaboration, concerned with improving general practice research world-wide, held its meeting at the Center. Many visitors from around the country and internationally visit the Center with and without appointments, bringing updates and concerns of relevance to family medicine and primary care. Reciprocally, the staff of the Center present and consult with other research and professional groups across the United States and internationally, e.g. New Zealand, Canada, Australia, and the UK.

Four themes continued to guide the work of the Center: Equity (includes universal inclusion and health and health care disparities), Scope of Practice, Infrastructures, and Patient Safety (Quality). The written word remains the primary product of the Graham Center, and since last year's report, 20 manuscripts, 9 one-pagers, and 2 book chapters/contributions were published. A synopsis of these publications is provided in appendix 3.

MANUSCRIPTS:

1. **Dovey SM, Weitzman M, Fryer G, Green L, Yawn B, Lanier D, Phillips R.** The ecology of medical care for children in the United States. *Pediatrics* 2003;111:1024-1029.
2. **Phillips RL, Parchman ML, Miyoshi TJ.** Using Geographic Information Systems to Understand Health Care Access. <http://gis.esri.com/library/userconf/health01/papers/hc01>
3. **Guirguis-Blake J, Phillips RL.** Oral vitamin D3 decreases fracture risk in the elderly. *J Fam Prac* 2003; 52:431,435.
4. **Fryer GE, Green LA, Dovey SM, Yawn BP, Phillips RL, Lanier D.** Variation in the ecology of medical care. *Ann Fam Med* 2003; 1:81-89.
5. **Mold JW, Green LA, Fryer GE.** General internists and family physicians: Partners in geriatric medicine? *Ann Intern Med* 2003;139:594-596.
6. **Green LA.** Disparities in health care in the United States apparent in the Ecology of Medical Care. *Macy-Morehouse Conferences on Primary Care for the Underserved.* Hager M (ed). New York, New York: Josiah Macy, Jr. Foundation, 2003. Pages 139-146.
7. **De Maeseneer JM, van Driel ML, Green LA, van Weel C.** The need for research in primary care. *Lancet* 2003; 362:1314-19.

8. **Phillips RL**, Starfield B. Why does a U.S. primary care physician workforce crisis matter? *Am Fam Physician* 2003; 68:1494-1498.
9. **Gonzalez EH, Phillips RL**, Pugno PA. A study of closure of family practice residency programs. *Fam Med* 2003;35:706-10.
10. **Phillips RL**, Phillips KA, Chen FM, **Melillo A**. Exploring residency match violations in family practice. *Fam Med* 2003;35:717-720.
11. **Phillips RL**, Bazemore A, Miyoshi TJ. Mapping tools for monitoring the safety net. In *Monitoring the Health Care Safety Net: Book III: Tools for Monitoring the Health Care Safety Net*. Weinick RM, Billings J (Eds). Agency for Healthcare Research and Quality. Rockville, MD. 2003. AHRQ Publication No 03-0027.
12. **Phillips RL, Fryer GE**, Chen FM, Morgan SE, **Green LA**, Valente E, Miyoshi TJ. The balanced budget act of 1997 and the financial health of teaching hospitals. *Ann Fam Med* 2004;2:71-78.
13. **Phillips RL**, Bartholomew LA, **Dovey SM, Fryer GE**, Miyoshi TJ, **Green LA**. Learning from malpractice claims about negligent, adverse events in primary care in the United States. *Qual Saf Health Care* 2004; 13:121-126.
14. Mold JW, **Fryer GE**, Thomas CH. Who are the uninsured Elderly in the United States? *J Am Geriatr Soc* 2004; 52:601-606.
15. **Fryer GE, Consoli R**, Miyoshi TJ, **Dovey SM, Phillips RL, Green LA**. Specialist physicians providing primary care services in Colorado. *J Am Board Fam Pract* 2004; 17:81-90.
16. **Phillips RL**. Splitting the Difference*Patient Preference vs Conservation of Resources. *Virtual Mentor*, June 2004. Available at: <<http://www.ama-assn.org/ama/pub/category/12469.html>> Accessed June 2, 2004.
17. **Green LA**. The research domain of family medicine. *Ann Fam Med* 2004;2(Suppl 2) S23-S29.
18. Mullan F, **Phillips RL**, Kinman EL. Geographic retrofitting: A method of community definition in community-oriented primary care practices. *Fam Med* 2004; 36:440-6.
19. **Green LA**. *Annals of Family Medicine* is 1 year old: So what and who cares? *Ann Fam Med* 2004; 2:197-199.
20. **Green LA**. Future of family medicine recommendations confirm need for increased research from family physicians. *Ann Fam Med* 2004; 2:282-283.

ONE-PAGERS:

Number	Title
20	The Robert Graham Center (Cohen D, Guirguis-Blake J, Jack B, Chetty VK, Phillips RL, Green LA, Fryer GE). Family physicians make a substantial contribution to maternity care: The case of the State of Maine. <i>Am Fam Physician</i> 2003 68:405.
21	The Robert Graham Center (Cohen D, Guirguis-Blake J, Jack B, Chetty VK, Phillips RL, Green LA, Fryer GE.) Family physicians are an important source of newborn care: The Case of the State of Maine. <i>Am Fam Physician</i> 2003 68:593.
22	The Robert Graham Center (Biola H, Green LA, Phillips RL, Guirguis-Blake J, Fryer GE.) The U.S. primary care physician workforce: Minimal growth 1980-1999. <i>Am Fam Physician</i> 2003 68:1483.
23	The Robert Graham Center (Biola H, Green LA, Phillips RL, Guirguis-Blake J, Fryer GE.) The U.S. primary care physician workforce: Persistently declining interest in primary care medical specialties. <i>Am Fam Physician</i> 2003 68:1484.
24	The Robert Graham Center (Biola H, Green LA, Phillips RL, Guirguis-Blake J, Fryer GE.) The U.S. primary care physician workforce: Undervalued service. <i>Am Fam Physician</i> 2003 68:1486.
25	The Robert Graham Center (Dovey SM, Green LA, Phillips RL, Fryer GE)The ecology of medical care for children in the united states: a new application of an old model reveals inequities that can be corrected . <i>Am Fam Physician</i> 2003 68:2192.
26	The Robert Graham Center (Stock Keister MC, Green LA, Phillips RL, McCann J, Fryer GE) What people want from their family physician. <i>Am Fam Physician</i> 2004 69:2310
27	The Robert Graham Center (Stock Keister MC, Green LA, Kahn NB, Phillips RL, McCann J, Fryer GE) Few people in the United States can identify primary care physician. <i>Am Fam Physician</i> 2004 69:2312.
28	The Robert Graham Center (McCann J, Phillips RL, Green LA, Fryer GE) Chiropractors are not a usual source of primary health care. <i>Am Fam Physician</i> 2004 69:2544.

BOOK CHAPTERS/CONTRIBUTIONS:

1. **Green LA, Phillips RL, Fryer GE.** The nature of primary care. Oxford Textbook of Primary Medical Care. Jones, Britten, Culpepper, Gass, Gol, Mant, Silagy (Eds.). Oxford University Press, Oxford and New York, 2004: Pages 3-10.
2. **Green LA.** Is primary care worthy of physicians? An ecological perspective. The Future of Primary Care. Showstack J, Rothman AA, Hassmiller SB (Eds.). Jossey-Bass, San Francisco, CA, 2004. Pages 143-160.

IMPACT

There is much evidence that the performance of the US health care system and the health status of the US population do not match what is known to be achievable. There is also considerable evidence that family medicine and primary care are under-performing and in recession, not ascendancy. The Graham Center's work has contributed to elucidating a primary care perspective of the nation's health concerns and helped identify some compass headings for possible improvements. While this is not a year to point to substantial positive movement from a health policy perspective, there were examples of impact by the Graham Center.

1. The Graham Center was the organizing entity for the Keystone III conference that led to the Future of Family Medicine Project, a collaborative project of all the national allopathic family medicine organizations, that published its final report this year. The Graham Center provided much of the data for the first task force working on the future of family medicine project and much of the analysis and bibliography incorporated into the final report that revealed the simultaneous important role of family physicians in the US and the serious threats to family medicine and primary care. This report is not perfect, but it has successfully galvanized the entire discipline and its national organizations into action around its 10 recommendations. The Graham Center continues to assist with the follow-up necessary to move the report into action. For example, the Center is represented on and advised the sixth task force created by the Future of Family Medicine Project to establish financial projections for New Model Practice as articulated in the FFM report; the group assembled to invent a nationally-scaled assistance organization to enable family practices to make the transformation needed now is meeting at the Graham Center; and the staff of the Graham Center are on the program circuit for national and regional meetings explaining the report and urging action. The data sets developed with consulting research groups by FFM is now housed at the Center, and the Center has published illustrations of how these data could be used by other investigators to further illuminate the situation of family medicine and primary care in the US. This FFM report is now established as the discipline's "call to arms" for a 5-10 year period of transformation of its model of practice and its training programs.
2. The Center's work is aligned with the Institute of Medicine's ongoing focus on quality of health care. Through review processes and personal contacts, staff of the Center have engaged the Institute of Medicine. IOM reports have incorporated additional primary care perspectives in their continuing series of reports about quality and safety and health care insurance coverage. For example, the IOM in the past year has exposed again and supported the International Classification of Primary Care, and the President of the IOM wrote a preface for the Future of Family Medicine Report linking it to the nation's needs.
3. Partly in response to Center work and engagement, the National Quality Forum (NQF) has turned its gaze toward quality measures for children and to a still insufficient extent toward safety issues in primary care. The Graham Center's work, in collaboration with the AAFP's National Research Network, on taxonomy for medical errors from a primary

care perspective has inspired and influenced further taxonomy development with NQF and the World Organization of Family Doctors (Wonca) through their classification committee.

4. The Center has continued to help make the case of avoidable disparities in health care particularly associated with race and ethnicity specifically in the physician's office setting where family physicians and other primary care clinicians could make a difference. Through collaborations with the National Center for Primary Care, the stubborn gap in all cause mortality between African Americans and white Americans has been verified and shown to span decades, and estimates of lives saved and the nation's international rankings that could be attained "if only we were equal" determined and organized for publication.
5. The potential impact on actually achieving community-oriented primary care (COPC) through "geographic retrofitting" using geospatial analytic techniques has been illustrated and disseminated through both governmental publications and peer-reviewed publication. This is a particularly significant development in the US where COPC has been thwarted for years by the lack of practice-level definitions of the community for which the practice cares.
6. The Chronicle of Higher Education carried a substantial investigative report that revealed the intransigence of the Office of Management and Budget concerning its use of the Graham Center's Title VII evaluation. While the use of Center's work by the OMB was satisfying, how they used it was not; and the coverage by the Chronicle was another example of a buffet of stories this past year questioning the Bush administration's selective use of evidence to support ideology.
7. As the nation establishes data standards that will be imbedded in electronic health records, the Graham Center has organized a concerted effort, fueled by former Graham Center Scholars in Residence and Advisory Board members, to bring a primary care perspective to critical decisions concerning classifications and terminologies. The Center collaborated with long-time developers of the International Classification of Primary Care (ICPC), the only field-tested primary care classification capable of episode analysis starting with the patients' reasons for going to the doctor, to create "The Banff Declaration." This position statement was immediately endorsed by the North American Primary Care Research Group and resulted in the US Committee on Health and Vital Statistics adding ICPC to its recommendations to Secretary Thompson. The WHO endorsed ICPC into its family of classifications this year, and the National Library of Medicine and the editorial board of SNOMED have included ICPC in their systems and mapping developments. The AAFP's relevant commissions have taken up an appraisal of ICPC and how it might assist primary care clinicians. International vendors of electronic records have been made aware of ICPC and some have incorporated it into their software development.
8. This year, the Annals of Family Medicine was indexed at the earliest possible moment by the National Library of Medicine (NLM), establishing a premier family medicine and

primary care publication unencumbered by the requirements of advertisers. The Graham Center assisted the development of this critical infrastructure by educating relevant leaders at NLM, serving on the founding corporate board, serving as manuscript reviewers, and most importantly as authors of manuscripts. Staff of the Center also bring a health policy perspective to peer-reviewed publication by serving other journals as editors and reviewers.

9. The Center collaborated this year with a former Scholar in Residence to help the World Organization of Family Doctors to hold in Canada an international conference to articulate the future needs of research in family medicine and primary care. The Center participated in the conference, in the preparation of the proceedings, and aiding publication as a discreet supplement to *Annals of Family Medicine*. This supplement prompted an email the week after it came out from a physician in Havana, Cuba, thanking WONCA for giving him hope.
10. The Center's investments in training analysts and marshalling talent for health policy work are seeding family medicine and primary care with young leadership. For example, this year one of the Center's interns was awarded a NRSA fellowship while still a resident, and the Robert Wood Johnson Foundation awarded \$300,000 Generalist Scholars Awards to another intern and one of the physicians who visited the Center to learn about large data set analysis. Two of the Center's fellows took positions this year at the Agency for Healthcare Research and Quality: one to oversee the continuing development of the nation's practice based research networks and another to staff the United States Preventive Services Task Force. Many of the Center's interns, and all the fellows, have gained visibility through authorship in association with the Graham Center.
11. The entire staff of the Center collaborated to prepare a position paper for consideration by the AAFP Board of Directors concerning the role of family physicians in chronic disease care and possible strategies to enhance the ability of family medicine and the rest of primary care to provide disease management. This paper was promptly adopted by the AAFP as a policy statement. This work linked to and supported other AAFP efforts to partner with the Center for Medicare and Medicaid Services and the national office of Blue Cross/Blue Shield to enhance chronic disease care IN primary care.
12. The Center has established an identity with the practicing physician members of the AAFP (approximately 71% of active US family physicians) sufficient to be acknowledged and ranked highly in the AAFP's annual member survey, associated with the members' highest priorities of advocacy and help with improving their practice.
13. The DC Primary Care Forum hosted by the Center sometimes leads to results that otherwise probably would not occur. For example, the President of the AAFP spoke at and lead the 1-mile walk at the Department of Interior's national health promotion event in Minneapolis as a consequence of a White House Fellow speaking at the forum, and an invitation to assist family medicine in reconsidering its academic relationships with the

leadership of academic health centers emerged from a presentation by the President of the Association of Academic Health Centers.

YEAR SIX

The approaching national elections are expected to presage another period of health policy work, still focused on the triad of access, quality, and cost. Family medicine and primary care can contribute to improvements in all three, and the Center expects to be attentive to emerging opportunities to enhance the performance of family physicians and other primary care clinicians. The elaboration of the electronic health record, experimentation with revisions of family medicine residencies, financing for new model practice, infrastructure support for family medicine research, patient safety, persisting health and health care disparities based on race and ethnicity, and reconsideration of the size and expectations of the family physician workforce will continue to be important policy issues in play. The Center has work planned related to all of these areas, still organized into the same themes that have guided the Center to date.

After a period of continuity among founders of the Center, there will be a substantial transition of personnel at the Center in the coming year. Dr. Bob Phillips will assume the directorship effective October 1, 2004. A new assistant director will be recruited. Dr. Martey Dodoo, newly appointed demographer and economist, will substantially enhance the analytic capacity of the Center. Dr. Ed Fryer will relocate to the University of Rochester to assist the American Academy of Pediatrics at their policy center. A new health policy analyst will be recruited. Dr. Green will rebalance his work toward responsibilities at the University of Colorado while continuing to work in DC at the Center one week per month. Jessica McCann, Arnita Wilson, and Lisa Klein expect to continue their current roles and responsibilities.

KEY GOALS FOR THE YEAR SIX INCLUDE:

1. Producing analytic maps that depict the impact of family medicine training on communities, specific opportunities for enhancing access to care for underserved populations, and geographies associated with physician payment bonuses.
2. Prepare a web-based environment for serving data and consumer-driven mapping.
3. Extending our patient-safety research with the National Research Network and the Physician Insurers Association of America.
4. Participating in the development of coding standards development for patient safety and clinical practice.
5. Developing our internal capacity for formal project management
6. Assembling our staff for the next phase of work at the Graham Center

7. Development of an RGC economic impact model for family physicians – a broad, simple but accurate, easy-to-understand model suited for quick assessments of the economic impacts of various health policy proposals on family physician practices of different sizes. Using this model we should be able to quickly determine the impacts of legislative health policy proposals and changes in legislation and regulations on the practice activities, services, expenses and revenues of family physicians.
8. A study to calculate the financial return to physicians of their medical education. We will compare the financial returns to family physicians of their medical education, with the returns to other physician specialties and determine whether the starting remuneration family physicians receive is supported by the nature and extent of professional education and training they receive.

CONCLUSION

After five years of operation, the Robert Graham Center has completed its initial development and is fully staffed and functioning as initially envisioned. The Center's work has had impact. It is visible within the family medicine and primary care communities as well as nationally and internationally as a potential partner and a source of information important to family medicine and primary care. It exists in a network of linkages with multiple organizations and individuals and is positioned to continue indefinitely to bring a family medicine and primary care perspective to health policy deliberations.

Appendix 1

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

Advisory Board Members

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

Mary Jane England, M.D.
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APPENDIX 2 ROBERT GRAHAM CENTER DATA ARCHITECTURE

National Data Sets:

American Hospital Association Guide (AHA)

*American Hospital Association Annual Survey Database (AHA)

*Healthcare Cost and Utilization Project - Nationwide Inpatient Sample (AHRQ)

*National Hospital Discharge Survey (NCHS)

*National Home and Hospice Care Survey (NCHS)

current resident file

discharged resident file

*National Nursing Home Survey (NCHS)

current resident file

discharged resident file

*National Health Interview Survey (NCHS)

household

person

office visits (before 1997)

hospitalizations (before 1997)

conditions (before 1997)

sample child (1997 and later)

sample adult (1997 and later)

Note: Files identified by survey respondent's county of residence for 1986-2001 analyzed on site at the NCHS Research Data Activity Center.

*National Ambulatory Medical Care Survey *concatenated years 1973-1999* (NCHS)

*National Hospital Ambulatory Medical Care Survey (NCHS)

*Medical Expenditure Panel Survey (*concatenated years 1996, 1998-2000*) (AHRQ)

household files

conditions files

event files

prescribed medicines

office visits

outpatient department visits

emergency department visits

hospital stays

home health care

dental visits

*Community Tracking Study Population Survey - both public use and restricted files (Agency for Studying Health Systems Change)

*Community Tracking Study Physician Survey - both public use and restricted files
(Agency for Studying Health Systems Change)

*Hospital Cost Report Public Use Files (CMMS)

National Practitioner Data Bank (HHS)

Socioeconomic Monitoring System Survey (AMA)

*American Medical Association Physician Masterfile (AMA)

Addendums:

Residency Training File

Board Certification File

Visa Status File

Office of Inspector General Exclusions Database (HHS)

*Area Resource File *concatenated all years* (HRSA)

Educational Commission for Foreign Medical Graduates birth country file (ECFMG)

Uniform Data System National Health Service Corp Provider File (HRSA)

Uniform Data System National Health Service Corp Site File (HRSA)

Uniform Data System Community Health/Migrant Center File (HRSA)

Title VII Grant file (HRSA)

U.S. Census Bureau Summary Tape Files (U.S. Census Bureau)

U.S. Census Bureau Congressional District File (U.S. Census Bureau)

U.S. Census Bureau Block Files (U.S. Census Bureau)

U.S. Census Bureau Census Designated Place File (U.S. Census Bureau)

U.S. Census Bureau Public Use Micro-sample Files (U.S. Census Bureau)

Accreditation Council for Graduate Medical Education Accredited Program and
Institution File (ACGME)

There are quite a few others, those below among them, that were not national in scope or are not the products of mandated on-going data collection. I would recommend we not include any but those listed above.

FFM FILES

- General public
- Family physicians
- Specialists
- Family Medicine residents
- Residents in other specialties
- Medical students
- Focus groups

OECD FILES

Oklahoma Practice Based Research Network Elderly Study Files

Kaiser Survey (1999)

PIAA Claims File

CMMS MEDICARE BETOS Files

AAFP Membership Files

AAFP Residency Survey Files

CAPRICORN PBRN Insurance Study File

Gallup Survey

Appendix 3

MANUSCRIPTS

Infrastructures

De Maeseneer JM, van Driel ML, Green LA, van Weel C. The need for research in primary care. Lancet 2003;362:1314-19.

Uniting the Donabedian triangle of structure, process and outcome with medical, contextual, and policy evidence, Dutch and US authors argued that the knowledge base of family medicine must be expanded using multiple methods to bridge the gap between evidence and practice and cross the quality chasm. It articulated 6 characteristics of trials most useful in family medicine and primary care, and pleaded for trials that start with usual complaints and symptoms. It concluded that a multimethod, transdisciplinary, participatory approach is necessary to create knowledge that retains connections with its meaning and context and, therefore, can be readily translated into practice.

Phillips RL, Jr. and Starfield B. Why does a US primary care physician workforce crisis matter? American Family Physician 2003;68:1494-99.

More than 2 decades of accumulated evidence reveals that having a primary care-based health system matters. This editorial summarized some of this evidence and confirmed that the United States, with its weak primary care system, has poor outcomes at great expense, while other countries with stronger primary care have better outcomes at less expense. Thus, the growing crisis in the primary care physician workforce probably matters to just about everyone.

Gonzales EH, Phillips RL, Pugno PA. A study of closure of family practice residency programs. Fam Med 2003;35:706-10.

Twenty seven residencies closed between 2000 and 2004 (5%), a substantial increase over previous years. Through surveys and interviews, the characteristics of the program that closed were determined; and financial, political, and institutional leadership changes were identified by program directors as the most frequent explanations for closures. Strategies were identified for strengthening programs, averting closure, and minimizing damage when closure is inevitable.

Phillips RL, Phillips KA, Chen FM, Melillo A. Exploring residency match violations. *Fam Med* 2003;35:717-20.

The National Resident Matching Program (“the match”) is a long-established mechanism with contractual obligations designed to enable medical students and residency programs to find what they are looking for in a fair, organized manner. Using a key informant approach this study reported substantial confusion among students about what constitutes a violation of the rules of the match as they apply and interview for positions as residents after medical school. Violations occur, and the authors analyzed students’ experiences to suggest strategies to improve the process for schools, the Matching Program, and Residencies.

Phillips RL, Fryer GE, Chen FM, Morgan SE, Green LA, Valente E, Miyoshi TJ. The balanced budget act of 1997 and the financial health of teaching hospitals. *Ann Fam Med* 2004;2:71-78.

The Balanced Budget Act of 1997 (BBA) included the largest cuts in the history of Medicare and was projected to reduce Medicare payments for graduate medical education (GME), the largest single source of financing of GME, by \$2.3 billion. This manuscript reported, not conjecture, but the results of this legislation and found deep cuts in the profitability of teaching hospitals between 1996 and 1999, not entirely attributable to the BBA. More than one third operated in the red in 1999; and contrary to the study’s hypotheses, family medicine single-residency hospitals had better Medicare margins and total margins than multiple-residency hospitals. Very importantly, this manuscript made transparent the Medicare cost reports and variables necessary to evaluate Medicare GME financing, revealing the plausibility of ongoing evaluation of Medicare’s GME policy decisions. Of particular note, was the finding that the projected GME payments associated with Medicare + Choice were 90% less than projected, a circumstance that still merits audit and attention.

Green LA. Future of family medicine recommendations confirm need for increased research from family physicians. *Ann Fam Med* 2004;2:282-283.

This editorial focused on the membership of the North American Primary Care Research Group (NAPCRG), calling their attention to the fact that the recently released report of the Future of Family Medicine Project relied on research findings and calls early and often for various types of research, especially effectiveness research. Two of the key challenges issues in the report depend in part on NAPCRG: addressing the public’s perception that family medicine and primary care are not grounded in science and technology, and winning respect in academic circles. Among the declared strategic priorities is “advancing research that supports the clinical decision making of family physicians and other primary care clinicians.”

Green LA. Annals of Family Medicine is 1 year old: so what and who cares? Ann Fam Med 2004;2:197-199.

This invited editorial reported the distribution of articles by type during the first year of publication of this new primary care research journal and observed that Annals has been a welcome new infrastructure for family medicine and primary care. It can be used as a reference for the claim that “never before has a nation spent so much to accomplish so little for so few.” And therein lies the answer to who should care about the Annals—just about everyone who has had enough of the disgrace that passes for a health care system in the US.

Mullan F, Phillips RL, Kinman EF. Geographic retrofitting: a method of community definition in communit-oriented primary care practices. Fam Med 2004;36:440-6.

Defining the community for which a primary care practice is responsible has been a major disabler for implementing the concepts of community oriented primary care in the United States. This report used the case of Boone County, Missouri to demonstrate how a technique named “geographic retrofitting” can aid the full implementation of community-oriented primary care. Extending geographic analysis to calculate levels of penetration of a practice into specific locations revealed how powerful an aid this technique can be for evaluation and planning.

Green LA. The research domain of family medicine. Ann Fam Med 2004;2:S23-S29.

This report was part of a special journal supplement reporting the World Organization of Family Doctors’ international research meeting in Hamilton, Ontario designed to elevate research on to the international primary care agenda. Taking six different approaches based on decades of published work, it characterized the research domain of family medicine and primary care as vast, but explorable. Just because one can’t find the edge of the universe does not mean the universe does not exist or can not be explored.

Scope of Practice

Mold JW, Green LA, Fryer GE. General internists and family physicians: Partners in geriatric medicine? Ann Intern Med 2003;139:594-96.

This invited editorial affirmed the basic thrust of a series of articles by internists lamenting the nation’s lack of preparedness to deal with the health care needs of older patients. It quantified the dominant role of family physicians and general internists in the care of geriatric patients 75 years of age and older. Together these 2 physician groups accounted for 45.3% (24.5% to internists and 20.8% to

family physicians) of all visits made by these patients to physicians' offices and most of the visits made for prevalent chronic diseases such as heart failure and diabetes. It then linked family medicine and internal medicine as necessary partners to meet the nation's needs and challenged the two disciplines to forget rivalry and cultivate cooperation.

Green LA. Is primary care worthy of physicians? An ecological perspective. The Future of Primary Care. Showstack J, Rothman AA, Hassmiller SB (Eds). Jossey-Bass, San Francisco, Ca, 2004: 143-160.

Part of a book that reported a national conference held by the Robert Wood Johnson Foundation, this chapter confirmed the continuing dependence of people in the United States, specifically those with chronic conditions, on their primary care physicians. It put forward arguments that primary care was not so simple anyone can do it, nor so hard that no one can do it. Instead, primary care is an intellectually rewarding function worthy of physicians that, done well, comprises the bulk of the clinical enterprise and has huge impact on individual and population health, something physicians should care about.

Fryer GE, Consoli R, Miyoshi TJ, Dovey SM, Phillips RL, Green LA. Specialist physicians providing primary care services in Colorado. J Am Board Fam Pract 2004;17:81-90.

There is overlap in the work of different types of physicians, but no fully adequate way to quantify specialty care provided by primary care physicians and primary care by specialty physicians to aid judgments about adequate access to different types of services. This manuscript used state-based data collected by the board licensing physicians to estimate how much primary care is provided by specialists. Almost half of the state's specialists reported providing primary care services, and as a group about 28% of specialists' direct patient care time was devoted to primary care activities. This analysis could not evaluate important elements of primary care, e.g. integration of care and sustained partnerships. Nonetheless, the contribution of specialists should be considered in needs assessments, and specialists who experience low demand for their particular specialties may be especially inclined to "fill up their practice" with services typically provided in primary care. How well specialists function as primary care providers remains uncertain.

Phillips RL. Splitting the Difference—Patient Preference vs Conservation of Resources. Commentary. Virtual Mentor. Ethics Journal of the American Medical Association. June 2004, Volume 6. www.ama-assn.org/ama/pub/categor/12469.html

This invited commentary linked clinical decision-making, allocation decisions, and macro-level health policy to illuminate at least 2 ethical issues in a case presentation concerning a depressed patient: the right of the patient to accept or refuse treatment and the responsibility to marshal community resources wisely. It also brought into clear view the need to weigh short term financial gains against possibly larger, later losses when trust and successful care plans are fractured.

Equity

Green LA. Disparities in health care in the United States apparent in the ecology of medical care. In Macy-Morehouse Conferences on Primary Care for the Underserved. Hager M (ed). Josiah Macy, Jr. Foundation. New York, New York. 2003; 139-146

This chapter contributed to a conference on primary care for the underserved that included the dedication of the National Center for Primary Care at Morehouse School of Medicine. It included evidence that: older patients are no different than others in their use of emergency departments, boys and men are rather dramatically less likely than girls and women to receive care in all settings except emergency departments; and with increasing educational attainment of heads of households people get less care in hospitals, home and emergency departments and more care in physicians' offices. This chapter identified physicians' offices and hospital outpatient departments as the remaining locus of reduced participation in health care by blacks compared to whites. It raised questions, such as "Is it likely that equity in health care can be achieved without assuring everyone a medical home?"

Mold JW, Fryer GE, Thomas CH. Who are the uninsured elderly in the United States? J Am Geriatr Soc 2004;52:601-606.

It is commonly assumed that all older Americans have health insurance coverage through Medicare, but this report revealed it is not so. Approximately 350,000 older people have no health insurance, and these are more likely to be Hispanic, not white, unmarried, poor, and foreign-born. These uninsured elderly have relatively high rates of chronic medical conditions, but are unlikely to receive outpatient or home health care services. Many of these people failed to qualify for Medicare, not because they did not work, but because of their working and marital arrangements. Based upon rapid growth of the elderly population in

general and Hispanics in particular, these figures can be expected to increase unless something is done to close the gaps in Medicare coverage.

Patient Safety and Quality

Phillips RL, Bartholomew LA, Dovey SM, Freyer GE, Miyoshi TJ, Green LA. Learning from malpractice claims about negligent, adverse events in primary care in the United States. Qual Saf Health Care 2004;13:121-126.

This report used the Physician Insurers Association of America's malpractice claims data for negligent adverse events from 1985-2000 to offer useful insight into errors in primary care. Honing in on peer-reviewed claims assessed as negligent, it was found that 68% of claims were for negligent events in outpatient settings, with no single condition accounting for more than 5% of all negligent claims. When standardized to frequency of conditions in the outpatient setting, new insights about error and risk in primary care emerged, e.g. appendicitis was 25 times more likely to generate a claim for negligence than breast cancer. Even with the considerable limitations of this malpractice data set, new insights about the nature of error in family medicine and primary care were discovered, continuing the Center's ongoing commitment to helping make care safer in the primary care setting.

Cross-cutting and Other Issues

Guirguis-Blake J and Phillips RL. Oral vitamin D3 decreases fracture risk in the the elderly. J Fam Pract 2003;52:431,435.

This "POEM" (patient-oriented evidence that matters) was co-authored with the Center's fellow and illustrates the intersections that always exist between frontline practice decisions, evidence, and policy.

Fryer GE, Green LA, Dovey SM, Yawn BP, Phillips RL, Lanier D. Variation in the Ecology of Medical Care. Ann Fam Med 2003;1:81-89.

This is another manuscript in a series of studies by the Center of the ecology of medical care in the United States. This one moved into new territory to characterize the variation in medical care that exists in association with one's personal characteristics and health care arrangements. Physicians' offices were overwhelmingly the most common site of health care for all subgroups studied, whether white or black, rich or poor, rural or urban. The particularly powerful enabling effects of having a usual source of care on participating in the various locations of health care was identified and quantified for outpatient departments, emergency departments, home care, hospitals, and physician offices. These

data provide policy makers with a menu of potentially important patterns of health care in communities of different composition and could help guide allocation decisions. The physician's office was solidly exposed as a logical platform for health education, prevention counseling, and chronic disease care for everyone.

Phillips RL, Bazemore A, Miyoshi TJ. Mapping tools for monitoring the safety net. In Monitoring the Health Care Safety Net: Book III: Tools for Monitoring the Health Care Safety Net. Weinick RM, Billings J (Eds). Agency for Healthcare Research and Quality. Rockville, MD 2003. AHRQ Publication No 03-0027.

This chapter reported actual experience from Baltimore to show how geography plays a critical role in health care and how analytic mapping tools can clarify relationships between clinics and patients that can and should inform decisions made by safety net providers. It described the basic elements needed from safety net providers to create comprehensive service maps. It then illustrated how to use mapping techniques to evaluate if the mission of the provider is being achieved, and also to define options, mobilize community action and galvanize political will.

Green LA, Phillips RL, Fryer GE. The nature of primary care. Oxford Textbook of Primary Medical Care. Jones, Britten, Culpepper, Gass, Gol, Mant, Silagy (Eds). Oxford University Press, Oxford and New York, 2004: 3-10.

The Center was invited to provide the opening chapter of this first edition of Oxford University's new primary care textbook. This chapter placed primary care into its historical and contemporary context and clarified various definitions of primary care. It also consolidated and quantified the reasons people go to US primary care physicians (by age and sex groupings) and what diagnoses are made by primary care physicians with what frequency. The established value of primary care was reported, referenced, and linked to the future high performance health care century imagined for the 21st Century. Placing health care into context and setting priorities is the realm of primary care, and primary care is indeed primary in the sense of being that care that is first, foremost, and fundamental.

Task Force 1. Report of Task Force on Patient Expectations, Core Values, Reintegration and the New Model of Family Medicine. Ann Fam Med 2004;2:S33-S50.

Task Force 1 was chaired and supported by the staff of the Center. This task force report was written collaboratively at the Center, and most of it was incorporated into the final report of the Future of Family Medicine Project, comprising approximately the first half of the final report and a large majority of the supporting references. This citation includes additional analyses and confirms simultaneously the current reliance of the United States on Family Physicians, the continuing desire of the public for what it is that family physicians strive to do, and the toxic environment that may make family medicine and primary care untenable in a 10 to 20 year time frame.

Phillips RL, Green LA, Fryer GE, McCann J. The new model of primary care: knowledge bought dearly. Policy Paper prepared for AAFP Board of Directors, adopted March 12, 2004.

After assembling evidence about the effects of primary care and concluding that they are overwhelmingly salutary, this paper developed possible options that could enable improved primary care practice specifically through the implementation of payment methods focused on the integration of care for individuals and the management of chronic conditions. There must be an business plan undergirding family medicine and primary care that rewards producing value and through which revenues can exceed expenses.

One Pagers

#20: Family Physicians Make a Substantial Contribution to Maternity Care: The Case of the State of Maine.

Family physicians provided nearly 20% of labor and delivery care in Maine in the year 2000. A substantial proportion of this care was provided to women insured by Medicaid, and those delivering in smaller, rural hospitals, and residency affiliated hospitals. As family medicine explores its future scope, research identifying regional variations in the maternity care workforce may clarify the need for maternity care training in residency and labor and delivery services in practice. (Cohen D, Guirguis-Blake J, Jack B, Chetty VK, Phillips RL, Green LA, Fryer GE. Am Fam Physician 2003;67:1422)

#21: Family Physicians Are an Important Source of Newborn Care: The Case of the State of Maine-Part II.

Family physicians provided 30 percent of inpatient newborn care in Maine in the year 2000. Family physicians cared for a large proportion of newborns, especially those insured by Medicaid and in smaller, rural hospitals where they also delivered babies. Family medicine's commitment to serve vulnerable populations of newborns requires continued federal, state, and institutional support for training and development of future family physicians. (Cohen D, Guirguis-Blake J, Jack B, Chetty VK, Phillips RL, Green LA, Fryer GE. *Am Fam Physician* 2003;68:593)

#22: The U.S. Primary Care Physician Workforce: Minimal Growth 1980-1999.

Growth in the primary care physician workforce (physicians per capita) in the United States has trailed the growth of the specialist physician population in recent years. This has occurred despite calls during the same period for increased production of primary care physicians and educational reforms focusing on primary care. (Biola H, Green LA, Phillips RL, Guirguis-Blake J, Fryer GE. *Am Fam Physician* 2003;68:1483)

#23: The U.S. Primary Care Physician Workforce: Persistently Declining Interest in Primary Care Medical Specialties.

A persistent, six-year trend in the choice of specialty training by U.S. medical students threatens the adequacy of the physician workforce of the United States. This pattern should be reversed and requires the attention of policy makers and medical educators. (Biola H, Green LA, Phillips RL, Guirguis-Blake J, Fryer GE. *Am Fam Physician* 2003;68:1484)

#24: The U.S. Primary Care Physician Workforce: Undervalued Service.

Primary care physicians work hard, but their fiscal compensation is not correlated to their work effort when compared to physicians in other specialties. This disparity contributes to student disinterest in primary care specialties. (Biola H, Green LA, Phillips RL, Guirguis-Blake J, Fryer GE. *Am Fam Physician* 2003;68:1486.)

#25: The Ecology of Medical Care for Children in the United States: A New Application of an Old Model Reveals Inequities That Can Be Corrected.

If equal and adequate access to health care for children in the United States is our goal, we are failing. That failing is most prominent in the setting where most children receive care and preventive services—the doctor's office. (Dovey SM, Green LA, Phillips RL, Fryer GE. *Am Fam Physician* 2003;68:2192.)

#26: What People Want from Their Family Physician.

The public wants and is satisfied by care provided within a patient-physician relationship based on understanding, honesty, and trust. If the U.S. health care system is ever to become patient-centered, it must be designed to support these values and sustain, rather than fracture relationships people have with their primary physician. (Stock Keister MC, Green LA, Kahn NB, Phillips RL, McCann J, Fryer GE. Am Fam Physician 2004;69:2310.)

#27: Few People in the United States Can Identify Primary Care Physicians.

Almost one decade after the Institute of Medicine defined primary care, only one-third of the American public is able to identify any of the medical specialties that provide it, and only 17 percent were able to accurately distinguish primary care physicians from medical or surgical specialists and non-physicians. This lack of discrimination compromises the goal of achieving primary care for all and merits immediate attention. . (Stock Keister MC, Green LA, Kahn NB, Phillips RL, McCann J, Fryer GE. Am Fam Physician 2004;69:2312)

#28: Chiropractors Are Not a Usual Source of Primary Health Care

Chiropractors are the largest source of office-based care in the United States that does not involve a physician, but people do not view chiropractors as primary providers of health care or advice. Unlike the care given by primary care providers, the majority of care provided by chiropractors is limited to musculoskeletal problems. (McCann J, Phillips RL, Green LA, Fryer GE. Am Fam Physician 2004;69:2544.)