



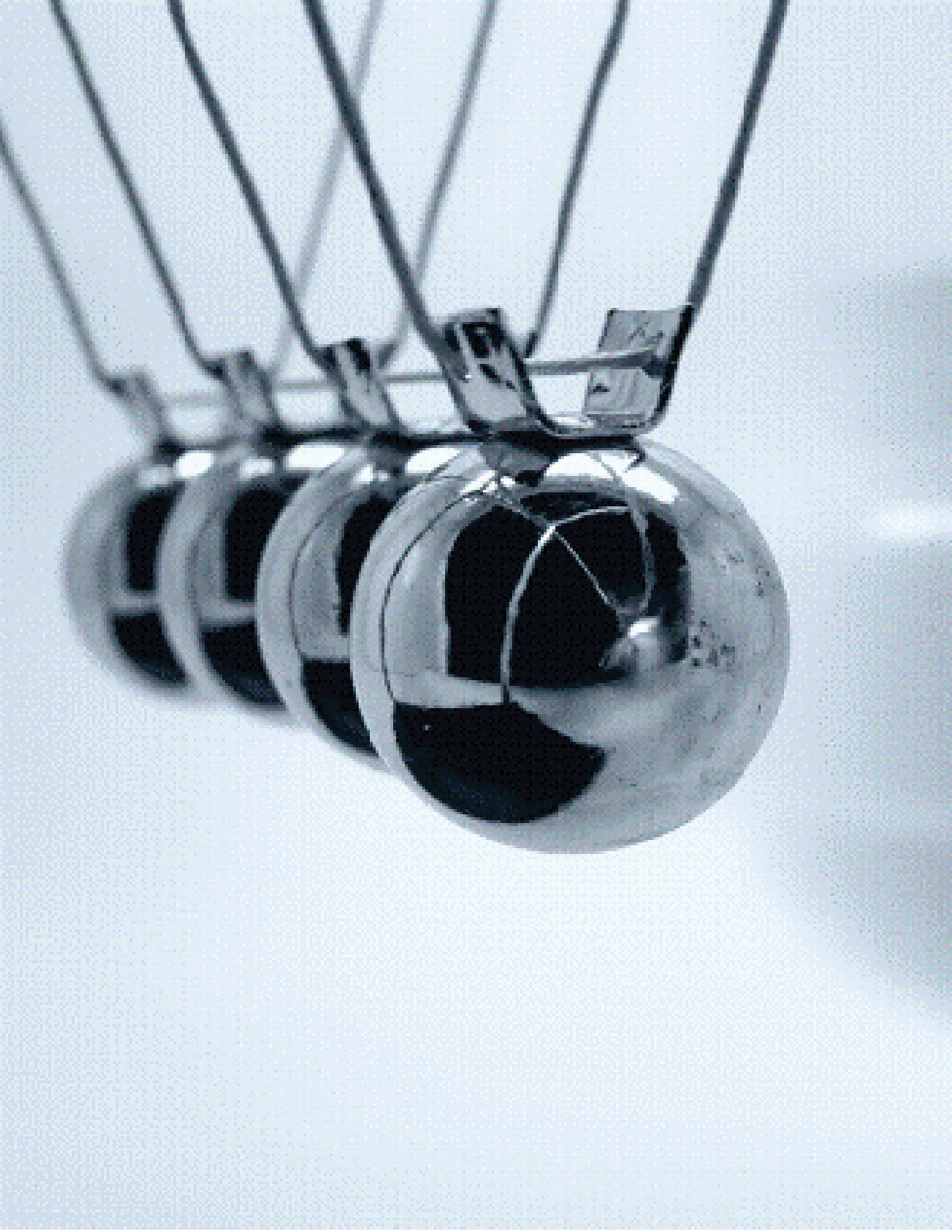
**The Robert Graham Center
Policy Studies in Family Medicine
and Primary Care**

2009 Annual Report



**ROBERT
GRAHAM
CENTER**

AAFP Center for Policy Studies



About the Graham Center

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



Letter from the Director

The arrival of the Obama administration and intense Congressional focus on health reform substantially increased calls on the Robert Graham Center for evidence and ideas. 2009 is a benchmark year for us in terms of meeting our mission of providing evidence for better policy-making. It has also been a banner year for research funding and partnerships. In both regards, this is our best year yet in reaping the investments made by our parent organization, the American Academy of Family Physicians (AAFP), in creating and sustaining the only non-partisan, editorially-independent health policy research center affiliated with a physician organization.

Our fundamental relationship with the AAFP gave us many opportunities this year to analyze health reform ideas for internal and external audiences. The Center produced white papers on Medicare bonus payment options and on proposed Federal Medicaid enhancements. We shared prior studies of Sustainable Growth Rate (SGR) formula modifications that were raised again in the context of health reform. We also contributed to many discussions of the Patient-Centered Medical Home (PCMH) concept and related payment models. The Graham Center was pulled into many conversations with Congressional and Administration staff to provide evidence and analyses about health reform.

Our partnership with the Josiah Macy Jr. Foundation produced a report on the factors affecting medical student and resident career choices that has been downloaded more than 2,400 times. It generated a perspectives piece in the New England Journal of Medicine, and related articles in several newspapers. The Macy Foundation is now supporting the development of a Medical School Footprinting tool that will help inform medical educators and policy-makers about the impact of schools on local and national physician workforce. We also have funding partnerships with the Agency for Healthcare Research and Quality and the Health Resources and Services Administration to study questions related to health care workforce, the patient-centered medical home, and community health center services. The National Association of Community Health Centers remains an important partner with whom we will be developing a 5th report, this time on the behavioral and dental health workforce needs in the U.S. The series of reports that we have produced with NACHC and George Washington University was recently nominated for a national award for research impact on policy.

The Larry A. Green Visiting Scholar program is thriving, thanks to the support of the Pisacano Leadership Foundation. One unique product of this program this year was legislative language for a Primary Care Extension Program that would put resources in most counties to help transform primary care practices into medical homes. Dr. Kevin Grumbach spent part of his sabbatical with the Graham Center working with the Senate Health, Education, Labor, and Pensions Committee and other collaborators to develop this concept and related language. He and Dr. Jim Mold, with help from Graham Center staff, produced a related manuscript subsequently published in the Journal of the American Medical Association. This year we added a second health policy fellow from Virginia Commonwealth University to our existing fellow position with Georgetown University. The scholars and fellows are a very important source of ideas and projects for us.

The year ahead will require managing increased demand on our capacity for informing policy, managing substantially more externally-funded projects, and maintaining capacity to be a resource for family medicine. Our website overhaul has improved our ability to share information, and *HealthLandscape* is increasingly attracting a community of people interested in producing geographically-depicted data. We will work this year on securing more long-term contractual arrangements to support needed growth of our research and support staff, and to improve dissemination of our work. In its 10th year, the Graham Center and its staff have never been better prepared to deliver on its mission and commitment to providing evidence that brings a family medicine and primary care perspective to health policy deliberations. We remain grateful to the AAFP, our partners, our past scholars and fellows for our success. I am both extremely lucky and proud to work with such a highly talented, creative and hard working team. We welcome your ideas and support in the next year.

A handwritten signature in white ink, appearing to read "Bob Phillips", is positioned above the printed name and title.

Bob Phillips, MD MSPH
Director



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2008-2009 Highlights

Seven Larry A. Green Visiting Scholars

Three Washington DC Primary Care Fora

Twelve Manuscripts Published

- Health Affairs
- Journal of Family Practice
- American Journal of Preventive Medicine
- Annals of Family Medicine
- Quality and Safety in Health Care

Two Special Reports

- Access Transformed: Building a primary care workforce for the 21st century
- Specialty and geographic distribution of the physician workforce: What influences medical student & resident choices?

Ten Consultations/Invited Seminars

Eleven Committees/Service

Numerous Conference Presentations, including:

- AcademyHealth
- North American Primary Care Research Group
- American Public Health Association
- NACHC Policy and Issues Forum
- American Association of Geographers
- ESRI Health GIS Conference
- Society of Teachers of Family Medicine



The Value of Primary Care

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

The Value of Primary Care

Primary care's eroding earnings: is congress concerned?

Despite increasing data demonstrating the positive impact primary care has on quality of care and costs, our specialty faces uncertainty. Its popularity among medical students is declining, and the income gap is growing between primary care and other specialties. Congress has the power to intervene in this impending crisis. If we want to influence lawmakers' actions, we need to know how they are thinking about these issues. **METHODS:** Using a set of questions covering several physician payment topics, we interviewed 14 congressional staff aides (5 aides on Medicare-oversight committees, 9 general staff aides) and one representative from each of 3 governmental agencies: the Medicare Payment Advisory Commission, Congressional Budget Office, and Government Accountability Office. **RESULTS:** Interviewees revealed that issues in primary care are not high on the congressional agenda, and that Medicare's Sustainable Growth Rate (SGR) is the physician-payment issue on the minds of congressional staff members. **CONCLUSION:** Attempts to solve primary care's reimbursement difficulties should be tied to SGR reform. Laing BY, Bodenheimer T, Phillips RL Jr, Bazemore A. Primary care's eroding earnings: is congress concerned? *J Fam Pract.* 2008 Sep;57(9):578-83.

Start-up and incremental practice expenses for behavior change interventions in primary care.

If behavior-change services are to be offered routinely in primary care practices, providers must be appropriately compensated. Estimating what is spent by practices in providing such services is a critical component of establishing appropriate payment and was the objective of this study. **Methods:** In practice expenditure data were collected for ten different interventions, using a standardized instrument in 29 practices nested in ten practice-based research networks across the U.S. during 2006–2007. The data were analyzed using standard templates to create credible estimates of the expenses incurred for both the start-up period and the implementation phase of the interventions. **Results:** Average monthly start-up expenses were \$1860 per practice (SE=\$455). Most start-up expenditures were for staff training. Average monthly incremental costs were \$58 (\$15 for provision of direct care [SE=\$5]; \$43 in overhead [SE=\$17]) per patient participant. The bulk of the intervention expenditures was spent on the recruitment and screening of patient participants. **Conclusions:** Primary care practices must spend money to address their patients' unhealthy behaviors—at least \$1860

to initiate systematic approaches and \$58 monthly per participating patient to implement the approaches routinely. Until primary care payment systems incorporate these expenses, it is unlikely that these services will be readily available. Dadoo MS, Krist AH, Cifuentes M, Green LA. Start-up and incremental practice expenses for behavior change interventions in primary care. *Am J Prev Med*. 2008 Nov;35(5 Suppl):S423-30.

Off the roadmap? Family medicine's grant funding and committee representation at NIH.

Family medicine is challenged to develop its own research infrastructure and to inform and contribute to a national translational-research agenda. Toward these ends, understanding family medicine's engagement with the National Institutes of Health (NIH) is important. **METHODS:** We descriptively analyzed NIH grants to family medicine from 2002 through 2006 and the current NIH advisory committee memberships. **RESULTS:** Grants (and dollars) awarded to departments of family medicine increased from 89 (\$25.6 million) in 2002, to 154 (\$44.6 million) in 2006. These values represented only 0.20% (0.15% for dollars) and 0.33% (0.22% for dollars), respectively, of total NIH awards. Nearly 75% of family medicine grants came from just 6 of NIH's grant-funding 24 institutes and centers. Although having disproportionately fewer grant continuations (62% vs. 72%) and R awards (68% vs. 74%)-particularly R01 awards (53% vs. 84%)-relative to NIH grantees overall, family medicine earned proportionately more new (28% vs. 21%) and K awards (25% vs. 9%) and had more physician principal investigators (52% vs. 15%). **CONCLUSIONS:** Departments of family medicine, and family physicians in particular, receive a miniscule proportion of NIH grant funding and have correspondingly minimal representation on standing NIH advisory committees. Family medicine's engagement at the NIH remains near well-documented historic lows, undermining family medicine's potential for translating medical knowledge into community practice, and advancing knowledge to improve health care and health for the US population as a whole. Lucan S, Phillips RL, Jr., Bazemore AW. Off the roadmap? Family medicine's grant funding and committee representation at NIH. *Ann Fam Med*. 2008 Nov-Dec;6(6):534-42.

The Value of Primary Care

Family medicine, the NIH, and the medical-research roadmap: perspectives from inside the NIH.

Family medicine has had little engagement with the National Institutes of Health (NIH), and it is unclear what NIH officials think about this. **METHODS:** Purposive sampling identified 13 key informants at NIH for open-ended, semi-structured interviews. Evaluation was by content analysis. **RESULTS:** NIH officials expressed the perception that family physicians have strong relationships with patients and communities and focus on interdisciplinary collaboration but that they do limited research and have weak research infrastructure. They also indicated that NIH has repackaged its stated focus, to include areas of research that might be applicable to family medicine, but whether this represents real change is questionable; NIH still emphasizes basic science and exclusionary trials. While NIH officials suggested that family physicians still have no obvious NIH home, they also suggest that family physicians are well-poised to recruit patients and inform questions, if not lead research. Family physicians have opportunity with Clinical and Translational Science Awards (CTSAs) but need areas of expertise and additional formal research training to succeed with greater research participation. **CONCLUSIONS:** NIH key informants generally appreciated family medicine clinically but viewed family medicine research as underdeveloped. Some identified opportunities for family medicine to lead, particularly CTSAs. Greater self-advocacy, research training, and developing areas of expertise may improve family medicine's engagement with NIH. Lucan SC, Barg FK, Bazemore AW, Phillips RL Jr. Family medicine, the NIH, and the medical-research roadmap: perspectives from inside the NIH. *Fam Med*. 2009 Mar;41(3):188-96.

Usual source of care: an important source of variation in health care spending.

Health care spending varies in unexplained ways, and physicians' behavior is thought to explain much of the variation. We studied the spending effects of having different usual sources of care, focusing on variations associated with the type of facility or physician specialty. Based on analyses of data from the 2001–2004 Medical Expenditure Panel Surveys, we found significant differences in annual spending, especially for adults. Use of and spending for subspecialists were similar to those for general internists, and both were significantly higher than those for family physicians. Variation in spending might be the result of training differences among primary care specialties. Phillips RL, Dadoo MS,

Green LA, Fryer GE, Bazemore AW, McCoy KI, Petterson SM. Usual source of care: an important source of variation in health care spending. *Health Aff (Millwood)*. 2009 Mar-Apr;28(2):567-77.

Effects of proposed primary care incentive payments on average physician Medicare revenue and total Medicare allowed charges.

The US Senate Finance Committee and the Medicare Payment Advisory Commission have both proposed incentive payments for primary care physicians who meet certain thresholds of "primary care-ness." With the support of the AAFP Foundation, the Graham Center analyzed how many physicians would meet proposed thresholds, and the potential impact on both physician revenue and Medicare costs. A 60% threshold (60% of claims dollars are for home, nursing home, or office visits) will capture about 60% of family physicians but only 40% of general internists. This suggests that a substantial bonus may influence more primary care physicians to deliver more primary care. But because it excludes more rural physicians than urban, these threshold codes may also be excluding physicians doing a broader scope of appropriate primary care. We do not yet suggest additional codes to be considered but suggest that Congress and the Administration need to re-evaluate their choices to avoid the unintended consequence of overly restricting the range of services needed for the Patient-Centered Medical Home. The Robert Graham Center. Effects of proposed primary care incentive payments on average physician Medicare revenue and total Medicare allowed charges. Washington, DC. May 2009.



Health Access and Equity

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

Health Access and Equity

Impact of Title VII training programs on community health center staffing and national health service corps participation.

This article examines the association between physicians' attendance in training programs funded by HRSA Title VII Section 747 Training Grants and 2 outcome variables: work in a CHC and participation in the NHSC Loan Repayment Program. METHODS: We linked the 2004 American Medical Association Physician Master-file to HRSA Title VII grants files, Medicare claims data, and data from the NHSC. We then conducted retrospective analyses to compare the proportions of physicians working in CHCs among physicians who either had or had not attended Title VII-funded medical schools or residency programs and to determine the association between having attended Title VII-funded residency programs and subsequent NHSC LRP participation. RESULTS: Three percent (5,934) of physicians who had attended Title VII-funded medical schools worked in CHCs in 2001-2003, compared with 1.9% of physicians who attended medical schools without Title VII funding ($P<.001$). A strong association was also found between attending Title VII-funded residency programs and participation in the NHSC LRP, controlling for year completed training, physician sex, and private vs. public medical school. CONCLUSIONS: Continued federal support of Title VII training grant programs is consistent with federal efforts to increase participation in the NHSC and improve access to quality health care for underserved populations through expanded CHC capacity. Rittenhouse D, Fryer GE, Phillips RL, Jr., Miyoshi T, Nielson C, Goodman D, Grumbach K. Impact of Title VII training programs on community health center staffing and national health service corps participation. *Ann Fam Med*.2008 Sep-Oct;6(5):397-405.

Navigating general practice - The use of geographic information systems.

Geographic information systems (GIS) are powerful tools for managing, analyzing and mapping geographical and associated data. In the health care setting, GIS can be used to map and graph health care provider and social and environmental data. This article uses two hypothetical cases to explore applications of GIS in general practice. Grinzi P, Bazemore AW, and Phillips, RL, Jr. Navigating general practice - The use of geographic information systems. *Aust Fam Physician*. 2008 Oct;37(10):855-8.

Specialty and geographic distribution of the physician workforce:What influences student & resident choices?

Unlike many Western nations, the United States does not manage or actively regulate the number, type, or geographic distribution of its physician workforce. As a result, medical trainees choose how and where to work. As with most free markets, equitable distribution is at risk without well-informed, evidence-based policies and incentives capable of promoting equitable access to appropriate care. This study incorporates nearly 20 years worth of survey data from graduating medical students about their experiences, their debt, their beliefs, and their intentions. It includes historical files over the same period of exposure to Title VII funds during training, and of participation in National Health Service Corps (NHSC). It includes cross-sectional data about physicians' current specialties and practice locations, and a five-year cross-section of service in Rural and Federally Qualified Health Centers. All of these data about individual physicians were brought together to test for associations between student characteristics and training influences that may have policy relevance for a more purposefully produced health care workforce. Phillips RL, Dodoo MS, Petterson S, Xierali I, Bazemore A, Teevan B, Bennett K, Legagneur C, Rudd J, Phillips J. Specialty and geographic distribution of the physician workforce:What influences student & resident choices? The Robert Graham Center, Washington DC. 2009.

Access Transformed: Building a primary care workforce for the 21st century.

Primary care professionals are undeniably needed in underserved communities today. To meet this workforce need, policies must address the location and career choices among practicing and future professionals that cause an oversupply in some areas and an acute shortage in others. This report lays out the workforce needed to reach these goals, as well as a multi-faceted policy approach that will strengthen the nation's primary care system and minimize health disparities, making it possible to ensure that every American can have access to vital primary health care. National Association of Community Health Centers, The Robert Graham Center, The George Washington University School of Public Health and Public Health Services. Access Transformed: Building a primary care workforce for the 21st century. Washington, DC. 2008.



Patient-Centered Medical Home

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

Patient-Centered Medical Home

Characterizing breast symptoms in family practice.

The frequency and outcome of breast symptoms have not been well characterized in primary care settings. To enhance and inform physician practice, this study aims to establish the proportion of visits and resultant diagnoses by age by examining longitudinal data on breast-related reasons for encounter. **METHODS:** We used data from a prospective longitudinal sample of patients seeking care in Dutch family physician offices between 1985 and 2003 to provide routine family practice data on breast symptoms as the reason for encounter; all visits were coded using the International Classification of Primary Care. Data on breast symptom prevalence are based upon 84,285 active female patients and 367,834 total encounters. **RESULTS:** Overall breast symptoms were reported in about 3% of all visits by female patients (29.7 per 1,000 active female patients per year); breast pain and breast mass were the most common breast-related complaints. Breast symptom complaints were highest among women aged 25 to 44 years (48 of 1,000) and among women aged 65 years and older (33 per 1,000). Of the women complaining of breast symptoms, 81 (3.2%) had breast cancer diagnosed. Breast mass had a markedly elevated positive likelihood ratio for breast cancer (15.04; 95% confidence interval, 11.74-19.28). **CONCLUSIONS:** As expected, of patients with breast symptoms only a small subset was subsequently given a diagnosis of breast cancer (3.2%); however, the presence of a breast mass was associated with an elevated likelihood of breast cancer. These data illustrate the use of systematic data collection and classification from primary care offices to extract information regarding disease symptoms and diagnoses. Eberl M, Phillips RL, Jr., Lamberts H, Okkes I, Mahoney M. Characterizing breast symptoms in family practice. *Ann Fam Med*. 2008 Nov-Dec;6(6):528-33.

Common measures, better outcomes (COMBO): a field test of brief health behavior measures in primary care.

Primary care offices have been characterized as underutilized settings for routinely addressing health behaviors that contribute to premature death and unnecessary suffering. Practical tools are needed to routinely assess multiple health risk behaviors among diverse primary care patients. The performance of a brief set of behavioral measures used in primary care practice is reported here. **METHODS:** Between August 2005 and January 2007, 75 primary care practices assessed four health behaviors, using a 21-item patient self-report

questionnaire for adults or a 16-item questionnaire for adolescents. Data were collected via telephone, paper, or electronic means, either with or without assistance. The performance of these measures was evaluated by describing risk-behavior prevalences, combinations of risk behaviors, and missing data. RESULTS: Of 227 adolescents and 5358 adults, most patients completed all of the survey questions. Two or more unhealthy behaviors were reported by 47.1% of adolescents and 69.2% of adults. Percentages of adults who completed all the survey items varied by health behavior: tobacco use, 98.5%; diet, 98.2%; physical activity, 96.2%; alcohol use, 85.1%. Missing data rates were higher for unassisted patient self-reporting. CONCLUSIONS: A relatively brief set of health behavior measures was usable in a variety of primary care settings with adults and adolescents. The performance of these measures was uneven across behaviors and administration modes, but yielded estimates of unhealthy behaviors consistent overall with what would be expected based on published population estimates. Further work is needed on measures for alcohol use and physical activity to bring practical assessment tools for key health behaviors to routine primary care practice. Douglas H. Fernald, Desireé B. Froshaug, L. Miriam Dickinson, Bijal A. Balasubramanian, Martey S. Dodoo, Jodi Summers Holtrop, Dorothy Y. Hung, Russell E. Glasgow, Linda J. Niebauer, Larry A. Green Common Measures, Better Outcomes (COMBO): A Field Test of Brief Health Behavior Measures in Primary Care. *Am J Prev Med*. 2008 Nov;35(5 Suppl): S414-S422.

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Healthcare Quality and Safety

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

Healthcare Quality and Safety

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

Little is known about the types and outcomes of testing process errors that occur in primary care. **OBJECTIVE:** To describe types, predictors and outcomes of testing errors reported by family physicians and office staff. **DESIGN:** Events were reported anonymously. Each office completed a survey describing their testing processes prior to event reporting. **PARTICIPANTS:** 243 clinicians and office staff of eight family medicine offices. **MAIN OUTCOME MEASURES:** Distribution of error types, associations with potential predictors; predictors of harm and consequences of the errors. **RESULTS:** Participants submitted 590 event reports with 966 testing process errors. Errors occurred in ordering tests (12.9%), implementing tests (17.9%), reporting results to clinicians (24.6%), clinicians responding to results (6.6%), notifying patient of results (6.8%), general administration (17.6%), communication (5.7%) and other categories (7.8%). Charting or filing errors accounted for 14.5% of errors. Significant associations ($p < 0.05$) existed between error types and type of reporter (clinician or staff), number of labs used by the practice, absence of a results follow-up system and patients' race/ethnicity. Adverse consequences included time lost and financial consequences (22%), delays in care (24%), pain/suffering (11%) and adverse clinical consequence (2%). Patients were unharmed in 54% of events; 18% resulted in some harm, and harm status was unknown for 28%. Using multilevel logistic regression analyses, adverse consequences or harm were more common in events that were clinician-reported, involved patients aged 45-64 years and involved test implementation errors. Minority patients were more likely than white, non-Hispanic patients to suffer adverse consequences or harm. **CONCLUSIONS:** Errors occur throughout the testing process, most commonly involving test implementation and reporting results to clinicians. While significant physical harm was rare, adverse consequences for patients were common. The higher prevalence of harm and adverse consequences for minority patients is a troubling disparity needing further investigation. Hickner J, Graham DG, Elder NC, Brandt E, Emsermann CB, Dovey S, Phillips R. Testing process errors and their harms and consequences reported from family medicine practices: a study of the American Academy of Family Physicians National Research Network. *Qual Saf Health Care*. 2008;17:194-200.

Medication errors reported by US family physicians and their office staff.

Most medication error studies come from inpatient settings. There is limited information about medication errors in primary care settings. **OBJECTIVE:** To describe medication errors reported by family physicians and their office staff and to estimate their preventability using currently available electronic prescribing and monitoring tools. **Design, setting, participants and study instrument:** In two error reporting studies conducted by the American Academy of Family Physicians (AAFP) National Research Network (NRN), 1265 medical errors were voluntarily reported by >440 primary care clinicians and staff from 52 physician offices. The 194 error reports related to medications were abstracted and analyzed using a medication error coding tool-Medication Error Types, Reasons, and Informatics Preventability (METRIP). **MAIN OUTCOME MEASURES:** Type, severity and preventability of medication errors and associated adverse drug events (ADEs). **RESULTS:** 126 (70%) of the medication errors were prescribing errors, 17 (10%) were medication administration errors, 17 (10%) documentation errors, 13 (7%) dispensing errors and 5 (3%) were monitoring errors. ADEs resulted from 16% of reported medication errors. The severity of harm from reported errors were: prevented and did not reach patients, (72, 41%), reached patients but did not require monitoring (63, 35%), reached patients and required monitoring (15, 8%), reached patients and required intervention (23, 13%) and reached patients and resulted in hospitalization (5, 3%). No deaths were reported. Of the errors that were prevented from reaching patients, 29 (40%) were prevented by pharmacists, 14 (19%) by physicians, 12 (17%) by patients and 5 (7%) by nurses. 102 (57%) of the reported errors might have been prevented with enhanced electronic prescribing and monitoring tools. **CONCLUSIONS:** Most medication errors reported from US family physician offices were related to prescribing errors and more than half of the errors reached patients. The errors were prevented by pharmacists, patients and physicians. More than half of the errors could be prevented by electronic tools. Kuo GM, Phillips RL, Graham D, Hickner JM. Medication errors reported by US family physicians and their office staff. *Qual Saf Health Care*. 2008 Aug;17(4):286-90.

How Can Primary Care Cross the Quality Chasm?

The chasm between knowledge and practice decried by the Institute of Medicine (IOM) is the result of other chasms that have not been addressed. They include

Healthcare Quality and Safety

the chasm between what we know and what we need to know to improve care; the chasm between those who provide primary care and those who do not fund, study, support, or publish practical primary care studies; and the chasm between research and quality improvement (QI). These chasms are a result of problematic concepts, attitudes, traditions, time frames, and financing approaches among the various participants. If we are to facilitate the production and use of the knowledge needed for primary care to cross IOM's chasm, major changes are needed. These changes include the following: (1) admission by all primary care professions that we have quality problems that require our unified attention and action; (2) conversion of the paradigm from "translate research into practice" to "optimizing health and health care through research and QI"; (3) development and facilitation of more partnerships among clinicians, researchers, and care delivery leaders for engaged scholarship in both research and QI; (4) modification of the agendas and methods of funders and researchers so they emphasize the problems of patients and patient care and support practical time frames and research designs; and (5) facilitation by funders and journals of the dissemination and implementation of lessons from QI and practical research. Solberg LI; Elward KS; Phillips WR; Gill JM; Swanson G; Main DS; Yawn BP; Mold JW; and Phillips RL Jr. How Can Primary Care Cross the Quality Chasm? *Ann Fam Med*. 2009;7:164-169.

Graham Center One-Pagers

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

Graham Center Policy One-Pagers

Will patients find diversity in the medical home?

Mexican Americans and blacks experience disparities in health outcomes relative to white populations. During the past five to 10 years, fewer blacks and Mexican Americans are going to medical school and entering primary care professions. To assure the availability of a patient-centered medical home for all Americans, policy makers must work to support a culturally competent and diverse primary care workforce. Turner EJ, Bazemore AW, Phillips Jr RL, Green LA. Will patients find diversity in the medical home? *Am Fam Physician*. 2008 Jul 15;78(2):183.

Changing patient health-risk behavior requires new investment in primary care.

Evidence supports the effectiveness of primary care interventions to improve nutrition, increase physical activity levels, reduce alcohol intake, and stop tobacco use. However, implementing these interventions requires considerable practice expense. If we hope to change behavior to reduce chronic illness, the way we pay for primary care services must be modified to incorporate these expenses. Dadoo MS, Lesser LI, Phillips RL, Jr, Bazemore AW, Petterson S, Xierali I. Changing patient health-risk behavior requires new investment in primary care. *Am Fam Physician*. 2008 Oct 15;78(8):924.

Having a usual source of care reduces ED visits.

The recent growth in the use of emergency departments (EDs) is costly, undesirable, and unnecessary. This trend is partly due to a growing proportion of persons who lack a usual source of care. This group is increasingly likely to rely on EDs for their health care needs compared with those who have a usual source of care. Petterson S, Rabin D, Phillips RL, Bazemore A, Dadoo MS. Having a usual source of care reduces ED visits. *Am Fam Physician*. 2009 Jan 15;79(2):94.

Primary care's ecologic impact on obesity.

With a costly obesity epidemic, policy makers must recognize factors that may influence obesity not only for each person, but also across communities. Increased primary care physician density on the county level is associated with decreased obesity rates. As we move to restructure the primary care workforce and engage our patients and communities in behavior change, the implications of this association merit closer investigation. Gaglioti A, Petterson SM, Bazemore AW, Phillips RL Jr, Dadoo MS, Zhang X. Primary care's ecologic impact on obesity. *Am Fam Physician*. 2009 Mar 15;79(6):446.

The effect of facilitation in fostering practice change.

Working with facilitation agents measurably improves the ability of motivated primary care practices to move towards improved models of care. Widespread primary care practice transformation will likely require facilitation capacity in most communities. The Robert Graham Center. Washington, DC: June, 2009.

Washington Primary Care Forum

The Graham Center hosts the Washington DC Primary Care Forum at the Cosmos Club. These breakfast forums draw 20-40 individuals from government, academia, professional societies, and advocacy groups. RWJF Policy Fellows often attend, and there are usually a few attendees from out of town. These fora provide a venue for primary care stakeholders to present and discuss policy-relevant research and ideas.

Washington Primary Care Forum

The Graham Center held three Washington DC Primary Care Forums at the Cosmos Club. These breakfast forums draw 20-40 individuals from government (HRSA, AHRQ), academia (Georgetown University, George Washington University), professional societies (AMA, ACP, AAP, AAFP, nursing, psychology), and advocacy groups. RWJF Policy Fellows often attend, and there are usually a few attendees from out of town. The series has been so successful that it inspired the US Agency for Healthcare Research and Quality to develop a parallel series of forums and we now coordinate schedules, topics and invitation lists.

Forum #59: Assuring access to health care: The role and needs for community health centers. John Sawyer, Bob Phillips, MD MSPH, and Michelle Proser.

Forum #60: What the federal government should do to revitalize the primary care infrastructure in the United States. Kevin Grumbach, MD.

Forum #61: Specialty and Geographic Distribution of the Physician Workforce: What Influences Medical Student and Resident Choices? Bob Phillips, MD MSPH.

Visiting Scholars and Primary Care Policy Fellowship

The Graham Center continues its visiting scholars and fellowship programs, which provide researchers an immersion experience in health policy while broadening and enriching Graham Center ideas and projects. The scholars and fellows programs are designed to seed primary care with leaders and researchers who experience and have an understanding of evidence-based policy development.

Larry A. Green Scholars Program

The Center hosted six Larry A. Green Scholars this year and an Australian Primary Health Care Research Institute (APHCRI)/Robert Graham Center Visiting Fellow, representing a broad array of skills and interests. Scholars work directly with staff on original research projects of interest to them, towards a goal of a national publication and dissemination. Since 2008, the scholars program has been sustained by the generous support of the Pisacano Leadership Foundation, the philanthropic foundation of the American Board of Family Medicine.

- Eleni O'Donovan, Boston University - Health insurance reform in Massachusetts
- Bridget Harrison, Stanford University - Title VII Section 747 and the primary care workforce
- Rachel Lee, University of Melbourne/APHCRI (Australia) - Defining and targeting areas of primary health care need, lessons from five countries
- Kevin Grumbach, University of California, San Francisco - Health care co-operative extension service
- Lars Peterson, Case Western University - House calls; Family physicians' present and future role in caring for the elderly
- Michael Fine, HealthAccessUSA - Healthcare costs and outcomes and primary care
- Peter Swain, Bayfront Family Medicine Residency - National Health Service Corps

Primary Care Health Policy Fellowship

The Graham Center continued its partnership with Georgetown University in 2008-09, hosting its seventh Health Policy Fellow, Dr. Keisa Bennett. Dr. Bennett spent her fellowship year conducting scholarly research on medical student and resident specialty and practice location selection and Medicare payment policy. She co-authored an essay published in the American Medical Association's Journal of Ethics, Virtual Mentor, entitled, "Closing the Gap: Finding and Encouraging Physicians Who Will Care for the Underserved." Dr. Bennett also produced a series of maps outlining potential variation and impact of cuts in Medicare payment for each state, which were published on the Graham Center's website and distributed to state chapters. In addition to her research, Dr. Bennett served as an attending physician at Unity Health Care's Upper Cardozo clinic, taught Georgetown University medical students, and precepted at the Georgetown University/Providence Hospital Family Medicine Residency Program.

Impact

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

Advisees:

- Grace Kuo, PharmD, MPH, AHRQ K08 University of California, San Diego
- John Orzano, MD, AHRQ K08 UMDNJ/RWJ Medical School
- Jennifer Devoe, MD DPhil, AHRQ K08 Oregon Health Sciences University

Requests for assistance/information:

- State Chapters
- Universities/Departments of Family Medicine
- Health Resources and Services Administration (HRSA)
- Department of Health and Human Services (HHS)
- Oregon Rural Practice-based Research Network (ORPRN) - Oregon Health and Science University
- University of Wyoming
- Virginia Commonwealth University
- University of North Dakota School of Medicine and Health Sciences

Selected Media/Press:

- Congress Allows Medicare Physician Scarcity Incentives to Expire. Jim Arvantes. *AAFP News Now*. July 31, 2008.
- Community Health Centers Face Primary Care Provider Shortage. Leah Nylen. *CQ Healthbeat News*. August 11, 2008.
- NRN Research: Testing Process Errors Leading to Negative Consequences 'Common' in Primary Care. Paula Haas. *AAFP News Now*. August 20, 2008.
- Testing Errors in The Doctor's Office. Douglas Kamerow. *All Things Considered*. National Pubic Radio. August 20, 2008.

- Reports Warn of Primary Care Shortages. Bridget M. Kuehn. *JAMA*. October 22/29, 2008—Vol 300, No. 16.
- Doctors tally the economic value practices bring to communities. Karen Caf-farini. *American Medical News*. Nov. 10, 2008.
- Study Says NIH Funding for Research Related to Family Medicine Inade-quate. Jeannie Baumann. *Medical Research Law & Policy Report*. Novem-ber 19, 2008.
- Family Physicians Have Little Input at NIH: Report. *The Washington Post*. November 17, 2008.
- Web Atlas Aids Researchers. *Health Data Management*. December 17, 2008.
- Expansion of Clinics Shapes Bush Legacy. Kevin Sack. *The New York Times*. December 25, 2008.
- Maps Give Policymakers Bird's-eye View on Health. James Ritchie. *Busi-ness Courier*. February 20, 2009.
- Medical Schools Can Play Role in Boosting Student Interest in Primary Care, Says Report. Jim Arvantes. *AAFP News Now*. March 11, 2009.

Committees/Service:

- NAPCRG -Board, Committee on Advancing the Science of Family Medicine
- US Council on Graduate Medical Education - Vice Chair
- Institute of Medicine - Committee on Parental Depression
- National Business Group on Health - Evidence Based Benefit Design Com-mittee and Primary Care Working Group
- Medical Education Futures Study - Advisory Board
- National Association of Community Health Centers - Research Advisory Board
- EU Linneaus Patient Safety Collaborative Advisory Board
- Geiger Gibson/RCHN Community Health Foundation Research Collabora-tive Advisory Board
- Distributed Ambulatory Care Research Network (DARTNet) Oversight Com-mittee and Advisory Board
- Capital Area Primary Care Research Network (CAPRICORN), Board of Di-rectors
- Shoulder to Shoulder, Inc- Board of Directors

Advisory Board

Fay Brown, M.H.S.

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Cincinnati, OH

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College of Medicine
University of Florida
Jacksonville, FL

Robert Graham Center Staff

Robert Phillips, Jr., MD, MSPH

Director

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

Andrew Bazemore, MD, MPH

Assistant Director

Andrew Bazemore, MD, MPH joined the Graham Center as its Assistant Director in July 2005. Dr. Bazemore has faculty appointments at the Department of Family Medicine at Georgetown University, George Washington University, and the University of Cincinnati. Prior to joining the Graham Center, Dr. Bazemore served as an Assistant Professor in the University of Cincinnati's Department of Family Medicine, where he also completed his residency training and faculty development fellowship. As a member of the Research Division as well as Director of the International Health Program, Dr. Bazemore developed interests in access to care for underserved populations both domestically and internationally and on the application of geographic information systems to the study of the U.S. safety net. Dr. Bazemore received his B.A. degree from Davidson College, his M.D. from the University of North Carolina, and completed his M.P.H. at Harvard University.

Martey Dodoo, Ph.D.

Senior Economist

Martey S. Dodoo is the economic and demographic analyst at The Robert Graham Center. He has held previous economist and statistician positions with the PSC: Western Integrity Center, New Jersey Department of Health and Senior Services, and MDRC in New York. His current research interests are in health access and coverage, workforce, labor and demographic economics, program evaluation, patient safety and health quality, utilization, cost and fiscal impact analysis. He earned his Ph.D. (Demography and Economics) degree from the University of Pennsylvania. He also has graduate degrees in Economics from

Robert Graham Center Staff

the University of Western Ontario (Canada), the University of Ghana, and an undergraduate degree in Biochemistry. He is a member of the International Health Economics Association, the Society of Government Economists, and the Society for Clinical Data Management.

Stephen Petterson, Ph.D.

Senior Health Policy Researcher

Stephen Petterson is a Senior Health Policy Researcher at the Robert Graham Center. Previously, as a sociologist and social statistician he was on the faculty at the University of Virginia and a researcher at the Southeastern Rural Mental Health Research Center. His research interests are in national and state health policy, access to care and health insurance, the relationship between primary care and mental health treatment and global health. He has a particular interest in understanding the barriers faced by disadvantaged populations in the health care system. He earned his Ph.D. (1993, Sociology) from the University of Wisconsin and an undergraduate degree from Haverford College (1984, Sociology and Anthropology).

Imam Xierali, Ph.D.

Health Geographer and Research Scientist

Imam Xierali is a Health Geographer and Research Scientist at the Robert Graham Center. Previously, he was a Statistical Analyst at Georgia Division of Public Health, actively participating in enterprise GIS management and applying Geographic Information Systems and spatial statistics into public health policy research. His research interests are in spatial disparities in health and health care, geospatial technologies for health applications, statistical modeling, and spatial statistics. He earned his Ph.D. in geography (2006) and M.A. in GIS (2004) from the University of Cincinnati. He also has an M.A. in political science (2003) from the University of Cincinnati. He is a member of the Association of American Geographers (AAG), American Public Health Association (APHA), Georgia Public Health Association (GPHA), and Pi Sigma Alpha.

Bridget Teevan, MS

Research Manager

Bridget Teevan joined the Robert Graham Center as Research Manager in April 2007 following the completion of her master's degree. She has particular interests

in global health and decision theory. Bridget manages the Robert Graham Center's research portfolio and administers the scholars and fellows programs. Bridget earned a B.S. in Chemistry from Florida State University in 1997 and a master's degree in International Studies from North Carolina State University in 2006. She earned a Graduate Certificate in Epidemiology in 2008, and is a current MPH candidate at the University of North Carolina at Chapel Hill School of Public Health. She is a member of Phi Beta Kappa.

Kim Epperson

Office Administrator

Kim Epperson joined the Robert Graham Center as the new Office Administrator in October 2009. Previously, Kim was Executive Assistant to the Vice President at a national non-profit where she was responsible for the daily operations of the department and handling of all administrative functions for the Vice President. Prior to joining the non profit, Kim had 16 years of service with US Airways in a variety of positions. During her career at US Airways, Kim was Lead on the Sales Cultural Assessment Team handling Rewards and Recognition for the Sales Department. She was also a member of the Minority Professional Association and the Women's Professional Group. Kim also volunteers for the Ben E. King "Stand By Me" Foundation at their annual golf tournament. Kim completed the Job Training Partnership Act Program at Forsyth Technical Community College and received a Certificate of Completion in Secretarial Science in 1984. Her interests include travel, flag football and reading.



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Policy Studies in Family Medicine and Primary Care

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