



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

2010-2011 Report



ROBERT
GRAHAM
CENTER

AAFP Center for Policy Studies

About the Robert 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.graham-center.org.



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2009-2011 Highlights

Twenty-one

Larry A. Green Visiting Scholars

Twenty-two

Manuscripts Published, including:

- Health Affairs
- Archives of Internal Medicine
- Journal of the American Medical Association
- Journal of Health Care for the Poor and Underserved
- Journal of the American Board of Family Medicine
- American Journal of Public Health

Ten

Policy Briefs

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

First Place

Best Web-based Application, 2011 ESRI International Users Conference

Numerous

Committees/Service:

- NAPCRG, Board, Committee on Advancing the Science of Family Medicine
- US Council on Graduate Medical Education, Vice Chair
- Institute of Medicine, Integration of Primary Care and Public Health
- National Business Group on Health, Evidence Based Benefit Design Committee/Primary Care Working Group
- EU Linneaus Patient Safety Collaborative Advisory Board
- Distributed Ambulatory Care Research Network (DARTNet) Oversight Committee and Advisory Board
- Capital Area Primary Care Research Network (CAPRICORN), Board of Directors
- Shoulder to Shoulder, Inc., Board of Directors
- American Board of Family Medicine, Young Leaders Group
- Health Workforce Information Center (HWIC) Advisory Board
- National Negotiated Rule-Making Committee on Shortage Designation
- International Medical Workforce Collaborative Steering Committee
- Advisory Panel, AHRQ Information Model for the Patient Centered Medical Home
- Health and Aging Policy Fellowship National Advisory Board



Letter from the Director

The passage and implementation of the Affordable Care Act, wide-spread interest in understanding what Patient-Centered Medical Homes and Accountable Care Organizations are, and general concern about the state of the primary care workforce were important drivers of work at the Robert Graham Center in 2010. If 2009 was a benchmark year for us in terms of meeting our mission, 2010 set an even higher standard. We also formally celebrated the 10th anniversary of the naming of the Robert Graham Center. We can now say with confidence that it takes nearly a decade for a health policy research center to really hit stride in terms of building relationships and producing work that consistently affects policy.

Our fundamental relationship with the AAFP continues to allow us to direct evidence at policy makers without being labeled as lobbyists. This year that was most exemplified by Medicare's change of the Primary Care Incentive Payment rule that broadens eligibility based on our research. Our participation as technical experts on the federal negotiated rule making committee for shortage and underserved area designation is also an important benchmark for us. If imitation is the best form of flattery, then the AAFP has a lot to be proud of. This year the American College of Surgeons developed a health policy center and we have been visited by two other medical professional societies considering doing the same. So far, we remain the only editorially-independent health policy research center affiliated with a physician organization.

Thanks to the efforts of Dr. Andrew Bazemore, Assistant Director at the Robert Graham Center, we realized a decade long dream by launching a new web-based mapping tool for the Health Resources and Services Administration. UDSmapper.org shows the patterns of patient visits to community health centers by neighborhood in relation to underservice and poverty. The perspective can also be reversed to look at neighborhoods with tremendous need that are not using community health centers. In this way it is quickly becoming an important resource for helping figure out where to invest more than \$10 billion in health center expansion funding. We plan to add other data to the tool as HRSA moves to double the capacity of health centers to serve the uninsured and underinsured. We're also participating in the Federal negotiated rule making process for creating new measures of geographic workforce shortage and underservice. Dr. Steve Petterson and our visiting fellows from Australia Primary Health Care Research Institute (APHCRI) in each of the last two years did important research on the factors that predict shortages, underservice, and poor health outcomes that will contribute to both the mapping tool and the rule making process. Our partnerships in Australia are headed toward the formal development of a linked geospatial health research center housed in APHCRI thanks to a \$2.5 million investment there.

Our relationships with foundations and federal agencies also put our research into important conversations. Our relationship with the Josiah Macy, Jr. Foundation led to a key article in the special Health Affairs issue focused on primary care. The Macy Foundation also supported a web-based mapping tool that shows the workforce impact of every medical school to help local decisions about expansion of training, as one example.

MedSchoolMapper.org also provides data to schools about where their graduates practice and in which specialties—information important to receiving federal funding. Health care workforce research for AHRQ and HRSA is contributing to current efforts to estimate shortages and to improve access to care. The Agency for Healthcare Research and Quality and the Commonwealth Fund partnered to allow us to hold an international conference, International Learning on Increasing the Value and Effectiveness of Primary Care (I LIVE PC), with six other countries providing ideas from their own system reforms about improving primary care. The Commonwealth Fund is also supporting our efforts to evaluate a patient centered medical home model Medicaid program in Illinois thanks to the legwork of our two health policy fellows last year, Drs. Matt Burke and Winston Liaw.

As predicted, the year past required managing increased demand on our capacity for informing policy. We've grown as a result, both in terms of staff and collaborations. Dr. Jennifer Rankin, Meiyang Han, Sean Finnegan, Ben Adler, Karen Payne and Anne Berry joined our team. We sadly said goodbye to good friends Dr. Martey Dodoo, Lindsay Withers, and Adam Schertz, all of whom contributed greatly to the success of the Graham Center. It is also rewarding to see Dr. Stephen Petterson take on the formal role of Research Director, and to see Bridget Teevan fully shift over to the research team. We are grateful to many friends in supporting our work and particularly to the AAFP for supporting our evolution. I am both extremely lucky and proud to work with such a highly talented, creative and hardworking team. We welcome your ideas and support.



Bob Phillips, MD MSPH
Director



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.

Estimated effects of Sec. 1721 of draft bill HR 3200 on physician gross revenue

House draft bill H.R. 3200 was introduced in the House on July 13, 2009. Section 1721 of HR 3200 relates to payments to primary care physicians and “requires that State Medicaid programs reimburse for primary care services furnished by physicians and other practitioners at no less than 80% of Medicare rates in 2010, 90% in 2011, and 100% in 2012 and after.” This white paper reports on analyses to assess and estimate the effects of Section 1721 of draft bill HR 3200 on the total gross revenue of the average physician nationally and the total gross revenue of the average family physician in each state. It shows the widely variable but important impact. Doodoo M. (2009). Robert Graham Center White Paper on the Estimated Effects of Sec. 1721 of draft bill HR 3200 “America’s Affordable Health Choices Act of 2009” on physician gross revenue. <http://www.graham-center.org/online/graham/home/publications/monographs-books/2009/dodoowp-estimated-effects.html>

Global choices: international health and medical student residency preferences

Bazemore AW, Diller P. Global choices: international health and medical student residency preferences. *Med Educ*. 2009 Nov;43(11):1079-80.

Does graduate medical education also follow green?

Teaching hospitals have favored higher revenue generating specialty training over primary care positions. Expansion of positions in the “R.O.A.D.” disciplines (radiology, ophthalmology, anesthesia, and dermatology) and emergency medicine over the last 10 years parallels losses in family medicine, general pediatrics, and general internal medicine. General internal medicine positions increasingly serve as channels for revenue generating subspecialty programs, leaving fewer internal medicine positions dedicated to primary care. Policy makers hoping to realize the superior health outcomes and decreased costs associated with greater access to primary care may find this trend alarming. Our findings support the concern expressed by the COGME that instead of responding to policy aims to correct shortage in the primary care pipeline, hospitals are instead training to meet hospital goals. Weida NA, Phillips RL Jr, Bazemore AW. Does graduate medical education also follow green? *Arch Intern Med*. 2010 Feb 22;170(4):389-90.

Primary care and why it matters for U.S. health system reform

The term primary care is widely used as if it were consistently defined or well understood. In fact, neither is the case. This paper offers a definition of primary care derived from historical perspectives—from both the United States and abroad. We discuss the evidence for primary care’s important functions and international experiences with primary care. We also describe how and why the United States has deviated from this fuller realization of primary care, as well as the steps needed to achieve primary care and health outcomes on a par with those of other developed countries. These include doubling primary care financing to 10–12 percent of total health care spending—a step that would be likely to pay for itself via resulting reductions in overall health spending. Phillips RL Jr, Bazemore AW. Primary care and why it matters for U.S. health system reform. *Health Aff (Millwood)*. 2010 May;29(5):806-10.

The social mission of medical education: ranking the schools

The basic purpose of medical schools is to educate physicians to care for the national population. We developed a metric called the social mission score to evaluate medical school output in these 3 dimensions. We measured the percentage of graduates who practice primary care, work in health professional shortage areas, and are underrepresented minorities, combined into a composite social mission score. The contribution of medical schools to the social mission of medical education varied substantially. Three historically black colleges had the highest social mission rankings. Public and community-based medical schools had higher

social mission scores than private and non-community-based schools. School rankings based on the social mission score differ from those that use research funding and subjective assessments of school reputation. These findings suggest that initiatives at the medical school level could increase the proportion of physicians who practice primary care, work in underserved areas, and are underrepresented minorities. Mullan F, Chen C, Petterson S, Kolsky G, Spagnola M. The social mission of medical education: ranking the schools. *Ann Intern Med.* 2010 Jun 15;152(12):804-11.

Building the research culture of family medicine with fellowship training

Background and Objectives: The future of family medicine is closely tied to the strength of family medicine research. Physicians with fellowship training have been shown to be more productive researchers than those without fellowship training. This study's objectives are to (1) identify fellowship programs available to family physicians, (2) explore how family medicine fellows are taught research skills, and (3) identify obstacles to enhancing research training in fellowships. **Methods:** Fellowship programs available to family physicians were identified by Internet searches and confirmed by telephone or e-mail. Directors of identified fellowships received a 33-item survey exploring research training provided by their program. Descriptive statistics were used to evaluate the quantitative data. Survey comments were analyzed qualitatively to identify themes. **Results:** We confirmed that 247 of 328 identified research fellowships are available to family physicians. Survey response rate from those 247 fellowships was 65%. Fellowships with and without a research focus are providing research training. They are threatened, however, by weak research infrastructure, inadequate funding, and attitudinal biases against family medicine research. **Conclusions:** There are many fellowship and research training opportunities for family physicians. But in many programs, research training is tenuous, and support for researchers is low. We recommend expanding research advocacy efforts within family medicine, Congress, and funding institutions. Bolon S and Phillips RL, Jr. Building the Research Culture of Family Medicine with Fellowship Training. *Fam Med.* 2010 Jul-Aug;42(7):481-7.



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

Race and ethnicity and rural mental health treatment

Research has shown that there is less use of mental health services in rural areas even when availability, accessibility, demographic, and need factors are controlled. This study examined mental health treatment disparities by determining treatment rates across different racial/ethnic groups. Methods: Data from the first four panels of the Medical Expenditure Panel Survey (MEPS) were used for these analyses. Results: Findings show that rural residence does little to contribute to existing treatment disparities for racial/ethnic minorities living in these areas. Conclusions: Findings suggest that characteristics of the rural environment may disadvantage all residents with respect to mental health treatment. In more populated areas where mental health services are more plentiful, complex racial and service system factors may play a greater role in evident ethnic/racial treatment disparities. S Petterson, PhD; IC Williams, PhD; EJ Hauenstein, PhD, LCP, MSN, RN; V Rovnyak, PhD; E Merwin, PhD, RN, FAAN. Race and ethnicity and rural mental health treatment. *Journal of Health Care for the Poor and Underserved* 20 (2009): 662–677.

Harnessing Geographic Information Systems (GIS) to enable Community-Oriented Primary Care

Despite growing acceptance of geographic information systems (GIS) in the public health arena, its utility for clinical population management and coordination by leaders in a primary care clinical health setting has been neither fully realized nor evaluated. Methods: In a primary care network of clinics charged with caring for vulnerable urban communities, we used GIS to (1) integrate and analyze clinical data and population data and (2) generate distribution, service area, and population penetration maps of those clinics. We then conducted qualitative evaluation of the responses of primary care clinic leaders, administrators, and community board members to analytic mapping of their clinic and regional population data. Results: Qualitative assessments of staff response to the process of mapping clinical and population data revealed enthusiastic engagement in the process. However, they also revealed barriers to further adoption. Conclusions: Analytic mapping was enthusiastically received and practically applied in the primary care setting, and was readily comprehended by clinic leaders for innovative purposes. Bazemore A, Phillips RL, Miyoshi T. Harnessing Geographic Information Systems (GIS) to enable community-oriented primary care. *J Am Board Fam Med*. 2010 Jan-Feb;23(1):22-31.

The impact of a clinic move on vulnerable patients with chronic disease: A geographic information systems (GIS) analysis

Changing locations disrupts the populations served by primary health care clinics, and such changes may differentially affect access to care for vulnerable populations. Methods: Online geographic information systems mapping tools were used to define how the relocation of a family medicine center impacted access to care for black and Hispanic patients with chronic disease. Results: Maps created from practice management data revealed a distinct shift in black and Hispanic patients with chronic disease being served in the new location. Conclusions: Geographic information systems tools are valuable aids in defining changing service areas of primary health care clinics. Bazemore AW, Diller P, Carrozza M. The impact of a clinic move on vulnerable patients with chronic disease: A geographic information systems (GIS) analysis. *Am Board Fam Med* 2010;23:128–130.

Avertable deaths associated with household income in Virginia

We estimated how many deaths would be averted if the entire population of Virginia experienced the mortality rates of the 5 most affluent counties or cities. Methods: Using census data and vital statistics for the years 1990 through 2006, we applied the mortality rates of the 5 counties/cities with the highest median household income to the populations of all counties and cities in the state. Results: If the mortality rates of the reference population had applied to the entire state, 24.3% of deaths in Virginia from 1990 through 2006 would not have occurred. An annual mean of 12954 deaths would have been averted. In some of the most disadvantaged areas of the state, nearly half of deaths would have been averted. Conclusions: Favorable conditions that exist in areas with high household incomes exert a major influence on mortality rates. SH Woolf, MD, MPH; RM Jones, PhD, MPH; RE Johnson, PhD; RL Phillips Jr, MD, MSPH; MN Oliver, MD; AW Bazemore, MD, MPH; A Vichare, MPH. *Am Journal of Public Health*. *American Journal of Public Health*. April 2010, Vol 100, No. 4. 750-755.

Rural-urban distribution of the U.S. geriatrics physician workforce

PURPOSE: To determine the distribution of geriatricians across the rural-urban continuum from 2000 to 2008 and to compare with primary care physicians in 2008. **DESIGN:** County-level analysis of physician data from the American Medical Association Physician Masterfile for 2000, 2004, and 2008 merged with U.S. Census data on the number of older (≥ 65) county residents. Descriptive statistics for each year were stratified according to 2003 Rural Urban Continuum Codes (RUCCs). **MEASUREMENTS:** Number of physicians per county elderly population. **RESULTS:** The number of self-identified geriatricians nationwide increased from 5,157 to 7,412 from 2000 to 2008. The number of geriatricians increased in each RUCC level, with nearly 90% of geriatricians residing in urban areas in all years. General internal medicine physicians are more plentiful in urban counties and declined as rurality increased. In contrast, family physicians were more evenly distributed with the elderly population across the rural-urban continuum. **CONCLUSION:** Small numbers of geriatricians combined with a growing elderly population poses a challenge and an opportunity. Healthcare systems and policy-makers will need to modify care models to better use the skill of geriatricians in concert with other providers to provide quality care for older rural and urban Americans. Peterson LE, Bazemore A, Bragg EJ, Xierali I, Warshaw GA. *J Am Geriatr Soc.* 2011;59(4):699-703.

Accounting for Graduate Medical Education production of primary care physicians and general surgeons: Timing of measurement matters

Legislation proposed in 2009 to expand GME set institutional primary care and general surgery production eligibility thresholds at 25% at entry into training. The authors measured institutions' production of primary care physicians and general surgeons on completion of first residency versus two to four years after graduation. Production of primary care physicians and general surgeons was assessed by retrospective analysis of the 2009 American Medical Association Masterfile. The authors measured production rates for each institution based on physicians completing their first residency during 2005-2007 in family or internal medicine, pediatrics, or general surgery. They then reassessed rates to account for those who completed additional training. Of 116,004 physicians completing their first residency, 54,245 (46.8%) were in primary care and general surgery. Of 683 training institutions, 586 met the 25% threshold for expansion eligibility. At two to four years out, only 29,963 physicians (25.8%) remained in primary care or general surgery, and 135 institutions lost eligibility. A 35% threshold eliminated 314 institutions collectively training 93,774 residents (80.8%). Residency expansion thresholds that do not account for production at least two to four years after completion of first residency overestimate eligibility. The overall primary care production rate from GME will not sustain the current physician workforce composition. Petterson S, Burke M, Phillips RL, Teevan B. Accounting for Graduate Medical Education production of primary care physicians and general surgeons: Timing of measurement matters. *Acad Med.* May 2011;86(5):605-608.

Use of measures of socioeconomic deprivation in planning primary health care workforce and defining health care need in Australia

Purpose: To examine whether measures of remoteness areas adequately reveal high need populations, measured against socioeconomic disadvantage and physician to population ratios. **Design:** Bivariate analyses examined associations between remoteness areas and index of relative socioeconomic disadvantage (IRSD). From this analysis, a composite score of deprivation was constructed combining measures of remoteness areas, physician to population ratios and IRSD, and validated against health outcome measures. **Results:** The percentage of small areas and populations within the most socioeconomically disadvantaged quintile rose with increasing remoteness. However, 12.8% of small areas within major cities and 40.7% of outer regional areas were also within the lowest socioeconomic quintile. There was a strong relationship between our composite score of deprivation and avoidable mortality, risk rate, diabetes rate and percent Indigenous. Regression analysis revealed the association between avoidable mortality and remoteness was lost after controlling for percent Indigenous. **Conclusions:** Using remoteness areas alone to prioritize workforce incentive programs and training requirements has significant limitations. Including measures of socioeconomic disadvantage and workforce supply would better target health inequities and improve resource allocation in Australia. Butler DC, Petterson S, Bazemore A, Douglas KA. Use of measures of socioeconomic deprivation in planning primary health care workforce and defining health care need in Australia. *Aust J Rural Health.* 2010 Oct;18(5):199-204



The 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.

Improving the delivery of preventive services to Medicare beneficiaries

While policy makers emphasize increased use of preventive care as central to health reform's ability to lengthen lives and save costs, busy clinicians still lack financial incentives to coordinate and effect evidence-based prevention. To realize these ambitions, the Department of Health and Human Services should align payments from the CMS with the preventive evidence base produced by the USPSTF. Simultaneously, Congress should implement innovative payment reforms driving new models of preventive coordination and accountability, revisit previously authorized but unnecessary services, and increase support for research on their effectiveness and cost-effectiveness. Lesser LI, Bazemore AW. Improving the Delivery of Preventive Services to Medicare Beneficiaries. JAMA. 2009;302(24):2699-2700.

Measuring primary care expenses

It is feasible to systematically collect intervention-specific expenses in primary care using formal expenditure methods. However, most practices and researchers lack the knowledge, expertise, and resources to collect such data independently. Further assistance and education is necessary to obtain reliable information about the expenses to transform and improve primary care. Krist AH, Cifuentes M, Dodoo MS, Green LA. Measuring primary care expenses. J Am Board Fam Med. 2010 May-Jun;23(3):376-83.

Case study of a primary care-based accountable care system approach to medical home transformation

We report a case study of a mature primary care-based accountable care organization that is both a health plan and a network of medical homes. Over 20 years, WellMed Inc. (San Antonio, Texas) implemented many patient-centered services, experimenting to find which belong within clinics and which operate best as system functions. The adjusted mortality rate is half that of the state for people older than 65 years. Hospitalization and readmission rates and emergency department visits have not changed over time, but preventive services have improved. Phased implementation across the network makes it difficult to link improvements to specific processes but they seem to have improved outcomes collectively. Phillips RL Jr, Bronnikov S, Petterson S, Cifuentes M, Teevan B, Dodoo M, Pace WD, West DR. J Ambul Care Manage. 2011;34(1):67-77.

Travel medicine and the Maryland family physician

As with most domains suited to primary care, emporiatrics is more about art than algorithm and should address--without exacerbating--the patient's leading concerns. Providing recommendations for a safe and healthy sojourn, without unnecessarily alarming travelers or blunting their cultural interchange and travel adventure, is a balancing act. That balance, best informed by thorough assessment of patient- and itinerary-specific risk, as well as risk tolerance, is an assessment perfectly suited to the relationships available to the traveler in the patient-centered medical home. Huntington M and Bazemore A. Travel Medicine and the Maryland Family Physician. The Maryland Family Doctor. Fall 2010; 47(2):10-3.



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.

A comparison of chronic illness care quality in US and UK family medicine practices prior to pay-for-performance initiatives

Following National Health Service (NHS) investment in primary care preparedness, but prior to the QOF, UK practices provided more standardized care but did not achieve better intermediate outcomes than a sample of typical US practices. US policymakers should focus on reducing variation in care documentation to ensure the effectiveness of P4P efforts while the NHS should focus on moving from process documentation to better patient outcomes. Crosson JC, Ohman-Strickland PA, Campbell S, Phillips RL, Roland MO, Kontopantelis E, Bazemore A, Balasubramanian B, Crabtree BF. A comparison of chronic illness care quality in US and UK family medicine practices prior to pay-for-performance initiatives. *Fam Pract*. 2009 Dec;26(6):510-6.

American Board of Family Medicine (ABFM) Maintenance of Certification: Variations in Self-Assessment Modules uptake within the 2006 cohort

More than two-thirds of eligible, certified family physicians completed stage-one MC-FP requirements. Concerns that technical aspects of the new MC-FP paradigm would leave parts of a widely distributed, poorly resourced primary care workforce disadvantaged may hold true for providers in some underserved areas, but differential completion among rural and remote physicians was not found. Understanding barriers to uptake is essential if the specialty boards are to meet their obligations to the public to promote quality of care through MOC for all physicians. Bazemore AW, Xierali IM, Petterson SM, Phillips RL Jr, Rinaldo JC, Puffer JC, Green LA. American Board of Family Medicine (ABFM) maintenance of certification: variations in self assessment modules uptake within the 2006 cohort. *J Am Board Fam Med*. 2010 Jan-Feb;23(1):49-58.

State tort reforms and hospital malpractice costs

This study explored the relation between state medical liability reform measures, hospital malpractice costs, and hospital solvency. It suggests that state malpractice caps are desirable but not essential for improved hospital financial solvency or viability. Ellington CR, Doodoo M, Phillips R, Szabat R, Green L, Bullock K. State tort reforms and hospital malpractice costs. *J Law Med Ethics*. 2010 Mar;38(1):127-33.

Seeking ethical approval for an international study in primary care patient safety

Seeking ethics committee approval for research can be challenging even for relatively simple studies occurring in single settings. This paper draws on the experiences of the LINNAEUS Collaboration in obtaining ethics approval to conduct an international study investigating medical error in general practice in six countries. It describes the ethics review processes applied to a study run in Australia, Canada, England, the Netherlands, New Zealand, and the U.S. Wide variation in ethics review responses to the research proposal occurred. The authors' experiences demonstrated that ethics committees operate in their own historical and cultural context, which can lead to radically different subjective interpretations of commonly-held principles. Dovey S, Hall K, Makeham M, Rosser W, Kuzel A, Van Weel C, Esmail A, Phillips R. *Br J Gen Pract*. 2011;61(585):197-204.

Comparison between U.S. Preventive Services Task Force recommendations and Medicare coverage

The purpose of this study was to evaluate the alignment of Medicare preventive services coverage with the recommendations of the USPSTF. We recorded all Medicare coverage for preventive services as listed in the Medicare preventive services guide of 2007 for all recommended (A- or B-rated) USPSTF and not recommended (D-rated) guidelines. The USPSTF recommended 15 preventive interventions for adults aged 65 years and older. Although Medicare partially reimbursed 93% of recommended services, full reimbursement for the preventive coordination, as well as the service, was available for only 7% of these services. Medicare coverage for preventive services needs to be reassessed. Lesser LI, Krist AH, Kamerow DB, Bazemore AW. *Ann Fam Med*. 2011;9(1):44-9.



Graham Center Policy Briefs

Policy Briefs offer succinct summaries of research pertinent to family medicine advocacy. These documents are distributed to congressional staff, AAFP leaders and staff, and other family medicine leaders. These briefs are also published as 'One-Pagers' in *American Family Physician*. In 2011, the Graham Center launched a second series of Policy Briefs in the *Journal of the American Board of Family Medicine*. Entitled "ABFM-Graham Center Policy Briefs" this series will feature in particular work derived from the robust research partnership that the Graham Center has enjoyed with the American Board of Family Medicine since 2009.

American Family Physician - Graham Center Policy One-Pagers

Decreasing self-perceived health status despite rising health expenditures

Despite steady increases in U.S. health care spending, the population's self-perceived health status has been in a long-term decline. Increased support for public health, prevention, and primary care could reduce growth in spending and improve actual and perceived health. Rabin D, Petterson S, Bazemore A, Teevan B, Phillips RL, Dodoo MS, Xierali I. Decreasing self-perceived health status despite rising health expenditures. Am Fam Physician. 2009 Sep 1;80(5):427.

Title VII's decline: Shrinking investment in the primary care training pipeline

Title VII, Section 747 is a source of federal funding intended to strengthen the primary care workforce. Despite evidence that Title VII has been successful, its funding has declined over the past three decades, threatening the production of primary care physicians. Harrison B, Bazemore AW, Dodoo MS, Teevan B, Wittenberg H, Phillips RL Jr. Title VII's decline: Shrinking investment in the primary care training pipeline. Am Fam Physician. 2009 Oct 15;80(8):872.

Family physicians' present and future role in caring for the elderly

The population of patients older than 65 years is projected to increase substantially in the coming years, particularly in rural areas. Family physicians are essential providers of geriatric care, especially in rural areas, but need payment reform to improve their capacity to meet the needs of older patients. Peterson L, Bazemore AW, Phillips RL Jr, Teevan B, Dodoo MS, Xierali I, Petterson SM. Family physicians' present and future role in caring for older patients. Am Fam Physician. 2009 Nov 15;80(10):1072.

Title VII is critical to the community health center and National Health Service Corps workforce

Community health centers (CHCs) and the National Health Service Corps (NHSC) are essential to a functioning health care safety net, but they struggle to recruit physicians. Compared with physicians trained in residency programs without Title VII funding, those trained in Title VII-funded programs are more likely to work in CHCs and the NHSC. Title VII funding cuts threaten efforts to improve access to care for the underserved. Harrison B, Rittenhouse D, Phillips RL Jr, Grumbach K, Bazemore AW, Dodoo MS. Title VII Is Critical to the Community Health Center and National Health Service Corps Workforce. Am Fam Physician. 2010 Jan 15;81(2):132.

Greater NIH investment in Family Medicine would help both achieve their missions

Family medicine is the predominant provider of primary health care in the United States, yet it receives relatively little research funding from the National Institutes of Health (NIH). Family medicine can help the NIH speed research discovery and improve research relevance; the NIH can help family medicine build its research capacity, and such mutual benefit could mean improvement in public health. Lucan SC, Bazemore AW, Xierali I, Phillips RL Jr, Petterson SM, Teevan B. Greater NIH investment in family medicine would help both achieve their missions. Am Fam Physician. 2010 Mar 15;81(6):704.

Greater family medicine presence at NIH could improve research relevance and reach

Advisory committees perform pivotal tasks at the National Institutes of Health (NIH), informing funding decisions, helping establish research priorities, and contributing to the vision for the nation's biomedical research agenda. Family medicine has not had a substantial role on these committees, but could, helping the NIH

make research more patient centered and informing translational efforts to improve population health. Lucan SC, Bazemore AW, Phillips RL JR., Xierali I, Petterson SM, Teevan B. Greater family medicine presence at NIH can improve research relevance and reach. *Am Fam Physician*. 2010 May 15;81(10):1213.

Loss of primary care residency positions amidst growth in other specialties

Since the 1997 Balanced Budget Act capped funding for graduate medical education (GME) programs, overall growth in GME has continued (+7.8 percent), but primary care specialties have experienced a substantial decline in their number of programs and residency positions. This decline will further exacerbate the current primary care shortage and severely affect future projections of primary care shortage. Weida NA, Phillips RL Jr, Bazemore AW, Dodoo MS, Petterson SM, Xierali I, Teevan B. Loss of primary care residency positions amidst growth in other specialties. *Am Fam Physician*. 2010 Jul 15;82(2):121.

Income disparities shape medical student specialty choice

Currently, a gap of more than \$135,000 separates the median annual subspecialist income from that of a primary care physician, yielding a \$3.5 million difference in expected income over a lifetime. These income disparities dissuade medical students from selecting primary care and should be addressed to ensure sufficient patient access to primary care. Wilder V, Dodoo MS, Phillips RL Jr, Teevan B, Bazemore AW, Petterson SM, Xierali I. Income disparities shape medical student specialty choice. *Am Fam Physician*. 2010 Sep 15;82(6):601.

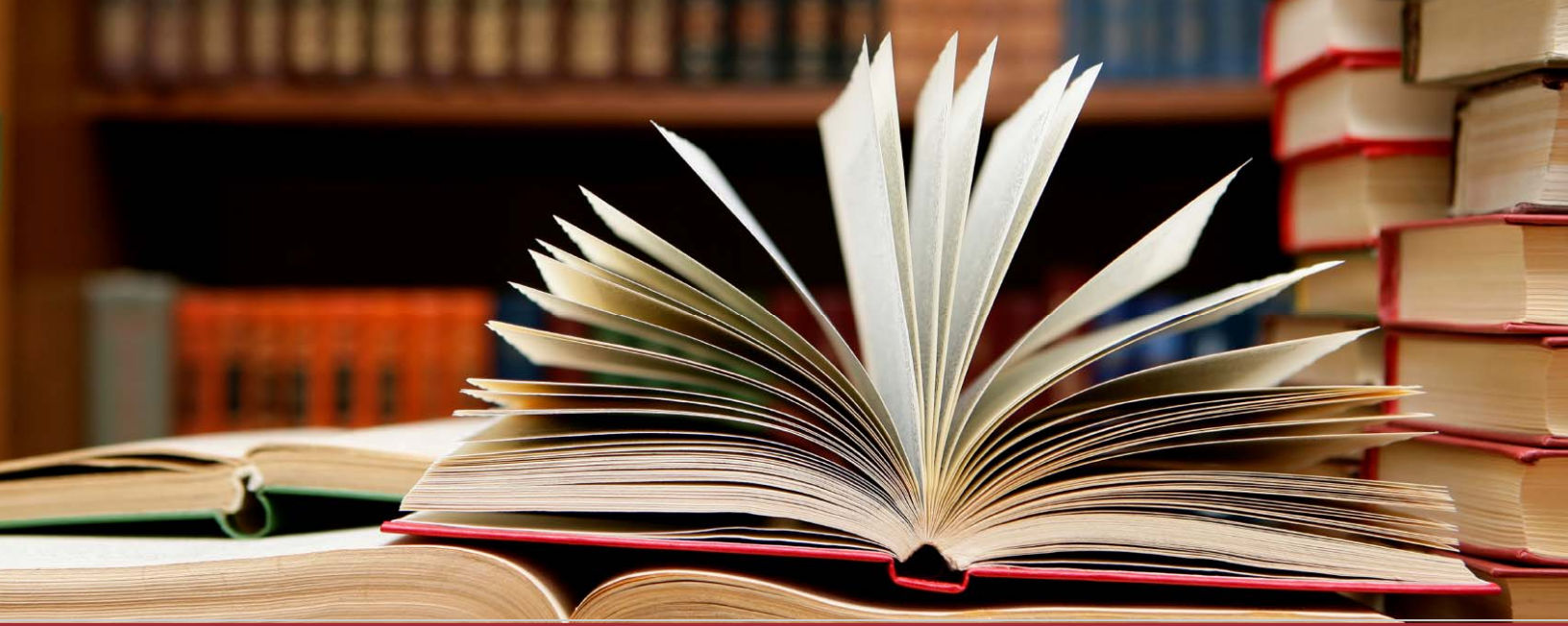
FPs Lower Hospital Readmission Rates and Costs

Hospital readmission after discharge is often a costly failing of the U.S. health care system to adequately manage patients who are ill. Increasing the number of family physicians (FPs) is associated with significant reductions in hospital readmissions and substantial cost savings. Chetty VK, Culpepper L, Phillips RL Jr, Rankin J, Xierali I, Finnegan S, Jack B. FPs lower hospital readmission rates and costs. *Am Fam Physician*. 2011 May 1;83(9):1054.

Journal of the American Board of Family Medicine - Graham Center Policy Briefs

Establishing a baseline: Health information technology adoption among family medicine diplomates

The Office of the National Coordinator and federal policy have dramatically expanded incentives for adoption and "meaningful use" of EHRs. However, there is little reliable information regarding adoption rates in primary care. A majority of board-certified family physicians in the United States now use EHRs. The most rural of family physicians lag slightly behind the national adoption frequency. Though board-certified family physicians may differ from those who do not maintain certification. Conclusion: Although further monitoring of adoption trends is important, the mounting challenge will not be adoption but the sufficiency of EHRs to help family physicians take better care of their patients. Bazemore A, Burke M, Xierali I, Petterson S, Rinaldo J, Green LA, Puffer J. *J Am Board Fam Med*. 2011;24(2):132.



Larry A. Green Visiting Scholars and Primary Care Health 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.

Visiting Scholars

The Center hosted twenty-one Larry A. Green Scholars and two Australian Primary Health Care Research Institute (APHCRI)/Robert Graham Center Visiting Fellows, 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.

- Nick Weida, Boston University—Graduate Medical Education
- Cat Livingston, Oregon Health and Science University—Accountable Care Organizations
- Ruben Frescas, Loyola University Chicago—Costs of Graduate Medical Education
- Venis Wilder, Harvard University—The Case for Primary Care: A Student Perspective
- Danielle Butler, University of Sydney/APHCRI (Australia) - Social Determinants of Health in Health Care Planning
- Chip Hixon, University of Hawaii—Primary Care Workforce
- Nicole Johnson, Albert Einstein College of Medicine—Scope of Primary Care
- Brad Richards, Georgetown University—International Medical Graduates
- Benjamin Miller, University of Colorado School of Medicine—Mental Health
- Howard Rabinowitz, Thomas Jefferson University—Supply and Retention of Rural Physicians
- Kara Walker Odom, UCLA, RWJ Clinical Scholars Program—Social Determinants of Health
- Libbie Bragg, University of Cincinnati—Geriatric Workforce
- Michael Dulin, Carolinas Medical System—Using GIS to Enhance Community-Based Primary Care
- Anjani Reddy, Montefiore Family and Social Medicine Residency—Social Accountability & Graduate Medical Education
- Kate Neuhausen, University of California, San Francisco—Access to Specialty Services in Community Health Centers
- Lachlan McIver, APHCRI/James Cook University (Australia) - Primary Care and Indigenous Health
- Sue Dovey, University of Otago (New Zealand) - Research Productivity of General Practice Academicians
- Sharon Kosmina, Rural Workforce Agency Victoria (Australia) - Area-Based Index of Need for Rural Victoria
- Chris van Weel, University Medical Centre Nijmegen (The Netherlands) - Lessons from the Dutch General Practice Database
- Erica Brode, University of California, San Francisco—Medical Student Interest in Primary Care
- Sarah Sweeney, Case Western Reserve School of Medicine —National Stakeholders' Perception of the Role of and Key Challenges to Primary Care
- Mark Carrozza, Health Foundation of Greater Cincinnati—Social Capital, Access to Care, and Health Status
- Benjamin Blagoev, Yale University—Social Determinants of Health

Policy Fellowship

The Graham Center continued its partnership with Georgetown University in 2009-10, hosting its eighth Health Policy Fellow, Dr. Matthew Burke. We were pleased to welcome an additional Health Policy Fellow in 09-10, Dr. Winston Liaw, through a new partnership with Virginia Commonwealth University. Drs. Burke and Liaw co-authored a case statement and request for proposals commissioned by the Illinois Academy of Family Physicians on two successful Medicaid primary care case management and disease management programs, Illinois Health Connect and Your Health Care Plus. Drs. Burke and Liaw also teamed up to organize a successful advocacy workshop for medical students and residents. In addition, Dr. Liaw contributed to COGME's "Advancing Primary Care: 20th COGME Report on GME." Dr. Burke co-authored a paper, "Accounting for Graduate Medical Education Production of Primary Care and General Surgery: Where You Measure Matters," published in Academic Medicine. In addition to their research, Drs. Liaw and Burke served as attending physicians at Fairfax Family Practice and Unity Health Care's Brentwood Square Health Center, respectively.

In addition to the fellows, Graham Center staff mentored the following:

Jennifer Devoe, MD DPhil, AHRQ K08 Oregon Health Sciences University

Candice Chen, MD MPH, George Washington University



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Robert Graham Center Staff

Robert L. Phillips, Jr., MD, MSPH

Director

Robert L. Phillips, Jr., MD, MSPH is a family physician and Director of the Robert Graham Center: Policy Studies in Family Medicine and Primary Care in Washington, DC. Dr. Phillips is a graduate of the Missouri University for Science and Technology and 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 Federally Qualified Health Center in Boone County, Missouri. He now practices part-time in a community-based residency program in Fairfax, Va. Dr. Phillips has faculty appointments at Georgetown University, George Washington University and Virginia Commonwealth University. He recently served as Vice-Chair of the U.S. Council on Graduate Medical Education, and was appointed by the Secretary of Health and Human Services to the Federal Negotiated Rule Making Committee on Health Workforce Shortage Redesignation. Dr. Phillips was elected to the Institute of Medicine in 2010.

Andrew Bazemore, MD, MPH

Medical Director, Policy Research

Andrew Bazemore, MD, MPH, is Medical Director, Policy Research of the Robert Graham Center for Policy Studies in Primary Care, where he directs research and projects related to access to care for underserved populations, health workforce, spatial analysis and health, and other topics. Dr. Bazemore remains an Associate Professor for the University of Cincinnati's Department of Family Medicine, where he also completed his residency training and faculty development fellowship. He serves on the faculty of the Department of Family Medicine at Georgetown University and in the Department of Health Policy at George Washington University School of Public Health. A member of the American Academy of Family Physicians, he practices and teaches students and residents weekly at VCU-Fairfax Family Medicine Residency program. Dr. Bazemore received his BA degree from Davidson College, his MD from the University of North Carolina, and his MPH from Harvard University.

Stephen Petterson, Ph.D.

Research Director

Stephen Petterson is Research Director at the Robert Graham Center. Previously, 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 Health Geographer and Research Scientist at the Robert Graham Center. Previously, he was a Statistical Analyst at Georgia Division of Public Health. 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 Pi Sigma Alpha.

Graham Center Staff

Jennifer Rankin, Ph.D., MPH, MS, MHA

UDS Project Manager and Health Geographer

Jennifer Rankin is UDS Project Manager and Health Geographer at the Robert Graham Center. Her career has focused on issues related to primary care and access to care, with a special interest in the geography of access to health care. She has worked with the HRSA Maternal and Child Health Bureau, the Texas Association of Community Health Centers, and the Association of State and Territorial Health Officials. Jennifer manages the Robert Graham Center's UDS Mapper project. Jennifer earned her Master of Health Administration from the Tulane School of Public Health and Tropical Medicine in 1997, as well as her Master of Science in Health Information Sciences (2005), Master of Public Health (2008) and PhD in Public Health Informatics (2008) from The University of Texas Health Science Center at Houston.

Meiying Han, PhD

Economist and Health Services Researcher

Meiying Han joined the Graham Center as Economist and Health Services Researcher in May 2011. Her general interests are in health economics, public health, and health services research. She has particular interests in health returns to medical spending, cost-benefit analysis, and racial/ethnic disparities in health care. Dr. Han earned a Ph.D. in Economics (2011) from the State University of New York at Stony Brook.

Bridget Teevan, MS

Research Associate

Bridget Teevan joined the Robert Graham Center in April 2007 following the completion of her master's degree. She has particular interests in global health policy and decision theory. 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.

Sean Finnegan

Research and GIS Data Manager

Sean Finnegan joined the Robert Graham Center in August of 2010 as the Research and GIS Data Manager. He is currently enrolled in the Geographic and Cartographic Information Systems Masters program at George Mason University. Sean attended the University of Missouri, Kansas City and received his bachelor's degree in Geography in 2005. He moved to Washington, DC for a National Geographic Geography Internship immediately after. Following three years of work for National Geographic and Discovery as a web producer he began work on mapping population and climate change for Population Action International. Sean's academic research has been broad in scope and includes mapping and public health.

Kim Epperson

Office Administrator

Kim Epperson joined the Robert Graham Center as Office Administrator in October 2009. Previously, Kim was Executive Assistant to the Vice President at a national non-profit. Prior to that, Kim worked 16 years at US Airways in a variety of positions, including Lead on the Sales Cultural Assessment Team. She was also a member of the Minority Professional Association and the Women's Professional Group. Kim 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.

Anne Berry**Research Project Manager**

Anne Berry joined the Robert Graham Center in August 2011. As a Research Project Manager, she guides the Center's multidisciplinary research teams in the planning, execution, and completion of policy studies in family medicine and primary care. She joined the Robert Graham Center from the Kansas Health Institute in Topeka, KS, an independent, nonprofit health policy and research organization, where she worked as a communications specialist. Prior to that, she worked in book publishing as an assistant editor at Random House, Inc., in New York, NY. Anne is a master of public policy candidate at George Washington University. She earned a bachelor's degree in English and a certificate in health policy from Duke University, and a certificate in editing from New York University.

Karen Payne, MA**Office and Research Manager**

Karen Payne became the Graham Center's Office and Research Manager in August 2011. Ms. Payne has garnered 20 years of Federal government contract and health care administrative experience with a background in biomedical research. Her government contract experience included working as a contractor with various government agencies within DHHS. She developed social marketing campaigns for CSAT, FDA, NIHCC, NIDA and OMHRC. She served as project director for logistical support grant reviews contracts with CSAP, ARHQ, and the Office of Rural Health Policy. Prior to relocating to the Washington area, Ms. Payne served as senior hospital administrator for 10 years in a variety of teaching hospital settings overseeing ambulatory services, surgery departments, emergency trauma services as well as developing, implementing, and marketing wellness programs to the local business community. She began her career as a laboratory research assistant in cytology and genetics research. Born and raised in Chicago Illinois, Karen earned her BA degree from Northwestern University and two masters degree, one in Hospital and Health Administration from the University of Iowa and the second in Public Communications from American University. She spends her free time traveling, skiing, reading and volunteering.



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