



The Robert Graham Center

Policy Studies in Family Medicine and Primary Care

2012-2013 Report



ROBERT
GRAHAM
CENTER

AAFP Center for Policy Studies

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Our Impact

Our Impact...is growing. Over the past year, Graham Center efforts have influenced:

1. ***Congressional Reports and Committee work:*** Meetings with the Graham Center were requested to inform Senate Subcommittee Chair Bernie Sanders' Report "30 Million New Patients and 11 Months to Go: Who Will Provide Their Primary Care?" submitted to Congress January 29, 2013 with several RGC references. Graham Center staff were asked to share the results of our research with staff from three other Senate and House subcommittees as well as the Government Accountability Office in the first half of 2013.
2. ***Placement of the nation's Federally Qualified Health Centers:*** In its 4th year, the Graham Center's Health Services and Resources Administration (HRSA) funded and award-winning UDS Mapper became a required part of New Access Point applications in the expansion of the primary care safety net.
3. ***Federal primary care workforce estimates:*** Through Agency for Health Care Research & Quality Factsheets and extensive coverage of related manuscripts and policy briefs.
4. ***Conversation about the reform of federally-funded Graduate Medical Education (residency training):*** Through collaborative evaluation of Rural Training Tracks for the Office of Rural Health Policy, and highlighting GME accountability analyses via peer-reviewed publications, collaboration with Washington Monthly, Capitol Hill with over 100 attendees, including 20 congressional staff.
5. ***State and local health system reform efforts:*** Through contracted analyses, reports, and presentations to the State of Rhode Island and its Health Care Planning & Accountability Advisory Council, analyses, reporting and data application building for the HRSA and the New Orleans Mayor's Office, and development of a Community Health Information Portal for statewide stakeholders in North Carolina.

... and much more.



Letter from the Director

It would be easy for me to simply label the past year one of transition, yet from a year-end vantage, much remains constant. High stakes federal elections and budgetary showdowns and state debates over insurance expansion suggested the potential for quantum shifts in policy. Similarly, the Graham Center navigated considerable transition, but has emerged with its momentum intact and commitment to informing primary care policy through evidence-making and data dissemination as strong as ever. The changes have been anything but trivial, including integrating and engaging with new leadership within the Center and the AAFP, moving into new space after months of careful design and deliberation, a turnover of one-half of our team, and significant shifts in roles and responsibilities.

However, despite an unprecedented degree of change here at the Graham Center, some things have remained constant – passion, productivity and impact. As you'll see in this report, our core ventures and products continue to grow – exemplified by the many scholars, projects, papers, one-pagers and policy briefs you'll find described inside. The new team has embraced the transition to reshape bodies of Graham Center work into more defined portfolios addressing key policy interests and talents - a Primary Care Economic Portfolio, a Social Accountability & Medical Education Portfolio, a Geospatial Analysis in Primary Care Portfolio, and an Integrated Behavioral Health and Primary Care Portfolio, to name a few.

Reflecting a growing awareness of its impact, the Center was called upon by policymakers and planners more than ever to inform their work. Calls and requests for Graham Center analytic insights on primary care payment, workforce, infrastructure and needs assessment came from staff serving federal interests such as the Government Accountability Office, Senate HELP committee, and House Energy & Commerce and Ways and Means committees, as well as a number of state and local partners.

Demand from agencies, states and local areas for Graham Center analyses, applications, and expertise has forced our transition towards synthesis and customization of our work. A year of partnership, analyses and mapping efforts with the mayor's office and stakeholders in Greater New Orleans resulted in the January 2013 release of a Community Health Improvement Report and deployment of a New Orleans Safety Net Mapper. The Graham Center's yearlong collabo-

ration with the nationally acclaimed Medicaid innovators Community Care of North Carolina (CCNC) and the Southern Piedmont BEACON community resulted in the launch of the North Carolina Community Health Information Portal. A public facing resource and a landmark effort to integrate public health/population data with clinical measures of quality and cost available only to CCNC's statewide network of Medicaid practice administrators.

The Center also completed analyses on behalf of the State of Rhode Island, presented them to Rhode Island's Health Care Planning and Accountability Advisory Council and saw their contributions to a final report help lead to the creation of a statewide Primary Care Trust Commission. The UDS Mapper Project continued to grow in prominence and impact as HRSA declared its use a requirement for all new access point applications by community health centers, and continued to request related and novel analyses and consultation. UDS and HealthLandscape were migrated to a common platform, novel service area analyses were created for each of the over 1200 CHC grantees nationwide, and analyses of small areas likely to see the highest demand for new services based on ACA-mandated insurance expansion were turned into online tools for public consumption.

**“The real art of
conducting consists
in transitions”
-Gustav Mahler**

Successful transition indeed reflects artful conducting. In our case, this comes from no one person, but a **team** of self-motivated and adaptable conductors-of projects and portfolios of work who have continued to grow the Graham Center's outputs and impact while navigating its rapid evolution. New additions Miranda Moore, Claire Gibbons, and Megan Coffman are welcome additions who will continue that trajectory. With a redesigned Primary Care Forum series launched this summer on Capitol Hill to record attendance, a new International Symposium series capturing the voices of our increasingly frequently scholars from abroad, ideas and energy from a growing number of visiting scholars, a new fellow, and five new grants and contracts received this summer, I hope you'll keep an ear out for our many harmonious efforts in the year ahead.

Andrew Baymore



Themes of the Graham Center

The Graham Center's purpose is to improve individual and population health by enhancing the delivery of primary care. The Center aims to achieve this vision through the generation or synthesis of evidence that brings a family medicine and primary care perspective to health policy deliberations at local, state, and national levels. That evidence falls under four broad categories described below:

The Value of Primary Care

At Alma Ata in 1978, global leaders asserted that primary care is the central foundation 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, the Robert Graham Center seeks to demonstrate the value of primary care and identify options for enhancing its value.

Health Access and Equity

Despite leading the world in health care 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, the Robert Graham Center seeks to inform policy that removes barriers to accessing health care and leads to a more equitable system of health care for all.

Delivery and Scope of the 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.

Health Care Quality and Safety

The United States must refocus on the delivery of safe, high-quality health care, a lesson made clear in two 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 health care. Through its research, the Robert Graham Center seeks to reduce threats to patient safety and improve quality of health care.

Our work over the past year has focused on:

- Continuing to highlight trends in training and location of the primary care workforce and testing the impact of policy solutions,
- State and regional applications of research and geospatial mapping to inform distribution of health and healthcare resources,
- Using geospatial mapping applications to support investigations into the supply, location and training of the primary care workforce,
- Calling attention to how resources like Graduate Medical Education funds are distributed to hold policymakers and the institutions that train primary care physicians accountable for the decisions they make about resource distribution, and
- Developing our primary care economic portfolio.



Primary Care Provider Workforce Trends

In order to help inform policy solutions, Graham Center research has applied the consequences of the projected shortage in primary care providers. The Graham Center remains a leader in workforce analysis and application development intended to reveal the variations in primary care workforce, primary to population ratios that optimize outcomes and align with need, factors that influence providers' decisions to practice in a primary care setting, maldistribution of physicians after they complete their training, and the effectiveness of policies meant to expand and alter the primary care workforce. Examples of published work over the past year include:

Projecting US Primary Care Physician Workforce Needs: 2010-2025

Researchers project the United States will need 52,000 additional primary care physicians by 2025 — a 25 percent increase in the current workforce — to address the expected increases in demand due to population growth, aging, and insurance expansion following passage of the Affordable Care Act. Analyzing nationally representative data, the researchers conclude population growth will be the single greatest driver of increased primary care utilization, requiring approximately 33,000 additional primary care physicians by 2025, while 10,000 additional physicians will be needed to accommodate population aging. Insurance expansion, they estimate, will require approximately 8,000 additional primary care physicians, a 3 percent increase in the current workforce. Petterson S, Liaw W, Phillips R, Rabin D, Meyers D, Bazemore A. Projecting US Primary Care Physician Workforce Needs: 2010-2025. *Ann Fam Med*. 2012;10(6):503-509.

Unequal Distribution of the U.S. Primary Care Workforce

The United States is facing a primary care physician shortage, but the most pressing problem is uneven distribution, particularly in poor and rural communities. Providing adequate access to care for the nearly 30 million uninsured people living in these communities will require potent incentives and policy. Petterson S, Phillips R, Bazemore A, Koinis G. *Am Fam Phy*. 2013;87(11).

Trends in Physician Supply and Population Growth

The physician workforce has steadily grown faster than the U.S. population over the past 30 years, context that is often absent in conversations anticipating physician scarcity. Policy makers addressing future physician shortages should also direct resources to ensure specialty and geographic distribution that best serves population health. Makaroff L, Green L, Petterson S, Bazemore A. *Am Fam Physician*. 2013 Apr 1;87(7).

The Association between Global Health Training and Underserved Care: Early Findings from Two Longstanding Tracks

Global health tracks (GHTs) improve knowledge and skills, but their impact on career plans is unclear. The objective of this analysis was to determine whether GHT participants are more likely to practice in underserved areas than nonparticipants. In this retrospective cohort study, using the 2009 American Medical Association Masterfile, we assessed the practice location of the 480 graduates from 1980--2008 of two family medicine residencies-Residency 1 and Residency 2. The outcomes of interest were the percentage of graduates in health professional shortage areas (HPSAs), medically underserved areas (MUAs), rural areas, areas of dense poverty, or any area of underservice. Liaw W, Bazemore A, Xierali I, Walden J, Diller P, Morikawa MJ. *Fam Med*. 2013;45(4):263-267.

The Primary Care Extension Program: A Catalyst for Change

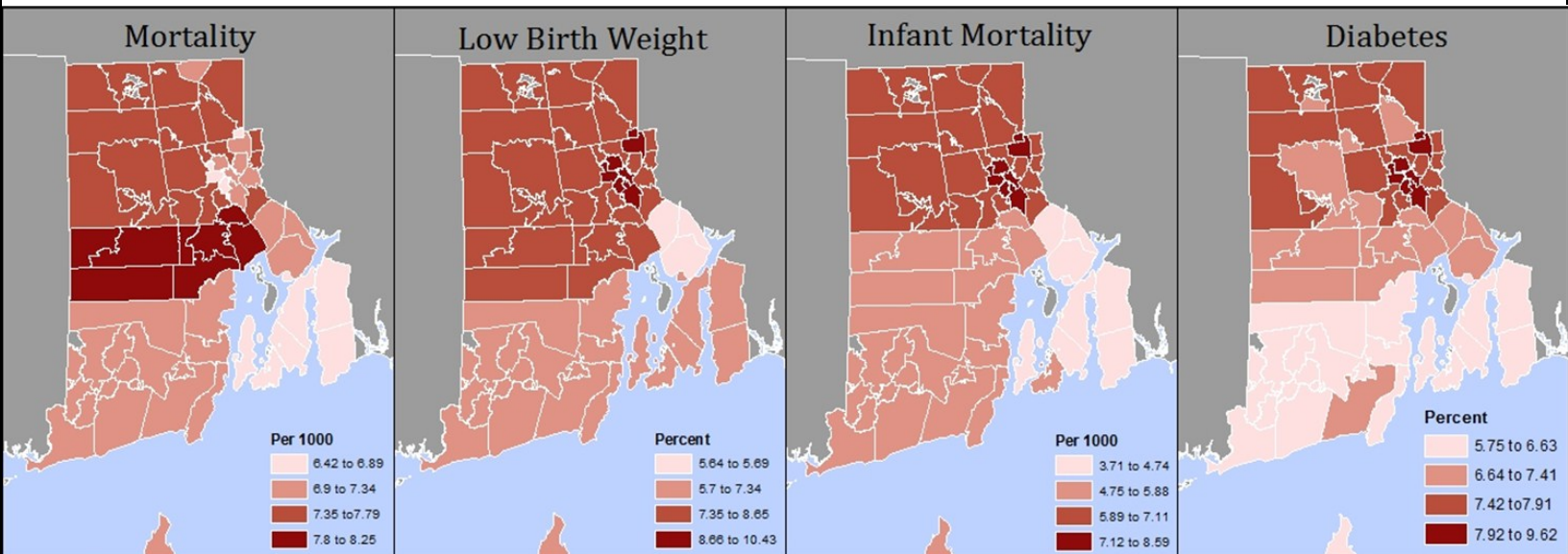
The Affordable Care Act authorized, but did not fund, the Primary Care Extension Program (PCEP). Much like the Cooperative Extension Program of the US Department of Agriculture sped the modernization of farming a century ago, the PCEP could speed the transformation of primary care. It could also help achieve other goals such as integrating primary care with public health and translating research into practice. The urgency of these goals and their importance to achieving the Triple Aim for health care should increase interest in rapidly building the PCEP, much as the need to feed the country did a century ago. Phillips RL Jr, Kaufman A, Mold JW, Grumbach K, Vetter-Smith M, Berry A, Burke BT. *Ann Fam Med*. 2013;11(2):173-178.

Most Family Physicians Work Routinely with Nurse Practitioners, Physician Assistants, or Certified Nurse Midwives

The U.S. physician workforce is struggling to keep pace with the demand for health care services, a situation that may worsen without efforts to enhance team-based care. More than half of family physicians work with nurse practitioners, physician assistants, or certified nurse midwives, and doing so helps ensure access to health care services, particularly in rural areas. Petterson L, Phillips R, Puffer J, Bazemore A, Petterson S. *J Am Board Fam Med* 2013;26:244-245.

Relying on NPs and PAs Does Not Avoid the Need for Policy Solutions for Primary Care

Physician assistants (PAs) and nurse practitioners (NPs) are often proposed as solutions to the looming shortage of primary care physicians. However, a large and growing number of PAs and NPs now work outside of primary care, which suggests that innovative policy solutions to increase access to primary care are still needed. Petterson S, Phillips R, Bazemore A, Burke M, Koinis G. *Am Fam Phy*. 2013;88(4):230.



Created by the Robert Graham Center, 2013

Informing State and Regional Primary Care Planning

In a post-ACA world, the policy implications of health reform are being operationalized at the state and local level. Over the past year, the Graham Center has been called upon for its capacities to help states and regions to plan for the best and most efficient healthcare workforce, to provide the best access to care for local populations, and contribute to improving health in communities.

New Orleans Health Access Planning Project

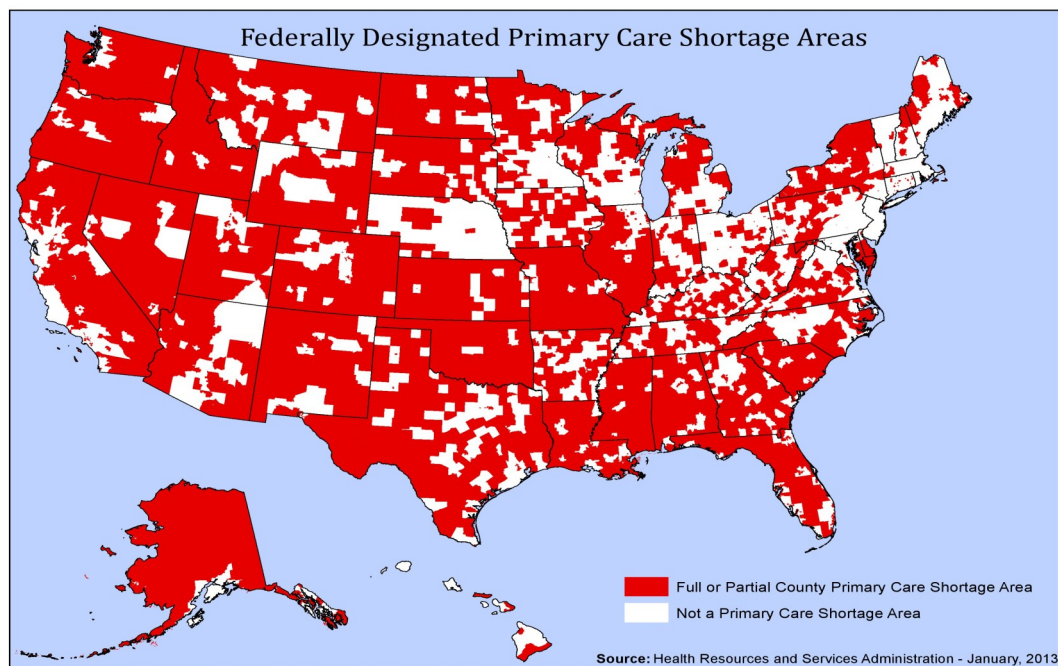
After eight years of federal, state and local investment in reconstruction of health infrastructure needed to overcome the devastating effects of Hurricane Katrina, most recovery funding for health care in Greater New Orleans is ending. The Mayor's office and regional stakeholders called upon the Graham Center for its analytic and geospatial expertise to help guide decision-making regarding investments in the health care infrastructure that may amount to \$2.2 billion over the next 4 years. The Graham Center was called upon to assist in the development of a master plan for health care access in New Orleans for use in planning and policy-making to achieve and maintain appropriate distribution of and equitable access to primary care safety net services. The Graham Center team worked to develop analyses of primary care safety net access and an online mapping tool revealing safety net service areas and overlap. The team presented findings to stakeholders and delivered interpretation of the maps, data outputs and policy recommendations.

Rhode Island Coordinated Health Planning Project

In the fall of 2012, the Rhode Island Executive Office of Health and Human Services (EOHHS), in collaboration with the Office of the Insurance Commissioner and the Department of Health (DOH), sought technical assistance and health planning expertise to begin a more comprehensive statewide health planning process. Rhode Island's Director of Health created a Health Care Planning and Accountability Advisory Council under the "Rhode Island Coordinated Health Planning Act of 2006" to make recommendations related to statewide health planning. The Robert Graham Center was selected to produce "gap analyses" regarding Rhode Island's primary care services to provide support for Rhode Island's EOHHS and DOH to utilize in creating a statewide health plan. The Graham Center conducted analyses using data from a variety of sources, and found that Rhode Island had natural strengths for population health planning relative to other states, including small land area size, population density, higher than national average physician to population and primary care physicians to population ratios, and adoption of Patient Centered Medical Homes, and lower than average poverty and uninsurance rates.

North Carolina Community Health Information Portal

The North Carolina Community Health Information Portal (NC-HIP) was designed to encourage informed conversation about health and health care in North Carolina and to contribute to healthier communities throughout the state. The portal is a web-based tool designed to map and display information from health and demographic databases to help identify trends and aid the development of appropriate interventions. NC-HIP allows users to observe clinical indicators and public health data to identify and answer questions that may improve the health of their community. The portal also provides clinicians, support staff and public health professionals with a new perspective of the measures they currently employ to areas where a wide variation in quality exists. NC-HIP was developed in a collaborative effort by the Robert Graham Center, HealthLandscape, LLC, Community Care of North Carolina, Community Care of Southern Piedmont, and the University of North Carolina.



Created by the Robert Graham Center, August 2013

A Growing Geospatial Portfolio

Visualizing and interacting with health and health care data can be a very powerful way to highlight and better understand areas of need for health interventions and changes in policy. The Graham Center's Geospatial Portfolio continued to grow this past year as the UDS Mapper expanded and the Residency Footprinting and Primary Care Physician Mappers were developed and made available to the public.

Residency Footprinting Mapper

The Residency Footprinting Mapper was redesigned, updated and re-launched at a national meeting in the Spring of 2013 to much acclaim. It depicts the relationship between a residency program and its community, region and state by displaying where graduates of all Family Medicine residency programs currently practice. Users can explore counties that could be considered shortage areas based on the population to physician ratios they have selected and see what would happen if graduates from selected programs were no longer practicing there. Residency programs can use these maps for internal reflection about whether they are fulfilling their missions, and to demonstrate their value to hospital and community leaders.

UDS Mapper

The UDS Mapper was developed to assist HRSA, the Bureau of Primary Health Care, and health center organizations to evaluate the geographic reach, penetration, and growth of the Health Center Program and its relationship to other federally linked health resources. By the end of August 2013, the UDS Mapper had more than 8,000 registered users from a variety of backgrounds.

The UDS Mapper project continues to evolve in response to the needs of its ever-growing user base. In August 2012, the Robert Graham Center released several exciting new features within the UDS Mapper. Users now have the capability to display patient-origin data for individual Health Center Program Grantees in order to analyze service areas. Another new UDS Mapper feature uses road network analyses to show the area within a specified driving time or distance to a chosen location. A variety of economic, social, and health data is also available in the UDS Mapper to help identify areas that may have a high need for health services.

In anticipation of dramatic insurance expansion in the next two years, an “Uninsurance Explorer” was created in the summer of 2013, allowing users to locate and visualize which areas around them have high densities of persons newly eligible for Medicaid or Health Insurance Marketplace subsidies. This tool is responsive to demand from HRSA and the National Association of Community Health Centers, and is likely to drive new users to the site. The integration of UDS Mapper into the broader HealthLandscape platform has just been completed, and promises UDS users an array of new tools and datasets to explore.

Primary Care Physician Mapper

The Primary Care Physician Mapper was completed and launched late in 2013, allowing users to explore the distribution of primary care physicians by state, county, or census tracts in metropolitan areas. The mapper allows users to dynamically set the threshold at which map areas with a certain physician to population ratio are displayed. Users may select individual primary care specialties to explore their unique distributions. For example, a user might search for pediatricians to understand variation in pediatrician to population ratios in a region or nationally. Users can also visualize counts of physicians or create maps showing the ratio of one or more primary care specialties to the population within a selected geography.



Graduate Medical Education Accountability

The dual realities of a widely acknowledged primary care physician workforce shortage and \$13 billion in annual spending to support our Graduate Medical Education (GME) system have inevitably led to questions of accountability. What role should medical schools play in creating new primary care physicians? What role should medical schools and residency programs play in encouraging physicians to practice in underserved or rural areas? What can policymakers do to encourage more primary care physicians to be trained? Research and geospatial projects by the Graham Center shed light on the lack of accountability in our GME system and highlight the relationship between GME funding and the production of primary care physicians.

GME Outcomes Mapper

The GME Outcomes Mapper allows users to explore graduate medical education (GME) outcomes for sponsoring institutions and primary teaching sites. Visitors to the site can click on a map of all residency training institutions in the country to see how many residents each program trains and the proportion of those residents entering underserved areas or primary care specialties.

Toward Graduate Medical Education (GME) Accountability: Measuring the Outcomes of GME Institutions

Graduate medical education plays a key role in the U.S. health care workforce, defining its overall size and specialty distribution and influencing physician practice locations. Medicare provides nearly \$10 billion annually to support GME and faces growing policy maker interest in creating accountability measures. The purpose of this study was to develop and test candidate GME outcome measures related to physician workforce. The average overall primary care production rate was 25.2% for the study period, although this is an over estimate because hospitalists could not be excluded. Of 759 sponsoring institutions, 158 produced no primary care graduates, and 184 produced more than 80%. Overall, 4.8% of graduates practiced in rural areas; 198 institutions produced no rural physicians, and 283 institutions produced no Federally Qualified Health Clinic physicians. These findings can inform educators and policy makers during a period of increased calls to align the GME system with national health needs. Chen C, Petterson S, Phillips R, Mullan F, Bazemore A, O'Donnell S. *Ac. Med.* 2013; September.

The Redistribution of Graduate Medical Education Positions in 2005 Failed to Boost Primary Care or Rural Training

Graduate medical education (GME), the system to train graduates of medical schools in their chosen specialties, costs the government nearly \$13 billion annually, yet there is little accountability in the system for addressing critical physician shortages in specific specialties and geographic areas. Medicare provides the bulk of GME funds, and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 redistributed nearly 3,000 residency positions among the nation's hospitals, largely in an effort to train more residents in primary care and in rural areas. However, when we analyzed the outcomes of this recent effort, we found that out of 304 hospitals receiving additional positions, only 12 were rural, and they received fewer than 3 percent of all positions redistributed. Although primary care training had net positive growth after redistribution, the relative growth of nonprimary care training was twice as large and diverted would-be primary care physicians to subspecialty training. Thus, the two legislative and regulatory priorities for the redistribution were not met. Future legislation should reevaluate the formulas that determine GME payments and potentially delink them from the hospital prospective payment system. Furthermore, better health care workforce data and analysis are needed to link GME payments to health care workforce needs. Chen C, Xierali I, Piwnica-Worms K, Phillips R. *Health Aff (Millwood)*. 2013;32(1):102



Primary Care Economic Portfolio

Primary Care Economic Portfolio

In the Fall of 2012, the Graham Center launched the new Primary Care Economic Portfolio, intended to foster knowledge of economic issues impacting primary care policy. Led by a newly-hired health economist, the Portfolio has already yielded a number of analyses in support of AAFP and other primary care interests on the impact of payment changes on the average clinician. Examples of this work include a review of the influence of Medicare's bonus and penalty payments on Medicare payments and an analysis of the impact of sequestration and changes in the Sustainable Growth Rate on Medicare payments.

The portfolio will continue to pursue research that generates new evidence highlighting the costs of primary care training and practice transformation, the economic impact of primary care, and new methods of paying for primary care functions. Results from these efforts are meant to inform policy decisions at the national and state level.

Collaboration with outside partners including other research groups, practice-based research networks, state and local agencies and university departments is essential. The Center has already submitted several applications for external funding, including one to AHRQ, and received early funding for a review of care management fees in primary care. The goal of this work is to help inform primary care physicians about care management fees on such topics as the range of 'typical' fees, the usual services and products covered under such fees, and issues other physicians have encountered in negotiating such fees. RGC partnered with Avalere in an ongoing investigation of alternative primary care payment models and valuation of care management. Results of this work will be released in the year ahead.

Recently, the Graham Center was awarded a grant from the Physician Assistant Education Association to assess economic factors that influence specialty choice among PA students. This opportunity allows the Graham Center to build on its existing workforce portfolio to include other health care providers.



Additional Publications

Factors Influencing Family Physician Adoption of Electronic Health Records

Physician and practice characteristics associated with family physician adoption of electronic health records (EHRs) remain largely unexplored but may be important for tailoring policies and interventions. Variation in EHR adoption is associated with physician and practice characteristics that may help guide intervention. Xierali I, Phillips R, Green L, Bazemore A, Puffer J. *J Am Board Fam Med*, 2013;26(4):388-393.

A Needs-Based Method for Estimating the Behavioral Health Staff Needs of Community Health Centers

Federally Qualified Health Centers are expanding to increase access for millions more Americans with a goal to double capacity to serve 40 million people. Health centers provide significant behavioral health services. However, many centers have difficulty accessing mental health and substance use professionals to meet their patients' needs. To meet the needs of the underserved and newly insured it is important to accurately estimate the number of behavioral health professionals needed. Burke B, Miller B, Proser M, Petterson S, Bazemore A, Goplerud E, Phillips R. *BMC Health Services Research*, 2013;13:245.

Communities of Solution

With Graham Center participation, in 2012 the Folsom Group published a new look at the landmark 1967 report "Health Is a Community Affair" in *Annals of Family Medicine* and presented their ideas in a Graham Center Primary Care Forum. In follow up, the Group guided a solicitation of manuscripts on working 'Communities of Solution' – an anchoring concept in the original report. These were published in a special edition of *Journal of the American Board of Family Medicine*, which features a number of primary care-led case studies and commentaries .

Additional Publications

Family Physicians Are Essential for Mental Health Care Delivery

As the largest and most widely distributed of primary care physicians, family physicians have an important role in providing mental health care, especially in rural and underserved areas. However, the proportion of family physicians who report providing mental health care is low. Policy barriers include payment for mental health services should be explored to ensure access to mental health care for patients in both urban and rural areas. Xierali I, Tong S, Petterson S, Puffer J, Phillips R, Bazemore A. J Am Board Fam Med. 2013;26(2):114-115.

Is NIH Research Funding to Medical Schools Associated with More Family Medicine?

National Institutes of Health (NIH) funding to family medicine departments is very low and has an inverse association with the production of family physicians at these medical schools. Clinical and Translational Science Awards and other efforts to include primary care in NIH research priorities should be considered to increase the family medicine workforce. Brode E, Petterson S, Bazemore A. Am Fam Phy. 2013;87(3).

A Small Percentage of Family Physicians Report Time Devoted to Research

Despite calls by family medicine organizations to build research capacity within the discipline, few family physicians report research activity. Policy that supports efforts in family medicine research and increases awareness of opportunities for primary care research in the practice setting is essential for family medicine to expand its scholarly foundations. Voorhees J, Xierali I, Bazemore A, Phillips R, Jaén C, Puffer J. J Am Board Fam Med. 2013;26(1):7-8.

Health Care Transitions

Youth with special health care needs who receive care within a patient-centered medical home (PCMH) are significantly more likely to receive services for transitioning to adult care. Broader implementation of the PCMH may contribute to wider use of health care transition counseling and enhanced support for such patients as they prepare to enter adulthood. Stoeck P, Cheng N, Berry A, Bazemore A, Phillips R. Am Fam Phy. 2012;86(11):1024.

The Rise of Electronic Health Record Adoption among Family Physicians

Realizing the benefits of adopting electronic health records (EHRs) depends heavily on clinicians and providers' uptake and meaningful use of the technology. This study examines EHR adoption among family physicians using 2 different data sources, compares family physicians with other office-based medical specialists, assesses variation in EHR adoption among family physicians across states, and shows the possibility for data sharing among various medical boards and federal agencies in monitoring and guiding EHR adoption. Xierali I, Hsiao C, Puffer J, Green L, Rinaldo J, Bazemore A, Burke M, Phillips R. *Ann Fam Med*. 2013;11(1):14-19.

Engagement of Family Physicians in Maintenance of Certification Remains High

Maintenance of Certification for Family Physicians was created to enhance the quality of care delivered by family physicians but risked decreasing their engagement due to the increased burden of meeting additional requirements to remain board-certified. Participation by family physicians in Maintenance of Certification remains higher than predicted. Puffer J, Bazemore A, Jaén C, Xierali I, Phillips R, Jones S. *J Am Board Fam Med*. 2012;25(6):761-762.

Community Oriented Primary Care Curriculum

The Community Oriented Primary Care (COPC) curriculum was developed to inform trainees at educational health centers about the basic tenets of COPC and provide tools for students to understand how to set up and manage COPC implementations in their communities. Resources include slides and note sets; pre-activity and case study modules with sample data; walkthroughs of online geographic information systems (GIS) tools with sample data; and resource guides. This project was funded by the National Association of Community Health Centers and was developed jointly by the Robert Graham Center and the Virginia Commonwealth University, Fairfax Family Medicine Residency Program.



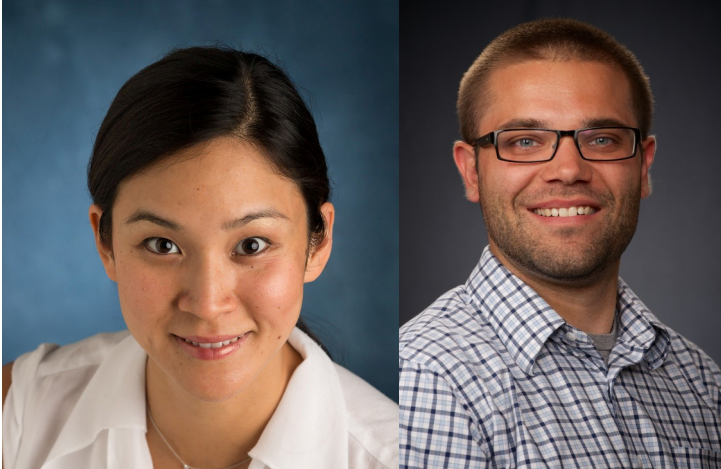
Larry A. Green Visiting Scholars and Primary Care Health Policy Fellowship

The Robert Graham Center continues its visiting scholars and fellowship programs. 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.

Policy Fellowship

Funded by a HRSA Title VII Grant, the Graham Center continues its policy fellowship partnership with Georgetown University. Dr. Laura Makaroff served as the ninth Primary Care Health Policy Fellow, until joining HRSA in April, 2013. Dr. Makaroff co-authored a full manuscript exploring trends in primary care of children. In addition to her research at the Graham Center, Dr. Makaroff served as an attending physician at Unity Health Care's Washington, DC General Clinic and taught residents and medical students in the Department of Family Medicine at Georgetown University.

Dr. John Parks joined us in July of 2013 as our tenth Fellow. Dr. Parks' research interests include scope of practice and primary care workforce issues. Dr. Parks serves as an attending physician at Unity Health Care's Washington, DC General Clinic and is teaching medical students and residents in the Department of Family Medicine at Georgetown University.



Visiting Scholars

The Center hosted 11 Larry A. Green Scholars and one Australian Primary Health Care Research Institute (APHCRI)/ Robert Graham Center Visiting Scholar, 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 publication. 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.

2012-2013 Larry A Green Scholars:

- Tammy Chang
- Nathan Kittle
- Casey Maddren (APHCRI)
- Hima Ekandham
- Manisha Sharma
- Karl Metzger
- Kat Wakeham
- Bill Rayburn
- Tom Freeman
- Din Chen
- Elise Meyers
- Blake Fagan



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Washington, DC

Robert Graham Center Staff

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

Newton Cheng joined the Robert Graham Center in July 2012. As a Research Associate, Newton conducts statistical analyses in support of Graham Center work on a range of topics, including access to care, primary care workforce, physician practice complexity, social accountability profile and physician compensation. Prior to joining the Graham Center, he worked as an information technology specialist at the Bureau of the Census. He earned a master's degree in statistics from Stony Brook University in 2009, and a bachelor's degree with a double major in applied math and statistics (AMS) and economics from Stony Brook University in 2008.

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

Kim Epperson joined the Robert Graham Center in October 2009 as the Office Administrator. Kim is the first point of contact and handles administrative operations for the Center. Previously, Kim was an 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 completed the Job Training Partnership Act (JTPA) Program at Forsyth Technical Community College and received a Certificate of Completion in Secretarial Science.

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Carrie Fahey joined the Robert Graham Center in June 2012. She primarily works with the center's health mapping tools, providing training, dissemination, geographic information science (GIS) skills, and research. Prior to joining the Center, she managed an immigrant literacy program within Georgetown University's Center for Social Justice. In 2011, Carrie spent 4 months at Tanzania's National Institute for Medical Research conducting thesis research on the intersection of food insecurity and malaria in a rural farming community. Carrie graduated with a Bachelors of Science in International Health from Georgetown University.

Sean Finnegan joined the Robert Graham Center in August of 2010. He manages a variety of the geospatial projects as well as the production of online mapping and data display tools and oversees the data management duties for the center. Sean has a strong background in geography and geospatial analysis and has previously worked for National Geographic, The Discovery Channel and Population Action International. Sean completed his Master's degree at George Mason University and attended the University of Missouri, Kansas City for his undergraduate studies.

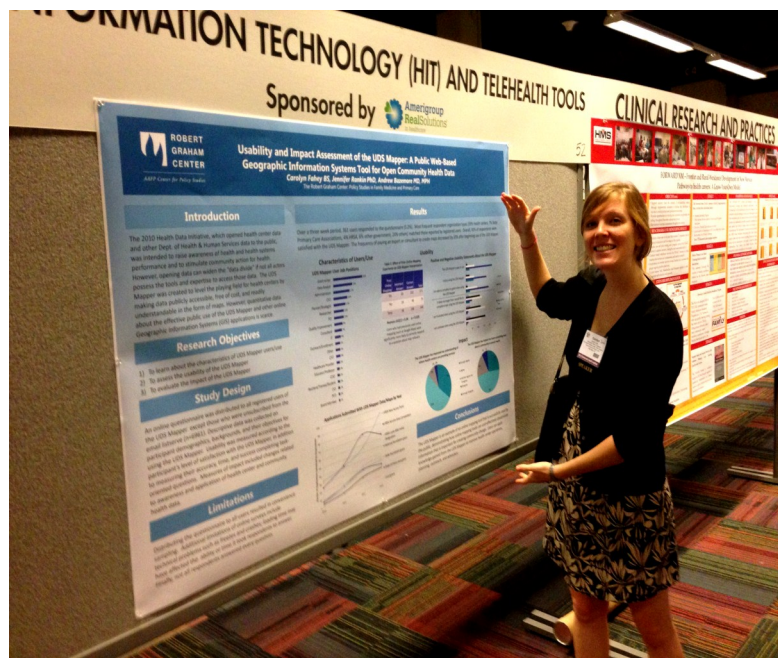
Claire B. Gibbons, joined the Robert Graham Center in February 2013 as the Senior Operations Manager. Claire helps to manage the Center's operations and participates in a variety of research projects. Previously, Claire was a Senior Research and Evaluation Officer at the Robert Wood Johnson Foundation where she designed and oversaw evaluations of programs to improve health care quality and reduce racial and ethnic disparities. She also designed research programs to study changes in payment systems and improvements in health care systems. Claire earned her BA in Economics, BA in Health and Society and Masters in Public Health from the University of Rochester and her Ph.D. in Maternal and Child Health from the University of North Carolina- Chapel Hill.

Miranda Moore joined the Robert Graham Center for Policy Studies in Primary Care in September 2012 as an Economist/Health Services Researcher. Miranda is particularly interested in family health care access and health outcomes, workforce issues, national and state health policy development, and the impact the structure of physician payment has on patient outcomes. Previously, at the U.S. Department of Labor, Employee Benefit Security Administration (EBSA), Office of Policy and Research, she worked on issues related to employer-sponsored employee benefit plans. Prior to working at EBSA, she was a teaching assistant at Stony Brook University, where she taught game theory. Miranda earned her economics graduate degrees, Ph.D. in 2010 and M.S. in 2006, from Stony Brook University and her B.B.A. in economics from the University of Georgia (2003).

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Stephen Petterson joined the Robert Graham Center in 2005. He is currently the Research Director, both overseeing and contributing to the Center's analytical activities. Previously, as a sociologist and social statistician, he was on faculty at the University of Virginia and a researcher at the Southeastern Rural Mental Health Research Center. Stephen has taught courses in graduate and undergraduate statistics, welfare policy, problems of urban life and sociology of work. He earned a Ph.D. in sociology from the University of Wisconsin in 1993, and an undergraduate degree in sociology and anthropology from Haverford College in 1984.

Jennifer Rankin joined the Robert Graham Center in May, 2010 as the Geospatial Informatics Senior Analyst. She directs all geospatial projects at the Graham Center, most notably the UDS Mapper. Her career has focused on issues related to primary care and access to care, with a special interest in the geography of access to health care. She has worked with the HRSA Maternal and Child Health Bureau, the Texas Association of Community Health Centers, and the Association of State and Territorial Health Officials. Jennifer earned her Master of Health Administration from the Tulane School of Public Health and Tropical Medicine 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.



Thank You

Thank you to all of our funders, partners and supporting institutions. We are grateful to all who made 2012-2013 a successful year for the Graham Center.

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