and, thus, stored health data in electronic health records (EHRs).[3]

For many reasons, effective HIE has failed to materialize. In part, EHR vendors and health systems have engaged in information blocking in order to increase revenue and market share. The Office of the National Coordinator, which leads and coordinates US HIT efforts, reports that information blocking "occurs when persons or entities knowingly and unreasonably interfere with the exchange or use of electronic health information."[1] While more research is needed to quantify the impact of these practices, one-half of national HIE leaders that responded to a survey reported that EHR vendors routinely block the flow of information. The most common practices include deploying products with limited interoperability, charging disproportionately high fees for HIE, and making third party access to standardized data difficult.[2]

These practices have implications for quality improvement, research, and patient care. Providers and scholars increasingly rely on EHR data to track diseases, study interventions, and refine the delivery of care. These activities are critical as health systems embrace learning health care principles.[4] Within primary care, organizations are aggregating demographic, social determinants of health, clinical, and billing data extracted from EHRs to coordinate care, conduct comparative effectiveness research, and accelerate learning across practices.[5–7]

Recognizing the importance of these data for the future of primary care research, the North American Primary Care Research Group's (NAPCRG) Research Advocacy Committee drafted and Board passed a position statement condemning information blocking.[8] This statement will guide advocacy efforts and policies and aligns with similar calls from the College of Family Physicians Canada and American Academy of Family Physicians.[9] As we seek to understand the scope of the problem and potential solutions, we welcome your feedback about this statement, your experiences with information blocking, and your ideas about how NAPCRG can support effective HIE (see the link for an online form).[8]

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CULLEN: FAMILY PHYSICIANS ARE HEROES IN 'EPIC ADVENTURE' OF US HEALTH CARE

John Cullen, MD, the AAFP's newly installed president, barely had time to catch his breath after his formal swearing-in on October 10, 2018 before he was thrust into the limelight at the opening ceremony of the AAFP's 2018 Family Medicine Experience (FMX) in New Orleans.

As he stood before a standing-room-only crowd of his family physician colleagues and other well-wishers, Cullen introduced himself and spoke of the joy and challenges of family medicine. "My practice in Alaska has been an adventure, but it has not been easy," said Cullen. The Valdez Medical Clinic where Cullen has seen patients for some 25 years is more than 300 miles from any other hospital. "The weather is something that must be experienced to be believed," he said. "Family medicine is the only specialty that can thrive where we live," Cullen told his audience.

He spoke of storms—a driving snowstorm in Valdez and a young mother in labor with twins at 34 weeks. "The first baby was breech," he said, and the family physicians in the audience gasped. "And there

was a prolapsed cord," he continued. The audience groaned before Cullen said, "There was not a chance of getting her to Anchorage." The story had a happy ending. Three family physicians, a medical student, and hospital staff took care of Mom and her babies that stormy night "because that is what family physicians do," said Cullen.

Family medicine is weathering its own storm—one born of dysfunctional politics, corporate greed that sees medicine as a business rather than a profession, and disruptive technologic innovation. Cullen urged family physicians to fight for their patients, their colleagues, and their specialty. "We will come through this stronger than ever," he assured them. He reminded his colleagues that the United States spends too much on health care—twice the amount of other industrialized nations—but not enough on primary care. "Our country spends roughly 5% of its health care dollars on primary care; we need to spend 15%," said Cullen. When this spending pattern changes, health care costs will be cut and disparities in care will be reduced, he noted. However, "If we are going to save the health care in this country, we will need more family physicians," Cullen declared. To achieve the necessary workforce balance, he explained, the AAFP is shooting to get 25% of graduating US medical students to match into family medicine by 2030.

Cullen spoke of other changes the health care system needs—like cutting administrative work that has nothing to do with patient care, paying family physicians properly for delivering complex care, and understanding that the intersection between private practice and public health is territory owned by family medicine. There's much work to be done to double the number of family medicine residency slots and ensure patient access to quality health care in both urban and rural America, said Cullen. "Health care outcomes should not depend on your ZIP code." The work ahead also includes taking control of new "disruptive technologies that are changing the face of medicine." The AAFP's new president spoke of the need for protection—protection of an ever-shrinking scope of practice, of confidentiality between patients and their physicians, and of physician colleagues who may be struggling with burnout. Cullen challenged his fellow FPs to do their part by donating to the Academy's political action committee, FamMedPAC (https://www.aafp.org/advocacy/donate/fammedpac/mem/donate.mem.html) and advocating at the local, state, and national levels. Lastly, he asked them to serve as teachers and mentors for the next generation of family physicians. "If you love what you do, please teach. Bring medical students into your practice, especially if you live in a rural or underserved area," he said. Doing so will give them a first-hand look at family medicine and negate what many of them have been told back at their medical schools—that family medicine is a waste of time.

That line hasn't changed in 30 years, said Cullen. "I use all of my medical training every day. And at 3 o'clock in the morning with a patient who is crashing—in the middle of a raging snowstorm and the nearest specialist is 300 miles away—there have been times when I wished I was smarter. But you can't be too smart to be a family physician," he said.

Despite living in a time of chaos and change, Cullen prefers to think of traveling the world of health care in 2018 as an "epic adventure" where family physicians are the heroes. "In my experience, adventures are difficult and uncomfortable, and they push you to the absolute limits of what you can do," said Cullen. "But they also give life purpose."

It is times like these when an organization such as the AAFP—one "filled with confidence and resolve and clarity of purpose"—can determine its own fate and that of our country, he said.

Finally, because Cullen lives in rural, remote Alaska, he spoke of bears. In fact, he recounted a bear story—not one of his own, but a tale passed along to him by a colleague. As the story goes, a hunter—a family physician's patient, no less—was charged by a bear, knocked to the ground and pinned there with 1 massive bear paw resting on the hunter's chest. Patiently, the bear waited for her 3 cubs to pass, then lifted that paw and followed them. "I want our Academy to be that bear," said Cullen. "There are 131,000 of us; that makes us a big mama bear, and we will fight for you and we will fight for your patients."

With that, the audience began to cheer and gave the AAFP's brand new president a standing ovation.

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