Family Medicine Updates

From the Society of Teachers of Family Medicine, North American Primary Care Research Group, and Association of Departments of Family Medicine

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ACADEMIC FAMILY MEDICINE'S RESPONSE TO CTSA

The Institutional Clinical and Translational Science Awards (CTSAs) are the cornerstone of the National Institutes of Health Roadmap Initiative that intends to transform research by promoting new models of research and expanding research training for the future. This initiative is designed to maximize the public's investment in the biomedical research enterprise through development of new models of clinical research and the training of new types of clinical researchers. Specifically, this model promotes collaboration between disciplines and emphasizes that many of the critical questions in medicine cannot be answered within the confines of single NIH institutes or traditional academic health centers. Additionally, CTSAs should "help deliver improved medical care to the entire population, helping to disseminate new technologies and new advances into clinical practice."[1]

The continuing maturation of research capacity in family medicine is occurring apace, even as the NIH's research enterprise continues to mature in ways that invite, if not require, greater emphasis on effectiveness, what works and why, in frontline practices where millions of people are seen daily.[2,3] This is terrain that family medicine knows about and needs to know much more about.[4]

The first round of CTSA grant applications were due in March 2006. The following awardees were announced in September, 2006: Columbia University Health Sciences, Duke University, Mayo Clinic College of Medicine, Oregon Health and Science University, Rockefeller University, University of California-Davis, University of California-San Francisco, University of Pennsylvania, University of Pittsburgh, University of Rochester, University of Texas Health Science Center at Houston, and Yale University.

In addition to these full grants, 52 "planning grants" of $150,000 each were awarded. The second round of CTSA applications were due January 2007. These grants will be reviewed in May and awardees will be announced in the fall. The request for applications (RFA) for the third round of grants was released March 22, 2007 with a due date of October 24, 2007 (http://grants.nih.gov/grants/guide/rfa-files/RFA-RM-07-007.html). The language of these RFAs has continued to evolve with a broader understanding of the concept of translation. The definition of translation includes "enhancing the adoption of best practices in the community" and has been expanded to include the "cost effectiveness of prevention and treatment strategies." The first sentence in the executive summary of the RFA states, "The ever increasing complexities involved in conducting clinical research are making it more difficult to translate new knowledge to the clinic – and back again to the bench." The financing of the awards has been expanded so that NCRR K12, K30, M01, and Roadmap T32 and K12 awards that the institution already has are in addition to the CTSA funds. Pediatric research has been carved out of the main CTSA. It should also be noted that the NIH has made it clear that all CTSA awardees are expected to participate in a national community of CTSAs that will work together to develop and expand new models for clinical research and collaboration.

The family of family medicine has been aggressive about seeking and collating information about family medicine participation in CTSA grants. Following discussion of this at the August Working Party meeting by leaders of family medicine organizations, a CTSA Strike Force was formed by ADFM to organize aggressive action. NAPCRG and ADFM conducted surveys to document family medicine participation. This information was presented at a special discussion session at the NAPCRG meeting in Tucson in October. CTSAs were a major topic of discussion among the family at the ADFM Fall meeting held in conjunction with the AAMC meeting in Seattle in October. The Working Party meeting in Las Vegas in January continued these discussions. Stories of family medicine's participation in CTSAs were collected and distributed at the ADFM annual meeting in February in Savannah.

At the NAPCRG meeting, presentations were made about the surveys and experiences at the University of Chicago and Duke. The survey of 647 members of NAPCRG yielded 92 responses. Sixty-four percent of respondents were not involved in their institutions' CTSA application, and of these, 60% did not know

about the CTSA. Thirty-five per cent were involved in either the planning grants or the CTSA applications. The majority of those involved were working in the community outreach component, including practice-based research. Almost all became involved upon invitation by their chair, dean, or CTSA principal investigator. Forty percent were satisfied or very satisfied with their involvement (of the remaining 60%, 25% were neutral, and 35% indicated they were not satisfied with their involvement).

For the ADFM initial survey there was a 44% response rate. Forty-five percent of responding departments said that their institution submitted a planning grant, and 25% of responding departments said that their institution submitted a full CTSA application. Twenty-five percent said there was no application from their institution, and 6% did not know.

Sixty percent of the departments responding to the survey reported that they had a substantive or key leadership role in the application. Some had roles such as being invited to be part of the steering or planning committee. Many reported participation or leadership in the community engagement component. In these cases the departments said they were valued because of their practice-based research networks and community linkages. There was concern by some about not being recognized as a true partner at the table from the beginning of the grant. There was also a concern voiced that their institutions lacked an atmosphere of collaboration, put lower importance on clinical research, had a "narrow" definition of translation, and were more interested in maintaining current NIH programs than seeking innovation. One half of the respondents' institutions were applying in the second round.

Following the survey, ADFM collected stories from individual departments about their participation at their institution. The level of involvement in the CTSA applications was quite varied. Those who participated included chairs, research directors, PBRN directors, geriatric researchers, and other established researchers. Areas of involvement included research networks, community outreach, research training, information technology related to research, expansion of definition of translation, and overall institutional reorganization. Having previously developed collaborative research relationships or having personal relationships with key research administrators was helpful. Recognition of family medicine success in forging relationships with the community was also crucial to many departments' involvement in the CTSA process.

Some departments were invited to participate in the beginning of the process, and others felt they were invited late. In some cases, especially if the institution received a poor score on community engagement, they were invited after the grant was funded. If the grant did not get funded, and there was a weakness in community engagement noted in the reviews, family medicine was sometimes invited at that time. Some departments had to convince the dean or CTSA leadership that they could be integral to the success of the proposal.

One of the weaknesses in departments of family medicine has been a lack of research infrastructure. There is a recognition that CTSAs can offer infrastructure in the forms of biostatistical support, research methods, grants management, bioinformatics, and research training. Additionally, the institution K12 awards can offer junior investigators support to get their research careers started.

Some departments expressed concern about being able to protect the community and the relationships that they have forged from the new interest of the academic health center. There is value to the trust that departments have built over time and they do not want to put that trust in jeopardy. Another concern has been whether their institutions will have the monetary and research resources to be competitive with larger or more research-oriented institutions. Some of the successful institutions put up a lot of their own money in transforming their research environment to make it more like that proposed by the Roadmap. Some chairs felt that their institutions were interested in participating in the CTSA process only to protect whatever infrastructure or funding streams they already had under the traditional NIH system rather than really being interested in transforming their clinical research enterprise.

Departments of family medicine should not look to the award as a way to get money (though some will be able to). The key is to be at the table of collaboration and be able to take advantage of the many opportunities that will come up.[5,6] Departments of family medicine have varied research capacities, and not all are poised to help their institution with research or a CTSA proposal. But many can, and many have.

The take-home messages from these comments are as follows:

1. *It is necessary to be proactive.* The department needs to go to the dean, the General Clinical Research Center (GCRC) director, or CTSA planning leadership and demonstrate what the department can offer.
2. *Family medicine should try to be active on multiple levels of the application, not just the community engagement component.* The real value of family medicine participation will only be realized when family physicians can speak the language of the basic scientists and truly activate the potential of bidirectional translation; and vice versa, when basic scientists can speak the language of clinical practice.

3. *Do not be afraid to be bold.* This transformation of clinical research is an iterative process that will be shared in a transparent manner, so that the "community" of CTSAs can learn from each other.

In January 2006 there was a meeting convened by STFM in Washington, DC, whose purpose was to determine the stance of the discipline toward NIH. This meeting was called in recognition of the increased success of family medicine researchers in getting NIH grants and the decline of funding for Title VII. There was consensus that family medicine can have influence in making NIH more accessible to primary care researchers by getting more family medicine representatives on study sections, educating NIH about the value of practice-based research networks, expanding definitions of research, and informing the language of RFAs. It is also important for family medicine as a discipline to advocate for increased funding for the NIH, particularly for practice-based research networks, training of clinicians and other arenas of clinical research that utilize primary care methods.

CTSA grants are an immediate opportunity for family medicine to contribute to the mission of the NIH and to move forward toward expanding and completing medical knowledge in frontline practice. Because it means so much to virtually everyone in the nation, those departments of family medicine who are situated such that they can enhance their institution's research enterprise should do so.

The Family Medicine CTSA Strike Force was initiated to promote the participation of family medicine in CSTA grants. The group has met by teleconference. This group has emphasized the urgency of the CTSA (there will be a total of 50 to 60 awards made by 2012). It is important that we continue to circulate information about CTSAs to the family of family medicine to maximize our participation in improving the health care to all Americans.[7-9]

Mark S. Johnson, MD, MPH; Ardis Davis, MSW and the CTSA Strike Force

Members of the CTSA strike force: Mark S. Johnson, MD, MPH; Ardis Davis, MSW; Peter Carek, MD; Larry Green, MD; Carlos Jaen, MD, PhD; Norman Kahn, MD; Rick Kellerman, MD; Erik Lindbloom, MD, MPH; Terry Steyer, MD; Hope Wittenberg.

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ACADEMY BUILDS COALITIONS FOR HEALTH SYSTEM REFORM

The Academy has been working hard at building coalitions during the past year, and some of those efforts are beginning to pay off. In January, the Academy led 9 other medical associations to introduce 11 principles for health system reform and called on Congress to enact health system reform based on those principles. Also in January, AAFP had a seat at the table as the only medical specialty association in an alliance of health care stakeholders, known as the Health Coverage Coalition for the Uninsured. Academy President Rick Kellerman, MD, Wichita, Kan, was there when coalition members announced a proposal that would extend health care coverage to America's nearly 47 million residents without health insurance.

Principles for Reform

AAFP was instrumental in leading a group of medical associations, including the American Academy of Orthopaedic Surgeons, American College of Cardiology, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Osteopathic Family Physicians, American College of Physicians, American College of Surgeons, American Medical Association, and American Osteopathic Association, to formulate 11 principles for health system reform, including access to health care, medical liability reform and management of health care costs.

The group first came together in November 2004 at the behest of the AAFP under the leadership of