Preservation of the program has been due to the advocacy efforts of the organizations of family medicine and membership under the leadership of Hope Wittenberg, MA, the Academic Family Medicine Advocacy Alliance government relations director. For paying attention to our concerns this year, Hope credits Marcia Brand, PhD, associate administrator of the Bureau of Health Professions, and Marilyn Biviano, director of the Division of Medicine and Dentistry, new to their present positions, but long time supporters of primary care. Because of the President's veto, issues remain in both the House and Senate FY08 spending bills in which the primary care cluster of Title VII was level funded at $47.998 million. Now any new version needs to preserve or increase the current funding levels.[7]

Scholarly activity can be promoted throughout the entire process—choosing a project, involving residents and faculty, writing the grant and submitting an institutional review board application. Title VII grants are an opportunity to gain additional funding, work cooperatively with other family medicine residency programs/departments, and add to the academic basis of our discipline.

Elissa J. Palmer, MD
Peter J. Carek, MD
Sandra M. Carr-Johnson, MD

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CTSAS AND FAMILY MEDICINE RESEARCH – TIME TO GET CONNECTED

The window is closing on the opportunity for family medicine departments, working through our medical schools and universities, to be included in the 50 to 60 institutions funded by the US National Institutes of Health (NIH) to transform the US clinical research infrastructure.[1] NIH Clinical Translational Science Awards (CTSAs), designed for this purpose, have been awarded in the first 2 rounds (2006 and 2007) to 24 individual institutions and consortia.[2] The third round of applications were due October 24, 2007. If 12 new CTSAs are awarded in the third and subsequent rounds, as was the case in each of the first 2 rounds, all of the planned CTSAs will have been awarded within the next 2 or 3 years.

Family medicine has potentially much to offer and gain, given the CTSA emphasis on community engagement, practice-based research, and the agenda to "help deliver improved medical care to the entire population, helping to disseminate new technologies and new advances into clinical practice."[2] Maximizing family medicine involvement in CTSAs should help advance the NIH agenda and facilitate the maturation of the family medicine and larger primary care contribution to the national clinical research enterprise. Several Web sites and publications provide extensive context and background information on the CTSA program.[1-3] The 24 current CTSA awardees as well as criteria for the award are listed on the CTSA Web site.[2] A family medicine CTSA Strike Force is organizing communications, strategies and surveys to facilitate family medicine's role.[4] Several publications contributed by family medicine authors provide useful resources on translational research[5-9] from a family medicine and primary care perspective. Our intent in this column is to describe current opportunities and strategies for family medicine involvement in CTSA programs.

Thus far, family medicine representation has varied widely. A few departments have leadership roles within their institution, overseeing all research network and community engagement activities, and teaching researchers across the institutions the principles of practice and community-based research. Other departments play critical roles within several of these activities. Commonly, however, departments have been

disengaged from the planning process, whether from lack of interest, or lack of invitation. Given the importance of the CTSA project and its level of funding, it is critical that all departments seek to engage, even if uninvited, and even if their institution is not actively seeking one of these highly competitive grants.

There are several successful methods of engagement in the planning process. The simplest is to meet with the proposed principal investigator, who is often a bench researcher with little knowledge of practice-based or community research, and to describe the departments programs and connections, and how the department can help achieve the CTSA requirements. Sometimes, repeated discussions are needed; failed submissions with low scores on the community engagement section (which is required) can facilitate these interactions.

It is important to note that consortia can submit for CTSA grants, and an increasing number of medical centers are doing so. The combination of a research intense medical school with 1 or more community-based schools can be a powerful and successful model.

The NIH will be conducting a series of workshops on community engagement over the next year, which will provide additional opportunity for all departments, networks, and community partners to share and learn about this exciting and evolving field of clinical translational science. Thus, all FM departments will have an opportunity to participate in this national experiment and to help share the evolution of the NIH. The first national workshop is on "Accelerating the Translation of Research into Practice" and is scheduled for May 8-9 in Bethesda, Maryland. The first day's topic is "Feasibility of Expanding and Integrating the Clinical Research Networks" and the second is "Accelerating the Dissemination and Translation of Clinical Research into Practice." In addition, a series of regional meetings on community and practice engagement are being planned, and will offer additional opportunities to showcase best practices and to learn from each other. Information of all of these meetings will be available on the NIH CTSA Web site (http://ctsaweb.org).

Bernard Ewigman, MD, MSPH, University of Chicago
Lloyd Michener, MD, Duke University

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AAFP CONTINUES TO FIGHT FOR PAYMENT REFORM

Payment reform for primary care physicians and, in particular, for family physicians is a top priority for the AAFP. Once again in 2007, the Academy fought long and hard to ensure members of Congress and federal officials recognized the importance of payment reform to ensure the health of the nation.

As 2006 drew to a close, Congress narrowly averted a scheduled 5% payment cut for family physicians, leading the Academy to immediately jump into the payment fray once again. Early in January, an AAFP-inspired group of 10 medical associations called on Congress to implement comprehensive health system reform that abides by 11 principles, including access to health care, medical liability reform, and management of health care costs. The "Principles for Reform of the U.S. Health Care System" calls on Congress "to take action on health system reform this year," said (then) AAFP President Rick Kellerman, MD, of Wichita, Kansas.

Then in March, the Academy, responding to a report on physician payment rates from the Medicare Payment Advisory Commission, urged Congress to replace the current payment structure with a system that compensates physicians for care-coordination services and creates incentives for the establishment of patient-centered medical homes.

Kellerman testified before the House Ways and Means Committee's Subcommittee on Health in May. He urged committee members to adopt a Medicare physician payment system that reimburses physician practices for providing a patient-centered medical home. "More than 20 years of evidence shows that having a health care system based on primary care reduces costs and benefits the patient's health," said Kellerman.