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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From the American Academy of Family Physicians

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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

then-President Mary Frank, MD, of Mill Valley, Calif, to create a plan for health care reform. The result is "Principles for Reform of the US Health Care System," which represents the first time so broad a swath of medical specialists have spoken with a unified voice, according to AAFP President Rick Kellerman, MD, of Wichita, Kan.

"Doctors want Congress to take action on health system reform this year," he said. "Physicians are coming together to support these principles because they want the best care for their patients, and if these principles are adopted, patients will be the main beneficiaries."

Moreover, the principles offer a solid foundation on which Congress can craft comprehensive health system reform, according to Frank, who chaired meetings of the organizations.

"Congress doesn't have to worry about infighting among the groups who support the principles, especially since the groups represent the majority of physicians in the United States," she said. "Not only are they (the principles) comprehensive, but they don't put the onus of the solution on any one group. That makes it more palatable to a legislator—that we say 'We're willing to step up to our part of responsibility, you step up to your part and we expect others to assume their part of the responsibility.'"

AAFP EVP Douglas Henley, MD, agreed. "The group represents a huge percentage of the physicians in this country," he said. "It recognizes the need for system reform, not just providing health care coverage to people."

According to the principles

- Health care coverage for all is needed to ensure quality of care and to improve the health status of Americans.
- The health care system in the United States must provide appropriate health care to all people within US borders, without unreasonable financial barriers to care.
- Individuals and families must have catastrophic health coverage to provide them protection from financial ruin.
- Improvement of health care quality and safety must be the goal of all health interventions, so that we can assure optimal outcomes for the resources expended.
- In reforming the health care system, society must respect the ethical imperative of providing health care to individuals, the responsible stewardship of community resources and the importance of personal health responsibility.
- Access to and financing for appropriate health services must be a shared public/private cooperative effort, and a system which will allow individuals/employers to purchase additional services or insurance.
- Cost management by all stakeholders, consistent with achieving quality health care, is critical to attaining a workable, affordable, and sustainable health care system.
- Less complicated administrative systems are essential to reduce costs, create a more efficient health care system, and maximize funding for health care services.
- Sufficient funds must be available for research (basic, clinical, translational, and health services), medical education, and comprehensive health information technology infrastructure and implementation.
- Sufficient funds must be available for public health and other essential medical services to include, but not be limited to, preventive services, trauma care, and mental health services.
- Comprehensive medical liability reform is essential to ensure access to quality health care.

Reducing the Ranks of the Uninsured

The Academy also has taken part in the Health Coverage Coalition for the Uninsured, or HCCU, which is proposing a mix of public programs and tax credits to extend health care coverage to America's nearly 47 million residents without health insurance. The HCCU estimates that their proposal, if fully implemented, would cover more than one half of the uninsured population.

In addition to the Academy, which is the only medical specialty association in the group, HCCU members include the AMA, Families USA, America's Health Insurance Plans, American Hospital Association, US Chamber of Commerce and United Health Foundation, as well as 9 other organizations. Coalition members have been meeting for more than 2 years to hammer out the consensus plan.

Reed Tuckson, MD, senior vice president of the United Health Foundation, moderated a news conference held in Washington, DC, at Union Station on January 18 to announce the plan. "Today, 16 powerful, influential, politically diverse and highly principled organizations, many of whom often do not come together on issues here in Washington, are gathered on this stage to announce a set of consensus recommendations—and to pledge our full and continuing support for the implementation of those recommendations," Tuckson told reporters.

The HCCU's proposal first focuses on expanding coverage to the nation's 9 million uninsured children. Under the proposal, states would be given the flexibility to deem uninsured children from low-income families eligible for and enroll them in Medicaid or the

State Children's Health Insurance Program, or SCHIP, when they qualify for other means-tested programs such as food stamps.

"Surveys have shown over and over that Americans want children covered because they see the health and well-being of children as being the health and well-being of our future," AAFP President Kellerman told reporters.

Speaking as a physician, Kellerman said getting kids insured "gives us an opportunity to discover developmental delays earlier, find medical problems when we can intervene and treat, take care of acute problems before they can become complications, and provide immunizations. So this proposal is not only cost-effective but also good medical care."

The HCCU proposal also calls for a tax credit to help families with more income pay for private health insurance for their children. Families earning as much as 3 times the federal poverty level would be eligible. The credit would cover a significant percentage of the premium, with the percentage graduated on a sliding scale based on family income.

In addition, the proposal's first phase would establish a grant program to enable states to experiment with innovative approaches to expand coverage.

The HCCU proposal's second phase focuses on uninsured adults. It would give states the flexibility and funds to expand Medicaid eligibility to cover all adults with incomes below the federal poverty level. Those with incomes between 1 and 3 times the federal poverty level would get a tax credit to help them pay for private insurance.

Too often, uninsured people don't get the primary and preventive care they need; instead, they "depend on the local emergency department as their family doctor," said Kevin Lofton, chair of the American Hospital Association Board of Trustees. "Delaying action on the uninsured will only increase the human suffering, the moral urgency, and the financial costs to our society and to our health system. According to the Institute of Medicine, an estimated 18,000 people die each year because they do not have health insurance."

Leslie Champlin
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AAFP News Now

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ABFM'S IN-TRAINING EXAMINATION

The American Board of Family Medicine's (ABFM) In-Training Examination was conceived in 1979 as part of a tripartite assessment process for family medicine residents in training. This 3-fold assessment process was developed under the aegis of the Conjoint Committee on In-Training Assessment (CONCITA), a group consisting of members from the American Academy of Family Physicians, the Society of Teachers of Family Medicine, and the then American Board of Family Practice. At that time, CONCITA had envisioned moving forward with the formulation of criteria for assessing psychomotor (procedural) skills, and a methodology for assessing interpersonal skills and attitudes (behavioral). The cognitive examination, first given with great success in 1979, and again each year thereafter, remains as the only vestige of this early work on resident assessment within our specialty.

Last year, the ABFM conducted a pilot project for its delivery of the In-Training Exam (ITE) directly to volunteer programs over the Internet. The purposes of the pilot project included the development of administrative relationships with program coordinators required for the successful implementation of the examination delivery over the Internet, as well as feedback from those program coordinators and residents. In addition, the pilot project allowed for determination of the range of technical requirements necessary for working with multiple residency programs and the impact of delivering the ITE in this manner on the ABFM's information technology infrastructure, including its broadband capacity and Web servers.

A total of 633 residents across 41 ACGME accredited residency programs participated in the Internet-Based ITE (IBITE) pilot project. In addition to the US family medicine residency programs, 2 international groups participated. The Hope Family Medicine Residency Program, located in Macau, had 4 physicians take the exam. The Australian College of Rural and Remote Medicine had 12 physicians from various geographic regions take the exam. The administration of the IBITE went very smoothly, with only minor difficulties arising which were cleared up in minutes with the assistance of the ABFM support staff. The summary statistical data comparing results of the written