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."

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From the American Board of Family Medicine

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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

ITE with the Internet-based ITE showed no significant differences in performance. The findings support the position that the ITE can be successfully and effectively administered via the Internet.

The ABFM has consistently underwritten some of the costs of the development and administration of the ITE over the years. This was in recognition of the economic factors affecting residency programs and their residents and the desire of the ABFM to limit any economic obstacles to participation in this valuable process. The fee has remained constant at $30 per resident since 1995. Our direct and indirect development costs of the ITE exam and the resulting scoring and reporting costs have consistently exceeded the amount collected.

The inflationary increase in the ABFM's costs, plus the development and maintenance costs of the ITE, have necessitated that we raise the fee for the ITE beginning in 2007. The 2007 fee will be $50 per resident. While this is a substantial increase over the current fee, it still does not allow for the ABFM to fully recover its costs. Nevertheless, the ABFM believes that the fee fairly reflects the improved efficiencies achieved in registering residents using the Resident Training Management (RTM) software; the advent of electronic reporting of ITE results to programs, to be consistent with how certification performance reports are presently made available; and the new Resident's Portfolio, which next year will allow residents to access their results directly.

All residents who have been entered in RTM have free availability of all of the components of the ABFM's program for Maintenance of Certification for Family Physicians (MC-FP). While RTM has streamlined the process of registering residents for the in-training and primary certification exams, it has also created the ability to make MC-FP modules developed by the ABFM accessible online for residents. The ABFM believes that the residency program directors and residents will find these to be valuable resources to assist with the achievement of many of the 6 ACGME general competencies, which are the same competencies used to assess family physicians in MC-FP.

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From the Association of Family Medicine Residency Directors

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P⁴ = INNOVATION

The initial goal of the Preparing the Personal Physician for Practice (P⁴) Initiative is innovation in family medicine residency training, in real-life situations, in various settings. After an exhaustive process of evaluation and review, 14 programs from the initial 84 applications have been selected to participate in the P⁴ Initiative. The portfolio of innovations represented in this group is expected to align with new models of practice to enhance the performance of family physicians as personal physicians in modernized, frontline medical practice. The announcement of these innovative programs in February was yet another major step in making the P⁴ Initiative a reality and kicked off another phase in the evolution of this important project.

So what is the scope of the innovations being proposed in this portfolio? In the initial call for proposals, the P⁴ Steering Committee identified 1 general requirement (alignment with the New Model Practice) and 5 different areas where innovation was likely to occur:

- *Scope and content* of training (eg, enhancements in chronic disease care, differentiation for a particular population)
- *Length* of training (eg, lengthened to achieve more breadth or depth of competency, or to decompress the residency experience)
- *Place* of training (eg, replacement of traditional family medicine center with other sites of training, reduced role of hospital in training)
- *Structure* of training (eg, processes of instruction and experience)
- *Measurement of competency* (eg, use of measures other than length of time)

These areas illustrated the possibilities for innovation, but were not meant to prescribe or prioritize the work of the residencies in P⁴. To that end, a "Wild Card" category was also included with the hope that a true "thinking outside the box" idea for training family medicine residents would emerge.

As hoped, all 5 categories are well-represented in this cohort of innovators and will be tested in this experimental initiative through a combination of adapting existing structures and creating new ones. Some of the innovations may require further modification to meet Liaison Committee on Medical Educa-