Thank you for the opportunity to give you an update! Since I joined ABFM full-time and moved to Lexington in July, my major responsibility has been to develop a strategic plan for ABFM. As of December 31, Dr. Puffer will retire and I will take over as President and CEO. Dr. Puffer will continue as a part time President Emeritus, with roles in ABMS, Sports Medicine, and other areas as necessary.

The fall has been busy. As I think I mentioned in August, ABFM has appointed Dr. Libby Baxley as a Senior Vice President of ABFM. She has a broad leadership portfolio, and I have asked her to have a major initial focus on Diplomate Engagement and Communications. In July, we launched the Center for Professionalism and Value in Health Care in Washington DC, which Dr. Bob Phillips will direct. The Center will assume our work with the PRIME registry and Primary Care Measures that Matter and is developing new initiatives across specialties and professions. I consider Dr. Phillips a member of our senior executive team. This fall, we announced the Family Medicine Certification Longitudinal Assessment Pilot (FMCLA), which has now been approved by ABMS and starts in January. We are also substantially revising our communication and Diplomate engagement strategy. As a part of that initiative, we will launch a major website revision likely in February.

Beyond this overview, here are the specifics:
1. On an ongoing basis, we have the work of developing materials for, testing and reviewing stage requirements for Board Certification of over 92,000 Diplomates. The numbers of Diplomates continues to increase rapidly. Every year, we certify about 9,000 in the spring and 3,400 in the fall. In addition, we are the administrative board responsible for Sports Medicine (along with Internal Medicine, Pediatrics, and PM&R) and participate in CAQ / subspecialties within Sports Medicine, Geriatrics, Hospice and Palliative Medicine, Adolescent Medicine, Pain Medicine, Sleep Medicine, and a Focused Practice Designation in Hospital Care with Internal Medicine.

We strive for ongoing improvement in how we administer the recertification examination. This spring we provided results to more than 90% of examinees within five business days of when they completed testing – much more rapidly than our traditional six to eight weeks. The goal was to reduce anxiety and reinforce competence. The feedback has been very positive so far. This fall, we piloted a “fast pass” program. Modelled after the TSA Precheck program, we have piloted a much less invasive security protocol in five different testing centers. The data on Diplomate acceptance is positive so far, although as of this writing we have not finished the analysis of feedback from the test centers.

It is important for you to be aware of the changing rules about who can call themselves “board eligible”. A number of years ago, ABMS required all boards to put a limit on how long an individual could remain “board eligible,” and ABFM set that limit at seven years from the time a resident is certified to graduate by their program director. Additionally, ABFM set a one-time, seven-year period for family medicine residency graduates prior to 2012 to become board-certified under this process. This time period expired 12-31-2018. We have communicated this regularly with all family physicians who fell into this category. Approximately 370 of these eligible physicians completed the entry requirements; of those roughly one-third passed the certification examination. By the time you read this, time will have run out, and individuals who have lost board eligibility must complete 12 full months of supervised retraining before applying for board certification again.

2. We are now well into the strategic planning process for ABFM. We chose to use a scenario planning process, which included many leaders from the family of family medicine (thank you!) as well as key stakeholders across the country. We were delighted by the energy and discussion that came out of our retreat. We are now in the process of taking the strategic needs and priorities identified at our retreat and developing a plan with the input of our Board. The process
will be final in May. I will be delighted to report more to you at our August meeting.

As a part of the strategic planning process, I have interviewed over 100 leaders across the country both inside and outside of Family Medicine. The key questions that guided the interviews were: What does the personal physician of 15 years from now look like, and what will her/his core competencies need to be? Secondarily, what impact will the dramatic consolidation of hospitals, AI and genomics, and new business combinations like CVS/Aetna, Amazon/Berkshire Hathaway have on the role and function of the personal function. Given their implications for residency expansion, I will be highlighting our learnings as a part of the organizational showcase session in January.

Our Board is heavily engaged in the process. While the details are still being defined, I anticipate that they will set in place significant evolution of our board portfolio over the next five years. We look forward to working with you to help our Diplomates in the future.

3. An early priority of our new strategic plan has been to develop another option for assessment of cognitive expertise, which we currently conduct as a recertification exam every ten years. As you may know, ABMS has approved our proposal for the Family Medicine Certification Longitudinal (FMCLA) pilot, which starts in January. Eligibility for the pilot is limited to those in good standing and are due for their recertification exam in 2019. Participation is optional. Based on the experience from other specialties, we anticipate that some people will choose to take the traditional exam—to get it out of the way in one day every ten years.

The pilot will run two years. We have planned an extensive evaluation. Longitudinal assessment is exciting for us because it offers the opportunity of setting the standard for cognitive expertise— which is one of the four core parts of our certification portfolio— while also providing a foundation for learning in the form of questions calibrated in difficulty against all other family physicians and delivered at a time and place convenient for the Diplomates. Participants will get answers, a critique and an open source reference in real time; annually they will get more detailed information about their performance and gaps compared to other family physicians. I believe that it is this focus on supporting learning, along with reducing time and expense and increasing convenience, which has led to the rapid growth of longitudinal assessment in other specialties.
How can you and we help our Diplomates prepare for the longitudinal assessment? We look to working with the AAFP and others to develop answers for this. For our part, in addition to immediate feedback for the Diplomates, we will be preparing additional reports to identify gaps in knowledge for our Diplomates. We will share those with you as they become available.

4. **Engagement of Diplomates** – Another part of our strategic plan is to change the nature of our relationship with Diplomates. To this end, we are engaging in substantial work to reach out to Diplomates and to reorganize our communications. Dr. Baxley is leading this effort. State AFP chapters have reached out to get more information about what we are doing, and we have started a process to meet with chapter leaders and attend chapter and regional meetings. We are grateful to the AAFP’s support in our efforts to meet the needs of the state chapters. Our new website will debut in the first part of 2019. We have made a concerted effort to both reduce the density of information, clarify confusing aspects and use more personalized language to change the tone to one of collaboration. Finally, we are planning a strategy of engaging Diplomates broadly to get their input on what we are doing. More to follow!

5. Another part of our strategic planning process is to review our policy regarding **additional credentials for our Diplomates**. Family physicians continue to have substantial interest in additional sub-specialty credentials. For example, more than 1,000 family physicians who are members of the Society of Hospital Medicine have lobbied for us to become a co-sponsor of a CAQ / subspecialty in critical care medicine. The AAFP supported the proposal and our Board endorsed formal application in this spring. Now the Critical Care Medicine board of ABIM is conducting a thorough review. I presented to them in November 2018 and we will hear more in the first half of 2019.

This is one example of a broader trend. We have gotten requests for additional credentials from Diplomates who work in emergency departments, particularly in rural areas, and Diplomates who provide substantial maternity care, including operative obstetrics and others.

It is important to understand that establishing new credentials would have a substantial impact on the specialty, from altering standards for residency training, to the knowledge necessary for board certification, to student interest and our responsibility to society. Because of the strategic importance of new credentials for the specialty, we believe it is time to get input from the Working
Party. We have raised this as an issue (in the form of a debate) for Working Party to discuss later this year.

6. As I write this, I await the report of the ABMS Vision Committee; the draft is expected later this month. This will be an important influence on the evolution of all ABMS boards, including ABFM. More to follow!

7. ABFM’s research enterprise continues to be robust. A core of our work is tracking what is happening in the discipline through our Diplomates and their practices. While it is difficult to summarize simply the breadth of our work, highlights from the last year include our ongoing work to develop, test and implement quality measures that capture the essence of the contributions of family medicine; explore the relationship between family physician burnout, employment model and declining scope of practice; and systematic efforts to track the outcomes of residency training. We see ABFM data as a national resource for the discipline. We highly value the collaborations we have with the AAFP Graham Center, AFMRD and many other external collaborators. As many of you know, we have just announced a national search for a new Senior Vice President of Research and Policy. This individual will provide strategic direction to our research initiatives and play a role in the Center for Professionalism and Value in Health Care

8. The Center for Professionalism & Value in Health Care is now organizing, engaging a wide variety of future partners across the country. The Center will take over the development of the PRIME registry, Primary Care Measures that Matter, and the Population Health Assessment Engine (PHATE), and is now developing new projects working with other specialties and professions. We are searching for a new office for the Center, identifying a Board of Advisors, developing foundational papers and a research agenda.

9. PRIME, the ABFM registry, continues to grow. As you know, it is free for ABFM Diplomates, translates EHR data into a quality measure dashboard, and supports a variety of reporting needs including MIPS. In the last year, we have added Population Health Assessment Engine (PHATE), our set of tools to help family physicians to map and address social drivers of health in their practice. Finally, we have launched a pilot of residency and department participation in PRIME.

10. We continue to be engaged with the ACGME. As many of you know, the Family Medicine RC is in the midst of minor revisions to the Family Medicine Residency Program Guidelines, in addition to the strategically very important
process of onboarding all the osteopathic residencies. We are continuing our research collaboration with the ACGME and look forward to discussions with the family about where the next major revisions of the RC should go.

11. New partnerships within the Family of Family Medicine – We have been delighted to work with AFMRD around the Clinic First and FM-NICCE initiatives, which will be discussed in the Working Party session, and with ADFM and specific departments to launch the Family Medicine Physician Scientist Training Pathway. We will be excited to learn the progress of the Preceptor Improvement project, which STFM is leading and the ABFM Foundation is funding. The key foci are efficient onboarding/improved preparation of students and active engagement of preceptors. To support this project, ABFM has granted continuing certification credit for quality and educational improvement.

12. Data for your consideration. What positions are we training our residents for? As you know, we conduct annual surveys of all family medicine residency graduates in the country. The response rate has been about 68%. The data demonstrate a dramatic gap between residency preparation and practice three years after graduation. One article summarizing the results is included in the readings for Working Party. Representative findings from 2017 include:

<table>
<thead>
<tr>
<th>Residency Prepared</th>
<th>Currently Practicing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn Hospital Care</td>
<td>88%</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>90%</td>
</tr>
<tr>
<td>ICU/CCU Care</td>
<td>65%</td>
</tr>
<tr>
<td>Endometrial Biopsy</td>
<td>63%</td>
</tr>
<tr>
<td>IUD Insertion</td>
<td>79%</td>
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Please do not hesitate to contact me if you have any questions about any of the items in this summary.

We look forward to the discussion!

WPN:CS