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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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-

tion (LCME) and Accreditation Council for Graduate Medical Education (ACGME) requirements, but the majority complies with current Residency Review Committee (RRC) requirements. This is important to the potential generalizability of the innovations.

As the portfolio of innovations has been reviewed and refined, a number of general themes have emerged. The major components of the New Model Practice (ie, patient-centered care, use of advanced information systems, chronic disease management and prevention, practice learning teams, and systems for assessing outcomes to improve quality and safety) are well represented within each program. Based upon preliminary finding from TransforMED's National Demonstration Project, future graduates will require additional training in change management, leadership, and organizational development. Many of the projects have already incorporated these important components of professional development into their curriculum and this aspect of the initiative will be critical in training graduates as change agents in their communities. There is significant focus on learner-centered, competency-based training that includes competency-based assessment and advancement.

Approximately one-half of the innovators are extending training beyond the current 36 months by offering a structured 4-year curriculum that allows pursuit of an area of concentration or an advanced degree. Many programs are offering significant flexibility in allowing residents to tailor their training to meet the needs of a community or accommodate their own interests and skills. Two programs are reaching back into the fourth year of medical school to assist students in gaining a higher level of competency before entering residency by providing additional, family-medicine-focused clinical experiences. Many of the programs are moving the primary location of learning from the traditional family medicine center to smaller community-based practices. With this transition comes a decrease in the time spent in the hospital and an increased emphasis on longitudinal training in ambulatory settings. Assessing the financial health and viability of these community practices will be a critical component of this transition.

In the final analysis, the P^4 Initiative can be viewed as a "voyage of discovery," and residency training can be considered as one crucial period in the lives of physicians. This voyage will be defined by the primary goals of the P^4 Initiative which are to *stimulate innovation* in family medicine graduate medical education in real life, *evaluate* the innovations, *study* what changes are needed to prepare graduates to succeed in new practice models, and *share the learnings* that will inspire change in training and certification. The first goal has been realized. The other 3 will be addressed and developed over the coming months and years. The best is yet to come.

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