4. Stewart M, Brown J, Levenstein J, McCracken E, McWhinney IR. The patient-centred clinical method. 3. Changes in residents' performance over two months of training. *Fam Pract*. 1986;3(3):164-167. 10.1093/fampra/3.3.164
5. College of Family Physicians of Canada. Standards of Accreditation for Residency Programs in Family Medicine. College of Family Physicians of Canada. Published 2020. Accessed Jan 22, 2023. https://www.cfpc.ca/CFPC/media/Resources/Accreditation/2020701-RB-V2-0-ENG.pdf
6. Batalden PB, Davidoff F. What is "quality improvement" and how can it transform healthcare? *Qual Saf Health Care*. 2007;16(1):2-3. 10.1136/qshc.2006.022046
7. Hosain J, Reis O, Verrall T, et al. Grounded in practice: integrating practice improvement into daily activities. *Can Fam Physician*. 2020;66(12):931-933. 10.46747/cfp.6612931
8. Pimlott N, Katz A. Ecology of family physicians' research engagement. *Can Fam Physician*. 2016;62(5):385-390.

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AAFP ISSUES NEW CLINICAL PRACTICE GUIDELINE ON HYPERTENSION

The AAFP has published a new clinical practice guideline on appropriate blood pressure treatment targets for adults with hypertension. The guideline applies to individuals with hypertension (with or without cardiovascular disease) and focuses on target blood pressure levels rather than specific treatments. It is available at **https://www.aafp.org/dam/AAFP/documents/journals/afp/AAFPHypertensionGuideline.pdf.**

The guideline strongly recommends that clinicians treat adults who have hypertension to a standard blood pressure target of less than 140/90 mm Hg to reduce the risk of all-cause and cardiovascular mortality. It also recommends that clinicians consider treating adults who have hypertension to a blood pressure target of less than 135/85 mm Hg to reduce the risk of myocardial infarction, based on evidence showing a small additional benefit with this lower target.

"This guideline is important because there are multiple competing guidelines with different recommendations for blood pressure treatment targets," explained Sarah Coles, MD, an associate professor in the Department of Family, Community and Preventive Medicine at the University of Arizona College of Medicine, Phoenix, and program director at the Colorado Plateau Family and Community Medicine residency program, North County HealthCare in Flagstaff, Arizona. "The AAFP guideline provides clear, evidence-based recommendations for optimal blood pressure targets for adults with hypertension."

Coles also served as the guideline panel chair. In addition to coauthoring the guideline, she helped develop the clinical questions, review the evidence and systematic reviews, and develop recommendations.

Recommendations and Key Points

The hypertension clinical practice guideline contains 2 recommendations.

First, the AAFP recommends that clinicians treat adults with hypertension to a standard blood pressure target of less than 140/90 mm Hg to reduce the risk of all-cause mortality and cardiovascular mortality. This is a strong recommendation based on high-quality evidence. While treating to a lower blood pressure target of less than 135/85 mm Hg may be considered based on patient preferences and values, the lower target does not provide additional benefit at preventing mortality.

The systematic review found no significant differences in total serious adverse events between the lower and standard target groups but did note a significant increase in all other adverse events (such as syncope and hypotension) when treating to a lower systolic target. Overall, the lower target group had an absolute risk increase of 3% for all other serious adverse events compared with the standard target group.

Second, the AAFP recommends that clinicians consider treating adults with hypertension to a lower blood pressure target of less than 135/85 mm Hg to reduce the risk of myocardial infarction (MI). This is considered a weak recommendation and is based on moderate-quality evidence. Although treating to a standard blood pressure target of less than 140/90 mm Hg reduced the risk of MI, there was a small additional benefit observed with a lower blood pressure target; however, there was no observed additional benefit in preventing stroke.

Coles, who served as the guideline panel chair, noted several key takeaways for family physicians to consider when implementing the recommendations.

"High-quality evidence shows that treating adults with hypertension to a target blood pressure of less than 140/90 mm Hg reduces the risk of all-cause and cardiovascular mortality," she said. "Treating a lower blood pressure target does not provide any additional benefit to mortality or stroke risk. This holds true for adults with and without preexisting cardiovascular disease.

"Treating to a target of less than 135/85 can further reduce the risk of MI by about 4 fewer MIs per 1,000 patients. However, treating to a lower blood pressure target does come with harms. People treated to a lower blood pressure target increased rates of adverse events, including syncope and hypotension, with a number needed to harm of 33 over 3.7 years. On average, each patient would need to take 1 additional medication to get to the lower target. This could increase cost, medication adverse effects, and drug-drug interactions.

"Because the potential benefit is small and there are increased risks, family physicians should use shared decision making when considering treating to a lower blood pressure goal to reduce MIs. These discussions should include a patient's risk of MI, potential for increased harms for lower targets, costs, and patient values and preferences."

Guideline Development

To create the new guideline, the AAFP's Commission on Health of the Public and Science appointed a development group that analyzed the evidence from a 2020 Cochrane systematic review and conducted a target literature search of additional trials. The primary objective was to determine whether lower blood pressure targets were associated with lower morbidity and mortality compared with standard blood pressure targets.

In constructing the guideline, the development group focused on patient-centered clinical outcomes such as total mortality, cardiovascular-related mortality, cardiovascular events such as stroke and myocardial infarction, and adverse events. The group also used a modified version of the Grading of Recommendations Assessment, Development and Evaluation system to rate the quality of evidence for each outcome and the overall strength of each recommendation.

Future Research

The authors and the guideline development group noted several gaps in the existing research. They called for additional studies that would, among other things,

- Evaluate longer-term outcomes
- Examine whether certain patient populations would benefit from lower blood pressure targets
- Evaluate blood pressure targets in younger individuals at low risk
- Examine the social determinants of health that contribute to health care disparities

Since all AAFP clinical practice guidelines are scheduled for review 5 years after completion (or earlier if new evidence is available), the authors said any new research into these and other areas will provide important information for future guidelines.

News Staff
AAFP News

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CORE OUTCOMES OF RESIDENCY TRAINING 2022 (PROVISIONAL)

The 2023 ACGME family medicine residency program requirements[1] call for the most significant change in family medicine residencies in the last 50 years. Major new features include an emphasis on the practice as the curriculum, outreach to communities to address health disparities, residency learning networks, independent learning plans for residents, flexibility for residencies and residents, a significant shift to competency-based education (CBME), and dedicated educational time for residency faculty to drive these changes.

All of these require significant change for residencies, faculty, and residents; most pressing now, however, is the transition to CBME because the new requirements go into effect July 1, 2023. These changes require the hard work of consensus building among the Family Medicine Review Committee (RCFM), the American Board of Family Medicine (ABFM), residency program directors, faculty and the residents themselves, as well as changes in data systems the RCFM uses to accredit residencies and the ABFM uses to evaluate board eligibility, and modifications of the assessments that residents and faculty use on a daily and weekly basis. For many experienced program directors, the changes called for in the new standards are dramatic—the elimination of the 1,650 visits requirement as well as many fewer standards for specific numbers of months or hours of specific curricula. Instead, there are expectations that residents be competent on graduation in dozens of required essential skills in many curricular domains, and much more flexibility for residencies to create curricula that meet community needs and take advantage of the unique educational opportunities each community has to offer.

It is important to understand why CBME is so important—and why now. Despite ubiquitous rhetoric of "innovation and transformation," the outcomes of health care in the United States are getting worse, with declining life expectancy,[2] worse outcomes across all ages and most diseases,[3] and COVID-19 teaching us all—again—about health disparities.[4] We believe that well-trained personal physicians, embedded in communities and supported by a robust team, can address these problems. The new ACGME FM residency requirements double down on the Starfield 4 C's—first contact care, comprehensiveness, continuity, and care coordination—and extend them to the community.[5] We assert that exposure does not equate to competence: a family medicine resident is not competent in the care of children just because she has completed 5 months of rotations! We expect residents to co-create their education and believe that this will attract the best medical students. CBME will also force rethinking of faculty development and continuous quality improvement of residency programs. Finally, and most importantly, CBME done well can help drive the broader residency redesign effort the specialty has envisioned.

The key features of CBME are now well understood (Table 1).[6] The first step is "to start with the end in mind"—to define the outcomes we expect from family medicine residencies. To that end, the ACGME RCFM, with input from ABFM, has begun to define the core outcomes of family medicine residency education. Beginning with the Entrustable Professional Activities (EPAs) developed as a part of *Family Medicine for Americas Health* by the American Academy of Family Physicians (AAFP), ABFM, American College of Osteopathic Family Physicians, the Association of Departments of Family Medicine, the Association of Family Medicine