AFMRD Association of Family Medicine Residency Directors
From the Association of Family Medicine Residency Directors

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CBME IS HERE – THE TIME IS NOW

Competency Based Medical Education (CBME) is here. The new Accreditation Council for Graduate Medical Education (ACGME) requirements started July 1, 2023, with explicit inclusion of competency-based medical education (CBME).[1]

These new requirements call on programs to think differently about how we assess and educate our residents. Gone are the days of counting to equate competence. Instead, programs will need to lean into adapting their curriculum to develop assessment strategies that focus on competence, faculty development, and individualized learning plans (ILPs) among many other things, while also focusing on program structure and training that meets the needs of their community. These upcoming changes have brought the "family" of Family Medicine together to move toward successful implementation for residency programs, faculty, and residents.

We know CBME is not new. In 1999, the ACGME and the American Board of Medical Specialties (ABMS) endorsed the 6 known core competencies, and since then we have gradually been leaning into CBME.[2] There have been numerous articles outlining the importance of CBME, including Van Melle's framework, with suggestions on implementation.[3] Now the ABMS and ACGME are collaborating further to bring CBME to graduate medical education, and family medicine is one of the specialties leading the way.[4]

To think about how to implement CBME, we need to build successful residency curriculums in this new era and "start with the end in mind," as stated by the American Board of Family Medicine (ABFM). Newton, et al recently published that end for Program Directors in the form of 12 "core outcomes."[5] Working together, the ABFM and the ACGME Family Medicine Review Committee established these outcomes.

We know that ACGME Milestones and core outcomes are different. Milestones describe performance levels residents are expected to demonstrate in the 6 Core Competencies in ACGME.[6] The intent of the ABFM core outcomes is to combine ACGME competencies with the transition to independent practice.[4] Both Milestones and core outcomes will need to be tracked to determine readiness, proficiency for autonomous practice, and for ABFM Board Eligibility.

The ABFM is explicitly shifting focus to competency-based Board Eligibility as GME shifts focus to CBME. Previously, program directors only had to attest residents completed residency, but starting June 2024 program directors will also have to attest that residents are competent in these newly established core outcomes.[4] This can seem a daunting task for our residency community; however,

Table 1. Schedule of Competency Attestation for ABFM Board Eligibility

In June 2024, we propose that program directors and CCCs will attest that each graduating resident is competent to:
Practice as personal physicians, providing first contact, comprehensive and continuity care, to include excellent doctor-patient relationships, excellent care of chronic disease and routine preventive care and effective practice management
Diagnose and manage acute illness and injury for people of all ages in the emergency department or hospital
Provide comprehensive care of children, including diagnosis and management of the acutely ill child and routine preventive care
Develop effective communication and constructive relationships with patients, clinical teams, and consultants
Model professionalism and be trustworthy for patients, peers, and communities
We will monitor progress and see further input, but for June 2025, we would extend attestation of assessment of competency by program directors and CCCs for each graduating resident to include competence in:
Practice as personal physicians, to include care of women, the elderly, and patients at the end of life, with excellent rate of continuity and appropriate referrals
Provide care for low-risk patients who are pregnant, to include management of early pregnancy, medical problems during pregnancy, prenatal care, postpartum care and breastfeeding, with or without competence in labor and delivery
Diagnose and manage common mental health problems in people of all ages
Perform the procedures most frequently needed by patients in continuity and hospital practices
Model lifelong learning and engage in self reflection
In June 2026, with continuing monitoring of progress, we would extend attestation by the program directors and CCCs to include the following competencies for each graduating resident
Practice as personal physicians, to include musculoskeletal health, appropriate medication use and coordination of care by helping patients navigate a complex health system
Provide preventive care that improves wellness, modifies risk factors for illness and injury, and detects illness in early, treatable, stages for people of all ages while supporting patients' values and preferences
Assess priorities of care for individual patients across the continuum of care—in-office visits, emergency, hospital, and other settings, balancing the preferences of patients and medical priorities
Evaluate, diagnose, and manage patients with undifferentiated symptoms, chronic medical conditions, and multiple comorbidities
Effectively lead, manage, and participate in teams that provide care and improve outcomes for the diverse populations and communities they serve

ABFM = American Board of Family Medicine; CCC = Clinical Competency Committees.

the ABFM has outlined a timeline with suggested assessment strategies. Clinical competency committees (CCCs) and program directors are being asked to assess these core outcomes, rolling out 5 core outcomes over the next 3 years (Table 1).[4]

As Barr and Stutzman stated, "what none of us can do alone, we can definitely do together."[7] We will need to work together as a community to build assessments that address ACGME milestones and the core outcomes. Thankfully, there is much work already in progress and the community is ready to do the work. ABFM laid out examples of assessments for the first 5 core outcomes we need to assess over this year to attest by June 2024 for our graduates (Table 2).[4] Additionally, look for resources from the Association of Family Medicine Residency Directors (AFMRD), including the program director toolbox, the member discussion forum, and upcoming webinars. For example, AFMRD-ABFM will have cohosted and recorded a CBME webinar in August that will be available to members. Other resources available outside the AFMRD, such as the ACGME Learn portal and the Society of Teachers of Family Medicine (STFM) Task Force on Assessment are looking to map ACGME competences to core outcomes, including other specialties, such as pediatrics. This work will require more evaluations and assessments of our residents, more direct observation, and more buy-in from residents themselves to help direct their own education in this transition to a more learner-centric model. We encourage each program to start planning early how they will meet these new expectations now. It can seem overwhelming when thinking of a complete overhaul of a program's curricula in order to support CMBE, but we encourage programs to take smaller steps to start, which can include additional assessments, engaging faculty members in any of the above resources, planning with residents to have effective individual learning plans, and engaging the entire educational team in the new process. By supporting each other we WILL do this. The time is now.

Table 2. Examples of Assessments for the 2024 Family Medicine Outcomes

Core Outcome	Example Assessments
Practice as personal physicians, providing first contact, comprehensive and continuity care, to include excellent doctor-patient relationships, excellent care of chronic disease, routine preventive care and effective practice management	• Feedback to residents on quality of care or preventive care • Efficiency of patient care assessments such as timeliness of seeing patients, completion of charting, and coding • Preceptor and behavioral health faculty assessments of effectiveness of doctor-patient relationship ◦ End of clinic shift cards ◦ Clinic field notes
Diagnose and manage acute illness and injury for people of all ages in the emergency department or hospital	• End of inpatient hospital rotation evaluation that includes: ◦ Efficiency and thoroughness of initial assessment and floor management ◦ Managing discharges and other transitions of care ◦ Effective collaboration with teammates, nurses, and other professionals ◦ Trustworthiness with team members and consultants • Use of multi-source feedback of all members of hospital teams
Provide comprehensive care of children, including diagnosis and management of the acutely ill child and routine preventive care	• Existing rotational assessments of pediatric inpatient, emergency department, and outpatient rotations that include: ◦ Recognition and management of emergencies ◦ Key procedures and communication with patients, families, and other professionals on the team • Precepting assessments in continuity clinic
Develop effective communication and constructive relationships with patients, clinical teams, and consultants	• Likely included in all rotational assessments ◦ Ideally develop way for CCC to monitor across rotations and settings so can request additional assessments as necessary • Assessments from special curricula in behavioral health
Model professionalism and be trustworthy for patients, peers, and communities	• Routine rotation assessments and reviews by faculty advisors or coaches should include a component of professionalism • Recommend asking specifically about trustworthiness from peers, faculty, and rotation leads in all rotation evaluations

CCC = Clinical Competency Committees.

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NAPCRG From NAPCRG

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THE GRANT GENERATING PROJECT: GIVING PRIMARY CARE RESEARCHERS TOOLS TO SUCCEED

As noted by McWhinney as early as the 1960s, one of the critical criteria for the ongoing development of an academic discipline, such as primary care, is an active area of research.[1] Added to this is the long-standing premise that it is essential for primary care evidence to be generated by primary care researchers with primary care physicians with and for primary care patients.[2,3] This has been the core tenet of NAPCRG since its founding in 1972,[4] and one of the reasons the Committee on Building Research Capacity launched the Grant Generating Project (GGP).[5] The 1-year "fellowship without walls" was developed to support researchers with consultation, technical assistance, and peer review for grant applications—resources that researchers often lacked in their academic environments.[6] Supported by the various organizations such as the American Academy of Family Physicians' Plan to Enhance Family Practice Research, NAPCRG's Committee on Building Research Capacity, the Society of Teachers of Family Medicine, and the Foundation of the American Academy of Family Physicians, the program successfully met research and scholarship capacity-building needs in primary care for over 20 years.[7]

During this time, research complexity steadily increased[8] and the number of grant applications being submitted more than doubled (NIH Data Book 2023) with success rates dropping from over 30% in 1998 to near 20% in 2022. Accompanying these challenging trends were innovative advances in andragogy through blended learning, active teaching, and improvements in education technology. With this shifting landscape, in 2017, NAPCRG took full responsibility for the GGP and committed to reimagining the program. As Chair of Committee for the Advancement of the Science of Family Medicine and having developed several primary care graduate degrees at McGill University,[9] I volunteered to lead the transition of GGP into a full blended-learning program. With the help of Dr Tamara Carver on the education technology front and GGP Alumni Dr Nancy Elder and Dr Douglas Archibald, this superannuated course that was taught during 4 in-person sessions over the course of a year was completely overhauled within 6 weeks. The program was turned into a cutting-edge blended-learning experience with tuition. The extensive online materials with 12 modules were complemented by 2 in-person sessions supported by 3 virtual classrooms. As part of this course, 1 module is dedicated to dissemination and implementation science as well as how to do community-partnered research. For the online curriculum, materials were developed that addressed both the United States' and Canadian funding contexts. Fellows from this program came from diverse backgrounds, with differing levels of experience and health care contexts. Building on earlier success of the program, the restructured version of GGP has continued to help new researchers to achieve funding success in the US and Canadian context. With the success in relaunching this important education initiative, several partner associations including STFM, ABFM, and the College of Family Physicians of Canada have committed to providing annual scholarships. With the relaunch in 2017 with 16 Fellows, we have created an annual cohort of learners who have developed enduring professional collaborations and successful grant applications. This year the GGP will see the addition of focus on primary care researchers applying for Artificial Intelligence/Machine Learning (AI/ML) grants through the generous support of the Gordon and Betty Moore Foundation.

While primary care has been identified as a critical component for the delivery of high-quality health care and for the improvement of global health,[10] we also live in an environment of rapidly changing health care systems with increasing expectations, knowledge, and involvement of patients, families, and communities. There is a growing preoccupation with cost and performance leading government or other decision makers to intervene, control, and reform. Finally technological developments such as artificial intelligence, big data and machine learning along with the genomics have created new hopes and expectations for primary care.[11] The advent and progression of a global pandemic only intensified these issues. All these factors lead to the conclusion that to improve health care, a strong evidence base for primary care is essential. To do this, we must prepare our researchers to be competitive in the funding application arena. GGP is one effort to ensure this happens.

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