Family Medicine Updates

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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 Residency Directors, NAPCRG, and the Society of Teachers of Family Medicine (STFM), along with concepts from the ACGME core competencies.[7,8] A national summit of family medicine organizations January 19-20, 2023 provided broad input, and a revised document was reviewed again by the RCFM, the ABFM, the leadership of the AAFP, and the Family Medicine Leadership Council in February 2023.

Table 2 lists the proposed core outcomes of family medicine residency education. These outcomes represent a commitment to the public on behalf of the RCFM, the ABFM, and the specialty. There are a total of 12 outcomes, more practical than the roughly 67 curricular competencies detailed in the 2023 standards, and lower than 17 and 18 EPAs in pediatrics and surgery, respectively. The list includes specific competencies, such as communication skills, and also entrustable activities such as competence in continuity care and management of the acutely ill patient in the hospital. It takes advantage of strengths of the current family medicine curriculum, including teaching in behavioral health, quality improvement, and community health. These strengths will allow for the repurposing of many current assessments. Table 2 is also provisional: we commit to learning with the community and adjusting as necessary.

What now? The RCFM is responsible for accrediting residencies. The RCFM and ABFM will now work with the ACGME data leadership to develop the data systems, including logs of clinical experiences and updating family medicine–specific resident survey questions, to allow the RCFM to monitor residencies. Importantly, family medicine is aligned with pediatrics, surgery, and other specialties, which are now moving from counts to competence: data systems will need to change. The RCFM understands that change will take time

Table 1. Van Melle Framework[6] for Competency-Based Medical Education

Component	Description
An outcomes-based competency framework	• Desired outcomes of training are identified based on societal needs. • Outcomes are paramount so that the graduate functions as an effective health professional.
Progressive sequencing of competencies	• In competency-based medical education (CBME), competencies and their developmental markers must be explicitly sequenced to support learner progression from novice to master clinicians. • Sequencing must consider that some competencies form building blocks for the development of further competence. • Progressions is not always a smooth, predictable curve.
Learning experiences tailored to competencies in CBME	• Time is a resource, not a driver or criterion. • Learning experiences should be sequenced in a way that supports the progression of competence. • There must be flexibility to accommodate variation in individual learner progression. • Learning experiences should resemble the practice environment. • Learning experiences should be carefully selected to enable acquisition of one or many abilities. • Most learning experiences should be tied to an essential graduate ability.
Teaching tailored to competencies	• Clinical teaching emphasizes learning through experience and application, not just knowledge acquisition. • Teachers use coaching techniques to diagnose a learner in clinical situations and give actionable feedback. • Teaching is responsive to individual learner needs. • Learners are actively engaged in determining their learning needs. • Teachers and learners coproduce learning.
Programmatic assessment (ie, program of assessment)	• There are multiple points and methods for data collection. • Methods for data collection match the quality of the competency being assessed. • Emphasis is on workplace-based assessment. • Emphasis is on providing personalized, timely, meaningful feedback. • Progression is based on entrustment. • There is a robust system for decision making. • Good assessment requires attention to issues of implicit and explicit bias that can adversely affect the assessment process.

and will extend grace to programs. The ABFM will use the list of core outcomes to set standards for board eligibility. We are committed to high standards across a broad scope of practice. Priorities for 2023 include assurance that residencies can assess competencies effectively and emphasis on the most important competencies for individual residents. For example, program directors and the clinical competency committees (CCCs) will need to assure the ABFM that individual residents provide excellent continuity care, can assess and treat a sick child appropriately, and be able to diagnose and manage an acutely ill hospital patient with multiple comorbidities. We also expect that graduating residents will be able to lead or participate in the hard work of interprofessional teams necessary for improving quality and addressing health disparities.

Neither the RCFM nor the ABFM, however, has the capacity to develop, test, and spread assessments or lead the new faculty development programs necessary across the country. We have learned from the experience of the College of Family Physicians of Canada[9] that it is vital that family medicine develop an explicit *assessment* strategy for what will be assessed and how assessment will take place, and a complementary *educational* strategy that underscores how residents will learn in the new system, including digital tools that allow real-time formative feedback to help faculty, CCCs, and program directors to guide residents' development. We are grateful to the STFM for leading this effort and engaging other organizations and specialties in the dialogue. All of the organizations of family medicine have a critical role to play: it takes a village to redesign residency education!

Several other specialty-wide interventions will support these efforts. As of this writing, the ACGME Board of Directors has reconsidered the specialty's request for more faculty time devoted to education; substantial work and advocacy remain, but we are cautiously optimistic. Dedicated faculty time for education is critical to CBME and to residency redesign. In addition, in early April, STFM will convene a national summit on residency learning networks. The examples of I^3, P4, Length of Training, Clinic First, and WWAMI have demonstrated huge benefits from residency collaboratives. We hope that all US residencies will participate in a learning collaborative addressing practice transformation and CBME, with departments, AAFP state chapters and other organizations serving as sponsors.[10] Soon, the ABFM Foundation will announce a $2,500,000 request for proposals for planning and seed funding for residency learning networks. In May, the ACGME will conduct a special workshop to "train the trainers"—the residency faculty who will help teach us all about the implementation of CBME. We are grateful to Dr Eric Holmboe and the ACGME for this tangible support for our specialty.

Family medicine starts with a considerable challenge. As a specialty, our residencies have suffered more than most

specialties from COVID-19 , and healing at the clinic, community, and personal levels will take years. We currently have 745 residencies, over 15,000 residents and are growing faster than any other specialty. And, of course, the changes called for by the new ACGME FM requirements are very ambitious. Despite all the challenges, almost 4,000 people participated in planning over the last 3 years. Our tribe is passionate about clinical care and education—and convinced our graduates can help heal our patients, communities, and the health care system. The RCFM and the ABFM are proud to have all of you as partners.

Table 2. Core Outcomes of Family Medicine Residency Training (Provisional)

The ACGME Family Medicine Review Committee, the American Board of Family Medicine, and family medicine residency programs and faculty across the country commit to the patients and communities they serve that residents who complete ACGME-accredited training in family medicine will be able to:

1. Develop effective communication and constructive relationships with patients, clinical teams, and consultants
2. Practice as personal physicians, providing first-contact access, comprehensive, and continuity medical care for people of all ages in multiple settings and coordinate care by helping patients navigate a complex health care system
3. 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
4. Evaluate, diagnose, and manage patients with undifferentiated symptoms, chronic medical conditions, and multiple comorbidities
5. Diagnose and manage common mental health conditions in people of all ages
6. Diagnose and manage acute illness and injury for people of all ages in the emergency room or hospital
7. Perform the procedures most frequently needed by patients in continuity and hospital practices
8. Care for low-risk patients in prenatal care, labor and delivery, and post-partum settings
9. Effectively lead, manage, and participate in teams that provide care and improve outcomes for the diverse populations and communities they serve
10. Model lifelong learning and engage in self-reflection
11. 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, medical priorities, and the setting of care
12. Model professionalism and be trustworthy for patients, peers, and communities

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