It Takes a Village to Redesign Residencies. . .

Warren P. Newton, MD, MPH and Michael Magill, MD

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After two years of re-envisioning family medicine residency education, [1–3] the Accreditation Council for Graduate Medical Education (ACGME) released draft standards for family medicine residencies for public comment on December 13, 2021. The Family Medicine Review Committee will revise them. If all goes well, the standards will be approved by the ACGME Board of Directors in June 2022 and become active by July 2023.

ABFM believes that these standards represent the most significant change in family medicine residency education since the 1970s. They are a serious response to the dramatic changes in patients and in health care since our founding in 1969: They promise a pathway for broad scope family physicians to play a major role in healing health care and the communities they serve. Further specification is necessary, but we are hopeful for the future.

But it will be a big lift, one that will take many years and one that will require the specialty to support residency directors, residency faculty and residents. The new standards require many changes, and this will occur after two years of pandemic with its associated organizational, financial and personal stresses. But the specialty has demonstrated remarkable engagement and resilience in residency redesign, and ABFM trusts that residency directors and faculty will be able to make most of these changes on their own, using the flexibility of the new standards to balance the needs of their community with availability of excellent educational experiences. However, for the big lifts–competency-based education, the practice is the curriculum and community engagement– the whole specialty will need to help.

The draft standards substitute systematic competency assessment for the 1650 visit requirement and many specific hour and curriculum requirements, with much more flexibility for residency directors. However, to take advantage of this opportunity, we believe that our program directors and faculty will need additional help. Although competency-based medical education (CBME) has been around for almost 50 years,[4] and although some family medicine faculty have gotten exposure to CBME as it has spread through undergraduate medical education, we have relatively few experts in CBME in family medicine residency education.

Residencies have already started to conduct meaningful competency evaluation with rotation evaluation forms addressing the ACGME six core competencies along with semiannual Clinical Competency Committee assessment of resident performance relative to milestones. These already require considerable effort and faculty, staff, and resident time to do well. But full CBME requires more, including robust resident engagement with their own learning, observation of competencies in specific clinical tasks by many observers, faculty development to improve the validity and reliability of observations, and program ability to flex resident experiences to support achievement of competency.

This is a tall order. A first and fundamental question is what competencies we should train for. We might start by building on the entrustable professional activities (EPAs) for residents that emerged from Family Medicine for America's Health. In this project, the specialty, led by STFM and AFMRD, identified 20 EPAs and mapped them to the initial ACGME residency milestones.[5,6] ABFM has used

From the American Board of Family Medicine, Department of Family Medicine, University of North Carolina (WPN); American Board of Family Medicine, Department of Family and Preventive Medicine, University of Utah (MM).

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Corresponding author: Warren P. Newton, MD, MPH, American Board of Family Medicine, 1648 McGrathiana Parkway, Suite 550, Lexington, KY 40511-1247, United States (E-mail: wnewton@theabfm.org).

these to inform its new examination blueprint. The ACGME's draft standards[7] describe approximately 68 competencies, and recently the American Academy of Family Physicians has set a list of 22, many of which have multiple parts.[8] Separately, the College of Family Physicians of Canada have identified approximately 27 competencies, along with 65 procedures and 105 common problems.[9] Innovation and progress will be difficult unless we agree on competency outcomes: this is urgent for all family medicine organizations to address.

A starting place is a manageable number of competencies and workable systems to use them. Residencies will need to develop or borrow assessments for each competency. If we are to preserve full scope family medicine, the assessment of inpatient medical care and maternity care competency will need to be robustly assessed.[10,11] The competencies will also need to harmonize with the ACGME milestones, which provide a method for tracking the developmental trajectory of residents and the performance of individual residencies.[12] To optimize CBME, residencies will need to develop learning environments in which residents cocreate their education, reviewing assessments frequently with clinical mentors. This, in turn, will require systems for capturing observations in real time and collating assessments for residents, faculty mentors and the clinical competency committee.

The perfect is the enemy of the good as we ramp up: Start with simple! For example, the M3 app[13,14] used by many residencies, provides real time feedback on specific clinical behaviors and automatically collates the information in a user-friendly way. Separately, Tufts[15] and many Canadian programs[16] have developed systems for collecting and reviewing hundreds of observations for each resident in each year, each linked to a competency. More broadly, ABFM believes that the specialty will need to work together to define a final set of competencies, develop a cadre of family experts in CBME in residency settings, perhaps working with the ACGME's existing robust faculty development programs. If we all share a model of which competencies we are aiming for and jointly develop a cadre of faculty with expertise, then the Association of Family Medicine Residency Directors, the Society of Teachers of Family Medicine, and the Association of Departments of Family Medicine are well suited to support development, assessment, and dissemination of CBME assessments and systems for managing them. Let us start at the 2022 spring meetings.

A second major lift for residencies is to implement the idea that "the practice is the curriculum." This is more than having patient panels, meaningful quality and cost metrics[17], and a patient and community advisory panel.[18] Whereas these are in themselves very important and challenging to implement, the core idea of enabling the practice to drive the curriculum is that residency clinical practices should be exemplars, modeling outstanding care across the continuum, constantly improving and making a difference in communities. In this context, the specialty should help define a limited number of metrics should represent excellent practice. ABFM urges focus on a limited number of metrics that really matter—access, continuity, referral rate, total cost and financial status of the practice. Beyond these metrics, practices should model telehealth that supports continuity and comprehensiveness of care, team-based care,[19] integrated behavioral health,[20] including not just screening with PHQ-2 (Patient Health Questionnaire) but also on-site treatment and registries for tracking patients with mental illness.

What should the specialty do to support "the practice is the curriculum?" Practice transformation is a long game, requiring clinical leadership; faculty, staff and resident engagement and development; and hands-on support of sponsoring institutions. The ACGME residency standards themselves will play an important role, requiring dedicated time for teaching and other education-related activities by residency faculty and setting priorities for electronic health records to enable patient panels and provide usable data for performance improvement. The specialty can help by defining the core measures and clinical standards necessary for outstanding primary care. Residencies themselves can focus a part of their didactics on practice transformation and begin to work with other residencies in networks. The draft standards call for participation in networks, and there is good evidence the residencies can improve care clinical significantly[21–23]; robust networks can support faculty, staff and resident development and provide connection and support. Partnering with others brings hope and company for the journey.

The third big lift is to engage communities. The commitment to community represents a response

to the social changes of the last several years and the need for fundamental improvement in the outcomes and disparities of our current health care. Of course, each residency will develop its own solutions for community engagement, based on local circumstances, resources, and partnership opportunities. ABFM believes that residencies and the broader specialty will have many creative solutions. The key components are a robust community needs assessment with significant engagement with community over time—more than a half day a week at a health department for a month! We hope that this work will show the promise of family medicine over time: working together, sharing ideas and outcomes, the specialty and the communities we serve will move forward. The academic organizations are well suited for supporting this work. We will learn from each other's innovations and work together to meet the needs of society.

As we write this editorial, many are commenting on the new standards, and family medicine organizations are distilling the feedback into broad themes for the Review Committee. As the process evolves, ABFM is committed to supporting excellence and innovation in residency education in whatever ways we can. This journey will take a number of years: We must give ourselves the grace of patience in the time of a pandemic. But we must start. We look forward to your suggestions. It takes a village. . .

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