

**ACGME Program Requirements for Graduate Medical Education
in Family Medicine
Summary and Impact of Major Requirement Revisions**

Requirement #: Definition of Specialty

Requirement Revision (significant change only):

Family physicians are generalists who care for diverse individuals in the context of their families and communities through accessible, comprehensive, continuous, and coordinated care. They provide empathic, compassionate, equitable, culturally humble and relationship-based care to their patients of all ages and life stages in a wide variety of settings.

As routinely the first contact for medical care, family physicians seek to understand and address the undifferentiated problems and health goals of patients. They have expertise in managing complexities and are able to address multiple co-morbidities through coordinated inter-disciplinary and inter-professional care. They are advocates for high-quality, cost-effective care providing high value to improve health outcomes and the patient experience, and to reduce care costs. Family physicians work to integrate knowledge of the structural determinants of health to advance equity in health and health care for all.

Family physicians provide care within the context of their patients' families and community, often caring for multigenerational members of the same family. This opportunity for contextual care gives family physicians an important perspective for understanding barriers to health. They use critical thinking skills in the service of understanding the patient illness experience, to arrive at a common shared therapeutic approach.

Family physicians are skilled in behavioral health, seeing the whole person and recognizing the breadth of unmet behavioral health needs in an increasingly complex society.

Family physicians excel at coordinated team-based care and are values-driven advocates of efficient care through their membership on diverse, inter-professional teams. They are superb communicators and serve as teachers to patients, colleagues, and community groups. They employ respect and compassion with colleagues and teams, as well as with patients and families. They embrace the concept of team care as members and leaders of the multiple teams required to provide complex and coordinated care.

Family physicians engage in self-reflection as master adaptive learners who continually assess professional development needs.

Family physicians are social justice advocates for their patients and their communities, engaging in health policy and local organizations, as appropriate, to voice and mitigate the impact of structural social determinants on health outcomes. They understand complex health issues and apply ethical principles to health care decisions as they care for diverse patient populations with diverse value structures within an unequal medical system.

Family physicians critically analyze and appropriately apply technology to provide better and more personal clinical care.

1. Describe the Review Committee's rationale for this revision:

Every 10 years, ACGME Review Committees are required to evaluate the applicable specialty-specific requirements for revision. The process used for this revision, which uses scenario-based strategic planning, requires a writing group (made up of Review Committee members and other stakeholders) and the specialty community to rigorously and creatively think about what the specialty will look like in the future prior to proposing any revisions, recognizing the future is marked with significant uncertainty.

Several themes emerged from the scenario planning efforts that provide insights into the family physicians of the future and their practice. It is recognized that the family physician of the future will not achieve full mastery of all these competencies during residency alone, but residency must serve as the foundation for career-long professional development and adaptation to a changing health care system and community needs.

This definition proposed here is therefore a much more comprehensive and inclusive definition of the specialty of family medicine. It captures seven themes that emerged from the consolidation of the diverse strategies:

- 1. Comprehensive clinically competent care (holistic/whole person)**
- 2. Community-focused population health**
- 3. Relationship-based communication**
- 4. Collaborative team-based leadership**
- 5. Adaptive lifelong learning**
- 6. Values-driven professionalism**
- 7. Technology integration**

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

As noted, the definition is a much more comprehensive and precise representation of the specialty of family medicine, the future of family medicine learners, and the commitment to improving the patient care these physicians deliver today and in their future independent practice.

3. How will the proposed requirement or revision impact continuity of patient care?

Continuous patient care is a foundational piece of the specialty of family medicine as will be highlighted throughout the document.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

N/A

5. How will the proposed revision impact other accredited programs?

N/A

Requirement #: I.B.5.

Requirement Revision (significant change only):

I.B.5 Participating sites should not require excessive travel without appropriate housing provisions, and when daily commuting is required, no more than one hour of travel time each way should be expected. (Core)

1. Describe the Review Committee's rationale for this revision:
Resident well-being was on the forefront of the Committee's thinking during the requirements revisions process. Acknowledging that programs may need to participate with other sites that are remote to provide residents with key educational/clinical experiences, the Committee felt programs must also ensure that, should circumstances arise whereby travel is not feasible, appropriate housing provisions must be accommodated to support resident well-being.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
To remove the potential stressor of lengthy travel or instances where travel is not feasible (weather issues, etc.) allows residents to focus on the care and well-being of their patients.
3. How will the proposed requirement or revision impact continuity of patient care?
By providing housing accommodations, residents may be freer to schedule time with a patient for continuity of care, rather than transferring care to another clinician in circumstances when they must travel to return to their primary clinical site.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
This requirement necessitate that an institution expend monetary resources to secure resident housing accommodations.
5. How will the proposed revision impact other accredited programs?
N/A

Requirement #: I.D.1.a)

Requirement Revision (significant change only):

I.D.1.a) The program must partner with other family medicine residency programs through regional learning collaboratives to share resources to facilitate programs and their Family Medicine Practice (FMP) sites attaining educational and community aims. (Core)

1. Describe the Review Committee's rationale for this revision:
The requirement encourages collaboration of learning within the program/institution itself, but also broadens that collaborative to create opportunities for programs to share their innovations with other programs and assist other programs to succeed in areas in which they may not have had the resources to do so before. Examples are areas of scholarship and sharing ideas and collaborating on scholarly works at the faculty member and resident levels.

N/A

Requirement #: I.D.1.e).(1)- I.D.1.e).(2)

Requirement Revision (significant change only):

I.D.1.e).(1)

Each FMP must organize patients into panels that link each patient to an identifiable resident and team. ^(Core)

I.D.1.e).(2)

Each FMP should have an identified panel reassignment process that includes notifying patients of changes to their primary physician (resident). ^(Detail)

1. Describe the Review Committee's rationale for this revision:
Residency is a critical time for establishing practice habits. There is strong evidence that quality and cost effectiveness are habits that are imprinted based on the environment in which a resident learns and trains. Patient panel organization for residents allows continuity and quality feedback that can help residents build quality and cost effectiveness skills. The proposed requirements are built on a foundation that the practice *is* the curriculum. An identifiable panel is crucial to assessment of competence and thus competency-based education.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
This revision will allow for improved assessment based on clinical outcomes for assigned patient panels. This direct feedback regarding panel outcomes will facilitate quality improvement.
3. How will the proposed requirement or revision impact continuity of patient care?
This requirement will improve continuity of care through clear identification of the assigned resident and care team.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
Most electronic health records have the capability to identify primary resident assignments and report this linkage. Modest additional administrative support may cause some financial impact for regular reporting.
5. How will the proposed revision impact other accredited programs?
N/A

Requirement #: I.D.1.i)-I.D.1.k)

Requirement Revision (significant change only):

<u>I.D.1.i)</u>	<u>Each FMP must utilize appropriate technology for communicating personal health information (PHI) securely.</u> ^(Core)
<u>I.D.1.j)</u>	<u>Telehealth modalities must be readily available.</u> ^(Core)
<u>I.D.1.k)</u>	<u>Interpretation services must be readily available for on-site in-person and telehealth services.</u> ^(Core)

- Describe the Review Committee's rationale for this revision:
Family physicians must ensure technology assists in the patient-physician relationship and enables and enhances compassionate patient-centered care. This technology should be accessible and provide improved continuity of care. To reduce disparities access must include appropriate interpretation services for both in-person and telehealth communications. The technology must be secure to ensure protection of personal health information. Residents will have an opportunity to continue to expand telehealth throughout their careers with ongoing advancements. It is important that the foundation established in residency is current and continues to expand with new technology.
- How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Access to communication with the care team through telehealth modalities improves patient satisfaction, access, and care quality.
- How will the proposed requirement or revision impact continuity of patient care?
This revision will expand continuity of care through communication via technology and telehealth services.
- Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
Most institutions have moved toward telehealth tools during the COVID-19 pandemic. Modest financial costs may be required as telehealth expands and technology innovations occur. Interpretation services are necessary to ensure access for all patients and for reducing health care inequities.
- How will the proposed revision impact other accredited programs?
N/A

Requirement #: I.D.1.l)-I.d.1.l).(a)

Requirement Revision (significant change only):

<u>I.D.1.l)</u>	<u>Each FMP must have members of the community, in addition to clinical leaders, serve on an advisory committee to assess and address health needs of the community.</u> ^(Core)
<u>I.D.1.l).(a)</u>	<u>The advisory committee should have demographic diversity and lived-experiences representative of the community.</u> ^(Detail)

1. Describe the Review Committee's rationale for this revision:
Family physicians are most effective when engaged in community-focused population health efforts. Family medicine practices need to have the perspectives of patients and community members to ensure that health care needs are being met. This revision requires the development of an advisory committee that is inclusive of diverse representation from the community including, those with lived experience, which will in turn provide perspectives essential to reducing health care inequities and recognizing barriers to health that may otherwise go unrecognized.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Patient care quality will be improved with appropriate representation from the community being served.
3. How will the proposed requirement or revision impact continuity of patient care?
N/A
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
Minimal additional institutional resources will be necessary, such as costs for administration of the advisory committee and for meeting support.
5. How will the proposed revision impact other accredited programs?
N/A

Requirement #: II.A.2.a)

Requirement Revision (significant change only):

II.A.2.a) At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program. Additional support for program leadership must be provided as specified below. This additional support may be for the program director only or divided among the program director and one or more associate (or assistant) program directors. ^(Core)

<u>Number of Approved Residents</u>	<u>Minimum support required (percent time/FTE or number of hours) for Program Director</u>	<u>Additional minimum support required (percent time/FTE or number of hours) for Program Leadership</u>
<u>1-6</u>	<u>20% FTE</u>	<u>n/a</u>
<u>7-12</u>	<u>20% FTE</u>	<u>10% FTE</u>
<u>13-18</u>	<u>40% FTE</u>	<u>10% FTE</u>
<u>19-30</u>	<u>50% FTE</u>	<u>20% FTE</u>

<u>31-45</u>	<u>60% FTE</u>	<u>30% FTE</u>
<u>46 or more</u>	<u>60% FTE</u>	<u>60% FTE</u>

1. Describe the Review Committee's rationale for this revision:
The proposed change is in alignment with the ACGME's new guidance related to dedicated administrative time.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
As reflected in the Background and Intent for Common Program Requirement II.A.2., the ultimate outcome of graduate medical education is excellence in resident/fellow education and patient care. The Common and specialty-specific Program Requirements related to administrative time and support are intended to ensure that the program director and, as applicable, the program leadership team, are able to devote a sufficient portion of their professional effort to the oversight and management of the program to ensure an effective and high-quality educational program.
3. How will the proposed requirement or revision impact continuity of patient care?
No impact is anticipated.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
The requirements define the required minimum dedicated time for administration of the program based on program size. For some programs, the new requirements represent a decrease in the minimum administrative time and support required for program leadership, while for other programs the new requirements represent an increase.

Programs for which the required minimum has decreased are encouraged to consider whether additional time and support should be provided based on factors such as program complexity and level of experience among the members of the program leadership team. It is anticipated that some programs may choose to decrease administrative time and support to the level specified in the new requirements if that is sufficient to meet the administrative requirements of the program. Other programs may determine that the time and support currently provided is optimal and elect not to make a change.

Programs for which the requirements for administrative time and support have increased will need, in partnership with their Sponsoring Institution, to provide additional support for administrative time as specified in the requirements.

Both provision of support for the time required for the leadership effort and flexibility regarding how this support is provided are important. Programs, in partnership with

their Sponsoring Institution, may provide support for this time in a variety of ways. Examples of support may include, but are not limited to, salary support, supplemental compensation, educational value units, or relief of time from other professional duties. Program directors and, as applicable, members of the program leadership team, who are new to the role may need to devote additional time to program oversight and management initially as they learn and become proficient in administering the program. It is suggested that during this initial period, the support described above be increased as needed.

5. How will the proposed revision impact other accredited programs?
Not applicable

Requirement #: II.A.3.e)

Requirement Revision (significant change only):

II.A.3.e) must include previous leadership experience. (Core)

1. Describe the Review Committee's rationale for this revision:
The median tenure of family medicine program directors is 4.5 years. The stability of programs depends on experienced leaders taking on the program director role. Succession planning and the development of associate or assistant program directors are strategies to ensure that departing program directors are leaving established programs set up for success. Previous leadership experience, particularly within graduate medical education, provides confidence that the program will make a smooth transition to new program leadership.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
This revision will ensure stability in resident education through transitions in program leadership.
3. How will the proposed requirement or revision impact continuity of patient care?
No impact on continuity of patient care is anticipated; stability of a program will ensure no negative impact.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
Leadership opportunities and professional development will be necessary to ensure recruitment and retention of strong, experienced leaders. This may require some institutional costs.
5. How will the proposed revision impact other accredited programs?
N/A

References:

Fernald D, Hester CM, Brown SR. Why Family Medicine Program Directors Leave Their Position. Fam Med. 2021;53(5):347-354. <https://doi.org/10.22454/FamMed.2021.746153>.

Requirement #: II.B.1.c)-II.B.1.d).(2)

Requirement Revision (significant change only):

II.B.1.c)	All programs must have family medicine physician faculty members <u>role modeling</u> and teaching and <u>providing broad spectrum family medicine that meets the mission of the program.</u> <small>(Core)</small>
II.B.1.c).(1)	maternal child health care, including deliveries; <small>(Core)</small>
II.B.1.c).(2)	inpatient adult medicine care; and, <small>(Core)</small>
II.B.1.c).(3)	care to inpatient children. <small>(Core)</small>
II.B.1.d)	<u>All programs must have family medicine faculty members role modeling competence in their respective scope of practice.</u> <small>(Core)</small>
II.B.1.d.(1)	<u>Programs should have family medicine faculty members providing care outside of an FMP, including skilled nursing facilities, hospital care, and home-based care.</u> <small>(Detail)</small>
II.B.1.d).(2)	<u>Programs providing maternity care competency training to the level of independent practice must have at least one family physician faculty member providing family-centered maternity care, including prenatal, intra-partum, vaginal delivery, and post-partum care.</u> <small>(Core)</small>

1. Describe the Review Committee's rationale for this revision:

The health care environments surrounding family medicine residency programs vary greatly based on patient population, practice patterns, geographic region, and size of community. The scope of practice based on the environment may cause challenges for role modeling. The proposed revision addresses this challenge by focusing the role modeling requirement on the mission of the program. Faculty members are expected to model competence in their scope of practice, but programs do not need to have faculty role models for all aspects of the breadth of family medicine if a particular element doesn't fit with the mission of the program or practice scope within the community served.

Programs that aim to provide education and training in maternity care are expected to have role models in this area.

Additionally, to provide comprehensive care, programs are expected to have faculty members providing care in settings outside of the FMP. The role modeling of care within the community in skilled nursing facilities (SNF), hospitals, and at home will ensure residents build confidence and competence in this care and are able to continue this community-based care in practice.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
The role modeling of broad-scope family medicine will improve resident education and patient care quality, particularly around transfers of care from hospital and SNF settings to home and ambulatory settings.
3. How will the proposed requirement or revision impact continuity of patient care?
This will improve continuity of care through transitions to different settings.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
Institutional support of full-spectrum family medicine will be necessary. There should be no financial impact of this revision. Some programs may choose to limit faculty members' scope of care to meet a program aim. For example, a program that does not intend to educate and train residents in independent maternity care may choose not to include a faculty member who performs maternity care. This may save expenses in some programs, particularly in regions where recruitment is challenging or malpractice insurance coverage is cost prohibitive.
5. How will the proposed revision impact other accredited programs?
N/A

Requirement #: II.B.2.i).(1)

Requirement Revision (significant change only):

II.B.2.i).(1) Each program should provide experience in integrated interprofessional behavioral healthcare. (Detail)

1. Describe the Review Committee's rationale for this revision:
Comprehensive care is essential to family medicine. The integration of behavioral health care is critical to comprehensive care. Integrated behavioral health care blends, in one setting, care for medical conditions and related behavioral health factors that affect health and well-being. The goal is better care and health for the whole person. While many FMPs have moved to an integrated behavioral health care model and have benefited from improved education and clinical care, other sites have not achieved integration yet. This proposed revision will ensure that programs have model practices with comprehensive care for educating and training future family physicians.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Research shows that integrated behavioral health improves health and patient experience, while reducing unnecessary costs in time, money, and delays.
3. How will the proposed requirement or revision impact continuity of patient care?
This requirement will allow continuity of care within the FMP for integration of medical care with behavioral health care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
This proposed requirement will necessitate that programs have a clinical psychologist or licensed clinical social worker to provide integrated behavioral health care. These professionals can support their salaries through appropriate billing for the clinical care they provide. Programs that currently have no integration within the FMP will incur some organizational costs to build the necessary structure.
5. How will the proposed revision impact other accredited programs?
Some programs may choose to integrate psychiatrists and psychiatry residency programs into the FMP or family medicine residency. This could allow opportunities for psychiatry residency programs to provide experience to their residents in the consultative model and within primary care settings.

References:

deGruy FV, McDaniel SH. Proposed Requirements for Behavioral Health in Family Medicine Residencies. *Fam Med.* 2021;53(7):516-520. <https://doi.org/10.22454/FamMed.2021.380617>.

Landoll RR, Cervero RM, Quinlan JD, Maggio LA. Primary Care Behavioral Health Training in Family Medicine Residencies: A Qualitative Study From a Large Health Care System. *Fam Med.* 2020;52(3):174-181. <https://doi.org/10.22454/FamMed.2020.681872>.

Requirement #: II.B.3.e)

Requirement Revision (significant change only):

II.B.3.e) The program director should integrate multiple non-physician professionals to augment education as well as inter-professional team clinical services. (Professions may include, but are not limited to NPs, CNSs, PAs, CNM, behavioral health, pharmacists, lab technicians.) (Detail)

1. Describe the Review Committee's rationale for this revision:
Family physicians meet the needs of patients within the context of highly effective interprofessional teams. The evidence for the impact of improved team function on meeting the Quadruple Aim* is robust. The integration of non-physician professionals in the education of family medicine residents will prepare residents for their future roles and also ensure that clinical services are provided within model practices.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Patient care quality and safety is improved through highly effective interprofessional teams.
3. How will the proposed requirement or revision impact continuity of patient care?
Team-based care improves continuity. Non-physician professionals extend the care the primary physician provides, and patients feel their care team is more available.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

Model FMPs are organized in teams that include interprofessional members as described in this proposed requirement. Evidence supports interprofessional teams in decreasing cost and increasing quality in primary care.

5. How will the proposed revision impact other accredited programs?

N/A

References:

Arenson C, Brandt BF. The Importance of Interprofessional Practice in Family Medicine Residency Education. *Fam Med.* 2021;53(7):548-555. <https://doi.org/10.22454/FamMed.2021.151177>.

*The Quadruple Aim simultaneously improved patient experience of care, population health, and health care practitioner work life, while lowering per capita cost.

Requirement #: II.B.4.c)-II.B.4.d)

Requirement Revision (significant change only):

II.B.4.c) There must be at least one core family medicine physician faculty member in addition to the program director for every six residents for programs with 12 or less residents, and one physician faculty member in addition to the program director for every four residents for programs with more than 12 residents~~in the program.~~ ^(Core)

II.B.4.d) At a minimum, the required core faculty members, in aggregate and excluding program leadership, must be provided with support equal to an average dedicated minimum of 25 percent time/FTE for educational and administrative responsibilities that do not involve direct patient care. ^(Core)

1. Describe the Review Committee's rationale for this revision:

Family medicine residency programs vary greatly in size and structure. These proposed requirements provide flexibility for programs of different sizes and structures to ensure appropriate faculty support. Smaller programs will be required to have a smaller number of faculty members as often their faculty cohort is smaller. Larger programs will be required to have a higher ratio as the complexity is greater. Aggregate time will allow programs to assign faculty responsibilities appropriate for the interests and aptitudes of the faculty members and to meet the unique structure of the program.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

This will improve resident education by providing programs the opportunity to use the strengths of the members of the faculty and provide adequate support to the curricular development and administration of the program.

3. How will the proposed requirement or revision impact continuity of patient care?

N/A

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
Faculty support is a necessary expense to programs and institutions. This may increase need for financial support for some programs, but may also decrease expenses for others. Previous requirements did not allow this amount of flexibility. Programs will be able to use their resources most efficiently for the best value.
5. How will the proposed revision impact other accredited programs?
N/A

Requirement #: II.C.2.a)

Requirement Revision (significant change only):

II.C.2.a) At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program. Additional administrative support must be provided based on program size as follows: ^(Core)

<u>Number of Approved Resident Positions</u>	<u>Minimum FTE Required for Coordinator Support</u>	<u>Minimum Additional Aggregate FTE Required for Administration of the Program</u>
<u>1-6</u>	<u>50</u>	<u>n/a</u>
<u>7-12</u>	<u>70</u>	<u>n/a</u>
<u>13-28</u>	<u>90</u>	<u>n/a</u>
<u>19-30</u>	<u>100</u>	<u>n/a</u>
<u>31-45</u>	<u>100</u>	<u>25</u>
<u>46 or more</u>	<u>100</u>	<u>50</u>

1. Describe the Review Committee's rationale for this revision:
The proposed change is in alignment with the ACGME's new guidance related to dedicated administrative time.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
The program coordinator plays a key role in developing and maintaining a high-quality educational program, and the Common and specialty-specific Program Requirements are intended to ensure that the FTE support for the coordinator is sufficient to meet the administrative needs of the program.
3. How will the proposed requirement or revision impact continuity of patient care?
No impact is anticipated.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
The requirements define the required minimum dedicated time for administration of the program based on program size. For some programs, the new requirements represent a decrease in the required FTE support for the coordinator, while for other programs the new requirements represent an increase. It is important to note that

the FTE support defined in the requirements must be devoted exclusively to responsibilities related to the accredited program. Time spent by a coordinator related to other duties, such as providing support for unaccredited fellowships or other departmental responsibilities, must not be counted toward the required FTE. Coordinators may support more than one accredited program only if the total FTE required across programs does not exceed 1.0 FTE.

Programs for which the required minimum has decreased are encouraged to consider whether additional time and support should be provided based on factors such as program complexity, the administrative responsibilities delegated to the coordinator, and the coordinator's level of experience. It is anticipated that some programs may choose to decrease administrative time and support to the level specified in the new requirements if that is sufficient to meet the administrative requirements of the program. Other programs may determine that the time and support currently provided is optimal and elect not to make a change.

Programs for which the requirements for administrative time and support have increased will need, in partnership with their Sponsoring Institution, to provide additional support for administrative time as specified in the requirements.

5. How will the proposed revision impact other accredited programs?
Not applicable

Requirement #: III.B.2.-III.B.3.

Requirement Revision (significant change only):

The program must offer at least ~~four~~two resident positions at each educational level. (Core)

The program should have at least ~~42~~6 actively enrolled residents. (Detail)

Specialty Specific Background and Intent: For an optimal learning environment, residents should be part of a cohort of learners. Smaller community programs provide important training opportunities and should maximize learning opportunities for the limited. Collaboration between programs is essential to providing diversity of faculty and residents for full spectrum training and role modeling.

1. Describe the Review Committee's rationale for this revision:
Family medicine is critical to serving the nation's primary care needs in all settings. This revision allows flexibility for smaller programs to serve the needs of rural and urban underserved communities. Improving access in rural communities requires that family physicians learn and train in these unique settings. Rural settings may not have the patient volume or resources to sustain a 4-4-4 program. The revision allows for smaller programs to capitalize on smaller quality learning environments. The education and training provided in these smaller programs will produce graduates who will serve in rural communities and allow for better health and life in rural America. Likewise, educating and training family medicine residents to work within urban underserved communities will provide graduates the skills and competence to serve these communities throughout their careers.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Patient access, care quality, and safety will improve with greater access to quality care in rural and urban underserved communities. The education and training will prepare family medicine residents to work in underserved communities with greater focus on triage, stabilization, and access in resource-limited environments.
3. How will the proposed requirement or revision impact continuity of patient care?
Continuity of patient care will be maintained as this is a critical aspect of the educational program in programs of all sizes.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
No additional resources will be required. The flexibility for smaller programs will reduce the burden for these programs and allow for better use of often limited resources.
5. How will the proposed revision impact other accredited programs?
N/A

References:

Schmitz D. The Role of Rural Graduate Medical Education in Improving Rural Health and Health Care. Fam Med. 2021;53(7):540-543. <https://doi.org/10.22454/FamMed.2021.792533>.

Requirement #: IV.B.1.b).(1).(a).(i)-IV.B.1.b).(1).(a).(i).(c)

Requirement Revision (significant change only):

[Residents must demonstrate competence to independently:]

IV.B.1.b).(1).(a).(i)	<u>integrate the family medicine approach to patients of all ages and life stages, including:</u>
<u>IV.B.1.b).(1).(a).(i).(a)</u>	<u>whole person care, family-centeredness, community-focused care, prioritizing continuity of care, first-contact access to care, coordination of complex care, and understanding allostatic load and the structural determinants of health;</u> <small>(Core)</small>
IV.B.1.b).(1).(a).(i).(b)	<u>understanding family dynamics, including impact of adverse childhood experiences; and,</u> <small>(Core)</small>
IV.B.1.b).(1).(a).(i).(c)	<u>addressing behavioral health and inequities in health and health care.</u> <small>(Core)</small>

1. Describe the Review Committee's rationale for this revision:
Family medicine is a unique specialty that is focused on the context of the individual within the family and community. The specialty is not limited by a patient's age, life stage, or diagnosis. The whole-person approach that integrates the tenets of primary care requires deliberate education and training in family dynamics and trauma-informed care, and the understanding of the impact of the structural determinants of health leading to inequities. Competence in these areas is essential to reducing inequities and improving access to care.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Patient access, care quality, and safety will all be improved with deliberate education and training to reduce inequities.
3. How will the proposed requirement or revision impact continuity of patient care?
Continuity of care will be prioritized through this approach.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
N/A
5. How will the proposed revision impact other accredited programs?
N/A

References:

Bazemore A, Grunert T. Sailing the 7C's: Starfield Revisited as a Foundation of Family Medicine Residency Redesign. *Fam Med.* 2021;53(7):506-515. <https://doi.org/10.22454/FamMed.2021.383659>.

Requirement #: IV.B.1.b).(1).(a).(xii)-IV.B.1.b).(1).(a).(xii).(f)

Requirement Revision (significant change only):

[Residents must demonstrate competence to independently:]

<u>IV.B.1.b).(1).(a).(xii)</u>	<u>provide care to women of childbearing age, including: (Core)</u>
<u>IV.B.1.b).(1).(a).(xii).(a)</u>	<u>diagnosing pregnancy and managing early pregnancy complications, to include diagnosis of ectopic pregnancy, pregnancy loss, and options counseling for unintended pregnancy; (Core)</u>
<u>IV.B.1.b).(1).(a).(xii).(b)</u>	<u>low-risk prenatal care; (Core)</u>
<u>IV.B.1.b).(1).(a).(xii).(c)</u>	<u>care of common medical problems arising from pregnancy or</u>

	coexisting with pregnancy; ^(Core) [Previously IV.B.1.b).(1).(c).(ii)]
<u>IV.B.1.b).(1).(a).(xii).(d)</u>	performing a <u>an uncomplicated</u> spontaneous vaginal delivery and ; ^(Core) [Previously IV.B.1.b).(1).(c).(iii)]
<u>IV.B.1.b).(1).(a).(xii).(e)</u>	demonstrating basic skills in managing obstetrical emergencies <u>and</u> ; and, ^(Core) [Previously IV.B.1.b).(1).(c).(iv)]
<u>IV.B.1.b).(1).(a).(xii).(f)</u>	<u>postpartum care, to include screening and treatment for post- partum depression, breastfeeding support, and family planning.</u> ^(Core)

1. Describe the Review Committee's rationale for this revision:
Comprehensive women's health care includes maternity care and is a defining feature of family medicine. Access to care for women in all life stages is essential to adequate health care particularly in rural and urban underserved communities. The proposed requirements and revisions require a minimum level of education and training that provides every graduate with the opportunity to develop competence in caring for women throughout all life stages consistent with the family medicine approach to comprehensive care.
 2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Patient care quality and safety are improved through access to care. These proposed requirements and revisions provide greater access to broad-scope women's health care.
 3. How will the proposed requirement or revision impact continuity of patient care?
Women will have greater continuity of care with the breadth of scope. Patients will be able to remain with their family physician during their childbearing years.
 4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
This will require that there are faculty members competent in women's health, as well as staffing and facilities to provide this care. (This is currently required, so no additional resources are necessary.)
 5. How will the proposed revision impact other accredited programs?
N/A
- References:
Barr WB. Women Deserve Comprehensive Primary Care: The Case for Maternity Care Training in Family Medicine. *Fam Med.* 2021;53(7):524-527. <https://doi.org/10.22454/FamMed.2021.451637>.

Requirement #: IV.B.1.b).(1).(a).(xiv)

Requirement Revision (significant change only):

[Residents must demonstrate competence to independently:]

IV.B.1.b).(1).(a).(xiv)

use multiple information sources to develop a personal patient care plan for patients based on current medical evidence and the biopsychosocial model of health; ^(Core) [Previously IV.B.1.b).(1).(a).(v)]

1. Describe the Review Committee's rationale for this revision:
Multiple morbidities affect greater than 50percent of people age 65 years or older. These multiple morbidities occur 10-15 years earlier in those with socioeconomic disadvantages, with greater incidence of mental health disorders as well. Family physicians are best suited to address these challenges. Residents must be educated and trained to address multiple morbidities through the use of multiple resources, including collaborative care plans, current evidence, and a biopsychosocial approach.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
This will improve patient safety and care quality by addressing complex care of individuals in an evidence-based approach.
3. How will the proposed requirement or revision impact continuity of patient care?
Care plans improve continuity of care within teams.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
N/A
5. How will the proposed revision impact other accredited programs?
N/A

References:

Mauksch L, Safford BH. Engaging patients in collaborative care plans. Fam Pract Manag. 2013 May-Jun;20(3):35-9. PMID: 23939738.

Mitchell KB, Bartell S. Multimorbidity and Resident Education. Fam Med. 2021;53(7):531-534. <https://doi.org/10.22454/FamMed.2021.106319>.

Requirement #: IV.B.1.c).(2)

Requirement Revision (significant change only):

IV.B.1.c).(2)

Residents must recognize the impact of the intersection of social and governmental contexts, including community

resources, family structure, trauma, racial inequities, mental illness, and addiction on health and health care received. ^(Core)

1. Describe the Review Committee's rationale for this revision:
The impact of the intersectionality of social contexts on health and health care have become more apparent. Family physicians have the opportunity to recognize the impact and reduce inequities.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Through the reduction of inequities, patient safety and care quality will be improved.
3. How will the proposed requirement or revision impact continuity of patient care?
Relationships will be improved through the recognition of intersectional impacts that will in turn improve continuity of patient care.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
N/A
5. How will the proposed revision impact other accredited programs?
N/A

Requirement #: IV.B.1.d).(1).(h)-IV.B.1.d).(1).(j)

Requirement Revision (significant change only):

Residents must demonstrate competence in:

IV.B.1.d).(1).(h) recognizing and pursuing individual career goals that incorporate local community needs and resources; ^(Core)

IV.B.1.d).(1).(i) demonstrating durable personal processes to respond to indicators of individual practice gaps and opportunities for improvement; and, ^(Core)

IV.B.1.d).(1).(j). providing feedback to others in a timely and specific manner. ^(Core)

1. Describe the Review Committee's rationale for this revision:
Adaptation of expertise over time is fundamental to the specialty of family medicine. These proposed requirements mandate residents' development of competence as master adaptive learners, which will serve graduates through their careers. Lifelong learning requires identification of goals based on community needs and responding to identified gaps. As team members and leaders, residents must not only receive, but be also able to provide feedback effectively.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
These requirements will improve resident education by developing processes for self-directed learning and self-assessment. As lifelong learners, residents will provide improved patient safety and care quality that addresses their community's needs.
3. How will the proposed requirement or revision impact continuity of patient care?
As residents assess community and patient needs, as well as opportunities to address gaps between resources and needs, continuity of care will be improved.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
Additional faculty development will be necessary regarding master adaptive learning techniques. Faculty members' time will be necessary to coach residents as they learn to be master adaptive learners and build independence.
5. How will the proposed revision impact other accredited programs?
N/A

References:

Edje L, Price DW. Training Future Family Physicians to Become Master Adaptive Learners. *Fam Med.* 2021;53(7):559-566. <https://doi.org/10.22454/FamMed.2021.192268>.

Requirement #: IV.B.1.e).(1).(g)-IV.B.1.e).(1).(h)

Requirement Revision (significant change only):

<u>IV.B.1.e).(1).(g)</u>	<u>establishing a trusted relationship with patients and their caregivers and/or families to elicit shared prioritization and decision-making; and, ^(Core)</u>
<u>IV.B.1.e).(1).(h)</u>	<u>communicating in a timely fashion through multiple methods, including telehealth and portals. ^(Core)</u>

1. Describe the Review Committee's rationale for this revision:
Patient centeredness is core to family medicine. Indicators of patient centeredness include patient engagement through shared decision-making and access to the health care team through multiple communication methods. The shared decision-making process allows agreement on a health care plan. Evidence demonstrates that when patients are involved with decision-making and understand what they need to do, they are more likely to follow through. The proposed requirements highlight the importance of these communication skills and resources for family medicine residents.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

Shared decision-making has been shown to improve patient-practitioner relationships and patient quality outcomes.

3. How will the proposed requirement or revision impact continuity of patient care?
Stronger patient-practitioner relationships will improve continuity of care.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
Additional technology resources may be required in some settings to provide portal access and telehealth.
5. How will the proposed revision impact other accredited programs?
N/A

References:

Ng CJ, Lee PY. Practising shared decision making in primary care. *Malays Fam Physician*. 2021;16(1):2-7. Published 2021 Mar 22. doi:10.51866/cm0001

Robert L. Ferrer, James M. Gill. Shared Decision Making, Contextualized. *The Annals of Family Medicine* Jul 2013, 11 (4) 303-305; DOI: 10.1370/afm.1551

Requirement #: IV.B.1.e).(2).(a)-IV.B.1.e).(2).(b)

Requirement Revision (significant change only):

<u>IV.B.1.e).(2).(a)</u>	<u>Residents must learn to assist patients with advance care planning that reflects the individual patient's goals and preferences.</u> ^(Core)
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<u>IV.B.1.e).(2).(b)</u>	<u>Residents must learn to address end-of-life goals in outpatient setting in advance of serious illness.</u> ^(Core)
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1. Describe the Review Committee's rationale for this revision:
The American Medical Association recognizes the process of advance care planning as a way to support patient self-determination, facilitate decision-making, and promote better care at the end of life. However, this process should not be limited to patients who are at the end of life. Discussions in advance of serious illness allows patients to make clear any preferences they have with respect to specific interventions. Critically important to these discussions is also their identification of who they want to make decisions for them in the event they cannot do so for themselves. Family medicine physicians are in a key position to have these discussions with patients and their families.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
There are multiple key outcomes to appropriate advance care planning, including improved patient and practitioner satisfaction and decreased moral distress in practitioners.
3. How will the proposed requirement or revision impact continuity of patient care?

These discussions build relationships between physicians, patients, patients' families and other caregivers. The strengthening of these relationship supports continuity of care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

Appropriate faculty development and resident education and training will require minimal additional resources.

5. How will the proposed revision impact other accredited programs?

N/A

References:

AMA Code of Medical Ethics Opinion 5.1. Accessed at <https://www.ama-assn.org/delivering-care/ethics/advance-care-planning> on 11.28.2021.

Requirement #: IV.B.1.f).(2).(a)

Requirement Revision (significant change only):

IV.B.1.f).(2).(a)

Residents must recognize and utilize community resources to promote the health of the population and partner to respond to community needs. ^(Core)

1. Describe the Review Committee's rationale for this revision:

Engaging with the community is important to the success of population-based initiatives and addressing community needs. Residents will learn to define their practice community and utilize a community needs assessment to set goals to improve population health within the community. These skills will be essential to their success in practice following graduation.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

This will improve resident education in community health and better prepare residents for future practice. Patient care quality will improve with a community-focused approach to care.

3. How will the proposed requirement or revision impact continuity of patient care?

N/A

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

Partnering with community resources will require relationship-building. The diversity of patients may broaden with greater service to the community.

5. How will the proposed revision impact other accredited programs?

N/A

References:

Wheat S. Community: The Heart of Family Medicine. Fam Med. 2021;53(7):528-531.
<https://doi.org/10.22454/FamMed.2021.503235>.

Requirement #: IV.C.2.a)

Requirement Revision (significant change only):

IV.C.2.a)

The program must provide instruction in a holistic pain management approach that includes pharmacologic and non-pharmacologic methods and an interdisciplinary team. (Core)

1. Describe the Review Committee's rationale for this revision:
Family physicians are in a unique position to address pain management through a patient-centered approach. To successfully meet patients' pain management needs while reducing risk of opioid dependence, family medicine residents must be educated and trained in holistic pain management with a multi-modal approach.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Patient safety and patient care quality will be greatly improved with a holistic pain management approach with an interdisciplinary team.
3. How will the proposed requirement or revision impact continuity of patient care?
Patients will be able to maintain continuity with their family medicine resident primary physician and the FMP with comprehensive pain management available.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
Faculty development and curricular development will incur minimal costs.
5. How will the proposed revision impact other accredited programs?
N/A

References:

2021 GME Stakeholders Congress on Preparing Residents and Fellows to Manage Pain and Substance Use Disorder Summary of Recommendations. Accessed at <https://www.acgme.org/globalassets/pdfs/opioidusedisorder/2021opioidcongresssummaryofrecommendations.pdf> on November 28, 2021.

Requirement #: IV.C.3.c).(5).(b)-IV.C.3.c).(6)

Requirement Revision (significant change only):

The resident's panel of continuity patients must be of sufficient size and diversity to ensure adequate education as well as patient access and continuity of care. (Core)

Panel must include a minimum 10% pediatric patients (less than 18 years of age). (Core)

Panel must include a minimum 10% older adult patients (older than 65 years of age). (Core)

Panel size and composition for each resident must be regularly assessed and rebalanced as needed. (Core)

Any gaps in the diversity of the panel (e.g., demographic and medical conditions) should be addressed. (Detail)

The resident's FMP experience must maximize continuity with their panel and engage team-based coverage when the resident is unavailable. (Core)

Residents must be able to maintain concurrent commitments to their patients in the FMP site during rotations in other areas/services as program required. (Core)

1. Describe the Review Committee's rationale for this revision:
Family physicians are generalists who care for diverse individuals of all ages and life stages. Family medicine residents need to build competence in comprehensive care. A diverse panel is essential to this experience to allow strong continuity relationships. Family physicians provide care within the context of their patients' families and community, often caring for multigenerational members of the same family. This continuity provides an important perspective for understanding barriers to health. Maximizing continuity through maintaining connection to FMPs during rotations in other areas is critical to building and maintaining the relationships that will provide the appreciation of the contextual nature of family medicine.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Comprehensive continuity care is associated with improved quality and value of care. Diverse panels of patients will improve resident education by allowing continuity experience with patients of all ages and stages of life.
3. How will the proposed requirement or revision impact continuity of patient care?
This addresses the importance of continuity of patient care with a diverse patient panel. The continuity will also include team-based coverage to ensure that relationship with the FMP is maintained for the patient.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
Additional IT resources may be needed to provide accurate assessments of panels. Though most electronic health records should be able to provide reports, pulling the reports and ensuring accuracy will require some administrative support. Maintenance of continuity in the complex residency schedule is essential but also requires additional administrative resources.
5. How will the proposed revision impact other accredited programs?
N/A

References:

Andrew Bazemore, Stephen Petterson, Lars E. Peterson, Robert L. Phillips. More Comprehensive Care Among Family Physicians is Associated with Lower Costs and Fewer Hospitalizations. The Annals of Family Medicine May 2015, 13 (3) 206-213; DOI: 10.1370/afm.1787

Requirement #: IV.C.3.d)-IV.C.3.f).(2)

Requirement Revision (significant change only):

<u>IV.C.3.d)</u>	<u>Residents must have experience dedicated to the care of newborns, including well and ill newborns.</u> ^(Core)
<u>IV.C.3.d).(1)</u>	<u>This experience should include inpatient and ambulatory settings, including in the continuity practice.</u> ^(Detail)
<u>IV.C.3.e)</u>	Residents must have 200 hours (or two months) of experience dedicated to the care of children and adolescents in the ambulatory setting. ^(Core) [previously IV.C.9.]
<u>IV.C.3.e).(1)</u>	<u>This care must include well-child care, acute care, and chronic care.</u> ^(Core) [previously IV.C.9.a)]
<u>IV.C.3.e).(2)</u>	<u>This care must include care of children of all ages, including infants, preschool-aged children, and school-aged children, and adolescents.</u> ^(Core)
<u>IV.C.3.f)</u>	Residents must have at least 200 hours (or two months) 100 hours (or one month) of and 250 patient encounters dedicated to the care of <u>experience with the care of acutely ill child patients</u> in the hospital and/or emergency setting. ^(Core) [previously IV.C.8.]
<u>IV.C.3.f).(1)</u>	This experience should include a minimum of 75 50 inpatient encounters. ^(Detail) [previously IV.C.8.a)]
<u>IV.C.3.f).(2)</u>	This experience should include a minimum of 75 50 emergency department encounters. ^(Detail) [previously IV.C.8.b)]

1. Describe the Review Committee's rationale for this revision:

Competence to care for children in the family medicine practice is critical to access for patients across the country and in particular in rural and urban underserved settings. Few family physicians care for hospitalized children as part of routine practice in the current environment. Hospitalized children are more often cared for by specialists in pediatric hospitalized care, and general pediatricians are also giving up hospital medicine.

The revisions maintain education and training in care of children at all ages in all settings to ensure comprehensive experience. Family physicians must be able to recognize ill children and access resources for appropriate care. The requirements ensure experiential learning with the breadth and volume of potential patients to

build competence in caring for children of all ages with diverse issues, including well care, acute care, and chronic care.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

The proposed language will ensure adequate volume and experience to provide high-quality patient care and safety.

3. How will the proposed requirement or revision impact continuity of patient care?

Residents will provide care for children of all ages in the continuity FMP, which will strengthen their skills in the outpatient continuity setting.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

The institution will need to support the incorporation of the residents within the pediatric services (newborn, emergency department, and inpatient).

5. How will the proposed revision impact other accredited programs?

The revisions may reduce the experience in some settings, and this might cause a reduction in workforce for some pediatric services. This may have impact on pediatric residencies in some settings.

Requirement #: IV.C.3.g)

Requirement Revision (significant change only):

IV.C.3.g)

Residents must have ~~at least 100 hours (or one month) or 125 patient encounters~~ an experience dedicated to the care of women with gynecologic issues, including well-woman care, family planning, contraception, and options counseling for unintended pregnancy. ^(Core) [previously IV.C.13.]

1. Describe the Review Committee's rationale for this revision:

No change to this requirement other than placement.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

N/A

3. How will the proposed requirement or revision impact continuity of patient care?

N/A

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

N/A

5. How will the proposed revision impact other accredited programs?

N/A

Requirement #: IV.C.3.h)-IV.C.3.h).(2)-(a)

Requirement Revision (significant change only):

IV.C.3.h) Residents must have at least 200 hours (or two months) dedicated to participating in ~~deliveries and providing prenatal and post-partum~~ maternity care. ^(Core) [previously IV.C.14.]

IV.C.3.h).(1) This experience must include a structured curriculum in prenatal, intra-partum, and post-partum care. ^(Core) [previously IV.C.14.a)]

IV.C.3.h).(1).(a) Residents must care for pregnant women in the outpatient setting, including prenatal care and the care of medical issues that arise in pregnancy. ^(Core)

IV.C.3.h).(1).(b) Each resident must have experience with a minimum of 25 vaginal deliveries. ^(Core)

IV.C.3.h).(1).(c) Each resident should care for post-partum women, including care for mother-baby pairs. ^(Detail)

IV.C.3.h).(1).(d) Some of the maternity experience should include the prenatal, intra-partum, and post-partum care of the same patient in a continuity care relationship. ^(Detail) [previously (IV.C.15.a)]

IV.C.3.h).(2) Residents who seek the option to incorporate comprehensive maternity care, including intra-partum maternity care and vaginal deliveries into independent practice, must complete at least 400 hours (or four months) dedicated to training on labor and delivery and perform or directly supervise at least 80 deliveries. ^(Core)

1. Describe the Review Committee's rationale for this revision:

Comprehensive care in family medicine includes care of women of childbearing age. The US rising maternal mortality, disproportionately affecting rural and Black, Indigenous, and People of Color (BIPOC) patients. Additionally, nearly half of US counties have no obstetricians/gynecologists, often leaving rural and urban underserved communities without access to care. Family physicians will likely encounter the need to care for pregnant women regardless of their choice of practice scope. It is critical that residents develop competence in caring for women in all stages, including during pregnancy.

Additionally, there is significant variation in scope of practice in different regions of the US. These proposed requirements provide the flexibility for some programs to

provide residents with the opportunity to develop competence in comprehensive maternity care with additional required experience. This flexibility is critical to allow future employers the ability to credential with evidence of appropriate experience.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

The proposed requirements will improve resident education by allowing flexibility and individualized learning based on future practice goals.

How will the proposed requirement or revision impact continuity of patient care?

The proposed requirements maintain the importance of some of the maternity experience to be within a continuity care relationship.

3. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

Faculty members will be necessary to provide residents with education in maternity care and to serve as role models in programs that plan to provide opportunities for education in provision of low-risk maternity care. This may reduce resources needed by some programs.

4. How will the proposed revision impact other accredited programs?

These requirements should not impact other programs. In some environments, obstetrics and gynecology programs may be impacted with reduced family medicine workforce on their service. In other institutions, there may be a need to collaborate with obstetrics and gynecology programs in new ways for individual residents interested in independent practice in maternity care.

Requirement #: IV.C.3.i).(1)

Requirement Revision (significant change only):

IV.C.3.i).(1)

Residents must have at least 100 hours (or one month) or ~~15 encounters dedicated to participate in the care of~~ ICU patients hospitalized in a critical care setting. (Core)
[previously IV.C.5.a)]

1. Describe the Review Committee's rationale for this revision:

No change to this requirement other than placement.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

N/A

3. How will the proposed requirement or revision impact continuity of patient care?

N/A

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

N/A

5. How will the proposed revision impact other accredited programs?

N/A

Requirement #: IV.C.3.j)

Requirement Revision (significant change only):

IV.C.3.j)

Residents must have at least ~~200 (or two months)~~100 hours of emergency department experience~~250~~ and at least 125 patient encounters dedicated to the care of acutely ill or injured adults in an emergency department setting. ^(Detail)~~(Core)~~ [previously IV.C.6.a)]

1. Describe the Review Committee's rationale for this revision:

No change to this requirement other than placement.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

N/A

3. How will the proposed requirement or revision impact continuity of patient care?

N/A

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?

N/A

5. How will the proposed revision impact other accredited programs?

N/A

Requirement #: IV.C 3.k)-IV.C.3.k).(2)

Requirement Revision (significant change only):

IV.C.3.k)

Residents must have at least ~~100 hours (or one month) or 125 patient encounters~~ a dedicated experience to in the care of older adults of at least 100 hours or one month and at least 125 patient encounters. ^(Core) [previously IV.C.7.]

IV.C.3.k).(1)

The experience must include functional assessment, disease prevention and health promotion, and management of adults with multiple chronic ~~diseases~~ conditions. ^(Core) [previously IV.C.7.a)]

IV.C.3.k).(2)

The experience should incorporate care of older adults across a continuum of sites. ^(Detail) [previously IV.C.7.b)]

1. Describe the Review Committee's rationale for this revision:

No change to this requirement other than placement.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
N/A
3. How will the proposed requirement or revision impact continuity of patient care?
N/A
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
N/A
5. How will the proposed revision impact other accredited programs?
N/A

Requirement #: IV.C.3.I)-IV.C.3.I).(1)

Requirement Revision (significant change only):

IV.C.3.I) Residents ~~must have at least 100 hours (or one month)an experience~~ dedicated to the care of surgical patients, ~~including hospitalized surgical patients.~~ ^(Core)
[previously IV.C.11.]

IV.C.3.I).(1) This experience should include pre-operative assessment, post-operative care coordination and identifying the need for surgery. ^(Detail)

1. Describe the Review Committee's rationale for this revision:
Comprehensive family medicine includes care of patients in all stages, including care of surgical patients. These proposed requirements leave flexibility for the length of experience and setting. Experience should include surgical patients throughout the surgical experience. Family physicians will often be the point of first contact for acute illness that might include problems that require surgical intervention. Residents must have experience in identifying the need for surgery, as well as provide continuity of care for their patients who need pre-operative assessment and when they are in recovery post-operatively.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Continuity of care throughout a surgical experience will assist in care coordination and maintenance of chronic illness.
3. How will the proposed requirement or revision impact continuity of patient care?
N/A
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
N/A
5. How will the proposed revision impact other accredited programs?

Some programs may currently be providing workforce resources in surgery teams. There may be an impact to some surgery programs if workforce is withdrawn or redistributed to meet the new requirement.

Requirement #: IV.C.3.m)-IV.C.3.m).(3)

Requirement Revision (significant change only):

<u>IV.C.3.m)</u>	Residents must have <u>at least 200 hours (or two months)an experience</u> dedicated to the care of patients with a breadth of musculoskeletal problems, <u>including:</u> ^(Core) [previously IV.C.12]
<u>IV.C.3.m).(1)</u>	<u>orthopaedic and rheumatologic conditions;</u> ^(Core)
<u>IV.C.3.m).(2)</u>	a structured sports medicine experience; ^(Core) and, [previously IV.C.12.a)]
<u>IV.C.3.m).(3)</u>	<u>experience in common outpatient musculoskeletal procedures.</u> ^(Core)

1. Describe the Review Committee's rationale for this revision:
Family physicians provide first-contact care for musculoskeletal problems in many situations. Musculoskeletal complaints account for 10-15 percent of all visits to primary care physicians. Specialty referrals are reduced when confidence in musculoskeletal care is improved. These proposed requirements and revisions allow programs to use available resources to build an experience that incorporates the breadth of musculoskeletal care without dictating amount of time in any setting or specialty.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Improved quality of patient care will be provided through access to musculoskeletal care in primary care setting and decreased need for referral.
3. How will the proposed requirement or revision impact continuity of patient care?
N/A
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
N/A
5. How will the proposed revision impact other accredited programs?
N/A

Requirement #: IV.C.3.n)-IV.C.3.n).(2)

Requirement Revision (significant change only):

IV.C.3.n) Residents must have experience in ~~diagnosing and managing~~ evaluating ~~common~~ dermatologic presentations and managing common dermatologic conditions. ^(Core) [previously IV.C.16.]

IV.C.3.n).(1) This experience must include evaluation of dermatologic findings in patients with a variety of skin colors and types. ^(Core)

IV.C.3.n).(2) This experience should include training in common dermatologic procedures. ^(Detail)

1. Describe the Review Committee's rationale for this revision:
Family physicians often provide the first point of care for dermatologic conditions. Access to quality care is important to address health care inequities in dermatologic conditions. Revisions expand experience in dermatology to require evaluation of diverse skin colors and types. Procedural education and training are important to reducing delays in diagnosis and treatment for skin disorders.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Reduction in delay in diagnosis and decrease in need for referrals through comprehensive dermatologic education and training will improve patient care quality.
3. How will the proposed requirement or revision impact continuity of patient care?
Continuity of care will be increased with residents' expanded breadth of dermatologic skills.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
Minimal resources may be needed for faculty development.
5. How will the proposed revision impact other accredited programs?
N/A

References:

Buster KJ, Stevens EI, Elmets CA. Dermatologic health disparities. *Dermatol Clin.* 2012;30(1):53-viii. doi:10.1016/j.det.2011.08.002

Requirement #: IV.C.3.o)-IV.C.3.o).(2).(a)

Requirement Revision (significant change only):

IV.C.3.o) The curriculum must incorporate behavioral health ~~is integrated into the residents' total educational experience, to include the physical~~ into all aspects of patient care. ^{(Detail)(Core)} [previously IV.C.17.]

<u>IV.C.3.o).(1)</u>	There must be a structured curriculum in which Residents are educated <u>must have a dedicated experience in the diagnosis and management of common mental illnesses, including interprofessional training in cognitive behavioral therapy, motivational interviewing, and psychopharmacology.</u> ^(Core) [previously IV.C.18.]
<u>IV.C.3.o).(2)</u>	<u>This experience should include identification and treatment of substance use disorders, including alcohol use disorder and Opioid Use Disorder.</u> ^(Detail)
<u>IV.C.o).(2).(a)</u>	<u>Treatment should include pharmacologic and non-pharmacologic methods and an interdisciplinary team.</u> ^(Detail)

1. Describe the Review Committee’s rationale for this revision:
Family medicine physicians are often the first point of contact for patients with behavioral health issues and mental illness. Broad experience, including the incorporation of behavioral health in all aspects of patient care, is critical to developing competence in family medicine. Applying the biopsychosocial model to care and providing patients adequate support through evidence-based modalities improve care of chronic illnesses and substance use disorders.
 2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Physician satisfaction, as well as quality and effectiveness of care are improved with competence in behavioral health.
 3. How will the proposed requirement or revision impact continuity of patient care?
N/A
 4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
Some programs may need to add behavioral health faculty members to ensure support for education and training in the full scope of care as described by the proposed requirements and revisions. Integration of behavioral health faculty members also allows reimbursement for clinical services provided.
 5. How will the proposed revision impact other accredited programs?
N/A
- References:
deGruy FV, McDaniel SH. Proposed Requirements for Behavioral Health in Family Medicine Residencies. Fam Med. 2021;53(7):516-520. <https://doi.org/10.22454/FamMed.2021.380617>.

Requirement #: IV.C.3.p)-IV.C.3.p).(4)

Requirement Revision (significant change only):

IV.C.3.p)	There must be a structured curriculum experience in which residents address population health, including the evaluation of health problems in the community. ^{(Detail)(Core)} [previously IV.C.19.)]
IV.C.3.p).(1)	<u>Each resident must have experience with providing clinical care to underserved populations.</u> ^(Core)
IV.C.3.p).(2)	<u>This curriculum should incorporate education and integration of assessment of health inequities and disparities in health care.</u> ^(Detail)
IV.C.3.p).(3)	<u>This curriculum should be relevant to the unique geographic and social context of the communities served by the program and include training and experience in advocacy.</u> ^(Detail)
IV.C.3.p).(4)	<u>Residents should incorporate the community-oriented primary care model, linking their clinical care to the needs of the community and engaging with the practice's community and patient/family advisory group.</u> ^(Detail)
<p>1. Describe the Review Committee's rationale for this revision: Family physicians are most effective when engaged in community-focused population health efforts. Providing education and training in this area will ensure graduates are prepared for their future practice. Engaging with community and public health agencies will broaden the impact of the practice, improve the health of the population, address the impact of social determinants of health, and reduce health inequities.</p> <p>2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality? Resident education will broaden to understand public health in a more substantive way, including the use of community-oriented primary care and community health assessment. The incorporation of these competencies will encourage partnerships between community agencies and the FMPs.</p> <p>3. How will the proposed requirement or revision impact continuity of patient care? Residents will be more engaged with the community of the FMP, and this may positively impact continuity of care.</p> <p>4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how? Additional partnerships with social scientists and community agencies may need to be formed to provide adequate education in community health. Modest financial support may be necessary to engage interprofessional faculty members.</p> <p>5. How will the proposed revision impact other accredited programs? N/A</p>	

Requirement #: IV.C.3.r).(4)-IV.C.3.r).(4).(a)

Requirement Revision (significant change only):

IV.C.3.r).(4)

Residents must receive regular data reports of individual/panel and practice ~~productivity, financial performance, and clinical quality, as well as the training needed to analyze these reports patterns.~~ ^(Core) [previously IV.C.22.c)]

IV.C.3.r).(4).(a)

Reports should include: clinical quality, health inequities, patient safety, patient satisfaction, continuity with patient panel and referral, diagnostic utilization rates, and financial performance. ^(Detail) [previously elements of IV.C.22.c)]

1. Describe the Review Committee's rationale for this revision:
Outcome data is critical to improving quality in practice. Model practices will provide this data to physicians to participate in ongoing improvement efforts. Residents will need access to the data and education and training in analyzing this data to plan improvement efforts for their individual practice as well as for the FMP.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Ongoing practice improvement will improve patient safety and care quality.
3. How will the proposed requirement or revision impact continuity of patient care?
Programs will be able to monitor continuity more closely with the reports and attach improvement programs to continuity as indicated for the practice or individual residents.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
Additional IT resources may be needed to provide accurate assessments of panels and practice patterns. Though most electronic health records should be able to provide reports, pulling the reports and ensuring accuracy will require some administrative support.
5. How will the proposed revision impact other accredited programs?
N/A

Requirement #: IV.C.3.s)-IV.C.3.s).(1)

Requirement Revision (significant change only):

IV.C.3.s) ~~The curriculum should include~~ Residents must have experience in diagnostic imaging interpretation pertinent to family medicine.
(Core) [previously IV.C.23.]

IV.C.3.s).(1) Residents should have experience in using point-of-care ultrasound in clinical care. (Detail)

1. Describe the Review Committee's rationale for this revision:
As the first point of care and to provide comprehensive care, family physicians must have a strong fund of knowledge and experience in diagnostic imaging interpretation. Point-of-care ultrasound is an emerging technology that optimizes patient-centered care. Programs need to continue to expand technology with evidence of improved quality and teach residents to use new technology, as well as to incorporate innovations.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Accurate and efficient diagnostic imaging interpretation at the point of care improves quality and patient safety.
3. How will the proposed requirement or revision impact continuity of patient care?
Expansion of scope of care allows increased continuity of patient care.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
Institutional resources will be necessary to ensure point-of-care ultrasound is available. This may include faculty development, as well as equipment costs. The return on investment with appropriate reimbursement will be a net benefit, but initial expenditures may be present.
5. How will the proposed revision impact other accredited programs?
Family medicine residents will benefit from collaboration with radiology programs in settings where available. This collaboration may provide benefit to the radiology program as well. In some settings, if point-of-care ultrasound is most available in emergency medicine, family medicine residents may access education and training in this setting as well as in the ambulatory setting. Neither of these collaborations (radiology and emergency medicine) should negatively impact other residency programs, and may provide teaching opportunities.

Requirement #: IV.D.1.b).(1)

Requirement Revision (significant change only):

IV.D.1.b).(1) The program must use regional learning collaboratives to create and share scholarly activity. (Core)

1. Describe the Review Committee's rationale for this revision:
The requirement encourages collaboration of learning within the program/institution itself, but also broadens that collaborative to create opportunities for programs to

share their innovations with and assist other programs to succeed in areas in which they may not have had the resources to do so before. Examples include areas of scholarship and sharing of ideas and collaboration on scholarly works at the faculty member and resident levels.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Multi-institutional scholarship will improve patient care quality and safety. Resident education will be expanded around collaboration, networking, and scholarship.
3. How will the proposed requirement or revision impact continuity of patient care?
N/A
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
There should not be a need for additional financial resources as most institutions already possess the technology that allows programs to collaborate and share ideas.
5. How will the proposed revision impact other accredited programs?
This revision will provide an example for other disciplines.

Requirement #: IV.D.3.c)-IV.D.3.d)

Requirement Revision (significant change only):

<u>IV.D.3.c)</u>	<u>Residents should work in teams to complete scholarship, partnering with interdisciplinary colleagues, faculty members, and peers.</u> (Detail)
<u>IV.D.3.d)</u>	<u>Residents should disseminate scholarly activity through presentation or publication in local, regional, or national venues.</u> (Detail)

1. Describe the Review Committee's rationale for this revision:
Family physicians must have the competence to contribute to evidence-based medicine and ensure ongoing expansion and understanding of quality care. Scholarly contributions should focus on better patient outcomes and improving population health. Team-based scholarly activity with dissemination will lead to further advancements and improve population health.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Scholarship will improve patient safety and care quality. Resident education will expand to include regular dissemination of scholarly work.
3. How will the proposed requirement or revision impact continuity of patient care?
N/A

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
Additional institutional resources may be needed to develop local collaborations and venues for dissemination.
5. How will the proposed revision impact other accredited programs?
Other institutional programs could benefit from collaboration and local venues for scholarly work dissemination, such as a GME Quality Symposium or other such event.

References:

Harper DM. Family Medicine Researchers—Why? Who? How? When? Fam Med. 2021;53(7):647-649. <https://doi.org/10.22454/FamMed.2021.629549>.

Requirement #: V.A.1.b).(2).(a)

Requirement Revision (significant change only):

V.A.1.b).(2).(a)

Evaluation of the FMP continuity experience should include assessment of quality measures, EHR management, and care coordination. (Detail)

1. Describe the Review Committee’s rationale for this revision:
Outcome data is critical to improving quality in practice. Model practices will provide this data to physicians to participate in ongoing improvement efforts. Residents will need access to the data, as well as education and training on analyzing this data to plan improvement efforts for their individual practice and for the FMP.
2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
Evaluation of the FMP continuity experience will allow for quality improvement efforts and improved patient safety through care coordination.
3. How will the proposed requirement or revision impact continuity of patient care?
Measuring continuity of care should allow for improvement.
4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
Additional IT resources may be needed to provide accurate assessments of panels. Though most electronic health records should be able to provide reports, pulling the reports and ensuring accuracy will require some administrative support. Maintenance of continuity in the complex residency schedule is essential but also requires additional administrative resources.
5. How will the proposed revision impact other accredited programs?
N/A

