Procedures in Family Medicine: Requirements for ABFM Board Eligibility

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Objectives

- Describe rationale and development of the ABFM list of required procedures
- Describe how the list will be used and provide data on current status of implementation
- Answer frequently asked questions…

Thank you!

The Journey from Core Outcomes to Competency Based Board Eligibility

From the American Board of Family Medicine

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CORE OUTCOMES OF RESIDENCY TRAINING 2022 (PROVISIONAL)

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

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

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

The key features of CBME are now well understood (Table 1).[6] The first step is "to start with the end in mind"—to define the outcomes we expect from family medicine residencies. To that end, the ACGME RCFM, with input from ABFM, has begun to define the core outcomes of family medicine residency education. Beginning with the Entrustable Professional Activities (EPAs) developed as a part of *Family Medicine for Americas Health* by the American Academy of Family Physicians (AAFP), ABFM, American College of Osteopathic Family Physicians, the Association of Departments of Family Medicine, the Association of Family Medicine Residency Directors, NAPCRG, and the Society of Teachers of Family Medicine (STFM), along with concepts from the ACGME core competencies.[7,8] A national summit of family medicine organizations January 19-20, 2023 provided broad input, and a revised document was reviewed again by the RCFM, the ABFM, the leadership of the AAFP, and the Family Medicine Leadership Council in February 2023.

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

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

BOARD NEWS

Implementing Competency Based ABFM Board Eligibility

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The transition from residency education that emphasizes counts and hours to competency assessment is a major change for Family Medicine. Starting July 1, 2023, it will affect all program directors, faculty, and residents. How should our community support this change?

Keeping in mind the "why" of residency redesign is important. Despite rhetoric of transformation and tech-driven innovation, the outcomes of health care in the US are getting steadily worse in comparison to other affluent countries[1]; life expectancy is declining,[2] even as costs rise unsustainably. Moreover, the pandemic has driven us to rediscover[3] disparities and has accelerated burnout and moral injury among family physicians and their teams. To meet the needs of our patients, communities, and health teams, Family Medicine must step up.

We in Family Medicine believe that well trained personal family physicians supported by robust teams and policy can be an antidote to the crisis in health and health care. The goal of the major revision of the ACGME Requirements for Family Medicine is to train the family physicians who can meet these needs. The new requirements represent the most significant changes since our founding and envision many changes in how we train residents, including emphasizing the practice as the curriculum, community engagement to address disparities, flexibility for residencies and residents, participation in residency learning networks, transition to competency-based medical education (CBME) and more faculty time dedicated to education and evaluation.

A first task—and one that will require engagement across the discipline over many years—is the implementation of CBME across the specialty. Of course, CBME, is not new—the WHO described it in 1978—and it has been incorporated into undergraduate medical education and widely across other health professions over the past 20 years.[4] Now it is coming to graduate medical education, propelled by an ABMS/ACGME collaboration with leadership from Pediatrics, Surgery and Family Medicine.

The challenges of spreading CBME in Family Medicine are great. We have 745+ residencies, distributed across a vast geography, with greatly variable resources in faculty and faculty development, and many have been wounded deeply by the pandemic in terms of finances, support staff and burnout. So how to start? The ABFM believes that we should start with the "end in mind"—the core outcomes we want from family medicine residency education. We use the term "core outcomes" because ABFM research last summer showed that only approximately 40% of family medicine program directors reported they are using the term Entrustable Professional Activities (EPAs), and what they mean by EPAs varies greatly.

From December 2022 through March 2023, the ACGME Family Medicine Review Committee (FMRC) and the ABFM established the "core

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Conflict of interest: The authors are employees of the ABFM.

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Why are procedures a core outcome?

- Procedures are **foundational to Family Medicine.** Family physicians understand consent, complications, interpretation and billing. Procedures represent **a promise** to our patients, communities and employers
- Family Medicine's " special sauce" is comprehensiveness. **Procedures differentiate family physicians from advanced practice professionals**
- **Employers increasingly expect family physicians to do procedures.**
- **Learn it or lose it! F**amily physicians learn over their careers, but residency is a *critical* period.
- Procedures are funand can ***attract medical students into Family Medicine***.

How did ABFM develop the procedure list?

- **10 years of Program Director submissions to ACGME** about procedures required for graduates, plus data from national graduate survey, STFM Procedures group and AAFP
- Formal Input from AAFP, AFMRD, ADFM, STFM, Rural Training Track PDs, FM leaders of large health systems, ABFM Board of Directors, and many individuals
- Mainstage presentation at RLS 2024 and 2025; breakfast tables also.
- Delay of requirement to June 2026 in spring of 2024; minor adjustments this spring.

The Final List (Provisional)

- Biopsy, Skin (excisional, punch, shave)
- Bracing/splinting
- Destruction of skin lesions, Acrochordon Removal
- EKG interpretation
- I&D Superficial Abscess
- Interpretation of CXR, KUB, extremities, spine/neck
- Laceration Simple with Sutures; Suture/Staple Removal
- Joint Injection/Aspiration
- Long Acting Reversible Contraception: IUD insertion or implant insertion and removal
- Pap smear sampling and management
- Toenail procedures
- Trigger point and other therapeutic injections

Training: ACLS, ALSO (or equivalent), NRP (or equivalent) initial certification

POCUS in 2027

These are continuity procedures; we hope residencies add/customize (“optional”)

Should anything else be on this list? We will revisit in the future?

On RTM and public website: : https://www.theabfm.org/app/uploads/2025/08/2025-08_Core-Competencies-for-2026-and-Beyond.pdf

What ABFM Expects from Residencies

- In June 2026, Program Directors, supported by their CCC, will verify competence in procedures for each graduating resident.
- The checkoff process will be simple…
- Residencies will develop **systems** for training tracking and assessing procedural competency.
- ABFM will ***not require specific*** numbers of procedures or specific assessments of residents' performance – just whether or not the resident is competent in the list of procedures. **Use your expertise and judgement**

Background questions

- What does the ACGME/Review Committee do vs. what does ABFM do? *The ACGME accredits residencies: the ABFM certifies individuals*
- What is the difference between "curricular" competencies and "clinical" competencies? *The RC guidelines are curricular guidelines…ABFM expects clinical competencies*
- What about other "optional" procedures, such as CT/MRI reading or colposcopy? *ABFM encourages these but will not ask for documentation.*
- Is list permanent? *These are provisional—for about 3-4 years. We look for your input and will work with the RC and the specialty to consider changes.*

How should residencies teach core procedures?

- ABFM **does not** require specific teaching techniques, numbers of procedures or assessments
- Need a system for teaching, assessment and tracking; there is a rich literature on this. ..
- **We trust your judgement and experience.**

Thank you to AFMRD!
providing guidance best practices for tracking, numbers and assessment

Contribute to the learning community --RLS, STFM, or in residency learning networks...

What about residents not competent in a procedure?

Board certification requires competence in all core outcomes…

Remediation depends on which procedure, but consider:

- **Prevention** is key—use electives…
- Extend residency if necessary
- Targeted, hands on CME
- Have new employers assess and certify

What about POCUS for 2027?

- STFM has launched an extensive process to identify a strategy for education for residents and practicing physicians--*FM POCUS experts, range of faculty, all FM organizations. Multiple Delphi Processes, a summit*.
- Draft recommendations on which examinations, volume of experience, supervision, sequence and Faculty Development
- Simultaneously: Research on POCUS impact on patient outcomes in continuity settings
- Tiered levels of assessments, organized by complexity and best sequence for teaching
- Residents would need to learn, for example, Tier One—eg in obstetrics, lie of baby.
- Much more to follow….we look for your input.

Frequently Asked Questions

- Can residents sit for April exam if they are not yet competent in procedures? *Yes. Board eligibility requires passing the exam, but also completing the residency, competence in the core outcomes and readiness for autonomous practice…*
- Is **exposure** sufficient? *Exposure is not enough: we are looking for competence. also, in Dreyfus terms, we are not necessarily looking for "expertise" or mastery.*
- What about residents with disabilities? *The residency/ CCC will make the decision; if disabled, will not be required for Board Eligibility.*
- Will conscientious objection to long acting contraception be allowed? *Yes; the PD and CCC will be able to attest to this.*

Frequently asked questions (con)

- Can supervisory family medicine residents assess interns' competence? *Yes; residency leadership must set this policy explicitly.*
- Can volume of experience count towards assessment of competence? ***Yes. We trust your judgement.***
- Should all preceptors be competent in these procedures? *Important that expertise exists among core faculty. ABFM will* ***not*** *track faculty competence.*
- Should all practicing family physicians do these procedures? *That is their choice: in residency our goal is to train pluripotential physicians who can meet the needs of their patients and communities, wherever they go…*

Are residencies ready for assessing procedures? Verification survey of 689 residencies…

June, 2025: Given your current systems for tracking competence in procedures, would you have been able to assess competence for your residents in the procedures required for ABFM Board Eligibility in June 2025?

YES: 74% (510)

Do you currently require:

- ACLS: 99+%
- ALSO: 75%
- NRP/NALS or other resuscitation training? 83%

Some final thoughts/questions…

- The foundation for all this work is a robust residency clinical practice: ***the practice is the curriculum***
- We are working together to support comprehensiveness among family physicians. ***ABFM trusts your judgement on how to teach and how to assess competence…***
- What *other* procedures should your residency teach? Should all preceptors competent in all these procedures?
- Use ***residency learning networks*** to share best practices for teaching/tracking procedures and faculty development…
- What do we want the standard of care for family medicine to be?

We welcome ideas…

Comments/Questions?