ACGME Requirements
Review and Comment Form

Title of Requirements	Family Medicine

Organizations submitting comments should indicate whether the comments represent a consensus opinion of its membership or whether they are a compilation of individual comments.

Select [X] only one	
Organization (consensus opinion of membership)	X
Organization (compilation of individual comments)	
Review Committee	
Designated Institutional Official	
Program Director in the Specialty	
Resident/Fellow	
Other (specify):	

Name	American Academy of Family Physicians
Title	Contact: Karen Mitchell MD, Vice President Medical Education
Organization	American Academy of Family Physicians (AAFP) with consensus from the Council on Academic Family Medicine (CAFM organizations): Association of Departments of Family Medicine, Association of Family Medicine Residency Directors, North American Primary Care Research Group, Society of Teachers of Family Medicine

As part of the ongoing effort to encourage the participation of the graduate medical education community in the process of revising requirements, the ACGME may publish some or all of the comments it receives on the ACGME website. By submitting your comments, the ACGME will consider your consent granted. If you or your organization does not consent to the publication of any comments, please indicate such below.

The ACGME welcomes comments, including support, concerns, or other feedback, regarding the proposed requirements. For focused revisions, only submit comments on those requirements being revised. Comments must be submitted electronically and must reference the requirement(s) by both line number and requirement number. Add rows as necessary.

	Line Number(s)	**Requirement Number**	**Comment(s)/Rationale**
	50-104	Int.B.	Overall positive comments were received about the definition of the specialty of family medicine. Line 50: The term “primary care specialists” is preferred over “generalists”. Line 94-95: To show incorporation of emerging knowledge and the context of “better” care we

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			recommended: “Family physicians critically analyze and appropriately apply emerging knowledge and technology to provide better and more personal clinical care.”
	161-168	I.B.5-6	Distance from primary clinical site: The proposed language clarifies the previous requirement.
	183-187	I.D.1.a)	Learning collaboratives: We support learning collaboratives to allow opportunities for partnership, cross-collaboration, and collective learning. Removal of the word “regional” is requested to allow more flexibility in bringing together programs with similar interests. Further explanation of what is entailed may be helpful in a FAQ document. We are concerned that implementation may be challenging and funding may be an issue as creating learning collaboratives will require both structure and time. Tie the language to IV.D.1.b).(1) (lines 1678-1679).
	194-197	I.D.1.c)	We support that having a mission statement is now a core requirement.
	199-202	I.D.1.d)	We support annual evaluation of the FMP facilities. We suggest adding the sentence "For resident well-being, program should offer a list of behavioral health resources readily accessible." We believe that behavioral support through a variety of methods would be beneficial for residents with irregular schedules and daytime responsibilities. Clarification of the term “psychological safety” and how it should be evaluated would be helpful. Inclusion of potential resources or best practices to evaluate physical and psychological safety in a meaningful way would be beneficial.
	204-206	I.D.1.e.	We support the emphasis that the FMP site serves the community.
	208-213	I.D.1.e). (1) and (2)	We affirm that patient panel assignments are critical for continuity of care. We are supportive of a culture of continuity but note that this may be challenging due to team-based care needs and significant patient turnover each year. Additionally, patient panel assignment and re-assignment process may require IT/EHR technology beyond current capability in some systems.
	235-236	I.D.1.k)	We affirm the importance of interpretation services. However, in some locations the

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			technology to offer telephone interpretation services for telehealth visits is not available.
	238-244	I.D.1.l)	We affirm the concept and purpose of a community advisory committee. Additional clarity on how such a committee is defined would be helpful. Some questions have arisen about whether a FQHC Board would suffice. A phased approach to this requirement may be needed as programs put it into practice, and it will be important to track the amount of administrative time spent to achieve this versus the actual impact.
	260-266	I.D.1.p)	We support use of outcomes in ongoing performance improvement. Assessing “continuity with patient panel” and “health inequities” will need further clarification to understand how to measure them. Panel management and measurement of continuity are beyond the capability of many current residency data systems. A phase-in approach may be helpful; not all programs will have the institutional and technological support needed at the start.
	326-329	I.D.4.a).(2)	We agree with the need for sufficient inpatient volume. Providing quantities or tying this to the inpatient requirement below may help assure sponsoring institution support.
	331-340	I.D.4.a).(3)	We recommend adding an explicit statement about competent gender affirming care to lines 331-334 to acknowledge the full spectrum of gender diversity. There is also some concern that removal of age ranges could negatively affect comprehensive training. We applaud requiring the use of the Community Health Needs Assessment (Background and Intent box)
	377-384	II.A.2.a)	We appreciate the flexibility in determining how time for administration of the program is divided among program leadership. We are concerned that the “administration” of the program is not clearly defined and lacks a distinct mention of no clinical time nor precepting time. Categories of “program support” versus “support for program leadership” are also not clearly defined, which will make it very difficult to account for this time. We are very concerned about an overall

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			decrease in protected administrative time for program leadership. While we agree it is up to the program to decide what administrative time is needed, the cost of this time will likely drive sponsoring institutions to support only the minimum required. We recommend what we recently endorsed following an STFM-led taskforce effort -- see: https://journals.stfm.org/familymedicine/2021/june/griesbach-2021-0017/
	406-408	II.A.3.e)	For the list of examples of recognized program director leadership experience, consider including relevant medical staff committees.
	538-541	II.B.1.c)	We appreciate and support the awareness of interprofessional faculty roles and decreased focus on physician faculty only throughout the revised requirements.
	543-560 652-654	II.B.1.d) ~~II.B.3.b).(3)~~	Feedback is mixed regarding the change away from requiring all programs to have family physician faculty role modeling their competence in maternal child health, inpatient adult care and inpatient pediatrics (particularly newborn care) to allowing our residents to learn those skills from other specialties and/or other non-physicians instead. For some, it will benefit the community served and enhance ability to recruit faculty. For others there is concern that it allows too much institutional interpretation and may decrease family physicians' scope. The requirements have previously served as impetus for family physicians' health system privileges. With these changes we will need to study downstream effects on resident competence and local access to pregnancy, newborn care and family medicine adult inpatient care.
	597-599 655	II.B.2.h)	We agree with the importance of family medicine physician faculty role modeling continuity and comprehensive care in the FMP.
	601-606	II.B.2.i) II.B.2.i).(1)	We strongly support a behavioral health interprofessional team addition and recognition of interprofessional behavioral health care.
	619 657	II.B.3.a) II.B.3.c)	We recommend use of "interprofessional" or other language instead of "non-physician" throughout the document.
	661-667	II.B.3.e)	We support encouragement for interprofessional teams as they benefit patient care and provide residents experience for collaboration in the

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			future as model of practice in ambulatory and inpatient settings. The word “augment” is important to address the concern that family physicians should remain as the primary preceptors of family medicine residents. We also appreciate in the background and intent box that interprofessional faculty members can be deemed core faculty if designated by the program director.
	684-694	II.B.4.c) II.B.4.d)	We support having specific minimum core faculty to resident ratios and a minimum amount of protected educational and administrative time for core faculty. We recommend language to overtly clarify that the educational and administrative responsibilities do not include resident supervision of patient care (i.e. precepting). We recommend the core faculty ratios and 30% FTE protected time as recommended by the family medicine organizations in https://journals.stfm.org/familymedicine/2021/june/griesbach-2021-0017/ The proposed 1:6 core faculty/resident ratio for small programs works only if non-core faculty assist in covering resident patient-care supervision in the clinic, inpatient, labor and delivery, skilled care nursing settings, particularly when the core faculty/program director are away on vacation or family leave. If the 30% protected time for educational and administrative core faculty duties is not an option, then the 1:4 faculty/resident ratio is needed together with the proposed 25% FTE aggregated protected time to at least approach the faculty time resources needed by programs. We remain concerned that core faculty have many educational and administrative duties that require dedicated time and that these responsibilities will further increase with implementation of the revised family medicine residency requirements. Some of the increased responsibilities include individualized education plan (IEP) development and implementation, baseline discussion, SMART goal plans, midyear evaluation, end of year evaluation, coaching,

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			learner assessment, encouraging active learning, assisting with prioritization of learning, demonstrating feedback seeking behaviors, working through IEPs. Additionally, management of patient advisory committees and learning collaboratives are being added. Residents will also need assistance with FMP panel data assessment.
	710-715 724	II.C.2.a) II.D.1	The two categories of support by program coordinators need to be clearly defined.
	786-790	III.B.2-3	We support the decrease in minimum program size to assist programs in rural and underserved locations. There is some concern that some institutions will use this to justify cutting family medicine residency positions and we would like to have this tracked.
	901-1104	IV.B.1.b).(1).(a) to IV.B.1.b).(2).(a)	We support the list of competencies for independent practice with a few recommendations as listed below. The AAFP supports expectations of family medicine graduates with this AAFP policy: https://www.aafp.org/about/policies/all/expectations-family-medicine-graduates.html
	924	IV.B.1.b).(1).(a).(ii)	We recommend inclusion of preventive care such as "…include common chronic medical conditions, acute medical problems and preventive care;"
	953-962	IV.B.1.b).(1).(a).(vii)	We recommend inclusion of lifestyle medicine including food as medicine to promote holistic patient health—a dynamic, culturally relevant lifestyle medicine curriculum focused on practice within underserved communities.
	975-976	IV.B.1.b).(1).(a).(xi)	We appreciate the specificity of care of ill children to include recognition, triage, stabilization and management.
	978-1007	IV.B.1.b).(1).(a).(xii)	We appreciate the specificity of providing pregnancy care. We recommend changing the language throughout this document to gender inclusive language, changing "women" to "people" and referring to pregnancy care (not maternity care) and care of people who are pregnant. We request that the program requirements acknowledge the full spectrum of gender diversity.
	1035-1036	IV.B.1.b).(1).(a).(xv)	"Address suffering in all its dimensions for patients and their families" is a lofty goal. Concern has been expressed about how this

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			would be measured or evaluated.
	1102-1104	IV.B.1.b).(2).(a)	The mention of new and emerging technologies is important to family medicine.
	1156-1165	IV.B.1.d).(1).(h)-(j)	We appreciate these concepts of master adaptive learning.
	1263-1265	IV.B.1.f).(2).(a)	We appreciate the emphasis on community and population health throughout the document.
	1311-1312	IV.C.3.c)	We appreciate that the FMP is the focus of learning as continuity is a great teacher.
	1342-1345	IV.C.3.c).(5).(b)	We are generally supportive of evidence-based emphasis on goals, rather than actual visit numbers. We do believe however that there needs to be further clarity regarding how competence in continuity patient encounters will be consistently measured. Some standardization in assessment would be helpful to ensure that our competency measures are robust enough in the absence of required minimum experiences. "Sufficient" size should be defined in some manner. There is concern that without some indication of panel size, volume or time in clinic that some institutions could use the change away from 1650 visits to decrease clinic time or decrease support for clinic volume. There are some formula-based panel models that could be utilized to determine a minimum panel size for residents according to year of training, with consideration of the complexity of the patients (expected number of visits per year) and availability of the resident. https://www.aafp.org/fpm/2019/1100/p23.html
	1347-1353	IV.C.3.c).(5).(b).(i) IV.C.3.c).(5).(b).(ii)	We appreciate the change in ages. We suggest the wording "age 65 years of age and older" (lines 1352-1353). We recommend mandating that at least 10% of visits or a definite raw number be pediatric (rather than 10% of resident panel) so that non-panel pediatric experiences could be counted. This would be particularly important at programs co-located with children's medical centers. Programs would have the opportunity to augment the resident experiences by aligning with local resources to meet the intent of the pediatric number requirement.
	1355-1361	IV.C.3.c).(5).(b).(iii)	We support assessing and rebalancing resident's

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		IV.C.3.c).(5).(b).(iv)	panels. Clarification about how this would be done and how often would be helpful, such as in a FAQ document. Keeping panels balanced for every resident could be very laborious and needs to be done without constantly reassigning patients and interfering with continuity from the patient perspective.
	1379-1382	IV.C.3.c).(7)	We support telemedicine in all forms as a part of panel management.
	1389-1411	IV.C.3.e)-IV.C.3.f).(2)	We heard mixed concerns about the requirement decrease in inpatient care of children. We understand the changing nature of inpatient care of children. The concern however is that decreasing requirements for inpatient care of children will make it easier for systems to generate only adult ambulatory physicians. We also request clarity about whether some or all of the ambulatory care of children experience can occur in the FMP.
	1413-1447	. IV.C.3.g - IV.C.3.h).(2)	With the removal of minimum time expectations, we have concerns about ensuring the continued inclusion and priority of gynecologic health/reproductive health in our specialty and ensuring the volume and quality of this experience. Guidance on how resident competence should be assessed in this domain would be helpful. We appreciate that there are two competency level options related to pregnancy care. We are uncertain of maintaining the requirement on the number of vaginal deliveries, when these revisions are generally moving away from number requirements and it was mentioned previously that residents should be competent in basic vaginal delivery management. We recommend removing the clause about 80 deliveries or changing the language to read “4 months or perform 80 deliveries.” 60 deliveries could also be considered as an alternative number of deliveries as the data is supportive of this number being more realistically achievable. With the additional time required to train for deliveries into independent practice, we recommend that those additional two months can come from elective time.

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			There are several places in section IV.C.3.g and IV.C.3.h where the language can be harmonized with current concepts of gender identity. Changing "women with gynecologic issues" to "people with gynecologic issues", "pregnant women" to "pregnant patients" and "post-partum women" to "post-partum patients" might be one way to achieve this.
	1467-1470	IV.C.3.j)	We recognize that the decrease in hours of emergency department experience is meant to give flexibility but we are also concerned that programs may not be able to get residents to levels of competence in clinical areas needed for our communities. We suggest some language that gives program directors permission to be more proscriptive in how elective time is utilized.
	1472-1483	IV.C 3.k)	Please clarify if encounters in the FMP count for care of older adult requirements.
	1485-1491	IV.C.3.l),	Care of surgical patients: We support the move away from number counting and the greater flexibility to align with educational needs of our Family Medicine residents. Given that several areas that have shifted from hours/rotations to educational models that are less timebound, we need to specify how we monitor our residents' abilities and competence during their "experiences." This is crucial so the education provided in critical areas (such as gynecologic care, surgery, and newborn care) does not become diluted and as a result leave our residents less prepared for their eventual practice settings. It may also be helpful to delineate the key essential learnings we expect all Family Medicine residents to have from each experience upon completion of their residency training.
	1493-1503	IV.C.3.m)	We heard mixed comments regarding musculoskeletal "experience". Some consider musculoskeletal problems so core to family medicine that definite rotation time should be specified. Others understand that the change from required hours to "an experience" give flexibility but are also concerned that programs may not be able to get residents to levels of competence in clinical areas needed for our communities. We suggest some language that gives program directors permission to be more

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			proscriptive in how elective time is utilized.
	1505-1514	IV.C.3.n)	Dermatology experience, including variety of skin colors and types: We support this addition as an important contribution to the provision of quality care and our ability to address health care inequities.
	1516-1534	IV.C.3.o) IV.C.3.o).(2).(a)	The increased specificity in the content of the behavioral health curriculum is helpful. For the ambulatory setting, we recommend a realistic curricular focus on “brief CBT interventions that can be integrated into a clinical visit” and the importance of a continuity relationship, as well as an emphasis on the role of the interdisciplinary team. Given that IV.B.1.b).(1).(a).(iv) (lines 938-942) includes “diagnose, manage, and integrate care for…substance use disorders (core)”, we recommend that “identification and treatment of substance use disorders” change from “should” to “must”. We also support an approach to care that reduces stigma against substance use disorders.
	1536-1555	IV.C.3.p)-IV.C.3.p).(4)	We applaud the emphasis on community here and elsewhere in document. We support the explicit education necessary to overcoming health disparities. We recommend that residents must be engaged with activities to increase health equity within communities in the broad sense and within our health systems. We strongly recommend required education for faculty and residents on the effects of implicit bias, microaggressions, and systemic racism in healthcare.
	1569-1600	IV.C.3.r)	We support regular data reports of the resident’s panel and practice. Some systems will require enhanced IT capability to produce the reports listed. We note that increased faculty time will be needed in supporting residents in their analysis and response to the data.
	1602-1607	IV.C.3.s)	We support education around emerging technologies like POCUS that are likely to improve our future practice. We note that this will require more dedicated faculty time for oversight, modeling, and curriculum development. We also recognize that this may result in some financial challenges for

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			programs with fewer resources due to the cost of training and equipment if solely done internally. We agree with including POCUS as a “should” (not a “must”) at this time.
	1609-1615	IV.C.3.t)	We understand the six months of elective time is to be driven by individualized education plans (IEPs) and future practice goals. IEPs require faculty experience, time and resources to develop. We request clarity that some of the elective months can be used to increase competency in specific areas, such as to achieve competency for independent practice in pregnancy care and deliveries. We also suggest some language that gives program directors permission to be more proscriptive in how elective time is utilized for specific levels of competence in clinical areas needed for our communities.
	1678-1679		We support learning collaboratives. We recommend removal of the word regional. See comments above for I.D.1.a) (lines 183-187)
	1725-1734	IV.D.3.c)	The language of this requirement needs some clarification, as to whether residents must work with all categories of team members. Additionally, it should be clarified whether a resident doing scholarly activity by themselves counts, or whether it only counts if it is done in the context of a team.
	1760	V.A.1.b).(2).(a)	We believe that clarification of what is meant by “EHR Management” would be helpful. Definition of quality metrics would be also helpful, such as are the quality metrics defined as timeliness, responsiveness to patients, completion of notes?
	1811-1831	V.A.1.d).(3)	We support individualized educational plans, but adequate protected faculty time is needed for this process.
	1833	V.A.1.d).(6).(b)	We appreciate the description of master adaptive learners in the background and intent.

General Comments:

We appreciate the effort to embody the future of family medicine while giving programs flexibility for innovation in meeting their community's needs. There are many good additions in the proposed requirements that will move our programs forward, including:

- Enhanced emphasis on community engagement
- Requirement for regional collaboration across programs
- Required community FMP advisory committees
- Enhanced emphasis on resident scholarship
- Removal of some required time and numbers, which will allow more program flexibility (however, this is also a double-edged sword- see below)
- Increased focus on resident patient panels and their analysis

We must also be cautious that some of the requirements may decrease family physicians' comprehensiveness and retreat away from the scope of family medicine. Examples include the decreased time and/or patient encounter requirements for inpatient care of children, gynecologic care and musculoskeletal care. We must continue the breadth of care that is core to family medicine in order meet the needs of our population.

We are also concerned about the increased responsibilities for faculty to meet the program requirements. Increased faculty (non-clinical) time will be needed for:

- learning collaboratives
- patient advisory panel administrative needs
- competency-based assessment including observation, reporting, feedback
- individualized education plans
- coaching toward master adaptive learning to include learner assessment, encouraging active learning, assisting with prioritization of learning, demonstrating feedback seeking behaviors and faculty growth mindset
- resident analysis and response to FMP and population/panel data
- oversight, modeling, and curriculum development of emerging technology

We believe that the future of Family Medicine is bright and that our specialty will continue to herald in the new era of healthcare as we continue to serve critical roles in patient advocacy, quality stewardship and the delivery of evidence-based frontline care.