

Dedicated Time for Education Is Essential to the Residency Learning Environment

Warren P. Newton, MD, MPH, Grant Hoekzema, MD, FAAFP, Michael Magill, MD, and Lauren Hughes, MD, MPH, MSc, MHCDS, FAAFP

(J Am Board Fam Med 2022;00:000–000.)

In June 2019, the Accreditation Council of Graduate Medical Education (ACGME) reduced faculty dedicated educational time for Family Medicine residencies by approximately two-thirds. Before that time, the ACGME required sponsoring institutions to provide Family Medicine Residency Directors with 0.7 FTE for educational and administrative responsibilities and 0.6 FTE educational time for each core faculty member, with 1 core faculty member required for every 6 residents. The 2019 ACGME requirements were imposed as part of the common program requirements for all residencies, despite formal objections from American Board of Family Medicine, the American Academy of Family Physicians, and the Council of Academic Family Medicine. To cushion the impact, as well as to support residency leadership succession, the ACGME Family Medicine Review Committee added a requirement for an assistant program director with 0.4 FTE devoted to residency education. For a residency with 24 residents, the cumulative effect of the 2019 changes meant reduction of time dedicated to residency education from 3.5 FTE to approximately 1.1 FTE starting in July 2019.

The impact of these changes on the learning environment in family medicine residencies was substantial. A survey of program directors¹ by ABFM and Association of Family Medicine Residency Directors (AFMRD) in July of 2020, 1 year after the changes,

demonstrated that 75% had already seen a significant negative impact. The overall response rate was 363/681 or 52.8%. Of respondents, 75% of these had seen an immediate and adverse impact, with almost 70% reporting rapid reductions of budget and/or reallocation of faculty educational time to clinical duties.

To respond to concerns from family medicine and other specialties, and to set more consistent policy across the various specialties, the ACGME created another special task force, took testimony from all specialty Review Committees and interested leaders in each specialty and then announced guidelines for all specialties to follow for leadership and educational time. The new guidelines provided for a range of dedicated time for residency directors and some dedicated educational time for core faculty, with some flexibility depending on the needs of the specialty and the opportunity to petition for exception.

The ACGME Family Medicine Review Committee used this framework to develop new guidelines for faculty educational time as part of its draft of the major revision of requirements². In addition to adjustments for support of the program leadership, the draft requirements propose dedicated educational time for core faculty of 0.25 FTE and reduction of the ratio of residents to core faculty 4:1. This proposal was based on data on faculty hours spent in educational duties collected by the ACGME itself from family medicine residencies over 10 years, and it was supported by an expert assessment from the Council of Academic Family Medicine, working from the recommendations of a Society of Teachers of Family Medicine (STFM) task force and with input from the AFMRD, the Association of Departments of Family Medicine and the AAFP³. So, for residencies with 24 residents, this would imply 2.4 FTE

Ahead of Print Publication 1 September 2022; Final Publication XX XXXX 2022.

From American Board of Family Medicine, Department of Family Medicine, University of North Carolina (WPN); Department of Family Medicine, Mercy Family Medicine Residency (GH); American Board of Family Medicine, Department of Family and Preventive Medicine, University of Utah (MM); American Board of Family Medicine, Department of Family Medicine, University of Colorado (LH).

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

of dedicated residency educational time, with lower requirements for smaller and rural programs. This would be a significant increase in dedicated time for education compared with the 1.1 FTE of dedicated educational time after the 2019 changes, although still significantly less than the pre-2019 requirements. In addition, Review Committee guidance will indicate that precepting time will not count toward dedicated educational time, because that faculty time is already partially supported by Medicare.

Why is dedicated educational time necessary for the learning environment of family medicine residencies? As educators know, education does in fact take time outside of precepting both in the outpatient setting and direct supervision of care in the hospital. The development, implementation, and evaluation of curriculum and assessment of resident performance are critical as is face to face teaching, which averages 4 to 8 hours a week⁴ in family medicine residencies. In Family Medicine, faculty time is particularly important given the complex curricula across the continuum of care, and the need for ongoing coordination and improvement of a variety of experiences. Family Medicine residency faculty keep a lot of plates spinning in the air!

In addition, the draft requirements will require substantially more faculty dedicated time. They envision a dramatic shift to competency based residency education (CBME): away from 1650 visits and defined specific hours for specific experiences, and to more general requirements, combined with robust assessments of competence across the core competencies, allowing much more flexibility for residencies to adapt to their local community's needs and for learning needs of individual residents. CBME, however, is largely new to family medicine residency faculty. They will require extensive faculty development, and there will need to be work across the specialty sponsored by our specialty academic organizations to develop and evaluate assessments for all 6 ACGME core competencies—not just clinical skills and knowledge, but also professionalism, communication, problem-based learning, and systems based practice.

In addition, the new requirements emphasize the power of imprinting⁵ and its implications for the Family Medicine practice over many years. Recognition that “the practice is the curriculum”⁶ will force increasing attention to the measured quality of the practice, the environment in which

our residents are “imprinted,” and affect the cost and quality of their care for years to come. This is innovative across specialties and very complementary to competency-based education. For example, metrics should include both continuity of care and referral rates, which are important assessments of core competencies of individual residents as well as the function of the family medicine centers. But transforming residency practice requires faculty leadership and time. Moreover, in response to dramatic increases in the incidence of behavioral health disorders, suicide and overdose deaths across the country, the new requirements also require substantial increased commitment to behavioral health. This also requires dedicated educational time of both physicians and behavioral science faculty.

Another emphasis of the new standards is meaningful extension of activity into communities⁷. The why do this is clear: shameful persistence of disparities of health and health care along lines of race, ethnicity, rurality and income, spotlighted by the COVID pandemic and events such as the murder of George Floyd. Family Medicine Residencies should play an important role in responding to the needs of communities and addressing the unfortunate frequent lack of trust between communities and sponsoring institutions. How to do this well is unclear, and family medicine residencies will learn together over the next decade. What is clear, however, is that dedicated faculty time will be needed to spearhead this effort.

Why should sponsoring institutions support dedicated educational time for family medicine? Why cannot family medicine do this work on top of their ongoing clinical work? Of course, federal GME funding is a public good: not all hospitals merit funding. Funding depends on sponsoring institutions meeting ACGME requirements; the mission of the ACGME itself envisions residency training as a path to improving the health of the public. Furthermore, the business model of family medicine in most settings does not support added time for time dedicated for education. The fixed costs of primary care practice are substantial, and most family medicine centers are expected to cover their expenses based on clinical revenue. The substantial indirect margin from the care of family medicine patients, including labs, hospitalizations and referral to subspecialists and the tests they perform typically goes to hospitals or to subspecialties, and is not reinvested back into family medicine

residency education. This stands in stark contrast to the subsidies teaching hospitals often provide to other specialties' practices and training programs. For example, proceduralists and other subspecialists often have the facility costs of their teaching settings—ORs, procedural suites, and hospital floors—covered by the hospital, not charged to their residency programs. Hospitals typically do not provide such subsidies for the costs of the Family Medicine Center and its teaching function. This is despite the systematically lower payment rates for outpatient facility evaluation and management (E&M) charges compared with inpatient rates and facility fees.

For the ABFM, dedicated faculty time for education is foundational to the residency learning environment. We have documented the extensive adverse impact on family medicine residencies of the June 2019 ACGME change of requirements¹. We also believe that dedicated faculty time is necessary for the transition to CBME—something the ACGME is in favor of—and is necessary for excellence in education and for meeting the promise of family medicine and primary care. We understand that teaching hospitals must preserve margin for ongoing capital investments, and that, at least early in the pandemic, teaching hospitals—like many stakeholders in medicine—had substantial financial challenges. We also understand the need for some consistency across specialties. But being a sponsoring hospital also incurs social accountability as well, including ultimately, responsibility for the health of the public.

ABFM sets standards for education which qualify family physicians to seek board certification. We

believe that learning environments must provide sufficient dedicated faculty educational and administrative time to implement the new vision of training for personal physicians embodied in the draft requirements. Providing adequate support for this dedicated time is essential.

To see this article online, please go to: <http://jabfm.org/content/00/0/000.full>.

References

1. Newton WP, Magill MM. The impact of the ACGME's June 2019 changes in residency requirements. *J Am Board Fam Med* 2020;33:1033–6.
2. Accreditation Council for Graduate Medical Education ACGME Program Requirements for Graduate Medical Education in Family Medicine; 2021. Available from: https://www.acgme.org/globalassets/pfassets/reviewandcomment/rc/120_familymedicine-_2021-12_rc.pdf. Accessed 27 July 2022.
3. STFM Task force advocates for ACGME requirements that protect time for faculty. Available from: https://stfm.org/news/2020-news/1-20-20_protectedtimerecommendations/. Accessed 26 July 2022.
4. Zakrajsek T, Newton W. Promoting active learning in residency didactic sessions. *Fam Med* 2021;53:608–10.
5. Phillips RL, Holmboe ES, Bazemore AW, George BC. Purposeful imprinting in graduate medical education: opportunities for partnership. *Fam Med* 2021;53:574–7.
6. Neutze D, Hodge B, Steinbacher E, et al. The practice is the curriculum. *Fam Med* 2021;53:567–74.
7. Wheat S. Community: The heart of family medicine. *Fam Med* 2021;53:528–31.