Point-of-Care Ultrasound in Family Medicine: Assessing Training Needs, Utilization Patterns, and Barriers Across the Northeastern United States

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Background

Point-of-care ultrasound (POCUS) is now recognized as an essential skill in family medicine, allowing practitioners to perform real-time diagnostic and procedural assessments in-office with **accuracy comparable to radiologist studies, sub-five-minute scan times, and reduced emergency referrals and costs**.

This timeline highlights **the persistent gap between training expansion and clinical adoption and the rapid acceleration toward formal competency requirements.**

2014 - 2019

In a 2014 CERA survey of U.S. Family Medicine Residency Program Directors[1], only **13.4% of programs had an established POCUS curriculum.** In a 2019 5-year follow-up survey, **this number had risen to 53%.**

Clinical adoption, however, has struggled to gain traction. For instance, 2019 CERA data showed that **73%** of surveyed POCUS applications were performed **less than once per year** by program physicians.

2024

ACGME adds POCUS to Family Medicine Program Requirements, formalizing POCUS within FM residency education.[2]

July 2026

STFM POCUS Education Task Force identifies 52 unique POCUS applications that should be included in a family medicine residency POCUS curriculum, organizes them into five implementation tiers.

Final Recommendation: Competency in 6 Tier 1 applications should be considered for ABFM board eligibility for residents graduating beginning in 2028.[3]

June 2029

ABFM: POCUS will become a required procedural competency for family medicine residency graduates by June 2029.

Despite the rapidly expanding body of literature, there remain gaps in understanding attitudes, usage, and barriers among community-based practitioners in the Northeastern U.S., and in characterizing physicians' training needs and specific educational preferences.

Methods

This is a **cross-sectional, anonymous survey administered through Qualtrics.** The targeted groups **were family medicine (1) residents, (2) faculty physicians, and (3) community-based physicians, all providing in-person, direct patient care** in the Northeast United States. Survey domains were developed with input and feedback from family medicine POCUS experts. Email invitations were distributed through family medicine physician network listservs.

The major domains evaluated include:

- **Frequency of usage/comfort level with 52 unique clinical applications**
- Barriers and facilitators to clinical adoption
- Motivation for learning POCUS
- **Training needs assessment** (including workshop preferences, ideal training modalities, and desired administrative/operational topics).

Phase 1 Data Collection / Early Results

Table 1. Characteristics of Phase 1 Survey Respondents.

The Phase 1 sample included 58 family medicine clinicians, comprising faculty physicians, community-based physicians, and residents. Respondents represented a range of career stages and practice settings, providing a preliminary cross-section of family medicine clinicians.

Characteristic	n (%)
Overall sample	**58 (100.0)**
Professional role	
Family medicine faculty physician	27 (46.6)
Community-based family medicine physician	21 (36.2)
Family medicine resident	10 (17.2)
Years in practice among non-residents	
<5 years	13 (27.1)
5–10 years	9 (18.8)
11–20 years	12 (25.0)
>20 years	14 (29.2)
Academic teaching role among non-residents	
Yes	40 (83.3)
Community type	
Suburban	30 (51.7)
Urban	19 (32.8)
Rural	9 (15.5)
Clinical setting	
Outpatient	56 (96.6)
Inpatient	29 (50.0)

Figure 1. Ultrasound Access, Current POCUS Use, and Interest in Future Training.

Although 67.2% of respondents had access to ultrasound and 89.3% expressed interest in further POCUS training, only 38.6% currently used POCUS in clinical practice. This suggests a notable gap between access, interest, and routine clinical adoption.

High % of respondents with interest in future POCUS training may reflect response bias.

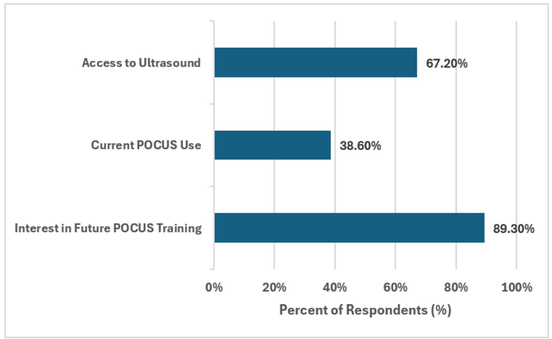


Figure 2. Primary Motivations for Further POCUS Training.

The leading motivations for further POCUS training were improving diagnostic accuracy and improving access to care, each selected by 47.1% of respondents. Increasing revenue was infrequently selected, suggesting that interest in POCUS training is driven primarily by clinical and patient-care benefits.

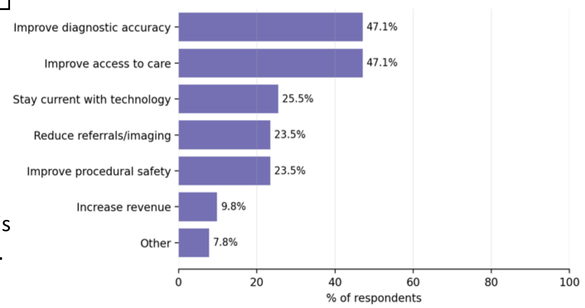
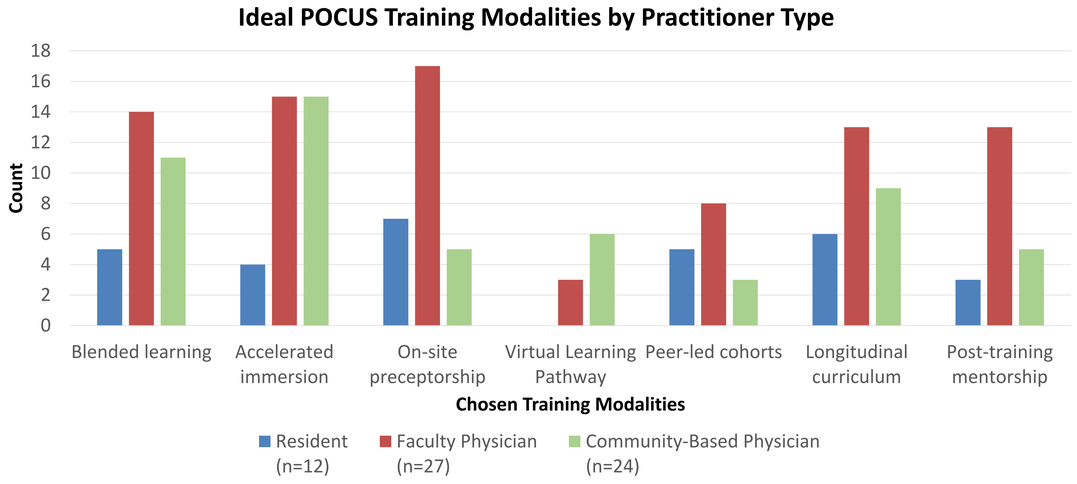


Figure 3. Preferred POCUS Training Modalities by Professional Role.

For training modalities to be included in an ideal POCUS training program, **hands-on learning models were highly favored. On-site preceptorship was the top choice for faculty (63.0%) and residents (58.3%).**

- The most frequently selected across all groups included an **accelerated immersion course**, **blended asynchronous plus hands-on learning**, **longitudinal curricula**, and **on-site preceptorship.**
- Notably, zero residents selected virtual learning, highlighting a clear aversion to asynchronous online workloads among clinical trainees.



Discussion & Next Steps

Insights gained from these localized results will be used to dynamically tailor educational sessions at PRIME POCUS hubs.

- **2-Day POCUS Workshop covering Tiers 1-3 at UConn (December 2026)**

1. In-Depth Analysis of Early Dataset:
With distribution to CT and the Northeast underway, the project is currently executing a secondary, in-depth analysis of the Connecticut dataset.

2. State/Regional Comparison
Once distribution channels outside CT are leveraged, our analysis will be able to capture how different states and regions vary in training needs/preferences. Findings will inform POCUS workshop design region by region.

3. Adapt Survey for Other Regional Hubs
Survey is being expanded across the PRIME POCUS network to scale the study nationally across other regional hubs.

Limitations

- Has not been evenly distributed to date; **oversampling of residents and faculty, underrepresentation of community-based physicians due to response bias**
- **The majority (71%) of responses to date are from physicians/residents practicing in CT. These trends may not be reflective of other states/regions.**
- Responses are skewed to those who graduated residency more recently
  - **~50% of surveyed faculty/community-based physicians report 10 or fewer years of experience**
- Small overall and subgroup sample sizes limit statistical power and the precision of between-group comparisons. **For this reason, the current analysis shown here is primarily descriptive**, and subgroup findings should be viewed as exploratory.

References

1. Hall JWW, Holman H, Barreto TW, et al. Point-of-Care Ultrasound in Family Medicine Residencies: 5-Year Update – A CERA Study. *Family Medicine*. 2020;52(7):505-511.
2. ACGME Program Requirements for Graduate Medical Education in Family Medicine. Accreditation Council for Graduate Medical Education; 2024.
3. Paulus R; STFM POCUS Education Task Force. Multiorganizational Recommendations for Point-of-Care Ultrasound in Family Medicine Residency Education. *Family Medicine*. Published online July 31, 2026. doi:10.22454/FamMed.2026.426882.
4. Clements, B., Rabaza, C., Williamson, B., Dalal, P., Cathcart, E., & Paulus, R. (2026). The State of Point-of-Care Ultrasound in Family Medicine. Family Medicine. https://doi.org/10.22454/FamMed.2026.777641