Association, will share her expertise as CEO of Medical Management Group Association on the role of leadership and leading change in primary care. Tom Bodenheimer, MD, MPH, director of the Center for Excellence in Primary Care at the University of California, San Francisco and an adjunct professor in the Department of Family and Community Medicine, will speak about resilience for clinical teams in pursuit of the Triple Aim.

Practice Management Boot Camp

Presenters Scott Fields, MD, MHA; Bruin Rugge, MD, MPA; Benjamin Cox, MBA, Oregon Health & Science University; and John Rugge, MD, Hudson Headwaters Health Network will lead an optional workshop for residents, new practicing physicians, and new faculty. Presenters will engage the participants in an active conversation and small-group activities addressing issues such as:

- How to be a good partner in a busy practice
- The role of primary care in accountable care organizations, understanding the importance of visit coding, relative value units, and payment
- What to know prior to signing a first contract; basic financial planning, including employer benefits, loan repayments programs, and planning for the future; and use of data to improve a practice and patients' health.

Family Medicine for America's Health Core Topics Track, Invited Presentations

The conference will include a track of sessions specific to the 6 core teams of Family Medicine for America's Health (FMAHealth) and how they envision the future of practices. The FMAHealth track will have presentations by core team members on practice, payment, research, technology, workforce, and engagement.

Other invited sessions will feature topics of direct primary care, social determinants of health, meaningful use, medical Spanish, and the changing environment of payment reform.

The Conference on Practice Improvement will be held December 3-6, 2015 at the Intercontinental Hotel in Dallas, Texas. More information is available at http://www.stfm.org/cpi.

Traci Nolte, CAE

ADFM Association of Departments of Family Medicine
VISION, VOICE, LEADERSHIP

From the Association of Departments of Family Medicine

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INFLUENCING STUDENT SPECIALTY CHOICE: THE 4 PILLARS FOR PRIMARY CARE PHYSICIAN WORKFORCE DEVELOPMENT

Medical students choose a career in family medicine based on the combined influence of many factors. A framework (pipeline, process of medical education, practice transformation, and payment reform) based on the Four Pillars for Primary Care Physician Workforce Development[1] provides a logical basis to address student interest in family medicine. Individual departments of family medicine (DFMs) have variable influence and ability to affect these pillars and subsequent student career choice. While the 4 pillars may imply equal impact of each factor on specialty choice, this commentary describes the differential influence of each, and opportunities for greatest return on investment to best meet the nation's urgent health care needs.

Pipeline

The first pillar is the pipeline, through which students demonstrate interest in a medical career and are subsequently selected for admission to medical school. The pipeline should begin no later than secondary school and progress through high school and college. Promoting an interest in family medicine to diverse groups early in the process, and ensuring an ample representation of family physicians on medical school admissions committees helps to enroll students who are more likely to choose careers in primary care and also to serve where needed.[2,3]

Process of Medical Education

This is the pillar that DFMs can influence most directly to guide student career choice. Engaging faculty who are inspiring, passionate, and who demonstrate the breadth of family medicine are the strongest role models for the discipline of family medicine. Departments should develop active family medicine interest groups (FMIGs) that engage students in the first 2 years of medical school, and support them through their clinical years. FMIGs are an excellent resource for community engagement, professional development, and identity formation. Involving students in longitudinal relationships with patients and transformational educational activities that demonstrate the central role family physi-

cians play in improving care and outcomes helps all students to see family physicians as foundational to well-functioning health care systems and patient-centered medical homes. DFMs must ensure that medical schools provide an environment of professionalism that discourages the toxic and untoward effects of 'professional badmouthing' and the 'hidden curriculum' on student interest in family medicine and primary care.

Practice

The practice pillar encompasses the dynamic interplay of the learners' experience of clinical care. DFMs need to position themselves as leaders in the rapidly changing clinical environment to ensure students participate in interprofessional teams and robust medical homes. Support for community faculty, who often provide the window through which students view what they consider the 'real world' of family medicine, improves the likelihood that students will view a possible future practice that improves care and outcomes of care while decreasing unnecessary costs.

Payment

Payment, over which DFMs and medical schools have the least direct control, is the last pillar. It is also the most important in influencing specialty choice. The gap between primary care and specialty care salaries must be narrowed. When relative reimbursement is normalized, graduating medical students select careers in primary care at rates adequate to the needs of the population.[4] The factors associated with reimbursement (prestige, lifestyle, ease of loan repayment, status of medical school departments) have a potent influence on specialty choice. The rising cost of medical education discourages students from lower socioeconomic status from choosing family medicine.[5] Students from wealthier families (particularly with physician parents) are less likely to choose family medicine for reasons associated with perceived prestige of various medical disciplines.

Specific ways that DFMs can influence the payment pillar demand our best attention. Developing scholarships and loan repayment programs for students, especially those from underrepresented minority groups is a priority. DFMs should assume roles of leadership in value-based payment mechanisms within respective practices, and advocate for reimbursement that values effectively improving the health of individuals and communities over quantity of services provided. Without meaningful payment reform, current fiscal realities dictate that the interest in primary care and family medicine will continue to lag, and population health gains that would be made with a more robust primary care foundation will remain elusive, at both human and economic cost. Ensuring a pipeline and investing in the educational process are necessary but not sufficient to create a more robust primary care workforce: payment reform that rewards family medicine based on the evidence for the contributions of our practice is essential for fixing a broken system. Working together with other partners committed to improving our population's health, academic departments of family medicine can create meaningful change that will influence medical education and health care delivery for generations to come.

Chris Matson, Ardis Davis, John Epling, Josh Freeman, Tochi Iroku-Malize, Mark Stephens, Allan Wilke and the rest of the ADFM Education Transformation Committee: Allison Arendale, Phil Diller, Allen Hixon, Chuck Perry, Amer Shakil, Mark Stephens, and Amanda Weidner. The opinions herein do not represent official opinion of The Uniformed Services University, The Dept of the Navy or The Dept of Defense. This commentary is endorsed by the ADFM Board of Directors.

References

1. Hepworth J, Davis A, Harris A, et al; and CAFM Four Pillars Taskforce. The four pillars for primary care physician workforce reform: a blueprint for future activity. *Ann Fam Med.* 2014;12(1):83-87.
2. Smedley BD, Stith Butler A, Bristow LR, eds. *In the Nation's Compelling Interest: Ensuring Diversity in the Health-Care Workforce.* Institute of Medicine (US) Committee on Institutional and Policy-Level Strategies for Increasing the Diversity of the U.S. Healthcare Workforce;. Washington, DC: National Academies Press; 2004.
3. Grumbach K, Odom K, Moreno G, Chen E, Vercammen-Grandjean C, Mertz E. Physician Diversity in California: New Findings From the California Medical Board Survey. San Francisco, CA: University of California, San Francisco, Center for California Health Workforce Studies; March 2008.
4. Kruse J. Income ratio and medical student specialty choice: the primary importance of the ratio of mean primary care physician income to mean consulting specialist income. *Fam Med.* 2013;45(4):281-283.
5. Asch DA, Nicholson S, Vujicic M. Are we in a medical education bubble market? *N Engl J Med.* 2013;369(21):1973-1975

Ann Fam Med 2015;13:495-496. doi: 10.1370/afm.1860.

THE RESIDENCY PERFORMANCE INDEX (RPI): AN AFMRD TOOL FOR FAMILY MEDICINE RESIDENCY PROGRAM ASSESSMENT

The Residency Performance Index (RPI) was developed by the Association of Family Medicine Residency Directors (AFMRD) in 2012 to spur residency program quality improvement, using program metrics and benchmark criteria specific to family medicine training.