tive workshop for faculty and community preceptors, participants will (1) identify and address barriers to recruitment and retention of community preceptors, (2) identify motivating factors for community preceptors, (3) describe onboarding/orienting community preceptors in this teaching role, (4) demonstrate how to give feedback to students in an outpatient clinical setting, and (5) discuss the needs of preceptors and health systems with regards to teaching students in the clinical setting.

STFM's Group on medical student education is conducting national focus groups of community physicians who are or may become preceptors to identify relevant factors in decisions to precept. They will then use lean methodology to rapidly test interventions and innovations to address barriers and create value for community physicians in their role as preceptors. This multi-institutional qualitative study of the preceptors will inform future preceptor recruitment and retention initiatives.

STFM is collaborating with Family Medicine for America's Health and the other family medicine organizations to address the preceptor shortage more globally. The organizations are discussing the possibility of bringing together a variety of stakeholders for a full-day summit to develop a detailed plan of action to:

- Reduce the time burden associated with precepting
- Increase the value of students in community practices
- Improve the quality of the precepting experience for preceptors and students

Family medicine education cannot succeed without community preceptors to train students in outpatient offices. Recruitment and retention of a sufficient number of preceptors in high-performing practices is going to be a continual challenge given the evolving healthcare environment and the increasing number of medical students and other trainees requiring clinical placements.

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VISION, VOICE, LEADERSHIP

From the Association of Departments of Family Medicine

Ann Fam Med 2016;14:184-185. doi: 10.1370/afm.1920.

ENGAGING LEARNERS TO ACHIEVE ESCAPE VELOCITY IN TRANSFORMATIONAL EDUCATION AND PRACTICE

"The dream of reason did not take power into account."[1] One of every $5 of the US gross domestic product now comes from the health care delivery industry. Approximately 30% of those health care dollars are superfluous, unnecessary, or downright wasteful based on objective assessments.[2] Despite this, the formidable financial forces in play within the complex US health care delivery system create a tremendous resistance to change.

Current dictum advocates a health care delivery system that focuses on delivering the Triple Aim of better outcomes, better patient experience, at a lower cost. Unfortunately, the ability to achieve sustainable steps toward these goals has continually been thwarted by financial incentives that serve to reinforce interests of traditional stakeholders[3] rather than empowering individuals to improve their health. Health care reform in the United States has yet to reach 'escape velocity' in order to break free of these 'gravitational' constraints.[4]

In a similar fashion, educational reform is revisited about every 20 years in US medical schools,[5] falling short of the necessary energy for true transformation. As Lin et al point out, the goal of medical education must move beyond increasing the supply of future physicians, to focus on better health outcomes for all Americans.[6] The integral synergy between educational and health care delivery systems can no longer be viewed separately or ignored.

To break free of existing paradigms and achieve peak escape velocity requires a new way of thinking about education in the context of clinical care that pushes towards equitable payment and focuses on quality, outcomes, and team-based care.[7]

To facilitate this change, a parallel groundswell of change in medical education must engage learners in identifying needs and opportunities for systems improvement, patient and environmental barriers that can be surmounted, and essential resources that can be made available. Who better to help identify deficits and disparities? Who better to contribute to designing, implementing and examining innovative models to improve health, lower cost, and improve patient

(and provider) satisfaction? Our students should be integral partners on inter-professional teams, helping to identify problems and recommend solutions in educational and health care delivery systems. Successful approaches are described below:

- Learners helped develop a value-driven pricing system for drug pricing[8] and created a system to assist uninsured patients when choosing a health insurance plan[9]
- M1 students provide health coaching, motivational interviewing, and patient education in community health centers via longitudinal primary care partnerships, and early learners provide transition of care navigation for patients discharged from the hospital[6]
- M3 clerks bring about quality improvement by conducting projects in their preceptors' offices in multiple family medicine clerkships, or assist with health literacy, both ideal transformational learning and service opportunities for the students[10]

The world of modern health care is increasingly dominated by integrated clinical networks and large health care systems. Gupta and colleagues[11] propose educating "bridging leaders" to lead collaborative efforts and bring about meaningful change. Bridging leader learners, in particular, can facilitate conversations between health care systems leaders and those in charge of residency training programs within the same system. Economic and educational forces need not always be in conflict. Historically, when these 2 forces collide, economic factors take precedent to the detriment of patients and learners alike. Engaging learners to "be the change they envision" not only takes advantage of their position to create positive change but also provides an innovative opportunity for explicit leadership development to meet the demands and challenges of modern health care.

In times of challenge and conflict, we can either curse the darkness or light a candle. Harnessing the intellect, passion, and collective power of a community of learners to foster education and system change, is another way family medicine can continue to lead meaningful educational and health system reform for the benefit of all—patients, providers, and learners.

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**The opinions herein are those of the authors. They do not represent official policy of the Department of Defense, the Department of the Navy or the Uniformed Services University*

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