Other important areas of focus include
- Increasing the skill set of family medicine faculty and learners related to diversity, equity, inclusion, and accessibility
- Promoting the adoption of best practices of educational scholarship through the development of a Family Medicine Scholarship Academy
- Developing curriculum for teaching and assessing professionalism that is challenged by changes in technology, market forces, and health care delivery systems

Through this strategic roadmap, STFM reaffirms its commitment to shaping the future of family medicine education, ensuring that it remains responsive to the evolving needs of members and the communities they serve. The strategic plan can be found at **stfm.org/strategicplan**.

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

From the Association of Departments of Family Medicine

Ann Fam Med 2025;23:85-86. https://doi.org/10.1370/afm.240596

RETURNING TO OUR VALUES: HOW TO CONTINUE DEIA EFFORTS IN AN EVER-CHANGING LANDSCAPE

The stark inequities in COVID-19 morbidity and mortality, coupled with the murder of George Floyd in 2020, resulted in broad support for our nation to refocus on advancing equity. Compelling evidence emerged that diversity, equity, inclusion, and anti-racism (DEIA) made good business sense, improved health outcomes, and enhanced belonging.[1-2] As a result, many institutions began to do DEIA work. We did not expect this broad support to last, however, and the strategies and approach to DEIA have had to evolve as people grapple with the challenges of a post-pandemic world. DEIA pushback continues to grow, making this work even more challenging than it was in the past for chairs and department DEIA leaders. The ADFM Diversity, Equity and Inclusion Committee explored how best to assist members in navigating these challenges through virtual events that highlighted key strategies from department chairs, DEIA leaders, and faculty members engaged in these efforts. This commentary will outline how department members are responding to the evolving DEIA climate, considering both the unique challenges faced across the country and successful strategies.

On June 10, 2024, ADFM hosted a Hot Topic Discussion on "Strategies for Addressing DEI Pushback." Four member departments, 3 of which are in states that have enacted laws or initiatives against DEIA, presented challenges related to DEIA efforts unique to their institution and how they addressed them.

Successful strategies presented include:
- Holistic admissions: Holistic review for admissions, focused on standardized behavioral questions and signaling, while hiding academic information. The example presented created a "CV Score" that uses items such as community college/associate degree, non-English language fluency, military service, other career, additional degrees to create a score that provides a more holistic view of an applicant.
- Advocacy and protection of admissions processes: Lobbying against "Do No Harm" legislation and the EDUCATE Act to restrict DEIA education in medical school, educating a board on the value of holistic admissions as described above, having a purposeful admissions committee, and ensuring family medicine representation on this committee.
- Language and job description changes: Changing roles and titles to reflect a broader position that aligns with other organizational priorities (eg, identifying and training physician candidates who are likely to serve local urban underserved and rural communities), instead of focusing specifically on DEIA initiatives.
- Working within the parameters of the law: If anti-DEIA laws have already been passed, move forward by continuing to build relationships (eg, wherever needed to form alliances and creatively co-create solutions where possible such as with legislators, health systems leaders, etc), identifying where there are overlapping priorities, and focusing on what is allowed to continue to meet the needs of patients and communities; for example, referencing socioeconomic status. Anti-DEIA laws may not inhibit federal funding, enabling working within the confines of state laws while continuing advocacy.

From these examples and audience discussion, we generated 6 broad strategies for consideration by departments of family medicine and others working in this space:

1. Work with national organizations, integrate the functions of DEIA into core activities, develop metrics and accountability, focus on shared goals, remember the business case, and continue to learn from each other.
2. Adjust tactics by adapting priorities, continuing to lead curricula, and staying compliant with new laws, while advocating for DEIA through permissible means.
3. Leverage leadership and testimonies, such as patient testimonies about the value of having physicians from their own communities,[2] to counter anti-DEIA laws and show its importance to curricular and health outcomes for ALL.
4. Engage with legislatures, university leadership, and communities by seeking to understand opponents' perspectives, while also mobilizing through grassroots efforts and highlighting the economic impact of restrictive policies.
5. Advocate internally and provide support by promoting faculty and staff members from underrepresented groups, ensuring solidarity, encouraging cross-departmental collaboration and, where allowed, making DEIA work visible and transparent within the institution. The role of the department chair is particularly important in protecting, supporting, and promoting members who are doing this work.

6. Be thoughtful about public messaging and communication; avoid direct confrontations; focus on shared values, and tie in historical and cultural references whenever possible.

The ADFM DEI committee is developing a list of DEI-related resources intending to assist with carrying out the above recommendations. These resources also include links to partner organizations both inside and outside of family medicine doing work in this arena. One example is STFM's advocacy DEI toolkit. Additionally, the Academic Family Medicine Advocacy Committee (AFMAC) has released a statement on diversity and continues to explore ways of engaging at the grassroots level.

ADFM represents the leadership of academic family medicine through the faculty, residencies, fellowships, medical students, teaching practices, research and institutions represented in our 160+ departments.[3] As family physicians, we are more likely to include the social context of our patients, work in and learn from communities, and address subjects of inequities in our teaching of medical students and residents. We must exercise our unique leadership roles in family medicine and academic health centers to help member departments and other family medicine organizations drive their mission-driven goals, to support and innovate within their DEIA programs where allowed, and to do so in ways that are creative, bridge divisions, and make sustainable impacts.

Montgomery Douglas; Steven Zweig, MD, MSPF; Sam Elwood; Brian Park, MD, SPH; Christina Kelly, MD; Cleveland Piggott, MD, MPH; and Jehni Robinson, MD

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AFMRD Association of Family Medicine Residency Directors — From the Association of Family Medicine Residency Directors

Ann Fam Med 2025;23:86-88. https://doi.org/10.1370/afm.240601

2024 AFMRD SALARY SURVEY RESULTS AND TRENDS

The Association of Family Medicine Residency Directors (AFMRD) biannually conducts a Salary Survey of membership as a member benefit. The survey invites program directors (PDs) to report compensation considerations for themselves, associate program directors, core faculty, program coordinators/administrators, and behavioral health faculty. Full survey reports are available to AFMRD members on its website.

The most recent survey was open between February and April 2024 and circulated to 589 family medicine (FM) PDs in the United States with 201 (34.1%) respondents. Participants were also surveyed as to additional training or certifications, length of practice, and scope of practice, and 57.5% of respondents reported being graduates of AFMRD's National Institute for Program Director Development. Key demographics of PD respondents and their programs are listed in Table 1.

The mean, standard deviation, and median annual taxable income by role within program are summarized in Table 2. Mean PD income among respondents increased from $268,500 in 2021. Income varied by program type, region of the country, and years of PD experience. Additionally, while the proportion of respondents reporting clinical or educational incentives as a portion of their compensation increased from 45.1% in 2021 to 51.6% in 2024, the mean dollar amount varied. The mean dollar amount associated with clinical incentives decreased 31% in 2024 compared to 2021 while the mean dollar amount for educational incentives increased by 17%.

Program Director Considerations

The AFMRD Board of Directors noted trends in the 2024 report compared to 2021 that may warrant further study. First, unlike recent previous surveys, the 2024 survey did

Table 1. Program Director Demographics

Program sponsor	Count	Percent
Health care system (non-medical school–based)	138	68.7
Medical school	45	22.4
FQHC/Teaching health center	7	3.5
Military	1	0.5
Consortium	8	4.0
Other	2	1.0
Gender		
Male	105	52.2
Female	86	42.7
Choose not to disclose	10	4.9
Race/Ethnicity		
Asian	16	8.0
Black/African American	10	5.0
Hispanic/Latino/Spanish	6	3.0
Middle Eastern/North African	3	1.5
White	149	74.1
Choose not to disclose	17	8.5
Degree		
MD	152	78.8
DO	41	20.7

DO = doctor of osteopathic medicine; FQHC = Federally Qualified Health Center; MD = doctor of medicine. -LC