provide foundational training for residency faculty. Courses cover the structure and requirements of residency education; how to be an effective and efficient faculty member; the nuts and bolts of curriculum development and teaching; and strategies for assessment, feedback, and remediation of residents.

Conducted the first meeting of the Precepting Expansion Oversight Committee. This multidisciplinary, interprofessional committee is overseeing the implementation of an action plan to decrease the percentage of primary care clerkship directors who report difficulty finding clinical preceptor sites and increase the percentage of students completing clerkships at high-functioning sites. Five tactic teams began meeting in 2017 and are now implementing strategies to ensure medical, nurse practitioner, and physician assistant students receive hands-on opportunities with patients in real-world settings.

Updated the Leading Change online course. The content is now delivered in shorter segments and the course includes interactivity, learning activities, and quizzes to promote understanding and retention.

Implemented new submission systems for the Family Medicine Residency Curriculum Resource and the STFM National Clerkship Curriculum. Submissions are now made through the same system STFM uses for its journals, which allows for better tracking of submissions and communication with authors.

Implemented digital badging on member profiles in STFM *CONNECT*. A digital badge is an online recognition of accomplishments, mastery of a skill, or completion of a learning experience. The goal of the badging is to recognize members, showcase their accomplishments and STFM involvement, and encourage participation in STFM programs and leadership activities.

The celebration and innovation of 2017 built momentum for the many products and activities planned for 2018: a Medical School Faculty Fundamentals Certificate Program, an enhanced online presence for *Family Medicine*, a revamped, mobile-friendly website, a new conference submission and review system, and ongoing work to address the shortage of community preceptors.

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

From the Association of Departments of Family Medicine

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For this issue, the ADFM is pleased to use this space for a paper by Family Medicine for America's Health, a collaboration of ADFM and 7 other national family medicine organizations. We also acknowledge specifically the contributions of ADFM's Education Transformation Committee.

A SHARED AIM FOR STUDENT CHOICE OF FAMILY MEDICINE: AN UPDATE FROM ADFM AND FAMILY MEDICINE FOR AMERICA'S HEALTH

Recently, through the Family Medicine for America's Health (FMAHealth) Workforce team, 8 family medicine organizations endorsed a "shared aim" to: increase the percentage of US senior allopathic and osteopathic medical students choosing family medicine from 12% to 25% by 2030. Twenty-five percent is a stretch goal aligning current efforts and resources with the ultimate primary care workforce goal of 40%.

The Four Pillars for Primary Care Physician Workforce Reform provides a blueprint with leverage points.[1] ADFM expanded on this to illustrate points where Departments of Family Medicine (DFMs) could engage along the "four pillars" continuum,[2] and the ADFM Education Transformation Committee provided a worksheet further addressing where DFMs could engage locally.[3]

In the last 3 years, the FMAHealth Workforce Team has explored strategies along the "four pillars" continuum. The FMAHealth Workforce Team's analysis of engagement is summarized below:

Pipeline

Workforce Diversity: Improving health professional diversity is central to pipeline efforts to produce the diverse primary care workforce needed. Collaborative efforts outside family medicine, such as the "Beyond Flexner Alliance," and working with leadership from organizations with missions including improving the health of underserved communities, are essential.

Student Factor Analysis: Medical students' specialty choice is a multifactorial process. Virtual focus groups conducted with both M4 students who choose and do not choose family medicine at schools with high and low family physician production identified several key themes, including a need for high quality

preceptors, the value of rural family medicine experiences, understanding the full scope of family medicine, and the importance of "top down" institutional influences.

Impact of Organizational Programming: Through work with the AAFP, preliminary data analysis on family medicine Interest Groups (FMIGs) identified significant positive correlates to match rates. Data showed that FMIG support is an important strategy for maintaining and increasing student choice, but should not be the only strategy, as students are motivated by different experiences and values. Attending the AAFP National Conference and AAFP student membership may also play an important role.

Process of Medical Education

Identity of "What Matters:" To identify changes in medical education with the greatest potential influence on student choice, the ADFM surveyed Department Chairs, medical school models of positive deviance were investigated, and focus groups of key stakeholders were conducted. A partnership between FMAHealth, AAFP, STFM, and ADFM created a Family Medicine Student Choice Learning and Action Network (SCLAN) to learn, test and measure the impact of interventions. ADFM's work on the Best Practice Guidebook Project will provide a SLAN pilot tool.

Training Future Advocates: As family physicians, one of our most important roles is as advocates for our patients. A CERA Program Director survey and national student/resident survey will identify needs and contribute to a model curricular resource for advocacy training.

Leadership Development: Through the Primary Care Leadership Collaborative (PCLC), a collaboration between FMAHealth, AAFP, and Primary Care Progress, a new FMIG leadership model is being tested teaching relational leadership skills. PCLC trains medical students to take meaningful action that advances their local primary care communities.

Shortage of High Quality Primary Care Community Preceptors: Identified by FMAHealth as an important issue, STFM convened a multi-stakeholder preceptor summit which included students, residents, health system leaders, policy experts, clerkship directors, community preceptors, and non-precepting physicians. The subsequent action plan identifies partnerships and initiatives to drive health system change.

Practice Transformation

Burnout prevention and wellness are major focus areas for physicians and trainees. Student and resident leaders implemented awareness-building strategies and assessed what has the biggest potential for change.

Payment Reform

Faculty Salary Gap: In addition to the broad impact which payment reform has on primary care physician workforce development,[2] the payment gap between faculty and employed/private practice physicians should be a part of payment reform work.

These programs highlight the collective impact of family medicine organizations on increasing student choice. Looking deeper into the evidence, collaborative opportunities within and outside family medicine, and innovative work around the four pillars will allow each of us to contribute to the shared aim.

FMAHealth Workforce Education & Development Team (C. Kelly); FMAHealth Workforce Project teams (M.A. Roett, K. McCrory, A. Coutinho, N. Bhuyan, M. Alavi, T. Ho, C. Stisher); AAFP (A. Bentley); ADFM Education Transformation Committee (M.A. Roett, P. M. Diller, & A. Davis); Georgetown University Medical Center Dept of Family Medicine (M. A. Roett)

References

1. Hepworth J, Davis A, Harris A, et al. The four pillars for primary care physician workforce reform: a blueprint for future activity. *Ann Fam Med.* 2014;12(1)83-87. http://www.annfammed.org/content/12/1/83.full.pdf+html.
2. Matson C, Davis A, Epling J, et al. Influencing student specialty choice: the 4 pillars for primary care physician workforce development. *Ann Fam Med.* 2015;13(5):494-495. http://www.annfammed.org/content/13/5/494.full.pdf+html.
3. Diller PM, Weidner A, Roett MA, Wilke A, Davis A. Putting the four pillars for primary care physician workforce into practice locally. *Ann Fam Med.* 2017;15(2):189-190. http://www.annfammed.org/content/15/2/189.full.pdf+html.

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THE NEW MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS): POTENTIAL IMPACT ON RESIDENT MOONLIGHTING

In 2015, the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) changed how payments are made by Medicare to physicians and other health care providers. This new system set up a 2-track, value-based payment model Medicare physician payment system, called the Quality Payment Program. The 2 tracks are the Alternative Payment Model (APM) and the Merit-Based Incentive Payment System (MIPS). Physicians can choose the track in which they will participate based on their