to resources on TeachingPhysician.org (subscription required for TeachingPhysician.org).

Preceptor Expansion Initiative

The STFM/ABFM Pilot Program was part of a Preceptor Expansion Initiative, being led by STFM, to address the shortage of clinical training sites for students. Five interprofessional, interdisciplinary teams are working on the following tactics:

- Tactic 1: Work with CMS to revise student documentation guidelines
- Tactic 2: Integrate interprofessional/interdisciplinary education into ambulatory primary care settings
- Tactic 3: Develop standardized onboarding process for students and preceptors & integrate students into the work of ambulatory primary care settings in useful and authentic ways
- Tactic 4: Develop educational collaboratives across departments, specialties, professions, and institutions to improve administrative efficiencies
- Tactic 5: Promote productivity incentive plans that include teaching & develop a culture of teaching in clinical settings

Learn more and follow the progress of the initiative at www.stfm.org/preceptorexpansion.

Disclaimer: All results in this article are preliminary.

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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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WHAT'S IN A NAME? DEPARTMENTS OF FAMILY MEDICINE AND ...

Every department that is a member of the Association of Departments of Family Medicine includes the term "family medicine" in its title. Fewer than one-half our member departments, however, *only* have family medicine in their titles. Many titles acknowledge the other major elements of work being done by the teachers, clinicians, researchers, and learners who make up our departments. We are Departments of Family Medicine AND: Community Medicine; Community Health; Social Medicine; Public Health Sciences; Rural Health; Comprehensive Care; and Geriatric Medicine. One department even has the titular trifecta of Family, Community and Preventive Medicine (Table 1).

Some of these names reflect formal administration of degree programs in public health or residency programs in preventive medicine that have been integrated into our clinical departments. Some highlight specific mission areas, such as rural health or geriatrics. Others speak to the leadership role of many family medicine departments in "population health" as health systems move to value-based care models. (Recognizing that the term "population health" conjures up many different meanings, ADFM has recently taken on the challenge of developing a working definition; this will be the focus of a future commentary.)

Among departments that have names that include terms in addition to family medicine, the most common additional word is "community." This reflects a long history of the importance of community to the discipline of family medicine. About one-third of departments had "community" in their title a decade ago—many with this name dating back to their incep-

Table 1. Departments of Family Medicine AND...

	2011 N = 145		2018 N = 154	
	No.	%	No.	%
Family Medicine	81	56%	76	49%
Family Practice	1	1%	0	0%
Community and Family Medicine	4	3%	4	3%
Community Health and Family Medicine	1	1%	2	1%
Community Medicine and Health Care	1	1%	0	0%
Family and Community Medicine	35	24%	44	29%
Family Medicine and Community Health	7	5%	10	6%
Family Medicine, Preventive Medicine and Community Health	1	1%	0	0%
Family, Community and Preventive Medicine	1	1%	2	1%
Family and Community Health	0	0%	1	1%
Family and Preventive Medicine	8	6%	5	3%
Family Medicine and Population Health	1	1%	1	1%
Family, Population & Preventive Medicine	0	0%	1	1%
Family Medicine and Public Health Sciences	1	1%	1	1%
Family Medicine and Public Health	0	0%	1	1%
Family Medicine and Rural Health	1	1%	1	1%
Family Medicine and Osteopathic Manipulative Medicine	0	0%	1	1%
Family Medicine and Comprehensive Care	0	0%	1	1%
Family, Internal, and Rural Medicine	0	0%	1	1%
Family and Geriatric Medicine	1	1%	1	1%
Family and Social Medicine	1	1%	1	1%

tion. Many departments were founded by leaders who, in the late 1960s and 1970s era of activism, social movements, community health centers, and Community Oriented Primary Care, had an understanding that family medicine departments needed to make explicit their commitment to community engagement and health system change. Among departments that have not always had "community" in their name, however, there has been a clear move in this direction in recent years; in the past decade, the percentage of departments of family medicine that include "community" in their titles has increased from 36% to 41%.

What does this change signify? Perhaps it shows a growing appreciation of social determinants of health and the role of family medicine clinicians, teachers, and researchers in addressing these community factors. From a series of posts on the ADFM Chairs' listserv over the last few years, it is clear that many departments have changed their name to better acknowledge what they were already doing, with a scope of work focusing on clinical family medicine AND on health generation, upstream prevention, and care in the community in interprofessional teams. Some listserv comments noted that the change was a decision to outwardly signify a commitment to providing primary care and training in underserved communities, including community-based services such as student-run free clinics, health screenings in churches, and food pantries. One chair remarked that adding "community" to the department's name was a way to highlight "a commitment to a culture and set of academic and professional skills that are distinct from, but complementary to, Family Medicine."

In the national context of growing attention to social determinants and movement of health systems towards a population-health model, we anticipate that this trend toward expanded departmental names will continue. Our organization may be the Association of Departments of Family Medicine, but the scope of our association's work will need to encompass the broader activities of our member departments that span boundaries with their focus on community and population health.

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PREPARING FOR THE 2019 ACGME COMMON PROGRAM REQUIREMENTS—WHAT'S NEW?

The Accreditation Council of Graduate Medical Education (ACGME) periodically conducts a thorough review of the Common Program Requirements to ensure they reflect the latest best evidence regarding resident education as it relates to patient safety, supervision, and competency development. To this end, the ACGME strives to meet the dual responsibility of educating and training the next generation of physicians while ensuring the safety of patients and residents. As its name implies, the Common Program Requirements are applicable to all residency programs, regardless of specialty. After a 45-day public comment period, the ACGME approved the next major revision, to be effective July 1, 2019.[1]

The latest Common Program Requirements stress 4 areas, (1) patient safety and quality improvement, (2) physician well-being, (3) team-based care, and (4) clinical and educational work hours. Table 1 highlights only a few of those changed areas important for family medicine program directors.

The Review Committee for Family Medicine (RC-FM) may provide additional specification to these Common Program Requirements, but only when permitted. By the publication of this article, the RC-FM should have published our specialty-specific changes for a 45-day public review and comment. There are some new Common Program Requirements listed that are less restrictive than our current RC-FM requirements, as listed in Table 2. It is essential that program directors review the final requirements and prepare for their implementation by July 1, 2019.

These new Common Program Requirements better define some important areas in resident education but also add additional burden to the program director and faculty in terms of teaching and administrative burden. We encourage program directors to discuss these changes on the AFMRD discussion forum so that we all may learn from each other how we can best implement these new changes.

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