From the Society of Teachers of Family Medicine

Ann Fam Med 2020;18:186. https://doi.org/10.1370/afm.2528.

STFM OFFERS MEDICAL SCHOOL FACULTY FUNDAMENTALS CERTIFICATE PROGRAM

It can be challenging to onboard new faculty and ensure they have the foundational skills and knowledge to be effective teachers. Faculty development is critical. Faculty with 5 years of experience or less identified these critical needs: teaching skills, developing scholarly activities, and career development.[1]

The Society of Teachers of Family Medicine (STFM) has launched the Medical School Faculty Fundamentals Certificate Program (MSFF), which provides distance learning in an online format, with interaction with a faculty instructor and real-life application of lessons.

"The Medical Student Faculty Fundamentals Course format allows faculty to access the information at their own pace and in the order that works best for them. If you're looking for ways to engage faculty new to medical student education or what to brush up yourself, take advantage of this opportunity," said Karly Pippitt, MD, MSFF faculty instructor. MSFF will cover fundamental topics such as the structure and requirements of medical student 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 students.

The MSFF Certificate Program's 14 self-led courses include readings, videos, interactive modules, quizzes, and assignments. Courses include:

- Curriculum Development
- Clinical Teaching Skills
- Classroom Teaching
- Assessment and Evaluation
- Scholarly Activity
- Giving Feedback
- Medical Students in Difficulty
- Writing for Publication
- Advising Medical Students
- Time Management
- Incorporating Students Into Your Clinical Workflow
- LCME and COCA Requirements
- Academic Structure and Professional Advancement
- Establishing Professional Boundaries

According to the best principles of instructional design, each course features clear, concise content; frequent quizzing; video interviews with stories; and advice from experienced faculty; and some assignments that receive feedback from a faculty instructor. The assignments are carefully designed to help a new faculty member learn more about the resources available to them at their own institutions.

Developed by the STFM Medical School Education Committee, STFM staff, and subject matter experts, the MSFF Certificate Program is intended to be completed over the course of an entire year, and each participant will earn 35 hours of CME credits.

To graduate from this national certificate program, participants must complete all courses and assignments and pass a final exam.

Traci Brazelton, CAE

References

1. Danilkewich A, et al. Implementing an evidence-informed faculty development program. *Can Fam Physician*. 2012;58(6):e337-343.

From the Association of Departments of Family Medicine

Ann Fam Med 2020;18:186-189. https://doi.org/10.1370/afm.2523.

INTRODUCING THE BEST PRACTICE GUIDE FOR STRATEGIC PLANNING TO INCREASE STUDENT CHOICE OF FAMILY MEDICINE

The family of Family Medicine has created several initiatives to increase student choice of Family Medicine over the years. The most recent is a set of strategies recommended by the Family Medicine for America's Health (FMAHealth) Workforce Education and Development Tactic Team[1] which has become the current collective effort to increase student interest, America Needs More Family Doctors: 25x2030.[2] The FMAHealth Workforce Tactic Team initiated several projects related to these strategies, one of which evolved into a guide of evidence and best practices for Departments of Family Medicine (DFMs) in their piece of the puzzle to attract, retain, and train a diverse workforce of family physicians to address the growing population of the United States.[3]

The ADFM Education Transformation Committee, targeting ADFM's strategic priority to "increase the number of US medical school graduates selecting family medicine as a career," produced the "Best Practice Guide for Strategic Planning to Increase Student Choice of Family Medicine" as a supporting activity for the 25x2030 initiative. The goals of the Guide are to (1) pro-

vide evidence-based best practice resources for DFMs regarding increasing student choice of Family Medicine; (2) provide a virtual community to share student choice resources for Council of Academic Family Medicine (CAFM) stakeholders; (3) provide a living repository of success stories and evidence-based strategic planning for DFMs; and (4) provide annual goals and objectives to the ADFM Education Transformation committee to support activities of the 25x2030 initiative.

The Guide builds on the CAFM Four Pillars framework,[4-6] a conceptual model to help DFMs organize their efforts to increase student choice for a family medicine career. The 4 pillars include: pipeline, process of medical education, practice transformation, and payment reform. Although the Guide itself is still under development, we wanted to take this opportunity to share the recommendations (Figure 1) and related data. On our 2019 ADFM member survey, 67% of department chairs reported that they have faculty teaching M1/M2 Community-Based Learning or Service Learning or required community service hours [recommendation #1], while 80% have faculty teaching M1/M2 students Ambulatory Family Medicine or primary care [rec #2], both well-known predictors of student choice of family medicine, along with longitudinal mentors [rec #3]. Pipeline programs for students underrepresented in medicine are more successful for encouraging family medicine if focused on rural or minority students from socioeconomically disadvantaged backgrounds [rec #4].[7] Predictors for medical student intention to practice in underserved areas include growing up in an underserved setting, a very strong sense of calling, and a high medical school social mission score.[8] International health electives also significantly influence student choice of family medicine.[9] Increased exposure to vulnerable patient populations [rec #5] makes it more likely that stidents will go on to practice as primary care physicians in underserved areas by improving self-efficacy through interacting with diverse patient populations.[10]

Sixty-five percent of DFMs have faculty engaged in curricular innovation including health policy, population health, and/or social determinants of health [rec #6]. Fewer departments (53%) report faculty engaging in research with medical students either in required or elective experiences, though another 40% do so on an ad hoc basis. Among those reporting research with students, 70% included a focus on health disparities and social determinants of health [rec #7]. The majority (70%) of departments reported sharing information regarding student debt, loan repayment, and scholarships during FMIG events, though only 21% disseminate information in collaboration with medical school or university financial aid officers [rec #9]. Additionally, only 11.5% include National Health Service Corps or other loan repayment program information, despite the NHSC track record as the most successful loan repayment plan for family medicine recruitment. While tools exist to assess predictors of family medicine on admission, formal processes such as holistic reviews hold limited evidence thus far, but presence on committees, and contributions to admissions policies hold promise for the future [rec #8].

We continue to gather data, best practice examples, and successes and challenges related to these 10 recommendations. At the 2019 ADFM Annual Conference, we introduced the goals of the Guide and took deeper dives into the topics of admissions committees and preceptorships, with some activating discussion questions. At the conference in 2020, we will focus on early longitudinal community-service or community-based learning; using social determinants of health research to engage and recruit students; student debt; and programs with structural changes such as the 3-year accelerated curricula (eg, 3+3) models.

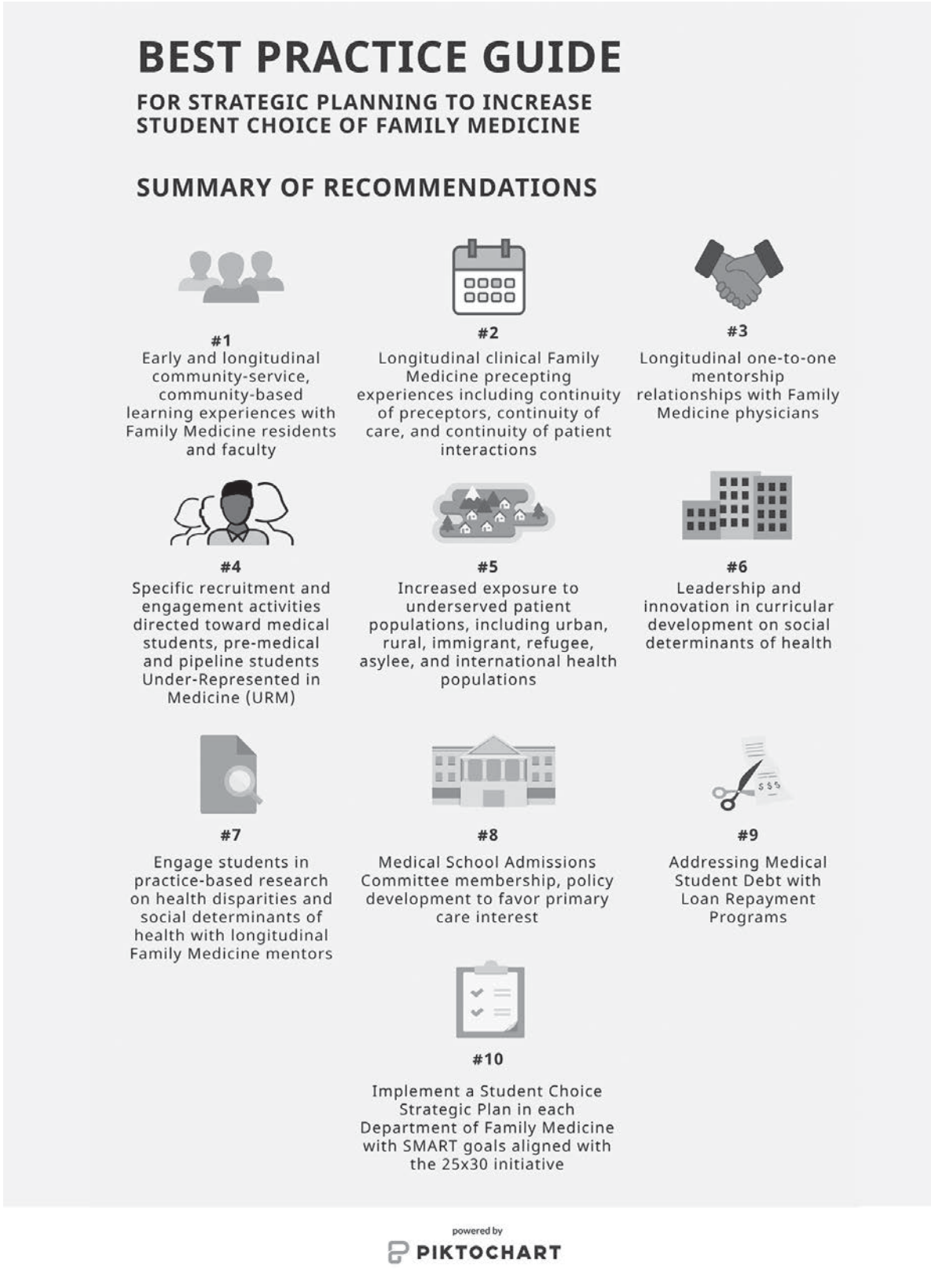
In addition to the conference session, special topic breakfast on recommendation #4, and a Twitter chat (#BPGatADFM), we will finalize the Best Practice Guide and partner with the American Academy of Family Physicians for web-based "living" resources, and a marketing plan to widely disseminate it, while encouraging DFMs to measure outcomes of their strategic plans [rec #10]. Please watch for more to come on this resource in the future!

Michelle Roett, MD, MPH, FAAFP, CPE;
Amanda Weidner, MPH
On behalf of the ADFM Education Transformation Committee

References

1. Hughes LS, Tuggy M, Pugno PA, et al. Transforming training to build the family physician workforce our country needs. *Fam Med*. 2015;47(8):620-627.
2. American Academy of Family Physicians. America needs more family doctors: 25x2030. https://www.aafp.org/about/initiatives/family-doctor-expansion.html.
3. Petterson SM, Liaw WR, Phillips RL Jr, Rabin DL, Meyers DS, Bazemore AW. Projecting US primary care physician workforce needs: 2010-2025. *Ann Fam Med*. 2012;10(6):503-509.
4. 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.
5. Matson C, Davis A, Epling J, et al; and the ADFM Education Transformation Committee. Influencing student specialty choice: the 4 Pillars for Primary Care Physician Workforce Development. *Ann Fam Med*. 2015;13(5):494-495.
6. 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.
7. Lupton K, Vercammen-Grandjean C, Forkin J, Wilson E, Grumbach K. Specialty choice and practice location of physician alumni of University of California premedical postbaccalaureate programs. *Acad Med*. 2012;87(1):115-120. 10.1097/ACM.0b013e31823a907f.

Figure 1. Best practice guide for strategic planning to increase student choice of family medicine.



8. O'Connell TF, Ham SA, Hart TG, Curlin FA, Yoon JD. A national longitudinal survey of medical students' intentions to practice among the underserved. *Acad Med*. 2018;93(1):90-97.
9. Jeffrey J, Dumont RA, Kim GY, Kuo T. Effects of international health electives on medical student learning and career choice: results of a systematic literature review. *Fam Med*. 2011;43(1):21-28.
10. NACHC. *Access Transformed: Building a Primary Care Workforce for the 21st Century*. Washington, DC: Robert Graham Center; 2008.

NAPCRG From NAPCRG

Ann Fam Med 2020;18:189-190. https://doi.org/10.1370/afm.2524.

THE DECLARATION OF ASTANA AND WHAT IT MEANS FOR THE GLOBAL ROLE OF NAPCRG AND WONCA

In Astana on October 27, 2018, the Global Conference on Primary Health Care organized by the World Health Organization (WHO) and UNICEF welcomed a declaration to strengthen primary health care in pursuit of health and well-being, and pursue universal health coverage—access for all to high-quality health care, without undue financial burden.[1] This paper, based on the International Forum of the 2019 NAPCRG conference, explores the critical roles of multinational primary care organizations such as NAPCRG and the World Organization of Family Doctors (WONCA) in realizing the vision of "Astana".

The Astana Declaration acknowledged the Alma Ata Declaration of 1978[2,3] commitment to the fundamental role of strong primary health care for population health. At the same time it embraced the United Nations (UN) Sustainable Development Goals,[4] stressed the importance of equity, and advocated the concept for health as being fundamental for societal development.

The Declaration[1] presents 3 interconnected components: empowered populations and communities that can prioritize and co-design responses to their health needs; high-quality primary care, integrated with public health; and multi-sectoral policy and action. Integrated health systems with primary care as a core function are required for its implementation, which must be linked to community services. It is the totality of this integration that is primary health care. In Astana, "primary care" and "primary health care" were used interchangeably, but it is important to understand that primary care is a core function of primary health care, and as such a priority. To implement, there is a need to build primary care research capacity globally.

A strong point of the Astana compared to earlier Declarations on primary health care is in its connection to the UN Sustainable Development Goals.[4] This connects the Astana Declaration, strengthened by the High-Level Meeting on universal health coverage[5] to the heads of state, and not just ministries of health. Pursuing health as a condition for societal development will enlarge partnerships and stakeholders for collaboration in health reforms.

Although the Declaration builds on high-quality primary care, a major shortcoming is its failure to acknowledge the professionalism of this field, and the professionals with their expertise to provide its value. This ignored an earlier WHO resolution that had stressed the importance of primary care nurses, midwives, allied health professionals, and family physicians, with the need of professional training and retention in their positions in communities around the world.[6]

This stresses the importance of continued advocacy for high-quality primary care and the disciplines and competencies required of its teams to deliver it. A central lesson from Astana is that declarations and resolutions are only able to guide policy when their content is consistently shared between all stakeholders. Here is a particular responsibility for WONCA and NAPCRG with their status in the international domain of primary care: primary care is essential for realizing universal health coverage, therefore every community around the world needs access to multidisciplinary primary care teams.

Teaching, training, and research are essential in realizing this ambition, and primary care should be an integral part of the education of future nurses, midwives, allied health professionals, and physicians. To ensure this, primary care must be part of every medical school and training institute of health professionals globally. Training programs should be multidisciplinary, in order to support robust primary care teams in every community of the world.

The performance of primary care teams has to be supported by research: building a robust primary care research capacity and infrastructure for the generation of new knowledge and the implementation of evidence and policy is a high priority—in particular in low- and middle-income countries.

NAPCRG and WONCA, as leading international organizations in primary care, see it as their responsibility to support WHO and UN to realize the ambitions of the Astana declaration, and will intensify their mutual collaboration in this to secure access to primary care teams with family physicians in every community of the world.[7] All nations need to prioritize:

- A department of primary care in every medical school[7]