- Family medicine sub-internships should include multiple different clinical settings
  - Clinics, wards, labor & delivery, and newborn nursery
- Autonomy is important for both learners and educators
- Student assessment is important
  - Entrustable Professional Activities (EPAs) may provide a framework
  - Students should be assessed on essential intern skills
  - Formative and summative assessments, with some direct observation, are encouraged

The task force consolidated what they learned into a curriculum that aimed to be concise, adaptable, and entirely built specifically for family medicine. They provided sample evaluation forms for both students and residency programs in Microsoft Word document format, so that programs could adjust them as needed. The curriculum was reviewed and supported by the STFM Medical Student Education Committee before endorsement by the STFM Board of Directors. The final curriculum was officially published in January 2022.

The Family Medicine Sub-Internship Curriculum

The curriculum itself consists of 3 components, which can be found at https://www.stfm.org/subicurriculum/

- Sub-I Curriculum (Kemp Model)
- Evaluation of Rotation Form
- Rotation Evaluation by Student Form

This curriculum:

- Builds off the foundations of the STFM National Clerkship Curriculum
- Uses Entrustable Professional Activities (EPAs) as a cornerstone of curricular elements and student assessment
- Provides a framework while allowing for flexibility and individualization
- Incorporates self-assessment by learners
- Recommends institutions provide appropriate support for this rotation through dedicated faculty and administrative support staff time

The task force hopes that this curriculum will be used widely with the goal of improving the family medicine sub-internship experiences for all students while also preserving the strengths and uniqueness of each program. They believe that improving the quality of learning during sub-internships can encourage student entry to family medicine, as well as standardize preparedness of medical students on their first days as family medicine interns.

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VISION, VOICE, LEADERSHIP

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DEPARTMENTS OF FAMILY MEDICINE MEETING POST-COVID NEEDS

The COVID-19 pandemic has exposed a variety of critical needs and inequities in our health care system. Several key deficiencies are access to comprehensive care and community and public health integration with medical care. The response to these priorities will shape the success of health care delivery models in the post-COVID-19 landscape. Departments of family medicine are entities that are uniquely positioned to meet those needs of the public through their educational, research, and clinical missions.

Understanding the perspectives and goals of multiple stakeholders (especially payers) is imperative in this post-COVID-19 landscape. The federal approach has prioritized strengthening primary care and efforts to bolster infrastructure that leads to accessible, equitable care.[1] The Commonwealth Fund has elevated strengthening the nation's primary care system and empowerment and engagement of people, families, and communities.[2] A National Academy of Medicine (NAM) task force of health care payers concluded that "COVID-19 has illustrated how misaligned financial incentives and the fragmentation of services across sectors contribute to inefficiencies and inequities in the American health system. …COVID-19 has also fostered new, innovative partnerships between payers and other sectors, such as collaborations with public health departments to improve disease surveillance, coordination with community-based organizations to meet patients' social needs."[3] The NASEM report on *Implementing High-Quality Primary Care* calls for policies ensuring that high-quality primary care is available to every individual and family in every community and to train primary care teams where people live and work.[4] All of these recommendations have as the foundation that primary care decreases mortality at a population level.[5] An increased supply of primary care is associated with better population health and more equitable outcomes.[3]

Why is family medicine built to address these population needs? "Family medicine," as defined by the American Academy of Family Physicians, is the medical specialty that provides continuing, comprehensive health care for the individual and family. It is a specialty in breadth that integrates the biological, clinical, and behavioral sciences. The scope of family medicine encompasses all ages, all genders, each organ system, and every disease entity.[6]

Family medicine delivers comprehensive care through telehealth, naturally prioritizes community engagement and integration with public health, and emphasizes an equitable

approach to health care delivery. Departments of family medicine are the key infrastructure engines that drive building capacity to meet these specific population needs through residency training, medical student education, research, and direct clinical care.

Departments of family medicine exhibit and train the most comprehensive models of care that emphasize both the biomedical science and the psychosocial experience of the disease. Residency training and clinical delivery models include inpatient and obstetric care in addition to ambulatory settings including, office, home, and nursing home settings. Payers have highlighted that fragmentation of services is prevalent.[3] Fewer than 1 in 5 Americans had a personal usual source of care.[7] In addition to reform of financing of primary care, primary care clinicians must be trained specifically to deliver comprehensive care. Many primary care clinicians may not be educated in environments conducive to the acquisition of skills for comprehensive primary care.[8] Departments of family medicine are those environments where intentional training in the skills of comprehensive care occurs unimpeded.

High degrees of integration with public health and community engagement have been hallmarks of family medicine departments for decades. Counseling around prevention screening and public health interventions is a standard in family medicine departments. These departments are often the key connectors to engagement with local communities for their medical centers or health systems. Departments of family medicine have demonstrated significant leadership in public health and health services delivery in their communities during the pandemic.[9-11] We look forward to seeing and sharing more of these stories.

The capacity-building effects of family medicine departments to train new generations of family physicians through GME and UME is key to building primary care infrastructure. They train physicians with the most comprehensive skill set to meet patient care needs and directly address health professional shortage areas nationwide. They also train physicians who can integrate medical care with public health, community focus, and health equity. Family medicine residents have shown their unique ability to provide care in all locations that were needed during the pandemic.

Government, private payers, and other stakeholders have articulated the key priorities for a post covid future for our healthcare system. Departments of family medicine are uniquely situated to directly address building capacity in comprehensive care, public health integration, community engagement, and to improve equitable population health outcomes. It is time for more direct, sustained advocacy that increases awareness and funding from payers. Without such awareness and funding, the ability of family medicine departments to provide solutions for the US health care system and the population will be severely limited.

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on behalf of the ADFM Healthcare Delivery Transformation Committee

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