writer's bureau. STFM is currently surveying pilot members about their participation.

The Challenge of Fairly Sharing the Burden

At the 2020 ADFM conference, a small group gathered to discuss the challenge of recruiting letters of support for academic promotion—specifically how it often falls on chairs to find multiple arms'-length letter writers. In response, ADFM queried our membership about the extent of this challenge for them. On the 2020 Annual Survey (n = 94, 57% response rate), 77 departments (82%) said their institutional promotion process require external "arm's-length" review letters. Of those 77 departments, most requests were sent by the chair (48, 62%) though about one-third were sent by someone at the school/university (22, 29%).

After this, ADFM created a virtual space and listserve for those interested in collaborating on this faculty promotions/letter writing challenge. The initial engagement was limited, however, so in summer 2021, we put out a call for anyone interested in coming together to brainstorm solutions. Ideas from this group included creating a form where departments could both sign up for letter writing requests and offer to write (a "swap" style), sharing templates, and ways to advocate internally in our institutions to change the promotion requirements. Due to logistical constraints and a lack of data on the scope of the issue, the additional ideas have not been implemented; however, the ADFM Board did advise that more data be gathered and continue to consider the challenge.

On our 2023 survey (n = 70, 43% response) we asked some follow-up questions about the number of required external letters, people contacted, and faculty up for promotion. Taken together, and extrapolating based on the response rate, there are approximately 500 faculty members up for promotion in a given year in family medicine who require external letters for promotion. It takes an average of 7 contacts to get 1 letter, and an average of 3 letters are required. This means that over 10,000 requests for external letters might be sent just in the discipline of family medicine in a given year.

Making Sure Those Who Agree to Write External Letters Deliver Appropriate Letters

Given the institution-specific criteria required in each letter for promotion, an additional challenge is that some letter writers may not write a letter with the required information, or in the correct format, which might delay the promotion process. In early 2021, STFM launched their Virtual Coaching program, and included an option for portfolio review and promotion letter writing to help address some of these challenges. STFM members who are interested in being a coach or receiving coaching can learn more at: **https://connect.stfm.org/virtualcoaching4/getstarted**

An Alternative for Consideration

The main intent of the external letter is to have someone who does not know the individual up for promotion assess whether they believe the person meets the criteria and whether they would be promoted to a similar rank at their own institution. The substantial amount of time required to review a long dossier and then distill it into a multi-page document that speaks to the institution's specific promotion criteria is an excessively burdensome way to answer these questions.

What if instead of asking for this time consuming "book report"–style letter, the institution instead requested a yes/no answer to the question: "Would this person be promoted similarly at your institution?" This question could be accompanied by an optional comment box that allowed for no more than a short paragraph.

To take this idea further, what if medical schools adopted a policy whereby they only asked for the answer to this question and in kind, their faculty were only allowed to supply the answer to this one question, when asked for an arm's-length recommendation? Would this make such a policy contagious, saving time for those doing outreach to find letter writers, those writing the letters, and the Faculty Promotions Committee who really just need a single question answered? Recognizing that the promotions policies of a university are not within control of a department of family medicine, but that this is a real issue for many of our members and ostensibly those in other disciplines as well, this potential approach to internal advocacy is an idea we share for consideration. Changing requirements for "arm's-length" letters for promotion could ultimately save our members hundreds of hours of time each year, time they could be spending doing important work that is meaningful to students and patients.

Amanda Weidner, Traci Brazelton, and Wayne Altman

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AFMRD Association of Family Medicine Residency Directors

From the Association of Family Medicine Residency Directors

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INDIVIDUALIZED LEARNING PLANS: WHO, WHAT, WHEN, WHERE, WHY, AND HOW?

Individualized learning plans (ILPs) are increasingly being integrated into graduate medical education (GME). The most recent Accreditation Council for Graduate Medical Education (ACGME) Program Requirements for GME in family medicine state that the program director (PD), at least annually and with input from the Clinical Competency Committee (CCC), must systematically provide faculty guidance to

residents in developing, documenting, and tracking progress on ILPs to "capitalize on their strengths and identify areas for growth."[1] Some PDs and faculty may be unfamiliar with ILPs, whereas others may have used a similar process or tool but called it a different name.

What is an ILP?

An ILP is a learner-centered tool that customizes learning opportunities throughout residency training and supports the attainment of professional goals preparatory for post-graduate practice. An ILP considers a resident's interests, learning needs, supports, electives, and other learning experiences through training. ILPs often use I-SMART (important, specific, measurable, attainable, relevant, and timely) goals that are remedial, aspirational, or both.[2-4]

Why are ILPs Important?

Individualized learning plans foster development in master adaptive learning (MAL) through the cycle of planning-learning-assessing-adjusting.[5] ILPs allow residents reflective practice, a critical component of adult learning theory, and offer faculty structure to discuss learning needs, both the needs that excite the resident and those that do not. Importantly, ILPs structure elective experiences in which residents can bolster weaknesses or explore new or in-depth learning.

When and Where are ILPs Relevant?

Resident creation of ILPs relate to the ACGME Family Medicine Milestones 2.0 Practice-Based Learning and Improvement Sub-Competency 2 "Reflective Practice and Commitment to Personal Growth" and to Professionalism Sub-Competency 3 "Self-Awareness and Help-Seeking Behaviors."[6] When used thoughtfully and continuously throughout residency, residents may focus on their paths both professionally and personally. When required for everyone, the ILP process acknowledges that all residents have areas of strength and areas of opportunity—not just those who on the surface need additional support. This approach focuses attention on areas where challenged learners may benefit from concrete goal-directed plans. This way, ILPs allow for specific assessment for each resident, assuming everyone progresses at different paces.

The ACGME requires development and monitoring of ILPs at least annually. Because ILPs can accommodate short, intermediate, and long-term goal planning, programs may choose to do so more frequently, perhaps on a semi-annual or quarterly basis. Particularly in situations with challenged learners, plans may require more frequent assessment and revision.

Who Creates an ILP?

ILPs should ideally be created by the resident, with assistance from faculty and input from the program CCC and PD. Creation by the resident allows critical self-analysis of progress for both personal and professional goals. Residents and faculty should be allowed protected time to create, use, and monitor ILPs. The current focus on ILPs comes at a time when some educators have noted that residents want a checklist of what must be accomplished and an ILP is not a checklist. Rather, it can be used to provide guidance on strategically homing in on the experiences a resident will need for their future practice.

How is an ILP Created, Used, and Monitored?

ILPs are iterative. The basic elements of an ILP are (1) reflection on long-term career goals and self-assessment of strengths and opportunities, (2) goal generation, (3) development of strategies to achieve the goals, (4) tracking or progress toward the goals, and (5) revision of goals/strategies or generation of new goals.[7] Though templates for ILPs exist, some programs may prefer to adapt these or devise their own for their local use. ILPs can be recorded on paper, electronically, or in web-based format using word processing, spreadsheet, or forms applications. Regardless of format, ILPs should flex to allow for residents at various levels and with distinct learning styles or needs with a plan for regular evaluation with a faculty coach or advisor. Simply having a method to track progress toward achieving learning goals is a prime characteristic associated with successful use of an ILP.[8]

Self-directed, lifelong learning is critical for medical professionalism and ILPs are one way to teach MAL for family medicine residents. The Association of Family Medicine Residency Directors is developing resources for PDs around ILPs. Other resources for PDs have been provided by the Society for Teacher of Family Medicine in the CBME Toolkit[9] and The American Association of Medical Colleges faculty development module.[10]

Although the ILP may seem initially to be daunting to undertake, it is a wonderful opportunity. The ILP provides residents, faculty, and PDs an opportunity to ensure reflection, guidance, and growth.

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NAPCRG From NAPCRG

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PaCE BUILDS ON THE TRADITION OF RESPONSIBLE RESEARCH WITHIN NAPCRG

Participatory research has been foundational to the values of NAPCRG. The document, "Responsible Research with Communities: Participatory Research in Primary Care,"[1] together with the recommendations for NAPCRG, was adopted as organizational policy by the NAPCRG Board of Directors and membership at the NAPCRG Annual Meeting on November 6, 1998, in Montreal, Canada. This document was further amended with "Engaging with Communities, Engaging with Patients: Amendment to the NAPCRG 1998 Policy Statement on Ethical Research with Communities"[2] in 2014. These policy statements offer considerable insights into both the practice of participatory research and its benefits.

In 2013, a group of 10 invited clinician–patient dyads convened as a pre-conference at the NAPCRG Annual Meeting in Ottawa, Canada. During that session, these dyads were introduced to the concepts of primary care, primary care research, advocacy, engagement, and related topics. From this session, the Patient and Clinician Engagement (PaCE) community originated.

The PaCE mission is to develop a robust community of patients and primary care providers with knowledge and understanding of the unique features of patient-centered outcomes research related to primary care. Participatory health research emphasizes co-creation, reciprocity, trust, active participation, and shared decision making from project start to finish, as well as the resilience, capabilities, and agency of people from these groups.[3,4] A systematic review examining the impact of participatory health research found that studies using participatory health research appropriately (not as tokenism)[5]: (1) ensure the cultural appropriateness of intervention implementation; (2) enhance recruitment and retention; (3) help those implementing (clinic teams in our case) to build their competence to negotiate and solve conflicts; and (4) promote the maintenance of program outcomes and unanticipated positive systemic changes.[4]

Supported with seed money from NAPCRG and later funding from Eugene Washington Awards from the Patient Centered Outcomes Research Institute (PCORI) of the United States from 2015-2019 and hosted by NAPCRG, PaCE grew and matured. To demonstrate its commitment to inclusion of patient voices, NAPCRG added 2 voting Patient Representatives to the Board in 2016: one US Representative and one Canadian Representative with staggered terms.

Since 2014, PaCE has hosted a Pre-Conference Program each year providing a patient and community-focused workshop for more than 250 patient/community, clinician, and researcher participants. Many of these participants have participated as or with patient and community partners in primary care research. PaCE members have also published peer-reviewed articles in the *Annals of Family Medicine*, *Canadian Family Physician*, and *Family Practice*; presented Oral and Poster Presentations; hosted webinars; and provided in-person seminars in Canada, Mexico, and the United States.

In 2021, PaCE became a committee. Since officially forming the PaCE Committee, the committee has established a mandate, specified terms of membership, selected co-chairs, and held monthly meetings. Among early accomplishments, the committee has:

- Created a PaCE Distinguished Service Award for a patient/community member who has made an exceptional impact on primary care research.
- Established a "PaCE Approved" Pin and criteria for award. The PaCE Approved Pin is awarded on-the-spot during the NAPCRG Annual Meeting to Poster or Research presenters who demonstrate patient or community engagement as part of their research.
- Obtained approval from the Board create a Scholarship Fund to enable bringing patients and community members to NAPCRG Annual Meetings.

As a NAPCRG committee, PaCE has commitments to the primary care community and the greater global patient/community it represents to make it more diverse, equitable, and inclusive; as well as maintaining responsible research which uses participatory approaches. PaCE Committee commitments include:

- Nurturing, mentoring, and supporting the Patient Representatives on the NAPCRG Board.
- Advocating for ongoing patient/community engagement within primary care research and NAPCRG.
- Co-creating year-long educational activities such as: a Learning Series; development of Best Practices in Patient-Oriented Research; policies related to patient/community compensation in research projects; and establishing some funding strategies for those who are unable to attend the NAPCRG Annual Meeting without funding support.

In the fall of 2023, we will host a Pre-Conference (Pre-Con) Program at the 51st Annual Meeting of NAPCRG which is focused on identifying the characteristics of the "Just-Right Researcher," that is, a Primary Care Researcher who is well suited to work closely with patient and/or