

Preceptor Expansion Action Plan—Description and Progress Update

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In recent years, there have been 24,000-25,000 US allopathic and osteopathic medical school graduates per year; 10%-11% of these graduates chose family medicine.^{1,2} In 2018 the family of family medicine has collaboratively set a stretch goal for family medicine: 25% of US medical students will choose family medicine as their specialty by the year 2030 (25% by 2030). The goal was an offspring of Family Medicine for America's Health (FMA-Health), a collaboration started in 2014 of the eight leading family medicine organizations in the United States to promote and drive continued improvement of the US health care system and demonstrate the value of true primary care.³

The eight family medicine organizations are:

- American Academy of Family Physicians (AAFP)
- American Academy of Family Physicians Foundation (AAFP-F)
- American Board of Family Medicine (ABFM)
- American College of Osteopathic Family Physicians (ACOFP)
- Association of Departments of Family Medicine (ADFM)
- Association of Family Medicine Residency Directors (AFMRD)
- North American Primary Care Research Group (NAPCRG)
- Society of Teachers of Family Medicine (STFM)

One of the initiatives STFM is spearheading that supports the 25% by 2030 goal is the Preceptor Expansion Initiative (PEI).

Family medicine and other primary care clerkships have been struggling to obtain and retain quality clinical training sites. Forty-seven percent of MD-granting schools' family medicine clerkship directors and 34% of physician assistant schools reported difficulty finding core clinical sites to train their students in primary care.⁴ This is one of many links in the chain that continues to bind the US health care system to a primary care workforce inadequately sized to provide the appropriate and necessary primary care needs of the population. It was time for action.

In 2016, reflecting the US Institute of Medicine's definition of primary care as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community,"⁵ STFM convened a diverse group of stakeholders to identify the most significant reasons for the shortage of community preceptors and shape the priorities, leadership, and investments needed to ensure the ongoing education of the primary care workforce.

This interdisciplinary, interprofessional summit, funded by the ABFM Foundation and STFM, brought together 52 participants including health system leaders, organizational representatives, policy experts, clerkship directors, community preceptors, physicians who do not precept, physician assistants, pharmacists, behavioral health providers, educators, residents, and students.⁶

Summit attendees were asked to identify strategies to achieve these two aims:

1. Decrease the percentage of primary care clerkship directors who report difficulty finding clinical preceptor sites.
2. Increase the percentage of students completing clerkships at high-functioning sites.

Five broad tactics were established to achieve these two aims.

Tactic 1: Work with the Centers for Medicare and Medicaid Services (CMS) to revise student documentation guidelines.

Tactic 2: Integrate interprofessional/interdisciplinary education into ambulatory primary care settings through integrated clinical clerkships.

Tactic 3: Develop a standardized onboarding process for students and preceptors, and integrate students into the work of ambulatory primary care settings (clinical clerkship sites) 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.

Each tactic has a tactic team and leader who have developed and are executing various action items and strategies. They report to the Preceptor Expansion Oversight Committee that is accountable to the STFM Board of Directors.

Tactic Updates

Tactic 1: Documentation Change Accomplished

The tactic team met with CMS to present data and explain some of the counterproductive effects of documentation requirements (eg, double data entry, spending more time documenting than teaching, that teaching medical students can add hours of uncompensated time to an office day, and diminishing willingness to teach students).

CMS revised its documentation requirements to allow student documentation of work observed or reproduced by the supervising teaching physician to “count” as documentation when attested to appropriately^{7,8}:

Students may document services in the medical record. However, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making.

The teaching physician must personally perform (or re-perform) the physical exam and medical decision-making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work.⁷

Tactic 2

Interprofessional education exemplars and experts are being engaged to explore ways to increase the number of learners at a given site without putting more pressure on the clinician. The goal is to develop workflow models and methods that target everyone along the learning spectrum from students to preceptors. This can be both an entry point and support for learning and practicing team-based patient care. The Physician Assistant Education Association (PAEA) has committed funds to support the success of this tactic.

Tactic 3

Onboarding resources are being identified to be used or further developed to enable and ensure that practices and students can more easily begin clerkships better prepared: preceptors are appropriately credentialed, there are shared expectations and standards, and proven strategies for integrating students into practices are accessible. The Association of American Medical Colleges (AAMC) 2008 Recommendations for Preclerkship Clinical Skills Education for Undergraduate Medical Education are being reviewed as a starting-point document to update—ideally in collaboration with AAMC—and to use to facilitate students consistently entering clerkships prepared for learning and with clinical skills that add value to the practice. STFM is exploring using TeachingPhysician.org to house the standardized documents and training.

Tactic 4

To identify new models and best practices that can be implemented across the United States, clerkships will submit for grant funding for self-identified new collaboratives that will improve administrative efficiencies for preceptors. Proposals could include ideas for State Authorized Reciprocity Agreements, centralized scheduling, shared administrative support, onboarding of preceptors and/or students, standardization of requirements, and shared on-site coordinators at precepting locations, to name a few. Strategies for dissemination and communication of findings are being developed.

Tactic 5: Continuing Certification Change

Continuous quality improvement (CQI) for the work of teaching will be encouraged and rewarded. The ABFM has agreed to a pilot project to give Performance Improvement (formerly called Part IV) credit for precepting that will be recognized in the Continuing Certification process. This proof of concept program allows academic units (sponsors) to develop and oversee the completion of performance improvement projects that meet ABFM requirements. To receive credit, teaching physicians must complete at least 180 one-to-one teaching hours and implement an intervention to improve the teaching process.

Additional avenues to promote and recognize high-quality teachers and practices are being considered. Actions that work to collaborate with health system employers to create incentives and cultures that foster a deeper pool of community preceptors include: (1) compile and distribute to primary care community preceptors and academic faculty information on incentive plans that include teaching; (2) develop a guiding definition of “high-quality ambulatory primary care clinical training sites”; and (3) determine the impact(s)—positive, negative, and neutral—of having medical students (and potentially nurse practitioner and/or physician assistant students) on ambulatory, primary care practices.

Presentation, vetting, and dissemination of processes and outcomes is occurring to interested parties across many organizations including AAMC, a focus group at a Texas Academy of Family Physicians chapter meeting, preceptors at KU-Wichita winter symposium, Michigan Academy of Family Physicians, STFM Conference on Medical Student Education, PAEA, STFM Annual Spring Conference, and National Area Health Education Center Organization.⁹

The Preceptor Expansion Initiative is an STFM-led collaborative response to a clear need to improve and support outpatient clinical training in primary care. It is off to a strong, positive, and impactful start, especially related to aspects of Tactics 1 and 5, with more to come as further tactic strategies are executed and implemented.

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