BRIEF
REPORTS

"The Adjunct Faculty Are Our Lifeblood": An Institution's Response to Deliver Value to Volunteer Community Faculty

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BACKGROUND AND OBJECTIVES: Because of the importance of and increasing competition for unpaid community faculty's time, we qualitatively evaluated the adjunct community faculty experience in order to identify mechanisms to improve the recruitment, training, and retention of these faculty members.

METHODS: The authors captured community faculty and key stakeholder opinion through interviews, focus groups, and a survey to elucidate their perspective of roles, responsibilities, facilitators, and barriers for providing quality teaching and learning experiences. After evaluating the data, we created an impact/effort matrix to guide suggested changes.

RESULTS: Key medical education stakeholders reported adjunct community faculty members were critical to delivery of the medical school curriculum and shared methods and barriers for retaining members. Adjunct community faculty focus groups revealed two major themes: (1) personal experience and motivation, and (2) individual advantages and institutional barriers that influence being a faculty member. The survey and impact/effort matrix led to interventions including an Office of Community Faculty to implement recruitment and retention programs and provide more comprehensive oversight, a clinical scheduling hub, improved access to specialists for community faculty, and awards to recognize the critical contributions of community faculty members.

CONCLUSIONS: As competition for community placements increases, including community faculty voices to inform action is an effective investment that enables an institution to direct resources towards interventions that maximize their support and engagement. Including community faculty perspectives also increases faculty's ability to participate in training the next generation of physicians.

(Fam Med. 2021;53(2):133-8.)
doi: 10.22454/FamMed.2021.565994

US medical schools often rely on volunteer community faculty to teach ambulatory patient care, outside the hospital setting, to medical students and primary care residents.[1-3] New medical schools have emerged and existing schools have expanded class sizes in response to the US physician shortage,[4] creating concern for academic administrators about a potential shortage of high-quality experiences in primary care.[4,5]

Studies of ambulatory preceptor motivation have not focused on community faculty,[6,7] who may experience decreased clinical productivity while precepting.[5,8-11] Allopathic medical schools face competition for clinical placement locations from other health professional schools that provide financial compensation.[12] Financial models for most public and some private medical schools cause compensation to be untenable.[13] Eighty-five percent or more of medical schools are concerned about clinical training sites and quality clinical preceptors; 41% report compensating community faculty, and 46% percent report concern about losing community faculty if they do not provide compensation.[4] In response to these

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trends, we systematically investigated our ability to recruit and retain community faculty.

Methods

Our institutional review board deemed this study nonhuman subject research. We identified community faculty as those who (1) held adjunct faculty appointments, (2) worked with trainees, (3) did not hold a tenure or nontenure track faculty position at the university, and (4) were unpaid by the university.

Using a semistructured interview guide, two authors (L.O. and L.W.) conducted stakeholder interviews with education leaders at the institution (associate deans, program directors, clerkship directors, faculty practice leaders). Three authors (L.O., L.W., W.H.) reviewed interview findings to develop themes, using audio recordings for clarification.

Based on stakeholder interviews, we created a focus group guide to elicit perceptions of roles, value of experience, and actions the medical school could take to enhance community faculty experience. We audio-recorded and transcribed verbatim the 90-minute focus groups. After every focus group, L.O., L.W., and W.H. identified key ideas. We continued the focus groups until no new themes emerged. Managing the data in NVivo 10, L.O., L.W., and W.H. developed a codebook, reviewed and coded transcripts using a thematic approach, discussed coding decisions, and all authors resolved differences through discussion.[14]

Using the focus groups results, we created a 33-question survey covering demographics, hours of faculty work, communication, promotion, benefits, value, and satisfaction. We identified 1,003 community faculty members to complete the anonymous web-based survey. We used SAS 9.4, for descriptive statistics for distributions and χ^2 tests for comparisons.

Authors L.O., H.H., and W.H. triangulated their findings and created an Impact/Effort Matrix,[15] which displays institutional effort versus impact of the change on the community faculty, to direct future efforts.

Results

Fourteen key education and system stakeholders participated in the interviews. Stakeholders emphasized the vital importance to the educational mission, identified challenges in recruiting, tracking, and retaining community faculty, and spoke of shared responsibility to prepare students for outpatient experiences (Table 1). Seventy community faculty members participated in nine focus groups, which revealed two themes: (1) community faculty experience (Table 2), and (2) institutional barriers and opportunities (Table 3).

Of 1,003 community faculty surveyed, 468 (46.7%) responded (Table 4). The respondents were representative of the pool. Most were satisfied with the responsibilities, given the benefits received (Table 4). Satisfaction did not vary by respondent age, where they trained, number of learners, time as a community faculty member, or department.

We used the findings, as integrated through the Impact/Effort Matrix (Figure 1) to guide institutional action. We created an Office of Community Faculty and appointed an assistant dean. We addressed communication issues identified by community faculty by distributing

Table 1: Summary of Stakeholder Structured Interviews (N=14 Stakeholders)

Themes	Example
Challenges for institution	• Challenging to recruit and retain qualified clinicians who are interested in teaching. • "Always" looking for teachers and clinical sites—thinner pool as student number increases and curriculum changes. • Training sites may not be able to manage the larger class size. • Need to figure out how to share community faculty members even though each program has different learning objectives. • Inconsistent need for placements of learners. • Shouldn't overburden with too many expectations because they are too valuable to lose.
Subjective challenges pertaining to community faculty members	• Teaching is a financial burden for community faculty members. It takes more time to teach and there is pressure to see a lot of patients. • Some have figured out how to effectively use students. Need to communicate how this is done or pay for the lost time. Don't want to go down the path of paying. • Community faculty training opportunities need to be available and convenient. Onsite, streamed live, or online for viewing later. • Need CME and MOC to maintain board certification; would be helpful if could offer.
Ideas for engaging and recognizing community faculty members	• Recruiting good people relies on recruiting good students. Present a better product and/or advantage—university learners are more professional, have more skill, can help in other ways than students from another institution. • Lean on the University name and reputation. • Some would like to be involved interviewing prospective medical students. Appreciated the offer in the past. • Recognize community faculty members regularly. Recognize for every 2/5/10 years of service. Offer awards, plaques, mugs, business cards, certification of service. Make them proud to volunteer, make it seem competitive.

Abbreviations: CME, continuing medical education; MOC, maintenance of certification.

Table 2: Community Faculty Experience—Areas or Issues in Which the Community Faculty Member Either Has Some Control or Which Results in a Direct Impact to Their Practice

Themes	Example or Quotation
Learners Are the Reason I Am a Community Faculty Member	
It keeps me sharp.	"I find that incredibly stimulating and it's a very, very enjoyable experience." "It makes me hopeful." "It makes our community stronger." "It's part of our heritage."
I offer a unique and valuable learning experience for my learners.	"I still think it's a valuable gift to a resident to be out in the community to see real world medicine practiced." "I think [we have] a different perspective. But when they come out to interact with the adjunct faculty, we teach them that there's another world out there, they can be part of that world."
I wish I had more time with the types of learners I like to work with / that the learners were motivated.	"I'm not inspired to do it for a resident who's going to show up, you know, 'oh, I have something else to do.' You don't care, I don't care." "If we could consistently count on residents being there, it would make a large difference in how we would approach having them."
Sacrifice	
I sacrifice time and money to have learners in my clinic.	"Sometimes it's a big sacrifice." "When you have a student, things slow you down." "You have to block out all kinds of extra time."

Table 3: Institutional Barriers and Opportunities Defined as Issues for Which the Community Faculty Had Little Control

Themes	Example or Quotation
Communication	
Coordinating community faculty member schedules with learner schedules is difficult and at times haphazard.	"They just show up. They may or may not be there." "We'll get all types of students … and so sometimes it gets a little confusing trying to figure out how am I going to coordinate which students are coming on which days and some of them are planned by the school of medicine and some of them just reach out to me directly."
I do not understand the curriculum and worry that learners won't learn what they need to from me.	"It's sometimes offensive when they don't see us as worthwhile contributors to the bulk of knowledge of medicine." "They send these residents to us and I guess I have no idea what the goals are for the residents at our clinic, what the residency program expects them to learn and get out of our—we just see them and teach them."
I want to be more involved than I am asked to be.	"Don't forget about us." "It's so easy to fall off the radar." "I don't have much opportunity to teach, but I think I have a lot to offer."
Procedural obstacles that make it difficult.	"…don't say they're coming until we know they're ready to hit the ground running…"
I don't understand what the expectations are.	"It'd be nice to know what they expect." "It's not helpful if you don't have any feedback." "Define the role. What is it? What do they want?"
Recognition	
Recognition for the services I provide	"Teaching is good and it's a two-way street, you learn as much as you impart. But it takes time, and it takes effort, and something to recognize that would be good." "I don't really expect much in terms of recognition. Recognition or pay for that matter. I do it all kind of out of goodness of my heart." "So, I'm not just an internist in the community, I'm not just a community physician, having that connection with the university I think gives you that little extra I guess I would say credibility."
My academic role as reflected by title, rank, and promotion.	"I assumed that if I was promoted from—I don't know the levels, but if I was promoted from associate to assistant or whatever, I assumed that meant that I was doing a good job teaching and they liked what I was doing."
Access	
Community faculty members have access to the university specialists.	"You have access; you feel the kind of thought of as you have access to people who are leaders in their field." "It would be nice if we could be integrated more with the specialists up at the hospital."
I feel like I am part of the university.	"I like having that connection with the medical school, just kind of staying in the loop."

Table 4: Community Faculty Survey

Characteristic	n (%)
Race	
White	356 (85)
Asian	19 (5)
Ethnicity	
Hispanic/Latino	13 (3)
Age	
28-45 years	152 (36)
46-65 years	232 (55)
> 65 years	35 (8)
Highest Degree	
MD	289 (68)
DO	22 (5)
MD/master	43 (10)
PhD/another doctorate	38 (9)
Other	31 (8)
University of Utah Alumni	
Completed any education in Utah	285 (63)
Graduate/professional	154 (33)
Residency/fellowship	172 (36)
Provide Clinical Care at Employment	
Yes	362 (80)
Primary Department	
Family medicine	131 (29)
Internal medicine	57 (13)
Pediatrics	46 (10)
Other E&M-based clinical	48 (11)
Procedure-based clinical	90 (20)
Hospital-based clinical	59 (13)
Basic science/other	16 (4)
Rank	
Professor	28 (6)
Associate professor	59 (13)
Assistant professor	83 (19)
Instructor	74 (17)
Do not know	203 (45)
Type of Work	
Clinical care with learners	341 (73)
Clinical care with no learners	53 (11)
Classroom/lab education	126 (26)
Research	58 (12)
Number of Learners in Clinical Setting	
1	180 (55)
2-4	148 (46)

(continued on next page)

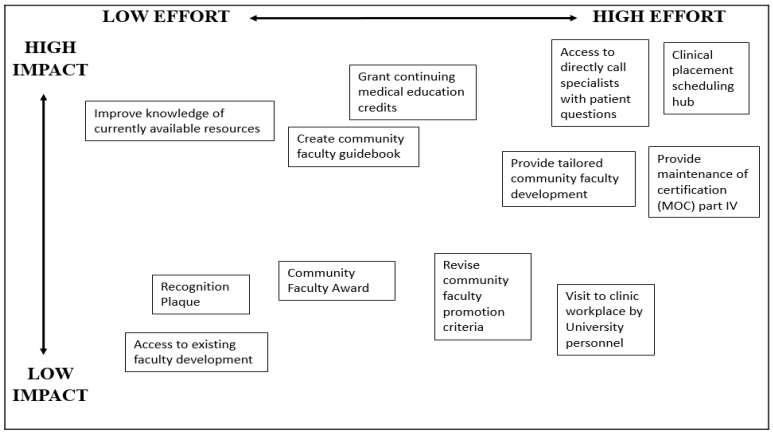
Table 4: Continued

Characteristic	n (%)
Type of Learner in Clinical Setting[1]	
Medical student	241 (51)
Resident	229 (49)
PA student/NP student	167 (25)
Undergraduate student	73 (16)
Fellow	58 (12)
Other	24 (5)
Reasonableness Given Benefits	
Not at all reasonable	21 (5)
A little reasonable	33 (8)
Somewhat reasonable	96 (23)
Very reasonable	220 (54)
Extremely reasonable	41 (10)

Abbreviations: E&M, evaluation and management; PA, physician assistant; NP, nurse practitioner.

[1] Could choose more than one response.

Figure 1: Effort and Impact of Activities Aimed to Retain Community Faculty



Effort anchored by question: "How easy is it for the stakeholders and university to address to improve retention and recruitment?" Impact anchored by ranking the value of the benefits identified by survey respondents.

an electronic newsletter spotlighting faculty, news, and development opportunities. We also created an online resource guide and support for promotion.

To improve teaching, we adapted existing faculty development programs.[5] Targeted curricula include integrating students into a busy practice environment and mitigating financial losses through scheduling. We now offer continuing medical education-accredited synchronous and asynchronous learning opportunities.

Although updating promotion guidelines was deemed low-impact, high-effort, when a large department updated theirs, we assisted. We now notify departments annually of community faculty eligible for promotion.

We recognize community faculty with a community faculty award, supported by a local business and the alumni association. Award winners, chosen with learner input, are featured in the newsletter, alumni magazine, social media, and at commencement.

To increase community faculty access to university specialists and maintenance of certification part IV credit, we partnered with institutional hospital and quality improvement groups. We recently launched a speed consult service via the electronic health record.

Our study's findings may be limited as it was conducted at a single institution. Some clinical specialties may have been overrepresented and professorial rank may be misreported by faculty.

Discussion

Education stakeholders clearly articulated the value of community faculty, while community faculty reported both positive and negative experiences. As the need for clinical teaching sites and preceptors outstrips availability, it behooves medical school leadership to demonstrate to community faculty they are valued.[1,7] Our findings elucidate areas of focus, including efforts to improve community faculty experience by addressing

institutional barriers and enhancing institutional advantages.

Our approach provided community faculty a voice and allowed us to triangulate their thoughts with those of other stakeholders. The majority of stakeholders and community faculty perceive the relationship as mutually beneficial. Consistent with self-determination theory and other studies,[6,7] the community faculty were intrinsically motivated. They identified the primary benefits of teaching students as "keeping me sharp," staying connected to medical advances, and contributing to future generations. Though they encounter financial or workload disincentives, community faculty perceive the overall value of participation as high.[7]

To preserve the relationship between the medical school and community faculty, institutions should address barriers including scheduling errors, ineffective communication, and lack of recognition. Optimizing scheduling and providing curricular goals and feedback are essential.

The Impact/Effort Matrix was crucial for prioritizing and allowed us to act first on low-effort, high-impact issues, such as highlighting resources and opportunities. We have brought institutional focus to implementation of high-effort, high-impact initiatives. For example, creation of a central clinical placement hub could decrease institutional barriers, and will take substantial investment from multiple institutional stakeholders.

At a time when competition for community placements is increasing, listening to the voices of community faculty members—an indispensable educational resource—produced new resources to support and retain them.

ACKNOWLEDGMENTS: The authors thank Dr Vivian Lee, whose support made this project possible, Drs Karly A. Pippitt and Terry D. Box for serving as inaugural assistant deans for community faculty, and Raheed Al Dumani, PhD for statistical analysis.

FINANCIAL SUPPORT: This investigation was supported by the University of Utah Study Design and Biostatistics Center, with funding in part from the National Center for Research Resources and the National Center for Advancing Translational Sciences, National Institutes of Health, through Grant 8UL1TR000105 (formerly UL1RR025764). Study data were collected and managed using REDCap electronic data capture tools hosted at University of Utah.

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