
1b. Developing and Adapting Curricula for Community Faculty Development

Constance D. Baldwin, Ph.D., and Mark Quirk, Ed.D.

UMass Community Faculty Development Center (CFDC): A Regional, Interdisciplinary Approach

Community Faculty Development Center (CFDC) Structure

1. Regional Advisory Committee (RAC) which defines mission and goals and participates in recruitment of workshop participants
2. Core Curriculum is delivered to preceptors during 3 two day workshops each year called Teaching of Tomorrow (TOT)
3. Participating institutions include UMass, UConn, Harvard, Yale, Dartmouth, Brown, UNECOM, Tufts, BU, NYMC, CUNY, UVM, Einstein, Albany, SUNY

Teaching of Tomorrow (TOT)

- Approximately 85 preceptors from family medicine, pediatrics and internal medicine commit to all 3 workshops in the series
- Fifteen faculty (primarily from UMass) deliver plenary and small group sessions
- Focus is on 1 / 1 teaching in the office setting
- Includes a “teach the teachers” component for purposes of dissemination

Core Curriculum

1. Organizing an educational experience
2. GNOME
3. Difficult and challenging teacher/learner interactions
4. Integrating learners into practice
5. Interacting purposefully with learners
 - Teaching styles
 - Teaching problem-solving
 - Modeling as a teaching technique
6. Motivating learners
 - Adult learning
 - Learning styles

7. Teach the teachers
 - Interactive presentations
 - Teaching in small groups
 - Planning workshops

TOT Workshop Methods

1. Interactive plenary presentations
2. Demonstration (videotape and live)
3. Small group discussions
4. Individual role-plays with feedback

Parallels Between Teaching and Clinical Practice

- Goals for learners / Goals for patients
- Assess learner’s needs / Assess patient’s needs
- Choose methods / Choose treatment
- Evaluation (observation, OSCE, etc.) / Follow-up (labs, clinical course, etc.)

Example: Assessing the Learner’s Needs using Teaching Styles

1. Assertive style — focussed questions: e.g., What questions should you ask to characterize a headache?
2. Suggestive style — leading questions: e.g., Under what circumstances would you use one antibiotic over another?
3. Collaborative style — open questions: e.g., What do you think is going on?
4. Facilitative style — reflective questions: e.g., How comfortable are you taking a sexual history?

Community Faculty Development at the University of Texas Medical Branch at Galveston:

Interactive Workshops On Teaching Skills

1. Annual full-day workshop (~30 preceptors/yr)

- Basic didactic curriculum: Organization and planning, teaching, observation and feedback, evaluation
 - Extensive interactions through brainstorming, discussion, role plays, Q/A regarding course expectations
 - Informal networking opportunities: reception, lunch with topic tables
2. Two-hour workshops at annual primary care CME courses (~ 75 preceptors/yr)
 3. Mini-sessions at regional dinner meetings on focused topics selected by group (6-12 preceptors/meeting)

Written FD Materials

1. Course materials: Learning goals and objectives, student profiles, evaluation forms, contact information
2. Faculty handbook: Condensed version of the basic teaching skills curriculum
3. Self-directed learning modules for CME credit (with mailed hard copy and Internet distribution options)

FD Activities at Practice Sites

1. Informal visits used to build rapport; address community faculty questions and concerns; provide individual feedback to preceptors; and develop community support staff as FD outreach agents
2. Formal site development activities (Terri Spear's model, N.C. AHEC program):
 - Basic teaching skills development for **all** members of the practice team (not MD focused!)
 - Given by invitation from practice only, at time and place determined by the practice
 - Brief, low-tech didactics + extensive, creative interactions

Master Teacher Program

Goal: To establish a network of excellent educators among our community faculty who can serve as FD outreach educators for our program.

Plan for Master Teacher program development:

1. Set up 6-12 MT practice sites with advanced telecommunications equipment
2. Organize MT's into a community advisory board that meets through tele-communications technology
3. Provide MT's with intensive faculty development, based on a plan negotiated individually with each
4. Develop and pilot with the MT's new community FD and student learning activities using tele-comm
5. Offer FD workshops via videoconferencing at regional sites, with MT's serving as on-site facilitators

Uses of Telecommunications to Enhance Community Faculty Development

1. Enhancement of collegial interactions through internet and video conferences
2. Collaborative student-preceptor education about clinical uses of telecommunications
 - Development of PBL cases with patients from the community practice
 - MEDLINE/PUBMED and Internet searches
 - Use of handheld computers to access DX protocols, practice guidelines, drug information
3. Web-based and video-based FD and preceptor evaluation
 - On-line self-directed learning modules on teaching skills with video enhancements
 - FD "OSTE" using standardized students (video-delivered) and structured preceptor responses
 - FD videoconferences, with on-site facilitators
 - Evaluations at a distance through video linkages

WORKSHOP HANDOUTS:**Developing and Adapting Curricula for Community Faculty Development**

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Condensed set of workshop overheads/slides

**University of Massachusetts
Community Faculty Development Center**

Teaching of Tomorrow II Workshop Curriculum

**University of Texas
Medical Branch at Galveston,
Generalist Physician Initiative Program**

1. Learning objectives for community faculty development
2. Summary of community faculty development activities
3. Community faculty development “pearls”
4. Community faculty needs assessment
5. Guidelines for community-based faculty appointments
6. Overview of community faculty evaluation
7. Educational consultation and problem solving regarding community faculty
8. Summary of UTMB program and Gulf Coast Consortium for Community-based Education

**ITEM 1
TEACHING SKILLS DEVELOPMENT
FOR COMMUNITY FACULTY:****Learning Goals and Objectives****Developing specific learning objectives for faculty development helps to:**

- Link curriculum with identified needs
- Clarify purpose of program for presenters and recipients
- Focus evaluation of the faculty development program
- Enhance efficiency of faculty development efforts

Learning objectives for community faculty should reflect:

- Needs assessment information
- Course priorities
- Community faculty interests and wishes
- Time available to community faculty
- Resources available

Sample Goals and Objectives

Goal 1. Understand and appreciate the purposes, goals and objectives of community-based medical education, including promotion of careers in generalist medicine, exposure of students to positive physician role models in the practice and community setting, and development of students’ skills in primary care medicine.

Specific learning objectives:

- a. List the purposes of community-based medical education.
- b. Describe the knowledge, attitudes and skills valuable for practice in a small community.

c. Demonstrate the rewards and benefits of a career in community medicine.

d. Effectively model the multiple roles of a community physician.

Goal 2. Understand how to orient and organize one's practice and staff to facilitate efficient and effective medical education.

Specific learning objectives:

- Describe the potential roles of all staff members in facilitating student learning.
- Prepare one's patients for their contributions to student education.
- Discuss methods for scheduling student learning activities in the practice setting to provide adequate opportunities for practice and feedback.
- Plan learning experiences that are appropriate to the students' stages of development.
- Cooperate and collaborate with other educators of medical students in your community.

Goal 3. Understand and appreciate the clinical skills best taught to students in the community practice setting, and develop a variety of methods for addressing these student needs.

Specific learning objectives:

a. Model for students' correct performance of patient interviews, physical examinations, and patient education and counseling.

b. Help students learn and practice a systematic approach to conducting patient interviews, physical examinations, and patient education and counseling, depending on the type of patient visit (new patient, health maintenance, acute care, chronic care).

c. Recognize in your observations of students their common errors in verbal interactions with patients, including:

- Failure to introduce themselves
- Failure to maintain eye contact
- Using complex vocabulary
- Obtaining information in a disorganized fashion
- Over- and under-controlling the interview
- Failing to request essential information from the patient (e.g., social history)
- Displaying judgmental behavior
- Failure to ask open-ended questions
- Asking leading questions
- Failure to respond to patient in way which encourages him/her to talk
- Demonstrating insensitivity or inappropriate affect
- Ignoring patient's behavioral cues or emotional state
- Providing incorrect information to the patient
- Failure to attend to patient confidentiality

d. Recognize in your observations of students their common errors during the physical examination and performance of procedures, including:

- Failure to demonstrate technical competence in examining body systems and evaluating body responses
- Failure to evaluate all the appropriate systems
- Insensitivity to patient's modesty
- Failure to explain procedures in advance
- Failure to prepare patient for embarrassing or painful procedures
- Failure to avoid unnecessary pain and minimize necessary pain to the patient

e. Recognize in your observations of students their common errors in providing patient education and counseling, including:

- Failure to develop rapport with the patient
- Failure to take an adequate family, social and environmental history
- Failure to inquire about the lifestyle and living conditions that may affect patient compliance
- Displaying judgmental behavior, particularly about risky behaviors and lifestyles
- Failure to adapt interventions to the needs and attitudes of the patient
- Failure to consider the influence of cultural and ethnic influences on patients concepts and attitudes

f. Provide opportunities for students to perform patient interviews, examinations, and patient education and counseling, and observe their performance during these activities.

Goal 4. Understand and appreciate the importance of frequent interactions between students and preceptors, including mutual observation and feedback, during clinical preceptorships.

Specific learning objectives:

- a. List the benefits of student/preceptor interactions. Among these, frequent interactions with students:
 - Clarify for student the objectives of the educational program and their accomplishment of these objectives
 - Demonstrate to student that preceptor is attentive to their learning
 - Provide opportunities for development of an adult relationship with the student
 - Provide opportunities for feedback to students to improve their skills and abilities

b. Plan a variety of methods for efficiently incorporating interactions with students into the daily routine of the practice.

Goal 5. Recognize the difficulties and develop skills in evaluating students and providing them with clear, sensitive and timely feedback.

Specific learning objectives:

- a. Overcome one's reluctance to confront students about inadequacies in their performance.
- b. Evaluate students at a level appropriate to their stage of development.
- c. Clearly focus praise and criticism of students on specific behaviors.
- d. Focus on observed behaviors and avoid voicing generalities based on inferences from these behaviors (e.g. if student neglects to perform a sexual history, don't accuse him/her of laziness or ignorance).
- e. Demonstrate sensitivity to students' feelings and self-esteem in providing negative feedback.
- f. Provide constructive feedback which encourages and informs students so they can improve their performance.
- g. Give the students opportunities to evaluate their own performance and share their feelings about their inadequacies.
- h. Provide students with opportunities for remediation and reevaluation.

Goal 6. Understand the student problems that may occur in the community practice setting and develop strategies for handling them.

Specific learning objectives:

- a. List the common student problems which arise in the community practice setting, including:
 - Student's cognitive performance is deficient.

- Student has difficulty learning required clinical skills.
- Student has difficulty performing technical skills.
- Student is disorganized or careless.
- Student is chronically late or absent.
- Student is tactless and rude in contact with patients, peers, support staff and/or preceptors.
- Student has emotion problems that interfere with his/her ability to interact with patients or colleagues.

Goal 7. Understand and appreciate the key teaching skills of clinical preceptors, and learn to evaluate and enhance these skills in oneself.

Specific learning objectives:

- List the teaching skills required of clinical preceptors, including:
 - Teaching students according to the principles of adult learning
 - Communicating specific and concrete expectations for student performance
 - Recognizing and exploiting “teachable moments”
 - Offering timely and effective feedback
 - Providing good role modeling
- Commit sufficient time and effort to interact with the student.
- Use student and peer feedback to guide improvement of your teaching skills.
- Use student performance as an indicator of the efficacy of your teaching efforts.
- Pursue continuing education opportunities relating to teaching in areas of need and interest.

**ITEM 2
SUMMARY OF COMMUNITY
FACULTY DEVELOPMENT ACTIVITIES**

a. Annual community faculty teaching skills workshop. Workshops emphasize interactive discussion and demonstration of teaching skills. A full-day workshop, taught by an education specialist, working with a clinician, and is offered each fall. Shorter workshops are offered to smaller groups locally.

b. Teaching skills workshops during annual review courses for internal medicine, family medicine, and pediatrics. 1-2 hour workshops that focus on essential teaching/learning concepts. These are repeated each spring.

c. Regional dinner meetings with teaching skills mini-sessions. 30-60 minute discussions of educational topics of interest to a community faculty group, selected after an informal group needs assessment. These are repeated for different groups of faculty in their communities.

d. On-site community faculty development visits by medical center faculty. These visits are being conducted around the state by medical education specialists and clinicians, who spend a half-day at a practice site answering questions and providing guidance about teaching and course goals.

e. Teaching skills handbook. We distribute this 20-page handbook, based on PEP workshop material, to all community faculty.

f. Self-directed learning modules on community-based education (under development). An alternative means of providing basic information on teaching to community faculty who do not come to our workshops. The modules will include a written handbook and illustrative videotapes, plus evaluation materials to obtain Category 1 CME credit.

g. Faculty development workshops given by community faculty. We are providing support to an experienced community faculty educator in Austin TX for a teaching skills workshop series for our many faculty in that area. We hope to propagate this efficient faculty development model in other communities. Community faculty “stars” can be cultivated by sending them to national meetings and workshops and including them as presenters at your faculty development workshops.

h. Teaching skills seminars for residents (i.e., future community faculty). These are included in our GPI seminar series for residents in family medicine, pediatrics, and internal medicine.

Sources of Information on Curriculum for Teaching Skills Workshops

1. Preceptor Education Project Instructor’s Manual and Participants Workbook (Society of Teachers of Family Medicine)
2. Faculty Development Workbook: A Multi-disciplinary Curriculum and Resource Guide for Teaching in Community Health Centers (Massachusetts Statewide AHEC Program)
3. Ferenchick, G., Simpson, D., Blackman, J., DaRosa, D. and Dunnington, G. Strategies for Efficiency and Effective Teaching in the Ambulatory Care Setting, *Academic Medicine* 1997; 72: 277-280.
4. Irby, D. Teaching and Learning in Ambulatory Care Settings: A Thematic Review of the Literature. *Academic Medicine* 1995; 70: 898-931.
5. Sheets, K. and Harris, D. Questions Asked by Family Physicians Who Want to Serve as Medical Student Preceptors. *J. Family Medicine* 1996; 42(5): 503-511.
6. Sachdeva, A. Use of Effective Feedback to Facilitate Adult Learning. *J. Cancer Education* 1996; 11:106-108.
7. Terri H. Spear, Edam, Southern Regional

AHEC, On the Road Again: A Traveling Preceptor Development Series, Train the Trainer Workshop, August 11-12, 1998, Galveston TX. [tspear@med.unc.edu]

Advantages and Disadvantages of Different Faculty Development Methods

Interactive Teaching Skills Workshops

Pros

- Can be packaged flexibly (duration, location)
- Stimulates faculty interest and participation
- Reasonably adaptable to needs of individual faculty
- Can build in incentives and rewards (e.g., free travel, hotel, and/or CME)
- Provides needs assessment information back to program

Cons

- Time intensive for presenters
- Must gather dispersed faculty at one location
- Expensive (facilities, food, travel)
- Time for interactions slows pace and limits scope of content
- Number of faculty included is limited

FD Visits to Practice Sites

Pros

- Builds faculty rapport with program
- Can target special program needs: e.g., need to increase feedback to students
- Can target individual faculty needs, questions, concerns
- Good way to assess and help “special needs” faculty

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- Can provide high quality evaluation data to program

Cons

- Time- and cost-intensive
- Impact limited to relatively few faculty members
- Inconsistent information may be given to different faculty members

Written/Self-instructional FD Materials

Pros

- Minimal labor after development
- Inexpensive to distribute widely (via mail or Internet)
- Can offer broad content and depth
- Offers consistent information to all faculty
- Can be used to target special interests, advanced skills of certain faculty

Cons

- Significant front-end labor and cost
- Requires a diverse development team
- Motivating faculty use is challenging
- Opportunities for interaction, questions are limited
- Provides limited information back to program

ITEM 3

RECOMMENDATIONS TO COMMUNITY-BASED FACULTY DEVELOPMENT PROGRAMS

1. Take advantage of the multiple functions that can be served by a faculty development program. A faculty development program can not only enhance the quality of education in community practice settings, but also improve relations between the medical center and community fac-

ulty, promote networking among community faculty members, build preceptors' enthusiasm for and satisfaction with teaching, and reward them for their efforts.

2. Link benefits to participation in faculty development activities, in order to provide incentives for good teaching. Using faculty development activities as a reward for preceptors provides two-way benefits; this strategy is especially effective if your program does not reimburse its community faculty. Consider covering their CME costs, paying for food, travel and/or lodging when they attend workshops, and including their family members in incentive packages linked to attendance at faculty development conferences.

3. Develop a curriculum that emphasizes efficient as well as effective teaching. Help preceptors create an educational environment that balances the demands of practice with the demands of teaching. Meeting this preceptor need will increase their satisfaction, reduce the risk of burn-out, and substantially enhance the teaching that they can provide to the student.

4. Include community faculty members as faculty development planners and teachers. Experienced community faculty can help make your curriculum useful and practical, and in workshops, they can speak to their peers with credibility. They can also be effective role models and "cheerleaders" for your program. Community faculty can be cultivated to provide faculty development sessions for their peers at convenient times and at places close to home.

5. At workshops, encourage community preceptors to teach each other through interactive activities. Faculty development activities which include group brainstorming, collective problem solving, and role plays of commonly encountered teaching situations provide learning which is directly relevant to the workplace. Experienced community faculty often have a great deal of teaching

wisdom to share with their peers; their input gives vitality and realism to the learning process.

6. Deal diplomatically with community faculty teaching problems, and have a clear plan for this process. Most teaching problems in the practice setting result from time constraints on the preceptor or confusion about course expectations. Orientation of the preceptor by telephone, a conversation with a more experienced preceptor, or a personal visit to the practice site is often sufficient. When serious problems arise, a written plan that lays out the rules for problem verification, communication, and intervention will reduce the potential for misunderstanding and confusion.

7. Expect the needs and interests of your community faculty to change over time. Your faculty development program cannot afford to stay the same: while new, inexperienced preceptors will always need basic skills development, your teaching veterans are more likely to stay interested in a changing faculty development curriculum that reflects their evolving needs and level of expertise. Keep an ear to the ground through your network of community preceptors to assess preceptors' concerns and identify new faculty development opportunities.

New Areas of Opportunity for Community-based Faculty Development Programs

1. Improved methods for evaluation of preceptor performance and faculty development program outcomes are needed. All educational programs need to be evaluated, but for new and experimental programs, careful evaluation can be a key to survival. Geographical and political barriers make program and preceptor evaluation in the community particularly challenging. We need to document that our community faculty are teaching well, and that students are progressing toward their learning goals. We must also document that faculty development programs are cost-effective, reach preceptors, and

meet their learning needs.

2. Telecommunications offer an exceptional opportunity to reach a widely dispersed community faculty. Limited time and long distances often restrict preceptors' access to faculty development opportunities. As internet use increases and access becomes increasingly affordable, faculty development that uses televideo and internet-based technologies will make our programs far more available to community faculty.

3. Faculty development curricula need to look beyond teaching skills. While teaching skills development is the appropriate focus of most programs, long range planning should consider new areas of medicine about which both preceptors and students need to become informed, such as managed care, evidence-based medicine, medical informatics, and telemedicine. Creative educational approaches in the community practice setting can address the needs of both preceptors and students simultaneously.

These recommendations were developed by Constance D. Baldwin, Ph.D.*, John A. Ullian, Ph.D.#, Harold G. Levine, M.P.A.*, Christine C. Matson, M.D.#, Al Denio, M.D.#, Mary P. Wainwright, M.S., R.N.+, William J. Crump, M.D.*+

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ITEM 4 COMMUNITY FACULTY DEVELOPMENT NEEDS ASSESSMENT

Purpose

- Target faculty development activities to highest priority needs
- Respond to community faculty interests

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- Adapt activities to changing needs
 - Use resources efficiently

Methods

Initial needs assessments

- Faculty self-assessment surveys
- Interviews with community faculty
- Review of training priorities of community-based courses
- Literature review
- Consultation with experienced programs

Ongoing needs assessments

- Faculty self-assessments
- Evaluation data (faculty, student, and program)
- On-site interactions with community faculty
- Information from community representatives (e.g., AHEC personnel)

TARGETING THE FACULTY DEVELOPMENT NEEDS OF COMMUNITY PRECEPTORS: THE RESULTS OF A TEXAS NEEDS ASSESSMENT SURVEY

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Since 1994, the University of Texas Medical Branch (UTMB) has been conducting yearly needs assessments of its large cadre of community preceptors with a survey which covers: 1) their interest in education-related rewards and incentives, 2) their preference for different types of faculty development, and 3) their interest in developing specific teaching skills which are important for edu-

cating students in the practice setting. The survey was designed to help us prioritize faculty incentives and target faculty development needs. We received responses from 231 primary care preceptors, about half of our active preceptor group. The respondents have a wide range of teaching experience and work in family medicine, general pediatrics, or general internal medicine practices in urban and rural communities throughout the eastern half of Texas.

Responses to our “wish list” of rewards and incentives indicate that the largest percentage of preceptors (70-80%) placed high priority on CME in patient care and educational books for their practice site. Items of high priority to 60-70% of respondents included CME in teaching skills, library access, and patient education materials. Items of high interest to 50-60% of respondents included improved communications with on-campus faculty, self-directed learning modules for faculty development, computer training and support, and a faculty appointment at UTMB. Only 29% of respondents gave a high rating to payment for teaching time (28% gave it the lowest rating). Some items on the “wish list,” such as participation in a primary care research network (32% with high ratings) and assistance in recruiting a physician for one’s practice (33% with high ratings), help to identify individuals for whom special incentives may be appropriate.

Types of faculty development offerings were ranked as follows, according to the percentage of respondents who gave them high ratings: individual activities at practice site, 52%; 2-hr seminars, 52%; distance learning, 48%; full-day workshops, 46%; and telephone access to campus experts, 39%.

The survey listed twelve teaching skills and asked how likely the respondent would be to participate in faculty development activities to develop his/her skills in each area. The largest percentage of preceptors gave high ratings to faculty development

on providing feedback (76%), followed by identifying trainee learning needs (75%), evaluating one's own teaching (69%), modeling physician attitudes and skills (67%), and modeling use of advanced technology (63%). All items except teaching small groups received high ratings from over 50% of respondents.

Responses to the survey were compared between subgroups of respondents divided by years of teaching experience, course taught, and discipline. Patterns of responses were generally similar between subgroups. The group with less than 2 years of teaching experience differed from more experienced teachers in having less interest in payment for their teaching time (21 vs 35% with high ratings), in involving clinic personnel in instruction (48 vs 63%), and in learning to teach small groups (19 vs 42%). Teachers of MS1-MS2 students in a longitudinal course, compared to MS3 clerkship preceptors, were more interested in learning to involve clinic personnel in teaching (68 vs 51%) and less interested in learning to observe students (44 vs 57%). The largest subgroup differences were observed between the disciplines. Pediatricians were less interested in a faculty appointment than internists (47 vs 71%), but more interested in teaching skills development than family physicians (81 vs 60%). Pediatricians gave consistently higher ratings than the other subgroups to the five faculty development options and twelve teaching skills. Compared to family physicians, internists were more interested in practice based research (44 vs 28%), and less interested in payment for teaching time (21 vs 40%), despite their high interest in receiving a faculty appointment (71% vs 58%).

ITEM 5 GUIDELINES FOR COMMUNITY- BASED FACULTY APPOINTMENTS

The Administration of the University of Texas Medical Branch recognizes that practicing physicians can and do make valuable contributions to

the various missions of UTMB, including: (1) active support of educational activities in either the undergraduate or graduate programs, (2) assistance in the development or support of clinical activities integral to the various missions of a department, and/or, (3) participation in a departmental or divisional research programs, (4) demonstration of other forms of service to a department. In response to these valuable contributions, UTMB would like to recognize many of these community-based physicians by offering community faculty appointments.

CRITERIA for APPOINTMENT:

As indicated above, the practicing physician may qualify for a faculty appointment by demonstrating support for a department in a variety of ways:

1. Active Support of Educational Programs:

- a. Regular and personal supervision of medical students and/or residents in the physicians practice setting;
- b. Regular attendance and supervision of clinical care activities on either the in-patient or out-patient service;
- c. Active participation in educational program planning, course planning or course management committee or task force at the University or Departmental level.

2. Support of the Clinical Activities of the Department:

- a. Organization or assistance in organization of satellite or out-reach clinics of a university department.

3. Participation in Research Activities:

- a. Performs as an active collaborator on clinical research protocols administered by members of the full-time faculty;
- b. Actively assists in the recruitment of research subjects or in the follow-up of such

subjects who are involved in UTMB, clinical research projects at UTMB;

- c. Organizes or assists in organizing clinical research projects.

4. Other Services to the Department:

- a. Demonstration of a continuing commitment to their community's healthcare by active involvement in local, state or national organizations;
- b. Active support for a department by service on local, regional or state **Advisory, Development or Alumni committees**;
- c. Active participation in various fund raising activities to support the missions of a department and/or the university.
- d. Regular and active participation in any appropriate Department or Medical School committee(s).

This document was prepared by L. Camp, Office of Primary Care Education, UTMB at Galveston 1/2/97

PRIVILEGES THAT MAY BE ASSOCIATED WITH SUCH AN APPOINTMENT:

Community Faculty Members May:

- Receive regular notification of Grand Rounds, research and educational seminars and lectures and be allowed to give presentations for these series by advanced arrangement;
- Have access to consultation with designated full time faculty regarding educational planning and teaching skills development;
- Have access to telecommunications packages available to all full-time faculty;

- Have access to teaching materials related to UTMB courses for which they are a designated instructor;
- Have access to selected facilities of a department including the departmental library, reprints, etc;
- Be allowed to attend/participate in university, departmental and/or divisional conferences and seminars and to obtain CME credit for this activity by advanced arrangement;
- Be allowed to attend and participate in the sub-specialty clinical activities by arrangement with the Division Director;
- Receive the departmental newsletter or other publications of the department;
- Attend the Annual Review Course specific to their discipline at the same tuition as the fulltime faculty;
- Be allowed to serve on departmental committees at the discretion of the the department chair;
- Be invited to participate in departmental social activities.

PROCESS FOR APPOINTMENT:

The process for appointment and/or promotion to the Community Faculty is similar to that used for the full-time faculty of a department.

A. Nominations/Applications:

1. Applications may be initiated by any of the following: (a) Department Chair (b) Director of any division (c) any full-time member of the department, (d) the community practitioner himself or herself.
2. The application/nomination should be made to the Chair of the appropriate department.

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3. The application or nomination must consist of:
 - a. a completed application form;
 - b. a supporting letter from one or more full-time faculty in the department;
 - c. a written expression of interest in the appointment by the practitioner;
 - d. a current Curriculum Vitae (CV).

The following two items are optional (at the discretion of the department chair):

- e. a copy of the (current) license renewal by the State Board of Medical Examiners;
- f. a copy of the current DEA & DPS certificates.

Other information may subsequently be requested to fulfill requirements of UTMB or the department.

B. Process:

1. The completed application will be reviewed for completeness of all requested documentation and then submitted to the department for processing.
2. After the department has had sufficient time to study the application and collect/request other appropriate data, the individual's nomination will be placed on the agenda for presentation and discussion by the full departmental review committee, if required by the individual department.
3. The application packet with recommendations of the departmental review committee, if appropriate, will be forwarded to the department chair for his/her action, and then will be forwarded to the Dean of Medicine, UTMB for final approval. The candidate will be notified of the final decision through the Office of the VP for Academic Affairs and Dean, School of Medicine.

C. Appointments and Reappointment:

1. An appointment to any rank within the category of Community Faculty will be for a period of one year.
2. Criteria for reappointment to the Community Faculty or for promotion in rank will be the same as those necessary for initial appointment. In addition, the candidate must have demonstrated ongoing service to the University or department in at least one category defined by these criteria.

Academic Rank:

An individual's initial appointment to one of the standard academic ranks (listed below) will be based on the individual's contributions in the categories previously described under Criteria for Appointment and also on one or more of the following:

1. Previous University appointments at UTMB or elsewhere;
2. Past residency/fellowship training and post-training CME credits;
3. Experience in practice;
4. Board certification and re-certification;
5. Documentation of prior service to the department and/or university, or to other academic institutions.

The **minimal** requirements for each rank are listed below:

A. Clinical Instructor:

1. Has completed a Residency Training Program in an LCME- approved program;
2. Is eligible to take the Certifying Examination (some exceptions);

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3. Has all necessary requirements to acquire full or associate membership on the Medical Staff of a hospital in their practice locality;
 4. Has the interest, willingness and potential to serve the University or department in one or more of the categories listed under Criteria for Appointment.

B. Clinical Assistant Professor:

In addition to meeting those criteria noted above, the physician:

1. Is Board certified; (this may be waived at the discretion of the department chair)
2. Is a member, in good standing, of the medical staff of one or more of the hospitals in the physician's community;
3. Has, by past performance, demonstrated commitment to the Department and its programs by rendering services in the categories listed under Criteria for Appointment.

C. Clinical Associate Professor:

In addition to meeting those criteria noted above, the physician:

1. Has served as Clinical Assistant Professor, or its equivalent, in this or another academic department, for a minimum of two years;
2. Has documentation of service to the department (as outlined in the Criteria for Appointment), on a continuing basis for at least four years.
3. Has undergone an extensive evaluation by the departmental review committee relative to past services to the department. Such review must be accompanied by letters from one or more members of the full-time faculty plus any additional evidence to support the clinician's activities;

4. Is actively involved in service to their community, beyond their standard practice of medicine, on the local, state or regional level. Documentation of such activities is required.

D. Clinical Professor:

In addition to meeting those criteria noted above, the physician:

1. Has documented continuing service to the University or department for at least eight years;
2. Has made major contributions to the health and welfare of his/her patients.
3. Has undergone an extensive evaluation by the departmental review committee relative to past services to the department. Such review must be accompanied by letters from 3 or more members of the full-time faculty;
4. Is actively involved in service to their community, beyond their standard practice of medicine, on the state, regional or national level. Documentation of such activities is required.

This document was prepared by L. Camp, Office of Primary Care Education, UTMB at Galveston 1/2/97

**THE UNIVERSITY OF TEXAS MEDICAL BRANCH at GALVESTON
APPLICATION for COMMUNITY-BASED FACULTY APPOINTMENT**

The following information is needed to process your appointment through the UTMB system and to develop a curriculum vitae in the UTMB format. Social Security Number, sex, race and marital status are all federal requirements even though they need not appear on the cv.

DATE: _____

APPLICANT CHECK LIST

_____ Completed Application	_____ ABP, ABIM, ABFP Certificate (copy)
_____ Residency Certification (copy)	_____ Hospital Credentials Cert. (copy); if applicable
_____ Texas Medical License (copy)	_____ Personal Statement (optional)
_____ DEA Certificate (copy)	

NAME: _____ **SS#** _____ - _____ - _____

D.O.B.: _____

SEX: _____ **RACE:** _____ **MARITAL STATUS:** _____

OFFICE ADDRESS: _____

OFFICE PHONE: _____ **FAX:** _____

EMAIL: _____

HOME ADDRESS: _____

HOME PHONE: _____ **BEEPER:** _____

MEDICAL TRAINING (Attach Copy Documentation)

MEDICAL SCHOOL: _____ **DATE:** _____

RESIDENCY TRAINING & DATES: _____

OTHER TRAINING & DATES: _____

PRACTICE EXPERIENCE:

TEXAS MEDICAL LICENSE #: _____ (Attach Copy of Current Renewal)

DEA #: _____ (Attach Copy of Current Renewal)

DPS #: _____ (Attach Copy of Current Renewal)

CURRENT HOSPITAL PRIVILEGES at:

(1) _____

(2) _____

(3) _____

(4) _____

RANK APPLIED FOR:

Clinical Instructor

Clinical Associate Professor

Clinical Assistant Professor

Clinical Professor

FACULTY REFERENCES

(Please have at least one of these persons submit a letter of nomination)

1. _____

2. _____

3. _____

Please submit a statement outlining your previous contributions to the department, to UTMB, or to academic institutions elsewhere. (Use extra sheets as necessary.)

Please outline what activities or functions of the department or University are of most interest to you and where you feel you could serve most effectively. (Use extra sheets as necessary.)

Please state how the department or the University can be of most service to you in your practice. (Use extra sheets as necessary.)

Signature: _____ Date: _____

Printed Name: _____

*(Please complete application and return to Associate Dean for
Faculty Affairs at UTMB %Faculty Appointment;
301 University Blvd. Galveston, TX 77555-____.)*

For Office Use only:

Date Application Received: _____/_____/_____

Complete Returned for Completion Date: _____/_____/_____

Date Application Forwarded to Department: _____/_____/_____

Date Application Received by Chairperson: _____/_____/_____

Date Application Assigned to Department Reviewer: _____/_____/_____

Date Reported to Department Committee: _____/_____/_____

Approved: Yes No

If no, please provide comments:

Date Decision Reported to Chairperson: _____/_____/_____

Date Decision Reported to Dean: _____/_____/_____

Date of Appointment: _____/_____/_____

Appointment as:

Date Primary Care Education Notified of Appointment: _____/_____/_____

Date AHEC notified of Appointment: _____/_____/_____

Date Applicant Notified by Phone: _____/_____/_____

By Mail: _____/_____/_____

Date Appointment added to UTMB faculty database: _____/_____/_____

Next Date for Mandatory Departmental Review: _____/_____/_____

NOTE: *The official database of Community Faculty Appointments will be maintained in the Office of the Administrative Secretary to the Associate Dean for Faculty Affairs, UTMB.*

ITEM 6

Overview of Community FACULTY EVALUATION

Purposes of Evaluation in Community Faculty Development Programs

1. To assess needs of the community faculty for orientation and teaching skills development.
2. To provide data for program improvement and evaluation of community faculty teaching skills and rapport with students.
3. To provide constructive feedback to community faculty about their continuing education needs as they relate to education.
4. To evaluate the faculty development program.

Steps in Creating a System for Evaluating Community Faculty

1. Develop a plan for evaluating the ability of community faculty to teach and organize educational experiences for students.
2. Develop a communication system to facilitate formal and informal collection of evaluation data and timely decisions about needed intervention.
3. Develop a communication system that conforms to the “political” realities of program management.
4. Develop an evaluation process that assures student and faculty confidentiality and follows due process.
5. Reach consensus on policies and procedures for addressing problems with faculty performance.

Sources of Information About Performance of Community Faculty

1. Student comments to community representatives and medical school faculty.
2. Student comments on standard evaluation forms.
3. Student comments in focus groups held after off-campus experiences.
4. Solicited comments from students about individual faculty members.
5. Information from discussions and observations at community practice sites by campus faculty and community representatives.
6. Self-evaluations by community faculty.

Information to be Obtained from Students

1. Satisfaction or dissatisfaction with: General treatment and acceptance by physician and staff, and avoidance of interpersonal conflicts, e.g., manifestations of racial prejudice, sexual harassment, etc.
2. Satisfaction with appropriate number, breadth, variety and level of responsibility, and level of delegation in dealing with patients.
3. Opportunity for call and emergency experiences.
4. Satisfaction with the time and attention paid to the student and the quantity and quality of feedback.
5. Quality of non-patient care experiences, e.g., community activities.
6. Reading and presentation assignments, if any.
7. Grading system and the grades received from the community faculty.

Information from Faculty Which May Relate to Faculty Development Needs

1. Faculty concerns and expectations of student performance and their perceptions of actual student performance.
2. Faculty methods of dealing with students' time demands.
3. Faculty methods of providing feedback.
4. Faculty expectations concerning students' use of time on work activities.
5. Faculty inquiries about the grading system.
6. Faculty concerns about "inappropriate" student behavior.
7. Faculty inquiries about issues that they hope the home institution will clarify, e.g., objectives of the community experience.
8. Responses to student comments.

Program Evaluation and Modification

1. A commitment to periodic review and modification of a faculty development program is needed to keep it in tune with changing needs and resources.
2. The scope and content of the faculty development curriculum is dictated by programmatic and community faculty needs. These needs change as the faculty become more experienced—eventually, both novice and accomplished preceptors will need to be accommodated.
3. Resource assessment should go hand-in-hand with needs assessment. New resources or altered priorities for existing resources may shift as a program develops and its needs change.
4. Faculty teaching performance is a key outcome measure, but assessment of the quality of education in the entire program may also dictate faculty development needs. E.g., faculty de-

velopment may need to improve specific clinical skills as well as teaching skills.

5. In addition to faculty performance, the program should evaluate the number and geographic distribution of community faculty reached and their frequency of exposure to faculty development activities.

A sample of a preceptor evaluation form is attached.

ITEM 7 EDUCATIONAL CONSULTATION AND PROBLEM SOLVING REGARDING COMMUNITY FACULTY

In order to improve the quality of teaching and education in our community-based programs, we need a procedure for dealing with teaching needs or problems regarding our community faculty. The process of educational consultation and problem solving was developed by the GPI Faculty Development Committee, working in collaboration with the East Texas AHEC and the Office of Primary Care Education.

We must deal effectively with teaching needs and problems that are identified at our community sites in order to maintain adequate standards in our teaching programs. We would like to resolve most teaching deficiencies without alienating community preceptors who may only need better orientation or targeted assistance to refine their teaching skills. Because so many UTMB components and personnel are involved in our community teaching program, it is essential that we develop a flexible but consistent process for dealing with faculty members who need skills development or other orientation. Lack of an agreed-on process is likely to lead to misunderstanding and conflict, unnecessary alienation of community faculty, and inefficiency or neglect in solving problems which need prompt resolution.

The purpose of the process described below is to facilitate, not complicate, problem solving. The most important element is good communication between the parties involved in identification and remediation of a problem. Confidentiality is also important, to avoid unnecessary conflicts between preceptors and students, or preceptors and program personnel. The thoroughness with which all steps of the suggested process are carried out and documented will vary considerably from case to case. More serious problems will require more thorough procedures and more complete documentation.

Throughout this document, we use the term “course director” to designate the individual ultimately responsible for dealing with problems with community faculty. Course directors may choose to delegate implementation of some of the tasks to others.

The Process

Identification of needs and/or problems:

Potential needs or problems with community faculty may be identified in several ways:

- Community faculty may ask for help with their teaching skills.
- AHEC staff or GPI site coordinators may observe and report problems at a site.
- Course directors or other campus faculty, GPI site coordinators or AHEC staff may receive informal or formal communications from students.
- Course directors may conclude from review of student evaluations that teaching deficiencies or site limitations need remedy.
- Other campus faculty who visit community sites may identify problems needing remediation.

Reporting needs or potential problems:

Whatever the source of the information, it is es-

sential that communications about problems are conveyed promptly but confidentially to those who need to know.

- The course director should be the first person notified. If more than one course director works with the preceptor, all should be informed, and they should decide among them who will oversee the problem-solving process.
- The course director should involve in the process those people who need to know.

Verification of needs or problems:

Verification of a potential problem should be under the direction of the course director. A suggested process would be to:

- Request detailed information from whoever reported the problem, in writing if the problem is serious.
- Discuss the problem confidentially with other involved parties (e.g., students, local AHEC staff, site coordinator, or co-preceptors at site) in an effort to confirm that a problem exists and define the circumstances (e.g., causes, effects, needs).
- Consider the problem in the context of other information available about the preceptor or the site (e.g., previous evaluation data).
- As indicated, call the community preceptor to discuss the situation.

Intervention:

If a need or problem is verified, a suggested process for intervention would be to:

- Define the desired outcomes of an intervention.
- Call the community preceptor to discuss potential solutions, including resources available to help him or her.

- Develop an intervention plan, which might be one of the following:
- Faculty member needs orientation or information only—the course director or AHEC staff can carry this out informally.
- Faculty member needs skills development—plan with the community faculty member, the Faculty Development Committee (which will provide expert resources) and AHEC (which will provide coordination services).
- Problem unresolvable—action taken at the discretion of the course director, after discussing options with the Office of Primary Care Education.
- Share the intervention plan with Dr. Camp, the AHEC staff involved, the Faculty Development Committee (if involved), or others who need to know.

Follow-up:

After an intervention has been implemented, a follow-up plan should be developed.

- Those who have been asked to intervene (e.g., faculty development specialists, AHEC personnel) should report to the course director when their work is completed.
- The community preceptor and site should be monitored as deemed appropriate by the course director.
- Community faculty member is given feedback as appropriate.
- For serious problems, documentation of efficacy of the intervention and further plans should be provided to the Office of Primary Care Education.

**ITEM 8
UTMB GENERALIST PHYSICIAN
INITIATIVE: BRIEF SUMMARY,
JANUARY 1997**

Since May 1994, the University of Texas Medical Branch at Galveston has undertaken an ambitious program of educational reform, infrastructure development and community outreach. The large size of our student body (800 students) and the size and distribution of our community faculty (400 preceptors with practices as far as 400 miles from Galveston) have provided many challenges. The size of our undertaking, however, enhances the significance of our successes. Our educational reforms promise to make a large impact on many future practitioners in the state, and hence on many underserved areas of Texas.

Over the past three years, we have developed our institutional infrastructure and partnership linkages to support generalist education in several important ways:

- **Primary Care Pavilion** opened for integrated primary care and generalist education.
- **Office of Primary Care Education** created, directed by L. Camp, Ph.D.
- **Recruitment of 400 community faculty** for practice-based clinical education
- **Extensive interactions with the East Texas AHEC** in community faculty recruitment, liaison, and development, as well as student recruitment.
- **Practice entry and support coordinator** hired.

These developments have made possible major curricular reforms, which are highlighted by the establishment of two new, required, community-based courses for a total of 600 medical students per year:

- **Community Continuity Experience (CCE)** places 400 MS1 and MS2 students in nearby community practices for longitudinal preclinical experiences in patient education, history taking, and physical examinations.
- **Multidisciplinary Ambulatory Clerkship (MAC)** is a 12-week clinical clerkship that places 200 MS3 students in general internal medicine, family medicine and pediatric practices in communities across east and southeast Texas.

Other developments in our educational programs include:

- **Summer generalist research experiences** for prematriculation and MS1 students.
- **Interdisciplinary experiences for primary care residents.**
- **Faculty development activities** for community faculty, including a variety of teaching skills workshops and written materials.

To track the success of these initiatives, evaluation processes have been developed to evaluate student and faculty performance in GPI-sponsored courses, monitor changes in student career preferences, and document graduate outcomes over time.

During the next three years, we will continue to monitor and refine our new courses and programs, particularly the MAC, which is now in its first year of full implementation. The CCE will be integrated with preclinical courses in patient evaluation and examination skills, medical ethics, and preventive and community medicine. Further development of the CCE and MAC will be meshed with major curricular changes to be implemented by the Dean of Medicine in 1998. New initiatives in interdisciplinary resident education will take full advantage of shared facilities in the Primary Care Pavilion. Faculty development activities will be intensified

as our community faculty grows. The practice entry and support component plans outreach activities in many rural communities that need generalist physicians.

These initiatives will help us to fulfill our commitment to the State of Texas as the pioneer institution among Texas medical schools in generalist education. We look forward to launching our first class of “GPI graduates” in 1998, and then documenting the career choices and practice outcomes of yearly groups of new physicians who have benefited from high quality primary care training in community settings.

Gulf Coast Consortium for Community-based Education

Consortium members:

- East Texas Area Health Education Center (AHEC) Program
- Community Partners
- Baylor College of Medicine
- University of Texas Health Science Center – Houston Medical School
- University of Texas Medical Branch at Galveston, School of Medicine

Mission. Through the effective collaborative efforts of member institutions, the Gulf Coast Consortium for Community-Based Education aims to ensure the availability to learners of high quality community-based educational experiences that make efficient use of community resources.

Goals

- Create comprehensive partnerships which cross traditional institutional, disciplinary and community boundaries to facilitate mutually beneficial outcomes for all participants in community-based education.

-
- Facilitate the efficient use of community resources in all aspects of community-based education by promoting collaboration and communication, in order to minimize confusion and the negative effects of competition.
 - Develop a telecommunications and logistical infrastructure that links member institutions, faculty, and students to support communications and distance learning.
 - Provide ongoing faculty development to enhance teachers' professional knowledge, skills, and attitudes that contribute to community-based education.
 - Develop and apply clear and consistent expectations across institutions of trainees and teachers at community sites.
 - Develop mechanisms for sharing financial and expert resources to support community-based education.
 - Acquire external funding to support collaborative ventures in community-based education.

The Gulf Coast Consortium for Community-Based Education is addressing these issues through cooperation and collaboration, with the goal of establishing common procedures for students and preceptors and sharing administrative resources to accomplish the mission and goals of the Consortium.

Background of the Consortium. In the past several years medical schools in the Gulf Coast area have been experimenting with programs to move students out of tertiary-care hospitals and into community offices and clinics. The challenges of establishing and maintaining community preceptorships include finding volunteer health care providers with the ability and the time to be good teachers; coordinating students' educational experiences to ensure the achievement of core competencies; establishing a reliable and standard method of evaluating student performance and abilities; and rewarding preceptors with meaningful incentives to encourage continued involvement. All of these problems are compounded when multiple schools are located within a relatively small geographical area.