Faculty Development Needs in Residency Redesign for Practice in Patient-centered Medical Homes: A P4 Report

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OBJECTIVES: The study's objective was to describe faculty development skills needed for residency redesign in 14 family medicine residencies associated with the Preparing the Personal Physician for Practice (P4) project.

METHODS: We used self-administered surveys to assess ratings of existing faculty development efforts and resident attitudes about faculty teaching between 2007 and 2011. Telephone interviews were conducted to assess faculty development activities and needs at baseline. Early project faculty development needs were addressed using tailored sessions delivered during site visits. We conducted a detailed content analysis of 14 site-specific comprehensive reports to characterize ongoing faculty development needs and faculty themes related to residency redesign.

RESULTS: Early in the P4 project, faculty needs included skills in using the electronic health record (EHR) in teaching, change management, curriculum design, evaluation, learning portfolios and individualized learning plans, career coaching, qualitative research, competency-based assessment, and leadership. As the project progressed, the need for a “learning together” approach when training residents in transformed practices emerged. Using the EHR more effectively, evaluation and competency-based assessment skills, individualized curriculum design, better career coaching skills, shared leadership, and team-based care skills were consistent faculty development needs. Redesign strategies included having a committed core faculty group, faculty retreats, curricular change process management, intra-residency collaboration, and providing adequate support for key individuals.

CONCLUSIONS: Faculty attempting to redesign residencies to train residents in patient-centered medical homes need new skills, and understanding these needs can inform faculty development programs nationally to achieve the crucial mission of training the workforce to accomplish this transformation.

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well underway. New skills needed to practice in a PCMH include managing relationships, information, and care processes to enhance quality and safety; use of appropriate evidence-based information in clinical decision making; and leadership based on interdisciplinary teamwork and shared decision making. Primary care redesign will have a dramatic effect on practice while simultaneously affecting how we teach learners in complex clinical settings. New and different skills are now needed for physicians who will implement reforms in the very near future. To succeed in creating an effective primary care workforce, there is a vital need to understand what is essential for those involved in residency training.

In 2004, the Future of Family Medicine Report called for a period of innovation and experimentation in the training of family physicians. In response to this call, Preparing the Personal Physician for Practice (P4) was established to catalyze and inform innovation in residency education in family medicine and primary care. The 14 residencies that constitute P4 are in the process of evaluating their innovative experiments. Collectively, they provide an informed view of both faculty and organizational challenges of implementing graduate medical education curricular redesign. Here we characterize the skills and strategies needed by faculty engaged in the redesign of family medicine residencies, especially to prepare residents to provide patient care in PCMHs.

**Methods**

**Setting and Participants**

The P4 project is a 5-year (2007–2012) national demonstration initiative of a spectrum of residency training innovations associated with the PCMH. The 14 participating programs are conducting experiments that include changes in length, structure, content, and location of training and expanded measurements of competency. Details of the P4 project and characteristics of the programs, including program type, size, and their specific innovations, are described elsewhere.

Each P4 site and the central evaluation team at Oregon Health & Science University (OHSU) received an IRB review. Sites were granted exemptions, waivers, or approvals by their sponsoring institutions.

**Data Sources**

Faculty development needs were obtained from three different sources: (1) Baseline Project Needs derived from an Initial Project Questionnaire, (2) Early Project Needs derived from a telephone interview with each program prior to their site visit, which informed the planning of a faculty development session delivered by the central evaluation team, and (3) Ongoing Needs derived from each program’s Collaborative Process Report, a document used to formally characterize the process of residency redesign. The Collaborative Process Reports were also used to identify redesign strategies for faculty.

The Initial Project Questionnaire was administered via telephone interviews with each program in summer 2007 to assess the status of IRB approval, feedback on core instruments, status of implementation and evaluation of innovations, faculty development needs, and current methods for engaging faculty and providing skill development.

The OHSU Evaluation Team and P4 Executive Committee co-chair visited 13 of the programs during the first 18 months of the project, allowing them to fully understand each program’s P4 innovation, clarify hypotheses to be tested, provide evaluation expertise, and deliver a customized faculty development session. The 14th program visit was delayed due to a devastating flood in that community. One to two months prior to each site visit, we conducted a structured telephone interview with residency faculty to collect data on their current faculty development needs. The information obtained from these interviews was used to construct 2- to 4-hour individualized faculty development sessions presented during site visits.

Each program’s Collaborative Process Report provides information from site visits and subsequent program contact (interval phone conferences and email exchanges), capturing the ongoing process of each innovation implementation and evaluation. The document is updated regularly to record this process status and any challenges. A standard report template is used to ensure consistency in capturing information in categories such as innovation components, implementation issues, measurement and evaluation issues, operational issues including threats and strengths, and site visit summary notes.

Each program’s faculty development activity status was derived from the Initial Project Questionnaire. Self-administered surveys collected annually at P4 sites captured existing faculty development effort ratings and resident attitudes about faculty teaching.

**Data Analysis**

Descriptive statistics were used to characterize ratings of faculty development efforts and resident attitudes toward faculty teaching at their respective P4 sites. One-way analysis of variance (mixed model) was used to assess changes in continuous measures over time, and chi-square was used to assess categorical variables. All tests were two-tailed with alpha levels set at 0.05.

To characterize ongoing faculty development needs, we conducted a detailed content analysis using classical techniques of the 14 site-specific Collaborative Process Reports. Two members of the evaluation team independently reviewed these reports and identified thematic areas that consistently reflected faculty development needs (MPE, EW). We used a standard iterative process to develop a coding document to ensure that theme definitions were applied consistently. After data were independently coded, consensus between coders was reached using
comparative analytic techniques until final thematic areas were agreed upon. The data presented here reflect the final thematic categories and their descriptions.

Results

Ratings of Faculty Development and Faculty Teaching in P4 Programs

Ratings of faculty development and faculty teaching in the 14 residency programs across the study years (2007–2011) are shown in Table 1. As illustrated, the quality of faculty development programs (rated by the program director) was in mid-range, on a 5-point scale from very low to very high, and did not change significantly over time. An increasing percentage of residents thought faculty in their programs spent enough time teaching residents during the first three project years, from 61.2% to 80.4% (P <.001). Though this declined to 75.4% in 2010/2011 for teaching, it did not decline enough to change statistical significance, and the trend for improvement in faculty teaching and supervision continued to hold. The quality of teaching was highly rated and increased over time, from 4.06 to 4.24, using a scale of 1 as substantially weak to 5 as substantially strong; a finding that is borderline in its statistical significance (P =.053).

Status of Faculty Development at the Start of P4

Faculty development activities present before the start of P4 in 2007 are listed in Table 2. Time devoted to faculty development activities varied considerably from self-directed efforts to regular faculty meetings (weekly, monthly, or quarterly intervals) and methods used included topic seminars taught by program faculty, retreats, outside speakers, and attendance at educational conferences.

Baseline and Early Project Needs

All P4 programs expressed the need for more faculty development as they embarked on their residency redesign journey. Programs identified specific skills in practice transformation (patient-centered care, using the EHR in teaching), change management, teaching (use of portfolios, adult learning), advising (career coaching, individualized learning plans), research (qualitative techniques, scholarly writing), curriculum design (competency-based objectives and evaluation), and leadership.

During site visits held in the first 2 years of the project, the evaluation team provided a faculty development session based on the needs of the program faculty at that time (Table 2). A total of 10 faculty development topics were delivered to the 14 programs. These sessions covered skills in curriculum design, teamwork, change management, and evaluation and research methods. Programs with site visits more than 10 months from the time of the Baseline Needs assessment (months 1–3 of project) were more likely to identify faculty development needs for the site visit sessions that differed from their needs at baseline.

Ongoing Faculty Development Needs

The faculty development needs that emerged from the analysis of the Collaborative Process Reports, presented in Table 3, are broadly categorized as Practice Transformation Skills and Educator Skills. The need to adopt a “learning together” approach when training residents to practice in a PCMH was the most predominant theme identified. New faculty skills identified in residencies undergoing practice transformation include (1) changing precepting to utilize the EHR more effectively and document competence during sessions, (2) greater proficiency at using the EHR for educational and quality activities, and (3) shared leadership and team-based care skills. More than half of the programs identified the need for better skills and resources for evaluation among their faculty.

Table 1: Ratings of Faculty Development and Faculty Teaching in P4 Programs

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<tbody>
<tr>
<td>Mean rating for quality of existing faculty development program scored by PD (SD) (scale: 1=very low to 5=very high)</td>
<td>3.14 (1.1)</td>
<td>3.14 (0.8)</td>
<td>3.29 (0.6)</td>
<td>3.29 (0.8)</td>
<td>.944</td>
</tr>
<tr>
<td>Resident Ratings of Faculty</td>
<td></td>
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<tr>
<td>Percent of faculty who spend enough time teaching residents</td>
<td>61.2%</td>
<td>71.7%</td>
<td>80.4%</td>
<td>75.4%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Percent of faculty who spend enough time supervising residents</td>
<td>70.9%</td>
<td>81.7%</td>
<td>84.9%</td>
<td>86.6%</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Mean rating for faculty teaching quality (SD) (scale: 1=substantially weak to 5=substantially strong)</td>
<td>4.06 (0.9)</td>
<td>4.17 (1.0)</td>
<td>4.23 (0.8)</td>
<td>4.24 (0.9)</td>
<td>.053</td>
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</table>

PD—program director
SD—standard deviation
<table>
<thead>
<tr>
<th>Program</th>
<th>Status of Faculty Development Activities at Project Start* (Month 0 of Project)</th>
<th>Baseline Needs* (Months 1–3 of Project)</th>
<th>Faculty Development Session Delivered by Evaluation Team (Early Project Needs) (Months From Baseline Needs to Session)</th>
</tr>
</thead>
</table>
| A       | • Self-development process for faculty to develop teaching modules  
         • Working on items from STFM task force, FMDRL | • Change Management  
         • Leadership in dealing with different cultures between hospital and clinic | Focus on Teamwork  
(1.5 months) |
| B       | • Informal programs  
         • Working on change management | • How to be a good mentor and mentee  
         • How to teach effectively in a busy practice  
         • Adapting to change  
         • Leadership | Shared Leadership for Managing Change  
(2 months) |
| C       | • Cover basic teaching skills and leadership skills  
         • Sessions taught by their own faculty or outside speakers | • Curriculum design and implementation  
         • Practice Transformation | Curriculum Design Workshop  
(4 months) |
| D       | • Quarterly faculty development programs for learning new skills | • Active coaching—performance-based proactive coaches rather than just advising, especially in area of career decisions.  
         • Adult Learning—use of Portfolios  
         • Writing objectives—specific, measurable objectives that are competency based | Resident Career Coaching  
(4 months) |
| E       | • Monthly meetings focused on faculty skills  
         • Recent topics: difficult conversations; scholarship  
         • Sessions taught by their own faculty and occasional link with affiliated local residency | • Scholarly Writing—How do they begin to write up the data they have collected and will be collecting  
         • Qualitative research techniques | Curriculum Design Workshop Collaborative Qualitative Research  
(4 months) |
| F       | • Faculty meets individually with chair  
         • Faculty topic every other month during noon meeting | • Helping faculty become more computer savvy  
         • How to use EHR to teach residents at the point of care | Precepting in the Electronic Era  
(8 months) |
| G       | • No formal program  
         • Faculty work with chair to establish plan to accomplish their goals | • No specifics identified | Educational Evaluation Methods |
| H       | • Weekly faculty meetings and one afternoon per month  
         • Recent topic: health behavior change | • Health behavior change  
         • Organizational change—dealing with uncertainty, increasing level of comfort, and being flexible | Educational Evaluation Methods  
(9 months) |
| I       | • Sporadic, but nothing systematic or structured  
         • Faculty retreats throughout the year | • Use of learning Portfolios, individualized learning plans  
         • Small group (case based) teaching and facilitation skills  
         • Competency-based evaluations | Competency-based Resident Evaluation  
(10 months) |
| J       | • Combination of seminars and attending conferences  
         • Core group meets regularly and focuses on resident training  
         • Planning sessions on patient-centered care | • Patient-centered care | Precepting in the Electronic Era  
(12 months) |

(continued on next page)
Other Educator Skills identified were (1) more curriculum design skills, especially for individualized curriculum, (2) better career coaching skills to assist residents in devising personalized educational plans, and (3) skills to accomplish competency-based assessment.

Discussion
This study identified a new and consistent set of faculty development needs in the P4 Project spanning from pre-project needs to those evident during site visits in the first 2 project years, to ongoing needs gleaned from the comprehensive reports across 4 project years. Not surprisingly, faculty engaged in residency redesign needed better skills in curriculum design and assessment. Though designing curriculum and assessing learners are not new faculty skills, some unique aspects of these skills were highlighted in the P4 project—specifically, individualized curriculum design and developing competency-based assessments.

Providing More Flexible, Individualized Training
Many of the P4 programs redesigned their residency training to establish core curricular elements while incorporating individualized training to meet the needs of residents’ personal career paths. Individualized training approaches are also part of residency redesign in general internal medicine and general pediatrics. This redesign element has altered both the content and process of residency education in these programs as they attempt to accomplish breadth and flexible customized depth. Residency faculty have traditionally provided career advising for residents. However, an enhanced set of career coaching skills, a better understanding of tools to use in career advising, and skills in assisting residents with personal educational plans will be increasingly important as residency training becomes more flexible and tailored to the individuals’ background, future career goals, and level of training progress. In addition to career advising for individualized training, faculty must also develop the capacity to support aspects of training related to individualized

Table 2: Continued

<table>
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<tr>
<th>Program</th>
<th>Status of Faculty Development Activities at Project Start* (Month 0 of Project)</th>
<th>Baseline Needs* (Months 1–3 of Project)</th>
<th>Faculty Development Session Delivered by Evaluation Team (Early Project Needs) (Months From Baseline Needs to Session)</th>
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| K       | • 1/2 hour each week during faculty meetings  
• Focusing on teaching consistency                                                  | • Managing Change Fatigue                                                               | Competency-based Resident Evaluation (13 months)                                                                                  |
| L       | • Haphazard or just in time                                                      | • Skills in adult learning and communication                                            | Building Capacity and Consistency for Change (14 months)                                                                           |
| M       | • Not available                                                                  | • Not available                                                                       | Instrument Design and Development for Program Evaluation (16 months)                                                              |
| N       | • “Vigorous faculty development from affiliated university  
• Recent topics: team development, conflict management  
• Quarterly programs for P4                                                   | • No specific areas identified                                                            | Building Capacity and Consistency for Change (27 months)                                                                           |

* Derived from an Initial Project Questionnaire administered during phone interviews conducted July–August 2007 at the start of the P4 Project
Table 3: Ongoing Residency Redesign Faculty Development Themes

<table>
<thead>
<tr>
<th>Themes Related to Faculty Development</th>
<th>Theme Descriptors</th>
<th># of Programs With Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Transformation Skills</td>
<td>PCMH skills are new to faculty, faculty are relative novices, faculty and residents working shoulder to shoulder, ample role modeling</td>
<td>6</td>
</tr>
<tr>
<td>New precepting skills</td>
<td>More tasks required during session (documenting competence, using point of care evidence); need techniques to use EHR during precepting</td>
<td>4</td>
</tr>
<tr>
<td>Greater EHR proficiency and use of EHR data</td>
<td>Residents are farther along than some faculty, residents teaching these skills to peers and faculty, using clinical data from the EHR to support educational activities and measurement of quality, generating reports at the team level to help build a sense of “teamness”</td>
<td>3</td>
</tr>
<tr>
<td>Shared leadership model for transformation</td>
<td>Faculty training on team-based practice redesign, physicians are not always the leaders, meetings for everyone to talk about PCMH development</td>
<td>2</td>
</tr>
<tr>
<td>Educator Skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation</td>
<td>Resources and capacity for evaluation is not great, overburdened with developing and implementing their innovations, shifting from implementation to analysis is important to start disseminating what they have learned, lack of on-site analytic expertise (qualitative and statistical)</td>
<td>8</td>
</tr>
<tr>
<td>Curriculum design</td>
<td>Faculty have content knowledge and experience but lack expertise in curriculum design, some faculty with curriculum design skills needed to mentor others, need specific time devoted to curriculum redesign</td>
<td>5</td>
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<tr>
<td>Career coaching</td>
<td>Faculty need career coaching skills and ability to assist residents in devising personal educational plan, need tools to assist in resident career advising, summary of a resident’s knowledge and skills helps in understanding of how to meet individual resident needs</td>
<td>4</td>
</tr>
<tr>
<td>Individualized curriculum design</td>
<td>Build in flexibility for variability in number of residents choosing a track, diversity in faculty beneficial in implementing individualized training, designate Track Coordinators and form Curricular Advisory Teams</td>
<td>2</td>
</tr>
<tr>
<td>Competency-based assessment</td>
<td>Measuring resident outcomes (what a resident does versus what they’re taught to do) is difficult, requires thoughtful planning</td>
<td>2</td>
</tr>
<tr>
<td>Redesign Strategies for Faculty</td>
<td></td>
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<tr>
<td>Faculty cohesion and commitment to project</td>
<td>Dedicated core faculty who are actively engaged in the project and committed to its success, capacity for implementing curricular changes directly tied to the cohesion and team spirit, faculty know their role and the roles of each other, willingness among faculty to experiment</td>
<td>6</td>
</tr>
<tr>
<td>Faculty retreats</td>
<td>Faculty retreats to slow down and reflect on changes, retreats have helped increase group involvement and shared responsibility</td>
<td>3</td>
</tr>
<tr>
<td>Curriculum management</td>
<td>Matching individual faculty with a curricular component they are passionate about, curricular elements developed in manageable pieces, step-wise approach to curriculum change</td>
<td>3</td>
</tr>
<tr>
<td>Collaboration with other residencies</td>
<td>Being part of a bigger effort to influence the discipline, motivated them to go forward</td>
<td>2</td>
</tr>
<tr>
<td>Providing adequate support for key people</td>
<td>Having enough faculty who can attend to the business of running a residency supports innovation process, a specific plan to free up additional time for core faculty</td>
<td>2</td>
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</tbody>
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PCMH—patient-centered medical home  
EHR—electronic health record
interests. For example, having faculty with more expertise in geriatrics, rural medicine, or advanced maternity care would be beneficial if individualized tracks in these areas were provided.

Accomplishing Competency-based Assessment

The Accreditation Council for Medical Education’s Outcome Project is based on measuring actual changes in learners’ knowledge and behavior.16 Many of the P4 innovations involve changes in the structure of training, including non-rotational longitudinal curricula and tailored learning plans with accompanying shifts to competency or performance-based assessment, rather than time- or event-based assessments. The P4 programs have struggled with the complexity and intensity of developing competency-based assessments, which was identified as a faculty development need for several programs, especially in early project years. The insufficient preparation of faculty to accomplish competency-based medical education has been highlighted elsewhere.17,18 Programs at the cutting edge of this process have also recognized difficulties in defining what competence is, whether it has actually been demonstrated, and how stable or reproducible it is. Currently, instruments for accurate, valid, and reliable measures of competency do not exist.19-21 Future faculty development efforts should address developing faculty skills in designing and administering competency-based assessments of learners, and adequate support must be given to this time-consuming task. A recent report describing a systematic process for developing tools to assess competency in a family medicine residency serves as one potential model for educators.22

New faculty development needs emerging from this analysis are based on skills required to practice effectively in a PCMH while simultaneously undertaking the difficult task of residency redesign. These skills expand the scope of faculty development to better prepare faculty for the changes occurring in clinical practice and medical education. As Steinert23 commented in a recent Academic Medicine faculty development theme issue, we should “broaden the focus of faculty development, remembering the critical role that faculty development can play in curricular and organizational change.”

Training Residents in a PCMH

An underlying principle of P4 is to learn how to improve graduate medical education of family physicians so they are well prepared to be outstanding personal physicians working in PCMHs. Educational features of PCMHs are more challenging when the concept continues to evolve, and faculty are relative novices in this type of practice. This has required a shift from traditional pedagogical approaches to a learning and discovering together approach. Faculty and residents practicing side by side in robust clinical practices and greater use of role-modeling as a teaching method will be necessary ingredients in future residency practices. This mirrors the National Demonstration Project evaluation team recommendation to “Learn to be a Learning Organization” given the emergent nature of the PCMH and the lack of true experts.24 Our findings are also consistent with others who have identified the need for faculty to receive more training in shared leadership and team-based skills.7,8

Greater use of technology and information mastery skills will be increasingly important to practice effectively in the future.7,9 The P4 experience demonstrates that new skills are needed to precept an electronic era to help residents gain EHR skills and use information effectively at the point of care. Faculty need to become more proficient at using the EHR as a tool to support educational and quality improvement activities. New payment systems based on meaningful use of EHRs further reinforce the need for these skills.25 The fact that residents are often farther along than faculty in adopting new technology suggests that the learning together approach can be applied here successfully. In some P4 residencies, residents emerged as key leaders and teachers who energized progress.

Managing Change

Early on, faculty identified a need for additional training in change management. The P4 programs have not merely been revising a few elements of residency training but are engaged in substantial redesign while simultaneously adapting to a rapidly shifting practice environment, which is resulting in fundamental and disruptive change. Program directors liken this work to running three different residencies simultaneously, ie, the old one, the transitional one, and the new one. Some programs have managed to overcome the resultant change fatigue and the steep learning curve for faculty. Strategies identified by these programs include time for targeted faculty development and reflection, acquisition of additional resources to provide support for key faculty working on curricular change, holding retreats, and planning face-to-face time with each other to reconnect to the values and vision of their project.

Given the complexity, time, and effort needed to transform practices and residencies, it is surprising that we found significant increases in resident ratings of faculty time spent teaching and supervising residents at a time when they would logically be drawn away from direct teaching. It is plausible that the learning together approach, more individualized training options for residents, and redesign strategies fostering faculty cohesion and commitment all led to a perception that faculty were more engaged and energized in their teaching.

Rigorous Evaluation Must Accompany Residency Redesign

Faculty in P4 programs identified a need for better skills in measuring and analyzing educational outcomes.
The quantitative and qualitative analytic expertise in P4 programs is under-developed and this, coupled with a focus on implementation over measurement, has led to limited evaluation capacity. This has made it difficult to shift from implementing changes to analyzing outcomes at a time when residencies and policy makers need guidance. Educators redesigning residency training must think and act more like researchers, and this is a significant culture shift. We need detailed information about competencies achieved by those completing these new programs, and we need to learn whether or not patients are receiving better care as a result. Meaningful assessment of the impact of program changes is a required price for innovation, and residencies must foster a greater focus on inquiry. For educational innovations to succeed in preparing the next generation of physicians for redesigned practices, rigorous evaluation and better outcome measures are needed.

To achieve this higher bar for evaluation and increase the strength of our evidence regarding educational interventions, all residencies need at least some faculty trained in educational assessment and research design. Future faculty development efforts should include skills in defining educational research questions and related hypotheses, utilizing mixed method designs, designing and testing measurement instruments, conducting simple analyses and interpreting data, and employing experts when needed for proper analysis.

A strength of this report is that faculty development needs were assessed before the P4 project started, during site visits in the early project years, and later through regular updating of the site-specific reports. This report is based on contemporary experiences of programs committed to improving their training for emerging systems of care. Though only 14 programs are included in the P4 project, and these programs are not necessarily representative of other family medicine and primary care residencies, they do include a diversity of sizes, geographic regions, program types (university-based and community-based), and settings (urban and rural). Importantly, faculty in P4 programs are early adopters of curricular change, and the faculty skills identified in this report may over-represent those needed to be innovators and experimenters and under-represent the new specific skills needed to train learners in medical homes.

This report is based on contemporary analysis. Future faculty development interventions, all residencies need over-represent those needed to be in innovative and experimenters and under-represent the new specific skills needed to train learners in medical homes.

In conclusion, the size and scope of expectations of family medicine and primary care residency during an unavoidable period of transformation are daunting. The faculty skills and strategies identified as necessary for residency redesign in the P4 project serve as a blueprint for the design and implementation of nationally available faculty development programs, supporting faculty in their crucial mission of training the workforce positioned to accomplish transformation.

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References