Developing the Developers: Faculty as Workforce Catalysts

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3RNET Annual Conference · Thursday, August 27, 2026

Approaches to Faculty Development Among New Rural Residency Programs

3RNET Annual Conference

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Disclosures

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The content are those of the presenters and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.

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Objectives

At the end of this session, the participants will be able to:

1. Describe the main types of faculty development programs being used by developing rural residency programs in the United States

2. Explore goals that may be achieved with various faculty development programs

3. Consider specific opportunities that may meet the needs of the participant’s program.

Background

1. Doctors are needed internationally in rural areas

2. Physicians who train in rural settings are more likely to stay and practice rurally

3. “Place based” training allows students to learn about their surroundings, capitalize on lived experiences, and take advantage of local leadership, investment, and connections for successful and sustainable learning opportunities

Background

- Since 2019, HRSA has funded the **Rural Residency Planning & Development (RRPD) program** designed to **start rural residency programs** (at least 50% training in rural settings).
- HRSA funds a **Technical Assistance Center** to support the RRPD grantees and others looking to start and sustain residency programs in needed specialties in rural & underserved settings.

102 Grantees	**36 + 1** States & Territory	**6** Specialties	**66** Accredited Programs	**818** Resident Positions

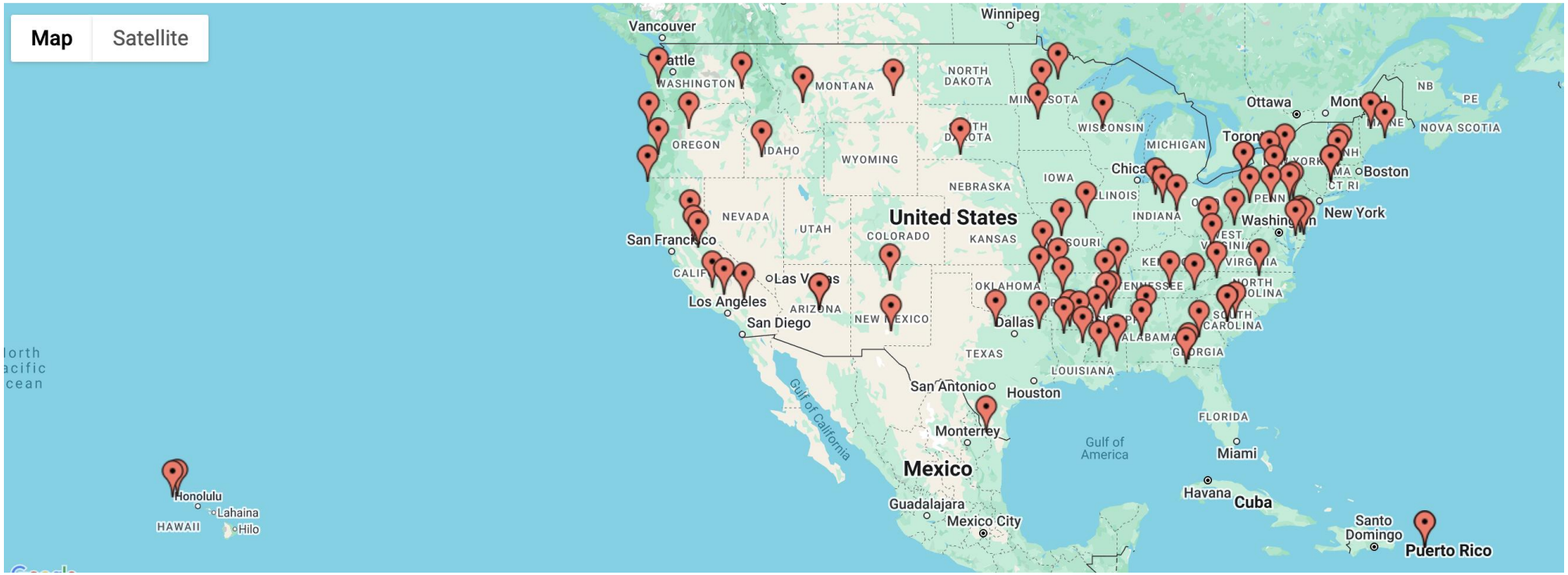
1. https://www.hrsa.gov/rural-health/grants/rural-health-research-policy/rrpd
2. https://www.ruralGME.org

RRPD Grantee Programs

Our Program

Rural Residency Planning and Development Grant Recipients

The U.S. Health Resources and Services Administration (HRSA) funded Rural Residency Planning and Development (RRPD) Program is supporting the development of new rural residency programs or Rural Track Programs (RTP) in family medicine, internal medicine, psychiatry, OB/GYN, general surgery, preventive medicine, and other specialties as determined by HRSA in future Notices of Funding Opportunities (NOFO). Explore all of the RRPD locations in the map below!



STAGE 1 Exploration

Community Assets

Identify community assets and interested parties.

Leadership

Assemble local leadership and determine program mission.

Sponsorship

Identify an institutional affiliation or sponsorship. Begin to consider financial options and governance structure.

STAGE 2 Design

Initial Educational & Programmatic Design

Identify Program Director (permanent or in development). Consider community assets, educational vision, resources, and accreditation timeline.

Financial Planning

Develop a budget and secure funding. Consider development and sustainability with revenues and expenses.

Sponsoring Institution Application

Find a Designated Institutional Official and organize the GME Committee. Complete application.

STAGE 3 Development

Program Personnel

Appoint residency coordinator. Identify core faculty and other program staff.

Program Planning & Accreditation

Develop curricular plans, goals and objectives; evaluation system and tools; policies and procedures; program letters of agreement; faculty roster. Complete ACGME application and site visit.

STAGE 4 Start-Up

Marketing & Resident Recruitment

Create a website. Register with required systems. Market locally and nationally.

Program Infrastructure & Resources

Hire core faculty and other program staff. Ensure faculty development. Complete any construction and start-up purchases. Establish annual budget.

Matriculate

Welcome and orient new residents.

STAGE 5 Maintenance

Ongoing Efforts

Report annually to ACGME and the Sponsoring Institution. Maintain accreditation and financial solvency. Recruit and retain faculty. Track program educational and clinical outcomes. Ensure ongoing performance improvement.

To advance to the next stage: Make an organizational decision to proceed with investing significant resources in program development.

To advance to the next stage: Finalize a draft budget. Complete program design to include curriculum outline and site mapping. Submit a Sponsoring Institution (SI) application & receive initial accreditation.

To advance to the next stage: Achieve initial program accreditation – requires successful site visit and letter of accreditation from the ACGME.

To advance to the next stage: Complete contracts and orient first class of residents. Hire all required faculty.

J Grad Med Educ. 2020 Aug;12(4):384-387. doi: 10.4300/JGME-D-19-00932.1.

Faculty members must…

From the 7/2026 ACGME Common Program Requirements:

2.8.e Faculty members must pursue faculty development designed to enhance their skills at least annually: (Core)

2.8.e.1. as educators and evaluators; (Detail)

2.8.e.2. in quality improvement, eliminating health care disparities, and patient safety; (Detail)

2.8.e.3. in fostering their own and their residents' well-being; and, (Detail)

2.8.e.4. in patient care based on their practice-based learning and improvement efforts. (Detail)

This Study

Objective: Characterize types of faculty development that new rural residency programs with RRPD awards are using, describe typical structures of these programs, and assess differences by specialty, region, size, or program structure.

Methods: Descriptive and bivariate analysis of HRSA performance report data for fiscal year 2023 of 43 RRPD grant recipients who were starting new residencies to determine types and structure of faculty development programs.

Program characteristics *(N=43)*

Program cohort	
Cohort 1	13 (30.2%)
Cohort 2	10 (23.3.%)
Cohort 3	9 (20.9%)
Cohort 4	11 (25.6%)
Program specialty	
Family Medicine	31 (72.1%)
Psychiatry	7 (16.3%)
Internal Medicine	4 (9.3%)
General Surgery	1 (2.3%)
Program size (number total residents)	
0 (not yet designated)	6 (14.0%)
6 to 8	10 (23.3%)
9 to 12	12 (27.9%)
15 to 18	12 (27.9%)
>18	3 (7.0%)
Types of faculty development offered FY23	
structured faculty development training program	16 (37.2%)
other faculty development activity	22 (51.2%)
no faculty-related activities conducted	12 (27.9%)

Structured programs *among those with any (N=16)*

Median structured programs offered per residency (max, min)	1 (1-9)
Total structured programs offered across all residencies	32
Median faculty trained in structured programs per residency (max, min)	3.5 (0*-49)
Total faculty trained in structured programs across all residencies	178
Median length of structured programs (hours) (max, min)	7 (0.25-416)
Median hours invested across structured programs by all faculty trained per residency (max, min)	21 (1-832)
Total hours invested across structured programs by all faculty trained	2238
Median percent of time spent in structured programs developing competencies for the following roles (min, max)	
Educator	75% (0-100%)
Administration	7.5% (0-100%)
Clinical	0% (0-95%)
Research	0% (0-50%)
Location of program	
Local	15/32 (46.9%)
Regional	7/32 (21.9%)
National	10/32 (31.3%)

Faculty development "activities" *among those with any (N=22)*

Median faculty development activities offered per residency (max, min)	3 (1, 10)
Total faculty development activities offered across all residencies	68
Median faculty trained in faculty development activities per residency (max, min)	6 (1, 90)
Total faculty trained in faculty development activities across all residencies	260
Median clock hours of a single faculty development activity (total hours for all participating faculty) (max, min)	38 (1, 118)
Median hours invested across all faculty development activities by all faculty trained per residency (max, min)	66 (4, 454)
Total hours invested across faculty development activities by all faculty trained	1931
Type of activity	
Professional Conference	52/68 (76.5%)
Training/Workshop for Continuing Education	16/68 (23.5%)
Grand Rounds for Continuing Education	0/68 (0.0%)
Delivery mode used to offer training activity	
Classroom-based	51/68 (75.0%)
Hybrid	7/68 (10.3%)
Distance learning	8/68 (11.8%)
Experiential or field-based	2/68 (2.9%)
Grand Rounds	0/68 (0.0%)

Summary & Highlights

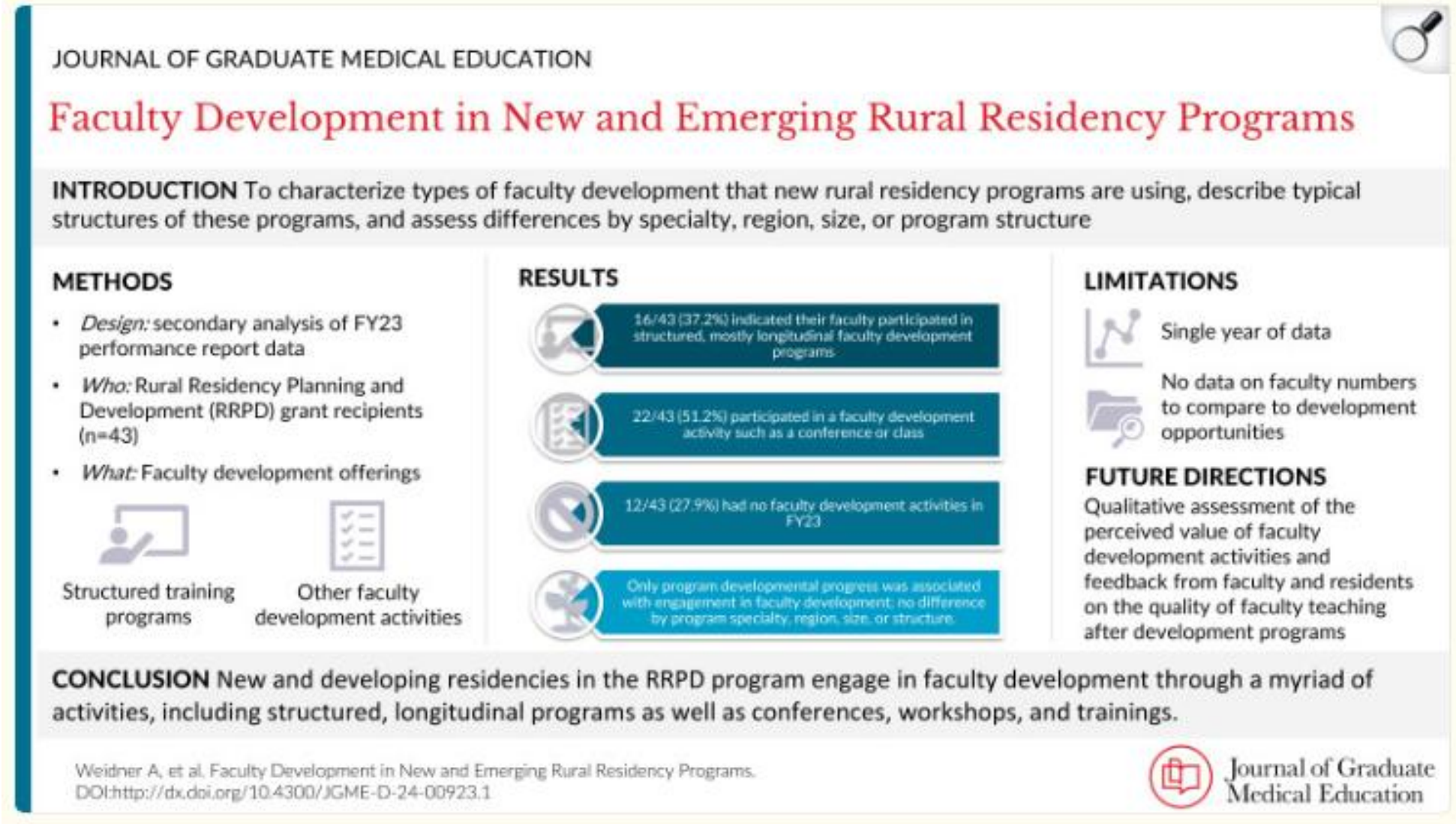
Of the 43 grant recipients in the reporting year:

- 16 (37.2%) indicated their faculty participated in structured, mostly longitudinal faculty development programs
- 22 (51.2%) participated in a faculty development activity such as a conference or class
- 12 (27.9%) reported no faculty-related activities in that year.

Those later in development were more likely to report engagement in faculty development.

There were no differences in quantity or type of faculty development based on specialty, region, size, or rural track structure.

Learn More!



JOURNAL OF GRADUATE MEDICAL EDUCATION

Faculty Development in New and Emerging Rural Residency Programs

INTRODUCTION To characterize types of faculty development that new rural residency programs are using, describe typical structures of these programs, and assess differences by specialty, region, size, or program structure

METHODS

- *Design:* secondary analysis of FY23 performance report data
- *Who:* Rural Residency Planning and Development (RRPD) grant recipients (n=43)
- *What:* Faculty development offerings

Structured training programs

Other faculty development activities

RESULTS

16/43 (37.2%) indicated their faculty participated in structured, mostly longitudinal faculty development programs

22/43 (51.2%) participated in a faculty development activity such as a conference or class

12/43 (27.9%) had no faculty development activities in FY23

Only program developmental progress was associated with engagement in faculty development; no difference by program specialty, region, size, or structure

LIMITATIONS

Single year of data

No data on faculty numbers to compare to development opportunities

FUTURE DIRECTIONS

Qualitative assessment of the perceived value of faculty development activities and feedback from faculty and residents on the quality of faculty teaching after development programs

CONCLUSION New and developing residencies in the RRPD program engage in faculty development through a myriad of activities, including structured, longitudinal programs as well as conferences, workshops, and trainings.

Weidner A, et al. Faculty Development in New and Emerging Rural Residency Programs. DOI:http://dx.doi.org/10.4300/JGME-D-24-00923.1

Journal of Graduate Medical Education

https://pmc.ncbi.nlm.nih.gov/articles/PMC12168987/

Conferences

A few examples…

- Rural And Health Center National GME Conference
- Rural Medical Training Collaborative* (formerly the RTT Collaborative)
- ACGME Annual Conference
- American Academy of Family Physician Residency Leadership Summit
- Society of Teachers in Family Medicine (STFM) Annual Conference
- Annual American Psychiatric Association meeting
- American Association of Directors of Psychiatric Residency Training
- Association of Program Directors in Internal Medicine

Longitudinal Programs

A few examples…

- VA's Rural Interprofessional Faculty Development Initiative (RIFDI)
- Harvard Macy Institute Program for Educators in Health Professions
- National Institute of Program Director Development (Family Medicine)
- STFM Faculty Fundamentals course (Family Medicine)
- Local or regional programs like the UNC Faculty Development Fellowship, Duke's Leadership Onboarding for Educators Accelerator Program (LEAP), Maine Medical Center Institute for Teaching Excellence (MITE)

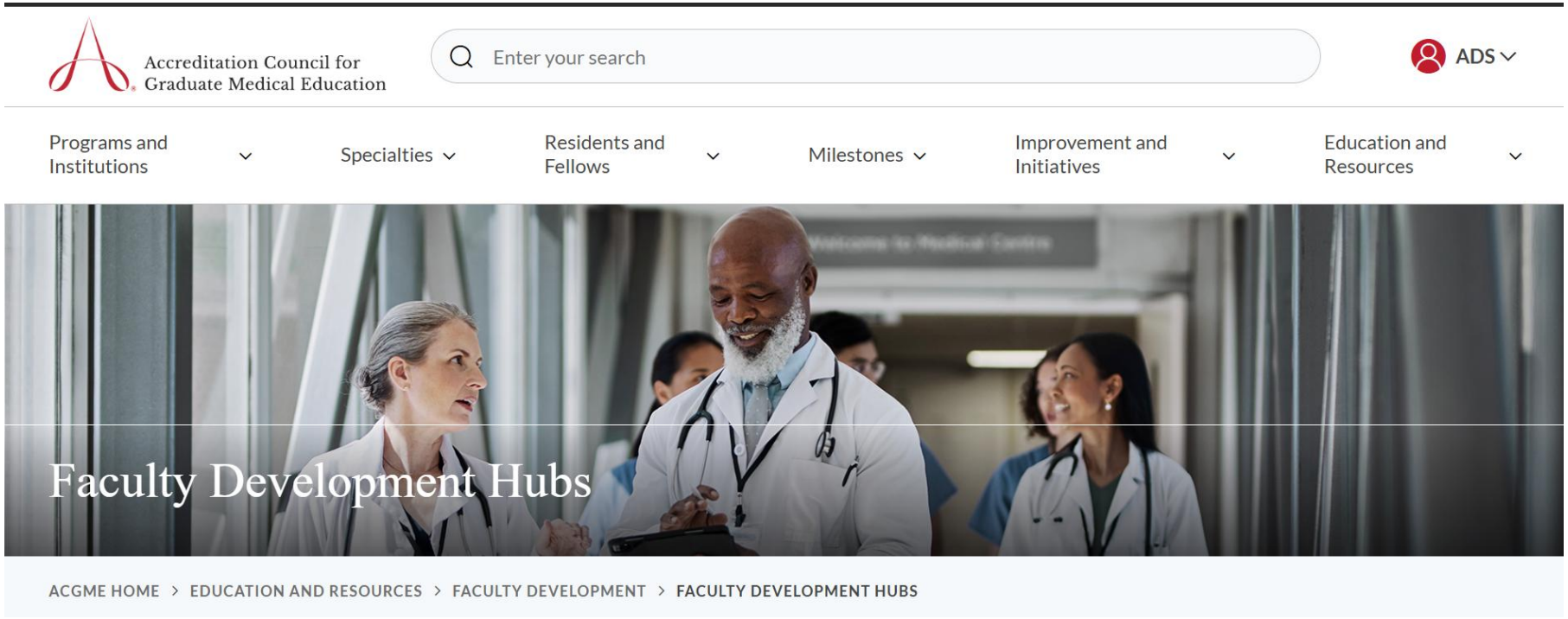
- And for coordinators/administrators too! Like Rural GME Coordinator Leadership Institute or AFMA Administrative Development Workshop

Other ideas

A few examples…

- Weekly micro learning (15 minutes on a particular topic each week)
- Webinars from the RRPD Technical Assistance Center and THCGME Technical Assistance Center
- Resources and guidebooks, e.g. *The Toolkit Series: A Textbook for Internal Medicine Education Programs*
- Look into offerings from your state and local medical society offerings, offerings at nearby medical schools, within your health systems…

ACGME Faculty Development Hub



https://www.acgme.org/education-and-resources/faculty-development/hubs/

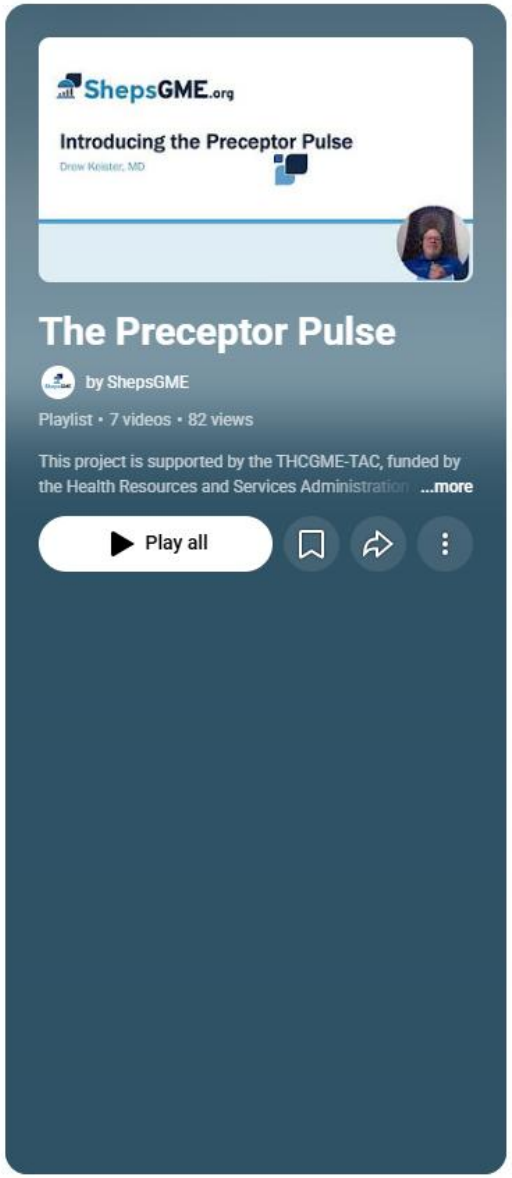
Scan for the ACGME Faculty Development Hubs

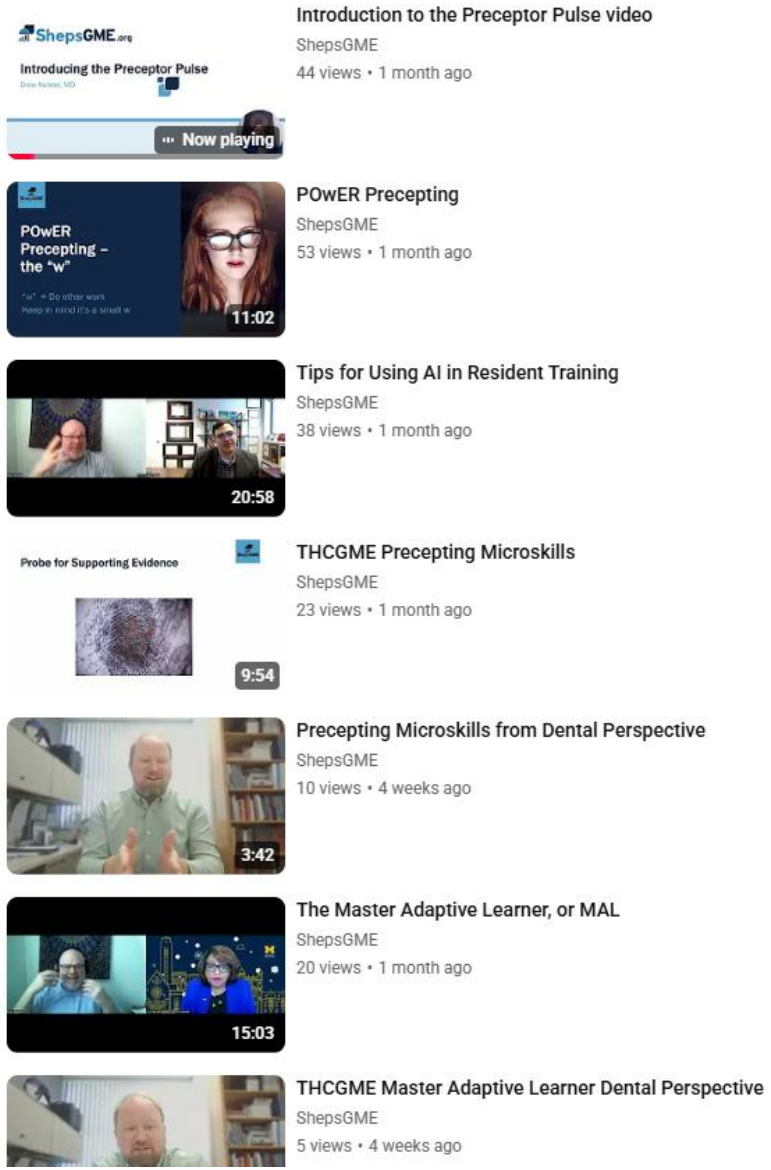
Faculty Development Hubs

- Carle Illinois School of Medicine
- Cathay General Hospital
- Chang Gung Medical Foundation
- China Medical University Hospital
- Cleveland Clinic Abu Dhabi
- Cleveland Clinic Foundation (Ohio)
- E-Da Hospital
- Hackensack Meridian School of Medicine
- International Medical Center
- Kaiser Permanente Hawaii
- Kaohsiung Medical University Hospital
- Karolinska Institute Stockholm
- Korea University Medicine
- Maine Medical Center
- Massachusetts General Hospital
- Mountain Area Health Education Center

Preceptor Pulse Podcast

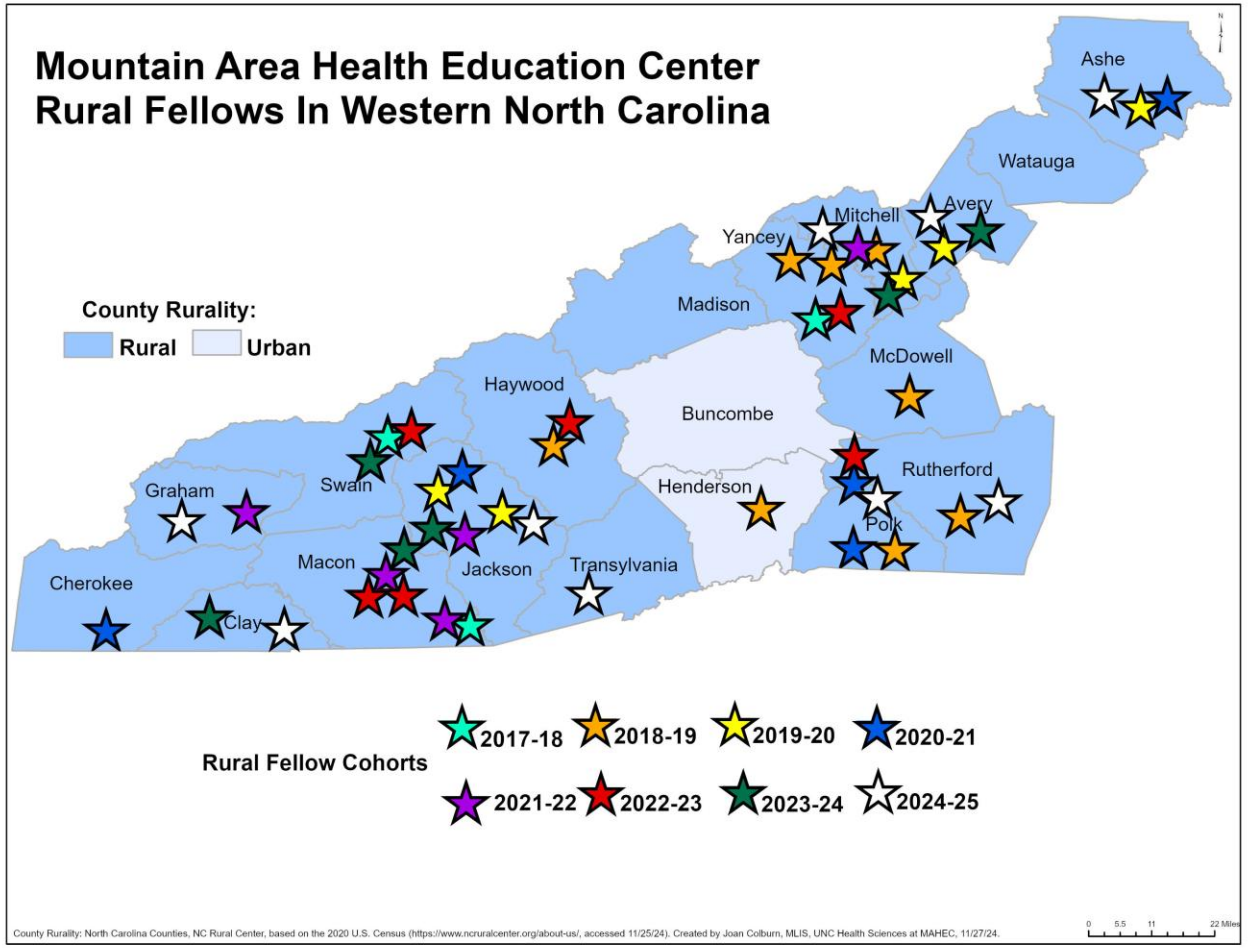
https://www.youtube.com/playlist?list=PLcpoYzFOEPLE



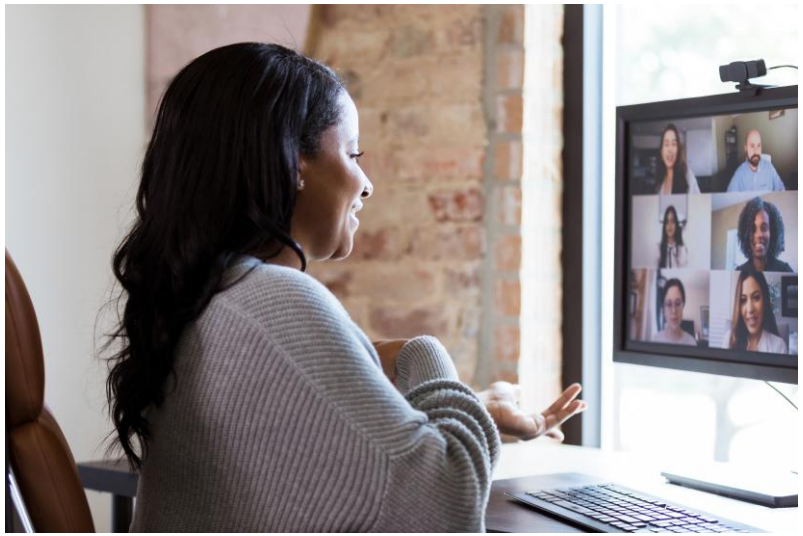


Mountains to Sea Statewide Rural Fellowship

https://mahec.net/rural-fellowship



NCGME Learning Network Sessions



Suggestions for topics?
Let us know!

Sessions are on the 4th Thursday of every month from 12:00-1:00pm EST.

Upcoming sessions:

- August 27, 2026: NC Office of Rural Health Updates: J1 Visas and Loan Repayment Programs
- September 24, 2026: Primary Care at the Farm: Building Community-Centered Care in Rural and Agricultural Settings

Future sessions:

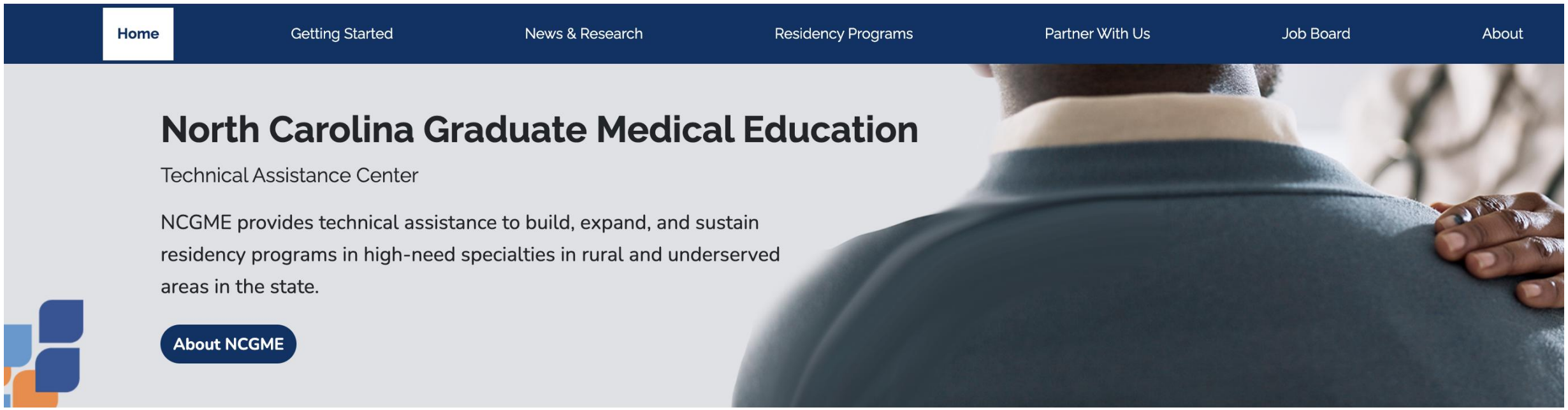
- NC Medicaid Office GME Reimbursement Q&A
- NRMP Exemption (direct pathway from med school to residency)
- Program Administration in Rural Programs

Specialty Specific Learning Community

- Rural general surgery program director and community faculty learning community – 2nd Thursdays, 5-6pm ET

Other Resources

NCGME.org



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ShepsGME

shepsgme.org

RuralGME

ruralgme.org

THCGME

thcgme.org

NCGME

ncgme.org

StateGME

stategme.org

Website Launching Soon

Tommy Koonce, MD, MPH · UNC Department of Family Medicine

3RNET Annual Conference · August 27, 2026 · Raleigh, North Carolina

Developing the Developers

One Faculty Development Strategy to Strengthen the Rural Workforce

The University of North Carolina at Chapel Hill

We Have Faced This Workforce Challenge Before

Academic family medicine then. Rural primary care now.

1970S–1980S

Building Academic Family Medicine

A rapidly growing new discipline

Too few prepared faculty and mentors

Limited academic and scholarly infrastructure

New departments, residencies, and curricula to build

Clinicians being asked to become educators and leaders

=

TODAY

Building the Rural Physician Workforce

Rapid expansion of rural training pathways

Too few prepared rural faculty and mentors

Professional and geographic isolation

New training sites, residencies, and partnerships to build

Clinicians being asked to become educators and leaders

The UNC Faculty Development Fellowship was created as part of the response to the first challenge.

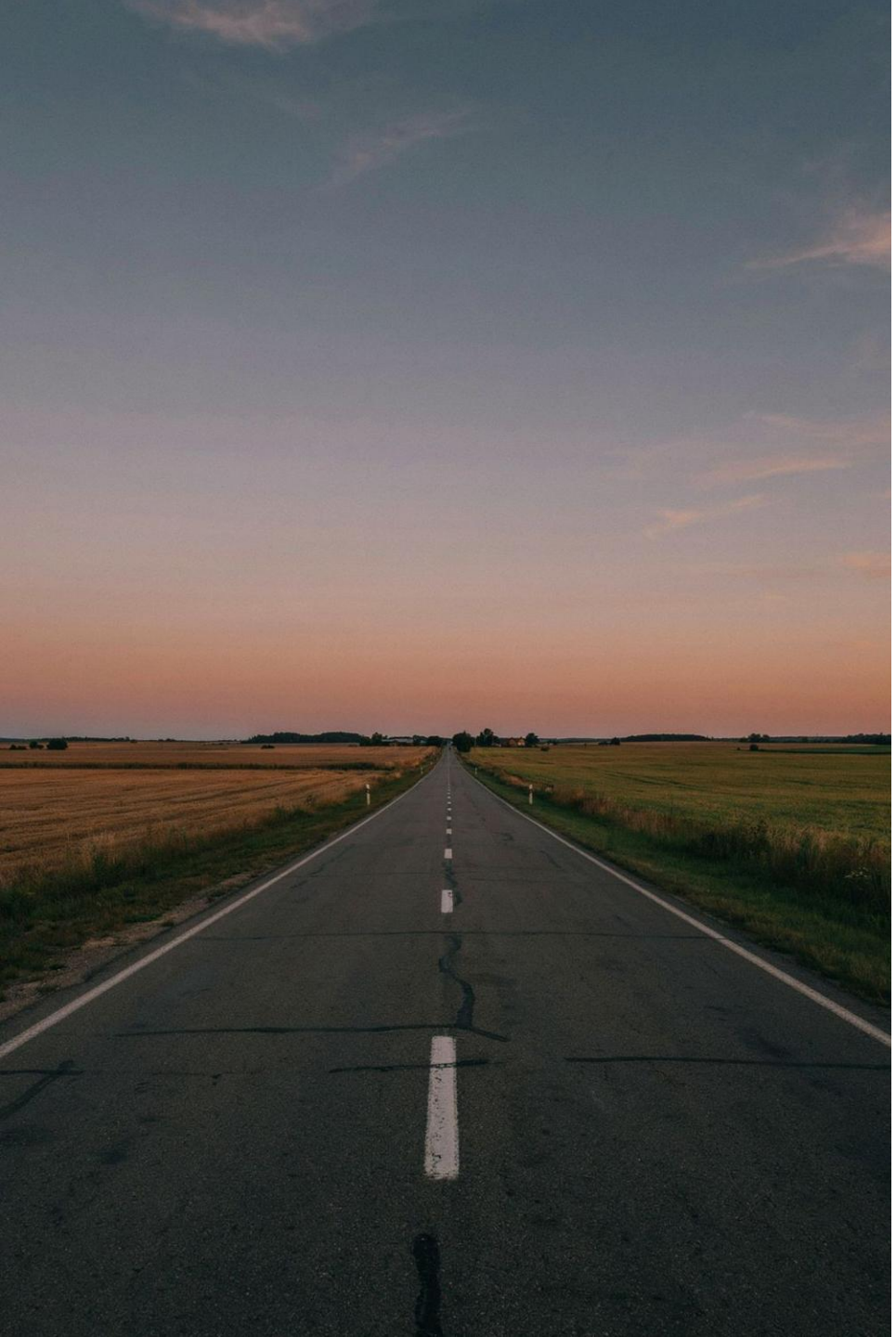
What might that experience teach us about the second?

The Question Behind Every Rural Training Program

Who will develop the people who develop develop the workforce?

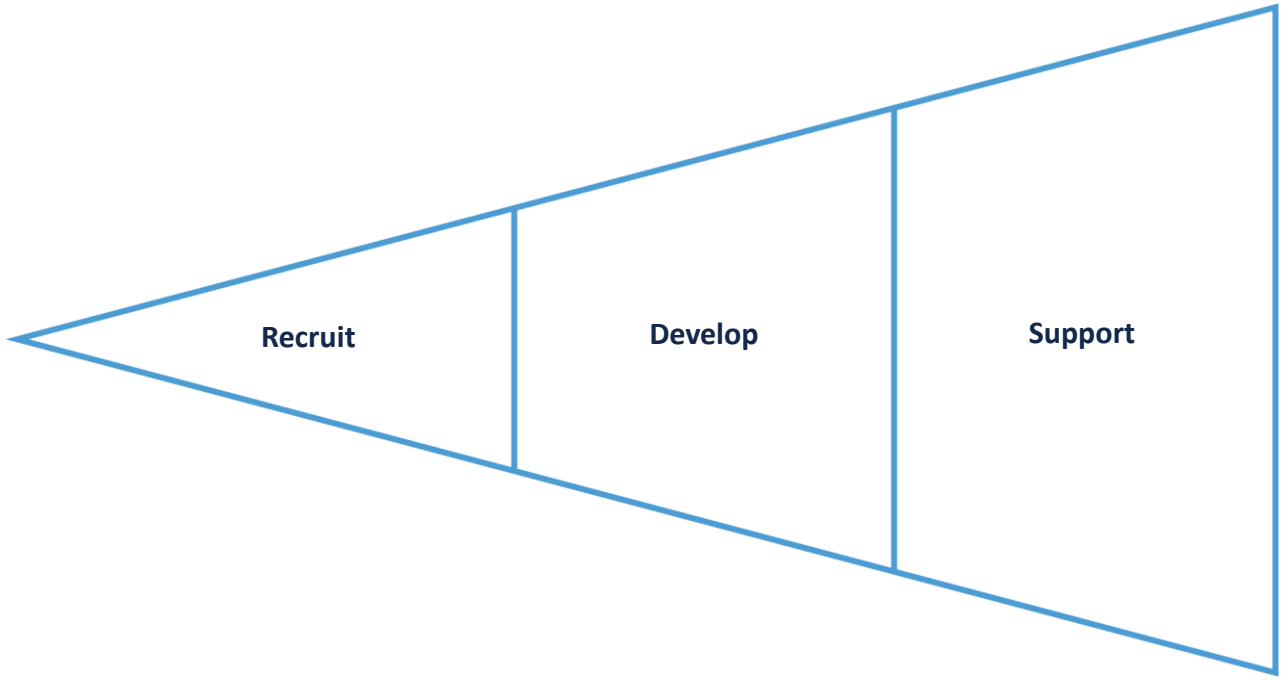
A successful rural workforce pipeline requires far more than physicians willing to practice in underserved communities. It requires a cadre of people who can teach, people who can teach, mentor, design programs, lead quality efforts, produce scholarship, and advocate for rural health. Before we can train rural physicians, we must physicians, we must invest in the people who will train them.

Teachers	**Mentors**
Program Builders	**Quality Leaders**
Scholars	**Advocates**



Recruitment Is Only the Beginning

Getting physicians to rural communities is only half the challenge. Research on rural physician retention consistently identifies professional support, development opportunities, strong peer networks, and community integration as essential factors. Physicians do not want to go somewhere they will be professionally isolated — and that isolation is as much professional as it is geographic.



Each stage of the pipeline depends on the one before it. Retention and multiplication — the stages that expand a that expand a community's workforce capacity — require deliberate investment in development and support. and support.

The Hidden Rural Workforce Bottleneck

Expanding rural training capacity is not simply a matter of funding more positions. Even when a rural clinician is willing to teach, willingness alone does not make an does not make an effective educator or program leader. Faculty *capability* — not just faculty presence — is a quiet barrier sitting between more rural learners and rural learners and more rural physicians.

More Rural Learners

Demand for rural training sites, clerkships, and residency tracks is growing across the country.

Faculty Capacity Is the Bottleneck

Training more physicians requires more people who can teach effectively, design effectively, design learning experiences, assess learners, lead improvement improvement work, produce scholarship, and build sustainable programs. programs.

*1978: Rapid growth of family medicine outpaced the supply of prepared faculty, role models, and scholars.

A Critical Distinction

Great clinicians do not automatically become great educators.

Clinical training prepares physicians to care for patients with skill and compassion. It does not necessarily prepare them to teach adults, develop curricula, deliver structured feedback, lead interprofessional teams, improve systems, create scholarship, or navigate an academic career. These are a distinct set of professional competencies — not deficiencies in a new faculty member, but skills that require intentional cultivation.

The Physician

- Diagnoses and treats patients
- Applies clinical evidence
- Leads patient care teams
- Continuously refines practice

The Physician Educator

- Designs learning experiences
- Gives effective feedback
- Leads teams and programs
- Produces and shares scholarship

Faculty Development Works

Systematic reviews of faculty development programs demonstrate meaningful, measurable benefits — well beyond well beyond simple confidence gains. Longitudinal programs with experiential learning, structured feedback, peer feedback, peer relationships, and direct application in the workplace show the strongest results.

Teaching Knowledge

Deepened understanding of adult learning principles and evidence-based teaching methods.

Observable Behaviors

Measurable improvements in teaching behaviors observed by learners and colleagues.

Educator Confidence

Faculty report greater readiness to teach, lead, and take on educational roles.

Educational Leadership

Graduates take on expanded program and organizational leadership responsibilities.

Beyond a Curriculum

A Fellowship Provides a Professional Home

For a rural faculty member who may be the only person in their community doing this work, a fellowship addresses the most persistent barrier in rural professional life: rural professional life: isolation. A well-designed longitudinal fellowship tells its fellows, directly and structurally, that they are not alone.

A Cohort

Peers navigating the same transition, forming forming lasting professional relationships.

Mentorship

Experienced educators who provide guidance, guidance, feedback, and professional sponsorship.

Protected Time

Dedicated learning time insulated from the the relentless demands of clinical practice. practice.

A National Network

Connections that persist long after the fellowship year ends.

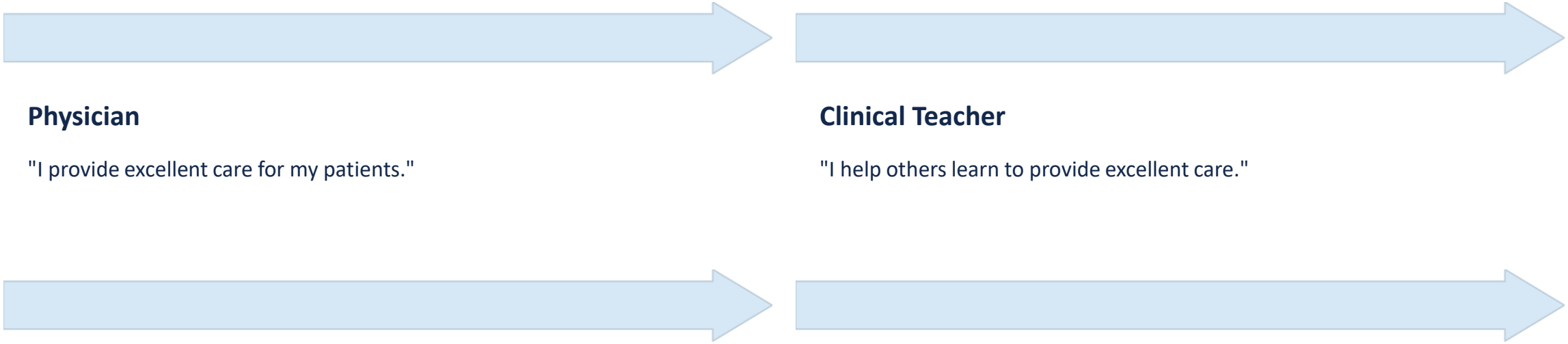
An Educator Identity

Space and structure to grow into a new, multidimensional professional self.

The Core Conceptual Frame

From Physician to Workforce Catalyst

Faculty development supports a genuine professional transformation — not a replacement of clinical identity, but an expansion of it. Each stage builds on the last, and builds on the last, and the final destination has direct implications for the communities these physician educators serve.



Physician

"I provide excellent care for my patients."

Clinical Teacher

"I help others learn to provide excellent care."

Physician Educator

"I design, evaluate, and improve education itself."

Workforce Catalyst

"I build the people and programs my community needs."

Many Paths to Faculty Development

No single program is right for every faculty member or every institution. The right model depends on the individual's goals, the institutional context, available time, and the level of investment the setting can support. The landscape spans from brief local workshops to multi-year degree programs.

1

Local Programs

Institution-based workshops, teaching certificates, and grand-rounds series

2

Regional Collaboratives

Multi-institutional consortia and professional-society teaching programs

3

Leadership Fellowships

National programs focused on organizational leadership and systems change

4

Longitudinal Fellowships

Year-long cohort programs integrating teaching, QI, scholarship, and leadership

The UNC Faculty Development Fellowship

UNC School of Medicine
Faculty Development Fellowship

Nearly five decades of developing family medicine educators

Established in 1980, the UNC Faculty Development Fellowship has grown into one of the most experienced and geographically expansive faculty development programs in the country. Its reach is national — but its purpose remains intensely local: preparing fellows to return home better equipped to strengthen their institutions, their training programs, and their communities.

1980

Year Founded

Over four decades of continuous operation

621

Alumni

Physician educators trained and returned to practice

48

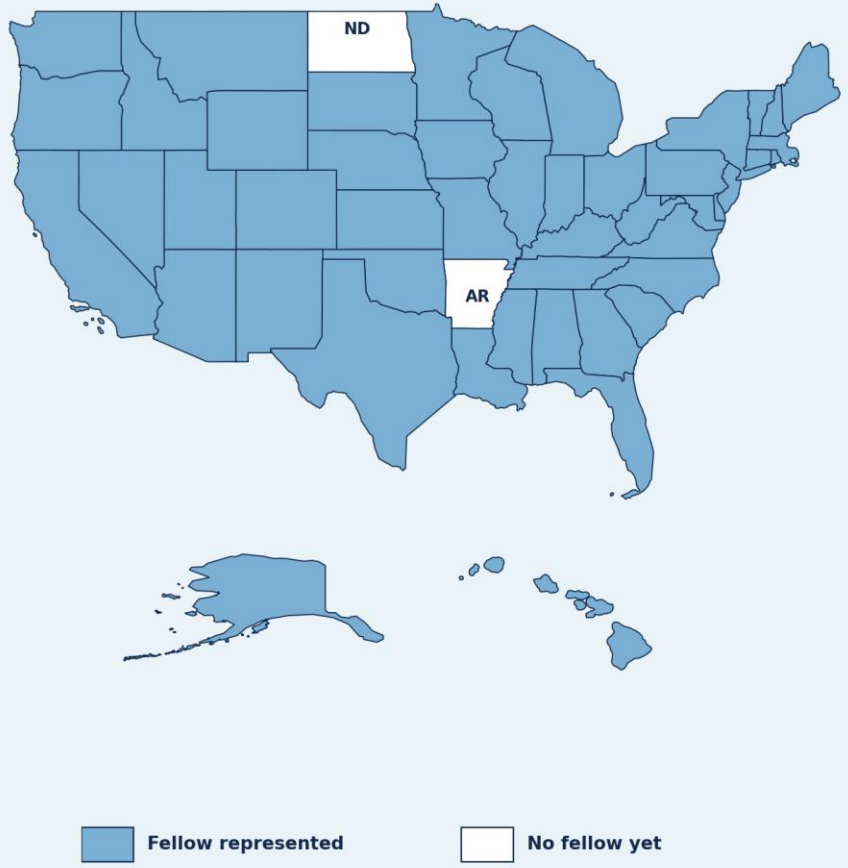
States Represented

Plus D.C., Puerto Rico, U.S. Virgin Islands, and six six other countries

> 2/3

Family Medicine Chairs

At one point, over two-thirds were program graduates



HOW THE FELLOWSHIP WORKS

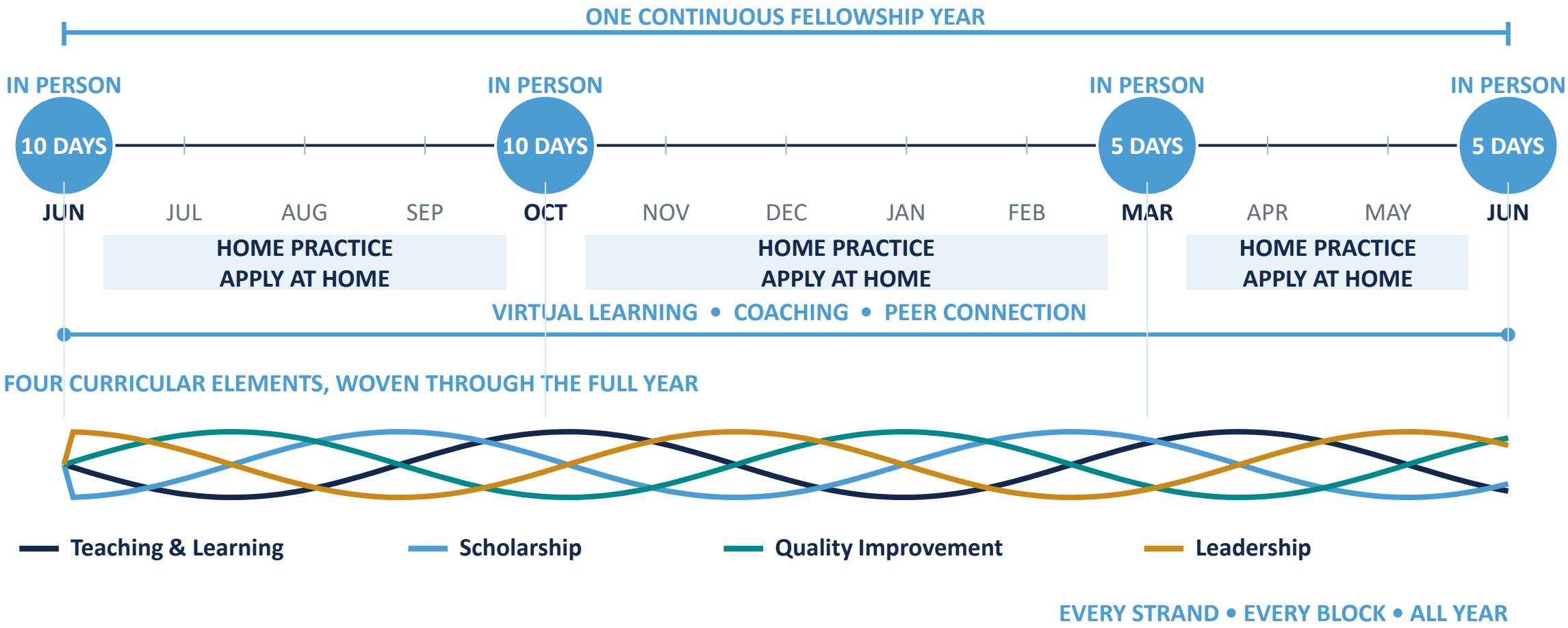
June to June, learning stays rooted in practice

01 LONGITUDINAL
A full year—not an episode

02 PART-TIME
Home roles continue between blocks

03 COHORT-BASED
16 fellows move together

04 APPLIED AT HOME
Projects advance between blocks



What a Physician Educator Needs to Succeed

Four Interdependent Capabilities

The UNC fellowship is organized around four core domains that consistently appear in research as key skills for effective physician educators. The domains are not silos, they intentionally inform and reference one another. Just as a rural residency expansion project, for example, is simultaneously an educational undertaking, a leadership challenge, an improvement effort, and a potential scholarly contribution.

Teaching & Learning

Design meaningful learning experiences and help individual learners improve learners improve through structured feedback and assessment.

Scholarship

Evaluate evidence, study important questions in medical education, and education, and share what works with broader communities.

Quality Improvement

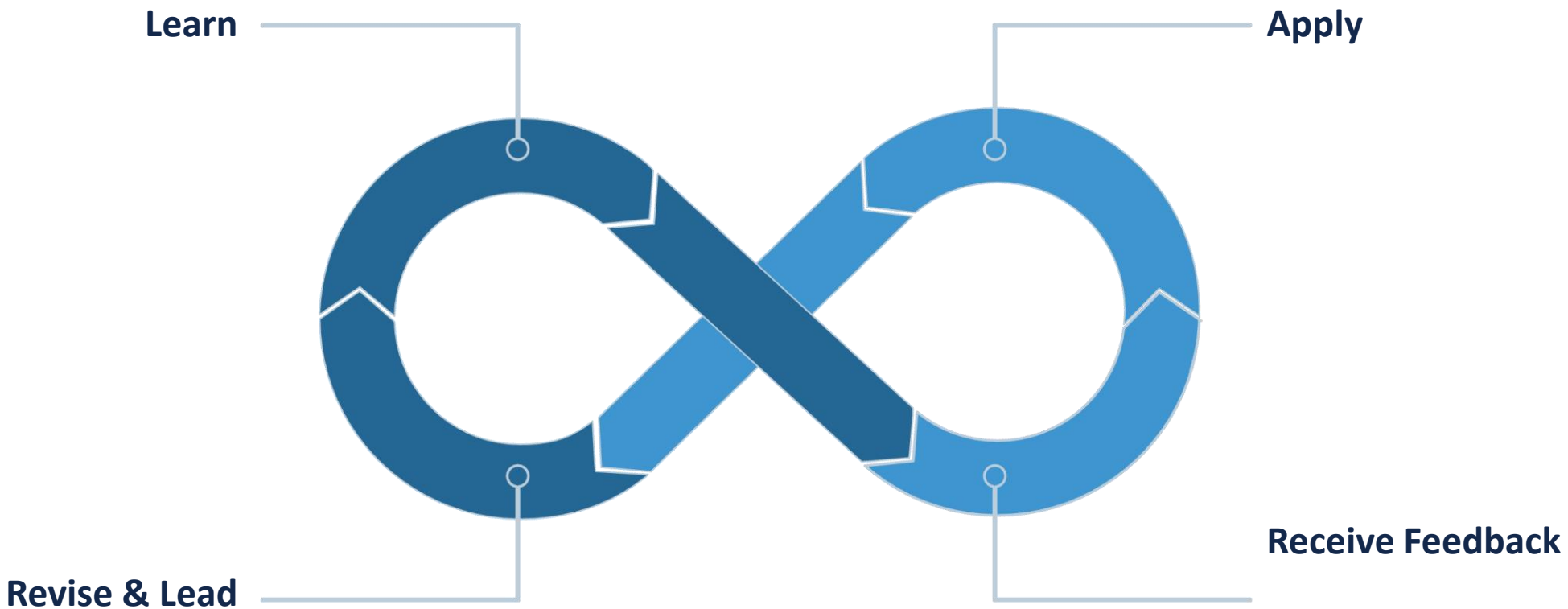
Turn pressing clinical and educational problems into measurable, sustainable sustainable change at the practice level.

Leadership

Build cohesive teams, navigate complex organizations, and move important ideas from vision into lasting action.

The Learning Is Applied

Fellows do not simply attend sessions — they learn, build, practice, receive feedback, and revise in real time. Every new skill is tied to a deliverable borne from consequential work happening at the fellow's home institution. The fellowship curriculum is the vehicle; the fellow's actual program is the destination.



Representative deliverables include an educational program plan, a large-group teaching experience, an individual leadership-development plan, a quality-improvement project, improvement project, collaborative scholarship, and structured reflection on professional growth.

The Home Institution Becomes the Laboratory

Every fellow arrives with real problems to solve and projects to tackle — problems and projects that matters to matters to their patients, their learners, and their community. The fellowship does not assign hypothetical case hypothetical case studies. It supports fellows in doing work they were already trying to do, but better equipped better equipped and no longer alone.

Rural Training Tracks

Expanding or establishing longitudinal rural clerkship and residency sites

FQHC Capacity

Building medical education infrastructure inside federally qualified health centers

New Clerkships

Designing and launching community-based rural clinical learning experiences

Underserved Pathways

Creating residency tracks that deliberately prepare physicians for underserved practice

FELLOW VOICE

Rural Training Pathway

> **“I joined the fellowship at a critical time in the expansion of our rural training pathway as we were developing the new site, strengthening our community relationships, and creating a vision for what expansion of the track would bring to the residency training program as a whole.”**
>
> **“The fellowship was perfectly crafted to support this project.”**
>
> **Gaby Castro, MD**

WHAT CHANGED

The fellowship learning was applied immediately to a consequential workforce initiative — not as an academic exercise, but as real-time support for the most important project the fellow was already leading.

FELLOW VOICE

Developing Local Improvement Capacity

> **“The QI training was essential for me. I now feel much more confident and equipped to lead QI and make measurable changes and improvements at my clinic.**

Margo Pray, MD

WHAT CHANGED

The multiplier effect matters here: the fellowship did not simply prepare one physician to complete one project. It prepared her to **teach residents to conduct improvement work themselves** — compounding the impact across an entire clinical team and patient population.

ONE FELLOW → RESIDENTS → CLINICAL TEAM → PATIENT POPULATION

FELLOW VOICE

Making Improvement Part of the Work

> **“The concepts of data-driven improvement were incredibly useful for me. I continue to meet with a PCIC coach monthly to improve our metrics for STEP Primary Care. We recently hired our first nurse and are making QI work part of our clinic routine.”**

Rupal Yu, MD

WHAT CHANGED

The fellowship helped move improvement from an individual skill to an ongoing organizational practice—supported by coaching, strengthened clinical capacity, and focused on a medically vulnerable population.

NEW SKILLS → CONTINUED COACHING → STRONGER TEAM → ROUTINE IMPROVEMENT → QI BECOMES PART OF HOW THE CLINIC WORKS

FELLOW VOICE

On Confidence and Capability

> **“I feel empowered from what I learned in the fellowship; it really changed how I see the world. This was a great experience, and I feel confident in my teaching and project management at my program and my clinic due to the skills that I learned during the fellowship.”**

Dawn Caviness, MD

WHAT CHANGED

Confidence is not the outcome — it is the signal. What the fellowship develops are concrete, practiced skills: designing a curriculum, running an improvement cycle, navigating an academic organization. Confidence follows from doing those things well, repeatedly, with expert feedback. That is a meaningful and durable change.

FELLOW VOICE

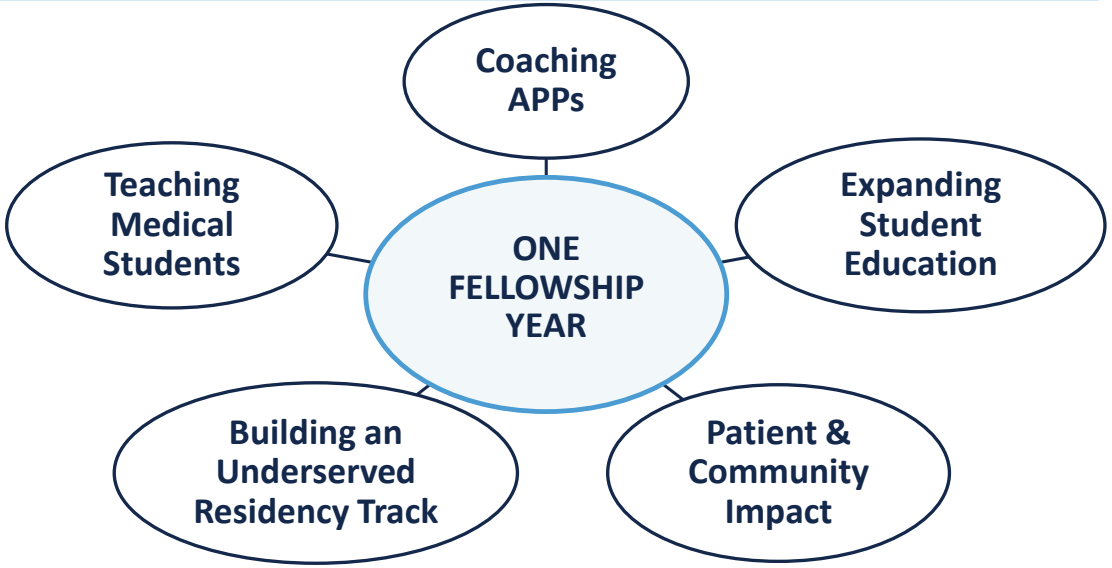
The Multiplier Effect in Practice

> **“The FDF fellowship equipped me to lead medical education efforts at the FQHC where I work. The QI training I received equipped me to better teach QI to medical students and to begin training APPs in QI at the FQHC where I work. I am better able to teach the core principles of QI and help medical students carry out QI projects during their Community Medicine clerkship. Additionally, I have now been given the responsibility to partner with several APPs at our practice to coach them through implementing QI projects in their practice. Currently we are growing our capacity for teaching medical students, and we are aiming to start an underserved Family Medicine residency track in partnership with our local Family Medicine program in the next 5 years.”**

Brendan Payne, MD

WHAT CHANGED

One fellowship year — and its consequences continue to compound. Dr. Payne is now teaching quality improvement to medical students, coaching advanced practice providers, expanding student education at his health center, and working toward an underserved family medicine residency track. One developed faculty member. Multiple professions. Multiple learners. A future residency pathway.



ONE DEVELOPED FACULTY MEMBER.
MULTIPLE LEARNERS. LASTING INFRASTRUCTURE.

Faculty Development Creates a Multiplier

A single developed faculty member does not influence a single learner. The effects cascade across an institution, a training program, and a community — growing each community — growing each year that faculty member continues to teach, lead, and develop others.

Teach Dozens of Learners

Students, residents, and colleagues benefit from improved teaching skills teaching skills and structured feedback.

Improve Multiple Clinical Teams

QI capabilities translate directly into measurable improvements across across patient care settings.

Build Durable Educational Programs

Fellowship projects become lasting infrastructure that outlives any single single faculty member's tenure.

Develop Future Faculty

Physician educators mentor and sponsor the next generation, compounding the return on investment.

North Carolina: Faculty Development as Workforce Infrastructure

In North Carolina, the fellowship is not just a national program housed at UNC. It has become part of the state's family medicine workforce infrastructure.

1

168+ Fellowship graduates have worked in North Carolina

2

19 family medicine residencies

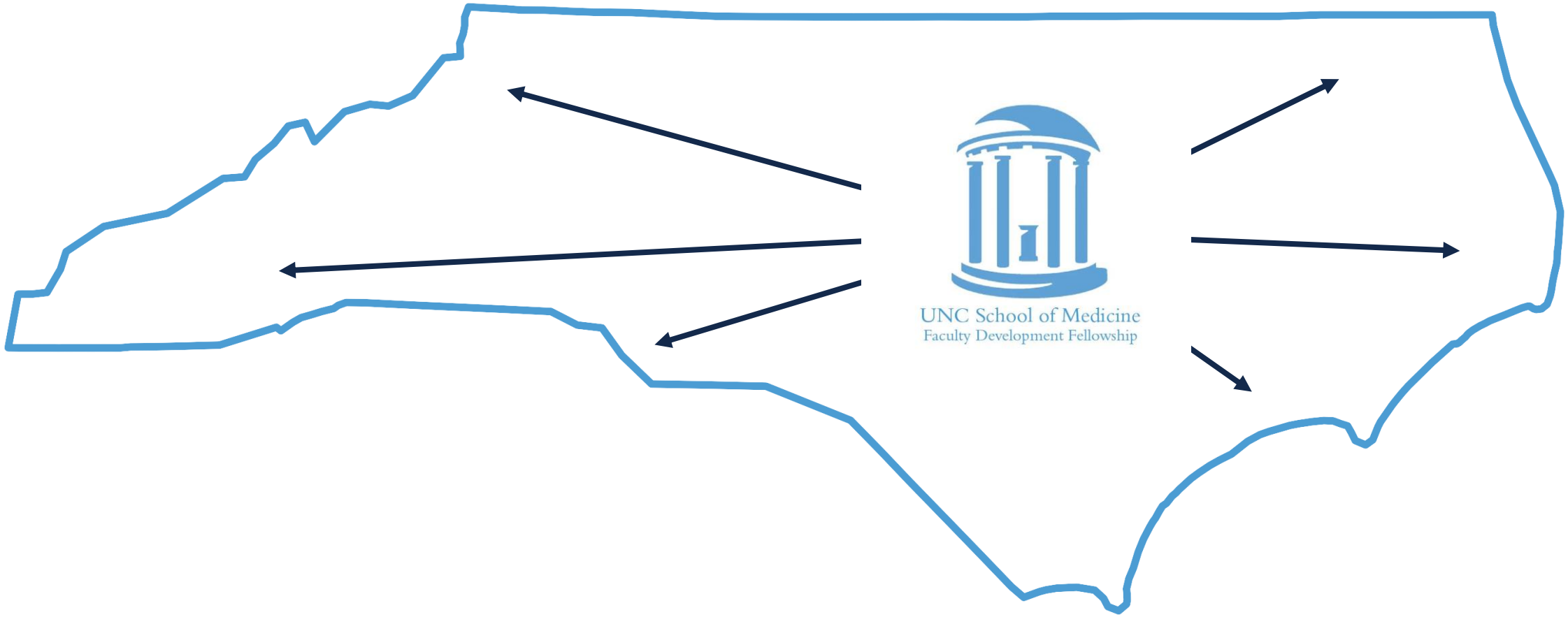
3

10 with rural tracks

4

NEARLY ALL have had UNC Faculty Development Fellows on faculty

From Faculty Development to Statewide Capacity



"When rural tracks succeed, they do not succeed because one person gives one lecture. They succeed because local faculty know how to teach, mentor, improve, lead, and build partnerships over time."

FDF ALUMNI → RESIDENCIES → RURAL TRACKS → LEARNERS → COMMUNITIES

FELLOW VOICE

A National Fellowship. Local Rural Impact.

> **“The fellowship has been profoundly impactful in my personal and professional development. I have applied what I learned by creating a year-long faculty development program for my own residency—resulting in more than 80 direct observations of residents since September 2025.”**

Associate Program Director
New Teaching Health Center residency · Denver, Colorado

FELLOWSHIP LEARNING APPLIED AT HOME

80+	Direct observations completed through a new residency faculty-development initiative
2	Quality-improvement projects addressing hypertension control and menopause care
10 fellows	Collaborating across multiple institutions on a shared QI and scholarship project
National network	Ongoing mentorship and peer support beyond the fellow’s home institution

> ***“In my decade of post-residency work, this has by far been the most impactful and beneficial program I have engaged with.”***

The Rural Value Proposition

Why This Model Fits Rural Settings

Specific rural workforce challenges are addressed by specific fellowship design choices.

RURAL REALITY	→	FELLOWSHIP RESPONSE
PROFESSIONAL ISOLATION		**National cohort and enduring peer network** Rural faculty gain colleagues, mentors, and a professional home beyond their local institution.
LIMITED LOCAL DEVELOPMENT RESOURCES		**Integrated preparation across teaching, leadership, QI, and scholarship** Faculty gain capabilities that may not be readily available in their immediate setting.
COMPLEX LOCAL PROBLEMS		**Coaching applied to real home-institution work** Fellows receive help turning promising ideas into feasible, locally appropriate programs.
FACULTY CANNOT SIMPLY LEAVE		**Part-time, longitudinal structure** Physicians continue caring for patients, teaching learners, and leading programs while they develop.
NEED FOR DURABLE LOCAL CAPACITY		**Develop the local leader—not dependence on an outside institution** Skills remain in the community and multiply through learners, teams, programs, and future faculty.

Faculty development complements—not replaces—adequate financing, staffing, compensation, and protected time.

THE SYNTHESIS

Evidence. Innovation. Action.

Develop the faculty, and they will develop the workforce.

Evidence

Faculty development improves teaching, confidence, behavior, and leadership.

Innovation

UNC’s model is longitudinal, cohort-based, part-time, and applied at home.

Action

Every rural workforce strategy needs a faculty-development strategy.

BOTTOM LINE

Who is developing the people who will develop your workforce?

Send Us Your Builders

Let's Build the People Who Build the Programs

The UNC Faculty Development Fellowship is actively seeking rural and community-based faculty who are ready to grow into the next stage of their professional lives. If you professional lives. If you work with — or know — a clinician who is teaching, leading improvement, or building programs in a rural or underserved setting, the fellowship was setting, the fellowship was designed for them.

1

Longitudinal Development

A full year of structured, integrated learning across teaching, scholarship, QI, and scholarship, QI, and leadership

2

National Cohort

Peers from across the country, forming lasting professional relationships and a relationships and a shared identity

3

Applied Projects

Real work at your home institution — not hypothetical exercises, but consequential programs and initiatives

4

Enduring Community

621 alumni, 47 states, and a network that outlasts the fellowship year by by decades

Tommy Koonce, MD, MPH · UNC Department of Family Medicine · Contact information and fellowship website available upon request

Thank You