Family Medicine Updates

From the Association of Departments of Family Medicine

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EVOLVING COMPETENCIES FOR CHAIRS OF DEPARTMENTS OF FAMILY MEDICINE

The rapidly changing environments of academic health centers (AHCs) are demanding adaptation to new roles for Chairs of Departments of Family Medicine (DFMs). Over a decade ago, the Association of American Medical Colleges identified 3 overarching areas of skills for Department Chairs: (1) managing conflict, (2) performance evaluation, and (3) managing diversity.[1] Grigsby described the need for a "future-oriented" Chair with ability to shift the focus from personal to others' success, to develop realistic business plans, to be resilient, and to be a team leader.[2] In 2013 Kastor asserted that the job of the Chair of a Department is now something new: that of a change agent, with loss of autonomy over budgetary management, and with more business responsibilities than the traditional focus on academic advancement.[3]

In addition to the roles of promoting diversity, managing conflict, and performance evaluation, the skills of leadership and change management are increasingly important to Family Medicine Chairs. Largely subspecialty-based AHCs have not historically embraced substantial roles for primary care disciplines. Even the smaller, community-based medical schools have often not included the primary care departments in significant economic decisions related to medical practice. In recent years, however, with the movement from volume- to value-based health care, AHCs and smaller medical school practice plans are calling on family medicine to develop new primary care networks on which they need to survive economically in the new world of health care delivery. The leaders of DFMs, and in particular the Chairs, are being asked to lead significant change within environments that are often resistant to such change.

The Association of Departments of Family Medicine (ADFM), witnessing substantial turnover in Chairs over the past few years, has identified the development of new chairs as a high strategic priority. As ADFM's Leadership Development Committee began to consider key competencies for Chairs, it became apparent that a number of the competencies needed by Chairs are also competencies of successful senior leaders within DFMs, many of whom may someday find themselves in a chair role. Through an iterative process, whereby input on key competencies has been received from participants of various ADFM leadership development sessions, an evolving set of competencies for Chairs of DFMs has emerged. Four major areas of competencies have been defined:

1. Leadership (eg, strategic planning, building a team, leading/managing change)
2. Administrative/management (eg, finances, human relations)
3. Personal development and management (eg, understanding your role, managing calendar, resiliency, and self-care)
4. Managing external relationships (eg, understanding where the department fits into institutional culture, external entities)

In planning a preconference for new chairs, senior leaders and ADFM fellows at the 2015 ADFM Annual meeting, registrants ranked Leadership as the competency area of highest need. Of the 8 specific competency areas under the heading of "Leadership," the preconference participants identified 3 as most important for their development: (1) building and sustaining a leadership team (including working effectively with an administrator partner); (2) leading and managing change (including having a framework and tools around meeting design, delegation, and group decision-making); and (3) understanding and changing department culture (including legacy issues).

As ADFM continues to explicate the evolving list of competencies for chairs, we will work closely with other partners, such as the Society of Teachers of Family Medicine (STFM) through the Leading Change Curriculum initiative. We will use our list of competencies to guide training development in our own ADFM Fellowship, in our work with ADFM member chairs and in working with senior leaders in DFMs. The ADFM Leadership Development committee is also tying key resources to the competencies and will be housing these resources on an open-access site so that all who are interested can view them. The current version of the competencies can be found at: http://adfm.org/Members/NewChairs.

Change is calling those of us in academic family medicine to respond not only to departmental needs but to much broader system needs. Chairs of DFMs

must be equipped to answer this call through leading at many institutional levels while leading their own faculty and departments through uncertain times. An important element of facing these challenges is understanding family medicine's position of power and relevance within the larger environmental context. As challenged recently, Chairs of Family Medicine must find meaning in answer to a fundamental question: "Are we institutional leaders who happen to be family physicians, or are we family physicians who happen to work at academic health centers?"[4]

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References

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2. Grigsby K, Hefner DS, Souba WW, Kirch DG. The future-oriented department chair. *Acad Med.* 2004; 79(6):571-577.
3. Kastor J. Chair of a department of medicine: now a different job. *Acad Med.* 2013; 88(7):912-913.
4. Plenary session at the 2015 Annual ADFM Winter Meeting: Thomas L. Schwenk, MD; *Family Medicine and Academic Medical Centers: Strangers in a Strange Land.* Savannah, GA, 2015.

From the Association of Family Medicine Residency Directors

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THE COUNCIL OF ACADEMIC FAMILY MEDICINE PROCEDURAL AND MATERNITY CARE TRAINING GUIDELINES: A BETTER PATH TO CONSISTENCY IN COMPETENCY ASSESSMENT IN FAMILY MEDICINE

As an organization devoted to training residents to deliver high-quality family medicine care to their communities, we have struggled to determine those procedures in which we should require all residents to develop competency. To date we have lacked consistency in educational standards for both procedural and maternity care training. This lack of standardization has led to a wide range of skills (or lack thereof) in our graduates, which has impacted our scope of care and potentially endangered our credibility as a specialty. A consistent methodology in determining competency has also been lacking.

The latest guidance by the RC-FM is, "Residents must receive training to perform clinical procedures required for their future practices in ambulatory and hospital environments."[1] In the FAQ related to this, the RC-FM states, "As the list of procedures performed by the practicing family physicians varies based upon the needs of the community, the program directors and members of the faculty should develop a list of required procedures based upon the needs of their FMP (family medicine practice) and recommendations of organizations…"[2]

In response, the Council of Academic Family Medicine (CAFM) formed 2 task forces in the spring of 2014. The AFMRD took the lead on developing these guidelines, working with faculty members across the country to provide input into the process. The Society of Teachers of Family Medicine (STFM) Maternity Care and STFM Hospital and Procedures groups formed much of the task forces. After conference calls, a careful literature review, and collaborative efforts, draft guidelines were completed in December 2014. Next steps: gather broader input from family physician educators, update the guidelines based on this feedback, then return the documents to CAFM for final approval.

The task forces agreed upon a better method of determining competency that actually passes the common sense test—blending a minimum experience with a standardized competency assessment tool that breaks down the skills that need to be demonstrated by the trainee. The key feature is not relying on numbers alone and, in fact, the minimum numbers are reserved for the most skilled residents, not for the average resident. Most residents will need to exceed the minimum number for complex procedures before they are ready for competency assessment and to potentially be signed off as ready for independent practice.

The Maternity Care Guidelines outline training expectations for the 3 tiers of maternity care already being practiced in our family medicine community. These tiers are designated Ambulatory Maternity Care, Comprehensive Maternity Care, and Advanced Maternity Care. Instead of having a one-size-fits-all requirement from the RC-FM, we will have recommendations that reflect what individual residents are seeking in their training, based on the community in which they intend to practice. However, since maternity care is within the domain of our specialty, all programs are expected to offer Ambulatory Maternity Care training to residents to allow them to possess basic spontaneous delivery skills and sound prenatal care training. Even if a graduate does not plan to provide prenatal care for their patients in their practice, they must still possess knowledge of the medical complications of pregnancy and to be able assess the maternity care their patients may be receiving from another physician.

The Comprehensive Maternity Care criteria now include labor management as a key portion of experi-