Family Medicine Updates

From the Association
of Family Medicine Residency Directors

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PLANNING FOR TRANSITION

A fundamental duty of program directors is to ensure the residency prospers, even in his or her absence. Every program director leaves eventually, due to retirement, health, new career priorities, etc. Despite this inevitability, programs don't always adequately prepare for transition. Many program directors are so consumed doing today's work and putting out fires, they often don't plan for their departure. Without thoughtful preparation, a residency program's institutional memory can disappear with its departing director.

Over the last 10 years, as the ACGME and ABFM have applied more rigorous standards, the job of program director has become more complex and demanding making it more essential than ever to design a clear road map for succession. How would your residency program adjust if the program director suddenly vanished?

We can learn much from the business world and their approach to leadership transition. Studies have shown that 50% to 85% of all nonprofit executives planned to leave their positions in the next 5 to 7 years.[1] This increase in turnover and disruption has created a need for organizations to engage in active transition planning. The goal of this approach is for leaders to plan responsibly for eventual transition. The family medicine education landscape is appearing similarly chaotic. In the last few years, the ACGME has reported that 50 to 60 programs hire new family medicine directors annually—a 12% to 14% turnover rate.

Why do organizations, including residency programs, struggle during poorly planned leadership transitions?[1]

- Survival fear/responsibility panic: Faculty and staff, specifically those recruited by the director, may wonder if they can survive without their leader. Anxiety exists envisioning a new leader with equal capability.
- Time and commitment anxiety: During transition, it may be discovered that the director was doing a lot of unacknowledged work which may actually have been the responsibility of others. This discovery creates anxiety over the realization there will be additional requirements placed on others.
- Unintended organizational weaknesses: Some directors may have particular leadership skills, relationships, or infrastructure methods that have created an organizational culture very dependent on that particular person. The loss of this type of leader may uncover challenging weaknesses in the program.
- Questionable direction: Leaders who have been passionate and focused on a particular strategic vision but who lacked the full enthusiasm and commitment of others may leave that organization off course with a need to refocus priorities.

The consequences of poor transition planning, the increasingly complex nature of running a residency program, and the growing frequency of leadership transition creates a clear need for programs to include transition planning as a required responsibility of program directors. Programs should engage in practices to ensure successful transition, even when no active leadership changes are planned[1,2]:

- Strategic planning: Continually update the program's strategic plan, including the mission, vision, and core values. Use the ACGME requirement of annual program evaluation to help set strategic priorities which are understandable and garner clear support.
- Succession planning: Groom an associate director, or develop faculty leaders in order to sustain the work of the program. Maintain at least one NIPDD trained faculty member at all times.
- Data organization: Maintain clear and accessible documentation regarding RC citations, institutional internal review documents, most recent PIF files, databases for WebADS data, annual program evaluation, ITE data, prior Match results, and username/passwords for program accounts (ACGME, ABFM, etc); ensure the coordinator and another faculty can always access.
- Policies and procedures: Write position descriptions for the director, associate director, coordinator, and faculty. Document the process for new faculty orientation, the interview and Match procedures, and new resident orientation. Clearly describe the attendees, purpose, and frequency of faculty meetings, retreats, and other important meetings. Define the budget management process.
- History/people and relationships: Develop a continuity file for the history of the program as well

"who's who" in the department and the sponsoring organization. Include details of how to work with senior leadership, navigate internal politics and potential land mines, and understand faculty strengths and weaknesses.

AFMRD's motto is "transforming family medicine one leader at a time." Planning for transitions is a prime example of how this motto is role modeled by one generation of program directors to the next.

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HEALTH INFORMATION TECHNOLOGY RESEARCH PRESENTATIONS GROWING AT NAPCRG MEETINGS

Almost 15% of the presentations at the 2012 NAPCRG Annual Conference in New Orleans examined the use of health information technology (HIT). This is an increase from nearly 10% at the 2011 conference in Banff. The definition of HIT can be quite broad, but in general it is the use of electronic technologies to improve human health. Annual conference HIT presentations and posters included examinations of electronic health record (EHR) implementation, home tele-monitoring of clinical data, personal health record use, electronic clinical decision support, educational simulations, and use of electronic patient registry data. While the range of research is fairly broad, all explore how we can exploit recent technologic capabilities to improve health. Some investigators even found that these technologies, despite great promise, did not improve health compared to more conventional approaches that did not use new technologies.

What accounts for this growing interest in HIT research among NAPCRG members? As primary care researchers, our focus on knowledge management is not new.[1,2] This is an obvious direction for our inquiries because management of knowledge and information is so vitally important to primary care. Primary care clinicians routinely struggle to integrate all possible information to inform shared decision-making with their patients. Assimilating and processing this information is a Herculean task that frequently challenges or exceeds our cognitive capacities.

Many look to information technology to assist us with the important task of managing clinical information. Beasley and colleagues have defined "information chaos" as 5 types of information problems that primary care physicians routinely face: information overload, information underload, information scatter, information conflict, and erroneous information.[3] This information chaos decreases clinician situational awareness and takes time to navigate, enabling loss of productivity, decreased patient access, physician burnout, and medical errors. Primary care clinicians are desperate for tools that will lighten this load, and this creates a research imperative to find and test new tools, interfaces, and ways to deliver care.

Much of HIT research is, in fact, implementation science. Researchers and clinicians are trying to use electronic tools to ensure that evidence-based interventions are successfully implemented to the fullest extent possible for patients and populations. As such, examination of the use of HIT in clinical care is a natural target for primary care researchers, who best understand the interface between clinical evidence and successful implementation of recommendations in clinical practice.

Another likely reason that HIT research is becoming more prevalent is that questions about the technologies we use arise so often in the everyday life of clinicians. The EHR has become such a huge factor in our work lives that it naturally provokes reactions and questions. Furthermore, these reactions and questions often center on less-than-expected EHR usability, and less-than-expected clinician satisfaction with many EHR systems.[4] Frequently, EHR and personal health portal implementations do not go as well as expected,[5] creating the perfect storm for the generation and examination of research questions: an unhappy clinician user with a passion to find an answer. That these implementations can dramatically affect productivity only heightens our interest. And so we are driven to examine the difference between the reality and the imagined concept, or even between what is and what should be. Our 2012 Annual Conference plenary speaker, Trisha Greenhalgh, and her colleagues, illuminated this "design-reality gap" in their description of abandonment of a personal electronic health record by the English National Health Service.[6]