ΑΩΑ 2016-2017 Fellows in Leadership are prepared to serve

by Richard Byyny, MD, FACP; Brian Clyne, MD; Nora Gimpel, MD; and Susan Lane, MD

Leadership in medicine, medical education, and health care is more complex in the 21st century than ever before. Escalating costs, unequal access, less than ideal outcomes, and political challenges have contributed to an unprecedented level of uncertainty in the delivery of health care and medical education.

The medical profession and the country are in need of leadership that is inspiring, insightful, engaging, and humble; leadership that understands and represents the needs of patients, physicians, medical educators, and trainees. Because of their unique knowledge of the practice of medicine, and understanding of medicine's core professional values, physicians are ideally prepared to serve as leaders.

Encouraging the development of leaders in academia and the community has been, and continues to be, a core ΑΩΑ value, and an important part of the organization's mission.

The ΑΩΑ Fellow in Leadership recognizes and supports the further development of outstanding physician leaders through the tenets of leading from within; upholding ΑΩΑ's values and mission; and a commitment to servant leadership.

The five essential components of the ΑΩΑ Fellow in Leadership are:

1. Self-examination, the inward journey, leading from within;
2. A structured curriculum focused on leadership, including an understanding of the relationship between leadership and management;
3. Mentors and mentoring;
4. Experiential learning to broaden the perspective and understanding of leadership as it relates to medicine and health care; and
5. Team-based learning, and developing communities of practice.

Nominations for the ΑΩΑ Fellow in Leadership are made by the senior executive of a medical school, hospital, or health care organization, who agrees to serve as a mentor for the Fellow. The nominating organization and Fellow designate at least one additional mentor who supports the completion of a leadership project, serves as a role model, offers advice as needed, and connects the Fellow with key individuals in leadership positions. At least one mentor is at the senior leadership level, i.e., a Dean, Chief Executive Officer, or the President of an association or an organization that has a regional or national presence.

These relationships, and leadership opportunities and experiences, are ongoing throughout, and after, the fellowship year.

The Fellows each receive a $25,000 award for further leadership development and project funding.

The third cohort of ΑΩΑ Fellows in Leadership–Brian Clyne, MD (ΑΩΑ, Warren Alpert Medical School of Brown University, 2016, Alumnus); Nora Gimpel, MD (ΑΩΑ, University of Texas Southwestern Medical Center at Dallas, 2016, Faculty); and Susan Lane, MD (ΑΩΑ, Stony Brook University School of Medicine, 2011)–were selected for their diverse backgrounds, career performance and success, leadership experience, mentor support, and proposed leadership project.

The Fellows have successfully completed their year of leadership development and join the growing ΑΩΑ Fellows in Leadership Community of Practice. They presented the findings, outcomes, and lessons learned from their projects to the ΑΩΑ Board of Directors during the October 7 annual meeting.

Brian Clyne, MD—Developing Physician-leaders in Undergraduate Medical Education

The ΑΩΑ Fellow in Leadership experience has surpassed my expectations, and has been a highlight of my career. I was drawn to the program for its commitment to developing physician-leaders, and its emphasis on service; however, it also proved to be an ideal setting to integrate my background in education with my interest in leadership development.

Addressing the physician leadership imperative

As a residency program director, I understand leadership as a professional obligation, and an essential part of the physician identity. Many residency graduates were well prepared for clinical practice, but ill-equipped to confront the complex challenges facing health care.[1] In their everyday work, physicians exercise leadership with individual patients, but are increasingly called on to assume leadership roles on multidisciplinary teams, and within organizations. To effect needed change, physicians must understand health care at the system or population level, and possess the skills to improve quality, lower costs, and increase

value.[2] As a result, there has been a proliferation of physician leadership training programs sponsored by universities, academic medical centers, and specialty societies.[3]

The focus of my AΩA project evolved throughout the year from a faculty development program to a student curriculum. It began as an effort to improve mid-career physician leadership by establishing a multidisciplinary leadership academy at Alpert Medical School in the Division of Biology and Medicine at Brown University.

The division includes more than 2,000 faculty members across six campus-based departments, and 15 clinical departments in seven hospitals. The proposed academy would be open to select faculty from all affiliated institutions.

The guiding principles of the academy would center on teamwork, experiential project-based learning, and faculty diversity. It would serve to retain talented people, and address issues of inclusion and diversity through leadership development. It would provide faculty with a community of peers with, and from whom, they can learn.

In the first phase of the project, an oversight group was established, and a local needs assessment to inform the program curriculum was completed. At the same time, various leadership frameworks, and the features of leadership development programs at peer institutions and those from other industries were studied. This led to the submission of a formal proposal to expand and centralize faculty leadership development.

As the project gained momentum, however, things took an unexpected change in direction, providing lessons on adaptability and resourcefulness.

Shifting priorities to future physician-leaders

Before the AΩA fellowship year began, I was working on a leadership curriculum for medical students, specifically those enrolled in a new Primary Care-Population Medicine (PC-PM) dual degree program at Alpert Medical School. This unique program allows up to 24 medical students per year to earn a Master's of Science in Population Medicine in addition to their Doctorate of Medicine. Students obtain these degrees through a course of study that includes research methods, population science, and leadership.[4] Students are selected based on a demonstrated interest in population health, and a commitment to developing as a leader.

The course I helped develop, Leadership in Health Care, was piloted in the PC-PM program in September 2016. It provides an introduction to core leadership topics like emotional intelligence, communication skills, conflict management, team-building, and leading change (see Table 1). It emphasizes self-awareness and servant leadership, and employs interactive teaching methods. A key component of the course is an experiential, team-based leadership action project (LAP) through which students identify and address a health care challenge. The LAP requires teamwork, experimentation, application of lessons learned, and deliberate practice.

Table 1
Alpert Medical School's Leadership in Health Care Core Sessions

Servant Leadership Theory
Leading with Personal Integrity
Essentials of Effective Interpersonal Communication
Team Dynamics and Team Building Workshop
Media Training Workshop: Speaking Persuasively in Public
Creating a Vision and Motivating Others
Conflict Management and Negotiation Skills
High Stakes Clinical Teamwork
Coaching, Mentoring, and Developing Others
Essentials of Political Advocacy
Emotionally Intelligent Leadership
Leading from the Middle: Influencing Change in Complex Organizations
Resilient Leadership and Life-long Learning

Feedback from the pilot was positive. The potential impact on the community through the students' projects was apparent. The capstone session was a highlight of the course during which students presented their projects to an audience of health care leaders from the community, medical school, and hospital system. Based on evaluations and student input, it was clear that Leadership in Health Care had played a role in increasing leadership behaviors, and improving team dynamics.

The success of the pilot course led to a commitment from the medical school to increase its support, and build more comprehensive, longitudinal leadership training opportunities.

Realizing that I could not simultaneously grow the student leadership program, and establish the faculty academy, I shifted my focus solely toward the students. For the Fall 2017 semester, Leadership in Health Care was expanded to include more students, with plans to integrate leadership throughout all four years of the medical school curriculum.

Lessons learned

Despite a mid-course adjustment to my AΩA project, I applied many of the same principles of curriculum development and leading change.[6,7] The experience highlighted the importance of staying true to one's core ideas and values, while remaining flexible when circumstances change.

Through the project, I also learned the importance of setting goals and communicating a clear vision. Critical to persuading stakeholders was painting a compelling picture of students as physician-leaders, and their potential for long-term impact. I've also learned that for a project to be successful, one must break it down into its component parts, and have a plan for each stage of the process—the specific task, the time frame, the responsible party, and how to ensure accountability. Above all, the AΩA experience helped me understand that doing meaningful work and influencing change takes time, discipline, and a team you can depend on.

The inward journey

The principles of servant leadership align well with my career philosophy and motivations. I view teaching as a direct extension of patient care, and believe in improving health care on a large scale through education. My interest in leadership development stems from the same values of teaching and service.

Throughout this experience, I've reflected on, and sought to demonstrate, the qualities of servant leaders—listening, empathy, awareness, and a commitment to the growth of others.[8] The inward journey of leadership has helped me understand that I am at my best when I am learning something with the intent of sharing it, and that I achieve more through collaboration with others.

Financial support from AΩA allowed me to complete the Executive Masters in Healthcare Leadership (EMHL) at Brown University. The EMHL's approach to project-based learning, and its team atmosphere, has been an excellent fit for my personality and learning style. The experience of being a student and teacher of leadership at the same time has been unique. I've gained a deeper appreciation for interactive teaching methods, and discovered that there are universal leadership skills that can be learned and enhanced regardless of whether one is an experienced health care executive or a medical student.

The concepts I've learned through EMHL courses on quality improvement, change management, and strategic planning have been directly applicable to my AΩA project. The EMHL also improved my understanding of health care policy, organizational culture, and finance—all of which have broadened my perspective.

The AΩA fellowship has reaffirmed my desire to continue learning, teaching, serving, and developing as a leader. I hope to create opportunities for others that I might give back what I've been privileged to receive.

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Nora Gimpel, MD—Developing a Coordinated Approach to Community Health Training in Medical School

Community health initiatives—specifically service learning—train medical students to assess the health needs of a specific population, and implement and evaluate interventions to improve outcomes. According to the Association of American Medical Colleges (AAMC), service learning is defined as a structured learning experience that combines community service with specific learning objectives,

preparation and reflection. It is also based on community identified concerns developed and implemented in collaboration with the community. Service learning takes students out of the classroom into real-world situations, and provides experiential learning.[1–5]

The University of Texas Southwestern Medical School (UTSW) is one of four medical schools in the University of Texas System. It serves 950 medical students who participate in more than 100 community health activities each year, including running and staffing four student-run free medical clinics in the Dallas area.

In 2015, UTSW redesigned its medical education curriculum to offer a shortened pre-clerkship period, and an extended clerkship period with a 12-week scholarly activity requirement. Medical students can choose to complete their scholarly activity in community health, quality improvement, global health, biomedical innovation, medical education, basic research, or clinical and translational research.

The present challenges in health care offer UTSW an opportunity, and a responsibility, to prevent and reduce the disproportionate burden of disease affecting vulnerable communities, and develop appropriate and effective models of health in all communities.

Multiple health initiatives (health fairs, students-run free clinics, community-based participatory projects, etc.) are implemented by UTSW students, with many of the service learning opportunities hosted in the Department of Family and Community Medicine. Although these programs have been very successful, students' activities often overlap in the community areas creating inefficiency, inconsistency, and redundancy.

My AΩA Fellow in Leadership project was to create a longitudinal integrated community health training program for first- through fourth-year medical students. Part of the project was to create a coordinated UTSW community health program.

In order to improve community health training for learners, the project addressed four questions:

1. What percent of medical students participate in community health initiatives? How does this percentage compare with graduating medical students in the United States?
2. What are the perceptions of medical students and education leaders regarding community health training?
3. What types of community health training programs and structure exist in other U.S. medical schools?
4. What gaps exist between community partners' needs and UTSW community health initiatives?

In conjunction with medical students, a project charter was created, and organizational buy-in was obtained to form the Community Health Initiative (CHI). Alignment meetings with the medical school's Provost, academic deans, Director of Student Support Services, and the Vice President of Community Affairs were held. A governance council with class representatives was formed,and student and faculty representatives were invited to participate based on previous involvement with community-focused activities at UTSW. The governance council held several meetings to create a roadmap, and identify resources needed to complete the key questions.

Two teams conducted internal assessments of current community health initiatives and perspectives from medical students and educational leaders at UTSW. Two other teams conducted external assessments to analyze community health training programs in other U.S. medical schools, and obtained perspectives and feedback from community organizations partnering with UTSW.

Internal assessments

The Medical Student Survey team identified the current community health initiatives at the medical school, and determined the perceptions of UTSW medical students. An electronic survey was sent to 950 medical students. To encourage survey participation, all participants were entered into a drawing for a $50 Amazon gift card.

The Stakeholder Interviews team determined the perceptions of UTSW educational leaders regarding the needs and expectations for the creation of an integrated community health program aligned with the institutional mission. The team conducted 45-minute open-ended response interviews with key educational leaders. Each interviewee was also sent a seven question post-interview electronic survey.

External Assessments

The Benchmark team analyzed community health training programs in other U.S. medical schools to determine if they had organized service learning opportunities defined by one of four requirements: activity, hours, reflection essay, and graduation track or distinction.

The team also determined the percent of U.S. medical school graduates who had participated in a community health initiative by reviewing the community health questions on the AAMC Graduate questionnaire.

The Community Partners team determined the gaps between local community partners' needs and UTSW initiatives using a mixed quantitative and qualitative study

design. The team hosted a three-hour breakfast inviting various community partners and UTSW affiliates to participate in facilitated community needs qualitative discussion. Participants also completed an 11-item quantitative survey prior to attending the event.

Preliminary results

Internal Assessment

The initial evaluation included 243 students (25% response rate), and the primary findings were:

- Students spend an average of six to 10 hours per month in service learning;
- Seventy percent of students are interested in volunteering in free clinics;
- Main benefits of serving include practicing medical skills, learning new skills, and engaging with the community; and
- Main areas of improvements are to provide new clinical experiences, have well-organized and planned activities, and establish effective communication regarding opportunities.

Eleven stakeholder interviews were conducted, and the preliminary findings include:

- There is a need for an integrated approached to service learning at UTSW;
- A coordinated community health program will bring the possibility of working more effectively in the community;
- There is a need for more sustainable projects; and
- There are opportunities to incorporate service learning experiences into the curriculum.

External Assessment

A literature search was conducted, and online website searches were completed to find specific requirements for service learning among medical schools in the U.S. The primary findings were:

- Based on the 2014-2015 AAMC Curriculum Inventory, out of a total of 135 medical schools that participated only 29 reported teaching service learning in any capacity, whether through clinical experience, demonstration, small- or large-group discussion, independent learning, lecture, or service learning activity;[6]
- Out of 49 medical schools reviewed, 26 don't have any service learning requirements, and 40 do not provide any service learning graduation track or distinction; and
- Although the medical schools analyzed generally offered service learning opportunities, there is a lack of mandatory activities, service hours, and reflection activities.

Fifty-five representatives from 30 community organizations that had worked with UTSW students, and 10 departments at UTSW participated in group exercises and discussions. The main themes identified were:

- Increasing the sustainability of projects, integration of partners and projects, optimizing project development, and expanding outreach and monitoring progress;
- Community partners are satisfied with the types, number, and cumulative working hours of volunteers; and
- Community partners would like to improve the coordination and sustainability of the service learning activities.

Medical students, faculty leaders, and community partners consider service learning to be an important component of medical education, however, an opportunity exists to create a longitudinal holistic community health training program at UTSW. In particular, most of the student-led service-learning activities lack visibility, coordination, and communication.

Across U.S. medical schools, there is a lack of uniformity and requirements for community health training. Consistent with other U.S. medical schools, the majority of UTSW service-learning activities lack learning objectives, an organized process, and requirements. UTSW needs to provide a sustainable, measurable, coordinated approach to community health training, and align student experiences to community needs.

The next step is to explore potential models to create a center of excellence in community health training that provides the infrastructure, resources, support, and training to make an impact in local communities. Prospective partnership with a national organization is in development.

Servant leadership—My inward journey

The AΩA Fellowship offered me unique opportunities for development, and provided for positive changes (internally and externally) in my inward journey of leadership.

Since I started the program, I have received guidance from my mentors, and have been able to participate in regular coaching sessions to recognize, understand, manage, and alleviate leadership challenges.

I attended formal leadership training monthly trough the LEAD (Leadership Emerging in Academic Departments) program at UTSW, and was able to expand my network to connect with leaders from AΩA, AAMC, UTSW, and other institutions

I had financial support that allowed me to develop a database to track services and learning opportunities at UTSW. This is the first time a tool to track those

experiences at UTSW has been implemented and available.

I was able to increase collaboration, and disseminate information about the work that is being done in the community.

I have had multiple abstracts accepted to national and international conferences, two publications were accepted, and my project was presented nationally.

I was able to learn how to apply effective leadership style and tools in my daily activities, and I learned how to formulate, plan, implement, and manage a project.

I faced multiple challenges that allowed me to put into practice the leadership lessons I have learned.

I have changed my "lenses," and reframed.[7] I have learned to step back from what is being said and done, and consider the lens through which this reality is being created, to understand the unspoken assumptions, and to constantly reflect on the future that I am committed to. I now listen, and practice the art of asking instead of telling.

My journey has led me to leadership.

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Susan Lane, MD—Development of a Sustained Clinical Rotation for Primary Care at the Shinnecock Reservation Indian Health Center

I am a general internist, and the program director of a large internal medicine residency program. Caring for the underserved, and promoting primary care training, has been the focus of my career. I am passionate about health care policy, particularly work force issues, and graduate medical education funding. Serving on the Alliance

for Academic Internal Medicine (AAIM) Health Policy Committee for more than 10 years, and chairing the committee for the past three years, has given me the opportunity to put policy passion into practice.

My AΩA Fellow in Leadership project was to realize a long-held dream to develop a clinical rotation for primary care residents at the Shinnecock Indian Health Clinic, located on the Shinnecock Reservation, at the eastern tip of Long Island.

There are a number of converging factors that make this an ideal time to forge a collaboration of Stony Brook Internal Medicine with the Shinnecock Tribe and Health Clinic. Stony Brook University Hospital leads the performing provider system of Suffolk County for the New York Department of Health DSRIP (Delivery System Reform Incentive Payment) program, whose goal is to meet the Institute for Healthcare Improvement requirements of the Triple Aim—improving the patient health experience, the health of populations, and reducing the per capita cost of health care. Stony Brook is in the final stages of a formal affiliation with the primary hospital that provides clinicians for the Reservation clinic, and is launching new population health programs. This project focuses on chronic disease management; understanding the impact of social determinants of health; interprofessional teamwork; and alignment with the population health efforts already under way.

My project provided an opportunity to engage the Shinnecock Clinic as a learning environment, and improve the health, and health care, of this indigenous population.

An orientation to leadership

On a bright summer day in California, the three 2016 Fellows arrived at the AΩA national office in Menlo Park with anticipation and uncertainty. A gracious welcome from Dr. Byyny (the AΩA Executive Director) at the airport assured me that this would be an individualized, welcoming, and supportive program.

The AΩA fellowship is unique in that the focus is on the inward journey to identify and cultivate one's nascent abilities in the here and now. Dr. Wiley "Chip" Souba

started us on our inward journey of leadership,[1] and laid our foundation for leadership growth. This fresh approach, and the entirety of the orientation, was like finding a riverbed in the desert. A leader's overall effectiveness is predicted as much by warmth as by competence.[3] Throughout the year we were enveloped by both.

Following the AΩA Leadership Orientation, I returned to my professional life as an internist and internal medicine program director. Although challenges that had been smoldering at work were flaring up, I noticed that I was paying closer attention to my interactions, reactions, and intentions; i.e., to my "ways of being and acting." As summer turned to fall, I had made little progress on my project, which I had started with a big vision and big mentors. I came to realize that my initial mentors would likely be very helpful five years into my project, but not at the earliest stages. I needed help at the ground level—how would I develop a relationship with the leaders of the Shinnecock Nation?

It was not clear to me at this point where my proverbial bus was headed, let alone who would be on it. I went down every avenue I could think of looking for connections, and began to assemble a team of professionals interested in primary care, the health of populations, and the social determinants of health.

Developing a team

I met with Stony Brook Medicine's Director of Community Outreach who had previously made an initial connection with the Shinnecock Tribe. She helped connect me with the Director of the American Indian Program for New York State, and we began to explore opportunities to work with the Long Island Native American tribes.

I then connected with the Director of Population Health for the DSRIP program, and met with the Southampton Hospital internal medicine and family medicine program directors to build a coalition of educators supportive of a primary care rotation at the Shinnecock Indian Health Clinic.

Several times, opportunities to change course and abandon my original project arose—often to a much smaller project with a finite end that did not lead back to Shinnecock. I debated changing course to pursue one of these easier projects with my AΩA mentors Dr. John Tooker and Dee Martinez, but ultimately decided to stay the course with my original project, even though it was more challenging.

I had added several people to my team, but had delegated little responsibility to them. Serendipity stepped in. I attended a project management workshop at the AAIM Skills Development Conference, and learned to use a project management tool. I reorganized my project, gained a better organizational understanding of the work, and was able to cast a wider net and make new helpful contacts.

Whenever opportunity presented itself I talked about my project. The more I talked, the more people showed interest, and wanted to be part of the team. A colleague at the Greater New York Health Association invited me to join a task force to create a social determinants of health curriculum. This was an opportunity to collaborate with experts in the field, and incorporate the task force's findings into my project.

I requested an exemption from the Accreditation Council for Graduate Medical Education, and obtained permission to proceed with the rotation.

My leadership development

In late fall, before recruitment season ruled my days, I identified several programs that I wanted to pursue over the next year with my AΩA stipend. Though I have been a member of the AAIM Health Policy Committee for a number of years, much of my health policy knowledge was learned on the job. To more formally develop health policy expertise, I applied, and was accepted, to the Society of General Internal Medicine (SGIM) Leaders in Health Policy (LEAHP) Program. I collaborated with my LEAHP colleagues and organizations outside of SGIM to build an advocacy curriculum for medical students and residents.

I recognized that I had deficiencies in finance and resource management, and heeding the advice of my mentors to "learn how to read a spreadsheet," I applied and was accepted to the AAIM Executive Leadership program. Shortly thereafter, I was nominated to run for, and was elected to, the Association of Program Directors in Internal Medicine Council.

Implementing the plan

Winter had arrived, and I was anxious to move from planning to implementation of my project. A colleague mentioned my project to a friend who has been the dentist at the Reservation clinic for several years. She recognized the need for enhanced medical care at the clinic; however, infrastructure challenges were discouraging for the project.

The dentist and I found ourselves meeting at a social gathering a few months later, and she explained that the new clinic manager was well-organized, enthusiastic for change, and wanted to meet me to learn more about my

project. Finally, on an early spring day, I headed out to the Shinnecock Reservation for my first visit. Talking with the clinic manager, I could tell how much she cared about her patients, and their access to care. We shared a common vision.

In late spring, I met with Dean Kaushansky and discussed my project's progress, highlighting its synergy with current institutional projects at Stony Brook, including a short track into primary care for medical students, telehealth opportunities, and population health. I developed a "one-pager" outlining the issues, the plan, and my ask. I gave him my project map to show existing and potential connections to institutional initiatives.

My ask was straightforward—I needed his help to arrange a meeting with a representative of the tribal leadership, Reverend Smith, who also holds a seat on the Stony Brook University Council. The Dean introduced me to Reverend Smith, we exchanged e-mails, and a meeting was set.

My main goal for my first meeting with the Shinnecock Tribal members was to listen, learn about their needs, and understand their hopes for their community. I knew that "here-and-now humility" is an essential practice in collaborative projects.[2]

Reverend Smith was enthusiastic about the project, and welcomed the plan to add primary care services to the clinic. He invited me to return the following week when members of the Department of Health and Human Services Indian Health Service (IHS) team would be visiting for their annual meeting with tribal leadership.

The IHS team meeting was amazing. I was invited to sit at their table and learn firsthand about challenges the Shinnecock Tribe was facing. I came to appreciate the myriad requirements to receive IHS services, including expanded clinical space.

I was humbled to be given time during the meeting to discuss my project proposal, and answer questions from tribal leadership and IHS representatives. I expressed my belief in, and dedication to, the idea that our primary care training program could enhance medical care for the Shinnecock community, now and into the future.

As the meeting came to a close, there was consensus that medical care provided by primary care residents would be part of the future of health care at the Shinnecock clinic!

Next steps

I have been working with a new faculty member exploring opportunities to bring telemedicine and residency training together as part of Stony Brook's work with the Shinnecock Clinic—an idea I had not even considered a year ago.

I now appreciate that projects that are dynamic, flexible, and evolve with the environment in which they live.

The AΩA fellowship and work on the Shinnecock Clinic project has enabled me to expand my circle of influence—not only geographically within my institution, community and region, but also academically in health policy, curriculum development, and population health. My AΩA fellowship project began, and continues, as a collaborative endeavor to improve health care delivery, and mitigate the social determinants of health for a vulnerable population.

My core beliefs and commitments have not changed, but a different me has started to show up. I am learning that our circle of influence is dynamic. I have learned to pay as much attention to the stillness as I have the movement. Important things happen in the quiet times, and you need to be watching and listening so that you don't miss them.

I have learned firsthand that you learn to lead through experience, and you develop expertise by doing. Herminia Ibarra's "outsight principle" describes my AΩA fellowship experience:

> …the only way to think like a leader is to first act—plunge yourself into new projects and activities, interact with very different kinds of people, experience with unfamiliar ways of getting things done…your true self emerges from what you do.[4]

I have heeded the advice of my mentors and coaches, "don't be afraid to take a chance." The AΩA leadership fellowship has been a life-changing experience, and I look forward to sharing what I have learned on my leadership journey with my colleagues, residents, and students.

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