ADFM Association of Departments of Family Medicine
VISION, VOICE, LEADERSHIP

ADFM Newsletter

• • Fall 2013 • • Volume 2 (4) • •

Inside this issue:

The ADFM Newsletter is a quarterly update of key information that all members of ADFM should know, with highlights on the recent work of our committees. We'd love to hear your feedback (to: aharris@fammed.washington.edu)!
Happy reading!

"Partnering - We are all in this together!"

2014 ADFM Winter Meeting
February 12-15, 2014
Loews Coronado Bay Resort & Spa
Coronado, CA

registration open November 27th at:
http://adfammed.org/meeting_information.aspx

Mark your calendars and get ready to register for the 2014 Winter Meeting, "Partnering - We are all in this together!"

A number of fantastic sessions focused around the theme of "Partnership" are in the works, including:

- Parnering with our Patients
- Partnering with Federal Partners: our US and Canadian Experience
- Chair and Administrator Partnerships
- Partnering with Specialty Colleagues
- Partners in Training: Interprofessional Education
- Partnering with Different Stakeholders - Real "On the Ground" Sories of Success and Challenges (including examples of unique partnerships with the media and medical students)
- Partnering with your Local Community Physicians
- Partnering to Increase Research Capacity
- Saturday breakfast session focus on stakeholder partnerships
- and more!

We have a number of fantastic speakers and guests lined up and there will also be an optional, interactive dinner workshop on Building Resilience intended for all Chairs, Administrators, Senior Leaders and ADFM Fellows, no matter where you are at in your career.

Registration for the meeting will be open by the end of November - watch for a message over the listservs!

Administrators' Pre-conference:

Getting Down to Business!
February 12, 2014
9:00am-3:30pm
Jennifer Johnson,
Preconference Chair

New Chairs and ADFM Fellows Pre-conference:

Change Management
February 12, 2014
1:00pm-5:00pm
Hosted by the ADFM Leadership Development Committee

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Pathway to Leadership in ADFM

ADFM Nominations Committee: Tom Campbell (Chair), Alan David, Warren Newton, Mike Rosenthal, Jeannette South-Paul, Allan Wilke and Ardis Davis (ex-officio)

1. Introduction into ADFM Leadership begins with the committees.

- Volunteer participation on the Winter meeting program committee is an entry level to leadership in ADFM.
- Active participation as a member of one of ADFM's strategic committees (Education Transformation, Healthcare Delivery Transformation, Research Development and Leadership Development) is the next level of entry into ADFM leadership
- Strategic Committee positions are approved by the Executive Committee in consultation with the Committee Chair
- Strategic Committee Chairs are approved by the Board.
- Winter Meeting Committee chair is appointed by the President-elect and approved by the Executive Committee

2. The most common pathways to getting onto the ADFM Board of Directors are through:

- Role of Committee Chair
- Election to Member-at-Large position on the Board

3. Member-at-Large positions on the board will be considered as one means of achieving desired diversity on Board. Optimally, membership on the Board of Directors will: 1) include members who desire active involvement and bring a collaborative spirit to the Board; and 2) reflect diversity in the following:

- Gender
- Length of time as chair
- Ethnic background
- Department size
- Private/public status of DFM
- Large Regional Medical Center status of DFM

If you are interested in participating in ADFM leadership in the future, please contact Ardis Davis (ArdisD7283@aol.com). We are maintaining a running list of those who have expressed interest.

OPEN CHAIR POSITIONS*

with an active search underway

- Brody School of Medicine at East Carolina University
- Cleveland Clinic
- Emory University
- Jefferson Medical College
- Loma Linda University
- Lousiana State University HSC SOM
- Northeastern Ohio Medical University
- Southern Illinois University
- SUNY-Buffalo
- University of Pennsylvania
- University of South Dakota
- West Virginia University SOM - East Campus
- Wright State University

** If this information is incorrect or you have additional information, please let Amanda Harris know (aharris@fammed.washington.edu).*

Criteria to consider for Single Slate Candidates for Pres-elect, Treasurer, Secretary:

- *REQUIRED QUALIFICATIONS:* At least 3 years as ADFM Member and Past or Current Participation as a member of the Board of Directors
- *PREFERABLE QUALIFICATIONS:* Committee Chair/Winter Meeting Program Chair
- *For President Elect* – In addition to the above: consideration of skills in relation to strategic plan – i.e has leadership skills required esp re: larger systems

2013 ADFM Annual Survey

Thank you all who have participated so far in the 2013 ADFM Annual Survey!

As of November 22, we have 106 of 150 departments responding, which is a 71% response rate. If you have not yet completed the survey, please take a few minutes to do so - we would love to beat last year's response rate of 77%!

Additional thanks go to those of you who completed the survey in advance of the November 1 Board meeting; the Board was able to use the preliminary data to help them in planning strategically for 2014!

Results of the survey will be presented at the 2014 ADFM Winter Meeting and will be used by the ADFM Board and the ADFM Strategic Committees for ongoing strategic planning and to inform ADFM projects and initiatives.

Associate Membership in ADFM: Sign up your Administrator!

Is your administrator an Associate Member of ADFM? Our ranks of Associate Members have been growing steadily since the introduction of the membership category in 2006; we now have over 90 Administrator Associate Members, which represents over 60% of our Departments of Family Medicine.

In a recent message to all Chair members, Chair/Administrator team from the University of North Carolina, Warren Newton, MD, MPH and Ronald Lingley, MSPH, write:

"Adding Associate Members has already provided our discipline with opportunities to develop further key members of our leadership teams and to bring Chairs and Administrators together to learn from others dealing with common issues. It has also provided Administrators the ability to learn more about the common institutional and national issues before us and to network. Administrators overwhelmingly provide high praise to membership, attending the Administrators' preconference, the ADFM Winter Meeting, as well as participation in the Administrators' listserv."

There is still time for administrators to join for 2014, allowing them to participate in the ADFM Winter Meeting and Administrators' Preconference. The additional cost of membership for adding an Administrator on your departmental membership is $300. Priscilla Noland (pnoland@stfm.org) can process this membership request.

Below is a list of ways that ADFM adds value for Admistrators and their departments. If you have any questions, please feel free to contact Warren (warren_newton@med.unc.edu) or Ron (ronald_lingley@med.unc.edu)!

Value of ADFM Associate Membership

ADFM membership to senior department Administrators is of great value. The value is even more if you consider the incremental cost of joint Chair/Administrator membership! Listed below are just a few of the administrator membership benefits:

- Annual Winter meeting (3 full days of packed agenda, annual theme, outside speakers, presentations on best practices, special topic breakfast discussions, opportunity to present an issue and get real time input/advice)
- Pre-conference session for Administrators (annual theme, agenda based on collective input from Administrators)
- Lots of time/opportunity to network with colleagues with common experiences and responsibilities
- Opportunity to volunteer to participate in ADFM sub-committees, or Administrator-led projects
- Opportunity to seek out and receive mentoring/guidance in self-development
- Ability to post a question (from simple to very complex) on the listserv, and receive responses in a short period of time
- Broader dissemination of industry benchmarks, best practices, emerging policies, and reference material via administrator listserv
- ADFM Newsletters
- Ability to view departmental profiles and identify the department that may be similar to yours (size, scope, complexity, issues/challenges)
- Access to various items being developed and placed into the "Administrator Tool Box"
- Opportunities to make new relationships and formulate plans for small/regional meetings

Call for application submissions:

2013 AAMC Clinical Care Innovation Challenge Award

Applications due by December 5, 2013

The 2013 Clinical Care Innovation Challenge will recognize AAMC member teaching hospitals and medical schools that have implemented—or are developing—programs to address clinical care innovations, including new delivery, payment and training models, which integrate education and research to improve value and quality.

Authors can submit proposals within two categories: successfully implemented programs and one year pilot project proposed programs.

Full information available: https://www.aamc.org/initiatives/quality/354304/clinicalcareinnovationandchallenge.html

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Have you discovered the gems of human resources living in your region?

Chris Matson, MD, Chair, ADFM Education Transformation Committee

Bob and Anita Taylor admit that they've 'failed retirement' -- if passing retirement means giving up the skills you used during your professional lifetime.

Physicians are fortunate in being able to continue to employ many of their skills beyond 'retirement,' such as in part-time employment, consulting, or volunteering services. Particularly if an academician retires in an area where a medical school is located, multiple possibilities for continued service may be available. The Taylors, after Bob served 14 years as chair of family medicine at Oregon Health and Science University and Anita served for 12 years as school of medicine director of career advising and most recently as assistant dean for students and in other roles, have approached retirement in stages. First Bob stepped down from his role as chair, and remained in a part-time capacity on the faculty in family medicine, while Anita maintained her full-time role in Student Affairs. Then in the spring of 2012 they took the big leap of relocating near their daughter and son-in-law and two grandchildren in Virginia Beach, Virginia. After establishing themselves there, it didn't take long for Eastern Virginia Medical School to approach Bob to present some Grand Rounds on his favorite and perennially helpful topics, for both to start serving on the school's admissions committee, and to offer their pooled wisdom and experience in advising the students through the Family Medicine Interest Group, to share the rich history of family medicine's journey, and to mentor students engaged in the challenging process of career choice.

Finding 'retired' colleagues who have a wealth of experience to share with potential family physicians of the future and those currently in training is a win/win/win: for students and residents new to the tremendous opportunities for service that family medicine offers; for our departments and institutions; and for our colleagues who've contributed much, but still can continue the gratification of sharing what they've learned with others.

WELCOME TO NEW CHAIR MEMBERS*

Aug 2013 to present

- Peter Carek *(University of Florida COM)*
- Richard Lord *(Wake Forest SOM)*
- Diane Harper *(University of Louisville)*
- Herbert Muncie *(Louisiana State University)*
- Christine Arenson *(Thomas Jefferson University)*

** New chair members since the last edition of the newsletter. If this information is incorrect or you have additional information, please let Amanda Harris know (aharris@fammed.washington.edu).*

Family Medicine for America's Health: Future of Family Medicine 2.0 (FFM 2.0)

Want to learn more about what is happening with "Family Medicine for America's Health: Future of Family Medicine 2.0"? The organizational updates are available on right-hand side of the main ADFM webpage (www.adfammed.org).

On November 3 in Philadelphia (in conjunction with the AAMC Annual Meeting), an open forum "town hall" to discuss FFM 2.0 was held for ADFM members. Forty chairs were in attendance for this valuable and productive discussion session. Follow up notes from this session were sent over the chairs' and administrators' listservs.

A second (optional) "town hall" session will be held over the lunch break on Thursday, February 13 at the ADFM Winter Meeting.

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Powerpoint detailing the NAS, CLER, and Family Medicine Milestones Posted

The ACGME has posted a powerpoint that gives an overview of the Next Accreditation System, the Clinical Learning Environment Review, and the Family Medicine Milestones and outlines the goals and expectations for each. These slides can be found at: http://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/FamilyMedicinePresentation. pdf
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Family Medicine and Global Health

Ardis Davis, MSW, ADFM Executive Director

I had the pleasure of representing ADFM at the 10th AAFP Global Health workshop last month with nearly 300 attendees (compared with 25 attendees at the first such workshop in 2003) featuring six plenary sessions, 48 breakout sessions and 50 poster sessions. Among attendees were a record number of residents (53), and 38 medical students. Following the conference, I also represented ADFM at a meeting of the Center for International Health Initiatives (CIHI) Board, where the issue of increasing some coordination in activities across the organizations was explored.

Major Themes Arising from the Global Health (GH) Workshop

- **Global health is a major attraction for both students and residents. Technology (i.e. social media, mobile devices) and innovation, inherent in much GH activity, are also key areas of attraction for students.**
- **Family medicine is the specialty with the skill set best positioned for global health – we need to capitalize on tying Family medicine and global health together as a viable a career path for both medical students and at the pre-med level. Family medicine residency programs need to have a GH component to be competitive.**
- Important to define what you mean by "Global Health", agree on expectations and tie back to your institutional mission when engaging your institutional leadership about opportunities in global health.
- Department of Family Medicine/Medical School infrastructure at international destinations is important.
- Global Health means both domestic and international – skills gained through global health experiences can be applied to underserved and under-resourced areas in the USA. This may be a critical message in helping your institutional leadership to see the value in pursing global health opportunities.
- Global Health provides leadership development and scholarly opportunities for learners.
- Leadership support "back home" is critical to sustainability – as a Chair, even if you are not directly involved, taking time to learn about and visit one of your institution's or Department's global health sites and lending support in that manner can be important.
- Need to work "along side" and "behind" leaders in other countries. Be sure to reflect on mistakes; beware of "too much, too soon, too fast". There is value to both short term experiences and long-term presence; ethical issues arise in both.

***Annals of Family Medicine* Nov/Dec commentary:**

"Another Century of 'Reform Without Change?'"

This edition's commentary, "Another Century of 'Reform Without Change'?" by Christine Matson, Ardis Davis, Mark Stephens, and the ADFM Education Transformation Committee examines the history of calls for curricular reform, the lack of meaningful change to date, and whether our current change mantra will be able to make greater progress.

The next edition of the *Annals* will include a collaborative commentary about the "Four Pillars of Primary Care Physician Workforce" from all of the CAFM organizations.

All *Annals* commentaries from ADFM are archived on our website, at http://www.adfammed.org/commentaries.aspx

John Tipton named new ADFM Representative to the Center for the HIstory of Family Medicine

ADFM President Barbara Thompson has appointed John Tipton, Chair at University of Oklahoma School of Community Medicine (Tulsa), as the new representative to the Center for the History of Family Medicine Board of Curators. John replaces Mike Coates, who had served in this role since 2010 and stepped down from his Chair position as of September 30, 2013 to focus on his clinical practice and teaching role as Professor of Family & Community Medicine at Wake Forest School of Medicine.

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Congratulations to new IOM members Carlos Jaen and Brian Jack!

Carlos Jaen and Brian Jack are among the 70 new members who were elected to the IOM at their annual meeting in October. For the complete list of new IOM members, visit: http://iom.edu/Global/News%20Announcements/2013-New-Members.aspx
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Takeaways from Research Consultations at NAPCRG

The Research Development Committee coordinated a series of individual "mini consultations" for chairs and research directors who are relatively early in their research development to talk with chairs and/or research directors from programs with more established programs at the annual NAPCRG meeting this year. Nine of these mini-consultations were held and pearls/take-aways were shared at the annual meeting of U.S. and Canadian chairs. A few of these pearls and hightlights from the "secrets of my research success" sessions are noted below. If you would like the full list of "pearls," contact Amanda Harris (aharris@fammed.washington.edu). Amanda is also keeping a running list of those who are interested in serving as consultants or recieving consultations in the near future; please let her know if you are interested in being added to either list.

Success in Research "Pearls"

from mini-consultations at joint Canadian/US DFM chairs' meeting and the "Secrets of My Research Success" sessions, NAPCRG, Ottawa, November, 2013

General advice:

- Persist, and take baby steps
- Both mosaic (variety of areas of inquiry) and melting pot (single theme) models of research divisions can work
- Don't think of research as a series of projects, but rather as a program of study in which one study sets the stage for the next.
- Be bold and embrace critics. Use self-doubt in a healthy way to be open to critiques and improvements, and realize that for good researchers, it never really goes away, and that is a good thing.

Finding a Research Question/Area of Inquiry:

- Be sure you answer the "so what" question first – your area of inquiry must be compelling.
- Always remember the source of your questions – the puzzles, pauses, or predicaments that motivate you to action
- Don't "jump in an intellectual box without a lid" – be ready to jump out when needed. An example of an intellectual box with a lid is to think of primary care research as having only with clinical care, vs. the population health perspective. In this case, focusing only on what happens in the clinic is a kind of "lid" to the box of your research area.

Getting Experience:

- Present posters as a first step – can build confidence for publications and aid in finding collaborators
- Encourage faculty to do a review article in their area of interest
- Serve on a study section – a wonderful way to learn what the funded grants have, and what the ones that aren't funded are lacking, and what the funders are interested in supporting.

Grants and Funding:

- Look for funding other than federal sources
- Grants don't come from grant writers, they come rom investigators

Training and Mentorship:

- Use a multiple mentor model – some for career guidance, some for content/methods expertise
- Don't just look up for mentors – also look sideways (that is, peers at similar level of development can still function as mentors)
- Create a journal club for the purpose of exploring methodology – partnering with School of Public Health at institution that has experts in the methods

Collaboration and Partnerships:

- Not all DFMs can/should be working to be research intensive. Know what you are really good at, and prioritize it. Not everyone needs to be a three legged stool. Consider partnering with other DFMs that are research intensive and provide them with a PBRN.
- Collaborate with clinical epi and biostats, if available locally

Research Environment – institutionally and locally:

- Take advantage of institutional expectations and resources – if they expect you to do research, define what that means and ask for the resources.
- Create documentation for purposes of research, even if it isn't billable (eg, the contributions of behavioral scientists in certain contexts)

Time and staff:

- Research administration can be done by someone other than a PI, which frees up PIs to do research
- Schedule time for reflection and writing, and don't let anything take its place. If it is not possible to do this during your normal work hours, then set aside time at times of the day when you tend to be most productive.

Top Educational Innovations

Compiled by Tochi Iroku-Malize, MD, MPH, FAAFP, SFHM, member of the ADFM Education Transformation Committee

1. ***Interactive self-directed learning model to augment the traditional lecture:*** The Miller School of Medicine Laurence B. Gardner, M.D., executive dean for education and policy. Premise: pre-recorded lecture broken into 10-15 minute core segments which students watch prior to class and then meet in the classroom in teams to discuss further the concepts, guided by faculty who facilitate discussions. Use of online student dashboards to keep track of individual student progress.
2. ***Seeking Innovative Medical Educators Interested in Teaching Value and Choosing Wisely:*** ABIM. While serving as chief resident at Yale, Robert Fogerty instigated a friendly competition among medical students, interns, residents, and attending physicians to reach the correct diagnosis with the fewest resources possible during morning report–style conferences.
3. ***"Computer Augmented Visualization Environment (CAVE)."*** With CAVE technology, the ultrasound and MRI images captured can be visualized and manipulated as multi-dimensional and in color. The images can be projected on a whiteboard, a surgical table-sized surface, a tablet, or a smartphone. A physician–student team can analyze the visualizations from all angles: 360-degree viewing is supported so that observers can see the "other side" of a chest wall or jaw, for example.
4. ***FOAM "free open-access medical education."*** Resources are packaged by those in the health professions for colleagues and peers and often are disseminated on social media channels. Dr. James McCormack began producing educational videos on the concept of minimally-disruptive medicine by reworking popular Top 40 and rock songs, His latest video, "Viva La Evidence," puts a new spin on Coldplay's Viva La Vida. The video discusses the principles of evidence-based medicine and delves into the history of the concept.
5. ***Twitter in the classroom:*** Diedre Bonniecastle @ Univ of Sasatchewan blogged about this.
   - Questions: Students asked questions about both the content and classroom processes (When is the exam?) and were answered by both the prof and other students which cut down on the time Profs spend answering individual emails.
   - Engagement: In large classes, it can be difficult to get students to engage with each other in the learning process. Twitter increases this activity both with fellow students and with the Prof.
   - Presence: In large classes, students can seem to flow together in a mass of faces. Twitter can give Profs a sense of who people are as individuals without breaching the professionalism divide.
   - Acceptance of new technology: Many students use twitter as a form of note taking that can be checked through what peers are saying about the content. Prof can check on how accurate the key points are being perceived.
6. ***Blackboard.*** An electronic course management system for distance education and face to face courses that can be used to distribute course materials, communicate with students, help organize students, facilitate student group work, deliver online quizzes and exams and manage student marks.
7. ***MOOC (Massive Open Online Course) in medical education.*** It is an online course aimed at large-scale participation and open (free) access via the internet. They are similar to university courses, but do not tend to offer academic credit. A number of web-based platforms (initiatives) supported by top universities and colleges offer MOOCs in a wide range of subjects.
8. ***Albert Einstein Medical School YouTube videos on medical topics.***
9. ***Animation via YouTube on medical topics:*** Dr. Mike Evans, useful when educating patients at the bedside or in office
10. ***Illness script via mindmaps:*** University of California. Ask students/learners to graph common illnesses as they progress through their training and by sharing your differential thinking. Illness scripts have the added advantage of forcing the student to think in terms of a broader differential without the power struggle of arguing about a whether a particular diagnosis is correct. These graphs can be kept in a binder and added to as the learner increases their knowledge. The final graph will be useful for studying for final exams. Both text-based and visual representations are acceptable depending on the student's personal learning preference. (Resources: Visual-literacy.org, NHS Map of Medicine and Google Squared.)

Twitter in the Classroom "How-To":

Begin with a course #hashtag something short, descriptive and clear that isn't being used elsewhere on Twitter. Ideally the students will be involved in coming up with something useful. Having a class #hashtag avoids the issue of students being added to personal twitter accounts. Add the course #hashtag to your presentations.

Decide how actively you want to be involved in the #hashtag:

- Minimal: set twitter office hours when you will answer questions
- Medium: sent articles, images, reminders and other resources that might enhance the learning experience and actively encourage students to tweet images and notes on your presentations
- High: Tweet your presentation as you are giving it by using tools like Status Present. Show the twitter feed for the class on a second screen or every 15 minutes and answer questions that are posted

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Highlights from sessions at the AAMC Annual Meeting

Linda French, MD, member of the Healthcare Delivery Transformation Committee

Health Care Improvement: Effecting and Studying Change Through Continuing Education, Professional Development and Lifelong Learning

Dr. Price from Permanente system presented an approach to educational research to study especially the professional aspects of QI and organizational change. It nominally took the tact of CME, but pretty equally embraced the agenda as HSR, educational research, and PI. Take homes: 1) Take an interprofessional approach to this agenda with other colleges such as nursing and pharmacy, under the provost/chancellor level. 2) Change approach to grand rounds to be driven by a QI agenda.

Preparing Your Institution for a Post-FFS World

We must know our costs. Financial experts at U Utah developed a tool to examine costs that can be analyzed by outcome, procedure, division, provider, etc. Leads to recognition of opportunities to improve value (high variability, high cost, etc). Example of hip replacement surgery included imaging costs, prosthetic hardware costs, OR time, etc. which was fed back to the surgeons involving them in PI processes using bottom-up approach. They are coupling that bottom-up with a more top-down strategic planning process. Changing P+T and comp systems to recognize and reinforce efforts.

Bundled Payment: Aligning Payment Incentives with Care Redesign

Bundled payment offers a limited approach for assuming risk that is good for learning. Activity-based costing is essential for forecasting and identifying opportunities for improvement. Readmissions from SNF are high risk. Admission source - transfers in have higher post-acute care. Interventions include: pre-op risk assessment, anticipatory discharge planning including home prep for discharge home as soon as feasible, assessing psychosocial abilities for self care, multidisciplinary care planning, warm handovers, patient family engagement to facilitate self-care at all stages, and contracting for supply costs.

The Medical Neighborhood: Improving Care at the Interface of Primary Care and Specialty Care

UCSF e-Consult system: PCP needs guidance from specialty to answer a question, specialists need reimbursement for non face-to-face work, and patients have need for improved access (long wait times). With shared EMR, first created templates for common referral problems - "PCMH neighborhood interface". Specifies what is requested, (ideally) salaried specialist reviewer decides how to handle - answer question or schedule visit urgent vs non-urgent. Expectation is 72 h response time from specialist. Awards 0.5 RVU to PCP and 0.5 RVU to specialist. Total consults did not go up. Access to specialists for new patients improved (esp from outside). ED visits and hospitalizations dropped concomitantly (no causal evidence). E-consults take 10 min on average for specialist to handle.

Project Echo in NM: Goal to expand capacity to provide best access in rural and underserved areas. Uses videoconferencing with GI, pharmacist, and mental health/psych to discuss 12-15 pts in 2 h conference. Set up 21 centers run by PCP, PA or NP in CHCs and prisons to co-manage with specialists until become experts. After are experts, accept referrals from other local providers. Prospective cohort study cure rate was same as specialist care and improved as compared with same population getting care from distant specialist. Started to treat hepatitis C, then expanded to other diseases. Huge Medicaid and VA savings on travel. Integrates HC delivery and public health. "Demonopolizes knowledge." National collaborations with VA, DOD.

Advancing the Academic Health System for the Future Advisory Panel on Health Care

Intro from Joanne Conroy, AAMC:
Apply business rigor to all missions, not just clinical; train providers for the future, not the past; the move to value-based payment modes is happening and will continue to happen; need to participate in consolidating markets - AMCs will not be able to go it alone, at minimum develop high performance regional system; need to manage population health

Tom Enders from Manatt Health Solutions (consultant group working with AAMC on this project):
The study profiles 4 areas: 1) strategy, and alignment of org structure to that end; 2) fiscal affairs including compensation models, investment strategies, etc.: 3) network services strategy; 4) approach to performance management

Future will be systems-based, large cities far advanced in forming giant systems; access to capital will be critical; new roles for physician leaders - ability to lead the faculty in time of change is critical; candid assessment of strengths and weaknesses essential to advance change; bias to action - underpinning theme

Needs: aligned governance, organizational, and management systems; leadership strategically and/or structurally aligned; aligned and effective decision making; trust between leaders and transparency esp regarding financial decision-making; effective management systems: IT, corporate finance expertise (including pricing) that is aligned and coordinated, leadership development
Where alignment = transparency, accountability, and unified direction

ADFM Strategic Committees

Leadership Development Committee:	
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