The Path to Physician Leadership in Community Health Centers: Implications for Training

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Background and Objectives: Community health centers are facing a shortage of primary care physicians at a time when government plans have called for an expansion of community health center programs. To succeed with this expansion, community health centers require additional well-trained physician leadership. Our objective was to ascertain how medical directors obtain leadership skills in an attempt to identify the best methods and venues for providing future leadership training programs. Methods: Using recorded interviews and focus group data with community health center medical directors, we identified patterns and themes through cross-case content analysis to determine leadership training needs in underserved settings. Results: Medical directors often enter positions unprepared and can quickly become frustrated by an inability to make system improvements. Medical directors seek multiple ways to obtain the leadership skills necessary, including conferences, peer networking, mentorship, and formal degree training. Many directors express a desire for additional training, preferring flexibility in curriculum and hands-on components. Conclusions: Additional leadership training opportunities for active and future medical directors are needed. Academic medical centers and other training sponsors should consider innovative ways to develop effective physician leadership to provide quality care to underserved communities.

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Community health centers (CHCs) take a lead role in providing quality care to the underserved. The Health Resources and Services Administration (HRSA) Bureau of Primary Care’s Community Health Center Program provides care for more than 16 million underserved people and has undergone rapid expansion. CHCs provide high-quality cost-effective care to underserved communities, improve access to care, and reduce health care disparities.

For CHCs to continue to expand in the face of limited resources, strong physician leadership is needed. However, there may not be a sufficient qualified workforce. Many active CHC medical directors may also lack sufficient training in practice management and the specific skills such leadership requires.

Although medical directors play an important role in direct patient care and CHC management, there is limited research elucidating their basic characteristics, such as roles and responsibilities, relationships with other administrators, retention, and satisfaction levels. Some studies suggest administrative inexperience and insufficient training may lead to poor retention of medical directors. Further, increased training correlates with improved leadership skills, as reported by CHC executive directors, and leadership skills play a significant role in achieving exemplary CHC practices. Guidance on how medical directors should obtain such leadership training, however, is lacking.

Our primary objective was to ascertain the need for leadership training programs for medical directors of CHCs. This included determining how medical directors obtain skills in practice management and leadership as well as the most appropriate methods and venues for this training.
Methods
We performed a qualitative study analyzing key informant interviews with current and former CHC medical directors. Semi-structured interviews, audio recorded and later transcribed, were performed over a period of 12 months during 2006–2007 by the same interviewer using a standardized question guide. The validity of the insights gained from these interviews were then evaluated through a focus group of a separate sample of medical directors. The study was approved by the Boston University School of Medicine Institutional Review Board.

Samples
We recruited a purposeful sample of 11 current and former medical directors through a hospital-affiliated urban network of independent CHCs in Boston. We specifically chose participants based on current and previous experience and community demographics to achieve a diverse group. All medical directors approached for interviews agreed to participate except one.

For the focus group, four current and former medical directors were recruited from a training program sponsored by the Massachusetts League of Community Health Centers. All were affiliated with CHCs outside of the Boston-based hospital-affiliated network that served as the source of key informants.

Instruments
We developed an initial question guide based upon literature review, personal experience of the authors, and discussion with individuals who provide medical director training, including leaders from state and national CHC organizations. After the first three recorded interviews with medical directors, the question guide was further refined to better address the core objectives of the study.

Analysis
All transcripts were coded and analyzed for common themes and higher-order categories using the qualitative research software NVivo 7 to perform cross-case content analysis. We performed pattern and theme recognition based on inductive and deductive processes using grounded theory principles in an iterative process and performed interviews until data saturation was achieved. Coded data was reviewed by the coauthors, neither of whom is affiliated with CHCs. Focus group responses were analyzed in a similar manner.

Results
Participant Demographics
Of the 15 medical directors participating, 12 were active medical directors at the time of the interviews. The remaining medical directors were previous medical directors now involved in administrative roles outside of CHCs; however, all continued to work closely with CHC medical directors. Ten of the medical directors were men. Although a majority were Caucasian, the sample did include physicians of multiple racial and ethnic backgrounds, not specifically identified so that we could maintain confidentiality.

Medical directors interviewed had a range of experience in the position, ranging from 1 month to 35 years (median 3 years). Time since graduation from residency ranged from 5 to 35 years (median 14.5 years). All were primary care physicians: nine were family physicians, three were pediatricians, three were internists, and one was trained in both internal medicine and pediatrics.

Content Analysis
Three prominent themes emerged in relation to leadership training: (1) motivation for improvement as the path to leadership, (2) inexperience as a barrier to achieving change, and (3) training as a facilitator for success.

Theme 1: Path to Leadership: Motivation for Improvement
Our subjects typically followed a path to leadership driven by a desire for health care improvement. Although some physicians were recruited to the medical director position immediately upon completing postgraduate training, most were not. More often, directors were recruited to leadership positions after becoming established in an initial clinical role either in a CHC or elsewhere. Most directors accepted their first clinical position in a CHC or other underserved setting, citing motivators such as a desire to participate in social change or community health. Respondents express a desire to make system improvements in care and as a result evolved into leadership positions. Some felt recruited or pulled into a leadership position by other CHC administrators. One director said:

I started off just being a pediatrician, but because of my nature of being a busybody and wanting to improve things, I sort of got sucked into the administrative thing. (Director A)

Another stated that:

I always felt that I would pay back the community for its investment in me, and so I had always planned to be involved in community medicine...A position opened up as medical director, and I thought I would like to try that…I was looking for a way to kind of have some influence beyond individual treatment...so I thought, you know, I might be able to do that being a medical director. (Director G)
Theme 2: Inexperience: A Barrier to Achieving Change

Once established, medical directors almost universally describe feeling unprepared for a poorly defined role. Many report little prior knowledge of CHCs, and only a few report a clear understanding of the role of a medical director. Job descriptions are often absent or considered outdated or inadequate. Even highly experienced medical directors have difficulty providing a focused, concise summary of their role. They cite extremely broad areas of responsibility encompassing multiple areas of leadership, sometimes overlapping the supervisory duties of other CHC administrators. One director reported that:

I remember telling him, ‘Do I get a job description on this?’ I mean, I had a sense. He said, ‘Ah, we can—it won’t help.’ He probably would have been right, because I don’t think he had a great idea. (Director F)

Another said:

I don’t even know, I don’t know what my job is, if I tell you the truth. (Director J)

While some medical directors accepted their position without formal leadership training, others had participated in fellowships or earned additional graduate degrees prior to becoming medical directors. Regardless of prior experiences, almost all frequently felt unprepared in the early phases of their careers as medical directors. The combination of inexperience and lack of direction in this period often acted as a barrier to achieving improvements within their CHCs.

As desire for improvement is a primary motivator, the ability to effect successful change within a CHC appears to play a large role in the satisfaction of medical directors. Medical directors unable to achieve successful CHC improvements express considerable frustration, often including a desire to leave the position, potentially contributing to troubles with retention and turnover. As one director said:

I took over one of the sites as the local site director and burned out in about a year. Just totally flamed out. Cause I wasn’t really ready. My skills weren’t really at the level that they needed to be. I couldn’t do it. (Director C)

Another reported that:

This is a place I see right now, as we stand, if we don’t make changes, it’s a place that you go the last five years before you retire. When you don’t give a damn about anything. So that’s what’s bothering me right now. And that’s a big issue. At least for me. Because I need to move on. I need to move on. (Director J)

Theme 3: Training: a Facilitator for Success

To address the barrier of inexperience, we explored the role of subsequent administrative education. Training fell into four main categories: conferences, peer networking, mentorship, and formal degree programs. Most medical directors attended at least one management conference designed specifically for CHC medical directors. One of the focus group participants stated that:

I can’t do this without some training, or I’m just gonna fail right away.

Medical directors frequently referred to peer networking as a potential method for skill enhancement. It is not clear, however, if medical directors use this primarily to discuss mutual areas of inexperience or if they actively benefit from each others’ experiences as surrogate knowledge. Peer networking takes place primarily through conferences and electronic mail. A sample comment was that:

So we can sit and just sort of talk about things in general, and get a sense of where each other are, call each other and ask for help or advice, or to discuss a topic. We have a listserv...where people put out questions to the whole medical director group, and people are very good about responding. To me, that's been very powerful... (Director H)

The guidance of a mentor is often mentioned as a highly effective training method. Those with mentors often praise the relationship. Some participants describe trying to provide mentoring for others, even when they lack such assistance themselves. When available, mentoring appears to be one of the most effective methods for achieving success and satisfaction in the position. Director A stated that:

Mentors are the only way I have survived.

Director C said that:

He was just a senior person, and...he was very helpful in terms of commenting on how the world works...I would say, ‘This thing just seems funny’ and he would say, ‘Well, this is why it’s not funny. This is why it really is how it is...’ And it was really useful to get reality checks from people like him.

Several of the medical directors interviewed pursued graduate degrees. In general, these are felt to be very helpful, particularly those focusing upon business or health care administration. A formal degree seems most helpful when obtained after acquiring some experience as a physician administrator, rather than prior to any such work experience.
I started working as the site director again a little while after I started business school. And I was much better able to do it after a while...the job just came at me slower. And so that was a much more enjoyable year. (Director C)

When asked about the types of training they would desire most, subjects preferred programs with a practical approach. Medical directors feel programs should allow them to directly apply training to problems in their own health centers. They also seek flexibility in adapting such training to fit their personal needs and commitments. Sample comments included:

It’d be nice to be able to take that [conference] stuff home, work on it, and get more feedback...later on. (Director D)

It could be, spend three hours on a Saturday morning...do that once a month, and then have time between courses where you live your life...Folks’l learn this interesting concept, and then carry it back to where they work, and then have enough time to noodle around with it while they’re doing their life. (Director C)

In the focus group, core themes from the individual interviews were confirmed. There was a particular focus on preferred training approaches.

In summary, medical directors entered leadership roles motivated by a desire to make improvements in CHC care. Many quickly found themselves unprepared and unable to achieve improvements they desired. Many sought training through conferences, peer networking, mentoring, and formal degree programs. In general, medical directors believe that additional training programs would be useful, especially if programs included longitudinal project work with direct application, components of peer networking and mentorship, and flexibility in interacting with the curriculum.

Discussion

In recent years, the medical community has focused attention on health care quality, patient safety, chronic disease management, operational improvement, and information management. The complexity of these tasks demands a higher level of leadership skill than ever before, yet many new physician leaders of CHCs feel unprepared. Our results show this to be compounded by poorly defined roles, lack of mentorship or peer networking opportunities, and medical directors’ own inexperience.

A resulting lack of success by medical directors in achieving CHC improvement may contribute to human resource issues of retention and turnover. To be successful, medical directors must provide transformative leadership to their institutions: training can assist in achieving this goal.13

Our findings suggest training methods that may be most useful. Longitudinal programs that provide mentoring and project work are preferred by our participants. A number of conference training opportunities are available, but these 1-day to 1-week courses do not suffice. The Health Disparities Collaboratives developed by HRSA and the Institute for Healthcare Improvement is one model that includes longitudinal project work and provides a number of helpful resources.19 It has the broad mission of health care system improvement focused on health disparities but does not focus specifically on the needs of CHC medical directors. We believe our findings demonstrate that additional accessible and comprehensive leadership training opportunities are needed specifically for the clinical leaders of these institutions.20

Although our data are limited by the urban nature of our sample, we expect these themes remain similar in other settings. While it is possible that physician leaders in rural CHCs have a different set of experiences and preferences, given inherent challenges in rural areas of accessing educational resources, it seems likely that rural medical directors would share many of the same frustrations regarding training and overall leadership preparedness. It also is important to note that our sample is recruited almost entirely from Massachusetts, an area with a high number of tertiary care medical centers and robust funding mechanisms of health care for the uninsured relative to many other areas of the country. These differences would seem to make it more likely, however, that our participating medical directors would have good access to postgraduate leadership training opportunities and fewer financial, recruitment, and other challenges relative to counterparts in other areas of the nation.

This research has important implications for medical education as well as public policy. At a time when comprehensive health care reform is being discussed, the fate of the medically underserved becomes inextricably entwined with the health of the entire nation, and CHC medical directors are a key group of primary care physician leaders necessary for providing high-quality health care to underserved populations. The struggles of these physician leaders may signal a more significant deficit in medical education regarding issues of physician leadership, particularly in primary care. Our results suggest further training is needed both to prepare new medical directors and successfully retain those currently serving in this role. Government, health centers, and academic and postgraduate training institutions will need to work together to generate adequate funding and develop and coordinate this important leadership training to provide the highest quality health care to all.

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