Presented by the Office of Academic Affairs and the Provost's Office

RUSH UNIVERSITY

2015-16 Teaching Academy

All Rush University Faculty Members

are invited to the 2015-16 Teaching Academy for skill and knowledge enhancement!
Presentations will be held every third Tuesday of the month from
12 – 1 p.m. in Room 994, Armour Academic Center.
Lunch will be provided.

Teaching Academy Workshops/Seminar Series

(Tentative Schedule and Topics)

July 21, 2015	**Faculty Vitality: Ways to Achieve and Build Resilience**
August 18, 2015	**Collaboration Contracts**
September 15, 2015	**Scholarly Publishing: Economics, Open Access and Academic Culture**
October 20, 2015	**Team Facilitation**
November 17, 2015	**Difficult Learning Situations**
December 15, 2015	**Teaching Patient-Centeredness**
January 19, 2016	**Teaching Health Literacy**
February 16, 2016	**Managing Emotions in Clinical Teaching**
March 15, 2016	**Professionalism in Academia**
April 19, 2016	**Research Matters! Transforming the Environment for Research Excellence**
May 17, 2016	**Building a Scholarly Community**
June 21, 2016	**Education and Technology**

Please send your RSVP and/or questions to Stephanie Sacriste,
Department Manager, Office of Academic Affairs at
Academic_Affairs@rush.edu or (312) 563-6395.

Faculty Vitality: Ways to Achieve

Patrick O. Smith, PhD, ABPP
Chief Faculty Affairs Officer (University of Mississippi Medical Center)
Associate Dean for Faculty Affairs (School of Medicine) &
Professor (Family Medicine)

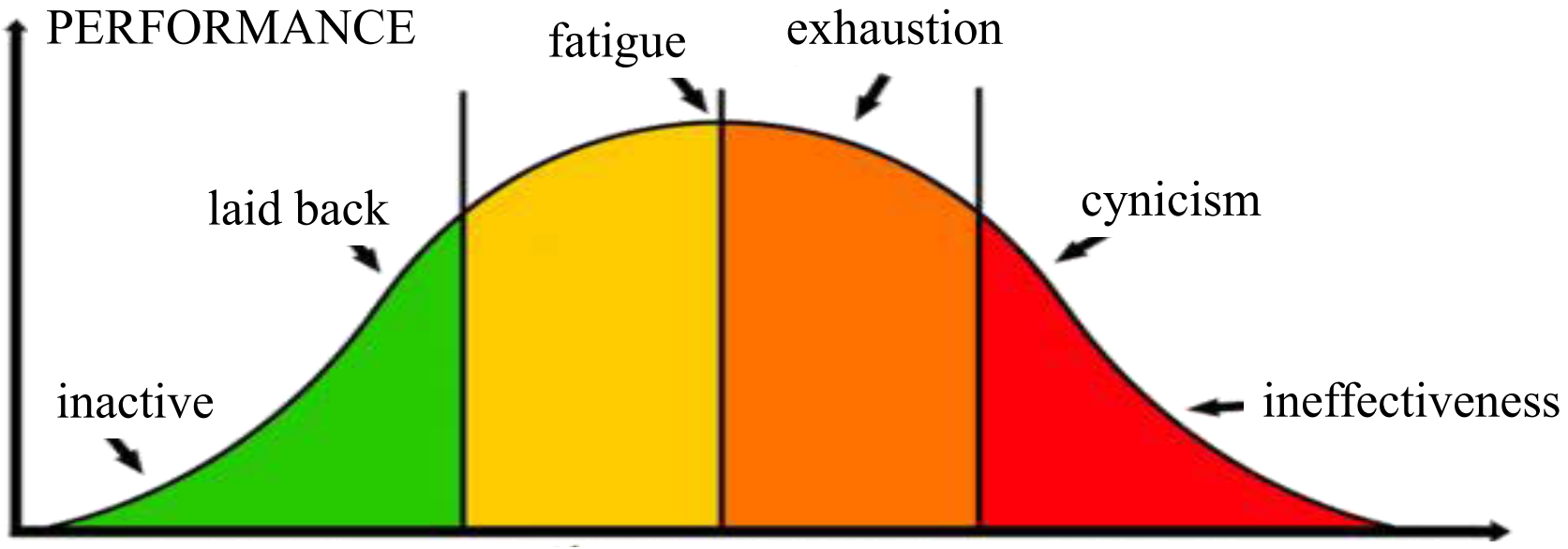
University of Mississippi Health Care

THOMSON TOP HOSPITALS

Topics

- Stress
- Faculty Stressors
- Locus of Control
- Cognitive Restructuring
- Goal Setting

STRESS CURVE



Yerkes & Dodson, J. D. 1908

University of Mississippi Health Care

THOMSON TOP HOSPITALS

Ted Talk: “How to make stress your friend” -Kelly McGonigal

Faculty Stressors

- Workload
- Knowledge
- Legislative
- Insurance
- Information mastery
- Accreditation
- JAHCO
- Risk Management
- IACUC & IRB
- Compliance
- Technology

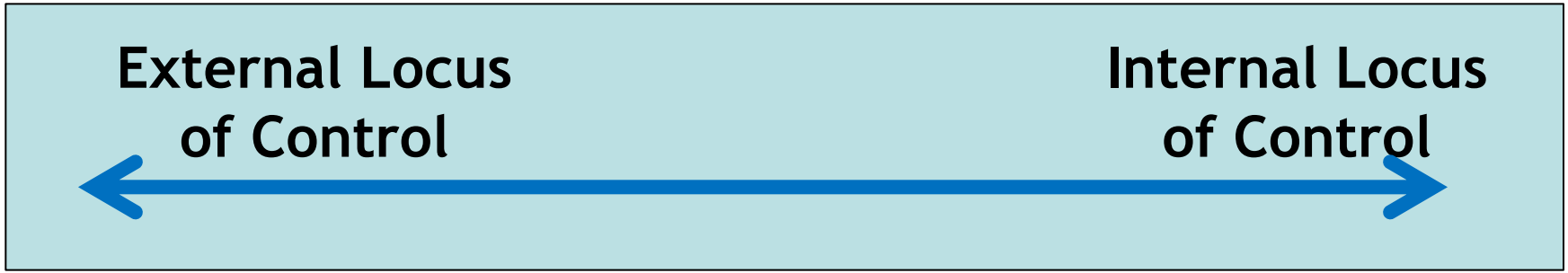
- Hidden Costs

- Fee for Service
- NIH Funding

University of Mississippi Health Care

THOMSON TOP HOSPITALS

Locus of Control



Person believes their life is controlled by factors they cannnot influence.

Person believes they can control their life.

Rotter, 1954

University of Mississippi Health Care

THOMSON TOP HOSPITALS

Locus of Control

- Writing a grant proposal or completing chart notes/reports

1. Internal locus of control
2. External locus of control

Locus of Control

- Using Microsoft Outlook as a time management tool

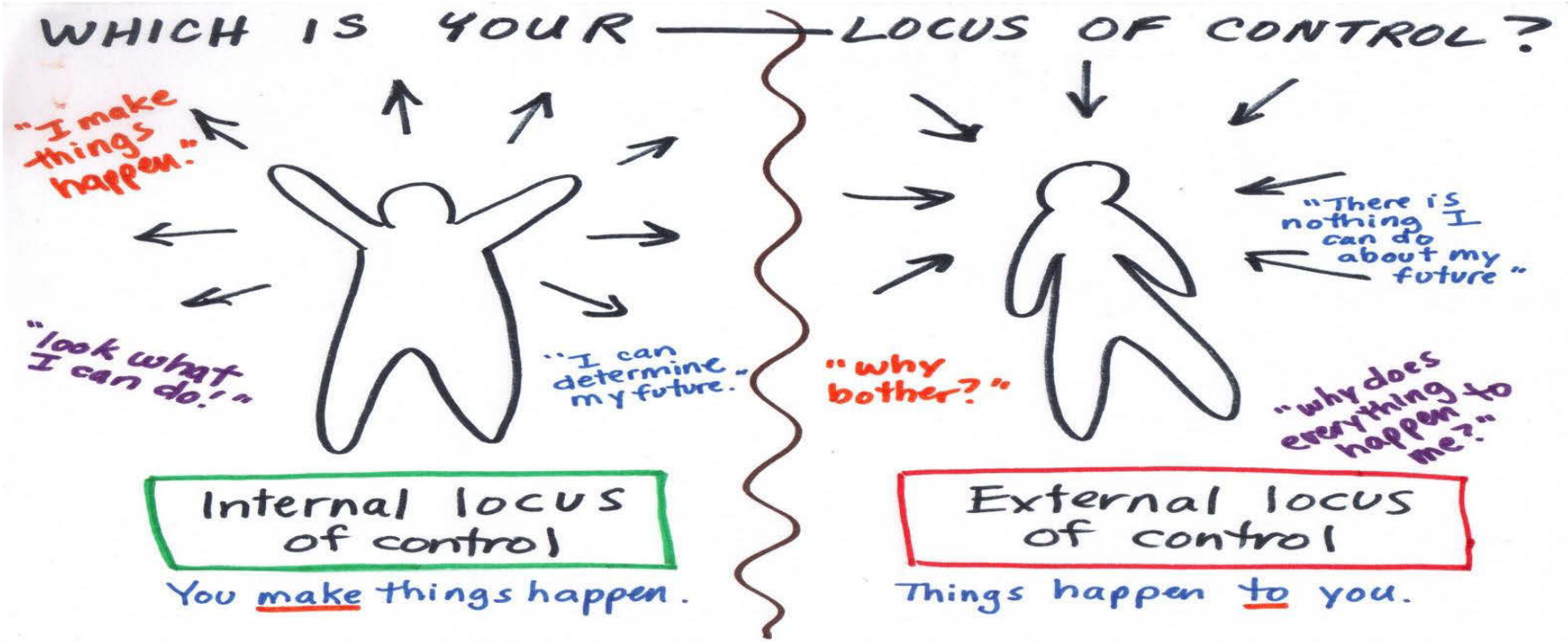
1. Internal locus of control
2. External locus of control

Locus of Control

Which is your Locus of Control?

1. Internal locus of control
2. External locus of control

Locus of Control



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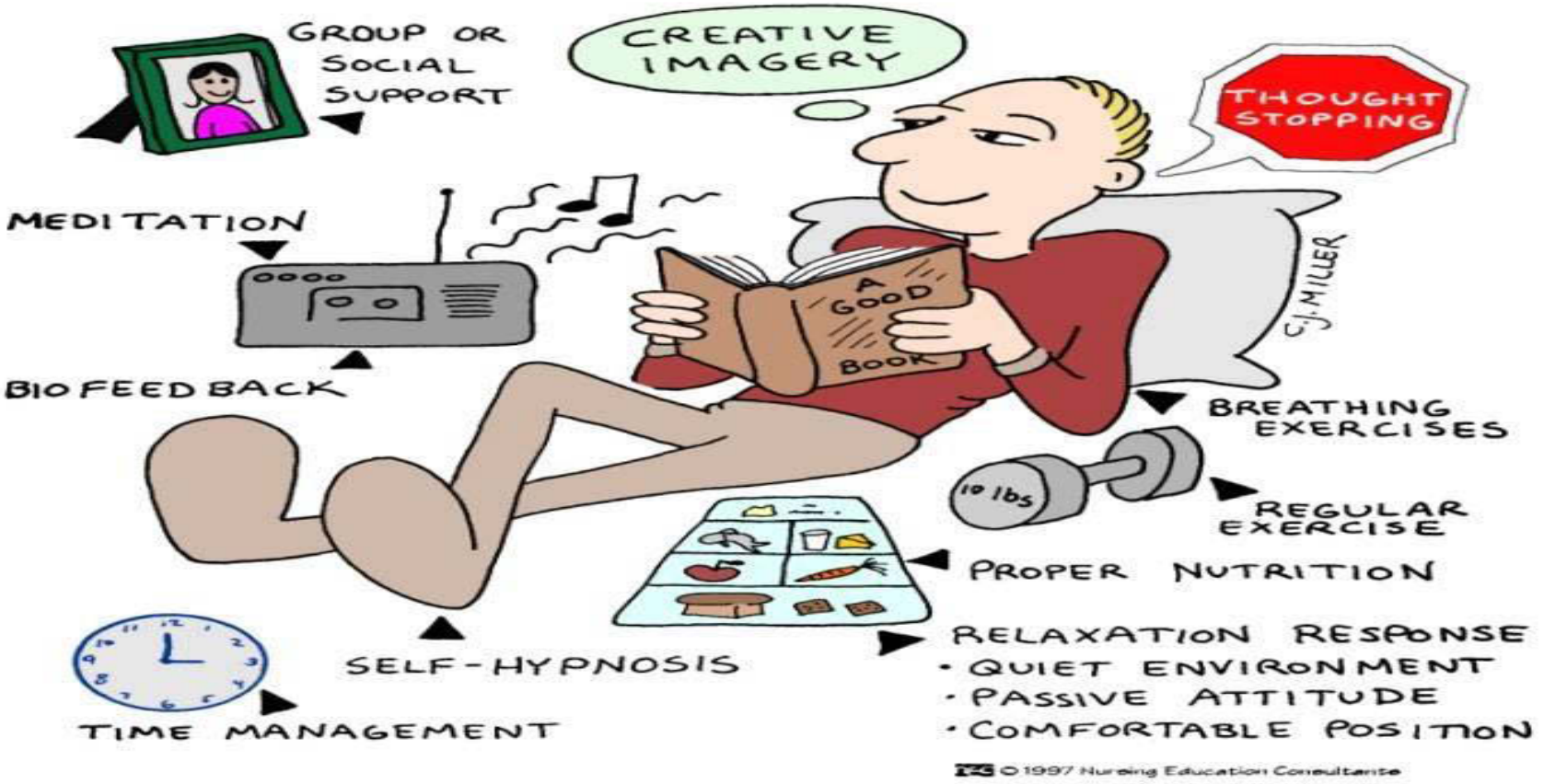
THOMSON TOP HOSPITALS

STRESS REDUCTION METHODS



SMART Goal Setting

S
M
A
R
T

- Specific
- Measurable
- Action-Oriented
- Realistic
- Time-Oriented

Thoughts

Words

Habit

Character

Destiny

University of Mississippi Health Care

THOMSON TOP HOSPITALS

Discussion?

References

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University of Mississippi Health Care

THOMSON TOP HOSPITALS

SMART GOALS – TEMPLATE

SMART goals help improve achievement and success. A SMART goal clarifies exactly what is expected and the measures used to determine if the goal is achieved and successfully completed.

A SMART goal is:

Specific (and strategic): Linked to position summary, departmental goals/mission, and/or overall School of Medicine goals and strategic plans. Answers the question—Who? and What?

Measurable: The success toward meeting the goal can be measured. Answers the question—How?

Attainable: Goals are realistic and can be achieved in a specific amount of time and are reasonable.

Realistic (results oriented): The goals are aligned with current tasks and projects and focus in one defined area; include the expected result.

Time framed: Goals have a clearly defined time-frame including a target or deadline date.

Examples:

Not a SMART goal:

- Dr. Smith will improve his writing skills.

Does not identify a measurement or time frame, nor identify why the improvement is needed or how it will be used.

SMART goal:

- The Department has identified a goal to improve communications with administrative staff by implementing an internal departmental newsletter. Dr. Smith will complete a business writing course by May 2015 and will publish the first monthly newsletter by July 2015. Dr. Smith will gather input and/or articles from others in the department and draft the newsletter for the Chair's review, and when approved by Chair, distribute the newsletter to all Department members by the 15th of each month.

SMART Goal Planning Form

1. Here's what I want to achieve **Specifically**: (eg. I want to create a departmental newsletter; who, how, what, where)

2. Here is my main **Measure** or measures for this achievement: (i.e., what I will see, hear, learn, or feel when I have achieved the above)

3. Is what I have chosen to do **Attainable/Achievable**? (i.e., Is it within my control to achieve it?)

4. Is my goal **Realistic** and if so, describe?

By

5. In what **Time** will my goal be completed? Timed – WHEN?

RUSH UNIVERSITY MEDICAL CENTER

www.rush.edu

NEW FACULTY ORIENTATION

2015

Katie Struck, Senior Associate General Counsel

Heather Kartsounes, Associate General Counsel

Alissa Bugh, Assistant General Counsel

IT'S HOW MEDICINE SHOULD BE®

CONTACT INFORMATION

- Office of Legal Affairs
  - 1700 W. Van Buren Suite 301
  - 942-6886

- Office of Risk Management
  - Kidston 3rd Floor
  - 942-7828
  - On-Call at 85-7101

WHY CONTACT?

- Contract Review (OPP 346)
  - All contracts/arrangements require legal review
  - If unrelated to research, the lead responsible person should send the arrangement to contractreview@rush.edu with the pertinent information (timing, special terms, business priorities/concerns).
  - With limited exceptions, the attorney reviewer must sign a Contract Approval Form before the agreement is executed
  - Once signatures are obtained, the lead responsible person must send an executed copy to attorney review or contractreview@rush.edu.

Common Contracts

- Consulting (must comply with Rush's Conflict of Interest Policy OP-0359)
- Clinical Affiliation Agreements
  - Questions regarding distance learning compliance should be directed to the Rush University Regulatory Coordinator, LaTonya Gunter LaTonya_Gunter@rush.edu.
- Research (see next slide)

- Research Agreements
  - Clinical Trial Agreements
  - Confidentiality Agreements
  - Material Transfer Agreements
  - Data Use Agreements
  - Novel Research Agreements
- Research Contract Process
  - All research contracts submitted to Office of Research Affairs for review and processing.
  - Research Affairs will collaborate with OLA and seek assistance when necessary.

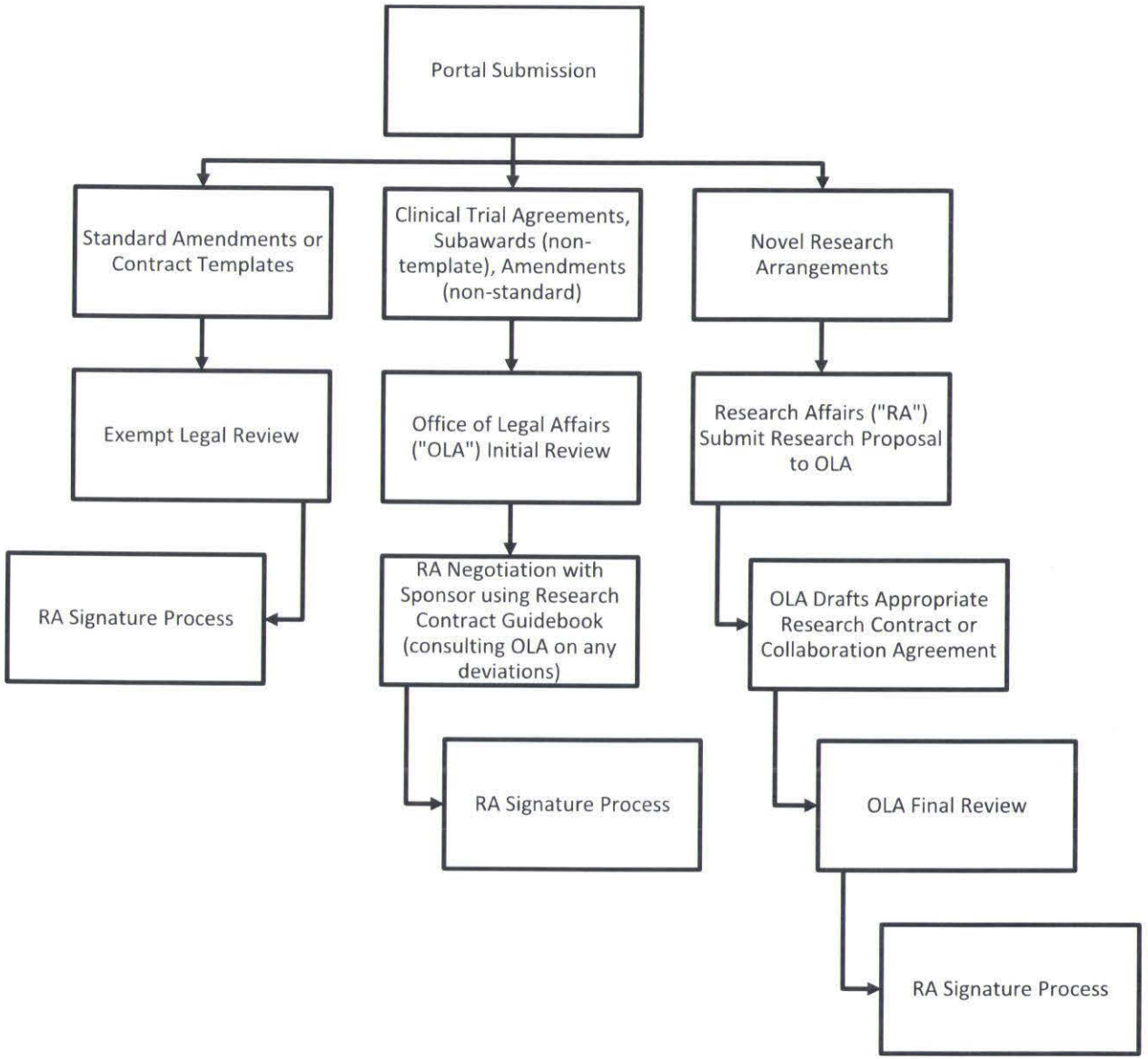
Intellectual Property

- All intellectual property disclosures must be made to Jay Vijayan (Shrijay_Vijayan@rush.edu) in the Technology Transfer Office.
- The Technology Transfer Office reviews all disclosures and makes recommendations for filing of intellectual property.
- Questions regarding intellectual property can be directed to Heather Kartsounes (Heather_A_Kartsounes@rush.edu) or Jay Vijayan.

OTHER REASONS TO CONTACT

- Patient Care Questions
- Patient Outcome Questions
- Patient Consent Questions
- Subpoenas
- Summons & Complaints
- Insurance Questions
- Claims Verifications

RUSH UNIVERSITY MEDICAL CENTER
RESEARCH CONTRACT REVIEW FLOW CHART



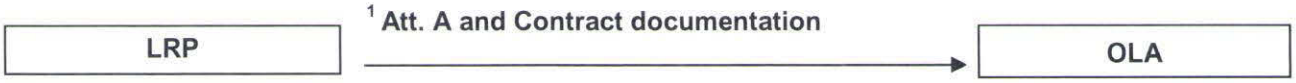
CONTRACT REVIEW AND APPROVAL POLICY

EXECUTIVE SUMMARY

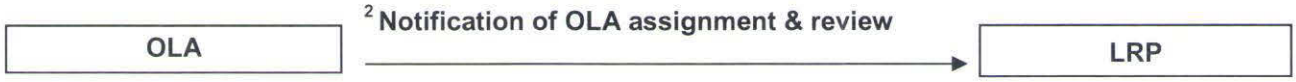
Lead Responsible Person = "LRP" **Office of Legal Affairs = "OLA"**

Attachment A – Contract / Arrangements Approval Form = "Att. A"

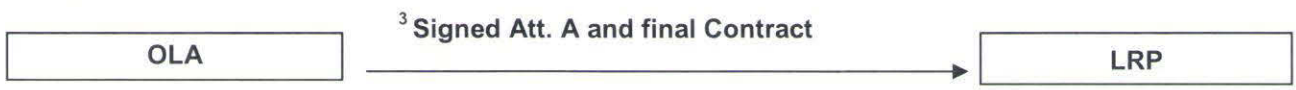
Contract / Agreement / Arrangement = "Contract"



1. LRP to OLA at Contract_Review@rush.edu – LRP completes Att. A and sends it to OLA with all relevant supporting Contract documentation, for review and approval.



2. OLA to LRP – OLA assigns an attorney or paralegal to review and approve the Contract and assigned OLA reviewer contacts LRP to notify LRP of assignment and with results of review (notification of assignment and results of review may be more than one contact).



3. OLA to LRP – Assigned OLA reviewer indicates approval of Contract by signing the properly completed Att. A and sends the signed Att. A and the final approved Contract to LRP (LRP then obtains signatures on the Contract and obtains vendor certificate of insurance if required in the contract).

4. LRP to OLA at Contract_Review@rush.edu – LRP has thirty (30) business days from receipt of the signed Att. A and final approved Contract to return a copy of the fully executed (signed by both parties) Contract to OLA, vendor certificate of insurance if required in the contract.

DEFINITIONS

1. **Arrangement**: Any transaction in which Rush University Medical Center (RUMC) assumes obligations or incurs liability.

2. **Contract**: Any written agreement, including, without limitation, a memorandum of understanding, a letter of intent, or any form of writing that documents an Arrangement. "Contract" also means any amendment to a previously executed Contract, as well any Template (defined below) that has been modified or includes attachments that modify the terms of the Template.

3. **OLA**: The RUMC Office of Legal Affairs.

4. **Attachment A**: The Contract Arrangement Approval Form that is to be completed by the Lead Responsible Person and submitted to OLA for review and approval of a Contract.

5. **Attachment B**: The list of those individuals that are authorized to sign a Contract on behalf of RUMC based on the particular details of the Arrangement.

6. **Immediate Family Member**: An immediate family member of a physician, including a husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

7. **Lead Responsible Person**: The individual responsible for negotiation of a Contract who will be the principal contact with OLA during the review and approval process of the Contract.

8. **Template Purchase Order**: RUMC's approved form of purchase order.

9. **Template**: A form Contract that has been approved by the Office of Legal Affairs for use in a particular Arrangement.

10. **Unmodified Template**: An approved RUMC Template that has not been modified and does not include any attachments that modify the terms.

POLICY

Rush policy mandates that all Arrangements must be memorialized in a written Contract. OLA review and approval of Contracts, as detailed in this Contract Review and Approval Policy (the "Policy"), is an important step in ensuring compliance with RUMC policies and procedures and RUMC legal requirements. Communication with OLA early in the planning process of an Arrangement is crucial to facilitating the effective and efficient review and approval of Contracts.

GUIDELINES

A. OLA will determine what type of Contract is appropriate given the specific circumstances of the Arrangement and will provide the Lead Responsible Person with an appropriate Template, if one exists. The Lead Responsible Person should contact OLA prior to using a previously provided Template to ensure that the Template has not been modified.

B. Except in certain circumstances as provided in this Policy, Contracts may not be signed without the approval of OLA. The Lead Responsible Person will initiate OLA review of a Contract by submitting a request to Contract_Review@rush.edu, along with a completed Attachment A and all supporting documentation that will assist OLA in performing the review. Upon receipt of a Contract review request, the Contract will be assigned to an OLA attorney or paralegal for review and approval.

C. The assigned OLA attorney or paralegal will contact the Lead Responsible Person to provide notification of the assignment, and to request additional information or supporting information, if necessary.

D. OLA will coordinate with the RUMC Corporate Compliance Department to identify any legal or compliance issues in the Contract and will notify the Lead Responsible Person of such issues. All legal and compliance issues must be resolved before any Contract can be approved.

E. Once any legal and compliance issues have been resolved and the terms of the Contract have been finalized, the assigned OLA attorney or paralegal will sign the Attachment A and return the signed Attachment A and the final approved Contract to the Lead Responsible Person.

F. Certain Contracts do not require review under this Policy. For (1) an Unmodified Template which has been provided by OLA for a particular Arrangement; or (2) a Template Purchase Order, that has not been modified, (where the Template Purchase Order serves as the Contract) and the purchase is for $20,000 or less, the Lead Responsible Person will complete the Attachment A and the Contract may be executed without OLA approval.

G. Once the signed Attachment A is provided, or it is determined that no Attachment A is required under the circumstances, the Lead Responsible Person will obtain signatures from both parties to the Contract.

H. Only individuals listed on Attachment B as having authorization to sign a given Contract may validly sign the Contract on behalf of RUMC. Within ten (10) business days following execution of the Contract, the Lead Responsible Person must return the fully-executed Contract (signed by both parties to the Contract), along with the vendor certificate of insurance if required in the contract, and with appropriate supporting documentation (as outlined in the Responsibility and Procedure section below) and the applicable Attachment A to OLA at Contract_Review@rush.edu for inclusion in the RUMC Contracts Database.

RESPONSIBILITY AND PROCEDURE

1. This Policy requires all Contracts to be reviewed by OLA.

2. The Lead Responsible Person for the Contract must forward the following to OLA at Contract_Review@rush.edu:

    a) A completed Attachment A, providing summary of the key terms of the Contract;
    b) Completed Exhibit 1 and/or Exhibit 2 to Attachment A, as applicable;
    c) A draft of the Contract (if one exists);
    d) Confirmation of the fair market value (if required by the Fair Market Value: Policy Number CC-R04) of any financial terms; and
    e) Any other pertinent written documentation or information.

    In the event of the use of an Unmodified Template (see Policy Statement F above) the Lead Responsible Person must still submit a completed Attachment A with the final Contract to OLA at Contract_Review@rush.edu (see Policy Statement F & G above).

    In the event of the issuance of a Template Purchase Order where the Template Purchase Order serves as the Contract and the purchase is for $20,000 or less (see Policy Statement F above) the Lead Responsible Person must still submit a completed Attachment A with the final Purchase Order to OLA at Contract_Review@rush.edu (see Policy Statement G above).

3. The assigned OLA attorney or paralegal will review the documents from a legal perspective and from a regulatory compliance perspective, including coordination with the RUMC Corporate Compliance Department. The Lead Responsible Person will be advised of any legal or compliance issues. Communication by the Lead Responsible Person with OLA beginning early in the Contract process, as well as providing key updates to OLA, is necessary to avoid potential last minute obstacles to execution of the Contract.

4. The Lead Responsible Person will assist as required to resolve any legal or compliance issues identified by OLA during the review process. The assigned OLA attorney or paralegal will be available to discuss possible solutions to any legal or compliance issues raised. The Lead Responsible Person must provide OLA with updated written documentation indicating resolution of identified issues before the Contract can be approved and executed.

5. Upon approval of the Contract, the OLA attorney or paralegal will sign the completed Attachment A to approve the Contract for execution. The Contract may not be executed if it has not been approved by OLA (except for as specifically detailed herein - see Policy Statement F above).

6. In the event of a conflict between this Policy and any existing policy, this Policy will control and represent the policy of RUMC.

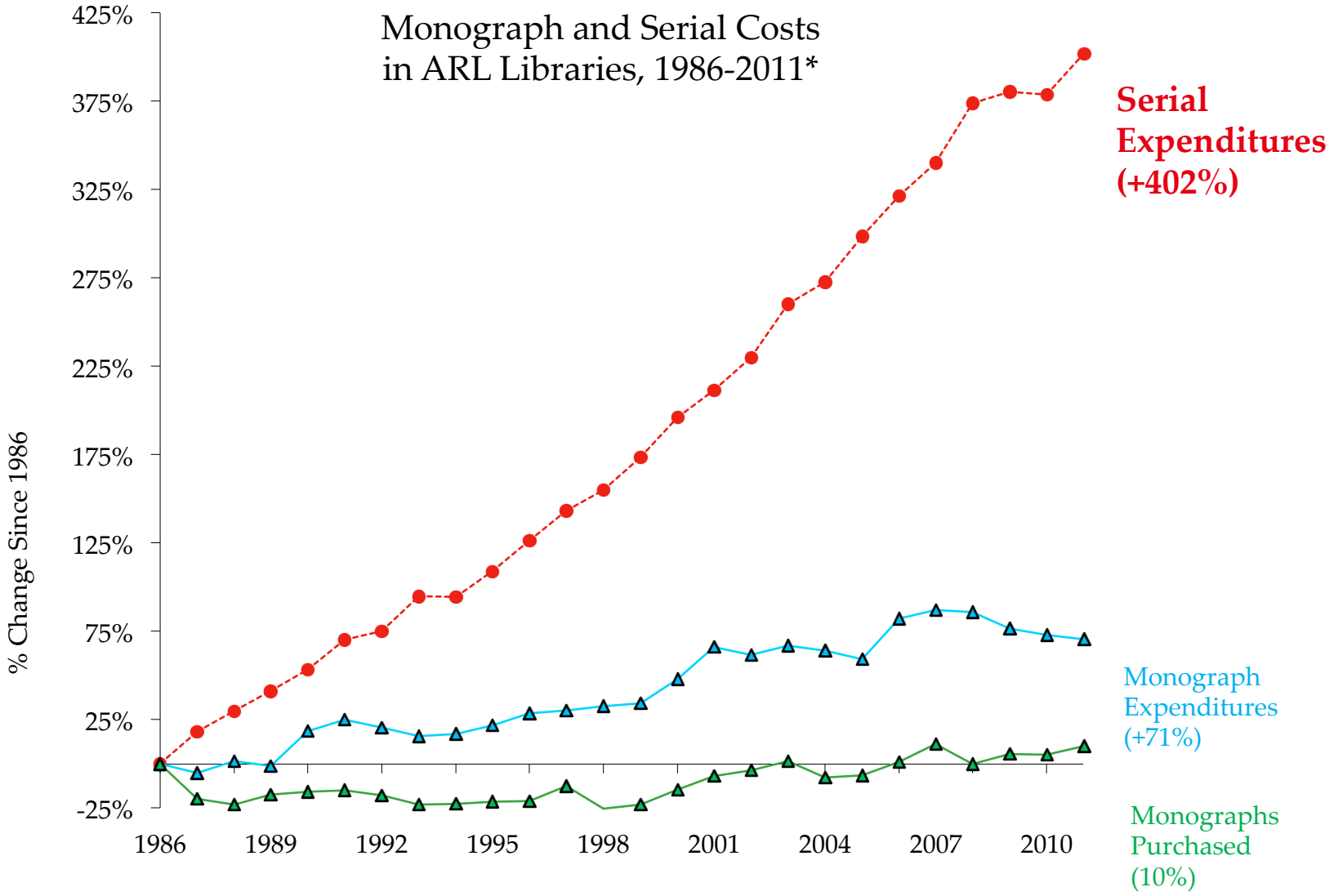
RELATED POLICIES

Fair Market Value: Policy Number CC-R04
Billing for Items/Services: Policy Number CC-B28
Conflicts of Interest: Policy Number OP-0359
Physician Practice Acquisition: Policy Number CC-G11
Prohibition Kickbacks: Policy Number CC-G09
Waiver of Co-Payments: Policy Number CC-B20
Professional Courtesy: Policy Number CC-B13
Information Technology: Policy Number OP-0335
Business Gifts: Policy Number CC-G12
Tenant Rental: Policy Number CC-G10
Prohibition on Engaging in Transactions or Arrangements that Violate Self-Referral Law: Policy Number CC-G14

Scholarly Publishing:

Economics, Open Access and Academic Culture

A Presentation for Rush University
Lee C. Van Orsdel, Dean of University Libraries, Grand Valley State University



Source: *ARL Statistics 2010-11* **Association of Research Libraries, Washington, D.C.**
***Includes electronic resources from 1999-2000 onward.**

SPARC

Rowland B. Wilson, *The Whites of Their Eyes*. New York: E.P. Dutton, 1962

Budapest Open Access Initiative (2002)

scholars = free online available

"Spanish" Flu Pandemic of 1918

Infected 500 Million

Killed 50-100 Milliion (3-5% of world's population)

Davidson Institute
for Talent Development

Davidson Fellow

Meredith Lehmann

$25,000 Scholarship Recipient

Personal Info

Age: 14
La Jolla, California

School, College and Career Plans

Meredith is a junior at The Bishops School and also takes classes at UCSD. For college, she hopes to find a good match for her combination of interests: science, mathematics, music and Classics, continuing to develop these and other yet undiscovered passions.

Davidson Fellows Submission (Science)

In her project, "*Transportation Networks and the Propagation of Novel H1N1 Swine Flu-Like Epidemics*," Meredith researched the spread of epidemics. Using trip data from all 3076 counties in the continental United States, she found long distance auto travel, which accounts for five times as many passenger-miles as air travel, governs simulated epidemic evolution. Large hub airports near population centers are not disproportionately more important in

Current Healthcare Shortcomings

- Number of drugs is too small and time to market too long
- Rare diseases are ignored
- Clinical trials are too limited in the number of patients and too expensive
- Education & training do not match well to current market needs
- Research is not cost effective
  - Not easily replicated
  - Too slow to disseminate

Philip Bourne, OpenCon 2014, Importance of Open Science to Human Health

How does the current system work?

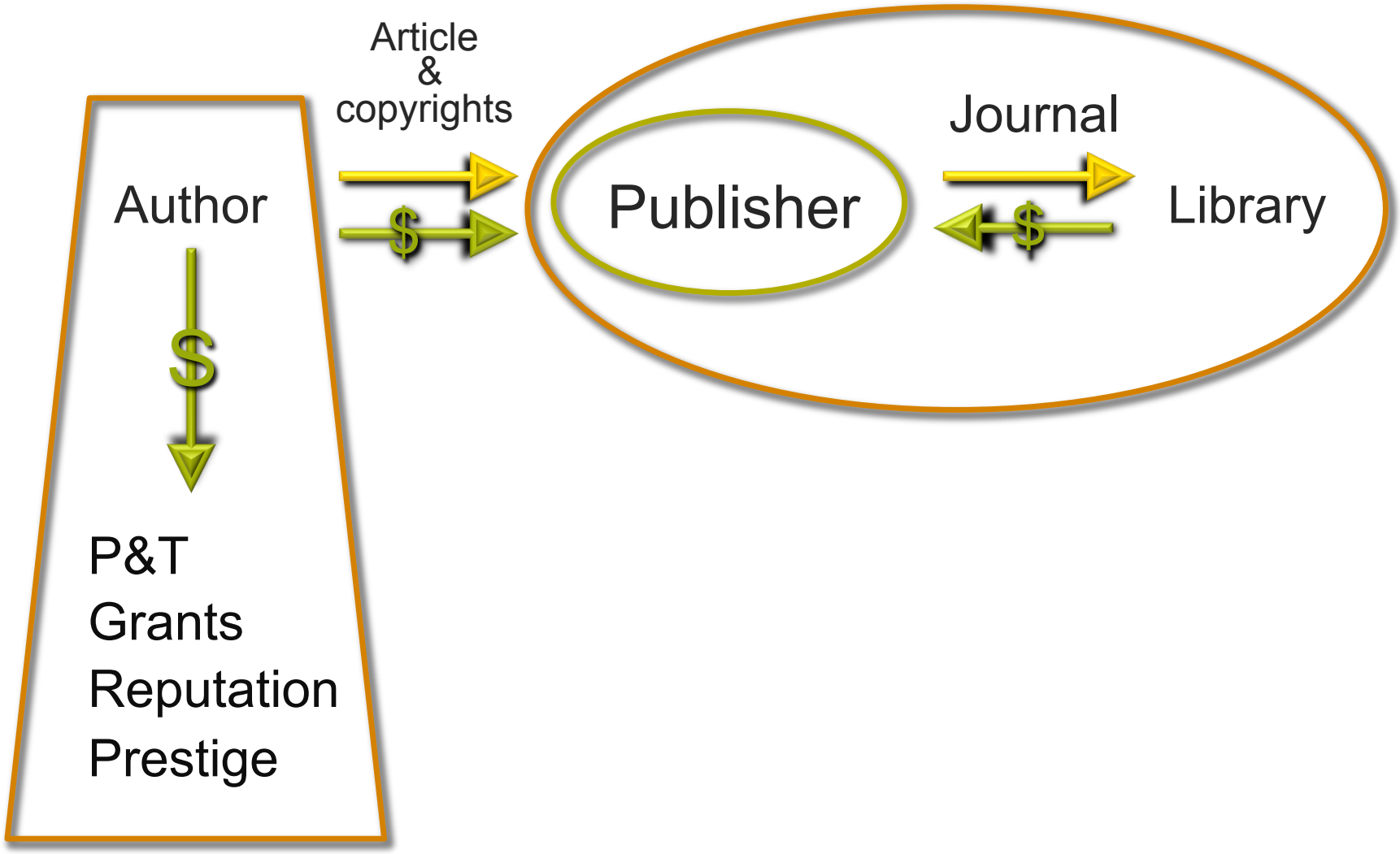
Scientific, technical, medical, legal and business journal publishing is a US $10 Billion per year revenue producing market

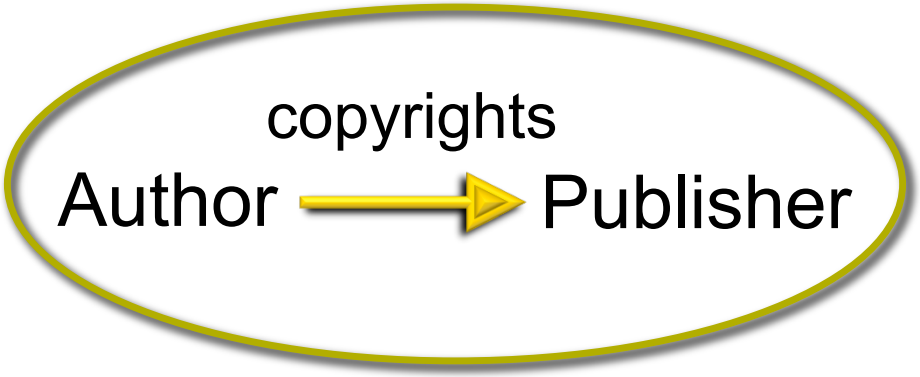
Heather Joseph at OpenCon 2014, November 15.2014.
http://www.slideshare.net/RightToResearch/state-of-oa-us

SPARC

normal economy

prestige economy



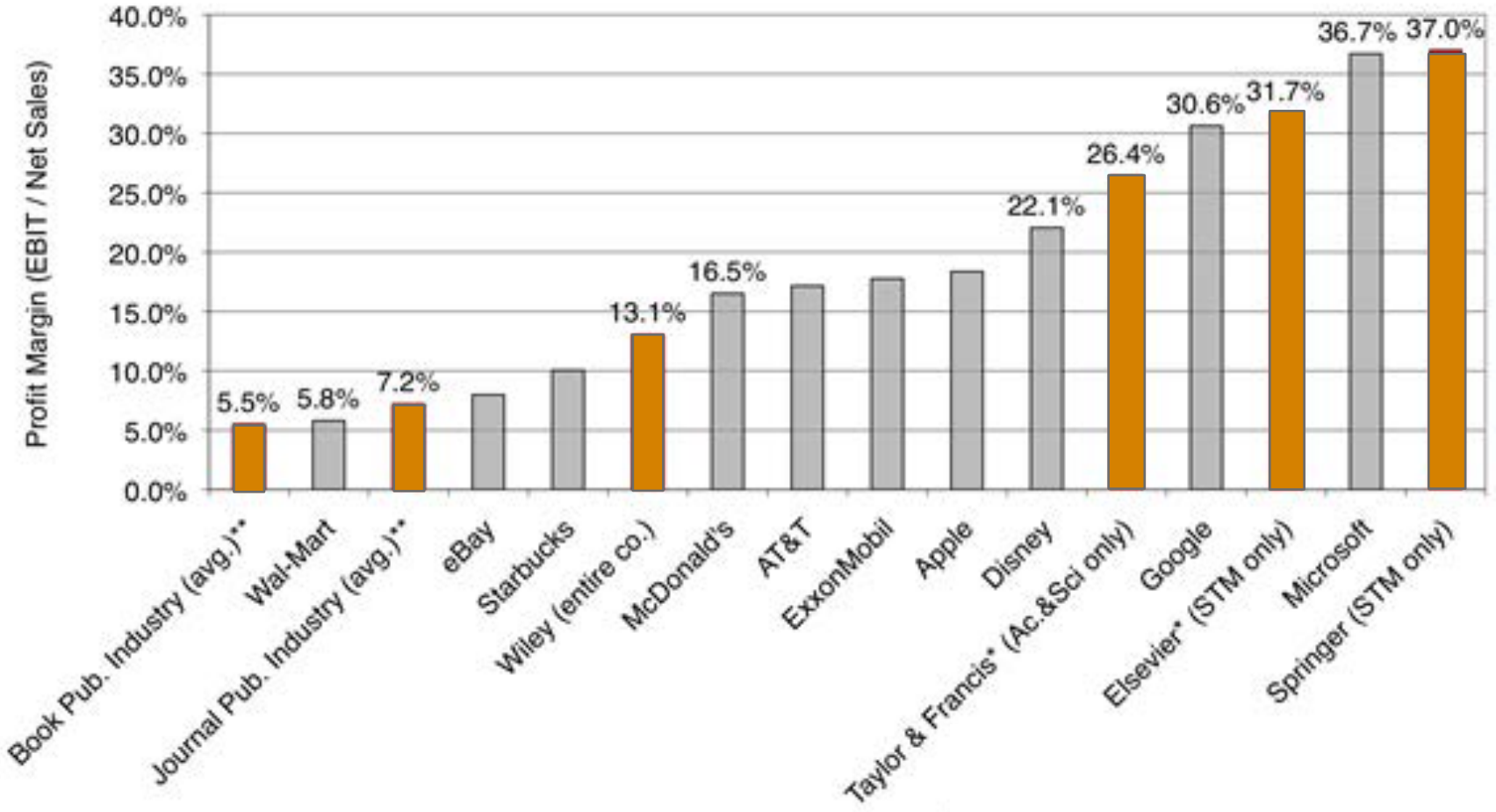


wholesale transfer of rights
creates scarcity
which drives prices up

high prices limit access

Faculty rewards system ties researchers to exploitative publishers & offers little incentive to explore new models for peer review and for dissemination

Profits: Journal Publishers vs. Other Companies



*Adjusted Operating Margin. **RMA Annual Statement Studies, 2007
Data from 2007 or 2008. Data source: MIT Libraries

The Economist

"Publishing obscure academic journals is that rare thing in the media industry:
a license to print money"

The Economist, Open sesame 403.8780 (Apr 14, 2012): 17

Basics of Open Access

OPEN *science*
access
data

textbooks
courseware

open and free to read

open to use with few or no restrictions

open to indexing and machine readable

More citations

Total number of studies so far	70
Studies that found a citation advantage	46
Studies that found no citation advantage	17
Studies that were inconclusive, found non-significant data or measured other things than citation advantage for articles	7

The CERN Workshop on Innovations in Scholarly Communication (OAI9) - 17-19 June 2015 (all day)

Studies that found no citation advantage	17
Studies that were inconclusive, found non-significant data or measured other things than citation advantage for articles	7

List of studies to date

Summary of results of studies

Retweeted by SPARC Europe

Expand

SPARC Europe 12 Jan @SPARC_EU

The SPARC EUROPE Weekly is out! paper.li/SPARC_EU/13338.. Stories via @wellcometrust @SHERPAServices

Better mining (text and data)

Allows for better discovery within and between disciplines

Especially promising in pharmaceutical, biomedical, and chemical research

OA & Evidence-Based Medicine

"evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients"

Sackett DL and Rosenberg WM. Cited in Maggio, M et al. Access of primary and secondary literature by health personnel in an academic health center: implications for open access. J Med Lib Assoc. 2013 July;101(3) 205-212

OA & Evidence-based Medicine

Only 20% of all journal articles are freely accessible within one year of publication

Maggio L, et al. Access of primary and secondary literature by health personnel in an academic health center: implications ofr open access. J Med Lib Assoc. 2013 July;101(3) 205-212

Unexpected audiences

interdisciplinary readers

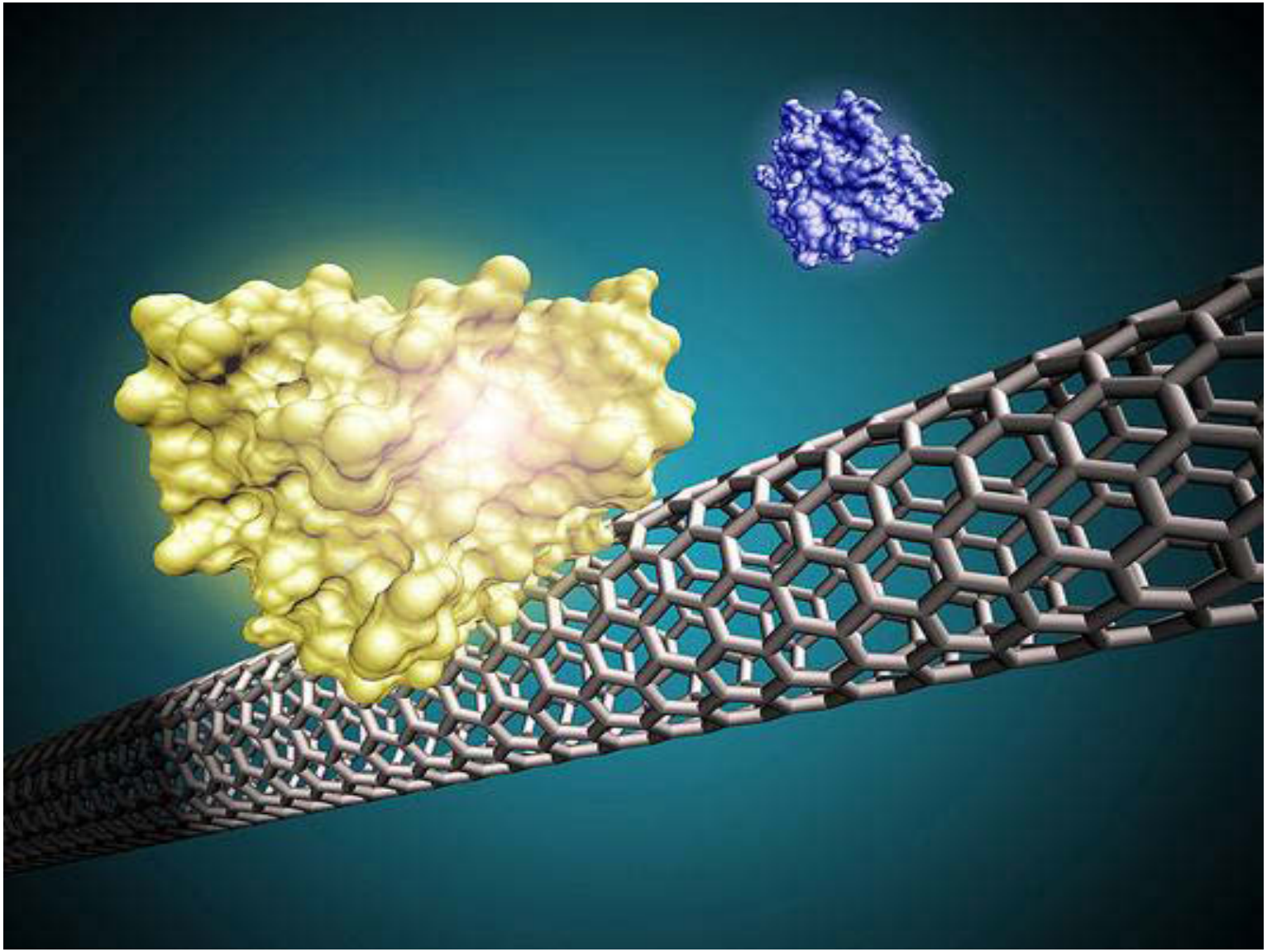
underfunded readers

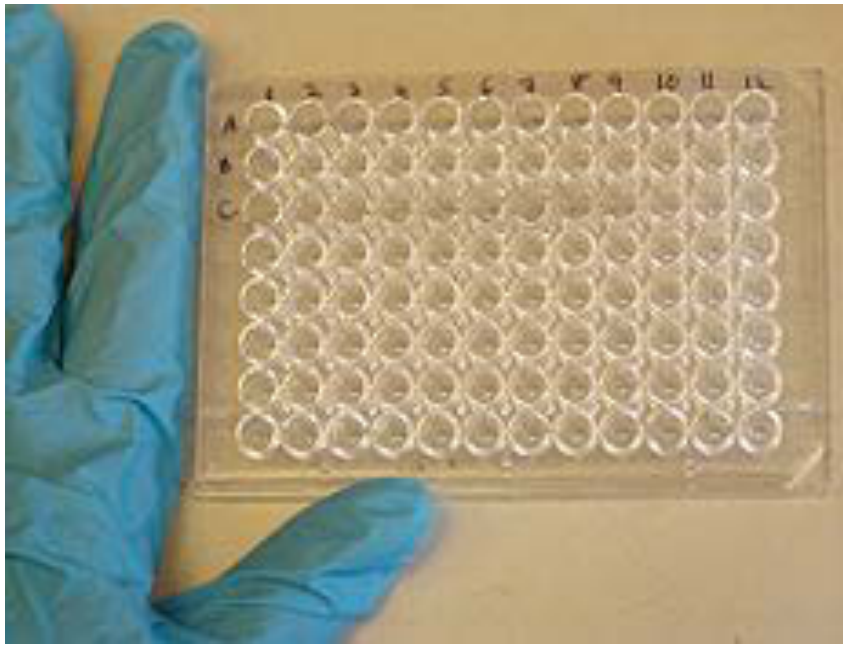
international readers

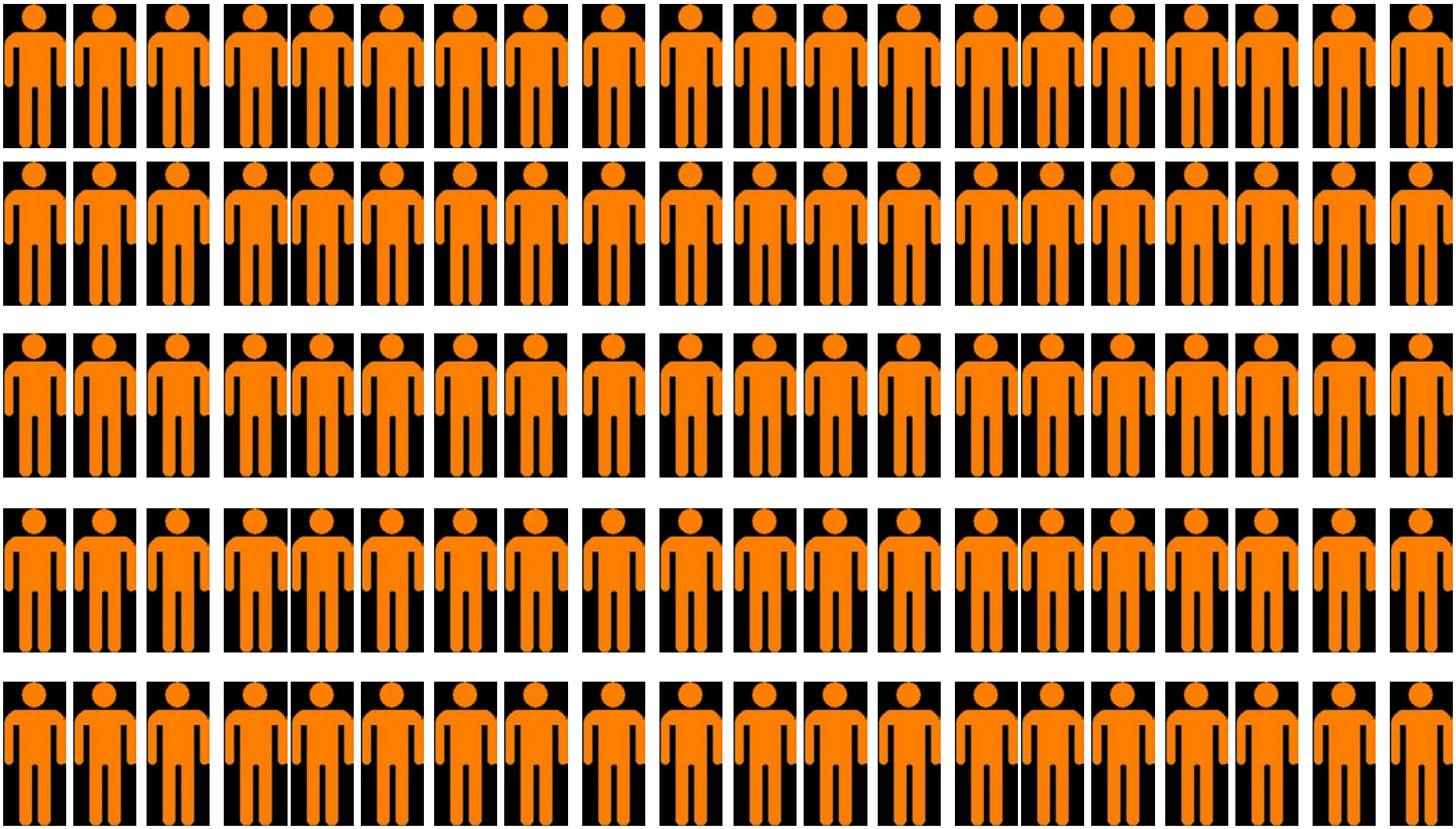
digital readers

serendipitous readers

From a talk given by Ellen Duranceau (MIT) at the 2012 SPARC Open Access meeting, March 12, 2012







From a presentation by Jack Andraka at the Berlin 11 Satellite Conference, November 18, 2013.

Getting to ‘Open’

Open Access Publishing

Effectively managed author rights

Digital repositories

Open Access Policies and Mandates

Open Access Publishing

Effectively managed author rights

Digital repositories

Open Access Policies and Mandates

10,528 open access journals

In essential ways, no different from traditional journals

Operations

Editor
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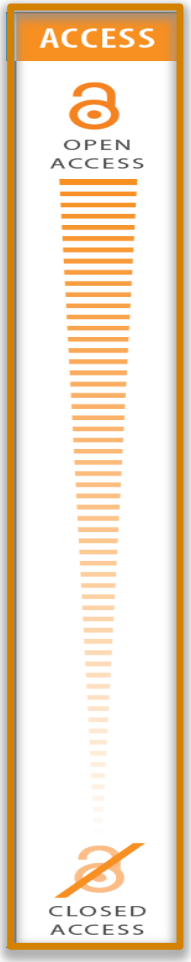

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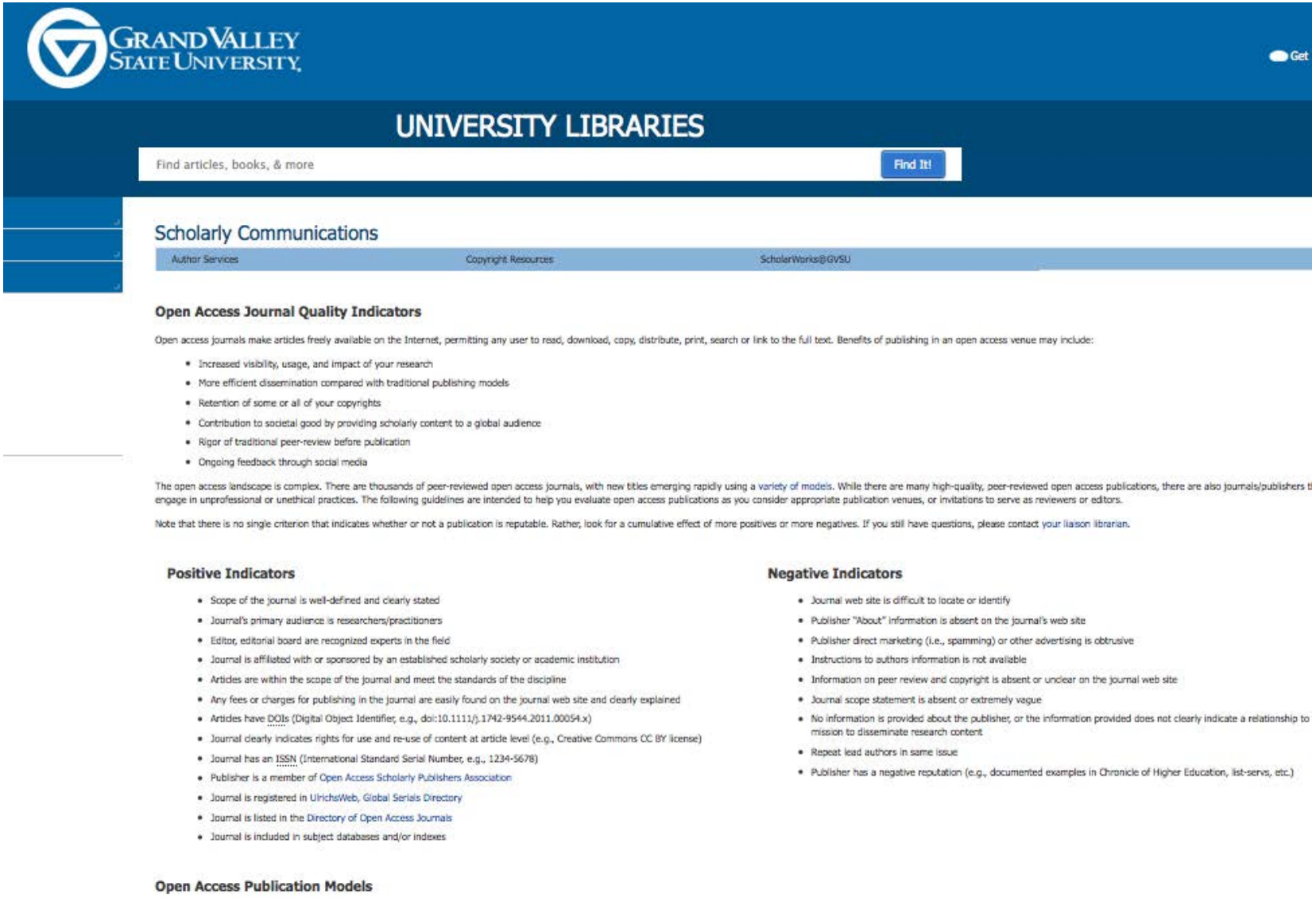

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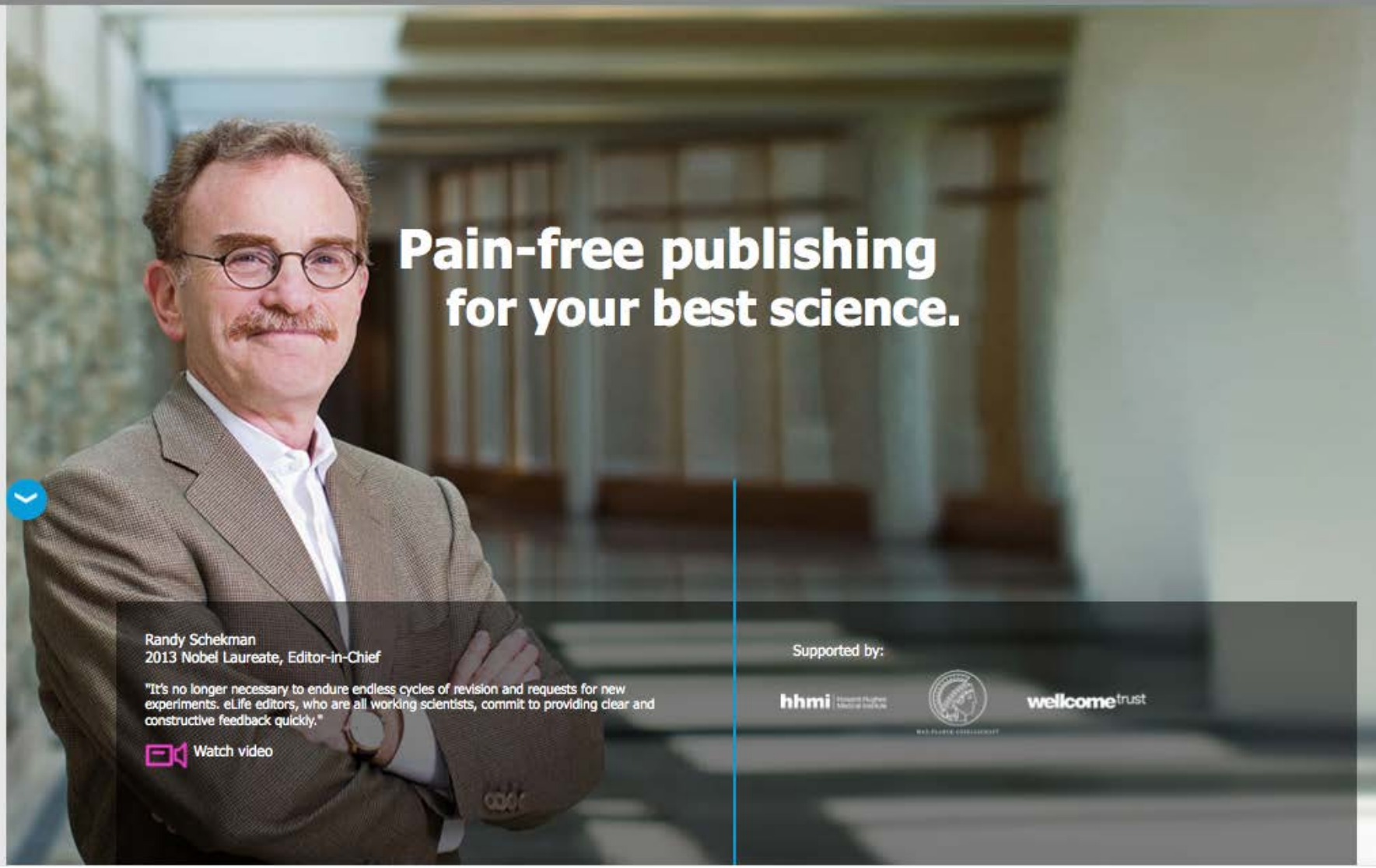

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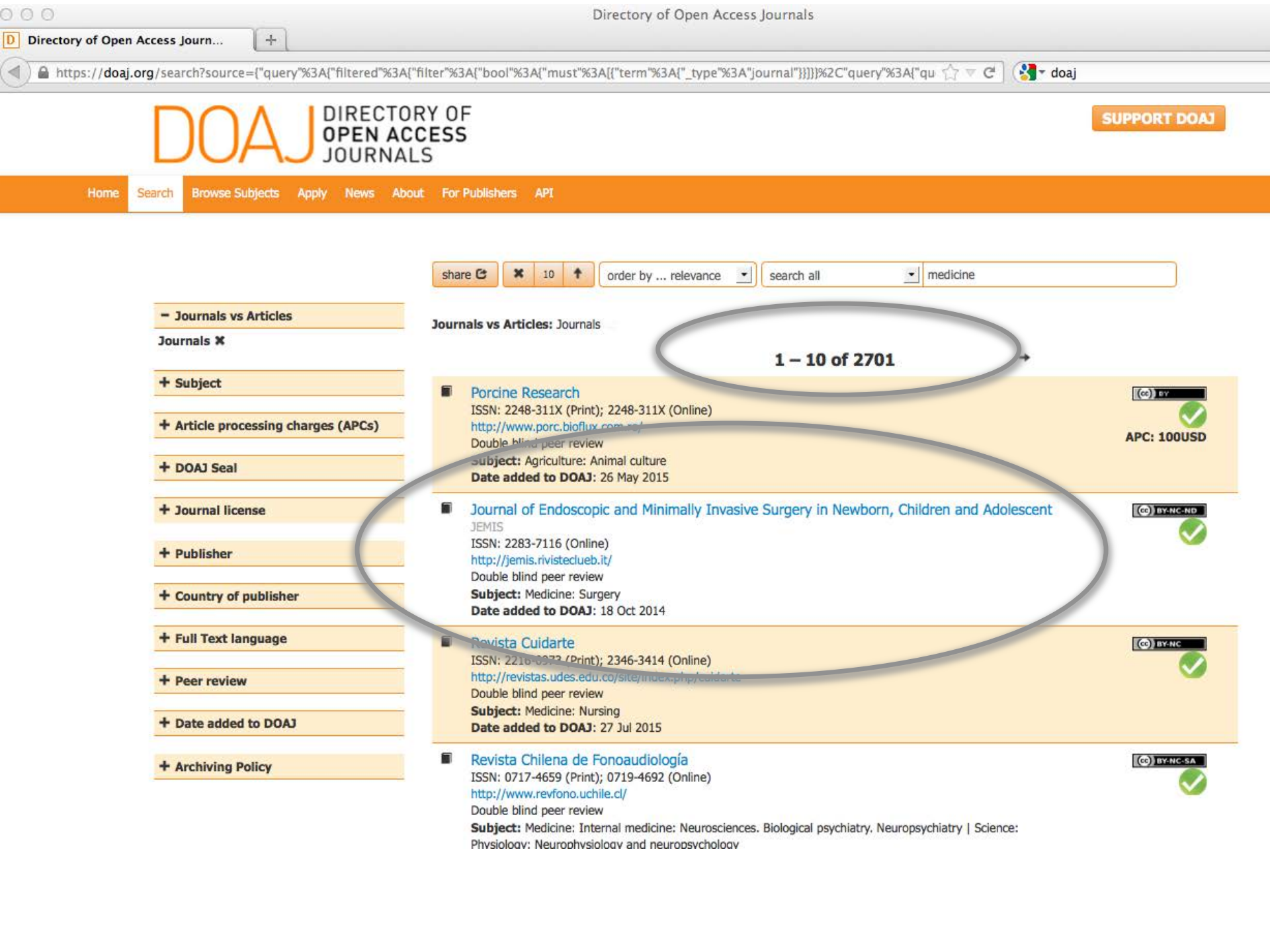
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Jesse Stommel ***is an assistant professor of digital humanities at the University of Wisconsin-Madison.***

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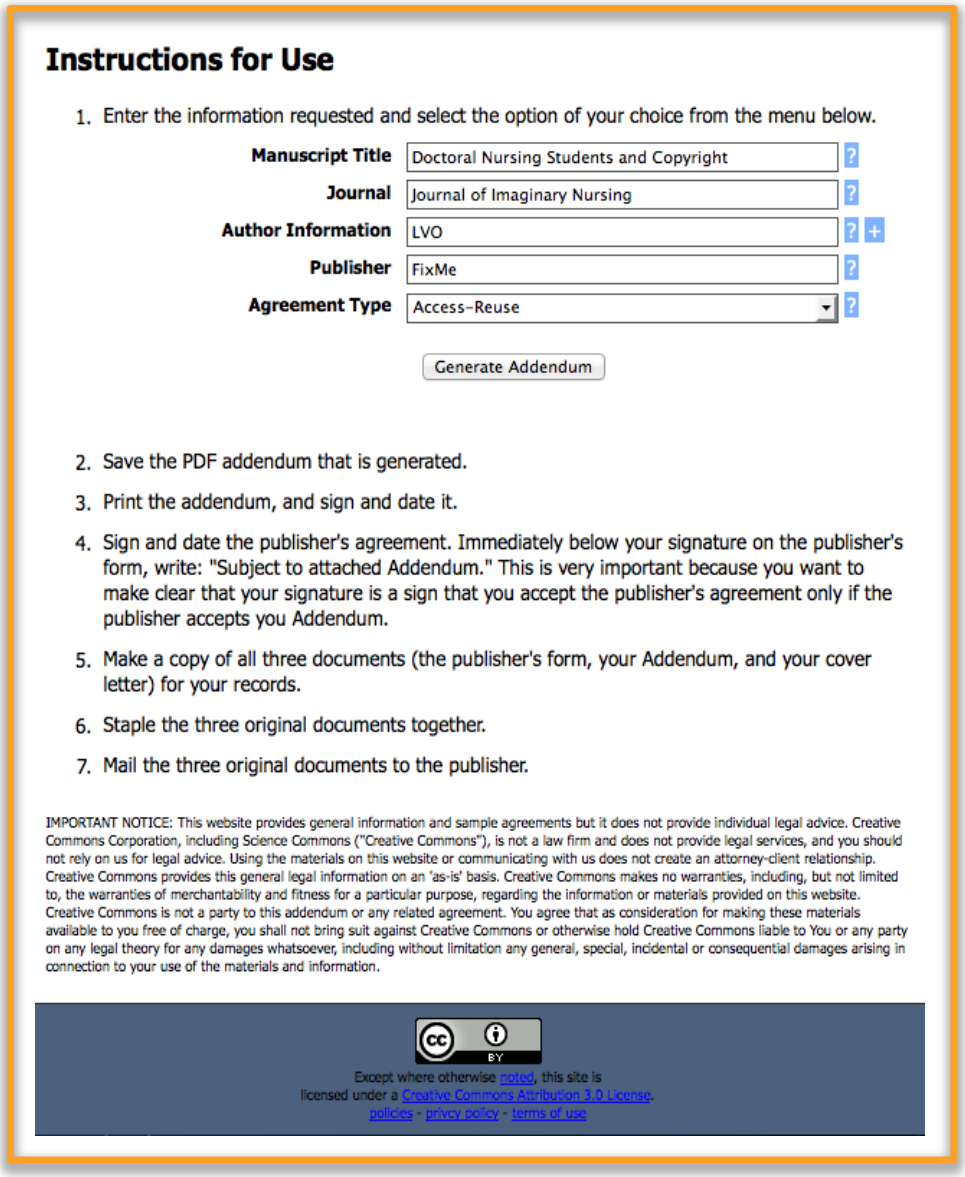

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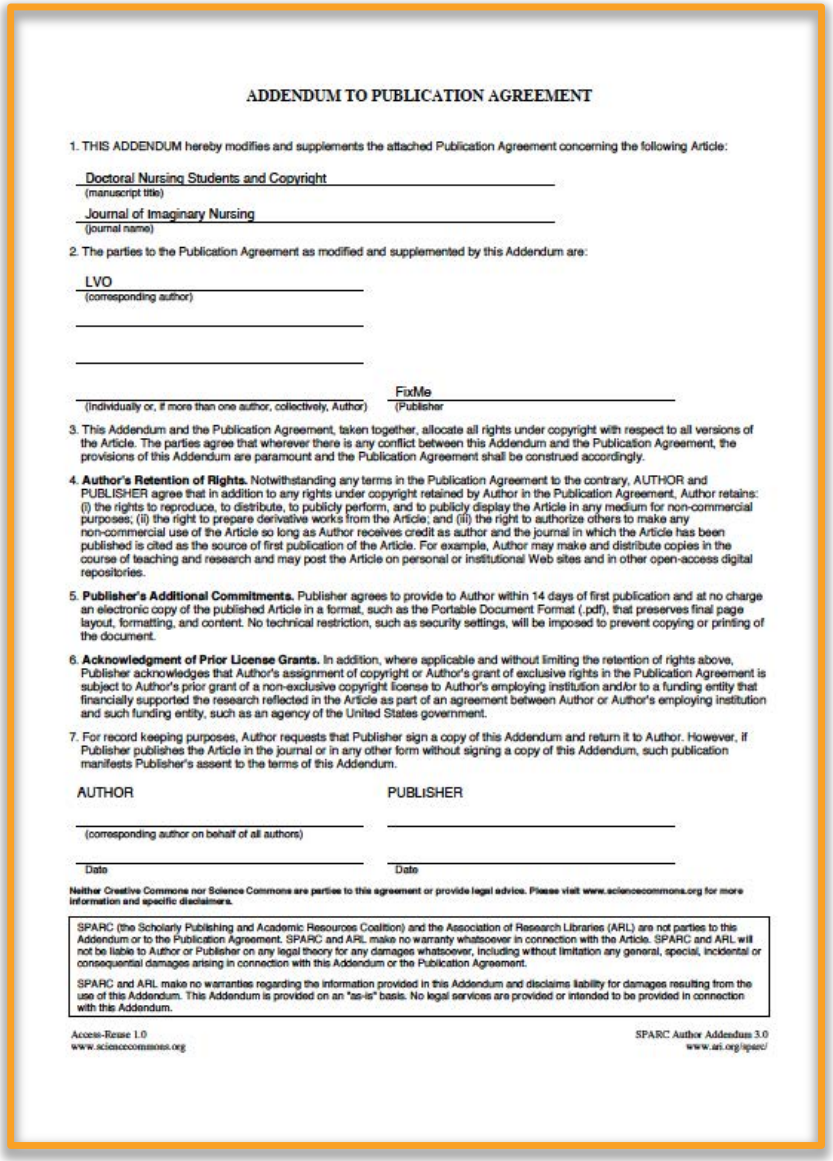

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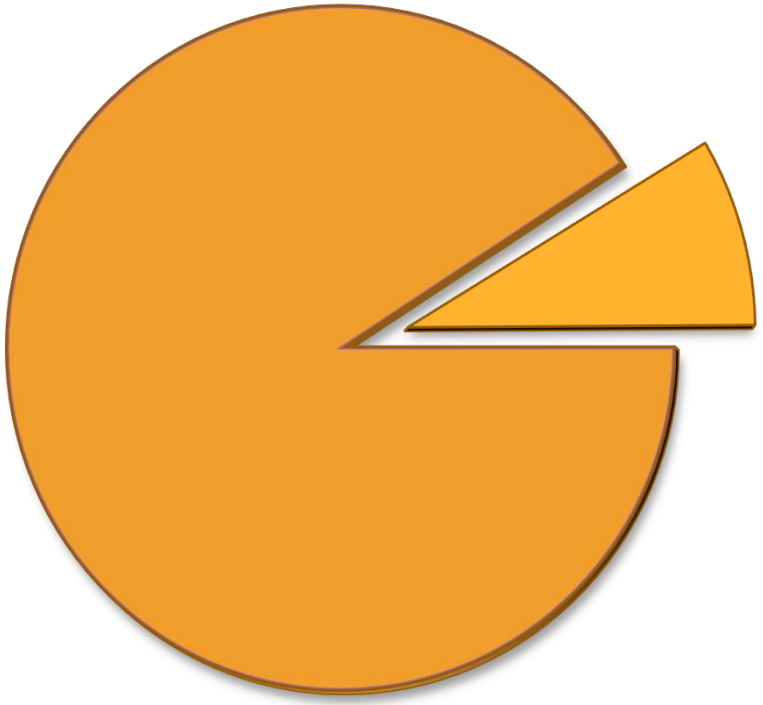

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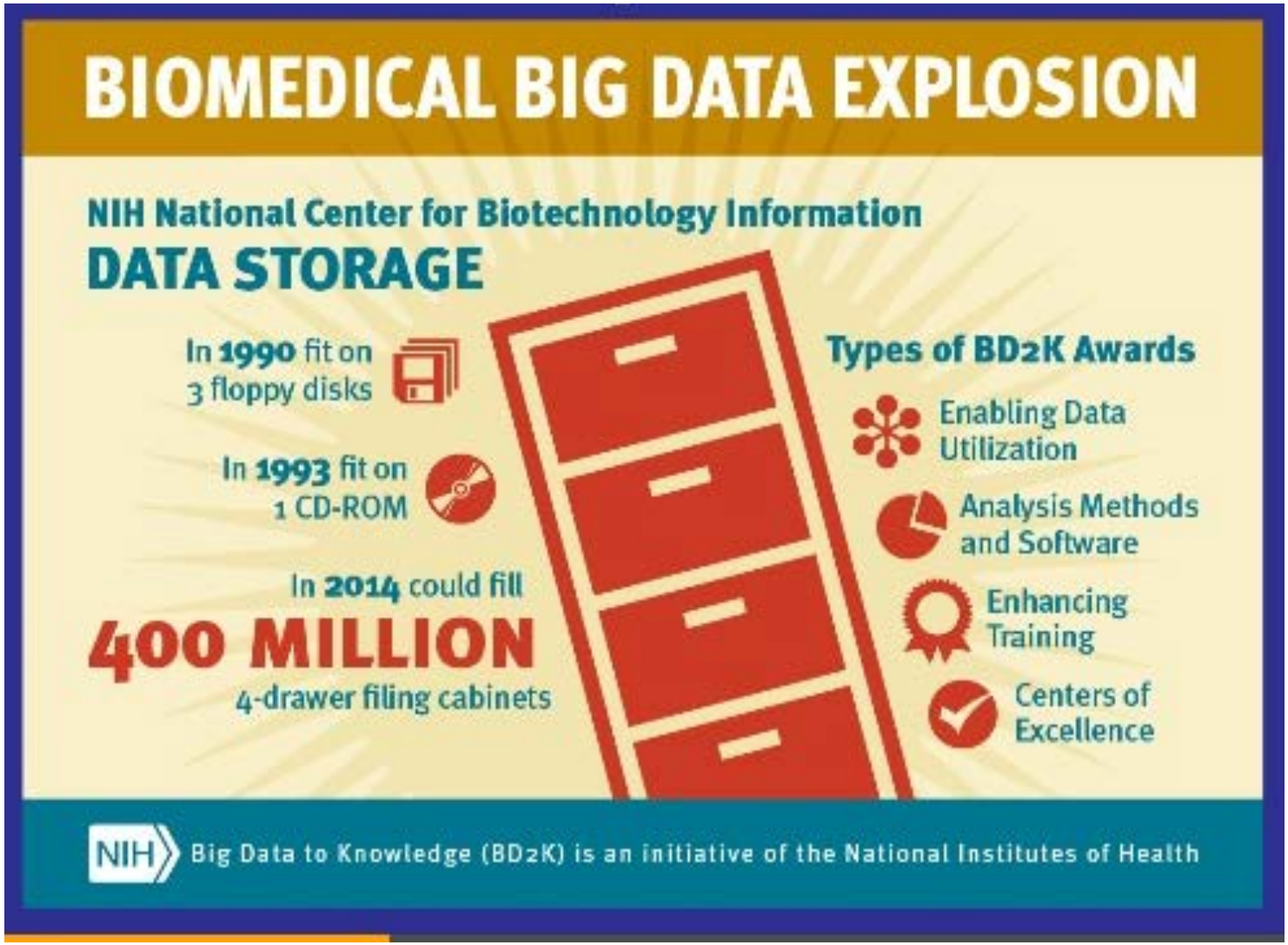

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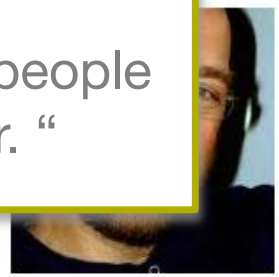

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Leading a group to synergy

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RUSH UNIVERSITY MEDICAL CENTER

Elissa Foster, PhD
Associate Professor
Jay Baglia, PhD
Associate Professor
College of Communication

DePaul University

What were you hearing?

- Why jazz?
- Group improvisation + listening-in + distributed leadership = synergy / flow

Learning Objectives

By the end of this learning activity you will be able to:

- Recognize the key features of small groups and teams
- Identify benefits of teamwork in healthcare
- Diagnose problems with/in team interaction

Why Teams?

- In the ACA--"interdisciplinary" appears 18 times and "team" appears 53 times in sections about:
  - geriatric care,
  - behavioral and mental health,
  - community health programs,
  - health workforce education,
  - and the patient-centered medical home.
- IHI Report "Improving Diagnosis in Healthcare" (September 2015)
- "Health care is a team sport" today's guiding metaphor (just Google it!)

Preview

- I. Group Activity (5-minutes)
- II. Team communication concepts
- III. Case study
- IV. Application to practice

I. Group Activity

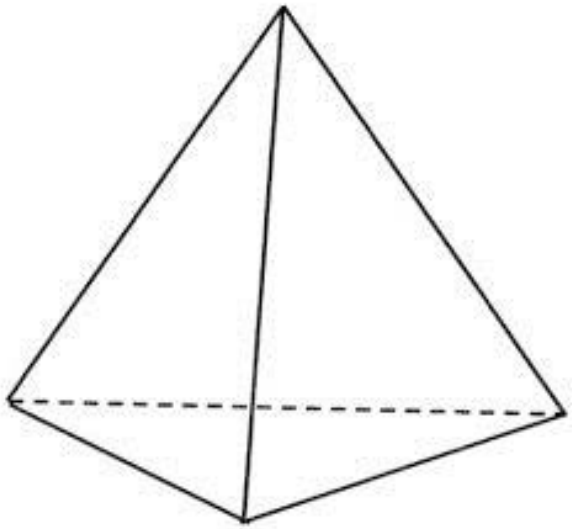
Activity: Groups of 5

- Open the envelope
- Find 6 toothpicks
- Arrange toothpicks to create 4 equilateral triangles (5 minutes)
  - Do not cross the toothpicks
  - Do not break the toothpicks
- One member acts as observer/reporter

- If you already know the solution; recuse yourself and volunteer as observer

1-minute Reflection

- What did you notice about the group?
- Who spoke?
- Who was silent?
- Who touched the toothpicks?
- Who was “the leader”?
- Who cracked jokes?
- What did you do to solve or not solve the puzzle?



II. Team Communication Concepts

What makes a team?

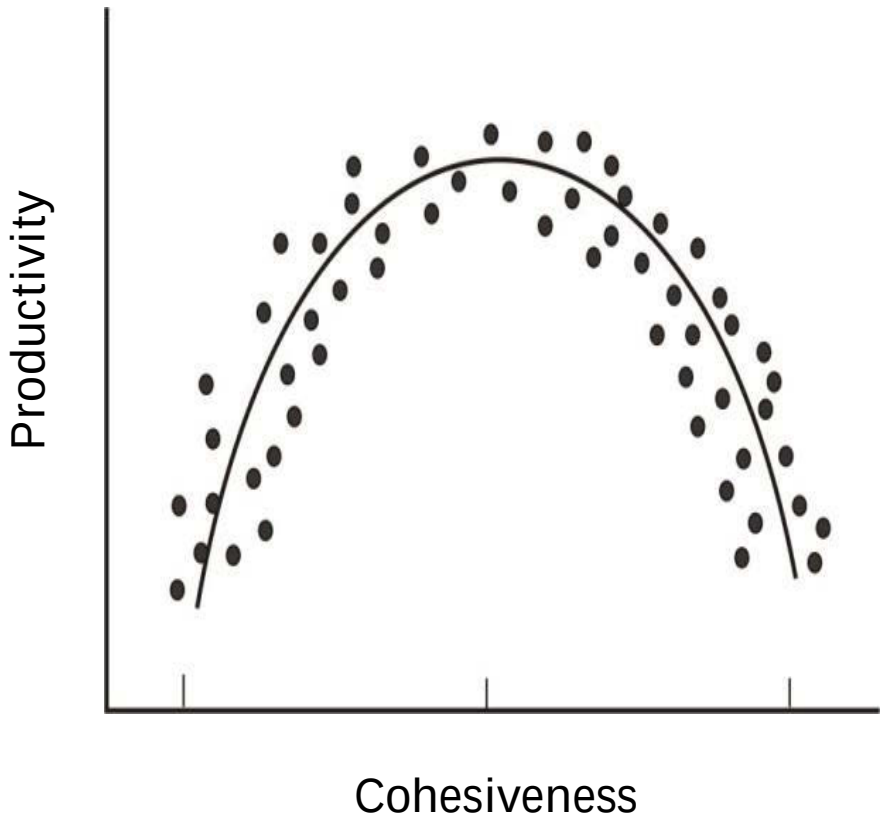
- Small group (3 or more; around 5-7; <12)
- Can hold clear impressions of each member as unique individuals
- Interdependent system
- Influence one another
- Shared goals or a common purpose
- Boundaries

Task and Social Dimensions

- Every message has a content and a relationship dimension
  - Content = information that is exchanged (what you say)
  - Relationship = what is conveyed about the relationship between communicators (how you say it)
- Every group has a task and a social dimension
  - Task = what is to be accomplished → productivity
  - Social = relationships and their impact on the group as a whole → cohesiveness

Relationship between Task and Social?

- Curvilinear
- Too much attention to cohesiveness can lead to stress if group fails to meet its goals or to "groupthink"
- Too much attention to productivity diminishes cohesiveness
- Example: the classic "group project" in an undergraduate class



Stages of Group Development

- Forming: Initial interaction, polite, tentative
- Storming: Tension, from relationships or from task-related issues
- Norming: explicit and implicit guidelines that regulate the group (norms can be + or -)
- Performing: generating "output," accomplishing your goals, achieving "synergy"
- (Adjourning: when the task is complete)
- Not linear; cyclical and iterative

Group Roles

- Task Roles
  - Initiator/contributor, opinion-seeker, coordinator, director, devil's advocate
- Maintenance (Relationship) Roles
  - Supporter-encourager, harmonizer, feeling expresser, tension-reliever
- Self-centered (Disruptive) Roles
  - Stage hog, loafer, isolate, clown, blocker, cynic

Leadership

- Definition: A process of influence between leader and followers
- Is directed towards change
- Reflects mutual purposes of group members
- Is achieved through competent communication
- Best thought of as “distributed” (not the trait of an individual)

III. Case Study

Case Study: Breaking News 6/23/15

- Listen to the recording of a medical team
- Consider what you have learned about teams
- After listening, you will work in groups of 5
  - What team dynamics did you notice?
  - What "went wrong" in this team?
  - How might this be prevented?
- A malpractice suit waiting to happen…
- 5 minutes to discuss and record your observations on the flip chart

IV. Application to Practice

IV. Application to Practice

- How can this information help you when you are the “team facilitator”? (Reflect and record)
- Diagnose imbalance between task and social dimensions
- Recognize roles—task, maintenance (relationship), and disruptive
- “Meta-communicate” about processes and relationships not just tasks
- Engage difficult conversations . . . the topic of November’s workshop.

Thank you!

Have a great day

2015 – 2016 Teaching Academy

RUSH UNIVERSITY MEDICAL CENTER

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Associate Professor
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Associate Professor
College of Communication

DePaul University

Team Facilitation: Leading a Group to Synergy

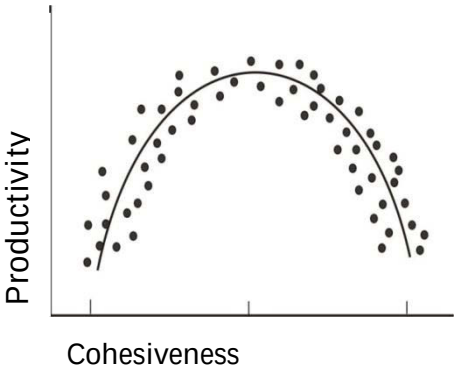
Elissa Foster, PhD
Associate Professor
(efoste10@depaul.edu)

Jay Baglia, PhD
Associate Professor

KEY CONCEPTS

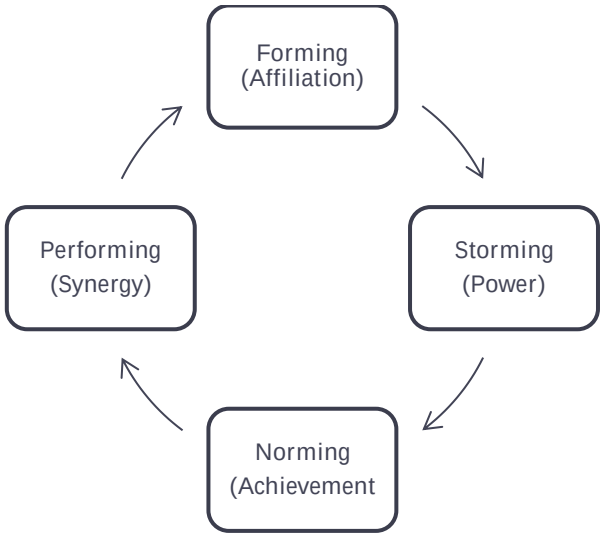
TASK and SOCIAL dimensions of group communication

Task output = productivity
Social output = cohesion
Relationship is curvilinear and interdependent



STAGES OF GROUP DEVELOPMENT

Forming, initial stage of group, characterized by excessing politeness
Storming, tension or conflict arising from task or relationship concerns
Norming, emergence of explicit or implicit rules about the group's processes, values, identity, etc.
Performing, emergence of productivity and cohesion from the group



GROUP ROLES

Task Roles: Initiator/contributor, opinion-seeker, coordinator, director, devil's advocate, energizer (action-oriented), evaluator-critic, information giver, recorder, procedural manager
Maintenance (Relationship) Roles: Supporter-encourager, harmonizer, feeling expresser, tension-reliever, follower, compromiser, gatekeeper
Self-Centered (Disruptive) Roles: Stage hog, dominator, loafer, help seeker, isolate, clown, blocker, cynic. special-interest advocate

Rush University Medical Center: 2015-2016 Teaching Academy

Difficult Learning Situations

Responding effectively when things aren't going well . . . .

2015 – 2016 Teaching Academy

RUSH UNIVERSITY MEDICAL CENTER

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Think: What difficult situations have you faced?

- Two colleagues can't work together and complain endlessly
- A new trainee is cheerful and kind, and also shows severe deficits in competency
- Your highly-credentialed supervisor communicates poorly and lacks confidence
- A new colleague enjoys "socializing" but shows little initiative in addressing work assignments

Learning Objectives

By the end of this activity you will be able to:

- Apply prevention strategies to manage difficult learning situations
- Use "microskills," perception checking, and assertive messages when a difficult situation arises with learners
- Engage different strategies for different communication challenges with learners and others

Regarding the content . . .

- These approaches are transferable
  - Connection between leadership and teaching
  - Professional/personal communication
- Mistakes are inevitable
  - We all encounter them
  - We all make them
  - We want to address them quickly and effectively
- Conflict is inevitable
  - Conflict avoidance is widespread
  - Failure to manage conflict escalates its negative effects

Preview

- I. Group discussion: Your stories (5-minutes)
- II. Four Strategies
  - Prevention
  - Microskills
  - Perception-checking
  - Assertive messages
- III. Case study
- IV. Questions

I. Group Discussion

Your Stories: Groups of 5

- Recall a difficult conversation you've encountered at work (30 seconds)
- In 3-5 sentences (only!) share your story with the group (avoid lengthy backstory)
- As a group, identify 1 – 2 themes: what made these conversations difficult?
- Report out

Feedback

- Two kinds
  - Formative: ongoing, directed towards change
  - Summative: at the end, looking back
- Formative – as the soup is cooking
- Summative – when it's on the table
- All feedback can be seen as formative in some way

II. Four Strategies

1. Prevention

- PRIMARY: Prevent the problem before it occurs.
  - Set expectations early
  - Determine others' expectations and goals
  - Orient thoroughly
- SECONDARY: Detect the problem early.
  - Have a plan; practice
  - Pay attention to "flags" and respond appropriately
  - Give feedback early and often
  - Document problems and responses (include others?)
- TERTIARY: Manage the problem to minimize impact.
  - Acknowledge impact of the problem (bolster your confidence)
  - Address the problem directly (include others)
  - Follow through with consequences

2. Microskills (One-Minute Preceptor)

Microskills	Script examples
• Get a commitment	• "Tell me what you were thinking when you . . . ?"
• Probe for supporting evidence	• "What led you to that decision?"
• Correct mistakes	• "Your approach seems reasonable, but here's where you went wrong . . ."
• Reinforce what was done right	• "What *did* work well was the way you . . ."
• Teach a "general rule"	• "When you face situations like this in the future, you need to remember . . ."

Microskills	Script examples
• Get a commitment	• "Tell me what you were thinking when you . . . ?"
• Probe for supporting evidence	• "What led you to that decision?"
• Correct mistakes	• "Your approach seems reasonable, but here's where you went wrong . . ."
• Reinforce what was done right	• "What *did* work well was the way you . . ."
• Teach a "general rule"	• "When you face situations like this in the future, you need to remember . . ."

BEFORE the exchange:
Set expectations

AFTER the exchange:
Make time to reflect and review

3. Steps for Perception-Checking

- Context? Behaviors that make you go “Huh?”
- “Be curious, not furious”
- Step 1. Describe the observed behavior (facts)
- Step 2. Propose TWO different (plausible) interpretations of the behavior
- Step 3. Request clarification
- Maintain appropriate non-verbals (facial expression and tone of voice)

4. Assertive Messages: Background

- Context? Things that make you go, “What the . . . ?!”
- Need to deliver a correction directly and effectively
- Difference between assertion and aggression
- Preserve the dignity of the other
- Be clear about your goals
- The assertive approach is appropriate for Tertiary Prevention (minimizing damage)

4. Steps for Assertive Messages

- Step 1. Check the facts (background)
- Step 2. Describe the problematic behavior
- Step 3. Describe the consequences of the behavior
- Step 4. Clearly state what should happen instead of the problem behavior
- Step 5. State consequences for not correcting the problem behavior

III. Case Study

Scene from the film "Wit"

- Patient: Vivian Bearing, 48yrs, professor, diagnosed with stage 4 ovarian cancer
- Doctor: Jason, an oncology fellow, former undergraduate student of Vivian's
- Jason has been sent to "practice" his history-taking and physical exam
- You are Jason's immediate supervisor (program director of fellowship)
- What strategies will you use?
- HANDOUT

IV. Questions

Complicating Factors

- Not all difficult situations are created equally
- Expectations for communication differ across culture, gender, age
- Hierarchy: communicating up versus down
- Health care context: legal environment
- Cognitive deficits, mental health concerns

IV. Questions

- Take a moment to consider the content
- What strategies do you currently use?
- What barriers do you perceive to trying these new ones?
- General questions and concerns?

Thank you!

Have a great day

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Difficult Learning Situations

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KEY CONCEPTS

Two Kinds of Feedback

- **Formative**: ongoing, directed towards change
- **Summative**: at the end, looking back
- All feedback can be formative in some way

STEPS FOR PERCEPTION CHECKING

- "Be curious, not furious"
- Step 1. Describe the observed behavior (fact)
- Step 2. Propose TWO different (plausible) interpretations of behavior
- Step 3. Request clarification
- Maintain appropriate non-verbals (facial expression and tone of voice)

STEPS FOR ASSERTIVE MESSAGES

- Step 1. Check the facts (background)
- Step 2. Describe the problematic behavior
- Step 3. Describe the consequences of the behavior
- Step 4. Clearly state what should happen instead of the problem behavior
- Step 5. State consequences for not correcting the problem behavior

Which will you try next?

What questions remain?

The Prevention Perspective

PRIMARY: Prevent the problem before it occurs.

- Set expectations early
- Determine others' expectations and goals
- Orient thoroughly

SECONDARY: Detect the problem early.

- Have a plan; practice
- Pay attention to "flags" and respond appropriately
- Give feedback early and often
- Document problems and responses (include others)

TERTIARY: Manage the problem to minimize impact.

- Acknowledge impact of the problem (bolster your confidence)
- Address the problem directly (include others)
- Follow through with consequences

Microskills (One-Minute Preceptor)

Skills	Script
Get a commitment	"Tell me what you were thinking when you . . . ?"
Probe for supporting evidence	"What led you to that decision?"
Correct mistakes	"Your approach seems reasonable, but here's where you went wrong . . ."
Reinforce what was right	"What *did* work well was the way you . . ."
Teach a general rule	"When you face situations like this in the future, you need to remember . . ."

DePaul University

Teaching Patient-Centeredness

Benefits for patients, providers, & health systems

2015 – 2016 Teaching Academy

RUSH UNIVERSITY MEDICAL CENTER

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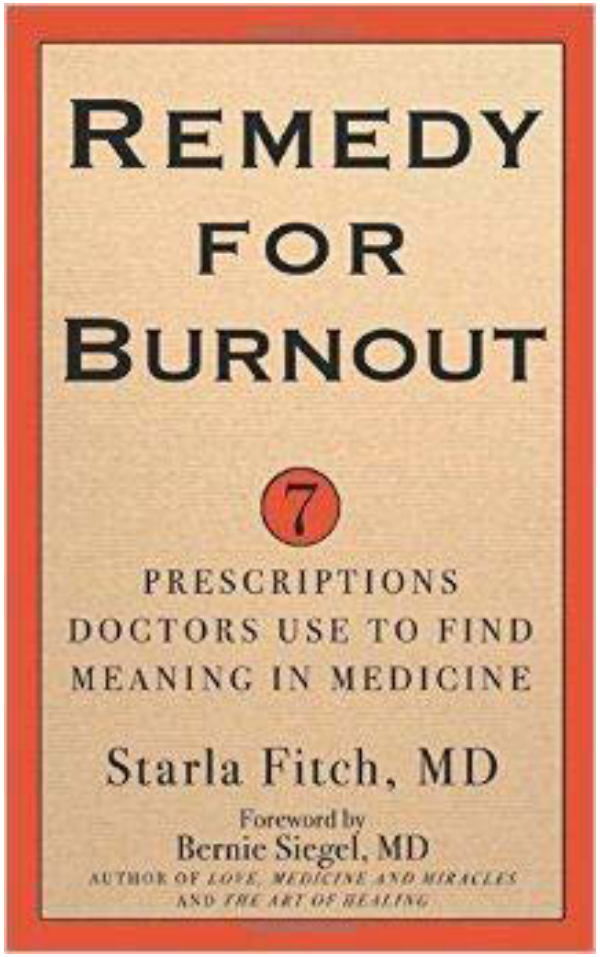
What's the resistance to patient-centeredness?

- Time
- "Don't want to get too involved."
- Habits of mind.



Why Patient-centeredness?

- Reduces burnout
- Better patient outcomes
- Enhances quality and safety
- Less likelihood of malpractice
- ACGME Competencies
  - Patient Care
  - Interpersonal & Communication Skills

The field of communication studies is concerned with how humans make meaning.

How does the physician demonstrate patient-centeredness?

Preview

I. Today's Learning Objectives (5 minutes)
II. Group Activity & Debrief (10 minutes)
III. Concepts (10 minutes)
IV. Application to practice (10 minutes)
V. Questions (10 minutes)

Patient-centered care is not new

"It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has."

William Osler

How & why did healthcare become physician-centered?

Compare to physician-centeredness

- Where professional caregivers:
  - Tend to ignore power dynamics
  - Do most of the talking
  - Choose conversational topics
  - Begin and end the communication episodes

I. Learning Objectives

Objective #1	Objective #2
Identify how professional health care providers and patients and their families interpret the meaning of the illness through different lenses (biomedical vs. biopsychosocial models).	Identify participatory strategies that support meaningful communication across cultures and demographics.

II. Group Activity

Activity: Groups of 5/6

- Each table has an envelope containing a fairly common medical condition
  - What does the condition mean to a medical professional (tests/labs, algorithms, treatment options, recovery time)?
  - What might the condition mean to the patient?
    - What questions do you need to ask?

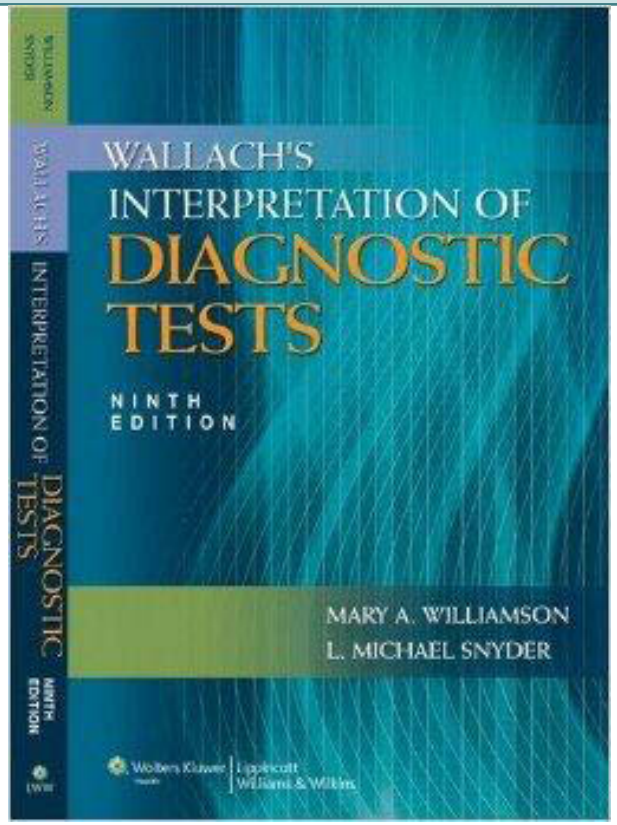
III. Communication Concepts

Every message contains both a content and a relationship dimension

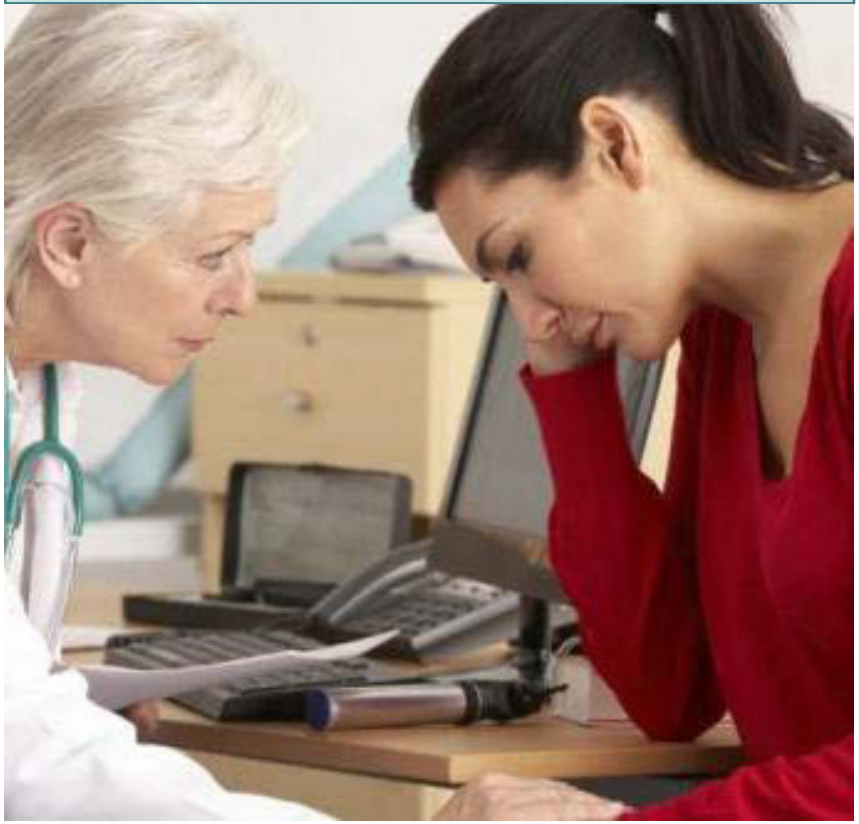
- Content
  - Information that is exchanged (what you say)
- Relationship
  - What is conveyed between communicators (what does it mean?)

What does a diagnosis *mean*?

BIOMEDICAL MODEL



BIOPSYCHOSOCIAL MODEL



Two Dominant Lenses in Healthcare

Biomedical Voice of Medicine	Bio+psychosocial – Voice of the Lifeworld
• Objective	• Subjective
• Focused & Specific	• Diffuse

• Evidence
  ▫ Symptoms,
  ▫ Tests, Lab Results
	• Feelings
	  ▫ Thoughts & Emotions
	  ▫ Pain & Discomfort

• Medical Chart	• Narrative
• Curing	• Healing
• "Disease"	• "Illness"

Communication Implications

Biopsychosocial	Biomedical
• Detached concern	• Depersonalization

• Treating the whole person
  ▫ Each patient is unique
	• Treating the symptoms
	  ▫ Symptoms are objective

Collaborative Interpretation Communication Model

- Professional caregivers and patients treat each other as peers who openly discuss health options and make mutually satisfying decisions.
  - Drawing upon each other's expertise

IV. Application to Practice

Participatory Strategies

IV. Application to Practice

- Listening
  - Active listening
    - Medical Scribes
  - Paraphrasing
- Making use of other communication systems
  - Patient portals
  - Email and phone

Application to Practice (cont.)

- Environment
  - Waiting
    - Texting patients regarding wait times
  - Planetree
    - Signage
    - Structure

Questions & Comments

Thank you!

We appreciate your commitment to providing better care.

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Teaching Patient-Centeredness

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KEY CONCEPTS

Biomedical Model	**Bio+Psychosocial Model**
• Objective	Subjective
• Focused & Specific	Diffuse
• Evidence	Feelings
▫ Symptoms,	Thoughts & Emotions
▫ Tests, Lab Results	Pain & Discomfort
• Medical Chart	Narrative
• Curing	Healing
• "Disease"	"Illness"

Collaborative Interpretation Communication Model: Drawing on each other's expertise, professional caregivers and patients treat each other as peers who openly discuss health options and make mutually satisfying decisions.

Patient-Centered Communication:

- Reduces burnout
- Results in better patient outcomes
- Enhances quality and safety
- Fewer incidents of malpractice
- Contributes to ACGME Competencies
  - Patient Care
  - Interpersonal & Communication Skills

FURTHER READING

Borrell-Carrio, F. et al. (2004). "The Biopsychosocial Model 25 Years Later," *Annals of Family Medicine, 2,* pp. 576-582.

Montgomery, K. (2006). *How Doctors Think: Clinical Judgment and the Practice of Medicine,* Oxford University Press.

Vanderford, M. et al. (1997). "Exploring Patients' Experiences as a Primary Source of Meaning," *Health Communication, 9,* 13-26.

Teaching Health Literacy

From Micro to Macro for Providers & Systems

Teaching Academy 2015-2016

RUSH UNIVERSITY MEDICAL CENTER

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Defining Health Literacy

- **Health Literacy (from Healthy People 2010)**
  - "the degree to which **individuals** have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions"
- **Public Health Literacy (from Freedman et al, 2009)**
  - "the degree to which **individuals and groups** can obtain, process, understand, evaluate, and act upon information needed to make public health decisions **that benefit the community**"

Critical Health Literacy

(Chinn, 2011)

1. **Collective Action**
2. **Social Determinants of Health**
3. **Critical Appraisal of Information/Educational Materials**

Rudolph Virchow (19th century) recognizes that disease is fundamentally a social problem.

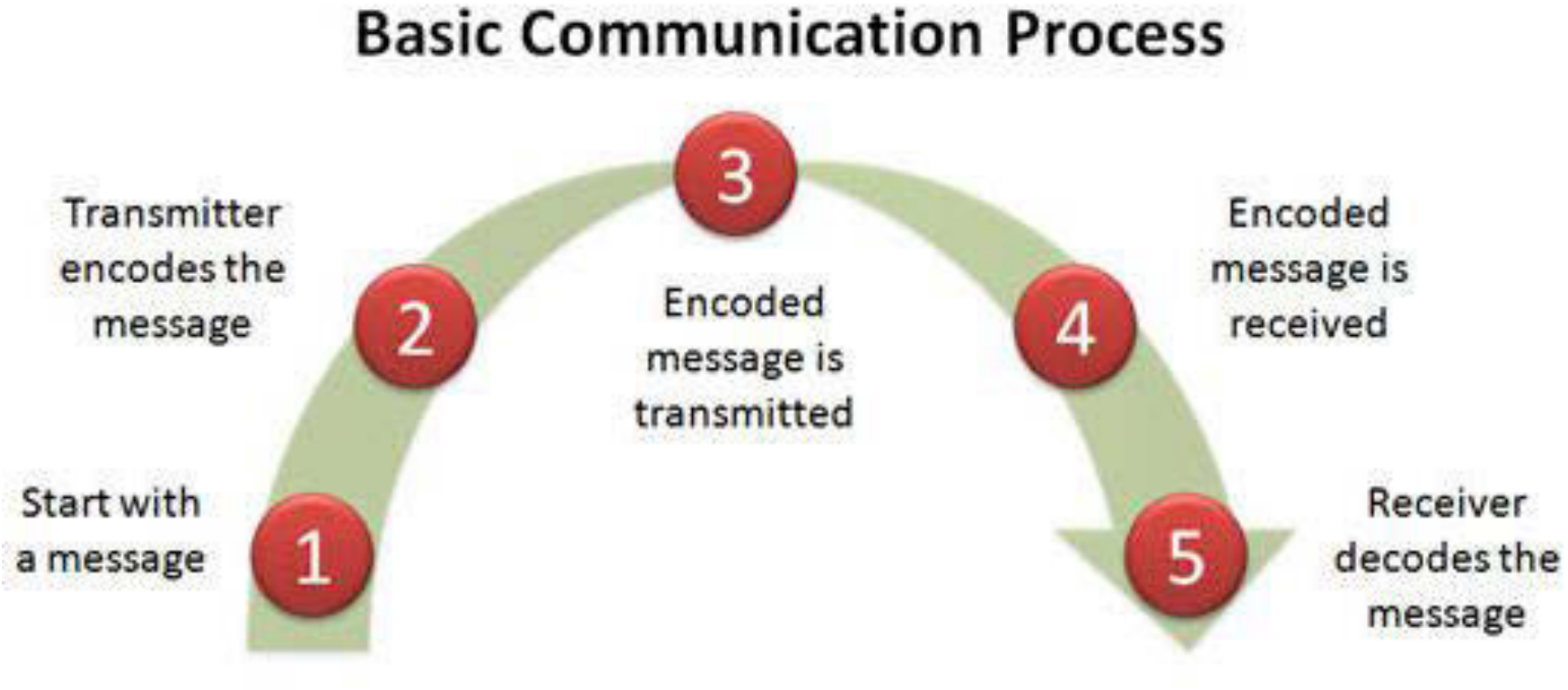
Preview for today's workshop

I. Communication Models
II. Warm-up: Small Group Activity
III. Clinical Setting
    A. Plain Language
    B. AskMe3
IV. Organizational
    A. *Hablamos Juntos*
    B. Health Literate Organizations
V. Community
    A. Barbershop
VI. Application

I. Communication Models

From Transmission to Shared Meaning

Transmission Model of Communication

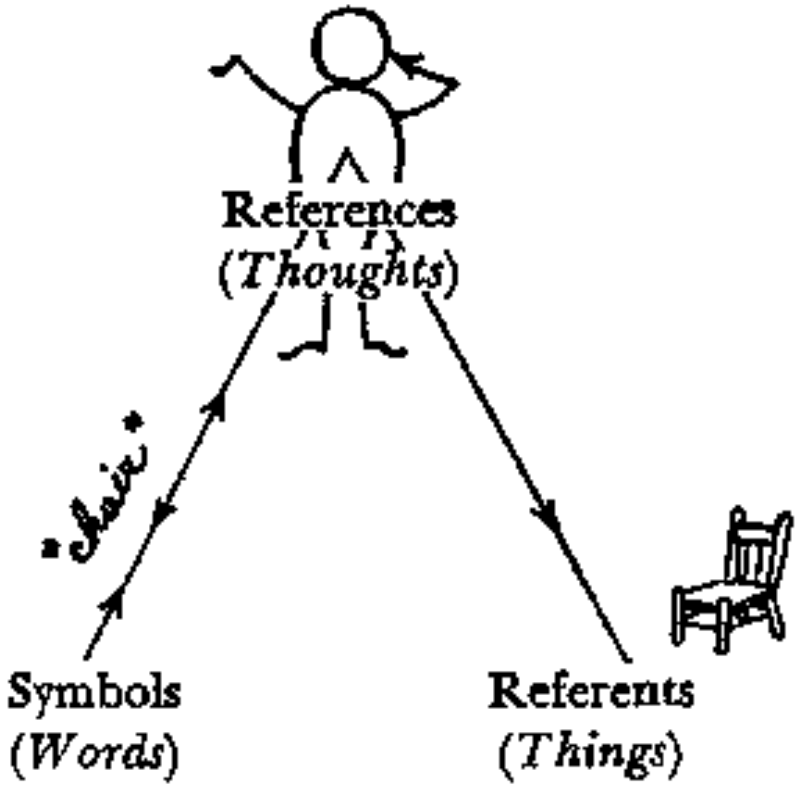


Other (better?) Models

Cultural Model

Communication is a symbolic process whereby reality is produced, maintained, **repaired,** and transformed.

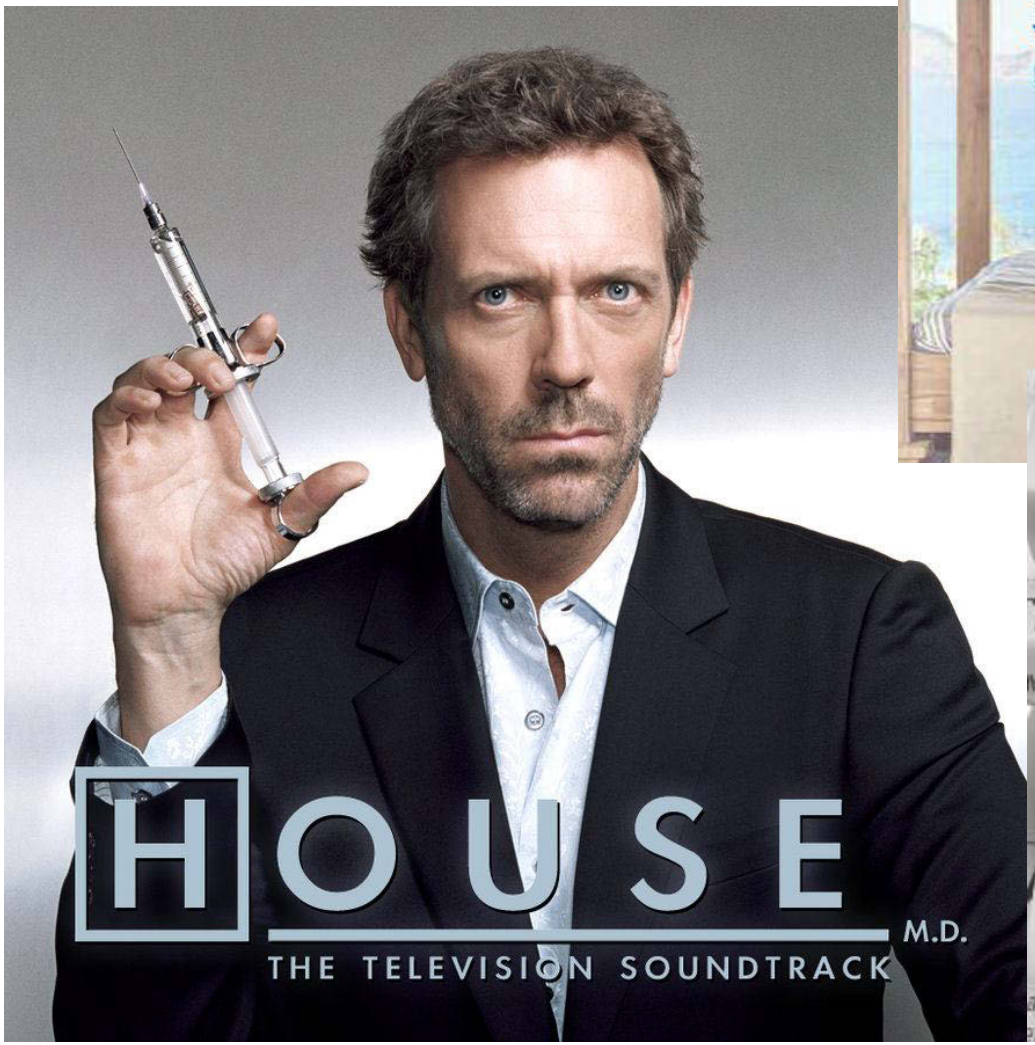
Triangle of Meaning



Who are we talking about?

- There is a positive correlation between higher formal education and high health literacy.
- The geriatric population has the highest rate of low health literacy when compared to other age groups.

Where do we get our health information?



II. Warm-up: Small Group Activity

Case Studies in Health Literacy

Case Studies in Health Literacy

- Write a short narrative (< 1 minute) that recounts a time when a patient exhibited low health literacy.
- Share these at your table.
- Have these in mind as we cover the content.

III. Health Literacy in the Clinical Setting

Plain Language, AskMe3, & Teachback

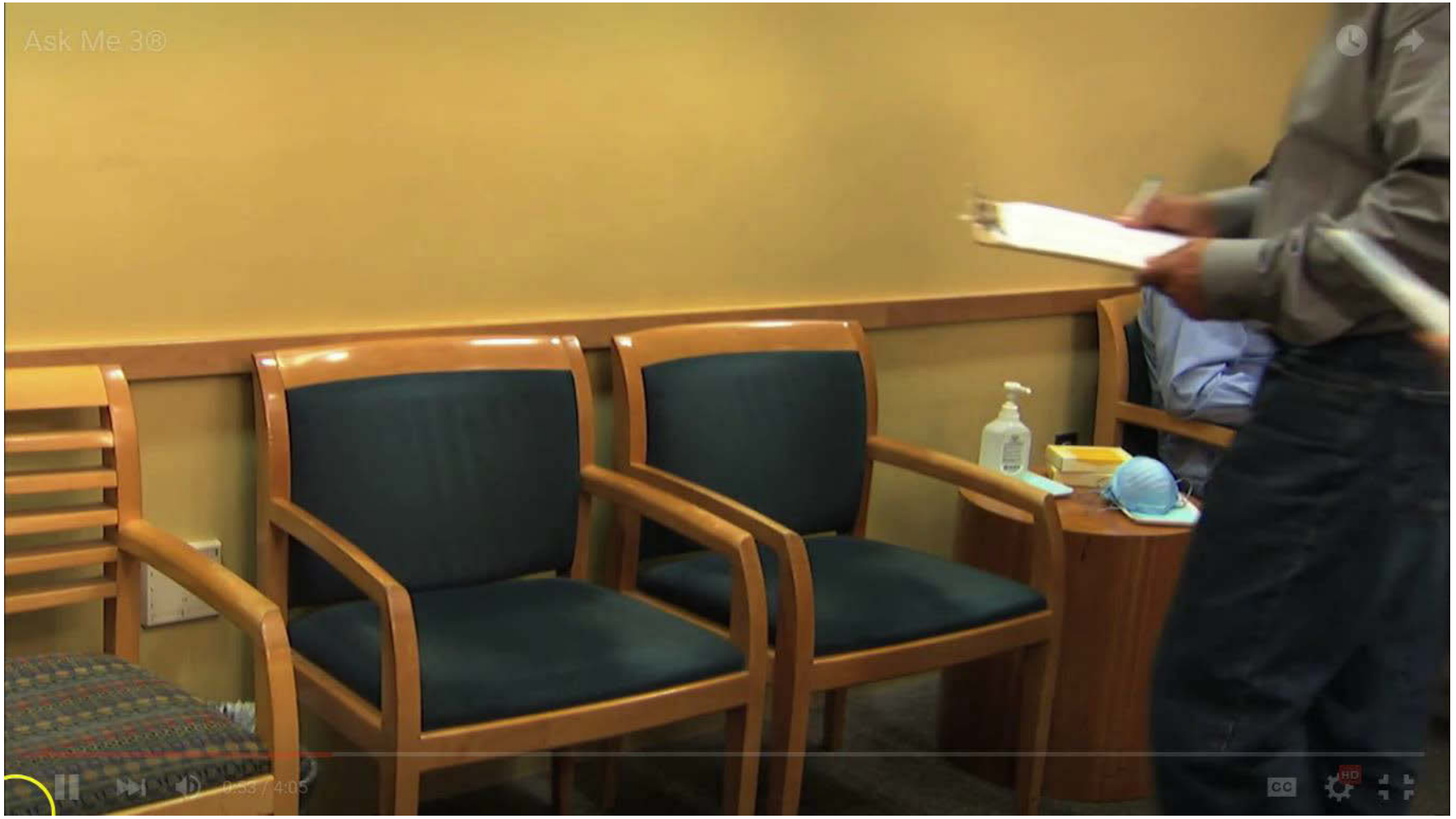
Plain Language (Living Room Talk)

SWAPPING FOR SIMPLER WORDS AND PHRASES

INSTEAD OF	*USE*
Accompany	Go with
Comply with	Follow
Designate	Appoint, choose, name
Facilitate	Ease, help
Indication	Sign
Methodology	Method
Pertaining to	About, of, on
Subsequently	After, later, then
Warrant	Call for, permit
Prioritize	Rank

Source: Simple Words and Phrases. Plainlanguage.gov website. plainlanguage.gov/howto/wordsuggestions/simplewords.cfm. Accessed September 16, 2015.

Ask Me 3 (National Patient Safety)



Teachback

- **Asking a patient to repeat what a provider has told them *in the patient's own words***
- Open-ended.
- **Paraphrasing, not parroting.**

Ⅳ. Organizational Health Literacy

Is this a Health Literate Organization?

This graphic reflects the views of the authors of the Discussion Paper "Ten Attributes of Health Literate Health Care Organizations" and not necessarily of the authors' organizations or of the IOM. The paper has not been subjected to the review procedures of the IOM and is not a report of the IOM or of the National Research Council

INSTITUTE OF MEDICINE

Attributes

Internal	External
• **Leadership Promotes** • **Plans, Evaluates, and Improves** • **Prepares Workforce** ▫ **Wellness Program** • **Targets High Risk Groups**	• **Ensures Easy Access** • **Designs User-Friendly Educational Materials** • **Communicates Effectively** • **Explains Coverage & Costs** • **Meets the Needs of All**

Hablamos Juntos

V. Community Health Literacy

Who are your patients?

Levels of health literacy in a community-dwelling population of Chinese older adults

Center for Community Health Equity (Rush-DePaul collaboration)

Improving Transitions Through Proactive Communication, Coordination, and Collaboration From the Hospital to the Community

Community Health Literacy

Partnering with community organizations to find out what <u>they</u> identify as health concerns

Barbershops & blood pressure

VI. Application

Application

- Individually:
  - 1. Recall your case from the beginning
  - 2. Reflect on the ideas presented
- Which one or two of these strategies would be most appropriate for your case?
- Share with your table

Questions? Comments

- We've really enjoyed this series and look forward to how we can continue this partnership.
- Thanks especially to Dina Rubakha & Mary Grantner for communication and coordination.

Teaching Health Literacy

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Definitions

Health Literacy: "the degree to which **individuals** have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (Healthy People 2010)
http://health.gov/communication/literacy/quickguide/factsbasic.htm

Public Health Literacy: "the degree to which **individuals and groups** can obtain, process, understand, evaluate, and act upon information needed to make public health decisions **that benefit the community**" (Freedman et al., 2009).

Concepts/Tools

American College of Physicians' Empathize, Evaluate, Educate: a three-stage communication mechanism to manage patient overutilization of medications or services.

"Teachback" – also called "Show Me" and "Closing the Loop, " teachback is a way of asking open-ended questions to ask patients to explain the diagnosis, the treatment, or trajectory *in their own words.*

10 Attributes of a Health Literate Organization: 1) Leadership promotes, 2) Organization plans, evaluates, and improves, 3) Prepares workforce, 4) Targets High Risk Groups, 5) Ensures Easy Access, 6) Designs User-Friendly Educational Materials, 7) Communicates Effectively, 8) Explains Coverage and Costs, 9) Includes Consumers, 10) Meets the Needs of All.
http://www.ahealthyunderstanding.org/Portals/0/Documents1/IOM_Ten_Attributes_HL_Paper.pdf

FURTHER READING

Chinn, Deborah (2011). Critical Health Literacy: A Review and Critical Analysis. *Social Science and Medicine, 73,* 60-67.

Cutilli, Carolyn & Schaefer, Cynthia (2011). Case Studies in Geriatric Health Literacy. *Orthopaedic Nursing, 30,* 281-287.

Freedman, Darcy et al. (2009). Public Health Literacy Defined. *Journal of Preventative Medicine, 36,* 446-451.

Osborne, Helen (2013). *Health Literacy from A to Z: Practical Ways to Communicate Your Health Message* (2nd edition). Jones & Bartlett.

Managing Emotion in Clinical Teaching

Offering Guidelines and Options for Quality Interaction

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At your table

1. Discuss the role that emotions play in the course of your day
2. List as many emotions as you can in 2 minutes
3. Identify 3 – 5 that are most challenging and circle them
4. Who experiences these emotions?

Learning Outcomes

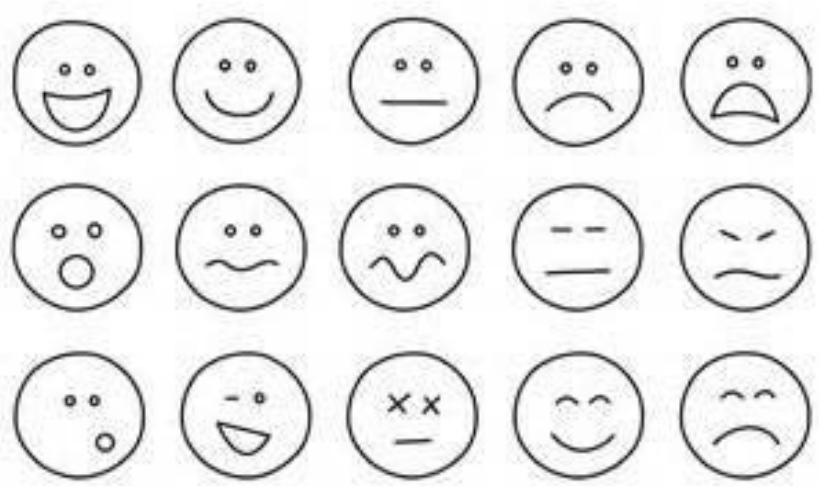
By the end of this learning activity you will be able to:

- Identify 3 effects of emotion in health care professions education
- Apply 2 strategies to communicating effective emotional responses in clinical teaching

No crying in . . .

Overview

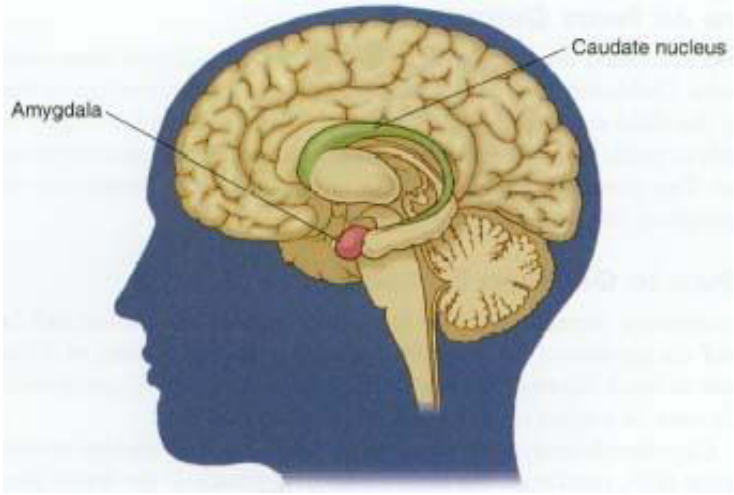
- What happens when emotions “run high”?
- Responding to Emotions
  - Empathic Opportunities
  - BATHE skill
  - Emotional Vocabulary
- Takeaways



What happens when emotions “run high”?

The “reptilian brain” (amygdala)

- Regulates emotion
- Role in affective learning (meaning is attached to knowledge)
- Emotional “flooding” short-circuits learning
- Reacting not Responding
  - Fight
  - Flight
  - Freeze



“Check your own pulse first . . .”

- Difficult to respond while *reacting*
- Recognize own beliefs and biases about emotion
- Opportunity to model effective emotion management
- Role as educator—support reflection-in-action (includes emotion)

Responding to Emotions

Components of Empathy

Some background (review)

Every message has two dimensions:

- Content
  - The basic information level of the message; what is said
- Relationship
  - The implicit level of the message that conveys emotions, intentions, relative status, expectations

We also must pay attention to:

- Process
  - Dyadic versus group communication
  - Timing and environment

Empathic Responses[1,2]

- Two dimensions
  - Attending to emotions (relational skill)
  - Responding to emotions (communicative skill)
- Types of responses to *empathic opportunity:*
  - Potential empathic opportunity continuer
  - Empathic response
  - Empathic opportunity terminator

1. Buckman, Tulsky, & Rodin, 2011; 2. Suchman, Merkakis, Beckman, & Frankel, 1997

BATHE (when emotions take over)[1]

- Background (Tell me what's been happening)
- Affect (How does it make you feel?)
- Trouble (What troubles you *the most*?)
- Handling (How have you been handling it?)
- Empathy (That must be terribly difficult.)

[1] M. R. Stuart & J. A. Liebeman III (2001) The fifteen-minute hour: practical therapeutic interventions in primary care (3rd. ed). Philadlephia, PA: Saunders.

Emotional Vocabulary

- Emotional Intelligence (EI/EQ) includes having a strong emotional vocabulary: Try these
- Angry? Betrayed, humiliated, irritated, dismayed
- Sad? Discouraged, wounded, drained, sorry
- Confused? Bewildered, flustered, hesitant
- Scared? Intimidated, distressed, discouraged
- Happy? Elated, pleased, relieved, reassured

Reflection

Using the space on the handout, take a moment to record two ideas that you might use in the future.

Thank you!

Have a great day

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Managing Emotions in Clinical Education

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KEY CONCEPTS

When emotions run high with a learner

"Check your own pulse first" and remember . . .

- Difficult to respond while *reacting*
- Recognize own beliefs and biases about emotion
- Opportunity to model effective emotion management
- Role as educator—support reflection-in-action (includes emotion)

BATHE Skill

- **B**ackground (Tell me what's been happening)
- **A**ffect (How does it make you feel?)
- **T**rouble (What troubles you *the most*?)
- **H**andling (How have you been handling it?)
- **E**mpathy (That must be terribly difficult.)

Responding with Empathy

- Two dimensions
  - Attending to emotions (relational skill)
  - Responding to emotions (communicative skill)
- Types of responses to *empathic opportunity:*
  - Potential empathic opportunity continuer
  - Empathic response
  - Empathic opportunity terminator

Developing an Emotional Vocabulary

General	More specific
Angry	Betrayed, humiliated, irritated, dismayed, appalled
Sad	Discouraged, wounded, drained, sorry, grieving, disappointed
Confused	Bewildered, flustered, hesitant, unsure, torn
Scared	Intimidated, distressed, discouraged, trapped, out of my depth
Happy	Elated, pleased, relieved, reassured, delighted, flattered, excited

How do you imagine using this information?

PROFESSIONALISM IN ACADEMIA

L. MORELAND, MS,MLS (ASCP)CM

INSTRUCTOR - RUSH UNIVERSITY

DEPT. OF MEDICAL LABORATORY SCIENCE

PROFESSIONALISM

- **Mastery of Theoretical Knowledge**
- **Capacity to Solve Problems**
- **Application of Theoretical Knowledge to Practice**
- **Ability to Create Knowledge as Well as Possess It**
- **Enthusiasm and Commitment to Clients**
- **Commitment to Continuous Learning About the Profession.**

PROFESSIONALISM

Areas of Life

- Home
- School
- Work
  - Future providers
  - Future colleagues

Expectations

- Being responsible and accountable for your actions

PROFESSIONAL IDENTITY

Definition:

- **The identity in which a person chooses to acquire the values, attitudes, interests, abilities and intellect of the group in which they seek to be a member**
  - Students' preconceptions
  - Peers and family
  - Education institution
  - Prior experiences

PROFESSIONAL IDENTITY

Professional socialization

- **The ongoing process or the journey in which one prepares for the occupational role, specifically the manner in which a professional identity is acquired and developed**
  - Community of Practice
  - Legitimate peripheral participation
  - Cognitive apprenticeship
    - Situated learning
  - Zone of Proximal development

PROFESSIONALISM & ACADEMIA

BASIC SKILLS

- Reading
- Writing
- Mathematics
- Listening
- Speaking

THINKING SKILLS

- Creative thinking
- Decision making
- Problem solving
- Learning
- Reasoning

PROFESSIONALISM & ACADEMIA

Personal Qualities

- Responsibility
- Self-Esteem
- Sociability
- Self management
- Integrity

PROFESSIONALISM & WORKPLACE

RESOURCES

- Time
- Money
- Materials/facilities
- Human resources

INTERPERSONAL

- Team player
- Teacher
- Leader
- Negotiates
- Diversity/cultural competence

PROFESSIONALISM & WORKPLACE

INFORMATION

- Acquires and evaluates
- Organizes and Maintains
- Interprets and communicates
- Computers

SYSTEMS

- Organizational
- Performance
- Design improvement

INSTRUCTIONAL STRATEGIES

- **Coursework**
  - Class content (face to face)
    - Interactive activities
    - Audience response technologies
  - Syllabus
    - Affective evaluation component
    - Example
      - "Upon completion of the course, the course director will evaluate the behavior of the student. This will be based on the students' attendance, adherence to safety rules, class preparedness, organizational and time management skills, honesty and integrity, and the ability to follow instructions. The student is expected to behave in a mature manner at all times."

INSTRUCTIONAL STRATEGIES

- **Online Coursework**
  - Assignments
    - Case study response essays
    - Student discussion groups
  - Blackboard Learn
    - Discussion boards-forums
    - Panopto, collaborate, videos
    - Journal, blog, surveys, tests
  - Simulation lab
    - Incorporate professionalism challenges within clinical exercises

INSTRUCTIONAL STRATEGIES

- **Clinicals**
  - Preceptor Affective evaluations
    - Detailed evaluation
    - Behavior descriptions
      - Safety, care & maintenance
      - Honesty, integrity, confidentiality
      - Adherence to work setting protocol
      - Interrelationships with professional personnel and peers
      - Communication skills
      - Reporting, records & assignments
      - Organization, judgement & initiative
      - Professional growth & reaction to stress

TOPICS

Common areas of student professionalism

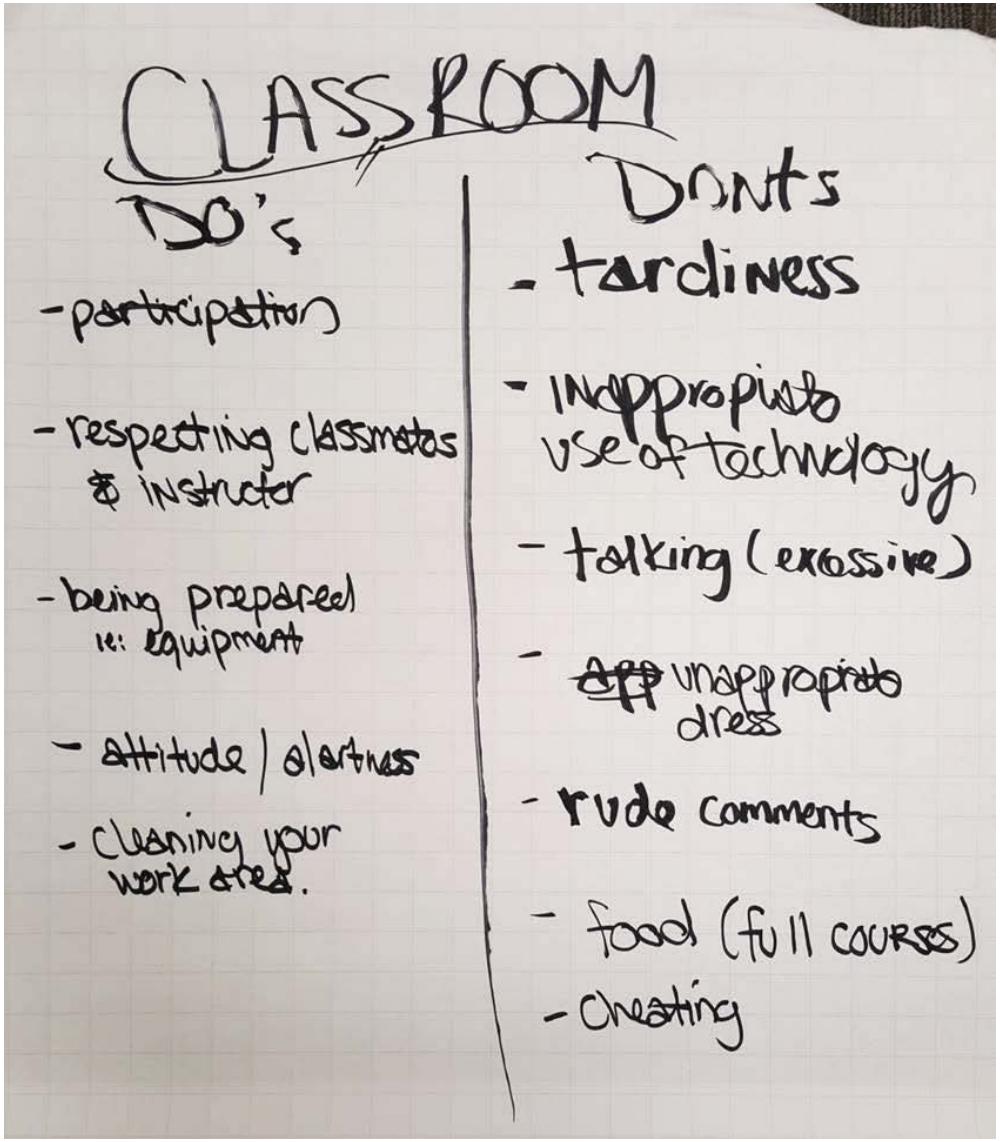
- Classroom etiquette
- Emails
- Student lab
- Assignments
  - Homework
  - Projects
  - Papers
- Clinicals/internships/externships/student employment
- Meetings
  - Advisor
  - Professor, dean
  - Principle investigator
  - employer

CLASSROOM

FACILITATOR

Eating inappropriate food
Showing up late
Talking
Surfing the net for shoes
Sleeping
Cell phones
Interrupting
Showing up the teacher

STUDENTS



EMAIL

FACILITATOR

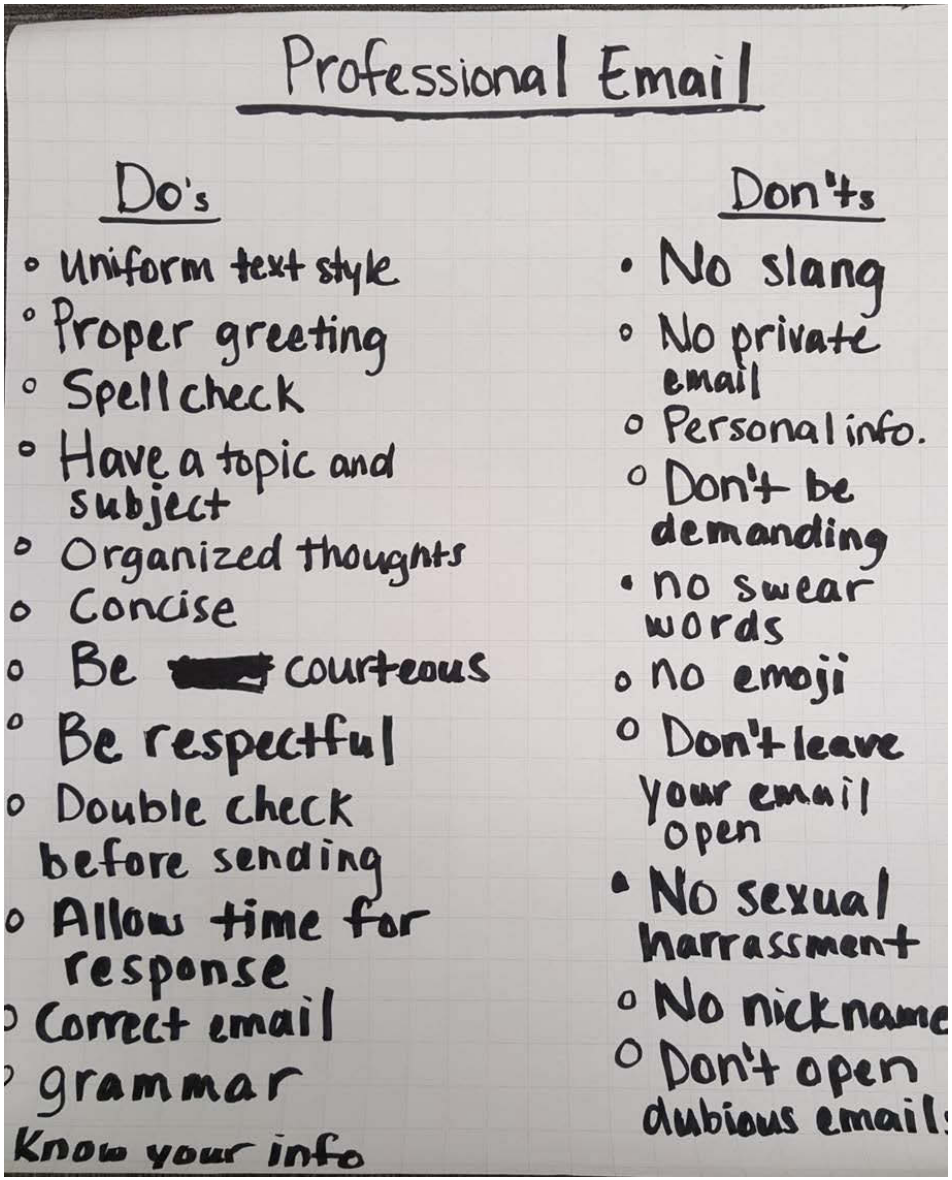
Greetings/salutations

Tone

Icons, abbreviations

Fonts

STUDENTS

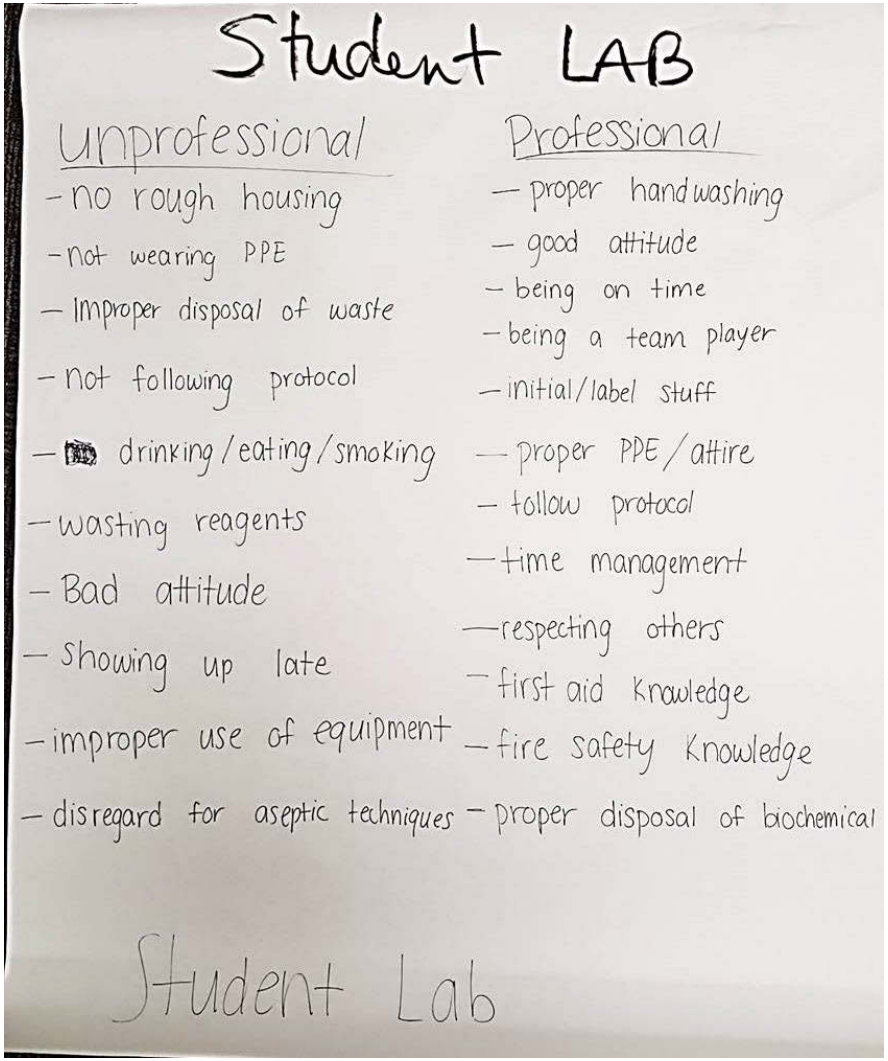


STUDENT LAB

FACILITATOR

- Not using PPE
- Not practicing Aseptic technique
- Horseplay, hot dogging, hijinks
- Skipping/showing up late
- Bringing in inappropriate items
- Leaving early/rushing

STUDENTS

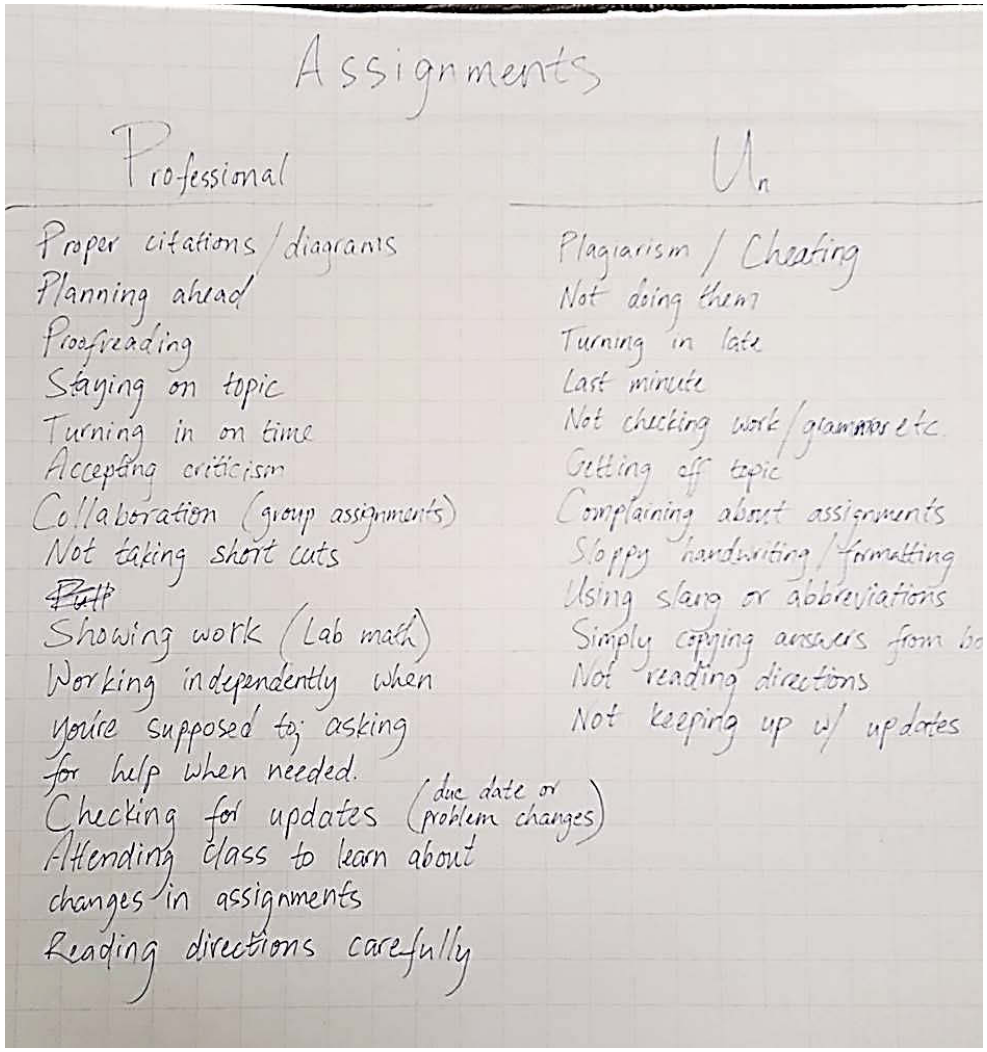


ASSIGNMENTS

FACILITATOR

- **Plagiarism**
- **Turning in late**
- **Not contributing to group work**
- **Jokes, comical**

STUDENTS



CLINICAL ROTATIONS/EMPLOYMENT

FACILITATOR

Tardy, not calling in, AWOL

Sleeping

Not engaged

Using school as an excuse

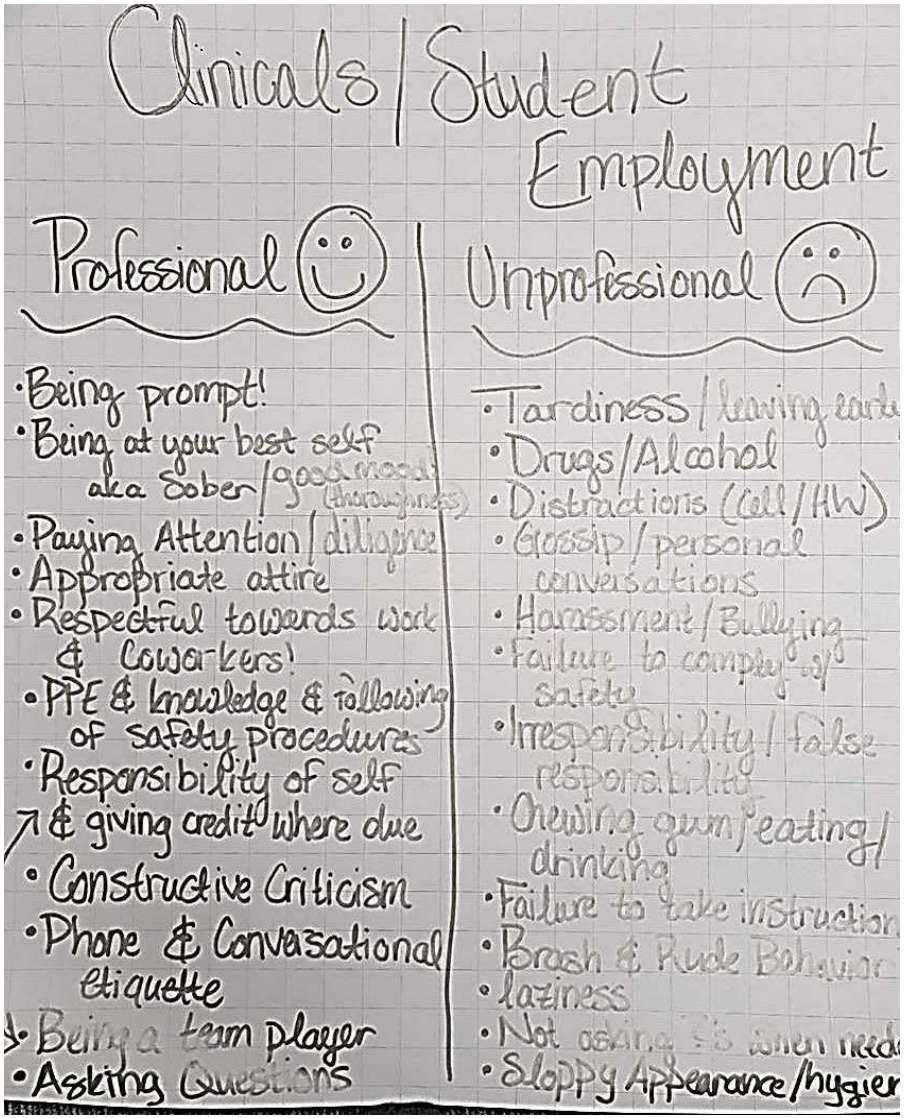
Violating HIPAA

Unpreparedness

Inappropriate behavior

Non-compliance

STUDENTS

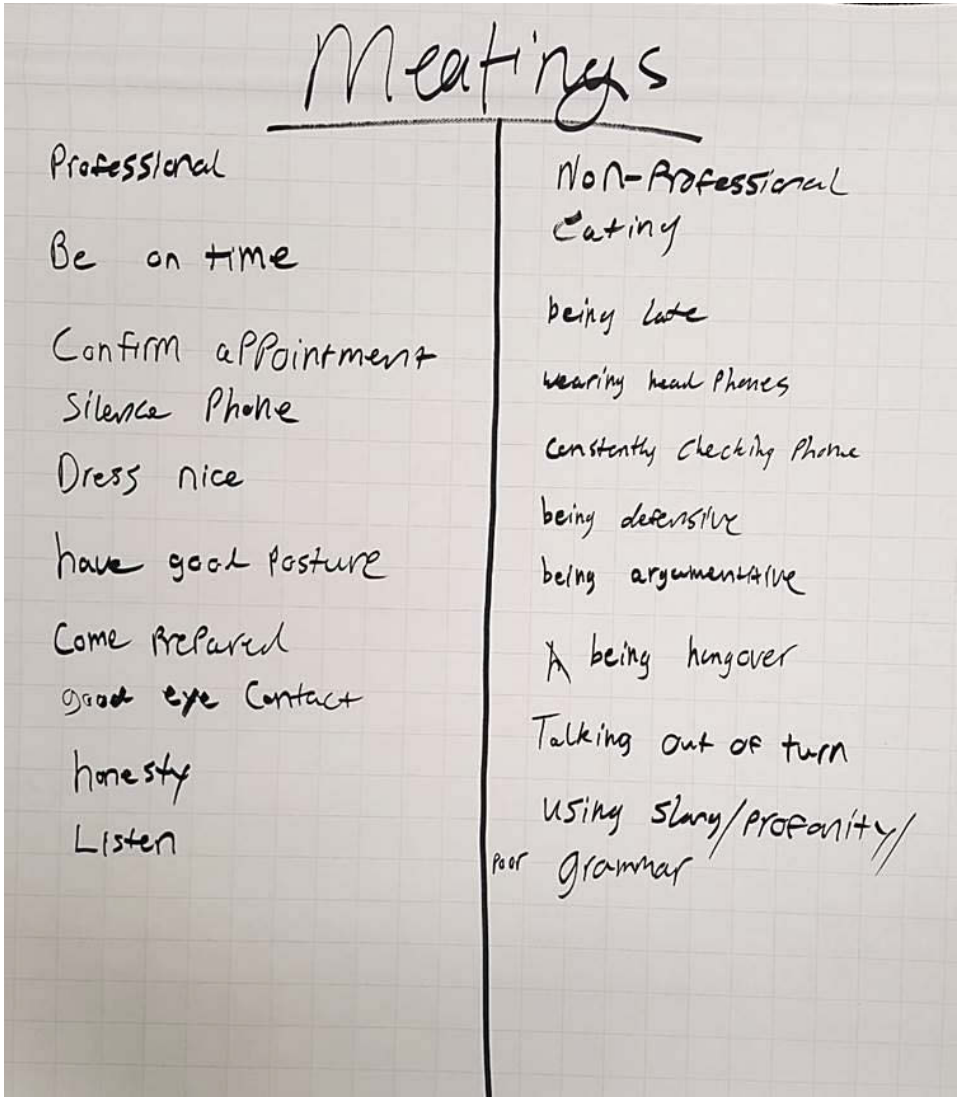


MEETINGS (ADVISOR, TEACHER, PI, DEAN, ETC.)

FACILITATOR

- Not properly making an appt or adhering to office hours
- Being on time
- Rescheduling ahead of time
- Prepared to discuss/questions
- Bringing appropriate materials
- Language, body language
- Valuing their time (researchers)

STUDENTS



SOCIAL MEDIA

FACILITATOR

Bad mouthing

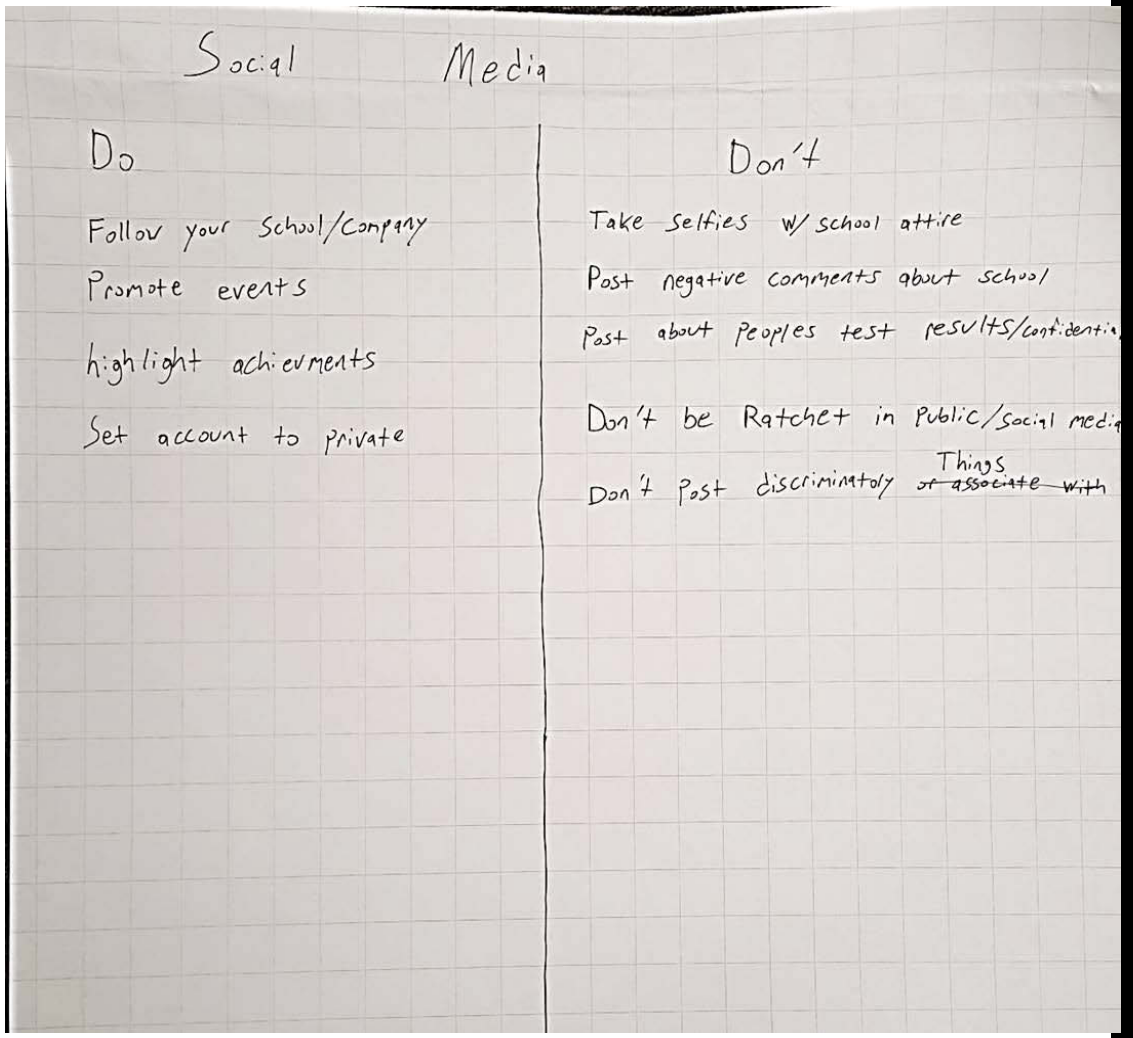
Embellishing the truth

Boasting

Attacking/Cyber bullying

Disclosing personal info

STUDENTS



SOURCES

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Basic skills Bootcamp Chaffey College

www.academicinnovations.com

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RUSH UNIVERSITY

RUSH MEDICAL COLLEGE • COLLEGE OF NURSING • COLLEGE OF HEALTH SCIENCES • THE GRADUATE COLLEGE

(Your) Research Matters! Transforming the Environment for Research Excellence

The Office of Research Affairs
Thomas J. Champagne, Jr. MBA, CM, C.P.M.
Spring 2016

Building Blocks & Words of Thanks

RUSH UNIVERSITY

The need for an Office of Research Affairs has roots in all Rush missions; and, our dedication to advancing knowledge that improves understanding of the human condition.

Today's ORA is a culmination of years devoted to service, I CARE values, and the spirit of Research inquiry. Early leaders, investigators, and ORA staff were intent on being "better tomorrow than we are today".

Particular thanks goes to long-serving faculty, ORA staff members, and supportive senior leaders - most notably, Drs. James Mulshine, Thomas Deutsch, along with Rick Davis, Don Boydston and Tom Wilson, who's collective vision helped establish a framework for our strategic path forward.

We embrace the responsibility to continuously pursue their vision.

Strategic Context & Objectives

RUSH UNIVERSITY

We're advancing six primary objectives to support Rush's Strategic Plans for Research; and strive for "best-in-class" research administration.

Strategic Objectives:

1. Clarify Leadership & Organization
2. Clarify Roles & Responsibilities
3. Deepen Training and Education
4. Document Policies, Procedures, SOPs
5. Increase Res. Admin. Technologies
6. Enhance Compliance Monitoring

Goals & Expected Outcomes:

- ✓ Progress toward **"best-in-class"** research administration
- ✓ Improved **quality, responsiveness, and efficiency** toward PI's & Administrators
- ✓ Improved operational **transparency and communication** with research community

Priorities: People, Process, Outcomes

RUSH UNIVERSITY

Our transformation energy is focused on 3 key variables: people, process, outcomes.

1. People

- Clarifying roles and job duties – eliminating redundancies
- Validating org charts and over 36 position descriptions
- Improving the value of staff investments/overhead

2. Process

- Drafting/vetting over 40 operational policies, procedures, SOPs
- Identifying critical process flows and related training needs
- Reducing time, effort, cost to complete core duties

3. Outcomes

- Consolidating key functions within the ORA
- Promoting data-driven decisions and service-focused operations
- Establishing a platform for growth, increased research capacity, responsiveness & awareness

A Path Forward

The ORA is poised to coordinate more complex research functions with an emphasis on value to the research community, responsiveness to RUMC needs, and operational efficiency.

Cataloguing our Tools for Growth / Transformation:

Volume I: ORA Summary Policies

Volume II: Review of Office Organization and Position Descriptions

Volume III: Framework for Comprehensive Training and Education Programs

Volume IV: Establishing a Comprehensive Compliance and Risk Mitigation Program

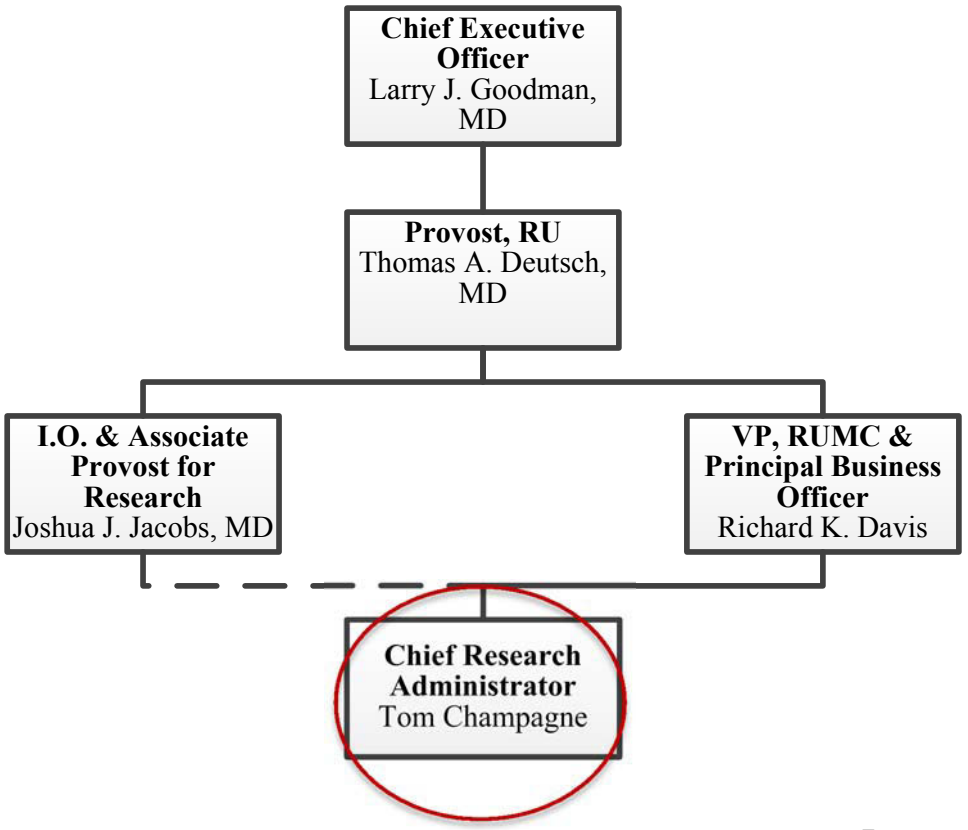
People: Organizing for Accountability

RUSH UNIVERSITY

We have introduced new roles to help hold the ORA more accountable, and to help instill higher levels of service and responsiveness.

Office of Research Affairs:
Consolidated key central research administration functions into a common office (see next page).

Created Chief Administrator role:
The CRA connects to broader institutional leadership to promote the role of research administration across RUMC.



People: Aligning Functions and Defining Divisions

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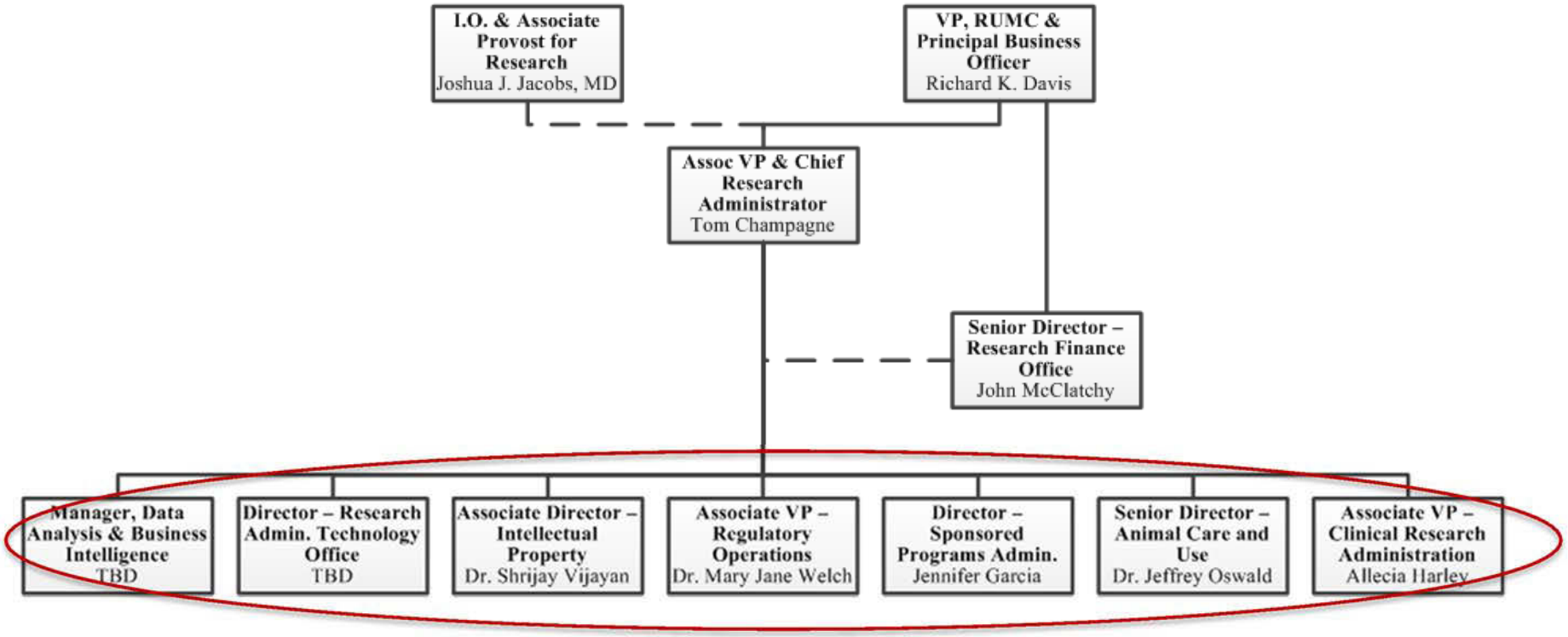
We are restructuring core research administration functions, aligning responsibilities within functions, and clarifying job duties for ORA.



Divisions now encapsulate clear functions, with clear leaders, duties, and organizational structures; relationships across the research enterprise are deepening.

People: Ensuring Leadership Capacity

RUSH UNIVERSITY

Leaders have been distinguished within each Division. Per-person coaching, communication, & engagement drives accountability & fosters succession.








Jennifer Garcia; B.S. Director, Sponsored Programs Administration
Stephanie C. Guzik; BSN, RN, MBA Director, Research Compliance & Integrity Officer*
Allecia A. Harley; MPH Associate Vice President, Clinical Research Administration
John H. McClatchy; B.S., BBA Senior Director, Medical Affairs Finance*
Jeffery P. Oswald; DVM Senior Director, Animal Care & Use
Karl L. Oder, M.S., MSRA Chief IS Architect, Research Information Systems*
Jay Vijayan; Ph.D., MBA Associate Director, Innovation & Technology Transfer
Mary Jane Welch; DNP, APRN, BC, CIP Associate Vice President, Research Regulatory Operations

*not a direct report to ORA

People: Clarifying Levels, Roles, and Responsibilities

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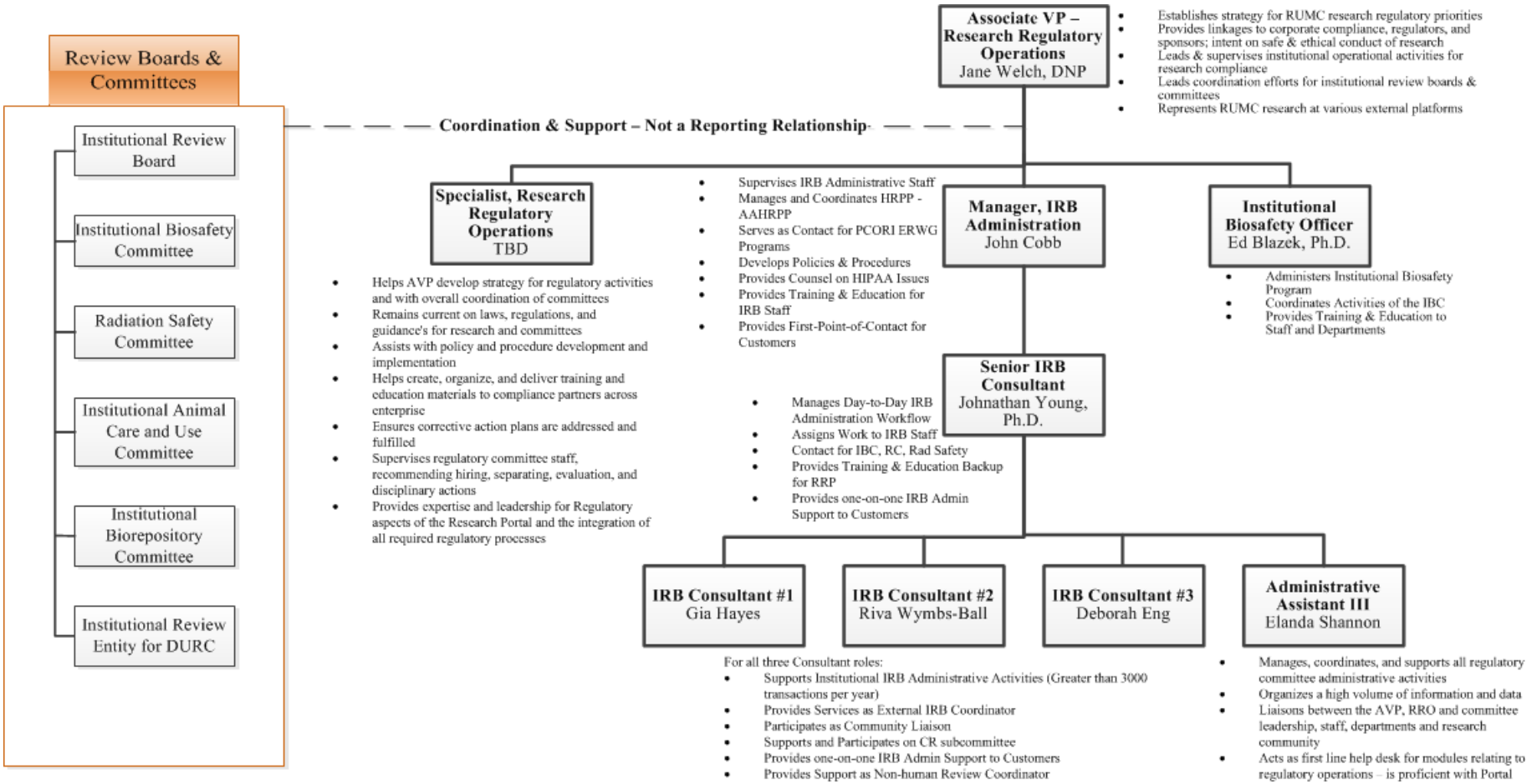
By Division, we're also focused on position leveling, inter-relationships of roles, and duty balance for each staff member within the ORA.



Process: Strengthening Policies, Procedures, SOPs

RUSH UNIVERSITY

To support PI's and staffs, we have drafted and reviewed over 40 policies, procedures and SOPs – ensuring each is inter-connected, bolsters service, satisfies compliance, and reinforces responsiveness & efficiency.

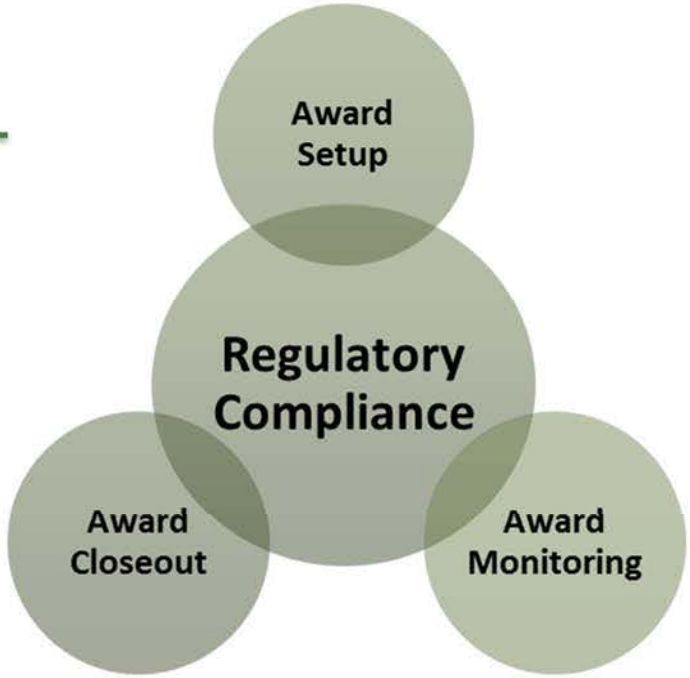
Policy <u>inter-connectedness:</u>
(Illustration connecting SPA & Regulatory)

A. Award Negotiation, Acceptance, Setup

B. Award Monitoring, Maintenance, Reporting

C. Award Reconciliation and Closeout

D. Regulation & Compliance



Process: Improving Training and Education

RUSH UNIVERSITY

We are developing comprehensive training and education programs to incentivize staff performance, promote skills, growth, and encourage professional development.

Flow of Actions:

1. **Identified Essential Competencies**
   Training and Education Matrices inventory key learning objectives

2. **Created Development Plans**
   Curriculum Maps outline staff development timeline

3. **Educated Leadership Team**
   Approach and Delivery satisfy learning & retention approaches

4. **Motivate Individual Behavior**
   Incentive-Based Training promotes external learning opportunities

Process: Enhancing Elements of Compliance

RUSH UNIVERSITY

We are helping to balance the need for compliance with the efforts of Researchers and their staffs – affirming the optimal mix of monitoring and risk mitigation for the size of our portfolio.

Example Actions:

- **Current vs. Desired State and SWOT Analysis**
  - ✓ Present compliance state compared to "best-in-class" compliance standards
- **Industry Gap Analysis and Gap Closure Plan**
  - ✓ Peer evaluation with strategy to better align with industry leaders
- **Roles and Responsibilities Matrix**
  - ✓ Inventory of compliance tasks and identification of compliance partner duties
- **ORA Compliance Duties & Process Maps**
  - ✓ Map of compliance oversight and primary duties by each ORA function

Outcomes: Metrics & Measuring

RUSH UNIVERSITY

We believe that what gets measured, gets done…

- Currently **more than 4 dozen detailed operational metrics are tracked and reported monthly**, by Division, within the ORA:
  - Volumes and Loads
  - Times and Frequencies
  - Complexities & Margins of Error
  - Responsiveness & Turn-around
  - Trends & History
- Still, **too much about "presenting data"** vs. integrating and understanding inter-relationships and causation
- Increasingly **building trust and reliance** – "what are the numbers showing?"
- Eventually, data and key performance indicators **will better inform research decisions**

See Supplemental Handout with Key Outcomes & Indicators…

Moving Forward: What's in it for the Researcher?

RUSH UNIVERSITY

Allegiance to the Research Strategic Plan, a Service Survey, plus:

- More **efficient and effective** research / departmental staff **onboarding**
- Potential administrative **grant writing assistance**/resources
- **"Shared Services" & shared staffing** models to facilitate / support D-Admins
- Concerted **look into Cores** & core services (e.g., Bioinformatics). Stronger **coordination of opportunities** between Chicagoland institutions
- **Enhanced technologies** supporting Research Admin, including LINK, portal improvements, "Profiles", a CTMS, and shared data-dashboards w/real-time grant spending status
- Increased **emphasis on Innovation, Tech Transfer, and Licensing**
- Continuous and proactive **research compliance monitoring** plans
- Targeted, JIT **training & education** for requesting PIs, Co-I's, and research staff

Moving Forward: Continuous, Responsive Strategies

RUSH UNIVERSITY

Over the next several months, the ORA will continue evolving toward a "best-in-class" service unit, supporting Rush's strategic vision for Research.

Internal Verticals			External Verticals	
People Who?	**Process** How?	**Outcomes** What?	**Position** Where?	**Value** Why?
Leadership Capacity	Delegated Authority	Scope & Quality of Work	Today vs Tomorrow	iCARE Values
Organizational Charts & Linkages to Institution	Policy & Procedure Implementation	Link Work to Research Strategic Plan	Exposure & Awareness	Freedom for Personal Expression
Filling Roles & Leveling	Methods & Approaches	Fair & Equitable Work Divisions	Marketing & Branding	Accountability & Ownership
Salary Administration & Incentivization	Data Measurement	Data Outcomes & Adjustments	Customer Service Surveys	Peer Acknowledgement
Training & Education/ Incentives	Communication Plans	Better Tomorrow Than We Are Today	National Landscape & Institutional Capacity	Patient Outcomes & Compassionate Care

Meet the Lab! those Who Really Do the Work…

RUSH UNIVERSITY

Thank you! Your Own Thoughts & Counsel??

RUSH UNIVERSITY

Tom Champagne - x3-2742
Cell 24/7: 312-927-8703

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"Research Affairs by the Numbers"

A. Sponsored Programs Administration:

- 34 # of proposals/Letters of Intent submitted in Feb 2016
- $57.4M dollar value of those Feb proposals

- 27 # of awards to Rush in Feb 2016
- $5.3M dollar value of those awards to over 12 Centers/Depts.

- $47.8M dollar value of awards received July '15 – Feb '16
- 2.8% level of increase over the same period a year ago
- 2.1% drop in Federal research awards over the same period a year ago
- 11.8% rise in industry-sponsored awards over the same period a year ago

B. Innovation, Intellectual Property & Tech Transfer:

- >185 # of invention disclosures filed since 2010

- >130 # of patent applications since 2010
- 28 # of patents issued since 2010

- 31 # of licenses & options executed since 2010,
- >$64M dollar value of related license income to Rush

C. Institutional Animal Care & Use:

- 2,600 # in the current animal census at Rush
- 90% percent of the census represented by rodents

- >23,000 g.s.f. of dedicated care, husbandry & procedure space in Cohn Research Building
- 9 # of dedicated CRC staff

Last updated Apr 2016

D. Clinical Research Administration:

- $10.3M dollar value of CT & Indus Sponsored cash receipts – FY '15
- >$307K dollar value reduction of A/R, >120 days, this fiscal year

- 8% increase in new clinical trial agreements this fiscal year
- 3% increase in new coverage analyses this fiscal year
- 10% increase in new Cancer CT enrollments this fiscal year

- 108 # of Research Nurses & Coordinators supported, enterprise-wide

E. Research Regulatory Operations:

- >1,700 # of active IRB protocols at Rush
- >30 # of currently-serving IRB members

- 6 # of regulatory oversight committees at Rush including planned Biorepository and potential Stem Cell committees

- 8 # of research cores, including a Biological Safety Program

- 60 # of PI consults since Mar '16 inception of "Consultation Services" program

F. Research Administration Technologies:

- 6 # of key technologies supporting Research - including LINK, a research portal, CTMS, Granite, and research website URLs

Last updated Apr 2016

Building a Scholarly Community

Sarah Ailey, PhD, RN, CDDN, APHN-BC
Professor, CSMH, College of Nursing

Olimpia Paun, PhD, PMHCNS-BC
Associate Professor, CSMH, College of Nursing

Rush University Teaching Academy
May 17, 2016

Presentation Objectives

- Define concepts
- Describe the process of building a scholarly community
- Discuss examples

Community defined

- Group of individuals linked by:
  - Shared similar interests
  - Common goals
- Actual and virtual communities
- Examples

http://www.merriam-webster.com/dictionary/community

Scholarship defined

- Serious, formal study or research of a subject
- Fund of knowledge and learning
- Qualities/activities of a scholar

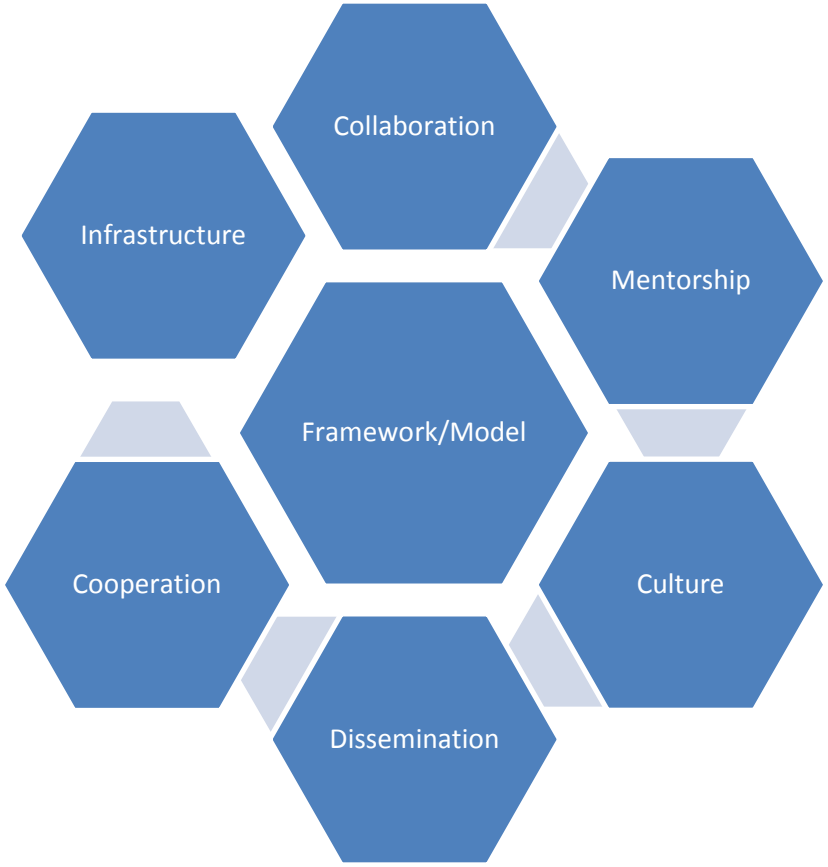
http://www.merriam-webster.com/dictionary/scholarship

Types of Scholarship

- Discovery/knowledge generating
- Integration of knowledge
- Application of knowledge-translation into practice
- Teaching/co-constructed knowledge

Boyer, 1990

Key Ingredients



Practitioner-Teacher Model

-Luther Christman, PhD, RN, first Dean of the Rush University CON

-Knowledge rooted in practice

-Fits with seminal work of Benner “novice to expert” and “radical transformation in nursing” – Benner’s work based on Dreyfus model of skills acquisition

Radical Transformation in Nursing

Describe the scope and depth of nursing

- "Thinking-in-action" and "reasoning-in-transition"
- Clinical reasoning more than abstract decision-making -no matter how useful
- Based on evidence but also knowing that clinical practice and clinical judgment require situated decision-making

Situated Learning

- Benner also calls for situated learning
- Context/environment for developing role
- Context/environment and building role capacities in the environment
- Consider experiences needed to learn

Benner, 2001

Situated learning (cont.)

- Need to contextualize learning
- Concerned with role formation
- Learning takes place
  - same context in which applied
- Social process – knowledge co-constructed by instructors and learners - emphasis on coaching with expert
- Legitimate peripheral participation in communities of practice

Radical Transformation in Nursing

- Describe the scope and depth of nursing
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Collaboration

- Interprofessional teams
  - ➢ Drs. Swanson and Keithley – complementary and alternative therapies studies
    - HIV/AIDS experts, GI/biochemistry researchers
  - ➢ Dr. Farran - dementia caregiver studies
    - RADC and RIHA
  - ➢ Drs. Reed and McNaughton-nutrition and physical activity study
    - Nutrition researcher

Collaboration (cont.)

- Interprofessional teams
  - Drs. Joanne Miller and J. Odiaga – Interprofessional Education Pediatrics through the Ages (IPEPA) funded by the Health Resources and Services Administration (HRSA) to prepare faculty and students from nursing and other disciplines in the care of persons with multiple chronic conditions
  - Drs. Worley and Johnson – Psychiatric Prescri
    Lived Experience with Patients who Engage
    in Doctor Shopping-Dr. Karnick (psychiatry)

Collaboration (cont.)

- Intraprofessional teams

  - Co-investigators from across departments
    - African American Nonresident Fatherhood Program clinical trial
    - Digital Parent Training Program

Mentorship

- Knowledge generating
  - Pairing of senior/junior faculty/pre licensure and doctoral students

    - Dr. Wilbur – Women's Walking Program
    - Dr. Farran – caregiver studies (CSBI/TRAC)
    - Dr. Julion- African American Nonresident Fatherhood Program
    - Dr. Breitenstein – Digital Parent Training Program
    - Dr. Heitschmidt – Pet Pause study (GEM students)- highlighted in the Chicago Tribune

Mentorship (cont.)

- Integration of knowledge

➢ Faculty/students – program expectations

3-manuscript PhD dissertation (1st manuscript is an integrated/systematic review)

- Yambo, t. & Johnson, M. (2014). An integrative review of the mental health of partners of veterans with combat-related posttraumatic stress disorder, *JAPNA,* 20(1), 31-41.
- Bevan, J.L., Senn-Reeves, J. N., Inventor, B.R., Greiner, S. M., Rivard, M.T., & Hamilton, R. J. (2012). Critical social theory approach to disclosure of genomic incidental findings. *Nursing Ethics, 19*(6), 819-828.

Mentorship (cont.)

- Application of knowledge: GEM/DNP student projects
  - •Training protocol for staff on psychiatric units to manage care of patients diagnosed on the Autism Spectrum
  - •Special needs buddies
  - •Care plans for care of persons with Intellectual Disability (ID) hospitalized on psychiatric units
  - •Human Rights Campaign – addressing LGBTQ issues in clinical settings
  - •Reduction in ED visits of persons with ID residing in group homes (3 DNP students collaborated with faculty)
- Mentoring staff nurses at RUMC and ROPH in identifying potential areas in need of further research
  - •Dr. Heitschmidt – advisory/consulting role

Infrastructure

- Office of Research and Scholarship
  - Tangible support
    - Pilot funding
    - Conference support for presenting students and faculty
    - Grant processing staff member
    - Data manager
    - Statisticians
  - Mentorship
    - “Think Tank” regular team meetings for grant proposal development and writing

Infrastructure

- Center for Clinical Research and Scholarship
  - Funded projects 2015-2016
    - Dr. Tanya Friese: Road Home Program at Rush: Empowering and Partnering with our Community
    - Dr. Masako Mayahara: Impact on Digital Pain and Analgesic Diary in Reducing medication Error in a Hospice Setting
    - Dr. Michael Kramer: Anesthesia Crisis Resource Management: Does Simulation Make a Difference?

Infrastructure

- Center for Clinical Research and Scholarship
  - Hospital-based projects:
    - Central Line Maintenance – EBP standardized procedure for central line flushing to decrease occlusion rates
    - Stress reduction initiative – roving massage/yoga caravan
    - Nasal pressure ulcers
    - Patient satisfaction

Infrastructure

- CON Research Committee
  - Mentorship and support for students submitting conference abstracts
  - Practice sessions in preparation for presentations
- Rush University Research Mentorship Program
- Writing Accountability Group

Dissemination

- Rush University Research Days: faculty/students
- GEM, DNP and PhD students consistently represent Rush at regional (MNRS) and national (APNA, APHA) conferences
- Top honors at MNRS
  - GEM, DNP, PhD posters
  - Shannon Halloway, PhD student awarded MNRS doctoral student grant and Best Student paper for 2014, published in WJNR
  - Dr. Mayahara's poster received honorable mention award in 2016

Culture

- Maintaining focus
  - Posted around CON: abstracts of ongoing studies, copies of recently published articles, student/faculty posters
  - Monthly department meetings featuring a faculty researcher
- Celebrating success: Dean-sponsored dinner for students and faculty presenting at major research conferences)

Design Thinking is about believing we can make a difference, and having an intentional process in order to get to new, relevant solutions that create positive impact. Design Thinking gives you faith in your creative abilities and a process for transforming difficult challenges into opportunities for design.

–*Design Thinking for Educators*, IDEO

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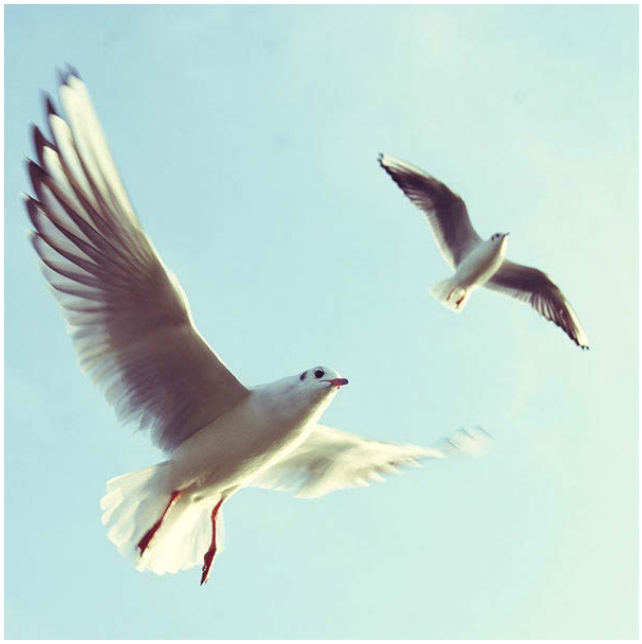

ELEMENTS OF DESIGN THINKING

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- It's **HUMAN-CENTERED**. Start from a place of deep empathy and understanding the needs of people – for our purposes, the students, educators & administrative stakeholders of our institutions.
- It's **COLLABORATIVE**. Multiple perspectives and the leveraged creativity of others can bolster your own.
- It's **OPTIMISTIC**. The fundamental belief here is that we can all create change & make a positive impact. Big-time locus of control stuff!
- It's **EXPERIMENTAL**. Try this one one for a change: *you're supposed to fail*. Sounds icky, right? NO! Design Thinking is about learning from failure, getting feedback, and iterating / improving. Learn by *doing*, and just keep getting better.

QUICK AND DIRTY INTRO VIDEOS

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If you are looking to get a quick overview of Design Thinking, here are some at-a-glance YouTube videos that will catch you up quickly!

- What is Design Thinking, by Daylight (4:20)
- How It Works: Design Thinking, by IBM Think Academy (4:10)
- Design Thinking, IDEO Insights, by Florence Rigneau (1:53)
- Design Thinking in Educational Administration Courses, by John Nash Teaching Channel (2:12)

If you want a slightly longer introduction, 60 Minutes did a feature on David Kelley/IDEO a few years ago. Check it out, if you have about 13 minutes to spare.