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)

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

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.
Topics

• Stress
• Faculty Stressors
• Locus of Control

• Cognitive Restructuring
• Goal Setting
PERFORMANCE

STRESS CURVE

fatigue

exhaustion

laid back

inactive

too little stress (underload)

optimum stress

too much Stress (overload)

burn-out

ineffectiveness

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
Locus of Control

External Locus of Control

Person believes their life is controlled by factors they cannot influence.

Internal Locus of Control

Person believes they can control their life.

Rotter, 1954
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

Which is your locus of control?

Internal locus of control
- You make things happen.
- "I can determine my future."
- "I make things happen."
- "Look what I can do."

External locus of control
- Things happen to you.
- "Why does everything happen to me?"
- "Why bother?"
- "There is nothing I can do about my future."

University of Mississippi Health Care
Thomson Top Hospitals 1000
STRESS REDUCTION METHODS

- Group or Social Support
- Creative Imagery
- Meditation
- Biofeedback
- Breathing Exercises
- Regular Exercise
- Proper Nutrition
- Relaxation Response
  - Quiet Environment
  - Passive Attitude
  - Comfortable Position
- Self-Hypnosis
- Time Management
SMART Goal Setting

- Specific
- Measurable
- Action-Oriented
- Realistic
- Time-Oriented
Discussion?


Graske J. Improving the mental health of doctors. BMJ 2003;327:s188.


Levey RE. Sources of stress for residents and recommendations for programs to assist them. Acad Med 2001;76:142-150.


References

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?
NEW FACULTY ORIENTATION

2015

Katie Struck, Senior Associate General Counsel
Heather Kartsounes, Associate General Counsel
Alissa Bugh, Assistant General Counsel
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
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.
CONTRACT REVIEW AND APPROVAL POLICY

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.
CONTRACT REVIEW AND APPROVAL POLICY

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
Monograph and Serial Costs in ARL Libraries, 1986-2011*

Serial Expenditures (+402%)

Monograph Expenditures (+71%)

Monographs Purchased (10%)

*Includes electronic resources from 1999-2000 onward.
What a magnificent ship! What makes it go?
Budapest Open Access Initiative (2002)

scholars taking their ideas and making their work available for free as a public good
“Spanish” Flu Pandemic of 1918
Infected 500 Million
Killed 50-100 Million (3-5% of world’s population)
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
How does the current system work?
Scientific, technical, medical, legal and business journal publishing is a \textcolor{orange}{US $10 Billion} per year revenue producing market
normal economy
prestige economy

Author

P&T
Grants
Reputation
Prestige

Publisher

Article & copyrights

Journal

Library

$
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
“Publishing obscure academic journals is that rare thing in the media industry: 

*license to print money*”
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

<table>
<thead>
<tr>
<th>Study Type</th>
<th>Count</th>
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</thead>
<tbody>
<tr>
<td>Total number of studies so far</td>
<td>70</td>
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<tr>
<td>Studies that found a citation advantage</td>
<td>46</td>
</tr>
<tr>
<td>Studies that found no citation advantage</td>
<td>17</td>
</tr>
<tr>
<td>Studies that were inconclusive, found non-significant data or measured other things than citation advantage for articles</td>
<td>7</td>
</tr>
</tbody>
</table>

**List of studies to date**

**Summary of results of studies**
Better mining (text and data)

Allows for better discovery within and between disciplines

Especially promising in pharmaceutical, biomedical, and chemical research
“evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients”

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

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
In the next two to five years
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
- Editorial Board
- Reviewers
- MSS process
- Copyright policy
- Funding Source
- Online platform

Aspirations
- Impact
- Reputation/prestige
- Quality of peer review
- Recognized by P&T
- Article quality
- Sustainability
Avoiding predatory publishers
http://gvsu.edu/library/sc/open-access-journal-quality-indicators-2.htm

Open Access Journal Quality Indicators

Open access journals make articles freely available on the Internet, permitting any user to read, download, copy, distribute, print, search or link to the full text. Benefits of publishing in an open access venue may include:

- Increased visibility, usage, and impact of your research
- More efficient dissemination compared with traditional publishing models
- Retention of some or all of your copyrights
- Contribution to societal good by providing scholarly content to a global audience
- Rigor of traditional peer review before publication
- Ongoing feedback through social media

The open access landscape is complex. There are thousands of peer-reviewed open access journals, with new titles emerging rapidly using a variety of models. While there are many high-quality, peer-reviewed open access publications, there are also journals/publishers that engage in unprofessional or unethical practices. The following guidelines are intended to help you evaluate open access publications as you consider appropriate publication venues, or invitations to serve as reviewers or editors.

Note that there is no single criterion that indicates whether or not a publication is reputable. Rather, look for a cumulative effect of more positives or more negatives. If you still have questions, please contact your liaison librarian.

Positive Indicators

- Scope of the journal is well-defined and clearly stated
- Journal’s primary audience is researchers/practitioners
- Editors, editorial board are recognized experts in the field
- Journal is affiliated with or sponsored by an established scholarly society or academic institution
- Articles are within the scope of the journal and meet the standards of the discipline
- Any fees or charges for publishing in the journal are easily found on the journal website and clearly explained
- Articles have DOI (Digital Object Identifier, e.g., dx.doi.org/10.1111/1752-9548.2011.00024.x)
- Journal clearly indicates rights for use and re-use of content at an arbitrary level (e.g., Creative Commons CC BY license)
- Journal has an ISSN (International Standard Serial Number, e.g., 1234-5678)
- Publisher is a member of Open Access Scholarly Publishers Association
- Journal is registered in UlrichsWeb Global Serials Directory
- Journal is listed in the Directory of Open Access Journals
- Journal is included in subject databases and/or indexes

Negative Indicators

- Journal web site is difficult to locate or identify
- Publisher “About” information is absent on the journal’s web site
- Publisher direct marketing (e.g., spamming) or other advertising is obtrusive
- Instructions to authors information is not available
- Information on peer review and copyright is absent or unclear on the journal web site
- Journal scope statement is absent or extremely vague
- No information is provided about the publisher, or the information provided does not clearly indicate a relationship to mission to disseminate research content
- Repeat basic authors in same issue
- Publisher has a negative reputation (e.g., documented examples in Chronicle of Higher Education, list-serves, etc.)
Many OA journals offer:

- better support for authors
- shorter time to publication
- rapid dissemination
- more eyes on the page
- better feedback to authors about use
- let authors keep copyrights
Pain-free publishing for your best science.

Randy Schekman
2013 Nobel Laureate, Editor-in-Chief

"It’s no longer necessary to endure endless cycles of revision and requests for new experiments. eLife editors, who are all working scientists, commit to providing clear and constructive feedback quickly."

Watch video
Why publish with us?

SPEED
Get your results out fast
Initial decisions are made in a few days, post-review decisions in about a month, and most articles go through only one round of revision. Every author also has the option to make their accepted manuscript openly available shortly after receiving a final decision.

GREAT BACKING
We support early career scientists
To support job, tenure and funding applications, the eLife Senior editor who handles your paper is willing to write a letter of recommendation that describes the significance of your article.

REVIEW PROCESS
Taking the pain out of peer review
The scientist editors who run eLife will give you feedback that's constructive and fair. If invited to revise your work, you’ll receive a single consolidated list of comments, so that you know exactly what you need to do to get your work published.

RESEARCH ASSESSMENT
eLife will not promote the Impact Factor
We’ll promote your work, and provide quantitative and qualitative indicators about its reach and influence. eLife is working to expand and enrich the concept of research impact beyond the use of a single number and a journal name.

REACH
Get great exposure
eLife papers get great media coverage in venues like the New York Times and National Geographic. We make every paper more accessible to a broad set of readers – including students, colleagues in other fields, and the public – through Impact statements, plain language summaries (eLife Digests), and selected expert commentaries (eLife Insights). eLife articles are immediately and freely available to the world – and there's no cost to publish.

COMMUNITY DRIVEN
Scientists make the decisions
eLife is a unique, non-profit, researcher-driven initiative. Editorial decisions are made exclusively by working scientists in your field.
Porcine Research
ISSN: 2248-311X (Print); 2248-311X (Online)
Double blind peer review
Subject: Agriculture; Animal culture
Date added to DOAJ: 26 May 2015

Journal of Endoscopic and Minimally Invasive Surgery in New JEMS
ISSN: 2283-7116 (Online)
http://jemis.rivisteclueb.it/
Double blind peer review
Subject: Medicine; Surgery
Date added to DOAJ: 18 Oct 2014

Revista Cuidarte
ISSN: 2216-0973 (Print); 2346-3414 (Online)
http://revistas.udes.edu.co/site/index.php/cuidarte
Double blind peer review
Subject: Medicine; Nursing
Date added to DOAJ: 27 Jul 2015

Revista Chilena de Fonoaudiología
ISSN: 0717-4659 (Print); 0719-4692 (Online)
http://www.revfono.uchile.cl/
Double blind peer review
Subject: Medicine; Internal medicine; Neurosciences; Biological psychiatry; Physiology; Neurophysiology and neuropsychology
Journal of Endoscopic and Minimally Invasive Surgery in Newborn, Children and Adolescent

2283-7116 (Online)

Publisher: CLUEB
Country of publisher: Italy
Date added to DOAJ: 18 Oct 2014

LCC Subject Category: Medicine: Surgery
Publisher's keywords: Endoscopic Surgery, Minimally Invasive Surgery, Pediatric Surgery
Language of fulltext: English
Full-text formats available: PDF, HTML

Publication Charges
- Article Processing Charges (APCs): No.
- Submission Charges: No.
- Waiver policy for charges? No.

Editorial Information
- Double blind peer review
- Editorial Board
- Aims and scope
- Instructions for authors
- Time From Submission to Publication: 12 weeks

Volumes
# Article Processing Charges

for journals in the Directory of Open Access Publishing

<table>
<thead>
<tr>
<th>Journal</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cell Reports</td>
<td>$5,000</td>
</tr>
<tr>
<td>PLoS ONE</td>
<td>$1,350</td>
</tr>
<tr>
<td>PeerJ (prepay)</td>
<td>$ 99</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>$ 964</td>
</tr>
</tbody>
</table>

70% charge nothing at all!**

http://sustainingknowledgecommons.org/2014/10/20/open-access-article-processing-charges-doaj-survey-may-2014/

Open Access Publishing

Effectively managed author rights

Digital repositories

Open Access Policies and Mandates
Most researchers do not know that copyrights can be negotiated—instead, they sign whatever is put in front of them from the publisher.
Who Controls Your Dissertation?

Jesse Stommel
Assistant Professor at University of Wisconsin-Madison
And here is the license being granted to Turnitin, according to its **usage policy**: “non-exclusive, royalty-free, perpetual, world-wide, irrevocable license to reproduce, transmit, display, disclose, and otherwise use your Communications on the Site or elsewhere for our business purposes. We are free to use any ideas, concepts, techniques, know-how in your Communications for any purpose, including, but not limited to, the development and use of products and services based on the Communications.”

---

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

He is the director of *Hybrid Pedagogy*, a digital journal of learning, teaching, and technology.
Excerpt from Copyright Transfer instructions to Authors:

“In consideration of LWW’s publication of the Work, the author hereby transfers, assigns and otherwise conveys all his/her copyright ownership worldwide, in all languages, and in all forms of media now or hereafter known, including electronic media such as CD-ROM, Internet, and intranet, to American Contact Dermatitis Society.”
Possible talking points with graduate students and early career researchers

We own copyrights until we sign them away.

Contracts are by nature negotiable, including publishing contracts.

Think ahead as to how you *might* want to use your work and try to reserve those rights for yourself.

Experiment with CC license or try attaching an addenda to the publishing agreement. It doesn’t negate peer review or threaten your chance of being published, though you may get a ‘no’ back.
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80% of research is publicly funded


www.sparc.arl.org
NIH Mandate

1 Million users access
3 Million+ articles a day

Users: 25% university personnel
       17% business companies
       40% general public
Big Data to Knowledge (BD2K)
Dr. Philip Bourne, Assoc. Dir. for Data Science at NIH

BIOMEDICAL BIG DATA EXPLOSION

NIH National Center for Biotechnology Information
DATA STORAGE

- In 1990 fit on 3 floppy disks
- In 1993 fit on 1 CD-ROM
- In 2014 could fill 400 MILLION 4-drawer filing cabinets

Types of BD2K Awards

- Enabling Data Utilization
- Analysis Methods and Software
- Enhancing Training
- Centers of Excellence

NIH Big Data to Knowledge (BD2K) is an initiative of the National Institutes of Health
FASTR Bill (S.779/H.R.1477)
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23 federal agencies
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We envision a world in which there is free and unrestricted access to information on malaria, independent of geographical locality or socio-economic status. Knowledge empowers. Empowered people prevent and control malaria better.
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Launched in Summer 2009

Built around the Student Statement on the Right to Research: access to research is a student right

International alliance of 75+ graduate & undergraduate student organizations, representing nearly 7 million students in over 100 countries worldwide
Setting the Default to Open
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

Elissa Foster, PhD
Associate Professor
Jay Baglia, PhD
Associate Professor
College of Communication
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
Difficult Learning Situations

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

2015 – 2016 Teaching Academy

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

Rush University Medical Center
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
1. 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
### Microskills

- Get a commitment
- Probe for supporting evidence
- Correct mistakes
- Reinforce what was done right
- Teach a “general rule”

### Script examples

- “Tell me what you were thinking when you . . . ?”
- “What led you to that decision?”
- “Your approach seems reasonable, but here’s where you went wrong . . .”
- “What *did* work well was the way you . . .”
- “When you face situations like this in the future, you need to remember . . .”
## Microskills

- Get a commitment
- Probe for supporting evidence
- Correct mistakes
- Reinforce what was done right
- Teach a “general rule”

## Script examples

- “Tell me what you were thinking when you . . . ?”
- “What led you to that decision?”
- “Your approach seems reasonable, but here’s where you went wrong . . .”
- “What *did* work well was the way you . . .”
- “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
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

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)

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<td>Reinforce what was right</td>
<td>“What did work well was the way you . . .”</td>
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<tr>
<td>Teach a general rule</td>
<td>“When you face situations like this in the future, you need to remember . . .”</td>
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Which will you try next?

What questions remain?
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**
Identify how professional health care providers and patients and their families interpret the meaning of the illness through different lenses (biomedical vs. biopsychosocial models).

**Objective #2**
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

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<th>Bio+psychosocial – Voice of the Lifeworld</th>
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<td>• Subjective</td>
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<td>• Focused &amp; Specific</td>
<td>• Diffuse</td>
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<td>• Evidence</td>
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<td>▫ Symptoms,</td>
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<td>▫ Tests, Lab Results</td>
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<td>• Medical Chart</td>
<td>• Feelings</td>
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<td>▫ Thoughts &amp; Emotions</td>
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<td>▫ Pain &amp; Discomfort</td>
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<td>• Curing</td>
<td>• Narrative</td>
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<tr>
<td>• “Disease”</td>
<td>• Healing</td>
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<td>• “Illness”</td>
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Communication Implications

**Biopsychosocial**
- Detached concern
- Treating the whole person
  - Each patient is unique

**Biomedical**
- Depersonalization
- 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.

2015 – 2016 Teaching Academy

Jay Baglia, PhD
Associate Professor
Elissa Foster, PhD
Associate Professor
College of Communication
Teaching Patient-Centeredness
Jay Baglia, PhD                Elissa Foster, PhD
Associate Professor           Associate Professor
wbaglia@depaul.edu

KEY CONCEPTS

Biomedical Model               Bio+Psychosocial Model

- Objective
- Focused & Specific
- Evidence
  - Symptoms,
  - Tests, Lab Results
- Medical Chart
- Curing
- “Disease”                   - Subjective
                           - Diffuse
                           - Feelings
                           - Thoughts & Emotions
                           - Pain & Discomfort
                           - Narrative
                           - Healing
                           - “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


Teaching Health Literacy

From Micro to Macro for Providers & Systems

Teaching Academy 2015-2016

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

Basic Communication Process

1. Start with a message
2. Transmitter encodes the message
3. Encoded message is transmitted
4. Encoded message is received
5. Receiver decodes the message
Other (better?) Models

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

<table>
<thead>
<tr>
<th>INSTEAD OF</th>
<th>USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accompany</td>
<td>Go with</td>
</tr>
<tr>
<td>Comply with</td>
<td>Follow</td>
</tr>
<tr>
<td>Designate</td>
<td>Appoint, choose, name</td>
</tr>
<tr>
<td>Facilitate</td>
<td>Ease, help</td>
</tr>
<tr>
<td>Indication</td>
<td>Sign</td>
</tr>
<tr>
<td>Methodology</td>
<td>Method</td>
</tr>
<tr>
<td>Pertaining to</td>
<td>About, of, on</td>
</tr>
<tr>
<td>Subsequently</td>
<td>After, later, then</td>
</tr>
<tr>
<td>Warrant</td>
<td>Call for, permit</td>
</tr>
<tr>
<td>Prioritize</td>
<td>Rank</td>
</tr>
</tbody>
</table>

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?
### Attributes

<table>
<thead>
<tr>
<th>Internal</th>
<th>External</th>
</tr>
</thead>
</table>
| • 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 they 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
Jay Baglia, PhD         Elissa Foster, PhD
Associate Professor    Associate Professor
wbaglia@depaul.edu

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.


FURTHER READING


Managing Emotion in Clinical Teaching
Offering Guidelines and Options for Quality Interaction

Elissa Foster, PhD
Associate Professor
Director, MA Health Communication
College of Communication
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\textsuperscript{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.)

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
Managing Emotions in Clinical Education
Elissa Foster, PhD
Associate Professor
(efoste10@depaul.edu)

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)

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

BATHE Skill
- **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.)

Developing an Emotional Vocabulary

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

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

DO'S
- Participation
- Respecting classmates & instructor
- Being prepared & equipment
- Attitude & alertness
- Cleaning your work area

DON'TS
- Tardiness
- Inappropriate use of technology
- Talking (excessive)
- Appropriate dress
- Rude comments
- Food (full course)
- Cheating
EMAIL

FACILITATOR

Greetings/salutations
Tone
Icons, abbreviations
Fonts

STUDENTS

Professional Email

Do's
- Uniform text style
- Proper greeting
- Spell check
- Have a topic and subject
- Organized thoughts
- Concise
- Be courteous
- Be respectful
- Double check before sending
- Allow time for response
- Correct email grammar
- Know your info

Don'ts
- No slang
- No private email
- Personal info.
- Don't be demanding
- No swear words
- No emoji
- Don't leave your email open
- No sexual harassment
- No nickname
- Don't open dubious emails
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

<table>
<thead>
<tr>
<th>Unprofessional</th>
<th>Professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>- no rough housing</td>
<td>- proper hand washing</td>
</tr>
<tr>
<td>- not wearing PPE</td>
<td>- good attitude</td>
</tr>
<tr>
<td>- improper disposal of waste</td>
<td>- being on time</td>
</tr>
<tr>
<td>- not following protocol</td>
<td>- being a team player</td>
</tr>
<tr>
<td>- drinking/eating/smoking</td>
<td>- initial/label stuff</td>
</tr>
<tr>
<td>- wasting reagents</td>
<td>- proper PPE/attire</td>
</tr>
<tr>
<td>- bad attitude</td>
<td>- follow protocol</td>
</tr>
<tr>
<td>- showing up late</td>
<td>- time management</td>
</tr>
<tr>
<td>- improper use of equipment</td>
<td>- respecting others</td>
</tr>
<tr>
<td>- disregard for aseptic techniques</td>
<td>- first aid knowledge</td>
</tr>
<tr>
<td></td>
<td>- fire safety knowledge</td>
</tr>
</tbody>
</table>

Student Lab
ASSIGNMENTS

FACILITATOR

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

STUDENTS

Professional
- Proper citations/diagrams
- Planning ahead
- Proofreading
- Staying on topic
- Turning in on time
- Accepting criticism
- Collaboration (group assignments)
- Not taking short cuts
- Effort
- Showing work (Lab work)
- Working independently when you’re supposed to asking for help when needed
- Checking for updates (prob. changes)
- Attending class to learn about changes in assignments
- Reading directions carefully

Unprofessional
- Plagiarism/Cheating
- Not doing them
- Turning in late
- Last minute
- Not checking work/grammar etc.
- Getting off topic
- Complaining about assignments
- Sloppy handwriting/submitting using slang or abbreviations
- Simply copying answers from b.
- Not reading directions
- Not keeping up w/ updates
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

Professional ☺
- Being prompt!
- Being at your best self
- Appropriate attire
- Respectful towards work & coworkers!
- PPE & knowledge & following of safety procedures
- Responsibility of self & giving credit where due
- Constructive Criticism
- Phone & Conversational Etiquette
- Being a team player
- Asking Questions

Unprofessional ☹
- Tardiness / leaving early
- Drugs / Alcohol
- Distractions (cell / HW)
- Gossip / personal conversations
- Harassment / Bullying
- Failure to comply / safety
- Responsibility / false responsibility
- Owning own / eating / drinking
- Failure to take instructions
- Rude & Rude Behavior
- Laziness
- Not asking if not sure / asking
- Sloppy Appearance / hygiene
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

Professional
Be on time
Confirm appointment
Silence phone
Dress nice
Have good posture
Come prepared
Good eye contact
Honesty
Listen

Non-Professional
Eating
Being late
Wearing head phones
Constantly check phone
Being defensive
Being argumentative
In being hangover
Talking out of turn
Using slang/profanity
Poor grammar
SOCIAL MEDIA

FACILITATOR
- Bad mouthing
- Embellishing the truth
- Boasting
- Attacking/Cyber bullying
- Disclosing personal info

STUDENTS

Do
- Follow your school/company
- Promote events
- Highlight achievements
- Set account to private

Don’t
- Take selfies w/school attire
- Post negative comments about school
- Post about people’s test results/content
- Don’t be ratchet in public/social media
- Don’t post discriminatory orassociate with
SOURCES


Basic skills Bootcamp Chaffey College

www.academicinnovations.com


Smith, Susan (2008). “Professional Dog Trainers: How we measure up?” *Texas small library association*
(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
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.
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

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Degree(s), Certification(s)</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jennifer Garcia</td>
<td>B.S.</td>
<td>Director, Sponsored Programs Administration</td>
</tr>
<tr>
<td>Stephanie C. Guzik</td>
<td>BSN, RN, MBA</td>
<td>Director, Research Compliance &amp; Integrity Officer*</td>
</tr>
<tr>
<td>Allecia A. Harley</td>
<td>MPH</td>
<td>Associate Vice President, Clinical Research Admin.</td>
</tr>
<tr>
<td>John H. McClatchy</td>
<td>B.S., BBA</td>
<td>Senior Director, Medical Affairs Finance*</td>
</tr>
<tr>
<td>Jeffery P. Oswald</td>
<td>DVM</td>
<td>Senior Director, Animal Care &amp; Use</td>
</tr>
<tr>
<td>Karl L. Oder, M.S., MSRA</td>
<td></td>
<td>Chief IS Architect, Research Information Systems*</td>
</tr>
<tr>
<td>Jay Vijayan, Ph.D., MBA</td>
<td></td>
<td>Associate Director, Innovation &amp; Technology Transfer</td>
</tr>
<tr>
<td>Mary Jane Welch</td>
<td>DNP, APRN, BC, CIP</td>
<td>Associate Vice President, Research Regulatory Ops</td>
</tr>
</tbody>
</table>

*not a direct report to ORA
People: Clarifying Levels, Roles, and Responsibilities

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

Review Boards & Committees

- Institutional Review Board
- Institutional Biosafety Committee
- Radiation Safety Committee
- Institutional Animal Care and Use Committee
- Institutional Biorepository Committee
- Institutional Review Entity for DURC

---

Specialist, Research Regulatory Operations TBD

- Helps AVP develop strategy for regulatory activities and with overall coordination of committees
- Remains current on laws, regulations, and guidelines for research and committees
- Aims to policy and procedure development and implementation
- Helps create, organize, and deliver training and education materials to compliance partners across enterprise
- Ensures corrective action plans are addressed and fulfilled
- Supervises regulatory committee staff, recommittees (increasing, separating, evaluating, and disciplinary actions)
- Provides expertise and leadership for Regulatory aspects of the Research Portal and the integration of all required regulatory processes

Manager, IRB Administration John Colb

- Supervises IRB Administrative Staff
- Manages and Coordinates HARP - AAPHP
- Provides Contact for PCORI ERWG Programs
- Develops Policies & Procedures
- Provides Counsel on HIPAA issues
- Provides Training & Education for IRB Staff
- Provides Fine-Points of Contact for Customers

Associate VP – Research Regulatory Operations Jane Welch, DNP

- Establishes strategy for RUMC research regulatory priorities
- Provides linkage to corporate compliance, regulation, and sponsorship
- Rectifies efforts for institutional review boards & committees
- Responsible for RUMC research at various external platforms

Institutional Biosafety Officer Ed Blazeck, Ph.D.

- Administers Institutional Biosafety Program
- Coordinates Activities of the BRS
- Provides Training & Education to Staff and Departments

Senior IRB Consultant Johnathan Young, Ph.D.

- Manages Day-to-Day IRB Administration Workflow
- Assigns Work to IRB Staff
- Contact for IRB, Inc. Research Safety
- Provides Training & Education for IRP
- Provides on-call for IRB Admin Support to Customers

IRB Consultant #1 Gin Hayes

- Supports Institutional IRB Administrative Activities (Greater than 3000 transactions per year)
- Provides Services on Internal IRB Coordination
- Participates in Community Liaison
- Supports and Participates on GR subcommittee
- Provides one-on-one IRB Admin Support to Customers
- Provides Support as Non-human Review Coordinator

IRB Consultant #2 Riva Wymne-Ball

IRB Consultant #3 Delores Eng

Administrative Assistant III Elaida Shannon

- Manages, coordinates, and supports all regulatory committee administrative activities
- Organizes a high volume of information and data
- Liaisons between the IRB (IRB) and committee leadership, staff, departments and research community
- Acts as the first line help desk for modules relating to regulatory operations - proficient with Portal
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 inter-connectedness:**
(Illustration connecting SPA & Regulatory)

A. Award Negotiation, Acceptance, Setup

B. Award Monitoring, Maintenance, Reporting

C. Award Reconciliation and Closeout

D. Regulation & Compliance
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

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

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?

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

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

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Internal Verticals

External Verticals
Meet the Lab! those Who Really Do the Work...
Thank you! Your Own Thoughts & Counsel??

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

Tom_Champagne@rush.edu
“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
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

- Infrastructure
- Collaboration
- Framework/Model
- Mentorship
- Cooperation
- Culture
- Dissemination
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
- “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
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 Prescribers’ 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)


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

ELEMENTS OF DESIGN THINKING
- - - - X

- 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

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](https://www.youtube.com/watch?v=5tR4yDTuN74) a few years ago. Check it out, if you have about 13 minutes to spare.