Professionalism and Leadership in Practice (PLP) Curriculum Enhancement
The Wright Center for GME

Professionalism and Leadership in Practice
Curriculum Enhancement for TWC-NFMR
Lead and POC: Meaghan Ruddy, MA, PhD
Contributors: WCGME and SOMA Teams

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PLP Concept: To enhance the training experience for NFMR residents and other stakeholders in the clinical learning environment by intentionally engaging in professionalism and leadership development within the existing curriculum framework.

Instructional Goal: The instructional goal for this curriculum enhancement is to increasing care team effectiveness via exposure to concepts and just-in-time active learning regarding team organization, team dynamics, and team work. A breakdown of the instructional goals for this curriculum enhancement are displayed in the table below.

GOALS	Content	Process	Premise
Knowledge	(KC) PLP concept, rationale for PCTE grant	(KP) How PLP program works	(KP2) How PLP changes teams
Skills	(SC) Roles/ QI	(SP) Navigating the nexus of the care team roles	(SP2) What skills each member brings to the team
Attitudes	(AC) Power/SEL/ Leadership styles	(AP1) Best practice use of power dynamics, SEL, and leadership styles	(AP2) How each role responds and can best respond in relation to others
Behaviors	(BC) Coaching/Mentoring/ Teaching/ Advising*	(BP1) Best practice use of CMTA	(BP2) How each role engages and can best engage in relation to others

*Advising seems a more appropriate term than consulting given this domain is education. In a non-education domain, consulting may be a better term.

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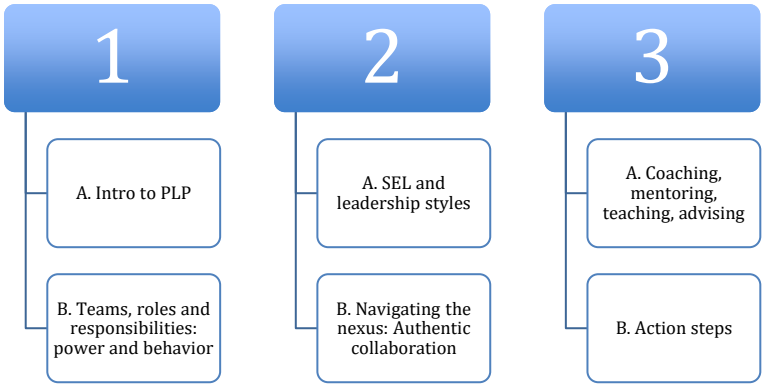
Elements:
6-month cycle consisting of:

1) Flipped classroom work and just-in-time action steps
2) 30-min seminars
3) Group and individual coaching during sessions and via email/ teleconference as needed

Progression:
Participants will progress through the curriculum as outlined below:

(1) Months 1-2: Team Organization
(2) Months 3-4: Team Dynamics
(3) Months 5-6: Team Work

Subsequent 6 month intervals will engage previous program participants as local champions in a cycle such that post-funding period the program processes and outcomes will be sustained via PLP's integration into the culture of the delivery site.



Session Delivery: in-person during weekly meetings, folded into pre-planned topics if possible such as performance measures or clinic-wide information session.

Pilot and Round 1 coaching/ facilitation to be led by Dr. Meaghan Ruddy, MA PhD, BCC. Subsequent round coaching to be led by previous participants.

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Session Outlines: Content informed by CLER expectations, IPEC Core Competencies and CPRs for ACGME Residency programs

1. **Team Organization**
   - **A. Intro to PLP: introduction to the program**
     Objectives: Discuss and summarize the PLP program and its relation to the PCTE grant; describe and discuss the sessions and processes of the PLP program; choose a clinic operational (costs, efficiencies, etc) and/ or patient population health outcome metric

     Brief discussion: PCTE grant and big picture; overview of sessions and processes
     Materials: Enhancement program packet: grant abstract, ACGME and IPEC competencies, CLER Pathways
     Discussion: Chose clinic metrics of interest
     Materials: Team choses metrics for baseline and progress measuring
     Discussion: Group coaching on status quo and next steps

   - **B. Team, roles, and responsibilities**
     Objective: Appraise team-based care delivery as it is occurring in the clinical learning environment (CLE)
     Discussion: who does what, why and how?
     Materials: IPEC competencies
     Activity: What are the roles in your team? How does each impact your selected metrics?
     Discussion: Group coaching on status quo and next steps

   - **C. Power, behavior, and roles**
     Objective: Appraise the impacts of different types of power on care team dynamics
     Discussion: How power impacts behaviors and roles in the care team and what to do about it
     Materials: Information on C-IQ
     Discussion: Group coaching on status quo and next steps

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2. Team Dynamics

A. SEL and leadership style

Objectives: Determine care team member leadership styles and E-IQ; Appraise how styles and E-IQ impact team care delivery; Appraise how SEL concepts may impact team care delivery

Discussion: what is your leadership style, how does it impact your care team collaboration and how might SEL help?

Materials: SEL readings and EI self-assessment
https://hbr.org/2015/06/assessment-whats-your-leadership-style

Discussion: Group coaching on status quo and next steps

B. Navigating the nexus: Authentic co-creation

Objectives: Evaluate and implement best practices for integrating styles and IQs into care delivery

Discussion: Servant leadership and psychological safety during care in real time

Activity: team discusses real cases

Discussion: Group coaching on status quo and next steps

3. Team Work

A. Coaching, mentoring, advising and teaching (CMAT)

Objective: Define the differences between coaching, mentoring, advising, and teaching and determine what each team member can do to coach, mentor, advise and teach other team members

Discussion: Who can do which and when?

Materials: Culture of learning, culture of feedback

Discussion: Group coaching on status quo and next steps

B. Wrap-up, Debrief, and Action steps

Objectives: Appraise value of PLP program; Outline specific action steps the care team will take to continue PLP learnings and outcomes

Discussion: How to immediately impact your care delivery

Activity: action steps and timelines

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Relationship of PLP Enhancement to ACGME and IPEC Competency Domains

Competency	PLP Section
ACGME	
Professionalism	All
Interpersonal and Communication Skills	All
Systems-based Practice	All
Practice-based Learning and Improvement	All
Patient Care	2B, 3B
Medical Knowledge	None
IPEC	
Interprofessional Communication	All
Values/ Ethics	All
Team and Teamwork	All
Roles/ Responsibilities	All
CLER Focus/ Pathways	
Patient Safety	Metric Dependent
Health Care Quality/ All	All
Care Transitions	Metric dependent
Supervision	None
Duty Hours; Fatigue Management and Mitigation	None
Professionalism/ ALL	All

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FACILITATION GUIDES

What follows are facilitation guides for each of the PLP sessions. In the **Slide Level Details** section, descriptions and explanations for facilitator edification are in italics. Non-italicized text can be used script for delivering content but facilitators are encouraged to use the language and slides as best fit their session. Most of the detail notes are also available in the notes section of the slides.

PLP 1_Intro Session

Session Running Time: 30-45 minutes

Purpose: Introduce the program and briefly discuss clinical learning environment (CLE) team roles.

Goals: The goal of this session is to introduce the PLP program to the participants and begin conversations and learning about the roles and responsibilities of everyone in the CLE.

Learning Objectives: (from slide 7)

- Discuss and summarize the PLP program
- Describe and discuss the sessions and processes of the PLP program
- Discuss/ choose a clinic operational (costs, efficiencies, etc) and/ or patient population health outcome metric
- Appraise team-based care delivery as it is occurring in the clinical learning environment (CLE)

Outline:

Prime for Engagement (described below in slide detail for slides 3-5)
Describe PLP program
Discuss CLE team roles and responsibilities

Slide Level Details

Slide 1-2: Intro and disclosure about HRSA funding for this project.

Slide 3: Priming for engagement.
Priming is valuable in education because it sets up learner expectations as well as psychological safety for all participants, including the facilitator. Every PLP session will being the same way, priming for engagement by creating (Intro session) and adding on to and remembering (subsequent sessions) a list of rules for engagement.

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Slide 4: Here we want to take time to create a framework for how to best work together both in these sessions but also generally. How would you prefer to engage in these sessions and with

your colleagues? How would you prefer they engage with you? For example, we might say open communication and listening actively, and those are great, but what does open communication mean? What does it look like? Let's get specific.

Facilitator: Please record your rules in a flipchart, on a whiteboard, or otherwise record them for future reference.

Slide 5: *(Please note: this image and other work by Glaser may not be shared without permissions from Glaser and the Creating WEInstitute. Dr. Meaghan Ruddy, creator of this slide deck, was trained by Glaser and as such attained permissions to share the work. Please do not copy C-IQ images for distribution beyond this deck.)*

This is the Conversational Intelligence dashboard created by Judith E Glaser, executive coach who has worked with companies such as New Wave Cinema, Burberry, and Google. Let's take a moment and look at this dashboard. On the left/ red side we have protective behaviors such as resisting and skepticism. Here the amygdala (small, almond-shaped pieces on either side of the brain), part of our goal/threat detection system, is initiating the release of a lot of cortisol which in turn is giving us the sense that we want to fly, fight, or freeze. On the right or green side of the dash, we have more open, partnering behaviors such as experimenting and co-creating, a term Glaser helped to popularize. Here our oxytocin is higher, allowing us to feel more safely bonded to those around us and therefore open to sharing and discovering with one another. In the middle is the yellow, wait and see section.

Notice that each section is described in terms of levels of trust – red is low, yellow is conditional, and green is high. The ways we converse with one another can shut people down into low trust, resisting, protective behaviors or promote conditional or even high levels of trust resulting in co-creating, partnering behaviors. We do this to one another all the time without realizing. Our patients do it to us, we do it to our colleagues, our superiors, our direct reports – think of what could happen is we harnessed this conversational ability and intentionally used it to promote an enjoyable, safe, and open working environment?

Ok. So look at this dashboard: where you are in terms of your position and what is happening in this clinic? *(Facilitator: allow for prolonged silence here. Someone will speak. Call back to the Rules of Engagement if needed. If no one is speaking, asking if speaking up should be added to the rules. Thanks everyone for their input. Somehow make a record of salient points.)*
Excellent. These are the things we want to keep in mind as we go through the PLP. That is why we are doing this.

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Slide 6: Now let's get into the content specific to our first session of professionalism and leadership in practice.

Slide 7: *These are the learning objectives for Session 1 of the PLP. Feel free to read them aloud and/ or ask if anyone has questions/ need clarifications.*

Slide 8: *(Facilitator: This is for background. Use as you see fit – if you do not have interest or see a need to include this slide feel free to remove it but please refer participants to the website* www.serveteachlearn.org *for more info on the generation of this project and it's use in conjunction with Community Oriented Primary Care.)* This project is the first of four objectives in our HRSA PCTE grant. They are described in a little more detail at serveteachlearn.org. Our work together will focus on the firs objective, Professionalism and Leadership in Practice or PLP.

Slide 9: Why professionalism and leadership in practice? Despite the fact that professionalism is an ACGME competency and that everyone seems to know what it and leadership mean, there remain a lot of challenges to operationalizing professionalism and leadership in clinical practice. Part of professionalism in practice today is interprofessionalism, a concept that has been promoted by pharmacy education since the 1970s but that has yet to catch consistent fire in medical education. Additionally, the medical education continuum has yet to catch up to the realities of teach care delivery. There are good and not so good reasons for this.

In nursing, there is a phrase: eat our own. It is often said in reference to the professional hazing that occurs to toughen up nurses in training for the realities of clinical work. The same happens in medical education. A great example is the 2016 rollback of duty hour restrictions, one of the rationales of which was to acclimate residents to the realities of clinical care. Rather than med ed being a leader in changing the unhealth culture of the industry, it has chosen to eat its own yet expects excellence in professionalism and leadership as well as interpersonal skills, things that get eroded when social and emotional needs are left to wither.

The good thing is that the knowledge, skills, attitudes, and behaviors for effective team care CAN. BE. TAUGHT! Work in emotional intelligence, social and emotional learning, conversational intelligence, and leadership styles demonstrates that intentional work in these areas can improve team effectiveness.

Slide 10: For the education wonks (detail geeks), here is how the PLP maps to ACGME and IPEC competency domains. It also takes the ACGME Clinical Learning Environment Review pathways into account.

The ACGME, or Single GME accreditation now that the AOA and ACGME are of one body on this subject, have competencies that all programs MUST measure in their residents. The details

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of what these look like different between specialties but after much research they decided that these 6 along with osteopathic practices and principles for DO programs cover the important areas of learning and development. Our program engages with all of the common areas in Professionalism, Interpersonal and Communications Skills, Systems-Based Practice, and Practice-Based Learning and Improvement. We also touch on sections 2B and 3B in the Patient Care Competency area. Note that this program does nothing specific with medical knowledge.

There is also a national Interprofessional Education Collaborative that created an interprofessional education competency list and as you can see here this program engages with all these areas.

Finally, here we have the ACGMR Clinical Learning Environment Review or CLER pathways. The CLER reviews are a new step in the standardization of GME. For those of you familiar with the JHCO visits, this is essentially the same sort of thing. They come to our CLEs unannounced and ask a bunch of questions, look at program documentation, then go off to discuss findings. As of right now, AY 2017-18, they are not yet at the point of using these visits for anything rewarding or punitive but the sense is that that is coming in that these CLER visits may likely be rolled into the continuing accreditation visit and review process.

We will get more into the details of the CLER pathways as our time together progresses.

Slide 11: What should we expect to get out of these sessions? We have the survey you all took and will take again at the end to ensure we are meeting our basic objectives, and we'll collect formative feedback on the program from your comments throughout. But more importantly we want to 1) improve the clinical learning climate and culture and 2) improve metrics of your choosing.

Why include clinical metrics? HRSA, the funder of this project, wants to know if and how their funding of projects is impacting patient care. The way we can look at this without violating any of our IRB or HIPPA rules is to look in aggregate at something that might be impacted by conversation and interpersonal workflows such as patient sat scores, workflow issues like handoffs and transitions of care where relevant – whatever makes the most sense in this environment.

(Facilitator: the clinic mgmt. may choose metrics for us. If not, use time now to brainstorm patient and/or clinic [such as utilizations. Costs, et al] metrics to be used for this project.)

Slide 12: This is how the PLP is organized. Let's all start with a beginner's mind, remember our rules of engagement, and dive in!

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Slide 13: *Facilitator, lead a quick stand and stretch session, about 90 seconds.*

Slide 14: On to the last part of our session today – team, roles, and responsibilities.

Slide 15: Given that team care delivery is not explicitly taught throughout the med ed continuum and this is primarily a medical residency program project, it seems to make sense to intentionally define the roles and scopes of responsibilities of everyone in the clinical learning environment.

Recalling our rules of engagement, let's make sure everyone knows what roles are present in this environment and how each impacts the metrics we're using for this project. It is important to identify the contributions of individual members/ roles because teams are comprised of individual "I"s who bring a lot to the table.

Slide 16: What roles are present in this clinical learning environment? *(If no one does, call out residents as learners AND providers, faculty and staff as providers/ staff AND teachers.)*

How do these roles impact the metrics you've chosen as the focus of this project?
(Facilitator: list the roles present in the clinic and their impacts here, on a whiteboard or flip board or somewhere visible to all the participants. Allow for some silence. If no one speaks up, call out some leaders for assistance in getting the ball rolling.)

Slide 17: One way to ensure that a team knows roles and responsibilities is to create a team charter. Ours may not have all these components, or different components, but what are some thoughts on whether or not a team charter might be helpful in addressing the conversational preferences and needs we identified earlier? *(Facilitator: if need be, call back to the dashboard conversation around roles and organizational direction.)*

(Facilitator: allow for some silence. If no one speaks up, call out some leaders or someone who has yet to engage for assistance in getting the ball rolling)

Slide 18: *(Facilitator: some outline of the next steps should be recorded and sent to everyone in a follow-up email or however everyone decides to maintain the conversation. Add this maintenance step to the Rules of Engagement.)*

Excellent! Thanks so much for your time and energy today. The next session will focus on power and it's effects on our behaviors in our roles. Look for some follow-up in the next few days. Thanks again!!

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PLP 2_Power, Behavior, and Roles

Session Running Time: 30-45 minutes

Purpose: Engage participants in realizing the power structures in their systems and how those structures impact team-based care in the clinical learning environment (CLE).

Goals: The goal of this session is to discuss different ways of thinking about and describing power in the CLE and begin conversations and learning about how power can have an effect on the roles and responsibilities of everyone in the CLE.

Learning Objectives: (from slide 5)

- Appraise the impacts of different types of power on care team dynamics
- Describe how conversations can change our internal and external environments

Outline:

Prime for Engagement (described below in slide detail for slides 3-5)
Describe some basic concepts in power dynamics
Discuss how things like Conversational Intelligence can help teams to work within and around habit structures such as power dynamics

Slide Level Details

Slide 1-2: Intro and disclosure about HRSA funding for this project.

Slide 3: Refresher

Sessions 2-6 have refresher activities built in. These activities are meant to scaffold learning by bringing the concepts from previous sessions back into working memory as a prime for the current session's work. The slides suggest online-based gamification activities but this can also be done analog with paper and pencil quizzes and games. Have fun with it!

Slide 4: *Title of session*

Slide 5: *Objectives for session*

Slide 6: Priming for engagement. ***This is the same in every presentation deck.***
Priming is valuable in education because it sets up learner expectations as well as psychological safety for all participants, including the facilitator. Every PLP session will being the same way, priming for engagement by creating (Intro session) and adding on to and remembering (subsequent sessions) a list of rules for engagement.

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Slide 7: *If the Rules were recorded during the last session, reprise them now with everyone and ask if anyone needs to add anything today.*

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Let's check in with where we are on the dashboard. Where are you in terms of this PLP project? (Facilitator: use this time to get feedback on your initial session and where things may need to go, how we may need to change the PLP, et al. Thanks everyone for their input.)

Slide 9: *Title of today's content.* What is power in the context of the CLE and how might it be influencing team relationships?

Slide 10: What types of power exist in interpersonal dynamics? Different researchers and authors talks about different types, but basically there is:

power of position, as in a hierarchical office structure;
charismatic power which is when someone who may not be in a position of power has a lot of social capital in an environment;
hard power which is the power of punishment and reward;
and soft power which is persuasion and encouragement.

Like the lines in this photo, we are all connected and all come with our own power supply as well as the ability channel the power of others. Some recent research indicates that the power we think we have, or don't have, changes the way we interact with one another in part because it changes the way certain brain structures called mirror neurons or mirror networks function.

Anyone know about mirror neurons? (*Wait for a response. If no one does, continue)* Very briefly, they are neurons in networks that light up for us as viewers the same way they light up for someone who is actually doing the task. For example, if we see someone raising a spoon to their lips, our spoon-raising network light up the same way that theirs does. Cool, huh?

To carry that example further and relate it to power, when someone feels they have more power than the spoon-raiser, the mirror network activity of the person feeling powerful is reduced or down-regulated. They seem to not mirror the other person as closely as someone who feels at the same power level as the spoon-raiser. Does this make sense? How might this relate to interactions between people of different power levels in the CLE?

Slide 11: Geert Hofstede is a Dutch social psychologist and pioneer of intercultural research. "Hofstede's Power distance Index measures the extent to which the less powerful members of

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organizations and institutions (like the family) accept and expect that power is distributed unequally. This represents inequality (more versus less), but defined from below, not from above. It suggests that a society's level of inequality is endorsed by the followers as much as by the leaders." – from http://www.clearlycultural.com/geert-hofstede-cultural-dimensions/power-distance-index/

He and his wife write about distance in cultures, and health care is a subculture not only of the US but anywhere it exists. It has it's own norms, rules, members and so on, so the concepts of larger cultural dynamics apply to health care on a smaller scale. Power distance is created by positional hierarchies as well as charismatic ones (newbies versus veterans, for example).

How can we bridge the distance(s)?

Slide 12: The clinical learning environment (CLE) contains a variety of power levels and dynamics. Not only are there the positions within the organization such as mgmt. and non-mgmt., there are the health care power dynamics between physicians, nurses, PAs, MAs, front desk and so on **AND** the dynamics of education – teacher and learner, resident and practitioner and learner and teacher and newbie...

There's a lot going on, a lot that can undermine trust. This is an unfortunate reality because without trust we down regulate our oxytocin and upregulate cortisol leading to reactive, protective behavior that jolts us up the ladder of conclusions.

However, the conversations we have with ourselves and others can change our and each other's biochemistry to nurture trust, upregulate oxytocin, down regulate cortisol, and create clinical learning environments where everyone can both teach and learn in a psychologically safe space. This is kind of a big deal in medical education because even in nursing there is a saying about eating our own (*facilitator: ask if any of the nurses in the audience will attest to this. Many of the other professions will be surprised to hear this.*).

Let's talk a bit about each of these images. The big one on the left about how the brain works – does this make sense? (*Facilitator: explain the image if people need more clarity. It is fairly self-explanatory but some people may not be able to see it well from their position.*)

Given that the brain areas respond to different things and we want to think more with the green side, the pre-frontal cortical area, and less with the red, hindbrain area, it is important to know what can count as a threat, or more precisely a goal attainment barrier, in our environment. The small square in the upper right asks us to know our threats: tone, humiliation, rejection, exclusion, anger, territoriality, and status; aka health professions education! (This is meant to be a joke but also an insightful observation.) (*Facilitator, take one or a few of the threats and ask people to relate them to their experiences, or use your own. Then relate these experiences to a*

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conclusion based on a belief, based on thoughts, based on feelings, based on the bioreactions in those experiences.)

How could we reframe that experience by walking it down the Ladder of Conclusions and acknowledging the chemical cocktail's chain reaction?

Slide 13: *(Facilitator: some outline of the next steps should be recorded and sent to everyone in a follow-up email or however everyone decides to maintain the conversation. Add this maintenance step to the Rules of Engagement.)*

Excellent! Thanks so much for your time and energy today. The next session will focus on social and emotional learning and leadership styles, and how awareness of our emotional intelligence and leadership preferences can make us more effective. Look for some follow-up in the next few days. Thanks again!!

Slide 14: Before our next session, please go to serveteachlearn.org and take the emotional intelligence (EI) and leadership styles self-assessments under the PLP section. The EI assessment is a browser-based, non-collection self-assessment meaning no data is being collected nor stored and when you close your browser it all disappears. It will be in your history but it should take you back to the start page, so if you want to save your result you'll have to take a screen shot.

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Professionalism and Leadership in Practice
Curriculum Enhancement for TWC-NFMR
Lead and POC: Meaghan Ruddy, MA, PhD
Contributors: WCGME and SOMA Teams

PLP 3_SEL and Leadership Styles

Session Running Time: 30-45 minutes

Purpose: Support the development of the clinical learning environment through social and emotional learning (SEL) and leadership style recognition.

Goals: The goal of this session is to introduce the participants to SEL and leadership styles and begin conversations and learning about how these concepts and activities can positively develop the roles and responsibilities of everyone in the CLE.

Learning Objectives: (from slide 5)

- Determine leadership styles and E-IQ
- Appraise how SEL concepts may impact team care delivery
- Appraise how styles and E-IQ impact team care delivery

Outline:

Prime for Engagement (described below in slide detail for slides 3-5)
Describe and discuss SEL and leadership styles
Discuss participants' self-assessment results and how they influence the CLE

Slide Level Details

Slide 1-2: Intro and disclosure about HRSA funding for this project.

Slide 3: Refresher

Sessions 2-6 have refresher activities built in. These activities are meant to scaffold learning by bringing the concepts from previous sessions back into working memory as a prime for the current session's work. The slides suggest online-based gamification activities but this can also be done analog with paper and pencil quizzes and games. Have fun with it!

Slide 4: *Title of session*

Slide 5: *Objectives for session*

Slide 6: Priming for engagement. ***This is the same in every presentation deck.***
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Let's check in with where we are on the dashboard. Where are you in terms of this PLP project? (Facilitator: use this time to get feedback on your initial session and where things may need to go, how we may need to change the PLP, et al. Thanks everyone for their input.)

Slide 9: *Title of today's content.*

Slide 10: *Caveat about next few slides.*

Slide 11: The term *social and emotional learning* was coined in 1994 by a group child advocates, educators, and researchers brought together to explore the social determinants of learning. The Collaborative for Academic, Social, and Emotional Learning (CASEL) was born from this meeting at the Fetzer Institute, the brainchild of what is now known as the Fetzer Group.

The driving concept of SEL is that social and emotional knowledge, skills, attitudes and behaviors (KSABs) can be taught/ learned via explicit instruction. Engagement in SEL creates nurturing learning environments, altering the implicit curriculum toward positive social and emotional program climates and learning conditions.

Slide 12: The Five Competencies of SEL are pictured here contextualized within the educational system. While the work of CASEL focused on K-12 education, the depiction may well be of medical education.

The 5 Domains:

Self-Awareness. Accurately assessing one's feelings, interests, values, and strengths; maintaining a well-grounded sense of self-confidence.

Self-Management. Regulating one's emotions to handle stress, controlling impulses, and persevering in addressing challenges; expressing emotions appropriately; and setting and monitoring progress toward personal and academic goals.

Social Awareness. Being able to take the perspective of and empathize with others; recognizing

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and appreciating individual and group similarities and differences; and recognizing and making the best use of family, school, and community resources.

Relationship Skills. Establishing and maintaining healthy and rewarding relationships based on cooperation; resisting inappropriate social pressure; preventing, managing, and resolving interpersonal conflict, and seeking help when needed.

Responsible Decision Making. Making decisions based on consideration of ethical standards, safety concerns, appropriate social norms, respect for others, and likely consequences of various actions; applying decision-making skills to academic and social situations; and contributing to the well-being of one's school and community.

What would we change on here to make it explicitly relevant to the CLE?

Slide 13: SEL is related but not entirely the same as emotional intelligence (EI). EI is an understanding of how emotions function in ourselves and in others, and how to regulate emotions in order to enhance living. Work on emotional intelligence began in the 1930s with an exploration into the ability of people to know how to best navigate within groups.

The term itself was coined in 1990 by psychologists Salovey and Mayer. Daniel Goleman's book of that name brought the concept into prominence and though not everyone agrees with his conception, there is ample evidence that EI exists in some form, those who have it excel, and those who don't have it can be taught how to get it.

Goleman's version of EI, the one most widely used and accepted, consist of four domains and 19 competencies. It is strikingly similar to the domains of SEL with SEL including a 5th area in responsible decision-making.

Self-awareness requires that we know our own emotions. When we're feeling something can we accurately acknowledge what is going on. What are some identifiers of anger vs frustration?

Self-management is the ability to manage our emotions and motive ourselves to engage more effectively. If I have identified that I am angry, how do I manage that in the moment and then afterward in a way that does not result in repression AND how do I motivate myself to do better?

Social awareness refers to being able to recognize the emotional state of others in our social engagements. It is the social cognate of self-awareness such that those questions asked of the self are now asked of our awareness of others. How is a patient, a colleague, a direct report, a friend feeling and how would we know?

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Goleman takes this social awareness one step further and, as with self-management, asks us to consider how we can use our increasingly accurate awareness of the emotional states of others to better and more effectively engage with others. This is skillful means, knowing your audience, paying attention to the other in the environment AND acting on that awareness.

SEL is contextualized for education and therefore includes the social component of acting, decision-making and it's impacts. We would need program evaluation to assess SEL en toto but we can get to the concept by focusing for the moment on the EI of everyone in the room.

(Facilitator: share your EI assessment [s3.amazonaws.com/eiassets/ei_responsive.htm] results and ask others if they would like to share theirs.)

Slide 14: Northouse's book, really one of many, is an academic deep dive into the major types of leadership, pros, cons, and how they manifest in real world organizations. It is pretty dense, maybe a bit old school, but excellent if you're looking to study scholarship on leadership.

The assessment we're using is from the Harvard Business Review and the categories seem to have been created by the authors of the assessment based on their experience in an executive search firm. They are as informative as any other, and a bit more fun than Northouse. If you haven't taken the leadership style assessment do so now.

(Facilitator: lead a discussion based on hbr.org/2015/06/assessment-whats-your-leadership-style. Take this assessment yourself in order to lead by example.)

How might people with different primary styles (a composer and produce for example) end up in protective mode? How could they move to co-creation?

(Facilitator: work to make the examples intrinsic to your group and their clinic. Real world cases are best.)

Slide 15: *(Facilitator: some outline of the next steps should be recorded and sent to everyone in a follow-up email or however everyone decides to maintain the conversation. Add this maintenance step to the Rules of Engagement.)*

Excellent! Thanks so much for your time and energy today. The next session will focus on effectively navigating the intersection of team-based care which we'll call the nexus. Look for some follow-up in the next few days. Thanks again!!

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PLP 4_Navigating the Nexus: Authentic Co-creation

Session Running Time: 30-45 minutes

Purpose: Improve the interactions amongst the CLE members.

Goals: The goal of this session is to tie together the concepts from the first 3 sessions and co-create best practices for everyone in the CLE.

Learning Objectives: (from slide 5)

- Discuss integrating styles and IQs into care delivery
- Discuss plan for promotion of authentic co-creation during care (in real time)

Outline:

Prime for Engagement (described below in slide detail for slides 3-5)
Describe some of the details of team-based care in the CLE
Discuss specific actions that can be taken toward improvements

Slide Level Details

Slide 1-2: Intro and disclosure about HRSA funding for this project.

Slide 3: Refresher

Sessions 2-6 have refresher activities built in. These activities are meant to scaffold learning by bringing the concepts from previous sessions back into working memory as a prime for the current session's work. The slides suggest online-based gamification activities but this can also be done analog with paper and pencil quizzes and games. Have fun with it!

Slide 4: *Title of session*

Slide 5: *Objectives for session*

Slide 6: Priming for engagement. ***This is the same in every presentation deck.***
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Let's check in with where we are on the dashboard. Where are you in terms of this PLP project? (Facilitator: use this time to get feedback on your initial session and where things may need to go, how we may need to change the PLP, et al. Thanks everyone for their input.)

Slide 9: *Title of today's content.* Navigating the nexus is another way of talking about working effectively with and within a variety of variables. For example (*advance slides*)…

Slide 10: …sometimes that nexus is our own body chemistry. We come to work with pre-existing conditionality, with chemicals manifesting in moods and levels of energy brought on by life situations, genetics, weather, all sorts of things. There is a lot of seen and unseen variability involved with, as Dr. Willie Souba would say, how we show up for one another every day.

Slide 11: We also must navigate the nexus of our colleagues, each of whom bring their own biochemistry and manifestations to and through the workday. When you consider what and how much we have learned to automatize in terms of our interactions and responses, it is pretty amazing. Because we don't think about a lot of these things, they just happen.

This is why it is helpful to know a bit about our personal emotional intelligence and preferred leadership styles. No one has to share their results, BUT if this is going to work we do have to promise to be honest (*Facilitator: offer to add this is to the rules of engagement if need be*) with ourselves about where we are versus where we could be. It is often so challenging to be honest in the workplace for reasons we'll get to in a moment and also because no one is perfect, no one. No one knows everything, no one is emotionally attuned all the time; we all have days and blind spots. The key is identifying, recognizing, and intentionally working to get better.

No one is operating at their absolute best 100% of the time because, remember from a session or two ago, how quickly we make judgments? .07 seconds, super quickly, and based on what? (take a beat, see if anyone speaks up). Based on our impressions which are at base biochemical reactions.

Let's try something.

Slide 12: In education, health care, business, and I'm sure other professions, professionalism is defined pretty narrowly. Dress appropriately, be on time… What are some attributes you would use to describe someone who is strictly professional? (*Facilitator, use the slide or a whiteboard or otherwise list out what participants say.*)

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Ok, now look at this list of attributes. Get a sense of Person A. (*Facilitator: give a few seconds, then click so it disappears*) Now we'll look at Person B. (*click for appearance*) Ge a sense. (*a few beats*) Ok now sort of this quick impression, which person is more trustworthy, A or B?

Slide 13: Those lists are the same except for the descriptions of cold and warm. Yet often professionalism is defined at least in part by diminished emotional connection, especially in health care! Don't get attached, don't take it personally… For the promotion for trust which is VITAL to team work of any kind, we might be better off if rather than promoting blanket emotional nonresponse we intentionally upregulate helpful emotional connection and down regulate unhelpful emotional connection.

This kind of change in the frame of interpersonal connectivity acknowledges the humanity of everyone involved (patients, colleagues) while also acknowledging that health care can be a challenging emotional environment.

Slide 14: What happens when trust is eroded or otherwise not present? Let's define this in terms of the dashboard. *(Facilitator: provide some silence to promote engagement, and acknowledge when engagement occurs)*

And how does resistance, skepticism, and even a wait and see attitude impact things like the clinic metrics that were identified? *(ibid)*

Trust is a powerful frame for team dynamics, right? We might not always think of it in terms of trust but if someone is cold or unapproachable for any reason, it actually erodes our ability to trust that person which in turn leads down any one of a number of unhelpful paths, territorialism or siloes being probably the most problematic for both health care AND education. As a CLE having this knowledge can be key to change.

Trust is really at the base of effective and ineffective interpersonal dynamics. There might also be racism, sexism, other types of power struggle, homophobia - a lot of things but even those things can be framed as issues involving lack of trust. Things that get in our way can be thought of as tribal issues, like me VS not like me. When we think others are not like me, we will protect. But even in a group as diverse as this, both in terms of work and personally, we can change the dynamic such that we greatly down regulate the emotions and reactions that cause protective behaviors. Out of the many we can create one.

So, when trust is a challenge, what can we do?

Slide 15: What we want to do is down regulate the fear and protectionism and upregulate the openness that allows us to share, partner, and create with one another. And the reason we talk about up and down regulation is because we have to recognize that we are working to promote

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what we prefer and demote what we find unhelpful but that we're talking about biochemistry here, not something we can completely eliminate.

But we CAN influence it and the way we show up for one another (Souba, 2011) can make a big difference. Often our intentions are great but our impact, the way our intention is received by others based on our tone, body language, and so on, our impact is the opposite of our intention. Conversational Intelligence describes three levels of conversations that we tend to have as we navigate the nexus of all of these things. Each type of conversation, any conversation, can have a push-pull dynamic. For example, I can push info at you or pull it from you and vice versa. That is Level I. It is a transaction in that it is a giving and receiving of information. It seems that a lot of clinical conversation is at this level, would you say? Does it have to be?

Level II goes a little deeper, beyond transactions to positions, and we can think of that a few ways: positions like positions of authority or positions like sides of an argument. (Facilitator: can offer example of an MA knowing that something is wrong – can s/he change it?)

Level III is even deeper in terms of connection. Notice instead of push and pull there is an intertwining, a true partnering – this is the right or green side of the dashboard. Now we can have Level I conversations in a Level III environment, but we will not ever have Level III conversations in a Level I environment. Does that make sense? (*beat*)

Here the power is shared – Glaser describes is as shifting energy and it is in a very physical sense. The energy of the brain and body feels very different when we're flowing in a conversation like this because in Level I we are likely tense and using a lot of the amygdala and related geographies of the brain whereas when we're in Level III we're more in the PFC and the body is more relaxed. Have you ever experienced that kind of shift? What would it be like if conversations here happened like this, at Level III, on a consistent basis? (*Facilitator: prompt for response*)

NOTE: What if it is a trust challenge is a power/ hierarchy challenge? For example, what if the leadership of a CHC or company or something isn't moving or doesn't seem willing to move to Level III but others are. No change in human behavior ever 100% guaranteed because there is pre-work involved, getting buy-in. A suggestion for how to cultivate buy-in from leadership is tying change to mission and metrics or talking about co-creation toward increasingly meaningful mission and metrics – speaking the language valued by those you're attempting to influence.

Slide 16: How do we build trust and get to Level III conversations and authentic co-creation? First we practice on ourselves, recognizing when we're in Level I being protective and resisting, disengage from the moment when we have the opportunity and walking back down the ladder of conclusions. It's taking those things we've automatized and making them intentional. It takes effort and when the effort is made, it works.

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As for others, asking discovery questions like what it will take to feel more engaged or want to co-create or want to figure it out, whatever it is, discovering within the context of the moment

whether it is work or home, wherever. Let others know you are seeing how they are showing up and that you're invested, attentive, and open will help them to walk back down their own ladders.

(Facilitator, click for image #2) This kind of interaction works because what we say to one another, how we show up for one another, our impact can be either to shut someone down or open them up. You don't have to take anyone's word for it – think of someone who makes you feel shut down versus someone around whom you feel very comfortable. Or take some time with this table. In C-IQ, Glaser points out that a lot of times and for a lot of reasons we are on the left side of this table. It is red for a reason – language of the type on this side has an impact of causing distrust and resistance in others. On the right side, the green side, there is language that promotes trust partnership in others.

Persistence is important, with yourself and with others. Pay attention to what is said and how it is said and the outcomes. If it is not a desirable outcome, what can be learned and how can a better one be co-created?

Slide 17: *(Facilitator: some outline of the next steps should be recorded and sent to everyone in a follow-up email or however everyone decides to maintain the conversation. Add this maintenance step to the Rules of Engagement.)*

In terms of making this CLE into a co-creative environment, what are be some immediate actions that can be taken? *(Facilitator make suggestions only if the participants do not have any of their own. Remind the participants about their metrics if that would help.)*

Excellent! Thanks so much for your time and energy today. Who is going to create the refresher questions for next session? (*wait for nomination and if no one speaks up, ask a few people. Due to schedules, you may still have to do it but encourage this deeper level of participation.*) The next session will focus on the differences between coaching, mentoring, teaching, and advising and how everyone can do each of those with one another. Look for some follow-up in the next few days. Thanks again!!

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PLP 5_Mentoring, Advising, Teaching, and Coaching (MAT-C)

Session Running Time: 30-45 minutes

Purpose: Co-create momentum for CLE members to build an authentic learning community.

Goals: The goal of this session is to introduce participants to the concepts of mentoring, advising, teaching, and coaching (MAT-C) and begin conversations and learning about everyone in the CLE not only can but has an obligation to MAT-C one another.

Learning Objectives: (from slide 5)

- Define the differences between mentoring, advising, teaching, and coaching
- Determine what each team member can do to mentor, advise, teach, and coach other team members

Outline:

Prime for Engagement (described below in slide detail for slides 3-5)
Describe the differences between the elements of MAT-C
Discuss how CLE team members can MAT-C one another

Slide Level Details

Slide 1-2: Intro and disclosure about HRSA funding for this project.

Slide 3: Refresher

Sessions 2-6 have refresher activities built in. These activities are meant to scaffold learning by bringing the concepts from previous sessions back into working memory as a prime for the current session's work. The slides suggest online-based gamification activities but this can also be done analog with paper and pencil quizzes and games. Have fun with it!

Slide 4: *Title of session*

Slide 5: *Objectives for session*

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Let's check in with where we are on the dashboard. Where are you in terms of this PLP project? (Facilitator: use this time to get feedback on your initial session and where things may need to go, how we may need to change the PLP, et al. Thanks everyone for their input.)

Slide 9: *Title of today's content.* In our daily work we can engage in one, some, or all of these activities. What are the differences and who can what when most effectively?

Slide 10: Although we have discussed some ways to make each of these session immediately relevant, here may be where it is most obvious how to make this PLP training real.

Slide 11: (*read the description if you like and click*) This image is Socrates or some Greek philosopher and it speaks of mentorship because the young men like our friend on the left here sought out people like Socrates because they wanted to learn from them, be like them, do what they did, model their behavior. This is what got Socrates killed, really, because he modelled the questioning of authority. Did he teach? Sure. Mentors can teach and often do but the key difference is that mentors are sought after and are seen as models, whereas this is not always the case for teachers.

Slide 12: (*read if you like and click*) This image seems to possibly be of a student approaching a teacher after a class and seeking out advice on a specific topic. Here again, the teacher takes on another role. It may not be direct content or process instruction but rather may be how to approach a situation, how to correct an error, something in addition to direct instruction. The student was likely assigned to the teacher, perhaps even assigned to him as his advisee as often happens in educational settings – unlike mentors who are sought out usually outside of the assignments of an educational institution.

Slide 13: (*read and click*) Here is a situation with which you are all likely very familiar, a clinical teaching moment. Lots going on here – some modelling, some advice giving perhaps, and some direct instruction. The point is that sometimes teachers, faculty, can be mentors and advisor as well as teachers but not always. Sometimes those activities are carried out by different people, but many times the faculty member is doing them all. Still, teaching, advising, and mentoring have different characteristics and each can be helped or hindered by the presence of the other.

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Does anyone have an example or an idea of how it can be that mentoring, teaching, and advising can get in each other's way?

(*Facilitator, use your own or the following example if no one has an idea. Let's say resident Smith is assigned to Dr. Doe as an advisee. Dr. Smith goes in to see Dr. Doe for the obligatory performance review and Dr. Doe, seeing Dr. Smith is deficient in some area, launches into direct instruction. How might Dr. Smith react?*)

Slide 14: Coaching is another activity altogether. (*read if you like. This slide is self-explanatory*)

Slide 15: (*again, read if you like then click*) The purpose, the role of the coach is to ASK QUESTIONS, hopefully powerful, insightful, catalyzing, open-ended questions that will help the coachee to find their own answers. This is more than Socratic teaching, although coaching can be Socratic in nature. Coaching is working with someone to help them find their own answers. It is not telling them, not modelling the answer, not providing advice – because when a coach does that, the coachee shuts down.

Coaching can be frustrating in a field where people are expecting to be told a single-best answer to memorize. But the lack of this type of engagement is why we have interns coming into residency with no real concept of how to do self-directed practice-based learning and improvement. It is why so many med student struggle with flipped classrooms and self-directedness. They've been told the answer the whole time.

And medical educators and clinical faculty have been used to telling, to giving the answers, because they too know were instructed in a single-best answer paradigm.

Slide 16: All that being said, (*read the question)* And how can tool like the Dashboard, Levels of Conversation, and the Ladder of Conclusions help us?

(*Facilitator: possible answers include but are not limited to using the Dashboard to help colleagues and ourselves identify how where we are on the meter might impact how we are dealing with an issue, thinking through whether a challenge is because we are engaging at the wrong level given the situation, and mentoring by walking ourselves down the Ladder in difficult moments or advising (reminding) or coaching someone down the ladder*)

Slide 17: Effective practice includes visualization. For this reason, it may be helpful for us to imagine scenarios based either on our actual experiences or on cases we've heard about.

Innovation exercise: Compound Words.

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- Pair up. Each person think of a word, an object or action. Now tell one another your words and in 1 few minutes come up with an invention based on your compound word. Return to the group and each team share their invention. No shame, no judgement.
- How would you mentor someone through your process?
- How would you advice someone on their process?
- How would you teach your process?
- How would you coach someone through this process?

We can do the same thing with a piece of a CLER pathway. (*click to reveal CLER PS1*)

This is the very first CLER Pathway subpath, Patient Safety #1. As you can see there are several pieces to this section, but they all have to do with error reporting. How can we apply MAT-C to error reporting?

> What would mentoring look like? (*possible answer: modeling error reporting by faculty and staff*)
> What would advising look like? (*possible answer: QI office or whomever is in charge reminding everyone that it needs to be done)*
> What would teaching look like? (*possible answer: teaching someone or everyone how to do it)*
> What would coaching look like? (*possible answer: coaching someone through whether or not something should be reported by asking questions such as "What do you think you should do?" "How would doing this help the system?" and so on)*

Slide 18: *(Facilitator: some outline of the next steps should be recorded and sent to everyone in a follow-up email or however everyone decides to maintain the conversation. Add this maintenance step to the Rules of Engagement.)*

In terms of making this CLE into a co-creative environment that nurtures MAT-C, what are be some immediate actions that can be taken?

Excellent! Thanks so much for your time and energy today. The next session will focus on the differences between coaching, mentoring, teaching, and advising and how everyone can do each of those with one another. Look for some follow-up in the next few days. Thanks again!!

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Professionalism and Leadership in Practice
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Lead and POC: Meaghan Ruddy, MA, PhD
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PLP 6_Wrap-up and Debrief

Session Running Time: 45-60 minutes

Purpose: Summarize the PLP training and get program feedback.

Goals: The goal of this session is to wrap-up the PLP program and support participants in continuing their conversations and learning about co-creating an authentic CLE.

Learning Objectives: (from slide 5)

- Appraise value of PLP program
- Outline specific action steps the care team will take to continue PLP learnings and outcomes

Outline:

Prime for Engagement (described below in slide detail for slides 3-5)
Wrap the PLP program objectives around the experience
Discuss next steps to continue the learning

Slide Level Details

Slide 1-2: Intro and disclosure about HRSA funding for this project.

Slide 3: Refresher

Sessions 2-6 have refresher activities built in. These activities are meant to scaffold learning by bringing the concepts from previous sessions back into working memory as a prime for the current session's work. The slides suggest online-based gamification activities but this can also be done analog with paper and pencil quizzes and games. Have fun with it!

Slide 4: *Title of session*

Slide 5: *Objectives for session*

Slide 6: Priming for engagement. ***This is the same in every presentation deck.***
Priming is valuable in education because it sets up learner expectations as well as psychological safety for all participants, including the facilitator. Every PLP session will being the same way, priming for engagement by creating (Intro session) and adding on to and remembering (subsequent sessions) a list of rules for engagement.

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Slide 7: *If the Rules were recorded during the last session, reprise them now with everyone and ask if anyone needs to add anything today.*

Slide 8: *(Please note: this image and other work by Glaser may not be shared without permissions from Glaser and the Creating WEInstitute. Dr. Meaghan Ruddy, creator of this slide deck, was trained by Glaser and as such attained permissions to share the work. Please do not copy C-IQ images for distribution beyond this deck.)*

Let's check in with where we are on the dashboard. Where are you in terms of this PLP project? (Facilitator: use this time to get feedback on your initial session and where things may need to go, how we may need to change the PLP, et al. Thanks everyone for their input.)

Slide 9: *Title of today's content.*

Slide 10: Bringing this back from Session 1 to remind us all that this is what we said we would do. Now we are going to quickly review the session basics and ask for examples.

Slide 11: **What we said was:** Given that team care delivery is not explicitly taught throughout the med ed continuum and this is primarily a medical residency program project, it seems to make sense to intentionally define the roles and scopes of responsibilities of everyone in the clinical learning environment.

Recalling our rules of engagement, let's make sure everyone knows what roles are present in this environment and how each impacts the metrics we're using for this project. It is important to identify the contributions of individual members/ roles because teams are comprised of individual "I"s who bring a lot to the table.

Does everyone know the roles of everyone in the CLE? Example? (*If not, what can we do to meet this objective?)*

Slide 12: The next topic was power and it's influence on the behavior of the individuals in the CLE and their ability to carry out their roles.

Does everyone know how power is influencing your work? Example? (*If not, what can we do to meet this objective?)*

Slide 13: Then we talked about social and emotional learning and leadership styles.

Would someone give us an example of how SEl or leadership styles can influence a CLE?

Slide 14: Then it was on to the nexus.

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(From previous session) Trust is really at the base of effective and ineffective interpersonal dynamics. There might also be racism, sexism, other types of power struggle, homophobia - a lot of things but even those things can be framed as issues involving lack of trust. Things that get in our way can be thought of as tribal issues, like me VS not like me. When we think others are not like me, we will protect. But even in a group as diverse as this, both in terms of work and personally, we can change the dynamic such that we greatly down regulate the emotions and reactions that cause protective behaviors. Out of the many we can create one. **So, when trust is a challenge, what can we do?**

(*click to reveal Dashboard*) How can a tool like this help us navigate the complex intersection or nexus of team care in a CLE?

Slide 15: **From previous session:** What we want to do is down regulate the fear and protectionism and upregulate the openness that allows us to share, partner, and create with one another. And the reason we talk about up and down regulation is because we have to recognize that we are working to promote what we prefer and demote what we find unhelpful but that we're talking about biochemistry here, not something we can completely eliminate.

But we CAN influence it and the way we show up for one another (Souba: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3050817/) can make a big difference. Often our intentions are great but our impact, the way our intention is received by others based on our tone, body language, and so on, our impact is the opposite of our intention.
Conversational Intelligence describes three levels of conversations that we tend to have as we navigate the nexus of all of these things. Each type of conversation, any conversation, can have a push-pull dynamic.

Would someone provide us with an example of a Level I interaction in the CLE? A 2? A 3?

Slide 16: As we said in a previous session, how can we build trust and get to Level III conversations and authentic co-creation?

1) We practice on ourselves, recognizing when we're in Level I or are being protective and resisting and disengaging from the moment when we have the opportunity to walk back down the ladder of conclusions.

2) We can help others by asking discovery questions like what it will take to feel more engaged or want to co-create or want to figure it out, because what we say to one another, how we show up for one another, our impact can be either to shut someone down or open them up.

Would someone provide an example of something that we can say less of or say more of? How about an example of how to walk down the ladder in the CLE?

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Slide 17: The last bit of content we worked on was what we're calling MAT-C, *(click)* mentoring, *(click)* advising, *(click)* teaching, and *(click)* coaching.

What is an example of how several of these elements can occur in the clinical learning environment?

Slide 18: Time for feedback! We will be using (*name method such as polleverywhere or whatever you're going to use*) so let's take a minute to stretch and get ready for honest, helpful feedback!

Slides 19-21: *polleverywhere slides; feel free to use your own but collect data on the program*

Slide 22: Pie Cthulu says keep it going! Keeping in mind the clinical metrics that were chosen at the beginning of our time together, and thinking about the development of the clinical learning environment, what can we commit to doing right now (piece of pie on the plate), in the next few weeks (pie in the fridge), then in the next few months (pie in the freezer)?

Or, thinking about projects with deadlines, what is the deadline (external or self-imposed)? What steps are involved? How much time will they take? When can you start and what do you start with?

Slide 23: Thank you all for your participation and energy – anyone have questions or concerns about next steps?

Watch your email for a post-PLP survey and be sure to fill it out and enter to win something nice!

(Facilitator: if you are doing a post-PLP survey or assessment, include the steps to access it here and/ or remind participants to watch for a message from you about how to access it.)

Program Evaluation

This training program was created with the hope that progressively development clinical learning environments would result in progressively developing clinical outcomes. Given that this is meant to be a programmatic enhancement and not a clinical trial, clear correlations are not probable unless the metric under study are employee satisfaction scores relating specifically to interpersonal dynamics or measures related to the program's stated objectives. The Survey Monkey survey questions below are part of what was given as a pre- and post-test (self-reported one a Likert 1-5 scale) and are based on the program's stated objectives. Feel encouraged to evaluate the PLP program as you see fit, and share the results!

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How confident are you in your understanding of the function of each member of your healthcare team in care delivery?

How confident are you in your understanding of how each team member impacts patient outcomes?

How confident are you in your understanding of the different types of power present in a care team?

How confident are you in your understanding of how type of power can impact team care delivery and patient outcomes?

How confident are you in your ability to manage team power dynamics?

How confident are you in your understanding of leadership styles and how they impact team care delivery?

How confident are you in your understanding of emotional intelligence and how it impacts team care delivery?

How familiar are you with the domains of social and emotional learning (SEL) and how they impact team care delivery?

How confident are you in your ability to effectively use leadership styles, emotional intelligence, and SEL to positively impact care outcomes?

How confident are you in your understanding of the differences between coaching, mentoring, advising and teaching (CMAT)?

How confident are you in your understanding of how each care team member can engage in CMAT for other members of the care team?

How confident are you in your understanding of how CMAT can facilitate a culture of learning and feedback in your clinical learning environment (CLE)?

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Final Thoughts

Thank you for engaging with the Professionalism and Leadership in Practice training program! We will be working with this in our organization and periodically making updates.

If you have insights, questions, comments, or other things to share, please contact us via the form available on the homepage of www.serveteachlearn.org or contact Dr. Ruddy directly at ruddym@thewrightcenter.org.

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