Transforming Academic Medical Center Culture to Achieve Health Equity

Moderator:
Leon McDougle, M.D., M.P.H.

Speakers:
Ricardo Azziz, M.D., M.P.H., M.B.A.
Deborah W. Davis, FACHE
Valerie N. Williams, Ph.D., M.P.A.
### Mission and Focus

**Mission**
The GDI is a national forum and recognized resource to support AAMC members in their efforts to realize the benefits of diversity and inclusion in medicine and biomedical sciences across all parts of their institutions and the community.

**Focus**
Diversity and inclusion in faculty, graduate medical education, and professional development/institutional climate.

### Membership

- **Designated GDI Representative**
  U.S. medical school *dean designates* a faculty or administrator who has responsibility for institutional multicultural/diversity affairs.

- **Individual GDI Representatives**
  *Open membership*, U.S. medical school dean or self-designated.

### Contact
Juan Amador, Director and GDI Program Leader
202.862.6149
jamador@aamc.org
www.aamc.org/gdi
Diversity as a core value embodies inclusiveness, mutual respect, and multiple perspectives and serves as a catalyst for change resulting in health equity. In this context, we are mindful of all aspects of human differences such as socioeconomic status, race, ethnicity, language, nationality, sex, gender identity, sexual orientation, religion, geography, disability and age.

Inclusion is a core element for successfully achieving diversity. Inclusion is achieved by nurturing the climate and culture of the institution through professional development, education, policy, and practice. The objective is creating a climate that fosters belonging, respect, and value for all and encourages engagement and connection throughout the institution and community.

Health Equity is when everyone has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance (Source: CDC).
# GDI National Priorities

## Diversity and Inclusion in Faculty

<table>
<thead>
<tr>
<th>Priority</th>
<th>Short Term</th>
<th>Long Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority 1</td>
<td>Identify GDI data needs and define a comprehensive data set</td>
<td>Develop a GDI toolkit on underrepresented groups in medicine and biomedical sciences (UGMBS) faculty for our academic institutions</td>
</tr>
<tr>
<td>Priority 2</td>
<td>Integrate issues unique to underrepresented groups in medicine and biomedical sciences (UGMBS) faculty into the Group on Faculty Affairs (GFA) New Member Toolkit</td>
<td>Develop an academic medicine pipeline/activities for underrepresented groups in medicine and biomedical sciences (UGMBS) to enhance the diversity in our faculty workforce</td>
</tr>
</tbody>
</table>

## Diversity and Inclusion in Graduate Medical Education (GME)

<table>
<thead>
<tr>
<th>Priority</th>
<th>Short Term</th>
<th>Long Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority 1</td>
<td>Develop Holistic Review for residency admissions</td>
<td>Develop an academic medicine pipeline for underrepresented groups in medicine and biomedical sciences (UGMBS) residents in collaboration with other AAMC Professional Development Groups</td>
</tr>
</tbody>
</table>

## Diversity and Inclusion in Professional Development/Institutional Climate

<table>
<thead>
<tr>
<th>Priority</th>
<th>Short Term</th>
<th>Long Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority 1</td>
<td>Provide professional development in collaboration with other AAMC Professional Development Groups</td>
<td>Develop a GDI Orientation Guide for the GDI Steering Committee and GDI members</td>
</tr>
<tr>
<td>Priority 2</td>
<td>Adding Lesbian, Gay, Bisexual, Transgender (LGBT) issues and concerns to national agenda at all levels</td>
<td>Continuous campaign to empower and engage GDI membership</td>
</tr>
<tr>
<td>Priority 3</td>
<td>Present GDI’s definition of diversity and inclusion to all AAMC memberships, organizations, and senior administration</td>
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Session Objectives

• Learn how to identify and overcome obstacles to creating and exercising effective leadership

• Understand the role of teaching hospitals in leading efforts to improve community health

• Recognize the role of recruiting, training, and retaining future leaders through faculty development leadership programs
"Sculpting in Clay"
Transformative Leadership in Shifting Times

Ricardo Azziz, MD, MPH, MBA
Professor, Obstetrics, Gynecology and Medicine
President, Georgia Health Sciences University
CEO, Georgia Health Sciences Health System
November 5, 2011
What Do Leaders Do?

• Provide vision
• Interpret the environment
• Empower & create teams
• Engage communities
• Model behavior
• Lead and manage change
What is Different in a Transformative vs. a Changing Environment?

Transformation implies a greater degree of change from what has been the norm

Transformation is necessary when:

• The external environment is changing rapidly and aggressively, or…

• The institution needs to go far to meet the current or future environmental challenges

• Or… more often, both
Why is GHSU on a Transformative Path?

Rapidly and aggressively changing external forces:

• Sharply declining state support
• Increasing competition locally and from other USG institutions
• Radically changing healthcare environment
• Increasing focus on discovery, and declining ability to support research efforts through clinical pass-through $
• Increasing mobility of work force
• Radically changing speed of communication
• Increasing global pressures and knowledge competition
• Marked economic recession
Why is GHSU on a Transformative Path?

... And GHSU is less prepared to face these environmental threats because so far it has been relatively well insulated and protected:

- Relatively high level of state support
- Primary focus on education with captive student population
- Steady incremental growth
- Limited competition within USG
- Clinical operations focused on local market
- Static employee population
- Relatively resilient local economy
- Little demand for more robust ROI
Transformative Leadership

Transformative leadership is the type of leadership required during radically shifting times or situations to achieve transformation, not just simply change, of an enterprise
Transformative Leadership

Transformative leadership requires different emphases, strategies, or skills than leadership in less radical or shifting situations

Because:

• Direction to be taken varies significantly from current course
• Prior institutional experience with change is limited
• The rapidity of the pace is critical
• Prevailing leadership culture and internal expertise may be unprepared or unsupportive
• Risk of failure is higher
Seven Critical Transformative Leadership Skills

1. The capacity to envision and formulate the workings of a new world
2. The willingness to personally and directly engage
3. An ability to sense and drive pace
4. A great need to recognize excellence
5. A readiness to address issues personally
6. The skill to build bridges
7. The willingness to accept extreme ambiguity and uncertainty
The ability to envision and build radically new structures and their workings should be:

- Guided by ultimate function and objective, rather than by ownership, credit, or authority
- Focused on the intangibles that form the core and essence of the mission

Formulating a working transformative vision requires borrowing from experiences beyond our training
Effecting Change – Where Should We Be?
The importance of setting the vision first

“If you do not know where you are going, every road will get you nowhere”

Henry Kissinger
2 – Willingness to Personally & Directly Engage: Selling the Vision

A transformative vision should be:

• Compelling, exciting, and inclusive
• Should highlight the path and workings…

Willing to engage in vigorous dialogue, vetting disparate and opposing views

If you aren’t selling, then nobody is buying!!
3 – Ability to Sense & Drive Pace

Understand that pace matters... and that windows of opportunity don’t stay open long...

Become adept at measuring progress to stay on course and on time

Respect your competitors... they help to set your pace

Comprehend that one must start ‘Now’
4 – The Need to Recognize Excellence

To lead to excellence you must recognize and know excellence

Always assume that you are competing with the ‘Best in Class’… so find out what the best do

Do not just expect and reach for excellence in your own niche… drive excellence

If “Good enough is good enough”… then maybe it’s not really needed

Seek & recruit excellence… and invest in people
5 – Readiness to Address Issues Personally

Normally, good leadership principles (and leaders’ survival) imply that:

- Team members and designees are empowered
- Much of the work… and tough actions… will be carried out by delegates

However, in a transformative environment few in the team may be prepared to act… which…

Requires that transformative leaders be willing and proactive in addressing issues directly & personally…

Along with leadership development/recruitment
6 – The Skill to Build Bridges

Bridges are two-way streets…. 

Bridges are bidirectional… but not necessarily built to equal extents…

Before building a bridge, the grounds should be ready… on both sides…

Bridges have to be built to last… outliving those that created them…

Bridges have to be built using many different approaches…
Building bridges does not obviate the need for individual accountability and responsibility…

When building bridges expect set-backs… **AND** accept them as proof that the bridge needs to be built…

Building bridges is about the right leadership…
7 – Willingness to Accept Extreme Ambiguity & Uncertainty:  
THE ART OF SCULPTING IN CLAY

Understand and communicate the fact that building new futures is an iterative process, rooted in ambiguity and uncertainty.

If all the signals were clear and the path well defined then leaders would not be needed.
Transformative Leadership is Risky

The risk of failure is greater due to:
- Significant institutional inertia
- Limited knowledge of the situation on ground
- Limited leadership support
- The need to highlight a vision and path early
- The need to leverage crises
- Degree of personal time/energy required

Greater speed $\rightarrow$ greater risk of error

“Change Agent” label

The conundrum of the ‘elected politician’

So ‘Transformative Leadership’ strategies should/can only be used for a limited time
Transformation at GHSU

- Operationalized Health System – 6 mos.
- Changed names of enterprise – 6 mos.
- Reorganized leadership structure – 4 to 12 mos.
- Integrated all major leadership functions – 12 mos.
- Recruited 75% of leadership – 24 mos.
- Implemented a Variable Pay/Salary-at-Risk Plan for all leaders – 12 mos.
- Completed short-term strategic assessment (ESP) – 4 mos.
- Initiated enterprise-wide LTSP (Transformation 2020) – 6 mos.
- Presented 8-year vision for Governor/Chancellor – 15 mos.
- Resolved litigation & established multiple Foundation model – 8 mos.
- Created Board of Visitors – 14 mos.
- Implemented an electronic process for T&E and eIRB – 12 mos.
- Initiated Quality initiative in HS – 4 mos.
- Initiated Service Line structure in HS – 18 mos.
- Addressed budget shortfall/integration savings with RIF – 15 mos.
The one quality that can develop by studious reflection and practice is the leadership of men

Dwight D. Eisenhower
(1890 –1969)
Transformative Leadership

Thank you
Innovations in Community Health:
How an Academic Medical Center is Leading the Way

Deborah W. Davis, FACHE
Chief Operating Officer
Medical College of Virginia Hospitals -
Virginia Commonwealth University Health System
November 5, 2011
VCU Health System Overview

• VCU Health System - the clinical delivery component of the VCU Medical Center
  • Only academic medical center in Central Virginia
  • Referral center for the state and Mid-Atlantic
  • 33,500+ admissions and 550,000+ outpatient visits
  • 84,000 emergency department visits

• MCV Hospitals
  • Teaching hospital of the VCU Health System
  • 805 licensed beds
  • 20.5% share of the Richmond inpatient market
  • The region's only Level-I Trauma Center

• Children’s Hospital of Richmond
  • Pediatric specialty hospital
  • 60 licensed pediatric long term care beds

• MCV Physicians
  • 560-physician, faculty group practice
  • Major funding source VCU School of Medicine

• Virginia Premier Health Plan
  • 150,000 member Medicaid Health Plan

• University Health Services, Inc.
VCUHS Source of Patients by Payer

55,698 Adj. Discharges for Twelve Months Ending June 30, 2011
Actual Governmental Payers/Self Pay is 75.3% of Total

- Medicaid / Uninsured, 51.6%
- Medicare, 23.7%
- Anthem, 14.3%
- Commercial, 10.4%
Improving Community Health for “At Risk” Populations

VCUHS is leading the way with several innovative approaches:

- Virginia Coordinated Care (VCC) for the Uninsured
- Virginia Premier Health Plan
- Office of Health Innovation
- Population Management
- Primary Care Initiative
Virginia Coordinated Care (VCC) for the Uninsured

• Established in the Fall of 2000
• Goal is to coordinate health care services for a subset of the patients who qualify for the Commonwealth’s Indigent Care program
• Target population is uninsured patients below 200% FPL in the Greater Richmond and Tri-Cities areas
VCUHS Partnerships Lead to VCC

Virginia General Assembly passes SJR179 to analyze primary care capacity

Richmond Urban Primary Care Initiative (RUPCI) determines there is a need for primary care in South Richmond

City Health Dept And VCUHS partner to create South Richmond Health Center (SRHC)

Health Department turns over management of the SRHC To VCUHS

VCUHS launches the City Care program

The VCC program is established in partnership with community PCP’s

SRHC is renamed Hayes Willis Health Center for VCU physician

Community and VCUHS reps examine the feasibility of expanding City Care to Uninsured adults

Intro of the PMI model for Health Care Reform

VCC Outcomes

• Enrollment in FY11 was over 30,000 patients
• 50 providers participated from Community-based Physician practices and Safety Net providers
• VCUHS has invested over $32 million to support the provision of care in community settings
• VCC program has resulted in reduced costs and utilization of services
  ▪ Reductions were observed from 2001 to 2003 in the proportions of enrollees with inpatient hospitalizations (17.6% vs 13.8%) and with emergency department visits (73.9% vs 42.9%) *
• VCUHS is transitioning the VCC program into a population health management program

Virginia Premier Health Plan

• Virginia Premier Health Plan is a non-profit managed care organization partnered with VCU Health System

• Mission: To meet the needs of underserved and vulnerable populations in Virginia by delivering quality driven, culturally sensitive, and financially viable healthcare

• Purchased by VCUHS in 1998 with roughly 14,000 Medicaid members

• VPHP now enrolls over 150,000 Medicaid members across Virginia
Virginia Premier endeavors to support the multiple missions of the VCU Health System through:

- **Financial contributions:** Since 2004, Virginia Premier has made donations and offered grants to the VCU Health System in excess of $22 Million.

- **Shared Administrative Costs:** Virginia Premier absorbed approximately $5 Million in administrative costs in FY11 that would otherwise be allocated to other business units within the VCU Health System. Total shared administrative costs through FY 11 is over $25 Million.

- **Operational Support:** Virginia Premier assists the Virginia Coordinated Care (VCC) program through provision of Third Party Administrative services (Claims payment to community physicians, member services, and other administrative services).
VA Premier Accomplishments


• In 2011 Virginia Premier Health Plan (VPHP) is ranked 26th Nationally out of over 200 Medicaid Health Plans

• Through VPHP’s nationally recognized Healthy Heartbeats Prenatal program, we have decreased the number of preterm and low-birth weight babies

• 2010 Best Practice Award for Anti-Depressant Medication Management - Awarded by Virginia Department of Medical Assistance Services (DMAS)

• The Center for Health Care Strategies awarded DMAS and VPHP the Innovation Award for Improving Health Care Quality for Racially and Ethnically Diverse Populations

• 2008-VPHP was awarded the “Recognizing Innovation in Multicultural Health Care Award” by the National Committee of Quality Assurance (NCQA)

• Virginia Premier is the only Virginia health plan that operates its own transportation system, inclusive of vans that will be utilizing alternative fuels (Compressed Natural Gas / Propane fueled vehicles)

• VPHP Awarded NCQA Accreditation Status – Top Rating “Excellent”
VCU Office of Health Innovation

- Establishes an operational unit to develop business opportunities to address the goals of the medical center
- Collaboration between VCU and VCUHS housed in the VCU School of Medicine
- Focus will be on the development of initiatives to prepare for health reform
- Innovation strategies will be developed through research initiatives, demonstration projects, and educational opportunities
- Partnerships will be critical to success of the VCU Office of Health Innovation
  - Relationships are being built with entities across Virginia including the stage agencies, professional societies, local health departments, community-based agencies, etc.
What the Office of Health Innovation will Accomplish

- Identification of federal grants and demonstration projects that align with interests of the VCU Health System and VCU faculty
- Development of population management strategies (e.g., ACO’s, Medical Homes, etc.)
  - Service delivery models
  - Payment reform models
  - Predictive modeling for populations
- Expansion of community engagement activities to include:
  - Translational research initiatives
  - Development of education and training models
  - Partnerships with community-based organizations
  - Collaborations with state agencies
  - Participation in initiatives with national organizations
  - Creation of patient education initiatives
The Population Management Initiative (PMI) will focus on the VCC patients that are generating the most costs.

### FY10 Allocation of VCC Hospital Costs

<table>
<thead>
<tr>
<th>Risk Stratification</th>
<th>Population*</th>
<th>Hospital Costs**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>61%</td>
<td>20%</td>
</tr>
<tr>
<td>Level 2</td>
<td>15%</td>
<td>24%</td>
</tr>
<tr>
<td>Level 3</td>
<td>6%</td>
<td>56%</td>
</tr>
</tbody>
</table>

*8% of the population did not use hospital services

**Based upon FY10 hospital costs of $56 million excluding Outpatient Pharmacy and physician services

80% of Costs
VCU Health System

Population Management Initiative

Care Coordination/Case Management
Network Re-Configuration
Physician Payment Re-structure
Information Exchange, Data and Analytics

Population
VCC (pilot)
Employees
Medicare
Medicaid
Commercial

Results:
- Improved Health
- Reduced rate of increased cost
- Providers working at “top of license”
Expected Outcome: An Accountable System of Care

- **Episodic population (Level 1)** – 61% of the population
  - Navigation support to clinical and social services
  - Chronic illness screening
  - Explore Urgent care options

- **Chronic/Stable population (Level 2)** – 15% of the population
  - Strengthen medical homes
  - Improve communications between VCUHS and medical homes
  - Implement value-based reimbursement model

- **High risk/high cost patients (Level 3)** – 6% of the population
  - Establish Interdisciplinary team model
  - Embed intensive case management in the “medical home”
  - Improve patient “hand-offs”
VCU Primary Care Initiative (PCI)

The VCUHS primary care initiative (PCI) includes two strategies:

1. Provide consultative assistance and support to small practices and Federally Qualified Health Centers (FQHC) to implement the patient centered medical home (PCMH) model
   - Develop a program in Central Virginia
   - Focus on underserved populations

2. Expand the number of primary care and dental residency programs in medically underserved areas
   - Focus on sites that are adopting components of the PCMH model
Formula for Primary Care Initiative

• Conduct a “Readiness” Assessment of Primary Care Practices
• Provide Consultative and Support Services for Practices
  ▪ Practice management support
  ▪ Health Information Technology
  ▪ Case Management/Care Coordination
  ▪ Data/Analytics
  ▪ Physician Payment
  ▪ Evaluation
• Work with Practices to identify Sustainability Options, including:
  ▪ Achievement of “Meaningful Use” standards
  ▪ Practice efficiencies that enhance attractiveness to payers interested in alternative payment models
• Review health reform demonstration grants to identify funding opportunities to establish primary care and dental residencies in existing FQHC’s
Expected Outcomes of PCI

- Improved efficiency at small practices and FQHCs to ensure long-term sustainability
- Expanded access to primary care and dental services for “at-risk” populations
- Larger healthcare workforce for the Commonwealth of Virginia, especially in medically underserved areas
- Development of a primary care blueprint that is transformative and transferable to other areas of Virginia and beyond
Why is it important for AMCs to lead efforts to improve community health?

• AMCs have resources and expertise to assist community providers and local/state governments with the management of “at risk” populations
  ▪ Leverage robust analytical and informatics capabilities
• Through training programs, AMCs are well positioned to introduce a new paradigm of health delivery to the future healthcare workforce
• AMCs are the nation’s “Safety Net” and have unmatched experience caring for the most vulnerable populations
“University-based urban academic medical centers… function most effectively and for the greater good when their care is a complement to, and not a substitute for, community health care providers.”

Acknowledgements

To request more information on programs at VCUHS, please contact:

Sheryl Garland
Vice President, Health Policy and Community Relations
VCU Health System
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Email: sgarland@mcvh-vcu.edu

Michael Vasell
Analyst
VCU Health System
Phone: (804) 628-2083
Email: mvasell@mcvh-vcu.edu
Leadership Development

Transforming Academic Medical Center Culture to Achieve Health Equity

Valerie N. Williams, Ph.D., M.P.A.
Vice Provost for Academic Affairs & Faculty Development
University of Oklahoma Health Sciences Center
November 5, 2011
Diversity as a core value embodies inclusiveness, mutual respect, and multiple perspectives and serves as a catalyst for change resulting in health equity. In this context, we are mindful of all aspects of human differences such as socioeconomic status, race, ethnicity, language, nationality, sex, gender identity, sexual orientation, religion, geography, disability and age.

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AAMC Group on Diversity and Inclusion
The mission of the University of Oklahoma is to provide the best possible educational experience for our students through excellence in teaching, research and creative activity, and service to the state and society.
University of Oklahoma Health Sciences Center Mission

Educate students at the professional, graduate, and undergraduate levels to become highly qualified health services practitioners, educators, and research scientists;

Conduct research and creative activities for the advancement of knowledge through teaching and development of skills; and

Provide continuing education, public service, and clinical care of exemplary quality.
OUHSC Provost and Executive Dean Andrews’ Vision

“The University of Oklahoma Health Sciences Center will be the premier enterprise for advancing healthcare, medical and health professions education, biomedical research and public outreach for the community, state and region.

Through our combined efforts, we strive to improve the lives of all people.”

Emphasis added
# Faculty (Full-time Fall 2010)

<table>
<thead>
<tr>
<th>Field</th>
<th>Faculty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied Health</td>
<td>57</td>
</tr>
<tr>
<td>Dentistry</td>
<td>48</td>
</tr>
<tr>
<td>Medicine</td>
<td>765</td>
</tr>
<tr>
<td>Oklahoma City (OKC)</td>
<td>661</td>
</tr>
<tr>
<td>Tulsa</td>
<td>104</td>
</tr>
<tr>
<td>Nursing</td>
<td>84</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>70</td>
</tr>
<tr>
<td>Public Health</td>
<td>42</td>
</tr>
<tr>
<td>Graduate College</td>
<td>27</td>
</tr>
</tbody>
</table>

**Faculty Total = 1,093**
Students (Fall 2011)

Allied Health 641
Dentistry 337
Medicine 1,035
Pharmacy 476
Public Health 259
Plus Graduate College

Plus over 600 physicians in residency and fellowship training in 60 specialties or subspecialties

Nursing 835

Student Total = 3,624
Diversity and Inclusion by Leadership Development: Three Examples and Lessons Learned

The Center for Learning and Leadership/ Oklahoma’s UCEDD

The NARCH Faculty Development Project

The OUHSC Faculty Leadership Program
## Disability in Perspective for Oklahoma

### 2009 Oklahoma Population Comparisons

<table>
<thead>
<tr>
<th>Population Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oklahomans with disabilities</td>
<td>565,619</td>
</tr>
<tr>
<td>Oklahomans (age 5 and up) who have cognitive difficulties</td>
<td>206,578</td>
</tr>
</tbody>
</table>

### Some comparative figures

<table>
<thead>
<tr>
<th>Population Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oklahoma City population</td>
<td>551,754</td>
</tr>
<tr>
<td>City of Tulsa population</td>
<td>386,622</td>
</tr>
<tr>
<td>School enrollment grades K-12</td>
<td>653,585</td>
</tr>
<tr>
<td>Oklahomans age 65 and over</td>
<td>473,565</td>
</tr>
<tr>
<td>Civilian veterans</td>
<td>313,711</td>
</tr>
</tbody>
</table>

Source: Oklahoma Department of Rehabilitation Services. [http://www.okrehab.org/info/OK_statistics.htm](http://www.okrehab.org/info/OK_statistics.htm)
History - Center for Learning and Leadership/UCEDD

• UCEDD founded 1992

• Vision: create accepting, respectful, accessible community for all Oklahomans

• Federally designated center for excellence with specific responsibilities

• “Core business”: education, systems change, policy/research

• OUHSC UCEDD collaborates with in-state Academic Partners and national network of **67 state/territory programs**

• **42** member Consumer Advisory Committee (CAC)

• CAC Co-Chaired by a community member and the program director

• CAC members include faculty, staff, private providers, public agency personnel and people with developmental disabilities and family members of PWDD

• Sibling orgs in Oklahoma: **Redlands Partners** - the Oklahoma Developmental Disabilities Council and the Oklahoma Disability Law Center
Center for Learning and Leadership/UCEDD

- “A Second Opinion”
- Family Faculty
- Partnership Values
Influences on Cultural Competence Expectations

<table>
<thead>
<tr>
<th>Social Paradigm “Alpha”</th>
<th>Social Paradigm “A”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hierarchy</td>
<td>Community</td>
</tr>
<tr>
<td>Exclusive</td>
<td>Inclusive/participation</td>
</tr>
<tr>
<td>Assimilate</td>
<td>Value diversity</td>
</tr>
<tr>
<td>Give and Take Orders</td>
<td>Build consensus</td>
</tr>
<tr>
<td>Control</td>
<td>Shared power/team work</td>
</tr>
<tr>
<td>Compete</td>
<td>Collaborate</td>
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*Our goal: Create a learning and leadership paradigm*

Adapted from Emerging values for a diverse workplace, J. Leach, 1995
The cultural competence skills continuum includes:

CD-------CI-------CB-------CO-------CC-------CP

CD: Cultural Destructiveness
CI: Cultural Incapacity
CB: Cultural Blindness
CO: Cultural Openness
CC: Cultural Competency
CP: Cultural Proficiency
What is Cultural Competence?

“Cultural competency” implies an awareness of health beliefs and behaviors, disease prevention and incidence, and treatment outcomes for different populations. It is, however, important to note that we have much to learn about how to operationalize cultural competency.”

“Within our group, I probably had the least clinical research experience. The NARCH research learning collaborative enabled me to begin research that I wanted to participate in and have a wealth of research experience at my fingertips. Learning the CBPR process and now feeling like a “go to” researcher in my tribal community is priceless.”

--Tom K. MD
Cultural Competence as a skill for research professionals might be measured by:

Ability to design and conduct research in ways that are acceptable and useful to the person participating in the research as a subject or community stakeholder because it is congruent with their cultural background and expectations.

NARCH created a research learning community to build our competence together.
Building Capacity for Cultural Competence

The National Center for Cultural Competence (Georgetown Univ) embraces a conceptual framework and definition of cultural competence that requires organizations to have the capacity to:

(1) value diversity,
(2) conduct self-assessment,
(3) manage the dynamics of difference,
(4) institutionalize cultural knowledge, and
(5) adapt to diversity and the cultural contexts of the communities they serve.
The OUHSC Faculty Leadership Program

• 1990: Decision to upgrade intentional mentoring for early- and mid-career faculty. Created OUHSC Faculty Leadership Program. Core based on work by C. Bland et al.

• 1990 early career longitudinal faculty development inaugurated. Faculty eligible post 1 year on board.
  • 1990 to 2003 had 24-month pgm; 2-days per
  • 2004 to present have 11-month pgm; ~1-day per
  • Accepted class downsized from 25 to 16 per year

• Since inception 363 early career faculty have completed. All OUHSC colleges participate.
# OU-FLP Program Overview

<table>
<thead>
<tr>
<th>Self Management</th>
<th>Mission Skills</th>
<th>Peer Feedback</th>
<th>Leadership Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Faculty Development Plan</strong> <em>(IFDP)</em> Fall – goal setting</td>
<td>Instructional strategies</td>
<td>FLP Faculty Fellow Orientation, ground rules and expectations</td>
<td>Strategic Overview and Goal Alignment</td>
</tr>
<tr>
<td>Goal Alignment Meeting w/ Dept Chair</td>
<td>Learner assessment</td>
<td>Teaching &amp; Test Question Writing simulation and peer feedback</td>
<td>Skills for working with the Media</td>
</tr>
<tr>
<td><strong>Time Management</strong> <em>(professional &amp; Prsnl)</em></td>
<td>Framing Research and Scholarship</td>
<td>Peer-Mentor meetings</td>
<td>Negotiation Advanced simulation</td>
</tr>
<tr>
<td>Individual Faculty Development Plan <em>(IFDP)</em> Spring – post annual review</td>
<td>Preparing the academic advancement CV and dossier</td>
<td>Presenting Your Work 1: Feedback items, set-up, delivery, Q&amp;A, acknowledgement, wrap and transition</td>
<td>Leadership Retreat personality, teamwork &amp; organization culture; leadership cases, legal issues/ case study</td>
</tr>
<tr>
<td><strong>Temperament &amp; Personality</strong></td>
<td>Presenting significance of Scholarship-in-Progress <em>(Abstract prep)</em></td>
<td>Presenting Your Work 2: Refinements and timing</td>
<td>Graduation Remarks by FLP Faculty Fellows</td>
</tr>
<tr>
<td><strong>Negotiation Basics</strong></td>
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</tr>
</tbody>
</table>
FLP Puts Leadership in Context

Teaching -> Administration

Administration -> Service

Service -> Research & Scholarship

Research & Scholarship -> Teaching
FLP Puts Leadership in Context

Care of self & spirit

Teaching

Administration

Service

Care of home and community

Research & Scholarship

Care of loved ones

Care of loved ones
## Early Career Faculty Reported Results – Skill Improvement

<table>
<thead>
<tr>
<th>Skill Description</th>
<th>Improvement (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding &amp; using leadership principles</td>
<td>91.7</td>
</tr>
<tr>
<td>Understanding &amp; using teamwork principles</td>
<td>91.7</td>
</tr>
<tr>
<td>Providing peer feedback to colleagues</td>
<td>91.7</td>
</tr>
<tr>
<td>Requesting focused feedback from senior colleagues</td>
<td>91.7</td>
</tr>
<tr>
<td>Preparing for/taking on a leadership role</td>
<td>91.7</td>
</tr>
</tbody>
</table>

**Summative Bi-Annual 2010 and 2011 cohorts. n = 22; RR 88%**
Lessons Learned

The Center for Learning and Leadership/Oklahoma’s UCEDD

The NARCH Faculty Development Project

The OUHSC Faculty Leadership Program
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• D. Frimberger
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• D. Thompson, PhD
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The 363 FLP Program Graduates to date
Questions?
Save the Date

GFA/GDI
Professional Development Conference

August 9-12, 2012
Indianapolis, Indiana