ADVANCING RELATIONSHIP-BASED CULTURES BOOK CLUB

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Contents

SESSION ONE

Healing Cultures

Assigned Reading—Advancing Relationship-Based Cultures, pp. 23-48.
Recommended additional reading—Advancing Relationships-Based Cultures, pp. 3-18

ONE: A Relationship-Based Way of Being

1. Authors Trout and Koloroutis present a portrait of a relationally proficient person as one who attunes, wonders, follows, and holds (pages 23-24). On pages 24-31 the practices and their benefits are further described.

    - Discuss why these practices would strengthen relational proficiency. Describe how and why they would facilitate instant connection with another person.

    - Which of these practices do you think you do most consistently in your personal and professional relationships? Which of the practices are you most likely to skip or find most difficult to do consistently?

2. Some of the benefits of attuning, wondering, following, and holding are described on pages 28-31.

    - Describe an experience in which you or someone else changed the course of an interaction for the better by attuning, wondering, following and/or holding.

TWO: Attuning, Wondering, Following, and Holding as Self-Care

1. Authors Long and Smith describe how attuning, wondering, following, and holding can be applied in one's relationship with self (pages 35-40).

    - What does it mean to have a relationship with yourself? Why does it matter?

    - How does applying the four practices to one's relationship with self, improve relational proficiency and professional efficacy?

2. Healthy boundary setting is described on pages 40-43.

    - How would improved relational proficiency lead specifically to better boundary setting?

3. The idea that one's own way of being always has an effect—positive or negative—on the whole, is discussed on pages 43-46. This phenomenon is referred to as the "Fractal Nature of Organizations."

    - Is it true that your level of self-care matters to everything and everybody? Why or why not?
    - Discuss the idea, espoused by many, that self-care is an ethical imperative for those in health care. Do you agree or disagree? Why?

On pages 32 and 48 of *Advancing Relationship-Based Cultures,* there are more questions that can guide you to further reflection, understanding, and inquiry.

SESSION TWO

Patients and Families in the Center

Assigned Reading—Advancing Relationship-Based Cultures, pp. 51-100.

THREE: Attunement as the Doorway to Human Connection

1. This chapter opens with a poem by Michael Trout about the loss of identity that can accompany hospitalization and/or serious illness (pp. 51-53).
    - What does this poem stir in you about the experience of being a patient?
    - Does this poem inspire further wonder for you about your patients? If so, in what way?
2. Koloroutis and Trout explain how illness and injuries put people into a non-ordinary state, as well as what a therapeutic response to the non-ordinary state looks like (pp. 53-57).
    - Articulate, in your own words, what is gained by viewing the illness experience as a non-ordinary state and how such insight supports a clinician's capacity to respond therapeutically.
3. The phenomenon of casual diminishment is described on pages 57-61.
    - Were you surprised to find how small a diminishment can be, and still be distressing to someone in a non-ordinary state? In what way does this discussion of casual diminishment help you recognize acts (and inactions) that contribute to the casual diminishment of people in your care? What are the implications for your practice?
4. The concept of "code compassion" is discussed on page 63.
    - What would it take to create a code compassion within your care team? What circumstances might call for a code compassion in your setting?

5. The reader is confronted with an ethical dilemma on pages 66-69: If attunement is the doorway to human connection, and human connection is fundamental to good care, is a failure to attune an *ethical* failure?

    - How might you make the case that the failure of a clinician to attune is an ethical issue?
    - What small actions can every health care worker do to be more attuned to patients and families?

FOUR: The Voice of the Family

1. Authors Koloroutis, Medeiros, and Strom explain on pages 75-83 why involvement of the patient's family is important and why many obstacles exist to involving family members. The point is made that family involvement is most prevalent when the patient is at the beginning or end of life.

    - If family involvement is seen as fundamental to the provision of good care in pediatrics and hospice, why is it more challenging in other adult care settings?
    - What are the barriers to involving family? How can they be overcome? When might it be appropriate to prevent family involvement?

2. Findings from a survey of the family members of patients are shared on pages 83-96. It was discovered that what disturbs family members most are 1) lack of compassion, 2) lack of attunement, 3) not listening to or believing the patient or family, and 4) unexpected outcomes without support and resolution.

    - If you were the family member of an ill or injured loved one, are there any of these experiences that would upset you more than another? Why or why not?

On pages 71, 99, and 100 of *Advancing Relationship-Based Cultures*, there are more questions that can guide you to further reflection, understanding, and inquiry.

SESSION THREE

Leadership (Part One: Loving Leadership/Physician Leadership)

Assigned Reading—Advancing Relationship-Based Cultures, pp. 105-143.

FIVE: Loving Leaders Advance Healing Cultures

1. Inspired leaders who love what they do and the people with whom they do it, inspire others to greatness. Loving leadership is defined as leadership marked by deep affection and caring for those with whom you work and lead (pp. 105-106). It involves nurturing, supporting growth and development, and wanting the best for each person—all in support of the overall mission.

    - What does loving leadership have to do with fulfilling the mission of human caring?
    - What are the potential benefits and detriments to openly using the word *love,* in a platonic way, at work?

2. Themes of 1) loving mentorship, 2) authenticity and vulnerability, 3) a sense that we're "all in this together," 4) humility, and 5) goodness are addressed on pages 108-120, through the words and experiences of loving leaders.

    - Do you recognize any of the traits of loving leaders in yourself? If so, which ones? Which (if any) of the traits do you struggle with, and why?

3. The four practices of attuning, wondering, following, and holding are applied to leaders on pages 120-124.

    - What immediate benefits are you likely to experience if you attune more fully to the people and teams you work with?
    - What immediate benefits are you likely to experience if you train yourself to wonder first, instead of judging or reaching a conclusion too soon?
    - What immediate benefits are you likely to experience if you embark on deeper, more thorough inquiries with your team, even if those inquiries take some time?

- What immediate benefits are you likely to experience if you consciously intend to put more holding into your environment—to accept the holding of others for yourself, and to extend it to others?

4. On page 125, the notion that it is possible to co-create a new cultural narrative in your organization or work area is addressed.

    - What are some of the beliefs that surface most often in the cultural narrative of your organization or work area? If there are unhelpful themes surfacing in your cultural narrative, what can you do to shift that narrative to something more positive, more often?

SIX: One Physician's Perspective on the Value of Relationships

1. In this chapter, David Abelson, MD identifies three assumptions physicians are likely to acquire during medical school and early practice and to hold onto for too long (pp. 131-136). The beliefs are 1) I am separate from and above others, 2) relationships are not part of the real work of medicine, and 3) I must never be vulnerable.

    - Do you agree that these three assumptions are part of the socialization of physicians? Why or why not? In what ways might understanding these assumptions call us to greater compassion and connection rather than judgment and isolation?

2. The notion that physicians have a unique leadership responsibility in health care is discussed on pages 137-142, and a call to action is issued for physicians to more actively cultivate healthy relationships among their colleagues in all disciplines and at all levels.

    - What are the benefits of physicians engaging in the organization as leaders and influencers of the culture?

    - How can you best support yourself or your physician colleagues in becoming more conscious, effective leaders?

On pages 127 and 143 of *Advancing Relationship-Based Cultures,* there are more questions that can guide you to further reflection, understanding, and inquiry.

SESSION FOUR

Leadership (Part Two: Embedding Relational Competence/HR's Role)

Assigned Reading—Advancing Relationship-Based Cultures, pp. 147-176.

SEVEN: Embedding Relational Competence

1. The behavioral practices that bring therapeutic practice to life are outlined on pages 147-151.
    - Using the table of behavioral practices at the end of this document as a reference, discuss what behaviors you see most consistently in your work area? What are the behaviors you see least often in your work area?
2. The integration of behavioral practices into a competency assessment program is discussed on pages 151-157.
    - Discuss the benefits of integrating behavioral practices into your competency assessment and development program. To what extent have you evaluated relational competence in the past? Has it been successful? Why or why not?
3. The leader's role in embedding the four therapeutic practices into a work culture is discussed on pages 158-163.
    - How much focus would you say leaders in your organization or work area have put on relational competence? What actions are possible now that you have access to a list of behaviors that demonstrate relational competence?

EIGHT: The Role of Human Resources in Advancing Culture

1. Opportunities to integrate relational competence into human resources functions are discussed on pages 167-175. Readers encounter content on how to integrate relational competence into 1) recruitment and selection of leaders and team members, 2) onboarding

of new people, 3) developing leaders and team members, 4) reviewing individual performance, and 5) helping outliers exit gracefully.

- Of the HR functions listed above, where would it be easiest to integrate either a clear articulation of the expectation for relational competence or content educating people on relational competence?
- Of the HR functions listed above, where is the requirement for relational competence *already* most clearly articulated in your organization or work area? How and where does relational competence currently show up as an articulated expectation?

On pages 164, and 176 of *Advancing Relationship-Based Cultures*, there are more questions that can guide you to further reflection, understanding, and inquiry.

SESSION FIVE

Teamwork and Interprofessional Practice

Assigned Reading—Advancing Relationship-Based Cultures, pp. 181-196.

NINE: Relationship-Based Teaming

1. The idea that teams are systems is discussed on pages 181-184. It is asserted that healing occurs when teams—and not just the individuals on teams, but the teams themselves—hold patients and families in the center of their care.

    - Koloroutis and Trout (2012, p. 205) suggest that consistent and visible teamwork is a therapeutic intervention in an of itself. Is this true? Why or why not?

2. The relational practice of attuning is applied to teams on pages 185-187.

    - What experiences have you had, as a clinician, patient, or family member, in which the attunement of a team—both to each other and to the patient and family—made a positive difference, or the lack of attunement made a negative difference?

3. The relational practice of wondering is applied to teams on pages187-190. The reflection of the occupational therapist as a member of the care team highlights how important it is for us to wonder about and understand what different disciplines can bring to patient care.

    - How often do you and/or your colleagues think about who might be added to the team, at least temporarily, to create a needed outcome? What disciplines is your team most likely to reach out to? What disciplines are you least likely to reach out to, and why?

4. The relational practice of following is applied to teams on pages190-191. Following (within teams) is defined as the practice of listening to and focusing on what team members are teaching us about what matters most to them and allowing that information to guide our interactions with them.

    - What are the benefits of this sort of close listening and willingness to change course when interacting with team members? What are some of the barriers that keep us from this sort of meaningful interaction with our teams, and how can those barriers be overcome?

5. The relational practice of holding is applied to teams on pages 191-194.

    - What are the benefits of feeling held by your team?
    - What are the benefits to you of being a holder of others on your team?
    - What actions could you take to put more holding into your organization or work area?

On page 196 of Advancing Relationship-Based Cultures, **there are more questions that can guide you to further reflection, understanding, and inquiry.**

SESSION SIX

Patient Care Delivery and System Thinking

Assigned Reading—Advancing Relationship-Based Cultures, pp. 201-220.

TEN: Care Delivery Design that Holds Patients

1. The importance of efficient, effective, compassionate care delivery design and the three simple rules for highly attuned care delivery systems are defined on pages 201-204.

2. Rule #1—Hold the patient and family—is defined and applied on pages 201-207. Applications include 1) use language that holds patients and families, and 2) design transitions that hold the patient and family.

    - What are some experiences you have had as a clinician, patient, or family member that underscore the importance of using language that holds patients and families? What kind of language would help patients and families feel held? What kinds of language could make patients and families feel dropped?

    - What sorts of transitions have you experienced or heard about that caused people to feel dropped? What can help transitions go more smoothly?

3. Rule #2—Make the best way the easiest way—is defined and applied on pages 207-212. Applications include 1) maximize the invaluable resource of the people closest to the work, 2) make it crystal clear who is responsible for what, 3) design processes and structures that minimize reliance on human memory, and 4) make care coordination a priority.

    - What do the people closest to the work see that no one else sees?

    - Why is it not enough for responsibility to be *assigned*? Why is it essential that someone actively, visibly accepts responsibility as well?

    - What are the positive implications of designing care so that care coordination is a priority? How would patients and families benefit? How would the care team benefit?

4. Rule #3—Support all relationships—is defined and applied on pages 212-216. Applications include 1) cultivate ownership and continuity of relationships through a system of

primary clinicians, 2) support interprofessional collaboration, and 3) treat the electronic health record (EHR) as your electronic team member.

- What are some of the benefits to patients and families of instituting a system of primary clinicians? What are some of the challenges, and how might they be overcome?
- Who benefits most from interprofessional collaboration and in what ways? Explain your answer.
- What are the benefits of treating the EHR as your electronic team member? What are some of the challenges, and how might they be overcome?

5. Leadership for care delivery design that is relationship-based is discussed on pages 216-217.

    - Why must the highest-level leaders concern themselves with care delivery design? If the people closest to the work of care delivery are the best people to design care, how would a high-level leader best engage in care delivery design?

On pages 219 and 220 of Advancing Relationship-Based Cultures, **there are more questions that can guide you to further reflection, understanding, and inquiry.**

SESSION SEVEN

Evidence

Assigned Reading—Advancing Relationship-Based Cultures, pp. 225-266

ELEVEN: Evidence that Relationship-Based Cultures Improve Outcomes

1. Peer reviewed studies on the impact of relational competence on quality, safety, the patient experience, employee and physician engagement, and financial performance are shared on pages 225-236.
    - What would explain the positive impact of high relational proficiency on outcomes such as quality and safety?
    - Why might an initiative that works directly on relationships improve employee and physician engagement scores more effectively than an initiative directly addressing employee and physician engagement?
    - Explain the correlation between relational competence and improved financial performance.
2. Findings on the impact of use of the Relationship-Based Care model on quality, safety, and the patient experience, employee and physician engagement, and financial performance are shared on pages 236-242.
    - Which of the outcomes listed in this chapter on the effectiveness of implementing Relationships-Based Care were most compelling to you?

TWELVE: Relationship-Based Care and Magnet® Recognition

1. An overview of Magnet® Recognition and other national awards is given on pages 247-250.
    - What do you see as the benefits of a Magnet or national recognition journey? What do you see as the early challenges an organization might face?

2. The synergy between Relationship-Based Care (RBC) implementation and a Magnet® Journey is explained on pages 250-262.

    - Articulate what you've learned about how an RBC implementation supports an organization's journey to Magnet designation or redesignation.

On pages 243, 244, and 264 of Advancing Relationship-Based Cultures, **there are more questions that can guide you to further reflection, understanding, and inquiry.**

SESSION EIGHT

Continuing the Conversation

Assigned Reading—Advancing Relationship-Based Cultures, pp. 267-270

Epilogue

1. The case is made, on pages 267-270, that appreciative conversations are vital to positive cultural transformation, and that every conversation can be made more appreciative through the actions of any individual who aims to do so.

    - How would you describe the predominant cultural narrative in your organization or work area? What kinds of things do you hear most often?

    - What are you willing to bring to the cultural narrative in your organization or work area? What kinds of questions could you ask or topics could you raise that would move the people around you into their most productive, inspired thinking?

See Me as a Person: Therapeutic Practices Clinician Core Competencies

Attuning	Wondering	Following	Holding
Attention, presence, mindful awareness "tuning in"	***Curiosity, openness, humility, acceptance, suspends judgment***	***Focus, listening, patience, acting on what we learn***	***Devotion, creating a safe haven, compassion, trust, love, transitions***
Tunes in to the energy in the room, including one's own energy, proximity, and pace of communication. Connects with the patient and family with a focus on their state of being (physical, emotional, mental, and spiritual). Minimizes interruptions to care in order to give focused attention to the person Tunes into the patient's family and/or people present who are important to the patient. Stays tuned in to the whole person even when doing technical aspects of care. Conveys openness and acceptance of the patient and family. Recognizes the potential for the electronic health record and other technology to interfere with the therapeutic connection and takes appropriate action to stay tuned in to the person. 	Conveys a genuine interest in the person receiving care. Demonstrates an openness and desire to listen and learn from the patient and family. Stays open and curious to new data and information about the person. Asks open-ended questions to learn about the person's perspective. Suspends own agenda, as appropriate, to learn about the person. Remembers that everyone has a unique history, culture, and backstory that will affect their interactions and responses to care. Avoids assumptions and consciously suspends judgments. Is aware of potential for personal bias.	Collaborates with the patient and family as involved partners in their care. Refrains from interrupting, correcting, or rushing to fix things before hearing the person's perspective. Listens for what is learned about what matters most to the patient. Provides care that is consistent with what the patient and family say matters to them. Notices verbal and nonverbal cues indicating anxiety or distress and responds appropriately. Provides enough time and attention for the patient and family to share what is on their minds. Listens to and validates the person with empathetic sounds and intentional body language. Clarifies and seeks to resolve areas of concern or disagreement with the patient and/or family. Notices and responds to the person's cues and/ or expressed preferences re: proximity, eye contact, touch, preferred name, etc.	Demonstrates knowledge and technical proficiency in the provision of care. Conveys a fundamental regard for the dignity and privacy of all persons. Participates in and encourages consistent and visible teamwork on behalf of the patient. Provides information and support during times of transition to assure that patients know what is happening and what to expect next in their care. Uses the electronic health record and other technology to keep the patient and family informed and involved in their care. Recognizes anger as an expression of fear and takes action to alleviate distress. Remains a steady presence even in the face of strong emotions and crisis. Follows through on commitments to the patient and family. Includes patient and family preferences in the provision of care. Asks for help from other team members, when necessary, to meet patient and family needs. Offers help to other team members to meet patient and family needs. Communicates information about the patient and family to other members of the health care team in respectful terms and language. Avoids derogatory labels or descriptors about the patient and/or family that may bias team members. Koloroutis, 2018