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Good morning, everyone. And welcome to another installment of Dean Lecture Series. We are still welcoming folks as they're coming in, but we'll get started with our introductions.

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So bear with us. My name is Shanaa Turner Smith and I am one of the learning and development managers for the Office of Diversity Equity Inclusion.

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As you now can see, the session will be recorded and shared out within 2 days. To all those who have registered for today's session.

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We do have a live transcription enabled. However, it is not perfect. And so please take care of yourself at this time, but we'll do our best to update the live transcription and provide it on the website.

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We ask that participants use the Q&A function during our session instead of the chat to ask any questions that you have of our guest lectures.

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In the chat you will find a few things pasted which includes a website to the Office of Diversity Equity Inclusion where you can find this recording and all past recordings under the education and training section.

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Additionally, we have provided links to the guest lecturers slide decks for your reference as well.

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And additionally, we asked that if you have any technical issues or accessibility needs that you contact us at DLS-ODEI@umn.edu.

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With that, please enjoy today's session and I'm going pass it over to Dr. Nunez to introduce our guest lectures.

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Good morning everybody. Looks like we are going to have another beautiful fall day, which is delightful.

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And frost isn't for maybe another 10 days or so, which is also delightful.

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I wanted to welcome everybody. I wanted to make a few comments before we get into our presentation.

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First off, I've had a few emails asking in terms of support for war torn areas and atrocities, how could we help?

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And I would suggest to you for to consider one of one of many credible sources, but doctors without borders in terms of making sure that your resources and support in terms of making sure that your resources and support in terms of sort of things get to the people rather than sit on a portrait of things get to the people rather than sit on a port somewhere things get to the people rather than sit on a port somewhere.

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So feel free to sort of provide your generosity in terms of the people rather than sit on a porch somewhere.

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So feel free to provide your generosity in terms of some of the awful things are happening in our society in terms of some of the awful things that are happening in our society right now, and some of the awful things that are happening in our society right now and help.

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So feel free to do that. Switching gears for our topic of conversation today is DEI structural transformation pilot grants that title is a mouthful.

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And so I just wanted to give you a sort of a back story in terms of where this comes from.

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When we talk about structural transformation that takes into account diversity, equity, and inclusion. It's kind of like running a building, having everything work, but switching out bricks that put it together, right?

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How do we change it? Because how it's running isn't really working in an optimal way for inclusive excellence.

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And so from my perspective in terms of the collective wisdom that we have here at the University of Minnesota's Medical School.

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My question was, let's garner that collective wisdom to come up with cross area sort of ideas and then have people figure out solutions because that's what we do.

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We're sort of the solution sort of folks. And towards that, the DEI structural transformation pilot grant project was birthed.

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We have the opportunity for works in progress today to hear from a number of our investigators in terms of sort of what's the question, why they're doing it, and what some early findings might be.

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And so I'm delighted to introduce sort of our speakers here. Our first speaker is Dr. Bashkar Ramskar, MDPHD, a cardiac and Pediatric anesthesiologist and educator with an educational interest in simulation.

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She believes the best care, patient care and health care education can be delivered in diverse, equitable, and inclusive environments.

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She held several titles as professor, residency program director, executive vice chair, department, department of anesthesia, interim vice chair of academic anesthesia at the VA, medical director of MSIM as well as medical director of MVAHCS SIM Center and the medical director University of Minnesota Medical Center East Bank OR.

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All right and with that she's still able to be sort of one of the copiers in terms of a truly interesting project.

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So Dr. Rebskar, I'm gonna turn it over to you. Take it away.

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Wonderful. Thank you for the kind introduction.

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Let me share my screen. And what I'm going to talk to you about today is a project that has been Developed by a team of people.

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Dr. Clark, he's the executive director of AM Simulation. And has contributed significantly to this project with her.

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Theater skills, Dr. Tiryaki is a DIO at the Minneapolis VA Hospital and some of the ideas for these actually came from her workshops that were teaching people about how to manage microaggressions.

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And then Jeremy Johnson, Julia Langard, and King Graham have been essential to developing and putting into action the project that we're working on.

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We have no disclosure, none of us and the problem that we're trying to address. Is the microaggressions that are very prevalent in our environment.

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They are oftentimes very subtle, unconscious, unintentional, or even, but they express prejudice or attitude towards a member of a marginalized group.

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And, as we were thinking through the problem of this being our reality, we felt that it would be important to do several things.

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First of all, a lot of people in our environment will not even recognize a microaggression that's happened because some of these things are so ingrained in our society.

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That they just go by us. We don't pay attention to them. We don't think there's anything that needs to be done and that's a problem.

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Then the second problem that often times exists is that even if people recognize it, they don't know what to do.

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And you know, for myself as an introvert. I always come up with something really, really good to say like 10†min later when the time has passed.

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I can't do anything about it anymore. So having some tools. In my pocket that I have been in a sense thought like even just sentences that I can use.

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To address those situations are helpful. And then, you know, part of the process of obviously is the introspection of trying to reflect on What are some of the things that lead?

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To us not responding. And also not knowing how to respond and there is definitely something to the you know the fact that as a bystander the bystander effect it's called.

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Where if you have a lot of people looking at the same situation, chances are that nobody's gonna do anything.

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And I'll talk a little bit about that. But at the gist of why we felt this would be important to do is the surveys both at the university and the VA hospital which do show that you know for the university there's 18% people who experienced microaggression and reported, I'm assuming.

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That there's more and that it's just not reported. And at the gist of the problem in both places interesting interestingly are the patients that is a relatively challenging group to address because we are also taking talking about patient physician relationship.

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So it gets very complicated very quickly. But we shouldn't completely discard it we should still consider ways of how to address it.

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And then faculty interprofessional teams and so forth. At the VA, the prevalence from staff is about 11%.

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I think those numbers to me seem like same high and I'm definitely not comfortable. Knowing that they probably in reality are higher.

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But I think it's a very important thing that we do have these surveys. As a resource for us to start to understand what are the issues.

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And how to address them. So the ways we can address. Oh, the issues of harassment and microaggressions are multiple and people have tried a lot of different ways.

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The online materials. Are low impact people maybe look at them and then it goes by. Workshops are very time consuming and that's what Dr.

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Teriyaki has learned. And the other thing she learned was that workshops are often attended by people who are already convinced.

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That this is a problem. Rather than by people maybe that we should be reaching with our programs.

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Focus groups are also time consuming, consuming, lecture detectives have low impact. We kind of listen to it and then we forget it.

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It is very important that the institutions have policies in place. Those are extremely important. And then there's also a push for diverse recruitment.

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If you have a reporting system for, harassment and by progression, it's extremely important that there's consequences and accountability.

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And that is an area where significant effort has to be put in. And then, you know, we are talking about changing culture and that as we all know, is extremely difficult and time consuming because some of the the the microaggressions that we are trying to address are really ingrained in our prevalent all around us.

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And you know, very simple low-hanging example of this is that female physicians within the clinical environment oftentimes get called honey.

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Or assume to be a nurse. And then, you know, having support and resources. Obviously, for anyone who is a target of harassment or microgression is also important.

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So a lot of institutional effort needs to go into this. But there's also programs like the one where we're participating in today where people can try to develop innovative ways to to pursue addressing the the issue.

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So our idea was so Dr. Aski was doing. Workshops where she was teaching people how to address microaggressions and I'll show you the model that we've been using for the workshops.

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But as I said, those were those are 2†h at least. Limited number of people can attend so you can touch relatively few people.

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So What we wanted to do is develop short, 10 to 15†min scenarios. That are acted out by standardized patients.

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In real life environment in the clinical world. And the, there is extreme emphasis on this being really short because in the clinical environment there is not time but to offset the shortness we would like to have high frequency.

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So to do that continuously in different environments with different people over and over and over again. The SPs are not only acting out the situation, which is really a scenario that we pulled out of the surveys that I've shown you.

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They're also trained to debrief the situation. So they act out. They things happen and then they debrief the situation with the people that are in that environment at that time.

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And then as I said, we repeat this over and over, share the, hopefully increase the awareness. Micro, different types of microaggressions.

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Hopefully also equip. People, general group of people within our healthcare system with tools to address these.

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What our goal would be is that we basically turn a bystander, which are All of us often times we see the situation, but we passively.

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Don't do anything either because we don't recognize it in time or we don't know what to do where we think somebody else can do it.

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We want to turn people into upstanders who feel confident that they can intervene. And also have tools of how to intervene and also educate everybody around them about what microaggressions are.

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In the technique we're teaching is the 5 D technique. It stands for distract. Delegate directly address delay document.

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So it gives people a variety of ways to address the situation. Distract is basically you just hear something and you go to either the targeted individual or to the person who is.

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Causing microgression and take them away. From the situation by saying, could you tell me where or whatever?

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And it's something like that. Delegate is useful when you are in a situation where you are hierarchically in a position where you don't feel like it would be safe for you to intervene and reach out to your superior.

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And it doesn't happen in the moment but it's still an intervention it still does not leave the situation unaddressed.

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Direct addressing. Is challenging often times. But the technique this tool basically gives you little sentences to use to address the situation.

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Something like I think this is very disrespectful, would be very direct if you're comfortable.

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Or saying I'm feeling uncomfortable, would you be able to explain what exactly you meant by that? So it gives you variety of different things.

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It even goes as far as to say you can just say Ouch. Which brings a tension to the fact that something happened.

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And then you can use the other individual present in in the environment to address the situation. Delay may be, also a very useful tool where you can.

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The situation happens and after the fact you either talk talk to the perpetrator and explain to them what happened and why.

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Maybe they should change how they. They do things or you can talk to the person who's been subjected to it and that is important because it technology is to that individual that something did happen that it's not okay that you saw it.

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With this confirmation is also extremely important. And then documentation, right? We should teach everyone around ourselves what the tools are in are in specific institution to document these events because if they're not documented that they did not occur as far as the institutional perspective goes.

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So when we implement it, so we started off with the survey, we took out the scenarios, then luck it for us, Dr.

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Clark worked in the theater so and was directing place and such. So she clearly knows how to write.

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Scenarios. And then ASPIs were trained to act them out and then engage people around them and all these happens in about 10†min.

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Including the debrief portion. And the debrief can be different based on what the people that are engaged do, they may not even notice and then the discussion is a little different.

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They may notice but do not intervene or they do intervene but it's not very effective or they are very good at this.

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And know exactly what to do. So asp's are trained to be able to Develop a discussion in whichever way is a necessary.

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Some of the things we've learned as we are starting to pilot these things. Was that first of all We are now making the environment where we're doing this clearly labeled.

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That the simulation is happening. We do oftentimes communicate, for example, with the nurse manager that it's gonna happen.

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And then, so there's, plenty signage and everything. One of the reasons for this is because we're doing this in clinical environment, there's patients and everything, so it's important for everybody to know that this is training.

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The other thing we've learned is that you can potentially with the scenarios we're playing out trigger people which is you know, something that we now put some emphasis on.

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Making sure the SPs are equipped. By the ability to respond to it. In terms of participants.

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What we've learned is that people are extremely reluctant to intervene and that's probably true of real life.

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Situations as well. In the scenarios we had to make quite absurdly obvious. And then, you know, we are more and more aware of the fact that we really need to speak to those 10†min.

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That's why we call the project take 10. Because in clinical environment that's gonna be a very important thing.

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I'm going to show you the video, one of the videos from our training and I'm you guys let me know if you can hear the sound once it comes on if not I'm gonna just Hi Alex, my name is Chris.

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I'm going to be your nurse in recovery. I just wanted to check in with you. What are your pronouns?

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Alright, and are you experiencing any pain at all? No pain. I feel great. All right, is there anything I can get for you before I get the report from your team?

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No. And, and, So this is Alex. He had a Hello, Lasty. Anyways, there is a drain that is hooked up near his parts.

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The drain has been sutured and covered with. Nepalax dressing. Oh, I'm sorry, my mistake.

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Anything else for the report? No, that should be everything. He They, did really well with us today.

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Anesthesia, you can do report. Good luck with everything Alice.

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So this is sort of a an example of what would happen. In the real clinical environment. We base this particular.

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A scenario on our experience in the periop area on the West Bank where we do significant number of the procedures.

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And have had some challenges with people knowing how to react how to behave how to use pronouns so this is one of the scenarios based on that.

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We also have Jen scenario related to age scenarios related to gender and our library of these scenarios is increasing.

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During the scenario, the individuals can react to it. immediately or if not, then we kind of discuss what happened.

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We can, play the whole scenario and have participants potentially. Try how they would address things. And then the intent is to hopefully over time.

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Show and that's we're thinking several years show change in the institutional surveys if we do this long enough.

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We're also doing brief surveys pre-imposed. Primarily just kind of targeting and exploring self-efficacy which you know is based on past experiences of individual, modeling by others, for the individual.

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Coaching and feedback that we can provide to people. And then, you know, how people are able to take what they've learned and put it into practice and feel themselves being successful.

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So, those are 2 ways that we're trying to measure, obviously the institutional survey will take some significant time.

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But we've done the scenarios at the VA hospital where this has become institutional priority. In 5 different clinical environments so far.

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And have gotten very positive feedback, just the subjective. Impression of how these were perceived. We've learned that majority of people do see about or at least or confident and aware that they've seen or participated in 2 or to 5 instances of microaggressions every year.

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And and with the, with the, scenarios that we bring to them, they feel more comfortable after one event that is frequent people will frequently feel more comfortable after they participated in simulation that does not necessarily mean that they have the the skills but Right, it's important.

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That, they, also, to understand that they are not 100% in these just yet.

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So they've, answered. Honestly, they did not say that for certain they say that they may feel more comfortable.

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They are more likely to intervene just because we also give them a badge body that basically gives you a few of these phrases to use.

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They think they would achieve the goal that they would have with the intervention and that they'll do well.

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These are obviously all subjective matter measures they're gonna be important to confirm with more objective tools.

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The observations from this, initial experiences are that there's very frequently people notice they can describe to us exactly what happened, but they do not intervene.

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And frequently they say they just didn't know what to do or how to approach the thing. And then part of these is oftentimes also what I've mentioned at the beginning, the bystander effect where you know, if there's several people, nobody does anything, there's some diffusion level of the fusion of responsibility.

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People also, well, if nobody is doing thinking if nobody's doing anything. Maybe. It's not so bad.

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Social cues around us. There's some assumptions. Oftentimes people are well, somebody will do something.

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And the situations are not, especially micro aggressive situations are not. Very obvious, but they're no less detrimental.

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And we always have to be aware that the microaggressions are cumulative and are happening to specific groups of people over and over all the time.

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There's some awkwardness. Some of us are introverts and are not, you know, very willing to expose ourselves.

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And maybe we even misinterpret situations and say, well, they were just this or that. And don't intervene so I think there's a lot of, for us to learn from the initial experiences, I think on the side of how to best.

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Deliver the the content. Also learning how to deliver these events safely for everyone. As I mentioned, there's some ability to potentially trigger people, which we have to be very cognizant of.

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And then obviously much more, data collection needs to occur. One thing that did transpire.

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Through our project is that the more different ways of delivering this content we can think of outside just of the civility code.

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We call them civility codes because we're equating them with the Mach codes that we do in the hospitals already for the actual resuscitative effort for patients and these are these we call civility codes.

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But that's not enough. I think that's why we recorded the videos to have that accessible to more people who can use the videos for their own purpose and to initiate the discussion.

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We need to do in person events. We need to continue to do workshops present these in conferences.

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Try to reach out to community outside of our state. And I think it's also important to have the support.

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It's crucial. For us, for example, at the VA for the institution as a whole.

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To make this a priority. It makes delivery of the content much easier. Than if there's not a serious institutional support.

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And with that, I'll stop. Thank you for your time and I think we're gonna be taking the questions at the end.

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Yes, I think.

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Apologize for the mighty noisy environment in the background, but I got full because of COVID that's going around I got pulled back into the OR today so I apologize for that.

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No, thank you very much for your presentation. Hopefully we'll be able to have you sort of with the QA, if not, maybe sort of answering sort of later.

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But thank you for a wonderful presentation. For those folks, please put in some of your questions and comments in the Q&A section, which we will attend to sort of at the end.

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So group number 2, being led by Dr. Katie Lingras, PhD LP, her experiences in early childhood mental health research, practical applications and policy implications.

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She specializes in socio-emotional development early in middle childhood with particular emphasis on children experience behavioral concerns after traumatic events.

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She's in the Department of Psychiatry in behavioral science. She co-directs the early childhood mental health program, serves as the director of inclusive excellence and well-being and co-founded the department's DEI committee in 2,017 way before I got here in addition to outpatient treatment and assessment for work is centered on community-based collaboration with pediatric

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primary care clinics, early childhood programs where she regularly conducts trainings that link DEI making it relevant and obviously to children's mental health talking with children about race and racism.

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She codorex the DI thread within the undergraduate. Education curriculum from 21 to 23 chair of the and as chair Emeritus in terms of the medical student DEI counsel with the office and diversity and inclusion.

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She's joined by Angela Goyle, MDMPH. Dr. Goyle is the developmental behavioral pediatrician currently works in academic medicine along the next generation of physicians.

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She's previously worked in the Twin Cities community practicing primary care. Infernal medicine and pediatrics for a decade, her passion for social justice brought her full circle and life back to advocating for equity and justice within medicine.

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She serves as the Associate Chair for Equity, Diversity, and Inclusion and Department of Pads currently serves as director of clinical coaching for the University of Minnesota Medical School and is one of our sort of inaugural DI coaches.

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Dr. G, Goyle earned her MD from the Medical College of Ohio, her MPH in maternal child health in the University of Minnesota.

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She completed her residency, internal medicine and pediatrics and fellowship and general academic practices at the U.

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Dr. Goyle's intention is to show up fully and authentically. Well, not easy.

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She embodies the practice to model her different vision for medicine. Mind-body medicine is at the court what she does, taking the patients to county residents and medical students from working with faculty to being wife.

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Mother and friend. Joining them is Dr. Gun Fan. And, and, Dr.

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Fom is the assistant professor of medicine, University of Minnesota. He completed his residency training at you in internal medicine pediatrics.

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He currently has a mix of clinics at Koop, Community University Healthcare Center where he serves the underserved citizens of Minneapolis, co-created the addiction, Medicine Service at the University of Minnesota's Medical Center and his associate vice chair for DEI.

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In the Department of Medicine, co-founder and the current president of Minnesota. Doctors for health equity.

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All right, so now like your talks done, right? Because you guys are so great. But I'm gonna turn it over to you, Dr.

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Linguist to sort of take it away with your colleagues. Thanks.

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Thank you. Dr. Nunez. We are all excited to be here with you this morning.

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So we'll go ahead and get started on our presentation which is entitled Recommendations for Inclusive and Act, Equitable Promotion and Tenure in Academic Medicine, which is a mouthful.

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And you'll hear from 3 of us this morning that are presenting on behalf of this amazing team. We have 6 faculty members across 5 departments.

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Who came together with 2 really wonderful medical student research assistants and they've been just truly critical to our team and our work.

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I want to just make a quick note about the one kind of fun fact about this team is that we had actually come together prior to the call for proposals for this particular grant.

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And we've kind of formed effectively a peer support group of folks who were doing DEI work across different departments and just kind of sharing ideas and experiences and support and so I think that's really kind of a novel.

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Fact about our group in that we had, really been looking for a way to work together when this all came out and so we kind of pulled together some ideas that we'd had of basically questions and topics we'd run into in our kind of pure support group to propose this project.

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So I think that has really affected kind of the the wonderful way that we're able to work together and happy to chat about that more in our Q&A.

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So let's get to the project in particular. So just give you a little bit of background of why this topic and what specifically we're talking about.

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We know that promotion and tenure processes are crucial for reputational purposes, for advancement to leadership, for recruitment and retention within our academic institutions.

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Of course, we also have prestige and at times financial incentives for pursuing that process as well.

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And at the same time we know that folks don't always go up for promotion and tenure even when they're eligible.

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So we had lots of folks both in our group and our colleagues that have experienced this and witnessed this.

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And we noticed particularly that a lot of folks who are working in spaces that are traditionally named service, especially within the DEI realm, we're not able to necessarily incorporate that work into the current PNT processes.

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And so in fact, this is underscored by the double AMCs recent survey of over a hundred medical schools.

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And they found that less than half have specifically focused DEI related scholarship or service kind of categories that we can kind of quote unquote count our work in that realm.

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We also realize specifically within our institution that there's really limited information about the experiences that applicants for promotion and tenure have after the fact.

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So we don't have a lot of opportunities to go back to those folks and say, how did this go for you?

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And so that was part of what motivated our questions here. I wanted to add this piece in because this is a podcast that was recommended to me by one of my colleagues who you heard from last month, Ganesh.

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And this is a team of physicians who are from. And this is a team of physicians who are from Emery and UCSF respectively, Dr.

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Mcmillan and Dr. Manning. And this most recent episode I happen to be listening to on Sunday, I just wanted to kind of pull quotes from the entire episode because it really articulates exactly the why for this question and these questions that we are pursuing in this project.

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So really briefly, Dr. Manning had gone up for or had had a meeting, a mentoring meeting about going up for a promotion and tenure and basically was told by somebody who was not racially concordant who was an older white man, you know, you're really not ready.

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And maybe in 3 or 4 years. And, you know, she made the interesting point of he wasn't trying to be mean, he wasn't, you know, trying to discourage me he was just saying that based on what he's seen and what he's seen is that people, it's people who look like him who do what he does, how he does it the way he does it.

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And she really kind of goes on to talk about this idea of creating the remix, a new generation, a new iteration of folks who are able to go up for promotion based on the really critical work that they're doing and the idea of that also being that those folks will be able to then pave the way for others coming after us to be able to say, you know, even though this doesn't traditionally fit into

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the box and what we might think of. It's important and here's why and here's where it's having an impact.

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And the final piece of that is really to allow folks to be able to go up and do this work and pursue their careers as authentically themselves without having to change themselves or their work or their passions or the things that they care about.

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So I'll pause the quotes there just because like I said, I could really quote this entire episode.

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I encourage you to check this out for more of that. Kind of underlying why. Okay, we are going to just share briefly about the overarching goal then of our project aims.

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And was really to create ultimately recommendations for departments to incorporate P and T processes that include a DEI informed approach.

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And so this is a big question we tried to kind of break it down to a few different steps. First of all, just looking at what's out there, what are our peer institutions doing to create DEI informed promotion and tenure processes.

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We then wanted to also review our own 5 departments and see what do those statements look like what criteria exist within the existing statements both.

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In general, NDI specifically related. And then experiences across our 5 departments and folks who have gone up for promotion and tenure in our departments.

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Ultimately, then we are intending to write a kind of written overview of best practices. Summarizing both what we're seeing at our peer institutions and what we're seeing in our departments and making some recommendations for the future.

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And we'll plan to also meet with our key stakeholders through the Office of Faculty Affairs, ODEI, and others who are working at these same goals.

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So our project is divided into 3 phases. The first phase was really that. Systematic review and analysis of what's publicly available.

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Related to criteria that are being used at our peer institutions. Our second phase is looking both qualitatively and quantitatively at the 5 departments in our, in our university and in this project here to really elucidate, elucidate barriers and facilitators of the process.

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Of both going up for a promotion and tenure and also for incorporating a more DEI informed view and approach into that process.

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And then finally, as I mentioned, that phase 3 is the formulating recommendations and suggesting some mechanisms for both implementation and sustainable change.

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So we're going to just briefly walk through a couple of these phases here and give you a sense of where we are at.

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So Anjali Goyle will share a little bit about our first couple phases here.

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Thank you. Katie. So as, I'll discuss phase one findings in our poster presentation.

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So Katie, you'll go on to next slide. Thank you. So as Katie alluded, we completed phase one, which was the systemic review of both publicly available statements from institutions comparable to the university in Minnesota as well as what literature we could find that identified DEI criteria that were used in the PNT process.

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And, Katie, you'll go into next slide. This is a picture of our presentation, our poster.

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And these are the key takeaways from the literature review. There was a dearth of literature on implementation of DEI considerations in PTTE criteria.

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And what we found is the work that does exist largely is limited to opinions and recommendations. In addition, only one.

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Medical school noted to require faculty to report DEI activities. And few schools really offer optional mechanisms for candidates to highlight their work such as specialized statements or portfolios and I I wanted to mention that poster was presented at a Department of Medicine research day by our bear 2 remarkable medical students.

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Next slide. All right, so phase 2 findings, looking at both quantitative and qualitative results from the interviews with our PNT chairs and those who had gone up for promotion.

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Okay, so qualitative information from the interviews that we're done with our PNT committee chairs.

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The good news. As stated here, majority see the process is going well. But we wanted to summarize some really important points here that there were many areas of improvement.

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That were mentioned by majority of chairs that have significant DEI implications. For example, if you got 5 listed here.

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The first one needing a clear and transparent process for feedback to committee chairs after promotion and tenure after faculty have got up for a promotion and tenure that that does not exist in each department.

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Many talked about the existence of unwritten rules such as what type of funding you need to receive to advance forward.

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And that that needs to become more transparent. Many of the chairs, brought up the issue of mentorship.

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And that while mentorship is a essential for promotion and tenure, what needs improvement is, is being able to recruit skilled mentors, being able to pair mentors and mentees.

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And all, and all PNT chairs. Spoke of the importance of that relationship and how that can facilitate.

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The process of going out for permission in tenure.

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Many of our department chair or sorry promotion tenure chairs mentioned demographics and specifically 2 areas.

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Committee chairs noted that they were not aware of whether those who are going up for promotion. And have been promoted actually represent the demographics of the department.

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And also not enough data is whether the P and T, the committee reflects the demographics of the department.

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And finally, lack of guidelines on incorporation of DEI work. And how to measure. The qualitative impact of the work.

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Next slide. Alright, so, hand it over to Ku.

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Thanks, Angela. Well, my name is Koo. I'm an assistant professor in the department of medicine and faculty since 2,011 have not gone up for promotion.

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But I'll be sharing with you the survey part of our study. This is focused on the faculty that have gone up for promotion.

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You decided to implement the survey for 5 years back and the reason we chose 5 years is when we created the academic track at that point in time.

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So we just wanted to make sure that the experience was similar during the last 5 years ago, rather going back 10 years.

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We had about 300 some people that had gone up for a promotion in the last 5 years.

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100 or 11 people responded to our survey. The survey was done this past summer. They're only 3 questions that were required of this survey.

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Under all the questions were optional, particularly around their demographics. The question they're required were around their rank.

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Department they're in and the track they want up for promotion and you can see that in the graphs right here.

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About 61% were going up on the academic track. And the reasons that you only see 5 departments is that these are the departments that the faculty on this research team are part of.

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And then in terms of demographics, about, 81% of people identified themselves as white.

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We only had one person identified themselves as black and 3 identified themselves as Latinx. Next slide.

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In terms of that quantitative part of this survey, we did a light chart scale. We had several statements that we wanted people to respond to.

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We asked people to respond to the statement of reflecting on the process for promotion. Please respond to the following statements.

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So most of the responses were neutral. The ones that are in black here in both the black were more of the either positive or on the disagree side.

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So on the agreement side that there were people that felt that the promotion process was well worth it. At the end of it was worth it to them.

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On the side of disagreeing, I have if it was helpful was in terms of time needed for preparation or whether the works program was helpful.

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In this process. And the last thing that we bully on this, on this table you see is in blue, we just wanted to make sure that we identified that what was the DI lens in the P and T process for people.

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And people's perception of it for most of the committee work was that it was neutral too. What I gather from this table is really that you know that promotion is hard work there's barriers to it but once you get through it's worth it for people.

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Next slide. Thanks.

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This is more of the qualitative side of our survey. These are open questions that we gave for people.

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None of these questions were, required. Our goal was really to understand the facilitators and barriers to promotion for our faculty.

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The preliminary themes that we got from these questions, particularly around their motivation, is number one, people wanted recognition and promotion, it had to be the right timing.

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And then promotion also helped them achieve their, their goals and their work, particularly for a professional opportunity standpoint.

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2 major things that people did bring up was around mentorship and needing more admin support. So people either felt that it was really good and those went up for promotion or really is something lacking in the process for them too.

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Thanks for holding them back from promotion was that in terms of timing and the process of it, it seemed overwhelming.

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There's lack of sometimes transparency or clarity for them. And then the last, the next slide is talking about the next steps overall.

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As Katie mentioned that, you know, as we finish our analysis of our interviews and surveys, we want to kind of build recommendations that we can come back and focus on really a systems change level.

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I'm not so much as in the, of change. We want to disseminate the survey to our the people who actually respond to the surveys and our PNT chairs and committees in general.

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And obviously bring back the feedback to our departments and our office effectively fears and the task forces, they're looking around promotion in general.

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And then next slide. And I don't want to go too deep in this because we don't have a lot of time left and I want to make sure this time for the other presenter is that you know what we've learned so far is there's lacking data understanding the demographics for the applicant pool for promotion.

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There is lacking of DEI criteria for promotion in general. Packle team need early engagement around promotion just so that there is some transparency and clarity in that process.

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And people just need more support in general, whether that is through what works looks like or admin or time.

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But ultimately our goal is to look at ways how to make sure that faculty are not left behind in terms of promotion and how to find all those barriers and facilities in that process.

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And then I think that's it. We'll do some Q&A afterwards. Thank you for listening.

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Alright, thank you very much. Team, interesting stuff, lots of questions, but let's get, Dr.

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Patel here. So Dr. Semi Patel, assistant professor, neurology at the U since 2,012 full-time clinician focusing on complex epilepsy management with surgical interventions and pharmacological treatment at the UMP, MSP, Epilepsy Care Program.

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She had her undergraduate degree in community health and health administration from University of Illinois, Urbana, Champagne, and her medical degree from Rush Medical College, completed a neuroresidency training at the Medical College of Wisconsin and until your epilepsy fellowship in Cleveland Clinic Foundation.

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She is passionate about resident education, female physician empowerment, epilepsy research, pretending to women with epilepsy and epilepsy clinical therapeutic trials.

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Welcome. Dr.

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Thank you so much for the night. And, Fishineo, you're gonna do the slides.

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Well, thank you. So our project is understanding DEI chair and lead experiences. We had an outstanding team with Katie Lingras, Kate Mackolette, and Vanessa Hemingson.

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Thank you so much for your hard work. And to ODI for the grant and the opportunity. Next slide, please.

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The focus of this project is to understand what DEI chairs and leaders what the strands and challenges are in this work.

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We have an outstanding medical school community. We do some really good work. We all know it's hard work.

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It's uncharted territory. So there's opportunities for learning and growth. And that's what I want to talk to you about today.

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Next slide. The structure of this program was divided into a brief survey. And interviewing. 23 participants in focus groups.

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3 focus groups from June to July of 2023. And these are all chairs or leaders in DEI within their department.

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Next. As we created the survey and the focus group questions, we really wanted to make sure to engage key stakeholders.

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We asked faculty members, Sea Winds Group, DEI Council, and ODI for their beat feedback on our methodology.

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Because one of the key aspects of this project is dissemination through this network also. Yes. Now the survey, is, a Kate Mcelot's idea, if you can go to the next slide, and Kate did an awesome job thinking about a needs assessment.

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So the survey really focused on what are the areas that DEI leaders need help with. And we focused on domains of knowledge, empowerment, experience, resources, support.

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And I will go a little bit more into this. Next slide. Kate. Those needs assessments are based off of Maslow's hierarchy and I'm gonna go into that momentarily.

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The demographics of our group is 67% predominantly women. 71% bipod, 29% LGBTQ.

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Predominantly academic faculty. Or assistant professors in early career. Do you want to point out with our demographics and we probably see this in our DEI chairs and leaders, this is a minority group.

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This is a group that cares about the war because it impacts them. It impacts them in their lives and their work and their bringing their aging to the table.

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So thank you for that. Next slide. No, Kate, came up with this wonderful needs assessment where we, she talked about Maslow's hierarchy and thinking about what do our DEI chairs need from a Maslow's hierarchy perspective.

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So some of the questions we asked. Are based on this and I will highlight the hierarchy.

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The bottom is the needs in the foundations. And as you go higher, it's where you get to self-actualization and higher impact.

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Next slide. So this is a assessment of needs and this was participants were asked in a survey to talk about.

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What they felt with their DEI role. Did they feel energized, safe, resource, knowledgeable, empowered in experiments?

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Now save and resourced is probably more on the foundation of that Maslow's hierarchy.

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Experience is probably in the middle and then as you get higher to that peak, this is where people make their impact.

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They feel energized. And empowered. And knowledgeable. So the.

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Areas that we're doing a really great job in our community safety. 3.5. So 4 represents most of the time.

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The 3.5 out of 4 tells us that leaders in DI in our community medical school community feel safe.

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That is wonderful because that is a fun. Now with that, how can we move up to the higher, actualization?

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3, a good majority people also feel energized, so they're feeling safe and energized to do the hard work that's required.

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To create diversity, equity and inclusion in our community. Now areas of opportunity are resources and feeling empowered.

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And gaining experience. So I want to talk a little bit more about that with our, other data.

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Now, this is a Pearson's correlation matrix. And we looked at if you the 2 areas where people needed were a little bit lower on the score or empowered and.

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I'd like to ask our leadership to kind of zone it on those 2 variables and see what can we do to make a difference for when you're feeling empowered.

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People, there's a high correlation that's statistically significant. People feel knowledgeable, safe, and resourced.

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So the empowerment piece is something as a community. We want to focus on. What does that entail?

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Now feeling resourced enough. Is highly correlated also with feeling empowered, knowledgeable, energized, and also having experience.

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Now this is a variable that the medical school and our leadership can control. So, and that also as I listed out is statistically significant.

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Next, the focus group was phenomenal. We had 30 pages of data. We zoomed in on the key points.

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So these are the different domains we found. So roles and expectations, 80% report unclear expectations for their votes.

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Now, this makes sense because this is new for many medical schools and universities throughout the country in the last several years.

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We are an uncharted territory. However, we do want to think about this is what our leadership in the DEI community in the departments are new.

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80% report that and some of the quotes are expectations are not clearly outlined. I think nobody has told us what the competencies are.

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So we're creating them as we go on. Excellent quote is feel like I've been building the plane with flying in.

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Next. Other challenges and concerns are. Of the participants, 80% feel they lack time to do the work.

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60% are concerned about succession. I turnover and earn out. And 55% report monetary compensation for their leadership.

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Which means, 45% are not compensated for their time. This goes back to the resources. So we need to think about ways to create that.

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Equity within and throughout the, yeah, leadership. In our medical school. Next.

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Some of the quotes are there's no protected time for the work. You know the building measurable, yeah, goals in terms of views and promotion and There's a minority tax.

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Due to being a minority, I get chosen. I did point out early in the demographics that most of these leaders are from.

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Let's. Now knowledge and training, 70% state they feel they have support by non leadership relations and resources at the university which is good the resources are at the university.

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50% black knowledge training and empowerment. 45% focused on self education through multiple modalities.

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Some of the quotes are finding out what's working at other institutions. We don't have formal training for some of these roles.

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Looking at what people are doing across the country and circling back again to the training portion. Next slide.

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Now I focused a lot on some of the challenges, but I really want to zone in and say we're doing again, John.

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We really are. I want to point out that safety number was high. And we have an energized community that cares about the work.

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We're doing the work and this. Brandon represents that. 45% talked about health and create grand rounds as being very positive.

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35% talked about speakers and facilitators being very helpful. As a successful strategy.

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30% highlighted that engagement with trainees and medical students is extremely positive. And I just wanted to point out justice talking circles.

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How cool is that? So people within our community were doing amazing work. It's innovative and there's opportunities for cross collaborations.

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Thanks. So summary and take away point is that the majority of our DEI leads do identify. With multiple socio demographic intersections from the historically disenfranchised groups.

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It's the minority tax is real. And we do wanna make sure that this group that is doing the work.

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With high levels of energy was feeling resourced. Cause if we do that, it's going to have a higher impact.

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Take us to that peak on that Do you work is complex necessary. It is adaptive change. Our community needs it.

00:58:10.000 --> 00:58:18.000
And thinking about ways that we can make our DIA leaders feel empowered and resource. This is a question for the leadership.

00:58:18.000 --> 00:58:23.000
This will help in a house all those other correlates, the safety knowledge experience of And that is the end of the presentation.

00:58:23.000 --> 00:58:30.000
Thank you so much.

00:58:30.000 --> 00:58:37.000
Great. Thank you so much. Thank you everybody. I know we sort of run out of time for Q&A's please enter them anyway.

00:58:37.000 --> 00:58:41.000
We'll stay for a few more minutes in terms of that so that we can sort of address them.

00:58:41.000 --> 00:58:54.000
I know I have sort of tons of questions, but I appreciate all your hard work. And hope your your feeling support in terms of sort of this presentation for sort of the great stuff you're doing.

00:58:54.000 --> 00:59:00.000
We are in nationally uncharted territory and you are all helping us in terms of moving forward.

00:59:00.000 --> 00:59:07.000
So look forward for ongoing discussions and to be respectful in terms of people's time. First stuff in the QA, onward and outward. Hope you have a great day.

00:59:07.000 --> 00:59:14.000
Thank you, panelists, for such a fabulous presentation. Appreciate it. Take care.

00:59:14.000 --> 00:59:20.000
Thank you, everyone. Again, a one question survey will appear in your well browser after ending this Zoom session.

00:59:20.000 --> 00:59:33.000
Please take a minute to complete as it will inform us of future presentation topics and a reminder that the session was recorded and it will be shared in about 2 days under the ODEI web page under education and training section.

00:59:33.000 --> 00:59:44.000
Save the date for our next session on November eighth. See you then.