A Relational Approach to Interprofessionalism and Workforce Diversity Management

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ABSTRACT

Interprofessional collaboration remains a challenge in the healthcare workplace, compounded by an increasingly diverse workforce. In recognition of these dual challenges, healthcare professionals now receive training in both interprofessional collaboration and diversity. Relational coordination theory suggests that effective management of both professional and social diversity requires the capability to build high quality relationships across differences. In addition, recent research suggests that professional and social diversity are two types of diversity that intersect, creating the phenomenon of invisible work and posing obstacles to achieving desired outcomes. We report on the development of an innovative pedagogical approach that combines interprofessional and diversity training, informed by existing research and findings from 15 semi-structured interviews of experts in interprofessional education, diversity training and relational coordination. We describe the resulting curriculum called "Relating Across Difference" that is designed to build high quality relationships across both professional and social diversity, embedded in the quality improvement context. We share participant feedback on key elements of this curriculum from an early pilot.

Key words: interprofessional collaboration; diversity; invisible work; relational coordination; training

INTRODUCTION

Though progress has been made, interprofessional collaboration remains an ongoing challenge in the healthcare workplace (House & Havens, 2017; Wang et al., 2018). Layered on top of the interprofessionalism challenge is the challenge of an increasingly diverse healthcare workforce. The healthcare workforce is becoming increasingly diverse for a number of reasons – changing population demographics, increase in retirement age and an increasing organizational interest in diversifying the composition of their workforce in order to retain the resources necessary to position them for success (Snyder, Frogner, & Skillman, 2018). In the U.S. the overall health workforce is slightly more diverse than the overall population; however, "the majority of people of color in healthcare jobs remain in entry-level and often lower paying jobs with little opportunity for advancement, such as aides, assistants, and technicians" (U.S. Department of Health and Human Services, 2017; Snyder, Frogner & Skillman, 2018; Wilbur et al, 2020). As a result, organizations are faced with an increasing need to facilitate collaboration across diverse workers with different levels of professional status in order to achieve desired outcomes…even as they work to enhance the status of, and opportunities for people in entry level jobs and support functions.

Following a review of the literature, this paper reports findings from semi-structured interviews of 15 experts in interprofessional education, diversity training, and relational coordination training. Informed by the literature review and interview findings, we report the development of an innovative pedagogy for training health professionals that uses a relational approach to interprofessionalism and diversity in the context of clinical improvement.

BACKGROUND

Relational Approaches to Interprofessionalism

High quality relationships, including civility (Oppel et al., 2019), shared goals, shared knowledge and mutual respect (Gittell, Godfrey & Thistlethwaite, 2013; Torring et al., 2019; Thygeson et al., 2021) are central to interprofessionalism. Relational coordination, defined as a mutually reinforcing process of communicating and relating for the purpose of task integration, is a relational approach to coordinating work that has been applied in multiple sectors, particularly in healthcare (for a systematic review see Bolton, Logan & Gittell, 2021). Relational coordination theory and the relational model of organizational change appear to provide a useful approach for strengthening interprofessional care (Gittell, Godfrey & Thistlethwaite, 2013). See **Figure 1**. From the educational perspective, several early experiments suggest that relational coordination serves as a useful component of medical education (Stoller, 2020; Traboulsi et al., 2021; Warde et al, 2014) and nursing education (Azar et al., 2017; Valenziano et al., 2018). In particular, relational coordination helps to focus attention on the quality of communicating and relating between professional roles, not just individuals, while orienting participants toward **systemness** - seeing their work in the context of the whole work process. As a multi-level model of systems change, relational coordination also provides guidance regarding relational, work process, and structural interventions for strengthening interprofessional role relationships (Gittell, 2016; Abu-Rish Blakeney, et al., 2019, 2020; Purdy et al., 2020; Thygeson, et al., 2021). At the micro level, when bringing people together across professional differences and hierarchies, it is helpful to create psychological safety, for example by asking participants to leave titles at the door, by role modeling appreciative and humble inquiry, by role modeling empathy and respect, and by role modeling relational responsibility and behavioral

accountability (Nembhard & Edmondson, 2006). At the meso and macro levels, structures can be designed to support high levels of relational coordination across diverse professions (e.g., Gittell, 2002; Gittell, Seidner & Wimbush, 2010; McDermott et al, 2019) and across distinct organizations and sectors (Gittell & Weiss, 2004; Caldwell, Roehrich & George, 2019).

Relational Approaches to Diversity Management

One central challenge that organizations face is that diversity tends to weaken the relationships that are needed for information processing, due to biases, misunderstanding, interpersonal conflicts and subgroup formations (Chatman & Flynn, 2001). People tend to form strong relationships with those with whom they share common characteristics while they tend to develop prejudices and stereotypes against those who differ from themselves (Van Knippenberg et al., 2004). Diversity in salient characteristics can therefore hinder workforce performance.

However, when managed effectively, diversity can improve organizational performance by integrating multiple perspectives, thereby improving the quality of decision-making, and enhancing performance (Lee & Kim, 2019). From a healthcare perspective, diversity among providers and between providers and patients offers the potential for greater information richness, which can enhance outcomes including patient well-being. The heterogeneous perspectives and high information levels found in a diverse workforce should increase task-related discussions, deepen understanding of work issues, and lead to a mutual interchange of fresh ideas (Ancona & Caldwell, 1988; Bantel & Jackson, 1989; Olson, Parayitam, & Bao, 2007; Van Knippenberg et al., 2004; Williams & O'Reilly, 1998).

Consistent with this relational approach to diversity management, social psychologists have found that people who are empathized with, respected and listened to are more likely to empathize with, respect and listen to others, even between in-groups and out-groups (e.g.,

Gutsell & Inzlicht, 2012; Kluger & Itzchakov, 2022; Itzchakov & Weinstein, 2021), and that training can help (e.g., Itzchakov, Weinstein & Cheshin, 2020). However, some argue that diversity training has been insufficiently attentive to building high quality relationships, instead falling into the trap of reducing people to caricatures and abstractions (e.g., Valdary, 2021). A newer strand of the diversity management literature argues that high quality relationships are central to effective diversity management (e.g., Lee & Kim, 2019). Though initially applied to professional diversity, relational coordination may be well suited to bridge across social diversity, due to the communication dimensions that enable information processing across differences, and the relational dimensions that enable cohesion across differences (Lee & Kim, 2019). Consistent with this argument, relational coordination has been shown to serve as a path between workforce diversity and performance outcomes, facilitated by structures that enable feedback among participants and shared accountability for outcomes (Lee & Kim, 2019).

Invisible Work

The challenges of managing diversity may be further exacerbated by the phenomenon of invisible work. Oftentimes, work that is important to the mission and vision of organizations remains unrecognized, unappreciated and undervalued. This has been described in the literature as "invisible work" (DeVault, 2014), a concept originally developed by feminists in the 1970s. The literature on invisible work is limited and, where it exists, is mostly attributed to the social identities (e.g., race, gender and socioeconomic status) of individuals performing the work. Fletcher (2001), who studied female engineers in a male-dominated industry, explained that certain behaviors are "disappeared" even when they are essential for desired performance outcomes, because they are associated with the feminine, relational or so-called softer side of organizational practice. DeVault (2014) described the visible and invisible work that people of

color do in order to maintain full membership in the society – and also the work that privileged groups do, either to assist or to block that kind of membership. DeVault (2014) also extended the idea of invisible work to the work of people living with disabilities.

Building on intersectionality theory (Crenshaw, 2017), invisible work has been identified as occurring at the intersection of multiple subordinated professional and social identities, for example, a nurse who is also a woman of color, or a patient care assistant who is also a recent immigrant of color (Olaleye & Hajjar, 2022). This intersection results in a compounded identity that is neglected to the point that their work becomes invisible, ultimately serving as an obstacle to team performance. In a clinical change initiative using relational coordination and lean improvement as complementary methods, Olaleye and Hajjar (2022) found that relational mapping and the measurement of relational coordination across professional roles helped participants to notice invisible work. However, there was insufficient understanding of what to do about it. The curriculum developed below is an attempt to build that understanding.

Learning Models

The hidden curriculum in professional education - values that are expressed implicitly through the policies and work processes - in how students are treated - can and often does undermine the formal curriculum, which may be advocating for collegiality and civility at the same time that one's clinical leaders and mentors demonstrate the opposite (Hafferty, 1998; McNair, 2005). According to the Institute of Medicine (2003): "Hidden curricula of observed behavior, interactions and the overall norms and culture of a student's training environment are extremely powerful in shaping values and attitudes. It often contradicts what is learned in the classroom." When training is embedded in the clinical context, faculty and students are better able to learn together, thus enhancing faculty's ability to serve as positive role models for their

students. In addition, due to the long-standing challenge of transferring learning into practice (Patterson et al, 2013), embedded learning is more effective than classroom learning particularly when participants are *learning how* versus *learning what*, for example, learning how to coordinate an emergency response as a member of a multidisciplinary team (Brazil et al., 2019).

Based on this review of the literature, we propose that a training intervention embedded in the clinical context that builds relationships of shared goals, shared knowledge and mutual respect across professional, gender, racial, ethnic and socioeconomic differences may enable healthcare organizations to better leverage the rich information offered by their diversity to improve patient and provider outcomes.

METHODS

To inform development of the curriculum, the first and last authors conducted semi-structured interviews of 15 experts in interprofessional education, diversity training, and relational coordination training. **Table 1** shows our interviewees and their areas of expertise. Each interview was scheduled for one hour, beginning with a brief background of the project, and followed by four areas of questioning: 1) What has been your experience with diversity training? In your experience what works and what does not work? Did you try to innovate/ seek outside resources in cases where it didn't work? 2) How might relational coordination principles and interventions contribute to a more effective diversity training? 3) How could we design this training to be most impactful through creative modes of delivery, and through putting together heterogeneous groups of healthcare professionals? 4) Do you have specific ideas about how we can evaluate this training? The interviews were recorded, transcribed verbatim, and coded for themes by the first and last authors, who met periodically to establish interrater reliability.

Informed by our review of the literature and these interview findings, we drafted a curriculum including both content and delivery methods and shared this draft curriculum with our interviewees for additional feedback. We then partnered with clinical leaders in the Cleveland Veterans Affairs (VA) Quality Improvement Scholars program to test key elements of the curriculum. Nine VA Quality Improvement Scholars involved in ongoing improvement projects participated in two 3-hour long workshops over a one-month period and completed a pre and post workshop survey about awareness of professional and social diversity on their healthcare team, comfort with thinking and talking about it, and knowledge of how to transform it into a source of strength.

RESULTS

Here we share three kinds of results - themes that resulted from our semi-structured interviews of experts, the curriculum that was informed by these interviews, and preliminary feedback on key elements of this curriculum.

Themes from Semi-Structured Interviews

Five primary themes and nine sub-themes emerged from coding verbatim transcripts from semi-structured interviews with 15 experts in interprofessional education, diversity training, and relational coordination training. The emergent themes and illustrative quotes for each of them are summarized here, and shown in greater detail in **Appendix A**.

Theme 1: Training should address multiple types of diversity. Interviewees noted that multiple types of diversity - race, religion, gender, gender identity, age, disability, interprofessionalism, and more - are often addressed by separate training initiatives. While separate trainings are useful for building specific awareness of the experiences of specific marginalized groups, interviewees also argued for the benefits of a training that would help

participants to address multiple types of diversity in an integrated way - in particular integrating across multiple kinds of social and professional diversity, based on the argument that professions themselves are a type of diversity that intersects with social diversity. One interviewee shared:

> *"When we talk about interprofessional collaboration, it is very much like diversity that we are talking about. Yeah, there are people, there are professions that are excluded. We don't include them, we don't allow them to speak - there's hierarchical behavior. We don't care what they have to say. And we've experienced that and … when you talk to people that have felt that way, individually, they describe similarities, so … there are some similar things to focus on."*

Theme 2: Training should build awareness. Interviewees also emphasized the importance of building participant awareness of the lived experiences of those with different identities than one's own, and awareness how those lived experiences differ from one's own. Multiple methods can be used for building these kinds of awareness. The use of storytelling and narrative was the most common method described, where awareness is achieved through telling one's own story and deeply listening to the stories of others.

> *"So listening to the experiences of people of color is a way to sort of start to get around that - so to create narratives and to start to hear what's happening. And that creates shared knowledge, right? I feel like I have much more shared knowledge of my colleagues now about their experience even if they don't look like me, because they tell me about it and we have, then used to hear about it. Responding to people's experience with validation and respect is really important. One of the big complaints that I've only recently become aware of is how often women and people of color feel like their experiences are invalidated, they're told that they were too sensitive, that they're imagining it that they're calling something racism that isn't racism and one of the big asks from our diversity leaders is stop doing that, that if, if, if that was their experience that with their experience you do not have to agree with their interpretation of it for yourself. But stop telling them that they shouldn't feel the way they feel and listen to it and validate it and try to be an ally and help respond to things that need to be responded to."*

Training should also build awareness of one's biases and privileges, for example by confronting participants with data or other evidence of their privilege. One participant shared for example:

> *"Some of it is about self-awareness of who you are, where you're at … I attended a special training on women, white women, and the power we have, and how we abuse that*

power, and it was from an expert on white women and racism. And so, a lot of it is really uncomfortable, it's like things you never had ever thought about. So, a lot of it is almost like you need to go away and sort of hug yourself and say, this is really hard. You're going to be okay, you know we're in it together, we're going to learn it, but my god I had no idea, why didn't I have any idea? I have a PhD. I should be a lot - you know - more in tune to what's going on in the world."

This confrontational method can be approached in a compassionate way, as described by this interviewee:

"So one of the things I started off with is letting everyone know when they come into this, that everybody wants to be seen as good and moral. That's an aspiration. And by and large people do act that way. But we're not always at our best. We're not always our noblest self or our biggest self. And in those moments when we don't have command of our emotions or command of our emotional challenges, we may say or do things that may be construed as being hurtful, discriminatory or racist. If, however, ...you're masking it, you're still in denial. You're losing a lot of goodwill and now trying to draw people into whatever you're going to do further is basically a hell of an uphill battle so that's the first thing is set the stage that you could be a good and moral person, capable of having done and acted in a racist way, but that doesn't necessarily define you as a racist. Okay, so you can lean into this space now and have that conversation. So, this is about that we don't have mutual respect, but we come to it in terms of honoring the dignity and worth of another human being. It sets the stage for actually being able to have shared goals, because we can now establish an area of commonality, and that allows us to share our knowledge because we're now being seen, and [we] take it on face value as coming from positive intent."

According to this interviewee, compassionate confrontation can build awareness in a way that sets the stage for building deeper relationships of shared knowledge and mutual respect.

Theme 3: Training should build skills. The third theme that emerged from our interviews was the importance of translating awareness to behavior change by building and practicing skills that enable participants to harness difference as a resource on their teams. Knowledge about differences alone does not always translate into action and so, a training that combines awareness with the development of skills for talking and acting on differences or to issues related to diversity are most effective. Sub-themes included methods for building these skills. By embedding training into the work that people do, it makes the training an organic

process and more relevant because it clearly demonstrates how to manage the interdependencies that exist across different types of diversities in real time.

> *"You have to create training that's relevant to the situation. So, we know that with relational coordination there has to be an interdependency right and that it has to be around something. It can't be a generic - here is this package of training - or it's not going to work. So, in this, specific work environment, in this particular workflow, how are you going to use that and what is the interdependency? And then the training should be relevant for that. …We just don't do relational coordination of everybody; it's got to be a specific group that has these interdependencies that make sense, and they have to be aware of what is it we're trying to do, like, our team was trying to improve, you know, patient outcomes in one unit because they were having poor patient outcomes."*

Embedding diversity training into one's everyday work is fairly novel, though it has been done in some innovative curricula with interprofessional training. Additionally, using simulation, case studies and videos that depict real work experiences helps to contextualize the learning experience and creates an environment that participants can relate to. One cautionary note however is the opportunity for re-traumatization as people learn new skills and test them out on colleagues in more subordinated identities:

> *"[I've seen a training where] the white students were very engaged in working on skills. … And the people of color were like, emotionally struck by it because this happens to them, and it wasn't an academic abstract subject, really, or a skill like learning how to suture like this is ways in which they are victimized regularly, and they needed time in the course to process it. They couldn't just go and practice microaggressions, they had to have some space to talk about what it meant in their lives because it was real for them in a way that, you know, it can be invisible for people with privilege. I think that for me that's changed how I think about some of this work, because I tend to be like those white students. I'm so excited, I want to get better, get to work on the skills. Let's practice because it's safe for me and I don't get treated that way. …What are the implications for an experiential field-based component of this work?"*

Theme 4: Training should build relationships. Perhaps the central theme in these interviews was the importance of training people to build high quality relationships. Managing diversity starts by knowing that people exist, and one way to do this is by acknowledging the

need for a relationship developed on shared knowledge of different experiences. As one interviewee shared:

> *"Key insights relational coordination can provide [are] making visible who is involved in the work, and what they actually do, and how that affects the others. There's some steps going out from there [but it starts with] knowing they exist, knowing what they do, acknowledging the need for a relationship. … And on the other hand, it's mutual respect. Because you cannot talk about timely, accurate and problem-solving communication with people you don't know exist, right?"*

Training should emphasize and demonstrate the importance of listening to learn and responding to varying experiences with validation and respect. Trainers can do this by role modeling humility - acknowledging their ignorance and stating their intent to be a partner and ally. Training should also create a safe space where all participants feel included and comfortable sharing about their experience and their biases without fear of judgment - both those in subordinated positions as well as those in power. One interviewee shared for example:

> *"You have to leverage the people in power … You know, if you want to put them to work, then you need to bring them on board somehow. And to me that's a relational view, right? It's sort of crafting a message of this is how we are in this together. And here are the parts that we are playing together. So, let's do that. Let's do something together. I think it is radically compassionate. I think some of it comes from my own religious background, my own personal beliefs … Right, so that's a radical take on forgiveness. We see these amazing miraculous stories, and I do think that's what we need."*

In short, diversity training should take a relational stance, helping to build shared goals, shared knowledge and mutual respect across professional and social diversity.

Theme 5: Organizations should support training success. Interviewees also discussed the role of the organizations that are hosting diversity training. Their motivation should be based on embodying organizational values and not just about achieving regulatory compliance. One interviewee shared that:

> *"Simply doing things because, for example, the Joint Commission requires us to provide interpreters for our patients - this doesn't work. It has to be part of the organization like a true commitment to make diversity important, regardless of who is watching - that is*

> *what works but when it becomes a check a box it doesn't because I've seen employees disappointed and demoralized when organizations just go through cycles of doing interventions that I just check the boxes."*

Another interviewee explained that one of the organization's motivations could be to build community:

> *"...You can't make people do stuff. So, you need to get people to want to be there. So, in terms of an institution and, and members of the institution … it should be clear to them why such training is going to be worthwhile. And I believe that it's not going to be effective if people are feeling attacked, or blamed. So there has to be a spirit of - I'm learning the term value proposition - so it has to be clear to people why - like why - show up? Whatever the color of your skin, you know why you're there. And how is this connected to sort of a broader sense of community that is beneficial to all of us."*

Organizations can show further commitment by articulating clear objectives, providing financial support and creating implementation structures for diversity management and the interventions that address it, thus avoiding the sense of a "one-off" event. It is important for example that there is leadership alignment and commitment to diversity management evidenced by investment, financially and in structures that support success of diversity management initiatives. Organizations can affect real change from top to bottom beginning with leadership embracing the culture of diversity as the starting point for alignment across the organization. Leadership alignment creates the environment that allows for organic conversations to happen and for true changes in behaviors and culture to occur at the system level.

Theory of Change and Curriculum Development

Our review of the literature and our qualitative data both were consistent with a multi-level relational theory of change. Our resulting curriculum, called "Relating Across Differences: An Improvement Process for Clinical Units," reflects this theory of change, focused on driving change in attitudes and behaviors on the frontline while recognizing the importance of organizational and leadership support for sustaining change. Theme 1 is reflected

in the content of each workshop, which addresses both professional and social identity diversity together, a strength of this curriculum design. Theme 2 is reflected in the design and content of the first workshop, which is focused on helping participants build self-awareness, and awareness of others as it relates to differences. Theme 3 is reflected in the design and content of the third workshop which focuses on helping participants develop and practice skills for harnessing difference as a resource in their everyday work. Theme 4 is captured in the design and delivery of all RAD workshops which emphasize the practice of group reflection aimed at recognizing and repairing bumps, but also for strengthening relationships of shared goals, shared knowledge and mutual respect. Theme 5 is part of our theory of change though it is not fully reflected in the design of the curriculum. Rather we aim to achieve leadership support at the health system level through site selection.

The curriculum is designed to be implemented through a sequence of activities on specific clinical units over a period of one year, as shown in **Table 2**. A detailed description of project roles and responsibilities required to successfully implement the curriculum is shown in **Table 3**. These workshops will be delivered to the QI and Leadership Teams and facilitated by the Coaching Team for each participating clinical unit. A current draft of the detailed curriculum is shown in **Appendix B**. The goals, content and follow-up activities for each of the four workshops are described briefly below.

Workshop 1: Build awareness. The goal of this workshop is to help participants develop awareness of their own and others' social and professional identities, how they experience differences and why it matters. The workshop will also enable participants to develop awareness of the value and potential challenges of diversity, and the importance of managing it well in order to achieve desired outcomes. This workshop will utilize personal

assessment tools, personal stories, response to videos, relational mapping and facilitated conversations. For example, participants will develop a relational map of a current coordination challenge in their clinical unit, identify all relevant roles in that coordination challenge, and assess the current state of relationships and communication within and between those roles. Between Workshops 1 and 2, participants will lead their colleagues through the same exercises.

Workshop 2: Build skills. The goal of this workshop is to help participants develop and practice skills for harnessing difference as a resource and for recognizing and repairing the inevitable ruptures and bumps. Participants will learn skills for creating a safe space with their colleagues, and interventions for strengthening relationships of shared goals, shared knowledge, mutual respect. Participants will also learn how to teach these skills to their colleagues. Between Workshops 2 and 3, participants will lead their colleagues through these same skill building exercises and will invite them to participate in a baseline Relational Coordination, Equity and Well-Being Survey.

Workshop 3: Review baseline data and design interventions. The goal of this workshop is for participants to review baseline data from the Relational Coordination, Equity and Well-Being Survey, to prepare to share the data with their colleagues, and to begin designing interventions based on the data. Between Workshops 3 and 4, participants will share baseline survey data with their colleagues, and design and implement interventions with them. Finally, they will invite their colleagues to participate in a follow-up Relational Coordination, Equity and Well-Being Survey.

Workshop 4: Review follow-up data and assess progress. The goal of this workshop is for participants to reflect and learn from their experiences in the previous workshops. They

will also review follow up data from the Relational Coordination, Equity and Well-Being Survey, assess progress thus far, and seek to identify areas for continued improvement.

Learning Lab. As each participating clinical unit completes the curriculum, members of the QI and Leadership Teams will be invited to join a Learning Lab facilitated by Coaching Teams from across all participating units. The goal of this Learning Lab is to provide ongoing support to clinical units by sharing, sustaining and disseminating their learning rather than allowing it to degrade over time. This Lab will provide an opportunity for regular check-ins and refreshers with other clinical units in their own and other health systems.

Feedback on Key Elements of the Curriculum

To practice and receive feedback on the elements of the curriculum that we were least familiar with, we carried out abbreviated versions of Workshops 1 and 2 with a focus on building awareness and skills to strengthen relationships across professional and social diversity. Participants included nine Cleveland VA Quality Scholars who were leading quality improvement projects with interprofessional clinical teams. Co-authors on this paper attended and provided detailed qualitative feedback. Feedback from this exercise lead to a few changes in the content and delivery of training curriculum including clearly defining and describing social and professional identity; laying out the objective of each activity beforehand; clearly tying the content and activities in training to differences (professional and social) and finally, utilizing stories and case studies all through the workshops to keep participants engaged. Feedback from the abridged version of the evaluation tool yielded the following finding (shown in **Table 4**):

Build awareness. Pre and post surveys suggested that participants were more *aware of the professional identities* of their team members, and more *aware of how their own professional identity impacts their team members*, following the two workshops relative to before. Likewise,

participants were more *aware of the social identities* of their team members, and more *aware of how their own social identities impact their team members*. Participants reported a small increase in seeing *professional diversity as a current source of strength* and a small decrease in seeing *social diversity as a current source of strength* on their team.

Build skills. Changes in reported skills were mixed. Participants' c*omfort with thinking and asking about professional identities* of their team members did not change. Participants' *comfort with thinking about their own social identities* did not change, but their *comfort with asking others about their social identities* increased. Perhaps most importantly, participants reported *increased knowledge of how to transform professional diversity into a source of strength*, and *increased knowledge of how to transform social diversity into a source of strength* on their team. While these are self-reports of increased skills from a very small pre-pilot, these are the kinds of skills the curriculum is intended to foster.

DISCUSSION

At the start of the project, findings from our literature review and from semi-structured interviews with 15 content experts suggested that 1) a training curriculum addressing interprofessionalism and diversity issues together would be feasible and potentially effective, 2) a sequencing of awareness building and skill building would be effective, and 3) delivering content in the context of an ongoing quality improvement project would mitigate the challenge of knowledge transfer and help to ensure implementation success. Based on these early findings, we developed a curriculum combining interprofessional education and diversity/ equity/ inclusion. This training curriculum has the goal of integrating what participants are already learning about IPE and DEI in their health systems into ongoing quality improvement activities, through developing high-quality relationships across professional and social diversity. Because

the curriculum focuses on building high quality relationships of shared goals, shared knowledge and mutual respect across professional differences (e.g., nurse, doctor, medical assistant, pharmacist) and social differences (e.g., race, gender, class), it can potentially address the issue of invisible work that is believed to be exacerbated by the intersection of these identities. These changes are expected to improve well-being for patients, staff, and leaders, with potential benefits for resilience and retention.

Consistent with findings from our literature review and semi-structured interviews, this innovative pedagogy sequences awareness and skill-based training. In addition to helping participants to gain more awareness about themselves, this sequencing enables them to develop shared knowledge about each other, potentially strengthening mutual respect. This sequencing results in cognitive changes in knowledge about diversity, attitudes to valuing diversity, as well as behavioral changes in skills which are important for the transfer of training into practice. The behavioral changes are characterized by the ability to communicate more effectively (accurately and timely) across differences. Additionally, this approach mitigates the limitations of an awareness-only training because it shifts perceptions from stereotype-reinforcing to stereotype-challenging. Consistent with our early findings, and to mitigate the challenge of initiative overload and standalone initiatives, this curriculum is designed to support QI teams using a coach-the-coach model to help them build relationships across differences in their clinical units as part of their quality improvement work.

Feedback from the pre-pilot suggests that the RAD curriculum has the potential to build awareness and skills for addressing professional and social identity diversity issues in healthcare teams. A practical implication of this is that it offers healthcare organizations and managers the opportunity to apply relational approaches to addressing issues of IPE and DEI in a more

effective and efficient manner. While the pre-pilot participants were few and lacked sufficient social diversity, the goal of that exercise was to test certain novel elements of the curriculum and to learn about the content and delivery from the process. Consequently, the pre-pilot exercise sets the stage for further development and testing of this innovative pedagogy.

Limitations going forward include the challenge of coaching QI teams to lead conversations about professional and social diversity, given QI team members may typically be selected and trained for their technical competencies more than their relational competencies.

CONCLUSION

In summary, this paper describes the process of developing an innovative pedagogy utilizing a review of relevant literature and multi-stakeholder engagement. Preliminary results from this process suggest that there is a potential benefit of combining interprofessional and diversity training using principles of relational coordination, because IPE and DEI both require the ability to relate across differences. It is therefore worthwhile and efficient to further develop and test this innovative pedagogy.

REFERENCES

Abu-Rish Blakeney, E., Lavallee, D. C., Baik, D., Pambianco, S., O'Brien, K. D., & Zierler, B. K. (2019). Purposeful interprofessional team intervention improves relational coordination among advanced heart failure care teams. *Journal of Interprofessional Care*, *33*(5), 481-489.

Abu-Rish Blakeney, E., Ali, H. N., Summerside, N., Lavallee, D. C., Kragen, B., Willgerodt, M. A., ... & Zierler, B. K. (2020). Sustaining improvements in relational coordination following team training and practice change: A longitudinal analysis. *Health Care Management Review*, 10-1097.

Ancona, D.G., & Caldwell, D.F. (1988). Beyond task and maintenance: Defining external functions in groups. *Group & Organization Studies, 13*(4), 468-494.

Azar, J. M., Johnson, C. S., Frame, A. M., Perkins, S. M., Cottingham, A. H., & Litzelman, D. K. (2017). Evaluation of interprofessional relational coordination and patients' perception of care in outpatient oncology teams. *Journal of Interprofessional Care*, *31*(2), 273-276.

Bantel, K.A., & Jackson, S.E. (1989). Top management and innovations in banking: Does the composition of the top team make a difference? *Strategic Management Journal, 10*(S1), 107-124.

Bolton, R., Logan, C., & Gittell, J. H. (2021). Revisiting relational coordination: A systematic review. *The Journal of Applied Behavioral Science*.

Brazil, V., Purdy, E., Alexander, C., & Matulich, J. (2019). Improving the relational aspects of trauma care through translational simulation. *Advances in Simulation*, *4*(1), 1-10

Caldwell, N. D., Roehrich, J. K., & George, G. (2017). Social value creation and relational coordination in public-private collaborations. *Journal of Management Studies*, *54*(6), 906-928.

Chatman, J.A., & Flynn, F.J. (2001). The influence of demographic heterogeneity on the emergence and consequences of cooperative norms in work teams. *Academy of Management Journal, 44*(5), 956–974.

Crenshaw, K. W. (2017). *On intersectionality: Essential writings*. The New Press.

DeVault, M. L. (2014). Mapping invisible work: Conceptual tools for social justice projects. *Sociological Forum*, 29(4): 775-790.

Fletcher, J. K. (2001). *Disappearing acts: Gender, power, and relational practice at work*. MIT Press.

Gittell, J. H. (2016). *Transforming relationships for high performance*. Palo Alto, CA: Stanford University Press.

Gittell, J. H. (2002). Coordinating mechanisms in care provider groups: Relational coordination as a mediator and input uncertainty as a moderator of performance effects. *Management science*, *48*(11), 1408-1426.

Gittell, J. H., Godfrey, M., & Thistlethwaite, J. (2013). Interprofessional collaborative practice and relational coordination: Improving healthcare through relationships. *Journal of Interprofessional Care*.

Gittell, J. H., Seidner, R., & Wimbush, J. (2010). A relational model of how high-performance work systems work. *Organization science*, *21*(2), 490-506.

Gittell, J. H., & Weiss, L. (2004). Coordination networks within and across organizations: A multi-level Framework. *Journal of management studies*, *41*(1), 127-153.

Gutsell, J. N., & Inzlicht, M. (2012). Intergroup differences in the sharing of emotive states: Neural evidence of an empathy gap. *Social cognitive and affective neuroscience*, *7*(5), 596-603.

Hafferty F. W. (1998). Beyond curriculum reform: Confronting medicine's hidden curriculum. *Academic Medicine*, 73 (4):403–7.

House, S., & Havens, D. (2017). Nurses' and physicians' perceptions of nurse-physician collaboration: A systematic review. *The Journal of Nursing Administration*, 47(3), 165-171.

Institute of Medicine (2003). *Health professions education: A bridge to quality*. Washington, DC: National Academy Press.

Itzchakov, G., Weinstein, N., & Cheshin, A. (2022). Learning to listen: Downstream effects of listening training on employees' relatedness, burnout and turnover intentions. *Human Resource Management Journal*.

Kluger, A. N., & Itzchakov, G. (2022). The power of listening at work. *Annual Review of Organizational Psychology and Organizational Behavior*, *9*.

Lee, H.W. & Kim, E. (2019). Workforce diversity and firm performance: Relational coordination as a mediator and structural empowerment and multisource feedback as moderators. *Human Resource Management*, 59(1), 5–23.

McDermott, A. M., Conway, E., Cafferkey, K., Bosak, J., & Flood, P. C. (2019). Performance management in context: formative cross-functional performance monitoring for improvement and the mediating role of relational coordination in hospitals. *The International Journal of Human Resource Management*, *30*(3), 436-456.

McNair, R. P. (2005). The case for educating health care students in professionalism as the core content of interprofessional education. *Medical Education*, 39(5), 456-464.

Nembhard, I. M. & Edmondson, A. C. (2006). Making it safe: the effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams. *Journal of Organizational Behavior*, 27: 941–966.

Olaleye, O. & Hajjar, L. (2022). *Building relational coordination for team-based care: An experience report.* Brandeis University Working Paper.

Olson, B.J., Parayitam, S., & Bao, Y. (2007). Strategic decision making: The effects of cognitive diversity, conflict, and trust on decision outcomes. *Journal of Management*, 33(2), 196-222.

Oppel, E. M., Mohr, D. C., & Benzer, J. K. (2019). Let's be civil: Elaborating the link between civility climate and hospital performance. *Health Care Management Review*, 44(3), 196-205.

Patterson, M. D., Geis, G. L., Falcone, R. A., LeMaster, T., & Wears, R. L. (2013). In situ simulation: Detection of safety threats and teamwork training in a high-risk emergency department. *BMJ Quality & Safety*, 22(6), 468-477.

Purdy, E. I., McLean, D., Alexander, C., Scott, M., Donohue, A., Campbell, D., ... & Brazil, V. (2020). Doing our work better, together: A relationship-based approach to defining the quality improvement agenda in trauma care. *BMJ Open Quality*, 9(1).

Snyder, C. R., Frogner, B. K., & Skillman, S. M. (2018). Facilitating racial and ethnic diversity in the health workforce. *Journal of Allied Health*, 47(1), 58-69.

Stoller, J. K. (2020). A perspective on the educational "SWOTh" of the Coronavirus Pandemic. *Chest*.

Thygeson, N. M., Logan, C., Lindberg, C., Potts, J., Suchman, A., Merchant, R., & Thompson, R. (2021). Relational interventions for organizational learning: An experience report. *Learning Health Systems*, e10270.

Tørring, B., Gittell, J. H., Laursen, M., Rasmussen, B. S., & Sørensen, E. E. (2019). Communication and relationship dynamics in surgical teams in the operating room: An ethnographic study. *BMC Health Services Research*, 19(1), 1-16.

Traboulsi, E. I., Blanchard, A. K., Passiment, M., Agrawal, D., Baron, R. B., Calongne, L., ... & Weiss, K. B. (2021). Pursuing excellence: Driving GME integration with health system strategic priorities. *Journal of Graduate Medical Education*, 13 (1): 153–160.

US Department of Health and Human Services. (2017). *Sex, race, and ethnic diversity of US health occupations*. Health Resources Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis.

Van Knippenberg, D., De Dreu, C.K., Homan, A.C. (2004). Work group diversity and group performance: An integrative model and research agenda. *Journal of Applied Psychology*, 89(6):1008-22.

Valdary, C. (2021). A hole in the heart of anti-racism training. *The Boston Globe*, February 3.

Valenziano, K. B., Glod, S. A., Jia, S., Belser, A., Brazell, B., Dellasega, C., ... & Dillon, P. W. (2018). An interprofessional curriculum to advance relational coordination and professionalism in early-career practitioners. *MedEdPORTAL*, 14.

Wang, Y. Y., Wan, Q. Q., Lin, F., Zhou, W. J., & Shang, S. M. (2018). Interventions to improve communication between nurses and physicians in the intensive care unit: An integrative literature review. *International Journal of Nursing Sciences*, 5(1), 81-88.

Warde, C. M., Vermillion, M., & Uijtdehaage, S. (2014). A medical student leadership course led to teamwork, advocacy, and mindfulness. *Family Medicine*, 46(6), 459-462.

Wilbur, K., Snyder, C., Essary, A. C., Reddy, S., Will, K. K., & Saxon, M. (2020). Developing workforce diversity in the health professions: A social justice perspective. *Health Professions Education*, 6(2), 222-229.

Williams, K.Y. & O'Reilly III, C.A. (1998). Demography. *Research in Organizational Behavior*, 20, 77-140.

Figure 1: A Relational Model of Organizational Change

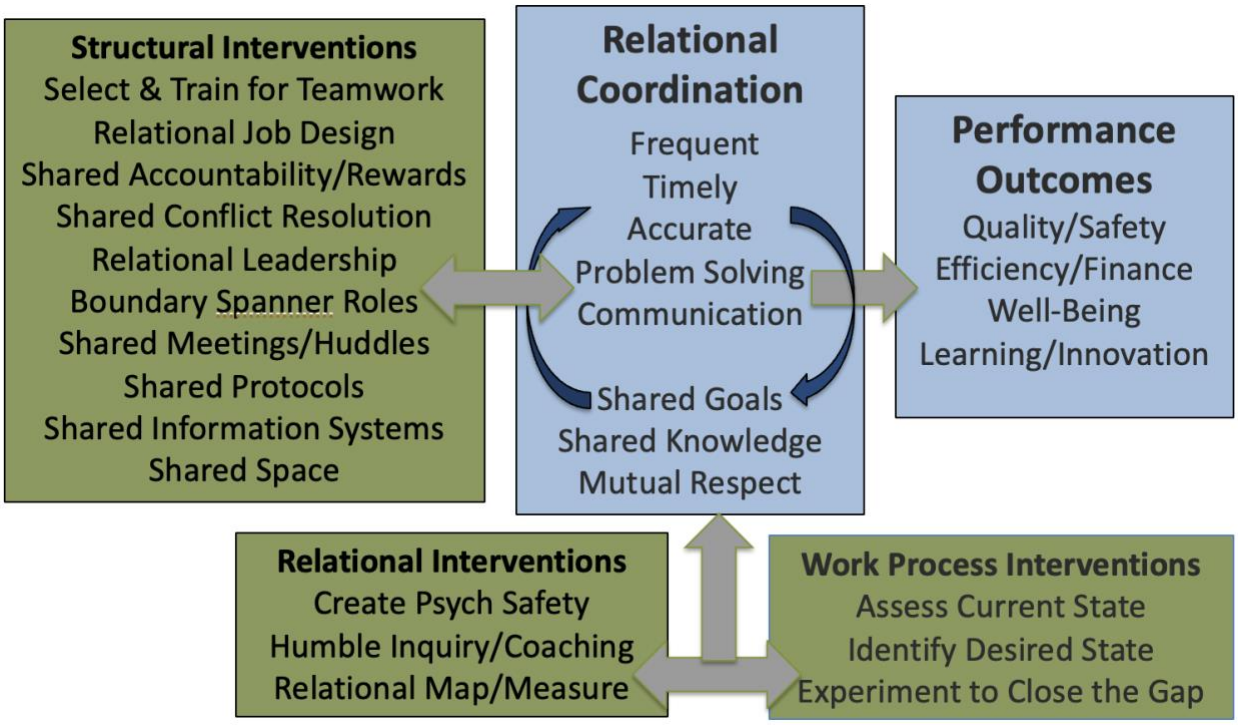


Table 1: Interviewees and Their Areas of Expertise

ID	Interviewees	Areas of Expertise
1	Linda Akuamoah-Boateng, Suffolk University	Interprofessional Education Diversity, Equity and Inclusion
2	Tyler Reimschisel Cleveland Clinic; Case Western School of Medicine	Interprofessional Education Diversity, Equity and Inclusion
3	Tony Suchman, Relationship Centered Health Care	Interprofessional Education Relational Coordination
4	Tim Gilligan, Cleveland Clinic	Interprofessional Education Diversity, Equity and Inclusion
5	Shyamal Sharma, Brandeis University	Diversity, Equity and Inclusion
6	Sherita House, Indiana University Health	Interprofessional Education Diversity, Equity and Inclusion Relational Coordination
7	Lauren Hajjar, Suffolk University	Diversity, Equity and Inclusion Relational Coordination
8	Khwezi Mbolekwa, City of Calgary	Diversity, Equity and Inclusion
9	John Paul Stephens, Case Western Reserve University	Diversity, Equity and Inclusion Relational Coordination
10	Julius Yang, Beth Israel Lahey Medical Center	Interprofessional Education Relational Coordination
11	Brenda Zierler, University of Washington Medical Center	Interprofessional Education Diversity, Equity and Inclusion Relational Coordination
12	Jane Cooper-Driver, Primary Care Progress	Interprofessional Education Diversity, Equity and Inclusion Relational Coordination
13	Gloria Coronado, Kaiser Permanente Northwest	Diversity, Equity and Inclusion
14	Carsten Hornstrup, Joint Action Analytics	Relational Coordination

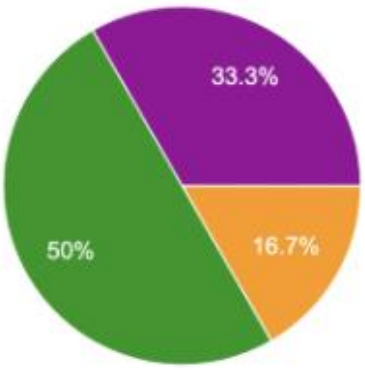
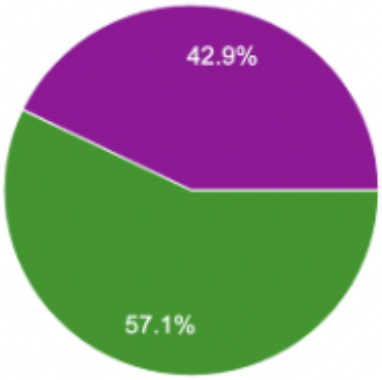
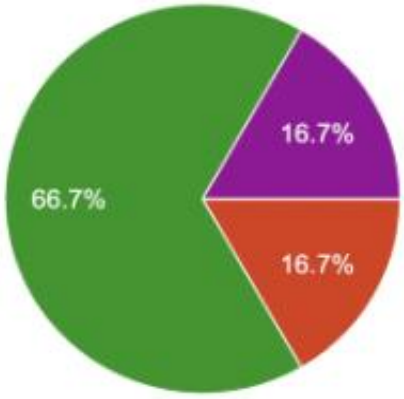
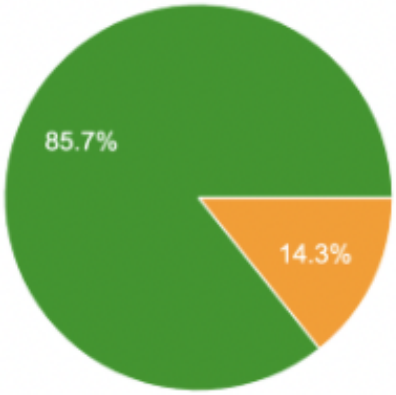
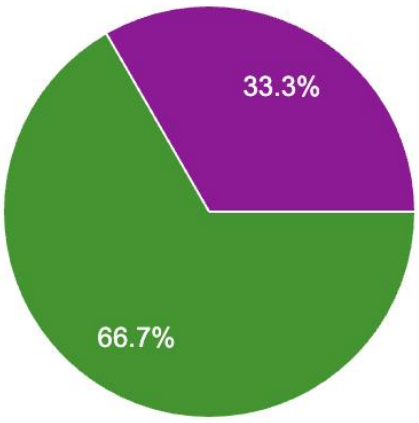
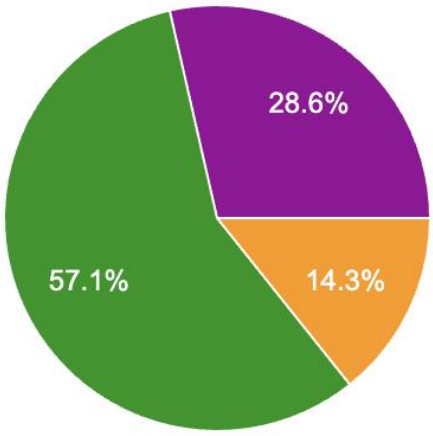
Table 2: Roles and Responsibilities for Participating Health Systems and Clinical Units

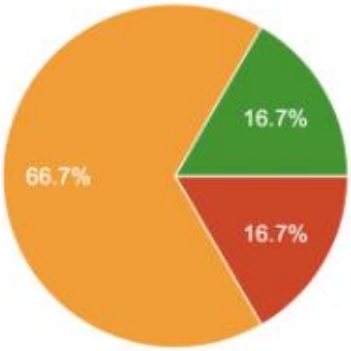
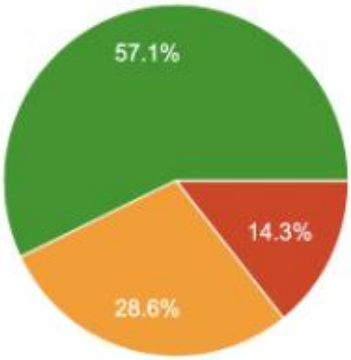
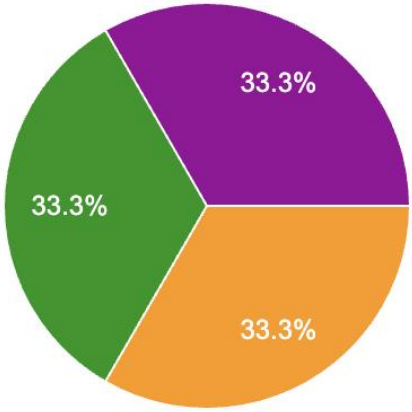
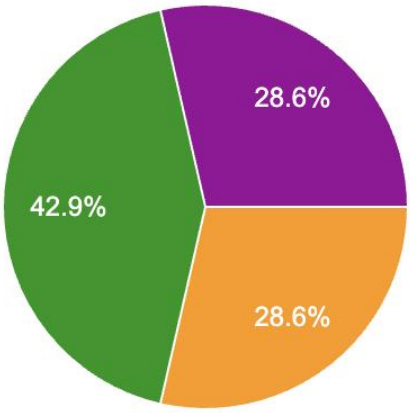
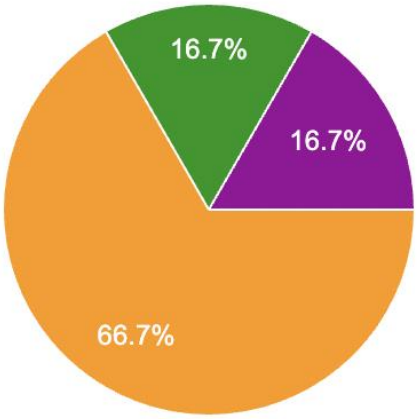
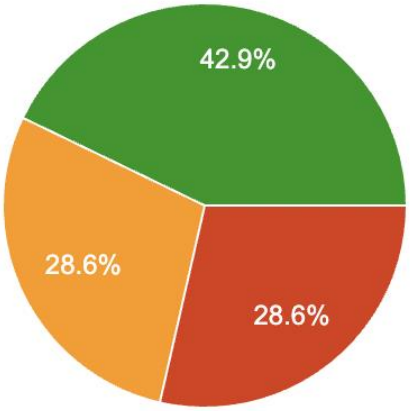
Roles	Description of Role	Description of Responsibilities
Coaching Team	An interprofessional team skilled in promoting introspection and reflection on interpersonal processes. External members include Olawale Olaleye and Tony Suchman. Internal members may come from the health system's own IPE and DEI functions.	The Coaching Team will be responsible for leading the workshops and coaching the QI Team and Leadership Teams.
QI Team	An existing interprofessional team working on a QI project for the clinical unit.	The QI Team will participate in the workshops and share lessons and skills with the Frontline Work Team.
Leadership Team	At least two interprofessional leaders from each participating clinical unit.	The Leadership Team will participate in the workshops, and work with the QI Team to share lessons and skills with the Frontline Work Team.
Frontline Team	All members of the participating clinical unit.	The Frontline Team will be coached by the QI Team and Leadership Team to implement lessons and skills from the workshops into their daily work.
Consortium for Curriculum Development	An interprofessional group with expertise in interprofessional education, DEI, relational coordination, workshop design, and evaluation.	The Consortium will provide advice on the content and design of the curriculum. They will also help to disseminate the curriculum after development and testing.

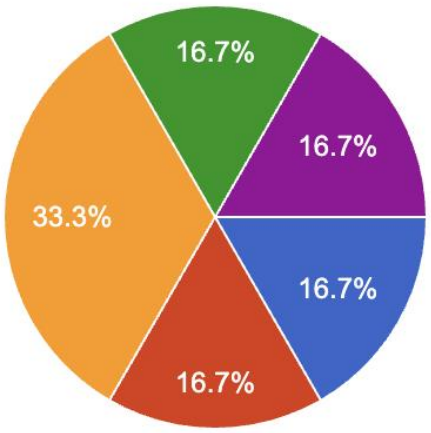
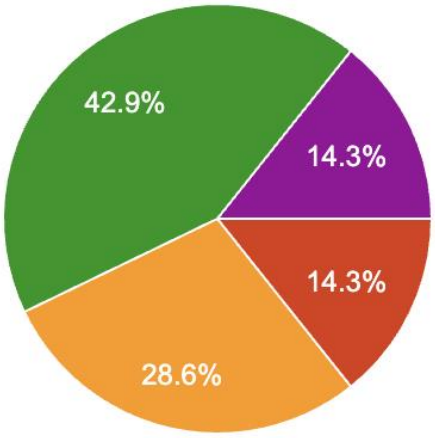
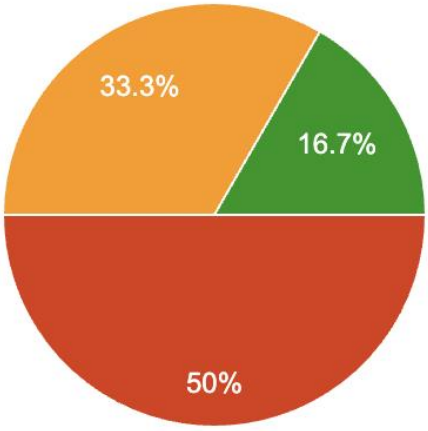
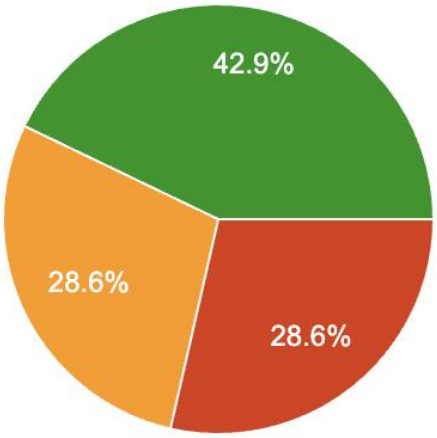
Table 3: Sequence of Activities for Participating Health Systems and Clinical Units

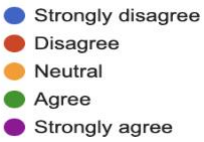
Timing	Activities
March	Form a Coaching Team in each health system with internal and external members.
April	Identify two clinical units in each health system that 1) have a QI Team that is already engaged in a suitable quality improvement or lean/six sigma project and is ready to adopt a relational approach to interprofessional and social identity diversity in the context of clinical improvement, and 2) have unit leaders who are ready to participate on a Leadership Team to support the work.
May	Onboard Leadership Teams and QI Teams from the two clinical units. Expand both teams if needed, with attention to professional and social diversity.
June	**Workshop 1: Develop Awareness** (3-4 hours)
Early September	**Workshop 2: Develop and Practice Skills** (3-4 hours)
Mid-September	**Baseline Assessment** Invite Frontline, QI and Leadership Teams to complete the Relating Across Differences Survey
Late September	**Workshop 3: Review Data and Prepare to Co-design Interventions** (2 hours)
October/ November	**Continue Rapid Cycle Improvement** Share data, co-design and modify interventions.
Early December	**Follow-Up Assessment** Invite Frontline, QI and Leadership Teams to complete the Relating Across Differences Survey
Mid December	**Workshop 4: Reflect on Progress, Celebrate and Plan** (2 hours)
January/ February	This period will be used to prepare site reports and presentations with the health system that has just completed implementation.
Starting January after Year 1 and continuing	**Relating Across Differences Learning Lab**

Table 4: Summary of Feedback from Pre-Pilot

	Before Workshops	After Workshops
Awareness of professional identity of self and others		
Awareness of social identities of self and others		
Comfort with asking about professional identity		

	Before Workshops	After Workshops
Comfort with asking about social identity		
Professional identity as a current source of strength on your team		
Social identity as a current source of strength on your team		

	Before Workshops	After Workshops
Knowledge of how to transform professional diversity into a source of strength		
Knowledge of how to transform social diversity into a source of strength		



Appendix A: Themes and Subthemes Identified from Semi-Structured Interviews

Theme 1: Training Should Address Multiple Types of Diversity
I thought it was all about race, age and gender. But I learned that, you know, there's so much more to diversity than just race, age and gender, that you have educational diversity, social, economic diversity, you have political, you know, people with, you know, different political affiliations and, you know, religious preferences. (ID 6) When we talk about interprofessional collaboration, it is very much like diversity that we are talking about. Yeah, there are people, there are professions that are excluded. We don't include them; we don't allow them to speak - there's hierarchical behavior. We don't care what they have to say. And we've experienced that and that's very much when you talk to people that have felt that way, individually, they describe similarities, so I mean it's, it's, there are some similar things to focus on. (ID 11) So, I've been asked to give talks on diversity twice in the past year and a half, two years. But I said yes because you know I study coordination and to me the principal challenge of coordination is having folks work across differences, in this case it's functional differences. Right? So, I'm like well how do we, you know, what can we learn, like we have this robust literature on coordination and how people constantly, constantly are resolving these different perspectives on knowledge bases. How does that translate to when not just your professional identity, but other forms of identity are implicated? (ID 9)
Theme 2: Training Should Build Awareness
Some of it is about self-awareness of who you are, where you're at … I attended a special training on women, white women, and the power we have, and how we abuse that power, and it was from an expert on white women and racism. And so, a lot of it is really uncomfortable, it's like things you never had ever thought about. So, a lot of it is almost like you need to go away and sort of hug yourself and say, this is really hard. You're going to be okay, you know we're in it together, we're going to learn it, but my god I had no idea, why didn't I have any idea? I have a PhD. I should be a lot, you know, more in tune to what's going on in the world. (ID 11) Feeling is how we know our experience, and it's, it's, you know, so. So, the thing that's the ground zero of diversity, equity and inclusion is, how are people making each other feel as they encounter each other? And so, are we making each other feel valued and respected and included, right? Inclusion is by definition an experiential quality, right? So, so, I think if you asked about a different label, I think you know it would be crafting a diversity experience rather than diversity training. And to me, all the things like exposure right that's experiential like you just described. You know, but not everybody can go to the Smithsonian African American Museum, or the Civil Rights Museum in Atlanta, which are both, you know, really impactful. But those are just examples right? So, you know, shared knowledge is super important. (ID 9)

I think that knowing some facts, and some history is important, especially in the healthcare world where people are data driven. So, I mean, a lot of the work I've seen done and I think it's important has included some background on racial disparities and disparities in, you know, workplace environments who gets promoted and who gets hired and things like that and and because when you start to see what the numbers are they're really quite bad, and they're hard to argue with me it's hard to argue that our status quo is acceptable, when you start looking at the data. (ID 4)

People have radically different experiences at work, and one of the challenges in doing this work is that people don't realize that they don't know what they don't know, and that the experience they're having is very different from the experience that other people are having…So it was important …to create opportunities for white people, and people of color to talk about the meaning of race in their lives and, and to validate it. And what was interesting to me as I presented this to our group and one of our very few black faculties who I don't have a close relationship with texted me, I felt seen tonight. And what was striking to me was I had done so little, but then it meant something at least. (ID 4)

Subtheme 2a: Training Should Build Awareness Through Storytelling

What works [is] capability mapping, narratives, appreciative inquiry, really learning to listen to other people's stories. Family systems therapy teaches you to ask questions of others, not for your own learning alone, but for them to learn about themselves. Then understanding that everyone comes from a different perspective or standpoint, and that is useful for understanding the world. Curiosity is at the heart of it all… so the more you can expand on your narratives for meeting people … with different competencies with different backgrounds with, you know, whatever the broader span of narratives you carry, the more you can actually see and appreciate what they come into the world with, and the more narrow you have your narrative, the less you see... The professional backgrounds of people and the history seems to be dominating what they have in common. In healthcare you have doctors and nurses and other people - they have that strong narrative, but sometimes that's actually quite short sighted because it doesn't even include what they did in high school or even earlier, whether it's their background or where they came from. (ID 15)

So, listening to the experiences of people of color is a way to sort of start to get around that so to create narratives and to start to hear what's happening. And that creates shared knowledge, right? I feel like I have much more shared knowledge of my colleagues now about their experience even if they don't look like me, because they tell me about it and we have, then used to hear about it. Responding to people's experience with validation and respect is important. One of the big complaints that I've only recently become aware of is how often women and people of color feel like their experiences are invalidated, they're told that they were too sensitive, that they're imagining it that they're calling something racism that isn't racism and one of the big asks from our diversity leaders is stop doing that, that if, if, if that was their experience that with their experience you do not have to agree with their interpretation of it for yourself. But stop telling them that they shouldn't feel the way they feel and listen to it and validate it and try to be an ally and help respond to things that need to be responded to them. (ID 4)

Subtheme 2b: Training Should Build Awareness Through Confrontation
So, one of the things I started off with is letting everyone know when they come into this, that everybody wants to be seen as good and moral. That's an aspiration. And by and large people do act that way. But we're not always at our best. We're not always our noblest self or our biggest self. And in those moments when we don't have command of our emotions or command of our emotional challenges, we may say or do things that may be construed as being hurtful, discriminatory or racist. If, however, …you're masking it, you're still in denial. You're losing a lot of goodwill and now trying to draw people into whatever you're going to do further is basically a hell of an uphill battle so that's the first thing is set the stage that you could be a good and moral person, capable of having done and acted in a racist way, but that doesn't necessarily define you as a racist. Okay, so you can lean into this space now and have that conversation. So, this is about that we don't have mutual respect, but we come to it in terms of honoring the dignity and worth of another human being. It sets the stage for being able to have shared goals, because we can now establish an area of commonality, and that allows us to share our knowledge because we're now being seen, and [we] take it on face value as coming from positive intent. (ID 8)
Theme 3: Training Should Build Skills
I've gained knowledge, but what I want to be able to do is translate that into my research world, into my teaching world, and into my service world. So, what looks different for me given this training and knowledge that I have? That part is hard for me to document. …We asked for strategies and tools because it's one thing to hear all of this, but it's like okay then how can I see your behavior right? It's how you think and how you behave, how can I behave in a different way, how can I behave in a more positive way? How can I be more inclusive, or step back and not say anything and make sure all voices are heard? All the things that we do in our [interprofessional] team training and trying to create psychological safety as well. (ID 11) There are ways you can speak up that are more acceptable and there's specific models for how to do that so that's one of the things we're trying to give the students skills for. Imagine, for example, if you have a cohort that goes through the conversational phase, a simulation phase and then they go and they continue to, they go they continue with their training as health professionals but continue to be. Just reconvene in facilitated sessions where they're sharing with each other what they've been trying and how it's working. And basically, have some, in a sense, a group coaching as they go back into their places of training, and they could have goals like …these are the things that I'm noticing in my workplace, these are the things I'm going to be doing and then you meet a month later it's like this is, this is how it worked, get advice from each other. So that seems like a way to take some of these skills, and then really situate them in your, in your workplace. (ID 4) The white students were very engaged in working on skills. … And the people of color were like, emotionally struck by it because this happens to them, and it wasn't an academic abstract subject, really, or a skill like learning how to suture like this is ways in which they are victimized regularly, and they needed time in the course to process it. They couldn't just go

and practice micro-aggressions, they had to have some space to talk about what it meant in their lives because it was real for them in a way that, you know, it can be invisible for people with privilege. I think that for me that's changed how I think about some of this work, because I tend to be like those white students. I'm so excited, I want to get better, get to work on the skills. Let's practice because it's safe for me and I don't get treated that way. …What are the implications for an experiential field-based component of this work. (ID 4)

Subtheme 3a: Training Should Build Skills by Embedding It Into the Work and Doing Work Together

[The training] can't just be a one-off thing that they do in isolation. (ID 7)

You have to create training that's relevant to the situation. So, we know that with relational coordination there has to be an interdependency right and that it has to be around something. It can't be a generic - here is this package of training - or it's not going to work. So, in this particular, specific work environment, in this particular workflow, how are you going to use that and what is the interdependency? And then the training should be relevant for that. …We just don't do relational coordination of everybody; it's got to be a specific group that has these interdependencies that make sense, and they have to be aware of what is it we're trying to do, like, our team was trying to improve, you know, patient outcomes in one unit from because they were having poor patient outcomes. (ID 11)

So, I think it's the principles of RC that are very much aligned with how I think DEI should be used in training, and it can't just be generic. It can't be one more thing, a competency that students have to accomplish. I mean it has to be situated in their clinical work there... So, they have to understand the case and what's going on and understand their roles, and then they could get into what they do together and then bring in the DEI issue whatever it is and the content should be what they would normally be working on together anyway. (ID 11)

The interdependencies are so abstract, so that's why the conversations of interdependencies are so nice because they kind of help people make more concrete in their minds - oh, that's what I get from you and oh that's what I do for you. Right, right. So, I think diversity experience is good, because if it's training and a workshop it can be really abstract. But if it's, we're going to put you into some experience that ultimately there's something being built, some sort of product - maybe it's an idea and initiative or whatever - but you're working towards something that's plainly valuable to all concerned. So, I do think there's something to immersion, and joint work. And so, you get this sort of common fate... that's really important for group cohesion. (ID 9)

I think a key lesson was joint collective work. So, a shared task. Yeah, I think because that's when everybody has some skin in the game. And I think the value gets operationalized in a task-based way which means maybe that's too instrumental, I don't know, but I think you see that in community initiatives like, let's get the graffiti off the wall, let's have the shared garden, but you have to go out of your way to include everybody on the block, right, like who's showing up to that stuff. So again, there has to be a very intentional outreach and an invitation,

right? But I do think that joint work, the actual doing together, helps folks to transcend some of those differences based and other kinds of identity. (ID 9)
Subtheme 3b: Training Should Build Skills Through Cases, Videos and Simulations
In many of the classes, there was half an hour where we had an eight-minute movie clip or some documentary - the empathy and embodiment of the other. And then he will stop and then he will ask us. And, you know, dark room. And then the lights come on. It's followed by very well thought out role playing. He will ask us to put ourselves in which version - choose what if you are this. And what do you fear in the same clip? What if you were this person or that person? …And then he would then lead our discussion on the principles of it's the whole empathetic bridge sort of. So, from being vulnerable to having self-agency, and how you transform that into a cause. And something you can act upon. There are some intersections with relational coordination, because just building mutual trust and empathy and all of that. This approach can be very effective in promoting genuine dialogue and creating relational narratives, because then if it inspires people to - it just makes them reach inside of themselves and find that sentiment and bring it alive and relate with it. (ID 5) Yes, I thought maybe doing some interactive case studies. And so, again, my first thought was to have just a session, like the first session should be like a let's be honest session, and having the participants really just be very, very upfront about what their biases are. And then, based off of those comments and responses, the facilitators could potentially develop case studies (ID 6) We created three simulations and it's still ongoing 10 years later. And for us, our goal was to improve teamwork and team communication and collaborative practice, but they needed to be able to deliver care together so we created scenarios where the three different ones were, you know, medical student had to do something as a physician, the nursing student had a role, the pharmacists had a role and the social worker and the PA had a role, and they could not succeed without all of those people there. So not only did they learn to collaborate, they learned about professional biases, and they learned that oh I didn't know a pharmacist could do that and so they learned about each other. We have a lot of IPE in the classroom, but that's not urgent and there's no time sensitivity, and there's no patient sitting there, but when you have a patient simulator or an after you've got to work together, because it is time sensitive so it's a really great way to teach DEI too and I would say that professional bias is part of the diversity training that we do because we know there's a lot of hierarchical behavior in different disciplines and disrespect. (ID 11)
Theme 4: Training Should Build Relationships
Subtheme 4a: Training Should Build Relationships through Psychological Safety
When they sit with a bunch of people from their own [part of the organization], some of them are more cautious. And often its people lower in the hierarchy that are most cautious in those circumstances. Yeah, so they really need a lot of extra attention to how to create a safe space for those in less privileged positions. (ID 15)

I remember reading the reflections of the white students and how threatened they felt. Wow, because they couldn't speak up. Right. And because they felt like the black students were so fluent about their experiences with race. But the white students were not because they are in the majority, right? It seemed like there wasn't the facilitation to manage that. So, I was like, well, how is this a dialogue, because if the white students are like, oh, I'm going to say something wrong, so I better just not say anything. Then how is this helping anybody? (ID 8)

There's a tension in the work between wanting to protect the interests and the experience of people who are victims of bias. And at the same time, you don't want to lose the engagement of more privileged people who you need to have on board to get to where we're trying to get to. So, I think there's sort of this balancing act of being sensitive to what makes white men like me defensive at the same time without making it feel like we're focusing this work on concerns about alienating white men which is not the primary motivation of this work. I mean it's sort of obvious but it's a delicate dance when you're trying to do it because if you walk into the room and launch into structural racism, you risk losing people who you want to have come along on the journey with you. (ID 4)

Subtheme 4b: Training Should Build Relationships through Relational Coordination

RC is an inclusive theory, right? So, it's role based, right? So that's the key. Because it's taking personalities out of the conversation, and it's really talking, what are your goals? And it often surfaces under those underlying issues which can come up when people are not valuing diversity for any host of reasons. So, I think that we could think of the mapping as sort of this unbounded tool that could be inserted into multiple contexts to really help to uncover where the focus of diversity efforts ought to be within an organization. (ID 7)

Key insights RC can provide include making visible who is involved in the work, and what they actually do, and how that affects the others. There's some steps going out from there [but it starts with] knowing they exist, knowing what they do, acknowledging the need for a relationship. The way I see RC theory today, it starts with knowing that people exist ... knowing that they exist and having just some idea about what they do. And on the other hand, it's mutual respect. Because you cannot talk about timely, accurate and problem-solving communication with people you don't know exist, right? (ID 15)

I would say that the principles of RC are key. … Also, RC is measurable. So, it's not something vague, that people, that trainees cannot see in concrete terms. So, it's actionable and measurable in that sense. They can be the principles, and the measure can be used very effectively for flattening or unbundling acquired prejudice that we all have implicit bias or unconscious bias or subconscious bias perception of perceptions. … It is a bundle of perception of culture, and social differences which are social constructs, for example race is a social construct. Religion is a social construct and interventions for the purpose of addressing this acquired prejudice, and for improving diversity, that's where it gets tricky. It is easier to change outward behavior. Perhaps it's easier to change outward behavior, especially in the short term, but only temporarily. So, we can change behavior with training temporarily,

outwardly. It's difficult to change acquired prejudice, which is so deep seated in our minds. It's attitudes and preferences. That's what is hard to change.…And so within the scope and time span of …. periodic training, they're hard to change, especially when the organization itself does not model RC principles, at the leadership level. (ID 5) In interviewing some folks … I have found that they've pulled together. They're like, yeah, we all have rallied together because we know we're all in this, we know we all need each other to get this done right? So that's where the common faith comes in. So, I do think that that's an intervention into shared knowledge… and that will help generate mutual respect. And framing it as problem solving instead of blaming, I think will also help. So, I do think there's a lot from the seven RC dimensions that you can leverage into some sort of experience. Not so much training, but it's like okay now you have to work together. So go work together and really feel how you are all bringing something good to the collective situation. (ID 9) You have to leverage the people in power … You know, if you want to put them to work, then you need to bring them on board somehow. And to me that's a relational view, right? It's sort of crafting a message of this is how we are in this together. And here are the parts that we are playing together. So let's do that. Let's do something together. I think it is radically compassionate. I think some of it comes from my own religious background, my own personal beliefs … Right, so that's a radical take on forgiveness… And we see these amazing miraculous stories, and I do think that's what we need. (ID 9)
Subtheme 4c: Training Should Build Relationships through Humility
The key thing is to have humility. I don't believe in cultural competence, let me just put that up front, because you can never be competent in anything. So, it's having that humility and the courage to admit that we don't know it all and being open to have that dialogue. That is what works once you have that foundation, and you build a trust, then people can openly bring their best selves to work but others can also feel safe to explore aspects of diversity that they are one, not comfortable with, or two they don't know about. (ID 1) There also needs to be something about relational repair. Start with humility. And, you know, my intention is to be a good partner. And I realized that there are things that I don't know. And I realized there are things that I'm going to say out of ignorance. And I already regret that. But I hope we can talk about that. (ID 3)
Theme 5: Organizations Should Support Training Success
Subtheme 5a: Organization Should Support Success Through Commitment Not Compliance
Simply doing things because for example, the Joint Commission requires us to provide interpreters for our patients - this doesn't work. It has to be part of the organization like a true commitment to make diversity important, regardless of who is watching - that is what works but when it becomes a check a box it doesn't because I've seen employees disappointed and demoralized when organizations just go through cycles of doing interventions that I just check the boxes. (ID 1)

I know, I mean we all know, as scholars and then as human beings, that you can't make people do stuff. So, you need to get people to want to be there... So, in terms of an institution and, and members of the institution, so in my case I'm a faculty member - faculty, staff, students are the main stakeholders - it should be clear to them why such training is going to be worthwhile. And I believe that it's not going to be effective if people are feeling attacked, or blamed. So there has to be a spirit of - I'm learning the term value proposition - so it has to be clear to people why - like why - show up? Whatever the color of your skin, you know why you're there. And how is this connected to sort of a broader sense of community that is beneficial to all of us. (ID 9)

Subtheme 5b: Organization Should Support Success Through Leadership Role Modeling and Systems Change

We had training, but there was this skepticism, whether the training is effective, whether the training is done with genuine investment by the leadership in the organization. (ID 5)

Or at least on paper, and you know, so I think that's where sort of it begins, is with the leadership, really embracing that culture of diversity that then allows for those organic conversations to happen. Because that's where the real change happens, [where] we can move the needle.

So, there were these three levels of alignment within the organization, which I think helps to solidify it as a, or institutionalize it as a practice that is valued. So, what you're suggesting is that there's so much of what made it valuable for you beyond, you know, this ability to reflect and get aware of your own biases and use it as personal development is there was an organizational context that was already set up to role model and reinforce that this was important, and we value this. (ID 7)

For long term behaviors…how are we going to change behavior at the participant level but also the system level? What in the system must change or how can we create a supportive environment for the study participants to be able to do what we're asking them to do? Because if they have the knowledge and the system is not enabling, then it's not going to translate to change. (ID 1)

Appendix B: Draft Curriculum

Relating Across Differences: An Improvement Process for Clinical Units

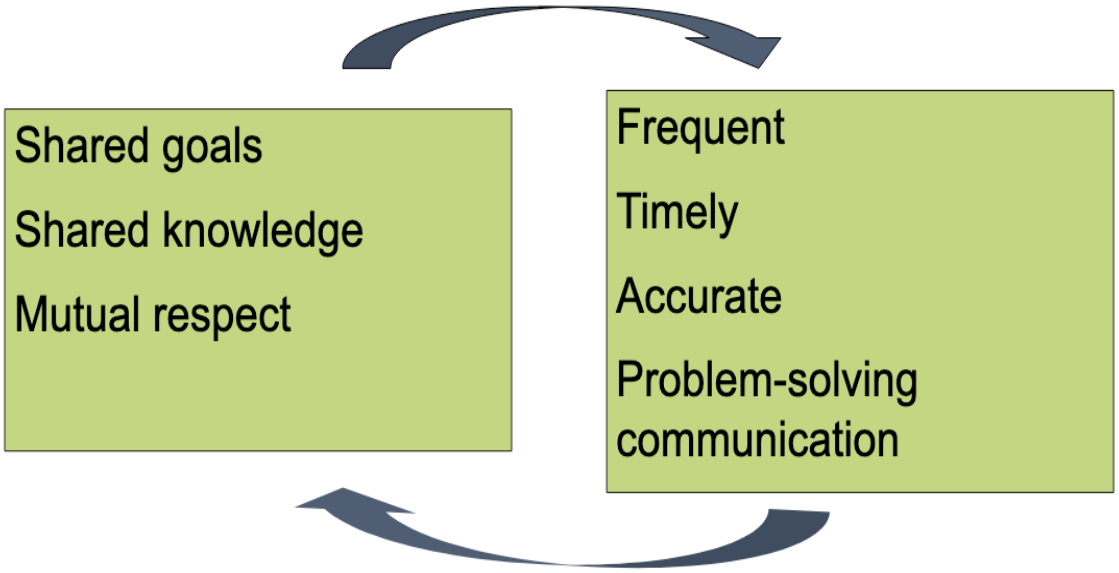
Overview and Conceptual Frameworks

Despite the benefits of increasing workforce diversity, if left unmanaged, it can weaken the relationships that are needed for care delivery due to biases, misunderstandings and subgroup formations. The improvement process offered here helps clinical units to create a work and learning environment characterized by relationships of shared goals, shared knowledge and mutual respect, supported by high quality communication across professional, gender, racial, ethnic and other differences. As a result, clinical units are better able to leverage the rich information offered by diversity to achieve better outcomes for patients, students, and staff.

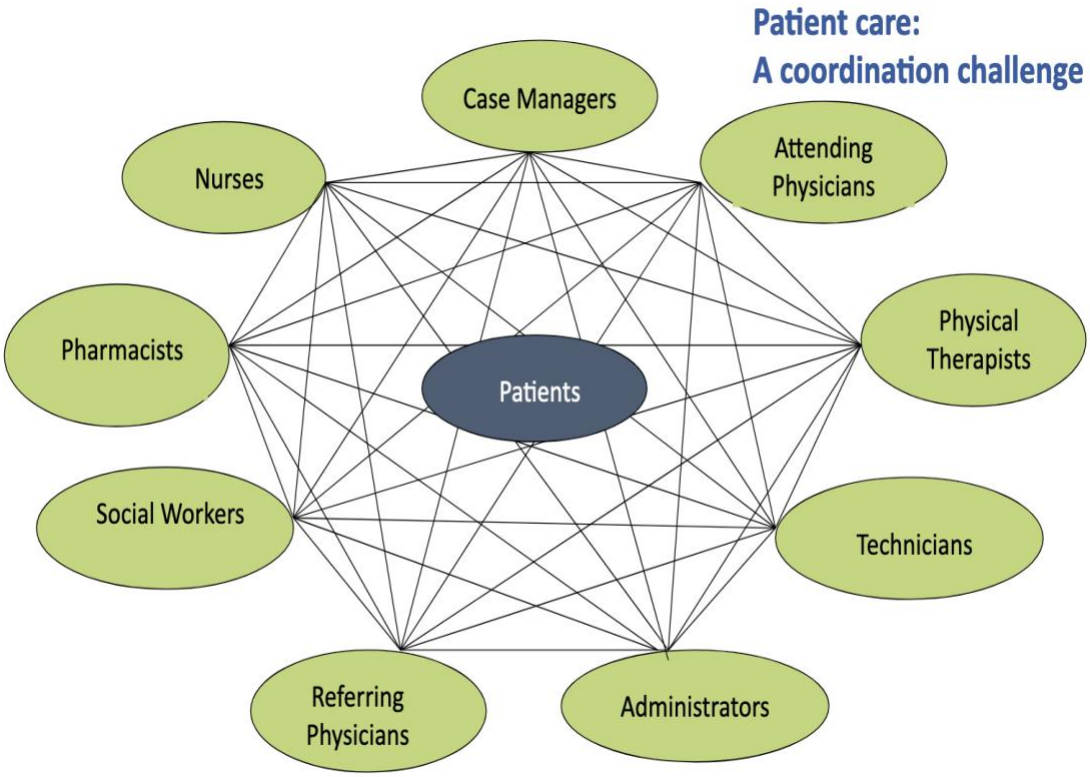
Relational coordination is communicating and relating for the purpose of task integration, based on shared goals, shared knowledge and mutual respect between diverse roles. Relational coordination is about identifying *shared goals* as a common starting point for identifying differences between people or ideas. For example, we may identify a shared goal to take good care of our patients and each other but have different interpretations of what that requires.

Relational coordination is also about building *shared knowledge* of others' lived experiences, expertise and perspectives. Inquiry, listening, personal narratives and conversations of interdependence are tools for building shared knowledge. Shared knowledge enables clinical units to use their diversity as a resource to integrate multiple perspectives into the process, thereby improving the quality of decision-making and enhancing performance. New perspectives may also help us recognize disparities in the care we provide.

Most importantly, relational coordination is about building *mutual respect*. Mutual respect is built by developing shared goals, and by recognizing how each participant contributes to achieving those shared goals. Furthermore, mutual respect is built through shared knowledge of others' lived experiences and the value they bring to patient care.



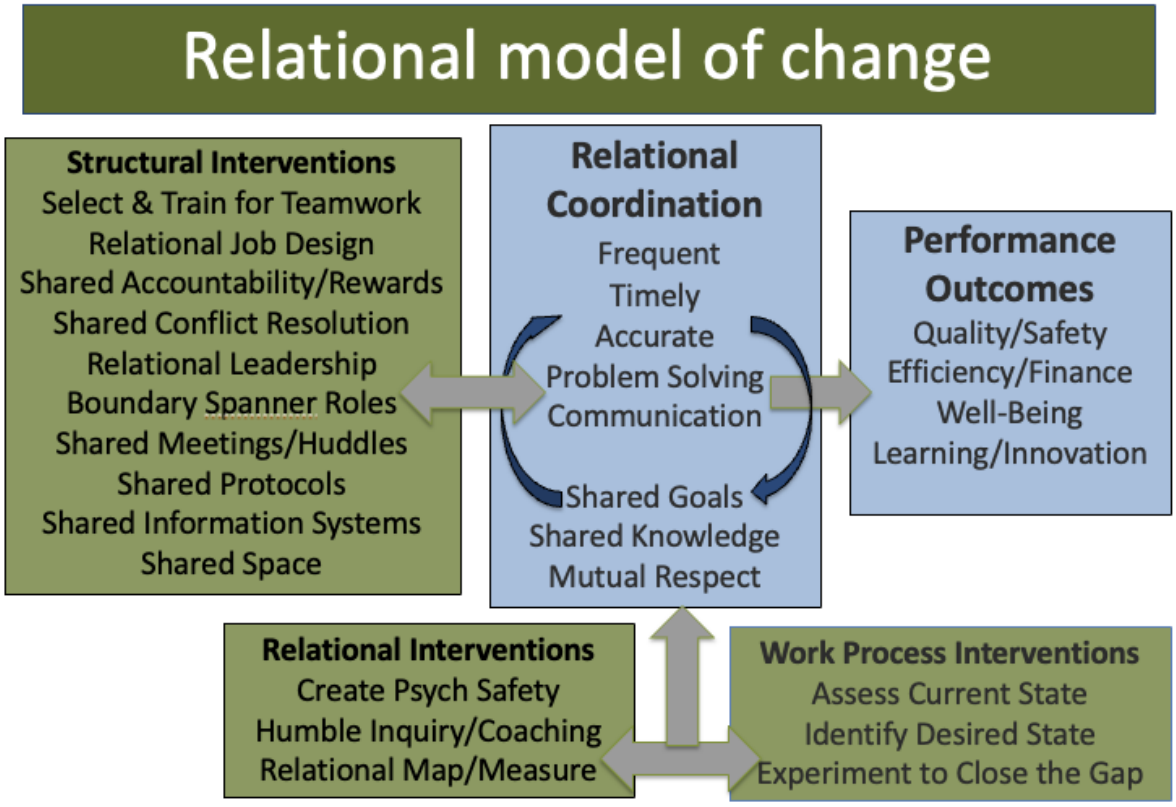
Relational mapping is a method to assess situations and notice bias. Relational mapping enables participants to see the team as whole, to identify the roles on the team including roles that tend to be less visible, and to identify the social identities represented in those roles. Participants can then assess the strength of relational coordination between professional and social identities using the seven dimensions of relational coordination - shared goals, shared knowledge and mutual respect, supported by frequent, timely, accurate, and problem-solving communication. Which of these dimensions are relevant in your context? Which are currently strong? Weak? Between which roles? From whose perspective? How do differences in professional and social identities influence each of the seven dimensions?

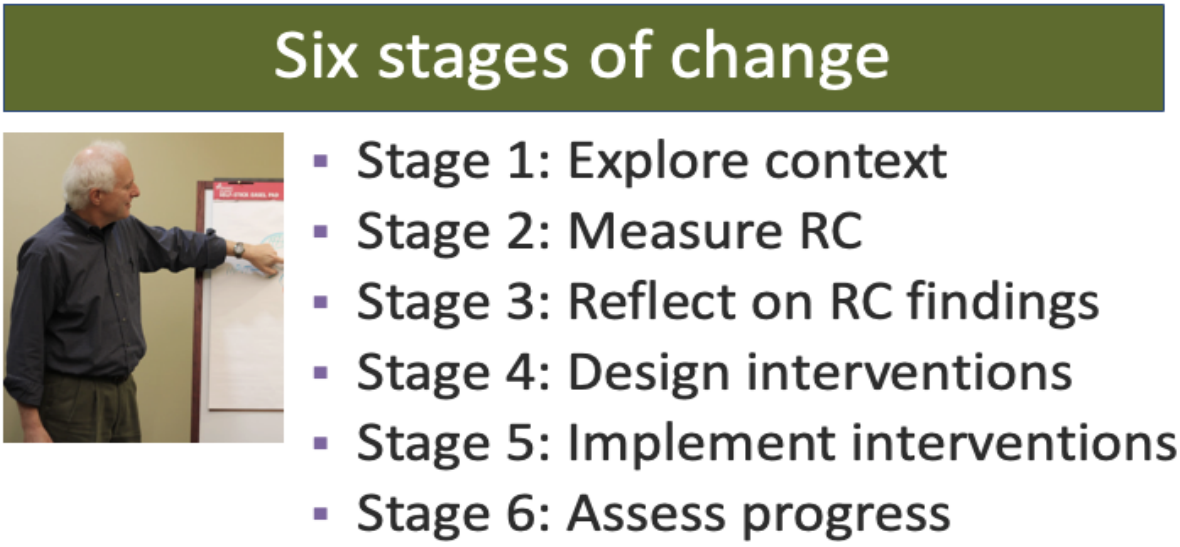


Relational mapping

Psychological safety is another key concept in this curriculum. Facilitators will create a relational space by asking students to leave titles at the door, by role modeling appreciative and humble inquiry, by role modeling empathy and respect, and by role modeling relational responsibility and behavioral accountability. People who are empathized with and respected are more likely to empathize with and respect others, and more likely to contribute their unique perspectives. Facilitators will therefore role model an empathetic rather than confrontational stance. Though facilitators will not seek out conflict, they will role model how to address it as it arises.

The Relational Model of Change along with the *Six Stages of Change* provides a systematic approach to improvement that brings together all the above concepts to improve outcomes for multiple stakeholders.





Workshop 1: Develop Awareness (3-4 hours)

Participants: QI and Leadership Teams, facilitated by Coaching Team

Objectives: Develop awareness of oneself and others. Learn how to learn about oneself and others, and why it matters. Develop awareness of the value and potential challenges of diversity, importance of managing it well in order to achieve desired outcomes. Develop a relational map. Learn how to develop relationships of shared goals, shared knowledge, mutual respect, and how to create a safe space with one's colleagues.

Modes of delivery: Personal assessment tools, personal stories, response to videos, relational mapping, facilitated conversations.

Pre-work: Develop a 3-minute personal story, using the Challenges & Choices format. Create a pie chart to represent your own social identities - for example race, gender identity, disability, education, parent education - not to be shared with others but as a basis for self-reflection. Watch "Dangers of a Single Story," "The Power of a Simple Idea" and "Building Psychological Safety."

Content: Welcome, the Coaching Team introduces themselves. Brief introduction to the frameworks for the change process. Review constructive and destructive listening behaviors. Co-create ground rules for our learning community, and how we will all deal with inevitable breaches.

Facilitate conversation about "Dangers of a Single Story," "The Power of a Simple Idea" and "Building Psychological Safety."

Share your personal story with one other participant. Practice mindful listening with each other. Introduce your partner to the whole group. Invite 2 or 3 participants to share their personal story with the whole group. Facilitate debrief with attention to professional and social identities. Did others' stories seem to overlap with your own? How did your identities shape your own story?

Ask participants to develop a relational map of their clinical unit, with attention to professional roles as well as social identities within those roles. Where is relational coordination currently strong? Where is it less strong? What are the consequences for outcomes? What are the root causes? How might social identities be affecting the relational map? How might social identities be affecting the seven dimensions of relational coordination - frequent, timely, accurate, problem-solving communication, shared goals, shared knowledge, mutual respect? What important information might you be missing? How can you learn more about that?

Process reflection: How are we doing as we learn how to learn about differences? What can we learn from what happened today about how to build shared knowledge, shared goals, mutual respect? About how to create a safe space?

Post-work: Use a weekly journal to reflect on what you learn. Pay special attention to professional and/or social identity differences on your relational map that are challenging in some way. Consider the impact of power differences due to professional and social identity, as well as seniority.

Workshop 2: Develop and Practice Skills (3-4 hours)

Participants: QI and Leadership Teams, facilitated by Coaching Team

Objectives: Develop and practice skills for harnessing difference as a resource and for recognizing and repairing the inevitable ruptures and bumps. Learn how to teach these skills to one's colleagues.

Modes of delivery: Simulations, games and/or theater to understand the perspectives of others and respond appropriately. As participants observe simulations, they will use protocols to help identify the seven dimensions of relational coordination. Which are relevant in each situation? Which are present? Which are lacking? From whose perspective?

Content: Welcome, invite participants to reflect on what they've learned since we last met. Engage in game or simulation. Invite participants to serve as actors and observers. Observation protocol includes attention to interactions around teamwork in general, then noting the influence of professional and social identities. Coaches lead a reflective debrief among actors - what did they think? How did they feel? - then invites observers to speak.

Process reflection: How are we doing as we learn how to learn about differences? What can we learn from what happened today about how to build shared knowledge, shared goals, mutual respect? About how to create a safe space through listening and power-sharing? Which

conversations about social identities would you like to have that you don't feel you can have now? What would help make that more possible?

Post-work: Set up and distribute the RC Survey to all participants in the clinical unit to assess the current patterns of relationships. With help from the facilitator, review and make sense of the data. Prepare to share with participants.

Individual post-work: Use a weekly journal to reflect on learning. Pay special attention to professional and social identity differences on your relational map that are challenging in some way. Consider the impact of power differences due to professional and social identities, as well as seniority.

Workshop 3: Review Data and Prepare to Co-design Interventions (2 hours)

Participants: QI and Leadership Teams, facilitated by Coaching Team

Objectives: Review baseline data from the Relational Coordination, Equity and Well-Being Survey. Prepare to share the data with colleagues on the unit, and to engage them in co-designing interventions based on the data.

Content: Review results of the baseline Relational Coordination, Equity and Well-Being Survey. Brainstorm how to share data with your colleagues on the unit, practice doing it. Brainstorm possible interventions. Develop and practice methods for co-creating interventions with your colleagues.

Workshop 4: Reflect on Progress, Celebrate and Plan (2 hours)

Participants: QI Team and Leadership Team, facilitated by Coaching Team

Objectives: Reflect on and learn from your experiences thus far. Review follow up data from the Relational Coordination, Equity and Well-Being Survey, assess progress. Celebrate! Identify areas for continued improvement.

Modes of delivery: Conversational, reflecting on participant experiences using qualitative and quantitative assessments.

Pre-work: Reflect on what you've learned thus far from your implementation efforts. What have you learned about yourself, about others, and about your workplace?

Content: QI Team assesses progress building relational coordination across professional and social identities and assesses progress toward other desired outcomes. Assess enablers and hurdles for speaking up, helping others, showing respect for differences, etc. and how you might address those. Help participants to navigate specific professional and social identity differences. Develop an updated action plan for continued progress.

Relating Across Differences Learning Lab: Ongoing Support

Participants: QI Teams, Leadership Teams, and Coaching Teams from all three health systems join this Learning Lab as they complete Year 1.

Objectives: To share, sustain and spread their learning over time rather than allowing their learning to degrade over time, inviting other clinical units to engage in this improvement process.

Modes of delivery: Conversational, reflecting on participant experiences, and making structured group presentations with updates on a periodic basis.

Content: Support participants in continuing to use the tools and concepts they learned, even when they move beyond the unit where they learned them. Create an environment for sharing the learning across clinical units and across health systems.