

Education Council (EC) Meeting Minutes
December 18, 2012

EC members present:	W Miller	EC members not attending:
L Anderson	M Nelson	M Baird
S Allen	C Niewoehner	Z Beatty
J Andrews	J Nixon	B Brandt
T Baultripp	J Pacala	L Carson
J Beattie	D Power	J Clinton
M Becker	M Rosenberg	K Crossley
J Chipman	L Schimmenti	A Duran-Nelson
B Clarke	A Severson	T Ebner
R Cormier	T Thompson	C Hegarty
J Eck	G Trachte	G Jacobs
R Egberg	K Watson	K Johnson
S Gladding	M Woods	J Metzger
A Johns		J Miller
S Katz	Guest: D Powell	T Stillman
B Marsh		C Sautter
		G Vercellotti

Education Council Minutes, December 18, 2012 <i>More detailed discussion is available by request for the 10/16/12 Meeting Synopsis</i>	Action Date	Final
November 20, 2012 Minutes were approved with no additions, corrections or changes.	12/18/12	
<p>Information & Updates Mark Nelson was introduced to the Council, he will serve as the Year-1 student representative to the EC for the academic year 2012-13.</p> <p>Discussion <u>EPAC</u> Dr. Deborah Powell spoke to EC members regarding the status of the Education in Pediatrics Across the Continuum (EPAC) Project. She provided the Guiding Principles (see meeting materials) established as the framework used in developing criteria for the Pilot. The Education Council previously endorsed the work of the EPAC Task Force in developing the specifics for the Pilot. Dr. Powell reported EPAC has reached the phase for implementation at four medical schools, which will hopefully include UMMS. As requested she returned to the EC to provide an update and to seek further endorsement to begin the EPAC Pilot at UMMS in the 2013-14 academic year.</p> <p>EPAC is a competency based curriculum model that spans UME and GME, offering a seamless progression of the student learner from medical student to GME to being able to sit for the Pediatrics Board Exam.</p> <ul style="list-style-type: none"> • Learner progress in the program is based on achieving certain milestones developed as Pediatric EPAs, originally developed for GME • in Yr-1 interested students will participate in experiences with children to help establish their level of interest • 4 to 5 medical students will be selected for EPAC with the expectation they will commit to the begin the program pathway at the beginning of Year-2 • the number of students is determined by the pediatric residency slots that are reserved for 		

<p>them (they will not participate in the Match)</p> <ul style="list-style-type: none"> • before beginning residency they will complete all medical school graduation requirements, assessments and residency matriculation requirements • residents will be placed in outpatient continuity clinics in pediatrics and will continue in that setting until completion of GME, equaling 5-plus years experience in a clinic • they will work with a healthcare team and accumulate their own panel of patients over that period • all schools will use EPAC specific assessments (currently under development) • all schools are expected to take 4 successive classes of EPAC students to allow a large enough pool to evaluate the program’s validity <p>This is a pilot program to test a competency based model and to test a model which integrates UME and GME. It’s a model that may be replicated in other specialties once tested and also a trial to see how early students are ready to make career choices.</p> <p>Additional information includes:</p> <ul style="list-style-type: none"> • Principles require that all students and faculty commit to “the learning community” • the model will aid in providing evidence about competency based assessment and advancement • a founding Principle states there will be “standardized outcomes with individualized progress” • tuition reduction will not exist, student groups haven’t focused on that factor, a residency guarantee has been a positive factor • benefits to UMMS: participation in a completely different pathway; an opportunity to test and foster a possible future component of medical education; opportunity for involved faculty to have access to the data for publications and research; first hand data/insight into the value of the team approach; participate in a new longitudinal curriculum • EPAC student participants will be selected by a team <p><u>Dr. Powell asked that members consider their willingness to embark on the this Pilot, at this point if EC does or doesn’t endorse participation it will determine whether or not the program will be implemented at UMMS for the entering class in 2013-14. Dr. Miller indicated that the Council members will make a determination at the January 15, 2013 EC meeting.</u></p>	<p>Propsd Action 1/15/13</p>	
<p>Education Steering Committee -- Update</p> <p>ESC and IWG members have been working together and have made progress for the Integration Work Group charge. Dr. James Nixon (IWG Co-Chair) summarized their process to this point, noting the Integrated Work Group has come together to consider the need to develop a model to integrate the basic science into clinical application through Yr 1-4 and across both campuses. Initially the focus was to look at one Corridor of Discovery and it was agreed that Diabetes would be a logical choice as an integrating focus. It was considered that this could also be incorporated as a part of competencies. The model would possibly become the mechanism for integrating other topics in the future. Their working concept refers to “strengthening connections between formal and experiential knowledge across the continuum of medical education, specifically by incorporating more clinical experiences earlier in medical school and providing more opportunities for knowledge building later in medical school....” Their discussions identified these problem areas in UMMS’ current system:</p> <p><u>students</u></p> <ul style="list-style-type: none"> -lack of relevance of basic science presented alone -preclinical and Step 1 are just hurdles to earn the privilege of training in the clinical setting <p><u>basic Science faculty</u> -students have no interest in science, the underpinning of medicine</p> <p><u>clinical faculty</u>- students arrive on the wards lacking creativity or intellectual curiosity, memorization of “basic science” has not enabled them to analyze clinical situations or to apply basic science knowledge to clinical scenarios.</p> <p>Their discussion has focused on how a more integrated curriculum could overcome these obstacles i.e., clarify early in Yr-1 the impact basic science has on success in clinical</p>		

<p>practice.</p> <p>Two issues IWG wants to emphasize are to determine where UMMS is at now and what the goals for long and short integration are. Because EC members will help make curricular decisions member must consider “where do we want to be”. He referred to a diagram (see meeting materials) of 11 Steps on the integration ladder (Harden 2000). This illustrates a continuum of integration across a range of development of skills and he described scenarios within medical education illustrating how several different steps may be in practice across courses. The Group has suggested number of frameworks and initial thoughts about models for integration.</p> <p>The ESC is working in conjunction with the IWG and more time will be committed to refining how these can be brought into the work to integrate the curriculum across both campuses. Dr. Chipman reported that the process for approaching how to work on integration was complex and the report brings together ideas from efforts to look at 4 years.</p> <p><u>Dr. Miller suggested the next step is to focus on a few areas to guide work that will begin in some of the Year 1 courses during the summer. Dr. Nixon noted it will be important for individual course directors taking interest in possible beginning steps and the other piece is the other the Medical School’s decision on what direction it will support.</u> Dr. Chipman noted that integration isn’t a singular goal; it’s a path that leads to continued integration as medical education changes (new developments and new findings). It is an on-going iterative process. Dr. Miller suggested it is important and will take work move beyond “awareness” to accomplish other levels of the ladder. Duluth has had the co-director model in place for several years. Dr. Rosenberg noted that integration of new knowledge to existing knowledge is a lifelong skill that crosses the continuum of integration. Teaching them how to integrate new knowledge is an important skill they will use over years of clinical practice. Dr. Kathleen Brooks reported that the ESC has talked about integration as a mechanism, the School’s position in how to deploy and the process to do it and the bi-campus process. She referred to Dr. Johns’ point regarding assessments and noted that assessments/milestones are one approach to integration across campuses. <u>Dr. Miller requested a proposal for what steps are needed to prepare to have a plan of action for summer 2013 year-1 courses.</u></p>		
<p>Annual Summary Reports</p> <p>Dr. Mark Rosenberg commended staff on the compilation of data and the final Report they have developed. He also thanked the ESC for their review and guidance in the what information the Report representation. Two things he appreciates most are highlighting student successes and of the teaching, he is especially with how well the students are doing. The second important piece it accomplishes is the identification of 4 critical themes that are based on the evidence as well as the LCME citations. The report develops action plans to address the changes needed to comply with LCME. Briefly he pointed out the clinical capacity, the integration, the clinical learning environment and the feedback and evaluation (part of an active learning, critical theme). Dr. Rosenberg added the importance of one additional theme; “how to prepare medical students for this modern practice environment”. He feels these themes provide a roadmap of where we should go in medical education.</p> <p>Dr. Alan Johns noted the data is the first comprehensive look at the new curriculum on both campuses and they show dramatic increases in the mean scores and very high pass rates. It is important to continue the data on an on-going basis. The education program principles state that “effectiveness of outcomes of the program will be monitored systematically with timely feedback to stakeholders”; the report does this and through this process EC members are asked to provide feedback. EC. The Report is a synthesis and</p>		

analysis that should provide guidance for program planning.

Dr. Sophie Gladding spoke about process and the work done to provide data for evaluation. The Student Assessment Committee (SAC) worked to put together information from across areas of UME (Duluth and TC). The Report was drafted and with input from senior leadership and a final review was done by the Education Steering Committee (ESC) who provided valuable input for additions. In discussion with ESC four critical themes were identified. Dr. Woods noted there was an important discussion to look at the value of providing more than just data, which led to the set of action items to work on this year. They considered how the Education Principles and the data work together, they questioned if data collected was supporting those Education Principles. In their review the question was raised whether the data collection and evaluation of it were meeting this Principle. They found areas where they were and some areas where they can strengthen the data that brought back to the Council.

Dr. Miller asked the team to review the four action items for Council members. The action items include the follow and details for actions to accomplish these goals are contained in the report:

- 1) addresses clinical capacity
- 2) course content integration
- 3) continuing to develop our technology
- 4) providing faculty development and resources for work on integration

The clinical learning environment (action items)

- 1) continuing to develop the milestones
- 2) continuing to look at the EPAs and work with EPAC
- 3) look at assessments across the continuum
- 4) creating teams to pro-actively conduct environmental scans at facilities

Feedback and evaluation

UMMS is increasing the amount of narrative of feedback for students. This is an immediate action that is being implemented at this time. Some courses have already begun to provide this to students. Information will be provided to faculty for new ways they can go about providing narrative feedback to their students. The clerkship evaluations will be revised; Dr. Woods will work with the Clinical Education Committee for Fall 2013 changes. This will begin in January, 2013. Areas of review will include are the right questions being asked and what should the next iteration try to capture. These are reconfigured every 2-3 years to make sure the feedback is meaningful.

Dr. Miller voiced strong support for further development and use the milestones and EPAs, because it's important to illustrate to medical students how improvement in clinical skills progresses and clarify the value of ongoing life-long learning. It will guide students by illustrating the level of excellence individuals can achieve throughout medical practice. EPAs will help to standardize feedback and help students understand what they need to achieve in working toward in their goals as a physician.

Concern for the response of 60% of UMMS graduating students who indicate they have personally experienced one of the mistreatment behaviors. Dr. Watson reported that the January 15th meeting will be spent discussing the topic of Mistreatment and Harassment. She did note that a new collection method was used for this data, so the numbers changed across all medical schools. But in comparison to medical students at other schools reporting at 43%, UMMS is well above that and this indicates a shift.

Clinical capacity is a high priority and Dr. Miller noted with the new ambulatory clinic planned for the campus; it is important for the design to allow students to be more closely involved in the physician setting. He recommends partnering with UMP in both education and research is critical for the future success of UMMS and its medical education. He feels it would be productive to have more than just an educational branch of UMP that interacts with both the Medical School and the residencies to help fulfill our needs at home. Dr. Rosenberg noted this has been discussed and more has to be done with regard to expectations for other healthcare systems to continue to respond to the clinical placement of our students if our system can't support the clinical component of UMMS. Dr. Watson notes one reason for concerns with clinical capacity is because on both campuses there have increased the need for clinical education tremendously, causing the traditional sites to be filled to capacity. Sites haven't been lost as much as the fact that there has been a great increase.

At the November Education Council meeting the Panel on UMMS student preparedness for residency discussed the feedback from healthcare systems that indicates our students are not well prepared to begin practicing after graduation and need to be trained for months before they are able to practice within their systems. Dr. Miller recommends engaging the healthcare systems about what they need and ask to establish a set of principles that are standardized across health systems and then figure out how to meet those principles during medical school as a continuum with residency. Dr. Pacala recommends more pressure on how the facility will interface with medical students. The design of the ACC should include students in a team model with a defined role for medical students. Dr. Rosenberg noted they have participated in a meeting with the architects regarding these questions. Dr. John Andrews noted there isn't a uniformity of opinion about the involvement of learners coming from the physician leadership. There are issues with the efficiency of medical education paired with healthcare practice and the financial concerns included in this setting.

The clerkship redesign is just beginning to be addressed and work will involve the CEC members; to include topics for sub-internships for all specialties, sequencing, capacity, and review of assessment standardization. Discussion for developing some pilots for longitudinal clerkships (other than EPAC). Two possibilities that have been raised include one longitudinal in Duluth and one at the VA. Another issue is the required OB clerkship, lack of sites and a discussion about whether women's health issues should be taught instead. This work will be done as part of the Clinical Education Committee charged with involvement of both campuses.

Dr. Miller raised the topic regarding the national initiative UMMS is leading for Interdisciplinary Education. Dr. Watson noted that the November EC meeting Panel included information about work at UMN AHC and at the national level. She reported that Dr. Brian Sic is collaborating with a pharmacy educator to develop inter-professional education in the third year. They have done this several times and have done really well. This will also be another component discussed in the clerkship redesign work. UMMS has been recognized nationally for the FIPSE sessions, which are part of the MS-1 curriculum. James Beattie serves as a FIPSE facilitator and as an FCT facilitator and the students are enthused and in FCT are talking about the inter-professional experiences they are having. They want the experiences and they are happening; the medical students are leading the way in the FIPSE sessions.

**Next EC meeting
January 15, 2013**

