

Education Council (EC) Meeting Minutes
February 19, 2013

EC members present:		EC members not attending:
S Allen	C Niewoehner	J Andrews
T Baultripe	J Nixon	M Becker
J Beattie	D Power	B Brandt
Z Beatty	Mark Rosenberg	K Brooks
J Chipman	C Sautter	L Carson
J Clinton	L Schimmenti	K Crossley
R Cormier	A Severson	A Duran-Nelson
C Hegarty	M Tate	T Ebner
K Johnson	T Thompson	A Johns
S Katz	G Trachte	J Metzger
B Marsh	G Vercellotti	J Miller
W Miller	K Watson	J Pacala
S Morean	M Woods	L Schimmenti
		T Stillman
		R Westra

Education Council Minutes, February 19, 2013	Action Date	Action
January 15, 2013 Minutes were approved with no additions, corrections or changes.		
<p>Information & Updates --Update – Learning Environment</p> <p>Dr. Mark Rosenberg reviewed the Council’s discussion of the “<u>Learning Environment</u>” ideas on January 15th. The initial concern is to comply with the LCME Standard to proactively monitor the learning environment, to make the evaluation process less student driven. The proposal endorsed by the EC in January includes establishing groups who will assess the environment (Learning Environment Rounds -LER) through visits to clinical teaching sites. The goal is to see what takes place and to use the opportunity to identify if problems exist. Most of all to show appreciation for the education that takes place at sites. It also provides the opportunity to identify best practices and to share best practices. If there are deficiencies identified, the LER group will interact with administration at the clinical site to make changes. Ideas for next steps have been put in motion. At this time Drs. Rosenberg and Watson have had conversations with the VA, Hennepin and Health Partners. The focus will be to partner together.</p> <p>An example of impact on the learning environment is the extensive WiFi network at the VA that students could potentially access but currently cannot use it. This is a way in which assessing the learning environment could lead to changes for the medical student educational experience. The proposal to collaborate with site representatives and the LER group will move forward and site visits will take place in the next six months. Dr. Watson noted they are working on developing logistics to recruit students, faculty, and non-medical participants. She invited those interested in the ELR group to email her.</p> <p>For ACGME, our ELR site visits as part of the residency program will be an advantage as part of program’s focus. The proposal is about the learning environment; an opportunity to support students in their learning experience by making the effort to ensure they have the right tools and space to support learning. Student feedback will play a role in gathering information for areas where improvement is needed. Evolving to best practices and quality improvement in the future.</p> <p>Dr. Miller noted this was an area not previously reviewed by LCME and developing this</p>		

plan is in response to their new requirements. It is an opportunity to find best practices and to specifically define “assessment of the LE” for our students. The LCME language has two features; evaluation of LE at sites cannot be based solely student reporting and secondly it requires the LE has a focuses on professionalism (tolerance, respectful communications, and is it safe). Most importantly, to determine if the learning environment at a site helps to develop students’ professional qualities.

Drs. Rosenberg and Watson have begun presenting at Grand Rounds at the VA on the topic of medical student education; providing a vision for the future. This is envisioned as part of LER where information can be communicated to sites where clinical education is occurring. Dr. Nixon is doing a Grand Round at UMMS on medical student abuse.

AMA Grant

Follow-up to the discussion at the November 2012 Council meeting with Dr. Brandt, Dean Friedman, and Dr. Rosenberg serving as a panel to focus discussion on the retreat held in September with the Community University Board, AHC leaders, and health care educators. Health systems leaders and health policy makers in Minnesota (MN Commissioner for Health and the Commissioner of Human Services) and other quality organizational leaders along with AHC leaders met, the focus is to train medical students, residents and fellows to be more prepared for the modern health care environment. Health practitioners will face changes when they leave medical school and enter residency to practice that include the following:

- accelerating change in health systems practice
- more focus on team based care
- interprofessional education
- working in quality environments
- paying attention to the cost and patient care experience

The health systems, the medical school and the AHC have committed to work together to develop better environments in which to train students, with more attention to quality. As this has been developing an RFP from the AMA (\$10,000,000) for the purpose of transforming medical education. The AMA’s strategic plan is to support medical education with the grant program. The “letter of intent” was due on February 15th, which UMMS has submitted. Their goal is to support ways to better prepare medical students for the modern health care environment. The timing of the RFP is lining up with discussions and work at UMMS. Between March 4th and 8th, twenty schools will be selected for round two and informed they can write their full proposal, due on May 15th. Those selected for the funding will be informed on July 1st, with the start date for the grant being September 1st.

The UMMS proposal is to address the gap that occurs where medical students finish UME and at what level of competence residencies and health care systems expect them perform. The gap is in working in teams, quality improvement and patient safety. UMMS will use the back bone of quality improvement, patient safety, and of system redesign to close the gap and we propose this will be a partnership between two integrated health care systems and policy makers at our two Medical School campuses (Minneapolis and Duluth). One health care partner is Essentia with their Institute for Rural Health and the Duluth Campus. Partnering with the TC campus is Health Partners. These two health systems are very interested in closing the gap. We are going to rely heavily on a lot of the reporting that comes out of Minnesota through MN Community Measures. Ideas include:

- building a model to engage learners and practitioners in longitudinal training and systems redesign
- teaching students early on in medical school principles of doing quality

<p>improvement and patient safety</p> <ul style="list-style-type: none"> • combining the knowledge for quality improvement with real world experience • address areas of importance to health systems • When graduated students they will have done a quality improvement project in an actual health system. • graduates will enter residency with these skills <p>The School is also interested in the continuum, how to integrate residents and fellows into this project. We would like to be able to provide maintenance of certification credit for practitioners in the health systems to participate in the quality improvement projects. The School would be a portfolio sponsor for maintenance of certification which everyone has to go through to be able to maintain their certification in their specialty.</p> <p>Drs. Woods and Watson and Leslie Anderson were actively involved in writing the 5 page letter of intent, with letters of support from Dr. Friedman, Dr. Brandt, Tom Elliott of the Rural Health Institute at Essentia and Brian Rank from Health Partners. They have all added ideas to the concept. He noted the UMMS bias is to do this process whether the School is selected for a portion of the grant or there is funding found elsewhere. The total grant amount available is \$200,000 per year for 5 years for ten schools. Those selected will be part of a learning community that will be formed of the funded Schools.</p> <p>The proposal indicates all year one and two students would be learning systems redesign and patient safety. They already do a QI proposal in their second year. The goal is to make that more aligned with some of the MN Community Measurements and then pilot year three and four with a subgroup of students where they would be paired really closely with practitioners from those health systems working on the projects.</p> <p>Dr. Rosenberg noted his experience at the VA was very eye opening; they went to teamed based care with a lot of focus on quality improvement. They spent (almost two years) time teaching people how to work in teams, about principles of systems redesign and QI. Even the most experienced practitioners hadn't spent much of their careers in teams. In the first 6 months of our grant development would gather together health systems, policy makers, and educators to work on curriculum elements that they would consider the most valuable. He noted there is also competition within UMMS because EPAC is applying as a consortium. He will update the Council as the phases of selection take place and aboutS the School's progress in the selection process.</p>	<p>3/8/13 20 Schools to be selected</p>	
<p><u>Integrated Work Group – Pilots for Success</u></p> <p>Dr. Nixon spoke about the steps of the IWG's work. Their process has identified a number of areas that they recommend investigating. Dr. Watson reviewed three areas that include the following: 1) courses organized to present content in sequence, coordinating between and across courses; 2) Situational learning i.e. FCT courses, clerkship experiences allow integration of critical thinking, communications and medical knowledge. 3) To address an LCME citation to integrate across the curriculum and between the two campuses. Dr. Nixon focused on consensus reached by the IWG members. Some recommendations are short term and others will have long term effects.</p> <p><u>Short Term</u></p> <ol style="list-style-type: none"> 1. Institute Dyad model for course directorships <ol style="list-style-type: none"> a. To included co-teaching by basic scientist and clinician 2. FCT Cases to be readdressed to become more connected to SF Curricula and serve and model for integration 3. Work with Black Bag to create a model for searching that improve course directors' ability to use it as an integration tool <ol style="list-style-type: none"> a. i. e. search strategies or key word addition or naming convention. b. Faculty development 		

<p>4. Create faculty development around integration topics</p> <ol style="list-style-type: none"> a. Co-Teaching b. Dyad <p><u>Medium Term</u></p> <ol style="list-style-type: none"> 1. Create a Champion or Module Leader who is responsible for integration of diabetes across classes 2. Create a working group to develop overarching diabetes objectives for medical student education 3. Transform SFC into a working group and hold combined meetings with CUMed to establish the work plan to achieve horizontal integration. 4. CEC to work with SFC and CEC around topic of vertical integration 5. Develop a timeline for where, when and to what degree diabetes is covered within our current 4 year curriculum. <ol style="list-style-type: none"> a. What gaps are present b. What unintentional redundancies are present c. Is current developmental progression is appropriate <p>Dr. Nixon reported that these efforts by the IWG to develop a model for use in integration of diabetes vertically and horizontally across the curriculum and on both campuses be used throughout Yr 1-4 with diabetes as the focus. Before integration can move forward, development of overarching diabetes objectives is required to establish what UMMS medical students need to know by the time they graduate. Next steps would then include review of the “logical progression” and “unintentional redundancies” and assessment at the end to establish outcomes. As discussed by IWG and ESC these are the recommendations:</p> <p>Discussion took place and the following ideas and suggestions were offered:</p> <ul style="list-style-type: none"> • consider time commitment to accomplish overall changes • suggested variations on where the work begins and where it flows to • proposal to begin within clinical disciplines for basic ideas • expand into the patient perspective, self care, public health & community health • learning to learn in-depth • over arching objectives –work groups in both basic science and clinical science to establish outcomes to achieve • communicating across courses and clerkships about diabetes may lead to a map for integrating other health topics • potentially focusing on one major health issue will open the process up to be used for integration in the full curriculum • evidence based medicine where appropriate in addition to the recommendations • where to go with the next steps when evidence is not longer available • Duluth is already doing some of the short term steps, the medium term steps may more quickly fit with their process. • Black Bag new capabilities for searching will be needed • use of dyads will cause changes in teaching functions within departments <p><u>A motion was duly made and seconded to endorse implementation of the proposed IWG Recommendations for both Short Term and Long Term steps toward achieving integration of diabetes throughout the UMMS Years 1-4 curriculum. The motion was approved by unanimous vote of EC members.</u></p> <p>Dr. Miller will forward the Recommendations to Dean Aaron Friedman, with the EC endorsement to move this forward. The Education Council will receive an update on the Short Term recommendations at the May 21, 2013 Council meeting.</p>	<p>2/19/13 Vote to move IWG Prpsl to Dean</p> <p>Updte May, 2013 EC</p>	<p>passed</p>
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