JOINT MEETING

Clinical Education Committee
Committee on Undergraduate Medical Education Duluth
Scientific Foundations Committee

January 13, 2017
7:00 – 8:30 am
Mayo B-646 & by Polycom

Minutes

2016-2017 Scientific Foundations Committee Members		
MEMBER	**COURSE/ROLE**	**ATTENDANCE**
Steve Katz	Chair (INMD 6814 Physiology)	x
David Baldes	INMD 6815 Human Behavior	
Matthew Chafee	INMD 6813 Neuroscience	x
H. Brent Clark	INMD 6819 HHD – N & P	x
Greg Filice	MS 2 ID Thread	x
Bob Kempainen	INMD 6808 HHD – C & R	x
Alicia Harrison	INMD 6809 HHD – R, D & O^3	x
Brian Muthyala	INMD 6803/6804/6805 ECM 1, ECM 2, ECM 3A	
Kaz Nelson	INMD 6819 HHD – N & P	x
Catherine Niewoehner	INMD 6810 HHD – R & E-R	x
James Nixon	INMD 6803/6805/6806/6807 ECM 1, ECM 3A/B/C	
Jan Norrander	INMD 6821 Human Histology	
Deborah Powell	INMD 6817 Principles of Pathology, MS2 Pathology Thread	
Michael Ross	INMD 6816 Human Sexuality	
Michel Sanders	INMD 6802 Science of Medical Practice	x
David Satin	INMD 6803/6804/6805/6806/6807 ECM 1, ECM 2, ECM 3	
Peter Southern	INMD 6812 Microbiology	x
Heather Thompson Buum	INMD 6811 HHD – GI & Heme	
Tony Weinhaus	INMD 6820 Medical Gross Anatomy & Embryology	x
Kevin Wickman	INMD 6818 Principles of Pharmacology	x
Blake Stagg	MS2 Student Representative	x
Mehdi Mulla	MS1 Student Representative	x
Mark Rosenberg	*Vice Dean for Medical Education*	*x*
Bob Englander	*Associate Dean for UME*	*x*
Anne Pereira	*Assistant Dean for Clinical Education*	*x*
Michael Kim	*Assistant Dean for Student Affairs*	*x*
Suzanne van den Hoogenhof	*Interim Assistant Dean for Assessment & Evaluation*	
Brad Clarke	*Director of Curriculum*	
Jim Beattie	*Director of MEDS / FCT Course Director*	
Austin Calhoun	*Chief of Staff, Medical Education*	*x*
Scott Slattery	*Director of Learner Development*	*x*
Heather Peterson	*Medical School Registrar*	*x*
Mary Ramey	*MS2 Lab Med/Path Coordinator*	*x*
Brian Woods	*Lead Course Manager*	*x*

Guests: Julie Ansell, Abbe Holmgren, Pat Schommer

The meeting was called to order at 7:04am.

Minutes

Approval of draft minutes from the December 9 meeting was deferred until February.

Announcements

TC Medical Education staffing & structure update – Anne Pereira

Dr Pereira outlined the new structure of the curriculum office and the office of assessment & evaluation in UME.

Curriculum Office

- Anne Pereira: Assistant Dean for Curriculum
- Brooke Nesbitt: Director of Integrated Curriculum – Clinical Sciences
- Brad Clarke: Director of Integrated Curriculum, Basic Sciences. Kelaine Haas will begin in the position starting January 23. Brad will retire March 10.
- Julie Ansell: Project Manager. She will keep any curriculum projects on track, including those that span years 1-4.

Office of Assessment & Evaluation

- Claudio Violato: New Assistant Dean for Assessment & Evaluation (Will begin in February.)
- Suzanne van den Hoogenhof: Director of Operations for Assessment & Evaluation

A summary of these changes will be distributed to all committees and will include each person's scope of responsibilities.

Discussion

Education Council Report – Betsy Murray

Dr Murray is the CEC liaison to Education Council. There is a new charge/initiative from the Education Council to institute continuous QI in clinical education. The idea is to transparently share student feedback (from the Graduate Questionnaire, CoursEval) between sites, including naming the site referenced, and full comments themselves.

The hope is that by sharing feedback, it would be used as constructive feedback for each site's improvement, it would engage leadership, and further best practice sharing. It would also encourage sites that score low in a particular rotation to contact other sites in that rotation that do well in order to find out what's working in those higher-performing sites. Clinical faculty often oversee a variety of sites, and this would allow them to compare different sites in the same rotation. The purpose is *not* for public shaming or punishment.

All sites would receive all information, and it would *not* identify individuals. Only the site name would be known. One of the issues still to be worked out is how this information will be shared in the most productive and meaningful way possible.

Committee discussion followed, touching on these points:

- Sometimes it's a problem to recruit sites, so knowing that potentially negative feedback will be shared may be a disincentive. A solution would be to identify the health system generally, rather than individual sites.
- Dr Englander emphasized that guidelines will be devised for sharing; protections will be in place for those receiving the feedback, and those giving the feedback; data will be aggregated; there will be a minimum number of participants at a site before reporting on that site.

- Question: What is the good to come from everyone knowing what's happening in everyone else's neighborhood?
- Another benefit would be that sites that are successfully doing something really creative would offer it to others to use for their improvement. On the other hand, individual sites could see that another site is "doing it better", so how can they improve to match that higher-performing site?
- Question: Would this be shared across disciplines? The idea is yes, it would.
- There are many variables that determine the opinion of a student at a particular rotation. These would have to be teased out, analyzed for applicability, and significant variables would have to be studied.
- There are two utilities to this idea: 1.) Sharing the problem, then 2.) Sharing the solutions. Part 2 may be the more valuable part to share.
- Students would want to know how changes have been implemented at a site due to their feedback. There needs to be a system in place to show the action that was taken as a direct result of feedback.
- Longitudinal date will be useful over several years, to see the improvement in a site, or to see if a site goes down in any category.

Dr Englander emphasized that this is a very important issue. We need the bigger picture of the curriculum.

Update on Education Retreat and Medical Education Guiding Principles – Bob Englander
See attached slides for details.
For Undergraduate Medical Education in the Medical School, Dr Englander is aiming for a new vision statement and guiding principles, with specific goals & objectives, to be ready by January 1, 2018, in order to allocate resources in the FY 2019 budget to capitalize on this plan.

He wants to engage everyone in this process. An initial draft of the vision statement and guiding principles has circulated for a few months. On January 11, 2017, there was an off-site education retreat with faculty, administration of the Medical School and health systems, students, and patients, where this initial draft was refined, sharpened, and reworked. For the remainder of the calendar year, there will be further refinement of this document, with prioritization of the guiding principles, and a reduction in number from the current 13.

Medical Education is moving from the traditional model (based on the 1910 Flexner report) to a model addressing the needs of the health systems & the patients (using competency-based education). Determining the product of the MD degree will now determine what the medical curriculum looks like.

Up to now, medical education has been in a paternalistic model. But healthcare is moving from a being a good to being a service. The "Hofstra model" is the most obvious example for the new delivery of medical education. There are no lectures, there are many small group activities, and students are given a choice of 5 practices, and they can independently determine which of these practices to devote time to during the course of a week. Education is also becoming a co-production with continuous improvement. The focus is on reward for improvement.

Can we continue in the current paradigm? Ideas are in evolution for a vision of the future of medical education. Dr Englander reviewed changes made to the earlier draft vision statement which was reworked during the education retreat. He then addressed the guiding principles, and instructed committee members to work in small groups and use a Q-sort exercise to rank these principles by importance.

Each group then reported their 1st, 2nd, and 5th columns in the Q-sort. Results were collated and compared with results from the same exercise done at the Education Retreat on January 11. Discussion followed regarding the reasoning for the choices that each group made. Dr. Englander reminded the group that after the guiding principles are finalized and set, specific goals and objectives for those principles will be drafted. He concluded with a review of the next steps in order to come up with a final Strategic Plan in time for the FY 2019 budget.

The meeting was adjourned at 8:30am.

The next meeting is February 10, from 7:30-9:00am in room Mayo B-646.

Respectfully submitted,
Brian Woods

Undergraduate Medical Education at the University of Minnesota Medical School

Robert Englander, MD, MPH
Associate Dean for UME

Background: This draft document is designed to further a strategic planning discussion to take place over the 2017 calendar year. The goal of this strategic planning will be to develop a vision, guiding principles and strategic goals *for education* at the University of Minnesota Medical School. The process will engage key stakeholders from within and beyond the medical school, including but not limited to students, patients, faculty (foundational sciences and clinical sciences), educational leaders, systems leaders, community leaders, community preceptors, interprofessional colleagues, and alumni.

Draft Vision: *Together, preparing physicians to meet the emerging needs of Minnesota and beyond***.**

Alternate Vision: *Learning together as we prepare physicians to meet the emerging needs of Minnesota and beyond*

Guiding Principles:

1) *Put Patients first*: The success of our graduates is ultimately only measured by their success in improving the health and health care of the patients and populations they serve. When possible, we should try to link student outcomes to patient outcomes. We should also engage patients as critical stakeholders in key education decisions.
2) *Engage Students*: Co-production of health professional's education by definition recognizes the learners' expertise as critical to the outcome of the education process. Students should be engaged in every aspect of the medical school that touches their education-from admissions to student life to curriculum to assessment and program evaluation.
3) *Support Educators*. We must ensure that those who engage in the learning environment are prepared as 21st century educators and have the resources to do their work.
4) *Standardize outcomes, individualize pathways*: We must ensure that our graduates demonstrate those competencies required for practice under indirect supervision as residents[1], and then provide pathways to attain those competencies that allow students to pursue their passions and optimize their learning styles.
5) *Foster Meaningful Relationships*: Fostering longitudinal relationships between students and their peers, supervisors and patients drives internal motivation to learn and mitigates both the decline in empathy and the burnout associated with our current system of medical education.

6) *Provide Evidence-based Education.* We must deliver innovative curricula and assessment grounded in the evidence about how we learn. (e.g. self-determination theory[2]; active learning principles such as the Khan academy and team-based learning literature; interleavement, spacing and assessment for learning[3]).
7) *Meet Minnesota's physician workforce needs*: 70% of the state's physicians spent some or all of their education and training at the University of Minnesota Medical School and/or its affiliates. We are uniquely positioned, therefore, to consider the needs of the state's populations in shaping our curricula.
8) *Focus on Diversity*. Diversity in medical education is both a goal and a strategy. It is a goal as evidence suggests that our ability to optimize care for our patients and populations and narrow the disparities gap can only occur if our practitioners better reflect the communities they serve. Diversity is also a strategy towards optimizing organizational functioning as one of the primary means to combat unconscious bias.
9) *Align learning across the continuum*. From medical school admission to practice, students, residents and practitioners should be striving for mastery in the requisite competencies of a physician. This requires a developmental approach in which the expected performance on those competencies is determined by where one is in the education-training-practice continuum.
10) *Optimize the learning environment*: Our learners spend time in a myriad of settings—we must ensure that all of those settings are safe and engage the students as active participants.
11) *Provide wise stewardship*. Resources for education are tight and the financial burden to students is great. We must seek to decrease that financial burden while simultaneously ensuring adequate resources to reach our vision and strategic goals.
12) *Facilitate continuous improvement*: A learning organization is measured by the extent to which continuous improvement is a habit and built into all of its processes.
13) *Build partnerships*. We must build and foster collaborative relationships with community partners and health care systems that enhance the education experience.

References

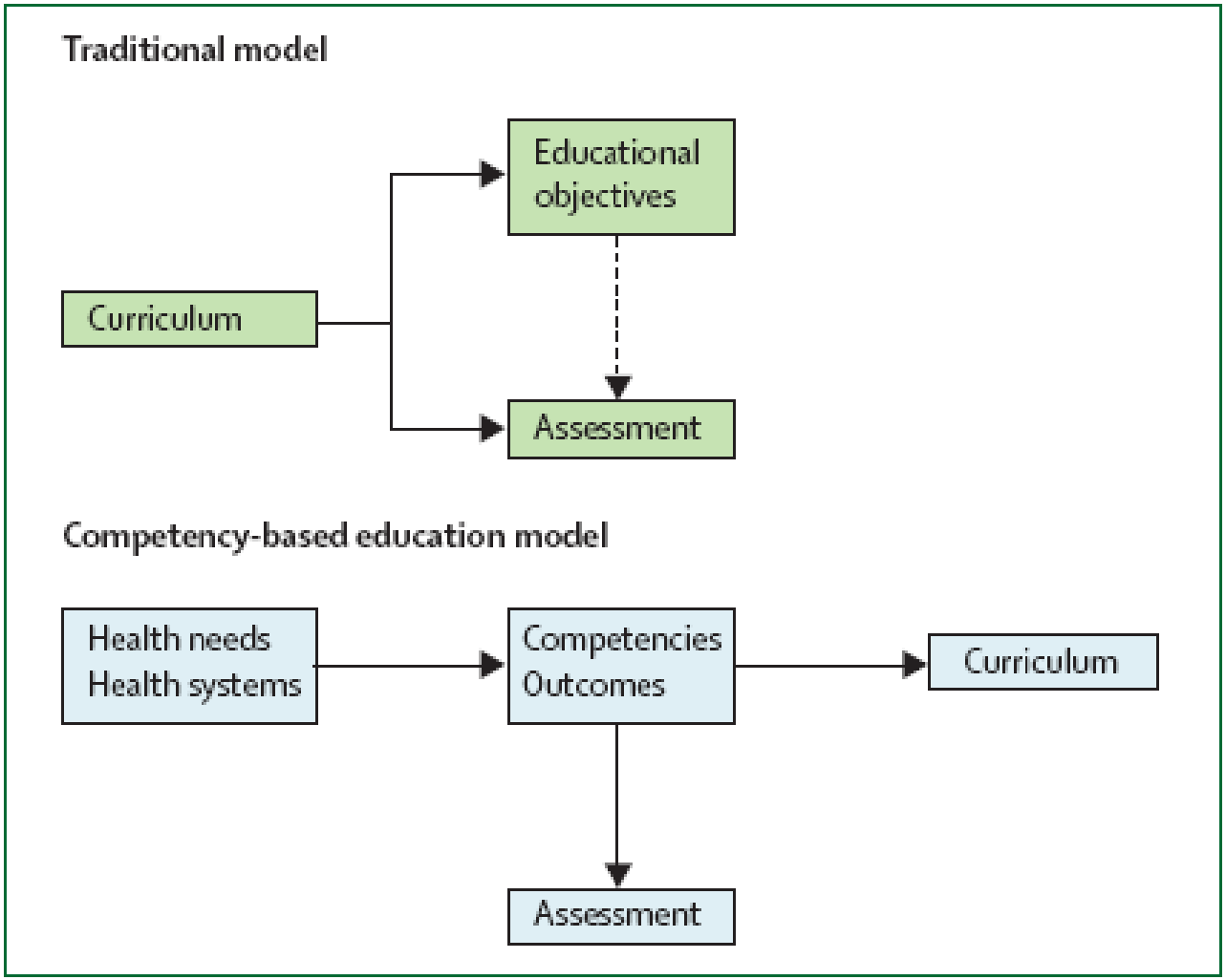
1) Englander R, Cameron T, Ballard AJ, Dodge J, Bull J and Aschenbrener CA. Towards a common taxonomy of competencies for the health professions. Academic Medicine. 2013; 88 (8): 1088-1094.
2) Deci, E.L. and Ryan, R.M. (1985). Intrinsic motivation and self-determination in human behavior. New York: Plenum.
3) Rohrer D and Pashler H. Recent Research on Human Learning Challenges Conventional Instructional Design. Educational Researcher, 2010, 39; 406-412.

Envisioning the Future of Medical Education at the University of Minnesota Medical School

Robert Englander, MD, MPH

January 13th, 2017

Combined CUMED, SFC, CEC meeting



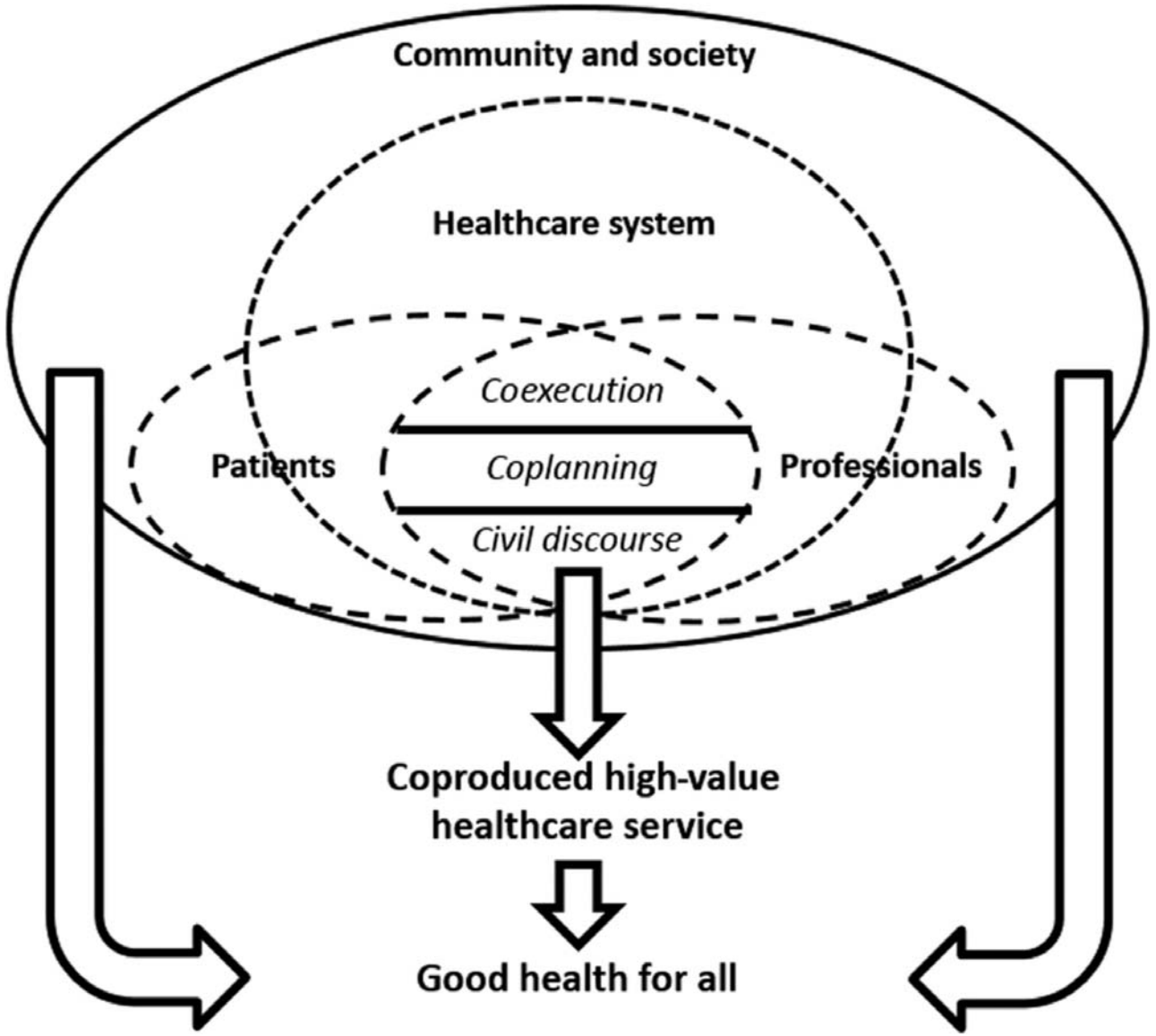
Frenk J, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. Lancet. 2010

Where we've been (are?): Paternalistic Model

Education	Healthcare
Teacher driven (teacher as expert)	Professional driven (professional as expert)
Input focused (sequence, courses, rotations)	Disease focused (patient as condition or disease)
Fixed time, variable outcome	Fixed treatment, variable outcomes
Siloes (interprofessional, intraprofessional e.g. Nsg: RN, NP, DNP or Med: UME, GME, CPD)	Siloes (interprofessional and intraprofessional)
Faculty/School needs trump learner's needs	Practice/System needs trump patient's needs
Limited system perspective - blame and punishment model for "improvement"	Limited system perspective –blame and punishment model for "improvement"
Education as a "goods" versus a service	Healthcare delivery as a "goods" versus a service

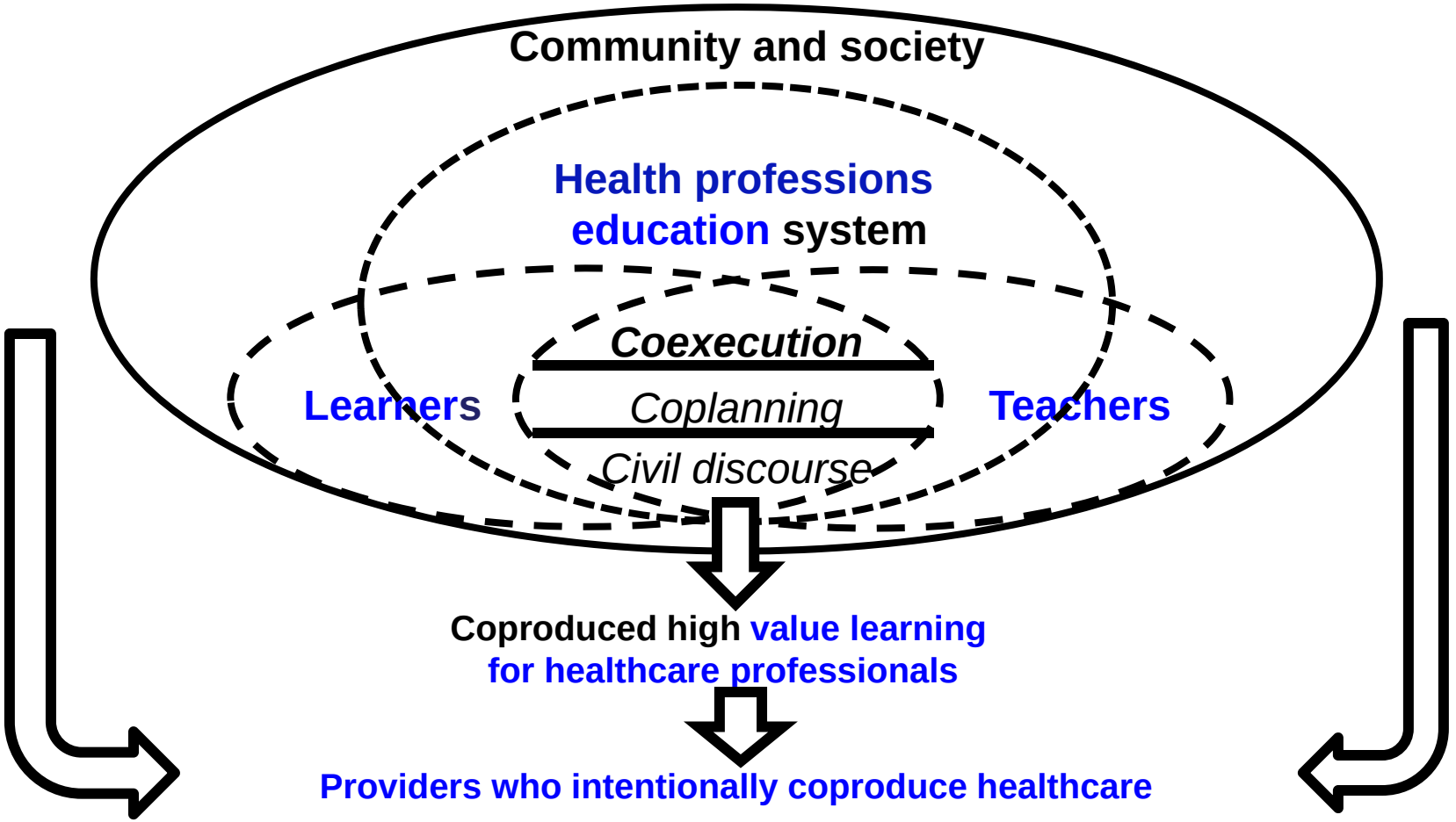
Where we are headed: Co-production with continuous improvement

Education	Healthcare
Learner-teacher partnership	Provider-patient partnership
Learner as expert	Patient as expert
System-population partnership	System-population partnership
Fixed outcomes, individual learning pathways	Patient defined outcomes, individualized health care pathways
Profound knowledge re: learning → guides design	Profound knowledge re: wellness and healing → guides design
System incentives for continuous improvement (CLER versus LCME)	System incentives for continuous improvement



Batalden M et al. Coproduction of healthcare service. BMJ Qual Saf 2015; 0:1-9

Can we move to the intentional co-production of healthcare and healthcare services if we continue to educate and train in the current paradigm?

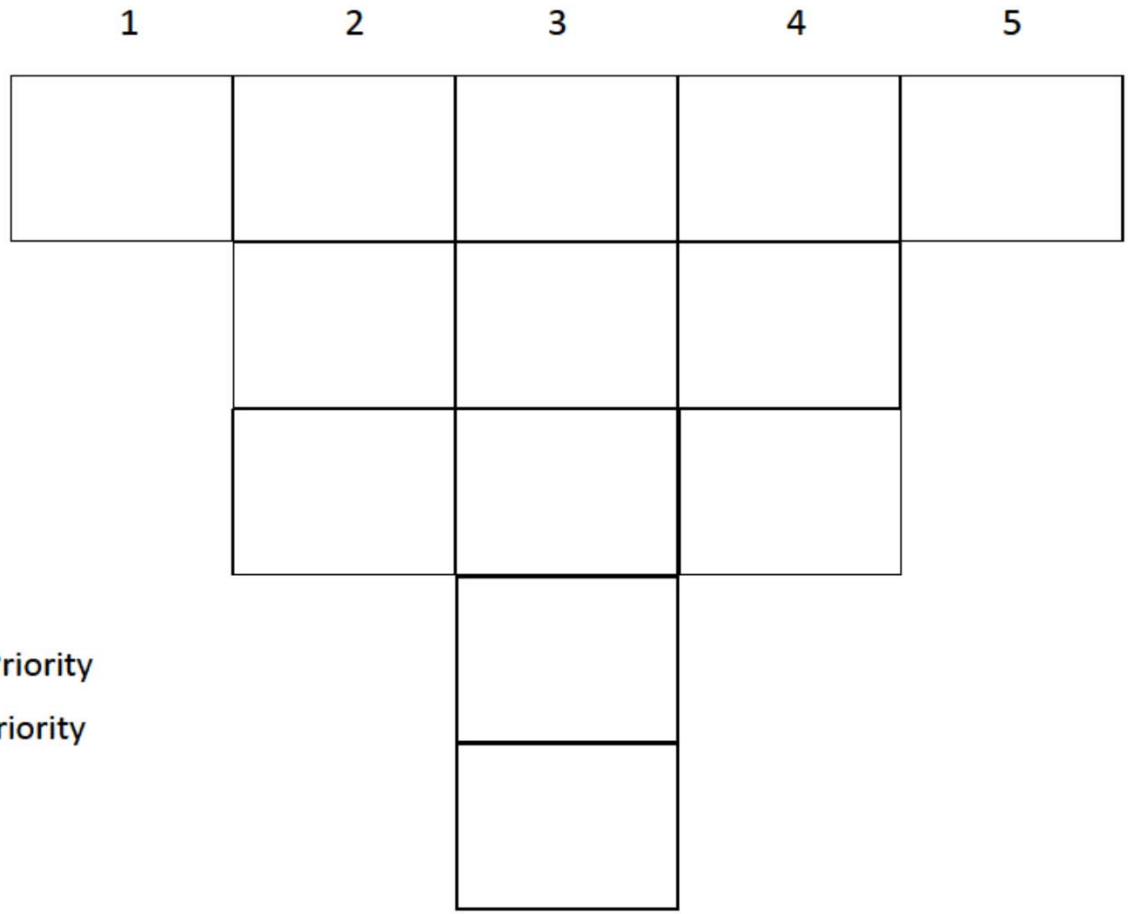


Adapted from Batalden M et al. Coproduction of healthcare service. BMJ Qual Saf 2015; 0:1-9

Convergent Thinking

- Use the Q-sort table to prioritize the Guiding Principles (20 minutes)
  - Each table can have only one consensus ranking
  - Criteria for ranking?
- Large Group Report Out and discussion (40 minutes)

Prioritizing the Guiding Principles for Education at the University of Minnesota Medical School



1 = Highest Priority

5 = Lowest Priority

Next Steps

- January-February 2017: Prioritizing Guiding Principles with student council, education council
- February-March 2017:Draft vision and guiding principles online for open comment
- May, 2017: Final draft of Vision and Guiding Principles
- Summer 2017-Development of Draft Goals and Objectives (med school admin)
- September 2017: Strategic Planning Retreat-revising goals and objectives
- October-November 2017: Feedback on Goals and objectives from faculty and student groups
- December 2017: Approval of final Strategic Plan for UME by Education Council in time for FY 2018 budget