CUMED 4/11/2017 *Meeting was called to order at 8:01 am*

Attended: *J. Boulger, R. Christensen, K. Diebel, J. Pearson, E. Onello, A. Shaw, G. Trachte, R. Westra, M. Conlon, K. Krasaway.* **Absent:** *R. Harden, A. Johns, R. Michaels, K. Nordgren, M. Novak, K. Haas (TC), C. Weber,*

Welcome:
Dr. Trachte identified edits in the March 16th minutes. Dr. Diebel entertained a motion to approve the meeting minutes of March, 16th with the change.
Dr. Trachte entertained a motion to accept the March 16th meeting minutes with the stated correction. Dr. Pearson seconded the motion: All in favor of approval: non-opposed.

Student Update:
Megan Conlon, MS I indicated no specific concerns known in MS I. Marlee Novak, MS II was not available for comment.

Education Council Representation:
Dr. Westra has not had a chance to discuss this topic with department faculty. April 13, 2017 is the next FMED department meeting and this will be discussed. If no one steps forward to volunteer, a faculty will be appointed.

Mini Retreat on Active Case Repository:

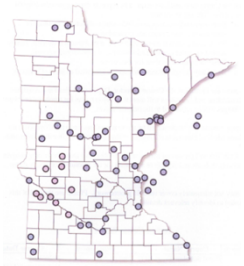
- A poll to identify a date in June has been sent out to Course Directors/Clinical Course Directors.
- Dr. Diebel presented a Google Form, housed in the Google Drive. Members are asked to review and send Dr. Diebel comments/edits prior to April 17th. When the final form is complete, an email will go out to the members to begin inputting cases.
- When case information is inputted into the form, it will automatically generate an excel database sheet for members. It should take approximately 2-3 minutes per case to enter.
- The list of entered cases will be compiled prior to the Mini Retreat to discuss the cases.
- Dr. Pearson has pulled last year's MS II class survey on cases and the current case survey has approximately 90% student response rate (with incentives to complete). We will have two years' worth of survey data about cases.
- Dr. Pearson suggested as an educational issue (not code of conduct) the Google Drive be hidden from students (including student committee members). The database needs to be used carefully. Dr. Diebel will insure the folder only has faculty access.

Annual Course Reports:
Drs. Christensen, Boulger & Onello presented ***Rural Medical Scholars Program II:***
The RMSP II ACR findings have been posted to the Google Drive folder. The RMSP II is a second–year component of the Rural Family Medicine, Native American, & Minority Health Scholars course, a longitudinal experiential clinical immersion course spaced over the first two years of medical school. Learner participate in acute, chronic, and longitudinal care in rural family medicine clinics and other health care systems in which they develop basic clinical skills and an understanding of rural medicine and educational competencies under guidance of the faculty of the Depart. Of Family Medicine, Biobehavioral Sciences and Population health and the direct tutorial/preceptorial experiences with community physicians throughout the state and region. One week is spent in Duluth developing basic clinical and

academic skills, and the remaining time is spent in the student's primary training sites in smaller communities. During the current academic year, 62 second-year students were assigned to 48 separate communities. The current second-year students spent the periods from 09/26/16 – 09/30/16 and from 2/13/2017 – 2/17/17 in the communities. In most instances, housing was provided by the family physician and his/her family at no cost to the student.

With 120 or so students to be matched each year, this is a definite challenge to line up volunteer preceptors. Recruitment is a continuous process throughout the year in order to secure the best placements for the students. Optimally, and in most cases this is the model implemented, the student moves in with the preceptor and her/his family for the five weeks of the course in order to get the maximal immersion experience. As this is a required course, all students must participate. We attempt to meet individual student needs; this is only possible because the faculty in Duluth are familiar with the practices and preceptors that have been utilized over years. If a new site/preceptor is added, one of the faculty typically site visits and discusses the practice and community strengths and weaknesses as a teaching site, answers any questions that the physicians and clinic/hospital administrators may have, discusses the need for and desirability of an affiliation agreement with the University, etc. Dr. Boulger added faculty development is ongoing. This year, involved faculty were subscribed to receive the electronic journal of the "Society of Teachers of Family Medicine, Teaching Physician". Development is not just on the student side; Preceptors try to recruit doctors. If students give a good review of the site, this can make it easier for them to fill spots. With our success, we have many Medical School Duluth Alumni working in our rural areas. This is good for our reputation, the communities and Minnesota.

If the site is to be used, further development of an affiliation agreement is pursued. The matching process is intensive, it attempts to holistically match the needs of the student both personally and educationally to the site, its preferences and housing arrangements, etc. Dr. Onello indicated with LCME Accreditation, affiliations agreements can be extreme: i.e. an affiliation agreement started back in November was not in place for students to have an immersed experience at the January site visits. The agreement was completed for the March site visits. Affiliations agreements are typically set for 5 years but take months to finalize. With RMSP threaded through the basic science courses, our students are applying that knowledge for robust experiences.



One within course metric, that is relevant to the success of the match process and the efforts that go into that process, is the number of moves of students from the original site to an alternate site during the two years. There can be many good reasons for this, of course, and many are not under control of course faculty (e.g. the preceptor takes a position elsewhere in the US, practice site changes, etc.). This year, no changes were made for the current second year class during the reporting period. One member of the second-year class was re-assigned to a different community when the physician who was acting as preceptor was terminated on the first day of the first session. This is rare, of course. Over the years, the original match has been sustained throughout the student's UMD career at a rate of 98%.

With upcoming class size increases, we will need to identify another 9 to 18 preceptors to accommodate program growth. This will be a challenge, but we believe that we can meet it. The upper limit of the tremendous volunteer efforts of our rural family physicians will be a problem as many, many other health education programs are after these practitioners to take their students as well. If the D.O. school proposed for Gaylord Minnesota comes to fruition, it will be doubly difficult as the D.O. training model in the private osteopathic schools is to pay stipends to the clinical training sites - which we cannot afford to pay.

Last year, we estimated the costs saved by using voluntary faculty in these rural communities. Over the past 45 years, we estimate that our rural Family Medicine colleagues have donated approximately 235,000 hours to this program. If we had to pay these physicians $50 per hour, this would be a program cost of approximately $11.7 million to date. Additionally, all housing in rural sites is provided at no cost by the Family Physicians and their colleagues.

Student feedback has been positive. All RMSP II students provide feedback through site evaluations at the conclusion

of RMSP II. We also hold RMSP II debriefings allowing oral feedback in learning communities and to the class. In their Learning Communities (LCs), the students discuss significant events that may have occurred onsite. The discussion may include disturbing or happy events. Faculty monitor the discussions and provide input when needed but in general this is a LCs function allowing open discussion.

We also make an effort to demonstrate site experiences (i.e. did you see/participate in a delivery, ER, etc). All students have personal access to course faculty and staff. Negative feedback is generally received by faculty personally, during the course, and in the site evaluations. This has involved only a few students since the program began - maybe 1-2 yearly. The evaluations are read by course faculty and concerns in the program are addressed immediately if needed and also each year at our faculty retreat as we establish the RMSP I &II course for the incoming class.

RMSP II is an administratively complex course. The sites are comparable, but each experience is individual. The Course Faculty and Staff are always available by email and if needed by phone when the students are on-site and additionally in person between community visits. Each student has an onsite preceptor (adjunct Med School faculty). Any student concerns onsite are handled by preceptors and if the preceptor or student has questions/concerns the course faculty are contacted. This seldom occurs and generally involves an unforeseen site problem and may require reassignment or other resolution.

RMSP II is an early medical career experience reinforcing the broad capabilities of rural practice and the reinforces the reasons students enter medical school. It allows preceptorship (practice experience), health system learning and understanding, longitudinal care, interprofessional opportunities, and community involvement.
Assignments are submitted to LC mentors and course faculty by each student. This has proven to be successful in teaching completion of H&P and SOAP notes.

One major problem is identifying and vetting enough comparable sites and, as noted above, is a constant responsibility of the Course Directors. A major issue is the loss of a preceptor or site at any time during RMSP 1&11. We struggle with affiliation agreements, different in each system and sometimes within systems. This can occur yearly with new site interpretations and personnel. This is an on-going concern.

Native sites are particularly difficult to identify and construct affiliation agreements with; housing seems to be more of a problem for some of these sites and we cannot promise Native sites to all students who want them. The Center for American Indian and Minority Health is an ally.

As with other UM Med School rural opportunities we struggle intellectually to assure constancy in rural preceptor evaluations of our students. Our experience in RMSP has shown minimal variation. Dr. Onello added in RMSP I, students do assignments as a prelude to going out into rural sites. With the research our students do in their assigned community, there is a stronger bond/connection for the student. It is a little harder to reassign students with unexpected events. All evaluation submissions have been subjective. Concerns have been addressed individually and immediately. Likert evaluations have been performed and used in the past in helping improve the course. *(N27/62 responses, Mean 4.3 out of 5).*

This is a nationally known, well-received course by students, preceptors, and communities (patients knowing they are teaching students). The course faculty is deeply entrenched in rural MN and regionally and in rural health knowledge. Without that familiarity and with external health profession student competition this would-be a near impossible course to institute. It is imperative that the Duluth campus maintain its rural ties and allegiance to insure continued rural support.

The course faculty is very deliberative in evaluating the course and strategically planning and refining it yearly. The proposed increase in class size will continue to challenge us. Comparable experience at all sites is always a concern. Learning Contracts are provided to the student for sharing with their preceptor prior to each RMSP site visit, updating

the students learning and capabilities. Affiliation agreements are taxing on faculty and especially staff (Thank you, Katy Fredrickson, for your work). Increasing the number of Native/Tribal healthcare sites for students with strong interest in Native American health issues are a constant goal. Faculty is also aware of the need for succession planning.

- Dr. Trachte indicated Dr. Englander likes the RMSP experiences our students receive.
- Dr. Pearson added the RMSP experiences drive the Medical School Duluth statistics. Moving forward there are many challenges to adapt; i.e. new benchmarks for increasing class size, the challenges within Minnesota, and inevitable curricular changes. What is the essential we don't want to lose?
- Dr. Christensen indicated there is interprofessional education built into the RMSP courses. From a rural standpoint, there are demographics/geography that have specific needs. The courses are an opportunity for our students to work closely with multi-talented doctors that work across multiple disciplines/professions in those areas.
- Dr. Onello indicated the experience needs to be crafted carefully and requires time to coordinate the longitudinal components.
- Dr. Westra stated the coordination of the course has a nice flow of block learning followed by an experience. Students are more engaged returning from a site visit as they are able to apply what they learned in class.
- Dr. Christensen added the Summer Internship in Medicine is an elective during the summer. At the beginning, the objective was to place students in a small community to gain experience. The course is open to the Twin Cities students and today the participating physicians are getting the students more involved in clinic experiences. It is nice to see the growth of clinical experiences over the last 10 years.
- Dr. Diebel acknowledged the preceptorships and the constant challenge of coordination in a reasonable timeframe. Dr. Christensen indicated housing has always been a challenge to find for our students. Students staying longer than a week with a preceptor can be stressful this is why students are only assigned for a week at a time. The extra weeks in the course is essential to practice the skills and other learning needs for community visits. Dr. Boulger indicated the preferred model is that the student move in and live with a preceptor and their family. Some preceptors left the program when the course was realigned to be a week-long experience instead of 3 days. Students are asked if their preference to stay. We take student dietary, religion preferences, allergy needs etc. into consideration.
- RMSP requirements have been modified based on individual student situations; i.e. students on a delayed program with other courses. Preceptors have been very gracious.
- Dr. Christensen is working with Heather Heart about the possibilities of how we can honor our preceptors. Doctors already have a lot of venues of events in their lives and it is difficult. The 1:1 connection has been the best. Dr. Boulger indicated when talking to the doctors, they really enjoy our students. Our students are representing our campus and Minnesota well.
- Dr. Onello stated the need to have optimal placement in the curriculum is essential as site visits can be up against other events like MEA week. One of the barriers in the two-year experience is doctors usually plan conferences and vacations at least 6 months in advance. We are not always able to give them the dates early enough. CUMED has always wrestled how far in advance our curriculum can be locked in.
- Dr. Westra pointed out the estimated overall cost of the program through the years of the voluntary faculty, site expense and also points out the added cost it puts on our students.

Dr. Diebel presents: ***Neurological Medicine:***

The Neurological Medicine course provides an interdisciplinary study of the human nervous system coordinated with the gross dissection of the head and neck. Specific topics include the embryologic development of the head, neck, face, palate, central and peripheral nervous system, eye and ear coupled with basic science content in anatomy, biochemistry, microbiology, pathology, pharmacology, and physiology is correlated with clinical cases and relationships.

In general, the Neurological Medicine course is organized to guide the student's learning of neurology starting with an overview of neurological systems, followed by sensory systems, the ear and eye, motor systems, and ending with executive functioning. Distributed throughout these blocks of instruction are themes of information that thread throughout the course. These themes include neurological exam procedures, gross anatomy, infectious disease, and

ethics.

As within the Skin/MS course, clinicians have been invited to teach within the Neurological Medicine course to provide expertise on Neurological physiology and disease. Also, as in the Skin/MS course, it is important for you to recognize that many diseases with widely divergent clinical presentations have common pathophysiologic mechanisms, and conversely, that many diseases with similar clinical presentations have different etiologies as well as mechanisms of disease. For each disease discussed the student should keep in mind the following:

1. Clinical presentation
2. Diagnosis (including physical findings, laboratory and imaging data)
3. Genetics
4. Etiology
5. Pathophysiology
6. Treatment (including pharmacology)
7. Prognosis

The complexity and the demands of Neuro is and has been a big issue over the years. There is about 200 hours of instruction. The course is 60% lecture, 40% other active learning. There are 17 faculty from BioMed. Running PBL cases involves 300 hours of faculty time to set up cases and facilitating. The sustainability of this moving forward is unlikely. Overall, the course evaluation from students is positive and they like the PBL format except for the wrap-up Q&A format. Students that are more vocal may get more out of the Q&A than those who listen. The future direction is to get students more engaged throughout the Q&A sessions and having expertise available. Students identified the course as dense. Students would like the pharmacology spread out over several weeks. Students comments were positive even though they were tired.

- 4 students will be remediating the course by exam prior to July 31st.
- 55 students Passed, 9 students received Honors
- Successes were increased PBL sessions (4 to 9). Added lectures to address deficiencies.
- Dr. Fernandez-Funes will be the Course Director for Neuro in AY 2017-18.

Other:

- Dr. Westra indicated the student should notify their Advisors about course failures. Advisors will work with Student Affairs on a future process.
- Dr. Trachte indicated at the Education Steering Committee there are conversations about the process to reduce curriculum hours. We continue to add lectures but there is no discussion of removing lectures. This should be a future topic for CUMED. Territorial issues will need to be addressed at the same time. Going through Annual Course Reports, as Course Directors we need to communicate and have these conversations with involved course faculty. Dr. Pearson indicated we need to right size and efficiently teach as we look towards future changes.
- ACR's for GI and HRM will be presented at the May CUMED meeting.

Meeting adjourned at 8:56 am. Next CUMED meeting: ***May 9th @ 8am (165 Med)***.
Minutes transcribed by Brenda Doup and reviewed by Dr. Diebel (Chair) & Dr. Johns (ex-Officio)