Clinical Education Committee
August 7, 2015
Minutes

Attendance: see last page

Review of minutes - June - approved as is

Announcements:
Acknowledgement of "retired" clerkship directors:
Briary Duffy, Internal Medicine
David Power, Family Medicine
Edward Santos, Ortho Surgery

Welcome to LICs - VALUE and EPAC directors added to membership lists.

Late Grades - Special thanks to clerkship coordinators for rounding up clinical evaluations and reporting grades on time.

CEC representative to Ed Council - Betsy Murray, Pediatrics, will represent CEC at Ed Council

Combined CEC/SFC/CUMED - September 11 - Dr Batinelli - please refer to message sent out by Dr Pereira.

*Dr. David Battinelli, Professor of Medicine, Dean for Medical Education at the Hofstra North Shore-LIJ School of Medicine and Chief Medical Officer of the North Shore-LIJ Health System will be visiting our school and will participate in this special session. He will present the innovative curriculum that they developed for their **new** school of medicine, and then we will have the opportunity for a Q&A session. We want this visit to give us opportunity to consider ways in which we could innovate for our students within our curriculum.*

In Dr. Battinelli's leadership capacity, he is responsible for facilitating alignment of the clinical initiatives of the Health System with those of the undergraduate, graduate and continuing medical educational programs. The Hofstra North Shore-LIJ School of Medicine has a fully integrated curriculum that enables students to apply medical science to the care of patients from the beginning of their medical education and throughout their educational program. A guiding principle of the School of Medicine is that assessment drives learning. To this end, the school has incorporated into the educational program a comprehensive competency-based assessment system that includes numerous opportunities for an ongoing cycle of observation, feedback, and assessment of each student's developmental progress in achieving the educational program's explicit objectives and competencies. The overriding goal of the school's comprehensive assessment system is to assist students in becoming reflective practitioners of medicine who embrace lifelong learning opportunities and complement them with a critical approach to self-assessment and self-improvement.

Updates:
EHR Curriculum -

1. Frustration by students and faculty about the amount of EHR training that students must complete at the beginning of each rotation. Dr Michael Pitt has been meeting with IT and Education leadership at major health systems to identify a core curriculum that students can complete online through the medical school with then a shortened site-specific training at each hospital. Goal is for 2016-2017, but there is the possibility that it can be put in place sooner.
2. Efforts also in place to develop a general EHR curriculum to be integrated into MS1-2 curriculum.

Mistreatment & Harassment -
Please note link to EthicsPoint in June minutes: https://secure.ethicspoint.com/domain/media/en/gui/9167/index.html**.** Important for clerkships to readily address this issue. EthicsPoint provides a neutral forum for students to identify experience, with appropriate follow-up To Dr Kim or Mary Tate for concerns with merit. Removes any conflict of interests - "our resident" or "our faculty." Inclusion of Student Affairs personnel helps keep focus on the student.

Discussion:

Clerkship Redesign-

Please see attached handouts and calendars. 2-, 3-, 4-, 6-, and now 8-week rotations continue to make scheduling difficult for student. Goals are to maximize the use of current capacity, while also working at the clerkship level to increase capacity. Administration is working with health systems and MMA to develop strategies for increased and optimal preceptor participation. Proposal includes:

1. Moving foundational clerkships into MS3.
2. Keeping advanced clerkships in MS4, with time for advanced electives, etc.

Looking at the landscape-formatted capacity chart shows clerkships with enough capacity for MS3, enough overall capacity but half-filled with MS4, and not enough capacity. Taking into account LIC, Flex, and remediating students, the safe denominator for number of needed spots is around 225.

By default, PCS has become an MS4 clerkship due to capacity and students having pushed it to MS4. Dr Prunuske shared opinion that based on the PCS curriculum, being an MS4 clerkship may be appropriate for sequencing. Dr Pacala noted, though, that PCS early on is important for students who are NOT going into Primary Care (last experience). There is competition to recruit primary care preceptors, both due to shortage and competition with other provider types. Dr Fiol questioned status of being able to add adjunct faculty status. Dr Rosenberg shared that preceptors do not all need faculty status, only the site director NEEDS to. It is unclear if there is a "pause" in the appointing of new adjunct faculty at the Faculty Senate level. Dr Gleich asked what the expectations of a new site might be? Distance, patient panel, curriculum, appointment? Dr Pereira stated that administration would defer to the department as to whether or not the site is appropriate for that particular clerkship. She noted the difficulty for clerkship directors to track quality when capacity is spread out to new sites. Dr Kim noted LCME standards that require students at different sites must have a comparable educational experience (not exactly the same, but similar). Dr Pereira added that there are efforts underway to better identify, track, and recognize (gifts) our current preceptors. MMA recently completed a survey of preceptors for their feedback about the preceptor experience and limitations.

Back to the *capacity chart*…. chart shows filled and unfilled spots. Note OBGYN and Pediatrics, where there is 0-1 spots left available for all of 2015-16. Trend also shows how increased capacity has helped to increase the number of spots filled by MS3 students (and therefore fewer spots needed by their classmates as MS4s the following year).Efforts will continue to fill any unfilled or new spots in 2015-2016 by MS3 students, so that even fewer MS4 students need spots in the following year, which equals more spots available to new MS3 students in 2016.

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Internal Medicine and Surgical Subspecialties not included into data, due to adequate capacity.

This is another view of the trends for clerkships that have enough overall capacity, but too many spots occupied by MS4 students, and clerkships that do not have enough overall capacity. 230 represents an average, conservative denominator of needed spots. Dr Nikakhtar (Internal Medicine) asked how much of an effect remediating students. Several members commented that the flux in the total number of needed spots (+/- 25) is almost impossible for hospitals to handle. Dr Kim shared that students needing a personal/health LOA may create more effect on the system than remediating students. Dr Prunuske shared the capacity discussions in Duluth and strategies to explore placements outside city limits of Duluth, while noting obstacles such as housing, transportation, etc.

Handout: *Proposed MS3-4 redesigned calendar for 2017-2018*. Overall goal is to better align the lengths and start dates of clerkships - only 2-, 4-, and 8-week rotation lengths. Will help with scheduling, clinical site onboarding, and semester alignment. There are also Intersession weeks distributed evenly through the year (versus period 9A). Dates were left out as term start dates continue to be fine-tuned.

Handout: *Redesign proposal*

Foundational and advanced clerkships adjusted to 4- or 8- weeks and aligned with either MS3 or MS4. Students rotate through clerkships in a specific order, starting the order in various spots. Dr Pereira referenced the pre-reading articles and other academic medicine literature with strategies for better student experiences - scope and sequence of curriculum, consistency of rotation sites, continuity of patients. EPAC and VALUE students are good examples of students for whom much of the "noise" present in our current schedule has

been removed. Clerkship directors should start to think about transitions, and strategies for intra-clerkship schedules, exams, etc.

Best Practices:

Recruiting a new Clerkship Director-

Internal Medicine recently recruited two new Clerkship Directors, Andrew Olson and Nersi Nikakhtar, for the Medicine Sub-Internship and Medicine 1 Externship, respectively, Dr Nixon used a process much different to his personal experience of becoming a clerkship director. He sent out an invitation to his faculty for interested persons to apply for the positions. A search committee was developed, including Dr Nixon, another IMED faculty, and Dr Pereira, who represented the program-level perspective. Overall, there were nine applicants and a powerful vetting process. In addition, the process identified other faculty who are interested in being leaders in Education within the department. Dr Pereira shared that it was helpful for her to get to know the candidates to ultimately became the new directors. Dr Nixon also shared that this process corrected his assumption that site faculty would not be interested in being the overall clerkship director. Dr Olson shared the value of going through an application process - he had not previously done such an interview. The formalized process was valuable not only to the department and program, but also the candidates. Dr Nixon also shared that the sites seemed pleased to be included in the search process.

Dr Acton shared that Surgery clerkship has an Assistant Clerkship Director and that he and Dr Chipman are continually looking to build their set of Education faculty, both within the department and with affiliate faculty.

Next meeting - Joint committees - September 11