

Clinical Education Committee

March 6, 2015

Minutes

Attendance:

MEMBER	CLERKSHIP/ROLE	ATTENDANCE
James Nixon	INMD 6805-6806-6807 Essentials of Clinical Medicine 3A-B-C; Process of Care Clerkships	X
Ray Christensen	Rural Medical Scholars Program	
Keith D. Henry	EMMD 7500 Emergency Medicine	X
David Power Chris Fallert	FMCH 7600 Family Medicine	<i>Peter Cao</i> X
Briar Duffy	MED 7500 Medicine I MED 7501 Medicine II	<i>Chris Miller</i>
Miguel Fiol	NEUR 7510 Neurology	X
Yasuko Yamamura	OBST 7500 Obstetrics & Gynecology	X
Katherine Murray	PED 7501 Pediatrics	X
Sheila Specker	ADPY 7500 Psychiatry	X
Robert Acton	SURG 7500 Surgery, CEC Chair	<i>X, Mitch Gmyrek</i>
Cornelius Lam	NSU 7200 Neurosurgery	X
Edward RG Santos	ORSU 7200 Orthopaedic Surgery	<i>Ali Hemphill</i>
Jennifer Hsia	OTOL 7200 Otolaryngology	X
Paul Gleich	UROL 7200 Urology	<i>X, Liz Mayock</i>
James Pacala	FMCH 7700 Primary Care Selective – Fam Medicine	<i>Peter Cao</i>
Sally Berryman	MED 7700 Primary Care Selective – Medicine	<i>Chris Miller</i>
Cindy Howard	PED 7700 Primary Care Selective – Pediatrics MED 7701 Primary Care Selective – Med/Peds	
Kathy Brooks	INMD 7200 Rural Physician Associate Program (RPAP)	<i>Bill Fricke</i>
Jacob Prunuske	Duluth Faculty Representative	<i>X, Paula Guisfredi</i>
Stephen Richardson	MS4 Student Representative	X
Ryan Dean	MS4 Student Representative	X
Maros Cunderlik	MS3 Student Representative	
Anna Gregoire	MS3 Student Representative	X
Kathy Watson	Senior Associate Dean for UME	X
Majka Woods	Assistant Dean for ACE	X
Anne Pereira	Assistant Dean for Clinical Education	X
Adam Maier	LMS Manager	X
Brooke Nesbitt	Clinical Education Manager, CEC staff	X
Abbe Holmgren	Clinical Scheduler	X
Leslie Anderson	OME Chief of Staff	X
Nacide Ercan-Fang	VALUE	X

Review of minutes - 2.6.15

Announcements

Neurology Clerkship Newsletter: Synapses

Student Issues - none at this time

LCME Update:

Status report due to LCME on April 1.

- Updates on Missing/Late Grades
- See handout for other updates

Discussion:

Entrustable Professional Activities (see PPT from Dr Englander)

- Keep the focus on healthcare needs of the public.
- Target these activities as a “core” not a “ceiling”
- Supplement, not supplant, mission or specialty-specific graduation competencies required by schools/regulatory bodies and promoted by specialty societies. Many of these are addressed in individual courses, but we do not currently address them longitudinally.
- Create a “product” that facilitates development of faculty as teachers and assessors. = This is what you are getting, some who is well-trained, etc.
- Make assessment the key driver at every step. What are components that feed forward, which components are hard stops, which components spiral through from early years to clerkship years?

Ideal Assessment System Provides:

- Ongoing low stakes formative assessment for continual improvement. Consistent feedback from faculty, students, and program directors of the importance of these opportunities, including reflection.
- Summative assessment required for graduation. =Continued development of current institutional assessments, but also enhancement of new assessments.
- Confidence that graduates are capable of performing at a predetermined level on Day 1 residency.
- A given foundation upon which program directors can begin to build on Day 1 of residency.

Faculty will need education and training to determine ways to individually assess students based on their sequence of clerkships and progress through the two-year schedule. (Period 1 MS3 vs Period 1 MS4). Students would need to be cognizant of their growth areas and advocate for themselves. Clerkships could focus in on one or two EPAs that they feel are a good match for their rotation. Dr Nixon identified a need for parallel systems - assessment of objectives within the specialty AND a longitudinal assessment of clinical learning objectives applicable to all fields. EPAs could be that second aspect, especially if it allows students to track, reflect, and be aware of areas in which they are still developing (more important than identifying excellence). Dr Ercan-Fang noted that LICs are a good venue for tracking EPAs over time due to their longitudinal nature - pilot? EPAs support philosophy of “feeding forward,” which is appropriate use of knowledge about students performance in prior clerkships. Dr Specker shared that, in COSSS, it is difficult to work with students who have problems that were repeated in clerkships but not addressed over time. Stephen Richardson shared that students do have fear going into rotations not knowing what their growth areas may be. Dr Gleich supported the desire of faculty to know what students need help with and to actually provide that help.

Conceptual Framework:

- Two overarching frameworks considered= Competencies AND Entrustable Professional Activities
- Competency - I can do the procedure.
- EPA - I can do the procedure in the matter I am supposed to and at the level I am supposed to.

Why EPAs?

- Enhance meaning for faculty, trainees, and the public by embedding abstract competencies into a clinical context.
- Unit of assessment is care delivery which is how we observe trainees in the workplace.

- Make assessment more practical by clustering and integrating competencies.
- Can be mapped to competencies and their milestones with the benefit of a comprehensive look at the learner.
- Explicitly add the notions of trust and supervision into the assessment equation.
- Aligns with current work in GME (both specialty and sub-specialty in pediatrics). Make connections with faculty that do GME teaching AND develop strategies for developing faculty that do not.

Each clerkship will need to think about which EPA's make sense to focus on and how to implement assessment of students. There also will need to be continuity of expectations (core EPAs for entering residency - 13).

1. H&P
2. Differential diagnosis following a clinical encounter
3. Diagnostic screening tests
4. Orders/prescriptions
5. Clinical encounter in patient record
6. provide an oral presentation
7. Form clinical questions
8. Give or receive a patient handover
9. Collaborate - interprofessional team
10. Recognize patient requiring urgent or emergent care and initiate....
11. Obtain informed consent.
12. Perform general procedures
13. Identify system failures

Qsort exercise.

Next meeting: April 3, 2015