

## ***Education Council (EC) Meeting Minutes***

*February 15, 2011*

**Members present:** S Allen, L Anderson, M Baird, J Beattie, B Benson, K Brooks, S Chahla, R Cormier, T Ebner, H Grothe, C Hegarty, K Hemesath, R Hoffman, G Jacobs, A Johns, S Katz, T Killeen, J Kreuser, B Marsh, W Miller, A Minenko, P Mulcahy, C Niewoehner, J Nixon, C Patow, L Perkowski, L Repesh, A Severson, R Sonnino, T Thompson, T Walseth, D Wangensteen, K Watson, P White, M Woods

**Guest:** Dr. Nersi Nakakhtar, Dr. Michael Kim

**Members absent:** B Brandt, K Crossley, L Hansen, M Hordinsky, M Kondrak, L Ling, M LuBrandt, J Miller, L Ryan, T Stillman, R Wong

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### **Minutes**

January 18, 2011 Minutes were approved with no additions or corrections

### **LCME**

Dr. Linda Perkowski reported that all LCME Subcommittees have begun work on their assigned questions for the database and are continuing to request data to use in responding to those questions. OME staff are pulling data together for the LCME data base to assist the Subcommittees. A mock site visit will be held in October, 2011 and the goal is to have all written documents completed for this test run. The mock event will help to point out gaps and/or weaknesses that need to be identified; there will be meetings with individual faculty and students to ask questions and assess how well the School has prepared. The format will be similar to the actual site visit.

Patti Mulcahy reported that the Steering Committee has met and are scheduled to meet monthly until June. At that time the Subcommittees will submit their documents; and the Steering Committee may meet more often as they use these responses to write the Summary. The Independent Student Subcommittee has distributed their survey which is scheduled to be completed by the student body next week. Dr. Alan Johns noted that Duluth members of the LCME ED Subcommittee have been participating in the group's meetings and work is progressing on the questions with their input for the Duluth portion.

### **Information**

#### **Education Steering Committee (ESC)**

Dr. Kathleen Brooks, Education Steering Committee Chair, reported they have set their meeting schedule for twice per month and are meeting regularly. They are currently reviewing details to determine appropriate areas for ESC to address for both on-going and new items. They have reviewed the Year-1 and the Year-2 course and recommend that the calendar remain the same for 2011-12. ESC members have started a review of the grading policies to identify as many issues as possible in addressing the variations of grading. Dr. Miller noted that ESC had received a request from EC to review a grading policy adopted by the ED members, which is probably not applicable to the range of courses in place this year. He asked if ESC would be able to bring a recommendation for changes and implementation to the EC for review. Dr. Brooks reported that ESC is planning to respond with a recommendation. They opened up the discussion to review as broadly as possible; i.e. reviewing a year-1 policy, a year-2 policy, exam grades and exam retake details. Their goal is to bring a recommendation to EC in March. Dr. Miller noted it is important to reconcile what was passed by EC with what appears in syllabi and is actually workable.

### **Discussion**

**Milestone I** Dr. Nersi Nidadhtar, faculty advisor, reported that Milestone I is done in the fall semester and is an assessment that measures areas of professionalism for beginning Year-1 medical students (see sample assessment tool). Students were required to assess their "body-buddies", these are students who have worked together in anatomy lab and who they've had the most consistent interaction with as new medical students.

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Also most all body-buddies were matched with others who they shared faculty advising groups and/or often ECM sessions. The main goal of the assessment is to acquire feedback about their professionalism because it is an area where they can demonstrate capabilities early on, is not very skill based and provides useful feedback to students. Dr. Nidadhtar reported major concerns weren't flagged or anything that hadn't been identified earlier but confirmed other minor concerns flagged in earlier interactions; i.e. tardiness and non-participation. It had a very strong affect on relationships between students. Assessment design includes:

- not blinded, they knew who had written the assessment
- Faculty advisors had 1:1 sessions with students shortly after the peer assessments were performed
- discussed their results with other students, especially those who had received negative feedback
- This was unexpected result
- discussed how to work out differences
- willing to identify their own issues
- found no real outliers in his set of students

The assessment and feedback has fostered relationships and identified willingness to work on problem behaviors early in their education.

Discussion continued, questions and input included the following:

- At TC 7 advisors each have approximately 24 advisees; at Duluth groups of 10 were used.
- TC FAs encountered very little defensiveness across the entire class.
- At Duluth feedback was given in groups of 3, sessions went well, and issues identified were minor.
- Duluth students got along well and demonstrated professionalism when interacting.
- Initially Duluth used role playing to provide examples of productive feedback. Each student modeled 3 different roles; feedback provider, receiver of feedback and as an observer
- TC FAs noted feedback is more specific and productive for students who shared FA groups together, For those acquainted in anatomy lab only feedback was less specific.
- An added concern at Duluth are a few students who demonstrate professional behaviors in formal settings, but have unprofessional behaviors when interacting with staff.
- Duluth reported using the MEDIS system as another feedback source.
- For the TC, use of the MEDIS feedback functions are being studied and have not been widely used.
- Duluth students will assess each other during the spring semester. Because they will know each other better, the second assessment will be used as comparison
- The TC FA system provides another source of support, students seem to be seeking it out earlier.
- FA system is allowing for early identification of concerns with professionalism for TC students
- FAs feel it may be more effective because it is coming from peers.
- Duluth notes earlier emphasis on professionalism seems to make a difference in Year-1 class overall
- TC because taken early in Yr-1 the focus is on areas that are observable, not medical knowledge.
- A standard for professionalism has not been available in the past for comparison, only anecdotal
- Added assessment in Sp '11 will be done with FCT groups.
- FA reports not many opportunities for blinded anonymous feedback sessions in classroom structure.
- With surprisingly frank comments, receiver acknowledges knowing their own shortcomings, are open to discussion.
- Goal is to instill in students, to give and receive feedback is not anonymous and is a skill to practice.
- Master tutors used anonymous feedback and found it useful.
- Important to gather feedback data from a broad source to get at what habits are present when no one is looking.

Questions

- At TC will assessment be continued in Yr-1 next year to use for comparison with this class?
- Will other components be added to Milestone I in the future?
- How is it possible to compare Yr 1 to Yr-2 when no previous focus or assessment or assessment was used?
- Where will information be housed and for what use?

- Yr-2 OSCE has an assessment for communication skills, can more insight be gained in Yr-2 OSCE?
- Early experience identifying professionalism is good, would blinded assessment be more candid?

In response to questions about future plans for how to ensure that professionalism continues to be measured, Leslie Anderson indicated that this will be continued in Milestone II and Milestone III. Dr. Miller asked if it is required in those courses and Ms Anderson reported that conversations with course directors will continue to prevent having them dropped and to also gain a balance. Addressing redundancy is a concern but getting it from multiple perspectives is important.

### CCA

Clinical Competency Assessment (CCA) is the Year-4 OSCE and this the 2<sup>nd</sup> year the multi-disciplinary OSCE has been held, reported Dr. Michael Kim. Eighteen months ago it was run as a trial when it was an optional non-graded exam. For 2010-11 it is true Milestone in that it is required to graduate with the MD Degree. Due to several changes it now includes 6 stations; pediatrics, internal medicine, emergency medicine, neurology and geriatrics. There were 228 students eligible to take the CCA, with 227 completing it; one had a health issue that required surgery and they were excused from taking the exam.

Dr. Kim asked the medical student representatives to step out of the meeting before beginning discussion of specific OSCE structure and assessment goals. The structure of the OSCE includes 15 minutes to interview a patient and six minutes after to write SOAP notes. The standard patients graded them on a specific rubric which identified whether they asked questions, performed physical exam skills and did they tell them appropriate information based on these things. They were graded on two different aspects of the exam; communication and history and physical. The assessment requires that they get 60% overall on the six cases on each of the two domains. Final results were an 11% failure rate and all of these failed as a result of the history and physical; none were due to poor communication skills. Communication was not critiqued as stringently as the history and physical. The majority of scores were just above the 60% range. All examinees were video taped and as the school year continues, some stations were adjusted by altering the questions to more appropriately measure students skills. Of the 25 who failed, during their remediation process Dr. Kim reviewed their tapes, what they wrote and interviewed them 1:1; he determined the failed 3 or more stations. All of the students who failed were required to read six articles that reviewed the content. The failure rate when the exam was high stakes (2010-11) were comparable to the rate when it was low stakes and not required. This is similar to what is seen at other institutions with like exams. Some reasons are timing of the exam because some students haven't had a portion of the curriculum and/or it may have been a year's since they have had a particular rotation. The pass/fail standard was determined by students' general performance in the pilot. The questions were asked if there were specific area(s) that were designated as absolute for passing; one discipline that was an absolute criteria for passing? Dr. Kim responded that the decision was made to set the bar low and no particular question and/or topic was the focus. He noted there isn't enough data at the time to point specifically to one area. Dr. Nixon stated that because it is a high stakes exam and questioned whether a more specific method for establishing the fail point would be a better assessment. Other schools do use specific questions that "drop dead" determinants, that are absolute for passing.

Dr. Kim gave details of the skill areas that were being examined. Statistically the failure of cases was distributed across the span of cases. Sixty percent of the failures were the result of failing three or four stations. Individual had similar knowledge deficits and the physical examinations more basic exam skills. For the group with the greatest rate of failure (18 students) most had very poor differential questions and didn't ask enough pertinent negative questions that were important to elimination. Basically they were not asking the kind of questions that should be asked in a setting where it was the first time they had seen a patient. This reflects on our role modeling and teaching especially in Yr-3 and Yr-4, which he feels comes down to the difference between teaching critical thinking versus pattern recognition. He feels that pattern recognition is more often taught, with little critical thinking being taught, which was showing in the students poor results in their differential diagnosis. He noted that in in-patient medicine there are a lot of pre-packaged patients where physical exam is de-emphasized because they are going to have an x-ray or CT scan. The six articles represented each case/station and what each result should have been recognized. This was to address the knowledge area, which was then tested with a written exam as follow-up to assess knowledge. Dr. Kim noted

that to address those same concerns they selected cases with health concerns that students would most likely to experience before the exam and more basic skill sets needed in those circumstances. The assessment also emphasized more history and physical that they did diagnostic decision making (there was some present). There wasn't an expectation that they perform at 100%. Dr. Kim responded that it is bringing the multi-disciplinary aspect all together in a 1-day set of encounters. It gives the assessment team to see if they interact with a patient, are they doing an appropriate physical exam, are they keeping their differentials relatively broad, are they coming up with a n appropriate workup. There were two SOAP notes that were graded to see how well they were able to document their ideas and how well they were able to put down those ideas in a legible thoughtful format.

- The assessment team is able to observe the following:
  - interaction with a patient to assess their physical exam skills
  - are their differentials relatively broad
  - are they developing an appropriate workup
  - two SOAP notes were graded to determine how well they document their ideas
  - to determine how well they put down those ideas in a legible thoughtful format

Council members asked specifically about the following:

- Are there enough stations, a standard of 15 to 16 is considered an appropriate assessment of differential diagnosis, diagnostic reasoning and decision making skills.
- Members voiced concerned that the number of cases doesn't measure how well students are prepared.
- The logics of more cases with the number of students that need to be assessed isn't workable.
- Are we able to achieve the desired outcomes, is it a good use of resources?
- It is bringing the multi-disciplinary aspect all together in a 1-day set of encounters.

It is important to also determine whether they are being taught the basics of these things and if not then the approach to general education needs to be modified, teaching a broader differential or teaching a better physical exam, and trying to emphasize more critical thinking. Dr. Miller noted that this is different than testing to determine if someone is competent. If we are seeking to use it for curriculum improvement then the question of whether it should be a high stakes exam is important to decide.

Discussion continued about pass and failure of the STEP 2 CS exam and the very low failure rate experienced by UMMS students, with not failures on retakes. Dr. Kim reported that a number of student have indicated that they consider the OSCE good preparation for the STEP2 CS. Dr. Ted Thompson asked if it will be possible to follow-up on how well those failing do in their first year of residency. Dr. Kim responded that it would depend on where they do their residencies, if in the Twin Cities, it would be possible. Students asked if the OSCE prepares students for the CS2, he indicated that it is a good preparation for a more diagnosis based exam, but that isn't the primary goal for the assessment. Students asked if there is any correlation between doing well on the CCA and performance on the CS2? Dr. Kim reminded them that the CS2 is P/F and so few fail that it is difficult to make any correlations. But he noted that anecdotally those who did fail this year's CCA didn't do well on this assessment.

Dr. Miller asked Dr. Perkowski for feedback on concerns that the construct of the CCA is not reliable enough to be used as a high stakes exam. She indicated that this is correct and that many institutions have the same circumstance. He noted that the breadth of what is assessed is of concern to him. Dr. Kim noted that students feel its important and the feedback they receive is valuable to them for their future performance. He noted that it can be used as a guide for changes in the curriculum. He also thinks it gives an indication for the level at which students are functioning. He noted that it wasn't treated as a high stakes exam and those who failed do not have failure noted on their transcripts. Dr. Miller asked if there is a proposal to make it a high stakes exam. Dr. Perkowski responded that the Student Assessment Committee was sponsoring the CCA and they meet next week. The SAC takes direction from the Education Council. Dr. Miller asked if there is a motion for action to go forward to the SAC? Sadi Chahla, Yr.-3 students representative, responded that its important for student to have trial assessments and they look forward to finding out how well they are able to perform. Dr. Miller asked if the exam should be formative or summative, not only P/F but P/P. Dr. Nixon concluded that it is not penalizing students, it doesn't appear on the transcript and that is serves to help students prepare for CS 2. Dr.

Kim noted that an issue which affects the quality of the exam is the inability to control what rotations are taken before they take the CCA. Dr. Perkowski noted a question which is asked of students after they take the exam is, “have you seen patients like those in the exam cases”, and they all reported yes they have seen them. Dr. Niewoehner asked if the resource intensive nature of the exam doesn’t have bearing on whether it should or could be expanded? She suggested going forward with the current format for another year as a low stakes exam and bring it back to determine whether it’s worth continuing it as low stakes or if it should be expanded to become a high stakes assessment. Discussion continued. Dr. Power asked if it would be possible to take it only after having done a specific set of rotations? Dr. Kim replied that due to the logistics with the IERC and the variable schedule for when students take the CS 2, that wouldn’t be possible. Dr. Brooks asked for clarification as to how the stakes are defined, whether it means they must pass it, or does it mean either pass the exam or pass it through remediation. Currently the rule for remediation is that it will be done on an individualized basis. Dr. Miller added that it wouldn’t appear on the transcript in any way. Upon a motion duly made and seconded recommending that the CCA remain as low stakes, used mostly for student feedback for CS2 exam preparation, the members voted and the recommendation passed unanimously.

### Kogan Workshop

Dr. James Nixon gave an overview of the Kogan Workshop, explaining that it was arranged to help the Department of Medicine prepare for their ACGME site visit, the workshop dealt with Competency Based Evaluation. He thought it might be useful for discussion with preparation for LCME taking place. Dr. Nixon reported that their Site visit is scheduled for April and the workshop is a guide to preparation for the visit. It was organized to help prepare faculty for the site visit. Core faculty and program directors received materials to orient them before the workshop took place. An assignment to Faculty was to look at each competency as related to how the competency is currently being assessed, what to improve, what are the strengths. Each core faculty lead a short discussion on how to improve their assessment of competencies, followed by an open discussion. By the end of the discussion they were charged to have a plan for improving the competencies. Follow-up includes a meeting to ask where each group is in developing their plan for improvement and will prepare a deliverable for improving their assessment. The goal is to take the actions needed to improve their residency program. Dr. Nixon felt it helped to get faculty invested in improving the program. The work also got more people engaged across all areas that need development. They have hired an individual, Sophie Glading from the Cleveland Clinic, who is charged with helping to develop direct observation goals as part of a portfolio.

Dr. Miller added that in each area they chose one tool to be the used as the observation tool for that competency. He reported that it has focused them on doing one thing really well and to recommit themselves to carrying out the assessment. An important message he took from the workshop is a concept shared by the presenter, who recommends observing an individual’s performance for a short period. She watches small pieces over several observation periods and puts that together when assessing someone; rather than observing for a number of hours for one time. Dr. Power felt it was an idea worth exploring. The presentation was very practical and focused and behaviorally based so it was much easier to grasp her ideas. Dr. Watson asked if any tools were identified that would work well for clerkship assessment? Dr. Nixon reported that there are adequate tools but the goal of getting someone in the room to actually observe. A better model is for a faculty member to observe and give pointers while the students is performing, rather than a scenario where the student is working on their own and then reporting in later. Saydi Chahla, MS-3 felt it may give more balance between student independence versus observation of procedures. Details were discussed for how to accomplish a variety of observations of short duration at different points in doctor (student)/patient interactions while individuals are being examined. Dr. Nixon felt it was useful in coalescing faculty toward a goal and it was useful of going through the process. He wished he had invited more people, they focused on residencies, but feels its applicable to UME. It was a good experience having residency program directors, clerkship directors and fellowship directors in the same place hearing how much they actually have in common. A new faculty member will focus on how to get residents more interested in teaching.

## Next Education Council Meeting – March 15, 2011