

**Education Council (EC) Meeting Minutes**  
**September 17, 2013**

<b>EC members present:</b>	E Scanlon	A Johns
L Anderson	L Schimmenti	B Marsh
J Andrews	S van den Hoogenhof	J Metzger
J Beattie	G Vercellotti	J Miller
J Chipman	R Westra	M Nelson
R Cormier	A Wojciechowski	J Nixon
J Eck	M Woods	D Power
G Jacobs	B Yueh	C Sautter
S Katz	<b>Guest:</b> Dr. Barbara Brandt	A Severson
R Michaels	Dr. Jeff Adams	T Stillman
W Miller	<b>Members not attending:</b>	G Trachte
S Morean	B Clarke	K Watson
J Pacala	J Clinton	
D Patel	K Crossley	
M Rosenberg	C Hegarty	

<b>Education Council Minutes, September 17, 2013</b>	<b>Action Date</b>	<b>Action</b>
Approval of Minutes (August 20, 2013) - approved as is, no opposition	9/17/13	<input checked="" type="checkbox"/>
<p><b>Information &amp; Updates</b></p> <p>Dr. Ruth Westra introduced Dr. Robin Michaels, the <b><u>new Duluth Ass't Dean, Admissions/Student Affairs</u></b> Dr Michaels comes from Colorado.</p> <p>Dr. Rosenberg introduced the concept for a new position, <b><u>Assistant Dean for Clinical Education</u></b>. The rationale: as we've been looking at strengths and areas for growth in OME it was identified that a position was needed to close gap between education and practice. The position is envisioned as a 0.7 FTE with main duties listed on draft handout that was distributed via email. This position would ensure longitudinal integration of clinical education across all years and sites, as well as work on integration with basic science education. This person should be a practicing MD clinician, perhaps a faculty position on teaching track, who has demonstrated accomplishments in developing clinical education and would continue to build relationships with clinical sites and organization. The position will be both strategic and operational, and will be pulled from existing funding. Please also refer to organizational chart that was distributed to see where position fits in with rest of OME. Dr Andrews asked for understanding on how this position would fit with GME as it relates to recruitment, development, and retention of preceptors and clinical sites. Dr Miller also referred back to a previous retreat where it was identified that incoming residents needed some retraining when starting resident rotations. Could this position be more closely tied with GME and also with UMP to build bridges and connect some gaps in training, and coordinate medical education within UMP. Dr Chipman asked if it would be UMP or Fairview; Dr Miller responded that with new integrated model, the connection would or could be to both. Dr Pacala stated that if it were disconnected, the model would be ineffective. The same obstacles are being met within Dr Brandt's work within IPE. Dr Westra asked for clarification on whether position would cross campuses; Dr. Rosenberg confirmed that this position would seek to look at clinical education for years one through four, across both campuses. Dr Westra added that the new position would need to collaborate with staff and faculty on Duluth campus who have similar duties and roles.</p>		

Dr. Pacala asked how this position would work with RPAP and MetroPAP and UCAM and some of the other longitudinal experiences. There is concern about changes made to one part of the system and how that might affect other programs. What attention will be directed towards making sure new, good ideas can be implemented without negative impact on the other elements? Dr Rosenberg responded that this position would be a good person to look across all programs and understand the connectedness and how changes to one clerkship would affect others. With a growing list of longitudinal clerkships, as well as changes to individual clerkships, a person to look at the entire program (as well as threads like patient safety and quality improvement) is needed to eliminate negative impact and keep clinical sites interested and involved. Dr Miller asked if this draft has been discussed with clerkship directors. The plan is to present at this month's Clinical Education Committee for feedback.

The Dean has vetted the concept and the concept has been discussed at the Education Steering Committee. Dr Miller asked for more feedback from all committees and affected parties before any one group could or should provide support. Dr Westra added that affiliation agreements should also be included in the scope of this position and that staff support will be needed to implement some of these projects. Dr Pacala asked also if the position would be like a facilitator/coordinator or a person creating curricula and putting together new education experiences. Dr Rosenberg responded that the staff support under this person would do the coordination, and that this assistant dean-level person would eventually be mostly strategic, instead of operational. Dr Katz asked if the staff support would include scheduling. Dr Woods responded that the staff support will be two positions; one person as the scheduler and a second person that would supervise the scheduler and other program-level projects that are not currently getting enough attention. This assistant dean position would oversee those two personnel. Some of these duties replace tasks that Dr Thompson had completed in the past. Dr Katz added that he is usually reluctant to support adding another layer of administration, but that this position is very much needed, both for standard students in standard rotations, as well as non-standard students and new rotation types. Dr Miller asked Dr Rosenberg for feedback after the committee discussions for next steps to EC. Dr Rosenberg added that a national search will be conducted in addition to looking at interested internal candidates

**SSC Report:** (see attached handout)

Dr Ruth Westra presented data on the Scholastic Standing Committee -Duluth.

Question 1: Total number of failures during the past two academic years and total number of repeat failures Y1-4. Dr Westra shared that total number of MS1 failures in 2011-2012 was 11; in 2012-2013 there were 8 total failures (correction from handout). The total number of MS2 failures in 2011-2012 was 15; total number of failures in 2012-2012 was 3. Changes in numbers may be different between years due to changes in the grading policy and the overall curriculum.

Question 2: Patterns?

Dr Westra shared there are patterns to students who fail Foundations of Medicine in the first fall and subsequent challenges later, especially Neurological Medicine. Those students are offered support as soon as they are identified as at risk.

Question 3: Grading Policy

Dr Westra stated that there have been connections between students who do well in course overall but struggle on final and their eventual success on re-take exam. Students who are below passing threshold on total course points AND the final

exam show more need for full remediation instead of just a re-take exam.

Question 4: Right students identified early?

Medical Education administration believe that they are being successful in identifying students who are struggling academically and setting them on plan to receive support. It is more difficult to identify other life areas that are causing the student to struggle.

Question 5: Remediation efforts.

Timing for remediation can be delayed depending on the academic calendar. Course directors and Student Affairs work with students to address the issues.

Question 6: Transition to Y3

Students at risk during MS1 and MS2 are discussed with TC campus staff and administration, but often the clerkship directors are not aware of any academic or other struggles. The lines of communication are getting better, but unless there is an actual course failure, there is room to improve the support, without highlighting the student unnecessarily.

**COSSS Report:** Jill Eck and Sheila Specker (paper handout shared in meeting)

Ms. Eck shared specific data on numbers of course failures and the patterns between MS1 and MS2 failures in the most recent academic year. All students with course failures met with COSSS sub-committee (Eck, Katz, Thompson) in order to manage the large numbers. The majority of students passed remediation by re-taking the final exam. Some students in data have not yet completed their remediation; this is reflected in data. Students with multiple failures were presented to COSSS. There were some adjustments in the Human Disease courses, per Dr Woods, as to how the 70% grading policy was applied to the course and exams. Some adjustments were made to this application which changed the overall numbers of course failures in the next year. Dr Schimmenti asked for clarification - what is a "bad exam structure?" Dr Woods clarified that in some courses the discipline distribution and scoring needed improvement. In addition, some courses had exams that were not written effectively, so it was not fair to fail the students - the exams themselves needed to be improved. Dr Katz added that as course directors improve in their exam creation skills, the variability will even out.

Dr Miller asked if Dr. Specker believed that COSSS had identified students who were truly at risk. Dr Specker responded that yes, overall, the students presented to COSSS, were at the bottom of the class across most courses with a significant pattern of academic risk.

Ms Eck shared that the remediation options for both campuses are similar, remediation by repeating the course or by retaking the final exam. Students receive a "T" grade that shows that they passed upon remediation ("Test credit"). The initial N and subsequent T grade are both on permanent record. Following some course failures, students may decelerate or take a leave of absence to address the causes of the course failure. Personnel from both campuses meet monthly to discuss students who may need additional support as they transition from years one/two to the clerkship years and/or from Duluth to the Twin Cities.

For Year 3 & 4 students, the numbers for clerkship failures vary, but not significantly, across academic years. Students who fail a clerkship will be contacted, but those with multiple failures are presented at COSSS and face dismissal (versus remediation). Out of the five hearings last year, one student was dismissed. The other four were not dismissed for various reasons and are still in system on either modified schedules, leaves of absence, etc. Students with professionalism issues, synthesis needs, and other issues were referred to specific faculty to attempt to address those issues before a final decision on dismissal was made. Some students have had personal circumstances that were relatively easy to address; other students have complex sets of issues requiring more elaborate plans.

On page 3, there is a key for the grades given to students - P, N, T, I.

Ms. Eck also noted that academic year 12-13, all students with a previous first-year course failure passed their second year two courses. Further attention is desired on the impact of a decelerated schedule, leave of absence, or other modified plan for the students who've had a course failure. In addition, what predictors could be used upon matriculation to identify students who may be at risk from the beginning? Dr Vercellotti commented that historically there has been a desire for this type of database. He asked Dr Westra if Neuroscience, as one of the first courses offered, has identified any preparation or prerequisites that students should be doing in the summer to be as ready as possible for tackling a difficult course. Dr Westra shared that they are looking at the affect for students who do not have some of the background that used to be, but is no longer required for admission. There are patterns that show that students, who struggle early, did not have some of the prerequisite knowledge that they would have benefitted from. Some students have been offered pre-matriculation opportunities; not all took advantage of the opportunity. Also, it is not clear if the students who were offered the opportunities were those that really needed it. TC offered a pre-matriculation course on-line to all students with content that was identified as beneficial as preparation. At the beginning of this year, student performance data was analyzed and presented to Admissions to start the process of identifying trends.

**Discussion**

**AHC Nexus, Interprofessional Education** - Barbara Brandt - PPT presentation  
Introduction/Background to project

Focus on team-base care and the effect on population health outcomes. The Nexus was identified to transform education and to keep pace with the rapidly transforming processes of care, create a closed-loop model between education and practice for continuous improvement (ties in with new Ass't Dean Clinical Education position), and work collaboratively to achieve the Triple Aim in both healthcare and education (UME and GME).

In Minnesota, a retreat was held last fall, but prior to that the rhetoric was intense and there was some reticence in how to bring together the disparate groups in order to move the conversation forward. Growth Works (a consultation agency) and George Thibault was brought in to assist in defining areas of concern and

<p>moving the conversation forward. A primary focus of concern was: Are there enough health professionals being trained that have had adequate inter-professional training and skills? Across the board, the university and affiliate health systems have similar data and similar goals for interprofessional collaboration. Results are similar across other institutions and their hospital sites.</p> <p>Five priorities were identified at the retreat:</p> <ol style="list-style-type: none"> <li>1. Vision</li> <li>2 Organizational Structure</li> <li>3. Education/Training</li> <li>4. Faculty/Clinician/Staff Development</li> <li>5. Policy and Advocacy</li> </ol> <p>Several leaders in medical education have been approached to lead or sit on steering committee to launch efforts. Overall, there are not enough sites and learning opportunities for health profession students and a larger forum needs to happen to advance this conversation.</p> <p>The National Center for Interprofessional Practice and Education is identifying goals and vision for the Nexus. The National Center has a major research agenda and will lead the efforts to collect data on these interprofessional issues. Presentations and partnerships are being given and developed with many national organizations; there is high interest from these groups to collaborate with the National Center on this research and a great environment to work on this issue.</p> <p>It is clear that more promotion is needed on the IHealth initiative, including the FIPCC course (in which first-year medical students participate). Data about where health profession students are going can be used to improve interprofessional education. An interprofessional curriculum is being gauged across the university. Faculty development is increasing around the topic of interprofessional education and will include national speakers and leaders. In addition, policy and advocacy will be increasing around scopes of practice.</p> <p>How can the Medical School best partner with the NCIFE:</p> <ul style="list-style-type: none"> <li>Request frequent updates and timeline</li> <li>Populate groups working on IPE</li> <li>Find ways that clinical partners can be involved in the creation of educational programs</li> <li>Engage with IPE implementation</li> <li>Take advantage of national and international visitors</li> <li>Help build a new system of experiential education to add value and control costs and duplications</li> <li>Support implementation of the national core data set (Smiley's and Broadway clinics have already been approached)</li> </ul> <p>Dr Miller followed up that residents spend a lot of time at Health Partners - why do they need to be retrained? Dr Brandt offered potential reasons such as not enough role models? Not enough primary care sites? Health system leaders need an appropriate conduit for giving feedback on curriculum for students and residents. Dr Miller also posed question of how to make interprofessional education concrete, versus abstract theory.</p>		
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<p>Dr Brandt commented that health systems are looking for longitudinal clerkship opportunities. It is costly to rotate students in short periods ("tourist" rotations). Noted that the medical school is actively trying to address this in the new Assistant Dean position draft.</p> <p>There are two new Physician Assistant programs and other for-profit programs that are locking up rotation slots. How can our school be competitive and collaborative in attaining and retaining slots for medical students and can the entire state be tapped as a resource? Dr Vercellotti commented that authenticity is important. Programs must address how interprofessional work plays out in reality, not role play. Students and residents on rotations see interprofessional collaboration and those experiences need to be reflected upon and supported. Dr Brandt confirmed that that is a firm goal of this work.</p> <p>Dr Andrews commented that the role of GME has not been addressed much in this conversation. If significant development of the residents is done during residency (versus during medical school), we cannot assume that interprofessionalism in medical student education is the only avenue. Professional development on interprofessionalism is also a GME-issue, both as resident learners and resident teachers (of students).</p> <p>Sarah Morean concluded the meeting with a reminder of the Medical School's 125th Anniversary celebration!</p> <p style="text-align: center;"><b>Next Meeting October15, 2013</b></p> <p style="text-align: center;"><b>4-5:30 B646 Mayo</b></p>		
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