

Education Council (EC) Meeting Minutes
January 21, 2014

EC members present:	D Power	K Crossley
L Anderson	M Rosenberg	C Hegarty
J Andrews	E Scanlon	G Jacobs
T Baultrippe	L Schimmenti	J Metzger
J Beattie	A Severson	R Michaels
K Brooks	G Trachte	J Miller
J Chipman	S van den Hoogenhof	M Nelson
J Clinton	K Watson	J Nixon
R Cormier	A Weiers	D Patel
Z Crise-Patil	M Woods	J Pacala
A Johns	Y Shimizu	C Sauter
S Katz	B Yueh	T Stillman
B Marsh	Guest: Dr. Briar Duffy	G Vercellotti
W Miller	EC members not attending:	A Wojciechowski
S Morean	L Carson	

Education Council Minutes, January 21, 2014

Minutes

Minutes for the December 17, 2013 were approved with no changes or addition

Information

Assistant Dean for Clinical Education search

Dr. Kathleen Watson reported that the search committee has reviewed 9 candidates at this time and will meet this week to screen them and narrow the pool of candidates to those who will be interviewed.

State of Medical Education Retreat

Dr. Rosenberg announced that everyone should have gotten the formal invitation to the Medical Education Retreat on February 13. All Medical Education Council members have been invited as well as many other groups, including the Scientific Foundations and Clinical Education committees. This should be a good opportunity with the goal of having a good discussion about education, which will be facilitated by Growth Works. They've done extensive consulting and facilitating with the AHC. It will involve the healthcare community, approximately 30 people from the healthcare community and institutions have committed to attend. There'll be a panel discussion and a lot of good opportunities for people to discuss medical education with the goal of trying to identify where we have gaps and what we can do to improve those areas. He asked EC members to remind faculty and administrators in their departments of the Retreat, to promote the retreat with inviting as many faculty as possible to attend.

Updates

Medicine Sub-Internship

Dr. Brier Duffy is the Medicine Clerkship Director, who is working closely with a Task Force to improve the UME educational experience for our medical students. As EC members have previously reviewed and approved the proposed Sub-I, she will present the current status of efforts to change the existing clerkship format. Currently these are a six-week Med-1 and a six-week Med-2 rotation. The plan includes plans for an eight-week Med-1 and a four-week Sub-I. The Task Force has been at work over last summer and during Fall and Spring semesters. The proposal has now been reviewed by the ESC. Dr. Duffy will point out key points in the proposal. In thinking about designing a sub-internship they developed guiding principles. They reviewed a number studies recently published on needs assessment scores, sub internships and curriculum for medicine sub internships developed at other schools.

Feedback from residency program directors regarding what skills interns should have and what students should experience in practice in clerkships or sub-internships to get ready for residency. It is thought to be most important for students to experience the following:

- primary responsibility for patients
- opportunity to participate in cross coverage orders
- demonstrate advanced clinical reasoning
- care for more complex patients
- when to seek help
- incorporating basic science knowledge in their decision-making
- communication skills in patient family meetings and in consulting with physicians
- teamwork and their professional skills
- end-of-life topics and discussions

The task force looked at what currently exists in our curriculum and what is a good fit. In looking at a four-week rotation stronger communications in the ICU or the intermediate care units is a key factor. The proposal is to be clinically located near the medicine ICU, surgical ICU, or the pediatric ICU. All sites are required to have common orientation, common assignments, common evaluation and common curriculum. Basically because patients in the ICU no matter what their problem are primarily surgical or primarily medical and often have crossover in terms of physician taking care of them. It's more about the process of care rather than the activity in the process. To be a true sub-internship there are prerequisites and therefore would have to be done later in their clinical training years. Because it's basically replacing Med-2, Med-1 is a prerequisite. Surgery is an important prerequisite. Also seeing what patients are like in a normal ambulatory scenario is important so they know what the goal is in keeping patients out of hospital. Students having done either the primary care selective or the Family Medicine rotation are important. If students want to be in the pediatric ICU or the NICU it is important that they've had a pediatrics rotation. Having had as many required rotations as possible would be ideal prior to enrolling in this rotation. So this does not typically happen before the end of third-year or ideally into their fourth year. It would be site neutral because enrolling in a particular site causes constraints, especially when students have emergencies and assignments have to be changed. It will work better if students sign up for the Sub-I and assignments are made closer to the time which allows more flexibility and allows for a great experience.

The proposal discusses capacity, which is dealt with a great deal in a clerkship. There is often a question whether there will be enough room for all of the medical students in a given clerkship. By expanding to multiple ICUs and as a coordinated experience, it appears we have partnerships with our other sites where we commonly do rotations; Regions, VA, and HCMC in particular, and Minneapolis Children's. With these locations we should be able to accommodate additional slots which could allow more students to take their Sub-I in the fall, fewer people taking it during interview season and fewer people taking it after interview season.

Next steps for the Task Force are discussions with various ICU partners at affiliate hospitals to see if there is an interest. In talking informally with colleagues specifically in pediatrics, they feel students will be more experienced and more capable. Because it will be centrally managed it will be less burden on the sites. Task Force members are hopeful that there will not have to be a hard sell to rotations. Medicine will be piloting several experiences at the University Hospital and students are already doing nights at the University on what is now known as Med-2. They have had one student at a time who does night floats. There is also a good possibility they can do night floats at the VA in the coming months and pilot scenarios with the other hospitals. The goal is to start the Sub-I so correlates with Period I of 2015. The development process includes piloting assessment tools over the next year, probably rolling them out at each site individually. The objective is to ensure that residents are prepared to assess students in these new roles. Task Force members are looking for feedback from EC members, especially those who have specific information about other

sites. Discussions with RPAP have begun and will continue to determine specifics for how this will work for those students. Currently Med-1 and Med-2 are outside of RPAP and will remain the same. There will be no change in their content but planning will have to be thoughtful about how this lines up with their start date. The goal is to have Med-1 before RPAP rotation and then take the new sub-I when they return. There have been discussions with those involved in EPAC and they are very interested in how this will work with their structure. The Task Force is well on its way to reaching a consensus for this new structure.

Dr. Miller asked for clarification on what the Task Force would like from the Council. Dr. Duffy reported they are seeking support for continued development of the new structure for what is now Med-2. Dr. Kathleen Brooks, reported that ESC is in close contact with the Task Force and their focus has been about how well this design will fit with the broader curriculum. This structure falls in line with the broader work being done on redesigning the clerkships and this is a good fit for the new models of clerkships. Dr. Rosenberg noted that discussions around preparation of UMMS students for GME and their preparedness for residencies is moving in the right direction. This is part of the strategy to make our students more competitive for the match and the beginning of the intern year.

Currently there is no ICU experience required; students now do Med II rotations at several hospitals (University-Fairview, Regions, VA and HCMC) many students rotating through ICUs. It's a six-week rotation, with 3 weeks of one specialty and 3 weeks of another at the same hospital and often 3 of the 6 week will be in an ICU setting. Two ICU electives are available, an elective in the ICU and one in the SICU. All students will be required to complete this new ICU experience; it replaces an existing required clerkship.

Dr. Watson noted in almost every field there is an advanced clerkship develop but they are not all called Sub-I or externships. These aren't standardized, this is the first opportunity to develop that standards. Secondly, based upon this information the model should and other specialties. This is highly innovative and will involve intra-disciplinary faculty. It's a great opportunity to work with several disciplines, including surgeons, internists, and other physicians who all care for patients needing this level of care. The goal is to focus this year's activities by piloting faculty/residents as intra—disciplinary and possibly training teams to go from site to site to see what the assessment should look like.

Dr. Miller recapped the discussion noting the proposal states students can choose disciplines, but the proposal doesn't include interdisciplinary experiences. Dr. Watson responded that within a certain period of time some students will be in Medicine I CUs and some will have asked for Surgical ICU experiences, these all flow as internal medicine experiences. The Task Force hasn't found a precedent for this anywhere else, they have found that medical schools do have sub-Is that are rigorous, but not designed in the same way. Medicine clerkship directors, have had a thorough discussion about the variety of experiences students have in clerkships. In some cases sites have no curriculum and just place students on the wards, with the expectation they will be able to perform a variety of patient care. Dr. Duffy indicated there are no publications around activities of this structure.

With regard to learning advanced critical reasoning skills, Dr. Miller asked if there are developed evaluation tools to assess students' performance in this area. Dr. Duffy reported there is a need for this kind of tool, for critical thinking exams right now; there are the S I M P L E cases which are part of online assessments currently used. This exam is medicine case based clinical exam. An exam for this new Sub-I, would be less about patient specific information and more about approach to patients. Development would be a process to carefully determine on what areas students would be tested. The goal is establish what students are demonstrating day-to-day in taking care of patients. There is also the possibility of using a portfolio with individual clinicians observing student performance in doing a procedure, participating in a family meeting, presentation and overall the skills. This would also help to ensure students are getting 1:1 observation and feedback. Dr. Miller noted the proposed structure forces the issue of measuring process rather than facts. Dr. Duffy agreed that this is a unique approach and will take some adjustment on the part of teaching faculty. Currently faculty who are surgeons and non-surgeons are cross covering the same units over night, with the

results providing cross disciplinary teaching opportunities. Dr. Chipman noted this is a unique aspect of what occurs at the University, the scenarios occur without tension between the disciplines.

Dr. Miller reiterated that the proposal has been approved and requests periodic updates to the Council to provide members with an opportunity to clearly understand how the development is progressing. He would like to have the next update take place in May or June 2014.

DISCUSSION

Medical Strategic Plan -- Faculty Development

In the Strategic Plan there were a number of areas which were not specifically detailed and education was one of the focus points. Dr. Mark Rosenberg has worked with his cohort on a number of areas, faculty development has a priority. He noted that Dr. Makja Woods' expertise in education has focused on faculty development, Dr. Anne Weber-Main joins today's meeting to offer additional expertise. Materials include the education portion of the Strategic Plan, which is a result of a request from the University's Strategic Plan Task Force for Medical Education key initiatives. This is the first segment that will be talked about today; these are really initiatives that will be implemented as a partnership between Office of Medical Education, the Education Council and the faculty. He reminded Council members of the other initiatives which include the following:

- improve relationships with affiliated partners and community stakeholders – how to engage the community and our affiliates in better ways
- strengthen curriculum changes -- that prepare our students for lifelong learning as well as this transformation in healthcare that is not ongoing
- metrics of excellence for GME programs which are being developed by Dr. John Andrews Department
- enhancing and increasing medical student research scholarship – a “craig’s list” for research opportunities has been implemented (details will be discussed at the February EC meeting)
- develop an infrastructure that aids students and learners and educators
- philanthropy directed at decreasing cost of medical school as well as being able to attract more diverse students into the UMMS class

Dr. Rosenberg noted to be able to move forward on the faculty development initiative, it's critical to have a very robust faculty development program. This proposal presented today is for the development of the Center of Excellence in Medical Education.

Dr. Majka Woods referred to the handout which is the result of considering what a very robust faculty development program would be at a school of our size, with the type of faculty we have and the programs we support. It's a working document, a proposal to develop a Center of Medical Education Excellence using some ideas from other schools that work and things that have worked at UMMS but have not been fully developed. This proposal has gone to Dr. Richard King's working group, the Strategic Plan Task Force. After their work was completed, our focus is to specifically develop this program of “excellence”.

The proposal for our Center of Excellence in Medical Education includes the developing and supporting excellent medical educators in teaching, research and scholarship. In talking to the Office of Faculty Affairs the following statistics provide a picture of changes that are occurring at UMMS. In 2011 there were seven people at the University of Minnesota and eight from affiliates that were on the teaching track. In 2013-14 there are now 137 faculty on the teaching track, some were moved off of incorrect tracks, and it is a six-fold increase over two years. This doesn't count the uncountable number of faculty who do significant amounts of teaching and are not on the teaching track. We will always have that circumstance, as we rely on all clinicians to teach when in contact with our students and residents. This begins to make the case for why the School needs robust faculty development.

When the numbers are broken down by department they indicate that Family Medicine and Medicine are providing the largest number of teaching faculty and by design these departments provide a fairly significant amount of internal faculty development for their faculty who teach. Duluth currently has three faculty currently in the Bio-medical Department and four in Family Medicine. All departments are providing teaching but not all of their faculty are in the teaching track. Dr. Miller noted that the Teaching Track wasn't very viable until 2010; also Medicine and Family Medicine are large departments who have been involved since inception of this track.

We have areas that provide a number of faculty development opportunities including:

- MEDS located in UME
- the RED program - provides faculty-development for residents
- Academic Health Center has its own faculty unit,
- Inter Professional Education is beginning their own faculty development unit
- Biomedical Library has its own faculty development program and curriculum
- at the University level there's the Teaching and Learning Center
- Duluth also has the equivalent of a Center for Teaching and Learning

There are a variety of opportunities, what is lacking, there is little connection and they aren't specific to those on the teaching track and necessarily to educators who are trying to move forward for their P & T. These widely distributed programs make it difficult to piece together what is necessary for P & T, especially for a new faculty member.

Other avenues do exist:

- department level faculty development, is a little more specific
- varying departments are bigger and more well-equipped
- there are Ph.D. educators within the departments
- some departments have developed their own certificates for teachers and medical educators
- there are scholarship opportunities
- some grant funded teaching and learning programs through the Office of Faculty Affairs and through MEDS
- journal club opportunities
- expanded grant writing workshop

These are not well connected among each other, for example there may be a great group of faculty in Medicine getting faculty development but they aren't necessarily cross pollinating with departments that may have smaller numbers. There are some great things going on in the departments and we have some great faculty who have gone out and received medical education degrees at other institutions. Some of the leaders in the nation right now in this field are UCSF, Stanford and Chicago. These programs require overhead for the faculty and for the departments to support these opportunities. Dr. Woods provided links to a number of programs and noted that the cost per person is in a range from \$5000 to \$25,000. A number of faculty have participated in these programs and there are those who return to teach here with what they've learned, mentoring junior faculty not all are able to have the time. This circumstance occurs often because there isn't a way to connect with faculty in a meaningful way.

In the Strategic vision, the Center for Excellence in Medical Education was proposed as a collaborative effort between the Office of Medical Education, the Office of Faculty Affairs and between the Duluth and Twin Cities Medical School campuses. They've begun to think strategically about how can provide faculty development that would allow our faculty to cross pollinate ideas and have a better long-term experience. Dr. Woods noted that dollars set aside to buy time for clinical faculty who would like to be teachers, depends on the Department. No money has been established in the Office of Medical Education or budgeted in the

Office of Faculty Affairs, for this purpose. Financing of this Center for excellence medical education is another issue. There has been philanthropy in the Department of Medicine that has allowed a few people to get masters and a couple of faculty have gone to the Stanford. In considering these issues the team has proposed a structure in the Center of Excellence that would be a series of granting programs. Most would be 9 to 12 months long and would require a fairly significant amount of a clinician/basic scientists time dedicated to learning and with department support, with dollars to accompany individuals.

There are criteria based upon national structures for schools of about our size. We are one of the few big ten schools that does not have a center of this type to support the faculty. There would be scholarship as part of this, for faculty who are working toward P & T who need to produce something at the end. Aspects of the certificate program would teach and train and support that scholarship, focused on exemplary teaching and practices to apply across the continuum of UME and GME and CME. It may be a fairly small group going forward because of the costs detailed in the budget. The certificates proposed in this rough first draft would include a master teacher, for a common set of curriculum for basic science and clinical faculty who are teaching. There would be breakout within the curriculum, specific to clinical education and basic science because they are different in practice. There would also be a certificate for program directors and one for educational leadership. There may be other certificates based upon other areas of interest, other areas of need for departments. There is potential in this format depending upon the infrastructure provided.

The certificate goals, in general, would be improvement addressed in the following:

- teaching skills
- increased faculty interactions
- improve educational research and scholarship opportunities
- to increase output and to develop a much larger impact on medical education scholarship coming out of the University of Minnesota Medical School to the national and international world.

This is an area where we are not currently well known, there is great potential here with many quality programs to be highlighted and shared. Institutionally we have not organized the expertise very well. There would be increased understanding around curriculum and evaluation, depending on how specialized within the individual certificate.

A priority for Dr. Woods would be the development of educational mentors who we would continue to rely upon as the programs grows. As people graduated from these programs they would return to become teachers in the program, mentors to other junior faculty, as they are providing scholarship. As they become experts they would help to support the educational community. After a few graduating classes we would have an exemplary educator's academy. Different institutions do this in different ways, but the academy would be some of the graduated individuals who remain very involved. The faculty are the backbone of the Center; this program cannot live without the involvement of the faculty to nurture the programs and to serve as the leaders.

The greatest issue at this point is the dollars that the University will put toward this proposal. Designing a program and the curriculum are very likely but to get faculty who are able to leave their clinical practice or their teaching in the basic sciences or their lab for half a day once a month is a significant investment in time. Dr. Woods noted when this is factored into the strategic plan concerns are:

- the proposed budget to support some such, at about \$1.7 million dollars per year
- involvement from department heads agreeing for the time commitment
- Expense to bring in expert scholars from outside
- administrative oversight of this
- space
- travel
- rewarding individuals at the end.

The budget information was used as a basis to get an understanding of what the cost might be but may not be the absolute for what will need to be provided to move forward.

Dr. Anne Weber-Main noted the big vision of the proposal is important to have in front of us to understand as educators looking for solutions. To do that it's important to introduce the scholarship and a way to create a pathway to accomplish this goal. The question she raises is whether this is the right step now at this point in time. A specific question being, how to get people to take advantage of the opportunities that are provided. Some things to consider include how many people are getting supported and try to balance that with infrastructure and make sure that both are being addressed simultaneously. With regard to the certificate programs, will they be newly created or can pathways be created that will allow participants to blend from different areas and determine variations in a pathway. There is a concern that the number of candidates may be affected by the ability of departments to provide money. Dr. Miller indicated that the CTS I requires that for every person involved, the department has to find \$250,000 of support.

Dr. Miller identified several areas to be considered:

- Stanford Program provides "train the trainer" techniques have an effect on a greater number of people learning.
- The Harvard Macy program "leadership educational change" which has been very powerful and was co-taught by the business school at Harvard.

His suggestion is to look outside the medical school to see what programs are available that can help to generalize this participation of a larger group, partnering with these programs would provide for broader numbers to learn from those who attend.

The numbers of faculty involved in the teaching track is known, but there is a great deal more teaching happening that isn't quantified. Is there a way to determine how many faculty might participate or is it necessary to find less formal ways for people to get recognized and then moved toward incentivizing them to participate in faculty development. Dr. Woods agreed that starting at a point to recognize what faculty can accomplish or have accomplished, outside of this formal structure, would aid in making this successful to begin with and would lessen the financial commitment required. She raised the question to ask what are the components that are really important to our departments and faculty now. If it's teaching basics what can we do to harness what's already being done in Medicine on teaching the basics, what can be done with the Biomedical Library's expertise, what can be done with the School of Education. It's important to determine what components we start with and how to encourage participation. A major concern is what occurred in the MEDS programs, a declining number attending for some very powerful programs. Senior faculty and retired faculty along with faculty from nursing and pharmacy attended. Very few medical education faculty were at these sessions, for a number of reasons how do we engage junior faculty. Using the Office of Faculty Affairs and partnering with their efforts to provide this in a more successful way. Aligning with Faculty Affairs could have more emphasis and focus on P & T. For tenure faculty need to have quality evaluations, demonstrate excellence in teaching and establish scholarship.

Dr. Rosenberg noted if the Medical School is going to achieve excellence maintaining faculty at the assistant professor level doesn't seem practical. So to be able to get promoted they have to have some way to achieve scholarship. He thinks the School has to provide support for them to be successful in gaining scholarship in order to advance in their careers. It seems that the scholarship of education is different than the scholarship of discovery; it's harder to prove, it's more qualitative, and funding is less. Any infrastructure, finding ways to financially support scholarship would be helpful considering how difficult it is to find that funding. It could be similar to having pilot grants for translational research, having different pots of money for different faculty support. Dr. Woods reiterated that connecting with Faculty Affairs is important because that is where that higher level of discussion tends to take place, as opposed to UME, GME or OME.

Dr. Johns congratulated Dr. Woods on the concepts represented in her presentation and noted the importance of making the opportunities to engage Duluth faculty in future developments for these opportunities. He spoke of the need to continue connection with individuals in Duluth through ITV and other means of interaction. Dr. Woods talked about the Academies Collaborative which she attended at the AAMC in November. Nationally schools similar in size to UMMS and those with regional campuses strongly support inclusion across campuses as a large part for those involved and then to also extend to the affiliate sites. This is especially important to those physician educators who are located at a distance that would require more than the 1-2 hours beyond class time to attend a faculty development event and with little ability to attend sessions on the TC campus. It's important to remember that at the regional sites work as closely with our students and residents as those who are local. Dr. Johns noted that the new faculty on teaching track are asking what the expectation is and what is available for them to gain promotion. Also junior faculty has identified that mentorship is one of the most important aspects of their continued learning as faculty.

Dr. Miller remarked on the alternative scholarship opportunities that can be measured and the importance of making those more visible and helping to make people more aware of the options that should be a priority. Possibilities include:

- junior faculty to recognize where they can participate
- the point of understanding where it fits on their CV
- linking planning to “what are my goals for myself as an educational scholar”
- advise more people to think in terms of their long and short term goals
- have the infrastructure in place for productive results

These factors are points in favor of a connection to support strengthening relationships between Medical Education, scholarship opportunities and partnering with the Office of Faculty Affairs. More concrete information for what a faculty member is expected to report on annually and to focus on as future goals and accomplishments. This makes it more plausible to be able to funnel them into the kinds of opportunities that are currently and continue to be identified. It is important to strategize on how to make the linkage with Faculty Affairs more formal. Dr. Watson noted there are great educators already in place, but what is lacking is visible education scholarship, of the kind being identified in this discussion. There are 1600 faculty, who is interested in gaining scholarship. Consensus of Council members is that it would be positive to have more individuals coming into the system on the teaching track. Perhaps the scholarship is visible but it isn't recognized. The development of the “SIMPLE cases” came out of the efforts by Dr. Nixon (Dept of Medicine) and used by virtually every medical student in US schools, but it hasn't been recognized across medical educators within UMMS. There are many similar examples that don't get discussed because of the lack of connectedness across departments and specialties. This is one area that can be developed to recognize scholarship among all 1600 educators not just those in the teaching track. Dr. Miller noted that it's one goal to create an opportunity but it's a different goal to create an expectation. In his view if there is going to be an educational development plan, it's important to figure out how to establish an expectation that faculty are going to have accomplishments and development in this area if they're going to be on the teaching track, the importance of linking an opportunity to a plan.

Dr. Brooks pointed out that in the proposal there are resources identified as available, within the Medical School and within the University. Her suggestion is to change the focus of the Academy to a place for mentoring, creating an individual plan, advise a course of study; so the resources are different are around coordinating and not specifically creating the curriculum. It also maybe a step into a bigger Center and then move on to figuring where more coursework would be logical. If the basic resources already exist that goes a long way toward using funding in more individualized way. Seeing that there could be a phased rollout moving toward the bigger achievement of developing a Center of Excellence (if there is by-in) would be very exciting goal and would fulfill support.

Dr. Duffy talked about her experience in attending the program at Pittsburgh to complete a master's in medical education, which is cross disciplinary. The program provides a great deal of support through the following examples:

- academy of medical educators, faculty from across their Medical School recognized as outstanding teachers
- monthly for seminars to talk about specific skills
- weekly across the School there is a 1-hour seminar on a given medical education topic
- medical education grand rounds monthly
- medical education research methods and innovative design seminars-involving research librarians, i.e. better lit search, opportunities to be published, how to approach survey questions with regard to curriculum design
- works in progress – for individuals who are doing masters projects to present them
- research conferences,
- expertise from across the Medical School and across departments
- Medicine focus has medicine conferences
- Retreats for people who are primarily teaching in medical school --to talk about the state of the curriculum, changes happening in specific curriculum and what is happening curriculum wide.
- retreats across their residency program

At Pittsburgh, all students were expected to attend the retreats consistently each week. Use of education credit units helped to establish a strong educational focus. This element required every teaching faculty to chart the educational work they do. As a course director or someone giving a lecture, they were required to log into a system to enter the number of credit hours they completed. Through this system funds are apportioned to departments based on the faculty education. Departments actually doing “boots on the ground teaching” are reimbursed and allowing department heads to distribute funds to those faculty. Dr. Miller noted that has been the practice at UMMS, but the faculty don't always recognize the return on their personal income, the process here isn't as explicit as this mechanism where each faculty's time is tracked. Statistical support was available in both translational research and medical education studies.

Dr. Rosenberg talked about areas to consider

- faculty at UMMS teach across the continuum in UME, CME, and GME
- UMMS doesn't provide support to teach them to run a program/educate at that level, which could be developed as a program
- more advanced program in educational leadership to focus on identifying the next generation of leaders.
- Promoting faculty development and scholarship, then not giving faculty the support to achieve, isn't productive long term.

As an example of collaboration, Dr. Miller reported that Medicine pays for some time from the School of Public Health to provide bio-statistical support for their clinical research. It can be used for either planning studies or grants, especially for new investigators. He suggested the statistical support and research design from an education point of view, may reason for housing this service in a “Center” and departments could buy into the established expertise. The University has a very strong statistical component that is also expensive, but they will give a discounted price if their expertise is purchased for a block of service. There is no funding budgeted at this time to purchase those services without having to write a grant and many faculty don't have the ability to write the grants. There is a sense that there are funds that could support this, but lack of connectedness causes delays and also just creates barriers to communicating across departments. Dr. Woods talked about the fact that so many of the pieces are here on campus, but there is no opportunity to coordinate the information to then make it possible to work across the Medical School as a whole. It hasn't been a priority of the Medical School as a whole; it takes a focused to put the pieces together.

Dr. Miller added a priority is to first figure out how to have success in faculty participation. Dr. Woods pointed out the faculty load that medical educators carry is very high and the time commitment needed to mentor junior faculty is growing. At this point they are at capacity and some department chairs may not be recognizing all that their faculty are doing. Dr. Watson noted that it's just as hard to be a good faculty as it is to be a good student and it's ironic that it takes time to fulfill that goal and responsibility.

Dr. Woods reported there is a group called the Academies Collaborative which has about 40 member schools. We attend their annual meetings because their model works and we have the ability to develop an Academy. All of them have a competitive process similar to Harvard Macy or Stanford, their budgets run in the multi-million dollar range every year. Their programs do bring in money because they have become competitive. Not only do departments pay, but people from outside their schools pay to attend. There is no reason that this can't be done at UMMS, there are wonderful components at this School. Dr. Brooks talked about her experiences as an educator at Harvard Macy, noting that one focus is to inform perspective participants the course work done at their Academy will qualify them to move into master's programs.

Medical student representatives supported the need for some form of infrastructure will need to be in place to support faculty involvement, but it also seems that the resources might be a limiting factor. They do agree it's important to assess how many prospective participants there are at UMMS before determining if it would be feasible. They suggest to potentially start by sending interested individuals through some components here, which might help to gauge how great is the interest. For students this level of on-going education of faculty would generate a greater level of interest and respect toward faculty. Making these efforts transparent to students will add to their support. Dr. Woods noted there is an idea to develop an elective that would pair these ideas for students who have an interest in becoming medical educators. This would provide an early pipeline opportunity in medical education leadership among students who then take that experience into their residency. A curriculum for this model already exists, but it's a matter of time to develop and manage a program. Medicine is currently providing this opportunity at the resident level and the elective would be the UME version of this program. Having an elective encourages students to stay locally because they have connections with the educators, which keeps excellent students within the Schools residency programs. In turn the seminars they provide encourage residents to stay on as medical education fellows and those who graduate from that program get into certificate and/or master's programs and have stayed on as faculty. In this way Pittsburgh has had an expanding pool of educators who are local. These teachers become role models as educators which then produce more of those interested in teaching at this level. Their Academy is available for consultation; which is part of the responsibilities of being accepted into the program; observing other emerging faculty in lecture, in rounding and observation in a variety of teaching settings to provide feedback. For medical students in Duluth they reiterated the importance of including educators and students in programs that are developed on the TC program for medical educators. Also they are concerned that newer faculty now at Duluth, who would be interested, may not be able to participate if they have to commit the time to commute to the TC campus for programs.

Dr. Miller provided a historical perspective on development of the teaching track and the efforts to establish a formalized role for clinicians who identify as medical educators. It took a number of years to develop the teaching track classification which came into practice in 2010. He talked about Dr. Duffy and others who have expanded their own educational background with study as medical educators and who are now applying their knowledge and skills in this field to improving and broadening the educational experience for medical students and residents. Dr. Rosenberg agreed that the development of medical educators supports the UMMS goal in striving for excellence and scholarship. Dr. Miller encouraged individuals who may have been told there isn't grant money available to support individual educational goals to continue to seek support to achieve their goals.