Education Council (EC) Meeting Minutes   May 20, 2014

EC members present:	D Patel	EC members not attending:
L Anderson	D Power	Z Crise-Patil
J Andrews	M Rosenberg	K Crossley
T Baultrippe	L Schimmenti	G Jacobs
J Beattie	A Severson	J Miller
J Chipman	S Slattery	M Nelson
R Cormier	S van den Hoogenhof	J Nixon
A Johns	K Watson	J Pacala
S Katz (Metzger)	A Weiers	A Pereira
M Kim	M Woods	Y Shimizu
R Michaels	B Yueh	T Stillman
W Miller		G Trachte
S Hansen	EC members not attending:	G Vercellotti
Z Lauer	K Brooks	
	L Carson	
	J Clinton	

Minutes
Minutes for the April 15, 2014 were approved with no changes or additions.

Education Steering Committee
Professionalism
As an update from the Education Steering Committee and the Clinical Education Committee, Dr. Majka Woods presented a statement on professionalism in relation to clerkship grading. This has been brought forward for review and discussion by both Committees. The statement is generally based on the Medicine Clerkship standard which states a student can fail a clerkship due to deficiencies in the area of professionalism. This standard has been adopted as a statement that will apply to student performance in all clerkship rotations. As a statement it's not a policy but a statement standardizing language across all clerkships with regard to grading. Grading can vary by clerkship and this is a recommendation that all have a component which includes professionalism and this statement clarifies that an unsatisfactory demonstration of professionalism can result in failure.

Issues have occurred for clerkships where information regarding professionalism hasn't been clearly stated in the syllabus and standardization of language will establish the importance of professionalism across clinical experiences.

It is technically included in the evaluation of MS clinical rotation performance and this clarification will make it more apparent. Because this is a clarification of grading practices and not a new policy no action is required by Education Council members. On the grading form "professionalism" is ranked the same as the other components and failing one component means failing the clerkship. There is no comparable statement in place for Years 1 and 2. Discussion at ECPC and the Education Steering Committee included possibly looking at Dr. Michael Cullen's study on behaviors of professionalism, which may be available by June and will add to future discussions on "professionalism". Some first year courses have a professionalism component; Science of Medical Practice also has a few points as part of MS-1 grading. Other year-1 and year-2 course grading also contain professionalism points and Duluth courses are similar. For Duluth students there are criteria for the rural experiences and for TC students the criteria in ECM assessing interactions with other team members and patient contact. There is also peer assessment by students of each other in Milestone I and II based upon interactions among them in small group sessions. The activities have been well received by students and when problems have been identified the information is communicated

through the faculty advisors, who then engage the students in 1:1 discussion. Duluth includes the professionalism component in their OSCE too and they report there will typically be one student identified who will need more 1:1 coaching and guidance with regard to behaviors. Facilitators for FCT are required to provide mid-semester feedback to each student and this serves as a tool that can include specific areas of communication and behavioral interactions that require work to correct.

Curriculum Retreat
Synthesis of the ideas that were generated at the Retreat.
The purpose of the Retreat was to prioritize and generate ideas in key areas of medical education that require improvement to "close the gap". The gap is what is happening in practice versus where we are at in medical education. There were pre-retreat mechanisms that were used to identify gaps. An important aspect of the Retreat was to understand the needs and expectations of the School's community partners and to start o identify volunteers to help with implementation. The real goal is to have actionable items that go into our programs. There were 113 participants who came to the Retreat and almost all of the teaching hospitals were represented. Community representatives are a group that have worked with Medical Education administration from the time when the AMA grant was written; some communities represented include: MN Department of Health, MMA and MHA, payers Blue Cross/Blue Shield and UCare who had been involved in developing relationships with the Medical School. These are the groups who work with UMSOM graduates and because we educate most of the physicians in the State, it's important to have them as part of the discussion on medical education. The Panel members included representation from those institutions where medical students train and where many of them do clinical practice. Included were representatives from the Department of Health, UMP, Health Partners and a long standing expertise on medical education.

The five themes that were been pre-identified from a variety of sources, i.e. through national conversations, to changes in USMLE, some from the survey and the OME innovations contest. Dr. Rosenberg added scholarship (for research) and also as a scholarly approach to medicine. The list includes the following:
- Quality improvement and patient safety
- Public health and public policy
- Interprofessional education
- New models of clinical education
- Integration of basic science into clinical education
- Scholarship

The work group will focus on determining the greatest opportunities or gaps that students and residents face relative to the changing health care environment. Some of the areas suggested at the retreat are zip code as a vital sign, public health advocacy, ability to function effectively in teams, population management, systems approach to health care and students learn by see what faculty do.

At the end of the Retreat, participants were asked to give advice to Medical School faculty and some of the comments are seen below:
seek out partnerships
understand the student experience
actively seek and respect student input
be aware of your influence as role model for professionalism, lifelong learning, and critical thinking
assess what content is core and what is expendable
take advantage of faculty development opportunities
accept and embrace change

As follow-up, work groups will use the input from people who attended the Retreat, organizing the information around the 5 main themes, to bring together volunteers for work groups who have shown interest in participating to help develop actionable steps. Starting with public and public policy and moving toward the larger areas of quality improvement and interprofessional education. Clinical education and integration of basic science/clinical science have already been a focus and progress continues to develop.

Dr. Rosenberg and the medical education leadership group have envisioned moving forward, each of the work groups will have an integration leader. The first group to be launched, the Public Policy/Public Health will be led by Dr. David Power and .2 FTE of his time will be supported by OME and Dr. Rosenberg will be the co-leader (each group will have an OME administration member). The group hasn't been formally set but the list is close to complete. Together this group will meet monthly for five months to work toward achieving the outcomes.

To begin the process there will be an environmental scan of what is taking place in the curriculum currently, for the topic Public Policy/Public Health (this format will be used across the work done by the five groups). Drs. Woods and van den Hoogenhof are determining where in the curriculum this content is already taking place. There are a number of areas where it's occurring; some were added as a result of proposals submitted during the Innovations contest. Developing and integrating new educational activities across the four years and across the two campuses will be elements of the updates. It will be necessary to evaluate whether the new educational initiatives are effective. The process will look at what we have; generating work to reformat in some cases and add some new things to them. There are a lot of good ideas on how to do it and this first group will work out how best to make adjustments. Part of the work of this group will be to develop the criteria that will go into the process of achieving a "digital badge" in public health. We are limited in many ways because it takes a lot of faculty skill and time to move change forward, as each theme advances it will be important to determine what faculty development will be valuable toward supporting each of the themes. Ideas have been generated for how to move forward with this project and this group will be a part of the discussion to help in clarifying ideas and processes. The digital "digital badge" idea will require development of the criteria students will have to accomplish to get a "digital badge" in Public Health.

Digital Badge
Recently Dr. Rosenberg attended a meeting of a UMF has a Scholarship in Medical Education Advisory Committee and Medical Alumni Society Board of Directors, who meet quarterly. This group commits a good deal of energy toward supporting medical students and medical education. They're charge with a number of things including fund raising for scholarships. Five medical students were invited to the meeting to speak about their experiences as students and about the financial challenges. Every one of the students is moving through the program without delays and all have done a number of things extra outside of the curriculum. Hearing their experiences and ambitious accomplishments establishes how important it is for the School to recognize their work and how it enhances their skill set. Especially with more competitive Match circumstances having the "digital badge" to formalize what students accomplish outside the program is critical to matching in the residency programs they want. The digital "digital badge" idea will require development of the criteria students will have to accomplish to get a badge in Public Health.

Dr. Kathleen Watson spoke about the number of students developing projects and acting upon ideas, doing research and writing and publishing. These projects are well beyond what the students also accomplish while they're in medical school completing all required work for their M.D. degree. At this point, the processes in Medical Education are not adequate to be able capture the depth of work and level of effort medical students are accomplishing outside the curriculum. Nor is it currently possible to fully define the outcomes and the long term impact their work creates.

Linking the "6 Themes" (developed through the Retreat process) to these efforts students are making above and beyond the curriculum provides the opportunity to capture the excellence of their work and the outcomes. The "digital badge" may provide the mechanism to allow students to use their self-directed learning to distinguish their work as medical students when in their residency application and interviews and for future employers. Formally there are Regent's Certificates that are represented on the transcripts; one for Public Health, along with 5-6 others. The Public Health certificate represents 16 credits of course work, most of it on-line and there is no time-line for how long it can take. The Flex MD program have allowed permits 12-20 student each year to get a dual degree and cost to the student is approximately $60,000. These are examples of "students who passion, what to learn something outside the curriculum and have outcomes".

Dr. Watson shared some history of the original development of the "digital badge" concept within the realm of social media. It is now becoming well developed enough to have received the Regents of the University of Minnesota approval as a mechanism for use by University. It was noted that UC-Davis is using this in one of their degree programs. It is a mini portfolio with multiple electronic layers that can be shared by a person authorized by an entity (such as the U of MN), such as program directors and/or future employers. It's required it be secured and it has the capability to have a number of assets uploaded to be shared with permission, to those designated individuals and/or programs. UMSOM will need a name, a clearly defined purpose and above all to limit its use to very specific criteria. There will be a review panel required for a review process of assets and who are willing to serve as evidence of approval for the level of excellence it exhibits, approval is dated and possibly an expiration date (if appropriate).

The "badge" is a way to recognize the work that students are already doing and to incentivize that key element of doctoring, self-directed learning. Much of it is informal learning beyond what is offered in the curriculum. The concepts and work are integrated throughout the curriculum, campuses and life-long learning. The "badge" supports a continuum and a commitment to learning outside the formalities of School.

The "badge" concept received strong support from EC members, comments included:
- it represents a skill or a collection of learned skills
- it could be used as a demonstration of focus and commitment
- it's a way to demonstrated a set of skills and knowledge
- originally it was seen by UC-Davis as a method to acknowledge competency
- perhaps electives could have a level excellence represented by a "badge"
- students have generated some ideas for projects they might find useful on a badge
- currently an individual could transfer credits they've achieved onto the U of MN badge
- the visual achievement would be positive
- extracurricular involvement
- some reservations are related to developing criteria, judging, tracking and awarding process all require a commitment by the Medical School
- it is considered that these will be very limited and not granted without thoughtful review
- resident program directors would appreciate the information
- document Gold Humanism selection

Dr. Watson asked for other input and it was noted that research and publications are very highly valued. It would be useful to know of special skills students and residents have acquired that can add depth to their work in a team setting. At the Retreat there were a number of areas identified that are almost core skills for someone who graduates from the UMSOM. Some students get recognized for their in depth learning and application of their knowledge. Dr. Rosenberg spoke about the integration of Public Health as integrated into the curriculum well enough that students can achieve competence. It will be important to define the criteria for a badge or for students who wanted an increased level of learning related to public health expertise. There may be a level of scholarship that a badge can represent; recognizing excellence that a student achieves and shares beyond themselves (teaching, sharing that knowledge). Using "scholarship" as criteria for a badge might lead students to share what they're learning and to teach what they learn. There is concern for the time commitment that would be required and what students might give up. Dr. Miller proposed that students are doing amazing things as part of their choices while in medical school learning and the "digital badge" is a way to recognize what they accomplish in that process. This is a meaningful way to distinguish what students have done while in medical school.

Next Meeting, August 19, 2014,
4-5:30 B646 Mayo