

# Education Council (EC) Meeting Minutes

March 17, 2015

<b>EC members present:</b>	R Michaels	A Weiers
L Anderson	J Nixon	M Woods
J Andrews	J Pacala	B Yueh
J Beattie	D Patel	
B Benson	A Pereira	<b>EC members not attending:</b>
J Chipman	D Power	K Brooks
R Cormier	M Rosenberg	B Clarke
S Hansen	L Schimmenti	K Crossley
R Holton	A Severson	S Katz
G Jacobs	S Slattery	J Miller
W Jenson	Y Shimizu	T Stillman
A Johns	G Trachte	G Vercellotti
M Kim	S van den Hoogenhof	M Wagar
Z Lauer	K Watson	J Weil

## Minutes

Minutes for the February 17, 2015 EC meeting were approved with a correction to the list of attendees.

## Information

The Search Committee for the Associate Dean for Student Affairs position has been selected and the Search process will be chaired by Dr. John Andrews. Dr. Mark Rosenberg reported that Dr. Kathleen Watson will step down from her current role as Sr. Associate Dean for Student Affairs, at the end of July, 2015. The timeline is set to allow for a number of different groups of stakeholders (including staff groups) to provide a broad range of input for search committee members to consider. The position has been posted and the idea is to receive applications through June and hope to have a candidate to recommend to the Dean by the end of the summer. He asked Council members to let potential candidates know of the posting. Dr. Andrews noted it will be helpful to have faculty publicizing the position; it's an important position. The Search is for the position of Associate Dean; Dr. Watson's position as Senior Associate Dean was based upon her length of tenure in Medical Education. Establishing the position as Associate Dean was determined by Dean Brooks Jackson and aligns the position with the Associate Dean of GME and Associate Dean for Admissions.

Dr. Rosenberg announced that Dr. Majka Woods will be leaving the University of Minnesota Medical School. She has accepted a position as Assistant Dean for Educational Development, at the University of Texas, Medical Branch – Galveston. Dr. Woods will continue in her current role through early June. Dr. Rosenberg noted both positions will be filled, although the transition plans for Dr. Woods' position are still being worked out. Due to these changes the Medical Education administrators are taking the opportunity to review the current structure of UME.

## LCME

Drs. Rosenberg reported that Drs. Watson and Woods have work together to respond to the LCME annual update regarding areas which require improvement and/or development. Members of ESC, SFC, CEC and CUMED have reviewed it and endorsed the content. Dr. Watson stated this is a collaborative effort; the work has involved Dr. Alan Johns, Dr. Majka Woods, Dr. Robin Michaels, Dr. Watson, Dr. Rosenberg and Leslie Anderson. Their process has focused on answering the questions from LCME, which make up the annual status report. Our goal is to be completely transparent while answering the questions based upon data.

Our student responses to the **Graduation Questionnaire** rate our Medical School below the national average for student support. Medical Education administration have tried to understand what this means. Dr. Woods and staff developed a questionnaire that was given to every medical student class by class to find out which

areas of student support were lacking. Ratings were generally overall fairly good across campuses, areas for improvement include the following:

- Duluth students don't understand what resources were available to them once they arrived on the TC campus and had trouble getting linked to them once they knew what they were
- Generally students didn't know who their advisors are and there were areas regarding the curriculum that students felt the advisors could have been more knowledgeable about.
- With meetings taking place today on the Duluth campus with students and faculty, an action plan has been developed and will respond to the concerns.

**Q:** Are the advisor groups too large?

**A:** To bring each group to a level of 8 to 10 students per advisor would mean tripling the number of advisors currently in place. For the size of the Program, the advisors are doing an excellent job on both campuses and the data bears this out; on this survey, the graduation questionnaire, and independently on the evaluations of faculty advisor. Whether the School should triple the budget for the advisement program above other priorities, is a difficult question. This is one area that highlights difficulties in having two campuses, two populations of students and faculty and students who all need to be supported for their 4-year educational experience, this is an ongoing challenge.

### **ED. 37 Monitoring Curriculum Content**

LCME requires all medical schools to map content to the objectives for all courses Years 1-4, for each campus and it has to be accessible to students, faculty and staff. We interpreted that this should be done through an accessible database system. In our last report to LCME we indicated that the goal was to use LCMS Plus as our tool to map all our course and clerkship content. After approximately two years of work with this tool we were able to map our curriculum and provide that to the LCME, but it became apparent this tool wasn't sustainable as a curriculum management system. Our statement to LCME was revised and we have reported to LCME that we will use Black Bag for our curriculum mapping for all of our curriculum; Years 1-2 on the Duluth campus and Years 1-4 on the TC campus. LCME is aware that we have complied with the Standard and have completed all of the mapping of our Year-1 and 2 curriculums. The LCME may ask as part of our letter for next year, how well is the Black Bag working, how is it working for our clinical education courses and are the faculty and students readily using the system. Their questions may focus on whether Black Bag works across both the basic science and the clinical curriculum, across both campuses.

In working through the transitions it appears that our School is complying with all of the LCME mapping requirements in relation to the PCRS. Two years ago using Black Bag was the plan, but it was found that more development was needed. With additional work, many underlying issues have been resolved and Black Bag's capabilities have been expanded, this has added to the confidence it will be successful. Areas of improvement include:

- Staffing has also been expanded and we now have a clinical team.
- We have transitioned Black Bag into the AHC giving it a more professional management structure.
- Black Bag now includes Admissions on both campuses
- Generally student feedback has been positive
- Year 1 and 2 course directors have established standards for course set-up, an excellent benefit to students.
- Clerkships may also adopt this standard to facilitate more effective use for clinical courses.

The largest cost factor has been personnel and it will probably be approximately 2 FTE, with some contract costs as well. It's essential and commercially it would be more expensive to purchase a software package and there isn't one product that can do it all. The plan has all required clerkships implemented within Black Bag by the beginning of the 2016 academic year. At that time all of the curriculum will live in Black Bag.

### **MS 37**

Dr. Watson reported space has been an issue that students are concerned about, throughout her tenure and numerous attempts at solutions have been implemented including the following:

- Student Council is moving toward creating a study space with some area for students to socialize.
- Survey of students indicates they are split pretty evenly on how to use the Adytum in terms of study and/or to socialize.

- Is there the possibility to involve the Center for Spirituality and Healing in helping with student wellbeing? Dr. Scott Slattery has met with staff from the Center and they are interested in working with the Medical School to develop programs to help deal with resources.
- Working on ideas to reach out and involve students through social media.
- The Center is doing a session for students early in April on Mindfulness Stress Reduction, as a kick-off to involve students.
- A major issue is how to promote wellness throughout all four years.

Several year-1 students will speak to the entire year-1 class to share specific details of wellbeing efforts and to enlist the class in a comprehensive program for next year when they enter their 2<sup>nd</sup> year. This past year Dr. Slattery has been involved understanding what the resources are and understanding which initiatives are effective for students. They see burnout and want to know how to help prevent it, students want to participate and it's a question of finding out what the resources are and how to apply them to help students. Dr. Benson noted that the focus on burnout has a lot to do with the need for space and whether there is adequate relaxation space. Dr. Kim spoke about learning what fits, how to inter weave wellness into the curriculum, how to monitor it and how to measure it.

**FA-2** In the past for Duluth, the LCME the number of faculty as a concern. There has been the potential their campus would not have enough faculty due to the eligibility for retirement, which would bring them below the required number of faculty. Dr. Johns provided a brief description of their current faculty group which now totals 41 faculty in place. This includes a number of early-career faculty.

**ED – 30** For late grades in the clerkships, the data shows we exceeded the deadline for grade submission several times. The narrative explains that staffing issues arose for a period of time; including loss of our Registrar. This led to suspension of our “frequent reminder” component while the position was vacant. As soon as the new Registrar (Heather) was in place in November, we again became 100% compliant. Also the Registrar has reached out to clerkship coordinators to help them resolve issues that have caused late grade reporting in the past. We have been 100% compliant since the Register was in place.

### **ED-32 Narrative assessment**

Narrative feedback is a concern for the TC campus and the efforts last year did not provide adequate information about the amount of narrative feedback provided by the faculty and faculty advisors. There has been no significant increase since the last year's letter. Duluth requires every faculty member to add a narrative assessment to a grade before it is submitted or the grade cannot be submitted, there is some slight variability. A survey of students found they were satisfied with the level of feedback they are getting.

Dr. Watson noted this is an example of accreditation language; all questions are answered transparently, we have listed all the data, and the student report is current. We will meet a standard and be asked to report again next year. It illustrates how accreditation sets the low bar not the high bar, because feedback orally or in a written form is a powerful tool for changing learning. In not successfully providing narrative feedback, Dr. Watson feels we have failed to rise to the occasion. Dr. Benson asked for specific recommendations, he noted it may fit the Dean's priorities for the department chairs for their metrics of accountability. One of which could be that faculty meet the deadline for evaluations so grades can be tallied on time. Faculty have stated they don't have time, the groups are too large, they don't know the students well, they're not trained to do this, and they need a convenient mechanism. Medical Education has attempted to provide a mechanism and this hasn't made any difference. The narrative feedback is required in FCT cases which has helped somewhat. This speaks to the culture in which the students are learning, she asked others including students to comment on this circumstance, noting that EC has the authority to say “fix this”.

- Most faculty feel they are already doing this for the students who need it.
- For those in the range of students from the 25<sup>th</sup> to the 80<sup>th</sup> percentile, there would be no real difference in the narrative.
- Numerous students don't attend class and it's a barrier to identifying students who need direct feedback.
- The goal of narrative feedback is to get at progress in the areas that aren't specific to medical knowledge.
- Narrative feedback focuses their professionalism skills, communication skills and on working in teams; which are the very skills they need to succeed in their clinical clerkships.
- Feedback in the small groups is important to getting at these skills.

- One suggestion to bring professionalism into the large group setting is to award professionalism points. If students seek out feedback it does happen and usually occurs on a 1:1 basis with faculty.
- As a plus for use of technology to establish standardized methods for feedback, Black Bag can be used to make narrative comments.

There are two pieces to narrative assessment questions and solution, one piece is getting the narrative assessment to the students so they know where they are performing well and where they need to for improvement. The other piece is how do we gather and collect that feedback, in a manner that can follow the student, to allow in a summative way tracking for where the students are in their progress. We need to have that mechanism built as other aspects of the narrative feedback are being developed. Dr. Woods noted there is a third component, which is training and developing comfort for use by faculty. Added to this part of this picture are the logistics of training those faculty who are not here routinely as core faculty but work with students as small group leaders. These individuals will need training and the opportunity to gain comfort with a system. There have been concerns raised by faculty in the past with regard to technology as part of an evaluation process.

Dr. Benson noted there is the component of being directly observed by faculty and who then puts that in the context of where the student is at and then describe the behaviors that will get the student to the next level. From a milestone standpoint the goal is not to just focus on the bottom 25% but for people to look at where is in their progress and then move them to that next level.

Dr. Benson talked about the Dean's engagement grants that are focused around system issues allowing partnering with someone to work on problem with a focus for improvement. Lack of quality feedback for students is a national issue; we have a local problem identified by LCME. Dr. Rosenberg supports the idea and noted that Medical Education is always pushing for money to support outcomes, education research with an idea for an outcome center. This issue would fit with the current efforts being explored in relation to an outcome center and the timing works well for raising these questions. It's making a strong statement about the value of solving this issue. In other departments, just the discussions about these grants generated conversations and attention and created engagement on the part of faculty. From a cultural standpoint, this may generate a similar growing interest in the narrative evaluation conversation.

From a student perspective

- It's important for faculty to understand the goal of the milestones and how narrative feedback would positively affect student outcomes.
- As a student looking back, during years 1 & 2 it wasn't apparent that these areas would be as closely followed as part of medical education.
- Educating students to the fact that they need to ask for this kind of feedback is almost as important as finding a way to measure the feedback. The student body overall isn't aware of the importance in asking for this feedback, but in years 3 and 4 it is the learning process used to understand and learn.
- Teaching these skills early on would advance students a great deal and seeking grants and other funding to move this forward would be a message to students that administration is vested in improving the evaluation process to incorporate the narrative feedback to all four years.
- In moving toward greater use of outcomes based education, the faculty need new skills. It will mean faculty are better prepared to work with the outcome measures once they are in place.
- Teaching the students to expect the narrative feedback will not only prepare them to do well in the clerkships, but will also set them up to be successful in GME and into their practice as physicians.
- Another potential linkage is that there are a number of attendings who are developing coaching for residents and senior residents; because they've expressed concern they don't have the skills to reach out to students.

Motion duly made and seconded for the approval and acceptance of the LCME update letter, passed unanimously.

### **PCRS**

Dr. Woods reported that the PCRS has gone through review by all of the education committee members; Scientific Foundations Committee (SFC) and the Clinical Education Committee (CEC) have approved adoption of the PCRS. The SFC on this campus did approve the PCRS with the caveat to add as number 9 in

the document, the UMMS original Scientific and Clinical Inquiry domain (with 2 competencies embedded in it). In checking recently with the Chair of the Committee on Undergraduate Medical Education –Duluth (CUMED), their members are still discussing the application of the PCRS and would like to have another opportunity to meet as a group. Dr. Johns reported that their question is related to Knowledge for Practice, 2.2, which includes a great deal of detail that makes it a very broad topic compared to the other 8 sections of the PCRS. Dr. Benson pointed out that the TC has done mapping of our curriculum and with use of the .9 in every category, it's possible to make some adjustments. Dr. Benson noted that the background paper is clear in that the PCRS language is used across the continuum, instead of differences for UME, GME and doctors.

In response to a suggestion that the UMMS domain wording be added to another of the PCRS sections, Dr. Jeff Chipman provided feedback from the discussion of the SFC members. They identified that the content is included in the existing PCRS, but they felt a proprietary ownership of the whole Scientific and Clinical Inquiry highlighting. Separating it out from the other 8 section, retains the level of importance it gained when the original Seven Domains were developed. Their point is to call it out rather than to embed it in the PCRS. Discussion followed:

- Will it be included in future ongoing milestone development?
- Currently the GME list is at six and it is projected to stay at that level.
- Added personal and professional aspects of competencies are being considered as #7
- There is a general consensus to have all levels follow the same set of standards, so these will be utilized across the continuum and across all medical schools.
- Should this become an extension to GME programs
- How would the research be measured
- It's the natural description of what the MSTP students are doing
- There is no reference to generating new knowledge, which is congruent with the Admissions Policy.

A motion duly made and seconded to accept the 8 existing sections of the PCRS with the addition of Scientific and Clinical Inquiry, as number 9, 9.1 and 9.2. The motion passed unanimously.

Dr. Rosenberg feels the statement with regard to Scientific and Clinical Inquiry is an important focus and the Dean will agree that separating it out, is an important statement of where we are headed. Dr. Benson noted that in doing the "gap analysis", administration found the importance of research isn't very well defined in the PCRS. In adding 9., Scientific and Clinical Inquiry, this will make adding 9.3 Creation of New Knowledge, an important consideration.

### **Residency Match - 2015**

Dr. Watson report this year's Match went very well. All of the Family Medicine positions filled. We graduated 237 students and when the week is complete, it's expected all students will have Matched. These details will be more defined when all of the details are available for the April meeting. There were some unfilled in the national Match. A detailed report is on the April Agenda.

**Next Meeting,  
April 21, 2015 4-5:30  
B646 Mayo Bldg**