

Assessment Committee

April 25, 2018
4:00 – 5:30 PM
Mayo B646

Chair: David Jewison

Co-Chair: Claudio Violato

Committee Members Present: Cassaundra Burt, Kevin Diebel, Sophia Gladding, Kelaine Haas, Jane Miller, Brooke Nesbitt, Stephen Richardson, Peter Southern, Suzanne van den Hoogenhof, Eric Velazquez

Committee Members Absent: David Jewison, Kelly Hallowell, Alicia Johnson, Joe Oppedisano, Aubrey Thyen,

Administrative Coordinator: Cynthia Johnson

MINUTES

1. The Minutes from March 28, 2018 were approved.
2. Request for Proposal - MedHub/New Innovations – Suzanne
 - Two vendors responded to the RFP: New Innovations and MedHub. GME and affiliate sites were included. They seem in favor of New Innovations, because they think that with it we will be using RMS, but that's not the case. Both are more expensive, but some blow-back from not going with New Innovations is expected. In scoring the two systems, we need one that's good for assessment in clinical environment, including direct observations. We hope to have mobile devices and collect data automatically, and MedHub already has the capacity to do that, whereas New Innovations can provide some of that functionality, but it is through a third party.
 - Another reason people prefer MedHub is that it can generate a spider web showing the student's progress compared to peers. New Innovations cannot do this, even though they've known for a year that we want this.
 - One fantasy outcome would be to have live capabilities, and MedHub is going to allow it.
 - These companies are FERPA compliant. RMS doesn't offer this.
3. ExamSoft – Peter Southern
 - Done – three hours final on Monday; three small delays with individual computers starting up. No red flags for going live with several courses. Dr. Southern doing a commentary for other course directors. Per Kevin Diebel in Duluth, it is working fine for them and they are finishing their fourth year using it. Alan Johns told Dr. Violato it would be nice to work on interfacing in 2019 when Duluth moves to the same portal. It cannot be done automatically at this time.
 - Adam Maier will do a demo at the next committee meeting
4. Direct Observation Activity – All
 - Committee members prepared to evaluate a situation without knowing whether the doctor was a student or not to determine whether the behavior of the clinician met the criteria you would expect without the supervisor present.

- Discussion of what a competency is:
 - Skill achieved by an individual at a particular time and place (time bound and measurable)
 - It is an actual behavior (or written) performance
 - Entrustable activities – how do you know if someone meets the criteria? It's a judgement (meets, not yet meets). The criterion is independent of the performer: it doesn't matter which year they are. A lot of preceptors slip in this, thinking we would expect beginning students not to meet the criterion. It's important to develop criteria-based evaluations.
 - Entrustability – is it the criterion or the judgement (criterion to meet the competency, but judgement by assessor). Judgement is instant, i.e. positive/negative; then if you ask someone what they thought; when judging prof behavior, like a clinical skill, we want to interpose data between our objective vs. intuitive judgement.
 - Criterion is the cut score; meets/doesn't meet or entrustable/not entrustable. We are entrusting beginning students to be able to do a physical exam with or without an assessor in the room. This requires a higher level of judgement.
 - With training, assessors can get quite good at this; the problem of subjectivity is usually due to lack of assessor training.
 - Subjectivity of judgements – when you have many judgements, it produces a more reliable assessment. You need either multiple assessments or trained assessors – of course we want both.
 - In GME, the biggest challenge is the logistics of getting people together, so they have done some online. Something positive has happened just in getting people together. It's hard to train raters, and learners have to be specific about asking up front. That's what they do in EPAC; it is the student's responsibility to ask.
 - At Wake Forest, Dr. Violato said the idea was to get professional assessors, they trained them, and they went onsite to every rotation. Each student was assessed on average five times on each rotation for roughly 12 mins of direct observation with the Mini CEX instrument. Cost can be a barrier, so it's important to balance factors of training vs. cost.
 - At Wake Forest the assessors were called coaches, and marks did not count against students. It was labor intensive, but a more ideal setup. Our challenge will be how to move in that direction to a system that is reliable.
 - Either performance measures up or it doesn't – some students will be excellent or terrible, but the bulk of students will fall in between.
 - Cassandra Burt expressed a preference for adequate or inadequate vs. meets/doesn't meet criteria. Dr. Gladding mentioned that in the absence of criteria, faculty use their own measures. Clinical performance assessments are often comparative, confusing norm references instead of criteria. Students (and faculty) will have to learn that a lot of criticism is to help them improve. The purpose is to give good formative feedback.
 - If this works well, there will be pressure to use it for summative assessments as well. We're trying it now in the LICs because they have 9-10 months to show their preceptors that they can grow. Because it will be the same person providing a summative assessment, they don't have the person do the formative assessments. Like coaching in sports, the coach helps you get better, and others judge your performance. This will require cultural shifts in

assessment.

- Kind of built on milestones that UMN set as requirements years ago. Clinical performance assessments will have to be updated to match PCRSes, but there is no definitive assessment of this right now.