

Assessment Committee

March 26, 2019

4:00 – 5:00 PM

Mayo B620

Present: David Jewison, Claudio Violato, Kirby Clark, Kevin Diebel, Sophia Gladding, Samuel Ives, Chloe Peyton, Pedro Fernandez-Funez, Stephen Richardson, Peter Southern, Lora Wichser, Jess Blum, Esther Dale, Amy Seip, Brinsley Davis, Cynthia Johnson

Absent: Sasha Buchner, Cassaundra Burt, Adam Kneepkens, Eric Velazquez

MINUTES

1. Introductions
2. The minutes from the February 26, 2019 meeting were approved.
3. Physician Competency Review Set (PCRS), Dr. Violato
 - a. To have a medical school, one needs mission, vision, values, goals, and a PCRS (Physician Competency Reference Set)
 - b. PCRS Domains – there are eight; they are what a medical school can have as major pedagogical goals/outcomes (goals frame the outcomes). Outcomes equal educational objectives.
 - i. Patient Care
 - ii. Knowledge for Practice
 - iii. Practice Based Learning and Improvement
 - iv. Interpersonal and Communication Skills
 - v. Professionalism
 - vi. Systems-Based Practice
 - vii. Interprofessional Collaboration
 - viii. Personal and Professional Development
 - ix. Scientific and Clinical Inquiry
 - c. The Committee's responsibility is to recommend an assessment framework – moving to a competency-based framework for assessment. The school is charged with assessing the PCRS; how do we do it? We already assess students, but are we up to best practices? We can always be better.
 - d. EPAs assess individual level – professional activity that is part of a health professional's job, i.e. everything physicians do. They are things we can directly observe and measure; in a way, they operationalize the competencies.
 - e. The AAMC has come up with EPAs; Esther Dale condensed them into 13 activities
 - f. If this is the framework we're going to use, we need to operationalize these EPAs.

- g. EPAC (Education in Pediatrics across the Continuum): at some point people transfer from students to professionals (they can practice their trade without direct supervision). The EPAs are intended to be entrustable activities going into residency.

4. Suggestions from Small Groups

- a. Duluth – use Sim Center
- b. EPA 4 – enter orders (some sites don't allow it, if so use an OSCE) EPA 5 – Notes (need to create rubric for note 6 – they do presentations every day)
- c. Assessors are different and part of doing this is to define expectations for assessors and students in each specialty and at each site. EPA 7 – once weekly, show and document that they formed a clinical question and did the lookup; assessed by homework (what they did to look up an answer). Researched and defined by student.
- d. EPA 1 – need for several components, such as an OSCE for standardized rubric and evaluators, observation. EPA 2 – written case, forming a differential diagnosis.
- e. Elements should be documented as components of every clerkship. Value to superimpose them on the clerkships. Relationship between EPAs 5 & 7; go see a patient, write up what you see.
- f. Students don't know they need to tell their preceptors what they do, such as looking things up, or the preceptors have no way of knowing what the student is doing.

5. Wrap Up

- a. Objective is to move toward a framework for assessment linked to something, such as EPAs.
- b. We're going to measure reliability, validity, authenticity. OSCEs are not entirely authentic; in a sense they are artificial. Does it psychologically feel like the real thing? How do we maintain the autonomy of the specialty? Mini version needs to respect autonomy while assessing students' skills.
- c. Clerkships are better at some EPAs than others, such as EPA 1, because someone would need to sit there and watch.
- d. We're thinking of 100 assessments per student per rotation using trained assessors.