Committee on Medical Education Minutes – May 26, 2016

Running Items

1. The April 28, 2016 Minutes were reviewed and approved.
2. Comments from Chair

   Dr. Stagno congratulated everyone on another successful academic year!
3. Comments from Vice Dean for Medical Education

   Dr. Thomas reported that commencement had a wonderful speaker.

   Dr. Thomas offered congratulations to the Kaiser Award winners:

   Colleen Croniger for Preclinical Teaching for the University Program

   John Daryl Thornton for Clinical Teaching for the University Program

   Dileep R. Nair for Preclinical Teaching for the College Program

   Skyler E. Kalady for Clinical Teaching for the College Program

   Students vote on these awards and each is a great honor.

   Dr. Thomas offered congratulations to Robert Petersen on being named the new Assistant Dean of Basic Science Education.

   Dr. Thomas offered congratulations to Ellen Luebbers on being named the Director of Interprofessional Education for all four schools.

   Dr. Thomas reported that first 24 Physician AssistantS Program students begin tomorrow. Next year, there will be 36 students, and then the program will reach its maximum enrollment of 50 in the third year. The PA Program bring a change in culture, as they will be sharing the building with the medical students. Dr. Wilson-Delfosse suggested having the PA faculty meet with the SOM Peer Handoff leaders to facilitate a smooth transition to the joint occupation of the building for this coming year.

   The Health Education Campus continues. Construction design is signed off now.
4. Comments from Student Representatives

   There was no report

5. Report from Joint Clinical Oversight Group

   Dr. Isaacson and Dr. Padrino reported that there was no meeting this month. Along with Dr. Lipman and Dr. Mehta, they are working on pilot to improve direct observation of students and are trying to identify one or two defined clinical activities in each clerkship for direct observation and feedback. For example, in surgery, suturing and the abdominal exam would fulfill this need. The feedback would be specific and there would be a checklist for each activity.

   Working on LCME database.

6. Report from WR2 Curriculum Committee

   The most recent WR2 Minutes have been provided. Dr. Wilson-Delfosse reported that they are working on contingency plans for how the RNC this summer might affect Block 1 and its community experiences. There will be a retreat for all four years of the curriculum in the fall.

7. Report from CCLCM Steering Council

   The most recent CSC Minutes have been provided.

   On a somber note, Dr. Hull reported that Dr. Dannefer passed away today.

8. Report from PEAC

   Dr. Papp reported that now that the Block 5 Executive Summary is finished, PEAC has completed Blocks 1-6 and is now working on Blocks 7 and 8. They will issue a report on concerns across all the blocks. In September they will begin reviewing core clinical rotations. These recommendations will require a great deal of work. Dr. Petersen will help along with the block leadership.

New Business

Informational:

1. Review of LCME Dashboard/Review of CQI:

   Monitoring Student Time: Policy on Medical Student Duty Hours and Workload

   Please see the attached policy.

   Dr. Papp presented the current workload policy.

   Two questions were added to end of rotation feedback:

      Do you know the duty hour policy for this clerkship?

      The duty hour policy was adhered to during this clerkship.

   The number of students who responded in the affirmative was high, 83-91%.

As the policy remains consistent throughout all clerkships and the duty hours are given to the students at their orientation, it was concerning that any of the students did not respond yes to the first question.

Duty hours are based on student safety, not patient care. These hours are not tracked for all students currently.

Action Item: Have JCOG review and update the Duty Hours policy

Dr. Luebbers reported on the Macy Grant and IPE. The Macy Foundation has awarded us a four year grant to create a new model for clinical interprofessional education based on perceived gaps. We will be piloting this new model, which will involve more than the current twice yearly activities. We are looking forward to what we can learn in clinical settings.

Please see the attached summary.

Dr. Wilson-Delfosse delivered a report from the Educational Programs Subcommittee. Please see the attached presentation.

Among the areas of strength, we find the strong scholarly environment, the acquisition of self-directed and lifelong learning skills, medical problem-solving, evidence-based clinical judgment, narrative assessment, and formative feedback

Among major concerns:

6.1 We need outcome measures for Systems Based Practice.

6.4 Inpatient and outpatient experiences are limited to due to capacity issues.

8.3 We need tools to review the curriculum and to make changes. We need more robust electronic tools such as mapping.

Major Areas of concern:

6.1 gap; need health systems outcome measures

6.4 inpatient/outpatient: limited capacity; capacity is an issue

8.3 need tools to review curriculum and make changes; we need more robust electronic tools such as mapping;

8.5 There is no central system to collect student feedback on faculty and residents. We need a centralized, city-wide faculty/resident teaching evaluation system.

9.4 There is concern regarding the observation of core clinical skills. JCOG is working on monitoring tools.

9.5, 9.7, 9.8 There is a 100% compliance of grade release within 6 weeks for the 2015-2016 academic year and this trend must continue. Mid-clerkship feedback is not happening consistently for all clerkships at all sites. We need to ensure clerkship directors meet with every student every 4 weeks.

Moderate objectives 7.9 course objectives for IPE initiative; Ellen Luebbers says that we have time to complete this appropriately.

Minor concerns include:

Service Learning 6.6

Central management of curriculum 8.1

Documentation of all policies and procedures 8.4

Comparability of education and assessment in clerkships 8.7

Communication and documentation around faculty responsibilities 9.3

Incomplete DCI 7.5, 7.6

2. Report of CWRU Student Achievement on USMLE Step 1, 2 CK, 2 CS

Please see attached.

Dr. Papp presented the report on CWRU Student Achievement on the USMLE.

Step 1 had a 99% pass rate, above the national average.

The following are interim

Step 2 had a 98% pass rate; above the national average again.

For Clinical Skills, we had a 95% passage rate, compared to the national average of 97%. We are revising our internal Clinical Skills exam in order to provide feedback to students and to prepare them for it better. With a substantially revised exam, we are hoping to identify students who need additional practice and skills. We are also creating a task force to work on the internal CS exam in order to improve it and help us identify students. Dr. Thomas suggested that we can increase the number of simulated patients and add practice in each clerkship.

Congratulations to both students and faculty for the good scores

Attending:

Dr. Susan Stagno, Chair

Dr. Joseph Bokar

Dr. Michael Dell

Dr. Kathleen Franco

Dr. Alan Hull

Dr. Bud Isaacson

Dr. Jeremy Lipman

Dr. Megan McNamara

Dr. Rami Manochakian

Dr. Ronda Mourad

Dr. Susan Padrino

Dr. Klara Papp

Dr. Robert Peteresen

Dr. Patricia Thomas

Dr. Amy Wilson-Delfosse

Dr. Ellen Luebbers

Nathaniel Robinson

Kathleen Blazar, Librarian

Yifei Zhu, Evaluations

Bart Jarmusch, Recording Secretary

SCHOOL OF MEDICINE
CASE WESTERN RESERVE UNIVERSITY

Block 5 Host Defense & Host Response

I. Executive Summary

PEAC concluded a systematic review of Block 5 Host Defense & Host Response which provides strong and high quality education in the important topics of immunology, hematology, infectious diseases, rheumatology, dermatology, and musculoskeletal physiology which are foundational concepts in the WR2 curriculum. We make the following observations in the spirit of continuous improvement with underlying admiration for the excellent overall quality of Block 5.

STRENGTHS

Block 5 employs a variety of instructional methods to effectively convey material in the disciplines listed above. Overall the integration and roll out of Block 5 with lectures, IQ cases, live material and clinical teaching is substantial. The lecture are very positively received. Overall, lectures are rated as the most effective learning venue. Many comments reflect the high quality of lectures especially in HemeOnc, Rheumatology, and Dermatology. These lecturers should be studied to develop best practices for the rest of the curriculum.

PEAC also observed that key faculty, notably Drs O'Brien and Dr Kalayjian, were involved with the design and development of this Block from the start. The stability of the leadership of this Block is a clear plus. Overall, student feedback reflected a well-organized Block with excellent lecturers. It was clear from the responses that student perception was strongly positive.

RECOMMENDATIONS

Consider careful review and revision of IQ cases. There could be improved on the basis of integration and careful editorial revision.

Target of some % increase in the inclusion of higher order SEQs and SSEQs. Our review estimated that fewer than half of the questions asked required higher order thinking beyond comprehension and recall of factual information.

Undertake a review of the Block's learning objectives to identify whether they are effective in guiding students learning throughout the Block.

Policy on Medical Student Duty Hours and Workload

Policy on Medical Student Duty Hours on Clinical Rotations

Medical students must be presented with a clinical working environment that supports their learning and safeguards personal health. The emphasis should be on opportunities to learn within a reasonable framework of clinical activities. Specific considerations:

- Educational priorities must outweigh the service needs of the clinical setting. Students must not be taken advantage of in attempting to cope with practice needs.
- Student participation in clinical activities must take into account the fact that fatigue impairs learning. Students need to be able to take advantage of opportunities to learn.
- Student participation in clinical settings must take into account the potential adverse impact of fatigue on personal health and safe travel to and from the practice site.
- Students completing a work shift in the hospital and assessing themselves as unsafe to drive must have access to facilities for sleeping and/or alternative transportation to home and back to the hospital.
- Student participation in basic core clinical settings should not exceed intern work hour policies (80 hours/week averaged over 4 weeks, at most 16 hours of continuous patient care followed by at least 8 hours out of hospital, average 1 day off/week). Students may elect to stay up to an additional 4 hours for purely educational activities.
- Student participation in Acting Internship and other elective clinical rotations must not exceed intern work hour policies (80 hours/week averaged over 4 weeks, at most 16 hours continuously in the hospital followed by at least 8 hours out of hospital, average 1 day off/week).
- Students participating in the required Friday afternoon curriculum must be excused from clinical rotations at 9 PM on Thursday nights to assure meaningful participation in the learning activities.

Monitoring of these guidelines will be the responsibility of the Discipline Leader and will utilize direct observation as well as oral and written feedback including end of rotation evaluations.

Policy on Medical Student Workload on Core Clinical Rotations

Medical students must be presented with clinical workload expectations that support their learning while maintaining an appropriate level of engagement with the clinical environment. The specific details of these expectations will vary somewhat with the clinical specialty or rotation, but must:

- Ensure that educational priorities outweigh the service needs of the clinical setting. Students must not be taken advantage of in attempting to cope with practice needs.
- Take into account the fact that fatigue impairs learning. Students must be able to take advantage of opportunities to learn.
- Provide adequate opportunities for assessment of student performance across the range of identified competencies

Monitoring of these guidelines will be the responsibility of the Discipline Leader and will utilize direct observation as well as oral and written feedback including end of rotation evaluations.

Macy Grant Summary

Interprofessional Learning Exchange and Practice (ILEAP) – A clinical education model

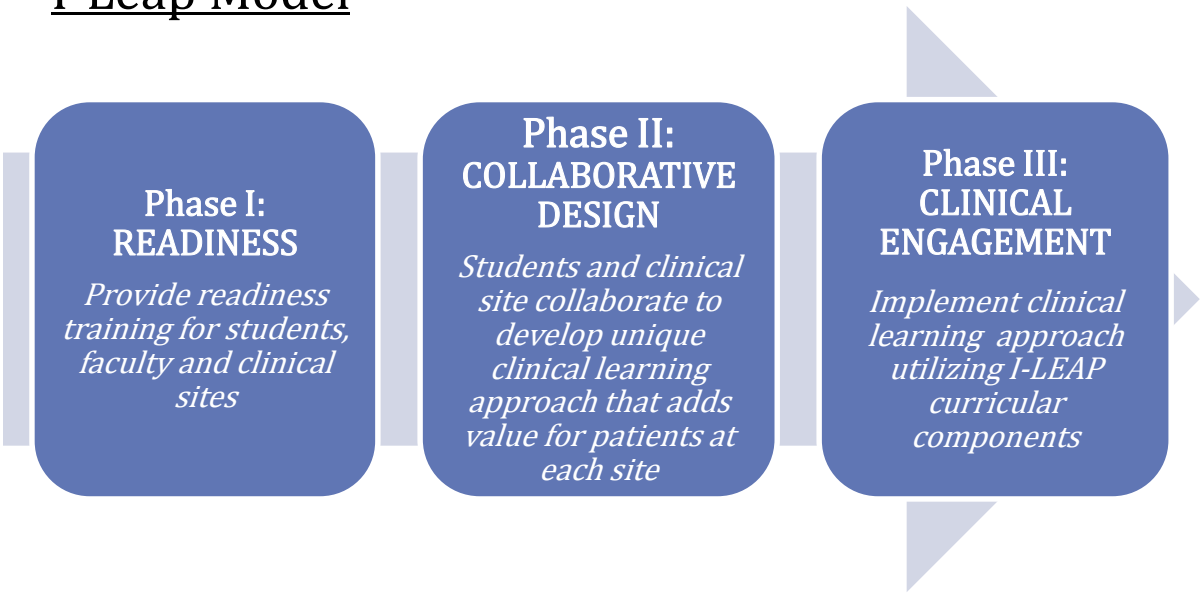
The overall **project goal** is to refine, implement and test a scalable model for interprofessional clinical education that will:

- Enhance student knowledge, skills, attitudes and behavior regarding collaborative care;
- Prepare faculty to facilitate learning experiences that promote interprofessional collaboration;
- Create opportunities for students to provide added value for clinical partners, patients and population health.
- Support an understanding of clinical site components that enhance interprofessional learning; and
- Inform and enhance existing curricula and interprofessional initiatives.

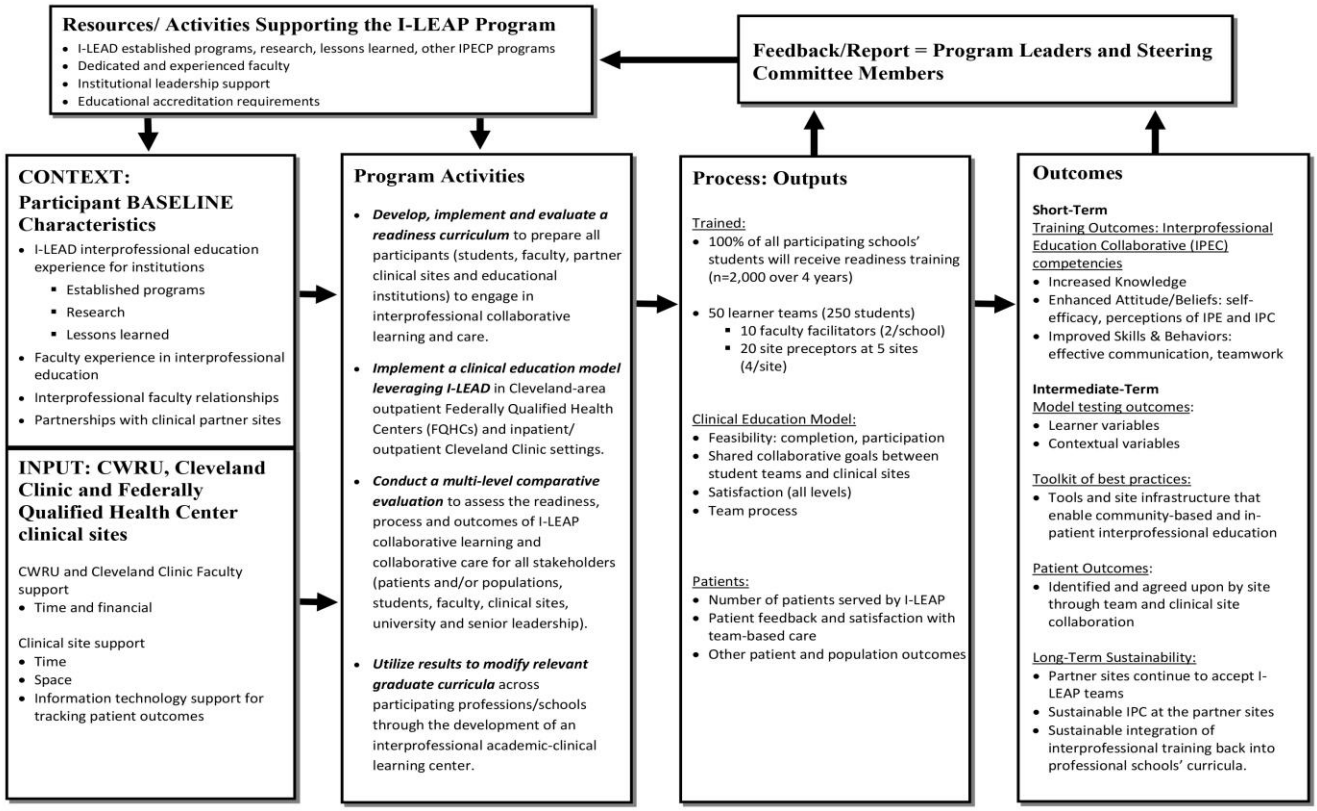
Specific **project objectives** include:

1. **Develop, implement and evaluate a readiness curriculum** to prepare all participants (students, faculty facilitators, partner clinical sites and educational institutions) to engage in interprofessional collaborative learning and care.
2. **Implement a clinical education model leveraging I-LEAD outcomes** (Student-Run Free Clinic successful practices and the Model of Interprofessional Dialectical Learning) in Cleveland-area outpatient Federally Qualified Health Centers (FQHCs) and inpatient Cleveland Clinic settings.
3. **Conduct a multi-level comparative evaluation** to assess the readiness curriculum, implementation process and outcomes of I-LEAP collaborative learning and collaborative care. Evaluation will be conducted for all stakeholders (patients and/or populations, students, faculty, clinical sites, university and senior leadership).
4. **Utilize results to modify relevant graduate curricula** across participating professions/schools through the development of an interprofessional academic-clinical learning partnership. Results will inform current clinical education efforts as well as new and existing interprofessional courses and experiences.

I-Leap Model



I-LEAP Logic Model



Educational Programs Subcommittee

Summary Report to the Committee on Medical Education

Standards 6, 7, 8, 9 and Elements 3.2 and 3.5

Co-Chairs: Amy Wilson-Delfosse, PhD and Alan Hull, MD, PhD

Committee Members: Keith Armitage, Hope Barkoukis, Beth Bierer, Colleen Croniger, Elaine Dannefer, Minoo Darvish, Richard Drake, Cecile Foshee, Linda Graham, Heidi Gullett, Bud Isaacson, Charles Lopresti, Christine Moravec, Susan Padrino, Klara Papp, Robert Petersen and student members: Jyoti Narayanswami, Kevin Allan, Alok Harwani, Emily Nizialek, Mindy Duong, John McAfee, Robert Borden

Educational Programs - Dashboard

Prior to Self-Study

Standard	3	6	7	8	9
Element		6.1	7.1	8.1	9.1
	3.2	6.2	7.2	8.2	9.2
		6.3	7.3	8.3	9.3
		6.4	7.4	8.4	9.4
	3.5	6.5	7.5	8.5	9.5
		6.6	7.6	8.6	9.6
		6.7	7.7	8.7	9.7
		6.8	7.8	8.8	9.8
			7.9		9.9

	Compliance
	Not sure; need to see results of ISA; more data needed; probable compliance
	Area of monitoring (no documentation of track record of compliance)
	Could go either way depending on site team and other factors
	Probable Non-compliance

After Self-Study

Standard	3	6	7	8	9
Element		6.1	7.1	8.1	9.1
	3.2	6.2	7.2	8.2	9.2
		6.3	7.3	8.3	9.3
		6.4	7.4	8.4	9.4
	3.5	6.5	*7.5	8.5	9.5
		6.6	*7.6	8.6	9.6
		6.7	7.7	8.7	9.7
		6.8	7.8	8.8	9.8
			7.9		9.9

	Compliance
	Not sure; need to see results of ISA; more data needed; probable compliance
	Area of monitoring (no documentation of track record of compliance)
	Could go either way depending on site team and other factors
	Probable Non-compliance
	Area of particular strength
*	Inadequate documentation in DCI

Educational Programs
DASHBOARD

Standard	3	6	7	8	9
Element		6.1	7.1	8.1	9.1
	3.2	6.2	7.2	8.2	9.2
		6.3	7.3	8.3	9.3
		6.4	7.4	8.4	9.4
	3.5	6.5	*7.5	8.5	9.5
		6.6	*7.6	8.6	9.6
		6.7	7.7	8.7	9.7
		6.8	7.8	8.8	9.8
			7.9		9.9

	Compliance
	Not sure; need to see results of ISA; more data needed; probable compliance
	Area of monitoring (no documentation of track record of compliance)
	Could go either way depending on site team and other factors
	Probable Non-compliance
	Area of particular strength
*	Inadequate documentation in DCI

- Systems Based Practice EPOs (6.1)
- Capacity limits for clinical training (6.4)
- Curriculum mapping (8.3)
- Evaluation of faculty/residents (8.5)
- Direct observation (9.4)
- Mid-clerkship feedback (9.7)
- Timely release of grades (9.8)

AREAS OF STRENGTH

- The medical school provides a **scholarly environment** for faculty and students and there is strong support and encouragement for medical students to participate in research. (3.2)

- The sufficiency and time dedicated to opportunities for students to acquire and demonstrate **self-directed and lifelong learning skills** is outstanding. (6.3)
- Experiences that permit students to directly apply the **scientific method** and to become familiar with the basic principles of clinical and translational **research** are robust and required. (7.3)
- The curriculum is robust in the inclusion of experiences to ensure that students develop skills in **medical problem-solving** and **evidence-based clinical judgment**. (7.4)
- A focus of the curriculum is to prepare students to recognize and appropriately address the medical consequences of common **societal problems**. (7.5)

- **Narrative Assessment** is frequent and high quality. (9.5)

- **Formative feedback** is frequent in the pre-clerkship curricula. (9.7)

MAJOR CONCERNS

STANDARD 6: COMPETENCIES, CURRICULAR OBJECTIVES, AND CURRICULAR DESIGN

*Q1. Have **educational program objectives** been developed that are stated in outcome-based terms and are they linked to the competencies expected of a physician? Evaluate **whether the objectives can be and are being used for the assessment of medical students' progress in achieving these competencies**. Evaluate whether the educational program objectives and the objectives of individual courses and clerkships have been shared with medical students and with relevant individuals and groups responsible for curriculum planning and implementation and for medical student teaching and assessment. (**6.1**)*

Concerns-Major: We do not yet have outcome measures for the Systems Based Practice medical Education Program Objective, "Promotes patient safety by analyzing errors within the health system and proposes changes to prevent similar errors".

Recommendations: Outcome measures need to be developed for both programs.

MAJOR CONCERNS

STANDARD 6: COMPETENCIES, CURRICULAR OBJECTIVES, AND CURRICULAR DESIGN

Q4. *Comment on the **adequacy of inpatient and outpatient experiences** in the curriculum to allow the objectives of the educational program and the individual clerkships to be met. (**6.4**)*

Concerns-Major: The limited capacity to offer in-patient and out-patient clinical experiences is a major concern.

Recommendations: Continue efforts to identify new sites and new ways of accomplishing clinical training.

MAJOR CONCERNS

STANDARD 8: CURRICULAR MANAGEMENT, EVALUATION, AND ENHANCEMENT

Q3. *Is there appropriate faculty participation in curriculum design, implementation, and evaluation? Are the units of the curriculum (i.e., courses and clerkships), the segments of the curriculum (i.e., years or phases) and the curriculum as a whole being reviewed according to a predetermined schedule?* ***Are there tools, such as a curriculum database, available to support these reviews*** *and to allow a determination of the adequacy and placement of curriculum content? Are the results of these evaluations used by the curriculum committee, the course leadership, and the departments to inform needed change? (**8.3** plus Overview section)*

Concerns-Major: 1) Our current, homegrown, learning management systems do not support curriculum mapping. While these systems are searchable, this feature is somewhat inefficient. 2) The third year curriculum has not yet fully been entered into the learning management systems. 3) PEAC has not yet reviewed any clerkships.

Recommendations: Short-term: 1) Introduce at least basic mapping features into current learning management systems. 2) Improve presentation of search results in eCurriculum. 3) Develop and populate a clerkship curriculum in a learning management system. Long-term: Upgrade learning management systems to include robust mapping features.

MAJOR CONCERNS

STANDARD 8: CURRICULAR MANAGEMENT, EVALUATION, AND ENHANCEMENT

Q5. *Evaluate the **adequacy of the system to collect student feedback** on courses and **clerkships** and on **faculty, residents**, and others who teach, supervise, and assess medical students. Does the system provide valid and reliable data, for example, through adequate response rates to questionnaires? How are the data used for program review and improvement? (**8.5** plus Overview section)*

Concerns-Major: There is not an acceptable, centralized, system in place to collect student feedback about teaching faculty and residents. Consequently, clerkship directors do not receive teaching evaluation data about their faculty and residents.

Recommendation: Develop a centralized, city-wide faculty/resident teaching evaluation system in CAS.

MAJOR CONCERNS

STANDARD 9: TEACHING, SUPERVISION, ASSESSMENT, AND STUDENT AND PATIENT SAFETY

Q3. *Evaluate the adequacy of the methods used to assess student attainment of the knowledge, cognitive and clinical skills, attitudes, and behaviors specified in the educational program objectives.* ***Is there evidence that students' core clinical skills are being observed?*** *Are there any limitations in the school's ability to ensure that the clinical skills of all students are being appropriately assessed? (**9.4** plus Overview section)*

Concerns-Major: A lower percentage of CWRU School of Medicine students report that they were observed performing histories and physical exams as compared to the national average.

Recommendations: 1) Develop a passport system for all clerkships to document when students are observed performing clinical skills. 2) Develop the real-time recording of feedback in CAS.

MAJOR CONCERNS

STANDARD 9: TEACHING, SUPERVISION, ASSESSMENT, AND STUDENT AND PATIENT SAFETY

Q4. *How effective are the processes and systems to ensure that students receive **comprehensive and timely formative assessment** and fair and timely summative in both the preclerkship phase of the curriculum and in the clerkships? Is narrative assessment included as a component of courses and clerkships where teacher-student interaction permits? (9.5, **9.7, 9.8** plus Overview section)*

Concerns-Major: 1) Mid-clerkship feedback is not happening consistently for all clerkships at all sites. 2) While time to grade release has been within compliance for 2015-2016 year to date, there were major violations to the 6-week expectation in the previous two academic years.

Recommendations: 1) Mid-clerkship feedback: engage assistance from department chairs to ensure that clerkship directors meet with every student every 4-weeks. 2) Grade release: Continue present plan as it seems to be working. There is 100% compliance of grade release within 6 weeks for the 2015-2016 academic year to date.

Educational Programs Subcommittee Summary

Major Concerns

- Systems Based Practice Educational Program Objectives (6.1)
- Capacity limits for clinical training (6.4)
- Curriculum mapping (8.3)
- Evaluation of faculty/residents during clerkships (8.5)
- Direct observation (9.4)
- Mid-clerkship feedback (9.7)
- Timely release of grades (9.8)

Moderate Concerns

- Course objectives for IPE initiative (7.9)

Minor Concerns

- Service learning (6.6)
- Central management of the curriculum (8.1)
- Documentation of all policies and procedures (8.4, broad applicability)
- Comparability of education and assessment in clerkships (8.7)
- Communication and documentation around faculty responsibilities (9.3 supervision)
- Incomplete DCI (7.5, 7.6)