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Medical Student Education Committee Minutes

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9-20-2016

### 2016 September 20 - Medical Student Education Committee Minutes

Medical Student Education Committee, East Tennessee State University

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**Medical Student Education Committee - MSEC**

The Medical Student Education Committee of the Quillen College of Medicine met on Tuesday, September 20, 2016 at 3:30 pm in the Academic Affairs Conference Room of Stanton-Gerber Hall, Building 178

**Attendance**

**Voting Members**

Ramsey McGowen, PhD, Chair  
Caroline Abercrombie, MD  
Martha Bird, MD  
Stephen Geraci, MD  
Jennifer Hall, PhD  
Dave Johnson, PhD  
Paul Monaco, PhD  
Jason Moore, MD (via phone)  
Jerry Mullersman, MD, PhD, MPH  
Robert Schoborg, PhD  
Omar McCarty, M3  
David Cooper, M2  
Hunter Bratton, M1

**Ex Officio Voting Members**

Rachel Walden, MLIS

**Ex Officio Non-Voting Member**

Kenneth Olive, MD, EAD

**Non-Voting Members & Guests**

Robert Acuff, PhD  
Brian Cross, Pharm D  
John Schweitzer, MD  
Cindy Lybrand, MEd  
Cathy Peeples, MPH  
Lorena Burton, CAP

Shading denotes or references MSEC ACTION ITEMS

Dr. McGowen called the meeting to order at 3:31 pm with a quorum.

**1. Approve Minutes of August 16, 2016 – Announcements**

The August 16, 2016 minutes were approved as drafted. Dr. McGowen welcomed two new MSEC members. Dr. Robert Schoborg, Biomedical Sciences and Hunter Bratton, M1 student representative; both begin their term as of today's meeting. Dr. McGowen reminded members of next month's Retreat, with lunch being served at 11:30 am and the Retreat starting at 12:00 noon. During the Retreat we will receive and discuss our first preliminary reports from each Implementation group.

**The August 16, 2016 minutes were approved as drafted.**

## 2. Announcements

### HIPAA Policy

Dr. Olive presented revisions to the *Health Insurance Portability and Accountability Act (HIPAA)* policy identified to our medical students in the *Student Catalog*. The HIPAA policy protects the health information of individuals and medical students that are routinely exposed to *Protected Health Information (PHI)* during clinical rotations. Lindsay Daniel, ETSU HIPAA compliance officer, made a few suggestions which were approved by the Faculty Advisory Council and these changes are now brought to MSEC for information. Ms. Daniel suggested that the ETSU HIPAA office be identified in the policy and that the levels of violations (I, II, & III) be replaced with examples of HIPAA violations that could result in disciplinary action. These range from verbal counseling through dismissal from medical school based on the severity of the violation. Dr. Schweitzer commented that looking at our **own** Protected Health Information (PHI) seems to catch most people off guard. Dr. Olive agreed that a statement needs to be added at the end to the example violation that says “*Unapproved accessing of PHI when the student is not involved in the care of the particular patient*” so that it reads “**Unapproved accessing of PHI when the student is not involved in the care of the particular patient, e.g., accessing your own medical records**”. Dr. Olive will make the change and notify the Faculty Advisory Council of the change before being published.

*The HIPAA Training, Violations and Disciplinary Action Policy is identified in the meeting document links found at the end of the minutes.*

### STEP Scores

Dr. McGowen presented the recent STEP Scores received for our current COM students. There was only one (1) STEP 1 failure and the current mean is 230. Last year’s QCOM mean was 221/National was 229. The STEP 2 CK mean is 240 with last year’s QCOM mean at 237/National was 242. There are some STEP 2 scores not yet received as the students are taking the exam later. Many areas contributed to this success – students studying hard, faculty paying attention to course content, NBME policies, grading policies, MSEC’s work with the CBSE, etc. **Everyone is to be congratulated for this effort and success!** MSEC discussion confirmed that all faculty be sent the summary STEP scores with confirmation of a job well-done.

*The STEP Score summary presented to MSEC is identified in the meeting document links found at the end of the minutes.*

## 3. Curriculum Integration Subcommittee

Dr. Olive announced that Dr. John B. Schweitzer, MD, has agreed to chair the Curriculum Integration Subcommittee (CIS). The subcommittee membership is being updated as well and the subcommittee should resume regular activity soon.

## 4. Curricular Content Query: Preventive Care

Dr. Olive reviewed a curriculum content query from extracted data from the curriculum database on the subject of preventive care. He reminded MSEC that a successful query on data is dependent on identification of “keywords” or “key phrases/USMLE strings” identified by course and clerkship directors in their objectives and mapping of covered topic material.

He reviewed sections of the LCME standards and Data Collection Instrument (DCI) that pertain to the need for MSEC to review curriculum content, including LCME Standard 7.2 (which identifies Preventive Care as one of several required content areas). He also reviewed our Institutional Educational Objectives which related to the specific topic of preventive care. These include 1.7, 1.8, 1.9, 2.3, 2.4, 3.8, 3.9, and 6.3.

Examples given where courses/clerkships cover Preventive Care (identification is dependent on the tagging of topic content) included: Cell & Molecular Medicine, Communication Skills, Physiology, POM:PPS, Immunology, Intro to Clinical Psychiatry, Pathology, Microbiology/Virology, Practice of Medicine, Pharmacology, Surgery, Transitions to Clerkships, Family Medicine, Pediatrics, Psychiatry, Internal Medicine, and OB-Gyn.

A second query was done on course/clerkship learning objectives produced additional results for coverage of Preventive Care related material. Yet another review of data from the Graduation Questionnaire (GQ) produced little results as the GQ no longer asks students about Preventive Care coverage in the curriculum.

The LCME DCI Table 7.2-1 requires us to respond with data supplied by the independent student analysis in each year/phase of the curriculum for:

- Education to diagnose disease
- Education to manage disease
- Education in disease prevention
- Education in health maintenance

MSEC discussion concluded that we do have quite a bit of Preventive Care content, beginning with basic sciences through to our preparation of resident interns. MSEC student member, Omar McCarty, confirmed Preventive Care coverage is good and he is confident about being able to discuss Preventive Care in the clinical setting. Dr. Abercrombie identified that this year the Transition to Clinical Clerkships course had increased the number of sessions on Preventive Care, but the curriculum database had not been notified of the updates.

*The Content Query: Preventive Care report is identified in the meeting document links found at the end of the minutes.*

## **5. Graduation Questionnaire Summary**

Dr. Olive presented a Power Point summary of the results from the 2015 Graduation Questionnaire (GQ). Overall, 93% of students polled strongly agreed/agreed that they were satisfied with the quality of their medical education received at QCOM. Dr. Olive walked through each of the student responses to individual questions covering: clinical relevance, clinical experiences integrating basic science content, individual course preparation for clerkships, quality of education experiences in clerkships, observation of skills performed, specific areas of responsibility, value of Veterans clinical training, and elective or volunteer activity. The Psychometric scales were better than national average in emotional climate, student-faculty interaction, tolerance for ambiguity, and exhaustion and at national average in empathy and disengagement.

The GQ included questions about awareness, knowledge, and types of experiences related to Mistreatment and professional behaviors/attitudes demonstrated by faculty. Also included are offices/facilities/services available to students. The response rate of students to all GQ questions was good, with overall positive results. Those areas where weakness was identified are not surprises to us and confirmed there are growth opportunities for us.

*The Graduation Questionnaire Summary is identified in the meeting document links found at the end of the minutes.*

## **6. Administrative Policy: Medical Student Performance Evaluation (MSPE)**

Dr. Olive introduced an Administrative policy that will guide Academic Affairs process for creating a student's MSPE letter. The process was developed to meet two (2) LCME Standards:

### **11.4 Provision of MSPE:**

*A medical school provides a Medical Student Performance Evaluation required for the residency application of a medical student only on or after October 1 of the student's final year of the medical education program.*

### **11.6 Student Access to Educational Records:**

*A medical school has policies and procedures in place that permit a medical student to review and to challenge his or her educational records, including the Medical Student Performance Evaluation, if he or she considers the information contained therein to be inaccurate, misleading, or inappropriate.*

The MSPE letter is made available to Residency Directors for those students applying to their program. It is not meant to be a letter of recommendation, but rather a summation of the student's performance and activities during their medical school years. It is a "snapshot in time" and is not changed after finalized.

Each year between May and July, Dr. Olive, EAD, meets with each upcoming M4 student and reviews their curricular vitae (CV) and personal statement as well as the student's progress thus far through medical school to include clerkship period grades. The student is expected to be professional dressed and prepared to participate in a "mock residency interview". The student does have the option to request another appropriate individual to develop their MSPE if they feel there is a conflict of interest with the EAD's development of the MSPE.

MSEC discussed the "ranking terminology" that is used in the MSPE letter. Each school identifies its own ranking system and defines what is mean in each category (e.g., by outstand or excellent).

**There were no identified changes by MSEC suggested for the Administrative MSPE Policy.**

*The Medical Student Performance Evaluation Administrative policy is identified in the meeting document links found at the end of the minutes.*

## 7. LCME Standard and Elements 8.5 and 8.6

Dr. Olive presented LCME Standards 8.5 and 8.6 to include the Standard description, requested Narrative Response, Documentation required, and the LCME Survey Team questions that will need responses by College of Medicine.

### **Standard 8.5**

**Description:** *In evaluating medical education program quality, a medical school has formal processes in place to collect and consider medical student evaluations of their courses, clerkships, and teachers, and other relevant information.*

**Narrative Response:** *Describe how and by whom evaluation data are collected from medical students on course and clerkship quality. Provide three recent examples of how student feedback has led to changes in the medical curriculum.*

*Describe whether medical students provide evaluation data on individual faculty, residents, and others who teach and supervise them in required courses and clerkship rotations.*

**Documentation:** *A copy of any standardized forms used by students in the evaluation of courses and/or clerkships. If there are no standardized forms, provide sample forms for individual courses and clerkships. Note if the forms are completed online or on paper. The response rates to questionnaires completed by students during the most recently-completed academic year for each course and clerkship where student evaluation data are collected.*

**Survey Team:** *Describe how student evaluations of courses and clerkships are conducted. Note whether and how medical students provide evaluation data on individual faculty, residents, and others who teach and supervise them in required courses and clerkship rotations. Note if standardized evaluations are used for courses and clerkships. Comment on the level of student participation in these evaluations. Provide examples of how student feedback has led to changes in the medical curriculum. Provide data from the ISA on student satisfaction with the school's responsiveness to student feedback on course/clerkships.*

### **Standard 8.6**

**Description:** *A medical school has in place a system with central oversight that monitors and ensures completion by all medical students of required clinical experiences in the medical education program and remedies any identified gaps.*

**Narrative Response:** *Describe the process(es) used by students to log their required clinical encounters and skills. Is there a centralized tool used for logging or do individual clerkships use their own systems? Summarize when and how each student's completion of clerkship-specific required clinical encounters and skills is monitored by the following individuals, including whether the results of monitoring are discussed with the students as part of a mid-clerkship review:*

1. *The student's attending physician, supervising resident, preceptor*
2. *The clerkship director*

*Summarize when, how, and by whom aggregate data on students' completion of clerkship-specific required clinical encounters and skills is monitored.*

*Describe how data on completion rates are used by clerkship directors and the curriculum committee and/or a relevant curriculum subcommittee.*

**Documentation:**

<b>Table 8.6-1   Alternative Clinical Experiences</b>			
Provide all required clinical encounters/skills for each listed clerkship that were satisfied with alternative methods by 25% or more of students in the most recently-completed academic year, and describe what the alternative methods were (e.g., simulations, computer cases). Add rows as needed. Only schools with regional campuses need to specify the campus for each clerkship. Refer to element 6.2 for the list of required clinical encounters/skills.			
	Campus	Clinical Encounters/Skills where Alternative Methods were Used by 25% or More Students	Alternative Method(s) Used for Remediating Clinical Encounter Gaps
Family medicine			
Internal medicine			
Ob-Gyn			
Pediatrics			
Psychiatry			
Surgery			

**Survey Team:** *Note the process(es) used by students to log their required clinical encounters and skills. Is there a centralized tool used for logging or do individual clerkships use their own processes/systems? Describe how, when, and by whom student clinical encounters and procedures are monitored and describe how data on completion rates are used by clerkship directors and the curriculum committee/relevant subcommittee(s).*

MSEC concluded that both LCME Standards are sufficiently addressed in the COM curriculum and we have processes in place that will allow COM to respond to provided needed documentation.

*The LCME Standard and Elements PowerPoint for 8.5 and 8.6 is identified in the meeting document links found at the end of the minutes.*

**8. Administrative Review Reports**

**Internal Medicine (IM) Inpatient Sub-internship Selective – Dr. Ibrahim, Course Director**

Dr. McGowen presented the completed Administrative review of the IM Sub-internship Selective. There is no syllabus for this selective, but an information sheet that provides a good summary of the course expectations is provided to the student. The course objectives are identified on the course description form and are mapped to the Institutional Educational Objectives. There were no recommended changes by the M3/M4 Subcommittee in 2014-2015, but MSEC did feel it was worthy to note that increasing the level of student responsibility, establishing a service at the VA of a one-on-one student and attending team, and continued development of the academic half-day were areas to continue to review. Formation of a lead resident paired with a student has been deemed as a strength of the course and has increased student responsibility.

Weaknesses noted were the absence of stable VA service preceptors which impeded continuity of the learning experience. The establishment of the Lead Resident Sub-I Team has helped satisfy this need. All students passed with the exception of one which was identified early in the rotation and the IM faculty are to be applauded for recognizing the serious issue of the student that prevented completion of the course. The overall student evaluation of course score was 4.22/5.0. The teaching faculty received positive evaluations from the students completing the course.

#### **M4 Elective-Selective Summaries**

Dr. McGowen began by identifying that the M4 Elective-Selective courses are reviewed on a yearly basis as part of MSEC's Periodic and Comprehensive Evaluation of the Curriculum. The curriculum has fifty-two (52) electives taken by the students with a range of one (1) to fifty-six (56) students participating in each elective. The overall range of evaluations of the electives was 3.0 to 5.0 with 75% above 4.5 and 35% were 5.0. The comments were uniformly positive with no significant problems identified. The most frequently taken electives were: Medical Humanities with 56% and Anatomy CT & Cross Sectional with 55%. The most frequent clinically based electives were: Anatomical Surgery with 20%, Advanced Physical Diagnosis at 17%, Emergency Medicine at 14%, and End of Life Care at 13%.

The curriculum's selective options are categorized into Intensive Care (Category A), Sub-internship (Category B), and Ambulatory (Category D). The overall range of evaluations of the selective courses was 3.5 to 5.0. The strengths identified were the faculty and resident teaching and the responsibilities given to the students. Weaknesses included EHR limitations and low census (down time). Across all selective options the teaching faculty evaluations were identified as good. Our review process for the elective and selective courses satisfy COM compliance with LCME 8.5.

**Both reports were accepted by MSEC as delivered.**

*All course Administrative reviews are identified in the meeting document links found at the end of the minutes.*

#### **9. Away Rotations Approved to Include Selective Options**

Cathy Peebles provided a summary of the 105 away-electives of which 56 of our 69 - M4 students have scheduled. This includes 28 away-electives that have been approved as selective options. The AAMC Visiting Student Application Service (VSAS) has received 921 applications from our COM students (students are able to submit several requests for the same elective, but for different weeks of delivery which enables a student to drop and/or pick up an elective as their schedules change with interview appointments). The away-electives approved as a selective include 15 Intensive Care, Category A, selective options; 11 Inpatient Sub-internship, Category B, selective options; and 2 Ambulatory, Category D, selective options. The away-electives range from 1 to 26 rotations for each category.

MSEC members inquired about the student evaluations completed by the away course directors and whether there was any type of comparison made between the COM student and other students completing the away rotation.



Ms. Peeples explained that the COM evaluation of student form is given to the student and they are asked to have it completed. Many times the away institution will complete both their own evaluation form and the COM form and return to us. There is a comment box provided on the COM evaluation form where the away course director can comment on the student's performance to include comparison with other students. As the current review of the COM evaluation form is completed an additional question could be added if needed. Ms. Peeples confirmed all COM students are able to view their completed evaluation forms for all COM courses and clerkships.

*The summary of Away Rotations Approved to Include Selective Options is identified in the meeting document links found at the end of the minutes.*

#### **10. Sub-internships Core Objectives / Mapping / Keywords**

Dr. McGowen introduced the next presentation of generic course expectations for selective courses and asked that MSEC keep in mind as they receive and review the information that they will need to accept or modify the generic course expectations either today or at the MSEC meeting in October.

Cathy Peeples lead MSEC through each of the selective categories and generic course expectations to include objectives, Institutional Educational Objectives/EPAs, and educational and assessment methods. For all selective categories students are expected to participate at the level of an intern. The generic course expectations introduced were:

**Critical/Intensive Care A Selective:** *Under direct faculty and/or senior resident supervision, students should be given primary responsibility for patient care and begin to act independently during the fourth-year rotation. Primary responsibility for patient care will help foster the students' ability to think critically, assess their knowledge and skills, and allow them to make clinical decisions affecting patient care.*

**Inpatient Sub-internship B Selective:** *Students will participate on the team in a sub-internship role under the supervision of the senior medical resident, taking responsibility for patient care including: initial history and physical exam; data gathering and interpretation; developing an assessment plan; reliable presentations orally and in writing; and management as the primary provider throughout the hospital stay, managing common pathology, and interacting with specialists, families, and colleagues. The student is expected to follow a patient panel size defined by the specialty.*

**Ambulatory Care D Selective:** *This elective will provide the student with clinical exposure in the ambulatory setting to a variety of medical experiences relevant to the specialty with emphasis on diagnostic and therapeutic decision making; development of their clinical skills in the ambulatory setting gaining exposure to the continuity of care experience; and provide instruction to patients in health maintenance, disease prevention, and relevant clinical epidemiology.*

Dr. Olive asked MSEC to also be prepared to discuss and identify whether we should limit Ambulatory Care selective options to only primary care or allow our students to fulfill the requirement with any ambulatory care specialty / experience. The generic course expectations will be forwarded to MSEC members for review prior to the October meeting.

**MSEC agreed that review of the generic course expectations is needed and will be prepared to vote at the October meeting to adopt or modify the general course descriptions for the selective requirements as well as provide a decision on whether to limit selective options to primary care only.**

*The Sub-internships Core Objectives / Mapping / Keywords Generic Course Expectations are identified in the meeting document links found at the end of the minutes.*

#### **11. Research Report: David Cooper: Knowledge and attitudes towards students use of external educational resources**

MSEC M2 member, David Cooper, presented his recently completed research project on the use of outside educational resources by medical students and the knowledge and attitudes of both students and faculty regarding this use. Objectives of his research were:

- To determine the use of external educational resources by medical students in the pre-clerkship curriculum.
- To determine preclinical clerkship medical faculty knowledge and use of external educational resources in the pre-clerkship medical curriculum.
- To determine how student and faculty use of external educational resources in the pre-clerkship medical curriculum correlate or differ.

Questions or areas covered in the survey and asked of both student and faculty were:

- Do you think it would be helpful if faculty knew which external resources were being used by students?
- Familiarity with the external educational resources that students use in the preclerkship year.
- What is the first resource used- asked of both students and faculty (provided list of resources provided)?
- Usage of review books- asked of both students and faculty (provided list of basic science courses).
- Which resource should be included in the financial aid package (provided list of resources)?
- Course specific exam questions (provided list of basic science courses)
- Why do students use external resources (provided list of basic science courses)?

*The entire research project PowerPoint is identified in the meeting document links found at the end of the minutes.*

#### **12. Family Medicine Grade Scale**

Dr. Moore, Family Medicine (FM) Clerkship Director, asked MSEC to reconsider the adopted NBME subject exam grade scale with regards to FM and how it will affect the Family Medicine student's final clerkship grade for this academic year. Dr. Moore addressed MSEC by phone from his duty position in Bristol.

Dr. Moore's concern was with any Family Medicine clerkship student having to retake the clerkship if they received an F grade based on poor NBME exam performance and proposed that a D grade be issued based on lack of experience with the NBME Family Medicine modular exam prior to this year. He was under the impression that there was a low cutoff score that students had to meet to pass a clerkship.

Prior to this academic year, the clerkship used a department developed exam derived from the fmCases quiz bank. It was not clear how the lower end score cutoff might affect a student's final grade when it was agreed to use the NBME subject exam.

Dr. Olive noted that there is no lower end cutoff for the NBME subject exam to pass a clerkship, but the scores are curved at the lower end. With the MSEC approved 15% grade component for Family Medicine Clerkship NBME subject exams for this academic year; there would be no students who would fail the clerkship based solely on their NBME score. They would have to have received low scores in all of the other grade components including the OSCE and preceptor evaluations. MSEC pointed out that the other clerkships do not allow a retake of the exam or other work to be completed if a student receives an F grade. The student must retake the entire clerkship.

MSEC discussion continued with Dr. Moore asking that a 10-point curve be added to all received NBME scores, in addition to maintaining the 15% grade component for Family Medicine clerkship, thus an NBME score of 53 would equate to a score of 63 and 15% would be applied for a final NBME percent of grade.

MSEC was concerned with those students who may be at risk of failing a clerkship and whether adding a 10-point curve to NBME scores would continue to identify these students. Dr. Moore reminded MSEC that the Family Medicine clerkship also administers an OSCE (25% grade component) which captures the student's knowledge and skills in other areas and would allow for identification of students who may be at risk of failing the clerkship.

Dr. Olive suggested that the equated percent correct score on the NBME exam be used, but Dr. Moore felt that if an equated percent score of 90 equals 99 percentile (but the student receives a score of 90) adding a 10-point curve to the equated percent score makes the 90 equal to 100. On the low end a score of 54 would be 64. In the past year there were students who had to remediate the exam based on their score, but they did not have to retake the clerkship. MSEC confirmed with Dr. Moore what he had used for this academic year Period 1 NBME exam scores.

**Dr. Monaco made a motion to allow Family Medicine to use the NBME equated percent correct score and add a 10-point adjustment to the score. There will be no identified low grade cutoff. This will be in addition to this academic year's approved 15% grade component for Family Medicine NBME subject exams. Dr. Johnson seconded the motion with MSEC majority voting to approve and two (2) members abstaining from vote.**

**Family Medicine will review grades over the remaining academic year clerkships and come back to MSEC in the spring semester of 2017 with outcomes of clerkship grades to include a comparison of NBME grades and prior year fmCases examination grades as well as a decision on Family Medicine's continued use of NBME subject exams for the clerkship.**

### 13. Standing Agenda Item: Subcommittee, Working Groups & Technology Updates

No comments.

The meeting was adjourned at 5:44 pm.

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### MSEC Meeting Documents

Window users will connect to the files in the Shared T Drive at: T:\Shared\Curriculum Management\MSEC Meetings; Membership;Subcommittees\MSEC Minutes; Documents

For MAC users you will need to connect to the ETSUFS2 server and then navigate to the T:\Shared folder and then navigate through to the Curriculum Management\MSEC Meetings; Membership;Subcommittees\MSEC Minutes; Documents

- [1. August 16, 2016 Minutes](#)
- [2. HIPAA Policy](#)
- [2. STEP Scores](#)
- [4. Curricular Content – Preventive Care](#)
- [5. Graduation Questionnaire](#)
- [6. MSPE Policy](#)
- [7. LCME 8.5 and 8.6 Review](#)
- [8. Administrative Review – IM Subinternship Selective](#)
- [8. M4 Elective Selective Summaries](#)
- [9. Away Rotations Summary](#)
- [10. Subinternship Generic Objectives/Mapping](#)
- [11. Research Report – Knowledge and attitudes towards students use of external educational resources](#)

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### Upcoming MSEC Meetings

Tuesday, October 18 – **Retreat** – 11:30-5:30 pm

Tuesday, November 8 – 3:30-6:00 pm\*

Tuesday, December 6 – 3:30-6:00 pm\*

Tuesday, January 17, 2017 – **Retreat** – 11:30-5:30 pm

Tuesday, February 21, 2017 – 3:30-6:00 pm

Tuesday, March 21, 2017 – 3:30-6:00 pm

Tuesday, April 18, 2017 – 3:30-6:00 pm

Tuesday, May 16, 2017 – 3:30-6:00 pm

Tuesday, June 20, 2017 – **Retreat** 11:30-3:30 pm/**Annual Meeting** 3:30-5:30 pm

\*Note not on the 3<sup>rd</sup> Tuesday of the month due to holiday scheduling

### QCOM Faculty Meetings:

December 14, 2016 at 5:00 pm – large auditorium

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### TIME LINE: Program Evaluation to LCME Visit

2015-16 Review of the entire medical education program

2016-17 Implementation planning of identified curricular changes

2017-18 Academic Year reported on in Self-study Summary Report and DCI

2018-19 Complete Self-study Summary Report and DCI based on academic year 2017-18 data; begin process in March 2018

2019-20 Self-study Summary Report and DCI due to LCME spring 2019 with site visit fall 2019