10-18-2016

2016 October 18 - Medical Student Education Committee Minutes

Medical Student Education Committee, East Tennessee State University

QUILLEN COLLEGE of MEDICINE
EAST TENNESSEE STATE UNIVERSITY

Medical Student Education Committee - MSEC

The Medical Student Education Committee of the Quillen College of Medicine met for a Retreat On Tuesday, October 18, 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
Stephen Geraci, MD
Jennifer Hall, PhD
Dave Johnson, PhD
Paul Monaco, PhD
Jason Moore, MD
Robert Schoborg, PhD
Jessica English, M4
Omar McCarty, M3
David Cooper, M2
Hunter Bratton, M1

Ex Officio Voting Members
Theresa Lura, MD
Rachel Walden, MLIS

Ex Officio Non-Voting Member
Kenneth Olive, MD, EAD

Non-Voting Members & Guests
Robert Acuff, PhD
Jennifer Gibson, MD
John Schweitzer, MD
Cindy Lybrand, MEd
Mariela McCandless, MEd
Cathy Peeples, MPH
Sharon Smith, CAP
Lorena Burton, CAP

Shading denotes or references MSEC ACTION ITEMS

1. Approve Minutes of September 20, 2016 – Announcements:

The September 20, 2016 minutes were approved as drafted and distributed with the MSEC meeting reminder.

Dr. McGowen reminded MSEC that the next meeting will be Tuesday, November 8th. This is a change from our normal every 3rd Tuesday meeting date.

Dr. Monaco made a motion to approve the September 20, 2016 minutes as drafted and Dr. Geraci seconded the motion. The motion was unanimously approved.

MSEC meeting minutes of September 20, 2016 are found in a link at the end of the minutes.

2. Selectives Generic Course Expectations / Objectives:

- Feedback Ambulatory Care Selective Options (Primary Care/Ambulatory Care Specialty

Generic course expectations and objectives (presented initially at the September 20, 2016, MSEC meeting) for 4th year Selectives that students may take for credit when completing away Selectives were discussed.

Cathy Peeples reviewed the current policy that allows students to receive selective credit for one (1) away elective. Selective credit can be taken in any category (Critical /Intensive Care [A], Inpatient Sub-Internship [B], or Ambulatory Care [D] categories). All students are required to participate in one required selective in the fall semester (June 27-October 21) with the remaining in the spring semester. A related question posed at the last meeting was whether Ambulatory Care (D) options should be restricted to Ambulatory Primary Care.

Ambulatory Care options at Quillen include: Family Medicine (FM), Internal Medicine (IM), OB/GYN, Pediatrics and Pediatrics-Adolescents, Psychiatry, Surgery Ambulatory Clinic plus several options for Rural Primary Care Tract (RPCT) students & the Rural Primary Care option for non-RPCT students: Johnson City Community Health Center; Rural Advanced FM Procedures; Rural Emergency Room; Rural FM; Rural Sports Medicine; Rural Geriatrics, and Rural Maternal & Child Care.

A list of pros and cons and a recommendation from the Program Evaluation Implementation Group 2 related to the Ambulatory Care Selective credit for away rotations were provided. MSEC discussed options including using the specific Ambulatory Care Selective settings currently approved for credit at QCOM as the basis for what should be approved for away rotation Selective credit.

MSEC discussed questions related to the generic description for Critical / Intensive Care, including the appropriateness of the objective related to "*the use and interpretation of invasive and non-invasive physiologic monitoring*" and students *"entering and discussing / prescribing prescriptions"* in the Critical / Intensive Care setting. A concern is that we may be setting expectations for the Critical Care / Intensive Care rotation too high for both our own rotations and away rotations. Revised wording for these objectives was discussed.

Dr. Monaco made a motion to accept the generic course expectations, objectives, IEO/EPA addressed, and the Educational Method and Assessment Method for the A, B, and D selective categories. This is to include a change to the Critical / Intensive Care (A) Selective description from "*use and interpretation of invasive and non-invasive physiologic monitoring"* to "*understand and interpret the findings of invasive and non-invasive physiologic monitoring"*. The motion was seconded by Dr. Geraci and unanimously approved. The Critical / Intensive Care (A) Selective will be performed in a Level I or Level II Trauma center.

Dr. Abercrombie made a motion to approve an equivalent away selective to that offered by COM for an Ambulatory Care selective. The decision on whether the away selective is equivalent will be made by the Executive Associate Dean for Academic and Faculty Affairs (EAD). The motion was seconded by Dr. Moore and unanimously approved.

The Generic Course Expectations for All Selective Courses are found in a link at the end of these minutes.

3. Program Evaluation - Approved Priority Action Plan - Priority 14: MSEC Action: Narrative Assessment and Formative Feedback Policies:

Dr. McGowen opened the discussion on Narrative Assessment and Formative Feedback policies that were distributed for review with the MSEC minutes.

Dr. Olive explained that to eliminate any confusion two (2) separate policies were created, even though there is some overlap between concepts in the policies.

The **Narrative Assessment Policy** addresses LCME Element 9.5 Narrative Assessment which states: ***A medical school ensures that a narrative description of a medical student's performance, including his or her non-cognitive achievement, is included as a component of the assessment in each required course and clerkship of the medical education program whenever teacher-student interaction permits this form of assessment.***

The policy statement identifies a narrative assessment as being a written narrative description of a medical student's performance, including his or her non-cognitive achievement. It will be included as a component of the assessment in each required course and clerkship of the medical education program whenever teacher-student interaction permits this form of assessment.

MSEC previously designated which pre-clerkship courses would require a narrative assessment and included all clerkships. Documentation of the feedback will be provided via New Innovations for archival purposes and accessibility for inclusion in each student's Medical Student Performance Evaluation (MSPE).

The **Formative Feedback Policy** addresses LCME Element 9.7 Formative Assessment and Feedback. MSEC discussed the rationale for, importance of, and appropriate documentation of compliance with these policies.

MSEC discussion / clarification centered on when / how formative feedback is to be documented. New Innovations will be used as the mechanism for narrative assessment in addition to being used for documenting mid-clerkship feedback. If the feedback in any course or clerkship concerns a student's low performance and / or failing grade then the documentation is to be formal with a written letter to the student and a documented meeting between the student and course / clerkship director is placed in the student's file.

Dr. Moore made a motion to approve both the *Narrative Assessment* and *Formative Feedback* policies with the *E. Remediation* title to be renamed *E. Notification of Remediation.* Dr. Abercrombie seconded the motion. The motion was unanimously approved.

The Narrative Assessment and Formative Feedback policies are each found in a link at the end of the minutes.

3. Step 1 Scores Comparison to M2 CBSE:
Dr. Olive presented two (2) years (class of 2017 and 2018) of data for individual student scores from the M2 CBSE and Step 1 exams (student identifiers were removed). The higher scores received on the CBSEs seem to correlate to the higher Step 1 scores. The comparison includes the CBSE score, the number of students receiving that CBSE score, the Step 1 equivalent score, and the actual Step 1 score. This information has been helpful to get the student's attention to the predictability of their Step 1 scores based on their CBSE score. Overall the CBSE score is a good predictor of how a student will do with the Step 1 exam. MSEC asked if this encouraged students to study more and Dr. Olive stated, "yes, we had only one (1) Step 1 failure in the first group taking the exam this year. There may have been other factors that influenced their performance, but it is felt that this information played a significant role in the student's study habits and performance."

The Step 1 Scores Comparison table is found in a link at the end of the minutes.

4. Outcomes Subcommittee Quarterly Report:
There were nineteen (19) benchmarks scheduled for review this quarter, however for six (6) of them, the New Innovations system was not functional in its reporting for us to complete the analysis. The Outcomes Subcommittee will report on them with the next quarterly report.

There was no new data available for two (2) of our new benchmarks.

Dr. McGowen presented each of the remaining Quarterly Benchmarks. For two benchmarks, minor changes in the benchmark measure were needed because of changes in how the data was collected, but these do not substantively change the measure. For the benchmark on Interprofessional Collaboration, a new benchmark is needed since the former measure was based on the Graduation Questionnaire, which has been changed and no longer provides the information needed. All benchmarks were met except for the finding that student satisfaction reported on the GQ indicated possible concerns with a few courses / clerkships. In addition, while the previous measure for the Interprofessional Collaboration benchmark is no longer available, information was presented from the Program Director's Questionnaire and the Resident's Questionaire (our graduates) that indicate our students perform well in this area.

The Outcomes Subcommittee did not recommend additional action by MSEC at this time. The courses were either taken by these seniors several years ago and more recent data indicates concerns have been addressed or there is evidence that efforts are in place to address the concerns; however student satisfaction will be monitored to see if improvements occur.

Outcomes Subcommittee Recommendations:

1. Rural Track Program:

The Outcomes Subcommittee discussed MSEC's request for the development of a benchmark related to the Rural Track program. The Subcommittee found there is not a good database source at this time, but the Family Medicine Research Division is participating in a national project to collect performance data on Rural Track programs in medical schools. Data is not yet available. Outcomes Subcommittee recommends that the development of a Rural Track benchmark be postponed until data is available to determine what measurement options are available. It is expected that the Outcomes Subcommittee will be able to report on practice type (primary care versus specialty care) in the future with the assistance of the data Family Medicine will collect.

Dr. Schoborg made a motion to hold action on the approval of a benchmark related to the Rural Track Programs and the number of students practicing in rural areas until sufficient data is available. Dr. Geraci seconded the motion. The motion was unanimously approved.

1. Comprehensive Basic Science Exam (CBSE):

The Outcomes Subcommittee discussed the value to the students and the costs to the school in administering the CBSE to the M1s at the completion of their first year as well as to M2s at the completion of their second year. Anecdotal reports suggest students find the exams being given in both the M1 and M2 years helpful in preparing for Step 1. Administration finds that having more than one (1) year of data helps the student make a more informed decision about their readiness to take their Step 1 exam. MSEC agreed that having more than one year of data, to include category performance (score bands), would be beneficial. MSEC asked about Academic Affairs' practice of sending out letters to those students who had low NBME subject exam scores during the year with a recommendation to devote more study to particular categories of the curriculum.

MSEC suggested that the student's performance on the CBSE be added to this letter as additional information as well as correlate delivery of the CBSE results and the NBME subject exam score performance prior to the start of the M1 break when students will have eight (8) weeks to concentrate on those categories (bands) of the curriculum where they scored lower than others.

Dr. Schoborg made a motion to continue administering the CBSE in both the M1 and M2 years as currently delivered with scores used as formative feedback to the students. Dr. Geraci seconded the motion. The motion was unanimously approved.

3. Interprofessional Collaboration:

A new benchmark measure for Interprofessional Collaboration is needed as the question used to measure this benchmark has been dropped from the Graduation Questionnaire. There are several options for a new measure to include:

A. Adding a question to the Keystone student evaluation for this year.
B. Developing a benchmark based on the M3 student assessment form (incorporating EPAs).
C. Using data from the Residency Program Director's Annual Survey and the Graduate Survey completed at the end of the PG1 year (last year's data from both of the surveys was positive).

Dr. Olive pointed out that option B would allow us to respond to the LCME Data Collection Instrument (DCI) that asks how we assess on an individual student level, the student's accomplishment of interprofessional collaboration. MSEC discussion included a benefit to asking this question of students when they are at the end of their educational training, i.e., 4th year / Keystone course and / or the first year of residency. The individual is able to have more experiences to draw from in their response. We may be able to use a couple of the options and look at the question from a couple of ways. There was some concern about the response rates we have had from option C and whether the responses could be beneficial. Dr. McGowen reminded MSEC that benchmarks are meant to hold us to external measures and using option C would allow our PG1 residents to be compared to other residents / schools. By using a couple of options we can see a correlation between the data and in future years one of the options might be able to be dropped.

Dr. Schoborg made a motion to employ both option B: "*Developing a benchmark based on the M3 student assessment form (incorporating EPAs)*" and option C: "*Using data from the Residency Program Director's Annual Survey and the Graduate Survey*" to develop a new benchmark. Dr. Geraci seconded the motion. The motion was unanimously approved.

Dr. Moore commented on the use of the Professionalism form and asked if there was not a conflict with Outcomes setting a benchmark that seems to say that minimal use of the form is better (<10% benchmark), yet course faculty and staff are encouraged to use the form. Dr. Olive stated that appropriate use of the form as formative feedback is more beneficial than not using the form.

When the benchmark was set it was not known how we would measure up to the benchmark. The benchmark is also an indicator of whether we have a professionalism issue that needs to be investigated further. Outcomes Subcommittee does support the use of the Professionalism form when it is indicated.

The Outcomes Quarterly Report is found in a link at the end of the minutes.

5. Revised Policy for Periodic and Comprehensive Review of the Curriculum:
Dr. McGowen confirmed that we have just finished our Periodic and Comprehensive Evaluation of the Curriculum and one of the areas we have identified is that our policy for review of the curriculum does not refer to how we review phases of the curriculum, which is an LCME requirement. We are to have a specified frequency and process for reviewing not just the components parts (courses and clerkships) or the curriculum or as a whole, but those logical portions that should be horizontally integrated. The Review Subcommittee Chairs and Administrative staff have looked at what administratively it would mean to adopt one way of reviewing phases versus another and ultimately this is MSEC's decision. MSEC needs to answer two questions in order to rectify this omission in our existing policy. Based on MSEC's discussion, the policy will be revised and brought back for approval and implementation.

Questions:

1. **How to define phases (time or function)** – given that they are to be logical portions of the curriculum that are integrated we could specify phases such as M1 and M2 term, and a M3 and M4 term or phase or preclerkship and clerkship phases. Another alternative is conceptualizing the phases by their educational function – a foundational phase, a core clinical phase, and then an individual educational phase. We have never done anything like this before and it is innovative and distinct, but it is not consistent with the way we have been accustomed to doing things so it is a little more complex.

   MSEC discussed options in detail and concluded that the specific goal / functionality of what we are doing be kept in mind and regardless of whether a method was innovative or not does not guide the decision, it is about what is needed to satisfy a need we have. Along those lines MSEC felt preclerkship / clerkship phases best define the types of courses that are delivered in those phases and it is functional. The AAMC / Medbiquitous terms identify phase in relation to the old "year" term. We may need committees looking at both preclerkship and clerkship along with separate committees looking at each year individually. The division by year (M1, M2, M3, M4) may be stages, not necessary a "year" definition.

Dr. McGowen asked MSEC to continue their discussion with the next question in mind.

2. **What is the process that should be used to conduct the phase reviews (who, when, what) -** Options include charging Phase reviews to the existing M1/M2 and M3/M4 Review Subcommittees, to the CIS Subcommittee or create additional Subcommittees. In addition, the option of phase reviews being coordinated administratively can be considered. Administration would still need to receive information from the existing committees, but it would not be the individual subcommittee's assignment to complete the Phase report. MSEC concurred with this option. There was discussion about what process to use. MSEC consensus was that each standing subcommittee should have input to the Phase review and that administrative staff should also be involved in developing the report that will be presented to MSEC. This may be each submitting a report to Administration or each submitting to each other M1 / M2 to M3 / M4, who submit to CIS, who then submits to Outcomes with Outcomes submitting to Administration, the outcomes of all subcommittees, or constitute a joint meeting of representatives from each standing subcommittee and administrative staff.

Dr. McGowen summarized both questions asked of MSEC and their discussion as there is a consensus for using M1 / M2 and M3 / M4 as phases of the curriculum and every (3) years a Phase report will be completed, and the process will be using the existing Review Subcommittees as compilers of overview information. Administration will take the summation of the discussion today and formulate a revised *Policy for Periodic and Comprehensive Evaluation of the Curriculum* to bring back to MSEC in November for review, revision if needed, and approval.

BREAK – 10 minutes

7. Program Evaluation – Approved Priority Action Plan – Priority 12 & Multiple Institutional Educational Objectives: Administrative Lead: Portfolios

Priority action items previously adopted by MSEC included some actions determined to be more administrative than instructional. One of these involved adoption of portfolios. Dr. Olive presented suggestions and examples for how portfolios might be used with priorities that may be more of a *soft skill* accomplishment by the students.

Initially, Administration is proposing a portfolio system is that is more of a snapshot at a point in time that is appropriate to see how students have accomplished certain objectives. It is suggested that we begin with a pilot project for portfolios in the 3rd year of the curriculum. The pilot project will allow Administration to identify if we can successfully manage the submission and evaluation of the pilot group of student submissions in preparation of rolling this system out to the entire 3rd year class the next year. Ideally as we develop maturity with a portfolio system it would be good to implement the system over a period of time when students could begin at an earlier level and build up, but initially we begin with a pilot project in the 3rd year, with a select group of students. A rubric has been set up for each of the priority submissions and an Administrative staff member, Mariela McCandless, will be reviewing each for the main points to be included in each submission. Those submissions which do not seem to include the main points would then be reviewed further by Faculty for feedback to the student.

Dr. Olive walked through several of the Institutional Educational Objectives and identified priorities for each that students would be asked to write responses for/to: 1.10, 3.4, 4.4, 5.2, 6.5, 6.6, 7.4, and 8.3. Each assignment submission should have required elements such as the setting, the audience, the behavioral role model and a summary reflection (what have you learned from this experience).

MSEC discussion included questions: where are the files that students submit going to be retained? Will later system implementation allow students to use the files for reflection and identification of experiences in role modeling, practice improvement, being in a consultative role, responsiveness to patient needs, participation identification of system errors, etc.? Dr. Olive responded that electronic documents are what we plan to implement, whether it is the D2L or New Innovations system, the students will have access to their submissions. Dr. Olive pointed out that what happens with the recommendations from Implementation Group 3 (Doctoring Course) may have some impact with the extent of how we eventually role this process out to the students. Dr. McGowen asked MSEC student members to comment on this proposal. Comments included concerns that students may struggle to see the value of the portfolio assignments and that care will be needed in presenting this to students to address such concerns. Omar McCarty, M3 representative, sees this as a preparation for residency interviews and a student would be able to keep the document submission updated throughout the 3rd year in preparation of their interviews in the 4th year. Other issues discussed included: assignments that require personal views could be used to support residency applications or to use with requests for recommendation letters that would allow those writing the letters to be more effective; the need to identify our purpose for a portfolio assessment system as either competency based or reflective; the demands associated with future rollout to all four (4) years; and the need for faculty development.

MSEC agreed with the initial rollout of a portfolio assessment method for the assessment of soft skills and to use a pilot with students in the 3rd year. A survey taken after the pilot will be considered to see how the portfolio system functioned and was adopted by the students. The survey results will come back to MSEC for discussion and action prior to implementation of a portfolio assessment method across the curriculum.

The Portfolio presentation documents are each found in a link at the end of the minutes.

8. Preliminary Reports: Program Evaluation – Approved Priority Action Plan – Multiple Priorities: Implementation Groups

Dr. McGowen introduced the preliminary presentation of each Implementation group proposing that each group present with questions for each group held until after all presentations are made. MSEC was reminded that while we are required to meet LCME accreditation standards, our purpose is to make recommendations to make our educational program be the best it can for our students. We are not looking at our curriculum to "check boxes" or have a certain number of hours; we are doing it to have the best possible curriculum and educational program that allows our students to become the best prepared medical students entering residency programs.

Implementation Group 1 (Preclerkship)

Rachel Walden, Chair presented the group's recommendations

Priority 5

1. Revisit scheduling and sequencing of years one (1) and two (2).
    a. Consider modifying current block structure.
    b. Revisit relative amount of content in years one (1) and two (2).
    c. Shorten duration of first year by two (2) weeks and second year by four (4) weeks.
    d. Develop a process for longer term improvements to curriculum (content, sequencing, integration) and faculty development across all four (4) years.

Short Term Recommendation

1. The short term recommendation to MSEC is to begin the M1 academic year in 2017-2018 on July 17, 2017, and the last day of the M1 academic year to be May 11, 2018. The M2 academic year will begin in 2018-2019 (the subsequent year) on July 9, 2018, and the last day of the M2 academic period on March 22, 2019. This will provide for a full six (6) week study period for STEP 1 preparation at the end of the M2 academic period and still allow M2 students to move into the Transition to Clinical Clerkships/3rd year Clerkships with no conflict.

The short term recommendations and strategies include:

- Shorten the duration of the M1 academic period by two (2) weeks from 41 weeks to 39 weeks.
- Shorten the duration of the M2 academic period by four (4) weeks from 39 weeks to 35 weeks.
- **Provide two options for each academic period with a recommendation that course directors review the options for feasibility prior to MSEC approval and implementation.**
- In an effort to be fair to all courses the contact time was reduced equally by determining the amount of time represented by **two (2) weeks of the M1 period as 5% and by four (4) weeks of the M2 academic period as 10%.**
- The number of hours used in the calculations were all hours associated with a course to include M1 and M2 **required and optional** lecture, lab, small group, out of class videos / assignments and assessment hours.
- The Preclerkship Scheduled Time and Workload Policy was kept in mind so that **none of the courses total recalculated hours per week would exceed 28 hours per week and no more than four (4) hours per day based in classroom lecture.**
- All hour and week determinations were rounded to the next whole number.
- The CBSE I and II are delivered on the last day of delivery of the academic period.
- A week-long fall break is incorporated into both M1 options.
- The M2 options have a 2-day fall break, but due to the shortening of the M2 academic year the spring break was eliminated.
- The time between the M1 and M2 academic periods remains at eight (8) weeks.
- **The time between the M2 and M3 academic periods is six (6) weeks to allow for a Step 1 study period.**

- The M1 Doctoring Course combines hours from Communication Skills for Health Professionals, Introduction to Physical Exam Skills, Profession of Medicine, and Career Explorations courses.
- Rural and Generalist Track Case Oriented Learning was not folded into the Doctoring course.

Long Term Recommendation

1. MSEC to form a subcommittee to examine the advantages, disadvantages, and feasibility of various curriculum models, including, but not limited to discipline based and organ system-based models, to determine if an extensive curriculum change is warranted at Quillen.
    a. It is recommended that the subcommittee be given four (4) years to present recommendations and have the recommendations vetted by the faculty, students, staff, and administration before implementation of recommendations in 2021.

The remaining priorities assigned to Implementation Group 1 will be delivered in the group's final report to be delivered in February 2017.

Implementation Group 2 (Clinical)

Caroline Abercrombie and Jessica English co-presented the group's recommendations. Tiffany Lasky, Chair, called in via phone.

Major Recommendation

1. Lengthen the M4 year by six (6) weeks
    a. M4 year would start six (6) weeks sooner – May 13, 2019 versus June 26, 2017.
    b. M3 year would start six (6) weeks sooner – May 4, 2019 with Transition to Clinical Clerkships course.
    c. M2 year would end six (6) weeks prior to Transition to Clinical Clerkships course.

Recommendations for 2017-2018 M4 Year

1. Implement Entrustable Professional Activities (EPAs) as the frame work for teaching and assessment in all M4 rotations.

2. Permit students to participate in up to three away electives without seeking prior approval while maintaining requirement for one required selective to be completed in the fall semester.

3. Increase the number of weeks students may participate in electives in the same specialty area from eight (8) to twelve (12) weeks. This is currently capped at eight (8) weeks.

4. Required Ambulatory Care Selective: Current Quillen Ambulatory Care selective options should remain the same, including General Surgery and Psychiatry.
    a. Requests for selective credit for an away rotation in this category will only be considered if it is an Ambulatory Primary Care rotation (FM, IM, Ob and Peds).

5. Need for additional ICU/Critical Care experience necessities being explored with our partnering medical centers.

6. Incorporate a required two-page write-up in each M4 Selective based on a patient care clinical question on EBM, Ethics/Medical Humanities, Patient Safety/QI, or a Cost Analysis of Services Provided.

Recommendations for 2017-2018 M3 Year
1. Implement Entrustable Professional Activities (EPAs) as the frame work for teaching and assessment in the M3 Jr. Clerkships.

2. For each EPA define the foundational pieces and identify where taught in the M1/M2 curriculum to ensure preparation for the clinical phase of the curriculum.

The recommendations and strategies include:
1. In 2018-2019 the M3 clerkships schedule is modified by reducing each clerkship period by one (1) week so clerkships end by April 26, 2019 versus June 22, 2018.

2. In 2019-2020 the M3 schedules would revert back to six (6) and eight (8) weeks and run May 13, 2019 to May 8, 2020.

3. In 2019-2020 the M4 year would begin May 13, 2019 versus June 25, 2018, six (6) weeks earlier than currently.

4. With a lengthened M4 year there is expanded time for away electives.
    a. Time for Step 2 study time, and time for residency interviews without the limitation of required rotations.
    b. Increase the number of required M4 weeks from 33 to 35 weeks.
    c. Add a required 2-week Emergency Rotation experience to be completed in either the M3 or M4 year.
    d. Create a 4-6 week sliding block for residency interviews when no other rotations are scheduled.

A list of Pros and Cons and projected schedules associated with each academic year's list of recommendations was reviewed with MSEC.

Implementation Group 3 (Doctoring Course)

Kenneth Olive, Chair presented the group's recommendations.

Recommendations
1. A Doctoring curriculum at Quillen should encompass the full four years of the program.

2. Current courses to be encompassed with this course should include:
    a. Profession of Medicine: Patients, Physicians, and Society
    b. Case Oriented Learning
    c. Introduction to Physical Exam Skills

d. Communication Skills for Health Professionals
e. Career Explorations I, II, III
f. Practice of Medicine
g. Clinical Preceptorships I & II
h. Transition to Clinical Clerkships
i. OSCE
j. Keystone Course
k. Consider including electives
   - Healer's Art
   - Medical Humanities
   - Medical Ethics
   - Medical Spanish
   - End of Life
   - MS4 Academic Medicine Elective

3. With the exception of the third year, the current number of total hours allocated to these courses is sufficient to deliver the curriculum.

4. Time should be shifted from year one to year two to allow better staging of content presentation.

5. Sessions should be scheduled throughout the third year at intervals of 4-6 weeks to address clinically relevant issues such as self-reflection, ethical issues, patient safety / quality improvement and interprofessional exposure.

6. Additional content to be incorporated includes:
   a. Ethics
   b. Quality Improvement
   c. System errors
   d. Clinical and translational research
   e. Critical judgment
   f. Evidence based medicine (not to include content covered in Biostatistics and Epidemiology course)
   g. Cultural competence
   h. Self-care
   i. Interprofessional – use of Cornerstone experience

7. Longitudinal placement of small groups

8. Maintain courses as separate or integrate into four (4) larger courses – one each year

9. Grading – Pass/Fail versus A, B, C.
10. Address resource issues

11. Naming of the course from Doctoring Course to "Becoming a Master Physician" or "Asclepius".

Each Implementation Group presentation document(s) is/are found in a link at the end of the minutes.

BREAK – 10 minutes

9. *Preliminary* Reports: Program Evaluation – Approved Priority Action Plan – Multiple Priorities: Implementation Groups

Discussion of each group's proposals were held after the presentations were made. MSEC questions and discussion included:

The requirement for the two (2) week mandatory Emergency Medicine rotation is based on the experiences an intern is exposed to in the emergency room. Implementation Group 2 felt it was a disadvantage to our students if they were not prepared for the experience. The requirement could be done while in either the M3 or M4 academic year. The main purpose is to have the student exposed to the patients and situations they may encounter in residency. It takes the student beyond taking the H&P into a triage and consultant role where the student would be involved in the decision-making process for admitting patients.

Implementation Group 2 clarified that to make scheduling work, a modified calendar will be needed for the initial year (transition to new calendar). During this year, the two (2) M3 elective options would not be cut, but rather each core clerkship will be shortened by a week. This includes the Jr. Clinical Experience which follows the Community Medicine rotation and Surgery's two week elective options currently scheduled following their six (6) week clerkship rotation.

Calendar year changes for the M1 academic year would begin with 2017-2018 academic year. Calendar changes for the M2 academic year would begin in 2018-2019. Calendar year changes for the M3/M4 academic years would begin with the 2018-2019 academic year. The entire Group 1 curriculum changes are predicated on acceptance of the M3/M4 curriculum changes.

The M4 curriculum changes to increase by four (4) weeks provides ~~the~~ time that the M4 students need to complete their educational requirements and still meet the residency program application and interview dates that continue to come earlier in the academic year. This would drive the need to end the M3 academic year earlier without cutting the M3 clerkships length. MSEC saw how decreasing the Surgery and Internal Medicine clerkships affected the student's NBME subject scores.

Increasing the M2 study period is important, but at the cost to bring M2 courses into the M1 year may not be the best option. There was a lot of discussion how best to align the courses in the M1/M2 years and whether stretching a course out over a longer period of time dilutes the content.

Our first job is to help our students be better doctors, not just get into the residency they want. We cannot know in advance how these changes will affect our students but we make the best informed decisions possible.

The important point we need to make is that we do not want the M1/M2 course directors to continue teaching the same material in a shorter time. Each course director needs to seriously look at how they can teach the material needed in the condensed time-frame.

From a student perspective our curriculum escalates in the same time period when the students need time to focus on studying for Step 1. The changes to the M1/M2 academic years seem to address this escalation.

Implementation Group 1, Option 2 for the M2 year ~~is~~ may provide the best opportunity for horizontal integration and decreases~~s~~ the compression of courses and allows for some integration of course material.

Implementation Group 1, Option 1 for the M1 year does not decrease compression of courses. Option 2 seems to offer more system based potential.

There were questions about whether the transition year 2018-2019 for the clerkships could be cut across the board making all the clerkships 6 weeks. Per Implementation Group 2, in order to line up the clerkships and have all end at the same time, this is not feasible. It is not possible to map eight, 6-week clerkships within the allotted curriculum period.

MSEC asked if there would not be student complaints expressed to LCME from the class that experiences the transition from one curriculum to another. In all situations where curriculum changes are made there will be students who must experience changes going from one to another curriculum to ensure they do not miss out on content. How the changes are rolled out to the students is important. It will be important to involve the clerkship directors to ensure content and objectives are covered / met when the clerkships are cut by one week for the transition year. There may need to be some adjustment to the NBME cut-off score because of the transition and shortened clerkships.

MSEC members are asked to seriously review the presentations and come to the next MSEC meeting prepared to vote on the calendar changes proposed for 2017-2018. Prior to that time, there will be a meeting set with the M1/M2 course directors to discuss the proposed changes, and their feedback will be brought back to MSEC. Implementation Groups will be available to answer / clarify questions MSEC may have regarding the draft reports presented today – please do not hesitate to contact the groups if you have questions. There will be time for more discussion and clarification at the November 8th meeting, but a vote will need to be taken by MSEC that affects calendar changes beginning in 2017-2018.

10. Administrative Reviews

Profession of Medicine: PPS I & II – Course Director, Dr. Theresa Lura, MD

The course objectives are mapped to the Institutional Educational Objectives and reflected in the course syllabus. The course mapping is complete and appropriate.

In follow up from last year's review a presentation on Research Ethics was added to the course at the request of MSEC and the session was favorably received by the students.

All students passed the course. Strengths identified by the students were the expertise of guest faculty members, the course intersessions, opportunities for independent learning and reflection and the small group sessions (small groups identified for Doctoring course). Weaknesses identified were course scheduling in completion with major basic science courses, compounded by weather related cancellations.

A new significant issue for MSEC's attention is that many of the students' suggestions were related to the concept of a "doctoring course" which is being addressed by Implementation Group 3. The course appears to be serving an important function in the curriculum. It addresses the Institutional Educational Objectives which are not well addressed by other courses. If a Doctoring Course is formally adopted by MSEC, the course's learning objectives and content will be significant components of the course.

In summary, the overall evaluation by students was 3.54/5 for the fall semester which is down from the 3.94/5 for fall 2014. The spring semester course was 3.53/5 which is down from the 4.11/5 for spring 2015. This decrease in overall evaluations is consistent with all course evaluations for this class. All evaluations were down between .2 and .4 on average across the first year curriculum. The two primary faculty members received positive evaluations ranging from 4.2 to 4.4/5.

Keystone (M4) – Course Director, Dr. Theresa Lura, MD
The course objectives are mapped to the Institutional Educational Objectives and reflected in the course syllabus. The course mapping is appropriate.

In follow up from last year's review changes in sessions included presenter for "Rent vs. Buy session; Functional Medicine was removed from the schedule; additional resources and clinical cases were provided to Cultural Competence presenters; recommended completing online training modules prior to Using Medical Interpreters session and added Pediatric Ventilator workshop.

This is a unique course in that each student designs their own curriculum beyond a few required sessions. This self-directed learning is important and strongly related to the Institutional Educational Objectives related to "practice-based learning and improvement" and "personal and professional development". All students passed the course.

Strengths identified by the students were the opportunities to add significant emerging medical issues at the last minute, the ability to alter the course to meet the identified needs of each individual class, the opportunity for senior students to determine which sessions will meet their needs in terms of preparing for residency training the most; and the level at which the volunteer faculty enjoy teaching the seniors each year.
Weaknesses identified were limitations of the schedule, especially at a time when the senior students are mostly focused on finding a place to live at their new residency location (the course depends on a large number of faculty and community physicians volunteering

their time).

A new issue for MSEC's attention is the succession planning for course directorship when Dr. Lura retires.

In summary, the overall evaluation by students was 4.1/5. This course has multiple sessions, most were rated favorably. A few had less positive or negative evaluations and the course director plans to revisit these prior to next year's course.

The Administrative reviews for both courses are found in the meeting document links at the end of the minutes.

11. LCME Standard and Elements Review 8.7 Comparability of Education / Assessment and 8.8 Monitoring Student Time

Dr. Olive presented LCME Elements 8.7 and 8.8. Included in the presentation were descriptions, requested Narrative Responses, Documentation (if identified), and the LCME Survey Team questions that will need responses by Quillen College of Medicine (QCOM).

Element Standard 8.7 Description: *A medical school ensures that the medical curriculum includes comparable educational experiences and equivalent methods of assessment across all locations within a given course and clerkship to ensure that all medical students achieve the same medical education program objectives.*

--QCOM has only two clerkships where this pertains: Rural Primary Care Clerkship where students attend either Mountain City or the Rogersville location and Family Medicine Clerkship where students attend the Kingsport, or Bristol, or Johnson City location. All the other clerkships may use more than one site, but the students rotate between the sites and are not located at one of the other sites for the duration of their clerkship responsibilities.

Narrative Response: *Describe the following for each course or clerkship offered at more than one instructional site, including geographically distributed campus(es), (also see the response to element 2.6).*

--We do not have geographically distributed campuses (an example of this would be if we had a QCOM campus in Morristown and the 3rd year student attended their entire 3rd year located in Morrristown). The Rural Primary Care Clerkship and the Family Medicine Clerkship have one Clerkship Director for each of these clerkships that are responsible for communicating with the faculty members at each site and orienting them on components of the clerkship.

- *The means by which faculty members at each instructional site are informed of and oriented to the core objectives, required clinical encounters and skills, assessment methods, and grading system for the course or clerkship.*
- *How and how often the individuals responsible for the course or clerkship communicate with faculty at each instructional site regarding course or clerkship planning and implementation, student assessment, and course evaluation.*

- *The mechanisms used for the review and dissemination of student evaluations of their educational experience, data regarding students' completion of required clinical experiences and grades, and any other data reflecting the comparability of learning experiences across instructional sites. Describe the specific types of data reviewed and how the reviews are conducted.*

--We have not reviewed and compared the student evaluations of individual sites since our last LCME visit and will need to put processes in place to review the data on a regular basis to be in compliantance with this element. We have the student evaluation data by site and NBME subject exam data so this is not going to be a problem with comparing the site data, but we need to be proactive in looking at the data on a regular basis. One way would be to ask for the data on the M3/M4 Clerkship Self-Studies and then report on the comparison data at MSEC.

- *Describe the individuals (e.g., site director, clerkship director, department chair) and/or groups (curriculum committee or a curriculum committee subcommittee) responsible for reviewing and acting on information related to comparability across instructional sites.*

--We will need to identify and document our process for completing the review across sites.

- *Provide examples of the mechanisms employed to address inconsistencies across instructional sites in such areas as student satisfaction and student grades.*

--This will need to be implemented before our next LCME site visit.

Dr. Olive also presented information regarding these elements from the Survey Team Guide and concluded we need to look at the data to be sure the educational experiences and methods of assessment are comparable.

Element 2.6 Functional Integration of the Faculty: *At a medical school with one or more geographically distributed campuses, the faculty at the departmental and medical school levels at each campus are functionally integrated by appropriate administrative mechanisms (e.g., regular meetings and/or communication, periodic visits, participation in shared governance, and data sharing).*

--We do not have a geographically distributed campus so this does not pertain to QCOM.

Element 8.8 Description: *The medical school faculty committee responsible for the medical curriculum and the program's administration and leadership ensure the development and implementation of effective policies and procedures regarding the amount of time medical students spend in required activities, including the total number of hours medical students are required to spend in clinical and educational activities during clerkships.*

--We have had for several years a *Student Duty Hours* policy and have monitored it centrally through New Innovations is reviewed on a consistent basis. It is asked about in the clerkship evaluations. This year, we developed the *Preclerkship Medical Student Scheduled Time and Workload* policy and identified the number of hours per week a student should be spending in a preclerkship course.

Narrative Response: *Describe how policies relating to duty hours were developed and by what individuals and/or groups they were approved.*

--We have the policies and will need to only write a response to how we disseminate them to the students.

- *Describe how policies relating to duty hours are disseminated to medical students, residents, and faculty.*

--Students receive the policies in the Transition to Clinical Clerkships course and the Clerkships disseminate the policies in their orientations. Centrally we notify the students we are monitoring those hours. We have not recently re-communicated that to the residents and faculty as a whole so we need to do this. Dr. Moore confirmed this is done in the Family Medicine orientation and includes the *Student Mistreatment* policy.

- *Describe how data on medical student duty hours are collected during the clerkship phase of the curriculum and to whom the data are reported.*

--We will describe how we use New Innovations to monitor the student's hours centrally. We probably need to be more consistent on how we report this to MSEC.

- *Describe the mechanisms that exist for students to report violations of duty hour policies. How and to whom can students report violations? Describe the steps that can be taken if duty hour limits are exceeded.*

--Our policy describes how to report. If there are violations they are reported in New Innovations.

- *Describe the frequency with which the curriculum committee or its relevant subcommittee(s) monitor the academic and clinical workload of medical students, in the context of formal policies and/or guidelines. How is the effectiveness of policies determined?*

--We need to work on this area. We have not identified how we will look at this in the preclerkship years. There is a question on the *Year 2 Survey* about the average number of hours the students spend per day in study related activities that may give us some national data for comparison.

Documentation: *The formal policy relating to duty hours for medical students during the clerkship phase of the curriculum, including on-call requirements for clinical rotations.*

--We will have to attach the policy in the appendix of the report.

Survey Team: *Describe the policy related to medical student duty hours in the clinical years. How are students, faculty, and residents informed of the policy?*

Note how and by whom duty hours are monitored.

Provide data from the ISA on student satisfaction with workload in the third-year clerkships.
--We will have to address this in the Independent Student Analysis questionnaire.

MSEC concluded that in general we are compliant with both LCME Elements, but there are some Administrative pieces that need to be put in place and/or reviewed for completeness.

The LCME Standard and Elements Power Point for 8.7 and 8.8 is identified in the meeting document links found at the end of the minutes.

12. **Standing Agenda Item:** Subcommittees, Implementation Groups & Technology Updates – no discussion identified.

Dr. McGowen thanked everyone for their attention to today's meeting agenda as there was a large amount of information to review and comment on. Everyone had great questions related to the presented information. The next MSEC meeting will be Tuesday, November 8th beginning at 3:30 pm.

The meeting adjourned at 5:02 pm.

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:Subcommitteess\ MSEC Minutes; Documents

1. September 20, 2016 Minutes
2. Generic Course Expectations for All Selective Courses
3. Narrative Assessment Policy – Formative Feedback Policy
4. Step 1 Scores Comparison
5. Outcomes Subcommittee Quarterly Report
6. Portfolio Background and Considerations – Portfolio Assignments
7. Implementation Group 1 Preliminary Report
8. Implementation Group 2 Preliminary Report – Pros/Cons - Calendars
9. Implementation Group 3 Preliminary Report
10. Administrative Reviews – Profession of Medicine – Keystone
11. LCME Elements 8.7–8.8 Presentation

Upcoming MSEC Meetings

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 3rd Tuesday of the month due to holiday scheduling

QCOM Faculty Meetings:

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

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