12-12-2017

2017 December 12 - 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

Minutes: December 12, 2017

The Medical Student Education Committee of the Quillen College of Medicine met on Tuesday, December 12, 2017 in Classroom C-002 of Stanton-Gerber Hall.

Attendance

Voting Members
Ramsey McGowen, PhD, Chair
Caroline Abercrombie, MD
Russell Brown, PhD
Patricia Conner, MD
Thomas Ecay, PhD
Stephen Geraci, MD
Russell Hayman, PhD
Dave Johnson, PhD
Paul Monaco, PhD
Jason Moore, MD
Robert Schoborg, PhD
Amanda Stoltz, MD
Hunter Bratton, M2
David Cooper, M3
Erin Lutz, M1

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

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

Non-Voting Members & Guests
Anjali Malkani, MD

Academic Affairs Staff
Lorena Burton, CAP
Cathy Peeples, MPH

Shading denotes or references MSEC ACTION ITEMS

1. Approve: Minutes from November 14, 2017 Meeting
Dr. McGowen asked for comments and changes to the November 14, 2017 minutes. With none being received the minutes were accepted as presented.

Announcements:

- Dr. McGowen reminded MSEC that the upcoming January meeting will be a retreat. Dr. Means will provide an update to MSEC on the November Faculty meeting discussion. The November MSEC and Faculty meeting were held on/at the same date/time.
- Dr. McGowen introduced Dr. Amanda Stoltz, Family Medicine, as the newest MSEC member. Dr. Stoltz's 's nomination was submitted and approved by the Faulty Advisory Council after MSEC member, Dr. Patricia Conner, announced her retirement from ETSU. Dr. Olive added that Dr. Stoltz is an ETSU alum, completing the Rural Track curriculum, and presently based in Bristol, after practicing in Rogersville.

MSEC voted to accept the November 14, 2017 minutes as presented. There were four (4) members abstaining.

The November 14, 2017 MSEC minutes are shared with MSEC members via a One Drive document storage option.

2. Report: Faculty Development Schedule and Tracking
Dr. McGowen referenced the April 2017 MSEC action based on the Implementation Group reports, to engage in long-term planning for curriculum development at Quillen College of Medicine (QCOM). The mechanism adopted for the action was to begin monthly Faculty Development Sessions to provide information/assist QCOM faculty on innovative types of curriculum models including emerging instruction and assessment methods.

A list of the sessions with descriptive information was presented. Sessions have covered curriculum content, content development, instructional technology and methods, assessment and other topics that cover multiple content. The average attendance has been twenty-one (21) to twenty-two (22) people with primarily people from Stanton Gerber attending. There have been people from the clinical departments outside of Stanton Gerber attend as schedules permit. MSEC members and course/clerkship directors are asked to attend as the sessions are broadly related to the QCOM educational program. The sessions are recorded and posted to the Faculty Development webpage as a YouTube video. Rachel Walden will follow up on whether the number of views of each session are recorded and reportable. The method of delivery does not allow electronic evaluation of the recorded sessions that have been viewed.

Two additional sessions have been scheduled, one for January 2018, on assessment practices and another curriculum development session scheduled for June 2017. Dr. Bobby Miller, Vice Dean for Medical Student Education at Joan C. Edwards School of Medicine, Marshall University, will present in June about Marshall's curriculum change process after an LCME visit and probation status.

Please watch for the announcements on each of the sessions.

The Faculty Development Schedule and Tracking report is shared with MSEC members via a One Drive document storage option.

3. Report: Curriculum Content Query: Coagulation
Dr. Olive presented a curriculum content report titled: *Coagulation* utilizing curriculum data taken from multiple resources, i.e., Curriculum Database, D2L course sites, discussion with course and clerkship directors, etc. The search for data included the term *bleeding disorders* as identified in the USMLE outline and related terms. Multiple courses/clerkships in the M1-M4 years were identified with topic coverage to include: Cellular & Molecular Medicine, Immunology, Microbiology, Pathology, Pharmacology, Internal Medicine Clerkship, and OB/GYN Clerkship. MSEC had no additional content coverage to add to the report. Dr. Olive's summary of the findings was that there appears to be a broad coverage of content related to *Coagulation* within the curriculum.

The Curriculum Content Query report on Coagulation is shared with MSEC members via a One Drive document storage option.

4. Report: LCME Standard-Element: 7.1 Biomedical, Behavioral, Social Sciences
Dr. Olive reviewed LCME Element 7.1 (last reviewed with MSEC in 2014) to include the Data Collection Instrument (DCI) Supporting Data Tables that will need to be populated as part of the submission to LCME in 2019 prior to our site visit. This data will come from the AAMC Graduation Questionnaire (GQ), the Independent Student Analysis (ISA) and a Narrative Response summarizing the two (2) recent years of curricular changes and placement of content areas. The LCME Survey Team will determine if there are any deficiencies in curricular content coverage in the biomedical, behavioral, and social sciences.

The LCME Standards-Elements, Guidelines and Procedures, etc. can be found at: http://lcme.org/publications/

The LCME Standard-Element PowerPoint presentation is shared with MSEC members via a One Drive document storage option.

5. Report: M1/M2 Review Subcommittee Annual Reports: 2016-2017 & 2017-2018

Medical Immunology for 2017-2018, directed by Dr. Rob Schoborg.
Dr. Johnson presented the annual report. There were no short-term or long-term recommendations. The course, currently in the M2 year, will be split into two components in the 2018-2019 academic year, with the first-half of the content delivered in the M1 Physiology course and the second-half of the content delivered in the M2 Microbiology course.

The course has performed well. Educational outcomes included 92% of the students receiving a letter grade of A or B. Student evaluations of the course were excellent with the course rated at 4.89/5.00.

Dr. Lura asked for clarification about the statement in the report related to the Step 1 board exam bands being highest. It was clarified that this is related to the score bands found on the specific Step 1 reports for QCOM. There is not a specific NBME subject exam, but rather Immunology content is included in the Microbiology NBME subject exam.

The Medical Immunology Annual Report for 2017-2018 was accepted by MSEC as delivered with the understanding that the report will be revised to reflect the upcoming changes being made to the course in the curriculum.

Clinical Preceptorship I & II for 2016-2017, directed by Dr. Ken Olive.
Dr. Johnson presented the annual report. There were no short-term or long-term recommendations. The preceptorships performed well in the academic year. The M1 Longitudinal preceptorship overall student evaluation of the course was 4.75/5.00. The M1 One-week preceptorship overall student evaluation of the course was 4.74/5.00. The M2 One-week preceptorship overall student overall evaluation of the course was 4.88/5.00.

The course director identified that recruitment of preceptors is an ongoing task due to scheduling and availability. It was also identified that preceptors would find it helpful to have a list of expectations for the students.

Dr. Olive noted that this course, like the Immunology course, will be in a different format in the 2018-2019 academic year. The M1 Longitudinal preceptorship is now a component of the Doctoring I course and identified as Clinical & Community Experiences which runs longitudinally from August through April. The M2 one-week preceptorship was delivered in October 2017 (academic year 2017-2018), but will become a component of the Doctoring II course in 2018-2019 and be identified as Clinical & Community Experiences and delivered as a longitudinal component. The M2 one-week preceptorship will no longer exist in 2018-2019.

The Clinical Preceptorship I & II Annual Report for 2016-2017 was accepted by MSEC as delivered with the understanding that the report will be revised to reflect the changes being made to the course in the curriculum.

Note: Dr. McGowen asked that any action on short-term or long-term recommendations related to the Rural Track M1/M2 Annual Course Reports occur after Agenda Item No. 6: Update / Discussion: Doctoring I Spring Implementation / Inclusion of Rural Track. This will allow MSEC to have a broader knowledge of the Rural Track needs and allow appropriate action to be taken.

Dr. Johnson then presented each Rural Track course report to MSEC.

Rural Track Case Oriented Learning and Preceptorship I & II for 2016-2017, directed by Dr. Joe Florence

The M1 course received an overall student evaluation of 3.51/5.00 with student concerns centered on course organization/structure and a desire for a greater amount of clinical experience. The M1/M2 Review Subcommittee has identified an ineffective communication between generalist track and basic science curriculum and Rural Primary Care Track (RPCT) faculty, which makes it difficult for RPCT faculty to organize the course in a way that mirrors the basic science curriculum and provide like clinical experiences. The newly established Doctoring I course planning timeline has made it difficult for RPCT faculty to plan clinical experiences that reinforce basic science curriculum being taught. The following short and long-term recommendations to MSEC are in response to the concerns received for the RPCT courses being reviewed.

Short-term recommendations to MSEC:

- **Consider creating** a master schedule that would highlights the major topics being covered for each day of the basic science curriculum that could be distributed to RPCT faculty (Dr. Florence as well as community faculty) prior to the RPCT schedule being due. This would allow RPCT faculty to plan clinical experiences that mirror the basic science curriculum and improve course organization and structure.

- **Consider** having course documents/cases labeled more descriptively for RPCT Faculty (Ex: “Type II Diabetes Case” rather than “Case 1”). RPCT faculty recognize that the subjects of cases often need to be hidden for the sake of learning; however is there some way for RPCT faculty to obtain this information while still being hidden from students?

- **Investigate the feasibility** of all RPCT faculty and staff having access to both Rural and Generalist Track D2L sites

- **Consider** including RPCT faculty in the scheduling of meetings for the M1M2 curriculum scheduling planning sessions that will make it easier for them to attend.

Long-term recommendations to MSEC:

- **Consider** a separate doctoring course that is specific to the RPCT. The Course Director believes that some of the uniqueness of the RPCT may be lost if the Doctoring I course were identical for RPCT and Generalist Track.

- Update QCOM catalogue to reflect course as a one-year course, not split into I and II.

Dr. Florence identified the proposed changes in response to issues identified above and the M1/M2 Review Subcommittee feel they are reasonable interventions in response to issues identified above:

- Faculty will work to balance clinical exposures and community experiences in response to the desire for more clinical experience.

- Provide clearer distinction between the COL/preceptorship course and the research course to help prevent negative perceptions of the research course coming out in the student evaluations of the COL/preceptorship course.

- Work with faculty to develop specific student deliverables for each clinical experience to help improve the quality of the time spent in the preceptorship.

- Continue to transition Rural COL and Preceptorship I and II into one course (i.e. one course syllabus with course objectives mapped to IEO's) in preparation for the Doctoring course.

- Continue to monitor sufficiency of volunteer clinical faculty as preceptors and identify needs of finding to Administration if assistance is needed.

MSEC discussion included access to the Basic Science course D2L sites by the RPCT faculty as they plan their curriculum delivery for Rural Track Case Based Learning. While the RPCT faculty have a generic login to D2L course sites, the review of each course is cumbersome and time consuming. The creation of a master schedule for the fall and spring semesters to include all courses, planned content coverage, and assessment specifics would allow both the Generalist and Rural Track curriculums to be informed and in sync with the planning of content delivery throughout the academic year.

Rural Health Research and Practice for 2016-2017, directed by Dr. Joe Florence
The M1 course received an overall student evaluation of 3.31/5.00 with student evaluations identifying course organization and structure as an area where the course can be improved. The M1/M2 Review Subcommittee identified the same short-term recommendations for the course, addressing the course organization/structure. There were no long-term recommendations.

The course provides a unique experience for students to engage in community research, work in teams, and interact with other health professions within a rural community. The experiences enable the course to meet components of Institutional Educational Objectives 4: Interpersonal and Communication Skills; and 7: Interprofessional Collaboration particularly well.

The M1/M2 Review Subcommittee noted that the course director suggests formatting schedules so that activities are more consistent between sections and providing students with a rough outline of course expectations for each day. Both should diminish the students' concerns about course organization and structure. The subcommittee also supports the course director's plan to emphasize to the students that the objectives of the course are not focused on individual patient care, but on community health.

The Practice of Rural Medicine for 2016-2017, directed by Dr. Joe Florence.
The M2 course received an overall student evaluation of 3.79/5.00. The M1/M2 Review Subcommittee feels the course continues to fulfill the purpose of the RPCT by providing early exposure to clinical skills, i.e., EKGs, writing SOAP notes, and BLS/ACLS certification – all in the context of a rural community. Common student concerns center around course organization, inefficient use of time, and a desire for more hands-on practice. The short-term recommendations, which mirror the Rural Case Based Learning recommendations, will help RPCT faculty improve organization and use of time and allow correlation with the basic science curriculum. The long-term recommendations mirror the Rural Case Based Learning course recommendations with the addition of the following three long-term recommendations.

Long-Term recommendations to MSEC:

- **Include** RPCT needs in the planning of Doctoring II. The course director feels that a separate RPCT Doctoring II course that is distinct from the Generalist Track Doctoring II course might be best for the RPCT.

- **Include** BLS training and ACLS certification in both the Generalist and Rural Track curriculums.

- **Continue** to monitor staff support needs and identify to Administration if assistance is needed.

6. Update/Discussion: Doctoring I Spring Implementation / Inclusion of Rural Track
Dr. Olive provided an update of the Doctoring I spring course planned implementations including Rural Track. Three issues must be considered regarding the inclusion of Rural Track in the Doctoring I and Doctoring II curriculums: 1) The evaluation of the Rural Track courses; 2) How well the Rural Track courses interdigitate with the other basic science courses; and 3) How well the Rural Track courses interdigitate with the clinical doctoring sequencing.

The Rural Track continues to have excellent outcomes that meet our QCOM mission with more Rural Track students entering Primary Care, Family Medicine, and the underserved rural areas than Generalist Track students. The implementation of Rural Track into the Doctoring I and/or Doctoring II courses can be difficult. The curriculum changes that we have been making continue to be refined and finalized which means that the notification and implementation of these changes are sometimes just prior to course delivery.

This has not allowed the Rural Track sufficient time for planning of the rural component of the content being delivered in the Generalist Track. Many of the Rural Track faculty are not full-time faculty and are not available for last minute planning.

Planning for the Doctoring II 2018-2019 course has begun and Generalist Track faculty are working to refine the scheduled delivery of content which means that the Rural Track faculty will have a schedule of M2 content earlier and will be able to plan accordingly.

Doctoring I curriculum delivery for 2018-2019 should be fixed for the most part. The main components are:

- Communications (separate functioning Interprofessional course) that all students complete.
- Career Exploration that all students complete.
- Physical Exam Skills that all students complete.
- Professionalism and Ethics which is a hybrid of the original Profession of Medicine course. Originally it was thought that parts of the component would be delivered in the Generalist Track and parts of it delivered in the Rural Track, but some of this content was last-minute in refinement and was not able to be implemented in the Rural Track.
- Case Based Learning which was to be separated for each track and allow each to use separate pedagogy and methodology applicable to the location. Some of the content now delivered in large group sessions that all students complete has been identified for small groups, and the content was moved out, but some of this content has not been able to be implemented in the Rural Track because the Rural Track did not have sufficient planning time to incorporate the content into their course schedule. Case Based Learning also includes the Cadaver presentations.
- Integrated Grand Rounds that all students complete.
- Clinical and Community Experiences were separated into the Generalist and Rural Tracks and this has for the most part gone well.

The problems have been with the Professionalism and Ethics and Case Based Learning components that were refined just prior to delivery in the Generalist Track and were not able to be included in the Rural Track at the last minute.

MSEC was asked to consider whether future notification related to content could be delivered to the Rural Track in a timely fashion to allow for implementation and if learning objectives needed to be identified for the components to allow the Rural Track to implement within their rural setting.

Doctoring II curriculum delivery for 2018-2019 will consist of:

- Practice of Medicine. There is a Rural Track Practice of Medicine course that currently delivers like content.
- Clinical Preceptorship will become Clinical and Community Experiences (now a longitudinal experience) that all students complete.
- Human Sexuality II that all students complete.
- Career Exploration.

There are some additional components that are going to be covered that either students complete together or within their separate tracks. This includes moving some of the Professionalism and Ethics content from the M1 curriculum to the M2 curriculum (Patient Safety/Quality Improvement, and a Pain Management component).

The questions that MSEC were asked to consider were:
1) Do the Rural Track students come back to the main campus for the added components or do we allow the Rural Track to implement within their rural setting?

2) Is it best to call this one course – Doctoring II and some of the content is covered for both tracks in unified sessions in the Generalist Track and other content covered separately?

3) Do we split the Doctoring I and Doctoring II course into Generalist Doctoring I and Rural Doctoring I and Generalist Doctoring II and Rural Doctoring?

MSEC discussion included how the Rural Track can incorporate the changes in the Doctoring I and Doctoring II courses. Dr. Florence asked that MSEC consider that the M1 Rural Research course taught be taught in the spring semester on Thursdays and the M2 Rural Community Projects course be taught in the fall Semester on Tuesdays. Generalist Track students are in Doctoring I and II the entire time and the proposed structure will require the Rural Track structure to be modified to accommodate the full day of scheduled activities resulting in Rural Track students receiving only ½ of the experiences. There is not enough time in the day to complete the Doctoring components and the Research or Projects components.

Dr. Schoborg asked about the utilization of the summer weeks to complete the Rural Track research component. This would necessitate that some of the summer weeks be required and consideration of enrollment, student debt, etc. would have to be considered. Dr. Olive pointed out that the two courses are not core to the QCOM degree, but they do meet degree requirements for students working on an MD/MPH.

Dr. Monaco commented on the Case Based Learning components and how they were once covered in both the Generalist and Rural Tracks when the Case Oriented Learning content was taught. It may be that the current academic year problems are related to timing and last minute changes which should not be a problem in the next academic year. It is not known how the Professional & Ethics content will be handled in the Rural Track. Separate Doctoring I & II courses could be more cumbersome to manage.

Dr. McGowen asked for clarification on whether the Rural Track is requesting separate Rural Doctoring I and II courses or that only components of each would be handled separately within the Rural Track curriculum, i.e., Case Based Learning components and the Clinical and Community Experiences. Dr. Florence wanted some clarity on what is core content that must be covered and what are the objectives to be met and what assessment processes are to be followed. Dr. Florence did feel that based on available Rural Track staffing it would be easier to have one Doctoring I and Doctoring II course that included both Generalist and Rural Track programs.

Dr. Olive identified the option that a decision on whether to have separate Doctoring I and Doctoring II courses be tabled which will allow Dr. Florence and Dr. Olive to continue discussion of options, then bring back a proposal to MSEC for the 2018-2019 academic year. Dr. McGowen reminded MSEC that this is why the recommendations identified in the M1/M2 Subcommittee reports boils down to the Rural Track needing help in implementing the curriculum changes both in 2017-2018 and those pending for 2018-2019.

Dr. Florence confirmed it is the new components that have not been able to be implemented in the Rural Track this academic year. MSEC felt that Rural Track may already be covering some of the new components, but in a different fashion. MSEC noted that future curriculum changes need to include additional time to plan and to avoid conflicts with implementation, delivery, and assessment.

MSEC discussed whether the M1/M2 Review Subcommittee recommendations can be voted on or if they need to be deferred until a decision is made on whether there are one or two Doctoring I and Doctoring II courses. MSEC also discussed the development of a "master" calendar of course content delivery that would be helpful in planning both the Generalist and Rural Track schedules and help both tracks to work together as one group. Dr. Lura reminded MSEC that the reports are based on the 2016-2017 delivery and the recommendations were made in anticipation of the curriculum changes that were being made in the 2017-2018 and 2018-2019 academic years. MSEC does need to continue discussing how the curriculum changes are being implemented, but acceptance of the reports should not be deferred.

MSEC voted to accept the Rural Track course reports for 2016-2017 noting that all short and long-term recommendations in each report would be worded in a manner that will allow MSEC to **consider** the feasibility of adoption before implementation. Dr. Monaco abstained from voting.

The M1/M2 Review Subcommittee Reports are shared with MSEC members via a One Drive document storage option.

The Meeting Agenda was revised to allow discussion and action on Agenda Item 9.

9. Action: Pediatrics: Medical Gastroenterology and Nutrition Elective for M4s

Cathy Peeples introduced the elective including its outline, course objectives and that it has been mapped to the QCOM Institutional Educational Objectives. The course director is Dr. Anjali Malkani, MD. Students will spend approximately forty-five (45) hours per week on the rotation. The elective will be primarily an ambulatory rotation (75%) at Mountain States Medical Group Pediatrics and 25% on the Inpatient rotation at Niswonger Children's Hospital. The elective will be available for either a 2-week or 4-week rotation with one (1) medical student per rotation. Dr. Malkani confirmed the one (1) medical student per rotation as she has others (residents, nursing students, and physician assistants rotating on the service).

Dr. Geraci made a motion to accept the Medical Gastroenterology and Nutrition Elective for M4s with Dr. Lura seconding the motion. MSEC unanimously accepted the motion.

The Medical Gastroenterology and Nutrition Elective for M4s is made available to MSEC members via a One Drive document storage option.

The Meeting Agenda resumed with Agenda Item 7.

7. Report: Outcomes Committee Quarterly Report

Dr. McGowen presented a quarterly Outcomes Committee report. There were a total of eighteen 18 benchmarks reviewed (two [2] that were not met and sixteen [16] that were met).

The two (2) benchmarks not met were:

Interpersonal and Communication Skills 1: 95% of students will pass performance based assessments on the first attempt	**Measure Not Met**: **94.12%** of students passed the M3 OSCE. 4 of 68 students did not pass, they require complete remediation. An additional 5 students require targeted remediation.

Interpersonal and Communication Skills was not met for the second year: The committee concluded the measure is a developmental measure and that the remediation the students receive has been reflected in only one student failing the Step 2 CS exam to date. No MSEC action is recommended because performance is very close to the benchmark and interventions have been successful.

Systems-Based Practice 1: 90% of graduates will be rated at "meets expectations" or above on the Residency Program Directors' Evaluation of PGY-1s for System-Based Practice	**Measure partially met**: Obtain informed consent for tests and/or procedures **- 95.83% / 2.29.** Identify patient safety system failures and contribute to a culture of safety and improvement/error reporting **- 87.50% / 2.04**

Systems-Based Practice 1 was not met for the second year: After committee discussion it was determined to monitor the measure for another year to assess how the recently implemented curricular changes will affect the measure**.**

The sixteen (16) benchmarks met were:

Benchmark 3
Interprofessional Collaboration 1
Medical Knowledge 5
Patient Care 4
Professionalism 3
Interpersonal and Communication Skills 4
Patient Care 2
Professionalism 4
Interpersonal and Communication Skills 3
Medical Knowledge 2
Medical Knowledge 4
Practice Based Learning and Improvement 1
Systems-Based Practice 1
Interprofessional Collaboration 3
Practice Based Learning and Improvement 3
Systems-Based Practice 2

Dr. Olive commented on the Interpersonal and Communication Skills 1 and the work by Dr. Abercrombie to assist students in remediating deficient performance on the OSCE. Dr. Abercrombie devotes much time and effort to these students to ensure they receive the training needed to successfully pass.

Dr. Olive also spoke to the Systems-Based Practice 1 benchmark that was not met as it speaks to the need for the curriculum to address patient safety system failures and contribute to a culture of safety and improvement/error reporting.

Dr. McGowen presented two (2) recommendations from the Outcomes Subcommittee for MSEC action.

Dr. McGowen explained that there are *General Program Expectation* benchmarks and benchmarks identified with each Institutional Educational Objective (largely based on the M3 Clerkship Composite Assessment forms). Because the M3 Clerkship Composite Assessment form changed this academic year from being based on the Educational Institutional Objectives (IEOs) to Entrustable Professional Activities (EPAs), the measures derived from the old forms

for six (6) benchmarks are no longer available. The Outcomes Subcommittee recommends that the six (6) benchmarks be replaced by one (1) General Program Objective benchmark based on performance on the EPAs from the new M3 Clerkship Composite and the M4 Student Assessment form for each required selective. The specific target number to be used for the benchmark measure (separate for M3 and M4) will be determined after initial review of the 2017-2018 data and benchmark recommendation will be brought to MSEC at that time.

Benchmark 4: 95% of matriculating students will complete the curriculum within 5 years. Based on the fact that LCME requires that a 4 (four) year graduation rate be reported, the Outcomes Subcommittee recommends adding this as Benchmark 4b and also to continue using the five-year graduation rate since the committee felt it was a better representation of curriculum performance (e.g., captures students who do not experience major difficulty but participate in the MPH program and other students that may have a short delay in their progression but do complete the curriculum within 4 years).

Proposed Benchmark 4b: The percent of students completing the curriculum within four years will be equal to or greater than the national average. The current national average is about 82.47%.

Dr. Geraci made a motion to accept the Outcomes Subcommittee Quarterly report as presented with Dr. Schoborg seconding the motion. MSEC unanimously adopted the proposed Benchmark 4b.

The Outcomes Subcommittee Report is shared with MSEC members via a One Drive document storage option.

8. Discussion/Action: Revised M3 NBME Grading Policy

Dr. McGowen began the discussion with a reminder to MSEC that at the November 2017 MSEC meeting a waiver was given to the clerkship directors for next academic year 2018-2019, for the NBME percentage. Cathy Peeples introduced the policy and explained that this policy was done to pull all the details of the M3 grading processes together into one policy. The original *Grading Policy for Clinical Clerkships MSEC 0111-3* is now known as *M3 NBME Grading Policy MSEC 0111-3.* The revisions will become effective with the 2018-2019 academic year.

The policy continues the allocation of clerkship grades at 65% for the clinical assessment component and 35% for the NBME subject exam component. The waiver for the NBME percentage allocation is for academic year 2018-2019 only. Students will continue to receive a letter grade of A-F. The proposed policy change presented is related to a proposed remediation process (rather than failure of the entire clerkship) when a student attains a passing score of at least 80% of the clinical assessment and the NBME percentile score is above 5%.

Under these circumstances a remediation process is proposed, effective for this academic year 2017-2018, which allows a student to remediate the clerkship by re-taking the failed NBME subject exam one (1) additional time for a passing score. Right now, students that pass the clinical assessment components of the clerkship, but fail the NBME subject exam are required to take the entire clerkship again.

Under the proposed policy, if successful in re-taking the NBME subject exam, the student would not be required to retake the clerkship, provided their clinical assessment components of the clerkship meet 80% of the total grade. The highest grade they would receive for the clerkship would be a C*. QCOM has a couple of students this year that have failed the NBME subject exam, but their clinical assessment components met 80% of their total clerkship grade. These students would be able to retake the NBME subject exam one time.

Dr. Olive stated that other schools were surveyed and reported that schools were allowing one (1) re-take of the failed NBME subject exam. The QCOM grade allocation of 35% derived from the NBME is consistent with other schools, which largely allocates 25% to 40% of the clerkship grade to the NBME subject exam.

MSEC discussed the schedule proposed for remediation of an NBME subject exam. Retakes of an NBME subject exam will be scheduled on the last day of the fall and spring breaks and the second Friday following the beginning of the M4 year which will allow students to study while continuing to complete scheduled clerkship rotations.

MSEC discussed the 10th percentile adjusted score of 69 proposed in the policy and felt that a 10th percentile adjusted score of 70 would keep the clerkship grading process consistent across all four (4) years of the curriculum. It was agreed this change should be made to the M3 NBME Grading Policy.

Dr. Schoborg made a motion to accept the revised M3 NBME Grading Policy MSEC-0111-3 effective with academic year 2018-2019, with a change of 69 to 70 for the 10th percentile. Dr. Lura seconded the motion. MSEC unanimously accepted the motion.

Dr. Abercrombie made a motion to accept the revised M3 NBME Grading Policy MSEC-0111-3 **Remediation** process to be effective with the 2017-2018 academic year. Dr. Johnson seconded the motion. MSEC unanimously accepted the motion.

The revised M3 NBME Grading Policy MSEC-0111-3 is made available to MSEC members via a One Drive document storage option.

10. Action: Pediatrics: Medical Genetics Elective for M4s

Cathy Peeples introduced the elective including its' outline, goal, course objectives and that the mapping of objectives to the QCOM Institutional Educational Objectives had been completed. The course director is Dr. MJ Hajianpour, MD. Students will spend approximately thirty-five (35) hours per week on the rotation, depending on the clinic schedule and patient load. The elective will be primarily an ambulatory rotation (80%) at ETSU Pediatrics and 20% in the inpatient rotation at Niswonger Children's Hospital. The elective will be available for either a 2-week or 4-week rotation with one (1) medical student per rotation.

Dr. Geraci made a motion to accept the Medical Genetics Elective for M4s with Dr. Schoborg seconding the motion. MSEC unanimously accepted the motion.

The Medical Genetics Elective for M4s is made available to MSEC members via a One Drive document storage option.

11. Action: Medical Education: Wilderness Elective for M4s

Cathy Peeples introduced the elective to include outline, goals, course objectives and that the mapping of objectives to the QCOM Institutional Educational Objectives had been completed. The course director is Dr. Jeff Sanders, MD. Dr. Olive stated that he has spoken with physicians that have worked with Dr. Sanders and he comes highly recommended. A criminal background check was done and returned with no findings.

Dr. Sanders is certified as a Wilderness First Responder by the Wilderness Medicine Institute and is working on a diploma in Mountain Medicine from the University of New Mexico. Dr. Olive remarked that it does appear Dr. Sanders comes to the course as trained and certified to teach this course.

The course will be offered for two (2) weeks, two (2) times per year based on faculty availability. There would be two (2) separate outings, one would be a rock-climbing and repelling outing and the other would be a wilderness backpacking trip for three (3) days. A minimum of three (3) students with a maximum of six (6) students will be accepted for the rotation.

Students will be expected to be present for all discussions and presentations, as well as to participate in the backpacking and rock climbing activities. Estimated costs to the student for this elective are up to $150 for travel and equipment. Many of the supplies needed can be rented from the CPA. Additional rock-climbing instructors would add substantially to the student's share of cost and an alternative venue for the rock-climbing requirement would be the CPA rock-climbing outdoor facility.

MSEC discussion centered on the required rock-climbing activities and what objectives it would satisfy, the assessment of the student, the costs to secure proper equipment, and the liability to ETSU/QCOM should a student be injured during the elective. Dr. Olive provided a recommendation from ETSU legal counsel stating an A*cknowledgement of Risk* be signed by the student prior to beginning the course. MSEC tabled consideration of the elective until the course director can speak with MSEC and address their concerns.

The Wilderness Elective for M4s was tabled until the course director is available to be present and address the MSEC concerns regarding the rock-climbing requirement of the elective.

The tabled Medical Education: Wilderness Elective for M4s is made available to MSEC members via a One Drive document storage option.

12. Standing Agenda Item: Subcommittees, Implementation Groups & Technology Updates

None were identified.

The meeting adjourned at 5:55 p.m.

MSEC Meeting Documents

MSEC Members have access to the meeting documents identified above through a shared One Drive document storage option made available with their ETSU Email account and login. Quick access to the files can be made by clicking on the below link and opening the August 15, 2017 MSEC meeting folder. https://etsu365-my.sharepoint.com/personal/mckinley_etsu_edu/_layouts/15/onedrive.aspx?id=%2Fpersonal%2Fmckinley%5Fetsu%5Fedu%2FDocuments%2FMSEC%20Meeting%20Documents

Select the "**new sign-in experience"** option and enter your ETSU email address and password.

If you are unable to access the One Drive link or have not set up your One Drive contact:

Matthew Carroll
Instructional Design and Technology Manager
Quillen College of Medicine
CARROLLMO@mail.etsu.edu
423-439-2407

Upcoming MSEC Meetings

MSEC Meeting Dates: * NOT 3rd Tuesday – Location To-Be Determined
January 16, 2018 Retreat 12:00 noon-5:00 pm
February 20, 2017 – 3:30-6:00 pm
March 20, 2018 – 3:30-6:00 pm
April 17, 2018 – 3:30-6:00 pm
May 15, 2018 – 3:30-6:00 pm
June 12, 2018 Retreat 12:00-3:00 pm & Annual Meeting 3:30-5:00 pm*