2020 EPC Curriculum Kickoff Working Group Notes

INDEX

2020 EPC Curriculum Kickoff working group notes:

Q1: Content and Methodology –

- Use an epidemiologic approach to **identify a set of most common / most urgent disease states or medical disorders** that should be central to the entire curriculum
- Emphasize **common pathophysiologic processes underlying** disorders in different systems. Task students to identify and discuss these commonalities
- Select **issues related to resource allocation, ethics, health systems science etc appropriate to level of learners, and integrate them** in multiple courses/experiences across all years
- Include medical current events and critical analysis
- **encourage more *continuous integration and review,*** *e*xpand on the ICE1/2 model of curricular integration
- Explore additional ways to **erase divide between preclerkship and clerkship curriculum** that are "realistic and do-able"
- **Select methods of teaching best suited to each particular topic – no one approach is best for all**
- Course Content: Is there too much? **Yes!**

Student members valued use of in-class sessions for problem-solving. They also identified important basic content that they believe is best "walked-through" by faculty in-class to facilitate student understanding by explaining and answering questions in real time.

- Explore educational approaches that include *facilitated* peer teaching
- **Present content in ways that make it accessible to students who learn in different ways or through different experiences, or perhaps even in different time frames**
- Assist students in figuring out ways of learning that may work best for them in medical school, including preparing them to do independent learning
- **Address Step 1-related issues** as currently many students stress about not just passing but about obtaining scores they believe are needed to successfully compete for certain residency positions
    - How important is it to identify step 1 content not covered in our curriculum and create a targeted study guide(s) on it?
    - How might curriculum enable students to view preparation for step 1 and for clerkships as largely overlapping– rather than as 2 separate activities?
    - Where/when should Step 1 be taken?
- **Curriculum should prepare students for what being a doctor is "really like"** to help manage expectations for the context in which they will practice medicine, and **to decrease burnout and disillusionment.** This implies need for appropriate **off-ramps from medicine and additionally for related on-ramps to careers involving other parts of the healthcare system**
- Focus **on critical thinking, team-based collaboration skills, and fostering curiosity** throughout the entire curriculum, with increasing emphasis on *clinical reasoning and judgment and healthcare-focused teams* as students move through their training
- Clerkships have core content and students learn through a dynamic emphasis as some teaching is based on patients seen; should we have a similarly dynamic as part of foundational curriculum management?

- **Identify a process for making/ assessing decisions about content – what and how much is presented, how it is sequenced, and how it builds longitudinally.rocess requires one or more individuals with <u>direct knowledge of and experience in broad swaths of our curriculum</u>.** Data from OASIS can help faculty with on-going, direct knowledge of multiple curricular components make cross-course and -year recommendations concerning content, integration and methods. Such **centralized, faculty-time-intense approaches would likely require significant changes in resources, compensation, and equally importantly in culture.**

Q2. Course and clerkship structure

- ↓ Pre – Clinical (consider moving Step 1 later) ↑ Clinical
- **Longitudinally and vertically integrate**: - Clinical content in pre-clinical years, Melding/Merging of courses – Interwoven, Integrated courses → content integration
- **More discussion w/clinical and pre-clin faculty**
- Keywords in OASIS – limited, how to utilize well
- Need to **right-size/off-load content instead of condensing**; How to identify prior material taught to prevent duplication
- **Schedules should be more predictable**
- Health care administrative Pathways - **↑ Pathway options**

Current clerkship model

- **3 x 16 week coordinated thematic sections**
    - **Decreases silos and supports coordination but scheduling challenges**
- **Early electives should be maintained**

Proposal

- **4 x 12 week groupings**
    - Univ IM/Community IM/ambul (2 weeks)/FCE (2 weeks)
    - Peds/Psych (2 x 6 week blocks, 5 weeks clerkship/1 week FCE)
    - OB/Family (2 x 6 week blocks, 5 weeks clerkship/1 week FCE)
    - Surg/Neuro (8 weeks surgery, 4 weeks neuro with neuro either at beginning or to maintain surgery linkage)
- Maintains early electives
- Need to look at scheduling in more detail – do we have the capacity, etc
- Propose start the first week in May to **align more closely with resident schedules** (requires moving transition to CCE earlier)

Challenges to clinical learning

1. Consistent content delivery in clinical experiences with variable patient population daily or by site; **Requires students participating in other types of learning opportunities** – didactic, core content, simulation – how to balance this with direct clinical exposure
    a. Students leaving clinical teams for curricula (including interstitial) can lead to disjointed feeling
2. Student rotations do not match resident schedule
3. **Time for formal learning is variable** (team size, patient acuity...)

4. **Faculty time and support**: direct offset for education, protected time; Physician involvement in planning curriculum is important

How are we using virtual classes? simulation? Other technology? Many opportunities

Course Structure

1. How to encourage **communication between courses and through the years**
2. Clarity regarding **content consistency and sequencing**
3. More **collaboration** in teaching between basic science and clinical faculty: alignment of content, engagement of more patients in foundational courses
4. Requires **faculty support**
5. More **case – based** learning examples that can support clerkship year; perhaps following independent preparation
6. Utilization of the **database for planning**; can artificial intelligence help this process?

Q3. Schedules and calendar development

- Better communication between and across curriculum years, courses, etc.
- **Required sessions should be grouped** on certain days 2-3 days per week
- Important for **PURCH days to be spaced** for learning
- Factor in **prep, consolidation and independent Learning** – how can we accurately identify and report it so faculty can schedule it accordingly?
- Pairing of courses and demands on time is important
- **Assessments thoughtfully scheduled** to allow time for wellness and resetting -- timing and number
- **Consistent scheduling** within a course, and across the curriculum is a plus
- **Consistent protected time** has value for student planning and wellness – balance of afternoon and morning
- Build in **Testing wks**: pre-clinical & clinical (also serves as relaxation/remediation time)
    - spass exam on Mon, get time off/elective time; If not, intensive remediation
    - how to open up time for this?
    - What about students who have to remediate during 'relaxation' time
    - students voluntarily engage in pathway programs/clinical experiences /community engagement/research - this would NOT be on the course schedule
    - Relaxation is important

With the goal of implementing a consistent calendar (preclinical and clinical)

- Timing of session types will play an important role: support **minimal travel time**
- placement of assessments (formative and summative, quizzes, NBME, CBSE, etc.)

Early exposure to board exams will benefit students - NBME/shelf exams following each system block (**formative or summative**)

LPP → resource issue, it would be difficult to accommodate all students if there is a fixed clinical half day – how can we manage this?

Intentional redundancy has educational value, repetition might not be as important if we organize in single-pass system blocks, when a block builds on the preceding ones (and has some intentional redundancy).

Q4. Assessment and evaluation:

1. **How do move from course-based assessment to global student assessment?** *across content areas, courses and curriculum years?*

- Consider **over-arching themes** that could be **globally assessed**
- Competency-based curriculum may assist with a **cross-course assessment**
- Consider globally assessing generic skills, such as: critical thinking, problem solving, adaptive learning
- Perhaps the **mentors** could walk students through their performance on semi-annual assessments? One example, perhaps DSF would have formative unit assessments, and 1-2 global assessments
- Consider **case-based learning within associated assessment**
- Continue FOM 1 & 2 assessments with review via assessment in year 3; block off 1-2 days for these inter-disciplinary case-based assessment(s)
- Clinical cases with data: ensure students **integrate their learning** via formative assess.
- Global assessments could more easily link UME with GME
- **Faculty development** required to move towards any form of global assessments
- Global assessments would ensure more consistent jargon

2. How might we structure a new assessment model?

- Consider a **clinical competency committee**

How can we effectively link UME to GME?

- Transferable skills would assist in identifying students who are prepared for GME
- Use longitudinal outcomes
- Utilize more team-based learning AND assessment linked to GME milestones

Q5. Faculty support and resources

- **Remove departmental ownership of course administration**
- Use **school-based funds** to administer support
- Streamline course support by **central administration --** using a model similar to current OUME support where
    - **Redundancies** are built in to the course administrator roles so that cross-training can occur
    - Back up administrators can be available within the same pool
    - One or more administrator can run one or more courses throughout a calendar year
- Develop **similar administrative/operational framework** for each course
- All operations and administrative support would be covered by the medical school to support a **professional-based track of administrators**
- Course directors would focus on **content, student development and teaching methodologies**

- could centralized administrative support be scaled to meet the needs of clinical teaching responsibilities (i.e. traditional clerkship, subinternships and electives)
- **Central Repository for student data** supports informed faculty, identify students in need earlier
- **IT resources** are important, **instructional designers** who can take on the innovation partnering with faculty
- Perception is that some Depts/ Supervisors/ Chairs **do not support time to teach**
- **Community Preceptors** – Cost $$, Private practices needed for clerkships
- **Include Residents** in Training programs, Teaching support for Residents waxed & waned
- Programs can't be grant funded, **must be sustainable**
- **Protect faculty time** (how much is expected of all, what else gets specific support?)

Q6. Faculty Development

Workshops: Scheduled Faculty Development – with support: topics could include

i. How to effectively do flipped classroom, small groups, podcasts, etc
ii. How to incorporate our partners/ affiliates
iii. How to Innovate on top of basic yearly updates
iv. When is tech appropriate? (Faculty need access to technology)
v. Interprofessional faculty and topics

Other models:

- Go to people in Depts.
- Create an **index of what's available**: What does each Dept have – Need index like iCELS
- **MASTERS Prepared Curriculum Designer** to advise courses
- **Teach faculty to Teach**
- Evidence Based
- SIM cases w/ Sim Expert + Content Expert
- How to use Data and create surveys;
- How to design study/ Research
- **Protected time** needed – who gets it? How much?
- **Apps** (hands on, easy access at all locations, **assessment, comments for students**)

LEAP (faculty academy program planned as part of IMPACT 2025 strategic initiatives)

- Build on what we have already (LC, BERST, TOT, LC etc)
- Recognize and enhance the good

What innovation or idea do you want to be sure the renovation working group hears?

- Increased resources are needed to address faculty development and education effort should include time to attend faculty development, preparation, etc. Education effort should consist a more complex rubric reflecting wide assortment of educator tasks needed to deliver curriculum
- Standardization of delivery of small group learning is needed

- Learners need to be comfortable with virtual learning in clinical setting (via case-based)
- Learners need to be comfortable with delivering virtual medicine
- SOM needs to integrate commercial tools/materials into UME courses
- Learners need to learn how to *apply* the knowledge, as opposed to rote memorization via lectures
- consider an 'on the fly' weekly evaluation whereby students could provide optional 'just in time' feedback to educators and/or course co-leaders
- A pathway for primary care that would allow students to follow patients longer? interesting, preceptors would be a challenge
- More interprofessional education? Scheduling and coordination are challenges
- pathways – how to balance student exposure with pathway focus
- Protected and valuable time dedicated to the teaching mission, especially in the clinical departments
- Structured support and interprofessional engagement between basic science and clinical science educators
- Physician engagement with actual protected time/financed at a competitive rate to clinical responsibilities
- Focus on clinical educators and the burnout struggles they deal with as class size expands and there is greater emphasis on patient care
- Physical space for clinicians to teach and interact with learners; either by hoteling offices or dedicated rooms available to give learner-centered feedback
- On clerkship evaluations, should there be questions for students to evaluate/make observations about clinical faculty 'burnout' and if the 'burnout' is affecting teaching and education

Students –

- How do they want to learn? Incorporate what they are using
    a. videos – Boards & Beyond Feedback, Study for Boards
    b. Some schools have already gone to NO lectures