Wexner Medical Center	The Ohio State University College of Medicine **Executive Curriculum Committee** Meeting Minutes Date: 1/26/16 | Location: 150 Meiling

Presiding Chair: Howard Werman, MD	Call to order:	4:00pm
Minutes recorded by: Casey Leitwein	Adjourned:	6:15pm

Member attendance

Name	Role	Present
Howard Werman	Chair, Faculty member	Y
Laurie Belknap	Faculty Member	Y
Douglas Danforth	Academic Program Director, LSI Part One	Y
John Davis	Associate Dean for Medical Education	Y
Courtney Gilliam	Med Student Representative	Y
Alex Grieco	Chair, Academic Review Board	Y
Sorabh Khandelwal	Assistant Dean, Med Ed	Y
Nicholas Kman	Academic Program Director, LSI Part Three	Y
Nanette Lacuesta	Assistant Dean, Affiliated program	Y
Cynthia Ledford	Assistant Dean, Med Ed	Y
Thomas Mauger	Clinical Science Chair	Y
Leon McDougle	Academic Program Director, Associate Dean Diversity	N
Wanda McEntyre	Faculty Member, Faculty Council Rep	N
Douglas Post	Assistant Dean, Med Ed	Y
Andrej Rotter	Faculty Member- Faculty Council Rep	N
Charles Sanders	Assistant Dean, Affiliated program	Y
Jonathan Schaffir	Faculty Member	Y
Larry Schlesinger	Chair, Basic Science Department	Y
Kim Tartaglia	Academic Program Director, LSI Part Two	Y
Donald Thomas	Med Student Representative	Y

Additional attendees: Jack Kopechek

Agenda items

Item 1, Approval of minutes

Item 2, Graduate/Program Director Survey

Item 3, Interim Part Three Program

Item 4, Academic Standing Committee Proposal

Item 1, Approval of last meeting's minutes

Discussion

1. The meeting minutes from November 24, 2015 were approved by the committee.

Item 2, Graduate/Program Director Survey
Presenters: Dr. Cynthia Ledford

Discussion

1. Dr. Ledford presented on the results of the 2015 Graduate/Program Director survey given to the graduates and program directors from 2014, representing our 2006 curriculum. This survey takes significant amount of staff effort to achieve a 75% residency director response and 55% student response. All responses are based on comparisons to peers. The presentation is attached with historical data provided back to 2010.
2. There were 2.5% of program directors that identified graduates with deficiencies. Negative comments by program directors were reviewed. Dr. Kman raised questions about the ability of program directors to provide direct feedback to the College. Dr. Davis' contact information is provided on the survey to invite feedback.
3. There was a particular concern about mental health issues commented on by one of the program directors. There was a discussion about appropriate disclosure of this information on the student's MSPE.
4. The graduates responses were reviewed. The major themes were concerns about procedural training, autonomy in patient care and practice of preventive care.
5. Committee members thought it would be interesting to identify what programs, if any, are having the most problems. Dr. Ledford was unsure if the raw survey data would reveal this information.
6. Dr. Clinchot noted that the scale for the survey is comparative in nature (comparison to others in training program) versus criterion referenced. Dr. Khandelwal asked if there were programmatic goals for the response average.
7. Dr. Ledford suggested unbundling the averages for the 13 items for next year, presenting the frequency distributions for the responses instead, thus enabling us to develop hard metrics such as "no students far below average."
8. There was a discussion on how to incorporate this information to improving the curriculum. Dr. Clinchot suggested that an open text box be added that solicits additional information if certain items were checked so that we would obtain actionable items from the survey. The impact on response rate of this action was discussed.

9. Drs. Kman and Ledford are revamping this survey and will be presenting this to the CITL and ECC. The next survey will begin to be distributed in March.

Action Items

1. Frequency tables need to be added for each component (and presented 2014 data) and information on how we report data needs to be distributed.
2. A question on "is this intern progressing to meet milestones?" needs to be added to the survey.
3. Feedback needs to be incorporated on the survey along with a proposal on how to assess the entrustable professional activities (EPA's) by program directors for graduates of the COM. The survey needs to address all of the Core Educational Objectives.
4. The ECC members would like to review the modified survey before it goes out in March and will continue to these surveys annually.
5. These actions were approved by the ECC.

Item 3, Interim Part Three Report
Presenter: Dr. Nick Kman

Discussion

1. Dr. Kman presented interim data on Part 3 that is directed at bridging the chasm between undergraduate and graduate medical education. The presentation is attached. Dr. Kman reviewed the physicians and staff leadership for Part 3, noting that he would like more ambulatory representation.
2. The program goals were reviewed including achievement of the six core competencies as well as specialty-specific objectives as the academic basis for Part 3.
3. Dr. Kman reviewed all of the individual components of Part 3 including the evaluations for each component. There was specific discussion of AMRCC and AMHBC components of the curriculum including the appropriate EPA's covered each component. The major limitation has been the use of MyProgress for student evaluation as well as the EM teaching consistency. Some of the lower ranked components were among items felt to be valuable from an educational perspective and meet core competency requirements.
4. Dr. Kman reviewed both the clinical tracks and advanced competency electives. Medstar enrollment numbers may be inaccurate due to irregular naming conventions. Other areas reviewed included the HSIQ project which included patient satisfaction and quality of care projects.
5. Graduation requirements were reviewed.
6. Strengths of the program include rigor of the program and a comprehensive assessment of the core competencies. Another strength

is the scholarly output from the LSI curriculum including presentations on EPA10 and EPA13.

7. Dr. Kman highlighted the challenges with scheduling in MedStar and MyProgress. He also highlighted the fact that due to the number of longitudinal experiences in Part 3, there is a risk of student procrastination with subsequent risk to completion of the curriculum. There have also been some challenges in faculty and clerical support, especially for clinical tracks.
8. There are six states that currently will not allow credit for away electives due to issues with the Office of Distance Education. Dr. Schlessinger raised questions about the low number of students involved in an Advanced Competency in Research. Dr. Kman wants to look programmatically at the Advanced Competency in Research to assess the requirements for this electvie to determine whether they are too rigorous.
9. Dr. Khandelwal discussed the importance of role modeling for reflection
10. Dr. Kman highlighted the importance of the educational portfolios

Action Item

1. Dr. Kman will follow-up on the data to look for trends along with the following action items for the upcoming academic year.
    a. MyProgress 6.0 is being piloted right now. It is currently used for EM CPA. Part 3 is considering a 2-part CPA that would track hours and attendance for AMRCC (was your student present, for how many hours).
    b. scheduling will improve and be handled by Vitals
    c. AMRCC will continue to look at non-clinical requirements for several reasons. Are they necessary, do they assess what we want, how do we divide the work?
    d. there are plans to shorten ground school in AMRCC
    e. MyProgress and Vitals will both be examined for accurate reporting and tracking of students' attendance and requirements
    f. will trend students taking an Advanced Competency in Research to provide accurate numbers
2. The recommendations were accepted and approved by the ECC with a follow up report in the coming year

Item 3, Academic Standing Committee Proposal
Presenter: Dr. Sorabh Khandelwal

Discussion

1. Dr. Khandelwal presented a proposal assuring follow through with students that have been referred to a level 2 or 3 committee. This is in response to a previous presentation that was provided at the September

ECC meeting. The proposal is attached. The USMLE Committee already has a strong follow up process and is not included.
2. The process would assure loop closure with the recommendations of the Academic and Behavioral Review Committee.
3. Interval reports from the students to the Academic Advancement Committee would assist in keeping students on task in meeting the Committee's recommendations and would provide continuous feedback between the student and level 1 Student Review Committees that may be consolidated under a separate proposal.
4. The Portfolio Coaches will be more involved in this process but would not be responsible for holding students accountable; their role would only be supportive. Administration has also approved that coaches can remain in contact with students that are on a Leave of Absence.
5. The Academic and Behavioral Review Committee has the option of meeting with the students who fail to achieve recommended actions.

Action Item

1. The committee recommended that the coaches be oriented on the new process and receive advanced education so they are adequately prepared.
2. The ECC supported the proposal with the addition of the requirement for interval reports but asked that the language for the Student Handbook be reviewed.

Student Preparation Evaluation Graduates of 2014

Prepared by Nicole Verbeck, MPH
Office of Evaluation, Curriculum Research & Development
Presented to ECC Jan 26, 2016
By Cynthia H. Ledford, MD, Assistant Dean E+A

Survey Question Summary

1. Both directors and graduates were first asked to rate their level of satisfaction with thirteen program components which included data gathering and recoding skills, patient relationship and management, preventative care, communication, independent learning, teamwork, and professionalism.
2. Both surveys asked how well the residents were prepared in comparison to graduates from other medical schools.
3. Graduates were asked if they were pleased with the match, if their education was deficient in preparing them, if they would make any changes to the Med II-IV program, and then given the opportunity for additional comments.
4. Directors were asked if they were pleased with the match, if their resident had any deficiencies that they believed were a result of inadequate medical school training, and then given the opportunity for additional comments.

Updated NV: 9/22/15

Response Rate & Survey Methods

2014 Graduates (as of 8/1/15)	Adjusted N	Electronic Survey	Paper Survey	TOTAL Valid	Adjusted Return Rate
Directors= 212	212	127	33	*159	75.0%
Graduates= 212	212	103	15	**117	55.2%

Residency Directors***
- Electronic survey sent April 15th, May 7th, and May 21st
- Paper survey sent May 29th

OSU COM Graduates
- Electronic survey sent March 24th, April 8th, May 1st, and May 20th
- Paper survey sent May 29th

Updated NV: 11/25/14

Table 4.1: Residency Directors' Response to the Survey Question:

Compared to graduates of other medical schools, describe this resident's level of undergraduate medical school preparation.

Comparison across graduating classes of 2010-14

	2014	2013	2012	2011	2010
Much Worse	**5.0%**	1.5%	0.0%	0.6%	4.7%
Slightly Worse	**0.0%**	6.7%	6.2%	3.9%	5.4%
Very Similar	**29.4%**	31.9%	38.8%	27.7%	28.9%
Better	**35.6%**	31.9%	26.4%	34.2%	32.2%
Much Better	**30.0%**	28.1%	28.7%	33.5%	28.9%

Table 4.2: OSUCOM Graduate's Response to the Survey Question:

Describe how your medical school training compares to the training received by graduates from other medical schools?

Comparison across graduating classes of 2010-14

	2014	2013	2012	2011	2010
Much Worse	**0.9%**	0.0%	0.0%	0.0%	0.9%
Slightly Worse	**0.0%**	3.1%	1.0%	0.9%	1.8%
Very Similar	**24.8%**	16.7%	22.9%	18.0%	17.1%
Better	**38.5%**	41.7%	40.6%	44.1%	44.1%
Much Better	**35.9%**	38.5%	35.4%	36.9%	36.0%

Table 5.1: Residency Directors' Response to the Survey Question:
Are you please you matched with this resident?
Comparison across graduating classes 2010- 2014

	2014	2013	2012	2011	2010
Yes	**98.1**	95.7	95.2%	94.2%	88.4%
No	**1.9**	3.5	4.1	4.5	8.4
Missing	**0.0**	0.7	0.7	1.3	3.2
N	**162**	141	145	156	155

Table 5.2: OSU Graduates' Response to the Survey Question: **Are you pleased you matched with this residency program?** graduating class 2014

	2014
YES	**95.7**
NO	**4.3**
MISSING	**0.0**
Valid N	**117**

Table 6.1: Directors' Response to the Survey Question :

Does this resident have any deficiencies that you believe are a result of inadequate medical school training?

Graduate class 2014

	2014
YES	**2.5%**
NO	**95.7**
MISSING	**1.9**
N	**162**

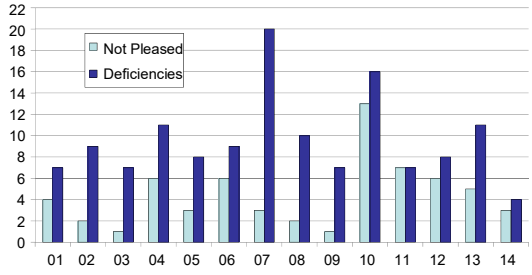
Table 6.2: Graduates' Response to the Survey Question:

Was your OSU medical education deficient in preparing you for residency in any way?

Comparison across Graduate classes: 2010-2014

	2014	2013	2012	2011	2010
Yes	**9.4%**	11.5%	12.3%	12.1%	17.1%
No	**89.7**	86.5	86.8	86.2	80.2
Missing	**0.9**	2.1	0.9	1.7	2.7
N	**117**	96	106	116	111

Figure 1. Frequency Counts: Directors Not Pleased to Match with Graduate or Reported Deficiencies in Preparation: Graduating Classes 2001-2014



N=159 director responses (75% response rate)

Graduating Class Year

Updated NV: 9/24/15

Comments from Directors Not Pleased to Match with Graduate

1. Not meeting pgy1 goals
2. this intern has very severe mental health issues (which I believe were known in medical school) and was not able to complete her intern year
3. this resident was not adequately prepared for PGY 1 year and required significant counselling in terms of adjustment to the intensity of the program and self-discipline

Updated NV: 9/24/15

Comments from Directors Regarding Resident Deficiencies They Felt were Due to Inadequate Medical School Training.

1. Student is kind and caring but very uncomfortable in social situations like interacting with teams.
2. more practice working in realistic clinical settings that will approximate work as an intern
3. Poor technical skills
4. as stated above, this resident clearly did not have a rigorous enough fourth year of medical school and came to residency ill-prepared in terms of knowledge base, attitude and work ethic requiring significant intervention

Updated NV: 9/24/15

Comments from Directors Regarding Resident Deficiencies They Felt were Not Due to Inadequate Medical School Training.

1. Has some difficulty with organizational skills and time management but I doubt that this is related to an inadequacy in medical school

Updated NV: 9/24/15

Comments from Graduates Who Felt their Medical Education was Deficient in Preparation for Residency (themes)

1. Procedures (7)
2. Discharges
3. More stringent and robust sub-I requirements (3)
4. ICU
5. Other Specific clinical content areas (hepatology, hem/onc, preventive medicine)

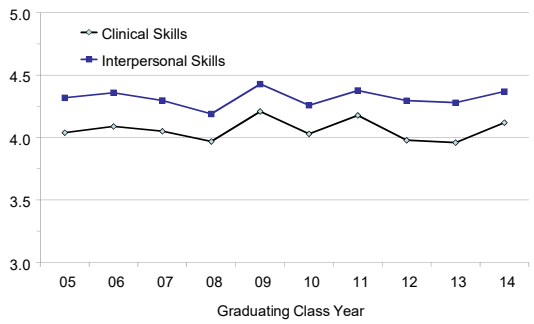
Updated NV: 9/22/15

See Table 3.1

Table 3.1: Mean ratings of medical school program components for Residency Directors and Graduates for Grad Classes 200

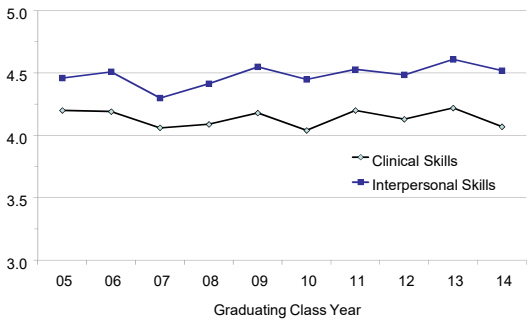
Program Component	Directors[1] Mean Ratings						Graduates[2] Mean Ratings					
Scale = (5) Very High (4) High (3) Medium (2) Low (1) Very Low	14	13	12	11	10	9	14	13	12	11	10	9
Data Gathering Skills	4.22	4.12	4.17	4.27	4.17	4.31	4.40	4.52	4.45	4.50	4.43	4.44
Data Recording Skills	4.22	4.07	4.17	4.21	4.16	4.28	4.28	4.38	4.31	4.42	4.27	4.29
General Medical Knowledge	4.08	3.84	3.97	4.16	4.06	4.25	4.09	4.28	4.27	4.32	4.09	4.26
Clinical Problem Solving	4.06	3.93	3.94	4.16	4.01	4.20	4.03	4.25	4.23	4.23	4.01	4.19
Clin. Skills involving procedures	4.05	3.82	3.86	4.04	3.89	4.05	3.60	3.84	3.53	3.70	3.56	3.77
Patient Management	4.08	3.98	3.99	4.17	4.01	4.20	4.03	4.07	4.00	4.01	3.93	4.13
COMP. CLINICAL SCALE AVG.	4.12	3.96	4.02	4.18	4.05	4.21	4.07	4.22	4.13	4.20	4.04	4.18
Communication Skills	4.18	4.18	4.19	4.25	4.19	4.30	4.56	4.51	4.46	4.42	4.41	4.51
Relationship with Patients	4.38	4.33	4.29	4.35	4.26	4.36	4.56	4.66	4.46	4.55	4.48	4.57
Professional Conduct	4.52	4.41	4.53	4.51	4.42	4.63	4.68	4.78	4.67	4.68	4.61	4.68
Participation on Health-Care Team	4.30	4.23	4.29	4.37	4.23	4.44	4.68	4.65	4.50	4.44	4.35	4.51
Sensitivity to Med. Ethics Issues	4.45	4.30	4.38	4.37	4.36	4.56	4.43	4.39	4.38	4.52	4.41	4.48
INTER / COMM SCALE AVG.	4.37	4.29	4.33	4.38	4.28	4.43	4.58	4.60	4.48	4.53	4.45	4.55
Independent Learning	4.21	4.08	4.11	4.26	4.08	4.30	4.23	4.39	4.28	4.2	4.15	4.40
Practice of Prev. Care	4.06	3.83	3.80	4.06	3.91	4.06	3.77	3.98	3.78	3.96	3.71	3.83
Sample Size (*Avg across all items)	*154	141	145	156	152	154	*117	96	106	116	111	122

Figure 2b. Residency Director's Average Ratings of OSU-COM Graduates, 2005-2014



Updated NV: 12/11/15

Figure 2d. OSUCOM Graduate's Ratings of Medical School Training: Classes of 2005-2014



Updated NV: 9/22/15

Accreditation Angst

(or How CQI Can Keep Your School Out of Trouble)

Dan Hunt, MD, MBA
LCME Co-Secretary

THE AAMC VIRTUAL MEDICAL EDUCATION EVENT

AAMC


TRUST ME
IM A DOCTOR

Role of Accreditation

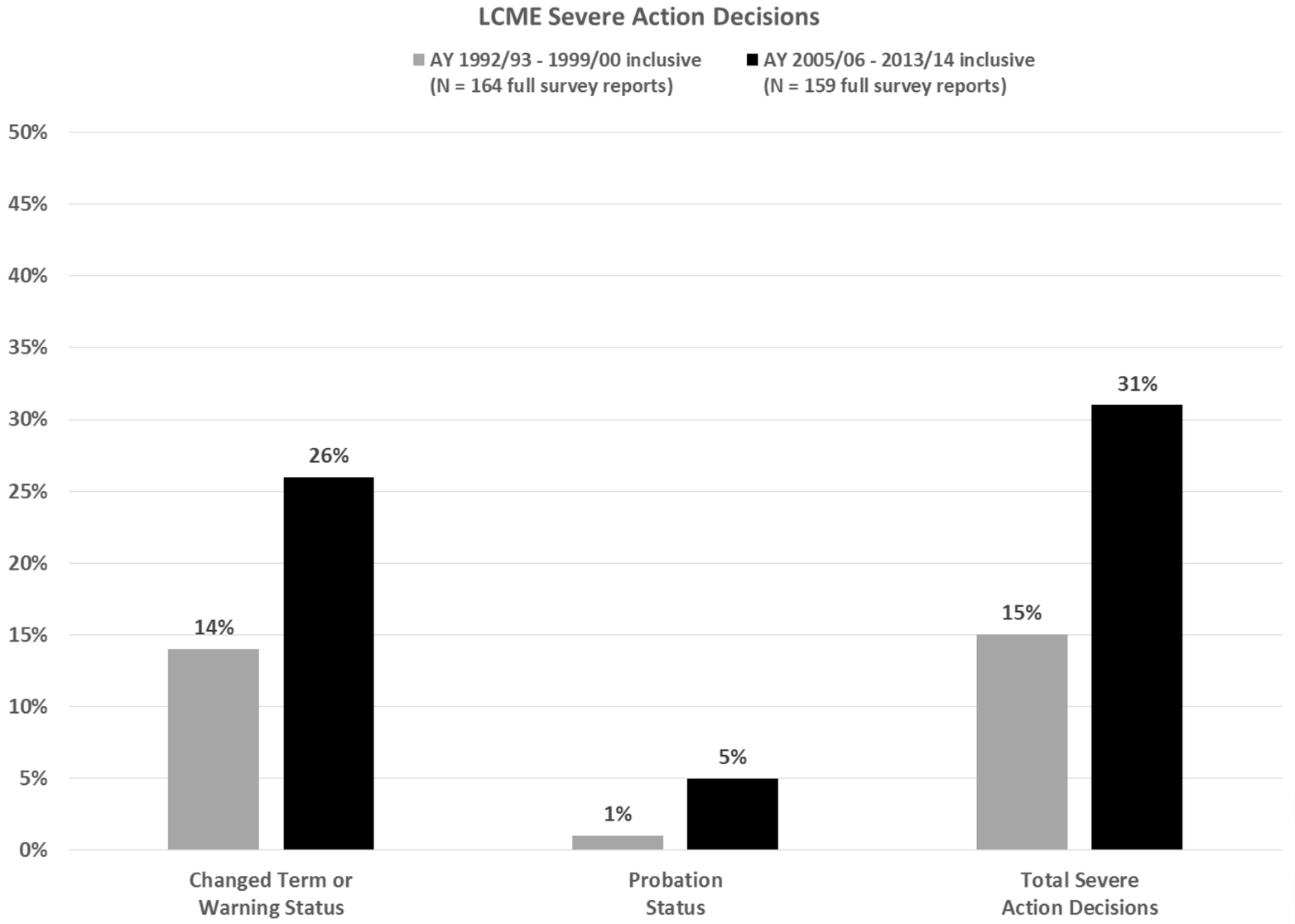
- Regulatory authority (5%)
- Quality assurance/improvement through peer review (90%)
- Agent of social change (5%)
- Organizational learning tool
- Language for a culture of quality

Non-Severe Action Decisions

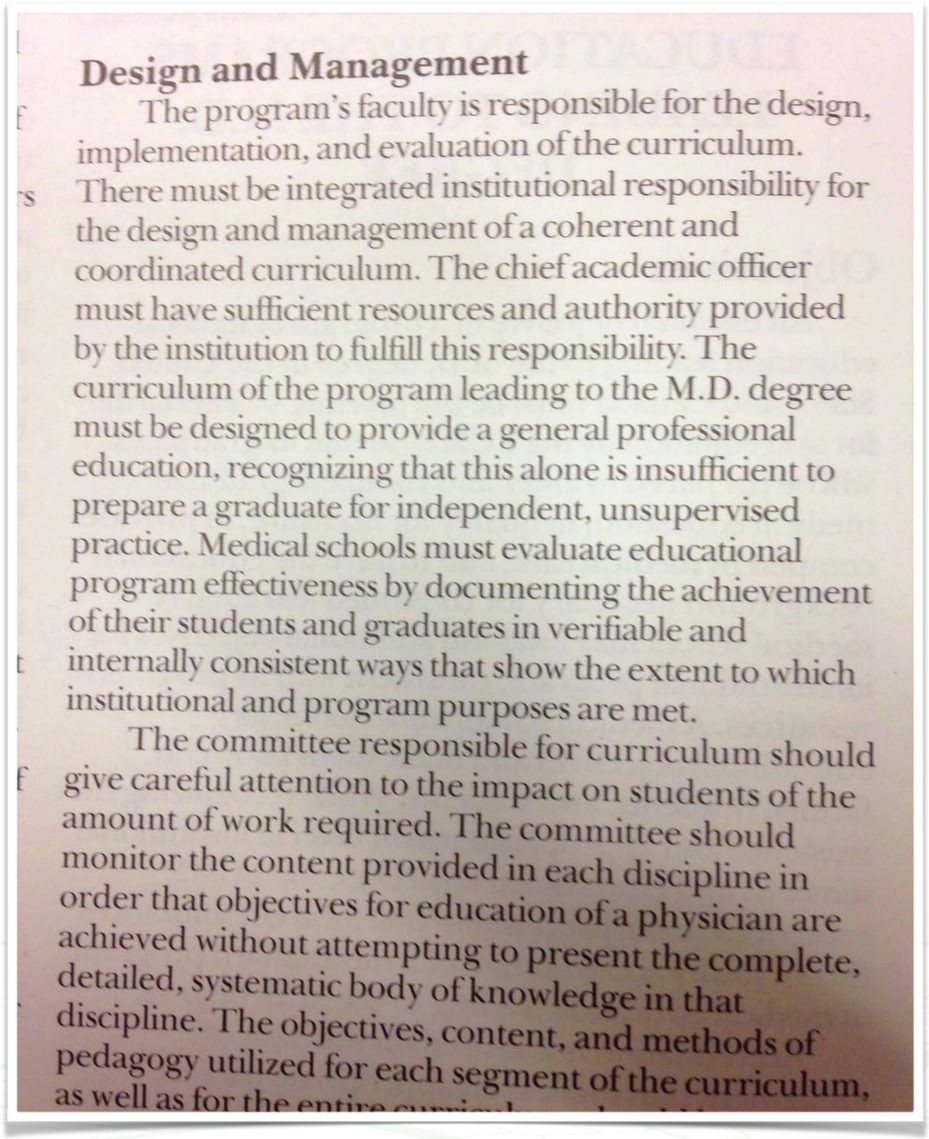
- full eight year term with possible status report due

Severe Action Decisions

1. Unspecified Accreditation Term (shortened)
2. Warning Status
3. Probation Status


LCME Severe Action Decisions
AY 1992/93 - 1999/00 inclusive
(N = 164 full survey reports)
AY 2005/06 - 2013/14 inclusive
(N = 159 full survey reports)
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
14%
26%
1%
5%
15%
31%
Changed Term or Warning Status
Probation Status
Total Severe Action Decisions

Pre-2002 Standards

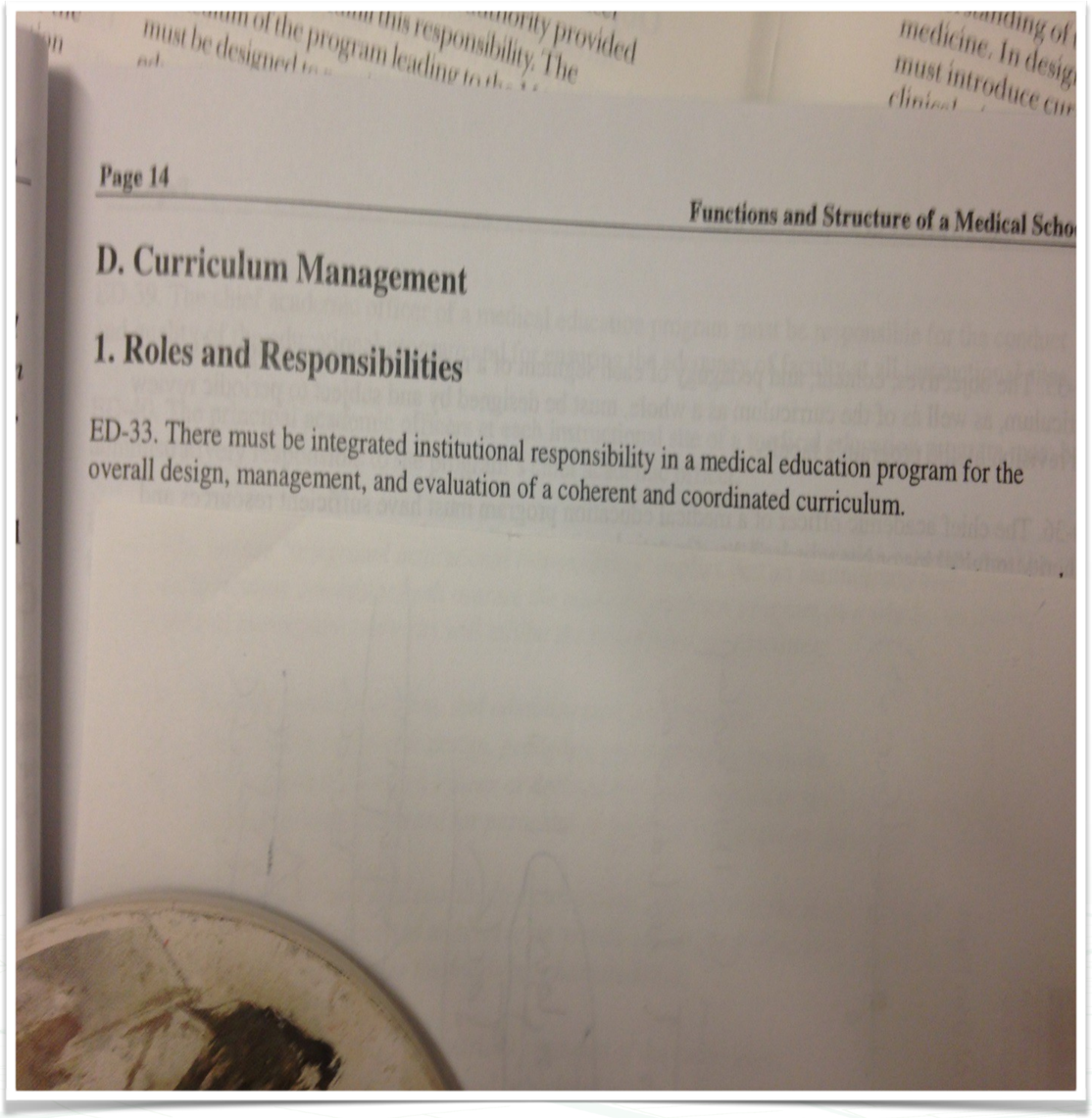


Design and Management

The program's faculty is responsible for the design, implementation, and evaluation of the curriculum. There must be integrated institutional responsibility for the design and management of a coherent and coordinated curriculum. The chief academic officer must have sufficient resources and authority provided by the institution to fulfill this responsibility. The curriculum of the program leading to the M.D. degree must be designed to provide a general professional education, recognizing that this alone is insufficient to prepare a graduate for independent, unsupervised practice. Medical schools must evaluate educational program effectiveness by documenting the achievement of their students and graduates in verifiable and internally consistent ways that show the extent to which institutional and program purposes are met.

The committee responsible for curriculum should give careful attention to the impact on students of the amount of work required. The committee should monitor the content provided in each discipline in order that objectives for education of a physician are achieved without attempting to present the complete, detailed, systematic body of knowledge in that discipline. The objectives, content, and methods of pedagogy utilized for each segment of the curriculum, as well as for the entire

Post-2002 Standards



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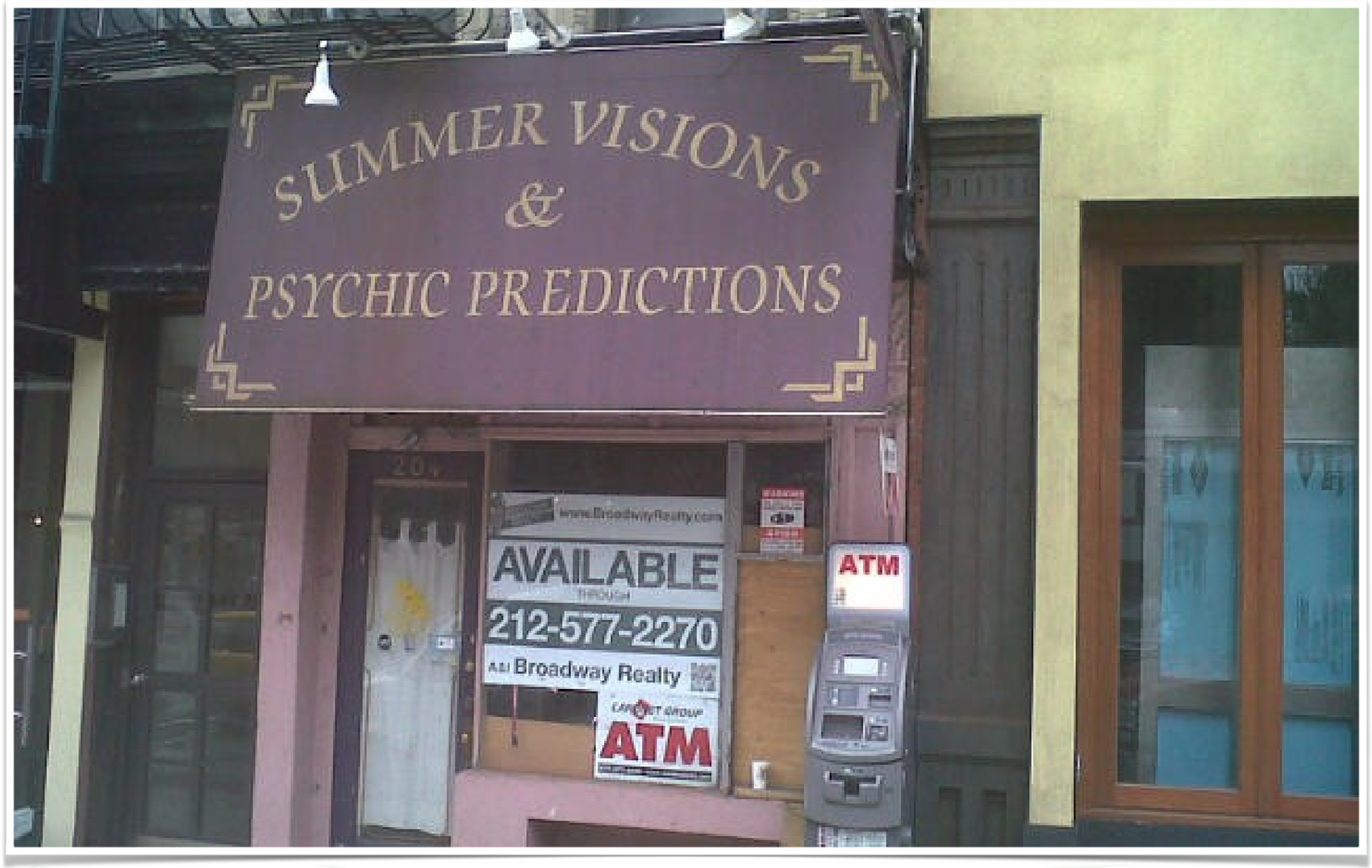
Functions and Structure of a Medical Scho

D. Curriculum Management

1. Roles and Responsibilities

ED-33. There must be integrated institutional responsibility in a medical education program for the overall design, management, and evaluation of a coherent and coordinated curriculum.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ATM
ATM

Continuous Monitoring is now a Prospective Requirement starting July 1, 2015

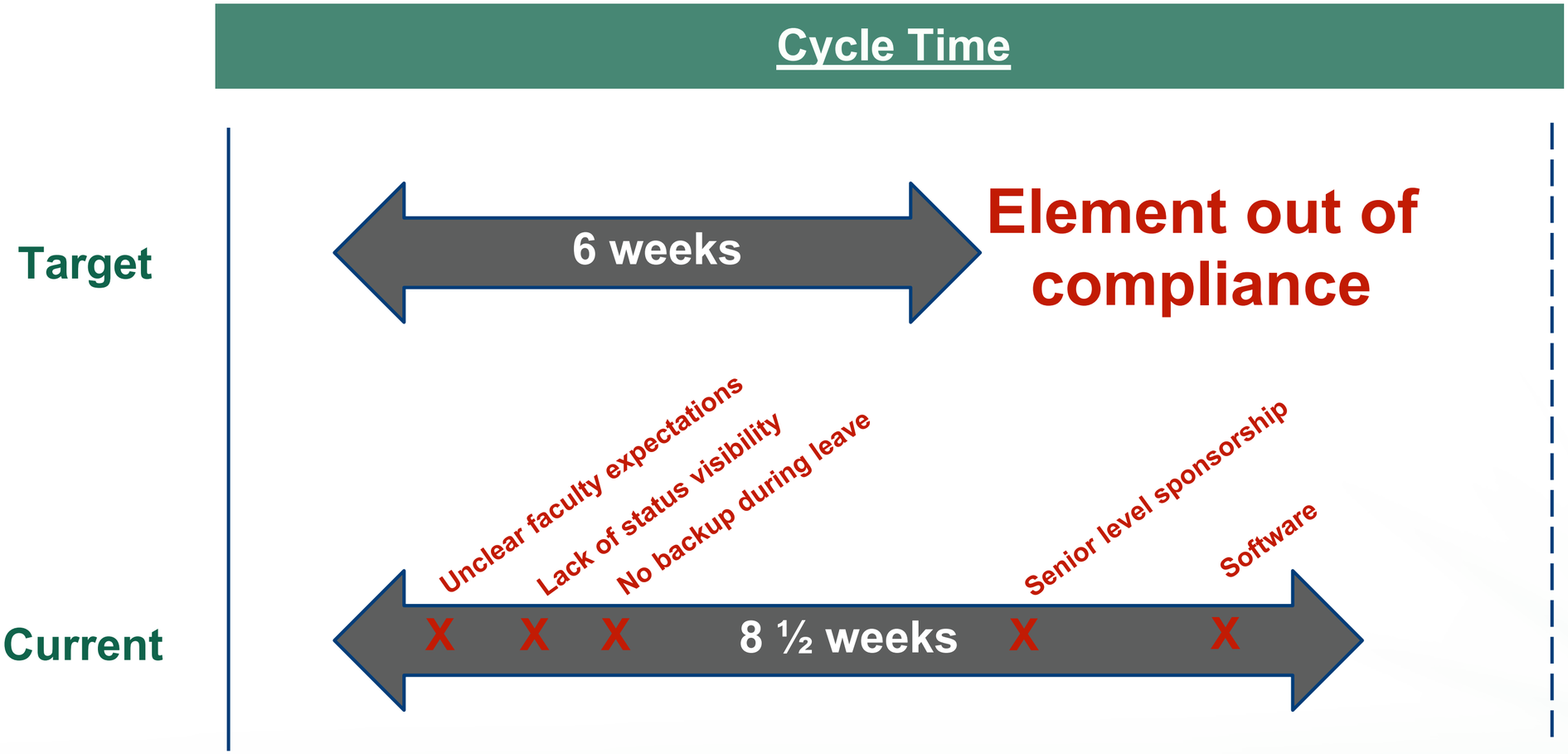
LCME Standard Element 1.1

A medical school engages in ongoing planning and continuous quality improvement processes that establish short and long-term programmatic goals, result in the achievement of measurable outcomes that are used to improve programmatic quality, **and ensure effective monitoring of the medical education program's compliance with accreditation standards.**

Different ways to manage educational CQI

- Contact for every school
- Canadian Checklist system for all standards/elements
- System monitoring for all standards/elements (Rosalind Franklin Chicago Medical School)
- Selective monitoring of key standards/elements (University of Chicago)
  - School priority areas (mistreatment, etc.)
  - Standards prone to “slippage” (direct observations)
  - Student environment (student safety)
  - New LCME standards

Element 9.8 Grades back to students in six weeks



Compliance versus Excellence?

11.1: Academic Advising

A medical school has an effective system of academic advising in place for students that integrates the efforts of faculty members, course and clerkship directors, and student affairs staff with its counseling and tutorial services and ensures that medical students can obtain academic counseling from individuals who have no role in making assessment or promotion decisions about them.

Measure: Academic Counseling mean satisfaction rate (on a scale of 1-5)**Standard of Compliance:** Within +/- 0.2 points of national mean
Standard of Excellence: More than 0.2 points above national mean

John Tomkowiak MD, MOL

Compliance versus Excellence?

8.7: Comparability of Education/Assessment

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.

Measure: Variation between student satisfaction ratings across all clinical sites

Standard of Compliance: Less than 20% variance

Standard of Excellence: Less than 10% variance

John Tomkowiak MD, MOL

Standards-Based Continuous Quality Leadership (CQL)

The determinations shown reflect self-assessments by the Chicago Medical School as a product of its continuing evaluation and process improvement efforts; as such, they are subject to change as circumstances and our assessments change. These determinations should not be interpreted as assessments of accreditation entities or other external bodies.

LCME STANDARDS DASHBOARD – Academic Year 2015-16 First Quarter

Status Key:

- = Achieved Excellence
- = In Compliance
- = In Compliance with Concern

Element	STANDARDS											
	S1	S2	S3	S4	S5	S6	S7	S8	S9	S10	S11	S12
1												
2												
3												
4												
5												
6												
7												
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10												
11												
12												

THE AAMC VIRTUAL MEDICAL EDUCATION EVENT

AAMC

THE AAMC VIRTUAL MEDICAL EDUCATION EVENT

AAMC

LSI Part 3
Interim Report to ECC

1/26/16

Dr. Nicholas Kman
@drnickkman

The Ohio State University
Wexner Medical Center

Goal of LSI Part 3

- Part 3 is the bridge from UGME to GME to prepare medical students for residency in their given specialty.

Part 3 Leadership Team

- Nicholas Kman MD, Academic Program Director
- Dan Cohen MD, Associate Director, Student Review
- Jenn McCallister MD, Director of Advanced Competencies and Clinical Tracks
- Ashley Fernandes MD PhD, Director of AMRCC
- Troy Schaffernocker MD, Director of AMHBC

Part 3 Leadership

- AMHBC
  - Dr. Troy Schaffernocker
  - Dr. Kristen Lewis
  - Dr. Laura Thompson
- AMRCC
  - Dr. Ashley Fernandes
  - Dr. Pat Ecklar
  - Dr. Kristen Rundell
- Advanced Competencies and Clinical Tracks
  - Dr. Jenn McCallister
  - Dr. Ansley Splinter
  - Dr. Meena Khan

Part 3 Expert Educators

- Dr. Allison Heacock (IM/Peds)
- Dr. Beth Liston (IM/Peds)
- Dr. David Lindsey (Acute Care Surgery)
- Dr. Jon Lipps (Anesthesiology)
- Dr. Cindy Leung (EM)
- Dr. DJ Scherzer (Peds EM)
- Dr. Nancy Liao (Peds)
- Dr. Mary Lynn Dell (Psychiatry/Ambulatory)

Part 3 Administrative Staff

- Laura Volk, LSI Part 2 and 3 Program Manager
- Katherine Ray, AMHBC-Mini Internship Coordinator
- Keri Nuesmeyer, AMRCC Coordinator
- Sharon Pfeil, AMHBC-EM Coordinator
- Beth Sabatino, Project Manager, VITALS
- Victoria Cannon, Director COM Office of Evaluation, Curricular Research and Development

Background

- The Part 3 Academic Program Committee is charged with certifying that a student has completed the requirements for Part 3 (i.e. the individual required courses and electives), and also is qualified for residency.
- Factors to be evaluated include:
  - Student's attitude toward patient care
  - Motivation
  - Attendance
  - Clinical problem solving ability
  - Adequacy of clinical medicine knowledge base
  - Evidence of increasing clinical competence over time
  - General suitability to be a physician.

7

Lyss-Lerman P, et al. What training is needed in the fourth year of medical school? Views of residency program directors. Acad Med. 2009 Jul;84(7):823-9.

- "Organizing the curriculum with **specialty-specific tracks** could be explored by looking at specialty-specific data and expanding the interviews to include more PDs."

8

Walling A, Merando A. The fourth year of medical education: a literature review. Acad Med. 2010 Nov;85(11):1698-704.

- ACGME policies and practices will increasingly influence medical student education
- **4th year as capstone for medical school versus preparation year for residency**
  - **Turned in favor of the pre-residency viewpoint**
- Other factors that increase pressure towards using 4th year to prepare for residency are student debt and growing specter of unmatched US graduates

Reddy ST, et al. ACE perspective paper: recommendations for redesigning the "final year" of medical school. Teach Learn Med. 2014;26(4):420-7.

- Demonstrate that they have mastered objectives (based on 6 ACGME Core Clinical Competencies)
- Complete a required capstone course prepares students for residency.
- **Structure their 4th year schedules to accomplish specialty-specific objectives that prepare them for their intended specialty.**
- Engage in thoughtful inventory of training. Identified gaps should be addressed through deliberate participation in rotations that address identified areas.

10

Reddy ST, et al. ACE perspective paper: recommendations for redesigning the "final year" of medical school. Teach Learn Med. 2014;26(4):420-7.

- 4th year is a bridge between medical school and Residency:
  - ACGME Competencies and AAMC Core Entrustable Professional Activities (EPAs) should be used to guide curriculum development.
- **These competencies and specialty-specific milestones and EPAs provide guidance to medical schools for the minimum level of competency for starting intern and can be used to design 4th-year curricula.**

11

Core Tenets of Part 3

- Preparing for residency through increased patient care and working toward Milestones
- Time for guidance and preparation for USMLE examinations and residency interviews
- Study and explore specialties/competencies in depth (career choice)
- Understanding different practice settings to prepare for later decisions
- Having time to foster and nurture socially responsible activities and interests such as service learning

12

PART 3 Components

Part Three
Advanced Clinical Management

- Advanced Management in Hospital Based Care (8 weeks)
- Advanced Management in Relationship Centered Care
- Advanced Competency Elective
- Other Electives (4 total required including Advanced Competency)
- Flex
- Gateway Activities
- HSIQ Project
- Showcase Portfolio

Clinical Tracks:
A longitudinal experience in a specialty or subspecialty designed to prepare students to be an intern/incoming resident by meeting entry level milestones in that field.

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Advanced Management in Hospital Based Care

	Mean	Std. Dev	N
Overall quality of the course: AMHBC (4-point scale: Poor, Fair, Good, Excellent)	3.41	0.52	74
Overall quality of learning: AMHBC-EM (4-point scale: Poor, Fair, Good, Excellent)	3.40	0.60	112
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4-point scale: Poor, Fair, Good, Excellent, n=74

Advanced Management in Hospital Based Care

	Mean	Std. Dev
Didactic components - EM	2.97	0.77
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OSCE MI	3.09	0.64
DOC – EM	3.11	0.71
EM clinical assignment	3.31	0.74
MI clinical assignment	3.55	0.74

4-point scale: Poor, Fair, Good, Excellent, n=74

Student Feedback
Areas of Strength

Simulations

"The EM simulation was great, as was the medic ride along. On MICU, I learned a ton and thought I had an appropriate patient load and responsibilities. Lots of opportunities for procedures on both. All the residents I worked with were fantastic."

"Simulation at the end of the EM rotation was very useful, particularly because of the feedback portion -- this helped pinpoint what went well and what needed improvement."

"For EM: enjoyed simulation activities and Expert Educator session For mini-I: residents and faculty very invested in teaching."

FOSCE/OSCEs

2

"The OSCE during the Mini-Internship was by far the best OSCE we have ever had, the realistic situations and the immediate feedback was extremely helpful. In my opinion, many of the OSCEs in third year should ideally be changed to have a similar format. Fewer stations with some immediate feedback from doctors was more beneficial than all the other OSCEs put together."

" It really focused on the practical skills that are important for internship but often get missed when you are in the role of the "Third Year Student". Things like obtaining informed consent, taking a nursing phone call, interpreting data to make quick management decisions. I discovered many gaps in my abilities that I could then work on during the course of the rotation.

Integration

3

"Integrating the two was helpful, especially if the courses are taken close together in time. I felt that the extra reading and modules were generally of high quality and worth the time spent on them."

"Most important time was that spent working with the team, seeing what residents do and seeing yourself in their shoes. On EM the expert educator rounds were really good."

"Good clinical experiences. The case conference was a good way to integrate the EM and sub-I components."

Wexner Medical Center

Student Feedback
Areas For Improvement

Simulations

"My main feedback is that the hands-on sessions for EM should have been at the beginning of the rotation. I know personally for me that would have helped me to build confidence and use those skills more often during the rotation. Also, some of the preceptors where I did EM were enthusiastic instructors and some basically tolerated my presence and seemed uninterested in teaching (Memorial in Marysville). The PA's and nurses there were all OUTSTANDING, might be worth letting future student rotators know that working directly with the PA's/nurses is a great option if the attending basically ignores you. The nurses do a LOT of triage/assessment work there and 90% of the time put in all the orders before the patient is even seen by the attending."

MyProgress

"My Progress. If myprogress must remain, then the focus needs to be on making it as smoothly integrated and minimally obtrusive as possible."

"It is sometimes difficult during busy EM shifts to ensure getting a "checklist" filled out, especially if traumas/emergency patients come within an hour of end of shift."

"Had a horrible experience getting myprogress to work on ED rotation. Really felt like I did not get very good feedback on this rotation because there was so much frustration getting myprogress to work."

Interdisciplinary Team

"The emergency medicine rotation where I was (OSU) was extremely hit and miss as far as teaching by attending physicians. Some encouragement for them to at least teach one thing each shift, even if it is not something that was seen during the shift, would be helpful. There were some attendings that had me staff with the residents and basically did not say a word to me the entire shift."

Wexner Medical Center

AMHBC Course Development and Expansion

- Targets for Expansion
  - Ross ICU – Anesthesia - Mini-I
  - Ob/Gyn – Mini-I
  - Inpatient Psychiatry – Mini-I
  - Surgical Subspecialties – Mini-I
- TLM Development
  - EM eModules/Quizzes
  - Mini-I Informed Consent Module

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Overall quality of the course: AMRCC (4-point scale: Poor, Fair, Good, Excellent)	2.95	0.53	43
Overall quality of learning: AMRCC-AMB (4-point scale: Poor, Fair, Good, Excellent)	4.35	0.64	100
Overall quality of learning: AMRCC-ICC (5-point scale: Poor, Fair, Good, Very Good, Excellent)	4.47	0.85	104

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AMRCC Overall Course Evaluation

- 1. Quality: Question #1 RATE THE OVERALL QUALITY OF THE COURSE, I.E. AMRCC AS A WHOLE.
  - 2.95/4.00—36/43 or 84% rating it good or excellent
  - GOAL FOR 2015-2016: Would like to see this number above 3.5, long-term, above 3.3 for next year
- 2. Organization: Question #2 THIS PART OF THE CURRICULUM WAS WELL ORGANIZED.
  - 3.84/5.00—33/43 or 77% agreed or strongly agreed
- 3. Integration within LSI: Question #3 THIS PART OF THE CURRICULUM WAS WELL INTEGRATED, I.E. CONSTITUENT PARTS WERE ORGANIZED IN SUCH A WAY AS TO FUNCTION AS AN INTERRELATED WHOLE.
  - 3.79/5.00—30/43 or 69% agreed or strongly agreed

Advanced Management in Relationship Centered Care

	Mean	Std. Dev
Didactic components	2.64	0.84
Ground school	2.67	0.67
TBLs	2.74	0.87
Critical appraisal of a topic	2.37	0.71
Home health visit	2.86	0.96
Reflection	2.49	0.82
DOC exercises	2.91	0.68
AMB clinical assignment	3.44	0.66
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4-point scale: Poor, Fair, Good, Excellent, n=74

Comments:

- "Cut the fat" (#, types of assignments)
- Communication: "Greater communication" about AMRCC off-site requirements, didactics, exams, hours with clinical sites
- TBLs—clearer questions: "It was especially difficult when we were asked what the best correct answer was out of 4 options that were all objectively correct.)

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A longitudinal experience in a specialty or subspecialty designed to prepare students to be an intern/incoming resident by meeting entry level milestones in that field.

Clinical Track Enrollment

Course	# of Students
Anesthesiology	9
Emergency Medicine	17
Family Medicine	17
Internal Medicine (Categorical and Combined)	50
Internal Medicine (preliminary)	19
OBGYN	10
Pediatrics	14
Psychiatry	10
Neurology	4
Radiology	6
Surgery / Surgical Subspecialties (Preliminary surgery included)	35
Total	191

Advanced Competencies

Course	2013-14 # of Students	2015-16 # of Students
Adv. Procedural Competency for Acute Practitioners / AC in Critical Care and Procedures	19	11
AC in Global Health	18	14
AC in Research	19	3
Biomedical Informatics	3	4
Emergency Preparedness / Disaster Management	13	12
Genetics	6	12
Health Literacy	2	4
Hot-Spotting Team Care of Frequent Healthcare Consumers	Not offered	0
Interdisciplinary Perspectives on Developmental Disabilities	Not offered	1
Interprofessional Care for the Underserved Patient	Not offered	4
Interprofessional Collaboration	10	Not offered
Latino Health	6	0
Medical Administration	2	Not offered
Patient Experience	22	0
Professionalism and Humanism	4	9
Teaching in Medicine	6	7
Ultrasound Immersion	26	5

Advanced Competencies: Highlights

- Global Health
- Emergency Preparedness and Disaster Response
- Ultrasound Immersion
- Interprofessional Care for the Underserved Patient

Advanced Competencies: Highlights

- **Global Health**
- Emergency Preparedness and Disaster Response
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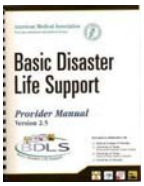
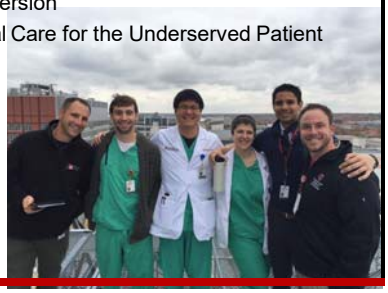
Advanced Competencies: Highlights

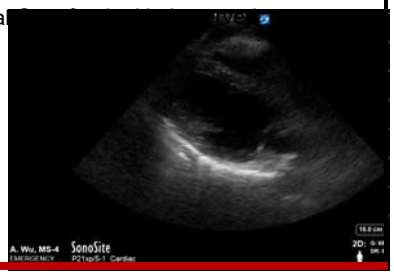
- Global Health
- **Emergency Preparedness and Disaster Response**
- Ultrasound Immersion
- Interprofessional Care for the Underserved Patient





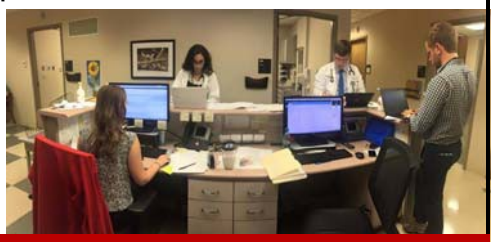
Advanced Competencies: Highlights

- Global Health
- Emergency Preparedness and Disaster Response
- **Ultrasound Immersion**
- Interprofessional



Advanced Competencies: Highlights

- Global Health
- Emergency Preparedness and Disaster Response
- Ultrasound Immersion
- **Interprofessional Care for the Underserved Patient**

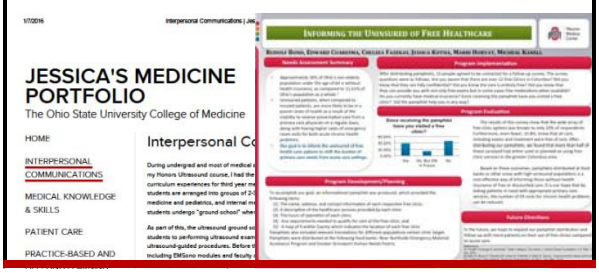


HSIQ in Part 3

- EPA 13: Identify system failures and contribute to a culture of safety and improvement
- HSIQ develops competency in application of DMAIC (Define, Measure, Analyze, Implement and Control) process improvement methodology to create healthcare improvement. Consists of group didactics in addition to student led value-creation projects.
- Project themes are:
- 1. Cost-conscious Care/High-Value Care
- 2. Improving the Patient Experience/Patient Satisfaction.

Certification for Match/Graduation

- Completion of 4 required courses, completion of 4 electives (including 1 or more advanced competencies), completion of HSIQ project and Showcase Portfolio.



Success of Part 3

- New rigor of Med 4 at OSU.
- AMHBC Mini Internship
- AMRCC Curricular Development
- Teaching and beginning of assessment for EPA's.
- Reality of the Clinical Tracks forming the structure of Part 3.
- Scholarship and Visibility of Part 3.

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Part 3 Scholarship

- Liston B, Tartaglia T, Schaffernocker T. Advanced Management in Hospital Based Care. *Presented at CDIM Meeting 2012.*
- Pollard KA, Bachmann DJ, Greer M, Way DP, Kman NE. Development of a disaster preparedness curriculum for medical students: A pilot study of incorporating local events into training opportunities. *Am J Disaster Med.* 2015 Winter;10(1):51-9.
- Thompson L, Leung C, Green B, Lipps J, Schaffernocker T, Ledford C, Davis J, Kman N. Assessment of Entrustable Professional Activity (EPA) 10 in a Mandatory Fourth Year Emergency Medicine (EM) Clerkship. *Presented at AAMC Medical Education Meeting (Baltimore, MD 11/11/15).*
- Gonsenhauser I, Clevenger A, Heacock A, Kman N, Tartaglia K, Ledford C, Davis J, Moffatt-Bruce S. Last But Not Least: EPA 13 - Entrusting the Clinicians of Tomorrow To Improve Healthcare Today. *Presented at AAMC Medical Education Meeting (Baltimore, MD 11/11/15).*
- Leung C, Russell D, Way DP, Thompson L, Greenberger S, Kman N. Observation without Active Participation is an Effective Method of Learning in High Fidelity Simulation. *Presented at the Council of Residency Directors (CORD) Annual Meeting (Phoenix, AZ 4/15/15) and at Society of Academic Emergency Medicine (SAEM) (San Diego, CA 5/13/15).*
- Kman NE, Leung C, Hartnett D, Greenberger S, Bachmann D, Way D, Khandelwal S, Martin D. An Expert Educator Teaching Shift Used as a Method to Assess Milestones in Students. *Presented at the Council of Residency Directors (CORD) Annual Meeting Curricular Innovations Session (Phoenix, AZ 4/16/15).*

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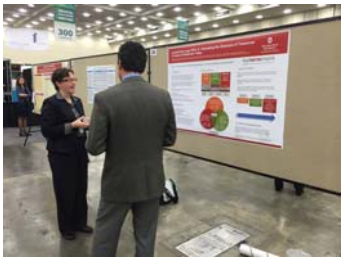

Part 3 Scholarship

- Kman N. The Transition to Residency: Alliance for Clinical Education (ACE) Panel Discussion. *AAMC Annual Meeting (Baltimore, MD 11/10/15).*
- Patwari R, Ko P, Askew K, Kman N. The Post-Clerkship Curriculum: A Lost Opportunity. *Problem Solving Session at The Generalists in Medical Education (Baltimore, MD 11/9/15).*
- Khan M, Kman N, McCallister J, Rundell R, Splinter A. Creation Of Advanced Clinical Tracks: Assessing And Assuring Preparedness For Internship Using The ACGME Milestones. *Workshop Presentation at the National Resident Matching Program (NMRP) National Conference: Transition to Residency: Conversations Across the Medical Education Continuum (New Orleans, LA 10/2/15).*
- Fernandes AK, Ecklar P, Clinchot D. Integrating simulated patients in TBL: A strategy for success in medical education. *Accepted for presentation at Team-Based Learning Collaborative Conference, Santa Fe, NM, March 3-5, 2016.*
- Prats MI, Royall NA, Panchal AR, Way DP, Bahner DP. Outcomes of an advanced ultrasound course: Preparing medical students for residency and practice. Journal of Ultrasound in Medicine. (In Press).
- **Part 3 Grant Submissions**
- Moffat-Bruce, Gonsenhauser, Heacock, Kman. Clinical Care Innovation Challenge Pilot Award AAMC 2015.

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Areas of Challenge

- MedSTAR: Scheduling process was fraught with difficulty for the students. Courses were not consistantly labelled and students "hoarded" AMHBC Mini-I's.
- MyProgress: Students were able to see and change evaluations in the ED. We have not yet gotten the app to work consistently in Part 3.
- AMRCC Non-Clinical Requirements (Challenge and Opportunity)
- Tracking of Student Progress on Longitudinal Rotations
- Faculty and Clerical Support for Part 3
- Away Electives/States

41

Action Plan

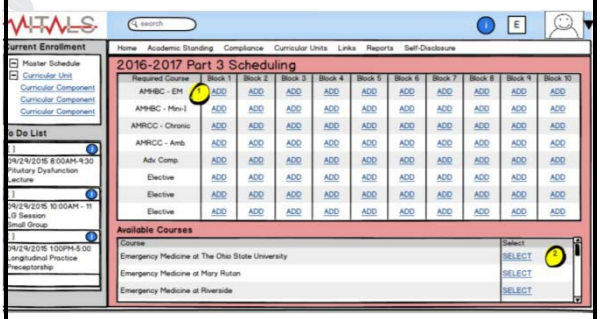
- Part 3 scheduling and course management will move to Vitals. Work with Beth to steamline scheduling process and faculty view of student schedule.
- My Progress 6.0 is being piloted right now. Currently used for EM CPA. Will attempt to move tracking and attendance for AMRCC here with limited CPA.
- AMRCC will continue to look at Non-Clinical Requirements for several reasons. Are they necessary, do they assess what we want, how do we divide the work
- My Progress and Vitals will both be examined for accurate reporting and tracking of students attendance and requirements
- I propose that Ashley Fernandes and Troy Schaffernocker be brought up to 0.25 FTE for the work and rigor required for their courses. Previously DOC directors each received 0.25 FTE.
- Unapproved States down to 6. IM working with Derm to steamline their process.

42

Action Plan

- Part 3 scheduling and course management will move to Vitals. Work with Beth to streamline scheduling process and faculty view of student schedule.
- Student schedules will be formatted so all blocks, including Flex time, will appear in schedule

Part 3 Scheduling In Vitals



Action Plan

- My Progress 6.0 is being piloted right now. Currently used for EM CPA. Will attempt to move tracking and attendance for AMRCC here with limited CPA.
- Considering a 2 part CPA that would track hours and attendance for AMRCC (was your student present, for how many hours).

Action Plan

- AMRCC will continue to look at Non-Clinical Requirements for several reasons. Are they necessary, do they assess what we want, how do we divide the work?
- Virtual patient cases have gone away.
- Plans to shorten ground school.

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Action Plan

- **Away Electives:** Unapproved States down to 6. Away elective process has been dissected and appears to be working well in most cases.
- Spoke to N/S and Ortho who would like to continue our current process. No sweeping changes needed.

Questions?

PART 3 PROGRAM EVALUATION AND INTERIM REPORT

CLASS OF 2016

DATA AND DATA ANALYSIS

Prepared by Kman N, Cannon V, Verbeck N, Volk L.

EXECUTIVE SUMMARY

Prepared by Nicholas E. Kman, MD FACEP

Executive Summary:

Best Successes

1. New rigor of Med 4 Part 3 year.
2. Assessment of Entrustment with focus on EPA's
3. Scholarship and visibility of Part 3

Areas of Challenge-

1. MedSTAR: Scheduling process was fraught with difficulty for the students. Courses were not consistantly labelled and students "hoarded" AMHBC Mini-I's.
2. MyProgress: Students were able to see and change evaluations in the ED. We have not yet gotten the app to work consistently in Part 3.
3. AMRCC Non-Clinical Requirements
4. Tracking of Student Progress on Longitudinal Rotations
5. Faculty and Clerical Support for Part 3
6. Away Electives: Approved States vs. Unapproved States

Action Plan:

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2. My Progress 6.0 is being piloted right now. Currently used for EM CPA. Will attempt to move tracking and attendance for AMRCC here with limited CPA.
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4. My Progress and Vitals will both be examined for accurate reporting and tracking of students attendance and requirements
5. I propose that Ashley Fernandes and Troy Schaffernocker be brought up to 0.25 FTE for the work and rigor required for their courses. Previously DOC directors each received 0.25 FTE.
6. Only 6 states remain on unapproved list.

Background:

Part 3 Academic Program Purpose: The Part 3 Academic Program Committee is charged with responsibility of certifying that a student has completed the technical requirements for Part 3 (i.e. the individual required courses and electives), and also is qualified to continue studies in an internship or residency. Factors to be evaluated include: student's attitude toward patient care, motivation, attendance, clinical problem solving ability, adequacy of clinical medicine knowledge base, evidence of increasing clinical competence over time, and general suitability to be a physician.

Several recent papers on the 4th year of medical school have recommended organizing the 4th year so that students accomplish specialty-specific objectives that prepare them for their intended specialty (1, 2, 3a). We structured Part 3 to better align with our competency based curriculum by creating specialty-specific clinical tracks. These tracks are used to guide fourth year students to customize their final year of medical school such that their rotations and experiences will prepare them for the specialty of their choosing. The goal for the creation of these tracks is to enhance students' preparation to begin internship by working towards a subset of entry level milestones over the fourth year of medical school for that particular specialty.

Part 3 Leadership, Administration and Expert Educators

Associate Program Director

Chair, Part 3 Student Review Committee

Dr. Dan Cohen

AMHBC

Director, Dr. Troy Schaffernocker

Associate Director Mini Internship, Dr. Kristen Lewis

Associate Director Emergency Medicine, Dr. Laura Thompson

AMRCC

Director, Dr. Ashley Fernandes

Associate Director, Dr. Pat Ecklar

Associate Director, Dr. Kristen Rundell

Advanced Competencies and Clinical Tracks

Director, Dr. Jenn McCallister

Associate Director, Dr. Ansley Splinter

Associate Director, Dr. Meena Khan

Part 3 Expert Educators

Dr. Allison Heacock (IM/Peds)

Dr. Beth Liston (IM/Peds)

Dr. David Lindsey (Acute Care Surgery)

Dr. Jon Lipps (Anesthesiology)

Dr. Cindy Leung (EM)

Dr. DJ Scherzer (Peds EM)

Dr. Nancy Liao (Peds)

Dr. Mary Lynn Dell (Psychiatry/Ambulatory)

Organization of the Data in this Report

This report compiles results of program evaluation measures for the 2016 Graduating Class of *Lead.Serve.Inspire for the academic year of 2015-2016.* This is a follow up of the report given to ECC on 3/24/15.

1. Evaluations of the entire program (i.e. End of Program Evaluation) are not yet available

2. Evaluations of each Curricular Unit and major Components (end of unit or component evaluations)

3. Evaluations of teaching sessions and teachers
    a. Teaching sessions- Teaching & Learning Method (TLM) Evaluations (rank order by type)
    b. Teachers
        i. of Didactics
        ii. of special groups of didactics
        iii. of Clinical Assignments

Evaluations of each Curricular Unit and major Components (end of unit or component evaluations)

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Genetics	6	12
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Interdisciplinary Perspectives on Developmental Disabilities	Not offered	1
Interprofessional Care for the Underserved Patient	Not offered	4
Interprofessional Collaboration	10	Not offered
Latino Health	6	0
Medical Administration	2	Not offered
Patient Experience	22	0
Professionalism and Humanism	4	9
Teaching in Medicine	6	7
Ultrasound Immersion	26	5

Part 3 Scholarship: Current Projects, Presentations and Publications:

1. Liston B, Tartaglia T, Schaffernocker T. Advanced Management in Hospital Based Care. *Presented at CDIM Meeting 2010?*

2. Pollard KA, Bachmann DJ, Greer M, Way DP, Kman NE. Development of a disaster preparedness curriculum for medical students: A pilot study of incorporating local events into training opportunities. *Am J Disaster Med.* 2015 Winter;10(1):51-9. doi: 10.5055/ajdm.2015.0188. PubMed PMID: 26102045.

3. Thompson L, Leung C, Green B, Lipps J, Schaffernocker T, Ledford C, Davis J, Kman N. Assessment of Entrustable Professional Activity (EPA) 10 in a Mandatory Fourth Year Emergency Medicine (EM) Clerkship. *Presented at AAMC Medical Education Meeting (Baltimore, MD 11/11/15).*

4. Gonsenhauser I, Clevenger A, Heacock A, Kman N, Tartaglia K, Ledford C, Davis J, Moffatt-Bruce S. Last But Not Least: EPA 13 - Entrusting the Clinicians of Tomorrow To Improve Healthcare Today. *Presented at AAMC Medical Education Meeting (Baltimore, MD 11/11/15).*

5. Leung C, Russell D, Way DP, Thompson L, Greenberger S, Kman N. Observation without Active Participation is an Effective Method of Learning in High Fidelity Simulation. *Presented at the Council of Residency Directors (CORD) Annual Meeting (Phoenix, AZ 4/15/15) and at Society of Academic Emergency Medicine (SAEM) (San Diego, CA 5/13/15).*

6. Kman NE, Leung C, Hartnett D, Greenberger S, Bachmann D, Way D, Khandelwal S, Martin D. An Expert Educator Teaching Shift Used as a Method to Assess Milestones in Students. *Presented at the Council of Residency Directors (CORD) Annual Meeting Curricular Innovations Session (Phoenix, AZ 4/16/15).*
7. Kman N. The Transition to Residency: Alliance for Clinical Education (ACE) Panel Discussion. *AAMC Annual Meeting (Baltimore, MD 11/10/15).*
8. Patwari R, Ko P, Askew K, Kman N. The Post-Clerkship Curriculum: A Lost Opportunity. *Problem Solving Session at The Generalists in Medical Education (Baltimore, MD 11/9/15).*
9. Khan M, Kman N, McCallister J, Rundell R, Splinter A. Creation Of Advanced Clinical Tracks: Assessing And Assuring Preparedness For Internship Using The ACGME Milestones. *Workshop Presentation at the National Resident Matching Program (NMRP) National Conference: Transition to Residency: Conversations Across the Medical Education Continuum (New Orleans, LA 10/2/15).*
10. Fernandes AK, Ecklar P, Clinchot D. Integrating simulated patients in TBL: A strategy for success in medical education. *Accepted for presentation at Team-Based Learning Collaborative Conference, Santa Fe, NM, March 3-5, 2016.*
11. Prats MI, Royall NA, Panchal AR, Way DP, Bahner DP. Outcomes of an advanced ultrasound course: Preparing medical students for residency and practice. Journal of Ultrasound in Medicine. (In Press).

Part 3 Grant Submissions

Moffat-Bruce, Gonsenhauser, Heacock, Kman. Clinical Care Innovation Challenge Pilot Award AAMC 2015.

References:

1. Reddy, S.T., et al., *Alliance for clinical education perspective paper: recommendations for redesigning the "final year" of medical school.* Teach Learn Med, 2014. **26**(4): p. 420-7.
2. Lyss-Lerman, P., et al., *What training is needed in the fourth year of medical school? Views of residency program directors.* Acad Med, 2009. **84**(7): p. 823-9.
3. Walling A, Merando A. The fourth year of medical education: a literature review. Acad Med. 2010 Nov;85(11):1698-704.
4. Chen HC, van den Broek WE, ten Cate O. The case for use of entrustable professional activities in undergraduate medical education. Acad Med. 2015 Apr;90(4):431-6
5. Elnicki, et al for the CDIM/Association of Program Directors in Internal Medicine Committee on Transition to Internship. Course Offerings in the Fourth Year of Medical School: How U.S. Medical Schools Are Preparing Students for Internship. Academic Medicine 2015.

ECC Recommendation for SR Follow Through

Sorabh Khandelwal, MD
January 26, 2016

The Ohio State University Wexner Medical Center

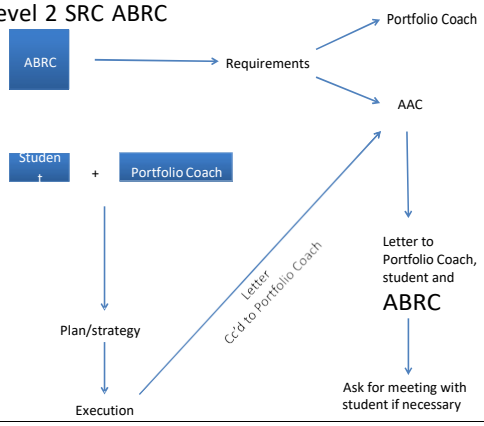
Part 1 SRC

1. Committee recommendations are put in vitals (as usual), Portfolio Coaches copied
2. Students must respond to the recommendations/ requirements (in vitals, or if we want by letter) within 1 month.
3. Monthly administrators will pull the report (or collate the letters received) and give them to the appropriate Associate Program Director.
4. APDs will review them and follow-up as needed, documenting any follow-up in vitals

USMLE Review Committee: Communication and Follow-up

- After meeting with the student, the USMLE Review Committee drafts and sends an official letter with recommendations and requirements via secure e-mail and USPS mail.
  - Secure e-mails are sent requesting delivery and read receipts.
- An entry is recorded in the student management system (Vitals and/or MedStar). The recommendations and requirements are recorded under the "Student Call to Action" section.
- Calendar reminders are placed on committee chair and support staff calendars to review requirement compliance of students.
  - Any non-compliant student is contacted via secure e-mail, phone call, or a certified letter.
  - Follow-up meetings are scheduled as needed.

ASC Level 2 SRC ABRC



Wexner Medical Center	The Ohio State University College of Medicine	
	Executive Curriculum Committee	
	Meeting Minutes	
	Date: 2/23/16	Location: 150 Meiling

Presiding Chair: Howard Werman, MD	Call to order:	4:00pm
Minutes recorded by: Casey Leitwein	Adjourned:	6:00pm

Member attendance

Name	Role	Present
Howard Werman	Chair, Faculty member	Y
Laurie Belknap	Faculty Member	Y
Douglas Danforth	Academic Program Director, LSI Part One	Y
John Davis	Associate Dean for Medical Education	N
Courtney Gilliam	Med Student Representative	N
Alex Grieco	Chair, Academic Review Board	Y
Sorabh Khandelwal	Assistant Dean, Med Ed	Y
Nicholas Kman	Academic Program Director, LSI Part Three	Y
Nanette Lacuesta	Assistant Dean, Affiliated program	Y
Cynthia Ledford	Assistant Dean, Med Ed	Y
Thomas Mauger	Clinical Science Chair	Y
Leon McDougle	Academic Program Director, Associate Dean Diversity	N
Wanda McEntyre	Faculty Member, Faculty Council Rep	N
Douglas Post	Assistant Dean, Med Ed	Y
Andrej Rotter	Faculty Member- Faculty Council Rep	N
Charles Sanders	Assistant Dean, Affiliated program	Y
Jonathan Schaffir	Faculty Member	Y
Larry Schlesinger	Chair, Basic Science Department	N
Kim Tartaglia	Academic Program Director, LSI Part Two	Y
Donald Thomas	Med Student Representative	Y

Additional attendees: Jack Kopechek, Joanne Lynn

Agenda items

Item 1, Approval of minutes

Item 2, Educational Portfolio and Coaching Program

Item 3, Graduate/Program Director Survey

Item 4, Student Mistreatment

Item 5, OBGYN Follow-up

Item 1, Approval of last meeting's minutes

Discussion

1. The meeting minutes from January 26, 2015 were approved by the committee.

Item 2, Educational Portfolio and Coaching Program
Presenters: Dr. Jack Kopechek

Discussion

1. Dr. Kopechek presented an overview of the Educational Portfolio and Coaching Program. The presentation is attached.
2. The portfolio in Parts 1 and 2 include performance assessments and reflection. The Showcase Portfolio is done in Part 3. The format is a formative reflection and self-assessment on achievements with some elements of assessment and professional development.
3. The Showcase Portfolio will be formally reviewed in Part 3 evaluations at the end of the year to get feedback.
4. Dr. Kopechek noted that portfolio reviews are scheduled regularly throughout Parts 1,2 and 3.
5. In reviewing the evaluations of the program, both coaches and students valued the coaching elements while the reflections were the least popular portions of the program. The program also supports student wellness.
6. Plans to improve the program include the program include the establishment of a Student Advisory Committee and develop more of a 'story-telling' approach on the student's progress over 4 years.
7. Dr. Tartaglia asked about evaluation by the students of their overall assessment of the Portfolio and Coaching program. It was noted that several questions in the end of Part 3 survey specifically assess the program.
8. Dr. Ledford asked what the key things from a student's perspective would be asked for the end of Part 3 survey. Specifically, has the program helped give them tools to demonstrate reflective practices? Dr. Kopechek felt that the students develop a skill of reflection and life-long learning.
9. ECC would like to know what the benefits of the program are, how it impacts student wellness and specific ways that we can document how the program has benefitted the students. Some of this information may come from the graduate survey.
10. Dr. Danforth stated that the coaching program is a good recruiting tool for the incoming students.

Action Items

1. The Committee report was accepted and we will continue to review faculty and student evaluation of the program.

Item 3, Graduate/Program Director Survey
Presenter: Dr. Cynthia Ledford

Discussion

1. Dr. Ledford brought the Graduate/Program Director Survey back to ECC for final edits from the committee prior to it being sent out in March. The questions map closely to the 6 competency domains as well as the 13 EPA's. Nine additional questions were added to cover all EPA's. This new survey will be administered to 2015 graduates and will provide a baseline against which the LSI graduates will be compared.
2. Dr. Ledford will add a question pertaining to students meeting milestones to the survey. This may be useful feedback for the Clinical Tracks in Part 3. Dr. Lacuesta suggested asking if there are any milestones that the graduates are not progressing towards with a yes/no response and a comment box to potentially obtain more detailed answers.
3. The committee asked that the question on Independent Learning be modified to represent reflective practice and self-directed learning.
4. An Educational Portfolio and Coaching Program question should be added next year.
5. There was a discussion on whether a Part One question should be added to the survey. There were concerns that this may make the survey too long.
6. Last year there was a 54% survey return rate from graduates and 74% from Program Directors.

Action Items

1. A motion was brought forth and approved to approve the Graduate/Program Director survey with the added questions on milestones and reflective practice/self-directed learning.
2. A specific question on the Educational Program and Coaching program will be added next year.
3. Dr. Ledford will report on the impact of the new (longer) survey on the response rate.

Item 3, Student Mistreatment
Presenter: Dr. Cynthia Ledford/Dr. Joanne Lynn

Discussion

1. The report represents a follow up on a 2013/14 LCME report on student mistreatment identified by their graduate survey. The ECC adopted an action plan that include addition of two confidential screening questions to

teaching evaluations and a notification to program to follow up with the instructor as well as better assessment of the learning environment. Today's report was a follow up to this action plan.

2. Dr. Lynn reported on the graduate survey. She reviewed the areas of mistreatment contained on the survey. It was noted that the OSUCOM decreased from an aggregate score of 37.9% in 2014 to 28.0% in 2015 in students reporting one or more complaints. It was noted that there was an increase in sexist remarks in 2014 but it declined in 2015. However, this year racially/ethnically offensive remarks increased to only 92% saying never. There will be an action plan to address this concern as well as grading disparities for gender, race and ethnicity as well as mistreatment due to sexual orientation.
3. Dr. Kman noted that Dr. Lynn's office is not routinely notified of student intimidation reports from the individual programs. It was suggested that these individual reports need to be collected centrally.
4. Dr. Ledford reviewed the data for intimidation and treated with respect on student evaluations. Less than 3% reported a neutral or level disagreement with an environment free of ridicule or intimation and being treated with respect by teacher in Part 2 data. The next step is to decrease these responses by getting individual feedback to faculty members. This data must be also provided to the Office of Student Life.
5. Dr. Belknap brought forth the problem of recurrent interventions with the occasional recalcitrant faculty members and residents as well as cultural norms in the teaching environment. Faculty development in creating a supportive teaching environment is an obvious part of the solution, especially among residents. This would also include some teaching about professional boundaries.
6. Dr. Khandelwal suggested that we need to develop a plan for loop-closure from Departments who receive reports on student intimidation.

Action Item

1. The report of Drs. Lynn and Ledford was accepted by the ECC.
2. The ECC will continue to monitor student intimidation and the teaching environment as part of the Program Committee reports from Parts 1,2 and 3. Dr. Lynn should be included in these reports.
3. Dr. Lynn and Dr. McDougle will present an action plan on combating some of the behaviors reported in the graduate report and report on the results of this plan.

Item 4, OBGYN Follow-up
Presenter: Dr. Wanjiku Musindi

Discussion

1. Dr. Musindi updated the ECC on the performance on the five OB/GYN sites. There were no difference in shelf scores or grade distribution
2. The student evaluation data revealed no significant differences in the overall educational experience. Certain sub-items did demonstrate differences but most were above a “3” rating.
3. Student teaching was equivalent at all sites except RMH; this may be due to small numbers and is being watched by the Clerkship Director.
4. In evaluating time spent in ambulatory clinics, both Grant and St. Ann’s were rated below “3.” Dr. Musindi is focusing specifically on the ambulatory experience at these sites. In some cases, students are competing with OU students and Family Practice residents. A plan to follow the primary resident back to their OSUWMC clinic site has been implemented. An alternative solution was proposed for next year that would enhance the quality of the experience. Dr. Sanders noted that there may be some cultural reasons for lower ambulatory scores at St. Ann’s.
5. Dr. Lacuesta asked if there were questions about the quantity of time spend with attending physicians at RMH. She is evaluating the reasons for the drop in student evaluations at that site.

Action Item

1. Dr. Musindi will report on the impact of these changes in the ambulatory teaching in OB/GYN on student evaluation scores as well as the overall experience in the ring after the year’s completion.

The meeting adjourned at 5:55 PM.

THE OHIO STATE UNIVERSITY
COLLEGE OF MEDICINE

Medical Student Preparation Survey 2016

The Ohio State University
College of Medicine

This survey is designed to assess how well *The Ohio State University College of Medicine* prepared you for your residency training. Please use the scale below to rate your level of satisfaction with each of the program components listed below. **Circle** your response.

1 = VERY LOW **2 = LOW** **3 = MEDIUM** **4 = HIGH** **5 = VERY HIGH**

If you are not sure or unable to assess, please circle N/A.

		Very Low	Low	Medium	High	Very High	Not Able to Assess
1.	Data gathering skills (taking history, perform physical exam)	1	2	3	4	5	N/A
2.	Data recording skills (documenting patient status: writing patient assessments, follow-up notes, discharge summaries)	1	2	3	4	5	N/A
3.	Relationship with patients	1	2	3	4	5	N/A
4.	General medical knowledge	1	2	3	4	5	N/A
5.	Clinical problem solving (overall)	1	2	3	4	5	N/A
6.	Clinical skills involving procedures (motor skills)	1	2	3	4	5	N/A
7.	Patient management (overall)	1	2	3	4	5	N/A
12.	Communication skills (overall)	1	2	3	4	5	N/A
16.	Participation on an Interdisciplinary team	1	2	3	4	5	N/A
17.	Professional Conduct	1	2	3	4	5	N/A
18.	Independent Learning	1	2	3	4	5	N/A
19.	Sensitivity to medical ethics issues	1	2	3	4	5	N/A
20.	Practice of preventive care	1	2	3	4	5	N/A

Other specific professional activities

1	Prioritize a differential diagnosis following a clinical encounter	1	2	3	4	5	N/A
2	Recognize a patient requiring emergent care and initiate evaluation	1	2	3	4	5	N/A
3	Recommend and interpret common diagnostic and screening tests	1	2	3	4	5	N/A
4.	Enter and discuss orders and prescriptions	1	2	3	4	5	N/A
5	Give or receive a patient handover to transition care responsibly	1	2	3	4	5	N/A
6.	Provide an oral presentation of a clinical encounter	1	2	3	4	5	N/A
7.	Obtain informed consent for tests and/or procedures	1	2	3	4	5	N/A
8	Form clinical questions and retrieve evidence to advance patient care	1	2	3	4	5	N/A
9	Identify system failures and contribute to a culture of safety and improvement (EPA 13)	1	2	3	4	5	N/A

Please continue on other side

THE OHIO STATE UNIVERSITY
COLLEGE OF MEDICINE

DIRECTIONS: Please respond to each question by circling your response and providing comments where applicable. Detailed comments are greatly appreciated.

1. Describe how your medical school training compares to the training received by graduates from other medical schools?

MUCH WORSE **WORSE** **ABOUT THE SAME** **BETTER** **MUCH BETTER**

2. Are you pleased that you matched with this residency program? **YES** **NO**
   Please explain:

3. Was your OSU medical education *deficient* in preparing you for residency in any way? **YES** **NO**
   If **yes**, please explain. Be as specific as possible.

4. If you could, what changes would you make to the Part 2 program?
   Please explain:

5. If you could, what changes would you make to the Part 3 program? Please explain:

THE OHIO STATE UNIVERSITY
COLLEGE OF MEDICINE

6. Additional comments:

Thank you for your participation in this survey.

Your information will ultimately lead to a better program for future students.

John A. Davis, MD, PhD
Associate Dean for Medical Education
The Ohio State University College of Medicine

THE OHIO STATE UNIVERSITY
COLLEGE OF MEDICINE

Medical Student Preparation Survey 2016

The Ohio State University
College of Medicine

This survey is designed to assess how well we prepared our graduate for residency training. Please use the scale below to rate the intern's level of performance. **Circle** your response. **Remove** the intern's information label before returning the survey to ensure confidentiality.

1 = VERY LOW **2 = LOW** **3 = MEDIUM** **4 = HIGH** **5 = VERY HIGH**

If you are not sure or unable to assess, please circle N/A

REMOVE GRAD NAME

REMOVE GRAD NAME

		Very Low	Low	Medium	High	Very High	Not Able to Assess
1.	Data gathering skills (taking history, perform physical exam)	1	2	3	4	5	N/A
2.	Data recording skills (documenting patient status: writing patient assessments, follow-up notes, discharge summaries)	1	2	3	4	5	N/A
3.	Relationship with patients	1	2	3	4	5	N/A
4.	General medical knowledge	1	2	3	4	5	N/A
5.	Clinical problem solving (overall)	1	2	3	4	5	N/A
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7.	Patient management (overall)	1	2	3	4	5	N/A
12.	Communication skills (overall)	1	2	3	4	5	N/A
16.	Participation on an Interdisciplinary team	1	2	3	4	5	N/A
17.	Professional Conduct	1	2	3	4	5	N/A
18.	Independent Learning	1	2	3	4	5	N/A
19.	Sensitivity to medical ethics issues	1	2	3	4	5	N/A
20.	Practice of preventive care	1	2	3	4	5	N/A

Other specific professional activities

1	Prioritize a differential diagnosis following a clinical encounter	1	2	3	4	5	N/A
2	Recognize a patient requiring emergent care and initiate evaluation	1	2	3	4	5	N/A
3	Recommend and interpret common diagnostic and screening tests	1	2	3	4	5	N/A
4.	Enter and discuss orders and prescriptions	1	2	3	4	5	N/A
5	Give or receive a patient handover to transition care responsibly	1	2	3	4	5	N/A
6.	Provide an oral presentation of a clinical encounter	1	2	3	4	5	N/A
7.	Obtain informed consent for tests and/or procedures	1	2	3	4	5	N/A
8	Form clinical questions and retrieve evidence to advance patient care	1	2	3	4	5	N/A
9	Identify system failures and contribute to a culture of safety and improvement (EPA 13)	1	2	3	4	5	N/A

Please continue on other side

THE OHIO STATE UNIVERSITY
COLLEGE OF MEDICINE

DIRECTIONS: Please respond to each question by circling your response and providing comments where applicable. Detailed comments are greatly appreciated.

1. Describe how your medical school training compares to the training received by graduates from other medical schools?

MUCH WORSE **WORSE** **ABOUT THE SAME** **BETTER** **MUCH BETTER**

2. Are you pleased that you matched with this residency program? **YES** **NO**
   Please explain:

3. Was your OSU medical education *deficient* in preparing you for residency in any way? **YES** **NO**
   If **yes**, please explain. Be as specific as possible.

4. If you could, what changes would you make to the Part 2 program?
   Please explain:

5. If you could, what changes would you make to the Part 3 program? Please explain:

THE OHIO STATE UNIVERSITY
COLLEGE OF MEDICINE

6. Additional comments:

Thank you for your participation in this survey.

Your information will ultimately lead to a better program for future students.

John A. Davis, MD, PhD
Associate Dean for Medical Education
The Ohio State University College of Medicine

The Educational Portfolio and Coaching

Executive Curriculum Committee
February 23, 2016
Jack Kopechek MD

The Educational Portfolio

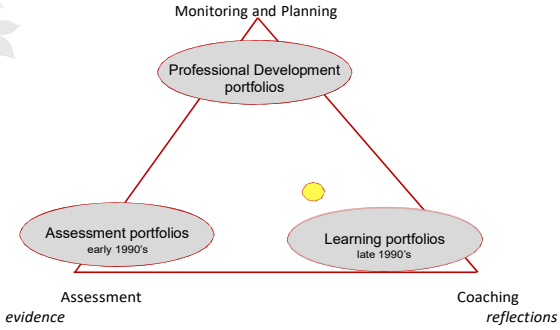
The Portfolio is the venue in which students track and reflect upon their personal development as a physician-in-training.

"The portfolio is the story of the development of the learner"

Portfolios :

- Improve knowledge and understanding, especially the ability to integrate theory with practice
- Lead to greater self-awareness and engagement with reflection
- Improve faculty feedback to students and faculty awareness of student needs
- Help students to cope with uncertain or emotionally demanding situations
- Prepare students for the postgraduate setting and reflective practice

Buckley, S, et al. The educational effects of portfolios on undergraduate student learning: A Best Evidence Medical Education (BEME) systematic review. BEME Guide No. 11



1. van Tartwijk, J et al. Portfolios for assessment and learning: AMEE no. 45. *Med Teach* 2009, 31: 790-801.

The goals of using the portfolio are to:

- improve self-assessment skills and performance
- enhance career achievement and satisfaction
- establish a pattern of reflective practice and lifelong self-directed learning.

Learning and Showcase Portfolios

Learning- Wordpress	Showcase- U.OSU.EDU
Private (high security)	Public (low security)
Part One and Part Two	Part Three
Shared with Portfolio Coach	Shared with portfolio coach, faculty assessors residency programs (optional)
Performance Reports and Reflections	Artifacts of Learning with Reflection
Formative	Formative and Summative

Part 3 Showcase Portfolio

- Showcasing artifacts of accomplishments
- Reflection on progress in each CEO domain
- Presentation to team of faculty with assessment

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	Work In Progress	Meets Expectation	Exceeds Expectation
Cites adequate evidence	Portfolio does not contain relevant artifacts for several of the required CEOS (three or more)	Portfolio contains at least one relevant artifact for all or nearly all of the required CEOs	Portfolio contains several artifacts for most of the CEOs
Reflects on progress towards each competency	Self -assessment narrative omitted for several of the CEOs (three or more)	Self- assessment narrative included for all or nearly all of the CEOs	Self- assessment narrative included for all of the CEOS with additional details or description for most
Reflects deeply and with insight on progress towards each competency	Reflection lacks insight for the majority of posts	Reflection demonstrates some insight for the majority of posts	Reflection demonstrates exceptional insight for the majority of posts
Defines goals and plans for further development of these competencies during residency	Narrative contains no goals and plans for the majority of the CEOs	Narrative contains goals and plans for the majority of the CEOs	Narrative contains goals and plans for the majority of the CEOs. Specific details are provided for the majority of goals and plans.
Demonstrates ability to communicate reflection conversationally	Demonstrates no insight during discussion with faculty assessors.	Demonstrates some insight during discussion with faculty assessors.	Demonstrates exceptional insight during discussion with faculty assessors.

Grading:

For each box in "Work in Progress" – 10 points

For each box in "Meets Expectation" – 15 points

For each box in "Exceeds Expectation" – 20 points

Remediate- below 70 Pass- 70-90 Exceptional- 90-100

The Ohio State University Wexner Medical Center

Portfolio Coaching

The Ohio State University Wexner Medical Center

Why Portfolio AND Coaching ?

- "The effectiveness of learning is enhanced when a mentor supports the portfolio process. Mentorship requires a substantial time investment but is crucial for the successful use of portfolios."
- Tartwijk and Driessen, Medical Teacher 2009

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Coaches may ask …..

- What is going well for you?
- What are you finding challenging?
- What do you want to work on?
- What are your current goals and next steps?
- What help or resources do you need to achieve your goals?

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Formal Meetings with Coach

- Usually occur on
  - First Friday of each block (Part One)
  - Friday of Ground School and Week 10 for each ring (Part Two)
  - At several defined intervals (Part 3)
- Includes review of
  - Performance data and student portfolio postings (Parts One and Two)
  - Residency application progress and showcase portfolio drafts (Part Three)

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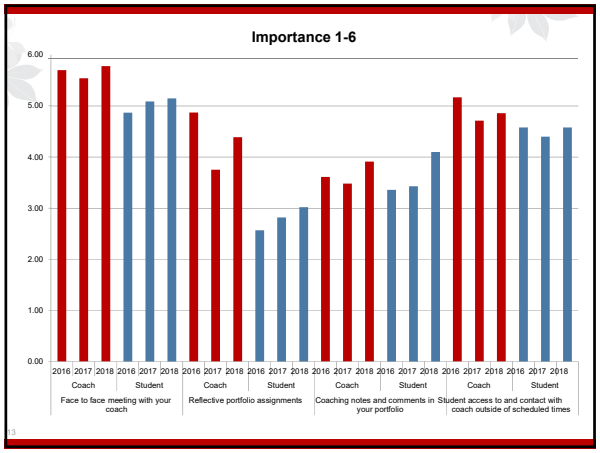


Program Strengths

- Coaches highly valued by students
- Coaching promotes student wellness- Part 1 Survey
- Enthusiastic faculty, excellent program coordinator, and strong support from college leadership, Evaluation and Assessment Team, Student Life, and OECRD

- Annual Report available upon request

Emerging Strength- Showcase Portfolios

- "I was impressed (and actually surprised) that they all stated that they actually did derive a lot from having to think about the reflections in the showcase portfolio and even if they had not written a lot - they had a lot to share. It made me feel more invested in the portfolio program/process and how to frame this experience even further with my students next year"
- "Inspirational - I heard in them the future of medicine and it gave me hope. They were amazingly insightful, mature, and reflective"
- Residency interview anecdote

Emerging Strength- Scholarship

- "Including Simulated Medical Students in the Training of Portfolio Coaches" has been accepted for the CGEA Spring Meeting as an Innovations in Medical Education (IME) Poster.
- Other projects/topics in development
  - Assessing coach needs for advanced training
  - Qualitative assessment of lessons learned from four years of coaching (coach exit interviews)
  - Elements of effective coach recruitment

Future Directions

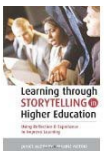
Increase student appreciation for reflective assignments

- Student Advisory Board

- Increased Choices for Reflection

Future Directions

- Reformat showcase portfolio to promote a storytelling approach



Program Director and Contacts:

Jack Kopechek, MD

Program Director
Educational Portfolio and Coaching
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Cheri Bardales, M.Ed., PhD

Program Coordinator
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Graves Hall B042D
614-685-5605

Mistreatment Assignment:

Drs. Lynn, McDougle and Ledford were charged by the ECC to explore issues related to negative teaching behaviors and mistreatment identified by the AAMC Graduate Questionnaire and formulate a plan of action in 2013.

The action plan adopted by ECC in December 2013 was as follows:

1. To improve capture of details of teacher behaviors to the Student Evaluation of Clinical Instruction forms (within Academic Programs)
    a. Add two screening items to teaching evaluations (based on UCSF)*
    b. To create more security, but setting evaluations of teachers to not release until program reviews/releases (delayed release)
    c. To set evaluations of teacher set to automatically notify course director AND coordinator of all low scores on these items (timely alert to problems)
2. To evaluate Learning Environments in more detail, with the added "safety" of a course independent source
    a. Associate Deans Staff will use screening questionnaire for Medical Student Performance Evaluations (MSPE) Proposed College Policy for all Academic Programs
    b. Programs will add learning environment items to the Part 1 and 2 Program evaluations**

* STANDARD ITEMS for all evaluations of clinical teachers [standard agreement response option]
----I was treated with respect by this individual
-----I observed others (students, residents, staff, patients) being treated with respect by this individual

**STANDARD ITEMS for Academic Program and Curriculum Unit Evaluations
---The learning environments promoted professionalism
---Students were treated with respect

February 23, 2016: Follow up of results of the action plan:

Preliminary Mistreatment Data

CH Ledford, MD
Assistant Dean for Evaluation & Assessment
February 23, 2016

This teacher avoided ridicule and intimidation

component	Item	NA	SD	D	D=A	A	SA	
IM	This teacher avoided ridicule and intimidation	4	2	5	19	231	991	
Psych	This teacher avoided ridicule and intimidation	16	1	2	4	89	356	
N	This teacher avoided ridicule and intimidation	8	1	10	16	128	430	
Surg	This teacher avoided ridicule and intimidation	57	8	21	45	278	789	
Ob/gyn	This teacher avoided ridicule and intimidation	178	8	17	44	339	1063	
periop	This teacher avoided ridicule and intimidation	5	1	5	1	49	253	
other adult	This teacher avoided ridicule and intimidation	0	0	0	2	24	30	
FM/IM	This teacher avoided ridicule and intimidation	3	1	4	6	45	145	
Peds	This teacher avoided ridicule and intimidation	29	0	8	31	333	1431	
xPart 2	This teacher avoided ridicule and intimidation	300	22	72	168	1516	5488	
		4%	<1%	1%	1%	21%	76%	

This teacher treated me with respect

component	Item	NA	SD	D	D=A	A	SA	
IM	This teacher treated me with respect	4	3	2	16	235	992	
N	This teacher treated me with respect	8	0	6	19	133	427	
	This teacher treated me with respect	16	0	0	3	82	367	
Surg	This teacher treated me with respect	57	3	11	34	291	802	
Ob/gyn	This teacher treated me with respect	175	6	12	47	352	1057	
periop	This teacher treated me with respect	5	1	1	6	52	249	
other adult	This teacher treated me with respect	0	0	0	0	24	32	
FM/IM	This teacher treated me with respect	3	0	3	3	35	160	
Peds	This teacher treated me with respect	28	0	3	35	340	1426	
xPart 2	This teacher treated me with respect	296	13	38	163	1544	5512	

This teacher treated others with respect

component	Item	NA	SD	D	D=A	A	SA	
IM	This teacher treated others with respect	4	1	4	1	239	988	
N	This teacher treated others with respect	8	0	7	20	140	418	
Psych	This teacher treated others with respect	16	0	1	2	101	348	
Surg	This teacher treated others with respect	56	7	18	37	324	756	
Ob/gyn	This teacher treated others with respect	176	6	8	44	370	1045	
periop	This teacher treated others with respect	5	1	4	5	59	240	
Other adult	This teacher treated others with respect	0	0	0	0	26	30	
FM/IM	This teacher treated others with respect	3	1	1	3	42	154	
Peds	This teacher treated others with respect	28	0	3	29	346	1426	
xPart 2	This teacher treated others with respect	296	16	46	141	1647	5405	

Discussion

Improving People's Lives Through Innovations in Personalized Health Care

2015-16 Ring I & II Site Comparisons

Wanjiku Musindi, MD

February, 2016

The Ohio State University
Wexner Medical Center

Site comparisons 2015 – 2016 data Ring I & II

	Grant	MCW	OSU	Riverside	MCSA	Mean	P-value
# of students	19	23	45	11	20		
NBME Shelf Mean score	77.5	82.5	79.2	79.0	81.1	79.9	0.250
Oral exam	82.5	83.9	81.7	73.6	86.4	82.3	0.103
OSCE	83.2	85.1	83.7	82.9	83.7	83.9	0.317
CPA	90.1	87.2	88.5	90.5	87.9	88.6	0.148
Quiz	76.8	79.8	76.2	74.6	77.0	76.9	0.434
Practical Exam	75.0	71.7	75.9	75.0	82.4	75.9	0.217
Mean total score	84.2	85.2	84.2	84.0	85.2	84.5	0.751

There were no significant differences in any score component by site.

2015-2016 Distribution of grades Ring I & II data

	# students	Honors	Letters
Grant	19	4 (21.1%)	4 (21.1%)
MCW	23	4 (17.4%)	4 (17.4%)
OSU	45	10 (22.2%)	5 (11.1%)
Riverside	11	3 (27.3%)	0 (0%)
St. Ann's	20	3 (15.0%)	7 (35.0%)
Total	118	24 (20.3%)	20 (16.9%)

Pearson Chi- square = 0.393

When looking at the results of the Person Chi-Square test we see that there are no significant differences in the results.

Student evaluation across sites Rings I & II 2015-2016 Academic Year

Question ID-MedStar	Question ID-VITALS	Question	N	Mn	SD	P-value
8181	1276	Clinical experiences, e.g. the setting (clinics, operating room and patients) facilitated my learning.	112	4.17	0.99	0.195
8182	1277	Small Group sessions contributed to my learning.	112	3.99	0.89	0.220
8183	1278	Oral Exams contributed to my learning.	106	3.34	1.21	0.246
8184	1287	Course coordinators were helpful.	110	4.00	1.13	0.126
8188	1292	Rate the quality of your overall educational experience during the Ob/Gyn experience.	112	3.59	1.09	0.182
8196	1279	Conferences I attended while on the Ob/Gyn services contributed to my learning.	104	3.82	0.95	0.105
8197	1070	Residents and fellows provided effective teaching during the the clerkship.	111	4.09	0.94	0.017
8198	1288	Faculty provided effective teaching during the the clerkship.	111	3.74	1.04	< 0.001
8214	1280	On line e-modules contributed to my learning.	92	3.00	1.05	0.556
8215	1282	The amount of time spent in ambulatory clinics was sufficient.	110	3.48	1.33	< 0.001
8216	1281	I would have liked to have had more lectures in the curriculum.	111	2.82	1.22	0.985
8217	1283	I had opportunities to learn how to use current literature to evaluate treatment plan options.	111	3.97	0.83	0.502
8218	1284	I had opportunities to learn how to recognize and address ethical dilemmas that surface in the practice of medicine.	111	4.17	0.79	0.450
8219	1285	I was provided clinical duties, opportunities to learn and was a productive member of the team.	111	3.94	1.01	0.009
8220	1286	I feel adequately prepared to discuss surgical and reproductive health topics with my patients in the future.	111	4.22	0.67	0.007

Student evaluations 2015 – 2016
Site Data for Ring I & II

	Mean	Grant	MCSA	MCW	OSU	RMH
Residents and Fellows provided effective teaching	4.09	3.56	4.21	4.19	4.33	3.64
Faculty provided effective teaching	3.74	3.50	3.63	3.71	4.26	2.36
Time spent in ambulatory clinics sufficient	3.48	2.59	2.21	4.33	4.10	3.09
Provided clinical duties, opportunities to learn and was productive member of team	3.94	3.22	4.16	4.10	4.14	3.64
Prepared to discuss surgical and reproductive health topics with my patients	4.22	3.72	4.42	4.33	4.31	4.09

Post hoc testing was conducted for those items that showed significant P-values in order to determine where the significant differences occurred.

Summary of Ob/Gyn Ring I & II Site Specific Data

- No difference in grades across sites
- No difference in distribution of Letters and Honors across sites
- Student evaluations
  - No difference across sites for Item 8188
    - Clinical experiences, e.g. the setting (clinics, operating room and patients) facilitated my learning.
  - Educationally significant differences noted
    - Grant and St Ann's with means below 3 for Item 8215
      - Time spent in ambulatory clinics sufficient
    - Riverside with mean below 3 for item 8198
      - Faculty provided effective teaching

Opportunities for improvement

- Creating quality ambulatory experiences at St. Ann's and Grant
  - Students attend continuity clinic at OSU with St. Ann's resident for Ring III
  - Implementation of ambulatory week in 2016-17 academic year. Working with Site Director to improve quality of experience
  - Combining Gyn/Gyn Onc weeks to improve contiguous clinical and ambulatory experience
- Faculty interaction
  - Model of weekly teaching rounds led by consistent attending has been successful at other sites and may be beneficial at Riverside

Wexner Medical Center	The Ohio State University College of Medicine Executive Curriculum Committee Meeting Minutes Date: 3/22/16 | Location: 150 Meiling

Presiding Chair: Howard Werman, MD	Call to order:	4:00pm
Minutes recorded by: Casey Leitwein	Adjourned:	6:00pm

Member attendance

Name	Role	Present
Howard Werman	Chair, Faculty member	Y
Laurie Belknap	Faculty Member	Y
Douglas Danforth	Academic Program Director, LSI Part One	Y
John Davis	Associate Dean for Medical Education	Y
Courtney Gilliam	Med Student Representative	N
Alex Grieco	Chair, Academic Review Board	Y
Sorabh Khandelwal	Assistant Dean, Med Ed	Y
Nicholas Kman	Academic Program Director, LSI Part Three	Y
Nanette Lacuesta	Assistant Dean, Affiliated program	N
Cynthia Ledford	Assistant Dean, Med Ed	Y
Thomas Mauger	Clinical Science Chair	N
Leon McDougle	Academic Program Director, Associate Dean Diversity	Y
Wanda McEntyre	Faculty Member, Faculty Council Rep	N
Douglas Post	Assistant Dean, Med Ed	Y
Andrej Rotter	Faculty Member- Faculty Council Rep	N
Charles Sanders	Assistant Dean, Affiliated program	Y
Jonathan Schaffir	Faculty Member	N
Larry Schlesinger	Chair, Basic Science Department	N
Kim Tartaglia	Academic Program Director, LSI Part Two	Y
Donald Thomas	Med Student Representative	Y

Additional attendees: Daniel Clinchot, Mary McIlroy

Agenda items

Item 1, Approval of minutes

Item 2, Proposal to Develop a Combined Student Review Committee

Item 3, Proposal to Set a Time-Limit for Student Reinstatement

Item 4, CQI and the Executive Curriculum Committee

Item 5, USMLE Part 1 Report

Item 1, Approval of last meeting's minutes

Discussion

1. The meeting minutes from February 23, 2015 were approved by the committee as presented.

Item 2, Proposal to Develop a Combined Student Review Committees
Presenters: Dr. Sorabh Khandelwal

Discussion

1. The Academic Standing Committee has proposed to combine the Student Review Committees for Parts 1, 2 and 3 (Level 1) to improve communication regarding students with difficulties in the curriculum (see Handout)
2. The proposed Committee includes Associate Program Directors, Expert Educators and additional faculty as well as additional administrative support. The goal is to treat LSI as a comprehensive curriculum. The proposal also includes a method of loop closure and accountability using Vitals and involvement of the Portfolio Coaches
3. Drs. Tartaglia and Danforth discussed the issue of administrative support and time commitment by the Associate Program Directors
4. Dr. McDougle questioned the need for the combined committee and expressed concern for the time commitment. Dr. Khandelwal noted that this would result in better efficiency and simplicity in the student review process by eliminating three individual committees and would enable forward feedback to reduce recurrent problems. Dr. Davis and Dr. Belknap also noted that this would allow a better understanding of the downstream effects of early student deficiencies.
5. Dr. Khandelwal also noted that members of this committee would develop a broader expertise in student remediation.
6. There was discussion about the differences between the functions of this combined committee and the Academic Advancement Committee
7. Dr. McIlroy asked that we develop specific measures of success in implementing this committee. Several committee members supported the need for good metrics to measure success of this new committee
8. Dr. Kman raised the issue of operating rules for this committee including minimal attendance of faculty from the specific parts of the curriculum based on the student under review.
9. Dr. Khandelwal and Dr. Davis discussed the need for standardization of process including addressing potential mental health issues as raised by Dr. McDougle

Action Items

1. The Executive Curriculum Committee supported the concept of developing a combined Level 1 Student Review Committee.
2. Dr. Khandelwal will report back to the ECC regarding the logistics implementing this combined committee as well as specific measures of its effectiveness

Item 3, Proposal to Set a Time-Limit for Student Reinstatement
Presenter: Dr. Daniel Clinchot

Discussion

1. Dr. Clinchot brought forth a proposal to set a time-limit for student reinstatement. His initial proposal was to limit the time to apply for reinstatement to four years. Dr. Clinchot noted that should time limits be implemented, it would not preclude students reapplying to the COM through the general admissions process.
2. Dr. Ledford clarified that this policy would apply to any student who is currently withdrawn from the COM once the new policy goes into effect. Dr. Clinchot agreed with this interpretation.
3. Dr. Grieco noted that the data considered for student reinstatement is very subjective and thus, challenging. He supported the four-year limit.
4. Dr. Clinchot was asked if there is historical data. He noted that two students who were reinstated after 4 years were not successful.
5. Dr. Khandelwal asked that we consider a two-year limit and suggested that any students who wish to be considered beyond that point to apply for re-admission through the admissions process. Dr. Sanders supported this concept. Dr. Ledford noted that MSTP students are often away from the medical school curriculum for four years.
6. Dr. McDougle clarified that there would be no guarantee of an invitation to be interviewed by the Admissions Committee for students who wish to be considered after the four years.
7. In discussing a time-limit of two years, Dr. Khandelwal raised the issue dismissal versus withdrawal. Dr. Grieco suggested that reinstatement would only be open to those who withdrew and not to those dismissed. This revision was supported by Dr. Belknap who noted that these individuals are at high risk of future Medical Board actions and Dr. Davis who raised the issue of success in the Match results for reinstated students.
8. It was decided to revise the reinstatement policy by removing the option for reinstatement if a student is dismissed. Dr. McIlroy raised the issue of whether this will force individuals to preferentially withdraw from the College.

Action Items

1. A motion was brought forth by Drs. Ledford and Sanders to set a time-limit of four years for students to apply for reinstatement only open to students who withdrew from the College. This proposal was approved by the Executive Curriculum Committee.
2. Dr. Grieco was tasked with evaluating the history of student reinstatement with a focus on years away from the curriculum.
3. The Student Handbook will be revised to reflect the time-limits for reinstatement and the elimination of this process for students who are dismissed from the College

Item 3, CQI and the Executive Curriculum Committee
Presenter: Drs. John Davis and Mary McIlroy

Discussion

1. Dr. Davis presented a slide presentation developed by Dan Hunt from the AAMC regarding the role of CQI in LCME accreditation (see attached). He emphasized the role of the ECC in the design and implementation of the curriculum. The expectation is that the ECC will engage in planning and continuous quality improvement of the curriculum based on outcomes. CQI programs from two institutions were presented in the slide presentation. Dr. Davis concluded that the ECC must continue to focus on ongoing evaluation of the entire curriculum.
2. Dr. Clinchot has created an LCME CQI office headed by Drs. McIlroy and Westman.
3. Dr. McIlroy stated that much of the CQI data already exists, citing the Part 1 report as an example of such information. She noted that we would need to continuously focus on the LCME standards and elements.
4. Dr. McIlroy emphasized the role of the program review process for each part of the curriculum, the comprehensive review process and our annual reports. The ECC will have to determine areas of priority for continuous monitoring based on the LCME recommendations.
5. Dr. Belknap asked if we could review prior ECC areas of focus. She noted that there are ongoing reviews conducted as part of the curriculum that can be folded into this continuous quality improvement process.
6. Several areas including comparability of student experiences at rotation sites and faculty/student diversity were discussed as potential areas of focus.

Action Item

1. Drs. Westman, McIlroy, Davis, Ledford and Werman will meet in the future to develop a structure and reporting process of our CQI evaluation of the curriculum to the ECC.
2. We will create an LCME folder under the ECC and include prior LCME reviews.

Item 4, USMLE Step 1 Report
Presenter: Dr. Cynthia Ledford

Discussion

1. Dr. Ledford reported on the most recent USMLE Step 1 results which was released on March 10th of each year based on the calendar year (see attached). These results reflect the second year of the LSI curriculum.
2. There was a 99% first-time pass rate and a mean score of 236 compared to a national mean of 229. These results reflect an overall excellent performance.
3. The histograms based on body systems and foundational sciences were presented. The greatest improvement was in the area of multisystem processes and disorders. Behavioral sciences, nutritional and pharmacology are areas of continued focus for improvement. Dr. Ledford was pleased with the performance in Biostatistics and Gross Anatomy.
4. Dr. Ledford noted that these were the same areas of challenge from the first year of LSI with the exception of improvement in Multisystem Processes and Disorders.
5. Information both pre- and post-LSI were presented. There is continued improvement in our student scores compared to the national performance.
6. Dr. Danforth noted that current efforts at improvement include nutrition (headed by Dr. Belknap) and pharmacology along with behavioral sciences.

Action Item

1. CQI: The ECC will continue to evaluate performance in these areas based on interventions made by the Part 1 program on the curriculum as part of their next annual report. Dr. Danforth will report back to the ECC.

The meeting adjourned at 6:00 PM.

Wexner Medical Center	The Ohio State University College of Medicine Executive Curriculum Committee Meeting Minutes Date: 4/26/16 | Location: 150 Meiling

Presiding Chair: Howard Werman, MD	Call to order:	4:03pm
Minutes recorded by: Casey Leitwein	Adjourned:	5:45pm

Member attendance

Name	Role	Present
Howard Werman	Chair, Faculty member	Y
Laurie Belknap	Faculty Member	Y
Douglas Danforth	Academic Program Director, LSI Part One	Y
John Davis	Associate Dean for Medical Education	Y
Courtney Gilliam	Med Student Representative	N
Alex Grieco	Chair, Academic Review Board	Y
Sorabh Khandelwal	Assistant Dean, Med Ed	Y
Nicholas Kman	Academic Program Director, LSI Part Three	Y
Nanette Lacuesta	Assistant Dean, Affiliated program	Y
Cynthia Ledford	Assistant Dean, Med Ed	Y
Thomas Mauger	Clinical Science Chair	Y
Leon McDougle	Academic Program Director, Associate Dean Diversity	Y
Wanda McEntyre	Faculty Member, Faculty Council Rep	N
Douglas Post	Assistant Dean, Med Ed	Y
Andrej Rotter	Faculty Member- Faculty Council Rep	N
Charles Sanders	Assistant Dean, Affiliated program	N
Jonathan Schaffir	Faculty Member	Y
Larry Schlesinger	Chair, Basic Science Department	Y
Kim Tartaglia	Academic Program Director, LSI Part Two	Y
Donald Thomas	Med Student Representative	N

Additional attendees: Coranita Burt, Quinn Capers

Agenda items

Item 1, Approval of minutes

Item 2, Residency Module Compliance

Item 3, Match Results

Item 4, OSU COM Admissions Process & Incorporating Feedback

Item 1, Approval of last meeting's minutes

Discussion

1. The meeting minutes from March 22, 2016 were approved by the committee as presented.
2. Dr. Khandelwal will present follow up on the single Student Review Committee proposal at a future ECC meeting
3. Dr. Grieco reported on limiting student reinstatement to 4 years. Two students were reinstated after 2 years; there was a 50% successful graduation among these students.

Item 2, Residency Module Compliance
Presenters: Coranita Burt

Discussion

1. The Director for Graduate Medical Education, Coranita Burt presented on the residents as teachers module compliance as a follow up to Dr. Bryan Martin's presentation in the fall on. The presentation is attached. Two major reasons for failure to complete the modules: not required prior to orientation and the modules are not pre-populated on NetLearning (now BuckeyeLearn). She also noted problems with an OSU-produced module which was developed in conjunction at AMA. Finally, individual Departments are already developing residents as teacher activities.
2. Suggestions made towards greater compliance including requirement to complete prior to orientation and work with GME program coordinators.
3. Dr. Belknap stated that the model of a 20 minute video and followed by a test seems archaic to resident learners. She has suggested that the modules need to be re-worked to be more innovative and engaging to newer learners.
4. Dr. Werman stated that LCME feels the content in the modules are an important element and this issue of noncompliance needs to be addressed maybe in partnership with GME office.
5. Dr. Davis likes the idea of front loading the modules for the residents with a message of importance and then engaging a resident or fellow initiative on improving the modules for Medical Education credit.
6. Dr. Khandelwal suggested building in teaching experiences for residents instead of watching videos would make the material more relevant to a teaching institution. He also suggested incentivizing residents who participate in educational development.
7. Dr. McDougle suggested querying the programs to look at deficiencies or performing a needs assessment to work on improvements as this is part of their educational milestones.
8. Coranita identified current challenges in resident compliance and commented that some residents do contact her ahead of the start of their residency to ask if they can complete any requirements ahead of time. Dr.

Kman noted that the residents are generally highly motivated at this time. She also commented that the orientation day is very long with lots of content being covered and they were looking to make the session more interactive based on feedback. Thus, an interactive challenge during orientation may not be successful.

9. Dr. Belknap suggested moving the content into an iBook and providing the residents with the material ahead of time so it can be discussed during orientation and serve as a resource.

Action Items

1. The committee approved the following recommendations based on the presentation and discussion.
    a. Front load modules and make them required by working with GME.
    b. Gather a small group together to look at how to solve the problem of 'residents as teachers' in the next year.

Item 3, Match Results
Presenter: Dr. John Davis

Discussion

1. The Match presentation for the 2015-16 academic years was given by Dr. Davis. The presentation is attached.
2. Un-matched positions have gone from approximately 500 to 8640 that is very concerning. Over 1100 graduating students did not find a position for next year. This total may include graduates from prior years.
3. Dr. McDougle stated that it would be interesting to have the data broken down for unfilled positions with regards to geography and specialty. Dr. Davis responded that the final report provides this information.
4. Historically the COM has had 6-10 students that have not matched in prior years. This year it was down to 3 students out of 185 students participating that did not match. Two deferred to next year and a third is considering a career outside of medicine. Overall, this was felt to be a highly successful year with regards to the match.
5. Dr. Davis gave a more detailed explanation of what occurred to students who did not match during the original Match round. He also reviewed the geographic and specialty distribution of students.
6. Dr. Werman stated that it would be nice to see the trends in hard metrics as a measure of how the LSI curriculum is received by residency programs. Dr. Davis noted that the impression is that the LSI curriculum has been well-received by residency programs.

Action Items

1. The Match presentation should be given by Dr. Lynn for next year.

Item 3, OSU COM Admissions Process & Incorporating Feedback
Presenter: Dr. Quinn Capers

Discussion

1. Dr. Capers presented a slide presentation on the admissions process. The presentation is attached. One out of nine applicants applied to the OSU College of Medicine.
2. The admissions process moved to a holistic review in 2012 that considers experiences, attributes and academic metrics. Dr. Capers reviewed examples of these attributes that map to the competencies needed for success in LSI. In particular, the holistic review has benefitted in our gender distribution and recruitment of URM's. He also noted that OSU COM's metrics including MCAT scores have actually improved.
3. Dr. Capers reviewed the actual review process and how holistic review is incorporated into every phase of the process (see slides)
4. Dr. Capers discussed group and individual feedback in order to improve the admission process. Hard metrics reviewed include Step I pass rates and Match Results. Additionally, the Committee uses admission MCATs as a function of USMLE Part I pass rates and timely graduation.
5. Dr. Capers also leads an Admissions Consortium with Admissions Committee co-chairs that occasionally will review specific student cases and use this information to improve to the admissions process in order to improve the process.
6. Dr. Capers sits on the Academic Review Board and the Academic Standing Committee to provide feedback and incorporate feedback in the admissions process.
7. Dr. Lacuesta expressed concern for the metric/point system that is used by the admissions committee. Dr. Capers assured the committee that after the students get a point value there is a group democratic decision and case by case discussion.
8. Dr. Ledford asked if there was a correlation for the holistic review for matriculants in terms a difference in yield from those offered admission or changes in offerings. Dr. Capers stated that the yield has gone up but they are also offering admission to a more diverse student body.
9. The OECRD team is looking at outcomes with the old MCAT data.
10. Dr. Davis asked Dr. Capers what are the hard endpoints that the Admissions Committee would like to hear about. Dr. Capers responded that he needs to know which potential hard endpoints are to assist in decision support.
11. Dr. Schlesinger asked about the relative weight of the interview for attributes and experience scores. Dr. Capers responded that it is integral to acceptance.

12. Dr. Werman stated that he worked on the best practices in admissions when serving on the Admissions Committee. During that process he researched the multiple mini-interview technique. This technique is resource intensive but Dr. Ledford pointed out that it would remove rater bias and perhaps we should revisit this technique to assure that we are admitting students with the proper attributes.
13. Dr. McDougle suggested incorporating some questions from the multiple mini-interviews into our process to standardize the process more.

14. It was asked if the data obtained during the admissions process was captured anywhere like VITALS. Dr. Capers indicated that the data was currently stored in shared drives but could be moved into VITALS.
15. Dr. Danforth commented that it would be nice to assess this data to be able to predict the students who might experience academic struggles and not wait until they fail in the LSI curriculum. This would allow the Student Life team to plan on how much tutoring is needed.
16. Dr. McDougle and Dr. Schlesinger reported that there are some correlations in resilience, engagement and maturity that predict success in the curriculum.
17. Dr. Schlesinger briefly discussed the admissions process for MSTP students.

Action Item

1. Dr. Capers was asked to come back to the committee in year to report on their continued work as well as bring back any considerations for changes to the admissions process.
2. A high priority is to develop a tool to predict students who may potentiallystruggle in the curriculum to allow early intervention.

Wexner Medical Center	The Ohio State University College of Medicine	
	Executive Curriculum Committee	
	Meeting Minutes	
	Date: 5/24/16	Location: 150 Meiling

Presiding Chair: Howard Werman, MD	Call to order:	4:05 pm
Minutes recorded by: Casey Leitwein	Adjourned:	5:17 pm

Member attendance

Name	Role	Present
Howard Werman	Chair, Faculty member	Y
Laurie Belknap	Faculty Member	Y
Douglas Danforth	Academic Program Director, LSI Part One	Y
John Davis	Associate Dean for Medical Education	Y
Alex Grieco	Chair, Academic Review Board	Y
Sorabh Khandelwal	Assistant Dean, Med Ed	Y
Nicholas Kman	Academic Program Director, LSI Part Three	Y
Nanette Lacuesta	Assistant Dean, Affiliated program	Y
Cynthia Ledford	Assistant Dean, Med Ed	Y
Thomas Mauger	Clinical Science Chair	Y
Leon McDougle	Academic Program Director, Associate Dean Diversity	Y
Wanda McEntyre	Faculty Member, Faculty Council Rep	N
Douglas Post	Assistant Dean, Med Ed	Y
Andrej Rotter	Faculty Member- Faculty Council Rep	N
Charles Sanders	Assistant Dean, Affiliated program	N
Jonathan Schaffir	Faculty Member	Y
Larry Schlesinger	Chair, Basic Science Department	Y
Kim Tartaglia	Academic Program Director, LSI Part Two	Y
Donald Thomas	Med Student Representative	N

Additional attendees: Joanne Lynn, Curt Walker

Agenda items

Item 1, Approval of minutes

Item 2, LSI Part 3 Overview

Item 3, HSIQ Revision

Item 1, Approval of last meeting's minutes

Discussion

1. The meeting minutes from April 26, 2016 were approved by the committee as presented.
2. Courtney Gilliam will be removed from the roster
3. Dr. Danforth suggested that data from the Admissions Committee be submitted into the Information Warehouse and placed in Vitals including sub-scores for metrics, attributes and experiences. Dr. Davis noted that this is currently being planned.

Item 2, LSI Part 3 Overview
Presenters: Nicholas Kman, MD

Discussion

1. Some comments on overall impression on LSI Part 3 were left off the end of year survey so some data is incomplete – the overall evaluations were included in the Buckeye Box.
2. There were overall positive comments on the preparation provided by Part 2 for LSI Part 3. Individual EPAs were assessed with overall excellent results. Opportunities for improvement included patient advocacy; entering orders and writing prescriptions; and identifying system failures and contribute to a culture of patient safety were identified as potential areas for improvement.
3. The overall assessment of AMHBC was very positive. Areas for improvement included the Emergency Medicine Articulate Modules and the OSCE for the mini-internship.
4. The overall assessment of AMRCC was slightly below 3 out of 4 although the individual quality of learning for the ambulatory and chronic care components were rated higher (4.35 and 4.47 respectively). Dr. Khandelwal asked why there was a disparity in overall quality and quality of learning. Dr. Kman noted that other non-clinical components (team-based learning, evidenced-based learning, etc.) contribute to lower ratings for the overall course. Some may also be based on the differences in scales used in evaluation.
5. The Advanced Competencies component of LSI Part 3 was highly regarded by students.
6. The Clinical Tracks were less highly ranked among students. Dr. Kman explained that this might have been due to the fact that this part of the curriculum was the last to be implemented. At the beginning of Part 3, only three Departments (IM, EM and Pediatrics) had fully developed curricula. Relevance of the Clinical Tracks may not be obvious to the students.
7. The Educational Portfolios were highly ranked and were previously discussed by Dr. Kman.

8. The successes of LSI Part 3 have included the overall rigor of the program, the AMHBC mini-internships, the revised curriculum to AMRCC, the teaching and assessment of EPAs and the scholarship that has been developed around LSI Part 3 on a national level.
9. Many of the challenges included technology issues with MedStar and MyProgress. Other challenges include AMRCC non-clinical requirements, tracking of students on longitudinal rotations, overall faculty and clerical support and problems with away electives currently involving 6 states.
10. LSI Part 3 sponsored a retreat to review the entire curriculum. Dr. Kman reported on the results:
    a. The scoring for the various components of LSI Part 3 was revised
    b. The evaluations for many of the components such as TLMs, courses and competencies have been simplified and standardized
    c. Looking for methods to improve experience in EPA-4: enter and discuss orders and prescriptions
11. There was a significant discussion on the issues surrounding those states that are creating barriers for participation in away rotations.
12. Dr. Schaffir raised the issue of students remaining engaged in the curriculum later in LSI Part 3. Dr. Kman discussed how some of these changes should increase rigor and maintain engagement.
13. Dr. Khandelwal asked how faculty are perceiving the training of students entering the last year of medical school relative to pre-LSI students. The discussion from the group seemed to concur that students were better prepared with exceptions in certain areas (e.g. prescription writing).

Action Items

1. The committee approved the LSI Part 3 report and action plan proposed by Dr. Kman to make improvements of LSI Part 3 Curriculum including:
    a. Move course management and scheduling to Vitals. There will be a debrief of successes and failures
    b. Move to the use of MyProgress 6.0 to solve issues of tracking and student feedback.
    c. Review and revise the non-clinical requirements within AMRCC component of LSI Part 3.
    d. Increase administrative support for LSI Part 3, specifically Ashley Fernandez and Troy Schaffernocker
    e. Continue to work with Office of Medical Education to reduce the number of states in which away locations are problematic
    f. Revise scoring system for LSI Part 3 with less emphasis on AMRCC and AMHBC and greater emphasis on electives in the overall score
    g. Implement simplified, standardized evaluation system
    h. Improve student experiences in EPA-4
    i. Add education in stress management/coping strategies, importance of self-care, recognition of burn-out and fatigue management

   j. Continue to promote scholarship around LSI Part 3
2. Dr. Kman will present a LSI Part 3 mid-year report in November, 2016.

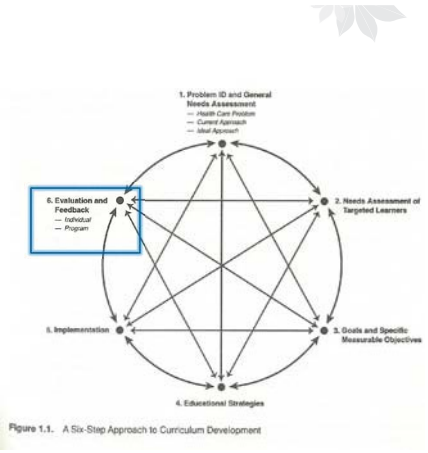
Item 3, Health Safety and Quality Revisions
Presenter: Nicholas Kman, MD

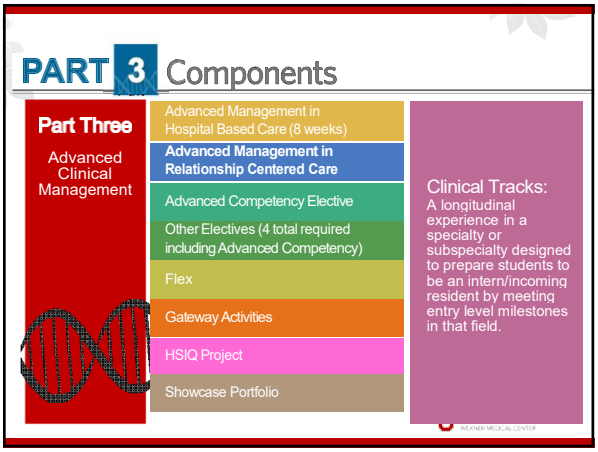
Discussion

1. Dr. Kman noted that although HSIQ was discussed as an independent part of LSI Part 3 that the course actually spans all parts of the LSI Part 3 curriculum including AMHBC and AMRCC. However, general scores were ranked at 2.59 out of 4
2. Issues were identified by general themes including timing of the project rollout, engagement from the group members, low levels of faculty support and relevance was not clearly established.
3. The timeline has been altered so that students are aware of the assignments and HSIQ projects can be initiated earlier in LSI Part 3.
4. Two major projects will be proposed by each student including a patient satisfaction project and a high-value care project. The second project will also require implementation of the proposed project. Dr. Danforth asked if the first project might also be implemented as an Advanced Competency.

Action Items

1. There has been a major revision to HSIQ and the student feedback from these revisions will be reassessed by the Executive Committee in the coming year





Please tell us how well the Part 2 (Med 3) program prepared you for Part 3 (Med 4)

#	Question	Strongly Disagree	Disagree	Disagree / Agree Equally	Agree	Strongly Agree	Total Responses	Mean
1	The Part 2 program provided relevant preparation for Part 3	0	1	14	96	48	159	4.20
2	Part 2 prepared me for Step 2 Clinical Knowledge (CK)	1	5	19	83	50	158	4.11
3	Part 2 prepared me for Step 2 Clinical Skills	0	2	20	77	59	158	4.22

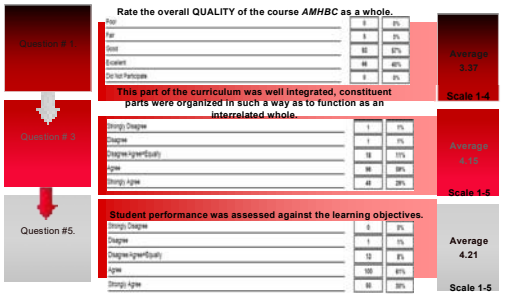
Overall Clinical Education

Question	Mean
I was offered opportunities to learn how to recognize and address ethical dilemma that surface in the real-world practice of medicine.	4.09
I was offered opportunities to learn about patient advocacy in medical school.	3.89
I was offered opportunities to learn to evaluate the cost of diagnostics tests and treatment in relationship to the benefits provided to patients.	4.15
I feel prepared to prioritize a differential diagnosis following a clinical encounter.	4.34
I feel prepared to recognize a patient requiring emergent care and initiate evaluation.	4.37
I am able to recommend and interpret common diagnostic screening tests.	4.33

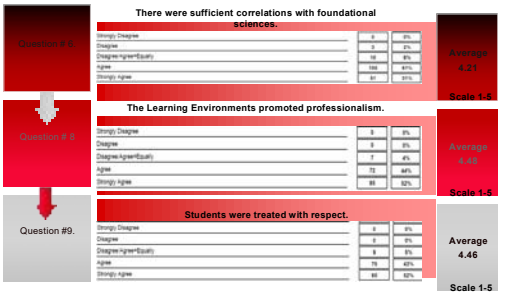
Overall Clinical Education, continued

Question	Mean
I feel prepared to enter and discuss orders and prescriptions.	3.71
I feel prepared to give or receive a patient handover to transition care responsibly.	4.13
I am able to provide an oral presentation of a clinical encounter.	4.44
I feel prepared to obtain informed consent for tests and / or procedures.	4.21
I am able to form clinical questions and retrieve evidence to advance patient care.	4.24
I feel prepared to identify system failures and contribute to a culture of safety and improvement.	3.95

AMHBC Course Feedback



AMHBC Course Feedback



Advanced Management in Relationship Centered Care

- Ashley Fernandes MD PhD, Director
  - Pat Ecklar MD, Associate Director
  - Kristen Rundell MD, Associate Director
- 4+4 week longitudinal or traditional block course which emphasizes team based care of patients with complex or chronic diseases.
- Some students will experience longitudinal care of patients with chronic disease and the intersection of care delivery and the patient experience.

The Ohio State University
Wexner Medical Center

Ambulatory

Block or Longitudinal (minimum 80 clinical hours)

ambulatory (outpatient) physician preceptor

learning goals and expectations geared toward advanced ambulatory management

patient-centered and

systems of care perspectives.

Critical Appraisal of Topic (CAT)

The Ohio State University Wexner Medical Center

Interdisciplinary Chronic Care (ICC)

interdisciplinary team care model, specialized to care for patient with complex chronic care needs

skills in home care, rehabilitative care, geriatrics, environmental influences, and caregiver stress

Block or Longitudinal (minimum 80 clinical hours)

learning goals and expectations geared toward advanced chronic care and the complexity of healthcare systems within the interdisciplinary team model.

Home Health Visit/Reflection

AMRCC "By the Numbers"

	Mean	Std. Dev	N
Overall quality of the course: AMRCC (4-point scale: Poor, Fair, Good, Excellent)	2.91	0.53	181
Overall quality of learning: AMRCC-AMB (5-point scale: Poor, Fair, Good, Very Good, Excellent)	4.35	0.64	100
Overall quality of learning: AMRCC-ICC (5-point scale: Poor, Fair, Good, Very Good, Excellent)	4.47	0.85	104

Advanced Competencies: Participation

Course	2013-14 # of Students	2015-16 # of Students
Adv. Procedural Competency for Acute Practitioners / AC in Critical Care and Procedures	19	11
AC in Global Health	18	14
AC in Research	19	3
Biomedical Informatics	3	4
Emergency Preparedness / Disaster Management	13	12
Genetics	6	12
Health Literacy	2	4
Hot-Spotting Team Care of Frequent Healthcare Consumers	Not offered	0
Interdisciplinary Perspectives on Developmental Disabilities	Not offered	1
Interprofessional Care for the Underserved Patient	Not offered	4
Interprofessional Collaboration	10	Not offered
Latino Health	6	0
Medical Administration	2	Not offered
Patient Experience	22	0
Professionalism and Humanism	4	9
Teaching in Medicine	6	7
Ultrasound Immersion	26	5

Advanced Competencies

Question	Mean
The learning objectives for my Advanced Competency were clearly communicated.	4.14
The assessments for my Advanced Competency were consistent with the outlined learning objectives.	4.16
My participation in the Advanced Competency helped me to develop or enhance a skill beyond that which was taught in the core curriculum.	4.16
Overall this was a good learning experience.	4.21

Clinical Track Enrollment

Course	# of Students
Anesthesiology	9
Emergency Medicine	17
Family Medicine	17
Internal Medicine (Categorical and Combined)	50
Internal Medicine (preliminary)	19
OBGYN	10
Pediatrics	14
Psychiatry	10
Neurology	4
Radiology	6
Surgery / Surgical Subspecialties (Preliminary surgery included)	35
Total	191

The Ohio State University Wexner Medical Center

Clinical Tracks

Question	Mean
The learning objectives or milestones for my Clinical Track were clearly communicated.	3.26
The assessments for my Clinical Track were consistent with the outlined learning objectives.	3.39
My participation in a Clinical Track helped me feel prepared for internship.	3.04
Overall this was a good learning experience.	3.13

Additional Feedback

Question	Mean
My 4th year allowed me to investigate the specialty of my choice.	4.52
My 4th year schedule allowed me to attend interviews.	4.58
My 4th year schedule allowed me to schedule and prepare for USMLE.	4.54

Part 3 Education Portfolio

#	Question	Strongly Disagree	Disagree	Disagree / Agree Equally	Agree	Strongly Agree	Total Responses	Mean
1	The Portfolio and Coaching Program has helped me to become a more reflective learner.	13	16	41	69	21	160	3.43
2	The Portfolio and Coaching Program has helped me become a more self-directed learner.	13	29	50	53	15	160	3.18
3	The Showcase Portfolio enabled me to demonstrate my ability to reflect on my development of competence in each of the six core educational domains.	17	20	34	66	23	160	3.36
4	My portfolio coach supported and guided my development as a medical professional.	7	10	27	54	62	160	3.96

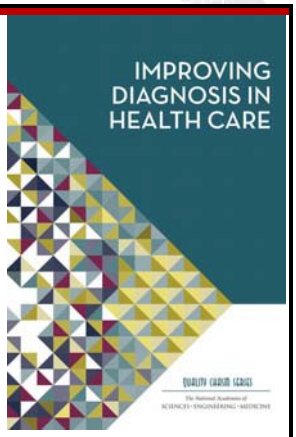
Debt

#	Answer		Response	%
1	None		26	17%
2	$1 to $14,999		3	2%
3	$15,000 to $29,999		3	2%
4	$30,000 to $44,999		4	3%
5	$45,000 to $59,999		4	3%
6	$60,000 to $74,999		2	1%
7	$75,000 to $89,999		5	3%
8	[illegible]		102	65%
9	Unable to estimate		8	5%
	Total		157	100%

Away Electives

- The following departments sponsored students completing multiple away electives:
  - Ophthalmology - 3 students did multiple
  - Urology - 5
  - Orthopedic Surgery - 4
  - OB/GYN - 1
  - Dermatology (IM) - 4
  - Neurosurgery - 2
  - Plastic Surgery - 1
  - Pediatric Endocrinology - 1
  - Neurology - 2
  - Internal Medicine (other than Derm) - 2
  - Family Medicine - 1
  - Surgery - 3
  - Radiation Oncology - 1
  - Emergency Medicine - 1
- These were combinations of approved and audited rotations.

HSIQ



Health Safety and Quality in Part 3

HBC

Question #11 I WAS OFFERED OPPORTUNITIES TO LEARN THE COST OF DIAGNOSTIC TESTS AND TREATMENT IN RELATIONSHIP TO THE BENEFITS PROVIDED TO PATIENTS.

	Count	Percent
NA	1	1%
Strongly Disagree	0	0%
Disagree	1	1%
Disagree/Agree=Equally	14	9%
Agree	83	51%
Strongly Agree	65	40%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.30	0	5	163	0.73	0 to 5

RCC

Question #12 I WAS OFFERED OPPORTUNITIES TO LEARN THE COST OF DIAGNOSTIC TESTS AND TREATMENT IN RELATIONSHIP TO THE BENEFITS PROVIDED TO PATIENTS.

	Count	Percent
NA	2	1%
Strongly Disagree	1	1%
Disagree	5	3%
Disagree/Agree=Equally	24	13%
Agree	99	55%
Strongly Agree	50	28%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.07	0	5	179	0.86	0 to 5

Total Responses: 181

HSIQ

#	Question	Strongly Disagree	Disagree	Disagree / Agree Equally	Agree	Strongly Agree	Total Responses	Mean
1	The HSIQ project helped me learn more about health care finance and high value care.	27	49	49	32	3	160	2.59
2	The HSIQ project helped me learn more about the importance of patient satisfaction in my specialty.	31	44	48	33	4	160	2.59

25

High Value Care Group Project

- Barriers to 2016 Class
  - Timing (Difficult to get group members together and complete assignments/intervention)
    - Timeline moved up so intervention done before interviews/Global Health
    - Not all members need to be in town for intervention
    - May do assignments including interventions early.
  - Confusion over requirements (rolled out in September)
    - Improved syllabus/structure
  - Interventions not feasible
    - Coaches
    - Dr. Heacock to approve all interventions/data collection plans prior to moving on.

HSIQ

- Comparison ('15 to '16)

Activity	Deadline	Location
IHI Module: QI 106	9/21/15	www.IHI.org/StudentCourses
IHI Module: QCV 100	9/21/15	www.IHI.org/StudentCourses
IHI Module: QCV 101	9/21/15	www.IHI.org/StudentCourses
Orientation/Session One	9/21/15-6pm-7:30pm	Meiling 160
Session Two	11/13/15	Carmen Course Dropbox
Session Three	11/13/15	Carmen Course Dropbox
Sessions Four & Five	1/10/16	Carmen Course Dropbox
Intervention implementation	03/07/16	Carmen Course Dropbox
Session 6: Debrief	4/1/16	Carmen Course Dropbox
Peer Evaluation	4/1/16	MedSTAR

Activity	Deadline	Competency Based Assessment
IHI Modules:		
QCV 100	07/25/16	Systems-Based Practice
QI 106	07/25/16	Systems-Based Practice
QCV 101	07/25/16	Systems-Based Practice
Individual Assignment Patient Satisfaction	07/25/16	Systems-Based Practice
Group Assignment One Group Members and Roles, Coach Identification, High Value Care Problem Focus, Prioritization Matrix & DMAIC Method	8/19/16	Systems-Based Practice
Group Assignment Two Problem Statement, Data Plan, and Intervention Design	10/14/16	Practice- Based & Life Long Learning
Group Assignment Three Implement an Intervention, Turn in Debrief and Data Request	12/9/16	Practice-Based & Life Long Learning
Group Assignment Four Analyze Data and Present Poster at Patient Safety Week	3/12/17-3/18/17	Systems-Based Practice
Peer Assessment Formative	10/14/16	Interprofessional Communication
Peer Assessment Summative	3/21/17	Interprofessional Communication
OVERALL		

HSIQ 2016-2017

Patient Satisfaction
- Individual Assignment

High Value Care
- IHI Modules
- 4 Group Assignments for High Value Care Improvement Project
- 2 Peer Assessments.

Patient Satisfaction Assignment

- Individual Assignment- Due August 1st

1. Review patient satisfaction data of one of the following
   1. Outpatient general medicine clinic
   2. Inpatient surgical service
   3. Emergency department
2. Define one patient satisfaction area for improvement
3. Describe in detail a possible intervention. Include
   1. Intervention
   2. Education plan including how to get buy in.

High Value Care Group Project

- Overview
  - Group project with the goal to complete an improvement project with implementation and measurement of change in high value care in your chosen specialty.
  - Culminate in poster presentation at Safety Week
  - Project is broken down into Four Assignments and Two peer evaluations.

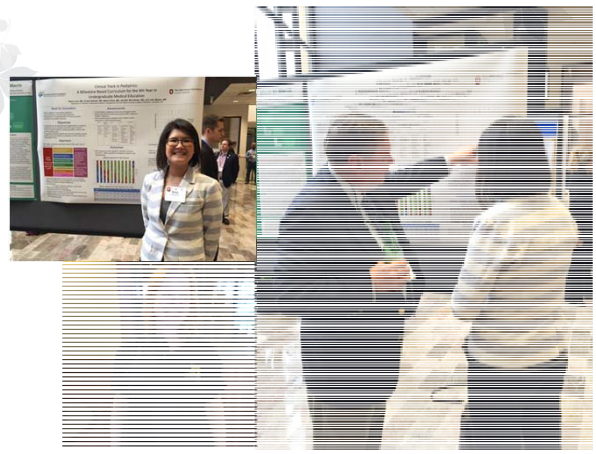
Choosing Wisely
An initiative of the ABIM Foundation

Areas of Challenge

- MedSTAR: Scheduling process was fraught with difficulty for the students. Courses were not consistently labelled and students “hoarded” AMHBC Mini-I’s.
- MyProgress: Students were able to see and change evaluations in the ED. We have not yet gotten the app to work consistently in Part 3.
- AMRCC Non-Clinical Requirements (Challenge and Opportunity)
- Tracking of Student Progress on Longitudinal Rotations
- Faculty and Clerical Support for Part 3
- Away Electives/States

Action Plan

- Part 3 scheduling and course management moved to Vitals.
- My Progress 6.0 is being used right now. Currently used for EM CPA. Will attempt to move tracking and attendance for AMRCC here with limited CPA.
- AMRCC will continue to look at Non-Clinical Requirements for several reasons. Are they necessary, do they assess what we want, how do we divide the work
- My Progress and Vitals will both be examined for accurate reporting and tracking of students attendance and requirements
- Ashley Fernandes and Troy Schaffernocker were brought up to 0.2025 FTE for the work and rigor required for their courses.
- Unapproved States down to 6.



LSI Part Three Program Scoring Breakdown 2015-2016

Unit/Course	Weight
Advanced Management in Hospital Based Care (AMHBC)	40
Advanced Management In Relationship Centered Care (AMRCC)	40
Clinical Track	2.5
Advanced Competency Elective	2.5
Elective Option 1	2.5
Elective Option 2	2.5
Elective Option 3	2.5
Health Systems, Informatics, and Quality (HSIQ) Project	5
Showcase Portfolio Assessment	2.5
Total	**100**

LSI Part Three Program Scoring Breakdown 2016-2017

Unit/Course	Weight
Advance Management in Hospital Based Care (AMHBC)	35
Advanced Management in Relationship Centered Care (AMRCC)	35
Clinical Track	4
Advanced Competency Elective	4
Elective Option 1	4
Elective Option 2	4
Elective Option 3	4
Health Systems, Informatics, and Quality (HSIQ) Project	5
Showcase Portfolio Assessment	5
LSI Part Three Total	100

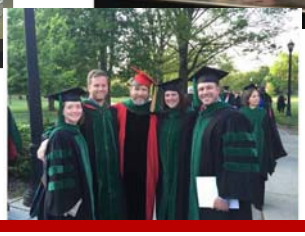
Action Items From Retreat

- Simplify Evaluations of TLM's, Courses and Instructors.
  - Stakeholders: Kman, Walker, Cannon, Leung
- Work on improving EPA4: Enter and Discuss Orders and Prescriptions.
  - Stakeholders: Part 3

Action Items 4.18.16

- AMHBC to add TLM on Stress management/ coping strategies, Importance of self-care, How to recognize burn-out, Fatigue management.
  - Stakeholders: Schaffernocker, Lewis, Thompson
- Debrief on Vitals for Part 3. What went well, what changes were needed, what can we improve?
  - Stakeholders: Kman, Volk, Sabatino
- Focus on Scholarship (each Part 3 member has a project, presentation, IRB, etc.).

Questions?



THE OHIO STATE UNIVERSITY
COLLEGE OF MEDICINE

The Ohio State University College of Medicine

Part 3 Academic Program Committee Retreat

Meeting Minutes

Date: 4.18.16 | Location: 1063 Graves

Chair: Nick Kman		Call to order:	1:00 PM
Minutes recorded by: Laura Volk		Adjourned:	5:45 PM

Last Name	First Name	Role	Present
Cannon	Victoria	Director, Office of Evaluation, Curriculum Research and Development	X
Casey	Anthony	Associate Program Director, Mount Carmel Health Systems	
Cohen	Dan	Part 3 Associate Academic Program Director	X
Cronau	Holly	Part 2 UPWP Director of Integration	
Curren	Camilla	Director, LG	
Davis	John	Associate Dean, Medical Education	X
Dell	Mary	Expert Educator, Psychiatry	X
Ecklar	Pat	AMRCC Associate Unit Director-Ambulatory	
Fernandes	Ashley	AMRCC Program Director	X
Grieco	Carmine	Faculty Representative, Radiology	
Heacock	Allison	Expert Educator, Internal Medicine	X
Khan	Meena	AC/AE Associate Unit Director	X
Khandelwal	Sorabh	Assistant Dean, Clinical Science	
Khurma	Anand	Associate Director, Education Technology	
Kman	Nicholas	Part 3 Academic Program Director	X
Lacuesta	Nannette	Associate Program Director, OhioHealth	
Leung	Cynthia	Expert Educator, Emergency Medicine	X
Lewis	Kristen	AMHBC Associate Unit Director, Mini-Int.	X
Liao	Nancy	Expert Educator, Pediatrics	X
Lindsey	David	Expert Educator, General Surgery	
Lipps	Jonathan	Expert Educator, Anesthesiology	X
Liston	Beth	Expert Educator, Hospitalist	X
Lucarelli	Maria	Expert Educator, IM/Pulmonary	
McCallister	Jennifer	Advanced Competency/Alternate Experience Program Director	X
Nuesmeyer	Keri	AMRCC Program Coordinator	X
Pfeil	Sharon	AMHBC EM Program Coordinator	X
Pfeil	Sheryl	Expert Educator, IM/GI	
Post	Doug	Assistant Dean, Foundational Science	X
Ray	Katherine	AMHBC Mini Int. Program Coordinator	X
Rundell	Kristen	AMRCC Associate Unit Director, Chronic Care	
Schaffernocker	Troy	AMHBC Program Director	X
Scherzer	DJ	Expert Educator, Pediatrics	X
Splinter	Ansley	AC/AE Associate Unit Director	X

Thompson	Laura	AMHBC Associate Unit Director, EM	
Volk	Laura	Part 2 / 3 Program Manager	X
Waddell	Valerie	Faculty Representative, OB/GYN	X
Werman	Howard	Faculty Representative, EM	X
Guests	Dan Clinchot, Curtis Walker		

Agenda Items:

1	1-2:45pm Part 3 Overall Review-Kman Part 3 Program Evaluation Summary of results Evaluations of TLMs, Courses and Instructors-Cannon, Walker Part 3 Overall Grade Breakdown (see Appendix A)-Group Part 3 Policies and Procedures (see Appendix B)-Group Permission Only Courses (fairness, number, etc)-Volk Foundational Science Correlates Grade Timing Expert Educator Duties •
2	2:45-3:30 pm AMHBC-Schaffernocker Presentation of AMHBC Evaluations Changes Indicate when in the curriculum the following topics are addressed in required sessions: Stress management/ coping strategies Importance of self-care How to recognize burn-out Fatigue management. Needs
3	3:30-4:15 pm Advanced Competencies and Clinical Tracks-McCallister Communicating Advanced Competencies to students prior to the start of Part 3. How do we advertise, which AC's are applicable. Changes Needs
4	4:15-5:00 pm AMRCC-Fernandes Presentations of AMRCC Evaluations Changes Needs
5	5:00-5:30 pm Student Review Update-Cohen, Liston Format Changes Needs
6	Technology – Cannon/Sabatino

Item 1: Overall Program Review

1. **Announcements and Scholarship:**
    a. Cindy Leung promoted to E&A Expert Educator

b. Allison Heacock HSIQ Expert Educator for Part 3
c. Thompson L, Leung C, Green B, Lipps J, Schaffernocker T, Ledford C, Davis J, Kman N. Assessment of Entrustable Professional Activity (EPA) 10 in a Mandatory Fourth Year Emergency Medicine (EM) Clerkship. Manuscript submitted to Medical Science Educator.
d. McCallister J, Khan M, Splinter A, Davis J, Kman N. Transition to Residency: Using Clinical Tracks to Assess Preparedness for Internship. Manuscript submitted to Medical Science Educator.
e. Leung C, Hartnett D, Gardner S, Kman N. Developing a Clinical Track in Emergency Medicine to Teach and Assess Level 1 Milestones. *Presented at the 2016 CORD Academic Assembly Advances in Education Research and Innovations Forum (Nashville, TN, 3/6/16).*
f. Thompson L, Leung C, Green B, Lipps J, Schaffernocker T, Ledford C, Davis J, Kman N. A Checklist for Assessment of Entrustment for EPA-10. *Presented at Curricular Innovations in Medical Student Education Oral presentation at the 2016 CORD Academic Assembly (3/8/16 Nashville, TN).*
g. Morgan H, Kman N, McCallister J, Santen S. Bridging the Continuum Between Undergraduate and Graduate Medical Education: A Feedforward Mechanism for Graduating Medical Students. *Presented at CGEA Meeting 4/7/16 (Ann Arbor, MI).*
h. Rundell, K, Ecklar P, Ledford C, Curren C, Mahan J, Bahner D. Enhancing Physician Teaching Skills in the Ambulatory Setting. *Presented at CGEA Meeting 4/7/16 (Ann Arbor, MI).*
i. Liao N, Splinter A, Mahan J, McCallister J, Khan M. Advanced Clinical Track in Pediatrics: A Milestone Based Curriculum for the 4th Year in Undergraduate Medical Education. *Poster presented at CGEA Meeting 4/7/16 (Ann Arbor, MI).*

2. N. Kman provided an overview of the first year of LSI Part 3.
    - C. Walker reviewed the program evaluation results such as items and response sets as well as frequency of questions. The following revisions were suggested:
        - Standardize and streamline evaluations across the curriculum
        - Align surveying with experience
        - Enhance querying abilities of survey items
        - Items and response sets
        - Develop evaluations for Advanced Competencies in Vitals

Action: A motion was made to standardize the language for the TLM evaluation forms deployed through Vitals. Motion was unanimously approved.
This will now be 4 questions per TLM:

Part 3 TLM Evaluation:

Rate the overall quality of this session.
- Poor
- Fair
- Good
- Very Good
- Excellent
- Not Applicable

Rate the overall teaching quality of this instructor.
- Poor
- Fair

- Good
- Very Good
- Excellent
- Not Applicable

Name one (1) or two (2) things this session or instructor has done well.
Name one (1) or two (2) things this session or instructor could do to improve.

- N. Kman led the discussion on the grading breakdown for the LSI components.

Action: A motion was made to change the LSI scoring breakdown to the following:

Unit/Course	Weight
Advance Management in Hospital Based Care (AMHBC)	35
Advanced Management in Relationship Centered Care (AMRCC)	35
Clinical Track	4
Advanced Competency Elective	4
Elective Option 1	4
Elective Option 2	4
Elective Option 3	4
Health Systems, Informatics, and Quality (HSIQ) Project	5
Showcase Portfolio Assessment	5
LSI Part Three Total	**100**

Motion was unanimously approved.

- A brief discussion was held regarding grade timing. The team was encouraged to keep better eye on the 6 week grade deadline.
- N. Kman mentioned the Task List for Expert Educators is in Buckeye Box and a separate meeting will be held to review the items and assignments.
- D. Clinchot informed the committee of the policy for dual degree students and the credits awarded.
  - MSTP are eligible for Advanced Competency elective credit if they were delayed entry into Med 4 to defend their thesis.
  - MD/MBA has to complete all Part 3 requirements in the first 8 months MBA coursework is completed January through April and qualifies for AC elective credit as well. The students can participate in MD activities during this time as long as it is documented and does not conflict with the MBA coursework (i.e. Showcase Portfolio and HSIQ).
- Brief discussion on why some courses require permission and possibly changing the policy for next AY (17-18).

Item 2: AMHBC

1. T. Schaffernocker provided an overview of AMHBC:
   a. Evaluations were reviewed…….

Action: A motion was made to approve the adjustment to the EM Unit Grading Matrix.

Domains assessed	Assessments		Weighting of assessments toward grade
Medical Knowledge	NBME EM subject exam,	Must pass: 1. minimum	35 NBME exam - If < 80%, not eligible for

(CEO 2)	Clinical Performance Assessments (CPA)- EM	passing score on NBME exam 2. minimum standard for Medical Knowledge on CPA.	honors designation. - <60 is failure
Patient Care (CEO 1)	Clinical Performance Assessments (CPA)- EM	Must pass: 1. minimum standard for Patient care on CPA. 2. Document essential clinical experiences (Log, PxDx) 3. minimum standard for patient management and entrustment during simulation sessions.	50% CPAs 5% simulation- - 2.5% for participation and completion of quizzes prior to the session, 2.5% for meeting entrustment on the first attempt 5% quiz questions- 3 points if 50-70 % 4 points if 70-85% 5 points if >85% 5% for professionalism – any answers of “yes” on CPA or other concerns that are brought up by faculty.
Practice-Based & Life Long Learning (CEO 3)	Clinical Performance Assessments (CPA)- EM	1. minimum standard for Practice Based and Life Long Learning on CPA .	
Interpersonal Communications (CEO 4)	Clinical Performance Assessments (CPA)- EM	1. minimum standard for Interpersonal Communications on CPA.	
Systems-Based Practice (CEO 5)	Clinical Performance Assessments (CPA)- EM	1. minimum standard for Systems-Based Practice on CPA.	
Professionalism, consistent and ongoing (CEO 6)	Clinical Performance Assessments (CPA)- EM	1. meet expectations for professionalism standard on CPA. 2. meet expectations during clerkship for professional behavior with faculty, staff and students during all	

clerkship activities.	

The motion was unanimously approved

b. Discussion focused on where in the curriculum the following topics are addressed:
    i. Stress Management/coping strategies
    ii. Importance of self-care
    iii. How to recognize burn-out
    iv. Fatigue management

Action: A motion was made to covering self-care reflection items.. The committee decided that the professionalism reflection in AMHBC would change to "Discuss how this professionalism issue relates to stress management, coping strategies and self care". The motion was unanimously approved.

Item 3: Advanced Competency / Clinical Tracks

1. J. McCallister presented an update on the AC/CT's
    a. A request to support funding for the Clinical Track Directors will be discussed at the Part 3 APC in May.
    b. Milestones for the CT's need to be mapped to the assessments so reports can be obtained.
    c. A process is needed to track longitudinal Advanced Competencies that cross more than 1 part of LSI. An ad hoc committee will be convened to map out a process to present to CITL.

Item 4: AMRCC

1. A. Fernandes provided a review of AMRCC. He has improved the rubric and assignment for the home health reflection and added a new TBL.

Item 5: Student Review Update

1. B. Liston reviewed the Student Review Committee changes. Once approved through ECC (?), the Student Handbooks will be updated.
    a. The SRS Subcommittees will be convened into one group.
    b. Standing meetings will be set throughout the year to accommodate all 3 Parts.
    c. The new committee will utilize all chairs and expert educators.

Item 6: Technology (Vitals and My Progress)

1. Discussion regarding Part 3 rollout in Vitals and My Progress upgrades. (No notes)

My Report

Last Modified: 03/15/2016

1. Please tell us how well the Part 2 (Med 3) program prepared you for Part 3 (Med 4)

#	Question	Strongly Disagree	Disagree	Disagree / Agree Equally	Agree	Strongly Agree	Total Responses	Mean
1	The Part 2 program provided relevant preparation for Part 3	0	1	14	96	48	159	4.20
2	Part 2 prepared me for Step 2 Clinical Knowledge (CK)	1	5	19	83	50	158	4.11
3	Part 2 prepared me for Step 2 Clinical Skills	0	2	20	77	59	158	4.22

Statistic	provided relevant preparation for Part 3	for Step 2 Clinical Knowledge (CK)	for Step 2 Clinical Skills
Min Value	2	1	2
Max Value	5	5	5
Mean	4.20	4.11	4.22
Variance	0.38	0.61	0.50
Standard Deviation	0.61	0.78	0.71
Total Responses	159	158	158

2. What did the Part 2 curriculum do particularly well to prepare you for Part 3?

Text Response
Felt well prepared to operate relatively independently
Lectures and small group were well organized and I felt that I was always learning while on rotation for the most part.
I think that studying for the shelf exams was good preparation
Exposure to clinical rotations, balancing studies and clinical responsibilities
Clinical rotations provided exposure to similar situations to part 3.
Clinical time and independent study time really helped prepare me for part 3.
Clinical rotations
wide variety of patients seen
Lots of opportunities to work patients up.
Good clinical preparation
Good clinical exposure in a diverse number of settings
Good amount of clinical time.
Exposure to a variety of rotations.
Shelf exams definitely prepared me to take CK (even months after 3rd year was over). OSCEs helped to prepare for CS, especially format. Overall rotations taught me how to be a good medical student to shine on SubIs/away rotations.
N/A - Took research LOA between third and fourth year. Did not participate in Part 2 curriculum.
Honing skills in H+P's, oral presentations; helping me familiarize with the hospital, where everything is and how it works
The ring structure which required you to study multiple topics simultaneously, helped me to retain more of the material which made preparing for step 2 and part 3 easier.
Good well rounded clinical experiences and taking the shelf exams.
Time in clinic got me used to the academic environment of medicine and how to present patients
good exposure to all the various specialities, liked the 2-4 week experiences
Good clinical knowledge base (developed primarily through clinical exposure, not didactics).
Prepared for Step Exams well Prepared to think critically about patients and participate in multidisciplinary teams
PArt 2 gave me a broad breath of clinical experiences.
Clinical rotations, in general, were the best prep for CK that I could find.
N/A - I started in 2011 and took LOA
Emphasis on preparation throughout the year versus just cramming at the end.
Exposure to many different specialties; hands on learning that helped to prepare for sub-i
I was very well prepared for the Step 2 CS and have sufficient knowledge for Step 2 CK. I felt prepared to be successful in my fourth year rotations.
general medical knowledge, how to work in a hospital, basics of presenting/note writing/interviewing/physical exam.

The clinical rotation sites provided excellent opportunities for learning from attendings and residents.
I liked having psych and neuro shelf exams near each other.
Provided broad exposure.
Provided solid foundation of knowledge and clinical experience.
The diverse patient population available at multiple clinical sites
My clinical experiences were very good preparation because of the teaching provided by residents and faculty
Shelf exams were good practice. Liked the opportunity to take Step 2 early.
The duration of each rotation was relatively well-balanced.
Exposed me to the clinical setting, explained how to behave there.
Good knowledge base.
Lots of experience on the wards during Part 2 made me feel much more comfortable during Part 3.
Shelves in general were very good preparation for CK. Clinical time was good for the most part.
I felt I had a good variety of clinical rotations to prepare me for the rotations fourth year. I was well prepared for step 2. I felt very comfortable and prepared during Step 2 CS, because our OSCE's during Part 2 were essentially identical to the format.
Nothing comes to mind.
the best parts were mostly just taking the shelves and learning while rounding with the team and being on service, the rest of the extra stuff didn't really help
Good clinical experiences
Introduced us to the hospital world and working in teams, becoming better with the EMR and being efficient
It was a broad experience with opportunities to actively participate of patient care
N/a
clinical experience
The rotations and lectures
all around exposure to different parts of medicine to prepare me to take full responsibility of a patient.
It was very helpful that in some rings there were elective options for rotations. I especially appreciated that we could do a short Emergency Medicine elective during Part 2, which really prepared me well for my Emergency Medicine AMHBC rotation during Part 3.
Rotations, learning the hospital
N/a; did not do Part 2
let students preference certain aspects of their rotations (pediatrics vs adult, etc.)
I had exposure to many different areas including various levels of patient acuity. Continued OSCEs during Part 2 helped with CS preparation. Taking multiple shelfs at the end of each block made it a bit less overwhelming to study for Step 2 CK.
Really enjoyed the emphasis on clinical experience.
Large variety of clinical exposures that covered most of the basics.
Many residents and attendings allowed for student autonomy and involvement which was particularly helpful when part 3 began.

Exposure to wide variety of pathology, diverse patient population. The vast majority of services in Part 2 gave sufficient student autonomy to prepare for Part 3.
Helped me progressively build skills from an observer and information gatherer, towards becoming a manager of patient plans.
Just being on rotation and seeing different specialties and getting experience in seeing patients
n/a
Just rotating through the different core rotations prepared me well for my mini-internships and electives
Clinical correlation/integration early on
good clinical rotations and integration of subjetcs
Good variety of clinical experiences
It allowed me to become familiar with the services within the hospital, helped me hone my exam skills and taught me how to utilize the literature to assist in my MDM.
I felt that it gave me a lot of comfort in dealing with a variety of patients and made some of the clinical rotations during 4th year feel rather simple by comparison.
More structured clinical experiences allowing greater diversity of services with the two week rotations and requirements that ensure clinical competency.
Hands on clinical time
Overall very helpful.
Set high expectations for requirements while on service.
exposure to different fields. good deal of clinical medicine experience
the clinical rotations, book studying, OSCEs
n/a
Diverse clinical experiences
Didactics
It allowed me to have elective time in my chosen specialty
See the variety of specialties
Breadth of experiences
Did not participate in Part 2
Experience on rotations.
Wide variety of rotations.
I really thought the variety of clinical experiences was very valuable.
It prepared me well for the clinical rotations with plenty of practice taking histories, doing physicals, presenting and forming plans.
Solid exposure to the 6 main specialties was helpful in choosing a specialty. I felt the amount of presentations and involvement in patient care as a M3 was helpful as a M4. Learning EPIC software was also helpful!
Clinical exposure
Good flexibility to allow clinical rotation time to do the teaching.

Clinical rotations
Clinical rotations
The inservice clinical experience.
We were encouraged to gradually take on more and more responsibilities and move from being reporters to interpreters. I felt well prepared for my sub-I rotation.
good rotation experiences
Like ground school, esp obgyn/surgery one
Gave me good resources to refer to as questions with the basic sciences came up

Statistic	Value
Total Responses	147

3. How might we improve the Part 2 curriculum to better prepare students for Part 3?

Text Response
Let us do ICU rotations in 3rd year, I learned more during 1 month of MICU in Part 3 than I did in my entire IM rotations
Organization and structure of some of the blocks could be better so that the flow throughout the ring is smoother and assessment week is more successful. I feel the way students were rotating back and forth through specialties could bring some stress and disorganization in their preparation for shelves.
I would suggest adding the Clinical EM workshop earlier in the year as an optional tool for learning. I found that while taking a test, its easy to know what the "best next step in management is," when you are in the actual setting it is different.
Less in person lectures, combine Psych with Family Med and Peds
Fewer iPad checklists. Improve ground school lecture quality.
The HSIQ lectures and "mini-projects" were not helpful in preparation for the part 3 project.
not having 3 shelf exams in a week would better prepare us to not have to relearn material for step 2 or for Sub-I's. Because of the crammed exam week we are forced to memorize material at an accelerated rate and less stays in our heads after the exam because we crammed SO MUCH so fast. To better prepare us for residency we need to have a better grasp on one subject instead of a small grasp on many.
One thing I didn't realize was important was getting to stick with the same attending for longer periods. Most of my third year was spent cycling between different attendings every one or two weeks. As a result I ended third year without any docs that I felt knew me well enough to write letters. I had to get 2 LORs from my Sub I which ended up working out fine but made me sweat a bit while on that rotation.
give students a better understanding of clinical tracks and how they will be implemented
Have a course pack and have the blocks be continuous followed by a shelf. I felt like I had to sacrifice a solid understanding of one topic for another instead of fully developing my competency in one area.
Didactic time was not very well spent, and it would have been nice to incorporate more elective time to help students decide on a career path before scheduling Part 3.
I was definitely unused to month-long rotations with exams at the end. I was much more accustomed to having an entire ring to study for shelves/exams. For example, emergency medicine shelf was harder for me to study for, as I had been used to prolonging my study schedule to accommodate the long (14 week) rings.
N/A - Took research LOA between third and fourth year. Did not participate in Part 2 curriculum.
Get rid of the multiple shelf exams in one week and going back and forth between rotations. There was no benefit to that system over the older system in my opinion. All it did was disrupt our schedule and our studying. Rings are okay to group rotations together, but let students have a full, immersive experience in each field of medicine by letting the student focus on that field. I think students will progress more during Part 2 if they aren't being tossed around between rotations, and would thus be better prepared for Part 3.

One possible improvement in part 2 could be to diversify the Tuesday afternoon lectures to include more things like reviewing clinical practice guidelines and other primary sources, rather than material just being presented as lectures.
Let med students go home earlier to have more time to study independently on days when there is nothing going on (this was particularly a problem at Nationwide).
Some additional support for part 2 CK would have been nice
n/a
Revise HSIQ with definitive standards, uniform curriculum / implementation, and meaningful content.
More cases in small groups - generation of Differentials, and focus on judicious use of labs/imaging
Continue to emphasize clinical experiences over formal teacher whether lectures or small groups.
Remove HSIQ, stop making us blog (ie reflect) constantly
N/A - I started in 2011 and took LOA
I would have liked more elective options particularly in the surgical subspecialties.
I did not take part in LSI Part 2
Having already organized HSIQ ideas that may be easier to implement.
Teach people how to put in orders, answer pages from nurses earlier on
I think it would have helpful if part 2 provided more elective experiences in specialty fields, even if only for 1-2 weeks.
I would recommend more general IM time. I personally had 1.5 weeks which is substantially less than other schools.
More general internal medicine. WAAAY less OB/GYN.
Would have enjoyed an additional block within general medicine or one of its subspecialties.
I do not see the goal of HSIQ especially doing the same thing as practice 3 times. I do recognize the importance of HSIQ in modern health care and the idea is good on paper. But given the stress that the clerkship grades applications and step 2 have I do not see this as a mandatory priority. It was not hard doing the assignments but note that this caused a lot of unnecessary stress and worry about meeting deadlines.
Allow more time for patient contact or ensure that mandatory didactic time is relevant, focused, and engaging. Didactics, especially in the PWP and SMN rings, often felt like they were overlong and irrelevant to learning. The large lecture format of these sessions just didn't work.
More flexibility in electives.
The only suggestion would be to shorten the OB/GYN duration in exchange for a chance to do more electives.
Longer general medicine rotation
Integrate more clinical components and give the students more practical experience.
Tuesday lectures were very hit and miss. An effort should be made to continue improving poor lectures or if need be cutting lectures that continue to get negative feedback. It would be nice to have at least 2 weeks per ring where students are given time to rotate on different electives, particularly those that are not represented in the core Part 2 rings (aka ENT, Derm, Rad, PM&R, etc.) because it is

currently difficult for students to explore any interest they may have in these fields until fourth year which is sometimes too late.
I felt at times that there was almost too much variety of rotations during part 2. I felt the 2 week rotations during PWSMN ring went by so quickly that you hardly had time to get comfortable on the team.
Nothing comes to mind.
get rid of extra stuff (lectures, TBLs, assignments, HSIQ, myprogress, etc), focus on clinical skills and shelf exam
More than 2 weeks on a service- difficult to make meaningful relationships with attendings and follow patient care
More General Medicine exposure maybe.
Increase oppportunities to experience fields of interest
1. Offer more opportunities to explore subspecialties - especially those that are direct entry. 2 weeks during PWP is not enough 2. Do not need to have redundant ultrasound/IV skills checkoffs 3x over over the year instead have varying skills that pertain to that particular ring 3. Continuing from point 2, there should be more hands on simulations like that in Part 3 where we ran the code as a team. There should one per ring that pertains to situations that you could face.
longer rotations
Dedicated study time
more opportunities for specialty exploration, such as shorter rotations. One week / Two week rotations would help expose students to more specialties and help them decide if they want to pursue a specific field further.
Some additional procedural exposure (not just simulations) during rotations. Although I don't know how exactly to promote this. Overall though I thought we were well prepared.
Not really. 4th year was not all that different from third year as far as rotations go.
N/A - I was not a part of the formal Part 2 curriculum
Did not do Part 2. Based on what I heard though, I would suggest fewer ground school lectures, and more hands-on clinical skills workshops/sims/etc.
less busy work
Eliminate HSIQ project implementation. I found the IHI modules beneficial and think it is reasonable to keep those in the Part 2 curriculum, but the project implementation (& doing the same exact thing 3 different times) was not helpful and it took away from other study time.
I thought it went well.
More internal medicine- we shouldn't have less internal medicine than psychiatry considering the amount of people going into those specialties. I had 4-5 weeks of psych and 2 of IM.
Many times, I did not receive feedback or guidance on patient notes. While I feel that it is not so important that I learn the format of notes, I do feel that I missed out on valuable experience developing my medical decision making.
The didactic series could be more focused/tailored to board prep.
No concerns.
Go back to the original rotation format without the stacked shelves and the ground school
more elective time.
More time on the general medicine service where we see the breadth of internal medicine cases

More basic foundational knowledge early on before building up on clinical integration
N/A
Add more simulations and OSCEs with in person feedback as similar to the AMHBC sessions. Also some lectures about lines/tubes would be helpful.
Some of the ground school lectures were not very good. I would only keep the lectures that were evaluated positively my the students. Any lecture with specific info pertinent to the clerk ships or exams would fall in this category.
It would be great if students were allowed a little more opportunity to work in clinic settings during Part 2; which would also help a bit with career decision making. Also, being able to do some order entry during part 2 would make the transition to mini-I's easier.
Shorten ground school. More high yield lectures or independent reading material.
I feel making students prepare for two disparate clerkship shelves was an impediment to learning each respective subject well solidly.
I found value in the simulations we did during the EM rotation and IM boot camp. They helped consolidate knowledge, identify areas of weakness, and helped me gain confidence. You often don't know what you don't know until your put in that situation and the simulations are a great way to figure that out before seeing patients. Also the nursing call simulation was helpful for intern year. I would advocate increasing the amount of this during part 2 of the curriculum. As part of the original ground school it would have been helpful to have an introduction to various lines and some of the functional aspects of medicine that aren't covered in the first two years of medical school.
Nothing, really.
more time on general inpatient internal medicine. have tuesday classes more geared towards step 2 information/testing
more simulation scenarios like we did in EM. This was VERY HELPFUL.
n/a
Less fluff - meaningless projects that sometimes seem to further the career of the administrator backing them rather than benefit students, annoying nit-picky requirements that do nothing to improve anybody's experiences. Be more willing to work with students' personal issues (e.g. surrounding childbirth)
Really disliked the ring structure
Allow more opportunities for electives and specialty specific training. IM should probably be longer than 2 weeks as well, while surgery could be shorter.
I did not like the splitting up of the rotations like psych and neuro (one week vs continuous).
Did not participate in Part 2
N/A
More elective time.
I am in the minority, but I think I would have liked more didactics, especially in the surgery ring.
Encourage practicing putting in orders and thinking of dosing for medications.
It would be REALLY helpful if they had a timeline upfront that could guide when they start needing to decide a specialty. For example showing when they would start ranking rotations - at which time a specialty idea is HELPFUL, but not needing to be set. I wish I

would have known that ranking m4 rotations was so early so I could have tried at least to get a better idea of specialty by then. A graph of M4 deadlines and how certain you need to be of specialty at each time point might be helpful.
More flexibility (ie. electives)
I wouldn't make any changes besides add more time for the general IM rotation
Taking multiple shelves in same week decreased our performance, especially having the hardest and most comprehensive ones on Friday (surgery, internal medicine). Explaining this structure on interviews led to confusion and feedback that it would create stress and negative performance. Ring structure led to limited flexibility in structuring year and planning for MS4.
Take out some of the projects that are redundant or unhelpful (such as the multiple HSIQ sessions or virtual patient emodules) so that students can focus on preparing for their rotations.
increased responsibility as the year progresses
Nothing I can think of
Less busy work would be great so that we can study more each night.
less extraneous activities and more lectures focused on medicine topics
NO projects. At all. They are not helpful. Too much work that is irrelevant to my residency.
More specific pharm
Nothing comes to mind.

Statistic	Value
Total Responses	144

4. In retrospect, have you discovered aspects of your early medical school curriculum (Part 1, Med 1-2) whose value become apparent as you progressed in training? If so, please describe

Text Response
Early exposure to real patients and patient care was good
LG and LP were particularly well run for me to figure out what to expect as a third year.
I thought anatomy and physiology was taught well. Many things have already changed since our first Part 1 of LSI so I would have to look at what was updated and compare. One thing I always wish we had more of in Part 1is practice questions that were indicative of what we would see on the test.
LG class
The longitudinal preceptorship was very useful. Also the formative (not assessment week) OSCEs were helpful in preparing for CS
In truth, as I progress further, I see less and less value in what we learned early on.
The independent study time we had for step 1 was the single most important thing that prepared me for part 2 and 3.
Nope
none
Longitudinal Group, specifically the early exposure to SOAP notes, detailed physical exam, and history-taking skills. They are the sort of things that seem obvious as you learn them but you really benefit from a long period of repetition.
Cardio physiology and EKG interpretation as well as anatomy. Additionally, I really appreciated the career exploration weeks, so that we could look into specialties which we may not be exposed to until Part 3
I liked having the course pack from the previous years because it helped me organize my knowledge and have a framework to add more complicated details to.
Part 1 was helpful in that many topics were repeatedly covered during the first two years
None
Forming good study habits and getting some early clinical experience. One thing that I thought was valuable and should probably be expanded was when we had to take the Neuro shelf during first year. This helped a lot in getting a feel for the types of questions the NBME likes to ask.
LP was very helpful to get used to seeing patients and attempting basic presentations in a low stress atmosphere. Host defense done last was great for both boards and being ready for the floors.
Broad clinical knowledge base.
OSCE's were very valuable in CK prep, and practice for clinical skills Small groups Anatomy labs were valuable - should have spent

more time cumulatively learning anatomy
Not that I am aware of.
The pathology and anatomy we learned is always relevant
N/A - I started in 2011 and took LOA
I thought the preparation for Step 1 greatly helped with Step 2.
n/a
LG was a very important part of my education, preparing me for third and fourth year, as well as CS.
I think a stronger foundation you lay down in the early medical school curriculum will be invaluable when you are presenting patients during your clinical rotations. You will be able to have a broader differential and understand the complexities of patients' conditions. The longitudinal preceptorships were also helpful in preparing students for the clinical rotations without much stress.
oSCES, note writing early on, LP, medical knowledge
LG discussions on empathy and positive interviewing were helpful.
Neuro was not useful for my clinical teaining
Most valuable thing that I did in medical school was to develop relationships with faculty early on.
Knowledge foundation developed during those years as well as history and physical exam skills were very beneficial in all of my rotations
Yes
Nothing in particular comes to mind
Early practice seeing/presenting patients in LP (although LP experiences varied greatly)
The ability to memorize things is useful
longitudinal preceptor ship was valuable
NA
OSCEs in helping prepare for Step 2 CS.
Nothing comes to mind.
-all the OSCEs made CS a breeze
N/A
The Osce's were obviously somewhat helpful for Step 2 CS and longitudinal Preceptorship helpful for understanding clinic
Clinical skills simulations have developed my ability to be a caring physician
I was part of the old curriculum so this question cannot be accurately assessed as I was not part of the LSI curriculum for Med 1-2.
No
The exams helped with board exams
knowledge gained discipline built
I think that our early clinical exposure, although it was only once every 2 weeks in LP, was very helpful in terms of making us more comfortable with taking H&Ps with patients, and interacting with patients in general. This helped us to dive right in when Part 2 started, with at least some amount of initial confidence and comfort.
LP clinic was nice to get earlier clinical exposure.

Honestly, not really. I feel like Med 1-2 was much less relevant than I thought it would be.
OSCEs. This was one of my least favorite parts of the early curriculum because they caused me so much anxiety. However, after going through Step 2 CS, I can't imagine having to go through that exam without so much OSCE practice. Students from some other medical schools I took the exam with had only done 1-2 OSCEs during medical school.
The early clinical experience was helpful.
I'm glad I learned a decent amount of pathology because there isn't much time to learn it later on.
HSIQ - while I continue to be somewhat frustrated with the way it was implemented, I saw during residency interviews that it is a valuable skill and something that will not be disappearing from my career. Overall, I am glad to have received training and exposure on the subject.
The value of performing a needs assessment became apparent during Part 3, whereas it felt like busy-work during first year.
LP was useful to give a head start to clinical acumen in Part 2, although translating from outpatient to inpatient was somewhat of a transition.
Pathophysiology of disease and how different pharmacologic agents target it (pharmacology I guess) has definitely made much more sense during Part 2 and 3 than it did in Part 1.
Learning how to give oral presentations (i.e. for rounds) during LG was helpful, and would be more helpful if preceptor feedback involved making brief and relevant presentations.
Yes, LG was invaluable in helping me advance my patient interviewing skills
Early clinical exposure
N/A
Early clinical experiences with LP were helpful. OSCEs were helpful. More in person feedback would be helpful.
I felt that our Host Defense block, Dermatology lectures were very useful.
I think the broad knowledge base of part 1 and the busy patient care of Part 2 really leads to a lot of comfort in handling patients and making decisions in Part 3.
CAPS curriculum really facilitated my clinical skills. The ethical discussions were also great preparation.
Good pathophysiological understanding made obtaining clinical knowledge easier instead of through rote memorization.
Having clinical experience throughout the part 1 experience was helpful
No.
.
I did well Part 1 and that foundational knowledge base helped me during M3 and M4. OSCEs were also very helpful.
no
Nothing additional
Yes. I feel as though I understand pathophysiology better from the experience of med 1/2.
n/a
Did not participate in the LSI Part 1 or 2 cirriculum
I think the time spent on physical exam skills and differential development during small groups was valuable.

LP experiences were good preparation for clinical rotations.
All of it was pretty valuable.
Longitudinal Preceptorship was very useful and prepared me well. LG was also very helpful. TBLs and small groups were most helpful for learning.
Certainly, I learn a LOT from studying for Step exams so that has been helpful. And what prepared me best for Step, was M1-2 lectures and exams. Looking back I think the topics we covered in LG where actually quite high yield in M3-4. They seem "fluffy" in M1-2 next to hard facts, but when you are in a situation when you have to deliver bad news, learning that SPIKES mneumonic is so helpful (Etc, etc) ! As much as they are not that fun, OSCEs (& LP - which is more fun!) did prepare me for getting a rhythm down of taking a history well. Also being exposed to presentations in LG was helpful, even though it is still hard once you have really patients!
NA
Strong clinical knowledge during MS1-2, but really needed better basic science for Step 1 preparation. OSCE's early on helped prepare in long run for CS. Enjoyed LP as it made me more comfortable immediately starting clerkships in MS3
The OSCEs and any direct observation sessions were enormously useful in improving interviewing and physical exam skills.
LG has great potential to be valuable. A curriculum more focuses on history taking, presentations, and clinical application would be useful
I think the LG course and OSCE's prepared us for clinical rotations fairly well, from learning how to conduct a history to conducting a physical exam.
All the information was useful when applied to patient cases, OSCEs, although awful, were helpful to prepare
IHI modules.
- LG makes so much more sense now! Having had more clinical experience I now have a heightened appreciate for LG, a time in which we dissect how doctors think and communicate.
LG and LP from Part 1 made transitioning to clinical years much easier, I felt ready and prepared to take histories and perform physical exams on my patients.
Nothing particular to LSI.
I took a Teaching In Medicine elective during part 3. As part of this course, we discussed the benefits of reflection. If we had been forced to watch this module during part 1, I feel like I would have appreciated the reflections more, seeing them as a benefit rather than just "busy work".
Doing well on the basic academic components of Med 1-2 was essential for success in Part 2 and Part 3. Having strong background medical knowledge helped immensely.
Na
Learning to interview patients skillfully in LG was particularly useful, as was the training in delivering patient presentations.
Ultrasound, LP, LG, case-based small groups were all very useful.

Statistic	Value
Total Responses	130

5. Please answer the following items, based on your overall Part 3 program experiences across all units:

#	Question	Strongly Disagree	Disagree	Disagree / Agree Equally	Agree	Strongly Agree	Total Responses	Mean
1	I was offered opportunities to learn how to recognize and address ethical dilemma that surface in the real-world practice of medicine.	0	4	18	98	40	160	4.09
2	I was offered opportunities to learn about patient advocacy in medical school.	1	5	35	89	30	160	3.89
3	I was offered opportunities to learn to evaluate the cost of diagnostics tests and treatment in relationship to the benefits provided to patients.	1	3	17	89	50	160	4.15
4	I feel prepared to prioritize a differential diagnosis following a clinical encounter.	0	2	8	84	66	160	4.34
5	I feel prepared to recognize a patient requiring emergent care and initiate evaluation.	0	0	9	83	68	160	4.37
6	I am able to recommend and interpret common diagnostic screening tests.	0	0	9	90	61	160	4.33
7	I feel prepared to enter and discuss orders and prescriptions.	4	13	32	87	24	160	3.71
8	I feel prepared to give or receive a patient handover to transition care responsibly.	0	3	18	94	45	160	4.13
9	I am able to provide an oral presentation of a clinical encounter.	0	0	8	74	78	160	4.44
10	I feel prepared to obtain informed consent for tests and / or procedures.	0	4	12	91	53	160	4.21
11	I am able to form clinical questions and retrieve evidence to advance patient care.	1	1	10	94	54	160	4.24
12	I feel prepared to identify system failures and contribute to a culture of safety and improvement.	3	3	26	95	33	160	3.95

Statistic	I was offered opportunities to learn how to recognize and address ethical dilemma that surface in the real-world practice of medicine.	I was offered opportunities to learn about patient advocacy in medical school.	I was offered opportunities to learn to evaluate the cost of diagnostics tests and treatment in relationship to the benefits provided to patients.	I feel prepared to prioritize a differential diagnosis following a clinical encounter.	I feel prepared to recognize a patient requiring emergent care and initiate evaluation.	I am able to recommend and interpret common diagnostic screening tests.	I feel prepared to enter and discuss orders and prescriptions.	I feel prepared to give or receive a patient handover to transition care responsibly.	I am able to provide an oral presentation of a clinical encounter.	I feel prepared to obtain informed consent for tests and / or procedures.	I am able to form clinical questions and retrieve evidence to advance patient care.	I feel prepared to identify system failures and contribute to a culture of safety and improvement.
Min Value	2	1	1	2	3	3	1	2	3	2	1	1
Max Value	5	5	5	5	5	5	5	5	5	5	5	5
Mean	4.09	3.89	4.15	4.34	4.37	4.33	3.71	4.13	4.44	4.21	4.24	3.95
Variance	0.46	0.58	0.53	0.40	0.35	0.33	0.82	0.45	0.35	0.47	0.42	0.61
Standard Deviation	0.68	0.76	0.73	0.63	0.59	0.58	0.91	0.67	0.59	0.68	0.65	0.78
Total Responses	160	160	160	160	160	160	160	160	160	160	160	160

6. Please answer the following items, based on your experiences in you Part 3 Advanced Competency.

#	Question	Strongly Disagree	Disagree	Disagree / Agree Equally	Agree	Strongly Agree	Total Responses	Mean
1	The learning objectives for my Advanced Competency were clearly communicated.	1	4	18	85	52	160	4.14
2	The assessments for my Advanced Competency were consistent with the outlined learning objectives.	1	3	19	83	54	160	4.16
3	My participation in the Advanced Competency helped me to develop or enhance a skill beyond that which was taught in the core curriculum.	4	4	17	73	62	160	4.16
4	Overall this was a good learning experience.	2	3	18	74	63	160	4.21

Statistic	The learning objectives for my Advanced Competency were clearly communicated.	The assessments for my Advanced Competency were consistent with the outlined learning objectives.	My participation in the Advanced Competency helped me to develop or enhance a skill beyond that which was taught in the core curriculum.	Overall this was a good learning experience.
Min Value	1	1	1	1
Max Value	5	5	5	5
Mean	4.14	4.16	4.16	4.21
Variance	0.58	0.56	0.80	0.66
Standard Deviation	0.76	0.75	0.89	0.81
Total Responses	160	160	160	160

7. Please answer the following items, based on your experiences in your Part 3 Clinical Track.

#	Question	Strongly Disagree	Disagree	Disagree / Agree Equally	Agree	Strongly Agree	Total Responses	Mean
1	The learning objectives or milestones for my Clinical Track were clearly communicated.	10	34	42	53	21	160	3.26
2	The assessments for my Clinical Track were consistent with the outlined learning objectives.	8	17	61	52	22	160	3.39
3	My participation in a Clinical Track helped me feel prepared for internship.	17	32	56	38	17	160	3.04
4	Overall this was a good learning experience.	15	28	57	41	19	160	3.13

Statistic	The learning objectives or milestones for my Clinical Track were clearly communicated.	The assessments for my Clinical Track were consistent with the outlined learning objectives.	My participation in a Clinical Track helped me feel prepared for internship.	Overall this was a good learning experience.
Min Value	1	1	1	1
Max Value	5	5	5	5
Mean	3.26	3.39	3.04	3.13
Variance	1.26	1.03	1.29	1.27
Standard Deviation	1.12	1.02	1.14	1.13
Total Responses	160	160	160	160

8. Please answer the following items, based on your experiences in the Health Systems, Informatics and Quality project.

#	Question	Strongly Disagree	Disagree	Disagree / Agree Equally	Agree	Strongly Agree	Total Responses	Mean
1	The HSIQ project helped me learn more about health care finance and high value care.	27	49	49	32	3	160	2.59
2	The HSIQ project helped me learn more about the importance of patient satisfaction in my specialty.	31	44	48	33	4	160	2.59

Statistic	The HSIQ project helped me learn more about health care finance and high value care.	The HSIQ project helped me learn more about the importance of patient satisfaction in my specialty.
Min Value	1	1
Max Value	5	5
Mean	2.59	2.59
Variance	1.10	1.20
Standard Deviation	1.05	1.09
Total Responses	160	160

9. What components of HSIQ did you find most effective and most ineffective? How might we improve these components?

Text Response
I did not find that HSIQ contributed meaningfully to my education. Even now, at the end of 4th year, I am unsure as to what the goals of the project were and how they are going to be applicable as a resident.
Effective learning tool however hard to get group with good communication as people have very different schedules in the year.
I found it a bit confusing at times, uncertain of the true objectives.
Effective - learned why QI is important Ineffective - everything else. So many ways it could have been improved - my suggestion would be to start designing the group project with people in your ring during part 2 and do the implementation right at the beginning of the year in part 3 before interviews start in earnest. Then it would actually make sense to present findings after interviews are over
The whole HSIQ project was poorly designed and as such there was a lot of redundancy. There was an obvious lack of communication which provided barriers to completing the projects in a timely manner and expectations were clearly set beyond the means of the students in the limited resource and time setting. Furthermore, deadlines were not well communicated resulting in mediocre projects as students scrambled to just turn something in without much thought invested.
Project components would have great value if they only included interested students and were more rigorous and more long term projects. Classroom learning aspects of HSIQ were poorly executed and added little value.
I think that this is a difficult project for medical students to carry out effectively. We lack the time to reach a full understanding of whatever place we are supposed to be developing the project for, and we lack the power to implement changes. Additionally, it is hard to coordinate as a group when people have different interests and are at different sites.
The logistics of the HSIQ project were a huge barrier to successful completion of the project. Having us meet with our group and identify a project in September-December is very difficult with people completing away rotations and interviews. Asking us to implement a project in January, when many are still interviewing, and February, when many are abroad, is a tall order. It is always hard to ask students to actually implement a project in a place where they are not working is very difficult. I understand the value of learning the skills necessary to complete a quality improvement project and that all residents are expected to complete a project. However, having a medical student implement a project with minimal resources and experience working in the environment where the project will be implemented is no where near ideal. Making the project more on a theoretical basis could help us learn, but not burden us or our site with extra logistics and hoops to jump through.
It should not be something required for 4th year but rather an option for those willing to do it
This project was not organized. If you require students who are traveling, interviewing etc to get together on a project then the project should be ready for us to complete as fast as we like. several students and myself tried to complete this project last year and were told that data was not available or that we could not proceed until next year. It seems silly to not allow us to move forward on a project at our own pace. Also, the project did not give us any real benefit. Most of us felt that it was just filling out a form to get through the project. THIS DID NOT ADD TO MY MEDICAL SCHOOL EXPERIENCE BECAUSE IT FELT MORE LIKE BUSY WORK. I recognize that throughout residency we will be doing this, but this project left me without the basic skills needed to really do this. For improvements I would suggest having the material available for students to go through the project at whatever pace best suits

them.
I understand the importance of grasping the concepts of QI projects as they are a part of American medicine, but these projects felt more like filling out insurance forms than actual learning experiences. Perhaps the HSIQ curriculum could be updated to allow for learning the concepts and tools of putting these projects together (Fishbone diagram, 5 why's, etc) and then hooking students in to an actual QI project at OSU to see one in action. Alternatively, if the format of the QI project is the main teaching goal, perhaps the class in general could brainstorm a medical college educational QI project to be implemented amongst students (i.e. problem: students are dissatisfied with xxx) and build a QI program where students will actually see outcomes.
Nothing was effective
It was unclear what type of topic we were supposed to choose. At first we were doing choosing wisely then we were doing patient satisfaction.
HSIQ has potential to be useful and enjoyable, but it was far too rushed for our class. It was not as organized as it could have been which led to lots of confusion and overall frustration.
I realize how vitally important quality improvement projects are. I recognize that I will be doing quality improvement projects throughout residency and even as an attending. However, I thought this project did NOTHING to help me better understand quality projects. It was confusing and cumbersome. The instructions were not clear. I didn't understand what we were doing the entire time and literally felt like we were making stuff up just to have something to turn in. In addition, I felt I was doing completely useless work -- useless for my learning, useless for the patients, useless for the other members of the team. I think it would be more effective if we could see how a current REAL project is being run -- what has already been done? How was the problem identified and the intervention decided on? Depending on the stage in which we enter to observe and possibly participate on a real project, assignments could be shaped from there. But these "fake" projects that we threw together just to graduate is not effective and did not at all contribute to my learning. Let me also say that the repetitive HSIQ assignments during part 2 were just as ineffective. My only impression of them was that they were busywork -- forms to fill out simply because I was required to. There was no learning there. Knowing how important quality improvement is, I was truly disappointed that this project has been such a failure for my learning. I wish I had the opportunity to learn more about quality improvement projects in an effective and constructive way -- and my opinion is the best way to learn is, like on rotations, through REAL experiences (not haphazardly thrown together because we're required to).
N/A - Took research LOA between third and fourth year. I only completed the online modules and was not required to do HSIQ project.
Effective - working in groups, going through each step of the process Ineffective - implementation of the curriculum was a little confusing and objectives/requirements were not always clear
The IHI modules were the most effective components of the HSIQ project as they walked us through how to use a variety of quality improvement tools. The most ineffective component of the HSIQ was the implementation of an intervention at a site with which we had limited experience. One way this could be improved is if interventions could be implemented at the site of a longitudinal rotation (possibly outside OSU), where the student is more familiar with system failures.
The whole project honestly felt like a bit of a half measure...We repeated things we had already done previously in Part 2 of the curriculum and then we sort of did a very basic project. I think this should be replaced with something else or students should be required to become involved with an actual project on a larger scale.

Early portion was far too repetitive. Feedback was too limited and not very personalized to our projects. In Part 3 the project was run better with more feedback and I liked picking our own project based on the choosing wisely campaigns.
the timeline was really not ideal given our 4th year schedules and many of us being out of the country jan-feb
The plan for implementing HSIQ was poorly thought through, and it was presented as a rock solid battle tested strategy, even when students knew this from experience to be false. Humility and communication / better reception to ideas from student representatives was / is needed.
This project should have been introduced at the beginning of Part 3. During the first few months of Part 3, everyone in my specialty area of focus were working in our respective specialty. To try to implement a project, pertinent to our specialty in January (when none of us were working clinically in the same department/area), was nearly impossible to coordinate.
HSIQ would be better served to be a series of small group activities which go through a HSIQ project instead of lectures followed by an implementation of a small project.
I thought overall HSIQ was ineffective on all fronts. It mostly felt like busy work that no one was interested in, not even the faculty advisers. I understand I should care about it because it somehow affects my pay.
N/A - I started in 2011 and took LOA
I enjoyed learning about HSIQ projects going on in the medical center and this helped me understand the big picture of the project. However, I felt that the directions and requirements for the project were unclear and constantly changing.
Did not do the HSIQ project
I did not find any aspect of HSIQ helpful or educational, especially not the fourth year version. I felt that I learned about the process of performing an HSIQ project from the first ring in third year, and any HSIQ after that was a waste of time and mostly fabricated.
Figuring out problems in my specialty was effective and thinking critically about these issues. There was a lot of problems with the project though, which include putting burden on 1-2 people per group, confusing objectives and project goals, and overall communication
It seemed there was a lot of repetition in the HSIQ project during Part 2. It would have been helpful to have the exercises vary during Part 2. During part 3, we designed two projects and implemented one project. I think with the timing, it would have been helpful to implement the project earlier and perhaps then only design one project Overall, I felt like I learned about quality improvement and was happy to participate in the HSIQ.
The implementation of the program could be more standardized to minimalist the variability the different teams faced when implementing their interventions
I think the idea of learning QI is important. I would have liked to start an actus project during M1 which would have lead to publication by ERAS time. I think everyone could achieve this, and it would be a more meaningful experience to work through one real project as opposed to many mock ones.
Cut it out. Offer it as an advanced competency course.
Very effective in teaching students the DMAIC process. Challenging aspect of the project was performing an intervention and colleting the relevant data.

I think it is best to offer this as an elective in part 3
Overall, the early HSIQ assignments (online modules about QI) were most valuable to me. I felt that I learned the most from these assignments. In addition, HSIQ during Part 2, where we developed mock projects and talked about the application of these principles, was valuable. HSIQ in Part 3 was ineffective for me. It required an unrealistic amount of work and coordination at a time when my classmates and I were scattered around the country and globe. In addition, there was little to no guidance and few resources available to help implement projects in a meaningful way. I think this part of HSIQ would be better served as an opt-in elective, where completion of a meaningful, longitudinal QI project could be more realistic.
Effective: group project, allowed us to see teamwork with a larger project Ineffective: descriptions of assignments and expectations were not clear
The staged submission process for each part of the HSIQ project was helpful in actually accomplishing a project. I'm sure the projects would have been of lower quality had there only been one final deadline. There is some difficulty in implementing a project, you may want to consider actually implementing a project as a advanced competency (vs hypothetically implementing w/ projected data as a graduation requirement)
It's a lot of busy work... You can dress it up however you want but it's always going to feel that way. However, I also understand that OSU's hands are tied, so I would be honest and say that.
I think this is an important topic to cover during medical education. I hope it will be better organized and presented in more of a "high yield" manner that is focused on what students need to know.
Overall HSIQ simply felt unpolished and unready. Assignments were consistently changed within a week of due dates due to student feedback. Final project was not even really completed because of issues getting us our patient satisfaction data. I hope that moving forward these problems will be fixed and the project will be of value, but as far my experience, HSIQ was not much more than a constant source of frustration and annoyance.
The HSIQ project proved to be difficult for our group. The goal of the project was confusing as the requirements kept changing throughout the year. We would get emails right before an approaching deadline which we almost always had forgotten about. Because of this we would often have to scramble to complete he requirements for that deadline. I think the biggest difficulty of this project is that everyone is doing such different things during their fourth year. People are out of town frequently and at times out of the country. Others are on a huge variety of rotations with different hours and locations. It became very difficult to come together as a group and get things done when people are doing such different things. This project would be much better suited to Part 2. If it continues to be a Part 3 project I think it would be helpful if the requirements are more lenient and much more clearly organized and stated upfront.
Nothing comes to mind.
being dragged through an HSIQ project 4+ different times with the same exact steps was not helpful. especially since the data was always given to us. during 4th year it was rather impossible to collect the data they were wanting us to, and therefore again unhelpful. there just really isn't enough time in medical school, especially years 3 and 4, to devote to doing these types of projects WELL. other medical schools don't even have things like this. it would be better to provide us with information about cost conscious care in a different way.
Start this earlier in 4th year with clear of objectives about actual implementation

It is hard to work with a group of students all on a different schedule who may be out of town on interviews, out of town on medical mission trips, completely different rotations. Makes it hard to make a consistent project flow.
Tools we learned to use, be concise and provide specific examples
Felt more like an exercise of coloring by number. We did that same project three times over. Instead a year long project that did not have to focus on each individual ring would have been more fulfilling.
Overall ineffective.
It was effective to learn about patient satisfaction in my specialty, but ineffective to do a group project during our 4th year as students are in many different rotations in various locations including out of the challenging,
working in an HSIQ project with a group was helpful. Doing the project at the beginning of the year with applications going on was stressful and unhelpful, and after applications were done was inefficient because lack of involvement,
Going through the process of solving a system issue was helpful. It is good to at least become familiar with it. The modules were only marginally effective. It was difficult to retain most of the information from them long-term, although I think I took away some of the major points from them. Applying what we learn from the modules to a real-life situation soon after we do them could possibly be helpful, although I am not sure if students would be motivated to do this. Possibly having an optional way to do this would be helpful, so students who are more interested can learn more and apply what they are learning.
Designing a quality improvement project for a service we have not started working on yet is impossible if a meaningful result is desired. Learning the "language" of QI with the simulated projects was useful, repeating the same process in each ring as a simulated process was not.
I did not have to do HSIQ since joining LSI during Part 3. I have not heard many positive things about it.
I don't think it's feasible to have medical students implement patient satisfaction projects when they are never in a clinical situation longer than 4 weeks. By the time you identify a problem, you are on another service. I did find the IHI modules helpful.
During firth year so many students are away from Columbus. This created practical barriers to the project.
Implementing the project was a complete waste of time. I honestly appreciated the HSIQ lectures and learning the principles and practice of implementing changes in a hospital system. I even thought the "practice runs" we did were kind of helpful. When we actually had to implement it, however, one person in the group was really put out because he had to carry the whole project. He had to seek out people and explain everything. Half of our group was out of the country and others were very busy (in an inpatient setting that was inappropriate for our project) or out of town. So one person had to do all of the work. None of us derived any benefit from this stage of the project and I hope you stop doing it.
It was often unclear (particularly in part 3) which aspects of the project were supposed to be implemented in the real world and which aspects were more of a theoretical exercise.
Redoing the HSIQ project every ring in Part 2 was redundant and time-consuming. Having to do it again in Part 3 was also a bit redundant.
I found the exercises of needs assessments and evaluating improvement to be important. I did not perform the project with students exclusively in the same clinical track, but in retrospect that would have been a more applicable/meaningful experience.
Project goals were too ambitious. We should run through a set of simulated projects, if anything to learn the process of quality improvement, but trying to actually implement a project with several students all on different clinical services is of very limited utility.

Overall ineffective. Deadlines frequently pushed back, significant confusion among students about different projects being implemented, etc.
I think the HSIQ project was a nice idea in theory but by the time we started doing something with it during Part 3, there was such resentment/cynicism about the project that I feel that most people did not get much out of it because they didn't take seriously due to an attitude of it just being "busy work" or a "completion item." I think it would have been better to make the project optional (like an advanced competency or something) so that the people who want to do it the most will get the best results on their projects. If this project will continue to be a requirement, I think that the introductory lectures during part 2 shouldn't require an assignment (make it a reading assignment) and then have students start on the project during Part 3 once they decide on a specialty. I think that having these lectures and assignments during part 1 and 2 ultimately hurt the project's goals because students were turned off by it.
It was useful to learn about the tools that are used in quality improvement projects. Trying to implement an actual meaningful change was difficult because of our limited access (both due to time and our status as just medical students).
Doing one project over the course of the whole year would be valuable instead of interpreting pre-existing data we were given. Also, there was a lot of repetition in the HSIQ lectures that we were given during each ring.
Very hard to do with rotating through services so quickly.
The HSIQ project during Part 3 was not feasible and ineffective.
The actual implementation phases are difficult to accomplish. Learning the tools and using them was helpful but there was significant unnecessary repetition.
The entire process of HSIQ was poorly communicated to students, starting from LSI part 2. This resulted in a level of distrust between students and administration regarding the utility of the project. I believe that the HSIQ project must be completely revamped (with student input) to make it a worthwhile learning project. Otherwise it just becomes just a box to check for graduation.
I think condensing HSIQ to one ring wound suffice. I also think that HSIQ during Med4 should be an elective and is not a good use of our time. It should be available for those who are interested in doing it as Med4 and not mandatory.
A lot of it felt very unhelpful in my career development. I think there needs to be a more convincing argument of why this is relevant and a better explanation of all the confusing jargon that it involves (with a recognition that the jargon is weird and confusing) rather than throwing these terms at us and pretending this is a normal way to talk about things. By the end, I felt an appreciation for some of the importance, but it was painful getting there.
Learning about the various methods to assess and quantify problems and present them graphically. The IHI courses were also helpful
The abstract concepts are very convincing, however theactual implementation of projects could be better. I believe strongly that HSIQ should be something we put the majority of the work into early on in Part 1, so that it foes not take away from our clinical experience in Parts 2 and 3.
I found the basic introduction to quality improvement concepts helpful. The main difficulty with the HSIQ project came with implementation. During my honors IM course as a fourth year we were paired with quality improvement projects that were already under way and worked with a physician mentor. This worked well and I think would be preferable to the current implementation phase of HSIQ as it exists now.

The organization, instructions, and expectations of the part 3 portion of HSIQ was not clearly explained. The proposed timeline for fabrication and implementation of the intervention was not well thought out in how it would fit with fourth year away rotations or interviews, making it difficult to complete a group project.
The method of implementation of this project i felt was ineffective, however the concept overall of learning about how to implement changes in a system I do feel are important. I partially think that med student teams should work with an experienced facult advisor to develop a good plan. more 1 on 1 attention with someone who really has experience with this would be the most helpful. also it was ahrd to implement a project during 4th year because most of us were out of town.
I found the entire HSIQ curriculum to be a complete waste of my time
Effective - initial lecture (ONCE) and doing the intial project (ONCE). Ineffective - repeatedly making up meaningless projects that don;t even go anywhere just to appease some academic bigwigs (doing the project ONCE taught enough). Future students should do one project more thoroughly (i.e. an ACTUAL QI PROJECT) rather than tiny little fake projects over and over.
The whole thing. It seems overtime we try to do one of these "projects" it just fails- due to poor communication, lack of overarching leadership, and perception of time-wasting. I recommend we be allowed to actually attend a meeting of ongoing quality/patient safety measures to actually see what it is like in practice.
Given the considerable time commitment required by HSIQ, the benefit of this program to an average student is heavily outweighed by the time and energy resources he or she must put in. I hope this is changed to an elective in the future.
ineffective: repeating the same project in part 3 three times, hsiq in part 4 effective: the first time we did the project in part 3
Repeated lectures on the same topics was very inefficient
I did not participate in the HSIQ
The whole project was completely redundant and a poor way to encourage students to care about quality control in a healthcare setting. I think this concept would be best taught through 1 simple quality improvement project that does not involve real data collection, a few in person lectures with discussion, and maybe a short quiz to assess knowledge. For those students interested in learning more, it should be developed into an advanced competency or elective. Subjecting the entire class to 2 years of HSIQ with extremely repetitive projects is completely unnecessary and a waste of time and effort for both students and staff.
For another course, we did a QI project that asked students to meet with an attending who was working on something, go through the QI process with this individual, then help in data collection. I learned much, much more from that project than the Part 3 HSIQ.
I felt that the project lacked clear direction and objectives. There wasn't really anything in this project that provided any additional understanding of the process of quality/safety improvement beyond what we learned in Part 2. For that reason it seemed laborious and unnecessary. I feel it either needs to be done away with in its entirety, or it needs to be completely re-imagined. Since we don't spend a great amount of time on any given team or unit, it is sometimes difficult to assess the problems in a given area. Maybe it would be better for teams to work with a faculty, or even a nursing staff, mentor to identify a problem. That mentor should then be available for the team to discuss interventions with. This would also allow a more seamless transition to implementation as the mentor could help notify the appropriate people and generally help facilitate the process.
Completing an entire project in part 3 made the most sense, but would be better to either join with the actual hospital QI teams to complete a project earlier. The online modules were somewhat helpful. Repeating practice project plans in part 2 was not helpful.
Student lack of understanding of the scope of the project made it difficult. I think I understood from the 1st session that we were

theoretically doing the first part, and actually doing the second part - but most did not seem to get that. The Carmen website was wonderful in that it had all the info for one due date on one page and the due dates were clear. I also felt what was due on each day was relatively clear. I think that general pass-fail-outstanding simple grading is beneficial for this activity.
Effective: being able to pick groups in a specialty of interest. Ineffective: difficult to implement project based on resources, people's different schedules, etc.
I think the implementation aspect, and the fact that it wasn't communicated to the majority of the class was detrimental to the feasibility of the project.
HSIQ had multiple repeated iterations that was inefficient and not meaningful. Instead, the single MS4 project should be initiated during MS3 and expand across both clerkship years to have more time to collect data. It was confusing to me why our problem statement was based on Choosing Wisely, but our intervention instead focused on patient satisfaction - this spread our resources and time too thin as MS4's during interview season and traveling. Please focus on one area to improve if HSIQ is to be continued.
I believe doing this project once in a meaningful fashion is more than enough preparation for us - if anyone wants more extensive experience than that, they should do an advanced competency or fourth year elective. Ideally, I would like to see this be done during first or second year with a faculty advisor who can walk their group through an HSIQ project that he or she has already done or is currently doing.
Redundancy of project
this project is an inappropriate use of our time in parts 2 and 3. we essentially repeated the same project over and over and the context for which this project was supposed to be carried out is not relevant to where we were/are in our careers. Our time is much better spent in clinical medicine than in achieving the vague and nuanced goals of a poorly designed project
I thought the HSIQ curriculum overall wasn't very effective. I understand that some changes have already been made for the classes below us so this may be redundant. However, in Part 2 we did the exact same project (except with slightly different data) 3 times. Each time we had meetings in which we would go over the same PowerPoint (which we had already seen in part 1). With fake data it was hard to relate any of this to the real world. I think if I were to design the curriculum I would have medical students do one real QI project during their time in medical school, and maybe even give them the 4 years to do it (they would have to reach certain milestones within each year). I think they would have ample opportunity to complete it and it would prepare them for the QI project that they will have to do in residency,
We did the same thing over and over again during 3rd year. This was not a beneficial learning experience. The project 4th year was difficult because classmates were spread across the country when assignments were due. Also the requirements were not very clear and changed over the year.
HSIQ is a well intentioned project designed to help us understand high value and efficient health care, however, the projects were drawn out over too long a period of time and without a centralized focus. To truly learn this topic, I believe we should be given a lecture and then tested on the knowledge with a quiz. This way, we would truly take something away from this important topic rather look at this from the standpoint of what do we have to do in order to pass/complete the next assignment.

Statistic	Value
Total Responses	147

10. Please answer the following items, based on your experiences in Part 3 Education Portfolio

#	Question	Strongly Disagree	Disagree	Disagree / Agree Equally	Agree	Strongly Agree	Total Responses	Mean
1	The Portfolio and Coaching Program has helped me to become a more reflective learner.	13	16	41	69	21	160	3.43
2	The Portfolio and Coaching Program has helped me become a more self-directed learner.	13	29	50	53	15	160	3.18
3	The Showcase Portfolio enabled me to demonstrate my ability to reflect on my development of competence in each of the six core educational domains.	17	20	34	66	23	160	3.36
4	My portfolio coach supported and guided my development as a medical professional.	7	10	27	54	62	160	3.96

Statistic	The Portfolio and Coaching Program has helped me to become a more reflective learner.	The Portfolio and Coaching Program has helped me become a more self-directed learner.	The Showcase Portfolio enabled me to demonstrate my ability to reflect on my development of competence in each of the six core educational domains.	My portfolio coach supported and guided my development as a medical professional.
Min Value	1	1	1	1
Max Value	5	5	5	5
Mean	3.43	3.18	3.36	3.96
Variance	1.20	1.19	1.41	1.21
Standard Deviation	1.10	1.09	1.19	1.10
Total Responses	160	160	160	160

11. What components of the portfolio and coach program did you find most effective and most ineffective? How might we improved these components?

Text Response
The coach was way more valuable than the writing itself. Maybe allow students to select their own coach based on shared interest, whether by specialty or other interest?
I enjoyed writing reflections I think it's important for students to do this because it builds on ones character and attributes. I think for more introspective people there could be a different option for reflection such as an oral meeting to go over the reflection item. Not everyone is good at writing and likes to use this as a means to reflect.
I thought it was helpful as I had many questions about how to proceed with the Showcase and with my interview what were able to be answered
Effective - my coach!! He is awesome Ineffective - having a different website for the portfolio every year felt very disjointed and made it harder to compile the showcase portfolio during part 3
Dr. Kman was very helpful in helping to shape my showcase portfolio and I greatly appreciate the amount of time he invested into it.
I enjoyed writing reflections and discussing them with my mentor. I think they would be higher quality of they were done less often but on the bigger picture of our educational experience.
Allowing us to reflect on anything that we wanted (and not having specific prompts) was very helpful. You could add a section for "personal reflections." When you reflect, you are supposed to show your personality a bit-not just tally what you have done.
Portfolio showcase is unnecessary
I never felt that I was given any effective feedback. Most of the sessions, including the showcase portfolio were people telling me I was doing well and that I should keep doing what i'm doing. There was no reason for me to stay a day after an exam to hear that I did a good job, when i already knew that. The same can be said for the portfolio showcase. It did not add to my educational experience and instead forced me to do extra work that did nothing more than allow a few strangers to say "good job." This was not used in my residency interviews. It was not something many of us feel a sense of pride over, and instead it is something that will be forgotten when we leave. I recognize the need to have coaches for students that are on the cusp of failing, or who have failed, but for students who regularly pass and do well, this is not needed and added nothing but an extra thing to my to do list
Below are some of the "most and least effective" points from the portfolio program, but I would like to say that in general, perhaps a less formal coaching relationship without required writing assignments would be more effective in creating reflective learners. Under other circumstances it has been good to reflect on my learning process as well as individual successes and failures, but this program felt forced. I don't feel that it enhanced my education or even my interviews. Most effective: providing space to reflect on unique clinical experiences. Least effective: "6 core educational domains" - I am not sure how these domains were decided upon, but I never really understood what they meant Coaching Staff: my coach throughout parts 1-3 was not on the teaching staff, and therefore not terribly knowledgable about the medical school curriculum or even professional growth from the student's perspective. It felt that they were only regurgitating learning objectives when going over my portfolio. When my coach was unable to meet and I met with an actual faculty member, the contrast was stark. They were able to provide actual advice and mentorship rather than

simply complementing my writing style.
I liked meeting with my coach to access how I was doing compared to my peers and make sure I was on the right track.
I enjoyed meeting with my coach, and actually enjoyed creating and presenting the showcase portfolio. No changes needed.
I liked having a coach who was separate from the grading process -- someone I could ask questions to and bounce ideas off of. I wish the Showcase portfolio had clearer guidelines. I personally was confused as to what an "artifact" was and what counted toward that requirement. For example, I included my ERAS personal statement and thought it was considered an "artifact," but was then told by my portfolio coach that it was not an artifact and I needed to write another reflection. Similarly, I included NUMEROUS past reflections (that counted toward the objectives) that were, apparently, NOT artifacts (according to my coach). So I had to write a whole new set of reflections, which I didn't at all appreciate. I thought the purpose of the Showcase was to showcase all of my reflections and experiences from the beginning of medical school -- to show my growth and personality. Discovering that none of my previous reflections counted (and I now had to reflect on reflections) was rather disappointing.
I do not think the portfolio is of any value. It took minimal effort to complete and did not really prompt any meaningful self-reflection. Furthermore, I think there was a universal consensus among my peers that using the portfolio for interview purposes is not helpful.
Effective - meeting with coaches to get feedback on grades
The most effective component was the frequent requirement to post reflective writings. This helped me to reflect as I went along, rather than just completing assignments at the end of the year. The most ineffective component was the showcase portfolio because we were unaware of this requirement until this year, which made collecting artifacts to represent learning earlier in medical school more difficult. This could be remedied by talking more about the showcase during part 1.
Loved my coach and getting the opportunity to check in with someone on a regular basis. I also think the portfolio is a great idea and will work well in the future when the classes are working on it and adding to it all along and will have it ready to go in order to potentially share with residency programs. Mine didn't come together fully until after my interviews were over.
The portfolio site ended up being a good idea but was implemented far too late for our year to really take advantage of it. The final presentation was a good way to get feedback. This could be a helpful way to start a lifelong portfolio if it is organized a bit better and broken into smaller chunks with small portions due somewhat regularly.
Ultimately it seemed relatively forced and reflections were often not broad enough to allow students to talk about subjects relevant to their experience. Allow students to find their own coach and provide more open ended reflections.
Coaching meetings were most effective in the Part 1 curriculum. The 1-1 counseling/mentorship was definitely the most valuable part of the program. The portfolio was much less valuable. The use of multiple systems and formats over the 4 years was cumbersome, and redundant (especially the showcase portfolio)
Having a dedicated faculty member to answer my questions when they arose was repeatedly helpful.
I thought keeping up writing skills was useful, but the portfolio itself was busy work.
I found this exercise a bit tedious, especially because I entered Part 3 without any other LSI experience so this was quite a different exercise than what I had been exposed to prior.

I enjoyed that my coach was a resource for me as I went through the residency process. However, I did not find that programs were interested in a portfolio as a supplement to the application.
Reflections were helpful, but as I completed it a concentrated span of time (only joining LSI for part 3) at times it seemed tedious/busy work.
Periodic reflections are a good component of a medical school education. The portfolio aspect, and the showcase of the portfolio, had no purpose as far as I could tell.
My eportfolio coach became another mentor and adviser who knew my trajectory throughout medical school. She was very helpful when I was reflecting on ways to improve my performance on exams as well as to prepare for residency applications. I thought the coach programs were a nice addition to the curriculum.
My coach was my mentor throughout med school. I think having artifacts and reflections on those artifacts focus on specific competencies is super helpful, but required specific questions and reflections on those questions are not always helpful. This should be more learner directed. I think the showcase would be so useful when it's implemented correctly, throughout all 4 years, and can be something to show to interviewers.
Having a coach was immensely helpful, especially during the early years when mentors in a particular specialty hadn't yet been identified. Further, it was nice to have a coach, even during 3rd and 4th year, to bounce ideas off of, talk about USMLE steps/applications, and get advice from.
I liked having someone to bounce ideas off of and it was fun to see how I grew as a person over these past four years.
The main goal was to reflect - which it accomplished.
Portfolio coaches were an amazing resource. Mine became a mentor for me through the course of my medical school education. No changes need to be made.
Nothing comes to mind
I enjoyed working with my coach the most. I wish I had known earlier about collecting artifacts so I could have been aware (i.e. some Med 1-2 artifacts)
Excellent way to keep on track of medical students who aren't performing up to their own standards. It really caused me to reflect on my performance especially when I felt I underachieved. Receiving feedback/criticism is difficult, but it was incredibly helpful to have an experienced physician help derive some direction/benefit out of it.
The reflections feel like 6th grade writing assignments but apparently there is some evidence behind them... The showcase portfolio is just ridiculous.
My portfolio coach was very flexible and was a resource I could always go to in medical school. I really appreciated her help. The showcase was a good thing. The showcase was like a residency interview and I think it would be really beneficial to students if they did it before they start on the interview trail. I think it is an important process to developing a professional identity that can really shine through during residency interviews if students can communicate it effectively.
I developed a very good relationship with my coach and this certainly enriched my medical training.
It would be much more helpful if we had been working on and towards our showcase portfolio since the beginning of medical school rather than having to copy over reflections and try to go back and find artifacts after the fact. If I had been doing that from the

beginning I think my showcase may have actually been something of value that I built over years rather than something I threw together last minute in the middle of 4th year.
I enjoyed working with my coach over the years. Things became a little difficult for our class as we switched portfolios twice throughout our years at OSU so it became somewhat less effective. However, I think if we were working on a single portfolio over the course of four years and had a big finished product at the end, then this would be helpful.
Nothing comes to mind.
I actually really enjoyed putting together the Showcase Portfolio and getting it reviewed. I'm not sure how much it benefits our medical education though.
Was frustrating to use multiple different websites . Wish we would've started working on showcase portfolio earlier
I appreciated meeting during every block or ring, helped me stay on task and get good feedback on my progress, and reassurance.
Support from my porfolio coach and some of the reflective exercises. Correlate reflections with questions asked commonly during residency interviews
No suggestions.
I think it is particularly helpful for students who are not self reflective. Being someone who is inherently very self-reflective I felt that this exercise was less valuable for me.
It was effective having a portfolio coach because it gave us a mentor to establish a relationship with for 4 years
reflections at times were worthless because they were more busy work then actually useful projects causing me to reflect.
coaches were probably one of my favorite things about LSI. A coach would essentially force you to reflect as well, but doing it with another human being is more natural and more engaging.
Most effective is having a coach to guide us through our 4 years of medical school. I think the showcase portfolio is only marginally beneficial. There are other ways we could go back and reflect on our experience without having to give a formal presentation.
Encouraging reflection is valuable. Artefact addition to reflections seemed superfluous/forced. Could be improved by keeping a consistent platform for the reflections in the future.
As someone who was new to the LSI curriculum for Part 3 , I think my opinion of the portfolio coach program is less informed than other students. From talking to others, it seems the coach was a good source of professional assistance and guidance. I think the reflective exercises were somewhat interesting, although I'm not sure that more requirements for the portfolio are necessary.
I thought having a portfolio coach was a really great idea, and a great way for students to have a consistent mentor and point of contact for questions. I'm bummed that I only got to do this for 1 year; it would have been nice in the old curriculum when it felt like no one cared about any of us. As for the showcase portfolio, I don't think it was particularly useful for promoting reflection or for professional development. That said, it wasn't all that painful and didn't take up too much time, so I guess it's better than HSIQ.
Enjoyed this process because I had a great relationship with my coach. The reflections were helpful to go back and remember various experiences throughout medical school .
Really enjoyed working with my coach. I was happy to have time set aside to talk to her over the four years.
I didn't mind the part 2 portfolio. It was a kind of interesting way to reflect on different aspects of medical school. It also gave us a starting point for discussion with our coaches. I think the showcase portfolio was a waste of time and shouldn't be mandatory.
I think it is not a bad program. For me personally, I don't feel that it had as much benefit because of previous life experience that had

helped me to develop the skill of self-reflection and being a self-directed learner. I think the program is able to help develop those skills and my portfolio coach was very supportive and helpful.
The coach program and reflective writing assignments were the most effective. They should be kept as they are. I'm not convinced of the usefulness of the showcase portfolio, but it wasn't that onerous either.
Really enjoyed personalized attention from very caring attendings.
Writing is not a way that I reflect on my learning or anything for that matter and I think that being forced to do it made me more salty about the project. I feel like many students shared my sentiments of the showcase portfolio being "another thing to get done."
I think it was useful to write reflections periodically throughout medical school. I enjoyed looking back at my reflections and seeing how I've grown and changed.
Excellent support group and gave me great advice
I felt like some of the meetings should not have been required, make it more optional if you have questions/concerns.
N/A
Having a designated mentor in the eportfolio was helpful.
The reflections seemed forced and as a result, did not feel genuine when I was writing them. The close ended prompts limited reflection. Also I am not one who l likes to write my feelings on a blog for others to read. I much rather have a discussion with my peers and a faculty facilitator in a group setting.
It was nice to at least have a set time and the person to ask questions to navigate LSI and it's confusing rules and requirements. However my coach did not always know the answer. The showcase portfolio Prost (website with artifacts) was not a good use of my time and did not benefit me in any way.
The coaching was helpful and I liked having that support. The portfolio itself seems virtually useless from a professional standpoint, and I struggle to imagine how I will ever end up using it after graduation.
I felt that the showcase portfolio was a helpful way to reflect on my medical training. Also, reflections during 3rd year are essential to ensure time to pause and reflect. Communication about deadlines and meetings was ineffective at times.
Having a portfolio covering our entire medical school career would give a better retrospective look at how far we have come and what directions we should take in the future.
The regular meetings with my portfolio coach were the highlight of the portfolio program for me
The process encouraged introspection and self-evaluation, but I imagine it is much less useful for those students that do these things innately. Perhaps this should be optional.
I appreciated having a neutral third party, who had knowledge of the medical center and employees, as well as the medical school journey to provide advice and guidance. I did not understand the utility of a showcase portfolio.
the fact that my coach was the same specialty as what i chose to go into was the only part I really found helpful. She helped put me in touch with faculty to assist me in my projects-research residency apps, conference and this was really great. She also became the advisor of my student group. However, I didnt feel like the checking in and reflecting did much-although i do beleive reflection is important, however, forced reflection didnt feel as useful. I did like the final culmination of the showcase, althuogh im not sure it

severes a purpose other than as memorabilia for students.
I would have chosen to not participate in the portfolio project if that option was available
Students should be allowed to opt out after a certain amount of time spent giving it a real chance. I'm sure it helps some students, but it does not help others and only serves as a waste of time.
Honestly, I do not feel the coaching program was worthwhile- just another time sink with little to no benefit.
While my coach was absolutely fantastic, I did not feel the showcase portfolio was a valuable usage of my or the faculty's time.
effective: having an extra mentor ineffective: did not feel it was necessary for me personally
I felt that the portfolio program added incredibly little value to my medical school education. While it was well executed, it disappoints me to know how many resources were dedicated to such a program. It is because of things such as these that result in the process to become a medical doctor takes at least eight years and hundreds of thousands of dollars.
n/a
My portfolio coach was a great mentor throughout medical school. I think having a coach was the most important part of this project, not necessarily the portfolio itself.
Meeting with the coach regularly was very helpful.
The meetings in the first 3 years were very helpful to discuss goals and how to plan to achieve them. The showcase was not helpful. It would be better to just work on the showcase all 4 years and include reflections but not have a separate portfolio for reflections.
It was not that hard, but if I had one wish, it would be that I did not have to do the technical set up of the website. I liked the 6 categories and I enjoyed putting up artifacts. I like the grading being an in person discussion with faculty. I liked getting to chose the faculty I got to work with. I appreciated that my portfolio coach checked through my final portfolio first. I was glad we had check in meetings with our portfolio coach and that she was able to proof my personal statement. I wish there was a coach meeting around when we were scheduling for M4 as that was when I felt very lost. However, it might actually be more helpful if it was someone in that specialty so I guess that a coach meeting might not work out like that always.
Enjoyed mentorship of the eportfolio coach. Did not find compiling previous work into a portfolio to be particularly meaningful as I had already done the work beforehand
Meetings with the coach was great just as a mentorship role
Showcase portfolio was helpful in reflecting on my growth during medical school. In-person meetings after each block wasn't as necessary.
I liked that we had a coach to walk us through our performance during medical school. However, I think that the portfolio needs to be something that is explained in full during first year so that students understand that they are building an online resume that will function as a cohesive whole. Additionally, I think that the utilization of this portfolio by program directors and residency committees needs to be explored, as I am concerned that students will put in a lot of work with no payoff.
useful to meet with coach
my coach was great. however, this portfolio (to me and in my opinion) is not essential to our learning or development. forcing us to journal, reflect, and create vague "artifacts" is a waste of our time when we need to be focusing on residency, interviews, our rotations, applications, and other essential components of our medical school experience.
My coach was a great mentor to me throughout medical school and I think that was a great help throughout medical school.

Portfolio coach was overall excellent and served as a mentor for me until I found the specialty that I wanted to enter.
Do not like the reflections. None of it is true reflection since you can't be incredibly honest when someone is grading you based on what you write. Showcase portfolio seemed pointless. Like many of the other projects we've done in the past 4 years, it's just something that takes up my time and that I forget about once it's done.

Statistic	Value
Total Responses	141

12. Please answer the following items, based on your experiences in Part 3.

#	Question	Strongly Disagree	Disagree	Disagree / Agree Equally	Agree	Strongly Agree	Total Responses	Mean
1	My 4th year allowed me to investigate the specialty of my choice.	0	2	7	57	94	160	4.52
2	My 4th year schedule allowed me to attend interviews.	1	2	8	42	107	160	4.58
3	My 4th year schedule allowed me to schedule and prepare for USMLE.	0	1	8	54	97	160	4.54

Statistic	My 4th year allowed me to investigate the specialty of my choice.	My 4th year schedule allowed me to attend interviews.	My 4th year schedule allowed me to schedule and prepare for USMLE.
Min Value	2	1	2
Max Value	5	5	5
Mean	4.52	4.58	4.54
Variance	0.41	0.50	0.39
Standard Deviation	0.64	0.71	0.62
Total Responses	160	160	160

14. To what extent has your overall graduate or professional experience influenced your future plans for graduate or professional studies?

#	Answer		Response	%
1	Very positively		24	16%
2	Generally positively		62	41%
3	Neither positively nor negatively (neutral)		34	22%
4	Generally negatively		6	4%
5	Very negatively		1	1%
6	Not relevant		26	17%
	Total		153	100%

Statistic	Value
Min Value	1
Max Value	6
Mean	2.84
Variance	2.62
Standard Deviation	1.62
Total Responses	153

16. At the time you graduate, approximately what will be the total amount borrowed to finance your graduate / professional education that you are personally responsible for repaying?

#	Answer		Response	%
1	None		26	17%
2	$1 to $14,999		3	2%
3	$15,000 to $29,999		3	2%
4	$30,000 to $44,999		4	3%
5	$45,000 to $59,999		4	3%
6	$60,000 to $74,999		2	1%
7	$75,000 to $89,999		5	3%
8	$90,000 or more		102	65%
9	Unable to estimate		8	5%
	Total		157	100%

Statistic	Value
Min Value	1
Max Value	9
Mean	6.45
Variance	7.68
Standard Deviation	2.77
Total Responses	157

17. Reflecting back, do you now think that the benefits you have received from attending Ohio State were worth the financial costs to you and your family?

#	Answer		Response	%
1	Strongly agree		67	43%
2	Somewhat agree		57	36%
8	Neither agree nor disagree (neutral)		22	14%
9	Somewhat disagree		7	4%
10	Strongly disagree		4	3%
	Total		157	100%

Statistic	Value
Min Value	1
Max Value	10
Mean	2.93
Variance	8.48
Standard Deviation	2.91
Total Responses	157

Part 3: Student Evaluation of Required Course: AMHBC

06/01/2015 - 04/01/2016

Aggregation Method: Course

Evaluation Program: General (Med 4)
Instance: LSI: Advanced Management in Hospital Based Care
Rotation: 6/1/2015-4/1/2016

Number of Evaluators: 164 ***Click to view evaluator listing for this course***

Total Responses: 164

Question #1 RATE THE OVERALL QUALITY OF THE COURSE, I.E. AMHBC AS A WHOLE.

	Count	Percent
Poor	0	0%
Fair	5	3%
Good	93	57%
Excellent	66	40%
Did Not Participate	0	0%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
3.37	2	4	164	0.54	0 to 4

Total Responses: 164

Question #2 THIS PART OF THE CURRICULUM WAS WELL ORGANIZED.

	Count	Percent
NA	0	0%
Strongly Disagree	0	0%
Disagree	1	1%
Disagree/Agree=Equally	14	9%
Agree	98	60%
Strongly Agree	51	31%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.21	2	5	164	0.61	0 to 5

LSI: Advanced Management in Hospital Based Care

Total Responses: 164

Question #3 THIS PART OF THE CURRICULUM WAS WELL INTEGRATED, I.E. CONSTITUENT PARTS WERE ORGANIZED IN SUCH A WAY AS TO FUNCTION AS AN INTERRELATED WHOLE.

	Count	Percent
NA	0	0%
Strongly Disagree	1	1%
Disagree	1	1%
Disagree/Agree=Equally	18	11%
Agree	96	59%
Strongly Agree	48	29%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.15	1	5	164	0.68	0 to 5

Total Responses: 164

Question #4 THE LEARNING OBJECTIVES WERE CLEAR.

	Count	Percent
NA	0	0%
Strongly Disagree	0	0%
Disagree	1	1%
Disagree/Agree=Equally	15	9%
Agree	97	59%
Strongly Agree	51	31%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.21	2	5	164	0.62	0 to 5

Total Responses: 164

Question #5 STUDENT PERFORMANCE WAS ASSESSED AGAINST THE LEARNING OBJECTIVES.

	Count	Percent
NA	0	0%
Strongly Disagree	0	0%
Disagree	1	1%
Disagree/Agree=Equally	13	8%
Agree	100	61%
Strongly Agree	50	30%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.21	2	5	164	0.60	0 to 5

Total Responses: 164

Question #6 THERE WERE SUFFICIENT CORRELATIONS WITH FOUNDATIONAL SCIENCES.

	Count	Percent
NA	0	0%
Strongly Disagree	0	0%
Disagree	3	2%
Disagree/Agree=Equally	10	6%
Agree	100	61%
Strongly Agree	51	31%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.21	2	5	164	0.63	0 to 5

Total Responses: 164

Question #7 SUFFICIENT TIME WAS ALLOTTED TO COVER THE ASSIGNED CONTENT OR OBJECTIVES.

	Count	Percent
NA	0	0%
Strongly Disagree	0	0%
Disagree	0	0%
Disagree/Agree=Equally	11	7%
Agree	96	59%
Strongly Agree	57	35%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.28	3	5	164	0.58	0 to 5

Total Responses: 164

Question #8 THE LEARNING ENVIRONMENTS PROMOTED PROFESSIONALISM.

	Count	Percent
NA	0	0%
Strongly Disagree	0	0%
Disagree	0	0%
Disagree/Agree=Equally	7	4%
Agree	72	44%
Strongly Agree	85	52%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.48	3	5	164	0.58	0 to 5

Total Responses: 164

Question #9 STUDENTS WERE TREATED WITH RESPECT.

	Count	Percent
NA	0	0%
Strongly Disagree	0	0%
Disagree	0	0%
Disagree/Agree=Equally	9	5%
Agree	70	43%
Strongly Agree	85	52%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.46	3	5	164	0.60	0 to 5

Total Responses: 164

Question #10 OVERALL, FACULTY AND STAFF WERE INTERESTED IN HELPING STUDENTS.

	Count	Percent
NA	0	0%
Strongly Disagree	0	0%
Disagree	0	0%
Disagree/Agree=Equally	10	6%
Agree	73	45%
Strongly Agree	81	49%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.43	3	5	164	0.61	0 to 5

Total Responses: 164

Question #11 I WAS OFFERED OPPORTUNITIES TO LEARN THE COST OF DIAGNOSTIC TESTS AND TREATMENT IN RELATIONSHIP TO THE BENEFITS PROVIDED TO PATIENTS.

	Count	Percent
NA	1	1%
Strongly Disagree	0	0%
Disagree	1	1%
Disagree/Agree=Equally	14	9%
Agree	83	51%
Strongly Agree	65	40%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.30	0	5	163	0.73	0 to 5

Total Responses: 164

Question #12 **FACULTY TEACHERS WERE ACCESSIBLE.**

	Count	Percent
NA	1	1%
Strongly Disagree	0	0%
Disagree	0	0%
Disagree/Agree=Equally	8	5%
Agree	83	51%
Strongly Agree	72	44%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.39	0	5	163	0.67	0 to 5

Total Responses: 164

Question #13 **FACULTY MEMBERS PROVIDED ME WITH SUFFICIENT FEEDBACK ON MY PERFORMANCE.**

	Count	Percent
NA	0	0%
Strongly Disagree	0	0%
Disagree	1	1%
Disagree/Agree=Equally	18	11%
Agree	87	53%
Strongly Agree	58	35%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.23	2	5	164	0.66	0 to 5

Total Responses: 164

Question #14 **RESIDENTS AND FELLOWS PROVIDED EFFECTIVE TEACHING DURING THE COURSE.**

	Count	Percent
NA	1	1%
Strongly Disagree	0	0%
Disagree	2	1%
Disagree/Agree=Equally	6	4%
Agree	75	46%
Strongly Agree	80	49%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.43	0	5	163	0.71	0 to 5

Total Responses: 164

Question #15 AVERAGED OVER FOUR WEEKS, DID YOU HAVE ONE DAY IN SEVEN FREE FROM CLINICAL RESPONSIBILITIES?

	Count	Percent
Yes	164	100%
No	0	0%

Total Responses: 164

Question #16 AT ANY TIME, DID YOU SPEND MORE THAN 80 HOURS IN A WEEK ENGAGED IN REQUIRED CLERKSHIP ACTIVITIES? (REQUIRED ACTIVITIES INCLUDE PATIENT CARE, IN-HOUSE CALL ACTIVITIES, AND SCHEDULED ACADEMIC ACTIVITIES BUT DOES NOT INCLUDE ANY SELF-STUDY OR OUTSIDE PREPARATION).

	Count	Percent
Yes	2	1%
No	162	99%

Total Responses: 55

Question #17 **IF YOU ANSWERED YES, PLEASE STATE THE CLINICAL ASSIGNMENT ASSOCIATED WITH MORE THAN 80 HOURS.**

1. N/A
2. N/A
3. n/a
4. N/A
5. N/A
6. N/A
7. n/a
8. N/A
9. Not applicable
10. not applic
11. n/a
12. N/A
13. N/a
14. N/A
15. N/A
16. N/A
17. n/a
18. none
19. n/a
20. N/A
21. N/A
22. N/a
23. N/A
24. n/a
25. N/A
26. n/a
27. did not say yes
28. N/A
29. None
30. n/a
31. n/a
32. N/A
33. n/a
34. N/A
35. n/a
36. N/A
37. n/a
38. N/A
39. n.a
40. N/A

Total Responses: 55

Question #17 IF YOU ANSWERED YES, PLEASE STATE THE CLINICAL ASSIGNMENT ASSOCIATED WITH MORE THAN 80 HOURS.

41. n/a
42. N/A
43. n/a
44. n/a
45. n/a
46. N/A
47. N/A
48. n/a
49. n/a
50. n/a
51. N/A
52. n/a
53. N/A
54. N/A
55. N/a

Total Responses: 164

Question #18 AVERAGED OVER A 4-WEEK PERIOD, HOW MANY HOURS PER WEEK WERE SPENT ENGAGED IN REQUIRED CLERKSHIP ACTIVITIES? (REQUIRED ACTIVITIES INCLUDE PATIENT CARE, IN-HOUSE CALL ACTIVITIES, AND SCHEDULED ACADEMIC ACTIVITIES BUT DOES NOT INCLUDE ANY SELF-STUDY OR OUTSIDE PREPARATION).

	Count	Percent
< 35 hours/week	14	9%
36-50 hours/week	60	37%
51-65 hours/week	62	38%
66-80 hours/week	28	17%
81-95 hours/week	0	0%
> 95 hours/week	0	0%

Total Responses: 164

Question #19 DID YOU FEEL SUPERVISION OF YOU AS A STUDENT IN THIS COURSE/CLERKSHIP WAS SUFFICIENT TO PROMOTE A SAFE ENVIRONMENT FOR YOU AND FOR YOUR PATIENTS?

	Count	Percent
Yes	164	100%
No	0	0%

Total Responses: 107

Question #20 IF YOU FELT SUPERVISION OF YOU AS A STUDENT IN THIS COURSE/CLERKSHIP WAS INSUFFICIENT TO PROMOTE A SAFE ENVIRONMENT FOR YOU AND FOR YOUR PATIENTS, PLEASE EXPLAIN WHY THIS WAS.

1. N/A
2. N/A
3. n/a
4. N/A
5. n/a
6. n/a
7. n/a
8. N/A
9. N/A
10. n/a
11. n/a
12. N/A
13. N/A
14. n/a
15. N/A
16. N/A
17. Not applicable
18. N/a
19. not applic.
20. n/a
21. n/a
22. N/A
23. n/a
24. N/A
25. N/A
26. n/a
27. N/A
28. n/a
29. N/A
30. N/a
31. n/a
32. n/a
33. N/A
34. n/a
35. n/a
36. none
37. n/a
38. N/A
39. N/A

Total Responses: 107

Question #20 IF YOU FELT SUPERVISION OF YOU AS A STUDENT IN THIS COURSE/CLERKSHIP WAS INSUFFICIENT TO PROMOTE A SAFE ENVIRONMENT FOR YOU AND FOR YOUR PATIENTS, PLEASE EXPLAIN WHY THIS WAS.

40. n/a
41. N/a
42. N/A
43. n/a
44. N/A
45. N/a
46. n\a
47. n/a
48. N/A
49. Did not feel supervision was insufficient
50. N/A
51. None
52. n/a
53. n/a
54. N/A
55. n/a
56. n/a
57. N/A
58. n/a
59. N/A
60. n/a
61. n/a
62. N/A
63. n/a
64. n/a
65. N/A
66. n/a
67. n/a
68. N/A
69. N/A
70. It was sufficient
71. n/a
72. n/a
73. n/a
74. N/A
75. n/a
76. Nothing comes to mind.
77. N/A
78. N/A

Total Responses: 107

Question #20 IF YOU FELT SUPERVISION OF YOU AS A STUDENT IN THIS COURSE/CLERKSHIP WAS INSUFFICIENT TO PROMOTE A SAFE ENVIRONMENT FOR YOU AND FOR YOUR PATIENTS, PLEASE EXPLAIN WHY THIS WAS.

79. N/A
80. n/a
81. N/A
82. N/A
83. n/a
84. n/a
85. N/A
86. n/a
87. n/a
88. n/a
89. I answered yes.
90. n/a
91. N/a
92. not applicable
93. N/A
94. n/a
95. n/a
96. N/A
97. n/a
98. n/a
99. n/a
100. N/A
101. n/a
102. N/A
103. n/a
104. N/A
105. N/A
106. n/a
107. N/a

Total Responses: 164

Question #21 DIDACTIC COMPONENT DURING EMERGENCY MEDICINE COMPONENT AS A WHOLE (EMODULES, READINGS, LECTURES, AND CLASSROOM ACTIVITIES)

	Count	Percent
Poor	3	2%
Fair	26	16%
Good	96	59%
Excellent	38	23%
Did Not Participate	1	1%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
3.04	0	4	163	0.72	0 to 4

Total Responses: 164

Question #22 SIMULATION ACTIVITIES (EPA-10)

	Count	Percent
Poor	0	0%
Fair	15	9%
Good	60	37%
Excellent	86	52%
Did Not Participate	3	2%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
3.44	0	4	161	0.80	0 to 4

Total Responses: 164

Question #23 CLINICAL SIMULATION (OSCE) ACTIVITIES DURING MINI-INTERNSHIP

	Count	Percent
Poor	2	1%
Fair	28	17%
Good	91	55%
Excellent	42	26%
Did Not Participate	1	1%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
3.06	0	4	163	0.73	0 to 4

Total Responses: 164

Question #24 DIRECT OBSERVATION AND FEEDBACK SESSIONS (DURING EMERGENCY MEDICINE COMPONENT)

	Count	Percent
Poor	4	2%
Fair	28	17%
Good	81	49%
Excellent	50	30%
Did Not Participate	1	1%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
3.09	0	4	163	0.79	0 to 4

Total Responses: 164

Question #25 EMERGENCY MEDICINE CLINICAL ASSIGNMENT

	Count	Percent
Poor	2	1%
Fair	13	8%
Good	75	46%
Excellent	73	45%
Did Not Participate	1	1%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
3.34	0	4	163	0.72	0 to 4

Total Responses: 164

Question #26 INTERDISCIPLINARY MINI-INTERNSHIP CLINICAL ASSIGNMENT

	Count	Percent
Poor	0	0%
Fair	14	9%
Good	58	35%
Excellent	89	54%
Did Not Participate	3	2%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
3.47	0	4	161	0.79	0 to 4

Total Responses: 147

Question #27 **WHAT DID THIS COURSE DO THAT HELPED YOU LEARN EFFECTIVELY? PLEASE IDENTITY 1-2 SPECIFIC CURRICULAR FEATURES OR TEACHING BEHAVIORS.**

1. I really enjoyed the hands-on sessions with feedback during the EM rotation
2. The EM simulation was great, as was the medic ride along. On MICU, I learned a ton and thought I had an appropriate patient load and responsibilities. Lots of opportunities for procedures on both. All the residents I worked with were fantastic. Cost conscious care assignment was useful and not too time consuming -- learned a lot from this.
3. N/A
4. how to talk to patients in setting of poor prognosis
5. It was best being encouraged to be more active while in clinical rotations and act as an intern. The attendings and residents were good at this and teaching relevant points. The EM simulation day was good, but it would have been nice to know we were being graded ahead of time.
6. Well organized, appreciated simplified list of requirements to keep track of things
7. I appreciated the heavy emphasis on clinical experiences throughout the rotation. Those didactics that we did have I found very helpful, particularly the airway and other procedural workshops.
8. The simulation was helpful in the EM rotation.
9. EM was very organized and I appreciated how far in advance we got our schedules. The MICU was a great place for a mini-I.
10. Integrating the two was helpful, especially if the courses are taken close together in time. I felt that the extra reading and modules were generally of high quality and worth the time spent on them.
11. Most important time was that spent working with the team, seeing what residents do and seeing yourself in their shoes. On EM the expert educator rounds were really good.
12. N/A
13. The simulation activities in both the mini-I and emergency medicine rotations were both very helpful
14. The OSCE during the Mini-Internship was by far the best OSCE we have ever had, the realistic situations and the immediate feedback was extremely helpful. In my opinion, many of the OSCEs in third year should ideally be changed to have a similar format. Fewer stations with some immediate feedback from doctors was more beneficial than all the other OSCEs put together.
15. I thought the requirements of each course were clearly stated. I also appreciate the flexibility that we were offered.
16. It really focused on the practical skills that are important for internship but often get missed when you are in the role of the "Third Year Student". Things like obtaining informed consent, taking a nursing phone call, interpreting data to make quick management decisions. I discovered many gaps in my abilities that I could then work on during the course of the rotation. I also really appreciated that in EM we did not have to do an in-person mid-rotation meeting back at OSU unless we wanted to. I would have driven all over to discuss very little, so that was good.
17. Really enjoyed the osce and em simulation exercise.
18. Good clinical experiences The case conference was a good way to integrate the EM and sub-I components
19. Excellent e-modules. Clinical experience was invaluable. Simulation at the end of the EM rotation was very useful, particularly because of the feedback portion -- this helped pinpoint what went well and what needed improvement.
20. Overall well organized course.
21. Good teams on both of my rotations, great teaching, supportive environment.
22. Lots of time on services, getting hands on experience
23. For EM: enjoyed simulation activities and Expert Educator session For mini-I: residents and faculty very invested in teaching
24. During my sub-I The residence and attending's or fantastic in regards to both didactic and bedside education. The same could be said for my experience in the emergency room. I truly believe that the staff during this block largely determined the quality of the experience.
25. I enjoyed the well structured and organization of the two rotations. I feel like I learned a lot of information and am well prepared to transition into intern year.

Total Responses: 147

Question #27 **WHAT DID THIS COURSE DO THAT HELPED YOU LEARN EFFECTIVELY? PLEASE IDENTITY 1-2 SPECIFIC CURRICULAR FEATURES OR TEACHING BEHAVIORS.**

26. Clinical rotations, EM simulation session
27. I learned more on my sub I and EM rotation than any other rotation thanks to the great residents faculty and staff
28. Great teaching
29. liked that we didn't have to repeat overlapping material between EM and the mini-I
30. EPA-10 was great. emodules were useful too. overall OSU was a great site for EM. OSU East was a great site for mini-I.
31. I felt the simulations were well timed and very well run.
32. very good experience
33. I became accustomed to intern schedule and learned how to handle greater responsibility
34. This course exposed me to great faculty in clinical environments. Faculty were uniformly very approachable and willing to teach. I felt that I was given sufficient autonomy on this rotation and was made a productive team member rather than just an observer.
35. Case conference was informative and fun and different way to learn
36. Good feedback was received from residents and attendings during both AMHBC rotations
37. Learning from every patient
38. Greatly enjoyed the simulation experience.
39. The emergency medicine simulation and debriefing was excellent. The case conference was also a great way to review interesting cases.
40. Autonomy in managing my own patients
41. Provided excellent clinical experience with good continuity. Required curricular activities were very helpful. In particular the simulation session during the emergency medicine rotation.
42. I loved the mini-internship aspect of this course; I was able to function as an intern and the people that I worked with was very receptive to having me as a member of the team.
43. I enjoyed the simulation day. Also the case conference was a great opportunity for students to present and discuss cases.
44. I enjoyed having an option for my mini-I that was relevant to the field I will be going into next year. I also enjoyed working in a community based setting during my emergency medicine rotation and felt like I got to see a lot and do a lot.
45. The simulation and expert educator shifts were great
46. Sim sessions
47. Helped me to learn to work independently in the context of a team.
48. Variety of problems Ability to act as intern
49. I had the opportunity to see a variety of patient presentations. Additionally, I was permitted to evaluate and present to the resident or attending before hearing their thoughts on the case which allowed me to identify weak points in my knowledge and evaluation.
50. Prepared me to be an intern next year.
51. good exposure to tasks and topics that will be expected of us next year.
52. Good format to allow students to stretch and grow their skills.
53. n/a
54. I thought all the attendings and residents did a great job of teaching during the rotations.
55. Good cases and complexity to teach medical problem solving.
56. Great opportunities to take responsibility for patient care and take the next steps toward becoming an intern.
57. Simulation lab was great. Clinical time helped

Total Responses: 147

Question #27 WHAT DID THIS COURSE DO THAT HELPED YOU LEARN EFFECTIVELY? PLEASE IDENTITY 1-2 SPECIFIC CURRICULAR FEATURES OR TEACHING BEHAVIORS.

58. Didactic sessions were largely unobtrusive to clinical assignments allowing for significant clinical experience
59. Learned a lot during both rotations thought this was very valuable.
60. Being involved in patient care at a more advanced level.
61. simulation session was helpful, allowed for direct feedback. The OSCE portion of the mini-I was also very beneficial to my learning and I feel directly reflected situations I would encounter as an intern
62. Provided a broad look at hospital based care. Provided a variety of learning resources and modalities.
63. The course gave me a greater understanding of hospital medicine and the transitions that occur throughout it. The didactics and additional topics outside of the rotation hours were helpful as well.
64. excellent organization
65. I loved the simulations that were part of the EM block. It was a great opportunity to put yourself to the test and find out what you would do when a patient was decompensating in front of you. I wish the simulations would get incorporated into more blocks throughout third and fourth year because they are the most efficient way to consolidate medical knowledge and identify gaps in your knowledge that you didn't even realize you didn't know
66. I enjoyed the minimal number of didactic opportunities which allowed for more clinical time. Also, I thought the simulation exercise was valuable and good to practice before we are interns next year.
67. Engaging instructors Good clinical experience
68. i had excellent clinical instructors
69. The Mini-Internship allowed me to greatly improve my communication skills with patients by encouraging students to deliver tough news and acquire consent. Both parts also allowed me to focus on clinical responsibilities which is where I learned the most.
70. Independent management, cost conscious care, differentials, lots more!
71. Both the EM and IM rotations helped solidify my medical learning. The time on the wards was incredibly valuable.
72. I really appreciated the responsibility I was given on my sub-I to carry patients independently with the supervision of my senior resident.
73. Independence of taking care of patients
74. shelf at the end
75. I really learned a great deal during these two blocks and loved all of the direct patient care experiences. I also really enjoyed working as a part of the health care team.
76. There were good quality attendings that I worked with. The ED lectures were interesting, especially with Dr. Kaide.
77. Focused on ppx abx and vent usage + proper presentation of complicated patients
78. I learned a great deal on my clinical assignments. The physicians I worked with were very accessible and eager to teach. I found the classroom activities and simulations to be helpful as well.
79. Strength of clinical assigment
80. 1. Student autonomy balanced with accessible support and help when needed 2. Wide array of clinical diversity to ensure preparedness for next year
81. Learned how to efficiently take care of patients in high volume settings. Had opportunity to perform and develop many procedural skills.
82. Great preparation for the ICU rotations that will compose a lot of y residency
83. I definitely enjoyed the Mini-I more than EM. I think it depends on your team and how much they want/don't want you to do and how open they are to teaching. I got lucky and my team was very engaging. I was able to put in a central line for the first time, and that was a great experience! For emergency medicine, I liked getting the exposure to how the ED is run and what being in the specialty would be like. However, I always felt somewhat useless no matter how much I was trying to do, mostly because everyone (attendings and residents) were so busy, they had to do most things (instead of having me do them - it would take longer).
84. patient handoffs, EKG readings, simulations were all great

Total Responses: 147

Question #27 **WHAT DID THIS COURSE DO THAT HELPED YOU LEARN EFFECTIVELY? PLEASE IDENTITY 1-2 SPECIFIC CURRICULAR FEATURES OR TEACHING BEHAVIORS.**

85. Requiring IV placements was a great idea. I get the sense that many interns have not done this (at all). MyProgress ended up being a significant issue, however. The required handoff curriculum was very good, although I think it would be better if you would assign an earlier due date during the Sub-I, say, end of Week 1. The Carmen readings and quizzes on DKA, hyponatremia, etc., were also very good, but I din't feel like I had sufficient time to read the articles as I would have liked. I am not sure of a good solution to this but, again, I think the due date was too late. Requiring a bunch of things all be submitted on the same day (the last Friday of the rotation) almost ensures that we rush through those assignments.
86. Minimizing time away from clinical activities.
87. Great teaching by the attendings, especially at my clinical sites as well as the Direct Observation sessions.
88. I thought it was an excellent block. Not too much overlap and very well organized.
89. Overall organization helpful. Mini-I good experience, personal learning objectives. SICU attendings David Lindsey and David Stahl stellar faculty teaching.
90. I enjoyed the handoff curriculum in the mini-I portion, and I absolutely loved the site I was at for my mini-I (Mt. Carmel West). The faculty there are great, and working with the hospitalist group you get a ton of one on one attending interaction which is great for teaching.
91. -Well-orgainzed
92. -just being on the rotation was the most valuable, getting to round, put in orders, call consults, etc
93. 1. I enjoyed the independence that my residents and faculty gave me in really owning the patient. I would see the patient, come up with my differential and present my assessment and plan to the team without any prior input from them. 2. I really liked giving a mini-presentation to the team about an important topic we saw on one of our cases.
94. Good clinical
95. While on the EM service I learned how to place orders, admit and discharge patients. I also had more autonomy in managing my own patients. I think this was a great experience in preparation for internship.
96. Minimized distractions from clinical time.
97. Great team members who were always wiling to answer questions and teach Daily lectures at noon were very educational
98. Helped us develop a foundation in management of basic acute medical problems. Good background in giving quality signout, answering pages, etc. Have learned helpful skills for internship.
99. let me perform at a sub-i level. work independently.
100. Great way to end medical school.
101. I really liked all of the EM components, from the direct obs to the simulations, the workshops and the lectures...all were fantastic. I liked my site, OSU, because everyone was willing to teach, especially the residents.
102. Sub-I: I really enjoyed my clinical assignment. I had the opportunity to be very involved in patient care. The teaching by the house staff was excellent. My attending was approachable and set a great tone for the rest of the team. I learned a ton and came away from the month feeling more confident about my clinical skills. EM: I was given the opportunity to be proactive and involved in patient care. The residents were great teachers and happy to have medical students working with them. I learned a lot and came away from the month feeling that my skills had improved. I also expanded my knowledge base quickly due to the variety of conditions and patients that I saw.
103. The course and the osces
104. simulations were good
105. Simulation
106. Allowed me to practice procedures under supervision (GI endoscopy at Mini-I, suturing and IV placement in the ED).
107. The simulation session was extremely helpful. It would be great to spend more time there on an ungraded basis, just to run through common trauma scenarios and ICU scenarios.
108. I had a great experience during my sub-I, and having EM in the spring allowed my to refresh my clinical knowledge. I thought the amount of didactic learning was appropriate.

Total Responses: 147

Question #27 **WHAT DID THIS COURSE DO THAT HELPED YOU LEARN EFFECTIVELY? PLEASE IDENTITY 1-2 SPECIFIC CURRICULAR FEATURES OR TEACHING BEHAVIORS.**

109. I thought the EM Expert Educator shifts were very useful, as there is not always time for in depth discussion about differentials during a normal EM shift.
110. Lectures were helpful. Simulation on EM was excellent.
111. Nothing comes to mind.
112. SICU promoted learning to care for complex patients. EM promoted efficient triage and initial workup/Tx.
113. Great Course
114. The course was designed with the recognition that the clinical experience we get on rotation is the most valuable source of education, and respected that. I appreciated that non-clinical requirements were kept to a minimum and did not interfere with service time.
115. N/A
116. I thought the clinical services were great, and the residents/attendings were great teachers. The course was very organized and the requirements were laid out clearly at the beginning of the rotation.
117. The most helpful aspects of the curriculum were simulations, workshops, articulate modules, and some aspects of the clinical sites such as opportunities to obtain H&Ps, document, and pend orders. In addition, discussing DDx with attendings is a an excellent opportunity that AMBHC-EM provided.
118. Both clinical experiences were extremely helpful in my training. Fantastic faculty and residents.
119. The expert educator session was excellent. I learned a lot of information that was both practical and high yield for the exam.
120. Great faculty and settings to work in.
121. Workshop sessions were useful for developing procedural skills.
122. I enjoyed the case conferences. The hospital peds and complex care attendings are also fabulous teachers and really encourage the sub-I to own their patients.
123. great attendings
124. This course helped to prepare me for intern level rotations. I felt capable of managing several patients at a time. I learned how to manage critically ill patients, as well as those presenting with unique chief complaints.
125. Working with the resident and attending clinicians.
126. Very well organized.
127. The modules were helpful and I appreciated being able to do them on my own time.
128. Simulation, direct observation
129. Clinical observations were well organized and scheduled at a time that I can attend. The evaluators were all knowledgeable and had great feedback.
130. Combining the inpatient and EM aspects of medicine fit well and they are complementary. The simulations and readings were high yield for actual clinical practice.
131. The simulation was the best part of this course. The learning articulates were good for this course
132. Increased autonomy while on both rotations allowed me to truly take ownership of my patients. In the same vein, I felt that the attendings with whom I'd worked treated me as a resident (i.e., strongly considered my plans, demanded a less thorough presentation on the assumption that I covered the required components and would report the pertinent information) and not just a medical student.
133. Had a large degree of autonomy that prepared me for intern year
134. Great teachers in general, great guidance on internship pearls
135. The modules provided a good review of important clinical topics.
136. Good exposure to broad topics.
137. Emodules & Simulations during EM block were great. Mini-I didactics & modules were helpful also.
138. - plenty of patient care time to help prepare me for intern year -residents interested in teaching -attendings saw me as

Total Responses: 147

Question #27 WHAT DID THIS COURSE DO THAT HELPED YOU LEARN EFFECTIVELY? PLEASE IDENTITY 1-2 SPECIFIC CURRICULAR FEATURES OR TEACHING BEHAVIORS.

an important part of the team

139. The focus on developing a good differential diagnosis in EM, and the focus on staying in clinic as much as possible for the Sub-I
140. Simulation in EM very helpful
141. simulations on emergency medicine were really helpful
142. I wish we did simulations like the ones we did in this course for all of Med school. Great course.
143. 1) The simulation sessions were useful
144. I was able to do more than just write progress notes and hospital courses. I learned how to enter orders, admit patients and staff them with the hospital service, give patient hand-off at sign out, and discharge patients. These experiences were very appreciated as I need to develop these skills for internship.
145. Simulation sessions were helpful. Expert Educator Shift was great - very informative, pertinent.
146. EM simulation was great, hands on experience in ED was good.
147. Covered the basics needed for internship Loved EM sim session

Total Responses: 144

Question #28 **HOW MIGHT THIS COURSE IMPROVE? PLEASE IDENTIFY 1-2 SPECIFIC WAYS.**

1. My main feedback is that the hands-on sessions for EM should have been at the beginning of the rotation. I know personally for me that would have helped me to build confidence and use those skills more often during the rotation. Also, some of the preceptors where I did EM were enthusiastic instructors and some basically tolerated my presence and seemed uninterested in teaching (Memorial in Marysville). The PA's and nurses there were all OUTSTANDING, might be worth letting future student rotators know that working directly with the PA's/nurses is a great option if the attending basically ignores you. The nurses do a LOT of triage/assessment work there and 90% of the time put in all the orders before the patient is even seen by the attending.
2. We didn't learn about the IV requirement until the very end of the first rotation (mine was EM, so that made things harder). The case conference was a good idea but somewhat poorly executed -- I think the attendings could abstain from talking over the presenting students as much in the future, this will help everyone take it more seriously.
3. N/A
4. none
5. It was difficult to contact the Madison County EM coordinator to make a concrete schedule earlier. It also would have been better to have one night once a week during the Sub-I instead of a full week of nights (lose continuity with the team and patients and the nights are much slower). It would be better to spend a full 24 hours once a week in the hospital then leave after rounds for the rest of the day off then return to regular days. This is how nights worked in surgery and Labor and Delivery and it worked out much better.
6. More clarification of which requirements were for AMHBC as a whole versus each individual component (example - IVs and nasal cannula placement)
7. I did not feel that the administrative side of the rotation was very well organized. Due dates were often unclear, and requests for clarification were often answered defensively and sometimes unhelpfully. I think having a personalized calendar for each student would be very helpful, in large part by removing any ambiguity over when the hand off curriculum and other peripheral assignments are due.
8. Would have been more helpful to do the simulation at the beginning of the rotation instead of the end.
9. More information about what the EM simulation actually entails would be really helpful. Better organization of the Mini-I by staff would be helpful.
10. No specific suggestions come to mind.
11. As with everything organization is key and that extends to the 5 different web sites we have to work with to log things, do e-modules on, fill out evaluations on etc.
12. N/A
13. The emergency medicine rotation where I was (OSU) was extremely hit and miss as far as teaching by attending physicians. Some encouragement for them to at least teach one thing each shift, even if it is not something that was seen during the shift, would be helpful. There were some attendings that had me staff with the residents and basically did not say a word to me the entire shift.
14. I'm not sure how beneficial it is to have these two courses combined as one overall block. I think EM and Sub-Is could be totally separate and the learning experience would be the same. It just seems like a lot of extra work for the staff that doesn't really affect the students in any way.
15. My Progress. If myprogress must remain, then the focus needs to be on making it as smoothly integrated and minimally obtrusive as possible.
16. more sub-i options
17. The FOSCE seemed like an unnecessary session that took us out of the clinical setting
18. I was taught some of the EM procedures by PAs (abscess I&D, suturing) since I rotated at a rural site, and while this was usually quite good, there was one instance that I can identify in which I was told to do a suture incorrectly. I realized this after I did some self-study on suturing, so I will never forget this now, but I think it would be better if we did the procedural training (venipuncture, suturing) earlier in the rotation so that we would have the knowledge on the wards.
19. Had a horrible experience getting myprogress to work on ED rotation. Really felt like I did not get very good feedback on this rotation because there was so much frustration getting myprogress to work.

Total Responses: 144

Question #28 HOW MIGHT THIS COURSE IMPROVE? PLEASE IDENTIFY 1-2 SPECIFIC WAYS.

20. n/a
21. As a 4th year I felt that the didactics were very reptitive and the quizzes were not very benificial.
22. - It is sometimes difficult during busy EM shifts to ensure getting a "checklist" filled out, especially if traumas/emergency patients come within an hour of end of shift.
23. More flexibility in regards to the emergency medicine rotation schedule, and not sending out 72 surveys in regards to clinical assessment
24. Nothing at the moment
25. Move extra required assignments from sub I month to EM month where there is more schedule flexibility/free time
26. i cannot think of anything at tis time
27. fewer e-modules
28. finding a way to present directly to attendings instead of residents during emergency medicine. Sometimes it was a logistical nightmare to find a resident to present to, and then have to wait around with that resident until a attending was then ready to present. Some attendings would just let me present to them and give me great feedback, but others would not.
29. Deadlines could be better elucidated for some of the non-clinical requirements.
30. none
31. I felt that the formal didactics were the weak point. I felt that many of the emodules could use an overhaul (many were too long and filled with extraneous information).
32. Most common chief complaints modules were not effective teaching
33. More small group learning
34. None
35. N/A
36. There was no feedback provided for the OSCE in the mini-internship section of the course. Additionally, individual evaluations from EM preceptors were distributed midway but not at the end of the EM course. Receiving more feedback would have helped direct future learning and topics to work on.
37. More responsibility on MICu
38. Nothing needs improvement.
39. I completed my ED shifts at Nationwide Children's and I felt like this whole experience was very frustrating. We were told to find a physician to work with at the beginning of our shift; this turned out to be a not-so-easy task. While some physicians were very nice to work with, others seemed very annoyed that they got stuck with the medical student. There were also a few shifts where I was only able to pick up 2-3 patients because I spent most of my time being punted from attending to attending while trying to find someone to staff with. All of that being said, Dr. Naprawa, Dr. Dishong, and Dr. Lloyd were absolutely wonderful to work with. Actually scheduling the students with a specific physician for each shift (perhaps the ones listed or other physicians that actually volunteer to work with students) would help eliminate this feeling of being unwanted.
40. The simulation was a very valuable learning experience, maybe adding other day of this would be useful for the students.
41. I would have liked an OB/gyn sub-I since that is what I am going into, but I still thought my rotation was valuable.
42. clinical workshops at the beginning of the ring. I
43. EM - improve MyProgress situation, mini-i is fine as it is
44. There were a lot of small components with varying due dates that were difficult to keep track of when you were immersed in your clinical experience. I would recommend making everything to have the same due date.
45. Formal teaching time
46. Overall this was an excellent course. One possible improvement would be to reduce the duration of the e-modules for the emergency medicine component to have them function more as study aids rather than full length lectures.

Total Responses: 144

Question #28 HOW MIGHT THIS COURSE IMPROVE? PLEASE IDENTIFY 1-2 SPECIFIC WAYS.

47. EM eModules could be revised/re-developed. Difficult to be integrated/part of the team during EM shifts at OSU, due to the nature of work-rooms and limited availability of computers in the the work rooms.
48. n/a
49. The online modules as a whole were not integrated well into that we were learning at the time, they also took a really long time for both components.
50. n/a
51. Please place all workshops at the beginning of the block so we can use whatever skills we learn during the rotation.
52. NA, good experience.
53. The emodules for the EM portion were way too long and detailed for the purposes of this course/shelf.
54. Give more responsibility to students. Very difficult to act like a "sub-intern" when I can't put in orders, be the primary contact person for consults and when residents are too busy to assist or when it is easier for them to just do the orders/consults themselves.
55. Nothing in particular
56. N/A
57. The disconnect between the two rotations was odd. I felt they could be integrated well and supplement each other, however mine were spread out with 4-5 months in between which decreased the overall integration value.
58. None
59. Maybe less additional things to do during the sub-I month outside of work hours.
60. n/a
61. Minimizing the other required activities during the month as much as possible (with the exception of the simulations).
62. I have no suggestions for improvement. Thanks!
63. Fewer preceptors: everyone wanted something different
64. i did not get much out of the emt ride along. i thought some of the assignments for the sub i were excessive, especially for people on surgery who spent long hours and early mornings at the hospital. the quiz material was tested on the shelfs and step 2.
65. I would have like the EM skills lab to be earlier in the rotation to practice skills before performing them in the ED.
66. Always love more cistern conscious care practical advise
67. The whole AMHBC/AMRCC structure is incredibly confusing. It doesn't make sense to combine Emergency Medicine and Inpatient Medicine in one chunk, especially if the two rotations do not need to be done side-by-side. The OSCE was really confusing - there was no background or template on breaking bad news that we could follow, so it was a 'learning exercise' without feedback or learning. The evaluations in Emergency Medicine were cumbersome and incredibly awkward. Each time I asked for my attending to fill them out, they would say, "oh. I have to do another one? Can't you just fill it out? You did fine today." And then, they would fill it out but the app wouldn't let them submit it. It would be nice to have a working, streamlined application in place before it is thrown at the students for daily use.
68. N/A
69. More lectures less emodules
70. no more CPE
71. It would be nice to do longer shifts at OSU during EM.
72. There were a lot of requirements, and some felt like busy work that didn't benefit my education.
73. None
74. No additional advice.
75. Expert educator sessions were not helpful
76. Decrease number of required events that keep us from our clinical responsibilities
77. Having didactics/simulations done earlier on in the rotation so that it would be helpful/be a good refresher.

Total Responses: 144

Question #28 **HOW MIGHT THIS COURSE IMPROVE? PLEASE IDENTIFY 1-2 SPECIFIC WAYS.**

78. accessible outside resources to suppllement clinical experience.
79. Fewer random tasks to complete would be nice, but I know it's probably unrealistic to ask that... but if there were fewer things for me to worry about/remember, it would make it so much nicer to focus on medicine! (But I guess that's not the real world...)
80. The OSCE was not a valuable learning experience.
81. The required handoff curriculum (during Sub-I) was very good, although I think it would be better if you would assign an earlier due date during the Sub-I, say, the end of Week 1. The Carmen readings and quizzes on DKA, hyponatremia, etc., were also very good, but I din't feel like I had sufficient time to read the articles as I would have liked. I am not sure of a good solution to this but, again, I think the due date was too late. Requiring a bunch of things all be submitted on the same day (the last Friday of the rotation) almost ensures that we rush through those assignments.
82. None.
83. Slightly more organization, and accounting for variances at EM clinical sites.
84. Nothing at all.
85. Emergency medicine - try to keep shifts with a limited set of attendings for more continuity. Wexner ED was not a particularly helpful location to get much effective one-on-one teaching with attendings and residents - OSU East was better.
86. Sometimes it felt like there was a lot of busy work for the sake of busy work. For example, in EM, the quizzes being just for completion but being required before simulations wasn't necessary. It would be more useful to make them due before the final exam, as students have varying work schedules and with interviewing during that time as well I never had a day off to work on quizzes.
87. -Condense mandatory activities into minimal number of days to avoid frequently leaving clinic
88. there is a lot of "filler" outside work that really doesn't have much value: the hand off curriculum, for example. being on rotation and actually doing it is a lot more valuable.
89. Less reflections/busy work. I didn't think it was a good use of time to reflect on my professional/learning objectives three times within a 4 week period. I am not sure what was to be gained from that activity.
90. Way too much logging on the iPad, goal setting, etc
91. None. This was one of my favorite rotations of part 3.
92. Nothing.
93. none
94. Nothing comes to mind.
95. more options for the different subspecialities to rotate in.
96. none.
97. They really aren't integrated much at all, could do a better job with this.
98. Sub-I: My friends at other medical schools have said that as Sub-Is, the patients that they carry are covered by senior residents, but not interns as well. That way the Sub-I functions as the intern for the patients that they carry. I think that OSU should perhaps consider adopting this model too, if possible. EM: Some of the attendings were more invested in teaching than others. There was a bunch of extra work for this course (E-modules, quizzes, evaluations, etc), some of which was not as helpful as other aspects of the course. The aspects of the course most helpful for learning were: clinical experience in the ED, hands-on clinical sessions and simulation exercises, and studying for the shelf exam.
99. Explanation of student roles
100. none
101. Allowing students to review feedback about sites from previous students that have rotated there. Most of the Mini-I Amb sites are at private physician offices and we did not know what to expect. Moreover, the number of attendings and residents at the OSU ED makes it difficult for students to be directly involved in patient care. I would suggest that student feedback be available to those signing up for AMHBC sites in the future.

Total Responses: 144

Question #28 HOW MIGHT THIS COURSE IMPROVE? PLEASE IDENTIFY 1-2 SPECIFIC WAYS.

102. In ground school for EM, have a lecture on common OB/GYN emergencies and treatments.
103. Some of the smaller requirements did not contribute much to my learning.. the message board posting and the expert educator session during EM.
104. Possibly less busy work such as requiring completion of the e- modules and quizzes. While the e-modules were helpful, I would have liked the option of picking and choosing to do only the topics that I thought I was weak on.
105. More simulations. OSCE's are useless if we don't get any feedback.
106. Nothing comes to mind.
107. DO's are useless
108. None
109. Nothing comes to mind
110. N/A
111. The e-modules were helpful in increasing my medical/clinical knowledge. However, a few of the emodules, while informative, were a bit lengthy.
112. I found simulations to be very valuable. More of these would be an excellent addition to the curriculum.
113. AMHBC seems like an unusual forced pairing of EM and the sub-I, which are totally separate experiences outside of a single joint conference (which could be accomplished even if the two units weren't under the AMHBC umbrella). Regarding the simulation experience, I think it would be more helpful to have multiple experiences with the equipment prior to the final simulation.
114. I think the simulation was a good idea and educational but could have been better if we were given a clearer picture of what we were expected to do
115. Please schedule the simulations and workshops for EM early in the rotation - it would be more helpful then.
116. Move simulations/skills sessions to earlier in block
117. Workshop sessions should be implemented earlier in EM rotation.
118. I personally didn't find the Northwestern handoff curriculum effective.
119. Please fix the glitch in My Progress with forms the attendings had to fill out each shift. Despite telling them to click it twice, I had to repeatedly go back and re-submit their forms. I'm not sure why the old paper and pencil forms were abandoned...
120. Cannot think of anything at this time.
121. none
122. none
123. During the mini-internship there seemed to be a little bit too much extra work. I was at the hospital for 12+ hours everyday and it was kind of a lot to have modules, extra assignments, and the group presentation to do all in one month.
124. More specific feedback from faculties
125. This can be improved by having the IV/suturing and airway training done in the beginning of the month as it will be a great preparation for the EM rotation.
126. Shorter articulate modules that are more engaging. Does not have to be a ppt based presentation but can be more of a high yield talk on clinical pearls.
127. n/a
128. These two rotations, and the requisite components, were overall very fair and appropriate.
129. Didactic schedule during EM did not really correlate to the clinical experience. I saw no patients in shock, no ACLS experience, etc. If didactics are going to cover this, give us more of an opportunity to practice those skills, in simulation or otherwise.
130. I think the hour logging business is silly for EM, there has to be a better way to keep track of all of that.
131. improve grading rubric for EM evals. unrealistic standards for medical students which was communicated to me by

Total Responses: 144

Question #28 HOW MIGHT THIS COURSE IMPROVE? PLEASE IDENTIFY 1-2 SPECIFIC WAYS.

multiple residents and attendings when they were giving me feedback

132. I did not see any areas that need improving/modifying at this time.
133. n/a
134. Trying to normalize the quality of the experience across clinical sites. Seems like some students have great experiences and others less so.
135. in terms of didactics/lectures/simulations- there were multiple times where faculty were late/unprepared for lectures or simulations. I definitely understand that sometimes there are things in life that make us late/unprepared, and it happens to students as well. However, I have heard and experienced students getting reprimanded for being late or forgetting about something and although we are expected to be professional and respect everyone else's time , I do not feel like our time is always respected.
136. Fewer extra-clinical activities
137. More incorporation of simulation
138. i would have liked to have had a mini-I that was in my specialty of choice
139. Nothing.
140. 1) Having some of the simulations earlier in the course would be helpful to give us more preparation for what we might see in the ED
141. No suggestions at this time. AMHBC was a great opportunity to prepare for internship and residency.
142. In terms of the Nationwide ED, I would prefer to be assigned a specific attending.
143. Put ED simulations at beginning of block and perhaps repeat at end
144. I would add review of other procedures like chest tube, etc

Part 3: Student Evaluation of Required Course: AMRCC

06/01/2015 - 04/01/2016

Aggregation Method: Course

Evaluation Program: General (Med 4)
Instance: LSI: Advanced Management in Relationship Centered Care
Rotation: 6/1/2015-4/1/2016

Number of Evaluators: 181 ***Click to view evaluator listing for this course***

Total Responses: 181

Question #1 RATE THE OVERALL QUALITY OF THE COURSE, I.E. AMRCC AS A WHOLE.

	Count	Percent
Poor	5	3%
Fair	39	22%
Good	105	58%
Excellent	32	18%
Did Not Participate	0	0%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
2.91	1	4	181	0.70	0 to 4

Total Responses: 181

Question #2 THIS PART OF THE CURRICULUM WAS WELL ORGANIZED.

	Count	Percent
NA	1	1%
Strongly Disagree	1	1%
Disagree	11	6%
Disagree/Agree=Equally	35	19%
Agree	100	55%
Strongly Agree	33	18%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
3.85	0	5	180	0.85	0 to 5

Total Responses: 181

Question #3 THIS PART OF THE CURRICULUM WAS WELL INTEGRATED, I.E. CONSTITUENT PARTS WERE ORGANIZED IN SUCH A WAY AS TO FUNCTION AS AN INTERRELATED WHOLE.

	Count	Percent
NA	1	1%
Strongly Disagree	3	2%
Disagree	14	8%
Disagree/Agree=Equally	44	24%
Agree	88	49%
Strongly Agree	31	17%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
3.72	0	5	180	0.93	0 to 5

Total Responses: 181

Question #4 THE LEARNING OBJECTIVES WERE CLEAR.

	Count	Percent
NA	2	1%
Strongly Disagree	1	1%
Disagree	10	6%
Disagree/Agree=Equally	34	19%
Agree	102	56%
Strongly Agree	32	18%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
3.86	0	5	179	0.88	0 to 5

Total Responses: 181

Question #5 STUDENT PERFORMANCE WAS ASSESSED AGAINST THE LEARNING OBJECTIVES.

	Count	Percent
NA	3	2%
Strongly Disagree	3	2%
Disagree	11	6%
Disagree/Agree=Equally	37	20%
Agree	96	53%
Strongly Agree	31	17%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
3.79	0	5	178	0.98	0 to 5

Total Responses: 181

Question #6 THERE WERE SUFFICIENT ILLUSTRATIONS OF CLINICAL RELEVANCE.

	Count	Percent
NA	2	1%
Strongly Disagree	1	1%
Disagree	3	2%
Disagree/Agree=Equally	22	12%
Agree	97	54%
Strongly Agree	56	31%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.14	0	5	179	0.85	0 to 5

Total Responses: 181

Question #7 THERE WERE SUFFICIENT CORRELATIONS WITH FOUNDATIONAL SCIENCES.

	Count	Percent
NA	3	2%
Strongly Disagree	1	1%
Disagree	10	6%
Disagree/Agree=Equally	24	13%
Agree	112	62%
Strongly Agree	31	17%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
3.91	0	5	178	0.90	0 to 5

Total Responses: 181

Question #8 SUFFICIENT TIME WAS ALLOTTED TO COVER THE ASSIGNED CONTENT OR OBJECTIVES.

	Count	Percent
NA	1	1%
Strongly Disagree	0	0%
Disagree	2	1%
Disagree/Agree=Equally	15	8%
Agree	101	56%
Strongly Agree	62	34%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.24	0	5	180	0.72	0 to 5

Total Responses: 181

Question #9 THE LEARNING ENVIRONMENTS PROMOTED PROFESSIONALISM.

	Count	Percent
NA	2	1%
Strongly Disagree	1	1%
Disagree	3	2%
Disagree/Agree=Equally	12	7%
Agree	98	54%
Strongly Agree	65	36%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.25	0	5	179	0.82	0 to 5

Total Responses: 181

Question #10 STUDENTS WERE TREATED WITH RESPECT.

	Count	Percent
NA	1	1%
Strongly Disagree	2	1%
Disagree	7	4%
Disagree/Agree=Equally	16	9%
Agree	91	50%
Strongly Agree	64	35%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.16	0	5	180	0.88	0 to 5

Total Responses: 181

Question #11 OVERALL, FACULTY AND STAFF WERE INTERESTED IN HELPING STUDENTS.

	Count	Percent
NA	1	1%
Strongly Disagree	0	0%
Disagree	4	2%
Disagree/Agree=Equally	14	8%
Agree	97	54%
Strongly Agree	65	36%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.24	0	5	180	0.75	0 to 5

Total Responses: 181

Question #12 **I WAS OFFERED OPPORTUNITIES TO LEARN THE COST OF DIAGNOSTIC TESTS AND TREATMENT IN RELATIONSHIP TO THE BENEFITS PROVIDED TO PATIENTS.**

	Count	Percent
NA	2	1%
Strongly Disagree	1	1%
Disagree	5	3%
Disagree/Agree=Equally	24	13%
Agree	99	55%
Strongly Agree	50	28%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.07	0	5	179	0.86	0 to 5

Total Responses: 181

Question #13 **FACULTY TEACHERS WERE ACCESSIBLE.**

	Count	Percent
NA	2	1%
Strongly Disagree	1	1%
Disagree	0	0%
Disagree/Agree=Equally	12	7%
Agree	113	62%
Strongly Agree	53	29%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.21	0	5	179	0.75	0 to 5

Total Responses: 181

Question #14 **FACULTY MEMBERS PROVIDED ME WITH SUFFICIENT FEEDBACK ON MY PERFORMANCE.**

	Count	Percent
NA	1	1%
Strongly Disagree	0	0%
Disagree	5	3%
Disagree/Agree=Equally	18	10%
Agree	105	58%
Strongly Agree	52	29%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.13	0	5	180	0.76	0 to 5

Total Responses: 181

Question #15 RESIDENTS AND FELLOWS PROVIDED EFFECTIVE TEACHING DURING THE COURSE.

	Count	Percent
NA	42	23%
Strongly Disagree	0	0%
Disagree	3	2%
Disagree/Agree=Equally	10	6%
Agree	71	39%
Strongly Agree	55	30%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
4.28	0	5	139	1.91	0 to 5

Total Responses: 181

Question #16 AVERAGED OVER FOUR WEEKS, DID YOU HAVE ONE DAY IN SEVEN FREE FROM CLINICAL RESPONSIBILITIES?

	Count	Percent
Yes	180	99%
No	1	1%

Total Responses: 181

Question #17 AT ANY TIME, DID YOU SPEND MORE THAN 80 HOURS IN A WEEK ENGAGED IN REQUIRED CLERKSHIP ACTIVITIES? (REQUIRED ACTIVITIES INCLUDE PATIENT CARE, IN-HOUSE CALL ACTIVITIES, AND SCHEDULED ACADEMIC ACTIVITIES BUT DOES NOT INCLUDE ANY SELF-STUDY OR OUTSIDE PREPARATION).

	Count	Percent
Yes	0	0%
No	181	100%

Total Responses: 49

Question #18 **IF YOU ANSWERED YES, PLEASE STATE THE CLINICAL ASSIGNMENT ASSOCIATED WITH MORE THAN 80 HOURS.**

1. n/a
2. n/a
3. N/A
4. n/a
5. N/A
6. n/a
7. N/A
8. n/a
9. Did not say No
10. N/A
11. N/A
12. n/a
13. n/a
14. n/a
15. yes
16. N/A
17. N/A
18. N/A
19. n/a
20. n/a
21. n/a
22. N/A
23. n/a
24. N/A
25. N/A
26. N/a
27. n/a
28. N/A
29. N/A
30. n/a
31. n/a
32. N/A
33. n/a
34. n/a
35. N/A
36. N/A
37. N/A
38. N/A
39. None
40. N/A

Total Responses: 49

Question #18 IF YOU ANSWERED YES, PLEASE STATE THE CLINICAL ASSIGNMENT ASSOCIATED WITH MORE THAN 80 HOURS.

41. N/A
42. N/A
43. N/A
44. N/a
45. N/A
46. N/A
47. n/a
48. n/a
49. n/a

Total Responses: 181

Question #19 AVERAGED OVER A 4-WEEK PERIOD, HOW MANY HOURS PER WEEK WERE SPENT ENGAGED IN REQUIRED CLERKSHIP ACTIVITIES? (REQUIRED ACTIVITIES INCLUDE PATIENT CARE, IN-HOUSE CALL ACTIVITIES, AND SCHEDULED ACADEMIC ACTIVITIES BUT DOES NOT INCLUDE ANY SELF-STUDY OR OUTSIDE PREPARATION).

	Count	Percent
< 35 hours/week	140	77%
36-50 hours/week	32	18%
51-65 hours/week	2	1%
66-80 hours/week	6	3%
81-95 hours/week	1	1%
> 95 hours/week	0	0%

Total Responses: 181

Question #20 DID YOU FEEL SUPERVISION OF YOU AS A STUDENT IN THIS COURSE/CLERKSHIP WAS SUFFICIENT TO PROMOTE A SAFE ENVIRONMENT FOR YOU AND FOR YOUR PATIENTS?

	Count	Percent
Yes	181	100%
No	0	0%

Total Responses: 115

Question #21 IF YOU FELT SUPERVISION OF YOU AS A STUDENT IN THIS COURSE/CLERKSHIP WAS INSUFFICIENT TO PROMOTE A SAFE ENVIRONMENT FOR YOU AND FOR YOUR PATIENTS, PLEASE EXPLAIN WHY THIS WAS.

1. N/A
2. N/a
3. n/a
4. n/a
5. n/a
6. n/a
7. N/A
8. n/a
9. n/a
10. N/A
11. N/A
12. N/A
13. n/a
14. Does not apply
15. n/a
16. N/A
17. Was not insufficient
18. N/A
19. N/A
20. N/A
21. N/A
22. N/a
23. n/a
24. N/a
25. n/a
26. N/a
27. N/A
28. n/a
29. n/a
30. n/a
31. n/a
32. N/A
33. n/a
34. n/a
35. N/A
36. N/A
37. n/a
38. N/A
39. n/a

Total Responses: 115

Question #21 IF YOU FELT SUPERVISION OF YOU AS A STUDENT IN THIS COURSE/CLERKSHIP WAS INSUFFICIENT TO PROMOTE A SAFE ENVIRONMENT FOR YOU AND FOR YOUR PATIENTS, PLEASE EXPLAIN WHY THIS WAS.

40. N/a
41. Nothing comes to mind.
42. N/A
43. n/a
44. n/a
45. n/a
46. n/a
47. n/a
48. N/A
49. n/a
50. n/a
51. N/a
52. n/a
53. n/a
54. n/a
55. n/a
56. N/a
57. none
58. n/a
59. N/A
60. N/A
61. N/a
62. n/a
63. n/a
64. N/A
65. n/a
66. n/a
67. n/a
68. N/A
69. N/A
70. I felt it was sufficient.
71. N/A
72. n/a
73. n/a
74. N/A
75. n/a
76. n/a
77. n/a
78. N/A

Total Responses: 115

Question #21 IF YOU FELT SUPERVISION OF YOU AS A STUDENT IN THIS COURSE/CLERKSHIP WAS INSUFFICIENT TO PROMOTE A SAFE ENVIRONMENT FOR YOU AND FOR YOUR PATIENTS, PLEASE EXPLAIN WHY THIS WAS.

79. n/a
80. N/A
81. n/a
82. N/A
83. N/A
84. n/a
85. N/A
86. n/a
87. N/A
88. N/A
89. n/a
90. None
91. n/a
92. N/A
93. N/A
94. N/A
95. N/A
96. n/a
97. N/a
98. N/a
99. N/A
100. N/A
101. N/A
102. N/A
103. N/A
104. n/a
105. N/a
106. n/a
107. n/a
108. N/A
109. N/A
110. n/a
111. n/a
112. n/a
113. n/a
114. It was sufficient.
115. No.

Total Responses: 181

Question #22 DIDACTIC COMPONENT AS A WHOLE (EMODULES, READINGS, LECTURES, AND CLASSROOM ACTIVITIES)

	Count	Percent
Poor	10	6%
Fair	69	38%
Good	80	44%
Excellent	20	11%
Did Not Participate	2	1%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
2.61	0	4	179	0.80	0 to 4

Total Responses: 181

Question #23 GROUND SCHOOL (INITIAL ORIENTATION AND DIDACTICS)

	Count	Percent
Poor	15	8%
Fair	76	42%
Good	74	41%
Excellent	16	9%
Did Not Participate	0	0%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
2.50	1	4	181	0.77	0 to 4

Total Responses: 181

Question #24 TEAM BASED LEARNING (TBL) EXERCISES

	Count	Percent
Poor	19	10%
Fair	62	34%
Good	73	40%
Excellent	27	15%
Did Not Participate	0	0%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
2.60	1	4	181	0.87	0 to 4

Total Responses: 181

Question #25 CRITICAL APPRAISAL OF A TOPIC ASSIGNMENT

	Count	Percent
Poor	22	12%
Fair	60	33%
Good	77	43%
Excellent	22	12%
Did Not Participate	0	0%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
2.55	1	4	181	0.86	0 to 4

Total Responses: 181

Question #26 HOME HEALTH VISIT

	Count	Percent
Poor	38	21%
Fair	39	22%
Good	67	37%
Excellent	37	20%
Did Not Participate	0	0%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
2.57	1	4	181	1.04	0 to 4

Total Responses: 181

Question #27 REFLECTION ASSIGNMENT RELATED TO HOME HEALTH CARE

	Count	Percent
Poor	34	19%
Fair	65	36%
Good	66	36%
Excellent	16	9%
Did Not Participate	0	0%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
2.35	1	4	181	0.88	0 to 4

Total Responses: 181

Question #28 DIRECT OBSERVATION AND FEEDBACK SESSIONS

	Count	Percent
Poor	14	8%
Fair	54	30%
Good	89	49%
Excellent	24	13%
Did Not Participate	0	0%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
2.68	1	4	181	0.80	0 to 4

Total Responses: 181

Question #29 AMBULATORY CLINICAL ASSIGNMENT

	Count	Percent
Poor	1	1%
Fair	24	13%
Good	70	39%
Excellent	85	47%
Did Not Participate	1	1%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
3.33	0	4	180	0.76	0 to 4

Total Responses: 181

Question #30 INTERDISCIPLINARY CHRONIC CARE CLINICAL ASSIGNMENT

	Count	Percent
Poor	7	4%
Fair	18	10%
Good	73	40%
Excellent	83	46%
Did Not Participate	0	0%

Average	Minimum	Maximum	Non-Zero Responses	Std Dev	Scale
3.28	1	4	181	0.80	0 to 4

Total Responses: 162

Question #31 WHAT DID THIS COURSE DO THAT HELPED YOU LEARN EFFECTIVELY? PLEASE IDENTITY 1-2 SPECIFIC CURRICULAR FEATURES OR TEACHING BEHAVIORS.

1. Enjoyed learning about the different aspects of nephrology - transplant clinic, lupus clinic, CKD clinic, dialysis sessions, interventional procedures
2. Let me learn at my own pace
3. Flexible schedule that fostered continuity of care.
4. I enjoyed the opportunity to participate in care in the outpatient setting as I previously did not have much exposure to outpatient medicine.
5. The best learning occurs in the clinical setting. The critical appraisal of the topic provided me a reason to do in depth research on a problem we encountered in the clinical setting.
6. THe environments were professional and well oriented to learning and growing. And the decreased clinical time was very helpful as I was also studying for Step 2 CK/CS.
7. I loved the different dynamics I had between my ambulatory and chronic care courses. I learned a lot about patient care and longitudinal care of underserved populations. The teachers were wonderful and I appreciated the time I spent on their services. Dr O'Handley from the mobile clinic is a wonderful doctor to learn from and work with.
8. Great experience at both of my sites. Several excellent lectures.
9. TBL structure being more hands on
10. Standardized pt session for breaking bad news was good. You really don't get to practice this as student.
11. Good hours with free time for studying
12. I thought the ACO modules were worth while. There is much about our national healthcare system that I do not know, and the modules helped bridge some of the gap. I also found value in the critical appraisal of a topic assignment. This helped me learn how to evaluate the medical literature. I think more assignments like this throughout the curriculum would have been helpful to me personally.
13. All of the physicians I worked with took the time to discuss patients and the approach to care.
14. The clinical experiences were very good. I also liked that the ethics material was covered in TBL format, which promoted discussion and a deeper understanding of the topics.
15. clinical time and working with attendings/fellows/residents
16. These particular emodules were easy to listen to and quick applicable topics, although maybe not applicable to the specific rotation, but more for life
17. It was useful to see patients in various settings throughout their healthcare experience, from home visits, to dialysis clinics to scheduled clinic follow ups, to outpatient procedures. I read about all this stuff in my studies, but its good to see exactly what patients go through during various phases of their treatment.
18. I enjoyed the TBLs, working through mock patient interactions with my classmates was a great learning experience.
19. Appreciated ground school topics not covered elsewhere such as pain control, geriatrics, palliative care. Appreciated transparent rubrics given high level of work required from students. Felt that given the lower amount of clinic hours this level of work was reasonable. Overall a wonderful experience. Individual feedback meetings with students had a really nice personal touch and if it continues to be possible to do this, I appreciated it.
20. The ACO modules are interesting.
21. - home health assignment broadened my understanding of the scope of medicine - TBL was an excellent exercise in handling domestic violence and child abuse, and in how to have a difficult conversation with patient - great flexibility in the scheduling, works great around interview season
22. Teaching me about outpatient responsibilities Learning about TBI treatment
23. 1. Gave a variety of study tools and sessions to appeal to different learning styles 2. Learned a lot from CAT assignment and cost-effectiveness
24. enjoyed rotating through a variety of services, even within each rotation
25. Flexible scheduling, lack of shelf exams made self-directed learning and personalized learning objectives very easy to do

Total Responses: 162

Question #31 WHAT DID THIS COURSE DO THAT HELPED YOU LEARN EFFECTIVELY? PLEASE IDENTITY 1-2 SPECIFIC CURRICULAR FEATURES OR TEACHING BEHAVIORS.

26. Ambulatory setting internal medicine.
27. I thoroughly enjoyed both my Chronic Care and Ambulatory Assignments. I thought the TBLs were appropriate and interesting and the home health visit was a great supplement to the material.
28. Clinical instructors engaged in teaching student
29. I enjoyed the TBLs, especially the second one.
30. This course, more than any other so far in medical school, focused on providing resources to learn about the business, ethics, and costs of healthcare, helping to expand my understanding of my profession
31. The clinic time was very helpful and the clinical faculty were fantastic teachers and very enthusiastic.
32. The orientation and the TBL were helpful to my learning.
33. -Home health visit was engaging and impactful
34. Spending time in an out-patient setting was very enlightening. I also thought the reading assignments were interesting and informative. The course was very organized and the syllabus helpful.
35. I thought that the clinical experiences were well organized and offered me a good mix of autonomy and supervision. I also felt that the "difficult patient "experience in the final TBL session was quite helpful.
36. The lecture material and emodules were helpful. My clinical assignment for Chronic Care Geriatrics was a very effective learning experience.
37. Home health visit was useful. Pain management and palliative lectures were the best.
38. Exposed me to other aspects of medicine than that were observed during 3rd year.
39. I enjoyed the TBLs and the ethical side of things, as we did not have any extensive training in this field. I also enjoyed the CAT paper, as I feel like this will really help during residency.
40. getting to work with different attendings
41. Clinical assignments were very useful learning experiences. I was typically working one-on-one with attendings and was given significant responsibility and instant feedback.
42. Good use of teaching time in terms of the TBLs, which covered many high yield ethical issues that I had not been really exposed to the rest of my medical career. It will help me in the future with making medical decisions and participate in shared decision making in the future
43. Faculty listened to my patient presentations and helped me put together assessments and plans.
44. The home visit was a great addition to the curriculum. I also really liked the breaking bad news TBL.
45. This course provided an immersive experience in outpatient medicine and all the different flavors of outpatient medicine. The sites I was at gave me a lot of autonomy in approaching patients and really helped me become comfortable in talking to patients on my own.
46. I had wonderful attending physicians with an interest in helping students grow.
47. More broad practices maximized my learning experience (surgical oncology has many more available preceptors vs hematology oncology had multiple students and residents rotating through which made it very difficult to schedule the 80 hours required). Preceptors very inviting of students.
48. The critical appraisal and direct observation components were quite useful.
49. Excellent readings and TBL on ethics
50. My Chronic care assignment was excellent. I saw exactly how an interdisciplinary team should work and saw a large population of interesting patients. This was my best learning experience related to AMRCC
51. I thought the course taught me the importance of palliative medicine and their role in the hospital. I learn when to consult them and how they can help with a patient.
52. I enjoyed my abulatory experience a lot, I got to work with a variety of doctors and residents.
53. It was a great opportunity to see what outpatient medicine really looks like.
54. Nothing comes to mind.

Total Responses: 162

Question #31 WHAT DID THIS COURSE DO THAT HELPED YOU LEARN EFFECTIVELY? PLEASE IDENTITY 1-2 SPECIFIC CURRICULAR FEATURES OR TEACHING BEHAVIORS.

55. TBLs and direct observation sessions
56. clinical rotations
57. n/a
58. It was great to work directly with patients and attendings and learn how to take personal responsibility; it really engaged me.
59. Overall, I felt that the courses were well organized. I thought that the extra educational experiences like the home health visit and TBL were helpful. The leadership was clearly very interested in teaching students and were helpful.
60. N/a
61. Using a standardized patient/role playing during didactic.
62. 1) The clinical time was only 20 hours per week, which enabled studying outside of the clinic and time to balance with other necessary 4th year activities 2) The readings were interesting
63. The preceptors for both my ambulatory and chronic care assignments were great teachers and tried to educate me more about "behind the scenes" aspects of medicine, especially cost of tests and billing. Also the CAT assignment was very useful ans prepared me for EBM talks I will have to give in residency.
64. In general my ambulatory GI clinic (Dr Kramer) and palliative rotations were a valuable experience and different from anything I'd seen in medicine to this point.
65. Great teacher
66. TBLs were useful. Didactic instruction was relevant. Taken as a whole, clinical instruction was very helpful.
67. TBLs
68. I really enjoyed the clinical sites I was in. I saw a great variety of patients and was able to see the interdisciplinary nature of medical care today. Having ground school on one day was also good.
69. The role of the outpatient visit, how it relates to hospital/emergency care, and its place in the healthcare system. How to not overspend in healthcare, and weighing health outcomes
70. I liked my clinical assignments. Dr. Eklar is great and should run this course.
71. Instruction during rotations were excellent
72. The assigned readings were useful. The home health visit assignment was enjoyable and I learned from the experience.
73. faculty for my rotations were great. I loved that i was able to work outside of the hospital setting. The emodules were a pretty good review. Liked the reduced hours allowing for interview prep-step 2 studying.
74. Clinical rotations were excellent, great learning opportunities.
75. Didn't take a lot of time.
76. This course helped me learn a lot more about outpatient care, especially since so much of 3rd year is dedicated to inpatient services.
77. It was great to have teaching on medical ethics. All faculty and staff promoted a great learning environment.
78. n/a
79. n/a
80. TBLs and related reading assignments were helpful. Learning to address emotional needs of patients during difficult conversations from Dr. Gustin in palliative medicine was one of the most eye-opening experiences I had in fourth year. I would recommend her to teach all of the 4th year med students to hone their skills in having difficult conversations.
81. Learned specialty specific aspects of patient care
82. wide variety of patients and really allowed me to take the lead of the healthcare team.
83. Helpful to have limited to 80 hours per rotation in order to get other tasks completed.
84. see more outpatient clinics

Total Responses: 162

Question #31 WHAT DID THIS COURSE DO THAT HELPED YOU LEARN EFFECTIVELY? PLEASE IDENTITY 1-2 SPECIFIC CURRICULAR FEATURES OR TEACHING BEHAVIORS.

85. Great overview of various ambulatory topics.
86. Good integration of clinical medicine and ethicss
87. Home visit was great.
88. James 5 rotation was great
89. The second TBL was my favorite activity of the AMRCC block. Having to deal with so many different issues with one patient (delivering bad news, reviewing power of attorney and living wills, navigating assisted suicide conversations) was a great way to address many of the more difficult situations we will face as residents.
90. The actual sites were wonderful and taught well when i was in clinic with them.
91. excellent clinical instructors
92. Working in the clinic was very beneficial. It was helpful to review primary preventative care of patients.
93. The clinical components were the best part of this course! I worked with the rheumatology attendings for ICC; they were very good about teaching. I was lucky enough to work with one attending on a longitudinal basis for the ambulatory component. This was my favorite part, hands-down. I went every Friday, which allowed me to easily schedule patients to follow-up with me. I saw many patients multiple times and worked on developing plans of care independently and becoming more efficient with visits and note-writing.
94. I did my ambulatory component longitudinally which I enjoyed and worked well with my schedule, especially given interviews during fourth year.
95. The variety of rotations available made it easy to find an interesting clinical site.
96. I really enjoyed the home health visit and my preceptors (even Dr. Flood!)
97. being on clinical service
98. Useful course, helpful to learn about ethics and costs.
99. I learned a great deal from both my ambulatory and chronic care clinics, and felt my time there was very well spent.
100. Very engaging faculty members. i enjoyed the time I spent at clinic the most as I felt i learned the most while seeing patients.
101. Short, concise notes on various topics were VERY HELPFUL and digestible (instead of long, drawn-out articles)
102. I really enjoyed the two courses I did for AMRCC and appreciated the broad range of courses offered to us. The course was well-organized. I appreciated how the clinical hours were cut down to give us enough time to work on all the other assignments for the course. This allowed for a good educational balance. I enjoyed the TBLs. I appreciated Dr. Fernandes' notes and found them to be helpful. However, some of the other readings for the TBLs were a bit too dense.
103. The clinical instructors that I worked with in clinic took time in clinic to teach. During my ICC component Dr Para had a list of people who he wanted me to meet with over the course of my rotation to help me have a fuller understanding of what happened in clinic (i.e. I met with the infectious disease pharmacist to talk through the different medications we used and the pros/cons of them) and the steps the patient would have gone through before their appointment.
104. TBL's were good. More time for discussion of these ethical issues woould have been helpful.
105. I think the ambulatory setting and the diverse availability of training sites was most helpful and effective.
106. I thought the TBL material was good overall, and the TBL format was a good way to solidify that knowledge.
107. Both rotations provided me with excellent clinical experience and information that I will continue to use in residency. The online hand outs were helpful in providing good notes.
108. Flexibility and broad exposure to practice of medicine issues that are more understandable and relevant as we enter residency.
109. Communicate with patients about about difficult diagnosis
110. Great variety of patients in combination with other learning outside the clinic that covers material not covered elsewhere.
111. I had ample time with 1:1 contact with attendings, and learned how to take on more responsibility as part of the

Total Responses: 162

Question #31 WHAT DID THIS COURSE DO THAT HELPED YOU LEARN EFFECTIVELY? PLEASE IDENTITY 1-2 SPECIFIC CURRICULAR FEATURES OR TEACHING BEHAVIORS.

healthcare team. This was an effective design given that I will be starting residency in the near future.

112. The rotation sites were good and the attendings and residents I worked with on those rotations were good.
113. This course allowed me to learn in new environments which really contributed to my education. Both of the rotations were places I had wanted to work in before graduating medical school.
114. The CAT paper was helpful because I didn't know anything about a CAT beforehand.
115. Allowed to see patients independently. Lots of chances to practice presentation skills.
116. The actual clinical components were very helpful and working with the same preceptor was very helpful.
117. Ability to practice procedures and patient management in the outpatient setting
118. very good debriefing session at end of clinic. Good opportunity to teach 1/2 year med students
119. Great rotation, good learning environment
120. Well taught; learned about chronic care and wound treatment
121. Reviewed very common things such as osteoarthritis and BPH. The home health visit was a great experience for understanding how home health works and when it may be a useful tool for our patients.
122. Clinical experiences were great
123. great ambulatory cites that let me learn more about my future career
124. Great outlook on outpatient medicine.
125. None
126. The palliative care rotation was a great experience. I learned so much about end-of-life care and pain management that I have seen no where else in my medical education. The various readings covering different aspects of chronic care were also helpful in gaining a well-rounded appreciation of various chronic care topics.
127. Excellent faculty at clinical assignments
128. The ability to follow patients at different phases of their care in the outpatient setting.
129. Being able to complete the rotation longitudinally was excellent
130. Offered two perspectives of chronic care. Offered team based approach to medicine in some rotations as some clinics had several ancillary staff.
131. N/a
132. Loved my clinical assignments. Specifically, the vascular rotation at stoneridge -- I wish I'd had the opportunity to rotate there earlier in medical school. There was so much relevant learning that I wish I'd had earlier in my education! I liked the flexibility of hours. If I wanted to put in the minimum 80 hours, I could. But if I wanted to do more (and on Chronic Care, I did), I could without penalty.
133. Great mentoring/education on ICC. A lot of autonomy on both ICC and ambulatory.
134. Covered things not covered elsewhere. Good ethics learning.
135. good course
136. E-modules, CAT, and TBLs were excellent learning opportunities.
137. Clinical experiences were the most valuable component.
138. Very much appreciated the clear goals during the rotation.
139. Good to work in a gynecologist's office longitudinally.
140. TBLs are a great idea. Please do not re-use the same ones next year, however. As a teacher, it is important to strive to improve them every time you use them. Some TBL materials felt a little stale.
141. Diversity of clinical assignments, particularly for chronic care portion.
142. I enjoyed my time on my clinical services - they were both services I would not have elected to take unless the requirement for AMRCC existed. Nevertheless, I learned an immense amount about topics that will be very relevant for my future career.

Total Responses: 162

Question #31 WHAT DID THIS COURSE DO THAT HELPED YOU LEARN EFFECTIVELY? PLEASE IDENTITY 1-2 SPECIFIC CURRICULAR FEATURES OR TEACHING BEHAVIORS.

143. Clinical assignments were excellent and a few of the didactic were helpful to have covered aspects of medical care that are not often taught/discussed
144. My home health visit was an excellent experience. I worked with Jennifer Slatzer from Gentiva and went on a home hospice visit. I also felt that the group interview activity of the second TBL was a good experience.
145. 1. Provided me with an opportunity to observe specialized care for cancer patients 2. integrated all aspects of chronic care in cancer patients
146. The residents and attendings were wonderful and always willinging to teach.
147. Enjoyed the emodules and both of my rotations. The attendings and residents were all excellent!
148. I felt that I learned about treating patients in a chronic care and ambulatory setting. Furthermore, I learned about these respective clinical settings.
149. Med Onc attendings were fantastic. Really enjoyed working with them.
150. The attendings I worked with were excellent and did a lot of teaching. There is ample time to complete the miscellaneous assignments as the work hours are not too strenous.
151. I really appreciated the chronic care component in peds renal as the attendings and fellows were VERY enthusiastic about teaching and let the student drive the learning to do what they wanted to do.
152. I was happy I was able to pick sites that had patients and pathology that will be relevant to my chosen field.
153. Clinical experience
154. It was simply more exposure to patient care in unique settings.
155. I enjoyed my rotation for chronic care. I enjoyed the assigned readings on medical ethics.
156. I thought the TBLs were interesting and it was helpful to run through how to do a critical appraisal of a topic.
157. Both of my clinical sites were amazing and facilitated my learning.
158. I enjoyed the home visits, seeing patients living conditions outside of the office setting.
159. diverse experiences, applicable to all of health care
160. The clinical assignments were great. Anything that took me away from clinical time was not helpful to my learning.
161. integrated the chronic care model and felt like I gathered a good basis and understanding for my specialty.
162. Time spent with the attendings and residents was the most beneficial for learning

Total Responses: 164

Question #32 **HOW MIGHT THIS COURSE IMPROVE? PLEASE IDENTIFY 1-2 SPECIFIC WAYS.**

1. Nothing!
2. Nothing comes to mind
3. Summarize key learning points after TBLs and ground school lectures
4. Overall, there could be greater communication between the administration and the clinical sites in terms of scheduling for things like TBLs and exams. If the site defines a predetermined clinic schedule without incorporating these events, it can be difficult to rearrange hours and obtain more clinic times if multiple students are at the same site.
5. Communication about the midterm and the final need to occur before students make schedules with their sites.
6. I didn't really understand what I was supposed to be doing for the CAT.
7. Lower Lights clinic is not very responsive to student contact and I had a hard time communicating with the coordinator there. However Dr Finkenbinder is a wonderful attending and loves to work with medical students, so she is a good resource there for med students.
8. So many stupid things to do. Please cut the fat. These assignments take more time to understand the instructions than anything else and add nothing to my learning. They are effective tools for creating frustration, consistent with much of LSI. Also grading should be more transparent. Clinical evals are so far from standardized that they should not be compared between graders let along across departments. Grading should include residents if we work with them for the majority of the time.
9. More guidance with final exam objectives
10. none
11. None
12. I did not find value in the self assessment or home health reflections. The home health visit itself was fine, but writing a reflection afterwards was not. I would also suggest allowing the myprogress feedbacks (if it is truly necessary to keep them) to be completed in either AMRCC block. I worked with physicians assistants and nurse practitioners regularly in my ambulatory block and would have gotten quality feedback from them but the non physician team member feedback was tied to my chronic care block where I effectively worked with no non-physicians.
13. I did not see any areas that need change.
14. I felt like I was too far removed from the material covered during ground school to be tested on it in detail (and I only had a couple months between my AMRCC blocks). I also thought that the test was oddly detail-specific in certain points and some of the material did not lend itself to multiple-choice questions with one right answer.
15. ICC with more clinical responsibility and less observing
16. It was confusing how there were the two courses within one course. It was not always exactly clear what assignment went with what rotation. I do not think we need to force these two rotations into one mega-rotation. Also - very poor experience with home health visit. Poorly organized and it was not very beneficial to my learning.
17. Not be spaced out, although I understand that takes away the flexibility students would like
18. More interactive didactics/tbls
19. I am thankful we did not have to do the virtual patient modules as I feel they are more work than is learned - as we interview real patients and write real notes frequently on our rotations.
20. Clearer questions and answers on the TBLs should be used.
21. - Ground school was too long and I find myself zoning out after two hours. Some lectures could be done in eModules or be more interactive
22. More clear questions on the TBLs More clear instructions on assignments
23. 1. Finalizing the virtual patient modules 2. Less MyProgress forms to fill out as they did not really add much to the learning
24. would prefer fewer longer readings for the TBL as compared to a bunch of shorter ones
25. Direct observations were very low yield.
26. Get rid of home health reflection busy work. Get rid of silly busy work.
27. To me, the only area that could be improved is the link between ground school and the final exam. I found it

Total Responses: 164

Question #32 **HOW MIGHT THIS COURSE IMPROVE? PLEASE IDENTIFY 1-2 SPECIFIC WAYS.**

somewhat challenging to study for the final exam, given that the material presented on ground school was learned many months prior to the final. Perhaps just doing two smaller "quizzes" and combining the scores or something would be more beneficial? Otherwise, I thought it was a helpful course!

28. Too much variability in evaluations across numerous clinical sites to accurately evaluate student performance.
29. I would have liked the preceptors to all understand we would not be working in excess of 80 hours. I worked quite a bit more than was required.
30. The CAT seems entirely unnecessary and out of place.
31. Some of the clinical sites did not offer a lot of flexibility in scheduling. More flexibility would be helpful for students doing AMRCC during interview season, when it is sometimes necessary to take a couple of days off to travel and interview at non-local programs
32. The TBL material was very subjective and should be evaluated in a more subjective format (reflection or case discussions) rather than objective TBL tests. It was especially difficult when we were asked what the best correct answer was out of 4 options that were all objectively correct. It would also be enter to have a greater variety of authors for the readings since the. Majority were written by. Dr. Fernandez. This would provide greater perspective of these ethical issues.
33. n/a
34. -Reading materials weren't completely consistent with exam questions or information provided on ground school powerpoints -Exam questions themselves were vague and evidence supporting answers seemed outdated -Ground school day was tedious, most lectures were not relevant to clinical assignments (exception: palliative lecture was a good discussion) -TBLs were worded poorly and seemed intentionally ambiguous -Hard to respect a course when one of the lead faculty prides himself on how many people fail the exam each block because of vague questions -Getting quizzed off "notes" from one of the faculty rather than a primary source seemed like a bad idea
35. It would be helpful if the hours tracker on my progress could be divided by AMRCC-ICC and AMRCC-AMB and also by date. As it is now, the entries for both courses were listed together and often mixed so it was difficult to keep track of what was actually logged.
36. I felt that the TBL questions were unnecessarily difficult. As I mentioned in my valuations of the sessions, despite the fact that we had all done the reading and were repaired, we often disagreed on answers and had many incorrect answers. In addition, I felt that that several of the topics we covered were not very helpful to the majority of students. The most egregious example is that we were expected to learn the details of the pediatric female genital sexual abuse exam. This is not an exam the vast majority of us will ever conduct, and it has already been covered during our pediatrics rotation. I felt that the detailed ethical discussions that we had on some topics would've been more appropriate for Part 1 or an elective course.
37. Ground school lectures should probably be done during the month of AMRCC in which we take the test, as opposed to the first month. Otherwise, if they are far apart, it is hard to remember and integrate the material reviewed.
38. PM&R lecture might have not been necessary.
39. CAT assignment was difficult to understand at first. Could use more explanation on Carmen.
40. I had a longitudinal ambulatory rotation that proved to be much more of a hassle than anything else. I liked the idea of doing this longitudinally, so that I had a better chance of seeing repeat patients. However, this would work better in a clinic where the physician works in the clinic 5 days/wk. The physician I was assigned to only worked certain days of certain weeks, and also had other medical students, which made scheduling more of a hassle. As a result, I had to reach out to other physicians in the clinic and tag along with them. Additionally, I feel like the evaluations that we were evaluated on did not necessarily reflect what was expected of me in these clinics. My chronic care month was an observation-type rotation; therefore, the evaluation did not fit with what I was doing and I was not evaluated in a manner that reflected what I was doing. Additionally, for my ambulatory rotation, they did not want me to write notes so that I would have more experience seeing patients. They also did not allow me to do any counseling because patients had difficult diagnoses; thus, the evaluation again did not match with what I was told to do. Also, in terms of the assignments outside of our clinical rotations (the final exam, the home health assignment, etc.), we were not given any true feedback on whether we passed, which was a little frustrating.
41. n/a

Total Responses: 164

Question #32 **HOW MIGHT THIS COURSE IMPROVE? PLEASE IDENTIFY 1-2 SPECIFIC WAYS.**

42. Ground school lectures were very poor quality. One lecturer did not even show up. I very much liked the attendings I worked with on the ambulatory component, but scheduling sessions was extremely challenging. I think there should be someone from the medical school who helps students navigate this better.
43. The test was hard as I had ground school almost 8 months ago. I would like there to be a high yield review session or refresher course for the ground school lectures that can help us review the materials that would be on the test. It was extremely difficult to find my old notes from ground school and use them to effectively prepare
44. The emodules were not helpful.
45. Allow some full days of work
46. A lot of heterogeneity in sites and expectations of students at these sites. At some sites students were paired with a different provider every day of the week, making it hard to build a longer-term learning relationship.
47. I felt that no one was sure what to do and when. We just got a rough idea from friends who had taken these in the past.
48. The required ethics readings for the final exam contained many specific religious references, which distracted from the learning points and made me uncomfortable that we were being tested on them - please edit them for the respect of people of all faiths. TBL questions wording should be clarified.
49. Clinical experiences were highly variable, with some sights relatively unprepared to utilize students effectively.
50. I felt the TBLs were not great learning because I don't feel multiple choice question format is the most effective way to test ethical topics. I also felt the delivery of the bad news portion of the second TBL was extremely disjointed and did not help me to practice the whole process of delivering bad news. I thought the home health reflection did not help me to reflect in a meaningful way because I was having to chose my thoughts based on how they could be supported or refuted by the paper I was assigned to read. I was not certain what I was supposed to be gaining from the CAT project. Without an introduction to the assignment I felt like I was just doing an assignment for the sake of doing it. I would have liked at least some kind of introduction to what a CAT is and what are good kinds of topics to pursue. The emodules related to the virtual patients were very elementary and did not provide me with any new knowledge. Then they were tested in an extremely detailed way that didn't seem to fit with how I would be practicing in real life (only having second line treatment options, having to know offhand the expense of drugs, etc)
51. Little more specific objectives for the exam
52. My palliative medicine month was spent shadowing the majority of the time, I would have liked more responsibility.
53. None
54. Nothing comes to mind.
55. Have options that could apply to surgical specialties and reduce the amount of redundant assignments
56. consolidating ground school time-lectures on specific topics did not always apply to students rotating at a large variety of sites
57. n/a
58. More time with patients.
59. No additional advice.
60. N/a
61. Less focus on assessment, more focus on teaching and learning. TBL for example was inefficient use of learning time.
62. 1) The home health visit component was sometimes difficult to coordinate and it would be good if that were more structured
63. The chronic care home visit was a good idea in theory but many students had experiences that were not very educational and there was some disorganization with schedules.
64. During my home health visit I drove with a home hospice nurse to a neighborhood that she described to me as "extremely dangerous". The patient wouldn't let medical student into the house so I sat out in the nurse's car for an hour. The nurse instructed me that this neighborhood was very dangerous so I am to sit in the car with the engine on and my foot on the gas pedal so I can escape at a moment's notice. She additionally gave me a container of mace in

Total Responses: 164

Question #32 HOW MIGHT THIS COURSE IMPROVE? PLEASE IDENTIFY 1-2 SPECIFIC WAYS.

case I needed it. I think we can all agree this isn't good use of a medical student's time nor should a student be put in this situation. Otherwise the hospice was great and the staff was very kind to me, but this situation was very negative and I don't want future medical students to find themselves in that position.

65. Structure
66. none
67. The extra assignments such as the home health visit reflection, CAT, and TBLs, felt like busy work. The syllabus was written in a somewhat antagonistic tone, implying that all the students were only interested in doing the minimum amount of work and don't value ambulatory health/chronic care.
68. This course could have dedicated objectives that a given attending is assigned to teach you based on the given rotation. For example, for a cardiology rotation, an attending could be tasked with ensuring that you learn EKGs really, really well.
69. I would have liked some more flexibility in scheduling the final exam (i.e. More available dates) especially since I was in the longitudinal course.
70. I think flexibility in it clinical assignments and less mandatory events. The final exam also does not correlate to the outpatient experience as much as it is an ethical exam. I would do away with it and place more emphasis on clincial evaluations.
71. We already filled out evaluations about each component, so I'm not sure why we have to fill out another evaluation on this course. Keri often doesn't throughly read emails and responds with unclear or abrupt answers, so I often had to email her more times than necessary to get answers to all of my questions. She also emails us to fill out evaluations far before the mediator deadline; if the evaluations need filled out earlier, just make the deadline earlier and medstar will send us automated reminders to fill out the evaluations. Dr. Fernandez rolled his eyes at a student asking questions in the 2nd TBL, which I didn't feel was appropriate. In general, the readings and e-learning modules were not helpful for this course. The final exam was poorly written and included ridiculously specific questions (ex. the cheapest medication to treat BPH) that nobody could know off the top of their head. People fail that exam because it is a bad exam, not because they didn't study. The clinical assignments should be the focus of this exam, and the rest of the material should be taken away.
72. it felt like there were too many "hoops" to jump through.
73. I would like to see better articulate modules on COPD, BPH, joint disease. I felt that these modules did not define the disease, go through standard work up, or present step wise treatment on the topics.
74. I dont feel that the reading and testing part of this course added much to my knwoledge base.
75. I think TBLs at this point in medical school are a waste of time. I also think the test at the end was fairly pointless. No students I talked to care about reflections. Emodules are a terrible way to learn. Overall my critique would be to reduce all the extra stuff and just let us enjoy 4th year, not hound us with extra assignments after we have already proven ourselves and passed step 2 and are basically 1 foot out the door. The learning value of these is low.
76. n/a
77. Cannot think of anything
78. Home health care visit could be better organized.
79. The TBLs, albeit very easy, did not add much to my education.
80. Dr Fernandes informed students during the October orientation session that no computers or cell phones were not going to be permitted during the orientation sessions. This month was the height of interview invitations for most specialities and the window from invitation to all interview slots being full could be rather small for some specialities. This action showed me how little Dr Fernandes actually cared about us as young professionals. This action was the beginning of the end for my respect of him as a professor but don't worry he provided additional actions to fully rid me of respect for him. Dr Fernandes was probably one of rudest professors and most disrespectful of students out of all professors that I had the privilege to work with during my time at The Ohio State University. To be honest based on my interactions with him and my peers interactions with him am I shocked that he is the Associate Director of the Center for Bioethics and Medical Humanities.
81. I would have liked the opportunity to perform the CAT as a group presentation of a topic in order to practice how this

Total Responses: 164

Question #32 **HOW MIGHT THIS COURSE IMPROVE? PLEASE IDENTIFY 1-2 SPECIFIC WAYS.**

would happen in residency, since it seems that many residency programs have EBM case conferences in which residents deliver researched CATs. I'm not sure that I did my CAT in a way that will have prepared me well for a similar assignment in residency. Feedback sessions were hampered by MyProgress, which is no change from M3 year. My feedback sessions consisted of me handing my iPad to the person, waiting for them to fill it out, and then pressing "submit" for them. I received very little usable feedback from these interactions because they were centered around the iPad instead of me. Please consider throwing out MyProgress and just collecting signatures certifying that the feedback discussion took place.

82. Would have liked greater variety of outpatient clinics for ambulatory. I feel like it would have been more beneficial for me to rotate through multiple subspecialty clinics rather than spend one month only in one specialty clinic, even though it was a good learning experience.
83. Originally I was in a longitudinal site, however that fell through because logistically it was very difficult to schedule. In the future I would encourage the AMRCC leadership to really look into the longitudinal sites they are placing students at. If there is already a Med 1 or 2 there doing LP then logistically it will be very hard for a Med 4 to get hours. Also as a Med 4, I would really prefer to be in the clinics and doing more "on the job" training. I would rather more clinic time (ex. 100 hours) and less "extra stuff" during the AMRCC blocks.
84. TBL material (#1) could be less biased
85. the final exam covers a lot of material that won't be relevant to us as interns, or some of us ever, depending on what subspecialty we go into.
86. Add descriptions of what we will be exposed to at various sites so we have a better idea when we select the site.
87. Need more flexibility in scheduling with only 80 hours to fill over four weeks, especially if clinical sites allow 40+ hours per week
88. Decrease number of ethics readings. Most were boring and redundant.
89. I don't really understand the purpose of the end of rotation test. I think required quizzes throughout the block would accomplish the same purpose.
90. The CAT review was not helpful; no one reviewed this or gave me feedback. My EMS ride along and home health days were less than ideal. Having heard some of my colleague's stories about their positive experiences made me feel like my assignments were not very good ones.
91. There was a lot of material that seemed superfluous, such as a reflection over the home health visit. I didn't feel this added much to the experience and was just another paper to turn in. By far this was course had too many "extras." These could be cut in half, as well as there not needing to be 2 TBLs AND an exam. Really at this point, we are 4th year students and down would allow us to concentrate on enjoying the experience of something many of us will never do again.
92. excessive assignments
93. Do not have a TBL or home health reflection assignment. Neither of these things were valuable experiences. One of the faculty recommended that instead of a home health reflection, we have a home health small group for <2 hrs that is run by a facilitator familiar with home health. I think that a small group would have been more valuable.
94. The home health visit was very frustrating. I was told to report at an agency at 9am; they seemed confused about what I was there for. When I finally explained I was supposed to do a home visit, they told me they might have one for the afternoon. I went home and waited for a call. Eventually, a nurse asked me to meet her around 3:45pm for a visit. She was about a half hour late. So, I was awkwardly waiting outside this patient's home for a half hour in my car. The visit ended around 5:15pm, so I spent the whole day trying to get this one hour task accomplished…
95. 1. Regarding some topics covered in ground school that were later tested on the exam, I was unclear as to what to glean from certain lectures. More specific objectives from each of the lectures would have been helpful in preparing for the final exam. 2. Some of the questions on the final exam seemed a little random and unreasonable. I studied all the materials for several days leading up to the exam and had taken extensive notes during ground school which I also studied. I STILL left the exam worried that I may have failed. I think this speaks to a discrepancy between what we were told to know and what was tested. Please ensure that the final exam approximates well with the objectives that are given and if you are looking for students to come prepared with very specific knowledge, this should be explicitly reflected in the objectives.

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Question #32 HOW MIGHT THIS COURSE IMPROVE? PLEASE IDENTIFY 1-2 SPECIFIC WAYS.

96. I was unhappy with how the assignments were evaluated. I was told I failed my home health reflection and that I did not follow the guidelines as outlined by the grading rubric. I did in fact follow these guidelines and when my reflection was re-read I was told that I had indeed passed. There needs to be a better way to evaluate reflections and make sure the person grading these is actually reading them. I did not appreciate getting an email that said I failed an assignment when I had actually done it correctly and spent quality time on it. This greatly changed how I felt about the course.
97. the CAT was useful but needs to be explained much better. The home health reflection seemed like busy work
98. seems a little disjointed as far as topic selection goes
99. The CAT and home health reflection weren't particularly educational, and the TBL created some conflict earlier in the year from what I heard.
100. I enjoyed the second TBL, especially the application exercises regarding breaking bad news. However, I did not feel that the other mandatory activities or assignments (TBL#1; home health reflection; CAT; final exam) furthered my knowledge. I believe that spending more hours in clinic would have been a more useful way to spend my time.
101. N/A
102. none
103. I definitely benefited from ground school, however, I feel that the lectures could have been more standardized and focused on highlighting high-yield points for the chronic care/ambulatory settings. This would have also made studying for the final exam more straightforward. It was a bit hard to figure out what the important points were from the slides and handouts, especially if you had ground school several months earlier.
104. The CAT assignment was particularly troubling for me because there was very little in the way of guidance or expectations of the assignment available. It would be beneficial to provide expectations for this assignment beyond what is currently available in the syllabus.
105. 80 hours of clinical time, is not much - especially in a curriculum where we already have so much built in flex time. There was loss of continuity in interactions with patients and attendings because of the truncated 80 hour
106. I personally think that while the midmonth feedback with the faculty and reflections are an interesting idea on paper, I do not see the practical advantage of having these assignments for further enhancing our medical education. Otherwise, I thought the other components of the course, the structure, and its administration were excellent.
107. Have everything in place before the course starts. It was difficult not knowing what we were going to have to do with the virtual patient encounters, as this kept shifting.
108. None
109. More dedicated attending at clinical sites. It can be hit or miss with an attending who is interested in teaching.
110. Nothing at this time
111. Too many reflections
112. First tbl was a little to subjective and just lead to a lot of discussion which wasn't all that productive.
113. Some of the required components, especially the TBL, seemed like they were more busy-work than actual learning. Overall, though, I really enjoyed my two AMRCC rotations.
114. The ground school, TBL, CAT, and home health visit were all set up in ways that were difficult for students to complete and did not add much to our understanding of the topics at hand. In addition, multiple students received aggressive, borderline unprofessional emails regarding their work on the course after providing information about why they were having difficulty and what steps they had taken to resolve the issues they faced. I felt that the course administration did not treat fourth year medical students as adult learners.
115. I really enjoy the course, there were a lot of moving parts and that is difficult to manage, but I thought everyone did a great job.
116. The syllabus was way too long and convoluted to be helpful.
117. Less busy work. At this stage it would be nice to focus on the clinical stuff and less time writing reflections and convincing physicians and patients to complete my progress checklists.
118. Be more flexible about obtaining hours for the longitudinal clinics. In the probably unnecessarily long syllabus, include

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Question #32 **HOW MIGHT THIS COURSE IMPROVE? PLEASE IDENTIFY 1-2 SPECIFIC WAYS.**

the important deadlines with the required items checklist, for instance include when the longitudinal hours need to be completed by. Proofread your exam questions - I noticed quite a few omitted/extra words and misspellings.

119. Please provide more information about the clinical sites. The pain rotation at OSU is poorly organized and the student's role is very unclear. I would have liked to know about this beforehand as course coordinator appeared aware of this ongoing issue during the mid-month feedback session. Would recommend if possible to send students to an outpatient pain clinic with one attending. Most of these patients are seen very briefly by the consult service at OSU and treated suspiciously and unprofessionally. Students are not given much of a chance in terms of learning opportunities.
120. a little difficult to meet hour requirements at only one free clinic
121. Nothing comes to mind
122. None
123. Better communication with providers about course expectations, specifically limited number of hours compared to more traditional rotations.
124. All the extra fluff is annoying and yields little gain
125. increase the scope of tbl 1. instead of palliative lecture, give a palliative problem set with learning about different symptom based management and dosing different drugs -- what we'll need to do on day 1 of intern year regardless of which field we go into. this is a big opportunity for us to learn truely useful and advanced management
126. N/a
127. None
128. The TBLs and exam did not test upon the more important concepts of this rotation and was not intuitive; a lot of the exam questions were written in a "read my mind" sort of way.
129. Use a platform other than MyProgress for evaluations and logging hours.
130. 1. It would be very helpful for members at the different sites to emphasize cost of diagnostics and discuss high value care. 2. In certain rotations, such as in AMRCC-ICC for chronic kidney disease, there wasn't much opportunity for a student to do health counseling. Transplant donors and recipients receive pre- and post-transplant counseling during the pre-transplant evaluation by the attending.
131. Nothing
132. Scheduling/hours needs to be understood by individual rotation lead for that clinical sites. The home health visit does not need to be an all day shadowing experience.
133. N/a
134. Less stuff to do. I realize that some of these things are required for accreditation, but a lot of them felt very much like busywork. For example, I couldn't simply reflect on my home health visit... I had to find articles to back it up. That seemed pointless -- I really just wanted to reflect on the experience. The CAT wasn't as bad, since it was sort of demonstrating evidence based medicine. The emodules/final exam/TBLs felt sort of useless to me, as most of the topics were things we had already learned about and been tested on (depression, COPD, BPH).
135. More time with physician on ambulatory.
136. Good structure overall.
137. nothing comes to mind
138. Identifying sites were med4s can be provided with some autonomy would be valuable in preparation for internship/residency.
139. The initial ground school lectures were not valuable, such as coding. Also, the longitudinal experience was difficult to get hours due to clinics only being offered 1 day/week and the requirements of other rotations or interviews.
140. Shorter ground school
141. Cannot think of anything at this time.
142. To improve this measure--"I was offered opportunities to learn the cost of diagnostic tests and treatment in relationship to the benefits provided to patients"--please give us LISTS OF PRICES. Do this often. That is how we will

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know what costs what. Hearing that "value" is a function of BOTH cost and outcomes is a waste of time the fourth time through. It's a simple concept, and I've got it. It isn't useful unless I actually know what some of those costs are, even if just as rough figures. Also, please say early on in AMRCC, and throughout, that hours in a longitudinal rotation must be complete by the end of March. Finding that out at the beginning of March was an unpleasant shock.

143. Re-evaluate some of the home health assignments. It seemed like many students had been placed in unsafe situations.

144. I found it difficult to draw parallels between a number of the ancillary assignments and learning that occurs on service. I think I would have benefited from clearer instructions and a clearer emphasis on the practical applications of some of the assignments or frankly just more time in the hospital and less on these assignments. I found that the TBL readings were also educational, but I did not find the same level of learning from the in-person sessions. The following comment does not mean to devalue those specific individuals that went above and beyond to help me while I was on AMRCC - it is more meant as a critique composed of my experiences and those of many of my classmates during these months as many of us scheduled similarly for interviews. The major difficulty that I faced this course was navigating an involved interview schedule. I did not feel particularly supported other than by my attendings in the course of my interview season. I firmly believe that it is inexcusable to not meet curricular requirements/required number of hours, however I'd echo the frustration, particularly for students applying for residencies in competitive fields. There are a number of programs that offer only 1 date for an interview, and it is highly damaging to restrict a student's residency prospects because of time-based requirements [such as TBLs, or home health visits etc]. While those are important for learning and professionalism, they pale in comparison to the importance of residency interviews. Though I ended up working everything out, I felt like I was often fighting an uphill battle with the course for something I expected would be obviously important to everyone. I agree that the responsibility lies with the student to plan a schedule that minimizes absences but unfortunately my interview season went from October through February and I could not avoid doing rotations for that entire time span. I would hope that administration will reexamine their priorities during interview season and bolster mentorship, guidance and support in advance of placements. Doing this would greatly enhance our ability to adequately fulfill the goals of the curriculum while providing enough time to ensure our future careers in medicine.

145. I feel a more efficient use of my time would have been to combine the two AMRCC rotations into a single 1 month rotation given the 20 hour weekly schedule.

146. Please refine the final exam. Too many typos and the first question on my exam asked me to refer the the previous question.

147. CAT assignment and home health assignment were not very helpful overall. The comments I received were not in agreement with my understanding of the learning objectives for these assignments (For instance, the reviewer pointed out that one RCT article should have been reviewed, but this was not clearly stated, additionally, some instances do not permit RCTs to start with, so I am not sure if the feedback I received is all that valid or helpful). I did not feel that my learning benefited from these assignments.

148. Some of the non clinical assignments, such as reflections, were not clear in terms of goals or utility.

149. Home health visit was very disorganized and was not beneficial to my learning. The home health nurses barely knew I was coming and spent have of the day waiting for them to organize all their materials. I believe the home visit was somewhat beneficial to my overall learning, but did not think a full day was needed. I got all I needed and learned about home health after 1-2 visits.

150. None

151. n/a

152. The home health visit is incredibly variable depending on where you go. Some are just nursing visits, some physician, some just vitals.

153. Dr. Fernandez was hardly ever present for a course he teaches and acted unprofessionally at times and seemed like students were bothersome to him. I think some better leadership would go a long way in improving the course

154. Questions on the TBL and final exam seemed more arbitrary than what I remember from other exams. I would be sure to scrutinize questions to make sure they are clear.

155. TBLs were not helpful

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156. The critical appraisal of a topic was not valuable. Home health visit was also not valuable.

157. Please discontinue the home health care requirement. No one I spoke to had a positive experience with this. I wasted a day and saw zero patients. The direct observations on MyProgress are cumbersome and in no way aided my education. The mid month meetings are not necessary, and in my case made a scheduling problem with my clinic as I could only be there certain hours. At this point, face time with attendings and patients are our greatest source of learning. I do not feel that a written test was necessary for this course. It is silly to pick only a few topics that relate to chronic care and test fourth year medical students on second year level material. I did learn a lot from the ethics readings. However, answering test questions on BPH and COPD seemed silly after I rotated on a GI service in August and a Rheum service in February. There is no need to test our medical knowledge at this point. We've all taken and passed the national tests required to graduate medical school, and those tests include chronic as well as acute conditons. The ethics TBL was the only evaluation I felt was even remotely appropriate for this course. In general, my frustration with this course was that I felt as though I was being treated like a first year medical student. A majority of the requirements for this course do not seem like something an intern would be doing, and at this point in our training, as almost doctors, we are trying to learn how to operate at that level. I feel like my colleagues and I did not always take this course seriously, because we were not taken seriously by the organizers of this block.

158. I felt that the longitudinal option felt disjointed. Because of scheduling issues on both the clinic and my end, I felt it took a lot longer than usual to become adjusted and comfortable working in the clinical setting I was assigned to. I feel that i could have had a better learning experience in the block setting. The home health visit was also disorganized. There did not seem to be clear communication with the home health agency.

159. I did not enjoy the TBLs or the direct observation, I felt the readings were helpful though

160. I think the home health visit was a good addition, not sure if the reflection was necessary.

161. more communication between administration and assignment site.

162. AMRCC had way too many components. Having a 37-page syllabus is RIDICULOUS. It was repetitive, pedantic, and pretty unhelpful. Assignments were scattered and most of them felt like busywork. Any time away from clinical assignments felt unhelpful to my education. I think it is worth noting that I felt like Dr. Fernandes was unapproachable and conducted the TBLs in an unprofessional manner. I asked a question during the first TBL and he responded with, "You obviously didn't do the readings because if you had done them, you would know that the frog-leg exam is the correct answer." In response to other questions, he repeatedly said, "I have a PhD in ethics." Instead of promoting discussion, his responses belittled and shut down any further conversation.

163. Clearer guidelines on the the extra clinical work that needed to be completed. Some of it was there (rubrics, objectives) however still felt lost for some assignments that lacked direction.

164. Fewer extra assignments such as the CAT. If you want to continue with the CAT, it needs to be explained better. The lecture and handouts were virtually useless as practical resources for learning how to correctly prepare a CAT.

HEALTH SYSTEMS, INFORMATICS, AND QUALITY PROJECT
PART 3 SYLLABUS
2016-2017

PROJECT DIRECTORS:

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PROJECT COORDINATOR

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HSIQ in Part 3: There will be a focus on patient experience/patient satisfaction at the beginning of the project using patient satisfaction data. Students will work up to proposing an intervention and measuring the effect of that intervention over time with a focus on high value care. The primary objective is to identify system failures and contribute to a culture of safety and improvement (EPA 13).

PART 3 HSIQ OBJECTIVES

1) **Recognize the interdependence of the component parts of the healthcare system and potential for unintended consequences. (CEO 5.3.1)**
2) **Identify and participate in patient satisfaction. (CEO 3.2.2)**
3) **Summarize how cost-effectiveness is determined and applied to patient populations. (CEO 5.2.1)**
   - **a)** Identify areas of redundancy and waste in healthcare by reviewing the choosing wisely campaign. (CEO 5.2.1)
   - **b)** Design a data plan to assess an area of redundancy and waste using DMAIC principles. (CEO 5.2.1)
   - **c)** Analyze means for reducing waste and improving the value of healthcare using DMAIC methods. (CEO 3.2.1)
4) **Apply an improvement intervention to a patient population. (CEO 3.3.1)**

5) **Using the HSIQ project measure change over time with pre and post intervention data.(CEO 3.2.2)**
6) **Demonstrate skills in interprofessional collaborative practice. (CEO 4.1.2)**
   a) Demonstrate the necessary skills to maintain a climate of mutual respect and shared values when working with individuals of other professions. (CEO 4.1.2)

PROJECT DETAILS

During Part 3 students will complete IHI modules, an individual patient satisfaction assessment and a group project where they implement an improvement and measure changes. Assignments are detailed below. Assignment-specific guides will be uploaded to Carmen to help students with the specific activities required to produce the required projects. All assignments other than peer assessments will be graded with the rubic provided on Carmen.

ASSIGNMENTS

1. Individual Patient Satisfaction Assignment

Students will review patient satisfaction data from one of three sites. You may choose from an outpatient general internal medicine practice, an inpatient surgery service or the emergency department. The data reports are loaded into Carmen along with an assignment guide. After reviewing the data, students will define one patient satisfaction area for improvement and describe a possible intervention. They will not implement this intervention for this assignment. **The assignment is due by August 1st, 2016. It will be graded by the rubric uploaded into Carmen and worth 15% of the project grade.**

2. High Value Care Group Project:

Assignment One: *Choosing Wisely* High Value Care Problem Focus

Students will form small groups (5-7 students). We suggest joining others in your chosen Clinical Track to define your group. You may form a sub-group of your clinical track depending on your topic of interest and the number of students in your track. After forming their group, students will identify a quality improvement mentor for their chosen specialty. A list of possible mentors will be posted on Carmen. You may also find a mentor of your choosing provided they agree to work with the group on the project. Your group will submit your mentor's name with this first assignment. Using the Choosing Wisely Campaign for the group's chosen specialty (http://www.choosingwisely.org/), students will identify areas of waste and redundancy to define one broad high value care problem**.** Students will then narrow their high value care problem focus using a prioritization matrix. Please remember if you choose a problem focus that has a patient satisfaction impact, we shouldbe able to provide you with patient satisfaction data. You may choose a problem that does not have a patient satisfaction impact but it may

be more difficult to obtain this data. Students will further define their identified problem using DMAIC methods, such as Flow Chart or Fish Bone Diagram.
This assignment requires the following components be turned into Carmen:

1. **Group members along with proposed responsibilities**
2. **Group mentor**
3. **Areas of waste and redundancy**
4. **Prioritization matrix**
5. **Flow chart or fish bone diagram**

This assignment is to be turned in by the end of Rotation 4 (August 19, 2016). This assignment needs to be approved by HSIQ leadership prior to moving on to the next assignment.

Assignment Two: Problem Statement, Data Plan, and Prioritization Matrix
For the second assignment, groups will be expected to generate a detailed DMAIC problem statement and design an intervention and data collection plan for the identified high value care problem, population, and location specified. The data plan should be designed to assess an area of redundancy and waste using DMAIC principles. Students will need to further assign group roles as not all members may be physically located on the service or clinic for the intervention period selected. You may still implement in an area and during a time when there is not a group member on that rotation. They will need to work to get buy in from practitioners and/or staff in that location during the intervention time.
For this assignment the following components will be turned into Carmen:

1. **Problem Statement**
2. **A detailed data plan**
3. **A detailed improvement plan which the group will implement.**

This assignment will need to be approved by HSIQ leadership prior to the implementation stage. This approval may require further communication via email or in person. This assignment is due by the end of Rotation 6 (October 14, 2016).

Formative Peer Assessment
Students will complete a formative mid-project peer assessment between Assignments Two and Three.

Assignment Three: Implement an Intervention
During Assignment three groups are expected to implement their intervention for a period of four weeks, completing their intervention by the end of Rotation 8 (December 9, 2016). Students will complete a debrief assignment post intervention. **All groups must finalize and submit a debrief and request for data by no later than December 9, 2016 in order to receive data for analysis**.
This assignment requires the following components be turned into Carmen:

1. **Data Request**
2. **Debrief**

Assignment Four: Analyze Data and Measure the Effect of Change

Students will complete their group project by analyzing data from their intervention and measuring the effect of change over time. Students will develop an A3 poster to be presented during Patient Safety Week

This assignment requires the following components be turned into Carmen:

1. **A3 Poster**

Student Activities and Assessments in Part 3 HSIQ

Activity	Deadline	Weight	Competency Based Assessment
IHI Modules:		2.5%	
QCV 100	**07/25/16**		Systems-Based Practice
QI 106	**07/25/16**		Systems-Based Practice
QCV 101	**07/25/16**		Systems-Based Practice
Individual Assignment Patient Satisfaction	**07/25/16**	15%	Systems-Based Practice
Group Assignment One Group Members and Roles, Coach Identification, High Value Care Problem Focus, Prioritization Matrix & DMAIC Method	**8/19/16**	10%	Systems-Based Practice
Group Assignment Two Problem Statement, Data Plan, and Intervention Design	**10/14/16**	10 %	Practice- Based & Life Long Learning
Group Assignment Three Implement an Intervention, Turn in Debrief and Data Request	**12/9/16**	10%	Practice-Based & Life Long Learning
Group Assignment Four Analyze Data and Present Poster at Patient Safety Week	**3/12/17-3/18/17**	40%	Systems-Based Practice
Peer Assessment Formative	**10/14/16**	2.5%Task Completion	Interprofessional Communication
Peer Assessment Summative	**3/21/17**	10%	Interprofessional Communication

OVERALL	Graded by Rubric. Exceptional performance in both Individual and Group Project in HSIQ will be recognized by an Honors designation	

Policies

Participation in all assignments is considered mandatory. Each student will have to explain their role and contribution to the project (contributing to all phases and significantly contributing to at least one phase of the project). These will be graded based on a check box rubric as a surrogate for entrustment. There will also be a Peer Evaluation of group members that meaningful participation occurred.

Important Forms

Please see the HSIQ course events in VITALS and Carmen for pertinent materials for each assignment.

The course syllabus can be found in the Links section of VITALS under Projects and in the HSIQ Carmen course.

Academic Integrity, Academic Misconduct

Academic misconduct may be found in any action that tends to distort the accurate assessment of any student's individual accomplishments that are evaluated for the purpose of grading or conferring academic credit. Note that a student may be guilty of academic misconduct, for example, by cheating, or plagiarizing, or by allowing another student to cheat or plagiarize. Note also that the distortion applies, for example, to exams, homework assignments, and laboratory work. To the extent that any class activity (for example: attendance or participation) is used for evaluation for the purpose of grading or conferring academic credit, falsifying or distorting such activity, or permitting another student to falsify or distort such activity, represents academic misconduct.

Note: Students should not request nor accept guidance on these matters from a teaching assistant, fellow student, or anyone other than the faculty instructor of record for this course.

Disabilities Statement

Any student who feels s/he may need an accommodation based on the effect of a disability should contact the Office for Disability Services to coordinate reasonable accommodations for documented disabilities.

Office of Disability Services contact information:

Web: Office of Disability Services	**Location:**
Phone:614-292-3307	**150 Pomerene Hall**
VRS: 614-429-1334	**1760 Neil Avenue, Columbus, Ohio 43210**

Wexner Medical Center	The Ohio State University College of Medicine	
	Executive Curriculum Committee	
	Meeting Minutes	
	Date: 6/28/16	Location: 150 Meiling

Presiding Chair: Howard Werman, MD	Call to order:	4:04 pm
Minutes recorded by: Casey Leitwein	Adjourned:	5:44 pm

Member attendance

Name	Role	Present
Howard Werman	Chair, Faculty member	Y
Laurie Belknap	Faculty Member	Y
Douglas Danforth	Academic Program Director, LSI Part One	Y
John Davis	Associate Dean for Medical Education	Y
Alex Grieco	Chair, Academic Review Board	N
Sorabh Khandelwal	Assistant Dean, Med Ed	Y
Nicholas Kman	Academic Program Director, LSI Part Three	Y
Nanette Lacuesta	Assistant Dean, Affiliated program	Y
Cynthia Ledford	Assistant Dean, Med Ed	Y
Thomas Mauger	Clinical Science Chair	Y
Leon McDougle	Academic Program Director, Associate Dean Diversity	Y
Douglas Post	Assistant Dean, Med Ed	Y
Andrej Rotter	Faculty Member- Faculty Council Rep	Y
Charles Sanders	Assistant Dean, Affiliated program	Y
Jonathan Schaffir	Faculty Member	Y
Larry Schlesinger	Chair, Basic Science Department	N
Kim Tartaglia	Academic Program Director, LSI Part Two	Y
Donald Thomas	Med Student Representative	N

Additional attendees: Joanne Lynn, Curt Walker

Agenda items

Item 1, Approval of minutes

Item 2, Academic Program Review- Part One

Item 3, Internal Program Review Discussion

Item 4, Combined Student Review Update

Item 5, Roadmap to Reality

Item 1, Approval of last meeting's minutes

Discussion

1. The meeting minutes from May 24, 2016 were approved by the committee as presented.

Item 2, Academic Program Review- Part One
Presenters: Doug Danforth, Ph.D.

Discussion

1. Dr. Danforth presented the Academic Program Review of Part One. The presentation is attached. Dr. Danforth recognized all of the individuals who contributed to the report and specifically mentioned Curt Walker for his contribution.
2. Dr. Danforth provided an overview of the LSI Part One Curriculum consisting of 8-9 blocks plus longitudinal experiences and projects that continue into Parts 2 and 3.
3. The program successes were reviewed (see slides). The areas that the ECC had previously identified for improvement included Community Heath Education and Health Coaching, subsections on Step I USMLE and the Guided Board Preparation Block. An action plan put in place to address these areas, as presented to the ECC, were reviewed.
4. Overall, there was increased satisfaction with LSI Part I based on student evaluation scores. All of the blocks showed improvement in satisfaction score among students compared to previous years, particularly in the area of Board Prep. Dr. Danforth noted that block scores may be influenced by the scores on the previous block. Of note, the focus the content and presentation on Health Coaching and Community Health Education resulted in higher student ratings.
5. Teaching and Learning Modules were generally highly rated.
6. Block Leaders had high evaluations for the Program Leadership. Similarly, there were high ratings of the Program by the faculty.
7. The Core Competencies assessed by LSI Part I and their individual scoring was reviewed. Medical Knowledge is the largest portion of the LSI Part I grade. The distribution of scores was reviewed. A total of 143 competencies in Medical Knowledge were not met by students and Professionalism had 43 competencies not achieved. Dr. McDougle suggested that Part One should look at trends on Medical Knowledge failures from one year to the next, voicing concerns about the jump in these scores. Dr. Ledford suggested that students with repeat failures should be targeted for early intervention.
8. Significant changes were made to the passing criteria for the Board Preparation Block that caused the performance against the learning objectives to decline. The major change was the manner in which students could meet the Medical Knowledge component of the block utilizing three

different methods: (1) pass the Comprehensive Basic Science exam at the beginning of the block, (2) pass the weekly exams throughout the block, or (3) pass the Practice Step 1 exam at the end of the block.

9. Dr. Danforth noted that in addition to numerical ratings, there is narrative feedback gathered from individual blocks, faculty, teaching and learning methods (TLM's), peer groups, Longitudinal Groups (LG) as well as scored dated which is considered by the program.
10. There was significant discussion regarding the slides presented on students leaving the curriculum and student review. Questions were raised on the impact of students coming into the curriculum with low MCAT scores as well as the effect of 'encore' students on this data. Dr. Danforth stated that historically about 10% of students leave the curriculum within the first two years. The committee asked LSI Part 1 to look at the 23 students that took a Leave of Absence (LOA) and correlate this to their Admissions criteria and interviews. There were questions regarding how this compared to our previous classes and to other institutions.
11. USMLE pass rate has been declining compared to last year although it was noted that there are 4 students who have asked for a delay in taking the exam.
12. The Part 1 survey included student mistreatment questions similar to those given to incoming third year students. It was the first year these questions were asked in Part One. There were four negative responses. The ECC had a significant discussion about identifying and following up on specific concerns raised in the survey as compared to disadvantages of eliminating anonymous responses. Dr. McDougle would like to see the depth these questions expanded and a method developed to de-identify the responders in order to address concerns. In particular, he suggested that demographics (race, gender, sexual orientation) be included. Dr. Davis suggested there may be an anonymous way to follow-up on any concerns utilizing the Student Life team.
13. Dr. Danforth discussed reflections on the Part I curriculum by Part 3 students who emphasized that longitudinal groups, longitudinal practice and OSCE's were, in retrospect, felt to be valuable.
14. Dr. Danforth reviewed the changes made in LSI Part 1 curriculum in response to last year's action plan.
15. Opportunities for the coming year include: lower passing rate on USMLE Part 1, making the Board Prep Block more helpful to students and challenges with simultaneous Assessment Weeks between Part I and Part 2 near winter break, pharmacology and nutrition education and integrating CQI into evaluation as required by LCME.

Action Items

1. The ECC discussed the LSI Part 1 Academic Program Review and approve an action plan to include the following the action plan proposed

by Dr. Danforth. The ECC approved an action plan to include the following:

a. Evaluate the number of students that left the curriculum and tie it back to Admissions metrics.
b. Continue to monitor student mistreatment.
c. Evaluate outcomes of pharmacology and nutrition revisions
d. Revise M1 Autumn calendar to resolve Assessment Week conflict
e. Evaluate the impact of integration of Health Coaching into LG
f. Revise Board Prep Block to meet student needs
g. Template and revise final exams for each block (A and B versions)
h. Integrate LCME compliance/CQI process

Item 3, Internal Program Review Discussion
Led By: Howie Werman, MD, John Davis, MD, PhD

Discussion

1. Internal Program Reviews will be completed on each of the three parts of the curriculum. Part 1 will be completed first. Dr. Davis handed out a 2006 document of the ECC's charge to a previous internal review committee. (attached)
2. Dr. Davis stated that the whole process of the review should take 1-2 months under the guidance of small committee (3-4 members).
3. The review is a longitudinal view of the curriculum that looks at how we are mapping learning objectives, what are the outcomes of the curriculum, etc.
4. Dr. Kman suggested that the Directors of Competencies might be a good fit to participate in these internal reviews.
5. Dr. Ledford suggested that we populate the committee with people that have roles within the curriculum.
6. Dr. Kman asked if the ECC could review the guidelines before deciding on the composition of this new committee. Dr. Davis asked for feedback on the document as well as suggestions for committee membership.

Action Items

1. The ECC members wanted to review the information provided further and send suggestions to Dr. Werman.
2. The LSI Part I Internal Review Committee will be appointed at the next ECC meeting.

Item 4, Combined Student Review Update
Presenter: Sorabh Khandelwal, MD

Discussion

1. Dr. Khandelwal updated the committee on the progress of developing a combined Student Review Committee. The proposed logistics were presented as a draft; however the task force is struggling with some procedural issues and outcome measures.
2. Dr. Mauger asked if the increased workload of a single committee might lead burnout. Dr. Khandelwal stated that this concern has been raised but one proposed solution is to have all Expert Educators serve as Student Review Committee members. This would allow for Committee transition as expert educators turn over. There is currently no term limit for members on the Combined Student Review Committee.

Action Plan

1. Dr. Khandelwal requested comments be sent to him; he will have the final version of the proposal to present at the next ECC meeting.

Item 5, Roadmap to Reality
Presenter: Cynthia Ledford, MD

Discussion

1. Dr. Ledford proposed an action plan as she transitions from her role as the Assistant Dean for Evaluation & Assessment. The presentation and report is attached.
2. She highlighted the historical development of evaluation and assessment prior to implementing the LSI curriculum and the maturation of E + A under the current LSI curriculum. Finally, she highlighted areas for improvement in the future (see full report) including need for more support resources, enhancement of faculty expertise and the development of Faculty Advisory Boards.
3. Dr. Kman suggested putting more resources into the infrastructure of VITALS in order to more fully leverage the system.
4. The Committee recognized Dr. Ledford for her contributions and leadership as the Assistant Dean. The ECC will take the report under advisement and discuss its recommendations at the next meeting.

Wexner Medical Center	The Ohio State University College of Medicine	
	Executive Curriculum Committee	
	Meeting Minutes	
	Date: 7/26/16	Location: 150 Meiling

Presiding Chair: John Davis, MD	Call to order:	4:00 pm
Minutes recorded by: Casey Leitwein	Adjourned:	6:00 pm

Member attendance

Name	Role	Present
Howard Werman	Chair, Faculty member	N
Jose Bazan	Faculty Member	Y
Laurie Belknap	Faculty Member	Y
Douglas Danforth	Academic Program Director, LSI Part One	Y
John Davis	Associate Dean for Medical Education	Y
Mary Fristad	Chair, Academic Review Board	Y
Sorabh Khandelwal	Residency Program Director	N
Nicholas Kman	Academic Program Director, LSI Part Three	Y
Nanette Lacuesta	Assistant Dean, Affiliated program	Y
Cynthia Ledford	Faculty Member	N
Thomas Mauger	Chair, Clinical Science Department	Y
Leon McDougle	Academic Program Director, Associate Dean Diversity	Y
Andrej Rotter	Faculty Member- Faculty Council Rep	N
Charles Sanders	Assistant Dean, Affiliated program	Y
Jonathan Schaffir	Faculty Member	Y
Larry Schlesinger	Chair, Basic Science Department	Y
Kim Tartaglia	Academic Program Director, LSI Part Two	Y
Lindsay Boles	Med Student Representative	Y

Additional attendees:

Agenda items

Item 1, Approval of minutes
Item 2, ECC Membership
Item 3, Internal Program Review Discussion
Item 4, Curriculum Management Proposal
Item 5, USMLE Step 1 Requirement Proposal
Item 6, Level 2 Committee Student Follow Up

Item 1, Approval of last meeting's minutes

Discussion

1. The meeting minutes from June 28, 2016 were approved by the committee as presented.

Item 2, ECC Membership
Presenters: John Davis

Discussion

1. New ECC members were introduced including Lindsey Boles (Student Representative), Mary Fristad (Chair, Academic Review Board), Jose Bazan (Faculty Representative)
2. New members were asked to review the materials posted in the Box account

Action Items

1. None

Item 3, Internal Program Review Discussion
Led By: John Davis, MD, PhD

Discussion

1. The document describing the Internal Program Review process was discussed by the Executive Curriculum Committee. The document described the goals of the review, the process of the review, the Internal Program Review Committee and the disposition of the final report.
2. Dr. Davis noted that Dr. Belknap has expressed interest in serving as the Chair of the Internal Review Committee. Dr. Kman asked whether the ECC or the Chair would name other members of the Committee. Dr. Davis noted that this was up to the ECC's discretion.
3. There was some discussion regarding whether Dr. Belknap as an expert educator could serve as chairperson; however, it was decided that since she has no decision-making authority and no direct role in student progress in LSI Part 1 that she qualifies to serve in this capacity.
4. The document was changed to reflect the fact that the Internal Review Chair could not have a role in program or unit leadership.

Action Items

1. The language change reflecting that the Chair could not be involved in program or unit leadership was approved by the ECC.
2. Dr. Belknap's appointment as the LSI Part 1 Internal Review Committee was approved by the ECC. She has been asked to constitute the Internal Review Committee as proscribed in the document and bring her proposed committee to the next ECC meeting.

Item 4, Curriculum Management Proposal
Presenter: John Davis

Discussion

1. Dr. Davis discussed the fact that the LSI Curriculum has now been fully implemented. As a result, the Curriculum Implementation Team Leadership has fulfilled its mission.
2. Dr. Davis suggested that there is still a continued need for optimization of the LSI curriculum that is ongoing that could either be assumed by the ECC alone or by subcommittees that can be charged by the ECC with managing two areas: Learner Assessments and Program Evaluation. A new structure was proposed where a new subcommittee of the ECC would be formed: "LSI MICRO." Dr. Davis reviewed the charge to this subcommittee and its workgroups and emphasized that ultimate responsibility for the curriculum continues to rest with the ECC.
3. The membership of the LSI MICRO was reviewed by the ECC. The Committee had both voting and non-voting members providing input.
4. The LSI MICRO would meet monthly in between ECC meetings. The committee would have two working groups: the Learner Assessment Working Group and the Program Evaluation Working Group. The charge for each of the working groups was reviewed by the ECC. Each group would meet at least quarterly. Both workgroups would provide input to the LSI MICRO Committee and the Associate Dean for Medical Education.
5. Dr. Lacuesta asked about leadership of the two workgroups. Initially, the Associate Dean of Medical Education would assume this role until a transition to new leadership could be achieved as appointed by the LSI MICRO Committee.
6. Dr. Kman asked about the role of Vitals representation in the working groups as an important support function.
7. Dr. Schlesinger noted that the proposed structure would make the ECC more efficient, leverage the expertise of each working group and allow for broader faculty input into the curriculum. Dr. Tartaglia suggested that the membership of the workgroups be expanded to include other interested educators.

Action Plan

1. The ECC moved and approved the proposal to establish the LSI MICRO Committee along with its two working groups.
2. It supported that language that charges each of these groups with their areas of responsibility, noting that ultimately their work would be considered by the ECC
3. This new structure will be implemented immediately by the ECC

Item 5, USMLE Step 1 Requirement Proposal
Presenter: John Davis

Discussion

1. A working group was convened to consider issues surrounding USMLE Step 1 requirement including deadlines for taking examinations and late starts into LSI Part 2.
2. The group proposed that deadline be moved from April 30 to the Saturday that falls within two weeks before the start of LSI Part 2. Implicit in this new deadline is a break for students prior to Part 2 and the ability to petition for an extension of the deadline. This also allows students to get assistance early if they are struggling in their USMLE Part 1 preparation.
3. Dr. Davis noted that including Board Prep Block, students had approximately 8 weeks to prepare (4 weeks after the conclusion of the block) for the USMLE Part 1 examination.
4. Two distinct late entry points were presented in the proposal: midway through the first ring of Part 2 and at the beginning of the second ring of Part 2. Students must post a passing score prior to re-entry.
5. Dr. Schlesinger proposed clarifying language to the proposal regarding the circumstances where an extension was requested.
6. Dr. Kman asked about the requirement to post a passing score within one year of completion of LSI Part 1. Dr. Davis clarified this requirement remains in place.
7. Finally, it was proposed that any student missing a deadline or failing a USMLE examination will be evaluated by the USMLE Review Committee.
8. The limit of three attempts to pass USMLE Part 1 was affirmed.

Action Plan

1. The ECC moved and approved the USMLE Part 1 proposal with specific word changes.

Item 6, Level 2 Committee Student Follow Up

Led By: John Davis, MD, PhD

Discussion

1. Dr. Davis presented a proposed wording of the concept previously approved by ECC regarding follow up of students who had been seen by Level 2 Academic Review Committees. This proposal had been requested by ECC at the time of the approval of the process.
2. Drs. Kman and Tartaglia noted that student appearances before a Level 2 Committee is not currently found in Vitals to assure loop closure. Additionally, there are issues with the timeliness of loop closure by students.

Action Plan

1. The ECC members will receive the specific language changes in the Student Handbook via email. An email vote will be conducted on this language.

Wexner Medical Center	The Ohio State University College of Medicine	
	Executive Curriculum Committee	
	Meeting Minutes	
	Date: 8/23/16	Location: 150 Meiling

Presiding Chair: Howard Werman, MD	Call to order:	4:05 pm
Minutes recorded by: Casey Leitwein	Adjourned:	6:00 pm

Member attendance

Name	Role	Present
Howard Werman	Chair, Faculty member	Y
Jose Bazan	Faculty Member	Y
Laurie Belknap	Faculty Member	Y
Douglas Danforth	Academic Program Director, LSI Part One	Y
John Davis	Associate Dean for Medical Education	Y
Mary Fristad	Chair, Academic Review Board	Y
Sorabh Khandelwal	Residency Program Director	Y
Nicholas Kman	Academic Program Director, LSI Part Three	Y
Nanette Lacuesta	Assistant Dean, Affiliated program	Y
Cynthia Ledford	Faculty Member	N
Thomas Mauger	Chair, Clinical Science Department	Y
Leon McDougle	Academic Program Director, Associate Dean Diversity	Y
Andrej Rotter	Faculty Member- Faculty Council Rep	Y
Charles Sanders	Assistant Dean, Affiliated program	Y
Jonathan Schaffir	Faculty Member	Y
Larry Schlesinger	Chair, Basic Science Department	Y
Kim Tartaglia	Academic Program Director, LSI Part Two	Y
Lindsay Boles	Med Student Representative	Y

Additional attendees: John Gunn, Jack Kopechek, Donald Mack, Nicole Verbeck, Mary Jo Welker, Curt Walker

Agenda items

Item 1, Approval of minutes

Item 2, Biomedical Undergraduate Program

Item 3, Part Two Program

Item 4, Educational Portfolio and Coaching Program

Item 5, HRSA Grant Proposal

Item 6, Part One Internal Review Progress Report

Item 1, Approval of last meeting's minutes

Discussion

1. The meeting minutes from July 26, 2016 were reviewed by the ECC and approved by the committee as presented.

Item 2, Biomedical Undergraduate Program
Presenters: John Gunn

Discussion

1. Dr. Gunn presented on the Biomedical Undergraduate Program for the past year.
2. The report is attached. This is a program to attract high performing undergraduates with an interest in health care sciences. The program began in 2005.
3. The current admission rate is approximately 27 students with some attrition after year one. The program is focusing on retention of students.
4. Of the graduating class, 13 are going into professional schools.
5. Research is a significant component of the program: 7 of 15 Denman presentations were award winners.
6. The Grever Internship program is open to 7 students who shadow an MD/PhD clinician. Historically, there is a significant number of students who pursue a MD, MD/PhD or PhD career in this program.
7. Dr. Gunn reviewed the 4-year curriculum which emphasizes a focus on research and clinical medicine (see attachment).
8. Current class received 161 applications (42% increase) from which 42 were offered admission and 24 accepted. Average ACT = 32.6 with 21% URM and 42% females.
9. 91% of graduates have pursued professional degrees with 56% pursuing an MD degree. Dr. Gunn noted that this is not a pipeline program for the College of Medicine

Action Items

1. The program goals were presented:
    a. Seek alternative sources of program funding
    b. Complete an manuscript on the BMS program highlighting the Grever Internship
    c. Increase incoming class to 26 students with a focus on retention
    d. Expand the service-learning opportunities in the program
    e. Reclassify BMS program manager to BMS program director
2. These program goals were accepted by the ECC

Item 3, Part Two Program
Led By: Kim Tartaglia

Discussion

1. Dr. Tartaglia presented the annual report on Part Two of the LSI curriculum for the past year. Dr. Tartaglia reviewed the overall layout of Part Two. The students enter Part Two in May and complete it by the following April.
2. The Action Plan for the previous year was reviewed:
    a. Phase out passive didactics and increase active learning small groups in ground school and Tuesday afternoon sessions
    b. Increase team-based learning
    c. Pilot to improve direct observation in UPRSN and a longitudinal component in UPWP
    d. Institute faculty evaluation into LSI Part 2
    e. Transition to 16 week rings
    f. Full transition to VITALS for curriculum management
    g. Analysis of student feedback and performance by site
    h. Monitor student performance on USMLE Part 2 CK and CS
3. There is an improvement of overall satisfaction in each of the rings from first to current year. Direct observation in the UPRSN ring has persistently low ratings primarily due to access to attending physicians. The ground school component and Tuesday didactics for UPSMN and UPWP remain poorly rated by students; UPRSN is more highly rated. Faculty in small groups is fairly highly rated by students. Finally, the HSIQ health coaching is not well-received by students.
4. The safety/supervision report demonstrated two significant violations in Neurology and Psychiatry. Questions on the Learning Environment regarding respect for student and colleagues identified two significant faculty violations who are under counseling.
5. The students reported too much time in didactics with an increase in response on ‘too little time to study.’ Upon completing Part 3, over 85% of students reported that they were well prepared by the LSI Part 2 curriculum as well as for USMLE Part 2 CK and CS.
6. The Learning Assessment Competencies Not Met report revealed that the highest amount of competencies not met are in Medical Knowledge. Overall, there were total of 39 competencies not met in the LSI Part 2 curriculum. There were repeat students in this group.
7. The results of USMLE Part 2 CK showed a 98.1% passing rate with an average score of 250 among this group. Three failures passed on second attempt. For CS, 96.9% passed on the first attempt with 4 passing on a second attempt and one pending at the time of this report.

8. The program evaluated strengths as: rating on clinical assignments by students and preparation for USMLE Part 2; areas of opportunity included student satisfaction with Tuesday didactics and groundschool, excessive awarded Honors and Letters of Commendation and software challenges with VITALS
9. Repeat students are included in the student data slides.
10. Dr. Schlessinger asked about time in didactics during ground school. Dr. Tartaglia reported that on average students are in four hours of didactics per ring. There is no didactic for surgery. Dr. Davis noted that the heavier didactics in the UPWP and UPRSN rings which are not well received.
11. The rings are embracing the use of Top Hat with large group sessions to encourage audience response.
12. Direct Observation will now use Expert Educators to schedule time. This was not well received by the UPRSN leadership. The ring has been charged to come up with a solution.
13. The students are currently filling out evaluations for Ring One on the changes that have been already been made. An interim report should be available soon.
14. Dr. McDougle suggested that information Duty Hours and Student Safety violations that are currently being manually captured in spreadsheets should be addressed in VITALS. This is on the roadmap for VITALS to be automatically captured. Dr. Davis noted that there are financial and programming limitations in implementing this request despite a recommendation from the ECC.
15. Dr. Lacuesta commented that it would be powerful for recruitment to see how valuable student feedback is incorporated. This was supported by Ms. Boles, the student representative. It may be beneficial to email the class with the improvements made to the rings based on student feedback. Dr. Davis noted that this could also be highlighted during orientation.

Action Items

1. ECC would like Part Two to focus on the following recommendations for this year.
    a. Increase student satisfaction with Ground school/Tuesday didactics on UPWP and UPSMN by 20%.
    b. Adjust designation (Honors/Letters) cut-offs to be within 25% of approved cut-offs (thus no higher than 15% for Honors and 25% for Letters)
    c. Improve quality of direct observation on UPRSN ring by 20%
    d. Implement a VITALS drop-down list to obtain more granular data on learning environment items for SECI (This teacher treated me with respect." etc)

2. A VITALS representative will be invited to a future ECC meeting to give a presentation on the current roadmap and timeline.

Item 4, Educational Portfolio and Coaching Program
Presenter: Jack Kopechek

Discussion

1. Dr. Kopechek presented highlights of the Annual Report of the Educational Portfolio and Coaching Program from the 2015-16 academic year.
2. Program Strengths:
    a. Coach-student meetings
    b. Collaboration with other support services
    c. Continued improvement in meeting program objectives – this was demonstrated graphically by improving student evaluations of the program
    d. Showcase portfolio assessment
3. Areas for Program Improvement: increasing the relevance and student appreciation of portfolio assignments, especially reflections. This was highlighted by the student evaluations which are lowest for this Program activity.
4. A student wellness survey rated coach-student meetings as the top intervention to assure student wellness
5. Dr. Kopechek presented the grading rubric for the Portfolio Program. He noted that three students had to remediate the course, one due to quality of presentation and two others for content.
6. Dr. Khandelwal focused on the issue of self-directed learning, noting that the students perceive themselves to be competent in self-directed learners. Dr. Davis suggested that the program add a pre and post-evaluation question asking students to evaluate their development as self-directed learners. There was some discussion about students' understanding of the definition of self-directed learning. Ms. Boles felt that students would require a rewording of this question.
7. Dr. Lacuesta asked about student narrative comments from evaluations regarding written assignments show they don't feel they are relevant, contrived and "busy work". Dr. Kopechek has opened the assignments up to photos, video and audio with little change to comments. In the future, the Program will place greater emphasis on reflecting on student development in the core educational objectives.
8. Dr. Kopechek presented an outline of a typical portfolio coach meeting. Dr. Danforth asked if the coaches felt there was enough time to discuss all the items on the list with students. Dr. Kopechek responded that most coaches feel they need more time. Informal meetings are encouraged.

9. Dr. Danforth asked about a feed forward mechanism to Program Directors. Dr. Davis noted that the original vision of the coaching program was for the coaches to be support for students. Coaches should work with students to explore going to the Program for help when needed.

Action Plan (developed with input from Student Advisory Committee)

1. Move towards a single portfolio (merge Learning and Showcase Portfolios)
2. Introduce the entire project at student orientation and in the Coaching articulate module
3. Center reflective assignments around coach/student meetings
4. Make the reflective assignments more open ended, geared towards the Portfolio Showcase and current educational or critical curricular events such as first exam, first OSCE or Career Exploration – due dates will be changed to reflect these events
5. Shift emphasis from reflection to feedback (rather than discussing separately)
6. Establish relevance of the Portfolio Showcase to residency application

Item 5, HRSA Grant Proposal
Presenter: Mary Jo Welker

Discussion

1. Dr. Welker presented information on a $2.5 million cooperative HRSA grant to the College of Medicine and College of Nursing that will impact the LSI curriculum. The presentation is attached.
2. There are multiple objectives of the grant involved in the proposal with the first being Health Coaching. Objectives 1 and 2 involve the College of Medicine.
3. Dr. Welker focused on the Health Coaching project involving interdisciplinary learning.
4. Dr. Mack contrasted the changes in the Health Coaching component of the medical school curriculum with the pilot program. Medical students will team with primary care nurse practitioner students to complete the Health Coaching project that is already part of the medical student curriculum. Teams of one medical student and nurse practitioner will initially be trained on health coaching skills involving patients from Nurse Practitioner Wellness Clinic. Upon successful completion of the training program and an OSCE that assesses team coaching skills, students will team coach patients with uncontrolled chronic disease who are referred into the program by primary care providers who practice at students' PCMH preceptorship sites. Co-led by Don Mack, David Hrabe, and Alice Teall.

5. By September 1, 2016 begin pilot of the nurse practitioner/medical student team health coaching project with 4 teams. A health coaching team will consist of a selected first-year medical student with a strong interest in a primary care career and a selected first-year nurse practitioner student selected from the primary care track.
6. By September 1, 2017 implement the first year of the nurse practitioner student/medical student team health coaching project. Participants will include medical students (n=12) taking the **3-year Primary Care Track or 4-year Family Medicine Interest** component of LSI; Nurse Practitioner student participants (n=12) will be selected from the primary care track.
7. Dr. Davis clarified that the learning objectives for the pilot program are the same for participating medical students. Dr. Welker noted that there is an additional learning objective on interdisciplinary learning. Dr. Danforth asked about coordinating the current LG program and this pilot project. Dr. Davis noted that these students will ultimately have a separate LG as part of the three year primary care track.
8. Dr. Welker and Mr. Walker provided a brief overview of the remainder of the grant.

Action Plan

1. The ECC moved and approved the HRSA Grant Health Coaching pilot project proposal.

Item 6, Part One Internal Review Progress Report
Led By: Laurie Belknap

Discussion

1. Dr. Belknap reported progress on the Part One Internal Review (see enclosure). She highlighted the roles and qualifications of the proposed Committee.
2. Dr. Danforth supported the named individuals, noting that Dr. Fontana had a potential conflict of interest as a block leader. This was discussed among ECC who felt that the benefits of her participation outweighed the potential conflict of interest.
3. Suggested for Appointment to the Review Committee:

Director of Competency	Sorabh Khandelwal
Director of Competency	Judith Westman
Associate Program Director Part 2	Benedict Nwomeh
Associate Unit Director Part 3	Ansley Splinter
Expert Educator Part 2	Jacquelyne Cios
Academic Tutor	Mary Beth Fontana

Action Plan

1. The ECC members formally approved the list of committee review members and asked Dr. Belknap to present a timeline for the review at the next ECC meeting.

Wexner Medical Center	The Ohio State University College of Medicine	
	Executive Curriculum Committee	
	Meeting Minutes	
	Date: 9/27/16	Location: 150 Meiling

Presiding Chair: Howard Werman, MD	Call to order:	4:05 pm
Minutes recorded by: Casey Leitwein	Adjourned:	6:00 pm

Member attendance

Name	Role	Present
Howard Werman	Chair, Faculty member	Y
Jose Bazan	Faculty Member	Y
Laurie Belknap	Faculty Member	Y
Douglas Danforth	Academic Program Director, LSI Part One	Y
John Davis	Associate Dean for Medical Education	Y
Mary Fristad	Chair, Academic Review Board	Y
Sorabh Khandelwal	Residency Program Director	Y
Nicholas Kman	Academic Program Director, LSI Part Three	Y
Nanette Lacuesta	Assistant Dean, Affiliated program	N
Cynthia Ledford	Faculty Member	Y
Thomas Mauger	Chair, Clinical Science Department	Y
Leon McDougle	Academic Program Director, Associate Dean Diversity	Y
Andrej Rotter	Faculty Member- Faculty Council Rep	Y
Charles Sanders	Assistant Dean, Affiliated program	Y
Jonathan Schaffir	Faculty Member	N
Larry Schlesinger	Chair, Basic Science Department	Y
Kim Tartaglia	Academic Program Director, LSI Part Two	Y
Lindsay Boles	Med Student Representative	N

Additional attendees: Nicole Verbeck, Curt Walker, Victoria Cannon, Mary McIlroy, Joanne Lynn

Agenda items

Item 1, Approval of minutes
Item 2, Graduate Questionnaire Results
Item 3, Part 2 Annual Report Follow Up
Item 4, Quality Improvement and LCME Standards
Item 5, LSI Part 1 Internal Review

Item 1, Approval of last meeting's minutes

Discussion

1. The meeting minutes from August 23, 2016 were reviewed by the ECC. Dr. Tartaglia had some suggested changes to the wording in the violations section of her report. Dr. McIlroy suggested that these changes also reflect loop closure on these reported violations. The minutes were approved by the committee as amended.

Item 2, Graduate Questionnaire Results
Presenters: Nicole Verbeck

Discussion

1. Ms. Verbeck took the data from the full Graduate Questionnaire Report and placed it in a graphical format (slides attached). Most slides combined the Agree and Strongly Agree responses and compared these to the national responses. Dr. Mauger asked if we were provided the national 25th and 75th percentile, suggesting that we compare ourselves to the upper quartile. This information is not provided in the report. The report reflected 2016 medical school graduates, the first class graduating under the LSI curriculum. The response rate was approximately 80 percent, consistent with prior years.
2. Over 90% of graduates reported being satisfied with their education, slightly higher than the national average and consistent with prior years. It was noted that Strongly Agree responses actually dropped significantly from 2015 responses. This trend will be followed closely in future years.
3. Basic science content ratings were reviewed, comparing 2015 to 2016 responses. It was noted that the responses were not collected at comparable times between these two surveys and that a historical goal of 95% had been previously set by the ECC. There was a brief discussion about possibly revising this aspirational goal. Again, comparisons were made to the national average. Overall, the integration of basic science material into the required clinical experiences was highly rated and well above the national average.
4. Individual basic science subjects were reviewed (sum of Good and Excellent responses) and compared to the national average. Biochemistry, Histology, Neuroscience, Pathology and Gross Anatomy were below the national average. Of particular note was a significant drop in ratings for Pharmacology.
5. Clinical science ratings were also reviewed. Emergency Medicine, Family Medicine, OB/GYN, Surgery, Psychiatry and Neurology were

rated above the national average; Internal Medicine and Pediatrics were slightly below the national average.

6. Ms. Verbeck then presented more detailed data on individual specialties. She noted that the integration of specialties within the rings as part of the LSI curriculum may have affected the responses. Questions assessed direct observation of the history taking, physical examination and whether mid-year feedback was provided. Faculty and resident teaching was also assessed. The overall trend for these responses was a slight decline from 2015 but exceeding the national average for most specialties.
7. Dr. Tartaglia noted that her data collected under MyProgress suggests that 99% of students report being directly observed in performing a history and physical examination which conflicts with the presented data. She also noted that the AAMC question changed from specifically asking about direct observation by faculty to asking only about direct observation. She wondered whether a combination of faculty and resident direct observation would be appropriate. It was noted by Dr. Belknap that there is some uncertainty by students about who can perform direct observation. A significant discussion ensued. There was also a discussion about the reasons for the discrepant answers between the Graduate Questionnaire and the end of ring survey.
8. The results of questions addressing preparation for residency were reviewed and appeared to demonstrate a high satisfaction by graduates that was consistent with prior years and at or above the national average.
9. A significant majority of graduates reported a change in their attitudes or opinions based on learning about those with diverse backgrounds and felt that it enhanced their training and skills. Several new questions addressing professionalism were reviewed by Ms. Verbeck. In many of the specific questions, our medical school is rated above the national average. These questions are relatively new on the AAMC Graduate Questionnaire.
10. The final questions addressed administrative support. The Office of Student Affairs, the Office of Curricular Affairs and general student support including career planning were rated above the national average. Lower scores on tutoring services was discussed. Dr. Lynn noted that there have been resource issues in this specific area that is currently being addressed.
11. Dr. Werman asked about the distribution of this material. Dr. Tartaglia will report to the Part 2 APC; it is also distributed to Department Chairs.
12. Ms. Verbeck summarized as follows:
    a. OSU is performing at or above national average 85% of questions
    b. new professionalism questions have been added

   c. mistreatment and specialty selection questions were not discussed in this report
   d. this represents the first set of data under LSI Curriculum. Future trends to be followed.

13. There was a discussion about the impact of the new curriculum on the lower results. Most agreed that these results were expected with the rollout of the new curriculum. Additionally, there were discussions about benchmarking our data against other high performing institutions; unfortunately, this information is not available from the AAMC.
14. There was significant discussion about moving forward with information from this report. Dr. Davis noted that we must review this data with the intent of goal setting as part of our College of Medicine dashboard. Dr. Ledford suggested that we pick 3-5 areas to address from this report. Dr. McIlroy suggested based on the LCME standard that resident teaching, student feedback and direct observation would be obvious areas to focus upon. There was further discussion on how to proceed with these results.

Action Items

1. The Graduate Questionnaire results will be reviewed by the ECC members and specific items to address will be discussed at the October 25, 2016 meeting.

Item 3, Part Two Annual Report Follow Up
Presenter: Kim Tartaglia

Discussion

1. Dr. Tartaglia presented follow up data from the annual report based on information obtained after completion of this year's first ring. The areas of focus were:
   a. Increased student satisfaction with ground school in UPWP and UPSMN by 20%
   b. Adjust designation (Honors/Letters) cut-offs to be within 25% of approved cut-offs.
   c. Improve quality of direct observation in UPRSN ring by 20%
   d. Implement a VITALS drop-down list to obtain more granular data on the learning environment for SECI
2. Dr. Tartaglia's report focused on items (a) and (c). There was no improvement in quality of direct observation, awaiting implementation of a plan to increase the quality of direct observation utilizing expert educators.
3. Changes were made to ground school in UPWP and UPMSN with improvement in the student satisfaction exceeding the 20% goal by

increasing interactive didactics and shortening portions of ground school.
4. Specifically focusing on Tuesday didactics, improvements were seen in UPWP based on their move to more interactive learning whereas there was no change in UPSMN where their didactic sessions simply realigned.
5. Dr. Tartaglia also noted that there have been improvements in HSIQ satisfaction in LSI Part 2 due to changes made to the curriculum.
6. Dr. McDougle asked about item (d), the drop-down list in VITALS. Dr. Tartaglia noted that this should be fully implemented by January.

Quality Improvement Action Items

1. None at this time as this was an interim report. Dr. Tartaglia will report back to the group during her next annual report.

Item 4, Quality Improvement and LCME Standards
Presenter: Mary McIlroy

Discussion

1. Dr. McIlroy suggested that the new LCME requires that a medical school have an ongoing quality improvement program based on the standards which will also impact the ECC. She presented a framework for meeting this requirement.
2. Dr. McIlroy noted that there is some flexibility in how each school maintains compliance with the standards. She and Dr. Westman have identified standards that are frequently cited. They have suggested that for each of these standards, how frequently it will be monitored and who is responsible for this monitoring. Several examples were provided including a review of the educational objectives, central monitoring of required clinical experiences, student evaluations and student outcomes.
3. There was a discussion on documenting clinical requirements in LSI Part 1 of the curriculum.
4. They have also suggested specific items that must be collected (Standard 6) and monitored (Standard 8) by each part of the curriculum.
5. Ultimately, this will be fed into a comprehensive Balanced Scorecard that includes areas of responsibility. ECC will be responsible that for several areas under Standard 8.
6. Two other items under development: a CQI Process Handbook and various Training Components. She suggested that we adopt a simple method for quality improvement activities such as PDSA as we review data.

7. Dr. McIlroy noted that the LCME Secretariat has a monthly webinar that emphasizes continuous monitoring, ongoing assessment and loop closure. She noted different topics have been covered including student independent learning, narrative assessment of students, timely feedback, independence of the Admissions Committee and resident teaching education.
8. She noted that one institution (LSU) starts their Independent Student Assessment two years before their LCME visit and incorporates their feedback as they prepared for their review.

Quality Improvement Action Plan

1. No actions at this time as the Continuous Quality Improvement plan is still under development
2. Recommend that ultimately the ECC should have dedicated time set aside for CQI follow up with Dr. Tartaglia's report serving as an example of such activities

Item 5, LSI Part 1 Internal Review
Presenter: Laurie Belknap

Discussion

1. Dr. Belknap presented the task completion timeline along with specific needs of the Committee including:
    a. recent LCME self-study and report (2014)
    b. prior internal reviews for ISP, IP and Med 3/4
    c. administrative support
    d. structure chart for LSI Part 1
    e. USMLE data
    f. ECC minutes and presented data
2. There was a discussion on the final timeframe. The Committee proposed an August 2017 completion. There were concerns about whether any changes could be implemented for the following year based on this timeline. It was suggested that a May completion would allow June ECC report presentation and analysis, further allowing for implementation of any changes in the coming year. Dr. McIlroy suggested a target of completion within the next 6 months.
3. Dr. Belknap also suggested in order to accommodate the timeline that additional Committee members may be required.

Action Plan

1. The ECC moved and approved revised timeline with completion of the report by the end of March (six months).

Wexner Medical Center	The Ohio State University College of Medicine	
	Executive Curriculum Committee	
	Meeting Minutes	
	Date: 10/25/16	Location: 150 Meiling

Presiding Chair: Howard Werman, MD	Call to order:	4:05 pm
Minutes recorded by: Casey Leitwein	Adjourned:	5:35 pm

Member attendance

Name	Role	Present
Howard Werman	Chair, Faculty member	Y
Jose Bazan	Elected Faculty Member	Y
Laurie Belknap	Faculty Member	Y
Douglas Danforth	Academic Program Director, LSI Part One	Y
John Davis	Associate Dean for Medical Education	Y
Mary Fristad	Chair, Academic Review Board	Y
Sorabh Khandelwal	Residency Program Director	Y
Nicholas Kman	Academic Program Director, LSI Part Three	Y
Nanette Lacuesta	Assistant Dean, Affiliated program	Y
Cynthia Ledford	Elected Faculty Member	Y
Thomas Mauger	Chair, Clinical Science Department	Y
Leon McDougle	Academic Program Director, Associate Dean Diversity	Y
Andrej Rotter	Faculty Member- Faculty Council Rep	Y
Charles Sanders	Assistant Dean, Affiliated program	Y
Jonathan Schaffir	Faculty Member	Y
Larry Schlesinger	Chair, Basic Science Department	Y
Kim Tartaglia	Academic Program Director, LSI Part Two	Y
Lindsay Boles	Med Student Representative	Y

Additional attendees: Nicole Verbeck, Curt Walker, Victoria Cannon,

Agenda items

Item 1, Approval of Minutes

Item 2, Graduate Questionnaire Follow up

Item 3, Post-Baccalaureate Program

Item 4, MICRO Report

Item 1, Approval of last meeting's minutes

Discussion

1. The meeting minutes from September 27, 2016 were reviewed by the ECC. The minutes were approved by the committee. In follow up to the minutes, Dr. Belknap reported that there will be a completed report from the Part 1 Review Committee by the May ECC Meeting.

Item 2, Graduate Questionnaire Follow Up
Presenters: Nicole Verbeck, Victoria Cannon

Discussion

1. Dr. Werman asked if there were any areas that specifically needed to be addressed by the ECC based on last month's report
2. Dr. Belknap had reviewed the written comments from students and identified some common themes. She noted that there were frequent changes in the curriculum with many of the changes implemented during the academic year. There was also concern about the variation in quality for both lectures and Articulate modules. Some students expressed concerns about a lack of identified texts or other resource materials for a given module. Students requested more interactive learning content. She also noted that there was a lack of understanding among students in distinguishing independent learning and self-directed learning. Finally, there were concerns about extraneous activities in the curriculum.
3. Dr. Belknap's summary is that the curriculum needs to have greater consistency in overall quality and specific content. She suggested that this is a time to re-evaluate the methods of asynchronous learning. Ms. Cannon reported that this review is currently underway. This was specifically applied to the Pharmacology module where poor student evaluations have been addressed. Dr. Ledford noted that LSI students have had more consistency and feedback than under the old curriculum.
4. Dr. Belknap noted a disconnect between qualitative and quantitative responses on the survey. She also pointed out that there were numerous positive comments, especially related to faculty teaching.
5. Written comments indicated that during clinical rotations, the students wanted better oversight and more direct feedback. This was noted on the written survey responses as well. Dr. Tartaglia noted that it is difficult to interpret the feedback results especially given the fact that this is a new question.
6. There was a suggestion that we consider the proportion of active versus passive learning among students. This will increase learner

engagement. Dr. Schaffir reported that he had received negative feeback regarding active learning in the Articulate modules.

7. Dr. Schlessinger stated that we should continue to focus on the satisfaction with the basic science education. Dr. Davis asked that the ECC develop goals based on the national data, including national percentiles. Should we consider a 50th %ile or 75th %ile or should be consider absolute number in developing a dashboard for the ECC? These parameters should be matched with hard outcomes on Step 1 scores. Dr. Ledford suggested we focus on areas that have a drop in scores as well as those below the national average. Those areas included microanatomy/histology, pathology, neuroanatomy and pharmacology.
8. Dr. Danforth noted that Step 1 scores on pharmacology did correlate with low student satisfaction whereas other topics scored well on Step 1 results. Dr. Lacuesta suggested that the perception of teaching was still important – Dr. Davis suggested that low USMLE score and low satisfaction might require a different solution. Dr. Danforth reminded the group that there is a temporal delay in the results considered in the Graduate Questionnaire and that long-term trends are important.
9. Dr. Tartaglia suggested that only the direct observation scores were concerning as it relates to the Part 2 data on the GQ Survey. Dr. Belknap noted variability is experiences in required rotations, in particular Family Medicine. She noted that this was particularly problematic in ambulatory rotations. Dr. Davis noted that we already have a methodology to assess consistency in these experiences based on our evaluation of the OB/GYN rotation. Dr. Khandelwal noted that faculty teaching in both Surgery and OB/GYN scores were low on the survey. Dr. Schlesinger suggested we determine if specific individuals are disproportionately contributing to lower scores. Dr. Khandelwal suggested that other factors such as cultural and environmental factors might contribute. Dr. Kman suggested that we make this an action item. Dr. Tartaglia noted that resident teaching in Psychiatry were lower than the national average.
10. There was a discuss about setting both attainable (50th percentile) and aspirational goals (75th or 90th percentile)
11. Dr. Khandelwal brought up the high number of neutral or below responses to the role of diversity in contributing to medical education. Dr. McDougle noted that this is the subject of an ongoing study. We will send out trends in our data and compare to national trends. Ms. Verbeck will send out the diversity

Action Items

1. Part I program will return in 6 months and report on underperforming basic science areas as identified by the ECC:

microanatomy/histology, pathology, neuroanatomy and pharmacology.
2. Part 2 in 3 months to report on consistency of clinical experiences in required courses, identifying and addressing underperforming clinical sites.
3. Part 2 in 7 months will identify and address factors related to low teaching scores in Surgery and OB/GYN, with a specific focus on underperforming teachers.

Item 3, Post-Baccalaureate Program
Presenter: Leon McDougle, Nikki Goldsberry

Discussion

1. Dr. McDougle presented information on the MedPath program. Eligible students are targeted by an entering MCAT of 21-24 with the goal of achieving an entering MCAT of greater than 25. Students participate in a comprehensive science curriculum as well as an MCAT prep. There is substantial financial support for incoming students.
2. Of 15 students accepted, the average GPA attained was 3.59 in coursework with one of 15 failing to achieve the MCAT metrics needed to matriculate. Eleven students had an increase of 5 points or greater on the MCAT with a current matriculant average of 30.
3. Concept mapping has been fully integrated into the MedPath curriculum with coaching provided during the first semester of the program.
4. Matriculating students get a copy of USMLE First Aid as well as tutoring by a successful senior student utilizing Q-Bank study questions. Recent first attempt pass rates are high (between 75-100%) with only 3 students in the past 4 years being unsuccessful.
5. Residents and fellows have been enlisted to serve in a mentoring program. Feedback on this program has been mixed, often based on effort of the student.
6. Introduction to Pathophysiology was the only poorly rated class, thought to be secondary to the fact that the class was only provided as an on-line offering.
7. There was also some negative feedback received on availability of the program leadership.
8. Dr. Kman asked about awareness of the program leadership regarding MedPath graduates who are struggling in the LSI curriculum. The program is made aware of through Ms. Golberry's participation in the Student Progress Committee.
9. It was suggested by Dr. Davis that additional feedback on the program be obtained from MedPath students after year 1 of the curriculum.

10. Dr. Schlesinger requested whether he might address the students to discuss the MSTP program to generate interest. Additionally, he offered to open the MSTP student organizational meetings to MedPath students.
11. Compliments were offered regarding the improvement in the MCAT and Step 1 scores. Dr. Ledford asked if this could be offered as a certificate program. Dr. McDougle has been exploring a Masters degree.

Quality Improvement Action Items

1. Get additional program feedback from MedPath students after year 1 of the LSI curriculum to gather meaningful data.
2. Follow Medical Knowledge scores of MedPath students following implementation of the Concept Mapping learning strategies.

Item 4, MICRO Report
Presenter: John Davis

Discussion

1. No report, minutes will be posted in the Box account

THE OHIO STATE UNIVERSITY COLLEGE OF MEDICINE	**The Ohio State University College of Medicine**	
	Executive Curriculum Committee	
	Meeting Minutes	
	Date: 11/22/16	Location: 150 Meiling

Presiding Chair: Howard Werman, MD	Call to order:	4:10 pm
Minutes recorded by: Casey Leitwein	Adjourned:	6:05 pm

Member attendance

Name	Role	Present
Howard Werman	Chair, Faculty member	Y
Jose Bazan	Elected Faculty Member	Y
Laurie Belknap	Faculty Member	N
Douglas Danforth	Academic Program Director, LSI Part One	Y
John Davis	Associate Dean for Medical Education	Y
Mary Fristad	Chair, Academic Review Board	Y
Sorabh Khandelwal	Residency Program Director	Y
Nicholas Kman	Academic Program Director, LSI Part Three	Y
Nanette Lacuesta	Assistant Dean, Affiliated program	Y
Cynthia Ledford	Elected Faculty Member	Y
Thomas Mauger	Chair, Clinical Science Department	Y
Leon McDougle	Academic Program Director, Associate Dean Diversity	N
Andrej Rotter	Faculty Member- Faculty Council Rep	N
Charles Sanders	Assistant Dean, Affiliated program	Y
Jonathan Schaffir	Faculty Member	Y
Larry Schlesinger	Chair, Basic Science Department	Y
Kim Tartaglia	Academic Program Director, LSI Part Two	N
Lindsay Boles	Med Student Representative	N

Additional attendees: Nicole Verbeck, Curt Walker, Allison Macerollo, Kristin Rundell, Erika Bruce

Agenda items

Item 1, Approval of Minutes
Item 2, Medical Scientist Training Program
Item 3, ECC Discussion of Step 2 CK/CS Results
Item 4, PCTE Grant & Primary Care Tract
Item 5, MICRO Report

Item 1, Approval of last meeting's minutes

Discussion

1. The meeting minutes from October 25, 2016 were reviewed by the ECC. The minutes were approved by the committee. In follow up to the minutes, Dr. Werman asked if there were any action items to the Graduate Questionnaire diversity questions. The Committee did not suggest any specific action items but instead will ask Dr. McDougle to identify any areas that need to be addressed.

Item 2, Medical Scientist Training Program
Presenters: Dr. Schlesinger, Ashley Bertran

Discussion

1. Dr. Schlesinger presented information about the Medical Scientist Program to the members of the ECC.
2. Dr. Schlesinger noted that there are two physician/scientists that direct the program with the assistance of two administrative staff.
3. He noted that there are three core disciplines including biomedical science graduate program, neuroscience graduate program and biomedical engineering. Affiliate programs are growing and currently include biophysics, chemistry, microbiology and public health.
4. Dr. Schlesinger presents information on the program schedule noting that students have required lab rotations during their first two summers, that there are sessions called MSTP roundtable that insure continuity during the medical school curriculum and that students are presented with materials for Host Defense early in the curriculum. By December of year 2, students are beginning their graduate work. A modified option exists for biomedical engineering graduate students. Finally, he noted that they have added MSTP Roundtable sessions focusing on bioethics hosted by Drs. Nash and Fernandez at the end of their graduate training as well as into years 3 and 4.
5. He noted that there has been steady growth in the program that is now up to 70 students. Students enter medical school with high GPA and MCAT scores. The program is 37% female, above the national average of 33%. Dr. Schlesinger noted that more recent applicant pools to our program have included a significant number of women. He also pointed out that the program includes 15.3% URM with an aspirational goal of 30%. He discussed several strategies to increase this number with two 'reverse pipeline' programs at the University of Maryland – Baltimore County and the University of Puerto Rico Humacao.

6. Dr. Schlesinger reviewed the success in external funding for the program including the University Fellowship programs (five funded) as well as the NIH F30/F31 programs (7 funded or pending funding).
7. Dr. Schlessinger noted that the overall attrition from the program has been less than 5%. Recent performance on Step 1 was reviewed with no failures in the 2013 and 2014 entering classes. Four students have had either academic or personal LOA's during this time.
8. Dr. Schlesinger reviewed some areas of recent concerns: Host Defense materials are introduced earlier in the curriculum and there seems to be less angst among the students; one student failed the block and is repeating with medical student peers. He noted that there are occasionally conflicts with required classwork between graduate school and LSI curriculum in autumn of year 2. He is working with the COM leadership to assure that alternative materials for learning are available. Finally, an MSTP study sessions are planned for Step 1 in December due to the earlier deadline.
9. Dr. Schlesinger discussed the recruitment process. This year, they have received over 240 applications, up 76% from the previous year. The goal is to offer 30 places for a final class of 10 students. Dr. Schlesinger discussed how the admission process is integrated with the COM admissions process as well as their Second Look Weekend.
10. Several initiatives were highlighted:
    a. a mentoring academy selected by incoming students
    b. an advanced competency in research topics beginning in Med-3 years including topics such as technology/commercialization, intellectual property, leadership/team science, industry connections, research ethics
    c. a bioethics seminar as noted above
11. The program is focusing on diversity within the program. Several initiatives were presented including:
    a. active engagement with the Office of Diversity and Inclusion
    b. attend a conference on diversity and inclusion
    c. SUCCESS program which specifically targets URM
    d. attending graduate and professional school recruiting events
    e. targeting specific universities as noted above

Action Items

1. continue to monitor diversity within the program with regards to URM's and gender
2. monitor performance on USMLE Part 1 and Host Defense block

Item 3, ECC Discussion on Step 2 CK and CS Results
Presenter: Curt Walker

Discussion

1. Dr. Walker noted that the results presented represent those students who took the examination in academic year 2015-2016. These results are primarily Med 4 scores with a few Med 3 results.
2. Considering first time takers for USMLE Part 2 CK results, the OSU pass rate was 98% with an average score of 251; this compared to a US Medical School pass rate of 96% and average score of 242. This compares to the prior year pass rate of 96% and average score of 246 for 2014-2015.
3. Dr. Lynn noted that students who fail Part 2 CK are not getting interviews for resident positions. A discussion ensued to better understand the factors that identify students at risk for failure.
4. A bar graph showed that OSU students' distribution trended towards higher scores when compared to national distributions.
5. The scores for individual knowledge areas were presented with all areas above the national mean. These scores will be distributed to the LSI Part 2 faculty.
6. A graph of OSU performance each year compared to the national average showed that OSU COM students have persistently been above the national mean and national pass rates.
7. Dr. Walker presented data on USMLE Part 2 CS. The OSU COM pass rate was 98% compared to a national average of 97%. OSU students met or exceeded national scores on all of the subcomponents of the examination. This held true for academic year 2014-2015.
8. OSU COM students have met or exceeded the national average since 2011 in USMLE Part 2 CS scores.

Quality Improvement Action Items

1. Dr. Curt Walker, Laura Volk, Dr. Lynn and Dr. Tartaglia will form a task force to exam the shelf examinations and other factors to identify students who are at risk of failing Step 2 CK will be identified for early intervention and report back to the ECC within 3 months

Item 4, PCTE Grant & Primary Care Tract
Presenter: Dr. Macerollo, Dr. Rundell, Erika Bruch

Discussion

1. Dr. Macerollo and Dr. Rundell reported on the Primary Care Training and Enhancement Grant provided by HRSA. The purpose is to develop, implement and evaluate innovative education and training initiatives designed to prepare future primary care health professionals to practice in and transform health care delivery systems. The goals of the grant were reviewed including the

promotion of interdisciplinary education, provide enhanced education to prepare for a future in health care leadership and the development of a three-year Primary Care Family Medicine track.

2. Based on the first two objectives of the grant, nine enhancements and refinements to the LSI curriculum are being proposed. Eight of the nine were presented for approval by the ECC. Students will declare themselves as possessing either a primary care interest or participants in the primary care track.
3. The nine refinements/enhancements were presented by Drs. Rundell and Macerollo including:
    a. Primary Care Longitudinal Group (LG+)
    b. Interprofessional Longitudinal Practice (LP+)
    c. Interprofessional Case Management for Working with Underserved Populations (ICM+)
    d. Interprofessional Community Health Education Project (CHE+)
    e. Nurse Practitioner Student/Medical Student Team Health Coaching Project* (HC+)
    f. Patients Within Populations Interprofessional Clerkship (PWP+).
    g. Modified Health Systems Informatics and Quality Project and
    h. Clinical Transformation (HSIQ+)
    i. InterprofessionalAdvanced Management of Relationship-Centered Care (AMRCC+)
    j. Advanced Competency in Hot Spotting (HS+)
4. Each of the components were reviewed and discussed by the ECC including which students (and how many) would be eligible to participate in each of these initiatives. At timetable for implementation was also presented. It should be noted that activity (d) has already been approved by the ECC.
5. The 3-year Primary Care Track was then presented to the ECC. To goals were to increase the number of students with an interest in Family Medicine, to train those students more efficiently and with less debt and to address the national shortage in Family Medicine.
6. A spreadsheet was reviewed which compared the proposed 3 year curriculum to the current LSI curriculum. It was noted that all of the core learning objectives from LSI were covered in the proposed curriculum. ECC members were asked to review the proposal for further discussion at the January meeting.

Action Items

1. The ECC reviewed the proposal presented by Drs. Rundell and Macerollo and after careful consideration, approved the enhancements and refinements proposed

Item 5, MICRO Report
Presenter: Dr. Davis

Discussion

1. Dr. Davis reported that the minutes from the past two meetings have been posted in the Box account for review. There were no action items to be brought forth