**UW SCHOOL OF MEDICINE**

# Longitudinal Integrated Clerkship (LIC) Working Group

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Frank Batcha, MD – Co-Chair
Jennifer Wright, MD – Co-Chair
Daniel Bechtold, MD
Danielle Bienz, MEd
Heidi Combs, MD, MS
Daniel Cornish, MD
Barb Doty, MD
Kellie Engle
Jay Erickson, MD
Michelle Fleming
Janelle Strampe, MS4
Laura Goodell, MD
Constance Lamb
Katie Martin, MD
Christina Marchion, MD
Vicki Mendiratta, MD
Richard Shugerman, MD
Sarah Wood


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**A. Make a recommendation to the Curriculum Committee about the optimal model(s) for Longitudinal Integrated Clerkships (LIC) at UWSOM.**

The workgroup contacted 10 institutions with LICs of various types to help investigate best practices (see appendix). These institutions varied from smaller regional campuses, to large city private schools, to a Canadian program. It became very clear that these schools had one of two models of LICs: 1) Multi-specialty based LICs that are more likely to be urban/small city based, focused on an improved pedagogical model, or 2) single specialty (primary care) based programs that are more likely to be rural and workforce focused.

1. Multi-specialty based LIC
    - Generally 10-12 months in length
    - Interspersed inpatient bursts 2-4 weeks long
    - Ranged from a few students participating to the whole class
    - There appeared to be a trend of more institutions developing LICs or expanding existing LICs
    - Outcomes compared with block style clerkships appeared to be equivalent based on USMLE scores, NBME test scores, and clinical grades
    - Developed based upon the hypothesis that this is a better structure for teaching medicine

2. Single specialty LIC
    - Outcomes compared with block style clerkships appeared to be equivalent based on USMLE scores, NBME test scores, and clinical grades
    - Workforce focused, generally on rural and primary care workforce needs

**Based on this information the LIC workgroup recommends the following:**

Within our large, diverse WWMAI region we feel there is an opportunity for expansion of two LIC models, while continuing to offer traditional block clerkships. There would be three different, mutually exclusive paths spanning the entirety of the Patient Care Phase that a student could take:

1. The traditional block model of clerkships, including both urban and rural teaching sites.
2. An expanded TRUST/WRITE patient care phase experience, with TRUST developed as an LCME Track*, and with WRITE developed as an independent course, focused on development of the skills required to become an excellent rural/underserved physician.
3. An expanded multi-specialty based urban or small city LIC patient care phase experience along the lines of the Olympia LIC.

**Multi-specialty model:**

The multi-specialty model as demonstrated in the Olympia LIC has a long track record of success in other programs. The University of Washington pilot Olympia LIC model has been successful in its educational goals but suffers from administrative difficulties. In order to address this, new multi-specialty LICs should have a standard structure, potentially decreasing the administrative burden. Additional potential sites may include Seattle (e.g. North Seattle within the UW/NWH groups), mid-size cities like Boise, Missoula, and Spokane. A goal would be to have a multi-specialty model available in each region.

**Single specialty model:**

The current TRUST/WRITE program has a long track record of success and has been a model for rural LICs both nationally and internationally. The current tension in this program is the administrative requirements of departmental oversight, the scheduling difficulties associated with departmental requirements, and the need to demonstrate curricular equivalence, all contributing to some

fragmentation of the continuity experience. Developing TRUST/WRITE as an LCME parallel track* and developing WRITE as a separate course could alleviate some of that tension.

**B. Make a recommendation to the Curriculum Committee regarding the efficient administration of LICs; where the responsibility for the curriculum should lie, oversight, learning objectives, assessment and evaluation and congruence in learning outcomes.**

Summary of administration practices of LICs surveyed:

- Oversight varied, from individual departments, to individual departments reporting to a LIC director, to a central oversight committee, to the individual site preceptor.
- There were multiple strategies for curricular equivalence/equity in grading and student assessment, ranging from individual department course objectives and shelf exams, to competency-based evaluations with overall patient care objectives as criteria. Several programs relied on OSCEs as part of the evaluation. Also, patient logging and web-based didactics were utilized.
- Faculty development strategies were varied, ranging from every 6 week visits to basically no formal faculty development.
- Administrative support varied but appeared more intense than traditional block style clerkships. In general, it appeared that most institutions offered significant financial support of their LIC programs. Administrative oversight varied as to central, regional, and local.

**The Committee recommends:**

1. An expansion of LIC opportunities.
2. The TRUST/WRITE model should become an independent parallel track* with its own curriculum, learning objectives and grading. To facilitate this, WRITE would be developed as a separate course, separate from the current clerkship model. The Departments will continue to offer support by sharing their learning objectives and the TRUST/WRITE leadership can apply what they feel is most applicable for their track. NBME shelf exams in the various specialties could still be used and may offer evidence of congruence in learning outcomes. The WRITE LIC will continue to need to be paired to an intensive inpatient block distinct from the traditional clerkships, this would be specialty based but specifically created to pair with the WRITE LIC experience, possibly in a select group of regional sites. This would allow for ease in scheduling, could potentially be closer to the WRITE site (e.g. Boise could host intensive inpatient to students doing WRITE in Idaho) and thus be more imbedded in the medical community that the student and their patients are working/living in, and could potential lead to teaching that is more focused on the future rural providers' learning goals. The implementation of this parallel track would require a new committee to help develop this parallel track, its curriculum and to help facilitate an efficient administration of this program.
3. The multispecialty LICs would get their leadership from the departments. There should be a designated LIC site director and administrator at each site who reports up to a central LIC director and administrator at the UWSoM to allow for standardization across sites and ease the administrative burden. Multispecialty LICs would be a full year experience at dedicated sites, ideally minimum of one per state,

with 2-3 in Washington based on regional class sizes. By creating multispecialty LICs in each state, our current state-specific tracks may be redundant. This could further ease the administrative burden of the registrar.

4. There needs to be a standardization of the content, timing and duration of all multispecialty LICs and the WRITE course, including the WRITE specific inpatient experience.
5. Traditional block clerkships would continue to be a mix of WWAMI sites across the 5-state region.
6. If significant student remediation or off-cycle time off was required, students could be moved into the traditional block clerkships for ease of administration.

**C. Capacity**

1. Based on the realities of our system (not necessarily the ideal driver) capacity will depend on availability of educators/teaching sites and funding.
2. Potential ways to help further clarify the capacity include:
    - An assessment of how many of the regional/rural single clerkship teaching sites exist. This will influence the recommended number of students who would need to continue to be in traditional block model clerkships.
    - An assessment of our mid-sized – large teaching sites regarding how many sites have all 6 core clerkships. These sites could be turned into multispecialty LICs.
    - TRUST/WRITE LIC intensive inpatient sites would ideally match the number of students in the TRUST/WRITE track in a given state.
    - The Committee considered going to an entirely LIC based patient care phase. However, this would contribute to loss of many of our rural and regional teaching sites. This would have an effect on capacity that would be unacceptable.

**Recommended Actions**

- UWSOM Academic, Regional and Rural Affairs Deans and Leaders to meet with University of Washington Registrar to discuss development and implementation of a non-department based program/course specifically regarding responsibilities faculty oversight, student evaluation, and grade assignment.
- Should the school decided to move forward, there is significant work that will need to go into the creation of the expanded full-year WRITE experience and a standardized multi-specialty LIC structure.

***LCME Designated Track**

LCME Definition: *Medical education track: A parallel program of study for a subset of the medical student body that requires participating students to complete specific programmatic learning objectives (e.g., in research, primary care, leadership) in addition to the medical educational program objectives required of all medical students. (Element 5.12)*