Clinical Skills Work Group Retreat
12:30 – 4:30pm, September 3, 2014
South Campus Center Room 346
Minutes

In Attendance: Amanda Kost, Margaret Isaac, Karen McDonough, Tom Greer, Tom McNalley, Jay Erickson, Michael Ryan, Kellie Engle, Sherilyn Smith, Lynne Robins, Sarah Shirley

Introduction/Updates

Dr. Michael Ryan gave an update on where the school is with the renewal process. UWSOM leadership are working with AMBiT project consultants to move forward with the 2015 start date. As of now, leadership members are identifying what work is absolutely necessary for the initial years of renewal, and what work can be moved into later years. For this work group, the UWSOM's hope is to work toward efficiency with all of the foundational clinical skills.

Overview of Current Courses:

ICM

Course Content

- Professionalism
    - Issues of professional development, including adjustment to the responsibilities and privileges of being a medical student
    - Continuity of care
    - Sensitivity and caring towards all patients, recognizing individuals' unique life experiences, culture, and values
    - Professional [and medical] ethics
    - Challenges in professional conduct related to biases, beliefs, and values conflicts in the medical encounter
    - Standards of professional conduct that include:
        - Appropriate appearance and demeanor in clinical settings
        - Responsible performance in commitments, appointments, and record keeping
        - Ethical conduct, especially regarding confidentiality and personal integrity
- Medical interviewing
    - Purpose and function
    - Specific questioning/listening/observational techniques
        - Patient-centered interviewing techniques/patient's narrative
    - Sensitive subjects
        - Sexuality/sexual history
        - Substance abuse/chemical dependency
    - Handling patient emotion
    - Specific populations
        - Pediatrics
        - Adolescents
        - Geriatrics
        - LGBTQ
    - Difficult interview
- Medical database/documentation
    - Gathering and organizing complete medical database

    - Documenting the complete medical database
        - History of present illness, including the patient's illness narrative
        - Past medical history (including medications, allergies, habits, and risk factors)
        - Family history
        - Social history
        - Review of systems
    - Problem list
- Physical exam
    - Standardized basic physical examination (perform and record), including use of medical instruments
- Oral case presentation
- Clinical reasoning (basic approach)

Delivery/Structure

- Seattle
    - Large group
        - Interactive (pair-share, ARS, patient interviews, panels)
    - Small group
        - Weekly (almost)
        - Balance of structured/unstructured
        - Volunteer faculty
    - Interviews (7/year) – includes SP, video
    - Physical exam labs
    - Other clinical activities (ENT tutorial, SNF visit)
- WWAMI Sites

Questions/Discussion:
Can you talk about the evaluation that goes along with the content? What kind of variation is there across the region?
Professionalism is evaluated by the small-group faculty. For medical databases and documentation, they do seven write-ups and interviews that are assessed by the small group leader. If there's a problem or concern course chairs go back and review these.

How many contact hours are there in ICM?
About 75 hours in Seattle, but it's variable across sites. Moscow-Pullman may have half the number of hours.

Do you have ICM every x day?
We have small groups about 26 days out of the year and have lecture for an hour each week. We also have about 7 interviews (at 7 hours) over the course of the year.

ICM 2:
ICM 2 is a year-long 13 credit course encompassing College mornings and afternoon lectures and small groups.

- Over the course of the year, each student will participate in:
    - 7 T wing tutorials
    - 6 full H&P sessions in hospitals
    - 12 bedside teaching sessions in hospitals

    - 1 Psychiatry tutorial morning
    - 1 Simulation workshop morning (including pharmacy students this year)
- Contact hours for the year ~ 75

Afternoon sessions include:

- Lecture topics:
    - Introduction & overview (1)
    - Care of the patient with life-threatening illness (2)
    - Clinical reasoning:
        - Developing an assessment (2)
        - Ordering and interpreting common labs (1)
        - Common clinical problems sessions (1/each)
            - Chest pain
            - Shortness of breath
            - Back pain
            - Shoulder pain
            - Dizziness and syncope
- Panel topics (2/each):
    - Patient panel: LGBTQ
    - Physician panel: Maintaining morale and momentum in medicine
    - Patient and family panel: Life-threatening illness
    - Physician panel: Shared decision making
- Skills small group topics (2/each):
    - Delivering serious news
    - Functional history and rehabilitation
    - Clinical reasoning: Chest pain simulations
    - Working with interpreters
    - Communicating with patient who have barriers to communication
    - Recognizing bias (new this year)
    - Clinical skills roundup
    - Clinical reasoning: another T wing simulation session, focus TBD
    - Interviewing patients with chronic pain
    - Outpatient skills
        - agenda setting
        - maximizing learning in clinic
        - outpatient notes & OCP)
    - Inpatient skills
        - PreroundinG
        - progress notes & daily OCPs
        - Specialty specific issues
    - Effective use of EHR (new, assuming we can get simulated EHR in place)
- Interprofessional small group topics (2/each):
    - Error disclosure
    - Care of veterans
    - Interprofessional ethics: A patient with heart failure who declines medications
    - TBD: disparities vs oral health
    - Costs of care (medicine/pharmacy only)

- 2 standardized patient sessions
- Pelvic exam tutorial

Questions/Discussion:
As a site director for a clerkship, I've noticed that students are not well practiced at efficient outpatient visits. Students know how to spend an extended time with patients in inpatient settings but aren't as strong with outpatient. Where is this being taught?
This was just added to the ICM curriculum last spring. We think that introducing the primary care clinical experience early on in the foundations phase will be very useful.

With the foundations curriculum renewal effort, we are trying to get people to think over four years. Perhaps we should ask that these skills be taught as a prerequisite during foundations, so students have these skills prior to the clerkship years.

In thinking about clinical skills for foundations, what can we teach students up-front, foundational, so that they can have these skills in context?
The group needs to consider both the content and the context in which clinical skills are being taught. Many RUOP programs have enabled students to do oral case presentations.
The group should also come up with a consensus about what content the clinical skills and patient care courses are delivering. What skillsets should students bring with them to the clerkships vs. what they should learn in the clerkships? This work should continue on into the fourth year.

Preceptorships:
The family medicine preceptorship is offered in two variations. The 501 preceptorship (all medicine and peds) is taught in 8 half days during any one quarter, while FAMED 502 is taken every two weeks for two quarters. Students identify the quarter they'd like to take the preceptorship and complete a survey regarding which specialty they prefer to take. The family med department then works to match students to their interests.

For the preceptorship, students will:
- Attend a mandatory course orientation with Jeanne Cawse-Lucas, course director
- Complete eight, four-hour preceptorship sessions (in one quarter for FAMED 501; over the course of two quarters for FAMED 502)
- Use the GLEAM tool with their preceptor to facilitate a conversation around the students' Goals, Learning style, Experiences, Activities, and More
- Complete a checklist for every session. The checklist describes certain required and optional activities for you to complete, either by observing or performing them, during the preceptorship. You do not have to do every item every time, but please observe and perform every required activity at least once.
- Read "Refocusing the System" by Barbara Starfield
- Do one case-based clinical presentation topic with their preceptor
- Complete at least one reflection on their experience by the end of the quarter on the Discussion Board
- Complete an electronic course evaluation

Questions/Discussion:
If a student takes the preceptorship in spring, could they get 3 credits for 502?
They can. Some students have been able to do this.

What kind of feedback have you gotten from faculty for students who've done the 502 option, over two quarters?
Many faculty members felt this setup worked, while others thought the bi-weekly visits made it take longer for the student to get integrated into clinic, and for the faculty to get to know the student. There have been mostly positive reactions, however.

In Montana, the preceptorships were structured much like pediatrics, where students would essentially shadow physicians. We wanted to make a more robust experience by using what's taught in ICM and see what should be practiced in preceptorships. There are currently 8 visits in the fall, 8 in the spring, and 6 required, with required write-ups and assignments, following the course content in ICM. There's still some variability but still a more robust experience. We think it would be good to hear from each site about what they do for preceptorships.

Chronic care clerkship:
In the chronic care clerkship, students will register to a single major clinical focus/discipline for the four weeks – physical medicine and rehabilitation, geriatric medicine, palliative and end of life care, or chronic pain management. Students will be involved in ward or clinic experiences, or other non-traditional clinically relevant activities, as well as case discussions and other activities in didactic sessions. Students are evaluated based on observation of preceptors, a comprehensive patient case write-up, and a presentation of the write up.

Questions/Discussion:
Regional instructors have struggled with getting broad experiences for students in the chronic care clerkship, but have done well with integrating with WRITE students. The work group discussed making content from Seattle available to the region online.

What do we want everyone to have at the end of medical school? How should we prepare them for this in third year and fourth year?
It seems like there is currently redundancy between the first year and the second year, and that this could be a good model for reviewing foundational skills. Many of the foundational clinical skills could be built into the foundations phase (such as an ADL analysis), or placed in a shadowing experience.

Under "guided observation," some students learn more this way so they can go through and give feedback. Under this model students are not giving grades, but can give feedback to other students to better help them learn. In Montana, Jay Erickson has students grade/evaluate him based on a PCC checklist.

Around this issue of the flipped classroom, online vodcasts could also be very useful. Students could look up how to do basic procedures or instructions on dosing, review the material, and then have it in-hand when they do the exercise in person.

Planned Clinical Skills: What is known, what is to be decided?

What is known about immersion?

- It will be 2 weeks at the start of school.
- Immersion will incorporate elements of orientation.

- Regional sites will be able to start earlier if they want to do other activities (such as rafting trips, etc.), but the core content will be the same.
- Students will not be able to choose their immersion site this year.

What needs to be decided about immersion?
- Flexibility of sites, and what components fit where (e.g., wilderness medicine)
- Content, teachers, assessment, etc.

What is known about clinical skills?
- Clinical skills will be one full day per week, with time shared with IPC3
- Clinical skills will incorporate ICM 1/2.

What do we need to decide about clinical skills?
- The number of contact hours
- How clinical skills will interface with colleges and IPCCC
- Content, teachers, assessment, etc.
- Will need to interface with block and thread leaders

What do we know about the colleges?
- Each site will have a college.
- Mornings are best for the college experience but can be variable by site.
- College experience will likely be a half-day every other week, for the entire 18 month experience.

What do we need to decide about the colleges?
- How much continuity are we giving our students?
- Where things are best taught?
- College faculty as teachers for additional content (immersion, clinical skills, PCCC?)
- Colleges content vs. IPC3 content
- Content, teachers, assessment, etc.

How much time do we need to devote to ensure that students have continuity and that the student-preceptor relationship develops?

IPCCC:
What we know:
- One full day per week (shared with clinical skills)
- Incorporates chronic care clerkship content
- Takes place in primary care physicians' practices and various locations as needed, to address IPCCC clerkship content

What we need to decide:
- Contact hours for various components
- Content, teachers, assessment, etc.

Comments/Discussion
Are we all teaching the same course together? Should we identify clinical skills as one thing?

We could consider the overall instruction of clinical skills as a "doctoring course" where we'll identify the best way to deliver the course to students with these various modalities. At a future retreat we could maybe identify another name for ourselves, and determine goals and objectives, and what to move forward with.

There was discussion of maintaining the Colleges' identity as a mentorship program and the "teaching of doctoring."

The work group emphasized the importance of ensuring that College faculty members are invested in this "teaching of doctoring" model and that there's a good balance between ICM and college teachers. Best possible model would be having a list of clinical skills and providing FTE support for faculty who'd be able to deliver the content of this overarching course.

What else need to be decided?
The work group needs a timeline. Additionally, some work group members are considering visiting regional sites. It will be important to include the site directors, clinical directors, and ICM directors in further clinical skills discussions. Regional representatives will be included in future meetings, and the work group should look into

From the region, we have to identify how much clinical need there is in terms of hiring faculty. What's going to happen very quickly is finding/identifying the clinical faculty and what kind of time commitments they'll have (like approximate FTE requirement). The regional sites need to have this information by around January.

What is driving the content in clinical skills?
The group could work off of the reference list of general physician competencies, and the LCME guidelines. The group could consider mapping the content and coming up with different options/packages to present to the region.

SWOT (Strengths, Weaknesses, Opportunities, and Threats)

Montana SWOT:

- Strengths:
    - Great ICM faculty with long history of teaching
    - Large number of PC preceptors
    - Integrated ICM/preceptorship experience
    - Support from hospital for teaching-new WWAMI campus at BDH
    - Livingston untapped for teaching (25 min drive from Bozeman)
    - Assoc. WWAMI director MD actively involved
    - Significant interest in teaching with WWAMI in Bozeman from physician's in area
    - Working into local WWAMI budget physician reimbursement for teaching
- Weaknesses:
    - Limited to only one day per week (Wed) could be problematic
    - Limited time to develop curriculum and preceptor involvement
    - Faculty Development resources
    - Funding
    - Geography
- Opportunities
    - Great support from WWAMI first year dean

    - Mike Spinelli- WWAMI assoc director
    - Native Health Coordinator
    - Zach Meyers
    - CEO BDH
    - New WWAMI budget being created at MSU-ability to fund new positions
    - IPE at MSU
    - Ability to incorporate multiple learners at various levels

- Threats:
    - Lack of regional involvement in planning for new curriculum
    - Change in delivery of health care, large organizations
    - Stresses on primary care practices
    - Effect one person can have on curricular change or lack of it

Alaska SWOT

- Strengths
    - Cohesive faculty that have a single vision and work well together.
    - Approachable/accessible clinical faculty.
    - Early and frequent clinical time.
    - Excellent and brand new teaching facilities (including high tech simulation lab)
    - PA/Nursing/WWAMI/lab tech program all in same bldg: starting interprofessional training this year to include students being paged by nursing students for communication skills experience and simulation lab with simulated cases and interprofessional teams.
    - Supportive hospital climate (students welcomed)
- Weaknesses
    - Need more primary care involvement from community (specialists more willing to mentor students than primary care)
    - Need administrative support for the clinical course/activities as logistics are a big component
    - Excellent clinical faculty available only one day during week as they are in clinical jobs for other 4 days (new curriculum should respect this by keeping one clinical day per week to include a pattern of college, small group ICM, LCE experience)
- Opportunities
    - Smaller environment lends itself to integration between ICM/college curriculum/LCE
    - Anchorage Fire Department Medical Director is interested in getting involved with students
    - 3 hospitals to achieve college curriculum
- Threats
    - As noted in weaknesses: clinical faculty available one day per week.
    - Limited teaching faculty so will need to overlap between college and ICM faculty
    - Really need to start recruiting NOW to get great faculty….they are hard to find. The sooner we know their time commitment and compensation, they sooner we can get started!

Idaho SWOT

- Strengths

    - UI ICM Course: Our site does a great job of offering students personal attention. We have some experience with "front loading" ICM to teach the history and physical in the first 10 weeks of the first year. We currently have access to clinic exam rooms after hours for teaching physical exam. We have also had access to a simulation lab at Pullman Hospital.
    - UI Preceptorship Course: We are able to offer a preceptorship to each student for each semester. Many of these preceptorship experiences are hands on…not just shadowing. The degree to which each student has "hand on" experiences is very variable – depending on preceptor style and comfort.
    - Small class size – the class becomes very close knit here
- Weaknesses
    - UI ICM Course: Our site faces a challenge recruiting local teaching faculty from Idaho. Primary care providers in our region are currently very busy! We do have new providers coming to the area though. Over the years we have depended on clinicians from the entire region: Moscow, Pullman, Colfax, Lewiston and Clarkston for clinician preceptors. Our students frequently travel for preceptorships.
    - For ICM, the clinics we use for teaching physical exam are located in 2 different communities, 8 miles apart which makes things interesting
    - Our region does not have a specialist for every discipline.
    - Our hospitals are small. We have learned not to rely only on inpatients for clinical interviews.
- Opportunities
    - UI ICM Course: Nurse practitioners in the area are a resource we have not used.
- Threats
    - UI ICM Course: See weaknesses above.

Future Work and Future Meetings

Look into the consideration of competencies taxonomy document. Sarah will send out summaries/reports from previous committees' work regarding clinical skills. A curricular mapping program is also on its way. The work group can do some work

The work group should determine detailed learning objectives and milestones for clinical skills. There was discussion of doing a sorting activity across the foundations phase in a later meeting.

What is the deadline for this work?
November 1, for identification of competencies and mapping of learning objectives.

- **Action item:** AA staff will find the survey of clerkship directors regarding what they expected of students on day one of clerkships. The work group can use this to further determine competencies and milestones.

- **Action item:** The work group should identify who best to contact regarding clinical skills for each site. This will be done through consulting either regional reps, or Suzanne Allen and Jay Erickson.

- **Action item:** The work group should review SWOTS for each site and ensure that they're accurate.

- **Action item:** Sarah Shirley will schedule meetings through the academic year (summer 2015) and will begin scheduling for future retreats.