Agenda

Curriculum CommitteeMeeting
September 13, 2012
4:30-6:00 PM
G403 Medical Center

1) Approval of Minutes of Last Meeting - Appendix A (Vote)

2)Update on ED5a, ED33 and ED21 Citations(Brian Dzwonek)

3) Competency Committee Update(Brian Dzwonek, Bobby Miller)

4)Approval of MSI and MSII Block Leaders (Will McCumbee, Susan Jackman)

5) Set date and venue for October Curriculum Retreat (Brian Dzwonek, Bob Miller)

6) Discussion and Vote on CC Approval of Fourth Year Electives (Brian Dzwonek)

7) Diversity Learning Modules Proposal (Darshana Shah)

8) New Business

9)Adjournment

10)Next regular meeting –4:30-6:00 PM, October 11, 2012

Appendix A – Curriculum Committee Meeting Minutes – August 28, 2012

Appendix B - Diversity Learning Modules Proposal

Appendix A – Curriculum Committee Meeting Minutes – August 28, 2012

CURRICULUM COMMITTEE MEETING MINUTES
08/28/2012

Present: Brian Dzwonek (Secretary), Richard Egleton, Paul Ferguson, TigranGarabekyan, Carl Gruetter (Chair, via Facetime), Elaine Hardman, Rebecca Hayes, MSIII, Susan Jackman, Hisham Keblawi, Will McCumbee, Farid Mozaffari , James Rollins, Bobby Miller (Acting Chair), Dilip Nair, Laura Richardson, Jonathon Seibert, Amy Smith, Nancy Webb, Sasha Zill

Absent: Wesam Bolkhir, Chuck Clements, Piyali Dasgupta, Elizabeth Evans, Jonathan Hess, Sean Loudin, Charles Giangarra, Justin Tolbert, Farid Mozaffari

The meeting started at 4:35 pm

1) **Approval of Minutes of Last Meeting - Appendix A** (Vote)

The minutes of the August 9, 2012 CC meeting were approved with the following revisions

- Jessie Shields has been replaced on the committee
- Justin Tolbert was absent
- Elaine Hardman and Rebecca Hayes were present
- The requested to OME for a demonstration of the iPad should be reworded as the request was not from Dr. Jackman
- Dr. Gruetter name misspelled

2) **Discussion of Possible Role of Competencies to Guide and Assess Integration within the Curriculum (**Bobby Miller)

Dr. Miller provided a brief history of Competencies. Graduate Medical Education is funded by the U.S. Government. How does the Government know they are getting a quality product? In the mid to late 90's the U.S. Government asked the ACGME to prove that they were producing competent physicians. The ACGME created six Core Competencies, which are our Institutional Objectives.

Those core competencies have been indoctrinated into all facets of the graduate level training of doctors. The competencies are the six Institutional Objectives of JCESOM, items below these are milestones, and Competencies frame a developmental process. Competencies are like the Dreyfus model of skill acquisition. An individual starts as a Novice then that individual moves through the following stages, Advanced Beginner, Competent, Proficient, and Expert. The Competency is at the end; the development occurs as you move through the stages to the competency and that is how development gets integrated into the framework. The ACME Competencies provide a framework for vertical integration as they are based on a developmental model. Students cannot move forward with the content without the foundation of knowledge for that content.

Dr. Miller indicated that the 124 page Pediatrics Milestones (Competencies) define all aspects of the curriculum as well as setting milestones. For undergraduate medical education, there is a foundation of knowledge and an outcome expectation, as an institution we have not defined the steps required to reach these outcomes.

Dr. Nair registered a concern about Competencies in Graduate Medical Education and asked for an opportunity to voice his concern if the opportunity presents itself.

Dr. Richardson indicated that after some reflection she understood that Competencies are part of an educational model referred to as the "three legged stool" of course design. Dr. Richardson elaborated that the first leg of the stool is to establish Objectives so that you know where you are going before you set out on a journey and when you get there you know you have arrived. The second is Assessment or how you know when you have arrived and the third is the Content and Pedagogy which is the journey to the Objectives.

Dr. Richardson voiced a concern that she is having difficulty understanding why the Curriculum Committee is being asked to consider a new model for the Curriculum when they have already voted on and have been working on a Systems Based Model of the Curriculum.

Dr. Richardson asked the Committee to consider the Competencies as the Objectives (first leg) for the Block Courses. She felt the members of the Blocks need to have some input into the objectives. Dr. Richardson voiced a concern that this process may take us off course on the planning of the curriculum but felt the Competencies represent a valid tool for organizing the curriculum.

Dr. Miller suggested that the Competencies provide us with a set of terms that frame the curriculum and allow us to describe the curriculum in an integrated way.

Dr. Richardson asked the Competency Committee to answer two questions, what do you want the students to know when they start medical school (the baseline level of knowledge) and where do you want them to be when they finish year 1-4.

Dr. Miller confirmed that Competencies are intended to accomplish this goal.

Dr. Egleton indicated that there is a separate committee working on student entry requirements and that it would be useful to consider what is expected of students who enter the medical school.

Dr. Dzwonek referenced the report of the Howard Hughes Medical Institute/AAMC working group that sought to outline the expectations of students entering medical school and reinforced the Scientific Foundations for Physicians.

Dr. Egleton reported that Pharmacology has core Competencies (146 pages) available as a reference.

Dr. Richardson asked that the Competency Committee report contain a list of Competencies that can be applied to the existing curricular model. The Competency Committee should create a list of Competencies for each year; this is the next step for organizing the Block Curriculum.

Dr. Egleton suggested Competencies provide us with a set of outcomes and that this is part of the LCME Action Plan. Dr. Egleton noted that as the new model does not have courses with grades there must be other outcomes that can be measured; the minimum expectations that a student should meet. Dr. Egleton suggested that when the current course objectives are combined from separate courses, Competencies can facilitate the task of unifying the objectives.

Dr. Nair made a motioned that at the next meeting the Curriculum Committee that the members of the committee, having reviewed the UNC framework, vote on adopting the UNC framework.

Dr. Miller suggested that the Committee use this or another framework to develop our own Competency framework which would allow more control of the final product.

Dr. Miller suggested that the LCME allows schools to adopt AAMC or ACGME frameworks for organizing their curriculum.

Following discussion the proposal was rewritten to clarify the scope of the Competency Committee's work. The changes have been integrated into the proposal in Appendix B.

3) Discussion and Possible Vote on Formation of a Competency Committee – Appendix B (Brian Dzwonek)

Following Committee Revisions to the *Proposal for Formation of Competency Committee* (attached below) the Curriculum Committee voted to approve (1 vote against) the formation of a of Competency Committee.

4) Discussion of Use of iBooks in the Curriculum (Richard Egleton)

Dr. Egleton voiced two concerns related an iBook download tab on the JCESOM Course Website. The first concern was that by placing a link on the Course Website without consulting the faculty or informing the Curriculum Committee, the action violated the role of the Curriculum Committee to oversee the curriculum. The second concern was that since the material was from the previous academic year students may be confused by the material.

Dr. Egleton suggested that if the Office of Medical Education is interested in gathering student feedback on the iBook format that a student focus group might be a suitable venue.

There was a motion that the link to the iBook format be removed. The motion was approved.

5) Other Business
No other business

6) Adjournment
The meeting was adjourned at 5:56 PM

8) Next regular meeting – 4:30-6:00 PM, September 13, 2012

Submitted by Brian Dzwonek

A Proposal to Establish a Competency Committee

August 28, 2012
Brian Dzwonek, Ed.D.
Associate Dean of Medical Education
JCESOM

Overview: The following is a proposal to establish a Committee to define Competencies for the JCSOM curriculum in response to the LCME citations for ED-5-A and ED-33 and the related LCME Action Plan as outlined below.

LCME Citations and Action Plan Items

ED-33 Finding: Both years one and two of the curriculum have been reorganized into systems-based blocks, where the subjects are coordinated temporally but have varying degrees of horizontal content integration. As yet, there has been little attention to achieving vertical integration of content across the curriculum, except in specific subject areas.

Action Plan Item: Complete a thorough evaluation of the curriculum of all required course/system

ED-5-A Finding: The first two years of the curriculum are highly dependent on lecture and offer few opportunities for medical students to develop the skills necessary for lifelong learning.

Action Plan Item: Create core learning objectives with outcome measures for each year and for each system to better illustrate the degree of curricular integration

Scope of Work: The Committee's primary task is to evaluate existing models of Competencies and develop Competencies for each year and report back to the Curriculum Committee.

Membership

- MSI (2 Faculty)
- MSII (2 Faculty)
- MSIII (2 Faculty)
- MSIV (2 Faculty)
- Residency Director (1)
- Resident (1)
- JCESOM Graduate (1)
- Office of Medical Education (1)

Report: The Committee will draft a report to the Curriculum Committee with a list of suggested competencies for each year.

Appendix B – Diversity Learning Modules Proposal

Proposal
Utilizing the Office of Minority Health: Think Cultural Diversity Training Modules
By
Shelvy L., Campbell, Ph.D., Director
Marshall University Joan C. Edwards School of Medicine
Office of Diversity Programs

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. Cultural competency is one the main ingredients in closing the disparities gap in health care. It's the way patients and doctors can come together and talk about health concerns without cultural differences hindering the conversation, but enhancing it. Quite simply, health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.

All too often, diversity education is treatedas incidental, taking the form of a 'half day workshop on sexuality' or a 'cultural diversityday', rather than being thoughtfully and thoroughly integrated into medical education curricula.Social identity is the obligation to direct education,research and service activities towardsaddressing the priority health concerns ofthe community, region, and/or nation theyhave a mandate to serve.

The LCME Educational Standards on Diversity are as follows:

- ED-21The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.
- ED-22 Medical students must learn to recognize and appropriately address gender and cultural biases in themselves and others, and in the process of health care delivery.
- ED-23 A medical school must teach medical ethics and human values, and require its students to exhibit scrupulous ethical principles in caring for patients, and in relating to patients' families and to others involved in patient care.

In reviewing the literature available on diversity cultural competence training from the context of formal health professions educational programs and residency training as well as information on the prevalence and format of training in the workplace and continuing medical education for physicians, it was evident that there is no standard diversity cultural competence training. Cultural competence training information and actual curricula are difficult to gather. Most of the curricula reviewed defined culture in a rather broad and inclusive manner that extends beyond the traditional parameters of race and ethnicity. Other aspects of culture such as gender and gender identity, sexual orientation, disability, age,

religion, socioeconomic status, class, and education were also reviewed. Focusing on cultural competence curricula there were a number of broad themes including:

- the important and relevant role of culture in health;
- core cultural issues;
- definitions of diversity and diverse populations;
- definitions of culture and cultural competency;
- self-awareness of one's own cultural background and self-assessment of biases;
- theoretical models for cultural competence;
- cultural models of health, disease, and illness;
- cross-cultural communication skills;
- working with interpreters;
- effective interviewing and taking cultural histories;
- cultural conflicts in the doctor-patient relationship;
- negotiation skills; and understanding complementary or traditional medicine practices.

After reviewing the 'Think Cultural Website https://www.thinkculturalhealth.hhs.gov/ website (The Think Cultural Health program), I registered for the program and reviewed the 3 themes in the curriculum: "Fundamentals of Culturally Competent Care, "Speaking of Culturally Competent Care," and "Structuring Culturally Competent Care."
This site is a great resource and could easily be integrated in the course content.

The modules were developed using the CLAS standards. The CLAS standards are a collective set of culturally and linguistically appropriate services, mandates, guidelines, and recommendations issued by the United States Department of Health and Human Services Office of Minority Health intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services (National Standards for Culturally and Linguistically Appropriate Services in Health Care Final Report, OMH, 2001).

Suggested courses to incorporate Diversity Learning Modules

MS-1	IDM715	Intro to Clinical Skills
MS-2	MED725	Approach to Patience Care
MS-3	FCH 742	Family and Community Health
MS-4	FCH 827	Sub1 – Family Medicine

The site was developed for self-study; however it is possible to complete the modules in a group discussion format (Instructions for Group Work in the Course Toolkit). The learning modules could be built into the curriculum in several ways. The two illustrations below are examples on how the faculty members could use the learning modules can be used.

Illustration 1: Faculty member would complete the Cultural Health learning module**.**

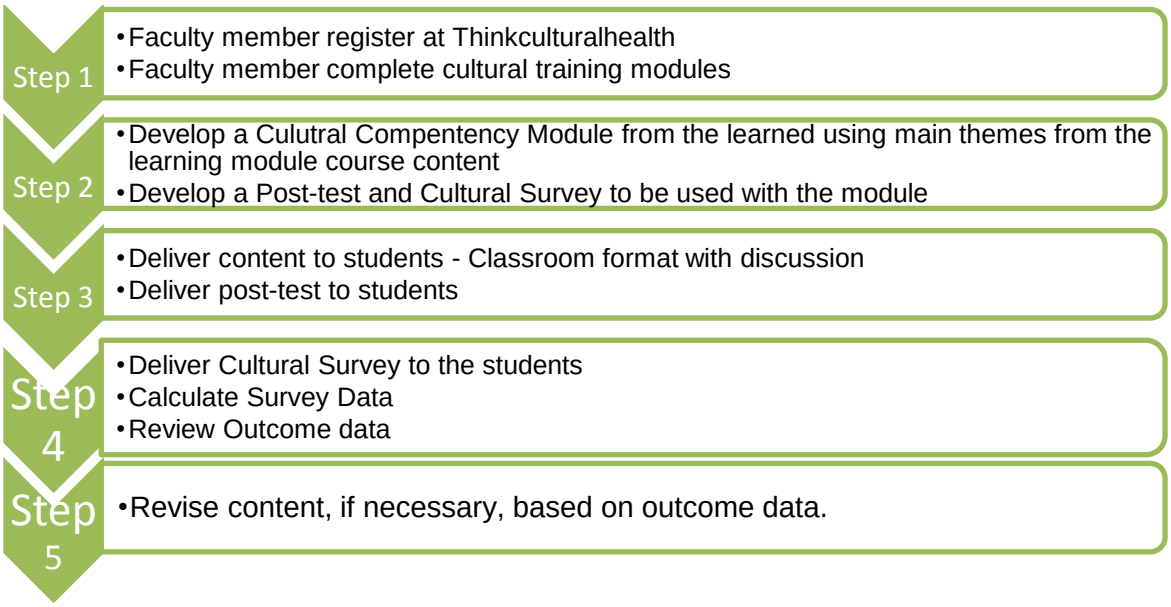
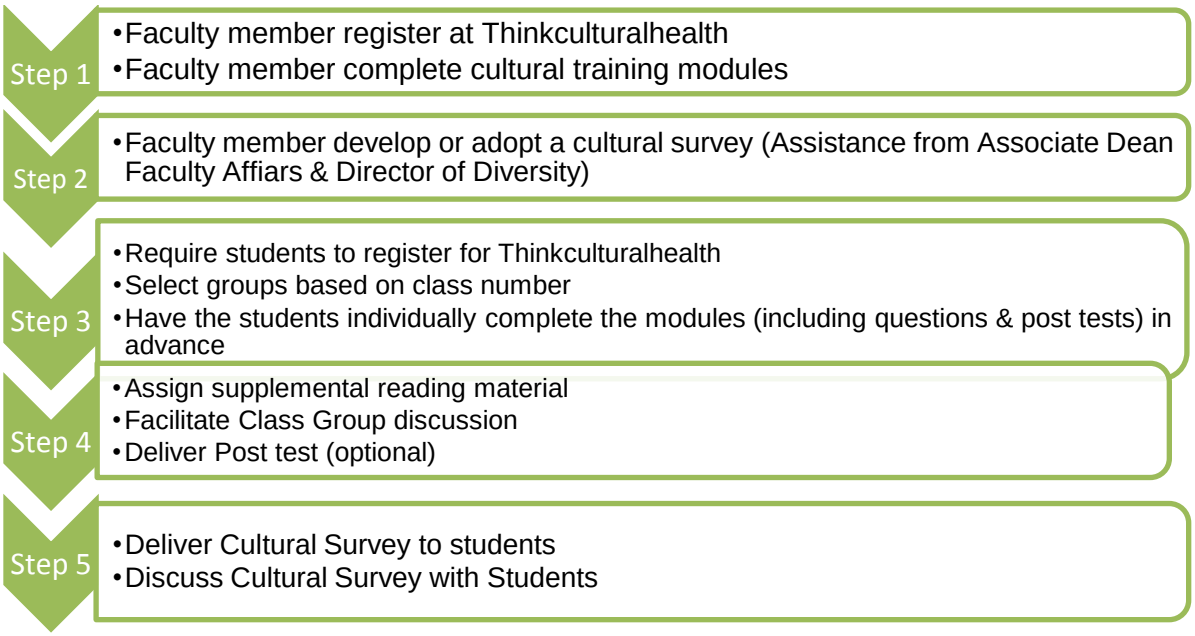


Illustration 2. Faculty member would complete the Cultural Health learning module and use the Module as an individual student and/or group learning component.



Expected Learning Modules Outcomes

1. Student's gain knowledge by reading and studying specific content related to each module.
2. Student's focus on awareness through reviewing a case, answering questions and discussing with their peers their personal opinions and assumptions regarding the cultural aspects of the case.
3. Students learn skills by applying the content of each module to the module case and their clinical practice by gaining the knowledge to be able to workwith people from all cultural identities in a way that promotes respect and dignity.
4. Student completion of the program modules provides them with a greater understanding of cultural competence in health by effectively operating in different cultural contexts with different groups of people thereby increasing the quality of health care andoverall healthcare outcomes.