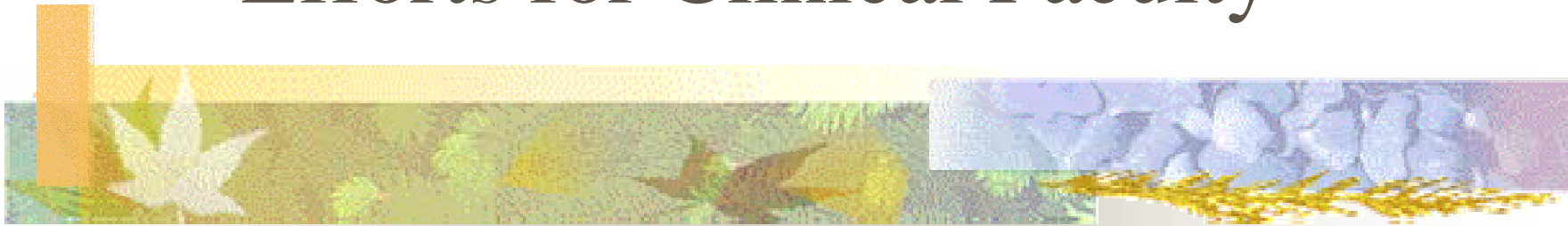


# 2002 Assessment Institute

## Assessing the Quality of Educational Efforts for Clinical Faculty



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School of Medicine



# Foundation of the University of New Mexico School of Medicine

- 1960s—UNM President presented plans for a medical school and stated that the school would never cost the State of New Mexico more than \$250,000 because:
  - the physician faculty would cover their salaries by earning professional fees
  - Non-physician faculty cover salaries with grants



# Primary Care Curriculum (PCC)

- NM -- 5th largest geographic state with less than 2 million people.
- In early 1970s, 2/3 of physicians were in Albuquerque and Santa Fe, but only 1/3 of population lived there.
- One of the reasons for establishing PCC-- increase likelihood of medical students going into primary care in rural areas.



# Nature of the PCC Education

- No lectures in the PCC track of 20 students whereas the Traditional Track of 53 students had almost all lectures
- PCC students involved in clinical areas from the start of medical school and spent 16 weeks with a primary care physician outside of Albuquerque at end of first year.
- Traditional students began clinical work at end of 2nd year.



# Nature of PCC

1. PCC was limited primarily to first 2 years of medical school. PCC students joined Traditional Track students at the start of the 3rd year.
2. Problem-based and life-long learning were the focus of PCC.



# US News & World Report

- “In the hierarchy of American medical education, a handful of elite and venerable institutions are thought to set the pace in innovation. When one of these schools launches a major initiative—Harvard’s problem-based “New Pathway “curriculum for example—that change is widely noted by the medical profession.



# US News & World Report

- More than often than not, however, Harvard and its peers are following the lead of less heralded institutions. ... these innovators have far more flexibility to transform themselves—and medical education. Perhaps the best example of these less visible trendsetters: the University of New Mexico School of Medicine.”



# Combining PCC and the Traditional Tracks in 1993

- Best of PCC and Traditional Tracks:
- Some lectures with emphasis on small-group tutorial learning.
- All students -- clinical care at beginning of medical school.
- Problem-based, contextual, and life-long learning emphasized.



## Expansion to 3<sup>rd</sup> & 4<sup>th</sup> Years

- With introduction of the new curriculum in 1993, the nature of education in first 2-years was extended into all four years of medical school and, in some cases, into Graduate Medical Education (GME).



# Medical Education Changes since 1979

- Problem-based and life-long learning for students, residents and faculty
- Development of Clinical Educator Track
- Establishment of an Medical Education Scholars Program
- Begin to define competencies and measurement of those competencies as part of faculty development, mentoring and promotion



# What we learned from PCC and New Curriculum:

- Change in educational philosophies take an extremely long time 1974-1993:
  - 20 years for entire faculty to accept innovative educational concepts in ONLY the first 2-years of medical school
  - New curriculum started expansion of innovative education into the into the 3rd and 4th years of medical school & GME, but the expansion is slow



# Medical Education & Problem-Based Learning

- The amount of emotional energy generated by a live patient problem captures attention, interest and dedication
- Time pressure to solve patient problems in a clinical setting is extreme—one cannot wait for 6 months to solve the patient’s problem
- Big difference in faculty solving the patient’s problem versus students and residents to be involved in decision making



# UNM's Relevance to Other Educational Environments

- Contextual learning —people learn more efficiently when concepts and data are placed in context of practice (or job)
- Life-long learning is important for all endeavors, not just medicine.
- Integration of classroom (hospital or clinic) and use of education is highly visible in medicine.
- Medicine's high visibility in society can help with emphasis on life-long and/or sustainable learning



## If Engineering Education were Similar to Medical Education:

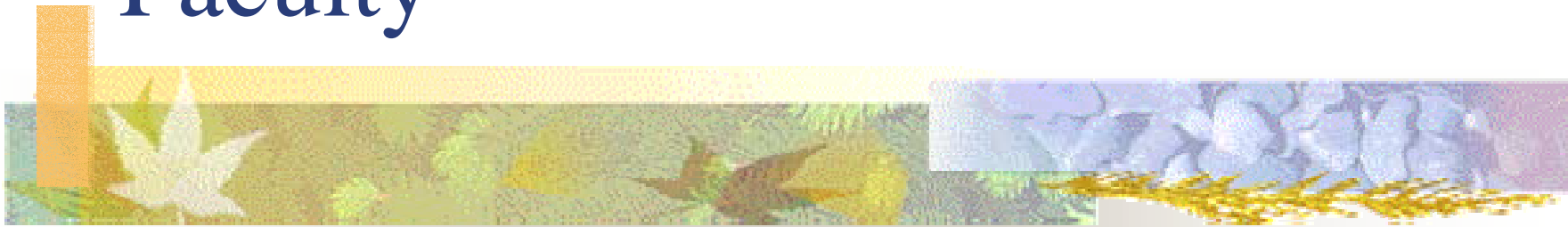
- College of Engineering might be responsible for planning, designing, constructing and maintaining state highways.
- Engineering faculty would support 60% or more of their salaries through engineering services.
- Will adult education and life-long learning move toward education more analogous to medical education in the next 20 years?



# Best UNM Example of Assessing Faculty Educational Role in the Clinical Environment

- Division of General Internal  
Medicine
- Carolyn Voss, MD, Director

# Assessing the Quality of Educational Efforts for Clinical Faculty



## UNM Pilot Project



# Missions of the UNM School of Medicine

## ■ Education

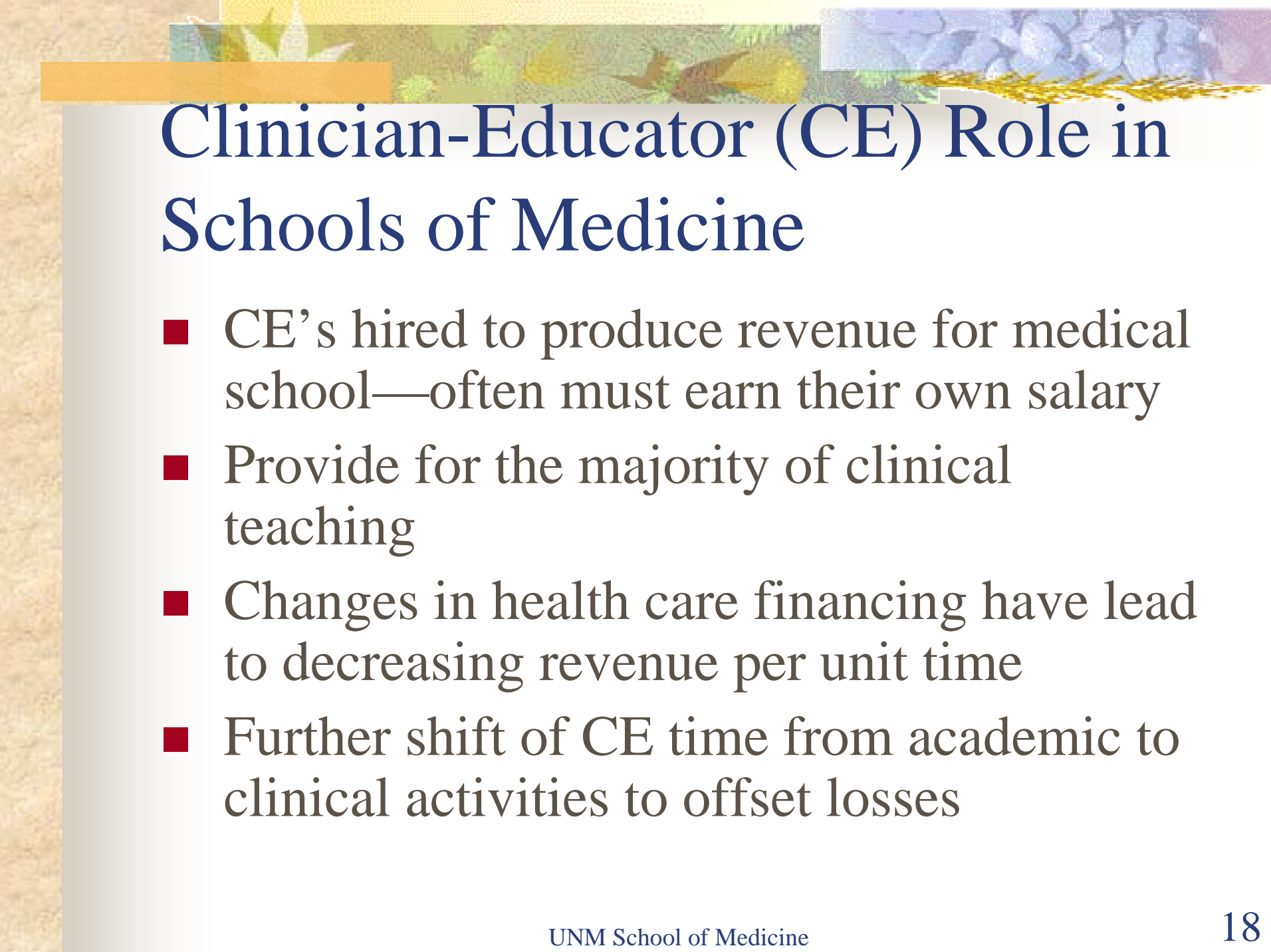
- Includes medical students, residents, Masters and PhD students, etc.

## ■ Research

- Includes basic bench research as well as clinical, epidemiological and health services research

## ■ Service

- Patient care and administration (committees, medical directorships, etc.)




# Clinician-Educator (CE) Role in Schools of Medicine

- CE's hired to produce revenue for medical school—often must earn their own salary
- Provide for the majority of clinical teaching
- Changes in health care financing have lead to decreasing revenue per unit time
- Further shift of CE time from academic to clinical activities to offset losses



# The Clinician-Educator Faculty

- Job duties no longer allow for the development of the ‘triple threat’ academician
- CE is a foreigner in the world of traditional academic medicine
- BUT problem-based and clinical teaching is more faculty time intensive than traditional forms of teaching



“To study the phenomenon of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all.”

William Osler



# The problem

- Lack of confidence in measures of educational activity and quality:
  - Penalizes good medical educators in the promotion process
  - Devalues the role of education among the missions of the medical school
  - Leaves junior faculty adrift regarding expectations and faculty development in education



# The Solution

- Create a systematic approach to measure education which:
  - Captures time and effort involved in education
  - Fairly compares the activities of faculty performing different sorts of activities
  - Allows for quality assessment that is structured and consistent, and which supports faculty development



# Educational Efforts for Clinicians

- Occasionally involves didactic teaching
- Often involves leading tutorial groups
- For advanced students and residents, always involves integrating teaching with service
- No truly ‘protected’ time for research or teaching



# General Internal Medicine (GIM)

- Pilot group to develop methodology for measuring educational quality
  - What should be measured?
  - What can be measured?
  - How will we measure it?



# GIM—Who we are

- 26 faculty members
- 24 Clinician Educators
- 2 Tenure Track



# GIM—Faculty Roles

- 30% Teaching or research/70% Service
- Provide direct ambulatory primary care
- Attend on inpatient service
- Attend for residents ambulatory primary care clinic
- Teach medical students in a variety of settings



# GIM—Why?

- Experience in multiple teaching venues
- Educational expertise within group
- Administrative support in place
- Motivated, energetic faculty
- Self-identified need for educational quality measures



# A Teaching Clinic

- Two Faculty teaching attendings
- Six-Eight Residents
- 25-40 Patients Scheduled
- 4 ½ hour session; ½ hour conference
- Medical Record and resources all electronic
- Goal is to train MD's (over 3 years) to provide primary care Internal Medicine



# A Teaching Clinic-Routine

- Resident sees a patient on their own
- Residents review record, formulate assessment
- Resident presents data and assessment to faculty
- Faculty member sees patient with resident
- Faculty and resident discuss findings, assessment, make management plans
- Resident returns to patient to review management plan



# Questions to Ponder

- What parts of the educational process in the clinic lend themselves well to faculty evaluation?
- What methodology should be used?
- What should be measured?




# Process

- Literature review and assessment
- Internal review of current quality assessment processes
- Divisional retreat and identification of key issues and core work group
- Small pilot projects
- Develop administrative tracking process



# How Does GIM Define Educational Success?

- Learner goals defined and known to both teacher and learner
- Evaluation of learner and faculty is timely and relevant to goals, is objective and standardized with room for individual adjustment
- Satisfaction with educational event is high for both learner and faculty



# What Makes an Excellent Clinical Teacher?

- Has a passion for teaching
- Clear, organized, accessible
- Exhibits integrity and respect for others
- Demonstrates clinical competence
- Utilizes planning and orienting strategies
- Engages in self-evaluation and reflection
- Targets teaching to learner needs



# Guiding principals

- Expectations for faculty must be clear, and possible
- Goals for teachers must be clearly linked to goals for learners
- Goals for learners must be specific, appropriate, and known to teachers
- Teacher and learner satisfaction are both important outcomes



# Guiding principals

- Feedback for faculty must be timely and consistent
- Benchmarks for overall teaching performance need to be explicit
- Quality reports for faculty should be linked with opportunities to improve
- Good performance, once measured, must be acknowledged and rewarded



# Pilot site

- Resident's General Medicine Clinic
  - 60 Residents learning outpatient primary care skills over three years, 1/2 day per week
  - Two GIM attendings for each group of 6-8 residents—total of 16 Faculty
  - Defined curriculum, revised annually by GIM
    - Knowledge, skills, behaviors



# Issues identified

- Some good faculty assessment processes were already in place.
  - But no systematic way for faculty to receive the feedback
- Importance of thoughtful learner feedback and satisfaction recognized.
  - But residents have numerous competing demands on their time.



# Issues identified

- Identified need and desire for peer review and feedback
  - Several GIM faculty uncomfortable with this and unevenly skilled
- Problem-based teaching skills apply naturally to clinical setting
  - But few IM residents have been exposed to this type of teaching at their medical schools



# Issues identified

- Faculty are under ever increasing pressure to produce clinical revenue and do teaching
  - Measuring and improving quality takes time
- Important for faculty member to be able to organize time for good teaching.
  - Learner schedules not under local control



# Teachable Moments in GMC

- Before and during conferences
- Pre-visit chart review
- Resident presentation
- Teaching with the patient
- Development of management plan
- Quality of documentation



# Domains of Faculty Assessment

- Professionalism
- Teaching
- Patient care
- Communication
- Medical Knowledge
- Systems Improvement



# Pilot Site—Faculty Assessment Methods

- Residents assess faculty
  - Written evaluation every 6 months (semi-anonymous)
  - Oral feedback session with residents quarterly
- Faculty assess each other
  - Clinic partners
- Faculty perform self assessment
  - Semi-annually, structured format



# Pilot Site—Faculty Assessment Methods

- All assessments tracked and collected centrally
- Loop closed with feedback report to faculty member every six months
- Suggestions for improvement/growth documented as part of annual review process



# Future Plans

- Additional faculty and resident development in giving/receiving feedback and coaching
- Self assessment methodology
- Faculty teaching quality data base & report
- Satisfaction outcome measure



# Summary

- Clinical faculty play a critical role in education in Schools of Medicine, but face increasingly difficult challenges
- Quality measures are important for faculty development, as well as for advancing the educational mission of the School of Medicine
- Measuring quality of educational work in the clinical setting requires attention to process and behaviors, as well as content and outcomes