The Evolving Landscape of Regional Campus Development – Discussion Notes

Compiled below are the notes collected from table discussions during the Evolving Landscape session at the GRMC Business Meeting held November 7th, 2014 during the AAMC Annual Meeting. This session consisted of six table topics for attendees to discuss issues related to these topics as they relate to current challenges they are experiencing on their campuses and learn potential solutions from peers or identify common challenges.

The table topics were:

- Comparable Curricula – Comparable vs. Identical
- Main Campus Relations
- Recruiting Students/Campus PR
- Recruiting and Engaging Faculty
- Campus Infrastructure (notes not available)
- Expectations of Student Experience (notes not available)

Please note: These notes reflect individual note taker’s differing styles. We will work on refining these summaries into a more uniform document in the future.

Comparable Curricula Discussion Notes

Dan Hunt provided copies of an LCME White Paper which was posted on their website (July 1) entitled Principles for Parallel Curricula (Tracks). This white paper can be accessed on the LCME Website at the bottom of the publications page: http://www.lcme.org/publications.htm

Group 1:

Dan took the proposed white paper to the CLIC meeting this past year for discussion of the draft.

They didn’t like alternate track as it has possible negative connotation. Went with Parallel Curriculum. Not a “track” as that has been used for other uses at medical schools. So, the new term is “parallel curriculum.”

Define the core – then you can add “bells and whistles” that fit the parallel curriculum.

Most important for Dan – “Assessment need not occur at the same time points in the regular and parallel curricula, but must occur by comparable and valid methods.”

Q: Without parallel curricula, must assessment be simultaneous? Led to next question.

Q: Who designates parallel curricula? School defines. Needs to send in the form to LCME to say that they will have this. LCME’s main interest in these change forms is to ensure that there are adequate resources for the new program.
LCME is interested in evaluating the core, so for example, they would not peruse 4th year electives, even if they’re required in your curriculum. Would not scrutinize how long it takes to get grades out, for example. The school should want to regulate this, but the LCME isn’t going to monitor it.

Think about how you can satisfy “comparable and valid methods” for assessment. You need to evaluate your methods.

“There has never been a citation based on a reformed curriculum.” – Hunt

Q: What does LCME look for in comparability and measures of same among campuses?

Working on distillation of milestones that might be available in the next few years that would say that you have to have a “gateway” in the 4th year, perhaps, to assess readiness for residency and the match. Discussion about whether Step2 CK satisfies this and is available soon enough.

Q: EPAs? LCME doesn’t really care about these, doesn’t differentiate based on these.

Resources are a key concern for the LCME.

EPAC (pediatrics initiative UME to GME) – more of an issue for ACGME, not LCME.

Group 2:

“Standards, publications and white papers on LCME web site”

Also, a white paper on how to have students from multiple schools on the same rotation – but still can’t do so with DO or Caribbean medical schools.

The white paper supersedes the former concept of “tracks.” These had additional learning objectives beyond the core. These days tracks have expanded to include things like LICs, etc. SO, LCME will not call things “tracks” any longer, rather they will be “parallel curricula.” Schools can continue to use “tracks” for their own purposes.

Dan Hunt drew attention to point 6, again, for the group.

For example, if you use the shelf at the end of OB in the standard curriculum, when do you do it in an LIC, if you have that as a parallel curriculum? Point 6 says that you can do this differently.

No question that LIC students retain knowledge, long term, better than traditional clerkship students.

Some discussion of how you attract students to a new LIC, especially if you have different testing that might not involve taking a shelf exam. A: You might want to give the shelf for different reasons than to satisfy the LCME. Comment from a new program that surveyed interest after a presentation of a proposed LIC – 6 volunteers from M2s by end of day.
Hunt: Initially, there is lots of angst and opinions of new LICs are not good. After about 3 months, this changes and it becomes much more attractive. Students who are not self-driven may not thrive as well in an LIC.

Comment: I just heard that some schools have 3-year programs. In some cases different campuses have 3 years or 4 years in the same medical school. This is OK with the LCME? A: Yes, as long as you have at least 130 weeks.

Other than NBME or a faculty generated exam, are there other valid sources for exams that the LCME recognizes? Hunt: No. None that I know of.

Q: Does anyone let students decide when to take their shelf exam? Comment from participant: Yes, somebody does, maybe Harvard. May be within a certain window.

Q: How many places have kids from other schools in a clerkship? A: It will be a bi-modal curve. Some in rural and some in big urban centers.

Spread the word about the new white papers on parallel curricula and on shared clerkships.

**Main Campus Table Discussion**
Gene Marsh, Moderator

**Summary**

1. Several budget models were presented. RMC leaders agreed that control of their own budget was beneficial, and would help them weather philosophical and regime changes at main campus. Some campuses did not have their own budget, and felt more vulnerable.
2. RMC’s may be handcuffed in soliciting donations. They may not be able to go after private donations, as the MC has identified deep pocket donors and has them on their MC donor list.
3. Communication is critical. There were RMC members on main campus committees, frequent video communications, faculty exchanges. Was there a difference between geographically remote campuses and those that work more closely connected? What is the extent of mingling on committees among RMC’s and MC’s?
4. How are policy changes developed and communicated? Does the MC dictate, or are RMC’s involved in decision-making and communication?
5. MC administrators fall into different groups
   a. no understanding of the RMC and no vision for it
   b. jealousy/hostility towards the RMC, seeing it as a budget liability
   c. realization that the RMC brings diversity and innovation capability
6. there are stages of acceptance of a new RMC among faculty (noted at Case Western)
disbelief/skepticism in the quality of the RMC and its faculty
- stressing the need for identical (not comparable) experiences at both campuses
- realization of the strengths of the RMC, and supporting it for the innovation and diversity that it brings.

Below are paraphrases, not translated verbatim, from the group meetings.

Session 1:

**Gene: building a campus is different from maintaining a campus. What are the critical differences?**

(WVU): main campus leadership. Especially with changes in main campus leadership, new relationships must be developed. Changes at MC regarding a new RMC involve a continuum:

- not understanding the RMC, having no vision for it
- hostility to the RMC, jealousy
- supporting and encouraging the development of the RMC

(TAM): situation changed with additional RMC’s. Initially they were the only campus, policies and resources were directed at them. Now that there are multiple campuses, they are “one of many” regarding resources and budget.

**Gene: what budget decisions are critical to RMC’s?**

(PSU): culture is important. There is an evolution of the opinions of the faculty on main campus:

- disbelief/skepticism in the quality of the RMC and its faculty
- stressing the need for identical (not comparable) experiences at both campuses
- realization of the strengths of the RMC, and supporting it for the innovation and diversity that it brings.

(TAM): is the budget control by main campus, or distributed in some way among all campuses?

(WIS): on main campus. MC does fundraising for the RMC. They also look for sharing space/facilities with community college and other institutions. They’re struggling to understand how to allow for “local flavor” while maintaining educational standards.
(Gene): University of Alabama RMC has independent budget. How do you maintain relationships with MC?

(WVU): consistent communication to maintain relationships. Weekly meetings with all RMC's. Geographic distance is a problem. Environment creates culture – Charleston campus in a bigger city attracts more urban students. Problem with going after donors – main campus has identified deep pockets, and does not want RMC's contacting donors, even in their area.

(WIS): main campus (Dean) was committed from the start to full training/immersion in the community, creating a four-year campus. Faculty and administration were skeptical and had to be convinced. At admission, students apply to regional campus sites. Regional campus chooses, looking for local applicants who are “focus”, often graduating three years. 2000 applicants for 25 slots.

(Gene): vision for the regional campus is critical, and must be communicated with main campus faculty and staff.

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Main Campus Table Gene Marsh, Moderator

Session 2:

(WVU): relationships are important with MC. Best way is to get involved in MC admissions committee.

(MTL): recruitment for their RMC is difficult due to geography. It is farther north.

(Gene): what is the most important aspect of the relationships between MC and RMC?

(WVU): equal involvement on decisions, such as meeting times and places, communicating policy changes, and decisions on student remediation.

(MCR): Savannah bylaws include placement of certain numbers of RMC members on MC committees. They recognize there is a “different culture” between campuses.

(WVU): how do campuses handle needlestick injuries?

(MCR): the handbooks for different campuses are similar, but different names and contact points are inserted.
(UGA): policy should be different, and leadership should allow differences. Handbooks should not be similar due to different clinical situations.

(MTL): differences should be addressed through leadership communication. Their campus uses weekly phone conferences. The approach of central (MC) leadership is critical.

**Gene: is there a formula for successful MC leadership, or is it due to the personalities of the leaders?**

(UGA): leadership personalities

(MCR): their campus has duplicate leadership positions at MC and RMC, with primary responsibility residing at different campuses for different administrative positions. MC has 60 students, Savannah RMC has 30 students, soon rising to 60. An academician with a strong reputation was hired to oversee the RMC curriculum expansion. Example of insensitive MC leadership – Dean at Macon bought two popcorn makers, sending one to Savannah, assuming they would want a popcorn maker too. They would prefer to spend the money on other items.

(UGA): who has budget control?

(WVU): we have our own budget. We have our own donors. We have our own clinical medical practice.

(PSU): fine line between comparability of campuses, equality (budget and reputation), and being a separate medical school.

(UGA): why not be independent? Example – Indiana with many campuses. Excellent administration, but perhaps a second medical school needed.

(PSU): med school the future may be an umbrella, offering different choices to different locations. Different schools would not offer as much choice.

**Gene: when the regime changes at a school, does this bring changes in philosophy?**

(UGA): yes, but budget control is critical. They have control of their budget, which can help weather philosophical changes at MC.

(MCM): autonomy = budget control. Their video connection is key. Meetings and classes through videoconferencing. Coordination for faculty development is key as well. MC campus visit RMC regularly and vice versa.

(MTL): with capitated payments from the government based on population, Main campuses need RMC.
(UG A): communities feel threatened that MC is taking over medical care in the region, and may divert patients away from them.

Discussion Topic: Recruiting of Students

- Two sessions of twenty-five minutes
- Thirteen participants representing eleven regional campuses

Summary of Discussion:

- Recruiting occurs at varied steps in the medical school student timeline. Some recruiting occurs during the pre-application process with pipeline and summer programs. During the application process some campuses present themselves to help students select the campus they will attend in year 1 or year 3. Other schools recruit during years 1+2 for clinical campus selection.

- Recruiting methods vary:
  Websites available for student viewing
  YouTube videos
  Bus trip for all enrolled students to each campus
  Personal phone calls to accepted students by faculty and alumni
  Dedicated admissions seats to rural applicants

- Student concerns:
  Comparability of sites
  Limiting their options for pursuing specific residencies and specialties
  Family factors (house, children, spouse with job, etc.)
  Where to live and expense of living

- How students are selected for regional campuses varied:
  Lottery
  Self-selection during and after admissions process
  Site-specific application process including interviews
  1:1 swaps are allowed at some campuses
  Compelling reasons for campus changes allowed at some campuses

- Use students to sell the campus!
  Panels
  Video diaries
  Tweets

- Other selling points that are used:
  Longitudinal integrated clerkships
  Housing availability
Mission
LCME comparability data
Three-year curriculum
Smaller classes and more personal attention
Connection with local residency

Table Topic: Recruiting and Engaging Faculty

Discussion 1:
There is interest in academics and scholarship though there isn’t protected time

- Recruiting student coaches is relatively easy
- Clinical faculty without core work focus
- How do you carve out FTE percentages to protect time?
- RVU Emphasis reduction

ACGME focus on scholarship helps with protecting time for scholarship in residency programs

Stipends help. Stipends come from education programs and other sources at USF.

Texas Tech – Round Rock has contracted faculty, each hired as a % FTE and uses a newsletter to engage these faculty. They also offer 3 CE credits per year to these faculty.

WWAMI – Alaska brings faculty together for development opportunities, travel is covered by the institution. The large area covered creates unique opportunities for engaging the faculty and communities have been engaging in the process.

Georgia’s state legislature has passed a tax credit allowing volunteer faculty a tax deduction for teaching time, up to a certain amount. Other states are pursuing this as an option for compensation, too.

Georgia also provides access to resources such as libraries and databases to volunteer faculty.

Retired physicians are also a resource for part-time teaching, though keeping current and licensure issues due exist. There is still opportunity to engage retired physicians as student mentors.

MCG incorporates all faculty across all campuses and sites into one faculty body creating a sense of family and unity.

Some specialties, such as primary care, can be difficult to recruit faculty because of a sizeable patient slate. This hinders time available for teaching. Some institutions provide a stipend to see less patients and protect time for teaching.
Discussion 2:

This table discussion started off with interest in longitudinal curricula. WVU expressed some opportunity created by their LIC structure:

- Find it easier to engage community faculty with 1-2 students 1-2 days a week.
- Small community structure is beneficial
- Students tend to feel behind in the beginning of the program, especially when they speak to other students not in the LIC.
- Curriculum has evolved into 2 week blocks. This evolved from surgery preceptors requesting to see students more than one time a week.

Faculty Compensation and Rewards: Some institutions –

- Create layers of protected time with regards to compensation, i.e. teaching, teaching and admin
- Pay for RVUs, the amount varies based on the specialty and number of students
- Cover conference attendance
- Cover CME Credit cost pending learning is properly documented

Additional points of discussion:

- Recruit faculty when they first start out in practice
- Some find new faculty are more apt to teach
- One institution tailored their clinical rotations to certain hospitals based on performance and ability to accommodate students
- Use residents to teach clinical skills