LCME Accreditation:
A Tool for Improvement

AAMC Learn Serve Lead 2016

Agenda

1. Introductions and Overview   *Veronica Catanese, MD, MBA*

2. Planning a System to Monitor Performance in LCME   *Barbara Barzansky, PhD, MHPE*
   Accreditation Standards

3. Continuous Quality Improvement as a Tool for Changing   *M. Lourdes Winberry, MPH*
   Culture

4. How Wayne State Used Accreditation to Drive CQI and   *Herbert Smitherman Jr., MD, MPH, FACP*
   Effect Organizational and Cultural Change Regarding
   Diversity

5. Q & A   *All*

Introductions

Facilitator

- **Veronica M. Catanese, MD, MBA**

    LCME Co-Secretary and Senior Director, Accreditation Services

    Association of American Medical Colleges

Speakers

- **Barbara Barzansky, PhD, MHPE**

    LCME Co-Secretary and Director, Division of Undergraduate Medical Education

    American Medical Association

- **Herbert Smitherman Jr. MD, MPH, FACP**

    Vice Dean, Diversity and Community Affairs

    Wayne State University School of Medicine

- **M. Lourdes Winberry, MPH**

    Associate Dean for Health Affairs

    The George Washington University School of Medicine and Health Sciences
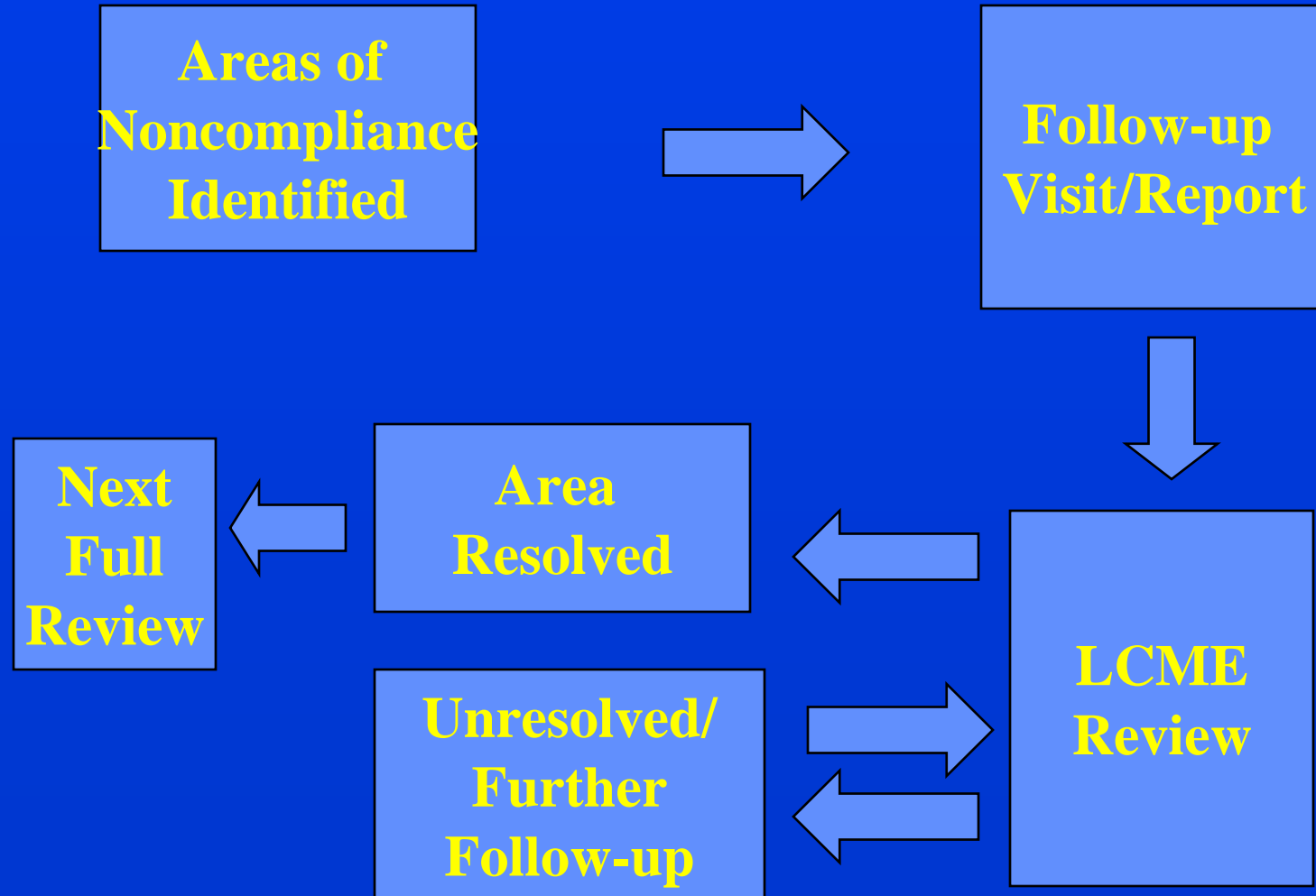
ELEMENT 1.1:
STRATEGIC PLANNING AND CONTINUOUS QUALITY IMPROVEMENT

A medical school engages in **ongoing planning and continuous quality improvement processes** that establish short and long-term programmatic goals, result in the achievement of measurable outcomes that are used to improve programmatic quality, and **ensure <u>effective</u> monitoring of the medical education program's compliance with accreditation standards**.

DCI QUESTIONS
(2016-17 ACADEMIC YEAR)

Describe the process used and resources available for quality improvement activities related to the medical education program. For example, is there an office or dedicated staff to support quality improvement activities at the levels of the medical school or university?

Describe how the medical school monitors ongoing compliance with LCME accreditation standards. The response should address the following questions:

- Which standards are monitored (e.g., all standards, a subset of standards)?
- How often is compliance with standards reviewed (mid-cycle, yearly, at some other interval)?
- What data sources are used to monitor compliance?
- What individuals or groups receive the results?

"DISCLAIMER"

- The LCME does not prescribe the characteristics of the CQI system the school must have in place. The decision of whether the school's monitoring is "effective" will be based on the answers to the specific questions in the DCI.

- Note that the purpose of the CQI system is to allow prospective identification and correction of areas not performing as expected in other elements.

POTENTIAL COMPONENTS OF A CQI SYSTEM

A system for the ongoing monitoring of accreditation elements would benefit from the following being in place:

- Policy

- Personnel

- Resources

SELECTING ELEMENTS TO BE MONITORED

The LCME has not specified which elements to monitor or the timing of reviews. Schools will select the elements to monitor.
There are potential categories that might assist a school's in planning what to monitor:

- Commonly-cited elements

- Elements that include an explicit requirement for monitoring or involve a regularly-occurring process

- New or recently-revised elements or changes in LCME expectations related to elements

SELECTING ELEMENTS TO BE MONITORED (con't)

- Elements that could be reviewed to ensure that policies are congruent with current operations

- Elements that directly or indirectly affect the core operations of the school

- Elements (prior standards) cited in the previous full survey

PLANNING FOR DATA COLLECTION AND REVIEW

A comprehensive work-plan would facilitate the monitoring process and ensure that it is appropriately resourced:

- The elements to be reviewed

- The data sources to be used for each element, the timing of data collection and review, and individuals/organizational roles responsible

- The individual(s)/committee(s) who will receive and act on the information

MANAGING DATA COLLECTION

- For efficiency, data collection processes and instruments already in place within the school (e.g., course/clerkship evaluations) or available from external sources (e.g., AAMC GQ) could be used/adapted.
  - o Consider creating a catalogue of available data

- Schools can also use specially designed instruments, but take care to avoid "data fatigue."

LCME WHITE PAPER

- At the October LCME Meeting, the LCME approved the white paper titled, **"*Implementing a System for Monitoring Performance in LCME Accreditation Standards.*"**

- The white paper is now available for download on the LCME website:

  http://lcme.org/publications/

1.1 Strategic Planning and Continuous Quality Improvement (CQI)

- A medical school engages in **ongoing planning** and **continuous quality improvement processes** that:
    - establish short and long term programmatic goals;
    - result in the **achievement** of **measurable outcomes** that are used to **improve** programmatic **quality;** and
    - ensure **effective** monitoring of the medical education program's compliance with accreditation standards.

Linking CQI to the new Strategic Plan

- GW SMHS was in the preliminary stages of revising its strategic plan when the LCME element 1.1 on CQI was introduced.

- GW leveraged the new element 1.1 (CQI) and included other LCME elements into the new strategic plan, specifically 3.3, 3.5, 6.6, 7.5, 7.6, and 7.9.

- *Leadership*: Promote a culture of excellence through leadership, **performance improvemen**t, **professionalism**, **diversity and inclusion for students, faculty and staff**.

- *Strategy*: Implement **Continuous Quality Improvement** (CQI) processes throughout SMHS programs that result in short- and long-term programmatic goals and the **achievement of measurable outcomes that improve quality.** [Develop a plan and performance metrics to facilitate achievement of **diversity plan goals as they apply to students, faculty and staff**].

- *Education*: […Leader in **interdisciplinary and inter-professional** education in response to changing health care systems…].

- *Community*: Commitment to **health equity**… through **service**, **education, advocacy**.

- *Resources* for CQI (and other LCME related elements) became a *requirement* for the school under the strategic plan. *Developing* and reviewing *plans with metrics to demonstrate effectiveness* are now *required* under *both* CQI and the strategic plan, and are monitored routinely and separately.

- In addition to CQI, resources were also allocated for other LCME related areas, including:
  - Diversity (3.3), faculty professional development (4.5), and service learning (6.6).
  - Other elements were funded indirectly through overall enhancement made to the Office of Medical Education, such as inter-professional collaborative skills (7.9), administrative offices (new staff in financial aid (12.1)), and further renovations to the study/lounge/storage spaces (5.11).

- Resources (time) were also allocated for the development of a new curriculum and its evaluation and assessment.

- Sr. Quality Analyst hired in 2014.

- Individual dedicated to monitoring compliance of LCME standards/elements, including: **on-going central monitoring** of **clerkship logging** with **real time reporting** back to **deans, clerkship directors and coordinators,** and eventually to the Clinical Education Subcommittee regarding the status of logging. Logging is performed at the mid-clerkship, a week before the end-of-clerkship, and at the end of the clerkship. It is performed in conjunction with duty hour reporting. Year-end assessment of overall utilization of alternative clinical encounter methods is also performed and presented (6.2, 9.7, 8.6, and 8.8).

- Other additional LCME elements monitored include:
  - 1.4 Affiliation Agreements
  - 3.3 Diversity/Pipeline Programs
  - 3.6 Student Mistreatment
  - 4.3 Faculty Appointment Policies
  - 5.5 Resources for Clinical Instructions
  - 5.11 Study/Lounge/Storage Space
  - 8.1 Curriculum Management
  - 9.2 Faculty Appointments
  - 9.8 Fair and Timely Summative Assessment, and several more.

Sr. Quality Analyst:

- In addition to CQI monitoring, position also:
  - Collects data (DCI) for the actual LCME site visit and full mid-cycle review
  - Participates in monthly LCME calls
  - Prepares reports for AAMC (i.e. LSSR)
  - Participates in *ad hoc* LCME related operational and financial planning/brainstorming meetings
  - Prepares independent data reports on certain focus areas (i.e. student debt, grades, comparability)
  - Reviews the UME and Dean's dashboard for accuracy/consistency (diversity, match, step scores)
  - Produces annual CQI report on activities, status of monitored elements
  - Gathers and produces report on institutional changes made based on student input " You Asked, We Listened." Generates final report for dean.
  - Analyzes and disseminates AAMC GQ data.

Associate Dean for Health Affairs:

- In addition to CQI, position assumes responsibility for:
  - Strategic planning
  - Clinical expansion
  - Funds flow and negotiations with affiliates
  - Business intelligence
  - Research metrics
  - Dean's dashboard
  - Board of trustees, etc;

- Participates in school and university meetings (i.e. deans, senior leadership, curriculum, board of trustees, financial, business intelligence, external consultants, clinical affiliates; and monthly LCME calls, etc.), thereby enabling identification of right people for brainstorming/solutions.

Associate Dean for Health Affairs:

- Participates in monthly LCME calls

- Reviews submissions for CQI and elevates for follow-up (discussion, action plan, and/or 1:1 meeting)

- Recommends review of an element based on input/concerns raised at meetings or communicates/elevates a recommendation for review obtained from various meetings/individuals

- Follows up with stakeholders regarding polices and procedures, congruity/validity/clarity, and dissemination of data and problem solving efforts

- Reviews/edits the entire LCME DCI for accuracy, congruity, integrity

- Maintains communication from LCME for dissemination at school/university level

- Leads action plan for focused review/follow-up/action on certain elements

- Prepares reports/dean's dashboard on status of LCME elements [and strategic plan] for university president and board of trustees.

- Initiates and leads full mid-cycle LCME review process.

Sr. Advisor to VPHA:

- Has extensive LCME accreditation experience, including participation/leadership in:
  - Monthly LCME conference calls
  - LCME national and regional meetings/conferences
- Has previous LCME site review experience, and is regarded as a nationally recognized expert who can serve as a neutral and final authority on compliance
- Works with faculty on nuances of methods to achieve compliance and correct LCME interpretation of elements in order to facilitate root cause analysis, problem-solving; and to propose clear, reliable processes for follow-up
- Participates in curriculum meetings and serves as the final say in process recommendations and interpretations vis-à-vis LCME standards.

Alternatives to Sr. Advisor:

- Single designated faculty member:
  - Who has a been a member of the LCME (if available)
  - With LCME site visit experience
  - Who attends Regional LCME Educational Meetings
  - Who attends AAMC national meetings
  - Who participates in monthly LCME phone calls
  - Who can contact LCME at the AAMC national meeting for private consultation and/or
  - Who can contact LCME directly for consultation/guidance

Core criteria for annual review includes elements recommended for review from LCME, based on the following:

- LCME elements frequently cited for "noncompliance"
- Elements frequently cited for "compliance with monitoring"
- 21 elements subsumed under "CQI process"
- Elements required for review based on conclusion of a **full mid-cycle review and/or full LCME site visit**
- Elements noted for monitoring from routine auditing or data sources (i.e. AAMC GQ, LSSR, student surveys)
- Elements recommended for monitoring by deans or any of the curriculum or student committees
- Elements recommended for monitoring after course review and/or any change (i.e. curriculum) that warrants monitoring.

- CQI processes regarding selection, adding, and dropping of an element for review are formulated with input from the deans and then codified and disseminated.

- Annual report on status of effectiveness of CQI monitoring is prepared and disseminated.

11 Most Common "Noncompliance" Findings According to LCME:

- 1.4 Affiliation Agreement

- 3.3 Diversity/Pipeline Programs and Partnerships

- 6.2 Required Clinical Experiences

- 8.6 Monitoring of Completion of Required Clinical Experiences

- 6.3 Self-Directed and Life-Long Learning

- 8.1 Curricular Management

- 8.3 Curricular Design, Review, Revision/Content Monitoring

- 9.1 Preparation of Resident and Non-Faculty Instructors

- 9.4 Variety of Measures of Student Achievement/Direct Observation of Core Clinical Skills

- 9.5 Narrative Assessment

- 9.8 Fair and Timely Summative Assessment

7 Most Common "Compliance with Monitoring" According to LCME:

- 3.3 Diversity/Pipeline Programs and Partnerships

- 3.5 Learning Environment/Professionalism

- 5.1 Adequacy of Financial Resources

- 9.4 Variety of Measures of Student Achievement/Direct Observation of Core Clinical Skills

- 9.8 Fair and Timely Summative Assessment

- 11.2 Career Advising

- 12.1 Financial Aid/Debt Management Counseling/Student Educational Debt

21 CQI Elements with Need for Monitoring According to LCME

- 1.1 Strategic Planning and Continuous Quality Improvement
- 1.5 Bylaws
- 3.3 Diversity/Pipeline Programs and Partnerships
- 3.5 Learning Environment/Professionalism
- 3.6 Student Mistreatment
- 4.4 Feedback to Faculty
- 4.5 Faculty Professional Development
- 5.1 Adequacy of Financial Resources
- 6.2 Required Clinical Experiences
- 6.3 Self-Directed and Life-Long Learning
- 8.1 Curricular Management
- 8.2 Use of Medical Educational Program Objectives
- 8.3 Curricular Design, Review, Revision/Content Monitoring
- 8.4 Program Evaluation
- 8.5 Use of Student Evaluation Data in Program Improvement
- 8.6 Monitoring of Completion of Required Clinical Experiences
- 8.7 Comparability of Education/Assessment
- 8.8 Monitoring Student Workload
- 9.1 Preparation of Resident and Non-Faculty Instructors
- 9.4 Variety of Measures of Student Achievement/Direct Observation of Core Clinical Skills
- 12.1 Financial Aid/Debt Management Counseling/Student Educational Debt

- 2015-2016: There were 29 elements reviewed
    - 25 from the "LCME findings list"
    - 4 generated internally

- 2016-2017: There are 27 elements for review
    - 24 from the LCME findings list,
    - 2 generated internally,
    - 1 generated internally and from LCME findings list.

Monitoring/tracking should include:

- Threshold for compliance (DCI requirements);
- What data is collected and when, whom and how it is reviewed;
- Overall frequency of monitoring and associated timelines;
- Responsible individuals;
- Expected outcome contrasted to actual outcome (i.e. need for ongoing monitoring based on evidence submitted and when next review is scheduled); and
- Summary analysis of overall effectiveness of monitoring back to stakeholders (formal and informal).

- Develop a system that is practical with metrics
- Master matrix prepared with all of the LCME elements should include:
  - Element number
  - Complete element statement
  - Issues/notes
  - Metrics used for compliance
  - Outcome
  - Individual/groups responsible
  - Expected date of accomplishment/scheduled review
  - Status
  - Date last reviewed with follow up notes

In the following example, the grid is collapsed, color coded for status levels (noncompliant, compliant, and pending), and populated for operational use

New LCME April, 2016 DCI - Continuous Quality Improvement (CQI) schedule for 2016-2017 --"Sample" Matrix using LCME DCI as a Tool

Criteria used to identify standards/elements for auditing:

| LCME Findings |
| 2016 LCME findings |
| **Elements with issues identified by SMHS or additions by LCME** |

Criteria used to identify outcome:

| Unsatisfactory |
| In Progress |
| Satisfactory |

Source	Element Number	Element Title	Element	Issue/Notes	Metrics used for compliance	Outcome	Individuals/ Groups Responsible	Expected Date of Accomplishment/ Audit/Interval	Status	Last Reviewed
LCME Frequently Cited across all medical school	3.3	DIVERSITY/ PIPELINE PROGRAMS AND PARTNERSHIPS	A medical school has effective policies and practices in place, and engages in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students, faculty, senior administrative staff, and other relevant members of its academic community. These activities include the use of programs and/or partnerships aimed at achieving diversity among qualified applicants for medical school admission and the evaluation of program and partnership outcomes.	Plan saved in Supporting Document- action folder 3/16/15. Need annual update on action plan from Office of Diversity and Inclusion.	See DCI 3.3. Audit data/tables trends annually to check increase in student and faculty diversity.	The Action Plan has specific outcomes and metrics; received 3/16/2015. Needs to be implemented. Quarterly memo in the CQI folder for Faculty.	NAMES	Review annually.	Satisfactory.	Nov. 2015
LCME Frequently Cited for Monitoring across all medical school	3.5	LEARNING ENVIRONMENT/ PROFESSIONALISM	A medical school ensures that the learning environment of its medical education program is conducive to the ongoing development of explicit and appropriate professional behaviors in its medical students, faculty, and staff at all locations and is one in which all individuals are treated with respect. The medical school and its clinical affiliates share the responsibility for periodic evaluation of the learning environment in order to identify positive and negative influences on the maintenance of professional standards, develop and conduct appropriate strategies to enhance positive and mitigate negative influences, and identify and promptly correct violations of professional standards.	Need to review instruments in August 2016.	See DCI 3.5. Audit examples of instruments used to evaluate the learning environment. Updated survey received - July 21st.	Learning Environment Survey audited.	NAMES	Review annually.	Satisfactory.	Dec. 2015

Mechanics:
Functional Grid

New LCME April, 2016 DCI - Continuous Quality Improvement (CQI) schedule for 2016-2017 --"Sample" Matrix using LCME DCI as a Tool

Criteria used to identify standards/elements for auditing:

LCME Findings
2016 LCME findings
Elements with issues identified by SMHS or additions by LCME

Criteria used to identify outcome:

Unsatisfactory
In Progress
Satisfactory

Source	Element Number	Element Title	Element	Issue/Notes	Metrics used for compliance	Outcome	Individuals/ Groups Responsible	Expected Date of Accomplishment/ Audit/Interval	Status	Last Reviewed
LCME CQI	3.6	STUDENT MISTREATMENT	A medical education program defines and publicizes its code of professional conduct for the relationships between medical students, including visiting medical students, and those individuals with whom students interact during the medical education program. A medical school develops effective written policies that address violations of the code, has effective mechanisms in place for a prompt response to any complaints, and supports educational activities aimed at preventing inappropriate behavior. Mechanisms for reporting violations of the code of professional conduct are understood by medical students, including visiting medical students, and ensure that any violations can be registered and investigated without fear of retaliation.	Review GQ Data in August 2016. Mistreatment policy in place.	See DCI 3.6. Code of Conduct approved; Data on student mistreatment from GQ to be analyzed in August.	Reduction in student reported mistreatment in GQ.	NAMES	Review annually.	Satisfactory	Dec. 2015
LCME CQI	4.4	FEEDBACK TO FACULTY	A medical school faculty member receives regularly scheduled and timely feedback from departmental and/or other programmatic or institutional leaders on his or her academic performance and progress toward promotion and, when applicable, tenure.	Annual Performance Reviews are completed with all relevant information.	See DCI 4.4., Feedback to faculty. Policies are adhered to; template is provided.	Timely feedback to faculty with APT path made clear.	NAMES	Review annually.	Satisfactory	

New LCME April, 2016 DCI - Continuous Quality Improvement (CQI) schedule for 2016-2017 --"Sample" Matrix using LCME DCI as a Tool

Criteria used to identify standards/elements for auditing:

| LCME Findings |
| 2016 LCME findings |
| **Elements with issues identified by SMHS or additions by LCME** |

Criteria used to identify outcome:

| Unsatisfactory |
| In Progress |
| Satisfactory |

Source	Element Number	Element Title	Element	Issue/Notes	Metrics used for compliance	Outcome	Individuals/ Groups Responsible	Expected Date of Accomplishment/ Audit/Interval	Status	Last Reviewed
LCME CQI	4.5	FACULTY PROFESSIONAL DEVELOPMENT	A medical school and/or its sponsoring institution provides opportunities for professional development to each faculty member in the areas of discipline content, curricular design, program evaluation, student assessment methods, instructional methodology, and or research to enhance his or her skills and leadership abilities in these areas.	4.5.1	See DCI 4.5. Audit a list/inventory of the faculty development programs and attendance annually.	Inventory of opportunities updated in DCI including research.	NAMES	Review annually.	Satisfactory 11/13/2015.	Dec. 2015
LCME Frequently Cited for Monitoring across all medical school	5.1	ADEQUACY OF FINANCIAL RESOURCES	The present and anticipated financial resources of a medical school are derived from diverse sources and are adequate to sustain a sound program of medical education and to accomplish other programmatic and institutional goals.	Review LCME Part I- A AFQ in December 2016	See DCI 5.1 (LCME Part I-A AFQ) 1. Total revenues 2. Operating margin 3. Revenue mix 4. Market value of endowments 5. Medical school reserves 6. Debt service 7. Outstanding debt 8. Departmental reserves	Total revenues have grown approximately 4% per year from FY 2012 through FY 2014. Operating margins have consistently ranged between break even to positive 5% over the last three years.	NAMES	Review annually	Satisfactory	Dec. 2015
Element with issues identified in AY 14-15	5.5	RESOURCES FOR CLINICAL INSTRUCTION	A medical school has, or is assured the use of, appropriate resources for the clinical instruction of its medical students in ambulatory and inpatient settings and has adequate numbers and types of patients (e.g., acuity, case mix, age, gender).	Analysis of clerkship by site performed 4.13.16 for the BOT to asses risk related to INOVA. Need update on alternative sites July - August 2016.	See DCI Tables 5.5.1 to 5.5.4 and Narrative 5.5; overall assessment of adequacy of clinical sites for transition year 15-16.	On-going monitoring during the transition year 15-16 after launch of new curriculum. Identified as compliant but recommend alternative sites to INOVA.	NAMES	Review at the end of every rotation and annually.	Satisfactory	Dec. 2015

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GW

New LCME April, 2016 DCI - Continuous Quality Improvement (CQI) schedule for 2016-2017 – "Sample" Mid-Cycle Review Matrix using LCME DCI as a Tool

Criteria used to identify standards/elements for auditing:

| LCME Findings |
| 2016 LCME findings |
| Elements with issues identified by SMHS or additions by LCME |

Criteria used to identify outcome:

| Unsatisfactory |
| In Progress |
| Satisfactory |

Source	Element Number	Element Title	Element	Issue/Notes	Metrics used for compliance	Outcome	Individuals/ Groups Responsible	Expected Date of Accomplishment/ Audit/Interval	Status	Last Reviewed
LCME Frequently Cited for Monitoring across all medical school	5.1	ADEQUACY OF FINANCIAL RESOURCES	The present and anticipated financial resources of a medical school are derived from diverse sources and are adequate to sustain a sound program of medical education and to accomplish other programmatic and institutional goals.	Review LCME Part I- A AFQ in December 2016	See DCI 5.1 (LCME Part I-A AFQ) 1. Total revenues 2. Operating margin 3. Revenue mix 4. Market value of endowments 5. Medical school reserves 6. Debt service 7. Outstanding debt 8. Departmental reserves	Total revenues have grown approximately 4% per year from FY 2012 through FY 2014. Operating margins have consistently ranged between break even to positive 5% over the last three years.	NAME	Review annually	Satisfactory	Dec. 2015
	5.2	DEAN'S AUTHORITY/ RESOURCES	The dean of a medical school has sufficient resources and budgetary authority to fulfill his or her responsibility for the management and evaluation of the medical curriculum.		See DCI 5.2. Updated Table of Org. Budgeted position and resources to support UME.	The senior associate dean for MD programs (SAD) provides primary oversight for the medical education programs including funding, faculty affairs, educational space, and educational infrastructure.	NAME	Review annually.	Satisfactory.	Dec. 2015
	5.3	PRESSURES FOR SELF-FINANCING	A medical school admits only as many qualified applicants as its total resources can accommodate and does not permit financial or other influences to compromise the school's educational mission.				NAME			
	5.4	SUFFICIENCY OF BUILDINGS AND EQUIPMENT	A medical school has, or is assured the use of, buildings and equipment sufficient to achieve its educational, clinical, and research missions.		See DCI 5.4. Annually audit classroom space to accommodate learning groups. Also audit inventory of faculty offices and research labs. List of renovation, construction in research or education space.	All new air handlers and thermostats, as well as major duct-work within the Himmelfarb Library has been resolved. Renovated all classrooms/study rooms in Himmelfarb with new lighting and acoustic tile ceilings and soundproofing to reduced unwanted noises.	NAME	Review annually.	Satisfactory.	Dec. 2015
Element with issues identified in AY 14-15	5.5	RESOURCES FOR CLINICAL INSTRUCTION	A medical school has, or is assured the use of, appropriate resources for the clinical instruction of its medical students in ambulatory and inpatient settings and has adequate numbers and types of patients (e.g., acuity, case mix, age, gender).	Analysis of clerkship by site performed 4.13.16 for the BOT to asses risk related to INOVA. Need update on alternative sites July - August 2016.	See DCI Tables 5.5.1 to 5.5.4 and Narrative 5.5; overall assessment of adequacy of clinical sites for transition year 15-16.	On-going monitoring during the transition year 15-16 after launch of new curriculum. Identified as compliant but recommend alternative sites to INOVA.	NAME	Review at the end of every rotation and annually.	Satisfactory	Dec. 2015

1) Develop criteria for selection of elements for review and then *prioritize focused review efforts after initial monitoring*

- Can perform routine review on many elements, but perform *focused* review on a few

2) Be explicit about CQI process and need for peer review and self-review

3) Convey process for adding elements as a means for problem solving and root cause analysis to stakeholders (i.e. present this as a resource, not as a negative)

4) Agree with stakeholders on metrics to be used and time expectations

5) Be clear about *threshold for compliance* at the start

6) Meet with "owners" of problem areas 1:1 until resolved

7) Perform root cause analysis when methods are ineffective

8) Discern need for continued monitoring

9) Question usefulness of existing or multiple sources of "data" when problems persist or compliance with an element is not sufficiently addressed. Propose new metrics/methods

10) Report successes back to deans and committees as a means of demonstrating *effectiveness*

11) Communicate results back to deans/committees/stakeholders.

Examples of Satisfactory → Satisfactory

3.3 A medical school has effective policies and practices in place, and engages in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students, faculty, senior administrative staff, and other relevant members of its academic community. These activities include the use of programs and/or partnerships aimed at achieving diversity among qualified applicants for medical school admission and the evaluation of program and partnership outcomes.

Diversity Categories and Definitions

Medical Students	Faculty	Senior Administrative Staff
Black/African American	Black/African American	Black/African American
Hispanic/Latino	Hispanic/Latino	Hispanic/Latino
Socioeconomically Disadvantaged	Women	Women
Women		

Offers Made to Applicants to the Medical School

School-identified Diversity Category	2014 Entering Class			2015 Entering Class		
	Declined Offers	Enrolled Students	Total Offers	Declined Offers	Enrolled Students	Total Offers
Black/African American	37	14	51	32	22	54
Hispanic/Latino	13	15	28	21	17	38
Socioeconomically Disadvantaged	7	8	15	11	10	21
Women	89	108	197	87	100	187

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Effectiveness

Examples of Satisfactory → Satisfactory

3.6 A medical education program defines and publicizes its code of professional conduct for the relationships between medical students, including visiting medical students, and those individuals with whom students interact during the medical education program. A medical school develops effective written policies that address violations of the code, has effective mechanisms in place for a prompt response to any complaints, and supports educational activities aimed at preventing inappropriate behavior. Mechanisms for reporting violations of the code of professional conduct are understood by medical students, including visiting medical students, and ensure that any violations can be registered and investigated without fear of retaliation.

Awareness of Mistreatment *Procedures* Among Students   Source: AAMC GQ

AY 2013-14		AY 2014-15	
School%	National%	School%	National%
90.0	78.6	97.0	80.5

Awareness of Mistreatment *Policies* Among Students   Source: AAMC GQ

AY 2013-14		AY 2014-15	
School%	National%	School%	National%
99.4	93.3	100	94.5

Effectiveness

Examples of Unsatisfactory → Satisfactory

6.2 The faculty of a medical school define the types of patients and clinical conditions that medical students are required to encounter, the skills to be performed by medical students, the appropriate clinical settings for these experiences, and the expected levels of medical student responsibility.

8.6 A medical school has in place a system with **central oversight** that monitors and ensures completion by all medical students of required clinical experiences in the medical education program and remedies any identified gaps.

Students with incomplete logs

Clerkship	Rotation 1	Rotation 2	Rotation 3	Rotation 4	Rotation 5
Internal Medicine	9	0	0	1	0
Surgery	21	0	3	4	0
Pediatrics	5	2	0	0	0
OBGYN	3	0	0	0	0
Psychiatry	0	0	0	0	0
Total	38	2	3	5	0

Effectiveness

Examples of Unsatisfactory → Satisfactory

9.8 A medical school has in place a system of fair and timely summative assessment of medical student achievement in each course and clerkship of the medical education program. Final grades are available within six weeks of the end of a course or clerkship.

Table 9.8-1 | Availability of Final Grades   Source: School-reported

For each required core clinical clerkship, provide the average number of weeks, and the minimum/maximum number of weeks it took for students to receive grades during the most-recently completed academic year. Also provide the percentage of students that did not receive grades within 6 weeks. Add rows as needed.											
	AY 2012-13				AY 2013-14				AY 2014-15			
Core Clerkship	Avg.	Min	Max	%	Avg.	Min	Max	%	Avg.	Min	Max	%
Ob/Gyn	5.67	4	6	0	5.53	3	6	0	5.5	5	6	0
Internal Medicine	6	6	6	0	6	6	6	0	6	6	6	0
Primary Care	6	6	6	0	6	6	6	0	6	6	6	0
Surgery	4.48	3	6	0	5.23	3	6	0	6	6	6	0
Psychiatry	6	6	6	0	6.1	4	8	16.67	5.3	4	6	0
Pediatrics	5.58	5	6	0	5.48	4	6	0	5.8	5	6	0

Examples of Satisfactory → Unsatisfactory

None

Effectiveness

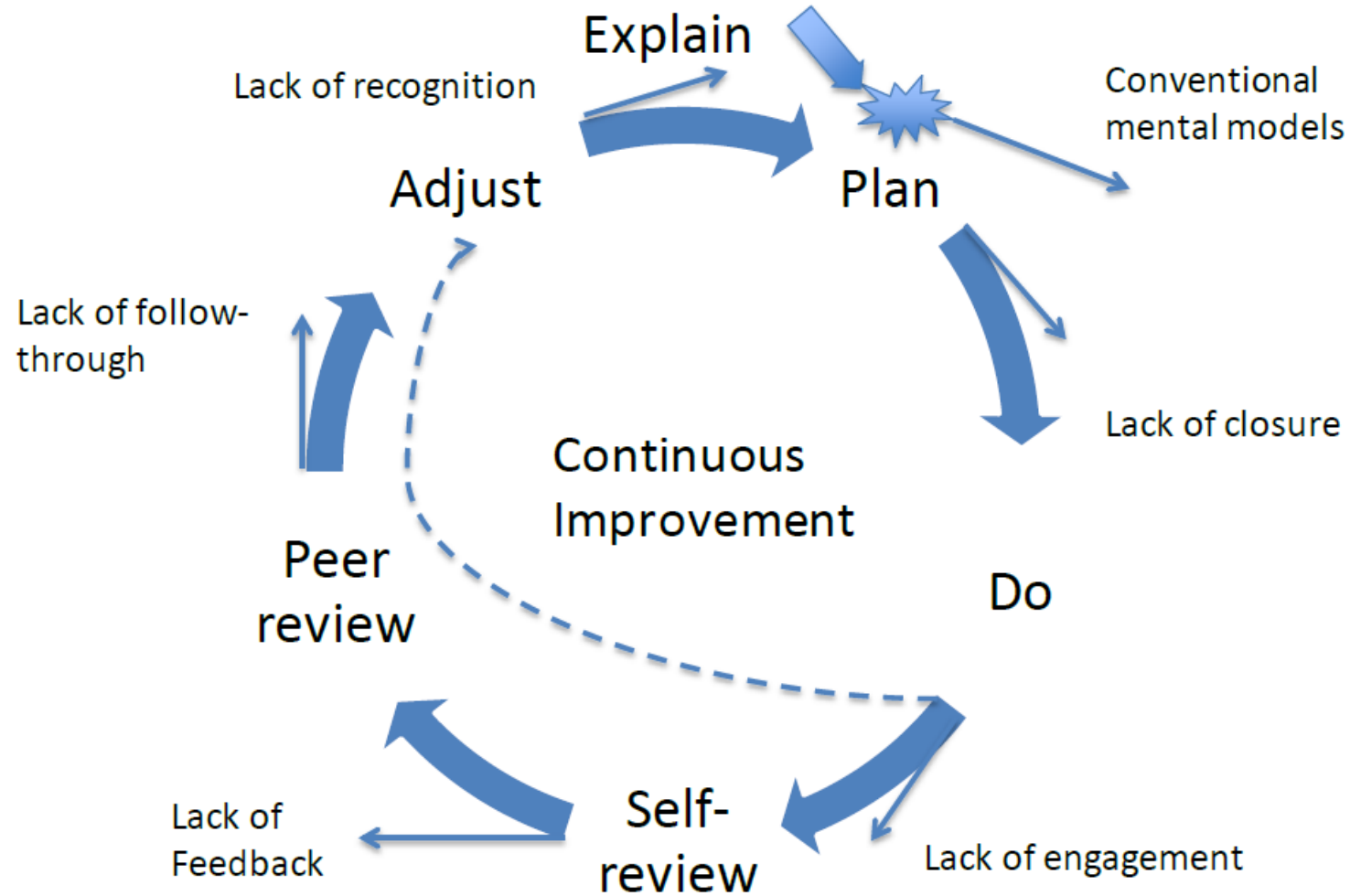Examples of Unsatisfactory → Work in Progress

12.0 A medical school provides effective student services to all medical students to assist them in achieving the program's goals for its students. All medical students have the same rights and receive comparable services.

Table 12.0-5 | Medical School Indebtedness Among Graduates   Source: LCME Part I-B Financial Aid Questionnaire, Section 6

Provide the total cumulative medical school educational indebtedness per class (excluding debt associated with enrollment in joint, dual, or combined degree programs) for each indicated academic year (as available).							
AY 2011-12		AY 2012-13		AY 2013-14		AY 2014-15	
% of Graduates with Medical School Debt	Average Graduate Debt	% of Graduates with Medical School Debt	Average Graduate Debt	% of Graduates with Medical School Debt	Average Graduate Debt	% of Graduates with Medical School Debt	Average Graduate Debt
67.8	197,485	72.7	218,356	68.1	216,782	79.6	197,292

The Improvement Cycle

Explain

Lack of recognition

Conventional mental models

Adjust

Plan

Lack of follow-through

Lack of closure

Continuous Improvement

Peer review

Do

Lack of Feedback

Self-review

Lack of engagement

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1. *Conventional models* will cause work groups to reject the new ideas and thus block the adoption process before it gets started.

2. *Lack of closure* reflects the academic tendency to argue endlessly over the fine points of proposed actions. Closure is produced by the need to deliver a timely project plan. Among other things, the plan should describe the actions to be taken and the criteria by which success will be gauged.

3. *Lack of engagement* causes the "doing" stage to falter partway through the trial period.

Source: Massy, W.F. *Reengineering the University: How to Be Mission Centered, Market Smart, and Margin Conscious.* Baltimore: The Johns Hopkins University Press, 2016

4. *Lack of feedback* prevents participants from achieving maximal benefit from the self-review. Peer review provides two kinds of benefits: the substance of the reviewers' comments and the incentive to bear down during the self-review process.

5. *Lack of follow-through* prevents the findings from the self-study and peer review from producing action and organizational learning. The mitigation is to organize a process by which deans or other administrators review the department's results and obtain new commitments about the way forward. Performance against these commitments should be tracked against agreed performance indicators whenever possible.

Source: Massy, W.F. *Reengineering the University: How to Be Mission Centered, Market Smart, and Margin Conscious.* Baltimore: The Johns Hopkins University Press, 2016

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6. *Lack of recognition* for a job well done will dissipate commitment. The mitigation is obvious: administrators should celebrate successes, build the work into performance reviews, and, where the institution's standards for scholarship can be met, include it in evaluations for promotion and tenure.

- The improvement cycle is designed to operate on an annual basis.

Evidence

Evidence is different from things such as "information," "data," or "fact" in at least five subtle but important ways:

Evidence should:

1. Cover knowledge and skills taught throughout the program's curriculum.
2. Involve multiple judgements of student performance.
3. Provide information on multiple dimensions of student performance.
4. Involve more than surveys and self-reports of competence and growth by students
5. Be relevant, verifiable, representative, cumulative, and actionable.

Source: Massy, W.F. *Reengineering the University: How to Be Mission Centered, Market Smart, and Margin Conscious.* Baltimore: The Johns Hopkins University Press, 2016

Conclusion

	Capability-maturity scales for operating units and the [school] as a whole	
Scale Value	**Work Group Criteria**	**School-Wide Criteria**
No effort	There is no initiative-based activity.	There is no leadership from the central administration.
Firefighting	Units respond to problems, but mostly with *ad hoc* methods.	More leadership from the central administration needed.
Emergent Effort	One sees initiatives by individuals and some experimentation with the principles, but the incidence is far from critical mass.	There is some leadership, and some groups have reached the "emergent effort" level on certain aspects of the initiative.
Organized effort	Group-wide actions begin to be planned and tracked, methods are systematically rooted in the principles, and the unit has begun to develop performance metrics and norms.	The administration exerts active leadership, and some groups have reached the "organized effort" level on certain aspects of the initiative.
Mature effort	The initiative is embedded in the group's culture, continuous improvement is a way of life, and organizational learning is fully established.	The initiative is a key results area for the central administration and all the work groups. Some groups have reached the "mature effort" level and the administration is working with the others.

Source: Massy, W.F. *Reengineering the University: How to Be Mission Centered, Market Smart, and Margin Conscious.* Baltimore: The Johns Hopkins University Press, 2016

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Three elements of leadership are required:

1. The champion and his or her senior colleagues must make a strong case for changing the status quo: why faculty and staff members should reallocate time and effort [to participate in CQI].

2. They should lay out and fund a strategy for effecting the necessary changes: one that comes across as intrinsically practical and beneficial for the people involved.

3. They should set up a system for encouraging experimentation, initiating pilot implementations and rolling out successful results across the institution, spurring their improvement, and then, importantly, following up to see that the improvements are sustained over time.

Source: Massy, W.F. *Reengineering the University: How to Be Mission Centered, Market Smart, and Margin Conscious.* Baltimore: The Johns Hopkins University Press, 2016

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- GW SMHS initiated CQI in 2014
  - Added/Hired Sr. Quality Analyst and Sr. Faculty Advisor
- At same time initiated process for completion of DCI (18 months prior to LCME site visit)
- LCME Survey Team → 2 findings:
  - 1 Satisfactory with Monitoring
  - 1 Unsatisfactory

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QUESTIONS?

AAMC Conference

LCME Accreditation: A Tool for Improvement

Herbert C. Smitherman, Jr., MD, MPH, FACP

Vice Dean, Diversity & Community Affairs

November 12th, 2016

LCME Accreditation: A Tool for Improvement of Diversity

Session Description/Objective:

- How we used Accreditation/LCME standards and elements:
  - As a tool for data-driven continuous quality improvement (CQI)
  - To bring about institutional cultural change, organizational transformation and innovation around Diversity

LCME Citation (June 2015)

LCME
LIAISON COMMITTEE ON
MEDICAL EDUCATION

ELEMENT 3.3
DIVERSITY/PIPELINE PROGRAMS AND PARTNERSHIPS

A medical school has effective policies and practices in place … **to achieve mission-appropriate diversity outcomes among its students, faculty, senior administrative staff**,……

Prop 2: MI since 2006

Affirmative Action Bans in the U.S.

YEAR	STATE	METHOD
2012	**Oklahoma**	Legislatively referred constitutional amendment
2011	**New Hampshire**	Statute
2010	**Arizona**	Initiative constitutional amendment
2008	**Colorado**	*Failed initiative constitutional amendment*
2008	**Nebraska**	Initiative constitutional amendment
2006	**Michigan**	Initiative constitutional amendment
1999	**Florida**	Executive order by governor
1998	**Washington**	Initiative statute
1996	**California**	Initiative constitutional amendment

PEW RESEARCH CENTER

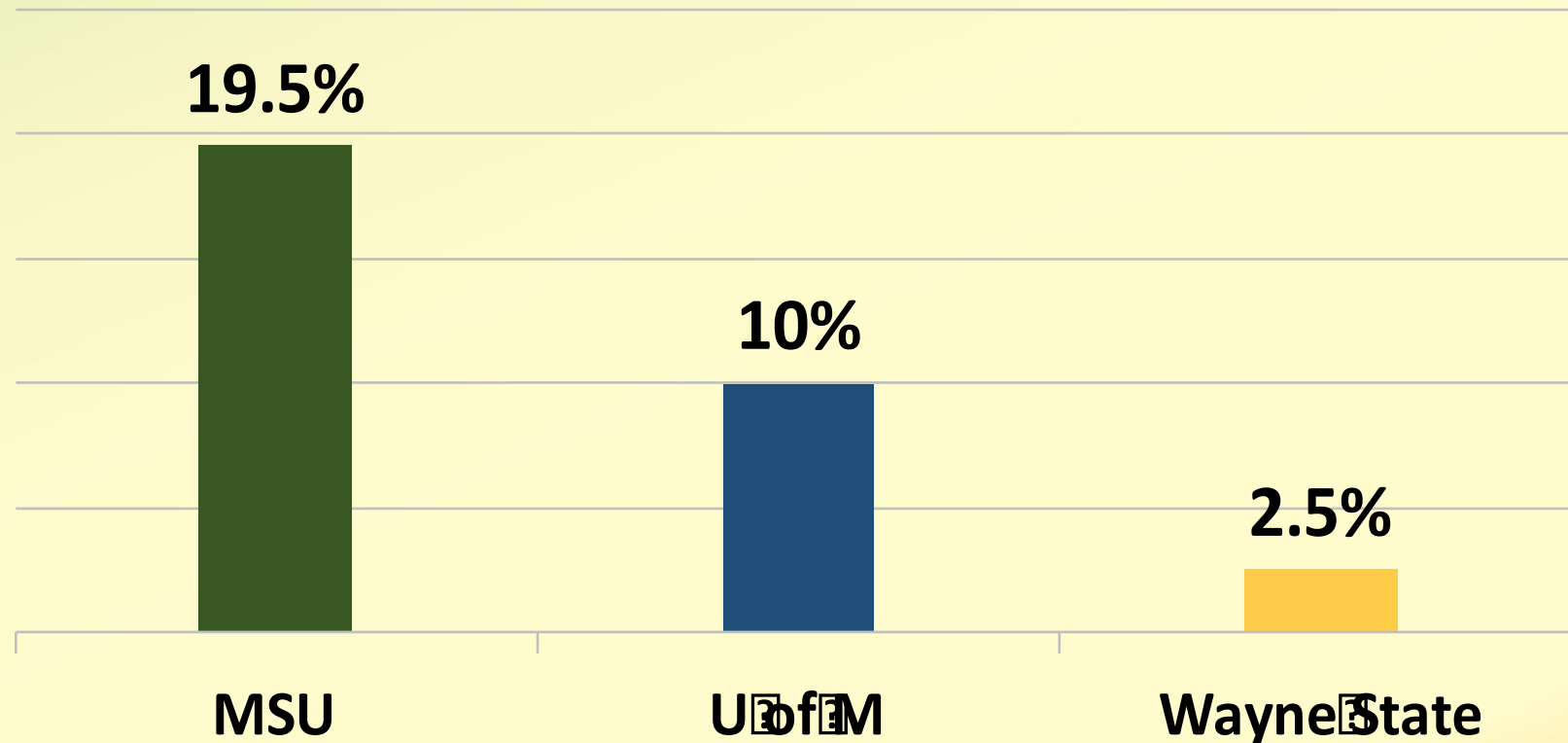| Public Medical Schools in States with Affirm Action Bans	Precentage of Class Underrepresented in Medicine* Class of 2014
University of California, Los Angeles David Geffen School of Medicine	33%
University of California, San Francisco School of Medicine	25.50%
UC Davis School of Medicine	24.50%
Florida State University College of Medicine	20%
Michigan State University College of Human Medicine	**19.50%**
University of California, San Diego School of Medicine	19.40%
University of Arizona College of Medicine (Phoenix)	17.50%
University of Florida College of Medicine (Gainesville)	17%
University of Colorado School of Medicine	13.70%
University of Oklahoma College of Medicine	12.70%
University of California, Riverside School of Medicine	12%
University of Michigan Medical Schools	**10%**
Florida International University Herbert Wertheim College of Medicine	10.10%
University of Arizona College of Medicine (Tucson)	9.60%
University of California, Irvine School of Medicine	9.60%
USF Health Morsani College of Medicine	7.10%
University of Nebraska College of Medicine	6.30%
University of Central Florida College of Medicine	5.80%
University of Washington School of Medicine	5.80%
Wayne State University School of Medicine	**2.50%**
Florida Atlantic University Charles E. Schmidt College of Medicine	1.60%
Central Michigan University College of Medicine	0%

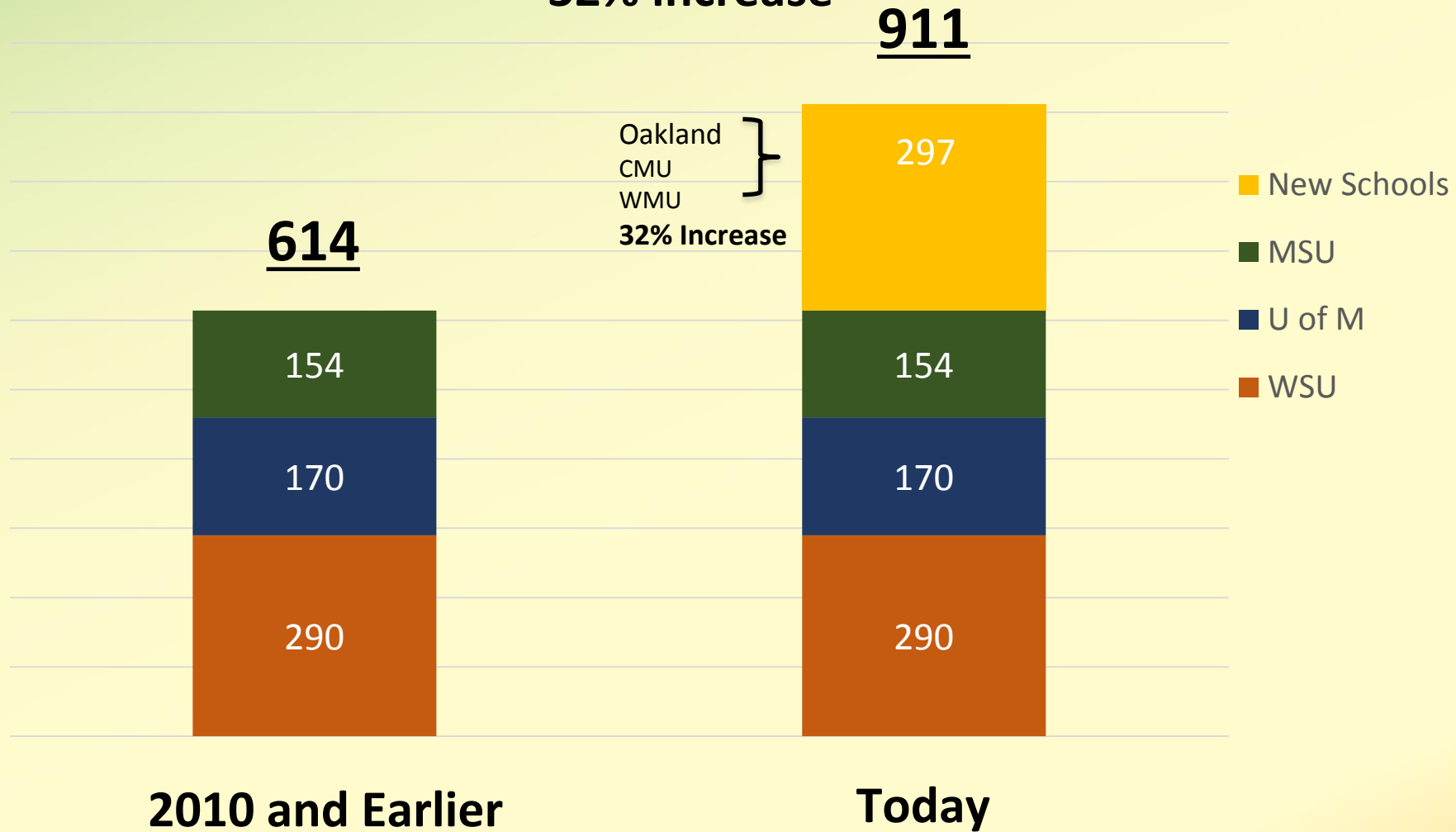- Data taken from the most recent version of the MSAR publication (2015)

AAMC Definition

Underrepresented Minorities =
Underrepresented in Medicine (URM)

"Those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population."

NEW ACCREDITATION PARADIGM

- The ability of an organization to:
  - Systematically & continuously identify challenges
  - Rapidly determine & synthesize relevant information/data
  - Diagnose root-cause of problems
  - Develop & implement appropriate interventions
  - Assess intervention effectiveness (measure results)
  - Modify accordingly

Culture of Assessment and Continuous Quality Improvement

Getting Started:
Systematically & Continuously identify challenges

- **Step 1:** Form a team with knowledge of the system
  - School of Medicine Diversity Advisory Council (DAC) of the Dean

Co-Chairs
Herbert C. Smitherman, Jr. MD, MPH
Jane R. Thomas, PhD

  - » **Medical Education/Diversity Admin (3)**
  - » **Associate Provost Diversity (1)**
  - » **Health System Partner CMO (1)**
  - » **Research Admin (2)**
  - » **Department Chairs (2)**
  - » **Faculty (6)**
  - » **Previous Dean (1)**
  - » *Staffed by the Dean's Chief of Staff*

Diagnose Root Cause Problems

- Uncommitted Leadership

- Lack of Mission focus

- Flawed application screening process

- Resource deficits (admission & diversity)

- Passive admission & recruitment strategies

- Poor marketing & branding

- Antiquated Med Ed Curriculum

- Lack of electronic automation

Lack of Vision & Clear Sense of Direction

New SOM: Vision, Mission & Commitment Statements

Vision

Wayne State University School of Medicine faculty and staff will graduate a diverse group of physicians and biomedical scientists who will transform the promise of equal health into a reality for all.

New SOM: Vision, Mission & Commitment Statements

Mission

We will educate a diverse student body in an urban setting and within a culture of inclusion, through high quality education, clinical excellence, pioneering research, local investment in our community and innovative technology, to prepare physician and biomedical scientific leaders to achieve health and wellness for our society.

New SOM: Vision, Mission & Commitment Statements

Commitment

We are privileged to serve our community, state, nation, and the world as innovators in medicine, health, prevention and wellness.

Develop Remediation Plans: Leadership

- University President M. Roy Wilson
  - Personal & professional commitment to improve
  - $550,000 per year increase in Diversity budget
  - New $1.6 million Merit scholarships
  - Access: priority on his calendar

Develop Remediation Plans: Leadership Changes

- ## WSUSOM Dean Jack D. Sobel
  - Appoint Vice Dean of Diversity and Inclusion at SOM level (new)
  - Appoint Associate Dean of Admissions
    - Personnel Change
    - Upgraded Position/Title
  - Recruitment of Richard S. Baker, Vice Dean of Medical Education
  - Support of staffing, process, personnel, & resource changes
  - Access: priority on his calendar

Transformational: Focused Leaders

Develop Remediation Plans: Admissions

Instituted holistic application review

- All Applicants receive Secondary Apps

- Individualized process

- All applications reviewed

Prior to 2016

Holistic Admissions

➢ Selection was based only upon:
- MCAT (80th percentile)
- GPA (3.7)
  - >3,000 applicants denied w/o any review of their primary or secondary application

AAMC Data
GPA & MCAT

➢ AAMC 2016 national data

- GPA > **3.6** with MCAT ≥ **78%** = 4 year graduation rates from 90-100%

Source: AAMC 2016 Data Book percentage of 2007-2009 Students who graduated from Med School in 4 years

How are we Holisticly measuring WSUSOM applicants?

Holistic Review: Assessed in 4 ways:

- ➢ Secondary Application Questions
- ➢ 1-1 Long Form Interview with a Physician/Ph.D. (Admission Committee Member)
- ➢ 5 Multiple Mini Interview Stations
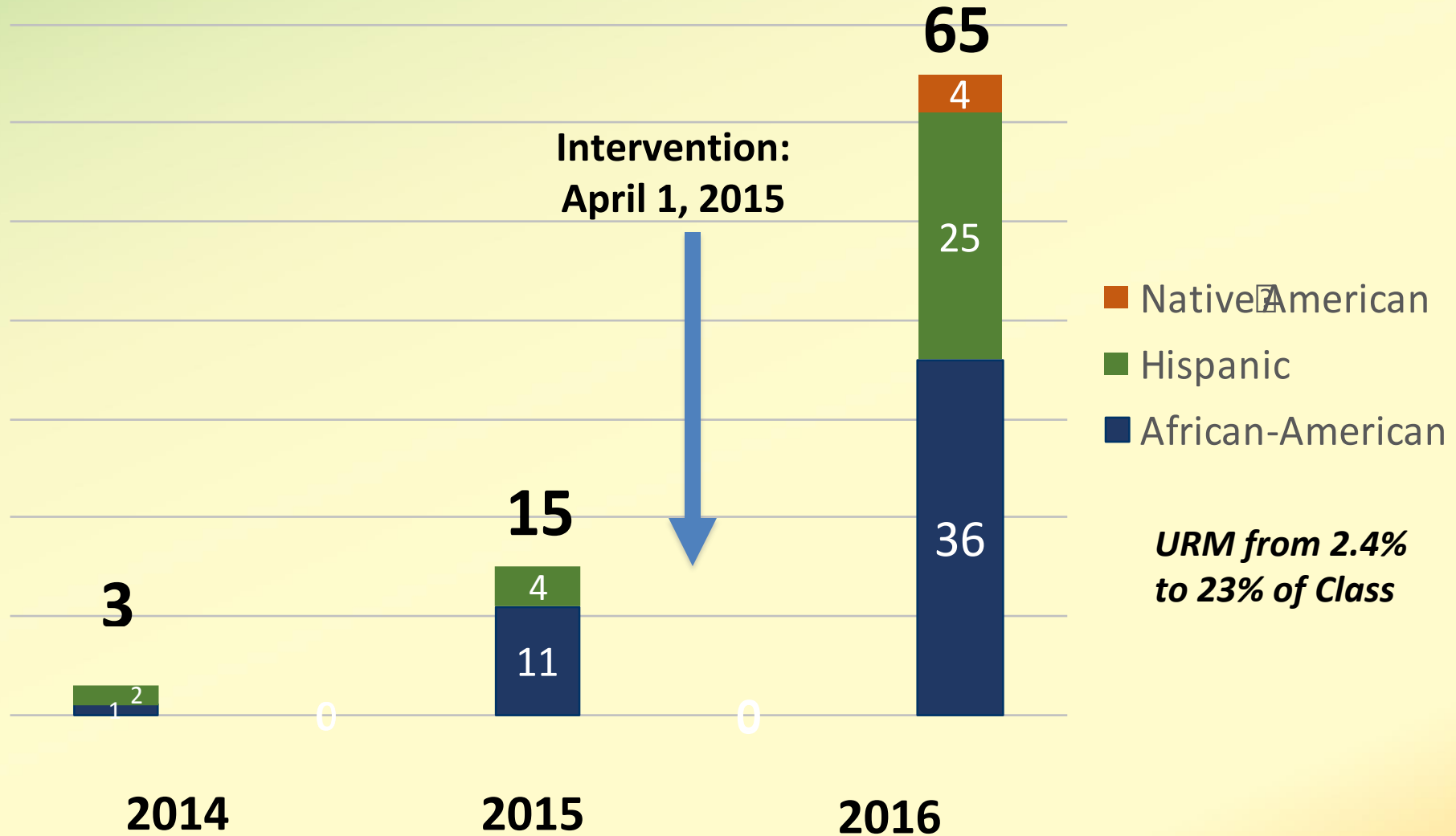- ➢ Standardizing all interview questions & aligning the process/questions with our mission

Develop Remediation Plans: Admissions

- Heavy Recruitment, Outreach & Marketing
- Expanded Admissions Committee
- Created new office with Director of Enrollment Management Services
- Formed new SOM Admissions Executive Committee (Advisory to Associate Dean of Admissions)
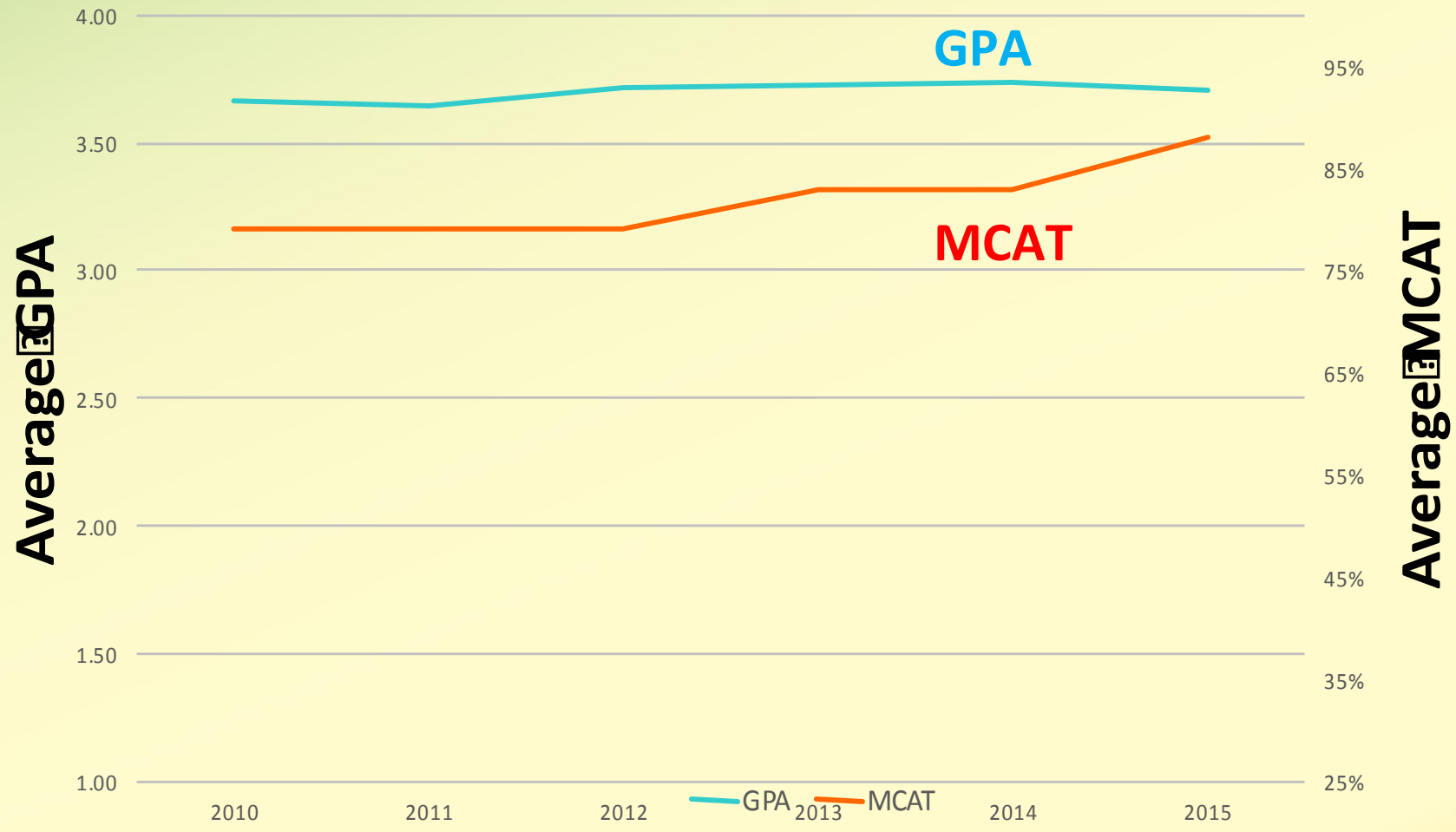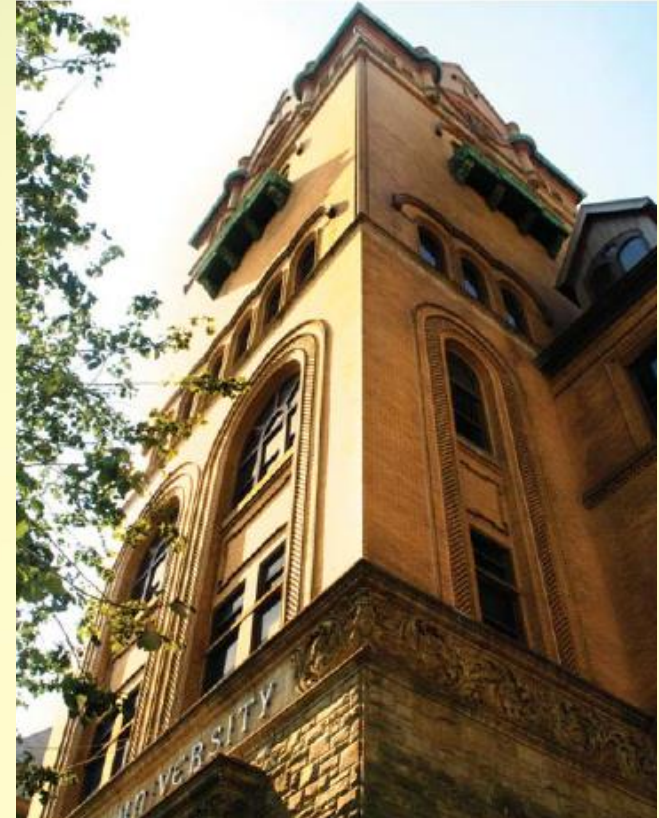
(New)
Wayne Med-Direct Program

Wayne Med-Direct: Eligibility

Accepting 10 high school students with minimum:
- GPA of 3.5
- SAT score: 1340 or ACT score: 30 (95th %tile)
- *Preference will be given to:*

a. *Students from disadvantaged socioeconomic backgrounds*

b. *Students interested in addressing urban health disparities*

Benefits

• Four years paid WSU undergraduate tuition

• Four years paid medical school tuition

• Undergraduate room and board in university housing

• Acceptance and admission to WSU School of Medicine with successful completion of WMD Program (i.e., successful completion of the BS or BA degree and MCAT)

Admissions Changes for 2016

2015-2016

- Marketing and Branding Enhancements

- Staff Hires (Recruiter, Marketing Manager)

- Holistic Review of Applications

- Implemented Technology Enhancements

Admissions Changes 2017

2016-2017

- Continued Marketing Enhancements

- Staff Hires (Data Analyst)

- Continued Technology Enhancements

- Targeted Recruitment Plans

- Interview Day Changes

- Launched Community Partners (MMI raters)

Branding Enhancements

- Admissions hallway mural and office sign

- Light pole banners along Canfield and in SOM parking lot

- Digital signage in Scott Hall

- Wayne State logos and SOM mission statement signs throughout SOM campus

Technology Enhancements

- An application status page containing a checklist for materials that applicants need to submit
- Email notifications generated at every completed step in the process
- Online payment and materials (photographs, technical standards) uploaded directly to the system
- Interviews scheduled directly through a scheduling system with auto reminders
- New tools for reviewing applicants
- New tool for scoring applicants

Continuous Quality Improvement

- **The process of accreditation required:**
  - an in-depth self examination of our need for change
  - benchmarking ourselves against peer institutions and aligning with best practices in the field
  - Establishing a CQI process ensures that all facets of our Diversity, Admissions & Educational programs are of the highest quality
  - Ensures transparency & accountability
  - Adjusted our strategy, focus & our resources

"Disguised Blessing"

- LCME action was impetus to change

- Without it, WSUSOM would not have been able to do what needed to be done:
  - Leadership change
  - Resource commitment
  - Warning vs. Probation

June 2015 LCME Sanctions
Students, **Faculty**, and Staff

		Gender		Race/Ethnicity										
	Total Faculty	Male	Female	American Indian/Alaskan Native	Asian	Black or African American	Hispanic, Latino, or of Spanish Origin	Native Hawaiian or Other Pacific Islander	White	North African/Middle Eastern	Multi-Race Hispanic	Multi-Race Non-Hispanic	Unknown	Other
All														
Instructor	4	2	2	0	3	1	0	0	0	0	0	0	0	0
Assistant	471	279	192	0	153	26	8	2	236	8	14	9	6	9
Associate	240	153	87	1	72	12	4	0	131	7	5	2	2	4
Professor	325	258	67	0	63	6	5	0	236	6	5	0	1	3
TOTALS	**1040**	**692**	**348**	**1**	**291**	**45**	**17**	**2**	**603**	**21**	**24**	**11**	**9**	**16**

6% of faculty URM; 33% of faculty Women!

Currently pivoting to address Faculty

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