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Connecting with the Secretariat Webinar

High Complexity, High Volume Systems: What the LCME Expects for Elements 1.1 and 3.3

March 9, 2023

1:30 pm – 3:00 pm ET

Welcome!

Thank you for joining us for today's webinar. The program will begin shortly.
You will not hear audio until we begin.

If you have technical questions, please email aamc@commpartners.com.

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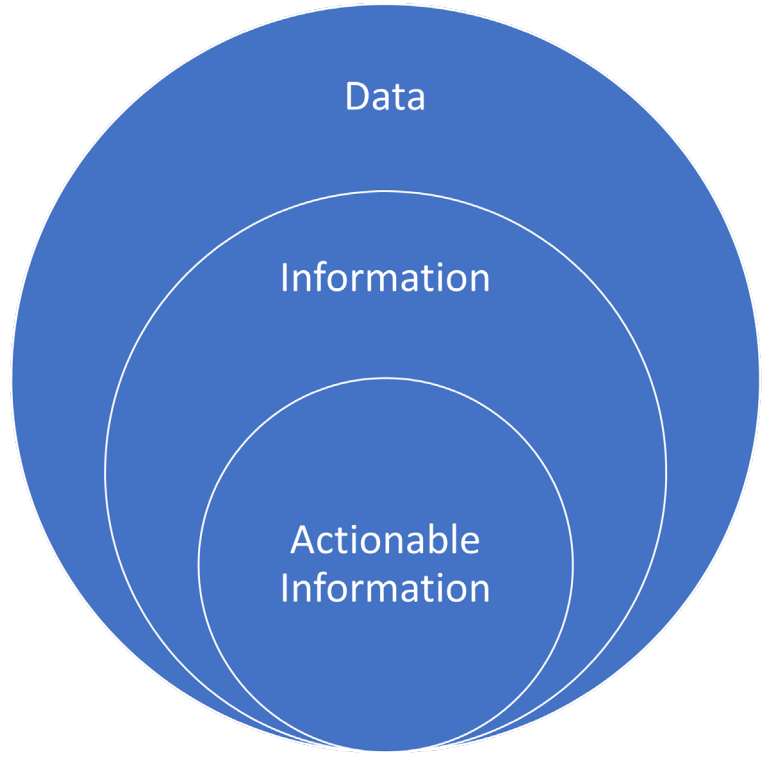
Element 1.1: Strategic Planning and Continuous Quality Improvement

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



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Element 1.1: Deconstruction

- **Collection of non-random, targeted data** identified prospectively based upon goals (for strategic planning) and intent of the accreditation elements (for CQI)
- **Organization of collected data into information** based upon **sub-goals** (for strategic planning) and an understanding of each component of an element's **intent** (guidance provided by the DCI, webinars, white papers)
- Delineation of **specific actionable information** based upon **knowledgeable analysis of overall institutional structure/function** and upon **knowledgeable search for/analysis of root causes** when concerns are identified (provision of actionable information to those empowered to design and implement actions)
- **Outcome evaluation** to gauge **effectiveness** of those actions/interventions **and**, if needed, to **redesign (if ineffective) or repeat (to document sustainability)** the targeted data collected in the next cycle

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Element 1.1: Common Pitfalls (Data)

- Collection of multiple individual data points without prospective identification of the goals/intent of the element

  Example:

  - Human resources data vs school-identified diversity category data

- Emphasis on quantity of data collected (or how it is displayed on a dashboard) rather than its quality and specific relationship to the SP goals and/or accreditation elements

  Examples:

  - Number of new faculty vs faculty trained and available to teach
  - New clinical sites vs quality and sufficiency of educational environment at those sites
  - Number of workplace-based assessments vs the ability of those assessments, in aggregate, to document student achievement of defined clinical skills by direct observation

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Element 1.1: Common Pitfalls (Information)

- Lack of organization of data into contextually useful categories

  Example:

  - Number of required clinical encounters/student/clerkship vs number of students meeting the school's required clinical encounters at each clinical site

- Organization of data into non-informative categories as a result of poor understanding of the element's intent

  Example:

  - Compilation of student evaluations of all courses and clerkships as evidence of curricular phase review and/or of review of the curriculum as a whole

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Element 1.1: Common Pitfalls (Actionable Information)

- Inability to identify and appropriately direct actionable information due to lack of knowledge of or appropriate utilization of institutional structure/function

  Example:

  - Reports of student mistreatment from a particular clinical site vs clear mechanisms and authority for addressing the source(s) of the problem at that site

- Failure to communicate to all interested parties the plans implemented in response to actionable information

  Examples:

  - M1 students informed of curricular modifications based upon M2 student feedback vs M1/M2/M3/M4 students regularly informed of these changes

- Failure to evaluate the effectiveness of the implemented plans and to adjust next CQI cycle accordingly

  Examples:

  - Identification of low rates of direct observation of clinical skills in a particular clerkship in a distributed model of education vs site-specific localization of challenging sites, determination of the root causes for the challenges, and design and implementation plans to correct the specific issues

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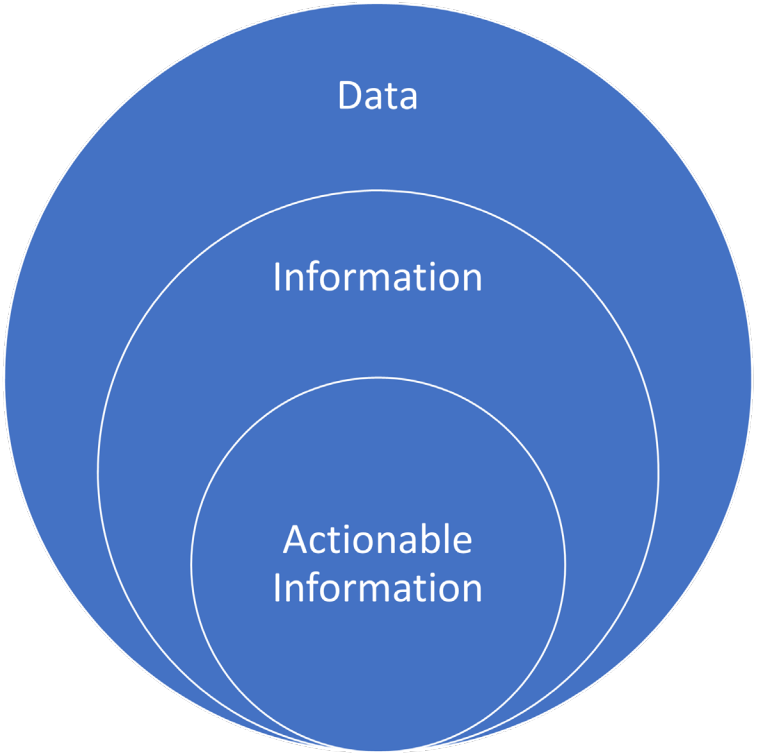
Element 3.3: Diversity Programs and Partnerships*

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.



* Title in place for the 2023-24 academic year

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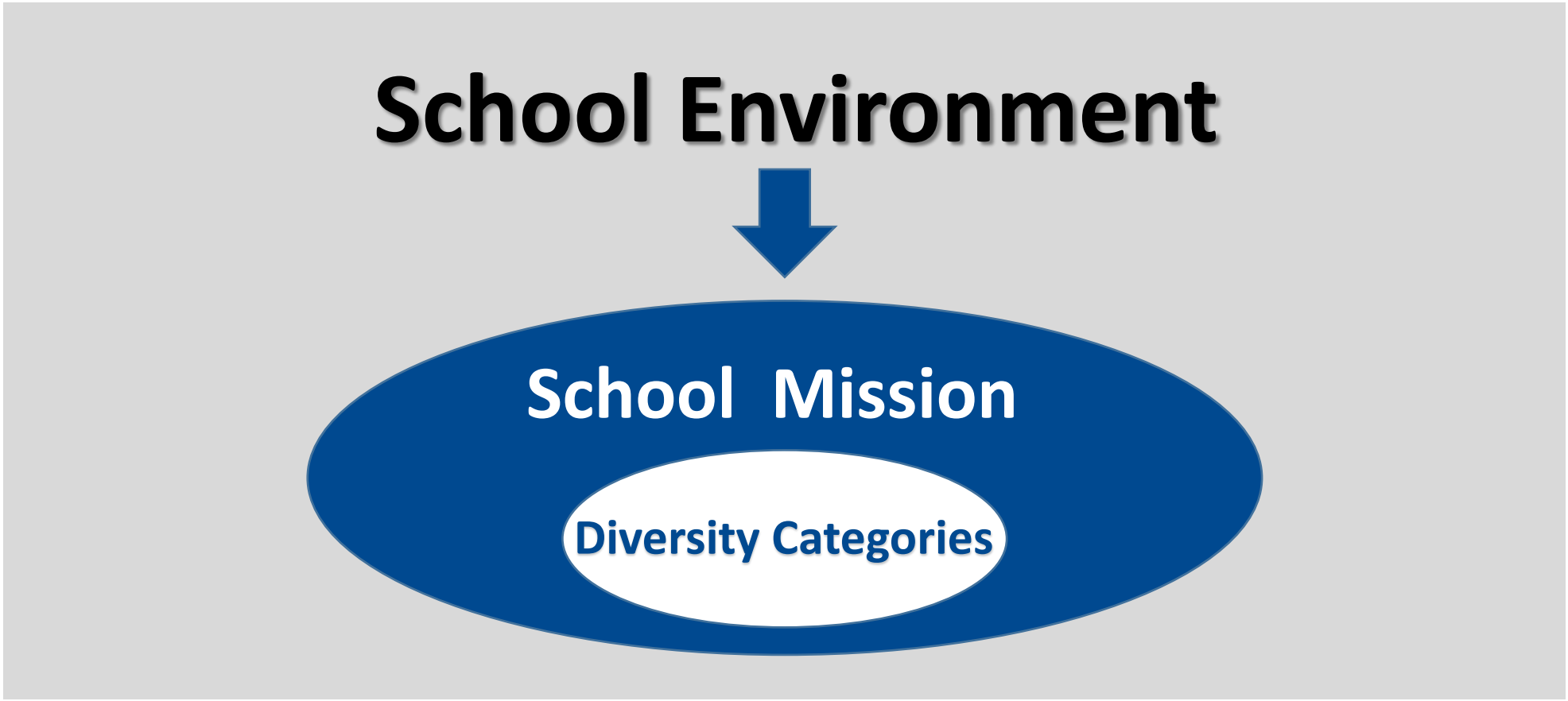
Element 3.3: Factors Influencing Diversity Categories



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Element 3.3: Deconstruction

- **Formal definition of specific diversity categories** for students, faculty, and senior administrative staff which will be the basis for school planning and programming
  - Categories will be specific to the institution based on mission/environment
  - Categories may differ among the groups (e.g., student categories differ from faculty)
- **Creation of programs/practices** to support recruitment and retention of individuals from the defined diversity categories
  - Sufficient personnel and other resources provided to support diversity activities
- **Collection of data**
  - **Offers made** to individuals from diversity categories (demonstrates effort)
  - **Number of enrolled/employed individuals** from each diversity category (demonstrates outcome)
- **Programs and partnerships created** to support the development of a national pool of qualified applicants to medical school (or potentially to other professions)
  - Programs implemented and **outcomes tracked**
  - Programs may support more than one diversity category

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Element 3.3: Common Pitfalls (Data)

- Collection of random data on institutional diversity without consideration of school-defined diversity categories
  - Data simply come from easily available data sets (e.g., from HR sources, AAMC national data)

- Data not defined/organized (e.g., specific definitions for categories lacking or categories aggregated in ways that make outcome analysis difficult) or data on relevant categories absent

- Data collected on programs (e.g., satisfaction) without attention to intent of the program or adequacy of committed resources

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Element 3.3: Common Pitfalls (Information)

- Diversity categories too broad, nonspecific to the school, not clearly defined so as to be accessible to school personnel and useful in program planning
  - Diversity categories are identical to those in the anti-discrimination policy
  - Diversity categories simply copy national lists (e.g., of groups underrepresented in medicine) without attention to school mission/environment
- Lack of match between diversity categories and programs (programs absent for some categories or lack of clarity about fit between programs and categories)
- Lack of match between identified categories and outcome monitoring
  - Monitoring of offers/enrollees includes more categories than the school has identified as its diversity categories or some categories not monitored
- Confusion of programs/practices for recruitment with programs/partnerships for developing the national pool of qualified applicants
  - Listing all activities without considering the specific goal (recruitment vs pool development)

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Element 3.3: Common Pitfalls (Actionable Information)

- Diversity policy and expectations not communicated to all relevant parties so institutional program planning proceeds in a vacuum, which leads to:
  - Inefficient use of resources (e.g., duplication of effort in program development/evaluation)
  - Lack of activities/programs for some diversity categories
  - Confusion among the relevant internal and external groups regarding the school's expectations

- Failure to use information (e.g., on success level of recruitments) as a basis to understand why diversity efforts are (or are not) effective and to make needed changes

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Submitted Question

In reviewing the most recent DCI and the most recent list of required ISA questions, we note there are questions in the ISA that are not explicitly reflected in any Elements within the DCI.

The DCI is the source of requirements for each Element and Standard, with required content that schools need to provide (including the ISA data) in order to demonstrate compliance. As such, why are there ISA questions that do not correspond to the DCI? Might these be an oversight? The risk here is that schools might overlook these questions in their CQI processes or fail to adequately connect them to the intended Element(s)

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Submitted Question

Element 3.3 Diversity Programs and Partnerships

1. Please explain the intent of Table 3.3-3 Offers Made for Faculty Positions.
   - The confidential data being asked for in this table is not something the medical school monitors.
2. Please explain the intent of Table 3.3-4 Offers Made for Senior Administrative Staff Positions.
   - The confidential data being asked for in this table is not something the medical school monitors.
3. Please explain the intent of Table 3.3-5 Students, Faculty, and Senior Administrative Staff.
   - The confidential data (employed faculty/sr. administrative staff) is not something the medical school monitors.

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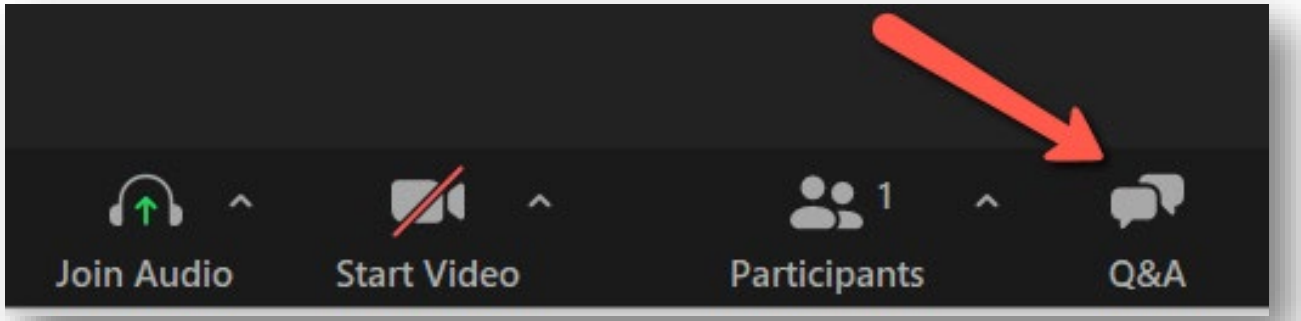
Open Q&A

How to ask questions in Zoom:

Participants can ask questions by hovering their mouse at the bottom of the screen to bring up their toolbar.



Click the Q&A icon and a box will open where you can submit a question.

Participants will not see other participants' questions. Only speakers will see the questions submitted.

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Next Webinar: Thursday, April 6, 2023

Topic of the Month:

LCME Process Changes: The Whats, Whens, and Whys

Email lcme@aamc.org with element or topic suggestions.