



SCHOOL OF MEDICINE

Oregon Health & Science University

TRIP REPORT

Listening Tour #1 for M.D. Curriculum Transformation – Meeting notes

July 15-17 2013

Eastern and Central Oregon

OHSU Participants: Mark Richardson, George Mejicano, Mark O'Hollaren, Kathleen McFall and Tim Kringen.

Rural clinical sites and groups visited/represented during Listening Tour #1: La Grande, Union/Elgin, Enterprise/Wallowa, Baker City, John Day, Prineville and Warm Springs.

The School of Medicine led a Listening Tour in eastern and central Oregon to gather information and feedback on the school's M.D. Curriculum Transformation initiative. The three-day tour included discussions with current preceptors; hospital, clinic and health system executives and clinicians; community and education leaders; health advocates; and tribal leaders.

For the School of Medicine, the goals of the tour were to:

1. Gather input and share information about the M.D. Curriculum Transformation initiative, with a focus on the future rural curriculum
2. Learn about future workforce needs, views on health care reform and evolving delivery systems, and how these factors could be reflected in a new curriculum
3. Introduce medical school educational leaders to regional partners
4. Strengthen relationships and improve communications channels with our educational partners

SUMMARY – “WHAT WE HEARD”

These notes are a compilation from multiple discussions over the three-day trip.

Broadly, all sites expressed the sentiment that their educational relationships with OHSU and the School of Medicine are important. The clinic sites visited (Baker City, John Day, Prineville and Warm Springs) as well as the hospitals demonstrated innovative approaches to care delivery, and many are practicing within the context of an integrated medical home/team-based model. All embody exceptional learning sites for our students.

Many meeting participants expressed concern that the Rural & Community Health Clerkship would be eliminated in the new curriculum, and shared their perspective on how this could negatively affect their practices and communities. Reasons ranged from the view that the clerkship was a primary connection

to OHSU to concerns that the clerkship influences physicians to choose to practice in rural Oregon (several preceptors were School of Medicine alumni and cited the clerkship as a reason for their choice to practice rural medicine). School of Medicine education leadership articulated the vision for the M.D. Curriculum Transformation initiative generally and the rural clerkship specifically, addressing information that was incorrect.

Dean Mark Richardson and Senior Associate Dean for Education George Mejicano assured participants that there are no plans to eliminate the current Rural & Community Health Clerkship in the new curriculum. They shared the [Rural Principles](#) associated with the M.D. Curriculum Transformation, and reiterated the school's commitment to these principles. These principles state that the current rural clerkship will be retained in the new curriculum as part of an expanded and strengthened rural clinical experience. In all cases, once assured that the current clerkship would remain as part of a broadened suite of options to fulfill a required rural rotation, productive discussions ensued about what those additional options might look like, and how innovations in the rural curriculum could better serve rural Oregon. The Rural Principles also stipulate that rural is defined for the purposes of the new curriculum as consistent with the definition provided by the [State's Office of Rural Health](#).

Representatives from some sites mentioned that they had heard that Principles of Clinical Medicine (PCM) course was being eliminated. Dr. Mejicano corrected this and explained how the foundations of PCM would be more effectively integrated across all aspects of the new curriculum. In some discussions, the [draft curriculum template](#) was reviewed.

Generally, discussions about how the practice of rural medicine is evolving and what future physicians will need to know to be effective in these settings provided important information for the transformation process. Key attributes that will be needed by future physicians were identified across most sites and matched many of the core competencies at the heart of the M.D. Curriculum Transformation initiative. There was a high degree of commonality of comments across all sites.

Key themes emerging from the Listening Tour were:

1. The current Rural & Community Health Clerkship is very valuable; improvements and innovations would be welcome and while all sites were interested in maintaining, or even expanding, their student numbers and disciplines, family medicine and primary care are cornerstones for rural health care in Oregon. Ensuring that a rural experience remains required within the new curriculum and retains a community-based aspect is important.
2. While the current Rural & Community Health Clerkship is valuable for rural physician recruitment purposes, it also plays a role in bridging the "urban-rural divide" by helping all future physicians better understand the complex clinical and community role of a rural physician, and ensures mutual respect among physicians practicing in different regions.
3. Some preceptors would appreciate greater faculty development and/or guidance from the School of Medicine as to what specific learning goals are appropriate for any given student rotating through their clinics. The variability of student engagement differs markedly. Some are

deeply involved and committed to the rural learning experience while a few tend to treat it as a “rotation vacation.”

4. Evolution of the current Rural & Community Health Clerkship to include more specialties, especially surgery, mental health and Ob/GYN, would be helpful to rural workforce recruitment needs. Some sites noted that such specialties are a crucial need in rural Oregon immediately, and that their practices hinge on the concurrent availability of these specialists.
5. Education partnerships could potentially be more effective if the model shifted to a focus on relationships with preceptor sites rather than its current relationship with individual preceptor physicians.
6. Key attributes (beyond broad-based clinical skills) that will be needed by future rural physicians mentioned multiple times across all sites during the trip included: leadership skills (especially of clinician teams), communications skills, systems-thinking, informatics abilities, small business training, an ability to manage complexity/diversity of cases, a capacity for lifelong learning/ability to assimilate new information, an ability to manage transitions of care and to provide leadership on quality improvement initiatives, and an ease with technology, including telemedicine techniques.
7. Most participants saw the evolution of health care delivery and the advent of CCOs as an opportunity to move toward a population-based approach to rural health care – to care for the health of the entire community. The use of the electronic health record and related analytical tools support this approach, and student education and training would ideally be aligned with this emerging model.
8. Some sites noted that rural practice was itself at a point of evolution, and that in order to retain/recruit future physicians, these sites would need to more aggressively adapt and integrate technology and other tools into their practice. A related comment heard several times was speculation about how rural practice would be organized in the future – would most physicians be employed by a health system?
9. Most sites saw a growing role for NPs, PAs and other clinicians to provide primary care, working in a team led/managed by a physician in ways that would empower the professional goals and abilities of all members of the team (this relates to the need for future physicians to have management/leadership skills).
10. Conversations about whether the medical school curriculum design should prioritize current workforce needs occurred in most cases. These conversations included ideas about how the new curriculum could strike a balance between meeting current workforce needs with what would likely be shifting workforce needs in coming decades.
11. All sites consistently recognized the value of a partnership with OHSU and, in some cases, an enthusiasm to be an advocate for OHSU’s public missions in rural Oregon. Many specifically mentioned the OHSU Consult Line, noting the frequency with which they use this resource, existing telemedicine relationships and key relationships with specific faculty members.
12. While the discussions focused specifically on M.D. education, all participants noted that the role of Graduate Medical Education was crucial to meeting future rural and other Oregon workforce needs, and requested additional conversations about how to expand GME in rural training sites. (See recent [JAMA article](#) “Association Between Dedicated Rural Training Year and the Likelihood

of Becoming a General Surgeon in a Small Town” describing data obtained from OHSU’s rural surgery GME program in Grants Pass, which was discussed at some sites as a good model for expanding GME).

13. Discussions about how to encourage careers in health care included reaching out to potential students earlier in the pipeline (elementary school) and finding ways to ensure that students who commit to rural practice are eligible for loan repayment or tuition waivers. Expanded opportunities for in-place distance learning would be helpful to rural students.
14. Representatives at our tribal partner site (Warm Springs) pointed out that many of the same issues that are of concern to rural Oregon are relevant there as well, but there are cultural factors that result in important distinctions, and that students should be aware of/educated to respect these differences. However, most of the other observations listed in these notes about educational partnerships with OHSU and attributes of future physicians were also voiced at Warm Springs.
15. Our educational partners all indicated they would appreciate ways to continue engagement in the M.D. Curriculum Transformation process. We identified and discussed several tactics, among them:
 - a. Regular progress reports in emails from school leadership
 - b. Presentation at key statewide events, including a session at the upcoming annual 2013 [Rural Health Conference](#) (October 23-25) in Portland, Ore.
 - c. Future clinic site visits from school leadership
 - d. Regular updates to the curriculum transformation website, with more detail about the competency-based approach to curriculum transformation and how success will be measured
 - e. Possible establishment of a School of Medicine Rural Community Advisory Group

Drs. Richardson and Mejicano have shared the feedback from this Listening Tour #1 with the Curriculum Transformation Steering Committee to ensure it will inform the ongoing process. The items indicated in #15 are underway.

Please visit www.ohsu.edu/newcurriculum for information on the M.D. Curriculum Transformation initiative.

OHSU participant particulars:

Mark Richardson, M.D., Dean, OHSU School of Medicine and President, OHSU Faculty Practice Plan
George Mejicano, M.D., Senior Associate Dean for Education
Mark O’Hollaren, M.D., Vice President for Clinical Outreach
Kathleen McFall, Director of Communications, OHSU School of Medicine
Tim Kringen, Senior Communications Specialist, OHSU