Summary: A Community Engaged Design and Dissemination Studio (CED^{2}S) in rural health professions education research
The RTT Collaborative Annual Meeting
April 20, 2017 – Anderson, SC

The following pages summarize the inaugural Collaborative for Rural Primary care Research, Education, and Practice (Rural PREP) Community Engaged Design and Dissemination Studio (CED^{2}S) in rural health professions education research, held in conjunction with The RTT Collaborative Annual Meeting and facilitated by Rural PREP associate project director, Randall Longenecker. The planned process and outline appears first, followed by notes. Rural PREP project director Davis Patterson and Dave Schmitz, a part of the core leadership team for Rural PREP, took notes, which are aligned in two columns.

Dr. Longenecker, although a "community member" of the rural health professions community of practice, is also executive director of The RTT Collaborative and as such holds inordinate power in this process. Once the process has been refined we will hopefully, in subsequent iterations of this process, recruit a community member who is not in leadership of Rural PREP to at least co-facilitate the process.

As leaders of Rural PREP, we took away several important lessons, which were validated by otherwise positive evaluations of the session:

1. This seems to be an excellent way to engage the community of practice in rural health professions education in developing, refining and implementing health professions education research
2. However, there needs to be better preparation of the presenters, to assure that they thoroughly understand the process and their role
3. It also would have been helpful to better prepare the community participants. Most did not complete the pre-work.
4. The fishbowl is an effective way to reduce the size of the advisory group, but may exclude important voices from the community; recruiting for the fishbowl group may need to be more deliberate and the participants, like the presenters, need to commit to significant pre-work.
5. If a fishbowl is employed, it will be important to mic the participants, so that everyone can hear.
6. A large group is very difficult to prepare for and then keep focused on the task at hand.

Randall Longenecker MD

Rural Health Professions Education Research Design and Dissemination Studio
Community Engaged Design and Dissemination Studio (CED^{2}S) in rural health professions education research
Thursday AM, April 20, 2017 – Anderson, SC

Modeled after the Community Engagement Studio process and Toolkit[1]
https://victr.vanderbilt.edu/pub/resources/upload/files/CES%20Toolkit.pdf
(Accessed March 8, 2017)

For a YouTube example of the Meharry process see:
https://www.youtube.com/watch?v=7ti-aBtThZY
(Accessed March 8, 2017)

Objectives of the Studio:

1. Strengthen research proposals,
2. Increase the relevance of the research to a community of practice,
3. Improve recruitment and retention of research participants, and
4. Build a cadre of research-engaged stakeholders
5. Make research more community centered, culturally relevant, and accessible to potential research participants

Process

1. An invitation to stakeholder members to participate as "community members" (To those attending the preconference CBPR workshop on April 19, and to the audience on April 20)

   Criteria for stakeholders – Attendees at the RTT Collaborative Annual Meeting who choose to participate, who are:

   a. a member of the investigator's target population (or having extensive knowledge of the population, e.g., as an advocate, caregiver, or provider),
   b. are willing to share their knowledge, and
   c. have an interest in improving research.

2. Selection of stakeholder participants (8-10 from CBPR participants); the remainder of attendees in the first session on April 20 will participate initially as an observer group (Fish-bowl strategy); the second session will engage the entire audience

3. A pre-reading assignment and preparatory materials will be sent to all CBPR participants 2 weeks prior, including this process document; the larger group who will be attending on Thursday will get the 2 articles on CBPR and Design & Dissemination Studios, and brief research summaries

4. A pre-meeting orientation for stakeholders and researchers – the CBPR pre-conference workshop will engage stakeholders; researchers will be engaged over phone in the two weeks prior to the meeting.

5. Community of practice engagement through an in-person meeting

   - A two-and-one-half hour format modeled after the Meharry-Vanderbilt process, but adapted to accommodate 2 research presenters in two 1-hour sessions, each focused on a single study, with an intervening break. This will include two of the following:
     - A completed research study, and its subsequent implementation in educational practice ("Something old")
     - A presentation of a study in process (after IRB approval and perhaps in the stage of data analysis and interpretation

[1] Joosten YA et al. Community Engagement Studios: A Structured Approach to Obtaining Meaningful Input From Stakeholders to Inform Research, Acad Med. 2015;90:1646–1650.

    - A presentation of a proposed study ("Something new") – data collection not yet implemented, not yet fully designed
- Facilitated by a community member (to minimize the power differential, and reinforce the idea of community member as "expert")
- Followed by larger audience interaction and generation of new research ideas

Time	Content	Responsible person
10 minutes	Introduction to the larger group, and convening of a smaller "fishbowl" group for the initial session	Longenecker
1 hour	• Research presentation on Rural Competencies (10 minutes) with a question(s) for the group • Clarifying questions (10 minutes) • Group discussion based on series of prompts – first with fishbowl group, then with observer group • Researcher response (5 minutes)	Presenter – Schmitz Facilitator - Longenecker
15 minutes	Break	
1 hour	• Research presentation on Primary Care outcomes (10 minutes) with a question(s) for the group • Clarifying questions (10 minutes) • Group discussion based on series of prompts • Researcher response (5 minutes)	Presenter – Deutchman Facilitator – Longenecker
5 minutes	Evaluation - http://tinyurl.com/RuralPREP	Longenecker

6. Evaluation online through Qualtrics, including participant demographics, evaluation of studio objectives, and general feedback; reflections from both small group and large group observers

   In comparison, from Joosten et al (2015):

   One hundred forty-seven (97%) strongly agreed or agreed that they received enough information from the investigator to give appropriate feedback, and 150 (99%) believed that their feedback would improve the project. Almost all stakeholders (150 [99%]) reported that the CE Studio was worth their time, and 149 (98%) indicated that they would be willing to participate again.

   In the 28 post–CE Studio evaluations, 22 researchers (79%) indicated that the CE Studio increased their understanding of and sensitivity to the study populations. Twenty researchers (71%) believed that the CE Studio input informed the feasibility of the project, and 17 (61%) stated that the input informed the strategies for recruitment and plans for dissemination.

7. Stakeholder Follow-up and Reporting – Participants can indicate in the online evaluation their desire to participate in a follow-up survey in 6 months

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39 participants, including presenters

Session I: Competence Revisited in a Rural Context (Dave Schmitz)

Using six rural competency domains first refined with a national group at the Society of Teachers of Family Medicine Annual Meeting in Baltimore in 2008, the authors employed a snowball strategy to survey medical educators and physicians regarding the importance and relevance of this list and to solicit additional domains and competencies. All six domains were considered important, with average responses for each domain ranging from 4.16 to 4.78 on a 5-point Likert scale (1 not important; 5 extremely important). Unique relevance to rural practice was more varied, with average responses for domains ranging from 2.36 to 3.6 (1 not at all unique; 5 extremely unique). Analysis of free text responses identified two important new domains—Comprehensiveness and Agency/Courage— and provided clarification of some competencies within existing domains.

Studio participants:

6 "fishbowl" participants
33 "audience" participants

Researcher's Question:

How can these competencies be used in each of your settings?

Clarifying questions

Q: How did you come up with competencies?
None existed for rural, developed for RTT in 2007, nominal group process in Baltimore at STFM, multiple refinements over time, including position paper for NRHA (see methods in paper).

Q: What's the overall goal? Practical implementation? (part of later discussion)

Q: Was there any cross-referencing with ACGME subcompetencies and milestones?
"Perpendicular" to ACGME competencies in the beginning, mapped to general competencies

Is this a question the group can answer?

How could this research be applied to your educational settings? (fishbowl portion of exercise)
Can they be used?

Fishbowl Discussion (2 note-takers)

Adaptability and Abundance… are the two I think should be addressed in rural setting.

Scope of practice: one of the first questions I ask residents—what do you want to do and how? Also collaboration and community—integrating in community is a factor in how long they stay.

How to implement in brand new program?
As part of sports med program, we'll be in the high schools and colleges. During process, new guys will become friends with coaches, be taken under their wings.

Sports medicine curriculum is in the community – become friends with the coaches, ask questions of interests of the residents and would draw them to a rural area

I ask residents what you like to do that brought them to our area. New resident connected with pharmacist: both like horses.

Possibly unique to rural: building of need for emotional intelligence that transcends role as professional to role as community member. Easier to be a role player in an urban community. In rural, need social intuition and context awareness. Without it, a setup for problems. I don't think it falls clearly into any of the domains, but maybe researchers on emotional intelligence could help us with that.

Building on a need for EQ from role as a physician to a community member (sic…is unique to rural practice). If you fail to have community intuition is a risk for failure. Doesn't seem to fall into the present design. That was my experience, it's more than the spotlight, you are in the spotlight. Might be in the reflective practice.

I think it's part of reflective practice—reflecting who you are in community.

For education: could set up time for reflective practice and community responsiveness. Can't think of ways to set up curriculum for the others?

Can set up training to be reflective, but the rest of the competencies, I don't see how you set up program to train on those.

I think these are all very important after my 11 years in rural practice. Example: at daughter's band concert and you're still a physician—people approach for medical advice. You're always in your role. I don't think there's a good way to prepare sometimes, except education about what to expect in a rural community—you're going to be in that glass house, be seen at Walmart, the grocery store, at different venues, be in that limelight. All of this is going to be very important.

All very important in my experience in rural practice. How do you prepare? Maybe education of knowing what to expect. Don't know how to train otherwise.

Leadership presence in the community—to be able to have that presence in the community. "Now's not the time—call me later and we can discuss." It takes a huge amount of finesse.

Leadership presence in the community and knowing how to be able to handle "questions in the grocery market" takes finesse and leadership.

Randy's summary>>>Lot of face validity, not sure if unique to rural practice, but more obvious in its absence in a rural place.

In a rural setting, we need to advocate for more diversity.

Rural settings need to advocate for diversity, we could be advocates for that.

How do we shape the residency to lead toward these competencies? I'm not seeing how to do that.

Wonder how we shape the residency to lead toward these competencies?

Maybe dedicated time: traditional residencies are oriented toward clinical skills acquisition. What seems to work is to have an intro month where we deal with developing cohesion and these skills in an intentional way in dedicated time—retreats, etc.—just as important as learning how to put on a cast. Part of skill package, self development to allow you to mature. That seems to bring people together, create cohesion. Easier to do with a large group (e.g., 10) than 2. Residents would see this list in the first week of residency.

Dedicated time toward not just skills and rotation experiences but also to have an introductory month "Introduction to FM" dealing with developing these skills and cohesion in a very intentional way. States up from that this is important and part of the skill package, allowing you to mature what you can do for others and what kind of person you are. Creates cohesion in the resident group.

List would be seen in the first week of residency.

Could be used to attract to residency—what does our student think?
A lot of medicine happens where there is so much ambiguity, especially, in a rural environment, which is part of why I'm attracted to it. In medical school, less focus on shades of gray (right or wrong), so this could be used to attract students to rural practice.

A lot of things are foreign from my experience as a student right now. A lot of medicine happens where these skills are important due to presence of ambiguity and important for rural. Might be unique to rural medical education and be a promoter for deciding on rural practice.

Will anyone use in their residency?

"Well, sure Randy; we will use these in our programs."

Maybe take one at a time, spend 5 minutes of didactics discussing.

I might do a talk on these or maybe take one of them at a time during didactics.

In Colorado, resiliency sticks out for me—one of the things we talk about with our faculty because it trickles down. If we are the model, we need to do this. It starts with me.

Wellness and resilience in faculty trickles down and this is important.

Will anyone measure these in your learners? If so, how would you measure?

My residency has a core measures group, scale of 1-5 expectations for behaviors. When we do that, it's amazing to see where people are at. Rate selves as 2 or 5. The 5's usually need to think about where they really are, the 2's think they're not doing as well as they are.

My health system has a core measures system and people rate themselves at 2 or 5; self-talk is important.

Simple quiz on measures of resilience and social intuition, readily available, could use for resilience, reflective practice. I don't see intuition, reading body language, context awareness. Most don't come from environment where we're going to practice. Most more privileged—it's not about you but about awareness of where you are that leads to your success. "The Emotional Life of Your Brain." One tool, not the only one.

"Emotional Life of Your Brain" interactive with first-year residents. This gives feedback on resilience and social intuition. Useful. Tied to resilience, reflective practice. What is missing is intuition and context awareness. Most physicians do not come from the same environment they practice in. Need to get to the point of "its not about you, it's about what is in the context".

For each of these, take one at the beginning of a talk to consider what it means in rural practice—a little bit of time for whatever else we're doing.

How do you prioritize? Should one be more important? Or tailor to each resident?

See how it correlates with milestones. I might use it.

Setting up an RTT, it's a good tool to use whether as anchors or for training in the main track and see where people are, where they're weak.

Expect resistance on this. People come in wanting concrete. The soft stuff is the hard stuff. It takes doctors a long time to realize this is at the root of their professional satisfaction and ability to have meaningful careers (as opposed to clinical content). Being the change. Too gooey for a lot of people who've been in traditional right/wrong medical education contexts. Once they get it, it begins to get some traction. Students don't come in asking for lessons on resilience.

To medical student: You start residency and get handed this list. What do you think?

I think initially it's not going to have a lot of effect on me. We get thrown so many things, but I think once we get experience, we can see. If presented in a nice way, it shows the program is worried about my long-term health and success as a physician.

How many medical students are competent in any of the areas?

How many admissions committees use these as criteria for selection?

Integrity is a given, from when you are 5. Almost all of them are learned before you get to medical school.

Some of them are characteristics, some can be learned—comprehensiveness.

I think the university setting is starting to change. My son's college has a resiliency course. When I went to school, that never happened.

Series of talks for each of these; "what does this mean in rural practice" in sessions as anchors.
Series of talks for each of these; "what does this mean in rural practice" in sessions as anchors.
How do you prioritize? Or tailored toward each resident? How to set up in curriculum.

Would be interesting to see how this correlates with the CCC in the Milestones. "I might use it".

In setting up a RTT, might be interesting to see in the core program and then tailor during the RTT years.

Expect resistance from medical students who "want concrete". It takes a while for young doctors to realize this is at the root of their success and happiness. Role modeling this and being the change is important but expect resistance. Once they get it during the experience in residency, they may come to it.

Student: Initially it's not going to have an impact on me. Hard to recognize until experiencing in your day to day. Hopefully solidify my ideas of why I am going to a rural training program. Nice program is concerned about my long-term health and success as a physician.

Do not feel that medical students come into medical school with these – except integrity. That is a given.

Almost all of them are learned before they come to medical school.

Some are characteristics. Some can be learned, like comprehensiveness.

College and university settings are starting to teach these things. Not so prior.

Open Discussion

These soft skills can be taught just as hard skills can be taught. You can lose integrity as you go through the system, e.g., in medical school that is not flexible or patient centered. In residency you have to turn it around and think about the whole person, not just the clinical skills. The idea of having an incredibly important relationship not only with your patient but with your community. In a town of 2,000, I might be able to change the environment somewhat for my patients. I think this screams out for deep community engagement experiences—being in patient's houses. It's amazing how difficult it is to get through the health care system, even people with education. People can give a lot of insight. Important for all students, but particularly for rural students. A lot of rural students want to be the important person. That's not unique to physicians. Everyone's in a fish bowl as "the person" with particular expertise. Some community engagement exercises might do wonderful things here. How do people live? Where do they get their medications? Physical activities?

Soft skills can be taught just like hard skills. You can lose some skills in a non-flexible and not patient-centered, need to recoup in residency. Looking at this not as a physician but as a patient advocate. Community is very important and the impact physician can have on the environment of the community for my patients are important. This calls for getting outside the clinical environment but getting into the community. Have a patient describe navigating the healthcare system. Go to a patient's home. Everybody is in a fishbowl in a small town with "the person with expertise" giving an opportunity to really impact. Ask patients how they live and I think this can impact the curriculum.

Change the word from "competence" to "skills"—implies you either have to have it or not. That can be discouraging. Maybe there are gradations of how you get to that point. Some even late in their career might be uncomfortable with some of it. If we call someone incompetent…

Change competence to skills. Competence is on/off. Have it or not. That is discouraging. There are gradations. Even later in their career, being incompetent is a problem. Skills can be improved. Agree with domains.

Stay with domains.
Don't let the RRC see this. Keep it as research. Also ask patients what they see as useful skills?

Don't let the RC see this as this is research and other people, the community of patients, need to be brought into this project to broaden the things to be looked at.
Each of these descriptors has a spectrum of behaviors that could be described and used as milestones and keep in the domain of research before codify this.

Notion of milestones—each skill has a spectrum of behaviors you can describe. Takes some work to develop. Keep in the domain of research for a long time before you codify it.

Milestones as guideposts are helpful and useful. Observable behaviors. These are very advanced skills and residency could be a start but good for practicing physicians.

The 6 ACGME competencies helped inform thinking but the milestones made it useful—behaviors to describe. These are really advanced skills.

I think the ACGME needs practical suggestions about how to improve milestones/competencies. The hardest thing is translating milestone into something I can understand and recognize. I think you've done that here. They are level 4 and 5 skills—maybe they can be recodified as level 1-5 skills within the milestones. I try to retranslate some of the milestones into language that clinicians who are training my residents can understand—helps them assess better. Like all competencies, sometimes you're competent, sometimes not. Part of lifelong learning and assessing where you are.

How I intend to apply: I like this. In a medical student setting, we have a summer experience after first year. Students joined at the hip with rural physicians, with no clinical learning objectives. What is it like to be a rural physician? This list is a perfect list to look at when you're out there. Give to students as a menu. They are good at seeing things. If they have permission to look at how things are working, what does it look like to you, what does it feel like to be in that place? No clinical responsibility but can sit back and observe. Ask to pick one or more domains and write about it.

As a social worker, interesting difference between my perception of what's going on and what's really going on. Patients model these.

I could see focus not just on individual student but interprofessional team. Useful for having students from different disciplines talk about these elements and looking at process of care.

Importance of including people outside the health care system. Have patients give input on what they want. Might be very different from what physicians think they're looking for. Also have faculty use as a self evaluation, do some hard looking at yourself.

I like them a lot. Soft but harder to learn, and so important to learn. It's probably what I like most

AGME needs some practical suggestions on improving this. These are recognizable, are level 4 and 5 skills; may need 1-3 as well. Except for agency and courage which is new for inclusion. Some days you are competent and some days you are not. I don't know that I would throw out this word. I would share with ACGME.
about our RTTs, how our rural family docs model this. I can picture our rural faculty sitting down once a month and picking one a month to talk about, discuss examples of when this happened. Role modeling. (Looking for competence)

How I intend to apply this is using this in a medical student setting, future RTT residents. Medical school summer experience with no clinical learning objectives. "what does it feel like to be a rural physician". This is a perfect list for that. Students communicate in a blog, with a theme. With this as a menu, they are good at seeing things. With the permission or mandate to say "how are things working" and what does this feel like? They can sit back and observe. Being observational and introspective is the first step in this.

I like them. They are so important to learn. Our rural family docs role model this life in their communities, that's what I like best about our RTTs. I could see a lunch a month with a rural faculty having folks talking about examples of when this happened.

As a SW, it was eye-opening to get patient's perspectives. Need perspectives from outside of the healthcare delivery system.

AHEC and interprofessional education. Could be done with the interprofessional team of students. Have them look at an issue and how they enter into the care of the patient.

This is faculty development. Self-development. Utility in having these out there and patients about what they want from physicians.

Dave Schmitz Response:
Many areas of further study. A glaring point for me: how would patients respond? Patient-centered approach and including their perspectives. In a rural context, understanding that we're all part of that community.

Session II: Who REALLY Goes into Primary Care? (Mark Deutchman)

[No fishbowl this time]

Researcher's Question:

How can we meaningfully describe the true primary care output of our medical schools?
[Have already piloted (see handout)]

Clarifying questions:

Want to look at MD/DOs. Looking for other institutions to join in a multi-site study.

Look at Medicare data and work backwards to decide if primary care.

Deans will say no to this study. (permission not needed) Measured on how well they do on this.

FM grads that do fellowships? If not done with training, they're not in the study.

Ask patients how they define PC: e.g., in urban areas, women may think of OB/GYN as their primary care provider

Back to question: Meaningful true PC (as defined by Mark)

How do institutions measure PC?

How do we recruit investigators? Get a cohort and track all grads longitudinally without being specific about measuring PC

Important to identify sample pop: all, public, schools that focus on PC?

True location and discipline 5 years after residency (up to that time, paying of loans, etc.)

Does ACGME track? No, but ABFM is now doing cert and recert surveys.

Have medical students in PC interest group look up their program grads (that's how pilot worked) to engage students. Each collaborator will have to decide how to get the data.

Dartmouth is in! 12 schools already in.

Methodology? 10-year cohort

Need buy-in for recruitment of schools to participate (discussion).
Can help purpose of Alumni association.

Need to define the school inclusion criteria will be.

Office for Healthcare Workforce Research – recommend study point of 5 years after residency. Maybe use licensure data for specialty.

If available like FM, could look at post-graduate surveys and re-certification exam surveys.

Would PC interest group be willing to participate at other medical schools? (Continue the utilized methodology.)

Found location of practice and then drilled down for primary care/not.

AMA Masterfile for ACGME physicians might be a source and then cross with Medicare data.

Why are we approaching it from medical school perspective? Why not survey those in PC and find out who those people are. (We're trying to debunk "the dean's lie.")

Consider the purpose of asking this question, the audience and who could be a partner in this.

How many do we need to debunk it? One school? Pick 5 of the top 10 (start with U.S. News and see if they really are top). But need a comparison group.

Focus on whether the measure is accurate rather than whether it's truthful (deans are reporting a momentary truth) to take some of the politics out of it.

Can we compare with a new metric and look at this question with a better measure of output.

Concern about accuracy of medical student doing this work—reliability of measurement (consistency in protocols, etc.)

Methodology seems loose, for accuracy.

Important to do this for workforce planning and to be able to look at what schools are doing

Need to understand what happens in medical school that turn people on or off

Mark Deutchman Response:

What I heard:

- Most promising idea: looking at billing data
- Need for clear protocols for students to do this work
- Focus: top ten only, or bottom ten for comparison?
- Snapshot in time has validity, then roll out for long-term tracking (with $2 million)
- Don't worry about tracking all grads—only our definition of nominal PC.