TEAM REPORT
OF THE FULL SURVEY OF

University of Missouri – Columbia School of Medicine

Columbia, Mo

January 10-13, 2016

PREPARED BY AN *AD HOC* SURVEY TEAM

FOR THE

LIAISON COMMITTEE ON MEDICAL EDUCATION

Barbara Barzansky, PhD, MHPE
Co-Secretary
Liaison Committee on Medical Education
American Medical Association
330 North Wabash Avenue, Suite 39300
Chicago, IL 60611-5885
Phone: 312-464-4933
E-mail: barbara.barzansky@ama-assn.org

Dan Hunt, MD, MBA
Co-Secretary
Liaison Committee on Medical Education
Association of American Medical Colleges
655 K Street, NW, Suite 100
Washington, DC 20001-2339
Phone: 202-828-0596
E-mail: dhunt@aamc.org

June 22, 2016

Michael A. Middleton, JD
Interim President
University of Missouri - Columbia
Office of the President
321 University Hall
Columbia, MO 65211

RE: Survey visit for full accreditation on January 10-13, 2016

Dear President Middleton:

The purpose of this letter is to inform you of the decisions made by the Liaison Committee on Medical Education (LCME) at its June 14-15, 2016 meeting regarding the accreditation status of the medical education program leading to the MD degree at the University of Missouri-Colombia School of Medicine and to transmit to you the determinations regarding compliance with accreditation standards and performance in elements on which the decisions were based. Enclosed[‡] with this letter is the report of the LCME survey team that conducted a survey visit for full accreditation on January 10-13, 2016.

After reviewing the survey report and survey team findings, the LCME voted as follows:

LCME Determination:	Continue full accreditation of the medical education program for an indeterminate term[†]
Required Follow-Up:	1. Secretariat consultation in the summer/fall of 2016 2. Action plan due December 1, 2016 3. Either a limited survey or status report depending on LCME determinations after review of the action plan
Next Full Survey Visit:	Pending - The program's next full survey will be determined following further LCME review

[†] Please note that the decision to grant the school an indeterminate accreditation term is one of four "severe action decisions" that the LCME can reach. If there is not sufficient progress toward compliance with the cited accreditation standards within 12 months, the LCME may impose probation. If there is not sufficient progress toward compliance with the cited accreditation standards within 24 months, the LCME may choose to withdraw accreditation.

The Medical School Directory on the LCME website, http://lcme.org/directory/, will be updated to reflect this change in the next full survey date to "Pending."

Section I of this letter summarizes the medical education program's compliance with each of the 12 LCME standards, based on the program's performance in the elements that collectively constitute the standard. Sections II and III of this letter summarize the LCME's findings for accreditation elements requiring follow-up. Section IV of this letter summarizes the required follow-up. Section V of this letter contains additional information important for the medical education program.

I. LCME Determinations of Compliance with Accreditation Standards

Standard	LCME Determination
Standard 1: Mission, Planning, Organization, and Integrity	CM
Standard 2: Leadership and Administration	CM
Standard 3: Academic and Learning Environments	*NC
Standard 4: Faculty Preparation, Productivity, Participation, and Policies	C
Standard 5: Educational Resources and Infrastructure	C
Standard 6: Competencies, Curricular Objectives, and Curricular Design	C
Standard 7: Curricular Content	C
Standard 8: Curricular Management, Evaluation, and Enhancement	*NC
Standard 9: Teaching, Supervision, Assessment, and Student and Patient Safety	CM
Standard 10: Medical Student Selection, Assignment, and Progress	C
Standard 11: Medical Student Academic Support, Career Advising, and Educational Records	C
Standard 12: Medical Student Health Services, Personal Counseling, and Financial Aid Services	C

C = Compliance, CM = Compliance with a Need for Monitoring, NC = Noncompliance

* United States Department of Education regulations require that the LCME document compliance with all LCME accreditation standards **within two years of the LCME sending the program its initial notification of noncompliance determinations.** Therefore, the LCME requires timely follow-up on all determinations of noncompliance. Please see section IV of this letter for details.

II. Accreditation Elements in which the Program's Performance is Satisfactory with a Need for Monitoring

Element	LCME Finding
Element 1.1 (strategic planning and continuous quality improvement)	While a longstanding CQI effort has served the school well, the direct monitoring of the elements, and particularly those that were identified as problem areas from the last visit, are less well addressed and this will require monitoring.
Element 2.3 (access and authority of the dean)	Four months before the survey visit, the medical school dean who had been in office for nine months resigned. Several months later, the President and Chancellor resigned following widely publicized issues related to University campus diversity. At the time of the visit, these positions were filled with respected individuals in interim appointments and there was no evidence that these changes had impacted the quality of the medical education program. However, the progress of the searches for the permanent appointments for these positions requires monitoring.
Element 5.11	Renovation of the first floor of the health sciences library and the

(study/lounge/storage space/call rooms)	construction of a new medical education building is underway, which is expected to alleviate student concerns about adequate study space. Scheduled for opening in August 2017, the completion of this new learning space should be monitored.
Element 9.4 (variety of measures of student achievement/direct observation of core clinical skills)	The school has implemented changes to address problems in ensuring that all students are directly observed performing core clinical skills. Preliminary information is promising but it is too early to know if these efforts will be successful and this should be monitored.
Element 9.8 (fair and timely summative assessment)	Clerkship grades have been returned within six weeks during the most recent six month period but more time will be needed to ensure that this is sustainable and this requires monitoring.

III. ACCREDITATION ELEMENTS IN WHICH THE PROGRAM'S PERFORMANCE IS UNSATISFACTORY

Element	LCME Finding
Element 1.4 (affiliation agreements)	Each affiliation agreement does not contain all elements required by the LCME.
Element 3.3 (diversity/pipeline programs and partnerships)	Cited as noncompliant in the previous survey, there have been increased efforts with student pipeline programs and some success in increasing enrollment of students from rural backgrounds and from socioeconomically disadvantaged backgrounds. However, there has been less improvement in other areas of student diversity and modest improvement in faculty diversity since the last visit.
Element 3.6 (student mistreatment)	The school has not created its own code of professional conduct for faculty-student relationships for the medical education program. The AAMC GQ demonstrates continued levels of mistreatment that are above the national average. At the time of the visit, several new initiatives had been started but these efforts are too recent to have sufficient evidence to assess effectiveness.
Element 8.1 (curricular management)	At the time of the last visit the neurology clerkship and the instruction of both pharmacology and anatomy were identified problem areas. Those same areas of instruction remain a problem at the time of the current survey visit. The team explored in depth the issues related to each of these areas and understood that a variety of efforts have been or will soon be implemented; however, the time taken to deal with these issues suggest deficiencies with the overall curriculum management process.

IV. REQUIRED FOLLOW-UP

The LCME requests the following:

1. The LCME Secretariat will conduct a consultation in the summer/fall of 2016 to assist Dean Patrice Delafontaine and his staff in developing an action plan to address the elements in which the program's performance is satisfactory with a need for monitoring and unsatisfactory, as defined in this letter. The LCME Secretariat will contact Dean Delafontaine to establish a date for the Secretariat consultation.

2. The action plan (template enclosed) should be prepared as a PDF file and emailed to the LCME Secretariat. The action plan should include a dated and signed cover letter that is addressed to both LCME Co-Secretaries. The action plan should be emailed to lcmesubmissions@aamc.org as a single PDF file no later than December 1, 2016 to be considered at the February 2017 LCME meeting. A paper copy of the action plan is not required.

3. The LCME will review the action plan to determine if the action steps to address each element that is satisfactory with a need for monitoring and unsatisfactory are feasible, timely, and have the potential to resolve the concerns of the LCME. Following its review of the action plan, the LCME will evaluate the accreditation status of the medical education program. Once the LCME approves the action plan, the LCME will either request a follow-up status report or direct the Secretariat to contact the dean to schedule a limited survey.

V. IMPORTANT INFORMATION FOR THE MEDICAL EDUCATION PROGRAM

NOTIFICATION TO THE USDE OF ACCREDITATION STATUS

The LCME is required to notify the United States Department of Education (USDE) and the relevant regional accrediting body of all of its final accreditation determinations, including determinations of "Accredited," "Accredited, with Warning," and "Accredited, on Probation." The LCME is also required by the USDE to make available to the public all final determinations of "Accredited" and "Accredited, on Probation."

ACCREDITATION STANDARDS

To review the current list of LCME accreditation standards and elements, please refer to the most recent version of the *Functions and Structure of a Medical School* document, available on the LCME website, http://lcme.org/publications/. Programs that have status reports due to the LCME are responsible for aligning the follow-up items in the reports with the *Functions and Structure of a Medical School* document whose effective academic year corresponds with the academic year in which the time the status reports are due.

CHANGES THAT REQUIRE NOTIFICATION TO THE LCME

The LCME awards accreditation to a medical education program based on a judgment that there exists an appropriate balance between student enrollment and the total resources of the institution, including faculty, facilities, and operating budget. If there are plans to significantly modify the educational program, or if there is to be a substantial change in either student enrollment or in the resources of the institution such that the balance becomes distorted, the LCME expects to receive advance notice of the proposed change. Substantial changes may lead the LCME to re-evaluate a program's accreditation status. More specific information about notification requirements is available on the LCME website, http://lcme.org/about/accreditation-process-overview/#maintaining-accreditation.

A copy of this letter and of the survey report are being sent to Dean Patrice Delafontaine *via* postal mail. The survey report is for the use of the University of Missouri-Colombia School of Medicine and the university, and any public dissemination or distribution of its contents is at the discretion of institutional officials.

Sincerely,

Barbara Barzansky, PhD, MHPE
LCME Co-Secretary

Dan Hunt, MD, MBA
LCME Co-Secretary

Enclosures[‡] (2): Team report of the full survey of the medical education program leading to the MD degree at the University of Missouri-Colombia School of Medicine, January 10-13, 2016

Instructions for action plan

[‡] Please note that the team report is enclosed only with the printed version of this letter that you will receive by postal mail.

CC: Patrice Delafontaine, MD
Dean, University of Missouri-Colombia School of Medicine

Element 1.4 Affiliation Agreements

In the relationship between a medical school and its clinical affiliates, the educational program for all medical students remains under the control of the medical school's faculty, as specified in written affiliation agreements that define the responsibilities of each party related to the medical education program. Written agreements are necessary with clinical affiliates that are used regularly for required clinical experiences; such agreements may also be warranted with other clinical facilities that have a significant role in the clinical education program. Such agreements provide for, at a minimum:

- **The assurance of medical student and faculty access to appropriate resources for medical student education.**
- **The primacy of the medical education program's authority over academic affairs and the education/assessment of medical students.**
- **The role of the medical school in the appointment and assignment of faculty members with responsibility for medical student teaching.**
- **Specification of the responsibility for treatment and follow-up when a medical student is exposed to an infectious or environmental hazard or other occupational injury.**
- **The shared responsibility of the clinical affiliate and the medical school for creating and maintaining an appropriate learning environment.**
- **Confirmation of the authority of the department heads of the medical school to ensure faculty and medical student access to appropriate resources for medical student education when those department heads are not also the clinical service chiefs at affiliated institutions.**

Table1.4-1 | Affiliation Agreements						Source: School-reported	
For each inpatient clinical teaching site used for required clinical clerkships, indicate (Y/N) if the current affiliation agreement specifically contains the following information. Add rows as needed.							
		Page Number(s) in Affiliation Agreement					
Clinical teaching site	Date agreement signed	Access to resources	Primacy of program	Faculty appointments	Environ. hazard	Learning environment	Authority of dept. head
Harry S Truman VA Hospital	11/4/2014	3	2	2	3	2, 3	2
Mercy Hospital - St. Louis	10/14/2011	5	N	N	3	N	5
Cox Monett Hospital	5/9/2014	5	1	1	2	1, 2, 4, 5	1
Freeman Health System - Joplin	11/5/2007	N	N	N	N	1, 2	1, 2
Mercy Hospital - Carthage	6/30/2014	3	2	2	3	4, 5	2
Mercy Hospital - Joplin	6/30/2014	3	2	2	3	4, 5	2
Mercy Hospital - Lebanon	6/30/2014	3	2	2	3	4, 5	2
Mercy Hospital – Aurora	6/30/2014	3	2	2	3	4,5	2
Missouri Delta Medical Center	1/18/2011	2	2	2	1	2	1, 2
Mosaic Life Care (previously known as Heartland Regional	12/20/2010	8	2	2	9	N	10

Medical Center)							
Ozarks Medical Center	8/24/2011	1	1, 2	2	1	2	1, 2
Phelps County Regional Medical Center	3/8/2012	2	1	2	1	2	2
Poplar Bluff Regional Medical Center	3/16/2011	1	1, 2	2	1	2	1, 2
St. Francis Hospital and Health System	4/30/2014	3	2	3	3	2	5
Twin Rivers Regional Medical Center	5/7/2007	8, 9	3	3	4	3, 8, 9	3

- Confirm that the school-provided information in Table1.4-1 is correct and comment on any deficiencies identified.

After a thorough review of the language in affiliation agreements and after discussion with the school leadership, the survey team noted several areas in which the agreements do not sufficiently meet the LCME standards for compliance. For example, there are deficiencies in having explicit language for the following affiliation agreements:

Mercy Hospital St. Louis
- Learning environment
- Primacy of the program
- Faculty appointments

Mosaic Life Care
- Learning environment

Freeman Health System-Joplin
- Access to resources
- Primacy of the Program
- Faculty appointments
- Environmental hazards

No affiliation agreement was provided for the University of Missouri Health Care

- Confirm whether up-to date affiliation agreements exist with all inpatient sites used for required clinical clerkships.

Affiliation agreements have been provided for all inpatient facilities at which required clinical clerkships take place, except for its own facility at University of Missouri Health Care (MUHC).

Element 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.

- Comment on the formal institutional policies related to diversity. Have policies formally been approved or otherwise codified?

The SOM has institutional policies that guide recruitment and retention activities for medical students, faculty, and senior administrative staff. These policies have been formally approved. The diversity policies are included in websites targeting pre-medical students, enrolled students, and faculty.

- Describe whether and how the medical school has categorized diversity for its students, faculty, and senior administrative staff. Include the medical school's definition of "senior administrative staff."

The SOM has categorized diversity for its students as African American, Hispanic, Native American (American Indian, Native Alaskan/Hawaiian Pacific Americans), rural and socioeconomically disadvantaged. The faculty and senior staff categories are overlapping, with the addition of females and the deletion of socioeconomic disadvantaged and rural. The SOM defines "senior administrative staff" as year 1-4 course and clerkship directors and deans with significant student contact.

- Briefly describe how the policies related to diversity and the identified diversity categories are reflected in recruitment and retention programs for medical students, faculty, and senior administrative staff. Are there sufficient resources to support diversity programs?

The SOM's medical student recruitment, selection and retention efforts are linked through a 2007-08 initiative known as "MU 2020 Admissions." The SOM states in a variety of places and a variety of ways that they recognize the relationship between a diverse learning environment and its educational goals. Given this recognition of the importance of a class that includes students from rural, minority and socioeconomically disadvantaged backgrounds, the SOM developed new activities and enhanced existing programs to encourage individuals from these diversity groups to pursue a career in medicine and to support enrolled students. Following the previous survey visit where the SOM was found to be noncompliant with both standard FA-1 (faculty diversity) and standard MS-8 (student diversity), the SOM established a new position, the Senior Associate Dean for Diversity and Inclusion, to oversee activities in this area. The individual initially appointed to this position has recently retired, and the position has been retained and filled.

Additional resources have been invested into this area after the last survey visit to track outcomes of the SOM's pipeline programs (e.g., the Bryant Scholars Program, an early identification and acceptance program for undergraduate students who are from rural backgrounds and who are committed to working in rural Missouri).

The High School Mini Medical School and the Mizzou MedPrep programs also receive resources for tracking the outcomes of these pipeline programs. For example, in one pipeline program (the Summer Research Internship), tracking data show that, while none of the program participants applied to the medical school, one was accepted in another medical school and one was in graduate school. Of note,

the SOM observed that, while it has been successful in attracting rural and non-minorities to pipeline programs. During the meetings with faculty, the team was told that the SOM will be rethinking its approach because few of the participants are minorities underrepresented in medicine. Overall, with the caveat that the pipeline programs do not appear to be attracting all of the designated groups, the resources appear to be adequate.

- Summarize, by referencing the table on institutional diversity the school's success in achieving diversity. Provide data from the ISA on medical student satisfaction with student and faculty diversity.

The 2008 full survey report identified diversity (formerly standards FA-1 and MS-8) as areas of noncompliance. For students at that time, African Americans made up 5% of all students, Hispanics made up 1%, and there were no Native American students. For faculty, the 2008 survey report identified one African American faculty member in a basic science department, making up 1% of that population, and six African American faculty members in clinical departments, making up 1.5% of that population. There were no Hispanic or Native American Faculty at that time. The finding for this noncompliance included the 2008 observation that:

> "Of concern, there was not a single African-American student in the first-year class. There currently is no administrator with leadership responsibilities, such as an associate dean for minority affairs, and no unified strategic plan to address the issue of diversity."

Following the 2008 survey and noncompliance findings, the SOM established and filled a new position of Senior Associate Dean for Diversity with a charge of focusing on the recruitment and retention of diversity groups for students, faculty and senior administrative staff. This senior associate dean retired in 2014, and a new associate dean is now in place.

Some progress has been made in the area of faculty diversity since 2008. The number of African American faculty has doubled to 2.3%, and Hispanic faculty now make up close to 2%, whereas there had been none before. The AAMC mission management tool for faculty was provided to the team as it allows comparisons across other medical schools. Some progress in recruiting and retaining women faculty members is noted in the table below, but the SOM remains in the 25th percentile using the AAMC benchmarking data shown below:

AAMC Mission Management Tool (MMT) for faculty

	2008	2012	2015
Percent who are Women	29.4%	32.4%	33.2%
Percentile of % who are women benchmarked against all medical schools	15th %tile	25th %tile	25th %tile
Percent who identify as URM	4.0%	5.0%	5.6%

Percentile who identify as URM benchmarked against all medical schools	15th %tile	40th %tile	45th %tile

With 9% of all students coming from rural backgrounds, the SOM has made progress in this area. However, there has been less success for other diversity categories. For example, while the most recently recruited class of students had 5% African American students, the total number of African American students in the combined classes is 3.3%, almost 2% less than in 2008. Hispanic students now make up 2.5% of all medical students up, from 1% in 2008.

The ISA identified this area as an area of concern for the students and recorded the following statement on page 6 of the student report:

> *"Students are overall satisfied with administration and faculty diversity. They also are strongly satisfied with the degree of exposure to patients with backgrounds different than their own and the adequacy of education about caring for a diverse population. They are, however, strongly dissatisfied with student diversity."*

This observation was based on the following summary from the student survey:

Q19: Administration and faculty diversity **CLASS**	**VERY DISSATISFIED** *N (%)*	**SOMEWHAT DISSATISFIED** *N (%)*	**SOMEWHAT SATISFIED** *N (%)*	**VERY SATISFIED** *N (%)*	**NA** *N*
M1	11 (13.0%)	12 (14.1%)	31 (36.8%)	31 (36.5%)	0
M2	7 (10.0%)	7 (10.0%)	23 (32.9%)	33 (47.1%)	3
M3	9 (12.3%)	12 (16.4%)	25 (34.3%)	27 (37.0%)	6
M4	2 (2.9%)	4 (5.7%)	22 (31.4%)	42 (60.0%)	3
TOTAL	29 (9.7%)	35 (11.7%)	101 (33.9%)	133 (44.6%)	12

Q20: Student diversity **CLASS**	**VERY DISSATISFIED** *N (%)*	**SOMEWHAT DISSATISFIED** *N (%)*	**SOMEWHAT SATISFIED** *N (%)*	**VERY SATISFIED** *N (%)*	**NA** *N*
M1	15 (17.7%)	23 (27.1%)	25 (29.4%)	22 (25.9%)	1
M2	6 (8.11.0%)	19 (25.7%)	23 (31.1%)	26 (35.1%)	1
M3	14 (19.2%)	20 (27.4%)	19 (26.0%)	20 (27.4%)	5
M4	3 (4.2%)	8 (11.3%)	24 (33.8%)	36 (50.7%)	2
TOTAL	38 (12.5%)	70 (23.1%)	91 (30.0%)	104 (34.3%)	9

Summary of Team Discussion

In summary, the issue of diversity was a part of the team discussion prior to and throughout the survey visit. The topic was revisited a number of times with the SOM. Of note is the fact, that during the visit, faculty members and students, both in the regular sessions and with private communications, raised their concerns to the team about problems in the learning environment related to diversity that may be impeding the ability of the SOM to recruit and retain the degree of diversity that it seeks.

The team took into account the student concerns, but also recognized the progress that the SOM had made in the category of rural and socioeconomically disadvantaged students. In addition, the team factored in that the ISA data about diversity may not be capturing the diversity that is represented by students from these rural backgrounds. The team took into account the increased efforts since the last full survey visit, but were also impressed with the SOM's acknowledgement that these programs had to date not been successful in engaging minority students and certainly did not lead to more admissions. The team also took into account the offers that were made to students (and to a lesser extent to faculty) who then declined the offer, but the team was also aware of the widely reported student protests on the main campus just months before the visit and the resulting resignation of the president and the chancellor related to diversity issues. The sense of the team was that, while efforts are being made, the SOM has yet to deal with the barriers that inhibit the enrollment of students and the hiring of faculty in the full range of diversity that the SOM seeks in order to maintain a quality learning environment.

By the end of the visit, there was unanimity among the team members that the determination for element 3.3 should be "unsatisfactory." While acknowledging improvements with rural and socioeconomic categories, the team also noted the following: 1) for some areas of diversity, there are fewer people now than eight years ago and little or no progress in other areas, 2) lack of diversity has been an issue for a considerable amount of time, and 3) concerns were raised by faculty members and students during the visit about the impact of the institutional culture on diversity recruitment and retention.

Table 3.3-1 | Diversity Categories and Definitions		Source: School-reported
Provide definitions for the diversity categories identified in medical school policies that guide recruitment and retention activities for medical students, faculty, and senior administrative staff. Note that the medical school may use different diversity categories for each of these groups. If different diversity categories apply to any of these groups, provide each relevant definition. Add rows as needed for each diversity category.		
Medical Students	Faculty	Senior Administrative Staff
African American Hispanic Native American (American Indian/Native Alaskan/Hawaiian Pacific Americans) Socioeconomically disadvantaged Rural (Socioeconomically disadvantaged and rural per AMCAS definitions, all others self-identified.)	African American Hispanic Native American (American Indian/Native Alaskan/Hawaiian Pacific Americans) Female -- (Diversity categories all self-identified.)	African American Hispanic Native American (American Indian/Native Alaskan/Hawaiian Pacific Americans) Female -- (Diversity categories all self-identified. Senior Admin Staff defined as Years 1-4 course/clerkship directors and deans with significant student contact; see 3.3.a.3)

Table 3.3-2 | Offers Made to Applicants to the Medical School	Source: School-reported

Provide the total number of offers of admission to the medical school made to individuals in the school's identified diversity categories for the indicated academic years. Add rows as needed for each diversity category.

	2014 Entering Class			2015 Entering Class		
School-identified Diversity Category	Declined Offers	Enrolled Students	Total Offers	Declined Offers	Enrolled Students	Total Offers
African American	6	1	7	4	2	6
Hispanic	1	2	3	3	4	7
Native American	3	0	3	3	0	3
Socioeconomically disadvantaged	3	14	17	13	34	47
Rural	4	14	18	8	9	17

Table 3.3-3 | Offers Made for Faculty Positions — Source: School-reported

Provide the total number of offers of employment made to individuals in the school's identified diversity categories for faculty positions. Add rows as needed for each diversity category.

	AY 2013-14			AY 2014-15		
School-identified Diversity Category	Declined Offers	Faculty Hired	Total Offers	Declined Offers	Faculty Hired	Total Offers
Female	7	22	29	3	33	36
African American	1	3	4	0	2	2
Hispanic	0	4	4	0	2	2
Native American (American Indian/Native Alaskan/Hawaiian Pacific Americans)	0	0	0	0	0	0

Table 3.3-4 | Offers Made for Senior Administrative Staff Positions — Source: School-reported

Provide the total number of offers of employment made to individuals in the school's identified diversity categories for senior administrative staff positions. Add rows as needed for each diversity category.

	AY 2013-14			AY 2014-15		
School-identified Diversity Category	Declined Offers	Staff Hired	Total Offers	Declined Offers	Staff Hired	Total Offers
Female	0	1	1	0	1	1
African American	0	1	1	0	0	0
Hispanic	0	0	0	0	0	0
Native American	0	0	0	0	0	0

Table 3.3-5 | Pipeline Programs and Partnerships	Source: School-reported

List each current program aimed at broadening diversity among qualified medical school applicants. Provide the average enrollment (by year or other), target participant group(s) (e.g., college, high school, other students), and a description of any partners/partnerships, if applicable. Add rows as needed.

Program	Year Initiated	Target Participants	Average Enrollment	Partners
1010GH Becoming a Physician	2003	College students (MU undergraduate freshmen and sophomores)	Up to 40 per year	MU Honors College
Area Health Education Center Career Enhancement Scholars (ACES)	2005	High school and undergrads with desire to serve underserved and rural communities	200 per year	High schools, community organizations, professional schools and institutions of higher learning
Bryant Scholars Program	1998	College students (sophomores) from rural high schools attending Missouri colleges	11 per year	13 participating higher education institutions in Missouri
Cristo Rey Health Professions Summit	2008	High school students (sophomore, junior or senior) from Cristo Rey high schools nationwide	40 per year	Cristo Rey high schools West Central Area Health Education Center MU Schools of Nursing, Health Professions, Nutritional Sciences and Veterinary Medicine
Excellence in Learning	1996	High school students (juniors) from St Louis public schools	44 per year	St Louis public schools Washington University School of Medicine MU Schools of Nursing and Health Professions
High School Mini Medical School (HSMMS)	1998	High school students (juniors) from Missouri high schools	112 per year	Missouri high schools
Minorities in Medicine (MIMO)	Many years	College students (MU undergraduate minority)	varies	Student National Medical

				Association
Minority Association for Pre-Health Students (MAPS)	Many years	College students (MU undergraduate minority)	varies	MU campus
Mizzou MedPrep 0 (Explorations)	2013	High school students (juniors and seniors) from Missouri public schools College students (freshmen and sophomores)	12 per year	N/A
Mizzou MedPrep I	2011	College students (juniors and seniors) and non-traditional applicants	50 per year	N/A
Mizzou MedPrep II	2011	College students (juniors and seniors) and non-traditional applicants	25 per year	N/A
Mizzou School of Medicine PreMed Day	2008	College students (any level) and non-traditional applicants	100 per year	N/A
Recruitment Career Fairs	Many years	High school and college students in and out of state	Up to 1000 contacts per year	N/A
Summer Research Internship in Medical Sciences	2011	College students (in and out of state)	3 per year	N/A

Table 3.3-6 | Students, Faculty and Senior Administrative Staff Source: School-reported

Provide the requested information on the percentage of enrolled students, employed faculty, and senior administrative staff in each of the school-identified diversity categories (as defined in table 3.3-1 above).

School-identified Diversity Category	First-Year Students	All Students	Employed/ Full-time Faculty	Senior Administrative Staff
	(Entering 2013)	(AY 2013-14)	(AY 2013-14)	(AY 2013-14)
African American	5.7%	3.3%	2.3%	4%
Hispanic	1.9%	2.5%	1.9%	8%
Native American	1.9%	1.8%	0.4%	0%
Socioeconomically Disadvantaged	3.8%	4.0%		
Rural	10.5%	9.0%		
Female			34%	35%

Element 3.6 Student Mistreatment

A medical school defines and publicizes its code of professional conduct for faculty-student relationships in its medical education program, 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 (e.g., incidents of harassment or abuse) are well understood by students and ensure that any violations can be registered and investigated without fear of retaliation.

- Are there formal standards of conduct in the teacher-learner relationship and are students, faculty, and residents familiar with these standards?

The SOM has not created its own code of professional conduct for faculty-student relationships for the medical education program, relying instead on a University policy (HR-519 Consensual Amorous Relationships) in the place of the expected teacher-learner relationship standards. When queried, neither students nor residents were aware of any standards of the conduct for teacher-learner relationships.

- Is there policy that describes the procedures for the prompt handling of violations of these standards and are students familiar and comfortable with the process for reporting incidents of mistreatment?

While there are no formal standards of conduct in the teach-learner relationship as noted above, there are adequate policies and procedures that describe how complaints of mistreatment are handled. Per the AAMC GQ and ISA (table 3.6-1 below), students are aware of the policies related to mistreatment comparable to the national average.

- Comment on data from the AAMC GQ on the level of student mistreatment.

The 2015 AAMC GQ data show levels of student mistreatment that are above the national benchmarks. While some areas did show improvement from the 2014 AAMC GQ, some issues remain. The 2015 AAMC GQ noted below shows a higher frequency for several areas.

	AY 2014-15							
	Never		Once		Occasionally		Frequently	
	School %	Nation%	School%	Nation%	School%	Nation%	School%	Nation%
Publicly humiliated	56.90	80.46	22.41	10.34	18.97	8.58	1.72	0.63
Subjected to offensive, sexist remarks/names	77.59	85.89	6.90	5.90	15.52	7.63	0.00	0.58
Denied opportunities for training or rewards based on gender	86.21	93.64	5.17	2.71	8.62	3.23	0.00	0.42

- Provide data from the ISA, by academic year as available, on satisfaction with mistreatment policies and the mechanisms to report mistreatment.

The ISA shows that the student body overall reports that the SOM's mistreatment policy, the mechanisms to report concern, and the activities by the SOM aimed at preventing mistreatment are adequate.

- Comment on the school's educational efforts to prevent mistreatment. Assess whether students perceive that the school's policies and procedures regarding mistreatment are effective.

In response to earlier AAMC GQ data showing lower awareness of mistreatment policies, the SOM initiated a successful program to help students understand both the policies and how they can report problems. This included enhanced communication at orientations throughout the four years that was routinely repeated at class meetings and in the Student Handbook. In June 2015, the SOM implemented the new electronic reporting system that is accessed through each student's home page in the dedicated Student Portfolio and is accessible electronically from anywhere. Students are advised that this system is the preferred route for reports to be made. Students are informed that, if they are uncomfortable utilizing the Student Portfolio, there are multiple alternative avenues for reporting outside the school of medicine.

- ✓ The MU campus reporting system, MU Equity, is available to all individuals in the school of medicine and provides the opportunity to report anonymously. Reports made through MU Equity are investigated by the MU Office of Diversity and Inclusion.

- ✓ In AY2014-15, the University of Missouri System (UM System) implemented a significant Title IX initiative intended to address deficiencies identified in the aftermath of the suicide of an undergraduate student. All UM staff and faculty (including residents) must now complete on-line Title IX mandated-reporter training. This includes acknowledgement of an understanding that reports of sexual assault must be forwarded to the Title IX office. Medical students are provided with information about Title IX reporting in the Student Handbook and at class meetings.

- ✓ The University of Missouri Health Care "Patient Safety Network" (PSN) system may also be utilized by students to report concerns about incidents in the learning environment. The PSN provides the option of an anonymous report. Any reports of mistreatment and unprofessional behavior in the medical student learning environment made through the PSN system are routed to the Associate Dean for Student Programs.

- ✓ The Bias Reporting Hotline is a new reporting mechanism implemented by University of Missouri Health System in AY2014-15. The Hotline is available to medical students and all other members of the academic health center community. It can be accessed online or by calling a live operator (855) 645-1384. Reports made via the Hotline are investigated by the Title IX coordinator for UMHS.

In addition, the associate dean for student programs and professional development meets with faculty/residents in clinical departments, all faculty and staff were required in AY2014-15 to complete two mandatory training modules on sexual harassment, and all M1 students must complete the SOM's "Show Me Respect" module on Civility. The surgery postgraduate director developed and presented an educational intervention to his residents. These materials were made available to all the postgraduate directors and have been utilized by other programs. The associate dean for curriculum and assessment, associate dean for curricular improvement and faculty director of clinical curriculum and evaluation meet annually with each clerkship director and the respective chair to review the mistreatment data. In October 2015, the MU Health Care Medical Staff modified its policies to tie

credentialing of physicians with appropriate behavior toward learners. In addition, the Chief Nurse Executive at University Hospital reported to the visit team the hospital has recently rolled out a training piece on acceptable behavior and is teaching utilization of the chain of command for reporting issues in the learning environment. The executive director of University Physicians noted that a new professional standards committee had been implemented and that each department was in the process of developing codes of conduct. The SOM also established the Committee on Civility and Respect in the Learning Environment (CiRCLE), in AY 2015-16; reports of student mistreatment are reviewed by the CiRCLE. This committee meets monthly or bimonthly, depending on the volume of reports made. The committee's charge is as follows:

- ✓ Reviewing all individual reports of possible mistreatment, de-identified if requested by the reporter, made through the Student Portfolio.
- ✓ Reviewing any actions already taken by the Associate Dean for Student Programs, the Office of Medical Education, and others in response to individual reports made by students.
- ✓ Recommending and undertaking further actions, as appropriate, with regard to individual reports, including disciplinary action and educational/awareness interventions.
- ✓ Reviewing trends in reports, particular settings that may be problematic, types of mistreatment, etc.
- ✓ Reviewing data from other sources with regard to student mistreatment (e.g., the AAMC GQ, the annual Learning Environment Survey, etc.).
- ✓ Recommending further institutional actions, including changes in policy, educational interventions, etc. as appropriate.
- ✓ Providing an annual report to the dean, school of medicine faculty, students, and the Curriculum Board of the school of medicine.

In summary, the necessary code of professional conduct has not been developed. The SOM has begun initiating new efforts targeting the higher prevalence of mistreatment reports. However, without the code of professional conduct for faculty-student relationships in the medical education program and with no evidence yet to evaluate these interventions, this element does meet expectations.

Table 3.6-1 | Awareness of Mistreatment Procedures Among Students			Source: AAMC GQ
Provide school and national benchmark data from the AAMC Graduation Questionnaire (GQ) on the percentage of medical students that reported *knowing school procedures for reporting the mistreatment of medical students* for each listed academic year.			
AY 2013-14		AY 2014-15	
School%	National%	School%	National%
76.1%	78.6%	81.0%	80.8%

Element 8.1 Curricular Management

A medical school has in place an institutional body (e.g., a faculty committee) that oversees the medical education program as a whole and has responsibility for the overall design, management, integration, evaluation, and enhancement of a coherent and coordinated medical curriculum.

- Describe the composition and frequency of meetings for the committee responsible for the management of the curriculum. Note the source of the committee's authority, such as bylaws. Briefly summarize the composition and charge/role of each subcommittee of the curriculum committee.

The faculty committee with primary responsibility for the curriculum is the School of Medicine Curriculum Board. The Curriculum Board is empowered through the SOM bylaws. The Curriculum Board is charged with the primary policy making authority of the Faculty Assembly in matters concerning the academic programs of the SOM. The Board consists of 13 members, nine of whom are Faculty Assembly members and four of whom are students. The dean appoints representatives from his or her staff to be *ex-officio* members without vote. The Faculty Assembly elects nine Faculty Assembly members at large, representing both the basic and clinical departments. The bylaws ensure that there will be no less than four members of the Board from either group.

Two subcommittees report to the Curriculum Board. The Pre-Clerkship Curriculum Steering Committee (PCSC), manages the M1 and M2 years and has a mix of block directors from those first two years, representatives of the PBL directors for each block and directors from the Introduction to Patient Care and Advanced Physical Diagnosis courses. The Associate Dean for Curriculum and Assessment, Associate Dean for Curricular Improvement, Chair of the Curriculum Board and Faculty Director for Curriculum and Assessment are *ex officio* members. This subcommittee meets monthly and provides the review and oversight of the first two years with responsibility to oversee assessment during this phase of the curriculum. Important aspects of the horizontal and vertical integration of this phase of the curriculum for which this subcommittee has responsibility are the design and placement of the PBL cases, selection of standardized patients, and lecture topics and clinical skills training.

The second subcommittee reporting to the Curriculum Board is the Clinical Curriculum Steering Committee (CCSC) which manages the M3 and M4 curriculum. The membership includes all clerkship directors, the medical director of the Rural Track and representatives of the Advanced Biomedical Science courses. The Associate Dean for Curriculum and Assessment, Associate Dean for Curricular Improvement, Associate Dean for Student Programs and Professional Development, Chair of the Curriculum Board and Director of the Simulation Center are *ex officio* members. The committee meets monthly and follows a calendar of events that includes oversight of assessments and regular reviews curriculum in the M3 and M4 years.

- Describe how the curriculum committee and its subcommittees participate in the following:

    - **Developing and reviewing the educational program objectives**

    The faculty bylaws charge the Curriculum Board with a triennial review of the overall educational goals of the SOM. A calendar of activities for each of the curriculum subcommittees was provided to the survey team. In addition to the routine reviews, the Curriculum Board also engages in larger strategic planning efforts that involve changes to the educational program objectives. The most recent review (termed the "Next Level of Excellence") was co-sponsored by

the Curriculum Board and the Office of Medical Education. This review contributed to the latest version of the overall educational goals, which were finalized in October 2013.

- **Ensuring that there is horizontal and vertical curriculum integration (i.e., that curriculum content is coordinated and integrated within and across academic years/phases)**

Each block director reports to the PCSC, and the annual preview of block plans serves to coordinate and integrate curricular experiences horizontally within the M1 or M2 academic year and across the pre-clerkship years. As an example, the selection of a PBL case for an M1 course is then followed by a discussion on how that selection may influence or require a change in an M2 PBL case. Similarly, changes in lecture sequencing and/or content in the M1 year are reviewed as they may influence sequencing of lectures in subsequent blocks. The PCSC includes members with leadership roles in both the pre-clerkship and clerkship years. In addition, the CCSC chair is an active contributor to PCSC discussions. In this way the PCSC ensures a vertical perspective.

The annual CCSC reports and the monthly meetings are used to stimulate coordination and integration horizontally across the clerkship years. Clerkship directors, as members of the CCSC, have access to data across all clerkships in order to monitor overall quality and outcomes. Two CCSC members have significant leadership roles in the pre-clerkship curriculum, ensuring a vertical perspective.

Both the PCSC and CCSC make regular reports to the Curriculum Board. These reports are focused on supporting the Curriculum Board's charge of monitoring how each objective is addressed at an appropriate point in the curriculum. The team was provided a calendar for all three curriculum management committees that ensure coverage of all aspects of the curriculum dealing with horizontal and vertical integration.

- **Monitoring the overall quality and outcomes of individual courses and clerkships**

Courses and clerkships are monitored on an annual basis for overall quality by their respective subcommittees; these committees, in turn, report these reviews to the Curriculum Board.

- **Monitoring the outcomes of the curriculum as a whole**

The Curriculum Board annually reviews the results of the AAMC GQ; USMLE Step 1, Step 2 CS, and Step 2 CK; Residency Program Directors Survey; National Resident Matching Program; Patient Log (PLOG); Student Perceptions of the Learning Environment Annual Survey; and student performance on the Patient-Centered Care OSCE (PCC OSCE). The Curriculum Board receives annual presentations from the PCSC chair, with a summary review of the M1 and M2 years, and the CCSC chair, with a summary of all required M3 and M4 clerkships. This summary includes reports on student performance and student feedback on the quality of the courses/ clerkships. The Curriculum Board also receives routine reports on COMPASS (a four-year longitudinal course) from the course director. The Curriculum Board convenes working groups to address areas of concern.

The most recent overall review of the curriculum beyond these annual checks was in 2013.

- Provide the team's overall assessment of the effectiveness of the school's curriculum management processes. Include evidence that there is integrated institutional responsibility for the curriculum, including examples of problems identified and changes made by the curriculum

committee/subcommittees. Cite evidence that the curriculum committee ensures that the curriculum is coherent and coordinated.

The team's overall assessment of the effectiveness of the SOM's curriculum management process was influenced by the finding that the same three courses that were identified by students on the previous full survey as problem areas remained of concern to the students as noted in the current ISA. Pharmacology (page 34 of 2008 report), anatomy (page 6 area of transition in summary findings), and neurology (page 6 area of transition in summary) have remained problematic for different reasons, but they have in common the durability of the student complaints. This suggested to the team that, while the process and policy of the curriculum management system appear adequate, the absence of improvement in these courses suggests inadequate authority or resources or both.

Neurology was a two week clerkship at the time of the last visit and was highlighted by the students as a problem. At the time of the last visit, the SOM indicated to that survey team that the clerkship would be made into a four-week rotation which was what the students had requested. Now, eight years later, it is still a two week clerkship with the same problems. The school is just now moving to make this course a four week experience. Apparently, at the time of the last visit, there were an insufficient number of neurology faculty to carry a four week rotation and only recently has the requisite number of neurology faculty been identified. The team reviewed the various attempts to improve the clerkship but were struck, however, by statements made by a department chair related to an unwillingness to consider some of the options that the curriculum board had developed. Whether this added to the delay in finding a solution or even if that particular solution was a good one seemed irrelevant to the team because it appeared that discipline based territoriality was a component of this delay. There were suggestions from other faculty that the team met that this might also be a contributing factor for the delay in finding an adequate solution to the problem with anatomy.

It should also be noted that there is no evidence that students perform poorly in these subject areas when looking at USMLE and internal examinations. In addition, for the two courses and the neurology clerkship, the Curriculum Board has not ignored the issue. The team was provided information about the various attempts to improve these courses and clerkship.

In summary, the team discussed these issues a number of times among themselves and interacted with SOM officials during several opportunities. The team's unanimous consensus was that, although effort had been put into trying to improve the neurology clerkship, pharmacology, and anatomy components of the curriculum, the persistence of these same problem areas over the eight years between survey visits indicates the lack of an effective curriculum management system.