IMPLEMENTING AAIM DOM SLOE RECOMMENDATIONS
BACKGROUND AND FREQUENTLY ASKED QUESTIONS (FAQs)

WHY THE SLOE IS RECOMMENDED

A SLOE can balance the desire to advocate for students, while helping programs know the possible strengths and weaknesses of a student, in order to provide a better fit for learners and residency programs, as well as a more reliable handoff tool.

Since a DOM SLOE contains standardized national assessment data and local data as well as information on cognitive and non-cognitive skills that are important to professional development, the document could be the most useful tool to PDs to advocate for the skillsets of a student and help PDs be prepared for resources a student might need when they match to a program. Using the comments sections to contextualize numerical data with background information can also help paint a more complete story. Emergency medicine has utilized a SLOE for over 20 years. Data from the emergency medicine experience with the SLOE has shown that over 99% of EM PDs think the SLOE is an important evaluative tool, which is a large improvement to our current Internal Medicine DOM summary letters.

The clerkship director and residency advising committee can further advocate for students by exploring career interests, learning styles and directing students to programs that have compatible missions, opportunities and learning environments conducive for a student's learning styles.

HOW A SLOE IS USED

1. Leaders at my institution are concerned that if we are extremely forthcoming with our students' individual scores etc., we could harm our students' competitiveness relative to students from schools that do not embrace full disclosure of data. What lessons are there to be learned from EM in terms of how to promote full disclosure while ensuring we are not harming our own institutions' students?

   Letters that provide more data will benefit students and will be more trusted as sources of truth than those letters which provide less data. Schools that provide less data harm the competitiveness of their students compared to schools which provide more data. Further, providing less data also harms the student if there are issues that a program is not prepared to address from the very beginning of the UME to GME transition. For example, if a student struggles with standardized test taking and schools are not transparent with standardized test grades, a resident's weakness may not be revealed until halfway through the intern year, after the results from their first in-training exam.

2. What is your systematic approach for program directors in reviewing DOM letters? What features of the letter (present or omitted) are worth noting?

   Every IM Residency Program has an individual approach to reviewing DOM letters. This is currently out of necessity as there is significant variability in the content and structure of the DOM letters across the country. Program Directors are looking for information that enables a PD to determine if the student would be a good "fit" in their program and compare students from within the same institution and across institutions. By presenting specific data in a

standardized and structured format, the proposed IM SLOE would enable a standardized and structured review of an applicant.

Many Program Director surveys have emphasized the desire for more quantifiable data on non-cognitive attributes rather than purely cognitive ones in order to perform a more holistic review. At this time, current assessment systems may not be robust enough to divide students into discriminating categories for each of the non-cognitive attributes recommended in the SLOE template. Devising assessments for these non-cognitive attributes and focusing on ways to report these qualities in a meaningful way will be something AAIM can continue to collaborate across schools and the educational spectrum to create.

3. How will program directors weigh DOM letters using this new SLOE format against other traditional DOM letters?

   Ideally, a letter in any format would contain the same information, and applicants would be ranked based on their fit for the program. If letters in the SLOE format contain more information than a traditional letter, program directors will be able to make better-informed decisions about an applicant whose file includes a SLOE. The components and structured nature of the SLOE will allow PDs to perform holistic reviews of applicants more efficiently. More efficient reviews may have the benefit of curtailing program directors' current use of ERAS filters to narrow the number of files to review.

HOW TO APPROACH INDIVIDUAL ELEMENTS

4. For schools with pass/fail grading systems (with or without additional ranking data made available to those writing the SLOE,) what recommendations can you give them to make the SLOE most useful?

   If your school has a pass/fail grading system, the DOM SLOE will become an even more important evaluative tool. Including separate assessment components of the IM Clerkship grade and sharing distribution and performance by the student will be particularly helpful in a pass/fail grading system.

5. Our school has a policy of not ranking students. How do you suggest that we answer those questions?

   Not ranking students will lead IM programs to use the only data they have which may be Step scores or a school's reputation which is highly biased and may cause more harm to an individual student as well as to improving diversity, equity and inclusion. In the EM SLOE, schools that do not provide a class rank still complete a global rating assessment since PDs value what an EM physician thinks of the student's fit for the specialty and program type which a Dean would not be able to specify based on specialty choice.

6. What is the best way to provide a template letter of recommendation when we can only provide clinical rankings on 2/3 of the students (others had no clinical experience during COVID)?

   Similar to MSPE recommendations, the IM SLOE provides a section to comment on how a students' IM experience may have been affected by COVID. We recommend separating the cohorts and report on the competencies for which data exists and the differences between the clinical experiences and assessment methods.

7. Typically, the EM SLOE letters are written by faculty who have directly observed their students. The Department of Medicine letters are often written by clerkship directors. At my institution, we send students to 11 different campuses and I have not worked personally with them. How can I choose a ranking for multiple different categories without direct observation?

   The creation of a Residency Advising Committee to create the rankings in and write Departmental SLOEs is a foundational practice. Deliberate attention to include site directors or other faculty who may have worked with various students an IM Clerkship CD may have had limited contact with, as well as interprofessional observations of the administrative team. Ensure the committee is diverse and require bias training to mitigate explicit and implicit bias.

   Another suggested way to rank students in these qualifications is ensuring your evaluation forms contain questions directed to these specific characteristics. Qualitative information, even more than quantitative, could be helpful in these domains.

8. How are you ranking your students' communication and teamwork relative to each other?

   Through narrative observations and quantitative data obtained from faculty/resident evaluations on all IM-specialty courses, including electives, for which we have access to, as well as performance within IM Clerkship, IM Selective, and other IM Dept activities (including residency advising processes). Also including interprofessional observations, including administrative team.

9. If our evaluations don't specifically assess students using the RIME model, should we still try to include information in the DOM SLOE assessing students using that structure?

   We recommend working toward assessing using RIME since using a common construct is helpful to standardize handoff; however, we acknowledge that even within RIME, different schools and PDs interpret the categories differently. Clear explanation of how you are defining the categories of student performance is useful.

10. What are your views on the shelf examination scores being part of the SLOE? If we have shelf cut off scores for high satisfaction and honors, is that enough?

    Including the shelf score is one piece of a student's story in taking standardized medical exams. It can be a way to illustrate improvement in test-taking skills, even if a student does not become

an above average test taker. It can also communicate to a program the learner's need to spend more time studying for the IM board exam during their residency training, an important handoff in the UME to GME transition. The variability of each school's approach to and reporting of grading forces PDs to spend much more time interpreting the data and making assumptions when data is not presented clearly. When multiplied over thousands of applications, this reporting forces a system more reliant on objective data than holistic review and can harm a student. Schools that provide shelf data could improve the UME to GME transition and can help advocate for the needs of a learner.

FUTURE DIRECTIONS

11. Regarding the "Qualifications for IM" Section, a large portion of students typically receive very high scores on CPAs for questions that would reflect Teamwork/Accountability. Even the "bottom 1/3" of a class displays qualities that would absolutely make them excellent residency applicants. Have other means of conveying a students' abilities with respect to these characteristics been considered?

    We anticipate the greatest amount of process change, scholarship and communication between UME to GME will occur in this domain to provide ways to report and handoff students' strengths and opportunities in the non-cognitive skills, including ideas on how to report discriminatory cohorts. As each school works to adopt the SLOE, sharing what programs have found helpful when reading the Qualifications section and what schools have found to be meaningful and reliable ways to handoff the information is a collaborative way to find a better way to communicate these important skills of a physician.

    When ranking students in a lower category, providing contextualization in the comments section for the reasons of the ranking, including if a student is on the cusp or barely missed the cut-off. If all students applying to medicine in this cohort are excellent in communication skills, one could contextualize that the comparative ranking does not indicate a deficiency but the area may not be a student's strength due to various factors (i.e. minor nervousness during presentations).

    EM has a specific committee dedicated to the ongoing work of the EM SLOE. A similar model could be applied to the Internal Medicine SLOE to ensure continued quality improvement, scholarship and collaboration.

OVERALL APPROACH TO ADOPTION/VALUE FOR THIS CYCLE

12. What would be the most critical elements of the DOM SLOE to adopt if all of the changes can't be implemented at this time?

    1. Data on grade/assessment component distributions and where the student fell within the distribution
    2. Setting and responsibilities of the IM rotations the student did complete and any COVID specific changes
    3. An overall ranking for the student
    4. IM Qualifications Section if your school has current reliable data

ADDITIONAL QUESTIONS

13. Our Chair of the Medicine Institute has not interacted with the students. Is a co-signature necessary?

    Different schools approach this differently. Most Departmental letters are written by the CD and Chairs review and sign the letters, without necessarily meeting the student. Some Chairs like to play more active roles. Meetings are not required for the completion of the letter.

14. How do we make a SLOE for IMGs?

    Emergency Medicine has many variations of the SLOE for off-service rotations, electives, etc. A separate workgroup could look to develop a SLOE directed to IMG programs.

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