

EDUCATOR'S PORTFOLIO

Maria H. (Rose) van Zuilen, PhD
Assistant Professor of Professional Practice
Division of Gerontology and Geriatric Medicine
Department of Medicine
University of Miami Miller School of Medicine

Prepared in support of candidacy for promotion from Assistant Professor to Associate Professor

- I. Teaching Responsibilities
- II. Philosophy of Education
- III. Teaching Performance and Program Evaluations
- IV. Curriculum Development
- V. Instructional Innovation
- VI. Assessment of Learner Performance
- VII. Professional Development
- VIII. Educational Research and Scholarship
- IX. Faculty Development and Mentoring
- X. Educational Administration and University Service

Note: When I joined the medical school faculty, the Department of Medicine did not have an educator (professional practice) track and I was placed on the research track. However, my main role was educational design and delivery with a relatively small portion of my time devoted to educational research. Unfortunately education is not one of the major areas upon which promotion may be based in the research track unless the career focus is educational research. After the educator track was created, I requested a change of track based on my faculty effort, training, credentials, and experience. Since 2010, I have been on this track and this has been a perfect fit for my career trajectory.

I. TEACHING RESPONSIBILITIES

My teaching record started when I was a graduate student in Clinical Psychology on the Main Campus of UM. Initially, I was a teaching assistant for both undergraduate and graduate courses and taught an intro to Psychology course. Because of my background and interest in geriatrics, I was asked to become the coordinator for the then two-week geriatric medicine clerkship for juniors. After a few years, the University Administration asked if we could add geriatrics training in the senior year. I worked closely with Psychiatry, Geriatric Medicine, and Neurology to develop a 4-week integrated clerkship. I also started coordinating the Geriatrics OSCE station. In 2000, the geriatrics training expanded to the first and second year students as one of the themes within the Doctoring Course. My role was to manage the 4-year longitudinal curriculum, coordinate all training sessions including the annual OSCE station, and develop a comprehensive evaluation framework. Over the years, the geriatrics training in the clinical years evolved. I co-developed a two week clerkship for the third year medical students and a two-week clerkship for the fourth year medical students. At the request of the medical school administration, eventually we combined the two separate clerkships into one mandatory 4-week Geriatric Medicine Clerkship. My current teaching responsibilities are as detailed below.

- A. Associate Director, Geriatric Medicine Clerkship:** I am the Associate Director of our 4-week required clinical clerkship. I handle all the administrative responsibilities for this clerkship and engage in direct teaching and student assessment. Approximately 145 medical students complete this clerkship annually (See Appendix A1 for the clerkship syllabus).
- B. Co-Director, Longitudinal Curriculum in Geriatrics, Pain Management, and Palliative Care:** I am the Co-director of this longitudinal theme which is one of the core themes within the Doctoring Course which spans all four semesters of the first two years of medical school training. Students participate in a home visit program in their first year and make three visits to active older adults living in community. The curriculum focuses on comprehensive geriatric assessment and communication with older adults. I grade a significant portion of the 450 student home visit assignments that are submitted each year. In the second year, students complete two half day clinical skills sessions in which students encounter older adults who have experienced functional declines. I manage the home visit and clinical skills programs as well as a number of small group activities that occur during these years, and online competency assessments that occur near the end of each year. Approximately 150 first- and 150 second-year medical students complete this curriculum each year (See Appendices A2-4 and F2-3 for some samples of teaching activities developed for the curriculum)
- C. Preceptor, Doctoring Course:** Over the years I have also precepted educational activities for several other themes in the Doctoring course including Sexual Issues in Medical Practice, Population Medicine and Communication Skills.
- D. Preceptor, Competency Assessment Week:** Each year I facilitate one or more small group sessions with first and/or second year medical students in which we review videotaped histories and discuss their most challenging moments during the interview.
- E. Faculty Educator, Geriatric Medicine Fellowship:** I am both a teacher and a mentor for the fellows. Our fellows are actively involved in the geriatric education of students during all four years of medical school both on the wards and in small group activities. I co-teach several teaching-to-teach sessions each year for our fellows on such topics as maximizing teachable moments and providing feedback. I monitor their teaching during the year and observe them during their weekly case conferences which students attend. I provide

ongoing feedback on their teaching style and efforts to involve the student learners. Approximately 7-10 geriatric medicine and advanced geriatric fellows from other disciplines participate each year.

- F. Administrator, GeriU, the Online Geriatrics University:** I am one of the administrators for the Geriatrics courses on GeriU, a Moodle-based learning management system. Each of our medical student classes has its own course which houses the instructional modules and much of the other learning content and student resources. Students complete virtually all of their assignments on GeriU. Over the years, we have created several courses on GeriU that have been used by other trainees both at our institution and at several other institutions across the country. For example, the University of New Mexico used GeriU content to train their students state-wide on the Mini Mental State Exam with the online module I co-developed. Students at our regional campus in Boca used GeriU to complete online training modules and competency assessments.
- G. Faculty Educator, Miami Area Geriatric Education Center (MAGEC):** I have been an educator for MAGEC for over a decade. MAGEC is a consortium of organizations that provides interdisciplinary geriatric continuing education throughout South and Central Florida. My area of specialty is aging sensitivity training. Over the years, I have conducted more than 30 half day workshops following the “Aging Game” format developed at Duke University. Working with a staff of at least 5 facilitators, a small group of participants are immersed in the aging experience and go through the sensory and functional losses that can accompany aging. Due to an increasing demand for this type of training, I developed a modified 2-hour aging sensitivity training workshop that can be administered with larger audiences. Over the years I have trained well over a thousand participants from a wide range of disciplines (e.g., physicians, psychologists, social workers, nurses, nursing home administrators, and law enforcement personnel) including a group of visiting physicians from Greece. I have developed and delivered workshops on several other topics including a more recent three-hour interactive workshop entitled *“Improving Cross Cultural Communication: Solutions for Reducing Health Care Disparities.”*

II. PHILOSOPHY OF EDUCATION

My philosophy of education is predicated on the notion that learning is a life-long process. As I learn more about the learning process, out of necessity, my philosophy evolves. First and foremost, I believe in creating a welcoming, positive and safe learning environment, one that accommodates different levels and disciplines of learners. My favorite teaching experiences are those where the different disciplines come together and interact to develop knowledge and skills. Collaboration among learners reduces stress and it enhances the learning experience for everyone.

Learners must be meaningfully engaged with the learning material. I believe that we can improve outcomes by treating students as active creators of their own knowledge rather than passive consumers. I try to achieve this by designing activity-based educational materials and sessions that involve more than just the visual and auditory senses. Encouraging learners to get up and move around, physically and emotionally interact with the learning materials, talk to each other, and actively reflect, promotes deeper learning. All learners have a unique “intelligence” or style of learning, but every learner benefits from using multiple senses in the learning process. I believe that outcomes are also maximized by a solid curriculum design process, one that establishes clear learning objectives and then links these directly with the assessments. This in

turn guides the determination of the instructional approach that best ensures learners have an opportunity to master the desired outcomes.

In most teaching sessions, I prefer to think of myself as a facilitator rather than a teacher. Whereas in my early days working with small groups of learners, I would try to answer the questions students raised, over time, I learned to direct the questions back to the group which greatly stimulated student involvement and it improved their (and my) satisfaction with the learning process.

I value the provision and solicitation of feedback. All too often our medical students perceive they are not receiving feedback during their clerkships, and yet, when they are met with the words “I’d like to give you some feedback,” a sense of concern inevitably washes over their face. While I make an effort to meet with students individually during the clerkship to give and solicit feedback, I make it clear to students that they will also feedback in situations when they are presenting to the group as this allows us to learn from each other. Before I give feedback, I encourage the students to give each other feedback and to make this feedback specific. On the flip side, I also actively seek out feedback. Not only does this promote a positive learning climate, it is invaluable to us as education directors in continually improving the learning experience. Below is an excerpt from an unsolicited email I recently received from one of our fourth year medical students.

Dear Dr. van Zuilen, Thank you for caring and putting so much energy into the clerkship. I can't remember the last time we were invited to give feedback in such a direct way, and it speaks volumes of your desire to create the best learning environment possible. (Feb, 2013)

In geriatrics, we teach our learners to perform comprehensive geriatric assessments that integrate information from the medical, psychological, socioeconomic, spiritual and functional domains. It is essential that our learners get to know the whole person and their social environment. To quote William Osler “*It is more important to know the person with the disease than the disease the person has.*” From a humanistic perspective, I encourage our students to spend time with their patients and family members – to simply sit with the patient and experience the sights, sounds, and smells of the environment – and ponder what questions or concerns families might have being in such an environment. This helps students gain insight into the patient’s and family’s experience and sensitizes them to their needs and concerns.

Being an educator is a special privilege. I am committed to a life-long process of personal development and to continually raise the bar for my learners and for myself.

III. TEACHING PERFORMANCE AND PROGRAM EVALUATIONS

As an educator, I actively seek out feedback from my learners and my peers that will help me refine my teaching skills and the educational programs and products I have developed.

Doctoring Course: Year 1 and Year 2 Medical Student Teaching Sessions

Evaluations by students of teaching sessions I have facilitated are generally very positive as are overall session evaluations from teaching activities I took a leading role in developing (See appendices B1 and B2). Feedback from faculty who have implemented the sessions based on the facilitator’s guides I developed for the sessions are also positive and indicate these sessions can be effectively implemented with no or minimal additional orientation (See Appendix B3).

Year 3 and 4 Medical Student Clerkships in Geriatric Medicine

The training in geriatric medicine for the medical students in their clinical years has gone through several iterations over the years, and at each phase of development, I have been one of the core curriculum designers. For a number of years, students completed 2 weeks in their third year and two weeks in their fourth year. Both clerkships were highly rated and Geriatrics II was voted as the Best Clinical Course by the Class of 2009.

Eventually, the medical school administration asked us to combine these courses into one 4-week course which is mostly completed by students during their fourth year of training. This initially presented a challenge as some students came in with a negative perception about taking four weeks of Geriatrics in their senior year. I became the associate clerkship director two years ago. In these past two years, I have worked with my colleagues to conduct ongoing QA and make targeted curricular improvements. Appendix B4 shows data from our internal clerkship evaluations and Appendix B5 shows data from the New Innovations evaluations collected by Medical Education for AY2011-2012. I am largely responsible for the overall organization of the clerkship. The evaluations reflect that students overwhelmingly agree that the clerkship is well organized. So far, the overall clerkship satisfaction ratings from New Innovations have improved almost 10% for AY2012-2013 with only two rotations to go. More work remains to be done, but these results are encouraging. Comments include: *"I thought it was very well organized. Always knew when and where to be, when assignments were due, and what was expected;"* *"Rose was super responsive and effective in communicating with students in a timely and thorough manner before and during the clerkship;"* and *"This must be one of the most well organized clerkships out of all of them."*

Sample of unsolicited emails received from students who completed the clerkship

5/5/12 (MS4) – *"I just wanted to send you a quick thank you for all of your help throughout this course. I never would have expected to learn so many valuable things in the last rotation of medical school. I am sure this will be useful during my intern year and anesthesia after that."*

4/25/12 (MS4) – *"It was an honor and a privilege to work with you and Dr. M over the past two years, I am looking forward to my clinical rotations and hope to get to learn more from you guys. It is incredible how you are teaching us to deal with the majority of patients we are going to be seeing; I don't want to get too sappy but thank you for teaching us about cleaning up meds, preventing falls, and taking care of our aging parents and country."*

4/11/12 (MS4) – *"Thank you so much, Rose. I really enjoyed my time on geriatrics. I learned so much that I can directly apply next year in residency, and I can't thank you enough for your time and dedication."*

CME/CEU Teaching

My continuing education teaching mostly consists of highly interactive workshops with interdisciplinary audiences, but I have also given presentations for PRIMED, the annual Board Review Course in Internal Medicine and at other local, regional and national conferences. I have consistently received very high ratings and positive remarks on my teaching format (See Appendix B6).

Departmental Evaluation of Teaching

My latest teaching evaluation completed as part of the annual Department of Medicine peer review process gave me the highest rating (See Appendix B7)

IV. CURRICULUM DEVELOPMENT

I have been involved in several major curricular initiatives at the local and state level and have led workshops on curriculum development at the local and national levels. For our medical students, as described above, I have taken a leading role in developing and updating our 4-year longitudinal curriculum. This includes teaching and assessment activities in the first two years of training as part of the Doctoring course and a 4-week mandatory geriatric medicine clerkship in the clinical years. I was also involved in the development of several earlier geriatrics clerkships. Below are a few highlights of my global curriculum development efforts. For a detailed list and description of the more than 60 instructional and assessment activities I have co-developed and how these activities were implemented, see Appendix C.

A. *Multimedia Educational Modules for statewide training of nursing home care providers*

In 2001, I began working with the Florida's Teaching Nursing Home Program to develop several dementia curricula for nursing home care providers. The multimedia training modules were developed in response to legislation by the State of Florida that all nursing home direct care providers for patients with dementia receive 4 hours of training. I served as content developer and editor for several basic, intermediate, and advanced curricula

1. *Nursing Home Alzheimer's disease and Related Disorders Training for LPNs. Basic and Intermediate Modules (4 hours)*
2. *Nursing Home Alzheimer's disease and Related Disorders Training for CNAs (4 hours)*
3. *Nursing Home Alzheimer's disease and Related Disorders Training II. Pain Assessment and Management - Advanced Module*

Impact: Two 7-module multimedia curricula were certified by Florida's Department of Elder Affairs and used for training LPNs and CNAs throughout Florida. These training materials can be accessed at: <http://ltc.geriu.org/>

B. *UME Competency-Based Curriculum in Geriatric Syndromes*

In 2003, we were awarded a 4-year grant entitled *Strategic Development of Physician Competency in Geriatric Syndromes* by the Donald W. Reynolds Foundation. As co-investigator, I served as the Program Coordinator and Lead Program Evaluator. Together with colleagues from my the division of Gerontology and Geriatric Medicine, I developed a comprehensive competency based curriculum focused on the geriatric syndromes of dementia, delirium, falls, pressure ulcers, and Polypharmacy. This curriculum is implemented across the four-years of medical school training and competency assessments occur at the end of years 1 and 2 and during the mandatory geriatric medicine clerkship (see Appendix D for a full list of competencies assessed). I am responsible for administering and grading all of the competency assessments.

Impact: 100% of students achieve the minimum competency standards.

C. *State-wide and National Initiatives to Develop Core Geriatrics Competencies for Medical Students and Residents.*

In 2001, I joined the Florida Consortium for Geriatric Medical Education (FCGME) a consortium of the five medical schools in the state at that time. Our division headed this effort. The consortium was sponsored by Florida's Teaching Nursing Home and endorsed by the deans of all five medical schools. One of the main initiatives I contributed to was the development of a set of core competencies for 10 geriatric syndromes proposed as requirements for all graduating medical students. Later I participated in workgroups at the national level to develop the now published AAMC geriatric competencies for medical students and the more advanced competencies for internal medicine residents. Our most recent efforts at these work meetings have focused on identifying the *Entrustable Professional Activities* (EPAs) of a Geriatrician.

Impact: The state-wide competencies provided the foundation for our subsequent curriculum development and for our successful grant application to the Donald W. Reynolds Foundation. The initial process for the development of national competencies was modeled after the one used by the FCGME. Several of the educational products I co-developed have been chosen by a separate national workgroup as appropriate tools to address one or more of the national competencies.

D. Aging Sensitivity Training Curriculum

I developed a 2-3 hour interactive workshop on aging sensitivity training geared towards health care professionals. This curriculum has been adapted for different audiences (e.g. law enforcement personnel, high school students). I have trained several other professionals to deliver this workshop. Appendix A5 shows an outline of this workshop.

Impact: As described earlier under my teaching roles, the workshop has reached well over a thousand participants. Core materials for the workshop along with an Instructor Guide have been disseminated at several national conferences. Educators I trained have successfully delivered this training at several local and regional interdisciplinary conferences on Aging.

E. MS1 Home Visit Program with Community Residing Active Older Adults.

One of the core components of the Geriatrics, Palliative Care and Pain Management Theme curriculum for first-year medical students is our home visit program. Students make 3 visits to the home of an older volunteer (their elder friend) to assess their function within the biopsychosocial domains. Visit 1 focuses on the comprehensive geriatric history and allows students to practice their interviewing skills. Visit 2 focuses on primary and secondary prevention and on education about serious medical illnesses, advance directives and emergency preparedness. Students have an opportunity to practice their counseling skills. Visit 3 focuses on safety assessment (home, community, and driving) safety. Students make specific safety recommendations. Below is some feedback from students.

The Elder Friend component of Doctoring was the most useful activity we've done all year, and I sincerely enjoyed the experience (2010)

The combined elder friend visits and small group sessions very strongly reinforced key themes and concepts, and even now I can provide details of home safety, geriatric health, ADLs and IADLs (2010).

V. INSTRUCTIONAL INNOVATION

Our educational program is nationally recognized for its innovative competency based curriculum and for our blended learning strategies. This is evidenced by the wide use of our educational products by other programs. I have been instrumental in designing, developing, implementing, and evaluating this program. Below are some of the hallmarks of our educational programs that exemplify innovation.

A. Blended Learning Curricula

I co-developed a series of curricula that combine online training modules with either preceptor-led training or other independent assignments. For example, our students complete an interactive home-safety assessment module before they go on a home visit with an older adult and perform the actual assessment and make specific recommendations for improving safety. This allows students to learn on their own time and at their own pace. It also maximizes the limited time we have as preceptors with students in person. Students

come more prepared to preceptor-led teaching sessions. In addition, many of our online training modules are used by students to remediate if they do not pass an exam or achieve the performance standard on our competency assessments, thus saving valuable faculty time. Our online training modules can be used as stand-alone instruction and have been used by others locally and nationally to prepare their students. For example, the Mini-Mental State Exam training module I co-developed has been used by the Population Medicine Theme to help students prepare for a small group session on screening for dementia and depression. It has also been used by the University of New Mexico to train students state-wide how to screen for cognitive impairment.

B. Competency Based Education

Accreditation agencies such as the LCME and the ACGME have started to place greater emphasis on programs clearly delineating and measuring student and resident competencies or outcomes. As stated earlier, I have been actively involved in state-wide and national initiatives to determine geriatrics competencies for students and residents. In 2003, I was a co-investigator on a successful grant application to the Donald W. Reynolds Foundation that allowed us to develop a competency based curriculum for medical students targeting 5 geriatric syndromes. The grant also allowed us to expand our training program for internal medicine residents. Our current UME program is nationally recognized for its innovative competency based curriculum. I was the lead author of an invited paper in *Gerontology and Geriatrics Education* that described our curriculum design, development, implementation and evaluation efforts (See Appendix E1).

C. Highly Interactive Teaching Activities

Whether it is a small or a large group of learners, I design learning experiences to be interactive when feasible. Interacting with the learning material and with other learners as well as using multiple sensory modalities in the process promotes deep learning. These types of learning experiences receive higher satisfaction ratings from students and from facilitators, and make them attractive to other educators looking to implement novel teaching modalities into their curriculum (see next section).

D. Exportable Instructional Materials

When developing high-quality educational resources, I believe we should make these available to other programs, especially those who lack the resources to develop them on their own. However, when it is meant for widespread use, the developer must provide the information that will allow others to use the resource as intended. Effective sharing of the materials requires maximizing utility and usability. A clearly written facilitator's or instructor's manual becomes an essential element of sharable educational materials. I was the lead author on a MedEdPORTAL publication on developing effective user guides for instructional materials (See Appendix F1) and I led a national workshop for geriatric educators on this topic and periodically receive requests for assistance.

Hi Maria Zuilen – I am working on learning styles in students and envisioning that awareness of learning styles can help in incorporation of "Blended Teaching " in curriculum. Can you advise how do I go about making a facilitator's manual. Thanks, Latha Kumar, Associate Professor, AIMST University, Kedah, Malaysia (Jun, 2009)

Educational products I co-developed are used by institutions across this country and countries around the world to assist them in training their learners and in developing curricula (See MedEdPORTAL usage reports in Appendix G). One of my products, a card sorting activity on dementia, depression, and delirium (the 3D's), is showcased as an example of an effective interactive training tool at Mt. Sinai School of Medicine in their

Curriculum and Career Development in Geriatric Medical Education Mini-Fellowship. Below are some comments that were posted on POGOe by users of our products.

Feedback on the Assistive Devices Card Sorting Activity

"I have used this exercise with my third year rehabilitation medicine selective students. They enjoy the exercise because it gets them to think about the indications and contraindications for the various devices. I also have samples of the devices for them to try, and I feel this enhances the activity greatly" Jun 3, 2011 by Nethra Ankam, MD, Thomas Jefferson University Hospital

"Very useful for my residents and medicine students." Dec 28, 2009 by Luis M. Cornejo MD., AGSF, Geriatrics Rehabilitation Medicine. Univ. of Panama, Republic of Panama.

"I adapted for noon conference presentation and received great feedback from family medicine residents. It was interactive and everyone (faculty, staff, residents, medical students) participated. It has been templated into the regular academic conference schedule." Oct 15, 2009

Feedback on the 3D Card Sorting Activity

I've used this card sort in several different settings and found it to be effective, educational and entertaining. Even though the authors recommend its use in small groups, I've found that it works well in larger groups too. I've used it twice in a lecture hall with a group of 40 pharmacy students and it kept them engaged and attentive throughout. Dec 7, 2009

VI. ASSESSMENT OF LEARNER PERFORMANCE

Over the years, I have worked with my colleagues to develop a broad range of assessments covering knowledge, skills, and attitudes. In addition to final examinations for the geriatric medicine clerkships, I led the development of several Geriatric Objective Structured Clinical Exams (See Appendix F4) and simulated patient assessments, as well as the competency assessments for five geriatric syndromes that are now a standing part of the curriculum for first and second year medical students and the students completing the clerkship. Through rigorous quality improvement, we have been able to raise the performance standards on many of our assessments over time and reduced the number of students needing to remediate.

Appendix C includes a description of all the assessments I have co-developed and the years they were implemented. We also developed an attitude scale linked to specific attitudinal learning objectives for the geriatric syndromes. Appendix H shows the results from a subgroup of students. Results indicate that the timing of students' development of more appropriate attitudes corresponds to the timing that we introduce related content in the curriculum. For example, students learn about falls early in the curriculum and the attitude shift occurs in the pre-clinical years whereas students learn about restraints in their clinical years and the attitude shift occurs later.

VII. PROFESSIONAL DEVELOPMENT

Ongoing professional development is critical as it keeps us up-to-date with new research on best learning strategies and emerging technologies for education. It also allows us to role model self-directed learning which is an important skill we expect our learners to develop. I have been

an Associate of the Educational Development Office since 2004, and more recently, in 2012, became a Founding Member and Fellow of the Academy of Medical Educators at the University of Miami Miller School of Medicine (See Appendix I). I attend the monthly education grand rounds and take advantage of workshops offered locally to improve my educator skills. I attend an annual conference of geriatric educators and participate in several teaching and learner evaluation workshops each year. I also periodically attend the annual Scientific Meetings of the American Geriatric Society and the Gerontological Society of America and stay up-to-date on curricular initiatives. As I mentioned earlier, I have been actively involved at these workshops in several national efforts to foster student and resident competency in geriatrics.

Below is a list of selected local professional development activities I have participated in.

- Dec 13, 2012 Enhancing Student Motivation and Learning: Aligning Research, Theory and Practice, UMMSM
- Nov 30, 2012 Team-Based Learning, UMMSM
- 2008 Accelerated Learning, a 2 day workshop presented at the Miami VAHCS
- 2005 Clinical Teaching Curriculum based on the Stanford Faculty Development Model, UMMSM
- 2003-2006 Donald W. Reynolds Faculty Development Program, a series of workshops on topics including: teaching small groups, case-based teaching, conducting workshops and seminars, providing feedback, assessment in medical education, writing MCQ questions, principles of QI, and writing a scientific research paper
- 2004 Instructional Design Certification, Florida International University
- 2003 Problem-Based Learning – Completed all three phases of a basic course in leading problem-based learning groups, UMSM, Miami, FL
- 2002 – 2003 Community Clinical Scholars Fellowship – Audited a faculty development program organized by the Department of Family Medicine and Community Health, UMSM, Miami, FL

VIII. EDUCATIONAL RESEARCH AND SCHOLARSHIP

Since joining the faculty, I have published a number of peer-reviewed education articles (several of which are published in the education section of the leading geriatrics journal) and book chapters. The articles largely focus on our innovative curricular approaches such as blended learning and competency based education, and the effectiveness of our curricular interventions. Quite a few of our educational products have also been peer-reviewed and are published on AAMC's MedEdPORTAL (www.mededportal.org). Most of them are also available on the Portal of Geriatric Online Education (www.pogoe.org) and are accessible by educators at universities worldwide (See Appendix G for MedEdPORTAL usage reports). I regularly showcase our educational products at national conferences, and, as detailed in my CV, I have co-authored over 40 published abstracts and a total of 59 presentations at national conferences, most of them on topics related to education. Five of the poster presentations at the Annual Scientific Meeting of the American Geriatrics Society (AGS) were selected to be in the presidential poster session (See Appendix J and K for some examples). The following paper received the **“best paper award”** in the education section at the 2011 Annual Scientific Meeting of the AGS.

van Zuilen MH, Rodriguez OL, Ruiz, JG, Roos BA, Mintzer MJ. (2011). Assistive devices for ambulation in the elderly: A curriculum for medical students.

Below is list of my most recent referred journal articles and educational products (See CV for a full list of publications and Appendices F2-F5 for some examples of my published work)

1. **van Zuilen MH**, Kaiser RM, Mintzer MJ (2012). A competency-based medical student curriculum: Taking the medication history in older adults. *Journal of the American Geriatrics Society*, 60(4), 781-781.
2. **van Zuilen MH**, Gonzalez J., Aguilar EA, Palacios JC, Mintzer MJ (2011). Geriatrics Medication History Objective Structured Clinical Exam. MedEdPORTAL: <http://services.aamc.org/30/mededportal/servlet/s/segment/mededportal/?subid=8274>
3. **van Zuilen MH**, Tunuguntla R, Rodriguez OL, & Mintzer, MJ. (2010). Revision of a home safety assessment curriculum improves medical student reporting of safety problems. *Journal of the American Geriatrics Society (letter to the editor)*, 58(7), 1398-1399.
4. Golden AG, **van Zuilen MH**, Mintzer MJ, Issenberg SB, Silverman MA, Roos BA. (2010). A fourth-year medical school clerkship that addressed negative attitudes toward geriatric medicine. *Journal of the American Geriatrics Society*, 58(4), 746-750.
5. Tunuguntla R, Rodriguez O, Ruiz J, Qadri SS, Mintzer MJ, **van Zuilen MH**, Roos BA. (2008). Computer-based animations and static graphics as medical student aids in learning home safety assessment: a randomized controlled trial. *Medical Teacher*, 30(8), 815-817.
6. **van Zuilen MH**, Rodriguez OL, Mintzer MJ. (2008) Eliminate Hazards in Your Home: A Safety Checklist with Recommendations. MedEdPORTAL; Available from <http://www.aamc.org/mededportal>, ID = 1063
7. Mintzer MJ, **van Zuilen MH**, Cordero M, Kaiser RM (2008). The Medication History: A Small Group Session on Interviewing a Patient Regarding Medication Use. MedEdPORTAL; Available from <http://www.aamc.org/mededportal>, ID = 1112.
8. **van Zuilen MH**, Rodríguez O, Paniagua M, Mintzer MJ, (2008). Choosing the Appropriate Assistive Device: A Card Sorting Activity. MedEdPORTAL; Available from <http://www.aamc.org/mededportal>, ID = 823.
9. **van Zuilen MH**, Mintzer MJ, Milanez MN, Kaiser RM, Rodriguez O, Paniagua MA, Ruiz JG, Roos BA. (2008). A competency-based medical student curriculum targeting key geriatric syndromes. *Gerontology and Geriatrics Education*, 28(3), 29-45.
10. Ruiz JG, Smith M, Rodriguez O, **van Zuilen MH**, Mintzer MJ. (2007). An interactive e-learning tutorial for medical students on how to conduct the performance oriented mobility assessment. *Gerontology and Geriatrics Education*, 28(1), 51-60.

In terms of my editorial responsibilities, I have been involved in editing and performance usability reviews on educational products developed by my colleagues, but have also been active as a peer reviewer for several journals, online publication services for educational materials, and annual conference abstracts and papers. I have gained recognition for my expertise in competency based education and was recently asked to review an article on this topic for the Journal of the American Geriatrics Society – Education and Training Section.

- 2012 – Ad Hoc Reviewer: Journal of the American Geriatrics Society, Education Section
- 2011 – Peer Reviewer: Multimedia Educational Resource for Learning and Online Teaching (MERLOT) – Health Sciences
- 2011 – Ad Hoc Reviewer: Journal of Palliative Medicine
- 2008 – Peer Reviewer: AAMC MedEdPORTAL (See Appendix L)
- 2009 – 2010 Peer Reviewer: Gerontological Society of America Annual Scientific Meeting
- 2008 – 2009 Peer Reviewer: International Conference on Communication in Healthcare
- 2006 – 2011 Peer Reviewer: Research in Medical Education (RIME) Conference
- 2006 – 2007 Peer Reviewer: American Academy on Physician and Patient Conference
- 2004 – 2005 Peer Reviewer: Portal of Geriatric Online Education
- 2002 – 2003 Content Editor: Nursing Home Alzheimer's Disease and Related Disorders Training CD ROMs

1997 – 1998 Ad Hoc Reviewer for: Neuropsychology Review, Schizophrenia Research, Behavior Therapy, Annals of Behavioral Medicine

I have been involved in several large educational grants.

2007 – Pres Faculty Educator, HRSA funded Miami Area Geriatric Education Center grant.

2003 – 2008 Co-Investigator, Program Coordinator, and Lead Program Evaluator, Donald W. Reynolds Foundation grant: Strategic Development of Physician Competency in Geriatric Syndromes.

2002 – 2004 Program Coordinator, John A. Hartford Foundation Geriatrician-Educator Career Development Grant: Enhancement of Teaching Skills and Mentored Career Advancement for Geriatrician-Educators.

IX. FACULTY DEVELOPMENT AND MENTORING

I am the Director of Faculty Development in our division. From 2002 to 2004 I was the program coordinator of a John Hartford Foundation Grant *Geriatrician-Educator Career Development Grant: Enhancement of Teaching Skills and Mentored Career Advancement for Geriatrician-Educators*. Then, from 2003 to 2008 I was the co-investigator, program coordinator, and lead program evaluator on a Donald W. Reynolds Foundation Grant *Strategic Development of Physician Competency in Geriatric Syndromes*. Both grants contained a substantial faculty development component. I organized a comprehensive series of faculty development workshops and retreats and promoted faculty involvement in teaching skills sessions that focused on a broad range of educator competencies. For example, the first year the Problem Based Learning (PBL) curriculum was implemented with our second year medical students, I arranged for 8 of our division's faculty members to complete the full training, 5 of whom assisted in the implementation of the PBL curriculum that year. I served as an ad-hoc facilitator myself for several years.

I support faculty and fellows in our division in the submission of abstracts for national conferences and the preparation of posters and presentations. I have mentored students, fellows and junior faculty on the development of PowerPoint and poster presentations, the design and development of educational products, and the submission of Geriatric Academic Career Development Awards. I routinely participate in our weekly VA GRECC and Laboratory for E-learning and Multimedia Research (LEMUR) meeting and provide feedback on new research protocols.

In 2004, I started a faculty learning community *Enhancing Undergraduate Geriatrics Clinical Teaching*. This resulted in a high degree of collaboration on several educational products that were subsequently published on MedEdPORTAL (see section on scholarship).

During the Geriatric Medicine Clerkship, I take time to mentor the students with their EBM assignments and other course requirements, but I also offer my assistance in reviewing their CVs and personal statements when it comes time for their residency application and have written support letters. As one of my mentees wrote:

"I really appreciate all your help, Dr. Van Zuilen. I wish I had someone like yourself who cared that much about my success early on during my career. I am very thankful for it!" Aug, 2012

In 2012, I was chosen to be a faculty mentor for the AGE Scholars Program, a Geriatric Faculty Development Program sponsored by the Miami Area Geriatric Education Center and worked with my mentee, Dr. Barbara Sparacino, to develop a training module on assessing substance use and abuse in older adults. She successfully implemented the training modules and delivered a scholarly presentation on her work.

In recent years, I have conducted the teaching assessments for the division faculty as part of the annual departmental peer review process. Dr. Symes, who received these assessments, commented: *"Thanks for the very thoughtful teaching assessments you did last year, they were a model for how these should be completed."*

X. EDUCATIONAL ADMINISTRATION AND UNIVERSITY SERVICE

My administrative role and service on University Committees has expanded over the years. As the co-director of the Longitudinal Curriculum in Geriatrics, Pain Management and Palliative Care for the past 10 years, I have been responsible for all the administrative components of this curriculum which reaches about 150 first-year and 150 second-year medicals students annually. In 2011, my administrative role expanded as I became the Associate Director of our mandatory 4-week geriatric medicine clerkship completed by about 140 students annually. I handle all administrative aspects of this clerkship. As Director of Faculty Development for our Division since 2003, I have established a comprehensive evaluation system to allow our clinical teaching faculty to obtain feedback on their teaching performance. Faculty members have access to these evaluations for their educator portfolios, and they are used to complete the annual departmental teaching evaluations.

I have a long-standing service on University-based of educational committees (see below). My most rewarding experience is that on the Admissions Committee even though it is a work-intensive committee experience. I truly enjoy spending time with the applicants and having a voice in selecting our incoming class. I look forward to continuing my service on this committee.

- 2011 – Admissions Committee, UMMSM
Responsibilities: Reviewing applicant files, interviewing candidates and writing reports, reviewing reports and voting on interviewed candidates, participating in bi-weekly committee meetings during interview season.
- 2007 – Clinical Curriculum Advisory Committee, UMMSM
Responsibilities: Attending bi-monthly meetings to discuss curricular changes, determine clerkship policies, and review existing clerkships; Preparing clerkship reports and LCME documentation.
- 2005 – Freshmen, Sophomore, and Junior/Senior Promotions Committees, UMMSM
Responsibilities: As a member of all three committees, I attend at least one meeting per month to discuss students who have academic or professionalism deficiencies.
- 2011 - Ad Hoc member, Miami Area Geriatric Education Center Executive Steering Committee meeting
- 2009 – 2010 Cultural Sensitivity Advisory Committee, Miami Area Geriatric Education Center, UMMSM
- 2007 – 2008 LCME Self-Study Committee on Student Affairs, UMMSM
- 2001 – 2003 Florida Consortium for Geriatric Medical Education (described earlier)
- 1998 – 1999 Geriatric Education Committee, University of Miami School of Medicine

List of Appendices

- Appendix A1 – Geriatric Medicine Clerkship Syllabus 2012-2013
- Appendix A2 – Guide to a Comprehensive Geriatric Assessment
- Appendix A3 – Facilitator’s Guide for MS1 Case Discussion
- Appendix A4 – Facilitator’s Guide for MS2 Breaking Bad News Session
- Appendix A5 – Aging Sensitivity Training Outline 2013
- Appendix B1 – Student Evaluations of Teaching
- Appendix B2 – Student Evaluations of Teaching Sessions Developed
- Appendix B3 – Peer Evaluations of Small Group Sessions Developed
- Appendix B4 – Internal Clerkship Evaluation 2012-2013
- Appendix B5 – Comparison of Clerkship Evaluation Results 2011-2012
- Appendix B6 – CME/CEU Evaluations of Teaching Performance
- Appendix B6 – van Zuilen Teaching Evaluation 2010-2011
- Appendix C – Inventory of Educational Products Developed
- Appendix D – Competency Learning Objectives Assessed
- Appendix E1 – Invited Article in Gerontology and Geriatrics Education
- Appendix E2 – 2012 Article: Journal of the American Geriatrics Society–Education Section
- Appendix E3 – 2010 Article: Journal of the American Geriatrics Society–Education Section
- Appendix F1 – MedEdPORTAL Publication – Guidelines for Developing User Guides
- Appendix F2 – MedEdPORTAL Publication – Choosing the Appropriate Assistive Device
- Appendix F3 – MedEdPORTAL Publication – The Medication History
- Appendix F4 – MedEdPORTAL Publication – Geriatrics Medication History OSCE
- Appendix G – MedEdPORTAL Usage Reports
- Appendix H – Medical Student Attitude Survey Results
- Appendix I – Academy of Medical Educators Letter
- Appendix J – Sample Poster Presentations at National Conferences
- Appendix K – Sample Paper Presentation at a National Conference
- Appendix L – MedEdPORTAL Peer Reviewer Letter