Preceptor Guidebook

2018-2019

WESTERN MICHIGAN UNIVERSITY
Homer Stryker M.D.
SCHOOL OF MEDICINE

Preface

The WMed Preceptor Guidebook serves to establish standards to assure a comparable experience for all students during each clerkship. Included you will find learner, educator, and staff member expectations as well as helpful references to the Medical Student and Faculty Handbooks. Recommendations are provided to facilitate preparation for the arrival of medical students in both inpatient and ambulatory settings.

Descriptions of the characteristics of excellent teachers are provided to assist faculty in reflecting upon their key roles in medical student education. Guidelines for student assessment are provided as well, to facilitate consistency in observing, assessing, providing feedback, and documenting student performance.

Our goal is to provide a useful guidebook for all teaching physicians. Please direct your feedback regarding this guidebook to Clerkship Directors, the Assistant Dean for Clinical Applications, and/or the Associate Dean for Educational Affairs. With our new digital format, we aim to continuously improve this guide to best serve your needs.

Thank you for your commitment to our medical students as you provide outstanding care to the patients you serve.

Sincerely,

Kristine M. Gibson, MD
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Mission, Vision, and Values

WMed Educational Pledge

Western Michigan University Homer Stryker M.D. School of Medicine is committed to providing an environment that promotes excellence in teaching and learning, service, research and discovery, and the practice of medicine and clinical care. All persons in the medical school shall respect every person's worth and dignity, and contribute to a positive learning environment. To that end, medical students, residents, fellows, faculty, staff and administrators take this pledge to create an atmosphere in which all participants can teach and learn to the best of their abilities.

As a Learner at Western Michigan University Homer Stryker M.D. School of Medicine, I pledge to:

- Acquire the knowledge, skills, attitudes and behaviors necessary to fulfill all established educational objectives
- Treat educators, learners, staff and patients with respect and fairness
- Embody the professional virtues of integrity, altruism, respect, collaboration, empathy, compassion, honesty, courage, and trustworthiness in all of my interactions
- Respect others by being on time for and participating fully in all educational and clinical experiences
- Take responsibility for my learning experience and commit the time and energy to studies necessary to achieve the goals and objectives of each experience
- Communicate concerns and provide educators with timely feedback, constructive suggestions and opportunities for improvement for the curriculum, didactic methods, and the learning environment in a respectful and professional manner
- Assist my fellow learners in meeting their professional obligations, while fulfilling my own obligations as a professional
- Be willing to try new methods, ideas, technologies and other innovations with a positive and inquisitive attitude, accepting that the pursuit of knowledge and positive change includes some risk of failure but contributes to a positive learning environment

As an Educator at Western Michigan University Homer Stryker M.D. School of Medicine, I pledge to:

- Strive to maintain currency in my professional knowledge and skills
- Strive for excellence in my instruction that conveys knowledge and skills in an effective format for learning
- Accept feedback and strive to improve my teaching skills
- Treat educators, learners, staff and patients with respect and fairness
- Embody the professional virtues of integrity, altruism, respect, collaboration, empathy, compassion, honesty, courage, and trustworthiness in all of my interactions
- Respect others by being on time for and participating fully in all educational and clinical experiences
- Provide learners with timely, formative feedback in a professional and respectful manner with constructive suggestions and opportunities for improvement and remediation
- Assess learners equally and objectively based on performance and without influence of conflicts of interest or conflicts of commitment
- Provide proper notification and respond appropriately to unprofessional behavior by any participant in the educational process
- Nurture learner commitment to achieve personal, family and professional balance
- Be willing to try new methods, ideas, technologies and other innovations with a positive and inquisitive attitude, accepting that the pursuit of knowledge and positive change includes some risk of failure but contributes to a positive learning environment

As a Staff Member at Western Michigan University Homer Stryker M.D. School of Medicine, I pledge to:

- Strive to maintain currency in my professional knowledge and skills
- Help ensure excellence of an educational curriculum that conveys knowledge and skills in an effective format for learning
- Treat educators, learners, staff and patients with respect and fairness
- Embody the professional virtues of integrity, altruism, respect, collaboration, empathy, compassion, honesty, courage, and trustworthiness in all of my interactions
- Be willing to try new methods, ideas, technologies and other innovations with a positive and inquisitive attitude, accepting that the pursuit of knowledge and positive change includes some risk of failure but contributes to a positive learning environment

Preceptor Expectations

Preceptors play a vital role in transforming medical students into exceptional clinical practitioners. Preceptors model professionalism, engender enthusiasm, encourage excellence, and facilitate continuous learning. They accomplish this by providing a rich learning environment that is grounded in the real practice of medicine. Preceptors enrich this environment by sharing their past experiences and clinical knowledge in a manner that helps students apply their classroom learning experiences to clinical practice.

Preceptors

- Assure students are supervised appropriately (by residents/or attending physicians)
- Are knowledgeable regarding EPAs, student knowledge, skill, and attitude development
- Provide clear expectations to students
- With residents, observe, assess, and provide ongoing feedback to students to facilitate progress in EPA development
- As appropriate, delegates supervision and teaching to residents

The Learning Environment

- Create the supportive learning environment
    - Discuss professional expectations, Culture of safety, Appropriate supervision, Monitoring work hours/Fatigue management (hidden curriculum), Establish system for providing daily feedback
- Supervisors and Preceptors are role models
- Be explicit with students when learning is
    - Patient-centered
    - Student/Learning Focused
- Be available for student questions, advising support

Model Concepts

- Focus the teacher-learner encounter on the decision-making process used by the learner. What did the learner do?
- Teacher needs access to the data the learner used in decision making and the decision-making process used
- Keep teaching encounters brief, less than 5 minutes (called the learning moment)

Getting Commitment

- Learner commits to the learning opportunity (diagnosis, work-up, or treatment plan)
- Learner should feel responsible for care of the patient (collaborative role in problem solving)

- Supportive environment for learning: honesty, admit limitations (the teacher), model reflection, and evidence-based practice.

Facilitating Questions

- What do you think is going on?
- What laboratory test are indicated? Most likely to yield the information needed?
- What would you like to accomplish in this session or during this visit?
- What might contribute to this patient's non-adherence?

Probe for Supportive Evidence

- What were the major findings which led to this diagnosis or plan?
- What is the reasoning behind recommending this medication?
- What factors did you take into account when you...
- What else should be considered?

Teach/Reinforce

- If appropriate, teach the pearl or general rule
- If the opportunity presents itself, reinforce what was done well...considered patient's economic situation, spent extra time listening, proceeded to get help, or checked the literature
- If appropriate provide constructive feedback regarding mistakes

Encourage Learning

- Foster self-directed learning
- This cycle is similar to evidence-based practice
    - Reflect on information/knowledge needed
    - Create a searchable question
    - Search for the best literature/answer
    - Appraise, apply, measure effect
- What do you need to learn more about?
- What additional information do we need?

The One Minute Preceptor

- Furney, SL, Orsini, AN, et al. (2001). Teaching the One-Minute Preceptor: A Randomized Controlled Trial. Journal of General Internal Medicine. 16:620-624

Medical Student Supervision on Clinical Services

Western Michigan University Homer Stryker M.D. School of Medicine (WMed) has established guidelines regarding the levels of supervision required of all students in the pursuit of their undergraduate medical training. WMed is committed to medical student education that will produce the highest quality physicians, while at the same time ensuring that patient safety is of the upmost priority. WMed provides all medical students with clinical experience that is progressive and in accordance with requirements of the Liaison Committee for Medical Education (LCME).

Medical students are learners and are not licensed to provide patient care. Supervising faculty and resident physicians are responsible for the evaluation and management of all patients. While some supervision of medical students may be delegated to house staff, the attending physician is ultimately responsible for the direct supervision of all medical students assigned to the clinical rotation.

While engaged in clinical activities, medical students should be incorporated into and accepted as a member of the patient care team. Students are permitted to participate in care of patients and expected to demonstrate appropriate responsibility for patient care. The extent of such responsibility should commensurate with the student's level of training and demonstrated abilities.

Course/clerkship directors will provide specific guidance to students to explain the student's level of responsibility and the scope of approved activities and procedures expected or permitted. This information will be shared with all teaching faculty, residents and staff annually.

<u>Faculty commit to:</u>

- Providing consistent direct supervision during all clinical activities
- Direct supervision of all students is provided by qualified faculty and/or resident physicians at all times that a student is on duty or on call.
- Students are provided with rapid, reliable systems for communicating with faculty and resident physicians.
- Supervision is designed to foster progressive responsibility as determined by each student's level of training and experience.
- Supervision is based on a student's ability, level of training and demonstrated competence, as well as specific goals and objectives for the rotation.
- Supervision is designed to provide constructive feedback in any problem areas encountered during the rotation and to facilitate mid-clerkship assessment and feedback.

- Supervision is designed to verify student-generated reports in a timely manner. Any major changes made to a report are discussed with students to enhance education.
- Faculty, residents, and students are educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.
- Respecting the needs and expectations of patients and contributions of other healthcare team members
- Nurturing the intellectual, professional, and personal development of all learners
- Fostering academic excellence, professionalism, cultural sensitivity, and commitment to maintaining competency
- Demonstrate respect for all learners, patients, families, and healthcare professionals without regard to gender, race, origin, ethnicity, religion, sexual orientation, and ability

<u>To facilitate the education of medical students, attending physicians and/or resident physicians must do the following:</u>

- While providing appropriate supervision, allow opportunities for students to demonstrate knowledge, skills and attitudes in patient care including:
    - Taking patient histories, performing complete and/or focused physical examinations and entering findings in the medical record of the patient with the approval of the patient's supervising attending physician and with review and oversight by the attending physician or designated house staff.
    - Writing daily progress notes, entering orders, and coordinating care in a fashion commensurate with their training level. The findings entered in the medical record of the patient will be for educational and student evaluation purposes only and cannot be used in lieu of any required medical staff and/or house staff documentation.
        - Students must clearly sign all entries in the medical record, along with the designation that they are medical students. Supervising attending physicians or graduate medical trainees are to review student notes and all order entries.
    - Performing specified, approved procedures under the direct supervision of the attending physician or designated house staff. In all patient care contacts the patient shall be made aware that the individual providing the care and/or performing the procedure is a student.
    - Review focused topics related to patients on the service and report information back to the team to demonstrate self-directed, clinical learning and application of knowledge to the care of patients.
- Provide students with regular feedback, both appreciative and constructive.
    - The clerkship/course director should be notified immediately if serious academic or professional gaps in student performance exist. Students should also perform regular self-assessment and report to the attending physician and resident identified areas for improvement along with a plan

for such improvement. Students should be encouraged to contact the attending and/or the clerkship/course director with problems or concerns in any clinical, administrative, professional or educational matters.

- Serve as a positive role model and demonstrate professionalism, empathy and collegiality.

Medical Student Duty Hours

The following guidelines help ensure that students are not over-extending their clinic time at the expense of their own health and personal study time. Excessive work hours can diminish the impact of training by decreasing the time students have to read and assimilate information. Generally, student hours should mirror those of the physicians and residents that the student is assigned to work with. If the physicians and residents work late, the medical student should stay late, and if the physicians and residents work on weekends, the medical student should be present on weekends.

Medical students rotating on clinical services are subject, by medical school standards, to the same principles that govern duty hours for first-year residents, based on current ACGME duty hour standards. The medical school develops student schedules following these principles:

- Medical student duty hours include clinical and academic activities that are part of the medical student curriculum (ie, patient care, experiences including provision for transfer of patient care, and scheduled academic activities such as conferences). Medical student duty hours do not include study time while away from the duty site.
- Duty hours are limited to a maximum of 80 hours per week, averaged over a four-week period.
- There must be at least one day free of duty every seven days, averaged over a four-week period.
- Continuous on-site duty, including in-hospital overnight call, must not exceed 24 continuous hours.
- There should be at least 10 hours, and there must be at least eight hours, free of duty between scheduled duty periods.
- Medical students may be assigned duty periods that fall outside of normal workday hours. There must be no more than six consecutive nights of scheduled night duty periods.

The medical school encourages and expects students to report duty hour circumstances that are not consistent with medical school standards. These circumstances should be reported to the Clerkship Director, associate dean for Student Affairs, or using the online form, “Report of Duty Hours Concern.” The medical school does not tolerate punitive actions against students who, in good faith, report potential duty hour concerns, even if the concerns prove unsubstantiated.

Clerkship Attendance

Core Clinical Clerkship Absence Policy

Students are expected to be present for all components of each clerkship. Personal activities such as weddings should be conducted during scheduled off days. Requests for scheduled absences (including religious observances and student presentations at professional conferences) are to be submitted at least 30 days prior to the first day of the absence using the course/clerkship absence form. If permission for an absence is granted, it is the student's responsibility to notify his or her clinical preceptor.

Illness or other unplanned personal events may necessitate absence. The supervising attending/senior resident, clerkship coordinator, and the clerkship director must be notified immediately. Students who are ill are expected to seek appropriate medical care and provide documentation. While all requests are subject to approval of the clerkship director, examples of acceptable unplanned absences include death of a close family member or serious illness/hospitalization of yourself or a close family member.

Students must successfully demonstrate all clerkship objectives. Students must attend all scheduled didactic and assessment activities. If a student misses any mandatory session(s), they must be remediated by the end of that week. Remediation of missed days within allotted limits may or may not require additional clinical experiences. Absences beyond designated limits will require additional clinical time. All remediation decisions are at the discretion of the clerkship director. Students will receive a grade of incomplete until all remediation is complete.

- Students are allowed up to three excused absences in a core clerkship which must be remediated by the end of the rotation.

Advanced Clinical Absence Policy

Students are expected to be present for all components of each clerkship. Requests for scheduled absences (including religious observances and student presentations at professional conferences) are to be submitted at least 30 days prior to the first day of the absence using the course/clerkship absence form. If permission for an absence is granted, it is the student's responsibility to notify his or her clinical preceptor.

Illness or other unplanned personal events may necessitate absence. The supervising attending/senior resident, clerkship coordinator, and the clerkship director must be notified immediately. Students who are ill are expected to seek appropriate medical care and provide documentation. While all requests are subject to approval of the clerkship director, examples of acceptable unplanned absences include death of a close family member or serious illness/hospitalization of yourself or a close family member.

Students must successfully demonstrate all clerkship objectives. Students must attend all scheduled orientation, didactic and assessment activities. If a student misses any mandatory session(s), they must be remediated by the end of that week. Remediation of missed days within allotted limits may or may not require additional clinical experiences. Absences beyond designated limits will require additional clinical time. All remediation decisions are at the discretion of the clerkship director. Students will receive a grade of incomplete until all remediation is complete.

- In a 2-week block, students are allowed one excused absence which must be remediated by the end of the clerkship.
- In a 4-week block, students are allowed up to two excused absences which must be remediated by the end of the clerkship.

Code of Professional Conduct

The Code of Professional Conduct outlines professional standards and behaviors that are aligned with the essential values of the Western Michigan University Homer Stryker M.D. School of Medicine (WMed) and the medical community. This code applies to all WMed faculty (including regular, clinical, community, adjunct, and emeriti faculty), residents, fellows, students, and staff. All WMed faculty, residents, fellows, students, and staff are expected to conduct themselves in accordance with the high ethical standards expected of physicians, educators, and healthcare professionals. Physicians, and medical students' after graduation, are licensed to practice medicine and assume responsibilities for the life and welfare of others. Each individual participating in clinical care, education, research, and service must demonstrate competence and behaviors consistent with their responsibilities.

Electronic Health Record

Definitions:

Designated Record Set
"Designated record set" as used in this policy has the meaning as defined in the HIPAA Privacy Rule, 45 C.F.R. & 164.501, as "The medical records and billing records about individuals maintained by or for a covered health care provider... that is used, in whole or in part, by or for the covered entity to make decisions about individuals."

Authorized Attending Physician
An "authorized attending physician" is a licensed physician who is a member of the WMed faculty who has been approved by WMed to supervise the education, training and clinical practice of the medical students and resident physicians enrolled in undergraduate and graduate medical education programs at WMed.

[Note: For the purpose of this policy the term "valid progress note" is synonymous with the term "personal note" as it is used in CMS Manual System Publication 100-04, Medicare Claims Processing; Transmittal 2303; Change Request: 7378 dates September 14, 2011.]

Valid Progress Note

A "valid progress note" is a progress note created in an electronic health record system (EHR) associated with a specific patient encounter that is locked and signed by an authorized attending physician using the electronic signature technology of the EHR and that, in the professional opinion of the attending physician who locked and signed the note, adequately and accurately documents the patient encounter for all relevant medical, legal, and billing purposes.

A valid progress note is presumed to be reviewed and approved as complete and accurate by the attending physician who signs and locks the note. Once he or she signs and locks the note, the attending physician takes ownership of all the information contained in the note and is responsible for any and all errors and omission in the note, regardless of the means by which the information was created in the note, unless the errors and omissions are due to a technical malfunction, data entry error, or other outside process over which the physician has no control AND such errors and omissions could not be detected by careful review by a competent licensed profe4ssional. A progress notes that meets this definition is valid regardless of the specific methodologies, technologies or workflows used to create the note.

Creation of a progress note in the EHR:

A valid progress note can be created by the attending physician in the EHR using a variety of methodologies, technologies, and workflows, including, but not limited to: typing directly into the note; adding pre-built templates; structured data, or macro-generated text into the note; electronically pasting or merging text or data from other relevant documents generated by the attending physician or other clinician; and merging or downloading data from devices such as blood pressure cuffs, EKGs, and spirometers.

Sections of the note may also be created by medical students, residents, nurses, Pas, therapists, social workers, and other authorized individuals provide the contribution of each individual can be clearly identified as to content and time of entry.

The progress note becomes a valid progress note when, after performing the necessary review, and completing any required modifications or revisions, and after adding the appropriate attestation language for services rendered by a resident, the attending physician locks and signs the note.

Medical student documentation in the progress note:

Learning how to document patient care in the medical record is an essential part of the education of medical students. Medical students should learn to provide complete and comprehensive patient documentation that includes all relevant aspects of the medical history, physical examination, laboratory findings, medical decision making and treatment plan in the patient's medical record. Medical students should learn and refine their documentation skills in a clinic environment using all available health information technology tool, wherever and whenever possible.

Medical students may enter information directly in an unlocked and unsigned attending physician's note provide appropriate audit, logging, and tracking tools are in place to identify the author of each entry as well as the date and time of the entry.

Medical students may participate in different parts of a patient encounter and document in the appropriate section of the note as follows:

- Medical students may take and document past family and social history (PFSH) without teaching physician being present.
- Medical students may conduct and document a review of systems (ROS) without the teaching physician being present.
- Medical students may conduct and document an HPI. The teaching assistant must verify the HPI, review any student documentation of the HPI, and correct, edit, or revise the documentation as needed to reflect the findings of the teaching physician.

- Medical students may perform and document an examination. The teaching physician must also perform the examination and correct, edit or revise the documentation as needed to reflect the findings of the teaching physician.

Medical students may also create a separate medical student note to document patient encounters.

Use of medical student note by attending physicians in the creation of a progress note:

Text and other information created by the medical student in a separate medical student note is not part of the designated record set of the patient medical record. The text and other information created by the medical student only becomes part of the designated record set of the medical record when it is actively selected for inclusion in a valid progress note by an authorized provider and subsequently reviewed, edited, or modified as needed and then locked by the authorized attending physician.

With the exception of a review of systems (ROS) and the recording of the past, family, and/or social history (PFSH) of the patient. Any contribution and participation of a medical student to the performance of a billable service must be performed in the physical presence of an attending physician. Any documentation of such service by a medical student in a medical student note may then be used by an attending physician in the creation of a progress note. The attending physician may document the relevant information from the medical student note into the valid progress note. Documentation can be performed using all available documentation tools of the EHR, including copy forward, and copy/paste features, provided that the EHR has the capability to log all actions that went into constructing the note and that the log clearly identifies the author of each entry, modification, edit, or other activity.

A review of systems (ROS) and the recording of the past, family, and/or social history (PFSH) of the patient may be performed by a medical student without an attending physician being physically present. Any documentation of these services created by a medical student may also be used in the creation of a progress note.

General Guidelines for Medical Student Use of Electronic Health Record Systems During Clerkship:

Purpose of these Guidelines:

Learning how to use an electronic health record (EHR) is an important part of the education and training of medical students. Medical students should be trained to use an EHR early in their medical school education and should make full use of the EHR during clerkship.

The Alliance for Clinical Education (ACE) has developed best practices recommendations for medical student use of EHR. These best practices specify that the medical student should learn to:

- Search for data within the EHR
- Review patient care protocols
- Find and use disease specific templates, reminders and decision support tools
- Enter data into the appropriate fields in the EHR
- Review screening and prevention recommendations for a given patient, bringing these to the attention of the supervising physician if needed

- Become familiar with and use associated EHR functionality for:
    - Selection of diagnoses, CPT/ICD-10 codes, and how these are linked to billing
    - Order entry, including linked diagnoses to tests
    - E-prescribing
    - Capturing Patient Centered Medical Home and other quality metrics
    - Capturing "Meaningful Use" metrics
    - Running queries that practices use for population management

<u>Workflow required for complying with CMS rules regarding student documentation in the medical record:</u>

CMS permits medical students to document in the medical record of a patient. CMS rules specify the following:

- Med students may take and document past family and social history (PFSH) without teaching physician being present.
- Med students may conduct and document a review of systems (ROS) without the teaching physician being present.
- Med students may take and document an HPI. The teaching physician must verify the PHI, review any student documentation of the HPI, and correct, edit, or revise the documentation as needed to reflect the findings of the teaching physician.
- Medical students may perform and document an examination. The teaching physician must also perform the examination and correct, edit or revise the documentation as needed to reflect the findings of the teaching physician.

Roles and Responsibilities

Medical Students:

- Understand and comply with the policy "MEDICAL STUDENT DOCUMENTATION IN THE ELECTRONIC HEALTH RECORD".
- Understand his or her role on the team
- Use his or her log-in when entering information in the EHR
- Enter documentation as required on a timely basis
- Proactively seek guidance/assistance if unsure about how to use the EHR
- Alert the teaching physician to any documentation needing review by the teaching physician
- Report any mistakes, missteps or other errors made in using EHR

Teaching physician

- Understand and comply with the policy "MEDICAL STUDENT DOCUMENTATION IN THE ELECTRONIC HEALTH RECORD"
- Explain to the medical student his or her role on the treatment team
- Verify, re-perform, review, edit, correct, confirm, and otherwise validate all work performed by the medical student, as well as the associated documentation created by the medical student when such documentation is included as part of the patient record
- Provide meaningful feedback to the medical student that helps him or her improve their use of the EHR

Technology Requirements

In order to implement workflows and processes that support medical students' full use of an EHR, the EHR technology should have features that:

- Provide a clear audit trail or tracking mechanism so that it can be determined who authored/edited all entries in a note or other documentation and what each user did
- Prevent medical students from performing actions that are not within their permitted scope of practice (e.g. locking and signing a progress note, sending an electronic prescription to a pharmacy, authorizing an order for a diagnostic test, etc.)
- Alert teaching physician when something is pending that needs to be reviewed, signed or authorized

WMed Domains of Competencies

Medical Student Competencies

The overall goal of medical education at the medical school is to train physicians across the continuum from medical school through residency and into practice to be outstanding clinicians, leaders, educators, advocates, and researchers. The medical student curriculum is structured as competencies, which are complex knowledge, skills, attitudes, behaviors, and values applied to specific situations. The medical school defines 58 required competencies across eight domains of competencies. Objectives are stated for each competency and are behavioral statements describing the goals of instruction. The curriculum competencies determine the learning objectives of each event, which inform both the learning activities and the associated assessments.

The competencies underscore that the practice of medicine is simultaneously both an art and a science, and that these separate elements must be integrated through the knowledge, skills, attitudes, behaviors, and values of each individual physician graduate. The medical school provides a competency-based education using a course-based approach with competencies across eight domains that prepares graduates to achieve these goals (Englander R, Cameron T, Ballard AJ, Dodge J, Bull J, Aschenbrener CA: Toward a common taxonomy of competency domains for the health professions and competencies for physicians. Acad Med 2013:88:1088-1094).

Medical students must achieve and demonstrate individually by the time of graduation all of the knowledge, skills, attitudes, behaviors, and values embodied in each of the 58 required competencies across the eight domains.

- Patient Care
- Knowledge for Practice
- Practice-Based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
- Systems-Based Practice
- Inter-professional Collaboration
- Personal and Professional Development

Required Clerkship Procedural Skills and Competencies

Class of 2019

Each WMed medical student learns and performs the following procedures in a simulated or clinical setting.

Definitions of Skill Levels:

Novice – Students may observe these procedures and are unlikely to participate in or perform these procedures prior to residency.

Advanced Beginner – Students receive a limited exposure to these procedures before they begin their residency. They are taught the basic tasks associated with this procedure and are observed preforming the skill correctly on a task trainer or in a simulated situation. There are no formal assessments for these procedures.

Competence - Students achieve competency for these procedures. Competency is assessed through the use of performance checklists. Evaluation includes the following elements: 1) correctly performing the procedure *once* over the course of the curriculum in either a clinical or simulation setting; and 2) passing a written exam for selected procedures. Students are ready to continue to further develop these skills during their clinical experiences.

Definition of Entrustment:

*Definitions are taken directly from the *AAMC Core Entrustable Professional Activities for Entering Residency: Curriculum Developers' Guide* (AAMC, 2014; accessed at https://www.mededportal.org/icollaborative/resource/887)

Entrustable – "worthy...to perform the activity without direct supervision."

Direct Supervision – The supervising physician is physically present with the [learner] and the patient.

Indirect Supervision with Direct Supervision Immediately Available – The supervising physician is physically within the hospital or other site of patient care and is immediately available to provide direct supervision.

Most of these procedures are referenced to curriculum content in *Procedures Consult* (available online through the Library) or a procedure video (which is also available online).

The following are the procedural skills required of medical students, grouped by level of skill required for advancement and graduation. Procedural training that is provided during courses or clerkships is denoted by *. Assessments occur during the courses or clerkships denoted by #.

Some procedures are taught during the first clerkship week and assessed during the final clerkship week. The associated course/clerkship director is responsible for training and/or assessment.

Competence: Indirect Supervision with Direct Supervision Immediately Available

Vital Sign Measurement

a) Transition to Medical School Course (August; MS1) / (November; POM CS1) *
b) POM CS 1 #
c) Expected Entrustment by start of clerkships

Hand Hygiene

a) Transition to Medical School Course (August; MS1) *
b) POM CS 1 #
c) Expected Entrustment by start of clerkships

Hand Washing, Gowning, Gloving, Sterile Field

a) Transition to Clinical Applications Course *
b) Transition to Clinical Applications Course #
c) Expected Entrustment by graduation

Otoscopy and Ophthalmoscopy (using OtoSim and OphthoSim trainers)

a) POM CS 1 and 2 – normal (November; MS1 and February MS2)
b) POM CS 4 – abnormal (January; MS2) *
c) POM CS 1, 2, and 4 #
d) Expected Entrustment by graduation

Competence: Direct Supervision Required Throughout Medical School

Bag-Valve-Mask Ventilation

a) Transition to Medical School Course (August; MS1) *
b) Transition to Medical School Course (August; MS1) / Transition to Clinical Applications Course #
c) Expected Entrustment by graduation
d) Direct supervision required throughout medical school

Basic Life Support Course (BLS)

a) Transitions to Medical School Course / Transition to Clinical Applications Course * #
b) Expected Entrustment by graduation
c) Direct supervision required throughout medical school

Phlebotomy

a) POM CS 1 (November; MS1) *
b) Transition to Clinical Applications Course #
c) Expected Entrustment by graduation
d) Direct supervision required throughout medical school

Intravenous Catheter Insertion

a) POM CS 1 (November; MS1) *
b) Transition to Clinical Applications Course #
c) Expected Entrustment by graduation
d) Direct supervision required throughout medical school

Urethral Catheterization (male)

a) POM CS 3 (August; MS2) *
b) Surgery Clerkship #
c) Direct supervision required throughout medical school

Urethral Catheterization (female)

a) POM CS 3 (August; MS2) *
b) Women's Health or Surgery Clerkship #
c) Direct supervision required throughout medical school

Nasogastric Tube Insertion

a) Surgery Clerkship *#
b) Direct supervision required throughout medical school

Pelvic Exam/Anatomic Correlations (Pelvic Mentor Trainer)

a) POM CS 3 (November; MS2) *
b) Women's Health Clerkship #
c) Direct supervision required throughout medical school

Advanced Cardiac Life Support Course (ACLS)

a) Transition to Clinical Applications Course * #
b) Direct supervision required throughout medical school

Advanced Beginner:

Interpret ECG

a) POM CS 3 (May; MS2) *
b) Medicine and Neurology Clerkship #

Lumbar Puncture

a) Pediatric and Adolescent Medicine Clerkship*
b) Medicine and Neurology Clerkship #

ABG, Obtain, and Interpret

a) POM CS 4 *
b) Advanced Critical Care Clerkship

Local Anesthesia

a) POM CS 2 (February; MS1) *
b) Advanced Emergency Medicine Clerkship

Wound management: exploration, cleaning, simple interrupted stitch, dressing, Laceration Repair / Stapling

a) Surgery Clerkship * #

Knot Tying (hand & instrument)

b) POM CS 2 (February; MS1) *
c) Women's Health and Surgery Clerkships * #

Nebulized and Inhaled Medication Delivery

a) POM CS 3 (June; MS2) *
b) Pediatric and Adolescent Medicine Clerkship

Novice:

General Splinting Techniques

a) POM CS 2 (March/April; MS1) *

Introduction to Bedside Ultrasound

a) POM CS 1 (November; MS1) *

FAST Exam

a) Surgery Clerkship *

Direct Laryngoscopy Endotracheal Intubation

a) POM CS 3 (June; MS2) *

Arthrocentesis

a) POM CS 2 (March or April; MS2) *

Revised April 19, 2017

Required Procedural Skills and Competencies

Class of 2020

Each WMed medical student learns and performs the following procedures in a simulated or clinical setting.

Definitions of Skill Levels:

Novice – Students may observe these procedures and are unlikely to participate in or perform these procedures prior to residency.

Advanced Beginner – Students receive a limited exposure to these procedures before they begin their residency. They are taught the basic tasks associated with this procedure and are observed preforming the skill correctly on a task trainer or in a simulated situation. There are no formal assessments for these procedures.

Competence - Students achieve competency for these procedures. Competency is assessed through the use of performance checklists. Evaluation includes the following elements: 1) correctly performing the procedure *once* over the course of the curriculum in either a clinical or simulation setting; and 2) passing a written exam for selected procedures. Students are ready to continue to further develop these skills during their clinical experiences.

Definition of Entrustment:

Definitions are taken directly from the *AAMC Core Entrustable Professional Activities for Entering Residency: Curriculum Developers' Guide* (AAMC, 2014; accessed at https://www.mededportal.org/icollaborative/resource/887)

Entrustable – "worthy...to perform the activity without direct supervision."

Direct Supervision: The supervising physician is physically present with the [learner] and the patient.

Indirect Supervision with Direct Supervision Immediately Available: The supervising physician is physically within the hospital or other site of patient care and is immediately available to provide direct supervision.

Most of these procedures are referenced to curriculum content in *Procedures Consult* (available online through the Library) or a procedure video (which is also available online).

The following are the procedural skills required of medical students, grouped by level of skill required for advancement and graduation. Procedural training that is provided during courses or clerkships is denoted by *. Assessments occur during the courses or clerkships denoted by #.

Some procedures are taught during the first clerkship week and assessed during the final clerkship week. The associated course/clerkship director is responsible for training and/or assessment.

Competence: Indirect Supervision with Direct Supervision Immediately Available

Vital Sign Measurement

a) Transition to Medical School Course (August; MS1) / (November; POM CS1) *
b) POM CS 1 #
c) Expected Entrustment by start of clerkships

Hand Hygiene

a) Transition to Medical School Course (August; MS1) *
b) POM CS 1 #
c) Expected Entrustment by start of clerkships

Hand Washing, Gowning, Gloving, Sterile Field

a) Transition to Clinical Applications Course *
b) Transition to Clinical Applications Course #
c) Expected Entrustment by graduation

Otoscopy and Ophthalmoscopy (using OtoSim and OphthoSim trainers)

a) POM CS 1 and 2 – normal (November; MS1 and February MS2)
b) POM CS 4 – abnormal (January; MS2) *
c) POM CS 1, 2, and 4 #
d) Expected Entrustment by graduation

Competence: Direct Supervision Required Throughout Medical School

Bag-Valve-Mask Ventilation

a) Transition to Medical School Course (August; MS1) *
b) Transition to Medical School Course (August; MS1) / Transition to Clinical Applications Course #
c) Expected Entrustment by graduation
d) Direct supervision required throughout medical school

Basic Life Support Course (BLS)

a) Transitions to Medical School Course / Transition to Clinical Applications Course * #
b) Expected Entrustment by graduation
c) Direct supervision required throughout medical school

Phlebotomy

a) POM CS 1 (November; MS1) *
b) Transition to Clinical Applications Course #
c) Expected Entrustment by graduation
d) Direct supervision required throughout medical school

Intravenous Catheter Insertion

a) POM CS 1 (November; MS1) *
b) Transition to Clinical Applications Course #
c) Expected Entrustment by graduation
d) Direct supervision required throughout medical school

Urethral Catheterization (male)

a) POM CS 3 (August; MS2) *
b) Transition to Clinical Applications Course #
c) Direct supervision required throughout medical school

Catheterization (female)

a) POM CS 3 (August; MS2) *
b) Transition to Clinical Applications Course #
c) Direct supervision required throughout medical school

Nasogastric Tube Insertion

a) Transitions to Clinical Applications *
b) Transition to Clinical Applications Course #
c) Direct supervision required throughout medical school

Knot Tying (hand & instrument)

a) POM CS 2 (February; MS1) *
b) Women's Health and Surgery Clerkships * #

Interpret ECG

a) POM CS 3 (May; MS2) *
b) Medicine Clerkship #

Interpret Chest XRay

a) Medicine Clerkship * #

Pelvic Exam/Anatomic Correlations (Pelvic Mentor Trainer)

a) POM CS 3 (November; MS2) *
b) Women's Health Clerkship #
c) Direct supervision required throughout medical school

Wound management: exploration, cleaning, simple interrupted stitch, dressing

a) Laceration Repair / Stapling
b) Surgery Clerkship * #

Advanced Cardiac Life Support Course (ACLS)

a) Transition to Advanced Clinical Management Course * #
b) Direct supervision required throughout medical school

<u>Advanced Beginner:</u>

ABG, Obtain, and Interpret

a) POM CS 4 *
b) Advanced Critical Care Clerkship *

Infant Circumcision

a) Pediatric and Adolescent Medicine Clerkship *

Joint Injection

a) Family and Community Medicine *

Local Anesthesia

a) POM CS 2 (February; MS1) *
b) Advanced Emergency Medicine Clerkship *

Infant Lumbar Puncture

a) Pediatric and Adolescent Medicine Clerkship *

Nebulized and Inhaled Medication Delivery

a) POM CS 3 (June; MS2) *
b) Pediatric and Adolescent Medicine Clerkships *

Toenail Removal

a) Family and Community Medicine Clerkship *

Vaginal Delivery Simulation

a) Women's Health Clerkship

Novice:

General Splinting Techniques

a) POM CS 2 (March/April; MS1) *

Introduction to Bedside Ultrasound

a) POM CS 1 (November; MS1) *

FAST Exam

a) Surgery Clerkship *

Direct Laryngoscopy Endotracheal Intubation

a) POM CS 3 (June; MS2) *
b) Advanced Critical Care *

Arthrocentesis

a) POM CS 2 (March or April; MS2) *

Revised April 2, 2018

Assessment

Introduction for Completing Summative Clinical Assessment

WMed uses Entrustable Professional Activities for Entering Residency (EPAs) as the guiding principle for assessing student performance in clerkships. The 13 EPAs represent the fundamental knowledge graduating medical students should have and the skills they should be able to perform without direct supervision on Day One of their residency education. The EPAs are further broken down into **Key Functions** which are critical to the performance of the skill set.

The **13 EPAs** are:

1. Gather history, perform physical examination
2. Prioritize differential diagnosis from clinical encounter
3. Recommend and interpret common diagnostic and screening tests
4. Enter and discuss orders and prescriptions
5. Document a clinical encounter in the patient record
6. Provide oral presentation of a clinical encounter
7. Form clinical questions and retrieve evidence to advance patient care
8. Give or Receive a patient handover to responsibly transition care
9. Collaborate as a team member of an inter-professional team
10. Recognize a patient requiring urgent/emergent care and initiate evaluation and management.
11. Obtain informed consent for tests/procedure
12. Perform general procedures of a physician
13. Identify system failures and contribute to a culture of safety and improvement

Schematics for each EPA and key function may be found as part of the AAMC EPA Project website, https://www.aamc.org/initiatives/coreepas/publicationsandpresentations.

For the 2018-19 Academic Year, WMED will be focusing student assessment at the level of the key function. We will be asking faculty to assess student outcomes based on the developmental trajectories for key functions as outlined by the AAMC.

The **Core Clerkship** (M3) assessments form will list specific key functions and note which EPA it is associated with. The responsibility of the preceptor is to assess the developmental progression toward entrustment for the students precepted. Your ratings should be based on the student's level of performance at the end of his/her time on your service or in your office. Clerkship directors have targeted assessments in the third year to mirror those tasks that are observable by any preceptor in that particular clinical setting. It is important you become familiar with the questions for which you will be asked to assess your students. In addition to rating the performance of EPAs, preceptors will also provide feedback on the foundational competencies required to

entrustment: truthfulness, conscientiousness and discernment. Comments on where students went above and beyond expectations are necessary to achieve an honors grade. **Advanced Clerkships** (M4) will be assessed on a broader number of key functions as we attempt to gather data to review whether a student is "entrustable" for a particular EPA. While our goal is to have as many EPAs assessed in the clinical setting as possible, there will be some that will require simulation or other forms of assessment.

Elective Clinical Clerkship assessments will focus on Foundational Competencies and narrative feedback. **Elective Non-Clinical Clerkships** will include additional questions regarding the attainment of learning objectives that were defined at the beginning of the elective.

Narrative feedback is vital to student learning and development as physician. Your comments regarding both what the student has done well and areas to target for growth are critical to future student success. Students need feedback not only on their current level of performance but also suggestions for future improvement (feedback "for learning").

There are multiple options that faculty can use to organize their narrative comments:

1. EPA developmental schema – review by following link on previous page

2. Supervision that was required by you to ensure safe, effective, appropriate medical care was provided to your patient.

   Modified Ottawa scale: (Rekman et al 2016)
   In supervising this student, how much did you participate in the task?
   1."**I did it."** - Student required complete guidance or was unprepared; I had to do most of the work myself.
   2**."I talked them through it."** - Student was able to perform some tasks but required repeated directions.
   3.**"I directed them from time to time."** – Student demonstrated some independence and only required intermittent prompting.
   4**."I was available just in case."** - Student functioned fairly independently and only needed assistance with nuances or complex situations.

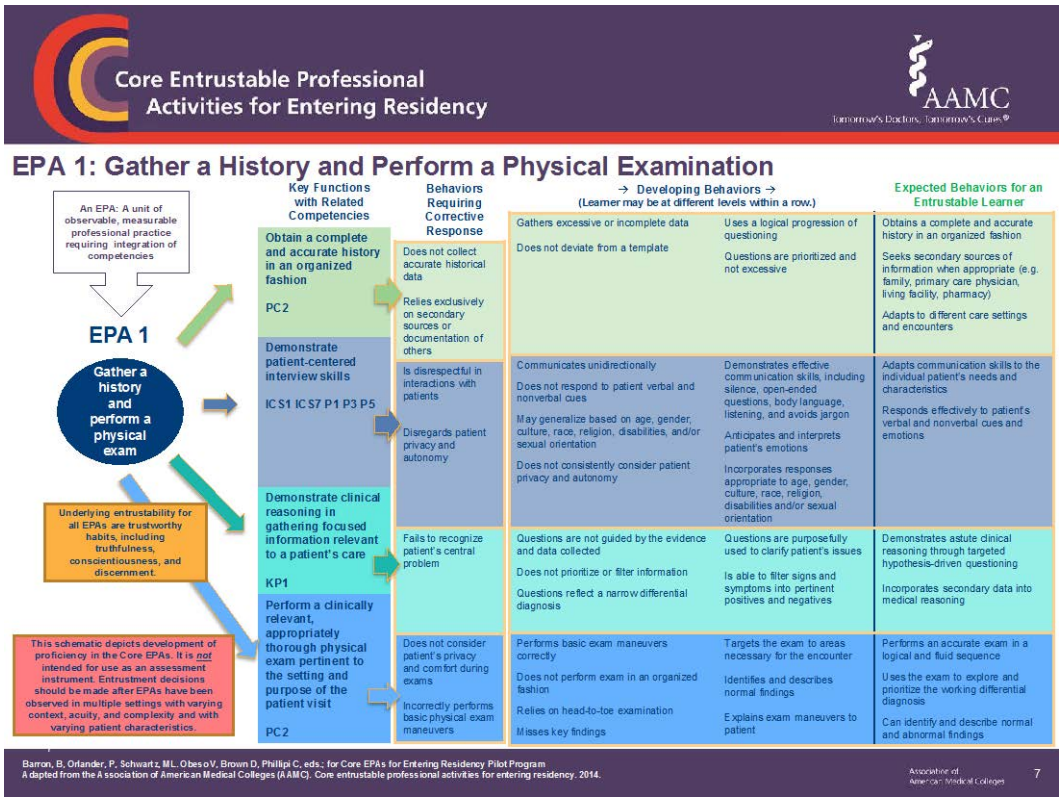
3. RIME

The RIME construct, as defined below, provide students with a consistent index across preceptors and clerkships for identifying their stage of growth and any learning needs they may have.

Reporter: owns facts accurately and independently, uses appropriate terminology, interacts professionally; consistent and reliable in carrying out responsibilities.

Interpreter: takes ownership of explaining patient findings; demonstrated ability to identify and prioritize problems; offers reasonable explanations for new problems; generates and defends differential diagnosis with data.
Manager: exhibits confidence and ability to make patient management decisions; proficiently tailors individualized patient plans; demonstrates sound interpersonal and procedural skills; shows increasing confidence, skill, organization, and maturity.

Educator: functions beyond basics; reads deeply, sharing new learning with others; derives relevant clinical questions; finds best evidence to answer questions and applies the information to patients; confidence to lead and educate other healthcare team members.


Core Entrustable Professional Activities for Entering Residency
AAMC
Tomorrow's Doctors, Tomorrow's Cures®
EPA 1: Gather a History and Perform a Physical Examination
An EPA: A unit of observable, measurable professional practice requiring integration of competencies
EPA 1
Gather a history and perform a physical exam
Underlying entrustability for all EPAs are trustworthy habits, including truthfulness, conscientiousness, and discernment.
This schematic depicts development of proficiency in the Core EPAs. It is not intended for use as an assessment instrument. Entrustment decisions should be made after EPAs have been observed in multiple settings with varying context, acuity, and complexity and with varying patient characteristics.
Key Functions with Related Competencies
Behaviors Requiring Corrective Response
→ Developing Behaviors →
(Learner may be at different levels within a row.)
Expected Behaviors for an Entrustable Learner
Obtain a complete and accurate history in an organized fashion
PC2
Does not collect accurate historical data
Relies exclusively on secondary sources or documentation of others
Gathers excessive or incomplete data
Does not deviate from a template
Uses a logical progression of questioning
Questions are prioritized and not excessive
Obtains a complete and accurate history in an organized fashion
Seeks secondary sources of information when appropriate (e.g. family, primary care physician, living facility, pharmacy)
Adapts to different care settings and encounters
Demonstrate patient-centered interview skills
ICS1 ICS7 P1 P3 P5
Is disrespectful in interactions with patients
Disregards patient privacy and autonomy
Communicates unidirectionally
Does not respond to patient verbal and nonverbal cues
May generalize based on age, gender, culture, race, religion, disabilities, and/or sexual orientation
Does not consistently consider patient privacy and autonomy
Demonstrates effective communication skills, including silence, open-ended questions, body language, listening, and avoids jargon
Anticipates and interprets patient's emotions
Incorporates responses appropriate to age, gender, culture, race, religion, disabilities and/or sexual orientation
Adapts communication skills to the individual patient's needs and characteristics
Responds effectively to patient's verbal and nonverbal cues and emotions
Demonstrate clinical reasoning in gathering focused information relevant to a patient's care
KP1
Fails to recognize patient's central problem
Questions are not guided by the evidence and data collected
Does not prioritize or filter information
Questions reflect a narrow differential diagnosis
Questions are purposefully used to clarify patient's issues
Is able to filter signs and symptoms into pertinent positives and negatives
Demonstrates astute clinical reasoning through targeted hypothesis-driven questioning
Incorporates secondary data into medical reasoning
Perform a clinically relevant, appropriately thorough physical exam pertinent to the setting and purpose of the patient visit
PC2
Does not consider patient's privacy and comfort during exams
Incorrectly performs basic physical exam maneuvers
Performs basic exam maneuvers correctly
Does not perform exam in an organized fashion
Relies on head-to-toe examination
Misses key findings
Targets the exam to areas necessary for the encounter
Identifies and describes normal findings
Explains exam maneuvers to patient
Performs an accurate exam in a logical and fluid sequence
Uses the exam to explore and prioritize the working differential diagnosis
Can identify and describe normal and abnormal findings
Barron, B, Orlander, P, Schwartz, ML, Obeso V, Brown D, Phillipi C, eds.: for Core EPAs for Entering Residency Pilot Program
Adapted from the Association of American Medical Colleges (AAMC). Core entrustable professional activities for entering residency. 2014.
Association of American Medical Colleges
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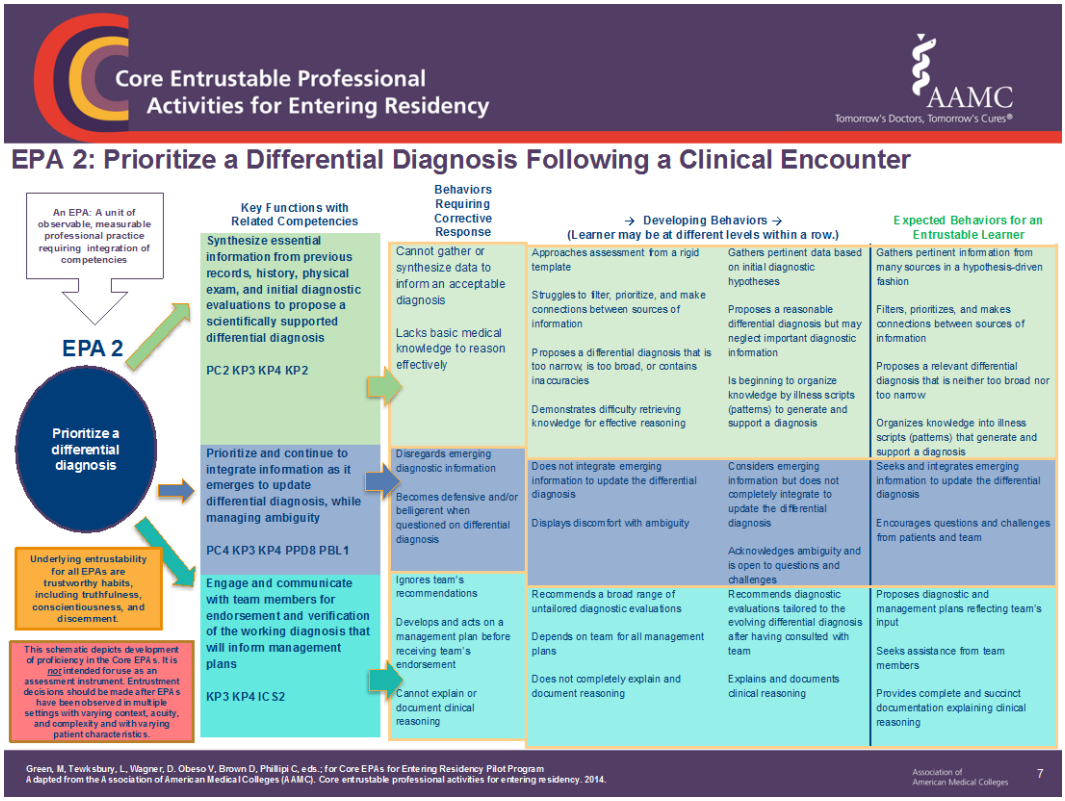
Core Entrustable Professional Activities for Entering Residency
AAMC
Tomorrow's Doctors, Tomorrow's Cures®
EPA 2: Prioritize a Differential Diagnosis Following a Clinical Encounter
An EPA: A unit of observable, measurable professional practice requiring integration of competencies
EPA 2
Prioritize a differential diagnosis
Underlying entrustability for all EPAs are trustworthy habits, including truthfulness, conscientiousness, and discernment.
This schematic depicts development of proficiency in the Core EPAs. It is not intended for use as an assessment instrument. Entrustment decisions should be made after EPAs have been observed in multiple settings with varying context, acuity, and complexity and with varying patient characteristics.
Key Functions with Related Competencies
Behaviors Requiring Corrective Response
→ Developing Behaviors →
(Learner may be at different levels within a row.)
Expected Behaviors for an Entrustable Learner
Synthesize essential information from previous records, history, physical exam, and initial diagnostic evaluations to propose a scientifically supported differential diagnosis
PC2 KP3 KP4 KP2
Cannot gather or synthesize data to inform an acceptable diagnosis
Lacks basic medical knowledge to reason effectively
Approaches assessment from a rigid template
Struggles to filter, prioritize, and make connections between sources of information
Proposes a differential diagnosis that is too narrow, is too broad, or contains inaccuracies
Demonstrates difficulty retrieving knowledge for effective reasoning
Gathers pertinent data based on initial diagnostic hypotheses
Proposes a reasonable differential diagnosis but may neglect important diagnostic information
Is beginning to organize knowledge by illness scripts (patterns) to generate and support a diagnosis
Gathers pertinent information from many sources in a hypothesis-driven fashion
Filters, prioritizes, and makes connections between sources of information
Proposes a relevant differential diagnosis that is neither too broad nor too narrow
Organizes knowledge into illness scripts (patterns) that generate and support a diagnosis
Prioritize and continue to integrate information as it emerges to update differential diagnosis, while managing ambiguity
PC4 KP3 KP4 PPD8 PBL1
Disregards emerging diagnostic information
Becomes defensive and/or belligerent when questioned on differential diagnosis
Does not integrate emerging information to update the differential diagnosis
Displays discomfort with ambiguity
Considers emerging information but does not completely integrate to update the differential diagnosis
Acknowledges ambiguity and is open to questions and challenges
Seeks and integrates emerging information to update the differential diagnosis
Encourages questions and challenges from patients and team
Engage and communicate with team members for endorsement and verification of the working diagnosis that will inform management plans
KP3 KP4 ICS2
Ignores team's recommendations
Develops and acts on a management plan before receiving team's endorsement
Cannot explain or document clinical reasoning
Recommends a broad range of untailored diagnostic evaluations
Depends on team for all management plans
Does not completely explain and document reasoning
Recommends diagnostic evaluations tailored to the evolving differential diagnosis after having consulted with team
Explains and documents clinical reasoning
Proposes diagnostic and management plans reflecting team's input
Seeks assistance from team members
Provides complete and succinct documentation explaining clinical reasoning
Green, M, Tewksbury, L, Wagner, D. Obeso V, Brown D, Phillipi C, eds.: for Core EPAs for Entering Residency Pilot Program
Adapted from the Association of American Medical Colleges (AAMC). Core entrustable professional activities for entering residency. 2014.
Association of American Medical Colleges
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Core Entrustable Professional Activities for Entering Residency

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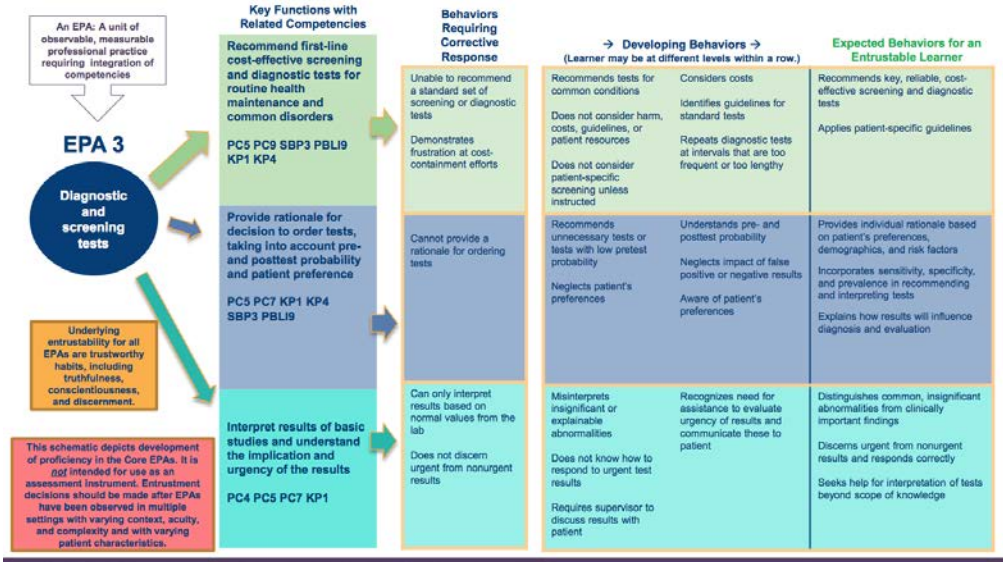
EPA 3: Recommend and Interpret Common Diagnostic and Screening Tests



Key Functions with Related Competencies	Behaviors Requiring Corrective Response	→ Developing Behaviors → (Learner may be at different levels within a row.)		Expected Behaviors for an Entrustable Learner
Recommend first-line cost-effective screening and diagnostic tests for routine health maintenance and common disorders PC5 PC9 SBP3 PBLI9 KP1 KP4	Unable to recommend a standard set of screening or diagnostic tests Demonstrates frustration at cost-containment efforts	Recommends tests for common conditions Does not consider harm, costs, guidelines, or patient resources Does not consider patient-specific screening unless instructed	Considers costs Identifies guidelines for standard tests Repeats diagnostic tests at intervals that are too frequent or too lengthy	Recommends key, reliable, cost-effective screening and diagnostic tests Applies patient-specific guidelines
Provide rationale for decision to order tests, taking into account pre- and posttest probability and patient preference PC5 PC7 KP1 KP4 SBP3 PBLI9	Cannot provide a rationale for ordering tests	Recommends unnecessary tests or tests with low pretest probability Neglects patient's preferences	Understands pre- and posttest probability Neglects impact of false positive or negative results Aware of patient's preferences	Provides individual rationale based on patient's preferences, demographics, and risk factors Incorporates sensitivity, specificity, and prevalence in recommending and interpreting tests Explains how results will influence diagnosis and evaluation
Interpret results of basic studies and understand the implication and urgency of the results PC4 PC5 PC7 KP1	Can only interpret results based on normal values from the lab Does not discern urgent from nonurgent results	Misinterprets insignificant or explainable abnormalities Does not know how to respond to urgent test results Requires supervisor to discuss results with patient	Recognizes need for assistance to evaluate urgency of results and communicate these to patient	Distinguishes common, insignificant abnormalities from clinically important findings Discerns urgent from nonurgent results and responds correctly Seeks help for interpretation of tests beyond scope of knowledge

Core Entrustable Professional Activities for Entering Residency

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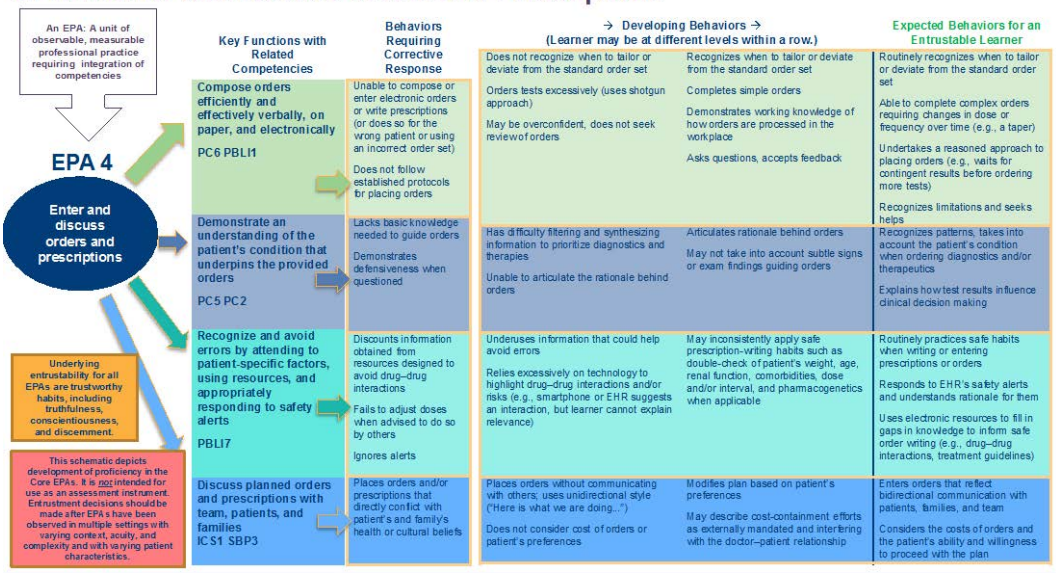
EPA 4: Enter and Discuss Orders and Prescriptions



Key Functions with Related Competencies	Behaviors Requiring Corrective Response	→ Developing Behaviors → (Learner may be at different levels within a row.)		Expected Behaviors for an Entrustable Learner
Compose orders efficiently and effectively verbally, on paper, and electronically PC6 PBLI1	Unable to compose or enter electronic orders or write prescriptions (or does so for the wrong patient or using an incorrect order set) Does not follow established protocols for placing orders	Does not recognize when to tailor or deviate from the standard order set Orders tests excessively (uses shotgun approach) May be overconfident, does not seek review of orders	Recognizes when to tailor or deviate from the standard order set Completes simple orders Demonstrates working knowledge of how orders are processed in the workplace Asks questions, accepts feedback	Routinely recognizes when to tailor or deviate from the standard order set Able to complete complex orders requiring changes in dose or frequency over time (e.g., a taper) Undertakes a reasoned approach to placing orders (e.g., waits for contingent results before ordering more tests) Recognizes limitations and seeks helps
Demonstrate an understanding of the patient's condition that underpins the provided orders PC5 PC2	Lacks basic knowledge needed to guide orders Demonstrates defensiveness when questioned	Has difficulty filtering and synthesizing information to prioritize diagnostics and therapies Unable to articulate the rationale behind orders	Articulates rationale behind orders May not take into account subtle signs or exam findings guiding orders	Recognizes patterns, takes into account the patient's condition when ordering diagnostics and/or therapeutics Explains how test results influence clinical decision making
Recognize and avoid errors by attending to patient-specific factors, using resources, and appropriately responding to safety alerts PBLI7	Discounts information obtained from resources designed to avoid drug–drug interactions Fails to adjust doses when advised to do so by others Ignores alerts	Underuses information that could help avoid errors Relies excessively on technology to highlight drug–drug interactions and/or risks (e.g., smartphone or EHR suggests an interaction, but learner cannot explain relevance)	May inconsistently apply safe prescription-writing habits such as double-check of patient's weight, age, renal function, comorbidities, dose and/or interval, and pharmacogenetics when applicable	Routinely practices safe habits when writing or entering prescriptions or orders Responds to EHR's safety alerts and understands rationale for them Uses electronic resources to fill in gaps in knowledge to inform safe order writing (e.g., drug–drug interactions, treatment guidelines)
Discuss planned orders and prescriptions with team, patients, and families ICS1 SBP3	Places orders and/or prescriptions that directly conflict with patient's and family's health or cultural beliefs	Places orders without communicating with others; uses unidirectional style ("Here is what we are doing...") Does not consider cost of orders or patient's preferences	Modifies plan based on patient's preferences May describe cost-containment efforts as externally mandated and interfering with the doctor–patient relationship	Enters orders that reflect bidirectional communication with patients, families, and team Considers the costs of orders and the patient's ability and willingness to proceed with the plan

Core Entrustable Professional Activities for Entering Residency

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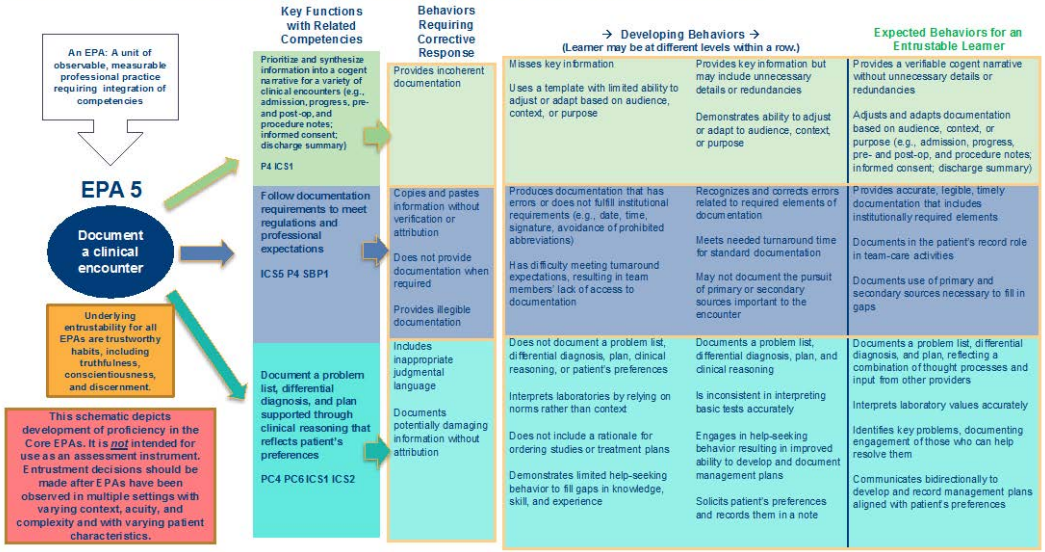
EPA 5: Document a Clinical Encounter in the Patient Record



Carter, TJ, Drusin, R, Moeller, J. Obeso V, Brown D, Phillipi C, eds.; for Core EPAs for Entering Residency Pilot Program
Adapted from the Association of American Medical Colleges (AAMC). Core entrustable professional activities for entering residency. 2014.

Association of American Medical Colleges 7

Core Entrustable Professional Activities for Entering Residency

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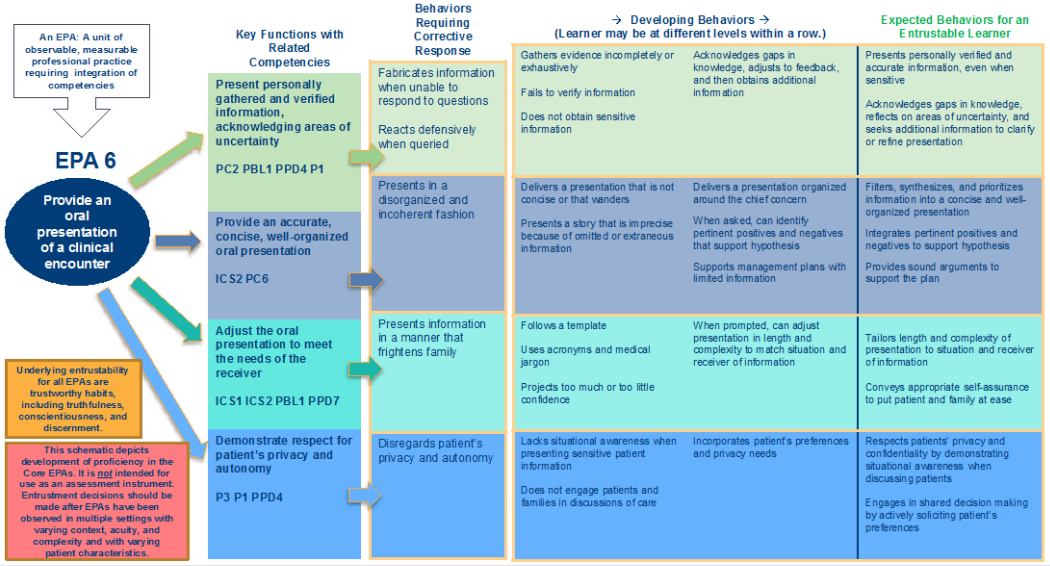
EPA 6: Provide an Oral Presentation of a Clinical Encounter



Catallozzi, M, Dunne, D, Noble JM, Obeso V, Brown D, Phillipi C, eds.; for Core EPAs for Entering Residency Pilot Program
Adapted from the Association of American Medical Colleges (AAMC). Core entrustable professional activities for entering residency. 2014.

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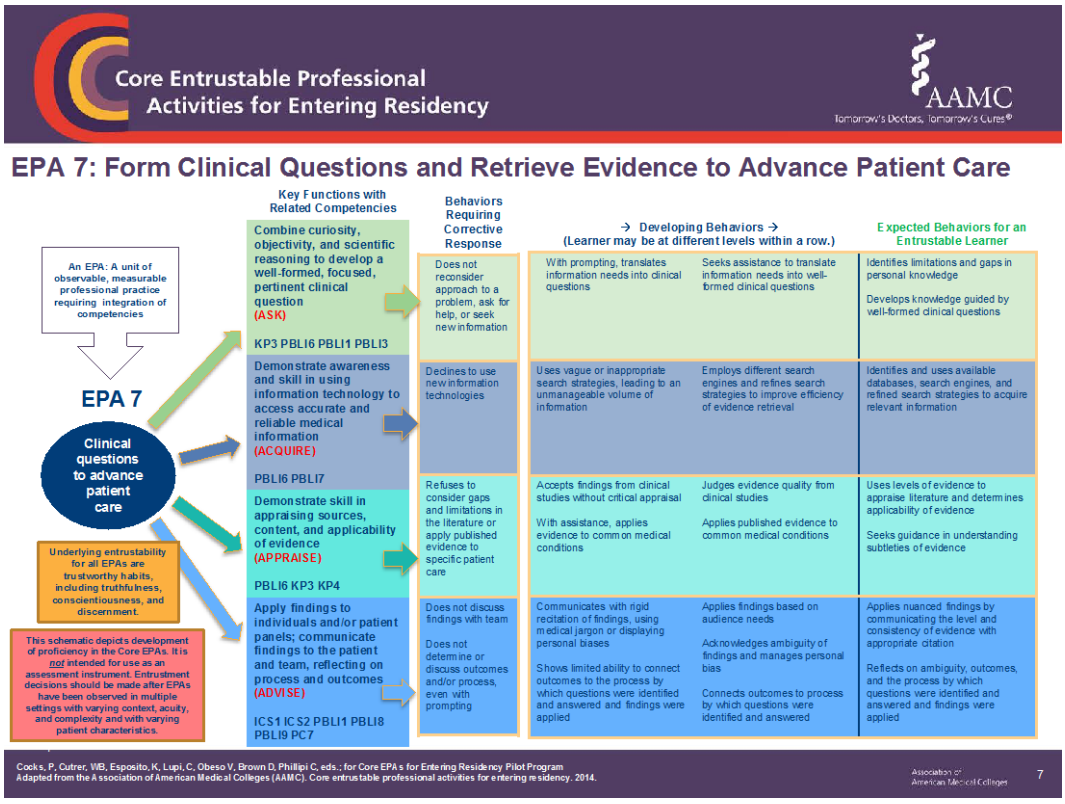
Core Entrustable Professional Activities for Entering Residency
AAMC
Tomorrow's Doctors, Tomorrow's Cures®
EPA 7: Form Clinical Questions and Retrieve Evidence to Advance Patient Care
An EPA: A unit of observable, measurable professional practice requiring integration of competencies
EPA 7
Clinical questions to advance patient care
Underlying entrustability for all EPAs are trustworthy habits, including truthfulness, conscientiousness, and discernment.
This schematic depicts development of proficiency in the Core EPAs. It is not intended for use as an assessment instrument. Entrustment decisions should be made after EPAs have been observed in multiple settings with varying context, acuity, and complexity and with varying patient characteristics.
Key Functions with Related Competencies
Behaviors Requiring Corrective Response
→ Developing Behaviors → (Learner may be at different levels within a row.)
Expected Behaviors for an Entrustable Learner
Combine curiosity, objectivity, and scientific reasoning to develop a well-formed, focused, pertinent clinical question (ASK)
KP3 PBLI6 PBLI1 PBLI3
Does not reconsider approach to a problem, ask for help, or seek new information
With prompting, translates information needs into clinical questions
Seeks assistance to translate information needs into well-formed clinical questions
Identifies limitations and gaps in personal knowledge
Develops knowledge guided by well-formed clinical questions
Demonstrate awareness and skill in using information technology to access accurate and reliable medical information (ACQUIRE)
PBLI6 PBLI7
Declines to use new information technologies
Uses vague or inappropriate search strategies, leading to an unmanageable volume of information
Employs different search engines and refines search strategies to improve efficiency of evidence retrieval
Identifies and uses available databases, search engines, and refined search strategies to acquire relevant information
Demonstrate skill in appraising sources, content, and applicability of evidence (APPRAISE)
PBLI6 KP3 KP4
Refuses to consider gaps and limitations in the literature or apply published evidence to specific patient care
Accepts findings from clinical studies without critical appraisal
With assistance, applies evidence to common medical conditions
Judges evidence quality from clinical studies
Applies published evidence to common medical conditions
Uses levels of evidence to appraise literature and determines applicability of evidence
Seeks guidance in understanding subtleties of evidence
Apply findings to individuals and/or patient panels; communicate findings to the patient and team, reflecting on process and outcomes (ADVISE)
ICS1 ICS2 PBLI1 PBLI8 PBLI9 PC7
Does not discuss findings with team
Does not determine or discuss outcomes and/or process, even with prompting
Communicates with rigid recitation of findings, using medical jargon or displaying personal biases
Shows limited ability to connect outcomes to the process by which questions were identified and answered and findings were applied
Applies findings based on audience needs
Acknowledges ambiguity of findings and manages personal bias
Connects outcomes to process by which questions were identified and answered
Applies nuanced findings by communicating the level and consistency of evidence with appropriate citation
Reflects on ambiguity, outcomes, and the process by which questions were identified and answered and findings were applied
Cocks, P, Cutrer, WB, Esposito, K, Lupi, C, Obeso V, Brown D, Phillipi C, eds.; for Core EPAs for Entering Residency Pilot Program
Adapted from the Association of American Medical Colleges (AAMC). Core entrustable professional activities for entering residency. 2014.
Association of American Medical Colleges
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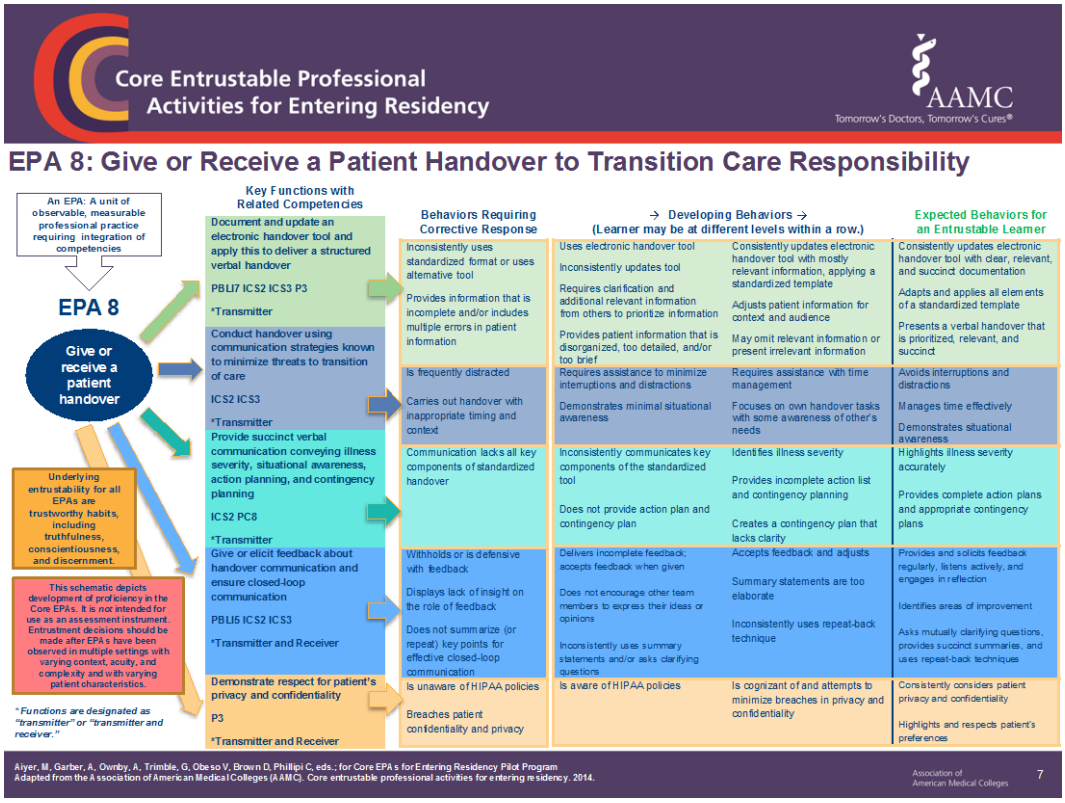
Core Entrustable Professional Activities for Entering Residency
AAMC
Tomorrow's Doctors, Tomorrow's Cures®
EPA 8: Give or Receive a Patient Handover to Transition Care Responsibility
An EPA: A unit of observable, measurable professional practice requiring integration of competencies
EPA 8
Give or receive a patient handover
Underlying entrustability for all EPAs are trustworthy habits, including truthfulness, conscientiousness, and discernment.
This schematic depicts development of proficiency in the Core EPAs. It is not intended for use as an assessment instrument. Entrustment decisions should be made after EPAs have been observed in multiple settings with varying context, acuity, and complexity and with varying patient characteristics.
*Functions are designated as "transmitter" or "transmitter and receiver."
Key Functions with Related Competencies
Behaviors Requiring Corrective Response
→ Developing Behaviors → (Learner may be at different levels within a row.)
Expected Behaviors for an Entrustable Learner
Document and update an electronic handover tool and apply this to deliver a structured verbal handover
PBLI7 ICS2 ICS3 P3
*Transmitter
Inconsistently uses standardized format or uses alternative tool
Provides information that is incomplete and/or includes multiple errors in patient information
Uses electronic handover tool
Inconsistently updates tool
Requires clarification and additional relevant information from others to prioritize information
Provides patient information that is disorganized, too detailed, and/or too brief
Consistently updates electronic handover tool with mostly relevant information, applying a standardized template
Adjusts patient information for context and audience
May omit relevant information or present irrelevant information
Consistently updates electronic handover tool with clear, relevant, and succinct documentation
Adapts and applies all elements of a standardized template
Presents a verbal handover that is prioritized, relevant, and succinct
Conduct handover using communication strategies known to minimize threats to transition of care
ICS2 ICS3
*Transmitter
Is frequently distracted
Carries out handover with inappropriate timing and context
Requires assistance to minimize interruptions and distractions
Demonstrates minimal situational awareness
Requires assistance with time management
Focuses on own handover tasks with some awareness of other's needs
Avoids interruptions and distractions
Manages time effectively
Demonstrates situational awareness
Provide succinct verbal communication conveying illness severity, situational awareness, action planning, and contingency planning
ICS2 PC8
*Transmitter
Communication lacks all key components of standardized handover
Inconsistently communicates key components of the standardized tool
Does not provide action plan and contingency plan
Identifies illness severity
Provides incomplete action list and contingency planning
Creates a contingency plan that lacks clarity
Highlights illness severity accurately
Provides complete action plans and appropriate contingency plans
Give or elicit feedback about handover communication and ensure closed-loop communication
PBLI5 ICS2 ICS3
*Transmitter and Receiver
Withholds or is defensive with feedback
Displays lack of insight on the role of feedback
Does not summarize (or repeat) key points for effective closed-loop communication
Delivers incomplete feedback; accepts feedback when given
Does not encourage other team members to express their ideas or opinions
Inconsistently uses summary statements and/or asks clarifying questions
Accepts feedback and adjusts
Summary statements are too elaborate
Inconsistently uses repeat-back technique
Provides and solicits feedback regularly, listens actively, and engages in reflection
Identifies areas of improvement
Asks mutually clarifying questions, provides succinct summaries, and uses repeat-back techniques
Demonstrate respect for patient's privacy and confidentiality
P3
*Transmitter and Receiver
Is unaware of HIPAA policies
Breaches patient confidentiality and privacy
Is aware of HIPAA policies
Is cognizant of and attempts to minimize breaches in privacy and confidentiality
Consistently considers patient privacy and confidentiality
Highlights and respects patient's preferences
Aiyer, M, Garber, A, Ownby, A, Trimble, G, Obeso V, Brown D, Phillipi C, eds.; for Core EPAs for Entering Residency Pilot Program
Adapted from the Association of American Medical Colleges (AAMC). Core entrustable professional activities for entering residency. 2014.
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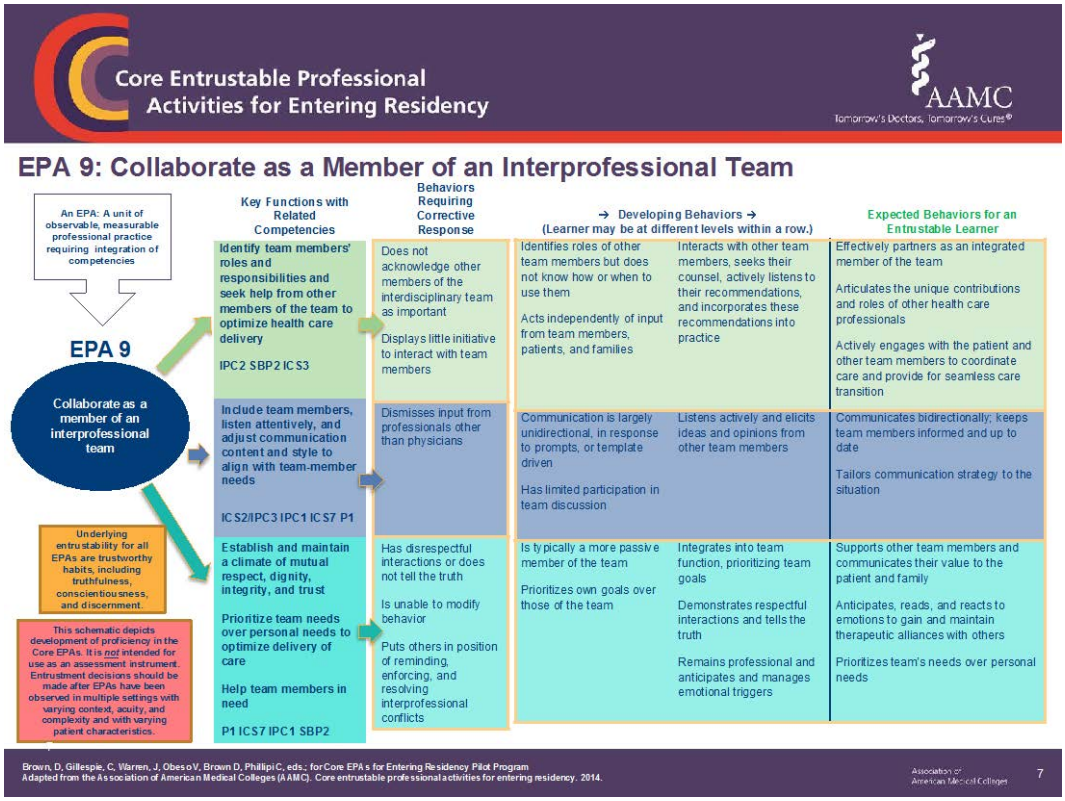
Core Entrustable Professional Activities for Entering Residency
AAMC
Tomorrow's Doctors, Tomorrow's Cures®
EPA 9: Collaborate as a Member of an Interprofessional Team
An EPA: A unit of observable, measurable professional practice requiring integration of competencies
EPA 9
Collaborate as a member of an interprofessional team
Underlying entrustability for all EPAs are trustworthy habits, including truthfulness, conscientiousness, and discernment.
This schematic depicts development of proficiency in the Core EPAs. It is not intended for use as an assessment instrument. Entrustment decisions should be made after EPAs have been observed in multiple settings with varying context, acuity, and complexity and with varying patient characteristics.
Key Functions with Related Competencies
Behaviors Requiring Corrective Response
→ Developing Behaviors → (Learner may be at different levels within a row.)
Expected Behaviors for an Entrustable Learner
Identify team members' roles and responsibilities and seek help from other members of the team to optimize health care delivery
IPC2 SBP2 ICS3
Does not acknowledge other members of the interdisciplinary team as important
Displays little initiative to interact with team members
Identifies roles of other team members but does not know how or when to use them
Acts independently of input from team members, patients, and families
Interacts with other team members, seeks their counsel, actively listens to their recommendations, and incorporates these recommendations into practice
Effectively partners as an integrated member of the team
Articulates the unique contributions and roles of other health care professionals
Actively engages with the patient and other team members to coordinate care and provide for seamless care transition
Include team members, listen attentively, and adjust communication content and style to align with team-member needs
ICS2/IPC3 IPC1 ICS7 P1
Dismisses input from professionals other than physicians
Communication is largely unidirectional, in response to prompts, or template driven
Has limited participation in team discussion
Listens actively and elicits ideas and opinions from other team members
Communicates bidirectionally; keeps team members informed and up to date
Tailors communication strategy to the situation
Establish and maintain a climate of mutual respect, dignity, integrity, and trust
Prioritize team needs over personal needs to optimize delivery of care
Help team members in need
P1 ICS7 IPC1 SBP2
Has disrespectful interactions or does not tell the truth
Is unable to modify behavior
Puts others in position of reminding, enforcing, and resolving interprofessional conflicts
Is typically a more passive member of the team
Prioritizes own goals over those of the team
Integrates into team function, prioritizing team goals
Demonstrates respectful interactions and tells the truth
Remains professional and anticipates and manages emotional triggers
Supports other team members and communicates their value to the patient and family
Anticipates, reads, and reacts to emotions to gain and maintain therapeutic alliances with others
Prioritizes team's needs over personal needs
Brown, D, Gillespie, C, Warren, J, Obeso V, Brown D, Phillipi C, eds.; for Core EPAs for Entering Residency Pilot Program
Adapted from the Association of American Medical Colleges (AAMC). Core entrustable professional activities for entering residency. 2014.
Association of American Medical Colleges
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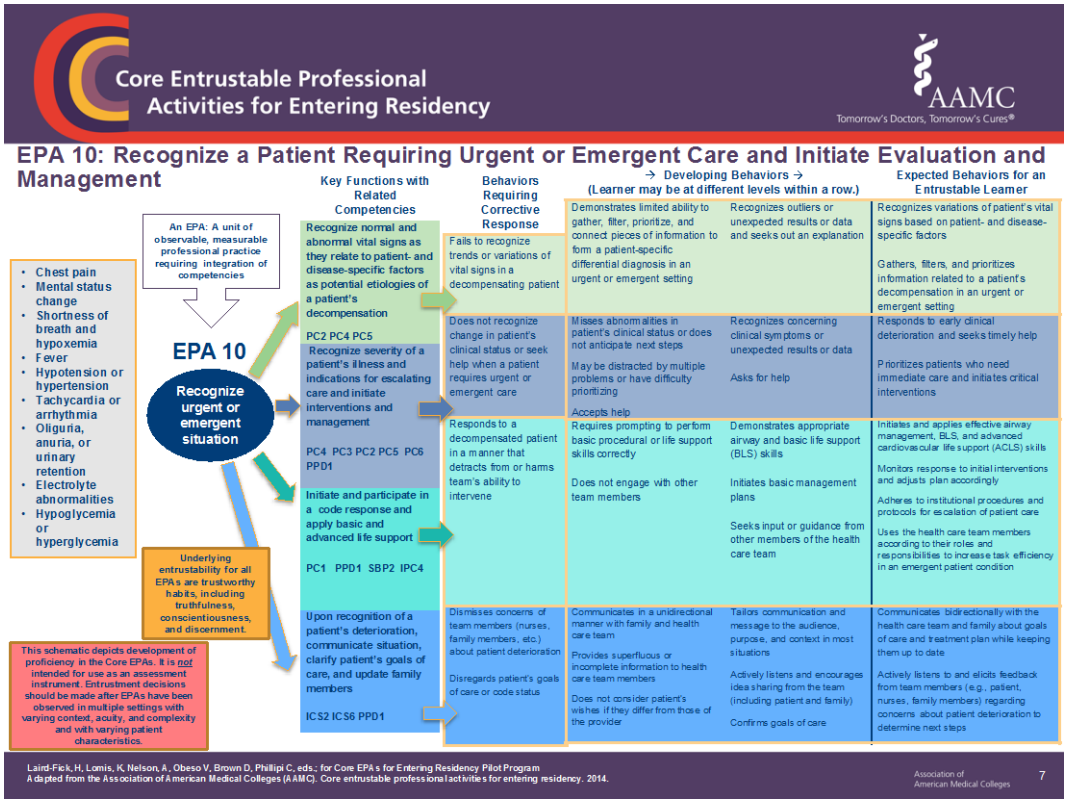
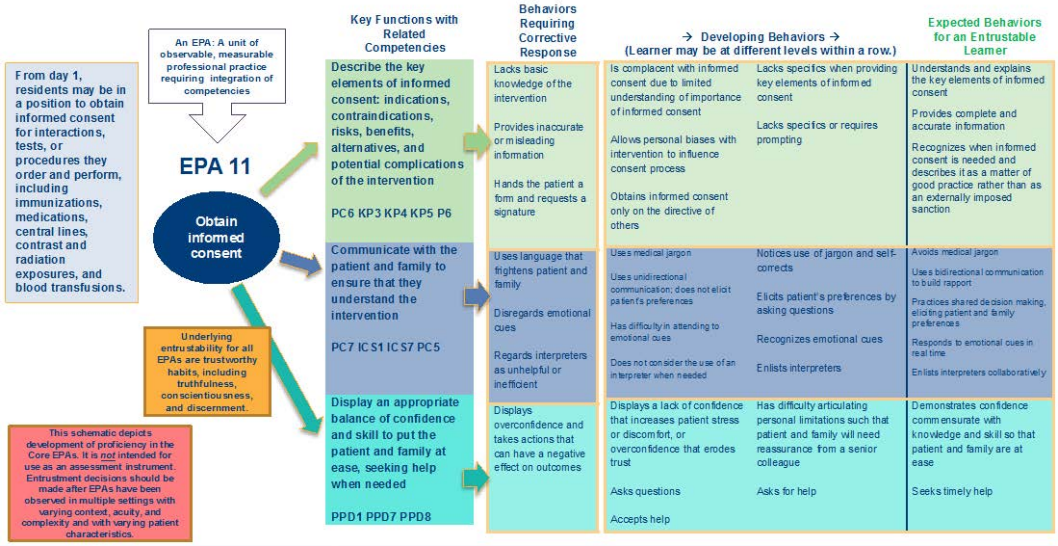

Core Entrustable Professional Activities for Entering Residency
AAMC
Tomorrow's Doctors, Tomorrow's Cures®
EPA 10: Recognize a Patient Requiring Urgent or Emergent Care and Initiate Evaluation and Management
An EPA: A unit of observable, measurable professional practice requiring integration of competencies
EPA 10
Recognize urgent or emergent situation
Chest pain
Mental status change
Shortness of breath and hypoxemia
Fever
Hypotension or hypertension
Tachycardia or arrhythmia
Oliguria, anuria, or urinary retention
Electrolyte abnormalities
Hypoglycemia or hyperglycemia
Underlying entrustability for all EPAs are trustworthy habits, including truthfulness, conscientiousness, and discernment.
This schematic depicts development of proficiency in the Core EPAs. It is not intended for use as an assessment instrument. Entrustment decisions should be made after EPAs have been observed in multiple settings with varying context, acuity, and complexity and with varying patient characteristics.
Key Functions with Related Competencies
Behaviors Requiring Corrective Response
→ Developing Behaviors → (Learner may be at different levels within a row.)
Expected Behaviors for an Entrustable Learner
Recognize normal and abnormal vital signs as they relate to patient- and disease-specific factors as potential etiologies of a patient's decompensation
PC2 PC4 PC5
Fails to recognize trends or variations of vital signs in a decompensating patient
Demonstrates limited ability to gather, filter, prioritize, and connect pieces of information to form a patient-specific differential diagnosis in an urgent or emergent setting
Recognizes outliers or unexpected results or data and seeks out an explanation
Recognizes variations of patient's vital signs based on patient- and disease-specific factors
Gathers, filters, and prioritizes information related to a patient's decompensation in an urgent or emergent setting
Recognize severity of a patient's illness and indications for escalating care and initiate interventions and management
PC4 PC3 PC2 PC5 PC6 PPD1
Does not recognize change in patient's clinical status or seek help when a patient requires urgent or emergent care
Misses abnormalities in patient's clinical status or does not anticipate next steps
May be distracted by multiple problems or have difficulty prioritizing
Accepts help
Recognizes concerning clinical symptoms or unexpected results or data
Asks for help
Responds to early clinical deterioration and seeks timely help
Prioritizes patients who need immediate care and initiates critical interventions
Initiate and participate in a code response and apply basic and advanced life support
PC1 PPD1 SBP2 IPC4
Responds to a decompensated patient in a manner that detracts from or harms team's ability to intervene
Requires prompting to perform basic procedural or life support skills correctly
Does not engage with other team members
Demonstrates appropriate airway and basic life support (BLS) skills
Initiates basic management plans
Seeks input or guidance from other members of the health care team
Initiates and applies effective airway management, BLS, and advanced cardiovascular life support (ACLS) skills
Monitors response to initial interventions and adjusts plan accordingly
Adheres to institutional procedures and protocols for escalation of patient care
Uses the health care team members according to their roles and responsibilities to increase task efficiency in an emergent patient condition
Upon recognition of a patient's deterioration, communicate situation, clarify patient's goals of care, and update family members
ICS2 ICS6 PPD1
Dismisses concerns of team members (nurses, family members, etc.) about patient deterioration
Disregards patient's goals of care or code status
Communicates in a unidirectional manner with family and health care team
Provides superfluous or incomplete information to health care team members
Does not consider patient's wishes if they differ from those of the provider
Tailors communication and message to the audience, purpose, and context in most situations
Actively listens and encourages idea sharing from the team (including patient and family)
Confirms goals of care
Communicates bidirectionally with the health care team and family about goals of care and treatment plan while keeping them up to date
Actively listens to and elicits feedback from team members (e.g., patient, nurses, family members) regarding concerns about patient deterioration to determine next steps
Laird-Fick, H, Lomis, K, Nelson, A, Obeso V, Brown D, Phillipi C, eds.; for Core EPAs for Entering Residency Pilot Program
Adapted from the Association of American Medical Colleges (AAMC). Core entrustable professional activities for entering residency. 2014.
Association of American Medical Colleges
7

Core Entrustable Professional Activities for Entering Residency

AAMC
Tomorrow's Doctors, Tomorrow's Cures®

EPA 11: Obtain Informed Consent for Tests and/or Procedures



Core Entrustable Professional Activities for Entering Residency

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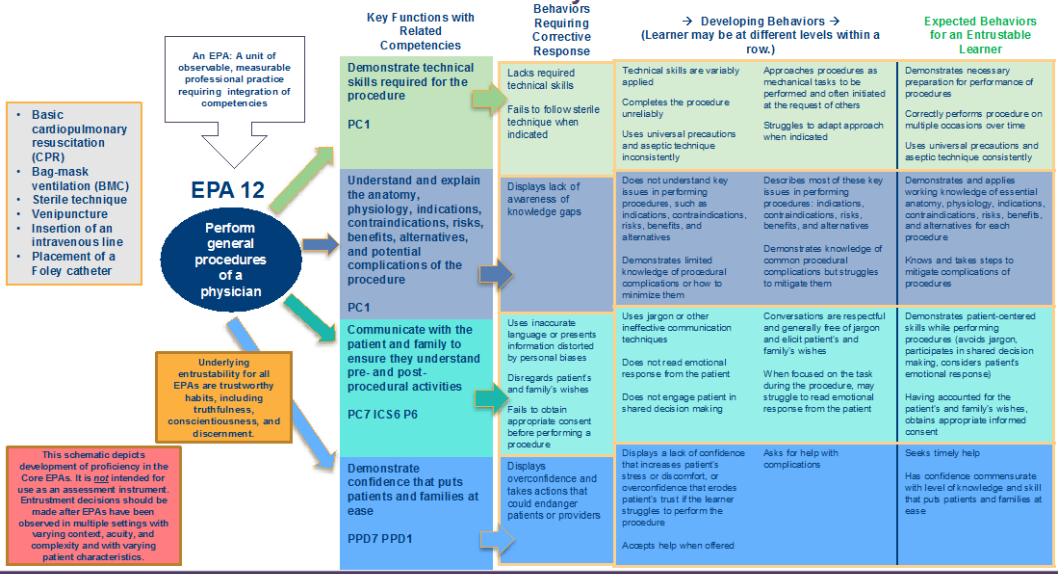
EPA 12: Perform General Procedures of a Physician



Core Entrustable Professional Activities for Entering Residency

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EPA 13: Identify System Failures and Contribute to a Culture of Safety and Improvement

An EPA: A unit of observable, measurable professional practice requiring integration of competencies

EPA 13

System failures and culture of safety

Underlying entrustability for all EPAs are trustworthy habits, including truthfulness, conscientiousness, and discernment.

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Key Functions with Related Competencies	Behaviors Requiring Corrective Response	→ Developing Behaviors → (Learner may be at different levels within a row.)		Expected Behaviors for an Entrustable Learner
Identify and report actual and potential ("near miss") errors in care using system reporting structure (e.g., event reporting systems, chain of command policies) KP1 ICS2 P4 PPD5	Reports errors in a disrespectful or misleading manner	Superficial understanding prevents recognition of real or potential errors	Identifies and reports actual and potential errors Demonstrates structured approach to describing key elements of patient safety concerns	Identifies and reports patient safety concerns in a timely manner using existing system reporting structures (e.g., event reporting systems, chain of command policies) Speaks up to identify actual and potential errors, even against hierarchy
Participate in system improvement activities in the context of rotations or learning experiences (e.g., rapid-cycle change using plan–do–study–act cycles, root cause analyses, morbidity and mortality conference, failure modes and effects analyses, improvement projects) PBLI4 PBLI10	Displays frustration at system improvement efforts	Passively observes system improvement activities in the context of rotations or learning experiences	Participates in system improvement activities when prompted but may require others to point out system failures	Actively engages in efforts to identify systems issues and their solutions
Engage in daily safety habits (e.g., accurate and complete documentation, including allergies and adverse reactions, medicine reconciliation, patient education, universal precautions, hand washing, isolation protocols, falls and other risk assessments, standard prophylaxis, time-outs) SBP4	Places self or others at risk of injury or adverse event	Requires prompts for common safety behaviors	Demonstrates common safety behaviors	Engages in daily safety habits with only rare lapses
Admit one's own errors, reflect on one's contribution, and develop an individual improvement plan P4 SBP5	Avoids discussing or reporting errors; attempts to cover up errors Demonstrates defensiveness or places blame	Requires prompts to reflect on own errors and their underlying factors May not recognize own fatigue or may be afraid to tell supervisor when fatigued	Identifies and reflects on own contribution to errors but needs help developing an improvement plan	Identifies and reflects on the element of personal responsibility for errors Recognizes causes of lapses, such as fatigue, and modifies behavior or seeks help

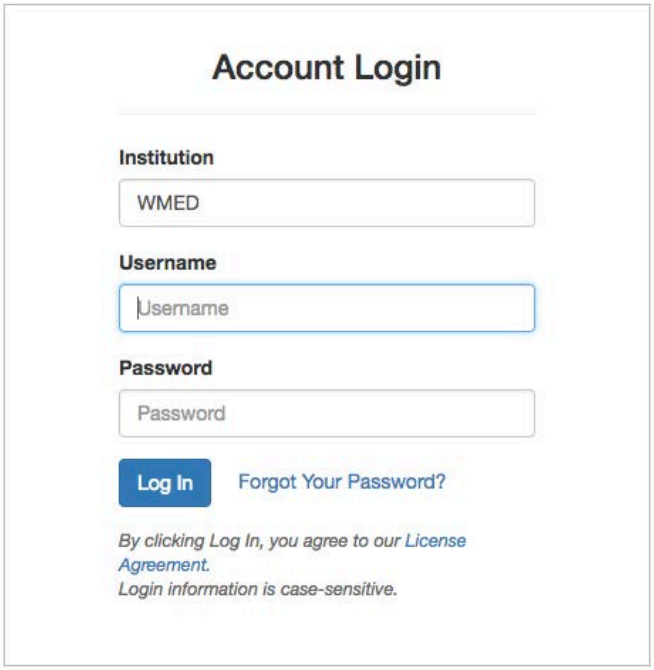
Crowe, R, Hyderi, A, Rosenfeld, M, Uthman, M, Yingling, S, Obeso V, Brown D, Phillipi C, eds.; for Core EPAs for Entering Residency Pilot Program
Adapted from the Association of American Medical Colleges (AAMC). Core entrustable professional activities for entering residency. 2014.

Association of American Medical Colleges 7

Assessment Completion – New Innovations

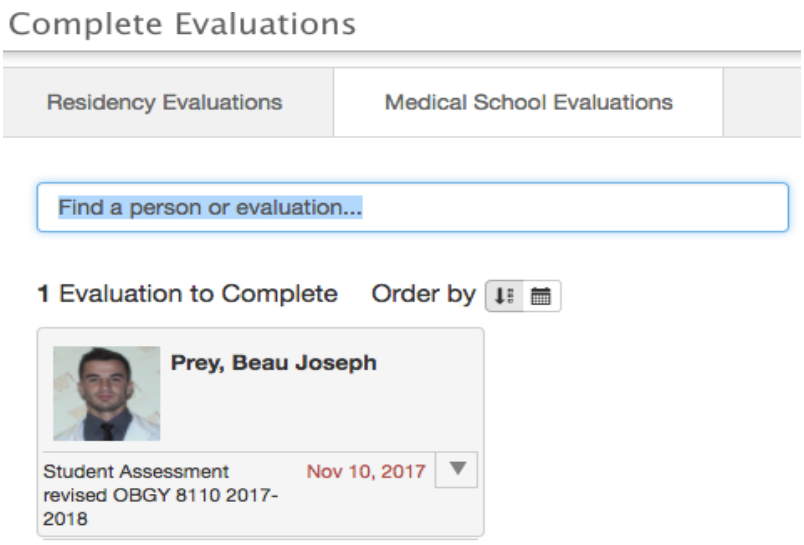
1. Go to this web address: https://www.new-innov.com/Login/Login.aspx

2. Make sure Institution says WMED and enter your Username and Password. If you are unable to sign in, please contact the clerkship coordinator at WMED.



3. Scroll down and click the link ½ way down the page: Notifications, Evaluations, (#) evaluations to be complete

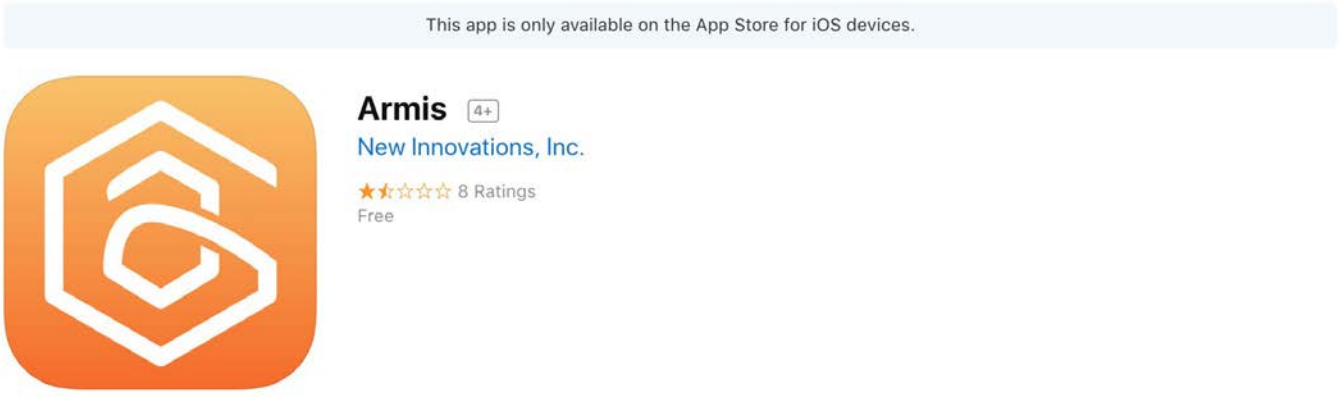
4. Make sure to click on the Medical School Evaluations tab at the top of the page.



5. Select the assessment to complete, complete it and click on submit at the bottom right of the assessment.

Using the Mobile Application

- Download New Innovations - App for iPhones



1. Download the app from the APP store on iPhone only*

2. Login with your New Innovations Credentials
under WMED

- WMED
- USERNAME
- PASSWORD

3. Complete evaluations on your phone!

Clinical Teaching Etiquette: Asking Questions

Asking questions can be a valuable learning tool in the clinical setting when done with forethought. However, asking questions in a manner to harass students or reinforce the attending's place at top quickly becomes "pimping" or "grilling" and can result in students filing harassment complaints.

Following the guidelines below helps promote the advancement of learning and helps avoid experiences that void beneficial learning experiences. Remember asking questions is a method of motivating the learner so avoiding humiliating the learner is critical.

- *Ask questions that promote critical thinking in a respectful manner and tone of voice*. Pose questions that inquire how learned knowledge is being applied to clinical scenarios. Use Socratic principles to formulate a question that requires learner collaboration, interpretive questioning, and, reflection. Posing questions to a medical team can generate discussion and help identify misconceptions, which leads to exploration about a case.
- *Respect educational order*. Ask for responses to questions starting with the lowest educational-ranked student. To avoid embarrassing situations, adhere to the protocol of always starting with the most junior student then sequentially ask in order to the chief resident.
- *Do not embarrass the other attending physicians.* Absolutely never call on another attending physician unless you are positive they know the correct answer. When another attending is present and they know more about a topic then you do, solicit the attending to make comments. Avoid setting yourself up to state inaccurate information and have the other attending correct you.
- *Look for the student avoiding to be called on and use opportunities to comfortably draw them into the conversation*. When a student shows signs of avoiding to be questioned, reduce the stress by asking them a simple question. You can also introduce humor into the encounter by asking a question with no known answer or stating you don't expect medical students to know the answer
- *Publicly apologize if you say something wrong*. Oops! If you do embarrass a student or say something inappropriate, use the first opportunity to publicly apologize.
- *Find opportunities to compliment students, either publicly or privately*. Sincere compliments on a good procedure or presentation helps motivate learners.
- *Remember questions are asked to help the student to learn*. The purpose of Socratic questioning is to activate critical thinking. To promote learning, questions should be asked in safe, respectful and supportive learning environments. Questions are not effective if asked to humiliate or harass a student.

*Detsky, A.S. (2009). *The Art of Pimping*. JAMA, 301:13, p.1379-1381

Faculty Appointment and Benefits

Appointment to WMed Faculty

Clinical faculty are an integral part of the medical school. The appellation "doctor" – from the Latin *docere*, meaning "to teach" – includes the responsibility of all physicians to share knowledge and information with colleagues, trainees, and patients. Physicians have the opportunity to give back to their profession by teaching the science, art, and ethics of medicine to medical students, residents, and fellows. The medical school provides the opportunity for clinical faculty to participate in training the next generation of physicians for tomorrow's patients, and ultimately, improving the health of the communities we serve.

WMU Homer Stryker M.D. School of Medicine faculty have a primary appointment in a department of the medical school whether or not they are directly employed by WMed. Clinical faculty are physicians and other healthcare providers who participate in teaching, clinical research, and administration of medical school programs.

There are three principles on which the faculty appointment is based: teaching activities, sustained efforts to improve personal teaching abilities, and service to the medical school. Clinical faculty participate directly in teaching or service to the medical school for a minimum of 50 hours in each year of the appointment period to continue to qualify for faculty appointment.

Benefits

- Recognition: Framed certificate for office posting
- Inclusion in faculty meetings, activities, CME events
- Opportunity to participate in WMed research
- Opportunities to serve on WMed committees
- Purchase computer equipment at discount
- Faculty development/education
- CME for teaching
- Full access to eLibrary

Frequently Asked Questions – New Medical Student Documentation Guidance

On February 2, 2018, the Centers for Medicare and Medicaid Services (CMS) released new guidance relaxing Evaluation and Management (E/M) documentation requirements for documentation created by medical students participating in a billable service. This policy change was identified by the CMS Documentation Requirement Simplification workgroup and is part of a broader goal to reduce administrative burden on practitioners.

1. **Question:** What is the definition of a medical student?
   Answer: A medical student is an individual who participates in an accredited program that is not an approved Graduate Medical Education (GME) program. A medical student is never considered to be an intern or a resident.

2. **Question:** What exactly has changed?
   Answer: *A teaching physician may now verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work.* Prior to this change, the teaching physician could only refer to the medical student's documentation related to review of systems and/or past/family /social history, which are not separately billable, but are taken as part of an E/M service. The teaching physician was required to re-document history of present illness, physical examination and medical decision-making activities of the service.

3. **Question:** How can a teaching physician "verify" student documentation?
   Answer: WMeds's Clinical Enterprise Integrity and Legal departments have approved the following attestation that may be added to the E/M documentation by the teaching physician verifying the student's documentation: *"A student assisted with documenting this service. I saw the patient and reviewed and verified all information documented by the student and made modifications to such information, when appropriate."*

4. **Question:** Can I create a dot phrase for this attestation?
   Answer: Yes, you may create a dot phrase.

5. **Question:** Can a resident "verify" the student documentation?
   Answer: The resident may not verify the student documentation on behalf of the teaching physician, but the resident may edit the student's documentation and provide additional documentation related to the service. Ultimately, the verification is the responsibility of the teaching physician.

6. **Question:** Can I combine attestations/verification in one statement when the service involves both a medical student AND a resident?

Answer: Yes, you can combine attestations. WMED's Clinical Enterprise Integrity and Legal departments have approved the following attestation that may be added to the E/M documentation by the teaching physician verifying both the resident's and student's documentation:
"A student assisted with documenting this service. I saw the patient and reviewed and verified all information documented by the medical student and resident, and made modifications to such information, when appropriate."

7. **Question:** The guidance states that any contribution and participation of a student to the performance of a billable service must be performed in the physical presence of a teaching physician or physical presence of a resident. Is that a new requirement?
   Answer: This is not new. CMS has always required physical presence with the student participating in patient care other than the review of systems and/or past/family/social history. If your student workflow does not currently abide by this physical presence requirement, you should contact the Clinical Enterprise Integrity department to evaluate the workflow for compliance.

8. **Question:** The guidance states that the teaching physician must personally perform (or re-perform) the physical exam and medical decision-making activities of the E/M service being billed. Is that a new requirement?
   Answer: This is not new. CMS has always required that the teaching physician perform the physica examination and medical decision-making activities of the service. If your student workflow does not currently abide by this personal performance requirement, you should contact the Clinical Enterprise Integrity department to evaluate the workflow for compliance.

9. **Question:** What about procedures? Does this guidance apply to procedures with student participation?
   Answer: This guidance is for E/M only, not procedures. WMED's Clinical Enterprise Integrity department is currently drafting internal guidance on how to compliantly involve medical students in procedures and how to document procedures for billable services. Guidance will be forthcoming in the next couple of months. If you require advice on procedures and student involvement, you may contact the Clinical Enterprise Integrity department for a compliance assessment.

10. **Question:** Can we apply the new student guidelines and attestation to other students (i.e. NP student or PA student)?
    Answer: Yes, this may be applicable to other types of students who are involved in E/M services using the approved attestation. Please contact the Clinical Enterprise Integrity department to evaluate the workflow for compliance.

mln MATTERS®
KNOWLEDGE • RESOURCES • TRAINING

E/M Service Documentation Provided By Students (Manual Update)

MLN Matters Number: MM10412 | Related Change Request (CR) Number: 10412
Related CR Release Date: February 2, 2018 | Effective Date: January 1, 2018
Related CR Transmittal Number: R3971CP | Implementation Date: March 5, 2018

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for teaching physicians billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10412 revises the Medicare Claims Processing Manual to allow the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work. Make sure your billing staffs are aware of the changes.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) is revising the Medicare Claims Processing Manual, Chapter 12, Section 100.1.1, to update policy on Evaluation and Management (E/M) documentation to allow the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work. Students may document services in the medical record. However, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work.

ADDITIONAL INFORMATION

The official instruction, CR10412, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3971CP.pdf.

If you have any questions, please contact your MAC at their toll-free number. That number is

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network

available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

DOCUMENT HISTORY

Date of Change	Description
February 5, 2018	Initial article released

Library Information

10 Things Faculty & Staff should know about WMed's Library

1. Get 24/7 access to articles, databases, ebooks, research guides, & more at med.wmich.edu/library
2. Find a quiet space to study
3. Borrow MacBooks & power-cords when you forget your own
4. Access the latest test prep online
5. Click the Article Linker button in library databases to link to full text
6. Use interlibrary loan & Get it Now for free copies of the articles we don't have
7. Email Ask.Librarian@med.wmich.edu when you have questions or schedule a consultation
8. Get to know WMed students by hosting tea in the library
9. Get ahead of the game with research, publishing, and writing support
10. Get help finding the best evidence-based medicine sources

Where to study:

Information Commons on the Upjohn Campus

- Bronson Hospital Library
- Borgess Hospital Library
- Kalamazoo Public Library (Just 2 blocks from the Upjohn Campus)

Ask a Librarian

Online:

- med.wmich.edu/library
- ask.librarian@med.wmich.edu

On the Phone:

- 269.337.6116 (Joe)
- 269.337.6117 (Anna)
- 269.337.6119 (Liz)

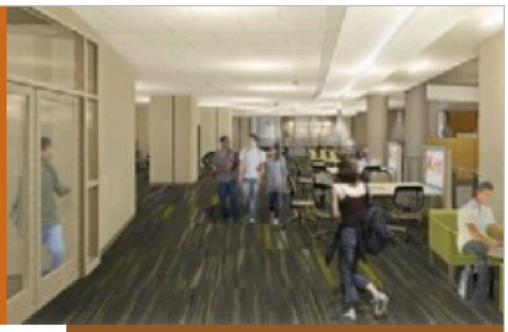
In Person:

- Information Commons on the Upjohn Campus

About the Collection

- 10,000+ biomedical & life-science e-journals
- 170,000+ e-books
- 86 biomedical databases

WMed Library
for Community Faculty



Access Resources

- Faculty appointment is required to access the WMed Library
- Start with http://med.wmich.edu/library to access articles, databases, & e-books
- Click the Article Linker button in WMed databases to find full text
- Remote access available using WMed network login
- WMed students will access clerkship textbooks, point-of-care applications, and library resources on iPad Minis

Access Databases like

- AccessMedicine
- Aquifer (Med-U)
- AudioDigest
- Case Files Collection
- DynaMed Plus
- Isabel Dx
- Johns Hopkins ABX Guide
- LexiComp
- Unbound Medicine
- Visual Dx

Find Resources

- Use the search box on the WMed Library website to find content across the library's collection including books, journals, and articles
- Review the Mobile Apps guide to find useful point-of-care tools for your mobile device: http://libguides.med.wmich.edu/home/mobile

Can't find what you're looking for?

Ask A Librarian!

Find us at:
med.wmich.edu/library

Locations:

- **Borgess Library** located in One West Borgess Medical Center
- **WMed Library** located in the W. E. Upjohn Building, 2nd Floor
- **Bronson Health Sciences Library** located in the North Pavillon

Email us:

- **Borgess:** LibraryStaff@ascension.org
- **WMed:** Ask.Librarian@med.wmich.edu
- **Bronson:** BronsonLibrary@bronsonhg.org

Call:

- **Jennifer Barlow at Borgess:** 269-226-7360
- **Liz Lorbeer at WMed:** 269-337-6119
- **Liz Colson at Bronson:** 269-341-8627

Resources to Get Started:

- **Databases:** libguides.med.wmich.edu/az.php
- **Faculty & Staff:** libguides.med.wmich.edu/GettingStarted
- **Mobile Apps:** libguides.med.wmich.edu/home/mobile
- **Test Prep:** libguides.med.wmich.edu/TestPrep

Access WMed Resources Off-Site

WMed Library's electronic resources are available remotely to WMed faculty, staff, residents, and currently enrolled students. Access is available anywhere on any device. Follow these instructions to access any of the library's resources off-site:

1. Start on the library's website: http://med.wmich.edu/library
2. Select a link to a database, journal, or book
3. When prompted, log in with your WMed network login
4. View all full text content to which WMed Library subscribes

More About Off-Site Access

The library's website uses the EZproxy service to verify authorized users who need remote access to subscribed content. All links on the library's webpages are coded to detect users that are not connected via the WMed network. For this reason, there is no need to log into the WMed Intranet prior to using the WMed Library website. When clicking on a link from the library's website, the user will be prompted to log into WMed's local authentication sign-on page with their WMed network login. This is the same username and password used when logging into a WMed computer. After sign- on, the remote user is automatically directed to the desired resource. The EZproxy service requires no configuration or downloading of software.

Remember to always begin your literature search from the WMed Library's website: http://med.wmich.edu/library. If you begin at a journal's website from off campus, rather than going through the WMed Library website, the publisher cannot confirm your affiliation and will deny access. Use the link provided on the library's website as the publishers have provided us with customized link outs to expedite access to content.

Need further help with remote access? Contact the WMed Librarians at ask.librarian@med.wmich.edu or call 269-337-6119.

Recommended Resources

Clinical Teaching Etiquette

Detsky AS. The Art of Pimping. *JAMA*. 2009;301:1379-1381.
http://jamanetwork.com.ezproxy.med.wmich.edu/journals/jama/fullarticle/183639

Working with Student Difficulties in the Clinical Setting

Hicks PJ, Cox SM, Espey EL, et al. To the point: Medical education reviews—Dealing with student difficulties in the clinical setting. *American Journal of Obstetrics and Gynecology*. 2005;193:1915-1922.
http://www.sciencedirect.com.ezproxy.med.wmich.edu/science/article/pii/S0002937805012652

Preceptor Expectations

Furney SL, Orsini AN, Orsetti KE, Stern DT, Gruppen LD, Irby DM. Teaching the one-minute preceptor: A randomized controlled trial. *Journal of General Internal Medicine*. 2001;16:620-624.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495264/pdf/jgi_00924.pdf
Neher JO, Stevens NG. The one-minute preceptor: shaping the teaching conversation. *Family medicine*. 2003;35:391.
http://www.stfm.org/Portals/49/Documents/FMPDF/FamilyMedicineVol35Issue6Neher391.pdf

EPA Toolkits and additional readings

Obeso V, Brown D, Aiyer M, Barron B, Bull J, Carter T, Emery M, Gillespie C, Hormann M, Hyderi A, Lupi C, Schwartz M, Uthman M,
Vasilevskis EE, Yingling S, Phillipi C, eds.; for Core EPAs for Entering Residency Pilot Program. Toolkits for the 13 Core Entrustable Professional Activities for Entering Residency. Washington, DC: Association of American Medical Colleges; 2017.
http://aamc.org/initiatives/coreepas/publicationsandpresentations

Domains of Competencies

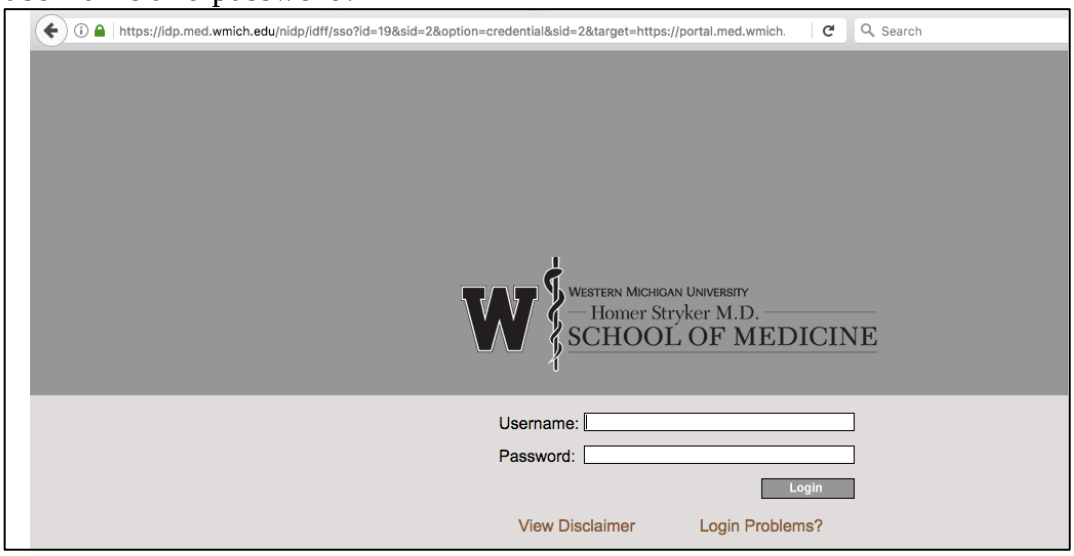
Englander R, Cameron T, Ballard AJ, Dodge J, Bull J, Aschenbrener CA. Toward a Common Taxonomy of Competency Domains for the Health Professions and Competencies for Physicians. *Academic Medicine*. 2013;88:1088-1094.
http://ovidsp.tx.ovid.com.ezproxy.med.wmich.edu/sp-3.25.0a/ovidweb.cgi?WebLinkFrameset=1&S=AFIKFPJHAIDDDPCPNCGKOEGCHICMAA00&returnUrl=ovidweb.cgi%3f%26Full%2bText%3dL%257cS.sh.38.39%257c0%257c00001888-201308000-00021%26S%3dAFIKFPJHAIDDDPCPNCGKOEGCHICMAA00&directlink=http%3a%2f%2fovidsp.tx.ovid.com%2fovftpdfs%2fFPDDNCGCOECPAI00%2ffs047%2fovft%2flive%2fgv024%2f00001888%2f00001888-201308000-00021.pdf&filename=Toward+a+Common+Taxonomy+of+Competency+Domains+for+the+Health+Professions+and+Competencies+for+Physicians.&pdf_key=FPDDNCGC

OECPAI00&pdf_index=/fs047/ovft/live/gv024/00001888/00001888-201308000-00021

Navigating the WMed Portal

The WMed Portal is a wealth of information for preceptors, from student handbooks and policy information to continuing education events and the WMed directory.

To access the portal, go to https://portal.med.wmich.edu/ and log-in using your WMed username and password.



On the main page, you will see a navigation bar on the left that provides access to all of the available resources.