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 also included 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 Assistant Dean for Clinical Competency and IPE. 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
Assistant Dean, Clinical Competency and IPE
Western Michigan University
Homer Stryker M.D. School of Medicine
TABLE OF CONTENTS

CLERKSHIP CONTACTS AND RESOURCES ................................................................. 3
ADDITIONAL CONTACTS ...................................................................................... 4
ADDITIONAL RESOURCES .................................................................................. 5
FAMILY EDUCATION RIGHTS AND PRIVACY ACT ............................................. 5
VERIFYING A STUDENT’S IDENTITY .................................................................... 6
CLERKSHIP ATTENDANCE POLICY ..................................................................... 6
ELECTRONIC HEALTH RECORD DOCUMENTATION ......................................... 7
FREQUENTLY ASKED QUESTIONS – MEDICAL STUDENT DOCUMENTATION GUIDANCE ..................................................................................... 11
ASSESSMENT ...................................................................................................... 13
ASSESSMENT COMPLETION – ELENTRA ............................................................ 14
FACULTY APPOINTMENT & BENEFITS ............................................................... 15
APPENDIX 1: EPAs & KEY FUNCTIONS .............................................................. 16
RIME NARRATIVE AND NEXT STEP EXAMPLES ............................................. 29
## Core Clerkship

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Director</th>
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## Advanced Clerkship

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RETURN TO TABLE OF CONTENTS
Additional Resources

WMed Faculty Portal

WMed Library

WMed Policies, Handbooks, Manuals, and Statements

Clinical Teaching Etiquette

The learning environment in remediation: a review

One-minute Preceptor Model
The one-minute preceptor model: A systematic review

The One Minute Preceptor: Shaping the Teaching Conversation
Neher JO, Stevens NG. Family medicine. 2003;35:391.

Take 5: One Minute Preceptor, Mayo Clinic OR One Minute Preceptor, Matthew Eberly

Domains of Competency

Family Education Rights & Privacy Act

WMed complies fully with the Family Educational Rights and Privacy Act (FERPA) of 1974, a federal law governing the privacy of students’ education records. The medical school takes seriously its commitment to protect the privacy of our students and their education records.

The FERPA definition of education records includes all of the information and records in any format that are used by the medical school in the instruction and evaluation of students. Education records include any information or documentation that is recorded in any way, including records produced by handwriting, computer, email, audio, and video, among others. Education records contain information directly related to a student, and may be maintained by the medical school or any party acting on its behalf.

FERPA protects the privacy of students’ education records by setting forth strict instructions and limitations governing the release of information about students. All WMed faculty, residents, and staff are responsible for protecting the educational records in our possession.

For more information regarding FERPA, please review the Student Policy Manual. Specific questions about FERPA should be directed to the registrar.
Verifying a Student’s Identity

In maintaining FERPA compliance, when speaking to students on the phone regarding their grades, academic performance, or any part of their educational record, WMed faculty, residents, and staff must verify the students’ identity before the conversation begins. Students’ identity may be verified by:

- Asking for and verifying their Student Identification number.
- Asking a specific question you can both answer that allows you to identify the student. An example is: “What is the name of the clinic where we last rounded together?”

When in doubt, or if you’re unable to verify the student’s identity, do not release confidential information. Face to face conversations or email through WMed’s secure server are the preferred method of communicating sensitive information to a student.

Clerkship Attendance

Students are expected to be present for all components of each clerkship. You or your office staff should be notified of assigned students 1-2 weeks before the start of each rotation block. 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 2 weeks prior to the first day of the course/ clerkship in which the planned absence will occur. 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 should maintain personal wellness activities including access to healthcare during clinical rotations. **Students will never be denied an absence for physical or mental health appointments.** Students should submit a planned absence form, which is then managed by the clerkship coordinator and clerkship director to ensure release from clinical responsibilities. On inpatient rotations, afternoons are a better time to schedule appointments when possible.

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 typically 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.

Core Clinical

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

Advanced Clinical

- In a 2-week rotation, students are allowed one excused absence, which must be remediated by the end of the clerkship.
- In a 4-week rotation, students are allowed up to 4 half-days (2 full days) excused absences, which must be remediated by the end of the clerkship.
**Electronic Health Record and Student Documentation**

**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 professional. 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, physician assistants, 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.

**RETURN TO TABLE OF CONTENTS**
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 tools, 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 physician 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

**Workflow required for complying with CMS rules regarding student documentation in the medical record:**

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 HER

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
Frequently Asked Questions – 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 changed with the latest CMS update?
   **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:** 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 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 physical 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.
Assessment of Medical Students

Introduction for Completing Clinical Assessments

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 & 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](https://www.aamc.org/initiatives/coreepas/publicationsandpresentations). To view the PDFs of each EPA, you may also go to **Appendix 1**.

Your clerkship director can review the specific form that you will be using in your department.

The responsibility of the preceptor during **core clerkships** (year 3) is to assess the developmental progression toward entrustment for the students on their service. Faculty ratings should be based on your observation of the student’s level of performance at the end of their time with you. The scale is developmental, with the far right column ready for independent performance as an intern. Core clerkships target reporter and interpreter skills that are observable by the preceptors in that particular clinical setting. It is important you become familiar with the key functions that are to be assessed for your students.

In addition to rating the performance of EPAs, preceptors are asked to rate the frequency with which you consistently observed students practice the foundational competencies required for entrustment: truthfulness, conscientiousness and discernment. Finally, and most importantly, preceptors are asked to provide narrative feedback to students on their clinical performance and next steps for future growth and development.

**Advanced Required Clerkships** (year 4) will be assessed on a broader number of key functions as students begin to take more responsibility and ownership of patient management and education. While our goal is to have as many EPAs assessed in the clinical setting as possible, we recognize there will be some that will require simulation or other forms of assessment.

RETURN TO TABLE OF CONTENTS
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 a physician. Your comments regarding both what the student has done well and areas to target for growth are critical to student understanding of their current level of performance, as well as providing suggestions for future improvement (feedback “for learning”).

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

1. EPA developmental schema and their performance narratives
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?
   a. “I did it.” - Student required complete guidance or was unprepared; I had to do most of the work myself.
   b. “I talked them through it.” - Student was able to perform some tasks but required repeated directions.
   c. “I directed them from time to time.” – Student demonstrated some independence and only required intermittent prompting.
   d. “I was available just in case.” - Student functioned fairly independently and only needed assistance with nuances or complex situations.
3. RIME - Reporter, Interpreter, Manager, Educator - See Appendix 2

**Assessment Completion – Elentra**
You will receive an email from WMED when you have an assessment that is due. Alternately, you may use your WMED login information to directly access the Elentra system. If you are having any difficulty finding or completing an assessment, please contact your clerkship coordinator. Our goal is for faculty to complete their student assessments within one week after you or the student leaves the service.

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**RETURN TO TABLE OF CONTENTS**
Faculty Appointment & 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
### EPA 1: Gather a History and Perform a Physical Examination

<table>
<thead>
<tr>
<th>Key Functions with Related Competencies</th>
<th>Behaviors Requiring Corrective Response (Learner may be at different levels within a row.)</th>
<th>Expected Behaviors for an Entrustable Learner</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gather a complete and accurate history in an organized fashion</strong></td>
<td>Gathers excessive or incomplete data</td>
<td>Obtains a complete and accurate history in an organized fashion</td>
</tr>
<tr>
<td>PC2</td>
<td>Does not collect accurate historical data</td>
<td>Seeks secondary sources of information when appropriate (e.g. family, primary care physician, living facility, pharmacy)</td>
</tr>
<tr>
<td><strong>Demonstrate patient-centered interview skills</strong></td>
<td>Relies exclusively on secondary sources or documentation of others</td>
<td>Adapts to different care settings and encounters</td>
</tr>
<tr>
<td>ICS1 ICS7 P1 P3 P5</td>
<td>Is disrespectful in interactions with patients</td>
<td>Adapts communication skills to the individual patient’s needs and characteristics</td>
</tr>
<tr>
<td><strong>Demonstrate clinical reasoning in gathering focused information relevant to a patient’s care</strong></td>
<td>Disregards patient privacy and autonomy</td>
<td>Responds effectively to patient’s verbal and nonverbal cues and emotions</td>
</tr>
<tr>
<td>KP1</td>
<td>Fails to recognize patient’s central problem</td>
<td><strong>Developing Behaviors</strong></td>
</tr>
<tr>
<td><strong>Perform a clinically relevant, appropriately thorough physical exam pertinent to the setting and purpose of the patient visit</strong></td>
<td>Questions are not guided by the evidence and data collected</td>
<td>Demonstrates astute clinical reasoning through targeted hypothesis-driven questioning</td>
</tr>
<tr>
<td>PC2</td>
<td>Does not consider patient’s privacy and comfort during exams</td>
<td>Incorporates secondary data into medical reasoning</td>
</tr>
<tr>
<td></td>
<td>Incorrectly performs basic physical exam maneuvers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performs basic exam maneuvers correctly</td>
<td>Performs an accurate exam in a logical and fluid sequence</td>
</tr>
<tr>
<td></td>
<td>Does not perform exam in an organized fashion</td>
<td>Uses the exam to explore and prioritize the working differential diagnosis</td>
</tr>
<tr>
<td></td>
<td>Relies on head-to-toe examination</td>
<td>Can identify and describe normal and abnormal findings</td>
</tr>
<tr>
<td></td>
<td>Misses key findings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Targets the exam to areas necessary for the encounter</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identifies and describes normal findings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Explains exam maneuvers to patient</td>
<td></td>
</tr>
</tbody>
</table>

**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.
EPA 2: Prioritize a Differential Diagnosis Following a Clinical Encounter

<table>
<thead>
<tr>
<th>Key Functions with Related Competencies</th>
<th>Behaviors Requiring Corrective Response</th>
<th>Developing Behaviors (Learner may be at different levels within a row.)</th>
<th>Expected Behaviors for an Entrustable Learner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Synthesize essential information from previous records, history, physical exam, and initial diagnostic evaluations to propose a scientifically supported differential diagnosis</td>
<td>Cannot gather or synthesize data to inform an acceptable diagnosis</td>
<td>Approaches assessment from a rigid template</td>
<td>Gathers pertinent data based on initial diagnostic hypotheses</td>
</tr>
<tr>
<td></td>
<td>Lacks basic medical knowledge to reason effectively</td>
<td>Struggles to filter, prioritize, and make connections between sources of information</td>
<td>Proposes a reasonable differential diagnosis but may neglect important diagnostic information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Proposes a differential diagnosis that is too narrow, too broad, or contains inaccuracies</td>
<td>Is beginning to organize knowledge by illness scripts (patterns) to generate and support a diagnosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Demonstrates difficulty retrieving knowledge for effective reasoning</td>
<td></td>
</tr>
<tr>
<td>Prioritize and continue to integrate information as it emerges to update differential diagnosis, while managing ambiguity</td>
<td>Disregards emerging diagnostic information</td>
<td>Does not integrate emerging information to update the differential diagnosis</td>
<td>Seeks and integrates emerging information to update the differential diagnosis</td>
</tr>
<tr>
<td></td>
<td>Becomes defensive and/or belligerent when questioned on differential diagnosis</td>
<td>Displays discomfort with ambiguity</td>
<td>Encourages questions and challenges from patients and team</td>
</tr>
<tr>
<td>Engage and communicate with team members for endorsement and verification of the working diagnosis that will inform management plans</td>
<td>Ignores team’s recommendations</td>
<td>Considers emerging information but does not completely integrate to update the differential diagnosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develops and acts on a management plan before receiving team’s endorsement</td>
<td>Acknowledges ambiguity and is open to questions and challenges</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cannot explain or document clinical reasoning</td>
<td>Recommends a broad range of untailored diagnostic evaluations</td>
<td>Proposes diagnostic and management plans reflecting team’s input</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Depends on team for all management plans</td>
<td>Seeks assistance from team members</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Does not completely explain and document reasoning</td>
<td>Provides complete and succinct documentation explaining clinical reasoning</td>
</tr>
</tbody>
</table>

An EPA: A unit of observable, measurable professional practice requiring integration of competencies.
EPA 3: Recommend and Interpret Common Diagnostic and Screening Tests

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

**EPA 3**

**Diagnostic and screening tests**

<table>
<thead>
<tr>
<th>Key Functions with Related Competencies</th>
<th>Behaviors Requiring Corrective Response</th>
<th>Developing Behaviors</th>
<th>Expected Behaviors for an Entrustable Learner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommend first-line cost-effective screening and diagnostic tests for routine health maintenance and common disorders</td>
<td>Unable to recommend a standard set of screening or diagnostic tests</td>
<td>Recommends tests for common conditions</td>
<td>Recommends key, reliable, cost-effective screening and diagnostic tests</td>
</tr>
<tr>
<td>PC5 PC9 SBP3 PBL19 KP1 KP4</td>
<td>Demonstrates frustration at cost-containment efforts</td>
<td>Considers costs</td>
<td>Applies patient-specific guidelines</td>
</tr>
<tr>
<td>Provide rationale for decision to order tests, taking into account pre- and posttest probability and patient preference</td>
<td>Cannot provide a rationale for ordering tests</td>
<td>Identifies guidelines for standard tests</td>
<td></td>
</tr>
<tr>
<td>PC5 PC7 KP1 KP4 SBP3 PBL19</td>
<td>Cannot provide a rationale for ordering tests</td>
<td>Repeats diagnostic tests at intervals that are too frequent or too lengthy</td>
<td></td>
</tr>
<tr>
<td>Interpret results of basic studies and understand the implication and urgency of the results</td>
<td>Can only interpret results based on normal values from the lab</td>
<td>Understands pre- and posttest probability</td>
<td>Provides individual rationale based on patient’s preferences, demographics, and risk factors</td>
</tr>
<tr>
<td>PC4 PC5 PC7 KP1</td>
<td>Does not discern urgent from nonurgent results</td>
<td>Neglects impact of false positive or negative results</td>
<td>Incorporates sensitivity, specificity, and prevalence in recommending and interpreting tests</td>
</tr>
</tbody>
</table>

**Developing Behaviors (Learner may be at different levels within a row.):**

- 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

**Expected Behaviors for an Entrustable Learner:**

- 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

**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

<table>
<thead>
<tr>
<th>Key Functions</th>
<th>Behaviors Requiring Corrective Response</th>
<th>Expected Behaviors for an Entrustable Learner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compose orders efficiently and effectively verbally, on paper, and electronically</td>
<td>Unable to compose or enter electronic orders or write prescriptions (or does so for the wrong patient or using an incorrect order set)</td>
<td>Recognizes when to tailor or deviate from the standard order set</td>
</tr>
<tr>
<td></td>
<td>Does not follow established protocols for placing orders</td>
<td>Completes simple orders</td>
</tr>
<tr>
<td>Demonstrate an understanding of the patient’s condition that underpins the provided orders</td>
<td>Lacks basic knowledge needed to guide orders</td>
<td>Demonstrates working knowledge of how orders are processed in the workplace</td>
</tr>
<tr>
<td></td>
<td>Demonstrates defensiveness when questioned</td>
<td>Asks questions, accepts feedback</td>
</tr>
<tr>
<td>Recognize and avoid errors by attending to patient-specific factors, using resources, and appropriately responding to safety alerts</td>
<td>Discounts information obtained from resources designed to avoid drug–drug interactions</td>
<td>Has difficulty filtering and synthesizing information to prioritize diagnostics and therapies</td>
</tr>
<tr>
<td></td>
<td>Fails to adjust doses when advised to do so by others</td>
<td>Articulates rationale behind orders</td>
</tr>
<tr>
<td></td>
<td>Ignores alerts</td>
<td>May not take into account subtle signs or exam findings guiding orders</td>
</tr>
<tr>
<td>Discuss planned orders and prescriptions with team, patients, and families</td>
<td>Places orders without communicating with others; uses unidirectional style (“Here is what we are doing…”)</td>
<td>Places orders without communicating with others; uses unidirectional style (“Here is what we are doing…”); uses unidirectional style (“Here is what we are doing…”)</td>
</tr>
<tr>
<td></td>
<td>Does not consider cost of orders or patient’s preferences</td>
<td>Modifies plan based on patient’s preferences</td>
</tr>
<tr>
<td></td>
<td>Does not consider cost of orders or patient’s preferences</td>
<td>May describe cost-containment efforts as externally mandated and interfering with the doctor–patient relationship</td>
</tr>
</tbody>
</table>

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

**EPA 4:** Enter and discuss orders and prescriptions

**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.**
### EPA 5: Document a Clinical Encounter in the Patient Record

**Key Functions with Related Competencies**
- Prioritize and synthesize information into a cogent narrative for a variety of clinical encounters (e.g., admission, progress, pre-and post-op, and procedure notes; informed consent; discharge summary)
- Follow documentation requirements to meet regulations and professional expectations
  - ICS5 P4 SBP1
- Document a problem list, differential diagnosis, and plan supported through clinical reasoning that reflects patient’s preferences
  - PC4 PC6 ICS1 ICS2

**Behaviors Requiring Corrective Response**
- Provides incoherent documentation
- Copies and pastes information without verification or attribution
- Does not provide documentation when required
- Provides illegible documentation
- Includes inappropriate judgmental language
- Documents potentially damaging information without attribution

**Developing Behaviors**  
(Learner may be at different levels within a row.)
- Misses key information
- Uses a template with limited ability to adjust or adapt based on audience, context, or purpose
- Produces documentation that has errors or does not fulfill institutional requirements (e.g., date, time, signature, avoidance of prohibited abbreviations)
- Has difficulty meeting turnaround expectations, resulting in team members’ lack of access to documentation
- Does not document a problem list, differential diagnosis, plan, and clinical reasoning that reflects patient’s preferences
- Interprets laboratories by relying on norms rather than context
- Does not include a rationale for ordering studies or treatment plans
- Demonstrates limited help-seeking behavior to fill gaps in knowledge, skill, and experience

**Expected Behaviors for an Entrustable Learner**
- Provides a verifiable cogent narrative without unnecessary details or redundancies
- Recognizes and corrects errors related to required elements of documentation
- Meets needed turnaround time for standard documentation
- May not document the pursuit of primary or secondary sources important to the encounter
- Provides a problem list, differential diagnosis, plan, and clinical reasoning
- Is inconsistent in interpreting basic tests accurately
- Engages in help-seeking behavior resulting in improved ability to develop and document management plans
- Solicits patient’s preferences and records them in a note
- Documents a problem list, differential diagnosis, and plan, reflecting a combination of thought processes and input from other providers
- Interprets laboratory values accurately
- Identifies key problems, documenting engagement of those who can help resolve them
- Communicates bidirectionally to develop and record management plans aligned with patient’s preferences

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Adapted from the Association of American Medical Colleges (AAMC). Core entrustable professional activities for entering residency. 2014.
EPA 6: Provide an Oral Presentation of a Clinical Encounter

**Key Functions with Related Competencies**

- Present personally gathered and verified information, acknowledging areas of uncertainty
  - PC2 PBL1 PPD4 P1

- Provide an accurate, concise, well-organized oral presentation
  - ICS2 PC6

- Adjust the oral presentation to meet the needs of the receiver
  - ICS1 ICS2 PBL1 PPD7

- Demonstrate respect for patient’s privacy and autonomy
  - P3 P1 PPD4

**Behaviors Requiring Corrective Response**

- Fabricates information when unable to respond to questions
- Reacts defensively when queried

- Presents in a disorganized and incoherent fashion

- Presents information in a manner that frightens family

- Disregards patient’s privacy and autonomy

**Developing Behaviors (Learner may be at different levels within a row.)**

- Gathers evidence incompletely or exhaustively
- Fails to verify information
- Does not obtain sensitive information

- Delivers a presentation that is not concise or that wanders
- Presents a story that is imprecise because of omitted or extraneous information

- Follows a template
- Uses acronyms and medical jargon
- Projects too much or too little confidence

- Lacks situational awareness when presenting sensitive patient information
- Does not engage patients and families in discussions of care

- Acknowledges gaps in knowledge, adjusts to feedback, and then obtains additional information

- Delivers a presentation organized around the chief concern
- When asked, can identify pertinent positives and negatives that support hypothesis
- Supports management plans with limited information

- When prompted, can adjust presentation in length and complexity to match situation and receiver of information
- Incorporates patient’s preferences and privacy needs

**Expected Behaviors for an Entrustable Learner**

- Presents personally verified and accurate information, even when sensitive
- Acknowledges gaps in knowledge, reflects on areas of uncertainty, and seeks additional information to clarify or refine presentation

- Filters, synthesizes, and prioritizes information into a concise and well-organized presentation
- Integrates pertinent positives and negatives to support hypothesis

- Tailors length and complexity of presentation to situation and receiver of information
- Conveys appropriate self-assurance to put patient and family at ease

- Respects patients’ privacy and confidentiality by demonstrating situational awareness when discussing patients
- Engages in shared decision making by actively soliciting patient’s preferences
EPA 7: Form Clinical Questions and Retrieve Evidence to Advance Patient Care

### Key Functions with Related Competencies

**Combine curiosity, objectivity, and scientific reasoning to develop a well-formed, focused, pertinent clinical question (ASK)**

- KP3 PBLI6 PBLI1 PBLI3

**Demonstrate awareness and skill in using information technology to access accurate and reliable medical information (ACQUIRE)**

- PBLI6 PBLI7

**Demonstrate skill in appraising sources, content, and applicability of evidence (APPRAISE)**

- PBLI6 KP3 KP4

**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

### Behaviors Requiring Corrective Response

**Developing Behaviors →**

- Does not reconsider approach to a problem, ask for help, or seek new information
- Does not determine or discuss outcomes and/or process, even with prompting
- Does not discuss findings with team
- With prompting, translates information needs into clinical questions
- Uses vague or inappropriate search strategies, leading to an unmanageable volume of information
- Accepts findings from clinical studies without critical appraisal
- Communicates with rigid recitation of findings, using medical jargon or displaying personal biases

- Seeks assistance to translate information needs into well-formed clinical questions
- Employs different search engines and refines search strategies to improve efficiency of evidence retrieval
- Judges evidence quality from clinical studies
- Applies evidence to common medical conditions
- Applies findings based on audience needs
- Acknowledges ambiguity of findings and manages personal bias

- Identifies limitations and gaps in personal knowledge
- Develops knowledge guided by well-formed clinical questions
- Identifies and uses available databases, search engines, and refined search strategies to acquire relevant information
- Uses levels of evidence to appraise literature and determines applicability of evidence
- Seeks guidance in understanding subtleties of evidence
- 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

### Expected Behaviors for an Entrustable Learner

- With prompting, translates information needs into clinical questions
- Seeks assistance to translate information needs into well-formed clinical questions
- 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
- Uses levels of evidence to appraise literature and determines applicability of evidence
- Seeks guidance in understanding subtleties of evidence
- 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
EPA 8: Give or Receive a Patient Handover to Transition Care Responsibility

<table>
<thead>
<tr>
<th>Key Functions with Related Competencies</th>
<th>Behaviors Requiring Corrective Response</th>
<th>Developing Behaviors (Learner may be at different levels within a row.)</th>
<th>Expected Behaviors for an Entrustable Learner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document and update an electronic handover tool and apply this to deliver a structured verbal handover</td>
<td>Inconsistently uses standardized format or uses alternative tool</td>
<td>Uses electronic handover tool</td>
<td>Consistently updates electronic handover tool with clear, relevant, and succinct documentation</td>
</tr>
<tr>
<td>PBL17 ICS2 ICS3 P3</td>
<td>Provides information that is incomplete and/or includes multiple errors in patient information</td>
<td>Inconsistently updates tool</td>
<td>Adapts and applies all elements of a standardized template</td>
</tr>
<tr>
<td>*Transmitter</td>
<td>Requires clarification and additional relevant information from others to prioritize information</td>
<td>Requires assistance to minimize interruptions and distractions</td>
<td>Presents a verbal handover that is prioritized, relevant, and succinct</td>
</tr>
<tr>
<td>Conduct handover using communication strategies known to minimize threats to transition of care</td>
<td>Provides patient information that is disorganized, too detailed, and/or too brief</td>
<td>Demonstrates minimal situational awareness</td>
<td>Avoids interruptions and distractions</td>
</tr>
<tr>
<td>ICS2 ICS3</td>
<td>Is frequently distracted</td>
<td>Requires assistance with time management</td>
<td>Manages time effectively</td>
</tr>
<tr>
<td>*Transmitter</td>
<td>Carries out handover with inappropriate timing and context</td>
<td>Focuses on own handover tasks with some awareness of other’s needs</td>
<td>Demonstrates situational awareness</td>
</tr>
<tr>
<td>Provide succinct verbal communication conveying illness severity, situational awareness, action planning, and contingency planning</td>
<td>Communication lacks all key components of standardized handover</td>
<td>Identifies illness severity</td>
<td>Highlights illness severity accurately</td>
</tr>
<tr>
<td>ICS2 PC8</td>
<td>Miscarried</td>
<td>Provides incomplete action list and contingency planning</td>
<td>Provides complete action plans and appropriate contingency plans</td>
</tr>
<tr>
<td>*Transmitter</td>
<td>Withholds or is defensive with feedback</td>
<td>Creates a contingency plan that lacks clarity</td>
<td></td>
</tr>
<tr>
<td>Give or elicit feedback about handover communication and ensure closed-loop communication</td>
<td>Displays lack of insight on the role of feedback</td>
<td>Delivers incomplete feedback; accepts feedback when given</td>
<td>Provides and solicits feedback regularly, listens actively, and engages in reflection</td>
</tr>
<tr>
<td>PBL15 ICS2 ICS3</td>
<td>Does not summarize (or repeat) key points for effective closed-loop communication</td>
<td>Summary statements are too elaborate</td>
<td>Identifies areas of improvement</td>
</tr>
<tr>
<td>*Transmitter and Receiver</td>
<td>Is unaware of HIPAA policies</td>
<td>Inconsistently uses repeat-back technique</td>
<td>Asks mutually clarifying questions, provides succinct summaries, and uses repeat-back techniques</td>
</tr>
<tr>
<td>Demonstrate respect for patient’s privacy and confidentiality</td>
<td>Breaches patient confidentiality and privacy</td>
<td>Is cognizant of and attempts to minimize breaches in privacy and confidentiality</td>
<td>Consistently considers patient privacy and confidentiality</td>
</tr>
<tr>
<td>P3</td>
<td>Is aware of HIPAA policies</td>
<td>Is cognizant of and attempts to minimize breaches in privacy and confidentiality</td>
<td>Highlights and respects patient’s preferences</td>
</tr>
<tr>
<td>*Transmitter and Receiver</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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.”

Adapted from the Association of American Medical Colleges (AAMC). Core entrustable professional activities for entering residency. 2014.
### EPA 9: Collaborate as a Member of an Interprofessional Team

#### Key Functions with Related Competencies

<table>
<thead>
<tr>
<th>Function</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify team members’ roles and responsibilities and seek help from</td>
<td>IPC2 SBP2 ICS3</td>
</tr>
<tr>
<td>other members of the team to optimize health care delivery</td>
<td></td>
</tr>
<tr>
<td>Include team members, listen attentively, and adjust communication</td>
<td>ICS2/IPC3 IPC1 ICS7</td>
</tr>
<tr>
<td>content and style to align with team-member needs</td>
<td>P1</td>
</tr>
<tr>
<td>Establish and maintain a climate of mutual respect, dignity, integrity,</td>
<td></td>
</tr>
<tr>
<td>and trust</td>
<td></td>
</tr>
<tr>
<td>Prioritize team needs over personal needs to optimize delivery of care</td>
<td></td>
</tr>
<tr>
<td>Help team members in need</td>
<td>P1 ICS7 IPC1 SBP2</td>
</tr>
</tbody>
</table>

#### Behaviors Requiring Corrective Response

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Develops Behaviors</th>
<th>Expected Behaviors for an Entrustable Learner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not acknowledge other members of the interdisciplinary team as</td>
<td></td>
<td>Effectively partners as an integrated member of the team</td>
</tr>
<tr>
<td>important</td>
<td></td>
<td>Articulates the unique contributions and roles of other health care professionals</td>
</tr>
<tr>
<td>Displays little initiative to interact with team members</td>
<td></td>
<td>Actively engages with the patient and other team members to coordinate care and provide for seamless care transition</td>
</tr>
<tr>
<td>Dismisses input from professionals other than physicians</td>
<td></td>
<td>Communicates bidirectionally; keeps team members informed and up to date</td>
</tr>
<tr>
<td>Has disrespectful interactions or does not tell the truth</td>
<td></td>
<td>Tailors communication strategy to the situation</td>
</tr>
<tr>
<td>Is unable to modify behavior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Puts others in position of reminding, enforcing, and resolving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>interpersonal conflicts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is typically a more passive member of the team</td>
<td>Integrated into</td>
<td>Supports other team members and communicates their value to the patient and family</td>
</tr>
<tr>
<td>Prioritizes own goals over those of the team</td>
<td>team function, prioritizing team goals</td>
<td></td>
</tr>
<tr>
<td>Integrates into team function, prioritizing team goals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates respectful interactions and tells the truth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remains professional and anticipates and manages emotional triggers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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### EPA 10: Recognize a Patient Requiring Urgent or Emergent Care and Initiate Evaluation and Management

#### Key Functions with Related Competencies

**Recognize normal and abnormal vital signs as they relate to patient- and disease-specific factors as potential etiologies of a patient’s decompensation**

**Recognize severity of a patient’s illness and indications for escalating care and initiate interventions and management**

**Initiate and participate in a code response and apply basic and advanced life support**

**Upon recognition of a patient’s deterioration, communicate situation, clarify patient’s goals of care, and update family members**

**Dismisses concerns of team members (nurses, family members, etc.) about patient deterioration**

**Communicates in a unidirectional manner with family and health care team**

**Provides superfluous or incomplete information to health care team members**

**Active listening and encourages idea sharing from the team (including patient and family)**

**Confirms goals of care**

#### Behaviors Requiring Corrective Response

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fails to recognize trends or variations of vital signs in a decompensating patient</td>
<td>Fails to recognize trends or variations of vital signs in a decompensating patient</td>
</tr>
<tr>
<td>Does not recognize change in patient’s clinical status or seek help when a patient requires urgent or emergent care</td>
<td>Does not recognize change in patient’s clinical status or seek help when a patient requires urgent or emergent care</td>
</tr>
<tr>
<td>Responds to a decompensated patient in a manner that detracts from or harms team’s ability to intervene</td>
<td>Responds to a decompensated patient in a manner that detracts from or harms team’s ability to intervene</td>
</tr>
<tr>
<td>Requires prompting to perform basic procedural or life support skills correctly</td>
<td>Requires prompting to perform basic procedural or life support skills correctly</td>
</tr>
<tr>
<td>Dismisses concerns of team members (nurses, family members, etc.) about patient deterioration</td>
<td>Dismisses concerns of team members (nurses, family members, etc.) about patient deterioration</td>
</tr>
<tr>
<td>Communicates in a unidirectional manner with family and health care team</td>
<td>Communicates in a unidirectional manner with family and health care team</td>
</tr>
</tbody>
</table>

#### Developing Behaviors

- **Expected Behaviors for an Entrustable Learner**
  - Recognizes variations of patient’s vital signs based on patient- and disease-specific factors
  - Responds to early clinical deterioration and seeks timely help
  - Prioritizes patients who need immediate care and initiates critical interventions
  - 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

- **Developing Behaviors**
  - Recognizes outliers or unexpected results or data and seeks out an explanation
  - Recognizes concerning clinical symptoms or unexpected results or data
  - Asks for help
  - 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
  - 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

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

**Key Functions with Related Competencies**

**Describe the key elements of informed consent: indications, contraindications, risks, benefits, alternatives, and potential complications of the intervention**
- PC6
- KP3
- KP4
- KP5
- P6

**Communicate with the patient and family to ensure that they understand the intervention**
- PC7
- ICS1
- ICS7
- PC5

**Display an appropriate balance of confidence and skill to put the patient and family at ease, seeking help when needed**
- PPD1
- PPD7
- PPD8

**Behaviors Requiring Corrective Response**

**Developing Behaviors**
(Learner may be at different levels within a row.)

- Lacks basic knowledge of the intervention
- Provides inaccurate or misleading information
- Hands the patient a form and requests a signature
- Uses language that frightens patient and family
- Disregards emotional cues
- Regards interpreters as unhelpful or inefficient
- Displays overconfidence and takes actions that can have a negative effect on outcomes
- Asks questions
- Accepts help

- Is complacent with informed consent due to limited understanding of importance of informed consent
- Allows personal biases with intervention to influence consent process
- Obtains informed consent only on the directive of others
- Uses medical jargon
- Uses unidirectional communication; does not elicit patient’s preferences
- Has difficulty in attending to emotional cues
- Does not consider the use of an interpreter when needed
- Displays a lack of confidence that increases patient stress or discomfort, or overconfidence that erodes trust
- Has difficulty articulating personal limitations such that patient and family will need reassurance from a senior colleague
- Asks for help
- Seeks timely help

**Expected Behaviors for an Entrustable Learner**

- Understands and explains the key elements of informed consent
- Provides complete and accurate information
- Recognizes when informed consent is needed and describes it as a matter of good practice rather than as an externally imposed sanction
- Avoids medical jargon
- Uses bidirectional communication to build rapport
- Practices shared decision making, eliciting patient and family preferences
- Responds to emotional cues in real time
- Enlists interpreters collaboratively
- Demonstrates confidence commensurate with knowledge and skill so that patient and family are at ease

From day 1, residents may be in a position to obtain informed consent for interactions, tests, or procedures they order and perform, including immunizations, medications, central lines, contrast and radiation exposures, and blood transfusions.
EPA 12: Perform General Procedures of a Physician

### Key Functions with Related Competencies

**Demonstrate technical skills required for the procedure**

- **PC1**
  - Understand and explain the anatomy, physiology, indications, contraindications, risks, benefits, alternatives, and potential complications of the procedure

**Communicate with the patient and family to ensure they understand pre- and post-procedural activities**

- **PC7 ICS6 P6**
  - Demonstrate confidence that puts patients and families at ease

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

### Behaviors Requiring Corrective Response

- **Lacks required technical skills**
- **Fails to follow sterile technique when indicated**
- **Displays lack of awareness of knowledge gaps**
- **Uses inaccurate language or presents information distorted by personal biases**
- **Disregards patient’s and family’s wishes**
- **Fails to obtain appropriate consent before performing a procedure**
- **Displays overconfidence and takes actions that could endanger patients or providers**

### Developing Behaviors → (Learner may be at different levels within a row.)

- **Corrects technical skills as variably applied**
- **Completes the procedure unreliably**
- **Uses universal precautions and aseptic technique inconsistently**
- **Demonstrates limited knowledge of procedural complications or how to minimize them**
- **Uses jargon or other ineffective communication techniques**
- **Does not understand key issues in performing procedures, such as indications, contraindications, risks, benefits, and alternatives**
- **Demonstrates knowledge of common procedural complications but struggles to mitigate them**

### Expected Behaviors for an Entrustable Learner

- **Demonstrates necessary preparation for performance of procedures**
- **Correctly performs procedure on multiple occasions over time**
- **Uses universal precautions and aseptic technique consistently**
- **Demonstrates and applies working knowledge of essential anatomy, physiology, indications, contraindications, risks, benefits, and alternatives for each procedure**
- **Knows and takes steps to mitigate complications of procedures**
- **Displays lack of confidence that increases patient’s stress or discomfort, or overconfidence that erodes patient’s trust if the learner struggles to perform the procedure**
- **Asks for help with complications**
- **Seeks timely help**

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### Key Functions with Related Competencies

- **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 PPDS**
  - 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)

- **PBL14 PBL110**
  - 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**
  - Admit one’s own errors, reflect on one’s contribution, and develop an individual improvement plan

### Behaviors Requiring Corrective Response

- **Reports errors in a disrespectful or misleading manner**

- **Displays frustration at system improvement efforts**

- **Places self or others at risk of injury or adverse event**

- **Avoids discussing or reporting errors; attempts to cover up errors**

- **Demonstrates defensiveness or places blame**

### → Developing Behaviors →

(Leader may be at different levels within a row.)

- **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**

- **Passively observes system improvement activities in the context of rotations or learning experiences**

- **Requires prompts for common safety behaviors**

- **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**

### Expected Behaviors for an Entrustable Learner

- **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**

- **Actively engages in efforts to identify systems issues and their solutions**

- **Requires prompts to develop common safety behaviors**

- **Identifies and reflects on the element of personal responsibility for errors**

- **Recognizes causes of lapses, such as fatigue, and modifies behavior or seeks help**

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

**EPA 13**

**System failures and culture of safety**

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# APPENDIX

The RIME (Reporter–Interpreter–Manager–Educator) Feedback Tool, with examples of feedback in ‘Next Steps’

<table>
<thead>
<tr>
<th>Skill area</th>
<th>Needs improvement</th>
<th>Competent</th>
<th>Strength</th>
<th>Next Steps (examples)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting</td>
<td>Data gathering and reporting are incomplete or disorganised. Rarely incorporates test results or other data (e.g. nursing information). Incomplete or incompetent physical examination.</td>
<td>Gathers pertinent data, reports in an organised fashion. Utilises lab results and information from colleagues. Competent physical examination skills, occasionally misses findings.</td>
<td>Data complete and concise, presentations and write-ups are organised. Always uses test results and data from colleagues. Physical examination thorough, focused when appropriate, and reliable.</td>
<td>You develop good rapport with your patients and ask good questions. Now I’d like you to organise your history for each problem by symptom description, systems review for the involved system, past history of the problem, risk factors, etc. You do a good job of suggesting a diagnosis for each problem. Now, for each problem please list, in order, three most likely diagnoses and one ‘do-not-miss’ diagnosis. You seem to enjoy managing patients and when we get your presentations more organised, you’ll be able to ask yourself better questions that will let you choose tests and treatments.</td>
</tr>
<tr>
<td>Interpretation</td>
<td>Rarely/occasionally able to generate a differential diagnosis including most likely and do-not-miss. Difficulty justifying or demonstrating clinical reasoning.</td>
<td>Usually generates a good differential including most likely and do-not-miss diagnoses. Justifies and demonstrates clinical reasoning when prompted.</td>
<td>Consistently generates a good differential diagnosis including most likely and do-not-miss. Justifies and demonstrates clinical reasoning without prompting.</td>
<td>You do a good job of suggesting a diagnosis for each problem. Now, for each problem please list, in order, three most likely diagnoses and one ‘do-not-miss’ diagnosis.</td>
</tr>
<tr>
<td>Management</td>
<td>Rarely able to suggest appropriate tests or therapy. Relies on preceptor almost exclusively.</td>
<td>Almost always able to suggest appropriate tests or therapy. Looks up questions.</td>
<td>Consistently orders appropriate tests and therapy. Incorporates outside reading.</td>
<td>You do a good job of suggesting a diagnosis for each problem. Now, for each problem please list, in order, three most likely diagnoses and one ‘do-not-miss’ diagnosis.</td>
</tr>
<tr>
<td>Education</td>
<td>Rarely does outside reading or incorporates information into patient care. Knowledge base concerns. Relies on preceptor for learning. Rarely self-directed.</td>
<td>Almost always reads specialty texts when needed. Teaches preceptors something occasionally. Mostly self-directed. Understands and applies evidence-based medicine concepts.</td>
<td>Practises evidence-based medicine independently using primary and secondary sources. Summarises information for colleagues. Teaches preceptor something frequently.</td>
<td>You are doing a good job of reading from the syllabus when I ask you to look up something or you do a good job of answering questions. Now I’d like you to try to look up a question on each patient, e.g. differential diagnosis before you present (or before you do your write-up). I’d also like you to look up medications.</td>
</tr>
<tr>
<td>Skill area</td>
<td>Needs improvement</td>
<td>Competent</td>
<td>Strength</td>
<td>Next Steps (examples)</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Interpersonal skills</td>
<td>Often poor rapport with patients and colleagues, disorganised, disrespectful. Does not demonstrate empathy.</td>
<td>Respectful, good rapport with patients and colleagues. Able to demonstrate empathy.</td>
<td>Always respectful. Excellent rapport with patients and colleagues. Regularly demonstrates empathy.</td>
<td>You have outstanding interpersonal skills. The next time you have a very upset patient, I’d like to watch you as you specifically work on expressing empathy to establish rapport with the patient.</td>
</tr>
<tr>
<td>Professionalism</td>
<td>Sometimes unprofessional, leaves work undone. Sometimes unprepared. Does the minimum.</td>
<td>Prompt, appropriate. Follows through on patient care and educational issues as asked.</td>
<td>Always prompt, well prepared, professional. Does patient care follow-up without prompting. Self-directed.</td>
<td>As you like to manage patients, let’s start having you check the labs the day after the visit and make a plan on each patient. Then we’ll talk about it and you can call your patients with results.</td>
</tr>
</tbody>
</table>

The teacher circles or checks the level attained by the student. The Next Steps column is filled in by the teacher. Examples of feedback are provided here. This method differs from RIME evaluation in that in RIME evaluation a student is expected to consistently perform appropriately at a level before proceeding to the next level, but the form can be used for cross-level feedback. For example, a student might do well at interpretation but be disorganised despite this and still need feedback on his or her organisation (reporting) skills.