Qualified Assessor Competency Assessment Faculty Development Workshop

May 25, 2016

Agenda

1:00 Introductions, review agenda and objectives of session – Tracy Bumsted, MD, MPH

1:15 EPAs, Competencies, and Milestones – Carrie Phillipi, MD, PhD (30 minutes)

1:45 Group Practice Assessing Competency (25 minutes)
Video of Learner
Small Group / Large Group Discussion of Video

2:10 First Small Group Activity – Discussion Using Your Submitted Pre-Work (15 minutes)

2:25 Large Group Report Out – Summary. Commonalities? Difficulties? Tools We Need? (20 min)

2:45 **BREAK (15 minutes)**

3:00 Second Small / Large Group Activity – Determining Milestone Level (P, A, E) for 3 learners:

Student 1 – individual work →small group table discussion →large group discussion

Student 2 -- individual work →small group table discussion →large group discussion

Student 3 -- individual work →small group table discussion →large group discussion

4:05 EPA Teaching, Assessment and You – Carrie Phillipi, MD, PhD (25 minutes)

4:30 EPA Small Group Work (15 minutes)

4:45 Group Discussion Challenges – Carrie Phillipi, MD, PhD and Tracy Bumsted, MD, MPH

4:55 Wrap Up and Closing Comments – Tracy Bumsted, MD, MPH

Qualified Assessor Competency Assessment Workshop for Clinical Experience Directors

May 25, 2016

Purpose

The purpose of this workshop is to practice completing a series of competency-based assessments (CBAs) to improve inter-rater reliability, and to generate discussion between the clinical experience directors regarding methods and tools used to arrive at the milestone judgments, and best practices for CBAs.

Objectives

- At the end of the workshop, participants will be able to consistently determine milestone levels (i.e., Pre-entrustable, Approaching entrustable, and Entrustable) for simulated medical students based upon the distillation of quantitative and qualitative data obtained from assessment instruments used in the clinical experiences.
- At the end of the workshop, participants will have a shared mental model of how milestones, competencies, domains of competence, and Entrustable Professional Activities (EPAs) are related – and how their responsibilities in selecting milestone levels for specific UME competencies in their clinical experience relate to the larger UME programmatic determination of whether a student has met the required EPAs for graduation.

Pre-work

To ensure we have enough time to complete several competency based assessments together on May 25th, we would like each Clinical Experience Director to come prepared having completed the following pre-work. Completion of this pre-work will also jump start your ability to complete the first round of Final Grade and Competency Assessments that are due on May 6th. To help make this more manageable we have broken the pre-work into increments with associated due dates:

Step 1: **Due May 2, 2016.** Send your completed work to Leslie Haedinger at haedinge@ohsu.edu

1. Using the most updated version of your **Clinical Experience Syllabus**, locate and **review the Competencies** you have selected for your experience (there are 4-12 for most clinical experiences).
2. Create a **chart listing the data points you will need to see from the four graded components** (e.g. evaluations, skills demonstrations, other assessment tools, assignments, professionalism, participation, etc.) plus a **description of the output that you will receive from that assessment tool**. This will **help inform your milestone level** (i.e., Pre-entrustable, Approaching entrustable, and Entrustable) **for each competency** on the Final Grade and Competency Assessment form in MedHub. This is important as it will allow you to clearly define in your own mind the essential information you need to be an effective qualified assessor.
    - Some questions to think about when doing this pre-work:
        - Do you wish to use only the average evaluation response from all of a students' combined clinical assessments or do you want to see all of the individual assessments?
        - If using an oral or written exam, do you only want the exam score or do you want to see their actual exam as well?

- Example of Chart Listing Data Points for MK2 and PCP2 in Internal Medicine:

Assessment	Description of Output Data	Scale (if applicable)	Competencies Linked to Assessment
Clinical Assessment Tool completed by Attendings and Residents in MedHub	Likert scale, narrative (question 3 and 5 - average of all attendings' and residents' scores)	1 to 6 scale (will use distribution of Likert scores evaluators)	MK2, PCP2
IM HAPEE Average score	MCQ score	0 – 100	MK2, PCP2
SIMPLE key features exam score	Short answers with a rubric	0 – 25	PCP2

3. Bring your work with you to the workshop on the 25th.

Step 2: Due May 16, 2016 Send your completed work to Leslie Haedinger at haedinge@ohsu.edu

- Using the list of data points from #2 above, create **an example student data output as you would receive in a sample grade packet for a student who is both** Pre- entrustable and Entrustable for **each competency** you have tied to your experience. What does a Pre-entrustable and Entrustable student look like for your experience? What scores would you want to see to select the milestone level of Entrustable? What scores would suggest Pre-entrustable? When reading narratives, how is an Entrustable student described by attendings or residents? What knowledge, characteristics, and attitudes do they possess?

Example: Using Competency **MK2** in **Internal Medicine**:

- **Clinical Evaluation questions:**
  - #3- Applying Medical Knowledge in patient care
    - **Pre-Entrustable =** Key words from narratives used to describe the student: "Clueless", "needs major improvement", "lacks basic skills"
      Clinical Evaluation Tool: 3 and below on two or more evaluations.
      IM HAPEE Average score 70 or less
      SIMPLE key features score 15 or less

    - **Entrustable** = Key words from narratives used to describe the student: "conscientious", "trustworthy", "knowledgeable", "mature", "enthusiastic", "well-prepared."
      Clinical Evaluation Tool: 5 and above on two or more evaluations.
      IM HAPEE Average score 90 or more
      SIMPLE key features score 22 or more

Medical Knowledge 2: Apply established and emerging knowledge and principles of clinical sciences to diagnostic and therapeutic decision-making, clinical problem-solving and other aspects of evidence-based healthcare.

Pre-Entrustable	Entrustable
May remember and understand clinical science principles but does not yet apply the knowledge to common medical and surgical conditions and basic preventive care.	Possesses sufficient clinical science knowledge and the ability to apply that required knowledge to common medical and surgical conditions and basic preventive care (e.g., can make a diagnosis, recommend initial management, and recognize variation in the presentation of common medical and surgical conditions).

- Bring your work with you to the workshop on May 25th.

Core Entrustable Professional Activities for Entering Residency

AAMC
Tomorrow's Doctors, Tomorrow's Cures®

The Core EPAs for Entering Residency:

The OHSU Core EPA Team

George Mejicano, Tracy Bumsted, Sophie Davis, Matt Dietz, Deepthika Ennamuri, Michelle Favreau, Joe Gilhooly, Anna Nelson, Carrie Phillipi, Kayce Spear, Lainie Yarris, Jamie Warren

By the end of this workshop you will:

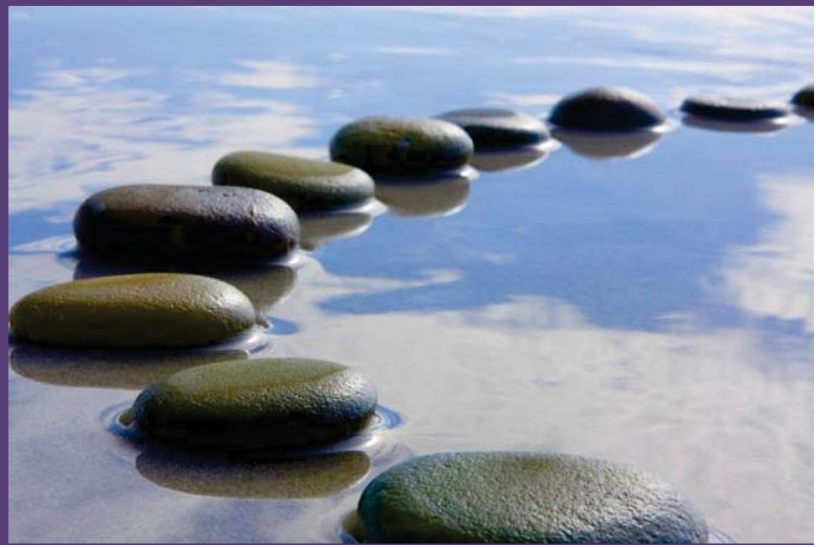
→Be able to describe an EPA to your colleague/ friend/ partner/mother

→Identify ideal places to teach and assess EPAs in your learning environment

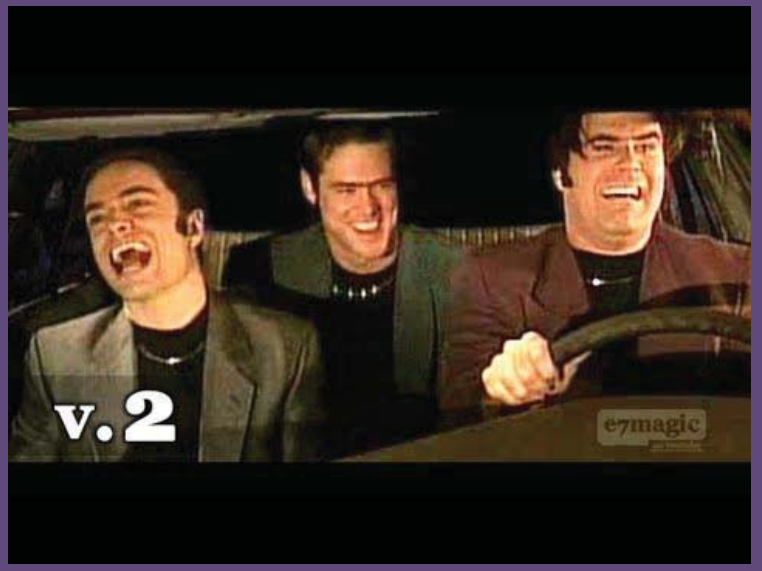
→Determine milestone levels (i.e.,Pre-entrustable, Approaching entrustable, and Entrustable) for simulated medical students from data obtained from assessment instruments used in the clinical experiences

→Understand how milestones, competencies, domains of competence, and Entrustable Professional Activities (EPAs) are related – and how selecting milestone levels for specific UME competencies in clinical experiences relate to the larger UME programmatic determination of whether a student has met the required EPAs for graduation.

What are the Core EPAs?




STUDENT
DRIVER
Please be
Patient


v.2
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EPA

An Entrustable Professional Activity is a "unit of professional practice, defined as ***tasks*** or ***responsibilities*** to be entrusted to the unsupervised execution by a trainee once he or she has attained sufficient clinical competence."

Olle ten Cate, 2013

Core Entrustable Professional Activities for Entering Residency

Charge: To delineate those activities that all entering residents should be expected to perform on day 1 of residency without direct supervision, regardless of specialty.

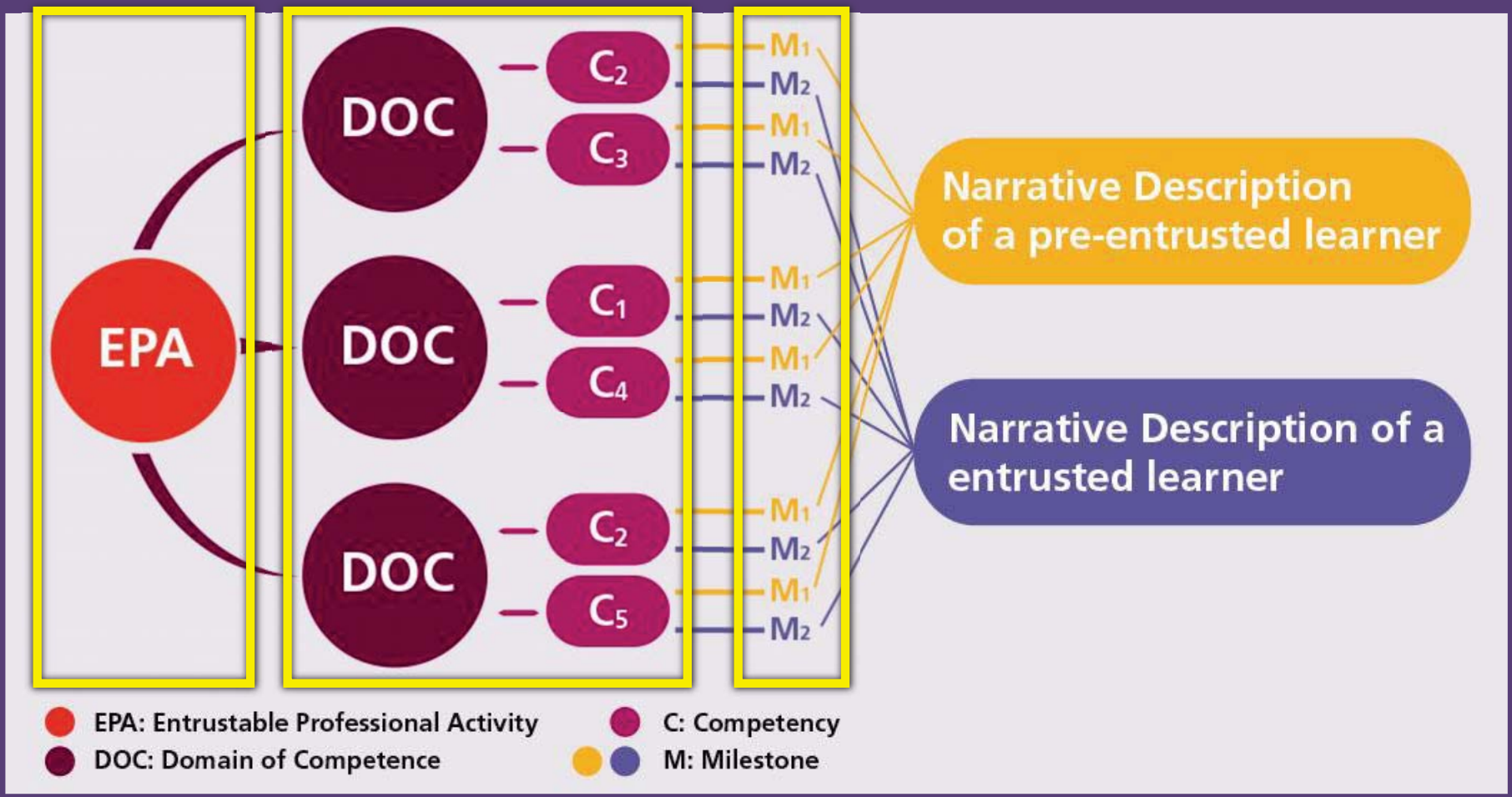
1. Gather a **history** and perform a **physical** examination
2. Prioritize a **differential** diagnosis following a clinical encounter
3. Recommend and interpret common diagnostic and screening **tests**
4. Enter and discuss **orders** and prescriptions
5. **Document** a clinical encounter in the patient record
6. Provide an **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 transition care responsibility
9. Collaborate as a member of an **interprofessional** team
10. Recognize a patient requiring **urgent** / emergent care and initiate evaluation / management
11. Obtain **informed consent** for tests and/or procedures
12. Perform general **procedures** of a physician
13. Identify **system failures** and contribute to a culture of safety and improvement

Core Entrustable Professional Activities for Entering Residency

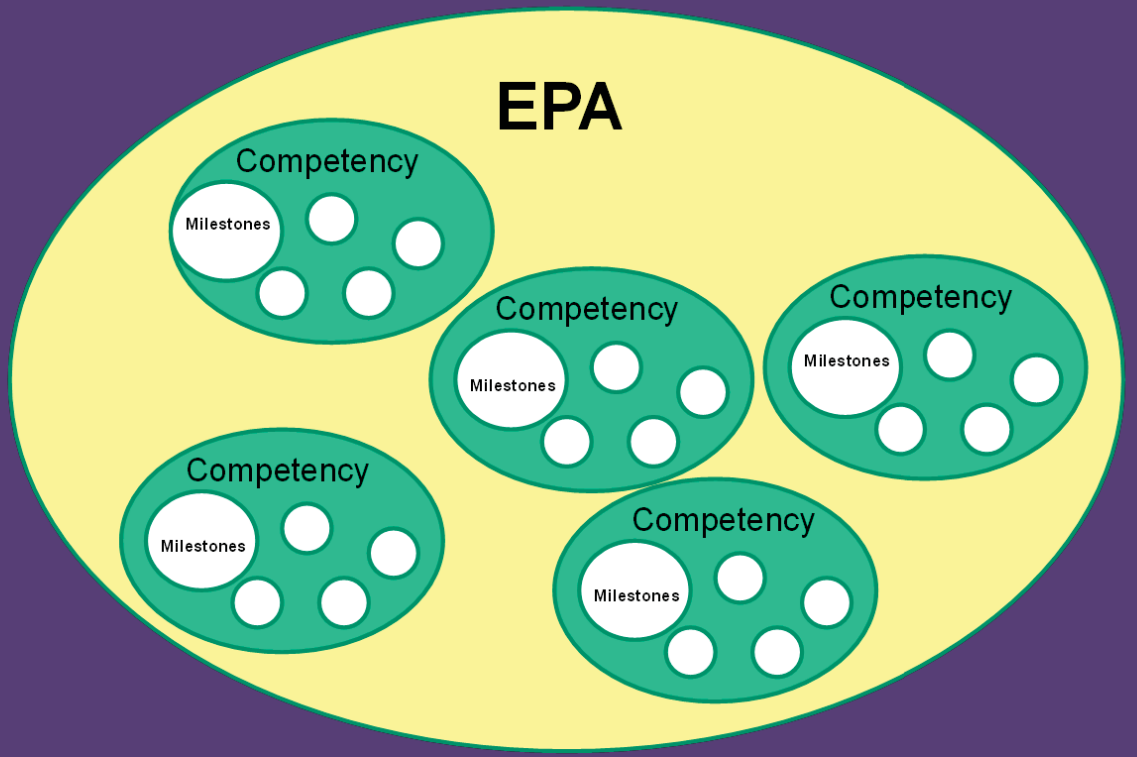
Entrustable Professional Activities

Competencies

Milestones

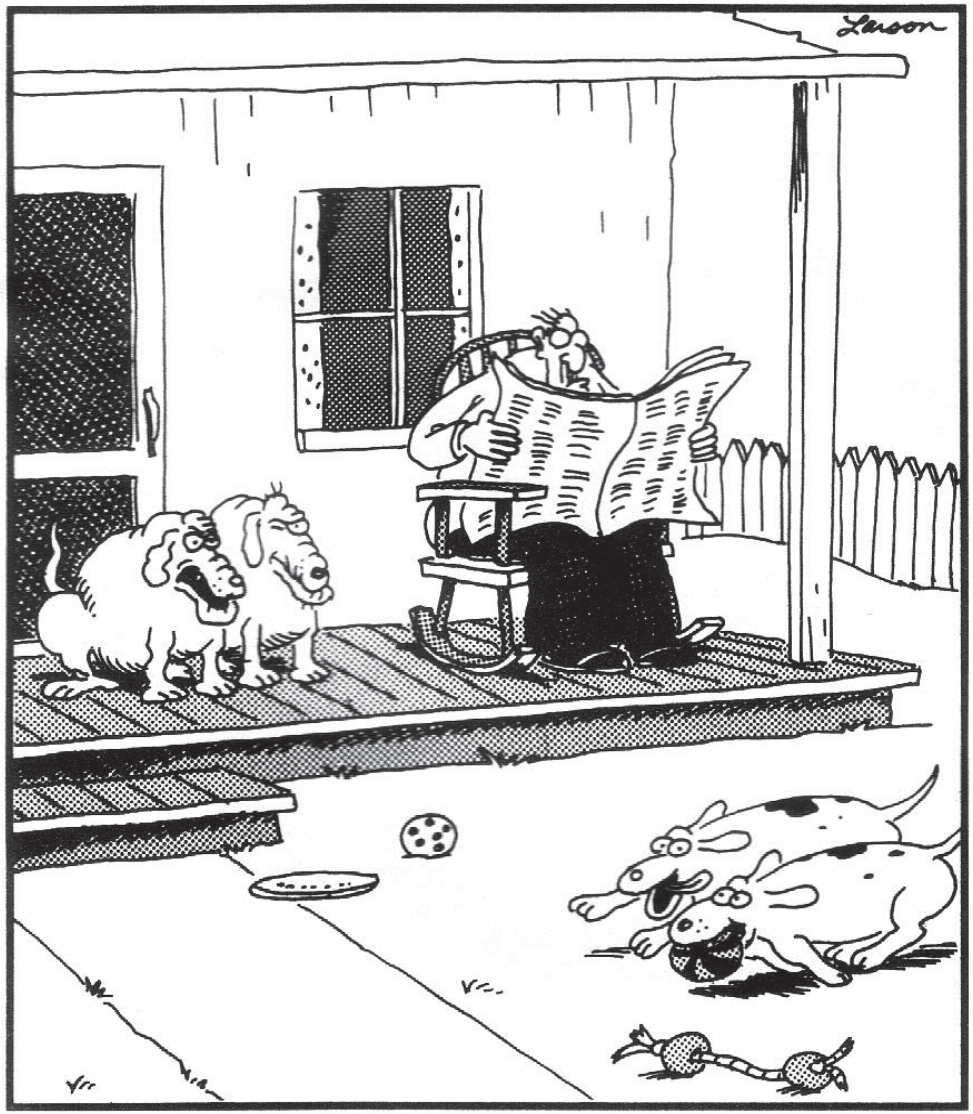


EPAs, Competencies, Milestones



Why bother?

Not as well trained as they used to be?



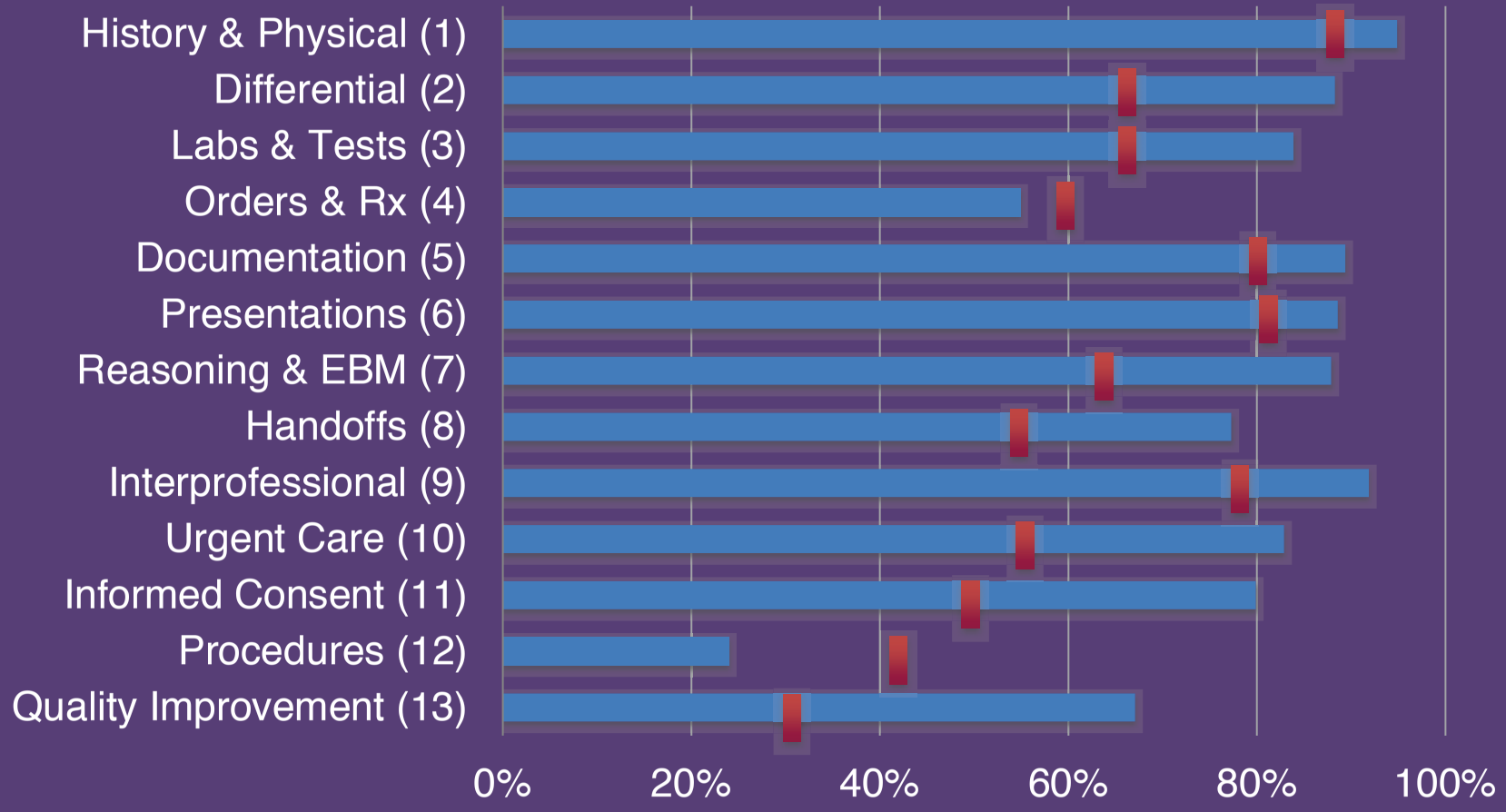
"Man, these pups today with all their fancy balls and whatnot. ... Why back in our day, we had to play with a plain old cat's head."

2014 Graduation Questionnaire

"How confident are you in your current ability to perform the following activities?"

2014 Program Director Survey

"Considering only the PGY1 residents in your program who are 2014 graduates of LCME-accredited U.S. medical schools, please indicate how many residents you are confident were prepared to do the following without direct supervision in the first week of residency."



Sondheimer 2014

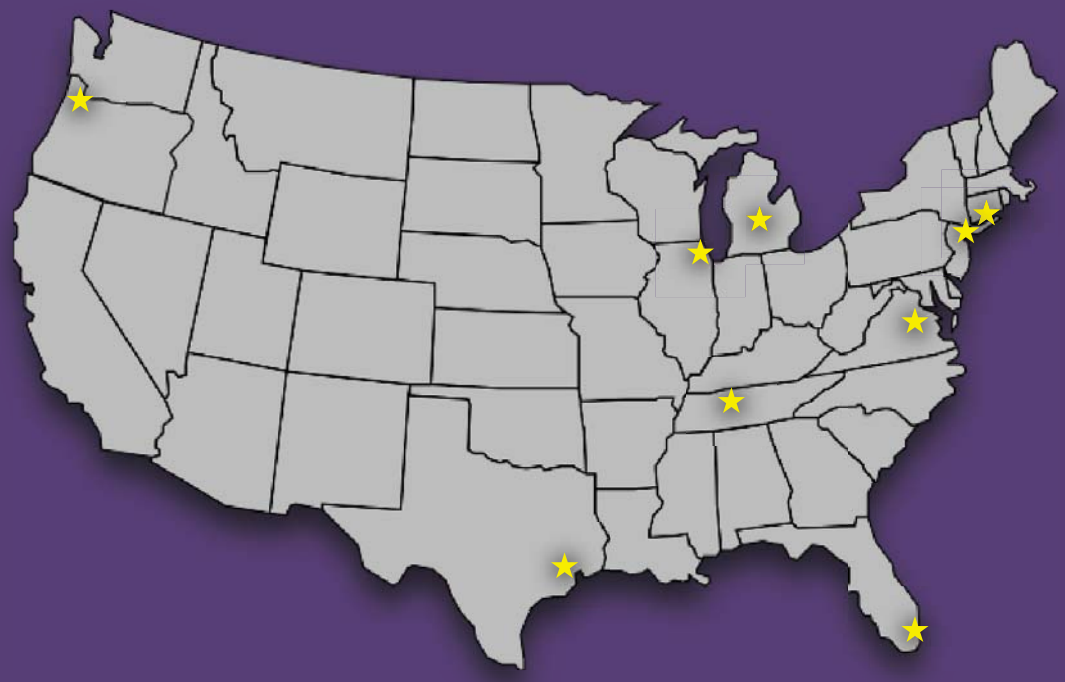
Vision To optimize safe and effective patient care by ensuring that each graduate from our medical schools is prepared for core initial duties as an intern

Aims To share lessons learned regarding the framework of the Core EPAs in order to optimize this approach and foster its propagation throughout UME institutions

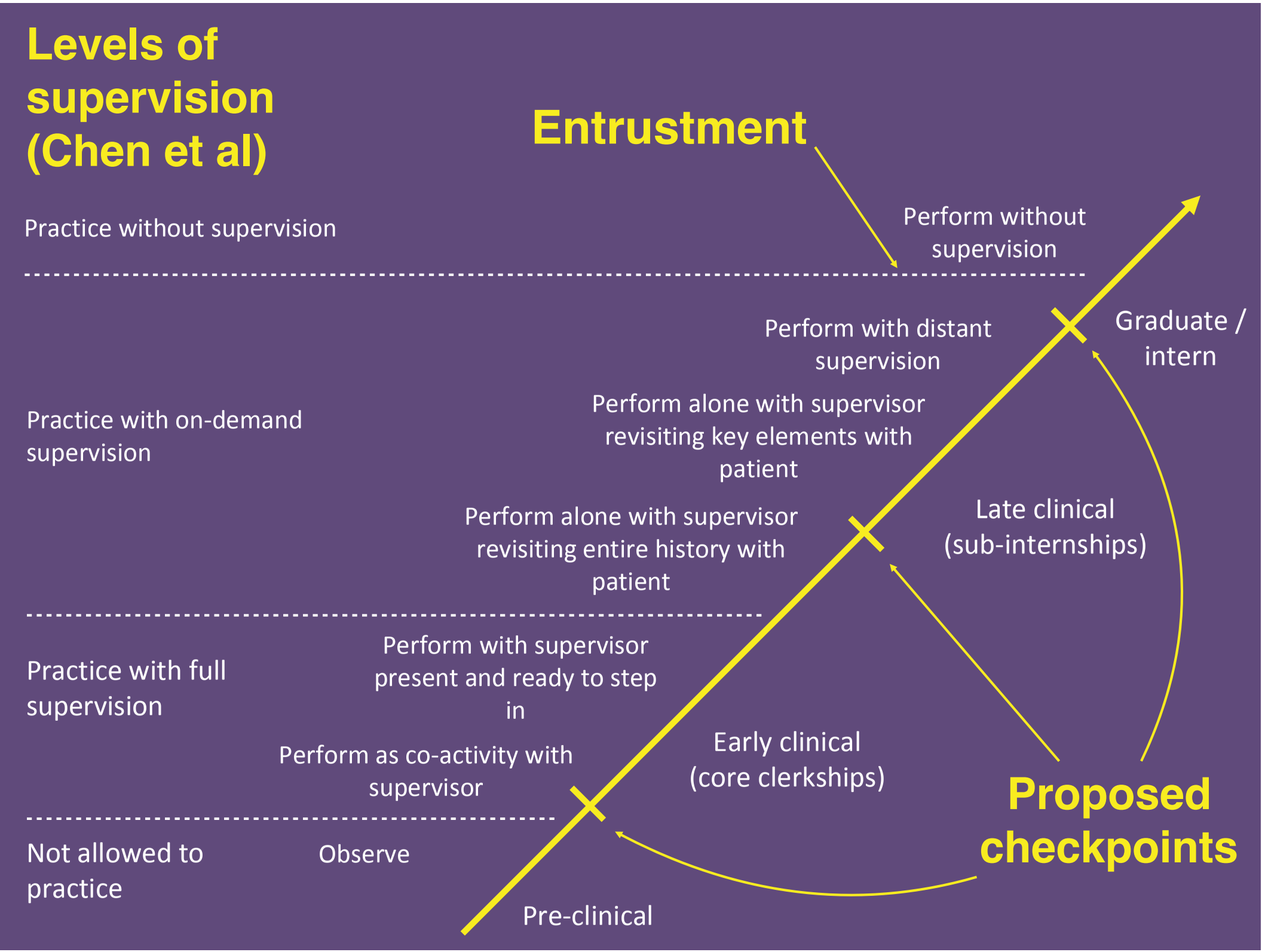
To facilitate the transition from UME to GME via valid assessments of student knowledge, skills, and trustworthiness in the EPAs

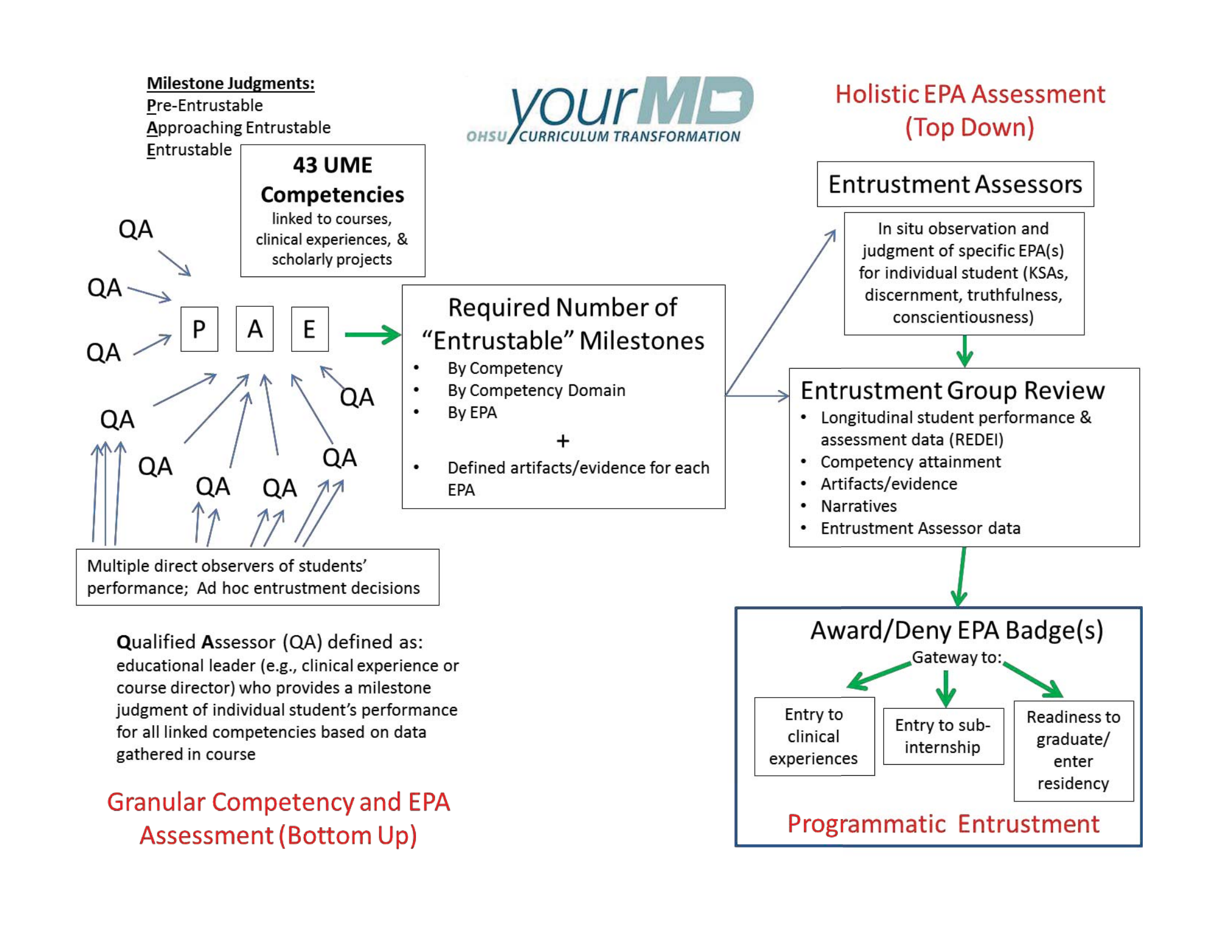
Institutions

- Columbia University
- Florida International University
- Michigan State University
- New York University
- Oregon Health & Science University
- University of Illinois
- University of Texas
- Vanderbilt University
- Virginia Commonwealth University
- Yale University

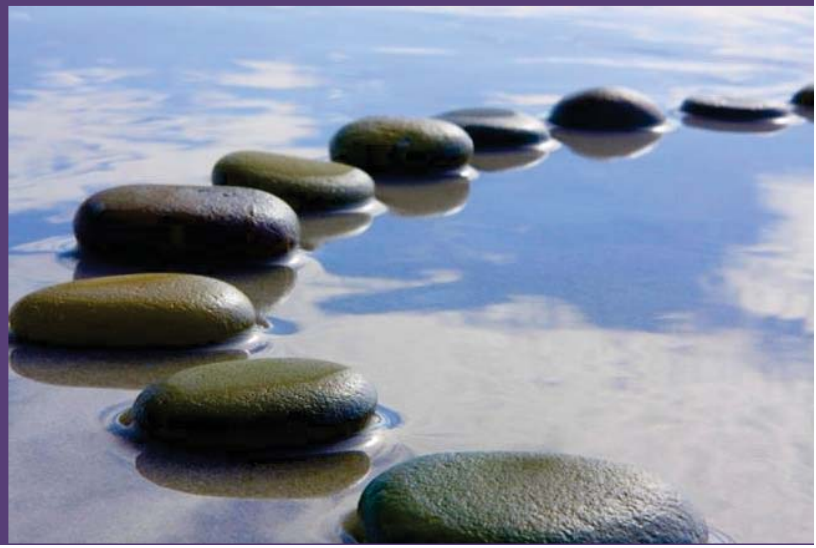


Term 5 Years (2014 - 2019)


Levels of supervision (Chen et al)
Entrustment
Practice without supervision
Perform without supervision
Perform with distant supervision
Graduate / intern
Practice with on-demand supervision
Perform alone with supervisor revisiting key elements with patient
Perform alone with supervisor revisiting entire history with patient
Late clinical (sub-internships)
Practice with full supervision
Perform with supervisor present and ready to step in
Perform as co-activity with supervisor
Early clinical (core clerkships)
Proposed checkpoints
Not allowed to practice
Observe
Pre-clinical


Milestone Judgments:
Pre-Entrustable
Approaching Entrustable
Entrustable
43 UME Competencies
linked to courses, clinical experiences, & scholarly projects
OHSU yourMD CURRICULUM TRANSFORMATION
Holistic EPA Assessment (Top Down)
Entrustment Assessors
In situ observation and judgment of specific EPA(s) for individual student (KSAs, discernment, truthfulness, conscientiousness)
QA
QA
QA
P
A
E
QA
QA
QA
QA
QA
QA
Required Number of "Entrustable" Milestones
By Competency
By Competency Domain
By EPA
+
Defined artifacts/evidence for each EPA
Entrustment Group Review
Longitudinal student performance & assessment data (REDEI)
Competency attainment
Artifacts/evidence
Narratives
Entrustment Assessor data
Multiple direct observers of students' performance; Ad hoc entrustment decisions
Award/Deny EPA Badge(s)
Gateway to:
Entry to clinical experiences
Entry to sub-internship
Readiness to graduate/ enter residency
Programmatic Entrustment
Qualified Assessor (QA) defined as:
educational leader (e.g., clinical experience or course director) who provides a milestone judgment of individual student's performance for all linked competencies based on data gathered in course
Granular Competency and EPA Assessment (Bottom Up)

Let’s Practice Assessing Competency



Trigger Encounter Video

An 18 month old child presents to the Pediatric Emergency Department with emesis and a first seizure

Special thanks to Dan Schumacher and Brad Benson for the writing and producing of this video

Performance Assessment

What if…
The Trainee was a MS-3 on an ED Elective

1. Unsatisfactory
2. Unsatisfactory
3. Unsatisfactory
4. Marginal
5. Satisfactory
6. Satisfactory
7. Superior
8. Superior
9. Superior

Performance Assessment

What if…
The Trainee was a PGY-3 Pediatric Resident on an ED Rotation

1. Unsatisfactory
2. Unsatisfactory
3. Unsatisfactory
4. Marginal
5. Satisfactory
6. Satisfactory
7. Superior
8. Superior
9. Superior

Performance Assessment

- Level1: Recites the history and physical and then looks to supervisor for synthesis and plan
- Level 2: Jumps from information gathering to broad evaluation without a focused differential
- Level 3: Synthesizes information to allow a working diagnosis and differential diagnosis that informs the evaluation and management plan
- Level 4: Rapidly focuses on correct working and differential diagnosis allowing for efficient and accurate evaluation and management plan

So what did we just do?

Assessed a learner using narratives that described their performance on the road to developing competency in making diagnostic and therapeutic decisions.

"The combination of the top-down and bottom-up approach to evaluating EPA performance is ultimately the most powerful. EPAs provide the clinical context for the assessment of competencies, which uses a "panoramic" lens for assessing learners who must integrate competencies to deliver care. Milestones provide a "zoom" lens for assessing the learner at a more granular level."

Englander R, Carraccio C.
Acad Med. 2014;89:1321–1323

Small Group Activity

Using the pre-work you submitted, share and discuss among your small group your data points and how you assign pre-entrustable, approaching entrustable, and entrustble milestones.

Large Group Report Out

Summary of how each dept. is reaching entrustable milestone decisions.

What are the commonalities you found in your small group from different disciplines?

Any difficulties, issues or concerns?

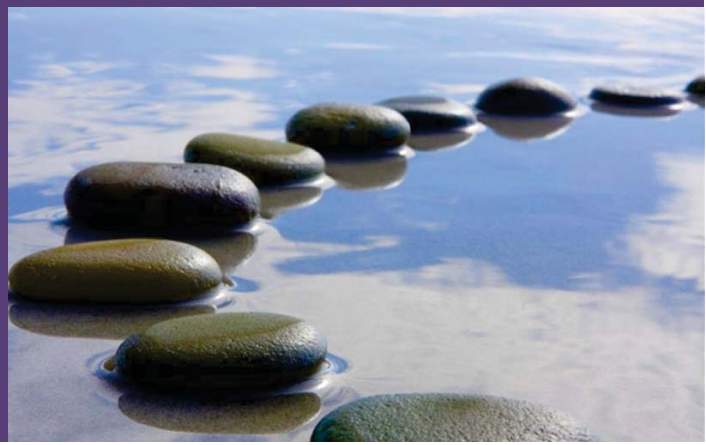
Small Group Activity

Determine Milestone Level

Student 1
Student 2
Student 3

EPA Teaching, Assessment & YOU

- What EPAs naturally fit in your clinical experience?
- What do you already teach?
- What do you assess?
- What sort of resources are needed for you to teach and assess an EPA?



Entrustment Concepts

- Type of decision
  - Ad hoc by supervisor in real time and done in authentic clinical settings
  - Summative decision by institution made by Clinical Competency or Entrustment Committees
- Four key aspects
  - Discernment
  - Truthfulness
  - Conscientiousness
  - Knowledge, skills and attitudes
- Level of supervision
  - Carrie Chen's Level 3a

What is EPAC?

Can this pilot help inform our work?

Sample Holistic EPA Assessment Form

UNIVERSITY OF MINNESOTA | EXTENSION
Driven to Discover℠

EPAC RATINGS FOR DOROTHY CURRAN

Based on your experience with Dorothy today, select your rating of Dorothy's current level of proficiency for **EPA 1: Gather a History and Perform a Physical Examination.**

- ○ 1a. Not trusted to practice EPA - Inadequate knowledge/skill; not allowed to observe (e.g., sterile field issues)
- ○ 1b. Not trusted to practice EPA - Adequate knowledge; some skill; allowed to observe
- ○ 2a. Trusted to practice EPA only under proactive/full supervision as coactivity with supervisor
- ○ 2b. Trusted to practice EPA only under proactive/full supervision with supervisor in room ready to step in as needed
- ○ 3a. Trusted to practice EPA under reactive/on-demand supervision with supervisor immediately available, all findings double-checked
- ○ 3b. Trusted to practice EPA under reactive/on-demand supervision with supervisor immediately available, key findings double-checked
- ○ 3c. Trusted to practice EPA under reactive/on-demand supervision with supervisor distantly available (e.g., by phone), findings reviewed
- ○ 4. Trusted to practice EPA unsupervised
- ○ 5. Trusted to supervise others in practice of EPA

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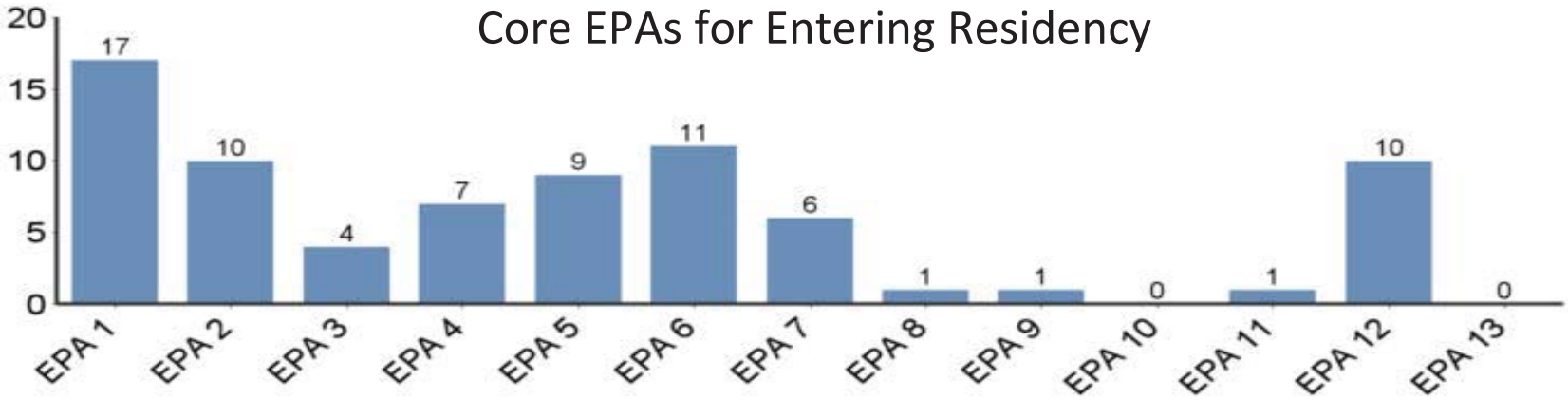
Sample Results from University of Minnesota

- Many evaluations: crowd sourcing entrustment decisions by gathering many “in the moment” observations
- Students have access to a live dashboard of all of their EPA assessments allowing them to monitor and plan their professional development



Sample of the number of times an EPAC student has been evaluated on each EPA to date. This student has had 61 evaluations in 5 months.

[Courtesy of Dr. Jenny Soep]

University of Colorado's UME Clinical Competency Committee

- Meets approximately every 6 months
- Reviews all student assessment data
  - Assessment forms and tools (paper and/or electronic)
  - Summative comments from clerkships
  - Student reflections
- Determines level of supervision required for EPAs in different contexts (well care, simple acute, chronic single, chronic complex, urgent/emergent)
- Creates summary report that is shared with student

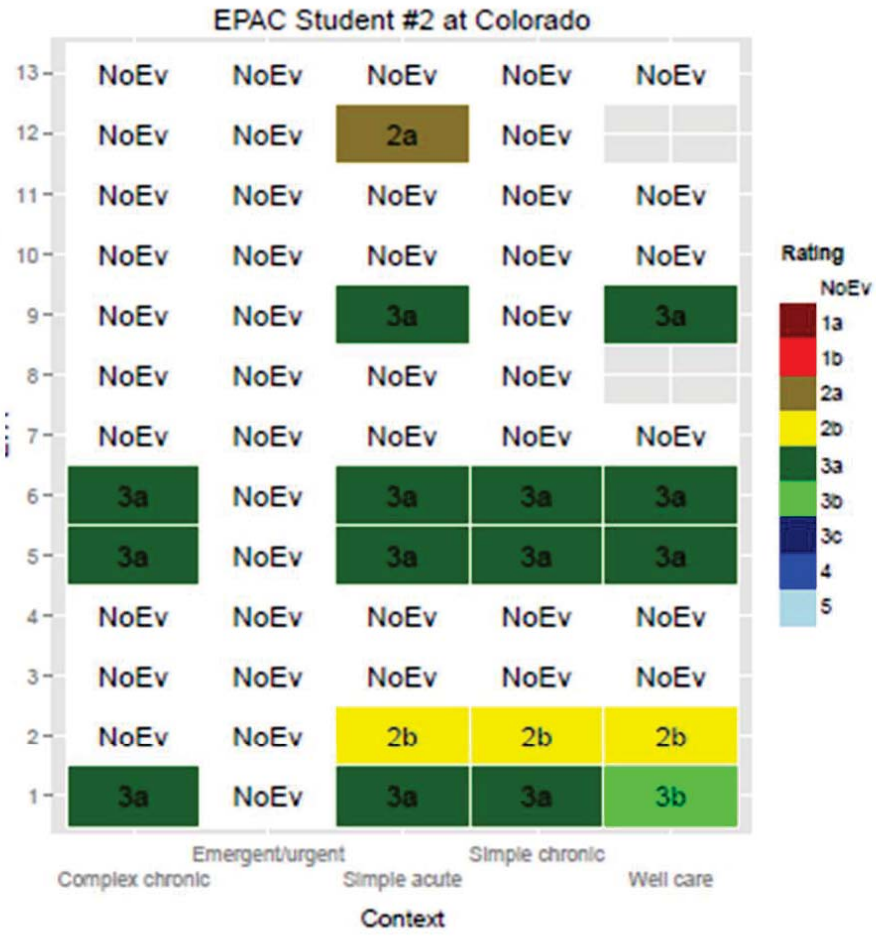
[Courtesy of Dr. Jenny Soep]

Colorado Student Assessment Summary Data

EPA/Context Table: EPAC Student #2 at Colorado

Beginning of Phase III (clerkships)

EPA	Well care	Simple acute	Simple chronic	Complex chronic	Emergent/urgent
1	3b	3a	3a	3a	NoEv
2	2b	2b	2b	NoEv	NoEv
3	NoEv	NoEv	NoEv	NoEv	NoEv
4	NoEv	NoEv	NoEv	NoEv	NoEv
5	3a	3a	3a	3a	NoEv
6	3a	3a	3a	3a	NoEv
7	NoEv	NoEv	NoEv	NoEv	NoEv
8	NA	NoEv	NoEv	NoEv	NoEv
9	3a	3a	NoEv	NoEv	NoEv
10	NoEv	NoEv	NoEv	NoEv	NoEv
11	NoEv	NoEv	NoEv	NoEv	NoEv
12	NA	2a	NoEv	NoEv	NoEv
13	NoEv	NoEv	NoEv	NoEv	NoEv

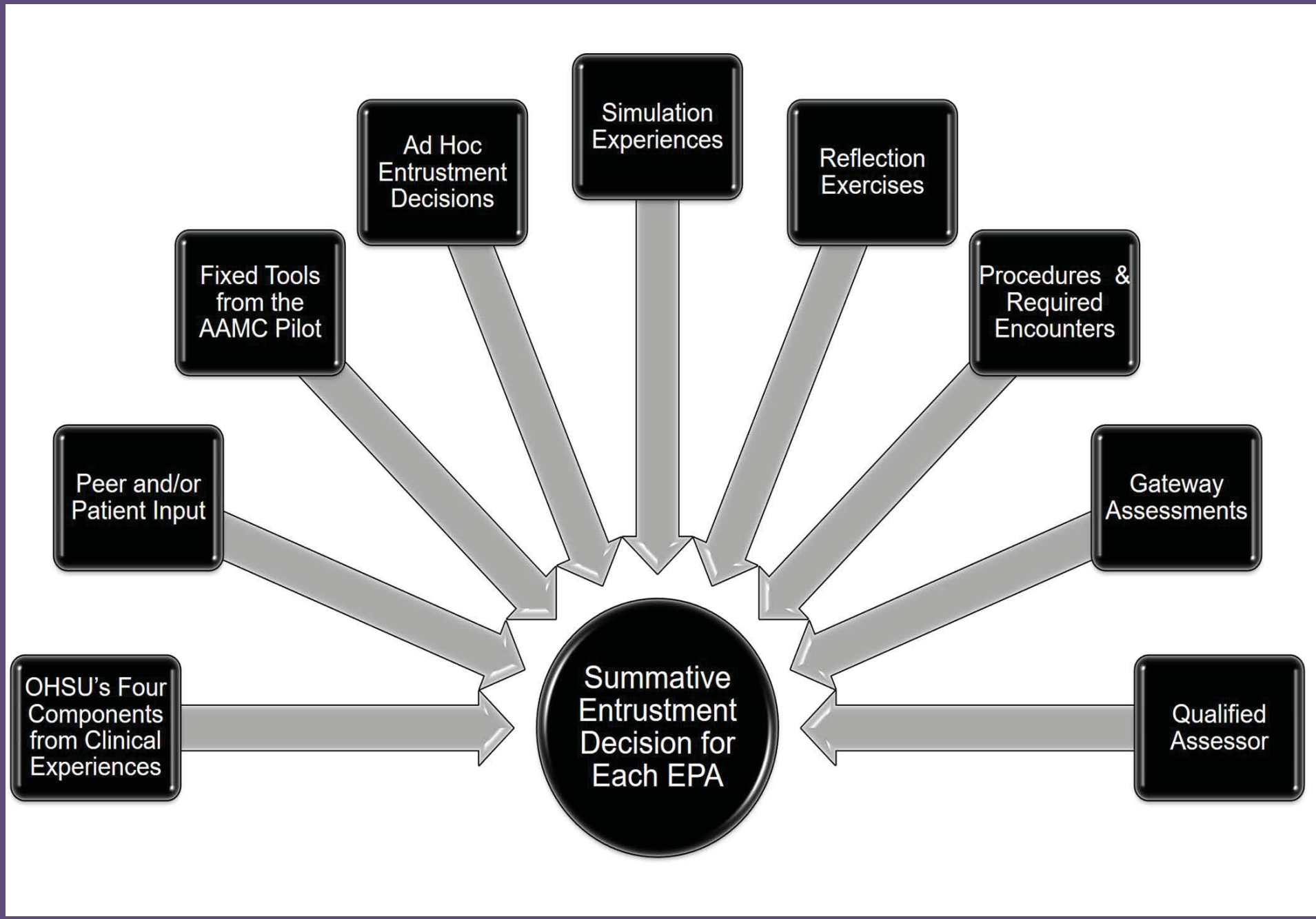


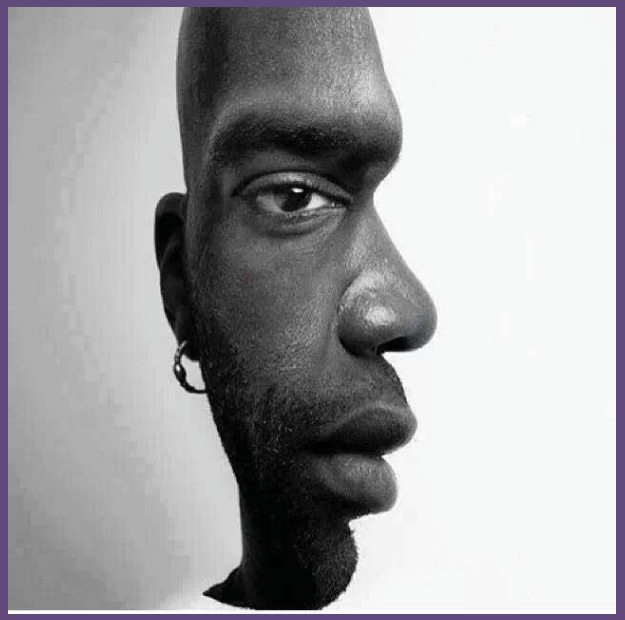
[Courtesy of Dr. Jenny Soep]

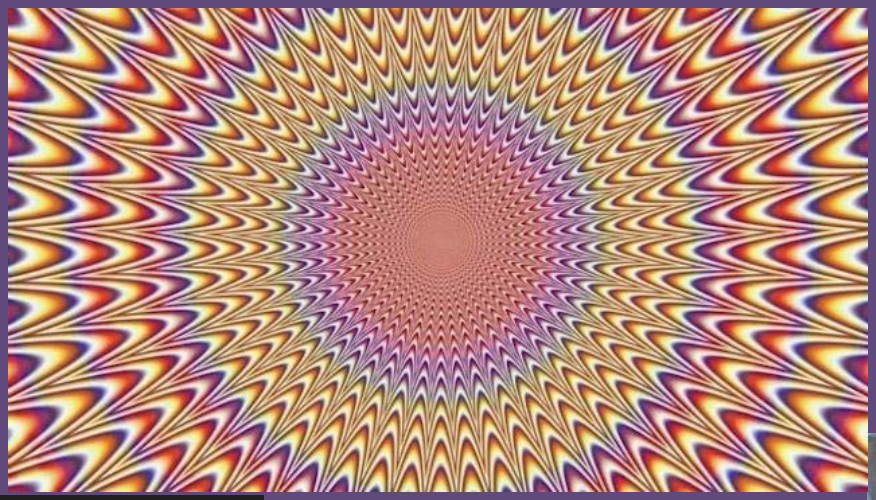
EPAC Sample of Assessment Instruments

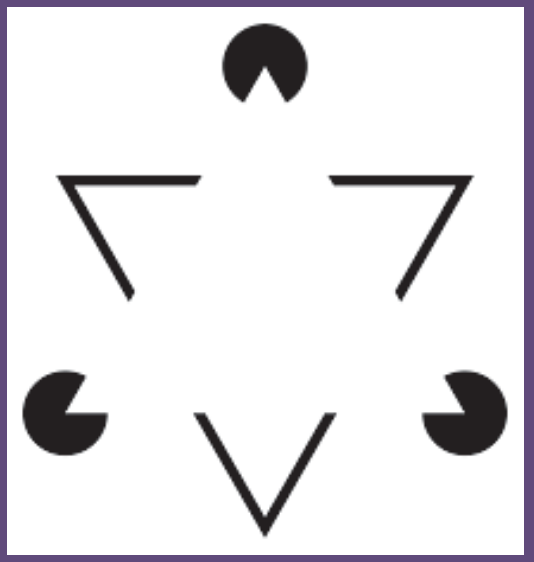
Instrument	EPA 2	EPA 7	EPA 9	EPA 10	EPA 13	General nature
Fresno Test of EBM		X				Test by learners, scored by faculty
Evidence-based practice questionnaire		X				Self-assessment
Faculty-observed EBM CATs		X				CATs by learners, scored by faculty
T-MEX			X			Faculty observations of behavior in teams
ICCAS (modified)	X		X			Self-assessment
QIKAT					X	Constructed response test, scored by faculty
MERIT					X	Reflection essays by learners, scored by faculty
UCSF QI Project Assessment					X	Faculty observations
CLIPP cases	X			X		Case analysis by learners, scored by faculty
PALS certification				X		Externally administered
APPD Western PedSCO	X					Faculty ratings of learners on an expertise scale using 29 items covering 4 domains (one of which, medical decision making, maps to EPA2)

[Courtesy of Dr. Jenny Soep]

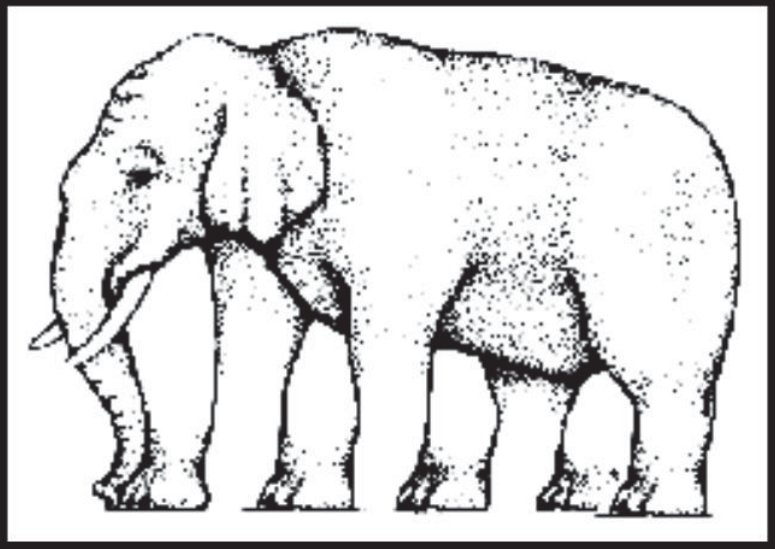

Simulation Experiences
Ad Hoc Entrustment Decisions
Reflection Exercises
Fixed Tools from the AAMC Pilot
Procedures & Required Encounters
Peer and/or Patient Input
Gateway Assessments
OHSU's Four Components from Clinical Experiences
Summative Entrustment Decision for Each EPA
Qualified Assessor







How Many Legs Does the Elephant Have?

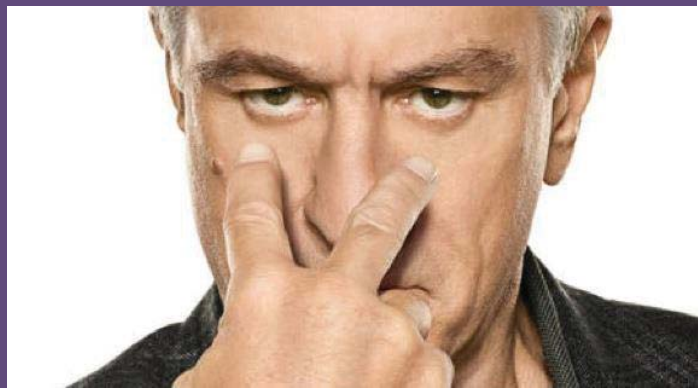


Group Work

- How will your EPA(s) be taught?
- How will your EPA(s) be assessed?
- How will entrustment occur?
  - -What does it mean, who confers?

Group Discussion Challenges

- How and when will entrustment decisions be rendered? Who will make the decisions? With what evidence?
- How do we develop faculty?
- What sort of resources are needed?
- Data Management?
- Remediation



Qualified Assessor Competency Assessment Faculty Development Workshop

May 25, 2016

Notes from Large Group Report Out

How have you approached completing the competency assessment so far?

- FM department created the customized form to assess Telemedicine competency. Formative OSCE simulated patient with diabetes or depression. Check list item map to entrustable language. Faculty fill out the checklist and comment.
- Incorporate entrustable verbiage into the clinical performance evaluation form.
- Map out competencies and use that to fill out the form. What we capture and what we are not capturing. Ideal world will be to incorporate various assessment tools, but in electives, there are some difficulties. Having a tool box available for directors will be helpful.
- Variabilities in performance evaluations by various evaluators → having multiple data points help to get more holistic view. But determining a cut-off is still difficult
- Taking a tool that existed already and tied competencies.
- Looked for consistencies from various evaluators in terms of numerical values as well as comments.

Challenges:

- Wording is confusing – "pre-entrustable", "approaching entrustable", "entrustable" for an individual competency. Suggest changing these milestone terms to something other than entrustment may help differentiate this from the EPAs that will be determined by the UME program.
- In rural elective, often times, there is only one preceptor filling out a clinical performance evaluation. QA has to base his/her competency milestone judgement upon one set of data/comments.
- In order to get data points, needed to modify and include more question items in the clinical performance evaluation form. Lengthy evaluation and rubric could potentially cause evaluation fatigue.
- Discrimination of students' performance based on the clinical evaluation form is difficult.
- Extreme (obviously entrustable or obviously pre-entrustable) is easy to identify, but approaching entrustable could be gray zone.
- The word entrustable is a loaded word. QA may not feel conformable with making the judgment.
- Using data from clinical performance evaluation forms to assign entrustable decisions on competencies is not as comfortable as assigning letter grades based. This could be due to competency assessment being such a new concept for MD students.
- How do we accurately assess students who the QA may not have worked directly with, and how do we overcome barriers of making milestone judgments?
- Need more experience with tools to feel comfortable.
- "Threshold setting"

What tools do you need?

- Beginning of clerkship, maybe assign faculty to fill out only a certain element or portion of the evaluation. Quality vs quantity.
- Crafting right verbiage for behavioral anchors on standard clerkship evaluation form, may make it easier in a long run. Anchor descriptions should be concise while giving enough explanation to evaluators.
- Responsibility to students – Sean Robinson wanted to be able to show students how the decisions were made in terms of entrustability, to be able to justify grading/milestone judgments.
- Common rubric would be helpful.
- Need to create inter-clerkship alignment of tools that are used by each clerkship for a same competency. For example, PCP1 is assessed in many clerkships, should all clinical experiences with that linked competency be using the same method to determine milestone judgment?
- Ability to add competencies would be great.
- The way this information is fed to students to MedHub is very limited. It would be great to have more detailed info provided to students.

STUDENT 1

Assess milestone level for SBPIC 4 competency

Evaluator 1:

Inadequate understanding of own limitations
Does not sufficiently demonstrate Teamwork

I did not have any issues, but many of my co-residents said he was very inappropriate and difficult to work with on the XX service, was threatening to some of the xx Residents.

Only worked with this student very briefly for a few hours when rounding, but had great enthusiasm and excitement about all subjects! Always had a big smile on his face.
Again, many concerns expressed by other residents although I did not have any issues.

Evaluator 2:

This student was so much fun to have on the XX service. He is one of the first 2nd year students have had the pleasure to work with on XX and his enthusiasm was off the charts. He was always excited to learn new things and introduced himself with a smile to patients. His presentations were well organized, and his understanding of YY was better than the 4th years of previous classes. Also, he worked well with his fellow students, and would often give them praise for their work when they were not around. I hope he is interested in YY and comes to OHSU for residency.

Evaluator 3:

Very enthusiastic and eager to learn. This was his first clinical rotation of medical school and he performed very well. Good rapport with treatment team. Excellent use of evidence-based medicine.

Evaluator 4:

After the first week, we discussed some concerns that arose between this student
and the residents on the team. By the time I talked with him, he had made some insights into things that he could have handled differently and had adjusted his expectations (this being his first clinical rotation). There were emails from senior residents assigning work and plans to meet. There were additional concerns for the residents in how he received feedback, which was offputting (such as suggestion to limit distracted learning by not looking at his screen on rounds or others were teaching). At times, he felt like he may not have been fully included (knowing where to be) and times when he didn't feel like he was being given as much opportunity to see patients (in particular, with a ZZ patient, I think he misconstrued the residents recommendation
that they examine the patient together). The communication between this student
and the resident escalated in texts/emails, to the point where he felt that he didn't want to participate in that patient's care anymore. This did not translate into any inappropriate care, and he met all clinical expectations. He revised his expectations for what he wanted to prioritize as a student (focusing on learning opportunities and not so

focused on finding ways to do things FOR us so that we would not have to do it ourselves). We also discussed ways that he could have handled the communication with the residents differently, and his comments were mature, and without any malice or defensiveness. There were no professionalism concerns in the second week with us, and I believe that he adjusted quite well to a difficult situation, having felt uncomfortable with the group dynamics the week before. He was told that I would be noting our conversation in this evaluation, not in a punitive way, but to help identify patterns that would ensure he would be most successful in residency and afterwards, which he acknowledged.

He is a well prepared medical student. He gave very well organized case presentations. He adapted presentations to more efficiently focus on pertinent negatives and positives. He looked up background information on conditions that were discussed outside of the context of his own patients, just to edify his learning, which is not something I see the majority of medical students doing when they have free time in the work room. He was able to provide supplemental journal information about YY manifestations of TTT, which helped with clinical decision making for the team.
I see many strengths and a lot of promise. I see intelligence and ambition. I encourage him to continue working on interpersonal communication with team members (residents, nurses, MAs, etc), and seek to understand others points of views. Use opportunities to learn from others' clinical experiences and not just from journal articles (you should be supplementing your education and finding the evidence base through lit searches, best performed after rounds).

Evaluator 5:

Inadequate understanding of own limitations
Does not sufficiently demonstrate Teamwork

I felt this student has difficulty with boundaries within the team and initially did not understand the difference between his role and the role of the resident. He appeared to feel threatened when residents took care of his patients. He also reacted to feedback (which we tried to give gently) with anger and defensiveness. He felt that he was not adequately informed about what the rotation entailed, but I and the other residents felt that we had tried to be clear with him, and other medical students including other 2nd years on their first rotation did not have this issue. I do believe that after reflection, he took our feedback to heart and modified his behavior accordingly.

He was very enthusiastic. He did a very good job of getting information from the original literature about the disease processes affecting our patients. When given feedback, he worked to correct the problems we pointed out.

This was his first rotation and I am certain that he will improve greatly during the next two years. His enthusiasm is obvious. I would like to see him be more involved in caring for and advocating for his patients, and in absorbing the constant education that occurs on rounds.

STUDENT 2

Assess milestone level for PCP 1 competency

Evaluator 1:

As part of the new curriculum, he is very early in his stages of information gathering. He was instructed to continue working on focusing on relevant information to shorten his patient interviews and provide a more succinct summary of the patient information.

He came to clinic with excitement and seemed ready to learn. He was prepared with reading on a chosen topic prior to clinic to focus on a relevant patient issue. He was motivated to modify his XX exam techniques to improve patient comfort. We discussed continuing to read on clinical topics of interest to improve his relevant clinical knowledge for patient care. We also discussed working on focusing the history and physical on relevant details.

Evaluator 2:

Appropriate for first rotation, though is very quiet and this contributes to a seemingly disorganized presentation with a lack of confidence

Student Patient Communication Skills: Appropriate for first rotation, though awkward with patients when interviewing them

Still developing his style of communicating with patients, which will evolve as he progresses through rotations.

Evaluator 3:

Attentive in teaching, prepared for rounds, made progress on clinic presentations

Evaluator 4:

Easy to work with. He was eager to be helpful to the team.

STUDENT 3

Assess milestone level for ICS 1 competency

Evaluator 1:

He is exceptionally kind and thoughtful in the care of his patients.

He has a good fund of knowledge and is diligent, polite, kind and honest in the provision of patient care. His oral and written presentations are at expected level for this, his first clinical rotation. He worked well patients and residents and we were proud to have him represent the xx team. He was eager to learn and be helpful, and established good rapport across the board.

As an early learner, I suggest to review his oral and written summary statements and problem-based plans in conjunction with his residents to better show his thought processes by mid-morning/mid-day. He should continue to follow a template for oral and written clinical documentation early in his training to ensure information flows in a logical and expected manner. Once these initial steps are secure, he can work toward formulating more robust assessments and plans.

Evaluator 2:

He engaged well with the patients and staff. He was always respectful, prepared and eager to learn.

He is an enthusiastic and motivated learner. He worked hard and showed improvement of presentations and in his ability to develop a meaningful differential diagnoses during this short rotation.

You have started out very strong for your first rotation!

Evaluator 3:

He was wonderfully professional . He became very comfortable with family interactions, and was consistently wonderful

He did a wonderful job in his first clinical experience. He was able to identify areas he wished to work on, and he made great strides in gathering and reporting information. By the end of our week, he was consistently reporting basic information, and starting to add more complexity and refinement to his reporting. His ability to manage patients increased over the week, and he became very comfortable with routine xx issues. I really appreciated that I could push him a bit when he was uncertain, and he did a terrific job of reasoning through new or more complex scenarios. He is going to be a great medical student, and he is well on his way!

Evaluator 4:

Great communication with patients and staff, very considerate and receptive to patient's attitudes, eager and enthusiastic

He was far above average with his communication skills. He knows how to read a room and patients-- I was never worried how he would handle a sensitive situation. He readily jumped at any opportunity to learn, he was grateful and extremely pleasant to work with. He was consistently professional, polite and enthusiastic.

He incorporated feedback effectively. He worked very hard to improve and refine his skills. For his very first inpatient rotation, he did very well! He was truly a pleasure, and one of my favorite students I've ever worked with. He will undoubtedly become a great clinician and an even better colleague due to his great attitude and disposition.

I discussed with him in person, but he could continue to improve the efficiency of his presentations and written notes as well as consistently present information in the appropriate order. I encouraged him to be bold and "strong and wrong" to improve the confidence of his presentations. He truly was a delight to work with!

Competency Worksheet- Core Department CEs

Clinical departments with core experiences : *Using the UME Competencies document and the Core department framework as references, link the 43 competencies* ***by domain*** *to each core department experience. Each experience must have a* ***minimum of four (4)*** *competencies*

	Family Medicine (4)	Internal Medicine (8)	Neurology (10)	Obstetrics/ Gynecology (13)	Pediatrics (8)	Psychiatry (10)	Surgery (8)
PCP		1,2,3	1,2,3	1,2,3	1,2, 4	1,2	1, 3
MK	2	2	1,2	2		1	2
PBLI	1	1	1	1		1	1
ICS	8,5	1	4,8	1	1, 7	1,5	5
PPPD		1,9	10	1, 10	9,10	1,9,10	9
SBPIC				3,4		4	3

Competency Worksheet- Elective Department CEs

Clinical departments with elective experiences : *Each experience must have a* ***minimum of four (4)*** *competencies*

	ANST 709A (4)	DERM 709A (6)	RADD 709A (6)	EMED 709D (4)	GERI 709 (8)	MGEN 709A (5)	OPTH 709A (5)	ORTH 709D (4)	OTOL 709E (8)	PATH 709A (8)	ORTH 709E rehab (4)	AMBL 709 Rural (6)	RSP Incl. FM core (8)
PCP	6	1, 2	2, 3, 4	6	1, 2, 3	1	1, 2	1	1, 2, 3		1, 2	1, 3	5
MK		1	2, 3			2		1	2	1, 2		2	2, 4
PBLI	1	2				4		1	1	1, 2		1	1
ICS					2, 7, 8	2	8		5	5, 6	1	6	1, 5, 8
PPPD	8	9	9	1, 11	1	1	7	6	9	10	10		
SBPIC	4	4		4	5		5		3	4		4	3

Preamble: In August, 2014, Oregon Health & Science University (OHSU) School of Medicine (SoM) launched a new curriculum for its entering medical school class. This curriculum transformation was the result of several years of planning, widespread input from key stakeholders, and careful deliberation in order to fundamentally change how we educate physicians-in-training so that we may achieve our primary goal: to optimally prepare our graduates for 21st century residency education and professional practice in order to meet the needs of society. The OHSU SoM Undergraduate Medical Education (UME) competencies outlined below have evolved from the previous *UME Program Objectives* from 2013, and are aligned with local and national perspectives for competency-based education. Specifically, the OHSU SoM UME Competencies in this document were compiled and devised using four primary sources:

- OHSU SoM UME Program Objectives (2013)
- OHSU Graduation Core Competencies (2013)
- Clinical Informatics Competencies for UME (2014)
- Association of American Medical Colleges (AAMC) General Physician Competencies (https://members.aamc.org/eweb/upload/Core%20EPA%20Curriculum%20Dev%20Guide.pdf)

Each of the 43 numbered competencies listed herein is categorized under one of six Domains of Competence (DOC) in **bold**. This is consistent with the Accreditation Council of Graduate Medical Education (ACGME) competency nomenclature for residency education and because of the continuum of medical education from UME to GME, and from GME to continuing professional development and lifelong learning. Medical students at OHSU will obtain the M.D. degree once all M.D. program graduation requirements have been met. This includes, but is not limited to, achieving designated milestones associated with each competency below as evidenced by robust, multi-modal competency-based assessments in classroom settings, as well as in both simulated and authentic (actual) clinical environments.

As competency-based medical education and assessment evolves, so will the OHSU SoM UME Competencies. In particular, as Entrustable Professional Activities (EPAs) and UME milestones are defined across and within, respectively, the competencies listed herein, the language in this document will be refined to best describe the desired learning outcomes for OHSU SoM medical graduates. Periodic minor updates and revisions to this document will be presented first to the SoM UME Curriculum Committee, and then to a smaller workgroup of the SoM Faculty Council for approval, members of which will be named by the Dean. Larger, substantive changes to this document will be presented first to the SoM UME Curriculum Committee before final approval by the full Faculty Council and subsequently, the Dean of the SoM.

Patient Care and Procedures: Provide patient-centered care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

1. Gather essential and accurate information about patients and their conditions through history taking, physical examination, review of prior data and health records, laboratory data, imaging and other tests.

Pre-Entrustable	Entrustable
Either gathers too little information or exhaustively gathers information following a template, regardless of the patient's chief complaint, with each piece of information gathered seeming as important as the next. Recalls clinical information in the order elicited. Limited ability to gather, filter, prioritize, and connect pieces of information. Still developing skills to correctly perform and elicit physical examination maneuvers. Takes a head-to-toe approach to the physical examination rather than tailoring it to the developmental level or behavioral needs of the patient. Does not seek or is overly reliant on secondary data.	Clinical experience allows linkage of signs and symptoms of a current patient to those encountered in previous patients. When gathering information, is able to filter, prioritize, and synthesize it into pertinent positives and negatives as well as broad diagnostic categories. Performs basic physical examination maneuvers correctly and recognizes and correctly interprets abnormal findings. Consistently and successfully uses a developmentally appropriate approach to the physical examination. Seeks and obtains data from secondary sources when needed.

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2. Interpret and critically evaluate historical information, physical examination findings, laboratory data, imaging studies, and other tests required for health screening and diagnosis.

Pre-Entrustable	Entrustable
Is inconsistent in interpreting basic diagnostic tests accurately. Still needs assistance with the concepts of pre-test probability and test-performance characteristics.	Consistently interprets basic diagnostic tests accurately. Understands the concepts of pre-test probability and test-performance characteristics.

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3. Construct a prioritized differential diagnosis and make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment.

Pre-Entrustable	Entrustable
Recalls and presents clinical facts in the history and physical in the order they were elicited without filtering, reorganization, or synthesis. Analytic reasoning through basic pathophysiology precludes pattern recognition and results in an exhaustive list of all diagnoses considered rather than the development of working diagnostic considerations, making it difficult to develop a therapeutic plan. The absence of a focused differential and working diagnosis also precludes incorporation of patient preferences into the diagnostic and management plan.	Abstracts and reorganizes elicited clinical findings using semantic qualifiers (such as paired opposites that are used to describe clinical information [e.g., acute and chronic]) to compare and contrast the diagnoses being considered. The emergence of pattern recognition in diagnostic and therapeutic reasoning typically results in a well-synthesized and organized assessment of a focused differential diagnosis and management plan. The focused differential and working diagnosis allows incorporation of patient preferences into the diagnostic and management plan.

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4. Develop, implement, and revise as indicated, patient management plans.

Pre-Entrustable	Entrustable
Develops and carries out management plans based on directives from others, either from the health care organization or the supervising physician. Does not routinely adjust plans based on individual patient differences or preferences. Communication about the plan is unidirectional, from the student to the patient/family. Inconsistently seeks additional guidance or consultation when needed.	Develops and carries out management plans based on both theoretical knowledge and some experience, especially in managing common problems. Follows health care-institution practice guidelines and treatment algorithms as a matter of habit and good practice rather than as an externally imposed sanction. Plans begin to incorporate patients' assumptions and values through more bidirectional communication, thus allowing for shared decision making. Consistently seeks additional guidance and consultation as needed.

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5. Apply personalized healthcare services to patients, families, and communities aimed at preventing health problems and maintaining health.

Pre-Entrustable	Entrustable
Less knowledgeable about health maintenance concepts. Inconsistently performs patient-specific (e.g., based on patient age, gender, risk factors) screening procedures. Answers patient's and families' questions, but does not routinely offer anticipatory guidance.	Has knowledge of health maintenance concepts. Uses available resources and begins to seek new and current resources, guidelines, and recommendations for health promotion and disease prevention. Usually performs patient-specific screening procedures. Typically offers anticipatory guidance without prompting. Frequently identifies unhealthy behaviors and other risk factors during patient interactions and addresses those with the patient/family.

6. Perform all medical, diagnostic, and surgical procedures considered essential for the specific clinical practice context.

Pre-Entrustable	Entrustable
Limited basic procedural skills including airway management, administration of universal precautions, and aseptic technique. Attempts, but has not yet mastered, listing indications, contraindications, anatomic landmarks, equipment, procedural technique, or potential risks and complications.	Demonstrates basic procedural skills including the administration of universal precautions and aseptic technique. Consistently able to list indications, contraindications, anatomic landmarks, equipment, procedural technique, potential risks and complications in procedural notes.

<u>Medical Knowledge (Knowledge for Practice)</u>: Demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care.

1. Apply established and emerging bio-medical scientific principles fundamental to the healthcare of patients and populations.

Pre-Entrustable	Entrustable
May remember and understand biophysical scientific principles but does not yet apply that knowledge to common medical and surgical conditions and basic preventive care.	Possesses sufficient biophysical scientific knowledge and the ability to apply that required knowledge to common medical and surgical conditions and basic preventive care (e.g., can make a diagnosis, recommend initial management, and recognize variation in the presentation of common medical or surgical conditions).

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2. Apply established and emerging knowledge and principles of clinical sciences to diagnostic and therapeutic decision-making, clinical problem-solving and other aspects of evidence-based healthcare.

Pre-Entrustable	Entrustable
May remember and understand clinical science principles but does not yet apply the knowledge to common medical and surgical conditions and basic preventive care.	Possesses sufficient clinical science knowledge and the ability to apply that required knowledge to common medical and surgical conditions and basic preventive care (e.g., can make a diagnosis, recommend initial management, and recognize variation in the presentation of common medical and surgical conditions).

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3. Apply principles of epidemiological sciences to the identification of health risk factors, prevention and treatment strategies, use of healthcare resources, and health promotion efforts for patients and populations.

Pre-Entrustable	Entrustable
May remember and understand epidemiologic principles but does not yet apply the knowledge to common medical and surgical conditions and basic preventive care. Inconsistently able to identify resources and recommend their use to help prevent common illnesses and promote health.	Possesses sufficient knowledge of epidemiology and the ability to apply that required knowledge to common medical and surgical conditions and basic preventive care (e.g., can make a diagnosis and recommend initial management). Able to identify resources and recommend their use to help prevent common illnesses and promote health.

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4. Apply principles of social-behavioral sciences to assess the impact of psychosocial and cultural influences on health, disease, care-seeking, care-adherence, barriers to and attitudes toward care.

Pre-Entrustable	Entrustable
Inconsistently considers the psychosocial and cultural influences on a patient's health and care plan. May be able to recognize when a patient has not adhered to a prescribed care plan, but still developing skills to assist patients in identifying barriers to overcome challenges.	Routinely considers psychosocial and cultural influences on a patient's health and care plan. Able assist patients having difficulty adhering to a treatment plan, helping them identify barriers and adapt plan that may address their challenges.

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5. Apply principles of performance improvement, systems science, and science of health care delivery to the care of patients and populations.

Pre-Entrustable	Entrustable
Limited knowledge or experience with quality measurement and improvement, Plan-Do-Study-Act (PDSA) cycles and error reduction processes. Limited ability to adequately interpret data related to performance measures such as run charts. Limited knowledge or experience with the various	Articulates the value of standardization in reducing errors and applies this in caring for patients in clinical settings. Uses measurement to understand the variance across the health care system. Constructs and interprets Plan-Do-Study-Act (PDSA) performance improvement cycles and run charts for

elements of the health care system, taking a physician-centered approach to patient care.	measures of performance of key processes. Articulates how various elements of the health care system (patients, families, populations, caregivers, procedures, activities, and technologies) are interdependent, and can apply this knowledge to meet the needs of individuals and communities.



<u>Practice-based Learning and Improvement</u>: Demonstrate the ability to investigate and evaluate the care provided to patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on analysis of performance data, self-evaluation, and lifelong learning.

1. Demonstrate skills necessary to support independent lifelong learning and ongoing professional development by identifying one's own strengths, deficiencies, and limits in knowledge and expertise, set learning and improvement goals, and perform learning activities that address gaps in knowledge, skills or attitudes.

Pre-Entrustable	Entrustable
Relies on external prompts for understanding one's strengths, deficiencies, and limits. The learner acknowledges these external assessments, but understanding of performance is superficial and limited to the overall grade or bottom line; there is less understanding of how the performance measure relates in a meaningful way to the learner's specific level of knowledge, skills, and attitudes. Reflection and insight into performance and help-seeking is in development, but not yet mature. Sets learning and improvement goals that are overly broad and/or may not be connected to personal insight, accountability, and self-improvement.	Relies primarily on internal prompts for understanding one's strengths, deficiencies and limits through a process of reflection and insight. Reflection may be in response to uncertainty, discomfort, or tension in completing clinical duties; a critical incident; or suboptimal practice or outcomes. Recognizes limitations and has developed a personal value system of help-seeking for the sake of the patient that supersedes any perceived value of physician autonomy, resulting in appropriate requests for help when needed. Sets learning and improvement goals that are connected to personal insight, require personal accountability and prompt meaningful reflection upon achievement or non-achievement.

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2. Participate in the education of peers and other healthcare professionals, students and trainees.

Pre-Entrustable	Entrustable
Limited or inconsistent attempts to provide evidence-based information to help peers and healthcare professionals understand any complex topics related to the practice of medicine.	Consistently provides evidence-based and factually correct information to help peers and healthcare professionals understand any complex topics related to the practice of medicine.

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3. Use clinical decision support tools to improve the care of patients and populations.

Pre-Entrustable	Entrustable
Lacks awareness of and inconsistently uses clinical decision support tools for patient management including drug-drug interaction checking, clinical alerts and preventive care reminders, patient data templates and order sets.	Demonstrates awareness, appropriate use, and limitations of clinical decision support tools for patient management including drug-drug interaction checking, clinical alerts and preventive care reminders, patient data templates and order sets. Tailors use of clinical decision support tools to specific clinical situation.

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4. Use information technology to search, identify, and apply knowledge-based information to healthcare for patients and populations.

Pre-Entrustable	Entrustable
Generally does not initiate attempts to use information technology without assignments and direct help. Unsure how to choose between multiple available databases for clinical query or for addressing learning needs. Does not routinely filter or prioritize the information retrieved, resulting in too much or not useful information. .	Demonstrates a willingness to try new technology for patient care assignments or learning. Able to identify and use several available databases, search engines, or other appropriate tools, resulting in a manageable volume of information, most of which is relevant to the clinical question. Basic use of an electronic health record (EHR) is improving, as evidenced by greater efficacy and efficiency in performing needed tasks. Beginning to identify shortcuts to finding the right information quickly, such as using filters. Also avoids shortcuts that perpetuate incorrect information in the EHR.

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5. Continually identify, analyze, and implement new knowledge, guidelines, practice standards, technologies, products, and services that have been demonstrated to improve outcomes.

Pre-Entrustable	Entrustable
Dependent on external direction to identify, analyze, and implement new knowledge, guidelines, standards, technologies, products, or services that have been demonstrated to improve outcomes. Sometimes reconsiders a new approach to a problem or seeks new information. Needs assistance to translate new medical information into patient care. Unfamiliar with critical appraisal in clinical research studies.	Starts to take some initiative but dependent on the helps of others to identify, analyze, and implement new knowledge, guidelines, standards, technologies, products, or services that have been demonstrated to improve outcomes. Routinely reconsiders approaches to a problem or seeks new information. Can translate new medical information needs into patient care. Able to critically appraise a topic by analyzing the major outcomes; however, may need guidance in understanding the subtleties of the evidence.

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6. Analyze practice data using quality measurement tools and adjust clinical performance with the goal of improving patient outcomes and reducing errors.

Pre-Entrustable	Entrustable
Still developing skills in reflection on practice. Limited understanding of quality reporting, types of quality measures, the principles of quality-improvement methodology or change management. Still developing skills to learn from the results of his or her practice. Still reliant on external prompts to inform and prioritize improvement opportunities at the population level.	Able to reflect on practice with the aim of adjusting clinical performance to improve health outcomes. Knowledgeable about types of quality measures, how these are calculated, and quality reporting. Readily grasps improvement methodologies enough to actively participate in quality-improvement efforts to improve care of both individual patients and populations.

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7. Participate in scholarly activity thereby contributing to the creation, dissemination, application, and translation of new healthcare knowledge and practices.

Pre-Entrustable	Entrustable
Limited or inconsistent attempts to conduct comprehensive literature searches for constructing relevant scholarly questions, or develop methods addressing gaps in the current field of knowledge. Still learning skills in effectively conveying how a proposed project will improve healthcare knowledge and/or practices. May not actively contribute to the implementation of the project to address specific aims. Unable to clearly communicate project rationale, methods, results, and conclusions to others.	Consistently able to systematically search the literature and develop relevant scholarly questions and, when appropriate, hypotheses. Can develop a feasible project that addresses the scholarly question(s), and can communicate how the project will improve healthcare knowledge and/or practices. Actively participates in the implementation of the project to address specific aims. Able to clearly communicate project rationale, methods and results to others, and synthesize how information learned will improve healthcare knowledge and/or practices.

8. Incorporate feedback received from clinical performance data, patients, mentors, teachers, and colleagues into clinical practice to improve health outcomes.

Pre-Entrustable	Entrustable
Receives feedback that is provided but still developing skills in solicitation of feedback. Limited incorporation of feedback into practice (e.g., through superficial or only transient change in behavior).	Regularly solicits feedback and engages in reflection. Internal sources of feedback allow for insight into limitations and engagement in self-regulation. Improves practice based on both external (solicited or unsolicited) feedback and internal insights (e.g., is able to point out what went well and what did not go well in a given encounter and makes positive changes in behavior as a result).

<u>Interpersonal and Communication Skills</u>: Demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

1. Communicate effectively with patients, families and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds.

Pre-Entrustable	Entrustable
Communication with patients and families generally unidirectional and based on a template. Still developing skills in varying the approach based on a patient's unique demographic, cognitive, physical, cultural, socioeconomic, or situational needs. Uses medical jargon. Still developing skills in engaging patients and families in discussions of care plans including shared decision making. Respects patient preferences when offered by the patient, but does not actively solicit preferences. Is uncomfortable or defers difficult conversations to other, more advanced members of the care team.	Communication with patients and families generally bidirectional. When based on a template, can adapt to the patient's unique demographic, cognitive, physical, cultural, socioeconomic, or situational needs. Avoids medical jargon. Uses a variety of techniques, including nontechnical language, teach back, appropriate pacing, and small pieces of information to ensure that communication with patients and their families is bidirectional and results in shared decision making. Is comfortable with even the most difficult communication scenarios.

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2. Counsel, educate and empower patients and their families to participate in their care and improve their health; enable shared decision-making; and engage patients through personal health records and patient health information access systems.

Pre-Entrustable	Entrustable
Conversations with patients and families contain medical jargon. Still developing skills in adjusting communication to a patient's specific circumstances. Defers discussion or questions with patients and families to other, more advanced team members. Defines a plan for the patient, rather than encouraging shared decision-making.	Engages in active listening to the patient/ family, allowing for the expression of caring, concern, and empathy. Maintains a respectful tone and rarely uses medical jargon. Assesses patient/family understanding. Recognizes that patients have varying circumstances and involves patient/family in shared decision making.

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3. Demonstrate insight and understanding about pain, emotions and human responses to disease states that allow one to develop rapport and manage interpersonal interactions.

Pre-Entrustable	Entrustable
Still developing skills in anticipating or reading others' emotions in verbal and nonverbal communication. Still developing skills in effectively managing strong emotions in self or others.	Anticipates, reads, and reacts to emotions in real time with appropriate and professional behavior in typical medical communication scenarios, including those evoking very strong emotions. Uses these abilities to gain and maintain therapeutic alliances with others.

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4. Use health information exchanges (e.g., Care Everywhere within the EPIC electronic health record) to identify and access patient information across clinical settings.

Pre-Entrustable	Entrustable
Inconsistently seeks and retrieves patient data from outside health information systems. May lack awareness of appropriate use of health information exchange systems such as Care Everywhere, immunization registries, and prescription drug monitoring program.	Actively seeks and retrieves patient data from outside health information systems. Recognizes appropriate use and limitations of health information exchange systems such as Care Everywhere, immunization registries, and prescription drug monitoring program.

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5. Effectively access, review, and contribute to the electronic health record for patient care and other clinical activities.

Pre-Entrustable	Entrustable
May neglect to review parts of the electronic health record database, or verify its accuracy with external sources. May neglect to inform the team of electronic health record errors or omissions. Documentation is in early development, and may be incomplete, or does not routinely include all important data and/or communicate clinical reasoning. Chooses templates without adequate alteration, possibly including no longer accurate or incorrect information. Documentation may take an excessive amount of time to be finalized and	Consistently reviews all parts of the electronic health record, verifying accuracy of the information as appropriate. Documentation is accurate and comprehensive and tailored to the specific situation. If used, templates are tailored to include only accurate and pertinent information. Appropriately utilizes electronic health record data sets and consistently is able to pend accurate and appropriate orders. Clinical reasoning is well documented. Documentation is completed and available in a timely fashion.

submitted. . May be able to verbalize desired orders, but is not reliably able to pend accurate orders in the electronic health record.	

☐ ☐ ☐

6. Effectively communicate with colleagues, other health professionals, and health related agencies in a responsive and responsible manner that supports the maintenance of health and the treatment of disease in individual patients and populations.

Pre-Entrustable	Entrustable
May communicate using a template or prompt with rules-based recitation of facts. Communication does not change based on context, audience, or situation. Still developing skills in matching communication tool to situation (e.g., email, telephone, pager, texting, electronic health record [EHR], face-to-face).	Successfully tailors communication strategy and message to the audience, purpose, and context in most situations. Fully aware of the purpose of the communication; can efficiently tell a story and provide rationale for decisions. Beginning to improvise in unfamiliar situations. Generally matches the communication tool to the situation.

☐ ☐ ☐

7. Effectively communicate patient handoffs during transitions of care between providers or settings, and maintain continuity through follow-up on patient progress and outcomes.

Pre-Entrustable	Entrustable
Demonstrates variability in quality of transfer of information (content, accuracy, efficiency, and synthesis) during a handoff. Still developing skills in using available resources (e.g., information from EHR) to coordinate and ensure safe and effective patient care within and across delivery systems.	Adapts and applies a standardized template, relevant to individual contexts, reliably and reproducibly during handoffs. Consistently uses available resources (e.g., information from EHR) to coordinate and ensure safe and effective patient care within and across delivery systems. Allows ample opportunity for clarification and questions. Occasionally anticipates potential issues for the recipient of the information.

☐ ☐ ☐

8. Act in a consultative role, including participation in the provision of clinical care remotely via telemedicine or other technology.

Pre-Entrustable	Entrustable
May choose to use telemedicine or technology in clinical scenarios where safety requires an in person consultation. May neglect to ensure that the patient/ consultant can hear/see/understand clearly. Still working on maintaining focus on the patient while using technology. The addition of the technology interface may cause frustration or difficulty with making informed clinical recommendations.	Chooses clinical applications which are safe to use this form of technology. Ensures patients/consultants are able to see/hear/understand using the technology. Makes adjustments and acknowledges any distractions when necessary to accommodate for technologic issues. Does not allow the technology interface to distract the focus on the patient. Is able to make informed clinical recommendations using the technology interface.

☐ ☐ ☐

Professionalism and Personal & Professional Development: Demonstrate a commitment to carrying out professional responsibilities, an adherence to ethical principles, and the qualities required to sustain lifelong personal and professional growth.

1. Demonstrate responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disability, socioeconomic status, and sexual orientation.

Pre-Entrustable	Entrustable
Sees the world through the eyes of his or her own background, may be ethnocentric, does not always seek to understand and/or accept the cultures of others. May generalize based on the patients' gender, age, culture, race, religion, disabilities, and sexual orientation.	Elicits and seeks to fully understand each patient's unique characteristics and needs based on gender, age, culture, race, religion, disabilities, and sexual orientation. Includes these concepts in care plans for patients and families. Families recognize this sensitivity. Demonstrates cultural humility.

☐ ☐ ☐

2. Demonstrate respect for protected health information and safeguard patient privacy, security, and autonomy.

Pre-Entrustable	Entrustable
Unintentionally compromises patient privacy and confidentiality such as discussing patient information in a public area (e.g., in an elevator) or accesses patient records for those not in their care. Still developing skills to protect patient privacy related to HIPAA. Still developing skills to solicit and incorporate patient preferences into practice.	Consistently maintains patient privacy and confidentiality related to HIPAA (e.g., only discusses patient care in private, secure environments). Accesses patient information in a secure manner and on appropriate patients. Engages patients and families in discussions of care plans (i.e., shared decision making). Solicits and respects patient preferences.

☐ ☐ ☐

3. Demonstrate a commitment to ethical principles pertaining to provision or withholding of interventions, palliative care, confidentiality, informed consent, and business practices, including conflicts of interest, compliance with relevant laws, policies, and regulations.

Pre-Entrustable	Entrustable
Has a basic understanding of ethical principles, formal policies and procedures, and does not intentionally disregard them, but does not apply them consistently to different ethical dilemmas.	Adheres to ethical principles and generally applies them consistently across ethical dilemmas. Follows formal policies and procedures. Acknowledges and limits conflict of interest.

☐ ☐ ☐

4. Demonstrate sensitivity, honesty, and compassion in difficult conversations about issues such as death, end-of-life issues, adverse events, bad news, disclosure of errors, and other sensitive topics.

Pre-Entrustable	Entrustable
Does not accurately anticipate or read others' emotions in verbal and nonverbal communication. Is unaware of one's own emotional and behavioral cues and may transmit emotions in communication (e.g., anxiety, exuberance, and anger) that can precipitate unintended emotional responses in others. Does not effectively manage one's own strong emotions or those of others.	Anticipates, reads, and reacts to emotions in real time with appropriate and professional behavior in typical medical communication scenarios, including those evoking very strong emotions. Uses these abilities to gain and maintain therapeutic alliances with others.

☐ ☐ ☐

5. Adhere to professional standards when using information technology tools and electronic/social media.

Pre-Entrustable	Entrustable
May unintentionally compromise patient confidentiality such as discussing cases in public areas. Occasionally accesses patient information for those they are not giving care to, or may post information pertaining to patient encounters on social media. Does not routinely obtain consent prior to taking clinical pictures of patients.	Maintains patient confidentiality. Accesses patient information in a secure manner and on appropriate patients. Discusses patient care in private, secure environments. Responsibly and ethical use of social media, and does not use social media for any aspect of patient-related experiences. Obtains proper consent for using any healthcare information whether it is de-identified or not.

☐ ☐ ☐

6. Demonstrate responsiveness to patient needs that supersedes self-interest by mitigating conflict between personal and professional responsibilities.

Pre-Entrustable	Entrustable
Inconsistently demonstrates responsiveness to patient needs in favor of self-interests. May leave the clinical setting right at sign-out/last clinic patient regardless of whether care responsibilities are finished. Schedule requests may be common, excessive or inappropriate.	Consistently responds to patient needs over fulfilling own self-interests. Consistently ensures all patient care responsibilities are complete. Always demonstrates punctual attendance. Understands that being present and on-time is a crucial component of medical education and patient care and therefore limits absences/time-off requests to those that are absolutely unavoidable.

☐ ☐ ☐

7. Demonstrate awareness of one's knowledge, skills, and emotional limitations and demonstrate healthy coping mechanisms and appropriate help-seeking behaviors.

Pre-Entrustable	Entrustable
Can identify basic principles of physician wellness, but does not yet employ them consistently. Unclear of the boundaries of a student's scope of practice in clinical settings. May accept feedback from faculty and colleagues but does not readily seek it out.	Identifies and employs basic principles of physician wellness. Consistently recognizes limits of knowledge and asks for assistance. Seeks constructive feedback from faculty members, colleagues and/or other members of the healthcare

Inconsistently incorporates feedback provided. Reluctant to ask for help. Ineffectively copes with stress inherent in medicine.	team. Consistently incorporates feedback. Seeks assistance and effectively copes with stress inherent in medicine.

☐ ☐ ☐

8. Demonstrate integrity, establish oneself as a role model, and recognize and respond appropriately to unprofessional behavior or distress in professional colleagues.

Pre-Entrustable	Entrustable
May wear attire inappropriate for the clinical setting. Occasional disrespectful interactions with patients or families, peers, and/or colleagues on the healthcare team. Unaware or inconsistently aware of physician and colleague self-care and wellness. May recognize unprofessional behavior or distress in a colleague, but may not respond appropriately or mitigates the situation in a non-confidential, ineffectual, or inappropriate way.	Adheres to basic professional responsibilities such as timely reporting for duty rested and ready to work, and appropriate dress/grooming. Is consistent in respectfully interacting with patients, families, peers, and colleagues on the healthcare team. Assists and responds to unprofessional colleagues or colleagues in distress in a professional and confidential manner. May promote programs for healthcare professional wellness.

☐ ☐ ☐

9. Demonstrate accountability by completing academic and patient care responsibilities in a comprehensive and timely manner.

Pre-Entrustable	Entrustable
Patient care documentation and/or course assignments may take an excessive amount of time to be finalized and submitted. May complete assigned tasks in a timely manner but may need excessive reminders. Course requirements may be either partially complete or not finished. May skip conferences or have sporadic attendance.	Functions as a reliable member of the health care team. Punctual completion of patient care documentation and course assignments without reminders. Consistently attends conferences and other required course seminars or didactics. Is prepared to present patients when called upon. Follows through all tasks to completion.

☐ ☐ ☐

10. Demonstrate trustworthiness that engenders trust in colleagues, patients, and society at large.

Pre-Entrustable	Entrustable
Demonstrates occasional lapses in professional conduct, such as through disrespectful interactions or lack of truth-telling, especially under conditions of stress or fatigue or in complicated or uncommon situations. This may put others in the position to remind, enforce, and resolve conflicts. There may be some insight into behavior, but learner is still developing skills to modify behavior when in stressful situations.	In nearly all circumstances, demonstrates professional conduct, such as through respectful interactions and truth-telling. Has insight into his/her own behavior as well as likely triggers for professionalism lapses and is able to use this information to act in a professional manner.

☐ ☐ ☐

11. Recognize that ambiguity and uncertainty are part of clinical care and respond by demonstrating flexibility and an ability to modify one's behavior.

Pre-Entrustable	Entrustable
Uncomfortable when faced with uncertainty or ambiguity. Still developing skills in managing response to uncertainty. May be risk averse. May propose clinical or therapeutic options in black and white terms, rather than discussing a variety of options available to patients. Inconsistently takes the patient's preferences into account.	Anticipates the likelihood of uncertainty at the time of diagnostic deliberation. Uses uncertainty as a prompt or motivation to seek information or understanding of what is unknown. Still struggles with balancing uncertainty and hope in discussions with patients and families, tending to err by emphasizing uncertainty, especially if risk averse (e.g., in diagnosis or prognosis).

☐ ☐ ☐

<u>System-based Practice and Interprofessional Collaboration</u>: Demonstrate an awareness of and responsiveness to the larger context and system of healthcare, as well as the ability to effectively call upon other resources in the system to provide optimal care, including engaging in interprofessional teams in a manner that optimizes safe, effective patient and population-centered care.

1. Participate in identifying system errors and implementing system solutions to improve patient safety.

Pre-Entrustable	Entrustable
Still developing skills in recognizing the potential for system error. May be defensive or blaming when encountering medical error. Uncomfortable with discussion of error or identification of the type of error. Approaches error prevention from an individual case, rather than a systems perspective. Often uses workarounds as a problem-solving strategy.	Open to discussions of error. Actively identifies and reports medical error events and seeks to determine the type of error. Usually identifies the element of personal responsibility for individual or systems error corrections or solutions. Sees examination and analysis of error as an important part of the preventive process.

☐ ☐ ☐

2. Incorporate considerations of resource allocation, cost awareness and risk-benefit analysis in patient and population-centered care.

Pre-Entrustable	Entrustable
Does not routinely consider cost in the evaluation and management of patients, including factors external to the system (e.g., socioeconomic, cultural, literacy, insurance status) and internal to the system (e.g., providers, suppliers, financers, purchasers).	Demonstrates understanding of external and internal factors related to cost. Critically appraises information available from an evaluation, test, or treatment to allow prioritization and optimization of cost and risk/benefit issues for an individual patient. Uses tools and information technology to support decision making and adopt strategies to decrease cost and risk to individuals.

☐ ☐ ☐

3. Demonstrate accountability to patients, society and the profession by fully engaging in patient care activities, and maintaining a sense of duty in the professional role of a physician.

Pre-Entrustable	Entrustable
Appears to be interested in learning medicine but not fully engaged and involved as a professional, which results in a more observational or passive role.	Demonstrates understanding and appreciation of the professional role and the gravity of being the "doctor" by becoming fully engaged in patient care activities. Has a sense of duty. Rarely lapses into behaviors that do not reflect a professional self-view. Demonstrates basic professional responsibilities such as appropriate dress/ grooming.

☐ ☐ ☐

4. Effectively work with other healthcare professionals to establish and maintain a climate of mutual respect, dignity, diversity, integrity, honesty, and trust.

Pre-Entrustable	Entrustable
Seeks answers and responds to authority from largely only intraprofessional colleagues. Does not routinely recognize other members of the interprofessional team as making significant contributions to the team. May dismiss input from professionals other than physicians.	Can articulate the unique contributions of other health care professionals. Seeks their input for appropriate issues and communicates their value to other members of the team and patients and families. As a result, is an excellent team player.

☐ ☐ ☐

5. Effectively work with other healthcare professionals as a member of an interprofessional team to provide patient care and population health management approaches that are coordinated, safe, timely, efficient, effective, and equitable.

Pre-Entrustable	Entrustable
Limited participation in team discussion, passively follows the lead of others on the team. Does not routinely take initiative to interact with all team	Demonstrates an understanding of the roles of various team members by interacting with appropriate team members to accomplish assignments. Actively works to integrate into team

members. More focus on his or her own performance than other team members.		function and understands the roles and responsibilities of all members of the team.

Approvals:

SoM Curriculum Committee: September 11, 2014
SoM Faculty Council first read: December 4, 2014
SoM Faculty Council second read: February 5, 2015
SoM Dean: February 9, 2015

DOCUMENT REVISED TO ADD PRE-ENTRUSTABLE AND ENTRUSTABLE DESCRIPTORS May 19, 2015, revised February 23, 2016

Evaluation Form

Printed on Apr 18, 2016

OHSU Medical Student Clinical Assessment

Evaluator: _____

Evaluation of: _____

Date: _____

Thank you for your help evaluating our student. For the student listed above, please answer the following questions. Please submit this form to Marcia Decaro at decaro@ohsu.edu

	Early Learner					Advanced	Not Observed
1. 1. Student/Preceptor Communication around patient care (e.g., presenting information to preceptors)*	☐ – Communication regarding patient care disorganized/incomplete	☐ -- Communication lacks focus & may give information out of sequence	☐ – Communication generally organized; may not be succinct in delivery	☐ – Communication of information succinct but some organizational problems exist	☐ – Communication of information directive, succinct, & complete in routine clinical patient	☐ – Communication of information tailored & reasoned in complex clinical patient	☐
2. 2. Student ability to gather patient-related data (e.g. history, examination, laboratory as assessed either through direct observation or indirectly through presentations)*	☐ – Information gathered incomplete or includes irrelevant information. – Findings inconsistent with preceptor's findings.	☐ – All information needed to diagnose patient gathered, but may contain impertinent information or lack key contributing factors. – Findings may not be reproducible by preceptor.	☐ -- Information gathered completely, including key contributing factors. – All findings reproducible except for subtle signs/nuanced history.	☐ – Information completely gathered from readily available sources, appropriate filtering of irrelevant data. – All findings reproducible	☐ – Information gathered completely and filtered efficiently with appropriate use of outside sources to find key missing information	☐ – Information gathered completely and filtered efficiently with appropriate use of outside sources to find key missing information even with clinically or socially complex patients	☐
3. 3. Applying medical knowledge in patient care*	☐ – Inability to recall appropriate information in the care of patients	☐ – Can recall core principles, but lacks depth to apply correctly in clinical situations	☐ – Can recall core principles and applies to common disease presentations	☐ – Can recall core principles and usually applies them to common diseases and typical variant states	☐ – Readily applies general pathophysiology of common disease and typical variant states to patient's clinical situation	☐ – Applies disease specific pathophysiology in the care of the patient even for rare diseases or atypical variants of common diseases	☐
4. 4. Clinical reasoning*	☐ – Difficulties identifying major clinical problems or differential dx not supported clinically. – Inefficient when managing information.	☐ – Identifies major clinical problems but unorganized list for differential dx. – Gets bogged down in details when managing information	☐ – Identifies major clinical problems. – Differential diagnosis is organized, but not prioritized. -- Usually has adequate understanding of information needed to manage care	☐ – Identifies major clinical problems and establishes prioritized differential diagnosis. – Always has adequate understanding of information needed to manage care	☐ – Efficient in use of clinical information. – Differential dx reflects individual patient rather than text book work-up	☐ – Excellent analysis of clinical problems. -- Very efficient with information management	☐
5. 5. Identifying appropriate treatment approaches*	☐ – UNABLE to identify appropriate treatment approaches, even for common/urgent conditions.	☐ – ABLE to identify SOME treatment approaches for common/urgent conditions. – UNABLE to provide supporting evidence for ANY treatments.	☐ – ABLE to identify MOST treatment approaches for common/urgent conditions. -- UNABLE to provide supporting evidence for MOST	☐ -- ABLE to treat common/urgent conditions but is UNABLE to suggest treatments for UNCOMMON conditions. – USUALLY provides evidence to	☐ -- ABLE to treat common/urgent conditions with appropriate evidence to support decision. -- ABLE to suggest treatments for SOME	☐ – ABLE to treat common/urgent condition. – ABLE to appropriately suggest treatments for uncommon conditions based on BEST available	☐

			treatments.	support treatments.	uncommon conditions.	evidence.	

6. 6. Professional behaviors with patients, peers and other health professionals*	☐ – DOES NOT approach role as medical student with honor and integrity. – OFTEN does not attend key events or is late. – IS NOT respectful of patients, peers and other health professionals	☐ – OCCASIONALLY approaches role as medical student with honor and integrity. – OCCASIONALLY does not attend key events or is late. – IS NOT always respectful of patients, peers and other health professionals	☐ -- USUALLY approaches role as medical student with honor and integrity. -- USUALLY attends key events and is RARELY late. – Is USUALLY respectful of patients, peers and other health professionals	☐ -- ALWAYS approaches role as medical student with honor and integrity. -- Is USUALLY prepared and attendance is GOOD. – Is ALWAYS respectful of patients, peers and other health professionals	☐ -- ALWAYS approaches role as medical student with honor and integrity. – Is prepared and on time. – Is ALWAYS respectful of patients, peers and other health professionals	☐ – ALWAYS approaches role as medical student with honor and integrity, – ALWAYS well prepared and often arrives early. – Spontaneous praise is received from patients, peers or other health professionals.	☐

Professionalism Concerns

If you have any concerns about this student's professionalism, please indicate your concerns here and provide descriptive comments in the space provided.

7. Are there any areas of this student's professionalism that are concerning? If so, please select the appropriate area(s) of concern and describe in the comments below. If not, please select the "No professionalism concerns" option.*

- ☐ No professionalism concerns
- ☐ Inadequate sensitivity to diversity
- ☐ Inadequate respect for patient privacy
- ☐ Inappropriately handles difficult conversations
- ☐ Inadequate responsiveness to patient needs
- ☐ Inadequate understanding of own limitations
- ☐ Does not sufficiently demonstrate honesty/integrity
- ☐ Does not sufficiently demonstrate Teamwork
- ☐ Other area not listed here (please describe below)

If you have noted professionalism concerns above, please provide comments about the student's professionalism (not for the Dean's Letter, but required if concerns were noted)

_____

_____

_____

_____

_____

Comments

Please use the spaces below to provide comments about the student's overall performance.

8. Narrative Feedback: *

_____

_____

_____

_____

_____

Final Grade

Please select a final grade for the student using ONE of the two scales below, either the 5 tier scale OR the Pass/No Pass scale.

9. Tiered Grade Selection:

- ☐ A (Honors)
- ☐ B (Near Honors)
- ☐ C (Satisfactory)
- ☐ D (Marginal)
- ☐ F (Fail)
- ☐ I (Incomplete)

10. Pass/No Pass grade selection:

- ☐ Pass
- ☐ No Pass