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Evaluation Form

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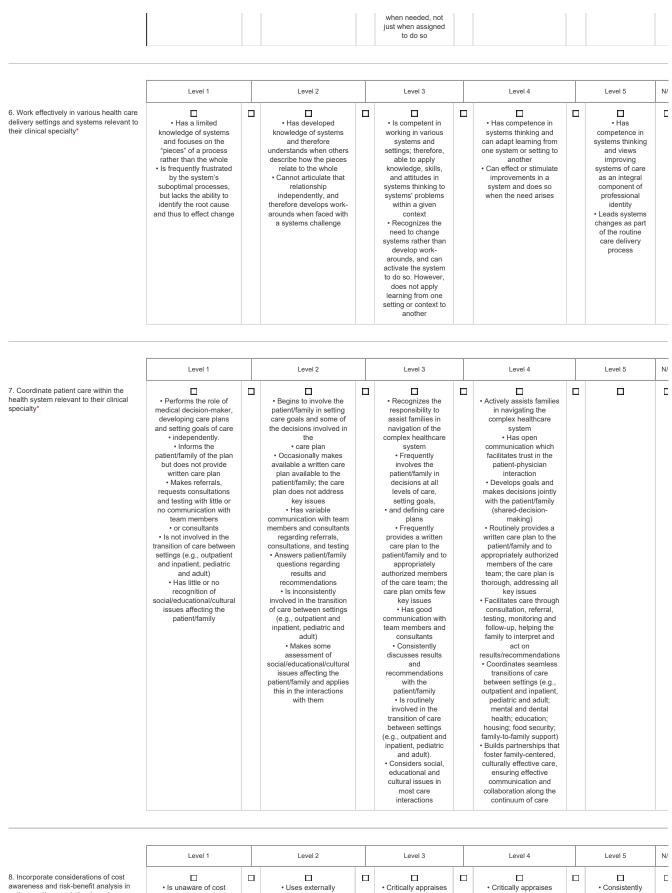
| B3. Fellow self evaluation (CCC) | | | | | | | | | | |
|---|---|--------|---|---------|--|---------|---|--------|--|----|
| Evaluator: | | _ | | | | | | | | |
| Evaluation of: | | _ | | | | | | | | |
| Date: | | | | | | | | | | |
| Select appropriate milestone levels. You mus program director and compared to that obtain | | ime ca | ses, you may fall in between | two dis | stinct milestones. This inf | formati | on will be discussed in the se | emianr | nual meeting with your | |
| | Level 1 | | Level 2 | | Level 3 | | Level 4 | | Level 5 | N/ |
| 1. Provide transfer of care that ensures seamless transitions* | Demonstrates variability in transfer of information (content, accuracy, efficiency, and synthesis) from one patient to the next Has frequent errors of both omission and commission in the handoff | | Uses a standard template for the information provided during the handoff Does not deviate from the handoff template to adapt to more complex situations May have errors of omission or commission particularly when clinical information is not synthesized Does not anticipate or attend to the needs of the receiver of information | | Adapts and applies a standardized template, relevant to individual contexts, reliably and reproducibly, with minimal errors of omission or commission Allows ample opportunity for clarification and questions Anticipates potential issues for the transferee | | Adapts and applies a standard template to increasingly complex situations in a broad variety of settings and disciplines • Ensures open communication, whether in the receiver- or provider-of information role through deliberative inquiry, including but not limited to read-backs, repeat-backs (provider), and clarifying questions (receivers) | | Adapts and applies the template without error and regardless of setting or complexity Internalizes the professional responsibility aspect of handoff communication, as evidenced by formal and explicit sharing of the conditions of transfer (e.g., time and place) and communication of those conditions to patients, families, and other members of the health care team | C |
| | | | | | | | | | | |
| | Level 1 | | Level 2 | | Level 3 | | Level 4 | | Level 5 | N/ |
| 2. Make informed diagnostic and therapeutic decisions that result in optimal clinical judgment* | Presents clinical facts in the history and physical in the order they were elicited without filtering, reorganization, or synthesis Develops a list of diagnoses, instead of a unified diagnosis Uses analytic reasoning through basic pathophysiology in diagnostic and therapeutic reasoning Does not effectively develop a therapeutic plan | | Focuses on the individual features of a clinical presentation and does not develop a unifying diagnosis leading to a continual search for new diagnostic possibilities Uses primarily analytic reasoning through basic pathophysiology in diagnostic and therapeutic reasoning Does not develop clear management plans and orders unnecessary tests and therapies | | Develops a well- synthesized and organized assessment of the focused differential diagnosis and management plan Uses illness scripts (clinical pattern recognition) in diagnostic and therapeutic reasoning Uses semantic qualifiers (medical terms to describe clinical information that are usually paired opposites [e.g., acute and chronic, proximal and distall) to compare and contrast the diagnoses being considered when presenting or discussing a case | | Develops a unifying diagnosis, focused therapies, an effective and efficient diagnostic work-up and management plan tailored to address the individual patient Uses robust illness scripts to rapidly develop directed diagnostic hypothesis testing; subsequent history, physical examination, and tests are efficiently used to confirm this initial schema. Can readily identify discriminating featuress between similar patients and avoids premature dosure, ie arriving prematurely at an inaccurate diagnosis | | | |
| | | | | | | | | | | |
| | Level 1 | | Level 2 | | Level 3 | | Level 4 | | Level 5 | N/ |
| Develop and carry out management plans* | | | | | | | | | | С |

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| | Develops and carries out management plans based on directives from others, either from the health care organization or the supervising physician Unable to adjust plans based on individual patient differences or preferences Communicates the plan in a unidirectional manner from the practitioner to the patient and family | Develops and carries out management plans based on one's theoretical knowledge and/or directives from others Can adapt plans to the individual patient, but only within the framework of one's own theoretical knowledge Unable to focus on key information, so conclusions are often from arbitrary, poorly prioritized, and time- limited information gathering Devises management plans based on the framework of one's own assumptions and values | Develops and carries out management plans based on both theoretical knowledge and some experience, especially in managing common problems Follows health care institution directives as a matter of habit and good practice rather than as an externally imposed sanction Able to more effectively and efficiently focus on key information, but still may be limited by time and convenience Begins to incorporate patients' assumptions and values into management plans through more bidirectional communication | Develops and carries out management plans based most often on experience Effectively and efficiently focuses on key information to arrive at a plan Incorporates patients' assumptions and values into management plan through bidirectional communication with little interference from personal biases | Develops and carries out management plans, even for complicated or rare situations, based primarily on experience that puts theoretical knowledge into context Rapidly focuses on key information to arrive at the plan and augments that with available information or seeks new information as needed Has insight into one's own assumptions and values that allow one to filter them out and focus on the patient/family values in a bidirectional conversation about the management plan | |
|--|---|--|--|---|--|---|
| | | | | | | _ |
| | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 | N |
| 4. Provide appropriate role modeling* | Performs routine duties and behaviors of profession without awareness of the impact on those around her May or may not reflect on actions as they occur (reflection in action) and does not share reflections with others | Inconsistently aware of the impact of one's behaviors and attitudes on others Sometimes teaches by example Occasionally will reflect openly on events as they occur (reflection in action) and privately on events that have already taken place (reflection on action) | Conscious of being a role model during many interactions Frequently teaches by example and often reflects in action openly in the presence of learners Behavior change implies frequent private reflection on action | Conscious of being a role model during most interactions Routinely teaches by example Regularly reflects in action and frequently reflects on action, sharing this analysis of practice with learners | Role modeling is a habit Recognizes that she/he is a role model in all actions and behaviors at all times Characteristically teaches by example Routinely reflects both in action and on action. Examines, analyzes, and explains actions/behaviors in the presence of learners and colleagues | |
| | | | | | | |
| | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 | N |
| 5. Critically evaluate and apply current medical information and scientific evidence for patient care* | • Explains basic principles of EBM, but relevance is limited by lack of clinical exposure | Recognizes the importance of using current information to care for patients and responds to external prompts to do so Able to formulate questions with some difficulty, but not yet efficient with on-line searching Starting to learn critical appraisal skills | Able to identify knowledge gaps as learning opportunitles. Makes an effort to ask answerable questions on a regular basis and is becoming increasingly able to do so Understands varying levels of evidence and can utilize advanced search methods Able to critically appraise a topic by analyzing the major outcomes; however, may need guidance in understanding the subtities of the evidence Begins to seek and apply evidence | Increasingly self- motivated to learn more, as exhibited by regularly formulating answerable questions Incorporates use of clinical evidence in rounds and teaches fellow learners Quite capable with advanced searching Able to critically aparaise topics and does so regularly Shares findings with others to try to improve their abilities Practices EBM because of the benefit to the patient and the desire to learn more rather than in response to external prompts | Teaches critical appraisal of topics to others Strives for change at the organizational level as dictated by best current information Able to easily formulate answerable Chioical questions and does so with majority of patients as a habit Able to efficiently search and access the literature Seen by others as a role model for practicing EBM | |

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awareness and risk-benefit analysis in patient and/or population-based care as appropriate*
 Image: State of cost issues in evaluation and management of patients
 Image: State of Cost is st

Critically appraises information available on an evaluation test or treatment to

information in the

context of not only the

individual patient but

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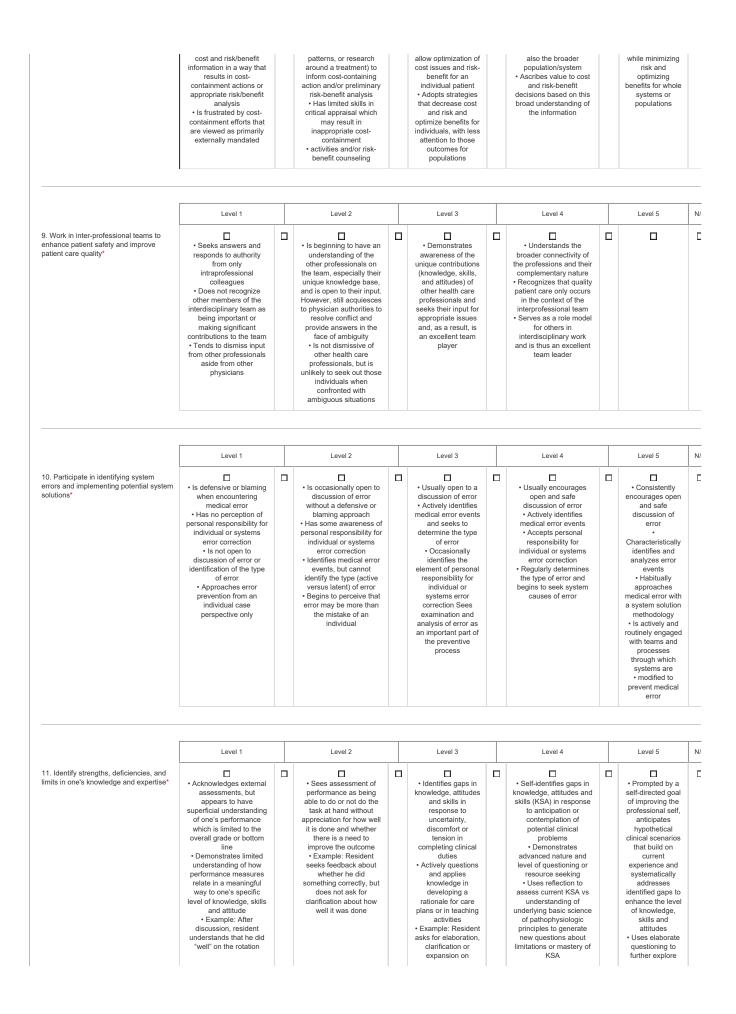
integrates cost

analysis into

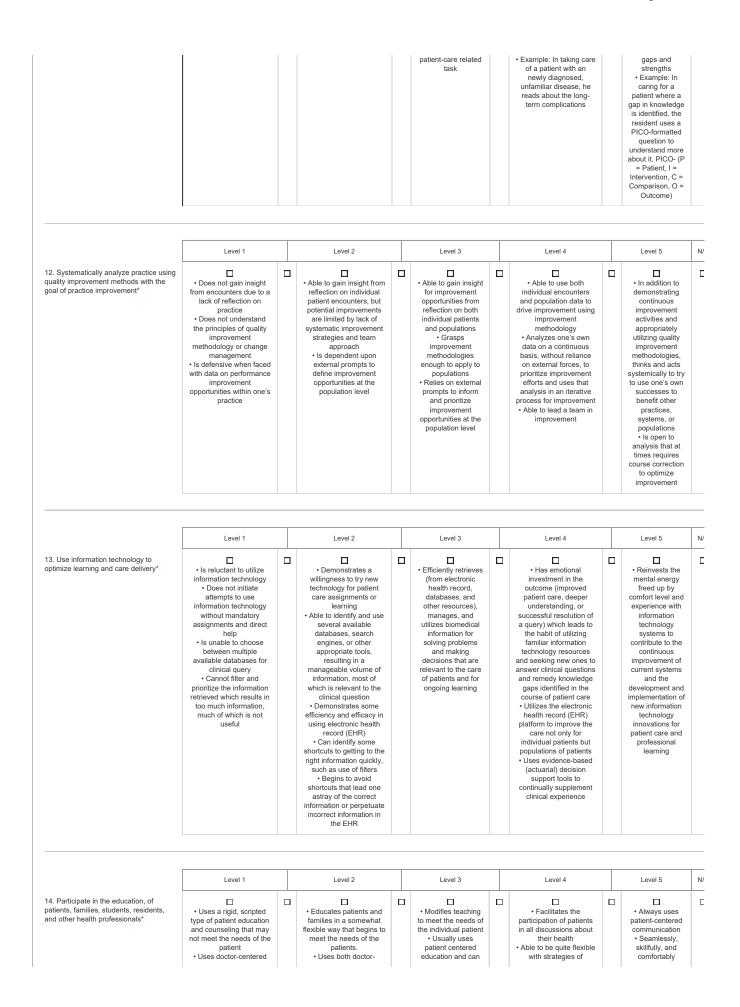
one's practice

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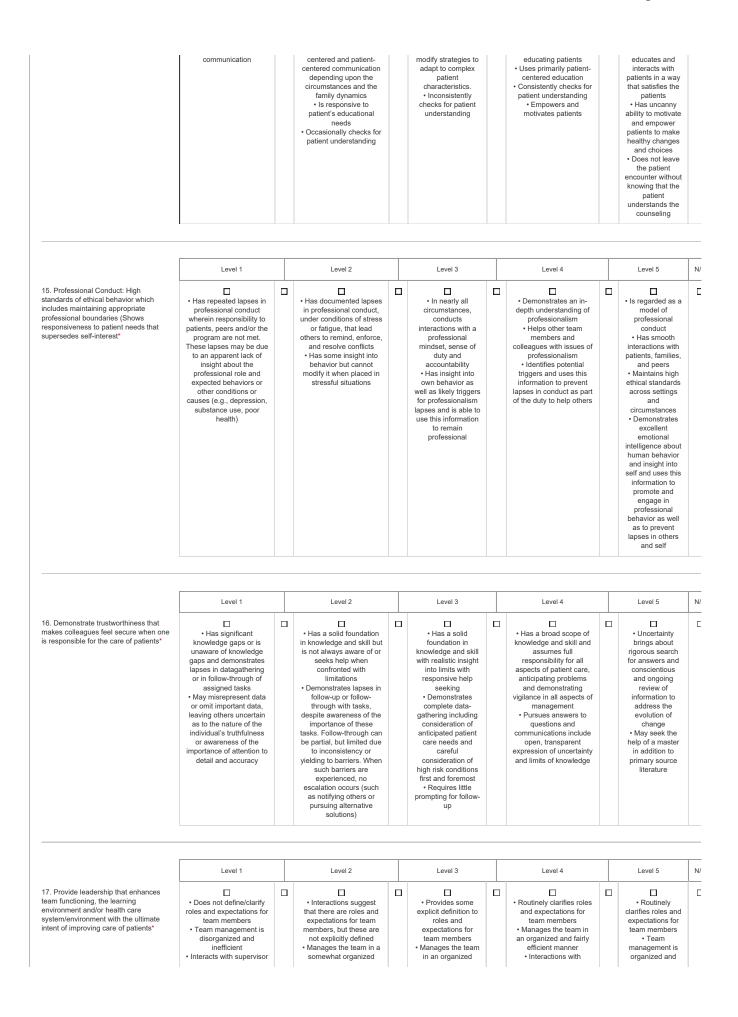
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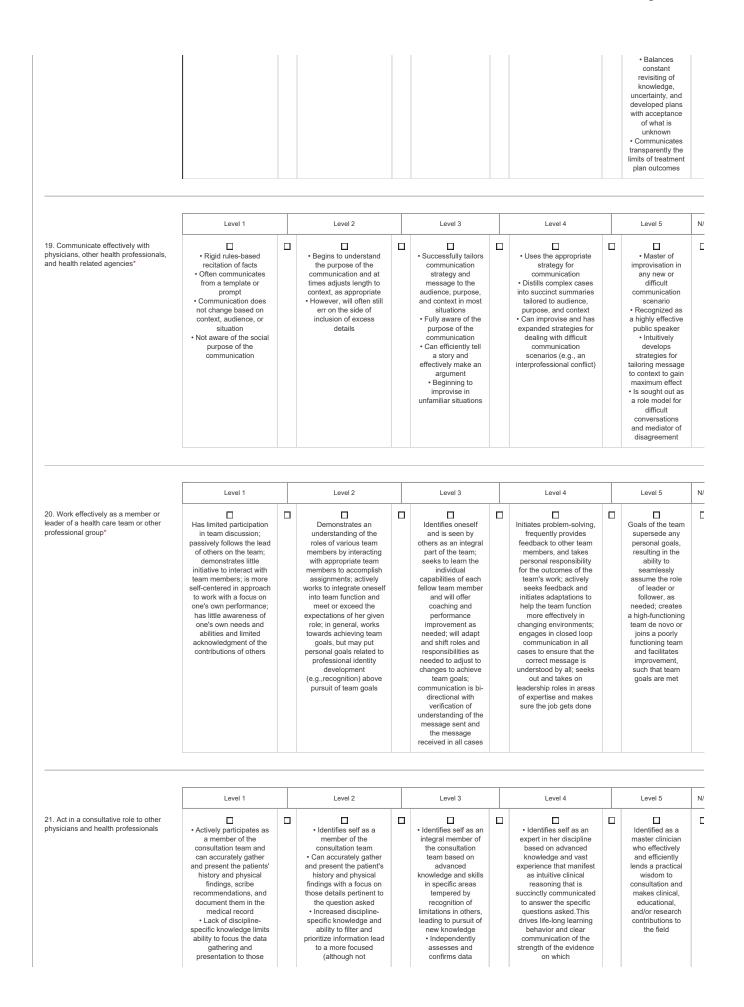


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| | (s) in an unfocused and indecisive manner Open communication is not encouraged within the team Team members are not given ownership or engaged in decision- making Manages by mandate Unable to advocate effectively for the team with faculty, staff, families, patients, and others | manner • Interacts with supervisor (s) in a somewhat focused but poorly decisive manner • Begins to encourage open communication within the team • Sometimes engages team members in decision-making processes • Manages most often through direction, with some effort towards consensus building • Attempts to advocate for the team with faculty, staff, families, patients, and others | manner. Interactions with supervisor(s) are focused and decisive in most cases • Open communication within the team is routinely encouraged • Team members are routinely engaged in decision-making and are given some ownership in care • Usually manages through consensus- building and empowerment of others, but sometimes reverts to being directive • Advocates somewhat effectively for the team with faculty, staff, families, patients, and others | supervisor(s) are focused and decisive • Creates a foundation of open communication within the team • Team members are expected to engage in decision-making and are encouraged to take ownership in care • Utilizes a consensus- building process and empowerment of others, only in rare instances becoming directive • Advocates effectively for the team with faculty, staff, families, patients, and others | efficient. Interacts with supervisor(s) in a focused and decisive manner • Creates a strong sense of open communication within the team • Team members routinely engage in decision- making and are expected to take ownership in care • Consensus- building and empowerment are the norm • Proactively and effectively advocates for the team with faculty, staff, families, patients, and others. Inspires others to perform | |
|---|--|--|--|--|--|----|
| | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 | N/ |
| 18. Recognize that ambiguity is part of clinical medicine and respond by utilizing appropriate resources in dealing with uncertainty. | Lever 1 • Feels overwhelmed and inadequate when faced with uncertainty or ambiguity • Is rigid and authoritarian in communicating with patients/families and developing therapeutic plans • Uses mathematical concepts to quantify uncertainty and risk without checking for patient/family • Seeks only self or self- available resources to uncertainty • Makes decisions based on own, but not the patient/family's, state of risk aversion or risk taking • Emphasizes full potential for negative outcome to family (defensive/protective of physician) and does not acknowledge patients' need for hope | Recognizes uncertainty and feels tension/pressure from not knowing or knowing with limited control of outcomes Explains situation to the patient in framework most familiar to the physician, rather than framing it with terms, graphics, or analogies familiar to the patient Seeks rules and statistics and feels compelled to transfer all information to the patient immediately, regardless of patient readiness, patient goals, and patient ability to manage information | Anticipates and focuses on uncertainty, looking for resolution by seeking additional information Aims to inform the patient of the more optimal outcome(s), framed by physician goals Does not manage overall balance of patient/family uncertainty with quality of life, need for hope, and ability to adhere to therapeutic plan Focuses on own risk management position for a given problem and does not suggest that more or less risk taking (different from physician's position) could be chosen Still seeks patient/parent recitation of uncertainty/morbidity as proof that patient/family understands the uncertainty | Anticipates that uncertainty at the time of diagnostic deliberation will be likely and uses such uncertainty or larger ambiguity as a prompt/motivation to seek information or understanding of unknown (to self or world) • Balances delivery of diagnosis with hope, information, and exploration of individual patient goals • Presents concepts of risk versus hope by using a conceptual framework that includes cost (e.g., suffering, lifestyle changes, financial) versus benefit; framed by patient health care goals • Expresses openness to patient position and patient uncertainty about his/her position and response | | |



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