

Entrustable Professional Activities (EPAs) Guiding the Medical Student Toward Competence

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Entrustable Professional Activities (EPAs)

- Understand the Entrustable Professional Activities (EPA's) and why they exist.
- Develop an understanding of how a preceptor should use the EPAs in evaluating medical students.
- Understand the problems with utilizing the EPAs as a source of evaluation of medical students.



Overview of the EPAs

- Over the past 10-15 years the directors of residencies across the U.S. were noticing a significant decline in the ability of first-year residents to perform basic tasks that were expected of them.
- Developed in 2014 by the Association of American Medical Colleges (AAMC)
- Goals: To delineate those essential daily activities that an entering resident should be expected to do (without direct supervision) on day 1 of their residency (regardless of specialty).
- EPAs focus on the integration of competencies needed to deliver care



**NEW MEDICAL INTERNS START
JULY 1ST**



RUN FOR YOUR LIFE!



- The AAMC has asked medical schools to develop a curriculum that helps students and preceptors measure the competency of medical students as they progress through their 3rd and 4th years.
- Purpose is to provide **ESSENTIAL** and **ACTIONABLE** feedback to the medical student to guide them in improving on the core competencies expected of them as they enter into their PGY1.



Two Guiding Principles

- Patient Safety: First and Foremost
- Enhance the Confidence of New Residents
 - Program directors
 - Patients (with respect to the residents' abilities to perform the activities they will be expected to do without direct supervision when they enter residency)



What would you expect a PYG-1 to be able to do without supervision on day one of his or her residency?



EPAs

- *Gather a History and Perform a Physical or Mental Examination
- *Prioritize a Differential Diagnosis Following a Clinical Encounter
- *Recommend and Interpret Common Diagnostic and Screening Tests
- *Enter and Discuss Orders and Prescriptions
- *Document a Clinical Encounter in the Patient Record
- *Provide an Oral Presentation of a Clinical Encounter
- Form Clinical Questions and Retrieve Evidence to Advance Patient Care



EPAs

- Give or Receive a Patient Handover to Transition Care Responsibility
- *Collaborate as a Member of an Interprofessional Team
- Recognize a Patient Requiring Urgent or Emergent Care and Initiate Evaluation and Management
- Obtain Informed Consent for Tests and/or Procedures
- Perform General Procedures of a Physician
- Identify System Failures and Contribute to a Culture of Safety and Improvement



EPA

Gather a History and Perform a Physical Examination



Competencies

Patient Care

Professionalism

Knowledge of Practice

Interpersonal and Communication Skills



Milestones

Pre-Entrustable

Entrustable



Professionalism

Integrity

<i>Question 1 of 8 - Mandatory</i>	<i>Unacceptable</i>	<i>Minimally Competent</i>	<i>Competent</i>	<i>Proficient</i>	<i>Not Observed</i>
Professionalism <i>Exhibits behaviors that demonstrate integrity</i>	Unreliable, dishonest, avoids responsibility, commitment uncertain, dresses inappropriately, unexplained absences, verbal and nonverbal disrespect towards preceptor, does not recognize own limitations and the need to seek assistance	Sometimes late, not consistently able to complete assignments or tasks	Punctual, dependable, accepts responsibilities; demonstrates a willingness to accept feedback regarding necessary change(s)	Diligently fulfills responsibilities and seeks new responsibilities	
	1	2	3	4	



Professionalism

Compassion

<i>Question 2 of 8 - Mandatory</i>	<i>Unacceptable</i>	<i>Minimally Competent</i>	<i>Competent</i>	<i>Proficient</i>	<i>Not Observed</i>
Professionalism <i>Exhibits behaviors that demonstrate compassion</i>	Unable to comprehend the point of view and emotional state of other people, judgmental of others, fails to recognize and respect cross-cultural and gender differences	Not consistently considerate of the feelings and emotional needs of others; sometimes judgmental	Appropriately shows concern for others' feelings and interacts accordingly; recognizes and respects cross-cultural and gender differences	Has genuine concern for patients' emotional needs; spends time listening empathetically; motivated by kindness	
	1	2	3	4	



- EPA: Gather a medical history
- **Day 1 residents** should be able to perform an accurate, complete or focused history in a prioritized, organized manner without supervision and with respect for the patient.
- The history should be tailored to the clinical situation and specific patient encounter.
- This data gathering and patient interaction activity serves as the basis for clinical work and as the building block for patient evaluation and management.
- Learners need to integrate the scientific foundations of medicine with clinical reasoning skills to guide their information gathering.



Data Gathering

Medical History/Interviewing Skills

<i>Question 3 of 8 - Mandatory</i>	<i>Unacceptable</i>	<i>Minimally Competent</i>	<i>Competent</i>	<i>Proficient</i>	<i>Not Observed</i>
Data Gathering: History / Interviewing Skills	Inefficient, disorganized, weak prioritization skills, misses major findings	Frequently asks too much or too little history, identifies most problems but doesn't fully characterize them	Gets a complete and accurate history	Skillfully interviews patients and carefully characterizes problems in depth	
	1	2	3	4	



- EPA: Perform a physical examination
- Day 1 residents should be able to perform an accurate complete or focused physical exam in a prioritized, organized manner without supervision and with respect for the patient.
- The physical examination should be tailored to the clinical situation and specific patient encounter.
- This data gathering and patient interaction activity serves as the basis for clinical work and as the building block for patient evaluation and management.
- Learners need to integrate the scientific foundations of medicine with clinical reasoning skills to guide their information gathering.



Data Gathering

Physical Examination Skills

<i>Question 4 of 8 - Mandatory</i>	<i>Unacceptable</i>	<i>Minimally Competent</i>	<i>Competent</i>	<i>Proficient</i>	<i>Not Observed</i>
Data Gathering: Physical Examination Skills	Fails to appreciate physical findings and pertinent information, insufficient attention to psychosocial issues	Occasionally misses findings, performs inappropriate or faulty exams	Performs exams of appropriate scope and accuracy	Exam perceptive, thorough, accurate and efficient	
	1	2	3	4	



- EPA: Prioritize a differential diagnosis following a clinical encounter
- To be prepared for the first day of residency, all physicians need to be able to integrate patient data to formulate an assessment, developing a list of potential diagnoses that can be prioritized and lead to selection of a working diagnosis.
- Developing a differential diagnosis is a dynamic and reflective process that requires continuous adaptation to avoid common errors of clinical reasoning such as premature closure.



- **Developing a Differential Diagnosis**
- Through the process of hypothesis generation and verification
- The skill of a master diagnostician is not due to distinctive reasoning but instead dependent on a clinician's ability to access knowledge from past experience to generate a short list of possible diagnoses
- Expert clinicians develop 3-5 hypotheses within seconds to minutes of starting a diagnostic inquiry.
- Early hypothesis generation is critical to the accuracy of the eventual diagnosis.
- If the clinician thought of the correct diagnosis within five minutes, eventual accuracy was 98%
- If they did not think of the correct diagnosis within five minutes, accuracy decreased to 25%
- Intuition is nothing more and nothing less than recognition.

Brush JE, Sherbino J, Norman GR; How Expert Clinicians Intuitively Recognize a Medical Diagnosis; Am. J. of Medicine Jun 2017 130(6)



5 Steps to the Development of the Differential Diagnosis

1. Acquire Data
2. Identify the Key Features in your data
3. Create a Problem Representation
4. Adopt a Framework
5. Apply the Key Features to the Framework



Clinical Reasoning

Prioritizing a Differential Diagnosis

<i>Question 5 of 8 - Mandatory</i>	<i>Unacceptable</i>	<i>Minimally Competent</i>	<i>Competent</i>	<i>Proficient</i>	<i>Not Observed</i>
Clinical Reasoning: Prioritize a Differential Diagnosis	Not able to organize or prioritize patient data in formulating a differential diagnosis based on common presentations	Able to apply basic and clinical science knowledge to the most common medical conditions; premature closure when working on differential diagnosis; overwhelmed by clinical ambiguity	Demonstrates working knowledge of pathophysiology and is able to use assessment skills to formulate a differential diagnosis. Does not utilize all sources of data	Demonstrates good clinical reasoning, integration of patient data, formulation and prioritization of potential diagnosis	
	1	2	3	4	



- EPA: Recommend and interpret common diagnostic and screening tests
- This EPA describes the essential ability of the day 1 resident to select and interpret common diagnostic and screening tests using evidence-based and cost-effective principles as one approaches a patient in any setting.



Clinical Reasoning

Recommend and Interpret Common Diagnostic and Screening Tests

<i>Question 6 of 8 - Mandatory</i>	<i>Unacceptable</i>	<i>Minimally Competent</i>	<i>Competent</i>	<i>Proficient</i>	<i>Not Observed</i>
Clinical Reasoning: Recommend and Interpret Common Diagnostic and Screening Tests	Lack of ability to understand which tests or imaging to order to assess common diagnoses. Does not understand concepts of pretest probability. Frequently recommends unnecessary tests. Unable to articulate how test results affect diagnosis or treatment. Unable to formulate an appropriate treatment plan.	Inconsistent in ordering and interpreting basic diagnostic tests. Recommends standard templates but is not able to explain the role of each study in diagnosis and management. Does not always consider the cost/benefit of tests. Beginning to formulate a basic treatment plan.	Recommends reliable, cost-effective tests. Explains how results of tests will influence diagnosis and management. Correctly interprets abnormal laboratory and imaging findings for common tests. Shows competency in recommending an appropriate treatment plan and medications.	Routinely recommends reliable, cost-effective tests. Explains how results of tests will influence diagnosis, management and health-risk stratification and subsequent evaluation. Identifies critical values and responds correctly. Able to develop a therapeutic strategy that may incorporate patient education, dietary adjustment, an exercise program, drug therapy, and the participation of nursing and allied health professionals.	



- EPA: Provide an oral presentation of a clinical encounter
- The day 1 resident should be able to concisely present a summary of a clinical encounter to one or more members of the health care team (including patients and families) in order to achieve a shared understanding of the patient's current condition.
- A prerequisite for the ability to provide an oral presentation is synthesis of the information, gathered into an accurate assessment of the patient's current condition.



Clinical Skills

Oral Case Presentation

<i>Question 7 of 8 - Mandatory</i>	<i>Unacceptable</i>	<i>Minimally Competent</i>	<i>Competent</i>	<i>Proficient</i>	<i>Not Observed</i>
Clinical Skills: Oral Presentations	Missing major pieces of information, inaccurate reporting	Beginning to demonstrate ability to prioritize information and identify conditions requiring follow up; cannot demonstrate ability to prioritize information according to clinical setting and need	Demonstrates ability to prioritize information and provide oral presentation of clinical encounter; clinical reasoning unclear at times	Demonstrates good clinical reasoning, integration of patient data, formulation and prioritization of potential diagnosis. Selects a working diagnosis and presents to a health care team.	
	1	2	3	4	



- EPA: Document a clinical encounter in the patient record
- Entering residents should be able to provide *accurate, focused, and context-specific documentation* of a clinical encounter in either written or electronic formats.
- Performance of this EPA is predicated on the ability to obtain information through history, using both primary and secondary sources, and physical exam in a variety of settings (e.g., office visit, admission, discharge summary, telephone call, email). Documentation is a critical form of communication that supports the ability to provide continuity of care to patients and allows all health care team members and consultants to:
 - Understand the evolution of the patient's problems, diagnostic work-up, and impact of therapeutic interventions.
 - Identify the social and cultural determinants that affect the health of the patient.
 - View the illness through the lens of the patients and family.
 - Incorporate the patient's preferences into clinical decision making.



Clinical Skills

Documentation of a Clinical Encounter

<i>Question 8 of 8 - Mandatory</i>	<i>Unacceptable</i>	<i>Minimally Competent</i>	<i>Competent</i>	<i>Proficient</i>	<i>Not Observed</i>
Clinical Skills: Documentation of Clinical Encounter	Documentation is grossly insufficient or excessive. Documentation contains inappropriate abbreviations.	Beginning to provide clearer documentation of evaluation. Needs to work on demonstrating more focused documentation in acute settings. Needs to work on being aware and correcting documentation errors.	Provides clear documentation of a patient encounter that is appropriate to the setting. Formulations need to be more concise.	Demonstrates ability to synthesize and prioritize formulation of potential diagnosis. Selects working diagnosis and documents appropriate orders and prescriptions.	
	1	2	3	4	



There are Two Milestones for each EPA:

- **Pre-Entrustable:** Not yet worthy of entrustment to perform the activity without direct supervision -- Medical Students
- **Entrustable:** Worthy of entrustment to perform the activity without direct supervision -- Residents



Using the EPAs to Evaluate Students

- Important measuring tool that allows students to see what they need to work on to improve their skill set.
- Begin each rotation by asking students which of the 8 EPAs (reference points) they would like to work on that month. Focus point
- Mid rotation feedback session is critical.
 - 10 minutes with the student, go over the rubric and give fair and appropriate feedback on each of the 8 categories. Offers suggestions for improvement. Choose 1-2 of the categories to focus on for the remainder of the month.
- Final Evaluation Session: at the end of the month. Be fair and open with the student. No surprises on the final evaluation.



Using the EPAs to Evaluate Students

- Use the EPAs as a framework for your feedback and evaluation session.
- Do not worry about the numerical grade. We are requesting you evaluate the student and not grade him/her.
- Rubric is designed that the majority of the grade is based on the student's COMAT score and completion of the modules and patient/procedure logs.
- Observation is essential. Using the EPAs as an assessment and feedback tool requires observation on your part.



Making the Rotation go Smoother

- Day 1: Establish the Rules
 - Set Expectations
 - Yours
 - Student's
 - Organization
 - Written instructions – clinic rules
 - Clinic orientation-Nurse or Office Manager
 - EMR Orientation
 - Dress Code
 - Contact numbers, emergency contact
 - Preparation
 - Calendar for month
 - Days on call, surgery days, hours, case presentation dates



QUESTIONS?



How to Give Effective Feedback Strategies for Working with “Millennials”

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Purpose

The purpose of this instructional session is to help clinical adjunct faculty feel comfortable with the skill of providing meaningful feedback for their student doctor's professional growth and development. Feedback should be **timely, effective, and efficient**.



Instructional Objectives:

1. Review the *One-Minute Preceptor* skills
2. Understand the importance of feedback
3. Increase understanding of millennial learners
4. Learn techniques for giving effective feedback



One-Minute Preceptor Review

Essential clinical teaching skills:

- Establishing and monitoring mutual expectations
- Setting limited goals
- Asking questions
- Stimulating self-directed learning
- Capitalize on role modeling
- Learner centered
- **Supports evaluation** of learner's knowledge and clinical reasoning skills
- Encourages **feedback** to reinforce desired behaviors and reduce undesired behaviors



Why Is Feedback Important?

- We have a limited ability to observe ourselves
Without this data, most of us assume we're pretty good
- We can become aware of which behaviors help or hinder effective communication
- Ranked as 2nd of 37 preceptor behaviors that most enhance learning (*Schultz et al 2004*)



How Have You Learned to Give Feedback?

GOAL-DIRECTED FEEDBACK ...

- Feedback given effectively focuses on:
 - What went well
 - What can be done differently in the future to improve without placing a positive or negative value on it
- Stated differently:
 - What the learner should **continue to do**
 - What the learner should **stop doing or change**



Descriptive, not Judgmental

Instead of ...

“By this point in the year, you really should have better presentations.”

“I noticed that you read your presentation directly from your written note .”



Brief

Instead of ...

“You could improve in the following ten areas...”

“I’d like to give you feedback after your presentation so that you can continue to work on your skills.”



Specific

Instead of ...

“Your presentations are way too long.”

“You can leave family and social history out of your clinic presentations.”



Suggest What You Want, NOT What You Do Not Want

Instead of ...

“Don’t interrupt the patient.”

“Be sure to leave time for your patient to answer your questions.”



Focus on Behaviors, not Personality

Instead of ...

“You are not very patient with the students.”

“Be sure to leave time for your patient to answer your questions.”



Feedback IS Future Oriented

When recommending behavior change, focus on future:

“Anything you’d want to differently next time?”

“Next time, you might consider....”



One approach to feedback utilizing the goal-directed approach

Ask/Tell/Ask Model

- **Ask** trainees their perception of how they are doing to encourage self-reflection
- **Tell** trainees your observations in a non-judgmental fashion
- **Ask** trainees how they might improve their practice
- **Act/Follow-up:** Reinforce and remind about teaching points



Examining Generational Differences

4 Generations Practicing Now

	<u>Born</u>
Traditionalists	1922 – 1945
Boomers	1946 – 1964
Generation X	1965 – 1979
Generation Y (Millennials)	1980 - 2001



Traditionalists (born before 1945)



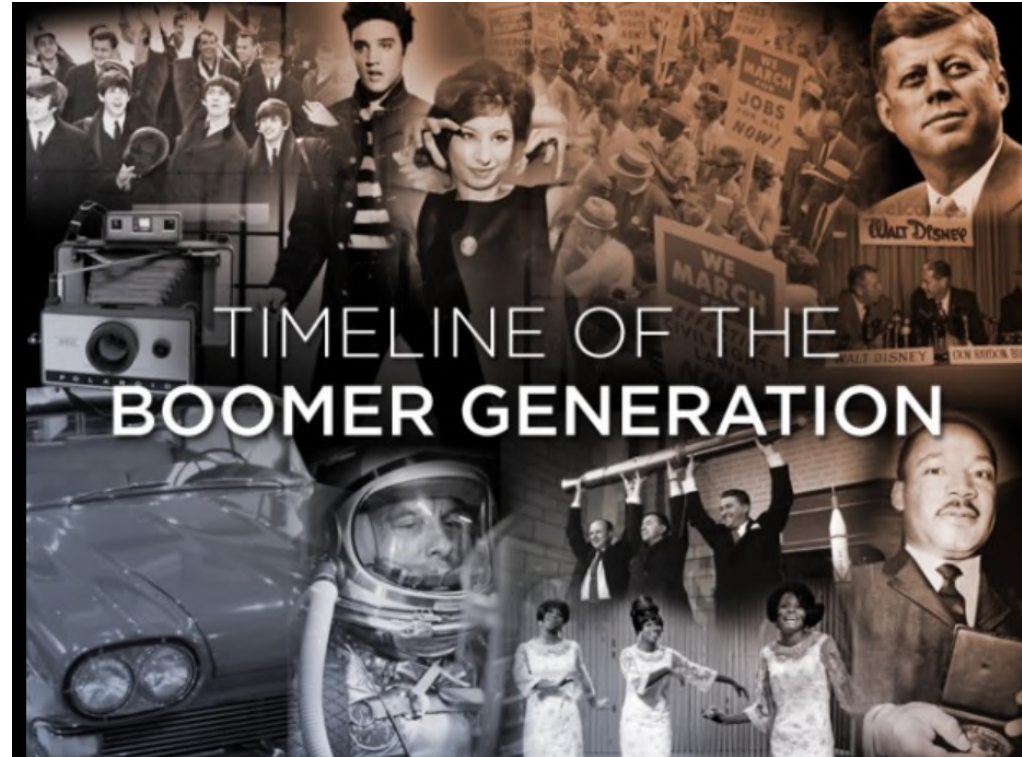
- Hard working
- Respect for authority
- Serious work ethic
- Conformers
- Rotary phones, read newspapers
- The satisfaction of a job well done



Boomers (1946 – 1964)

- Workaholic
- Service oriented
- Optimistic
- Personal gratification, money, title
- Technology...nice but not necessary

"Look Sharp, Be Sharp, Go Army!"

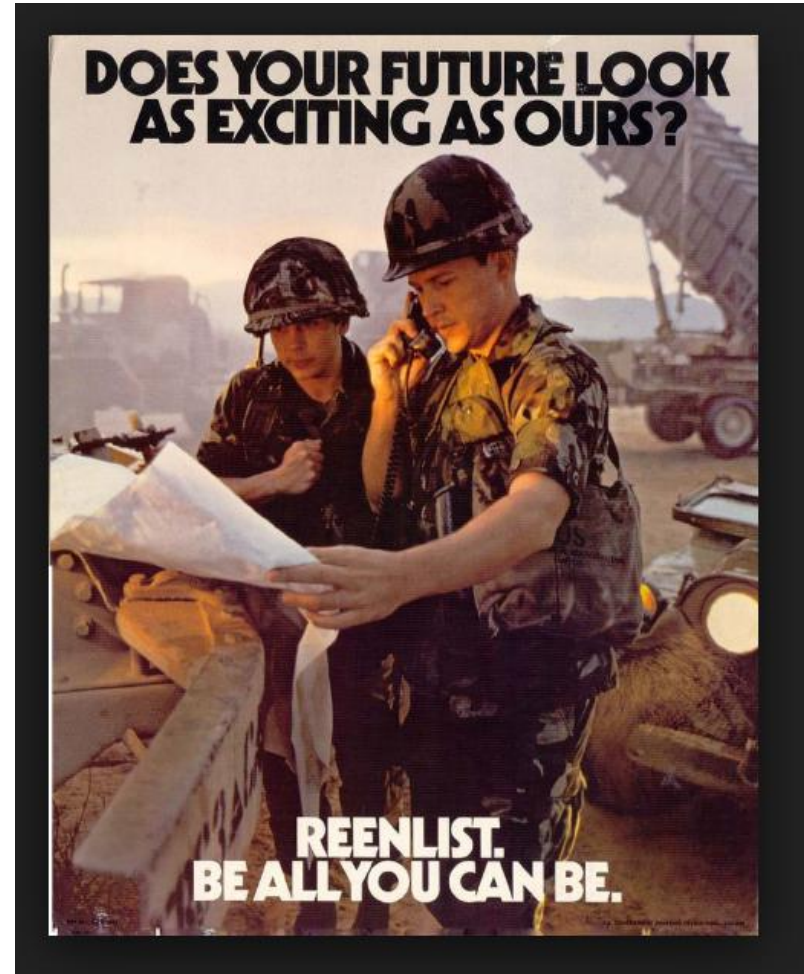


Generation X (1965 – 1979)

- Love a challenge
- Work/life balance
- Build a portable career
- Accept that job change is necessary
- Freedom and autonomy

“Today’s Army Wants to Join You!”

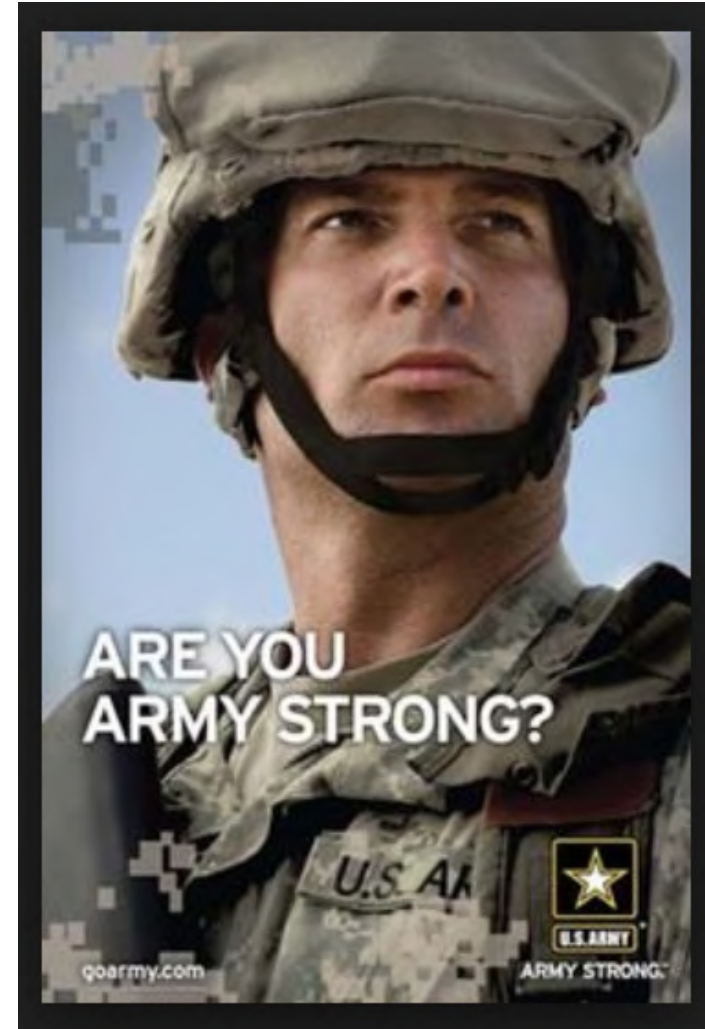
“Be All You Can Be!”



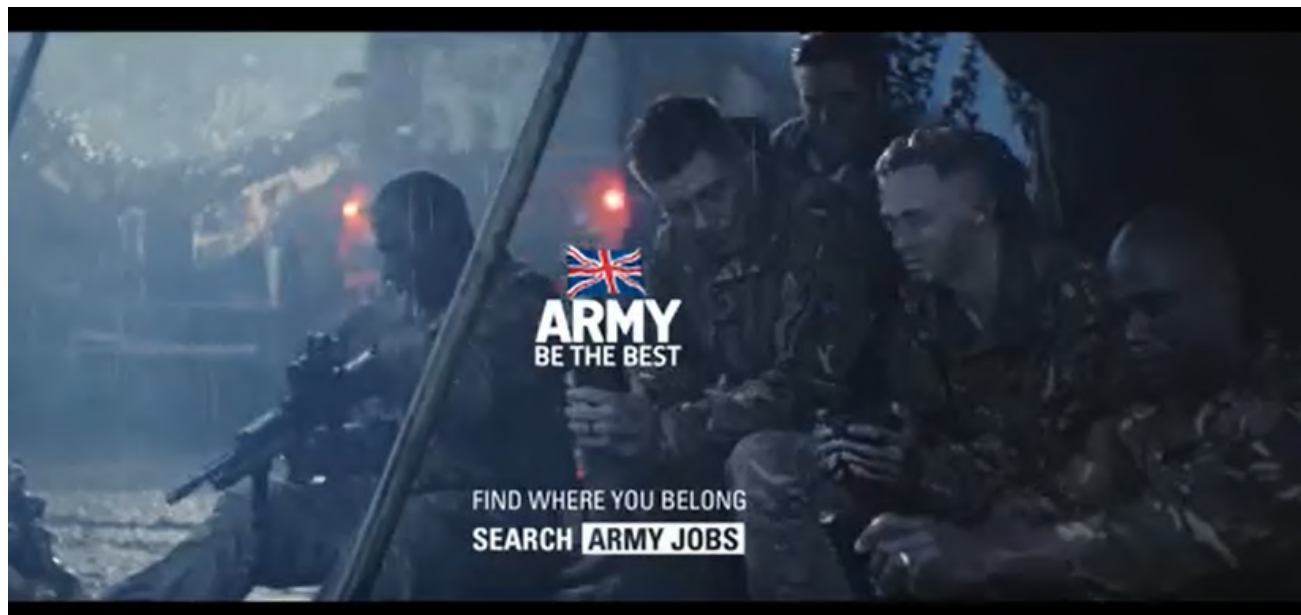
Millennials (1980 – 2001)

- Confident
- Social diversity
- Hard working on their time
- Technology savvy – part of their routine
- Work that has meaning; flexible hours

“Army Strong!”

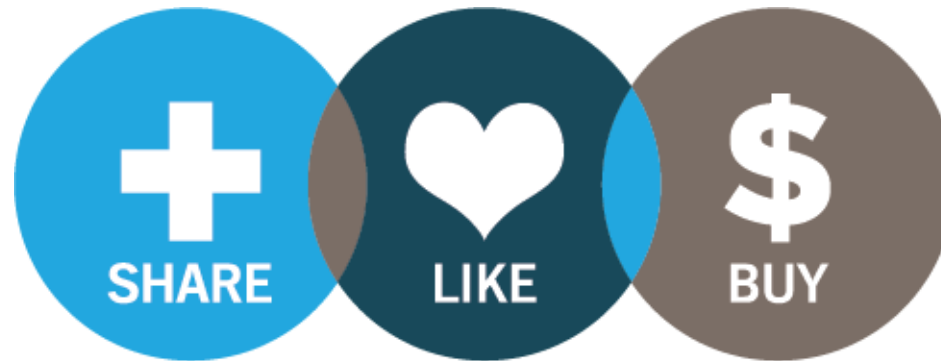


New for
2017...



Understanding Millennials

- They have been accused of being:
 - Tough to manage
 - Entitled
 - Narcissistic
 - Self-interested
 - Unfocused
 - Lazy



YOUTH. TRENDS. MARKETING.



Understanding Millennials

- Purpose and impact are important
- High rate of depression ... they are not tough and they do not have it figured out
- Many of them are incapable of forming deep, meaningful relationships
- Also, the MG has decreased traditional academic literacy (the ability to comprehend and critically appraise traditional print media such as textbooks, journals, or newspapers), whereas their ability to understand social media and electronic communications (such as texting) is increased



Research communicates

- They do not have coping mechanisms for dealing with stress
- They believe everything they want, they can have ... except job satisfaction and strength of relationships
- Lower self-esteem than previous generations
- Unhappy ... high rate of suicide
- Increase in accidental death due to drug overdose
- Increasing rate of students taking a leave of absence because they cannot cope with the stress of the academic environment
- They need help learning patience ... the things that really matter in life take time



Effective Communication and Feedback

1. Explain what the learner needs to learn and why this learning is important.

Preceptor Resources:

- LUCOM Student Clinical Manual
- LUCOM Preceptor Handbook
- LUCOM Third-Year Rotation Syllabi
- LUCOM Preceptor Evaluation of Student



Effective Communication and Feedback

2. Let students know what is flexible and what is not. They may not understand what is up for choice, where flexibility is allowed, or where they may have input.
3. Inform students where teamwork is okay. They may not understand what is group work and what is individual work.
4. Discuss ethics and professionalism in your practice.
5. Give frequent feedback – recommend giving feedback on process rather than person.



Effective Communication and Feedback

Feedback that enforces innate qualities, such as telling a student he/she is intelligent, promotes a fixed mindset.

Those with a fixed mindset have difficulty facing adversity and consider cheating more quickly.

When Breath Becomes Air by Paul Kalanithi



Feedback vs. Evaluation

EVALUATION

- Scheduled
- Summative
- Formal
- Judgment based on comparison to peers or norms
- Example: middle or end of rotation

FEEDBACK

- Brief
- Formative
- Nonjudgmental, specific, and descriptive
- Focus on behaviors learner can modify
- Example: right after clinical presentation



Written Evaluation of Students

- Behavioral focus
- Non-judgmental
- Relate to the learning goals or objectives for the rotation (case presentations, H and Ps, differential diagnosis)
- Offer suggestions for improvement
- Comments on student's professionalism, team play

Most important:

The final evaluation should **NOT** be a surprise to the student
Discussed face-to-face at the end of the rotation



Let's Practice

Scenario 1: Preceptor

- You are precepting a third-year medical student – Chris – who seems to have a weak knowledge base compared with the dozens of students you've taught in your career. You are now two weeks into an eight-week clerkship and nothing you've suggested seems to have made a difference so far. You've assigned topics for presentation and, unlike other students who go to the primary literature, Chris has gone to Up-to-Date and, even with that, made a very superficial presentation. You've asked all the students to go back to basics and describe the underlying pathophysiology of their patients' problems; Chris's analyses were both cursory and flawed. You decide that it's time to sit down and have a very frank discussion with Chris. (Please play this role as assertively as possible.)



Let's Practice

Scenario 1: Chris

- You are a third-year student in a four-week clerkship. There are 3 other students on your team, an intern, a chief resident and a preceptor who seems pretty nice, albeit a task master. This is your third clerkship and finally one in a field you're considering as a career. You've been following, on average, two patients a day, plowing your way through the assigned textbook, and occasionally looking up stuff on Up-to-Date. So, things are going along pretty well and you see no reason why you shouldn't get *proficient* marks this time out – well, at least *competent*. (Please play this role defensively.)



Let's Practice

Scenario 2: Preceptor

- You are precepting a third-year medical student – Jan – who seems to have a strong knowledge base and is a real go-getter. Jan seems to read more primary literature than any student you've ever encountered, not to mention being up-to-the-minute on the patients' labs or other findings. However, you've noticed some behavior that seems a little odd. You almost don't know what to make of it. For instance, you noticed that Jan doesn't seem to be well integrated into the team. The other students tend to hang together but Jan always seems to be paired with the chief resident. Then this morning you heard one of your patients referring to the test that "*Dr. Johnson*" – meaning Jan – had her undergo the day before. What test was that? Could Jan have ordered a test you knew nothing about? You're going to check on this and before the day is out sit down and have a very frank discussion with Jan. (Please play this role as assertively as possible.)



Let's Practice

Scenario 2: Jan

- You are a third-year student on the clerkship that's going to make your career. You are knocking yourself out to do everything just right, to show initiative, to shine above all others, to let the residents and those attending know you and see you at your best. You love to learn about the diseases patients on this service have. In fact, you've got some theories about one of them that you're following up on your own. You've never felt so confident, so sure that this is the place for you. (Please play this role defensively.)



Debrief/Summary

- What worked well?
- What was challenging?
- What key points do you have to share that have not already been mentioned?
- Questions?



Questions ...



Thank you ...



The Feedback Model is a Mirror Image of the One-Minute Preceptor 5-Step Microskills Model

5-Step Microskills

- Get a Commitment
- Probe for Supporting Evidence
- Reinforce What was Done Right or Well
- Give Guidance about Errors and Omissions (Correct Mistakes)
- Teach a General Principle about the Case

5 Steps That Only Require 2 Minutes!

1. Set up the discussion
2. State the specific issue or concern
3. Ask for the person's input
4. Ask the person for a plan / commitment
5. Summarize the discussion and express appreciation



References

1. Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong II O. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Rep* 2003;118:293-302.
2. Moreno-Walton L, Brunett P, Akhtar S, DeBlieux PMC. Teaching across the generation gap: a consensus from the council of emergency medicine residency directors 2009 academic assembly. *Acad Emerg Med* 2009 Dec;16:Suppl 2:S19-S24.
3. Howe N, Strauss W. *Millennials rising: the next great generation*. Vintage 2000.
4. Wilson M, Gerber LE. How generation theory can improve teaching: strategies for working with the “Millennials.” *Currents in Teaching and Learning* 2008;1:29-44.
5. Twenge JM. Generational changes and their impact in the classroom: teaching Generation Me. *Med Educ* 2009;43:398-405.
6. Considine D, Horton J, Moorman G. Teaching and reading the Millennial Generation through media literacy. *Journal of Adolescent & Adult Literacy* 2009 Mar;52:471-81.
7. Hopkins G. How can teachers develop students' motivation—and success? *Education World*. www.educationworld.com/a_issues/chat/chat010.shtml. Accessed June 6, 2014.



Residency

How to Advise an Osteopathic Student

‘It’s all about the Match’

Michael B. Weigner, MD, FACEP
Associate Dean of Graduate Medical Education
Associate Professor of Emergency Medicine



ERAS

- Electronic Residency Application Service
- The way most applications happen
- Standardizes the system
- Applications open in July of 4th year
- Interviews through the fall
- Rank lists in early winter



The Match

- Two most relevant Matches to LUCOM are the AOA Match and the NRMP or “Main Match”
- As we move towards the Single Accreditation System in 2020, the AOA Match will disappear



Timeline

- | | |
|---------------|-----------------|
| • July/August | Apply |
| • Fall | Interview |
| • Winter | Rank Order List |
| • February | AOA Match |
| • March | NRMP Match |



2017 NRMP Results and Data

- 124-page detailed summary of the Main Match
- <http://www.nrmp.org/wp-content/uploads/2017/06/Main-Match-Results-and-Data-2017.pdf>



The Match by the Numbers

- Over 40,000 Applicants
- Under 30,000 PGY1 Positions

Figure 1 Applicants and 1st Year Positions in the Match, 1952 - 2017

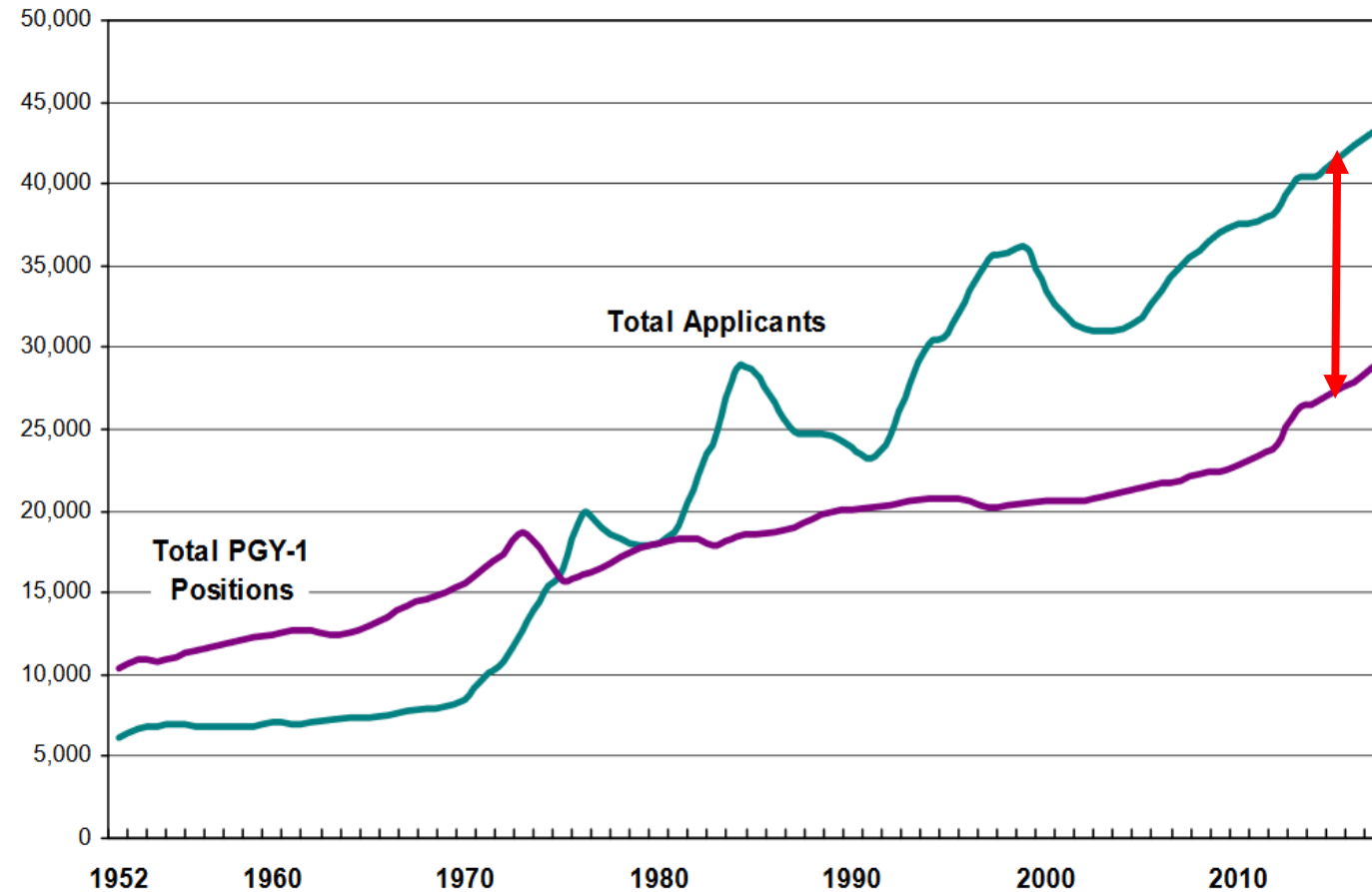


Table 2**Matches by Specialty and Applicant Type, 2017**

Specialty	Number of Positions	Number Filled	U.S. Senior	U.S. Grad	Osteo	Canadian	5th Pathway	U.S. IMG	Non-U.S. IMG	Number Unfilled
PGY- 1 Positions										
Anesthesiology	1,202	1,146	803	20	164	0	0	74	85	56
Child Neurology	128	119	97	1	8	0	0	3	10	9
Dermatology	26	26	24	0	0	0	0	1	1	0
Emergency Medicine	2,047	2,041	1,601	50	283	1	0	86	20	6
Emergency Med-Family Med	4	4	2	0	1	0	0	1	0	0
Family Medicine	3,356	3,215	1,513	132	574	1	0	658	337	141
Family Med-Preventive Med	6	6	5	0	0	0	0	0	1	0
Internal Medicine (Categorical)	7,233	7,101	3,245	131	690	2	0	1,030	2,003	132
Medicine-Anesthesiology	6	4	4	0	0	0	0	0	0	2
Medicine-Dermatology	6	6	6	0	0	0	0	0	0	0
Medicine-Emergency Med	26	26	21	1	3	0	0	1	0	0
GRAND TOTAL	31,757	30,478	19,343	917	3,234	7	0	2,932	4,045	1,279

- Number matching broken down by category (MD, DO, FMG etc)



Table 11 Osteopathic Students/Graduates Matched to PGY-1 Positions by Specialty,* 2013 - 2017

Specialty	2017		2016		2015		2014		2013	
	No.	%	No.	%	No.	%	No.	%	No.	%
▲ Anesthesiology	164	5.6	154	6.4	137	5.9	123	5.8	111	5.5
Child Neurology	8	0.3	5	0.2	10	0.4	5	0.2	5	0.2
Dermatology	0	0.0	0	0.0	0	0.0	0	0.0	1	0.0
▲ Emergency Medicine	283	9.6	224	9.3	203	8.7	177	8.3	178	8.9
Emergency Med Family Med	1	0.0	0	0.0	1	0.0	0	0.0	0	0.0
▲ Family Medicine	574	19.6	381	15.9	446	19.1	394	18.5	380	19.0
Family Med-Preventive Med	0	0.0	3	0.1	0	0.0	1	0.0	1	0.0
▲ Internal Medicine (Categorical)	690	23.5	498	20.8	511	21.8	444	20.9	413	20.6

- Total number DO candidates and the % of total in a given specialty



2016 'Charting Outcomes' (Osteopathic)

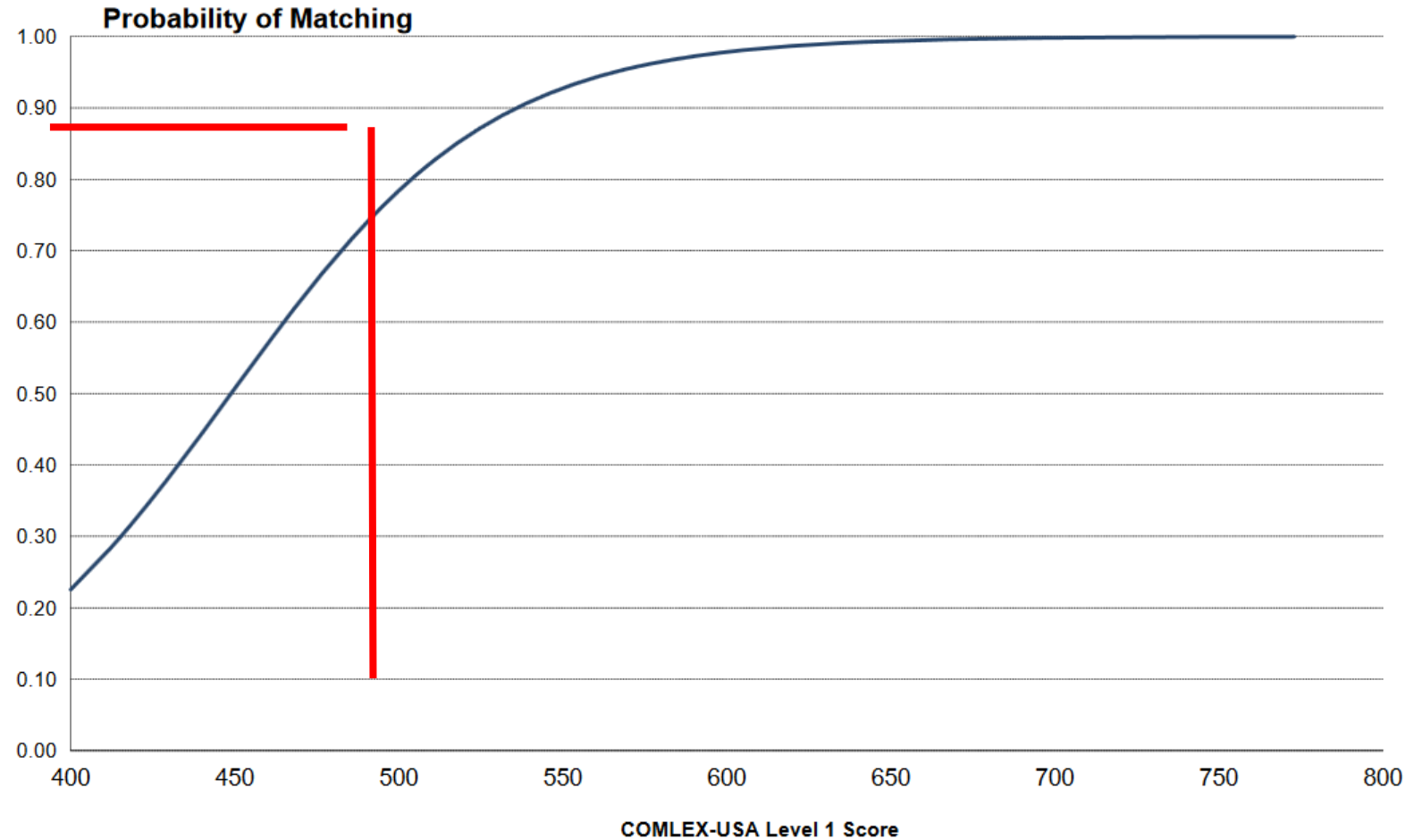
- 128-page look at osteopathic students experience with the NRMP
- Takes data from the NRMP summary and presents osteopathic focus
- 2017 will be out in Fall
- <http://www.nrmp.org/wp-content/uploads/2016/09/Charting-Outcomes-US-Osteopathic-2016.pdf>



- A lot of specialty-specific data
- Example graph showing likelihood of matching in anesthesia with a given COMLEX 1 score

**Graph
AN-2**

**Probability of U.S. Osteopathic Medical Students/Graduates Matching to Preferred Specialty by
COMLEX-USA Level 1 Score
Anesthesiology**



Sources: COMLEX-USA scores provided by NBOME; Match outcomes from NRMP Data Warehouse

Note: Probabilities calculated based on 2016 applicants only.

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2016 NRMP Program Director Survey

- Tells what PDs look at to make match-related decisions
- <http://www.nrmp.org/wp-content/uploads/2016/09/NRMP-2016-Program-Director-Survey.pdf>

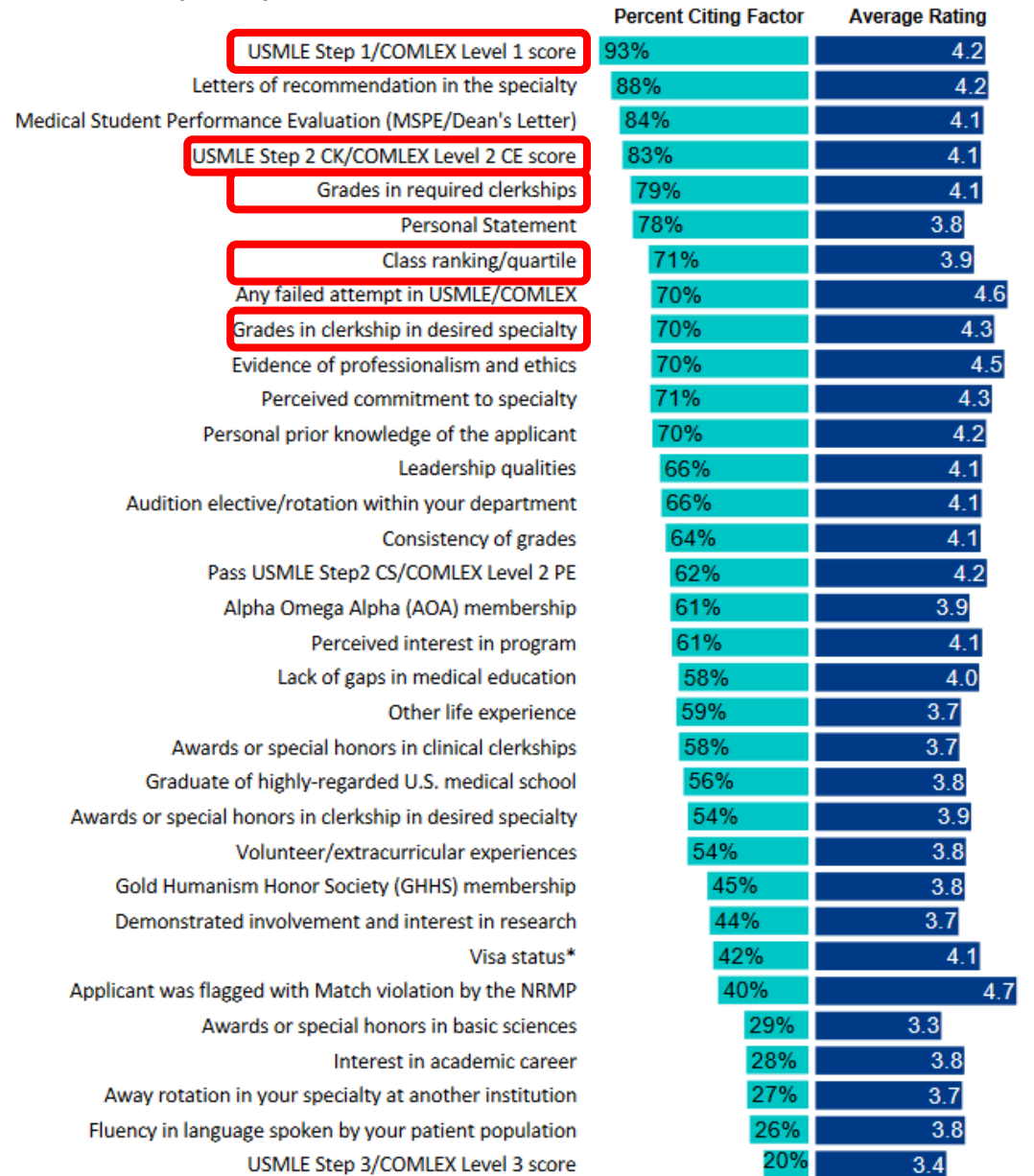


Interview (All Specialties)

- Board Scores
- Grades

Figure 1

All Specialties
Percentage of Programs Citing Each Factor And Mean Importance Rating¹ for Each Factor in Selecting Applicants to Interview
(N=1,300)



¹ Ratings on a scale from 1 (not at all important) to 5 (very important).

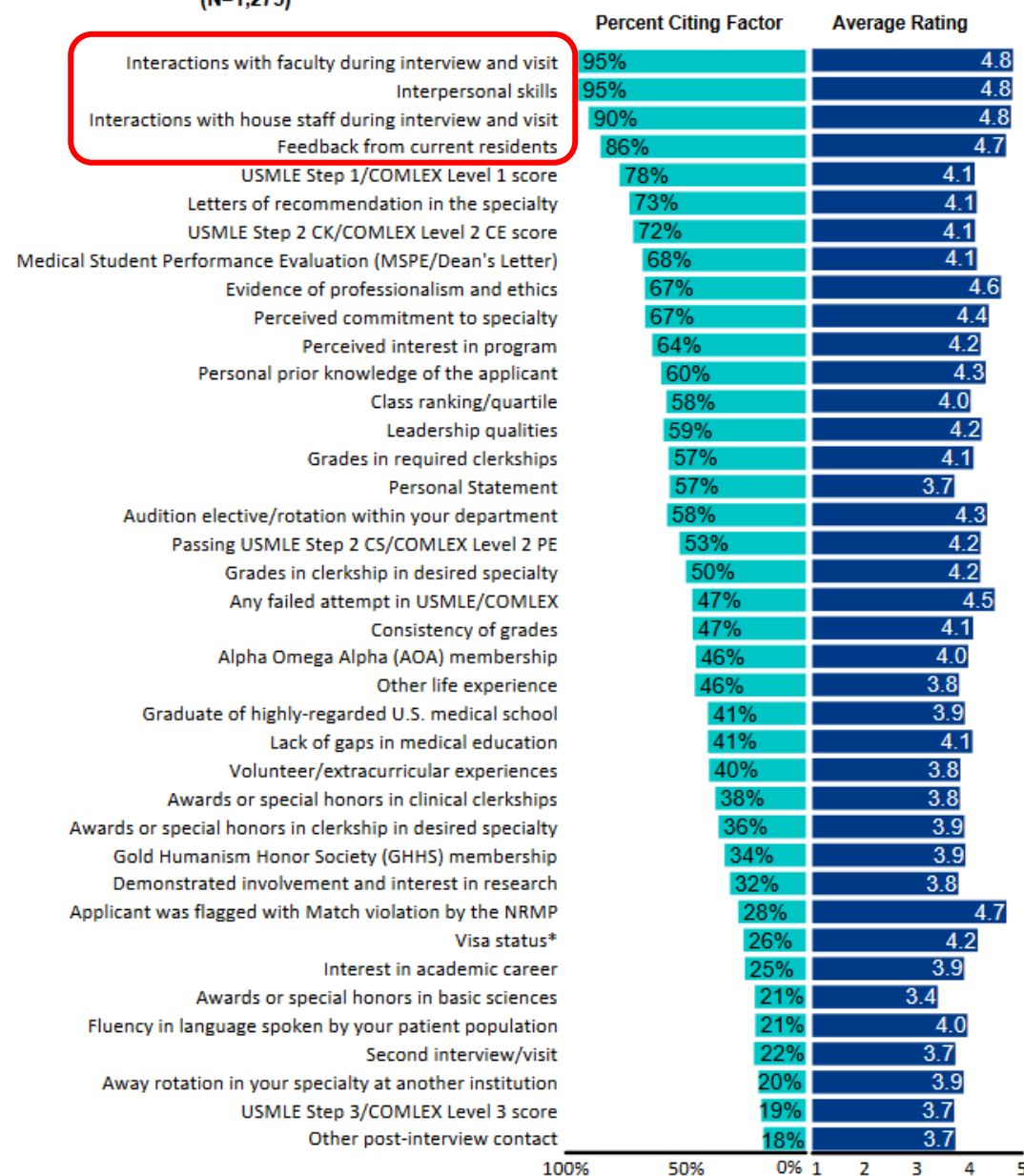
* International Medical Graduates only

Rank (All Specialties)

- Interpersonal Skills

Figure 2

All Specialties
Percentage of Programs Citing Each Factor And Mean Importance Rating¹ for Each Factor in Ranking Applicants
(N=1,275)



¹ Ratings on a scale from 1 (not at all important) to 5 (very important).

* International Medical Graduates only

What a Preceptor Can Do

- The Match is a big deal
- If a student asks for advice or insight, these resources are helpful
- May refer them to me
- Letters of Recommendation
- Advice with CVs and Personal Statements



Letters of Recommendation

- Specific process in ERAS
 - On letterhead
 - Formatting requirements
 - Student will email you a link with their request, you (or your staff) must upload it. LUCOM is not allowed to participate in this process
- You can ask student for CV, Personal Statement, etc.
- Don't put grades or boards scores in letter
- Student should waive right to see the letter
- Give honest appraisal of potential with specific examples
- If you can't write a good letter, decline the student's request



Comments in Evaluation

- The comments to write in the end-of-rotation evaluation go into the Dean's Letter
- We format, correct size restrictions and fix grammar
- But ... good and bad comments go into the letter
- Be specific, use examples
- Try to give more than one phrase/sentence



