

Evaluation Form



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VA GI Consult Evaluation

Evaluator: \_\_\_\_\_

Evaluation of: \_\_\_\_\_

Date: \_\_\_\_\_

Please answer questions to the best of your ability. On topic area questions you may answer not yet assessable if you have no information about the fellows knowledge in that topic area

Not Yet Assessable	Level 1	Level 2	Level 3	Level 4	Level 5
	Does not or is inconsistently able to collect accurate historical data. Does not perform or use an appropriately thorough physical exam, or misses key physical exam findings. Relies exclusively on documentation of others to generate own database or differential diagnosis or is overly reliant on secondary data. Fails to recognize patient's central clinical problems. Fails to recognize potentially life threatening problems.	Consistently acquires accurate and relevant histories. Consistently performs accurate and appropriately thorough physical exams. Inconsistently recognizes patient's central clinical problem or develops limited differential diagnoses.	Acquires accurate histories in an efficient, prioritized, and hypothesis-driven fashion. Performs accurate physical exams that are targeted to the patient's problems. Uses and synthesizes collected data to define a patient's central clinical problem(s) to generate a prioritized differential diagnosis and problem list.	Obtains relevant historical subtleties, including sensitive information that informs the differential diagnosis. Identifies subtle or unusual physical exam findings. Efficiently utilizes all sources of secondary data to inform differential diagnosis. Effectively uses history and physical examination skills to minimize the need for further diagnostic testing.	Role-models and teaches the effective use of history and physical examination skills to minimize the need for further diagnostic testing.

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1. PC1 Gathers and synthesizes essential and accurate information to define each patient's clinical problem\*

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Not Yet Assessable	Level 1	Level 2	Level 3	Level 4	Level 5
	Attempts to perform invasive	Possesses insufficient technical skill for	Possesses basic technical skill for the completion and	Consistently demonstrates technical skill to	Demonstrates skill to independently

	procedures without sufficient technical skill or supervision. Fails to recognize cases in which invasive procedures are unwarranted or unsafe. Does not recognize the need to discuss procedure indications, processes, or potential risks with patients. Fails to engage the patient in the informed consent process, and/or does not effectively describe risks and benefits of procedures.	safe completion of common invasive procedures with appropriate supervision. Inattentive to patient safety and comfort when performing invasive procedures. Applies the ethical principles of informed consent. Recognizes the need to obtain informed consent for procedures, but ineffectively obtains it. Understands and communicates ethical principles of informed consent.	interpretation of some common invasive procedures with appropriate supervision. Inconsistently manages patient safety and comfort when performing invasive procedures. Inconsistently recognizes appropriate patients, indications, and associated risks in the performance of invasive procedures. Obtains and documents informed consent.	successfully and safely perform and interpret invasive procedures. Maximizes patient comfort and safety when performing invasive procedures. Consistently recognizes appropriate patients, indications, and associated risks in the performance of invasive procedures. Effectively obtains and documents informed consent in challenging circumstances (e.g., language or cultural barriers). Quantifies evidence for risk-benefit analysis during obtainment of informed consent for complex procedures or therapies.	perform and interpret complex invasive procedures that are anticipated for future practice. Demonstrates expertise to teach and supervise others in the performance of invasive procedures. Designs consent instrument for a human subject research study; files an Institution Review Board (IRB) application.
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2. PC 4a. Demonstrates skill in performing and interpreting invasive procedures\*

Not Yet Assessable	Level 1	Level 2	Level 3	Level 4	Level 5
	Lacks foundational knowledge to apply diagnostic testing and procedures to patient care.	Inconsistently interprets basic diagnostic tests accurately. Does not understand the concepts of pre-test probability and test performance characteristics. Minimally understands the rationale and risks associated with common procedures.	Consistently interprets basic diagnostic tests accurately. Needs assistance to understand the concepts of pre-test probability and test performance characteristics. Fully understands the rationale and risks associated with common procedures.	Interprets complex diagnostic tests accurately while accounting for limitations and biases. Knows the indications for, and limitations of, diagnostic testing and procedures. Understands the concepts of pre-test	Anticipates and accounts for subtle nuances of interpreting diagnostic tests and procedures. Pursues knowledge of new and emerging diagnostic tests and procedures.

										probability and test performance characteristics. Teaches the rationale and risks associated with common procedures and anticipates potential complications of procedures.
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3. MK 2 Knowledge of diagnostic testing and procedures.\*

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Not Yet Assessable	Level 1	Level 2	Level 3	Level 4	Level 5
	Ignores cost issues in the provision of care. Demonstrates no effort to overcome barriers to cost-effective care.	Lacks awareness of external factors (e.g., socio-economic, cultural, literacy, insurance status) that impact the cost of health care, and the role that external stakeholders (e.g., providers, suppliers, financers, purchasers) have on the cost of care. Does not consider limited health care resources when ordering diagnostic or therapeutic interventions.	Recognizes that external factors influence a patient's utilization of health care and may act as barriers to cost-effective care. Minimizes unnecessary diagnostic and therapeutic tests. Possesses an incomplete understanding of cost-awareness principles for a population of patients (e.g., use of screening tests).	Consistently works to address patient-specific barriers to cost-effective care. Advocates for cost-conscious utilization of resources such as emergency department visits and hospital readmissions. Incorporates cost-awareness principles into standard clinical judgments and decision-making, including use of screening tests.	Teaches patients and health care team members to recognize and address common barriers to cost-effective care and appropriate utilization of resources. Actively participates in initiatives and care delivery models designed to overcome or mitigate barriers to cost-effective, high-quality care.
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4. SBP3 Identifies forces that impact the cost of health care, and advocates for, and practices cost-effective care.\*

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Not Yet Assessable	Level 1	Level 2	Level 3	Level 4	Level 5
	Disregards need for communication at time of transition. Does not respond to requests of caregivers in other delivery systems. Written and verbal care	Inconsistently utilizes available resources to coordinate and ensure safe and effective patient care within and across delivery systems. Provides incomplete written and verbal care plans	Recognizes the importance of communication during times of transition. Communicates with future caregivers, but demonstrates lapses in provision of pertinent or timely information.	Appropriately utilizes available resources to coordinate care and manage conflicts to ensure safe and effective patient care within and across delivery systems.	Coordinates care within and across health delivery systems to optimize patient safety, increase efficiency, and ensure high-quality patient outcomes. Role-models

	plans during times of transition are absent.	during times of transition. Provides inefficient transitions of care that lead to unnecessary expense or risk to a patient (e.g., duplication of tests, readmission).		Actively communicates with past and future caregivers to ensure continuity of care. Anticipates needs of patient, caregivers, and future care providers and takes appropriate steps to address those needs.	and teaches effective transitions of care.
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5. SBP 4 Transitions patients effectively within and across health delivery systems.\*

Not Yet Assessable	Level 1	Level 2	Level 3	Level 4	Level 5
	Never solicits feedback. Actively resists feedback from others.	Rarely seeks and does not incorporate feedback. Responds to unsolicited feedback in a defensive fashion. Temporarily or superficially adjusts performance based on feedback.	Solicits feedback only from supervisors and inconsistently incorporates feedbacks open to unsolicited feedback. Inconsistently incorporates feedback.	Solicits feedback from all members of the interprofessional team and patients. Welcomes unsolicited feedback. Consistently incorporates feedback. Able to reconcile disparate or conflicting feedback.	Performance continuously reflects incorporation of solicited and unsolicited feedback. Role-models ability to reconcile disparate or conflicting feedback.

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6. PBLI 3 Learns and improves via feedback.\*

Not Yet Assessable	Level 1	Level 2	Level 3	Level 4	Level 5
	Is consistently unreliable in completing patient care responsibilities or assigned administrative tasks. Shuns responsibilities expected of a physician professional.	Completes most assigned tasks in a timely manner but may need reminders or other support. Accepts professional responsibility only when assigned or mandatory.	Completes administrative and patient care tasks in a timely manner in accordance with local practice and/or policy. Completes assigned professional responsibilities without questioning or the need for reminders.	Prioritizes multiple competing demands in order to complete tasks and responsibilities in a timely and effective manner. Willingly assumes professional responsibility regardless of	Role-models prioritizing many competing demands in order to complete tasks and responsibilities in a timely and effective manner. Assists others to improve their ability to prioritize many

								the situation.	competing tasks.
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7. PROF 2 Accepts responsibility and follows through on tasks.\*

Not Yet Assessable	Level 1	Level 2	Level 3	Level 4	Level 5
	Ignores patient preferences for plan of careMakes no attempt to engage patient in shared decision-making. Routinely engages in antagonistic or counter-therapeutic relationships with patients and caregivers.	Engages patients in discussions of care plans and respects patient preferences when offered by the patient, but does not actively solicit preferences. Attempts to develop therapeutic relationships with patients and caregivers but is inconsistently successful. Defers difficult or ambiguous conversations to others	Engages patients in shared decision-making in uncomplicated conversations. Requires assistance facilitating discussions in difficult or ambiguous conversations. Requires guidance or assistance to engage in communication with persons of different socioeconomic and cultural backgrounds	Identifies and incorporates patient preference in shared decision-making in complex patient care conversations and the plan of care. Quickly establishes a therapeutic relationship with patients and caregivers, including persons of different socioeconomic and cultural backgrounds	Role-models effective communication and development of therapeutic relationships in both routine and challenging situations. Models cross-cultural communication and establishes therapeutic relationships with persons of diverse socioeconomic and cultural backgrounds. Assists others with effective communication and development of therapeutic relationships.
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8. ICS 1 Communicates effectively with patients and caregivers.\*

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Not Yet Assessable	Level 1	Level 2	Level 3	Level 4	Level 5				
	Does not or inconsistently collects accurate historical data. Does not understand concept of alarm symptoms that may warrant further investigation. Cannot perform directed physical exam to assess for complications of acid peptic	Consistently acquires accurate and relevant histories and physical exams. Uses and synthesizes collected data to define a patient's central clinical problem(s) to generate a prioritized differential diagnosis and problem list. Test ordering is targeted towards the main clinical problem but may not incorporate	Recognizes anatomy and physiology of the esophagus, stomach and duodenum, and pathophysiology of gastric acid secretion in health and disease, including hypersecretory states. Can describe the natural history, epidemiology and complications of acid peptic disorders including role of NSAID and H Pylori. Recognizes the pathophysiology of gastroesophageal reflux disease and potential for	Obtains relevant historical and examination subtleties that informs the differential diagnosis. Recalls the pharmacology, efficacy, appropriate use, routes of administration, and appropriate use of medications for acid-peptic diseases, including antacids, histamine-2	Recalls conditions that mimic or confound the diagnosis of acid peptic disorders, eosinophilic esophagitis, stress ulcer syndrome, achlorhydria, pernicious anemia, gastric polyps and neoplasia, other esophageal and gastric inflammatory disorders, and				

	disorders; cannot recognize potentially life threatening problems; cannot focus diagnostic test ordering.	cost effectiveness, clinical guidelines, patient safety and/or preferences.	premalignant conditions including Barrett's esophagus. Appropriately orders testing including endoscopy, pH monitoring, manometry and radiology.	receptor antagonists, proton pump inhibitors, mucosal protective agents, prostaglandin analogues, prokinetic agents, and antibiotics. Can perform supervised EGD without hands-on assistance	elevated gastrin. Test ordering is appropriate, cost effective and incorporates patient safety and preferences. Recognizes when surgical management is indicated and works effectively as a leader in interdisciplinary team.
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9. Acid Peptic Disorders\*

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Not Yet Assessable	Level 1	Level 2	Level 3	Level 4	Level 5
	Does not know the appropriate indications for upper and lower endoscopy. Does not know the risks and benefits of upper and lower endoscopy. Cannot effectively provide informed consent to patients or family members. Does not systematically document pre-anesthesia evaluation, informed consent, procedure documentation and discharge instructions.	Can summarize the appropriate indications, risks and benefits for both upper and lower endoscopy, considers alternatives. Obtains a thorough informed consent in language appropriate to the patient's level of understanding. Can determine the adequacy of bowel prep during colonoscopy. Can recognize landmarks in upper and lower endoscopy, normal and abnormal findings. Always documents pre-anesthesia evaluation, informed consent, procedure note and discharge plans/instructions.	Can summarize screening/surveillance guidelines related to colon cancer, inflammatory bowel disease, Barretts and varices. Can define potential quality metrics for endoscopic procedures. Understands the pharmacology of conscious sedation and can direct administration and monitor comfort and safety. Can intubate to second portion of duodenum, to cecum and can retroflex when appropriate. Can counsel patients about prep and the system used to communicate results to the patient. Communicates effectively with staff during procedure.	Manages antiplatelet and anticoagulant therapy and use of antibiotics with endoscopy. Conducts a thorough examinations, identifies landmarks, demonstrates adequate polyp detection. Performs biopsy, and polypectomy of pedunculated and sessile polyps and ensures adequate hemostasis. Performs endoscopic therapies including band ligation, foreign body removal, dilation, injection therapy, PEG. Recognizes complications or need to abort procedure for safety.	Reviews own quality performance metrics and incorporates changes to meet goals. Can list and perform techniques utilized for removal of various lesions including flat and laterally spreading polyps. Can determine which lesions are best managed by submucosal injection and cap or band-assisted resection. Recognizes the spectrum of normal and abnormal endoscopic findings, determines the clinical relevance, best management and can communicate this effectively to the patient, family and other physicians.

10. Endoscopy\*

Not Yet Assessable

Level 1

Level 2

Level 3

Level 4

Level 5

Does not or inconsistently collects accurate historical data relevant to GI bleeding. Does not understand concept of alarm symptoms and the need to expedite further evaluation. Cannot perform directed physical exam to assess for hemodynamic stability and possible etiologies of GI bleeding. Cannot direct appropriate resuscitation when necessary. Tries to avoid urgent endoscopic intervention when indicated.

Obtains accurate history related to GI bleeding and underlying disease and accurately determines hemodynamic status. Recommends PPI, octreotide, antibiotics and transfusion of blood products appropriate to the disease process and resuscitation needs. Appropriately recommends management of antiplatelet and anticoagulant therapy in the setting of acute bleeding. Can describe the indications, risks and benefits of EGD, colonoscopy, small bowel enteroscopy and capsule endoscopy for GI bleeding.

Determines timing , location and whether upper, lower endoscopy or both is needed. Recognizes presentations at high risk for variceal source. Assembles necessary endoscopy equipment, administers sedation safely and effectively and communicates with assistants effectively. Obtains a thorough informed consent in language appropriate to the patient's or family's level of understanding. Performs upper and lower endoscopy with limited hands-on assistance.

Performs appropriate upper and lower endoscopy, accurately identify mucosal lesions, stigmata of bleeding and other anatomical findings and summarizes the appropriate endoscopic and medical management. Recognizes indications for anesthesia support and airway protection. Summarizes available endoscopic hemostasis techniques including electrocautery, band ligation, hemoclips, injection of hemostatic agents. Can interpret capsule endoscopy findings

Understands appropriate utilization of radiologic and surgical interventions to manage GI bleeding including limitations of radiologic evaluation and intervention in upper GI bleeding. Appropriately recommends management of anti-platelet and anti-coagulants after GI bleeding. Recognizes and manages complications expeditiously. Works effectively with surgeons, intensivists and radiologists. Can recognize and advise when intervention is futile. Performs upper and lower endoscopy without hands-on assistance.

11. Endoscopy and GI Bleeding\*

Not Yet Assessable

Level 1

Level 2

Level 3

Level 4

Level 5

Does not or inconsistently collects accurate historical data related to GI malignancy. Does not understand concept of alarm

Consistently acquires accurate and relevant histories and accurate physical exams. Can discuss cancer epidemiology, primary prevention and

Considers cost effectiveness, patient specific risk factors and patient preferences when ordering tests. Knows the guidelines and can site literature supporting screening for GI neoplasia. Performs basic

Understands the importance of genetic counselling in managing patients with inherited GI disease. Can describe the clinical genetics related to GI

Is able to discuss the new diagnosis of GI cancer with a patient and family in a compassionate manner and answer questions about further

	symptoms that may warrant further investigation. Cannot perform directed physical exam to assess for signs and findings of GI malignancy. Cannot focus diagnostic test ordering.	screening for GI malignancies. Orders somewhat appropriate tests for diagnosis, screening, surveillance and staging of GI malignancies, may not consider cost effectiveness, patient specific risk factors, or patient preferences.	endoscopy to diagnose and treat GI neoplasia including colonoscopic polypectomy, NBI/biopsy Barretts. Identifies appropriate surveillance intervals and makes use of medical systems to support compliance. Counsels patients appropriately based upon personal and family history.	malignancies including FAP, HNPCC and other rarer polyposis syndromes. Can define the initial staging, management and expected prognosis of patients with newly diagnosed GI cancer. Demonstrates the capabilities and limitations of endoscopic therapy for early GI cancers ie intramucosal esophageal adeno, GIST, carcinoid.	evaluation, therapy and prognosis. Works with a multidisciplinary team including primary care, oncologists, surgeons, pathologists, and radiologists to care for patients with GI malignancy. Recognizes and acknowledges the psychological consequences to the patient and family. Is able to discuss transition to palliative care with patient and family.
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13. Please comment on areas in which this fellow excels \*

14. Please comment on areas in which this fellow could improve \*