AAMC recent advisory on Electronic Health Records (EHRs) in Academic Health Centers states “The AAMC has developed Core Entrustable Professional Activities (EPAs) for Entering Residency—guidelines intended to help bridge the gap between patient care activities that new physicians should be able to perform on day one of residency training and those they feel ready to perform without direct supervision—that are now being pilot tested by 10 medical schools. It is apparent throughout the guidelines that the ability to work in an electronic health record is an important tool to achieving the desired skills for each of the EPAs. Two of the EPAs speak directly to the student’s ability to interact with the EHR: “Enter and discuss orders and prescriptions” and “document a clinical encounter in the medical record”.

Medical students MUST:

- Have their own unique login and password (not use their preceptor’s login and password) to chart in the EHR.

- Have access to:
  - Review/update of the past, family/social history and ROS.
  - Enter needed data into the EHR
  - Search for patient data within the EHR

On average, students must have a minimum of one complete chart note (including assessment and plan) –per half-day on outpatient and per day on inpatient rotations--routed to the preceptor for feedback.

Medical students SHOULD:

- Have opportunities to pend medications, consultations and other orders.
- Become familiar with (if relevant / available):
  - Selection of diagnoses, CPT/ICD codes, and how these are linked to billing
  - Medication reconciliation and other tasks on admission and discharge
  - Patient Centered Medical Home metrics, to which they may contribute
  - Meaningful Use metrics, to which they may contribute.
  - Query functions that practices use for population management

Based on Society of Teachers of Family Medicine EHR Guidelines, June 2013

DISCLAIMER: There will be exceptions to this policy.

030215 Approved Required Clerkship Committee