Clinical Assessment Process & System (CAS) – Students

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The Clinical Assessment Process

- During the Basic Cores I and II students will electronically record in the patient log component of the Clinical Assessment System (CAS) each patient encounter in which they have direct, significant involvement with the patient.

- **Student Expectations**: Students will request that the responsible supervising faculty or resident assess student performance in a subset of these encounters.
  
  - Students are expected to complete at least one patient log for each of the required diagnoses and presenting problems for each Basic Core and to request an assessment for the majority of these encounters.
  
  - General guidelines are at least 1 assessment request for each half day during outpatient-based activities with a maximum of 2 for each half day and minimum of 2-3 per week during inpatient-based activities with a maximum of 10/week.
  
  - Students must arrange for this assessment by electronically sending the request to the supervising faculty or resident.
  
  - Assessments must be sent to faculty within 3 days of the targeted activity.

- These patient encounter logs and related assessments serve as the basis for student assessment during the Clinical Rotations.

- **On-line reports** are available in the CAS detailing the patient logs that each student has completed as well as the details about the number of assessments that have been requested and the number of assessments that have been completed.
  
  - Students should review this report frequently to be sure that a sufficient number of encounters, diagnoses and presenting problems, procedures, and assessments are being recorded.
  
  - If students have any questions and/or difficulty in completing encounter logs and receiving assessments, they should contact the Rotation Director as soon as possible.

- **Interval Formative Assessments**
  
  - During the Basic Cores every four weeks students will review their feedback and their progress in attaining block objectives and meet with the appropriate discipline leader(s) to discuss this experience and develop learning plans as indicated. During the advanced cores and other clinical rotations, this process should occur at mid-rotation (usually 2 weeks).
  
  - Each student’s advisor (Society Dean for University students, Physician Advisor for CCLCM students) will have access to the results of these meetings and meet with the students as needed.
  
  - Students are encouraged to discuss their progress with their advisor.

- **Composite End of Rotation Assessment**
  
  - A final report for each Discipline/rotation will be developed for each student. The final end of rotation report will include a summative assessment for each competency: “Exceeds expectations”, “Meets expectations”, “Meets expectations with concerns”, “Does not meet expectations, remediation required” or “Failed”. Please note that there is a separate process for assigning grades for the University Students in each discipline.
- For “Does not meet expectations, remediation required” a remediation plan will be created. This remediation plan must address all elements that did not meet standards for competency.
- This report will be available to the student’s advisor. Students are encouraged to discuss this report with their advisor in order to address areas of weakness when planning clinical electives and other learning activities.

**Basic Core Performance Summative Assessment – Week 16**

- Students will receive notification regarding Basic Core performance as to whether the degree of remediation outlined in the discipline remediation plans for the Basic Core warrants their needing to repeat the entire Basic Core.
The Clinical Assessment System (CAS)

System Overview: What will I use the CAS for?

- The CAS is a stand-alone system available on the WWW from any computer at https://casemed.case.edu/CAS. Use your Case ID to log in.
- You will use this system to:
  - Create logs and follow-up logs of meaningful patient encounters
  - Request patient-based and non-patient-based assessment from faculty and other assessors. The CAS will email your request. (Note: assessments must be requested within 3 days of the encounter/situation.)
  - Review received assessments
  - Track and review the kinds of patients you’ve seen and the assessment feedback you’ve received
Let’s get started…

Logging In

You will find a link to the CAS on your Portal or you can go directly to https://casemed.case.edu/CAS. You will need to log in using your Case ID.

The first time you log in, you’ll need to click “Forget your password?” so that you can create your password. On the next page enter your Case email address (for CCLCM students too) and you’ll receive a link to a page where you’ll enter a password.
Featuring Your CAS homepage

Login information, Logout

Navigation: Home, Add a Log, Request Assessment, Search, Reports and Help

Change the # of items you see in each section below

Logs you’re still working on

Assessments you’ve received in the last 30 days

Finished logs from encounters less than 3 days ago may be assessed

Assessments you’ve requested but haven’t yet received

The CAS Banner

The banner is available on most pages and will give you immediate access to the following options throughout the CAS:

Log out

Request non-log based Assessment

Your Reports

Create a New Log

Search

Help
Let’s look at the tasks you’ll be using the CAS to complete…

Creating a new log

After you’ve seen a patient you’ll need to log the encounter. There are 2 buttons on the homepage that will take you to the Create New Log page:

Creating a patient/procedure log is a process with **5 important steps**, 4 of which are required for the log to be finished and Available for Assessment:

1. Describing the Encounter
2. Describing the Patient
3. Documenting Your Role in the encounter
4. Describing any Procedure(s) done (optional)
5. Recording your Preceptor(s)

We’ll now look at each Step in depth…
Step 1, the Encounter

1. Fill the fields on this page. They’re all required (*), but defaults make it easier to fill out.
   - **Encounter Date**: defaults to today’s date (this date cannot be changed once this page is saved).
   - **Block**: defaults to the current Block. If this encounter had occurred during a different Block, I could change the drop-down to that selection.
   - **Discipline**: choose from the drop-down list.
     - At this point you can enter the Preceptor’s Specialty if you know it. Leave it at the default if you’re not sure. Entering the Preceptor’s Specialty will help you in searching for an assessment you’ve received later on.
   - **Site**: defaults to your current Site. If the patient had been seen at a Site other than I am assigned to, I could change the drop-down to that selection.

2. With the Encounter information complete, we’ll move on by clicking **Save & Proceed**.

   If we wanted to stop working and come back later, we’d click “Save & Exit.”

   - Ignore the “I’ve seen this patient before” button for now. We’ll look at that button later when we create a follow-up log.
Step 2, the Patient

1. Fill the Required fields (*):
   - Age
   - Gender
   - Race
   - Primary Symptom or Diagnosis

   Note: If “Other” is chosen as a Symptom/Diagnosis, you must type it in and select a Corresponding System.

2. Input any Secondary Symptom and Diagnosis by choosing a Symptom/Diagnosis and clicking “Add.” To remove a Symptom/Diagnosis, choose it and click “Remove.”

3. When you’re finished, click Save & Proceed to continue.
Step 3, my Role

1. Complete applicable checkboxes describing your Role in this encounter.

<table>
<thead>
<tr>
<th>SKILL</th>
<th>Performed/Discussed/Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Alone</td>
</tr>
<tr>
<td>History Taking</td>
<td>□</td>
</tr>
<tr>
<td>Physical examination</td>
<td>□</td>
</tr>
</tbody>
</table>

2. Enter any comments you want to record regarding this encounter.

Comments:
- Highlight learning issues and challenges rather than summarizing the case.
- Avoid patient identifiers.
- Comments will be visible to your preceptor if you choose to send the log for assessment.

3. Did you do a **Procedure** at this encounter? If so, check the box to move to the Procedure entry page. If the box is unchecked, you will skip the Procedure Step.

4. After making your choices, click “Save & Proceed” to move forward. We’ll check the box to Add a Procedure.
Step 4, Procedure

1. Select the Procedure(s) from the drop-down, using the “Add” and “Remove” buttons to manage multiple selections. *Note: You can delete all added Procedure(s) at once by clicking “Delete procedure(s)” at the top of the page.*

2. Each selection will add a row to the Role table. Record your Role in the procedure by checking the appropriate box.

3. Enter any Comments particular to the procedure portion of the encounter.

4. Click “Save & Proceed” to continue to the final step.
Step 5, Preceptor(s)

You must enter at least one Preceptor for every log. Only Preceptor(s) entered here will be available to send an assessment request.

1. Start typing your Preceptor’s last name in the text box.

For example, typing Dr. Mehta’s name reveals that he’s in the system as a Preceptor. His name shows in the list of “M’s” to be selected. If he hadn’t shown up in the list, I could input his name, last name first.

2. Make sure the correct role is selected for this Preceptor and choose the portions of the encounter during which this person precepted you.

3. Save. The log is now finished, and the finished log and the Preceptor you’ve added are available for an assessment request.

You now have the following options: Delete or Edit the Preceptor you just entered, add another Preceptor, go directly to Request Assessment, or simply Exit to the homepage.
Creating a log for a Follow-up Patient

There are two ways to create a follow-up log. Use the workflow that works best for you.

First option:

1. Start a new log as usual but, instead of filling the fields on the first page, click “I’ve seen this patient before”

2. We’ll help you find the follow-up patient so their information will pre-fill into your new log and this log will be tied to this patient.

   Is the patient one of the last 10 you’ve seen?
   - If so click “Select” next to that patient and the window will close and you’re ready to begin.
   - If not, “Search” for the patient using the standard search fields to search the logs you’ve created...
In the results you can choose the correct patient by clicking the select button. This will close the window and pre-fill the patient’s information into your new log.

Second Option:

If you’ve already searched for and opened a prior log for the follow-up patient, you can create your follow-up log by clicking “Create a follow-up log” at the top of the completed log.
Making Changes to a Saved Log

First, determine if the log is In Progress or finished…

Log is In Progress: If you’ve clicked “Save & Exit” while creating a log, or exited a log before completing all the steps, the log is In Progress and available on the homepage.

- Click on the log to resume work.
- You can delete logs that are In Progress with the delete icon.

Log is finished: If you completed the final step of a log, the log will be either Available for Assessment, if it’s within 3 days of the encounter, or it will be archived and accessible by searching. As long as you haven’t sent an assessment request for the log, you will be able to open the log and edit it.
Request Assessment for a Patient and/or Procedure Log

There are 2 ways to get to the Assessment Request page:

- After entering your Preceptor(s) in step 5, click the “Request Assessment” button
- From the homepage, click on a log that’s “Available for Assessment”

Requesting a log-based assessment triggers an email to the Preceptor(s) you designate with a direct link to the necessary assessment form.

- You can request a single log be assessed by one or multiple Preceptors (as long as you’ve added those Preceptors in step 5 of your log)
- You can request a day or week’s worth of logs be assessed.
  - Students in the Basic Cores should still be getting feedback on individual encounters but will have the option to group patient logs for the same date and preceptor. Discuss this feature with your preceptor to see if he or she would like you to group logs. This "grouping" feature was designed for advanced rotations and should not be generally used for basic cores.
  - Students in Advanced Cores will be expected to utilize this feature to group their logs. Ask your preceptor whether you should group patient logs only for the same day or wait until the end of the week to request an assessment on all logs for that week. The 3 day deadline for logs available for assessment still applies. For example if you are grouping logs for a week, you need to send the request within 3 days of the last log for that week.
- You can request a Patient and/or Procedure assessment, but the Preceptor(s) must have been added for that portion of the encounter in step 5 of the log.
- All log-based assessment requests must be within 3 days of the log’s Encounter Date.

Note: Requesting an assessment means that Preceptor(s) will be reviewing your log(s), so your log(s) will be locked ☑️ and no longer editable.

1. Select an available Preceptor. If you do not see a desired Preceptor here, you may need to add him or her using the “Add/Edit Preceptor(s)” button or you may have already sent a request to that Preceptor.
2. Selecting a Preceptor displays the request form for that Preceptor. Make sure your desired Request Type is selected and the email address is correct. Type a note to the Preceptor, perhaps to remind him or her of this particular encounter, without including any patient identifiers. It’s a good idea to double check the pre-filled email address. If you have been given a different email address for the preceptor, enter it in the text box.

3. If you would like to group other patient logs with this request, click the button “Combine this Request” to open the grouping option:

You will need to choose whether you want to combine for a week or a day. Basic Core students will not have any option here – they can only group logs for a day. The logs that will be grouped are displayed on the right. If you do not want to group logs, simply click on the “Combine this Request” button again to close this feature.

4. Select and review any additional Preceptors for this request and click “Request Assessment(s)”. The request will show up in your Outbox to track. Note: You will be able to make changes to your requests from the homepage. You will not be able to edit the log once a request is sent.
Requesting an Assessment that’s Not Patient Log-Based

You may want to request assessments that are not based on a specific patient encounter. There are 2 buttons on the homepage that will take you to the Request Assessment page:

From the Request Assessment page:

1. Choose the Type of Assessment you would like. Block and Site will contain your defaults but may be changed. Choose the Discipline from the drop-down list.

2. Fill in the recipient the same as an Assessment Request for a Log - start typing the Preceptor’s last name in the box and choose the name from the drop-down. If the
Preceptor isn’t in the list, type his or her name, last name first. Confirm his or her role. Enter any comments regarding this assessment request and click “Add Preceptor”.

3. Review your selected Preceptor(s). It’s a good idea to double check the pre-filled email address. If you have been given a different email address for the preceptor, enter it in the text box.

4. Click “Request Assessment.” The request may be changed or deleted from your Outbox.
Review/Modify an Assessment Request

Send an assessment request to the wrong person? Decide not to send a request at all? You can manage your assessment requests from your homepage Outbox.

Once your Preceptor starts the assessment, the request will be locked and cannot be modified. Requests that are available to review may be opened by clicking on the request name.

The review page provides 3 options:

1. Edit the request (email address or your note)
2. Delete the request entirely

3. Redirect the exact same request to another Preceptor.

The new recipient must be a Preceptor entered in step 5 of the log, so if you don’t see the desired person you must Add/Edit Preceptor(s) and then redirect.
Still haven’t received an assessment?

There are a few reasons your request might still be outstanding.

- The recipient intends to do the assessment, but it slipped his or her mind. Don’t worry, the CAS will send an automatic reminder a week after the request was sent and then in two weeks if necessary.
- The intended recipient never received the request. You may want to open and review the assessment request from your Outbox and make sure the emailed request went to the right person at the correct email address.
- The recipient decided to opt-out of doing the assessment. You may want to check your Outbox for any requests that have the opt-out icon displayed. If the opt-out was due to an error or a miscommunication, you may want to review your request.
Viewing Assessments You’ve Received

You will find completed assessment in your Inbox on your homepage.

- New assessments are bold
- Completed assessments are stored in the Inbox for 30 days. Use the Search feature to find assessments older than this.

Click on the assessment to view. It will open in a new window:
Searching for Completed Logs and Assessments

To view assessments older than 30 days and finished logs with an encounter date more than 3 days past (remember logs are available for assessment only within 3 days of the encounter), use the Search feature.

Search for logs and log-based assessments using any or none of the fields provided. Specifying no terms will show results of all logs completed. To search by date, type in the date or click on the Calendar icons.
Results of your Search will appear below your Search terms…

There’s also a way to look for non patient log based assessments that has a different set of choices for searching…

Click “Search Non-Log Based Assessments.” This Search works much the same.
Accessing your own Reports

Reviewing the different kinds of patient encounters you’ve experienced and your own performance is easy – click on the Reports button…

for 2 types of reports:
- Patient and Procedure log totals
- Competency summary

**My Reports**

<table>
<thead>
<tr>
<th>Symptom/Diagnosis</th>
<th># Seen: Primary (Secondary)</th>
<th>Assessments Requested</th>
<th>Assessments Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Anemia</td>
<td>2(0)</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Back pain</td>
<td>1(0)</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Competency**

<table>
<thead>
<tr>
<th>Competency</th>
<th># Assessments for Competency</th>
<th># Assessments for Targeted Areas For Improvement</th>
<th># Assessments for Areas Of Strength</th>
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<tr>
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<td>0</td>
<td>9</td>
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<tr>
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<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Practice-based Learning</td>
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</tr>
<tr>
<td>Professionalism</td>
<td>11</td>
<td>2</td>
<td>10</td>
</tr>
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</table>