MEDICINE

WMed Preceptor Guidebook

2020 - 2021

Preface

The WMed Preceptor Guidebook serves to establish standards to assure a comparable experience for all students during each clerkship. Included you will find learner, educator, and staff member expectations as well as helpful references to the Medical Student and Faculty Handbooks. Recommendations are provided to facilitate preparation for the arrival of medical students in both inpatient and ambulatory settings.

Descriptions of the characteristics of excellent teachers are provided to assist faculty in reflecting upon their key roles in medical student education. Guidelines for student assessment are provided as well, to facilitate consistency in observing, assessing, providing feedback, and documenting student performance.

Our goal is to provide a useful guidebook for all teaching physicians. Please direct your feedback regarding this guidebook to Clerkship Directors, the Assistant Dean for Clinical Applications, and/or the Associate Dean for Educational Affairs. With our new digital format, we aim to continuously improve this guide to best serve your needs.

Thank you for your commitment to our medical students as you provide outstanding care to the patients you serve.

Sincerely,
Kristine M. Gibson, MD
Assistant Dean, Clinical Applications
Western Michigan University
Homer Stryker M.D. School of Medicine

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Clerkship Contacts & Resources

Critical Care

Director: Jeff Wilt, MD
Phone: 269-308-7223, jeffrey.wilt@med.wmich.edu

Coordinator: Alaina Kaupa
Phone: 269-337-4580, alaina.kaupa@med.wmich.edu

Emergency Medicine

Director: Kate Redinger, MD
Phone: 269-337-6600, kathryn.redinger@med.wmich.edu

Coordinator: Sose Klein
Phone: 269-337-4539, sose.klein@med.wmich.edu

Family & Community Medicine

Director: Wesley Eichorn, DO
Phone: 269-349-2641 ext.440, wesley.eichorn@med.wmich.edu

Coordinator: Jayme Salinas
Phone: 269-337-4536, jayme.salinas@med.wmich.edu

Medicine Core Clinical

Director: Melissa Olken, MD
Phone: 269-352-9801,
melissa.olken@med.wmich.edu

Coordinator: Karen Tulik
Phone: 269-337-6114, Karen.tulik@med.wmich.edu

Medicine Advanced Clinical

Director: Prashant Patel, DO
Phone: 269-337-6350, prashant.patel@med.wmich.edu

Coordinator: karen.tulik
Phone: 269-337-6114, Karen.tulik@med.wmich.edu

Pediatric & Adolescent Medicine Core Clinical

Director: Maria Demma Cabral, MD
Phone: 269-337-4489,
mariademma.cabral@med.wmich.edu

Coordinator: Paula Hawkes
Phone: 269-337-6011, paula.hawkes@med.wmich.edu

Pediatric & Adolescent Medicine Advanced Clinical

Director: Natalie Behrle, MD
Phone: 269-337-6504, natalie.behrle@med.wmich.edu

Coordinator: Paula Hawkes
Phone: 269-337-6011, paula.hawkes@med.wmich.edu

Psychiatry/Neurology

Neurology Director: Michelle Crooks, MD Phone: 269-598-4394, crooksm@bronsonhg.org

Psychiatry (Interim) Director: Sonia Shariff, MD
Phone: 269-337-4388, sonia.shariff@med.wmich.edu

Coordinator: Sjana Markusic
Phone: 269-337-4580, sjana.markusic@med.wmich.edu

Surgery

Director: Lisa Miller, MD
Phone: 269-337-6260, lisa.miller@med.wmich.edu

Coordinator: Paula Hawkes
Phone: 269-337-6011, paula.hawkes@med.wmich.edu

Women's Health Core Clinical

Director: Silvia Linares, MD
Phone: 269-330-7183, silvia.linares@med.wmich.edu

Coordinator: Ashley Earl

Phone: 269-337-6352, ashley.earl@med.wmich.edu

Women's Health Advanced Clinical

Director: Rebekah Sharp, MD Phone:
269-337-6079, rebekah.sharp@med.wmich.edu

Coordinator: Ashley Earl
Phone: 269-337-6352, ashley.earl@med.wmich.edu

Additional Contacts

Assistant Dean, Clinical Applications: Kristine Gibson, MD
Phone: 269-337-6464, kristine.gibson@med.wmich.edu

Associate Dean, Office of Educational Affairs: Mike Busha, MD
Phone: 269-337-4551, mike.busha@med.wmich.edu

Director, Office of Educational Affairs: Karen Tulik
Phone: 269-337-6114, karen.tulik@med.wmich.edu

Assistant Director, Office of Educational Affairs: Shannon Coleman
Phone: 269-337-4511, shannon.coleman@med.wmich.edu

Associate Dean, Office of Faculty Affairs: Lisa Graves, MD
Phone: 269-337-4512, lisa.graves@med.wmich.edu

I.T. Help Desk - Support
Phone: 269-337-4409, support@med.wmich.edu

Additional Resources

WMed Faculty Portal

WMed Library

WMed Policies, Handbooks, Manuals, and Statements

Clinical Teaching Etiquette
Detsky AS. The Art of Pimping. *JAMA*. 2009;301:1379-1381.

Student difficulties in the clinical setting
Hicks PJ, Cox SM, Espey EL, et al. *American Journal of Obstetrics and Gynecology*. 2005;193:1915-1922.

One-minute Preceptor Model
Teaching the One-minute Preceptor A Randomized Controlled Trial
Furney SL, Orsini AN, Orsetti KE, Stern DT, Gruppen LD, Irby DM. *Journal of General Internal Medicine*. 2001;16:620-624.

The One Minute Preceptor: Shaping the Teaching Conversation
Neher JO, Stevens NG. *Family medicine*. 2003;35:391.

Take 5: One Minute Preceptor, Mayo Clinic ***OR*** One Minute Preceptor, Matthew Eberly

Domains of Competency
Englander R, Cameron T, Ballard AJ, Dodge J, Bull J, Aschenbrener CA. Toward a Common Taxonomy of Competency Domains for the Health Professions and Competencies for Physicians. *Academic Medicine*. 2013; 88:1088-1094.

Family Education Rights & Privacy Act

WMed complies fully with the Family Educational Rights and Privacy Act (FERPA) of 1974, a federal law governing the privacy of students' education records. The medical school takes seriously its commitment to protect the privacy of our students and their education records.

The FERPA definition of education records includes all of the information and records in any format that are used by the medical school in the instruction and evaluation of students. Education records include any information or documentation that is recorded in any way, including records produced by handwriting, computer, email, audio, and video, among others. Education records contain information directly related to a student, and may be maintained by the medical school or any party acting on its behalf.

FERPA protects the privacy of students' education records by setting forth strict instructions and limitations governing the release of information about students. All WMed faculty, residents, and staff are responsible for protecting the educational records in our possession.

For more information regarding FERPA, please review the Student Policy Manual. Specific questions about FERPA should be directed to the registrar.

Verifying a Student's Identity

In maintaining FERPA compliance, when speaking to students on the phone regarding their grades, academic performance, or any part of their educational record, WMed faculty, residents, and staff must verify the students' identity before the conversation begins. Students' identity may be verified by:

- Asking for and verifying their Student Identification number.
- Asking a specific question you can both answer that allows you to identify the student. An example is: "What is the name of the clinic where we last rounded together?"

When in doubt, or if you're unable to verify the student's identity, do not release confidential information. Face to face conversations or email through WMed's secure server are the preferred method of communicating sensitive information to a student.

Clerkship Attendance

Students are expected to be present for all components of each clerkship. Personal activities such as weddings should be conducted during scheduled off days. Requests for scheduled absences (including religious observances and student presentations at professional conferences) are to be submitted at least 30 days prior to the first day of the absence using the course/clerkship absence form. If permission for an absence is granted, it is the student's responsibility to notify his or her clinical preceptor.

Illness or other unplanned personal events may necessitate absence. The supervising attending/senior resident, clerkship coordinator, and the clerkship director must be notified immediately. Students who are ill are expected to seek appropriate medical care and provide documentation. While all requests are subject to approval of the clerkship director, examples of acceptable unplanned absences include death of a close family member or serious illness/hospitalization of yourself or a close family member.

Students should maintain personal wellness activities including access to healthcare during clinical rotations. **Students will never be denied an absence for physical or mental health appointments**. Students should submit a planned absence form, which is then managed by the clerkship coordinator and clerkship director to ensure release from clinical responsibilities. On inpatient rotations, afternoons are a better time to schedule appointments when possible.

Students must successfully demonstrate all clerkship objectives. Students must attend all scheduled didactic and assessment activities. If a student misses any mandatory session(s), they must be remediated by the end of that week. Remediation of missed days within allotted limits may or may not require additional clinical experiences. Absences beyond designated limits will typically require additional clinical time. All remediation decisions are at the discretion of the clerkship director. Students will receive a grade of incomplete until all remediation is complete.

Core Clinical

- Students are allowed up to three excused absences in a core clerkship that must be remediated by the end of the rotation.

Advanced Clinical

- In a 2-week rotation, students are allowed one excused absence, which must be remediated by the end of the clerkship.
- In a 4-week rotation, students are allowed up to two excused absences, which must be remediated by the end of the clerkship.

Electronic Health Record

Definitions:

Designated Record Set

"Designated record set" as used in this policy has the meaning as defined in the HIPAA Privacy Rule, 45 C.F.R. & 164.501, as "The medical records and billing records about individuals maintained by or for a covered health care provider… that is used, in whole or in part, by or for the covered entity to make decisions about individuals."

Authorized Attending Physician

An "authorized attending physician" is a licensed physician who is a member of the WMed faculty who has been approved by WMed to supervise the education, training and clinical practice of the medical students and resident physicians enrolled in undergraduate and graduate medical education programs at WMed.

[Note: For the purpose of this policy the term "valid progress note" is synonymous with the term "personal note" as it is used in CMS Manual System Publication 100-04, Medicare Claims Processing; Transmittal 2303; Change Request: 7378 dates September 14, 2011.]

Valid Progress Note

A "valid progress note" is a progress note created in an electronic health record system (EHR) associated with a specific patient encounter that is locked and signed by an authorized attending physician using the electronic signature technology of the EHR and that, in the professional opinion of the attending physician who locked and signed the note, adequately and accurately documents the patient encounter for all relevant medical, legal, and billing purposes.

A valid progress note is presumed to be reviewed and approved as complete and accurate by the attending physician who signs and locks the note. Once he or she signs and locks the note, the attending physician takes ownership of all the information contained in the note and is responsible for any and all errors and omission in the note, regardless of the means by which the information was created in the note, unless the errors and omissions are due to a technical malfunction, data entry error, or other outside process over which the physician has no control AND such errors and omissions could not be detected by careful review by a competent licensed profe4ssional. A progress notes that meets this definition is valid regardless of the specific methodologies, technologies or workflows used to create the note.

Creation of a progress note in the EHR:

A valid progress note can be created by the attending physician in the EHR using a variety of methodologies, technologies, and workflows, including, but not limited to: typing directly into the note; adding pre-built templates; structured data, or macro-generated text into the note; electronically pasting or merging text or data from other relevant documents generated by the attending physician or other clinician; and merging or downloading data from devices such as blood pressure cuffs, EKGs, and spirometers.

Sections of the note may also be created by medical students, residents, nurses, physician assistants, therapists, social workers, and other authorized individuals provide the contribution of each individual can be clearly identified as to content and time of entry.

The progress note becomes a valid progress note when, after performing the necessary review, and completing any required modifications or revisions, and after adding the appropriate attestation language for services rendered by a resident, the attending physician locks and signs the note.

Medical student documentation in the progress note:

Learning how to document patient care in the medical record is an essential part of the education of medical students. Medical students should learn to provide complete and comprehensive patient documentation that includes all relevant aspects of the medical history, physical examination, laboratory findings, medical decision making and treatment plan in the patient's medical record. Medical students should learn and refine their documentation skills in a clinic environment using all available health information technology tool, wherever and whenever possible.

Medical students may enter information directly in an unlocked and unsigned attending physician's note provide appropriate audit, logging, and tracking tools are in place to identify the author of each entry as well as the date and time of the entry.

Medical students may participate in different parts of a patient encounter and document in the appropriate section of the note as follows:

- Medical students may take and document past family and social history (PFSH) without teaching physician being present.
- Medical students may conduct and document a review of systems (ROS) without the teaching physician being present.
- Medical students may conduct and document an HPI. The teaching physician must verify the HPI, review any student documentation of the HPI, and correct, edit, or revise the documentation as needed to reflect the findings of the teaching physician.
- Medical students may perform and document an examination. The teaching physician must also perform the examination and correct, edit or revise the documentation as needed to reflect the findings of the teaching physician.

Medical students may also create a separate medical student note to document patient encounters.

Use of medical student note by attending physicians in the creation of a progress note:

Text and other information created by the medical student in a separate medical student note is not part of the designated record set of the patient medical record. The text and other information created by the medical student only becomes part of the designated record set of the medical record when it is actively selected for inclusion in a valid progress note by an authorized provider and subsequently reviewed, edited, or modified as needed and then locked by the authorized attending physician.

With the exception of a review of systems (ROS) and the recording of the past, family, and/or social history (PFSH) of the patient, any contribution and participation of a medical student to the performance of a billable service must be performed in the physical presence of an attending physician. Any documentation of such service by a medical student in a medical student note may then be used by an attending physician in the creation of a progress note. The attending physician may document the relevant information from the medical student note into the valid progress note. Documentation can be performed using all available documentation tools of the EHR, including copy forward, and copy/paste features, provided that the EHR has the capability to log all actions that went into constructing the note and that the log clearly identifies the author of each entry, modification, edit, or other activity.

A review of systems (ROS) and the recording of the past, family, and/or social history (PFSH) of the patient may be performed by a medical student without an attending physician being physically present. Any documentation of these services created by a medical student may also be used in the creation of a progress note.

General Guidelines for Medical Student Use of Electronic Health Record Systems During Clerkship:

Purpose of these Guidelines:

Learning how to use an electronic health record (EHR) is an important part of the education and training of medical students. Medical students should be trained to use an EHR early in their medical school education and should make full use of the EHR during clerkship.

The Alliance for Clinical Education (ACE) has developed best practices recommendations for medical student use of EHR. These best practices specify that the medical student should learn to:

- Search for data within the EHR
- Review patient care protocols
- Find and use disease specific templates, reminders and decision support tools
- Enter data into the appropriate fields in the EHR
- Review screening and prevention recommendations for a given patient, bringing these to the attention of the supervising physician if needed
- Become familiar with and use associated EHR functionality for:
    - Selection of diagnoses, CPT/ICD-10 codes, and how these are linked to billing
    - Order entry, including linked diagnoses to tests
    - E-prescribing
    - Capturing Patient Centered Medical Home and other quality metrics
    - Capturing "Meaningful Use" metrics
    - Running queries that practices use for population management

Workflow required for complying with CMS rules regarding student documentation in the medical record:

CMS permits medical students to document in the medical record of a patient. CMS rules specify the following:

- Med students may take and document past family and social history (PFSH) without teaching physician being present.
- Med students may conduct and document a review of systems (ROS) without the teaching physician being present.
- Med students may take and document an HPI. The teaching physician must verify the PHI, review any student documentation of the HPI, and correct, edit, or revise the documentation as needed to reflect the findings of the teaching physician.
- Medical students may perform and document an examination. The teaching physician must also perform the examination and correct, edit or revise the documentation as needed to reflect the findings of the teaching physician.

Roles and Responsibilities

Medical Students:

- Understand and comply with the policy "MEDICAL STUDENT DOCUMENTATION IN THE ELECTRONIC HEALTH RECORD".
- Understand his or her role on the team
- Use his or her log-in when entering information in the EHR
- Enter documentation as required on a timely basis
- Proactively seek guidance/assistance if unsure about how to use the EHR
- Alert the teaching physician to any documentation needing review by the teaching physician
- Report any mistakes, missteps or other errors made in using EHR

Teaching Physician:

- Understand and comply with the policy "MEDICAL STUDENT DOCUMENTATION IN THE ELECTRONIC HEALTH RECORD"
- Explain to the medical student his or her role on the treatment team
- Verify, re-perform, review, edit, correct, confirm, and otherwise validate all work performed by the medical student, as well as the associated documentation created by the medical student when such documentation is included as part of the patient record
- Provide meaningful feedback to the medical student that helps him or her improve their use of the HER

Technology Requirements

In order to implement workflows and processes that support medical students' full use of an EHR, the EHR technology should have features that:

- Provide a clear audit trail or tracking mechanism so that it can be determined who authored/edited all entries in a note or other documentation and what each user did
- Prevent medical students from performing actions that are not within their permitted scope of practice (e.g. locking and signing a progress note, sending an electronic prescription to a pharmacy, authorizing an order for a diagnostic test, etc.)
- Alert teaching physician when something is pending that needs to be reviewed, signed or authorized

Frequently Asked Questions – New Medical Student Documentation Guidance

On February 2, 2018, the Centers for Medicare and Medicaid Services (CMS) released new guidance relaxing Evaluation and Management (E/M) documentation requirements for documentation created by medical students participating in a billable service. This policy change was identified by the CMS Documentation Requirement Simplification workgroup and is part of a broader goal to reduce administrative burden on practitioners.

1. **Question:** What is the definition of a medical student?

   Answer: A medical student is an individual who participates in an accredited program that is not an approved Graduate Medical Education (GME) program. A medical student is never considered to be an intern or a resident.

2. **Question:** What exactly has changed?

   Answer: *A teaching physician may now verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work.* Prior to this change, the teaching physician could only refer to the medical student's documentation related to review of systems and/or past/family /social history, which are not separately billable, but are taken as part of an E/M service. The teaching physician was required to re-document history of present illness, physical examination and medical decision-making activities of the service.

3. **Question:** How can a teaching physician "verify" student documentation?

   Answer: WMed's Clinical Enterprise Integrity and Legal departments have approved the following attestation that may be added to the E/M documentation by the teaching physician verifying the student's documentation: *"A student assisted with documenting this service. I saw the patient and reviewed and verified all information documented by the student and made modifications to such information, when appropriate."*

4. **Question:** Can I create a dot phrase for this attestation?

   Answer: Yes, you may create a dot phrase.

5. **Question:** Can a resident "verify" the student documentation?

   Answer: The resident may not verify the student documentation on behalf of the teaching physician, but the resident may edit the student's documentation and provide additional documentation related to the service. Ultimately, the verification is the responsibility of the teaching physician.

6. **Question:** Can I combine attestations/verification in one statement when the service involves both a medical student AND a resident?

   Answer: Yes, you can combine attestations. WMED's Clinical Enterprise Integrity and Legal departments have approved the following attestation that may be added to the E/M documentation by the teaching physician verifying both the resident's and student's documentation:

   "A student assisted with documenting this service. I saw the patient and reviewed and verified all information documented by the medical student and resident, and made modifications to such information, when appropriate."

7. **Question:** The guidance states that any contribution and participation of a student to the performance of a billable service must be performed in the physical presence of a teaching physician or physical presence of a resident. Is that a new requirement?

   Answer: This is not new. CMS has always required physical presence with the student participating in patient care other than the review of systems and/or past/family/social history. If your student workflow does not currently abide by this physical presence requirement, you should contact the Clinical Enterprise Integrity department to evaluate the workflow for compliance.

8. **Question:** The guidance states that the teaching physician must personally perform (or re-perform) the physical exam and medical decision-making activities of the E/M service being billed. Is that a new requirement?

   Answer: This is not new. CMS has always required that the teaching physician perform the physical examination and medical decision-making activities of the service. If your student workflow does not currently abide by this personal performance requirement, you should contact the Clinical Enterprise Integrity department to evaluate the workflow for compliance.

9. **Question:** What about procedures? Does this guidance apply to procedures with student participation?

   Answer: This guidance is for E/M only, not procedures. WMED's Clinical Enterprise Integrity department is currently drafting internal guidance on how to compliantly involve medical students in procedures and how to document procedures for billable services. Guidance will be forthcoming in the next couple of months. If you require advice on procedures and student involvement, you may contact the Clinical Enterprise Integrity department for a compliance assessment.

10. **Question:** Can we apply the new student guidelines and attestation to other students (i.e. NP student or PA student)?

    Answer: Yes, this may be applicable to other types of students who are involved in E/M services using the approved attestation. Please contact the Clinical Enterprise Integrity department to evaluate the workflow for compliance.

Assessment

Introduction for Completing Summative Clinical Assessment
WMed uses Entrustable Professional Activities for Entering Residency (EPAs) as the guiding principle for assessing student performance in clerkships. The 13 EPAs represent the fundamental knowledge graduating medical students should have and the skills they should be able to perform without direct supervision on Day One of their residency education. The EPAs are further broken down into **Key Functions**, which are critical to the performance of the skill set.

The **13 EPAs** are:

1. Gather history, perform physical examination
2. Prioritize differential diagnosis from clinical encounter
3. Recommend and interpret common diagnostic and screening tests
4. Enter and discuss orders and prescriptions
5. Document a clinical encounter in the patient record
6. Provide oral presentation of a clinical encounter
7. Form clinical questions and retrieve evidence to advance patient care
8. Give or Receive a patient handover to responsibly transition care
9. Collaborate as a team member of an inter-professional team
10. Recognize a patient requiring urgent/emergent care and initiate evaluation & management.
11. Obtain informed consent for tests/procedure
12. Perform general procedures of a physician
13. Identify system failures and contribute to a culture of safety and improvement

Schematics for each EPA and key function may be found as part of the AAMC EPA Project website, https://www.aamc.org/initiatives/coreepas/publicationsandpresentations.

Contact the clerkship director to review the specific form that you will be using in your department.

The responsibility of the preceptor during **core clerkships** (year 3) is to assess the developmental progression toward entrustment for the students precepted. Your ratings should be based on the student's level of performance at the end of his/her time on your service or in your office. Clerkship directors have targeted assessments in the third year to mirror those tasks that are observable by any preceptor in that particular clinical setting. It is important you become familiar with the questions for which you will be asked to assess your students. In addition to rating the performance of EPAs, preceptors will also provide feedback on the foundational competencies required to entrustment: truthfulness, conscientiousness and discernment. Comments on where students went above and beyond expectations are necessary to achieve an honors grade.

Advanced Clerkships (year 4) will be assessed on a broader number of key functions as we attempt to gather data to review whether a student is "entrustable" for a particular EPA. While our goal is to have as many EPAs assessed in the clinical setting as possible, there will be some that will require simulation or other forms of assessment.

Elective Clinical Clerkship assessments will focus on Foundational Competencies and narrative feedback. Elective Non-Clinical Clerkships will include additional questions regarding the attainment of learning objectives that were defined at the beginning of the elective.

Narrative feedback is vital to student learning and development as a physician. Your comments regarding both what the student has done well and areas to target for growth are critical to future student success. Students need feedback not only on their current level of performance but also suggestions for future improvement (feedback "for learning").

There are multiple options that faculty can use to organize their narrative comments:

1. EPA developmental schema – review by following link on previous page

2. Supervision that was required by you to ensure safe, effective, appropriate medical care was provided to your patient.
   Modified Ottawa scale: (Rekman et al 2016)
   In supervising this student, how much did you participate in the task?
   a. "**I did it.**" - Student required complete guidance or was unprepared; I had to do most of the work myself.
   b. **"I talked them through it."** - Student was able to perform some tasks but required repeated directions.
   c. **"I directed them from time to time."** – Student demonstrated some independence and only required intermittent prompting.
   d. **"I was available just in case."** - Student functioned fairly independently and only needed assistance with nuances or complex situations.

Assessment Completion – Elentra

You will receive assessment reminders via email. You may use your WMed login information to access the Elentra platform. If you have additional questions please contact your clerkship coordinator.

Faculty Appointment & Benefits

Appointment to WMed Faculty

Clinical faculty are an integral part of the medical school. The appellation "doctor" – from the Latin *docere*, meaning "to teach" – includes the responsibility of all physicians to share knowledge and information with colleagues, trainees, and patients. Physicians have the opportunity to give back to their profession by teaching the science, art, and ethics of medicine to medical students, residents, and fellows. The medical school provides the opportunity for clinical faculty to participate in training the next generation of physicians for tomorrow's patients, and ultimately, improving the health of the communities we serve.

WMU Homer Stryker M.D. School of Medicine faculty have a primary appointment in a department of the medical school whether or not they are directly employed by WMed. Clinical faculty are physicians and other healthcare providers who participate in teaching, clinical research, and administration of medical school programs.

There are three principles on which the faculty appointment is based: teaching activities, sustained efforts to improve personal teaching abilities, and service to the medical school. Clinical faculty participate directly in teaching or service to the medical school for a minimum of 50 hours in each year of the appointment period to continue to qualify for faculty appointment.

Benefits

- Recognition: Framed certificate for office posting
- Inclusion in faculty meetings, activities, CME events
- Opportunity to participate in WMed research
- Opportunities to serve on WMed committees
- Purchase computer equipment at discount
- Faculty development/education
- CME for teaching
- Full access to eLibrary