Supplemental Digital Appendix 1

Sample Executive Summary, New Educator Portfolio (EP 2.0) Template, University of California, San Francisco

Executive Summary of Most Significant Contributions to Teaching and Education	
Name: Name (click to enter text)	**Department**: Medicine
Overall faculty roles: In one sentence, list your faculty roles (teaching, research, patient care, administration) and approximate time allocation to each.	
My roles include 27.5% as Associate Director for PRIME (Area of Distinction in the Internal Medicine Residency), 10% as Co-Director for the Data and Reasoning (DR.) Block in the School of Medicine's (SOM) Bridges Curriculum (increases to 20% with course launch in 2017), 10% as Director of several clinical services in the VA Hospital Medicine Section, and 52.5% for patient care.	
Changes in role(s) over time: In one sentence, describe any major changes in teaching roles over the past 2 or 3 years.	
I became Associate Director of PRIME in 2013, design co-lead of the DR. Block in 2015, and DR. Block Co-Director in 2016, leading me to reduce my administrative role in the VA Hospital Medicine Section from 20% to 10%, with a plan to phase out of my administrative role in 2017 when DR. Block launches.	
Important contributions to education: Identify educator role in parentheses and list contribution in a phrase. Describe what was done, how well it was done and its impact in 2-3 sentences. Use only as many as are appropriate to your teaching (1-5). Note that (a) Teaching and at least one additional Detailed Role Description are required for Academy membership applications, and (b) you must select from the contributions below in preparing your Detailed Role Descriptions (over the past 2 or 3 years).	
First important contribution to education: Teaching	
- *Clinical Teaching:* Medicine residents have rated my skills highly compared to other VA faculty attending on medicine wards (VA faculty means in parentheses): 2013-14: Overall Rating: 8.67/9 (8.29), Overall Teaching Skills 5/5 (4.68); 2014-15: Physician Role Model 8.67/9 (8.34), Medical Knowledge 8.67/9 (8.3). In 2015-16, students on their medicine clerkship also rated me highly, with Overall Teaching Skills at 5/5 (4.82), Promotion of Critical Thinking 5/5 (4.73) and Direction and Feedback 5/5 (4.64). - *Faculty in Hospital-Based Medicine: A Clinical Skills Tutorial:* I teach students referred for clinical skill remediation, and self-selecting students. My average overall faculty score on end-of-the-elective surveys is 5/5. A highlight from comments includes "Dr. --------'s ability to push me to verbalize my differential diagnosis and think through each one has made me more conscious of my interpretation of illness."	
Second important contribution to education	
(Curriculum Development) *Faculty in Hospital-Based Medicine: A Clinical Skills Tutorial:* I designed, launched in 2012, and have sustained a novel elective for second year medical students aimed at building clinical skills for students referred for remediation, and those who self-select to advance their skills. In the first two years of the elective students rated the course's overall quality at 4.89/5 (range 4-5, SD: 0.32). Compared with students waitlisted for the elective, during their first clerkship, participants rated themselves higher in physical exam (elective mean 3.7/5, SD: 0.7 vs. waitlisted mean 2.9/5, SD: 0.9, p = .004), oral presentation (elective mean 3.8/5, SD: 0.8 vs. waitlisted mean 2.9/5, SD: 1.1, p = .006), and Assessment and Plan creation (elective mean 3.5/5, SD: 0.8 vs. waitlisted mean 2.5/5, SD: 1, p = .001).	
Third important contribution to education	
(Curriculum Development) *PRIME Clinical Reasoning (CR) Curriculum:* I developed a novel curriculum for PRIME internal medicine residents focused on explicitly teaching diagnostic reasoning and the biases increasing risk for error. The curriculum includes an introduction to a clinical reasoning framework, application of CR concepts to clinical cases, and simulation sessions for third year residents focused on diagnostic uncertainty. Satisfaction with the simulation component of the curriculum is high; residents rated the 'likelihood that session will change my practice' as 4.86/5 (n=21) this academic year.	
Fourth important contribution to education	

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(Curriculum Development) *Data and Reasoning Block:* I have completed a comprehensive curriculum plan and implementation plan, and a set of learning activities for the clinical reasoning half of a novel capstone course for second year medical students in the SOM's Bridges curriculum, launching in 2017.
Fifth important contribution to education
(Educational Leadership) *Associate Program Director (APD) for PRIME, Internal Medicine Residency Area of Distinction*: After a needs assessment, I re-focused our weekly curriculum on three areas: clinical reasoning/knowledge, research skills, and professional development. After I joined PRIME, from 2013-16, residents rated the 'overall value of this rotation' at 4.71/5 (SD 0.47) vs. 4.21/5 (SD 0.75) in 2011-12.

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Supplemental Digital Appendix 2

Sample Detailed Teaching Role Description, New Educator Portfolio (EP 2.0) Template, University of California, San Francisco

ROLE: Teaching (classroom or clinical)	
Name: Name (Click to enter text)	**Department:** Medicine
1. Name your teaching activity(ies): Identify the impactful activity(ies) you select to focus on.	
A. Clinical teaching on medicine wards, medicine consult, procedure service, and co-management B. Teaching in Elective Course: 170.39 *Hospital-Based Medicine: A Clinical Skills Tutorial* C. Didactic teaching in PRIME (Internal Medicine residency area of distinction) pathway's longitudinal Clinical Reasoning (CR) Curriculum	
2. Your role(s): Describe your role(s) and specifically what you contribute.	
A. Clinical teaching: As medicine attending, I provide feedback on presentations, exam skills, clinical reasoning and communication with an emphasis on building frameworks for key clinical syndromes. On medicine consult (@ 5 wks/yr) and co-management (@1 mo/yr), I teach peri-operative management. On Swing (@5 wks/yr), I teach bedside procedures (thoracentesis, paracentesis, lumbar puncture). *B. Elective:* I coach students one-on-one in history-taking, exam, reasoning, and oral presentations. *C. PRIME CR Curriculum:* In case-based seminars, I teach a framework for clinical reasoning while reinforcing medical knowledge and developing residents' appreciation for the risk of diagnostic error.	
3. Learners and amount of contact: Describe types, levels and numbers of learners; amount of contact you have with them.	
A. *Clinical teaching:* In ward blocks (currently 2/yr, expanding to 3-4), I teach two third year medical students, two sub-interns, two interns and one senior resident. On medicine consult, I teach one senior resident daily; on co-management, I teach one orthopedic surgery intern per day. My procedural teaching varies while on our Swing service, and encompasses medical students and medicine housestaff. B. *Elective:* I teach 8-10 half-day sessions annually to second year medical students. Some students are referred to the elective for remediation; others self-select. C. *PRIME CR Curriculum:* This year there are 54 second and third year PRIME residents (39 in the prior year). I teach 1.5h seminars 1-2 times per month, plus 4 annual half-day simulation sessions.	
4. Builds on best practice/evidence: Describe your preparation including the use of best practice and evidence where available, your professional development, and/or congruence with national, curriculum, and/or program goals.	
❖ In 2015, I joined the Teaching Scholars Program, gaining additional faculty development on teaching strategies. My teaching is informed by the SOM and residency's goals to encourage clinical milestone development via observation and feedback, and, for residents, Entrustable Professional Activities. ❖ To enhance my ability to teach the art of communication, I participated in the American Academy on Communication in Healthcare's 2015 ENRICH conference, a 4-day workshop focused on relationship-centered communication, and I am registered for the 2016 ENRICH course. ❖ PRIME's Program Director frequently attends my reasoning seminars and offers feedback on my instructional approach; my hospitalist group engages in peer observation during attending rounds.	
5. Goals and learning objectives: List goals and learning objectives of program. If these are extensive, provide just a few illustrative examples.	
A. *Clinical teaching:* My teaching is informed by SOM objectives: "use deductive reasoning to…generate differential diagnoses; address cultural forces and communication issues affecting patient care." For residents, key program objectives include: "evaluate…and manage acutely ill patients, ensure compassionate communication with patients, promote communication between…interdisciplinary team." *B. Elective:* Capitalizing on adult learning theory, students set personal goals with Individualized Learning Plans (ILPs). Examples of student objectives include: "Perform a complete physical exam," "Become more adept at forming a differential diagnosis," "improve the organization of my presentations."	

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C. PRIME CR Curriculum: Highlights of objectives include: "apply a clinical reasoning framework to developing a differential diagnosis, describe high-risk situations that predispose clinicians to make errors in reasoning, and develop at least one personal strategy to reduce this risk."

6. Methods: Describe the methods used for instruction, how these align with objectives, and rationale for choices.

A. *Clinical Teaching:* To increase learner engagement, I utilize the 'one minute preceptor,' probing the foundations of learners' knowledge. I use clinical reasoning concepts including problem representation, illness scripts, and cognitive error to structure feedback. My methods are closely tied to the SOM and residency program's objectives to express clinical reasoning and formulate reasoned differentials. A focus on probing questions encourages trainees to consider patients' perspectives while creating management plans, and to develop a holistic view of patient care, tied to our interdisciplinary setting.
B. Elective: To capitalize on our one-on-one tutorial model and ILPs, I calibrate my teaching to each student's unique strengths and challenges, tailor the clinical experience to students' learning goals, and maximize time spent on direct observation and feedback targeted to students' specific goals.
C. PRIME CR Curriculum: My focus during didactics is on active learner engagement and participation. I accomplish this through a range of methods including pair shares and reporting back to the larger group, pauses for self-reflection, embedded questions requiring audience response, and a case-based approach. Our simulation curriculum creates an experiential opportunity to apply lessons learned.

7. Results and impact: Describe evidence of learner ratings of teaching/course, learning outcomes, application of knowledge in other settings at UCSF, impact on educational programs within the institution, and/or teaching awards.

- ❖ Calvin Chou Award for Education in 2014 for excellence in teaching awarded by PRIME residents
- ❖ Excellence in Teaching Award from the UCSF Academy of Medical Educators in 2012
- ❖ E-value ratings by medicine residents: 2013-2014: 5/5 (SD 0) Overall Teaching Skills, 8.67/9 (SD 0.58) Overall Faculty Rating; 2014-2015: 8.33/9 (SD 0.58) Overall Faculty Rating, 8.67/9 (SD 0.58) Physician Role Model, 8.67/9 (SD 0.58) Medical Knowledge; (Current academic yr suppressed due to #). Comments include: "fostered a fun and supportive environment that allowed me to grow into my resident role comfortably," "encouraged us to think critically about our patients and their care."
- ❖ From 2013 through April 2016, students rated my Overall Teaching Skills 4.63/5, Teaching Enthusiasm 4.75/5, Cultural Sensitivity 5/5, and Promotion of Critical Thinking 4.63/5; comments include: "consistently gave personal feedback regarding presentations and incorporation into team," "helped me think through the process of a differential diagnosis in a logical way I had not seen before."
- ❖ Ranked 5/5 in teaching effectiveness by 9 students completing Elective evaluations in 2012 and 2013 academic years; 5/5 by two students in the current academic year; comments included: "Dr. -------'s ability to push me to verbalize my differential diagnosis and think through each one has made me more conscious of my interpretation of illness."
- ❖ Resident comments on my facilitation of PRIME CR Simulations in 2014 and 2015 include: "excellent, allowed for opportunity to reflect and provided focused feedback," "loved how [she] related learning points to each case," "comfortable atmosphere for feedback."

8. Dissemination: Describe how your efforts have been recognized by others externally through peer review, dissemination, use by others, or teaching awards nationally.

- ❖ Co-authored a chapter on providing feedback, which strengthened my teaching expertise: **----------**, Chou, CL, Davis, DL. (2014). Feedback and Remediation: Reinforcing Strengths and Improving Weaknesses. In A. Kalet & C. L. Chou (Eds.), Remediation in Medical Education A Mid-Course Correction (pp. 249-263). Media, New York: Springer.
- ❖ I recently co-authored a paper which formalizes our approach to struggling students: **----------** & Dhaliwal, G. When less is more for the struggling clinical reasoner. Diagnosis. 2015; 2(3):159-162.
- ❖ Based on my experiences caring for and teaching about "unbefriended patients" (lack medical decision-making capacity, no surrogate decision-makers), I co-presented an SFVA Medical Grand Rounds and regional SGIM Workshop focused on this issue. We developed our presentations into a paper detailing our approach: **----------**, Elkin GD, Lee K, Thompson V, Whelan H. The Unbefriended Patient: An Exercise in Ethical Clinical Reasoning. J Gen Intern Med. 2015 Oct 5.

9. Reflective critique: Describe your reflections, what went well and plans for improvement.

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- ❖ In my clinical teaching, focusing on learner engagement enables me to identify knowledge gaps, which I can then fill, rather than teaching generically without first understanding each learner's unique needs.
- ❖ While I cover the cognitive domain of clinical reasoning well, based on learner feedback, I am working to increase bedside physical exam teaching. A recent Society of General Internal Medicine seminar presented a framework for exam teaching that I plan to incorporate into my next ward attending block.
- ❖ In my didactic teaching, I have been successful in creating a supportive learning climate and, as a result, my PRIME seminars have had consistent and active participation.
- ❖ I plan to involve more learners as co-presenters in PRIME's CR curriculum, to further capitalize on adult-learning and motivation theory, and to increase the authenticity of learning.

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Supplemental Digital Appendix 3

Frequently Asked Questions about the New Educator Portfolio (EP 2.0) Template, University of California, San Francisco, 2017

Section I: DEVELOPING AN EDUCATOR'S PORTFOLIO	
1. What is an Educator's Portfolio?	An Educator's Portfolio is a document that makes visible the most important teaching contributions of a faculty member in relation to the five roles of an educator: teaching, mentoring and advising, curriculum development, educational leadership and learner assessment. At UCSF, there is a standardized format that facilitates peer review for academic advancements and for application to the Academy of Medical Educators.
2. Why do I need one? What does it do for me?	The full spectrum of an educator's contributions, as described in the five educator roles, is not reflected in the current academic CV. The Portfolio encourages documentation of the diversity of contributions of each educator and allows them to describe their engagement in a scholarly manner. Without a portfolio, the varying contributions of an educator may not be visible, peer reviewed or considered scholarly.
3. What are the components of the UCSF Educator Portfolio?	There are two parts to the Educator's Portfolio: 1) an executive summary in which the educator can list up to five significant contributions to the educational mission in one page, and 2) 1-3 detailed descriptions of recent, significant contributions listed in the executive summary in a maximum of two pages each. There are templates available to ensure appropriate descriptions of essential elements of each educator role in both the Executive Summary and in the Detailed Descriptions. These templates are derived from national guidelines for documenting the scholarly contributions of educators. An Executive Summary alone may be appropriate for Advance; both parts are required for application to the Academy of Medical Educators. (See Section II, below.)
4. What is the relationship between the Executive Summary and Detailed Descriptions?	The Executive Summary is the equivalent of an abstract in a research paper because it describes in summary the 1-5 most important recent contributions of the faculty member to the educational mission, a select number (1-3) of which can be described in greater detail in the Detailed Descriptions.
5. How do I decide what to include and exclude, and which educator roles to describe?	Faculty members must decide for themselves what their most important contributions are to teaching and education at UCSF. Each contribution should be related to a designated educator role (teacher, mentor and advisor, curriculum developer, leader, assessor), although several important contributions might be within the same role (e.g., leadership) but for different activities (e.g., clerkship director and chair of curriculum committee). When deciding among different educator roles, preparers should focus on whichever role better demonstrates excellence and highlights their individual contribution(s).

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6. What timeframe does it cover?	The timeframe covered should be either two or three years to coincide with advancement. In the case of application to the Academy of Medical Educators, the timeframe can be expanded up to five years. (See Section II, below.)
7. What criteria will be used to assess my entries?	Six criteria have been established nationally for assessing the scholarly contributions of an educator: Clear goals, adequate preparation (informed by the literature and best practices in the field), appropriate methods, significant results in impact, dissemination and reflective critique. These six criteria along with examples are available for those creating portfolios and those reviewing them. See the Workbook Part 1.
Section II: FOR APPLICATION TO THE ACADEMY OF MEDICAL EDUCATORS	
1. When should I apply for membership in the AME?	When applicants can meet the criteria and can document the success of their contributions.
2. How long do I have to be on the faculty before I can apply to the Academy? Does it all have to be at UCSF?	Applicants must have at least three years of experience on the faculty, preferably at UCSF, in order to determine relevant role(s) and contributions locally, and affirm excellence.
3. Are there minimal numbers or types of learners that I must teach to be eligible to apply to the Academy?	There are no specific numbers of learners that need to be taught by applicants. Numbers will vary depending upon the type of teaching performed, e.g., clinical precepting, classroom instruction, mentoring, and/or faculty development.
4. How is the personal statement used?	The personal statement offers insight into and overall perspective on the applicant.
5. Are more detailed descriptions better than less?	For the Academy application, the Executive Summary and the Detailed Descriptions are needed plus a personal statement and checklist. Every applicant must apply in teaching and anyone with a significant educational leadership role must apply in that role as well. Up to three roles may be described in detail. However, candidates should be mindful that the focus is on quality, not quantity, and on individual contributions. It is preferable to demonstrate excellence in one role rather than adequacy in two or three roles. By focusing on depth, not breadth, the portfolio reflects scholarly approach and impact through a few detailed descriptions.
6. Why do I have to include a detailed description of my educational leadership role, if I have one?	If you are an educational leader, this is a primary educator role and needs review in the same way as teaching does.

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7. If I have ratings that are less than excellent, what do I do?	Excellence in teaching is the primary criterion that must be met in every AME application. If there are less-than-excellent learner ratings, the applicant should describe why and what has been done to address the situation. Candidates are not penalized for taking risks with new opportunities/innovations, challenging learners, difficult material, etc. but it needs to be explained.
8. What documentation would best describe excellence in mentoring and advising?	The best documentation demonstrates a *program* of mentoring that elevates it beyond baseline expectation of faculty; e.g. demonstrates trainee outcomes and broader impact.
9. How important is evidence of impact and scholarly dissemination for the application?	To make the claim that education is scholarly, we need to examine evidence of **local impact** and **extramural dissemination**. Evidence of impact locally is important, whereas evidence of dissemination is desirable but not required (i.e., is aspirational).
10. How does dissemination factor into membership decisions?	Dissemination is valued as the highest form of scholarship because it allows others to build on our work. Documentation of impact and dissemination strengthens the application. This can also include descriptions of the process as well as outcomes, and can be contextualized with reflective critique. Note, however, that dissemination is aspirational and not required in all roles.

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