# WORKING WITH STUDENTS 2023: ANSWERS TO YOUR QUESTIONS

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# DAY ONE ON SERVICE

- After introducing yourselves, please provide them your contact information
- Give them your orientation
- Make sure they know when and where rounds are
- Get them access to team list
- Get them seeing patients (MS 4 must have at least 2 patients)
- MS 3 A side, MS 4 B side
- Students should have only patients from one side
- CAN see patients in airborne
- May opt in to see COVID patients if fully vaccinated

# WHAT DO I NEED TO KNOW ABOUT STUDENT SCHEDULES?

# SCHEDULES

- Arrive around 6, leave after 4 pm on weekdays
- Tues AM:
  - MS3 rounds with attending instead of going to AHD
  - MS4 go to AHD but attending may elect to work with them during AHD
- Tues PM:
  - MS3 ALWAYS have class
  - MS4 usually have class
  - Sub I REQUIRED to return to BUMCP if their team is long call
- MS3 have additional LPC (Wed afternoon, once every 6-8 weeks)
- No MS3 on NF; they'll do 2 weeks on a wards team & the other 2 weeks will be either ambulatory, orange team, &/or Geriatrics (this may change—contact Dr. Bergin if questions).
  - Weekend between the 2-week sub-sections is a golden weekend (halfway through their month with us); other 2 weekends for the month, students work 1 weekend day.

# STUDENT DONE EARLY?

- Residents should NOT excuse the students early  (before 4 pm on weekdays) WITHOUT ASKING ATTENDING—sometimes attendings want to spend time with students in late pm
- Have your student remain on site
- Students can do the following:

  Help with medicine reconciliation

  Review charts

  Talk to family members

  Talk to specialists

  Talk to case management, PT/OT, speech, wound

  (BTW the above does not constitute SCUT)

  Prepare presentations; do reading around patients, EBM articles, etc.

  MS3s: study – reading, Aquifer cases, flashcards, etc.

# DAYS OFF

- MS4: Assigned by Dr. Novoa
- MS3: Flexible within guidelines/framework (see below)
- Switches need to be approved by site director (noted above)
- MS3:
  - In general, 1 day off per week – usually a weekend short call day.
  - Weekend halfway through the month (between 2-week sub-sections on wards/other experiences) is a golden weekend.
- MS4 1 day a week, could be during the week but prefer weekend short call day

# NIGHT FLOAT

- During NF: typically MS4 off Monday (due to didactics) and Friday; if student is scheduled to work the night before didactics, they have to leave by 11:45 pm
- No MS3 on NF.  Contact Dr. Bergin if questions
- Students must be present the whole evening and should participate in NF rounds unless otherwise scheduled

# HOLIDAYS

- MS3: Memorial Day, Juneteenth, July 4th, Labor Day, Veterans Day, Thanksgiving, MLK Day.
- MS 4: NONE—they are like you.  You work holidays and so do they.  They can only take a holiday off IF your team is short call and an intern would be allowed to take the day off.

# STUDENT NO SHOWS/LEAVES UNEXPECTEDLY

- Want to make sure student is OK
- CALL YOUR ATTENDING
- EMAIL DR BERGIN (MS3) or DR. NOVOA (MS4)/YOUR ATTENDING –must be documented
- What do we do with information? Pass it on to school to track for patterns of abuse, bring concerns for wellness to student affairs

# WHAT DO I NEED TO KNOW ABOUT MEDICAL STUDENTS AND ROUNDS?

# PREPARING YOUR STUDENT FOR ROUNDS

- Make sure they know when & where rounds are
- Students should pre-round on and discuss patients with resident, finish their work related to those patients (to include notes) before attending rounds
- Have them take care of eating/drinking/personal business before rounds
- PRACTICE! Particularly in April, May June when the MS3 just starting clinicals
- Help them know what the pertinent positives and negatives are for a given case (symptoms, physical exam, labs)
- Students (MS3 and MS4) expected to stay with attending on rounds so they can see patients from both sides of the team

# PRESENTING NEW PATIENTS ON ROUNDS

- Practice with MS before rounds
- HPI should leave listener with ddx by the end of it (if not, needs more detail)
- HPI SHOULD NOT include ER course/interventions
- ROS and PE should be based on pertinent positives and negatives
- Labs/studies focus on important results
- All other information (fully detailed ROS/FHx/PMH/Soc HX/PE) on written documentation and available on demand to listener
- Clinical illness statement after labs/studies
- List items in DDX (do not give details unless asked for them)
- Then assessment and plan by problem starting with working dx of main reason for admission with rest organized by order of importance

# GOAL FOR STUDENTS(MS 3 IN PARTICULAR) & INTERNS FOR DAILY PRESENTATIONS (NOT NEW PTS): PROBLEM-BASED PRESENTATIONS ("MINI-SOAP") … SEE NEXT SLIDES

# MINI-SOAP (PROBLEM-BASED PRESENTATIONS)

**Problem based presentation format**

Overnight notable events

Vital signs

Priority problem #1:

- Subjective
- Objective
- Assessment
- Plan

Priority problem # 2:

- Repeat same sequence

As relevant for this specific problem

Reprioritize problem list daily (issues that are more urgent and/or keeping patient in the hospital will be higher priority)

# PROBLEM-BASED PRESENTATIONS: EXAMPLE

**Problem based presentation format (Example)**

Overnight notable events – *No notable events overnight*

Vital signs : *BP previously high, now at goal of 120/70, remains on 2L02 but not tachypneic*

Priority problem #1: *decomp HFrEF due to ischemic CM*

- Subjective – *pt sleeping better, able to ambulate to bathroom, no CP*
- Objective – *last 24h, I/O, weight down 2 kg, O2 decreased to 2LNP, exam shows improved JVP, minimal rales, and improving LE edema, SCr stable at 1.5, Mg/K/Phos at goal Telemetry shows 24h stable NSR with less frequent PVCs than before*
- Assessment – *improving decompensation, awaiting ECHO for updated EF, currently on Lasix 30mg TID, 2gm Na restriction, 2L fluid restriction*
- Plan – *continue medications above, ambulate more today, wean O2 as tolerated, d/w cardiology need for ischemic work up*

Priority problem # 2:

- Repeat same sequence

# FOLLOW UP PRESENTATIONS USING CONVENTIONAL SOAP-OK FOR DR NOVOA (MS4)

- Help keep the students organized: subjective material is presented in subjective etc.
- Ok to briefly state overnight events in subjective but save details of assessment and plan for that segment of presentation
- Help student be CONCISE in subjective and objective—highlight pertinent positives and negatives, help them keep if BRIEF
- Assessment and plan by problem (COMPLETE problem list-both oral and written documentation)—this is where bulk of time/energy should be spent. Inactive problems may be grouped at the end with plan to continue home meds in oral presentation
- In A/P use one of these methods
  - Mini (S)OAP where S may be silent-highlight objective elements as in previous slides then discuss assessment and plan
  - mini SBAR (situation, background, assessment, and recommendation) for each problem OR
  - what is going on? Why is it happening? What do you think about it? What do you want to do about it?

10-20% of time

80-90% of time

# WHAT DO I NEED TO KNOW ABOUT STUDENT DOCUMENTATION?

# STUDENT DOCUMENTATION FOR BILLING

- Can bill off of student note for H&P, consultation, progress notes
- Use regular note for this
- Title note: BUMG or IM (can list team color) Teach Note
- Supervising physician (intern, resident or attending) must be with student during interview and exam
  - Let the student take the history; only jump in at the end (or if really needed) with additional questions
- Must cosign note with Banner approved verbiage--- *I, the resident was present with the medical student during the visit. I personally performed an exam, made the assessment and developed the care plan (e.g. medical decision making), as documented above. I have verified student's documentation and agree with the student's findings.*
- STUDENTS CANNOT AUTHOR DISCHARGE SUMMARIES IN CERNER—if student does, it could be rejected and pushed back to resident to author

# STUDENT NOTES

- Students should ALWAYS write notes daily
- Notes do NOT have to be used for billing
- If not used for billing, have student use ‘medical student note’—having the student write medical student notes may be best early in the year (particularly the first couple of days with a new attending)
- If not used for billing, intern or resident do not need to be present

# STUDENT NOTES #2

- When possible, don't 'fix' their note (replace what they have written)
- If you always 'fix' their note, we can't tell what they are actually doing
- when you write your addendum to the note which will be used for billing, write a paragraph that ADDS to the note..mostly about the clinical reasoning behind decision making and justifying plan
- Your addendum can also fix/add on to ros/pe etc—would write 'additional ros____, additional PE__'
- If the note needs LOTS of corrections or additional information needed in addendums is extensive OR you feel compelled to rewrite most of the assessment and plan, have the student write a med student note and let the attending know

# I HEARD THAT THERE ARE FORMS TO FILL OUT FOR THE STUDENTS?

# MS3: CLINICAL SKILLS FEEDBACK PORTFOLIO

- Residents can complete CEX and EBM forms
- Residents can complete PRIME + in the MyTIP app
  - Formative feedback; please give both positive & constructive feedback, even if brief – be specific
- Attendings complete oral presentation and H&P feedback

# ASSIGNMENTS TO PREPARE SUB-I FOR INTERNSHIP

- GRADED BY YOU (SENIOR RESIDENTS)
- discharge summary
- social determinants of care
- patient hand off
- Transition of care notes (student is handing off to ICU or next intern—NOT a discharge summary)
- Must take call
- MS4 on direct care: attendings will complete above forms
- Complete two of these a week—if sub I asks you to do all in week 3, you can decline

# SUB-I CALL

This form is required-can only be filled out by resident or attending

Sub I on orange team and direct care hospitalist service may work selected Monday (extended duty hours) and Fridays (full shift) with NF team or complete requirements with noctunist

One form for each night

Your signature means student

- Saw the patients you asked them to
- Participated in cross cover
- Completed any written documentation required
- Participated in rounds
- Stayed the duration of call
- Performance was in all ways satisfactory and met standards expected of your intern

CORE SUB INTERNSHIP CALL REPORT FORM

Instructions: complete this form during your night of call. Your supervising physician (resident or attending) must sign off on successful call completion. Interns may not sign form. Submit form for credit. Four calls are required; on time submission required for honors. Due Tuesday after rotation ends by 8am.

Student name _____ Date_____

Rotation _____ Location_____

Briefly describe new admissions you assisted with:

Briefly describe cross cover issues you participated in:

Procedures: indicate if you observed a procedure or describe your participation in the procedure

To be completed by supervising physician:

Formative feedback:

I certify that _____(student name) actively participated in on call responsibilities.

_____ _____

Supervising physician name (printed) Supervising physician signature

# HOW ARE STUDENTS GRADED?

# (P)RIME

- P=Professionalism
- R=Reporter
- I=Interpreter
- M=Manager
- E=Educator/expert

# MS3 GRADING

- PASS=REPORTER. H&P presentations should be fluid, student report on whatever is written in the chart (labs, imaging, and consultant notes)
- HIGH PASS=INTERPRETER. Identifies clinically important data/information (labs, imaging, consultant notes), describes how clinically relevant
- HONORS=EARLY MANAGER. Takes the important clinical data and then formulates an evidence-based plan based on reading—not expected to manage at level of intern or at level of sub I
- HONORS=EDUCATOR. Teaches the team based on reading they have done, may incorporate it into assessment/plan part of presentation does not have to be a stand alone talk

# MS4 GRADING

- FAIL=REPORTER. H&P presentations should be fluid, student report on whatever is written in the chart (labs, imaging, and consultant notes)
- PASS=INTERPRETER. Identifies clinically important data/information (labs, imaging, consultant notes), describes how clinically relevant
- HIGH PASS=EARLY MANAGER. Takes the important clinical data and then formulates an evidence based plan based on reading
- HONORS=MANAGER goes more in depth into management +EDUCATOR. Teaches the team based on reading they have done, may incorporate it into assessment/plan part of presentation does not have to be a stand alone talk—managing at or near level of July intern

## REPORTER

- Reports what is in chart
- Consult notes
- Imaging
- Labs-normal and abnormal

Student able to say acute HFrEF exacerbation and can list physical findings etc.

## INTERPRETER

- Accurately determines significance of data
- Volunteers information about patients
- Can explain the clinical significance of data (when asked)

Student interprets information such as hyponatremia, elevated creatinine and is able to say why
Comes up with tailored differential diagnosis

## MANAGER

- Makes appropriate diagnostic/ therapeutic plans based on data
- Volunteers information about patients
- Discusses clinical reasoning
- Can answer questions about patient management-and you are convinced that they know what they are talking about

Makes management recommendations IV diuretics, initiate ACEI, when to use entresto, beta blockers, mineralocorticoid receptor antagonist and WHY
Makes contingency plans

## EDUCATOR

- Teaches team about their patients
- Ideally gives short teaching points on their patients during oral presentation of patients
- Does not wait to do an oral presentation on a subject to teach team
- One short presentation does not make a manager

Educates team about heart failure: advanced management-aqauphoresis , nesiritide, milrinone, LVAD

# HOW CAN I HELP MY STUDENTS SHINE? ENCOURAGE THEM TO THINK ABOUT

- what is going on and why
- how to I make the diagnosis
- how severe is the condition
- how should this be evaluated
- how should it be treated
- why was one diagnostic modality selected over another
- why was one therapeutic intervention selected over another
- any new information/changes from overnight
- what is the next step in diagnosis
- what is the next step in management
- what do we need for discharge planning?

## THEN SHARE THIS INFORMATION NOT JUST WITH YOU, THE INTERN/RESIDENT, BUT WITH THE ATTENDING!

# WHAT IF I AM NOT SURE MY STUDENT IS PASSING?

- If your third year student is better than your fourth year student…….
- If you think your sub I would get eaten alive during the first month of residency or would be singled out by the RCC/CCC…..
- If you see NEVER behavior from your student…. (includes professionalism)

# PERFORMANCE CONCERNS

- Let your attending & Dr. Bergin (MS3) OR Dr. Novoa-Takara (MS4) know immediately
- Students must be counselled by attending in person and must be documented by attending by mid point in rotation or as soon as possible (if issue comes to attention after mid month)
- We can get the student extra help at UACOMP or if rotating sub-I, their school may be able to help

# WHEN DO STUDENTS GO OFF SERVICE?

# END OF ROTATION

- MS3: If at the end of 1st month of rotation (block A), check out Friday at 1:00pm (no earlier)
- MS3: In 2nd month of IM block (block B): students check out Thursday at 1pm and are excused to prepare for shelf exam
- MS4: check out last Friday of rotation, if NF check out at 7:30 am, if on regular team by 4pm
- MS4 may return to work with team until excused by resident