

PRECEPTOR'S HANDBOOK
Primary Care & Subspecialty Components
Integrated Clerkship for Primary Care and Psychiatry
Yale University School of Medicine
2015-2016

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Clerkship Website: In Construction

Revised 3/8/16

PREFACE

This handbook is written for physicians who teach office-based internal medicine, family medicine and pediatrics to third-year medical students at Yale. It has two purposes:

1. To assure that preceptors know about the clerkship and the educational objectives for students.
2. To suggest teaching strategies preceptors can use to help students achieve those objectives.

Ambulatory care education is inherently decentralized. In the Primary Care Component for the Integrated Clerkship for Primary Care and Psychiatry at Yale, students are dispersed across more than 50 primary care sites and 30 subspecialty offices. No two sites are the same. They employ different physicians to serve different patient populations. Some practices employ one physician while others employ many.

Within the decentralized structure of ambulatory education, a major educational challenge is to assure that each student receives high-quality instruction under a uniform curriculum. Wherever students are assigned, they should encounter preceptors who are capable of helping them achieve the objectives of the clerkship rotation. The purpose of this handbook, therefore, is to inform preceptors of the educational objectives for the Integrated Clerkship for Primary Care and Psychiatry. In addition, the handbook reviews basic strategies for successful office-based precepting. In the 30 years since office-based teaching has made its comeback, much has been learned about how to make it work for patients, students, and preceptors. The suggestions in this handbook are derived from many sources to help new preceptors hit the road running and to help veteran preceptors master new skills.

Please let me know if there is anything I can do to facilitate your work and boost your satisfaction with clinical teaching.

Thank you for teaching in this clerkship.

Walter N. Kernan, M.D.

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Arthritis & Osteoporosis Center Sonia Gordon-Dole Deborah Desir C. Roxana Ciubotaru Jennifer Becker Vivian Shi	Gastroenterology Associates (NEMG) Andrew Bedford	Peter Rogol, MD, LLC Peter Rogol
Brett Gerstenhaber, MD, LLC Brett Gerstenhaber	Gastroenterology Center of CT Latha Alaparthi	NEMG Pulmonary (NEMG) Kevin Twohig
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Cardiology Group Jonathan Brier Leonard Grauer Jeremy Nadelman Ron Nudel Martin Plavec	Gastroenterology Specialists Jeffrey Dreznick Harold Schwartz Jonathan Simon	St. Raphael Campus Cardiology Samuel Hahn
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Connecticut GI Douglas Miller Jon White Jon Ernstoff	Medical Oncology Thomas Fynan	Yale Medical Group Rheumatology Lenore Buckley
Connecticut GI David Sack	Arthritis & Rheumatism Associates (NEMG) Mirela Dumitrescu	

Primary Care Classroom Faculty 2015-2016			
Report		Low Back Pain Case Conference	
Will Becker	Ernest Moritz	Walter Kernan (Chair)	
Dan Federman	Robert Nardino	Will Becker	
Robert Fogerty	Patrick O'Connor	Leo Cooney	
Michael Green	Brad Richards	Peter Ellis	
Janet Henrich	Andre Sofair		
Stephen Holt	Daniel Tobin		
Walter Kernan	Laura Whitman		
Theodore Long			
Student Faculty Rounds		Hypertension Case Conference	
William Asch	Inginia Genao	John Setaro (Chair)	Walter Kernan
David Banach	Matthew Grant	William Asch	Namrata
Wassim Fares	Craig Gunderson	David Geller	Krishnan
Dan Federman	Walter Kernan	Joni Hansson	Aldo Peixoto
Ada Fenick	Kirsten Wilkins		Jeffrey Turner
Rosemarie Fisher	Maricar Malinis		
Brett Fortune	Brad Richards		
Abdominal Pain Case Conference		Asthma Case Conference	
Hamita Sachar (Chair)		Geoffrey Chupp (Chair)	
Cyrus Kapadia		Clemente Britto-Leon	
Walter Kernan		Lauren Cohn	
Avlin Imaeda		Walter Kernan	
Tamar Taddei		Peter Marshall	
		Jose Luis Gomez Villalobos	
Infectious Diseases Case Conference		Diabetes Case Conference	
Matthew Grant (Chair)	Malicar Malinis	Silvio Inzucchi (Chair)	Robert Gelfand
Raffaele Bernardo	Walter Kernan	Renata Belfort De Aquiar	Janice Hwang
Patrick Cudahay	Zach Porterfield	Jonathan Bogan	Walter Kernan
Uchenna Ikediobi	Heidi Zapada	Clare Flannery	
Problem Focused Visit Workshop		Reverse Report	
Susan Kashaf (chair)	Walter Kernan	Karen Brown	
Sharon Anderson	Rebecca Kosowicz	Elin Christensen	
Abhay Dhond	Cynthia Mcnamara	Matt Ellman	
Joseph Donroe	Anna Reisman	Ada Fenick (pediatrician)	
Peter Ellis	Brad Richards		
Michael Green	David Rosenthal		
Seonaid Hay	Chris Ruser		
Anne Hyson	Jacqueline Satchell		
Anita Karne	Sarita Soares		
Jerry Kerins	Juliette Spelman		
Screening Flash Rounds		Principles of Screening Lecture	
Peter Ellis		Lynn Tanoue (Chair)	
Sexual Health Case Conference		Opioid Prescribing and Abuse Case	

Primary Care Classroom Faculty 2015-2016			
		Conference	
TBN		TBN	
Orthopedic Examination Workshop		Medically Unexplained Symptoms Case Conference	
Peter Ellis (chair) Lenore Buckley Leo Cooney Joseph Donroe	Walter Kernan Rowland Mayor Mary O'Connor Adam Perrin John Reach	Ani Annamalai Peter Ellis Walter Kernan Brad Richards	

ABOUT THE CLERKSHIP

The Integrated Clerkship for Primary Care and Psychiatry (I-C*AP) is a designed to help medical students develop core competencies for both specialties as required for residency training. It emerged from a school-wide curriculum redesign that began in 2012 to improve the integration of basic and clinical sciences, strengthen clinical teaching, and make medical education more efficient. The architects of the redesign paired up discipline-based clerkships that shared scientific content, mission, or care delivery processes with the idea that they would collaborate to raise the quality of clinical instruction in each. Psychiatry was placed with primary care out of an awareness that our health care system relies heavily on primary care physicians to diagnose and treat patients for psychiatric conditions and co-manage patients with advanced psychiatric disease. Psychiatrists need primary care physicians to meet population needs for mental health care. By integrating training, the architects hoped to prepare students to provide higher quality mental health in non-mental health settings and to marshal the educational resources of the department of psychiatry to assist in this endeavor. At the same time, the integrated design maintains the high quality of training in advanced clinical psychiatry that Yale is known for. To summarize, four observations underlie the pairing of primary care and psychiatry:

- ❖ A vast amount of psychiatric care, particularly for mood and anxiety disorders, is delivered by primary care physicians.
- ❖ The quality of psychiatric care in primary care can be improved by inter-professional collaboration.
- ❖ A psychiatrists approach to communication, observation, and diagnosis can enhance all aspects of primary care.
- ❖ Patients with severe psychiatric morbidity have high rates of medical comorbidity.
- ❖ Patients with debilitating chronic illness are at risk of developing depression.

During this clerkship, students will be divided into three tracks which will determine the order in which they complete three one-month rotations:

Track	Month 1	Month 2	Month 3
1	Full time psychiatry	Full time primary care	Part time rotations in primary care and psychiatry
2	Part time rotations in primary care and psychiatry	Full time psychiatry	Full time primary care
3	Full time primary care	Part time rotations in primary care and psychiatry	Full time psychiatry

During the month of full time primary care, students will spend eight half-days in practice and two half-days in class. Some students may spend all clinical sessions in one primary care practice which may be general internal medicine, family medicine or

pediatrics. Other students may divide their time between a primary care practice and an adult subspecialty practice that is closely related to primary care, such as cardiology, gastroenterology, endocrinology, pulmonary, or rheumatology. The subspecialty component is intended to help students develop deeper knowledge in one area of primary care, appreciate the challenge of providing high-quality chronic disease management, and learn skills for collaborative practice and effective consultation.

The teaching philosophy for the primary care and subspecialty components of this integrated clerkship is that third-year medical students learn best by having as much responsibility for patient care as is commensurate with their preparedness. It assumes that effective learning requires students to practice the skills and apply the knowledge they are attempting to master. Students will work with preceptors who provide suitable learning environments, orchestrate patient encounters, and closely supervise the student's progress. To learn clinical judgment and diagnostic reasoning, and to acquire medical knowledge, students should be questioned about medical facts and asked to make a commitment about their interpretation of clinical findings.

This clerkship is distinct from many others in that students work continuously and intensely with established physicians. All of their supervision is from internists, family physicians, or pediatricians rather than residents or other trainees. Direct attending supervision assures efficient learning, authoritative supervision, and accurate assessment.

The success of a student's clerkship rotation depends on four parameters:

- 1) The clinical environment
- 2) The clinical skill of the preceptor(s)
- 3) The teaching skill of the preceptor(s)
- 4) The student's attitude toward learning

With the exception of the student's attitude, the other parameters are determined by the preceptor's skill and resolve to teach.

CLERKSHIP LEARNING OBJECTIVES

Overall Goal

The goal of the Integrated Clerkship for Primary Care and Psychiatry is to provide students with the experiences and instruction required to develop specific and complementary competencies in these two disciplines. By the end of the rotation, all students are expected to achieve 15 specific learning objectives that are based on templates from professional societies and school-wide objectives for Yale Medical School.

Learning Objectives

At completion of the 12-week Clerkship, students should:

- I. Demonstrate behaviors consistent with the highest standards of professionalism and medical ethics in all patient encounters.

Criteria: Preceptors will certify that the student can and does:

1. Describe and implement basic elements of informed consent.
2. Demonstrates consideration of each patient's specific value for health and illness.
3. Demonstrate a commitment to caring for all patients regardless of gender, race, socioeconomic status, intellect, sexual orientation, or ability to pay.
4. Demonstrate respectful attitudes toward patients with psychiatric disorders and the ability to connect with their underlying humanity.
5. Demonstrate respect for all members of the health care team, including physician and non-physician providers as well as non-providers who support the caring mission.
6. Demonstrates patient-centered care.
7. Use self-reflection to manage internal feelings to improve therapeutic alliances with patients.
8. Manage professional boundaries in the context of the doctor-patient relationship.

- II. Incorporate core concepts for primary care and psychiatry during the care of patients.

Criteria: Preceptors will certify that the student can and does:

1. Explain the importance of understanding family, community, and societal roles in providing care to patients with medical or psychiatric conditions.
2. Appreciate the changing needs of persons across the lifespan.
3. Explain the key components of primary care (prevention, first evaluation of symptoms, management of chronic disease) and how these functions give primary care a foundational role in public health.
4. Describe and apply the biopsychosocial model in the care of patients.
5. Demonstrate an ability to work as a member of an interdisciplinary care team.

- III. Obtain an accurate and appropriately focused medical history for a specific setting and amount of time.

Criteria: By observing the student and speaking with the patient, the primary care or psychiatric preceptor or tutor will certify that:

1. The chief complaint is accurately identified.
2. The history is obtained in a logical, organized, and thorough manner.

3. The student demonstrates effective verbal skills, including appropriate use of open- and closed-ended questions, repetition, facilitation, explanation, summation, and interpretation.
4. The depth and breadth of the history is appropriate to the visit type (e.g., problem-focused visit vs new outpatient visit vs inpatient admission)
5. The student seeks the patient's point of view.
6. Alternate sources of information are used to obtain history when needed, including but not limited to family members, fellow healthcare providers, living facility, and pharmacy staff.

IV. Complete an appropriately focused, accurate physical and mental status examination for an adult or child patient.

Criteria: By observing the student and speaking with the patient, the preceptor will certify that:

1. The physical examination is appropriately focused for the setting and purpose, without incorporation of unnecessary maneuvers or omission of essential maneuvers.
2. The student's findings are accurate.
3. The student demonstrates appropriate technique for eliciting all pertinent signs, including mastery of the mental status examination in identifying evidence for cognitive impairment, mood disturbance, and disordered thinking.
4. The student identifies, describes, and documents abnormal physical and mental status exam findings.

V. Formulate and describe the differential diagnosis and a diagnostic plan for children and adults presenting with various complaints in primary care or psychiatry.

Criteria: By observing the student and speaking with the patient, the preceptor will certify that:

1. The student can synthesize essential clinical information into an accurate patient representation.
2. The student's differential usually includes the correct diagnosis plus other plausible diagnoses.
3. The student appropriately prioritizes items in the differential diagnosis according to both probability and seriousness.
4. The student identifies key economic, statistical, and clinical factors (e.g., physical risk) that may affect choice among test options.
5. The student elicits and accounts for the patient's perspective in diagnostic decision making.

VI. Deliver an effective oral presentation and write a note based on the findings from an interview and examination of an adult or child in primary care or psychiatry.

Criteria: The preceptors will certify that for almost every patient he or she cares for, the student:

1. Completes the oral presentation succinctly, in an appropriate amount of time given the audience and setting.

2. Includes a chronologically-developed present illness, medication list, past history, and pertinent positives and negatives from the family history, social history, and physical and mental status examination. Describes the differential diagnosis.
3. Writes the note in SOAP format according to examples in the course prospectus (primary care setting) or as instructed by the resident or attending physician (psychiatry setting).
4. Completes the note the day of the visit.
5. In the inpatient setting, reflects in both presentations and notes the pertinent changes in patients' clinical status.

VII. Ascertain and interpret the results of common tests.

Criteria 1: Preceptors will certify that for at least a few patients, the student correctly:

1. Describes the results of common tests in terms of related pathophysiology.
2. Describes the meaning of sensitivity, specificity, pre-test probability, and predictive value.
3. Anticipates (describes) the implications of results before ordering tests.
4. States the post-test probability based on test results.

Criteria 2: For almost every patient you care for, the preceptor will certify that you:

1. Personally review test results.

VIII. Develop, describe, and implement appropriate therapeutic plans.

Criteria: The preceptor will certify that the student can:

1. Describe key factors to consider in choosing among treatment options, including risks, cost, and efficacy.
2. Formulate an initial therapeutic plan.
3. Write prescriptions accurately.
4. Involve the patient in therapeutic decision making, explaining the risks and benefits of treatment options.
5. Demonstrate a commitment to involve the patient in his or her health care.

IX. Demonstrate the learning skills and ability to identify and meet emerging information needs for diagnosis, prognosis and treatment of patients cared for in primary care or psychiatry.

Criteria: Preceptors and tutors will certify that the student can:

1. Develop well-formed, focused, pertinent clinical questions.
2. Acquire, interpret, and apply information from a diverse array of sources to optimize diagnosis and management of individual patients.
3. Classify information sources according to broad scientific categories: original research, meta-analysis, structured reviews, narrative reviews.

X. Demonstrate skills for coordination of care and communication with colleagues.

Criteria: Preceptors will certify that the student can:

1. Participate in requesting a consultation and identifying the specific questions to be addressed.
2. Participate in coordinating care outside the hospital.

3. Demonstrate an attitude of teamwork and respect towards all members of the health care team as manifested by reliability, responsibility, and honesty.
4. Demonstrate acceptance of the premises that various physician styles may each be appropriate and that different valid approaches to patient care may coexist.
5. Work as an effective member of the patient care team.

XI. Demonstrate the knowledge required to provide care for patients presenting with the most important and common needs in psychiatry and the three domains of primary care (i.e., evaluation of symptoms, preventative health, and chronic disease management).

Criterion 1: Course director will certify the student.

1. Receives a passing score on the in-house exam (see Appendix 1 for list of topics).
2. Documents independent, needs-based study during the clerkship.

Criterion 2: Preceptors will certify that the student has adequate synthetic knowledge as demonstrated by achieving objectives V (differential diagnosis), VII (diagnostic testing) and VIII (therapy).

XII. Recognize and diagnose selected emergencies in primary care and psychiatry and describe the initial approach to management of each.

Criteria: Course director will certify the student:

1. Receives a passing score on the in-house exam.
2. Documents their completion of required reading for a list of 13 conditions specified in Appendix 2.

XIII. Demonstrate the ability to deliver evidence-based brief behavioral interventions.

Criteria: Course faculty will certify the student:

1. Employs the Screening, Brief Intervention and Referral to Treatment (SBIRT) intervention correctly.
2. Uses the SMART (specific, measurable, action-oriented, realistic, timely) goal format and collaborate with a patient to develop a behavioral activation plan.

XIV. Recognize the various ways in which primary care and psychiatry in the United States are practiced and the mechanisms/forces which have shaped primary care and psychiatry.

Criteria: The course director will certify that the student can:

1. Describe the differences between different models of care
2. Name several factors which have shaped the current state of primary and psychiatric care in the US
3. Provide definitions for primary care and psychiatry.

XV. Describe benefits of providing mental health within primary care practice.

Criteria: Course Faculty will certify that the student can:

1. Identify the most common primary care and mental health disorders
2. Describe why treating patients under a biopsychosocial approach leads to better overall treatment
3. Name several reasons why primary care and mental health care should be integrated

CURRICULUM

C.1 Overview

The curriculum includes classroom exercises and clinical instruction in family medicine, general internal medicine, subspecialty internal medicine, pediatrics, and subspecialty pediatrics. Clinical instruction will occur in a variety of sites including community health centers, health maintenance organizations, hospital clinics, private practices, and the Veterans' Administration Medical Center. Because students are likely to have quite different experiences in each clinical site, we have designed a classroom program to assure that every student learns about key topics and illnesses.

C.2 Family Practice, General Medicine Practice, and Pediatrics

In most clinical sites, students will practice with an attending physician and will see the physician's personal patients. At some participating hospital clinics, students will be supervised by residents or attending physicians in the care of patients who do not have a personal doctor.

Physicians at all clinical sites will encourage students to become actively involved in the care of patients. Under close supervision, students will take primary responsibility for at least two patients per half-day session by seeing the patient before other providers, writing the visit note, and following-up on tests. Whenever possible, the student will see patients in return visits.

In addition to active learning, students will also observe senior clinicians at work. The purpose of this observation is to acquaint students with the attitudes, interviewing skills, and examination skills of accomplished internists.

With the guidance of the preceptor, each student will be expected to consult library resources to answer important clinical questions on specific patients.

C.3 Subspecialty Practice

In most subspecialty sites, students will have direct responsibility in patient care just as for general medicine sites. In some subspecialty sites, however, students will have less direct responsibility than they can anticipate at primary care sites.

Through participation in subspecialty practice and discussion with physicians, students will have an opportunity to learn behaviors required for effective consultation. Students will also learn how to make an effective subspecialty referral.

C.4 Classroom Exercises

C.4.1 Workshop on Conducting a Focused Office Visit

In the first week of the clerkship, students participate in a two-hour workshop on conducting a 20-minute, problem focused office visit. The goal is to help student acquire the skills in interviewing, physical examination, and communication that are required to complete an efficient, time-constrained evaluation of a patient who presents with a new symptom. The workshop is based on a highly-specified model of patient-centered care and was developed by Dr. Frederick Haeseler at Yale. After reviewing the model, students then practice implementing the model by interviewing each other in a highly structured role-play format. After each role-play, students debrief with a physician-facilitator.

C.4.2 Case Conferences, Workshops, and Lectures

During the 12-week rotation, students will meet once or twice a week to discuss cases or case sets, attend workshops, or hear lectures. The topics (shown below) involve fundamental principles in the diagnosis, management, and outcome of common conditions encountered in primary care.

Topics	
Abdominal Pain	Infectious Diseases
Anxiety Disorders	Insomnia
Asthma	Low Back Pain
Cancer Screening	Mood Disorders
Delirium and Dementia	Opioid Prescribing and Abuse
Diabetes	Orthopedic Examination Techniques
Hypertension	Somatic Symptom Disorder

C.4.3 Student-Faculty Rounds (SFR)

Once during the rotation, each student will design and lead an educational exercise for his or her peers in which he or she serves as the “faculty” member. The duration of each student’s exercise will be one-half hour. The topic for a student’s SFR may be based on a particular patient he or she has seen, although this is not required. As long as the topic can be directly related to the practice of primary care, students may use this occasion to learn more deeply about a special interest. The aims for these rounds are:

- 1) To help students learn techniques for effective small-group learning.
- 2) To assure that students broaden their knowledge of medicine.

A faculty member will attend each session.

C.4.4 Report

At various times within the classroom curriculum, students will meet with an attending physician to review patients encountered at clinical sites. Selected students will be notified in advance that they will be asked to present a patient, although some sessions will be driven by patients presented by the faculty. The format will be a traditional report.

C.5 Clinical Skill Evaluations

C.5.1 Visit-Note Evaluation

Each week, starting with the second week of the clerkship, students must give a visit note to the site coordinator or a designated preceptor. With the notes, students are required to supply a visit note evaluation form. Preceptors should return the note (with corrections) and the completed evaluation form to the student within 48 hours. These notes should be in a SOAP format (guidelines are provided to students in the prospectus). They should be appropriately short (rarely more than two handwritten pages) but complete for the problems identified during the visit. Detailed guidelines for evaluating notes are in a later section of this booklet.

C.5.2 Observation of an Interview

Once during the rotation (hopefully more often) we ask preceptors to observe each student conduct a patient interview. This usually involves no more than 5-10 minutes of direct observation, followed later in the day by debriefing and feedback. During the observation, the preceptor sits in the exam room, positioned to observe the student-patient interaction. The preceptor can leave when the interview transitions to the examination, or before if needed. Even brief observation can provide very helpful information for use in coaching the student.

NOTE: keeping the period of observation brief assures that the preceptor can keep up with other responsibilities and makes the exercise more practical in the busy office environment. If the exercise is brief and easy, a preceptor is more likely to repeat it during the month.

Observation requires some preparation:

- ❖ The student should be informed how and when the observation will occur, its purpose, and the importance of debriefing afterward. It is also a good idea to let the student know it may occur “on the fly” as opportunity arises.
- ❖ The patient should also be informed before the exercise begins. This can be accomplished right at the beginning of the observation as the student and preceptor walk in to greet the patient. For example, the preceptor might say, “As part of Student X’s training, I sometimes watch him as he begins a patient visit, which I would like to do now, if that is OK with you. I would sit over here and watch as the two of you begin to talk. I won’t say anything. After a few minutes, I will leave without interrupting. Later, I will meet with Student X to talk about the interview and provide suggestions. Would this be OK with you? Do you have any questions?”

- ❖ Finally, the teacher must be prepared for the observation task by understanding what to look for, how to look for it, and then how to provide constructive feedback to the student. A checklist of things to look for in the interview is attached as Appendix 3.

C.5.3 Observation of a Visit Closure

The visit closure refers to the last part of a patient encounter when the provider explains the diagnosis, describes a plan for evaluation or treatment, confirms the patient's understanding, and solicits his or her response. The final plan is then revised to incorporate the patient's preference and values.

Of all parts of the patient encounter, this may be the most difficult for third-year students. It requires both solid communication skills and deep knowledge of the pertinent medical issues. While it may be tempting to exempt students from this part of the encounter, such a policy would not serve their need to develop this skill. As with all clinical skills, mastery requires practice under the guidance of experienced teachers.

Once during the rotation (hopefully more often) we ask preceptors to observe each student conduct a visit closure. How this is accomplished can vary depending on the time available to the preceptor and the pace of the office. Here are some potential strategies, starting with one that is most time-intensive for the preceptor:

- ❖ Watch the student do the visit closure from beginning to end (typically 5-10 minutes). After the student and patient have finished talking, enter the discussion and complete the closure to assure yourself that all matters have been properly addressed. Sometime after the patient has departed, meet with the student to debrief and provide feedback.
- ❖ Send the student alone into the examination room to do the visit closure while you do other work. Before the patient leaves, go into the examination room to confirm the patient got the correct message, had his or her questions answered, etc.
- ❖ Send the student alone into the examination room to do the visit closure while you do other work. The student then discharges the patient from clinic. This is only appropriate when you know the student can do the closure properly.

A BRIEF PRIMER ON OFFICE-BASED PRECEPTING

P.1 Preparation for the Student's Arrival

P.1.1 Prepare the Office Staff

The staff of an office or clinic has a key role in assuring that each student has a successful rotation. By helping the student learn about office routines and the location of critical resources, they help a student become functional and confident. By readily offering help and answering questions, staff can make a student feel welcome and facilitate his or her integration into the practice. Students, like their preceptors, depend on staff for patient scheduling and for assistance during a patient's visit. Most importantly, nurses and clerical staff can create a welcoming, professional learning environment.

Preceptors should not assume that receptionists, schedulers, and nursing staff automatically know what role the student will have in a practice. The preceptor should usually inform the staff about how the student will interact with them and with patients. Consider having a meeting with staff in advance of the student's arrival to discuss:

- ❖ The student's name.
- ❖ The student's schedule (when they will be in the office).
- ❖ The student's expected role in patient care.
- ❖ The expected effect of the student on office operation. Will fewer patients be scheduled? Will the preceptor be busier?
- ❖ How patients will be scheduled for the student.

In addition, it may be helpful to mention that students are just learning about the organization of office-based care where inter-professional collaboration and team-based care are particularly important. This is an opportune time for students to learn the value of each member of your practice and develop respect for their roles and responsibilities. You might consider assigning your student to spend a few hours with various member of the office staff to observe the work of nurses, medical assistants, and administrative personnel. Invite staff members to show students their work on the fly.

P.1.2 Consider any Desired Modification to Patient Scheduling.

It is not necessary to change the change patient templates or scheduling practices to accommodate a student. It is very common to assign patients to the student from the customary roster of scheduled patients and urgent visits.

However, preceptors often find that some accommodation can improve work flow and relieve pressure on their time. Two strategies are common: managing the number of patients seen per session and creating a separate schedule for the student.

P.1.2.1 Potential Strategy 1: Managing Visit Volume. In general, a preceptor will have difficulty providing adequate supervision to a student when more than three patients are seen per

hour (combined total for student and preceptor). The optimal number of patients per hour depends, of course, on the customary severity of patients seen in the office, their average age, etc. In the usual office, limiting the number of patients to three per hour is adequate. One way to accomplish this is to schedule “Teaching Time” for a few slots that would otherwise be held for a patient.

P.1.2.2 Potential Strategy 2: Wave Scheduling. Students like to have a prepared list of patients they may expect to see during an office session. A list helps them set goals, facilitates their interaction with staff members, and helps them feel like a provider. A patient list improves a student’s interaction with staff by reminding staff that the student is there to provide care. A list also assures that a student stays busy and on schedule. A popular method for scheduling patients is the “wave” system (see Lesky 1995 and Ferenchick 1996). Here is what it looks like:

<u>Model “Wave” Schedule for Ambulatory Care Teaching Sites</u>	
8:00 a.m. to 8:20 a.m.	Student sees patient 1, while preceptor see patient 2.
8:20 a.m. to 8:40 a.m.	Patient 1 is seen by student and preceptor together.
8:40 a.m. to 9:00 a.m.	Student charts on patients 1, while preceptor sees patient 3.
9:00 a.m. to 9:20 a.m.	Student sees patient 4, while preceptor sees patient 5.
9:20 a.m. to 9:40 am.	Patient 4 is seen by student and preceptor together.
[Wave-scheduling pattern would be continued throughout the day.]	

P.1.3 Confirm There Is an Extra Examination Room for the Student

To maintain office/clinic efficiency, both the student and the preceptor need an examination room of their own. This is essential. Multiple examination rooms allow the preceptor to see one patient while the student sees another. Patient flow is maintained. Many preceptors prefer to have two rooms for themselves and a third for the student.

P.1.4 Become Familiar with the Curriculum

The Integrated Clerkship for Primary Care and Psychiatry has a defined curriculum for classroom and clinical work. Students learn about the curriculum during orientation and, therefore, anticipate the responsibilities, experiences, and supervision they will have throughout their month. The time that a preceptor spends to understand the curriculum (e.g., by reading this document) will assure that he or she correctly anticipates the student’s needs and expectations and can mitigate risk for any later misunderstanding between student and preceptor.

P.1.5 Offer the Student a Place to Hang His or Her Hat

Students appreciate having a room or desk where they can write notes and keep their personal belongings. Students often describe the advantage of having a place where they can be “found” by staff and preceptors. This may be a designated examination room, but other space may be equally suitable.

P.2 Orientation

Orientation serves two purposes. First, it assures that students quickly develop the functional capability to work efficiently. Second, it conveys a message that students are welcome and that their functionality is appreciated.

Orientation should include introductions to key members of the staff (e.g.: nurses, receptionists, laboratory technicians, file clerks), a tour of the facility, and a description of office procedures. In particular, students should know procedures for making appointments, retrieving medical records, bringing patients into examination rooms, ordering tests, retrieving test results, and charting. If there is a computer in the office, they need to know how to use it.

Students need access to the information sources (e.g., medical references, the electronic medical library, laboratory test data) that allow them to be effective providers.

P.2.1 Get to Know the Student from the Start

This is key. When things go wrong in office-based education it is most often because of misunderstanding or mistrust between student and teacher. On the first day the student arrives or at the end of that day, preceptors should make time to meet with the student to build a foundation of trust, shared goals, and open communication. Here are some specific suggestions for how this important conversation.

- ❖ Tell the student about yourself, your personal narrative and your interests.
- ❖ Explain what drives you to teach in this course. Teachers often use this occasion to say they value the professional tradition of “teaching the children of my teacher” and, in this way, teaching gives value and meaning to a teacher’s life. Make it personal. Explain why you believe students belong in your practice and that you believe they improve the service you can provide to patients, etc. Explain why you like having a student around. What do you get out of it?
- ❖ Ask the student about their hopes and expectations for their time with you. A nice way to do this is to ask what has gone well during prior rotations and what they have most valued in their work with other supervisors. Ask about the conditions that help them learn best. Ask, “How do you hope to be different at the end of the rotation?”
- ❖ Review the learning objectives above.
- ❖ Discuss your vision and expectations for the student’s role in the office. Be specific regarding things like arriving on time, seeing a minimum number of patients, setting a limit on time with each patient, completing notes on time, doing follow-up. Describe how you will work together in the care of specific patients (e.g., Will someone speak with the patient before the student goes in? Will the student present in the exam room? How much time should the student spend with each patient?) Then ask if the student wishes to suggest any modifications to your vision and expectations.
- ❖ State that you want to make this rotation be as effective and fun as possible for this student.

- ❖ Make plans to stay in touch. How will you meet to talk about specific patients in depth? What about feedback? How often will it occur and in what format?

P.3 Orchestration of the Patient-Student Encounter

Several educators have published guidelines [Alguire, 2001; Ferenchick, 1997; Kernan, 1996, 2000; Lesky, 1995; Neher, 1992; Rubenstein, 1992; Whitman, 1995] that set forth practical, well-grounded models for ambulatory teaching. These guidelines have several common sets of features that include the following ideas:

P.3.1 Selection of Patients

Students generally prefer seeing patients with acute problems and exposure to such patients should be a priority for ambulatory care rotations. Acute visits provide students with an opportunity to solve a problem, meet a patient's urgent needs, and to have major responsibility for patient care. The excitement of an unknown diagnosis and the immediacy of an urgent visit provide powerful motivation for learning and performance. To provide broad grounding in office-based internal medicine, students also need to see patients returning for management of chronic conditions and health maintenance. They need to see a mix of young and old, male and female. They need to see a variety of health care problems.

P.3.2 Recruiting the Patient

It has been well established that patients are usually pleased to have a student involved in their care. To assure patient satisfaction, guidelines recommend that patients be informed in advance of the student's status and responsibility. Patients should know how the student will be supervised, and they should have an explicit opportunity to decline student involvement.

A common mistake preceptors make is to apologize for their student in advance. Asking the patient "for a favor", for example, misrepresents the student's capability and undermines his or her authority. An alternative approach is to describe the student as "a medical student who is learning about office medicine and helping me this month". Explain that the student will "find out how you've been since your last visit and how we can help you, perform a brief examination, and then get me so I can hear about you and see you. The student and I will work together to be sure we address all of your needs and concerns."

This invitation can be given by the preceptor, a nurse, or a receptionist. In some cases, the student may appropriately introduce himself or herself.

P.3.3 The Student's Role

All guidelines emphasize that students need the opportunity to practice the skills they are attempting to master. That is, they must be able to interview and examine patients independently, communicate with patients and colleagues, interpret clinical information, and demonstrate the full spectrum of behaviors that constitute professionalism. Students who receive these opportunities often report that they become partners with their preceptor, sharing in the

work of his or her practice. Because students arrive with different levels of capability, responsibility for patient care may need to be graduated over time. The common rule in most guidelines, however, is that students should receive as much responsibility for patient care as they are prepared to accept and as much supervision as is required to assure outstanding patient care and learning.

A preceptor's main role is to facilitate a student's encounter with patients, assuring the student has meaningful, graduated responsibility. Generally, students should conduct all critical tasks in the patient visit from the initial history to the closing discussion. Beginning students will benefit from up-front guidance about the purpose of a patient's visit (e.g., abdominal pain, pap smear) and time limits. You might say, "Plan on spending 20 minutes taking the history and doing a focused examination. Come and get me at the end of 20 minutes".

After the visit, students should be expected to write the visit note, check labs, and make any necessary follow-up calls.

P.3.4 Case-Based Learning

For an excellent discussion of case-based learning, see Chapter 5 in Teaching in Your Office by Patrick Alguire and colleagues. Case-based learning starts when a student presents a patient to you using the typical verbal format of history of present illness, past medical history, physical examination, data, and assessment. From this presentation, teachers use a variety of techniques to probe a student's knowledge, identify learning needs, and address those needs. Case-based learning involves questioning, mini-lectures, role modeling, observation, and encouragement of self-directed learning. One model of case-based learning is the Microskills Model

P.3.4.1 The Microskills Model

The microskills model was developed as an efficient strategy for office-based teaching (Neher 1992). It includes the following components:

Get a Commitment

For every patient seen by the student, ask the student "what do you think is going on?" Without this question, preceptors cannot identify a student's learning needs. Unless this question is asked, furthermore, a student will not have the satisfaction of demonstrating their accomplishments. The answer to this question marks a starting point for further discussion.

Probe for Supporting Evidence

Here, preceptors can use a variety of questions to test the student's reasoning ability and lead him or her to greater understanding. Examples include, "what else did you consider", "what led you to that conclusion", etc. Use of hypothetical scenarios can be very effective. For example, you might say, "Suppose this patient with right neck pain also reported left hand weakness, then what might the diagnosis be?"

Teach General Rules

After you have determined the student's learning needs, provide general rules. General rules provide more enduring instruction than very specific teaching. Examples of general rules include, "when a patient's blood pressure is not under control and you change a medication, see them soon in follow-up rather than waiting months". "An abscess generally will not resolve without drainage".

Tell Them What They Did Right

When you catch a student doing something well, you can reinforce the behavior by praise. Third-year students are more likely to maintain good habits with this reinforcement. Also, students love praise and will be motivated to work harder by your positive remarks.

Correct Mistakes

Positive and negative feedback should be given in close temporal sequence to the observed behavior. Don't wait days and weeks to provide corrective advice.

Students want advice on improving their clinical performance. They want specific comments that provide clear direction for improvement. Your direct, clear comments will be appreciated. Try to give criticism in a manner that conveys to the student "I'm telling you this so you will become an outstanding doctor – and I know you can be".

P.3.4.2 A Caution

Preceptors commonly ask students to present their patients with the patient in attendance. This is efficient for the preceptors and pleasant for the patient. Students, however, often object. The reason they object is that they do not like fielding questions in front of patients. If the student is unsure of an answer, he or she may become embarrassed and his or her authority may be compromised. If students do know an answer, they may not want to speak in front of the patient without first speaking alone with the preceptor. At least until you have established the student's comfort, it may be best not to ask questions about differential diagnosis, pathophysiology, prognosis, and pharmaco-therapeutics in front of the patient. Step outside with the student for this discussion. Give the student a chance to test ideas and develop a sound plan at a safe distance from the patient.

P.4 Special Considerations for Supervision of Students in Pediatrics

As this may be the student's first foray into pediatrics, he or she may need some tips from you about:

P.4.1 Charming the Patient: How do you typically enter the room? Who do you look at? How do you increase comfort for the child and family? Do you use jokes, magic?

P.4.2 Interview of the Patient: Whom to interview (parent, patient + parent, or patient alone) based on the developmental level of the child. How do you handle it when the parent must step outside? If it is an adolescent, how do you help the student finesse the transition? What are interviewing techniques you use commonly? The student will have had classroom discussions about these topics by the time you meet them, but will not have the practical experience needed.

P.4.3 Examination: In what order should they examine the patient? Are there tips you have for them to increase comfort in the exam? What are the considerations for the smaller child? What about the adolescent? Do you use patient chaperones?

GUIDELINES FOR EVALUATING STUDENT PERFORMANCE

A clear and comprehensive performance evaluation will help students identify areas for continued growth and constitute the basis for a personalized learning program. Evaluations are also required to certify that students meet the minimum standards required for graduation and to provide descriptive material for the dean's letter.

The Primary Care Component of the Integrated Clerkship for Primary Care and Psychiatry is graded Pass/Fail. The criteria for preceptors to use in the assessment of pass/fail are provided in the appendix.

Several suggestions for evaluating student performance in ambulatory settings are listed below:

G.1 Observe students frequently, looking for specific behaviors.

Here are some examples:

Patient Interviews:

1. How effective was the student in ascertaining the patient's agenda?
2. In what ways did the student facilitate the patients' telling his/her own story?
3. How effective was the student in eliciting the patient's attribution of symptoms?
4. How effectively did the student listen to the patient's concerns?
5. How appropriate was the student's use of silence?
6. How successful was the student in demonstrating empathy to the patient?
7. In what ways did the student educate the patient?
8. Did the student obtain all history pertinent to the clinical problem?

Physical Examinations:

1. Did the student demonstrate correct technique for examining the abdomen?

Verbal Presentation of Case:

1. How accurate, complete, and succinct was the student in presenting data related to the patient's history and physical exam?
2. Was the presentation in a SOAP format?
3. Does the student use valid evidence to support reasoning?
4. Did the student describe an adequate differential diagnosis?

Relationship with Faculty/Staff:

1. How effective was the student in working with office staff?
2. In what ways did the student demonstrate understanding and respect for members of staff?

Visit Notes:

1. Did the student successfully use the SOAP format?
2. Were all pertinent problems listed in the assessment?
3. Does the assessment include a differential diagnosis and adequately justify a correct plan?
4. Is the signature readable?

Independent Learning:

1. What evidence do you have that the student completed reading assignments you gave?
2. In what ways did the student use research and reference material to promote independent learning?

Follow-up Activities:

1. How responsible was the student in obtaining test information?
2. Did the student adequately complete all assigned telephone calls?
3. Did the student discuss abnormal tests with you in a timely manner?

G.2 Evaluate attitudes by looking for behavioral manifestations of those attitudes.

For example, if you are evaluating the attitude that “the patient’s values and beliefs are important to consider in formulating diagnostic and therapeutic plans”, look for specific behaviors that might be indicative of that attitude, (e.g., student asks for patient’s impression of proposed therapeutic plan, student negotiates with patient to maximize adherence). In evaluating an attitude of “respect for the patient”, did the student introduce himself/herself, call the patient by surname, and use language appropriate for the patient?

G.3 Use questions to evaluate cognitive behavior.

Closed questions are often used to ascertain knowledge of specific factual information, and open-ended questions are more effective in assessing critical thinking and clinical problem solving. It is important to give adequate time for students to respond to all questions.

G.4 Ask students for their own self-assessment.

Because self-directed learning is a major learning objective, encourage students to evaluate their own performance in the ambulatory setting. This often obviates a preceptor’s need to critique a student. Students are often excellent judges of their own learning needs. When they identify and discuss those needs, the educational experience may be more satisfying to them.

G.5 Provide appropriate feedback regularly and in a timely manner.

Giving valid feedback is a highly significant skill. Every time you interact with a student, you have an opportunity to give constructive feedback. Remember to ask for feedback yourself, when appropriate. This openness to receiving feedback promotes collegiality.

G.6 Create an environment in which the student trusts that the preceptor's intention is only to help the student become the best physician possible.

At the beginning of the learning experience, the preceptor can establish the foundation for a supportive relationship by clearly communicating the roles and responsibilities of the preceptor and the student.

GUIDELINES FOR EVALUATING VISIT NOTES

One of the core responsibilities of each site coordinator or preceptor is to evaluate the student's skill in written communication. To promote this evaluation, students are required to turn in one visit note per week during the last three weeks of the clerkship. These are graded by preceptors using a standard form. In addition to the grading, preceptors are asked to give written or verbal criticism to students on every note.

When evaluating notes, please remember that students are instructed to write in the SOAP format. The prospectus includes examples of SOAP notes and guidelines for following this format. As you criticize notes, please consider:

1. Is the note dated on every page?
2. Is the patient's name on every sheet?
3. Is the student's name clearly written?
4. Is the SOAP format used?
5. Are all appropriate problems identified in the subjective section?
6. Did the student write in succinct, clear prose and avoid obscure abbreviations and symbols?
7. Is the history adequate for each problem?
8. Is the described physical examination complete for the complaints listed?
9. Are medications listed accurately? In particular, are all medications listed using generic terms and indicating tablet or capsule strength?
10. Is the plan appropriately complete and devoid of grossly inadequate testing or therapy?
11. Is there an appropriate differential diagnosis for each problem? Does the student adequately explain his/her clinical reasoning?
12. Did the student clearly state when the patient is to return and whom the patient is to see?
13. Did the student indicate the name of the supervising attending (e.g., seen with Dr. Kernan)?
14. Is the note adequately brief?

Preceptors grade each note on a scale of outstanding, excellent, very good, satisfactory, and poor. In the final evaluation for the clerkship, we will indicate the average grade, with missing notes graded as "poor". To receive an "outstanding" grade on any note, the student must adhere to all 14 points above. In general, very simple problems (e.g., routine F/U hypertension) will not warrant an "outstanding" grade unless the clinical evaluation and assessment is extraordinary (and beyond what might be expected for a routine evaluation of the problem).

FACULTY APPOINTMENTS FOR TEACHERS

The Liaison Committee on Medical Education (LCME), the group that certifies medical schools, requires medical schools to appropriately evaluate teachers for their role in the curriculum. At Yale, this process involves securing a faculty appointment for all teachers. Thus, all preceptors in the Integrated Clerkship for Primary Care and Psychiatry are nominated for an appointment on the clinical faculty.

Criteria for Appointment at each Rank

RANK	Basic Requirements	
	Service Hours*	Other
Clinical Instructor	50	Regular contribution to academic programs
Assistant Clinical Professor	75	Achievement of recognition for scholarship, clinical activity, research or made contributions in one of the following ways: High level of commitment to teaching Publication or other substantial contributions to professional discipline Contribution to research in the Department
Associate Clinical Professor	100	Outstanding scholarship and sustained contribution to academic life including teaching and research
Clinical Professor	150	Long-standing excellence and achievement as an educator, scholar, or clinician including: Exceptional service to Department or School Regional or national reputation
Retired		At existing rank
*In this clerkship, each hour that the preceptor is responsible for the student in his or her office counts as one service hour. Teaching is the principal contribution voluntary faculty members make to Departments of the Medical School. However, contributions can also be made in patient care, scholarship, medical administration, or community service.		

The full guideline for “Appointment and Promotion for the Clinical Part-Time (Voluntary) Faculty of the Department of Internal Medicine” is available upon request. It is also available on the web at:

http://medicine.yale.edu/intmed/yahp/326_32020_IMVoIFacApptsPromos_April2012.pdf

Selected Privileges for Faculty Appointed to Clinical Ranks

With a clinical appointment, faculty members are able to obtain a Yale ID that provides access to discounts at local New Haven merchants, including the Yale bookstore. The Yale ID also provides:

1. No-cost access to Yale libraries, including borrowing and stack privileges where such privileges are available to employees.
2. No cost enrollment in two CME courses at YSM and ten hours of on-line YSM CME education per year.
3. No-cost access to evening transportation by the Yale Mini-Bus Service.
4. Employee membership rates at Payne Whitney Gymnasium and the Yale Golf Course.
5. Employee discounts when offered by the Yale Repertory Theater.
6. Access to the Yale Outdoor Recreation Center and to the Yale Sailing Center, subject to such fees as may be charged to employees.
7. No-cost access to the Peabody Museum. (May not be available during special events.)
8. Discounts on purchases at the sales desks of the Yale Art Gallery and the British Art Center.
9. Employee prices for football ticket coupon booklets (limit of 2 per family).
10. Access to film society screenings, subject to admission and membership fees.

Full remote access to the Yale Medical Library is also one of the most widely used benefits. Here are links to library resources and services:

Medical Library Home Page
<http://www.med.yale.edu/library>

Remote Access page
<http://www.med.yale.edu/library/technology/connect.html>

Medical Library PDA Page
<http://www.med.yale.edu/library/technology/PDA/>

For more information about how to get set up with library services contact Mark Gentry at mark.gentry@yale.edu

For information on CME enrollment, please contact the Yale CME Office: Tel 203-785-4578 or Email: cme@yale.edu

RESOURCES

A. Books

1. Alguire PC, DeWitt DE, Pinsky LE, Ferenchick GS. Teaching in your office. Second Edition. Philadelphia: American College of Physicians, 2008.
2. Whitman N, Schwenk TL. Preceptors as teachers: A guide to clinical teaching. Salt Lake City: Department of Family and Preventive Medicine, 1995.
3. Rubenstein W, Talbot Y. Medical teaching in ambulatory care. New York: Springer Publishing Company, 1992.
4. Fortin A.

B. Articles

1. Lesky LG, Hershman WY. Practical approaches to a major educational challenge. Arch Intern Med. 1995;155:897-904.
2. Ferenchick G, Simpson D, Blackman J, DaRosa D, Dunnington G. Strategies for efficient and effective teaching in the ambulatory care setting. Arch Med. 1997;72:277-280.
3. Kernan WN, Goroll AH. A strategy for precepting medical students in ambulatory settings. Connecticut Medicine 1996;60:203-209.
4. Kernan WN, Lee MY, Stone SL, Freudigman KA, O'Connor PG. Effective teaching for preceptors of ambulatory care: A survey of medical students. Am J Med. 2000;108:499-502.
5. Neher JO, Gordon KC, Meyer B, Stevens N. A five-step "microskills" model of clinical teaching. J Am Board Fam Pract 1992;5:419-424.

C. Web Sites

1. ACP/ASIM Community Based Teaching Project
 - a. www.acponline.org/education_recertification/education/
2. Alliance for Academic Internal Medicine
 - a. www.im.org/
3. Society of Teachers of Family Medicine
 - a. www.stfm.org/
4. Yale Medical Library
 - a. www.library.medicine.yale.edu/
5. Yale Promotions Criteria for voluntary faculty
 - a. http://medicine.yale.edu/intmed/ya hp/326_32020_IMVolFacApptsPromos_April2012.pdf

APPENDIX 1
Knowledge Learning Objectives
Integrated Clerkship for Primary Care and Psychiatry

1. Describe similarities and distinctions in the patient-physician relationship for psychiatrists and primary care physicians.
2. Demonstrate respect for the influence of the patient's personal, cultural, ethnic and spiritual beliefs on their experience of health and illness and on the patient's clinical decision-making process.
3. Compare and contrast the organization and delivery of primary care and mental health care in the US today with emerging notions of more effective models for managing the nation's health.
4. Develop an evidence-based health promotion and disease prevention plan for a patient of a given age and gender.
5. Discuss the impact of untreated or undertreated psychiatric illness on a patient's overall health.
6. Describe operational features of organizations that provide primary care or psychiatry that contribute to a culture of safety.
7. Clinical Conditions: know major signs, symptoms, DSM-5 criteria (where applicable), and general principles of evaluation and management for the following:
 - 7.1. ADHD/Learning Disability
 - 7.2. Autism/Pervasive Developmental Disorders
 - 7.3. Adjustment Disorder
 - 7.4. Anxiety Disorders
 - 7.4.1. Generalized Anxiety Disorder
 - 7.4.2. Obsessive Compulsive Disorder
 - 7.4.3. Panic Disorder
 - 7.4.4. Phobias
 - 7.4.5. Post-Traumatic Stress Disorder
 - 7.5. Cardiovascular Disorders
 - 7.5.1. Chest pain
 - 7.5.2. Hypertension
 - 7.5.3. Heart failure
 - 7.5.4. Arrhythmias
 - 7.6. Cognitive Disorders
 - 7.6.1. Major neurocognitive disorder (dementia)
 - 7.6.2. Minor neurocognitive disorder (mild cognitive impairment)

- 7.6.3. Delirium
- 7.7. Dermatology
 - 7.7.1. Acne and Rosacea
 - 7.7.2. Actinic keratosis and squamous cell carcinoma
 - 7.7.3. Atopic dermatitis (childhood)
 - 7.7.4. Bacterial skin infection
 - 7.7.5. Basal cell carcinoma
 - 7.7.6. Contact dermatitis
 - 7.7.7. Eczema
 - 7.7.8. Melanoma
 - 7.7.9. Petechial purpura and vasculitis
 - 7.7.10. Pitiriasis Rosea
 - 7.7.11. Psoriasis
 - 7.7.12. Scabies
 - 7.7.13. Stasis dermatitis and leg ulcers
 - 7.7.14. Tinea pedis
 - 7.7.15. Tinea versicolor
 - 7.7.16. Warts
- 7.8. Eating Disorders
- 7.9. Endocrine Disorders
 - 7.9.1. Adrenal insufficiency
 - 7.9.2. Diabetes
 - 7.9.3. Hyperaldosteronism
 - 7.9.4. Obesity
 - 7.9.5. Thyroid disease
- 7.10. Gastrointestinal Disorders
 - 7.10.1. Abdominal pain
 - 7.10.2. Constipation
 - 7.10.3. Diarrhea
 - 7.10.4. Cholelithiasis
 - 7.10.5. Dysphagia
 - 7.10.6. Hematochezia
 - 7.10.7. Irritable bowel disorder
 - 7.10.8. GERD
 - 7.10.9. Odynophagia
 - 7.10.10. Ulcer
- 7.11. Geriatric medicine
 - 7.11.1. Fall prevention

- 7.11.2. Screening for major conditions (hearing loss, vision loss, incontinence, fall risk, polypharmacy, depression, dementia, malnutrition)
- 7.12. Hematology
 - 7.12.1. Anemia
 - 7.12.2. DVT
 - 7.12.3. Pulmonary Embolism
 - 7.12.4. Sickle Cell Anemia
- 7.13. Infectious Disease
 - 7.13.1. Cellulitis
 - 7.13.2. Endocarditis
 - 7.13.3. Lower respiratory infection
 - 7.13.4. Meningitis
 - 7.13.5. Community Acquired Pneumonia
 - 7.13.6. Sexually transmitted disease
 - 7.13.6.1. Chlamydia
 - 7.13.6.2. Gonorrhea
 - 7.13.6.3. HIV
 - 7.13.6.4. Syphilis
 - 7.13.6.5. Herpes Simplex
 - 7.13.6.6. Human Papilloma Virus
 - 7.13.7. Upper respiratory infection
 - 7.13.7.1. Otitis Media
 - 7.13.7.2. Pharyngitis
 - 7.13.7.3. Sinusitis
- 7.14. Law and Medicine
 - 7.14.1. Involuntary hospitalizations
 - 7.14.2. Medico-legal basis
 - 7.14.3. Informed consent in a patient with a psychiatric disorder
 - 7.14.4. Confidentiality issues
- 7.15. Mood Disorders
 - 7.15.1. Depressive disorders
 - 7.15.2. Bipolar disorders
 - 7.15.3. Mood disorders associated with pregnancy and the menstrual cycle
 - 7.15.4. Electroconvulsive therapy
- 7.16. Nephrology
 - 7.16.1. Acute renal failure
 - 7.16.2. Chronic renal failure
 - 7.16.3. Glomerulonephritis

- 7.16.4. Interstitial nephritis
- 7.17. Neurology
 - 7.17.1. Headache
 - 7.17.2. Insomnia
 - 7.17.3. Peripheral Neuropathy
 - 7.17.3.1. Diabetic Polyneuropathy
 - 7.17.3.2. Facial Palsy
 - 7.17.3.3. Femoral Neuropathy
 - 7.17.3.4. Sciatica
 - 7.17.3.5. Ulnar Neuropathy
 - 7.17.4. Stroke
- 7.18. Oncology
 - 7.18.1. Prevention and early detection strategies for:
 - 7.18.1.1. Breast cancer
 - 7.18.1.2. Cervical cancer
 - 7.18.1.3. Colorectal cancer
 - 7.18.1.4. Lung cancer
 - 7.18.1.5. Prostate cancer
- 7.19. Ophthalmology
 - 7.19.1. Diagnosis of the red eye
 - 7.19.2. Glaucoma
 - 7.19.3. Visual loss
- 7.20. Orthopedics
 - 7.20.1. Common orthopedic diagnoses in primary care
- 7.21. Personality Disorders
- 7.22. Pharmacology. State the indications and mechanism of action (where known), and be able to perform informed consent for a patient considering the following treatments:
 - 7.22.1. Anxiolytics/hypnotics
 - 7.22.2. Antibiotics (oral)
 - 7.22.3. Antidepressants
 - 7.22.4. Antihistamines
 - 7.22.5. Antiplatelet agents
 - 7.22.6. Antipsychotics
 - 7.22.7. Calcium
 - 7.22.8. Calcium channel blockers
 - 7.22.9. Corticosteroids (topical, nasal, inhaled, oral)
 - 7.22.10. Diuretics

- 7.22.11. Mood stabilizers
- 7.22.12. Narcotics, including methadone
- 7.22.13. RAAS agents
- 7.22.14. Statin therapy
- 7.22.15. PPIs
- 7.22.16. Vaccinations, common adult and pediatric
- 7.23. Psychotic Disorders
 - 7.23.1. Schizophrenia
 - 7.23.2. Schizoaffective disorder
 - 7.23.3. due to medical conditions and substances
- 7.24. Pulmonary and Critical Care Medicine
 - 7.24.1. Asthma
 - 7.24.2. COPD
 - 7.24.3. Cough
 - 7.24.4. Pulmonary Embolism
- 7.25. Rheumatology
 - 7.25.1. Inflammatory arthritides
 - 7.25.2. Low back pain
 - 7.25.3. Osteoarthritis
- 7.26. Sexual Health
- 7.27. Special Topics
 - 7.27.1. Pain
 - 7.27.1.1. Approach to non-cancer chronic pain
 - 7.27.1.2. Acute versus chronic pain
 - 7.27.2. Cognitive Behavioral Therapy
 - 7.27.2.1. evidence base
 - 7.27.2.2. basic principles
 - 7.27.3. Psychodynamic approaches to treatment.
 - 7.27.4. Special populations, care considerations:
 - 7.27.4.1. Adolescent
 - 7.27.4.2. Geriatric
 - 7.27.4.3. ethnic minorities
 - 7.27.4.4. LGBT
- 7.28. Substance Use Disorders
 - 7.28.1. Intoxication and Withdrawal
 - 7.28.2. Treatment
- 7.29. Somatic Symptom and Related Disorders

APPENDIX 2

Emergencies Students Should Be Able to Recognize, Diagnose, and Manage Integrated Clerkship for Primary Care and Psychiatry

1. Anaphylaxis
2. Acute coronary syndrome
3. Acute respiratory failure
4. Delirium, including the agitated patient
5. Altered consciousness
6. Stroke/TIA
7. Suicidal risk
8. Hypotension
9. Hypertensive emergency
10. Meningitis
11. Sepsis
12. Pulmonary embolism
13. Arrhythmias
14. Temporal arteritis
15. Hypoglycemia and hyperglycemia
16. Intoxication/withdrawal

Appendix 3
Checklist for Observing the Interview

The check list corresponds to the Master Interview Rating Scale (MIRS) used elsewhere in the Yale Medical School curriculum and includes skills and techniques used in the performance of a patient-centered medical interview.

Rating is on a scale of 5 (Best performance) – 1 (Worst Performance)

1. Opening 5—4—3—2—1

Introduces self, clarifies role, inquires how to address patient

2. Elicits concerns 5—4—3—2—1

Elicits full spectrum of patient concerns at interview onset in first few minutes of encounter

3. Elicits narrative thread 5—4—3—2—1

Gives patient the opportunity to tell the story without interruption at interview onset

4. Timeline 5—4—3—2—1

Chronological progression of all of the symptoms from onset to present time

5. Organization 5—4—3—2—1

The interview follows a logical order; does not jump from section to section

6. Pacing 5—4—3—2—1

Neither too fast nor too slow with no interruptions or long pauses

7. Types of questions 5—4—3—2—1

Begins with open-ended question (describe, tell me about), followed by direct questions; avoids leading, negative, and multiple questions

8. Summarizing 5—4—3—2—1

Data is summarized by the end of the interview

9. Duplication 5—4—3—2—1

Questions are not repeated, except for clarification or summarization

10. Lack of jargon 5—4—3—2—1

Lay vocabulary is used; medical terms are explained immediately

11. Verification 5—4—3—2—1

Pursues/verifies the details of symptoms, events, meds (dates, dosages, quantities)

12. Verbal facilitation 5—4—3—2—1

Verbally encourages patient to tell the story; gives verbal reinforcement for positive behaviors

13. **Non-verbal facilitation** 5—4—3—2—1

Encouraging and supportive gestures, body language, and appropriate eye contact are used; no physical barriers

14. **Empathy** 5—4—3—2—1

Names, understands, respects, supports emotion

15. **Support systems** 5—4—3—2—1

Inquires about friends, family, social services, support groups, finances and spiritual resources

16. **Encourages questions** 5—4—3—2—1

Asks patients if they have questions or additional concerns

17. **Closure** 5—4—3—2—1

Explain briefly what you did and learned, share thoughts about diagnosis and make suggestions, and agree upon a plan (what interviewer will do, what patient should do, next communication date)

Checklist for Observing the History, Specifically

This is a template for the initial history items for a problem-focused office visit. In a given patient several problem pertinent items, obtained with “additional” questions, would be added.

Chief complaint

_ Symptom(s)

HPI

- _ Onset
- _ Quality
- _ Location/ radiation
- _ Severity
- _ Timing
- _ Relief
- _ Made worse by
- _ Made better by
- _ Related events
- _ Related symptoms
- _ Review of problem pertinent system(s)

PMHx

- _ Childhood
- _ Illness
- _ Medications
- _ Allergies
- _ Surgery
- _ Hospitalizations
- _ OB

FH

- _ Illness
- _ Deaths
- _ Similar symptoms

SH

- _ Household
- _ Work
- _ Habits
- _ Support

ROS

- _ Review of additional problem pertinent systems

Appendix 4
 Criteria for Pass/Fail
 Integrated Clerkship for Primary Care and Psychiatry
 Yale School of Medicine

Performance Criteria for receiving a grade of pass in the Integrated Clerkship for Primary Care and Psychiatry. The specific skills represent a sampling of indicator skills deemed necessary for third year medical students. Preceptors will be asked to evaluate students on each of the five general competency areas, based on observed behavior for each specific skill listed in this table. Students may use these criteria for self-assessment during the clerkship.

			Criteria for Pass		
General Competency	Performance Area	Specific Skill	Can Do*	Usually Does†	Always Does‡
Communication	Patient Interview	Accurately identifies chief complaint	✓	✓	
		Gather data thoroughly (most pertinent historical facts)	✓	✓	
		Use effective verbal skills (e.g., open- and closed-ended questions, repetition, facilitation, explanation, summation, and interpretation)	✓	✓	
		Respond appropriately to the patient and his/her concerns	✓	✓	
		Accurately reconcile medication lists (student should do this without prompting)	✓	✓	
	Verbal Presentation	Include pertinent positives and negatives in the HPI	✓	✓	
		Organize the HPI appropriately (e.g., chronologically)	✓	✓	
		Include and organize all appropriate components (i.e., CC, HPI, → plan)	✓	✓	
		Speak clearly and concisely	✓	✓	
	Written Communication	Use the SOAP format	✓	✓	
		Include instructions on when to return to clinic	✓	✓	
		Include indication "seen with [name of preceptor] . . ."	✓	✓	
	Care Coordination	Write consultation requests effectively (e.g., lists precise question, provides all appropriate background information)	✓	✓	
		Coordinate care with other providers (e.g., VNA nurse)	✓	✓	
Considers social and environmental opportunities and barriers in helping individual patients		✓	✓		
Physical Examination	Appropriately focus the examination for the chief complaint	✓	✓		
	Effectively implement basic techniques (e.g., listens to heart across chest, under clothing)	✓	✓		
	Accurately identify non-subtle diagnostic findings	✓	✓		
Clinical Reasoning	Differential diagnosis and Clinical Reasoning	Create a reasonably thoughtful & comprehensive differential diagnosis	✓	✓	
		Consider cost, accuracy, risk in selecting diagnostic tests	✓	✓	
		Anticipate the implications of test results before ordering	✓	✓	
		Inform patients about the diagnostic plan and invite questions	✓	✓	
	Demonstrate participatory, patient-centered decision making on testing	✓	✓		
	Interpretation of Test	Relate observed abnormal results correctly to the potential cause	✓	✓	

	results				
		Explain accurately the meaning of sensitivity, specificity, pre-test probability, predictive value in the context of specific patients	✓	✓	
	Therapeutic Decision Making	Formulate an initial therapeutic plan	✓	✓	
		Consider key factors in choice of therapy (e.g., cost, risk, effectiveness)	✓	✓	
		Demonstrate participatory, patient-centered decision making	✓	✓	✓
		Write prescriptions in correct format	✓	✓	
Learning Skills		Identify and meet his or her own learning needs (e.g., through reading)	✓	✓	
		Acquire, interpret, and apply information from appropriate sources to optimize diagnosis and management for individual patients.	✓	✓	
		Respond appropriately to feedback (e.g., accepts criticisms graciously or seeks clarification and does not inappropriately defend past actions)	✓	✓	
		Demonstrate initiative to seek information bearing on clinical decision making	✓	✓	
		Acknowledge uncertainty and ask for help	✓	✓	
		Shares results and implements, as needed, results of independent reading to improve patient care	✓	✓	
Professionalism		Arrive on time and prepared	✓	✓	
		Obtain prior permission for any absences	✓	✓	✓
		Show respect for every member of the office team and patients	✓	✓	✓
		Demonstrate honesty	✓	✓	✓
		Safeguard patient confidentiality (e.g., no talking about patients in public places)	✓	✓	
		Put patient convenience, comfort, health, safety first	✓	✓	✓
		Prove reliable in completing assigned/expected tasks	✓	✓	
<p>*Can do = student has demonstrated the ability to perform the skill during an exercise designed to test the student or at least once during casual observation. For example, a preceptor may observe a student using effective verbal skills during an observed patient interview.</p> <p>†Usually does = student demonstrates the skill or behavior in almost all circumstances that call for it.</p> <p>‡Always does = student never fails to demonstrate the behavior when circumstances call for it. Some behaviors, like honesty, are called for always.</p>					