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HEALTH SCIENCES CENTER™
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Paul L. Foster School of Medicine

Family Medicine Sub Internship.

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**Texas Tech University HSC, Paul L Foster School of Medicine
Family Medicine Sub-Internship Rotation Syllabus**

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Introduction:

The Family Medicine (FM) sub-internship is a 4-week rotation in the 4th Year curriculum. Its purpose is to assist the student in reviewing and mastering competencies necessary for the evaluation and management of general Family Medicine patients. During the rotation, students will hone many of the skills used in the management of patients in both the inpatient and ambulatory setting. These skills include the evaluation and management of medical conditions and also practical skills that will enable them to be ready to function as interns from the start of their residency programs. These skills include, but are not limited to, transitions of care, order entry, interaction with consult and other ancillary hospital and clinical services.

**Learning Objectives of the FM sub-internship rotation corresponding to the PLFSOM
Medical Education goals and objectives**

Patient Care

Goal:

Provide patient-centered care that is compassionate, appropriate and effective.

Objectives:

Demonstrate proficiency in coordinating a comprehensive and longitudinal patient care plan through documenting a complete history, physical examination, laboratory data and images (1.1, 1.2)

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Prioritize tasks for daily patient care in order to utilize time efficiently (1.3,1.4)
Patient notes and presentations are accurate, organized and focused (1.1, 1.7)
Interpret laboratory data, imaging studies, and other tests required for the area of practice (1.3)
Develop appropriate differential diagnosis and management plan using the given patient information and following up-to-date scientific evidence (1.2, 1.6).
Recognize life threatening conditions and patients requiring immediate attention (1.5).
Communicate effectively with the patients and families, involving the patients in decision making, and providing them with preventive health care services (1.8, 1.9).
Demonstrates the ability to write and discuss admission orders using treatment guidelines and algorithms (1.2, 1.6).
Recognizes when a patient's condition or preferences requires deviation from general treatment guidelines and algorithms (1.2, 1.6).

Assessment:

Clinical performance as evaluated by supervising residents and faculty.
Admission History and Physical Examination, and daily progress notes (SOAP notes), assessed by the direct supervising faculty.
One written order set for admission of a patient seen during rounds. Due during mid-rotation feedback.
One discharge summary due by mid-rotation feedback.

Knowledge for Practice

Goal:

Demonstrate Knowledge of established and evolving knowledge in Family Medicine and apply this knowledge to patient care.

Objectives:

Demonstrate knowledge of health problems, risk factors, and treatment strategies of commonly encountered health conditions (2.4, 2.6).
Apply basic and updated evidence based medicine to patient care (2.2, 2.3).

Assessment:

Clinical assessments

Practice-Based Learning and Improvement

Goal:

Demonstrate ability to continuously improve patient care based on self-evaluation and feedback.

Objectives:

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Identify and address self-limitations (3.1).

Accept feedback from faculty and residents, and continue to work on self-improvement (3.3).

Use the available resources and references to access evidence based medicine to solve clinical problems (3.4,3.5)

Assessment:

Clinical assessments

Interpersonal and communication skills

Goal:

Demonstrate the ability of effectively communicate with Patients, families and health care professionals.

Objectives:

Communicate effectively with patients and patient's family members (4.1)

Communicate effectively with physician and non-physician members of the health-care team and consultants (4.2)

Assessment:

Clinical assessments

Professionalism

Goal:

Demonstrate understanding of and behavior consistent with professional responsibilities and adherence to ethical principles.

Objectives:

Demonstrate sensitivity to cultural issues and to patient preferences and incorporate knowledge of these issues into discussion with patients (5.1)

Show respect for patient autonomy and the principle of informed consent (5.2)

Demonstrate respect for patient's rights and confidentiality (5.2)

Show respect for, and willingness to, assist all members of the health care team (5.3)

Demonstrate compliance with local and national ethical and legal guidelines governing patient confidentiality in both written documentation and verbal communication with the patient's family members (5.5)

Respect time, and meet all the academic commitments during the rotation (5.7)

Assessment:

Clinical assessments

System-Based Practice

Goal:

Demonstrate the ability to use the system resources to provide optimal care.

Objectives:

Access the clinical information system in use at the site of health care delivery (6.1)

Coordinate care plan, involve social workers when needed, to reduce risks and costs for the patients (6.3)

Demonstrate the ability to work effectively with physician and non-physician members of the health care team including nursing staff, physician assistants and nurse practitioners, social workers, therapists, pharmacists, nutrition support staff and discharge planners (6.4)

Demonstrates the ability to organize and prioritize information for handover communication (4.2)

Assessment:

Clinical assessments

Sub-Intern Encounter form

Interprofessional Collaboration

Goal:

Demonstrate the ability to engage in an Interprofessional team in a manner that optimizes safe, effective patient and population-centered care”

Objectives:

Recognize one’s own role as well as the roles of other health care professionals (7.1, 7.2)

Engage effectively as a team member during daily rounds and be able to manage conflicts appropriately (7.3, 7.4)

Assessment:

Clinical assessments.

Personal and Professional Development

Goal:

Demonstrate the qualities required to sustain lifelong personal and professional growth.

Objectives:

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Recognize when to call a consult for a patient (8.1)

Identifies one's limitations and seek self-improvement through problem identification and critical appraisal of information (8.1, 8.5)

React appropriately to stressful and difficult situations (8.2, 8.3)

Demonstrate improvement following mid-rotation feedback (8.5)

Assessment:

Clinical evaluations.

FM Sub-Internship Rotation

This is largely an in-patient experience; however, students will have a weekly continuity clinic (one half-day per week) at the Family Medicine Clinic as listed below. This sub-internship will include the following **required** clinical and learning activities:

- Morning rounds - consists of pre-rounds with the senior resident and then team rounds with the attending faculty. The student will finish any pending work and admit any new patients or consults. Hours are 6A.M. to 6 P.M. daily.
- Student is required to be present and participate in all handoffs and sign-outs. Student is responsible for signing out their patients to oncoming night float resident or team. A minimum of 2 Sub- Intern Transition of care encounter card filled by the supervising senior resident must be submitted to the Sub-I director by the end of the rotation.
- A comprehensive history and physical exam with assessment and plan must be performed on all new patients assigned to sub-intern patients the day of admission and recorded in the EMR, which will be evaluated by the direct supervising faculty.
- Sub-intern is responsible for writing daily problem-oriented notes on all their patients, which will be evaluated by the direct supervising faculty. All the admission notes and the progress notes written by the students will be used only for student assessment, and cannot be further signed or used by residents or other health care team members (intern/senior/faculty).
- Sub-interns will write up one history and physical, one discharge summary, and one admission order set on a patient they have taken care of during their rotation and present to the Year 4 Sub-internship director for review, critique, and grading. The discharge summary will be done in the clinic EMR (on a clinic patient in the hospital and routed to Sub-I Director prior to mid-rotation feedback for evaluation and comments). The admission order will be written using a paper order set and submitted

at the time of mid-rotation feedback. The History and Physical will be either typed up or printed from Cerner and submitted to the Sub-I Director at the time of mid-rotation feedback. If printed from Cerner, the note must have been written by the sub intern.

- Call schedule – Sub-intern will have 1 week of night float during the rotation 6 P.M to 8 A.M with the rest of call schedule mirroring the intern’s schedule.
- Didactics- Every Thursday afternoon students will attend family medicine conferences after student patients are appropriately transferred to covering afternoon resident. These conferences include Nursing Home Rounds, the monthly quality improvement (QI) conference as well as the patient centered medical home (PCMH) conference
- Students will have continuity with discharged inpatient service patients in a weekly continuity clinic at the Family Medicine Clinic. Students will be paired with the senior inpatient family medicine resident in clinic.

Locations:

University Medical Center, El Paso, TX

Family Medicine clinic, 9849 Kenworthy Street, El Paso TX 79924

Duration:

Four weeks

Sample Sub-I Calendar:

January/February 2018

Sample Sub-I Calender

Family Medicine Sub-Internship

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1/29 6am – Noon UMC 1 -5 pm Ken Cl with Sr. Resident	1/30 6am – 5:30 pm UMC	1/31 6am – 5:30 pm UMC	1 6am – Noon UMC 1pm – 5pm Ken CL Resident Conference	2 6am – 5:30 pm UMC	3 6am – 8 pm UMC
4 OFF	5 6am – Noon pm UMC 1 -5 pm Ken Cl with Sr. Resident	6 6am – 5:30 pm UMC	7 1pm – 5:30 pm UMC Procedure Clinic Ken CL 8am-Noon	8 6am – Noon UMC 1pm – 5pm Ken CL Resident Conference	9 6am – 11 am, 1 pm – 5:30 pm UMC Mid Rotation Feedback w/Course Director 11:30 am- 12 pm	10 6am – 8 pm UMC
11 OFF	12 Night Float UMC 6pm – 8am	13 Night Float UMC 6pm – 8am	14 Night Float UMC 6pm – 8am	15 Night Float UMC 6pm – 8am	16 Night Float UMC 6pm – 8am	17 OFF at 8 am
18 OFF	19 6am – Noon UMC 1 -5 pm Ken Cl with Sr. Resident	20 6am – 5:30 pm UMC	21 6am – 5:30 pm UMC	22 6am – Noon UMC 1pm – 5pm Ken CL Resident Conference	23 6am – 11 am, 1 pm – 5:30 pm UMC Final Rotation Feedback w/Course Director 11:30 am- 12 pm	24 OFF
25 OFF	26	27	28			

Assignments:

Admission Orders:

Submit typed admission order on 1 patient admission

Admission Order mnemonic ADC VAAN SISML or Maxwell handbook example can be followed

Be sure to include:

- Vital signs
- Activity
- Diet
- Nursing Instructions
- IVF if indicated
- Studies and Labs
- Medications

To be submitted to Sub-I Director by the Mid-Rotation Feedback

Will be evaluated on completeness

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History and Physical

Submit one complete History and Physical for 1 patient (may be completed on the Family Medicine History and Physical Form available at UMC or may be typed)

Should Include

- a. Chief Complaint
- b. History of Present Illness
- c. Past Medical History
- d. Past Surgical History
- e. Allergies
- f. Complete Medication List
- g. Family History
- h. Social History
- i. Review of Systems- Pertinent Findings
- j. Vital Signs
- k. Complete Physical Exam
- l. Labs
- m. EKG
- n. Imaging
- o. Assessment and Plan

Should be submitted to the Sub-I Director by the Mid-Rotation Feedback

Will be evaluated on completeness and conciseness

Discharge Summaries:

1. DC Summary follow standard format (sample below)
2. Helpful Hints:
 - a. What would you want to know if you had this patient in the office next week?
 - b. What would you say on the phone to that provider if you were calling directly?
 - c. A good discharge summary is: Brief, summative, succinct, cohesive
 - d. A good discharge summary is NOT: Recounting the entire H&P, a day-by-day synopsis of progress notes
3. To be routed to Sub-I Director on centrality EMR by Mid-Rotation Feedback
4. DC Summary will be evaluated on consistency, completeness, being concise and pertinent.

DC Summary Sample Format:

ADMIT DATE:

DISCHARGE DATE:

ADMIT DIAGNOSIS: This is the problem that led to hospitalization and can include brief pertinent HPI only if necessary (can also include that in Hospital course)

DISCHARGE DIAGNOSIS:

ATTENDING ON SERVICE:

BRIEF HISTORY OF PRESENT ILLNESS

Including why patient admitted to floor or PICU

Include pertinent physical exam at time of admission/or transfer

HOSPITAL COURSE BY PROBLEMS WITH PLAN:

**Include the course of management for each individual the patient was treated for during admission along with plan following discharge

**Incorporate consultations, complications, and outstanding medical/social issues

**Proposed management plan and anticipated problems and suggested interventions

**Key findings, procedures, test results should be incorporated into hospital course (include key dates)

PHYSICAL EXAM AT TIME OF DISCHARGE/TRANSFER – Pertinent is useful along with brief functional and cognitive function (walking with walker, mental status baseline of ____)

PERTINENT LABS: should have been noted in hospital course

PERTINANT IMAGING: should have been noted in hospital course

PROCEDURES DURING HOSPITALIZATIONS: should have been noted in hospital course

PENDING LABS/IMAGING:

*Any labs or imaging studies that are pending to be followed up with PCP

DISCHARGE MEDICATIONS: Explicitly state those that are started, stopped, changed, or to be continued

DISCHARGE INSTRUCTIONS: Diet, Activity Restrictions and Return Precautions

FOLLOW UP: Primary Care Physician, Consultant, Therapy follow-ups

Grading/ Assessment:

Student will receive weekly evaluations by supervising faculty and senior resident on the service. They will have mid-rotation feedback with Sub I Director at which time we will review evaluations to date, op logs, written History and Physical, written admission order set and written discharge summary.

Student clinical performance is based on the sub-internship director's judgment as to whether the student honors, passes, or fails to meet expectations on each of 8 competencies described above, as stated by the PLFSOM discipline performance rubric. The final clinical performance assessment is conducted at the end of the rotation based on the student's level of performance at that point in time.

Possible Final Grades are Honors, Pass, Fail, and Incomplete. A student who fails Professionalism may receive a Pass or a Fail overall at the discretion of the course director depending on the gravity of the professional lapse, regardless of the scores on all other items. Overall grade is based on the assessment in each of the 8 competencies:

- **Honors**, if all of the following are true:
 - Minimum of 4 of the 8 individual competencies rated as “Honors” on the Final Feedback evaluation
 - No individual competency rated as “needs improvement” on the final assessment.
- **Pass** if all of the following are true:
 - Minimum of 6 of the 8 individual competencies rated as “Honors” or “Pass” on the Final Feedback evaluation
 - No more than 2 individual competencies rated as “needs improvement” on the Final Feedback assessment
 - Professionalism concerns are, in the judgment of the course director, not significant enough to warrant a Fail on the Final Feedback evaluation.
- A **failing** clinical assessment is assigned if *any* of the following are true.
 - 3 or more individual competencies rated as “needs improvement” on the Final Feedback assessment
 - Professionalism concern deemed by the course director significant enough to warrant a Fail on the Final Feedback evaluation.
- An **incomplete** grade will be assigned any student who has not completed required assignments, or who has not fulfilled all clinical experience obligations, pending completion of the required work.

Components

Clinical Performance:

Daily feedback during rounds.

Weekly clinical evaluations.

Sub- Intern transition of care form. (See attached at the end of the Syllabus)

Documentation:

Admission History and Physical Examination, and daily progress notes (SOAP notes), evaluated by the direct supervising faculty.

One History and Physical at the mid rotation feedback evaluated by course director

One discharge summary at the mid rotation evaluation evaluated by the course director.

Once admission order set evaluated by the course director.

Attendance of daily rounds, Thursday afternoon didactics and weekly continuity clinic.

Mid-Rotation and Final Evaluations

Weekly evaluations will be assigned to the senior residents and direct supervising faculty. The course director will review the evaluations at the midpoint and final evaluation. The evaluation will help the student to identify strength and weakness, for further improvement.

Mid-rotation evaluation

will include review of evaluations till date, discharge summary, plan, one discharge summary, and one admission order set.

Knowledge for Practice

Can independently apply knowledge to identify problems
<input type="radio"/> N/A <input type="radio"/> Needs Improvement <input type="radio"/> Pass <input type="radio"/> Honors

Patient Care and Procedural Skills

Addresses patient's agenda
<input type="radio"/> N/A <input type="radio"/> Needs Improvement <input type="radio"/> Pass <input type="radio"/> Honors

Completes an appropriate history
<input type="radio"/> N/A <input type="radio"/> Needs Improvement <input type="radio"/> Pass <input type="radio"/> Honors

Exam is appropriate in scope
<input type="radio"/> N/A <input type="radio"/> Needs Improvement <input type="radio"/> Pass <input type="radio"/> Honors

Identifies pertinent physical findings
<input type="radio"/> N/A <input type="radio"/> Needs Improvement <input type="radio"/> Pass <input type="radio"/> Honors

Develops a treatment plan appropriate to the patient and based on up-to-date scientific evidence.
<input type="radio"/> N/A <input type="radio"/> Needs Improvement <input type="radio"/> Pass <input type="radio"/> Honors

Appropriately documents findings.

- N/A Needs Improvement Pass Honors

Independently performs exam with proper technique.

- N/A Needs Improvement Pass Honors

Interpersonal and Communication Skills

Communicates effectively with patients and families across a broad range of socio-economic and cultural backgrounds.

- N/A Needs Improvement Pass Honors

Presentations to faculty or resident are organized.

- N/A Needs Improvement Pass Honors

Practice-Based Learning and Improvement

Demonstrates knowledge of current peer-reviewed literature in relation to patient management.

- N/A Needs Improvement Pass Honors

Takes the initiative in increasing clinical knowledge and skills; for example, identifies a learning issue on rounds or in the OR and reports back to the team/resident.

N/A Needs Improvement Pass Honors

Systems-Based Practice

Effectively utilizes medical care systems and resources to benefit patient health.

N/A Needs Improvement Pass Honors

Professionalism

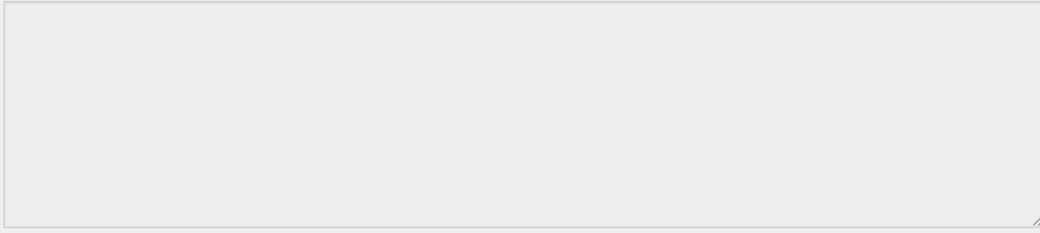
Displays appropriate level of professionalism.

N/A Needs Improvement Pass Honors

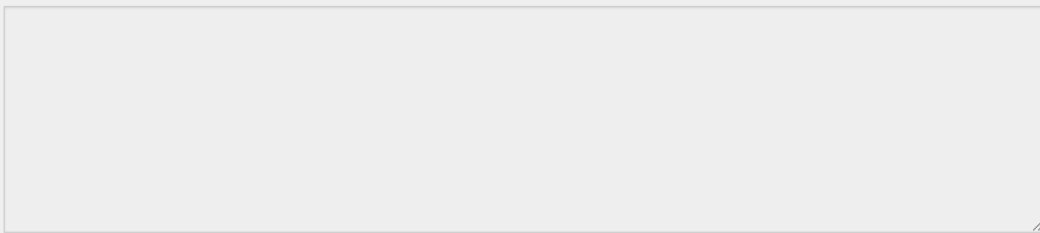
Planned date of discussion

Actual date of discussion

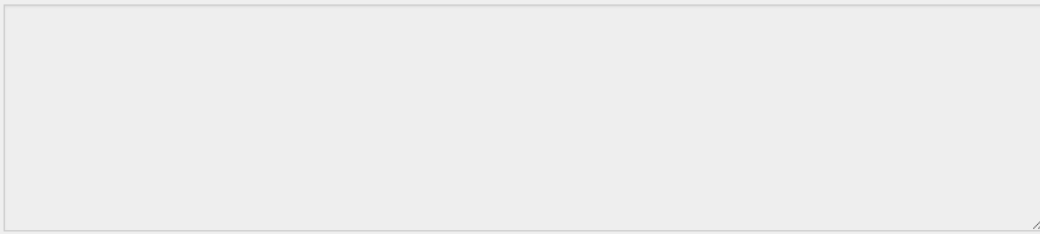
Areas that would yield the greatest improvement in the student's skills

A large, empty rectangular text box with a thin border and a small cursor icon in the bottom right corner, intended for writing areas for improvement.

OpLog - Discuss student's oplog documentation and any areas where the students does not appear on track. Identify date when student should come back to see you if he/she has not yet met the requirements

A large, empty rectangular text box with a thin border and a small cursor icon in the bottom right corner, intended for writing OpLog details.

Please discuss the student's 2-3 strongest performance areas

A large, empty rectangular text box with a thin border and a small cursor icon in the bottom right corner, intended for writing performance areas.

Close

Print

Final evaluation will review clinical evaluations and progress made toward the final grade.

Interpersonal and Communication Skills

Grade
<input type="radio"/> Needs Improvement <input type="radio"/> Pass <input type="radio"/> Honors

Please Justify the grade in this competency
<div style="border: 1px solid gray; height: 100px;"></div>

Practice-Based Learning and Improvement

Grade
<input type="radio"/> Needs Improvement <input type="radio"/> Pass <input type="radio"/> Honors

Please Justify the grade in this competency
<div style="border: 1px solid gray; height: 100px;"></div>

Systems-Based Practice

Grade

Needs Improvement

Pass

Honors

Please Justify the grade in this competency

Professionalism

Grade

Needs Improvement

Pass

Honors

Please Justify the grade in this competency

Interprofessional Collaboration

Grade

Needs Improvement

Pass

Honors

Please Justify the grade in this competency

Personal and Professional Development

Grade

Needs Improvement

Pass

Honors

Please Justify the grade in this competency

Statement for MSPE

This is a narrative that describes the student's strengths during rotation and any persistent weaknesses that the student did not improve after feedback. You must include a narrative on the student's professionalism. Any feedback that you do not want to include in the MSPE should be included below in the "Comments" field. As a reminder, please use complete sentences and check your grammar, etc. as these comments go out to residency directors across the country.

Comments (Please write about strengths, weaknesses and areas for improvement)

Please Select an Overall Grade

- Fail
- Pass
- Honors
- Incomplete

Close

Print

Absence Policy:

Please see the PLFSOM Common Rotation Requirements.

Op-Log

These are a list of the standard cases expected to be logged by the MS4 during the FM rotation. The student is required to log a minimum of 1 on each of the first 13 conditions (In asterisk) on the list. Mandatory conditions must be at the level of manage or assist. Students are required to submit an op-log by mid rotation feedback and updated by the end of the rotation. This includes patient they have personally cared for, (managed) or observed with the Team during rounds (observed). If Student is unable to see any of this cases by the 3rd week of the rotations they are required to inform the Sub-I coordinator so that case readings may be assigned to them. Case readings will be provided through AAFP articles.

1. Diabetes*
2. Hypertension*
3. ACS*
4. Renal Failure (Acute and Chronic)*
5. Asthma*
6. Cardiac Arrhythmias*
7. COPD*
8. Community Acquired Pneumonia*
9. Heart Failure*
10. Delirium and Dementia*
11. Peri-Operative medicine (Pre-Op evaluation)*
12. UTI*
13. Pain management*
14. Hospital Acquired Pneumonia
15. Sepsis syndromes

16. Stroke

17. Thromboembolic Syndromes

Preparation for Teaching

Attending faculty and residents will be oriented to the experience by the Family Medicine Sub-Internship Clerkship Director or their designee, and provided copies of the syllabus and forms that they will use to assess student performance.

Residents will be required, as part of their training and orientation, to function as teachers. All residents are required to participate in a “Residents as Teachers” program that is administered by the Office of Graduate Medical Education. In addition, each resident will be provided copies of the Medical Student syllabus with particular emphasis on goals, objectives, and assessment methods and criteria.

References

PLFSOM Institutional Learning goals and Objectives, by the PLFSOM Curriculum and educational Policy committee, March 9, 2015.

Common Clerkship requirements, Office of Medical Education, TTUHSC, El Paso, PLFSOM 2016.

Core Entrustable Professional Activities for Entering residency, curriculum developer’s Guide, Association of American Medical colleges (AAMC), version 1.0, 2014.

Core Medicine clerkship curriculum Guide, A Resource for Teachers and Learners, Version 3.0, 2006.

Informal feedback (not for the record):

Comments for formal evaluation:

Approved by the CEPC on 6-11-2019

SUB - INTERNSHIP ENCOUNTER CARD - FAMILY MEDICINE

Transition of Care/ Handoff Evaluation

Date:	Level of Performance		
	Below Expectation	At Expectation	Not applicable
Identify Patient (2 identifiers)			
Patient Diagnosis and current status			
Changes in condition during the shift			
Outstanding tasks (labs, imaging consult, SW FU)			
Anticipated changes in condition			
DNR Status			
<i>***Please provide comments on the side***</i>			
Clinical Setting Observed: <input type="checkbox"/> Hospital <input type="checkbox"/> Other:			
Student Name:	Resident Signature:		