Clinical Supervision of Medical Students:
Promoting Patient and Student Safety

Faculty Guidelines

Boston University School of Medicine

This document and additional faculty resources can be found on our website at:
http://www.bumc.bu.edu/busm/education/medical-education/faculty-resources/
<table>
<thead>
<tr>
<th>INSTITUTIONAL LEARNING OBJECTIVE</th>
<th>MEDICAL EDUCATION PROGRAM OBJECTIVE</th>
</tr>
</thead>
</table>
| **B - Behaves in a caring, compassionate and sensitive manner toward patients and colleagues of all cultures and backgrounds. (Interpersonal and Professionalism)** | B.1 - Apply principles of social-behavioral sciences to provision of patient care; including assessment of the impact of psychosocial and cultural influences on health, disease, care-seeking, care compliance, and barriers to and attitudes toward care. (2.5)  
B.2 - Demonstrate insight and understanding about emotions that allow one to develop and manage interpersonal interactions. (4.7)  
B.3 - Demonstrate compassion, integrity, and respect for others. (5.1)  
B.4 - Demonstrate sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. (5.5) |
| **U - Uses the science of normal and abnormal states of health to prevent disease, to recognize and diagnose illness and to provide and appropriate level of care. (Medical Knowledge and Patient Care)** | U.1 - Perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (1.1)  
U.2 - Gather essential and accurate information about patients and their conditions through history-taking, physical examination, and the use of laboratory data, imaging and other tests. (1.2p)  
U.3 - Interpret laboratory data, imaging studies, and other tests required for the area of practice. (1.4)  
U.4 - Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence and clinical judgement. (1.5)  
U.5 - Develop and carry out patient management plans. (1.6)  
U.6 - Provide health care services to patients, families, and communities aimed at preventing health problems or maintaining health. (1.9)  
U.7 - Demonstrate an investigatory and analytic approach to clinical situations. (2.1)  
U.8 - Apply established and emerging bio-physical scientific principles fundamental to health care for patients and populations. (2.2)  
U.9 - Apply established and emerging principles of clinical sciences to health care for patients and populations. (2.3)  
U.10 Recognizes that ambiguity is a part of clinical health care and respond by utilizing appropriate resources in dealing with uncertainty. (8.8) |
| **C - Communicates with colleagues and patients to ensure effective interdisciplinary medical care (Interpersonal and Communication Skills; Patient Care)** | C.1 - Gather essential and accurate information about patients and their conditions through history-taking, physical examination, and the use of laboratory data, imaging and other tests. (1.2h)  
C.2 - Counsel and educate patients and their families to empower them to participate in their care and enable shared decision making. (1.7)  
C.3 - Participate in the education of patients, families, students, trainees, peers and other health professionals. (3.8)  
C.4 - Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds. (4.1)  
C.5 - Communicate effectively with colleagues within one’s profession or specialty, other health professionals, and health related agencies (4.2, see also 7.3)  
C.6 - Maintain comprehensive, timely, and legible medical records. (4.5)  
C.7 - Demonstrate sensitivity, honesty, and compassion in difficult conversations, including those about death, end of life, adverse events, bad news, disclosure of errors, and other sensitive topics. (4.6)  
C.8 - Communicate with other health professionals in a responsive and responsible manner that supports the maintenance of health and the treatment of disease in individual patients and populations. (7.3) |
| **A - Acts in accordance with highest ethical** | A.1 - Demonstrate responsiveness to patient needs that supersedes self-interest. (5.2)  
A.2 - Demonstrate respect for patient privacy and autonomy. (5.3) |
| standards of medical practice (Professionalism) | A.3 - Demonstrate accountability to patients, society, and the profession. (5.4) |
| A.4 - Demonstrate a commitment to ethical principles pertaining to provision or withholding of care, confidentiality, informed consent, and business practices, including compliance with relevant laws, policies, and regulations. (5.6) |
| A.5 - Work with other health professionals to establish and maintain a climate of mutual respect, dignity, diversity, ethical integrity, and trust. (7.1) |
| A.6 - Demonstrate trustworthiness that makes colleagues feel secure when one is responsible for the care of patients. (8.5) |

| R - Reviews and critically appraises biomedical literature and evidence for the purpose of ongoing improvement of the practice of medicine. (Practice-Based Learning and Improvement and Medical Knowledge) | R.1 - Apply principles of epidemiological sciences to the identification of health problems, risk factors, treatment strategies, resources, and disease prevention/health promotion efforts for patients and populations. (2.4) |
| R.2 - Locate, appraise, and assimilate evidence from scientific studies related to patients' health problems. (3.6) |
| R.3 - Continually identify, analyze, and implement new knowledge, guidelines, standards, technologies, products, or services that have been demonstrated to improve outcomes. (3.10) |

| E - Exhibits commitment and aptitude for life-long learning and continuing improvement (Practice-based Learning) | E.1 - Identify strengths, deficiencies, and limits in one's knowledge and expertise. (3.1) |
| E.2 - Set learning and improvement goals. (3.2) |
| E.3 - Identify and perform learning activities that address one's gaps in knowledge, skills, and/or attitudes. (3.3) |
| E.4 - Incorporate feedback into daily practice. (3.5) |
| E.5 - Obtain and utilize information about individual patients, populations of patients, or communities from which patients are drawn to improve care. (3.9) |
| E.6 - Develop the ability to use self-awareness of knowledge, skills, and emotional limitations to engage in appropriate help-seeking behaviors. (8.1) |
| E.7 - Manage conflict between personal and professional responsibilities. (8.3) |

| S - Supports optimal patient care through identifying and using resources of the health care system. (Systems-Based Practice and Patient Care) | S.1 - Provide appropriate referral of patients including ensuring continuity of care throughout transitions between providers or settings, and following up on patient progress and outcomes. (1.8) |
| S.2 - Systematically analyze practice using quality-improvement methods and implement changes with the goal of practice improvement. (3.4) |
| S.3 - Use information technology to optimize learning. (3.7) |
| S.4 - Work effectively with others as a member or leader of a health care team or other professional group. (4.3, see also 7.4) |
| S.5 - Work effectively in various health care delivery settings and systems relevant to one's clinical specialty. (6.1) |
| S.6 - Coordinate patient care within the health care system relevant to one's clinical specialty. (6.2) |
| S.7 - Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care. (6.3) |
| S.8 - Advocate for quality patient care and optimal patient care systems. (6.4) |
| S.9 - Use the knowledge of one's own role and the roles of other health professionals to appropriately assess and address the health care needs of the patients and populations served. (7.2) |
| S.10 - Participate in different team roles to establish, develop, and continuously enhance interprofessional teams to provide patient- and population-centered care that is safe, timely, efficient, effective, and equitable. (7.4) |

**BUSM Clerkship Learning Objectives**
During the third-year clerkships, students will
- Demonstrate use of patient-centered interviewing and communication techniques (U.2)
- Take a clinical history that demonstrates both organization and clinical reasoning (U.7)
- Perform accurate and relevant physical exam techniques (U.2)
Family Medicine Clerkship Learning Objectives

At the end of the family medicine clerkship, each student should be able to:

- Discuss the principles of family medicine care including comprehensive and contextual care, continuity of care, coordination/complexity of care, and the biopsychosocial approach to care (B.1, B.2, B.3, B.4, U.6, S.1, S.5, S.6, S.7, S.8, S.9)
- Gather information, formulate differential diagnoses, and propose plans for the initial evaluation and management of patients with common presentations in family medicine (U.2, U.3, U.4, U.5, U.6, C.1)
- Manage follow-up visits with patients having one or more common chronic diseases (U.2, U.3, U.4, U.5)
- Develop evidence-based health promotion/disease prevention plans for patients of any age or gender (B.4, U.6)
- Discuss the impact of psychosocial and cultural influences on health, disease, care-seeking, care compliance, and barriers to and attitudes toward care (B.1, B.2, B.3, B.4)
- Utilize advanced, patient-centered communication techniques to discuss unanticipated or “bad” news, assist patients in making health behavior changes, provide patient-centered education and counseling, and to effectively use a medical interpreter (C.2, C.3, C.4, C.7)
- Discuss the critical role of family physicians within any health care system (S.1, S.5, S.6, S.7, S.8, S.9)
- Discuss the concepts of information mastery and utilize point-of-care resources to find and integrate the best available evidence into clinical decision making (R.1, R.2, R.3, E.2, E.3, S.3)
- Consistently demonstrate professional behavior consistent with the values of the medical profession (A.1, A.2, A.3, A.4, A.5, A.6, E.7).
- Display skills of lifelong learning including generating clinical questions or identifying one’s own learning needs, using appropriate resources to answer questions or close learning gaps, engaging in self-assessment and goal setting and demonstrating growth in response to feedback (E.1, E.2, E.3, E.4, E.6)

Contact Information

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Thank you for serving as a preceptor in the Family Medicine Clerkship. We appreciate your dedication to medical education and your support of the discipline of Family Medicine. The following is core information about the clerkship.

**Family Medicine Clerkship Goals**
The purpose of the third year clerkship family medicine clerkship is to provide instruction in the basic knowledge, attitudes and skills of family medicine. This foundation in the basic tenets of family medicine will prepare the student for his/her future role as a physician, regardless of specialty choice. The clerkship will demonstrate the importance of the family physician in providing continuous, comprehensive care to the patient, and will teach the importance of the doctor-patient relationship, interviewing skills, appropriate physical exam, and clinical problem-solving in caring for patients. Additionally, the clerkship will provide exposure to family medicine as a specialty choice for third year students, and support those students considering family medicine as a career.

**Family Medicine Clerkship Structure**
The family medicine clerkship is a required six week rotation in the third year. While we provide a robust and integrated didactic curriculum to the students (see below), your office is where the students will learn the bulk of family medicine on their clerkship. The student should be present at your office on all days except for those mentioned below during which they will be at the school. You will be notified of schedule changes due to official school holidays or meetings.

Students should be present at their clinical sites as follows:

- Week 1: 6 sessions (each session is a half day)
- Week 2: 10 sessions
- Week 3: 10 sessions
- Week 4: 6 sessions
- Week 5: 10 sessions
- Week 6: 6 sessions

(Home Visit: 1 clinical session during the 6 weeks)

Students should have a total of 48 clinical sessions during their clerkship (which includes the home visit) if there are no holidays or class meetings that fall during the 6 weeks. Students can do night or weekend sessions; if they do work nights or weekends, we ask that the student is compensated back that time during the week (e.g. if they work a Saturday morning, you can give them a Friday afternoon back- or whatever works best with the clinical schedule) to equal a total of 48 sessions.

While students are at your office, their time should be devoted to activities that reflect the spectrum of care provided at the site or by its staff. These experiences could include sessions with Family NP’s, residents, or other clinicians associated with the practice site; nursing home visits; or obstetrical deliveries. If you or your practice partners do inpatient work, we recommend that the students participate with you in some rounding on patients of the practice who may be in the hospital. In the event that the preceptor has a half-day or full day off each week, the student can work with other physicians, residents or FNP’s designated by the primary preceptor, or can visit community agencies. In residency settings, students can attend conferences for residents and staff. Students can also participate in on-call responsibilities with you.
The time that is not spent at your office is for students to: attend the core curriculum days at BUSM (4 days), perform a home visit (1 half day, which should be included in their clinical time), and to return to BUSM to prepare for (1 day before final exam day) and complete their final-exam (last day of the clerkship). If there are sessions that you will not be seeing patients in the office, please make other arrangements for your student. This can include working an evening or weekend session, working with another physician, performing their home visit, or doing a community project.

Here is a sample clerkship schedule. Some components will vary from site to site.

<table>
<thead>
<tr>
<th>Week #</th>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Didactic session #1 at BUSM (8:30-5)</td>
<td>Didactic session #2 at BUSM (8:30-5:00)</td>
<td>Orientation at clinical site</td>
<td>Initial Clinical Observation</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td>Mid-Clerkship Review meeting with preceptor at site</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Didactic session #3 at BUSM (8:30-5)</td>
<td>Didactic session #4 at BUSM (8:30-5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>AM: Home Visit PM: Clinical Work</td>
<td>Home Visit Case Presentation at site</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>Final Clinical Observation</td>
<td>Exit meeting with preceptor at site</td>
<td>Reading Time (8-5)</td>
<td>Final Exam Day at BUSM (8-5)</td>
</tr>
</tbody>
</table>

**Family Medicine Clerkship Core Curriculum**

On the first and second working days of week one and of week four (although occasionally this varies by block), students will participate in the core curriculum at the medical school. Using a modified problem-based learning format and standardized patient encounters, they will address the needs of two standardized families—the Riveras and the McQs. Members of these families have their own patient charts dating back five years, which students review, and family members are followed through a series of problem-based scenarios. Students also interview and examine McQ and Rivera family members, represented by standardized patients. Students prepare for these sessions through a series of readings and discussion groups led by faculty in the department. In the course of these small group discussions, readings and interviews, the diagnosis, treatment and management of many problems commonly encountered in the outpatient setting are covered in an interesting and lively manner. On the final day of the clerkship, students will interview standardized patients in one of the families and write a progress note, both of which will be graded. The core curriculum didactic days also include an acute respiratory infections workshop, grand rounds, an acute presentations workshop (using high fidelity simulators), clinical skills workshops (musculoskeletal examinations, procedure workshop), a session on physician
Family Medicine Clerkship Didactic Schedule

### Orientation/Session 1

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 - 10:15</td>
<td>Orientation</td>
</tr>
<tr>
<td>10:15 – 11:00</td>
<td>Overview of Family Medicine</td>
</tr>
<tr>
<td>11:00 - 12:30</td>
<td>Information Mastery Workshop</td>
</tr>
<tr>
<td>1:30 – 3:00</td>
<td>Acute Respiratory Infections Workshop</td>
</tr>
<tr>
<td>3:15-5:00</td>
<td>Procedure Workshop</td>
</tr>
</tbody>
</table>

### Session 2

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 - 11:30</td>
<td>Small group case discussion of McQ and Rivera family member</td>
</tr>
<tr>
<td>12:00 – 1:00</td>
<td>Grand Rounds (lunch provided)</td>
</tr>
<tr>
<td>1:15 – 5:15</td>
<td>Interview of McQ and Rivera family members (standardized patients)</td>
</tr>
<tr>
<td></td>
<td>Advanced Clinical Skills Workshops (MSK)</td>
</tr>
<tr>
<td></td>
<td>Physician Wellness</td>
</tr>
</tbody>
</table>

### Session 3

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 - 11:30</td>
<td>Small group case discussion of McQ and Rivera family members</td>
</tr>
<tr>
<td>11:30 - 12:00</td>
<td>Site Review with clerkship directors</td>
</tr>
<tr>
<td>1:00 – 4:00</td>
<td>Interview of McQ and Rivera family members (standardized patients)</td>
</tr>
<tr>
<td></td>
<td>Advanced Clinical Skills Workshops (MSK)</td>
</tr>
<tr>
<td></td>
<td>Mid-Clerkship individual meetings with clerkship directors</td>
</tr>
</tbody>
</table>

### Session 4

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 – 11:30</td>
<td>Small group case discussion of McQ and Rivera family members</td>
</tr>
<tr>
<td>12:00 – 12:30</td>
<td>Family Medicine Interest Group (<em>Optional</em>)</td>
</tr>
<tr>
<td>12:30 – 1:20</td>
<td>Healthcare Maintenance Jeopardy</td>
</tr>
<tr>
<td>1:30 - 5:00</td>
<td>Interview of McQ and Rivera family members (standardized patients)</td>
</tr>
<tr>
<td></td>
<td>Acute Presentations Workshop</td>
</tr>
</tbody>
</table>

### Final Exam Day

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-12</td>
<td>OSCE and OSCE write-up</td>
</tr>
<tr>
<td>1-5</td>
<td>Shelf exam</td>
</tr>
</tbody>
</table>
The following is a general outline of the topics covered during the small group sessions. Sites are encouraged to schedule patients for the students, and to discuss the cases that reflect these issues concurrently.

<table>
<thead>
<tr>
<th>Session One</th>
<th>Session Two</th>
<th>Session Three</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Routine screening and prevention in adult men and women</td>
<td>➢ Workup of the patient with newly diagnosed diabetes</td>
<td>➢ Initiation of insulin in a patient with diabetes</td>
</tr>
<tr>
<td>➢ Diagnosis of pregnancy; Routine prenatal screening tests</td>
<td>➢ Depression in patients with comorbid diseases</td>
<td>➢ Diabetes follow-up care</td>
</tr>
<tr>
<td>➢ Initial prenatal visit including risk factor assessment</td>
<td>➢ Smoking cessation</td>
<td>➢ Normal post-partum signs and symptoms</td>
</tr>
<tr>
<td>➢ Office diagnosis/management of uncomplicated lower urinary tract infection in pregnancy</td>
<td>➢ Routine prenatal care; Common signs and symptoms in 2\textsuperscript{nd}/3\textsuperscript{rd} trimester pregnancy</td>
<td>➢ Contraception</td>
</tr>
<tr>
<td>➢ Unplanned pregnancy and options counseling</td>
<td>➢ Screening for domestic violence</td>
<td>➢ Breast-feeding</td>
</tr>
<tr>
<td>➢ Office diagnosis of hypertension; treatment of hypertension</td>
<td>➢ Erectile dysfunction</td>
<td>➢ Geriatric assessment and functional decline</td>
</tr>
<tr>
<td>➢ Screening and treatment guidelines for hypercholesterolemia</td>
<td>➢ Continuing management of hypertension</td>
<td>➢ Approach to the patient with multiple medical problems; motivational interviewing</td>
</tr>
<tr>
<td>➢ Diagnosis and management of pediatric asthma</td>
<td>➢ Well child check</td>
<td>➢ Advance Directives</td>
</tr>
<tr>
<td>➢ Health disparities in asthma</td>
<td>➢ Diagnosis and management of acute low back pain</td>
<td>➢ Mammography: sensitivity, specificity, predictive value</td>
</tr>
<tr>
<td></td>
<td>➢ STI screening</td>
<td>➢ Delivering “bad news”</td>
</tr>
</tbody>
</table>
Patient Encounters/Case Logs
Across the third year there are required patient encounters and procedures that students must log whenever they are seen. To log the patient encounter, students must have participated in the history, physical exam, assessment and plan development of the patient.

Required Patient Encounters for the third-year
http://www.bumc.bu.edu/busm/education/medical-education/faculty-resources/

Family Medicine Clerkship Required Patient Encounters and Procedures

The required patient encounters for family medicine are as follows:

1. Fatigue
2. Depressed/sad (outpatient)
3. High BP
4. The ambulatory patient with chest pain
5. Cough
6. Back Pain
7. The ambulatory patient with abdominal/pelvic pain
8. Sexual dysfunction
9. Skin lumps/lesions/rashes
10. The well adult
11. The well child
12. The patient with obesity
13. The patient with diabetes
14. The patient with chronic pain
15. The patient with a substance use disorder

The required procedures for family medicine are as follows:

1. Venipuncture (sim)
2. Vaccine administration (sim)

These two procedures are only required to be done as a simulation, which will happen during the core clerkship procedure workshop, but we ask that you provide students with the opportunity to perform both of these procedures at your clinical site if possible.

Students are required to log all patients they see with any of the BUSM core diagnoses that they have provided comprehensive care for (e.g. taken a history, done a physical exam and come up with a management plan/written a note) during their clerkship year, but the above 14 patient types must be logged by the end of the family medicine clerkship.
Other Family Medicine Clerkship Requirements

Students are expected to complete a self-assessment and write three learning goals prior to their first session at your office, and we ask that you review this with them and provide them with feedback.

Students are also expected to complete a home visit and an information mastery assignment (see below).

Student Evaluation on Family Medicine

Students will be evaluated with respect to the core goals and learning objectives of the clerkship. Students and preceptors both have specific responsibilities for the evaluation process. The grid below shows the preceptors' responsibilities shaded grey.

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Timing</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation by Preceptor</td>
<td>As often as possible but ideally a semiformal observation in week 1 and week 6</td>
<td>• Clerkship FOCuS forms&lt;br&gt;  ○ Interviewing and Data Collection&lt;br&gt;  ○ Physical Exam&lt;br&gt;  ○ Patient Education&lt;br&gt;  ○ Documentation&lt;br&gt;  2 of the 4 FOCuS forms should be completed by the mid-meeting and all 4 by the end of week 6 (*see next section for details on the FOCuS form)</td>
</tr>
<tr>
<td>Mid-Clerkship Evaluation</td>
<td>End of third week at site</td>
<td>• Meeting between student and preceptor.&lt;br&gt;  • Mid-Clerkship Review form completed and signed</td>
</tr>
<tr>
<td>Home Visit Case Presentation</td>
<td>By sixth week at the clinical site of the home visit patient</td>
<td>• Student presentation of case to site staff/faculty&lt;br&gt;  • Submitted in written form (de-identified) to clerkship director at the end of the clerkship</td>
</tr>
<tr>
<td>Final Evaluation</td>
<td>Last Wednesday at site</td>
<td>• Meeting between student and preceptor to review the final summative evaluation data</td>
</tr>
<tr>
<td>Information Mastery Assignment</td>
<td>End of the fourth week</td>
<td>• Student submits through blackboard and it is graded by a medical librarian&lt;br&gt;  • Student discusses it with preceptor (optional but encouraged)</td>
</tr>
<tr>
<td>MCQ Exam</td>
<td>Last Friday of Clerkship</td>
<td>• Family Medicine Shelf Examination</td>
</tr>
<tr>
<td>Clinical Exam</td>
<td>Last Friday of Clerkship</td>
<td>• OSCE examination and progress note at BUSM</td>
</tr>
<tr>
<td>Clinical Evaluation</td>
<td>Submitted by preceptor within two weeks of rotation’s end</td>
<td>• As the preceptor, you should provide us with the raw data on the student’s clinical skills.&lt;br&gt;  • We will process the data you provide us on the clinical evaluation form, and will combine it with the student’s scores on the core grade components to determine the final “word” grade.&lt;br&gt;  • If the student has worked with other physicians or providers, you should collect feedback and evaluation data from those providers, and collate it into the final clinical evaluation (proportional to how often the student worked with each preceptor) to be submitted to the clerkship staff.</td>
</tr>
<tr>
<td>Compilation of Final Grade</td>
<td></td>
<td>The Clerkship Director will submit a final grade with narrative comments to the Registrar’s office.</td>
</tr>
</tbody>
</table>

**HOW MUCH EACH PART OF YOUR GRADE IS WORTH:**

<table>
<thead>
<tr>
<th>Component</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Grade</td>
<td>52%</td>
</tr>
<tr>
<td>Shelf/Exam Percentage</td>
<td>30%</td>
</tr>
<tr>
<td>“Other” Components Percentage</td>
<td>18%</td>
</tr>
</tbody>
</table>

**HOW YOUR FINAL WORD GRADE IS CALCULATED:**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Honors</td>
<td>87 – 100</td>
</tr>
<tr>
<td>High Pass</td>
<td>80 – 86.9</td>
</tr>
<tr>
<td>Pass</td>
<td>60 – 79.9</td>
</tr>
<tr>
<td>Fail</td>
<td>&lt; 60 OR &lt;50% Clinical grade OR &lt;5%tile shelf</td>
</tr>
</tbody>
</table>

**SHELF/EXAM GRADING**

Exam minimum passing (percentile/2 digit score) 5%tile (first quartile stats)/60

**What is “Other” and what percentage is it worth?**

<table>
<thead>
<tr>
<th>Component</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Mastery Assignment</td>
<td>4%</td>
</tr>
<tr>
<td>Home Visit Report</td>
<td>2%</td>
</tr>
<tr>
<td>OSCE Interview</td>
<td>8%</td>
</tr>
<tr>
<td>OCSE Progress Note</td>
<td>4%</td>
</tr>
</tbody>
</table>

**Other components that need to be completed in order to pass the clerkship**

- Patient log
- FOCuS forms
- Duty Hour Logs
- Demonstrate competency in the advanced clinical skills taught and assessed during the clerkship
- Submit all required documentation, quizzes and paperwork

**Standard Clerkship Clinical Grade Procedures/Policies**

- Preceptors will provide clinical evaluations that contain the “raw data” on the student’s clinical performance. Preceptors DO NOT determine the final “word” grade. You are encouraged to regularly ask for specific behaviorally-based feedback on your clinical skills from your preceptors. However, do not ask them what word grade you will get, as that is a multifactorial process of which the clinical evaluation is one component.

- The CSEF form will be used to numerically calculate your clinical grade: 1 to 4 points (depending on which box is checked) for each of the 13 items for a total of 52 possible points. Each CSEF will be weighted based on how long the student worked with each evaluator.

- Primary preceptors at sites with multiple preceptors will collect evaluation data from the other clinicians with whom the student works. The primary preceptor will collate this data, and submit the final clinical evaluation.

**BUSM Professionalism Statement**

Evaluation of a medical student’s performance while on a clinical clerkship includes all expectations outlined in the syllabus and clerkship orientation as well as the student’s professional conduct, ethical behavior, academic integrity, and interpersonal relationships with medical colleagues, department administrators, patients, and patients’ families. Any lapses in professionalism may result in a loss of up to 3% of the total possible clerkship points regardless of performance in other areas of the clerkship. Any professionalism lapses resulting in a loss of clerkship points will require narrative comments by the clerkship director in the professionalism comment section of the final evaluation and a discussion with the student.
Clerkship Failure and Remediation Policies/Procedures

- A score of 1-1.9 (averaged score across evaluators) in any CSEF domain, may result in failure of the clerkship
- Students who fail the shelf examination can re-take it. Students who fail the re-examination must repeat the entire Family Medicine Clerkship

* More information about feedback and evaluation is included in the next section.
GOALS OF THE CLINICAL CLERKSHIP
During the clinical clerkships at BUSM, we aim to create a learning climate where students have the opportunity to learn high quality clinical skills by:

· Creating a culture that challenges and supports the students
· Providing opportunities for meaningful involvement in patient care with appropriate supervision
· Role modeling by exemplary physicians
· Coaching students by setting clear expectations, providing frequent observations of core clinical skills, asking questions to assess knowledge and reasoning, explicitly modeling and providing timely, specific feedback

CLERKSHIP STRUCTURE
Each clerkship is run by a clerkship director. Each clerkship clinical site is run by a clerkship site director who ensures that students are appropriately supervised. In addition, clerkships usually have multiple clinical faculty that have varying degrees of exposure to the student.

OVERALL RESPONSIBILITIES

Clerkship Director/Assistant Clerkship Director
1. Oversee the design, implementation, and administration of the curriculum for the clerkship
2. Create and maintain an appropriate learning environment, modeling respectful and professional behaviors for and toward students
3. Ensure student and faculty access to appropriate resources for medical student education
4. Orient students to the clerkship, including defining the levels of student responsibility necessary for required diagnoses and procedures
5. Oversee teaching methods (e.g. lectures, small groups, workshops, clinical skills sessions, and distance learning)
6. Develop faculty involved in the clerkship
7. Evaluate and grade students
   a. Develop and monitor assessment materials
   b. Use required methods for evaluation and grading
   c. Assure mid-clerkship meetings and discussion with students
   d. Ensure students are provided with feedback on their performance
   e. Submit final evaluations for students via E*Value
8. Evaluate faculty and programs via peer review and reports from the Office of Medical Education and national reports
9. Support each student’s academic success and professional growth and development, including working with students experiencing difficulties
10. Participate in the BUSM clerkship EQI and peer review processes
11. Ensure LCME accreditation preparation and adherence
12. Adhere to the AAMC-developed guidelines regarding Teacher-Learner Expectations
Clerkship Coordinator
1. Support the clerkship director in the responsibilities provided above
2. Create and maintain an appropriate learning environment, modeling respectful and professional behaviors for and toward students
3. Maintain student rosters and clinical schedules
4. Coordinate orientations and didactic sessions
5. Liaise with site directors and administrators to coordinate student experiences across all sites
6. Verify completion of clerkship midpoint and final evaluations for each student
7. Monitor students’ reported work hours and report any work hours violations to the clerkship director
8. Coordinate and proctor clerkship exams

Clerkship Site Director
1. Create and maintain an appropriate learning environment, modeling respectful and professional behaviors for and toward students
2. Orient students to the clinical site
3. Sets student expectations for clinical encounters and discusses student role and responsibilities
4. Supervises students by observing history taking, physical exam skills and clerkship specific required observations.
5. Ensures formative feedback in an appropriate and timely fashion
6. Delegates increasing levels of responsibility
7. Meets with the student for the Mid-clerkship review
8. Meets with the student for the final exit meeting
9. Recognize students who have academic or professional difficulties and communicate this to clerkship leadership
10. Collects feedback and evaluation data from all physicians who work with the student
11. Evaluates students fairly, objectively and consistently following medical school and department rubrics and guidelines
12. Ensure student and faculty access to appropriate resources for medical student education
13. Adhere to the AAMC-developed guidelines regarding Teacher-Learner Expectations

Primary Clinical Faculty/Residents
1. Set and clearly communicate expectations to students
2. Supervise students by observing history taking and physical exam skills, and document it on the FOCuS (Feedback based on Observation of Clinical Student) Form
3. Delegate increasing levels of responsibility to the student within clerkship expectations
4. Maintain appropriate levels of supervision for students at site.
5. Create and maintain an appropriate learning environment, modeling respectful and professional behaviors for and toward students
6. Recognize student learning or professional difficulties and communicate to clerkship director directly in real time in person or via email or phone
7. Give students appropriate and timely formative feedback
8. Assess students objectively using the CSEF form
9. Adhere to the AAMC-developed guidelines regarding Teacher-Learner Expectations
ORIENTATION OF THE STUDENT TO THE CLINICAL SETTING

This sets the tone for the rest of the experience and has a direct effect on the success of the rotation for both student and preceptor. It can also reduce student anxiety. You should:

- Orient the student to the clinical setting, the staff, and team at your site
- Review workflow
- Discuss student’s learning experiences to date
- Discuss student’s learning goals

SETTING EXPECTATIONS FOR THE STUDENT

It is important to be clear regarding your expectations for the student. On the first day, describe the expectations around their role, presentations, documentation, and participation. Consider reviewing the assessment form and the specific expectations described. A tool to help set expectations with the student is the One Minute Learner, which can be found at: http://www.stfm.org/NewsJournals/EducationColumns/Mar2013

SUPERVISING THE STUDENT

Initially, the primary clinical faculty members should designate time to observe the student performing: history taking, focused physical exam, clinical problem-solving and interaction with patients and patient education. Once the supervisor establishes the student’s level of confidence and competency, the student should be delegated increasing levels of responsibility in patient care, as appropriate. Although students may initiate a particular patient encounter on their own and without direct supervision, the faculty must at some point review the encounter with the student and inform the patient in-person that the student’s assessment and management plan has been reviewed and approved by the faculty. The faculty is ultimately responsible for the evaluation, treatment, management, and documentation of patient care.

Under no circumstances should the following occur:

- Patient leaves the office/hospital with never having had a direct face-to-face encounter with clinical faculty.
- Primary faculty gives “prior approval” for student to perform intervention (order labs, prescribe meds) without satisfactory review.
- Patient leaves office/hospital without being informed that assessment/management plan has been directly reviewed and approved by the faculty.
- Learning in which a student is expected to perform an intervention or encounter without the prerequisite training and/or adequate supervision.
- Student note provides the only record of the visit. Although all faculty see all patients, faculty must document that they were actually the person responsible for seeing and examining the patient.
Federal Guidelines for documentation

**CMS Guidelines from February 2, 2018, state:**

- “The Centers for Medicare & Medicaid Services (CMS) is revising the Medicare Claims Processing Manual, Chapter 12, Section 100.1.1, to update policy on Evaluation and Management (E/M) documentation to allow the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work. Students may document services in the medical record. However, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work.”

**EMR Documentation**

- Students are allowed and encouraged to write complete notes in patient electronic charts as designated by the site and the site’s documentation policy.

**SUPERVISION AND DELEGATING INCREASING LEVELS OF RESPONSIBILITY**

It is expected that the level of student responsibility and supervision will be commensurate with student’s competency and level of confidence. When the student arrives in your practice, you may wish to have them observe you or the resident for the first session. Thereafter, they should begin to see patients on their own. In the outpatient setting, the student should initially perform 4-5 focused visits per day in the first week, increasing to 6-12 thereafter. In the inpatient setting, the student should initially follow 1-2 patients and increased to 3-4 thereafter. When a student feels that he or she is being asked to perform beyond his or her level of confidence or competency, it is the responsibility of the student to promptly inform the preceptor. It is then the preceptor’s responsibility to constructively address the student’s concerns and appropriately restructure the teaching encounter to address the student’s learning needs.

**STUDENT ASSESSMENT**

**BUSM CLINICAL STUDENT EVALUATION FORM (CSEF):** BUSM utilizes the same clinical evaluation form for all clinical rotations. It is a behaviorally based evaluation tool. This means that you will grade your clerk based on his or her knowledge/skills/attitudes, rather than how he or she compares to other students.

For example, under “Differential Diagnosis Skills”:

There is a target behavior listed. Following that are the four behavioral anchors. The highest level is the box to the far right, and the lowest to the far left. Your job is to check the box with the behaviors that the student is consistently performing.
For more detail, please refer to CSEF form.

FEEDBACK

Feedback is vital for student learning and growth and should be given regularly. Feedback during a clerkship should be given multiple times which include: real-time feedback during patient care, recap feedback at the end of the session/day and summative feedback at the mid and end of the rotation. The FOCuS (Feedback based on Observation of Clinical Student) forms required for each clerkship provide formative assessment through direct observation of CSEF behaviors. FOCuS forms required for that clerkship must be completed for each student by the end of the rotation (See Appendix A for an example). The BUSM Formative Assessment and Feedback Policy can be found here:
Best practices regarding feedback include:

● Start with getting the student’s perspective on how they performed or are performing.
● Feedback should be specific and actionable. What could the student do differently next time?
● Feedback should be based on direct observation, i.e. what you have seen.
● Feedback should be timely (in close proximity to when you observed a behavior).
● Feedback should be respectful and encourage future growth.

EARLY RECOGNITION OF LEARNING PROBLEMS

The clerkship director and the medical school are committed to providing additional educational support as required for the student’s successful completion of the program. The clerkship director should be notified as soon as possible if the preceptor and/or student identify significant deficiencies. This will allow for supportive interventions to be implemented prior to the end of the clerkship.

If a primary faculty is concerned that the student may be at risk of receiving an unsatisfactory rating in ANY category, this information should be shared with the student face-to-face as soon as possible, and certainly during the mid-clerkship evaluation. Once informed, the student may wish to obtain additional academic assistance from the clerkship director and support personnel. Identifying potential problems early on allows the student the opportunity to enhance performance prior to the end of the clerkship. Faculty should also feel free to contact the clerkship director if learning difficulties or related problems are identified at any time. However, in fairness to the student, the primary faculty should also inform the student of the problem at that time.

MID ROTATION MEETING

The clinical faculty/site director should sit privately with the student at the mid-point in the rotation to give feedback. It is highly recommended that the faculty working directly with the student complete a copy of the Clinical Student Evaluation Form (CSEF) before the meeting, and then directly address each item on the CSEF with the student to provide more detailed feedback about how they are performing. Feedback for the student, including strengths and areas that need improvement should be reviewed (See Appendix B).
The site director/clerkship director and the student are required to complete the **BUSM Mid-clerkship Evaluation form** for the mid rotation meeting. Learning goals for the latter half of the clerkship should be discussed. The student’s patient log should be reviewed and a plan should be made for remediation of any deficiencies (e.g. strategizing how the student could see a patient with that clinical condition, discussing opportunities to complete the requirement with an alternative experience, etc) The student should update and review the summary statistics of their duty hour log and patient log before their meeting with you. FOCuS forms should also be reviewed (Appendix A).

**FINAL GRADE AND NARRATIVE COMMENTS**

On the last day at the site, the site director and student are to meet for 15-30 minutes to review the final Clinical Student Evaluation Form. This session should allow for an important educational interchange between the clinical site director/faculty and the student. We strongly suggest that evaluations from other faculty and residents with whom the student has worked be collected, and that the evaluation form be completed by the site director **PRIOR TO** the meeting with the student if at all possible. This information is very important to students and is best reviewed with them directly. If you are unable to complete the evaluation form before the final interview, please submit it no later than one week after the end of the clerkship block. It should reflect as closely as possible the substance of your discussion with the student. The narrative portion of the form is especially important.

The comments sections of the CSEF are very important. The more specific you are, including examples, the more helpful the evaluation is to the student and the medical school. The **summative** comments get put in the students’ Dean’s letters that go out to residency programs- so having accurate, detailed information is very helpful. This box is where you should put what you observe about the student, trying to highlight their strengths and specifics of their performance. The second box is for **areas for improvement**. These are comments that are not included in the Dean’s letter. These are the constructive comments for the student- areas to work on, ways they can grow. We encourage every preceptor to provide information to the student in this section so that the student can have direction in what they need to work on in the future.

**Example Narrative Comments:**

This is an example of the type of summative comments that the medical school is looking for from one of our sites: (the student’s name has been replaced to maintain their anonymity)

“Rocco did an excellent job during his Family Medicine Clerkship. He is able to develop rapport with patients very quickly and meaningfully. He avoids medical jargon when speaking to patients. He is able to identify the patient’s major problems and reason through the most likely diagnosis. His physical exams skills are accurate. He should continue to think about his differential when completing his exam. He generates well thought out differential diagnoses and is able to routinely provide a rationale for his most likely diagnosis. By the end of the rotation, Rocco was able to discuss parts of the plan with the patient and do some brief..."
patient education on nutrition and exercise. His progress notes were always appropriate, well organized, timely, and complete. His case presentations were organized, focused and complete. Rocco demonstrated a solid fund of knowledge right from the beginning and was able to answer questions. He should continue to explore the use of point of care resources in the clinical setting. He exhibited a very calm and professional manner when working with patients, putting them at ease and allowing for more effective and empathetic communication. He was active in the learning process. He routinely identified what he wanted to learn from the rotation and continued to work on those items up to the very last minute of the rotation. He exhibited a professional attitude towards the clinic staff and patients.

HOME VISIT

Certain clerkships have home visits. Primary faculty need to provide complete instructions regarding the home visit and expectations for the student. See Appendix D for the FM Home Visit Requirements.

Home visit safety

Student and patient safety is a priority for home visits. Students are required to go to their home visit with another student or clinician (MD, NP, RN, Resident, etc). At no time should a student participate in an experience where they are in danger or feel uncomfortable. Please assist the student in finding an appropriate patient for their home visit with respect to educational, patient care, logistical, and safety goals. Students are encouraged to talk with their preceptor or the clerkship director if they have questions or concerns at any point. The student should notify the primary preceptor or a designated staff member of the date and location of their home visit before they go to the patient’s home.

IMPORTANT CLERKSHIP POLICIES

Attendance Policies

On-site hours must be limited to 80 hours per week, averaged over a two-week period. Violations should be reported directly to the clerkship director or to an Associate Dean (Medical Education or Student Affairs). Time off requests must comply with the Attendance & Time Off Policy.

- Work Hours: http://www.bumc.bu.edu/busm/education/medical-education/policies/work-hours/
- Core Clerkship Personal Days Policy: http://www.bumc.bu.edu/busm/education/medical-education/policies/personal-days-policy/
**Appropriate Treatment in Medicine**
Boston University School of Medicine (BUSM) is committed to providing a work and educational environment that is conducive to teaching and learning, research, the practice of medicine and patient care. This includes a shared commitment among all members of the BUSM community to respect each person’s worth and dignity, and to contribute to a positive learning environment where medical students are enabled and encouraged to excel.

BUSM has a ZERO tolerance policy for medical student mistreatment. Students who have experienced or witnessed mistreatment are encouraged to report to the Appropriate Treatment in Medicine Committee (ATM), Dr. Robert Vinci at Bob.vinci@bmc.org


**Boston University Sexual Misconduct/Title IX Policy**

**Needle Sticks and Exposure Procedure**
FOCUS: Feedback and Observation of Clinical (UME) Students

DOCUMENTATION

Please review student’s documentation and provide them with feedback based on the behaviors listed below:

- Ask student about specific areas they want to work on or areas you should focus your review/feedback
- Encourage student assessment
- Describe specific behaviors - use CSEF language below as prompts

### Target Behaviors

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Check if observed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Documents history and physical exam in a complete, accurate and organized fashion</td>
<td></td>
</tr>
<tr>
<td>2) Independently (not cut and pasted) completes note in a timely fashion</td>
<td></td>
</tr>
<tr>
<td>3) Write-up is focused around the primary problem</td>
<td></td>
</tr>
<tr>
<td>4) Problem list is appropriately documented and prioritized</td>
<td></td>
</tr>
<tr>
<td>5) Documents a well-developed synthesis statement (that includes a commitment to a leading diagnosis and/or a do not miss diagnosis)</td>
<td></td>
</tr>
</tbody>
</table>

### Reach Behaviors

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Check if observed</th>
</tr>
</thead>
<tbody>
<tr>
<td>6) Displays diagnostic reasoning using pertinent positives and negatives and key findings that imply the differential in the history, physical and assessment</td>
<td></td>
</tr>
<tr>
<td>7) Clinical reasoning is clear, logical and convincing</td>
<td></td>
</tr>
<tr>
<td>8) The note concisely emphasizes relevant data; integrates data from all relevant sources (EMR, other facilities, caregiver)</td>
<td></td>
</tr>
<tr>
<td>9) The note incorporates evidence-based data</td>
<td></td>
</tr>
</tbody>
</table>

☐ I directly observed this student
☐ I provided verbal feedback to the student

**Student Reflection** - What would you change or do differently?
Next steps for student growth developed in collaboration with student (please use above behaviors as guide)

1.
2.
3.
**MID-CLERKSHIP EVALUATION FORM**

Student Name: ________________________________
Faculty Reviewer: ________________________________

During the Mid-Clerkship Meeting, faculty and student should meet, complete, discuss, and sign the Mid-Clerkship Review form (this paper) by week 2 on a 4 week clerkship, week 3 on a 6 week clerkship and week 4 on an 8 week clerkship.

**Step 1:** Faculty please complete a Mid-Clerkship CSEF, review each domain with the student and provide feedback and/or review completed FOCuS Forms with the student.

**Step 2:** Please review student’s required patient encounter log, duty hour log and their FOCuS forms

**PATIENT LOG (REQUIRED DIAGNOSES and PROCEDURES)**
Required patient encounters remaining:
Plan and timeline for completion or alternative experiences:

**FOCuS FORMS** Review complete: Yes ☐ No ☐
Direct Observation and Feedback Forms Remaining:
Plan and timeline for completion:

**DUTY HOUR LOG** Review complete: Yes ☐ No ☐

**Step 3:** Written feedback

List AT LEAST 2 SPECIFIC student strengths and comments on their performance (List behaviors, skills, etc.)

List AT LEAST 2 SPECIFIC items to work on during the second half of the clerkship (discuss action plan with student):
Please provide feedback on professionalism:

**Step 4: Action Plan**

**Students:** Write 3 learning goals for the rest of the rotation based on the feedback you received and discuss them with your faculty reviewer

1. 

2. 

3. 

Student signature ____________________________

Faculty signature ____________________________

Clerkship director signature__________________
(if not the same as above)
Purpose: To outline appropriate preventative measures and what to do in case of unprotected exposure to body fluids.

Covered Parties: Medical students.

Procedure:

To prevent exposure to potentially infectious materials, students must use standard precautions with all patients and when performing any task or procedure that could result in the contamination of skin or clothing with blood, body fluids, secretions, excretions (except sweat), or other potentially infectious material, regardless of whether the those fluids contain visible blood.

Standard precautions are to be observed to prevent contact with blood or other potentially infectious materials. ALL body fluids are considered potentially infectious materials. All students are responsible for their personal safety and the safety of their teammates. Students should follow safe practices when handling sharps. Students must use appropriate personal protective equipment such as, but not limited to, gloves, gowns, laboratory coats, face shields or masks and eye protection, and mouthpieces, resuscitation bags, pocket masks, or other ventilation devices.

Standard Precautions include:

- Hand hygiene
- Eye and face protection
- Use of gowns and gloves
- Sharps management

Additional “Transmission Based Precautions” must be used in addition to standard precautions for patients with known or suspected infection or colonization with highly transmissible or epidemiologically important pathogens.

In the event of a needle stick or any unprotected exposure to blood, bloody body fluids, or other potentially infectious material, either in a lab or a clinical setting you should:

- Wash the exposed area and perform basic first aid
- Notify your supervisor – resident or faculty – of the occurrence and that you are leaving to seek care immediately.
- Get evaluated immediately: it is extremely important to receive counseling regarding the risk of acquiring a communicable disease. If indicated, prophylaxis should be started right away, usually within one hour.

If you are at Boston Medical Center
BMC’s Occupational Health clinic during working hours or the BMC Emergency Department after hours and on weekends

**Location**

The Working Well Occupational Health Clinic is located:
Doctor’s Office Building (DOB 7) – Suite 703
720 Harrison Ave, Boston MA 02118
**Telephone:** 617-638-8400
**Pager:** 3580
**Fax:** 617-638-8406
**E-mail:** workingwellclinic@bmc.org
**Hours:** Monday-Friday, 7:30a.m. – 4:00p.m.

- Tell the receptionist you have had an unprotected exposure (needle stick), and you will be fast-tracked into the clinic.
- A counselor will discuss post-exposure prophylaxis with you
- DO NOT DELAY!

BMC’s Occupational Health will notify the Office of Student Affairs of exposures occurring at BMC within 48 hours. These situations can be very stressful and we are here to help. To speak to a dean immediately about the incident, please page the dean on duty by calling (617) 638-5795 and sending a page to #4196 or sending a text page to pager #4196 through the pager directory.

If you are at a non-Boston Medical Center site

Immediately check with your supervising physician about the site-specific needle-stick protocol
- If the site has its own emergency room or occupational health you will be directed to go there
- If the site does not have its own emergency room or occupational health, you will go to the nearest emergency room
- DO NOT DELAY!

Coverage for provided services is included in the Aetna student health insurance plan offered by the University. In the event that you do not have Boston University School of Medicine health insurance (Aetna), you must contact your carrier and determine the level of services covered. Submit any billing received to your insurance company. The OSA will provide reimbursement for out-of-pocket co-pays. We strongly encourage you to keep your health insurance card in your wallet at all times.

For questions regarding this policy please contact Dr. John Polk, the assistant dean in charge of post-exposure management, or Dr. Angela Jackson, Associate Dean of Student Affairs. Drs. Jackson and Polk can be reached in the Office of Student Affairs (617-358-7466).

Last revision: June 2018

*Adapted from the Family Medicine's Preceptor Manual, written by Miriam Hoffman, MD and Molly Osher-Cohen, MD
Updated 4/2018, 5/2019 Medical Education Office*
Family Medicine Home Visit and Report Guidelines

During the clerkship you will complete a home visit to a patient with a chronic medical condition. Your preceptor will help you choose an appropriate patient.

Home visit: The goal of the home visit is to focus on the impact of the medical problem on the patient and the family. Accordingly, patients appropriate for home visits are those whom you have seen, and who have an acute or chronic illness that has some significant impact on the patient’s life, or is likely to in the future. Generally, visiting and talking with a patient with a chronic illness (heart disease, cancer, arthritis, pulmonary condition, etc..) is particularly valuable. You are especially encouraged to see elderly patients. The following guidelines may be useful in arranging and conducting the visit:

The student can either ask permission for a home visit at the time the patient is seen in clinic, or may call the patient at home. Directions and best time of day for an appointment should be determined.

For safety purposes, students are required to go in pairs or go with a clinician. Students are advised to exercise caution and common sense with respect to personal safety. The location/neighborhood of the patient’s dwelling should be reviewed with your preceptor or other clinic staff to make an assessment as to whether or not safety is a concern. If, upon arrival at the patient’s dwelling, the student has any concern for their personal safety, the student should return to the clinic. Please see the Home Visit Safety Policy.

The interview may take from 1-2 hours, and the student may also wish speak to other family members either at the same visit, or on another occasion, regarding the impact of the illness on the family and patient.

While the preceptor can guide the selection of likely patients, it is the responsibility of the student to make the contact and arrangements for the visit.

For more information on home visits please read the AAFP article on House Calls by Unwin and Tatum which you will find on Blackboard in the Home Visit section.

Home Visit Report: You should complete the Home Visit Report based on the information you learn about your patient. This report includes the patient’s genogram.

You should give a copy of the report to your preceptor, and hand in a copy to the Department on final exam day. The information you obtain is often of great value to the physician. Your preceptor can also provide you with feedback, prior to submitting the completed report.

Do not include identifying information (such as name) in the copy of the report that you hand in on final exam day.

Genogram: Read the article by Ian Waters, et.al. which describes the utility of genograms and how to do them. This article is on Blackboard in the Home Visit section. Your ICM Handbook also has an excellent genogram description in its Appendix. Construct a genogram on the patient spanning at least three generations. It should include important medical and social elements. It need not be all-inclusive.
**Presentation:** Many sites will ask you to present your report to the faculty and staff at your site towards the end of the rotation. This is not a very formal presentation. It should be arranged through your preceptor and it should illustrate an understanding of 1) what you have learned from the case, 2) the importance of the family context of the patient and the patient’s care, and 3) an understanding of preventive medicine. You and your preceptor should determine how much time is appropriate for the presentation. You can organize your presentation to make clear the following:

* how you initially thought about the case;
* your initial encounter with the patient and brief medical history and description of the illness;
* your account of the home visit, as described above;
* how illness impacts the patient’s ability to function
* presentation of the genogram (if manageable);
* discussion of the preventive measures that are employed, or might be;
* what you learned from the case about approaching similar clinical problems when they present in other patients.

Be sure to allow time for questions and interaction with your listeners.
Chronic Medical Condition Home Visit Report

Student Name________________________
Patient Name ________________________
(Don’t include patient identifiers in the copy handed into the clerkship.)
Date of Visit _________________________

Reason for visit/patient concerns:

Past Medical History:

Impairments/Immobility

Evidence of cognitive impairment  Yes___ No___ Uncertain___

Functional Assessment
Activities/recreation _________________
Satisfied with daily activities  Yes___ No___
Drives  Yes___ No___
Knows how to dial 911 in emergency  Yes___ No___
Knows how to contact health care providers  Yes___ No___

Katz Index of Activities of Daily Living
I, independent;  A, assistance;  D, dependent

1. Bathing (sponge, shower, or tub):
2. Dressing
3. Toileting
4. Transfer
5. Continence
6. Feeding

OARS Instrumental Activities of Daily Living
I, independent;  A, assistance;  D, dependent

1. Telephone
2. Travel
3. Shopping
4. Meal preparation
5. Housework
6. Laundry
7. Medication
8. Finances

Adapted from the Family Medicine's Preceptor Manual, written by Miriam Hoffman, MD and Molly Osher-Cohen, MD
Updated 4/2018, 5/2019 Medical Education Office
Demonstrates Advanced Activities of Daily Living

1. Employment/Volunteering:
2. Reading:
3. Music:
4. Hobbies:
5. Socialization:
6. Other:

Fall History
Falls?  Y____  N____
Assistive device ______
Number of falls since last visit ____
Is patient at risk of falls? (check all that apply)
- gait instability
- fear of falling
- vision problems
- hearing problems
- cognitive deficits
- ETOH abuse
- foot problems
- neuro problems
- cardiac problems
- polypharmacy
- orthostasis
- chronic kidney disease
- unsafe environment
- fracture risk
- prolonged down time

Sensory impairments (Y/N – and if Y please expand):
Hearing
Vision
Smell
Taste
Tactile

Nutrition
Eating Habits:

Variety and quality of foods:
- Pantry:
- Refrigerator:
- Freezer:
Nutritional status:
- Obesity:
- Malnutrition:
- Other:
Fluid intake:
Do you have enough money to buy food?
Do you have a hard time chewing or swallowing food?
Oral health

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Home Environment

Neighborhood:

Exterior of Home:

Interior of Home (check all that apply):
Crowding
Good housekeeping
Hominess
Privacy
Pets
Books
Television
Memorabilia
Internet
Information and communication technology

Other People

Caregiver? Y____ N____

If yes, who? ____________
   Tasks: ____________
   Hours of caregiving per day:_____
   Stress? ____________
   Coping? ____________
   Need for respite? ______
   Physically or emotionally capable? _____

Informal supports
Family members:
Living arrangements:
Other supports
---friends
---pets
---religious or spiritual

Advance Directives
Health Care Proxy:
Medications

Medication Review
List the names and dosages of medications, including over the counter medications, supplements, herbs, etc.

Medication / Dosage

| ________________ | ________________ |
| ________________ | ________________ |
| ________________ | ________________ |
| ________________ | ________________ |
| ________________ | ________________ |

Yes ___  No___ Are there multiple prescribers?

Yes ___  No___ Are medications organized?

Yes ___  No___ Are medications being taken in accordance with instructions on bottles?
   If no, why not? ________________________________

Yes ___  No___ Is patient taking alternative medications? (Herbs, minerals, etc.)
   If yes, what are they? ________________________________

Yes ___  No___ Is patient taking medications prescribed for another person?

Yes ___  No___ Are there medications that are ineffective or not indicated?
   If yes, what are they?

<table>
<thead>
<tr>
<th>Medication</th>
<th>Side effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>___________</td>
<td>___________</td>
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<tr>
<td>___________</td>
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</tbody>
</table>

Examination

General physical condition:

Gait:

Oriented x3  Yes___ No___

PHQ9 or Geriatric Depression Scale depending on patient’s age (65+ use Geriatric depression scale, <65 use PHQ-9)
See Appendix
Safety social/spiritual and services

Environmental Safety Assessment
Yes ___ No ___ Are stairs well lit?
Yes ___ No ___ If there is carpet, is it secure?
Yes ___ No ___ Are there hazards to walking such as loose carpets, cords or objects on the floor?
Yes ___ No ___ Are bathrooms safe?
Yes ___ No ___ Are there hand holds?
Yes ___ No ___ Can the toilet seat be raised if needed?
Yes ___ No ___ Does the shower or bath tub have a non-slip surface?
Yes ___ No ___ Is the floor slick?
Yes ___ No ___ Are electrical cords frayed?
Yes ___ No ___ Does the smoke detector work?
Yes ___ No ___ Is there a fire extinguisher?
Yes ___ No ___ Is furniture sturdy and balanced?
Yes ___ No ___ Are emergency numbers near the phone?
Yes ___ No ___ Is there an emergency plan?
Yes ___ No ___ Does the heat and AC work?
Yes ___ No ___ Is the kitchen adequately stocked?
Yes ___ No ___ Is there evidence of burned pots?
Yes ___ No ___ Do the stove and refrigerator work?
Yes ___ No ___ Is there a neighbor to check in?

Abuse/neglect screening
Is afraid of someone
Has been threatened/scolded/hurt
Has had something taken without being asked
Has been touched without giving consent
Has been made to sign papers he/she has not understood
Is alone a lot
Someone has failed to help take care of him/her

Education level:

Working history:

Substance use:

How do your medical problems affect your life?
Spiritual health (or cultural and ethnic influences):

**Services** (check all that apply)
Transportation to appointments
Community services agency
Home services
- homemaker
- personal care attendant
- home delivered meals
- laundry service
- shopping service
- money manager
Certified Home Health Agency
Adult Day Health
Assisted Living
Rest home
Hospice
Adult Foster Care
Adult protective Services
Other

**Impression** Please write a brief description of this patient as a person. Discuss the impact of illness on function. Use all of the information you collected and apply it to your assessment of the patient. Discuss their home environment and social supports. Include special talents/interests or challenges that this person faces.

**Complete a Genogram for your patient**